Alaska Department of Health and Social Services (DHSS)

Behavioral Health Performance Review

September 29, 2015

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EXECUTIVE SUMMARY

The Alaska Division of Legislative Audit (DLA) engaged Public Consulting Group, Inc. (PCG) to conduct a performance review of the Alaska Department of Health and Social Services (DHSS or "the Department") behavioral health services. PCG has considerable experience conducting system studies and evaluations for government agencies across the country, including financial and programmatic reviews of behavioral health and long term care programs. This performance review was authorized in accordance with Chapter 19 SLA 2013. Results of the analysis are to be included in a report to the Alaska Legislative Budget and Audit Committee (LBAC).

DHSS is a complex organization with eight operating divisions and a Fiscal Year (FY) 2015 budget of approximately $2.6 billion, of which $1.3 billion is funded by state general funds (GF) and $1.3 billion by federal funds. Its behavioral health programs are administered primarily by the Division of Behavioral Health (DBH or "the Division"), but service components that impact the behavioral health system can also be found in other program units throughout the Department. The Division of Health Care Services (HCS) and Public Assistance (DPA) also play an administrative role in limited aspects of the delivery system.

PCG was tasked with 13 distinct review objectives spanning all facets of the Department's behavioral health system. The study began in November 2014 and encompasses reviews of available reports and budget documents, five years of Alaska behavioral health service utilization and financial data, peer state and nationwide best practice benchmarks, site visits to behavioral health provider and agency offices throughout the state, and meetings with stakeholders throughout the different state, veteran, and tribal behavioral health systems serving Alaska.

PCG interviewed over 100 system stakeholders, including state officers within DHSS, the Department of Corrections (DOC), and the Alaska Court System (ACS), as well as behavioral health providers, consumers and consumer advocates, and other community leaders. PCG's team members visited sites in every region of the state, including Alaska's three metropolitan areas of Anchorage, Juneau, and Fairbanks, but also smaller hub communities in Kenai, Soldotna, Dillingham, Bethel, and Kotzebue. PCG also participated remotely in public meetings held in Juneau, Anchorage, and Fairbanks.

This report represents the culmination of PCG's work on this performance review. The report provides the results of PCG's research, utilization and cost studies, and service analyses that inform the final recommendations presented here.

In order to complete the project successfully, PCG worked closely with staff from DLA and DHSS. PCG is indebted to the positive relationship and information supplied by these parties, as well as the candor of discussions about the Department's accomplishments and challenges. Aside from the helpful collaboration among these partners in identifying key stakeholders and specific departmental expertise, along with disseminating detailed and comprehensive data about the services administered by the Department, the information presented, analyses conducted, and recommendations offered in this report represent PCG's

independent judgment and conclusions regarding the performance review of DHSS behavioral health services.

This Executive Summary provides an overview of PCG's findings and recommendations for each of the 13 review objectives identified by DLA for PCG's investigation. Our findings for each individual review objective are summarized in a brief narrative, followed by specific recommendations where applicable.

Review Objective 1: Comprehensive Overview

PCG was tasked with providing a comprehensive overview of the Department's behavioral health system and making recommendations for how to improve the tools used by the Department for reporting the financial and service structure of the DHSS behavioral health system to the Legislature.

The Department funds and operates a wide array of behavioral health programs to ensure that Alaskans across the state have access to the full continuum of mental health and substance abuse services required to promote wellness and recovery. This array of services extends across the lifespan of the consumers needing care, from Fetal Alcohol Spectrum Disorders (FASD) prevention to mental health services for the aging population. Ranging from prevention to inpatient psychiatric hospitalization, the behavioral health services funded and delivered by DHSS also span a wide range of intensity. The Department strives to provide a comprehensive continuum of care of behavioral health services needed to meet the complex needs of Alaskans.

Alaska's behavioral health network relies on partnership and collaboration among multiple public and private entities. The vast majority of funding and administrative authority for behavioral health services is consolidated within DBH. Eighty-nine percent of State expenditures on behavioral health programs and services are under the purview of DBH. However, DBH works closely with other DHSS divisions, such as the Division of Senior and Disabilities Services (SDS), the Office of Children's Services (OCS), and the Division of Juvenile Justice (DJJ), but also the Alaska Mental Health Trust Authority (AMHTA), the Department of Corrections (DOC), and the Department of Education (DEED). The Division also collaborates with the Alaska Behavioral Health Association (ABHA), the Alaska Association of Homes for Children, the Tribal Behavioral Health Consortium, Tribal Courts, and private behavioral health providers and advocacy groups.

DBH is the direct service provider for a number of community-focused behavioral health prevention and early intervention services. These are low-intensity and high-impact services, reaching large sections of the general population. Community-based treatment and recovery services make up the bulk of the behavioral health services funded by the Department. These services, spanning from outpatient therapeutic counseling and medication services to more intensive case management, living and community supports, are delivered by private service providers, with DBH serving as system administrator.

Inpatient and hospital-based services constitute the highest acuity levels of service along the care continuum, and are also the most expensive services overseen by DBH. The Division is a direct service provider of inpatient psychiatric services at the Alaska Psychiatric Institute (API), but it also funds acute

inpatient psychiatric care through its Designated Evaluation and Stabilization (DES) and Designated Evaluation and Treatment (DET) programs and other psychiatric beds based at private hospitals. API is the only acute care inpatient psychiatric facility for all ages within the state of Alaska and is the nucleus of the inpatient and hospital-based behavioral health treatment system. At the highest intensity pole of the care continuum, DBH also funds long-term residential psychiatric care for children and adolescents, by contracting with Residential Psychiatric Treatment Centers (RPTC) in Alaska and in the Lower 48 states.

The funding and delivery patterns of behavioral health services within Alaska are summarized and reviewed in a number of documents made available to the Legislature. PCG finds that the Division's "budget visualization" of behavioral health funding and programs presents all relevant information regarding cost, volume, and funding sources of behavioral health services. The format of the budget visualization, including both a continuum of care graphic and table of consolidated figures, is effective in that it provides a complete picture of the activities of DBH.[1] Likewise, the Governor's Amended Budget document generally appears to be effective at meeting its intended goal of providing comprehensive budget information on the entirety of DHSS and the relationship between budgetary components and departmental organization and services.

In the following list of recommendations, PCG identifies several improvements that could be made to the current reporting tools that would enhance their ability to summarize the structure and performance of the Department's behavioral health services.

RECOMMENDATION 1.2.3. Reorientation of the order of information on the budget visualization would improve communication of budget details.

RECOMMENDATION 1.2.5. The use of visual aids in the Governor's Amended Budget could be further improved by standardizing the timelines used on these visual elements.

RECOMMENDATION 1.2.6. The presentation of Department challenges and accomplishments in the Governor's Amended Budget would be improved with a discussion of solutions, as well as an assessment of whether accomplishments meet Department goals.

RECOMMENDATION 1.2.7. The Governors Amended Budget could be improved through the inclusion of an introduction and description of programs for each Results Delivery Unit (RDU) that would orient the reader to the detailed information that follows. The inclusion of historical and projection data would also facilitate the evaluation of program elements over time.

[1] A full summary of the services delivered and programs administered by DBH can be found in Section 1.1.

Review Objective 2: Delivery and Administration

In accordance with the legislative questions mandated in this review objective, PCG provided a high-level evaluation of all aspects of the Department's behavioral health services, including types, delivery, funding, and monitoring, determining the extent to which different services along the care continuum are operating effectively and efficiently.

Our review of the overall effectiveness of Department services consisted of an analysis of the delivery system according to three distinct domains of effectiveness: 1) *Structure,* 2) *Access,* and 3) *Quality*. PCG first examined the structural configuration of service types, along with the array of coordinated interactions between different system layers, needed to ensure a seamless care continuum serving a broad range of behavioral health demands and acuities. Although the lack of a "sub-acute" layer of care for adults is the major gap in the service system—and treated at greater length in PCG's discussion of referral and placement policies—we also identified lesser deficiencies in the service continuum of intensive supports, living supports, and community and recovery supports, as well as the paucity of substance abuse services in many regions of the state.

The second domain of effectiveness consisted of an evaluation of the level of access to services, both in terms of the number and characteristics of the individuals served, as well as potential variability in the types of services available to different populations in distinct regions of the state. PCG's discussion of access can be broken down into two parts: 1) an analysis of changes within the service infrastructure that have increased or decreased access to different service types, and 2) an analysis of service utilization trends that connects changes in service capacity to system impacts in the numbers and population characteristics of individuals served.

In the first instance, PCG notes that the Department has successfully introduced new service capacities and more effective types of treatment in some parts of the care continuum, while other parts of the continuum have witnessed a reduction in service capacity. Prominent among the Department's accomplishments has been a rapid growth in the State's telebehavioral health infrastructure, as well as a maturation of the acute and sub-acute services newly available to the youth population in the wake of the successful Bring the Kids Home (BTKH) initiative. On the other hand, lack of financing mechanisms for substance abuse has resulted in several prominent treatment facility closures over the course of the review period. Additionally, in some regions of the state, particularly in the fast-growing Matanuska-Susitna Valley, system effectiveness has become substantially diminished by a lack of basic behavioral health services. The unavailability of appropriate and affordable housing resources continues to be a challenge throughout Alaska. Related to these changes in the system infrastructure, PCG finds that access to services has increased significantly during the review period, but that growth in service utilization has occurred unequally across regions, and disproportionately in mental health over substance abuse, largely as a result of macro trends in behavioral health financing.

The third domain involved a review of the quality of services provided within the system, as measured by the indicators identified in the Department's performance management framework. PCG analyzed three broad classes of performance indicators used by the Department as proxy measures to evaluate its

continuum of acute psychiatric, community treatment, and prevention services. In this domain, PCG finds that, while DBH has demonstrated some important achievements in particular service lines and select interventions, regressive trends have emerged in other areas. On the whole, outcome measures have produced mixed results with system performance and service quality remaining relatively static.

PCG's review of the efficiency of the behavioral health delivery system generated several findings of note. Overall, the pattern of growth in the Department's annual behavioral health budget from 2009 to the present reveals that DHSS is increasingly adept at leveraging federal funding through Medicaid to supplement scarce State general fund dollars to preserve and expand the revenues available to fund services. However, increasing reliance on Medicaid as the dominant source of funds for behavioral health services has led to disparate effects on youth and adult services, fostering different kinds of efficiencies and inefficiencies within the two systems.

Although the Department's overall behavioral health funding has increased from year to year—a trend also reflected in the steady growth of already extremely high per capita expenditures—when these growth trends are broken down by recipient instead of by per capita general population figures, one actually finds a decreasing trend in dollars spent per recipient. The dynamics becomes even more complex when adult and youth community treatment costs are distinguished, exposing a sharp decline in per capita funding available for adults, contrasted by rapid growth in expenditures for children and adolescents.

To some extent, these trends reveal inefficiencies in both delivery systems. On the one hand, expenditures per child grew by 41% between 2009 and 2013, outpacing even the highest rates of medical inflation in Alaska. This growth suggests that Department cost containment efforts have primarily targeted services for the adult population, which have decreased per recipient by over 35% during the same period. The fact that the adult service system was able to serve 50% more consumers in 2013 than 2009, with fewer total funds available, certainly suggests that grantee providers were able to find additional efficiencies. However, successful cost containment does not necessarily generate value in service delivery.

In fact, a combination of negative trends emerged in 2012, following the drop in expenditures for adult services. These include a spike in the percentage of individuals with serious mental illness (SMI) within the mental health population, stagnation in substance abuse service capacity, and a sharp rise in admission and re-admission rates at API. Based on these trends, it is perhaps more probable that diminishing system resources introduced new inefficiencies into the care continuum, with providers becoming more strained in their ability to deliver proactive, preventive interventions while still retaining their focus on core services for higher acuity consumers.

In addition to evaluating these broad delivery system trends, PCG produced summary findings for each of the major service layers within the Department's behavioral health continuum of care. These findings are listed below:

- The Department's **acute intensive services** are neither effective nor efficient, due to a combination of administrative inefficiencies, inadequate sub-acute infrastructure, and lack of community partners. (2.5.1)

- Gaps in the Department's **residential services** system limit its effectiveness, but efforts to improve service capacity for certain populations have significantly improved efficiency. (2.5.2)
- The Department's limited capacity for **intensive support services**, especially for assertive community treatment and substance abuse intensive outpatient services, substantially limits the effectiveness and efficiency of care for high-need populations. (2.5.3)
- The Department is limited in the resources available to provide **living supports** such as transportation and assisted living services effectively, but it has made improvements in using scarce resources efficiently. (2.5.4)
- The Department is deficient in providing key **community and recovery supports**, such as housing, mentoring, and caregiver supports. Peer services have not been integrated into providers' recovery supports to allow the most effective range of services. (2.5.5)
- The Department's **outpatient and medication services** are broadly effective, but are increasingly overburdened and unable to keep pace with growing consumer demand. (2.5.6)
- The Department has made progress in improving **engagement services**, including assessment, evaluation, and service planning processes. However, more work needs to be done to deliver these services efficiently. (2.5.7)
- The Department's **prevention and wellness services** have made significant progress in building strong community coalitions, but need to be integrated more effectively into core Division activities. (2.5.8)
- Department efforts to foster **care integration services** of behavioral health and primary care have been mixed in their effectiveness and efficiency. (2.5.9)

RECOMMENDATION 2.4.1. Reforming staffing policies and practices at API, including more competitive hiring and retention efforts, could significantly improve the quantity and quality of care without increasing costs.

RECOMMENDATION 2.4.2. The Department should build additional service capacity for substance use disorder (SUD) treatment, both to increase access to services and improve quality. Additional investment would lead to significant savings in medical, nursing home, and criminal justice costs, producing interventions that "pay for themselves" in cost offsets from other essential State services.

Review Objective 3: Service Delivery Best Practices

PCG's review here consisted of brief descriptions of emerging best practices and promising innovations in behavioral health service delivery across the country. In this section, PCG highlights a set of novel programs, practices, and financial mechanisms that are demonstrating success in other states and are thought to be appropriate for Alaska's behavioral health system, but have not yet been implemented in the state. Since this section of the review consists exclusively of recommendations, the summary recommendations are provided below:

RECOMMENDATION 3.0.1. The Department should develop a statewide strategy for sustained support of integrated care across mental health, substance abuse and primary care delivery systems.

RECOMMENDATION 3.0.2. The Department should integrate Assertive Community Treatment (ACT) teams into the State's delivery and payment systems.

RECOMMENDATION 3.0.3. The Department should continue to promote greater capacity and utilization of peer support services.

RECOMMENDATION 3.0.4. The Department should pursue implementation of Certified Community Behavioral Health Clinics (CCBHCs) in order to take advantage of enhanced federal Medicaid financing for vital delivery system reforms.

RECOMMENDATION 3.0.5. The Department should consider expanding Medicaid to cover adults under 65 with income up to 133% of the Federal Poverty Level (FPL), taking advantage of substantially enhanced federal funding to build additional infrastructure to meet the needs of underserved behavioral health populations.

RECOMMENDATION 3.0.6. The Department should transform the State's current Medicaid 1915 waivers, including implementation of 1915(i) and 1915(k) options to refinance and improve community behavioral health service delivery.

RECOMMENDATION 3.0.7. The Department should consider the pursuit of a Medicaid 1115 waiver to broaden the array of behavioral health services financed by Medicaid.

RECOMMENDATION 3.0.8. The Department should develop a Medicaid behavioral health rate structure that covers provider costs, incentivizes quality, and minimizes administrative burden.

RECOMMENDATION 3.0.9. The State should develop local sources of funding for behavioral health initiatives.

Review Objective 4: Department Performance Measures

As a part of PCG's review of the effectiveness and efficiency of services, PCG was tasked specifically with evaluating whether the Department's current results-based measures are adequate in gauging the success of DHSS initiatives and the quality of program administration. In this section, we detail our conclusions about the utility of the Department's behavioral health results-based measures for demonstrating the effectiveness and efficiency of the agency's core services, goals, programs and objectives. PCG evaluated the appropriateness of DHSS performance measures for the wide range of services administered by the Department, and has provided recommendations for improving the measurement framework where applicable.

Overall, PCG finds that the Department has made significant strides in collecting the data necessary for effective measurement of behavioral health services. In 2011 the Department initiated the Results-Based

Accountability (RBA) initiative. The system addresses accountability from the highest level across all DHSS services. It vertically aligns the services and activities of each division with department-wide priorities. The RBA framework identifies department-wide priorities, department-wide "core services" within each priority, and division-level core services that directly relate to the department-wide core services, creating a vertical linkage between broad, department-wide priorities and specific division-level core services and activities. This vertical structure is complemented by objectives for each core service and performance measures that evaluate the Department's performance on each objective.

Prior to the Department's RBA initiative, DBH developed its own performance management system, called Performance-Based Funding (PBF). Tied to the Division's grant and contract management efforts, PBF is a system of compliance and quality measures that allocate grant funding based on past performance. According to interviewed providers as well as DBH staff, PBF has thus far had limited impact on funding levels for providers since its implementation, but it has spurred DBH to sharpen its efforts to identify the effectiveness and outcome measures needed to evaluate behavioral health services. DBH plans to integrate PBF into the RBA framework as both initiatives continue to evolve.

PCG reviewed both the data collection capacities of the Department, as well as the specific metrics it uses to evaluate the performance of the State's behavioral health system. PCG compared the Department's framework to performance measurement initiatives implemented in other states, conducting a nationwide scan for high-level characteristics, and a more detailed peer state analysis to provide a frame of reference for how measures are used in other states. PCG also evaluated the alignment of the Department's measurement framework with emerging national standards endorsed by the Substance Abuse and Mental Health Services Administration (SAMHSA) and a number of accrediting agencies and behavioral health quality organizations.

The Department's progress in behavioral health performance measurement appeared to be consistent with the practices of other state behavioral health agencies nationwide. In contrast to many other states, in which crucial data is fragmented among multiple departments, the fact that behavioral health data is collected primarily through data systems housed within DHSS is important to the Department's ability to harness the data requisite for performance management. In comparison to other states, Alaska is also focused more strongly on *results-based measures* that prioritize outcomes over processes. According to a recent study of behavioral health quality measures used across state Medicaid agencies, classification of states' measures within the Donabedian structure-process-outcome model reveals that only 20% of current measures are genuine outcome measures.[2] Process measures constitute roughly 60% of state measures, and the remaining 20% are structure measures. In the Department's RBA framework, on the other hand, PCG identified over 45% of the measures as outcome measures, with the remaining 55% made up of process measures and no structure measures.

One respect in which performance measurement practices in many other state differ from Alaska is a much higher rate of adoption of uniform metrics derived from measurement sets developed and implemented

[2] Julie Seibert et al., Use of Quality Measures for Medicaid Behavioral Health Services by State Agencies: Implications for Health Care Reform, PS in Advance, March 2015, page 3.

nationally. As the behavioral health field has begun to standardize its administrative reporting systems and consumer survey tools, performance indicators that rely on standard data sources and reporting instruments have become more widespread nationwide. For example, the Healthcare Effectiveness Data and Information Set (HEDIS) is a tool that uses claims and encounter data to measure health system performance. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) family of surveys is the most commonly used consumer experience measure among the sampled behavioral health systems. Of the 29 state survey reviewed by PCG, 69% of states have incorporated HEDIS into their Medicaid quality measurement frameworks.

The types of services for which the Department has developed the strongest set of results-based measures are more traditional, institutional psychiatric services delivered at state hospitals and in residential programs. The most robust performance indicators in the RBA framework apply to API and DBH's RPTC network, and measure the re-admission rate to these high-cost forms of care. Since these institutions must comply with well-established accreditation requirements that mandate proven effectiveness and efficiency measures, the Department's institutional measures are understandably the most developed.

DBH's Prevention and Early Intervention performance indicators also provide robust measurement of program effectiveness and efficiency. The prevention programs draw on a public health approach that relies heavily on quantifiable population indicators, and these performance measures are also well-established. Interventions targeting FASD, tobacco and alcohol are also closely allied with medical and criminal justice programs with significant experience in modern performance measurement and reporting programs.

However, PCG found that the Department's performance measures are least developed for community treatment and recovery services. Many of the RBA measures for these types of services rely on process proxies instead of true treatment outcomes, and it is difficult to determine the ultimate impact of community services from the present framework developed by DHSS. Partly, this current state is due to a lack of consensus among treatment providers nationwide regarding the most salient outcome measures, but PCG also believes that it stems from the added complexities of administration in this layer of the system, in which DBH is the payer and system-level administrator, but not the managing provider responsible for service delivery.

Although the RBA framework formally recognizes multiple levels of accountability within DHSS, so far these different levels of performance measurement have been aligned only within the DHSS organizational hierarchy itself, but have not been adapted and extended to meet the needs of the privatized service delivery system typical of DBH community services. Currently, DHSS does not effectively distinguish between the responsibilities and activities of the State agency and those of state-funded, but privately-owned, providers. In the behavioral health delivery system, in which management responsibilities are bifurcated between payer and provider, the Department's performance measures need to reflect this division of labor by addressing DBH performance at *administering* community-based T&R services in addition to provider performance at *delivering* these services. For the most part, each of the recommendations below target different aspects of this need for more coordinated performance management.

RECOMMENDATION 4.3.1. The Department should distinguish more clearly between measures of Division activities and the activities of funded providers.

RECOMMENDATION 4.3.2. The Department should develop a consistent approach to measuring behavioral health performance across divisions.

RECOMMENDATION 4.3.3. The Department should ensure continuity among program, division, and departmental-level evaluation of services, with appropriate degree of specificity and generality.

RECOMMENDATION 4.3.4. The Department should incorporate performance measures that are more appropriately outcome-oriented.

RECOMMENDATION 4.3.5. The Department should incorporate nationally recognized behavioral health treatment and recovery measures into the Department's performance measurement strategy.

RECOMMENDATION 4.3.6. The Department should align performance measurement of community providers, as far as possible, with measures used in accreditation requirements.

Review Objective 5: Placements and Referrals

In our review of the Department's performance in ensuring the most appropriate level of care for recipients of behavioral health services, PCG found that placement and referral policies and procedures are adequate for most sections of the behavioral health continuum. However, a number of factors have combined to generate greater demand on the State's behavioral health acute psychiatric care and emergency services system than the current infrastructure can support. In some cases, service providers have responded to these conditions by implementing placement and referral policies focused more on alleviating pressure on the system than assuring the most appropriate setting for a consumer's care needs.

While some of the factors driving utilization for acute care services can be attributed to Alaska's unique geography and demographics, others stem from under-development of services in less-intensive strata of the care continuum, as well as broader executive and legislative priorities that have contributed to inappropriate utilization. In summarizing PCG's detailed findings, we identify two related trends resulting from inadequate capacity for emergency and community treatment services within the public behavioral health system: 1) over-utilization at API, and 2) the rising prevalence of behavioral health disorders within the corrections system.

As a result of critical deficiencies in service capacity in other parts of the care continuum, API has transitioned within the last decade to a more rigid acute care model that no longer attends to long term stabilization and treatment, but aims exclusively to resolve acute symptoms inhibiting the consumer's daily functioning that precipitated the need for hospitalization. Subsequently API admits and discharges patients with high frequency, a trend that has also resulted in high rates of readmission that further exacerbates the hospital's census pressure.

Compounding the issue is the significant number of inappropriate long-term dementia and disability placements in API, as well as the growing number of forensic placements. These individuals reside at API due to a statewide deficiency in the long term and sub-acute residential services appropriate to serve these subpopulations; there are no intermediate care facilities dedicated to persons with intellectual developmental disabilities, and there is insufficient capacity within the available Assisted Living Facilities (ALF) to meet the needs of consumers requiring this level of care. The Department's referral system between acute and residential services is ineffective and inefficient due to the statewide lack of long-term and sub-acute capacity, resulting in costly and inappropriate treatment within API.

These sources of intensifying admissions pressure have forced the acute care system to implement increasingly tight controls over admission designed to prioritize scarce resources for cases with the highest severity, but not necessarily to promote optimal coordination with community providers and assure proper placement. Partly for these reasons, the community-based system does not control admission to API, in contrast to referral practices in many states. Increasingly, admission decisions are made based on the emergency medical system and court authorities, which are themselves impacted by the deficiencies in community service capacity. Yet the growing role these institutions play in determining how inpatient psychiatric resources are used only further disconnects hospital treatment from community services.

This decoupling of institutional and community care is also reflected in the communication and data sharing structures between API and community-based behavioral health providers. Hospital and community-based data systems are not interoperable, and as a result, the referral system still depends heavily on paper records. On the one hand, API makes insufficient use of the community provider records of patients' trauma and treatment histories, due to data incompatibilities with its own EHR. On the other hand, DBH program managers are forced to monitor the API waitlist actively in order to bridge the gap between API and the community-based system. This process is currently labor intensive and involves manual daily notification of community providers of API capacity, but can and should be routinized.

Nationwide, individuals with behavioral health issues are overrepresented in the correctional system, and Alaska is no exception. Currently, DOC is the single largest behavioral health provider in the state, a fact that has rightfully become a significant policy concern for state leaders throughout all branches of government. While the criminal justice system is playing an increasing role in behavioral health throughout the nation, a number of social and geographic factors particular to Alaska have rendered it especially vulnerable to these trends, increasing the need to ensure that Alaska puts best practices in place to mitigate the pattern of criminalization of behavioral health disorders.

Notably, the State has begun to respond with greater focus to this system-spanning challenge, with a recently developed Recidivism Reduction Plan calling for coordinated action far beyond DHSS. In our report, PCG has also identified a number of fronts in which the Department needs to increase its coordination with DOC: achieving macro-level consensus on a prisoner re-entry framework to guide the process of "handoff" from corrections to the community, assuring the adequacy and non-duplication of community services financed in parallel by the two departments, and improving data sharing and analysis capabilities.

Outside of these major challenges, the Department's referral and placement policies appear to be aligned with best practices and reasonably effective and efficient. PCG organized its review findings in this area by evaluating "layers" of the continuum, focusing broadly on child and adolescent residential services, community treatment and recovery services, and early intervention services. The BTKH initiative has significantly improved Department placement policies by increasing residential capacities in Alaska and making major progress in assuring appropriate care in beneficiaries' home communities. PCG also found that the customary referral procedures of community outpatient providers are effective at placing consumers in the least-intensive and least-restrictive care appropriate for treatment. The Division's two main early intervention programs, focused on FASD and alcohol safety, appeared to be operating effectively and efficiently, with ASAP receiving particular praise for its success in jail diversion.

PCG's recommendations focus primarily on referral and placement processes that can help the Department improve its ability to divert individuals with behavioral health needs away from hospitalization and incarceration and into community treatment when more appropriate. The first set of recommendations calls for specific improvements in the State's crisis response and emergency psychiatric service capacities to reduce system dependence on emergency room visits and inpatient hospitalization for delivering acute psychiatric care. These improvements should also generate significant overall health cost savings to the State. Overlapping these proposed improvements in the emergency system are additional recommendations focused on strategies for jail diversion and recidivism reduction that aim to mitigate the economic and human costs of incarceration and the criminalization of mental illness.

RECOMMENDATION 5.5.1. The Department should implement a consistent and interoperable information technology solution for referrals across the behavioral health continuum of care.

RECOMMENDATION 5.5.2. The Department should build capacity for mobile crisis units in communities with high rates of unnecessary use of the emergency department for behavioral health-related issues.

RECOMMENDATION 5.5.3. The Department should support targeted case management services for high-utilizers of the psychiatric emergency system in order to divert these consumers from costly acute care and ensure delivery of services oriented to prevention.

RECOMMENDATION 5.5.4. The Department should promote Crisis Intervention Team training for a minimum number of law enforcement personnel in communities with high referral rates to Alaska Psychiatric Institute.

RECOMMENDATION 5.5.5. The Department should improve coordination efforts with the Department of Corrections to ensure consistency in treatment programs and protocols for individuals exiting correctional facilities.

RECOMMENDATION 5.5.6. The Department should implement the recommendations presented in the State's Recidivism Reduction Plan.

RECOMMENDATION 5.5.7. The State should develop a coordinated Forensic Services unit to oversee forensic evaluations and service coordination, and to minimize costs incurred by the Alaska Court System, Department of Corrections, and the Department of Health and Social Services.

RECOMMENDATION 5.5.8. The State should reform Title 12 to distinguish between violent and non-violent misdemeanor offences in the code governing forensic psychiatric evaluations for misdemeanor offenders.

Review Objective 6: Organizational Structure

In this section, PCG reviewed the organizational structure developed by the Department to support behavioral health service provision. PCG determined whether the present organizational structure is effective and efficient, and identified areas in which streamlining could potentially reduce expenditures without negatively affecting direct services.

PCG first compared the organization of DBH within the Department to organizational hierarchies within other State Mental Health Authorities (SMHAs) and related substance abuse agencies. Purely from the perspective of macro-level organizational hierarchy, DBH's location within state government appears to promote efficient administration of behavioral health services. Nationwide, SMHAs that are positioned within an umbrella agency spend less money per capita than SMHAs that exist as independent departments within state government. Additionally, the Department funds community-based treatment and recovery services rather than providing the services directly, which tends to encourage more financial and operational efficiency, based on expenditures reported by behavioral health authorities across states.

States' administrative costs can also be compared to evaluate relative administrative efficiency. In FY 2013 the Department spent 3.3% of behavioral health GF expenditures on mental health and substance abuse administration. In the same year state mental health agencies overseeing mental health systems with similar organizational structures devoted, on average, 3% of expenditures to mental health administration. The nationwide average of 2% refers only to mental health administration, excluding substance abuse. In light of that difference, Alaska's administrative spending on behavioral health services is reasonable and well in line with national norms.

Not only does DBH oversee the grant funding available to the State's behavioral health service providers, but it also administers Department behavioral health services covered through Medicaid, which in many other states, falls under an independent Medicaid authority. The consolidation of behavioral health administration within DBH promotes more effective blending and braiding of funding sources for behavioral health services. While DBH's authority over Medicaid behavioral health services improves its ability to coordinate the Medicaid system with grant-funded services, the decentralization of the State's broader Medicaid authority among the different divisions also results in regulatory efforts that may be less focused than in states with independent, centralized Medicaid authorities.

DBH's authority over two major funding sources—with distinct requirements and regulatory responsibilities—is reflected in a significant bi-furcation of oversight functions between the Division's Treatment & Recovery (T&R) and Medicaid and Quality (MQS) sections, which are responsible for grant and Medicaid program management, respectively. Department staff frequently commented on the discrepancies between the "white hat" approach of T&R versus the "black hat" approach of MQS in regard to the Division's oversight over community providers. Although T&R and MQS each conduct provider reviews, with different aims and responsibilities, the Division has endeavored to coordinate its diverse regulatory obligations into a consolidated review process that reduces auditing redundancy both for DHSS employees and for providers under review, minimizing duplication of effort and overall administrative burden.

Other branches of the Department also oversee behavioral health services for their populations, but these services are not always properly coordinated with the DBH system, resulting in potential inefficiencies in service delivery for populations that straddle the jurisdictional boundaries of multiple divisional authorities, such as individuals with autism, Alzheimer's disease and related dementia (ADRD), or Traumatic Brain Injury (TBI). PCG finds that the Department's lack of formalized cross-divisional organizational structures and communication contributes to deficiencies of care for these shared subpopulations. The mechanisms to coordinate strategy, engage in case management, and share data between divisions regarding the same consumers are inadequate.

However, the Department has endeavored to break down its siloes in a number of important ways. For some critical initiatives, DHSS has created dedicated units with cross-divisional focuses, with the authority to coordinate departmental resources under multiple divisions. DBH's Office of Integrated Housing & Services (OIHS) is an example of this approach. Housing is a resource that spans numerous sub-agencies within the Department; the Division of Behavioral Health, Alaska Pioneer Homes, Senior and Disabilities Services, and Office of Children's Services all offer at least one variety of housing for consumers. The OIHS is intended to be an integrated DHSS housing resource that will support and guide the development of supportive housing and housing opportunities for consumers struggling with behavioral health issues.

The second approach adopted by the Department has been to create a looser set of workgroups along the strategic lines developed within the RBA initiative. To respond to the need for coordinated, cross-divisional activities, the RBA initiative called for the development of cross-divisional workgroups oriented along the Department's "core services," and are composed of representatives from the units responsible for jointly delivering the same core service. The workgroups are designed to call attention to areas with higher potential of mismanagement due to the dispersed responsibility and mitigate the risk of neglecting such services, programs, or subpopulations.

RECOMMENDATION 6.1.5. The Department should continue to develop division-level workgroups within the Department's Results-Based Accountability "core services" structure to address the needs of neglected subpopulations.

RECOMMENDATION 6.4.1. As Medicaid plays an increasing role in financing the Department's behavioral health services, the Department should consider a thorough review of position descriptions and delineation of regulatory responsibilities to optimize Medicaid administrative reimbursement.

RECOMMENDATION 6.4.2. The consolidation of grant and Medicaid review responsibilities can reduce costs and administrative burden on providers, but only if reorganization does not conflict with Medicaid administrative claiming processes or dilute the Department's regulatory role.

Review Objective 7: Proposed Budget Reductions

PCG was tasked in this section with reviewing the proposal for 10% budget reductions submitted by the Department in response to a directive from the Legislature. In keeping with AS 44.66.020(c)(2)(C), PCG finds that the proposed reductions represent a "good faith effort," because the Department identified GF expenditures for behavioral health services that could be reduced and refinanced through federal sources without compromising the Department's ability to meet its mission in regard to behavioral health. However, the Department did not respond to the Legislature's request for proposed budget reductions in a timely fashion, nor did it deliver the requested proposal of 10% reductions. Instead, it offered a proposal for reductions drafted originally in response to the Governor's request for 5% and 8% program reductions. The Department's submission was unresponsive to the specific terms of the statutory request.

The Department's proposed budget identifies approximately $1.9 million in budget reductions related to the delivery of behavioral health services, and another $20 million in unspecified cost containment measures.

- **$1.6 million** in budget reductions for Behavioral Health Treatment & Recovery Grants;
- **$347,000** in budget reductions to the Alaska Psychiatric Institute, generated by elimination of the hospital's Medical Director position;
- **$20 million** in budget reductions to be achieved through unspecified Medicaid cost containment measures, a proportion of which is likely to come from efforts targeted at behavioral health services.

A review of each proposed impact shows that the cumulative consequences of the proposed budget reductions are unlikely to compromise the Department's ability to meet its mission in regard to behavioral health. The list of reductions presented by the Department is consistent with opportunities for potential cost savings and cost avoidance identified in the review.

The results of the performance review have not indicated that alternative programmatic elements should be targeted for further budget reductions. However, the review has yielded recommendations suggesting that further cost savings can be achieved in the form of revenue enhancement opportunities that utilize additional local and federal funding sources. The review has also identified potential cost efficiencies to be gained through reforming grant and contract administration and improving Medicaid program integrity functions.

Review Objective 8: Information Technology

PCG evaluated whether the Department's use of information technology effectively supports the programs and services administered by DHSS. As a part of our review, PCG was tasked with examining the Department's ability to track and report on individuals receiving different DHSS benefit types, as well as whether departmental use of technology is cost-effective and aligned with behavioral health best practices.

The behavioral health community's use of information technology has lagged behind progress in the medical community, and only recently have community behavioral health providers and oversight agencies begun to incorporate information management systems heavily into service delivery. PCG finds that the Department's use of information technology systems is consistent with standard practices across state mental health agencies nationwide. The regulation of EHRs used by providers, the level of integration of health information technology across both hospital and community-based providers, and the data sharing practices are all consistent with nationwide behavioral health information technology practices. Furthermore, costs incurred by the Department for information technology personnel and systems are cost-effective in comparison to peer agencies in other states. Annual maintenance costs for AKAIMS, the Department's primary data platform for community-based behavioral health services, are also within national standards.

AKAIMS is capable of collecting metrics needed to support behavioral health programs and services, but it is administratively burdensome and requires double entry from many service providers, including API. Although AKAIMS' electronic health record functionality provides considerable benefit to behavioral health providers who could not otherwise afford it, the use of AKAIMS as an EHR unfortunately also impedes provider efforts to integrate behavioral health and primary care services. Furthermore, the data architecture underlying the AKAIMS system was designed for grant management and is structurally limited in its capacity to meet Medicaid billing requirements.

The Department's IT systems have the capability to track and report on benefit recipients, but these processes remain ad hoc, and are only minimally effective. To some extent, the Department is able to use its various IT systems to identify the extent to which recipients are receiving multiple benefits and whether recipients are Medicaid eligible. MMIS programs routinely contain edits that eliminate the payment of duplicate benefits and restrict payments for only those dates of service that the recipient was Medicaid eligible. However, lack of interoperability among the Department's multiple information systems impedes its ability to track which recipients receive multiple benefits for non-Medicaid services. The Master Client Index is so far unsuccessful at allowing DHSS to track and report on multiple benefit recipients efficiently, though recently-mandated reporting by providers through AKAIMS has allowed the Department to identify recipients of behavioral health services who are potentially eligible for Medicaid.

Although many providers voiced criticism of the administrative burden of the Department's reporting requirements, most were complimentary of the level of assistance offered by the Department to support its IT requirements and to facilitate widespread adoption of electronic systems. The Department appears to adequately support stakeholders in implementing state-mandated behavioral health IT systems. Furthermore, it actively promotes the effective use of IT for telebehavioral health services and plays a

leading role in the State in integrating these systems into the service delivery system. Lastly, PCG finds that the Department's GEMS grant management system is effective at supporting behavioral health grant awards.

RECOMMENDATION 8.3.1. The Department should develop automated reporting for both MMIS and AKAIMS behavioral health data.

RECOMMENDATION 8.3.2. The Department should prioritize development of interoperability of data for all recipients of behavioral health services, from SDS to DBH to OCS.

RECOMMENDATION 8.3.3. In the near term, the Department should transition all behavioral health providers across the continuum of care to data reporting through AKAIMS.

RECOMMENDATION 8.3.4. The Department should develop clear and consistent priorities for data collection and incorporate these into the Minimum Data Set in AKAIMS.

RECOMMENDATION 8.3.5. The Department should integrate AKAIMS and API data to the greatest extent possible.

RECOMMENDATION 8.3.6. The Department should prioritize implementation of an accurate and complete Master Client Index.

Review Objective 9: Grants and Contracts

In this section, PCG reviewed the Department's procurement of behavioral health services through the use of grants and contracts. This review included examining the Department's solicitation, review, and award process for cost-effectiveness and administrative efficiency, as well as recommending best practices to improve monitoring and oversight and maximize the benefits received by clients.

PCG finds that DBH uses grants and contract procurement more extensively than any other DHSS division. In quantity of procurements and total value, DBH exceeds the seven other divisions in its use of both grants and contracts. This proportion of grant-based funding for behavioral health services is consistent with state mental health agency practices nationwide, and the procurement of services through non-state providers is the most appropriate structure for the Department's behavioral health system. The procurement process fairly evaluates proposals with regard to both cost and technical approach, and the combination of competitive and non-competitive solicitations is effective at procuring needed mental health and substance abuse treatment services. Grants provide flexible funding for delivery of non-Medicaid eligible services while contracts stimulate utilization of crucial services. DBH works with the Grants and Contracts Section of the Department to manage all behavioral health procurements, and the combined efforts of DBH program managers and Grants and Contracts employees have contributed to effective grant monitoring and oversight.

While the overall procurement and management of behavioral health services is effective at maintaining a stable provider network across the state, there are areas in which DHSS can improve these procedures. The recent implementation of the Grants Electronic Management System (GEMS) has improved efficiency of grants management, but the Department is only moderately effective at tracking administrative costs of both providers and DBH staff. Additionally, PCG finds that there is some inconsistency in DBH grant and contract management due to ambiguous regulations and high staff turnover. Grant-based funding is essential to the behavioral health system due to the flexibility it provides when presented with unpredictable service utilization, but the objective of the Department to use grant procurement to stimulate market competition and quality can be better achieved with a more robust performance measurement system and stricter definition of certain grant regulations.

Although there are a few deficiencies within the behavioral health grants and contract management practices, overall the Department effectively uses competitive and non-competitive solicitations to procure needed behavioral health services, encourage utilization, and promote quality standards. Both the Grants and Contracts Section and DBH program managers support behavioral health grantees and vendors effectively enough to maintain a statewide behavioral health network within some of the most logistically-difficult services areas in the country, providing Alaskans with needed mental health and substance abuse treatment services.

RECOMMENDATION 9.2.4. The Department should amend its grant and contract requirements to more strongly incentivize behavioral health providers to leverage third party insurance.

RECOMMENDATION 9.3.4. The Department should consider revising Medicaid regulations to increase non-grantee, private provider participation in Medicaid.

RECOMMENDATION 9.3.7. Although the Department has produced user training videos for GEMS that have been praised by the provider community, it should also consider a user manual to accompany training videos to support instruction in rural communities with limited internet bandwidth.

RECOMMENDATION 9.4.3. The Department should provide comprehensive training to all Division of Behavioral Health employees acting as grant and contract managers.

RECOMMENDATION 9.4.4. The Department should improve the year-end report to focus more strongly on outcomes and performance metrics as opposed simply to dollar amounts or tasks accomplished.

RECOMMENDATION 9.5.3. The Department should include a simple dashboard into the GEMS program that visually tracks program goals and percent completion. Although tracking for some qualitative measures may be difficulty, simple graphics demonstrating percent completion are useful in helping grantees to remain on track.

RECOMMENDATION 9.5.4. The Department should increase its ability to monitor, track, and limit the administrative costs incurred from the grants and contracts management process.

RECOMMENDATION 9.5.5. The Department should consider limiting administrative costs during the contracting process to 7-10% of the total contract cost.

RECOMMENDATION 9.5.6. The Department should also consider further monitoring grant and contract budgets to ensure costs are properly allocated across each of the major cost or functional areas.

RECOMMENDATION 9.5.7. The Department should continue its progress in transitioning from grants to contract-based financing for behavioral health services that are amenable to fee-for-service billing.

RECOMMENDATION 9.5.8. The Department should review the grant management process to ensure that grant administrative burden is commensurate with the size of the grant award.

Review Objective 10: Federal Cost Collaboration

In this section, PCG determined whether the Department's current program structure maximizes available opportunities for collaboration and partnership with the Alaska Native Tribal Health Consortium and federal entities such as the Department of Veterans' Affairs (DVA) and Indian Health Services (IHS). PCG evaluated DHSS' relationships with the tribal and veteran behavioral health systems, identifying recent accomplishments and suggesting fruitful areas for increased partnership and continuing cost collaboration.

Although State and tribal systems behavioral health systems operate in parallel, in many rural service areas of Alaska, the two systems typically converge at the provider level, with all public services delivered through a single tribal provider that receives funding from all systems. This arrangement can be mutually beneficial for both the State and tribal systems, since the Department receives 100% federal reimbursement for Medicaid services delivered to American Indians and Alaska Natives (AI/AN) in a tribal facility, and the tribal system gains access to substantial Medicaid revenues to compensate for inadequate federal IHS funding.

PCG finds that the Department actively pursues opportunities for federal cost collaboration through Medicaid program by partnering with the Alaska Native Tribal Health Consortium and other tribal entities. Following a 2007 report to the Legislature by Pacific Health Policy Group that identified opportunities for mutually beneficial collaboration between the two systems through Medicaid, the Legislature authorized SB 61 to implement recommendations for streamlining Medicaid regulations, building long term care and behavioral health infrastructure among tribal providers, and exploring wider Medicaid payment reforms to bring maximum economic benefit to the State and to both systems. Today, many of the opportunities originally identified in the report have already been fully implemented.

Of indirect benefit to behavioral health services, mutual State and tribal investment in tribal long term care capacity, both in Anchorage and in several key regional hubs in rural Alaska, has allowed many AI/AN individuals in need of long term care to remain closer to their home communities, while yielding significant cost savings to the State. In behavioral health, collaboration strategies have been more incremental than

seismic, consisting of regulatory changes to support behavioral health and primary care integration, and to promote Medicaid provider and service categories specially adapted to serving the rural Alaska population. Behavioral health collaboration has borne the most fruit in the expansion and efficient use of telebehavioral health infrastructure throughout both systems. Most remaining opportunities for substantial cost collaboration, however, depend on more far-reaching State reforms of the Medicaid system through expanded eligibility, behavioral health waiver demonstrations, and additional reimbursement reforms.

Apart from these transformations, the best remaining opportunity for maximizing collaboration and ensuring proper assignment and payment of costs is to establish a larger number of inpatient psychiatric beds within the tribal health system, especially in the Anchorage/Mat-Su region. The Department currently serves a disproportionate number of Alaska Natives with SMI due to under-developed service capacity for these individuals within the tribal system, both in rural areas and in Anchorage.

New opportunities for cost collaboration between the State and veterans' behavioral health systems have also opened up in recent years, due to changes in federal laws and regulations, as well as pilot programs operated by the Department to improve access to services for veterans. Importantly, there have been two recent changes to the VA's health procurement policies that create a new potential funding source for community providers: the Patient Centered Community Care (PC3) program, begun in 2013, and the Veterans Access, Choice and Accountability Act of 2014 ("Choice Act").

In the PC3 program, the VA has been authorized to contract with large provider networks across the country to provide certain health care services when they are not readily available through a VA health care facility. The PC3 program increases the overlap between the VA and State-run health systems by expanding the health providers receiving both State and Federal reimbursements. Likewise, under the Choice Act, veterans who are unable to receive an appointment within 30 days of their requested date, who live more than 40 miles away from a VA facility, or face excessive travel burdens, can choose to receive care from eligible non-VA health care providers. Veterans who are eligible for the Choice Program receive a "Choice Card" that allows them to receive care from non-VA providers, without the in-network provider limitations to which the PC3 program is subject. Like the PC3 program, though, the Choice Program further expands the pool of providers available to veterans and increases the number of Alaskan behavioral health providers able to diversify their funding sources among state grants, Medicaid and VA reimbursement.

Since 2010, the Department has also collaborated directly with the VA Healthcare System through the Rural Veteran Health Access Program (RVHAP) to expand telehealth capacity in Southeast Alaska and enroll non-tribal providers as VA vendors. The Department coordinates RVHAP through the Division of Public Health's Health Planning and Systems Development section and Office of Rural Health. DHSS and the VA have applied for federal subsidies to help cover the cost of providing bandwidth to rural providers, established video connectivity in six rural areas, and begun service expansion to three remote sites.

RECOMMENDATION 10.2.1. The Department should continue to encourage tribal providers to develop greater service capacity for meeting the needs of Alaska Natives with SMI.

RECOMMENDATION 10.2.2. The Department should improve its efforts to identify veteran recipients who may be eligible for services through the VA Healthcare System.

RECOMMENDATION 10.2.3. The Department should proceed with implementing Medicaid 1915(i) and 1915(k) options in order to open up new opportunities for Medicaid financing through partnered tribal providers.

Review Objective 11: Behavioral Health Advisory Groups

In this section, PCG evaluated the effectiveness and efficiency of the Department's three behavioral health advisory groups, Alaska Mental Health Board (AMHB), Advisory Board on Alcoholism and Drug Abuse (ABADA), and Suicide Prevention Council (SPC). These advisory groups were reviewed on the basis of their success in developing plans and providing guidance to the Department.

In general, PCG finds that the three advisory groups provide adequate support and guidance regarding behavioral health issues. The joint meetings of AMHB and ABADA enable effective planning for a fully integrated behavioral health system of care, while the co-location of AMHB, ABADA, and SPC staff and resources has allowed for a more economical use of departmental funding without detracting from the focus and specific division of labor of the separate advisory bodies.

PCG finds that the groups' functional relationships with various system stakeholders, including Department officials, providers, and consumer and consumer advocates, appear to be appropriate and support the groups' ability to carry out their planning and advisory tasks. DBH and the advisory groups have a productive relationship grounded in the regular and systematic transfer of information, advice, and guidance through the groups' participation in the Division's planning activities. The boards provide research support to and collaborate with DBH on strategic planning initiatives, as seen through their contributions to the Comprehensive Integrated Mental Health Plan, without diminishing the influence of non-departmental voices over planning and consumer advocacy. The advisory groups appear to be able to operate independently from the Department and from other dominant stakeholder interests, enhancing the objectivity of their recommendations. Furthermore, the guidance provided to the Department sufficiently incorporates consumer feedback and advocates for the needs of their constituents.

The review did not identify any significant areas of ineffectiveness or inefficiency which would require changes to advisory group organization or operations.

Review Objective 12: Utilization Tracking

Alaska's behavioral health system continues to be based on a regional network of Community Behavioral Health Centers (CBHCs) that provide comprehensive behavioral health services to all Alaskans within designated catchment areas. Traditionally, this CBHC-based system has fostered both care coordination and regional monitoring of utilization, since the CBHC serves as the principle provider for all behavioral health services in a geographic area. The growth of Medicaid-financed behavioral health challenges the effectiveness of this delivery system in some important ways, however, particularly in regard to utilization, due to the fact that fee-for-service reimbursement sometimes incentivizes increased service volume at the expense of appropriate care coordination.

By requiring behavioral health providers to apply for and receive a grant from DBH in order to enroll in Medicaid, the Department has been able to provide an effective check on over-utilization of Medicaid behavioral health services, and to prevent the de-coupling of service delivery based on the two different payment systems. The DBH regulatory framework preserves a linkage between grant-funded and Medicaid-reimbursable behavioral health services. It also ensures that every provider delivering behavioral health services funded by the Department, through grants or Medicaid dollars, reports treatment information to DBH according to a uniform standard.

However, the Department's ability to regulate behavioral health utilization through the CBHC-based system has also been diminished by changing service standards that typically overwhelm the ability even of "comprehensive" providers to deliver the full range of services needed within the system. To ensure the availability of appropriate and modern behavioral health services, the Department has responded positively to new service pressures by increasingly funding services outside the CBHC system, by providing grants to additional providers to target specific evidence-based practices and interventions and to supplement service capacity in underserved regions. With the addition of specialty grants, the Department has gradually shifted away from a "planning" approach that organizes utilization around comprehensive regional providers, to a "market" approach that attempts to stimulate greater quantity and quality of services through competitive procurements that incentivize volume for needed service lines.

However, with the proliferation of numerous grant types, the regional management of services employed by DBH no longer provides for effective tracking of utilization. A single grantee receiving multiple grants may now be associated with multiple grant managers, just as grantees under the purview of a particular DBH regional office may be accountable to grant managers outside the regional office. In PCG's discussions with DBH program managers, it was evident that the division's regional- and service-based management configurations overlap and increasingly cross-cut each other in ways that fail to bring important utilization trends into clear view. Arguably, this tangle of management responsibilities was the most significant factor in the Division's belated and indecisive response to the 2013 implosion of the Fairbanks Community Behavioral Health Center.

The Department still has some distance to go in successfully coming to terms with the competing demands of managing utilization through a hybrid grant and fee-for-service based system. Although it has improved its tracking capabilities through mandated grantee data reporting into AKAIMS, a small number of

providers continue to submit data through a parallel system, called EDI. The EDI architecture lacks the capability to identify unique clients. Moreover, it is still not feasible for DBH to create unduplicated client counts across institutional and community-based service settings, because of AKAIMS inherent limitations in meeting API's comprehensive EHR needs, on the one hand, and the sophisticated billing requirements of an MMIS, on the other.

For these reasons, the Department should adapt the current system of utilization control to incorporate structures more appropriate to fee-for-service reimbursement over grant-based funding. The existing system of utilization tracking and regulation relies on the structure of the regionalized CBHC-based system and control offered by selective grant funding. With the financing of behavioral health services increasingly dependent on Medicaid reimbursement, these structural controls will cease to be fully effective (even if still needed), necessitating that the Department incorporate additional utilization controls specific to fee-for-service reimbursement.

RECOMMENDATION 12.2.1. As the behavioral health system becomes increasingly dependent on Medicaid financing, current utilization tracking must be adapted to incorporate utilization controls more appropriate to fee-for-service payments than grant-based reimbursement.

RECOMMENDATION 12.2.2. The Department should develop a consistent and transparent data analysis and reporting system, accessible throughout the Department, that illustrates regular, monthly performance trends without reliance on ad hoc reporting.

RECOMMENDATION 12.2.3. The Department should implement a uniform utilization reporting structure across the behavioral health continuum of care.

Review Objective 13: Fraud, Waste, and Misuse

The State has significantly improved its fraud recovery efforts in recent years. In Fiscal Year 2013, recovery efforts yielded nearly $5 million from overpayments, a roughly five-fold increase from the approximate $1 million of Medicaid spending recovered in Fiscal Year 2009. These gains have also been seen within behavioral health specific Medicaid fraud recovery efforts, including a 2014 investigation against an Anchorage psychiatrist that led to the identification of $1.2 million in fraudulent billing. Although current payment recovery efforts total only 1% of Medicaid spending, the State's fraud reduction program has improved significantly, and the resources dedicated to fraud recovery efforts have been used effectively to recoup state funds.

While recent successes demonstrate that program integrity is a priority for DHSS, additional opportunities for reducing fraud, waste, and abuse remain. PCG identified four areas of deficiency in which improvements could strengthen DHSS' Medicaid program integrity efforts:

1. Lack of enrollment of some rendering provider types creates opportunities for fraudulent providers excluded under one provider type to continue billing for services under other provider types. (13.1.6)
2. Medicaid beneficiaries currently have few incentives and little information to provide a check on potential fraudulent practices by their providers. (13.1.7)
3. Abuse of prescription opioid narcotics is both a major behavioral health concern as well as a significant source of fraud and abuse in the health care system. Alaska's current Prescription Drug Monitoring law creates barriers that restrict DHSS and the Department of Law from accessing prescription drug data and using it to identify patient doctor-shopping and other prescribing practices that are potentially fraudulent or abusive. (13.1.8)
4. Ambiguities in the Medicaid regulations for some behavioral health services diminish their enforceability and leave the behavioral health program vulnerable to fraud, waste, and abuse. (13.1.9)

Based on CMS estimates of likely overpayment within the Medicaid program, PCG projects that the State could generate another $5-10 million in combined cost savings and avoidance through improved Medicaid program integrity efforts. Assuming the rate of overpayment for behavioral health services is similar to the level of estimated fraud in the Medicaid program as a whole, then improved program integrity activities could yield approximately $1 million in additional combined cost savings and avoidance for behavioral health services.

RECOMMENDATION 13.2.1. The Department should strengthen Medicaid provider enrollment activities by requiring enrollment of all rendering provider types.

RECOMMENDATION 13.2.2. The Department should engage Medicaid recipients in helping to identify fraud by providing them with Explanation of Benefits (EOB) statements.

RECOMMENDATION 13.2.3. The State should consider increasing criminal penalties for Medicaid fraud and assessing interest and additional financial penalties on individuals convicted of Medicaid fraud.

RECOMMENDATION 13.2.4. The State should consider strengthening its seizure laws and consider bonding requirements for high-risk providers.

RECOMMENDATION 13.2.5. The State should create a robust prescription drug control program, including financial support for and upgrade of the Prescription Drug Database to real-time functionality and removing statutory barriers to state agency access to the database to facilitate fraud identification and drug abuse prevention.

1.0. COMPREHENSIVE OVERVIEW

Develop a comprehensive overview of how behavioral health services are delivered and funded in the State of Alaska and provide recommendations for how the Department's annual budget can be constructed to provide the legislature a more easily understood format with sufficient detail to allow for a comprehensive review of services and funding needs by program. This should address the following:

A. Identify and provide recommendations for how the number of individuals served, cost of services provided, and funding sources utilized can be organized and presented to provide a comprehensive yet easily understood annual review of behavioral health services and funding needs.

B. Identify strengths and weakness of the current budget reporting format.

1.1. Recommendations for Organizing Departmental Overview of Services

The State of Alaska consolidates the funding and delivery of behavioral health services within the Division of Behavioral Health (DBH) of the Department of Health and Social Services (DHSS). Eighty-nine percent of State expenditures on behavioral health programs and services are under the purview of DBH.[3] The Division funds and operates behavioral health programs to ensure that Alaskans across the state have access to a full continuum of mental health and substance abuse services. This array of services extends across the lifespan of the consumers needing care, from Fetal Alcohol Spectrum Disorders (FASD) prevention to mental health services for the aging population. Ranging from prevention to inpatient psychiatric hospitalization, the behavioral health services funded and delivered also span a wide range of intensity. DHSS strives to provide the full continuum of care of behavioral health services needed to meet the complex needs of Alaskans.

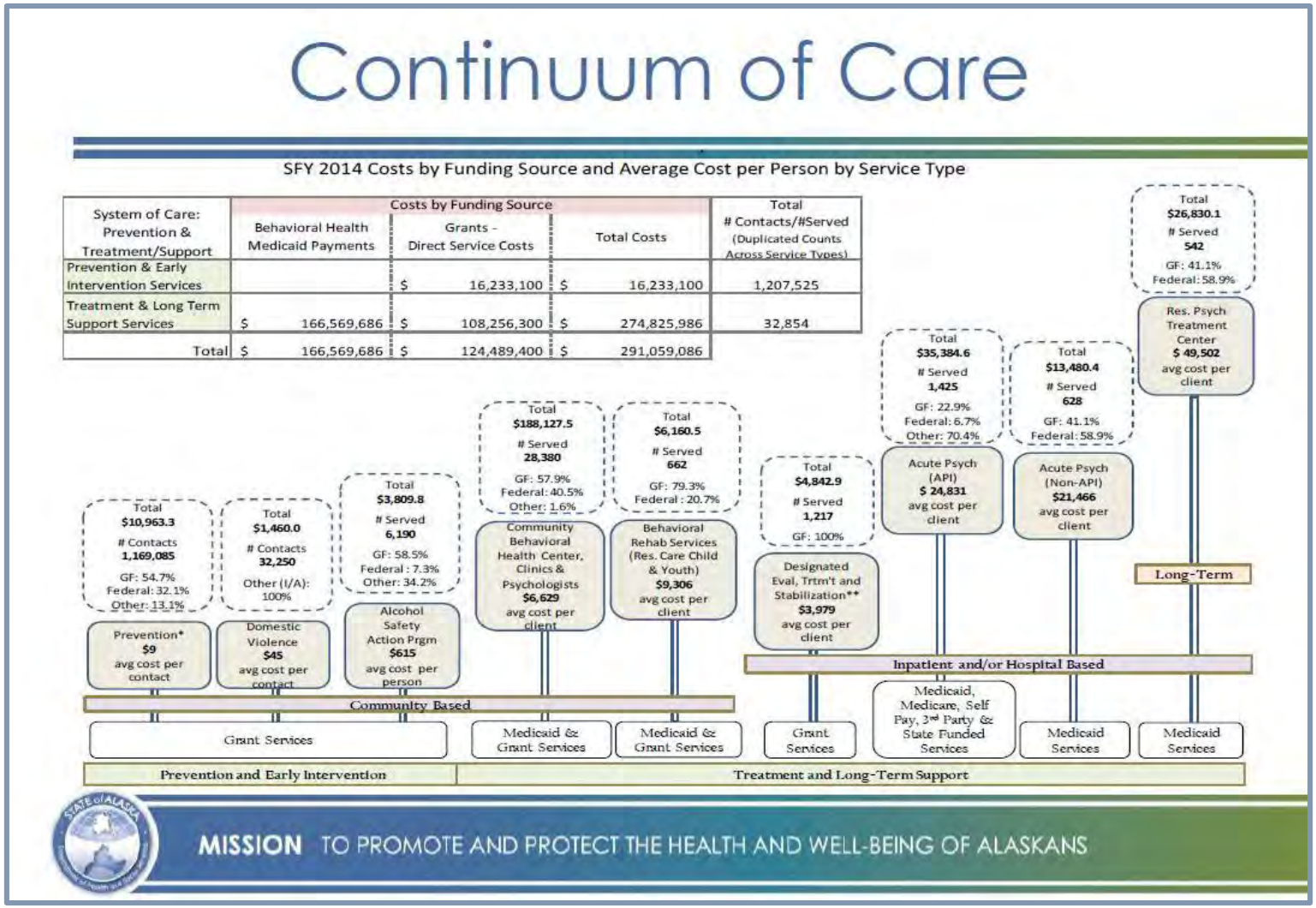
Providing mental health and substance abuse services requires the combined efforts of medical professionals, counselors and therapists, social workers, rehabilitation specialists, and community coalitions, among other stakeholders. Alaska's behavioral health network relies on partnership and collaboration among multiple public and private entities. Within the State, DBH works closely with other DHSS divisions, such as the Division of Senior and Disabilities Services (SDS), the Office of Children's Services (OCS), and the Division of Juvenile Justice (DJJ), as well as the Department of Corrections (DOC), the Department of Education (DOE), and the Alaska Mental Health Trust Authority (AMHTA). It also collaborates with, the Alaska Behavioral Health Association (ABHA), the Alaska Association of Homes for Children, the Tribal Behavioral Health Consortium, Tribal Courts, and private behavioral health providers and advocacy groups. These extensive partnerships and efforts at cooperation maximize the treatment types and services available across the state. The Department also relies on a variety of funding streams to administer behavioral health services:

[3] Enrolled House Bill 66, Alaska Legislature, 2013.

- Federal Grants
- Federal Matching Funds
- Unrestricted General Fund
- Designated General Fund
- Mental Health Trust Authority Authorized Receipts
- Interagency Receipts
- Capital Improvement Project Receipts
- Statutory Designated Program Receipts

A comprehensive overview of how behavioral health services are delivered and funded within the Department is provided through the DBH Continuum of Care Budget Visualization, seen on the following page.

Figure 1.1. DBH Continuum of Care Budget Visualization



As seen in the graphic on the previous page, the Department funds or provides services ranging from prevention and early intervention to acute treatment for mental health and substance abuse disorders. The external prevention services supported by DHSS, located on the left-hand side of the visualization, are completely funded through grants. These services include prevention and early intervention programs, domestic violence and sexual assault prevention, and the Alcohol Safety Action Program. The Department's funding for prevention services comes from the General Fund (GF), Federal funding sources (Fed), Capital Improvement Project Receipts (CIP), and Interagency Receipts (I/A). FY 2014 DBH prevention expenditures totaled $16,233,100.

Table 1.1. Prevention and Early Intervention Services

Program	Description	Funding Source	Role
Comprehensive Behavioral Health Prevention and Early Intervention Services	DBH provides community-level grants for integrated behavioral health promotion, prevention and early intervention services with clearly defined qualitative performance outcomes. Community-focused approach.	GF and Fed	Payer
Alcohol Safety Action Program	DBH provides intensive case management, early intervention, and referral services to consumers referred to substance abuse services through the criminal justice system. Through ASAP DBH also oversees Alcohol Drug Information Schools and other educational and training programs.	GF, I/A and CIP	Payer Provider
Rural Human Services System Project	Provides grants for workforce development and educational programs designed to build a network of trained and culturally responsive rural behavioral health care providers.	GF	Payer
Suicide Prevention	Suicide prevention strategies including mental health promotion, postvention training, and the operation of Careline, a crisis call center.	GF	Payer Provider
Fetal Alcohol Syndrome Disorder Diagnostic Teams and Case Management	Maintains and manages the network of trained and approved community-based FASD diagnostic teams.	GF	Payer Provider
Alaska's Strategic Prevention	Disperses grants for the development of community-based foundations for promotion, prevention, and	Fed	Payer

Program	Description	Funding Source	Role
Framework State Incentive Grant	early intervention with a focus on youth alcohol abuse, adult heavy and binge drinking, suicide prevention, and youth resiliency.		
Rural Domestic Violence & Sexual Assault Prevention Programs	Leads three projects combating domestic violence and sexual assault: Rural Domestic Violence and Sexual Assault Prevention projects, Trauma Informed Care Training for service providers, and the Family Wellness Warriors Initiative expansion project.	I/A	Payer
Tobacco Enforcement and Education	Monitors the compliance of tobacco retail outlets to reduce youth access to tobacco products by working directly with communities across the state.	GF	Payer Provider

DBH funds and provides a wide array of community-focused behavioral health prevention and early intervention services. These are low-intensity and high-impact services that reach large sections of the general population. Of the behavioral health services provided by DHSS, prevention services have the lowest cost per encounter or consumer. ASAP services have an average cost of $615 per individual, domestic violence and sexual assault prevention programs cost on average $45 per encounter, and the remaining mental health and substance abuse prevention services have an average cost of $9 per encounter.

Community-based treatment and recovery services follow prevention services in terms of intensity on the continuum of behavioral health services funded and provided through DBH. They are near the middle of the budget visualization, one level higher than prevention and early intervention services. Community-based treatment and recovery services span a wide range of intensity, from outpatient therapy to residential treatment. Programs include adult and youth treatment for substance use disorders (SUD), psychiatric emergency services (PES), treatment for seriously mentally ill (SMI) adults, and treatment for seriously emotionally disturbed (SED) youth. The Department does not provide any of these services directly, and solely funds and oversees these programs. Funding for these services is provided through grants and Medicaid reimbursements. DHSS uses GF, federal funds, and Mental Health Trust Authority Authorized Receipts (MHTAAR) to finance grants for community-based treatment services. In FY 2014, DBH expenditures, including both Medicaid payments and grants, on community-based treatment services totaled $194,288,000.

Table 1.2. Community-Based Treatment and Recovery Services

Program	Description	Funding Source(s)	Role
Substance Use Disorder Treatment Services	Provides grants for community behavioral health agencies to provide, for adult and youth populations, the following treatment services for consumers with substance use disorders: • Outpatient • Intensive outpatient • Residential treatment • Detoxification Grants are also provided to agencies to deliver supportive services in addition to treatment services: • Housing • Employment • Peer support • Education • Advocacy • Case management	Medicaid, GF, Fed, I/A, and MHTAAR	Payer
Psychiatric Emergency Services	Awards grants to community behavioral health agencies for PES services to treat consumers experiencing a behavioral health crisis. These services include: • Crisis intervention • Brief therapeutic interventions for stabilization • Family, consumer, and community wrap-around supports	GF	Payer
Services for Seriously Mentally Ill Adults	Disperses grants to community-based providers to deliver services for SMI adults. These services enable consumers with SMI to live within their home communities in the least restrictive environment. SMI treatment services include: • Assessment • Psychiatry • Medication management • Clinical therapies • Rehabilitation	GF, Fed, and MHTAAR	Payer

Program	Description	Funding Source(s)	Role
	• Treatment services are delivered concurrently with additional support services, including: • Supported living • Supported employment • Intensive wrap-around supports		
Alaska Complex Behavior Collaborative	An initiative intended to develop competency and capacity within the Alaskan behavioral health workforce to effectively deal with challenging behaviors of SMI adult consumers. The CBC provides consulting and training services to community-based providers currently treating individuals with complex behavior management needs with the intent to keep these individuals within the community and out of inpatient settings.	GF, Fed, I/A, and MHTAAR	Payer
Bridge Home	A program that provides transitional housing and services for SMI adults who have failed in other supported living environments due to challenging or difficult behaviors. Bridge Home reduces the use of inpatient psychiatric and Department of Corrections services by consumers who have a documented history of high utilization of those resources.	GF, Fed, I/A, and MHTAAR	Payer
Individualized Service Agreements	Through Individualized Service Agreements (ISAs) DBH offers flexible funding to agencies treating consumers with a high risk of hospitalization. Funds are directed towards regions where API admissions are highest, and covered services include: • Cost of psychiatric medication • Transportation to behavioral health services • Housing assistance • Discharge planning	GF, Fed, I/A, and MHTAAR	Payer
Department of Corrections Discharge Incentive Grants	These grants fund community-based post-release services for SMI adults and SED/SUD youth exiting a correctional institution. The funding enables programs to provide transitional supports until the consumer can	GF, Fed, I/A, and MHTAAR	Payer

Program	Description	Funding Source(s)	Role
	be integrated into the community-based treatment system.		
Services for Seriously Emotionally Disturbed Youth	DBH provides grants to community behavioral health agencies to deliver treatment services for SED youth. The grants prioritize services in the least restrictive environment and home community. Services covered by these grants include: • Outpatient clinic and rehabilitation • Residential treatment • Interventions for transition-aged youth • Treatment for consumers with co-occurring disorders	Medicaid, GF, I/A, and MHTAAR	Payer
Behavioral Rehabilitation Services (Residential Care for Children and Youth)	Residential BRS services are provided to children and youth in residential settings to treat debilitating psychosocial, emotional, and behavioral disorders. DBH funds these services through Medicaid reimbursements and grant awards. BRS treatment builds the strength and resiliency of consumers and their families. There are three BRS levels of care funded: • Level II, Emergency Assessment and Stabilization • Level III, Residential Treatment Program • Level IV, Residential Diagnostic Treatment Program Residential BRS providers continue to work with consumers following discharge to ensure a successful transition back into a community setting.	Medicaid, GF, I/A, and MHTAAR	Payer

Community-based treatment and recovery services encompass a wide variety of treatment services, spanning from outpatient therapeutic counseling to residential psychotherapeutic treatment. The majority of grant funding for these services comes through the Comprehensive Behavioral Health Treatment and Recovery (CBHTR) grant program. Grant funding for these treatment and recovery services flows through four components of the CBHTR program: Behavioral Health Grants, SMI Adults, SED Youth, and PES. In FY 2014, DBH community-based services grant funding totaled $78,726,700 and was supplemented with

$115,561,300 in Medicaid payments. BRS programs have a higher average cost than other community-based treatment services, with a mean expenditure of $9,306 per consumer versus $6,629 for other community-based services.

Inpatient and hospital-based services are the highest acuity, and also the most expensive, behavioral health services overseen by DBH. They are represented on the right-most third of the budget visualization. The programs include Designated Evaluation and Stabilization (DES) and Designative Evaluation and Treatment (DET), the Alaska Psychiatric Institute, acute psychiatric care provided outside of API, and Residential Psychiatric Treatment Centers (RPTC). API is a direct service component of DBH. It is the only acute care inpatient psychiatric facility for all ages within the state of Alaska and is the nucleus of the inpatient and hospital-based behavioral health treatment system. Funding for acute psychiatric services is provided primarily through grants and Medicaid reimbursements, although API also operates using Medicare, self-pay, and third-party payments. The Department uses GF, Medicaid reimbursements, Federal funds, I/A receipts, MHTAAR receipts, and Statutory Designated Program Receipts (Stat) to cover expenditures for inpatient psychiatric services.

Table 1.3. Inpatient and/or Hospital-Based Services

Program	Description	Funding Source(s)	Role
Designated Evaluation and Stabilization (DES) and Designated Evaluation and Treatment (DET) Services	DBH provides funds to hospitals for the treatment of patients experiencing acute behavioral health crises in order to return them to their home community or refer them to the next level of care. The DES and DET treatment array includes: Inpatient psychiatric evaluation, up to 72 hours Crisis stabilization, up to 7 days Inpatient psychiatric treatment services, up to 40 days	GF	Payer
Alaska Psychiatric Institute	DBH treats acute psychiatric illness within API when hospitalization is medically necessary for consumers. The treatment delivered focuses on the resolution of acute symptoms which interfere with daily functioning and the precipitating psychosocial stressors that contributed to the need for hospitalization.	Medicaid, GF, Fed, I/A, MHTAAR, and Stat	Payer Provider
Acute Psychiatric Services	The Department also funds, through Medicaid reimbursement, short-term acute psychiatric services delivered outside of API. Medicaid payments are made to institutions providing acute psychiatric	Medicaid	Payer

Program	Description	Funding Source(s)	Role
	services to eligible individuals within an inpatient setting.		
Residential Psychiatric Treatment Center	Through Medicaid payments the Department funds RPTCs to provide long-term intensive treatment to children and youth at the most acute level of care in a residential setting. RPTCs provide 24-hour interdisciplinary, psychotherapeutic treatment services in a secure or semi-secure facility. There are 5 RPTC programs in Alaska and 22 in the continental United States receiving Alaska Medicaid reimbursements for these acute services.	Medicaid	Payer

Acute inpatient and hospital-based services are intensive, high-cost behavioral health treatment services. DES/DET services are the only acute psychiatric services funded by the Department through grants. Federal funds and Medicaid payments cannot be used to finance DES/DET services, and DHSS relies completely on GF dollars to finance them. The DES/DET grants are a component of the CBHTR grant program. Conversely, RPTCs and acute psychiatric services delivered outside of API are funded only through Medicaid payments. Total FY 2014 DBH expenditures on inpatient and hospital-based services totaled $80,538,000. DES/DET services, a short program, has the lowest average cost per consumer at $3,979. Acute psychiatric services delivered within API ($24,831) and outside of API ($21,466) have similar average costs. Treatment within an RPTC is the most expensive type of care, with an average cost per consumer of $49,502.

1.2. Strengths and Weaknesses of the Current Budget Reporting Format

The funding and delivery patterns of behavioral health services within Alaska are summarized and reviewed in a number of documents made available to the Legislature. The DBH budget visualization seen earlier is made available to the House Health & Social Services Committee as a part of a presentation on DBH, and it covers at a high-level the funding and programs. DHSS also compiles an annual Performance and Budget Summary Book (PABS), formerly known as the Budget Overview Book.[4] The PABS provides an overview of the Department, including identified priorities and budget graphics, and includes summaries of each division. The DBH summary provides an introduction to DBH, describes the continuum of behavioral health care funded and overseen, and includes a statistical summary of costs and utilization. Finally, the

[4] Fiscal Year 2015 Performance and Budget Summary Book, Alaska Department of Health and Social Services.

Governor's Amended Budget provides comprehensive budget information on the entirety of DHSS. This document includes the most detail regarding funding sources and budget allocations.

Of these documents used to review DHSS funding and delivery of behavioral health services, PCG reviewed the DBH budget visualization and the Governor's Amended Budget. The budget visualization was presented to the House Health & Social Services Committee on February 19, 2015 and was used to provide an overview of DBH to the Legislature. The Governor's Amended Budget is prepared by the Office of Management & Budget and used by the Legislature during the annual budget review process.

1.2.1. FINDING: The Division of Behavioral Health's budget visualization includes all relevant information regarding cost, volume, and funding sources, but can be improved by reorganization of the information presented.

The budget visualization is intended to provide the Legislature with a comprehensive overview of the DBH budget and services overseen. PCG finds that the budget visualization presents all relevant information regarding cost, volume, and funding sources of behavioral health services. The format of the budget visualization, including both a continuum of care graphic and table of consolidated figures, is effective in that it provides a complete picture of the activities of DBH. For each behavioral health program or service, the budget visualization includes the following details:

- Total expenditures
- Method of funding
  - Grant
  - Medicaid
  - Other
- Percentage breakdown of funding sources,
  - State
  - Federal
  - Other
- Number of consumers served
- Average cost per consumer
- Service setting
  - Community-based
  - Inpatient and/or hospital-based
- Type of service
  - Prevention and/or early intervention
  - Treatment and long-term support

1.2.2. FINDING: The Division of Behavioral Health's budget visualization presents the number of individuals served, cost of services provided, and funding sources used in a comprehensive manner that utilizes all space available.

The budget visualization is successful at providing the Legislature with the baseline information needed to understand behavioral health services funded and delivered through DBH. It informs the legislature of the cost of each service and uses the graphic to represent visually the expense of each service, using the vertical position of each service line to indicate its relative cost. The budget visualization also uses horizontal bars to group types of service lines together. The bottommost bar distinguishes between prevention and early intervention services and treatment and long-term support services. Higher on the page, one bar links

community-based services together, and another links the inpatient and/or hospital-based services. The budget visualization effectively uses graphic features to communicate the information presented. The table and the linear figure organize the baseline information needed to provide a comprehensive overview of how behavioral health services are delivered and funded.

1.2.3. RECOMMENDATION: Reorientation of the order of information on the budget visualization would improve communication of budget details.

While the budget visualization effectively uses graphic features to communicate the information presented, the overall efficiency of the document is hampered by the cluttered layout. The layout is efficient in that it uses all space available on the page, but that efficiency of space is occasionally achieved at the expense of legibility. The small font required to fit the necessary details makes it difficult for readers to read and comprehend the presented material easily, increasing the time spent understanding the document and thus decreasing its overall efficiency. DBH could fix this cluttered appearance by expanding to a two-page format or a legal (11" x 17") paper size.

Additionally, the structure of the visualization is counterintuitive. The best practice for budget design is progression from broad overview to specific details. Readers typically begin reviewing a page from the top and move downwards. With the best practice orientation of broad to narrow, this structure orients the readers with more general information first, priming them with the information needed to comprehend the significance of the details provided. However, the DBH budget visualization does not follow this pattern. While the total funding is presented in a table at the top, the broad characterization of services as either prevention or treatment lies at the bottom of the page. The most specific details – total expenditures, number of contacts, and breakdown of funding services per service line – are positioned in the middle. A simple restructuring such that the document proceeds from broad to narrow, top to bottom would improve the visualization and make it more comprehensible.

The expansion to a larger paper size or two-page format would also allow DBH to consider including additional details in this budget visualization. Data from prior years or projections of future growth, both expenditures and volume, would enable readers to make comparisons and see how behavioral health services are evolving over time. Including a description of the programs and service lines would also provide the readers with a more complete picture of the services being funded and delivered. Readers may not be familiar with the specifics of each program or service line and may wish to have additional understanding of the services being funded. Overall, PCG finds that the DBH budget visualization effectively provides a comprehensive review of behavioral health services. However, its efficiency could be improved simply by expanding and restructuring the format of the document.

1.2.4. FINDING: The Governor's Amended Budget presents all necessary information at the appropriate level of detail.

PCG has reviewed the FY 2016 Governors Amended Budget as posted by the Office of Management and Budget (OMB) and concludes that the budget provides the Legislature with the required information. Although PCG has identifies a few small opportunities for improvement with small formatting changes, the budget document generally appears to be effective at meeting its intended goal. The document is daunting at 1,817 pages in length, but this is a reasonable size considering the quantity of information and detail covered. The organizational structure mitigates any potential difficulties in comprehending such a large document. The Budget Book opens by reviewing the Department as a whole and successively addresses each Results Delivery Unit (RDU). The broad-to-narrow structure is effective at introducing the reader to DHSS organization and programs, and subsequently delves into detailed explanations of each RDU. This organizational structure is replicated within each RDU component section, beginning with summaries of each RDU and then detailing component budget changes. The consistent organizational structure contributes positively to the ability of the reader to comprehend the Budget Book and its effectiveness at communicating the intended information.

1.2.5. RECOMMENDATION: The use of visual aids in the Governor's Amended Budget, such as bar graphs and tables, assists readers in comprehending and understanding the information presented. These could be further improved by standardizing the timelines used on these visual elements.

In the DHSS overview section at the beginning of the Budget Book, the Department is successful at communicating its mission, current challenges, and changes expected in FY 2016. The introduction provides the relevant details needed to understand the activities and funding of the Department within the Core Services table.[5] This table identifies the Department's core services, or focus areas, and a clear breakdown of the expenditures for each core service by source: UGF, DGF, Other, Federal Funds, and Total. The table also includes a breakdown of the permanent full-time, permanent part-time, and non-permanent employees dedicated to each core service. Complementing these figures is the percentage of each core service funded through GF dollars; with that information, the table successfully provides an introduction to the priorities of the Department and the State resources allotted to each core service.

The following section of the Budget Book's introduction is *Measures by Core Service*, which consists of a series of graphs that depict the change over time in the performance measures used to evaluate each core service. The Department's core services are:

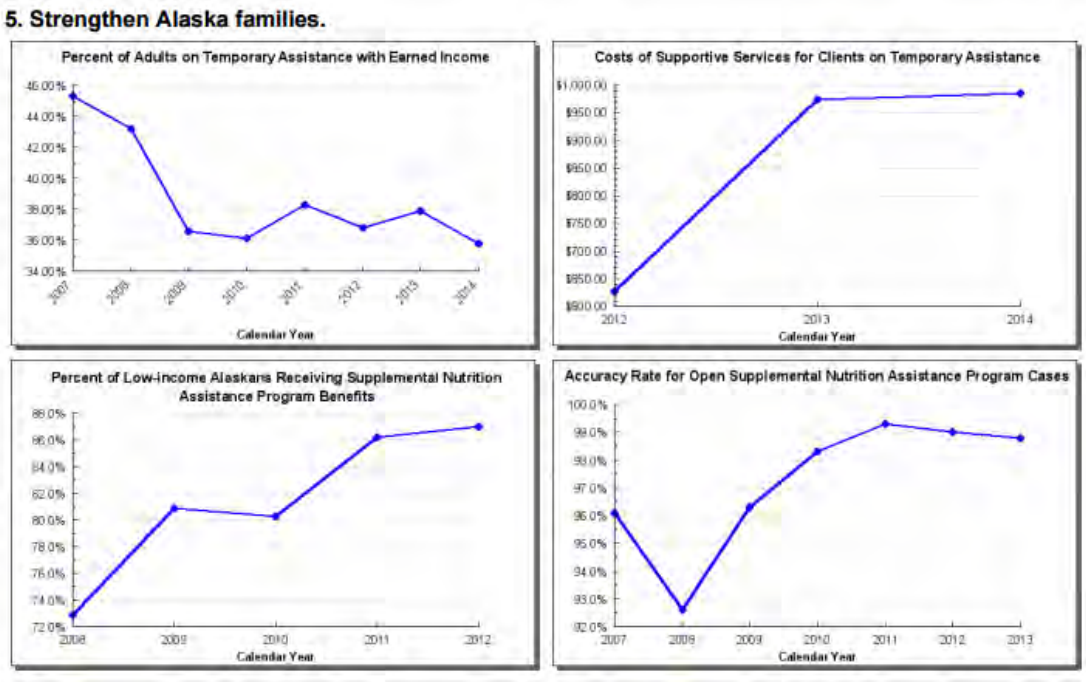
- Protect and promote the health of Alaskans.
- Provide quality of life in a safe living environment for Alaskans.

[5] Fiscal Year 2015 Performance and Budget Summary Book, Alaska Department of Health and Social Services, 10.

- Manage health care coverage for Alaskans in need.
- Facilitate access to affordable health care for Alaskans.
- Strengthen Alaska families.
- Protect vulnerable Alaskans.
- Promote personal responsibility and accountable decisions by Alaskans.

The graphs are effective visual aids that clearly depict the Department's progress towards meetings its goals for each core service. They are well-labeled and easy to understand. However, the potential for confusion exists in the fact that these graphs span different periods of time. As seen in the screenshot on the following page, each of the four graphs for Core Service 5 (Strengthen Alaska families) spans a different number of years. This inconsistency creates some level of confusion when trying to compare performance year to year. Nonetheless, the graphs are effective visual aids and assist the reader in understanding the information presented. Standardizing the years displayed is recommended to further improve their effectiveness.

Figure 2. Core Service 5 Graphs



1.2.6. RECOMMENDATION: The presentation of Department challenges and accomplishments in the Governor's Amended Budget would be improved with a discussion of solutions, as well as an assessment of whether accomplishments meet Department goals.

The next section of the Budget Book is *Major Department Accomplishments.* In this section, DHSS presents the successes of the Department in the past fiscal year. It lists each significant accomplishment and provides accompanying information with sufficient detail to explain why the action can be viewed as a success and how it is relevant to the functioning of the Department. This section is effective at highlighting positive

outcomes from the past year, but could be improved by providing the goals for the prior year. Listing the goals alongside the accomplishments would enable readers to determine whether the Department met, exceeded, or fell short of its aims.

Key Department Challenges immediately follows the discussion of major department accomplishments. This section outlines the goals towards which the Department is striving and the obstacles to achieving those goals. For FY 2016 the identified challenges include the following:

- Assuring intra-departmental and inter-departmental activities are planned in a manner that considers both short and long-term results, and maximizes generation of non-state revenues;
- Serving the growing senior population;
- Managing services for an aging population with complex health care needs;
- Sustaining the Health Information Exchange;[6]
- Addressing obesity;
- Developing quality local Psychiatric Emergency Services throughout the state and alternatives to hospitalization to minimize admissions to Alaska Psychiatric Institute;
- Retaining staff, particularly within the Office of Children's Services;
- Expending staff resources to resolve the increased number of rejected claims unable to be processed by the Medicaid Management Information System.

DHSS clearly states the foreseen challenges facing its ability to accomplish its goals and objectives in the coming year. However, while the obstacles are identified effectively, the Department fails to discuss its proposed solutions and mitigating strategies. DHSS has most likely discussed possible approaches to tackle these challenges, but the lack of mention of such strategies leaves an open question in the mind of the reader as to whether the Department is capable of solving the problems it faces. A brief mention of the proposed solutions to the challenges identified within this section would improve the ability of the Budget Book to communicate the Department's overall strategy at achieving its objectives. The following section, *Significant Changes in Results to be Delivered in FY 2016,* discusses the major changes likely to be observed in the coming fiscal year. It effectively and efficiently brings to the reader's attention potential changes in the budget and service delivery, along with the rationale behind each change. This section successfully communicates upcoming changes in the Department, and would be even more effective with the inclusion of potential solutions in *Key Department Challenges,* as the reader could link the challenges, solutions, and changes together.

Within the *Significant Changes* section is a subsection titled *Impacts of Key Proposed FY2016 DHSS Operating Budget Reductions* that effectively describes how proposed budget reductions would impact Alaskans. This section is crucial to the overall effectiveness of the Budget Book because it communicates to the Legislature the specific ways in which budget reductions will affect the Alaskan population. This thorough understanding of how budget reductions will change the services available allows the readers to weigh the relative advantages and disadvantages of each proposed reduction. The importance of this section

[6] The Health Information Exchange is what facilitates the electronic sharing of health-related information between electronic health record systems across providers.

is amplified by the inclusion of proposed solutions to the consequences of budget cuts. The sole behavioral health-related budget cut addressed lies within the Division of Juvenile Justice:

- **Proposed reduction**
  - Repurpose the Ketchikan Regional Youth Facility from a locked detention facility to a residential facility offering treatment to dually diagnosed (mental health, substance abuse) youth from across the state.
  - Delete 20 positions and associated funding.
- **Impact**
  - Increase youth treatment beds by up to ten, reducing the number of dually diagnosed children who need to leave Alaska for treatment.
  - Travel costs for youth and staff would increase.
  - Ketchikan youth housed at the Juneau facility have fewer face-to-face visits with their families.
  - Increase the caseload for remaining probation staff and reduce the level of service provided.
- **Solution**
  - The repurposed facility would become a Medicaid services provider and be reimbursed for behavioral health services provided to youth.
  - The Johnson Youth Center in Juneau would absorb the detention youth.

PCG finds that *Impacts of Key Proposed FY2016 DHSS Operating Budget Reductions* is crucial to the ability of the Budget Book to communicate how services are delivered and how changes in funding affect the Department's delivery and management of health and social services. The amount of description provided enables readers to understand how the reduction will affect both Alaskans and the Department. For example, the description of changes for the Division of Juvenile Justice clearly indicates that behavioral health services will be affected and the Division of Behavioral Health, responsible for managing Medicaid-enrolled behavioral health providers, will also be impacted. This subsection is highly effective at communicating the effect of funding changes within DHSS and across Alaska.

1.2.7. RECOMMENDATION: The Governor's Amended Budget could be improved through the inclusion of an introduction and description of programs for each Results Delivery Unit (RDU) that would orient the reader to the detailed information that follows. The inclusion of historical and projection data would also facilitate evaluation of program elements over time.

