SB

169

<TARGET><BILL>SB 169</BILL><SUBJECT>SB
169</SUBJECT><COMM>SHSS30</COMM></TARGET>

ALASKA STATE LEGISLATURE

1500 W Benson Boulevard
Anchorage AK 99503
907-269-0181

State Capitol
Juneau AK 99801-1182
907-465-4843
800-892-4843

North to the Future

Senator Cathy Giessel

Senate District N

Senate Bill 169 Medicaid: Behavioral Health Coverage Sponsor Statement (CS vsn J)

For most of us, Alaska is a great place to live – diverse, challenging, and full of opportunity. But this is not the case for some Alaskans, who experience the negative impacts from opioid misuse, domestic violence, depression, malnutrition, Adverse Childhood Experience Syndrome (ACES), alcoholism and other debilitating problems.

Alaska has mental health care professionals who can provide needed services to Alaskans. However, the system has built-in constraints on where and how providers can offer mental health services, limiting access to many.

The lack of behavioral health care services was discussed at length during the Medicaid Reform initiative in 2016 during deliberations on SB 74. One barrier to care is an existing state regulation mandating that mental health professionals in a behavioral health clinic must have a supervising psychiatrist physically present in their clinic 30% of the time.

There have been reports that some clinics have up to a 2-year waiting list. That is completely unacceptable; while patients wait, their conditions worsen and often lead to other negative behaviors such as assault, robbery, severe depression and even death.

Supervision of mental health therapists, by a psychiatrist, is mandated by state regulation. Senate Bill 169 appropriately manages this mandate by allowing a psychiatrist or an advanced practice registered nurse (certified in psychiatric or mental health services via AS 08.64) to supervise providers in a clinic either in person or by communication device. This allows use of modern technology to accomplish the supervisory oversight.

With health care services expanding in Alaska via the use of telemedicine, particularly in rural areas, the removal of this barrier opens doors to expand needed behavioral health care treatments to many more Alaskans.

It's 2018, we can't ignore this mounting crisis, and the time to act is now. Please join me in support of SB 169

Chair Senate Resources Committee
Senator.Cathy.Giessel@akleg.gov

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North to the Future

Senator Cathy Giessel
Senate District N

Senate Bill 169 Medicaid: Behavioral Health Coverage Sectional Analysis (vsn J)

<u>Section 1:</u> Amends 47.07.030 ("Medical services to be provided.") by adding a new subsection that defines "supervision" for purposes of medical assistance coverage to mean supervision by a psychiatrist or an advanced practice registered nurse (APRN) who is licensed under AS 08.68 and is certified to provide psychiatric or mental health services.

It states that the supervision can be either in person or by communication device and outlines characteristics of the supervisory role.

Chair Senate Resources Committee
Senator.Cathy.Giessel@akleg.gov

Fiscal Note

State of Alaska
2018 Legislative Session

Bill Version: SB 169
Fiscal Note Number:
() Publish Date:

Identifier: SB169-DHSS-BHA-2-28-18
Title: MEDICAID: BEHAVIORAL HEALTH COVERAGE
Sponsor: GIESSEL
Requester: Senate HSS

Department: Department of Health and Social Services
Appropriation: Behavioral Health
Allocation: Behavioral Health Administration
OMB Component Number: 2665

Expenditures/Revenues

Note: Amounts do not include inflation unless otherwise noted below. (Thousands of Dollars)

	FY2019 Appropriation Requested	Included in Governor's FY2019 Request	Out-Year Cost Estimates				
OPERATING EXPENDITURES	**FY 2019**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
Personal Services							
Travel							
Services							
Commodities							
Capital Outlay							
Grants & Benefits							
Miscellaneous							
Total Operating	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Fund Source (Operating Only)

None							
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Positions

Full-time							
Part-time							
Temporary							

Change in Revenues

None							
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimated SUPPLEMENTAL (FY2018) cost: 0.0 *(separate supplemental appropriation required)*
(discuss reasons and fund source(s) in analysis section)

Estimated CAPITAL (FY2019) cost: 0.0 *(separate capital appropriation required)*
(discuss reasons and fund source(s) in analysis section)

ASSOCIATED REGULATIONS

Does the bill direct, or will the bill result in, regulation changes adopted by your agency? No
If yes, by what date are the regulations to be adopted, amended or repealed? N/A

Why this fiscal note differs from previous version/comments:

Not applicable; initial version.

Prepared By:	Randall Burns, Director	Phone:	(907)269-5948
Division:	Behavioral Health	Date:	02/12/2018 11:00 AM
Approved By:	Shawnda O'Brien, Assistant Commissioner	Date:	02/28/18
Agency:	Health and Social Services		

FISCAL NOTE ANALYSIS

STATE OF ALASKA
2018 LEGISLATIVE SESSION

BILL NO. SB169

Analysis

SB169 amends AS 47.07.030 *Medical services to be provided* and eliminates the current requirement that mental health physician clinics must be operated by a psychiatrist who must be physically present within the clinic at least 30% of the clinic's operating hours.

This bill would allow psychiatrists to provide supervision either in person or by a communication device. Adding supervision by a communication device provides viable alternatives to on-site supervision.

Mental health physician clinic services are rendered by licensed mental health professionals whose conduct is governed by statute and professional ethics standards.

There are no costs associated with this bill for the Division of Behavioral Health.

THE STATE *of* ALASKA

GOVERNOR BILL WALKER

Department of Health and Social Services

Senior and Disabilities Services
Governor's Council on Disabilities & Special Education
Patrick J. Reinhart, Executive Director

3601 C Street, Suite 740
Anchorage, Alaska 99503
Main: 907.269.8990
Fax: 907.269.8995

February 16, 2018
RE: SB169 Letter of Support
To Senator Giessel:

The Governor's Council on Disabilities and Special Education (the "Council") fills a variety of federal and state roles, including serving as the State Council on Developmental Disabilities (SCDD) under the Developmental Disabilities Assistance and Bill of Rights Act. As the state DD Council, the Council works with Senior and Disabilities Services (SDS) and other state agencies to ensure that people with intellectual and developmental disabilities and their families receive the services and supports that they need, as well as participate in the planning and design of those services. One of the duties of the state DD Council is providing comments on bills that may have an impact on individuals with intellectual and/or developmental disabilities and their families.

