

Request to Extend the
Alaska Section 1115
Demonstration Waiver
Project No. 11-W-00318/0

**The Alaska Substance Use
Disorder Treatment and Behavioral
Health Program 1115 Waiver
Extension Request
(Behavioral Health Reform Waiver)**



Table of Contents

EXECUTIVE SUMMARY	4
OVERVIEW OF ALASKA STATE MEDICAID PROGRAM	5
ALASKA'S MEDICAID PROGRAM	6
ALASKA'S BEHAVIORAL HEALTH SYSTEM	6
DEMONSTRATION SUMMARY AND OBJECTIVES	8
HISTORICAL NARRATIVE	8
Program Description	8
Progress Toward Demonstration Goals and Plans for the Future	13
REQUESTED REVISIONS	19
LIST OF PROPOSED WAIVER AND EXPENDITURE AUTHORITIES	20
WAIVER AUTHORITY	20
Authority Requested	20
Waiver Authority No Longer Requested	21
EXPENDITURE AUTHORITY REQUESTED	21
QUALITY ASSURANCE	25
LEVEL OF CARE TOOL	25
INFORMAL PROVIDER SITE VISITS	26
ONGOING PROGRAM OVERSIGHT	26
BUDGET NEUTRALITY	27
HISTORICAL AND PROJECTED EXPENDITURES	27
FINANCIAL ANALYSIS OF CHANGES	31
EVALUATION REPORT	32
DOCUMENTATION OF PUBLIC NOTICE	44
PUBLIC NOTICE PROCESS	45
Summary of Public Notice Process	45
Public Notice	45
Public Hearings	45
Tribal Consultation	46
SUMMARY OF PUBLIC COMMENTS AND STATE RESPONSE	46
Vision for the 1115 Waiver and Future Enhancements	46
Administrative Streamlining	47
Dependable Claims Payment	47
Payment Rates	47
Provider Capacity	48
Workforce	48

Service Array	49
Beneficiary Experience	50
Geographic Considerations	50
Data Availability	51
Technical Edits	51
SUMMARY OF TRIBAL CONSULTATION AND STATE RESPONSE.....	52
1115 Waiver Vision and Early Successes.....	52
Data Sharing and Transparency	52
Workforce Capacity.....	53
Administrative Burden and Claims Payment.....	54
Assessment and Screening	54
System Rebalancing.....	55
Tribal Engagement and Collaboration.....	55
SUMMARY OF REVISIONS:	56
APPENDIX A: CMS APPROVAL TO EXTEND APPLICATION SUBMISSION DEADLINE.....	57
APPENDIX B: BUDGET NEUTRALITY WORKSHEETS.....	59
APPENDIX C: DRAFT INTERIM EVALUATION REPORT	65
APPENDIX D: FORMAL PUBLIC NOTICE.....	283
APPENDIX E: ABBREVIATED PUBLIC NOTICE.....	294
APPENDIX F: CMS APPROVAL TO HOLD VIRTUAL PUBLIC HEARINGS.....	296
APPENDIX G: TRIBAL NOTICE	298

Executive Summary

Alaska is submitting this application to renew the authorities granted in its section 1115 Demonstration, titled Substance Use Disorder Treatment and Behavioral Health Program (SUD-BHP, also referred to herein as “the 1115 Waiver”) (Project No. 11-W-00318/0) from the United States Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS), in order to support the continued transformation of its mental health and substance use disorder (SUD) delivery system.

Alaska has launched an ambitious vision for behavioral health system transformation. The authorities granted in the SUD-BHP 1115 Waiver Demonstration program continue to serve as a foundation from which the state can leverage available tools, such as state regulations, provider requirements, and rate setting to achieve the vision. The Alaska Department of Health, Division of Behavioral Health (DBH) recognizes that achieving the state’s vision is a long-term path. While progress has been made over the course of the original 1115 Waiver period, there has not been enough time to fully implement waiver programs and realize the desired outcomes. Additionally, the COVID-19 pandemic has undermined progress, creating additional barriers to implementation, and simultaneously contributing to higher behavioral health morbidity and mortality. As such, DBH envisions the 1115 Waiver extension as a continuation of efforts toward a consistent vision and set of strategic goals for behavioral health service delivery in Alaska.

Building together, these efforts also serve to advance concurrent state initiatives to address public safety, prevention, and family supports. DBH understands that identifying and treating underlying behavioral health needs is foundational to ensuring the health and wellbeing of all Alaskans. Through the approval of this extension request, Alaska proposes to update the 1115 Waiver name from the current *Substance Use Disorder Treatment and Behavioral Health Program (SUD-BHP)* title to now be known as the *Behavioral Health Reform Waiver*, with the broader behavioral health term encompassing both mental health and substance use disorder and reflecting Alaska’s ongoing commitment to program reform and system transformation. No other substantive changes are requested as the state seeks this renewal opportunity to continue to operationalize and refine the program to reach its full promise.

Overview of Alaska State Medicaid Program

Alaska's original SUD-BHP 1115 Waiver laid out an aspirational plan to improve access to comprehensive behavioral health services by building a Medicaid behavioral health delivery system pointing to integrated and recovery-oriented care and aligning with evidence-based best practices. The state took steps to achieve this vision through an enhanced benefit package authorized by the 1115 Waiver, covering a continuum of behavioral health care services emphasizing screening, community-based services, residential treatment when appropriate, and enhanced peer recovery supports. These services are meant to meet people where they are, promoting prevention, early intervention, recovery, and integrated, whole-person care. Despite significant hurdles associated with the state's historical and geographic context, ongoing workforce shortages, and disruptions caused by COVID-19, the state has been able to make substantive progress toward achieving waiver goals and remains committed to this vision as Alaska plans for the extension of the Behavioral Health Reform Waiver.

It is important to consider these behavioral health system reform goals and progress in the context of Alaska's complex geography. As the country's least densely populated and largest geographical state, Alaska's unique characteristics lead to higher costs for health care than other states, which, coupled with significant challenges with recruitment and retention of a qualified behavioral health workforce, often impede access to care. These long-standing workforce challenges have been exacerbated by the COVID-19 pandemic, and Alaska has necessarily relied on traveling practitioners to fill workforce shortages. Existing behavioral health provider shortages, long appointment wait times, and reimbursement rates below that of other health care services represent additional challenges. The Health Resources and Services Administration (HRSA) has designated most of Alaska's geographic area as Health Professional Shortage Areas based on the lack of mental health clinicians. According to HRSA, 56.5% of Alaska's population is designated to reside within a mental health professional shortage area in 2022.¹

In 2016, the Alaska Legislature passed a monumental health care reform mandate. Senate Bill 74 (SB 74) is a multi-dimensional Medicaid reform package that includes 16 separate initiatives, including the 1115 Waiver for behavioral health services.² SB 74 includes direction to reduce operational barriers, minimize administrative burden, and improve the behavioral health system's effectiveness and efficiency. To this end, Alaska Medicaid has focused on improving access to care via telehealth, enhancing care management services to improve coordination and efficiency, improving quality targets for providers, and modernizing the health information infrastructure to better maintain patient records and improve integration capabilities. It was this legislative package that first articulated the state's vision for a high-functioning behavioral health delivery system and laid the groundwork for the state to embark on a long-term path to realize that vision.

¹ Health Resources and Services Administration. (2022, September 30). *Designated Health Professional Shortage Areas Statistics*. Retrieved October 18, 2022, from <https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport>

² S.B. 74, 29th Legislature, 2016 Reg. Sess. (Alaska. 2016). <https://www.akleg.gov/basis/Bill/Text/29?Hsid=SB0074Z>

ALASKA'S MEDICAID PROGRAM

As of December 2022, Alaska's Medicaid Program covers approximately 260,000 individuals, over one-third of the total state population, with children representing roughly 103,000 of the combined Medicaid and CHIP enrollees.³ Since February 2020, prior to the start of the COVID-19 public health emergency, Medicaid enrollment has grown 16.6%, likely due to the continuous enrollment provisions established by the Families First Coronavirus Response Act and economic stressors experienced as a result of the pandemic.

Alaska operates a fee-for-service (FFS) Medicaid delivery system, which creates barriers to implementing and administering large-scale delivery system innovations like 1115 demonstration waivers. The FFS payment system, as it is currently organized, lacks care coordination and financing tools to shift incentives and accountabilities toward population health outcomes and cost efficiencies. Because the FFS system itself cannot meet this challenge on its own, the operational lift of implementing large scale program changes falls largely on the state and behavioral health providers, whereas in other states, the infrastructure and capacities offered by managed care organizations (MCOs) can support the operational changes, administration, and expertise needed to effectuate delivery system reform. During the initial Demonstration period, Alaska made a targeted investment in developing some of these capacities through the adoption of an Administrative Services Organization (ASO) vendor for behavioral health services, the full potential of which is not yet realized. Further opportunity to build care coordination capacity in the behavioral health service delivery system exists through the recent restructuring of Alaska's Department of Health and Social Services into two separate departments. DBH continues to be positioned with the Division of Public Health under the new Department of Health and seeks to leverage this organizational shift, aligning missions and resource priorities to improve integration of behavioral health services into primary care.

The 1115 Waiver is one tool among many Medicaid policy levers available to DBH to advance Alaska's vision for behavioral health. State policy and regulations are the primary vehicles for operationalizing the services authorized through the 1115 Waiver and are updated annually to reflect ongoing feedback from individuals, their families, and providers to improve the delivery experience.

The state is also continuing to seek out program enhancements by exploring enhanced funding available to support provider-led care coordination through certified community behavioral health clinics (CCBHCs) and health homes, as well as assessing the feasibility of a care coordination demonstration project piloting managed care in a limited geography.

ALASKA'S BEHAVIORAL HEALTH SYSTEM

Prior to implementing the 1115 Waiver, Alaska's behavioral health system was fragmented and missing crucial elements in the continuum of behavioral health services, particularly among SUD providers who were funded through private pay or through state and federal grants.

³ *Medicaid in Alaska Dashboard*. Alaska Department of Health. (2022, December 1). Retrieved December 22, 2022, from <https://health.alaska.gov/healthyalaska/pages/dashboard.aspx>

Providers were delivering mental health and SUD services, but many were not enrolled in Medicaid as providers or eligible to bill Medicaid because of federal law prohibiting states from using Medicaid funds for services provided to non-elderly adults in “institutions for mental diseases” (IMDs). Services that were determined medically necessary and clinically appropriate were delivered in community mental health centers, counseling centers, Tribal health organizations, hospitals, and specialty clinics. The 1115 Waiver enabled Alaska to transition to a more sustainable financing model and ensure access to the full continuum of mental health and SUD services across a continuum of clinical settings, authorizing services delivered to individuals with SUD residing in IMDs and broadening the service array to support individuals with SUD and mental health needs in the community. Alaska is cognizant that this transition represented a significant shift and lift for providers to adopt to a different revenue model and build the necessary infrastructure and administrative processes to implement Medicaid billing and reimbursement. DBH seeks to partner with organizations such as the Alaska Mental Health Board, Alaska Advisory Board on Alcoholism and Drug Abuse, Alaska Mental Health Trust, and the Alaska Behavioral Health Association to leverage their networks, resources, and insights to offer provider training and make available technical assistance through this transition process.

Demonstration Summary and Objectives

HISTORICAL NARRATIVE

Program Description

Overview of Original Intent

Historically, Alaska has been significantly challenged in its ability to address the dual crises of opioid addiction and growing behavioral health needs of the population. Ongoing barriers have included issues with infrastructure, provider capacity, and workforce development, among others. With these challenges in mind, the vision of the Demonstration was to establish a foundation through a comprehensive continuum of cost-effective, high-quality, and evidence-based SUD and behavioral health services to make sure Alaskans have access to the right services at the right time in the right setting. Aligning with evidence-based best practices, this continuum includes services that span each level of care, including early intervention and prevention, outpatient care, intensive outpatient/partial hospitalization, residential treatment/inpatient, and intensive inpatient. The table below lists the full continuum of SUD and behavioral health services authorized by the 1115 Waiver.

TABLE 1. CONTINUUM OF SERVICES AUTHORIZED BY THE 1115 WAIVER⁴:

SUD Program	Behavioral Health Program
<ul style="list-style-type: none"> ▪ Early Intervention- Services* ▪ Outpatient Services* ▪ Medication-Assisted Treatment (MAT)* ▪ Opioid Treatment Services (OTS) for persons experiencing an Opioid Use Disorder (OUD) ▪ Intensive Outpatient Services ▪ Ambulatory Withdrawal Management ▪ Partial Hospitalization Program (PHP) ▪ Residential Treatment ▪ Clinically Managed Residential Withdrawal Management ▪ Medically Monitored Intensive Inpatient Services ▪ Medically Monitored Inpatient Withdrawal Management ▪ Medically Managed Intensive Inpatient Withdrawal Management <p><i>*Services authorized under the State Plan</i></p>	<ul style="list-style-type: none"> ▪ Community Recovery Support Services (CRSS) ▪ Home-based Family Treatment ▪ Intensive Case Management Services (ICM) ▪ Partial Hospitalization Program Services (PHP) ▪ Intensive Outpatient Services (IOP) ▪ Children’s Residential Treatment (CRT) ▪ Therapeutic Treatment Homes ▪ Assertive Community Treatment Services (ACT) ▪ Adult Mental Health Residential Services (AMHR) ▪ Peer-based Crisis Services ▪ Mobile Outreach & Crisis Response Services (MOCR) ▪ 23-Hour Crisis Observation & Stabilization Services (COS) ▪ Crisis Residential/Stabilization Services

⁴ These services descriptions may be operationalized through multiple service codes and may also include further delineation through the use of levels captured by modifiers. Aligning the service descriptions in the waiver’s requested expenditure authorities to the service descriptions operationalized through the state’s code sets will occur during the negotiation of the special terms and conditions.

To realize this vision, Alaska’s 1115 Waiver has centered around three overarching objectives:

1. Rebalance the current behavioral health system of care to reduce Alaska’s over-reliance on acute, institutional care and shift to more community- or regionally-based care.
2. Intervene as early as possible in the lives of Alaskans to address behavioral health symptoms before they cascade into functional impairments.
3. Improve overall behavioral health system accountability by reforming the existing system of care.

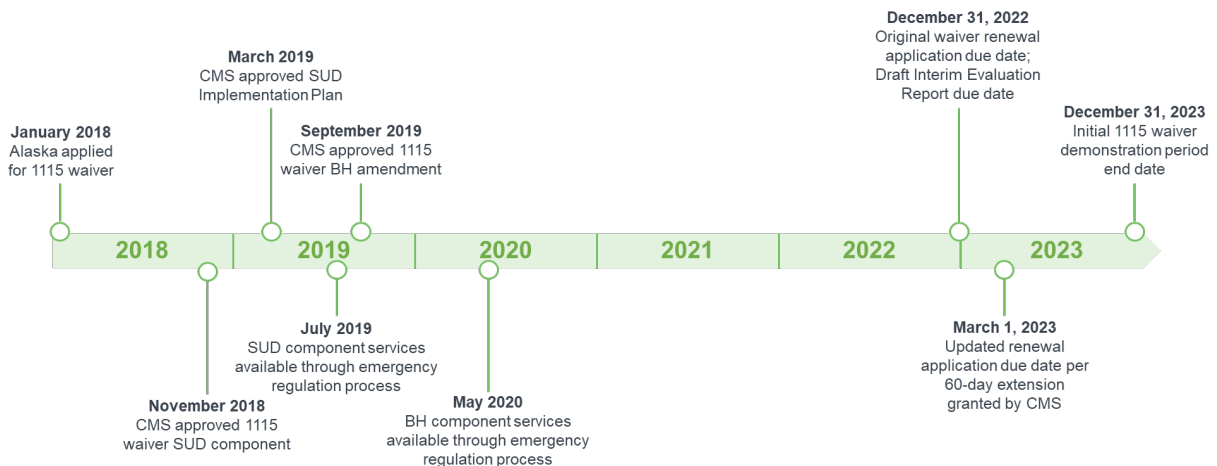
Authorities Granted by the Original 1115 Waiver

The 1115 Waiver permitted Alaska to waive sections of the Social Security Act requiring statewide access to and comparability of benefits, while granting expenditure authority to create a more robust continuum of mental health care and SUD services. The waiver authorizes 25 services, including residential treatment for individuals with SUD receiving short-term residential and inpatient treatment in IMDs, a crisis services infrastructure, community-based outpatient services, and residential treatment when appropriate. The waiver also has an emphasis on early interventions and enhanced community recovery supports.

Waiver Implementation

CMS initially approved the 1115 Waiver in November 2018 with an approval period of January 1, 2019, through December 31, 2023 (see Figure 1).

FIGURE 1. DEMONSTRATION TIMELINE



This first approval authorized Alaska to receive federal financial participation (FFP) for the provision of all Medicaid state plan services and a continuum of 13 community-based demonstration services to treat addictions to opioids and other substances for Medicaid enrollees primarily diagnosed with opiate use disorder (OUD) and/or other SUD who are short-term residents in residential and inpatient treatment facilities that meet the definition of an IMD.

DBH issued emergency regulations outlining provider requirements, as well as service criteria and definitions for the new 1115 SUD services, which went into effect July 1, 2019.

On September 3, 2019, CMS approved the remaining sections of the Alaska waiver which authorized the state to implement 12 additional behavioral health services to enhance the comprehensive service array for children, youth, at risk youth, and adults with serious mental illness (SMI), serious emotional disturbance (SED), and/or SUDs. Alaska again used the state emergency regulation process to make available these new behavioral health services, effective May 21, 2020.

The state initially planned to phase in implementation across two years, with approximately one half of the state covered in Waiver Year 1 and the remaining population covered in Year 2. However, due to feedback from the delivery system, DBH instead permitted all providers statewide to begin delivering services as they became ready, regardless of their geography.

Operationalizing the SUD/ODD program and behavioral health benefits occurred on a staggered basis, as a result of the sequential federal approvals. Unfortunately, this has led to some misalignment of operational functions and provider confusion. It is DBH's view that the Behavioral Health Reform Waiver extension presents an opportunity to better streamline implementation of behavioral health and SUD benefits authorized under the Demonstration, for example, by streamlining credentialing processes for SUD and behavioral health service providers.

While the written request and application to renew the Behavioral Health Reform Waiver was initially due to CMS by December 31, 2022, CMS granted Alaska a 60-day extension (see approval on October 2022, *Appendix A*). Extending the renewal deadline to March 1, 2023, was important to permit additional time to incorporate a robust interim evaluation report in the application package.

Early Successes

Throughout the course of the initial 1115 Waiver demonstration period, DBH was able to improve access to behavioral health services by increasing the array of community-based mental health and SUD services covered by Medicaid, and by developing provider capacity to effectively deliver these services. Since the approval of the 1115 Waiver, DBH promulgated regulations and issued guidance to providers to set forth provider qualification requirements and administrative procedures for providing and billing for the expanded scope of services. These expanded authorities and operational program changes have allowed the state to achieve an increase in the number of Medicaid-enrolled providers and services available, ranging from community-based peer support services to services provided in residential treatment facilities. As of September 2022, DBH had authorized approximately 60 mental health agencies and 60 SUD agencies to participate in Medicaid. These agencies are operating over 360 site locations and include over 1,800 individual rendering providers.⁵

⁵ Alaska Department of Health and Social Services. (2021, April 1). *Alaska Medicaid Section 1115 SUD Demonstration Status Report*. Retrieved October 18, 2022, from <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/state-annual-report-demonstration-yr2-deliverable.pdf>

Additionally, as the COVID-19 pandemic disrupted access to in-person services, providers were able to adopt or expand the use of telehealth in order to maintain providing access to critical behavioral health and SUD services. Given the state's geographic context in which many Medicaid beneficiaries live in rural and remote regions, expanded availability of behavioral health services through telehealth quickly became a critical lifeline, and Alaska succeeded in assuring long-term access to these services by making telehealth a permanent Medicaid-covered option through amendments to the Alaska Administrative Code authorized by House Bill 265 Health Care Services by Telehealth in 2022.⁶

The state has also made progress in aligning with nationally recognized criteria for behavioral health and SUD providers, notably through the implementation of the peer support specialist and Qualified Addiction Professionals (QAP) provider certifications. DBH has worked to balance the goal of establishing rigorous and evidence-based provider standards to ensure reliable and high-quality care for Medicaid beneficiaries with the administrative burdens faced by providers in achieving the standards. In consideration of the unique challenges experienced by Tribal health care and rural providers, DBH chose to afford more flexibility in the types of providers who could become a QAP or behavioral health clinical associate and established a process to administer provisional waivers to allow providers to bill for services while working toward their credentials or higher-level degrees. Additionally, in response to the COVID-19 public health emergency (PHE) and to accommodate provider concerns about needing additional time to complete their credentialing, DBH extended the time period for provisional certification. By design, this approach has allowed culturally specific providers such as traditional healers to meet provider standards and better serve Alaska Native populations. Through the Behavioral Health Reform Waiver extension period, DBH will continue to engage with providers, funders, and other key stakeholders to understand ongoing administrative burdens and provide the necessary support and guidance to help providers achieve provider requirements and build the capacity to provide 1115 services.

Implementation Setbacks

Despite the progress that has been made to date, Alaska has faced challenges in implementing the 1115 Waiver, most notably due to the COVID-19 pandemic. The unprecedented public health emergency put strain on a provider workforce that was already stretched thin, while Alaska's unique geographical context and high cost of providing access to care have made it difficult to recruit and retain behavioral health workers. At the same time, national trends are showing that behavioral health morbidity and mortality have seemingly worsened since the onset of the pandemic, particularly with regard to opioid overdose and child/adolescent mental

⁶ S.B. 265, 32nd Legislature, 2022 Reg. Sess. (Alaska, 2022). <https://www.akleg.gov/basis/Bill/Detail/32?Root=HB265>

health and substance use.^{7,8,9} Alaska has been hit particularly hard by the opioid epidemic in recent years, due in part by the increasing availability of fentanyl.¹⁰ The concurrence of increased needs with workforce and access barriers has made it particularly challenging to make progress toward the state's waiver goals.

Coinciding with the implementation of 1115 Waiver services, DBH launched a new vendor arrangement with an ASO for behavioral health services. DBH originally envisioned the transition to an ASO model for behavioral health service administration as a strategy for supporting key administrative functions like provider credentialing and paying claims, as well as supporting the state in the achievement of waiver goals, such as the implementation of universal screening. This approach was intended to streamline operations of waiver programs and lessen the administrative load for the state and for providers. Unfortunately, providers have noted several administrative challenges associated with the ASO launch. The state continues to work through operational changes and remains fully committing to supporting providers and reducing administrative burdens within the program throughout the extension period.

Adding further stress to the implementation, Alaska's "dhss.alaska.gov" website was the target of a cyberattack in May 2021 and a total of 19 systems were taken offline for a period of time, including Alaska's Automated Information Management System (AKAIMS), the background check system, vital records, and the State's grants and contracts online system, the Grants Electronic Management System (GEMS). During this time, DBH provided guidance and instructions to providers for temporary, manual processes which required reconciliation when AKAIMS became publicly available again in November 2021. The cyberattack increased both the state's and providers' workloads and diverted resources away from implementation of the 1115 services.

Department of Justice Investigation of the State of Alaska's Behavioral Health System for Children

In December 2022, the United States Department of Justice (DOJ), Civil Rights Division issued a report summarizing its investigation of unnecessary institutionalization of children with behavioral health disabilities, in potential violation of Title II of the American Disabilities Act (ADA). Many of the services identified by the DOJ to fill gaps in the state's delivery system are services provided under the 1115 waiver. Alaska is committed to providing services in the most integrated setting as appropriate to individuals' needs. Renewal of the 1115 waiver provides DBH with the necessary ongoing foundational regulatory authority, as well as additional time to support full implementation of the community-based service array through enhanced payment

⁷ State Unintentional Drug Overdose Reporting System. (2022, June). *Drug Overdose Deaths in 28 States and the District of Columbia: 2020 data from the State Unintentional Drug Overdose Reporting System*. Retrieved October 18, 2022, from https://www.cdc.gov/drugoverdose/databriefs/pdf/SUDORS_Data-Brief_Number_1.pdf

⁸ Panchal, N, Rudowitz, R., & Cox, C. (2022, June 28). *Recent trends in Mental Health and substance use concerns among adolescents*. KFF. Retrieved October 18, 2022, from <https://www.kff.org/coronavirus-covid-19/issue-brief/recent-trends-in-mental-health-and-substance-use-concerns-among-adolescents/>

⁹ Little Hoover Commission. (2021, August). *COVID-19 and Children's Mental Health: Addressing the Impact*. Retrieved October 18, 2022, from <https://lhc.ca.gov/sites/lhc.ca.gov/files/Reports/262/Report262.pdf>

¹⁰ Alaska Department of Health. (July 25, 2022). *Alaska Facts and Figures: 2021 Drug Overdose Mortality Update*. Retrieved February 22, from https://health.alaska.gov/dph/VitalStats/Documents/PDFs/DrugOverdoseMortalityUpdate_2021.pdf

policies, streamlining operational functions, and exploration of targeted investments in infrastructure.

Progress Toward Demonstration Goals and Plans for the Future

Alaska seeks to apply lessons learned from the initial implementation of the SUD-BHP Demonstration and make continued progress toward the long-term goals established under the 1115 Waiver. In this section, we identify Alaska's notable accomplishments and setbacks under each goal and describe how those experiences will inform implementation of demonstration programs in the extension period. As the Demonstration's midpoint assessment is not yet published, this waiver renewal application represents a significant opportunity for the public, providers, and other interested parties to have visibility into the Demonstration's progress in meeting its goals.

Alaska intends to hold these goals constant in the waiver extension period, under the Demonstration's new name, *Behavioral Health Reform Waiver*, in order to continue the progress made and gain more implementation experience in the wake of the COVID-19 pandemic before considering any significant change to its overall approach.

It is important to acknowledge that progress toward these goals will occur in the context of the unwinding of the PHE as the state undertakes enhanced outreach efforts to minimize disruptions in care and keep eligible individuals enrolled in Medicaid as redeterminations resume. Additionally, the state will continue to monitor the behavioral health impacts of the pandemic and leverage the continued implementation of the Behavioral Health Reform Waiver to address evolving population health priorities, such as youth and adolescent mental health and suicide prevention, opioid overdose prevention, and racial and ethnic disparities.

1. Increased rates of identification, initiation, and engagement in treatment for SUD and behavioral health issues

Progress Towards Goals: Alaska observed improvements as well as some setbacks in relation to identification, initiation, and engagement in treatment for SUD and behavioral health needs. The number of available SUD providers increased over the course of the Demonstration, and engagement in care was supported by the expanded availability of services delivered through telehealth. However, identification and initiation in care suffered as a result of the COVID-19 pandemic as individuals' touchpoints with the health care system were reduced overall. For instance, many SUD residential treatment and withdrawal management programs temporarily closed or reduced bed capacity due to lack of staff during the height of the pandemic. Some individuals also likely delayed treatment due to fear of contracting the virus. The midpoint assessment of Alaska's 1115 Waiver observed reductions in initiation and engagement in alcohol and other drug dependence, and use of outpatient services during this period.¹¹ DBH also experienced delays in implementing universal screening for SUD due to the pandemic and other implementation set-backs associated with onboarding a new ASO vendor for behavioral health services; the state

¹¹ Alaska Substance Use Disorder and Behavioral Health (SUD-BH) Program Section 1115 Waiver Evaluation, Mid-Point Assessment

appropriately prioritized public health pandemic response efforts and basic operations ahead of innovative initiatives like universal screening.

Future Goals: In the extension period, Alaska hopes to sustain the gains in expanded telehealth access to support engagement in treatment. Additionally, DBH will work with its ASO vendor and provider partners to apply lessons learned and feedback received by testing a more targeted approach to screening for early identification for both SUD and behavioral health needs. This approach will be more structured with regard to populations of interest, clinical settings for screening, and processes for optimal referral, follow up, and coordination. This will allow the state and its contractors to dedicate the appropriate resources to stand up a successful screening initiative, using data and evidence-based practices to guide prioritization of sub-populations and ensuring appropriate training for on-the-ground providers. In particular, DBH recognizes the need for focus on early identification of children with serious risk of institutional placement in order to engage them in timely community-based services, as appropriate. DBH will also explore opportunities to compensate providers for administering SUD and mental health screenings outside of behavioral health settings. This is seen as one mechanism for the extension of the Behavioral Health Reform Waiver to serve as an opportunity to explore implementing formal collaboration between treatment providers and ancillary service contacts such as child welfare, primary care, homeless services providers, and early childhood services.

2. Increased adherence to and retention in treatment for SUD and behavioral health issues

Progress Towards Goals: Similar to the first goal, Alaska observed both progress and challenges related to adherence to, and retention in, treatment. As a frontier state, Alaska has faced long-standing workforce shortages across numerous industries, the state's behavioral health system not the least among them. As such, behavioral health provider workforce transformation has been a key area of focus as DBH implemented the SUD and behavioral health benefits authorized by the SUD-BHP Demonstration. The implementation of peer support specialist and QAP provider standards and the growth of the Medicaid SUD provider base in theory should provide beneficiaries with improved access to a consistent, high standard of care. Alaska observed an increase in SUD provider availability from 398 at the beginning of the Demonstration to 906 at the time of the midpoint assessment finalized in June 2022.¹² This updated provider count reflects the number of providers enrolled in Medicaid and qualified to deliver SUD services during the measurement period and demonstrates the process improvements that allow for more accurate counts of individual provider enrollment.

Additionally, DBH partnered closely with the Alaska Mental Health Trust Authority to stand up a peer certification program which went live in January 2021. This program provides training at no cost to individuals in recovery to gain the knowledge and tools to become certified peer support professionals. Since creation of the program, Alaska has certified 111

¹² *ibid*

peer support professionals, and there are currently 47 pending applications. As the program has grown, it has gained great momentum, with continued demand for training and expanded implementation. The state is committed to continuing to promote and fund peer support specialist training and certification as one strategy to address workforce shortages and also offers training for supervisors of peer support specialists. Despite this progress, retention in care for SUD continues to lag, as the midpoint assessment notes that engagement of alcohol and other drug treatment declined by 36%; this is likely related to COVID-19 and the ongoing stressors experienced by the Medicaid population.¹³

Future Goals: Looking forward, Alaska intends to use the extension of the Behavioral Health Reform Waiver to focus on expanded treatment options for specific subgroups such as those with co-occurring substance use and psychiatric disorders, justice-involved individuals, and pregnant and parenting individuals. Alaska will pay special attention to the anticipated updates to the American Society of Addiction Medicine (ASAM) criteria and align provider standards and processes appropriately.¹⁴ In addition, DBH is interested in exploring innovative delivery system initiatives, such as the state plan option to implement health homes¹⁵ or the federal CCBHC demonstration,¹⁶ which may complement the Behavioral Health Reform Waiver, present opportunities to bring in additional resources, and build integrated care capacity to support achievement of this goal.

3. *Reduced overdose deaths, particularly those due to opioids*

Progress Towards Goals: Opioid overdose represents a significant and ongoing crisis in Alaska, as is the case in much of the country.¹⁷ The 1115 Waiver afforded Alaska the opportunity to expand its SUD benefit across the continuum of care. We are pleased that the 1115 midpoint assessment found an increase in medication-assisted treatment (MAT) utilization, and as previously mentioned, DBH has implemented evidence-based SUD provider standards and invested in the expansion of the peer recovery specialist workforce. Notably, during the Demonstration period, two additional Opioid Treatment Providers (OTPs) launched service to Alaskans. Alaska has also increased the number of practitioners with approved Drug Addiction Treatment Act of 2000 (DATA 2000) waivers to be able to prescribe or dispense buprenorphine to treat opioid dependency. Despite these system improvements, Alaska observed a nearly 50% increase in overdose deaths since the beginning of the Demonstration period. This was likely influenced by social isolation and

¹³ *ibid*

¹⁴ American Society of Addiction Medicine (ASAM). (n.d.). *Proposed updates to the 4th Edition of The ASAM Criteria*. Retrieved October 18, 2022, from https://sitefinitystorage.blob.core.windows.net/sitefinity-production-blobs/docs/default-source/publications/criteria-4th-edition/updated-major-changes.pdf?sfvrsn=41c62057_3

¹⁵ *Health Home Information Resource Center*. Medicaid. (n.d.). Retrieved October 18, 2022, from <https://www.medicaid.gov/resources-for-states/medicaid-state-technical-assistance/health-home-information-resource-center/index.html>

¹⁶ *Section 223 demonstration program to improve community mental health services*. Medicaid. (n.d.). Retrieved October 18, 2022, from <https://www.medicaid.gov/medicaid/financial-management/section-223-demonstration-program-improve-community-mental-health-services/index.html>

¹⁷ Centers for Disease Control and Prevention. (2021, November 17). *Drug overdose deaths in the U.S. top 100,000 annually*. Centers for Disease Control and Prevention. Retrieved October 18, 2022, from https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm

added stressors related to the pandemic,¹⁸ as well as the concurrent increase in availability of fentanyl, resulting in an ongoing overdose crisis in Alaska.¹⁹ Sadly, this experience is consistent with national trends, as the CDC reports a 75% increase in overdose deaths between 2015 and 2020.²⁰

Future Goals: While it is impossible to discern the extent to which SUD-BHP implementation may have mitigated this steep rise in overdose deaths, it is clear that DBH must continue to strengthen the SUD service system and explore opportunities to improve the delivery system's responsiveness to the overdose crisis, from prevention, treatment, and recovery. DBH will continue to partner closely with the Division of Public Health to better understand the overdose data and to leverage Opioid Settlement funds and other resources to reinforce and build upon the continuum of care sustained by the extension of the Behavioral Health Reform Waiver. Additionally, the targeted implementation of screening for SUD as described under the first goal will support the delivery system's ability to identify needs early and connect individuals with appropriate care based on screening and assessment results.