The RDU summaries that follow the DHSS overview provide details about each RDU. This information is presented logically and mirrors the structure of the DHSS overview. The framework is as follows:

- Contribution to the Department's Mission
- Results
- Core Services
- Measures by Core Service
- Major RDU Accomplishments in FY 2014
- Key RDU Challenges

- Significant Changes in Results to be Delivered in FY 2016
- RDU Financial Summary by Component
- Summary of RDU Budget Changes by Component
- Component summary *(repeated for each RDU component)*
    - Contribution to Department's Mission
    - Core Services
    - Major Component Accomplishments in FY 2014
    - Key Component Challenges
    - Significant Changes in Results to be Delivered in FY 2016
    - Statutory and Regulatory Authority
    - Budget tables
        - Component Financial Summary
        - Estimated Revenue Collections
        - Summary of Component Budget Changes
        - Component Detail All Funds
        - Change Record Detail – Multiple Scenarios with Descriptions
        - Line Item Detail
        - Restricted Revenue Detail
        - Interagency Services

The organizational structure of the RDU sections includes the information necessary to understand the budget and activities of each RDU. It is easy for readers to follow the progression of the section. Additionally, the budget tables are effective at presenting financial information for the high-level component summary, the low-level line item detail, and all levels in between. However, the Department should consider the addition of a brief introduction and program summary to enhance the effectiveness of each RDU section at providing an overview of the activities of that RDU. This introduction would provide context for the reader and facilitate a more holistic understanding of the RDU. It could even include high-level utilization data, enrollee data, and the number and type of providers involved, enabling the reader to understand where, how, and why funding is being spent. Furthermore, the Department should consider including outcomes data within the RDU section summary. Describing results and outcomes of the services provided is important to justify programming expenditures, and this information is not included currently in the budget document.

Finally, the Department should consider adding additional historical budget data to each of the RDU sections. Although FY 2014 actuals are included, it is easier for readers to see year-to-year changes and growth trends with budget data from additional years. This historical data will also enable readers to compare the growth of different programs and components and track their evolution over time. Despite the ability to improve certain areas of the Budget Book PCG finds that the Budget Book effectively presents an overview of services funded and delivered by the Department. The organizational structure and visual aids efficiently communicate this information to the reader. With the standardization of graph timelines, addition of RDU narrative summaries, and inclusion of additional data, the Budget Book would be a highly effective budget reporting document.

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2.0. DELIVERY AND ADMINISTRATION

Using recognized standards for determining such, examine and evaluate all aspects of behavioral health services including the types, delivery, funding, and monitoring; and determine the extent services are effectively and efficiently delivered and administered. This should address the following:

A. Do the Department's behavioral health services, goals, programs, and objectives tie directly to the Department's mission?

B. Are the Department's behavioral health programs and services delivered and administered effectively?

C. Are the Department's behavioral health programs and services delivered and administered efficiently?

D. Are there opportunities for the Department to increase the quantity and/or quality of services provided to clients with the same or reduced level of funding?'

E. Are there any behavioral health programs and services that are not effective or efficient?

2.1. Departmental Mission

2.1.1. FINDING: The Department has developed a clearly-articulated mission with well-defined goals and objectives to direct department, division, and program-level activities.

To the Department's credit, significant effort has been invested into defining core DHSS objectives and activities in order to ensure that precious State resources are aligned with the Department's mission, and that services and administrative activities operate in the fulfillment of these goals. Among the Department's numerous behavioral health programs and service types, PCG did not identify any activities that do not serve the Department's mission or are not directly tied to DHSS' strategic objectives. For a detailed analysis of the Department's mission, goals, and program alignments, see Section 4.0. In this section, PCG's analysis of the Department's mission is confined mainly to the extent to which the services offered by DHSS assist the Department in fulfilling its objectives effectively and efficiently.

2.2. Effectiveness of Services

PCG evaluated the overall effectiveness of the Department services by examining the service delivery system according to three distinct domains of effectiveness: *structure, access, and quality*. The first major component of effective service delivery is the establishment of an appropriate *structure* of service delivery,

which involves a constellation of service types and coordinated interactions within the delivery system designed to provide a seamless care continuum capable of serving a range of behavioral health needs and acuities. To evaluate the structural effectiveness of the delivery system, PCG reviewed the range of service types available within the State system to determine the extent to which the services funded by the Department align with national standards for ensuring an effective continuum of care. Although the findings in this Section give a summary treatment of the various service gaps within the system, Section 5.0 provides a more detailed account of some of these critical deficiencies in the Department's care continuum, insofar as they impact the effectiveness of placements and referrals within the system.

The second domain of effectiveness includes an evaluation of the level of *access* to services, both in terms of the number and characteristics of the individuals served, as well as potential variability in the types of services available to different populations in distinct regions of the state. PCG's discussion of access can be broken down into two parts: 1) an analysis of changes within the service infrastructure that have increased or decreased access to different service types, and 2) an analysis of service utilization trends that illustrates how changes in service capacity have impacted both the numbers and population characteristics of individuals served.

The third domain is a review of the *quality* of services provided within the system. Because the Department administers an extensive range of services with an equally extensive range of indicators developed to measure service quality, PCG's discussion here is not intended to be comprehensive. Rather, the analysis focuses primarily on the proxy measures identified by the Department in its *RBA Framework* and *Healthy Alaskans 2020* health indicators as the most important measures of system performance and the most reflective of DHSS core activities. A more detailed treatment of the specific measures employed by the different sections of DBH to measure service effectiveness can be found in Section 4.0.

2.2.1. FINDING: The Department does not provide the full continuum of care required to deliver effective behavioral health services.

A variety of clues regarding overall service delivery effectiveness can be gleaned simply by reviewing the structure of the service system. Since the now classic 1999 Surgeon General's report on mental health[7] detailed the growing catalog of interventions proven to promote successful recovery, widespread consensus has emerged among clinicians and behavioral health policy experts on the array of services needed to foster an effective behavioral health system.

A complete and effective behavioral health system of care provides the full range of high quality services needed to meet the mental health and substance abuse needs of the entire population served, regardless of age, gender, culture, or ethnicity. Although the individual service lines required within the service system depend to some extent on characteristics of particular populations, there is broad consensus on the

[7] Office of the Surgeon General, "Mental Health: A Report of the Surgeon General." National Institute of Mental Health, 1999.

overarching levels of care required to manage varying acuities within the behavioral health system.[8] According to the federal Substance Abuse and Mental Health Administration (SAMHSA), the following service domains are essential components of a complete behavioral health system:

Table 2.1: Continuum of Services

Domain	Types of Services
Care Integration	• General and specialized outpatient medical services • Acute primary care • General health screens, tests, and immunization • Comprehensive care management • Care coordination and health promotion • Comprehensive transitional care • Individual and family support • Referral to community services
Prevention and Wellness	• Screening, brief intervention, and referral to treatment • Brief motivational interviews • Screening and brief intervention for tobacco cessation • Parent training • Facilitated referrals • Relapse prevention/wellness recovery support • Warm line[9]

Engagement Services	• Assessment
	• Specialized evaluations
	  ○ Psychological
	  ○ Neurological
	• Service planning and crisis planning
	• Consumer/family education
	• Outreach

Outpatient Services	• Individual evidence based therapies • Group therapy • Family therapy • Multi-family therapy • Consultation to caregivers
Medication Services	• Medication management • Pharmacotherapy, including Medication Assisted Treatment (MAT) • Laboratory services
Rehabilitative Community Support	• Parent/caregiver support • Skill building ○ Social

[8] Description of a Good and Modern Addictions and Mental Health Service System, SAMHSA, April 18, 2011.
[9] A *warm line*, in contrast to a crisis hotline, is an earlier intervention that provides resources to individuals in need to prevent escalation into crisis.

Domain	Types of Services
	○ Daily living ○ Cognitive • Case management • Behavioral management • Supported employment • Permanent supported housing • Recovery housing • Therapeutic mentoring • Traditional healing services
Recovery Supports	• Peer support • Recovery support coaching • Recovery support center services • Supports for self-directed care • Continuing care for substance use disorders
Other Living Supports	• Personal care • Homemaker • Respite • Supported education • Transportation • Assisted living services • Recreational services • Interactive communication technology devices • Trained behavioral health interpreters
Intensive Support Services	• Substance abuse intensive outpatient services • Partial hospital • Assertive Community Treatment • Intensive home based treatment • Multi-systemic therapy • Intensive case management
Out of Home Residential Services	• Crisis residential/stabilization • Clinically managed 24-hour care • Clinically managed medium intensity care • Adult mental health residential services • Children's mental health residential services • Adult substance abuse residential services • Youth substance abuse residential services • Therapeutic foster care
Acute Intensive Services	• Mobile crisis services • Medically monitored intensive inpatient • Peer based crisis services • Urgent care services • 23 hour crisis stabilization service • 24/7 crisis hotline

The categories of services listed in Table 2.1 are widely recognized as the foundation of an effective mental health and substance abuse system: a "good and modern" behavioral health system.[10] With a comprehensive continuum of care in place, a system is able to treat each consumer effectively in an appropriate service setting, regardless of age, diagnosis, or acuity. Conversely, any deficiencies in this service array preclude individuals needing a specific level of care from receiving the most appropriate treatment, diminishing the effectiveness of referral and placement policies at directing consumers to proper care, and typically resulting in costlier, more restrictive, or less effective care. It is best practice for a behavioral health system to provide this wide array of services, from prevention to acute care, without any gaps in the continuum.

From the perspective of overall structure, the Department's delivery system does not include all of the levels of care and service capacity needed for effectiveness. The most significant gap in the system is evident in the lack of sub-acute services for the adult population. Typically, this level of care includes a variety of residential services that target consumers at high risk of experiencing crisis, but who are not currently severely unwell. These intensive residential services offer a short-term alternative to inpatient treatment, have either 24-hour staffing or staff on-call, and incorporate therapy or psychoeducational programs. They do not have capacity for the highest levels of acute intervention, but are consequently also less expensive than acute care. In general, these services are designed to be a *step-down* (and *step-up*) between institutional services and traditional community-based care.

Although the Department has invested heavily in the last decade into building both long-term and sub-acute residential infrastructure for youth through the Bring the Kids Home (BTKH) initiative, there is no analog for these types of services in the adult population. As a result, the Department does not provide effective services for the small but potentially extremely high-cost population of individuals with serious mental illness (SMI) who require a lower level of intervention than inpatient psychiatric care, but more intensive than the services available at a typical community provider. Similarly, this lack of infrastructure prevents the State from utilizing sub-acute resources to manage transitions proactively between hospital and community.

Although the lack of a sub-acute layer of care for adults is the major gap in the service system—and treated at greater length in Section 2.5 and in PCG's discussion of referral and placement policies in Section 5.2—regional deficiencies in the service continuum can be found throughout the state in many higher-acuity services, particularly many acute and intensive support services that depend upon larger population centers and do not scale well to Alaska's extensive rural areas. Regional gaps include intensive supports, living supports, and community and recovery supports, as well as a paucity of substance abuse services in many areas, including the Southcentral Region, which is discussed in more detail in the next section.

[10] Ibid.

2.2.2. FINDING: Although the Department has successfully introduced new service capacities and more effective types of treatment in some parts of the care continuum, other parts of the continuum have witnessed a reduction in service capacity.

Related to the service gaps in the Department's behavioral health continuum of care discussed in the previous section, PCG's review also revealed a gradual reduction in service capacity in some parts of the continuum that have affected utilization. In some regions of the state, particularly in the fast-growing Matanuska-Susitna Valley, system effectiveness has become substantially diminished by a lack of capacity for providing core behavioral health services, while in other areas, such as Fairbanks and the Interior region, provider insolvency has led to significant service disruptions in recent years. Additionally, lack of financing mechanisms for substance abuse has resulted in diminished treatment services for SUD, as reflected both in the plateau of numbers served, as well as facility closures at various times during the review period. The unavailability of appropriate and affordable housing resources continues to be a challenge throughout Alaska.

On the other hand, the Department can boast a number of important successes and areas of progress in developing the State's service delivery system. Prominent among the Department's accomplishments has been a rapid growth in the State's telebehavioral health infrastructure, as well as a maturation of the acute and sub-acute services newly available to the youth population in the wake of the BTKH initiative. However, even in these areas, much of the Division's progress has involved "laying the groundwork" for future services, through regulatory overhauls and new financing mechanisms, indirectly supporting service delivery, but still requiring partnered providers to take advantage of these opportunities in order to build additional capacity for priority services. Among these administrative transformations, DBH recently established a unified set of regulations designed to align mental health and substance abuse services into an integrated behavioral health system. As discussed more fully in other sections, DBH also implemented a uniform electronic management system to collect and report grantee performance,[11] as well as a performance management framework for monitoring public funding.[12] Significantly, the Department also developed payment mechanisms for some previously unfunded services, such as peer support, in order to incorporate these needed resources into the delivery system through Medicaid.

PCG describes specific areas of service growth and decline in more detail in our evaluation of the Department's continuum of care in Section 2.5.

[11] See Sections 8.0 (Information Technology), 9.0 (Grants and Contracts), and 12.0 (Utilization Tracking) for details on the Department's accomplishments in this area.
[12] See Section 4.0 (Results-Based Measures) for details on the Department's accomplishments in this area.

2.2.3. FINDING: Access to services increased significantly during the review period, but the growth in service utilization has occurred unequally across regions, and disproportionately in mental health over substance abuse services.

Among the most significant trends in service delivery is the increase across the board in the number of individuals receiving services within the State system. From 2009-2013, all of the major service populations within the Department showed growth during the five-year period; however, the rate of growth is sharply distinguished between mental health and substance abuse. Additionally, there were important differences in the growth rate for adult mental health consumers versus children and adolescents: a fact which is especially important when considering relative expenditures between adult and youth populations.[13] Table 2.2 shows the disparities in growth over the period. The fastest growing population among consumers was clearly the adult mental health population; the number of adults with any mental illness (AMI) grew by over 53.4%. The subset of adults with a serious mental illness (SMI) grew even faster, at 65.9%. The youth population demonstrated moderate growth as a whole, though the incidence of youth exhibiting serious emotional disturbance (SED) did not show the same pattern as the mental health population as a whole. The substance abuse population, by contrast, grew by only 5.7% during the period, remaining essentially flat.

Table 2.2

Growth Rate of Individuals Receiving Community Services, 2009-2013					
Fiscal Year	**Youth SED**	**Total Youth MH**	**Adult SMI**	**Adult AMI**	**SUD**
2009	2,728	4,605	6,793	8,834	6,994
2010	2,833	4,919	7,532	9,650	7,049
2011	3,031	5,199	7,767	10,353	7,038
2012	2,924	5,232	10,414	12,953	7,461
2013	2,978	5,339	11,269	13,553	7,391
5-Yr. Growth	**9.2%**	**15.9%**	**65.9%**	**53.4%**	**5.7%**

Source: DHSS, AKAIMS

When viewing the sharp increase in the adult mental health population, it should be noted, however, that the Department began in FY 2012 to include consumers who received only self-management services from community providers, which was not a part of the counts in prior years. However, even when these recipients are bracketed off of the community utilization figures, the increase in the adult mental health population has remained steady, at roughly 36% growth.

[13] See Section 2.3.4.

Of course, detailing the raw numbers of individuals served provides only an incomplete picture of the Department's success in serving individuals in need throughout the state. Utilization needs to be contextualized, on the one hand, by comparing the number of consumers served to the estimated prevalence of behavioral health disorders within Alaska's population, and on the other hand, by measuring the growth in recipients against the growth of the general population. Each of the two comparisons yields a distinct type of "service penetration rate," which provides a measure of the level of access to services within the population.

For adults, the prevalence of mental health disorders within a population is most commonly estimated based on data collected annually through SAMHSA through the National Survey on Drug Use and Health (NSDUH). As presented in Table 2.3, the estimated prevalence of SMI within Alaska's population varies between 3.5% and 4.3% of the population, which extrapolated from census data, includes approximately 18,100 to 23,600 individuals. When compared to the number of unique SMI individuals receiving community services during that time, it appears that the penetration rate for community services improved from 37.5% to 47.7%, which suggests major improvements in the Department's ability to reach its core service population.

Table 2.3

Percentage of Estimated SMI Population Receiving DHSS Community Services				
Year	**Estimated State SMI Prevalence***	**Estimated SMI Prevalence as % of State Population****	**Unique SMI Individuals Served in Community**	**DHSS Penetration Rate**
2009	18,095	3.5%	6,793	37.54%
2010	21,586	4.1%	7,532	34.89%
2011	22,127	4.1%	7,767	35.10%
2012	22,546	4.2%	10,414	46.19%
2013	23,613	4.3%	11,269	47.72%

* Estimated number of individuals based on census estimates of Alaskans aged 18 and older.
** Prevalence estimates based on National Survey on Drug Use and Health.

The prevalence of mental health issues in the general population—the AMI population—is calculated similarly, using the same NSDUH data, the major difference being that the estimated prevalence of mild to moderate mental health disorders is significantly higher than the debilitating disorders of the SMI population. From 2009-2013, estimates of AMI prevalence ranged from 17-19% population, or between 86,000 and 103,000 people in the state thought to have some sort of mental health disorder. For the AMI population, like the SMI population, the penetration rate increased during the period, from 10.2% in 2009 to 13.3% in 2013.

In the case of children's mental health, there is no instrument for measuring youth disorders comparable to NSDUH. Many individual studies employ a variety of methodologies, with differing results. Consequently, policymakers often employ the most conservative prevalence estimates found among these studies, which

estimates that SED can be found in approximately 5% of a given youth population. PCG applied these assumptions to Alaska's census figures to yield a penetration rate of over 60% of the youth population. Since the increase of SED consumers was more gradual than the adult population during the period, the penetration rate did not grow dramatically, but certainly held steady with estimated prevalence, and perhaps made slight inroads into serving a greater share of the state's SED population.

Table 2.4

Percentage of Estimated SED Population Receiving DHSS Community Services				
Year	Estimated State SED Prevalence*	Estimated SED Prevalence as % of State Population**	Unique SED Individuals Served in Community	DHSS Penetration Rate
2009	4,361	5.0%	2,728	62.55%
2010	4,461	5.0%	2,833	63.50%
2011	4,518	5.0%	3,031	67.09%
2012	4,570	5.0%	2,924	63.98%
2013	4,598	5.0%	2,978	64.77%

* Estimated number of individuals based on census estimates of Alaskans aged 9-17.
** Prevalence estimate of 5% based on Surgeon General's Report of Mental Health.

In the case of substance abuse, it does not appear that the penetration rate for SUD services manifested any statistically significant increases. Table 2.5 reveals a slight increase in the penetration rate between 2009 and 2013, from 12.95% to 13.32%.

Table 2.5

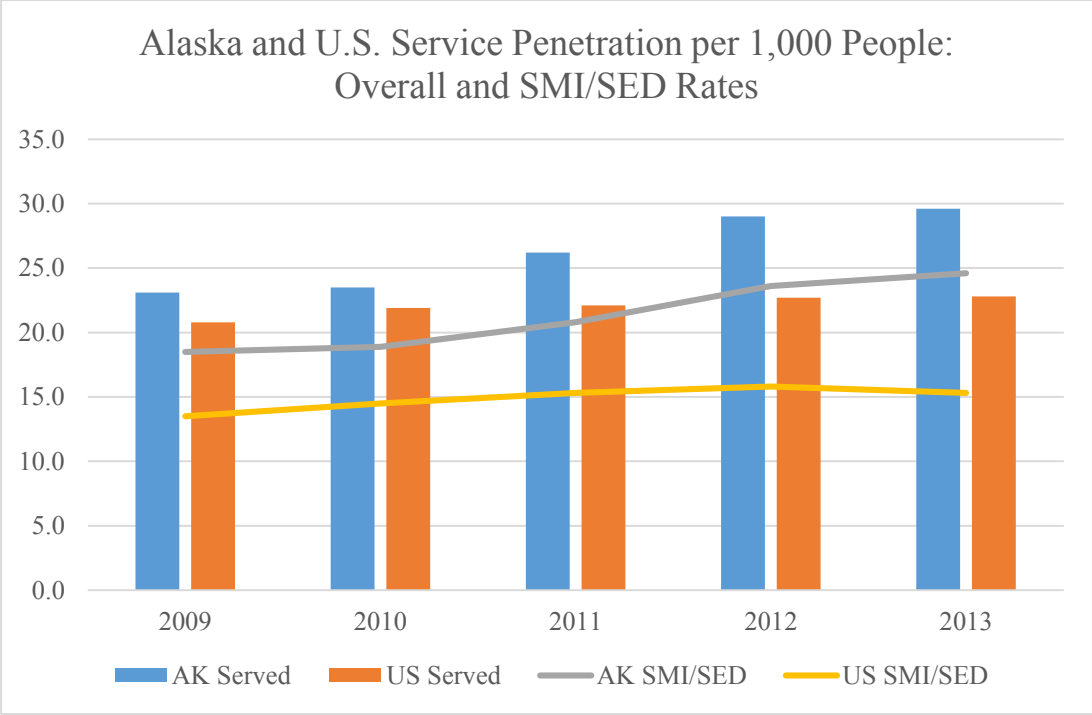
Percentage of Estimated SUD Population Receiving DHSS Community Services				
Year	Estimated State SUD Prevalence*	Estimated SUD Prevalence as % of State Population**	Unique SUD Individuals Served in Community	DHSS Penetration Rate
2009	54,001	9.4%	6,994	12.95%
2010	55,239	9.4%	7,049	12.76%
2011	55,220	9.3%	7,038	12.75%
2012	59,901	9.9%	7,461	12.46%
2013	55,473	9.1%	7,391	13.32%

* Estimated number of individuals based on census estimates of Alaskans aged 18 and older.
** Prevalence estimates based on National Survey on Drug Use and Health.

What is more striking in this table is the low penetration rate overall for the state, suggesting that significant opportunities still exist for outreach to SUD individuals who are not currently seeking services, or for whom services are not available. Based on extrapolations from the NSDUH sample, there were roughly 49,000 SUD individuals in 2012-2013 who did not receive treatment. Of these, an estimated 47,000 did not feel the need for treatment, leaving approximately 2,000 individuals who either did not seek treatment, but believed they needed it, or sought out treatment but were unable to receive it from a community provider.[14] PCG's recommendations for improving SUD treatment capacity can be found in Section 2.4.2.

In addition to evaluating service penetration as a function of estimated prevalence, it is also helpful to measure penetration relative to the general population, which in many respects, offers greater insight into improvements in service capacity and simplifies comparison with other state programs. Based on penetration rate figures that measure individuals served per 1,000 population, Alaska appears to have increased access to its mental health population significantly during the period. Penetration rates in Alaska were both higher than U.S. averages overall, and exhibited stronger increases from 2009 to 2013 than national trends. These comparative penetration rates are illustrated in Figure 2.1 below:

Figure 2.1



Source: SAMHSA Uniform Reporting System, 2009-13

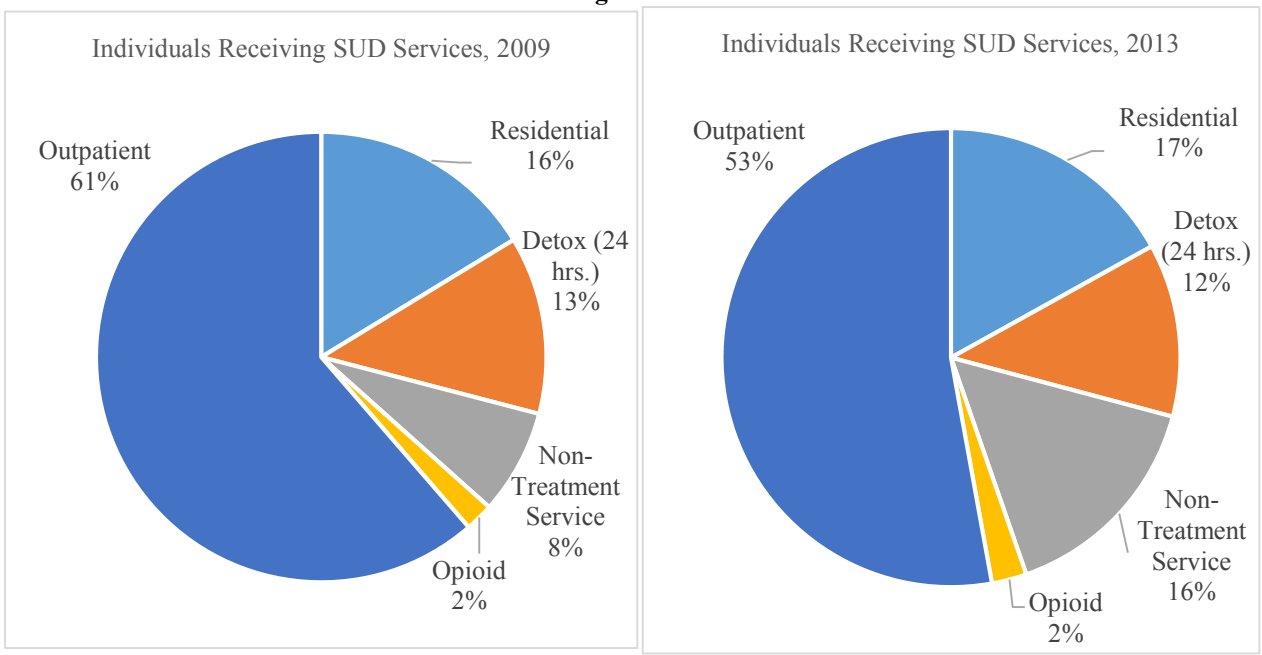
In the case of the SUD population, national comparison data was not available to determine how well Alaska's SUD service penetration rate per 1,000 population fares in comparison to national averages.

[14] NSDUH Estimates, 2012-2013.

However, it is clear that DHSS has not been able to make significant inroads into improving access to SUD services within the state, considering that the penetration rate from 2009 to 2013 declined slightly, from 10.2 to 10.1 per 1,000 population.[15]

Also problematic is the fact that utilization during the period shifted significantly away from delivery of treatment services to more superficial contacts between community providers and SUD individuals in need. In other words, even though the number of individuals receiving *any* SUD services increased slightly during the review period, the number of individuals receiving *treatment* services actually declined. In 2009, 6,447 individuals received some sort of SUD treatment service; by 2013, this number decreased to 6,172.[16] As illustrated in Figure 2.2, a combination of individuals receiving outpatient, detoxification, and residential SUD treatment made up 92% of the service population in 2009. By 2013, only 84% of the individuals included in the SUD population were receiving treatment. The rest received exclusively non-treatment services, such as assessment or case management, but these services did not lead to treatment. This section of the population grew from 8% to 16% between 2009 and 2013.

Figure 2.2



Source: DHSS, AKAIMS

In order to evaluate the Department's success in improving access to behavioral health services, it's also necessary to understand how services increased or decreased on a regional basis within the state. PCG's regional analysis followed DBH practice in employing the Alaska-defined administrative areas used in the

[15] Figures derived from Alaska census data and SUD service population reported in AKAIMS.
[16] Figures from DHSS, AKAIMS.

Division of Behavioral Health Regions,[17] which divides the state into four geographical regions: Anchorage,[18] Northern Region,[19] Southcentral Region,[20] and Southeast Region.[21] When service populations are broken down by region, several facts become apparent:

1. Disparities in overall access to services exist between regions, as a function of general population,
2. Improvement in access to services has occurred unevenly across the state, and
3. Regional capacity by service line varies significantly across the state.

Figure 2.3 provides some insight into the first two points. Assuming relatively equal levels of behavioral health need among different regions, it would be expected that the Anchorage Region would have the greatest number of individuals receiving services, relative to the other three regions. As Figure 2.3 illustrates, it is probably the case that Anchorage was underserved in 2009, given the fact that only 32% of the service population was based in Anchorage, despite the fact that approximately 40% of the state population resides in the municipality. To the Department's credit, Anchorage experienced significant growth in the population served, so that by 2013, the Anchorage service population is proportionate to the percentage of the general population residing in Anchorage. However, access to service appears to be more robust in the Southeast Region than the remaining two regions, considering that 21% of the service population resides in the Southeast, despite representing only 10% of the general population.

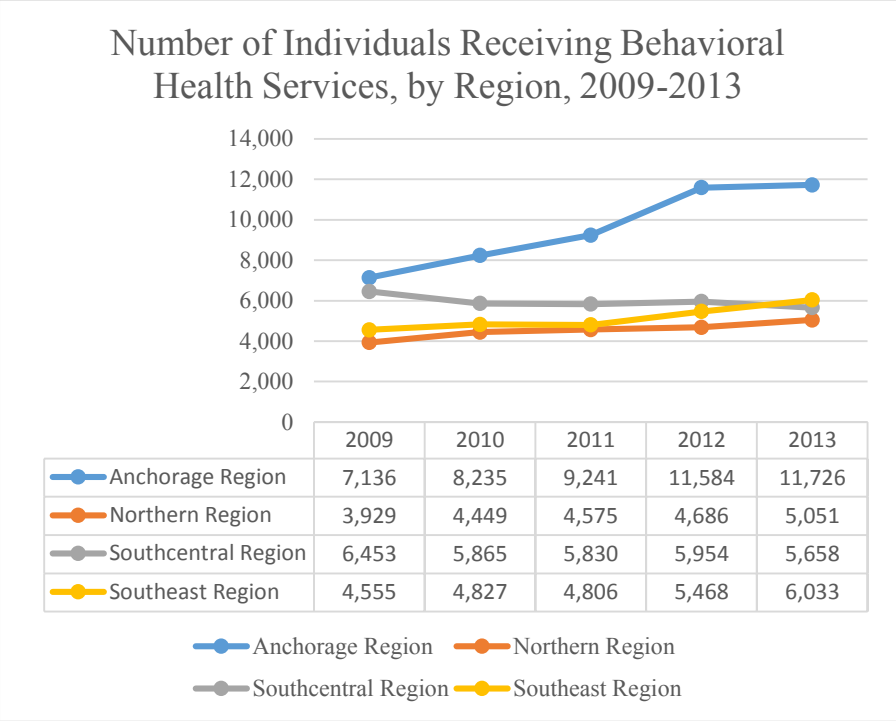
In regard to the second point, it is also clear that access increased disproportionately across the state, ranging from rapid growth in Anchorage to eroding access in the Southcentral Region. Figure 2.3 indicates that improvements to access in Anchorage far outpaced the other three regions, partly in response to an apparent deficit in access at the beginning of the review period. From 2009 to 2013, the number of individuals receiving behavioral health services in Anchorage grew by 65%, in comparison to 23% growth in the overall service population. Notably, the service population also grew steadily in the Northern and Southeast Regions, 29% and 32% respectively. However, the number of individuals receiving services in the Southcentral Region actually receded by 12% during the period, dropping from a service population of 6,453 to 5,658.

While the numbers convey a picture of overall improvement in access within the system, the decline in the service population in Southcentral Region is of some concern, especially when considering this trend in the broader context of demographic change in Alaska. Census figures indicate that the Southcentral Region, primarily in the Matanuska-Susitna Valley, is the fastest growing region of the State. Not only has access to services not kept pace with these demographic patterns, but also regional service trends appear to be

[17] See http://dhss.alaska.gov/dph/InfoCenter/Pages/ia/brfss/geo_dbh.aspx for specific composition of each region by borough and census area.
[18] Anchorage Region includes Municipality of Anchorage only.
[19] Northern Region includes the following boroughs and census areas: Bethel, Denali, Fairbanks North Star, Southeast Fairbanks, Nome, North Slope, Northwest Arctic, Kusilvak, and Yukon-Koyukuk.
[20] Southcentral Region includes the following boroughs and census areas: Aleutians East and West, Bristol Bay, Dillingham, Kenai, Kodiak, Lake and Peninsula, Matanuska-Susitna, and Valdez-Cordova.
[21] Southeast Region includes the following boroughs and census areas: Haines, Hoonah-Angoon, Juneau, Ketchikan, Petersburg, Prince of Wales-Hyder, Sitka, Skagway, Wrangell, and Yakutat.

moving in the opposite direction. It should be noted that the Department and other system stakeholders are well-aware of the access trends specific to the Matanuska-Susitna Valley. Many of the service capacity issues there have already been studied extensively,[22] and PCG does not intend to reproduce analyses that have been published at length elsewhere. However, some of the broader service implications are discussed here, as well as in Sections 5.0 and 10.0, especially as they affect referrals and placements and opportunities for federal cost collaboration.

Figure 2.3

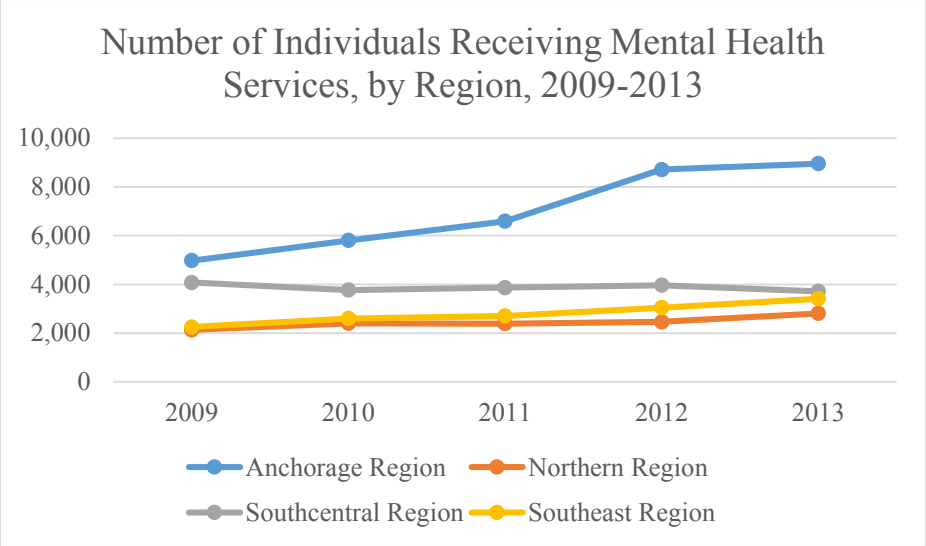


Source: DHSS, AKAIMS

In addition to these regional trends in overall access, other disparities become evident when the behavioral health service population is broken down into distinct mental health, substance abuse, and co-occurring disorder populations. As indicated in Figure 2.4, the mental health service population appears to have driven overall behavioral health trends. Regional disparities in access to mental health services also reflect the trends discussed for behavioral health services as a whole, with the greatest improvements in access occurring in Anchorage, more moderate improvements in the Northern and Southeast Regions, and declines in the Southcentral Region.

[22] See, for example, a recent report by the Mat-Su Health Foundation, *Mat-Su Behavioral Health Environmental Scan: Report 1* (November 2014), for a more detailed treatment of the current service challenges facing the region.

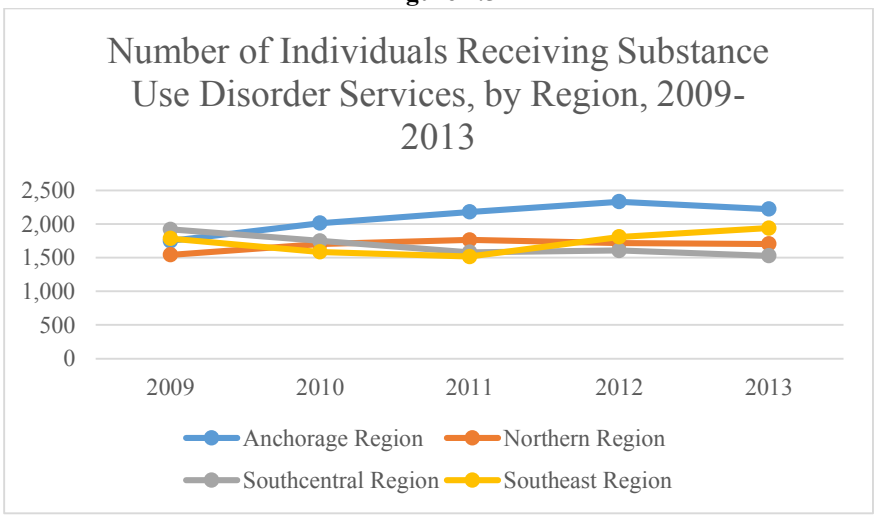
Figure 2.4



Source: DHSS, AKAIMS

The picture changes significantly, however, when the SUD population is considered separately from the mental health population. Regional trends become more ambiguous, with none of the regions demonstrating unqualified gains during the review period. Figure 2.5 illustrates changes in the SUD population:

Figure 2.5



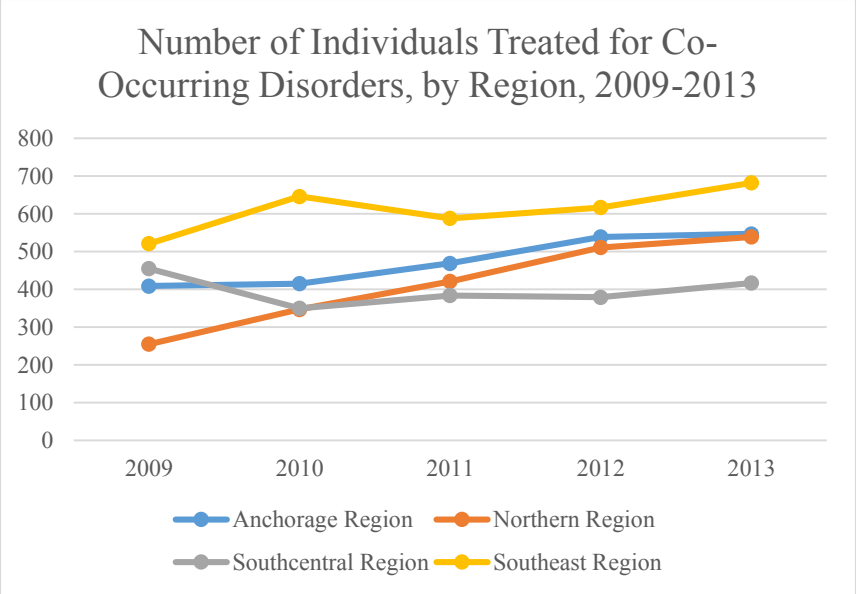
Source: DHSS, AKAIMS

Figure 2.5 shows that the greatest increases were again achieved in the Municipality of Anchorage, also accompanied by overall improvement in the Northern and Southeast Regions and reduction in the Southcentral Region. But unlike the mental health population, numbers for the SUD service population seems to be more variable from year to year, with all regions experiencing decline and recovery at different

points in the review period. While the number of individuals receiving services in Anchorage and the Northern Region increased in aggregate between 2009 and 2013, by the final year of the review, these populations appeared to be in decline. The Southeast, on the other hand, witnessed a dip in 2011, only to augment the population in later years. The Southcentral service population, consistent with other trends, saw an overall reduction in access.

Finally, growth trends in the service population for co-occurring disorders are also peculiar relative to overall trends. Although the Anchorage, Northern, and Southeast Regions showed growth, in contrast to Southcentral decline, the Southeast served the largest number of co-occurring disorders, despite representing only 10% of the general population. One reason for this access indicator may be the fact that service capacity for substance abuse services appears to be more robust in the Southeast Region, potentially enabling stronger integration of mental health and substance abuse services than in regions in which mental health and substance abuse capacity are more lopsided. Figure 2.6 illustrates the regional growth trends for individuals with co-occurring disorders.

Figure 2.6



Source: DHSS, AKAIMS

2.2.4. FINDING: The quality of overall service delivery has remained relatively static over the course of the review period.

The wide range of behavioral health performance measures currently used by the Department will be discussed in more detail in Section 4.0. In this section, PCG summarizes the most important measures employed by DHSS as a proxy for system performance. Most of the indicators analyzed here are also

identified in the DHSS RBA Framework as measures of the Department's core behavioral health activities. PCG's evaluation of individual service types can be found in Section 2.5. Three broad classes of performance indicators have been identified to measure the Department's hospital, community treatment, and prevention services. Although DBH has demonstrated some important successes in particular service lines and targeted interventions, in other areas, regressive trends have emerged. On the whole, outcome measures have produced only mixed results, with system performance remaining relatively static.

The most concerning performance trends can be seen in worsening re-admission rates at the Alaska Psychiatric Institute (API), as illustrated in the table below. Although the hospital demonstrated some success in curbing re-admission rates from 2009 to 2011, API's transition to an acute care model in FY 2012 due to spiking admission rates appears to have only exacerbated re-admission rates. Indicators for both 30-day and 180-day re-admissions increased sharply by 2012-2013 and have not abated. Currently, one third of all admissions at API are re-admissions.

Table 2.5

API Re-Admission Rates		
Year	**30-Day**	**180-Day**
2009	13.2%	29.0%
2010	14.2%	29.1%
2011	13.0%	26.5%
2012	15.6%	32.9%
2013	16.7%	32.9%

Source: SAMHSA Uniform Reporting System, 2009-13

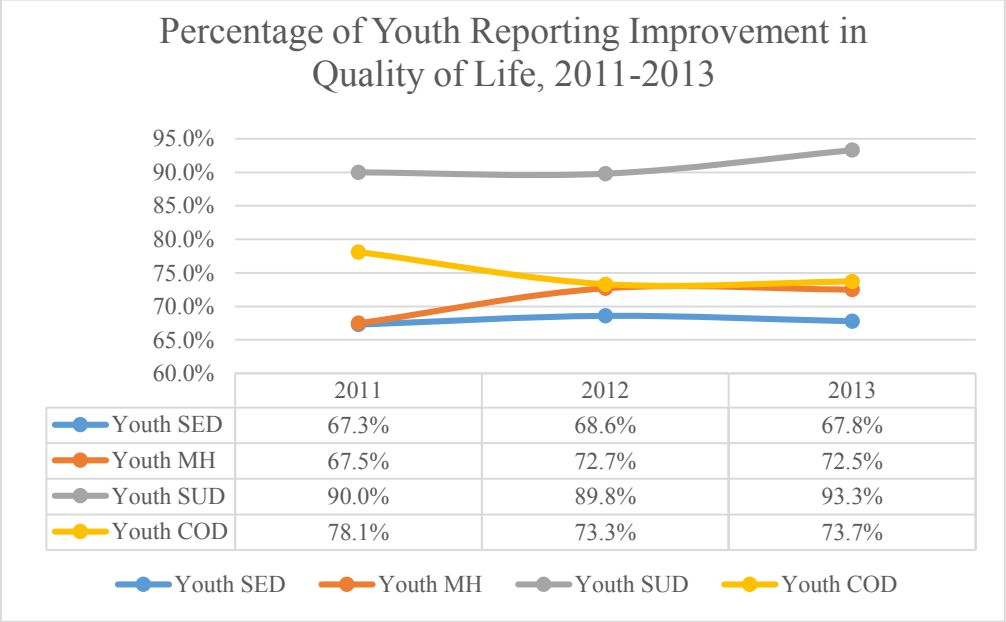
There are two major performance indicators for the Department's community treatment and recovery services, which make up the bulk of DHSS behavioral health expenditures. For mental health services, the primary metric used by the Department to measure provider performance are the *quality of life* improvement indicators captured in the Client Status Review (CSR) reporting tool. For substance abuse services, the proxy indicator of service quality is the measure of the percentage of individuals who successfully completed their substance abuse treatment program. In both of these domains, quality improvement has remained relatively flat.

The survey questions used to solicit responses to measure *quality of life* differ in important respects for adults versus children and adolescents, since an indicator like the ability to find meaningful employment may be crucial for determining an adult's level of improvement, but is clearly not relevant for a young child. For this reason, the Department has developed different CSR instruments for the two populations, and measures are broken out by results for the two populations. There are two interesting points to be noticed about the youth and adult outcomes. First, the detailed performance trends for youth and adults are in most respects mirror images of the other, with adult measures showing improvements where youth

measures reveal setbacks, and vice versa. Second, overall improvements in quality of life are mixed for both groups, upward trends for some service populations and downward trends for others.[23]

The table below presents reported improvements in quality of life for youth. Although consumer responses show significant improvements for the *general mental health* (MH) and *substance use disorder* (SUD) populations, for the Department's core *seriously emotionally disturbed* (SED) youth population, quality of life remained static, while youth with co-occurring disorders reported a significant decline. It should be noted here that significant changes in the service delivery system for youth, accompanied by increases in DBH spending per recipient, occurred during this period. Following up on the completion of the BTKH initiative, the Department began to develop new funding sources for youth SUD treatment as well as building additional sub-acute infrastructure for children which increased DHSS' ability to focus on a broader range of acuity in the youth behavioral health population.

Figure 2.7



	2011	2012	2013
Youth SED	67.3%	68.6%	67.8%
Youth MH	67.5%	72.7%	72.5%
Youth SUD	90.0%	89.8%	93.3%
Youth COD	78.1%	73.3%	73.7%

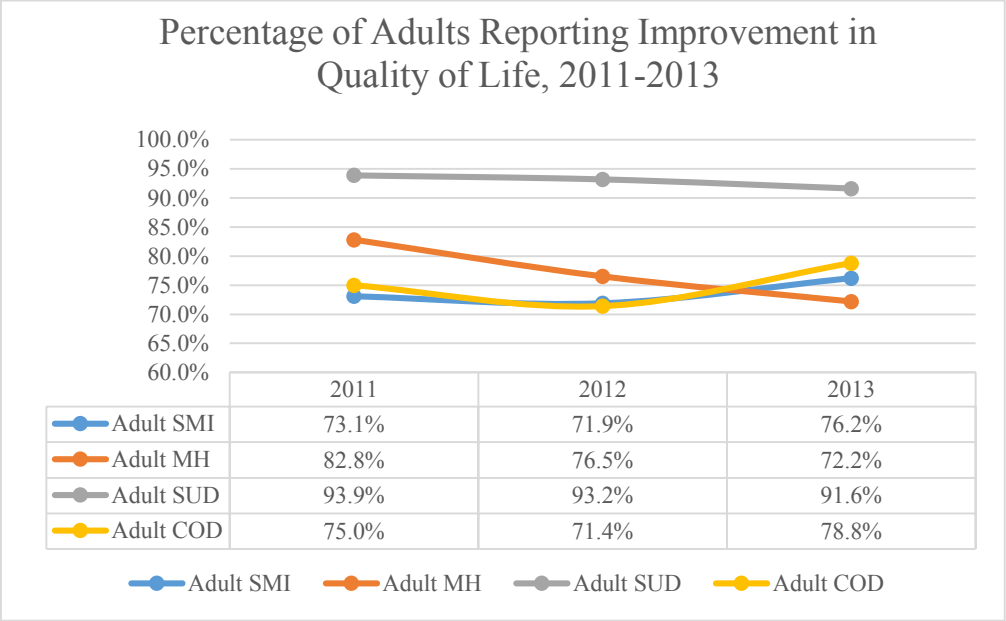
Source: SAMHSA Uniform Reporting System, 2009-13

The picture for adult service populations is somewhat different, but leads to a similarly equivocal conclusion. In Figure 2.10, an inconclusive portrait of quality of life improvement becomes evident, with major fluctuations in outcomes across services that resulted in overall gains for some populations, but not others. Although the SMI population demonstrated improvement in quality of life, the general mental health and SUD populations reported decreases—substantial in the case of mental health. Finally, in contrast to

[23] Quality of life improvement is reported here only for 2011-2013. Specific CSR tools for each population were developed and implemented at different times during PCG's review period, and cross-population results are only available for the last three years of the review period.

the youth population, the system appeared to demonstrate overall progress in serving the population with co-occurring disorders.

Figure 2.8



	2011	2012	2013
Adult SMI	73.1%	71.9%	76.2%
Adult MH	82.8%	76.5%	72.2%
Adult SUD	93.9%	93.2%	91.6%
Adult COD	75.0%	71.4%	78.8%

Source: SAMHSA Uniform Reporting System, 2009-13

Specific to substance abuse, the Department measures rates of successful completion of DHSS-funded SUD treatment programs. Derived from CSR data, this indicator serves as a process proxy for quality outcomes in the SUD services offered by the State's private providers. Performance in this domain remained flat during the review period, hovering around a 50% successful completion rate. Beginning from a 53% baseline completion rate in 2009, outcomes actually dropped during the middle of the review period, but returned to a 53% success rate by 2013.

The Department's behavioral health prevention efforts make up the third major area of DHSS performance measurement. Although prevention measures constitute some of the best indicators of long-term performance trends, they are also the least integrated into DBH's quality improvement framework. For these types of services, the Division often works within broader coalitions of stakeholders focused on health prevention and promotion initiatives, such as the Division of Public Health, and typically is not the primary steward of the Department's performance indicators for population-based prevention. However, as is illustrated in the most recent report on *Healthy Alaskans 2020* strategic initiatives, the Division's Prevention and Early Intervention (PEI) section and advisory groups are key partners in influencing the population trends for which the Department holds itself accountable.[24]

[24] Healthy Alaskans 2020. *Strategies, Actions, and Key Partners to Reach Our 25 Health Improvement Goals*. July 2015. Available at: http://hss.state.ak.us/ha2020/assets/HA2020_Strategies_Actions.pdf

Broadly, DHSS prevention and promotion measures focus on four domains: tobacco, alcohol, mental health promotion, and suicide. Like the other sectors of DHSS behavioral health intervention, Department prevention outcomes have been mixed. In the first domain, which focuses on tobacco reduction, Alaska has seen the most consistent long-term improvements, with adolescent cigarette use dropping from 19.2% to 14.1% from 2001 to 2011.[25] Among adults the percentage of cigarette use has also declined, from a high of 29.4% cigarette use in 2002 to a 21% reported use in 2012.[26] The long-term results of alcohol prevention efforts have been more inconclusive. For instance, the State has been unable to reduce adult binge drinking over the long-term. Between 2000 and 2013, the binge rate has decreased only a percentage point, from 19.7% to 18.5%, with significant fluctuations, from a 16.1% low in 2008, to a high of 21.8% in 2010.[27]

Three population indicators have become special Department priorities within the *RBA Framework* due to the lack of success in reversing negative outcomes. These indicators involve the state's suicide rate, which is among the highest in the nation, as well as related trends in youth and adolescent mental health indicators. Since identifying these trends as priority areas in the *RBA Framework* and in the *Healthy Alaskans 2020* prevention plan, the Department's prevention efforts so far have not yielded improvements. The percentage of adolescents reporting sadness or hopelessness lasting longer than two weeks increased from 25.2% in 2009 to 27.2% in 2013. Similarly, the average number of reported "mentally unhealthy days"[28] reported by adults rose from 2.6 per month in 2009 to 3.1 per month in 2013. Alaska's suicide mortality rate per 100,000 has also remained relatively static over the long-term. The rate increased from 19.6 in 2009 to 23.4 in 2013. Despite oscillations in the rate from year to year, the suicide mortality rate has not moved significantly from a rate of 21.1 in 2000 and the Department has failed to meet its own objectives in decreasing the rate.

2.3. Efficiency of Services

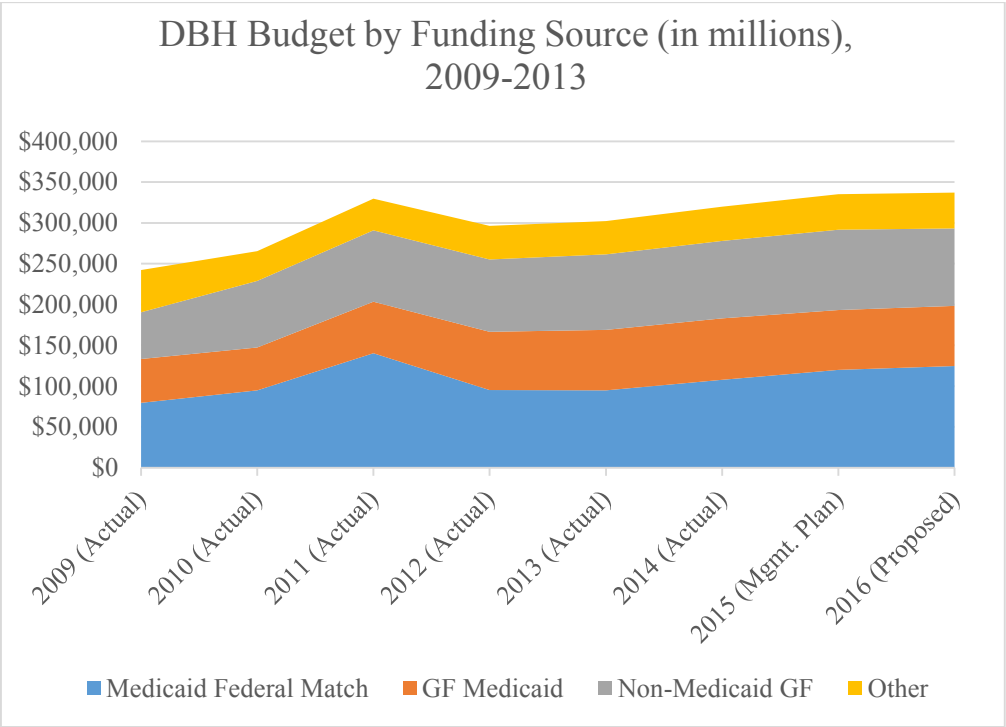
2.3.1. FINDING: Due in part to the Division of Behavioral Health's control over Alaska's Medicaid behavioral health expenditures, the Department has successfully leveraged federal matching funds to increase overall funds for services and coordinate behavioral health financing more efficiently.

As will be discussed in various sections throughout this report, the State's decision to house its Medicaid and behavioral health authorities under the same agency is for the most part good news for behavioral health services. Not only is administration organized to coordinate behavioral health service delivery across the grant- and Medicaid-financed delivery systems, but it also allows the Department to leverage multiple sources of federal financing in order to reduce the State's GF burden overall and to ensure that State spending can be targeted efficiently at the points in the delivery system where these dollars are most needed.

[25] Youth Risk Behavior Survey (YRBS)
[26] Behavioral Risk Factor Surveillance System (BRFSS)
[27] Ibid.
[28] The definition of "mentally unhealthy" days used in this measure, as surveyed in the BRFSS, includes stress, anxiety, depression, and other emotional disorders.

In most respects, the Department has taken advantage of this organization, infusing additional dollars into the behavioral health system at a time when many state mental health authorities (SMHAs) have experienced fiscal stagnation, and in some cases, drastic reductions in their budgets. From FY 2009-2013, the Division's mental health budget grew by over 22.5%, in contrast to 3.4% growth in SMHA-controlled spending nationally.[29] Much of this growth has been achieved by successfully transitioning the payment system from behavioral health grants funded primarily by GF spending into a Medicaid-driven system better suited to leveraging federal matching funds in order to extend GF dollars further. Figure 2.9 shows the pattern of overall growth in the Division's budget, from $242 million in FY 2009 to $337 million in the Governor's proposed FY 2016 budget.

Figure 2.9



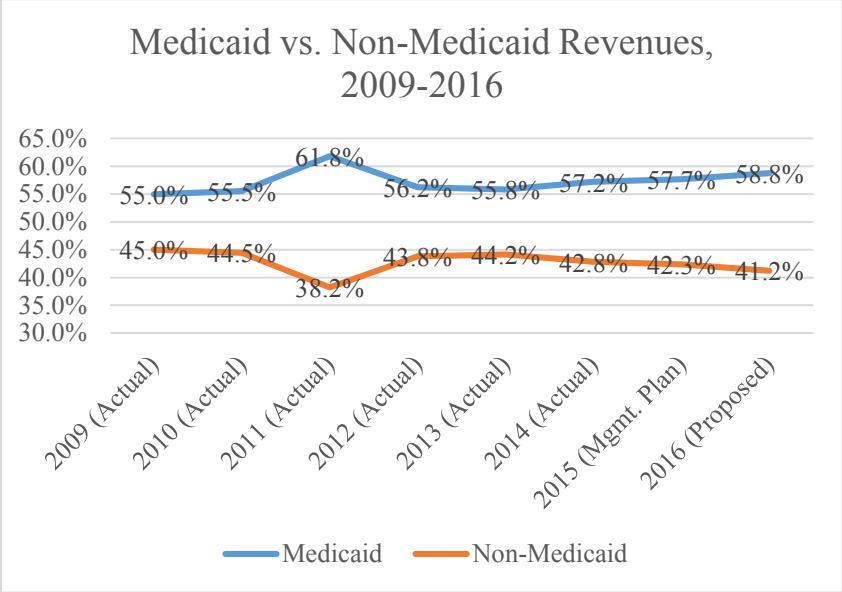
Source: Alaska Office of Management and Budget

The chart provides a high level orientation in regard to the major financing mechanisms used to fund the Department's behavioral health services. In 2013, GF dollars made up nearly 55% of total behavioral health spending, as compared to 45% in 2009. The State spent $166.8 million in GF in 2013, with roughly $74.2 million used to provide matching funds for the Medicaid program, and $92.6 million used to fund treatment grants and deliver direct services for hospital care and prevention programs. While 48% of GF spending was used to finance Medicaid in FY 2009, that percentage was down to 45% in FY 2013, and now hovers at 43%, reflecting the fact that GF dollars have increasingly shifted to grants to support services not covered adequately by Medicaid. Despite the fact that GF financing has grown significantly to maintain behavioral

[29] NASMHPD Research Institute, State Profile System, 2009-2013.

health grants, the role of grant financing within the delivery system actually declined during the review period. As shown in Figure 2.10, Medicaid has played an increasingly dominant role in underwriting the system over time.

Figure 2.10



Source: Alaska Office of Management and Budget

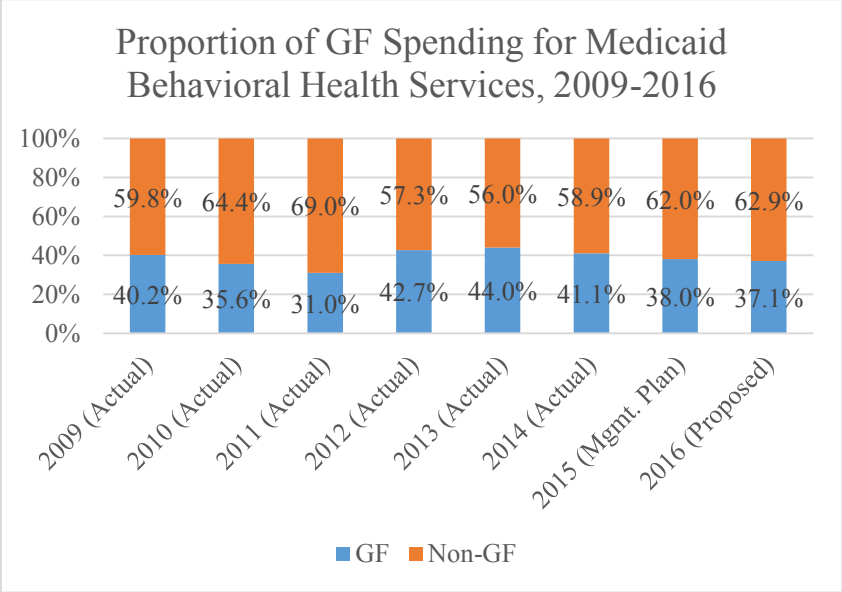
Figures 2.9 and 2.10 can be taken together to gain a broader perspective on the dynamics of change within the payment system from FY 2009 to the present. The most noticeable aspect of both charts is the "bump" that emerges from FY 2010 to 2012, which reflects the enhanced Federal Medical Assistance Percentage (FMAP) available to Alaska as a result of increased federal matching through the American Recovery and Reinvestment Act of 2009 (ARRA). ARRA was in effect from October 2008 to June 2011, temporarily increasing Alaska's federal match from an FMAP typically hovering between 50-52% to an elevated FMAP of 61-62%. Although the aberration in expenditures due to ARRA obscures some of the more gradual, underlying shifts in behavioral health financing, it is an important part of the story, considering that some sectors of the delivery system maintained levels of spending characteristic of the ARRA period, even after the FMAP returned to the normal percentage.[30] The ARRA bump merely exaggerates the trend in spending shifting gradually from non-Medicaid to Medicaid services. Although the Department now spends lower proportions of its GF dollars on Medicaid behavioral services, it is increasingly proficient at using those dollars to draw down higher federal revenues, increasing the share of total Medicaid money within the system.

Figure 2.11 illustrates the ratio of GF to non-GF dollars used to finance Medicaid behavioral health services. In this figure, the ARRA bump is also visible, with the proportion of non-GF dollars spiking at 69% in FY

[30] Some of these effects are discussed in more detail in Section 2.3.4.

2011 as a result of the enhanced match. Importantly, although Alaska's FMAP decreased in FY 2012 to a percentage lower even than the pre-ARRA FMAP,[31] the figure also makes it evident that the Department has capitalized on opportunities to leverage enhanced federal matching where available.

Figure 2.11



Source: Alaska Office of Management and Budget

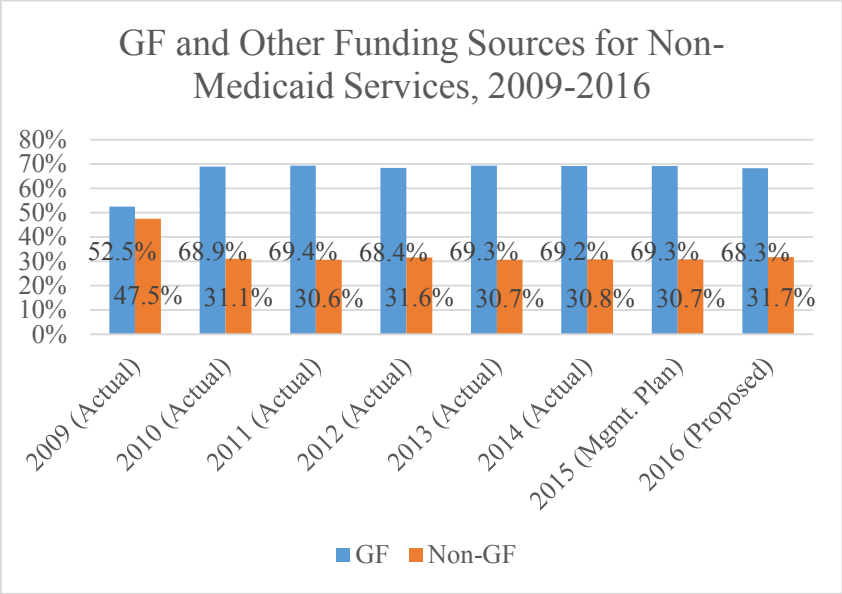
Although the percentage of Medicaid GF spending increased again to 43% after the historic low of 31.% in FY 2011, due primarily to ARRA, it has receded steadily in the Medicaid budget since that time. Two of the major reasons that the actual federal match is ultimately higher than the Medicaid FMAP are: 1) that a substantial part of the volume of Medicaid services is made up of claims for children's services, which receive an enhanced FMAP of 65%, and 2) that another large segment of services consists of claims from tribal providers in the state, which draw 100% FMAP when rendered to American Indian and Alaska Native (AI/AN) consumers.

However, on the non-Medicaid side of the State system, GF spending continues to make up the vast majority of funding for grant-based services. While grants play an increasingly smaller role within the system, they are extremely important, insofar as they provide the major source of funding both for community services and populations not covered by Medicaid, as well as making up for Medicaid shortfall. The adult service population, in particular, is dependent on GF grant spending, with a significantly lower proportion of Medicaid-eligible consumers in this population than in the youth population. This is especially the case for adults receiving substance abuse services. Figure 2.12 indicates the GF spending trends for non-Medicaid services. Although total GF dollars spent on non-Medicaid grants and direct services have increased

[31] The FY 2008 FMAP was 52.48% versus the FY 2012 FMAP of 50.00%.

gradually from FY 2009 to the present, in general their role as a funding source has remained static, without significant changes since FY 2010.

Figure 2.12



Source: Alaska Office of Management and Budget

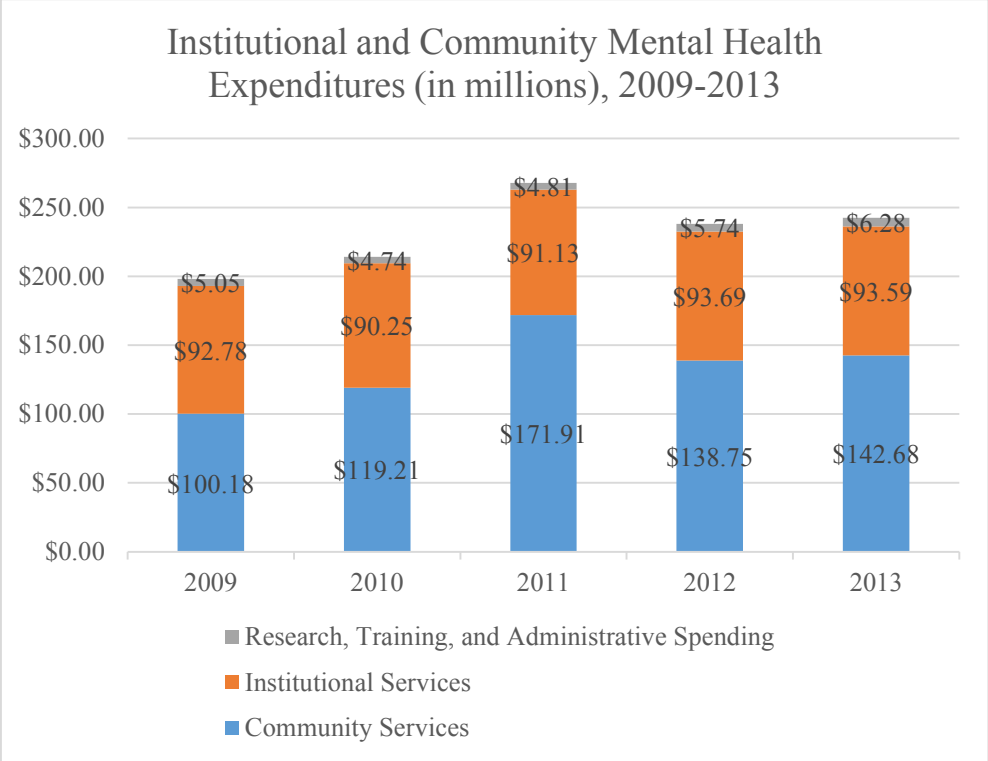
2.3.2. FINDING: Although the Department has progressively shifted spending away from institutional care to finance more efficient treatment within the community, increased numbers of community providers offering more intensive services are needed to realize the full benefits of community treatment.

Since the latter part of the 20th century, Alaska has undertaken a thorough process of de-institutionalization. As bed capacity and at API has gradually decreased over the last three decades, a greater share of Department resources have been transitioned to community providers to deliver services to behavioral health consumers in more cost-effective community settings when appropriate. Currently, API's operational bed capacity is only 80 beds, with approximately 55 beds available to adults in need of acute psychiatric care. As a result, only 12-14% of the Department's annual budgets in FY 2009-2013 was devoted to care delivered at the state hospital. Alaska is in the lower quartile of states in terms of the percentage of its annual budget spent on maintaining state hospitals.

Of course, API is not the sole setting for inpatient psychiatric care in the State, and a significant percentage of the Department's behavioral health dollars continue to be used to fund inpatient services at community hospitals and other inpatient facilities throughout the state. While the cost of inpatient care at API amounted to $31.7 million of FY 2013 behavioral health expenditures, the Department spent another $61.9 million on inpatient services at non-API facilities, meaning that API expenditures constitute nearly a third of all

inpatient expenditures. During PCG's five-year review period, total inpatient expenditures held steady at $90-93 million annually, despite the overall increase in spending between FY 2009-2013. As Figure 2.14 makes evident, increases in Department spending occurred almost entirely in community services.

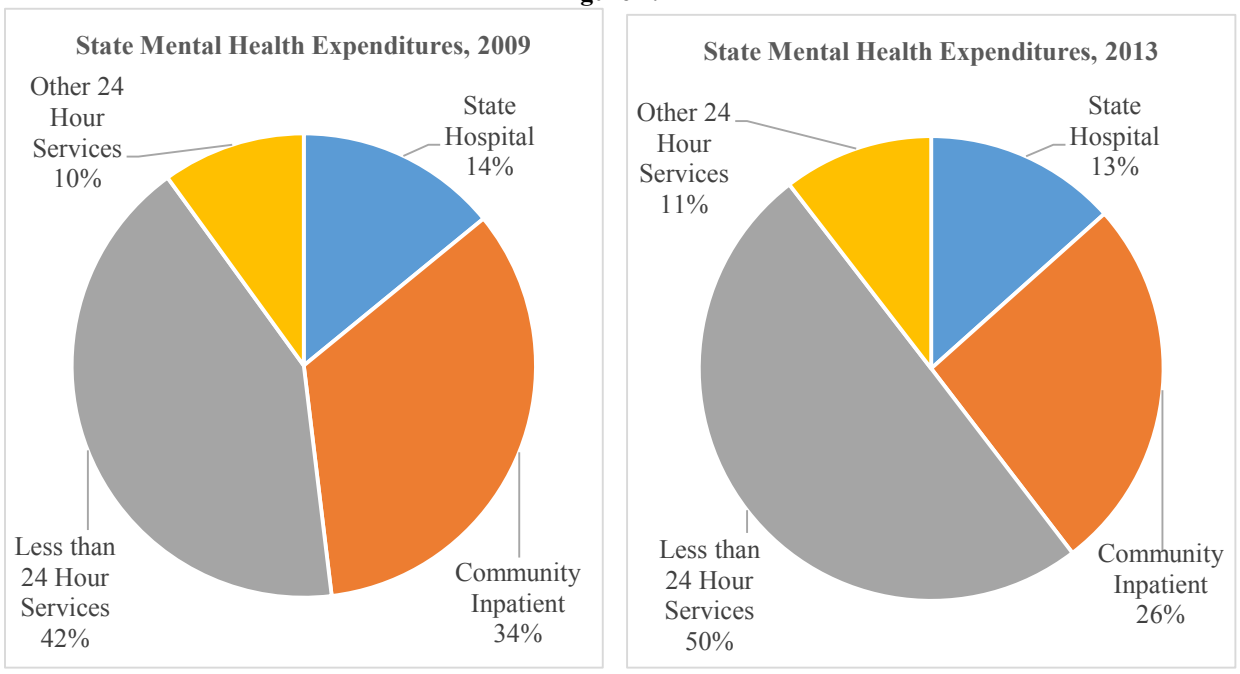
Figure 2.13



Source: NAMHPD Research Institute, State Profile System, 2009-13

Given the high cost of inpatient services relative to treatment in the community, the fact that the State has held inpatient spending constant is an encouraging trend in Department expenditures. Indeed, nearly all of the significant growth in expenditures has occurred in lower-cost outpatient community services. Figure 2.14 provides a more detailed picture of the different types of community and institutional services represented in overall mental health spending. Institutional services are divided primarily between inpatient services delivered at API and those delivered at private facilities. Community services are distinguished between less-than-24-hour outpatient services, and other-24-hour residential services. The figure clearly indicates the substantial shift from the hospitals to community outpatient settings. Outpatient services increased from 42% of behavioral health spending in FY 2009 to over 50% in FY 2013. With residential services included, community treatment made up 61% of total behavioral health expenditures by the end of the PCG review period.

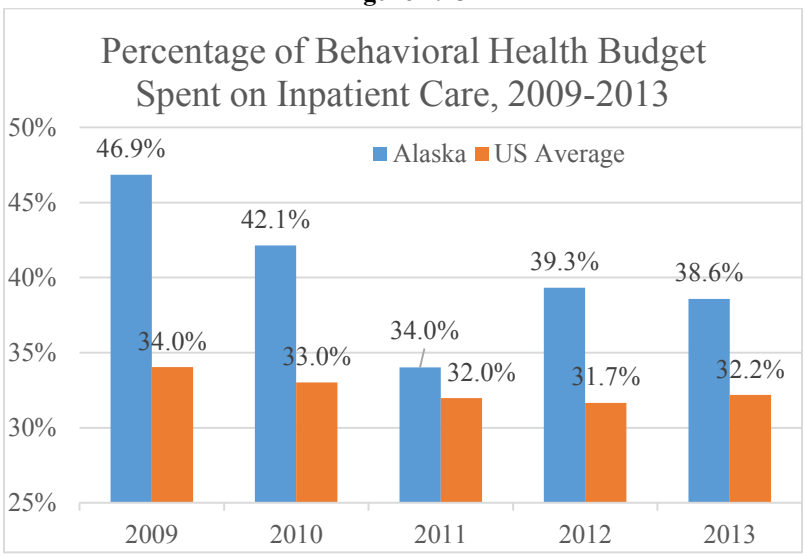
Figure 2.14



Source: NAMHPD Research Institute, State Profile System, 2009-13

Despite this significant progress in long-term de-institutionalization trends, there is evidence that Alaska continues to be over-dependent on inpatient care in comparison to many other states, as seen in Figure 2.15:

Figure 2.15

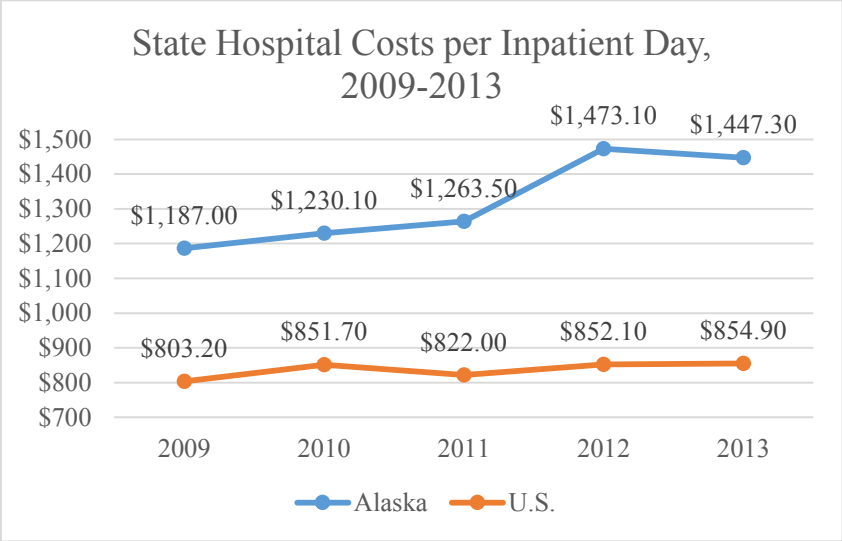


Source: NAMHPD Research Institute, State Profile System, 2009-13

De-institutionalization efforts nationally have reduced relative inpatient spending to roughly one-third of state behavioral health budgets, with the remainder of care provided in the community. As Figure 2.15

demonstrates, Alaska's proportion of inpatient psychiatric spending continues to be higher than national averages, suggesting that opportunities exist to build stronger community infrastructure able to minimize the need for hospitalization. Furthermore, the cost of inpatient care at API is considerably higher than national average, and growing at a faster rate:

Figure 2.16



Source: SAMHSA Uniform Reporting System, 2009-13

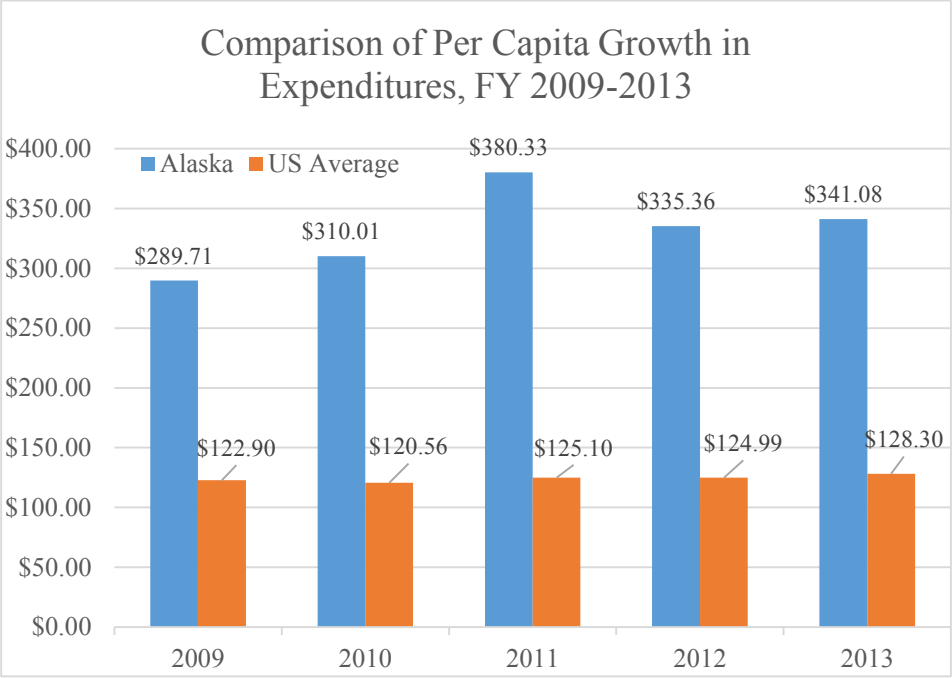
Although the State has been able to reduce some of the GF burden for these costs by serving some consumers through private hospitals eligible to receive Medicaid reimbursement for psychiatric services, more recently, the State has a had a difficult time retaining community partners to provider inpatient care. For example, in 2009, 71% of inpatient expenditures were spent on non-API beds, which declined to 66% by 2013. However, this trend is still positive in comparison to U.S. averages, in which only 25% of inpatient spending occurs outside of state hospitals.

2.3.3. FINDING: Per capita behavioral health spending in Alaska is among the highest of any state. Although expenditures per capita continue to rise annually, expenditures per recipient have actually decreased over the period.

Frequently noted in the evaluation of behavioral health services in Alaska is the high cost of care in the state. Per capita, Alaska is typically in the top three states for the most expensive care in the nation. The high cost of living is, of course, a major factor in the heightened expense of services in the state, but major cost drivers, such as transportation, which affect all economic activities in Alaska, have particularly strong impacts on the behavioral health delivery system. Figure 2.17 calculates the costs of mental health services on a per capita basis, in which expenditures are divided by the general population of the state, in order to allow meaningful comparison with large scale spending in other states. The figure not only shows that per

capita spending is far higher in Alaska when contrasted to national averages, but also that spending has grown considerably faster in the state then in the rest of the country.

Figure 2.17



Source: NAMHPD Research Institute, State Profile System, 2009-13

Although it is valuable to capture expenditures per capita, especially for the sake of comparison with spending levels in other states, this type of analysis does not necessarily yield a full picture of the dynamics driving increasing costs. Especially when considering the fact that access to services also increased substantially during the review period—as illustrated in depth in Section 2.2.3—expenditures per recipient notably decreased from FY 2009-2013. Table 2.6 shows expenditure trends for the system's mental health population, which grew by 41% during the period.

Table 2.6: Expenditures per Recipient, FY 2009-2013

Year	Total MH Expenditures	Total Served	Expenditures per MH Recipient
2009	$165,770,000	13,439	$12,335
2010	$179,510,000	14,569	$12,321
2011	$230,770,000	15,552	$14,839
2012	$200,230,000	18,185	$11,011
2013	$204,620,000	18,892	$10,831

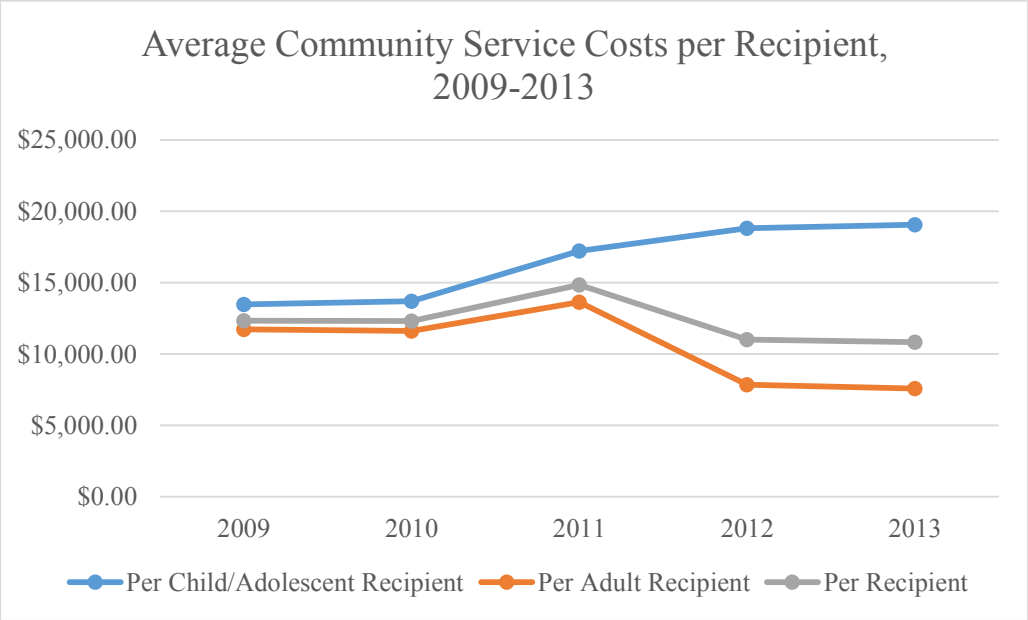
Source: NAMHPD Research Institute, State Profile System, 2009-13 and DHSS, AKAIMS

Despite the fact that mental health expenditure climbed steadily during these years, growth in expenditures appears to have been driven to some extent by increased access and utilization. Although expenditures per recipient rose significantly in FY 2011, reflecting the "ARRA bump" of enhanced federal Medicaid match, the more important trend is the declining per recipient spending levels from FY 2009 to 2013. Spending dropped 12% per recipient from the beginning to the end of the period.

2.3.4. FINDING: Increasing reliance on Medicaid as the dominant source of funds for behavioral health services has led to disparate effects on youth and adult services, fostering different kinds of efficiencies and inefficiencies within the two systems.

The dynamics of the reduction in costs per recipient become even more complex when adult and youth community treatment costs are distinguished. After breaking out expenditures by the adult and youth populations, PCG's analysis reveals a sharp decline in the funding available per recipient for adults, without a similar effect in funding per recipient for children and adolescents. As Figure 2.18 illustrates, expenditures for the two populations deviate considerably from one another. Spending for the adult population generally resembles per recipient spending as whole, which makes sense, because adults are a much larger proportion of the mental health consumer population. To some extent, they drive the broader trend. By contrast, spending for youth mental health services grew precipitously from FY 2009-2013, and was apparently undaunted by the significant budget cuts that affected the Division in FY 2012.

Figure 2.18

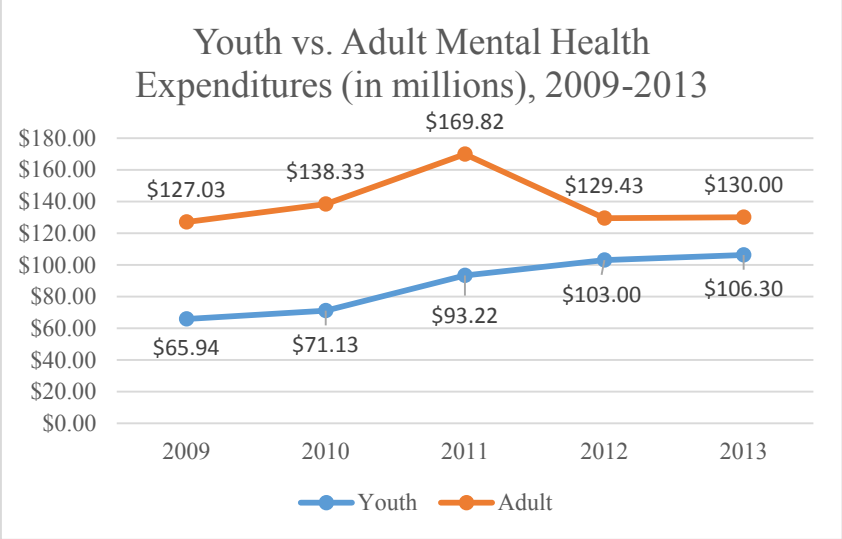


Source: NAMHPD Research Institute, State Profile System, 2009-13. Community service population derived from AKAIMS.

When considering overall mental health expenditures for each population, rather than costs per recipient, the diverging pattern of Figure 2.18 is replaced in Figure 2.19 by a converging pattern, in which adult

spending remains essentially static (with the notable exception of the ARRA bump in FY 2011), while total mental health expenditures for children and adolescents eventually rivals adult spending. Figure 2.19 includes inpatient spending at API (which mostly serves adults), but when considering *only* community services, spending for children and adults were basically equivalent in FY 2013, with the youth population costing $101.8 million versus $102.9 million for adults.[32]

Figure 2.19



Source: NAMHPD Research Institute, State Profile System, 2009-13

The chief difference in the spending patterns for the two populations is most likely connected to major differences in Medicaid eligibility policy and reimbursement for the two different populations. As in many states, eligibility standards are far broader for Alaska youth than for adults, and a significantly larger percentage of the general population of children qualifies for Medicaid. Moreover, children's spending is governed by a much more favorable FMAP than the adult population: 65% versus 50% federal matching in FY 2019.[33] Consequently, a greater share of adult mental health services have to be financed through GF-funded grant services, while children's services are largely funded through Medicaid.

It is reasonable to inquire to what extent these distinct cost profiles for each population reveal potential efficiencies or inefficiencies in the quantity and quality of services delivered. Certainly, the lopsided growth in expenditures during the period suggests that Department cost containment efforts primarily targeted services for the adult population, whose cost decreased per recipient by over 35%. On the other hand, expenditures per child grew by 41% between FY 2009 and 2013, outpacing even the highest rates of medical inflation in Alaska. On the face of it, the fact that the adult system was able to serve 50% more consumers in FY 2013 than 2009, with fewer total funds available, certainly suggests that grantee providers were able

[32] Expenditures reported in NAMHPD Research Institute, State Profile System, FY 2013.
[33] In FY 2016, the FMAP for CHIP/Children's Medicaid increases again to 88%.

to find additional efficiencies. However, successful cost containment does not necessarily generate value in service delivery, nor do risings costs necessarily signal waste.

Table 2.7

SED among Youth Mental Health Recipients			
Year	**Total Youth SED**	**Total Youth MH**	**% SED**
2009	3,572	4,605	77.6%
2010	3,735	4,919	75.9%
2011	3,994	5,199	76.8%
2012	3,860	5,232	73.8%
2013	3,987	5,339	74.7%

Source: DHSS, AKAIMS

In the adult population, funding diminished despite sharp increases in the number of individuals accessing services. Probably related to these tends is the fact that the prevalence of SMI within the population of adults also increased noticeably, from 77% in FY 2009 to 83% in FY 2013, suggesting that outreach and treatment efforts were focused increasingly on providing services to a higher acuity population. Figure 2.8 indicates the ratios of SMI and non-SMI mental health disorders within the adult services group.

Table 2.8

SMI among Adult Mental Health Recipients			
Year	**Total SMI**	**Total AMI**	**% SMI**
2009	6,793	8,834	76.9%
2010	7,532	9,650	78.1%
2011	7,767	10,353	75.0%
2012	10,414	12,953	80.4%
2013	11,269	13,553	83.1%

Source: DHSS, AKAIMS

Arguably, the presence of all these factors within adult services can be used to make a case for growing efficiency in service delivery, with providers able to serve more people in greater need with fewer resources. However, these numbers alone do not ultimately speak to the quality of services during the review period. Although the major quality treatment indicators used by the Department do not reveal a substantial decline, it is nonetheless true that a combination of negative trends emerged in 2012, following the drop in expenditures for adult services. These include a spike in the percentage of SMI within the mental health population, stagnation in substance abuse service capacity across much of the state, as well as a sharp rise in admission and re-admission rates at API. Based on these trends, it is probable that diminishing system resources introduced new inefficiencies into the care continuum, in addition to more streamlined business

practices, with treatment providers potentially becoming more strained in their ability to deliver proactive, preventive interventions while still retaining their focus on core services for higher acuity consumers.