In some parts of our state, communities have been enduring a lack of mental health services for several years or more. In those areas, mental and behavioral health providers are overwhelmed and unable to provide services for those who have little money and/or no health insurance coverage. Medicaid providers limit their clientele to the most severe cases or those leaving the correctional system. Most private mental health providers will not accept Medicaid, making severely limiting access to mental or behavioral health services to vulnerable populations.

Alaska has mental health care professionals who can provide needed services to Alaskans. However, the system has built-in constraints on where and how providers can offer mental health services, limiting access to many. One barrier to care is an existing regulation mandating that mental health professionals in a behavioral health clinic must have a supervising psychiatrist physically present in their clinic 30% of the time.

There have been reports that some clinics have up to a 2-year waiting list. Many of these individuals waiting for care are unable to work or function in their community. Many are homebound because they cannot cope with their mental health issues without receiving services. That is completely unacceptable; while patients wait, their conditions worsen and often lead to other negative behaviors such as assault, robbery, severe depression and even death.

Federal Medicaid law mandates supervision of mental health therapists by a psychiatrist. Senate Bill 169 would allow a psychiatrist to supervise providers in a clinic by consultation or communication device. This allows the use of modern technology to accomplish the same supervisory oversight. With health care services expanding in Alaska via the use of telemedicine, particularly in rural areas, the removal of this barrier opens doors to expand needed behavioral health care treatments to many more Alaskans.

The Governor's Council on Disabilities and Special Education advocates and supports people experiencing disabilities. A large majority of this vulnerable population experiences mental health issues and would be better able to live more independently if they had more access to affordable mental health services. These services are absolutely needed now because lives are at stake, and those contemplating suicide or harmful behaviors cannot continue to linger on waitlists.

Respectfully,

Maggie Winston, Chair

Art Delaune, Legislative Chair

Tom Chard
Executive Director
Alaska Behavioral Health Association (ABHA)
P.O. Box 32917 Juneau, Alaska 99803
(907/toll-free 855) 523-0376
tom@alaskabha.org

February 23, 2018

Senator Cathy Giessel
State Capitol Room 427
Juneau AK, 99801

Re: Senate Bill 169

Senator Giessel –

The Alaska Behavioral Health Association (ABHA) is a member-driven, non-profit trade group with senior leadership from mental health and substance abuse treatment providers throughout the state. ABHA has over 60 member organizations from small community clinics to the largest healthcare employers in the state. We are continually working to improve access to quality, cost-effective treatment services and view Senate Bill 169 as a way to help accomplish that goal.

Senate Bill 169 adds a new section to statute at A.S. 47.07.030 to clarify that a psychiatrist's supervision of behavioral health treatment services can be conducted remotely. It further annuls current regulation at 7 AAC 135.030(e) requiring onsite supervision.

The provisions in Senate Bill 169 apply to mental health physician clinics only. Community Behavioral Health Centers (CBHCs) are not subject to the current statutory and regulatory requirements addressed in SB169. Specifically, Community Behavioral Health Centers do not have a requirement mandating a psychiatrist be onsite at least 30% of the time for supervision. There are other checks in place to help safeguard quality, including a physician agreement required by regulation at 7 AAC 70.100(3). The changes proposed in SB169 do not directly affect the operations of community behavioral health centers. It is our understanding that there are very few (if any) mental health physician clinics currently operating in the state of Alaska. No mental health physician clinics are currently members of the Alaska Behavioral Health Association. ABHA offers the following perspective as system advocates working to improve access to mental health and substance abuse treatment services for Alaskans.

When ABHA examines proposed legislation or other policy changes, it does so through a framework that assesses potential impact on access, cost, and quality.

In our estimation, SB169 would improve access to behavioral health services. Currently, regulation at 7 AAC 135.030(e) requires a mental health physician clinic to have a psychiatrist on premises for at least 30 percent of the time they are open in order to provide clinical supervision. The requirement has proven to be challenging in at

least three distinct ways: First, a limited number of licensed psychiatrists in Alaska has contributed to difficulties recruiting and retaining the workforce needed to meet behavioral health needs in our state. Secondly, the requirement that a psychiatrist be *on premises* does not take advantage of advances in technology that make the delivery of behavioral health services more efficient and more possible than ever, particularly in remote areas of the state. Finally, the requirement that the psychiatrist be onsite *at least 30% of the time* has proven to be logistically challenging, especially for psychiatrists providing supervision in multiple clinic settings. It is our understanding that current requirements have contributed to an environment that has discouraged mental health physician clinics from practicing and, as a result, there are very few (if any) mental health physician clinics operating in Alaska today. By allowing for supervision to occur remotely and by eliminating the requirement to provide supervision at least 30% of the time, SB169 helps address some of these challenges. As a result, ABHA anticipates that SB169 will help support and encourage behavioral health services offered through mental health physician clinics thereby improving access to treatment.

ABHA understands there is often a commensurate cost involved with increased access to services. Identifying and intervening in behavioral health disorders early is both cost-effective and helps limit the traumatic and disruptive impact on individuals, their families, and communities. The provision in SB169 allowing for remote supervision using available technology is also anticipated to reduce the overall cost of behavioral health treatment services.