4. Reduced utilization of emergency departments and inpatient hospital settings for SUD and behavioral health treatment where the utilization is preventable or medically inappropriate through improved access to other more appropriate and focused services

Progress Towards Goals: Emergency department utilization was significantly impacted by COVID-19 and related policies on non-emergency care during the height of the pandemic²¹, making assessment of progress toward achievement of this goal particularly challenging. More recently, the state has observed an increase in adolescent hospitalizations for SUD and behavioral health issues, which is consistent with recent trends documented in the research literature and attributed to pandemic related stressors.²² As the state adapts to the post-pandemic context, the authorities granted under the 1115 Waiver and initial implementation of the waiver represent a foundation from which Alaska will continue to build. The waiver authorized expenditure authority for a comprehensive array of behavioral health and SUD services aimed at keeping individuals out of higher acuity settings when they do not require that level of care. In particular, the Demonstration allowed the state to initiate the creation of a crisis services system, which holds promise for diverting unnecessary emergency department utilization. DBH was able to operationalize these authorities through updates to the Alaska Administrative Code and accompanying provider

¹⁸ U.S. Department of Health and Human Services. (2022, June 3). *Covid-19 & Substance use*. National Institutes of Health. Retrieved October 18, 2022, from <https://nida.nih.gov/research-topics/comorbidity/covid-19-substance-use>

¹⁹ *Governor Dunleavy addresses fentanyl crisis in Alaska – Mike Dunleavy*. Office of Governor Mike Dunleavy. (2022, May 3). Retrieved October 18, 2022, from <https://gov.alaska.gov/governor-dunleavy-addresses-fentanyl-crisis-in-alaska/>

²⁰ Centers for Disease Control and Prevention. (2022, June 2). *Drug Overdose Deaths*. Drug Overdose. Retrieved October 18, 2022, from <https://www.cdc.gov/drugoverdose/deaths/index.html>

²¹ Alaska Substance Use Disorder and Behavioral Health (SUD-BH) Program Section 1115 Waiver Evaluation, Mid-Point Assessment

²² Reece, L., & Sams, D. (2022, January). *The impact of covid-19 on adolescent psychiatric inpatient admissions*. Clinical Child Psychology and Psychiatry. Retrieved October 18, 2022, from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8689095/#:~:text=A%20total%20of%20340%20adolescents,crises%20related%20to%20COVID%2D19>

guidance to outline service definitions, eligibility requirements, staffing requirements, documentation, service authorization, and billing rates.²³⁻²⁴ While provider participation in achieving the requisite qualifications and delivering these crucial services has grown, DBH has heard concerns from providers regarding administrative burden, rate adequacy, and clarity of process. The state has demonstrated its responsiveness to provider concerns and commitment to supporting the behavioral health provider base in implementing waiver services throughout the Demonstration through listening sessions, periodic updates to regulations, guidance, and fee schedules. DBH will continue to do so during the extension period.

Future Goals: Building upon these experiences, Alaska will continue to deepen its ability to expand access to high quality behavioral health and SUD services, particularly crisis services, to prevent avoidable emergency department and inpatient hospitalizations and keep individuals in their communities. DBH is committed to partnering with providers to strike the necessary balance between easing administrative burden while maintaining high standards of care, aligned with evidence-based criteria and national best practices. DBH will practice effective oversight of its ASO vendor to ensure all provider processes and procedures are efficient and clearly communicated. DBH also intends to use the extension period to streamline regulations, guidance, and operational procedures for the SUD and behavioral health components of the waiver, which have historically been implemented separately. Lastly, DBH will continue to explore opportunities to better incentivize and fund care management and innovative care delivery models at the provider level, which is expected to support Alaska’s vision for prevention, early detection, and early intervention in behavioral health. The state plan option for health homes is one avenue Alaska is particularly interested in further exploring, as a strategy to improve holistic, person-centered, and recovery-oriented care and expanding the availability of waiver services for individuals with behavioral health needs.

5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate

Progress Towards Goals: As with many health care utilization metrics, readmission rates were impacted significantly by the COVID-19 pandemic as individuals socially distanced and stayed at home, often at the expense of seeking needed care. While readmissions among beneficiaries with SUD declined by 10% during the waiver period, this finding is challenging to interpret and difficult to be viewed as a success, given the simultaneous increases in overdose deaths. The 1115 Waiver afforded expenditure authority to cover services to individuals who are short-term residents in IMDs for treatment and withdrawal management for SUD, which has enabled access to this critical level of care for many individuals. The midpoint assessment found that the number of beneficiaries who received treatment for

²³ Simpson, A. (2020, September 4). *Filed Permanent Regulations: Department of Health and Social Services*. Office of the Lieutenant Governor. Retrieved October 18, 2022, from <https://aws.state.ak.us/OnlinePublicNotices/Notices/Attachment.aspx?id=124334>

²⁴ State of Alaska Department of Health and Social Services. (2021, June 30). *Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Provider Services*. Retrieved October 18, 2022, from <https://health.alaska.gov/dbh/Documents/1115/Standards-and-Administrative-Procedures-for-Behavioral-Health-Provider-Services.pdf>

SUD in an IMD increased by over 50%, and that the average length of stay was 19.5 days, in compliance with CMS' directive to "aim for a statewide average length of stay of 30 days in residential treatment settings."²⁵ Between improved access to residential and inpatient care settings for individuals who require that level of care, as well as comprehensive community-based services that are accessible post discharge, Alaska's goal is to continue to support beneficiaries in receiving the right care at the right time as a means to preventing avoidable or medically inappropriate readmissions.

Future Goals: Although the observed average length of stay is trending favorably, the state will work diligently with providers in order to continue to maintain a compliant average length of stay during the extension period. DBH will monitor this metric closely as the state adapts to post-PHE operations, onboards new providers, and works to reduce readmissions. Alaska's goal is to ensure that beneficiaries receive clinically appropriate levels and duration of care, avoiding inappropriate utilization while ensuring beneficiaries remain engaged in care for an amount of time sufficient to reduce the likelihood of readmission.

As mentioned previously, DBH intends to use the Behavioral Health Reform Waiver extension period to adopt more targeted focus on improved care coordination and transitions between levels of care. Peer support specialists have positive impacts on readmissions, as they can provide the mentoring and support to individuals during critical transition periods and ensure connection to community-based care post discharge.²⁶ DBH will continue to partner with the provider community to increase the number of peer support services providers receiving certification.

6. Improved access to care for physical health conditions among beneficiaries

Progress Towards Goals: Alaska observed a reduction in access to preventive/ambulatory health services for individuals with SUD during the initial waiver period, which was likely impacted by COVID-19 related disruptions, similar to other findings. Much of the waiver period focused on operationalizing the new service array, supporting providers in meeting new standards, transitioning to ASO administered claims payment, all while responding to the pandemic, for instance by supporting the expansion of telehealth services. Given the operational and COVID-19 related challenges that were experienced in the initial waiver period, and recognizing the operational lift that providers experienced in adapting to the new 1115 regulations and processes, the state's ability to implement initiatives focused on primary care integration was limited. In response to the provider community's feedback and implementation experiences, DBH continues to identify opportunities to revise the regulatory language governing 1115 Waiver service delivery and make updates to operational processes that may help reduce provider administrative burden.

²⁵ Medicaid.gov. (2021, May 27). *Alaska Approval letter*. Alaska Substance Use Disorder and Behavioral Health Program (SUD-BHP). Retrieved October 18, 2022, from <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ak/ak-stcs-apprvl-ltr-05272021.pdf>

²⁶ Eddie, D., Hoffman, L., Vilsaint, C., Abry, A., Bergman, B., Hoepfner, B., Weinstein, C., & Kelly, J. F. (2019, June 13). Lived experience in new models of care for substance use disorder: A systematic review of Peer Recovery Support Services and recovery coaching. *Frontiers in Psychology*. Retrieved October 18, 2022, from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6585590/>

Future Goals: The extension of the Behavioral Health Reform Waiver presents an opportunity for DBH to partner with providers to advance this goal. For many individuals, SUD and behavioral health treatment providers are the primary access point for linkage to health care and other ancillary services. As the system of care deepens its experience in meeting industry recognized standards, it is anticipated that their capacity and expertise in providing person-centered coordination with other services and providers will increase. DBH intends to explore opportunities to improve formal collaboration between behavioral health service providers and primary care providers, looking to the growing evidence base and innovations in other states that may be replicated in Alaska. In particular, Alaska is interested in the opportunities presented by the health home and CCBHC models to improve whole person care coordination and integration of behavioral health and primary care to better support individuals with mental health and SUD needs in preventing and managing chronic health conditions.

REQUESTED REVISIONS

Alaska affirms the renewal extension application requests no substantive changes other than a technical revision to the name and to reflect statewide implementation. The state seeks the opportunity to continue to implement and improve the original vision.

List of Proposed Waiver and Expenditure Authorities

DBH is requesting the same waiver and expenditure authorities as those approved in the current Demonstration, with the exception of the waiver of statewideness which is no longer required, as described in more detail below.

WAIVER AUTHORITY

Authority Requested

Alaska will continue to target the services under the Behavioral Health Reform Waiver and requests an extended waiver of comparability under section 1902(a)(10)(B) of the Social Security Act to vary the amount, duration, and scope of services to only the eligible beneficiaries defined in the Alaska Administrative Code, as copied below.

Section 7 Alaska Administrative Code (AAC) 139.010 outlines the recipient criteria to receive the behavioral health services:

- An eligible youth under age 21 who
 - is diagnosed with a mental health or substance use disorder
 - is at risk of developing a mental health or substance use disorder based upon a screening conducted according to 7 AAC 135.100
 - is at risk of out of home placement
 - is currently in the custody of the state, or
 - has been detained in a juvenile justice facility or treated in a residential treatment program or psychiatric hospital within the past year.
- An eligible individual who meets the criteria under 7 AAC 135.055 for experiencing a serious mental illness
- An individual who is experiencing a mental disorder who meets the diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders, adopted by reference in 7 AAC 70.910, or the International Classification of Diseases - 10th Revision, Clinical Modification, (ICD-10-CM), adopted by reference in 7 AAC 70.910.

Section 7 AAC 138.010 outlines the criteria to receive the substance use disorder waiver services:

- A child at least 12 years of age and under 18 years of age who may have a substance use disorder, or may be at risk to develop a substance use disorder as determined through a screening conducted according to 7 AAC 135.100
- A youth at least 18 years of age and under 22 years of age who may have a substance use disorder or may be at risk to develop a substance use disorder as determined through a screening conducted according to 7 AAC 135.100.
- An adult who is diagnosed with a substance use disorder or is at risk of developing a substance use disorder as determined through a screening conducted according to 7 AAC 135.100.

Medicaid eligibility standards and methodologies remain applicable to individuals under the waiver. To qualify for waiver services under 7 AAC 139.010 and 7 AAC 138.010, individuals must derive their eligibility through the Alaska Medicaid State Plan and are subject to all applicable Medicaid laws and regulations regarding initial and ongoing eligibility.

Waiver Authority No Longer Requested

Alaska has completed the phased-in schedule to cover the behavioral health benefits and continuum of SUD services as set forth in the approved STCs and SUD Implementation Plan Protocol, beginning January 1, 2019, and September 3, 2019, under the original waiver applications. As such, the waiver services are available on a statewide basis and Alaska no longer seeks to waive section 1902(a)(1) of the Social Security Act as it related to statewideness.

EXPENDITURE AUTHORITY REQUESTED

Alaska requests an extension of the expenditure authorities granted in the original 1115 Waiver.²⁷ Alaska intends to continue to pilot the service array authorized by the waiver, given initial implementation challenges such as the staggered start dates of waiver programs, the COVID-19 pandemic, and the transition to ASO administration of core functions. Alaska will rigorously evaluate and monitor the provision of services under the extension period and use these learnings to inform the state's future approach to providing behavioral health services through state plan authority.

1. **Residential Treatment for Individuals with Substance Use Disorder.** Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder who are short-term residents in facilities that meet the definition of an IMD.
2. **Opioid Treatment Services (OTS) for Persons Experiencing an Opioid Use Disorder (OUD).** Expenditures for medication and counseling services to eligible individuals with severe OUD, in accordance with an individualized service plan determined by a licensed physician or licensed prescriber and approved and authorized according to state requirements.
3. **Intensive Outpatient (IOP) Services for Substance Use Disorder.** Expenditures for IOP services and structured programming provided to eligible individuals when determined to be medically necessary and in accordance with an individualized treatment plan.
4. **Intensive Outpatient (IOP) Services for Behavioral Health.** Expenditures for IOP services and structured programming to individuals determined to be medically necessary and in accordance with an individualized treatment plan.

²⁷ These services descriptions may be operationalized through multiple service codes and may also include further delineation through the use of levels captured by modifiers. Aligning the service descriptions in the waiver's requested expenditure authorities to the service descriptions operationalized through the state's code sets will occur during the negotiation of the special terms and conditions.

5. **Partial Hospitalization Program (PHP) Services for Substance Use Disorder.** Expenditures for PHP services provided to eligible individuals including services designed for the diagnosis or active treatment of a SUD to maintain the person's functional level and prevent or decrease risk for recurrence of or inpatient hospitalization. Payment for Room and Board are prohibited.
6. **Partial Hospitalization Program (PHP) Services for Behavioral Health.** Expenditures for PHP services provided to individuals, in a highly structured treatment environment for services that will provide diagnosis or active treatment of an individual's psychiatric disorder, with a diagnosis of Serious Mental Illness (SMI) or Serious Emotional Disorder (SED) in accordance with an individualized treatment plan. Payment for room and board costs are prohibited.
7. **Medically Monitored Intensive Inpatient Services.** Expenditures for services provided in a residential setting or a specialty unit of an acute or psychiatric hospital. Individuals receiving Medicaid coverable services at this level of care require 24-hour services, professionally directed evaluation, observation, medical monitoring, and addiction treatment in an inpatient setting.
8. **Medically Managed Intensive Inpatient Services.** Expenditures for services provided in a hospital setting (acute care or specialty) for individuals with acute medical, behavioral, or cognitive conditions. Medically managed services involve daily medical care and 24-hour nursing requiring the full resources of an acute care or psychiatric hospital.
9. **Ambulatory Withdrawal Management Services.** Expenditures for outpatient services provided to eligible individuals at a mild withdrawal risk with a high commitment to the withdrawal management process.
10. **Clinically Managed Residential Withdrawal Management.** Expenditures for services provided in a social setting focusing on peer support programs, including daily individual and group therapies, support, and health education services.
11. **Medically Monitored Inpatient Withdrawal Management Services.** Expenditures for services provided in a freestanding withdrawal setting with inpatient beds, specializing in clinical consultation, for individuals experiencing severe withdrawal and needing clinical consultation and supervision for cognitive, biomedical, emotional, and behavioral problems.
12. **Medically Managed Intensive Inpatient Withdrawal Management Services.** Expenditures for services provided in an acute care or psychiatric hospital in a patient unit, specializing in medical consultation, full medical acute services and intensive care for individuals experiencing severe, unstable withdrawal needs (usually hospital-based), including 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.
13. **Community Recovery Support Services (CRSS) for SUD.** Expenditures for community recovery support services to help decrease risk for recurrence of symptoms and promote recovery, and to support transition between levels of care for SUD.

14. **Community Recovery Support Services (CRSS) for Behavioral Health.** Expenditures for community recovery support services to help decrease risk for recurrence of symptoms and promote recovery, and to support transition between levels of care for behavioral health services.
15. **Home-Based Family Treatment Services (HBFT).** Expenditures for HBFT services for children/youth ages 0-20 who are at risk for out-of-home placement or detention in a juvenile justice facility and for whom a combination of less intensive outpatient services has not been effective or is deemed likely not to be effective.
16. **Children's Residential Treatment (CRT).** Expenditures for residential treatment services provided by an interdisciplinary treatment team in a therapeutically structured, supervised environment for children and youth whose health is at risk while living in their community. This authority does not apply to IMDs. Payment for room and board costs are prohibited.
17. **Therapeutic Treatment Homes.** Expenditures for trauma-informed clinical services which include placement in a specifically trained therapeutic treatment home for children/youth who have severe mental, emotional health needs diagnosed with a SMI or SED or a behavioral health need, and who cannot be stabilized in their home settings. This authority does not apply to IMDs. Payment for room and board costs are prohibited.
18. **Assertive Community Treatment (ACT) Services.** Expenditures for an evidence-based practice designed to provide treatment, rehabilitation and support services to individuals who are diagnosed with a severe mental illness and whose needs have not been well met by more traditional mental health services.
19. **Adult Mental Health Residential (AMHR) Services.** Expenditures for AMHR services provided by an interdisciplinary treatment team in a therapeutically structured, supervised environment for adults with acute mental health needs, diagnosed with a SMI or SED, whose health is at risk while living in their community. This authority does not apply to IMDs. Payment for room and board are prohibited.
20. **Peer-Based Crisis Services.** Expenditures for community-based services that divert individuals from emergency department and psychiatric hospitalization use. These services are facilitated by children and adults that have lived with or have experience with a mental illness or a substance disorder (including parents).
21. **Intensive Case Management Services for SUD.** Expenditures for services for adults with substance use disorders (if their needs cannot be met by SUD Care Coordination).
22. **Intensive Case Management Services for Behavioral Health.** Expenditures for services for children/youth at risk of out-of-home placement, and adults with acute mental health needs.
23. **Mobile Outreach and Crisis Response (MOCR) Services.** Expenditures for services which prevent a mental health crisis or stabilize an individual during or after a mental health crisis or a crisis involving both substance use and mental health disorders.

24. **23-Hour Crisis Observation and Stabilization (COS) Services.** Expenditures for evaluation and/or stabilization services for individuals presenting with acute symptoms or distress. Services are provided for up to 23 hours and 59 minutes of care in a secure and protected environment.
25. **Crisis Residential/Stabilization Services.** Expenditures for medically monitored short-term, residential program in an approved 10-15 bed facility that provides 24/7 psychiatric stabilization services. These facilities are not IMDs. Payment for room and board are prohibited.

Quality Assurance

DBH monitors and validates the quality of care provided under the 1115 Waiver through several assurance processes, each described in more detail below. As a FFS delivery system, Alaska does not have many of the managed care oversight tools specified in the federal regulations governing waiver applications, such as External Quality Review (EQR) Reports. Rather, Alaska uses the following mechanisms to ensure quality of demonstration service provision:

- **Level of care tool** to assess and approve provider readiness to deliver 1115 waiver services
- Informal **provider site visits** to review service implementation compliance; and
- Ongoing **program oversight** including claims review, program integrity, complaints and appeals tracking, and access monitoring

LEVEL OF CARE TOOL

To ensure that providers meet the service component requirements as defined in the Alaska Behavioral Health Providers Service Standards and Administrative Procedures, Alaska Administrative Code, and the ASAM criteria, DBH utilizes a provider checklist tool to review and approve provider applications to deliver a new level of care or service. As a key component of the quality review and approval process, DBH makes the tool available to providers to assist them in their application development and documentation. The following services require DBH review and approval before provision of any services to beneficiaries.

TABLE 2. 1115 WAIVER SERVICES REQUIRING PROVISIONAL APPROVAL

SUD Levels of Care	Behavioral Health Services
2.5 Partial Hospitalization	Assertive Community Treatment (ACT)
Residential SUD Treatment levels: 3.1, 3.3, 3.5, 3.7, 4.0	Adult Mental Health Residential Treatment Levels 1 & 2
Withdrawal Management programs: 1.0/2.0-WM, 3.2-WM, 3.7-WM, 4.0-WM	Children's Mental Health Residential Treatment Levels 1 & 2
23-Hour Crisis Stabilization and Observation	Partial Hospitalization Program
Mobile Outreach Crisis Response	Therapeutic Treatment Homes
Crisis Residential Stabilization	23-Hour Crisis Stabilization and Observation
	Mobile Outreach Crisis Response
	Crisis Residential Stabilization

Required elements reviewed in the tool include service capacity, staff qualifications, admission/assessment policy, treatment planning policy, treatment plan review policy, transfer/discharge policy, accreditation status, and evidence of community partner collaboration.

INFORMAL PROVIDER SITE VISITS

DBH conducts informal provider site visits to each new Adult Mental Health Residential (AMHR) program to review implementation of residential treatment services in accordance with the program criteria, service definitions, eligibility requirements, required service components, staffing requirements, documentation, and service authorization requirements as outlined in the Alaska Behavioral Health Providers Service Standards and Administrative Procedures manual. In these visits, DBH conducts interviews with key staff to discuss their program implementation experiences, ongoing operations, successes, and challenges. Additionally, DBH reviews clinical charts to ensure appropriate documentation and that the AMHR treatment facility is providing the required number of treatment hours for their level of care. Identified performance issues and provider concerns are documented in the Informal Agency Visit Report for DBH to address and monitor for ongoing compliance. DBH follows up with providers to ensure resolution of any identified concerns and to provide hands-on assistance as needed.

Licensure requirements for assisted living facilities (ALFs) transitioning to residential treatment programs were common implementation concerns. Further issues include access and length of stay beyond medical necessity as discharge planning is challenged by the lack of both available affordable housing and ALFs.

ONGOING PROGRAM OVERSIGHT

DBH performs ongoing quality review of claims data to identify opportunities for provider education and service delivery improvement. Staff review weekly the 10 services with the highest billing volumes as well as the 10 services which have the highest denial rates. Through collecting and analyzing this data, DBH examines the billed services across the entire service continuum to identify outliers including:

- High volume of services at the most acute placement setting;
- Services at an inappropriate level of care;
- Services not reaching the target populations; or
- Inappropriate number of billed units per day.

This informs DBH quality improvement and practice management outreach, guidance documents, technical assistance, and individual provider trainings. Additional ongoing oversight includes access monitoring and the tracking and trending of beneficiary and provider complaints and appeals.

The Medicaid Program Integrity Unit ensures that services provided are medically necessary. The team works with the Alaska Medicaid Fraud Unit program which has responsibility for investigating and prosecuting Medicaid fraud and the abuse, neglect, or financial exploitation of patients in any facility that accepts Medicaid funds to ensure it is providing quality and efficient care.

Budget Neutrality

HISTORICAL AND PROJECTED EXPENDITURES

The budget neutrality demonstration includes projected experience from demonstration year (DY) 6 through 10, defined as January 1, 2024 through December 31, 2028. Budget neutrality is a comparison of without waiver expenditures (WoW) to with waiver expenditures (WW). CMS recommends two potential methodologies of demonstrating budget neutrality:

1. Per Capita Method: Assessment of the per member per month (PMPM) cost of the Demonstration
2. Aggregate Method: Assessment of both the number of members and PMPM cost of the Demonstration

Budget neutrality for this Behavioral Health Reform Waiver, which was developed using CMS budget neutrality requirements, will be demonstrated using the per capita method. The budget neutrality worksheets are attached as *Appendix B*. The rest of this section documents the supporting data and methodology included in the worksheets.

A. Historic Data

We have provided five years of actual historical data in three separate groupings that correspond to the Medicaid Eligibility Groups (MEGs) incorporated in the previous demonstration period. Historic Years (HY) 1 through 2 reflect January 1, 2017 through December 31, 2018 incurred experience while DY 1 through 3 reflect January 1 2019 through December 31, 2021 incurred experience. Eligible member months and expenditures were assigned to each grouping using the following methodology:

- **SUD IMD.**
 - Historical eligible member months for the SUD IMD grouping were calculated based on service recipient months rather than member eligibility months. Recipient months were identified by summarizing incurred SUD residential claims for members at providers assumed to be IMDs. We assigned one eligible member month for each combination of member and month where the member received SUD residential services at an IMD provider.
 - Corresponding claims for the SUD IMD grouping consist of all monthly Medicaid claim expenditures attributable to member months assigned to the SUD IMD grouping. This includes all service types.
- **SUD Non-IMD.**
 - For the SUD Non-IMD grouping, member months were calculated based on total member months for all Medicaid-eligible members under the age of 65.
 - SUD Non-IMD claims were identified based on SUD covered services included in the 1115 waiver. Expenditure amounts do not reflect state plan services not authorized via the 1115 waiver.

- **BH Non-IMD.**

- BH Non-IMD member months were identified consistent with SUD Non-IMD member months.
- BH Non-IMD claims were identified based on covered services included in the 1115 waiver that were assumed to be BH Non-IMD. Expenditure amounts do not reflect state plan services not authorized via the 1115 waiver.

Please note that for the SUD Non-IMD and BH Non-IMD groupings, PMPM cost varied materially among years during the demonstration due to ramp-up in utilization of 1115 services.

B. DY 05

With the demonstration beginning January 1, 2024, the bridge period is January 1, 2022 to December 31, 2022 and the base year, DY 5, reflects the January 1, 2023 to December 31, 2023 time period. We have applied 24 months of aging to get from the midpoint of the historical data (July 1, 2021) to the midpoint of DY 5 (July 1, 2023).

As part of the budget neutrality projections, we have reflected the impact of programmatic considerations which require modification to the trend rates used to move from DY 3 to DY 6, in addition to the aforementioned ramp-up in 1115 utilization that results in the high PMPM cost trend rates shown on the Historic Data tab.

Program Change 1: Public health emergency.

DY 3 (January 1, 2021 through December 31, 2021) includes increased enrollment relative to prior periods due to the decrease in member disenrollment under the COVID-19 PHE. In developing projected amounts under the demonstration, we reflected lower enrollment relative to the DY 3 experience under the assumption that member disenrollment will have occurred prior to the start of the next demonstration period, coinciding with an assumed PHE end date of January 1, 2023. As part of the adjustment, we assumed that following resumption of regular enrollment processes, approximately 90% of the enrollment increase observed during the PHE would dissipate. We further assumed that the members who are disenrolled will have lower morbidity than those who remain in the program. Note that the SUD IMD grouping was not impacted by this program change since eligible member months for that grouping are defined on a service recipient basis.

Program Change 2: 1115 service reimbursement increase.

Modeling anticipated that the reimbursement for 1115 waiver services would increase by approximately 4.5% effective October 1, 2022. DBH anticipated the rate increase would have been in effect October 1, 2022 and completed the actuarial modeling to reflect this date. The rate increase must go through the regulatory process for adoption before it can be effective. The modeling effective date is not the same as the effective regulation date. We applied this increase to the portion of the total claims in each grouping that is attributable to 1115 waiver services. Note that this represented all expenditures for the SUD Non-IMD and BH Non-IMD groupings but only a portion of expenditures for the SUD IMD grouping. This is

because the SUD IMD grouping also includes expenditures for services that are not 1115 waiver services.

Program Change 3: IHS rate increase.

Effective January 1, 2022, claims for behavioral health services billed by Indian Health Service (IHS) providers received a 17% reimbursement increase. To reflect the impact of this program change, we applied this increase to the assumed portion of total expenditures in each grouping that are billed by IHS providers.

Program Change 4: State plan service shifting.

As part of the behavioral health service array available to the Medicaid population, members may utilize services authorized via Alaska’s state plan and/or via the 1115 waiver. In many cases, an increase in a member’s utilization of 1115 services corresponds with a decrease in utilization of state plan services. Throughout the current demonstration period, the state has observed that a material amount of utilization has shifted from state plan services to 1115 waiver services.

Since the SUD Non-IMD and BH Non-IMD groupings in the budget neutrality demonstration include expenditures *only for 1115 waiver services*, this shifting of utilization from state plan to 1115 waiver services has the potential to produce material discrepancies between the original budget neutrality projections and the experience that emerges during the demonstration. Our methodology for developing this adjustment consisted of analyzing the cost distribution between state plan and 1115 waiver services over time. We observed that in recent quarters, 1115 waiver service utilization as a percentage of total (state plan plus 1115) has increased materially relative to previous time periods, including the DY 3 (CY 2021) period which serves as the base period for the budget neutrality projections in the next demonstration. To reflect the impact of state plan to 1115 waiver shifting that has already occurred, plus the potential impact of further shifting during the next demonstration period, we adjusted DY 3 experience to reflect the anticipated distribution of state plan and 1115 service cost during the demonstration.

Table 3 below illustrates the impact of each of these items as part of the development of the modified DY 5 member month and PMPM cost trend rates.

TABLE 3: IMPACT OF PROGRAM CHANGES

PROGRAM CHANGE	SUD IMD		SUD NON-IMD		BH NON-IMD	
	MEMBER MONTHS	PMPM COST	MEMBER MONTHS	PMPM COST	MEMBER MONTHS	PMPM COST
DY 3, Unadjusted	1,461	\$ 12,548.15	2,867,917	\$ 19.94	2,867,917	\$ 24.17
Public Health Emergency	0.0%	0.0%	(8.5%)	7.6%	(8.5%)	7.7%
1115 Service Reimbursement Increase	0.0%	3.7%	0.0%	4.5%	0.0%	4.5%
IHS Rate Increase	0.0%	0.5%	0.0%	10.6%	0.0%	6.2%
State Plan Service Shifting	0.0%	0.0%	0.0%	18.3%	0.0%	54.9%
DY 3, Adjusted	1,461	\$ 13,076.75	2,624,473	\$ 29.33	2,624,473	\$ 44.77
Trend to Demonstration Year 5	1.0%	4.5%	1.0%	4.5%	1.0%	4.5%
Demonstration Year 5	1,490	\$ 14,280.14	2,650,717	\$ 32.03	2,650,717	\$ 48.89

C. Without-Waiver (WOW) Projections, PMPM Costs, and Member Months

We manually altered the trend rates on the WOW tab used to calculate the DY 5 and DY 6 PMPM cost and eligible member months. This was done to account for the inconsistent historical data due to state plan shifting, reimbursement rate increases, and the change in PMPM and member months due to the potential PHE end. Trend rate 1 was calculated based on the values provided in Table 1, whereas trend rate 2 was selected consistent with the previous 1115 waiver budget neutrality projections: 1.0% for eligible member months and 4.5% for PMPM cost.

D. With-Waiver (WW) Projections, PMPM Costs, and Member Enrollment

Based on CMS guidance regarding hypothetical 1115 waivers, both the WoW and WW scenarios equal one another. The table below contains a summary of the projected enrollment and expenditures, where DY 03 represents the most recent calendar year of incurred experience (calendar year 2021) and DY 06 through 10 represent the renewal Demonstration period.

TABLE 4 - 1115 BUDGET NEUTRALITY PROJECTIONS BY GROUPING

GROUPING	DY 03	DY 06	DY 07	DY 08	DY 09	DY 10
SUD IMD						
Persons Eligible: Avg Monthly	122	125	127	128	129	131
PMPM Cost	\$ 12,548.15	\$ 14,922.75	\$ 15,594.27	\$ 16,296.01	\$ 17,029.33	\$ 17,795.65
Expenditures	\$18,332,845	\$22,462,823	\$23,708,381	\$25,023,007	\$26,410,532	\$27,874,997
SUD Non-IMD						
Persons Eligible: Avg Monthly	238,993	222,922	225,152	227,403	229,677	231,974
PMPM Cost	\$ 19.94	\$ 33.47	\$ 34.98	\$ 36.55	\$ 38.19	\$ 39.91
Expenditures	\$ 57,193,269	\$ 89,534,506	\$ 94,509,596	\$ 99,738,965	\$ 105,256,399	\$ 111,096,903
BH Non-IMD						
Persons Eligible: Avg Monthly	238,993	222,922	225,152	227,403	229,677	231,974
PMPM Cost	\$ 24.17	\$ 51.09	\$ 53.39	\$ 55.79	\$ 58.30	\$ 60.92
Expenditures	\$69,329,383	\$136,669,193	\$144,250,067	\$152,241,774	\$160,682,065	\$169,582,143
Total Expenditures	\$144,855,497	\$248,666,522	\$262,468,044	\$277,003,747	\$292,348,996	\$308,554,042

Notes:

1. Values reflect state and federal expenditures.
2. DY 06 - DY 10 represent the waiver demonstration period of January 1, 2024 through December 31, 2028.
3. SUD IMD persons eligible are based on service recipients, while persons eligible for the Non-IMD groupings include all Medicaid eligible members under age 65.
4. PMPM cost for the SUD IMD grouping reflects expenditures for all services. For the Non-IMD groupings, PMPM cost reflects 1115 services only.
5. Persons eligible for both the SUD Non-IMD and BH Non-IMD groupings represent total eligible members.

E. Disproportionate Share Hospital (DSH)

Not applicable.

F. Summary

We have made no changes to the template functionality which summarizes information from previous tabs.

G. Dropdown

We have made no changes to the template.

FINANCIAL ANALYSIS OF CHANGES

We do not anticipate a material financial impact related to changes in this Behavioral Health Reform Waiver extension relative to the previous demonstration, including the provision of making services available statewide. Under the previous demonstration, the budget neutrality projections were developed such that the Historic Data and projected experience reflected Medicaid enrollees in all regions of the state.

Evaluation Report

Health Services Advisory Group, Inc. (HSAG) serves as the independent evaluator for Alaska's 1115 Waiver Demonstration. On April 5, 2021, CMS formally approved the SUD-BHP evaluation design,²⁸ and HSAG has since completed the interim evaluation, as required within the 1115 Special Terms and Conditions (STCs). The evaluation applies a mixed-methods approach that features interviews with key informants, beneficiary surveys, and quantitative assessment of a robust set of monitoring metrics to assess the effectiveness of the behavioral health and SUD waiver programs authorized by the 1115 Demonstration.

In general, HSAG's interim evaluation showed favorable improvement in:

- Increased number of practitioners providing SUD and behavioral health services
- Reduced emergency department (ED) visits specifically for opioid use disorder (OUD) and behavioral health disorders
- Improved rates of service utilization for SUD treatment
- Timelier initiation of treatment for SUD

In addition to overall results suggesting an increase in the provision of appropriate care, the interim evaluation identified improvements in meeting the statewide target for average length of stay in an IMD of 30 days, declining from over 76 days in 2018 to just under 27 days.

While these preliminary results are promising, the interim evaluation also uncovered unfavorable trends, likely attributable at least in part to the COVID-19 PHE:

- Reduced percentage of beneficiaries screened for SUD or behavioral health disorders
- Lower rates of follow-up after discharge from an ED visit for SUD or behavioral health disorder
- Reduced rates of access to preventive and primary care.
- Reduced screening for chronic conditions and SUD/behavioral health comorbidities.
- Higher rates of statewide (including non-Medicaid) overdose deaths, including those from opioids

The full interim evaluation is included in this extension application as *Appendix C*.

Alaska envisions this waiver renewal as an opportunity to continue to operationalize and refine the demonstration program to reach its full promise, in the wake of an implementation period disrupted by COVID-19, workforce shortages, and other challenges. For this reason, this Behavioral Health Reform Waiver extension is being requested without substantial changes, and as such, the state's Demonstration goals and hypotheses will remain consistent with those articulated in the original Demonstration STCs. However, as the state continues its reforms to

²⁸ Medicaid.gov. (2021, April 5). *CMS Approval SUD Evaluation Design*. Alaska Substance Use Disorder and Behavioral Health Program (SUD-BHP). Retrieved October 18, 2022, from <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ak/ak-behavioral-health-demo-ca.pdf>

the system, DBH will consider any updates to evaluation hypotheses that may be useful to gauge ongoing success of the demonstration.

The table below summarizes the evaluation questions, hypotheses, and measures that will continue to be assessed in the extension period. The evaluation design will similarly remain unchanged.