2.4. Opportunities for Improving Services

2.4.1. RECOMMENDATION: Reforming staffing policies and practices at API, including more competitive hiring and retention efforts, could significantly improve the quantity and quality of care without increasing costs.

In PCG's interviews with system stakeholders, commentators were generally agreed that the acute care model adopted by API since 2012 has failed to meet both the demand for emergency psychiatric services within the system and the complex treatment needs of individuals in crisis. High re-admission rates have only exacerbated worsening trends in census pressure, and the hospital finds itself in a spiral of ever shorter lengths of stay to make room for new admissions. From 2009 to 2013, median length of stay at API dropped from nine days to five days for adults. In the same period, median length of stay across the United States rose from 62 days to 79 days. Alaska is ninth in the nation for the shortest lengths of stay at its hospitals. A similar measure of quality of treatment, the bed turnover rate, also paints a stark picture. Even in 2009 before adoption of the acute care model, the average bed at API transitioned over 16.29 patients in a year—the second highest rate in the country—whereas the hospital average across the nation in the same year was only 3.56 patients.

Mandatory, abbreviated lengths of stay take their toll on the workforce as well as the consumers of institutional care. The workforce shortage of qualified psychiatrists in the state is aggravated at API, and the hospital has resorted to sub-optimal personnel policies that maintain staffing levels in the short-term, but ultimately hurt long-term workforce development, while increasing administrative challenges. For example, shortages both in psychiatrists and in psychiatric nursing staff have led API to establish mandatory staff overtime. This policy not only harms the hospital's competitiveness in hiring and retention, but it also contributes to a worrying rise in workplace injury rates at the hospital. High turnover rates and physician vacancies subsequently force the hospital to contract with Locum Tenens agencies costing **twice as much** as a state employed physician.[34] Because locum tenens psychiatrists are frequently also less qualified than staff psychiatrists, this policy creates quality and continuity of care issues as well as budgetary inefficiencies. Overtime wages and locum tenens salaries are more expensive than regular wages and full-time salaries with benefits. By relying on mandatory overtime and locum tenens psychiatrists to staff API, the Department experiences higher staffing costs while delivering a lower quality of care. Additionally,

[34] *Locum Tenens* (Latin: "to hold the place of") is a phrase used in the medical field to describe physician substitution. Locum Tenens agencies provide physician staffing services to fill short-term absences or temporary vacancies. These physician substitution systems are established for medical activities that require the presence of a supervising physician.

frequent turnover and less qualified staff require the provision of additional trainings, as well as contribute to a higher rate of workplace injury.

The Department needs to tackle chronic workforce shortages at API by refocusing staff hiring and retention efforts, and restructuring personnel policies where appropriate. One potential avenue would be to advocate for changes in the State's current payroll schedule, which establishes low salary ceilings for State-employed psychiatrists that ultimately hamper hospital recruitment efforts. Although the Department has taken a positive step this year by requesting staff raises in the FY 2016 budget, the most significant changes to working conditions can only occur with reforms in the delivery system that alleviate census pressure on the hospital and promote more efficient approaches to inpatient psychiatric care.

2.4.2. RECOMMENDATION: The Department should build additional service capacity for substance use disorder (SUD) treatment, both to increase access to services and improve quality. Additional investment would lead to significant savings in medical, nursing home, and criminal justice costs, producing interventions that "pay for themselves" in cost offsets from other essential State services.

In Section 2.5, PCG identifies several layers within the care continuum in which service capacity is either undeveloped or under-resourced to meet the mental health and substance abuse needs of behavioral health consumers. Although there are a number of opportunities to improve service infrastructure in order to promote greater access and quality of care, in many cases, enhanced value would necessarily require greater expenditure, without necessarily generating cost savings down the road as a result of additional investment. However, treatment for substance use disorder is an important exception in this regard, as it typically produces an array of direct and indirect cost offsets to the State, and is supported by an extensive research literature demonstrating the economic as well as clinical benefits of SUD treatment.

Not only is substance abuse directly connected to serious medical complications and chronic medical illness, but unlike the mental health population, in which consumers are typically medically underserved, SUD consumers tend to incur excessive or unnecessary medical expenses, as a result of seeking medical care driven by psychological or psychiatric factors rather than true medical need. Some researchers have estimated that use of medical services by individuals who receive outpatient alcohol treatment is approximately 40% lower than it is for persons who are referred for treatment but decline it.[35] These savings are largely attributable to lower medical inpatient costs. Moreover, individuals with substance use disorder

[35] R.M. Sherman, S. Reiff, and A.B. Forsythe, "Utilization of Medical Services by Alcoholics Participating in an Outpatient Treatment Program," *Alcoholism: Clinical and Experimental Research* 3 (1979): 115–120; and A.B. Forsythe, B. Griffiths, and S. Reiff, "Comparison of Utilization of Medical Services by Alcoholics and Non-Alcoholics," *American Journal of Public Health* 72 (1982): 600–602.

are more likely to be involved with the criminal justice system than some other behavioral health service populations, with 68% of jail inmates nationwide estimated to have substance dependence or abuse issues.[36]

Some states have found that providing adequate mental health and addiction-treatment benefits can dramatically reduce healthcare costs and Medicaid spending, as well as other costs associated with law enforcement and incarceration. For example, a study of alcohol and drug abuse treatment programs in Washington State found that providing a full addiction-treatment benefit resulted in a per-patient savings of $398 per month in Medicaid spending. Medical costs for people in treatment were $311 lower per month than for those who needed but did not receive treatment, and state hospital expenses for those in treatment were lower in comparison by $48 per month.[37] Moreover, for those who received treatment, the likelihood of being arrested decreased 16%, and the likelihood of felony convictions dropped 34%, further contributing to cost savings for the state.[38]

A later study in Washington found similar positive outcomes associated with greater state investment. Under relatively conservative assumptions, researchers estimated a return on investment of 2:1 in the first four years of expanded treatment, based on the observed trends in health care and SUD treatment costs, with two dollars in medical and nursing facility costs saved per dollar invested in the state's treatment program.[39] Other studies have reported even stronger outcomes. Research into SUD treatment in California found that, for every dollar spent on substance abuse treatment, the state saved $4 in healthcare costs and $7 in law enforcement and other criminal justice costs. On average, substance abuse treatment cost $1,583 per patient, but was associated with a cost offset of $11,487, representing a 7:1 ratio of benefits to costs.[40]

Research also documents that substantial savings from providing appropriate SUD treatment can come in the areas of indirect costs: employee productivity, absenteeism, speed and quality of return to work after disability, and reduced turnover. For example, another study in California found that greater than 70% of the estimated costs of alcohol abuse can be attributed to lost productivity. In this case, substance abuse treatment for 60 days was estimated to have saved over $8,200 in healthcare and productivity costs.[41]

Considering the strong probability of short-term and longer-term cost offsets, coupled with the high prevalence of substance abuse in the state and critical gaps in SUD service infrastructure in many regions of Alaska, PCG recommends that the State prioritize additional investment into SUD treatment, both for its

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[36] James, D.J., and Glaze, L.E. (September 2006). Mental Health Problems of Prison and Jail Inmates. Washington DC: Bureau of Justice Statistics.
[37] Estee, S. and Norlund, D. (2003). Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project: 2002 Progress Report. R.a.D.A. Division and W.S.Do.S.a.H. Services, Washington State.
[38] Ibid.
[39] Mancuso, David and Barbar E. M. Felver. (2010) Bending the Health Care Cost Curve by Expanding Alcohol/Drug Treatment. RDA Report 4.81. . R.a.D.A. Division and W.S.Do.S.a.H. Services, Washington State.
[40] Etner, S., Huang, D., Evans, E., Ash, D. R., Hardy, M., Jourabchi, M., & Yih-Ing, H. (2006) Benefit-Cost in the California Treatment Outcome Project: Does Substance Abuse Treatment "Pay for Itself"? *Health Services Research*. 41(1): 192–213.
[41] Jordan, N., Grissom, G., Alonzo, G., Dietzen, L., Sangsland, S. (2007). Economic benefit of chemical dependency treatment to employers. *Journal of Substance Abuse Treatment, 34,* 311-319.

health benefits for the people of Alaska and for its positive economic impacts on current health and criminal justice spending by the State.

Currently, expenditures for SUD services are more heavily reliant on GF dollars from grant funding than many mental health services, because these services have fewer avenues for accessing Medicaid funds to pay for treatment. The greater dependence on grant funding is a function partly of Medicaid restrictions on medical necessity and disabling conditions, but is also a consequence of Alaska's current Medicaid eligibility criteria, which excludes a substantial section of the SUD population on the basis of income. A significant proportion of SUD individuals would likely become eligible under the Medicaid expansion made available by Affordable Care Act (ACA) reforms. Without further transformation of the behavioral health service reimbursement system, through some combination of Medicaid expansion and waiver reform, the initial costs of investment in substance abuse service would probably have to come from additional GF spending. PCG discusses several transformation options, including the potential impacts of Medicaid expansion and Medicaid 1115 reforms on SUD services, in Section 3.0.5 through 3.0.7.

2.5. Ineffective or Inefficient Services

In the detailed conclusions below, we embed our findings regarding ineffective and/or inefficient services within a wider evaluation of the accomplishments and challenges of each of the major layers of the Department's continuum of care. In categorizing the State's care continuum, PCG has chosen to adopt the classification of services developed in SAMHSA's codification of the "good and modern" behavioral health system. This classification differs in some respects from the characteristics of the care continuum as DBH typically defines it. The rationale for using the SAMHSA categories is grounded in PCG's effort to evaluate the Department's care continuum from the perspective of system standards nationwide. First, it is relatively unproblematic to assign the different service lines within Alaska's behavioral health delivery system to one of the nine levels of care in the SAMHSA framework. Second, this typology allows PCG to highlight some of the important service gaps in the system. The typology also identifies levels of care within the continuum where service capacity should exist, but where services are not currently delivered.

PCG's evaluation rubric includes an evaluation of five distinct domains of each service layer, as well as a determination of overall performance. In accordance with the requirements of the review objectives, PCG judges each of the service categories by the effectiveness and efficiency of the services delivered. However, the evaluation also reviews other characteristics of importance, such as the viability and sustainability of financing for the service level, as well as the quality of Department administration and monitoring. Finally, the evaluation also tries to note whether the level of care has demonstrated improvement over the course of the review period.

Each of the domains, including overall performance, is rated on a three-part scale that registers performance as *good*, *poor*, or *mixed*. A *mixed* performance typically involves a service array in which parts of the overall service system are performing well or operating normally, but are challenged in other respects. For example, outpatient services may be extremely efficient for children, but inefficient for adults, resulting in a mixed performance rating overall. The legend below indicates the icons used in the performance scale:

Good Performance	Mixed Performance	Poor Performance
		

2.5.1. FINDING: The Department's **acute intensive services** are neither effective nor efficient, due to a combination of administrative inefficiencies, inadequate sub-acute infrastructure, and lack of community partners.

The *Acute Intensive Services* domain involves a variety of acute and emergency psychiatric care services that currently exist within the state, as well as services that have not yet been developed. Typical acute intensive services include mobile crisis services, medically monitored intensive inpatient, peer-based crisis services, urgent care services, 23-hour crisis stabilization services, and 24/7 crisis hotline services. Within the Department's current continuum, acute care services available at API, as well as the State's DES/DET facilities and other inpatient psychiatric beds, all belong to this acute intensive services layer. Additionally, some of the community Psychiatric Emergency Services (PES) funded by the Department are involved with this layer of care, though DBH more frequently categorizes these services on the basis of outpatient or brief intervention and referral services.

Service Domain	Effective Delivery	Efficient Delivery	Viable Funding	Proper Monitoring	Improving Quality	Overall Performance
Acute Intensive Services						

Effective Delivery. As the only hospital with psychiatric acute care inpatient capacity serving a metropolitan area greater than 425,000 people, API is burdened by high demand for bed utilization that sometimes exceeds capacity. The system is challenged to create additional inpatient capacity in the private sector. In the Matanuska-Susitna Valley, emergency services are delivered primarily by the Emergency Department at Mat-Su Regional Medical Center. High readmission rates at API, combined with a dearth of acute care alternatives, suggests that the system overall is not effective.

Efficient Delivery. The inefficiency of the acute care model implemented at API is discussed in Section 2.4.1, and also at length in Section 5.0. While PCG notes that the daily cost of care remains less expensive than alternative inpatient care at other hospitals in the state, these discussions of service delivery challenges at API suggest that significant room for improvement remains.

Viable Funding. Since API is under the Medicaid Institute for Mental Disease (IMD) exclusion[42], much of its funding comes from state GF dollars. One of the central issues in building community partnerships with other hospital systems is the need to operate inpatient psychiatric beds through facilities that are eligible to draw Medicaid dollars.

Proper Monitoring. As a high-cost, hospital-based system with strong performance measures and accountability structures, the performance of acute care services is heavily monitored. Bed utilization at API is probably the most actively monitored element in the behavioral health system.

Improving Quality. Key performance indicators for measuring the quality of services in this domain all demonstrated negative trends during the review period.

2.5.2. FINDING: Gaps in the Department's **residential services** system limit its effectiveness, but efforts to improve service capacity for certain populations have significantly improved efficiency.

The *Out-of-Home Residential Services* domain involves a variety of short-term and long-term residential programs currently operating within the DHSS system, as well as a broad class of services that unfortunately have not be been developed in the state. Typical residential services include crisis residential/stabilization services, clinically managed 24-hour care and medium intensity care, adult and children's mental health residential services, youth substance abuse residential services, and therapeutic foster care. Within the Department's current continuum, youth Residential Psychiatric Treatment Centers (RPTCs), residential substance abuse and detoxification services, and youth residential rehabilitative behavioral services (RBS) are all services that belong to the out-of-home residential services domain.

Service Domain	Effective Delivery	Efficient Delivery	Viable Funding	Proper Monitoring	Improving Quality	Overall Performance
Residential Services						

Effective Delivery. The development of youth residential services through the BTKH initiative is one of the major accomplishments of the Department, not only building a robust layer of services for high need SED youth within the state, but also creating opportunities to develop additional supports for children and adolescents with lower acuity needs. The state of development for adult services is a stark contrast, however. Currently, adults in need of sub-acute residential services are treated through inpatient care.

Efficient Delivery. For children's residential services, BTKH has certainly created efficiencies in Department spending. According to outcomes published by the Division, use of out-of-state RPTCs

[42] The IMD exclusion in Medicaid prevents psychiatric hospitals from billing care to Medicaid for adults aged 22-64.

decreased significantly: yearly *admissions* were down by 87.2% between FY 2004 and FY 2011, from 752 to 96 youth. Similarly, Medicaid expenditures for out-of-state RPTCs decreased by 69 percent between FY 2006 and FY 2011 ($40 million to $12.5 million). Medicaid expenditures for in-state RPTCs during the same time period increased by 55.1% ($14.3 million - $22.2.million), generating substantial net savings. Subsequently, these funds have been re-invested into the system to build additional sub-acute housing capacity, as well as a broader framework of habilitative and rehabilitative supports. However, spending for youth services has grown considerably since FY 2011, and it is open to question whether these additional service lines have brought new efficiencies into the system. Significantly, the lack of adult residential services has introduced major inefficiencies into other areas of the service continuum.

Viable Funding. For children's residential services, substantial funding is available through a combination of Medicaid and grant sources. The primary reason for the lack of development of adult services is the inability to link these services to a sustainable funding source outside of GF monies.

Proper Monitoring. As a part of the State's institutional care network, even out-of-state RPTCs are heavily monitored by the Division's Medicaid and Quality Section (MQS) through audits and onsite visits. Standard performance metrics are used to determine quality for these services.

Improving Quality. The residential capacity built up through BTKH is mature at this point. No significant gains have been made for adult services.

2.5.3. FINDING: The Department's limited capacity for **intensive support services**, especially for assertive community treatment and substance abuse intensive outpatient services, substantially limits the effectiveness and efficiency of care for high-need populations.

The *Intensive Support Services* domain, like residential services, involves a set of intensive interventions designed to assist individuals who live at critical transition points between the need for inpatient and community outpatient care. Typical intensive supports include substance abuse intensive outpatient services, partial hospitalization, assertive community treatment, intensive home-based treatment, multi-systemic therapy, and intensive case management. Within the Department's current continuum, some types of detoxification programs, as well as many of the most intensive, high-acuity services classified within DBH's community outpatient services, fall under this category.

Service Domain	Effective Delivery	Efficient Delivery	Viable Funding	Proper Monitoring	Improving Quality	Overall Performance
Intensive Support Services						

Effective Delivery. Until very recently, many types of intensive support services for mental health or co-occurring disorders did not exist within the system. Although a limited set of mental health intensive

supports are now available through the Complex Behavior Collaborative, which has been operating since 2012, other planned services, such as assertive community treatment, have not yet come online. Service infrastructure is more robust in the substance abuse delivery system, but substance abuse intensive outpatient resources in many parts of the state, and especially in Anchorage, are wholly inadequate to the level of need.

Efficient Delivery. Given the limited scale and timeframes in which these services have been established it is difficult to determine whether programs are operating efficiently or are properly coordinating resources existing within multiple home divisions.

Viable Funding. Since many of the targeted interventions and intensive case management functions required for these services are not billable in Medicaid without a waiver, the Department's reluctance to pursue waiver options for behavioral health due to the perceived administrative burden has meant that financing options are limited to GF revenues and AMHTA pilot monies. The Complex Behavior Collaborative had not yet identified a significant and sustainable funding vehicle that would allow it to scale appropriately to the level of need. Although some of the substance abuse treatments in this category are billable through Medicaid, much of the population in need of these services fall within the Medicaid expansion population, and so are not currently covered by Medicaid.

Proper Monitoring. By their nature, many of the intensive support services discussed here are efforts developed by behavioral health agencies to monitor and ensure stronger outcomes for extremely high risk and expensive populations. To the extent that these programs exist and are implemented effectively, they tend to be well-monitored.

Improving Quality. Many of the Department's intensive support services are still in development in the pilot stage. Since 2009, there has been significant progress in the State's ability to target the high-need, high-cost population that utilizes these services. However, intensive support capacity for substance abuse has not kept up with need. At the time of writing, the Department has plans to implement Assertive Community Treatment (ACT) and Intensive Case Management (ICM) data by the end of 2015.

2.5.4. FINDING: The Department is limited in the resources available to provide **living supports** such as transportation and assisted living services effectively, but it has made improvements in using scarce resources efficiently.

The *Living Supports* domain involves a set of habilitative supports designed to facilitate the transition to independent living for individuals in recovery. Typical living supports include personal care, homemakers, respite, supported education, transportation, assisted living services, recreational services, and behavioral health interpreters. Within the Department's current continuum, the living supports delivered by community behavioral health providers are not classified independently from the broad category of outpatient services funded by DBH. However, services like respite, transportation, and assisted living are typically delivered under the auspices of the outpatient care infrastructure.

Service Domain	Effective Delivery	Efficient Delivery	Viable Funding	Proper Monitoring	Improving Quality	Overall Performance
Living Supports						

Effective Delivery. Many services, like personal care and respite, which are typically understood as living supports, have been developed more extensively within SDS than DBH in order to serve the long term care needs of its senior and disabilities population. Service capacities for living supports specific to behavioral health are much more limited, due to the Division's reticence to pursue Medicaid 1915 waivers required to implement these programs. DBH currently funds a limited amount of assisted living services, but these resources are in short supply, largely as a result of the unavailability of affordable housing in many parts of the state. Given the geography of Alaska, delivering effective transportation options is a persistent challenge.

Efficient Delivery. Acknowledging the relative scarcity of these services within the care continuum, PCG finds that the services are delivered efficiently, especially in light of the considerable logistical challenges facing the state.

Viable Funding. Some of the most important vehicles for funding livings supports are Medicaid 1915 waivers, which the Division has opted not to pursue so far, due to perceived administrative burden.

Proper Monitoring. Recognizing the importance of this service layer, the Department has now established dedicated administrative resources to build, coordinate and oversee many of the services that fall within this domain. Accreditation requirements on community providers, once fully implemented, should also improve oversight.

Improving Quality. The creation of an integrated housing resource within the Department has been an important step in improving the quality of community supports.

2.5.5. FINDING: The Department is deficient in providing key **community and recovery supports**, such as housing, mentoring, and caregiver supports. Peer services have not been integrated into providers' recovery supports to allow the most effective range of services.

The *Community and Recovery Supports* domain is composed of a wide array of supportive services intended to facilitate greater involvement of the consumer into the community as well as community involvement in the consumer's own recovery. Recovery supports, in particular, are designed to promote consumer self-empowerment and frequently rely on use of peer supports and consumer self-direction. Typical community supports include parent/caregiver support, skill-building, case management, behavioral management, supported employment, permanent supported housing, recovery housing, therapeutic mentoring, and traditional healing services. Typical recovery supports include peer support and recovery coaching, support

center services, supports for self-directed care, and continuing care for substance abuse disorders. Like the domain of habilitative Living Supports, rehabilitative community and recovery supports are not typically distinguished from the broad class of community outpatient services defined within the Department's current continuum. Community and recovery support programs are maintained by the State's network of private community providers.

Service Domain	Effective Delivery	Efficient Delivery	Viable Funding	Proper Monitoring	Improving Quality	Overall Performance
Community and Recovery Supports						

Effective Delivery. Although community and recovery support infrastructure exists within the state, this layer of services overall is extremely thin and largely inadequate to serve consumer need. In particular, the scarcity of subsidized housing vouchers available through the Alaska Housing Finance Corporation creates a hardship for many SMI individuals, potentially causing destabilization, risking movement to higher levels of care, preventing transitions to independence from Assisted Living Homes, and an inability to transition out of homelessness. Another major issue is "collateral treatment," or the level of supports available not only to individuals suffering from behavioral health disorders, but also to their families and caregivers. For instance, children comprise approximately 25% of all clients served, and receive clinic and rehabilitation services. However, the majority of services delivered target the child and not the child *and* their families. According to a 2013 DBH utilization analysis, Medicaid data indicated that 62% of all youth served did not receive any family services. Of those 38% who did, it only resulted in an average of 5.8 hours per year. The level of family based treatment is minimal at best, and by default, results in unintended consequence of institutional parenting of children, reinforces a dependency on treatment providers, and undermines the potential for good treatment outcomes for children and their families. Division concerns that lack of adequately trained behavioral health professionals in this area among community providers are also reflected in the slowness of providers to adopt peer support capacity.

Efficient Delivery. One of the strengths of utilizing peer recovery supports is the cost efficiency yielded by this workforce when services are properly implemented. The system does not appear to be harnessing these potential resources to a significant degree. Additionally, Department housing resources are largely limited to assisted living arrangements, without a broader range of supported housing options needed both to ensure the appropriate level of care and to bend the cost curve for higher acuity populations. On the other hand, the Department has now made efficient use of scarce housing resources a significant priority and has sought to reduce uncoordinated use of housing resources among multiple divisions with housing programs.

Viable Funding. Although the Department established a financing vehicle through Medicaid for peer services during the review period, for many key rehabilitative services such as supported housing, the unavailability of affordable housing and the economics of providing supportive services within this setting are not viable without a wider array of services to offset financial losses. One Medicaid service line used by providers to generate viable financing for community supports, called Recipient Supportive Services (RSS), has now been identified by the Department as a potential source of wasteful spending in need of

additional regulation. Notably, the Division has not yet opted to pursue various Medicaid 1915 waivers that provide an additional financing vehicle for these types of services.

Proper Monitoring. Recognizing the importance of this service layer, the Department has now established dedicated administrative resources to build, coordinate and oversee many of the services that fall within this domain. Accreditation requirements on community providers, once fully implemented, should also improve oversight.

Improving Quality. The creation of an integrated housing resource within the Department is an important step in improving the quality of community supports. Although peer supports have not been implemented as widely among community providers as hoped, the Department in partnership with AMHTA has ensured that training and funding sources for peer services are available within Alaska.

2.5.6. FINDING: The Department's **outpatient and medication services** are broadly effective, but are increasingly overburdened and unable to keep pace with growing consumer demand.

The *Outpatient and Medication Services* domain involves an array of more traditional outpatient and therapeutic and medication management services. Typical outpatient services include individual evidence-based therapies, group and family therapy, multi-family therapy, multi-family therapy, and consultation to caregivers. Medication management, pharmacotherapy, and laboratory services make up the sub-category of medication services. Within the Department's current continuum, all of these services fall within the grouping of outpatient services.

Service Domain	Effective Delivery	Efficient Delivery	Viable Funding	Proper Monitoring	Improving Quality	Overall Performance
Outpatient and Medication Services						

Effective Delivery. As a core level of care provided by community behavioral health providers, outpatient services overall tend to be effective for the vast majority of the service population. While percentages vary among different service populations, most recipients of outpatient services report significant improvements in quality of life. Furthermore, the delivery system—while clearly overstressed—has been able to bear increases in the number of individuals receiving services.

Efficient Delivery. As discussed in Section 2.3, there are significant differences in apparent cost efficiencies between adult and children's services.

Viable Funding. While the mix of Medicaid and grant financing presents funding viability for some higher acuity services, outpatient service parameters and funding mechanisms tend to be well-defined and well-established.

Proper Monitoring. The effectiveness of Department administration over community treatment providers is robust in some respects, but deficient in others. Current challenges are treated in more detail in other sections of the report. In Section 4.0, PCG addresses the need for the Department to establish stronger performance measures for community providers. Section 12.0 also describes some of the current challenges in utilization tracking for these services, while Section 9.0 considers improvements that can be made in grant and contract oversight. Accreditation requirements on community providers, once fully implemented, should improve oversight over outpatient services.

Improving Quality. Although PCG notes earlier in this section that access has improved for many outpatient services, this is not true for all populations across services and regions. Outpatient services appear to have diminished overall for the SUD population. Furthermore, quality metrics for these services have remained static over the course of the review period.

2.5.7. FINDING: The Department has made progress in improving **engagement services**, including its assessment, evaluation, and service planning processes. However, more work needs to be done to deliver these services efficiently.

The *Engagement Services* domain involves a set of brief interventions frequently oriented to outreach to underserved populations or early intervention for individuals at risk of developing more complicated behavioral health conditions. Services typically include assessments, specialized evaluations and service planning, as well as consumer and family education and outreach. To some extent, these services can be found at either end of the acuity spectrum, as assessment, evaluation, and service planning are an important accompaniment to prevention and wellness activities, as well as crisis-oriented settings, in which assessment and crisis service planning are significant interventions designed to mitigate the need for higher-acuity care. Within the Department's current continuum, many of the assessment, evaluation, and service planning activities delivered through DBH's Early Intervention units fall under this category, as do the specialized assessments and evaluation services delivered by the Department on behalf of the Alaska Court System and the forensic system.

Service Domain	Effective Delivery	Efficient Delivery	Viable Funding	Proper Monitoring	Improving Quality	Overall Performance
Engagement Services						

Effective Delivery. Given that engagement services are utilized within the crisis and emergency psychiatric sector, the forensic sector, and in early intervention programs, relative effectiveness should be distinguished between these high acuity and low acuity populations. Engagement services in the Department's early intervention programs appear to be highly effective at meeting strategic objectives. For crisis engagement services, however, overall effectiveness seems to depend on region. Many regions appear to employ highly effective interventions to divert consumers in crisis away from API and toward community services

available closer to home. Engagement services in Anchorage and the Mat-Su Valley, which make up 80% of referrals to API, appear to be far less effective. This ineffectiveness and the substantial size of the region's population contribute to a disproportionate volume of API referrals originating in Anchorage and the Mat-Su Valley.

Efficient Delivery. Distinctions between high and low acuity populations also need to be made when considering efficiency. Assessments, evaluations, and service planning appear to be efficient for low acuity populations, but not for the crisis and forensic population, where substantial inefficiencies continue to predominate. PCG details many of these inefficiencies throughout Section 5.0, with special attention to forensic services in Sections 5.3.4 and 5.5.7.

Viable Funding. Most of the Department's engagement services are supported through GF funding and come through either the Division's grant framework or its operating funds. The viability of this funding depends to some extent on service line and the efficiency of service delivery. The Alcohol Safety Action Program (ASAP), for example, appears to deliver high value interventions that "pay for themselves" in cost savings through successful jail diversion. However, it is questionable whether the inefficiency within the current forensic evaluation process is financially sustainable.

Proper Monitoring. The metrics used by the Department to monitor the quality of these services appears adequate to ensure successful administration.

Improving Quality. The system at both lower and higher intensities appears to be increasingly overburdened, largely as a result of failures in the care continuum that direct consumers to the acute care system and to the courts and DOC.

2.5.8. FINDING: The Department's **prevention and wellness services** have made significant progress in building strong community coalitions, but need to be integrated more effectively into core Division activities.

The *Prevention and Wellness Services* domain involves a set of preventative interventions and health promotion activities designed to curb unhealthy behaviors before they arise or become habitual. Typical services include evidence-based practices such as Screening, Brief Intervention, and Referral to Treatment (SBIRT); brief motivational interviews; tobacco cessation programs; parent training; facilitated referrals; relapse prevention and wellness recovery support; and the use of "warm lines." Within the Department's current continuum, most of the activities of the Division's PEI section fall under this category. Early intervention units such as ASAP and the FASD diagnostic teams, employ a combination of screening, brief interventions, and referrals that fall within this category, even though they are also involved with engagement.

Service Domain	Effective Delivery	Efficient Delivery	Viable Funding	Proper Monitoring	Improving Quality	Overall Performance
Prevention and Wellness						

Effective Delivery. As detailed in Section 2.2.4, overall results of behavioral health prevention efforts have been mixed. The State has yet to make a significant dent in the suicide mortality rate, and despite some notable successes in combating underage binge drinking, adult alcohol consumption and abuse remains high within the state. On the other hand, tobacco enforcement activities and early intervention efforts, such as ASAP, have produced impressive results. Overall, effectiveness tends to vary by particular service line.

Efficient Delivery. Since prevention activities are more dependent on federal grants than many other services provided by the Department, prevention is also subject to the constraints of federally-mandated protocols and reporting requirements, which can be misaligned at times with Department and community priorities. In reference to the Department's SPF-SIG grants, it was common to hear criticism of the inefficiency and arbitrariness of planning processes stemming from requirements in the grants. Outside of a few service lines such as ASAP, which is integrated into the Division's AKAIMS infrastructure, PEI has yet to implement data collection, reporting, and communication processes that are routinized and easily accessible, both to the public and other departmental units.

Viable Funding. One of the difficulties of maintaining preventative activities is that they are often viewed as "luxuries" in tight fiscal environments and are often de-funded to prioritize core treatment services. To the Department's credit, the PEI section has proactively sought out federal grant opportunities and worked hard to align federal goals with state and Department objectives. However, it is difficult to rely on prevention grant structures as a permanent source of funding for behavioral health prevention activities while maintaining continuity in service priorities, and the Department has yet to integrate prevention activities into the range of services within the community that it supports.

Proper Monitoring. Through gradual coalition building, the Division's PEI section has laid significant groundwork for assisting and monitoring community prevention and promotion efforts within various regions of the state. Although time- and resource-intensive, need assessments conducted recently have ensured that the Department has an appropriate view of community resources and challenges. The Department also appears to have established appropriate organizational structures, through the Suicide Prevention Council and a diversity of cross-system collaborations, that can provide focus and energy to tackling the most persistent prevention challenges within the state, including alcohol abuse and suicide prevention. Furthermore, the Department's public health approach and population indicators provide robust measures of performance. Direct services such as tobacco enforcement, ASAP and FASD diagnostic teams also appear to be well-administered.

Improving Quality. Many of the Division's early interventions activities are well-established and well-administered at this point. The review period also witnessed improvements in cross-system collaboration and community infrastructure to support statewide prevention strategies.

2.5.9. FINDING: Department efforts to foster **care integration services** of behavioral health and primary care have been mixed in their effectiveness and efficiency.

The *Care Integration Services* domain involves a set of mental health, substance abuse, and primary care integration efforts designed to facilitate whole-person care that treats an individual's medical and behavioral health needs in holistic and mutually re-enforcing ways. Services typically include general and specialized outpatient medical services, acute primary care, general health screens, tests, and immunizations, comprehensive care management, care coordination and health promotion, comprehensive transitional care, individual and family support, and referral to community services. The Department's current continuum does not formally designate care integration services as a unique service area, though DBH and other departmental units are actively pursuing behavioral health and primary care within the delivery system under a range of models and local experiments and demonstrations.

Service Domain	Effective Delivery	Efficient Delivery	Viable Funding	Proper Monitoring	Improving Quality	Overall Performance
Care Integration						

Effective Delivery. The results of early care integration pilots have been mixed. Among some providers within the state, care integration has proven to be a highly effective practice. Some local models, such as Southcentral Foundation's Nuka System of Care, have received national attention for its whole health approach. However, other demonstrations have been partially implemented and then abandoned, while others are mired in active struggles between the distinct medical and behavioral health cultures of allied providers.

Efficient Delivery. Although integrated care, when properly implemented, is inherently more efficient than care delivered in artificial mental health, substance abuse, and medical siloes, the data and communication infrastructure necessary to reap the full benefits of these efficiencies has yet to be developed by many providers. In some instances, current DBH reporting requirement actually harm the cause of care integration, since data administration through the AKAIMS system actually imposes a barrier to regional community providers otherwise well-positioned to integrate the data structures used by their primary care and behavioral health divisions.

Viable Funding. DBH and AMHTA have both been involved in funding individual care integration pilots, such as IMPACT Teams, and they also provide financial supports for ongoing financial initiatives. However, behavioral health and primary care integration is in an early stage of development, with the long-term financial model(s) still evolving. Typically, care integration works best under reformed payment systems that incentivize providers to conduct the care coordination and case management activities that are inadequately reimbursed under "pure" fee-for-service systems such as Alaska's Medicaid program. In some

cases in Alaska, implementation of an integrated delivery system within a federally qualified health center (FQHC) financing framework has been detrimental to behavioral health services, as the economics has substantially favored primary care delivery over behavioral health services. In many respects, it remains too early to tell what kind of integrated care financing will work best for the Alaska context.

Proper Monitoring. The Department's most significant accomplishments in care integration have involved laying the regulatory groundwork for system-wide care integration. During the period under review, DBH completed an extensive regulatory restructuring that facilitated mental health and substance abuse integration within the broader behavioral health domain, which has in turn paved the way for increased efforts to facilitate the integration of behavioral health and primary care. As a part of broader DHSS reforms beyond behavioral health, the Department has invested considerable resources into developing patient-centered medical homes, which serve as a significant first step in creating and administering a health home vehicle for primary care integration. However, to ensure effective administration as the system matures, the Department will need to lead discussion on the most relevant metrics to judge the system-wide and individual provider successes.

Improving Quality. Care integration services are a relatively recent development, both in Alaska and across the country. Despite some setbacks and active challenges in effective implementation, there has been a clear, progressive trend toward more robust, fully-integrated service structures.

3.0. SERVICE DELIVERY BEST PRACTICES

Identify best practices for effective and efficient delivery of behavioral health services, and provide recommendations on practices which could be readily adopted by the Department to more efficiently maximize resources.

3.0.1. RECOMMENDATION: The Department should develop a statewide strategy for sustained support of integrated care across mental health, substance abuse and primary care delivery systems.

Integration of mental health, substance abuse, and primary care delivery systems helps create a seamless system of care that offers consumers and patients the services they need, when they need them, in an environment in which they are comfortable. Many individuals with behavioral health conditions forgo treatment because it is inconvenient or it is not identified by a primary care provider. Additionally, most individuals with diagnosed mental health and substance use disorders require physical health care in addition to behavioral health treatment services. An integrated health system removes the boundaries between behavioral health and primary care providers, increases care coordination, and reduces access barriers. This integrated model results in more effective universal screening practices, efficient referrals, and improved health outcomes. Moreover, integrated care systems reduce expenditures for consumers with both behavioral health and primary care diagnoses.[43]

The Department has engaged in a number of initiatives aimed at integrating behavioral health and primary care services. In 2014 DHSS partnered with the Alaska Mental Health Trust Authority (AMHTA) and the Alaska Primary Care Association to sponsor the Alaska Patient Centered Medical Home Initiative, of which one of the objectives is to "[i]ncrease clinic capacity to serve more patients, including more patients with challenging conditions including mental illness, substance abuse and other complex conditions which frequently present in primary care settings."[44] Additionally, AMHTA collaborated with API to implement the IMPACT (Improving Mood – Promoting Access to Collaborative Treatment) model for treating depression in adults within the primary care setting. Furthermore, providers have also initiated behavioral health and primary care integration. Southcentral Foundation, Mat-Su Health Services, and Peninsula Community Health Services of Alaska, among others, have all adopted care integration frameworks to embed behavioral health services into the larger array of medical services they provide. Southcentral Foundation developed a holistic model of care that addresses the complete needs of an individual, and Mat-Su Health Services introduced primary care into behavioral health settings.

[43] Mike Nardone et al., Integrating Physical and Behavioral Health Care: Promising Medicaid Models, Kaiser Family Foundation, February 2014.
[44] Request for Grant Proposals: Alaska Patient Centered Medical Home Initiative, Alaska Primary Care Association, March 28, 2014.

State mental health agencies are moving towards integration of behavioral health and primary care treatments services, and with good reason. As seen in the success of Southcentral Foundation's Nuka System of Care, integrated care is effective at promoting both physical and mental wellbeing. Although Southcentral's experience with care integration represents an important success in delivery system reform, other providers' experiments in care integration have been more ambivalent in their outcomes. The Department has initiated integration in limited settings, but as local solutions continue to emerge and prove their success as strategies applicable to other regions, the Department should expand these efforts by developing the lessons learned into a statewide strategy to support and promote the integration of mental health, substance abuse, and primary care delivery systems across Alaska's wider health networks.

A coordinated effort to integrate behavioral health and primary care will facilitate the implementation of consistent integrated care models throughout the state and break down the barriers between behavioral health and primary care services that remain prevalent in many parts of the state. Care integration is also a prominent aspect of the Certified Community Behavioral Health Clinic (CCBHC) currently under development by Substance Abuse and Mental Health Services Administration (SAMHSA), which PCG recommends for implementation in Section 3.0.4.

3.0.2. RECOMMENDATION: The Department should integrate Assertive Community Treatment (ACT) teams into the State's delivery and payment systems.

The Department should also integrate ACT teams into its behavioral health service delivery and payment structures. ACT programs are an evidence-based practice that have been shown to reduce rates of psychiatric hospitalizations and emergency room visits, and increase housing stability in ACT recipients. The teams are composed of a multi-disciplinary array of providers including psychiatry, nursing, substance abuse, and vocational rehabilitation specialists, among others. ACT teams provide integrated community care for people with serious and persistent mental illnesses. The providers deliver assertive outreach, treatment, and support to individuals who may be homeless, or for whom traditional forms of outpatient treatment have been ineffective. The mobility of ACT teams allow services to be provided in the individual's natural environment, limiting the system's dependence on intensive settings to treat this population of consumers.

Anchorage has the volume of seriously mentally ill individuals requiring, but not currently receiving, intensive outpatient behavioral health treatment to support an ACT team, a subject discussed in depth in Section 2.5.3. Like targeted case management, which PCG recommends in Section 5.5.3, ACT interventions are a part of the vital layer of intensive support services that remain underdeveloped in Alaska, but which will need to be further supported if the Department hopes to take advantage of major delivery system reforms currently on the horizon.[45] By implementing an ACT team in Anchorage, and other communities with the consumer volume to warrant a full team, the Department will strengthen its community-based service system and reduce rates of hospitalization and other high-intensity and high-cost

[45] See PCG's recommendations in Section 3.0.4.

services. States have used a variety of methods to fund ACT teams, including grants, contracts, and Medicaid. The Department should explore these funding options to develop a sustainable method of financing for the ACT program. Based on estimates of the observed savings per ACT recipient and the eligible population, it is estimated that an ACT program could save the Department up to $2 million each year.

3.0.3. RECOMMENDATION: The Department should continue to promote greater capacity and utilization of peer support services.

To further increase the capacity of the community-based system, the Department should continue its efforts to promote utilization of peer support services. The Department recently established peer support as a Medicaid-reimbursable service. Peer support can now be billed to Medicaid when provided by a peer support specialist who is supervised by a mental health professional clinician. This policy encourages utilization of peer support services and reflects the Department's support of this therapy. Peer support services is an important treatment due to the peer provider's ability to empathize with the consumer. Peer providers can communicate with consumers without the gaps in experience or background that often separate a behavioral health consumer and professional. This service is particularly valuable for people who distrust traditional medical environments, and in tribal communities peer support specialists can engage consumers more effectively than other behavioral health providers. DHSS should continue to build peer support services by renewing the Adult Rural Peer Support grant program, encouraging utilization, and maintaining the Medicaid reimbursement rate.

While the clinical benefits of incorporating peers into the recovery process are overwhelmingly clear, there is also increasing evidence that greater use of peer support services also makes sense from financial perspective. The Washington State Institute for Public Policy conducted a meta-analysis on studies that have attempted to quantify the savings to be yielded from peer support substance abuse services, estimating that the benefit-to-cost ratio of implementation is likely to be $2.00. In other words, for every dollar spent to peer support services for substance abuse, an average of $2.00 would be expected to accrue in cost savings.[46] While the beneficial economic impacts of peer supports for SUD are well-supported, the prospect of cost savings to be gained for mental health treatment are less conclusive. Although some research suggests that the inclusion of peers into psychosocial rehabilitation and other types of community supports can reduce costs associated with psychiatric hospitalization,[47] other studies have not shown a discernible

[46] WSIPP, Benefit-Cost Results: Mobile Crisis Response (July 2015).
See: http://www.wsipp.wa.gov/BenefitCost/ProgramPdf/289/Mobile-crisis-response.
[47] See Barton, R. (1999). Psychosocial rehabilitation services in community support systems: A review of outcomes and policy recommendations. Psychiatric Services (Washington, D.C.), 50(4), 525–534. Also see: Landers, G. M., & Zhou, M. (2011). An Analysis of Relationships Among Peer Support, Psychiatric Hospitalization, and Crisis Stabilization. Community Mental Health Journal, 47(1), 106–112; and Min, S.-Y., Whitecraft, J., Rothbard, A. B., & Salzer, M. S. (2007). Peer Support for Persons with Co-Occurring Disorders and Community Tenure: A Survival Analysis. Psychiatric Rehabilitation Journal, 30(3), 207–213.

effect on overall health expenses.[48] The differences in cost outcomes between SUD and mental health peer services are probably reflective of the potential for cost offset to be found in the two service populations more generally, and should not necessarily be taken as a sign of disparity in relative *clinical* effectiveness.

Current deficiencies in the State's peer support service capacity are also examined in Section 2.5.5. It should also be noted that peer support services can also play an important role in improving the Department's emergency psychiatric service infrastructure, which is discussed in Section 5.5.2 through 5.5.4. Peer services are also a required element in proposed federal delivery system reforms recommended for implementation by PCG in Section 3.0.4 below.

3.0.4. RECOMMENDATION: The Department should pursue implementation of Certified Community Behavioral Health Clinic (CCBHC) services in order to take advantage of enhanced federal Medicaid financing for vital delivery system reforms.

The Department should also seek to strengthen the community-based behavioral health system through the SAMHSA's Certified Community Behavioral Health Clinics (CCBHC) Demonstration Program. In 2014 Congress passed the Protecting Access to Medicare Act, which includes provisions that represent the single largest demonstration project and grant investment in community behavioral health in more than 50 years. The behavioral health provisions in this legislation are known as the *Excellence in Mental Health Act*, and were enacted to establish demonstration programs, funded through Medicaid, to improve community behavioral health services. In the first phase of the program, up to 25 states will each receive a maximum of $2 million to certify clinics as CCBHCs, establish prospective payment systems for Medicaid reimbursable services, and prepare an application to participate in the second phase. In the second phase, up to eight states will be selected to participate in the two-year CCBHC pilot and receive the Enhanced Federal Medical Assistance Percentage (eFMAP) for eligible services delivered through CCBHCs.

SAMHSA developed a set of criteria to define a CCBHC that spans all aspects of operating a community behavioral health center. These criteria were developed with a focus on using the following methods to improve public behavioral health systems:

- Providing community-based mental health and substance abuse services;
- Advancing integration of behavioral health and physical health care;
- Utilizing evidence-based practices on a more consistent basis;
- Promoting access to high quality care.[49]

The goals of the CCBHC program are aligned with the objectives of the Department's community-based behavioral health system and encompass the service delivery best practices identified in Recommendations

[48] Stant, A. D., Castelein, S., Bruggeman, R., van Busschbach, J. T., van der Gaag, M., Knegtering, H., & Wiersma, D. (2009). Economic Aspects of Peer Support Groups for Psychosis. Community Mental Health Journal.
[49] Request for Application for Planning Grants for Certified Community Behavioral Health Clinics, Substance Abuse and Mental Health Services Administration, 2015.

3.0.1, 3.0.2, and 3.0.3. Furthermore, the eligibility requirements to be a CCBHC closely mirror those of the Division of Behavioral Health's (DBH) Comprehensive Behavioral Health Treatment and Recovery (CBHTR) grant program. Through the CCBHC planning grant DBH would receive funds specifically targeted towards objectives it is already pursuing, such as the implementation of evidence-based best practices.

The second focus of the CCBHC demonstration program, the establishment of a prospective payment system (PPS), would also benefit the Department by transforming Medicaid reimbursement of community-based behavioral health services and increasing the federal percentage of Medicaid payments. A PPS establishes predetermined reimbursement amounts based on service classifications that incorporate patient acuity. The PPS options developed by SAMHSA incorporate a behavioral health rate structure that both covers costs and incentivizes quality. The Department would choose one of two PPS options developed by SAMHSA, and receive the eFMAP for the Medicaid-eligible services included in the PPS fee schedule and delivered through the CCBHC. The PPS feature of this demonstration program would assist the Department in maximizing Medicaid payments for behavioral health services and reducing DBH's dependence on GF dollars. Additionally, through the eFMAP it would maximize federal payments for Medicaid-eligible behavioral health services.

The CCBHC Demonstration Program is an opportunity for the Department to receive federal funding to strengthen its community-based behavioral health system. It will enable DBH to assist community-based behavioral health providers in improving quality of care, increasing care coordination, and integrating behavioral health and primary care by developing the providers as CCBHCs. The planning grants and eventual demonstration project are designed specifically to support states in finding the right fit for the CCBHC model within their current system redesign efforts. For that reason, the Department should leverage this opportunity to plan and implement other reform efforts, such as those discussed in Sections 3.0.5 through 3.0.7. Additionally, this program provides the Department with the opportunity to transform its Medicaid behavioral health rate structure with a PPS (see PCG's recommendation in Section 3.0.8) and receive additional federal Medicaid reimbursement for eligible behavioral health services. The Department should apply to participate in both phases of the CCBHC Demonstration Program.

3.0.5. RECOMMENDATION: The Department should consider expanding Medicaid to cover adults under 65 with income up to 133% of the Federal Poverty Level (FPL), taking advantage of substantially enhanced federal funding to build additional infrastructure to meet the needs of underserved behavioral health populations.

Although Medicaid expansion is a politically contentious issue currently in Alaska, from the perspective of improving the quantity and quality of service delivery, this eligibility reform offers an array of substantial opportunities for the State, and should be considered in depth by the Department. In agreement with the majority of medical and behavioral health care organizations in Alaska, PCG recommends Medicaid expansion as a service delivery best practice, primarily for the potential it offers for service coordination

across medical, behavioral health, and criminal justice systems, as well as for the federal cost collaboration opportunities it affords, both in the State Medicaid program, and across the State and tribal behavioral health systems.

Based on national projections as well as Departmental planning, expansion is particularly relevant to the behavioral health population, as the expansion population tends to have a higher rate of behavioral health disorders than both the general population and the current Medicaid population. This is particularly the case with individuals diagnosed with substance use disorders, whose income levels tend to fall within the gap between Medicaid eligibility and affordability of private insurance. According to national figures, roughly 14.6% of the Medicaid expansion population is estimated to have a substance use disorder, compared to 11.5% of the current Medicaid population.[50] Expansion estimates for Alaska project a newly eligible adult population of approximately 40,000 individuals. If the sub-section of Alaska's newly eligible population qualifying for SUD services aligns with national estimates, then somewhere between 5,000 and 6,000 adult Medicaid recipients will be newly eligible to receive Medicaid behavioral health services. Of course, this does not necessarily translate into thousands of previously unserved consumers of DHSS behavioral health services; many of these individuals may already be consumers of State-financed SUD services, but are funded through DBH grants. If a substantial proportion of current consumers become Medicaid eligible, the shift to Medicaid financing would amount to substantial cost savings in GF expenditures. However, of the newly eligible population, a significant portion would probably also be new consumers not previously served by the behavioral health system, which would incur new costs and create additional demand.

Given the manner in which SUD services are currently reimbursed, combined with the potential influx of new consumers into a fragile SUD service infrastructure, it would be unwise to view Medicaid expansion as a panacea for fixing all the defects within the current payment and delivery systems. In many respects, Medicaid expansion can only play a role in effective system transformation if tied to needed Medicaid rate increases (a distinct, if related, issue covered in Section 3.0.8) or paired with Medicaid waiver reforms (discussed in Sections 3.0.6 and 3.0.7). Without rate increases, Medicaid expansion is unlikely to impact GF spending positively, as it would merely increase the level of Medicaid shortfall in reimbursement to providers, exacerbating the need for additional grant funding to supplement inadequate payment rates. In other words, in an expansion scenario without rate reform, behavioral health providers would only sink underwater faster. Compounding this effect would be the fact of new demand for services, further burdening a system characterized by insufficient service capacity. Finally, while the federal government is likely to bear the vast majority of the costs associated with expansion, there are additional GF costs to be accounted for, both in serving the newly eligible population, and in paying for likely rate increases to cover the current Medicaid population, which would be required for effective implementation.

That said, the eventual 90% FMAP offered for the expansion population creates major opportunities for investment into the system, opening up avenues for federal cost collaboration across multiple delivery systems, including the tribal system, which can draw 100% FMAP when serving the American Indian and

[50] Busch, SH, E Meara, HA Huskamp, and CL Barry (June 2013). "Characteristics of Adults with Substance Use Disorders Expected to Be Eligible for Medicaid under the ACA." *Psychiatric Services* 64(6): 520-526.

Alaska Native (AI/AN) individuals expected to make up roughly 30% of the newly eligible population. These investments are needed to build additional efficiencies into the service system in order to reap short-term and long-term cost savings. Especially in the area of SUD treatment services, investment into increased service capacity promises substantial cost offsets to the State, both in criminal justice expenditures and in acute medical and long term care costs, but these system efficiencies are probably unattainable without systematic reform. The cost benefits of improved SUD treatment capacity are discussed in more detail in Section 2.4.2.

Among the delivery system efficiencies most frequently associated with Medicaid expansion are those to be gained from integrating SUD treatment services into the medical system, especially into primary care. However, the role that Medicaid expansion is likely to play in coordinating services delivered across the DHSS system and the criminal justice system is no less important. To use national estimates, of the 2.3 million inmates in U.S. prisons in 2010, 1.5 million prisoners, 65% of the total population, met the DSM-IV medical criteria for alcohol or other drug abuse or addition.[51] Approximately 68% of jail inmates have substance dependence or abuse.[52] About 90% of jail detainees and inmates are uninsured prior to entry, with substance abuse, mental illness, and chronic health conditions often treated for the first time while in the system.[53] Coordination with the criminal justice system and ensuring continuity of coverage currently presents state Medicaid programs with significant logistical and policy challenges that can be helped, if not fully resolved, by a coverage expansion that bridges some of the gap between the two systems. For this reason, Medicaid expansion should also be considered in the context of the reforms recommended by PCG in Sections 5.5.4 through 5.5.7, in relation to coordination with the Department of Corrections (DOC).

3.0.6. RECOMMENDATION: The Department should transform the State's current Medicaid 1915 waivers and implement the 1915(i) and 1915(k) options to refinance and improve community behavioral health service delivery.

The Department should use the 1915(i) and 1915(k) waiver options to open up new opportunities for Medicaid financing for behavioral health services and align present 1915(c) waivers with the 1915(i) and 1915(k) options to prevent duplication of services and create a DHSS-wide 1915 waiver strategy. A 1915(i) waiver expands the home and community based services (HCBS) eligible for Medicaid reimbursement by redefining the standards of eligibility to receive HCBS. Under a 1915(i) waiver individuals can receive the array of HCBS even when they don't require an institutional level of care. The services authorized under 1915(i) specifically include "day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with

[51] The National Center on Addiction and Substance Use at Columbia University (February 2010). Behind Bars II: Substance Abuse and America's Prison Population. New York: Columbia University.
[52] James, D.J., and Glaze, L.E. (September 2006). Mental Health Problems of Prison and Jail Inmates. Washington DC: Bureau of Justice Statistics.
[53] Veysey, BM (January 2011). The Intersection of Public Health and Public Safety in U.S. Jails: Implications and Opportunities of Federal Health Care Reform. Newark: Community Oriented Correctional Health Services.

chronic mental illness."[54] A 1915(i) waiver would also support many of the targeted case management services recommended by PCG in Section 5.5.3 to manage the intensive needs and high costs of individuals at increased risk of emergency and acute services. The Department should implement a 1915(i) waiver to refinance community behavioral health service delivery.

Additionally, the Department should exercise the 1915(k) option. 1915(k) authorizes the Community First Choice (CFC) program. CFC is a Medicaid state plan option that encourages the use of HCBS by supporting a 6% increase in FMAP and reimbursing states for additional attendant services. To receive authorization for the CFC program from CMS, the Department must make hands-on assistance and instruction provided for essential and instrumental activities of daily living Medicaid-eligible. Under this program, the aforementioned services provided to Medicaid-eligible individuals who meet the institutional level of care will be reimbursable. Many consumers served by the Department require an institutional level of care and would benefit from assistance with daily living activities. The 1915(k) option will enable the Department to address the complex needs of Alaskans with behavioral health issues more effectively.

In conjunction with implementing the 1915(i) and 1915(k) options, the Department should align its existing 1915(c) waivers with the proposed 1915(i) and 1915(k) waiver options. Having a focused 1915 waiver strategy will reduce duplication of services, increase coordination between DHSS divisions, and have a greater impact on the financing of community-based behavioral health services. Estimated savings from these waivers amount to $24 million dollars. The Department should explore and strategically pursue 1915(i) and 1915(k) waiver options to improve community behavioral health service delivery.

3.0.7. RECOMMENDATION: The Department should consider the pursuit of a Medicaid 1115 waiver to broaden the array of behavioral health services financed by Medicaid.

Additionally, PCG recommends the Department pursue a Medicaid 1115 waiver to further expand the array of Medicaid-reimbursable behavioral health services. Section 1115 waivers authorize demonstration and pilot projects as opportunities for states to improve their Medicaid programs. PCG has identified three possibilities for the Department to explore in a 1115 waiver:

1. *Waive the Institutions for Mental Disease (IMD) Exclusion.* The IMD Exclusion prevents the Department from billing Medicaid for services provided to individuals between 21 and 64 years old in a facility with more than 16 beds that is primarily engaged in providing diagnosis, treatment, and care for individuals with mental health and substance use disorders.[55] A waiver of this exclusion would allow the Alaska Psychiatric Institute (API) to bill Medicaid for medically necessary services, reducing the Department's reliance on GF dollars for acute inpatient psychiatric services.

[54] Social Security Act: Section 1915(i) and Section 1915(c)(4)(B), Social Security Administration.
[55] The IMD Exclusion has been in place since the enactment of Medicaid in 1965 and was most recently updated in 1988. It was originally intended to promote deinstitutionalization of the mentally ill. On occasion, CMS has waived it through selective waivers and demonstration programs, most recently in August 2015, in an 1115 waiver amendment submitted by the State of California to allow Medicaid payments for a residential substance abuse services.

2. *Create a delivery system reform incentive payment (DSRIP) program.* A DSRIP program transforms delivery systems through infrastructure development, innovative care models, and optimizing the efficiency of service delivery. Under the 1115 waiver the Department can receive the Medicaid federal match for state and local funds allocated to the DSRIP program. By allocating unused Disproportionate Share Hospital funds, supplemental payments, and other funding sources to a DSRIP program the Department would receive federal matching funds and be able to fund needed behavioral health infrastructure development.

3. *Expand the Safety Net Care Pool (SNCP).* The 1115 waiver potentially provides federal matching funds for "safety net" programs that deliver care to the uninsured and are funded solely by the State. The source of this increased funding is typically derived from a state's Disproportionate Share Hospital (DSH) fund allotment, along with other supplemental payment programs implemented in the state, and can be used to establish a special "safety net care pool" to finance delivery system reforms or costs incurred by the uninsured, which are not otherwise eligible for federal matching funds. Through this option the Department could receive federal funding for its SNCP to provide non-emergency behavioral health services to uninsured Alaskans, a subset of services that are currently funded exclusively through GF spending.

The Department should explore a Medicaid 1115 waiver in order to broaden the array of behavioral health services financed by Medicaid and increase the funding it receives from the federal government for certain mental health and substance abuse treatment services. The amount of additional funding is variable and depends on specific parameters agreed upon by the State and CMS, but it is estimated that Alaska could achieve $10-$15 million in savings through an 1115 waiver. Regardless of the amount of funding received, the State will not have an increase in costs as 1115 waivers are required to be budget neutral. Notably, Alaska has only drawn about 50% of its annual DSH allotment in recent years, yielding a potentially rich source for waiver financing, even under the budget neutrality constraints of an 1115 waiver.

3.0.8. RECOMMENDATION: The Department should develop a Medicaid behavioral health rate structure that covers provider costs, incentivizes quality, and minimizes administrative burden.

The Department should overhaul its Medicaid behavioral health reimbursement rates and methodology. The most recent update of behavioral health Medicaid rates occurred in 2007. Since that time the Department has transitioned towards funding a larger proportion of mental health and substance abuse services through Medicaid reimbursement rather than grant awards. That transition, along with inflation and the possibility of Medicaid expansion, necessitates a close evaluation and restructuring of the behavioral health rate structure in the Department's Medicaid fee schedule. The wide array of behavioral health services included in the fee schedule will be most appropriately funded through a fee schedule that incorporates up-to-date reimbursement methods. Examples of such methods include:

- Bundled payment;
- Monthly rate;
- Regionalized per diem payment;

- Risk-based payment;
- Shared savings model;
- Supplemental payment; and
- Value-based payment.

The Department has already recognized the importance of incentivizing quality and efficiency in service delivery through its performance-based funding system for grant awards. DHSS should extend these principles to the Medicaid behavioral health rates. It is important that rates be modernized to adequately cover provider costs without outsized administrative burden to sufficiently promote the provision of appropriate care rather than indirectly incentivize the utilization of well-reimbursed services. Additionally, inadequate Medicaid reimbursement rates are currently supplemented by grant funding. Developing a robust behavioral health rate structure would shift some of the burden borne by grant funding back to Medicaid payments, increasing the federal share of behavioral health treatment services. The Department should work to update and modernize its behavioral health reimbursement rates and methodologies in order to more appropriately fund Medicaid-eligible behavioral health treatment services.

3.0.9. RECOMMENDATION: The State should develop local sources of funding for behavioral health initiatives.

The State should work with municipalities to develop local sources of funding for behavioral health initiatives. Despite the lack of a county structure there are many opportunities for generating additional local revenue that have yet to be explored. Although the Department currently requires a 25% match of all State funding for community behavioral health grants, the State should also explore a tax or assessment on hospitals as an additional source of funding. Assessments are used by many states to generate matching funding for Medicaid supplemental payment programs such as DSH and Medicaid upper payment limit programs. By levying a tax on hospitals within a municipality and dedicating that tax to the State's share of Medicaid payments, the Department will receive additional federal matching funds that can be redistributed within the provider community, so long as the redistribution benefits the local safety net hospital. This financing mechanism would expand the funds available for behavioral health infrastructure development to include the revenue from the provider tax, decreasing the Department's dependence on the General Fund for infrastructure improvements.

Local sources of funding have the capacity to reduce the Department's reliance on the General Fund and increase federal matching funds for mental health and substance abuse services. Provider taxes are currently used by all states except for Alaska. The State should explore this method of generating local revenue for reinvestment in the community's behavioral health service delivery system. It is estimated that the Department could achieve $1 million to $6 million dollars in additional revenue through local funding streams.

4.0. RESULTS-BASED MEASURES

Using a recognized standard or methodology for measurement, determine whether the Department's behavioral health results-based measures demonstrate the effectiveness and efficiency of the agency's core services, goals, programs and objectives; and recommend necessary improvements. This should address the following:

A. Do the behavioral health results-based measures used by the Department demonstrate the effectiveness of related programs and services?

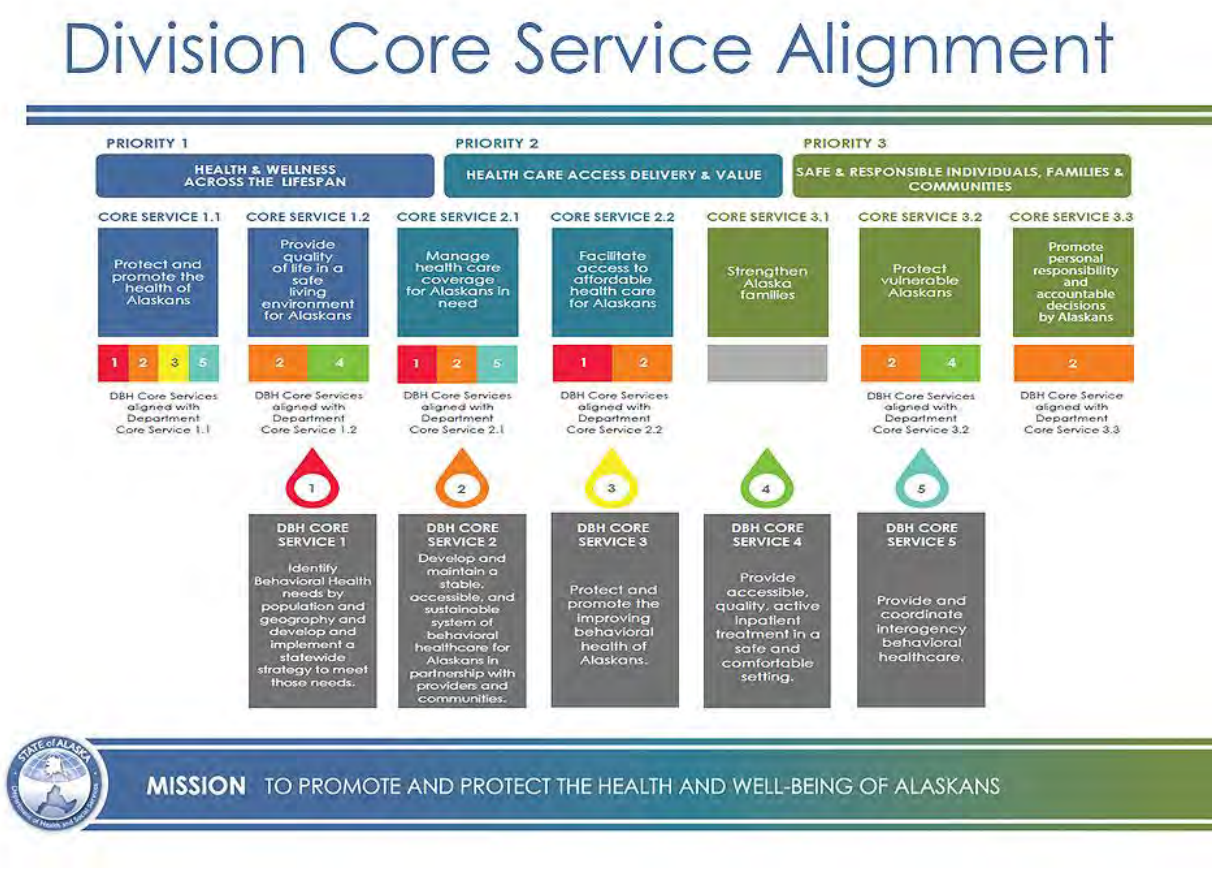
B. Do the behavioral health results-based measures used by the Department demonstrate the efficiency of related programs and services?

C. Are there alternative behavioral health results-based measures that could be used to better demonstrate the effectiveness and efficiency of related programs and services?

4.1. Effectiveness Measures

4.1.1. FINDING: The Department has made significant strides in collecting the data necessary for effective measurement of behavioral health services.

In 2011 the Department of Health and Social Services (DHSS) initiated the Results-Based Accountability (RBA) Initiative. The system addresses accountability from the highest level across all DHSS services. It vertically aligns the services and activities of each division with department-wide priorities. The RBA framework identifies department-wide priorities, department-wide "core services" within each priority, and division-level core services that directly relate to the department-wide core services, creating a vertical linkage between broad, department-wide priorities and specific division-level core services and activities. For example, the Division of Behavioral Health (DBH) has five division core services, and each of these have a well-defined alignment with one or more core services articulated by the Department. The framework states that one of DBH's core services is to "protect and promote the improving behavioral health of Alaskans" (DBH Core Service 3). As seen in the graphic on the following page, this division-level core service is aligned with the Department's core service, "protect and promote the health of Alaskans" (DHSS Core Service 1.2), which is derived from the Department-wide priority of fostering "health and wellness across the lifespan" (DHSS Priority 1). The complete alignment of division services within the RBA services is visualized in the following graphic:



This vertical structure delineated above is complemented by objectives for each core service and performance measures that evaluate the Department's performance on each objective. As these performance measures rely on data collection, the adoption of the RBA framework has subsequently improved the Department's focus on behavioral health performance and data collection efforts across DHSS to support more effective performance measurement.

DBH uses its own provider performance management system, developed prior to the Department's RBA Initiative, known as performance-based funding (PBF). Tied to the Division's grant and contract management efforts, PBF is a system of compliance and quality measures that allocate grant funding based on past performance. DBH adjusts Treatment and Recovery (T&R) grant awards for the upcoming fiscal year according to grantee performance over the first three quarters of the previous fiscal year. For example, FY 2015 grantees received more or less funding based on their performance relative to other grantees in the first, second, and third quarters of FY 2014. The measures used for PBF evaluate compliance, efficiency, and effectiveness and attempt to capture both clinical and administrative performance. According to interviewed providers as well as DBH staff, PBF has thus far had limited impact on funding levels for providers since its implementation, but it has spurred DBH to sharpen its efforts to identify the effectiveness and outcome measures needed to evaluate behavioral health services.

RBA and PBF are separate performance management schemas. The RBA initiative encompasses all of DHSS, while PBF is restricted to DBH T&R grantee providers. RBA and PBF are similar in that each provides a framework for the oversight agency, either DHSS or DBH, to make strategic decisions based on performance as measured by specific indicators. However, the two systems differ in their impact on the budget and funding. The RBA Initiative aligns the DHSS budget with the DHSS priorities and core services. Through Results-Based Budgeting (RBB), an additional component of the RBA framework, the Department can finance programs more strategically, shifting funding from one core service to another in order to buttress high-performing activities or decrease support for low-impact activities, for example. PBF provides DBH with more limited latitude, as the division can only use PBF to reassign funds among Comprehensive Behavioral Health Treatment and Recovery (CBHTR) grant recipients.

Each performance management system relies on the Department's information technology capacities and data collection processes. The ability to collect data related to performance measurement is integral to the successful implementation of any performance management system. Unlike Alaska, many states encounter difficulties with basic data collection for behavioral health system performance measures because the state mental health agency (SMHA) and Medicaid authority exist in separate branches of state government. Alaska has an advantage in this area because both the Medicaid authority and the SMHA exist within DHSS. Additionally, in states that have managed care Medicaid systems behavioral health data is fragmented and spread across multiple data systems. While the Department's IT systems will be discussed in further detail in Section 8.0, the fact that behavioral health data related to performance measurement is collected primarily through the Alaska Automated Information Management System (AKAIMS), Medicaid Management Information System (MMIS) and Alaska Psychiatric Institute (API) electronic health record (EHR) systems, all of which are housed within DHSS, is important to the Department's ability to collect data needed to effectively measure behavioral health services.

4.1.2. FINDING: The Department's progress in behavioral health performance measurement is consistent with the practices of state behavioral health agencies nationwide.

The passage of the Affordable Care Act (ACA) required health care agencies nationwide to accelerate their investment in performance and quality measurement strategies. Historically, the development of metrics for behavioral health care has lagged behind performance measurement standards for medical care, and behavioral health providers have failed to reach the same level of consensus in identifying the most important indicators of behavioral health in comparison to physical health. However, the field is beginning to move closer to consensus in response to major federal and state efforts to reform health care delivery and payment systems. At the federal level, the ACA-mandated requirement that the Department of Health and Human Services (HHS) develop a national quality framework has prompted behavioral health regulators to better coordinate existing performance measurement efforts into a focused national behavioral health quality strategy. Recently, the Substance Abuse and Mental Health Services Administration (SAMHSA) developed the National Behavioral Health Quality Framework (NBHQF), which provides a mechanism to examine and prioritize quality prevention, treatment, and recovery elements of behavioral health care. The

NBHQF engages internal and external stakeholders to evaluate existing behavioral health performance measures, including SAMHSA's own National Outcome Measures (NOMs), and to develop a catalog of key behavioral health quality measures available for use in behavioral health systems nationwide.

Behavioral health performance measures typically rely on a combination of administrative claims and encounter data, electronic health record information, and consumer experience data, collected through consumer experience surveys. As the behavioral health field has begun to standardize its administrative reporting systems, performance indicators and metrics that rely on these data sources have been adopted increasingly nationwide. For example, the Healthcare Effectiveness Data and Information Set (HEDIS) is a tool maintained by the National Committee for Quality Assurance (NCQA) that uses claims and encounter data to measure health system performance. Although this set of indicators was developed initially to track performance outcomes in medical managed care, it has now expanded to include a variety of behavioral health indicators.

In the domain of consumer experience, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) family of surveys is the most commonly used quality measurement tool among behavioral health providers. CAHPS is developed and maintained by the Agency for Healthcare Research and Quality (AHRQ), and is comprised of multiple surveys regarding both general and specific types of care. Many states use the general CAHPS Clinician & Group (CG-CAHPS) survey to evaluate health care, while others rely on the behavioral health-specific Experience of Care and Health Outcomes (ECHO) survey which asks consumers about their experience with mental health and substance abuse services.

Alaska currently relies on internally developed measures and a state-specific performance management system for behavioral health quality measurement. Although the behavioral health field continues to evolve on the topic of quality and performance measurement, the aforementioned nationally recognized measure sets do exist. Participation in the HEDIS and CAHPS surveys is advantageous to agencies that implement them because it facilitates comparison to behavioral health services in other states. A nationwide study of behavioral health performance management data found that of the 29 states surveyed, 20 incorporated HEDIS behavioral health measures into their quality measurement system.[56] Of these same states, 10 used a state-developed consumer experience survey, similar to Alaska's reliance on the Client Status Review (CSR). The behavioral health HEDIS measures were most often accompanied by non-HEDIS measures, as HEDIS measures comprised 23% of the behavioral health measures used by the surveyed states.

This study also analyzed the *type* of measures used, as classified by the Donabedian conceptual model of structure, process, and outcome.[57] 20% of the measures sampled were structure measures, 60% were focused on the process of delivering care, and 20% were classified as outcome measures. For comparison,

[56] Seibert et al., 3.
[57] The *Donabedian quality-of-care framework*, as defined by the study authors, is as follows: "structure measures concern the attributes of the setting, human resources, financing, and organizational structure; process measures describe what occurs in giving and receiving care; and outcome measures refer to the effects of health care on the health status of patients and populations." Seibert et al., 3.

55% of the behavioral health performance measures included in the Department's RBA framework can be classified as process measures, 45% as outcome measures, and none as structure measures.

There are five peer states that provide a lens for a more in-depth comparison to Alaska's behavioral health quality performance measures. From this peer state analysis it is possible to see the strengths and weaknesses of the Department's behavioral health performance management system in relation to similar state agencies. Colorado, Iowa, Kansas, New Mexico, and Texas were all selected as peer states for this analysis based upon similarities to Alaska or to the Department's use of behavioral health performance indicators, or other characteristics of the State's behavioral health performance measurement system.

Colorado: Colorado was selected as a peer state due to its similar ratio of structure, process, and outcome measures. Where DHSS uses a roughly equal percentage of process and outcome measures, and does not use any structure measures, only 7% of Colorado's measures are outcome measures, while 55% are process measures and 37% are structure measures.[58] Additionally, Colorado uses 61 non-HEDIS measures and only 4 HEDIS measures, figures that closely align with the Department's complete reliance on non-HEDIS measures.

The Colorado Department of Health Care Policy and Financing (HCPF) administers Medicaid and other health care programs, including the community behavioral health services program. Each Coloradan eligible for state-funded behavioral health services is assigned to a Behavioral Health Organization (BHO) that provide the services directly. HCPF evaluates the BHOs on a set of 22 indicators.[59] The indicators rely exclusively on information from claims and encounter data, with the exception of prevalence rates which incorporate national HEDIS data. HCPF measures the quality of behavioral health service delivery with the aforementioned indicators, but evaluates the performance of the Colorado Office of Behavioral Health (OBH) with a different set of measures. OBH is similar to DBH in that it operates Colorado's state psychiatric hospitals and also serves as the state behavioral health authority responsible for program monitoring and evaluation, policy development, and oversight of behavioral health services. Colorado uses C-Stat, a performance-based analysis strategy, to measure the impact of the activities of OBH.[60] These measures utilize data collected both from community-based providers and mental health institutes. Additionally, Colorado uses a non-HEDIS consumer survey to assess the consumer experience of behavioral health services, the Mental Health Statistics Improvement Program (MHSIP) consumer survey. The MHSIP survey was developed by an outside agency and was only used by four states in the survey.

Colorado's behavioral health quality management strategy can inform the Department's due to its distinction between the measures evaluating the performance of behavioral health providers and the performance of the state agency responsible for oversight of those services, a nuance the Department has

[58] Seibert et al., 4.
[59] Fiscal Year 2014 BHO-HCPF Annual Performance Measures Scope Document Version 6, Behavioral Healthcare, October 29, 2014.
[60] C-Stat Summary Report October-December 2014, Performance Management on behalf of Colorado Department of Human Services.

yet to develop. With a similar make-up of structure, process, and outcome measures and a non-CAHPS consumer experience survey, a system that is analogous to Alaska's, Colorado is able to effectively measure the performance both of the behavioral health system and of the state at administering that system.

Iowa: Iowa is similar to Alaska in that it uses only non-HEDIS measures in its behavioral health performance measurement system. Of the 23 measures included, none stem from the HEDIS dataset.[61] Additionally, 56% of Iowa's measures can be classified as process measures, a figure nearly identical to DHSS' 55%.

The Iowa Department of Human Services (IDHS) contracts with Magellan, a private organization, to manage behavioral health services. IDHS evaluates Magellan on a large set of performance indicators, some of which are tied to financial compensation. These performance indicators measure the service delivery processes, administrative efficiency, and clinical outcomes. Similar to DBH'S PBF initiative, IDHS applies financial incentives and disincentives to Magellan's performance on process and administrative efficiency measures, and monitors the clinical outcomes performance measures but does not tie them to financial incentives and disincentives. These indicators include a mix of HEDIS measures gathered from the CAHPS survey and internally developed measures. Additionally, IDHS includes behavioral health prevention and treatment indicators in its Adult Quality Performance Measures. This set of measures was identified by the Centers for Medicare and Medicaid Services (CMS) in partnership with the AHRQ.

Iowa's behavioral health performance management system is instructive in that it addresses all aspects of behavioral health service delivery and oversight. IDHS evaluates its behavioral health provider on clinical processes, clinical outcomes, and administrative inefficiency, and monitors population health indicators. This system is a more developed version of PBF that effectively ties performance to financial compensation. Additionally, Iowa also does not use HEDIS measures, but nonetheless incorporates externally developed indicators into its system through the prevention and treatment indicators developed by CMS.

Kansas: Kansas was selected for this peer state analysis because, among the 29 states surveyed, Kansas uses the largest quantity of behavioral health quality measures. Kansas uses 69 different performance measures, of which 38% are structure measures, 43% are process measures, and 19% are outcome measures, and all are state-developed measures rather than HEDIS measures.

State funded behavioral health services in Kansas are delivered through KanCare, the Kansas Medicaid program. KanCare relies on managed care organizations (MCOs) to deliver mental health and substance abuse treatment services and the State does not directly deliver those services, similar to the community-based T&R services in Alaska. Within the state Quality Strategy intended to evaluate the performance and quality of health services are performance measures specific to behavioral health services. Kansas uses a total of 69 measures to evaluate the quality of behavioral health services. The State relies on data from the CAHPS survey, claims database, and quarterly reports to populate these measures. In contrast to Alaska, there are more structure measures (26) than outcome (13), but Kansas is similar to Alaska in that the largest

[61] Seibert et al., 3.

cohort (30) are process measures.[62] These measures evaluate the quality of services provided and administrative efficiency of the MCOs at providing the services. Additionally, Kansas has a system of financial incentives tied to behavioral health quality. The State uses a "pay for performance" schema that rewards MCOs based on their ability to effectively and appropriately treat consumers with behavioral health needs. While Alaska and Iowa do not tie treatment outcomes to their financial incentive programs, Kansas includes outcome measures in its pay for performance indicators. For example, *The number and percent of members, receiving SUD (Substance Use Disorder) services, whose employment status increased* and *The number and percent of youth with an SED (Serious Emotional Disturbance) who maintained their residential status* are pay for performance indicators.

Kansas' performance and quality management system effectively measures the quality of behavioral health services, the ability of the MCOs to provide these services efficiently, and the effectiveness of the services provided. Most notable about this system is the linkage of treatment outcomes to financial incentives. Outcome measures that evaluate the ability of care to be effective at delivering a specific treatment outcome, such as increase in employment status, are included within the pay for performance indicators. Alaska's performance measures require further development in this domain, and Kansas' system is a good example of well-developed outcome measures that evaluate how a consumer was impacted by a program rather than just whether they completed it.

New Mexico: New Mexico was selected as a peer state due to its high percentage of American Indians. Alaska has the largest percentage of American Indian/Alaska Natives (14.3%), and New Mexico has the second largest (9.1%).[63] New Mexico and Alaska have similar behavioral health performance management systems with regards to the quantity of measures used and reliance on state-developed measures, although it is important to note that the similarities in demographics is likely not the cause. New Mexico's system informs Alaska by serving as an example of another state that largely relies on state-developed measures while nonetheless participating in an externally-developed survey.

To inform budget decisions and evaluate the performance of state services, New Mexico implemented the Results First Initiative, a structure with goals similar to that of the RBA framework. In New Mexico the behavioral health system is the responsibility of a 17-member Behavioral Health Purchasing Collaborative (BHPC). The BHPC is responsible for coordinating the statewide behavioral health system, ensuring each individual has access to quality behavioral health services. The Results First Initiative includes nine behavioral health performance measures, a figure similar to the 11 behavioral health RBA performance measures. The New Mexico measures are overwhelmingly focused on the setting in which care is delivered and the process of behavioral health service delivery. In addition, New Mexico uses the MHSIP to evaluate consumer experience with behavioral health services. These measures are not included within the Results First performance measures. In total New Mexico reports on 19 quality measures, nine of which are structure measures, six of which are process measures, and six of which are outcome measures. Although

[62] Seibert et al., 3.
[63] "American Indian & Alaska Native Populations," Centers for Disease Control and Prevention. Accessed June 18, 2015. http://www.cdc.gov/minorityhealth/populations/REMP/aian.html.

New Mexico uses the MHSIP, it does not incorporate any HEDIS measures into performance measurement, and it uses state-developed measures within the Results First Initiative.

Texas: Although no state can compare to Alaska's size and vast geography, Texas is the second largest state by land mass. It was chosen as a peer state based upon its geographic size and rural communities. Similar to Alaska, Texas uses only process and outcome behavioral health performance measures, with eight process measures and four outcome measures.

Although Texas is a decentralized system in comparison with Alaska, with public behavioral health services coordinated by Local Mental Health Authorities (LMHAs), at the state level, the Mental Health and Substance Abuse Division (MHSA) within the Department of State Health Services (DSHS) is responsible for managing the state's behavioral health system. The MHSA has a comprehensive plan to evaluate financial, clinical, and quality performance of behavioral health service delivery, and it includes two separate sets of measures: one for institutional programs and one for community-based services. DSHS uses a vertical alignment of accountability that is similar to the RBA framework; the performance indicators are aligned with MHSA-specific goals, the MHSA goals are aligned with DSHS-specific goals, and those goals are designed to meet the strategic goals of the entire statewide health system. Additionally, Texas uses the CAHPS survey to evaluate consumer experience. In total Texas monitors 12 behavioral health performance and quality indicators, of which 10 are HEDIS measures.

The behavioral health performance management system used in Texas relies on 12 indicators to evaluate the quality of behavioral health services delivered. It is informative to Alaska based upon its vertically aligned accountability framework, a structure that closely mimics Alaska's RBA initiative. The Texas and Alaska frameworks both rely solely on process and outcome measures. In spite of these similarities, Texas is an example of a state that uses both internally developed and externally developed indicators, relying on the CAHPS survey for its consumer experience data and HEDIS measures for a majority of its other indicators.

The Department's progress towards effective performance measurement of behavioral health services is consistent with the practices of other state agencies. DHSS is working towards a cohesive, comprehensive system to evaluate the quality and effectiveness of behavioral health services. Across the country states are increasingly adopting nationally-recognized performance indicators such as the HEDIS measures or the CAHPS surveys. As the NBHQF takes shape, national standards for behavioral health performance measurement will be codified and the benefits of using standardized indicators and survey instruments will increase. Alaska has not yet fully embarked on this trend, but nonetheless its mix of structure, process, and outcome measures is consistent with national norms.

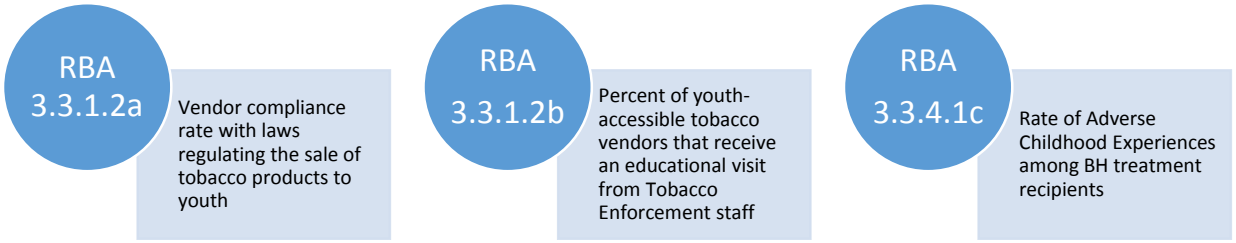
4.1.3. **FINDING**: Department behavioral health measures sufficiently demonstrate whether Prevention and Early Intervention (PEI) services are effective.

The PEI section of DBH is responsible for delivering two distinct types of behavioral health services within the Department. As the name implies, the first part of PEI's section responsibilities are aimed at prevention,

and employs a public health approach to address behavioral health endemic within the general population, such as suicide and substance use issues. The other half is oriented to early intervention, which involves treatment interventions that target individuals who are at risk of developing more serious behavioral health problems develop. Although early intervention activities are similar to traditional T&R services in their focus on individuals, prevention activities are more commonly community efforts that involve partnerships with numerous stakeholders both inside and outside DHSS and state government.

In the case of prevention services, unlike early intervention services, departmental performance can only be measured indirectly by evaluating the overall impact on population outcomes rather than the activities of particular service providers or programmatic units. Despite these limitations in PEI's ability to measure its performance directly, PCG finds that DBH's prevention measures adequately guide its prevention efforts and sufficiently demonstrate the effectiveness of PEI services.

Within the RBA framework, performance measures include three measures which evaluate the effectiveness of PEI services. Of those measures, one evaluates the ability of DBH to perform its prevention activities, and two evaluate the effectiveness of those prevention activities:



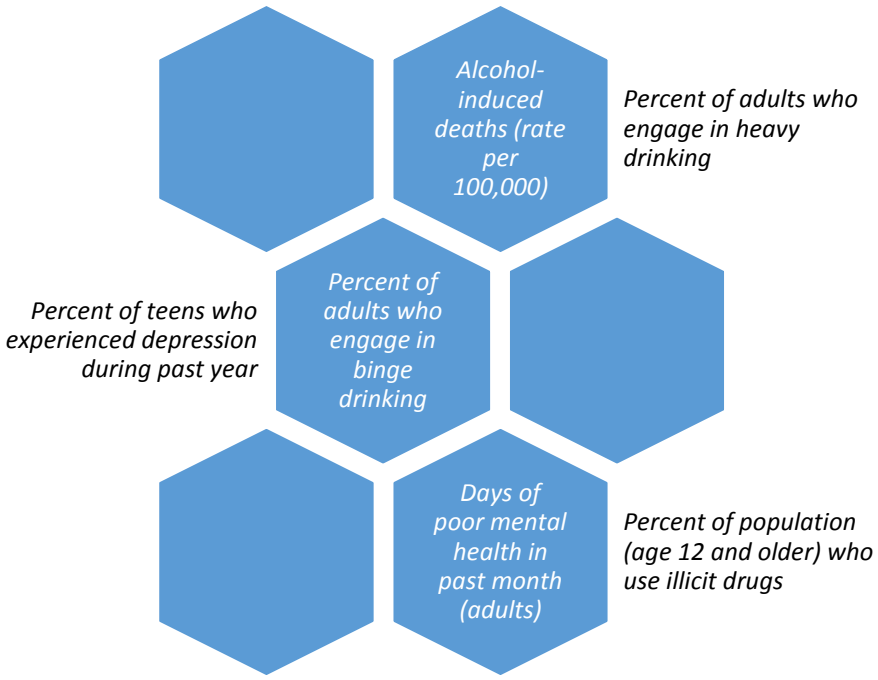
Performance Measure 3.3.1.2b directly evaluates DBH performance on one of its primary responsibilities, conducting the Tobacco Enforcement Program and visiting youth-accessible tobacco vendors. This indicator addresses the capability of the Department to carry out tobacco enforcement activities successfully. *Performance Measure 3.3.1.2a* and *Performance Measure 3.3.4.1c* capture the effectiveness and impact of PEI services. *Measure 3.3.1.2a* assesses the effectiveness of tobacco vendor education by measuring the vendor compliance rate. *Measure 3.3.4.1c*, by capturing the frequency of adverse childhood experiences among behavioral health consumers, indicates the effectiveness of PEI services both at preventing adverse childhood experiences and mitigating the long-term behavioral health consequences of such experiences. DBH's performance in conducting prevention activities as well as the effectiveness of those activities are sufficiently evaluated within the RBA framework.