Lastly, in regard to the potential impact on the quality of service delivery, current regulation at 7 AAC 135.030(d) allows for reimbursement of services provided only by certain licensed behavioral health practitioners operating in mental health physician clinics (explicitly including psychiatrists, psychologists, psychological associates, licensed clinical social workers, physician assistants, advanced nurse practitioners, psychiatric nursing clinical specialists, licensed marriage and family therapists, and licensed professional counselors). It requires the direct supervision of a psychiatrist (that would be permissible remotely through SB169) and requires the psychiatrist to assume responsibility for the treatment services delivered. Effectively, quality controls primarily rest on the individual practitioner's license. ABHA believes that strict enforcement of professional licensing requirements and oversight will help ensure good clinical practice. Additionally, ABHA recognizes that a value-based system requires access to accurate, meaningful, and comparable client health outcome data. A data reporting system has been developed and is universally required for community behavioral health providers; a similar system has yet to be developed for other provider types.

As a final consideration, ABHA believes that proposed changes to the service delivery system should be fair and equitable to all provider types. Unfairly advantaging certain provider types often results in much larger system consequences with downstream impact on Alaskans in need of behavioral health services and supports. We believe that all behavioral health providers should be subject to the same requirements.

In summary, the potential benefit SB169 offers Alaskans through increased access to behavioral health services outweighs any concerns about potential impacts on cost or quality, therefore the Alaska Behavioral Health Association is in support of Senate Bill 169.

Sincerely,

Tom Chard
Alaska Behavioral Health Association (ABHA)

MAT-SU HEALTH FOUNDATION

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Phone: (907) 352-2863 • Fax (907) 352-2865
www.matsuhealthfoundation.org

March 4, 2018

Senator David Wilson
Chair, Senate Health and Social Services
Alaska State Legislature
120 4th Street
Juneau, AK. 99801

Dear Senator Wilson,

The Mat-Su Health Foundation strongly supports Senate Bill 169, "Medicaid, Behavioral Health Coverage," and we appreciate that it is being heard in the Senate Health and Social Services Committee.

The prevalence of mental health and substance abuse issues is increasing in the Mat-Su and statewide. There are severe gaps in the continuum of care for behavioral health, and these gaps cause minor problems to go untreated, often resulting in escalation that erupts in devastating and costly full-blown crisis. Sadly, Alaska's main paths to behavioral health care are emergency rooms and jail. We all know this isn't where we should be investing our state's dollars, but that is exactly what we are doing today.

In 2016 alone, 3,443 patients with behavioral health diagnoses went to the Mat-Su Regional Medical Center Emergency Department. Their charges totaled $43.8 million, and that's not counting additional costs for law enforcement, 911 dispatch, and transportation, which were estimated at $1.6 million for 2013 and are significantly higher today. The average annual growth rate for visits for patients with a behavioral health diagnosis to the Mat-Su Regional Emergency Department grew 20 percent from 2015 to 2017. Additionally, from 2014 to 2017, the number of behavioral health assessments required for patients in crisis in the emergency department grew from 349 to more than 1,000 – all in a hospital that does not currently provide behavioral health care.

In the Mat-Su Health Foundation's 2013 Mat-Su Community Health Needs Assessment, the people of Mat-Su told us that the top five health issues they were concerned about were all related to mental health and substance abuse. Mat-Su citizens want an improved and coordinated system of care that makes treatment for behavioral health more readily accessible. Thousands of Alaskans of all ages – children, families, and older Alaskans - are struggling with mental health concerns. They came from all walks of life, and they live all across our great state. One thing they have in common is that they have problems that they simply cannot tackle on their own. Another thing they have in common is that there is not enough access to behavioral health care. This legislation helps address these issues. It will improve access, reduce cost, and – most importantly – help people to get the care they need.

Sincerely,

Elizabeth Ripley

Chief Executive Officer

Cc: Senators Giessel, von Imhof, Micciche, Begich

"Improving the health and wellness of Alaskans living in the Mat-Su!"

CS FOR SENATE BILL NO. 169(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTIETH LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): SENATOR GIESSEL

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to the definition of 'direct supervision' for purposes of medical**
2 **assistance coverage of behavioral health clinic services."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 * **Section 1.** AS 47.07.030 is amended by adding a new subsection to read:
5 (h) For purposes of medical assistance coverage, the department may require
6 behavioral health clinic services to be provided by or under the direct supervision of
7 either a physician licensed under AS 08.64 or an advanced practice registered nurse
8 licensed under AS 08.68 who is certified to provide psychiatric or mental health
9 services. In this subsection, "direct supervision" means that a physician licensed under
10 AS 08.64 or an advanced practice registered nurse licensed under AS 08.68 who is
11 certified to provide psychiatric or mental health services is available, either in person
12 or by a communication device, to
13 (1) provide clinical consultation or oversight to the supervisee;
14 (2) approve behavioral health treatment plans;

1 (3) review each case to determine the need for continued care;

2 (4) ensure that the services provided to recipients of behavioral health

3 clinic services are medically necessary and clinically appropriate; and

4 (5) assume professional responsibility for the services provided.

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North to the Future

Senator Cathy Giessel

Senate District N

Senate Bill 169 Medicaid: Behavioral Health Coverage Sectional Analysis (vsn D)

Section 1: Amends 47.07.030 ("Medical services to be provided.") by adding a new subsection that defines "supervision" for purposes of medical assistance coverage.

Section 2: Annuls AAC 135.030(e):

7 AAC 135.030. Provider enrollment and organization

(a) To be eligible for payment under 7 AAC 135.010 - 7 AAC 135.290 for providing Medicaid behavioral health services, a provider must be enrolled in Medicaid under 7 AAC 105.210 and must be either

(1) a community behavioral health services provider;

(2) a mental health physician clinic that meets the requirements of (d) and (e) of this section; or

(3) a psychologist who

(A) meets the requirements of 7 AAC 110.550; and

(B) provides psychological testing and evaluation under 7 AAC 135.110(g).

(b) If a community behavioral health services provider is administratively, organizationally, financially, or otherwise connected to a health facility, as defined in AS 47.07.900, the community behavioral health services provider must account for income and expenses separately from the health facility to verify that the cost used by the department to determine the health facility's prospective payment rate under 7 AAC 150 is excluded from the operating cost of the community behavioral health services provider.