TABLE 5. SUMMARY TABLE OF EVALUATION QUESTIONS, HYPOTHESES, AND MEASURES

Measure Description	Data Source	Analytic Approach	Comparison Group ¹	Primary Driver ²
Evaluation Question: Does the Demonstration increase access to and utilization of substance use disorder and mental health disorder treatment services by increasing access to community based care?				
Evaluation Hypothesis: The Demonstration will increase the number of beneficiaries in the waiver population who are referred to and engage in treatment for substance use disorder and behavioral health disorder in sub-acute, community- or regionally-based outpatient settings.				
Number of beneficiaries screened for symptoms of SUD using industry recognized, evidence- based screening instruments	Claims Data	Descriptive; Pre/post; Single-year DiD	Beneficiaries pre-implementation Beneficiaries in Year 2 Regions	Universally screen all Medicaid recipients, regardless of setting, using industry-recognized, evidence- based SUD screening instruments.
Number of beneficiaries screened for symptoms of behavioral health disorders using industry recognized, evidence- based screening instruments	Claims Data	Descriptive; Pre/post	Beneficiaries pre-implementation	Universally screen all Medicaid recipients, regardless of setting, using industry-recognized, evidence- based MH and SUD screening instruments.
Number of beneficiaries in the waiver population with SUD or behavioral health diagnosis, by setting	Claims Data	Descriptive; compare setting; out-of-state comparison; Single-year DiD	Beneficiaries in Year 2 Regions National survey (NSDUH: UDPYILAL)	N/A

Measure Description	Data Source	Analytic Approach	Comparison Group ¹	Primary Driver ²
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF 0004)	Claims Data	Pre/post; compare to national benchmarks; Single-year DiD	Beneficiaries pre-implementation Beneficiaries in Year 2 Regions NCQA benchmarks	Increase SUD and BH treatment options for youth (ages 12-17) and adult (18 and over) Medicaid recipients, particularly non-residential, step-up and step-down treatment options.
Follow up after discharge from emergency department visits for SUD, and specifically for OUD, by setting (NQF 2605)	Claims Data	Pre/post; compare to national benchmarks; Single-year DiD	Beneficiaries in Year 2 Regions NCQA benchmarks	Implement American Society of Addiction Medicine (ASAM) Criteria (3rd Edition) to match individuals with SUD with the services and tools necessary for recovery.
Follow up after discharge from emergency department visits for a behavioral health disorder, by setting (NQF 2605)	Claims Data	Pre/post; compare to national benchmarks	NCQA benchmarks	Provide treatment, rehabilitation, and support services to individuals who are diagnosed with a severe mental illness
Number of Medicaid qualified SUD providers (identified by provider ID numbers) who bill for SUD services	Administrative/ provider enrollment records	Descriptive by region	Providers pre-implementation	Improve SUD provider infrastructures and capacity utilizing industry-recognized standards for certification and ongoing accountability (with emphasis on residential providers, but across-the-board).

Measure Description	Data Source	Analytic Approach	Comparison Group ¹	Primary Driver ²
Number of Medicaid qualified professionals licensed in the state to provide behavioral health who bill for behavioral health disorder services	Department of Commerce, Community and Economic Development, Occupational Licensing Section Database, MMIS/ASO	Descriptive by region	Providers pre-implementation	Improve SUD provider infrastructures and capacity utilizing industry- recognized standards for certification and ongoing accountability (with emphasis on residential providers, but across-the-board).
Providers' reported barriers before, during, and shortly following expansion of BH and SUD services	Provider focus group	Qualitative synthesis & thematic analysis	N/A	
Providers' experience in expanding services.	Provider focus group	Qualitative synthesis & thematic analysis	N/A	
Administrators' reported barriers before, during, and shortly following expansion of BH and SUD services.	Administrator key informant interview	Qualitative synthesis & thematic analysis	N/A	
Administrators' plan for program sustainability and anticipated challenges.	Administrator key informant interview	Qualitative synthesis & thematic analysis	N/A	
Alaska tribal entities reported changes in quality of care and access to care following expansion of BH and SUD services	Provider focus group. Quarterly Meetings with Alaska Tribal Entities	Qualitative synthesis & thematic analysis	N/A	
Evaluation Hypothesis: The Demonstration will decrease utilization of emergency department, inpatient, or institutional settings within the beneficiary population.				

Measure Description	Data Source	Analytic Approach	Comparison Group ¹	Primary Driver ²
Inpatient admissions for SUD, and specifically for OUD, by setting	Claims Data	Descriptive; ITS; out-of- state comparison; Single year DiD	Beneficiaries pre-implementation Beneficiaries in Year 2 Regions National survey (NSDUH: TXYRHOSAD)	Increase SUD and BH treatment options for youth (ages 12-17) and adult (18 and over) Medicaid recipients, particularly non-residential, step-up and step- down treatment options. Improve SUD provider infrastructures and capacity
Inpatient admissions for behavioral health disorders, by setting	Claims Data	Descriptive; ITS; out-of- state comparison	Beneficiaries pre-implementation National survey (NSDUH: AUIXXXX [multiple variables])	Increase SUD and BH treatment options for youth (ages 12-17) and adult (18 and over) Medicaid recipients, particularly non-residential, step-up and step- down treatment options.
Emergency department visits for SUD, and specifically for OUD, by setting	Claims Data	Descriptive; ITS; out-of- state comparison; Single year DiD	Beneficiaries pre-implementation Beneficiaries in Year 2 Regions National survey (NSDUH: TXYREMRAD)	Increase SUD and BH treatment options for youth (ages 12-17) and adult (18 and over) Medicaid recipients, particularly non-residential, step-up and step- down treatment options. Improve SUD provider infrastructures and capacity
Emergency department visits for a behavioral health disorder, by setting	Claims Data	Descriptive; ITS; out-of- state comparison	Beneficiaries pre-implementation National survey (NSDUH: NMERTMT)	Increase SUD and BH treatment options for youth (ages 12-17) and adult (18 and over) Medicaid recipients, particularly non-residential, step-up and step- down treatment options.

Measure Description	Data Source	Analytic Approach	Comparison Group ¹	Primary Driver ²
Mean length of stay measured from admission date to discharge date, by setting	Claims Data	Descriptive; ITS; out-of- state comparison; Single year DiD	Beneficiaries pre-implementation Beneficiaries in Year 2 Regions National survey (NSDUH: NMNGTHS2)	Increase SUD and BH treatment options for youth (ages 12-17) and adult (18 and over) Medicaid recipients, particularly non-residential, step-up and step- down treatment options. Improve SUD provider infrastructures and capacity
30 day readmission rate to inpatient facilities following hospitalization for an SUD related diagnosis, by setting	Claims Data	Descriptive; pre-post; Single year DiD	Beneficiaries pre-implementation Beneficiaries in Year 2 Regions	Implement American Society of Addiction Medicine (ASAM) Criteria (3rd Edition) to match individuals with SUD with the services and tools necessary for recovery.
30 day readmission rate to inpatient facilities following hospitalization for a behavioral health related diagnosis, by setting	Claims Data	Descriptive; pre-post	Beneficiaries pre-implementation	Implement American Society of Addiction Medicine (ASAM) Criteria (3rd Edition) to match individuals with SUD with the services and tools necessary for recovery.
Evaluation Hypothesis: The Demonstration will increase the percentage of beneficiaries who adhere to treatment for substance use disorders and mental health disorders.				
Number of beneficiaries with a SUD diagnosis including those with OUD who used services in the last month or year, by service or benefit type	Claims Data	Descriptive; pre-post	Beneficiaries pre-implementation	Increase SUD and BH treatment options for youth (ages 12-17) and adult (18 and over) Medicaid recipients, particularly non-residential, step-up and step- down treatment options.

Measure Description	Data Source	Analytic Approach	Comparison Group ¹	Primary Driver ²
Number of beneficiaries with a behavioral health diagnosis who used services in the last month or year, by service or benefit type	Claims Data	Descriptive; pre-post	Beneficiaries pre-implementation	Increase SUD and BH treatment options for youth (ages 12-17) and adult (18 and over) Medicaid recipients, particularly non-residential, step-up and step-down treatment options.
Time to treatment, by service type (National Behavioral Health Quality Framework [NBHQF] Goal 1)	Claims Data	Descriptive; pre-post	Beneficiaries pre-implementation	Increase SUD and BH treatment options for youth (ages 12-17) and adult (18 and over) Medicaid recipients, particularly non-residential, step-up and step-down treatment options.
Evaluation Question: Do enrollees receiving substance use disorder services experience improved health outcomes?				
Evaluation Hypothesis: The Demonstration will increase the percentage of beneficiaries with substance use disorder or a mental health disorder who experience care for comorbid conditions.				
Access to physical health care	Claims Data	Pre/post; compare to national benchmarks; Single year DiD	Beneficiaries pre-implementation Beneficiaries in Year 2 Regions NCQA Benchmarks	Increase SUD and BH treatment options for youth (ages 12-17) and adult (18 and over) Medicaid recipients, particularly non-residential, step-up and step-down treatment options.
Screening for chronic conditions relevant to state Medicaid population	Claims Data	Pre/post; compare to national benchmarks; Single year DiD	Beneficiaries pre-implementation Beneficiaries in Year 2 Regions NCQA Benchmarks	Universally screen all Medicaid recipients, regardless of setting, using industry-recognized, evidence-based SUD screening instruments to identify symptoms, preventive measures, and intervene as early as possible before use becomes dependence.

Measure Description	Data Source	Analytic Approach	Comparison Group ¹	Primary Driver ²
Screening for co-morbidity of behavioral health and substance use disorders within the waiver population compared to the total Medicaid population	Claims Data	Pre/post; compare to national benchmarks; Single year DiD	Beneficiaries pre-implementation Beneficiaries in Year 2 Regions NCQA Benchmarks	Improve SUD provider infrastructures and capacity utilizing industry- recognized standards for certification and ongoing accountability (with emphasis on residential providers, but across-the-board).
Percentage of beneficiaries who rate the quality of their health care as very good or excellent	Beneficiary survey	Descriptive; comparing institutional and community care experience, where appropriate; compare to national benchmarks	NCQA Benchmarks	Increase SUD and BH treatment options for youth (ages 12-17) and adult (18 and over) Medicaid recipients, particularly non-residential, step-up and step- down treatment options.
Percentage of beneficiaries who rate overall mental or emotional health as very good or excellent	Beneficiary survey	Descriptive; out-of-state comparison; compare to national benchmarks	NCQA Benchmarks National survey data (NSDUH: HEALTH, BRFSS: GENHLTH)	Increase SUD and BH treatment options for youth (ages 12-17) and adult (18 and over) Medicaid recipients, particularly non-residential, step-up and step- down treatment options.
Percentage of beneficiaries who demonstrate very good or excellent knowledge of available treatment and services	Beneficiary survey	Descriptive; comparing institutional and community care experience, where appropriate; out-of-state comparison	National survey data (NSDUH: NDTXDKWHR)	Increase SUD and BH treatment options for youth (ages 12-17) and adult (18 and over) Medicaid recipients, particularly non-residential, step-up and step- down treatment options.

Measure Description	Data Source	Analytic Approach	Comparison Group ¹	Primary Driver ²
Maternal depression ³	CUBS	Pre/post	Beneficiaries pre-implementation	Increase SUD and BH treatment options for youth (ages 12-17) and adult (18 and over) Medicaid recipients, particularly non-residential, step-up and step-down treatment options.
Maternal domestic abuse ⁴	CUBS	Pre/post	Beneficiaries pre-implementation	Increase SUD and BH treatment options for youth (ages 12-17) and adult (18 and over) Medicaid recipients, particularly non-residential, step-up and step-down treatment options.
Percentage of beneficiaries who experienced alcoholism or mental health disorder among household members	CUBS	Pre/post	Beneficiaries pre-implementation	Universally screen all Medicaid recipients, regardless of setting, using industry-recognized, evidence-based SUD screening instruments to identify symptoms, preventive measures, and intervene as early as possible before use becomes dependence.
Percentage of beneficiaries who witnessed violence or physical abuse between household members	CUBS	Pre/post	Beneficiaries pre-implementation	Universally screen all Medicaid recipients, regardless of setting, using industry-recognized, evidence-based SUD screening instruments to identify symptoms, preventive measures, and intervene as early as possible before use becomes dependence.

Measure Description	Data Source	Analytic Approach	Comparison Group ¹	Primary Driver ²
Percentage of youth beneficiaries who have ever been physically hurt by an adult in any way	CUBS	Pre/post	Beneficiaries pre-implementation	Increase SUD and BH treatment options for youth (ages 12-17) and adult (18 and over) Medicaid recipients, particularly non-residential, step-up and step-down treatment options.
Maternal marijuana or hash use in the past two years	CUBS	Pre/post	Beneficiaries pre-implementation	Increase SUD and BH treatment options for youth (ages 12-17) and adult (18 and over) Medicaid recipients, particularly non-residential, step-up and step-down treatment options.
Frequency of maternal marijuana or hash use (days per week)	CUBS	Pre/post	Beneficiaries pre-implementation	Increase SUD and BH treatment options for youth (ages 12-17) and adult (18 and over) Medicaid recipients, particularly non-residential, step-up and step-down treatment options.
Evaluation Hypothesis: The Demonstration will decrease the rate of drug overdoses and overdose deaths due to opioids				
Rate of overdose deaths, specifically overdose deaths due to any opioid	Vital Stats	Pre-post; out-of-state aggregate data comparison; Single year DiD	Beneficiaries pre-implementation Beneficiaries in Year 2 Regions Comparison to out-of-state data	Reduced overdose deaths, particularly those due to opioids by end of FY2024
Non-fatal Overdoses (all cause)	Claims Data	Pre-post; Single year DiD	Beneficiaries pre-implementation Beneficiaries in Year 2 Regions	Reduced overdose deaths, particularly those due to opioids by end of FY2024
Use of Opioids at High Dosage in Persons Without Cancer (NQF 2940)	Claims Data	Pre-post; compare to national benchmarks; Single year DiD	Beneficiaries pre-implementation Beneficiaries in Year 2 Regions NCQA Benchmarks	Reduced overdose deaths, particularly those due to opioids by end of FY2024

Measure Description	Data Source	Analytic Approach	Comparison Group ¹	Primary Driver ²
Evaluation Question: Does the Demonstration reduce the cost of Medicaid for Alaska and the Federal Government?				
Evaluation Hypothesis: The Demonstration will reduce Alaska's per capita Medicaid behavioral health costs.				
Total costs of health care (sum of parts below), by state and federal share	Claims Data	Panel Analysis (ITS)	Beneficiaries pre-implementation Beneficiaries in Year 2 Regions	Increase SUD and BH treatment options for youth (ages 12-17) and adult (18 and over) Medicaid recipients, particularly non-residential, step-up and step-down treatment options.
Total cost of SUD, SUD- IMD and SUD-Other and Non-SUD, by setting (including claims data (inpatient (IP), outpatient (OT), pharmacy (RX), long-term care (LT), and capitated payments to managed care organizations)	Claims Data	Panel Analysis (ITS)	Beneficiaries pre-implementation Beneficiaries in Year 2 Regions	Increase SUD and BH treatment options for youth (ages 12-17) and adult (18 and over) Medicaid recipients, particularly non-residential, step-up and step-down treatment options.
Total cost of behavioral health diagnosis by IMD and Other, by setting (including claims data (inpatient (IP), outpatient (OT), pharmacy (RX), long-term care (LT), and capitated payments to managed care organizations)	Claims Data	Panel Analysis (ITS)	Beneficiaries pre-implementation Beneficiaries in Year 2 Regions	Increase SUD and BH treatment options for youth (ages 12-17) and adult (18 and over) Medicaid recipients, particularly non-residential, step-up and step-down treatment options.

Measure Description	Data Source	Analytic Approach	Comparison Group ¹	Primary Driver ²
<p>¹Comparison groups are not necessarily mutually exclusive. Measures that utilize beneficiaries in year 2 regions will also utilize other comparison groups in order to evaluate the full duration of the Demonstration period.</p> <p>²Primary drivers were selected as the most relevant driver for the measure. Multiple primary drivers may relate to the measure.</p> <p>³This will be a composite measure of the following four questions from the CUBS survey (Phase 5, 2015-2018): During the past 3 months, how often have you felt down, depressed or hopeless? During the past 3 months, how often have you had little interest or little pleasure in doing things you usually enjoyed? During the past 3 months, how often have you felt down, depressed or hopeless OR had little interest or little pleasure in doing things? During the past 12 months, did a doctor, nurse or other health care or mental health provider talk to you about depression or how you are feeling emotionally?</p> <p>⁴This will be a composite measure of the following two questions from the CUBS survey (Phase 5, 2015-2018): During the past 12 months, did your husband or partner push, hit, slap, kick, choke or physically hurt you in any other way? During the past 12 months, did your husband or partner threaten you, limit your activities against your will or make you feel unsafe in any other way?</p>				

Documentation of Public Notice

Ongoing engagement with participating providers, interested parties, and the broader public has been a cornerstone of the 1115 Waiver. Alaska led a robust public engagement process in the design and development of the initial waiver application and has continued to garner critical input to guide Demonstration implementation and ongoing operations. Notably, the state led a series of roundtables to support the creation of the SUD implementation plan, soliciting provider input into topics including screening and assessment tools and processes, ASAM standards and training requirements, expanded use of pharmacotherapy, identification of evidence-based practices, and QAP provider standards. In addition to roundtables, within the first six months of implementation, the state held webinars, provider trainings, and convened a Continuum of Care/1115 Task Force comprised of providers, associations, and tribal representatives to identify challenges and inform planning and implementation.

The state engages in regular tribal consultation through Alaska Tribal Health System (ATHS) meetings, biannual Alaska Native Health Board MEGA Meetings, the Tribal Behavioral Health Director (TBHD) Quarterly Meetings, and the quarterly State Tribal Medicaid Task Force (MTF) Meetings. Monthly meetings are held with the Alaska Behavioral Health Association and the Alaska Mental Health Board to receive feedback from providers and beneficiaries with lived experience. Broader public engagement processes have been carried out as state regulatory changes were made, and DBH maintains a distribution list and email account for stakeholder comments, questions, and input on an ongoing basis. All public documents and public engagement opportunities are posted on the state's website:

<https://health.alaska.gov/dbh/Pages/1115/default.aspx>.

Throughout implementation of the Demonstration, the input, suggestions, and concerns received from providers and key stakeholders have provided critical direction on key policy and programmatic decisions, ranging from provider standards and training requirements, service definitions, claims processing and provider enrollment processes, and use of telehealth modalities.

In order to solicit feedback from interested parties during the drafting of the Demonstration extension application, Alaska held six "pre-release" stakeholder engagement sessions:

- Advisory Board on Alcoholism and Drug Abuse and Alaska Mental Health Board, September 9, 2022, virtual format
- Alaska Mental Health Trust Authority, September 16, 2022, virtual format
- Tribal Behavioral Health Directors, September 21, 2022, virtual format
- Alaska Hospital & Healthcare Association, September 23, 2022, virtual format
- Alaska Behavioral Health Association, September 30, 2022 and October 11, 2022, virtual format

Alaska values and appreciates input from all interested parties, and the pre-release sessions created an opportunity to include feedback from a range of stakeholders into the development of the Behavioral Health Reform Waiver extension application, in advance of the formal public

comment period. During these sessions, interested parties were encouraged to share feedback on the 1115 waiver to help inform the waiver narrative. Some of the topics of discussion included lessons learned, opportunities for improvement, strengths of the current waiver, biggest accomplishments, and future enhancements.

As the state prepares this Behavioral Health Reform Waiver extension application, we have continued to prioritize public engagement, in compliance with public notice processes as specified in 42 CFR section 431.408. Provider preferences, experiences, and concerns expressed at the “pre-release” stakeholder engagement sessions primarily related to lessons learned on administrative processes for provider enrollment and billing through an ASO model and identifying additional resources to support provider workforce stability through fee schedule changes and innovative Demonstration programs.

PUBLIC NOTICE PROCESS

Summary of Public Notice Process

In accordance with 42 CFR section 431.408 and 431.420(c), the state has complied with the public notice requirement. The state conducted a 30-day public notice and comment process from January 9, 2023 to February 8, 2023. This allowed the public and interested parties to provide input on the demonstration extension request. The state held two virtual public hearings to solicit feedback and comments. To encourage feedback and compliance with accessibility, a copy of the draft waiver was made accessible at the state’s dedicated waiver webpage and was available in hard copy.

Public Notice

The state verifies that public notice of the Behavioral Health Reform Waiver extension application was provided. A copy of the formal public notice is attached as *Appendix D* and a copy of the abbreviated public notice document is attached as *Appendix E*. Both documents are also available for viewing on the state’s website:

<https://health.alaska.gov/dbh/Pages/1115/default.aspx>.

The state verifies that a notice of the public comment opportunity was posted to the state’s Administrative Record. Alaska’s regulations also require public notices to be published to a widely distributed newspaper in the state. The state verifies that notice was posted to the Anchorage Daily News. The state used an electronic mailing list to notify the public of the extension, hearings, and opportunity to comment.

Public Hearings

The state held two public hearings during the 30-day notice and comment period. Due to the ongoing public health emergency in response to the COVID-19 pandemic, DBH received approval from CMS to conduct the public hearings virtually, *Appendix F*.

Meeting information for the two public hearings is listed below:

Public Hearing #1: Hosted virtually on January 20, 2023, from 9:30 – 11:30 am AKST

Public Hearing #2: Hosted virtually on January 27, 2023, from 9:30 – 11:30am AKST

Tribal Consultation

The department and DBH complied with the tribal consultation policy as outlined in the state plan and sent notice of opportunity for tribal consultation on the Behavioral Health Reform Waiver extension request to designated entities in accordance with 42 CFR § 431.408 on December 28, 2022. In alignment with the approved consultation policy, and at the request of Alaska Tribal Health Organizations (ATHOs), the state held an in-person meeting with Tribal representatives on January 20, 2023, engaging in meaningful discussions regarding the proposed submission. A copy of the formal correspondence sent soliciting input on the extension request can be found in *Appendix G*.

SUMMARY OF PUBLIC COMMENTS AND STATE RESPONSE

During the 30-day public comment period, DBH received oral comments from individuals representing two organizations during the public hearings and written comments from individuals representing seven organizations. Written comments included a collaborative submission reflecting the joint recommendations of six organizations. DBH reviewed and considered all comments received. The following summary provides themes of public comments received followed by the state's response.

Vision for the 1115 Waiver and Future Enhancements

Comment Summary: Commenters were supportive of waiver goals and DBH pursuing a waiver renewal. Several commenters encouraged DBH to transition waiver services to state plan authority to ensure sustainability of waiver services. Commenters also voiced a desire to collaborate with DBH to co-create a vision for sustainable state-funded behavioral health services in a planning process that includes engagement with communities, peers, and persons with lived experience. One commenter encouraged the state to pursue opportunities to implement the CCBHC model. Another commenter highlighted that a strong behavioral health care system was a necessary component of a broader strategy to address homelessness in Alaska.

Response: DBH appreciates the support for the waiver renewal application and appreciates input on future enhancements to the behavioral health delivery system. In the long-term, DBH intends to transition 1115 services to the Medicaid state plan once there is sufficient time to fully implement and evaluate the continuum of services. DBH will be considering further delivery system enhancements, such as health homes and CCBHCs as reform efforts continue, either through waiver amendments or alternative regulatory pathways. DBH is committed to ongoing partnership with providers and community members and appreciates the suggestion for the creation of a shared vision. DBH also agrees with the connection between behavioral health care and homelessness, and hopes to continue dialogue with stakeholders to identify further opportunities to support this vulnerable sub-population.

Administrative Streamlining

Comment Summary: Many commenters described significant administrative burdens experienced by providers in implementing the waiver services. Administrative challenges related to service authorizations, provider enrollment, and data entry requirements were cited as particular issues, and it was noted that these challenges have contributed to ongoing workforce shortages. Commenters noted a desire for similar obligations with non-behavioral health medical providers in terms of documentation requirements. Some commenters indicated that guidelines from the state were challenging to understand. Commenters made suggestions for DBH to streamline administrative processes and requested additional support, transparency, and responsiveness from DBH in navigating the administrative processes.

Response: DBH appreciates this feedback and welcomes input on opportunities to streamline administrative processes while maintaining compliance with federal guidance and state licensing requirements. Efforts to improve administrative functions will be pursued outside the scope of the 1115 waiver renewal process through state policy, regulations, and sub-regulatory actions that can be achieved alongside this request for ongoing authorities. DBH is open to partnering with providers to explore additional administrative improvements and provider supports.

Dependable Claims Payment

Comment Summary: Commenters raised concerns about claims processing, citing challenges experienced by many providers in receiving timely and accurate payments. Providers noted ongoing challenges with the ASO vendor and described experiences with inappropriate rejections, denials, missing claims, and other claims processing issues that contribute to the administrative burden and have resulted in financial losses. Commenters requested additional accountability for dependable claims payments. One commenter suggested that claims for behavioral health payment be incorporated into the standard MMIS fiscal agent system.

Response: DBH acknowledges the challenges experienced by providers regarding timely and accurate payment of behavioral health and SUD claims and the adverse impacts to providers. Efforts to improve administrative functions will be pursued outside the scope of the 1115 waiver renewal process. Specifically, DBH is actively utilizing its contractual oversight mechanisms with the ASO to monitor compliance with contractual obligations. DBH is committed to ongoing partnership and dialogue with providers as these issues are resolved.

Payment Rates

Comment Summary: Commenters expressed concerns about the reimbursement rates for services authorized under the waiver, indicating the current rates for many services do not reflect the cost of providing the services. Many commenters indicated that the reimbursement rates have created barriers to the expansion and full implementation of waiver services, and some indicated that these barriers were particularly salient for smaller, independent providers and providers in rural regions. Some commenters called for parity of payment rates between behavioral health services and medical services. Comments that provided suggestions to DBH

for improving payment rates included: rate increases, adoption of regular inflation adjustments and rate rebasing processes, implementation of a comprehensive rate review, and pairing Medicaid reimbursement with grant funding.

Response: DBH appreciates the feedback and acknowledges the need to increase reimbursement rates for waiver services. DBH is in the process of pursuing a 4.5% rate increase through the standard regulation adoption process. Once the regulation is in place, DBH is committed to operationalizing it as quickly as possible. The planned 4.5% increase is distinct from other future rate-setting and rebasing decisions and activities. DBH will continue to engage with community partners in conversations about service-specific rates.

Provider Capacity

Comment Summary: Commenters described the level of effort required for providers to implement new services under the waiver in terms of the up-front investment, administrative effort, and time needed for start-up. Commenters requested assistance from DBH in providing technical training to providers on business modeling, navigating the administrative processes to become enrolled and bill for services, and ongoing general support. Some commenters also requested financial resources to aid providers in starting-up new services. Commenters noted that these types of capacity building supports could improve access by encouraging providers in rural regions, as well as small, independent providers throughout the state to offer Medicaid services while also enabling existing Medicaid providers to expand their service offerings.

Response: DBH acknowledges the level of effort and investment required for providers to stand up new services and recognizes the need for start-up resources and ongoing provider supports and training on the 1115 waiver services. Efforts to improve provider capacity will be pursued outside the scope of the 1115 waiver renewal process. DBH remains committed to continued partnership with the provider community in strategically identifying mechanisms and resources to support start-up costs and system capacity building.

Workforce

Comment Summary: Commenters articulated significant challenges in recruiting and retaining qualified staff to provide waiver services. While comments noted administrative challenges and reimbursement rates as contributing factors to workforce shortages (as described above), some commenters also cited certification requirements as a barrier. One commenter specifically suggested updating a requirement in the QAP standards to replace CDC-2 with CDC-1 to reduce educational requirements. Commenters also suggested ongoing partnership with institutions of higher education to explore enhancements to training programs, creation of career ladders, and incentives for individuals to enter the workforce.

Response: DBH agrees that workforce supply is an ongoing issue that has preceded the 1115 waiver and must be addressed to realize the full benefits of the demonstration. While DBH appreciates input on enhancements to provider standards, certification requirements are not being addressed through the waiver renewal process, but rather state policy and regulations. DBH remains committed to continued partnership with the provider community in identifying

regulatory and sub-regulatory strategies to increase the supply of qualified providers. Additionally, DBH appreciates the suggestion to engage with educational partners, and will explore opportunities to do so.

Service Array

Comment Summary: While commenters were generally supportive of the continuum of services and the waiver of the IMD exclusion authorized by the demonstration, commenters provided specific feedback on a number of services:

- Mobile crisis units and crisis stabilization: Some commenters identified crisis services as an area for growth and improvement. One commenter indicated a need for investment in system setup and provider support and requested that funding not be reliant on multiple funding streams. Another commenter indicated support for the state's development of a crisis response system as critical in the state's response to homelessness.
- Community Recovery Support Services (CRSS): One commenter requested the addition of a specific code for family skill development
- Treatment Plans: One commenter requested modifications to the service description to align the service definition with billing limitations. Another commenter requested a telehealth qualifier for this service.
- Home-Based Family Treatment Level 2: One commenter requested amendments to the process for determining level of care criteria.
- Screening and Intervention Services: One commenter supported the state's focus on prevention and early intervention and praised the state's efforts in providing reimbursement for screening and brief intervention in primary care settings. The commenter supported further efforts to allow for payment for those services.
- Family Navigation: One commenter suggested the inclusion of family navigation services to support families in engaging in services and coordinating between health care, behavioral health, school, and IDD systems.

One commenter also reiterated support for the availability of grant funds to support provision of services that are not covered by Medicaid.

Response: DBH appreciates input on how to improve the service array authorized by the 1115 waiver. DBH also acknowledges the need for start-up and ongoing provider support and training on the 1115 waiver services, particularly for crisis services, which requires significant capacity development. While DBH is committed to identifying and allocating funds to support this capacity development, DBH must operate within the regulatory parameters that dictate how funding streams may be used. For instance, DBH was able to direct block grant and American Rescue Plan Act (ARPA) funds to build crisis system capacity, while the authorities granted in the 1115 waiver enable funding for the service component of Alaska's crisis responses system.

DBH also appreciates input on adjustments to service requirements and is committed to exploring opportunities to enhance service definitions and provider requirements through state

policy and regulations processes. DBH remains committed to continued partnership with the provider community as these efforts move forward.

Beneficiary Experience

Comment Summary: One commenter expressed concerns about beneficiary experience in navigating and receiving behavioral health services, characterizing the system as complex and burdensome, leading to barriers to access. The commenter suggested DBH engage with communities, peers, and people with lived experience in planning processes.

Response: DBH appreciates the input and is committed to ongoing partnership with providers and engagement with community members and persons with lived experience as implementation continues.

Geographic Considerations

Comment Summary: Many commenters expressed concerns about the availability of waiver services in certain regions of the state, particularly in rural and remote areas. These concerns were noted to be exacerbated by workforce challenges, administrative burdens, and timely and accurate payments, as described in other sections. One commenter referenced data presented in the Interim Evaluation Report, stating that there are no SUD billing providers in regions 3, 6, 7, and 9 of the state.

Response: DBH would like to clarify the data referenced in Table 5-7 of the Interim Evaluation. In summary, the table presents the number of Qualified Addiction Professionals (QAPs) who billed claims with alcohol/substance misuse diagnoses or relevant procedure/treatment or pharmacy codes. Provider regions were determined by mapping the zip code from provider reference data to regions. The table only reports providers who actually billed relevant services during the reporting period and does not report providers who were qualified to bill relevant services but who did not do so during the relevant reporting period. Additionally, since claims data are tied to the provider's primary location, rather than to a provider's satellite location or to the location of the beneficiary, DBH cannot determine where a service was provided, particularly in cases where a beneficiary located in regions 3, 6, 7, and 9 may have been served by a provider whose primary location is in one of the other regions, such as in a primary hub city or community, either in-person or via telehealth. Going forward, DBH plans to investigate alternative data sources and/or methodologies for the summative evaluation that would report the location of the client receiving such services from a QAP, rather than only the location of the provider. Since there are CMS requirements for metric definitions, some of which are very specific, and since the independent evaluator must follow the CMS-approved Evaluation Design, DBH may seek CMS permission to modify the definition of such metrics, and/or to additionally report at the client location level rather than solely at the provider location level. Retaining the provider location methodology would assist with multiyear comparisons and while adding a beneficiary location methodology would permit additional type and depth of analysis to better inform evidence-based decision making about program needs.

Data Availability

Comment Summary: Many commenters expressed concerns about the availability and completeness of data used to evaluate the waiver experience. Commenters requested ongoing and transparent data reporting on access, utilization, and investment across settings in the form of a public-facing dashboard. Other commenters expressed concerns about the use of claims data to evaluate access, quality, and cost neutrality. One commenter requested ongoing analyses of budget neutrality to evaluate progress toward system rebalancing.

Response: DBH acknowledges the importance of transparent and ongoing data sharing, especially with providers, to share progress in waiver implementation. That said, it is important to note the constraints in DBH's ability to share this information in a way that is timely and accurate. DBH submits regular data reports to CMS, which must allow time for claims runout, reporting, and review by CMS. These processes take a long time but must be completed before DBH can share them with the public. DBH is willing to engage with providers and others in identifying other opportunities to provide transparent updates into waiver progress.

DBH would also like to clarify that an assessment of the state's progress toward rebalancing goals would be most effectively addressed outside of the waiver budget neutrality calculations. The budget neutrality calculation compares spending under the waiver to expected spending absent the waiver. DBH is open to continued dialogue to establish a more effective methodology to track progress toward system rebalancing.

Technical Edits

Comment Summary: DBH received three comments requesting technical edits to the waiver renewal application. One commenter indicated that Table 1 listing the 1115 services did not include Children's Residential Treatment Level 2 or Treatment Plan Development Review and requested the services be added. The same commenter noted that the waiver renewal application stated that the 4.5% rate increase went into effect in October 2022, which was not accurate.

Response: DBH appreciates the feedback and suggestion for technical edits. The waiver renewal application has been updated for accuracy.

SUMMARY OF TRIBAL CONSULTATION AND STATE RESPONSE

As noted previously, at the request of Alaska Tribal Health Organizations (ATHOs), the state held an in-person meeting with Tribal representatives. The state received comments on the waiver renewal application from two tribal organizations. The following sections summarize themes from the comments received from ATHOs followed by the state's response.

1115 Waiver Vision and Early Successes

Comment Summary: Both commenters expressed support for the primary objectives of the 1115 waiver, particularly the focus on early intervention, rebalancing the system through expanding access to community-based services, and improving system accountability. Commenters identified successes in the implementation of the waiver, namely a broadened set of reimbursable services, the peer support services certification process, the waiver of IMD exclusion, enhanced focus on levels of care, and increased interest in standing up community-based programs. One commenter described the services and programs that they have been able to expand in the implementation of the waiver.

Commenters supported the waiver renewal and the state's direction to better integrate the SUD and mental health components of the waiver. One commenter recommended that DBH consider broadening the waiver to cover services to address social determinants of health (SDOH) in future waiver amendments. Both commenters requested that the Tribal health system be consulted as the state explores initiatives related to health homes and CCBHCs.

Response: DBH appreciates the support and ongoing partnership with the Tribal Health Organizations throughout the implementation of the waiver. DBH also appreciates the suggestion to explore opportunities to enhance the waiver through the addition of services to address SDOH. DBH is interested in exploring future enhancements through future waiver amendment processes or alternative regulatory pathways and is committed to further engagement to identify strategies that can address SDOH. DBH is committed to ongoing Tribal partnership as delivery system innovations such as health homes and CCBHCs are explored.