The Department also reports on the performance of DBH in carrying out prevention activities through the Annual Synar Report. The Synar report is submitted to SAMHSA every fiscal year as a requirement of the Tobacco Regulation for the Substance Abuse Prevention and Treatment (SAPT) Block Grant, through which the State receives funding for tobacco prevention activities. This report includes many measures of the effectiveness of DBH at carrying out tobacco prevention activities, including:

Synar Report Measures		
Whether citations or warnings are issued to retailers or clerks who sell tobacco to minors for inspections that are part of the Synar survey	Whether every tobacco outlet in the state received at least one compliance check that included enforcement of the state youth tobacco access law(s) in the last year	The number of citations issued for violations of state youth access to tobacco laws by local and/or state law enforcement agencies

The measures included within the Synar survey are especially helpful for evaluating program effectiveness, because they focus specifically on the success of division activities and not just population outcomes.

The Department measures additional facets of PEI services through the Alaska Scorecard.[64] The scorecard measures the rate of suicide (per 100,000) and the percent of adults reporting serious thoughts of suicide. With a state rate nearly double the nationwide rate, suicide is a serious concern for Alaska. Capturing these two metrics sufficiently evaluates the impact of the suicide prevention activities undertaken by DHSS. The scorecard also includes six additional PEI measures:



These measures capture the primary domains of PEI services. Four measures address the domain of substance abuse and two address mental health. Together with the two measures evaluating suicide, the

[64] Alaska Scorecard, Division of Public Health, Alaska Department of Health and Social Services.

behavioral health indicators included in the Alaska Scorecard enable the Department to monitor the impact of PEI services effectively.

Additionally, the Department measures the effectiveness of PEI services through the Strategic Prevention Framework State Incentive Grant (SPFSIG) plan and the Healthy Alaskans (2020) initiative. DBH tracks 20 additional performance measures through SPFSIG, 16 of which are SAMHSA NOMs and four of which are internally tracked measures. The measures tracked through SPFSIG, such as *Abstinence from Drug Use/Alcohol Abuse* are population indicators that evaluate the effectiveness of PEI activities indirectly. The indicators tracked through Healthy Alaskans are also population indicators that provide only an indirect evaluation of the effectiveness of PEI activities. For example, *Adult Tobacco Use* tracks the percentage of adult Alaskans who have smoked cigarettes in their lifetime but are currently not smoking cigarettes.[65] The Healthy Alaskans initiative is a joint effort of DHSS and the Alaska Native Tribal Health Consortium (ANTHC) and is managed by the Division of Public Health (DPH).

Having DPH as the steward of the Healthy Alaskans measures speaks to the shared responsibility for population wellness and behavioral health. With the exception of the RBA performance measures, the measures used by DHSS to evaluate the effectiveness of PEI services are all population indicators. This is reflective of the difficulty of determining the causal effect of prevention activities; these activities affect the entire Alaskan population and it is impossible to isolate the specific effect of DBH prevention activities. However, to the extent that the population measures evaluate the ultimate outcomes of DHSS activities, the Department sufficiently measures the effectiveness of PEI services.

4.1.4. **FINDING**: Department measures do not sufficiently demonstrate whether community T&R services are effective.

The performance measures relating to community-based T&R services do not successfully demonstrate the effectiveness of the behavioral health services provided. There are five measures focused on T&R within the RBA framework:

[65] Complete Indicator Profile of Tobacco Use – Adults (18+), Alaska Department of Health and Social Services. http://ibis.dhss.alaska.gov/indicator/complete_profile/CigSmokAdlt.html.

RBA 1.1.3.1a

- Percent discharged from substance abuse treatment services that successfully complete treatment

RBA 1.2.4.1a

- Percent of behavioral health recipients who report improvement in quality of life

RBA 2.2.1.5a

- Percent of the estimated need for behavioral health services met through community-based services

RBA 2.2.1.5b

- Percent of clients whose wait time to access treatment is less than 7 days

RBA 2.2.1.5c

- Percent of substance abuse residential treatment providers with a bed utilization rate of 85% or higher

The focus of these performance measures should be on the effectiveness of the programs and services provided. The measures should focus on the *outcomes* of the treatment provided rather than on the *process*. *Performance measure 1.1.3.1a Percent of Alaskans discharged from substance abuse treatment services that successfully complete treatment* exemplifies the misdirected focus of the community-based T&R services because it measures only whether consumers complete a program, not whether the program achieves the intended outcome or whether the consumer is successfully recovering as result of the program. *Performance measure 1.2.4.1a Percent of behavioral health recipients who report improvement in quality of life* is an effective outcome measures. It evaluates the outcome of behavioral health treatment rather than the process. However, it is the only measure of community-based T&R behavioral health outcomes within the RBA framework. The other four measures examine access to behavioral health services and treatment delivery processes. Despite the fact that there are effective means to directly measure behavioral health quality outcomes, such as those used in Kansas, the RBA framework includes only one measure of behavioral health quality. Additionally, *Performance measure 1.2.4.1a* is a non-specific measure of the outcome of the T&R services received by the consumer. The measure is based on the consumer's perception of improvement in nine quality of life domains:

- Housing;
- Ability to support basic needs of food, housing, etc.;
- Safety in their home or where they sleep;
- Safety outside their home;
- How much people in their life support them;
- Friendships;
- Family situation;
- Sense of spirituality, relationship with a higher power, or meaningfulness of life; and
- Life in general.

Although DBH collects sufficient data to measure the effectiveness of community based T&R services at improving consumer quality of life in specific domains, such as housing, the sole T&R outcome measure included in the RBA framework fails to address specific treatment outcomes. The effectiveness of T&R services is not adequately measured by the indicators included in the RBA framework.

Additionally, the Department measures the effectiveness of T&R services through indicators included in the PBF system. Of the 21 T&R indicators reported on within PBF, twelve evaluate the effectiveness of behavioral health services by focusing on the outcome of mental health and substance abuse treatment. These 12 indicators are comprised of three indicators applied to four populations: SMI, SED, Substance Abuse Adult, and Substance Abuse Youth. The performance measures are:

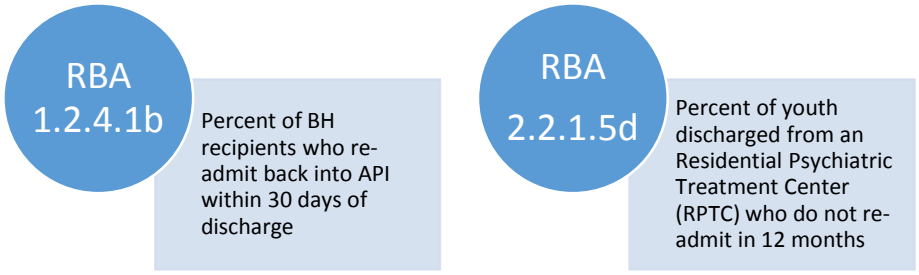
PBF	*Percent of Clients with Improvement (or No Change) in Mental Health/Substance Abuse Domain*
	Percent of Clients with Improvement (or No Change) in Quality of Life Domains
	Percent of Clients Satisfied with Services: Improved Quality of Life

The data supporting these measures is collected through the consumer-reported CSR. *Percent of Clients with Improvement (or No Change) in Mental Health/Substance Abuse Domain* is an effective measure of specific treatment outcomes of T&R services. However, the remaining indicators are too broad to sufficiently report on the effectiveness of community-based T&R services. *Percent of Clients with Improvement (or No Change) in Quality of Life Domains* and *Percent of Clients Satisfied with Services: Improved Quality of Life* do not measure the effectiveness of T&R services at achieving specific treatment outcomes. These measures are not specific enough to adequately inform DBH about the effect of treatment on the consumer.

Although DHSS collects large quantities of data from its community-based T&R grantees, the Department falls short at utilizing the data collected and at collecting the appropriate data points to measure the effectiveness of these services. DHSS reports on many aspects of community-based T&R programs within the NOMS data collected by the SAMHSA Center for Mental Health Services (CMHS) Uniform Reporting System, but does not include those effectiveness measures in its performance management systems. For recommendations related to this finding, please see Sections 4.3.1, 4.3.4, and 4.3.5.

4.1.5. FINDING: Department measures sufficiently demonstrate whether institutional behavioral health services are effective.

The DHSS RBA performance measures include two indicators that evaluate the effectiveness of institutional behavioral health services:



PCG finds that these measures sufficiently evaluate the outcome of behavioral health treatment within an institutional setting. By examining the percentage of discharged consumers who re-admit to API within 30 days, DHSS is able to evaluate whether the treatment received at API improved the consumer's mental wellness enough that inpatient hospitalization was no longer needed, a robust indicator of the effectiveness of the treatment received within API. Similarly, evaluation of the percentage of discharged youth who are not re-admitted to a residential psychiatric treatment center (RPTC) within one year indicates whether the youth received care that improved their long-term wellbeing. Another measure at API, the medication error rate, reflects the effectiveness of API to provide medication service safely and accurately.

4.2. Efficiency Measures

4.2.1. FINDING: Department measures demonstrate whether PEI services are efficient.

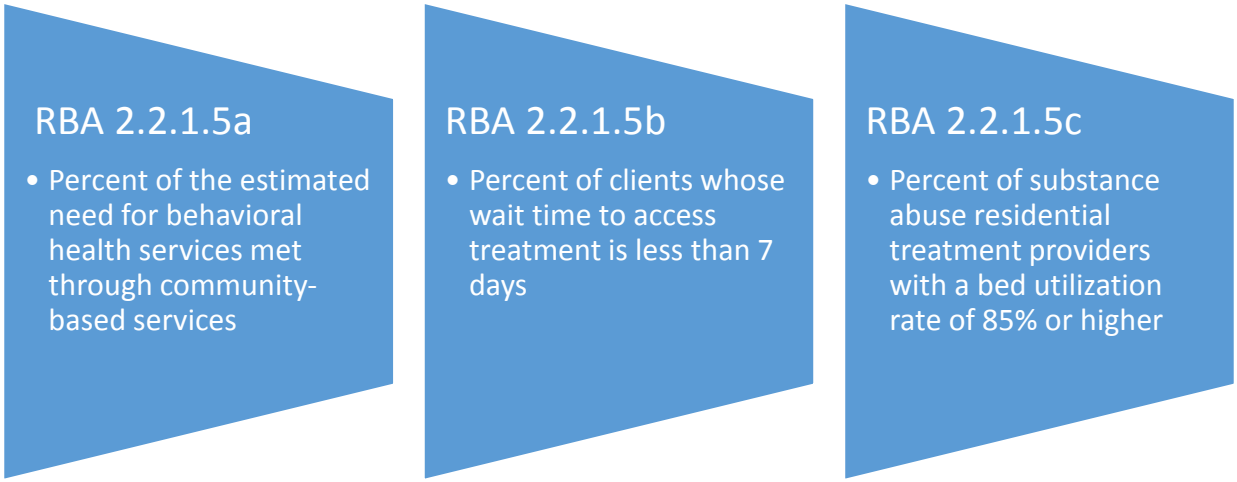
Prevention and early intervention activities reduce the need for more expensive and intensive behavioral health treatment by contributing to the prevention of mental health and substance abuse disorders. Thus, they tend to be highly efficient almost by definition. The cost of delivering prevention programs is lower than delivering treatment programs, while the number of consumers reached by prevention programs far outreaches the number of consumers served in treatment programs, making behavioral health prevention programs the most efficient approach to addressing general behavioral health concerns. To the extent that PEI services are effective, then they are by their nature also efficient.

Despite the fact that PCG did not identify any measures directly evaluating the efficiency of PEI services, PCG finds that the Department's performance management system nonetheless demonstrates the efficiency of PEI services at promoting wellness and prevention behavioral health issues. However, PCG heard anecdotally that DBH is not delivering and managing prevention services in an efficient way. Specifically the burdens placed on community stakeholders to comply with the State's SPFSIG plan are highly labor

intensive and inhibit the efficient delivery of behavioral health services. Although the Department's performance management system does demonstrate the efficiency of PEI services it is not done systematically in a way that evaluates both the efficiency of PEI services and the efficiency of the Department at managing and delivering these services.

4.2.2. FINDING: Department measures do not demonstrate whether community Treatment and Recovery services are efficient.

Of the five T&R services-focused measures included within the RBA framework, three relate to the efficiency of community-based T&R services:



The above RBA performance measures all pertain to the process of providing community-based T&R services, but do not sufficiently evaluate the efficiency of these services. While *Performance measure 2.2.1.5a* is an adequate indicator of the ability of the community-based system to meet the demonstrated need for behavioral health services, the measure does not address the ability of the system to deliver community-based services *efficiently,* with low costs and high effectiveness. *Performance measure 2.2.1.5b* also provides more general information about the timeliness of the community-based T&R services and fails to measure the efficiency. The final RBA measure, *Performance measure 2.2.1.5c*, reflects both the capacity of the system and the efficiency of the placements. The performance measures in the RBA framework must be sufficiently broad to speak to the entirety of the community-based T&R system, but PCG finds that the measures do not provide enough information to sufficiently evaluate the efficiency of these services.

Within the PBF indicators there are four measures intended to evaluate the efficiency of T&R services.

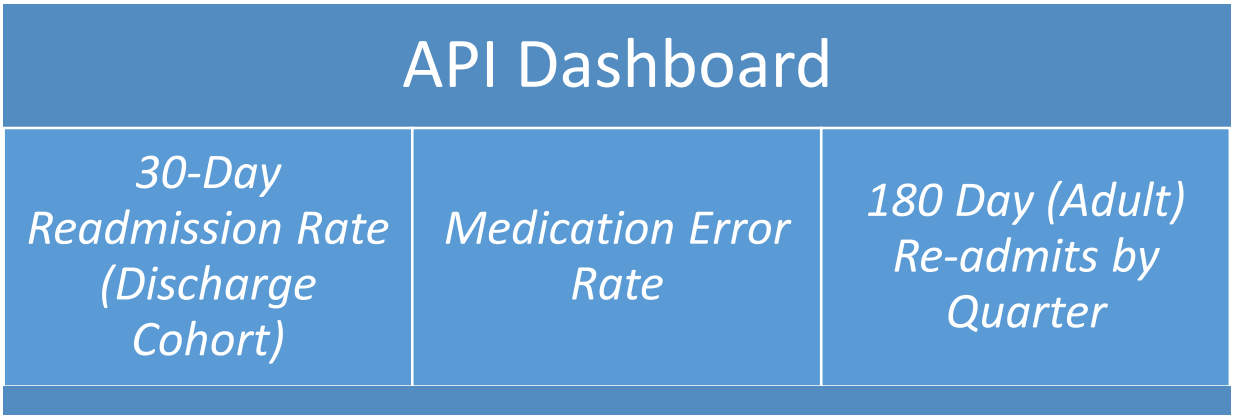
PBF B.2	PBF B.3	PBF B.4	PBF B.5
• Annual Household Income: Percent of Served Clients with Missing or Bad Data	• Average Number of Days from Screening (AST) to First Treatment Service	• Percent of Clients Served within 30 Days of Program Enrollment	• Percent of Enrolled Clients Not Served within 135 Days

Measure *B.2 Annual Household Income: Percent of Served Clients with Missing or Bad Data* measures the rate at which providers collect complete datasets on consumers. The other three measures all evaluate the ability of the community-based system to treat consumers in a timely fashion. The four measures do reflect the efficiency of T&R services, but they only encapsulate two domains. The PBF measures fail to represent the cost-efficiency of each program or service, the average length of a successful treatment strategy, and other indicators of efficiency.

PCG finds that the Department does not adequately measure the efficiency of community-based T&R services. Although the measures collected reflect some measures of efficiency, they fall short of providing the comprehensive information needed to adequately report on the efficiency of the system. Furthermore, the measures reflect the activities of the providers and of the system as a whole. They do not speak to the efficiency of DBH at supporting the T&R services and performing their duties. For recommendations related to this finding, see Sections 4.3.2 and 4.3.5.

4.2.3. FINDING: Department measures sufficiently demonstrate whether institutional behavioral health services are efficient.

DHSS measures the efficiency of institutional behavioral health services through evaluation of hospital readmission rates of discharged consumers and average lengths of stay. Included within the API Dashboard are the following measures of efficiency:



Two of these three indicators evaluate the readmission rates of discharged consumers. These measures are indicators of both the outcome of treatment and the ability of treatment to prevent re-hospitalization, thus reflecting the efficiency of treatment programs at preventing costly institutional care. The third, medication error rate, reflects the ability of API to provide medication service safely and accurately. These measures all demonstrate the efficiency of institutional behavioral health services, and PCG finds that the Department sufficiently measures the efficiency of institutional behavioral health services. In certain respects, all three measures are indicators of the overall effectiveness of treatment as well.

4.2.4. FINDING: The Department's measures of institutional behavioral health are consistent with nationwide best practices.

The prevailing standard for inpatient psychiatric hospital performance measures are the Hospital-Based Inpatient Psychiatric Service (HBIPS) set of measures. The HBIPS dataset is a group of standardized, uniform measures for inpatient psychiatric care. These measures are required by The Joint Commission (JC) and CMS.[66] API reports all of the HBIPS measures to the JC and to CMS, although it only includes two (*Restraint Hours (per 1000 inpatient hours)* and *Seclusion Hours (per 1000 inpatient hours)*) on the API dashboard. However, these measures are nonetheless publicly available through the JC. The additional measures included in the API Dashboard fall into domains recognized by the National Association of State Mental Health Program Directors (NASMHPD) National Research Institute (NRI) as standard practice: patient experience of care, patient injury rates, medication error rates, and readmission rates.[67] Between the HBIPS measures and the additional indicators included in the API Dashboard, PCG finds that the indicators used by DHSS to evaluate institutional behavioral health services are consistent with nationwide best practices.

[66] "Hospital-Based Inpatient Psychiatric Services (HBIPS)," NRI, Accessed June 22, 2015. http://www.nri-inc.org/#!hbips-services/c1oqt.
[67] "Inpatient Performance Measures," NRI, Accessed June 22, 2015. http://www.nri-inc.org/#!inpatient-performance-measures/c8da.

The API dashboard includes 16 indicators that measure the quality of the institutional behavioral health services provided to consumers:[68]

- Client injury rate / 1000 inpatient days;
- Elopement rate;
- 30-day readmission rate (discharge cohort);
- Restraint hours (per 1000 inpatient hours);
- Percent restrained;
- Seclusion hours (per 1000 inpatient hours);
- Percent secluded;
- Patient survey – outcome;
- Patient survey – dignity;
- Patient survey – rights;
- Patient survey – environment;
- Patient survey – participation;
- Medication error rate;
- Rate of COPSD (Co-occurring psychiatric & substance use disorders);
- 180 day (adult) re-admits by quarter;
- Total number of patient assault events toward staff or other patients.

4.3. Recommendations for Improving Measures

4.3.1. RECOMMENDATION: The Department should distinguish more clearly between measures of Division of Behavioral Health activities and the activities of funded providers.

Although the RBA framework formally recognizes multiple levels of accountability within DHSS, so far these different levels of performance measurement have been aligned only within the DHSS organizational hierarchy itself, but have not been adapted and extended to meet the needs of the privatized service delivery system typical of DBH services. Currently, DHSS does not effectively distinguish between the responsibilities and activities of the state agency and those of the state-funded, but privately owned, providers. In the behavioral health delivery system, in which management responsibilities are bifurcated between payer and provider, the Department's performance measures need to reflect this division of labor by addressing DBH performance at *administering* community-based T&R services in addition to provider performance at *delivering* these services.

Many of the measures for which DHSS holds itself accountable reflect the activities of the state-funded providers rather than the specific duties of state staff. While these measures are essential to evaluating the overall status of the state-funded behavioral health system, the current performance measurement framework contributes to a diffused accountability structure, making it difficult to determine with any precision where specific service or administrative support activities are failing or succeeding. Although

[68] Alaska Psychiatric Institute Dashboard, Alaska Department of Health and Social Services, 2014.

DBH is responsible for coordinating and overseeing all aspects of the state-operated behavioral health system, it is the direct service provider only for PEI services and for institutional services at API. While the division's performance management system includes a variety of robust outcome measures, these tend to cluster around service areas for which DBH is the direct service provider, namely PEI and API services. In cases in which performance measures focus specifically on DBH activities, such as the RBA measure of educational visits by Tobacco Enforcement staff to tobacco vendors, these are measures of preventive services in which PEI is the service provider. The same is true for some of the strongest outcome measures for services delivered at API, such as *Performance Measure 1.2.4.1b, Percent of BH recipients who re-admit back into API within 30 days of discharge.*

Collectively, the State, private service providers, and the Alaskan populace are all responsible for the overall behavioral health of Alaska. Each of these entities has distinct responsibilities that impact population health: DHSS is responsible for efficiently managing the behavioral health system and effectively providing direct PEI and API services, private providers are responsible for delivering effective care in the community, and individuals and partner grassroots organizations are responsible for striving to maintain wellness. To some extent, the RBA framework already attempts to capture the performance of these multiple levels of system actors, but it fails to do so in a systematic way that aligns these different activities into a coherent system of mutual accountability among DHSS and its partners.

In the current version of the RBA framework, it is possible to find numerous instances of department, provider, population, and system-level measures. Examples of each type are illustrated below:

- **Department Performance**: Performance Measure 3.3.1.2b, Percent of youth-accessible tobacco vendors that receive an educational visit from tobacco enforcement staff;
- **Provider Performance**: Performance Measure 1.1.3.1a, Percent of Alaskans discharged from substance abuse treatment services that successfully complete treatment and Performance Measure 1.2.4.1a Percent of BH recipients who report improvement in quality of life;
- **Population Performance**: Performance Measure 3.3.4.1c, Rate of Adverse Childhood Experiences among behavioral health treatment recipients;
- **System Performance**: Performance Measure 2.2.1.5a Percent of the estimated need for behavioral health services met through community-based services.

Within this approach of distinct department, provider, population, and system responsibilities, it is important that DBH identify how its measurement of provider and community coalition activities contributes to the DBH core service objectives and the performance measurement of its own administrative activities. Making the appropriate distinctions will enable DHSS to hold all participating organizations accountable for measures within their direct area of responsibility.

The state of development of the Department's RBA framework is understandable, it is much more complicated to evaluate the performance of DHSS when it is serving merely as system administrator and regulator than as direct service provider, as it continues to do in the case of PEI and API services. But when the State's role is restricted to these functions, the need to establish appropriate results-based measures for each stakeholder within the system becomes even greater, since management responsibilities are de-

centralized and accountability for system outcomes is diffused. For this reason, the performance measures used by DHSS should more clearly reflect both DHSS' effectiveness and efficiency at executing its duties and the effectiveness and efficiency of the state-funded behavioral health system as a whole. For more information regarding this recommendation, see Sections 4.1.4 and 4.2.2.

4.3.2. RECOMMENDATION: The Department should develop a consistent approach to measuring behavioral health performance across divisions.

While the majority of DHSS activities related to behavioral health fall under the purview of DBH, there are other arms of the Department which impact behavioral health services and, therefore, share with DBH some responsibility for the effectiveness and efficiency of service delivery. For example, the Division of Senior & Disabilities Services (SDS) serves a population with many behavioral health needs, including complex cases such as dual-diagnosis or traumatic brain injury (TBI). Similarly, the Office of Children's Services (OCS) regularly engages with the behavioral health system through mandated substance abuse services, family counseling, and mental health treatment. DHSS should work towards a horizontal alignment of performance measures of behavioral health services.

The Department is beginning to move in this direction through the RBA framework. Each core service objective has an accompanying set of performance measures that evaluate DHSS performance on that core service. The divisions are held accountable to the performance measures relating to their specific areas of responsibility for that core service. As the Commissioner's Office coordinates the development of the RBA Initiative, this structure contributes to a standardization of performance evaluation of behavioral health programs and services. Continuing and expanding upon these efforts to align behavioral health performance measures across divisions, both within the RBA framework and through other means, will facilitate consistency of both behavioral health service delivery and system delivery across the State. For more information regarding this recommendation, see Sections 4.1.4 and 4.2.2.

4.3.3. RECOMMENDATION: The Department should ensure continuity among program, division, and departmental-level evaluation of services, with appropriate degree of specificity and generality.

Performance measures are used for many purposes: to improve the behavioral health services available to Alaskans, to evaluate DHSS on its competence and ability to fulfill its duties, and to inform the legislature's decisions about funding and resource distribution. It is crucial that the performance measures used adequately meet these needs. The measures used at the program, division, and departmental-levels should be tailored appropriately to the evaluation needed and should be closely aligned such that the most specific measures feed upwards into the more general measures. For example, an outcome measure at the program level would speak to the percentage of consumers treated by a certain provider for a specific diagnosis who report significant, moderate, mild, or no improvement. That measure could be one of many that is included in an aggregate measure that evaluates whether grant-funded programs treating that diagnosis improve the

wellness of consumers. DHSS should continue its efforts within the RBA framework to develop meaningful and significant performance measures that capably meet all departmental evaluation needs.

4.3.4. RECOMMENDATION: The Department should incorporate performance measures that are more appropriately outcome-oriented.

The AHRQ classifies healthcare quality measures, including those evaluating behavioral healthcare, according to the Donabedian conceptual model. Within this framework it is understood that information about quality of care can be collected from three categories: structure, process, and outcome.[69] A comprehensive set of performance criteria needs to include all three types of measures.

- ***Structure*** measures assess the factors that affect the setting in which healthcare is delivered, such as facilities, qualification of care providers, and structure of programs.
- ***Process*** measures examine the activities that compose healthcare, such as treatment and diagnosis, discharge, and patient education.
- ***Outcome*** measures evaluate the effects of healthcare on patients and populations, including patient satisfaction and changes to health status, behavior, and quality of life.

While a comprehensive set of performance criteria needs to include all three types of measures, outcome measures are acknowledged to be the most important indicators of quality. The current set of RBA behavioral health performance measures contain five outcome measures, six process measures, and zero structure measures. The community-based T&R PBF measures include 12 outcome measures, 8 process measures, and 1 structure measure. Outcome-oriented measures are well represented among these sets, but many are not robust, to the extent that they rely on consumer *perceptions* of the quality of care rather than more objective indicators of recovery, such as the ability to secure stable housing or improved employment status. The Department should revise the performance measures to include additional and more robust outcome-oriented measures along these lines.

4.3.5. RECOMMENDATION: The Department should incorporate nationally recognized behavioral health treatment and recovery measures into the Department's performance measurement strategy.

To strengthen its performance measurement of behavioral health services, the Department should incorporate nationally recognized behavioral health measures into its performance management system. As mentioned earlier in Section 4.1.2, HEDIS measures are used by approximately 70% of states in their behavioral health quality measurement schema. Since HEDIS relies on readily available administrative data, the implementation of HEDIS measures does not require additional burdensome reporting by providers, and its uniformity allows for national performance comparisons.

[69] Evaluating the Quality of Medical Care, Milbank Memorial Fund Quarterly, Avedis Donabedian, 1966.

HEDIS classifies a number of behavioral health performance indicators as within the domain of "Effectiveness of Care," indicating that they reflect the outcome of treatment.

- Antidepressant medication management;
- Follow-up care for children prescribed ADHD medication;
- Follow-up after hospitalization for mental illness;
- Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medications;
- Diabetes monitoring for people with diabetes and schizophrenia;
- Cardiovascular monitoring for people with cardiovascular disease and schizophrenia;
- Adherence to antipsychotic medications for individuals with schizophrenia;
- Use of multiple concurrent antipsychotics in children and adolescents;
- Metabolic monitoring for children and adolescents on antipsychotics.

Out of this pool of HEDIS behavioral health measures, there are nine potential measures that would strengthen the Department's quality measurement efforts and would help to establish national comparability between DBH activities and the performance of other state system. These HEDIS measures are:

- Antidepressant medication management (AMM) ages 18 years and older;
- Effective acute phase treatment: percent who remained on an antidepressant medication for at least 84 days;
- Effective continuation phase treatment: percent who remained on an antidepressant medication for at least 180 days;
- Follow-up after hospitalization for mental health or alcohol or other drug dependence;
- 7-day follow-up: percent who received follow-up within 7 days of discharge;
- 30-day follow-up: percent who received follow-up within 30 days of discharge;
- Initiation of alcohol and other drug (AOD) dependence treatment (IET) ages 13 and older;
- Initiation of AOD treatment: the percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis;
- Engagement of AOD treatment: the percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.

These HEDIS measures have been endorsed by the NBHQF[70,71] and can provide DBH with a more nuanced understanding of the community-based behavioral health system's ability to engage with and treat consumers. *AMM* speaks to a provider's effectiveness at maintaining contact with consumers experiencing Major Depressive Disorder and pursuing evidence-based therapies. *Follow-up after hospitalization* examines the community-based system's ability to provide an outpatient visit, intensive outpatient encounter, or partial hospitalization with a mental health practitioner within two time frames, seven and 30 days, to a consumer who was hospitalized or treated in an Emergency Department setting for a behavioral health disorder. This measure evaluates the continuity between the Department's institutional and

[70] 2015 Summary Table of Measures, Product Lines, and Changes, National Committee for Quality Assurance.
[71] "National Behavioral Health Quality Framework," SAMHSA, Accessed June 22, 2015. http://www.samhsa.gov/data/national-behavioral-health-quality-framework.

community-based treatment services. Additionally, this measure is endorsed by the National Quality Forum. *Initiation of AOD Dependence Treatment* captures the efficiency of the community-based behavioral health system at treating a consumer within a short period of time of their diagnosis, and the effectiveness of the system at engaging the consumer with a treatment program.

DHSS should adopt the preceding HEDIS measures for use within its performance management system. The incorporation of nationally recognized measures will provide more valuable insight into the efficiency and effectiveness of the behavioral health system, and will facilitate comparison to peer state agencies.

4.3.6 RECOMMENDATION: The Department should align performance measurement of community providers, as far as possible, with measures used in accreditation requirements.

DHSS mandates that behavioral health service providers be accredited by a DBH-approved, private, non-state organization that assesses the provider for meeting best practice and quality of care standards. National accreditation is an expensive and time-intensive process that places a large burden on providers but nonetheless is beneficial to the State, providers, and broader behavioral health system. The standards used by national accreditation organizations more quickly incorporate trends in evidence-based best practices, and 45 states have a variation of an accreditation requirement. Additionally, accreditation organizations offer prompt and practical technical assistance for a provider to achieve and maintain the required quality standards.

As providers are already being evaluated by certain quality indicators, DHSS should include measures used by national accreditation organizations within its performance management system. Two of the leading accreditors are the Commission on Accreditation of Rehabilitation Facilities (CARF) and the JC. PCG has identified three performance measurement parameters used by these national accreditors that would strengthen the Department's performance management of behavioral health services:

- The organization identifies individuals at risk for suicide (JC)
- An individualized service plan is developed based on the person's strengths, abilities, preferences, desired outcomes, and other issues identified by the person served (CARF)
- The majority of scheduled program hours consist of therapeutic services (CARF)

The adoption of these measures would enhance the Department's performance management system of behavioral health services. The JC measure, *The organization identifies individuals at risk for suicide*, provides valuable insight into the provider's ability to contribute to suicide prevention efforts. The first CARF measure regarding the development of individualized service plans evaluates a program's capacity to deliver care appropriate to the unique needs of each consumer. The second CARF measure, *The majority of scheduled program hours consist of therapeutic services*, directly measures the efficiency of behavioral health providers at delivering treatment services. The Department should adopt these measures and consider adopting additional measures as needed to improve the efficacy of its behavioral health performance and

quality measurement system. For more information regarding this recommendation, please see Sections 4.1.2, 4.1.1, 4.2.2 and 6.2.3.

5.0. REFERRALS AND PLACEMENTS

Evaluate the continuum of behavioral health services the Department pays for, including services provided at the Alaska Psychiatric Institute (API), and provide best practice recommendations to ensure placements and referrals are effective and cost efficient. This should address the following:

A. Are there best practices to ensure placements and referrals for behavioral health services are effective and cost efficient?

B. Do the Department's placement and referral policies and procedures align with best practices?

C. Are the Department's policies and procedures effective and efficient in this area?

D. Are there external factors inhibiting the Department's ability to operate effectively and efficiently in this area?

E. Identify areas for improvement in department policies and procedures that would either reduce the costs incurred or improve the Department's effectiveness and efficiency in this area.

5.1. Best Practices for Placements and Referrals

In our review of the Department's performance in ensuring the most appropriate level of care for recipients of behavioral health services, PCG found that placement and referral policies and procedures work well for most sections of the behavioral health continuum. However, a number of factors have combined to generate greater demand on the State's behavioral health acute psychiatric care and emergency services system than the current infrastructure can support. In some cases, service providers have responded to these conditions by implementing placement and referral policies focused more on alleviating pressure on the system than assuring the most appropriate setting for a consumer's care needs.

While some of the factors driving utilization of acute care services can be attributed to Alaska's unique geography and demographics, others stem from under-development of services in less-intensive strata of the care continuum, as well as broader executive and legislative priorities that have contributed to inappropriate utilization. In the findings that follow, PCG summarizes two related trends resulting from inadequate capacity for emergency and community treatment services within the public behavioral health system: (1) over-utilization at API, and (2) the rising prevalence of behavioral health disorders within the corrections system. In the first instance, PCG has developed a set of recommendations calling for specific improvements in the State's crisis response and emergency psychiatric service capacity. These recommendations are designed to reduce the system's dependence on emergency room visits and inpatient hospitalization for delivering acute psychiatric care, which in turn should generate significant overall health cost savings to the State. In many respects, these improvements also overlap with PCG's other set of

recommendations, which focus on strategies for jail diversion and recidivism reduction to reduce the economic and human costs of incarceration and the criminalization of mental illness.

5.1.1. FINDING: National best practices require treatment of individuals at the least-intensive level of care appropriate to support community integration and social inclusion. Furthermore, widespread consensus exists on the array of mental health and substance use services required to ensure effective referral and placement into the most appropriate level of care.

It is nationally recognized best practice to treat individuals with behavioral health issues with the least-intensive level of care appropriate to their recovery.[72] A behavioral health system should be configured so that consumers receive at all points in the treatment and recovery process the least-intensive and least-restrictive services possible. Providing services within the consumer's home community ensures that the consumer remains integrated with other important supports, such as peers, family, employment, and housing. Having access to those supports augments the behavioral health treatment delivered and encourages recovery. Maintaining community integration is a key benefit of treating consumers according to this approach to the system of care.

Additionally, it is a best practice for behavioral health providers to treat consumers with the least-intensive and least-*restrictive* level of care appropriate to meet their needs. Providing services in the least-restrictive manner within an institutional setting is one of the Substance Abuse and Mental Health Service Administration's (SAMHSA) principles of crisis intervention practices.[73] The World Health Organization (WHO) also recognizes treating individuals with mental illness with the least-restrictive care possible as a basic principle.[74] Least-restrictive mental health interventions and treatments minimize the use of coercion and maintain personal autonomy to the extent possible. Treating consumers at the least-intensive and least-restrictive level of care prevents unnecessary isolation of consumers from their peer and family support systems, maintains individual autonomy and sense of ownership over treatment, and promotes recovery through the preservation of linkages to other supports, such as housing and employment, which are crucial to behavioral health well-being.

PCG notes that trends in Department expenditures and organizational re-alignments in the last decade are fully reflective of its commitment not only to continuing mental health de-institutionalization, but also to providing a broader range of community interventions to ensure the right care at the right time in the right setting. This recovery-oriented philosophy is most evident in the continuing re-direction of State behavioral health dollars to community settings from inpatient psychiatric settings such as API. In 2009, expenditures for inpatient services constituted 46.9% of Department expenditures. By 2013, only 38.6% of behavioral

[72] Best Practices, Division of Behavioral Health Service, Nebraska Department of Health and Human Services, 2005.
[73] Practice Guidelines: Core Elements in Responding to Mental Health Crises, Substance Abuse and Mental Health Services Administration, 2009.
[74] Mental Health Care Law: 10 Basic Principles, Division of Mental Health and Substance Abuse, World Health Organization, 1996.

health funds were used on inpatient care, with the remainder channeled into supporting a wider range of services available within the community.[75]

Although the Department has consistently demonstrated its commitment to the SAMHSA-defined "good and modern" behavioral health system, with the comprehensive spectrum of services needed to support successful placement and referral, in practice it has nonetheless faced challenges in putting some of the pieces of this infrastructure into place. DBH has had some success in working with AMHTA and other partners to build new service capacities such as peer support, assisted living, supported housing, and children's services, but significant gaps in the continuum remain. Although particular service gaps are discussed in more detail in Section 2.0, several of these deficiencies are summarized again in this section, to the extent that they affect the Department's placement and referral policies. For recommendations related to this discussion of best practices, see Sections 5.5.2 through 5.5.4.

5.1.2. FINDING: Best practices have emerged nationwide for referrals between community behavioral services and services delivered in the criminal justice system. These practices include jail diversion programs on the front end of the criminal justice system, and prisoner re-entry programs on the back end.

Nationwide, individuals with behavioral health issues are overrepresented in the correctional system, and Alaska is no exception. Currently, the Department of Corrections (DOC) is the single largest behavioral health provider in the state, a fact that has rightfully become a significant policy concern for state leaders throughout all branches of government. While the criminal justice system is playing an increasing role in behavioral health throughout the nation, a number of social and geographic factors particular to Alaska have rendered it especially vulnerable to these trends, increasing the need to ensure that Alaska puts best practices in place to mitigate the pattern of criminalization of behavioral health disorders.

In response to the unprecedented growth of behavioral health disorders within jails and the prison system, experts across the nation have developed best practices for effective referral between community-based behavioral health services and services delivered within correctional facilities. On the front end of the criminal justice system, successful placement and referral policies have emerged that aim to reduce criminalization of behavioral health disorders through a variety of jail diversion programs. On the back end of the criminal justice system, placement and referral best practices are focused on intensive coordination between correctional facilities and community-based service providers that are designed to facilitate smooth re-integration of prisoners back into the community.

Front end approaches to jail diversion typically take two forms: 1) a police-based, "pre-booking" intervention that attempts to route individuals with behavioral health needs to appropriate services at the point of contact with first responders, and 2) a court-based, "post-booking" intervention, which may rely

[75] State Mental Health Agency Revenues and Expenditures, NRI, 2013. These spending patterns are discussed in more detail in Section 2.3.

on dedicated filing, disposition, or sentencing protocols for individuals who volunteer to receive treatment as an alternative to incarceration, or on specialty "therapeutic courts" with dockets focused specifically on offenses involving addiction or mental health issues.

The vast majority of pre-booking jail diversion programs are derived from the highly successful Crisis Intervention Team (CIT) model developed by law enforcement in Memphis, Tennessee. Although some police departments in major cities have developed expanded crisis response models that involve police and mental health co-responders, these generally incorporate CIT principles as well. Moreover, CIT has already been partially adopted in Alaska and is probably the most feasible approach for Alaska's population.

The Crisis Intervention Team (CIT) model is an approach for law enforcement to safely and effectively address the needs of persons with mental illness. It is widely accepted as a best practice for law enforcement agencies across the country.[76] CIT is a collaborative first-responder model for police-based crisis intervention. The model provides law enforcement personnel with the skills needed to assist individuals with mental illness appropriately and improves the safety of police officers, consumers, and the community. The successful implementation of a CIT program requires changes in police department procedures as well as the development of formalized working relationships with mental health providers and other community stakeholders. The CIT program has been shown to increase the number and proportion of calls involving possible mental illness, increased the rate of transport of individuals experiencing mental health crises to emergency treatment facilities by CIT-trained officers, and decreased the use of force in mental health crisis response incidents.[77] It is a highly effective means of improving the community-based response to mental health crises.

Pre-booking jail diversion programs such as CIT are not only among the least stigmatizing and psychologically disruptive interventions available to the behavioral health and criminal justice systems for working with individuals at risk of incarceration; they are also among the most cost effective for states feeling the financial pinch of high incarceration rates and poor coordination in health and social services for behavioral health "super-utilizers." A study of 25,133 in Connecticut, for example, found that the state spent nearly double the amount of money both to incarcerate and to treat a person with serious mental illness, in comparison to the cost of treatment alone.[78] A cost-effectiveness assessment of jail-diversion programs in New York City showed an average of $7,038 lower jail costs per person.[79] Similarly, implementation of a diversion program in Massachusetts serving 200 people saved an estimated $1.3

[76] The Crisis Intervention Team Model of Police Response to Mental Health Crises: A Primer for Mental Health Practitioners, Amy C. Watson and Anjali J. Fulambarker, Best Practices in Mental Health, December 2012.
[77] Ibid.
[78] Swanson, J. (2011). Costs of Criminal Justice Involvement among Persons with Severe Mental Illness in Connecticut. See: http://www.pacenterofexcellence.pitt.edu/documents/Costs_of_Criminal_Justice_Involvement_in_Connecticut_-_Final_Report_Dec_28_2011.pdf
[79] Cowell, A. J., et al. (2002). Assessment of the Cost-Effectiveness of New York's Jail Diversion Program. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration. Research Triangle Park, NC: RTI International.

million in episodic emergency health services (for example, ER visits, ambulance) and jail-related costs.[80] All of these jail diversion programs incorporate CIT as a core component in law enforcement response. For these reasons, PCG recommends in Section 5.5.4 expanded use of CIT among Alaska first responders as a fundamental step in the incremental development of pre-booking jail diversion processes in Alaska.[81]

Specialty drug and mental health courts, known as therapeutic courts, have also proven to be effective post-booking jail diversion programs by providing an alternative justice model for individuals with mental illness or substance abuse disorders who have been convicted of a felony or a misdemeanor. These courts rely on collaborative teams that closely monitor offenders who choose to participate in the treatment program in lieu of incarceration. During weekly meetings, team members review an individual's progress and develop a system of incentives and sanctions to encourage the individual's successful performance in the program.

Participants in therapeutic court programs convicted of a felony have lower re-arrest and reconviction rates than comparable offenders processed through the corrections system.[82] Additionally, individuals convicted of misdemeanors who graduate from a therapeutic court program have lower re-arrest and reconviction rates than comparable offenders.[83] PCG finds that by reducing recidivism through case management and treatment models, the therapeutic court system is an effective alternative justice model for individuals with behavioral health issues who have been convicted of a felony or misdemeanor. The Alaska Court System (ACS) currently operates 12 distinct therapeutic courts throughout the state, which are closely involved both with DHSS and DOC behavioral health staff.

The "back end" coordination of correctional and community-based services is just as important to tackling patterns of criminalization of behavioral health, but it is only just beginning to receive the detailed attention it deserves from policy-makers within the state. Although DHSS and DOC have both made great strides in a short period of time in improving their re-integration efforts, building the infrastructure and linkages required to reduce recidivism is a systemic issue that affects multiple departments, and consequently demands broader executive initiatives by the State. The recent 2015 Recidivism Reduction Plan, released to the Legislature in February 2015, identifies many of these best practice initiatives, and is an important step in fostering the intensive inter-departmental collaboration recommended in Section 5.5.6.

Although the Recidivism Reduction Plan calls for coordinated action far beyond DHSS, the Department has a substantial responsibility to work with DOC on a number of fronts: achieving macro-level consensus on a prisoner re-entry framework to guide the process of "handoff" from corrections to the community, assuring the adequacy and non-duplication of community services financed in parallel by the two departments, and improving data sharing and analysis capabilities.

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[80] Massachusetts Department of Mental Health Forensic Mental Health Services, BEST Metro Boston Jail Diversion Program (2010).
[81] Cost savings specific to CIT are discussed in greater depth in Section 5.5.4.
[82] Recidivism in Alaska's Therapeutic Courts for Addictions and Department of Corrections Institutional Substance Abuse Programs, Teresa White Carns, Larry Cohn, and Dr. Stephanie Martin, March 2012, p. 9.
[83] Carns, Cohn, and Martin, p. 8.

One of the best practices called for by the Recidivism Reduction Plan is the expansion, both within DHSS and DOC, of proven re-entry models such as the Institutional Discharge Project Plus and Assess, Plan, Identify and Coordinate (APIC). Both models have received limited implementation in Alaska, but need further support from both departments in order to be established more widely.

The APIC model, for example, is widely recognized as one of the most effective practices for facilitating coordinated referrals. The APIC model links incarcerated individuals with community-based treatment services upon reentry to the community. It provides a formalized framework for collaboration among jail and prison facilities, health and social service organizations, and other stakeholders, encouraging the collaboration necessary to develop and implement effective referrals between institutional and community-based services.

Table 5.1. APIC Model[84]

Action	Description
Assess	Assess the inmate's clinical and social needs, and public safety risks, using valid and reliable screening instruments. For individuals with positive screens indicating the need for behavioral health treatment services, conduct a comprehensive assessment to guide appropriate program placement and service delivery.
Plan	Plan for the treatment and services required to address the inmate's needs both while in custody and upon reentry. Develop individualized treatment and service plans, and collaborative responses between behavioral health and criminal justice that match the individual's behavioral health need with the appropriate level of supervision and treatment.
Identify	Identify required community and correctional programs responsible for post-release services. With the understanding that the period of time immediately following release is critical for a successful re-entry, identify appropriate interventions as part of the transition planning process. If not in place already, develop policies and practices that facilitate the continuity of care through direct linkages with post-release behavioral health providers.
Coordinate	Coordinate the transition plan to ensure implementation and avoid gaps in care with community-based services. Facilitate communication among service providers and corrections staff.

Critical to the success of APIC is that it makes funding available for providing both case management services prior to release and direct treatment services during the transitional post-release period, when the inmate is most vulnerable to recidivism and typically unable to access behavioral health services until state and federal entitlements are processed and restored. This "warm handoff" can be strengthened even more effectively with key changes in Medicaid eligibility policy by DHSS, summarized in the Section 5.1.3.

[84] Guidelines for the Successful Transition of People with Behavioral Health Disorders from Jail and Prison, Alex M. Blandford, Fred Osher, and the Council of State Governments Justice Center, November 2013.

5.1.3. FINDING: Suspending Medicaid eligibility policy for inmates in corrections is more cost effective than terminating eligibility entirely and reduces the risk of recidivism by facilitating continued access to behavioral health services for citizens returning to the community post-incarceration.

Federal regulations require that states discontinue Medicaid benefits to incarcerated individuals. However, states have the option of either fully *terminating* or merely *suspending* these benefits. The law prohibits payments to incarcerated individuals but does not eliminate the individual's Medicaid eligibility.[85] Terminating benefits requires former inmates to re-initiate a lengthy eligibility determination process, potentially interrupting treatment and leading to a gap in care during the critical re-entry period following incarceration, arguably, the moment when a strong community response is most needed. Conversely, suspending benefits allows individuals to begin receiving benefits immediately after release. Research has shown that individuals with serious mental illness (SMI) who had access to Medicaid services upon release resulted in higher use of community-based behavioral health services and fewer re-arrests.[86]

Additionally, having access to Medicaid-eligible behavioral health services on the day of discharge from correctional facilities improves the retention and effectiveness of community-based services. Suspending rather than terminating benefits reduces the wait times of individuals exiting correctional facilities and allows correctional discharge plans to include pre-scheduled, same-day appointments with behavioral health providers. Timely access to care has been shown to reduce no-shows and cancellations and improve engagement individuals in the treatment and recovery process.[87] "Suspend/Restore" Medicaid eligibility policies improve the chances of a successful exit from the correctional system.

Currently, it is State policy to terminate benefits following one month of incarceration.

5.2. Department Alignment with Best Practices

5.2.1. FINDING: Critical gaps in the continuum of care have prevented the Department from aligning its referral and placement policies with best practices for acute and sub-acute psychiatric care needs.

The Department's ability to align referral and placement procedures with best practices is inhibited by service gaps in the behavioral health continuum of care. DHSS strives to provide the full array of behavioral health services needed to serve the Alaskan population, but falls short due to a combination of funding constraints, regional logistical challenges, and in some areas of the state, at least, the lack of community

[85] The Effect of Incarceration on Medicaid Benefits for People with Mental Illness, Bazelon Center for Mental Health Law.
[86] Expedited Medicaid Restoration: Introduction & Overview, Joe Morrissey, March 22, 2013.
[87] 2015 Recidivism Reduction Plan: Cost-Effective Solutions to Slow Prison Population Growth and Reduce Recidivism, Recidivism Reduction Workgroup, 2015, p. 41.

partners willing to provide costly high-end services. Highlighted on the graphic below are the deficient areas of the continuum of care.

The service gaps and deficiencies all fall under the broad categories of adult acute and sub-acute psychiatric services. Although these gaps are detailed more extensively in Section 2.0, they are rehearsed again here to illustrate their effect on referrals to and from Alaska's acute psychiatric care system.

Crisis services are provided by state-operated programs and facilities, such as API, and private providers under contract with DHSS, including community behavioral health service providers and hospitals operating inpatient beds for individuals requiring involuntary commitment. Hospitals with acute capacities comparable to API are classified as Designated Evaluation and Stabilization (DES) or Designated Evaluation and Treatment (DET) facilities, though a layer of lower acuity emergency services are available in principle to support consumers whose severity does not require the restrictive setting of API or DES/DET facilities. These psychiatric emergency services include: crisis intervention, brief therapeutic interventions for stabilization, and family, consumer, and community wrap-around supports. With the exception of API, which is part of the Division, these other services are funded by Psychiatric Emergency Services (PES) Grants from the Department.

The most intractable problem within the referral system is that infrastructure for crisis and residential services generally only exists in urbanized areas surrounding Anchorage, Juneau, and Fairbanks, and are typically unavailable in rural Alaska. However, even in metropolitan areas such as Anchorage, acute and sub-acute psychiatric capacities are underdeveloped in relation to need. For example, outside of API and Providence Hospital, there is no 24-hour open door in Anchorage to provide crisis services, and in emerging population areas such as the Matanuska-Susitna Valley, the emergency department of the Mat-Su Regional Medical Center—which is **not** a behavioral health provider—is the only intermediary between community outpatient services and hospitalization at API.

In addition to crisis services, the lack of adult residential service capacity—either long-term or sub-acute short-term—is another major deficiency in the state, which distorts how placement and referral policies operate in the acute care system. In mental health, residential psychiatric treatment centers (RPTC) exist only for children and adolescents, with no capacity available for adults. Capacities for treating higher severity substance abuse issues are marginally better, though detoxification centers and residential substance abuse treatment services are lacking, even in urban areas. Where capacity exists, long waitlists are the norm. No Intermediate Care Facility exists anywhere in the state for individuals with intellectual and developmental disabilities, and available residential programs are inadequate to meet the needs of individuals with autism, Alzheimer's Disease and Related Dementia (ADRD), and other disabilities involving aggression or co-occurring disorders. These service gaps preclude the Department from fully

aligning its placement and referral policies with best practices. Consumers cannot be safely placed in the least-intensive level of care appropriate when that level of care does not exist.

When limited sub-acute and community emergency services capacities are exhausted, consumers are admitted by default to API for acute inpatient psychiatric hospitalization, regardless of whether treatment and stabilization requires the restrictive level of care API is designed to provide. Often these situations occur with consumers from rural Alaskan communities; the small community lacks the services needed to provide adequate care for the individual, and so the consumer is referred to DES/DET services in the nearest regional hub or to API. Additionally, consumers with complex behavior needs, aggression and ADRD are transferred to API rather than a secure, but less-restrictive facility. PCG finds that across the system behavioral health consumers are often placed in a level of care inappropriate to their needs, indicating a lack of alignment with best practice referral and placement procedures that place individuals in the least-intensive level of care and prioritizes community integration and social inclusion.

5.2.2. FINDING: The Department's referral and placement policies and procedures for acute behavioral health care do not align with best practices. Chronic shortage of psychiatric hospital beds, lack of step-down services, and inappropriate utilization of acute care services have resulted in strict admission and utilization controls at the Alaska Psychiatric Institute that disconnect it from the community referral process.

The lack of adequate service capacity in other parts of the care continuum results in cascade effects that lead to misalignment of referral and placement policies and procedures with standard best practices for acute behavioral health services. As a combination of decreased bed capacity and increasing demand for hospitalization in the last decade, API has transitioned to a more rigid acute care model that no longer attends to long term stabilization and treatment, but aims exclusively to resolve acute symptoms inhibiting the consumer's daily functioning that precipitated the need for hospitalization. Subsequently API admits and discharges patients with high frequency. In 2011, approximately 62% of patients treated in API stayed for 14 days or fewer.[88,89] Compounding these heightened turnover rates and demand for services are a significant number of long-term dementia and disability placements, as well as growing census pressure resulting from forensic placements.

Intensifying admissions pressure has forced the acute care system to implement increasingly tight controls over admission designed to prioritize scarce resources for cases with the highest severity, not necessarily to promote optimal coordination with community providers and assure proper placement.

[88] Emergency Mental Health Services Utilization Project: Current and Historical Admissions Patterns at Alaska Psychiatric Institute, UAA Center for Behavioral Health Research & Services, 2012.
[89] Joint State of Agreement between Providence Alaska Medical Center and Alaska Department of Health and Social Services, March 23, 2011.

Unlike many states, the community-based system does not control admission to API; increasingly, admission decisions are made based on the emergency medical system and the authority of the courts, which further disconnects institutional services from the community. The Providence Psychiatric Emergency Department (PPED) serves as the single point of entry for admissions to API from Anchorage, and API's admissions policies require that all persons seeking admission be medically cleared prior to admission. The PPED is intended to provide an unobstructed, clearly identified route for those with mental illness to access the most expedient and least restrictive care that is clinically appropriate for the individual. However, the issues of coordination and collaboration extend to this shared service. Furthermore, there is a lack of consensus between DHSS and ANTHC over the intent of the PPED and the proper protocol for discharge, centering on the referrals between community-based providers and the most appropriate facility for discharge.

On the legal side, nearly all admissions to API are made up of involuntary commitments that must be approved by the court system. Voluntary commitments are rare, and must be approved by API's medical director. Because the majority of admissions are involuntary commitments, API's internal policies and the Alaska Court System ultimately dictate which consumers receive acute psychiatric services.[90] In recent years, even the high legal bar for admission has been insufficient to triage admissions, with API in some cases insisting on performing its own evaluations over the courts to determine appropriate utilization. Further, approvals for admission to API are processed through HCS as a function of hospital utilization management rather than DBH's behavioral health service utilization management. Ultimately, all of these indicators point to the fact that a lack of capacity at API to meet the acute psychiatric needs of individuals within the community has led to the consolidation of control of acute psychiatric services outside of the community-based system.

This disconnect is also reflected in the communication and data sharing structures between API and community-based behavioral health providers. API uses a medical EHR, Meditech, to record consumer data and treatment information. This system is not interoperable with AKAIMS, the community-based data system that tracks consumers across community services and keeps a complete record of their treatment history. Although API is a crucial component of the Department's behavioral health system, the hospital is isolated in important respects from the activities of the rest of the system.

5.2.3. FINDING: The Department's referral and placement policies and procedures for child and adolescent residential services largely align with best practices.

While it is ideal for children to be treated within their home community, sometimes severely emotionally disturbed (SED) youth are most appropriately treated in a residential setting. The key best practices of effective residential treatment for children and adolescents are maximizing regular contact between the child and family, actively involving and supporting families with a child in residential treatment, and

[90] State Mental Health Agency Profiling System, NRI, 2013.

providing ongoing support and post-release care for the child and family.[91] The Department's child and adolescent residential services system incorporates these best practices by striving to treat the child in a RPTC as close to home as possible. Through its Behavioral Rehabilitation Services (BRS) Program the Department provides residential services in 11 different communities across Alaska, facilitating the treatment of children near or within their home community.

Although the state's vast geography and diffuse population preclude the Department from funding an RPTC in every community, Department initiatives have been effective at promoting family involvement in the child's treatment through telehealth networks and the Building Bridges program. Building Bridges is a national initiative that promotes partnerships and collaboration between families, youth, and community service providers. The Department uses Building Bridges to achieve positive outcomes for youth in residential treatment settings, largely through the focus on family support in the recovery program. Additionally, the Department uses the SAMHSA-approved evidence-based practice, *Parenting with Love and Limits* (PLL), to incorporate constructive parental involvement in child and youth residential treatment programs. PCG finds that the Department's placement and referral policies and procedures align with best practices through their emphasis on family involvement, implementation of evidence-based programs, and intent to treat children within or near to their home community.

5.2.4. FINDING: The Department's referral and placement policies and procedures for community treatment and recovery services largely align with best practices.

Best practices for effective referral policies hinge on a closely integrated community-based treatment and recovery system. Individuals with mental illness and substance use disorders require a retinue of services, from medication management to living supports. Alaska's small population precludes each community from offering the complete array of community services, yet providers work together to deliver services most needed within that community. Although PCG has noted the challenges affecting referrals between the community and the acute care systems, within the network of community services, referral and placement processes seem to be largely adequate, and the Department's provider grantees appear to work together to ensure that their consumers are referred to appropriate services where these are available. The close-knit provider community shares information about utilization, and each provider has a thorough understanding of the services available. PCG finds that referral and placement policies for community-based services largely align with best practices and make full use of the integration of the community-based behavioral health system to refer consumers to the appropriate level of care.

[91] Principles of Care for Treatment of Children and Adolescents with Mental Illnesses in Residential Treatment Centers, American Academy of Child and Adolescent Psychiatry, June 2010.

5.2.5. FINDING: The Department's referral and placement policies and procedures for early intervention services largely align with best practices.

The Department's placement and referral procedures for early intervention services largely align with best practice recommendations. Through the fetal alcohol spectrum disorders (FASD) programs and the Alcohol Safety Action Program (ASAP), DHSS utilizes policies that promptly place consumers in the least intensive level of care appropriate to their needs. As early intervention services, the FASD program and ASAP strive to identify consumers and link them with necessary treatment services prior to consumer mental health and substance abuse issues becoming emergent or acute. The referral policies are thus adept at placing consumers in treatment programs in a timely manner. Additionally, FASD and ASAP referral policies incorporate community integration and supports. Both programs work with consumers and their family and peer support systems to identify treatment possibilities that allow the individual to remain in their home community. ASAP facilitates this best practice referral policy by allowing consumers, and their advocates to choose treatment programs based on proximity to the consumer's home and work locations, promoting community inclusion and integration. The DHSS referral and placement procedures for early intervention services incorporate the key elements of best practice recommendations.

5.3. Effectiveness and Efficiency of Placements and Referrals

5.3.1. FINDING: Insufficient funding for community-based, prevention-focused behavioral health treatment has increased the need for costly psychiatric services.

Community-based, prevention-focused behavioral health services are the most cost-effective form of treatment for consumers with mental illness and substance use disorders. The average cost per client treated within community-based services in FY 2014 was $6,629.[92] The average cost per client treated within API was $24,831, and the average cost per client treated with acute services outside of API was $21,466. At the Mat-Su Regional Medical Center Emergency Department, behavioral health diagnoses are associated with significantly higher emergency treatment costs. The approximate cost per visit for a patient with a behavioral health diagnosis was $3,230, in comparison to the $2,580 for a patient without a behavioral health diagnosis. Emergency behavioral health services are more costly to the Department than community-based services.

Community providers act as a gatekeeper to acute psychiatric services by treating individuals effectively to keep them functioning within the community. When funding remains stagnant while the cost of doing business rises at or above inflation, or when funding is cut, providers are forced to decrease staffing levels, which diminishes the effectiveness of care. While the service capacity decreases, the needs of consumers

[92] Presentation: Division of Behavioral Health, House Committee on Health and Social Services, February 19, 2015.

with serious mental illness are consistent, and the provider is often no longer able to meet the complete treatment needs of those consumers.[93]

In recent years, numerous Alaskan facilities have closed all or part of their programming, either temporarily or permanently, due to funding problems, including the Clitheroe Center, Nugen's Ranch, SouthEast Regional Health Consortium, and Fairbanks Community Behavioral Health Center. While recent closures have occurred for a variety of reasons—many due to factors beyond Department control—the scale and timing of these closures does indicate the fragility of the provider network in the state and its diminished ability to absorb financial losses. As providers have adapted to more restrictive financing mechanisms, and in some cases, simply tightened their belt, many have been confronted with the difficult choice of prioritizing costly, but vital services to their core SMI/SED populations, over making long-term investments in consumers with more moderate needs through early interventions aimed at prevention. Without some of these long-term investments, however, the need for high-cost psychiatric services will itself only increase over time. Recommendations related to this finding can be found in Sections 3.0.4 through 3.0.8.

5.3.2. FINDING: The Department's policies and procedures for referrals between acute care services and long-term services and supports are not effective or efficient.

The Department's placement and referral procedures between acute care services and community long-term services and supports are not effective or efficient. As the only publicly funded inpatient psychiatric hospital in Alaska, API is intended to provide acute psychiatric services to individuals requiring inpatient psychiatric hospitalization. However, currently API houses individuals requiring long term services and supports in addition to consumers requiring medically necessary acute psychiatric treatment. API administrators note that approximately 15 of the 55 adult beds in API are occupied by individuals requiring long term rather than acute care. Consumers needing long term services and supports are those with Alzheimer's disease or related dementias (ADRD) with coexisting mental illness and complex behavior needs or individuals with intellectual and developmental disabilities.

These individuals are housed in API due to a statewide deficiency of the long term and sub-acute residential services appropriate to serve these subpopulations; there are no intermediate care facilities dedicated to persons with intellectual developmental disabilities, and there is insufficient capacity within the appropriate assisted living facilities (ALF) to meet the needs of consumers requiring this level of care.[94] The Department's referral system between acute and residential services is ineffective and inefficient due to the statewide lack of long-term and sub-acute capacity, resulting in costly and inappropriate treatment within API.

[93] Impact of Proposed Budget Cuts to Community-Based Mental Health Services, Health Management Associates, 2011.
[94] Complex Behavior Collaborative Recommendation: Continued Funding, Alaska Commission on Aging, 2013.

Additionally, referrals between acute care services and detoxification services are neither effective nor efficient due to a dearth of inpatient detoxification beds. The Division of Public Health's (DPH) Health Planning and Systems Development (HPSD) section classifies the availability of services on a spectrum from 'none' to 'excellent.' Table 5.2 depicts the detoxification service capacity according to community level, as determined by population size.[95]

Table 5.2. Detoxification Services Capacity[96]

Community Type	Level I: Frontier/Village	Level II: Sub-Regional Center or Town	Level III: Regional Center or Small City	Level IV: Urban Center	Level V: Metropolitan Area
Capacity	None	Very Limited	Very Limited	Limited	Limited

The limited availability of detoxification services contributes to further ineffectiveness and inefficiency of the Department's referral processes between acute and sub-acute services. As a result of the lack of availability of detox services, consumers are treated within the emergency department and discharged to community-based services rather than to the appropriate residential services.[97] Eventually, the consumer will spiral again into crisis, coming into contact with the emergency system once more, only to repeat the cycle due to inadequate treatment resources to deliver a decisive intervention.

The Department's referral and placement procedures between residential services and acute inpatient care are not wholly effective and are inefficient. The lack of sufficient acute and sub-acute care capacity is the primary contributor to the ineffectiveness and inefficiency of these procedures. In many cases, acute emergency services are unable to refer consumers to more appropriate and less costly care because the care simply does not exist. The problem is exacerbated now by the transition-aged youth (16-24 years old) exiting the residential facilities developed through the BTKH initiative. BKTH began in 2004, and its success created a generation of consumers receiving services in Alaska, whereas previously they would have been treated out-of-state and remained out-of-state as adults. These consumers are no longer eligible for treatment in RPTCs and require treatment in adult long-term or sub-acute care facilities, which still do not really exist in Alaska. The effectiveness and efficiency of the Department's referral and placement procedures between acute and residential services are inhibited by the lack of capacity in these layers of lower-acuity treatment. See Section 5.5.1 for a recommendation related to this finding.

[95] Community types are defined by the following minimum populations: frontier/village (25), sub-regional center or town (500), regional center or small city (1,500), urban center (25,000), and metropolitan area (200,000).
[96] "Continuum of Care Matrix for Alaskans with Behavioral Health Disorders," Division of Public Health, Alaska Department of Health and Social Services, Accessed July 1, 2015. http://dhss.alaska.gov/dph/HealthPlanning/Pages/movingforward/matrices/carecontinuumbhd.aspx.
[97] Mat-Su Behavioral Health Environmental Scan Report 1 – The Crisis Response System, McDowell Group, Western Interstate Commission on Higher Education, Mat-Su Health Foundation, November 2014, p. 38.

5.3.3. FINDING: The Department's policies and procedures for referrals between acute care services and other community supportive services are not effective or efficient.

The Department's placement and referral policies between acute care services and other community supportive services are not effective or efficient. As already discussed, the effectiveness and efficiency of these procedures is hampered by the lack of interoperability between the community-based and API electronic records system. Community providers use AKAIMS to track and manage consumer data, while API uses Meditech as its electronic health record. AKAIMS and Meditech are not interoperable and it is not possible to share data between the two systems. This separation impedes the effectiveness and efficiency of the referral process in two ways.

First, when a consumer is referred from community-based services to acute care treatment at API, the protocol is to share the consumer record via fax, an inefficient and outdated process. During the period of review, API began working with AKAIMS to report data to DBH. PCG notes that it is now possible for API to access the consumer record without requiring a fax from a community provider, and this referral process may be changed in the near future. Second, API providers rely on the Meditech profile to treat consumers and so do not have easy access to the complete consumer record. The acute care providers have access to the paper record faxed from the community service provider, but must take additional steps to review it and incorporate the information within it into the consumer's treatment. As it is burdensome for API staff to fully reconcile the two records within Meditech, important consumer data – such as a history of trauma – is not always addressed by the API providers. The referral process from community services to acute care is limited in its effectiveness by the difficulty of securely sharing consumer records between community and acute providers.

Additionally, acute care services are overburdened and experiencing severe census pressure. This lack of capacity negatively impacts the effectiveness of the referral and placement processes between community and acute care services, and there is a waitlist for consumers in need of admittance to API. DBH actively monitors the API waitlist in order to bridge the gap between API and the community-based system. This process is currently labor intensive and involves manual daily notification of community providers of API capacity. This aspect of the referral process could be more efficient if routinized. The census pressure also limits the effectiveness and efficiency of referrals between acute inpatient and community-based services by overburdening community behavioral health center (CBHC) services. With frequent discharges from API and correctional institutions, CBHCs are inundated with referrals from acute care settings. The placement procedures are ineffective in that they overburden CBHCs and decrease the capacity of CBHCs to treat community members.

API policies do not mandate that consumers be discharged with developed treatment plans, and currently, API does not have the staffing needed to conduct even voluntary discharge planning. API has been faulted in the recent past for returning individuals to the community without contacting community-based providers, forcing those providers to develop a transition and treatment plan without a comprehensive

understanding of the acute treatment the individual received within API. The problem is particularly pronounced with rural providers outside of Anchorage and Juneau. If a patient requests a treatment plan, API treatment staff work to develop one, but otherwise patients exit acute psychiatric care without referrals to community long-term supports and services. The policy of optional discharge and referral planning is not effective at transitioning consumers to community-based services. The 30-day readmission rate to API speaks to the ineffectiveness of referrals from acute care to community long-term services. In the first quarter of 2013, API's 30-day readmission rate was 16 percent, twice the national average of approximately eight percent.[98] In other words, consumers return to API following discharge twice as frequently as they do nationwide. That rate calls attention to the inefficiency of these referral procedures at engaging the consumer in appropriate community long-term services and supports.

For this reason, the discharge policies for individuals exiting API are both ineffective and inefficient. There is inadequate collaboration between API psychiatric staff and community-based providers. Community providers attempt to compensate for this deficiency by conducting treatment planning and case management services themselves. For example, the Tribal Health Consortium funds a tribal discharge planner specifically to conduct discharge planning for Alaska Natives exiting API. Even when taking into account the informal efforts of providers to compensate for inadequate formal referral policies, The standard referral and placement procedures from acute care services to community-based services and supports are neither effective nor efficient. For recommendations related to this finding, see Sections 5.5.2, 5.5.4, and 5.5.5.

5.3.4. FINDING: The Department's policies and procedures for referrals between acute care services and justice-involved services are not effective or efficient.

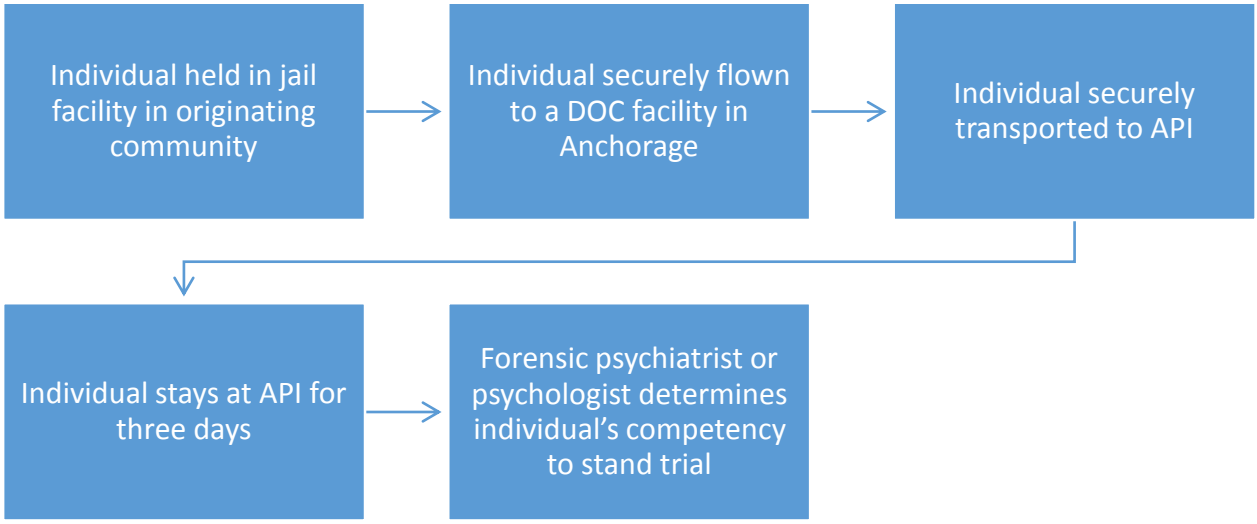
The Department's policies and procedures for referrals between acute care services and justice-involved services are neither effective nor efficient. In addition to the systemic pressures that result in diversion of consumers from the community behavioral health system to corrections which have already been discussed, there are two processes that demonstrate problematic methods for transferring consumers between API and the corrections systems.

The first is a concerning rise in "criminalization" of consumer behavior at API itself. API staff have the right to press charges against consumers for assault or violent interactions and have increasingly exercised this option, despite the fact that consumers are typically admitted to the hospital precisely because they are a threat to themselves and others. This process spurs the transfer of the consumer from API to DOC, resulting in a kind of automatic placement from one system to the other. Not only is this practice an indication of inadequacies in API staffing or procedures, but it also suggests, in effect if not intent, that DOC is the safety net behavioral health provider for the State.

Second, the forensic evaluation protocol is inefficient. Forensic psychiatric evaluations are by their nature complex and involve substantial time and labor resources not only from DHSS, but also from DOC, and

[98] Alaska Psychiatric Institute Dashboard, Alaska Department of Health and Social Services, 2014.

the Alaska Court System (ACS). When an individual appears in court with a reasonable assumption of mental illness and the presiding judge deems a psychiatric evaluation is necessary to determine the individual's mental competency, the following steps are taken:



If the individual is deemed mentally competent they are flown back to the community to stand trial. If the individual is deemed incompetent but capable of becoming competent with treatment, they are committed to API until the achievement of competency or for 90 days.[99] This sequence of events is costly and inefficient as a result of insufficient communication between the local court, DOC, and DHSS. If individuals can be held securely within the community and a licensed behavioral health professional capable of performing the evaluation is available there as well, there is no need for the Department to pay for stays at API, which come at a flat rate of $1,288 per day[100]. The current process is unnecessarily labor intensive and inefficient. Third, API's admissions policy includes an additional screening following a court-ordered API commitment to determine whether the consumer should be placed in API or in a correctional facility. That screening decreases the efficiency of the referral by slowing access to care, and is another means by which API diverts consumers to correctional institutions.

The placement and referral procedures between acute services and justice-involved services are not effective or efficient. Challenges of collaboration and communication with the numerous partners involved in referrals of mentally ill individuals inhibit the ability of the Department to have effective and efficient policies. Additionally, Alaska's geography presents unique challenges to a forensic evaluation process that

[99] Judge's Guide to Handling Cases Involving Persons with Mental Illness, Judge Stephanie Rhoades.
[100] McDowell Group et al.

requires expert professionals located only in the urban areas of the state. Recommendations related to this finding can be found in Sections 5.5.5, 5.5.6, 5.5.7, and 5.5.8.

5.3.5. FINDING: The Department's referral and placement policies for child and adolescent residential services are effective and efficient.

The Department's placement and referral policies for child and adolescent residential services are both effective and efficient. Through the BTKH initiative, DHSS and AMHTA worked to develop community-based services and youth and adolescent RPTCs within Alaska. BTKH began in 2005. In FY04 there were 749 children receiving services in out-of-state RPTCs. In FY 2012 there were only 203 youth recipients of out-of-state RPTC services. Additionally, from FY04 to FY 2012 the rate of RPTC placements per 1,000 Medicaid youth recipients decreased from 15.5 per 1,000 to 5.9 per 1,000, and the RPTC recidivism rate decreased from 20% to five percent.[101]

BTKH drove the development of increased community-based and residential treatment programs to treat youth with SED and other behavioral health disorders. The Department now effectively utilizes individualized service agreements (ISA) to ensure youth are served as close to their home community as possible. DHSS also used focused Home and Community Based Capacity Grants to increase the capacity of community behavioral health providers to treat SED youth. Additionally, DHSS expanded the residential treatment capacity by working with OCS to use Behavioral Rehabilitation Services (BRS) beds for non-custody children. As a result of these efforts, in 2013, Alaska's admission rate of youth to residential treatment centers was 0.8.[102] The figure is markedly decreased from the rate of 1.03 observed in 2011 and is significantly lower than the 2013 national average of 1.16.[103]

The Department's referral and placement policies are effective and efficient at treating children and adolescents in the least restrictive setting appropriate. The key components of effective residential treatment are maximizing regular contact between the child and family, actively involving and supporting families with a child in residential treatment, and providing ongoing support and post-release care for the child and family.[104] The DHSS child and adolescent residential services system includes these components and is effective at placing children in the least restrictive environment. With the changes implemented through BTKH, the Department's placement and referral policies for child and adolescent residential services are effective and efficient.

[101] Bring the Kids Home Focus Area Fact Sheet, Alaska Mental Health Trust Authority, January 2013.
[102] Alaska 2013 Mental Health National Outcome Measures (NOMS): CMHS Uniform Reporting System, Uniform Reporting System (URS), SAMHSA, 2013.
[103] Alaska 2011 Mental Health National Outcome Measures (NOMS): CMHS Uniform Reporting System, Uniform Reporting System (URS), SAMHSA, 2011.
[104] American Academy of Child and Adolescent Psychiatry.

5.3.6. FINDING: The Department's referral and placement policies and procedures for community treatment and recovery services are effective and efficient.

The Department's referral and placement policies are effective at placing consumers in the lowest level of care appropriate to their needs. The behavioral health provider community is largely collaborative, as seen through the large membership of the Alaska Behavioral Health Association (ABHA) and engagement with DBH work groups, such as AKAIMS user groups or the Outcomes Identification and System Performance Project (OISPP). Because demand for services outpaces supply, competition that might inhibit the willingness of providers to refer consumers across agencies is limited, resulting in effective and efficient referrals across the community-based behavioral health system. With the exception of acute and residential services, whose placement challenges have already been discussed, customary community referral procedures are effective at placing consumers in the least-intensive and least-restrictive care appropriate for treatment. The system-wide implementation of AKAIMS augments the efficiency of referrals by allowing providers to share consumer records and treatment history with one another more easily. Overall, the Department's referral and placement policies for community-based treatment and recovery services are both effective and efficient.

5.3.7. FINDING: The Department's referral and placement policies and procedures for early intervention services are effective and efficient.

The Department manages two primary early intervention services: FASD programs and the ASAP. FASD programs focus on the early diagnosis of FASD, swift referral to appropriate treatment programs, and the inclusion of families and caregivers in treatment and recovery. These referral policies emphasize early placement treatment services and community integration, two of the hallmark best practices for placement policies. Additionally, DHSS collaborates with AMHTA, the Department of Law, the Department of Corrections, the Public Defender Agency, the Office of Public Advocacy, Partners for Progress, and behavioral health treatment providers to deliver early intervention services through the therapeutic and specialty court system. The DBH's ASAP program provides direct services that manage the treatment of individuals referred to substance abuse services through the justice system. The therapeutic court system consists of the following courts:

Table 5.3. Therapeutic Court System

Purpose	Courts

Felonies	• Anchorage Wellness Court
	  ○ Felony Drug Court
	  ○ Felony DUI Court
	• Fairbanks Wellness Court

Felonies and Misdemeanors	• Anchorage Coordinated Resources Project • Anchorage Veterans Court • Bethel Therapeutic Court • Juneau Therapeutic Court • Ketchikan Therapeutic Court • Palmer Coordinated Resources Project
Misdemeanors	• Anchorage Municipal Wellness Court • Juneau Coordinated Resources Project
Juvenile Offenders	• Fairbanks Juvenile Treatment Court
Child in Need of Aid (CINA) Cases	• CINA Therapeutic Court - Anchorage

The therapeutic courts are an effective form of early intervention. Using intensive case management techniques, ASAP coordinators ensure consumers are treated at the appropriate level of care and are integrated into the community, again meeting the best practice standards. Misdemeanor offenders have a re-arrest rate of 23% and a re-conviction rate of 9% in the first year following graduation from the therapeutic court program.[105] In comparison, misdemeanor offenders processed through the traditional court system have a 36% re-arrest rate and a 25% re-conviction rate within the first year following their release. Similar reductions in re-arrest and re-conviction rates are observed in felon offenders who graduated from a therapeutic court program. In addition to being effective, the therapeutic courts are also efficient. The average daily cost to operate the mental health courts in Anchorage and Palmer is $19.82 per participant.[106] In 2009, the average daily cost of incarceration per offender was $136.[107] The therapeutic court system is an efficient means of early intervention by diverting offenders from high-cost incarceration.

The effectiveness of these early intervention services is accompanied by efficiency facilitated through the inclusion of FASD and ASAP modules in AKAIMS. Both programs use AKAIMS to refer consumers to community services and transmit the consumer record.

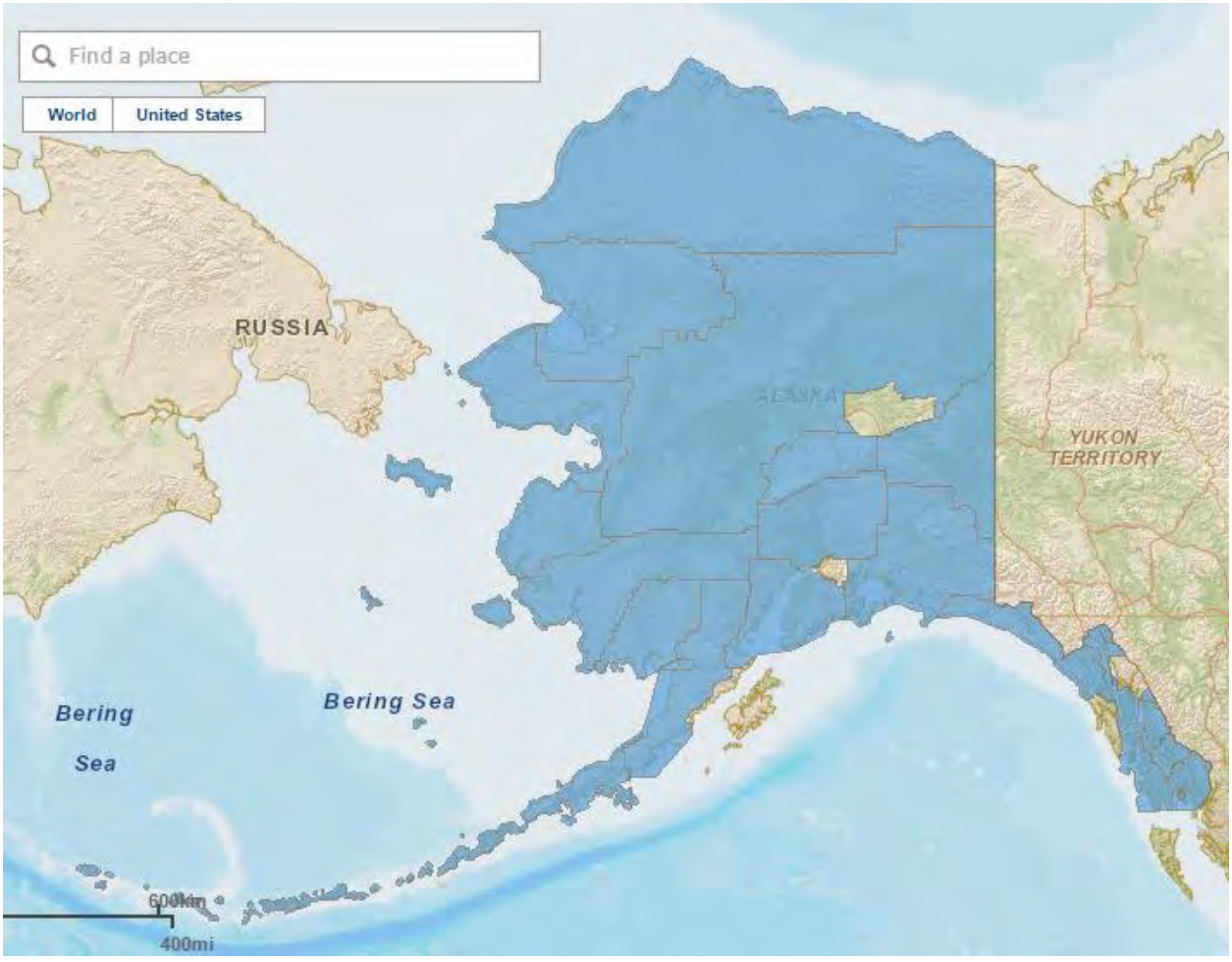
[105] Carns et al.
[106] Recidivism Reduction Workgroup.
[107] Alaska's Five-Year Prisoner Reentry Strategic Plan 2011-2016, University of Alaska Anchorage, *Alaska Justice Forum,* 2011.

5.4. External Factors Inhibiting Effectiveness and Efficiency

5.4.1. FINDING: Low supply of psychiatrists nationally, along with a statewide shortage of other behavioral health professionals, impair the Department's efforts to ensure an effective service array of behavioral health services.

With the exception of Anchorage, Fairbanks, and Juneau, the entire state of Alaska is designated as a Health Professional Shortage Area (HPSA) with respect to mental health professionals by the federal Health Resources and Services Administration (HRSA).

Figure 5.4. Mental Health Professional Shortage Areas[108]



[108] HRSA Data Warehouse Map Tool.

Alaska suffers especially from an acute shortage of psychiatrists, a problem found nationwide. The HRSA estimates that 2,800 additional psychiatrists are needed to de-designate all HPSAs lacking an adequate supply of psychiatrists.[109] In Alaska, a 2010 Alaska Department of Labor study found that the State had a shortage of 51 in-state psychiatrists, or a 46.4% deficit. A 2012 Alaska Center for Rural Health study, that includes out-of-state psychiatrists licensed to work within Alaska, estimates the rural vacancy rate at 15% and the urban vacancy rate at 22%. The statewide shortage of mental health professionals includes other professionals as well, with vacancies most often higher in rural than urban areas[110]:

Table 5.5. Behavioral Health Professional Vacancies

Professional	Urban vacancy	Rural Vacancy	Statewide Vacancy
Clinical Psychologist	6%	13%	7%
Clinical Social Worker	8%	15%	10%
Counseling Psychologist	4%	10%	5%
Marriage and Family Therapists	5%	-	5%
Mental and Behavioral Health Clinicians and Counselors	6%	12%	8%
Other Health Related Therapists and Clinicians	7%	29%	9%
Behavioral Health Clinical Associates	14%	10%	12%
Behavioral Health Aides and Village Counselors	8%	19%	17%
Rehabilitation Counselors	17%	-	10%
Substance Use Disorder Counselors	9%	12%	10%
Other Behavioral Health Counselors	3%	21%	12%

The widespread shortage of behavioral health professionals impede the Department's efforts to support a full array of behavioral health services. As behavioral health provider clinics can only bill Medicaid if they have a psychiatrist on staff, the shortage of psychiatrists severely limits access to behavioral health services by constraining the provider population. Additionally, independent providers operating outside CBHCs must be licensed as a physician, PhD psychologist, or an advanced nurse practitioner to bill Medicaid for behavioral health treatment services. The seven percent statewide vacancy rate creates a bottleneck for consumers entering the behavioral health treatment. The shortage of all other behavioral health counselors and clinicians limits the availability of community-based services and supports that are crucial to prevention and the success of outpatient treatment, contributing to unnecessary utilization of emergency care. PCG finds that the behavioral health workforce shortage limits the Department's ability to offer a complete continuum of care. See Section 9.3.4 for a recommendation related to this finding.

[109] The Complexities of Physician Supply and Demand: Projections from 2013 to 2025, IHS Inc. for the Association of American Medical Colleges, March 2015.
[110] Alaska's Health Workforce Vacancy Study: 2012 Findings Report, Katherine Branch, August 2014.

5.4.2. FINDING: Alaska's vast geography impedes the Department's ability to manage comprehensive behavioral health services efficiently.

Alaska is unlike any other state in its vast geography and population of remote areas. It has the highest share of Frontier and Remote (FAR) areas of any other state. The distance from the state's sole psychiatric hospital in Anchorage to the northernmost behavioral health provider in Barrow is over 700 miles. The only transportation between Barrow and larger cities is via plane. Many remote areas, such as McGrath, are completely off the road system and are only accessible with a small boat, plane, or snowmobile. The vast geography goes hand in hand with small local populations. In 2013, 20 percent of the Alaskan population lived in places with fewer than 2,500 people and 3 percent lived in unorganized territory, where the State performs all governmental functions.[111] Small towns do not have the scale to support the full spectrum of behavioral health services within their community, and often can barely support one or two behavioral health providers. Even in Kotzebue, which had a 2013 population of approximately 3,200, there is only one DBH treatment and recovery grantee.

Subsequently, the Department is forced to rely on inefficient protocols of high-cost transportation to make behavioral health services available to a all Alaskans. Telebehavioral healthcare is improving the efficiency of community-based treatment services by facilitating remote counseling and evaluation services, but when a community provider refers a consumer to psychiatric emergency care, DHSS must fly the consumer to Anchorage, and upon discharge must fly the consumer home. Additionally, through the Complex Behavior Collaborative, the Department sends treatment providers to remote communities to work with individuals with complex needs in order to keep them within the community setting, as that is the most efficient setting for effective service delivery. As rural and FAR areas are unable to support essential behavioral health providers within the community, the Department necessarily continues to depend on costly and time-consuming travel protocols to provide and administer behavioral health service across the state.

5.4.3. FINDING: The availability of affordable housing in Anchorage, Juneau and other population centers poses challenges for transitioning consumers into the community.