(c) If a community behavioral health services provider is operated by a governmental or corporate entity that concurrently operates a health facility, the health facility may provide administrative and other support services to the community behavioral health services provider. However, the department will not include the cost of providing those behavioral health services in determining the health facility's prospective payment rate under 7 AAC 150. If a physician or other health professional is employed by the health facility and by the community behavioral health services provider, the physician or other health professional must be employed under a separate written agreement with the community behavioral health services provider that requires that the cost of services provided by the physician or other health care professional be

(1) separately accounted for by the community behavioral health services provider; and

(2) excluded from the costs considered by the department in determining the health facility's prospective payment rate under 7 AAC 150.

(d) The department will pay for behavioral health clinic services provided by a mental health physician clinic only if

(1) those services are for treatment of a diagnosable mental health disorder; (2) those services are provided by a psychiatrist or by one of the following individuals who work under the direct supervision of that psychiatrist:

(A) a psychologist who is licensed as required under 7 AAC 110.550; (B) a psychological associate who is licensed under AS 08.86 or in the jurisdiction where services are provided, and who renders the services in association with a licensed psychologist within the scope of practice identified in 12 AAC 60.185;

(C) a clinical social worker who is licensed under AS 08.95;

(D) a physician assistant who is licensed as required under 7 AAC 110.455;

(E) an advanced nurse practitioner who is licensed and certified as required under 7 AAC 110.100;

(F) a psychiatric nursing clinical specialist who is licensed under AS 08.68 or in the jurisdiction where services are provided;

(G) a marital and family therapist who is licensed under AS 08.63 or in a jurisdiction with requirements substantially similar to the requirements of AS 08.63 where services are provided, and who works in therapist's field of expertise under the direct supervision of a psychiatrist; or

(H) a professional counselor who is licensed under AS 08.29 or in a jurisdiction with requirements substantially similar to the requirements of AS 08.29 where services are provided, and who works in the counselor's field of expertise under the direct supervision of a psychiatrist;

(3) the psychiatrist operating the mental health physician clinic provides direct supervision to each individual provider in the mental health physician clinic and assumes responsibility for the treatment given;

(4) necessary adjunctive treatment is provided either directly or through a written agreement with a mental health professional clinician or other member of the mental health physician clinic staff; that individual must be licensed under AS 08 and work under the direct supervision of a psychiatrist; and

(5) those services are provided on the premises of the mental health physician clinic or through a telemedicine application under 7 AAC 110.620 - 7 AAC 110.639, unless

(A) the service

(i) could not otherwise be provided; or

(ii) is provided at a location that is clinically more appropriate than the premises of the mental health physician clinic; and

(B) the reason that the clinic service was provided in a location other than the premises of the mental health physician clinic or through a telemedicine application is clearly documented in the recipient's clinical record.

(e) In this section, "direct supervision" means that a psychiatrist is on the premises of the mental health physician clinic to deliver medical services at least 30 percent of the time the mental health physician clinic is open for providing medical services and those medical services include

(1) approving the behavioral health treatment plan in writing;

(2) at least every 90 - 135 days, reviewing each case to determine the need for continued care;

(3) providing direct clinical consultation and supervision to mental health physician clinic staff;

(4) assuring that the services provided are medically necessary and clinically appropriate; and

(5) assuming professional responsibility for the services provided

~Senator Giessel office
2-11-18

SB 169 Annuls (e) from the Following Rule:

7 AAC 135.030. Provider enrollment and organization

(a) To be eligible for payment under 7 AAC 135.010 - 7 AAC 135.290 for providing Medicaid behavioral health services, a provider must be enrolled in Medicaid under 7 AAC 105.210 and must be either

(1) a community behavioral health services provider;

(2) a mental health physician clinic that meets the requirements of (d) and (e) of this section; or

(3) a psychologist who

(A) meets the requirements of 7 AAC 110.550; and

(B) provides psychological testing and evaluation under 7 AAC 135.110(g).

(b) If a community behavioral health services provider is administratively, organizationally, financially, or otherwise connected to a health facility, as defined in AS 47.07.900, the community behavioral health services provider must account for income and expenses separately from the health facility to verify that the cost used by the department to determine the health facility's prospective payment rate under 7 AAC 150 is excluded from the operating cost of the community behavioral health services provider.

(c) If a community behavioral health services provider is operated by a governmental or corporate entity that concurrently operates a health facility, the health facility may provide administrative and other support services to the community behavioral health services provider. However, the department will not include the cost of providing those behavioral health services in determining the health facility's prospective payment rate under 7 AAC 150. If a physician or other health professional is employed by the health facility and by the community behavioral health services provider, the physician or other health professional must be employed under a separate written agreement with the community behavioral health services provider that requires that the cost of services provided by the physician or other health care professional be

(1) separately accounted for by the community behavioral health services provider; and

(2) excluded from the costs considered by the department in determining the health facility's prospective payment rate under 7 AAC 150.

(d) The department will pay for behavioral health clinic services provided by a mental health physician clinic only if

(1) those services are for treatment of a diagnosable mental health disorder; (2) those services are provided by a psychiatrist or by one of the following individuals who work under the direct supervision of that psychiatrist:

(A) a psychologist who is licensed as required under 7 AAC 110.550; (B) a psychological associate who is licensed under AS 08.86 or in the jurisdiction where services are provided, and who renders the services in association with a licensed psychologist within the scope of practice identified in 12 AAC 60.185;

(C) a clinical social worker who is licensed under AS 08.95;

(D) a physician assistant who is licensed as required under 7 AAC 110.455;

(E) an advanced nurse practitioner who is licensed and certified as required under 7 AAC 110.100;

(F) a psychiatric nursing clinical specialist who is licensed under AS 08.68 or in the jurisdiction where services are provided;