Data Sharing and Transparency

Comment Summary: Both commenters expressed concerns about the lack of timely and regular data sharing made available to providers and the public. Additionally, commenters questioned the methodologies and data sources used to evaluate the waiver experience. Specifically, the use of paid claims data to evaluate access, quality, and cost neutrality was called into question. Commenters requested access to ongoing and transparent data reports from the state to understand progress toward waiver goals and inform Tribal Health System planning but requested that additional data sharing not come at the expense of additional provider administrative burden. Commenters requested partnership with the state in data collection and evaluation activities.

Response: DBH appreciates the suggestion to share data with Tribal providers on a regular basis and acknowledges the Tribal Health System's need for accurate and timely data to inform programming and system planning. That said, it is important to note the constraints in DBH's

ability to share this information in a timely manner. DBH submits regular data reports to CMS, which must allow time for claims runout, reporting, and review by CMS. These processes take a long time but must be completed before DBH can share them with the public. DBH is willing to engage with providers and Tribal health leaders in identifying other opportunities to provide transparent updates into waiver progress.

Workforce Capacity

Comment Summary: Commenters described workforce shortages that preceded and were exacerbated by the pandemic and alluded to the importance of increasing reimbursement rates through the regulatory adoption process as a critical strategy to increase provider supply. Commenters suggested that DBH engage in partnerships with training programs, explore legislative or regulatory mechanisms for licensing reciprocity for providers moving to Alaska, and support the improvement of licensure renewal processes.

Commenters expressed concerns about the QAP certification and indicated that the one-year extension to meet requirements would not be sufficient. Concerns about the QAP certification were noted to lead to turnover and added costs to providers, and commenters suggested that the certification burden may have contributed to the evaluation finding that there were no billing providers in regions 3, 6, 7, 8, and 9. Upcoming changes to CDC counselor II (CDC II) and CDC supervisor (CDC-S) requirements were identified as additional threats that would disproportionately impact Tribal Health Organizations without a change to QAP requirements. One commenter recommended that DBH change the QAP requirement from a CDC II to a CDC I.

Response: DBH agrees that workforce supply is an ongoing issue that has preceded the 1115 waiver and must be addressed to realize the full benefits of the demonstration. While DBH appreciates input on potential changes to provider standards, certification requirements are not being addressed through the waiver renewal process, but rather state policy and regulations. DBH remains committed to continued partnership with the Tribal provider community in identifying regulatory and sub-regulatory strategies to increase the supply of qualified providers, particularly in light of upcoming changes to certification requirements. Additionally, DBH appreciates the suggestion to engage with educational partners, and will explore opportunities to do so.

DBH would also like to clarify the data referenced in Table 5-7 of the Interim Evaluation. Since claims data are tied to the provider's primary location, rather than to a provider's satellite location or to the location of the beneficiary, DBH cannot determine where a service was provided, particularly in cases where a beneficiary located in regions 3, 6, 7, and 9 may have been served by a provider whose primary location is in one of the other regions, such as in a primary hub city or community, either in-person or via telehealth. Going forward, DBH plans to investigate alternative data sources and/or methodologies for the summative evaluation that would report the location of the client receiving such services from a QAP, rather than only the location of the provider.

Administrative Burden and Claims Payment

Comment Summary: Both commenters indicated that the ASO added significantly to the administrative burdens experienced by providers, particularly related to service authorizations, separate 1115 waiver enrollment and claims processes, level of care documentation, and difficulty in finding accurate regulations and guidelines to stand up programs. These burdens have led providers to hire new administrative staff and incur additional costs. Commenters recommended that medical necessity be determined based on clinical documentation as one strategy to reduce administrative burden while remaining compliant with CMS guidance. Commenters also requested administrative simplification to reduce the need for duplicative enrollments, service authorizations, and data entry requirements, and assessment of clinical documentation requirements as compared to conventional health care documentation. Administrative burden was noted as a particular barrier for providers in rural and remote regions of the state. Commenters expressed concerns about the re-start of service authorizations following the expiration of the PHE.

Commenters also expressed concerns about claims processing and timely and accurate payment, resulting in financial losses experienced by providers and calling into question the validity of evaluation findings that relied on paid claims data. Commenters expressed a lack of confidence in the ASO to fulfill contractual obligations. One commenter suggested that the ASO hire staff that are familiar with Alaska and the Tribal health system.

Response: DBH acknowledges the administrative challenges that have resulted from the initial waiver implementation and appreciates this feedback and welcomes input on opportunities to streamline administrative processes. Efforts to improve administrative functions will be pursued outside the scope of the 1115 waiver renewal process through state policy, regulations, and sub-regulatory actions that can be achieved alongside this waiver renewal request. DBH also acknowledges the challenges regarding timely and accurate payment of behavioral health and SUD claims and the adverse impacts to providers. DBH is actively utilizing its contractual oversight mechanisms with the ASO to monitor compliance with contractual obligations. DBH is committed to ongoing partnership and dialogue with providers as these issues are resolved.

Assessment and Screening

Comment Summary: Both commenters supported the state's intentions to explore reimbursement for mental health and SUD screening and brief intervention outside of behavioral health settings. One commenter requested that the state provide flexibility to providers and consideration of cultural sensitivity as DBH considers future guidelines for screenings and assessments.

Response: DBH appreciates the support and agrees that it is necessary to reimburse providers outside of behavioral health settings in order to improve the system's ability to provide early interventions for behavioral health needs. DBH is committed to ongoing partnership with the Tribal health system as any changes to clinical and administrative processes are contemplated.

System Rebalancing

Comment Summary: Commenters referenced the recent Department of Justice report and acknowledged that while issues pre-dated the 1115 waiver, that the implementation of the waiver can help to address the underlying reliance on institutional care, including out-of-state placements. Commenters noted that the content of the report was particularly salient for Alaska Native people and emphasized the urgency of the need to rebalance the behavioral health system. Commenters requested partnership with the state to support infrastructure funding, technical assistance, programmatic start-up funding for at least three years, workforce development, housing for providers, and data to drive system improvements. Commenters also requested engagement to discuss modifications to service definitions to support service provision in rural and remote areas.

Response: DBH acknowledges that it is both urgent and important to reduce the over-reliance on institutional and out-of-state care and agrees that continued efforts toward implementing the robust continuum of community-based care envisioned by the 1115 waiver is the solution. DBH also acknowledges the level of effort and investment required for providers to stand up new services and recognizes the need for start-up resources and ongoing provider supports and training on the 1115 waiver services. Efforts to improve provider capacity and modifications to service definitions will be pursued outside the scope of the 1115 waiver renewal process. DBH remains committed to continued partnership with the Tribal health system in strategically identifying mechanisms and resources to support start-up costs and system capacity building, particularly in rural regions.

Tribal Engagement and Collaboration

Comment Summary: Commenters requested an agreed upon process for DBH and the Alaska Tribal health system to collaborate on the continued implementation of the waiver to ensure 1115 services are available in regions across the state. One commenter referenced a prior effort to engage with the state to address administrative burden which resulted in limited state participation. The commenter emphasized the need for state partnership to address barriers that are particularly impactful to Tribal providers due to workforce shortages and resource limitations, particularly in rural and remote regions. One commenter explained that Tribal behavioral health providers' expertise is needed to inform clinical guidance and achieve the desired outcomes, while providers need access to data from the state in order to respond to Alaskan's needs.

Response: DBH appreciates the feedback and commits to ongoing dialogue and collaboration with the Tribal health system to overcome the administrative challenges and improve upon our early experiences in implementing the 1115 waiver. As mentioned previously, DBH is open to exploring ways to improve data sharing and transparency.

SUMMARY OF REVISIONS:

In response to the comments received, minimal changes were made to the waiver renewal application. Three technical edits were made for accuracy, as noted above. Most comments focused on waiver implementation, describing experiences in providing the authorized services and providing recommendations for improvement. DBH appreciates the depth and breadth of feedback received and acknowledges that the implementation of the waiver is what will ultimately determine its success. While DBH does not intend to diminish the importance of the implementation or the feedback received, responses to the majority of feedback will not be reflected in changes the waiver renewal application. Rather, DBH will address feedback through state policy, regulations, and ongoing partnership with providers and other key stakeholders.

Appendix A: CMS Approval to Extend Application Submission Deadline

From: Nocito, Jack (CMS/CMCS) <[REDACTED]>
Sent: Monday, November 14, 2022 6:17 AM
To: Wall, Albert E (DOH) <[REDACTED]>; Carpenter, Heather R (DOH) <[REDACTED]>; Moreau-Johnson, Gennifer L (DOH) <[REDACTED]>; Brown, Farina E (DOH) <[REDACTED]>; Ricci, Emily K (DOH) <[REDACTED]>; King, Courtney O (DOH) <[REDACTED]>; Russell, Laura O (DOH) <[REDACTED]>
Cc: Risa Nakajima <[REDACTED]>; Kokkeler, Traci (CMS/CMCS) <[REDACTED]>; Garza, Maria (CMS/CMCS) <[REDACTED]>; Kazi, Paula (CMS/CMCS) <[REDACTED]>; Trieger, Michael (CMS/CMCS) <[REDACTED]>
Subject: RE: CMS acknowledges receipt of AK - Request for Extension - 1115 Waiver

CAUTION: This email originated from outside the State of Alaska mail system. Do not click links or open attachments unless you recognize the sender and know the content is safe

Hi Alaska team,

CMS accepts the state's request for a 60-day extension for its renewal application. This approval will allow the state to submit the renewal application for its "Alaska Substance Use Disorder and Behavioral Health Program (SUD-BHP)" 1115 demonstration to CMS no later than March 1, 2023.

Please keep me informed if the state would like to setup any ad-hoc calls to discuss transparency or needs any guidance with the renewal application.

Thank you.

Respectfully,

Jack Nocito, MPH
Lieutenant, U.S. Public Health Service
HHS/CMS/CMCS
Division of System Reform Demonstrations
7500 Security Boulevard, S2-24-04
Baltimore, MD 21244-1850

Appendix B: Budget Neutrality Worksheets

Interim Section 1115 Demonstration Application Budget Neutrality Table Shell

	A	B	C	D	E	F	G
1	5 YEARS OF HISTORIC DATA						
2							
3	SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:						
4							
5	SUD IMD	HY 1	HY 2	DY 01	DY 02	DY 03	5-YEARS
6	TOTAL EXPENDITURES			\$ 7,529,358	\$ 15,211,425	\$ 18,332,845	\$ 41,073,628
7	ELIGIBLE MEMBER MONTHS			677	1,280	1,461	
8	PMPM COST			\$ 11,121.65	\$ 11,883.93	\$ 12,548.15	
9	TREND RATES						3-YEAR
10				ANNUAL CHANGE			AVERAGE
11	TOTAL EXPENDITURE				102.03%	20.52%	56.04%
12	ELIGIBLE MEMBER MONTHS				89.07%	14.14%	46.90%
13	PMPM COST				6.85%	5.59%	6.22%
14							
15	SUD Non-IMD	HY 1	HY 2	DY 01	DY 02	DY 03	5-YEARS
16	TOTAL EXPENDITURES			\$ 24,564,096	\$ 23,088,716	\$ 57,193,269	\$ 104,846,081
17	ELIGIBLE MEMBER MONTHS			2,556,411	2,674,086	2,867,917	
18	PMPM COST			\$ 9.61	\$ 8.63	\$ 19.94	
19	TREND RATES						3-YEAR
20				ANNUAL CHANGE			AVERAGE
21	TOTAL EXPENDITURE				-6.01%	147.71%	52.59%
22	ELIGIBLE MEMBER MONTHS				4.60%	7.25%	5.92%
23	PMPM COST				-10.14%	130.97%	44.06%
24							
25	BH Non-IMD	HY 1	HY 2	DY 01	DY 02	DY 03	5-YEARS
26	TOTAL EXPENDITURES			\$ 3,645,492	\$ 4,961,739	\$ 69,329,383	\$ 77,936,615
27	ELIGIBLE MEMBER MONTHS			2,556,411	2,674,086	2,867,917	
28	PMPM COST			\$ 1.43	\$ 1.86	\$ 24.17	
29	TREND RATES						3-YEAR
30				ANNUAL CHANGE			AVERAGE
31	TOTAL EXPENDITURE				36.11%	1297.28%	336.09%
32	ELIGIBLE MEMBER MONTHS				4.60%	7.25%	5.92%
33	PMPM COST				30.12%	1202.84%	311.73%

HEALTH INSURANCE FLEXIBILITY AND ACCOUNTABILITY DEMONSTRATION COST DATA

	A	B	C	D	E	F	G	H	I	J	K
1	DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS										
2											
3											
4	ELIGIBILITY	TREND	MONTHS	BASE YEAR	TREND	DEMONSTRATION YEARS (DY)					TOTAL
5	GROUP	RATE 1	OF AGING	DY 05	RATE 2	DY 06	DY 07	DY 08	DY 09	DY 10	WOW
6											
7	SUD IMD										
8	Pop Type:	Medicaid									
9	Eligible Member Months	1.0%	24	1,490	1.0%	1,505	1,520	1,536	1,551	1,566	
10	PMPM Cost	6.7%	24	\$ 14,280.14	4.5%	\$ 14,922.75	\$ 15,594.27	\$ 16,296.01	\$ 17,029.33	\$ 17,795.65	
11	Total Expenditure					\$ 22,462,823	\$ 23,708,381	\$ 25,023,007	\$ 26,410,532	\$ 27,874,997	\$ 125,479,741
12											
13	SUD Non-IMD										
14	Pop Type:	Medicaid									
15	Eligible Member Months	-3.9%	24	2,648,582	1.0%	2,675,067	2,701,818	2,728,836	2,756,125	2,783,686	
16	PMPM Cost	26.7%	24	\$ 32.03	4.5%	\$ 33.47	\$ 34.98	\$ 36.55	\$ 38.19	\$ 39.91	
17	Total Expenditure					\$ 89,534,506	\$ 94,509,596	\$ 99,738,965	\$ 105,256,399	\$ 111,096,903	\$ 500,136,368
18											
19	BH Non-IMD										
20	Pop Type:	Medicaid									
21	Eligible Member Months	-3.9%	24	2,648,582	1.0%	2,675,067	2,701,818	2,728,836	2,756,125	2,783,686	
22	PMPM Cost	42.2%	24	\$ 48.89	4.5%	\$ 51.09	\$ 53.39	\$ 55.79	\$ 58.30	\$ 60.92	
23	Total Expenditure					\$ 136,669,193	\$ 144,250,067	\$ 152,241,774	\$ 160,682,065	\$ 169,582,143	\$ 763,425,242

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	DY 05	DEMO TREND RATE	DEMONSTRATION YEARS (DY)					TOTAL WW
			DY 06	DY 07	DY 08	DY 09	DY 10	
SUD IMD								
Pop Type: Medicaid								
Eligible Member Months	1,490		1,505	1,520	1,536	1,551	1,566	
PMPM Cost	\$ 14,280.14	4.5%	\$ 14,922.75	\$ 15,594.27	\$ 16,296.01	\$ 17,029.33	\$ 17,795.65	
Total Expenditure			\$ 22,462,823	\$ 23,708,381	\$ 25,023,007	\$ 26,410,532	\$ 27,874,997	\$ 125,479,741
SUD Non-IMD								
Pop Type: Medicaid								
Eligible Member Months	2,648,582		2,675,067	2,701,818	2,728,836	2,756,125	2,783,686	
PMPM Cost	\$ 32.03	4.5%	\$ 33.47	\$ 34.98	\$ 36.55	\$ 38.19	\$ 39.91	
Total Expenditure			\$ 89,534,506	\$ 94,509,596	\$ 99,738,965	\$ 105,256,399	\$ 111,096,903	\$ 500,136,368
BH Non-IMD								
Pop Type: Medicaid								
Eligible Member Months	2,648,582		2,675,067	2,701,818	2,728,836	2,756,125	2,783,686	
PMPM Cost	\$ 48.89	4.5%	\$ 51.09	\$ 53.39	\$ 55.79	\$ 58.30	\$ 60.92	
Total Expenditure			\$ 136,669,193	\$ 144,250,067	\$ 152,241,774	\$ 160,682,065	\$ 169,582,143	\$ 763,425,242

Panel 1: Historic DSH Claims for the Last Five Fiscal Years:

RECENT PAST FEDERAL FISCAL YEARS					
	20__	20__	20__	20__	20__
State DSH Allotment (Federal share)					
State DSH Claim Amount (Federal share)					
DSH Allotment Left Unspent (Federal share)	\$ -	\$ -	\$ -	\$ -	\$ -

Panel 2: Projected Without Waiver DSH Expenditures for FFYs That Overlap the Demonstration Period

FEDERAL FISCAL YEARS THAT OVERLAP DEMONSTRATION YEARS						
	FFY 00 (20__)	FFY 01 (20__)	FFY 02 (20__)	FFY 03 (20__)	FFY 04 (20__)	FFY 05 (20__)
State DSH Allotment (Federal share)						
State DSH Claim Amount (Federal share)						
DSH Allotment Projected to be Unused (Federal share)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Panel 3: Projected With Waiver DSH Expenditures for FFYs That Overlap the Demonstration Period

FEDERAL FISCAL YEARS THAT OVERLAP DEMONSTRATION YEARS						
	FFY 00 (20__)	FFY 01 (20__)	FFY 02 (20__)	FFY 03 (20__)	FFY 04 (20__)	FFY 05 (20__)
State DSH Allotment (Federal share)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
State DSH Claim Amount (Federal share)						
Maximum DSH Allotment Available for Diversion (Federal share)						
Total DSH Allotment Diverted (Federal share)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
DSH Allotment Available for DSH Diversion Less Amount Diverted (Federal share, must be non-negative)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
DSH Allotment Projected to be Unused (Federal share, must be non-negative)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Panel 4: Projected DSH Diversion Allocated to DYs

DEMONSTRATION YEARS					
	DY 01	DY 02	DY 03	DY 04	DY 05
DSH Diversion to Leading FFY (total computable)					
FMAP for Leading FFY					
DSH Diversion to Trailing FFY (total computable)					
FMAP for Trailing FFY					
Total Demo Spending From Diverted DSH (total computable)	\$ -	\$ -	\$ -	\$ -	\$ -

Budget Neutrality Summary

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 06	DY 07	DY 08	DY 09	DY 10	
<u>Medicaid Populations</u>						
SUD IMD	\$ 22,462,823	\$ 23,708,381	\$ 25,023,007	\$ 26,410,532	\$ 27,874,997	\$ 125,479,741
SUD Non-IMD	\$ 89,534,506	\$ 94,509,596	\$ 99,738,965	\$ 105,256,399	\$ 111,096,903	\$ 500,136,368
BH Non-IMD	\$ 136,669,193	\$ 144,250,067	\$ 152,241,774	\$ 160,682,065	\$ 169,582,143	\$ 763,425,242
<u>DSH Allotment Diverted</u>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
TOTAL	\$ 248,666,522	\$ 262,468,044	\$ 277,003,747	\$ 292,348,996	\$ 308,554,042	\$ 1,389,041,351

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 06	DY 07	DY 08	DY 09	DY 10	
<u>Medicaid Populations</u>						
SUD IMD	\$ 22,462,823	\$ 23,708,381	\$ 25,023,007	\$ 26,410,532	\$ 27,874,997	\$ 125,479,741
SUD Non-IMD	\$ 89,534,506	\$ 94,509,596	\$ 99,738,965	\$ 105,256,399	\$ 111,096,903	\$ 500,136,368
BH Non-IMD	\$ 136,669,193	\$ 144,250,067	\$ 152,241,774	\$ 160,682,065	\$ 169,582,143	\$ 763,425,242
TOTAL	\$ 248,666,522	\$ 262,468,044	\$ 277,003,747	\$ 292,348,996	\$ 308,554,042	\$ 1,389,041,351

VARIANCE	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
-----------------	------	------	------	------	------	------

Appendix C: Draft Interim Evaluation Report



State of Alaska Department of Health, Division of
Behavioral Health

Alaska Substance Use Disorder and Behavioral Health Program Section 1115 Waiver Evaluation

Interim Evaluation Report

December 2022



Table of Contents

Executive Summary	1
Conclusions	1
Overall Results	4
Lessons Learned and Recommendations	5
1. Background	1-1
Alaska’s Substance Use Disorder Landscape.....	1-1
Historical Background of Alaska’s Section 1115 Waiver.....	1-3
Demonstration Background.....	1-4
Demographics.....	1-8
Evaluation Activities	1-10
2. Evaluation Questions and Hypotheses	2-1
Demonstration Goals.....	2-1
Hypotheses and Research Questions.....	2-1
3. Methodology	3-1
Evaluation Design Summary.....	3-1
Evaluation Measures	3-3
Data Sources.....	3-5
Analytic Methods	3-8
4. Methodological Limitations	4-1
Evaluation Design	4-1
Data Sources.....	4-2
5. Results	5-1
Results Summary.....	5-1
6. Conclusions	6-1
Research Question 1	6-3
Research Question 2.....	6-4
Research Question 3.....	6-5
7. Interpretations, and Policy Implications, and Interactions with Other State Initiatives	7-1
Interpretations.....	7-1
Policy Implications.....	7-2
Interactions With Other State Initiatives	7-3
Background on Other State Initiatives	7-3
8. Lessons Learned and Recommendations	8-1
Provider Billing Procedures	8-1
Expanding Services	8-1

Executive Summary

The Alaska Department of Health (DOH) Section 1115 Demonstration Waiver renewal application, Substance Use Disorder and Behavioral Health (SUD-BH) Program, was approved by the Centers for Medicare & Medicaid Services (CMS) on November 21, 2018, effective January 1, 2019, through December 31, 2023.¹ The waiver allowed DOH to develop a data-driven, integrated BH system of care for children and youth with, or at risk of, severe emotional disturbance (SED) and/or SUD, and adults with serious mental illness (SMI) and/or SUD. The SUD-BH Program was designed to support three goals:

- **Goal 1:** Rebalance the current BH system of care to reduce Alaska’s over-reliance on acute, institutional care and shift to more community- or regionally based care.
- **Goal 2:** Intervene as early as possible in the lives of Alaskans to address BH symptoms before symptoms cascade into functional impairments.
- **Goal 3:** Improve the overall BH system accountability by reforming the existing system of care.

Pursuant to the special terms and conditions (STCs) of the Section 1115 Demonstration Waiver, DOH contracted with Health Services Advisory Group, Inc. (HSAG), as an independent evaluator to conduct a comprehensive evaluation of the SUD-BH Program. The goal of this evaluation is to provide CMS and DOH with an independent evaluation that ensures compliance with the Section 1115 Demonstration Waiver requirements; assist in both State and federal decision making about the efficacy of the Demonstration; and enable DOH to further develop clinically appropriate, fiscally responsible, and effective Medicaid demonstration programs. This is the Interim Evaluation Report for the SUD-BH Program Section 1115 Demonstration Waiver. This report evaluated the first three years of the demonstration waiver, January 1, 2019, through December 31, 2021. After the conclusion of the demonstration waiver in 2023, a Summative Evaluation Report will include an analysis of the full five-year demonstration period.

Conclusions

Goal 1

Evaluation of this goal was complicated by the coronavirus disease 2019 (COVID-19) public health emergency (PHE), which began one year after the start of the demonstration approval period and coincided with many implementation milestones. As a result, measures that assess utilization of services were adversely impacted by the PHE as lock-down orders were in effect.

Successes and challenges associated with Research Question 1 include the following.

Successes

- Increased number of practitioners providing SUD and BH services.
- Reduced emergency department (ED) visits specifically for opioid use disorder (OUD) and BH disorders.
- Improved rates of service utilization for SUD treatment.

¹ Centers for Medicare & Medicaid Services. Demonstration Approval. Available at: <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ak-behavioral-health-demo-benefits-amend-appvl-09032019.pdf>. (medicaid.gov). Accessed on Nov 4, 2022.

- Timelier initiation of treatment for SUD.

In addition, there were potential successes in a shift of the type of services that beneficiaries utilized. Specifically, among beneficiaries with a SUD, there appeared to be a shift from the outpatient (OP) setting to residential, inpatient (IP), and intensive outpatient/partial hospitalization (IOP/PH) settings. Because OP services were originally covered under the State plan but IP and IOP/PH were new services provided under the waiver, this may indicate that beneficiaries were not getting an appropriate level of care prior to the demonstration.

Challenges

Notable challenges include:

- Reduced percentage of beneficiaries screened for SUD or BH disorders.
- Lower rates of follow-up after discharge from an ED visit for SUD or BH disorder.

Lower rates of screening for SUD and BH disorders, chronic conditions, and SUD/BH comorbidities were likely driven by the COVID-19 PHE, as screening rates in 2019 were higher than in 2020 and 2021 and generally similar to 2018 rates; however, screening rates did not increase in 2021 following the reopening and the consequent delays in any routine, nonessential care.

Rates of follow-up visits after discharge from an ED for SUD or BH disorders also declined following approval of the demonstration in 2019, with seven-day follow-up rates declining by nearly 9 percentage points, a 20 percent relative decline, and 30-day follow-up rates declining by 8.4 percentage points, or a 14 percent relative decline. This represents a notable shift that is likely not attributable to the COVID-19 PHE, as rates began to decline in 2019 prior to the PHE.

Goal 2

This goal was measured using administrative claims data, beneficiary surveys, the Alaska Childhood Understanding Behaviors Survey (CUBS) instrument, and overdose data to address this research question. Because beneficiary surveys were conducted at a single point in time, no causal conclusions can be drawn, and results are interpreted in a descriptive manner.

Successes

Due in part to data limitations, there were no successes that could be attributed to the demonstration. However, there was a reduction in non-fatal overdoses among Alaska residents statewide (Medicaid and non-Medicaid recipients). Although analysis of the CUBS data indicates a reduction in frequency of maternal marijuana usage after the waiver approval, this decline was observed in 2020 and could be attributable to revisions in the survey instrument that year.

Among survey measures of Medicaid recipients, there were promising signs regarding the number of treatment services that were known to beneficiaries. No statistical testing was conducted because these surveys were conducted at a single point in time after approval of the demonstration and no viable comparison group could be used, but over half of beneficiaries indicated they knew where to receive SUD treatment (for both adults and children), while over two-thirds knew where to receive BH treatment. Among those who did know where to find treatment, every setting for adult treatment was known to over two-thirds of beneficiaries, and every setting for child treatment was known to at least 70 percent of beneficiaries.

Challenges

Notable challenges include:

- Reduced rates of access to preventive and primary care.
- Reduced screening for chronic conditions and SUD/BH comorbidities.
- Higher rates of statewide (including non-Medicaid) overdose deaths, including those from opioids.

Lower rates of access to preventive and primary care are likely attributable to the COVID-19 PHE because rates did not begin to decline until 2020 and 2021; however, there was no rebound in rates in 2021 following the reopening.

Similar to screening for SUD and BH disorders, lower rates of screening for chronic conditions and SUD/BH comorbidities were likely driven by the COVID-19 PHE, as screening rates in 2019 were higher than in 2020 and 2021 and generally similar to 2018 rates; however, screening rates did not increase in 2021 as the healthcare system reopened.

The increased rate of overdose deaths was exacerbated by the COVID-19 PHE, as was seen across the country during this time.² Data on Medicaid recipients specifically were not available, and all-cause overdose death rates did not increase substantially until state fiscal year (SFY) 2021. Opioid overdose deaths increased slightly in SFY 2020 and increased substantially in SFY 2021. Studies have shown that COVID-19 had a disproportionate impact on overdoses in rural areas.³

Goal 3

Costs for the waiver beneficiaries did not demonstrably change following implementation of the demonstration.⁴ Total costs among beneficiaries with a SUD diagnosis increased by 0.20 percent per month both before and after approval of the demonstration. Costs among beneficiaries with a BH diagnosis declined by 0.08 percent per month.

There were two notable increases in costs among the SUD population when examining costs by setting. Unsurprisingly, average institutions for mental disease (IMD) costs increased significantly following approval of the demonstration, which allowed Medicaid to reimburse a greater proportion of IMD stays. Long-term care (LTC) costs also increased significantly among the SUD population after approval of the demonstration.

Similar to the SUD population, IMD and LTC costs among the BH population also increased following the approval of the demonstration. It is important to note that because the SUD and BH populations are not mutually exclusive, it is possible that members in the BH population who were treated in an IMD were primarily there for SUD-related treatment. Additionally, pharmacy costs saw an increase in costs following approval of the waiver, which may signify that beneficiaries are receiving needed treatment that they had not been receiving prior to the waiver.

² Centers for Disease Control and Prevention. "Overdose Deaths Accelerating During COVID-19," Press Release, December 17, 2020. Available at: <https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html>; Accessed on: Nov 3, 2022.

³ Walters SM, *et al* "Structural and community changes during COVID-19 and their effects on overdose precursors among rural people who use drugs: a mixed-methods analysis." *Addiction Science & Clinical Practice* 17, 24(2022) Available at: <https://asepjournal.biomedcentral.com/articles/10.1186/s13722-022-00303-8>. Accessed on: Nov 8, 2022.

⁴ Note that the cost analyses do not refer to nor attempt to replicate the formal Budget Neutrality test required under the Section 1115 Demonstration Waiver program, which sets a fixed target under which waiver expenditures must fall that was set at the time the waiver was approved.

Overall Results

Results suggest that Alaska beneficiaries with a SUD or BH disorder were receiving more appropriate care after approval of the waiver than before approval. Beneficiaries with a SUD began reducing their utilization of OP services following the approval of the waiver and there were noticeable increases among new settings of care for treatment, such as IO/PH and residential IP. Similarly, beneficiaries with a BH disorder appeared to transition away from the OP and ED settings more permanently following the COVID-19 PHE in favor of telehealth. Beneficiaries with a BH disorder also exhibited a significant upward trend in pharmacy costs following the approval of the PHE, potentially indicating that these beneficiaries were receiving needed treatment.

There were also improvements in meeting the statewide target for average length of stay in an IMD of 30 days. The average length of stay in an IMD decreased significantly following approval of the demonstration, declining from over 76 days in 2018 to just under 27 days.

Finally, the number of providers billing for SUD services increased substantially following approval of the waiver. In 2018, only 17 providers billed for SUD services, who were located in two regions (Anchorage and Fairbanks). By 2021, 134 providers were billing for SUD services across five regions. The number of providers billing for BH services also increased following the demonstration, but at a lesser extent than SUD providers.

The COVID-19 PHE greatly impacted access to care in 2020 and 2021, which is evidenced by lower rates of SUD and BH screening and access to physical care in both 2020 and 2021. The decline in access to care measures is consistent with what has been seen nationally across Medicaid health plans. Improvements could be made, however, in follow-up visits after discharge from the ED for a SUD or BH disorder. Because follow-up visits after discharge from the ED specifically for OUD increased while they decreased for SUD generally, this suggests disproportionate handling of ED visits for OUD compared to alcohol or other drug abuse. Moreover, rates of follow-up visits are not as susceptible to the effects of the COVID-19 PHE as access to care measures, as national rates for Medicaid health plans did not decline substantially in 2020 or 2021.

Costs

It is too early in the demonstration to determine whether the demonstration will result in cost savings. The slight increase in costs among the SUD population was primarily driven by costs directly associated with a SUD diagnosis. Increases in cost trends were seen among the non-ED OP, LTC, and professional settings. Cost trends among the SUD population in the OP, ED OP, dental, and pharmacy settings.

The slight decline in the cost trend among the BH population was primarily driven by a decline in OP (both ED and non-ED), LTC, and dental costs. The trend in costs increased significantly for pharmacy and increased slightly among professional and IP settings.

The cost analysis thus far centered on overall costs to Medicaid. Additional research is needed as more post-implementation data points are gathered to assess the impact at the individual level. It is possible that as the demonstration matures, the impact on overall costs may not result in a reduction, given various stages in SUD or BH treatment among the population. That is, at the individual level, the trajectory of costs increases initially as members receive treatment before beginning to decline as the lower cost of treatment leads to lower costs over the longer run. In aggregate however, because at any given point in time there are individuals in all stages of treatment, this individual effect is unlikely to translate to an overall reduction in costs (unless the proportion of beneficiaries with a SUD fundamentally decreases). HSAG expects that with additional data points being available to assess beneficiary-level costs in the Summative Evaluation Report, a more robust panel analysis can be conducted to evaluate the trajectory of costs at the member level following waiver implementation.

Lessons Learned and Recommendations

Provider Billing Procedures

- **Issue:** Providers noted some frustration regarding the changes made to and differences between State plan codes and waiver codes
 - **Recommendation:** The State should assess the State plan codes that were replaced or duplicated by waiver codes to ensure there is not a disincentive for billing waiver codes. For example, one provider noted that the waiver code for peer support services had fewer hours associated with it than the State plan code, which provides a disincentive to bill the waiver code.

Expanding Services

- **Issue:** Several providers expressed difficulties in obtaining clearance through a background check for peers to provide peer support services.
 - **Recommendation:** The State should continue working with the Division of Health Care Services to streamline or expedite the approval process or provide financial incentives for peers so they are encouraged to remain in the program while their paperwork is being approved.
- **Issue:** From the evaluation, gaps were found in the number of providers billing for SUD services, particularly in rural/frontier regions.
 - **Recommendation:** The State should ensure that the certification process for becoming a Qualified Addiction Professional (QAP) who provides SUD services is simplified to the extent appropriate and that providers are educated on the process to encourage providers to expand the types of services offered.

1. Background

Section 1115 of the Social Security Act allows states the ability to design and test their own methods for providing and funding healthcare services that differ from services required by federal statute but meet the objectives of the federal Medicaid program and Children’s Health Insurance Program (CHIP). Thus, Section 1115 waiver demonstrations allow states flexibility in how to operate and fund their healthcare. The Centers for Medicare & Medicaid Services (CMS) designed a national evaluation strategy to ensure demonstrations meet program objectives while also comparing to other states’ Section 1115 Medicaid waivers.

CMS approved the substance use disorder (SUD) portion of Alaska Department of Health (DOH) Department of Behavioral Health’s (DBH’s) Section 1115 Waiver Demonstration application, Substance Use Disorder and Behavioral Health (SUD-BH) Program, on November 21, 2018. The SUD portion of the waiver demonstration took effect January 1, 2019, and the entirety of the waiver application, which included the behavioral health (BH) portion of the waiver, started on September 3, 2019, with an overall demonstration period of January 1, 2019, through December 31, 2023. The following section outlines the history, guidance, and application of the SUD-BH Program including the goals of the demonstration, timelines for evaluation, and demographics of the beneficiaries, both in total and program specific in accordance with CMS’ special terms and conditions (STCs) of the waiver.¹⁻¹

Alaska’s Substance Use Disorder Landscape

In line with national trends, opioid use and overdose in Alaska became significantly more prevalent over the last decade. Since 2008, deaths involving opioids have been at historical highs and, while small improvements were made at the turn of the last decade, the most recently available data showed that Alaskan opioid death counts continued to rise from 2013 to 2018.¹⁻² By 2021, opioid-related overdose deaths nearly quadrupled from 2010, averaging 27.3 per 100,000 deaths.¹⁻³ From 2017 to 2021, 546 of Alaska’s 778 overdose deaths involved opioids, slightly over 70 percent.¹⁻⁴ While opioid misuse was not exclusive to the State of Alaska, self-reported opioid misuse in the last year was higher in Alaska compared to national trends, with 3.8 percent of Alaskans reporting misuse of any opioids and 6.2 percent of Alaskans reporting illicit drug use, compared to national rates of 3.5 percent and 4.9 percent, respectively, in 2020.¹⁻⁵ According to the 2019–2020 National Survey on Drug Use and Health (NSDUH), 18.0 percent of Alaskan adults reported binge alcohol use in the past month, compared to a national rate of 15.7 percent; 10.2 percent of Alaskans had a SUD, compared to a national rate of 7.4 percent;¹⁻⁶ and 6.7 percent of Alaskans reported needing but not receiving treatment for illicit drug use in the past year,

¹⁻¹ Centers for Medicare & Medicaid Services. Demonstration Approval. Available at: <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ak-behavioral-health-demo-benefits-amend-appvl-09032019.pdf>. (medicaid.gov). Accessed on: Aug 9, 2022.