The statewide crisis of affordable housing poses challenges for the effective transition of consumers back into the community. The problem is particularly acute in Alaska's metropolitan and urban areas of Anchorage, Juneau and Fairbanks, and is not sufficiently addressed by the Alaska Housing Finance Corporation. Historically, the Department's focus on housing availability centered on residential programs, and thus today the housing available to consumers exiting institutional programs is concentrated in ALFs. However, what is needed is permanent supportive housing (PSH). *PSH* is safe, affordable, community-based housing that provides occupants with links to community support services. Individuals with mental

[111] Alaska Population Overview: 2013 Estimates, Alaska Department of Labor and Workforce Development, February 2015.

illness, psychiatric disabilities, and other debilitating conditions need stable, secure housing to remain in treatment and on the road to recovery. Unfortunately, due to the lack of PSH and other affordable housing options, consumers are placed in ALFs or return to being homeless. The lack of affordable housing makes it difficult for the Department to discharge individuals securely with the expectation that they will successfully complete or continue treatment.

5.4.4. FINDING: Transitioning consumers from institutional care back into rural Alaska communities is complicated by limited village capacities to care for individuals with serious mental illness.

Multiple DHSS officials and provider representatives noted in discussions with PCG that the transition between community care in rural Alaska and institutional care at API in Anchorage is often one-way, with SMI individuals frequently not returning to their home villages after discharge back into the community, but residing in Anchorage instead. While this pattern of referral and placement is problematic in terms of delivering truly effective, culturally-responsive care within a consumer's community, the challenge of facilitating the return of rural Alaskans to their home communities is compounded by factors specific to rural Alaska and beyond the capacity of DHSS to influence substantially. On the one hand, effective community treatment for SMI, even in the best circumstances, depends upon a critical mass of community support services, such as stable housing, peer support, outpatient treatment and recovery services, and case management services. Regardless of the efficiency of service delivery in the state, these services cannot be scaled to be feasible in rural villages, and community under these circumstances must necessarily involve regional hubs and not just the resources available in villages.

On the other hand, serious mental illness impacts rural village communities in a particularly challenging ways that make it more difficult for SMI individuals to return once they've left the community. Although village communities can be extremely resilient, serious mental illness can be so disruptive to the small, close-knit social networks that define rural Alaska, that when SMI individuals "burn bridges" in the community, as they often do, the impacts emanate far outside the tiny nucleus of family and friends more characteristic of other communities in the United States. For rural Alaskan communities, admission to API is truly the last resort, and occurs only after an otherwise resilient community has exhausted its resources for caring for an SMI individual. Consequently, these individuals are frequently unwelcome in these communities after discharge and lack the material resources and family and social support systems to facilitate their recovery in their home villages. This dynamic is a significant cultural factor that complicates the recovery process for rural Alaskans exiting institutional behavioral health care, making inclusion and community reintegration far more challenging in Alaska than in many other parts of the United States.

5.5. Recommended Improvements to Departmental Policies and Procedures

5.5.1. RECOMMENDATION: The Department should implement a consistent and interoperable information technology solution for referrals across the behavioral health continuum of care.

Implementing a consistent and interoperable information technology system capable of facilitating referrals across the complete behavioral health continuum of care will improve the efficiency of behavioral health placements. As a short term solution, DHSS should create consistent referral protocols based in AKAIMS. As the result of recent DBH policy changes, all publicly funded behavioral health providers now use AKAIMS to report data. The Department should require providers, including API, to utilize the AKAIMS referral functionality to transfer consumer records across providers. Such a change would strengthen the links between the community and acute behavioral health systems. In the long term, the Department should work with providers to facilitate referrals and data-sharing through the State's Health Information Exchange (HIE). That will further improve the referral process by reducing the duplication of efforts resulting from many providers, including API, using both AKAIMS and a separate electronic health record. For information related to this recommendation, see Sections 5.3.2 and 5.3.3.

5.5.2. RECOMMENDATION: The Department should build capacity for mobile crisis units in communities with high rates of unnecessary use of the emergency department for behavioral health-related issues.

Mobile crisis units provide services within the community, even within a consumer's own home. These units are composed of a dispatcher, an on-the-ground or remote psychiatrist, and master's- or doctoral-level licensed clinicians. The behavioral health services offered through these units are pre-screening assessments and treatment planning. These units are able to provide a rapid response, assessment, and resolution of crisis situations involving persons with behavioral health issues, subsequently reducing inappropriate utilization of the local emergency department. By increasing the capacity of the system to provide behavioral health-specific rapid responses, mobile crisis units also reduce psychiatric hospitalization and arrests of mentally ill offenders.

The cost savings to be gained from developing mobile crisis units are also considerable. In one study, researchers analyzed the effectiveness and efficiency of a mobile crisis program by comparing it to regular police intervention. The average cost per case was $1,520 for mobile crisis services, which included $455 for program costs and $1,065 for psychiatric hospitalization. For regular police intervention, the average cost per case was $1,963, which consisted of $73 for police services and $1,890 for psychiatric hospitalization. In this study, mobile crisis services resulted in a 23% lower average cost per case.[112]

[112] Scott, R. L. (2000). Evaluation of a mobile crisis program: effectiveness, efficiency, and consumer satisfaction. *Psychiatric Services*, *51*(9), 1153-1156.

Another study found that mobile crisis intervention services can reduce costs associated with inpatient hospitalization by approximately 79% in a six-month follow up period after the crisis episode.[113] More recently, the Washington State Institute for Public Policy conducted a meta-analysis on these studies and others, estimating the likelihood of a $1.42 benefit-to-cost ratio following implementation, based on findings across the research literature. In other words, for every dollar spent to operate mobile crisis units, an average of $1.42 would be expected to accrue in cost savings.[114]

The Department should develop the capacity for mobile crisis units in communities with demonstrated high rates of unnecessary use of the emergency department for behavioral health-related issues. These units would improve the Department's ability to treat consumers within the least restrictive environment by reducing unnecessary hospitalization and diffusing crises within the community. For more information regarding this recommendation see Sections 5.2.1, 5.2.2, 5.3.1, 5.3.2, and 5.3.3.

5.5.3. RECOMMENDATION: The Department should support targeted case management services for high-utilizers of the psychiatric emergency system in order to divert these consumers from costly acute care and ensure delivery of services oriented to prevention.

The Department should fund and support intensive case management services targeted for high-utilizers of psychiatric emergency services. DHSS should identify consumers that are the most frequent utilizers of the emergency department, API, and other emergency services for behavioral health-related issues, and provide community-based, intensive case management services to these individuals. *Intensive case management services* are defined by the following principles and activities:[115]

- Low staff to consumer ratio;
- Individualized service planning;
- Eligibility and enrollment assistance;
- Navigation between needed services; and
- Facilitation and communication between all service providers.

Research shows that targeted intensive case management services for individuals with high levels of hospital and emergency services reduces the utilization of those services.[116] Intensive case management services divert consumers from costly emergency services and treat consumers through community-based behavioral health wellness promotion and treatment services. As these services have high potential for

[113] Bengelsdorf, H., Church, J. O., Kaye, R. A., Orlowski, B., & Alden, D. C. (1993). The cost effectiveness of crisis intervention: Admission diversion savings can offset the high cost of service. Journal of Nervous and Mental Disease, 181(12), 757–762.
[114] WSIPP, Benefit-Cost Results: Mobile Crisis Response (July 2015).
See: http://www.wsipp.wa.gov/BenefitCost/ProgramPdf/289/Mobile-crisis-response.
[115] Step-by-Step: A Comprehensive Approach to Case Management, Kathleen Guarino, SAMHSA Homelessness Resource Center, 2011.
[116] Use of intensive case management to reduce time in hospital in people with severe mental illness: systematic review and meta-regression, British Medical Journal, July 13, 2007.

improved treatment outcomes and decreased costs, DHSS should support targeted intensive case management services.

The service options permitted under a Medicaid 1915(i) waiver, which PCG recommends in multiple sections of this report, provide a potential financing vehicle for the targeted case management services endorsed here, which could achieve savings of up to $250,000 each year. See Sections 3.0.6 and 3.0.7 for PCG's recommendations on Medicaid waivers as a policy and financing vehicle for supporting the case management services advocated here.

5.5.4. RECOMMENDATION: The Department should promote Crisis Intervention Team training for a minimum number of law enforcement personnel in communities with high referral rates to API.

The Department should work with local law enforcement to require and fund Crisis Intervention Team (CIT) training for a minimum number of law enforcement personnel needed to ensure fidelity to program standards and to guarantee the effectiveness of the intervention. Although CIT has received limited implementation in metropolitan areas such as Anchorage, the program requires expansion, both in the Municipality and in communities in the Matanuska-Susitna Valley, which are currently seeing high referral rates to API and a high proportion of emergency calls involving individuals with behavioral health issues.

Research has found CIT training to be effective at enacting the following changes:[117]

- Increase number of calls involving persons with mental illness;
- Increase proportion of calls involving persons with mental illness;
- Increase rate of transport by CIT-trained law enforcement personnel of individuals with mental illness to emergency facilities;
- Increase rate of voluntary transport to emergency facilities.

A successful CIT partnership between law enforcement, the behavioral health system, consumers and consumer advocates is effective at increasing access to needed emergency services for individuals experiencing a mental health crisis. CIT partnerships increase the proportion of individuals receiving treatment for mental illness and ensures an effective referral to the services needed.

In Alaska, the average emergency room visits costs between $700 and $3,000,[118] while the daily cost of a prison bed is $158.[119] By contrast, the daily cost to the State of treating an individual in the community is

[117] Crisis intervention team training for police officers responding to mental disturbance calls, Psychiatric Services, February 2006.
[118] Per DHSS estimates, as reported in the KTUU February 12, 2015 news article, "The cost of chronic homelessness." See: http://www.ktuu.com/news/news/the-cost-of-chronic-homelessness/31245054. Retrieved August 3, 2015.
[119] 2015 Recidivism Reduction Plan: Cost-Effective Solutions to Slow Prison Population Growth and Reduce Recidivism, Recidivism Reduction Workgroup, 2015, p. i.

$18.[120] It stands to reason that any program connecting individuals in crisis to community outpatient treatment—when these services are more appropriate than hospitalization or incarceration—makes good economic sense. In fact, a substantial body of evidence has been produced to demonstrate the superiority of CIT interventions over traditional law enforcement responses to disruptive crisis as a means of preventing escalation, lowering officer injury rates, reducing stigma, and ultimately promoting recovery. One study, for example, found that CIT-trained officers are 25% more likely to transport a person to treatment in the community emergency evaluation and treatment facilities than police without special training.[121]

Additionally, research indicates that CIT success in connecting persons with mental illness to psychiatric services and diverting them from jail detentions and emergency room visits can also be extremely cost effective. A study conducted in 2014 of the CIT program in Louisville, Kentucky, examined the costs associated with officer training, increased emergency psychiatric visits, and hospital admissions resulting from CIT activity when compared with the savings associated with diverted hospitalizations and reduced legal bookings. The study found approximately $1 million in annual cost savings as a result of the CIT program. Based on an average of 2,400 CIT calls annually in the medium-sized city of 612,000, the overall costs associated with CIT per year were $2.4 million (approximately $146,000 for officer training, $1.8 million for patient hospitalizations brought in by CIT, $509,000 for psychiatry evaluations, and $6,823 for arrests). The annual savings, however, were $3.5 million ($1.1 in deferred hospitalization, $2.3 million in reduced inpatient referrals from jail, and $9,925 in avoided bookings and jail time).[122]

For these reasons, the Department should play a greater role in championing the development of CIT partnerships statewide. The State should consider mandating a minimum number or percentage of law enforcement personnel in high-impact areas be CIT trained in order to increase the rate of appropriate first response to mental health emergencies. See Sections 5.1.1, 5.2.1 and 5.2.2 for more information related to this recommendation.

5.5.5. RECOMMENDATION: The Department should improve coordination efforts with the Department of Corrections to ensure consistency in treatment programs and protocols for individuals exiting correctional facilities.

DHSS should improve its coordination efforts with DOC on behavioral health services for individuals within and exiting the correctional system. DOC is the largest provider of behavioral health services within Alaska.[123] Developing a coordinated service delivery system such that behavioral health treatment programs available within the correctional system are based on the same principles and utilize the same evidence-

[120] The figure, $18.32, is derived by totaling the Division's FY 2014 annual expenditures for community outpatient treatment, dividing by 365 days in a year, and then dividing by the number of individuals who received treatment.
[121] Teller, J., Munetz, M., Gil, K. & Ritter, C. (2006). "Crisis intervention team training for police officers responding to mental disturbance calls." *Psychiatric Services*, 57, 232-237.
[122] El-Mallakh, PL, Kiran K, and El-Mallakh RS. (June 2014). "Costs and savings associated with implementation of a police crisis intervention team." Southern Medical Journal, 107(6):391-5.
[123] Mentally Ill Inmates in Alaska Prisons, Antonia Moras, Alaska Justice Forum, 2004.

based practices as those services available within the community would provide continuity of care for individuals exiting the correctional system. This continuity and minimal disruption of behavioral health care eases the reentry process and promotes a successful transition back into the community. PCG suggests the Department work with DOC to create consistency in treatment programs and protocols offered within and outside correctional facilities. See sections 5.1.2, 5.1.3, and 5.3.4 for more information related to this recommendation.

5.5.6. RECOMMENDATION: The Department should implement the recommendations presented in the State's Recidivism Reduction Plan.

The Department recently collaborated with the DOC, Alaska Mental Health Trust Authority (AMHTA), Alaska Housing Finance Corporation (AHFC), Department of Labor and Workforce Development, ACS, and community stakeholders and tribal organizations to produce a 2015 Recidivism Reduction Plan.[124] To improve the Department's ability to administer and provide behavioral health services to all Alaskans, the Department should implement specific recommendations presented in this plan. These recommendations have the potential to reduce costs, improve the behavioral health services provided, and increase the effectiveness and efficiency of community behavioral health referrals:

- Expand community-based substance abuse treatment;
- Continue and improve the following programs;
    - Residential substance abuse treatment;
    - Living success substance abuse treatment;
    - Alaska Native substance abuse treatment;
    - Institutional discharge project plus;
    - Assess, plan, identify, and coordinate;
    - AHFC special needs housing grant program;
    - AHFC tenant based rental assistance program;
    - Housing first programs;
    - ACS collaborations;
- Establish reentry coalitions;
- Enact legislation to "ban the box";
- Provide community-based substance abuse treatment for class C felony drug offenders and property offenders who are drug/alcohol abusers;
- Explore alternative sentencing approaches;
- Provide community-based cognitive behavioral treatment (CBT) programs for high and moderate risk offenders; and
- Increase the number of pretrial offenders released on bail.

[124] Recidivism Reduction Workgroup, 2015.

5.5.7. RECOMMENDATION: The State should develop a coordinated Forensic Services unit to oversee forensic evaluations and service coordination, and to minimize costs incurred by the ACS, DOC, and the DHSS.

Currently in Alaska, forensic behavioral health consists of an informal relationship among DHSS, the ACS and DOC working together to fulfill each entity's statutory obligations. However, because forensic services are often disconnected and embedded in multiple systems, there is a lack of comprehensive data and proactive channels of communication to support informed system-wide management of forensic services. Many states have developed dedicated forensic services units, typically housed under the state mental health authority, equipped with adequate authority and data-management capacity to ensure a strategic, integrated approach to services for the forensic population. These units are charged with establishing statewide procedures to facilitate forensic evaluations, train forensic evaluators, and monitor quality in forensic evaluation reports: areas in which the state has demonstrated an acute need for a more coordinated approach.

As detailed in Section 5.3.4, Alaska's current evaluation process involves numerous jurisdictional transfers and expensive transport costs, with significant opportunities for logistical streamlining. Alternatives to the current system would involve improved communication between DHSS and regional ACS and DOC entities that would allow forensic evaluations to be conducted on-site, closer to home communities, instead of multiple flights among several jurisdictions. Transport of the forensic examiner would be less costly than the secure transport required for the individual being evaluated. The Department should create a dedicated unit to coordinate forensic evaluations statewide, in an effort to improve efficiency and minimize the costs incurred by all three partners from the current process.

5.5.8. RECOMMENDATION: The State should reform Title 12 to distinguish between violent and non-violent misdemeanor offences in the code governing forensic psychiatric evaluations for misdemeanor offenders.

Title 12 of the Alaska Statute dictates a single forensic psychiatric evaluation process for both violent and non-violent misdemeanor offenders, a process described in detail in Section 5.3.4. Regardless of the classification of the misdemeanor, and whether individuals are considered a threat to themselves or others, the court system follows the same procedure for individuals requiring a forensic psychiatric evaluation. Although the current procedure meets the security standards for violent misdemeanor offenders, in cases of non-violent offences, the evaluation process is unduly burdensome and can be streamlined significantly to make better use of precious clinical resources. A forensic evaluation specific to nonviolent offenders could be sufficiently completed with a forensically trained expert rather than requiring the services of API. The State should distinguish between violent and non-violent offences in statute in order to reduce resources expended unnecessarily on treatment of nonviolent misdemeanor offenders.

6.0. ORGANIZATIONAL STRUCTURE

Determine whether the Department's organizational structure ensures effective and efficient access to behavioral health services, or whether streamlining and other organizational changes could reduce overall department expenditures while maintaining the level of services. Also, determine whether the number of Department of Health and Social Services (DHSS) staff devoted to behavioral health administration within the varying department divisions is either commensurate with or disproportionate to the level of services overseen by DHSS.

A. Does the Department's organizational structure facilitate the effective delivery of behavioral health services?

B. Does the Department's organizational structure facilitate the efficient delivery of behavioral health services?

C. Is the number of staff devote to behavioral health administration within the varying department divisions commensurate with or disproportionate to the level of services overseen by the Department?

D. Are there changes to the organizational structure that could reduce costs while maintaining the level of services?

6.1. Organizational Effectiveness

6.1.1. FINDING: The consolidation of behavioral health administration within the Division of Behavioral Health (DBH) promotes more effective blending and braiding of funding services for behavioral health services.

DBH is responsible for the management and provision of behavioral health services throughout the state of Alaska. Not only does DBH oversee the grant funding available to the state's behavioral health service providers, but it also administers Department behavioral health services covered through Medicaid, which in many other states, falls under an independent Medicaid authority. DBH also provides direct acute psychiatric care through the Alaska Psychiatric Institute (API), and is responsible for program evaluation and approval for treatment and recovery services. This consolidation of behavioral health administration encourages a more effective blending and braiding of funding behavioral health services. The staff and leadership of DBH have a comprehensive overview of the state-funded behavioral health system and thus are in a position to be able to allocate funding more appropriately to meet the most pressing behavioral health needs of Alaskans. With the oversight of the funding contained within one division, the Department also is able to leverage all funding sources, such as federal grants, state general funds, and Medicaid, to fund behavioral health services and programs. Locating operational control and administration of

behavioral health services funding within DBH is an effective strategy for managing the diverse array of financing mechanisms required to operate a state behavioral health system.

6.1.2. FINDING: The organizational alignments facilitated by the Department's Results-Based Accountability (RBA) framework provide an effective structure for necessary cross-divisional communication.

The RBA framework promotes both vertical integration of the Department's division-, section-, and program-level units, as well as horizontal partnerships across divisions that focus on areas of shared service populations and program responsibilities. To respond to the need for coordinated, cross-divisional activities, the RBA Initiative called for the development of cross-divisional workgroups oriented along the Department's "core services," and are composed of representatives from the units responsible for jointly delivering the same core service.

The intent of the *core services workgroups* is to facilitate cross-divisional communication amongst divisions with services dedicated to the same core service. Thus, the workgroups call attention to areas with higher potential of mismanagement due to the dispersed responsibility and mitigate the risk of neglecting such services, programs, or subpopulations. Furthermore the core services workgroups force division leadership to formally discuss these shared services, providing the opportunity for best practices sharing and reducing inefficiencies and redundancies. core services workgroups are an effective structure for formalized cross-divisional communication.

A prominent example of workgroup operation is DHSS Core Service 2.2, "Facilitate Access to Affordable Health Care for Alaskans," for which DBH serves as the leading division, or core service champion.[125] Although the division leads the workgroup initiative, DBH works with representatives from other divisions responsible for the objectives of Core Service 2.2, improving access to health care and improving rural access to health care. The other divisions with services dedicated to these objectives are Public Health (DPH), Public Assistance (DPA), Health Care Services (HCS), and Senior and Disabilities Services (SDS). The members of the workgroup collaborate to identify any improvements or changes in their common services that would move DHSS towards improving access to healthcare across the state. As a result of this workgroup focus, the Department recently identified the need for better coordination of telemedicine services to address work force shortages and limited access to healthcare professionals in difficult-to-reach areas. Because DBH has the most developed telemedicine system, a direct result of these workgroup discussions has been increased collaboration among divisions–DBH, DPH, DPA, HCS, and SDS–regarding shared network access and efforts to expand.

[125] Annual Report, Alaska Department of Health and Social Services, 2014.

6.1.3. FINDING: Despite improvements in cross-divisional communication, deficiencies in care for specific subpopulations of shared interest, such as individuals with dementia, autism, and traumatic brain injury.

Behavioral health service administration primarily falls under the purview of DBH, but other branches of the Department both provide behavioral health services and have responsibility for populations of shared interest. For example, SDS provides services to individuals with Alzheimer's disease and related dementias (ADRD), a population also served by DBH. Currently API houses consumers with complex needs arising from ADRD because of a lack of cross-divisional programming appropriate to meet their needs. Similarly, adults with autism spectrum disorders (ASD) have no home within the Department's behavioral health system. 67% of individuals with ASD meet the criteria for an additional mental health disorder and have a need for mental health treatment.[126] The Women's, Children's, and Family Health Section within DPH addresses the ASD population, but there is no means of collaboration between DBH and DPH on working to provide these consumers with the complete array of services and supports needed. The Department's lack of formalized cross-divisional organizational structures and communication contributes to deficiencies of care for these shared subpopulations. The mechanisms to coordinate strategy, engage in case management, and share data between divisions regarding the same consumers are inadequate.

The Complex Behavior Collaborative (CBC) is an example of such a cross-divisional organizational structure that enables the Department to more effectively serve subpopulations addressed by multiple sub-agencies within the Department. The CBC is intended to assist the Department in meeting the needs of Medicaid clients with complex issues that may be aggressive and difficult to support.[127] The subpopulation served by the CBC are those individuals with a cognitive impairment who also suffer from chronic mental illness, intellectual disability, dementia or Alzheimer's disease, traumatic brain injury, or substance abuse issues. The CBC is a partnership between departmental sub-agencies DBH, SDS, Pioneer Homes, as well as other state-associated entities including the Alaska Mental Health Trust Authority (AMHTA), the Governor's Council on Disabilities and Special Education, the Alaska Commission on Aging, the Alaska Mental Health Board, and the Advisory Board on Alcoholism and Drug Abuse.

The CBC is an effective mechanism for addressing subpopulations with needs addressed by multiple DHSS agencies. Yet, due to funding and resource constraints, the CBC only impacts a small number of consumers; in FY 2013 the CBC served 42 participants.[128] There is a deficiency of resources and formalized structures for cross-divisional collaboration and data sharing that contributes to inadequacy of care for certain populations. See Section 6.1.5 for a recommendation related to this finding.

[126] Autism & Mental Health Issues, Center for Autism and Related Disabilities, University of South Florida.
[127] "Complex Behavior Collaborative, Alaska Department of Health and Social Services, Accessed June 11, 2015. http://dhss.alaska.gov/dbh/Pages/ComplexBehavior/Default.aspx.
[128] Complex Behavior Collaborative (CBC) Project Annual Report SFY 2013, Division of Behavioral Health, 2013.

6.1.4. FINDING: The Department's current information technology shared services model is inadequate to provide 24/7 support for acute behavioral health services.

The Department's standardization of its information technology infrastructure and system development does not meet the complete needs of behavioral health services administration. The Department's information technology services (ITS) unit provides support for all desktop services, such as computer hardware, server access, and network connectivity. ITS support operates from 8am – 5pm Monday – Friday. While the vast majority of the Department's management of behavioral health services falls within those same operating hours, a crucial element operates nonstop. DHSS is the direct service provider of acute psychiatric care through the Alaska Psychiatric Institute (API). API relies on the full spectrum of IT services to function, including computer hardware, internet connectivity, and database access. These tools are essential to deliver intensive psychiatric care. Subsequently API staff may require the assistance of ITD outside of normal business hours. In these situations, the Department's ITD staff resort to extraordinary measures to respond to the needs of API, such as providing API employees with their home telephone numbers.

ITD is not structured to support a 24-hour organization such as API and their efforts to do so are a major stressor on the Department's IT support staff. The misalignment between the ITD and API structures forces ITD to devote additional time and effort outside of the resources formally budgeted and allocated to DBH. While the shared services model and IT support structure is adequate to the community-based treatment and prevention needs, it is insufficient for the needs of an acute care system. PCG finds the existing IT organizational structure inadequate to meet the needs of acute behavioral health services.

6.1.5. RECOMMENDATION: The Department should continue to develop division-level workgroups within the Department's RBA core services structure to address the needs of neglected subpopulations.

The Department should continue to develop and utilize the aforementioned core services workgroups. The horizontal communication facilitated by these workgroups benefits the Department by promoting collaboration among divisions with areas of shared interest. The workgroups bring into focus the programs and services that contribute to each departmental core service and formally link the disparate divisions providing or managing those services. The Department should aim to maximize the benefits of the core services workgroups, particularly to address subpopulations of shared interest. For example, improving the treatment of individuals with ADRD would meet the objective to "Improve the health status of Alaskans" that is addressed by Core Service 1.1.[129] That workgroup provides the Department with the opportunity to collaborate with its State partners to address the ADRD population.

[129] Annual Report, Alaska Department of Health and Social Services, 2014.

Additionally, the workgroups encourage program and service alignment for each core services, resulting in a standardization that better facilitates data collection and program evaluation. The focus of Core Service 1.2, Provide quality of life in a safe living environment, includes supported housing programs. SDS, OCS, and DBH each manage variations of supported housing, and this workgroup could be a vehicle for the Department to coordinate strategies for performance measurement and program evaluation with its peer agencies. By continuing to utilize the core services workgroups to develop efficient strategies to meet the objectives of each core service the Department will progress towards its goal of meeting the behavioral health needs of Alaskans. For more information regarding this recommendation, see section 6.1.3.

6.2. Organizational Efficiency

6.2.1. FINDING: DBH's organizational position within the Department promotes more efficient delivery of behavioral health services.

The location of DBH within the state government promotes efficient administration of behavioral health services. DBH serves as the state mental health agency (SMHA). Nationwide, SMHAs that are positioned within an umbrella agency spend less money per capita than SMHAs that exist as independent departments within the state government.[130] The Department's organizational structure that positions DBH as a division within the larger agency of DHSS is the most efficient way to deliver and administer behavioral health services. Additionally, the Department funds community-based treatment and recovery services rather than providing the services directly. This structure spends approximately $44 less per capita nationally than states whose SMHA operate community-based systems.[131] The Department's structure of behavioral health administration and service delivery encourages financial and operational efficiency.

6.2.2. FINDING: The Department's reported administrative costs for behavioral health services are lower than national averages for state mental health authorities.

In FY 2013 the Department devoted 3.3% of behavioral health GF expenditures to behavioral health administration. In the same year, peer state mental health agencies reported an average of 3% of spending dedicated to administration. The nationwide average refers only to mental health administration, excluding substance abuse, while the Department's 3.3% includes both mental health and substance abuse administrative expenditures. While the comparison is inexact, the Department's administrative costs compare favorably with the national average when one considers that the Department administers both mental health and substance abuse services with nearly the same percentage of funds most agencies use to

[130] Assessment #10: Expenditures, NASMHPD, October 1, 2014.
[131] Ibid.

administer only mental health services. DHSS efficiently administers and manages behavioral health services relative to its peers.

6.2.3. FINDING: The Division of Behavioral Health's coordinated Medicaid and grant review process reduces auditing redundancy for both DHSS staff and behavioral health providers.

The Department utilizes a coordinated annual review process to evaluate behavioral health providers. These integrated behavioral health reviews are designed to meet the requirements of the Treatment and Recovery (T&R) Section to evaluate providers for program approval and the Medicaid and Quality Section (MQS) to perform audits for Medicaid program compliance. The comprehensive reviews provide the Department with a complete picture of the ability of each provider to meet grant requirements, the quality of services delivered, and the level of compliance with Medicaid policies and procedures. Each review requires an onsite visit. Previously, the reviews were conducted separately, with T&R conducting a review independent of the MQS review. Although T&R and MQS have different aims for their respective reviews, there exists overlap between the scope of the separate reviews. Thus, the consolidated review processes reduce auditing redundancy both for DHSS employees and the behavioral health providers under review. The integrated behavioral health reviews are more efficient than having T&R and MQS conduct separate reviews by reducing duplication of effort within the Department and decreasing the administrative burden placed on behavioral health providers.

6.2.4. FINDING: The Department's allotment of information technology (IT) resources specific to behavioral health enables DBH to support behavioral health service delivery more efficiently.

Although the Department's information technology structure struggles to meet the needs of behavioral health service administration, within DBH, dedicated information technology resources are available apart from the Department-wide shared IT resources that enables DBH to efficiently support behavioral health services. The Policy and Planning Section of DBH houses the management and development of Alaska's Automated Information Management System (AKAIMS). *AKAIMS* is a web-based application and database that serves as a management information system and contains elements of an electronic medical record. The system collects data needed by the Department to meet state and federal reporting requirements on utilization, prevalence, outcomes, and quality of care. Recently, DBH mandated the use of AKAIMS across all behavioral health providers, an initiative expected to be completed in July 2015.

The data collected by AKAIMS is analyzed and processed by employees within the Policy and Planning Section. The close collaboration required between the staff managing and developing AKAIMS and the personnel dedicated to reporting on and analyzing the data collected by AKAIMS is necessary to fulfill reporting requirements. This close collaboration is facilitated by the organizational position of AKAIMS within DBH, and specifically within the Policy and Planning Section. The Department's dedication of IT resources specific to behavioral health enables DBH to support behavioral health service delivery more efficiently.

6.2.5. FINDING: The development of the Office of Integrated Housing & Services has improved the ability of DHSS to provide more efficient management of housing resources within the Department, but increased support and collaboration are needed.

The Department's Office of Integrated Housing and Services (OIHS) has improved the ability of DHSS to manage housing resources more efficiently, but there continues to be a need for increased support and collaboration. Housing is a resource that spans numerous sub-agencies within the Department; the DBH, Alaska Pioneer Homes, SDS, and OCS all offer at least one variety of housing for consumers. Prior to the development of the OIHS there was no coordinated housing strategy across the Department. The diffusion of responsibility for housing services has contributed to inefficient management of these resources and inadequate housing opportunities available to the consumers served by the Department. Given the scarcity of affordable housing resources within the state and the importance of stable housing as a central factor in recovery, the Department cannot afford uncoordinated or suboptimal use of these precious resources.

The OIHS is intended to be an integrated DHSS housing resource that will support and guide the development of supportive housing and housing opportunities for consumers struggling with behavioral health issues. Currently there are four full-time employees dedicated to the OIHS, although one position is vacant.[132] The OIHS has the potential to increase the ability of the Department to meet the demonstrated need for supportive housing facilities through the development of a coordinated housing strategy that promotes the efficient use of resources. The OIHS requires additional stakeholder commitment and engagement from other department entities to be fully effective. The Department needs to increase the support provided to OIHS and opportunities or structures for collaboration between OIHS and the other relevant sub-agencies to realize its goal of efficient management of supportive housing facilities.

6.3. Administrative Staffing

6.3.1. FINDING: DHSS staffing for oversight of community behavioral health services is sufficient to support service delivery.

DBH has 14 permanent full-time staff devoted to the oversight of community behavioral health services. These employees are housed within the T&R Section of DBH. The administrative staff dedicated to the oversight of community behavioral health services are responsible for the following activities:

- Program approval;
- Grant review processes;

[132] "Integrated Housing & Services Unit, Division of Behavioral Health, Accessed June 1, 2015. http://dhss.alaska.gov/dbh/Pages/Initiatives/IntegratedHousing/Integrated-Housing-Services-Unit.aspx.

- Strategic distribution of grant funding to meet the community-based behavioral health needs of Alaskans;
- Technical assistance to grantee providers; and
- Management of Behavioral Rehabilitative Services (BRS) system.

The staff allocated to the management and administration of community behavioral health services is sufficient to support behavioral health service delivery. The resources dedicated to these tasks are adequate to provide effective oversight of services to optimize the Department's ability to meet the Alaskan population's community-based behavioral health treatment needs. There is no unnecessary resource availability in this area of behavioral health administration.

6.3.2. FINDING: Administrative staffing at API is consistent with average staffing patterns of state psychiatric hospitals nationwide.

There are 33 permanent full-time employees (FTEs) dedicated to administrative operations at API, out of a total of 336 FTEs. The administrative FTEs make up 9.8% of FTEs employed at API and account for 11.0% of total compensation. PCG works with inpatient hospitals across the country on cost reporting. Our clients include state medical and psychiatric inpatient psychiatric hospitals. The volume of personnel and staffing costs are consistent with average staffing patterns of state-operated inpatient psychiatric hospitals. The administrative staffing costs are proportional to the type of services and patients treated within API. For additional comparison, at the Clarinda Mental Health Institute – one of Iowa's four inpatient psychiatric facilities – 12% of total FTEs are administrative.[133] The staffing levels at API are on par with peer states and national norms, and are commensurate to the volume of services overseen.

6.3.3. FINDING: Staffing for prevention and early intervention (PEI) services is commensurate with the administrative capacities required for direct service delivery.

The PEI Section within DBH provides direct services to Alaskans. In FY 2015, the PEI Section contained 31 permanent fulltime employees and 21 nonpermanent employees. This level of staffing is commensurate with the capacities necessitated by direct service delivery of prevention services. The programs overseen and managed by this section are:

- *Alcohol and Drug Information Schools,* includes management of program approval and provision of trainings.
- *Alcohol Safety Action Program,* includes substance abuse screening and case management services.
- *Fetal Alcohol Spectrum Disorders* (FASD), includes management of the FASD Diagnostic Team Network and participation in the Alaska FASD Partnership.
- *Resiliency and Youth Development,* includes technical assistance, advising, and the provision of professional and public education.

[133] Clarinda Mental Health Institute Narrative, Iowa Department of Human Services, 2014.

- *Substance Abuse Prevention,* includes community-based grant programs.
- *Suicide Prevention*, includes the Community-Based Suicide Prevention Program, the Alaska Postvention Project, and suicide prevention trainings.
- *Tobacco Enforcement and Youth Education,* includes management of tobacco enforcement investigators, enforcement of tobacco laws, education of vendors, and partnerships with tobacco control community grantees.

Across these programs the PEI Section had over 1.2 million client contacts in FY 2014. Additionally, PEI staff is responsible for managing the Strategic Prevention Framework State Incentive Grant (SPFSIG), a grant program offered by SAMHSA to assist Alaska in preventing and reducing substance-abuse related problems. As the Department is the primary provider of behavioral health prevention, early intervention, and mental wellness promotion services across the state, the staffing counts are proportional to the quantity of services overseen. Staffing resources dedicated to PEI services are sufficient to meet the administrative need of these services.

6.3.4. FINDING: Overall administrative staffing is commensurate with the level of behavioral health service overseen by the Department.

In FY 2014 the Department had 343 permanent employees and 28 non-permanent employees within the DBH. The staffing dedicated to the administration of the Department is found within the following sections:

Table 6.1. DBH Administrative Staffing

Section	Permanent Staff
Administrative Support Team	14
Behavioral Health Director's Office	3
Policy & Planning Section	11

This level of staffing is commensurate to the operational and strategic oversight of behavioral health services administration within the Department. These staff resources available are sufficient to meet the administrative needs of DBH.

6.4. Recommendations for Improvements to Organizational Structure

6.4.1. RECOMMENDATION: As Medicaid plays an increasing role in financing the Department's behavioral health services, the Department should consider a thorough review of position descriptions and delineation of regulatory responsibilities in order to optimize Medicaid administrative reimbursement.

The Department should undertake a comprehensive and thorough review of each position. It would behoove the Department to have a detailed and accurate description for each staff position in order to capture all administrative costs eligible for a federal Medicaid match. With the gradual reduction of grant funding and the increasing financial role of Medicaid in supporting behavioral health services, the Department should undertake efforts to ensure that available federal match funding for Medicaid administrative costs are properly optimized. A clear delineation of the regulatory responsibilities across staffing rolls will enable the Department to maximize its Medicaid administrative reimbursement. See Section 12.2.1 for more information regarding this recommendation.

6.4.2. RECOMMENDATION: The consolidation of grant and Medicaid review responsibilities can reduce costs and administrative burden on providers, but only if reorganization does not conflict with Medicaid administrative claiming processes or dilute the Department's regulatory role.

The Department currently conducts integrated reviews within the MQS and T&R sections. This structure is cost efficient in two ways. First, it reduces administrative costs to the Department by minimizing redundant audit and review processes. Second, it reduces the administrative burden on providers and reduces the resources required to meet audit requirements, thereby allowing more grant funding to be devoted to the provision of services. In spite of these advantages, there is also a danger of jeopardizing Medicaid administrative claiming by conflating Medicaid-reimbursable and non-reimbursable activities. For this reason, the Department should closely evaluate any proposed reforms to the review process to determine its impact on Medicaid administrative claiming processes and the Department's Medicaid regulatory role. The Department will have a lower risk of a federal Medicaid audit by CMS if there are clearly demarcated Medicaid administrative employees and positions. Currently T&R reviews program quality and service delivery and MQS evaluates regulatory compliance, a distinction discussed more extensively in Section 13.1.4. The blending of the review processes potentially blurs these responsibilities and is a possible risk to the integrity of the Department's Medicaid administrative claiming and regulatory processes.

7.0. BUDGET REDUCTIONS

Determine if the Department's proposed behavioral health budget reductions are supported by the performance review, including whether DHSS complied with AS 44.66.020(c)(2) when proposing cuts to behavioral health services. Compare the agency's priorities submitted to the legislature under AS 37.07 with the list of programs identified for reduction. Identify any areas in which the reductions are not aligned along service priorities and include a rationale for conclusions. This should address the following:

A. Do the proposed reductions represent a good faith effort by the Department to identify behavioral health related areas that can be reduced without compromising the Department's ability to meet its mission in regards to behavioral health?

B. Are the reductions recommended by the Department in response to AS 44.66.020(c)(2) consistent with results derived from the review of each applicable objective within this Scope of Work?

C. Did work on any of the review objectives within this scope of work reveal other potential areas that could be subject to a budget reduction without inhibiting the ability of the Department to fulfill its mission in regards to behavioral health?

7.1. Good Faith of Department Budget Reduction Proposal

7.1.1. FINDING: The Department did not respond to the Legislature's request for proposed budget reductions in a timely fashion.

The legislation mandating departmental review requires that agencies under review submit proposed budget reductions as described in AS 44.66.020(c)(2). The statute states the agency under review must submit the proposed budget reductions "before November 1" in the year prior to the year of the review.[134] The Department did not respond to this statutory request for proposed budget reductions in a timely fashion. DHSS submitted the requested budget reductions on February 25, 2015. While the Department delivered a list of proposed budget reductions to the Legislature, it did not comply in accordance with the requested timeline.

[134] Alaska Statute Title 44, Chapter 66.

7.1.2. FINDING: The Department did not submit a proposal of 10% reductions for the Legislature. Instead, it offered a proposal for reductions drafted originally in response to the Governor's request for 5% and 8% program reductions. The total amount of proposed reductions for behavioral health services is below 10%.

Alaska Statute 44.66.020(c)(2) asked the Department to submit to the Legislature "a list of programs or elements of programs that compose at least 10 percent of the general funds in the agency's budget appropriated from the general fund that could be reduced or eliminated."[135] The Department did not provide the Legislature with proposed 10% budget reductions and instead submitted proposed reductions drafted originally in response to the Governor's request for 5% and 8% budget reductions. Within its response, the Department offered reductions of approximately $50 million.[136] In the FY 2015 Management Plan the Department expended approximately $1.254 billion of Unrestricted General Fund (UGF) dollars.[137] Thus the Department's proposed reductions amount to only 4.0%, falling short of the 10% requested by the Legislature. The proposed behavioral health services budget reductions amounted to only 2.4% of UGF behavioral health expenditures in the FY 2015 Management Plan.

Table 7.1. Budget Reductions Percentage

Type	Proposed Budget Reductions	FY 2015 Management Plan UGF	% of FY 2015 Management Plan UGF
DHSS Total	$49,806,200	$1,253,650,000	4.0%
Behavioral Health Services	$1,906,000	$78,695,600	2.4%

7.1.3. FINDING: In keeping with AS 44.66.020(c)(2), the proposed reductions represent a "good faith effort" because the Department identified General Fund expenditures for behavioral health services that could be reduced and refinanced through federal sources without compromising the Department's ability to meet its mission in regard to behavioral health. Nevertheless, the Department's submission was unresponsive to the specific terms of the statutory request.

Although the Department did not comply with the exact terms of the statutory request for budget reductions, DHSS acted in a "good faith effort" to identify behavioral health related areas capable of sustaining budget reductions without compromising its ability to meet its mission with regards to behavioral health. The Alaskan Statutes include at least three definitions of "good faith." "Good faith" is defined as:

- "*Good faith* means honesty in fact in the conduct of the transaction concerned." (AS 34.03.360)

[135] Ibid.
[136] Draft Change Record Summary, Alaska Department of Health and Social Services, February 25, 2015.
[137] Department Totals – Operating Budget, Alaska Department of Health and Social Services, March 19, 2015.

- "*Good faith* means reasonable reliance on fact, or that which is held out to be factual, without the intent to deceive or be deceived and without reckless or malicious disregard for the truth." (AS 23.10.699)
- "*Good faith* means honesty in fact and the observation of reasonable commercial standards of fair dealing in the trade." (AS 45.25.990)

These references to good faith define it as the honest presentation of information without intent to deceive the recipient of the information believed to be true. In its response to AS 44.66.020(c)(2), the Department did not intend to deceive the Legislature. The Department responded to the request with the reductions believed to be possible without compromising the integrity of its programs and ability to meet its mission with regards to behavioral health. When submitting its response to the Legislature, the Department did not claim that the reductions amounted to 10% and clearly indicated that they were taken from the FY 2016 Governor's Amended Budget.

The Department's response to AS 44.66.020(c)(2) represents a "good faith effort" to comply with the Legislature's request. The Department identified the UGF behavioral health expenditures it believed could be reduced or refinanced without compromising the ability of the Department to meet the behavioral health needs of Alaskans. Although the Department's response was noncompliant with the specific terms of the statutory request, it does represent a "good faith effort" to comply.

7.2. Consistency with Findings

7.2.1. FINDING: The Department's proposed budget identifies approximately $1.9 million in budget reductions related to the delivery of behavioral health services.

The Department's proposed budget reductions are spread across all results delivery units (RDUs). The total value of proposed reductions is approximately $50 million. The reductions related to the delivery of behavioral health services include the following items related to behavioral health services:

Table 7.2. Behavioral Health Proposed Budget Reductions

Results Delivery Unit	Component	Description	Amount of Reduction
Behavioral Health	Behavioral Health Treatment and Recovery Grants	Reduce behavioral health treatment and recovery grants through equitable distribution; shift clients to Medicaid	$1,558,700
Behavioral Health	Alaska Psychiatric Institute (API)	Delete API Medical Director	$347,300
		Total:	$1,906,000

As seen above, the proposed reductions submitted to the Legislature include $1,906,000 related to the delivery of behavioral health services.

7.2.2. FINDING: A review of each proposed impact shows that the cumulative consequences of the proposed budget reductions are unlikely to compromise the Department's ability to meet its mission in regard to behavioral health.

The Department derived its budget reductions for behavioral health services from two specific components, behavioral health treatment and recovery grants (BHTRG) and API. The reductions in these areas are unlikely to compromise the Department's ability to meet its stated mission in regard to behavioral health: "to improve the quality of life of Alaskans through the right service to the right person at the right time."[138] The reductions to BHTRG will be mitigated by shifting clients to Medicaid-reimbursable services, subsequently preserving the availability of treatment and recovery services to Alaskans. Similarly, the proposed API reductions are unlikely to have substantial negative impact on the Department's ability to provide behavioral health consumers with appropriate care. The $347,300 in reductions will be achieved by eliminating the position of medical director, a position which has remained vacant since December 2014. Provided other administrative and executive staff can absorb the duties of the medical director, this reduction should not have a direct effect on patient care. Overall, although the reductions represent 2.4% of the FY 2015 Management Plan, the proposed cuts are unlikely to compromise the Department's ability to meet its mandate with regards to behavioral health.

7.2.3. FINDING: The Department's proposed $1.6 million in budget reductions for BHTRGs are unlikely to impair behavioral health services substantially, because reductions are spread proportionately across services and providers, and are drawn primarily from lapsed funding amounts derived from the previous fiscal year.

The BHTRG program funds a wide array of behavioral health services, including outpatient mental health and substance abuse treatment programs, crisis intervention services, case management and residential support services, and therapeutic assessment services. The BHTRG funds are distributed to behavioral health providers to treat consumers with serious mental illness (SMI) and substance use disorders (SUD), as well as children and youth with behavioral health developmental disorders and severe emotional disturbances. The Department has proposed $1,558,700 of cuts to BHTRG funding.

To enact the proposed budget reductions to BHTRG funds, the Department will "implement cuts to agencies based on lapsed funds for the previous year and the success of agencies in efficiently using their funds."[139] In conjunction with this cut, the Department intends to shift clients to appropriate Medicaid-reimbursable services through planned Medicaid transformation efforts. This two-pronged strategy minimizes the negative impact of budget cuts on consumers by eliminating the allocation of funds unused, or lapsed, in FY 2015, and by maximizing Medicaid behavioral health service utilization. Thus, the Department ensures funding remains stable for the most highly utilized and crucial grant-funded behavioral health services.

[138] "Division of Behavioral Health," Alaska Department of Health and Social Services, Accessed June 25, 2015. http://dhss.alaska.gov/dbh/Pages/default.aspx.
[139] Fiscal Year 2016 Governor's Amended Budget, *DHSS FY 2016 Governor's Amended Budget Book*, p. 115.

Additionally, DHSS hopes to rely on its Grant Equitable Distribution (GED) System to identify providers ineffectively and inefficiently using grant funds, and reducing the BHTRG funds granted to those providers. This merit-based system maximizes the value of the BHTRG funds distributed and prevents any one consumer population from being unfairly impacted by enacting cuts across the entire BHTRG program. The proposed BHTRG budget reductions are unlikely to impair substantially the quality or quantity of behavioral health services funded and delivered by the Department.

7.2.4. FINDING: The Department's proposed $347,300 in budget reductions to the Alaska Psychiatric Institute consist of the elimination of the hospital's medical director position. Assuming that staffing levels are maintained for service staff and the functions of the medical director are able to be distributed effectively to remaining administrative staff, the review does not anticipate service delivery at API to be substantially impaired.

The Department's proposed $347,300 in budget reductions to the UGF funds allocated to API are derived from the elimination of the hospital's vacant medical director position from the budget. Public Consulting Group (PCG) evaluated API's administrative staffing levels in Section 6.0 and found them to be in line with national norms. Provided that the Department maintains its current administrative and operations staffing levels, the functions of the medical director are in principle able to be absorbed by the remaining administrative staff. In many cases, the administrative responsibilities of the medical director can be assumed by the chief of psychiatry, the chief medical officer, and other executive staff. It should be noted, however, that PCG has not reviewed API's specific plans for transitioning the functions of the medical director.

7.2.5. FINDING: The Department also proposed $20 million in budget reductions to be achieved through unspecified Medicaid cost containment measures. Although these reductions presented by the Department are not specific to behavioral health services, these proposed reductions would likely affect behavioral health services.

As part of its proposed budget reductions provided to the Legislature, the Department proposed $20,000,000 of cuts to be achieved through unspecified Medicaid cost containment measures. While the Department did not identify specific services to be affected by these reductions, it is likely that these proposed reductions would affect behavioral health services. If the Medicaid cost containment measures are spread out across the full spectrum of Medicaid services, behavioral health services will not be unduly affected. Discussion with Department officials leading the State's Medicaid transformation and expansion efforts suggested in interview that these cost containment efforts would largely consist of improved fraud, waste, and misuse reduction efforts, which have also been identified by PCG as areas for potential cost savings and cost avoidance in Section 13.0. In particular, officials indicated that tightened language around Medicaid regulations for behavioral health residential support services (RSS) would be a prominent part of heightened

cost containment efforts.[140] However, without an understanding of the Department's regulatory changes to behavioral services or its other planned cost containment initiatives, it is impossible to determine what proportion of the $20,000,000 in proposed cuts will be applied to behavioral health services. PCG is thus unable to conclude in any further detail what the impact on behavioral health services will be.

7.2.6. FINDING: The list of reductions presented by the Department is consistent with opportunities for potential cost savings and cost avoidance identified in the review.

The reductions proposed by the Department are in part achieved by shifting clients served by grant-funded services to appropriate Medicaid-reimbursable services and by enacting Medicaid cost containment strategies. These strategies for cost savings are consistent with the opportunities identified during this review. Maximizing the value and efficiency of Medicaid-reimbursable services is a key way to reduce costs. Reforming the Medicaid program to allow more services and consumers to be financed through matching Medicaid dollars over GF grant dollars is consistent with opportunities identified by PCG, as well as implementing cost containment strategies to direct the growth of the Medicaid program. These sources of reduction—or in some cases, mitigation of the negative impact of reduction—proposed by the Department include methods also identified to stretch GF monies as far as possible.

7.3. Other Opportunities for Reduction

7.3.1. FINDING: The results of the performance review have not indicated that alternative programmatic elements should be targeted for further budget reductions. However, the review has yielded recommendations suggesting that further cost savings can be achieved in the form of revenue enhancement opportunities that utilize additional local and federal funding sources. The review has also identified potential cost efficiencies to be gained through reforming grant and contract administration and improving Medicaid program integrity functions.

This performance review has not yielded any additional programmatic elements to be targeted for further budget reductions. As mentioned previously, the reductions proposed by the Department are consistent with PCG's analysis of cost saving opportunities. The review team did not identify other reductions that could be feasibly implemented without compromising the ability of the Department to meet its mission with regards to behavioral health. However, the review has generated recommendations for cost savings that could be achieved by utilizing additional local and federal funding sources, as discussed more extensively in Section 3.0. There is also potential for additional revenue through collaboration with federal partners, such as tribal entities and the Veterans Affairs Healthcare System. Section 10.0 addresses these areas for cost collaborations in more detail.

[140] The review specifically addresses the opportunity to contain costs by improved regulation of RSS billing in Section 13.0.

Additionally, the review identified potential cost efficiencies to be achieved through reforming grants and contract administration and Medicaid program integrity functions. There are currently no benchmarks or metrics evaluating administrative costs and efficiency of behavioral health grant administration, and a reform of that process, combined with further administrative streamlining, could yield additional cost savings for the Department. Although none of the opportunities identified by PCG in this arena are likely to produce a windfall of new revenues or savings, cumulatively, they have the potential for creating efficiencies sufficiently robust, at least, to offset anticipated budget reductions by the Department. These recommendations are discussed more extensively in Section 9.0. Improving Medicaid program integrity efforts would also yield significant cost savings for behavioral health service delivery and administration. PCG estimates multi-million dollar savings are possible through improving fraud, waste, and abuse regulatory efforts. That prospect is addressed in detail in Section 13.0.

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8.0. INFORMATION TECHNOLOGY

Evaluate whether the Department's use of information technology effectively supports the various behavioral health programs and services. The evaluation should assess the extent DHSS can track and report on benefit recipients, including the extent recipients are receiving multiple benefits and whether recipients are Medicaid eligible. As applicable, the evaluation should recommend new types and uses of technology to improve efficiency and effectiveness in line with recognized best practices. Recommendations should include a justification that benefits outweigh costs. The review team will exclude the recently implemented Medicaid Information System, which will be certified by the Centers for Medicaid and Medicare Services (CMS) upon full implementation. This should address the following:

A. Does the Department utilize technology to effectively and efficiently deliver and administer behavioral health services?

B. Does information technology allow the Department to track and report on benefit recipients, including the extent recipients are receiving multiple benefits and whether recipients are Medicaid eligible?

C. Are there areas where the Department could utilize technology best practices to improve the effectiveness or efficiency of such services? What are the potential savings or costs to the Department if it adopts a recommended technology or best practice? What is the net benefit to the Department by adopting a recommended technology or best practice?

D. What are the estimated long-term maintenance costs for the technology or best practice identified?

8.1. Effectiveness and Efficiency of Use of Technology

8.1.1. FINDING: The Department's use of information technology systems is consistent with standard practices across state mental health agencies nationwide.

Across the nation behavioral health providers lag behind the majority of the medical hospitals and professionals in adoption of health information technology. The expansion of the Affordable Care Act and availability of financial incentives and technical assistance to implement health information technology has spurred the behavioral health community to hasten its usage of health information technologies.

DHSS uses the Alaska Automated Information Management System (AKAIMS) to collect data across the state-funded behavioral health system. While some providers use AKAIMS as an electronic health record (EHR), many use a separate EHR as well. Nationwide, only five states have a single EHR across state

psychiatric hospitals and community-based providers, while 42 have separate systems.[141] Additionally, Alaska and 36 of its peers do not set specific standards or requirements for EHRs used by inpatient or community-based providers, while only 12 have such standards in place. The integration of mental health and substance abuse information technology is also standard practice; 35 states have combined mental health and substance abuse information technology, while 12 do not. The characteristics of behavioral health information technology systems are summarized in the table below.

Table 8.1. State Behavioral Health IT Characteristics 2013

State Mental Health Agency (SMHA) Survey Question	States Reporting 'YES'	States Reporting 'NO'	Alaska
Have state psychiatric hospitals implemented EHR?	26	13	No
Is a single EHR used for both state hospitals and community mental health?	5	42	No
Does your SMHA set standards or have requirements for state psychiatric hospital and/or community mental health EHRs?	12	37	No
Are EHRs used in state psychiatric hospitals hosted centrally by the SMHA?	14	21	No
Is EHR client data between community providers and state hospitals?	11	31	No
Do consumers have access to their own EHR data via the SMHA?	7	36	No
Is substance abuse and mental health IT combined?	35	12	Yes

The Department's use of information technology for behavioral health service is aligned with standard practices across state mental health agencies nationwide. The regulation of EHRs used by providers, the integration of health information technology across both hospital and community-based providers, and the data sharing practices are all consistent with nationwide behavioral health information technology practices.

8.1.2. FINDING: Costs incurred by the Department for information technology personnel and systems are reasonable in comparison to peer agencies in other states.

AKAIMS is the information technology system specific to behavioral health. It is important to note that the Medicaid Management Information System (MMIS) is also used by behavioral health providers but is excluded from the scope of PCG's review. The Department's expenditures on AKAIMS personnel, maintenance and management are reasonable in comparison to other state mental health agencies. The Department's FY 2013 budget for behavioral health information management ranked 19th out of 42 agencies reporting. Additionally, the original cost of AKAIMS ranked ninth out of the 17 agencies reporting costs. This trend extends to AKAIMS training costs, which ranked fifth out of 12 agencies reporting that figure.

[141] The statistics cited in this section are drawn from the NRI database.

The number of permanent employees devoted to behavioral health information technology was also aligned with nationwide averages, with DHSS ranking 20th out of 46 agencies reporting.

While there is variation in the characteristics of the SMHA data systems, there were no identified over- or under-expenditures regarding behavioral health information technology management. The Department's expenditures for behavioral health information technology are reasonable when compared to other SMHAs across the country.

8.1.3. FINDING: The Department's primary data platform for community-based services, AKAIMS, is capable of collecting metrics needed to support behavioral health programs and services.

Community-based service providers are required to submit data and information to the division through the web-based AKAIMS system, which serves as the primary data platform. The data required is known as the *minimum data set* (MDS) and is determined by the Division of Behavioral Health (DBH). It includes the Client Status Review and Alaska Screening Tool modules. AKAIMS has the capability to be used as a limited-functionality EHR, which is beneficial to many smaller behavioral health providers in the state that could not otherwise afford to implement an EHR. AKAIMS is built on the Web Infrastructure for Treatment Services (WITS) platform, a system designed for grant reporting functions. A handful of other state behavioral health agencies have also implemented open-source and supported versions of the WITS platform.

AKAIMS is effective as a management information system reporting tool and allows the Department to meet state and federal reporting requirements. The WITS platform was specifically designed to capture client treatment data and satisfy these mandatory government reporting requirements for inpatient and outpatient behavioral health treatment programs, prevention programs, problem solving courts, and grant management programs. It is an adaptable system which can be modified to accommodate additional or shifting requirements. Currently, AKAIMS collects data from the following programs and services:

- Alaska Psychiatric Institute (API)
- Community-based mental health and substance abuse treatment providers;
- Alcohol Safety Action Program (ASAP);
- Private behavioral health providers that receive referrals from ASAP;
- Fetal alcohol spectrum disorder (FASD) diagnostic teams;
- Behavioral Rehabilitation Services (BRS) residential service providers;
- Therapeutic courts;
- Individualized Service Agreements (ISA);
- Department of Corrections (DOC) substance abuse services.

There are no inherent structural barriers to prevent AKAIMS from collecting the metrics needed by the Department to support behavioral health services effectively. The system has the ability to collect the outcome measures, demographic data, clinical information, and utilization statistics necessary to meet state and federal reporting requirements, and to facilitate the planning, administration, and monitoring of inpatient and community-based behavioral health services.

8.1.4. FINDING: AKAIMS is administratively burdensome and requires double entry from many service providers, including API.

While AKAIMS is capable of collecting the metrics needed to monitor behavioral health services, it cannot deliver the full spectrum of health information technology services desired by many providers, such as clinical productivity management. Many providers choose to use a separate EHR to harness enhanced functionality that AKAIMS lacks, in spite of grant requirements that mandate data entry into AKAIMS. Because the Department is unable to aggregate data from other information technology systems, many providers have opted to use their chosen EHR in the client encounter, even at the cost of duplicating effort by entering the MDS into AKAIMS at a later time.

Many providers employ multiple full-time employees solely for the purpose of data entry into AKAIMS. Even API, a part of the Department, devotes personnel resources to AKAIMS double data entry. The pervasiveness of this practice suggests that AKAIMS is a cumbersome and administratively burdensome system. For this reason, AKAIMS places significant administrative burdens on community-based service providers as well as API. Double data entry is a time-consuming and cumbersome process that provides value to the Department rather than to the providers expending time and financial resources to conduct the data entry.

8.1.5. FINDING: Although AKAIMS' EHR functionality provides considerable benefit to behavioral health providers who could not otherwise afford it, the use of AKAIMS as an EHR also impedes provider efforts to integrate behavioral health and primary care services.

The primary purpose of AKAIMS is to collect the MDS from behavioral health providers. It also has optional expanded functionality as a fully Health Insurance Portability and Accountability Act (HIPAA) compliant EHR. The Department offers AKAIMS to all providers free of charge, regardless of whether they opt to use it as an EHR. This practice benefits small providers who would otherwise be unable to afford an EHR. However, the functionality of AKAIMS as an EHR is ancillary to its primary purpose as a management information system. Although it meets the criteria for an EHR, it has only the minimum EHR functions and lacks useful features such as the ability to distinguish between a child, adolescent, and adult client record. Additionally, the EHR capabilities of AKAIMS are specific to behavioral health services. AKAIMS cannot be used as an EHR for other health care services.

This limitation presents an impediment to behavioral health–primary care integration. For small providers this limitation prevents behavioral health–primary care integration because they would need to use an alternate EHR, or manual record system, for primary care services, presenting considerable financial and resource barriers. AKAIMS' ability to serve as a limited-function EHR benefits certain behavioral health providers while simultaneously posing a barrier to system-wide behavioral health–primary care integration.

8.1.6. FINDING: The data architecture underlying the AKAIMS system was designed for grant management and is structurally limited in its capacity to meet Medicaid billing requirements.

The AKAIMS system was designed for grant-funded services and is inadequate to meet Medicaid billing requirements. According to sources in other state behavioral health agencies where WITS has been implemented, the WITS platform is unable to roll-up or combine services provided on the same day into one line item. The ability to roll-up same day services is a requirement for fee-for-service claiming and precludes AKAIMS from being able to support a Medicaid billing module. Furthermore, the data architecture for rounding in WITS is inconsistent with the 15-minute intervals typical of Medicaid billing systems. This inconsistency presents a large hurdle to AKAIMS ever being adapted for use as a Medicaid billing system. AKAIMS is designed for grant-funded system management and does not have the capacity to meet Medicaid billing requirements.

8.1.7. FINDING: Community behavioral health providers currently report data on multiple platforms, creating significant administrative challenges to accurate reporting and analysis.

Currently, community behavioral health providers report data to the Department on multiple platforms. The majority of provider agencies now submit data using the AKAIMS system, yet there are three which continue to supply data through the Electronic Data Interface (EDI). *EDI* is a legacy system that enables providers to submit data from a non-AKAIMS information management system. EDI has a different data architecture than AKAIMS, and the data submitted to the Department through EDI is stored in separate databases. Likewise, the reports designed for EDI data must be created using a separate logic from those designed for AKAIMS data. As a consequence of the different underlying architectures, DHSS staff must process AKAIMS and EDI separately in order to conduct any comprehensive system-wide analyses.

The existence of these disjointed reporting mechanisms poses significant obstacles to the Department's ability to accurately report and analyze the behavioral health data it collects. Operating parallel systems also precludes the automation of report generation, impeding the Department's ability to conduct system-wide analysis and research, and potentially undermining data fidelity. Furthermore, the numerous additional steps required to generate a comprehensive report limits the Department's ability to respond to legislative requests in a timely manner. The submission of community behavioral health data through two different platforms poses substantial challenges to accurate reporting and analysis. See Section 8.3.3 for a recommendation related to this finding.

8.1.8. FINDING: The Department adequately supports stakeholders implementing state-mandated behavioral health IT systems.

The Department provides sufficient support to the agencies and providers using AKAIMS. There are three full time employees within the AKAIMS subsection of DBH. These individuals are responsible for training

and supporting AKAIMS users across the behavioral health system, as well as for maintaining and updating the system. The WITS platform is regularly and continuously updated by FEI Systems, the contractor who supplied it initially. In its efforts to support its stakeholders and ensure AKAIMS functions optimally, AKAIMS staff conduct quality assurance processes on new updates, identify bugs, and only incorporate version updates into AKAIMS that are fully vetted and functional. These efforts form an underlying layer of support that safeguard the Department's ability to provide the most capable and informed support possible to the AKAIMS user group. By testing and choosing which WITS updates to apply to AKAIMS, the Department strives to ensure the behavioral health information technology meets the needs of the stakeholders and is buttressed by competent support staff.

The behind-the-scenes information technology support is complemented with direct user support delivered to stakeholders across the behavioral health system. The AKAIMS subsection of DBH uses the following methods to train and support users:

- 24/7 telephone support;
- Online support repository of training videos and process documentation;
- Twice-monthly user group meetings;
- Ongoing technical assistance.

The AKAIMS staff rely on all possible resources to provide support to their users. AKAIMS stakeholder support has improved significantly in recent years. With the limited time and budgetary resources available the AKAIMS staff attempt to meet the information technology support needs of its user group. As many behavioral health providers operate outside of normal business hours, to meet the goal of providing sufficient customer service and support AKAIMS staff chose to supply users with personal telephone numbers for after-hours support. Additionally, the Department hosts twice-monthly user group meetings. These meetings are specific to the AKAIMS user types, with separate meetings for users of the MDS and users of the expanded EHR functionality. These meetings allow stakeholders to ask questions, and are opportunities for DBH employees to inform users of changes and updates.

The Department is mostly effective at supporting AKAIMS users and stakeholders. The DBH staff support the behavioral health information technology stakeholders by providing many avenues for customer service and technical assistance, and by ensuring ongoing monitoring and maintenance of the AKAIMS system. While the user group meetings are adequate means of notifying stakeholders of changes, the Department can improve upon its methods to clearly communicate changes to the MDS and other system updates.

8.1.9. FINDING: The Department supports and facilitates effective use of IT for telebehavioral health services.

The vast geography of Alaska poses a significant challenge to the Department's ability to provide services statewide. Telebehavioral health services are an important tool in surmounting that challenge, addressing one of the key cost drivers for services in the state and enabling services to be delivered regardless of geographic distance and local behavioral health workforce availability. The Department has effectively supported and promoted the use of telebehavioral health services to meet the behavioral health needs of

Alaskans across the state. Alaska is among eight states and the District of Columbia that receive the American Telemedicine Association's highest ranking for telebehavioral health services.[142]

In 2010, the Alaska Medicaid program began reimbursing providers for telebehavioral health services. The Medicaid regulations provide clear and concise guidelines regarding the reimbursement policies for telebehavioral health services. Whereas other states restrict coverage to services delivered via live video conference, the Alaska Medicaid program pays for telebehavioral health services that are delivered using live audio or video transmission, store-and-forward transmissions[143], and home self-monitoring.[144] Alaska is one of only 10 states that provide Medicaid reimbursement for store-and-forward transmissions, and one of 13 that reimburse for home self-monitoring.[145] The following behavioral health services are reimbursable by Medicaid when delivered via telehealth technology:

- Psychiatric or substance abuse assessments;
- Consultation to confirm diagnosis;
- Initial or follow up office visits;
- Individual psychotherapy;
- Individual medication management;
- Diagnostic, therapeutic, or interpretive services.

The Department reimburses behavioral health Medicaid providers for the above services. Additionally, the Alaska Medicaid regulations do not restrict telebehavioral health reimbursement by service setting.[146] The Department does not define specific patient settings allowed for a telemedical encounter. This policy facilitates the use of telebehavioral health services in rural and remote communities which have limited medical service settings.

Moreover, the API operates the Frontline Remote Access Clinic (FRAC), a telebehavioral health services initiative that was opened in 2010. The FRAC provides access to behavioral health consultation and treatment services for primary care and behavioral health providers in remote communities. Remote providers must have videoconference connectivity to schedule an appointment. Scheduling an appointment for a consumer merely requires the provider to request an appointment via telephone, and complete and fax the required clinical, referral, and patient documentation forms to FRAC. FRAC offers child, adolescent, and adult behavioral health services. To fill staffing needs, the FRAC partners with Seattle Children's Hospital for psychiatric professionals. Additionally, API operates the API Telebehavioral Health Clinic. This virtual clinic serves larger health care providers throughout the state. Providers enter a formal long-

[142] State Telemedicine Gaps Analysis: Coverage and Reimbursement, American Telemedicine Association, May 2015.
[143] Store-and-forward is a telecommunications technique in which data is sent to an intermediate station, stored, and forwarded at a later time to another intermediate destination or to the final destination. This technique is commonly used in networks with intermittent connectivity.
[144] Self-monitoring is a method by which the patient is monitored in his or her home via a telehealth application and the provider is indirectly involved from another location.
[145] State Telehealth Policies and Reimbursement Schedules: A Comprehensive Scan of the 50 States and the District of Columbia, Center for Connected Health Policy, September 2014.
[146] State Medicaid Best Practice: Telemental and Behavioral Health, American Telemedicine Association, August 2013.

term agreement that allows them to access API psychiatric staff via telemedical technology during designated hours.

Within the Department, DBH is recognized as a leader in telehealth services. DBH operates the most developed system of telehealth care within DHSS and the behavioral health network includes over 200 sites.[147] The Department, spearheaded by DBH, effectively supports and facilitates the use of information technology for telebehavioral health services.

8.1.10. FINDING: The Department's Grants Electronic Management System (GEMS) is effective at supporting behavioral health grant awards.

The Department uses a single web-based grant management system for all sub-agencies. GEMS is used by the Grants and Contracts section of Finance and Management Services to manage grants and contracts with a standard process across disparate divisions and departments. Department employees and grant recipients have access to the GEMS system. Through GEMS, grant managers and administrators can conduct the following activities:

- Post solicitations;
- View grant applications;
- Manage grant payments;
- Track grantee performance metrics; and
- Monitor grantee reporting.

GEMS is an effective mechanism for the Department to manage behavioral health grant awards. It provides the tools necessary to post grant opportunities, track awards, monitor grantee performance, and conduct general grant management activities. GEMS also meets the needs of grantee programs and agencies. Through GEMS, grant recipients are able to:

- Find grant opportunities and solicitations;
- View public notices;
- Submit grant proposals and applications;
- Track payment;
- Update agency and program information; and
- Revise grant budgets.

Grant recipients are able to use GEMS to meet the departmental requirements of grantees, including budget and performance reporting, submitting applications, and viewing public notices and amendments. PCG finds that GEMS is an effective grant management system that enables the Department to support behavioral health grant awards by facilitating the efficient management and administration of grant awards.

[147] Annual Report, Alaska Department of Health and Social Services, 2014.

8.2. Recipient Tracking and Reporting

8.2.1. **FINDING**: The Department's information technology systems have the capability to track and report on benefit recipients.

The Department uses multiple information technology systems to manage and administer behavioral health services. The primary system is AKAIMS. Additionally the Department uses MMIS to manage Medicaid-reimbursable behavioral health services. The data systems used by the Department have the capability to track and report on benefit recipients. There is 100% penetration of these systems among providers within the public behavioral health system. Although not all providers are enrolled in the Medicaid system, every provider receiving grant funds from the Department is required to submit data through AKAIMS.[148] Thus, every provider reports data to the Department through AKAIMS and every Medicaid enrolled provider also submits data through administrative claims within the MMIS.

Between the AKAIMS and MMIS data management systems, the behavioral health information technology systems have the capability to track utilization of behavioral health services. Provided that the Department utilizes the full functionality of each system and accurately identifies the relevant data to be included in AKAIMS' MDS, the Department is able to track and report on benefit recipients effectively.

8.2.2. **FINDING**: Ad hoc tracking and reporting of benefit recipients is minimally effective.

The Department collects data across the behavioral health system to meet state and federal reporting requirements, respond to legislative requests, and facilitate the review of utilization and performance. DBH research staff have delineated the process for generating certain reports, but there is nonetheless a widespread lack of automation throughout the data tracking and reporting processes. Because evolving data collection policies and reporting requirements have contributed to a lack of automated reporting processes, much of the reporting on the beneficiaries of behavioral health beneficiaries continues to be ad hoc.

This problem is particularly acute with respect to the tracking of utilization of prevention services. The division relies on a time-intensive manual process to develop reports on behavioral health prevention services. DBH struggles to collect standardized quarterly reports from prevention grantees. Each grantee submits the required worksheets to DBH but they are often completed with different data structures. Upon receipt of this disorganized and non-aligned data DBH research staff manually clean the data and consolidate it into Microsoft Access databases to meet federal reporting requirements. This process lacks any automation; each quarter requires a resource-intensive initiative to report on the prevention data. Subsequently, DBH performs few analyses on this information due to the resources required to conduct

[148] There are a small number of providers who have yet to transfer to AKAIMS, but it is a department requirement that providers submit the required data through AKAIMS.

them, resulting in an underutilization of available research data and ineffective tracking of recipients of behavioral health prevention services.

A second area of inefficiency in reporting is the performance-based funding (PBF) system. Since the inception of PBF, the division has annually altered the metrics by which grantees are evaluated. Although required by the Legislature to evaluate grantee performance, the specific measures evaluated are at the discretion of DBH. These annual shifts have precluded research analysts from developing automated processes for completing PBF monitoring and reports. Instead, staff must develop novel PBF reporting procedures every year. While the reports are sufficient to meet the needs of the Department, they are developed through an unnecessarily inefficient and time-intensive process.

Furthermore, manual reporting processes are the norm for treatment and recovery grantee providers, the group of service providers that provide the majority of community-based behavioral health services. This process relies on data from the grant database, MMIS, and AKAIMS systems. The reporting process differs by type of service provided. While the reporting processes for some services are clearly defined, for others the process requires manual input. For example, the reporting on substance abuse outpatient services requires DBH research analysts to align the different data elements that describe the program type in each of the three systems. The need for additional resources to complete these reporting processes diminishes the effectiveness of the Department's behavioral health tracking and reporting.

The Department engages in resource-intensive tracking of behavioral health service recipients. These ad hoc, manual reporting procedures are minimally effective. The belabored steps required to complete this reporting inhibits the Department from optimally utilizing and analyzing the data collected to administer and manage behavioral health services. For a recommendation related to this finding, see Section 8.3.1.

8.2.3. FINDING: The Department's ability to generate unduplicated counts of benefit recipients is uncertain and beset with administrative inefficiencies.

The ability to report on unduplicated counts of benefit recipients is central to effective management of behavioral health services. Unduplicated counts of service recipients enable administrators and research analysts to determine the quantity of services received by each unique individual. Consumers may receive behavioral health services through multiple providers, and it is essential for effective utilization and financial tracking that the data system be able to associate each separate encounter with the same consumer.

Currently, the ability of DBH to generate these unduplicated counts of behavioral health service recipients is hampered by discrepancies between two distinct data collection systems. Until recently, the reporting logic failed to query properly the data collected through the AKAIMS system in a way that would facilitate the generation of unduplicated counts of recipients. A focused effort on the part of DBH research staff to reform the suite of reports and queries used have rectified this issue and the division is now able to report on unduplicated counts of recipients seen by providers entering data through AKAIMS. However, due to the existence of the secondary data collection method through the EDI interface, DBH remains unable to generate unduplicated counts of behavioral health recipients seen across the entire system. There is no way

to identify a unique client within the EDI database. The underlying architecture of EDI differs from that of AKAIMS, and the data points collected through EDI do not include unique client identifiers.

The Department is unable to report on unduplicated counts of consumers of behavioral health services. The reliance on disparate data collection systems contributes to this deficiency. The recent changes to the queries used to report on the AKAIMS data facilitate the generation of unduplicated counts of recipients, but these are restricted to providers entering data through AKAIMS. For a recommendation related to this finding, see Section 8.3.3 and 8.3.5.

8.2.4. FINDING: The grant-funded system impedes the Department's ability to report on the costs of individual benefit recipients.

The Department funds behavioral health services through a combination of grants and Medicaid financing. DHSS is capable of accurately tracking and reporting on costs of behavioral health services paid for by Medicaid. The grant-funded services do not offer this capability. The Department awards grants to private agencies to deliver mental health and substance abuse treatment services. Through AKAIMS these agencies report to DBH the total volume of consumer encounters and the number of individual consumers treated. The agency's grant application, proposed budget, and quarterly financial reports provide DBH with the total costs spent on each program.

This information allows the Department to calculate the average cost per recipient in a specific service setting, e.g. the cost of an encounter within a community behavioral health center or clinic. However, it does not readily allow DBH to align the cost of services with specific recipients. As grants are awarded for the provision of a broad range of services and consumers often receive multiple services across programs, the agencies and the Department are hard pressed to identify the costs of a consumer at an individual basis. The grant-funded system significantly complicates the process of tracking and reporting on the costs of individual benefit recipients, to the extent that the structure of cost allocation obscures the relationship between the cost of grant-funded programs and individual services provided. For more information regarding this finding, see Section 12.2.2.

8.2.5. FINDING: The information technology used by the Department can identify the extent to which recipients are receiving multiple benefits and whether recipients are Medicaid eligible. MMIS programs routinely contain edits that eliminate the payment of duplicate benefits and restrict payments for only those dates of service that the recipient was Medicaid eligible. However, lack of interoperability among the Department's multiple information systems impedes its ability to track which recipients receive multiple benefits for non-Medicaid services.

While the majority of non-Medicaid behavioral health services are overseen by DBH, the Department also funds and provides non-Medicaid behavioral health services through other divisions, including Senior and Disabilities Services (SDS), the Office of Children's Services (OCS), and the Division of Juvenile Justice (DJJ). Each division uses a separate information management system, and currently data from DBH, SDS,

OCS, and DJJ data are not integrated. This lack of interoperability prevents the Department from identifying recipients receiving multiple non-Medicaid behavioral health services, allowing for potential duplicative treatment and service delivery. PCG finds that the siloed systems tracking non-Medicaid behavioral health benefits impedes the Department's ability to effectively track consumers receiving multiple benefits. See Section 8.3.2 for a recommendation regarding this finding.

8.2.6. FINDING: The Master Client Index is so far unsuccessful at allowing DHSS to track and report efficiently on recipients who receive multiple benefits.

DHSS has instituted a Master Client Index (MCI) to improve the collection of client data and increase coordination of services throughout the Department. The MCI is intended to gather data from all divisions within the Department by interacting directly with the division-specific information management systems, such as AKAIMS in DBH. By merging the records from multiple division systems the MCI will be able to create a single consumer record that includes data from the entire spectrum of services provided by the Department. This record will offer a complete view of consumers' healthcare and social service history. Additionally, the MCI has the ability to indicate client eligibility for different programs and services, such as Veteran status or Medicaid eligibility.

To date, the MCI has not achieved the desired goal of being an accurate index of all consumers served by the Department. The MCI is incomplete and has not achieved integrity of data. The implementation and successful development of the MCI has been hampered by issues of interoperability between the MCI and the division-specific systems. Although the MCI is connected with AKAIMS, not all division-specific systems are connected with the MCI and thus the behavioral health consumer data within the MCI does not reflect the full scope of consumers receiving behavioral health services across the Department. Additionally, the data within the MCI does not represent the highest quality standard of data. Due to these deficiencies DBH cannot rely on the MCI for client data and does not use it to track recipients of behavioral health services. The MCI is so far unsuccessful at enabling the Department to efficiently track and report on benefit recipients. See Section 8.3.6 for a recommendation regarding this finding.

8.2.7. FINDING: The Department has effectively identified Medicaid eligible recipients of behavioral health services through AKAIMS.

The department strives to identify Medicaid eligible recipients of behavioral health services through AKAIMS. Included within the AKAMIS mandatory MDS is the reported income of the consumer. DBH requires that grantees record the income level of at least 95% of enrolled recipients. The percent of clients with complete income data reported is one of the measures included within the DBH PBF system. The grantees are subject to penalty through a decline in the value of their grant award if income is not adequately reported. This structure incentivizes the collection of consumer income data with which DBH can identify Medicaid-eligible recipients of services.

The department's efforts at identifying Medicaid eligibility fall short of complete effectiveness on account of two factors:. (1) The income is self-reported by the consumer and unverified. (2) The standard of 95% allows for five percent of consumer records to be completed without income data. In spite of these deficiencies, the Department is mostly effective at identifying Medicaid-eligible recipients of behavioral health services as the inclusion of consumer income in the MDS and its inclusion in the PBF measures ensures that grantees report consumer income through AKAIMS.

8.3. Technology Best Practices

8.3.1. RECOMMENDATION: The Department should develop automated reporting for both MMIS and AKAIMS behavioral health data.

DHSS should develop automated reporting processes for behavioral health data collected through the MMIS and AKAIMS systems. Ad hoc tracking and reporting prevents the Department from effectively monitoring the behavioral health system. The Policy and Planning Section of DBH uses a developed suite of automated reports for some of its reporting and analysis. However, the ability of these processes to be fully automated is hindered by so-called "dirty" data and inconsistencies in provider data entry processes. Other reports, such as prevention services tracking, lacks any element of automation. The Department should automate as much as possible behavioral health reporting on MMIS and AKAIMS data. Automation will increase the efficiency of the Department at compiling basic reports by reducing the amount of time spent on regular reporting and allowing staff to conduct more in-depth analysis of the data. This additional analysis will enable DBH to be more effective at identifying emerging needs and issues, and at monitoring the behavioral health system in real-time. For findings related to this recommendation, see Section 8.2.2.

8.3.2. RECOMMENDATION: The Department should prioritize development of interoperability of data for all recipients of behavioral health services, from SDS to DBH to OCS.

While a majority of behavioral health services funded by the Department are delivered and managed through the Division of Behavioral Health, Alaskans also receive behavioral health services through SDS and OCS. These agencies use separate information management systems to collect consumer data. SDS collects data within the Data System 3 (DS3) system and OCS uses the Online Resource for the Children of Alaska (ORCA) system to track service delivery. In order to have an accurate and complete understanding of the recipients of behavioral health services, the Department needs to be able to easily share data between divisions. AKAIMS, DS3, and ORCA are not interoperable. The department is currently incapable of collecting and reporting on the entirety of behavioral health service data.

The Department should prioritize the development of interoperability or smooth data sharing linkages across all divisions providing behavioral health services. This capability will enable the Department to identify duplication of services more easily, obtain an accurate understanding of the total cost of behavioral health services, and capture system-wide trends. The ability of research teams and behavioral health

administrators to draw upon data from DBH, SDS, and OCS simultaneously will contribute to more efficient reporting and data analysis, improving the Department's ability to meet the behavioral health needs of Alaskans. See Section 8.2.5 for more information regarding this recommendation.

8.3.3. RECOMMENDATION: In the near term, the Department should transition all behavioral health providers across the continuum of care to data reporting through AKAIMS.

At the time of this review, three community-based providers were continuing to submit the required MDS through the EDI interface rather than through AKAIMS. All other behavioral health service providers submit the required data to DBH through AKAIMS. DBH should transition the three remaining EDI providers to data submission and reporting through AKAIMS in the near future. The continued use of disparate data collection systems is an inefficient use of resources that requires otherwise unnecessary database maintenance, data analysis, and duplicate report generation. The consolidation of all reporting through a single system, AKAIMS, will allow DBH to reinvest the resources expended on EDI into the continued development and maintenance of the AKAIMS infrastructure and other behavioral health information technology needs. For more information regarding this recommendation, see Section 8.1.7.

8.3.4. RECOMMENDATION: The Department should develop clear and consistent priorities for data collection and incorporate these into the MDS in AKAIMS.

The MDS provides the basis for behavioral health data collected by the Department. The data elements included in the MDS determine what information is available to inform the Department's tracking, reporting, research, and analysis of the behavioral health system. DBH defines the elements included within the MDS. The current version of the MDS requires service providers to enter the following fields:

- Client Profile – personal information including social security number, Medicaid identification number and veteran status;
- Intake – encounter details such as intake staff and source of referral, and client status details such as presenting problems and clinical impressions;
- Alaska Screening Tool – symptoms and presenting conditions; and
- Client Status Review – quality of life metrics.

The above elements are required of every individual seen by a behavioral health grantee provider. They provide the Department with eligibility information, demographic data, and clinical status. If the consumer is admitted to a treatment program, the grantees are required to submit additional elements of the MDS:

- Profile – current symptoms, medication, and treatment history;
- Financial and household information;
- Youth – If consumer is under 18;
- Substance abuse information;
- Legal – legal status and recent arrest history;
- American Society of Addiction Medicine (ASAM) Assessment;
- Diagnosis; and

- Program enrollment – program and start date.

There is also a separate set of MDS data elements that providers collect at discharge:

- Profile – details of discharge;
- Legal history;
- Status changes since admission – lifestyle information such as living arrangement and occupation;
- Substance abuse;
- Treatment summary – assessments and education given to consumer; and
- Client diagnosis.

These data elements are required of all grantees, regardless of program or service provided. Additionally, DBH requires certain programs to complete additional data sets that collect information specific to the program. For example, the MDS requirements of ASAP providers include ASAP case management data. DBH collects a large quantity of data through the MDS and it is imperative that this data be aligned with the priorities of the Department. The Department develop clear and consistent priorities for data collection and that these priorities be reflected in the MDS. The MDS needs to include not only the data needed to meet state and federal reporting requirements, but also that data needed to evaluate performance on both DBH and department Results-Based Accountability core services, clinical effectiveness by program type, and system-wide trends. The department should clarify these priorities, identify and develop the data elements to address them, and amend the MDS – including the AST and CSR – as needed.

8.3.5. RECOMMENDATION: The Department should integrate AKAIMS and API data to the greatest extent possible.

AKAIMS is the primary data management system for the community-based behavioral health system. It has the capability to complete referrals from one community-based grantee provider to another. Providers are able to transmit securely consumer records, including demographic data, diagnosis, treatment plans, and prescription history. This feature provides for efficient referrals within the behavioral health grantee network. It facilitates more efficient use of grant funding by reducing the amount of time spent on administrative tasks by provider staff members. One goal of the division is to treat each consumer in the lowest-intensity service environment appropriate to the consumer's needs. As such, consumers move from treatment within API to community-based providers and vice versa.

Although API submits data to DBH using AKAIMS, its EHR is unable to export or import data from AKAIMS. When a consumer is referred from API to a community-based provider, the individual's consumer record, including current medication, diagnosis, and treatment plan, must be transmitted via fax or secure messaging. These outdated information sharing methods inhibit the ability of the community-based provider to provide efficient and effective care. Delays resulting from busy provider schedules or administrative inefficiency prevent the timely provision of care. For individuals suffering from severe mental illness, even a small disruption in treatment can have outsized negative consequences on rehabilitation and recovery.

The Department should integrate the AKAIMS and API data systems to the greatest extent possible. This process will improve the quality of care provided and reduce unnecessary administrative inefficiencies. It will enable both API and community-based providers to provide appropriate psychiatric treatment in a timely manner and reduce the risk of mistreatment stemming from an incomplete patient history. See Section 8.2.5 for more information regarding this recommendation.

8.3.6. RECOMMENDATION: The Department should prioritize implementation of an accurate and complete Master Client Index.

The continued development of an accurate and complete Master Client Index should be a priority for DHSS. A trustworthy and comprehensive MCI offers many advantages to the Department and improves its ability to fund and deliver behavioral health services. As a true "repository of the golden record" the MCI will allow the Department to:

- Eliminate duplicate consumer records;
- Reduce the creation of duplicate consumer records;
- Increase coordination of services;
- Expand secure access to consumer data;
- Provide a consolidated view of a consumer's healthcare and social service history;
- Improve the quality of consumer data.

The capabilities of a fully operational MCI provide many advantages to the Department. Increased coordination of services enables the Department to identify and reduce duplicative service offerings. It will also facilitate the identification of consumers interacting with the health and social service system through many different programs and services, providing the basis for research into effective means of managing those consumers and meeting the complex needs of Alaskans. The Department prioritize the implementation of the MCI such that it reliably serves as a repository of accurate and complete client data, and thereby improve its ability to efficiently manage behavioral health services. For more information regarding this recommendation, see Section 8.2.6.

8.4. Potential Long-Term Maintenance Costs

8.4.1. FINDING: Annual maintenance costs for AKAIMS are within national standards.

The annual maintenance contract with FEI, the developer of the WITS platform on which AKAIMS is built, was an actual cost of $484,700 for FY 2013.[149] The average cost of annual maintenance for behavioral health information technology systems of the 24 state mental health agencies reporting data was $444,603.50. AKAIMS' maintenance expenditures ranked 14th out of the 24 reported values. The department's annual maintenance costs fall within the middle 50% of nationwide behavioral health

[149] Behavioral Health Administration Component Budget Summary, Fiscal Year 2015 Governor's Operating Budget, December 12, 2013.

maintenance expenditures. Therefore, the annual maintenance costs for AKAIMS are within national standards. For recommendations that involve extending the functionality and wider adoption of AKAIMS, PCG does not anticipate significant new maintenance costs.

PCG has also identified "business requirements" for improving the Department's technology systems to support behavioral health services that probably exceed both the current and future functional capacities of AKAIMS. However, we have refrained from attempting to quantify the long-term maintenance costs necessary to establish systems and processes that would fulfill these requirements. PCG's view is that the most promising and most needed technological efficiencies in behavioral health are to be derived from establishing data systems that integrate care with other health and social service sectors. We have recommended the use of data systems within the Department that are integrated or interoperable among multiple divisions, and also potentially with other State agencies and health organizations. For this reason, even shorter-term "fixes" need to be implemented with a longer-term objective of data integration in mind.