(G) a marital and family therapist who is licensed under AS 08.63 or in a jurisdiction with requirements substantially similar to the requirements of AS 08.63 where services are provided, and who works in therapist's field of expertise under the direct supervision of a psychiatrist; or

(H) a professional counselor who is licensed under AS 08.29 or in a jurisdiction with requirements substantially similar to the requirements of AS 08.29 where services are provided, and who works in the counselor's field of expertise under the direct supervision of a psychiatrist;

(3) the psychiatrist operating the mental health physician clinic provides direct supervision to each individual provider in the mental health physician clinic and assumes responsibility for the treatment given;

(4) necessary adjunctive treatment is provided either directly or through a written agreement with a mental health professional clinician or other member of the mental health physician clinic staff; that individual must be licensed under AS 08 and work under the direct supervision of a psychiatrist; and

(5) those services are provided on the premises of the mental health physician clinic or through a telemedicine application under 7 AAC 110.620 - 7 AAC 110.639, unless

(A) the service

(i) could not otherwise be provided; or

(ii) is provided at a location that is clinically more appropriate than the premises of the mental health physician clinic; and

(B) the reason that the clinic service was provided in a location other than the premises of the mental health physician clinic or through a telemedicine application is clearly documented in the recipient's clinical record.

(e) In this section, "direct supervision" means that a psychiatrist is on the premises of the mental health physician clinic to deliver medical services at least 30 percent of the time the mental health physician clinic is open for providing medical services and those medical services include

(1) approving the behavioral health treatment plan in writing;

(2) at least every 90 - 135 days, reviewing each case to determine the need for continued care;

(3) providing direct clinical consultation and supervision to mental health physician clinic staff;

(4) assuring that the services provided are medically necessary and clinically appropriate; and

(5) assuming professional responsibility for the services provided

~Senator Giessel office

2-11-18

Annulment of Psychiatrist Oversight 30% of the Time Rule

Info Points

- **Annul 7 AAC 135.030(e) Provider enrollment and organization** (document)
- **Since 2016 Medicaid Reform discussions access to mental health services has not improved, with waitlists as long as 18 months to 2 years.**
- **There are only a few clinics in Anchorage that can accept clients for mental health services and can bill Medicaid, and few smaller ones who can take a handful of clients**
- **Clinics must be physician owned and supervised in order for providers to bill Medicaid – this drastically limits access to vital mental health care**
- **The Recidivism Reduction Program established through SB 91 in 2016 was established to help rehabilitate parolees, most of who need mental health and/or substance abuse services**
- **2016 multi-dimensional Medicaid Reform bill directed DHSS to apply for Section 1115 Medicaid Behavioral Health Demonstration Waiver to assist in comprehensive and integrated behavioral health system, linking networks of providers and clinical disciplines to deliver care over a 5 year period...Well! The waiver is still not off the ground and the numbers of patients on waiting list continues to grow!!!**
- **Department of Corrections is experimenting using Vivitrol with seriously addicted parolees but this must be paired with mental/behavioral services, and this is not happening as it should.**

~ Senator Giessel office
2-11-18

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/31/18

FURTHER: Rules

DATE TURNED IN TO OFFICE: 3.8.18

Health and Social Services Committee considered SENATE BILL NO. 169

SB 169 MEDICAID: BEHAVIORAL HEALTH ELIGIBILITY

"An Act relating to the definition of 'supervision or direct supervision' for purposes of medical assistance coverage of behavioral health clinic services."

and recommends:

[✓] be **replaced** with **CS** SB 169 (HSS) [ ] *Same Title* [✓] *New Title*

[ ] adopt **previous CS** ________ (______) [ ] *Same Title* [ ] *New Title*

[ ] attached amendment(s)

[ ] adopt ________ Letter of Intent

[ ] further referral to ________ Committee

Dept Abbr.	
ADM	LWF
CED	LAW
COR	LEG
EED	MVA
DEC	DNR
DFG	DPS
GOV	REV
DHS	DOT
AJS	UA

NEW FISCAL NOTE(S)

Dept.	Fiscal	Indet.	Zero	FN #
DHS			✓	1

PREVIOUS FISCAL NOTE(S)

Dept.	Fiscal	Indet.	Zero	FN #

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
[signature]	Begich	✓			
[signature]	Von Imhof	✓			
[signature]	MICCICHE	✓			
[signature]	Giessel	✓			
CHAIR: [signature]	Wilson	✓			

30-LS1283\J.1
Glover
3/5/18

AMENDMENT #1

OFFERED IN THE SENATE BY SENATOR BEGICH

TO: CSSB 169( ), Draft Version "J"

1 Page 1, line 7:
2 Delete "psychiatrist"
3 Insert "physician"
4
5 Page 1, line 9:
6 Delete "psychiatrist"
7 Insert "physician"

Adopted 3.7.18
U.C.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM

March 6, 2018

SUBJECT: Physicians and psychiatrists (CSSB 169( ); Work Order No. 30-LS1283\J.1)

TO: Senator Tom Begich
Attn: Joshua Spring

FROM: Kate S. Glover KSG
Legislative Counsel

You requested an amendment that adds physicians to the list of medical professionals who may supervise behavioral health clinic services for the purpose of medical assistance coverage. The attached amendment accomplishes that by substituting "physician" for "psychiatrist." The term "physician" includes both physicians and psychiatrists. A psychiatrist is a physician licensed under AS 08.64 who specializes in psychiatry. There are no separate licensing statutes for psychiatrists. Therefore, including both psychiatrists and physicians would be duplicative. For that reason, the amendment would substitute the broader term, physician, for the term psychiatrist, allowing either a physician or a physician who is a psychiatrist to provide the required supervision.

If I may be of further assistance, please advise.