¹⁻² Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2020 on CDC WONDER Online Database released in 2021. Data are from the Multiple Cause of Death Files, 1999-2020, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. 2020. Available at: <http://wonder.cdc.gov/mcd-icd10.html>. Accessed on: Aug 5, 2022.

¹⁻³ Alaska Department of Health. 2021 Drug Overdose Mortality Update. Available at: https://health.alaska.gov/dph/VitalStats/Documents/PDFs/DrugOverdoseMortalityUpdate_2021.pdf. Accessed on: Aug 9, 2022

¹⁻⁴ Ibid.

¹⁻⁵ Kaiser Family Foundation. State Health Facts: Mental Health & Substance Use. Available at: <https://www.kff.org/state-category/mental-health/alcohol-drug-dependence-and-abuse/>. Accessed on: Aug 10, 2022.

¹⁻⁶ Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer, Alaska, Volume 6. Available at: https://www.samhsa.gov/data/sites/default/files/reports/rpt32818/Alaska-BH-Barometer_Volume6.pdf. Accessed on: Aug 8, 2022.

compared with a national rate of 4.8 percent.¹⁻⁷ Self-reported opioid use was also higher among Alaskans, with 4.8 percent reporting pain reliever use disorder in the past year, compared to 3.7 percent nationwide, and 0.7 percent reported heroin use in the past year, compared to 0.3 percent nationally.¹⁻⁸ Notably, alcohol misuse was prominent in Alaska, which ranked eighth in the nation for highest prevalence rate of adult binge drinking in 2021.¹⁻⁹

The need for BH services, which often coincided with the need for SUD treatment, was more prominent among Alaskans than the nation as a whole. Data from the 2020 Behavioral Risk Factor Surveillance System (BRFSS) showed that 9.9 percent of Alaskans and 11.8 percent of Alaska Natives reported frequent mental distress, defined as 14 or more days per month of poor mental health.¹⁻¹⁰ In addition, Alaska's 2020 suicide rate of 28.0 per 100,000 Alaskans was more than twice the 2015 national rate of 12.32 per 100,000 Alaskans, and the Alaska Native population was over two times as likely to complete suicide than non-Alaska Natives.¹⁻¹¹ With rates of mental illness, suicide, illicit and opioid drug use, overdose deaths, and binge drinking stable or on the rise, and in line with or surpassing national trends, Alaskans continued to need services for SUD and BH as well as intervention to address downstream effects that further perpetuate the need for these services.

For example, with the rising rates of adult SUD between 2007 and 2016, the percentage of Medicaid-covered infants diagnosed with neonatal abstinence syndrome increased nearly fourfold, from 4.4 percent to 16.9 percent.¹⁻¹² In addition, children living with adults with SUD and other BH ailments were known to have experienced adverse childhood experiences (ACEs) that placed them at a significantly higher likelihood of risky behaviors such as substance misuse, alcoholism, smoking, and unsafe sex practices and subsequent sexually transmitted infections (STIs). Children with a high prevalence of ACEs were more likely to experience physical and mental morbidities including certain cancers, obesity, depression, or premature mortality including suicide, in adulthood.¹⁻¹³ In 2019, the prevalence of children living with an adult with SUD in Alaska was 13.0 percent, and the prevalence of living with an adult with mental illness was 11.3 percent, compared to 8.5 percent and 7.4 percent nationally, respectively.¹⁻¹⁴ The higher rates of ACEs in Alaska not only coincided with higher rates of adult SUD and BH ailment, they also perpetuated a cycle of high rates of SUD and BH ailment as ACE-affected children aged into adulthood with an increased aptitude to partake in risky behaviors. As a result, there was a clear need for intervention across all age groups in Alaska.

¹⁻⁷ Kaiser Family Foundation. State Health Facts: Mental Health & Substance Use. Available at: <https://www.kff.org/state-category/mental-health/alcohol-drug-dependence-and-abuse/>. Accessed on: Aug 10, 2022.

¹⁻⁸ Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer, Alaska, Volume 6. Available at: https://www.samhsa.gov/data/sites/default/files/reports/rpt32818/Alaska-BH-Barometer_Volume6.pdf. Accessed on: Aug 8, 2022.

¹⁻⁹ The Drinks Business. These are the drunkest states in America, ranked. Available at: <https://www.thedrinksbusiness.com/2021/08/these-are-the-drunkest-states-in-america-ranked/>. Accessed on: Aug 10, 2022.

¹⁻¹⁰ Centers for Disease Control and Prevention. BRFSS Prevalence & Trends Data. Available at: <https://www.cdc.gov/brfss/index.html>. Accessed on: Aug 9, 2022.

¹⁻¹¹ Alaska Department of Health and Social Services. Alaska Vital Statistics 2020 Annual Report. Available at: https://health.alaska.gov/dph/VitalStats/Documents/PDFs/VitalStatistics_AnnualReport_2020.pdf. Accessed on: Aug 9, 2022.

¹⁻¹² Department of Health and Human Services. Centers for Medicare & Medicaid Services. State Demonstrations Group [letter]. March 21, 2019. Available at: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ak/behavioral-health/ak-behavioral-health-demo-appvd-implementation-20190321.pdf>. Accessed on: Aug 9, 2022.

¹⁻¹³ Felitti VJ, Anda RF, Nordenberg D, et al. Am. J Prev Med. Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. 1998;14(4). Available at: <https://www.ajpmonline.org/action/showPdf?pii=S0749-3797%2898%2900017-8>. Accessed on: Aug 9, 2022.

¹⁻¹⁴ United Health Foundation. America's Health Rankings. Adverse Childhood Experiences, Alaska. 2019. Available at: https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/overall_mch/state/AK?edition-year=2019. Accessed on: Aug 10, 2022.

Further exacerbating the challenges of providing SUD and BH interventions in Alaska was the unique infrastructure of the State. While Alaska is the largest state in terms of land mass, the comparative population density of Alaskan cities was far less than average cities in the lower 48 states. For example, Alaska's largest city, Anchorage, had an estimated population of 288,121 in 2021, much smaller than many cities in the lower 48 states that had populations upwards of one million.¹⁻¹⁵ In addition, Alaskan communities are widely distanced, often inaccessible by road, and are medically underserved as a result. Due to the large geographic size and small population size of Alaska, SUD and BH support in many communities is less accessible and healthcare professionals are less numerous than in communities in the contiguous United States. Additionally, weather conditions constantly pose a challenge for accessibility, given Alaska's northern and unforgiving climate.

Lastly, Alaska consists of a diverse population with 229 Federally recognized tribes, 20 different native languages, and a growing immigrant population throughout the State. To serve the tribal population, Alaska is home to 37 tribal health organizations, many of which were grant recipients from DBH. The diversity of the population presents challenges for providing culturally and regionally appropriate care

Historical Background of Alaska's Section 1115 Waiver

Alaska's Medicaid system, run through DOH, provides healthcare to the State's eligible population. Alaska's Medicaid is operated on a fee-for-service (FFS) model through DenaliCare and Denali KidCare, Alaska's CHIP.¹⁻¹⁶ The program has operated since September 1972 when it was established under Title XIX of the Social Security Act.¹⁻¹⁷

In September 2015, Alaska expanded Medicaid under the Patient Protection and Affordable Care Act (ACA), providing coverage to all adults ages 19–64 with an income of 138 percent or less, or under the federal poverty level (FPL). The expansion decreased the rate of uninsured Alaskans by 39 percent between 2010 and 2019. A total of 247,581 Alaskans were covered under Medicaid or CHIP as of May 2021.¹⁻¹⁸

Due to the need to address the mental health of its population, the Alaska State Legislature passed two reform bills during the 29th Legislature in 2016. The first, Senate Bill (SB) 74, was a Medicaid reform packaged aimed at reducing fraud, waste, operational barriers, and administrative burden while also building a comprehensive and integrated BH system. The bill encouraged telehealth service expansion, encouraged the integration of social services into mental healthcare, and mandated payment reform. SB 74 gave direction to DOH to submit a State plan amendment or apply for waivers, including Section 1115 waiver demonstrations of the Social Security Act, to achieve the goals listed.¹⁻¹⁹

The second bill, SB 91, was a criminal justice reform effort that reduced sentencing guidelines for nonviolent offenders. Money saved from reducing the population of correctional facilities was reinvested into programs that would encourage potential reoffenders from reoffending. The bill was expected to increase the demand of community-based treatment and community-based recovery supports. However, the BH system was already

¹⁻¹⁵ United States Census Bureau. Quick Facts. Available at:

<https://www.census.gov/quickfacts/fact/table/anchagemunicipalityalaska.US/PST045221>. Accessed on: Aug 9, 2022.

¹⁻¹⁶ Alaska Department of Health. Division of Public Assistance. Available at: <https://health.alaska.gov/dpa/Pages/default.aspx>. Accessed on: Aug 9, 2022.

¹⁻¹⁷ HealthInsurance.org. Alaska and the ACA's Medicaid Expansion. Available at: <https://www.healthinsurance.org/medicaid/alaska/>. Accessed on: Aug 9, 2022.

¹⁻¹⁸ Ibid.

¹⁻¹⁹ State of Reform. Unpacking Alaska's Medicaid reform bill SB 74. Available at: <https://stateofreform.com/news/alaska/2016/03/unpacking-alaskas-medicaid-reform-bill-sb-74/>. Accessed on: Aug 9, 2022.

strained prior to SB 91, creating a need to reform the system.¹⁻²⁰ SB 91 was eventually repealed in 2019 by House Bill (HB) 49 and HB 14.¹⁻²¹

A 2016 concept paper was released in response to key reform mandates as a prelude to the Section 1115 waiver demonstration. The concept paper outlined the high-level goals, key target populations, and the overall vision with which the waiver needed to comply. These goals included:

1. Expansion of treatment capacity and improved access to services.
2. Integration of care.
3. Cost and outcomes reform.
4. Provider payment and accountability reform.
5. Delivery system reform.¹⁻²²

DBH submitted an application for a Section 1115 waiver demonstration with a SUD and BH focus on January 31, 2018, with principles of the concept paper included.¹⁻²³

The Alaska Department of Health and Social Services (DHSS) began reorganization on March 19, 2022, into two departments including DOH and the Department of Family Community Services (DFCS).¹⁻²⁴ DBH was subsequently included in DOH and performed the same roles and responsibilities as prior to the reorganization. DHSS was officially split into DOH and DFCS on July 1, 2022.

Demonstration Background

On January 31, 2018, DOH submitted an application for a Medicaid Section 1115 Demonstration Project from CMS to develop a data-driven, integrated behavioral healthcare system for children and adults with serious mental illness (SMI), severe emotional disturbance (SED), and/or SUD. In addition, the demonstration aimed to increase services for at-risk families to support the healthy development of children and adults through various BH interventions. On November 21, 2018, CMS approved the SUD component of the SUD-BH Program while the BH component was under review, allowing the SUD component to take effect January 1, 2019. On September 3, 2019, CMS approved the SUD-BH in its entirety, with an overall demonstration period of January 1, 2019, through December 31, 2023. In brief, the purpose and goal of the SUD-BH Program was to increase access to SUD and BH services for Alaskans to anticipate or eliminate crises and strengthen a continuum of care, including early intervention services and community support. Specific goals, with their unique objectives of the SUD-BH Program, are illustrated in Figure 1-1.

¹⁻²⁰ Alaska Legislature. Senate Bill No. 91. Available at: <https://www.akleg.gov/PDF/29/Bills/SB0091A.PDF>. Accessed on: Aug 9, 2022.

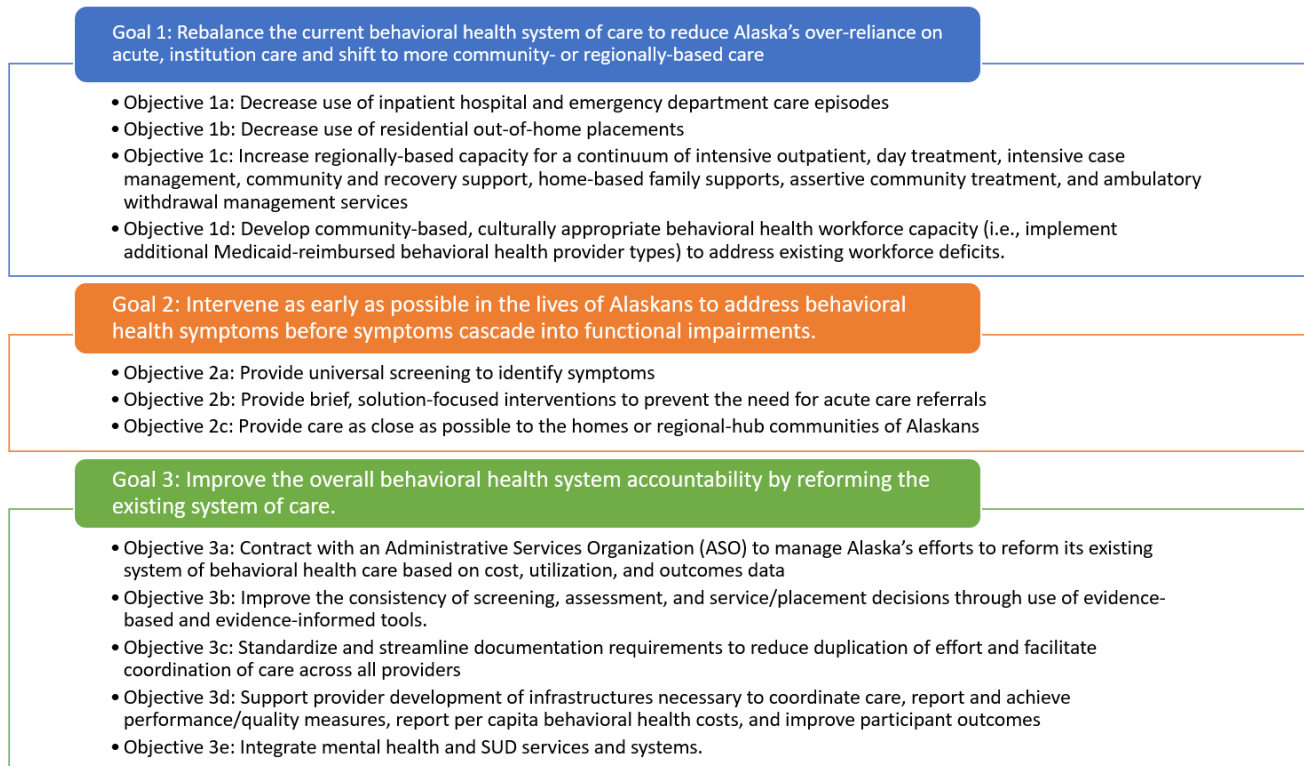
¹⁻²¹ Anchorage Daily News. Alaska Senate votes to repeal and replaces most of SB 91. Available at: <https://www.adn.com/politics/alaska-legislature/2019/05/29/alaska-senate-votes-to-repeal-and-replace-most-of-sb-91-sending-crime-bill-to-governors-desk/>. Accessed on: Aug 9, 2022.

¹⁻²² Alaska Department of Behavioral Health. Alaska Behavioral health Reform 1115 Waiver Concept Paper. Available at: https://health.alaska.gov/dbh/Documents/1115/1115_ConceptPaper1-5-17wAppendix.pdf. Accessed on: Aug 9, 2022.

¹⁻²³ Alaska Department of Health and Social Services. Medicaid Section 1115 Behavioral Health Demonstration Application. Available at: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ak/behavioral-health/ak-behavioral-health-demo-pa.pdf>. Accessed on: Aug 3, 2022.

¹⁻²⁴ Alaska Department of Health and Social Services, DHSS Reorganization. Available at: <https://dhss.alaska.gov/pages/default.aspx> Accessed on Dec. 5, 2022.

Figure 1-1—SUD-BH Goals and Objectives ¹⁻²⁵



Implementation of SUD-BH Program

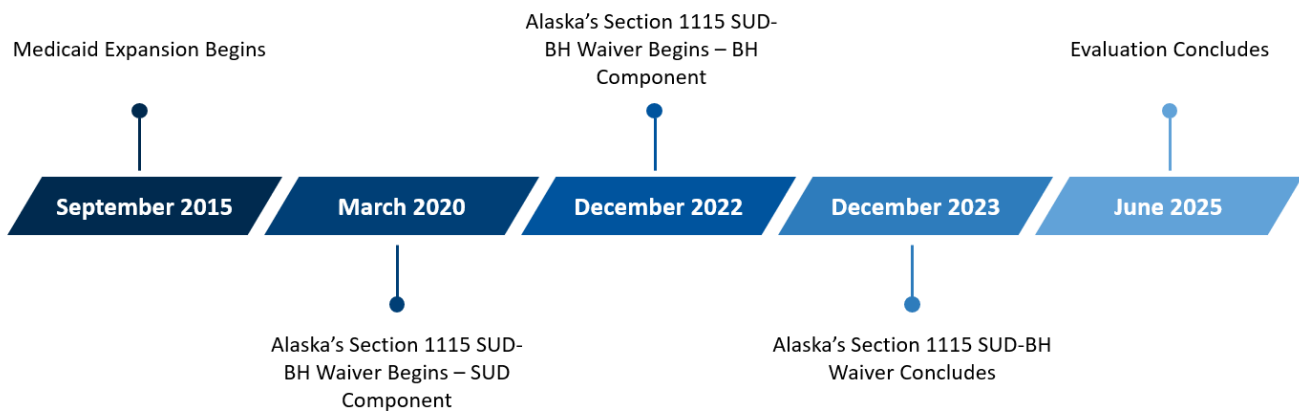
While the demonstration consists of a SUD and a BH component, the implementation plan included only elements of the SUD portion of the waiver. The Implementation Plan was approved by CMS on March 21, 2019, and outlined the State’s strategies to implement each of the six milestones of the SUD portion of the waiver. During the five-year demonstration period, Alaska intends to have a particular emphasis on the first two years and aims to cover approximately one half of the State population under the SUD portion of the waiver in Demonstration Year 1 and the other half by the end of Demonstration Year 2. The implementation was organized by key milestones identified by CMS and used nine Alaskan geographic regions to phase-in the waiver implementation in segments.¹⁻²⁶ However, the implementation of the SUD-BH waiver was instead completed by the readiness of providers to transition. Providers that were deemed more “sophisticated” and had the resources to implement the waiver did so in the first year while all other providers waited until the second year to complete implementation.

Figure 1-2 displays a timeline of the key demonstration milestones for the SUD-BH Program.

¹⁻²⁵ Ibid.

¹⁻²⁶ Centers for Medicare & Medicaid Services. Alaska 1115 Substance Use Disorder Waiver Implementation Plan—Final, March 13, 2019. Available at: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ak/behavioral-health/ak-behavioral-health-demo-appvd-implementation-20190321.pdf>. Accessed on: Aug 11, 2022.

Figure 1-2—Timeline of the SUD-BH Demonstration



Program Population

The waiver impacted three Alaskan Medicaid beneficiary population groups. Medicaid eligibility standards were not altered as a result of the Section 1115 waiver demonstration.

- **Group 1:** Children, adolescents, and their parents or caretakers with or at risk of mental health disorders and SUDs
- **Group 2:** Transitional age youth and adults with acute mental health needs
- **Group 3:** Adults, adolescents, and children with SUDs

Group 1: Given that a significant proportion of Alaska’s children and adolescents encounter the child welfare system or juvenile justice system at some point in their upbringing, the waiver intended to strengthen the support system for this group in hopes of preventing crises and reducing the need for out-of-home placements. Beneficiaries in Group 1 were under the supervision or in the custody of the Alaska DOH Office of Children’s Services, the Division of Juvenile Justice, or in tribal custody; formerly in kinship care, foster care, or residential care; or at risk of an out-of-home placement. Waiver services for this population included home-based family treatment, intensive case management (ICM), partial hospitalization program (PHP) services, intensive outpatient (IOP) services, children’s residential treatment (CRT) level 1, and therapeutic treatment homes.

Group 2: Group 2 comprised transitional age youth and adults who experienced mental health disorders and had comorbidities or dual diagnoses of intellectual, developmental, or sensory disabilities making their care needs more complex. For Group 2, waiver services included assertive community treatment services, ICM, PHP services, adult mental health residential services, and peer-based crisis services.

Group 3: Group 3 consisted of adults, adolescents, and children between 12 and 64 years of age who had at least one diagnosis for substance-related and addictive disorders from the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), or the most current version.

Waiver services for this group were aimed at enhancing the availability of and providing a more comprehensive continuum of SUD treatment and included:

- Opioid treatment services
- IO services
- PHP services
- Residential treatment
- Medically monitored intensive inpatient (IP) services
- Medically managed intensive IP services
- Ambulatory withdrawal management
- Clinically managed residential withdrawal management
- Medically monitored IP withdrawal management
- Medically managed intensive IP withdrawal management

Select waiver services replaced State plan services while others were added as new services. Waiver services complied with American Society of Addiction Medicine (ASAM) level-of-care criteria to place patients in the right setting at the right time.¹⁻²⁷

Administrative Services Organization

DOH contracted with an administrative services organization (ASO) to provide service delivery reform and was determined to be necessary after completing readiness assessments. The ASO, Optum, was onboarded to help provide the capacity needed to support an enhanced BH system envisioned by the waiver demonstration. DOH provided several goals for Optum to achieve:

1. Increase regional access to appropriate BH services;
2. Improve health outcomes for all publicly funded beneficiaries of BH services (i.e., Medicaid and non-Medicaid State and federal grant funded BH programs); and
3. More efficiently and effectively manage the cost of BH service delivery in Alaska.¹⁻²⁸

Optum worked with the State to provide additional capacity to assist the State with providing SUD and BH services. Key responsibilities of Optum included but were not limited to:

- Developing a database to track BH screenings.
- Developing a monitoring protocol.
- Providing prior and service authorizations when needed (e.g., all services above ASAM Level 2.5).
- Reducing barriers to patients' intake process.
- Establishing a 1-800 call center.
- Conducting on-site reviews.

¹⁻²⁷ Alaska Department of Health and Social Services. Medicaid Section 1115 Behavioral Health Demonstration Application. Available at: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ak/behavioral-health/ak-behavioral-health-demo-pa.pdf>. Accessed on: Aug 9, 2022.

¹⁻²⁸ Ibid.

- Providing ASAM trainings.
- Monitoring providers' performance and report results to DBH.
- Creating evidence-based system for clinical guidelines.

Optum worked closely with tribal health organizations (THOs) and honored the government-to-government relationship required between tribes and the State of Alaska.¹⁻²⁹

Workforce Development and Training Requirements

Alaska routinely encounters difficulties recruiting and retaining qualified SUD and BH providers due to the unique landscape of the State. Different from other states, Alaska has an entity called the Alaska Mental Health Trust Authority (the Trust) which facilitates a comprehensive and integrated mental health program instead of the federal government facilitating this type of program. The Trust helped to facilitate the recruiting and retaining of providers and provided access to training resources, however, many initiatives fell outside the scope of the waiver.

The Alaska Training Cooperative (AKTC) was developed by the Trust, University of Alaska, and providers across the State prior to the waiver demonstration implementation. However, in response to the readiness assessments conducted in preparation of the waiver demonstration by DBH, the AKTC was made responsible for providing the education and training needed. Continuing education (CE) was offered on a web-based platform and integrated evidence-based practices with traditional practices.¹⁻³⁰

Demographics

The SUD-BH Program waiver is intended to target three groups of Medicaid recipients:

- **Group 1:** Children, adolescents, and their parents or caretakers with or at risk of mental health disorders and SUDs
- **Group 2:** Transitional age youth and adults with acute mental health needs
- **Group 3:** Adults, adolescents, and children with SUDs

Individuals in Group 1 are under 21 years of age and currently in the custody or under the supervision of the Alaska Department of Health and Social Services' Office of Children's Services, the Division of Juvenile Justice, or in tribal custody; formerly in kinship care, foster care, or residential care; or at risk of an out-of-home placement. Group 2 is composed of transitional age youth and adults (16–24 years of age) who experience mental health disorders with complex co-morbidities or dual diagnoses of intellectual, developmental, or sensory disabilities. Group 3 includes adults, adolescents, and children between 12 and 64 years of age who have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders for substance-related and addictive disorders.

¹⁻²⁹ Department of Health and Human Services. Centers for Medicare & Medicaid Services. State Demonstrations Group [letter]. March 21, 2019. Available at: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ak/behavioral-health/ak-behavioral-health-demo-appvd-implementation-20190321.pdf>. Accessed on: Aug 9, 2022.

¹⁻³⁰ Alaska Department of Health and Social Services. Medicaid Section 1115 Behavioral Health Demonstration Application. Available at: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ak/behavioral-health/ak-behavioral-health-demo-pa.pdf>. Accessed on: Aug 9, 2022.

Figure 1-3 illustrates monthly population count by waiver group from 2018 through 2021. Group 1 and Group 3 population counts increased from 2018 through the start of the SUD-BH Program and into the beginning of 2020. Both groups demonstrated a similar drop in counts following the coronavirus disease 2019 (COVID-19) public health emergency (PHE). Group 2 exhibited the opposite trend; population counts decreased after the start of the SUD-BH Program and increased in the period after the COVID-19 PHE began.

Figure 1-3—Monthly Population Count by Waiver Group, 2018–2021

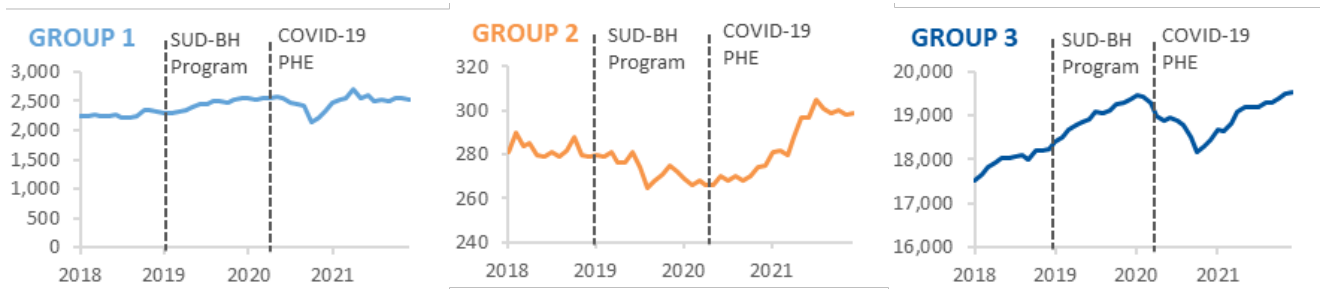


Figure 1-4 shows that 38 percent of Group 1 and Group 3 beneficiaries and over half of Group 2 beneficiaries were enrolled in Medicaid for a full 12 months in 2021. Nearly one-third of Group 1 beneficiaries had fewer than six months of Medicaid enrollment in 2021, compared to 18 percent and 25 percent of Group 2 and Group 3 beneficiaries, respectively.

Figure 1-4—Duration of Medicaid Enrollment by Waiver Group, 2021

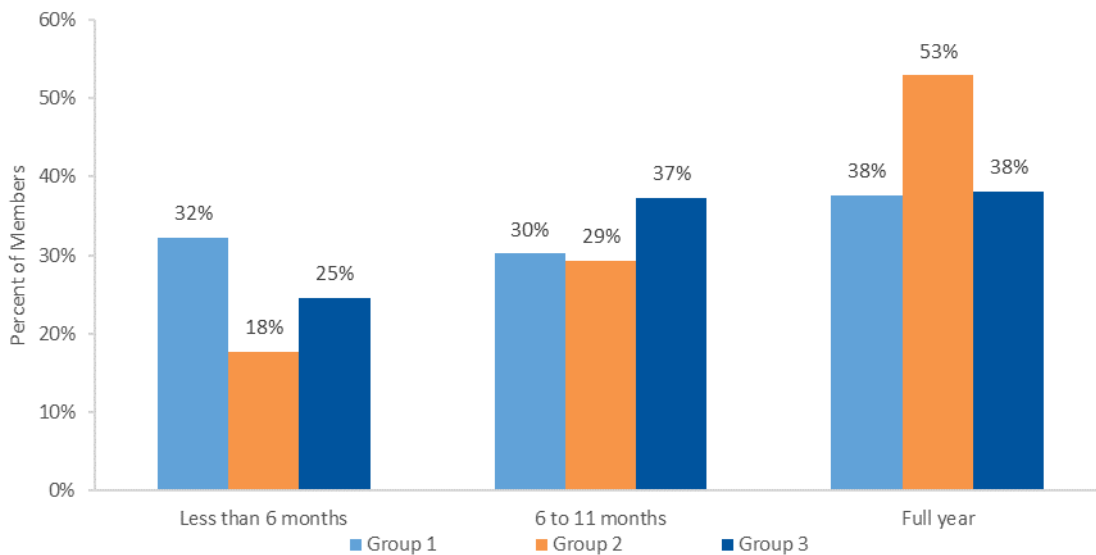
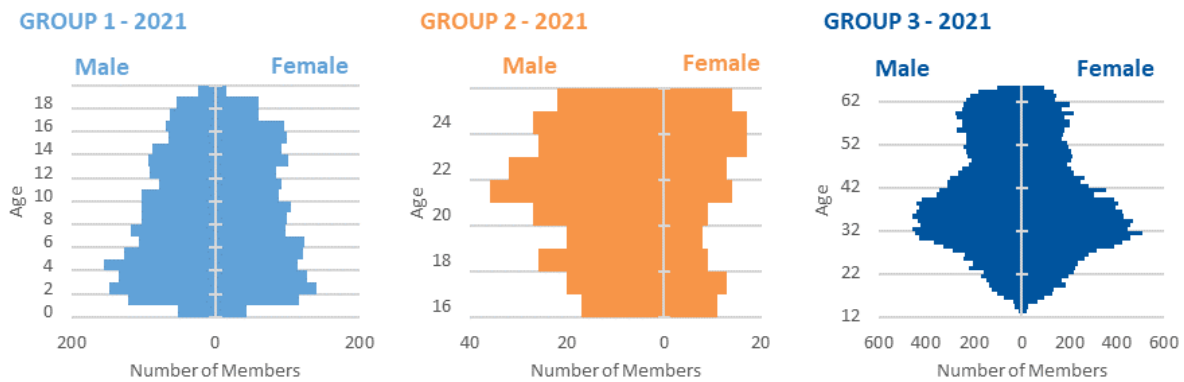


Figure 1-5 illustrates the age and gender distribution of waiver beneficiaries in 2021. The Group 2 population is skewed toward having more males than females, accounting for two-thirds of the group’s total population counts. Additionally, the Group 3 population has relatively more older males enrolled compared to older females.

Figure 1-5—Age and Gender Distribution by Waiver Group, 2021



Evaluation Activities

In response to the STCs, DBH contracted with an independent evaluator, Health Services Advisory Group, Inc. (HSAG), to conduct comprehensive evaluations (i.e., interim and summative) of the SUD-BH Program, Alaska’s Medicaid Section 1115 waiver demonstration.¹⁻³¹ The purpose of this evaluation is to provide CMS and DBH with an independent evaluation of the SUD-BH Program, ensure compliance with Medicaid Section 1115 requirements and provide recommendations to improve program efficacy along the way.

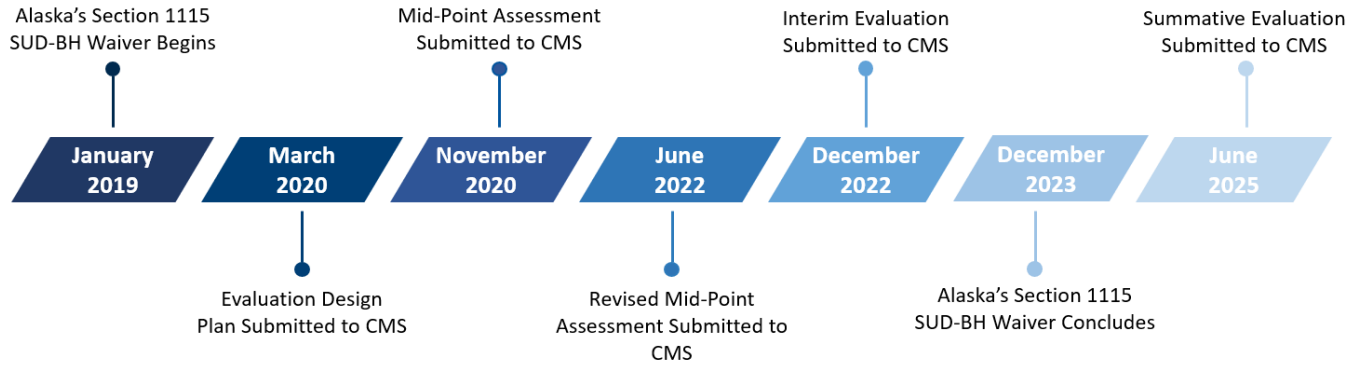
- **Evaluation Design Plan**—The plan for how to accomplish the evaluation explaining how it is expected to achieve the goals of the waiver along with specifying hypotheses, evaluation questions, associated measures, and analytic methods. The evaluation design plan for the SUD-BH Program was developed by DBH, revised by HSAG, and approved by CMS on April 5, 2021.¹⁻³²
- **Mid-Point Assessment (MPA)**—The report on the status of the implementation process of the SUD-BH Program including monitoring metric results on six milestones from CMS. The report was developed by HSAG and submitted to CMS on November 27, 2020. The MPA was revised to comply with updated CMS standards and resubmitted June 30, 2022.
- **Interim Evaluation Report**—The report will include the goals of the evaluation, the hypotheses related to the demonstration, and the methodology of the evaluation. The report will provide interpretations of the findings; assessments of the outcomes; explanations on the limitations of the design, data, and analyses; and recommendations to the State from January 1, 2019, to December 31, 2021.
- **Summative Evaluation Report**—The report will follow the same structure as the interim report for the entirety of the demonstration period (January 1, 2019, to December 31, 2023).

Figure 1-6 displays the timeline of the evaluation activities.