The task of identifying specific *best practices* for meeting wider objective, to which one could attach concrete cost estimates, would require understanding other Departmental activities and collecting the business requirements of other units that fall outside the scope of this review. Recommendations for specific technology platforms and processes made on the basis of the limited requirements of the behavioral health system over other core services in the Department would be myopic and likely only to contribute further to the current fragmentation in the Department's data systems as well as the wider network of behavioral health providers. Ultimately, the implementation of an appropriate information technology framework is an enterprise-level task, requiring an enterprise-level analysis that falls beyond the scope of this review.

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9.0. GRANTS AND CONTRACTS

Evaluate the Department's procurement of behavioral health services through the use of grants and contracts. Evaluate the Department's process for solicitation, review and award of grants and contracts. Review cost effectiveness and evaluate the level of administrative expenses to deliver services. Recommend best practices to maximize the benefits received by clients and/or improve monitoring and oversight. This should address the following:

A. Does the Department's grant and contract procurement process maximize the quantity and quality of behavioral health services delivered to recipients and minimize the administrative costs of such services?

B. Does the Department's grant and procurement process adequately leverage other funds such as fees, insurance, and matching funds?

C. Does the Department's grant and contract procurement process provide for maximum and fair competition, evaluation, and award?

D. Does the Department's grant and contract procurement process ensure adequate monitoring and oversight of the quantity and quality of behavioral health services?

E. Could the Department's grant and contract procurement process be improved to provide more effectiveness and efficiency?

9.1. Maximizing Quantity and Quality of Services

9.1.1. FINDING: While a handful of state agencies throughout the country have assumed direct responsibility for treatment and recovery services, Alaska's system of service procurement through non-state providers is the most appropriate option for the State's public behavioral health system.

The Department has developed its public behavioral health system by procuring services through private, non-profit providers. While DHSS provides direct treatment services through the Alaska Psychiatric Institute (API), all behavioral health community treatment programs are delivered by non-state providers. This partnership model is the most appropriate system configuration for meeting the mental health and substance abuse treatment needs of Alaskans.

There are three behavioral health system structures used by state mental health agencies across the country:

- State as the direct service provider using statewide funds:
- Counties as direct service provider using local and state funds: and
- Private agencies as direct service provider using state funds.

The lack of counties and low-density population and geography of Alaska preclude the Department from operating a county-based system. Of the remaining two options, the State as the direct service provider is also incompatible with Alaska. Tribes are sovereign entities and operate their own health facilities, thereby creating a public behavioral health network. With the State as the direct service provider, the Department would need to develop facilities in all regions of Alaska to avoid issues of regulatory authority, requiring in essence a parallel public behavioral health network. Two parallel systems in a state with low-density population would be highly inefficient, as the Department would be funding its own system and would also be contributing to the tribal behavioral health system through Medicaid. Nevada has attempted to develop a state-operated behavioral health system but the consumer need consistently outstrips the capacity of the public authority to build the necessary infrastructure, a problem that would be replicated in Alaska.

In light of the deficiencies of the former two options, procuring services through private providers is the most appropriate way for the Department to develop and manage a public behavioral health system. It enables DHSS to be the regulatory authority and funder without the burden of being the direct service provider. Additionally, this system promotes collaboration with the tribal health system by relying on tribal facilities as the sole provider in rural and rural-remote regions. The Department can use Medicaid, grants, and contracts to procure services for non-Natives from tribal providers, capitalizing on the existence of other public systems and ensuring efficient service delivery.

9.1.2. FINDING: Although the utilization of grant procurements by the Division of Behavioral Health (DBH) exceeds other divisions in the Department, both in the number and value of grants released, this method and scale of financing is consistent with state mental health agency practices nationwide.

DBH relies heavily on grant procurements to manage and provide behavioral health services across the state, and the Division's utilization of grants exceeds that of other DHSS divisions in both number and value. This method of financing is consistent with the practice of state mental health agencies nationwide. Historically, behavioral health services have been funded through grants. Public payers, notably Medicare, have not traditionally covered mental health and substance abuse services. Lack of coverage and reimbursement is particularly prevalent for the community-based behavioral health services that create the backbone of a state-funded behavioral health system. Accordingly, state mental health agencies customarily use grant procurements to provide mental health and substance abuse services. The comparatively high utilization of grant procurement within DBH is reflective of national patterns within state-financed behavioral health systems. The proportion of services, both in quantity and value, financed through grant funding is aligned with state mental health agency practices across the country.

9.1.3. FINDING: The grants and contracts management process was reformed approximately a decade ago from a process administered by each division to a centralized function administered within Finance and Management Services. The transformation has helped to streamline and standardize management of the Department's grants and contracts.

In in the Department's 2003 administrative reorganization the grants management process was consolidated within the Grants and Contracts Section of the Office of Finance and Management Services (FMS). Prior to that reorganization each division administered a separate grants and contract management process. The transformation streamlined the Department's grants management process and aligned the process across divisions. Now, the Grants and Contracts Section directs grant management for all seven DHSS divisions. This centralization of grants and contract management helps ensure that all grants and contracts are procured consistently and with minimal variation across divisions.

Additionally, the consolidation of grants and contracts management within the Grants and Contracts Section reduced the silo effect that existed previously. There is now greater transparency across divisions about grants and contract management processes. The Grants and Contracts Section is able to implement best practices for management of grants and contracts across all DHSS divisions. The centralization of grant management within the Grants and Contracts Section has contributed to the standardization and streamlining of DHSS procurement procedures.

9.1.4. FINDING: The Department has significant room for improvement in minimizing administrative costs of grants and contracts, as limits or benchmarks have not been established to monitor administrative costs.

The Department can improve its efforts to minimize the administrative costs of its grants and contract programs. Currently, there are no limits in place to curb or minimize administrative costs of grant procurement and contract management. DHSS operating grants follow the regulations defined in Title 7, Chapter 78 of the Alaska Administrative Code (AAC). The guidelines outlined in 7AAC 78.160 are summarized below:

> *(b) A grantee may use grant money to pay the following costs for capital grants:*
> *(1) general construction;*
> *(2) allowable administrative expenses, as provided in the grant agreement, and subject to (r) of this section;*
> *(p) Except for capital grant projects, a grantee may use grant money to pay indirect costs of the grant project in accordance with an indirect cost rate agreed upon by the federal government and the grantee.*
> *(q) Except for capital grant projects, an applicant that does not have a federally approved indirect cost rate may include administrative costs in the applicant's proposed budget as direct costs. The applicant shall document the proposed costs in the applicant's justification narrative for the proposed budget.*

> *(r) The department will specify the amount of administrative and general costs the grantee may charge a capital grant project in the request for proposal, request for letters of interest, or other method of solicitation, and in the grant agreement.*[150]

The administrative code allows the Department to determine and define the specific allowable administrative costs within grant agreements. A sample of behavioral health Requests for Proposal (RFPs) was reviewed to evaluate whether and how the Department exercises this authority.[151,152,153] The sample included the RFP for Comprehensive Behavioral Health Treatment and Recovery (CBHTR) Grant services, the largest DHSS grant program in both number of awardees and value. The RFPs used to procure behavioral health services do not include specific limits on administrative costs. While the RFPs mandate that the applicant's proposed budget meet the requirements of 7 AAC 78.160, include the applicant's federal Indirect Cost Rate Agreement, and follow the DHSS Grant Budget Preparation Guidelines,[154] the guidelines do not include any specific metrics or limits for administrative costs.

Some states require vendors and grantees to limit the administrative costs included in their proposed budgets. These cost limits are typically established as a set dollar limit or as a percentage of the total contract value, depending on the nature and value of the grant or contract. Typical allowable administrative cost percentages range from seven to nine percent of the total value of the grant or contract. PCG finds that the Department has significant room for improvement in minimizing the administrative costs of its grants and contract programs, achievable by exercising its right to define limits of administrative costs. We note, however, that there are potential practical challenges to implementing a robust policy, especially considering the considerable variability in how different providers account for administrative costs, which are sometimes claimed as indirect costs, but sometimes as direct expenses. Moreover, the Department is required by state and federal regulations to include providers' federally-negotiated indirect cost rate, rendering a straightforward, unilateral limit on these costs infeasible. For PCG's detailed recommendation, see Section 9.5.4.

[150] Title 7 Health and Social Services, Part 6 Miscellaneous, Chapter 78 Grant Programs, Alaska Administrative Code.
[151] Request for Grant Proposals: Comprehensive Behavioral Health Treatment and Recovery for FY 2014 thru 2016, Grants and Contracts, Alaska Department of Health and Social Services, March 22, 2013.
[152] Request for Grant Proposals: Residential Care for Children & Youth for FY 2014 thru 2016, Grants and Contracts Support Team, Alaska Department of Health and Social Services, November 2012.
[153] Request for Grant Proposals: Comprehensive Behavioral Health Prevention and Early Intervention Services for FY 2012 thru 2014, Grants & Contracts Support Team, Alaska Department of Health and Social Services, February 2011.
[154] DHSS Grant Budget Preparation Guidelines, Finance and Management Services, Alaska Department of Health and Social Services, March 26, 2009.

9.1.5. FINDING: The Division recently implemented some of the grant administration "streamlining" recommendations drafted by the Division's advisory boards and the Alaska Behavioral Health Association, which has improved the efficiencies of the grant management process.

In 2014 the Alaska Behavioral Health Association, Alaska Mental Health Board, and Advisory Board on Alcoholism and Drug Abuse collaborated with DBH to develop concrete recommendations intended to reduce the administrative burden of behavioral health grants. DBH recently implemented three of the eleven recommendations developed through this "streamlining initiative." The recommendations adopted are (1) the elimination of quarterly Alaska Automated Information Management System (AKAIMS) summary reports, (2) the elimination of logic models in the application and reporting process, and (3) the elimination of pro forma quarterly narrative reports.

Previously grant reporting requirements included a quarterly AKAIMS summary from each CBHTR grant recipient. The streamlining initiative workgroup found that over 40% of the information included in these summary reports was duplicative of information already entered into AKAIMS by each CBHTR provider. The duplicative data elements included client demographics and client employment and housing status. Accordingly, submitting the quarterly AKAIMS summary increased the administrative burden of DBH grant managers. Grant managers were presented with this subset of data elements on two separate occasions, during their normal AKAIMS monitoring and upon receipt of the quarterly AKAIMS summary reports. DBH adopted the workgroup's recommendation to eliminate duplicative submission of AKAIMS data and focus quarterly reporting on information not already readily available to the Department.

Additionally, behavioral health grant applications previously required the development and submission of a logic model. A logic model is a visual representation sequence of activities and resources used to bring about change and achieve program goals. It is a tool often used by funders and managers to evaluate the effectiveness of a program. The streamlining workgroup determined that the logic model added little value to both grantees and DHSS' ability to manage the behavioral health system. Additionally, the logic model's measures of effectiveness do not align with the Department-wide Results-Based Accountability (RBA) framework, core services, and performance measures. The Division adopted the following recommendations made regarding the logic model:

a) Logic models no longer be required for applying for any behavioral health treatment grant from DHSS;
b) Logic model reporting no longer be required of behavioral health treatment grantees;
c) Providers be informed about the DHSS core service and RBA frameworks at the Fall/Winter Change Agent Conference;
d) The treatment grant application and reporting process be aligned with the core service and RBA frameworks in a way that is efficient for and provides value to DHSS and providers.[155]

[155] Streamlining Initiative Recommendations, Alaska Mental Health Board, Advisory Board on Alcoholism and Drug Abuse, Alaska Behavioral Health Association, June 30, 2014.

The Division adopted this subset of recommendations related to the logic model. Logic models are no longer a required part of grant applications or grant reporting requirements. Instead, the FY 2016 quarterly reports include a RBA performance measure reporting form to help the Division evaluate the effectiveness of the program.[156] The Division also incorporated the recommendation to eliminate pro forma quarterly narrative reports and replace them with a more flexible format. Previously grantees were required complete a quarterly narrative form, which the workgroup found was too rigid to share a full picture of the context and environment of the provider. Now grantees are given a list of key points to address and the freedom to construct the narrative such that it accurately represents the status of the agency and provides the Division with the information needed to effectively manage the behavioral health system. By adopting these changes recommended by the behavioral health advisory groups and stakeholder workgroup DBH has improved the efficiency of its grants management processes.

9.1.6. FINDING: In an effort to stimulate service delivery and improve provider accountability the Department has recently increased the use of provider agreements.

Over the past decade the Department has transitioned its procurements of some behavioral health services from traditional grants to grant types with more contract-like features. Specifically, DBH frequently uses provider agreements called *individualized service agreements* (ISAs) to procure behavioral health services to fill needs not met by traditional grants. ISAs are also managed by the Grants and Contracts Section and DBH program managers, and like other types of grants, can be procured through competitive solicitations, non-competitive solicitations, and alternate procurement methods. ISAs are similar to the fee-for-service reimbursement used by Medicaid. DHSS establishes agreements with providers to deliver certain behavioral health services, and providers will invoice the Department after delivering those services to consumers.

DBH uses ISAs to encourage utilization of mental health and substance abuse services needed by consumers but not traditionally funded through grant-based financing. While traditional grants are restricted to non-profit agencies, a for-profit provider can enter into an ISA provider agreement with the Department. The expansion of eligible behavioral health providers to include for-profit agencies widens the array of services able to be procured by the Department. One of the important service lines funded through this mechanism is wraparound services for adults with serious mental illness (SMI), and youth experiencing a severe emotional disturbance (SED) or substance-use disorder (SUD). Examples of the adult SMI, youth SED and youth SUD procured through the ISA are:

- Adult crisis respite;
- Medicaid-eligible services for non-Medicaid eligible consumers;
- Transitional housing assistance;
- Case management services; and

[156] FY 2016 Quarterly Report Coversheet and Checklist, Division of Behavioral Health, Alaska Department of Health and Social Services.

- Vocational rehabilitation.[157]

The Department uses ISAs to encourage utilization of effective behavioral health services that are expensive or difficult to provide, yet are an essential component of a complete continuum of care. Grants procure a wide array of services but typically do not enable DBH to track the specific costs of each service. ISAs operate more like a contract by providing a fixed reimbursement for a specific service, requiring providers to record their costs and expenditures more accurately. The use of provider agreements for a wider variety of services reflects the Department's efforts to improve provider accountability and stimulate service delivery.

9.1.7. FINDING: Although the transition from grant-based to contract-based financing is likely to improve the quantity and quality of many behavioral health services procured by DBH, grants remain an essential funding mechanism for providers of comprehensive services due to the flexibility these funds afford.

There are different advantages to grant-based and contract-based financing of behavioral health services, and the Department relies on both methods to procure the complete array of mental health and substance abuse services needed by Alaskans. This blending and braiding of grant, contract, and Medicaid-based funding methods ensures that resources are used to the greatest benefit of the consumer population. Grants are a flexible funding structure that allows for a responsive and adaptive community-based needs approach to service delivery. Contracts, on the other hand, have more explicit parameters and deliverables that result in greater provider accountability. Although contracts offer DHSS the security of enhanced financial accountability from the contracted providers, it comes at the expense of dynamic and flexible treatment options tailored to meet the needs of the community.

Grants are an essential funding mechanism for the public behavioral health system. By transitioning certain services to contract-based financing, DBH obtains greater authority over the quantity and quality of the services being delivered under those contracts. However, there will never be enough certainty over the consumer acuity mix and treatment needs to finance the behavioral health system solely through contracts and Medicaid reimbursement. It is imperative for providers to have a pool of discretionary funds that allow them the flexibility to fund specific needs as they arise in the community. This is particularly important for comprehensive behavioral health centers (CBHCs) which are required to treat all consumers needing treatment. The needs of those consumers are too unpredictable to be funded through provider agreements and necessitate the flexibility of grant funding.

Additionally, grants are able to finance the gap between the fee-for-service reimbursement used in contracts and Medicaid billing and the cost of providing services. There are unavoidable administrative, capital, and other indirect costs incurred by providers as they work to provide mental health and substance abuse treatment services. Grants can supplement the gap between Medicaid reimbursement and actual cost, and ensure providers have enough funding to stay in business. While the transition to contract-based funding

[157] Individualized Service Agreements (ISA) Presentation, Division of Behavioral Health Policy and Planning Section, June 22, 2012.

has increased provider accountability, grants remain an essential component of the Department's behavioral health financing strategy.

9.2. Fees, Insurance, and Matching Funds

9.2.1. FINDING: The Department has taken a widely accepted approach in incorporating fees and matching funds into the overall grants and contract process.

The Department has taken a widely accepted approach to incorporating fees and matching funds into the overall grants and contract process. The Grants and Contracts Section does not collect fees from behavioral health vendors applying for grants or negotiating for contracts. As behavioral health grants include funds for indirect costs, levying fees on applicants would only increase the administrative costs of the provider and reduce the impact of the grant funding on behavioral health consumers. However, the Department does levy fees on individuals entering the Alcohol Safety Action Program. In FY 2014, DHSS collected $373,300 in Alcohol Safety Action Program (ASAP) assignment fees.[158] PCG finds the Department's limited use of fees to be effective at generating revenue without diminishing the value to Alaskans of funds distributed through grants and contracts.

Additionally, the Department effectively incorporates matching funds into its behavioral health operating grants programs. Table 9.1 describes the array of funds used by each operating grant in FY 2014.

Table 9.1. Fiscal Year 2014 Behavioral Health Grants

Grant	General Fund	I/A Receipts[159]	MHTAAR[160]	Alcohol Tax Funds	Federal
Adult Rural Peer Support	✓				
ASAP	✓				✓
Behavioral Health Provider Association	✓				
Bethel Community Service Patrol and Sobering Center	✓				
Bring the Kids Home	✓		✓		

[158] Fee Report – HB30 Perf Audit, Alaska Department of Health and Social Services.
[159] Interagency Receipts.
[160] Mental Health Trust Authority Authorized Receipts.

Grant	General Fund	I/A Receipts[159]	MHTAAR[160]	Alcohol Tax Funds	Federal
Chemical Dependency Professionals Certification				✓	
CBHTR	✓		✓	✓	✓
Family Wellness Warriors Initiative		✓			
Residential Care for Children and Youth	✓				
Residential Care for Children and Youth Training Program	✓				
Rural Community Domestic Violence & Sexual Assault		✓			
Rural Human Service System	✓			✓	
Senior Outreach, Assessment and Referral Project	✓				
Strategic Prevention Framework State Incentive Grant					✓
Substance Abuse Treatment for the Office of Children's Services (OCS) Engaged Parents	✓				
Substance Abuse Treatment for the OCS Engaged Families	✓				
Supported Employment					✓
Therapeutic Court		✓			
Trauma Informed Training for Behavioral Health Providers	✓				

Ten of 19 behavioral health grant programs incorporate non-GF dollars into their funding mechanism. Furthermore, 10.5% of the over $70 million in behavioral health grant funding comes from federal receipts. An additional 2% of grant funding comes from the Alaska Mental Health Trust Authority (AMHTA). The Department leverages available external sources of funding to support its grant programs and match its own contribution. Overall, the Department has taken a widely accepted approach to incorporating matching funds into its behavioral health grant programs.

9.2.2. FINDING: The fees involved in the Department's grants and contracts are consistent with typical programmatic fees collected to support program operations.

The Department's utilization of fees to support its operations of grant and contract procurement is consistent with typical practices. The Department only collects fees for ASAP. It does not collect fees through other behavioral health grant or contract programs. DBH behavioral health grants are in part intended to bridge the gap between Medicaid reimbursement and the cost of providing a sufficient array of behavioral health services to meet the needs of the Alaskan population. All grantees are non-profit agencies that operate with slim revenue margins due to their low-income consumer population and reliance on state funding through Medicaid and grants. Levying fees on providers would merely be an exercise in moving money around. With additional fees the indirect cost of providing behavioral health services would increase and would be accompanied by an increase in proposed budgets on grant applications, resulting in no net gain in revenue for the Department. Accordingly, the Department's grant and contract fee policies are consistent with typical fee structures in grant-funded behavioral health systems.

9.2.3. FINDING: The Department's grant and contract requirements adequately encourage providers to leverage third party insurance.

PCG reviewed a sample of behavioral health grant procurements and provider agreements and found that the Division's grant and contract structure adequately incentivizes providers to leverage private and non-state health insurance prior to using Department funding. While behavioral health RFPs do not include specific guidelines on leveraging third-party insurance, the Division's contracts ensure that vendors adequately leverage third-party insurance to pay for service delivery.[161,162,163,164]

Within the behavioral health RFPs reviewed there was no requirement that grantees follow a specific policy to ensure third-party and non-state payers are billed prior to using grant funds to treat consumers requiring

[161] Grant procurements reviewed are included in the citations for Finding 9.1.4.
[162] Complex Behavior Collaborative Consultation and Training Provider Agreement, Grants & Contracts Support Team, Alaska Department of Health and Social Services, July 25, 2012.
[163] Misdemeanor Access to Recovery Pilot Project Provider Agreement, Grants & Contracts Support Team, Alaska Department of Health and Social Services, September 2012.
[164] Provider Agreement for Individualized Services for Adults Experiencing a Serious Mental Illness (SMI) or for Youth Experiencing a Severe Emotional Disturbance (SED) or Youth Experiencing a Substance-Use Disorder (SUD). Grants & Contracts Support Team, Alaska Department of Health and Social Services, September 2013.

mental health or substance abuse treatment. Yet behavioral health grantees have no disincentive to check each consumer's insurance coverage. Rather, the Department's behavioral health funding and delivery system encourages grantees to use state funding as the payer of last resort. Non-state insurers, including private insurance and federal payers such as the veterans' program, generally reimburse at higher rates than the State's Medicaid program. Grantees receive a fixed amount of grant funds to provide the specified behavioral health treatment services to all consumers requiring care in that region. It is in the financial and operational best interest of the provider to leverage all other types of insurance before relying on grant funds, as grant funds cannot be replenished.

However, each provider agreement reviewed included a clause or requirement encouraging the behavioral health provider to leverage outside insurance prior to billing the Department for the service specified within the contract. These billing and insurance guidelines are summarized below:

- DHSS is the payer of last resort;
- Funds from the agreement must only be used to pay for services not covered by any third party payers; and
- The provider must make a reasonable effort to bill all eligible services through private third party payers, Medicaid, and other primary payers prior to seeking payment through this provider agreement.

The contracts reviewed state that the providers must explore all other payment options prior to billing the Department through the service agreement. The guidelines clearly explain the billing policies and regulations, and the Department's intent to collect from the provider any payment that is subsequently paid by a third-party payer. PCG finds that the Department's behavioral health contracts adequately leverage other sources of payment.

9.2.4. RECOMMENDATION: The Department should amend its grant and contract requirements to more strongly incentivize behavioral health providers to leverage third party insurance.

DBH currently incentivizes its behavioral health grant recipients to leverage third party payers, such as private insurance or veterans' benefits, through the structure of the public behavioral health system. To receive grant funds from the Department, a behavioral health provider must be a non-profit. To enroll in the Medicaid program, a provider must be a grantee. Thus, all providers delivering mental health and substance abuse treatment services funded by the State, through either grants, contracts, or Medicaid reimbursement, are non-profit agencies.

DBH distributes grant funding to ensure that Alaskans have access to a full continuum of behavioral health services, not all of which are covered by Medicaid or other payers. Grantees receive a finite amount of grant funds each quarter that are intended to cover the costs of providing services that aren't eligible for reimbursement through third party payers. Recipients of CBHTR grants are required to provide services to any individual who walks through the door, and when the cost of non-reimbursable services required by consumers in a given quarter exceeds the amount of grant funds received that provider is faced with a budget shortfall and financial strain. It is in the provider's best interest to receive reimbursement from third

party insurers whenever possible, freeing up grant funds to treat additional consumers or invest in capital projects. The funding structure of the Department's behavioral health system passively incentivizes providers to leverage other insurance before relying on grant funds.

This structural encouragement is effective and that providers strive to bill Medicaid and other third party payers. Yet, the Department should further incentivize this practice by building specific requirements into its RFPs and grant agreements. The Department should include a clause or section similar to that included in DBH contracts, as detailed in Section 9.2.3**.** Making grant approval contingent on demonstration of consistent screening for third party insurance and eligibility would strengthen the ability of the Department's grants and contract procurement process to adequately leverage insurance.

9.3. Maximizing Fair Competition, Evaluation, and Award

9.3.1. FINDING: The Department has established a fair and effective process that leverages technology and ensures competition, proper evaluation, and award.

The Department has established a fair and effective grants and contracts procurement process that leverages technology and ensures competition, proper evaluation, and award. The Grants and Contracts Section drives the grants and contracts procurement process across DHSS and follows the guidelines set out in 7 AAC 78. All grants and contracts are planned, evaluated, and awarded in conjunction with the appropriate division(s). There are four stages to the grant procurement process: Plan, Solicit, Recommend and Approve, and Manage.

- *Plan:* the Grants and Contracts Section meets with Division directors and commissioners to develop the upcoming grant cycle. Once DBH receives the funding, the Grants and Contracts Section requests the authority to distribute the funds. That request includes specifying the type of procurement to be used for this pool of funding, the length of the grant or contract, the dollar amount, and the description of services to be procured.

- *Solicit:* The Grants and Contracts Section moves to solicit responses for the services requested. They gather needed information from DBH and develop the procurement document to be issued to the public. During this phase, DBH determines who will review the solicitation responses.

- *Recommend and Approve:* Within the grant award recommendation and approval (GARA) process, the Proposal Evaluation Committee (PEC) reviews the responses and develops recommendations for approval. Subsequently managers for the program under review evaluate the responses and develop their own recommendations. The recommendations are reviewed by the deputy division director, division director, and the deputy commissioner, before ultimately being sent to the commissioner for approval.

- *Manage:* Following approval of the grant recommendations, funding is distributed to grantees and the Grants and Contracts Section and DBH grant managers work together to manage the grants for the duration of the grant cycle. Both members of the Grants and Contracts Section and DBH grant managers are in direct contact with grantees, ensuring that each grantee submits the required quarterly utilization and fiscal reports and meets the requirements of the grant terms.

The fairness of the system is based in the evaluation of responses to solicitations. The PEC is composed of a grants and contracts representative and program managers from DBH. The program manager is selected based on familiarity of the community and provider dynamics involved with the grant program under review. Evaluation of grant responses differs from the evaluation of contract responses. When evaluating responses to a competitive solicitation in which there are likely to be more than one awardee, the PEC assigns a score to each response and also considers grantee experience, provider density in its geographic area, and other factors when developing recommendations. To ensure fair evaluations and eliminate opportunities for bias and favoritism, the program manager selected for a grant PEC oversees a *different* grant program from the one being reviewed. As contracts are likely to be awarded to only one vendor the PEC relies solely on the score of each proposal to develop its recommendation. The objectivity of the scoring process allows for the program manager on a contract PEC to manage the program under review.

The structure of the grant procurement process ensures that all grants are managed with consistency while also allowing for necessary flexibility with regard to competitive solicitations for certain services. Grant PECs can factor in grantee experience, regional need, and provider geographic density when evaluating grant proposals for behavioral health services. That practice is essential for the Department to meet its mandate to provide statewide access to mental health and substance abuse treatment. Rural providers are often unable to submit a high scoring proposal due to facility limitations or staff shortages, but still need to receive grant awards to serve a region devoid of any other behavioral health provider. The Department has established a fair grants and contract procurement process that is effective at awarding funding and contracts to vendors most capable of delivering the requested services at a reasonable cost.

9.3.2. FINDING: Grants are offered in both competitive and non-competitive solicitations. Most grants are procured as a competitive RFP, and non-competitive grants are procured using a waiver of competitive solicitation.

The Division primarily relies on grant procurement, rather than contract negotiations, to fund and deliver behavioral health services. The Department offers grants through both competitive and non-competitive solicitations. The majority of grants are procured as a competitive solicitation. Non-competitive solicitations are procured using a waiver of competitive solicitation. Non-competitive solicitations are often used for the continuation of an existing grant award past the end date of the original grant cycle. Additionally, non-competitive solicitations for behavioral health services are often requested at the discretion of the Grants and Contract Section and the Division for the following circumstances:

- Only a single potential grantee or limited number of potential grantees have the knowledge, capability, or expertise necessary to accomplish the goals of the grant project; or
- Only a single or limited number of potential grantees can meet the goals of the grant project more satisfactorily than any other potential grantee.[165]

[165] Grant Regulations Chapters 7 AAC 78 and 81, Alaska Department of Health and Social Services, pp. 7-8.

In these situations the Grants and Contracts Section will request a waiver of competitive solicitation to receive authorization to issue a non-competitive solicitation and, if necessary, send letters to potential grantees requesting that they apply. The use of non-competitive solicitations is particularly important to the procurement of behavioral health services. The ability of the Grants and Contracts Section to solicit grant applications is essential to ensure the Department provides access in regions with few behavioral health providers. The grant procurement process effectively utilizes both competitive and non-competitive solicitations to procure the needed array of behavioral health services.

9.3.3. FINDING: Although competitive solicitations and performance based funding (PBF) are designed to improve quality by stimulating market competition, these processes are less effective in rural regions that cannot sustain multiple providers.

The primary objective of the Division's use of the procurement process is to develop a statewide behavioral health system that offers a full continuum of mental health and substance abuse services. However, DBH also employs the procurement process to encourage and promote standards of quality and value. The competitive solicitation evaluation process, explained in detail in Section 9.3.5, rewards proposals that indicate an agency can (1) provide high quality services with effective treatment outcomes, (2) deliver essential services at a low cost, or (3) meet the behavioral health treatment needs of the surrounding community with a balance of quality and cost. PBF serves a similar purpose. It is a system that relies an array of compliance and quality measures to reallocate grant funding based on past performance. Both PBF and the competitive procurement process encourage competition amongst providers and promote quality; PBF uses financial incentives to encourage providers to meet quality standards determined by DBH, and competitive solicitations require providers to achieve higher quality or lower costs than their competitors in order to receive a grant award.

While these competitive processes stimulate market competition in regions with more concentrated populations, they are less effective at promoting quality in rural regions that cannot sustain multiple providers. There are rural and rural-remote regions of Alaska where the Division's chief objective is not to reward high quality services, but instead to ensure providers are available to offer any behavioral health services. In these region types, there is no competition among providers because the area can only sustain a single provider. DBH currently applies PBF across the state, but in rural and rural-remote regions, PBF functions mainly to encourage compliance with grant regulations rather than promote quality standards through competitive solicitation. In these areas it would be more reasonable for DBH to utilize the simple grant renewal process; competitive solicitations and PBF require administrative management and resources, and there is little reason to expend those resources on ineffective activities. Overall, competitive solicitations and PBF are effective at stimulating market competition in urban areas, but can only be applied on a more limited basis in rural and rural-remote regions.

9.3.4. RECOMMENDATION: The Department should consider revising Medicaid statutes and regulations to increase non-grantee, private provider participation in Medicaid.

To expand utilization of Medicaid-reimbursable behavioral health services and preserve grant funding for only those services that are incompatible with contracts and fee-for-service reimbursement, the Department should consider revising Medicaid regulations to increase non-grantee, private provider enrollment in the Medicaid program. State statute currently limits Medicaid billing for behavioral health services to providers who are "grantees of the State."[166] While the statute allows CBHCs, licensed psychologists and Licensed Clinical Social Workers (LCSWs) to bill for services, psychologist billing is restricted to evaluations, and LCSW billing is restricted by Department regulation. In effect, the State's Medicaid regulations restrict the pool of eligible behavioral health providers by requiring (1) that providers be a DHSS grantee, and (2) that Medicaid-reimbursable services be performed in a clinic associated with a psychiatrist, or by an independent psychiatrist, PhD psychologist or APRN.[167] Arguably, these restrictions also put Alaska's Medicaid program at odds with federal rules mandating "free choice of providers."[168] Removing the requirement that providers receive DHSS grant funds in order to enroll in the Medicaid program would allow private for-profit providers to bill Medicaid for eligible behavioral health services. This modification would lead to an uptick in utilization of Medicaid-eligible services and reduce the burden on grant-based procurements, while achieving clearer compliance with federal regulation.

A similar effect would be achieved by expanding the types of providers able to perform Medicaid-eligible behavioral health services, such as Licensed Professional Counselors and Licensed Marriage and Family Therapists. Alaska is a mental health professional shortage area and there is a dearth of qualified behavioral health professionals across the state. Restricting the independent provider pool to psychiatrists, PhD psychologists, and APRNs greatly limits the quantity of providers able to deliver needed behavioral health services. The Department should consider amending the Medicaid regulations to allow behavioral health professionals such as masters-level clinicians or licensed clinical social workers to independently deliver certain behavioral health services, such as mental health and substance abuse intake assessments. DHSS already recognizes the ability of these provider types to perform such services as they are authorized to bill Medicaid when the services are delivered through a larger clinic or agency. This change would increase utilization of Medicaid-billable behavioral health services and reduce the burden of grants to fill the gap between the current service capacity and the volume of treatment services needed by Alaskans.

It should be noted here that PCG is not suggesting that the Department dilute its clinical standards for services that require high-level rendering or supervising practitioners in order to guarantee competent care delivery. Rather, this recommendation is aimed at removing artificial grantee and qualification requirements only to the extent that they are imposed by the Department for the sake of controlling Medicaid costs and utilization, but not for maintaining clinical standards. In Section 12.0, PCG provides a detailed discussion of how these restrictions serve as administrative mechanisms for tracking and managing

[166] AS 47.
[167] See Section 12.0 for an in-depth analysis of the Department's utilization controls.
[168] 42 CFR 431.51(b)(1)

utilization within the system. Although the restrictions allow DHSS to control costs by limiting private provider participation in Medicaid, global cost containment is probably less of a concern than minimizing unnecessary costs resulting from inappropriate utilization and poor care coordination in an unmanaged fee-for-service system. Grantee and provider restrictions help to ensure that service delivery is routed through a comprehensive care coordinator, with the ability to connect consumers to needed services within the system and to minimize services that are not truly needed for recovery.

The restrictions also have the effect of minimizing the risk of market failure, which can be substantial for Alaska's fragile provider networks. The restrictions shield the system from some of the destructive effects of market completion: from inefficiencies arising from duplication of services and from the threat of financial insolvency posed by private providers cherry-picking more profitable service lines and healthier consumers from comprehensive providers. Finally, the restrictions incentivize Alaska's behavioral health workforce to work within the Community Behavioral Health Center framework, fostering a vital workforce development pipeline within the state while helping public providers to remain competitive in hiring and retention.

Despite these many virtues, it is nonetheless true that the restrictions reduce access to services, and from the perspective of federal Medicaid authorities, at least, impose an artificial and arbitrary barrier to eligible provider participation in the Medicaid care network. Based on these regulatory considerations alone, it is unlikely that the restrictions can remain in place indefinitely. Furthermore, areas like Anchorage, where access is a critical problem, are probably less subject to market failure than rural regions that cannot support significant provider competition. These service areas, which also generate the highest volume of services in the State, would benefit from quality improvements likely to result from more competition with private providers for consumers and public dollars. Finally, even though the risk of inappropriate utilization (and elevated costs) arising from uncoordinated care and volume-driven reimbursement is a genuine problem to consider before removing current restrictions, it is also the case that more sophisticated, data-driven utilization controls and program integrity operations have evolved to better address these issues in fee-for-service reimbursement. For this reason, PCG offers this recommendation only in combination with recommendations in Sections 12.0 and 13.0 that call for improvements in the Department's data analytics capabilities. The Certified Community Behavioral Health Clinic (CCBHC) model, developed recently by federal authorities and recommended for implementation by PCG in Section 3.0.4, offers an important institutional framework for meeting these utilization management challenges.

9.3.5. FINDING: The proposal evaluation process for grants and contracts promotes the Department's objectives in selecting strong technical proposals that deliver value to the State.

During the evaluation, the PEC reviews technical proposals while cost proposals remain hidden. Reviewers evaluate the proposals based solely on technical merit without consideration of cost. This practice prevents expense from clouding the evaluators' perceptions of which proposal is the most appropriate for the procurement. After the review of the technical proposals, the cost proposals are examined and the cost is factored into the overall evaluation. A calculation is used to convert the cost to points so it can be incorporated into the scoring system. The cost proposal calculation is as follows:

The maximum points for cost are specified in each RFP. By converting the cost to points, the grants procurement process effectively weights the cost proposal as a portion of the overall score. This calculation ensures the Department is receiving the best combination of technical expertise and cost efficiency for each dollar award through grants.

The practice of evaluating technical proposals and cost proposals separately allows for the identification and recognition of strong technical expertise that speaks to an applicant's capability to successfully deliver the services requested by the Department. By shielding evaluators from cost bias during the scoring of the technical proposals the grant procurement process ensures the proposals are scored purely on merit and appropriateness for the procurement rather than expense. The proposal evaluation process reflects the Department's objective to select applicants able to provide strong technical expertise at a reasonable cost.

9.3.6. FINDING: The Grants Electronic Management System (GEMS) provides all-encompassing grant administrative support and has served as a major improvement to the management process during the year in which it has been operational.

GEMS is the online information and management system for DHSS operating and capital grants. It provides all-encompassing grant management support and is used by both DHSS staff and grant recipients. GEMS has been operational for approximately one year and is a major improvement to the grants management process. In PCG's conversations with providers and DBH staff, the system was widely praised for its ease of use and compilation of grant information in one location. While users noted some minor issues, such as the additional level of approval needed to revise a budget, the opinion of GEMS across all user groups was fundamentally positive.

One notable efficiency of GEMS is the streamlining of the signature and approval process. The commissioner, assistant commissioners and division directors are now able to sign documents electronically, a feature that saves time for all parties involved and reduces administrative inefficiency in grant management procedures. GEMS has significantly improved the grant management process in the past year by streamlining procedures and serving as an effective hub for grant management tasks for both DHSS employees and grant recipients.

9.3.7. RECOMMENDATION: Although the Department has produced user training videos for GEMS that have been praised by the provider community, it should also consider a user manual to accompany training videos to support instruction in rural communities with limited internet bandwidth.

Prior to the release and implementation of GEMS, the Department distributed training and user videos to current grantees. These videos were well received by the provider community. Grantees found the videos

helpful and effective at teaching them how to use the new system. These videos contributed to the smooth transition to using GEMS to manage DHSS operating and capital grants. However, in rural areas internet bandwidth and connectivity issues prevented grantees from making full use of the videos. The Department should distribute a user manual to accompany the training videos. A downloadable and printable manual would be accessible to providers and other GEMS users when internet is unavailable. Limited bandwidth prevents some GEMS users from being able to stream the training videos and interact with the system simultaneously. The user manual requires less bandwidth than video streaming and so could more easily be referenced by a user as they are accessing GEMS.

9.4. Grant and Contract Monitoring and Oversight

9.4.1. FINDING: The Department has established a structure for grant and contract monitoring that promotes accountability in overall management of its behavioral health grants.

The Department has developed a structure for grant and contract management that ensures accountability and functional procurement processes. The combined efforts of the grant administrators within the Grants and Contracts Section and the program managers at DBH are successful at managing behavioral health grant recipients and contracted providers. This management process hinges on the quarterly reports required of each grantee. The components of these reports provide the various grant and contract administrators with the information necessary to gain an understanding of the overall performance of the provider and adherence to the grant regulations. The specific components required vary by grant type, but most include utilization data, fiscal information, and quality measures. The information submitted through quarterly reports in GEMS is bolstered by AKAIMS data that is readily accessible to DBH. The individuals involved in monitoring grants and contracts are adept at collecting and analyzing the information necessary to manage procurements.

However, this system of management becomes less reliable as the Department transitions from solely grant-based funding to contracts, Medicaid, and other funding mechanisms. As an increasing number of services are transitioned to methods of reimbursement more appropriate to those service lines, the understanding afforded by evaluation of grant programs is of a diminishing size. This can make it difficult for the Department to actively manage behavioral health providers. One example is Fairbanks Community Mental Health Services (FCMHS). In light of changes in financing, and internal administrative inefficiencies, FCMHS was forced to shut its doors until DBH could work with Anchorage Community Mental Health Services (ACMHS) to take over its operations. The grant management process that has been effective at managing a grant-funded community-based behavioral health system is not wholly transferable to management of a behavioral health system funded through a variety of mechanisms.

In spite of some difficulties, overall, the Department is largely effective at monitoring ongoing grants and contracts. The behavioral health provider network in Alaska is fragile, and without the efforts of the Department's grant administrators many providers would be unable to remain solvent. DBH staff are adept at managing grant funds as a portion of the blended and braided funding mechanisms and balancing the needs of the providers, the Department, and the consumers. It is difficult to maintain a system with low

Medicaid reimbursement rates and unpredictable service utilization, yet so far the Department has developed a system that ensures its grant managers achieve those objectives. However, as Medicaid reimbursement rates remain constant while costs rise, it will become increasingly challenging and unsustainable to preserve the system through grant management.

9.4.2. FINDING: Providers consistently reported regular site visits by Division staff and frequent, supportive communication with state program managers.

Following conversations with representatives from the Grants and Contracts Section, DBH grant managers, and behavioral health provider grantees, PCG finds that DBH assists its grantees through site visits and regular, supportive communication. One facet of the grant management process is on-site visits and reviews. DBH grant managers visit each grantee annually to evaluate compliance with grant requirements, observe the standard of care and service delivery, and provide technical assistance. Providers report that the site visits are well organized and efficient. The grant managers work closely with the grantee to ensure the time spent on-site is productive and wastes neither time nor resources of DBH or of the provider. Additionally, providers shared that the grant managers at effective at minimizing the disruption caused by a site visit.

Furthermore, Division staff are effective at providing support and managing grantees remotely. From offices in Juneau and Anchorage, DBH grant managers answer questions, resolve problems, and monitor grantees throughout the entirety of the grant cycle. Grant managers regularly field phone calls from providers with concerns about issues such as lapsed funds, changes in reporting requirements, and the audit process. The grant managers are often the strongest link between the provider and the Department and serve as “interpreters” of formal notices. Providers reported that they rely on grant managers for assistance in understanding the Division’s intent behind a change in regulations or for more information regarding a recently posted public notice. The informal and informal communication between grant managers and providers facilitates an effective grant management process and monitoring of grantees.

DBH program staff engage in grant management through both site visits and communication via email and telephone. The site visits are essential for grant managers to have a thorough understanding of the grantee’s facility, environment, and day to day operations. They also offer the Division an opportunity to closely evaluate grantee performance and provide technical assistance when necessary. A trusting, working relationship is critical for effective grant management. The combination of site visits and email and telephone responsiveness builds those relationships and makes it easier for grant managers to implement changes in regulations, explain changes in funding, and gather quarterly reports. DHSS grantees interact with grant managers from both the Grants and Contracts Section and from DBH, and providers receiving multiple grants often interact with multiple managers from each unit. Overall, providers reported that managers from both the Grants and Contracts Section and DBH are responsive via telephone and email to questions and concerns. The Department’s grant managers are effective at providing frequent, supportive communication and conducting annual site visits as part of the grant management process.

9.4.3. RECOMMENDATION: The Department should provide comprehensive training to all Division of Behavioral Health employees acting as grant and contract managers.

To standardize grant and contract management procedures across DBH staff, the Department should provide training to all employees conducting program management activities. The existing inconsistency in understanding of grant requirements and the role of the grant or contract manager would be ameliorated by developing a training that explains the role of the program manager, the objectives of each reporting requirement, expected program monitoring activities, and the intricacies of the grant cycle. Such trainings would help both the Department and the behavioral health grantees. The Division and the Grants and Contracts Section would find greater consistency in materials received from providers, and grantees will be able to comply more easily with reporting and program requirements. The Department should develop and implement a grant and contract management training for DBH staff to increase consistency within grant and contract management procedures. See Section 9.3.7 for more information regarding this recommendation.

9.4.4. RECOMMENDATION: The Department should improve the year-end report to focus more strongly on outcomes and performance metrics as opposed simply to dollar amounts or tasks accomplished.

In addition to quarterly reports, the Department requires each grantee to submit a year-end report through GEMS. During the review, both DHSS staff and providers commented on the ineffectiveness of the year-end report in its current form. The report is intended to monitor the provider's budget and program performance. The Department should amend the report to focus more strongly on outcomes and performance metrics rather than dollar amounts and task completion. By linking the year-end report to the Department's Results Based Accountability (RBA) and Results Based Budgeting Initiatives the Department will receive more useful information and insight into the grantee's performance over the past year. DHSS will be more effective at grant management and performance monitoring with data on each grantee's quality of service delivery and treatment outcomes. The Department should improve the year-end grant report by focusing it on outcomes and including relevant RBA performance measures. See Section 4.3.1 for more information regarding this recommendation.

9.5. Improvements to Effectiveness and Efficiency

9.5.1. FINDING: The Division's non-adherence to the standard timelines of the Department's grant cycle has resulted in administrative inefficiencies in the grant procurement process.

DBH does not adhere to the Department's standard timelines of the grant cycle and that this non-adherence has resulted in administrative inefficiencies in the grant procurement process. Conversations with several providers and discussions with DHSS employees indicated that DBH misses internal deadlines with regularity. The Grants and Contracts Section uses one timeline across all DHSS divisions. Each division is

expected to supply the Grants and Contracts Section with procurement requests by the stated deadline so that solicitation release dates, evaluation, approval, and disbursement of funds can all occur on the same schedule. When DBH fails to submit grant program requirements or procurement requests on time, the entire process is delayed, and funding may not be delivered by the start of the grant cycle.

As described previously, DBH is the largest user of grant procurements and provider agreements within the Department. The behavioral health system relies more heavily on grant-based funding than any other aspect of the State's health and social services framework. Delays in grant fund disbursement are thus very detrimental to behavioral health providers. Providers rely on grant funds to remain solvent, and if funds are not available at the beginning of the quarter they are often forced to take out loans to continue operating. The Division's non-adherence to standard grant cycle timelines has created administrative inefficiencies within the grant procurement process that impacts both the Department and the provider community. For more information regarding this finding, see Section 4.3.1 and 4.3.4.

9.5.2. FINDING: The flexibility of grant requirements and the variety of service delivery methods they facilitate are substantial factors in the value and necessity of grant procurements, but the Department would ensure greater accountability of both providers and Division employees if grant requirements were defined more strictly.

Grant procurements are essential for the Department to maintain statewide access to mental health and substance abuse services. The flexibility afforded to provider grantees to use funds as needed within a specific program enables them to respond to the specific needs of their community. The community-needs-based model is only possible with the flexibility that stems from grant-based financing. However, the drawback to grant funding is limited accountability. Often deliverables and expectations are not clearly communicated by DBH at the onset of a grant cycle resulting in both real and perceived non-compliance of providers. The confusion and occasional muddiness that results from ambiguous regulations regarding how to spend grant funds and how to define service lines calls into question both the performance of providers and the performance of DBH at managing grant procurements. Without a robust system of performance measurement that is linked to grant procurements neither grant managers nor grantees can be held accountable for their respective responsibilities.

For example, utilization of evidence-based practices is a requirement of many Treatment and Recovery grants. This requirement is built into the grant requirements to promote effective treatments and ensure the Department is procuring value and effectiveness rather than just volume. DBH grant and program managers define evidence-based practices much more broadly than SAMHSA, and with good reason. Often DBH will accept the provider's word that they are utilizing the evidence-based practice in lieu of conducting a program alignment analysis to see if it meets the requirements. Alaskan communities are for the most part starkly different from the regions in which these practices were tested, and it would be inappropriate to rigorously enforce evidence-based practice program standards. In this situation, the flexibility of the requirements appears to benefit providers, DHSS, and consumers, yet slightly more rigid requirements would better serve the needs of the Department and the behavioral health system overall.

While flexible regulations regarding evidence-based practices ensure grantees are not needlessly providing inappropriate or inadequate mental health and substance abuse treatment services to Alaskans, they are not ensuring that providers are providing effective treatment. Within these flexible regulations DBH grant and program managers are able to confirm providers are delivering evidence-based practices without testing the fidelity of the programs, and because the purpose of requiring evidence-based practices is to ensure that the Department is procuring effective, rather than ineffective, treatments without rigid adherence to the program standards the Department cannot be sure that the services are achieving the desired treatment outcomes. This issue would be moot if DBH had a robust performance measurement system that evaluated service effectiveness. As discussed in Section 4.0, the Division is still working towards that goal.

The Department can redefine key aspects of the grant regulations to increase accountability without losing the important flexibility inherent in grant funding. By amending the regulations such that there is specific flexibility in certain areas, such as evidence-based practices, but strict definition in others, such as services at high risk for fraud, the Department could preserve the needed flexibility without sacrificing accountability. Integrating grant procurements with a performance measurement system would improve provider accountability while maintaining the ability of providers to adapt service delivery to best meet the needs of their community. Providers would still be able to adapt evidence-based practices to be appropriate for their consumers provided that the resulting programs are still effective. Additionally it would improve accountability on the part of grant and program managers to make sure they are fulfilling their responsibility to enforce grant regulations and facilitate service delivery. Without an integration of grant funding and performance measurement, grant procurements become simply a means for the Department to transfer funds to behavioral health providers rather than a means to promote quality. The Department can define grant regulations more strictly without sacrificing the essential flexibility afforded by grant funding. See Sections 9.2.4 and 9.3.4 for recommendations related to this finding.

9.5.3. RECOMMENDATION: The Department should include a simple dashboard in the GEMS program that visually tracks program goals and percent completion. Although tracking for some qualitative measures may be difficult, simple graphics demonstrating percent completion are useful in helping grantees to remain on track.

As the Department moves towards a standardized method of performance metrics and evaluation, the Department should include a simple dashboard in GEMS that visually tracks grantee performance. GEMS is used by grant and contract managers within the Grants and Contracts Section, program managers at DBH, and behavioral health grantee providers. A clear, easily understood visualization of grantee performance on the metrics used by the Department to evaluate grant compliance, treatment outcomes, and other areas of interest would be of service to all parties. It would make it much easier for grant managers to see a snapshot of how each grantee is performing, such as with RBA measures or budget and finances, and anticipate or identify serious issues requiring assistance. The dashboard would also assist grantees in tracking their own performance and completion of grant requirements. The Department should develop a dashboard viewable within GEMS that visualizes grantee performance on key indicators that speak to the agency's grant compliance, fiscal stability, and program quality. See Sections 9.3.6 and 9.4.1 for more information related to this recommendation.

9.5.4. RECOMMENDATION: The Department should increase its ability to monitor, track, and limit the administrative costs incurred from the grants and contracts management process.

The Department should improve its monitoring of administrative costs of grant and contract management. Currently the regulations governing administrative and other indirect costs of the operations of grant recipients and contracted vendors are loose and ambiguous. The fiscal information collected by grant and contract managers within the Grants and Contracts Section and DBH does not clearly indicate the administrative costs incurred by grantee agencies in their efforts to comply with the Department's grant and contract requirements. The Department should improve its data collection and tracking of these administrative costs to better inform both the grants and contract procurement and management processes. See Sections 4.3.1 and 9.1.4 for more information related to this recommendation.

9.5.5. RECOMMENDATION: The Department should consider limiting administrative costs during the contracting process to 7-10% of the total contract cost.

The Department should limit administrative costs allowed within its grants and contracts to 7-10% of the total cost. As discussed in Section 9.1.4., the Department has the option within the Alaska Administrative Code to define the administrative costs allowed within each grant agreement. A review of behavioral health grant procurements and conversations with the Grants and Contracts Section indicated that DHSS does not currently exercise this option. Other states often require grantees and vendors to limit administrative costs to 7-10% of the total value of the contract. While this tactic may spur providers to "hide" their administrative costs by shifting them to other areas or "buckets," the proposed budget guidelines are sufficiently detailed in all other areas to limit a provider's ability to hide excessive administrative costs elsewhere. The Department should amend its grant agreements to limit allowable administrative costs to 7-10% of the total value of the grant in order to maximize funding devoted to direct behavioral health service delivery and minimize funding dedicated to indirect costs.[169]

9.5.6. RECOMMENDATION: The Department should also consider further monitoring grant and contract budgets to ensure that costs are properly allocated across each of the major cost or functional areas.

The Department should analyze its budget for behavioral health grants and contracts to ensure costs are allocated appropriately across its focus areas. As the Department implements results based budgeting, it is important that the Department have an in-depth understanding of the budget for its operating grants. The grants and contract budget analysis would entail an examination of the DHSS operating budget dedicated to grants and contracts administration within the Grants and Contracts Section and DBH and the funds distributed to behavioral health grantees and vendors. After collecting that budget information and detailing

[169] It is important to note the caveats, discussed in Section 9.1.4, currently constraining the Department's ability to establish strict limits to provider administrative costs.

how the funding is used, the analysis should align expenditures with RBA performance measures, DBH core services and priorities, and areas of urgent need. The Department should increase its monitoring of grant and contract budgets to ensure expenditures are allocated appropriately across service lines. See Section 9.1.4 for more information regarding this recommendation.

9.5.7. RECOMMENDATION: The Department should continue its progress in transitioning from grants to contract-based financing for behavioral health services that are amenable to fee-for-service billing.

The Department should continue its progress in transitioning certain mental health and substance abuse services from grant-based to contract-based financing. ISAs and other contracts can be used to stimulate utilization of important behavioral health services, as well as fund services with predictable and consistent costs and utilization. The Department should continue to use ISAs and contracts to procure treatment services that are essential to a robust behavioral health system, such as the wraparound services covered in the SMI, SED, and SUD ISA.

Additionally, DBH should continue to identify services that have customary annual charges per consumer, set a reasonable yearly maximum utilization, and procure those services through contracts. While many services are best funded through grants due to unpredictable costs and need, there are also behavioral health services amenable to fee-for-service like reimbursement that can be financed through contracts. DBH can determine these services through analysis of AKAIMS utilization data and procure them through contracts, thereby improving provider accountability and stabilizing the budget. The Department should continue to transition appropriate services to contract-based financing in order to maintain utilization of essential services and improve provider and budget accountability. For more information regarding this recommendation, refer to Section 9.1.6.

9.5.8. RECOMMENDATION: The Department should review the grant management process to ensure that grant administrative burden is commensurate with the size of the grant award.

As requirements currently exist, behavioral health grantees have the same reporting requirements regardless of the size of the grant award. The documentation procedures and grant reporting requirements are onerous yet for each grant program they are required of all recipients, regardless of the value of the grant. Behavioral health providers receiving over a million dollars in grant funding and those providers receiving only the so-called “dollar grants” to be eligible for Medicaid enrollment are required to submit to DBH the same information regarding finances, utilization, performance measures, and outcomes. The Department should review the administrative burden associated with grant management and, so long as they meet federal requirements and the needs of the State, take steps to ensure the burden is proportional to the value of the grant award.

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10.0. FEDERAL COST COLLABORATION

Determine whether the Department's current program structure maximizes available opportunities for collaboration and partnership with the Alaska Native Tribal Health Consortium (ANTHC) and federal entities to ensure appropriate assignment and payment of costs are allocated to federal entities such as Veterans' Affairs and Indian Health Services. This should address the following:

A. Does the current structure maximize the collaboration and partnership opportunities with federal entities to ensure proper assignment and payment of costs?

B. Are there changes that can be made to increase the level of collaboration and partnership with federal entities?

C. What cost savings can be realized by increasing the level of collaboration and partnership with federal entities?

10.1. Ensuring Proper Assignment and Payment of Costs

10.1.1. FINDING: The Department continues to be a national leader in its cost collaboration with tribal health systems through the Medicaid program.

DHSS collaborates extensively with tribal health systems to provide behavioral health services to all Alaskans. Each year the Department meets with the Alaska Native Health Board (ANHB) Tribal Health Directors and ANTHC in a "mega meeting" to discuss federal and state legislative priorities and initiatives.[170] DHSS division directors and tribal leaders contribute to the discussion of areas for improvement in federal-state-tribal collaboration and reducing disparities in care, and together develop priorities for legislative advocacy at the state and federal level. These discussions continue in more detail through the State/Tribal Medicaid Task Force (MTF). The MTF is an alliance built upon the shared recognition of the importance of Medicaid funding to the health and wellbeing of Alaska Natives and the value of a robust tribal health system to the State. Through these partnerships, the Department works to maximize cost collaboration and cost sharing opportunities with the federal government for the treatment of American Indian and Alaskan Natives (AI/AN) with behavioral health disorders.

At the policy level, this cost collaboration can be seen in the Department's telebehavioral health policy. All customary behavioral health providers, including psychiatrists, masters-level clinicians, social workers, and behavioral health aides are eligible to provide Medicaid-reimbursable telebehavioral health services.[171]

[170] "Collaborative State/Tribal Meetings," Alaska Department of Health and Social Services, Accessed July 10 2015. http://dhss.alaska.gov/Commissioner/Pages/TribalHealth/meetings.aspx.
[171] Alaska Medical Assistance Provider Billing Manuals: Tribal Facility Services, Policies and Procedures, Xerox State Healthcare LLC, July 31, 2012.

Telebehavioral health is essential to provide access to needed behavioral health services in rural tribal communities, and the Department has structured its Medicaid telehealth policies to encourage utilization of telebehavioral health services.[172] It is one of only eight states to receive the highest ranking from the American Telemedicine Association on telebehavioral health services.[173] Furthermore, Alaska Psychiatric Institute's (API) Telebehavioral Healthcare Services outpatient program currently partners with the Maniilaq Health Corporation and the Copper River Native Association to provide intensive outpatient treatment for AI/AN individuals in those communities. By authorizing an expanded array of telebehavioral health services in tribal facilities the Department is effectively maximizing its federal Medicaid reimbursement.

Furthermore, in many areas of Alaska, the tribal and the DHSS-operated behavioral health systems typically converge, with all services delivered through a single tribal provider that receives funding from both systems. While there is significant need for behavioral health treatment, the population and communities are too small to support a diversity of behavioral health providers. Additionally, it is difficult to find behavioral health providers who are looking to work in rural and rural-remote communities. Consequently, tribal providers are the only providers in certain DBH service areas in Alaska.[174] The Department receives 100% federal reimbursement for services delivered to American Indians and Alaska Natives in a tribal facility, so when tribal facilities are the only option available to the community, the Department is guaranteed to maximize its opportunity for cost collaboration with the federal government. For example, Yukon-Kuskokwim Health Corporation (YKHC) is the principal health care provider in the Y-K Delta and the only provider of Medicaid-eligible behavioral health services for that region.

The Department works extensively with the tribal health system to develop and manage a behavioral health service structure that meets the needs of the AI/AN population while maximizing the opportunity for reimbursement and funding from Centers for Medicare and Medicaid Services (CMS). DHSS is effective at identifying and pursuing areas for cost collaboration with the federal government through CMS.

10.1.2. FINDING: As an early adopter of Medicaid outreach and enrollment initiatives among tribal providers and recipients, the Department operates a mature partnership that already takes advantage of most readily available opportunities for cost collaboration with the tribal system.

With 14% of its population identifying as AI/AN, Alaska has the highest percentage of American Indian and Alaska Natives of any state.[175] The AI/AN population has a higher rate of eligibility for Medicaid services than non-Natives and about 40% of Alaska Medicaid enrollees identify as American Indian or Alaska Native. The Department recognized the importance of outreach and enrollment initiatives early on in the development its Medicaid program and has worked to overcome common barriers to enrollment, such as distrust of the State government, language and literacy challenges, and geographic or transportation

[172] See Section 8.0 for a more in-depth treatment of this topic.
[173] American Telemedicine Association.
[174] FY 2015 Treatment and Recovery Grantees, Division of Behavioral Health, February 10, 2015.
[175] State & County QuickFacts: Alaska, United States Census Bureau.

barriers. To encourage and strengthen outreach services the Department has developed strong working relationships with the Alaska Native health corporations.[176]

These early outreach and enrollment tactics have contributed to what is today a mature partnership between the Medicaid and tribal systems. The efforts have been captured in what has been called "excellent" data collection practices.[177] The Medicaid program experienced a surge in enrollment in the early 2000s, but has experienced a slower rate of growth than the national average since 2004.[178] Furthermore, the Native and non-Native populations are projected to experience the same low rate of growth, 1.1% over the next 15 years.[179] The Medicaid program is already effective at identifying and taking advantage of the readily available opportunities for cost collaboration resulting from enrollment initiatives.

The Department also pursues opportunities for cost collaboration through infrastructure development of the tribal system. Following a 2007 report to the Legislature by Pacific Health Policy Group that identified opportunities for mutually beneficial collaboration between the two systems through Medicaid, the Legislature authorized SB 61 to implement recommendations for building long-term care and behavioral health capacities among tribal providers and to explore wider Medicaid payment reforms to bring maximum economic benefit to the State and to both systems. Today, many of the opportunities originally identified in the report have already been fully implemented.

In long-term care, for example, tribal-operated nursing homes were initially established in Kotzebue and Bethel, followed by construction of a major long-term care facility on the campus of the Alaska Native Medical Center (ANMC) in Anchorage. Through 2013 Senate Bill No. 88, the Legislature authorized the Department of Administration to partner with ANTHC to develop a patient housing facility.[180] By increasing the accessibility of ANMC for AI/AN individual traveling from across the state, the Department will save an estimated $8 million per year in Medicaid spending.[181] Suggested collaboration between State and tribal systems on behavioral health have also borne fruit, with systems working together to facilitate administrative streamlining, coordinated telebehavioral health expansion, behavioral health and primary care integration, and cooperation to open up Medicaid provider and service categories specially adapted to serving the rural Alaska population. However, most remaining opportunities for substantial cost collaboration depend on more far-reaching reforms of the Medicaid system through expanded eligibility, waiver demonstrations to establish federal funding for state-only behavioral health services, and additional reimbursement reforms.

[176] American Indian and Alaska Native Eligibility and Enrollment in Medicaid, SCHIP, and Medicare: Individual Case Studies for Ten States, Kathryn Langwell et al., December 2003.
[177] Medicaid and Indian Health Programs: Indian Health Finance, Edward J. Fox and Verné Boerner, March 2009.
[178] Medicaid Program Review, The Pacific Health Policy Group, January 2007.
[179] Long-term Forecast of Medicaid Enrollment and Spending in Alaska: Supplement 2009-2029, Medicaid Budget Group, Finance and Management Services, January 2010.
[180] "State Moves Funding of Alaska Native Tribal Health Consortium Housing Forward," Alaska Department of Revenue, August 26, 2014.
[181] "Will $35 Million Facility at Alaska Native Medical Center Save Millions?," Alaska Dispatch News, April 9, 2013.

10.1.3. FINDING: The Department has formulated Medicaid regulations and grant and contract requirements to serve the needs of tribal communities, meet the challenges of rural-remote populations, and maximize opportunities for collaboration with tribal providers.

The Department's Medicaid regulations and grant and contract requirements have been molded to meet the needs of tribal communities. Numerous policies are in place that specifically address the needs of tribal and rural-remote populations. With the largest population per capita of AI/AN, and a third of residents living in rural and rural-remote areas, the Department has recognized the difficulties inherent in serving these communities and adapted its policies and regulations to address them.

For example, the Department's Community Health Aide Program (CHAP) recognizes behavioral health aides (BHAs) as Medicaid-eligible provider types when operating in the tribal health system. BHAs provide counseling, health, education and advocacy in tribal communities to individuals with behavioral health disorders and their families.[182] The training and certification required to become a BHA is less onerous than other staple Medicaid provider types, such as a social worker or masters-level clinician, and is better positioned than traditional credentialing systems to take advantage of the available workforce already residing in community service areas. The Department's sponsorship of this provider type significantly increases access to behavioral health services in rural Tribal communities. Because BHAs deliver services in tribal communities, their billable services are typically eligible for 100% federal Medicaid reimbursement. This program is an example of highly effective collaboration between the Department and the tribal health system.

Additionally, the Department's grant and contract requirements are formulated to adapt to the needs of tribal and rural communities. There is an increasing focus across the nation on requiring behavioral health providers to implement evidence based practices. For example, the Substance Abuse Mental Health Services Administration (SAMHSA) includes evidence-based practices as criteria for receiving funding through the Strategic Prevention Framework Incentive Grant (SPFSIG). According to SAMHSA, a practice must be included in one of the following three categories to be classified as an evidence-based practice:[183]

1. The intervention is included in Federal registries of evidence-based interventions;
2. The intervention is reported (with positive effects on the primary targeted outcome) in peer-reviewed journals; and
3. The intervention has documented evidence of effectiveness, based on guidelines developed by SAMHSA and/or the State, tribe or jurisdiction.

Despite the strong push for greater penetration of evidence-based practices in the nation's public behavioral health systems, clinicians familiar with rural Alaska contexts have questioned the appropriateness of standard evidence-based prevention and treatment practices in relation to the cultural factors and specific

[182] Behavioral Health Aides: A Promising Practice for Frontier Communities, National Center for Frontier Communities, August 2012.
[183] SAMHSA Criteria, Center for Substance Abuse Prevention, SAMHSA, 2009.

behavioral health needs of rural Alaska.[184] Most interventions documented in peer-reviewed journals have been tested in urban areas in the lower 48 states. Alaska's rural and rural-remote populations are unique in their isolation and, in the case of tribal communities, culture and history. Behavioral health interventions that are culturally sensitive and appropriate to the scale of the community are likely to be developed only within rural Alaska. Even so, these interventions are unlikely to meet evidence-based criteria, given the funding- and time-intensive resources required for extensive clinical research.

The Department's prevailing attitude to evidence-based practices appears to emphasize flexibility in clinical requirements and the adaptability of evidence-based treatment protocols to local conditions. Overall, the Department operates on the basis of "local solutions for local challenges"[185] and grants considerable discretion to partnered providers to determine what works in practice in rural Alaska. Rather than force the implementation of inappropriate behavioral health interventions, the Department works with grantees to build customized strategic plans for treating their communities. Although this position potentially invites fraud, waste, and misuse risks, to be sure (see Section 13.1.9 for some of the potential program integrity implications), it can also facilitate more effective interventions while simultaneously reducing the regulatory barriers that lead to excessive spending constraints and inefficient expenditures.

One such example of this approach is the implementation of the Parenting with Love and Limits (PLL) and Transition to Independence Process (TIP) evidence based programs. DBH piloted these programs across the state but chose to "refine the practices for village settings and Alaska Native population to address disparities."[186] Another example is the Family Wellness Warriors Initiative, a grant program intended to restore wellness to the Alaska Native community by bringing together tribal leaders, regional corporations, health providers, and other interested stakeholders to address all forms of violence that occur within a family.[187] Within the Medicaid regulations, grant criteria, and specific programs operated the Department has tailored policies to address the unique challenges of rural and tribal communities. Its core structure as a *community-based* behavioral health system has allowed DHSS to address these challenges effectively and maximize opportunities for collaboration with the tribal provider system.

10.1.4. FINDING: The Department has already fully developed opportunities to incentivize tribal provider participation in Medicaid through enhanced reimbursement rates.

CMS offers the option of 100% Federal Medicaid Assistance Percentage (FMAP) for Medicaid services provided AI/AN individuals in tribal facilities. This option benefits both the State and the tribal

[184] See, for example, Lisa Wexler and Joseph Gone, "Culturally Responsive Suicide Prevention in Indigenous Communities: Unexamined Assumptions and New Possibilities," *American Journal of Public Health*, vol. 102: no.5 (May 2012), p. 800-6.
[185] Suicide in Alaska: Research and Community Prevention Strategies, James Gallanos, Division of Behavioral Health, December 2009.
[186] State of Alaska's Partnership to Improve Outcomes for Adolescents and Families Substance Abuse and Mental Health Services Administration: FY 2013 Cooperative Agreement for State Adolescent and Transitional Aged Youth Enhancement and Dissemination Public Notice, Alaska Department of Health and Social Services.
[187] Fiscal Year 2014 Operating Grants, Alaska Department of Health and Social Services, December 2013.

organizations. The State receives additional federal dollars to support its Medicaid program, and tribal facilities receive more money to provide care. The Department negotiated with CMS to receive the 100% FMAP for eligible services, and has advocated for the widest possible array of services to receive the 100% FMAP. Alaska's Medicaid program allows for the following additional services to be covered on top of the standard services provided in tribal facilities:

- Services delivered by providers that provide care to the AI/AN population through Indian Health Services (IHS) contracts but are not owned or operated by IHS; and
- Emergency transportation services.[188]

The Department has taken advantage of all opportunities available to encourage tribal provider participation in the Medicaid program through enhanced reimbursement rates. Tribal provider participation is also incentivized by the encounter rate set by IHS. For certain behavioral health services, IHS tribal providers receive an encounter rate rather than a fee-for-service reimbursement. The outpatient encounter rate is set by the federal government, and Alaska's rate is substantially better than the prevailing rate in the lower 48 states. In 2014, Alaska's encounter rate was $564 in comparison to $342 for the other states. The rate is also considerably higher than the reimbursement available to non-tribal providers in Alaska. Although the Department does not set the encounter rate, it is another way in which tribal providers are encouraged to participate in the Medicaid program and affects the cost structure of the Department's Medicaid program.

10.1.5. FINDING: The Department serves a disproportionate number of Alaska Natives with serious mental illness (SMI) due to under-developed acute inpatient psychiatric capacity for these individuals within the tribal system.

Considering the vast, sparsely-populated coverage areas and chronic workforce shortages faced by many tribal providers, the range of behavioral health services they are able to offer to consumers in their regions is impressive. However, some of the acute and residential psychiatric services at the costliest end of the care continuum are not economically feasible in rural Alaska, and can only be found within the state's population centers. Behavioral health services with the highest acuity continue to be delivered predominantly by non-tribal providers, either at API or through the DHSS-funded Designated Evaluation and Treatment (DET) beds at hospitals in Fairbanks and Juneau.

Yukon-Kuskokwim Health Corporation (YKHC), based in Bethel, is the only tribal provider that operates a Designated Evaluation and Stabilization (DES) program that provides evaluation, stabilization, and short-term treatment and referral services on par with these critical services. Tribal providers in other regional hubs, are more likely to have one or two set-aside beds in their medical centers for psychiatric or alcohol patients. Because full federal funding is available only when care is provided through an IHS or tribal facility, the State bears much of the cost of providing high-end inpatient psychiatric services to the AI/AN population when delivered through non-tribal hospitals.

[188] The 100% Federal Medical Assistance Percentage: A Tool for Increasing Federal Funding for Health Care for American Indians and Alaska Natives, Megan J. Renfrew, Columbia Journal of Law and Social Problems, 2006.

As a matter of demographics within the state, the psychiatric bed infrastructure within the tribal system is clearly underdeveloped, especially in the Anchorage/Mat-Su Region, where it is arguably most critical. Approximately 30% of the AI/AN population in Alaska resides in this region,[189] and it is also home to the state's flagship tribal hospital and the leading tribal behavioral health provider. Although ANMC in Anchorage maintained 18 psychiatric beds when first built in 1960, the hospital currently does not operate any psychiatric beds.[190] YKHC, which serves the second-largest regional population of Alaska Natives (19%), supports only two inpatient psychiatric beds in its DES. Overall, acute psychiatric services represent a missing layer of the continuum of care within the tribal behavioral health system.

With the high prevalence of SMI among AI/AN adults and the expense associated with effective treatment of SMI, the development of acute psychiatric care capacity is a leading opportunity for cost collaboration with the tribal system, both to alleviate overwhelming census pressure on API and to ensure that the federal government meets its obligations in providing services to AI/AN communities. In Alaska, DHSS can receive a 100% FMAP for Medicaid-eligible services provided to AI/AN individuals in an IHS or tribal facility. In FY 2014, the Department spent approximately $9 million dollars on acute psychiatric services for AI/AN treated at API.[191] In the absence of an IHS or tribal inpatient psychiatric facility, the Department covers the cost of these services and receives only the statewide FMAP of 50%[192] when these services are Medicaid-eligible and full cost when they are not. Although the Department has a responsibility to serve all Alaskans with SMI and does not see a dichotomy between its responsibility for tribal and non-tribal members, the capacity for drawing fully-matched Medicaid payments for the State's most expensive services is of great potential financial benefit for both systems.

10.1.6. FINDING: In 2012, the Alaska Veterans Affairs Healthcare System (AVAHS) established sharing agreements with 26 tribal providers, which increased enrollment in veterans' programs, reduced VA system costs, and infused new funding sources into the tribal health system. Although the Department is not a party to these agreements, the expansion of VA-reimbursable options reduces dependency on state-funded direct care provided by tribal providers.

The Department benefits indirectly from reimbursement and sharing agreements between tribal providers and AVAHS. In 2012 the VA and IHS signed a formal agreement intended to improve access to health care services for veterans across the country. Under the terms of this agreement, the VA is able to enter into formal sharing and reimbursement agreements with tribal health providers that enable the VA to reimburse tribal clinics for services provided to veterans. AVAHS signed sharing and reimbursement agreements with 26 tribal health providers. While each tribal organization negotiated its own agreement with AVAHS, the agreements are nearly identical and include the following foundational features:

[189] Alaska Population Overview: 2013 Estimates, Research and Analysis Section, Alaska Department of Labor and Workforce Development, February 2015.
[190] 2014 Annual Report, Alaska Native Tribal Health Consortium, 2014.
[191] Presentation: Division of Behavioral Health, House Committee on Health and Social Services, February 19, 2015.
[192] ASPE FMAP 2014 Report, Department of Health and Human Services, November 30, 2012.

1. All AI/AN eligible veterans in the geographic area in which the tribal health program operates have access to the health services for which they are eligible that are provided by the tribal health program; and
2. All eligible veterans have access to emergency services provided by the tribal health program.[193]

The agreement functionally expands the VA provider network in the regions served by the tribal health programs by allowing veterans to receive healthcare benefits from non-VA providers. It also allows all eligible veterans, regardless of ethnicity, to access emergency services. Additionally, some tribal health providers chose to adopt a resolution authorizing non-Native veterans to receive all eligible health services rather than solely emergency services.[194] Although the Department is not a party to these sharing and reimbursement agreements, its capacity for cost collaboration between state and tribal systems increases by diversifying the payer mix at tribal health providers. In rural and rural-remote communities there is a limited supply of healthcare providers, and expanding the VA-reimbursable options available reduces dependency on state-funded direct care provided by tribal providers. See Section 10.2.2 for a recommendation related to this finding.

10.1.7. FINDING: Recent changes in the Veterans Health Administration's authority to procure non-VA behavioral health services increase the overlap between VA and State systems, creating additional opportunities for cost collaboration.

There have been two recent changes to the VA's health procurement policies that present additional opportunities for cost collaboration. In 2013, the VA initiated the Patient Centered Community Care (PC3) Program.[195] The VA contracted with large provider networks across the country to provide certain health care services when they are not readily available through a VA health care facility. The services purchased under PC3 contracts include mental health services. Accordingly, veterans requiring behavioral health services not available through their local VA health facility will receive the needed services through a provider in the contractor's network. The PC3 Program increases the overlap between the AVAHS and State-run health systems by expanding the health providers receiving both state and federal reimbursements. This overlap provides the Department with additional opportunities for cost collaboration such as data sharing and improved identification of benefits-eligible veterans and targeting of behavioral health services to areas of highest utilization.

Additionally, the Veterans Access, Choice and Accountability Act of 2014 ("Choice Act") expands veterans' access to non-VA providers and increases the Department's opportunities for collaboration with AVAHS. Under the Choice Act, veterans who are unable to receive an appointment within 30 days of their requested date, live more than 40 miles away from an AVAHS facility, or face excessive travel burdens

[193] VA Approved Template: Sharing and Reimbursement Agreement between Department of Veterans Affairs, Alaska VA Healthcare System and Alaska Tribal Health Program for Direct Care Services, Alaska Native Health Board, 2014.
[194] "Begich Applauds Historic Agreement to Bring Health Care," Office of Senator Mark Begich, May 4, 2012.
[195] "Patient-Centered Community Care (PC3) – Information for Veterans," U.S. Department of Veterans Affairs, Accessed July 8, 2015. http://www.va.gov/PURCHASEDCARE/programs/veterans/nonvacare/pccc/PC3_for_Vets.asp.

can choose to receive care from eligible non-VA health care providers.[196] Veterans who are eligible for the Choice Program receive a "Choice Card" that allows them to receive care from non-VA providers, without even the in-network provider limitations to which the PC3 program is subject. Like the PC3 Program, though, the Choice Program further expands the pool of providers available to veterans and increases the number of Alaskan behavioral health providers able to diversify their funding sources among state grants, Medicaid and VA reimbursement.

10.1.8. FINDING: Since 2010, the Department has collaborated directly with the VA Healthcare System through the Rural Veteran Health Access Program to expand telehealth capacity in Southeast Alaska and enroll non-tribal providers as VA vendors.

DHSS collaborates with the AVAHS to develop and manage the Rural Veterans Health Access Program (RVHAP). RVHAP is funded by the federal Health Resources and Services Administration (HRSA) as a demonstration project from 2013-2016.[197] The object is to increase access to and quality of mental health care for veterans and rural residents in Southeast Alaska through telehealth and health information technology (HIT). DHSS works with AVAHS to develop the a telehealth network and capacity for electronic communication between these providers, expanding access to mental health services and improving care coordination for veterans seen by both VA and private providers. The network is framed by the involvement of a non-tribal community health center (preventing duplication of scarce telehealth resources with the tribal system), as well as a critical access hospital, and a community mental health center all located in Southeast Alaska.[198] To date, telebehavioral health services and outreach for assistance with VA eligibility and claims have been implemented at five rural sites.

The Department coordinates the RVHAP through the Division of Public Health's Health Planning and Systems Development Section and Office of Rural Health. RVHAP does not fall under the authority of DBH, though DBH has included it in its Change Agent Conference and is involved in the program's development. Within RVHAP, DHSS and AVAHS have applied for federal subsidies to help cover the cost of providing bandwidth to rural providers, established video connectivity in six rural areas, and begun service expansion to three remote sites. This initiative is an effective mode of cost collaboration, and the Department has seized the opportunity to use federal funds to develop telebehavioral health capacity.

[196] Veterans Choice Program, U.S. Department of Veterans Affairs.
[197] HRSA Funded Rural Veterans Health Access Program, Health Planning and Systems Development Section, Division of Public Health.
[198] Rural Veterans Health Access Program Presentation, Health Planning and Systems Development Section, Division of Public Health, February 2015.

10.2. Recommendations for Increasing Collaboration with Federal Entities

10.2.1. RECOMMENDATION: The Department should continue to encourage tribal providers to develop greater service capacity for meeting the needs of Alaska Natives with SMI.

The Department should continue to encourage tribal health providers to develop the service capacity necessary to meet the needs of AI/AN individuals with SMI. The treatment capacity available to consumers with SMI is insufficient to meet the needs of the Alaskan population. This pattern extends to the tribal system. As SMI occurs within the Alaska Native population at a rate over double that of the general population, increasing the capacity of the tribal system to provide SMI services would be a significant opportunity for collaboration and cost sharing.

More specifically, the Department should encourage and collaborate with tribal providers to develop the capacity for inpatient psychiatric beds and acute psychiatric care at tribal health facilities. In site visits to Bethel, PCG learned that discussions are underway with Yukon-Kuskokwim Health Corporation (YKHC) to become a DET facility. Adding DET bed capacity in that region would remove the need for consumers to travel to Anchorage to receive DET services and allow individuals to remain closer to their home communities. However, this critical capacity is also needed in Anchorage as much as at the state's regional hubs.

Of course, a cost collaboration solution between State and tribal systems that simply shifts the cost burden from one system to the other is not likely find positive reception. The goal must really be to optimize the collective funds available within both systems to support continued development of high-acuity infrastructure, to allow for significant re-investment by each system into stronger preventative and early intervention services, and to promote appropriate utilization within and between the two systems. Despite more favorable reimbursement rates and greater discretion in the use of behavioral health funding available to tribal providers, in comparison to the Medicaid rates and grant requirements to which non-tribal providers are subject, the tribal system is under considerable financial pressure in its own right. Historically-low IHS allotments, compounded by federal sequestration measures, have reverberated throughout the tribal system and diminished critical service capacity.[199] For this reason, PCG has recommended other steps the Department could take to facilitate the expansion of tribal psychiatric bed capacity, in order to share some of the cost and administrative burdens and ensure the sustainability of cross-system partnerships.

By working with tribal providers to increase capacity for acute psychiatric services, the Department can improve access of AI/AN individuals to care that is potentially more culturally responsive. Institutional psychiatric treatment is not representative of any community, but it is particularly alienating for individuals hailing from rural and rural-remote areas who are unfamiliar with the urban environment. It is advantageous for all parties involved – DHSS, tribal corporations, behavioral health consumers, and the consumer's family and social supports – for individuals with SMI to remain within their community as long as possible.

[199] The most dramatic impact on Alaska's tribal system was SEARHC's closure of the Bill Brady Healing Center following the federal sequestration, which has further harmed the state's already low drug and alcohol treatment capacity.

By continuing to encourage tribal providers to develop the service capacity needed to treat individuals with SMI, the Department can better serve AI/AN consumers with SMI, alleviate census pressure on API, and create the opportunity for substantial cost savings to the State. See Sections 10.1.5 and 10.3.1 for more information regarding this recommendation.

10.2.2. RECOMMENDATION: The Department should improve its efforts to identify veteran recipients who may be eligible for services through the AVAHS.

To improve cost collaboration and cost sharing with AVAHS, the Department should continue to improve its efforts to identify veterans who may be eligible to receive behavioral health services through AVAHS rather than the State. The State already uses a variety of mechanisms to identify an individual's status as a veteran. For example, Alaskans can choose to indicate their veteran status on their driver's license. Additionally, the Permanent Fund Corporation tracks the veteran status of Alaskans. The Department should build upon its own and other State efforts to identify veteran behavioral health care recipients to maximize the volume of services reimbursed or funded by AVAHS rather than DHSS.

The Department can augment the aforementioned to identify veteran recipients of behavioral health services with a complete implementation of the Master Client Index (MCI) and utilization of the Public Assistance Information Reporting System (PARIS) "Veterans Match" report. As a shared system across all of DHSS, the MCI has one unique client profile for each individual. If an Alaskan veteran is served by Senior and Disabilities Services (SDS) prior to seeking public behavioral health services and reports their veteran status to SDS, DBH providers will be able to access the client record and identify the individual as a veteran. An accurate and complete MCI will improve the Department's efforts to identify veterans.

Additionally, the Department should explore using PARIS, a federal data matching service that checks to see if recipients are receiving duplicate benefits in more than one state. The Department does not currently use PARIS matching to identify behavioral health consumers who are veterans and may qualify for federal VA benefits. By improving its ability to identify veterans eligible for behavioral health services through AVAHS the Department will have the opportunity for additional cost collaboration and cost sharing with the federal government, with savings of up to $1 million.[200] See Section 10.1.6 for more information regarding this recommendation.

10.2.3. RECOMMENDATION: The Department should proceed with implementing Medicaid 1915(i) and 1915(k) options in order to open up new opportunities for Medicaid financing through CMS.

The Department should implement 1915(i) and 1915(k) options to open up new opportunities for Medicaid financing through partnered tribal providers. 1915(i) is a section of the Social Security Act (SSA) that

[200] It should be noted that the greatest share of potential cost savings/cost avoidance is likely to accrue from the third-person liability identified for Medicaid long-term care services. The proportion of cost savings attributable directly to behavioral health services is too difficult to estimate with the information available.

established an optional federal Medicaid benefit which gives states a new method to cover home and community based (HCBS) services.[201] The services authorized under 1915(i) specifically included "day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness."[202] Importantly, States can take advantage of 1915(i) through a state plan amendment rather than a waiver, avoiding the additional administrative burden and cost normally associated with Medicaid waivers.

The Medicaid 1915(k) option also impacts HCBS services. This section of the SSA, added in 2010 as a part of the Affordable Care Act, established the Community First Choice (CFC) program. CFC is Medicaid state plan option intended to encourage the use of HCBS services by supporting a six percent increase in FMAP and reimbursing states for additional HCBS attendant services. To receive authorization for the CFC program from CMS, the State must make hands-on assistance and instruction provided for essential and instrumental activities of daily living Medicaid-eligible. Under this program, the aforementioned services provided to Medicaid-eligible individuals who meet the institutional level of care will be reimbursable. Many consumers served by the Department require an institutional level of care and would benefit from assistance with daily living activities. The 1915(k) option will enable the Department to more effectively meet the behavioral health needs of the population served and achieve additional cost sharing with CMS.

Both the 1915(i) and 1915(k) Medicaid options can be administered through a state plan amendment rather than a waiver. With these options, the potential for increased administrative burden and cost is low, the benefits afforded to consumers in terms of access to needed services is high, and the financial contribution of the federal government is high. It is estimated that the Department could achieve annual savings of between $10 and $15 million with these waivers. The Department should continue with its implementation of the 1915(i) and 1915(k) options in order to open up new opportunities for Medicaid financing. For more information regarding this recommendation, see Section 3.0.6.

10.3. Potential State Cost Savings from Increased Collaboration

10.3.1. FINDING: Based on current Division spending for acute and sub-acute behavioral health services, it is estimated that the Department could save at least $1 million if a tribal provider established an inpatient psychiatric unit.

The Department could achieve substantial cost savings if a tribal health facility established an inpatient psychiatric unit and expanded the availability of acute and sub-acute behavioral health services. In FY 2014 the Department spent nearly $50 million dollars on Medicaid-reimbursable acute psychiatric services delivered in an inpatient or hospital-based setting.[203] Roughly 30% of adults receiving treatment for SMI within the public behavioral health system are AI/AN individuals.[204] At an average cost of $23,800 per individual for institutional intensive psychiatric services, the Department spent approximately $14.5 million

[201] P.L. 109-171: Deficit Reduction Act of 2005, Social Security Administration, February 2006.
[202] Social Security Act: Section 1915(i) and Section 1915(c)(4)(B), Social Security Administration.
[203] Presentation: Division of Behavioral Health, House Committee on Health & Social Services, February 19, 2015.
[204] UAA Center for Behavioral Health Research & Services.

dollars on intensive psychiatric care for AI/AN consumers. PCG estimates that if five inpatient psychiatric beds are established in a tribal health facility, which makes the services eligible for 100% federal reimbursement, the Department could achieve savings of at least $1 million. If across the state, 15 inpatient beds are established within the tribal system, the potential savings amount to over $3 million. The establishment of an inpatient psychiatric unit by a tribal provider would contribute to significant cost savings for DHSS.

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11.0. ADVISORY GROUPS

Evaluate the effectiveness and efficiency of DHSS behavioral health advisory groups in developing plans and providing guidance. This should address the following:

A. Are the Department's behavioral health advisory groups effectively advising and guiding the delivery and administration of behavioral health services?

B. Are the Department's behavioral health advisory groups efficiently advising and guiding the delivery and administration of behavioral health services?

C. Are there changes that could be made to improve the effectiveness or efficiency of behavioral health advisory groups?

11.1. Effectiveness of Department Advisory Groups

DHSS has three advisory groups that provide support and guidance regarding behavioral health service delivery: the Alaska Mental Health Board (AMHB), the Advisory Board on Alcoholism and Drug Abuse (ABADA), and the Suicide Prevention Council (SPC). These organizations serve to assist the Department in improving the behavioral health services available to Alaskans through planning, education, and advocacy.