KSG:dls
18-105.dls

Attachment

30-LS1283\J
Glover
2/28/18

CS FOR SENATE BILL NO. 169( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTIETH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATOR GIESSEL

A BILL

FOR AN ACT ENTITLED

1 **"An Act relating to the definition of 'direct supervision' for purposes of medical**
2 **assistance coverage of behavioral health clinic services."**

3 **BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

4 *** Section 1.** AS 47.07.030 is amended by adding a new subsection to read:
5 (h) For purposes of medical assistance coverage, the department may require
6 behavioral health clinic services to be provided by or under the direct supervision of
7 either a psychiatrist licensed under AS 08.64 or an advanced practice registered nurse
8 licensed under AS 08.68 who is certified to provide psychiatric or mental health
9 services. In this subsection, "direct supervision" means that a psychiatrist licensed
10 under AS 08.64 or an advanced practice registered nurse licensed under AS 08.68 who
11 is certified to provide psychiatric or mental health services is available, either in
12 person or by a communication device, to
13 (1) provide clinical consultation or oversight to the supervisee;
14 (2) approve behavioral health treatment plans;

1 (3) review each case to determine the need for continued care;
2 (4) ensure that the services provided to recipients of behavioral health
3 clinic services are medically necessary and clinically appropriate; and
4 (5) assume professional responsibility for the services provided.

United States Arctic Research Commission

December 13, 2017

The Honorable Cathy Giessel
State Senate
Alaska State Capitol
Juneau, Alaska 99801-1182

Commissioners

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Anchorage, AK

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Cheryl Rosa, DVM, PhD
Deputy/Alaska Office Director
Anchorage, AK

Dear Senator Gissel:

I am writing to to share three summaries of work that have been part of the U.S. Arctic Research Commission's focus for the last few years. As you know, USARC was created by Congress to provide advice about research priorities for the federal government and others. USARC has three working groups in Alaska: The Alaska Rural Water and Sanitation Working Group, the Arctic Renewable Energy Working Group and the Arctic Mental Health Working Group. Each of these are briefly summarized in the papers included with this letter. For more information please see www.arctic.gov/working_groups.html.

I would like to bring special attention to the Arctic Mental Health Working Group (AMHWG), which was formed by USARC in 2015 to promote research on, and raise awareness of, the significant mental and behavioral health disparities that exist between Arctic and non-Arctic populations. A critical component of addressing the mental and behavioral health needs in Northern communities is the presence of a well-trained cadre of mental health providers. Unfortunately, in Alaska, the mental health care provider to population ratio is below the national average. Additionally, most Alaskan mental health care providers are centered in our urban areas, resulting in fewer providers in the rural communities where the need is greatest.

The AMHWG has developed the enclosed publication on needs and research recommendations related to Alaska's mental health care workforce shortage. This publication highlights research that is needed in a variety of areas ranging from better understanding the magnitude and scope of this shortage to the development of alternative means of mental health care provision in remote areas.

Hopefully this publication will be useful to you as you address this challenging issue that touches so many Alaskans. Please let us know if we can be of any assistance.

Sincerely

Fran Ulmer

Fran Ulmer
Chair, U.S. Arctic Research Commission

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Alaska's Mental Health Care Workforce Shortage

A Publication of the Arctic Mental Health Working Group

Needs and Research Recommendations

To address the shortage of mental health care providers in Alaska, research is needed to:

- Understand the magnitude and composition (i.e., type of providers needed) of the shortage
- Inform solutions to increase the number of providers, their retention, and job satisfaction, and to develop alternative means to provide care in remote areas

Mental Health Care Needs

Alaska's suicide rate is among the highest in the nation, with the prevalence among the Alaska Native population, particularly in the most remote areas of the state, surpassing that of the general Alaskan population[1] (Figure 1). The 2016 Alaska Behavioral Health Systems Assessment Report estimated that 145,790 adult Alaskans—**roughly 20% of the state's population**—need mental and behavioral health services.[2] One component necessary to address mental health issues is a well-trained cadre of mental health care providers to provide preventative support and treatment.

The Alaska Behavioral Health Systems Assessment Report further indicated that **only 19% of those in need received mental health care services** with funds from the State of Alaska Medicaid and/or Behavioral Health Fund.[2] No data exist to determine if the remaining 81% received mental health services paid for by other means or simply did not receive services.[2]

There are several reasons why individuals needing mental health services do not receive them. In some cases, the perceived stigma associated with the problem or illness prevents individuals from seeking help. In other cases, individuals may be more comfortable seeking help from alternative providers such as faith-based, tradition/culture-based or peer-support resources within their community. Finally, particularly in remote areas, **availability and access to mental health care providers are often limited.**[3,4]

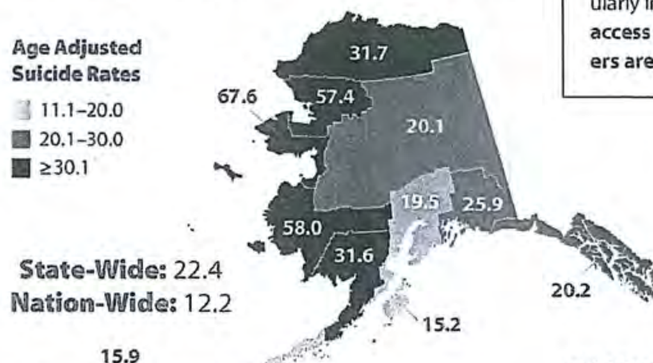

FIGURE 1. Suicide rates (age-adjusted rate* of suicide per 100,000 individuals) in Alaska by region 2006–2015. Source: Alaska Health Analytics and Vital Records, last updated 2/13/17.

How Many Mental Health Care Providers Are Needed?

Despite the number of individuals in need of mental health care services, the ratio of mental health care providers to population is lower in Alaska than nationally (Figure 2). Furthermore, most providers work in urban areas,[5] such that the state's remote areas have even lower provider/population ratios.