¹⁻³¹ Centers for Medicare & Medicaid Services. CMS Initial Approval - No Implementation Plan. Available at: <https://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ak/behavioral-health/ak-behavioral-health-demo-appvd-implementation-20190321.pdf>. Accessed on: Aug 9, 2022.

¹⁻³² Centers for Medicare & Medicaid Services. CMS Approved SUD Evaluation Design. Available at: <https://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ak/ak-behavioral-health-demo-ca.pdf>. Accessed on: Aug 9, 2022.

Figure 1-6—Timeline of Evaluation Activities



2. Evaluation Questions and Hypotheses

The primary purpose of the interim evaluation is to determine whether the Substance Use Disorder and Behavioral Health (SUD-BH) Program is achieving the three goals outlined in the Background section. This section provides the program’s logic models, hypotheses, and research questions, which focus on evaluating the impact of these goals.

Demonstration Goals

The SUD-BH Program supports improvements to achieve three primary goals (cited earlier in this report):

1. Rebalance the current BH system of care to reduce Alaska’s over-reliance on acute, institutional care and shift to more community- or regionally based care.
2. Intervene as early as possible in the lives of Alaskans to address BH symptoms before symptoms cascade into functional impairments.
3. Improve the overall BH system accountability by reforming the existing system of care.

These goals are consistent with the six goals for the SUD-BH Program provided by the Centers for Medicaid & Medicare Services (CMS):²⁻¹

CMS Goal 1: Increased rates of identification, initiation, and engagement in treatment for substance use and BH issues by the end of fiscal year (FY) 2024.

CMS Goal 2: Increased adherence to and retention in substance use and BH treatment by the end of FY2024.

CMS Goal 3: Reduced overdose deaths, particularly those due to opioids by the end of FY2024.

CMS Goal 4: Reduced utilization of emergency departments (EDs) and inpatient (IP) hospital settings for substance use and BH treatment where the utilization is preventable or medically inappropriate through improved access to other more appropriate and focused services by the end of FY2024.

CMS Goal 5: Reduced readmissions to the same or higher level of care where readmission is preventable or medically inappropriate by the end of FY2024.

CMS Goal 6: Improved access to care for physical health conditions among beneficiaries by the end of FY2024.

To accomplish these goals, the SUD-BH Program includes key activities and interventions to develop a data-driven, integrated BH system for children and adults with serious mental illness (SMI), severe emotional disturbance (SED), and/or SUD.

Hypotheses and Research Questions

Three research questions led to the development of six hypotheses, each of which were identified to comprehensively evaluate the goals of the SUD-BH Program. Hypotheses were developed based on the potential

²⁻¹ Centers for Medicare & Medicaid Services. CMS Approval SUD Evaluation Design. Available at: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ak/ak-behavioral-health-demo-ca.pdf>. Accessed on: Oct 25, 2022.

for improvement, the ability to measure performance, and the use of comparison groups to isolate the effects of the SUD-BH Program and the interventions. The research questions and hypotheses are presented in Table 2-1.

Table 2-1—SUD-BH Program Research Questions and Hypotheses




Research Questions	Hypotheses
Does the SUD-BH Program increase access to and utilization of SUD and BH disorder treatment services by increasing access to community-based care?	<p>The SUD-BH Program will increase the number of beneficiaries in the waiver population who are referred to and engage in treatment for SUD and BH disorders in sub-acute, community, or regionally based OP settings.</p> <p>The SUD-BH Program will decrease utilization of EDs, IP, or institutional settings within the beneficiary population.</p> <p>The SUD-BH Program will increase the percentage of beneficiaries who adhere to treatment for SUD and BH disorders.</p>
Do enrollees receiving SUD services experience improved health outcomes?	<p>The SUD-BH Program will increase the percentage of beneficiaries with SUD or a BH disorder who experience care for comorbid conditions.</p> <p>The SUD-BH Program will decrease the rate of drug overdoses and overdose deaths due to opioids.</p>
Does the SUD-BH Program reduce the cost of Medicaid for Alaska and the federal government?	<p>The SUD-BH Program will reduce Alaska’s per capita Medicaid BH costs.</p>




Logic Model

A logic model was developed which relates the goals of CMS and the SUD-BH Program, the primary drivers that contribute to achieving the goals, and the secondary drivers that are necessary to achieve the primary drivers.

Table 2-2 illustrates the logic model for the SUD-BH Program.

Table 2-2—SUD-BH Program Logic Model

 CMS Goals	 Primary Drivers¹	 Secondary Drivers²
<p>Goal 1: Increased rates of identification, initiation, and engagement in treatment for substance use and BH issues by the end of FY2024</p>	<ol style="list-style-type: none"> 1. Universally screen all Medicaid recipients, regardless of setting, using industry-recognized, evidence-based SUD screening instruments to identify symptoms for preventive measures and intervene as early as possible before use becomes dependence. 2. Implement ASAM Criteria (3rd Edition) to match individuals with SUD with the services and tools necessary for recovery. 3. Increase SUD and BH treatment options for youth (ages 12–17) and adult (ages 18 and older) Medicaid recipients, particularly non-residential, step-up, and step-down treatment options. 	<p><u>Milestone #1:</u> Access to Critical Levels of Care for SUD Treatment</p> <p><u>Milestone #2:</u> Use of Evidence-Based, SUD-Specific Patient Placement Criteria</p> <p><u>Milestone #5:</u> Implementation of Comprehensive Treatment & Prevention Strategies to Address Opioids</p> <p><u>Milestone #6:</u> Improved Care Coordination and Transitions Between Levels of Care</p>

 <p>CMS Goals</p>	 <p>Primary Drivers¹</p>	 <p>Secondary Drivers²</p>
<p>Goal 2: Increased adherence to and retention in substance use and BH treatment by the end of FY2024</p>	<ol style="list-style-type: none"> 1. Implement ASAM Criteria (3rd Edition) to match individuals with SUD with the services and tools necessary for recovery. 2. Increase SUD and BH treatment options for youth (ages 12–17) and adult (ages 18 and older) Medicaid recipients, particularly nonresidential, step-up, and step-down treatment options. 	<p><u>Milestone #1:</u> Access to Critical Levels of Care for SUD Treatment <u>Milestone #2:</u> Use of Evidence-Based, SUD-Specific Patient Placement Criteria <u>Milestone #5:</u> Implementation of Comprehensive Treatment & Prevention Strategies to Address Opioids <u>Milestone #6:</u> Improved Care Coordination and Transitions Between Levels of Care</p>
<p>Goal 3: Reduced overdose deaths, particularly those due to opioids, by the end of FY2024</p>	<ol style="list-style-type: none"> 1. Universally screen all Medicaid recipients, regardless of setting, using industry-recognized, evidence-based SUD screening instruments to identify symptoms for preventive measures and intervene as early as possible before use becomes dependence. 2. Implement ASAM Criteria (3rd Edition) to match individuals with SUD with the services and tools necessary for recovery. 3. Increase SUD and BH treatment options for youth (ages 12–17) and adult (ages 18 and older) Medicaid recipients, particularly non-residential, step-up, and step-down treatment options. 4. Improve SUD provider infrastructures and capacity utilizing industry recognized standards for certification and ongoing accountability (with emphasis on residential providers, but across-the-board). 5. Improve SUD workforce by carefully reviewing existing certification requirements and modifying as appropriate to align with Medicaid Waiver and industry-recognized credentialing standards. 	<p><u>Milestone #1:</u> Access to Critical Levels of Care for SUD Treatment <u>Milestone #2:</u> Use of Evidence-Based, SUD-Specific Patient Placement Criteria <u>Milestone #3:</u> Use of Nationally Recognized SUD-specific Program Standards for Residential Treatment Facility Provider Qualifications <u>Milestone #4:</u> Sufficient Provider Capacity at Critical Levels of Care <u>Milestone #5:</u> Implementation of Comprehensive Treatment & Prevention Strategies to Address Opioids <u>Milestone #6:</u> Improved Care Coordination and Transitions Between Levels of Care</p>
<p>Goal 4: Reduced utilization of EDs and IP hospital settings for substance use and BH treatment where the utilization is preventable or medically inappropriate through improved access to other more appropriate and focused services by the end of FY2024</p>	<ol style="list-style-type: none"> 1. Implement ASAM Criteria (3rd Edition) to match individuals with SUD with the services and tools necessary for recovery. 2. Increase SUD and BH treatment options for youth (ages 12–17) and adult (ages 18 and older) Medicaid recipients, particularly non-residential, step-up, and step-down treatment options. 3. Improve SUD provider infrastructures and capacity utilizing industry-recognized standards for certification and ongoing accountability (with emphasis on residential providers, but across-the-board). 	<p><u>Milestone #1:</u> Access to Critical Levels of Care for SUD Treatment <u>Milestone #2:</u> Use of Evidence-Based, SUD-Specific Patient Placement Criteria <u>Milestone #3:</u> Use of Nationally Recognized SUD-specific Program Standards for Residential Treatment Facility Provider Qualifications <u>Milestone #4:</u> Sufficient Provider Capacity at Critical Levels of Care <u>Milestone #5:</u> Implementation of Comprehensive Treatment & Prevention Strategies to Address Opioids <u>Milestone #6:</u> Improved Care Coordination and Transitions Between Levels of Care</p>

 CMS Goals	 Primary Drivers¹	 Secondary Drivers²
<p>Goal 5: Fewer readmissions to the same or higher level of care where readmission is preventable or medically inappropriate by the end of FY2024</p>	<ol style="list-style-type: none"> 1. Implement ASAM Criteria (3rd Edition) to match individuals with SUD with the services and tools necessary for recovery. 2. Increase SUD and BH treatment options for youth (ages 12–17) and adult (ages 18 and older) Medicaid recipients, particularly non-residential, step-up, and step-down treatment options. 3. Improve SUD provider infrastructures and capacity utilizing industry-recognized standards for certification and ongoing accountability (with emphasis on residential providers, but across-the-board). 	<p><u>Milestone #1:</u> Access to Critical Levels of Care for SUD Treatment <u>Milestone #2:</u> Use of Evidence-Based, SUD-Specific Patient Placement Criteria <u>Milestone #3:</u> Use of Nationally Recognized SUD-specific Program Standards for Residential Treatment Facility Provider Qualifications <u>Milestone #4:</u> Sufficient Provider Capacity at Critical Levels of Care <u>Milestone #5:</u> Implementation of Comprehensive Treatment & Prevention Strategies to Address Opioids <u>Milestone #6:</u> Improved Care Coordination and Transitions Between Levels of Care</p>
<p>Goal 6: Improved access to care for physical health conditions among beneficiaries by the end of FY2024</p>	<ol style="list-style-type: none"> 1. Increase SUD and BH treatment options for youth (ages 12–17) and adult (ages 18 and older) Medicaid recipients, particularly non-residential, step-up, and step-down treatment options. 2. Improve SUD provider infrastructures and capacity utilizing industry recognized standards for certification and ongoing accountability (with emphasis on residential providers, but across-the-board). 3. Improve SUD workforce by carefully reviewing existing certification requirements and modifying as appropriate to align with Medicaid Waiver and industry-recognized credentialing standards. 	<p><u>Milestone #1:</u> Access to Critical Levels of Care for SUD Treatment <u>Milestone #2:</u> Use of Evidence-Based, SUD-Specific Patient Placement Criteria <u>Milestone #3:</u> Use of Nationally Recognized SUD-specific Program Standards for Residential Treatment Facility Provider Qualifications <u>Milestone #4:</u> Sufficient Provider Capacity at Critical Levels of Care</p>

Causality ←
Causality ←

¹ Primary drivers are major domains through which Alaska may accomplish the six goals adapted from CMS’ special terms and conditions (STCs).

² Secondary drivers are from Alaska’s implementation plan, utilizing key milestone identified by CMS.

Note: ASAM: American Society of Addiction Medicine; BH: behavioral health; ED: emergency department; FY: fiscal year; SUD: substance use disorder; IP: inpatient.

3. Methodology

The primary goal of an impact assessment in policy and program evaluation is to establish a causal relationship between the introduction of a policy or program and related outcomes. To accomplish this, a comparison of outcomes between the intervention group and a valid counterfactual—the intervention group had its members not been exposed to the intervention—must be made. The gold standard for experimental design is a randomized controlled trial which would be implemented by first identifying an intervention population, and then randomly assigning individuals to the intervention and the rest to a control group, which would serve as the counterfactual. However, random assignment is rarely feasible in practice, particularly as it relates to healthcare policies.

As such, a variety of quasi-experimental or observational methodologies have been developed for evaluating the effect of policies on outcomes. The research questions presented in the previous section will be addressed through at least one of these methodologies. The selected methodology largely depends on data availability factors relating to (1) data to measure the outcomes, (2) data for a valid comparison group, and (3) data collection during the time periods of interest—typically defined as one or two years prior to implementation and annually thereafter. Table 3-1 illustrates a list of analytic approaches that will be used as part of the evaluation and whether the approach requires data gathered at the baseline (i.e., pre-implementation), requires a comparison group, or allows for causal inference to be drawn. It also notes key requirements unique to a particular approach.

Table 3-1—Analytic Approaches

Analytic Approach	Baseline Data	Allows Causal Inference	Notes
Interrupted time series	✓	✓	Requires sufficient data points prior to and following implementation
Trend analysis	✓		Requires multiple baseline data points
Pre-test/post-test	✓		
Descriptive time series analysis			Relies on descriptive interpretation; does not involve statistical testing

Evaluation Design Summary

The evaluation design of the Substance Use Disorder and Behavioral Health (SUD-BH) Program utilized a mixed-methods evaluation design.³⁻¹ Quantitative methods included descriptive statistics showing change over time in both counts and rates for specific metrics, or interrupted time series (ITS) analysis to assess whether the waiver interventions effected changes across specific outcome measures. A valid comparison group could not be used because data were unavailable for a comparable population not targeted by the intervention. Initially, the State had planned on implementing the waiver through a regional phased approach, which would allow for a comparison between regions that had implemented the demonstration and those that had not. However, due to delays in implementation including those caused by the coronavirus disease 2019 (COVID-19) public health emergency (PHE), this phased roll-out did not occur. Additionally, out-of-state Medicaid data through the

³⁻¹ Centers for Medicare & Medicaid Services. CMS Approval SUD Evaluation Design. Available at: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ak/ak-behavioral-health-demo-ca.pdf>. Accessed on: Aug 26, 2022.

Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF) were not available or viable at the time of evaluation for the interim report. T-MSIS data from other states may be viable for the Summative Evaluation Report, but only covering a limited period of the demonstration due to the two-to-three year data lag.

Beneficiary surveys were used to assess beneficiaries' rating of their personal doctor, health plan, and overall healthcare. A qualitative component of the waiver was also completed. Providers, provider stakeholders, tribal health organizations (THOs), and State administrators were interviewed during the first three demonstration years to share their view of the SUD-BH Program.

Target and Comparison Populations

The SUD-BH Program targeted three groups of Medicaid recipients:

- **Group 1:** Children, adolescents, and their parents or caretakers with or at risk of mental health disorders and SUDs
- **Group 2:** Transitional age youth and adults with acute mental health needs
- **Group 3:** Adults, adolescents, and children with SUDs

Analysis of measures utilizing administrative Medicaid claims and eligibility data were limited to these groups of interest. In accordance with Centers for Medicare & Medicaid Services' (CMS') guidance for analyzing costs associated with Section 1115 SUD and serious mental illness (SMI)/severe emotional disturbance (SED) demonstrations,³⁻² beneficiaries were included in the cost analyses beginning with the first month in which a relevant SMI/SED or SUD diagnosis or treatment claim was observed, and for the subsequent 11 additional months following. When beneficiaries had a period of one year without a relevant diagnosis or treatment claim, they were excluded from further analyses, unless they had another relevant diagnoses or treatment claim at a later time. A relevant SMI/SED diagnosis or treatment claim was defined as having a claim with a diagnosis code from the Healthcare Effectiveness Data and Information Set (HEDIS)^{®3-3} Mental Health diagnosis value set. A relevant SUD diagnosis or treatment claim was defined as having a claim with a diagnosis code from the Alcohol Abuse and Dependence, Opioid Abuse and Dependence, or Other Drug Abuse and Dependence value sets, or a medication-assisted treatment (MAT) dispensing event.

Comparison population groups varied in keeping with best practices for such evaluation designs. For some analyses the target population served as its own comparison group, as in pre-post design analyses, and variations on pre-post analyses that utilized multiple observation points. For other analyses, additional comparison groups were identified as needed. For example, to increase the robustness of the evaluation design, and to permit analyses when in state comparison groups are not available or feasible, comparisons with national data and data from other states were utilized. Among considerations when choosing non-Alaska comparison groups, there were pragmatic issues such as the feasibility and ability to access the comparison group data within a reasonable timeframe and in a usable format, and methodological issues, such as whether a comparison group based on data from another state shared sufficient similarities to Alaska, in terms of population size and demographics, rurality, geography, size of the Native population, economic and political climate, etc. Additionally, since the SUD-BH Program utilized a phased implementation, other opportunities for analysis and comparison were presented within State data between

³⁻² Centers for Medicare & Medicaid Services. Appendix C: Approaches to Analyzing Costs Associated with Section 1115 Demonstrations for Beneficiaries with Serious Mental Illness/Serious Emotional Disturbance or Substance Use Disorders. Available at: <https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/smi-sed-sud-cost-appendix-c.pdf>. Accessed on Oct 21, 2022.

³⁻³ HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

regions and services that were phased in and those not yet phased in. Together, this broad range of comparative population possibilities provided ample opportunity and sufficient sample sizes for in-depth analysis of the effectiveness of the SUD-BH Program from multiple perspectives and approaches.

Evaluation Period

Time periods covered in this report are presented in Table 3-2.

Table 3-2—Time Periods

Baseline Period	Interim Report Evaluation Period
January 1, 2017 – December 31, 2018	January 1, 2019 – December 31, 2021

For measures utilizing administrative claims data and were thus calculated for the target waiver population, the first year of the baseline period served as an intake year for identifying members with a SUD diagnosis. Specifically, Group 3, defined as adults, adolescents, and children with a SUD diagnosis, were identified similarly to the method for identifying target beneficiaries outlined in CMS guidance for evaluating costs for SUD and SMI/SED demonstrations.³⁻⁴ Therefore, members identified in early 2017 necessarily had a claim for SUD.³⁻⁵ However, because all members in Group 3 had a claim, rates for this time period were biased due to the definition of “group identification”. To provide an unbiased analysis, all measures using administrative claims data omitted 2017 from analysis.

Evaluation Measures

The evaluation measures were based on data sources that provided valid and reliable data which were readily available throughout the SUD-BH Program and evaluation activities. Health Services Advisory Group, Inc. (HSAG), reviewed the quality and completeness of each data source to determine if the data used were complete and accurate. The Alaska Division of Behavioral Health (DBH) used a comprehensive standardized reporting framework based on recommendations from the CMS State Toolkit for Validating Medicaid Encounter Data for Alaska Medicaid quarterly. As often as possible, measures in the evaluation were selected from nationally recognized measure stewards. However, due to the highly specialized and targeted nature of the evaluation, most measures were customized based on existing measure specifications, such as HEDIS technical specifications or SUD monitoring metrics, in order to provide the most consistent and accurate calculation of measures. Table 3-3 displays the evaluation measures.

³⁻⁴ Centers for Medicare & Medicaid Services. Appendix C: Approaches to Analyzing Costs Associated with Section 1115 Demonstrations for Beneficiaries with Serious Mental Illness/Serious Emotional Disturbance or Substance Use Disorders. Available at: <https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/smi-sed-sud-cost-appendix-c.pdf>. Accessed on: Oct 21, 2022.

³⁻⁵ In the extreme example, all members identified as part of Group 3 in January 2017 had a claim for a SUD diagnosis because a SUD diagnosis is the qualification criterion for inclusion in the study. These members were then followed for a minimum of 11 months thereafter.

Table 3-3—Evaluation Measures

Measure Number	Measure Name
1	Number of beneficiaries screened for symptoms of SUD using industry recognized, evidence-based screening instruments
2	Number of beneficiaries screened for symptoms of BH disorders using industry recognized, evidence-based screening instruments
3	Number of beneficiaries in the waiver population with SUD or BH diagnosis, by setting
4	Initiation and engagement of AOD abuse or dependence treatment (NQF 0004)
5	Follow-up after discharge from ED visits for SUD, and specifically for OUD, by setting (NQF 2605)
6	Follow-up after discharge from ED visits for a BH disorder, by setting (NQF 2605)
7	Number of Medicaid qualified SUD providers (identified by provider ID numbers) who bill for SUD services
8	Number of Medicaid qualified professionals licensed in the State to provide BH who bill for BH disorder services
9	Providers' reported barriers before, during, and shortly following expansion of BH and SUD services
10	Providers' experience in expanding services
11	Administrators' reported barriers before, during, and shortly following expansion of BH and SUD services
12	Administrators' plan for program sustainability and anticipated challenges
13	Alaska tribal entities' reported changes in quality of care and access to care following expansion of BH and SUD services
14	IP admissions for SUD, and specifically for OUD, by setting
15	IP admissions for BH disorders, by setting
16a	ED visits for SUD, by setting
16b	ED visits for OUD, by setting
17	ED visits for BH disorders, by setting
18	Mean length of stay measured from admission date to discharge date, by setting
19	30-day readmission rate to IP facilities following hospitalization for an SUD-related diagnosis, by setting
20	30-day readmission rate to IP facilities following hospitalization for a BH- related diagnosis, by setting
21	Number of beneficiaries with a SUD diagnosis including those with OUD who used services in the last month or year, by service or benefit type
22	Number of beneficiaries with a BH diagnosis who used services in the last month or year, by service or benefit type
23	Time to treatment, by service type (National Behavioral Health Quality Framework [NBHQF] Goal 1)
24	Access to physical healthcare
25	Screening for chronic conditions relevant to state Medicaid population
26	Screening for co-morbidity of BH disorders and SUDs within the waiver population compared to the total Medicaid population
27	Percentage of beneficiaries who rate the quality of their healthcare as very good or excellent
28	Percentage of beneficiaries who rate their overall mental or emotional health as very good or excellent

Measure Number	Measure Name
29	Percentage of beneficiaries who demonstrate very good or excellent knowledge of available treatment and services
30	Maternal depression
31	Maternal domestic abuse
32	Percentage of beneficiaries who experienced alcoholism or mental health disorder among household members
33	Percentage of beneficiaries who witnessed violence or physical abuse between household members
34	Percentage of youth beneficiaries who have ever been physically hurt by an adult in any way
35	Maternal marijuana or hash use in the past two years
36	Frequency of maternal marijuana or hash use (days per week)
--	Social support— care when sick (Supplemental CUBS Measure 1)
--	Desire to obtain SUD/BH treatment options and obtainment of SUD treatment in the past three months (Supplemental CUBS Measure 2)
37	Rate of overdose deaths, specifically overdose deaths due to any opioid
38	Non-fatal overdoses (<i>all cause</i>)
39	Use of opioids at high dosage in persons without cancer (NQF 2940)
40	Total costs of healthcare (sum of parts below), by State and federal share
41	Total cost of SUD, SUD-IMD and SUD-Other and Non-SUD, by setting, including claims data (IP, OP, RX, LTC, and capitated payments to managed care organizations)
42	Total cost of BH diagnosis by IMD and Other, by setting, including claims data (IP, OP, RX, LTC, and capitated payments to managed care organizations)

Note: AOD: alcohol and other drug use; BH: behavioral health; CUBS: Childhood Understanding Behaviors Survey; ED: emergency department; IMD: Institutions for Mental Disease; IP: inpatient; LTC: long term care; NBHQF: National Behavioral Health Quality Framework; NCQA: National Committee for Quality Assurance; NQF: National Quality Forum; OP: outpatient; OUD: opioid use disorder; RX: prescription; SUD: substance use disorder; SUD-BH: Substance Use Disorder-Behavioral Health.

Data Sources

Multiple data sources were used to evaluate the six hypotheses for the evaluation.

- Administrative Data
 - Medicaid claims and eligibility data
 - Provider enrollment data
 - Vital records
- National and Beneficiary Surveys
 - Survey of Alaska Medicaid members
 - National Survey on Drug Use and Health (NSDUH) data
 - Alaska Childhood Understanding Behaviors Survey (CUBS) data
- Key Informant Interviews

Data were collected from beneficiary surveys regarding beneficiaries’ experiences with improvements in care coordination and integration, as well as their experiences with ease of access to healthcare, care quality, and health improvements. The beneficiary surveys utilized questions from the Consumer Assessment of Healthcare

Providers and Systems (CAHPS)³⁻⁶ and included additional questions customized to assess beneficiary knowledge of SUD and BH services in the State. Additional data were collected from virtual stakeholder interviews with providers, non-provider stakeholders, and THOs on interviewees' perspective on the expansion of SUD and BH services, program sustainability, and anticipate challenges, and their experience with the COVID-19 PHE.

Administrative

Administrative data supplied by DBH were used to calculate most measures in this Interim Evaluation Report. These data include fee-for-service (FFS) claims, recipient eligibility and demographic data, and provider information. Due to changes in the processing of SUD Medicaid claims in 2020, multiple claims data sources were combined to provide the most complete picture of Alaska Medicaid claims possible.³⁻⁷ In particular, three primary data sources were supplied by DBH: data used for legislative audit; quarterly data from the State's administrative services organization (ASO); Optum; and weekly financial data. Legislative audit data were the sole source of claims data through early 2020, when Optum began processing SUD claims. The quarterly Optum data and weekly financial files both contained much of the same information but with some important differences. The weekly financial claims data contained both debited and credited claims, which is necessary for a complete financial analysis, but the weekly financial claims did not contain many critical data elements used for analysis such as diagnosis code or place of service. Moreover, among all SUD claims in the quarterly Optum and weekly financial files, only 80 percent were found in both (when matched by member ID and claim number). Sixteen percent of the SUD claims came only from the weekly financial files, meaning these claims did not have any diagnosis code information, which may have limited the ability to identify members with a SUD.

National Surveys

NSDUH is a comprehensive, face-to-face household survey of substance use, SUDs, mental health, and the receipt of treatment services for those disorders. Information from this survey was used where possible to provide context for similar measures nationally.

Beneficiary Surveys

Customized surveys were developed for the evaluation to assess knowledge and self-assessed health status of adult and child Medicaid beneficiaries that could not be obtained through administrative claims data or other sources. These surveys asked beneficiaries about their overall health, mental and emotional health, and whether they knew where to obtain various types of treatment services for SUD or BH disorders. These data will serve as a baseline for follow-up surveys that are planned for 2023.

One round of beneficiary surveys conducted via telephone occurred in the second quarter of 2021. A stratified random sample of 2,000 beneficiaries was utilized based on region, urbanicity, and other relevant characteristics. Six hundred twenty-seven surveys were completed—267 adult surveys and 360 child surveys.

Data from the CUBS instrument were utilized to assess parenting behaviors; social supports; and child safety, experiences, and development. CUBS is a research project sponsored by the Alaska Department of Health, Division of Public Health, and serves as a three-year follow-up to the Alaska Pregnancy Risk Assessment

³⁻⁶ CAHPS[®] is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

³⁻⁷ Alaska Medicaid Section 1115 SUD Demonstration Status Report. Available at: <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/state-annual-report-demonstration-yr2-deliverable.pdf>. Accessed on: Sept 23, 2022.

Monitoring System (PRAMS) of mothers who completed PRAMS and are still living in Alaska. HSAG submitted a research proposal and data request to obtain anonymized beneficiary-level information for 2012 through present (survey phases 4, 5, and 6). However, due to periodic changes in the survey instrument, some survey items were added, removed, or the language was substantively revised, which limited the ability to assess these items for the full time frame.³⁻⁸ Because CUBS is a follow-up survey among women who completed the PRAMS, the sampling strategy is based off respondents of the PRAMS and includes both Medicaid and non-Medicaid recipients. HSAG applied analytic weights supplied with the data in order to obtain representative statewide estimates. To correctly calculate standard errors for Medicaid respondents, HSAG conducted a statistical domain analysis.

Key Informant Interviews

Administrative data and surveys provide metrics capturing processes and outcomes of interest in the evaluation. These data sources, however, do not provide a clear view into the implementation of the SUD-BH Program as experienced by key stakeholders. Stakeholder interviews were performed with DBH State administrators, healthcare providers, non-provider stakeholders, and THOs to collect qualitative information regarding the impacts of the expansion of SUD and BH services. Three rounds of interviews occurred from August 2020 to June 2022.

State administrators were interviewed to obtain their perspective on the expansion of SUD and BH services, program sustainability, and anticipated challenges, and their experience with the COVID-19 PHE. Seven state administrators were interviewed in year one, followed by eight in both years two and three. Healthcare providers were interviewed about their experience with care coordination, integration, and quality of services provided with the SUD-BH Program and the impact of COVID-19. Five providers were interviewed in year one, followed by six in year two and nine in year three. Non-provider stakeholders, professional organizations representing BH providers, and Alaskans with mental health issues and SUDs were asked for their perspective on changes in access to care and the quality of care following the expansion of SUD and BH services as well as the impact of COVID-19. Two non-providers were interviewed in all three years of interviews. Similar to the other stakeholder groups, THOs were interviewed about their perspective on changes in access to and quality of care following BH and SUD service expansion and the impacts of COVID-19. Interviews with THOs began in the second year, when five THOs were interviewed. This increased to interviews with eight THOs in year three.

The key informant interviews provided context for how the demonstration implementations evolved over time, drivers of success, areas of concern, and changes to the quality of or access to care during the demonstration.

All interviews were recorded for accuracy in notetaking and transcription. Notes and transcriptions were analyzed using open coding techniques to identify key themes and concepts raised by interviewees. Axial coding techniques were subsequently used to identify relationships between concepts identified during open coding. The results of the analysis did not provide a statistically representative sample of experiences with the SUD-BH Program implementation. Rather, the responses obtained through stakeholder interviews were intended to provide the context for the breadth and variety of experiences among key stakeholders. Particularly with respect to provider responses, experiences of other providers may differ from those described in this report.

³⁻⁸ Current and historical survey instruments can be found on the CUBS website: <https://health.alaska.gov/dph/wcfh/Pages/mchept/cubs/default.aspx>; Accessed on: Sept 20, 2022. Phase 4 surveys were administered between 2012 and 2014, phase 5 was administered between 2015 and 2019, and phase 6 began in 2020.

Publicly Available Financial/Actuarial Files

Budget neutrality workbooks downloaded from Medicaid.gov were utilized in the cost-effectiveness assessment. These workbooks consist of a standardized reporting form that consolidates financial data for each demonstration into a unified report to reduce redundancy while, simultaneously strengthening and enhancing CMS reviews.

Analytic Methods

Multiple analytic techniques were used, depending on the type of data for the measure and the availability of data.

Descriptive content analysis was used to present data related to process evaluation measures gathered from document reviews. The data were summarized to describe the activities undertaken, including highlighting specific successes and challenges.

Descriptive statistics, including frequency distributions and time series (presentation of rates over time), were used for quantitative process measures to describe the output of specific waiver activities. These analysis techniques were also used for some short-term outcome measures in cases where the role of the measure was to describe changes in the population, but not to show specific effects of the SUD-BH Program.

Interrupted Time Series

The ITS design included annual, quarterly, or monthly observations of each measure over time, beginning at least one year prior to SUD-BH Program implementation. The counterfactual for the analysis was the trend, as it would have happened, without being “interrupted” by the SUD-BH Program. Specific outcome measures were collected for multiple time periods both before and after the demonstration period and related interventions. The measurements collected after the SUD-BH Program were then compared to the projected outcome to evaluate the impact the program had on the outcome. The generic ITS model is:

$$Y_t = \beta_0 + \beta_1 time_t + \beta_2 post_t + \beta_3 time \times post_t + \mu_t$$

Where Y_t is the outcome of interest for the time period t , $time$ represents a linear time trend, $post$ is a dummy variable to indicate the time periods post-implementation, and $time \times post$ is the interaction term between $time$ and $post$. The coefficient, β_0 , identifies the starting level of outcome Y , β_1 is the slope of the outcome between the measurements before the program, β_2 is the level change in the outcome at implementation, and β_3 is the change in the slope for the measurements after the program.

For measures calculated quarterly or monthly, indicator variables were added to the ITS model specified above for each quarter of the year to adjust for seasonality in the trend. Adjustment for the COVID-19 PHE was conducted by creating an indicator variable for quarter 2 (Q2) of 2021 to represent the initial wave of COVID-19 PHE-related shutdowns and stay-at-home orders, and a separate indicator variable for Q3 of 2020 through the end of Q1 of 2021 to reflect subsequent state-specific public health orders. For measures calculated annually, an indicator variable for 2020 was included in the model to adjust for the COVID-19 PHE.

Where necessary and appropriate, binomial logistic regression was used to analyze rates that are bounded by 0 and 1. Results for these analyses are presented in this report as the percentage change in odds given a δ unit increase in X , given by the following formula where $\delta = 1$:³⁻⁹

³⁻⁹ Long J.S. (1997). *Regression models for categorical and limited dependent variables*. Sage Publications, Inc.

$$100[\exp(\beta_k \times \delta) - 1]$$

There are two coefficients of interest from the ITS analysis, β_2 (level change at implementation) and β_3 (change in the monthly trend). The variable “level change at implementation” indicates that, controlling for seasonality, months impacted by COVID-19, and the linear trend in the rate, the odds of the outcome of interest changed by $100[\exp(\beta_k) - 1]$. The variable “change in monthly trend” indicates that, all else equal, the odds of the outcome of interest changed by $100[\exp(\beta_k \times \delta) - 1]$, where $\delta = 1$ for a one-month change.³⁻¹⁰

Similarly, the ITS analysis on costs employed a generalized linear model (GLM) with a log link to accommodate the right-skewed nature of healthcare costs and to constrain predicted costs to positive numbers only. Results are presented as percentage changes in per member per month (PMPM) costs, given by the same formula as above.

Full regression results of all parameters and unadjusted estimates are presented in Appendix A.

Trend Analysis

For measures wherein an ITS analysis was not available, a regression model incorporating both the linear trend in the baseline period and dummy variables for the evaluation period years was used for trend analysis. In this model, observed rates during the evaluation period were compared against the projected rates if the baseline trend had continued. Logistic regression was utilized to evaluate measures with binary outcomes.

The general form of the model is:

$$\ln(Y) = \beta_0 + \beta_1 TIME + \sum \beta_t \delta_t$$

Where β_0 is the intercept representing the natural log of the rate at the first baseline year; β_1 is the average annual change in the logged rate during the baseline period, as a function of *TIME*; and $\sum \beta_t \delta_t$ represents the impact of a series of dummy variables representing each evaluation year *t*. The coefficients for these dummy variables represent the difference in the logged rate from the last year of the baseline period to the year represented by the dummy variable. *TIME* is the piecewise trend parameter for the baseline period defined as a linear trend in the baseline period and is held constant in the evaluation period by setting it equal to the value of the last year of the baseline period.

A series of hypothesis tests of the linear combination of coefficients were performed to determine if the evaluation period rates were significantly different from the projected evaluation period rates based on the *TIME* coefficient and the intercept.