Alaska Mental Health Board

Alaska Statute 47.30[205] mandates AMHB to serve as the planning and coordinating agency for the Department, as required by state and federal laws. AMHB is located within the Department for budgetary purposes, but has an independent voice separate from DHSS. Currently, there are 21 Board members, of whom 14 are appointed by the Governor and seven are *ex officio* positions.[206] The AMHB also functions as a channel for consumer feedback and perspectives on the system. Statute dictates that at least 50% of the Board must consist of persons who have a mental disorder themselves or have an immediate family member affected by mental illness. Additionally, the board members must include the following persons:

- Director of the Division of Behavioral Health (DBH);
- Two licensed mental health professionals who represent private and public providers;
- One member licensed to practice law in Alaska.

Advisory Board on Alcoholism and Drug Abuse

Alaska Statute 44.29 codifies ABADA as an organization intended to act in an advisory capacity to the legislature, governor, and state agencies with regard to mental health issues related to alcoholism and drug

[205] Alaska Statute Title 47, Chapter 30.
[206] "Members," Alaska Mental Health Board, Accessed June 18, 2015. http://dhss.alaska.gov/amhb/Pages/members.aspx.

abuse. ABADA, like AMHB, serves as the planning and coordinating agency required by federal and state laws relating to alcohol, drug, and other substance abuse prevention and treatment. Currently, there are 14 board members, the director of DBH among them.[207] Statute dictates that the board member composition include the following persons:

- One who is licensed to practice medicine;
- One who is licensed to practice law;
- Four who are chronic alcoholics in recovery;
- Three who are substance abuse treatment professionals who represent private and public providers; and
- Five who have shown an interest in the problems of alcoholism and drug abuse and who have knowledge of the social problems associated with alcoholism and drug abuse.

Suicide Prevention Council

The SPC was established by SB 198 in 2001 and it is codified in AS 47.29 as a council to serve in an advisory capacity to the legislature regarding what action should be taken to reduce suicide and its effects throughout the state. SPC board members include four state legislators, two from the Senate and two from the House. The director of DBH also sits on the SPC. Additionally, statute mandates that the SPC membership include the following persons:

- Two employed in the executive branch of state government;
- One member of the ABADA;
- One member of the AMHB;
- One person recommended by the Alaska Federation of Natives, Inc.
- One employee of a secondary school;
- One who is active in a youth organization;
- One who has experienced the death by suicide of a close family member;
- One from an off-the-road rural community;
- One member of the clergy;
- One individual between 16-24 years old;
- One military veteran; and
- One member of the general public.

While ABADA and AMHB conduct ongoing activities and will exist indefinitely, the SPC has a sunset date of June 30, 2019. The SPC has a broad mandate to reduce suicide, improve public awareness of suicide and risk factors, enhance suicide prevention efforts, work with partners and faith-based organizations to develop healthier communities, create and implement a statewide suicide prevention plan, and build and strengthen partnerships to prevent suicide. The SPC's activities fall within the recommendations in its statewide suicide plan, *Casting the Net Upstream: Promoting Wellness to Prevent Suicide.*[208] The staff, a shared executive director and one council assistant, work in tandem with the council to fulfill these responsibilities.

[207] "Members," Advisory Board on Alcoholism and Drug Abuse, Accessed June 11, 2015. http://dhss.alaska.gov/abada/Pages/members.aspx.
[208] Casting the Net Upstream, Promoting Wellness to Prevent Suicide FY 2012-2017, Statewide Suicide Prevention Council, January 2012.

These include hosting a Statewide Suicide Prevention Summit, holding public meetings, and partnering with other organizations to prevent suicide and promote wellness. For example, in 2014, the SPC worked with the Department of Education and Early Development to expand the Suicide Awareness, Prevention, and Postvention Grant Program for school-based suicide prevention. Additionally the SPC, through both council members and staff, makes educational presentations across the state. Overall, the SPC utilizes its allocated resources effectively to increase awareness of suicide, engage in prevention efforts, and improve the wellness of Alaskans through reducing suicide.

11.1.1. FINDING: The department's three behavioral health advisory groups provide adequate support and guidance regarding behavioral health issues.

The advisory groups provide adequate and sufficient support and guidance to DHSS regarding behavioral health services and the mental wellness of Alaskans. They engage in a number of activities that all contribute to the goal of guiding the Department, the Legislature, and the governor in their efforts to promote wellness and provide prevention and treatment services for mental illness and substance abuse. The activities of all three organizations are closely intertwined and are directed by a shared executive director. ABADA and AMHB have a common mission to "advocate for programs and services that promote healthy, independent, productive Alaskans."[209] The functions of ABADA and AMHB are to "plan, coordinate, educate, advise, evaluate, and advocate."[210] The board members are supported by full time staff that conduct research, collect data, and perform outreach on behalf of the organizations.

To incorporate consumer feedback in these activities, ABADA and AMHB host regular public forums and encourage consumers to reach out to local community leaders and state policymakers. Together they publish annually a legislative advocacy report detailing the recent legislation affecting the Alaskan behavioral health community. Additionally, ABADA and AMHB staff members collaborate with department staff and the Alaska Mental Health Trust Association (AMHTA) on a variety of initiatives. For example, ABADA and AMHB partnered with DBH and AMHTA, in addition to private providers, to conduct the Alaska Behavioral Health Systems Assessment. On these projects, ABADA and AMHB provide research and analytic support, contributing the time of their staff members and facilitating interactions within smaller communities.

11.1.2. FINDING: The joint meetings of AMHB and ABADA enable effective planning for a fully integrated behavioral health system of care.

The joint meetings and closely intertwined activities of ABADA and AMHB are beneficial to the Department, because they facilitate the development of a fully integrated behavioral health system.

[209] "Mission Statement," Advisory Board on Alcoholism and Drug Abuse and Alaska Mental Health Board, Accessed June 11, 2015. http://dhss.alaska.gov/abada/Pages/mission.aspx.
[210] Making it Work Behavioral Health in Alaska: Annual Implementation Report, Advisory Board on Alcoholism and Drug Abuse, January 2009.

ABADA and AMHB participated in the Comprehensive Integrated Mental Health Plan, along with DBH and AMHTA. As the goal of DBH is to provide services and enhance the well-being of individuals suffering from mental illness or substance use disorders, as well as those with co-occurring disorders, the common input from both ABADA and AMHB best serves that purpose. The boards can speak to the shared interests of the entire target population and direct planning and development in a way that meets all needs. Additionally, as the primary avenue for consumer involvement and feedback, the interconnectedness of ABADA and AMHB allows the boards to gauge the performance and consumer opinion of the entire behavioral health system without being dependent on information sharing between two wholly separate groups. The structure allows both boards to see their own interests as part of the larger picture, and thus create more effective and nuanced plans.

11.1.3. FINDING: The independence of the advisory groups from the Department and other stakeholders enhances the importance of the advice provided.

An important feature of the advisory groups is their autonomy and independence as written in the statutes. Each organization has a voice and opinion that is able to be separate from the Department's. Although the funding for the advisory bodies flows through DHSS, the board members and the organizations themselves are able to speak more freely and with more latitude than departmental employees who manage the behavioral health system. The governor-appointed board members are not paid a salary by the Department or the State, and so they are able to speak purely on behalf of the constituencies they represent. This independence increases the efficacy and credibility of the advice they provide to the Department and to the legislature.

11.2. Efficiency of Department Advisory Groups

11.2.1. FINDING: The guidance provided to the Department sufficiently incorporates consumer feedback and advocates for the needs to the boards' constituencies.

Additionally, the advice and guidance offered by the advisory groups effectively incorporates consumer feedback. The SPC achieves this goal of representing the interests of Alaskans by having a diverse board composition. The explicit statutory requirements for board members, such as including at least one individual from an off-the-road community and one person recommended by the Alaska Federation of Natives, effectively ensure that the SPC reflects the needs and concerns of a broad spectrum of Alaskans. AMHB and ABADA have fewer specifications regarding the composition of their board members, but nonetheless successfully represent the interests of consumers and provides an avenue for consumer input in planning and development. AMHB and ABADA host open public forums for Alaskans to comment on behavioral health services. As Alaskans can participate either in person or via telephone they are accessible to a large portion of Alaskans.

AMHB and ABADA also encourage individuals to reach out directly to policymakers. They provide guidance and training to Alaskans on how to convey the desired message both at state and local levels. The

consumer and stakeholder engagement of AMHB and ABADA extends to legislative advocacy as well. When the boards become aware of upcoming legislative hearings affecting behavioral health services, they rally consumers known to have a special interest in the matter at hand, thereby ensuring the legislator receives input directly from the impacted population. In all areas, the advisory groups are an important mechanism for consumer input regarding behavioral health services and that they effectively represent the interests of Alaskans.

11.2.2. FINDING: The co-location of AMHB, ABADA, and SPC staff and resources has allowed for a more economical use of departmental funding without detracting from the focus and specific division of labor of the separate advisory bodies.

Furthermore, the three advisory organizations are co-located in a private office building near Department offices and the Capitol in Juneau. The three groups share office space, supplies, and resources. This sharing of physical resources is an efficient use of funding by promoting the maximum utilization of resources. There are no resource limitations in spite of the three groups sharing these same resources. Additionally, AMHB and ABADA share staff resources. The total staff consists of:

- One executive director;
- Two health and social services planners;
- One advocacy coordinator;
- One research analyst; and
- One administrative assistant.

This structure provides for the efficient utilization of personnel. The shared staff are able collectively to allocate skills and time both to AMHB and ABADA as needed, ensuring each advisory group receives the time required. Additionally, it prevents the duplication of efforts and facilitates the equitable distribution of department funding to both AMHB and ABADA. The SPC has a total of two staff members, the shared Executive Director and one Council Assistant. The total of seven fulltime employees dedicated to the advisory groups meets the resource needs of the organizations as a result of the efficient utilization of staff time.

11.2.3. FINDING: The close relationship between DBH and the advisory groups facilitates regular and systematic transfer of information, advice, and guidance, without diminishing the influence of non-departmental voices over planning and consumer advocacy.

An additional feature of the advisory groups is their proximity to DHSS administrators and employees who are responsible for behavioral health services. From the director of DBH to individual program staff, the advisory groups interact frequently with the Department. The director of DBH serves on each advisory group and thus is easily able to give and receive input regarding the planning activities undertaken by those organizations. Furthermore, the staff members have a close working relationship with other departmental employees. For example, the executive director of the advisory groups serves as a member on the Advisory

Council for the Alaska Strategic Prevention Framework Incentive Grant operated by the Prevention and Early Intervention Section of DBH. Even more, the organizations share data to reduce inefficiencies and redundancies in reporting. Due to the statutory independence of the advisory groups and consumer-focused board composition, this interconnectedness with DHSS does not diminish the weight of the guidance offered by the advisory groups. Rather, it enhances the ability of the advisory groups to direct planning and development of behavioral health services by providing additional avenues for influence over the processes.

11.3. Recommendations for Improvement

11.3.1. FINDING: The review did not identify any significant areas of ineffectiveness or inefficiency requiring changes to advisory group organization or operations.

The advisory groups are each robust mechanisms for providing guidance and feedback to DHSS regarding behavioral health service delivery. The combined efforts of AMHB and ABADA provide informed, consumer-oriented advice to DHSS on mental health and substance abuse prevention and treatment across Alaska. The advisory bodies are important partners to the Department in the planning and development of behavioral health services. Similarly, the SPC is effective at producing a statewide suicide prevention and reduction plan that directs Alaska's initiatives at combatting its high rate of suicide. PCG did not identify any significant areas of ineffectiveness or inefficiency within the advisory groups and does not recommend implementing any changes to board organization, operations, or available resources.

12.0. UTILIZATION TRACKING

Evaluate the Department's current method of tracking utilization of behavioral health services by clients and, if necessary, recommend new methods to improve the Department's effectiveness in this area. This should address the following:

A. Does the Department effectively track the utilization of services by clients who are receiving behavioral health services?

B. Are there national best practice recommendations to improve the methods of tracking the utilization of services by clients that would improve the effectiveness and efficiency of behavioral health service delivery?

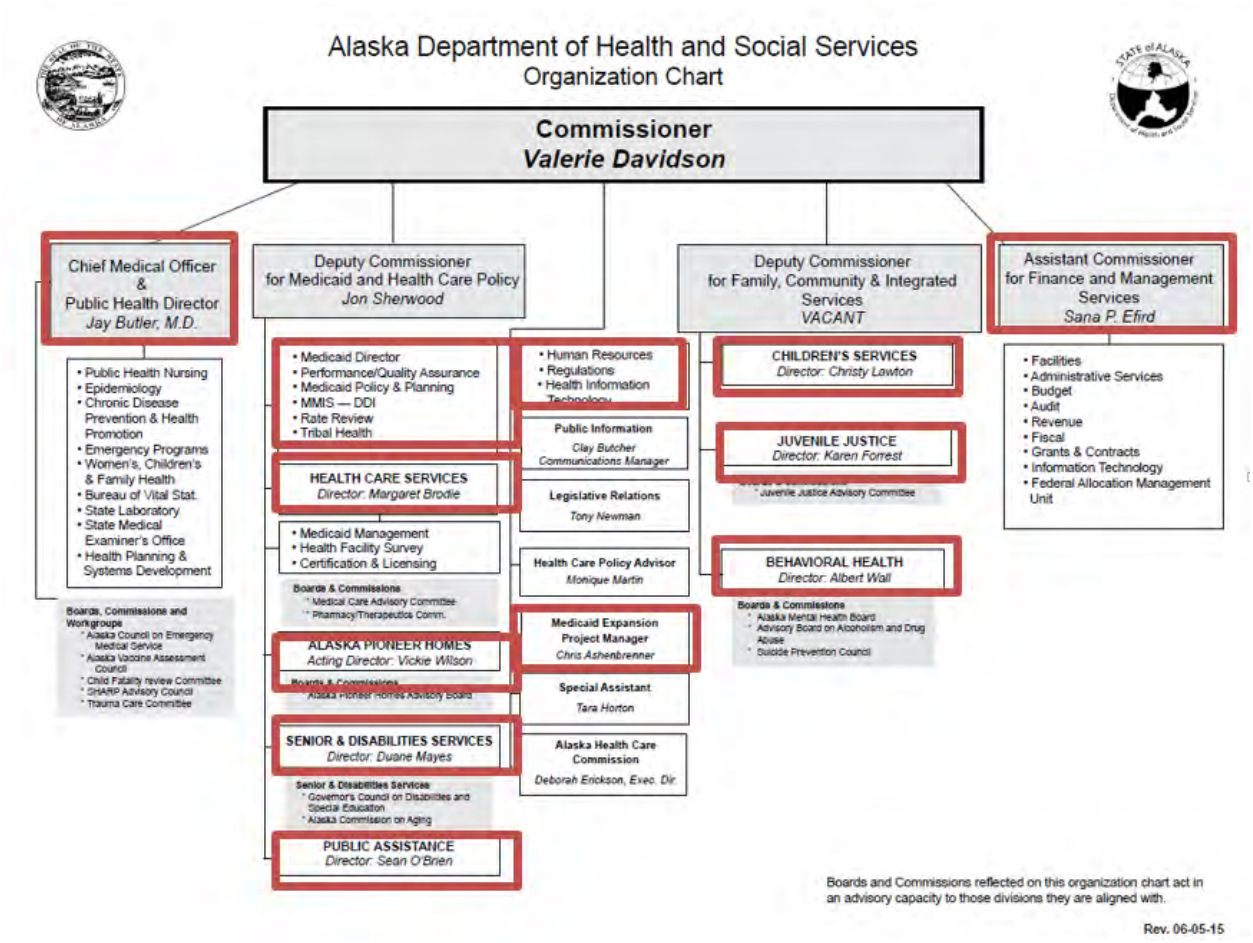
12.1. Effectiveness of Utilization Tracking

12.1.1. FINDING: The Department's wide-ranging authority over health services creates strong potential for robust utilization tracking, but significant organizational challenges to data integration.

The Department has authority over a majority of state-funded health services delivered across Alaska. As the state agency responsible for both health and social services, the Department oversees all behavioral health services delivered outside of the correctional system. While the Division of Behavioral Health (DBH) oversees direct acute psychiatric care, community-based treatment programs, and behavioral health-specific prevention activities, other DHSS sub-agencies also provide or manage behavioral health services.

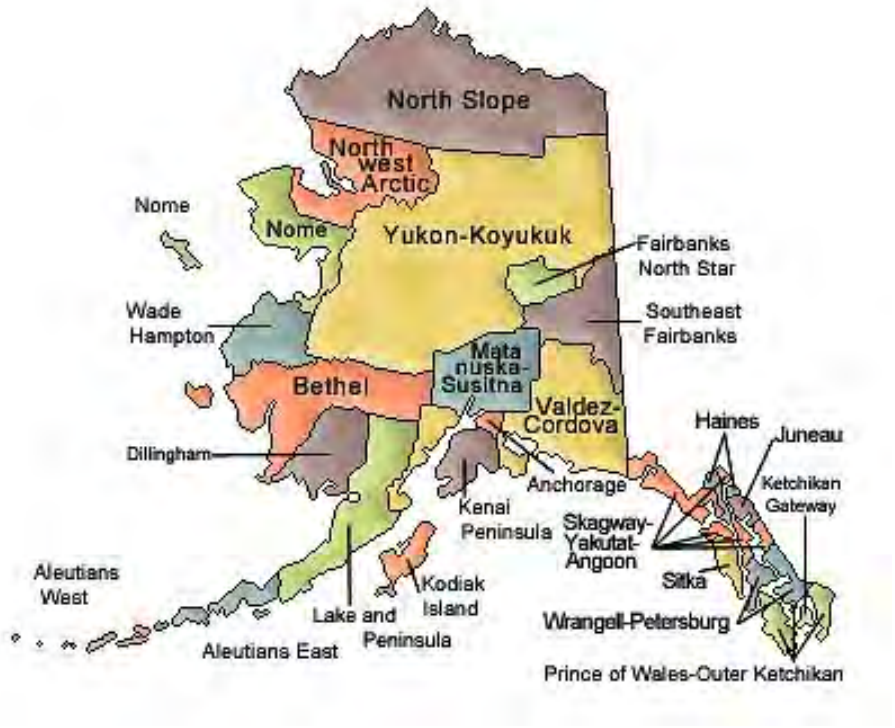
This expansive oversight over health services offers strong potential for robust utilization management. The Department can engage in financial tracking and reporting, program audits, and claims reviews. In particular, the Department's role as both the Medicaid and State Mental Health Authority grants it authority over behavioral health Medicaid regulations, reimbursement rates, provider eligibility, and program approval. This authority, combined with data collected from services delivered through DBH, Senior and Disabilities Services (SDS), Office of Children's Services (OCS), and Division of Juvenile Justice (DJJ), provides the Department with the data needed to effectively track utilization. However, the organizational siloes among these sub-agencies also extends to their data management systems. The resulting fragmentation of the Department's data resources, collected through separate systems and stored in disjointed databases, presents a challenge to the Department's capability to efficiently track utilization.

In the graphic below, entities outlined in red engage in activities related to behavioral health:



12.1.2. FINDING: The Department has traditionally monitored and managed utilization through its regional network of community behavioral health center (CBHC) grantees. This grant-based, regionalized service delivery system has contributed significantly to the Department's effective collection of utilization data.

The behavioral health system is based on a regional network of CBHCs. This structure relies on a CBHC to provide comprehensive behavioral health services to all Alaskans within a center's catchment area. The Department provides grants to CBHCs based on geographic need, and in principle, there should be no overlap among the different CBHC catchment areas. Traditionally, this CBHC-based system has fostered both care coordination and regional monitoring of utilization, since the CBHC serves as the principle provider for all behavioral health services in a geographic area. Without other behavioral health grantee providers in the same geographic region, each consumer would receive community-based services through a single agency, effectively preventing duplication of services, promoting effective use of scarce behavioral health resources, and ensuring that consumers with complex needs receive coordinated care. Alaska's catchment areas correspond roughly to the census areas illustrated in the map below:



With the growth of Medicaid-financed behavioral health, effective utilization controls have become even more important, due to the fact that fee-for-service reimbursement sometimes incentivizes increased service volume at the expense of appropriate care coordination. To date, the Department has been able to provide an effective check on over-utilization of Medicaid behavioral health services, largely by requiring behavioral health providers to apply for and receive a grant from DBH in order to enroll in Medicaid. This regulation creates a linkage between grant-funded and Medicaid-reimbursable behavioral health services. It also ensures that every provider delivering behavioral health services funded by the Department, through grants or Medicaid dollars, reports treatment information to DBH according to a uniform standard.

As a result, the grant-based funding structure has contributed to the development of effective data collection processes across the behavioral health system. Every grantee, regardless of the magnitude of the grant received, is required to fulfill grant reporting requirements. To receive grant funds behavioral health providers are required to submit data to DHSS. These requirements have guaranteed that the Department receives utilization data from all funded behavioral health providers. Furthermore, because of its role as the dominant funder of community services within the system, DHSS is also able to collect utilization data on the majority of behavioral health services delivered throughout the state. For these reasons, PCG finds that the grant-based behavioral health system significantly contributes to the effective collection of utilization data.

The Department has traditionally relied on three additional provider restrictions to manage utilization.

- Grant funds can only be awarded to non-profit agencies.
- Agencies or clinics wishing to enroll in Medicaid must be associated with a psychiatrist.

- Independent providers wishing to enroll in Medicaid must be licensed as a psychiatrist, PhD psychologist, or advanced nurse practitioner (APRN).

Not only does DHSS require that every provider receive DBH grant funds to claim Medicaid, but it also requires that every grantee be a non-profit agency. With few exceptions, all behavioral health providers receiving Medicaid reimbursement are non-profit agencies. If for-profit agencies were able to bill Medicaid selectively, focusing entirely on profitable service lines to the neglect of more costly services, cherry-picking by private providers would render the continuum of care vulnerable to fragmentation. The policy goal in this case is to promote appropriate utilization: minimizing selective focus on healthier populations and more profitable service lines by private providers that would leave CBHCs exclusively to treat the most high-acuity consumers requiring the costliest care, potentially endangering their financial solvency and capacity to deliver a comprehensive service array to any consumer who walks through the door. The Department has effectively eliminated this possibility and safeguarded the existence of the CBHC system by requiring that all grantees be non-profit agencies and all Medicaid-enrolled providers be grantees, ensuring a more balanced and sustainable case mix.

Furthermore, due to the regulation that Medicaid-enrolled providers have an association with a psychiatrist or be a PhD psychologist or APRN, most behavioral health providers have historically worked within the service umbrella and care coordination networks of the CBHC system. Outside of Medicaid, neither private nor public health insurance plans typically includes coverage for comprehensive behavioral health services, and community-based mental health and substance abuse service providers are particularly dependent on Medicaid financing. Because of the State's credentialing restrictions, licensed therapists, rehabilitation specialists, and other behavioral health professionals providing Medicaid-reimbursable services have been required to affiliate with comprehensive providers that receive grant funds from DBH and employ high-level supervising practitioner types in order to access needed public funding.

Through a carefully constructed CBHC system and restrictive Medicaid regulations, the Department has managed the behavioral health system across the state, preventing the fragmentation of the community-based continuum of care and ensuring availability of community-based behavioral health providers. The regionalized CBHC system and linkage of the grant-funded and Medicaid-reimbursable behavioral health services provide the Department with an effective set of structural controls over behavioral health services delivered within Alaska.

12.1.3. FINDING: The Department's grant reporting requirements ensure effective collection of community utilization data.

DBH requires behavioral health grantees to submit utilization data as a condition of receiving grant funds. Providers submit grant reporting data to DBH through two primary means: Alaska Automated Information Management System (AKAIMS) and quarterly reports. Within AKAIMS, each provider is required to complete and submit the minimum data set (MDS) for each consumer receiving behavioral health treatment services. Discussed in more detail in Section 8.1.3, the MDS includes demographic data, referral source, and presenting symptoms. Providers submit data through AKAIMS for every consumer encounter, providing the Department with real-time utilization data. Additionally, behavioral health grantee providers

must submit reports to DBH each quarter. These reports are submitted through the Grant Electronic Management System (GEMS). The reports differ according to the grant type, and agencies receiving more than one type of grant submit separate reports according to each grant's specific requirements. The Comprehensive Behavioral Health Treatment and Recovery (CBHTR), the largest grant type, quarterly report requirements include:

- Cumulative financial report;
- Specialty program reports (e.g. Peer Navigation),
- Community Action Plan minutes;
- Logic model;
- Narrative on the agency's overall status;
- Staff hires and vacancies; and
- Recent and upcoming audits.

The quarterly reports provide DBH with additional information on the current utilization of the behavioral health system. With the AKAIMS data, DBH staff can monitor encounters, demographics, diagnoses, and other client-level data. The quarterly reports complement that information with a narrative of stressors facing each provider, financial status, and community engagement. Providers cannot bill Medicaid without receiving a grant from the Department, so the quarterly reports are collected from all providers delivering Department-funded mental health and substance abuse treatment services. PCG finds that the grant reporting requirements ensure that DBH collects this data and provides the Department with a comprehensive understanding of behavioral health service utilization.

12.1.4. FINDING: Lack of standardization in provider data reporting diminishes the efficiency of the Department's utilization tracking.

The majority of utilization data is reported to the Department through the AKAIMS and Medicaid Management Information System (MMIS) systems. However, a small number of providers continue to submit the MDS through the Electronic Data Interface (EDI) system, and Alaska Psychiatric Institute (API) uses a separate data management system altogether. This lack of standardization in data reporting diminishes the efficiency of the Department's utilization tracking.

The data submitted through EDI contains the same information as the data submitted through AKAIMS, but the underlying architecture of the EDI data differs from that of AKAIMS. The data are stored in separate databases and cannot be merged to form one complete database. Additionally, the EDI architecture lacks the capability to identify unique clients. The incompatibility of the EDI and AKAIMS data, along with this underlying flaw in the EDI design, together inhibit the Department's ability to track utilization efficiently within the behavioral health system. As the EDI data does not include a unique client number, it is impossible to get a complete and accurate count of unduplicated recipients of behavioral health services. Furthermore, API's reliance on a separate electronic health record (EHR) further complicates efficient utilization tracking. API enters data into its Meditech EHR, which constitutes a third, independent database that cannot be consolidated with either the EDI or AKAIMS databases.

The incompatibility of the three databases significantly impacts the efficiency of the Policy & Planning section at reporting on utilization. The data has to be analyzed and reported on separately before being manually combined for a comprehensive report. PCG finds that this lack of standardization in provider reporting contributes to inefficiencies in the Department's utilization tracking procedures. See Section 12.2.2 for a recommendation related to this finding.

12.1.5. FINDING: Flaws in AKAIMS' data infrastructure have diminished the efficiency of utilization tracking until recently.

An essential component of utilization tracking is the ability of the administrator to know how many unique consumers are being served by the system under review. Having an accurate, unduplicated count of the individuals seen within the behavioral health system enables the Department to identify super-utilizers, track trends across different subpopulations, and develop a more comprehensive understanding of how the behavioral health system is serving the population. As consumers may receive services through multiple providers, it is essential that the data management system be able to link each individual with every encounter, regardless of the service setting. For example, an individual may be hospitalized at API and then treated within the community-based system. Only a system that can associate that same consumer with the two separate encounters will have the capacity to track utilization and determine whether the community-based system is adequately meeting the needs of that consumer.

Until recently, the Department's behavioral health data management system, AKAIMS, did not have the capacity to produce unduplicated counts of behavioral health service recipients. There are two similar fields within AKAIMS, *unique client identifier* and *unique client number*. *Unique client identifier* refers to the consumer's identification number within a particular agency. *Unique client number* is a number associated with a consumer across the entire behavioral health system. While one consumer may have multiple unique client identifiers, they can only have one unique client number. Previously, the reports run by the Policy and Planning Section within DBH relied on the unique client identifier rather than the unique client number. The utilization data drawn from AKAIMS thus could not produce an unduplicated count of behavioral health treatment recipients, because it relied on the field that identified an individual within an agency, meaning that individuals treated by more than one agency would be counted twice.

This reporting logic diminished the efficiency and effectiveness of the Department's utilization tracking. Without unduplicated counts DHSS did not know how many individuals were receiving behavioral health services or which individuals and subpopulations were receiving multiple services simultaneously. The field used to populate these reports has been changed to unique client number, improving the efficiency of the Department's data collection efforts. Flaws in the AKAIMS reporting structure contributed to inefficiency in utilization tracking, but that recent changes have rectified many of those issues and improved the Department's efficiency at tracking the utilization of behavioral health services.

However the utilization tracking capabilities still fall short of being fully effective and efficient. As discussed in Section 8.1.7, a small number of providers continue to submit data through EDI rather than AKAIMS. The EDI architecture lacks the capability to identify unique clients. Moreover, it is still not feasible to create unduplicated client counts across institutional and community-based service settings. It

should be noted that the Department has improved upon the inefficiency in utilization tracking that resulted from flaws within AKAIMS reporting, and that the anticipated elimination of EDI data collection will further improve both the effectiveness and efficiency of utilization tracking. See Sections 8.3.4 and 12.2.3 for recommendations related to this finding.

12.1.6. FINDING: Anticipated service delivery and payment reforms are likely to challenge the effectiveness of CBHC-based utilization management, requiring the Department to respond to inappropriate utilization through new methods of oversight and intervention.

The Department's ability to regulate behavioral health utilization through the CBHC-based system has been gradually diminished through system pressures occurring nationwide, all of which have led to major reforms in payment methods and delivery system standards for behavioral health services. Since the inception of the CBHC-based system, regional management through grant monitoring has allowed the Department to track and regulate behavioral health service utilization. As a reflection of this approach, DBH has traditionally organized its grant management of behavioral health providers through regional offices, with program staff assigned to cover each region. However, as national mental health and substance abuse service standards have evolved, changing service demands and new financing mechanisms have stressed the capacity of regionally-based CBHCs to provide the full range—and full quantity—of services needed to meet the population's complex needs. Despite the obsolescence of the CBHC framework in many urban areas of the country, a regional approach remains relevant in Alaska, where designated catchment areas dominated by single, comprehensive providers continues to make sense for the state's vast geography and widely distributed population. Nonetheless, it is true that the increased need for specialty services and related shift to Medicaid financing are together challenging the capacity of the CBHC system to provide a full continuum of behavioral health services in Alaska as well as in other states.

To ensure the availability of appropriate and modern behavioral health services, the Department has responded positively to these pressures by increasingly funding services outside the CBHC system and providing grants to additional providers, both to target specific evidence-based practices and interventions and to supplement service capacity in underserved regions. With the addition of specialty grants, the Department has gradually shifted away from a "planning" approach that organizes utilization around comprehensive regional providers, to a "market" approach that attempts to stimulate greater quantity and quality of services through competitive procurements that incentivize volume for needed service lines.[211]

Of course, under a regional system built around a single point of care for behavioral health consumers, the Department is able to use its grant awards to establish structural controls over the type and volume of services available within a catchment area, as well as the number of providers delivering services, and the total cost of services for each region. However, with the proliferation of numerous grant types, the regional management of services employed by DBH no longer provides for effective tracking of utilization. A single grantee receiving multiple grants may now be associated with multiple grant managers, just as grantees under the purview of a particular DBH regional office may be accountable to grant managers outside the

[211] These developments are discussed in more detail in Section 9.0.

regional office. In PCG's discussions with DBH program managers, it was evident that the division's regional- and service-based management configurations overlap and increasingly cross-cut each other in ways that fail to bring important utilization trends into resolution. In the Department's FY 2013 *Budget Overview Book*, the Division references its traditional approach to utilization tracking and acknowledges some of the fresh challenges posed by delivery system transformation:

> *The treatment and recovery section for DBH currently has multiple grant programs to fund behavioral health treatment for SMI adults, SED children and SUD adults and adolescents. The reasons for this relate to service expansion that has occurred through new funding coming into the system to promote change: BTKH initiative, disability justice initiatives, housing initiatives, and peer services to name a few. In order to track these services as they were implemented, we kept them separate. Now we have an overwhelming burden of small grant programs that are hard for us to manage and create additional administrative burden for our grantees*.[212]

Ultimately, this system of multiple configurations contributes to a diffusion of management responsibilities and oversight, weakening the Division's ability to deliver a fully responsive, focused approach to utilization tracking and management through its previous grant management methods. Arguably, this tangle of management responsibilities was the most significant factor in the division's belated and indecisive response to the 2013 implosion of the Fairbanks Community Behavioral Health Center, creating a geographical gap in services that not only left a substantial proportion of the state without services for several weeks, but has also resulted in a reduced service infrastructure from which the system has yet to recover fully. This weakened sense of administrative "ownership" over each region has borne itself out in less regional coordination and diminished ability to effectively track utilization of behavioral health services.

The shift from a purely grant-based system to a financial hybrid of grants, contracts, and Medicaid fee-for-service reimbursement has also created challenges in service coordination on the side of providers that mirror the administrative issues facing DBH program managers. While the growth of Medicaid reimbursement since the 1980s has decreased the behavioral health system's reliance on grant funding, Medicaid financing has introduced new service restrictions and incentives for inappropriate utilization that require an altered approach to utilization management. On the one hand, a grant-based system provides a comprehensive financing mechanism for care coordination and case management, and also allows a certain degree of flexibility in quantity of services provided and system uncertainty regarding consumer need. On the other hand, in fee-for-service, provider solvency and success depends heavily on maximizing service volume for profitable services in an uncoordinated care environment. As the behavioral health system becomes more reliant on Medicaid funding, providers are increasingly incentivized to over-utilize services with strong reimbursement rates while under-utilizing loss leaders, despite the real needs of the service population.

Alaska has already witnessed some of these negative effects. For example, the gradual deterioration of substance abuse service capacity throughout the state is largely attributable to a set of Medicaid eligibility and service restrictions that make reimbursement for these services difficult and impossible to sustain without supplementary grant funding. Moreover, in a Medicaid environment in which behavioral health

[212] Fiscal Year 2013 Budget Overview, Alaska Department of Health and Social Services, p. 156.

services are significantly underpaid in comparison to medical services, integration of behavioral health and primary care services can have a harmful effect on service capacity, as providers build their medical service capacity at the expense of revenue lost through a "too robust" array of behavioral health services. This phenomenon occurred most recently at Mat-Su Health Services, which despite its beginnings as a behavioral health provider, shifted rapidly to primary care services after converting into a federally qualified health center (FQHC), leaving a high level of unmet behavioral health need in its fast-growing region.

Aside from these general trends emerging from the system transformation already underway, there are specific Medicaid reforms under consideration by the Department that are likely to continue to diminish its capacity to regulate utilization by traditional means through the CBHC framework. On the one hand, changes to the regulations regarding provider eligibility for Medicaid will have a significant impact on division and CBHC utilization controls, largely for the reasons already discussed in this section. Additionally, there is a fear among some within the system that loosening Medicaid's credentialing restrictions could lead to an exodus of the CBHC workforce, effectively dismantling the CBHC system and its unique framework of service utilization management through grant reporting. On the other hand, a parallel and reinforcing dynamic could ensue if the State repeals the grantee requirement for Medicaid providers.

It should be noted that PCG has recommended these changes to the Medicaid regulations in our report, due to the substantial opportunities they offer for increasing access and addressing current unmet need, promoting improved quality through increased competition, and simplifying administrative requirements for providers. However, in order for the Department to reap the full benefits of these reforms, it will need to develop a more sophisticated, data-driven approach to managing utilization through Medicaid functions rather than the structural controls of its traditional grant management processes. See sections 5.5.1, 5.5.3, 9.3.4, and 12.2.1 for recommendations related to this finding.

12.2. Utilization Tracking Best Practices

12.2.1. RECOMMENDATION: As the behavioral health system becomes increasingly dependent on Medicaid financing, current utilization tracking must be adapted to incorporate utilization controls more appropriate to fee-for-service payments than grant-based reimbursement.

The Department should adapt the current system of utilization control to incorporate structures more appropriate to fee-for-service reimbursement over grant-based funding. The existing system of utilization tracking and regulation relies on the structure of the regionalized CBHC-based system and control offered by selective grant funding. With the financing of behavioral health services increasingly dependent on Medicaid reimbursement, these controls will cease to be fully effective, necessitating that the Department incorporate additional controls specific to fee-for-service reimbursement. Examples of such controls include:

- Specific utilization targets based on prior utilization data;
- Pre-payment claims review;

- Linkage of payment to clinical quality metrics; and
- Comparative provider performance reports.

The above measures are methods of tracking and regulating utilization within a fee-for-service based behavioral health system. Fee-for-service reimbursement relies on a lower level of uncertainty in service volume than grant-based reimbursement does, making it important for the Department to set targets to help regulate utilization. Additionally, pre-payment claims review, linking payments to clinical quality metrics, and tabulating reports on comparative provider performance can assist DHSS in its efforts to track and regulate utilization by promoting cost containment and quality service delivery. The Department should consider incorporating these utilization controls into its utilization tracking system.

12.2.2. RECOMMENDATION: The Department should develop a consistent and transparent data analysis and reporting system, accessible throughout DHSS, that illustrates regular, monthly performance trends without reliance on ad hoc reporting.

The Department should develop a standardized data analysis and tracking system that easily facilitates the identification of monthly performance trends and reduces the reliance on inefficient, ad hoc reporting processes. Currently, data collection is fragmented due to the existence of various data management systems, contributing to both the inefficiency and ineffectiveness of current analysis and reporting procedures. Research analysts must combine datasets manually in order to obtain complete behavioral health utilization data, thereby preventing the automation of reporting processes and reducing the resources available to monitor system performance trends effectively. The development of a consistent data analysis and reporting system would reduce this inefficiency, and when combined with a widely accessible, transparent utilization dashboard would augment the Department's effectiveness at utilization tracking. The Department already has the timely data collection policies needed to facilitate monthly utilization and performance tracking, and DHSS should complement that capacity with efficient analysis and reporting to improve its overall utilization tracking of behavioral health services. See Section 12.1.4 for more information regarding this recommendation.

12.2.3. RECOMMENDATION: The Department should implement a uniform utilization reporting structure across the behavioral health continuum of care.

The Department should institute a standardized utilization reporting structure across the entire behavioral health continuum of care. While community-based treatment providers receiving DBH grant funds submit the same MDS, the current utilization reporting structure differs for services elsewhere in the continuum and for services provided under the auspices of other sub-agencies such as SDS. Although some services on the continuum, such as tobacco prevention activities, are not adaptable to the MDS, and other services, such as inpatient psychiatric care provided through API, require more data for effective utilization tracking, a uniform reporting structure that collects utilization data on the same schedule and through one system would nonetheless improve the Department's utilization tracking procedures. Such a structure would

diminish the inconsistencies between utilization tracking of different services and enable the Department to more effectively capture utilization and performance trends.

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13.0. FRAUD, WASTE, AND MISUSE

Recommend improvements based on nationally recognized best practices to reduce, prevent, or detect fraud, waste, and misuse of services. This should address the following:

A. Does the Department effectively reduce, prevent, or detect behavioral health related fraud, waste, and misuse?

B. Are there recommended best practices that could be utilized by the Department that would reduce fraud, waste, and misuse of behavioral health services?

C. Are there cost savings that will result from reducing, preventing, or detecting fraud, waste, and misuse of services?

13.1. Effectiveness of Department Fraud, Waste, and Misuse Efforts

13.1.1. FINDING: Alaska Medicaid fraud recovery, while currently less than one percent of total Medicaid expenditures, has significantly improved in recent years as a result of additional dedicated resources and a corresponding increase in recoveries and convictions.

The State has significantly improved its fraud recovery efforts in recent years. The Medicaid Fraud Control Unit (MFCU) within the Department of Law (DOL) is responsible for prosecuting allegations of fraud and recovering overpayments. In October 2012, the State made substantial changes to the way Medicaid fraud is identified and prosecuted and dedicated additional resources to fraud control, nearly doubling the size of the investigative unit. From 2010-2012, investigations produced only three convictions of Medicaid fraud within Alaska.[213] Following program expansion and the additional allocation of resources, there were 19 convictions in 2013 and 24 in 2014.

These gains have also been seen within behavioral health specific Medicaid fraud recovery efforts. In April 2014, the MFCU announced the arrest of an Anchorage psychiatrist for fraudulently billing Medicaid for hundreds of thousands of dollars.[214] In December 2014, the psychiatrist pleaded guilty to fraudulently billing Medicaid for approximately $1.2 million for services that were never performed.[215] The success of this case came from the collaborative efforts of DOL, Alaska State Troopers, Anchorage Police Department, DHSS, the Federal Department of Health and Human Services (HHS), the Office of Inspector General (OIG), the FBI, and Immigrations and Customs Enforcement Homeland Security Investigations. These state and federal entities worked together to identify and prosecute a behavioral health Medicaid fraud case of

[213] Alaska Medicaid Fraud Control Unit Presentation, Michael Geraghty and Andrew Peterson, Alaska Department of Law, 2014.
[214] Press Release, Alaska Department of Law, April 16, 2014.
[215] Press Release, Alaska Department of Law, December 1, 2014.

great magnitude. Although the current payment recovery efforts total only one percent of Medicaid spending, the State's fraud recovery efforts have improved significantly in recent years and the resources dedicated to fraud recovery efforts have been used effectively to recoup state funds.[216]

13.1.2. FINDING: The Medicaid Program Integrity (MPI) Section is the departmental unit with primary responsibility for identifying and reducing provider fraud, waste, and misuse. It has established a wide range of pre-payment and post-payment controls that have aligned the State with nationwide program integrity best practices.

MPI is the departmental unit responsible for protecting the integrity of the Medicaid program. MPI proactively develops strategies to prevent, deter, and identify fraud, waste, and misuse. This unit conducts provider claim reviews, manages audit subcontractors, and coordinates provider overpayment recovery and reporting. MPI uses a wide array of pre-payment and post-payment controls to meet federal and statutory fraud control requirements that are aligned with nationwide best practices. These controls are as follows:

Table 13.1. Medicaid Fraud Controls[217]

Pre-Payment Controls	Post-Payment Controls
• **Provider certification** • **Background check** • **Provider enrollment** • **Provider screening (as defined by Affordable Care Act Section 6401)** • **Claims processing edits** • **Pre-payment review** • **Payment suspensions**	• Recipient Explanation of Medicaid Benefits (REOMB) process • Audits • Claims data mining • Provider technical assistance • Provider sanctions • Fraud investigations and charges • Provider terminations • OIG list of excluded individuals and entities

MPI uses these controls to maintain Medicaid program integrity and identify fraud, waste, and misuse. These activities are conducted in compliance with the following federal regulations and state laws governing Medicaid fraud control:

[216] There is no current estimate of the percentage of Medicaid spending attributable to fraud. CMS is currently working to develop an estimate of the incidence of fraud for certain services (https://www.cbo.gov/sites/default/files/cbofiles/attachments/49460-ProgramIntegrity.pdf). However, 1% is less than most experts believe the incidence of fraud to be.
[217] Department of Health and Social Services Medicaid Fraud and Abuse Prevention Presentation, Douglas Jones, February 2014.

Table 13.2. Medicaid Fraud Control Programs[218]

Program	Description
Alaska Statute 47.05.200 Audits	Contracted review of selected providers evaluating the appropriateness of Medicaid payments
Medicaid Integrity Program	CMS-mandated review of appropriateness of Medicaid payments of certain providers
Surveillance and Utilization Review Subsystem	Routine claims activity performed by MMIS vendor required by CFR 455 Subpart C
Payment Error Rate Measurement	Federally contracted review of state claims payments to measure error rate required by CMS

The controls and fraud identification activities undertaken by MPI are aligned in essentials with nationwide best practices and constitute reasonable efforts to prevent, detect, and identify fraud, waste, and misuse of Medicaid services. MPI is effective at referring cases of Medicaid fraud to the Department of Law (DOL) and collaborating with DOL on the prosecution of those cases.

While MPI coordinates program integrity functions across the Department, other units with a purview over specific services or functions, such as Health Care Quality Assurance, Behavioral Health Quality Assurance, and Background Check units, also play crucial roles in the Department's provider-focused program integrity activities.

13.1.3. FINDING: The Division of Public Assistance Fraud Control Unit is the departmental unit with primary responsibility for identifying and reducing recipient fraud, waste, and misuse. It has established an effective array of preventive and investigative strategies to generate substantial cost avoidance and direct savings to the Department.

The Fraud Control Unit (FCU) within the Division of Public Assistance (DPA) leads the Department's efforts to identify and reduce recipient fraud, waste, and misuse of welfare services, including Medicaid. From offices in Anchorage, Fairbanks, Wasilla, and Kenai, the FCU conducts investigations of complaints and allegations of fraud received from caseworkers regarding both applicants and recipients.[219] When a suspicious or questionable application is submitted, the FCU conducts home visits and verifies circumstances to prevent applicants intent on defrauding the Department from receiving social assistance. Potential recipient fraud cases are referred to the FCU by the public, caseworkers, and other DPA staff. FCU investigates the case and presents the recipient with the option of accepting program disqualification

[218] Additionally, MPI manages the Recovery Audit Contractor (RAC) program that is required by CMS. However, the RAC program is not currently operational. The difficulty of aligning the RAC audit process with Alaska's fee-for-service reimbursement structure precluded the subcontractor's ability to generate income in Alaska and caused them to suspend the performance of audits in 2014.
[219] Welfare Fraud Control Accomplishments Report State Fiscal Year 2013, Division of Public Assistance, 2013.

and repaying the debt, or facing an Administrative Disqualification Hearing. In cases of egregious fraud or high dollar value, the FCU refers the case to the DOL for criminal prosecution. The FCU is effective at identifying and reducing applicant and recipient fraud. In FY 2013 the FCU completed 1,600 Medicaid fraud investigations. The combined value of cost avoidance, fraudulent claims identified, and direct savings achieved through these investigations amounted to $2,287,195.[220]

13.1.4. FINDING: Overall responsibility for reducing and preventing fraud, waste, and misuse is currently decentralized among multiple state departments and DHSS program units. This diffusion of responsibilities has created challenges for the State in coordinating anti-fraud, waste, and misuse efforts.

The Department's fraud, waste, and misuse prevention, detection, and identification is spread across multiple departments and units. As described above, the FCU within DPA is responsible for recipient fraud activities and MPI is responsible for provider fraud activities. The MFCU within the DOL, outside the purview of DHSS, is responsible for investigation and criminal prosecution of serious or high value cases of Medicaid fraud. The MFCU receives referrals from DHSS, recipients, providers, and other entities, evaluates whether the complaint merits an investigation, and either accepts or rejects the claims. For accepted claims, the MFCU conducts an investigation, and for rejected claims the unit refers the case to another agency or closes the case entirely.[221]

Additionally, the Medicaid & Quality Section (MQS) plays a role in the prevention and identification of fraud specific to behavioral health services. MQS works with providers to maintain compliance with Medicaid regulations, coordinates the Department's behavioral health fraud activities, and refers cases to MPI and MFCU when fraud is suspected. For behavioral health services, MQS is the first line of fraud control. The section serves as an advisor to behavioral health providers on Medicaid program compliance. By working closely with and providing technical assistance to Medicaid enrolled behavioral health providers, MQS ensures that providers have an understanding of the Medicaid regulations and what types of activities are fraudulent, abusive, or wasteful. MQS responsibilities are a key element of the Department's fraud prevention control.

With this constellation of agencies involved in fraud control, responsibility for program integrity is shared among multiple DHSS agencies and DOL, and no entity has complete responsibility for managing and operating the Department's fraud prevention and identification activities. There are audits or investigations performed by private subcontractors, DOL personnel, and DHSS personnel. Additionally, the federal government prescribes many of the State's fraud prevention activities and is closely involved with State efforts to complete those activities. This decentralization of management and operation of Medicaid fraud, waste, and misuse controls significantly increases the need for coordination and the level of effort required to ensure clear communication among program units. Although recent improvements have clearly enhanced the collaboration among these units, functional ambiguities and communication challenges still exist within the program that inhibit consensus on the proper definition and enforcement responsibilities for certain

[220] Ibid.
[221] Alaska Medicaid Fraud Control Unit Presentation, Michael Geraghty and Andrew Peterson, Alaska Department of Law, 2014.

Medicaid regulations. Recent changes in the regulations for recipient support services (RSS) offer a good example of the need for improvement in coordination among departmental units involved in program integrity. RSS is discussed in more detail in Section 13.1.9.

13.1.5. FINDING: State audits of Medicaid providers conducted on behalf of the Department's Audit Committee have proven effective, identifying $5 million in overpayments since October 2012.

The recent enhancement of fraud prevention and identification activities have been effective at achieving savings in Medicaid payments. MPI contracts with the firm Myers and Stauffer to conduct audits under the auspices of AS 47.05.200. The DHSS Audit Committee, comprised of representatives from all Medicaid-serviced divisions (Seniors and Disabilities Services (SDS), Health Care Service (HCS), and DBH), works with Myers & Stauffer and the DHSS Commissioner's Office to determine which providers to review. The subcontractor is contracted to perform 80 audits per year. Each review uses provider claims and corresponding documentation to evaluate the appropriateness of Medicaid payments and identify overpayments. Between October 2012 and December 2013 the audits carried out under AS 27.05.200 have identified $5 million in overpayments.[222] When compared to national benchmarks, $5 million is a reasonable amount of overpayments for the volume of the Department's Medicaid expenditures. The collaborative efforts of SDS, HCS, DBH, MPI, and the Commissioner's Office to conduct and manage these audits are effective at identifying Medicaid overpayments.

13.1.6. FINDING: Lack of enrollment of some rendering provider types creates opportunities for providers to commit fraud.

Within Medicaid claiming there are both billing providers and rendering providers. The rendering provider is the provider who actually performs services; the billing provider is the provider submitting the claim. Individual practitioners will likely be both the rendering and billing provider, while in multi-practitioner organizations there will be multiple rendering providers within one billing provider. Furthermore, providers are classified as a certain provider type that indicate their area of specialty and the services commonly performed by that type of provider. Practitioners can have more than one provider type, indicating training in multiple specialties and service lines. Alaska's Medicaid regulations do not currently require all rendering provider types to be enrolled as Medicaid providers.[223] This structure creates the opportunity for fraud in two ways:

1. Rendering providers caught engaging in fraud under one provider type can continue billing for services under another provider type. If the rendering provider has multiple provider types and is excluded from billing Medicaid under one provider type due to fraud, but qualifies for a second provider type not required to be enrolled as a Medicaid provider, the provider can continue to perform services and bill Medicaid under the second provider type.

[222] 2014 Annual Report of the Alaska Health Care Commission, Health Care Commission, p. 10.
[223] Ibid.

2. For rendering provider types not required to be individually enrolled, a rendering provider can submit claims through multiple billing providers. A practitioner intent on committing fraud, who is not required to be an individually enrolled rendering provider, has the opportunity to submit claims for services delivered in different towns on a timeframe inconsistent with the distance in between each town.[224]

The lack of enrollment of all provider types and individual rendering providers creates opportunities for practitioners to defraud the Medicaid program. These opportunities for fraud are not available to provider types required to be enrolled as individual rendering providers. See Section 13.2.1 for a recommendation related to this finding.

13.1.7. FINDING: Medicaid beneficiaries currently have few incentives and little information to provide a check on potential fraudulent practices by their providers.

Medicaid beneficiaries currently have limited incentives and insufficient information to participate in fraud control and identify fraudulent activities by their providers. Medicaid recipients do not receive an Explanation of Benefits (EOB) statement upon enrollment in the Medicaid program. It is customary practice in private insurance to provide enrollees with a clear and comprehensible overview of the benefits include in their insurance coverage. EOB statements create an informed consumer population, and with this information privately insured individuals can examine claims submitted on their behalf and identify wasteful or fraudulent activities. However, recipients of Alaskan Medicaid benefits lack this information and subsequently hampered in their ability to identify potentially fraudulent practices by their providers.

Currently, the Department's Medicaid regulations do not include financial incentives to beneficiaries for reporting suspected improper payments, or any other provision for rewarding benefit recipients for aiding in prevention or detection of fraudulent activities. The federal Medicare program, by contrast, has long offered financial rewards of up to $1,000 for reporting verified fraud. At present, there is no advantage or benefit to Medicaid enrollees to report suspected fraud, waste, and misuse, and so nothing impels them to report potential fraud. The Department's fraud prevention and detection activities are limited by the lack of information and incentives for benefit recipients to participate in such activities.

[224] Medicaid Integrity Program: Alaska Comprehensive Program Integrity Review, Centers for Medicare & Medicaid Services, January 2014, p. 8.

13.1.8. FINDING: Abuse of prescription opioid narcotics is both a major behavioral health concern as well as a significant source of fraud and abuse in the health care system. Alaska's current prescription drug monitoring law creates barriers that restrict DHSS and the Department of Law from accessing prescription drug data and using it to identify patient doctor-shopping and other prescribing practices that are potentially fraudulent or abusive.

The abuse of prescription opioid narcotics is a major concern to both behavioral health services and the Department's fraud and abuse activities. Across the nation, abuse and misuse of prescription narcotics is estimated to cost $53.4 billion in lost productivity, criminal justice costs, and medical costs.[225] For every death due to prescription painkillers, there are 10 treatment admissions for abuse, 130 individuals abusing or dependent, and 825 non-medical users. More than three out of four people who misuse prescription painkillers use drugs prescribed to someone else. Alaska's rate of prescription drug abuse is higher than most other states, and in 2008 Alaska ranked 5th for deaths due to prescription drug overdose.[226]

The abuse of prescription opioid narcotics is of significant importance to the behavioral health system and the Medicaid fraud control units. PCG finds that Alaska's current Prescription Drug Monitoring law, AS 17.30.200, creates barriers that restrict DHSS and DOL from accessing prescription drug data and using it to identify fraudulent activities. Statutory restrictions regarding access of state law enforcement personnel reads as follows.

> *(d) The database and the information contained within the database are confidential, are not public records, and are not subject to public disclosure. The board shall undertake to ensure the security and confidentiality of the database and the information contained within the database. The board may allow access to the database only to the following persons and in accordance with the limitations provided and regulations of the board;*
>
> > *(5) federal, state, and local law enforcement authorities may receive printouts of information contained in the database under a search warrant, subpoena, or order issued by a court establishing probable cause for the access and use of the information.*[227]

Currently, Department investigators are unable to access the prescription drug database in a manner that would facilitate truly effective fraud control. Subsequently it is more difficult for the Department to identify significant sources of prescription fraud, such as abusive prescribing practices or recipient doctor-shopping. These barriers limit the Department's ability to effectively prevent, detect, and identify behavioral health Medicaid fraud stemming from the abuse of prescription narcotics. See Section 13.2.5 for a recommendation related to this finding.

[225] 2013 Annual Report of the Alaska Health Care Commission, Health Care Commission, p. 21.
[226] Ibid.
[227] Alaska Statute Title 17, Chapter 30.

13.1.9. FINDING: Substantial changes in behavioral health service delivery, such as mental health and substance abuse integration and the integration of behavioral health and primary care, have required significant revisions to the State's Medicaid rules and regulations. Despite recent updates to the Medicaid regulations by DBH, ambiguities remain in the regulations for some behavioral health services that leave the program vulnerable to fraud, waste, and misuse.

The cornerstone of preventing Medicaid fraud, waste, and misuse is having a clear, detailed set of enforceable guidelines codified in regulation. The various DHSS units dedicated to fraud control of behavioral health services rely on the State's Medicaid regulations to identify and prosecute fraud. In the past, the State funded behavioral health services primarily through grants rather than the Medicaid fee-for-service reimbursement, and relied more heavily on traditional grant management processes to control fraud, waste, and misuse. Medicaid, on the other hand, depends upon a fundamentally different model of "good governance" for appropriately managing program resources.

The shift from grant-based to fee-for-service reimbursement for behavioral health services has been occurring steadily for decades, with fee-for-service Medicaid reimbursement—and its unique and complex billing structures—assuming an ever larger role in financing services throughout the state. In 2011, the Department significantly revised the State's Medicaid rules and regulations to keep pace with these developments and to address the regulatory challenges of integrating mental health and substance abuse services. DHSS amended the regulations in order to include billable services and enrollment requirements for both mental health and substance abuse services. MQS worked with the DBH Policy & Planning section and MPI unit to define the regulations and incorporate these changes so that behavioral health services could be funded and managed through the Medicaid fee schedule.

Despite these efforts to define and develop behavioral health Medicaid regulations, ambiguities nevertheless remain for certain billable behavioral health services that expose the Medicaid program to potential fraud, waste, and misuse. For example, there has been a lack of cohesion between MPI, MQS, and other DBH section in communicating clear regulatory guidance to behavioral health providers regarding Recipient Support Services (RSS), billed under code H2017.[228] An increase in RSS claims caught the attention of MPI and Centers for Medicare and Medicaid Services (CMS), spurring a review of the service. While MPI believed the code was being misused, the regulations were too ambiguous to allow them to create a case of administrative overpayment. DBH and MPI have now collaborated more extensively to clarify the specifics of RSS billing practices and communicate them to the providers, but this situation is emblematic of the ambiguities that remain in the behavioral health Medicaid regulations that limit the Department's effectiveness at identifying and prosecuting fraud, waste, and misuse.

Whether the funding comes from grants or from Medicaid, DHSS is responsible for providing the complete array of behavioral health services needed by consumers. As the funding mechanisms shift more heavily towards fee-for-service Medicaid reimbursement, it is necessary that the Department continue to update and amend the Medicaid regulations governing mental health and substance abuse services. Without tightly

[228] Community Behavioral Health Services Policies and Procedures, Alaska Medical Assistance Provider Billing Manual, Alaska Department of Health and Social Services.

defined and authoritative regulations that concretely indicate the boundaries of appropriate service delivery through Medicaid, the Department is unable to be fully effective in its efforts to limit fraud, waste, and misuse.

Additionally, new initiatives to integrate behavioral health and primary care services will likewise require close evaluation of the Medicaid regulations and continued collaboration of HCS, MQS, Policy & Planning, and MPI to ensure that all stakeholders agree upon the services covered and the intended utilization of each service code. Any vagueness or ambiguity will leave the Medicaid program vulnerable to fraud and misuse of behavioral health services.

13.2. Best Practices for Reducing Fraud, Waste, and Misuse

13.2.1. RECOMMENDATION: The Department should consider strengthening Medicaid provider enrollment activities by requiring enrollment of all rendering provider types.

The Department should consider strengthening Medicaid fraud prevention activities by requiring the enrollment of all provider types as individual rendering providers. As discussed earlier in this section, Alaska's Medicaid regulations do not currently require all provider types to be enrolled in the Medicaid program as individual rendering providers. This structure creates opportunities for fraud by enabling providers excluded from billing services under one provider type to bill Medicaid through a separate provider type, and for practitioners performing Medicaid services under multiple billing providers to submit fraudulent claims.

The 2013 Alaska Comprehensive Program Integrity Review performed by CMS identifies the Department's individual enrollment of Personal Care Attendants (PCAs) as a "noteworthy or 'best' practice."[229] The Department had previously identified PCA services as a high-risk area for fraud, waste, and misuse. To address that risk potential, DHSS requires all PCAs to enroll as individual rendering providers and to be employed with an agency enrolled with the State as a Medicaid provider. This strict regulation of individual rendering provider enrollment enables DHSS to track a practitioner's claims activity more easily, which is of particular importance when the practitioner is employed by more than one agency. In the report CMS recommends that other states "consider emulating this activity," and the Department should extend these regulations across all provider types to prevent fraudulent providers from submitting claims under secondary provider types or additional billing providers. See Section 13.1.6 for more detail relating to this recommendation.

[229] Medicaid Integrity Program: Alaska Comprehensive Program Integrity Review, Centers for Medicare & Medicaid Services, January 2014, p. 7.

13.2.2. RECOMMENDATION: The Department should engage Medicaid recipients in helping to identify fraud by providing them with EOB statements.

The Department can expand its Medicaid fraud prevention and detection efforts by engaging recipients in fraud identification. Although MPI engages in the REOMB process as part of post-payment controls, only recipients whose claims are under review receive that information. Upon enrollment into the Medicaid program it is not customary for Alaskans to receive EOB statements or pamphlets as do consumers with private insurance. Subsequently, Medicaid recipients are unable to verify services billed on their behalf by providers. This shortcoming of consumer engagement presents providers with the opportunity to submit fraudulent claims. Without an informed consumer population, practitioners intent on defrauding the Medicaid program can more easily receive payments for inappropriate or unnecessary services, or services which they never performed. The Department should engage Medicaid recipients in fraud control efforts by providing them with EOB statements and the information required to identify fraud, waste, and misuse of Medicaid services. See Section 13.1.7 for more information related to this recommendation.

13.2.3. RECOMMENDATION: The State should consider increasing criminal penalties for Medicaid fraud and assessing interest and additional financial penalties on individuals convicted of Medicaid fraud.

The current criminal penalties and consequences for Medicaid fraud are milder than those that would be more effective at deterring and discouraging Medicaid fraud. A July 10, 2014, press release from the Anchorage FBI office states that an individual convicted of robbing an Anchorage bank of $2,078 was sentenced to 60 months in jail.[230] In contrast, an April 8, 2015, MFCU press release announced that an individual who stole over $1.6 million from the Medicaid program received only four months in jail,[231] and the Alaska Dispatch News reported that an individual received no jail time after being convicted of falsely billing nearly $90,000 in Medicaid claims.[232] Punishing Medicaid fraud with light criminal penalties provides individuals with an economic incentive to defraud the Medicaid program. The Department should consider increasing criminal penalties for Medicaid fraud to strongly discourage and more effectively prevent fraudulent Medicaid activity.

Additionally, the Department should consider assessing additional financial penalties and interest on individuals convicted of Medicaid fraud. A review of press releases and news items does not indicate that monetary penalties or financial interest is customarily levied on persons convicted of Medicaid fraud. While offenders are required to pay restitution of the amount stolen, they are not required to pay interest or additional monetary penalties. The Department should collect both penalties and interest in situations where the Medicaid program has been defrauded, in addition to restitution and criminal penalties, to more

[230] Press Release, Federal Bureau of Investigation, July 10, 2014.
[231] Press Release, Alaska Department of Law, April 8, 2014.
[232] "Anchorage woman sentenced for $90k of Medicaid fraud," Alaska Dispatch News, March 20, 2014.

effectively prosecute and prevent fraud. See section 13.3.1 for estimated savings related to this recommendation.

13.2.4. RECOMMENDATION: The State should consider strengthening its seizure laws and imposing bonding requirements for high-risk providers.

To enhance the Department's fraud deterrence and prosecution efforts, the State should consider strengthening its seizure laws and implementing bonding requirements for high-risk providers. Stronger seizure laws will enable the Department to recoup overpayments and payments made on fraudulent claims more easily. Prosecutions of cases of fraud will be more effective and yield a greater percentage of funds distributed in error. Additionally, instituting bonding requirements for high-risk providers will insure the State against payments made in cases of fraud that will better protect the interest of the State. With enhanced bonding requirements, billing providers will be required to repay a set amount or percentage to the Department in the event of fraud, ensuring the Department receives a higher percentage of restitution payments. Together, strengthened seizure laws and bonding requirements will both enhance the effectiveness of the Department's fraud prosecution activities and deter providers from engaging in fraud by expanding the negative consequences of Medicaid fraud. See Section 13.3.1 for estimated savings related to this recommendation.

13.2.5. RECOMMENDATION: The State should create a robust prescription drug control program, including financial support for and upgrade of the Prescription Drug Database to real-time functionality and removing statutory barriers to state agency access to the database to facilitate fraud identification and drug abuse prevention.

Fraud and abuse of prescription drugs is more prevalent than in other behavioral health service areas. To improve its fraud identification and drug abuse prevention efforts, the State should create a more robust prescription drug control program. This program should include financial support for the Prescription Drug Database sufficient for its upgrade to real-time functionality. Real-time functionality inhibits the ability of consumers to fill multiple prescriptions for prescription opioid narcotics by maintaining an up to date complete prescription history. This functionality is nationally recognized as a best practice at improving prescription drug monitoring and preventing fraud.[233]

Additionally, the State's improved prescription drug control program should remove statutory barriers to state agency access to the prescription drug database to more easily facilitate fraud identification and drug abuse prevention. Alaska's current Prescription Drug Monitoring Law, AS 17.30.200, restricts the ability of DOL and DHSS personnel to access the data within the prescription drug database in order to identify improper prescription practices. Examples of prescription drug fraud include abusive prescribing practices

[233] Prescription Drug Monitoring Programs: An Assessment of the Evidence for Best Practices, The Prescription Drug Monitoring Program of Excellence, September 20, 2012.

and recipient doctor-shopping, both identifiable through review of the prescription drug database. The State should provide additional financial support and remove statutory barriers to access to the prescription drug database in order to create a more robust prescription drug monitoring program and prevent prescription drug abuse and fraud. It is estimated that the Department could save from $30,000 to $150,000 annually with a more robust prescription drug control program. See Section 13.1.8 for more information regarding this recommendation.

13.3. Potential Cost Savings

13.3.1. FINDING: Based on CMS estimates of improper payment within Medicaid programs nationwide, PCG projects that the State could generate another $5-10 million in combined cost savings and avoidance through improved Medicaid program integrity efforts.

The Department's program integrity efforts target improper and inaccurate payments in addition to intentional fraud, waste, and misuse. CMS estimates that 3-10% of all Medicaid payments are lost due to improper payments.[234] Based on that rough estimate, PCG projects that the State could generate another $5-10 million in combined cost savings and cost avoidance through improved Medicaid program integrity practices. The State's FY 2016 Budget includes nearly $700 million budgeted for General Fund (GF) Medicaid expenditures.[235] A conservative estimate of 3% in savings amounts to $20 million. Due to the variability of improper payment rates across states, the uncertainty of what percentage of improper payments the Department will be able to prevent, identify, and recoup, and the savings already being realized through existing program integrity efforts, the potential added savings from enhanced program integrity activities could total $5-10 million. See Sections 13.1.6, 13.1.7, 13.2.3 and 13.2.4 for more information regarding this finding.

13.3.2. FINDING: Assuming the rate of improper payment for behavioral health services is similar to the level of estimated improper payment in the Medicaid program as a whole, then improved program integrity activities could generate approximately $1 million in additional combined cost savings and avoidance for behavioral health services.

PCG finds that the Department could generate approximately $1 million in additional combined cost savings and avoidance for Medicaid funded behavioral health services. The FY 2016 budget allocates nearly $80 million of General Fund expenditures for Medicaid-funded behavioral health services.[236] Assuming that the rate of overpayments for behavioral health services is also 3-10%, similar to the level of estimated overpayments in the overall Medicaid program, a conservative estimate of three percent savings amounts

[234] Module 10: Medicare and Medicaid Fraud Prevention, 2013 National Training Program, Centers for Medicare & Medicaid Services.
[235] Fiscal Year 2016 Governor's Amended Operating Budget, DHSS FY 2016 Governor's Amended Budget Book, p. 115.
[236] Ibid.

to $2.3 million. When estimating the potential cost savings and cost avoidance, PCG accounted for the savings already achieved through current program integrity activities and the unlikelihood of identifying 100% of improper payments. As a result, PCG concluded that enhanced program integrity efforts and payment reviews could generate approximately $1 million in additional General Fund cost savings and cost avoidance gleaned from Medicaid-funded behavioral health services. See Section 13.1.2 for more information regarding this finding.

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APPENDIX A: SUMMARY OF POTENTIAL COST SAVINGS

Section(s)	Description	Potential Annual Savings	Source
2.4.2	The Department should invest in additional SUD treatment capacity in order to reap savings from cost offsets to medical, nursing home, and criminal justice costs.	2:1 ROI	Research literature estimating cost offsets cited in section
3.0.2	The Department should integrate Assertive Community Treatment (ACT) Teams into the State's delivery and payment systems.	$1-2 million	The target population and average savings per ACT recipient observed in other states
3.0.3	The Department should continue to promote greater capacity and utilization of peer support services. (NOTE: estimates of potential cost savings are exclusively for substance abuse services; mental health cost offsets are more difficult to demonstrate)	2:1 ROI	Cost-benefit analysis conducted by Washington State Institute for Public Policy (discussed in more detail in section)
3.0.7, 10.2.3	The Department should transform the state's current Medicaid 1915 waivers and implement the 1915(i) and 1915(k) options to refinance and improve community behavioral health service delivery.	$24 million	Department of Health and Social Services (DHSS) legislative document related to Governor's Medicaid expansion bill
3.0.8	The Department should consider the pursuit of a Medicaid 1115 waiver to broaden the array of behavioral health services financed by Medicaid.	$10-$15 million	Department of Health and Social Services (DHSS) legislative document related to Governor's Medicaid expansion bill
3.0.10	The State should develop local sources of funding for behavioral health initiatives.	$1-6 million	Department of Revenue White Paper and peer state use of provider taxes and fees
5.5.2	The Department should build capacity for mobile crisis units in communities with high rates of unnecessary use of the emergency	1.4:1 ROI	Cost-benefit analysis conducted by Washington State

	department for behavioral health-related issues.		Institute for Public Policy (discussed in more detail in section)
5.5.3	The Department should support targeted case management services for high-utilizers of the psychiatric emergency system to divert these consumers from costly acute care and ensure delivery of services oriented to prevention.	$150,000-$250,000	The target population and average savings per targeted case management recipient observed in other states
5.5.4	The Department should expand Crisis Intervention Team (CIT) training for law enforcement and other emergency first responders in the Anchorage/Mat-Su region.	$500,000	Savings extrapolated from comparisons between Anchorage area and mid-size cities where CIT cost-benefit analysis has been conducted. See section for details
10.2.2	The Department should improve its efforts to identify veteran recipients who may be eligible for services through the AVAHS.	$1 million	Medicaid-eligible veteran population in Alaska and DHSS behavioral health Medicaid spending
10.3.1	Based on current Division spending for acute and sub-acute behavioral health services, it is estimated that the Department could save at least $1 million if a tribal provider established an inpatient psychiatric unit.	$1 million	DHSS behavioral health Medicaid spending on American Indian/Alaskan Native individuals
13.2.5	The State should create a robust prescription drug control program, including financial support for and upgrade of the Prescription Drug Database to real-time functionality and removing statutory barriers to state agency access to the database to facilitate fraud identification and drug abuse prevention.	$30,000-$150,000	DHSS behavioral health Medicaid spending and estimates related to Governor's Medicaid expansion bill
13.3.1	Based on CMS estimates of improper payment within Medicaid programs nationwide, PCG projects that the State could generate another $5-10 million in combined cost savings and	$5-10 million	DHSS behavioral health Medicaid spending and CMS

	avoidance through improved Medicaid program integrity efforts.		estimates of fraud and overpayment
13.3.2	Assuming the rate of improper payment for behavioral health services is similar to the level of estimated improper payment in the Medicaid program as a whole, then improved program integrity activities could generate approximately $1 million in additional combined cost savings and avoidance for behavioral health services.	$1 million	DHSS behavioral health Medicaid spending and CMS estimates of improper payments

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APPENDIX B: GLOSSARY OF ACRONYMS

AAC - Alaska Administrative Code

ABADA - Advisory Board on Alcoholism and Drug Abuse

ABHA - Alaska Behavioral Health Association

ACA – Affordable Care Act

ACS - Alaska Court System

ACT – Assertive Community Treatment

ADHD – Attention Deficit Hyperactivity Disorder

ADRD - Alzheimer's disease and related dementia

AHFC - Alaska Housing Finance Corporation

AHRQ - Agency for Healthcare Research and Quality

AI/AN - American Indians and Alaska Natives

AKAIMS - Alaska Automated Information Management System

ALF – Assisted Living Facility

AMHB - Alaska Mental Health Board

AMHTA - Alaska Mental Health Trust Authority

AMI – Any Mental Illness

AMM – Antidepressant Medication Management

ANTHC -Alaska Native Tribal Health Consortium

API - Alaska Psychiatric Institute

APIC - Assess, Plan, Identify and Coordinate

APRN – Advanced Practice Registered Nurse

ARRA - American Recovery and Reinvestment Act of 2009

ASAP - Alcohol Safety Action Program

ASD – Autism Spectrum Disorders

AVAHS - Alaska Veterans Affairs Healthcare System

BHO – Behavioral Health Organization

BHPC - Behavioral Health Purchasing Collaborative

BHTRG – Behavioral Health Treatment and Recovery Grants

BRS – Behavioral Rehabilitation Services

BTKH - Bring the Kids Home

CAHPS - Consumer Assessment of Healthcare Providers and Systems

CARF - Commission on Accreditation of Rehabilitation Facilities

CBC - Complex Behavior Collaborative

CBHC - Community Behavioral Health Centers

CBHTR - Comprehensive Behavioral Health Treatment and Recovery

CBT – Cognitive Behavioral Treatment

CCBHC - Certified Community Behavioral Health Clinic

CFC - Community First Choice

CHAP - Community Health Aide Program

CIP - Capital Improvement Project Receipts

CIT – Crisis Intervention Team

CMS – Center for Medicare and Medicaid Services

COPSD – Co-Occurring Psychiatric and Substance Use Disorders

CSR - Client Status Review

DBH - Division of Behavioral Health

DEED - Department of Education

DES - Designated Evaluation and Stabilization

DET - Designated Evaluation and Treatment

DHCS – Division of Health Care Services

DHSS –Department of Health and Social Services

DJJ - Division of Juvenile Justice

DLA –Division of Legislative Audit

DOC – Department of Corrections

DPA – Division of Public Assistance

DPH - Division of Public Health

DSH – Disproportionate Share Hospital

DSHS – Texas Department of State Health Services

DSRIP - Delivery System Reform Incentive Payment

DVA - Department of Veterans' Affairs

ECHO - Experience of Care and Health Outcomes

EDI – Electronic Data Interface

eFMAP - Enhanced Federal Medical Assistance Percentage

EHR - Electronic Health Record

EOB - Explanation of Benefits

FAR - Frontier and Remote

FASD - Fetal Alcohol Spectrum Disorders

FCU - Fraud Control Unit

FMAP - Federal Medical Assistance Percentage

FPL – Federal Poverty Level

FRAC - Frontline Remote Access Clinic

GC–CAHPS - Consumer Assessment of Healthcare Providers and Systems Clinician & Group

GED - Grant Equitable Distribution

GEMS - Grants Electronic Management System

GF – General Fund

HBIPS - Hospital-Based Inpatient Psychiatric Service

HCBS – Home and Community Based Services

HCPF - Colorado Department of Health Care Policy and Financing

HCS – Division of Health Care Services

HEDIS - Healthcare Effectiveness Data and Information Set

HHS – U.S. Department of Health and Human Services

HIT – Health Information Technology

HPSA - Health Professional Shortage Area

HPSD - Health Planning and Systems Development

HRSA - Health Resources and Services Administration

I/A - Interagency Receipts

ICM - Intensive Case Management

IDHS - Iowa Department of Human Services

IHS - Indian Health Services

IMD - Institute for Mental Disease

IMPACT - Improving Mood – Promoting Access to Collaborative Treatment

ISA - Individualized Service Agreements

ITS – Information Technology Services

JC – Joint Commission

LBAC – Alaska Legislative Budget and Audit Committee

LCSW - Licensed Clinical Social Worker

LMHA - Local Mental Health Authority

MAT – Medication Assisted Treatment

MCI - Master Client Index

MCO – Managed Care Organization

MHSA - Mental Health and Substance Abuse Division

MHSIP - Mental Health Statistics Improvement Program

MHTAAR - Mental Health Trust Authority Authorized Receipts

MMIS - Medicaid Management Information System

MQS - Medicaid and Quality Section

MTF - Medicaid Task Force

NASMHPD - National Association of State Mental Health Program Directors

NBHQF- National Behavioral Health Quality Framework

NCQA - National Committee for Quality Assurance

NOMs - National Outcome Measures

NRI - National Research Institute

NSDUH - National Survey on Drug Use and Health

OCS - Office of Children's Services

OIHS - Office of Integrated Housing & Services

ORCA - Online Resource for the Children of Alaska

PABS – Performance and Budget Summary

PARIS - Public Assistance Reporting Information System

PBF - Performance-Based Funding

PC3 - Patient Centered Community Care

PCA - Personal Care Attendants

PEI - Prevention and Early Intervention

PES – Psychiatric Emergency Services

PLL - Parenting with Love and Limits

PSH – Permanent Supportive Housing

RBA - Results-Based Accountability

RBB – Results Based Budgeting

RDU - Results Delivery Unit

RPTC -Residential Psychiatric Treatment Centers

RSS - Recipient Supportive Services

RVHAP - Rural Veteran Health Access Program

SAMHSA - Substance Abuse and Mental Health Services Administration

SAPT - Substance Abuse Prevention and Treatment

SBRIT - Screening, Brief Intervention, and Referral to Treatment

SDS - Division of Senior and Disabilities Services

SED – Seriously Emotionally Disturbed

SMHA - State Mental Health Authorities

SMI – Seriously Mentally Ill

SNCP – Safety Net Care Pool

SPC - Suicide Prevention Council

SPFSIG - Strategic Prevention Framework State Incentive Grant

SSA – Social Security Act

SUD - Substance Use Disorders

T&R - Treatment & Recovery

TBI - Traumatic Brain Injury

TIP - Transition to Independence Process

UGF – Unrestricted General Fund

WHO – World Health Organization

YKHC - Yukon-Kuskokwim Health Corporation

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APPENDIX C: DEPARTMENT OF HEALTH AND SOCIAL SERVICES RESPONSE

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THE STATE of ALASKA
GOVERNOR BILL WALKER

Department of Health and Social Services

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November 13, 2015

Ms. Kris Curtis, CPA, CISA
Legislative Auditor
Legislative Budget and Audit Committee
Division of Legislative Audit
P.O. Box 113300
Juneau, Alaska 99811-3300

Dear Ms. Curtis:

RE: Response to Confidential Management Letter No. 3, Department of Health and Social Services (DHSS) Performance Review

We appreciate the opportunity to review and evaluate the performance report and associated recommendations as shared in your confidential preliminary report received October 8, 2015. The following are the responses to the report's findings, recommendations and sections:

1.2.1 FINDING: The Division of Behavioral Health's budget visualization includes all relevant information regarding cost, volume, and funding sources, but can be improved by reorganization of the information presented. (p.39)

DHSS concurs with the finding. Orientation of information in the budget overview is coordinated, in part, by the Executive Branch's Office of Management and Budget and the Legislative Branch's Legislative Finance Division.

1.2.2 FINDING: The Division of Behavioral Health's budget visualization presents the number of individuals served, cost of services provided, and funding sources used in a comprehensive manner that utilizes all space available. (p.39)

DHSS concurs with the finding. Orientation of information in the budget overview is coordinated, in part, by the Executive Branch's Office of Management and Budget and the Legislative Branch's Legislative Finance Division.

1.2.3 RECOMMENDATION: Reorientation of the order of information on the budget visualization would improve communication of budget details. (p.40)

DHSS concurs with the recommendation. Orientation of information in the budget overview is coordinated, in part, by the Office of Management and Budget and the Legislature's Legislative Finance Division and can be arranged in a variety of orientations to assist in presentation.

1.2.4 FINDING: The Governor's Amended Budget presents all necessary information at the appropriate level of detail. (p.41)

DHSS concurs with the finding.

1.2.5 RECOMMENDATION: The use of visual aids in the Governor's Amended Budget such as bar graphs and tables, assists readers in comprehending and understanding the information presented. These could be further improved by standardizing the timelines used on these visual elements. (p.41)

DHSS concurs with the recommendation. Visual aids are developed yearly in an effort to provide information to the Legislature and the public in the most accessible and meaningful ways possible.

1.2.6 RECOMMENDATION: The presentation of Department challenges and accomplishments in the Governor's Amended Budget would be improved with a discussion of solutions, as well as an assessment of whether accomplishments meet Department goals. (p.42)

DHSS concurs with the recommendation. It is important to note that the length of presentation materials is often a concern of the various legislative committees which govern the presentation materials and length of time.

1.2.7 RECOMMENDATION: The Governor's Amended Budget could be improved through the inclusion of an introduction and description of programs for each Results Delivery Unit (RDU) that would orient the reader to the detailed information that follows. The inclusion of historical and projection data would also facilitate evaluation of program elements over time. (p.44)

DHSS concurs with the recommendation. Budget documents are a product of collaboration between DHSS and our legislative house and senate finance committees.

2.1.1 FINDING: The Department has developed a clearly-articulated mission with well-defined goals and objectives to direct department, division, and program-level activities. (p.47)

DHSS concurs with the finding.

2.2.1 FINDING: The Department does not provide the full continuum of care required to deliver effective behavioral health services. (p.48)

DHSS does not concur with the finding, as it provides for all of the domains in the Continuum of Services (pages 49-50). Some services are provided through state-funded grants, some through Medicaid or Waivers, and some through federal grants.

2.2.2 FINDING: Although the Department has successfully introduced new service capacities and more effective types of treatment in some parts of the care continuum, other parts of the continuum have witnessed a reduction in service capacity. (p.52)

DHSS partially concurs with the finding. Reduction in service capacity on some parts of the service continuum is related to a complex set of variables including lack of rate increases/inflation adjustments for the providers, workforce shortages in all sectors, and provider decisions to limit capacity.

2.2.3 FINDING: Access to services increased significantly during the review period, but the growth in service utilization has occurred unequally across regions, and disproportionately in mental health over substance abuse services. (p.53)

DHSS partially concurs with the finding. Note that uneven service utilization is a result of several issues including provider business decisions to reduce or eliminate certain service, and the migration of rural clients to larger communities, which has increased market share in the growing urban areas.

2.2.4 FINDING: The quality of overall service delivery has remained relatively static over the course of the review period. (p.61)

DHSS partially concurs with the finding as the trend for quality has improved, however slightly, over the review period. This trend continues as outcome measures increase the statistical ability of the Department to track service delivery quality, quantity, and efficacy.

2.3.1 FINDING: Due in part to the Division of Behavioral Health's control over Alaska's Medicaid behavioral health expenditures, the Department has successfully leveraged federal matching funds to increase overall funds for services and coordinate behavioral health financing more efficiently. (p.65)

DHSS concurs with the finding. Having both the grants and Medicaid systems for behavioral health in one division has allowed for excellent coordination between regulations, policy, and provider assistance. This environment has allowed the division to capitalize on matching funds from the Medicaid program while providing services not covered by Medicaid through grant funds with efficiency and efficacy.

2.3.2 FINDING: Although the Department has progressively shifted spending away from institutional care to finance more efficient treatment within the community, increased numbers of community providers offering more intensive services are needed to realize the full benefits of community treatment. (p. 69)

DHSS concurs with the finding. The department is in the process of evaluating options and resources.

2.3.3 FINDING: Per capita behavioral health spending in Alaska is among the highest of any state.

Although expenditures per capita continue to rise annually, expenditures per recipient have actually decreased over the period. (p.72)

DHSS concurs with the finding. More study will be required to identify the relationship between rising per capita expenditures and falling per recipient expenditure.

2.3.4 FINDING: Increasing reliance on Medicaid as the dominant source of funds for behavioral health services has led to disparate effects on youth and adult services, fostering different kinds of efficiencies and inefficiencies within the two systems. (p.74)

DHSS partially concurs with the finding. Disparate effects of funding and treatment for all types of services and ages of recipients must continue to be analyzed for the potential of positive and/or negative impact on the system of care over time. As services are delivered statewide in widely diverse communities, the strength of various local support systems in each delivery area can also be expected to impact service efficacy.

2.4.1 RECOMMENDATION: Reforming staffing policies and practices at API, including more competitive hiring and retention efforts, could significantly improve the quantity and quality of care without increasing costs. (p.77)

DHSS partially concurs with the recommendation. The department is working within state guidelines and collective bargaining agreements to reform staffing policies and procedures at API.

2.4.2 RECOMMENDATION: The Department should build additional service capacity for substance use disorder (SUD) treatment, both to increase access to services and improve quality. Additional investment would lead to significant savings in medical, nursing home, and criminal justice costs, producing interventions that "pay for themselves" in cost offsets from other essential State services. (p.78)

DHSS concurs with the recommendation and is exploring a variety of waiver options and reformation option for Medicaid reimbursement. This includes the development of an 1115 waiver option for SUD services delivered in facilities with more than 16 beds. This will allow a federally matched funding mechanism for those services, and will greatly improve statewide accessibility and affordability.

2.5.1 FINDING: The Department's acute intensive services are neither effective nor efficient, due to a combination of administrative inefficiencies, inadequate sub-acute infrastructure, and lack of community partners. (p.81)

DHSS does not concur with the finding. In particular, the Alaska Psychiatric Institute is one of the more efficient means of delivering acute services, when daily cost of care is compared to the cost of care in other hospitals in the state. Primarily due to limited funding available to the Department and therefore to providers, the provider community has been hesitant to take the steps necessary to open crisis recover services, mobile crisis units, and acute care of the voluntarily or involuntarily committed (the latter usually because of court costs and legal issues). As a result, community hospitals take the majority of cases with a critical profile for triage and referral. DHSS is working on a number of reforms to its system of care to

encourage more provider participation in acute, intensive services. Medicaid expansion offers the best answer to this issue as it provides a payer source for many adults who did not previously have coverage for this service.

2.5.2 FINDING: Gaps in the Department's residential services system limit its effectiveness, but efforts to improve service capacity for certain populations have significantly improved efficiency. (p.82)

DHSS concurs with the finding.

2.5.3 FINDING: The Department's limited capacity for intensive support services, especially for assertive community treatment and substance abuse intensive outpatient services, substantially limits the effectiveness and efficiency of care for high-need populations. (p.83)

DHSS partially concurs with the finding. Historically, this has been true. However, DHSS is building intensive support service capacity in Anchorage. An Assertive Community Treatment (ACT) grant and an Intensive Case Management (ICM) grant were awarded in April of 2015, for services to begin September 1st. As of this response, both the ACT and ICM services are up and running and have successively moved individuals from the indigent population into supported housing and treatment. Pending the availability of sustainable funding, more of these types of services will be built in other communities.

2.5.4 FINDING: The Department is limited in the resources available to provide living supports such as transportation and assisted living services effectively, but it has made improvements in using scarce resources efficiently. (p.84)

DHSS concurs with the finding.

2.5.5 FINDING: The Department is deficient in providing key community and recovery s u p p o r t s , such as housing, mentoring, and caregiver supports. Peer services have not been integrated into providers' recovery supports to allow the most effective range of services. (p.85)

DHSS does not concur with the finding. Housing shortages are an issue for all populations in many Alaska communities. In response to this need, the Division of Behavioral Health is considering a change to its General Relief program, to focus specifically on supported housing. Additionally, critical partnerships have been developed with the Alaska Mental Health Trust Authority and the Alaska Housing Finance Corporation (AHFC) to address the issue of housing, and a recent award of both a federal 811 grant for housing and 120 vouchers from AHFC has been realized for this purpose. At this time, peer services are a reimbursable service and can be developed anywhere in the state. Very few providers currently choose to offer these services due to lack of housing availability for the individuals in need of peer support services (example: in many communities, housing may not be available for those convicted of sexual offenses or felonies.)

2.5.6 FINDING: The Department's outpatient and medication services are broadly effective, but are increasingly overburdened and unable to keep pace with growing consumer demand. (p.87)

DHSS concurs with the finding and is developing a plan to encourage providers of both outpatient services and medication services. Medicaid expansion will assist in this development as it will provide a payer source for a large part of the population in need.

2.5.7 FINDING: The Department has made progress in improving engagement services, including its assessment, evaluation, and service planning processes. However, more work needs to be done to deliver these services efficiently. (p.88)

DHSS concurs with the finding. A number of changes are in process which will enable more efficient delivery of services.