There are many types of mental health providers in Alaska (e.g., psychiatrists, neurologists, psychologists, counselors, clinicians, technicians, behavioral nurse practitioners, and behavioral health aides), though as an example, here we consider only the shortage of psychiatrists. Two studies estimated a need for 25.9[6] and 15.3[7] psychiatrists per 100,000 adults nationally, with the authors of the second study noting that the mental and behavioral health care needs of rural populations may not have been adequately captured.[7] National estimates do not account for Alaska's unique population, geography, and need but can serve as a benchmark for estimating the number of psychiatrists needed in Alaska. Based on 2010 Census data, Alaska needs 184 or 106 psychiatrists, respectively.

ALASKA: GREATER NEED, FEWER CLINICIANS

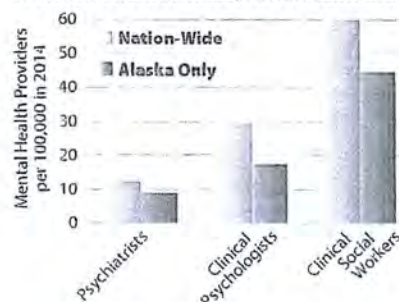

FIGURE 2. The ratio of mental health providers per 100,000 adult population in 2014 in the United States versus Alaska. US data from World Health Organization, Global Health Observatory Data repository, https://goo.gl/62f48K. Alaska-only data are from the Alaska Department of Labor and Workforce Development (https://goo.gl/wCctk3) and 2010 US Census data.

* Age-adjustment is a statistical process applied to rates of disease, death, injuries, or other health outcomes which allows communities with different age structures to be compared.

In comparison to this estimated need, the Alaska 2015–2016 Primary Care Needs Assessment identified 85 licensed psychiatrists in Alaska.[5] This figure is likely high, as "licensed" does not necessarily mean practicing. This number is also 54% and 20% below the need estimated based on the national studies referred to above.

Several barriers to hiring and retaining mental health care workers in Alaska have been identified that may lead to this shortage:

- Limited state and federal funding for mental health care provider positions[8, 9]
- Compensation packages are insufficient to attract qualified candidates[10]
- Social and geographic isolation (especially in rural locations)[10]
- Alaska's extreme climate[10]
- State-required documentation burdens reduce patient contact time and job satisfaction[2,8]

2.9 Years

The average retention time for mental health care providers* in Alaska[11]

Over 1 in 5

The ratio of vacant mental health provider positions in rural Alaska as compared to 1 in 10 in urban Alaska.[9]

Research Recommendations to Address Alaska's Shortage of Mental Health Care Providers

- **Establish *Alaska-specific* estimates for the number and types of mental health care providers needed.** Without more information on those receiving mental health services paid for by non-Medicaid/Behavioral Health Fund sources (i.e., commercial/private insurance or self payment), it is difficult to know the true shortage of providers. Alaska-specific research similar to the previously mentioned study[7] on the national requirements for behavioral health practitioners would provide insight into the different types of providers most urgently needed and the most effective approaches for workforce development.
- **Understand and predict how the redesign of Alaska's Medicaid program and the potential integration of mental and primary health care will impact the shortage of mental health care providers.** Behavioral health redesign and reform is part of the larger Medicaid reform initiative (https://goo.gl/Aomx9f) to improve mental health care quality and accessibility. Research is needed to understand how policy changes will impact the need for the various types of mental health care providers in the state, and inform recruitment and retention solutions.

- **Create research-informed alternative approaches to providing mental health care in remote areas.** Remote telemedicine systems and other e-health applications offer significant technical and clinical benefits when applied within broader-based systems serving isolated populations.[12] These benefits can improve the quality of care provided.[13] Evaluation of telemedicine as an alternative approach, as well as the evaluation of community and behavioral health aides as frontline mental health care providers in rural Arctic communities could be undertaken to assess the impact of these approaches on both patient and provider.
- **Investigate job satisfaction and retention to better understand how to grow and strengthen the mental health workforce.** Challenges in hiring and retaining employees and in ensuring an appropriate level of job satisfaction are not unique to Alaska. Indeed, this is an issue across the Arctic. However, research into the Alaska-specific challenges would assist with solution development. A better understanding of various approaches (e.g., job or task-sharing strategies, rotating positions, "grow-your-own" strategies) successfully employed in rural communities elsewhere in the Arctic could help inform potential solutions for Alaska.

Next Steps

To determine specific efforts needed to address these research recommendations, input will be solicited from a broad suite of stakeholders, including community members, researchers, practitioners, and administrative personnel through future USARC workshops and conference sessions.

* "Provider" includes psychiatrist, psychologists, clinicians, counselors, behavioral health aides, and technicians

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9 Branch, K. 2014. *Alaska's Health Workforce Vacancy Study – 2012 Finding Report*. Alaska Center for Rural Health, University of Alaska Anchorage.
10 *Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues*. 2013. US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (January 24, 2013).
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AMHWG

Arctic Mental Health Working Group

GROUP MISSION: To strengthen systems of care to prevent suicide and improve mental health in the circumpolar North via the promotion of indigenous knowledge, research, and evidence-based early intervention and primary prevention efforts.

Suicide is a devastating event, with a web of causality encompassing social, emotional, environmental, and other health factors. In Alaska, the suicide rate is almost twice the US national suicide rate, with even more disproportionate statistics reported from Native Alaskan communities (Figure 1).[1]

Similarly, high rates of suicide exist across the Arctic[2] where remote indigenous communities are adapting to the social, political, economic, and environmental changes that characterize rapid modernization. Many of these communities have also experienced historical trauma through early interactions with Western cultures. These pressures, and the myriad ways in which they impact access to resources and the perceived future prospects of young people, are manifest in the health disparity of Arctic indigenous youth suicide.[3,4]

The US Arctic Research Commission coordinates the Arctic Mental Health Working Group (AMHWG), which aims to work collaboratively with tribes, healthcare providers, and other stakeholders to promote research on, and raise awareness of, the significant mental and behavioral health disparities that exist between Arctic and non-Arctic populations. As an initial focus, AMHWG has chosen to address suicide prevention in Arctic communities with a specific emphasis on early intervention approaches for children and youth.