Descriptive Time Series

Measures in which there are insufficient data points for a robust ITS analysis and no viable comparison group for difference in differences (DiD) testing were assessed through a descriptive analysis of trends in the data.

³⁻¹⁰ Note: To calculate a change other than one month, it is not appropriate to multiply the change in odds by the number of months. Instead, the reader is encouraged to use the Appendix tables to calculate the change based on the desired number of months using the unadjusted parameter estimates. For example, a 12-month change would be calculated using this formula: $100[\exp(\beta_3 \times 12) - 1]$ where β_3 is the parameter estimate for “change in monthly trend.”

Pre/Post Analysis

Due to limitations of available and appropriate comparison groups, a one-group pre/post analysis was utilized for many measures. Average rates during the baseline period were compared against average rates during the evaluation period using a Chi-square test, *t*-test, or other statistical test appropriate for the given data. Specifically, comparisons were made using this model:

$$Y = \beta_0 + \beta_1 * post$$

Where *Y* is the rate of the outcome being measured each year, β_0 captures the average rate in the baseline years, and the coefficient β_1 for the dummy variable, *post*, representing the evaluation years, captures the change in average outcome between the baseline and evaluation time periods.

Binomial logistic regression was utilized to evaluate measures that are binary outcomes or presented as rates. Due to the lack of a comparison group, it is difficult to conclude whether the changes in rates are a direct result of the specific program, as simultaneous external factors occurring during the same time period may have also had an impact that could not be accounted for.

Financial Analysis

The cost analysis is designed to analyze the differences between actual and projected costs and trends for the evaluation period. Note that the cost analyses do not refer to or attempt to replicate the formal Budget Neutrality test required under the Section 1115 Demonstration Waiver program, which sets a fixed target under which waiver expenditures must fall that was set at the time the waiver was approved.

In accordance with CMS guidance on analyzing costs associated with section 1115 demonstrations for beneficiaries with serious mental illness/serious emotional disturbance or substance use disorders, two separate cohorts of beneficiaries were identified.

The first cohort consisted of beneficiaries enrolled in the measurement period with a SUD diagnosis. SUD diagnoses were defined as having a SUD-related treatment service or SUD diagnosis in one of the following HEDIS MY 2020 Value Sets or Medications Lists:

- Alcohol and Other Drug (AOD) Medication Treatment Value Set
- Alcohol Use Disorder Treatment Medication Lists
- Opioid Use Disorder Treatment Medication Lists
- Alcohol Abuse and Dependence
- Opioid Abuse and Dependence
- Other Drug Abuse and Dependence

The second cohort consisted of members with a BH diagnosis, defined as those enrolled in the measurement period and who have a claim with a diagnosis code from the HEDIS MY 2020 Mental Health Diagnosis Value Set during the measurement period.

Members were considered a part of the SUD/BH cost analysis group beginning the first month in which they have a relevant diagnosis or treatment claim for either SUD or BH, and up to 11 additional months that did not include relevant claims, if the beneficiary remained enrolled in Medicaid. If a member has additional claims with a relevant diagnosis or treatment code, their inclusion in the SUD/BH cost analysis group is extended to include up to 11 additional months following the subsequent claim, if the member remained enrolled in Medicaid.

Cost of care for both SUD and BH beneficiaries based on fee-for-service reimbursement amounts were calculated for each member in each month across the following categories of service:

- Total Costs
- Inpatient (IP)
- Outpatient (OP)
 - Emergency Department (ED) OP
 - Non-ED OP
- Long-term care (LTC)
- Professional
- Dental
- Pharmacy

The following were calculated for the SUD population only:

- SUD-Institutions of Mental Disease (IMD)
- SUD-Other
- Non-SUD

The following were calculated for the BH population only:

- BH-IMD
- BH-Other
- Non-BH

Data were then aggregated across all members in order to calculate per-member per-month costs for each month of the demonstration and 12 months prior.³⁻¹¹ An interrupted time series analysis was constructed for each level of cost stratifications using the framework described above. Seasonality indicators and variables indicating time periods affected by the COVID-19 PHE were included in the model to control for these factors.

³⁻¹¹ Although CMS guidance describes utilizing two years of baseline data to establish a more reliable trend, HSAG found that because analysis groups were identified using diagnoses and treatment events, costs during the first baseline year (2017) were biased upwards when following the CMS guidance. In order to achieve unbiased calculations, the first baseline year was excluded from analysis. HSAG will work with DBH for the Summative Report to include data from 2016 which should allow for two unbiased years of baseline data. Additionally, CMS guidance describes constructing an interrupted time series with member-level controls. However, due to a low prevalence of costs for most members—especially when stratified by category of service—robust statistical analysis at the member-level was not feasible. CMS guidance references literature on evaluating healthcare expenditures using a two-part model as one mechanism to account for this issue; however, the method described in the literature is not applied in an ITS framework, which relies on assessing trends in costs. Given the frequency of months in which beneficiaries did not incur any costs and the unbalanced nature of the panel dataset, member-level trends could not be reliably estimated.

4. Methodological Limitations

The following section details the methodological limitation of the Interim Evaluation Report for the Substance Use Disorder and Behavioral Health (SUD-BH) Program Demonstration Waiver.

Evaluation Design

In this Interim Evaluation Report, Health Services Advisory Group, Inc. (HSAG), presents baseline and evaluation period rates for performance measures and other metrics that align with the primary objectives of the demonstration waiver. A particular strength of this evaluation is the use of varied data sources to address a wide breadth of metrics assessing service utilization, access to care, quality of care, and beneficiary knowledge of services and well-being.

There are two primary limitations related to the evaluation design of the analyses used in this Interim Evaluation Report. First, no in-state comparison group exists because the demonstration waiver was implemented for all targeted beneficiaries in the State simultaneously. A comparison group of similarly situated Medicaid beneficiaries who have not received additional services provided by the demonstration waiver will be critical for obtaining a proper counterfactual comparison in the Summative Evaluation Report. The comparison group will serve as the basis for understanding what may have happened to the healthcare and health outcomes of targeted Alaska Medicaid beneficiaries had the demonstration not been implemented. It is possible that Transformed Medicaid Statistical Information System (T-MSIS) data covering other states from the Centers for Medicare & Medicaid Services (CMS) may become available for use in forming a counterfactual comparison group by the time the Summative Evaluation Report is written. Additionally, at the time of the Interim Evaluation Report, data could not be obtained from another state with similar population characteristics and Medicaid policies and procedures in place. Therefore, the counterfactual comparison used in this report is the comparison of measure rates across the baseline and evaluation periods of the demonstration. For many measures, only a pre-post comparison of outcomes prior to the SUD-BH Program to outcomes post-demonstration implementation was possible. Where sufficient data points were available, HSAG employed an interrupted times series (ITS) analysis to make comparisons while accounting for underlying seasonal trends in the outcome. The results indicate whether the measure rates increased or decreased, and whether the results represented statistically significant changes in performance. Both methods were limited to using only one pre-demonstration year (2018) since the methodology for identifying members with a SUD diagnosis necessitated treating the first year of baseline as an intake year; the use of one baseline year may not have captured the complete picture of what Medicaid care looked like prior to the SUD-BH Program. Furthermore, it is possible that co-interventions or other events occurring at the same time as the demonstration may have confounded measure rates; as such, a comparison of rates during the baseline period to the evaluation period would not be able to disentangle those effects from demonstration effects.

A second key limitation of the results presented in this Interim Evaluation Report is the impact of the global coronavirus disease 2019 (COVID-19) public health emergency (PHE). The COVID-19 PHE impacted the healthcare industry and the entire population on a global scale, requiring substantial changes to the processes used in the delivery of healthcare. In Alaska, as in other locations, healthcare utilization was significantly reduced in 2020 (and to a lesser extent in 2021) and is likely to have impacted the results shown in this Interim Evaluation Report. Where possible, adjustments for the impact of the COVID-19 PHE were made in the analyses. For measures analyzed using ITS, knowledge on state-specific case counts, shutdowns, and stay-at-home orders was incorporated into the model to account for the effect of COVID-19 through controlling for affected quarters or years in regression analyses. For many other measures, however, the specifications for calculating rates require

lengthy look-back periods, or annual assessments of beneficiaries that would not allow such adjustments to be made. Because of this limitation, for some measures, the 2020 rates confound the impact of the COVID-19 PHE with any program impacts, and the analysis cannot disentangle the two sources of change.

Data Sources

As described in the Data Sources section of the Methodology, most measures used in this Interim Evaluation Report rely on administrative data including Medicaid claims, beneficiary eligibility, demographic, and provider data. Three data sources were provided for use in the evaluation, which had differing characteristics and layouts. The weekly financial claims data contained both debited and credited claims, which are necessary for a complete financial analysis, but the weekly financial claims did not contain many critical data elements used for analysis such as diagnosis code or place of service. Moreover, among all SUD claims in the quarterly Optum and weekly financial files, only 80 percent were found in both (when matched by member ID and claim number). Sixteen percent of the SUD claims came only from the weekly financial files, meaning these claims did not have any diagnosis code information, which may have limited the ability to identify members with an SUD.

5. Results

The following section details measure results by research question and related hypotheses for the Substance Use Disorder and Behavioral Health (SUD-BH) Program Demonstration Waiver. This interim report provides results from the baseline period and first three years of the evaluation period. *Note that some numbers presented may not tie out due to rounding.* Details on the measure definitions and specifications can be found in Appendix D.

Results Summary

Research Question 1: Does the SUD-BH Program increase access to and utilization of SUD and BH disorder treatment services by increasing access to community-based care?

Hypothesis 1: The SUD-BH Program will increase the number of beneficiaries in the waiver population who are referred to and engage in treatment for SUD and BH disorders in sub-acute, community or regionally based OP settings.

Number of beneficiaries screened for symptoms of SUD using industry recognized, evidence-based screening instruments (Measure 1)

Measure 1 assesses the number of waiver beneficiaries screened for symptoms of substance use disorder (SUD) using industry recognized, evidence-based screening instruments to help assess whether the demonstration is increasing the percentage of beneficiaries who are utilizing treatment services. Table 5-1 shows that the rate of waiver beneficiaries being screened for symptoms of SUD decreased steadily, from 18.2 percent in 2018 to 15.3 percent in 2021. Overall, the average rate for screening of SUD symptoms in the evaluation period was 16.2 percent—a drop of 1.9 percentage points between the rate in the baseline period and evaluation period. This decline was partially driven by the coronavirus disease 2019 (COVID-19) public health emergency (PHE), which adversely impacted beneficiaries’ typical utilization of healthcare services, including the opportunities for SUD screening. This difference was found to be statistically significant.

Table 5-1—Number of Beneficiaries Screened for Symptoms of SUD Using Industry Recognized, Evidence-Based Screening Instruments

		Baseline Period		Evaluation Period			Percentage Point Change	p-value
		2018	2019	2020	2021	Weighted Average		
Beneficiaries screened for symptoms of SUD using industry recognized, evidence-based screening instruments	Rate	18.2%	17.7%	15.7%	15.3%	16.2%	-1.9pp	<0.001***
	Count	5,477	5,602	4,890	4,746			

Note: pp=percentage point
*p< 0.1, **p < 0.05, ***p<0.001

Measure 1 Conclusion: Does not support the hypothesis

Number of beneficiaries screened for symptoms of BH disorders using industry recognized, evidence-based screening instruments (Measure 2)

Measure 2 assesses the number of waiver beneficiaries screened for symptoms of behavioral health (BH) disorders using industry recognized, evidence-based screening instruments to help assess whether the demonstration is increasing the percentage of beneficiaries who are utilizing treatment services. As seen in Table 5-2, the rate of waiver beneficiaries being screened for symptoms of BH disorders was 21.9 percent in 2018, remained stable in 2019, but declined, in 2020 to 19.6 percent and in 2021 to 18.1 percent. Overall, the average rate of screening for BH disorder symptoms decreased by 1.9 percentage points between the baseline and evaluation periods, a statistically significant decrease ($p < 0.001$). This decline was partially driven by the COVID-19 PHE, which adversely impacted beneficiaries’ typical utilization of healthcare services, including the opportunities screening of a BH disorder.

Table 5-2—Number of Beneficiaries Screened for Symptoms of BH Disorders Using Industry Recognized, Evidence-Based Screening Instruments, 2018–2021

		Baseline Period		Evaluation Period		Weighted Average	Percentage Point Change	p-value
		2018	2019	2020	2021			
Beneficiaries screened for symptoms of behavioral health disorders using industry recognized, evidence-based screening instruments	Rate	21.9%	22.2%	19.6%	18.1%	20.0%	-1.9pp	<0.001***
	Count	6,610	7,052	6,104	5,607			

Note: pp=percentage point
 * $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Measure 2 Conclusion: Does not support the hypothesis

Number of beneficiaries in the waiver population with SUD or BH diagnosis, by setting (Measure 3)

Measure 3 aims to determine whether the demonstration has increased utilization of SUD and BH services by assessing the percentage of Medicaid beneficiaries who were diagnosed with a SUD or BH disorder. Overall, the percentage of beneficiaries with a SUD or BH diagnosis decreased slightly from 88.1 percent in 2018 to 86.8 percent in 2021 as displayed in Table 5-3. This decline was partially driven by the coronavirus disease 2019 (COVID-19) public health emergency (PHE), which adversely impacted beneficiaries’ typical utilization of healthcare services, including the opportunities for diagnosis of SUD or BH disorder. The average rate of beneficiaries being diagnosed with a SUD or BH disorder in the evaluation period was 87.3 percent; this was 0.9 percentage points lower than the rate in the baseline period, a statistically significant difference ($p < 0.001$). Because this measure relates to prevalence of SUD or BH diagnosis, a higher rate does not necessarily indicate better performance nor does a lower rate. Therefore, results are provided contextually and neither supports nor fails to support the hypothesis, which relates to referral and engagement in treatment.

Table 5-3—Percentage of Beneficiaries in the Waiver Population with SUD or BH Diagnosis, 2018–2021

	Baseline Period		Evaluation Period			Percentage Point Change	p-value
	2018	2019	2020	2021	Weighted Average		
Percentage of beneficiaries in the waiver population with SUD or BH diagnosis	88.1%	87.5%	87.5%	86.8%	87.3%	-0.9pp	<0.001***

Note: pp=percentage point
 *p< 0.1, **p< 0.05, ***p<0.001

Measure 3 Conclusion: Neither supports nor fails to support the hypothesis

Initiation and engagement of AOD dependence treatment (NQF 0004) (Measure 4)

Measure 4 intends to examine whether the demonstration has increased access to and utilization of SUD treatment options by assessing the percentage of beneficiaries with a new episode of alcohol or other drug (AOD) dependence who either initiated or engaged in AOD treatment. As shown in Table 5-4, the rate of initiation of AOD treatment was 33.2 percent in 2018 and trended upwards until 2020, peaking at 36.1 percent before decreasing to 33.4 percent in 2021. Overall, the rate of initiating AOD treatment among beneficiaries with a new episode of AOD was 34.4 percent in the evaluation period, 1.2 percentage points greater than the rate during the baseline period. This increase was found to be statistically significant (p=0.020). The rate of engagement in AOD treatment exhibited a similar pattern from 2018–2021. The rate of engagement of AOD treatment in 2018 was 12.1 percent and trended upwards until 2020, peaking at 14.0 percent before decreasing to 11.6 percent in 2021. The average rate of engagement in AOD treatment among beneficiaries with a new episode of AOD was 13.0 percent in the evaluation period. This was 0.9 percentage points greater than the rate during the baseline period, a statistically significant difference (p=0.013).

Table 5-4—Initiation and Engagement of AOD Dependence Treatment, 2018–2021

	Baseline Period		Evaluation Period			Percentage Point Change	p-value
	2018	2019	2020	2021	Weighted Average		
Initiation of AOD Dependence Treatment (NQF 0004)	33.2%	33.8%	36.1%	33.4%	34.4%	1.2pp	0.020**
Engagement of AOD Dependence Treatment (NQF 0004)	12.1%	13.5%	14.0%	11.6%	13.0%	0.9pp	0.013**

Note: pp=percentage point
 *p< 0.1, **p< 0.05, ***p<0.001

Measure 4 Conclusion: Supports the hypothesis

Follow-up after discharge from ED visits for SUD, and specifically for OUD (NQF 2605) (Measure 5)

The goal of Measure 5 is to examine whether the demonstration has been effective in matching individuals with a SUD with the services necessary for recovery by assessing the percentage of waiver beneficiaries who received a follow-up visit after being discharged from an emergency department (ED) visit for SUD, and specifically for

opioid use disorder (OUD). Table 5-5 and Figure 5-1 show that seven- and 30-day follow-up rates were higher for OUD visits than SUD visits.

For waiver beneficiaries discharged from ED visits for SUD, rates of follow-up within seven and 30 days decreased steadily between 2018–2021. In 2018, the follow-up rate for SUD discharges within seven days was 14.4 percent, decreasing to 11.6 percent in 2021. The average rate of follow-up within seven days after discharge among SUD waiver beneficiaries in the evaluation period was 13.1 percent, which was 1.3 percentage points less than the rate of follow-up within seven days in the baseline period. This difference was found to be statistically significant ($p=0.034$).

Similarly in 2018, the follow-up rate for SUD discharges within 30 days was 23.0 percent, decreasing to 19.8 percent in 2021. On average, the rate of follow-up within 30 days after discharge among SUD waiver beneficiaries in the evaluation period was 21.4 percent, 1.6 percentage points less than the rate of follow-up within 30 days in the baseline period—a statistically significant difference ($p=0.021$).

Among waiver beneficiaries discharged from ED visits for OUD, the rate of follow-up within seven days was 28.5 percent in 2018 and peaked at 35.7 percent in 2019 before declining to 28.7 percent in 2021. The average rate of follow-up within seven days after discharge among OUD waiver beneficiaries in the evaluation period of 32.2 percent was 3.7 percentage points higher than the follow-up during the baseline period, though this result was not statistically significant.

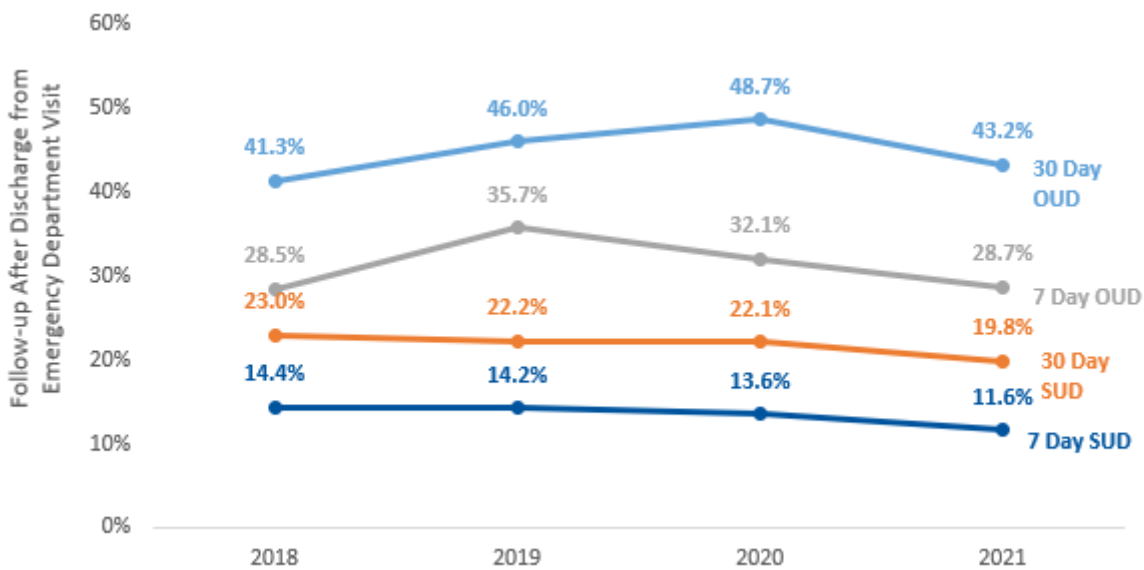
The rate of follow-up within 30 days among waiver beneficiaries discharged from ED visits for OUD in 2018 (41.3 percent) increased in both 2019 and 2020, peaking at 48.7 percent in 2020 before decreasing to 43.2 percent in 2021. The average rate of follow-up within 30 days after discharge among OUD waiver beneficiaries in the evaluation period (45.8 percent) was 4.5 percentage points higher than the rate of follow-up during the baseline period, which was also not statistically significant.

Table 5-5—Rates of Follow Up After Discharge from ED Visits for SUD/OUD, 2018–2021

	Baseline Period	Evaluation Period				Percentage Point Change	p-value
	2018	2019	2020	2021	Weighted Average		
Follow-Up within 7 Days After Discharge from ED Visit for SUD	14.4%	14.2%	13.6%	11.6%	13.1%	-1.3pp	0.034**
Follow-Up within 30 Days After Discharge from ED Visit for SUD	23.0%	22.2%	22.1%	19.8%	21.4%	-1.6pp	0.021**
Follow-Up within 7 Days After Discharge from ED Visit for OUD	28.5%	35.7%	32.1%	28.7%	32.2%	3.7pp	0.240
Follow-Up within 30 Days After Discharge from ED Visit for OUD	41.3%	46.0%	48.7%	43.2%	45.8%	4.5pp	0.182

Note: pp=percentage point
 * $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Figure 5-1—Rates of Follow Up After Discharge from ED Visits for SUD/OD, 2018–2021



Although the rates of follow-up visits within seven- and 30-days after an ED visit for OUD increased on average during the demonstration period, this increase was not statistically significant; and rates of follow-up visits for SUD more broadly declined during the demonstration period by a statistically significant degree. Although the increase among OUD was greater than that of SUD, due to smaller size of the OUD population, statistical power among this population was lower, inhibiting the ability to find statistically significant differences of the same magnitude among the SUD population. The average denominator size among the OUD population was only 293 compared to 4,502 for the SUD population as a whole, or approximately 6 percent. Because the decline in rates among the SUD population was statistically significant, the results generally do not support the hypothesis.

Measure 5 Conclusion: Does not support the hypothesis

Follow-up after discharge from ED visits for a BH disorder, by setting (NQF 2605) (Measure 6)

Measure 6 aims to examine whether the demonstration has been effective in providing the needed support services to individuals with a BH related diagnosis by assessing the percentage of waiver beneficiaries who received follow-up after being discharged from an ED visit for a BH-related diagnosis.

For waiver beneficiaries discharged from ED visits for a BH diagnosis, rates of follow-up within seven days after discharge and within 30 days after discharge decreased steadily between 2018–2021 as shown in Table 5-6 and Figure 5-2. In 2018, the follow-up rate for BH related discharges within seven days was 45.0 percent and decreased to 32.5 percent by 2021. The average rate of follow-up within seven days after discharge for a BH related diagnosis in the evaluation period was 36.1 percent, 8.9 percentage points less than the rate of follow-up within seven days in the baseline period, a statistically significant difference ($p < 0.001$).

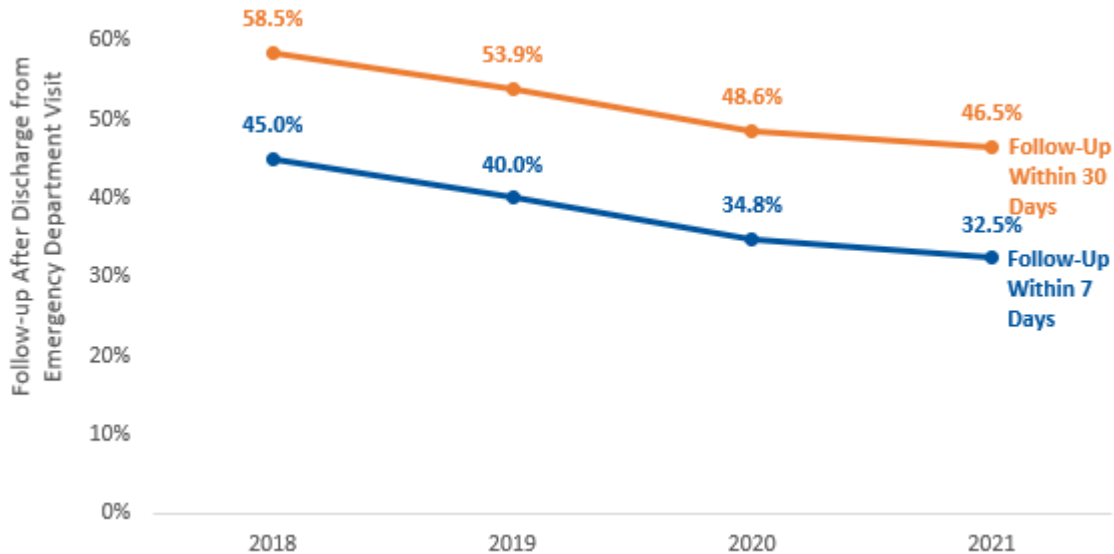
Similarly in 2018, the follow-up rate for BH discharges within 30 days was 58.5 percent, declining to 46.5 percent by 2021. On average, the rate of follow-up within 30 days after discharge among BH waiver beneficiaries in the evaluation period was 50.0 percent, 8.4 percentage points less than the rate of follow-up within 30 days in the baseline period—a statistically significant difference ($p < 0.001$).

Table 5-6—Rates of Follow Up After Discharge from ED Visits for a BH Related Diagnosis, 2018–2021

	Baseline Period		Evaluation Period			Percentage Point Change	p-value
	2018	2019	2020	2021	Weighted Average		
Follow-Up within 7 Days After Discharge from ED Visit for BH Related Diagnosis	45.0%	40.0%	34.8%	32.5%	36.1%	-8.9pp	<0.001***
Follow-Up within 30 Days After Discharge from ED Visit for BH Related Diagnosis	58.5%	53.9%	48.6%	46.5%	50.0%	-8.4pp	<0.001***

Note: pp=percentage point
 *p < 0.1, **p < 0.05, ***p < 0.001

Figure 5-2—Rates of Follow Up After Discharge from ED Visits for a BH Related Diagnosis, 2018–2021



Measure 6 Conclusion: Does not support the hypothesis

Number of Medicaid qualified SUD providers (identified by provider ID numbers) who bill for SUD services (Measure 7)

Measure 7 aims to determine whether the demonstration has increased access to SUD services by assessing the number of Medicaid qualified SUD providers who are billing for SUD services in each region. Overall, the number of providers increased from 17 in 2018 to 134 in 2021, a nearly eight-fold increase. Regions 1 and 2 saw the greatest increases of 59 and 27 providers, respectively, between 2018 and 2021. Region 5, with zero providers in 2018 and 2019, increased to six providers in 2020 and 23 providers in 2021. No Medicaid qualified SUD providers were found to be billing for SUD services in regions 3, 6, 7, or 9. Table 5-7 below shows the yearly counts of Medicaid qualified SUD providers who bill for SUD services, by region.

Table 5-7—Number of Medicaid Qualified SUD Providers Who Bill for SUD Services, by Region, 2018–2021

Provider Region	Baseline Period	Evaluation Period		
	2018	2019	2020	2021
Region 1 - Anchorage Municipality (Anchorage)	12	27	53	71
Region 2 - Fairbanks North Star Borough (Fairbanks)	4	14	21	31
Region 3 - Northern and Interior Region (Fairbanks and Utqiagvik)	--	--	--	--
Region 4 - Kenai Peninsula Borough (Soldotna and Homer)	--	--	6	6
Region 5 - MatSu Borough (Wasilla)	--	--	6	23
Region 6 - Western Region (Kotzebue, Nome, and Bethel)	--	--	--	--
Region 7 - Northern Southeast Region (Juneau and Sitka)	--	--	--	--
Region 8 - Southern Southeast Region (Ketchikan)	--	--	--	3
Region 9 - Gulf Coast/Aleutian Region (Anchorage, Dillingham, and Kodiak)	--	--	--	--
No associated region	1	1	--	--
Total	17	42	86	134

Measure 7 Conclusion: Supports the hypothesis

Number of Medicaid qualified professionals licensed in the State to provide BH who bill for BH disorder services (Measure 8)

Measure 8 aims to determine whether the demonstration has increased access to BH services by assessing the number of Medicaid qualified BH providers who are billing for BH services in each region. From 2018 to 2021, the total number of Medicaid qualified professionals who are licensed to provide and are billing for BH services increased from 641 to 684. Region 1 increased by 53 total providers, the highest increase in overall number of providers from 2018 to 2021. Region 5 had the greatest percentage change for providers, increasing from 49 to 71, a 45 percent increase. Region 7 had a slight decrease falling from 71 to 66 providers. Table 5-8 shows the yearly counts of Medicaid qualified BH providers who bill for BH services by region.

Table 5-8—Number of Medicaid Qualified Professionals Licensed in the State to Provide BH Who Bill for BH Disorder Services, by Region, 2018–2021

Provider Region	Baseline Period	Evaluation Period		
	2018	2019	2020	2021
Region 1 - Anchorage Municipality (Anchorage)	258	330	340	311
Region 2 - Fairbanks North Star Borough (Fairbanks)	57	65	58	63
Region 3 - Northern and Interior Region (Fairbanks and Utqiagvik)	4	5	6	4
Region 4 - Kenai Peninsula Borough (Soldotna and Homer)	40	45	53	40
Region 5 - MatSu Borough (Wasilla)	49	79	86	71
Region 6 - Western Region (Kotzebue, Nome, and Bethel)	37	44	47	44
Region 7 - Northern Southeast Region (Juneau and Sitka)	71	79	65	66

Provider Region	Baseline Period		Evaluation Period	
	2018	2019	2020	2021
Region 8 - Southern Southeast Region (Ketchikan)	17	20	15	21
Region 9 - Gulf Coast/Aleutian Region (Anchorage, Dillingham, and Kodiak)	23	27	30	29
No associated region	85	49	41	35
Total	641	743	741	684

Measure 8 Conclusion: Supports the hypothesis

Providers' reported barriers before, during, and shortly following expansion of BH and SUD services (Measure 9)

Providers highlighted administrative burden as a key concern throughout the three rounds of interviews. Initially, providers experienced long wait times to enroll in Medicaid. Once providers were enrolled, they expressed confusion in interpreting and complying with waiver guidelines and what they perceived as restrictions on provider’s ability to provide services in a specific manner. Many struggled to comply with the certification processes associated with employing qualified addiction professionals (QAPs). The certification process was costly and lengthy with no chance for reimbursement; many providers did not feel there was enough time for certification. Providers also found it difficult to become familiar with new paperwork associated with the waiver.⁵⁻¹

Providers noted that workforce challenges were a continued concern throughout the three years of interviews. Providers experienced extensive staffing issues and had difficulty hiring and retaining staff. One provider noted a 56 percent turnover among staff in the preceding 12 months. Another provider noted that four clinicians had left its organization in the past year. Workforce challenges shared by providers included difficulty getting workers to move to Alaska, inability to pay relocation fees, difficulty getting workers to remain in Alaska, and difficulty in offering competitive wages.

In year one of interviews, providers shared concerns about the sunseting of State plan services before the 1115 waiver would be viable. State plan codes were discussed again in year three, when providers expressed frustration that waiver services were not always a direct replacement for State plan services, especially with regard to adult mental health residential services that were formerly provided under the state plan. One provider cited issues with the transition from home-based State plan codes to waiver codes; the provider, in anticipation of the State plan codes being sunsetted, transitioned its billing to use waiver codes. However, The Alaska Division of Behavioral Health (DBH) delayed the sunseting a few days before State plan codes were expected to be sunsetted. The provider had already transitioned its systems away from State plan codes and was unable to reverse in time, causing the provider to stop providing school-based services, resulting in a major loss in revenue.⁵⁻²

There was also discussion about differences between the State plan codes and waiver codes. Specifically, peer support and community recovery support services (CRSS) had a lower limit of 200 hours on the waiver compared to 840 available hours on the State plan codes. The provider felt that in this situation it would not make sense to bill to the waiver codes. Similarly, an additional provider shared that it continued to bill State plan codes for peer support, case management, assessment, and psychotherapy. Another provider indicated that they understood why

⁵⁻¹ DBH increased the certification period from three years to four years due to the PHE.

⁵⁻² School-based services provided by the Tribal Behavioral Health System (TBHS) remain in the Alaska state plan.

some providers are continuing to bill to State plan codes and expressed their wish that 1115 and State plan billing codes were the same. Medicaid and non-Medicaid services use different codes; one provider noted that it would like the State to make these codes match.⁵⁻³

Informants expressed additional concerns surrounding billing:

- Inability to bill for arranging travel for case management resulted in providers spending unpaid hours on this process.
- Lack of understanding on the documentation required to bill for peer support. The administrative burden of this billing process was too high, and a provider explained that its staff worked weekends to bill for these services.⁵⁻⁴
- Fears over the return of service authorizations after the PHE ends.
- Lack of clarity on bill codes and paybacks.
- Difficulties in providing every location and provider their own National Provider Identifier (NPI).
- Optum not itemizing payments and voids, leaving providers vulnerable in an audit.

Many providers experienced concerns specifically with the administrative services organization (ASO), Optum. In years one and two, the majority of interviewed providers highlighted the difficulty of the transition from Conduent to Optum. Issues in this transition included billing issues (e.g., denied claims, providers not in the billing system); inconsistent instructions; lack of communication; and a reduction in information technology (IT) and technical support. Providers felt that the transition to Optum being concurrent with the waiver and the COVID-19 PHE was overwhelming. Additionally, providers felt that Optum did not provide the cost reduction and support that was originally indicated. By the third year of interviews, interviewed providers did not express any concerns regarding Optum.

Providers also expressed a similar lack of support, training, and guidance from DBH regarding the billing and documentation processes in the first year of interviews. Some interviewees felt that DBH's responses were inconsistent. By the third year, similar feelings remained. Providers noted that DBH was not responsive to questions, and that different DBH representatives gave different answers to the same question. Providers who did feel that DBH was responsive maintained that answers were unclear. Informants expressed the need for more transparency from DBH. Several providers shared that they were looking forward to meeting with DBH in person to have their questions answered.

Several providers experienced difficulties providing services in 2021 due to a cybersecurity attack on the AKAIMS system. Prior to the incident, providers billed Medicaid through Alaska's Automated Information Management System (AKAIMS) and were forced to switch to Optum's provider express system online. One provider missed timely filing when AKAIMS was taken offline and were not given a grace period under the waiver or the state plan; the provider estimates a loss of approximately \$40,000 over seven months. There were additional areas of concern highlighted throughout the evaluation period:

- The geography of Alaska limited providers' ability to provide services within a safe driving distance.

⁵⁻³ If the recipient is ineligible for Medicaid, then neither State plan nor 1115 billing codes should be used. For those ineligible for Medicaid, State grants are used to support provider organizations that serve non-resourced service recipients; funding for this population has continued during the demonstration period to ensure access to services via grants. Providers are only required to provide services to non-Medicaid recipients as a component of their grant requirements.