2.5.8 FINDING: The Department's prevention and wellness services have made significant progress in building strong community coalitions, but need to be integrated more effectively into core Division activities. (p.89)

DHSS concurs with the finding and is working closely with its partners to integrate services in divisional activities.

2.5.9 FINDING: Department efforts to foster care integration services of behavioral health and primary care have been mixed in their effectiveness and efficiency. (p.91)

DHSS concurs with the finding. The development of integrated behavioral health and primary care services has been attempted both nationally and in Alaska, with various results. The department continues to work diligently on this complex process, moving toward a stronger integrated care system. An upcoming National Association of Medicaid Directors conference on this topic in December of this year will likely help the department advance this effort.

3.0.1 RECOMMENDATION: The Department should develop a statewide strategy for sustained support of integrated care across mental health, substance abuse and primary care delivery systems. (p.93)

DHSS concurs with the recommendation and is developing a statewide strategy for sustainable service in accordance with the Substance Abuse and Mental Health Services Administration (SAMHSA) description of the Good and Modern System of Care including Primary Care integration.

3.0.2 RECOMMENDATION: The Department should integrate Assertive Community Treatment (ACT) teams into the State's delivery and payment systems. (p.94)

DHSS concurs with the recommendation. The department has initiated grant-funded ACT services in Anchorage and is in the process of integrating this service into the State's delivery and payment system.

3.0.3 RECOMMENDATION: The Department should continue to promote greater capacity and utilization of peer support services. (p.95)

DHSS concurs with the recommendation. The department needs to clarify that peer services are reimbursable and can be developed anywhere in the state by providers who choose to do so.

3.0.4 RECOMMENDATION: The Department should pursue implementation of Certified Community Behavioral Health Clinic (CCBHC) services in order to take advantage of enhanced federal Medicaid financing for vital delivery system reforms. (p.96)

DHSS concurs with the recommendation and has applied for this opportunity.

3.0.5 RECOMMENDATION: The Department should consider expanding Medicaid to cover adults under 65 with income up to 133% of the Federal Poverty Level (FPL), taking advantage of substantially enhanced federal funding to build additional infrastructure to meet the needs of underserved behavioral health populations. (p.97)

DHSS concurs with the recommendation. Medicaid Expansion was implemented on September 1, 2015.

3.0.6 RECOMMENDATION: The Department should transform the State's current Medicaid 1915 waivers and implement the l 915(i) and 1915(k) options to refinance and improve community behavioral health service delivery. (p.99)

DHSS concurs with the recommendation and is in the process of reforming its current Medicaid system. This process includes writing both a 1915(i) and (k) option.

3.0.7 RECOMMENDATION: The Department should consider the pursuit of a Medicaid 1115 waiver to broaden the array of behavioral health services financed by Medicaid. (p.100)

DHSS concurs with the recommendation. The department is in the process of reforming its current Medicaid system and this process includes pursuing an 1115 waiver option.

3.0.8 RECOMMENDATION: The Department should develop a Medicaid behavioral health rate structure that covers provider costs, incentivizes quality, and minimizes administrative burden. (p.101)

DHSS concurs with the recommendation and has initiated a comprehensive rate re-basing study for all Medicaid behavioral health reimbursement rates.

3.0.9 RECOMMENDATION: The State should develop local sources of funding for behavioral health initiatives. (p.102)

DHSS concurs with the recommendation. The Department is currently working with the Alaska Mental Health Trust Authority to develop additional funding sources for behavioral health services, specifically within the Municipality of Anchorage. It also continues to explore other potential funding strategies.

4.1.1 FINDING: The Department has made significant strides in collecting the data necessary for effective measurement of behavioral health services. (p.103)

DHSS concurs with the finding.

4.1.2 FINDING: The Department's progress in behavioral health performance measurement is consistent with the practices of state behavioral health agencies nationwide. (p.105)

DHSS concurs with the finding.

4.1.3 FINDING: Department behavioral health measures sufficiently demonstrate whether Prevention and Early Intervention (PEI) services are effective. (p.110)

DHSS concurs with the finding.

4.1.4 FINDING: Department measures do not sufficiently demonstrate whether community T&R services are effective. (p.113)

DHSS does not concur with the finding. The Division of Behavioral health has been collecting outcome data for community behavioral health treatment and recovery grants since 2008 and has well developed federal reporting on this issue. Further, the Division of Behavioral Health works closely with behavioral health providers, through the Alaska Behavioral Health Association, to provide ongoing outcome assessment and revision.

4.1.5 FINDING: Department measures sufficiently demonstrate whether institutional behavioral health services are effective. (p.116)

DHSS concurs with the finding.

4.2.1 FINDING: Department measures demonstrate whether PEI services are efficient. (p.116)

DHSS concurs with the finding.

4.2.2 FINDING: Department measures do not demonstrate whether community Treatment and Recovery services are efficient. (p.117)

DHSS does not concur with the finding. As above (see response to finding 4.1.4), the Division of Behavioral health has been collecting outcome data for both the efficiency and effectiveness of community behavioral health treatment and recovery grants since 2008 and has well developed federal reporting on this issue. Further, the Division of Behavioral Health works closely with behavioral health providers, through the Alaska Behavioral Health Association, to provide ongoing outcome assessment and revision of reporting requirements as needed. This includes the Performance Based Funding process which specifically measures the efficiency of an agency's use of funds.

4.2.3 FINDING: Department measures sufficiently demonstrate whether institutional behavioral health services are efficient. (p.118)

DHSS concurs with the finding.

4.2.4 FINDING: The Department's measures of institutional behavioral health are consistent with nationwide best practices. (p.119)

DHSS concurs with the finding.

4.3.1 RECOMMENDATION: The Department should distinguish more clearly between measures of Division of Behavioral Health activities and the activities of funded providers. (p.120)

DHSS concurs with the recommendation and will explore ways to further distinguish measurement of Division of Behavioral Health activities from those of funded providers.

4.3.2 RECOMMENDATION: The Department should develop a consistent approach to measuring behavioral health performance across divisions. (p.122)

DHSS concurs with the recommendation. DHSS strives to align performance measures across divisions, through use of the Results Based Accountability framework.

Together with the Alaska Native Tribal Health Consortium, DHSS has launched the Healthy Alaskans 2020 project. The project takes a holistic approach to measuring the health and wellbeing of Alaskans and provides a science-based framework to guide efforts toward improving health and ensuring health equity for all Alaskans. Six of the performance measures are related to behavioral health. This initiative provides a solid foundation for cross-divisional work to develop behavioral health performance measures.

4.3.3 RECOMMENDATION: The Department should ensure continuity among program, division, and departmental-level evaluation of services, with appropriate degree of specificity and generality. (p.122)

DHSS concurs with the recommendation. The department will continue efforts to ensure continuity among program, division, and departmental level evaluation of services.

4.3.4 RECOMMENDATION: The Department should incorporate performance measures that are more appropriately outcome-oriented. (p.123)

DHSS partially concurs with the recommendation. The department has had performance measures of its programs in place since 2008. However, these performance measures are constantly being revised to

address changing needs and services. As resources allow, the department will explore adopting more objective indicators of recovery, in order to provide a more robust set of outcome oriented measures.

4.3.5 RECOMMENDATION: The Department should incorporate nationally recognized behavioral health treatment and recovery measures into the Department's performance measurement strategy. (p.123)

DHSS concurs with the recommendation. The department understands the advantages of incorporating nationally recognized behavioral health treatment and recovery measures into its performance measurement strategy. To that end, as resources allow, it will explore adoption of the HEDIS and other strategies identified in the report to potentially strengthen performance measurement efforts.

4.3.6 RECOMMENDATION: The Department should align performance measurement of community providers, as far as possible, with measures used in accreditation requirements. (p.125)

DHSS concurs with the recommendation. The department will explore ways to integrate data collected by grantees and other providers into the Department's performance management system. Specifically, the Division of Behavioral Health will look at incorporating into its performance management system the three specific recommended measures, as set forth by Joint Commission and the Commission on Accreditation of Rehabilitation Facilities.

5.1.1 FINDING: National best practices require treatment of individuals at the least-intensive level of care appropriate to support community integration and social inclusion. Furthermore, widespread consensus exists on the array of mental health and substance use services required to ensure effective referral and placement into the most appropriate level of care. (p.128)

DHSS concurs with the finding.

5.1.2 FINDING: Best practices have emerged nationwide for referrals between community behavioral services and services delivered in the criminal justice system. These practices include jail diversion programs on the front end of the criminal justice system, and prisoner re-entry programs on the back end. (p.129)

DHSS concurs with the finding. The department is collaborating with the Department of Corrections and other state work groups, including Alaska Prisoner Reentry Task Force and regional reentry coalitions in Anchorage to address the need.

5.1.3 FINDING: Suspending Medicaid eligibility policy for inmates in corrections is more cost effective than terminating eligibility entirely and reduces the risk of recidivism by facilitating continued access to behavioral health services for citizens returning to the community post-incarceration. (p. 133)

DHSS partially concurs with the finding. Prior to Medicaid expansion, when most inmates qualified for Medicaid under disability categories for which redetermining eligibility is a complex, time-consuming, expensive endeavor, use of suspension was an appropriate response. However, since the original finding, DHSS has implemented coverage of the Medicaid expansion population. With much simpler eligibility

criteria and highly automated eligibility processes under Medicaid expansion, it is uncertain that past efficiencies gained by implementing suspension would offset the additional administrative effort of maintaining cases in suspension for long periods of time. A DHSS and Department of Corrections work group is developing the most efficient way to 1) ensure Medicaid eligibility is determined quickly and claims paid timely when inmates are hospitalized for over 24 hours; and 2) develop processes by which inmates are connected with assistance programs, including Medicaid as part of the re-entry process. DHSS will monitor these transitions and reconsider implementing suspension if needed.

5.2.1 FINDING: Critical gaps in the continuum of care have prevented the Department from aligning its referral and placement policies with best practices for acute and sub-acute psychiatric care needs. (p.134)

DHSS concurs with the finding. The department is currently working to reform its system of care and encourage providers to provide services at levels currently not represented in the system. Medicaid expansion will help address this issue as it provides a payer source for many individuals previously not covered for services .

5.2.2 FINDING: The Department's referral and placement policies and procedures for acute behavioral health care do not align with best practices. Chronic shortage of psychiatric hospital beds, lack of step-down services, and inappropriate utilization of acute care services have resulted in strict admission and utilization controls at the Alaska Psychiatric Institute that disconnect it from the community referral process. (p.135)

DHSS concurs with the finding. However, there are larger system and historical issues at play. As part of the Department's Community Mental Health/API 2000 Replacement Project (CMH/ARP), Public Consulting Group found that Alaska's psychiatric emergency services system could function successfully with a 72-bed hospital, including a 10 bed forensic unit (instead of the 40 forensic beds). An earlier version of that PCG report even supported a much smaller hospital option.

This current PCG report finds fault with the Department's "referral and placement policies and procedures" for both civil and forensic patients. The State's decision to build just a 72/80 bed hospital in the early 2000's was predicated on the State agreeing to fully fund and maintain the range of services identified by PCG as necessary to keep utilization of such a small hospital manageable. That expansion of community-based services throughout the state did not occur to the degree necessary as funding for those services was not provided. Medicaid expansion will address some of these issues as it provides a payer source for individuals previously not covered for services outside of an Institution for Mental Disease.

5.2.3 FINDING: The Department's referral and placement policies and procedures for child and adolescent residential services largely align with best practices. (p.137)

DHSS concurs with the finding.

5.2.4 FINDING: The Department's referral and placement policies and procedures for community treatment and recovery services largely align with best practices. (p.137)

DHSS concurs with the finding.

5.2.5 FINDING: The Department's referral and placement policies and procedures for early intervention services largely align with best practices. (p.138)

DHSS concurs with the finding.

5.3.1 FINDING: Insufficient funding for community-based, prevention-focused behavioral health treatment has increased the need for costly psychiatric services. (p.138)

DHSS concurs with the finding. Currently, when an individual is in need of behavioral health intervention they often do not receive the intervention at a lower level of care because it is unavailable in their community. Because they do not receive the lower level of preventative care their behavioral health needs often escalate to a level of crisis at which medical or legal intervention becomes necessary. Often, individuals with a first time psychotic break or a serious substance abuse issue enter the system of care at the emergency room or at a court ordered round of treatment at the Alaska Psychiatric Institute when it could have been avoided by consistent, preventative care. DHSS is working with its partners to address this issue.

5.3.2 FINDING: The Department's policies and procedures for referrals between acute care services and long-term services and supports are not effective or efficient. (p.139)

DHSS partially concurs with the finding. While much of the efforts of case management and placement referral between acute care services and long-term services and supports do currently work, there is much room for improvement. These policies and procedures are often hampered by a lack of specifically needed services being provided in the state. A number of reforms are currently being developed to address this issue including the writing of a 1915(i) and (k) state plan option which will provide a payer source for many services currently not offered in the system.

5.3.3 FINDING: The Department's policies and procedures for referrals between acute care services and other community supportive services are not effective or efficient. (p.141)

DHSS partially concurs with this finding. While much of the finding accurately reflects the present state of Alaska's acute care referral system, the following should also be noted:

- *All API clinical staff, as well as all staff hired into any position at the facility since February 2015, have been trained in trauma-informed care. A patient's trauma history is always considered when providing care and making discharge plans – with particular awareness of the state's high rates of domestic violence, spousal abuse, alcohol and other substance abuse, and suicidal events in both rural and urban areas;*
- *PCG's assessment that API policies do not require the development of a treatment plan for each person admitted to the hospital is incorrect;*

- *PCG's assessment that API has an optional discharge and referral planning process is incorrect. API policy requires that staff have a discharge plan in place for each patient leaving the hospital;*

While much of the effort of case management and placement referral between acute care services and community supportive services and supports do currently work, there is room for improvement. Existing policies and procedures are often hampered by a lack of specifically needed services being provided in the state. A number of reforms are currently being developed to address this issue, including the writing of both 1915(i) and 1915(k) Medicaid State Plan option proposals, which will provide a payer source for many services currently not offered by DHSS' service system partners.

5.3.4 FINDING: The Department's policies and procedures for referrals between acute care services and justice-involved services are not effective or efficient. (p.142)

DHSS partially concurs with the finding. While much of the efforts of case management and placement referral between acute care services and justice-involved services and supports do currently work, there is room for improvement. These policies and procedures are often hampered by a lack of specifically needed services being provided in the state. A number of reforms are currently being developed to address this issue including the writing of a 1915(i) and (k), and an 1115 waiver option which will provide a payer source for many services currently not offered in the system.

5.3.5 FINDING: The Department's referral and placement policies for child and adolescent residential services are effective and efficient. (p.144)

DHSS concurs with the finding.

5.3.6 FINDING: The Department's referral and placement policies and procedures for community treatment and recovery services are effective and efficient. (p.145)

DHSS concurs with the finding.

5.3.7 FINDING: The Department's referral and placement policies and procedures for early intervention services are effective and efficient. (p.145)

DHSS concurs with the finding.

5.4.1 FINDING: Low supply of psychiatrists nationally, along with a statewide shortage of other behavioral health professionals, impairs the Department's efforts to ensure an effective service array of behavioral health services. (p.147)

DHSS concurs with the finding. This is also a national issue, as a shortage of qualified behavioral health providers exists in many areas of the country.

5.4.2 FINDING: Alaska's vast geography impedes the Department's ability to manage comprehensive behavioral health services efficiently. (p.149)

DHSS concurs with the finding.

5.4.3 FINDING: The availability of affordable housing in Anchorage, Juneau and other population centers poses challenges for transitioning consumers into the community. (p.149)

The Department concurs with the finding. The department is working closely with the Alaska Housing Finance Corporation and the Alaska Mental Health Trust Authority to address this issue.

5.4.4 FINDING: Transitioning consumers from institutional care back into rural Alaska communities is complicated by limited village capacities to care for individuals with serious mental illness. (p.150)

DHSS concurs with the finding. Barriers to returning individuals from institutional care to their rural communities are many and complex. Some of these barriers include lack of specific levels of care or support systems in their home of origin, rejection by their village, or their simple choice not to return. Some of these issues are being addressed through intensive case management approaches in the larger cities, the re-entry program being implemented with the coordination of the Department of Corrections, and working with the Municipality of Anchorage to design programs that address this specific issue.

5.5.1 RECOMMENDATION: The Department should implement a consistent and interoperable information technology solution for referrals across the behavioral health continuum of care. (p.151)

DHSS partially concurs with the recommendation. The department concurs that information technology solutions for referrals across all DHSS divisions is highly desired. However, a fiscal analysis would be needed to determine whether the department has the available resources for a complete implementation.

5.5.2 RECOMMENDATION: The Department should build capacity for mobile crisis units in communities with high rates of unnecessary use of the emergency department for behavioral health-related issues. (p.151)

DHSS concurs with the recommendation. The department has implemented its first Assertive Community Treatment team. Further, there are a number of reforms in process that will address mobile crisis and behavioral health urgent care. DHSS is working with its partners to develop these services in communities with high rates of unnecessary ED use. Medicaid expansion will help these efforts as it will provide for a payer source for many individuals not previously covered for these services.

5.5.3 RECOMMENDATION: The Department should support targeted case management services for high-utilizers of the psychiatric emergency system in order to divert these consumers from costly acute care and ensure delivery of services oriented to prevention. (p.152)

DHSS concurs with the recommendation. The department has implemented a 'super-utilizer' program to address this issue.

5.5.4 RECOMMENDATION: The Department should promote Crisis Intervention Team training for a minimum number of law enforcement personnel in communities with high referral rates to API. (p.153)

DHSS concurs with the recommendation. The Department is working with the Alaska Mental Health Trust Authority on this issue as they have a specific role of advocacy to the Departments of Law and Public Safety.

5.5.5 RECOMMENDATION: The Department should improve coordination efforts with the Department of Corrections to ensure consistency in treatment programs and protocols for individuals exiting correctional facilities. (p.154)

DHSS concurs with the recommendation. The department is collaborating with the Department of Corrections and other state work groups, including Alaska Prisoner Reentry Task Force and the regional reentry coalitions in Anchorage to ensure consistency and efficacy of treatment programs for incarcerated individuals.

5.5.6 RECOMMENDATION: The Department should implement the recommendations presented in the State's Recidivism Reduction Plan. (p.155)

DHSS partially concurs with the recommendation. The department is working to implement the recommendations in the State's Recidivism Reduction Plan. However, the plan includes other agencies outside DHSS who share in the responsibility of implementation. Many of the recommendations in the plan have already been implemented, such as the continued funding of Partners for Progress, Medicaid determination for individuals transitioning from an institution to the community, and coordination of substance abuse treatment in the 24/7 and ASAP program and through the Alaska Mental Health Trust Authority with substance abuse providers statewide.

5.5.7 RECOMMENDATION: The State should develop a coordinated Forensic Services unit to oversee forensic evaluations and service coordination, and to minimize costs incurred by the ACS, DOC, and the DHSS. (p.156)

DHSS concurs with the recommendation and would develop a coordinated Forensic Services unit should funding become available. The Department will discuss this issue with the Departments of Law, Corrections, and ACS in an attempt to find a solution.

5.5.8 RECOMMENDATION: The State should reform Title 12 to distinguish between violent and non-violent misdemeanor offences in the code governing forensic psychiatric evaluations for misdemeanor offenders. (p.156)

DHSS partially concurs with the recommendation. This recommendation applies to the State and requires actions from other entities outside of this department, such as the Alaska Court System.

6.1.1 FINDING: The consolidation of behavioral health administration within the Division of Behavioral Health (DBH) promotes more effective blending and braiding of funding services for behavioral health services. (p.157)

DHSS concurs with the finding.

6.1.2 FINDING: The organizational alignments facilitated by the Department's Results-Based Accountability (RBA) framework provide an effective structure for necessary cross-divisional communication. (p.158)

DHSS concurs with the finding.

6.1.3 FINDING: Despite improvements in cross-divisional communication, deficiencies in care for specific subpopulations of shared interest, such as individuals with dementia, autism, and traumatic brain injury. (p.159)

DHSS concurs with the finding, and may explore implementation of cross-divisional teams to focus on specific subpopulations of shared interest. Additionally, DHSS is working with providers to encourage them to provide an array of services not currently offered in state. Some of this encouragement comes in the form of applying for options like the 1915(i) and (k) and some includes writing the necessary framework of regulations necessary to set up new types of services in the state. A good example is the recent legislation for professional licensure of Applied Behavioral Analysts and the related effort to develop reimbursement through Medicaid.

6.1.4 FINDING: The Department's current information technology shared services model is inadequate to provide 24/7 support for acute behavioral health services. (p.160)

DHSS partially concurs with the finding. DHSS is currently pursuing a contract to provide 24/7 call-center triage services for IT help desk requests. This service allows for after hour calls to be made to a centralized help center which can then prioritize and dispatch trouble tickets to technicians who can address technology issues. On-call, 2nd and 3rd shift strategies have been explored to provide onsite technical resources, but funding and resources to meet this need continue to be a challenge.

6.1.5 RECOMMENDATION: The Department should continue to develop division-level workgroups within the Department's RBA core services structure to address the needs of neglected subpopulations. (p.160)

DHSS concurs with the recommendation.

6.2.1 FINDING: DBH's organizational position within the Department promotes more efficient delivery of behavioral health services. (p. 161)

DHSS concurs with the finding.

6.2.2 FINDING: The Department's reported administrative costs for behavioral health services are lower than national averages for state mental health authorities. (p.161)

DHSS concurs with the finding.

6.2.3 FINDING: The Division of Behavioral Health's coordinated Medicaid and grant review process reduces auditing redundancy for both DHSS staff and behavioral health providers. (p.162)

DHSS concurs with the finding.

6.2.4 FINDING: The Department's allotment of information technology (IT) resources specific to behavioral health enables DBH to support behavioral health service delivery more efficiently. (p.162)

DHSS concurs with the finding.

6.2.5 FINDING: The development of the Office of Integrated Housing & Services has improved the ability of DHSS to provide more efficient management of housing resources within the Department but increased support and collaboration are needed. (p.163)

DHSS concurs with the finding, and has developed a strategic plan for this work that integrates work processes across Divisions and stakeholder groups. Implementation began in September of 2015 and includes the services delivered through a collaborative approach with Senior and Disabilities Services, the Alaska Housing Finance Corporation, the Alaska Mental Health Trust Authority, and funds awarded through the federal 811 Housing grant that was awarded at the end of FY15.

6.3.1 FINDING: DHSS staffing for oversight of community behavioral health services is sufficient to support service delivery. (p.163)

The Department concurs with the finding.

6.3.2 FINDING: Administrative staffing at API is consistent with average staffing patterns of state psychiatric hospitals nationwide. (p.164)

DHSS concurs with the finding.

6.3.3 FINDING: Staffing for prevention and early intervention (PEI) services is commensurate with the administrative capacities required for direct service delivery. (p.164)

DHSS concurs with the finding.

6.3.4 FINDING: Overall administrative staffing is commensurate with the level of behavioral health

service overseen by the Department. (p.165)

DHSS concurs with the finding.

6.4.1 RECOMMENDATION: As Medicaid plays an increasing role in financing the Department's behavioral health services, the Department should consider a thorough review of position descriptions and delineation of regulatory responsibilities in order to optimize Medicaid administrative reimbursement. (p.166)

DHSS concurs with the recommendation. DBH has initiated a review of behavioral health positions and responsibilities as they relate to Medicaid.

6.4.2 RECOMMENDATION: The consolidation of grant and Medicaid review responsibilities can reduce costs and administrative burden on providers, but only if reorganization does not conflict with Medicaid administrative claiming processes or dilutes the Department's regulatory role. (p.166)

DHSS concurs with the recommendation.

7.1.1 FINDING: The Department did not respond to the Legislature's request for proposed budget reductions in a timely fashion. (p.167)

DHSS does not concur with the finding. The department is required to comply with multiple statutes that are all determined by the legislature and it does not have the authority to decide which statute is more important than another as implied by the report. It is still the department's position that the elimination of assistance programs or elements of assistance programs should be identified through the state budget process with the department implementing those changes.

7.1.2 FINDING: The Department did not submit a proposal of 10% reductions for the Legislature. Instead, it offered a proposal for reductions drafted originally in response to the Governor's request for 5% and 8% program reductions. The total amount of proposed reductions for behavioral health services is well below 10%. (p.168)

DHSS does not concur with the finding. Please reference response to finding 7.1.1.

7.1.3 FINDING: In keeping with AS 44.66.020(c)(2), the proposed reductions represent a "good faith effort" because the Department identified General Fund expenditures for behavioral health services that could be reduced and refinanced through federal sources without compromising the Department's ability to meet its mission in regard to behavioral health. Nevertheless, the Department's submission was unresponsive to the specific terms of the statutory request. (p.168)

DHSS partially concurs with the finding. The department does concur that a good faith effort was represented and for the reasons shared in its response to finding 7.1.1, does not concur with the statement that its submission was unresponsive to the statutory request.

7.2.1 FINDING: The Department's proposed budget identifies approximately $1.9 million in budget reductions related to the delivery of behavioral health services. (p.169)

DHSS concurs with the finding.

7.2.2 FINDING: A review of each proposed impact shows that the cumulative consequences of the proposed budget reductions are unlikely to compromise the Department's ability to meet its mission in regard to behavioral health. (p.170)

DHSS concurs with the finding.

7.2.3 FINDING: The Department's proposed $1.6 million in budget reductions for BHTRGs are unlikely to impair behavioral health services substantially, because reductions were spread proportionately across services and providers, and are drawn primarily from lapsed funding amounts derived from the previous year. (p.170)

DHSS concurs with the finding. DBH would like to clarify that the Community Behavioral Health Treatment and Recovery grants (CBHTR) is the affected component. Further, the budget reductions reflect both lapsed funds and services that will be moving from grant services to Medicaid services.

7.2.4 FINDING: The Department's proposed $347,300 in budget reductions to the Alaska Psychiatric Institute consist of the elimination of the hospital's medical director position. Assuming that staffing levels are maintained for service staff and the functions of the medical director are able to be distributed effectively to remaining administrative staff, the review does not anticipate service delivery at API to be substantially impaired. (p.171)

DHSS concurs with the finding.

7.2.5 FINDING: The Department also proposed $20 million in budget reductions to be achieved through unspecified Medicaid cost containment measures. Although these reductions presented by the Department are not specific to behavioral health services, these proposed reductions would likely affect behavioral health services. (p.171)

DHSS concurs with the finding.

7.2.6 FINDING: The list of reductions presented by the Department is consistent with opportunities for potential cost savings and cost avoidance in the review. (p.172)

DHSS concurs with the finding.

7.3.1 FINDING: The results of the performance review have not indicated that alternative programmatic elements should be targeted for further budget reductions. However, the review has yielded

recommendations suggesting that further cost savings can be achieved in the form of revenue enhancement opportunities that utilize additional local and federal funding sources. The review has also identified potential cost efficiencies to be gained through reforming grant and contract administration and improving Medicaid program integrity functions. (p.172)

DHSS partially concurs with the finding. The report does not provide adequate detail to fully support or evaluate this finding.

8.1.1 FINDING: The Department's use of information technology systems is consistent with standard practices across state mental health agencies nationwide. (p.175)

DHSS concurs with the finding.

8.1.2 FINDING: Costs incurred by the Department for information technology personnel and systems are reasonable in comparison to peer agencies in other states. (p.176)

DHSS concurs with the finding.

8.1.3 FINDING: The Department's primary data platform for community-based services, AKAIMS, is capable of collecting metrics needed to support behavioral health programs and services. (p.177)

DHSS partially concurs with the finding. However, DHSS notes that AKAIMS does not collect data from the Alaska Psychiatric Institute, and requests that it be removed from the bulleted list on page 177 of the preliminary report.

8.1.4 FINDING: AKAIMS is administratively burdensome and requires double entry from many service providers, including API. (p. 178)

DHSS partially concurs with the finding. The Division of Behavioral Health (DBH) uses the Alaska Automated Information Management System (AKAIMS) to gather the metrics needed to manage and support behavioral health programs and services. The metrics are gathered and compiled into the minimal data set (MDS). A portion of DBH providers use AKAIMS as their Electronic Health Records (EHR) system. The rest of the DBH providers choose to use their own EHR system to manage their patients and only use AKAIMS to submit the needed data for the MDS. Currently, this results in double data entry for a large portion of DBH providers.

DBH is working with Departmental information technology planning to on-board AKAIMS onto Alaska's health information exchange (HIE). DBH will benefit from connecting/interfacing AKAIMS to the HIE to not only contribute to the health care data contained in the HIE clinical data repository but also support providers ability to transmit data to DBH in one simple method, eliminating the need for double data entry.

8.1.5 FINDING: Although AKAIMS' EHR functionality provides considerable benefit to behavioral health providers who could not otherwise afford it, the use of AKAIMS as an EHR also impedes provider efforts to

integrate behavioral health and primary care services. (p.178)

DHSS partially concurs with the finding in that the current system can be difficult. DBH is working with Departmental information technology planning to on-board AKAIMS onto Alaska's health information exchange (HIE). DBH will benefit from connecting/interfacing AKAIMS to the HIE to not only contribute to the health care data contained in the HIE clinical data repository but also support providers ability to transmit data to DBH in one simple method, eliminating the need for double data entry. One benefit is the integration of both primary care and behavioral health data. The HIE can extract data from AKAIMS and a primary care provider's EHR that is also connected to the HIE to compile a complete health profile of an individual or aggregate integrated health information on statewide level.

8.1.6 FINDING: The data architecture underlying the AKAIMS system was designed for grant management and is structurally limited in its capacity to meet Medicaid billing requirements. (p.179)

DHSS partially concurs with the finding. AKAIMS is built on the Web Infrastructure for Treatment Services (WITS) platform. The goal of the AKAIMS is to develop, implement, and maintain an evolving, web-based application and database that serve the dual purpose of a management information system (MIS) and an electronic health record (EHR). As an MIS reporting tool, the system allows the Division to meet current and emerging State and Federal reporting requirements, such as state Quarterly Reporting, Treatment Episode Data Set (TEDS), the Mental Health and Substance Abuse Integrated Block Grant, Legislative Reporting, Results Based Accountability and the National Outcome Measurements (NOMs).

As an EHR, AKAIMS gives providers a management tool which allows them to assess clients, administer facilities, manage waitlists, measure data completeness, Quality Assurance/Quality Control of documentation, group notes module, emergency services and measure staff productivity and collect outcome data in real-time with a secure, web-based framework.

The WITS platform has the capability to manage Medicaid billing. Alaska is one of over 30 states/counties using the WITS platform as their EHR/MIS. Several of these states/counties use the WITS platform to manage their Medicaid billing for their behavioral health providers.

8.1.7 FINDING: Community behavioral health providers currently report data on multiple platforms, creating significant administrative challenges to accurate reporting and analysis. (p.179)

DHSS partially concurs with the finding. Many reporting requirements are federally mandated. A benefit of on-boarding AKAIMS onto the HIE would be the elimination of the need for behavioral health providers to report data on multiple platforms. DBH currently has three providers that use their own EHR to submit the MDS via an electronic data interface (EDI) into a separate data base. The EDI data base was developed in an attempt to solve the double data entry issue that currently exists for agencies that use their own EHR. When the three EDI providers on-board to the HIE they can submit their MDS via the HIE into AKAIMS.

8.1.8 FINDING: The Department adequately supports stakeholders implementing state-mandated behavioral health IT systems. (p.179)

DHSS concurs with the finding.

8.1.9 FINDING: The Department supports and facilitates effective use of IT for telebehavioral health services. (p.180)

DHSS concurs with the finding.

8.1.10 FINDING: The Department's Grants Electronic Management System (GEMS) is effective at supporting behavioral health grant awards. (p.182)

DHSS concurs with the finding.

8.2.1 FINDING: The Department's information technology systems have the capability to track and report on benefit recipients. (p.183)

DHSS concurs with the finding.

8.2.2 FINDING: Ad hoc tracking and reporting of benefit recipients is minimally effective. (p.183)

DHSS partially concurs with the finding. DBH is in the process of addressing the issues and inefficiencies that have developed with ad hoc reporting of performance based funding (PBF), for the behavioral health prevention grantees, and non-aligned AKAIMS and EDI data bases.

DBH continues to work on refining the PBF methodology that evaluates the overall performance of DBH providers. With the switch to the new Xerox Medicaid Management Information System (MMIS) Cognos in 2013, DHB has had to revise the metrics used within the PBF. Currently DBH is working with Xerox on the development of system generated reports for the data elements that will be used within the PBF.

DBH is also currently adding a Prevention Module to AKAIMS to gather data for behavioral health prevention grantees. This will allow for the use of automated/preformatted reports to gather and report population/community based prevention data.

DBH will eliminate the need for the EDI data base once AKAIMS is on boarded to the HIE. Providers will then be able to submit their medical data set (MDS) via the HIE into AKAIMS. In addition, DBH will eventually be able to integrate several data sets from AKAIMS, API's Meditech EHR, and MMIS. DBH would have the ability to analyze the entire behavioral health care system across the spectrum of care with a combined data environment.

8.2.3 FINDING: The Department's ability to generate unduplicated counts of benefit recipients is uncertain and beset with administrative inefficiencies. (p.184)

DHSS partially concurs with the finding. As indicated previously, this issue can be addressed by on-boarding AKAIMS onto the HIE. When AKAIMS is on-boarded to the HIE with a unified database, it will be relatively simple to provide an unduplicated count of behavioral health recipients. There will also be greater accuracy within the data of the MDS agencies. There is the potential for error in reporting the MDS when there is double data entry. The potential for data entry error will be significantly reduced if the HIE extracts the data directly from the MDS's EHR into AKAIMS.

8.2.4 FINDING: The grant-funded system impedes the Department's ability to report on costs of individual benefit recipients. (p.185)

DHSS partially concurs with the finding. There is no evidence that grants currently impede cost reporting. To the contrary, cost reporting is a normal part of grant management and has been greatly improved with the introduction of the Department's Grants Electronic Management System (GEMS). However, DHSS agrees that in the grant program costs are not aligned individually by recipient. Grants exist, by design, to provide 'safety-net' services to individuals in need of various types of care not neatly assigned to billing including paying for keeping beds open for emergent need. This renders a cost per individual difficult for grant funding but does not mean the system is poorly designed or failing.

8.2.5 FINDING: The information technology used by the Department can identify the extent to which recipients are receiving multiple benefits and whether recipients are Medicaid eligible. MMIS programs routinely contain edits that eliminate the payment of duplicate benefits and restrict payments for only those dates of service that the recipient was Medicaid eligible. However, lack of interoperability among the Department's multiple information systems impedes its ability to track which recipients receive multiple benefits for non-Medicaid services. (p.185)

DHSS partially concurs with the finding. As indicated previously on-boarding AKAIMS onto the HIE will allow DBH to work with other divisions to track recipients' service utilization across multiple divisions.

8.2.6 FINDING: The Master Client Index is so far unsuccessful at allowing DHSS to track and report efficiently on recipients who receive multiple benefits. (p.186)

DHSS partially concurs with the finding. AKAIMS has been connected to the Master Client Index (MCI) but only for demographic data. Further DHSS discussion will occur regarding the data elements that could be reported to the MCI.

8.2.7 FINDING: The Department has effectively identified Medicaid eligible recipients of behavioral health services through AKAIMS. (p.186)

DHSS concurs with the finding.

8.3.1 RECOMMENDATION: The Department should develop automated reporting for both MMIS and AKAIMS behavioral health data. (p.187)

DHSS concurs with the recommendation and is working with Xerox to develop automated reports to report behavioral health related data within MMIS. DBH is also working to develop automated reports within AKAIMS for prevention data, as well as for treatment and recovery behavioral health data.

8.3.2 RECOMMENDATION: The Department should prioritize development of interoperability of data for all recipients of behavioral health services, from SDS to DBH to OCS. (p.187)

DHSS partially concurs with the recommendation. As indicated previously, when AKAIMS is on-boarded to the HIE, DBH will be able to develop the interoperability with other management information systems within DHSS.

8.3.3 RECOMMENDATION: In the near term, the Department should transition all behavioral health providers across the continuum of care to data reporting through AKAIMS. (p.188)

DHSS partially concurs with the recommendation. The department is working to on-board AKAIMS to the HIE. DBH will first need to create the software and its infrastructure within AKAIMS to on-board to the HIE. The development of this infrastructure is scheduled to be completed by January 2016. This would allow the EDI providers time to also build the infrastructure needed within their own systems to allow them to also on-board to the HIE.

8.3.4 RECOMMENDATION: The Department should develop clear and consistent priorities for data collection and incorporate these into the MDS in AKAIMS. (p.188)

DHSS concurs with the recommendation. The department has initiated efforts to align performance measures with the RBA framework across multiple divisions. DBH already uses elements from the MDS to provide the data used within the RBA framework.

8.3.5 RECOMMENDATION: The Department should integrate AKAIMS and API data to the greatest extent possible. (p.189)

DHSS concurs with the recommendation. The department believes the data should be integrated and is addressing this through the HIE, which would also allow for the integration of API's Meditech data into AKAIMS.

8.3.6 RECOMMENDATION: The Department should prioritize implementation of an accurate and complete Master Client Index. (p.190)

DHSS partially concurs with the recommendation due to competing priorities and limited funding. The department is in the process of releasing the Client Services Dashboard (formally known as the Cube) which will allow DHSS staff to research Master Client Index data.

8.4.1 FINDING: Annual maintenance costs for AKAIMS are within national standards. (p.190)

DHSS concurs with the finding.

9.1.1 FINDING: While a handful of state agencies throughout the country have assumed direct responsibility for treatment and recovery services, Alaska's system of service procurement through non-state providers is the most appropriate option for the State's public behavioral health system. (p.193)

DHSS concurs with the finding.

9.1.2 FINDING: Although the utilization of grant procurements by the Division of Behavioral Health (DBH) exceeds other divisions in the Department, both in the number and value of grants released, this method and scale of financing is consistent with the state mental health agency practices nationwide. (p.194)

DHSS concurs with the finding.

9.1.3 FINDING: The grants and contracts management process was reformed approximately a decade ago from a process administered by each division to a centralized function administered within Finance and Management Services. The transformation has helped to streamline and standardize management of the Department's grants and contracts. (p.195)

DHSS concurs with the finding.

9.1.4 FINDING: The Department has significant room for improvement in minimizing administrative costs of grants and contracts, as limits or benchmarks have not been established to monitor administrative costs. (p.195)

DHSS partially concurs with the finding. However, it is important to note the difference between administrative costs claimed as direct expenses and those claimed as indirect costs. For grantees with a federally negotiated indirect cost rate in accordance with 2 CFR 200.414, pass-through entities are required by 2 CFR 200.331(a)(4) to include this rate in the grant award. Current department regulations at 7 AAC 78.160(p) require DHSS to honor a grantee's federally negotiated indirect cost rate. While potential regulatory changes are within the control of the department, federal requirements per 2 CFR 200 are not. Consequently, the department does not have the ability to set a unilateral limit on these costs.

9.1.5 FINDING: The Division recently implemented some of the grant administration "streamlining" recommendation drafted by the Division's advisory boards and the Alaska Behavioral Health Association, which has improved the efficiencies of the grant management process. (p.197)

DHSS concurs with the finding.

9.1.6 FINDING: In an effort to stimulate service delivery and improve provider accountability the Department has recently increased the use of provider agreements. (p.198)

DHSS concurs with the finding. Provider agreements are a type of grant and are defined in Alaska Administrative Code 7 AAC 81. Grant Services for Individuals. The eligibility requirements and the documentation required by the department to verify eligibility of the potential provider is published and if the provider meets the eligibility, the department will enter into an agreement with that provider.

9.1.7 FINDING: Although the transition from grant-based to contract-based financing is likely to improve the quantity and quality of many behavioral health services procured by DBH, grants remain an essential funding mechanism for providers of comprehensive services due to the flexibility these funds afford. (p.199)

DHSS concurs with the finding.

9.2.1 FINDING: The Department has taken a widely accepted approach in incorporating fees and matching funds into the overall grants and contract process. (p.200)

DHSS concurs with the finding.

9.2.2 FINDING: The fees involved in the Department's grants and contracts are consistent with the typical programmatic fees collected to support program operations. (p.202)

DHSS concurs with the finding.

9.2.3 FINDING: The Department's grant and contract requirements adequately encourage providers to leverage third party insurance. (p.202)

DHSS concurs with the finding.

9.2.4 RECOMMENDATION: The Department should amend its grant and contract requirement to more strongly incentivize behavioral health providers to leverage third party insurance. (p.204)

DHSS concurs with the recommendation. The department already has this language incorporated into the Request for Proposal (RFP) language. "Grant Income: Applicants providing Medicaid reimbursable services must also have a Medicaid Provider Number and seek Medicaid reimbursement for all eligible services." In the applicant's proposed budget, both anticipated receipts and expenditures for all grant income must be clearly evident in both the detailed and narrative budgets and actual receipts and expenditures must be reported on a quarterly basis.

9.3.1 FINDING: The Department has established a fair and effective process that leverages technology and ensures competition, proper evaluation, and award. (p.204)

DHSS concurs with the finding.

9.3.2 FINDING: Grants are offered in both competitive and non-competitive solicitations. Most grants are procured as a competitive RFP, and non-competitive grants are procured using a waiver of competitive solicitation. (p.206)

DHSS concurs with the finding.

9.3.3 FINDING: Although competitive solicitations and performance based funding (PBF) are designed to improve quality by stimulating market competition, these processes are less effective in rural regions that cannot sustain multiple providers. (p.206)

DHSS concurs with the finding.

9.3.4 RECOMMENDATION: The Department should consider revising Medicaid regulations to increase non-grantee, private provider participation in Medicaid. (p.207)

DHSS concurs with the recommendation. The department has integrated these objectives into its Medicaid redesign plan.

9.3.5 FINDING: The proposal evaluation process for grants and contracts promotes the Department's objectives in selecting strong technical proposals that deliver value to the State. (p.209)

DHSS concurs with the finding.

9.3.6 FINDING: The Grants Electronic Management System (GEMS) provides all-encompassing grant administrative support and has served as a major improvement to the management process during the year in which it has been operational. (p.209)

DHSS concurs with the finding.

9.3.7 RECOMMENDATION: Although the Department has produced user training videos for GEMS that have been praised by the provider community, it should also consider a user manual to accompany training videos to support instruction in rural communities with limited internet bandwidth. (p.210)

DHSS concurs with the recommendation. The department has GEMS user manuals available.

9.4.1 FINDING: The Department has established a structure for grant and contract monitoring that promotes accountability in overall management of its behavioral health grants. (p.210)

DHSS concurs with the finding.

9.4.2 FINDING: Providers consistently reported regular site visits by Division staff and frequent, supportive communication with state program managers. (p.211)

DHSS concurs with the finding.

9.4.3 RECOMMENDATION: The Department should provide comprehensive training to all Division of Behavioral Health employees acting as grant and contract managers. (p.212)

DHSS concurs with the recommendation. The department initiated annual program manager training in SFY 2015.

9.4.4 RECOMMENDATION: The Department should improve the year-end report to focus more strongly on outcomes and performance metrics as opposed simply to dollar amounts or tasks accomplished. (p.212)

DHSS concurs with the recommendation. The department is evaluating how to increase focus on outcomes and performance metrics in the reports it requires from providers.

9.5.1 FINDING: The Division's non-adherence to the standard timelines of the Department's grant cycle has resulted in administrative inefficiencies in the grant procurement process. (p.213)

DHSS concurs with the finding. DBH works closely with the Department's Grants & Contracts Section, continuing to evidence improvement in meeting timelines.

9.5.2 FINDING: The flexibility of grant requirements and the variety of service delivery methods they facilitate are substantial factors in the value and necessity of grant procurements, but the Department would ensure greater accountability of both providers and Division employees if grant requirements were defined more strictly. (p.213)

DHSS partially concurs with the finding. Comprehensive grants are, by their very nature, flexible and broad in their requirements as all services necessary to meet the needs of clients in that location are addressed. However, more closely defining such services may be beneficial in the coming FY17-19 solicitation.

9.5.3 RECOMMENDATION: The Department should include a simple dashboard into the GEMS program that visually tracks program goals and percent completion. Although tracking for some qualitative measures may be difficult, simple graphics demonstrating percent completion are useful in helping grantees to remain on track. (p.215)

DHSS concurs with the recommendation. The department agrees a dashboard could be useful and GEMS has the capacity to provide a dashboard for grantees. However, a fiscal analysis is needed to ascertain if resources are available to implement the recommendation.

9.5.4 RECOMMENDATION: The Department should increase its ability to monitor, track, and limit the administrative costs incurred from the grants and contracts management process. (p.215)

DHSS partially concurs with the recommendation. However, it is important to note the difference between administrative costs claimed as direct expenses and those claimed as indirect costs. For grantees with a

federally negotiated indirect cost rate in accordance with 2 CFR 200.414, pass-through entities are required by 2 CFR 200.331(a)(4) to include this rate in the grant award. Current department regulations at 7 AAC 78.160(p) require DHSS to honor a grantee's federally negotiated indirect cost rate. While potential regulatory changes are within the control of the department, federal requirements per 2 CFR 200 are not. Consequently, the department does not have the ability to set a unilateral limit on these costs.

9.5.5 RECOMMENDATION: The Department should consider limiting administrative costs during the contracting process to 7-10% of the total contract cost. (p.215)

DHSS partially concurs with the recommendation. However, it is important to note the difference between administrative costs claimed as direct expenses, and those claimed as indirect costs. For grantees with a federally negotiated indirect cost rate in accordance with 2 CFR 200.414, pass-through entities are required by 2 CFR 200.331(a)(4) to include this rate in the grant award. Current department regulations at 7 AAC 78.160(p) require DHSS to honor a grantee's federally negotiated indirect cost rate. While potential regulatory changes are within the control of the department, federal requirements per 2 CFR 200 are not. Consequently, the department does not have the ability to set a unilateral limit on these costs.

9.5.6 RECOMMENDATION: The Department should also consider further monitoring grant and contract budgets to ensure that costs are properly allocated across each of the major cost or functional areas. (p.216)

DHSS partially concurs with the recommendation. The department does monitor grant and contract budgets for efficient and effective allocation of funding. Allocation of funds across major functional areas is an individualized process for each grant and contract. This process is based on the available funding, an assessment of regional need, and collaboration between the Department, provider associations, boards, and provider agencies. Grants are typically awarded in a three year cycle and are adjusted in each continuance year based on information gathered during the year that may affect allocation of funding for the following year.

However, it is important to note the difference between administrative costs claimed as direct expenses, and those claimed as indirect costs. For grantees with a federally negotiated indirect cost rate in accordance with 2 CFR 200.414, pass-through entities are required by 2 CFR 200.331(a)(4) to include this rate in the grant award. Current department regulations at 7 AAC 78.160(p) require DHSS to honor a grantee's federally negotiated indirect cost rate. While potential regulatory changes are within the control of the department, federal requirements per 2 CFR 200 are not. Consequently, the department does not have the ability to set a unilateral limit on these costs. This affects the Department's ability to uniformly allocate funds across different grants as some grants have higher costs in a major functional area, such as administration, as opposed to others.

9.5.7 RECOMMENDATION: The Department should continue its progress in transitioning from grants to contract-based financing for behavioral health services that are amenable to fee-for-service billing. (p.216)

DHSS partially concurs with the recommendation. Please reference clarification for finding 9.1.6. DBH has been increasing the use of provider agreements as appropriate. Additionally, both provider agreements (7

AAC 81) and contracts would potentially open funding opportunities for service delivery to agencies outside of Alaska.

9.5.8 RECOMMENDATION: The Department should review the grant management process to ensure that grant administrative burden is commensurate with the size of the grant award. (p.217)

DHSS partially concurs with the recommendation. Some administrative costs of grant management exist regardless of the monetary amount of the grant.

10.1.1 FINDING: The Department continues to be a national leader in its cost collaboration with tribal health systems through the Medicaid programs. (p.219)

DHSS concurs with the finding. The department is on the cutting edge of collaboration due to a large volume of AI/AN recipients, the associated dollar value of services, and the critical role that tribal health providers play in Alaska's health care delivery system.

10.1.2 FINDING: As an early adopter of Medicaid outreach and enrollment initiatives among tribal providers and recipients, the Department operates a mature partnership that already takes advantage of most readily available opportunities for cost collaboration with the tribal system. (p.220)

DHSS concurs with the finding. The department is on the cutting edge of outreach efforts with Tribal Medicaid Administrative Claiming efforts to assist with enrollment and re-enrollment of recipients per tribal health organization regions.

10.1.3 FINDING: The Department has formulated Medicaid regulations and grant and contract requirements to serve the needs of tribal communities, meet the challenges of rural-remote populations, and maximize opportunities for collaboration with tribal providers. (p.222)

DHSS concurs with the finding.

10.1.4 FINDING: The Department has already fully developed opportunities to incentivize tribal provider participation in Medicaid through enhanced reimbursement rates. (p.223)

DHSS concurs with the finding.

10.1.5 FINDING: The Department serves a disproportionate number of Alaska Natives with serious mental illness (SMI) due to under-developed acute inpatient psychiatric capacity for these individuals within the tribal system. (p.224)

DHSS concurs with the finding. The department has a responsibility to serve all Alaskans with a serious mental illness and does not see a dichotomy between its responsibility for tribal and non-tribal members. The state's financial obligation is decreased to the extent that federal Medicaid funding and enhanced federal funding for tribal services support this need.

10.1.6 FINDING: In 2012, the Alaska Veterans Affairs Healthcare System (AVAHS) established sharing agreements with 26 tribal providers, which increased enrollment in veterans' programs, reduced VA system costs, and infused new funding sources into the tribal health system. Although the Department is not a party to these agreements, the expansion of VA-reimbursable options reduces dependency on state-funded direct care provided by tribal providers. (p.225)

DHSS concurs with the finding.

10.1.7 FINDING: Recent changes in the Veterans Health Administration's authority to procure non-VA behavioral health services increase the overlap between VA and State systems, creating additional opportunities for cost collaboration. (p.226)

DHSS concurs with the finding.

10.1.8 FINDING: Since 2010, the Department has collaborated directly with the VA Healthcare System through the Rural Veteran Health Access Program to expand telehealth capacity in Southeast Alaska and enroll non-tribal providers and VA vendors. (p.227)

DHSS concurs with the finding.

10.2.1 RECOMMENDATION: The Department should continue to encourage tribal providers to develop greater service capacity for meeting the needs of Alaska Natives with SMI. (p.228)

DHSS concurs with the recommendation. The department has been meeting with the Tribal BH Directors on a quarterly basis to discuss increased service capacity and rates since early 2004. DHSS also worked with CMS/IHS to gain approval to pay the encounter rate for tribal BH services in 2007, in order to generate additional revenue that could then be redirected/reinvested to increase prevention and other under or unfunded services in respective tribal regions, depending on the varying service patterns per tribal entity.

10.2.2 RECOMMENDATION: The Department should improve its efforts to identify veteran recipients who may be eligible for services through the AVAHS. (p.229)

DHSS partially concurs with the recommendation. The department has been partnering with the VA and participated in a VA outreach to rural areas to cover essential BH services for veterans. This is discussed at the State Tribal Medicaid Task Force which occurs quarterly. This venue offers government to government discussion across VA, Tribes and the State of Alaska. A result of these discussions included the VA modeling payments for these services after the department's encounter rate process. Additionally, DHSS already requires community behavioral health providers to collect third-party coverage information from all recipients and to utilize these benefits to the extent possible. While the department agrees that additional data matching efforts may result in identification of additional payer sources, implementation of these efforts to including interfaces with direct service providers, as would be necessary for non-Medicaid recipients, are large and expensive. Medicaid expansion may improve the ability of DHSS to provide this information to

providers. The report indicates a possible $1 million in savings to be identified without supporting information.

10.2.3 RECOMMENDATION: The Department should proceed with implementing Medicaid 1915(i) and 1915(k) options in order to open up new opportunities for Medicaid financing through CMS. (p.229)

DHSS concurs with the recommendation. The department is initiating efforts to develop additional Medicaid Waivers including exploring the potential for an 1115 Demonstration Waiver to support recipients receiving services in residential substance abuse that currently cannot be reimbursed through Medicaid as they are considered Institutes of Mental Disease (IMD).

10.3.1 FINDING: Based on current Division spending for acute and sub-acute behavioral health services, it is estimated that the Department could save at least $1 million if a tribal provider established an inpatient psychiatric unit. (p.230)

DHSS concurs with the finding. The department agrees that there may be some savings to be realized through the establishment of tribal inpatient, acute psychiatric treatment.

11.1.1 FINDING: The department's three behavioral health advisory groups provide adequate support and guidance regarding behavioral health issues. (p.235)

DHSS concurs with the finding, but recognizes that it gets support and guidance from the tribal entities referenced above.

11.1.2 FINDING: The joint meetings of AMHB and ABADA enable effective planning for a fully integrated behavioral health system of care. (p.236)

DHSS concurs with the finding.

11.1.3 FINDING: The independence of the advisory groups from the Department and other stakeholders enhances the importance of the advice provided. (p.236)

DHSS concurs with the finding.

11.2.1 FINDING: The guidance provided to the Department sufficiently incorporates consumer feedback and advocates for the needs to the boards' constituencies. (p.236)

DHSS concurs with the finding.

11.2.2 FINDING: The co-location of AMHB, ABADA, and SPC staff and resources has allowed for a more economical use of departmental funding without detracting from the focus and specific division of labor of the separate advisory bodies. (p.237)

DHSS concurs with the finding.

11.2.3 FINDING: The close relationship between DBH and the advisory groups facilitates regular and systematic transfer of information, advice, and guidance, without diminishing the influence of non-departmental voices over planning and consumer advocacy. (p.238)

DHSS concurs with the finding.

11.3.1 FINDING: The review did not identify any significant areas of ineffectiveness or inefficiency requiring changes to advisory group organization or operations. (p.238)

DHSS concurs with the finding.

12.1.1 FINDING: The Department's wide-ranging authority over health services creates strong potential for robust utilization tracking, but significant organizational challenges to data integration. (p.239)

DHSS concurs with the finding. The department is in the process of releasing the Client Services Dashboard (formally known as the Cube) which will allow DHSS staff to research Master Client Index data to search for individuals, providers, addresses, high utilizers and not only see demographic information but also see what services are being rendered and in some cases costs of these services.

12.1.2 FINDING: The Department has traditionally monitored and managed utilization through its regional network of community behavioral health center (CBHC) grantees. This grant-based, regionalized service delivery system has contributed significantly to the Department's effective collection of utilization data. (p.240)

DHSS concurs with the finding.

12.1.3 FINDING: The Department's grant reporting requirements ensure effective collection of community utilization data. (p.242)

DHSS concurs with the finding.

12.1.4 FINDING: Lack of standardization in provider data reporting diminishes the efficiency of the Department's utilization tracking. (p.243)

DHSS concurs with the finding. The department is in the process of releasing the Client Services Dashboard (formally known as the Cube) which will allow DHSS staff to research Master Client Index data to search for individuals, providers, addresses, high utilizers and not only see demographic information but also see what services are being rendered and in some cases costs of these services.

12.1.5 FINDING: Flaws in AKAIMS' data infrastructure have diminished the efficiency of utilization tracking until recently. (p.244)

DHSS partially concurs with the finding. However, DBH has resolved this issue within the data reporting infrastructure with the use of a primary indicator field for all behavioral health clients within AKAIMS.

12.1.6 FINDING: Anticipated service delivery and payment reforms are likely to challenge the effectiveness of CBHC-based utilization management, requiring the Department to respond to inappropriate utilization through new methods of oversight and intervention. (p.245)

DHSS does not concur with the finding. DBH has consolidated its grants in the budget structure for more efficient management and realigned its staff to meet new service delivery and payment reforms. This breaking down of barriers between grant management and Medicaid administration will produce more efficiency, flexibility, and responsiveness to its oversight and service to providers.

12.2.1 RECOMMENDATION: As the behavioral health system becomes increasingly dependent on Medicaid financing, current utilization tracking must be adapted to incorporate utilization controls more appropriate to fee-for-service payments than grant-based reimbursement. (p.247)

DHSS partially concurs with the recommendation. Medicaid financing and billing has its own set of utilization tracking metrics which will need to be further developed to accommodate more billing provider types. DHSS believes further analysis is required before adopting the specific methods of utilization control identified.

12.2.2 RECOMMENDATION: The Department should develop a consistent and transparent data analysis and reporting system, accessible throughout DHSS, that illustrates regular, monthly performance trends without reliance on ad hoc reporting. (p.248)

DHSS concurs with the recommendation. The department has this capability through its MMIS, however, staff training will be needed.

12.2.3 RECOMMENDATION: The Department should implement a uniform utilization reporting structure across the behavioral health continuum of care. (p.248)

DHSS concurs with the recommendation. With the interoperability that would be developed through the HIE, DBH could effectively develop uniform utilization reporting.

13.1.1 FINDING: Alaska Medicaid fraud recovery, while currently less than one percent of total Medicaid expenditures, has significantly improved in recent years as a result of additional dedicated resources and a corresponding increase in recoveries and convictions. (p.251)

DHSS concurs with the finding.

13.1.2 FINDING: The Medicaid Program Integrity (MPI) Section is the departmental unit with primary responsibility for identifying and reducing provider fraud, waste, and misuse. It has established a wide range

of pre-payment and post-payment controls that have aligned the State with nationwide program integrity best practices. (p.252)

DHSS partially concurs with the finding. While the MPI section plays a crucial role in reducing Provider fraud waste and misuse, Health Care Services Quality Assurance, Behavioral Health Quality Assurance, Senior and Disability Services Quality Assurance, and the Background Check unit all play an important role in establishing pre-payment and post-payment controls and ensuring they are in place and functioning properly. MPI is part of a well-functioning team which includes all the Medicaid division's quality assurance sections.

13.1.3 FINDING: The Division of Public Assistance Fraud Control Unit is the departmental unit with primary responsibility for identifying and reducing recipient fraud, waste, and misuse. It has established an effective array of preventative and investigative strategies to generate substantial cost avoidance and direct savings to the Department. (p.253)

DHSS concurs with the finding.

13.1.4 FINDING: Overall responsibility for reducing and preventing fraud, waste and misuse is currently decentralized among multiple state departments and DHSS program units. This diffusion of responsibilities has created challenges for the State in coordinating anti-fraud, waste, and misuse efforts. (p.254)

DHSS partially concurs with the finding. While overall responsibility is decentralized, mechanisms are in place to address communication challenges and functional ambiguities. The Medicaid Fraud Control Unit is required to be separated organizationally from the single state agency. The remainder of the sections involved with reducing and preventing fraud waste and misuse among Medicaid providers are all housed within DHSS. The report cites functional ambiguities and communications challenges without any specifics or examples. There are multiple audit activities, but these are largely prescribed by state or federal statute. The DHSS audit committee meets monthly and helps ensure appropriate communication within DHSS and coordination of audit activity to the extent allowed by statute. In addition, DHSS meets with MFCU on a regular basis and recently have set up a share point site to share information with DHSS divisions and the Medicaid Fraud Control Unit. Given statutory limitations, DHSS believes that it is largely able to overcome the challenges in an effective, efficient manner.

13.1.5 FINDING: State audits of Medicaid providers conducted on behalf of the Department's Audit Committee have proven effective, identifying $5 million in overpayments since October 2012. (p.255)

DHSS concurs with the finding.

13.1.6 FINDING: Lack of enrollment of some rendering provider types creates opportunities for providers to commit fraud. (p.255)

DHSS partially concurs with the finding. Enrollment of all Medicaid rendering providers does strengthen the department's ability to track service utilization at an individual direct service provider level. This

improves oversight and strengthens SURS activities. However, the BH system requires that all rendering providers have a current background check on file with the department. Any individual attempting employment by a new BH provider is required to have their background check affiliated with the new provider, therefore the first opportunity for fraud described in the finding does not apply to BH services. Additionally, the BH outpatient services are provided by a department approved clinic authorized to provide services at specific locations.

13.1.7 FINDING: Medicaid beneficiaries currently have few incentives and little information to provide a check on potential fraudulent practices by their providers. (p.256)

DHSS partially concurs with the finding. The department agrees that providing Medicaid recipients with an EOB for all services paid may be beneficial and is reviewing this service. However, this effort also requires significant resources and effort to make the system changes to educate recipients and answer various stakeholder questions and concerns.

13.1.8 FINDING: Abuse of prescription opioid narcotics is both a major behavioral health concern as well as a significant source of fraud and abuse in the health care system. Alaska's current prescription drug monitoring law creates barriers that restrict DHSS and the Department of Law from accessing prescription drug data and using it to identify patient doctor-shopping and other prescribing practices that are potentially fraudulent or abusive. (p.257)

DHSS concurs with the finding. Abuse of prescription opioid narcotics is a major health concern and a significant source of fraud. The Department is actively working to address statutory requirements by acting in an advisory role to the Alaska Criminal Justice Commission, and collaborative action with the Department of Law regarding these issues.

13.1.9 FINDING: Substantial changes in behavioral health service delivery, such as mental health and substance abuse integration and the integration of behavioral health and primary care, have required significant revisions to the State's Medicaid rules and regulations. Despite recent updates to the Medicaid regulations by DBH, ambiguities remain in the regulations for some behavioral health services that leave the program vulnerable to fraud, waste, and misuse. (p.258)

DHSS partially concurs with the finding. The department agrees that the current regulations could be strengthened to ensure consistent interpretation and equitable application of program rules by all providers. To address these concerns, the department is developing a refined set of program regulations which will be more prescriptive but will ensure more consistent service provision.

13.2.1 RECOMMENDATION: The Department should consider strengthening Medicaid provider enrollment activities by requiring enrollment of all rendering provider types. (p.259)

DHSS concurs with the recommendation. Enrollment of all Medicaid rendering providers does strengthen the department's ability to track service utilization at an individual direct service provider level. This

improves oversight and strengthens SURS activities. Because of the increased utilization controls afforded by enrollment of renderers, the department is planning to enroll BH rendering providers.

13.2.2 RECOMMENDATION: The Department should engage Medicaid recipients in helping to identify fraud by providing them with EOB statements. (p.260)

DHSS partially concurs with the recommendation. The department agrees that providing Medicaid recipients with an EOB for all services paid may be beneficial and is reviewing this service. However, this effort also requires significant resources and effort to make the system changes, to educate recipients and answer various stakeholder questions and concerns.

13.2.3 RECOMMENDATION: The State should consider increasing criminal penalties for Medicaid fraud and assessing interest and additional financial penalties on individuals convicted of Medicaid fraud. (p.261)

DHSS concurs with the recommendation. While the department agrees with the recommendation, it requires legislative changes prior to implementation.

13.2.4 RECOMMENDATION: The State should consider strengthening its seizure laws and imposing bonding requirements for high-risk providers. (p.261)

DHSS concurs with the recommendation. While the department agrees with the recommendation, it requires legislative changes prior to implementation.

13.2.5 RECOMMENDATION: The State should create a robust prescription drug control program, including financial support for and upgrade of the Prescription Drug Database to real-time functionality and removing statutory barriers to state agency access to the database to facilitate fraud identification and drug abuse prevention. (p.261)

DHSS partially concurs with the recommendation. The department recognizes the importance of this program, but does not operate the program or have statutory authority to make the recommended changes.

13.3.1 FINDING: Based on CMS estimates of improper payment within Medicaid programs nationwide, PCG projects that the State could generate another $5-10 million in combined cost savings and avoidance through improved Medicaid program integrity efforts. (p.262)

DHSS partially concurs with the finding. The department agrees potential savings may exist through enhanced PI activities. It does not concur with the proposed calculations in the finding. However, since the department already has additional safeguards and many fraud detection and program integrity activities in place, estimating the savings will require additional analysis.

13.3.2 FINDING: Assuming the rate of improper payment for behavioral health services is similar to the level of estimated improper payment in the Medicaid program as a whole, and then improved program

integrity activities could generate approximately $1 million in additional combined cost savings and avoidance for behavioral health services. (p.262)

DHSS partially concurs with the finding. The department agrees potential savings may exist through enhanced PI activities, it does not concur with the proposed calculations in the finding. The report fails to provide the necessary basis for the estimated cost savings. While these are additional safeguards, many fraud detection and program integrity activities are already in place in the current system.

ADDITIONAL COMMENTS, CLARIFICATIONS, AND TECHNICAL CORRECTIONS

Additional Corrections Executive Summary (p.5-28): Several recommendations differ from those identified and discussed throughout the report. While some differences appear strictly technical, a few differences appeared more substantial. For example:

- *Recommendation #1.2.5 page 7 versus page 41: DHSS determined as technical issue;*
- *Recommendation #9.3.4 page 22 versus page 207: DHSS determined as technical issue and the additional detail was in recommendation located with discussion;*
- *Recommendation #10.2.3 page 25 versus page 229: DHSS did not identify any changes to the discussion supporting this recommendation on pages 229-230. As such responded to the recommendation on page 229;*
- *Recommendation #13.2.1 page 28 versus page 259: DHSS determined this difference would not change the department's response regardless of the wording of " should strengthen" as compared to" should consider strengthening";*

Additional Correction Finding 6.1.3 (p. 159): The finding as written is an incomplete sentence.

Additional Correction Second Sentence following Recommendation 9.5.7 (p. 216): The second sentence is inaccurate as written "ISAs and other contracts…". ISAs are not contracts and the sentence should be corrected by removing the word "other" to prevent misleading the reader.

Additional Comments Section 11 (P. 233 to 238): Advisory Groups: DHSS would add that in addition to the three department advisory boards mentioned, both the Statewide Tribal BH Directors and the State Tribal Medicaid Task Force or MTF provide support and guidance. Both meet quarterly. The Tribal BH Directors report to the MTF. These are chartered workgroups under the Alaska Native Health Board, which meets biannually with DHSS at what are known as the mega meetings. The mission is to partner with the State to collaborate on policy and program changes and development, such as Behavioral Health Aides, encounter rates, new facilities, etc. The Tribal BH Directors are part of the ABAHA, AMHB, etc. but they also function and collaborate/consult on their own as a government to government entity with the Department. The Tribal BH Directors were chartered during the SB61 work that focused on refinancing and increasing rural BH systems. The Tribal LTC Directors were also chartered at the same time and associated to the SB61 work on nursing home construction.

Please contact Sana P Efird, Torrey Jacobson, or Linnea Osborne if you have any questions or require additional information. Thank you for the opportunity to evaluate and share additional insight on these recommendations and findings.

Sincerely,

Valerie J. Davidson
Commissioner

Cc: Sana P. Efird, Assistant Commissioner
Jon Sherwood, Deputy Commissioner
Karen Forrest, Deputy Commissioner
Margaret Brodie, Director of HCS
Albert Wall, Director of DBH
Doug Jones, Program Integrity Manager
Darla Madden, Grants & Contract Manager
Tim Banaszak, DHSS IT Manager
Torrey Jacobson, DHSS Internal Auditor
Linnea Osborne, Accountant V

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APPENDIX D: PCG RESPONSE

November 20, 2015

Legislative Budget and Audit Committee
P.O. Box 113300
Juneau, Alaska 99811-3300

RE: Public Consulting Group (PCG) response to the legislative performance review report titled: Performance Review of the Alaska Department of Health and Social Services Behavioral Health Services.

Dear Members of the Legislative Budget and Audit Committee:

PCG appreciates the opportunity to respond to comments made by the Alaska Department of Health and Social Services (DHSS) during its review of our report on the Behavioral Health Services Performance Review. Via this letter, PCG provides a summary of the comments received from DHSS and responds to selected comments. In addition to responding to comments from DHSS, PCG is including an appendix in response to requests from the Legislative Budget and Audit Committee. Appendix B, a *Glossary of Acronyms*, provides a reference for all acronyms used within the report.

Overall, DHSS submitted a total of 202 comments in response to PCG's Performance Review. A majority of these comments exhibited a stance by DHSS of either "concurring" or "partially concurring" with PCG's findings and recommendations. For those recommendations in which DHSS partially concurred, further comment was provided. In most cases, these comments noted either that (1) DHSS believes there is a need for further analysis to understand the feasibility of the recommendation, (2) DHSS believes that it is currently addressing the most significant issues related to the recommendation, or (3) DHSS does not have the personnel to incorporate the recommendation

On the following pages PCG has chosen to respond specifically to 22 DHSS comments that either express a lack of concurrence with PCG's recommendation or a need for further explanation. Once again, thank you for the opportunity to provide feedback.

Sincerely,

James Waldinger
Associate Manager
Public Consulting Group, Inc.

DELIVERY AND ADMINISTRATION

Finding 2.2.1 on page 48
DHSS's comment: DHSS does not concur with the finding, as it provides for all of the domains in the Continuum of Services (pages 49-50). Some services are provided through state-funded grants, some through Medicaid or Waivers, and some through federal grants.

PCG Response: PCG stands by its finding.

Finding 2.5.1 on page 81
DHSS comment: DHSS does not concur with the finding. In particular, the Alaska Psychiatric Institute is one of the more efficient means of delivering acute services, when daily cost of care is compared to the cost of care in other hospitals in the state. Primarily due to limited funding available to the Department and therefore to providers, the provider community has been hesitant to take the steps necessary to open crisis recover services, mobile crisis units, and acute care of the voluntarily or involuntarily committed (the latter usually because of court costs and legal issues). As a result, community hospitals take the majority of cases with a critical profile for triage and referral. DHSS is working on a number of reforms to its system of care to encourage more provider participation in acute, intensive services. Medicaid expansion offers the best answer to this issue as it provides a payer source for many adults who did not previously have coverage for this service.

PCG Response: While PCG acknowledges that specialized psychiatric hospitals deliver acute psychiatric care more efficiently than community hospitals, we believe the efficiency of Alaska Psychiatric Institute should be evaluated in comparison to other psychiatric hospitals rather than community hospitals. PCG offered a number of financial and service delivery comparisons to support this evaluation, and stands by its findings.

Finding 2.5.5 on page 85
DHSS comment: DHSS does not concur with the finding. Housing shortages are an issue for all populations in many Alaska communities. In response to this need, the Division of Behavioral Health is considering a change to its General Relief program, to focus specifically on supported housing. Additionally, critical partnerships have been developed with the Alaska Mental Health Trust Authority and the Alaska Housing Finance Corporation (AHFC) to address the issue of housing, and a recent award of both a federal 811 grant for housing and 120 vouchers from AHFC has been realized for this purpose. At this time, peer services are a reimbursable service and can be developed anywhere in the state. Very few providers currently choose to offer these services due to lack of housing availability for the individuals in need of peer support services (example: in many communities, housing may not be available for those convicted of sexual offenses or felonies.)

PCG Response: PCG noted in Finding 5.4.3 that housing shortages and the lack of affordable housing is a problem statewide, and largely out of the Department's control. PCG also noted in Finding 2.5.5 that the Department has made progress in establishing peer supports as a reimbursable service.

RESULTS-BASED MEASURES

Finding 4.1.4 on page 113

DHSS comment: DHSS does not concur with the finding. The Division of Behavioral health has been collecting outcome data for community behavioral health treatment and recovery grants since 2008 and has well developed federal reporting on this issue. Further, the Division of Behavioral Health works closely with behavioral health providers, through the Alaska Behavioral Health Association, to provide ongoing outcome assessment and revision.

PCG Response: PCG noted that the Department has an established performance measurement system for its community treatment providers, but questioned whether the implemented performance indicators appropriately measure outcomes over process proxies. PCG stands by its finding.

Finding 4.2.2 on page 117

DHSS comment: DHSS does not concur with the finding. As above (see response to finding 4.1.4), the Division of Behavioral health has been collecting outcome data for both the efficiency and effectiveness of community behavioral health treatment and recovery grants since 2008 and has well developed federal reporting on this issue. Further, the Division of Behavioral Health works closely with behavioral health providers, through the Alaska Behavioral Health Association, to provide ongoing outcome assessment and revision of reporting requirements as needed. This includes the Performance Based Funding process which specifically measures the efficiency of an agency's use of funds.

PCG Response: PCG stands by this finding for the same reasons explained in its response to DHSS comments on Finding 4.1.4.

REFERRALS AND PLACEMENTS

Finding 5.1.3 on page 133

DHSS comment: DHSS partially concurs with the finding. Prior to Medicaid expansion, when most inmates qualified for Medicaid under disability categories for which redetermining eligibility is a complex, time-consuming, expensive endeavor, use of suspension was an appropriate response. However, since the original finding, DHSS has implemented coverage of the Medicaid expansion population. With much simpler eligibility criteria and highly automated eligibility processes under Medicaid expansion, it is uncertain that past efficiencies gained by implementing suspension would offset the additional administrative effort of maintaining cases in suspension for long periods of time. A DHSS and Department of Corrections work group is developing the most efficient way to 1) ensure Medicaid eligibility is determined quickly and claims paid timely when inmates are hospitalized for over 24 hours; and 2) develop processes by which inmates are connected with assistance programs, including Medicaid as part of the re-entry process. DHSS will monitor these transitions and reconsider implementing suspension if needed.

PCG Response: Because Medicaid expansion was implemented after the completion of the performance review, PCG has not been able to evaluate the current policy or whether the conditions supporting the original finding still hold.

Finding 5.2.2 on page 135

DHSS comment: DHSS concurs with the finding. However, there are larger system and historical issues at play. As part of the Department's Community Mental Health/API 2000 Replacement Project (CMH/ARP), Public Consulting Group found that Alaska's psychiatric emergency services system could function successfully with a 72-bed hospital, including a 10 bed forensic unit (instead of the 40 forensic beds). An earlier version of that PCG report even supported a much smaller hospital option. This current PCG report finds fault with the Department's "referral and placement policies and procedures" for both civil and forensic patients. The State's decision to build just a 72/80 bed hospital in the early 2000's was predicated on the State agreeing to fully fund and maintain the range of services identified by PCG as necessary to keep utilization of such a small hospital manageable. That expansion of community-based services throughout the state did not occur to the degree necessary as funding for those services was not provided. Medicaid expansion will address some of these issues as it provides a payer source for individuals previously not covered for services outside of an Institution for Mental Disease.

PCG Response: PCG concurs with the points raised by DHSS. PCG's original recommendations to reduce bed capacity were predicated on an expansion of community-based services. As DHSS noted, this expansion was not fully funded, which has resulted in our finding.

Finding 5.3.3 on page 141

DHSS comment: DHSS partially concurs with this finding. While much of the finding accurately reflects the present state of Alaska's acute care referral system, the following should also be noted: All API clinical staff, as well as all staff hired into any position at the facility since February 2015, have been trained in trauma-informed care. A patient's trauma history is always considered when providing care and making discharge plans – with particular awareness of the state's high rates of domestic violence, spousal abuse, alcohol and other substance abuse, and suicidal events in both rural and urban areas; PCG's assessment that API policies do not require the development of a treatment plan for each person admitted to the hospital is incorrect; PCG's assessment that API has an optional discharge and referral planning process is incorrect. API policy requires that staff have a discharge plan in place for each patient leaving the hospital; While much of the effort of case management and placement referral between acute care services and community supportive services and supports do currently work, there is room for improvement. Existing policies and procedures are often hampered by a lack of specifically needed services being provided in the state. A number of reforms are currently being developed to address this issue, including the writing of both 1915(i) and 1915(k) Medicaid State Plan option proposals, which will provide a payer source for many services currently not offered by DHSS' service system partners.

PCG Response: PCG's finding is specifically concerned with the trauma history data available to API staff from community treatment providers, not with the adequacy of API staff training in trauma-based care. PCG has noted in its evaluation of referral and placement policies that many of the challenges currently seen in the hospital discharge process are due to a lack of adequate community services following discharge.

Recommendation 5.5.8 on page 156
DHSS comment: DHSS partially concurs with the recommendation. This recommendation applies to the State and requires actions from other entities outside of this department, such as the Alaska Court System.

PCG Response: PCG tried to note in its recommendation language that these changes cannot be implemented unilaterally by the Department, even if they would improve placement and referral policies.

BUDGET REDUCTIONS

Finding 7.1.1 on page 167
DHSS Comment: DHSS does not concur with the finding. The department is required to comply with multiple statutes that are all determined by the legislature and it does not have the authority to decide which statute is more important than another as implied by the report. It is still the department's position that the elimination of assistance programs or elements of assistance programs should be identified through the state budget process with the department implementing those changes.

PCG Response: PCG stands by its finding that the Department did not respond to the Legislature's request for proposed budget reductions in a timely fashion.

Finding 7.1.3 on page 168
DHSS Comment: DHSS partially concurs with the finding. The department does concur that a good faith effort was represented and for the reasons shared in its response to finding 7.1.1, does not concur with the statement that its submission was unresponsive to the statutory request.

PCG Response: PCG stands by its finding.

Recommendations 7.3.1 on page 172
DHSS Comment: DHSS partially concurs with the finding. The report does not provide adequate detail to fully support or evaluate this finding.

PCG Response: PCG stands by its finding.

INFORMATION TECHNOLOGY

Finding 8.1.3 on page 177
DHSS Comment: DHSS partially concurs with the finding. However, DHSS notes that AKAIMS does not collect data from the Alaska Psychiatric Institute, and requests that it be removed from the bulleted list on page 177 of the preliminary report.

PCG Response: In interviews with API staff, PCG was informed that staff time was used in conducting double data entry into the Meditech electronic health record as well as AKAIMS. Although PCG notes that the Department's electronic reporting policies through AKAIMS have been in a process of evolution throughout the course of our review, our finding reflects the information made available to us at the time.

Finding 8.1.6 on page 179

DHSS Comment: DHSS partially concurs with the finding. AKAIMS is built on the Web Infrastructure for Treatment Services (WITS) platform. The goal of the AKAIMS is to develop, implement, and maintain an evolving, web-based application and database that serve the dual purpose of a management information system (MIS) and an electronic health record (EHR). As an MIS reporting tool, the system allows the Division to meet current and emerging State and Federal reporting requirements, such as state Quarterly Reporting, Treatment Episode Data Set (TEDS), the Mental Health and Substance Abuse Integrated Block Grant, Legislative Reporting, Results Based Accountability and the National Outcome Measurements (NOMs). As an EHR, AKAIMS gives providers a management tool which allows them to assess clients, administer facilities, manage waitlists, measure data completeness, Quality Assurance/Quality Control of documentation, group notes module, emergency services and measure staff productivity and collect outcome data in real-time with a secure, web-based framework. The WITS platform has the capability to manage Medicaid billing. Alaska is one of over 30 states/counties using the WITS platform as their EHR/MIS. Several of these states/counties use the WITS platform to manage their Medicaid billing for their behavioral health providers.

PCG Response: PCG's finding is based in part on discussions with behavioral health administrators in other states who have experienced difficulties in integrating the Web Infrastructure for Treatment Services (WITS) platform—which was designed specifically and used primarily for grants management—with the more complex requirements of Medicaid billing systems. To date, the Department has not implemented AKAIMS to manage Medicaid billing. PCG stands by its finding.

Finding 8.2.4 on page 185

DHSS Comment: DHSS partially concurs with the finding. There is no evidence that grants currently impede cost reporting. To the contrary, cost reporting is a normal part of grant management and has been greatly improved with the introduction of the Department's Grants Electronic Management System (GEMS). However, DHSS agrees that in the grant program costs are not aligned individually by recipient. Grants exist, by design, to provide 'safety-net' services to individuals in need of various types of care not neatly assigned to billing including paying for keeping beds open for emergent need. This renders a cost per individual difficult for grant funding but does not mean the system is poorly designed or failing.

PCG Response: PCG's finding pertains to the difficulties of isolating costs per individual consumer and not to inadequacies in overall cost reporting. PCG stands by its finding.

GRANTS AND CONTRACTS

Finding 9.1.4 on page 195

DHSS comment: DHSS partially concurs with the finding. However, it is important to note the difference between administrative costs claimed as direct expenses and those claimed as indirect costs. For grantees with a federally negotiated indirect cost rate in accordance with 2 CFR 200.414, pass-through entities are required by 2 CFR 200.331(a)(4) to include this rate in the grant award. Current department regulations at 7 AAC 78.160(p) require DHSS to honor a grantee's federally negotiated indirect cost rate. While potential regulatory changes are within the control of the department, federal requirements per 2 CFR 200 are not. Consequently, the department does not have the ability to set a unilateral limit on these costs.

PCG Response: While we understand that not all is within departmental control, PCG stands by its finding.

Recommendations 9.5.4 and 9.5.5 on page 215

DHSS comment: DHSS partially concurs with the recommendation. However, it is important to note the difference between administrative costs claimed as direct expenses and those claimed as indirect costs. For grantees with a federally negotiated indirect cost rate in accordance with 2 CFR 200.414, pass-through entities are required by 2 CFR 200.331(a)(4) to include this rate in the grant award. Current department regulations at 7 AAC 78.160(p) require DHSS to honor a grantee's federally negotiated indirect cost rate. While potential regulatory changes are within the control of the department, federal requirements per 2 CFR 200 are not. Consequently, the department does not have the ability to set a unilateral limit on these costs.

PCG Response: While we understand that not all is within departmental control, PCG stands by its recommendations to monitor the administrative costs of its vendors more closely.

Recommendations 9.5.6 on page 216

DHSS comment: DHSS partially concurs with the recommendation. The department does monitor grant and contract budgets for efficient and effective allocation of funding. Allocation of funds across major functional areas is an individualized process for each grant and contract. This process is based on the available funding, an assessment of regional need, and collaboration between the Department, provider associations, boards, and provider agencies. Grants are typically awarded in a three year cycle and are adjusted in each continuance year based on information gathered during the year that may affect allocation of funding for the following year. However, it is important to note the difference between administrative costs claimed as direct expenses, and those claimed as indirect costs. For grantees with a federally negotiated indirect cost rate in accordance with 2 CFR 200.414, pass-through entities are required by 2 CFR 200.331(a)(4) to include this rate in the grant award. Current department regulations at 7 AAC 78.160(p) require DHSS to honor a grantee's federally negotiated indirect cost rate. While potential regulatory changes are within the control of the department, federal requirements per 2 CFR 200 are not. Consequently, the department does not have the ability to set a unilateral limit on these costs. This affects the Department's ability to uniformly allocate funds across different grants as some grants have higher costs in a major functional area, such as administration, as opposed to others.

PCG Response: While we understand that not all is within departmental control, PCG stands by its recommendations to monitor the administrative costs of its vendors more closely.

UTILIZATION TRACKING

Finding 12.1.6 on page 245

DHSS comment: DHSS does not concur with the finding. DBH has consolidated its grants in the budget structure for more efficient management and realigned its staff to meet new service delivery and payment reforms. This breaking down of barriers between grant management and Medicaid administration will produce more efficiency, flexibility, and responsiveness to its oversight and service to providers.

PCG Response: PCG stands by its finding. This discussion of new administrative challenges related to service delivery reform was not intended to reflect criticism of the Department's grant management efforts, but rather to provide the context that has necessitated recent positive changes in the Department's grant management and administrative structure.

FRAUD, WASTE, AND MISUSE

Finding 13.1.4 on page 254

DHSS comment: DHSS partially concurs with the finding. While overall responsibility is decentralized, mechanisms are in place to address communication challenges and functional ambiguities. The Medicaid Fraud Control Unit is required to be separated organizationally from the single state agency. The remainder of the sections involved with reducing and preventing fraud waste and misuse among Medicaid providers are all housed within DHSS. The report cites functional ambiguities and communications challenges without any specifics or examples. There are multiple audit activities, but these are largely prescribed by state or federal statute. The DHSS audit committee meets monthly and helps ensure appropriate communication within DHSS and coordination of audit activity to the extent allowed by statute. In addition, DHSS meets with MFCU on a regular basis and recently have set up a share point site to share information with DHSS divisions and the Medicaid Fraud Control Unit. Given statutory limitations, DHSS believes that it is largely able to overcome the challenges in an effective, efficient manner.

PCG Response: PCG has noted significant recent improvements to the Department's fraud, waste, and misuse efforts as well as their relationship to overall improvement by other entities within the State. However, PCG stands by its finding, insofar as the decentralized structure of these programs presents additional administrative challenges. Except in the specific circumstances noted in the report, PCG found that the Department is increasingly successful at meeting these challenges.

Finding 13.1.6 on page 255

DHSS Comment: DHSS partially concurs with the finding. Enrollment of all Medicaid rendering providers does strengthen the department's ability to track service utilization at an individual direct service provider level. This improves oversight and strengthens SURS activities. However, the BH system requires that all rendering providers have a current background check on file with the department. Any individual attempting employment by a new BH provider is required to have their background check affiliated with the new provider, therefore the first opportunity for fraud described in the finding does not apply to BH services. Additionally, the BH outpatient services are provided by a department approved clinic authorized to provide services at specific locations.

PCG Response: PCG did not find evidence that this issue affects behavioral health providers. However, PCG stands by its finding, to the extent that the finding remains relevant for the Department's broader fraud, waste, and abuse efforts.

Findings 13.3.1 and 13.3.2 on page 262
DHSS Comment: DHSS partially concurs with the finding. The department agrees potential savings may exist through enhanced PI activities. It does not concur with the proposed calculations in the finding. However, since the department already has additional safeguards and many fraud detection and program integrity activities in place, estimating the savings will require additional analysis.

PCG Response: PCG stands by its findings.

ADDITIONAL COMMENTS, CLARIFICATIONS, AND TECHNICAL CORRECTIONS

Additional Comment: Executive Summary
DHSS comment: Several recommendations differ from those identified and discussed throughout the report. While some differences appear strictly technical, a few differences appeared more substantial.

PCG Response: Unfortunately, some of PCG's revisions to the body of the report were not applied to the wording of some of the recommendations in the Executive Summary. While PCG believes that the discrepancies between the two versions are minimal, where the meaning is unclear or varies between the two versions, the language of the body text should be regarded as authoritative.

Additional Comment page 159
DHSS comment: The finding as written is an incomplete sentence.

PCG Response: The verb "remain" should have been included in this sentence.

Additional Comment page 216
DHSS comment: The second sentence is inaccurate as written "ISAs and other contracts…". ISAs are not contracts and the sentence should be corrected by removing the word "other" to prevent misleading the reader.

PCG Response: PCG notes that ISAs, while operating similarly to contracts in some respects, are not contracts. We did not intend to conflate the two and appreciate the clarification.

Additional Comment page 233-238

DHSS comment: DHSS would add that in addition to the three department advisory boards mentioned, both the Statewide Tribal BH Directors and the State Tribal Medicaid Task Force or MTF provide support and guidance. Both meet quarterly. The Tribal BH Directors report to the MTF. These are chartered workgroups under the Alaska Native Health Board, which meets biannually with DHSS at what are known as the mega meetings. The mission is to partner with the State to collaborate on policy and program changes and development, such as Behavioral Health Aides, encounter rates, new facilities, etc. The Tribal BH Directors are part of the ABAHA, AMHB, etc. but they also function and collaborate/consult on their own as a government to government entity with the Department. The Tribal BH Directors were chartered during the SB61 work that focused on refinancing and increasing rural BH systems. The Tribal LTC Directors were also chartered at the same time and associated to the SB61 work on nursing home construction.

PCG Response: PCG agrees that a supplementary paragraph with this information would improve the report, as these relationships are not fully detailed in the review. However, PCG restricted its evaluation to the three advisory boards discussed in this section. The Review Objective directs the evaluation to the Department's own advisory boards, without reference to external advisory bodies.

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