Research has shown that early intervention and prevention programs are critically important in reducing the risk and occurrence of suicide.[5,6] Promoting wellness, developing protective factors, and raising awareness of suicide risk factors are examples of early interventions that can provide support to individuals and communities before a crisis situation arises.[5,6]

FOCUS AREAS

AMHWG focuses on the following topics:

- Strengthening mental health protective factors and resilience in children and youth
- Emphasizing the importance of follow-up contact when patients are discharged from psychiatric services
- Raising awareness about unmet mental health provider needs in Alaska
- Encouraging research needed to better understand and address the instability of the mental health care provider workforce
- Promoting improved information technology infrastructure to support data integration and analysis
- Supporting the forensic review of suicides to refine prevention strategies and provide support to communities

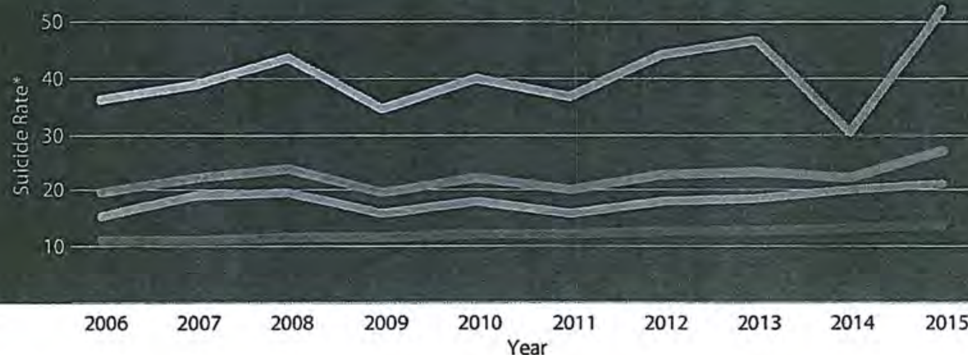

FIGURE 1. Age-adjusted suicide rate: United States, State of Alaska, Alaska Natives, and Alaska Non-Native. Data source: Alaska Bureau of Vital Statistics as of October 28, 2015.

** Age adjusted per 100,000 individuals.*

Alaska Native
Alaska Non-Native
Alaska (Overall)
US

[1] Alaska State Suicide Prevention Council. http://dhss.alaska.gov/SuicidePrevention/Pages/Statistics/aksuiciderate_nativenonnative96-05.aspx.

[2] Young, T.K, B. Revich, and L. Soininen. 2015. Suicide in circumpolar regions: An introduction and overview. *International Journal of Circumpolar Health* 74:27349. http://dx.doi.org/10.3402/ijch.v74.27349.

[3] Suicide Prevention Resource Center. 2013. *Suicide Among Racial/Ethnic Populations in the U.S.: American Indians/Alaska Natives*. Education Development Center, Inc., Waltham, MA.

[4] U.S. Department of Health and Human Services. 2010. *To Live To See the Great Day that Dawns: Preventing suicide by American Indian and Alaska Native youth and young adults*. Substance Abuse and Mental Health Services Administration, Rockville, MD.

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[6] Mackin, J., T. Perkins, and C. Furrer. 2012. The power of protection: A population-based comparison of Native and non-Native youth suicide attempters. *American Indian and Alaska Native Mental Health Research* 19(2):20–54.

Did you know?

Suicide is the leading cause of death for ages 15–24 in Alaska.[7]

In 2015, 33.6% of Alaskan high school students reported feeling sad or hopeless almost every day for two weeks or more during the past 12 months.[8]

To promote increased capacity and strengthened systems of care[9], AMHWG encourages the following research and activities:

1. Collect, integrate, and analyze data to improve our understanding of the epidemiology of mental and behavioral health issues, including suicidality.

Effort in this area will improve communication among the various agencies addressing mental and behavioral health issues. Specifically, AMHWG will highlight how enhanced sharing of information and data will enable current health care systems to better identify and provide earlier assistance to those needing care. A focus on data collection at the community level also supports locally based actions, which can often be more effective. AMHWG will encourage improving information technology infrastructure to better support data integration and analysis and will support greater forensic review of suicides to further understand their epidemiology.

2. Improve mental and behavioral health workforce capacity in Alaska.

An obvious and critical component of systems of care is a well-trained cadre of mental health care providers. AMHWG will encourage measures to ensure that there are a sufficient number of qualified individuals in rural communities available to assist with mental health and wellness promotion, prevention, and treatment. The working group will gather information on, and raise awareness of, the level of unmet mental health provider needs in rural Alaska. AMHWG will also promote research needed to understand and address the observed instability in this workforce.

3. Strengthen mental health protective factors of children and youth with a focus on community-based efforts.

AMHWG will encourage research into the mental and behavioral health of children and youth, including family, cultural and community protective factors that support and enhance healthy development. Additionally, the group will emphasize the importance of community-based early intervention and follow-up support for children and youth at risk.

AMHWG MEMBERSHIP

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Alaska Department of Corrections

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Alaska Native Tribal Health Consortium

M. Baldwin
Alaska Mental Health Trust

D. Caldera
Alaska Public Health Association

C. Chipp
Aleutian Pribilof Islands Association

K. Craft
Alaska Health Workforce Coalition

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National Institutes of Health

R. Droby
Norton Sound Health Corporation

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North Slope Borough Health and Social Services

L. Wexler
University of Massachusetts

[7] American Foundation for Suicide Prevention
[8] 2015 Youth Risk Behavior Survey
[9] Systems of care are a service delivery approach that builds partnerships to create a broad, integrated process for meeting families' multiple needs (Children's Information Gateway; https://www.childwelfare.gov/topics/management/reform/soc).

FIGURE 2. AMHWG has identified three specific foci.

For more information on the AMHWG, go to https://www.arctic.gov/AMHWG