⁵⁻⁴ There may be confusion among providers between peer support services and peer-based crisis services. Peer support services are provided under the Alaska state plan, while peer-based crisis services have not been implemented.



- Difficulty in providing services to youth with BH needs due to the limited number of beds, especially residential psychiatric treatment beds for youth.
- Community stigma against SUD residential providers.
- Some providers felt that access to care had not changed, some felt it had increased, and others felt that access decreased. Reasons that providers believe access decreased include:
 - One provider was forced to stop providing school-based youth services due to confusion surrounding multiple sunset dates for State plan codes and closed an entire clinic due to waiver billing issues.
 - Patients must wait for service authorizations while in crisis. This was identified as burdensome and clinically unhealthy.
- Providers struggled to continue providing services to non-Medicaid patients.
 - Prior to the waiver, the same services were available to Medicaid and non-Medicaid patients. The waiver created a gap in services available between groups.
 - The State maintained a heavy focus on Medicaid and, according to one provider, forgot that providers must serve non-Medicaid patients to stay in business.
- The waiver's focus on early intervention and prevention was not conducive to adults with long-term serious mental illness (SMI).
- Providers had to identify the client's setting when the client received telehealth services (i.e., at home or another setting).
- Agencies had to become licensed as an assisted living facility to provide adult mental health residential services.

Barriers were present in all three years of interviews. Certain barriers persisted throughout the evaluation period while others were identified in single years. There was progress towards the hypothesis with the resolution of several barriers; however, since considerable barriers have remained, the overall findings for this measure are mixed and therefore neither supports nor fails to support the hypothesis.

Additional qualitative results are located in Appendix C.

Measure 9 Conclusion: Neither supports nor fails to support the hypothesis

Providers' experience in expanding services (Measure 10)

Providers explained that services expanded steadily across all three years of interviews, as providers were able to offer new services and expand their capabilities to provide a broader continuum of care throughout the evaluation period including the addition or expansion of the following:

- American Society of Addiction Medicine (ASAM) Level 1.0, 2.1, 2.5, and 3.1 services⁵⁻⁵
- Broader use of screening, brief intervention, and referral to treatment (SBIRT)
- Crisis intervention
- Withdrawal management

⁵⁻⁵ DBH also expanded 3.3 services along with adolescent SUD services (2.5 and 3.1) although providers did not mention expanding these services.

- Improved care planning processes
- Case management and intensive case management services
- Counseling and community support services (CCSS)⁵⁻⁶
- Peer support services⁵⁻⁷
- Adult mental health residential
- CRSS
- Support for independent living⁵⁻⁸
- Assertive community treatment-based teams working with SMIs

Most services were expanded in the first and second years of the demonstration. Several providers did not add services in the third year. Additional areas of action included pioneering the license variance for adult mental health residential, requiring parent involvement in their children’s care in a concentrated nonassertive approach, receiving level of care certifications, hiring peer support specialists, and improving awareness and consistency of care through SUD care coordination. Many providers expressed excitement about expanding peer support group services.

However, providers also reported experiencing difficulties in expanding services, namely in providing peer support services. Peers had difficulties gaining clearance via a background check to perform peer support services because many peers had an issue appear on the background check. Providers had to complete a variance to allow the peer to work which could take up to eight weeks to gather all the correct paperwork. Many peers dropped out of the program because they could not wait while being unpaid.⁵⁻⁹ Additionally, providers felt there was not enough funding and resources for proper implementation. One provider required grant funds to operate for the first six months of implementation.

The COVID-19 PHE was perceived as creating a backlog for higher levels of service as more patients and staff were impacted by mental health crises. Throughout the COVID-19 PHE, providers continued to expand services but at a slower rate than originally anticipated, to meet the needs of the community. Response to the pandemic led stakeholders to work together in creative ways that brought a spirit of innovation that will continue as the pandemic becomes less acute. For example, providers who normally did not work together collaborated to provide joint access to 23-hour crisis stabilization for quarantined individuals, hoping that this solution would last beyond the needs of the pandemic. Additional qualitative results are located in Appendix C.

Overall, providers experienced success in standing up services, leading to increased access for beneficiaries to engage in necessary services. Therefore, the hypothesis is supported.

Measure 10 Conclusion: Supports the hypothesis

⁵⁻⁶ CCSS has been sunsetted but was mentioned as being expanded by a provider. CCSS was replaced by Community Recovery Support Services.

⁵⁻⁷ Peer support services are provided under the state plan.

⁵⁻⁸ Independent living support services are not provided under the Alaska 1115 SUD-BH waiver but were mentioned by a provider with respect to services they have expanded related to SUD and BH care and is included as such.

⁵⁻⁹ Background checks and clearances are under the purview of the Division of Health Care Services (HCS). DBH is collaborating with HCS to reduce the process time to enroll peer support staff.



Administrators' reported barriers before, during, and shortly following expansion of BH and SUD services (Measure 11)

When asked to share their concerns about the waiver, State administrators noted several areas of concern including the bifurcation of BH and SUD services, administrative burden, and workforce challenges. State administrators acknowledged that the bifurcation of SUD and BH waiver service regulations had resulted in some unintentional complexity and inconsistencies between the handling of SUD and BH services that may have interfered with their goal of providing integrated care and may have caused confusion among other stakeholders. State administrators found that providers seemed to have had an easier time switching to SUD waiver services compared to BH services. They reported awareness that some providers experienced issues due to SUD and BH QAP certification requirements being different despite QAPs performing the same responsibilities for SUD and BH services. One State administrator also identified that the bifurcation may have resulted in a greater focus on SUD services rather than BH services, resulting perhaps in missed BH opportunities.

State administrators shared awareness of and concern for providers' experience of administrative burden as a result of the waiver, particularly related to billing for services and the fears related to potential future Medicaid audits. State administrators understood that some providers found waiver regulations difficult to understand, and that this was perhaps exacerbated by the volume of changes to regulations as well as the differences between the separately released SUD and BH components. Informants recognized that there may have been some disconnect between the administrative burden they believed they were imposing with the regulations and that experienced by providers seeking to work under the regulations.

State administrators reported an adjustment period as DBH became accustomed to working with Centers for Medicare & Medicaid Services (CMS) and its regulatory environment and noted that they had faced increased administrative burden internally as they worked through the waiver process. For example, Alaska's fee-for-service (FFS) environment added complications not-present for many states that use managed care entities to provide Medicaid services.

Several State administrators also shared the broader stakeholder community's concerns about billing under the waiver. One informant acknowledged that reimplementing service authorizations will be a challenge when the COVID-19 PHE ends and recognized the need to educate providers on the process. For example, there might be misapprehensions about how authorizations would relate to discharges.

Administrators acknowledged that they heard providers' requests for payment reforms and concerns about whether they can grow their service array on the current rate trajectory; however, the State has limited ability to change rates set or approved by CMS. Another concern was finding a middle ground between coverage of services that were borderline long-term care (LTC) and might not be able to be billed to Medicaid. Informants were aware of issues related to the sunseting of State plan codes, particularly in how rates were impacted by the transition.

One administrator mentioned concern about DOH's internal restructure that occurred during the third year of interviews. The informant specifically noted a split of internal resources between new departments. Most State interviewees, however, believed that the restructure would have had limited impact on waiver issues.

State administrators cited lessons learned about the process of onboarding the ASO, Optum. For example, one informant indicated that Optum did not capture NPI numbers, so DBH had to pull data from other sources. The transition to Optum was described as difficult by several state administrators, who said that many providers had not successfully transitioned as of the second year of interviews; however, this was no longer reported to be an issue by the third year of interviews.

Other delays and challenges noted by State administrators included:



- Significant workforce shortages in Alaska continued to impact waiver expansion and services at the provider and State administrative levels.
 - Alaska’s geography, cost of living, and access to broadband contributed to workforce challenges.
 - A volatile economy reflecting reliance on the oil industry.
- Lack of specific guidance from CMS regarding its expectations for engaging in meaningful dialogue with tribal entities.
- An increased urgency of children’s mental health issues with the evolution of the COVID-19 PHE.
- The waiver renewal occurring during an election year.
 - The new administration may not have recognized the importance of the waiver.
 - Negotiations for the waiver occurred during the legislative session, increasing the pressure on the timeframe for renewal.
- Increase in opioid-related overdose deaths prior to the implementation of the waiver.

Many of the barriers brought up by state administrators described providers’ experiences with the waiver implementation, which directly impacts the care that beneficiaries receive and engage in. Therefore, the conclusion for this measure is does not support the hypothesis.

Additional qualitative results are located in Appendix C.

Measure 11 Conclusion: Does not support the hypothesis

Administrators' plan for program sustainability and anticipated challenges (Measure 12)

State administrators highlighted a variety of topics related to sustainability. COVID-19 greatly impacted the sustainability of core services during the first year due to a loss of face-to-face engagement, impact to providers’ revenue, and slowed expansion growth.

The second year of interviews highlighted several new topics related to sustainability. Interviewees reiterated the need to examine improved outcomes from providing early intervention in the long term when judging sustainability. Several state administrators described difficulty obtaining the data needed to demonstrate sustainability from Optum, while acknowledging that some of these difficulties might be due to the COVID-19 PHE rather than the waiver. At that time, State administrators expressed a clear view of the waiver’s financial impact which included \$200 million entering Alaska to pay BH providers’ Medicaid claims.

State administrators identified the waiver as generally stable in year three, although sustainability planning continued to be an ongoing process. Interviewees shared concerns about funding and that they were seeking additional grant dollars to support waiver services. One informant highlighted that grant funding, specifically COVID-19-related funding, may have caused a general decline in the Medicaid budget due to a line veto performed by the State legislature. State administrators also discussed issues regarding select reimbursement rates. Youth crisis residential services were noted as being too low and not cost effective while mobile crisis services were identified as difficult to implement without proper staffing.

Overall, several state administrators reported that there was more money available for Medicaid as a result of the SUD-BH Program. However, there were consistent concerns surrounding reimbursement rates. The SUD-BH Program allowed more beneficiaries to engage in proper treatment and State administrators are actively working to ensure the sustainability of the waiver leads to the conclusion that this measure supports the hypothesis. Additional qualitative results are located in Appendix C.

Measure 12 Conclusion: Support the hypothesis**Alaska tribal entities reported changes in quality of care and access to care following expansion of BH and SUD services (Measure 13)**

Tribal health organizations (THOs) informants were asked to share their perspective on changes in access to care following the expansion of SUD and BH services. In the second year of interviews, THOs were facing long wait lists for crucial services and a shortage of residential beds, primarily for children. THOs had not seen any growth in the number of providers, but they did see some improvement in early interventions and support for families. By the third year, THOs provided a mixed response on changes in access to care for their patients. Several were still experiencing long waitlists, others stated there had been no change, while another mentioned that access to psychiatric medication management had improved.

THOs were also asked to provide their perspective on changes in quality of care following the expansion of BH and SUD services. In year two of interviews, THOs felt it was too early to note any changes in quality and highlighted that their mission was to provide high-quality care regardless of the waiver's existence. One informant applauded the inclusion of a cultural competency continuing education unit (CEU) requirement for certification of QAPs, acknowledging the importance of including cultural sensitivity training for providers in certification standards.

In the third year of interviews, responses regarding changes in quality of care were mixed. Several THOs mentioned an increase in the quality of care due to enhanced patient engagement as peer support services began. Others reported that the bifurcation of SUD and BH services along with a lengthy paperwork process resulted in a decrease in the quality of care. One THO felt that differences were only operational, and quality of care had not changed because the THO had been an accredited organization prior to the waiver. Another THO noted that in the future, it hoped to make cultural-specific care and other similar practices more standardized to continue to improve quality.

Several THOs expressed difficulties performing their typical duties for several months in 2021 due to a statewide cyberattack that impacted AKAIMS. During the cyberattack, THOs were forced to switch to a paper-based record systems instead of an electronic version. This caused one THO to have to spend time away from patients and physically move records around the facility each day, impacting the quality of care they were able to provide. During the cyberattack, progress towards expanding services and implementing key waiver functions halted as THOs focused on providing care while using cumbersome paper methods. One THO mentioned that having to deal with the cyberattack and the COVID-19 PHE simultaneously was a challenge and there continues to be a need to provide early intervention and prevention services.

Overwhelmingly, THOs responded with mixed experiences regarding changes in the quality of care and access to care. Due to the lack of consensus, either negative or positive, the conclusion for this measure is does not support nor fails to support the hypothesis. Additional qualitative results are located in Appendix C.

Measure 13 Conclusion: Neither supports nor fails to support the hypothesis

Hypothesis 2: The SUD-BH Program will decrease utilization of ED, IP, or institutional settings within the beneficiary population.

Inpatient admissions for SUD, and specifically for OUD (Measure 14)

An interrupted time series (ITS) analysis was used to assess the rate of inpatient (IP) admissions for SUD in the year prior to waiver approval and the first three years of the demonstration. Table 5-9 shows the primary results from the ITS analysis, and Figure 5-3 illustrates the model-based average rate in each month (blue line) and projected rate had the baseline trend continued (gray dashed line).

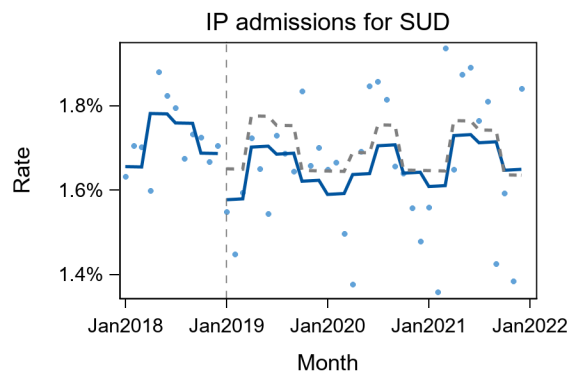
Table 5-9—Primary ITS Results (Measure 14: Any SUD)

Variable	Change in Odds	p-value
Baseline monthly trend	-0.03	0.959
Level change at implementation	-4.60	0.235
Change in monthly trend	0.09	0.856

*p < 0.1, **p < 0.05, ***p < 0.001

Note: Full model results are presented in Appendix A.

Figure 5-3—Illustration of ITS Analysis (Measure 14: Any SUD)



Analysis indicates that there was no significant change in the rates of IP admissions for SUD following the approval of the demonstration in 2019. On average, the odds of an IP admission for SUD declined by 4.6 percent upon implementation, but this decrease was not statistically significant.

Similarly, the rates of IP admissions specifically for opioid use disorder (OUD) also did not change significantly following the implementation of the demonstration, as indicated in Table 5-10 and Figure 5-4.

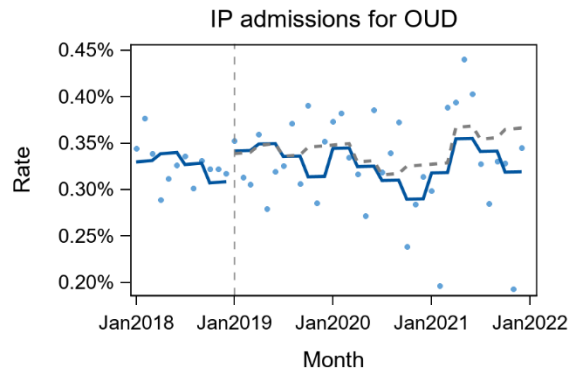
Table 5-10—Primary ITS Results (Measure 14: OUD)

Variable	Change in Odds	p-value
Baseline monthly trend	0.22	0.850
Level change at implementation	1.04	0.909
Change in monthly trend	-0.16	0.893

*p < 0.1, **p < 0.05, ***p < 0.001

Note: Full model results are presented in Appendix A.

Figure 5-4—Illustration of ITS Analysis (Measure 14: OUD)



Because statistical analysis did not detect a measurable change in the rate, results from this analysis neither support nor fail to support the hypothesis.

Measure 14 Conclusion: Neither supports nor fails to support the hypothesis

Inpatient admissions for BH disorders (Measure 15)

An ITS analysis was used to assess the rate of IP admissions for BH disorder in the year prior to waiver approval and the first three years of the demonstration. Table 5-11 shows the primary results from the ITS analysis, and Figure 5-5 illustrates the model-based average rate in each month (blue line) and projected rate had the baseline trend continued (gray dashed line).

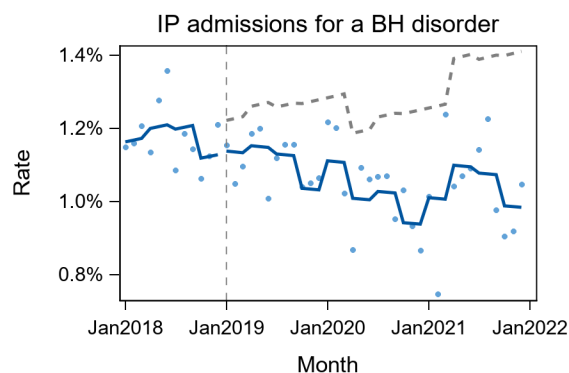
Table 5-11—Primary ITS Results (Measure 15)

Variable	Change in Odds	p-value
Baseline monthly trend	0.42	0.516
Level change at implementation	-6.38	0.175
Change in monthly trend	-0.61	0.330

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Note: Full model results are presented in Appendix A.

Figure 5-5—Illustration of ITS Analysis (Measure 15)



Although the rate of IP admissions for a BH disorder decreased relative to the projected rate had the baseline trend continued, this decrease was not statistically significant. The odds of an IP admission for a BH visit decreased by 6.38 percent upon implementation and the odds decreased by 0.61 percent per month. Because results of this analysis were not statistically significant, results to-date neither support nor fail to support the hypothesis.

Measure 15 Conclusion: Neither supports nor fails to support the hypothesis

ED visits for SUD, by setting (Measure 16a)

An ITS analysis was used to assess the rate of ED visits for SUD in the year prior to waiver approval and the first three years of the demonstration. Table 5-12 shows the primary results from the ITS analysis, and Figure 5-6 illustrates the model-based average rate in each month (blue line) and projected rate had the baseline trend continued (gray dashed line).

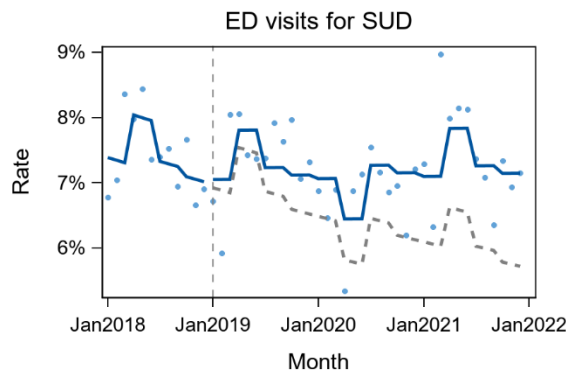
Table 5-12—Primary ITS Results (Measure 16a: Any SUD)

Variable	Change in Odds	p-value
Baseline monthly trend	-0.58	0.025**
Level change at implementation	1.38	0.488
Change in monthly trend	0.60	0.020**

*p < 0.1, **p < 0.05, ***p < 0.001

Note: Full model results are presented in Appendix A.

Figure 5-6—Illustration of ITS Analysis (Measure 16a: Any SUD)



Analysis shows that the odds of an ED visit for SUD increased by 0.60 percent following the implementation of the demonstration compared to the projected rates had the baseline trend continued, which was statistically significant (p=0.020).

Measure 16a Conclusion: Fails to support the hypothesis

ED visits for OUD, by setting (Measure 16b)

However, the rate of ED visits for OUD specifically decreased relative to the projected baseline trend, as indicated in Table 5-13 and Figure 5-7.

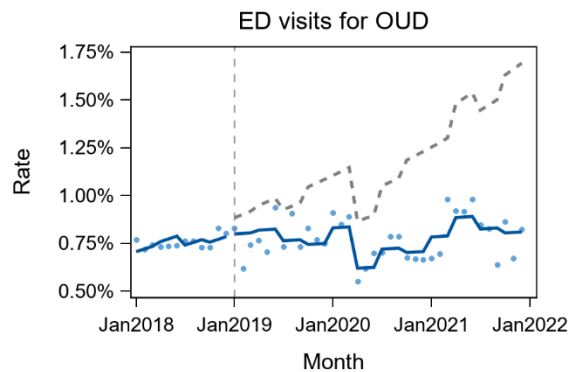
Table 5-13—Primary ITS Results (Measure 16b: OUD)

Variable	Change in Odds	p-value
Baseline monthly trend	1.90	0.016**
Level change at implementation	-8.26	0.139
Change in monthly trend	-1.54	0.044**

*p < 0.1, **p < 0.05, ***p < 0.001

Note: Full model results are presented in Appendix A.

Figure 5-7—Illustration of ITS Analysis (Measure 16b: OUD)



Analysis shows that the odds of an ED visit during the baseline was increasing significantly, by 1.90 percent ($p=0.016$). After implementation of the demonstration, this trend essentially flattened with a relative decrease in the trend of 1.54 percent ($p=0.044$).

Measure 16b Conclusion: Supports the hypothesis

ED visits for a BH disorder, by setting (Measure 17)

An ITS analysis was used to assess the rate of ED visits for BH disorders in the year prior to waiver approval and the first three years of the demonstration. Table 5-14 shows the primary results from the ITS analysis, and Figure 5-8 illustrates the model-based average rate in each month (blue line) and projected rate had the baseline trend continued (gray dashed line).

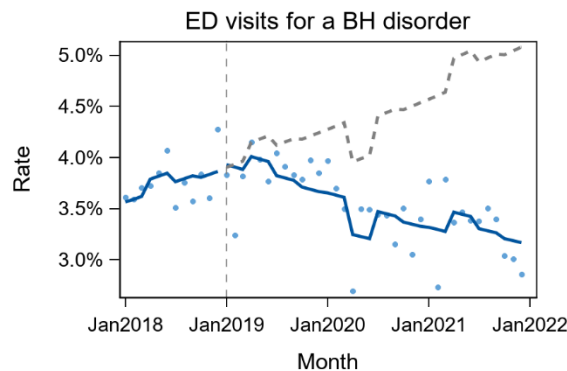
Table 5-14—Primary ITS Results (Measure 17: ED Visits)

Variable	Change in Odds	p-value
Baseline monthly trend	0.79	0.028**
Level change at implementation	2.13	0.433
Change in monthly trend	-1.41	<0.001***

*p < 0.1, **p < 0.05, ***p < 0.001

Note: Full model results are presented in Appendix A.

Figure 5-8—Illustration of ITS Analysis (Measure 17: ED Visits)



Analysis shows that prior to the start of the demonstration, the rate of ED visits for BH disorders was increasing—the odds of an ED visit was increasing by 0.79 percent per month ($p=0.028$). After implementation, the odds of an ED visit for BH decreased significantly compared to the projected rates had the baseline trend continued, by 1.41 percent per month ($p<0.001$).

Measure 17 Conclusion: Supports the hypothesis

Mean length of stay measured from admission date to discharge date, by setting (Measure 18)

Measure 18 intends to examine whether the demonstration has decreased utilization of institutions for mental diseases (IMD) within the waiver population by assessing the mean length of stay from date of admission to date of discharge within IMDs for SUDs. As shown in Table 5-15, the mean length of stay decreased from 2018–2021. In 2018, the average length of stay in an IMD for SUD was 76.12 days. The average length of stay decreased in 2019 to 27.00 days and in 2020 to 18.48 days before increasing in 2021 to 43.92 days. The average length of stay in an IMD for SUD in the evaluation period was 26.90 days which was 49.22 days less than the average length of stay in an IMD for SUD in 2018. This was found to be a statistically significant difference ($p<0.001$). Although the appropriate length of stay is determined by medical necessity, the State is targeting a statewide average length of stay of 30 days.⁵⁻¹⁰ Because the average length of stay trended closer to the targeted average, this represents an overall improvement. Length of stay declined from 76.1 days (46 days more than the targeted average) to 26.9 days (3.1 days less than the average) which represents an overall improvement.

Table 5-15—Mean Length of Stay Measured in an IMD for SUDs from Admission Date to Discharge Date, 2018–2021

	Baseline Period		Evaluation Period			Weighted Average	Change In Days	p-value
	2018	2019	2020	2021				
Mean length of stay measured from admission date to discharge date, in days	76.12	27.00	18.48	43.92	26.90	-49.22	<0.001***	

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

⁵⁻¹⁰ Special Terms and Conditions, #21 <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ak/ak-stcs-apprvl-ltr-05272021.pdf>; Accessed on: Oct 31, 2022.

Measure 18 Conclusion: Supports the hypothesis

30-day readmission rate to IP facilities following hospitalization for a SUD related diagnosis, by setting (Measure 19)

Overall, quarterly 30-day readmission rates to IP facilities following hospitalization for SUD related diagnoses among waiver beneficiaries were inconsistent from 2018 to 2021. Rates reached their lowest point in Q3 and Q4 of 2018 at 10.5 percent before increasing to their peak at 23.0 percent in Q4 2020 as seen in Figure 5-9. The rate then fell back to 12.5 percent in Q4 2021. Table 5-16 shows a 2.3 percentage point increase in the 30-day readmission rate among waiver beneficiaries between the baseline period and evaluation period on average, though this was not a statistically significant difference ($p=0.201$).

Figure 5-9—30 Day Readmission Rate to IP Facilities Following Hospitalization for a SUD Related Diagnosis, 2018–2021

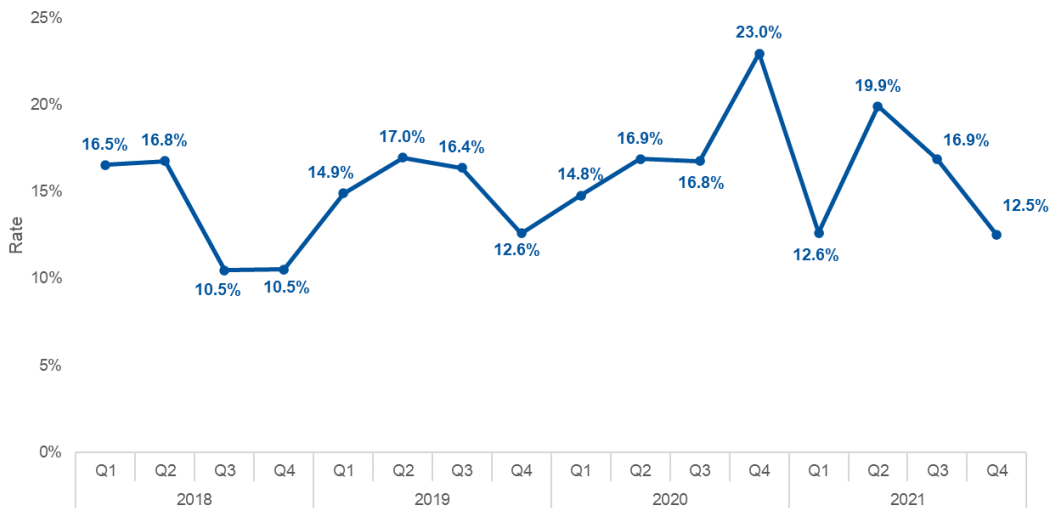


Table 5-16—30 Day Readmission Rate to IP Facilities Following Hospitalization for a SUD Related Diagnosis

	Baseline Period (2018)	Evaluation Period (2019-2021)	Percentage Point Change	p-value
	Weighted Average	Weighted Average		
30-day readmission rate to IP facilities following hospitalization for a SUD related diagnosis	14.1%	16.4%	2.3pp	0.201

Note: pp=percentage point
 * $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Measure 19 Conclusion: Neither supports nor fails to support the hypothesis

30-Day readmission rate to IP facilities following hospitalization for a BH related diagnosis, by setting (Measure 20)

Similar to quarterly 30-day readmission rates to IP facilities following hospitalization for SUD, quarterly 30-day readmission rates to IP facilities following hospitalization for BH-related diagnoses among waiver beneficiaries were inconsistent from 2018 to 2021, as shown in Figure 5-10. Of note, the readmission rate reached its lowest point of 10.0 percent in Q2 2020, which could possibly be attributed to the COVID-19 PHE. The rate then

increased to 13.2 percent in Q3 2020. Table 5-17 shows a 0.2 percentage point difference between the average baseline period rate and the average evaluation period rate, which was not found to be statistically significant ($p=0.881$).

Figure 5-10—30 Day Readmission Rate to IP Facilities Following Hospitalization for a BH Related Diagnosis

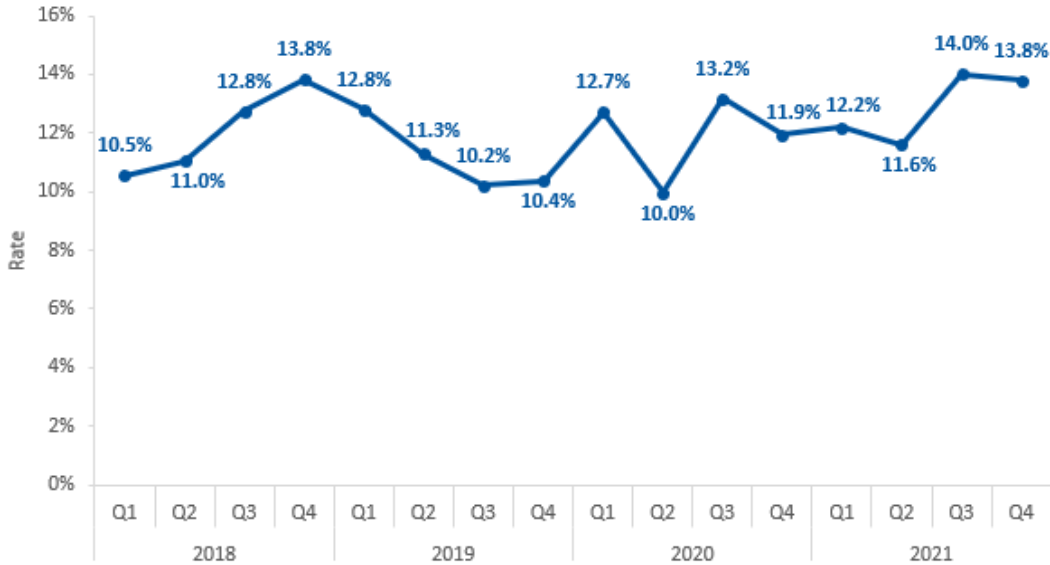


Table 5-17—30 Day Readmission Rate to IP Facilities Following Hospitalization for a BH Related Diagnosis

	Baseline Period (2018)	Evaluation Period (2019-2021)	Percentage Point Change	p-value
	Weighted Average	Weighted Average		
30-day readmission rate to IP facilities following hospitalization for a BH-related diagnosis, by setting	11.8%	12.0%	0.2pp	0.881

Note: pp=percentage point
 $*p < 0.1$, $**p < 0.05$, $***p < 0.001$

Measure 20 Conclusion: Neither supports nor fails to support the hypothesis

Hypothesis 3: The SUD-BH Program will increase the percentage of beneficiaries who adhere to treatment for SUD and BH disorders

Number of beneficiaries with a SUD diagnosis including those with OUD who used services in the last month or year, by service or benefit type (Measure 21)

An ITS analysis was used to assess the percentage of beneficiaries with a SUD diagnosis utilizing relevant treatment services in the year prior to waiver approval and the first three years of the demonstration. Settings included are:

- Early Intervention (CMS SUD Monitoring Metric #7)

- Outpatient (OP) (CMS SUD Monitoring Metric #8)
- Intensive Outpatient and Partial Hospitalization (IOP/PH) (CMS SUD Monitoring Metric #9)
- Residential and IP (CMS SUD Monitoring Metric #10)
- Withdrawal Management (CMS SUD Monitoring Metric #11)
- Medication-assisted Treatment (CMS SUD Monitoring Metric #12)

Due to low and highly variable rates of early intervention particularly in the baseline (average rate of 0.057 percent per month in 2018 and 0.171 percent in 2019–2021) results of statistical testing are not reliable.

ITS analysis shows that the rate of beneficiaries with SUD utilizing OP services was increasing slightly but statistically significantly during the baseline period as displayed in Table 5-18 and Figure 5-11. Shortly following implementation of the waiver in 2019, the rate began to decline by a statistically significant degree compared to the baseline trend. The odds of an OP visit declined by 1.54 percent per month relative to the baseline trend.

Table 5-18—Primary ITS Results (Measure 21: OP Services)

Variable	Change in Odds	p-value
Baseline monthly trend	0.81	<0.001***
Level change at implementation	7.63	<0.001***
Change in monthly trend	-1.54	<0.001***

*p < 0.1, **p < 0.05, ***p < 0.001

Note: Full model results are presented in Appendix A.

Figure 5-11—Illustration of ITS Analysis (Measure 21: OP Services)

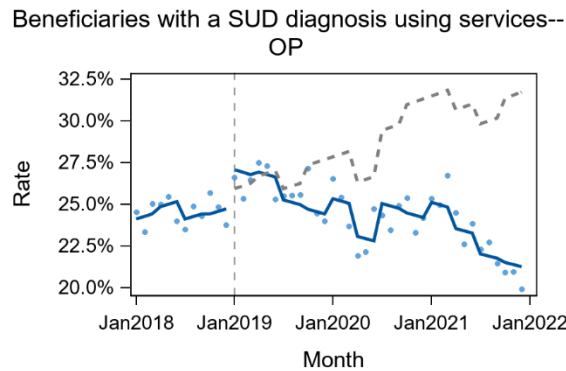


Table 5-19 and Figure 5-12 display the ITS results of IOP/PH. In contrast to OP services, the utilization of IOP/PH services declined during the baseline period, with the odds decreasing by 3.13 percent per month. Following implementation of the demonstration, however, rates began to stabilize before trending upwards and increasing significantly in 2021. In 2021, utilization of IOP/PH increased substantially for Region 1 (Anchorage Municipality) and Region 6 (Western Region [Kotzebue, Nome, and Bethel]). The odds of an IOP/PH visit increased by 7.72 percent per month relative to the baseline trend.

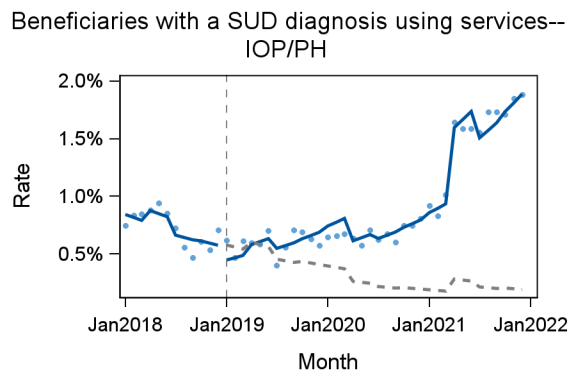
Table 5-19—Primary ITS Results (Measure 21: IOP and PH Services)

Variable	Change in Odds	p-value
Baseline monthly trend	-3.13	<0.001***
Level change at implementation	-28.18	<0.001***
Change in monthly trend	7.72	<0.001***

*p < 0.1, **p < 0.05, ***p < 0.001

Note: Full model results are presented in Appendix A.

Figure 5-12—Illustration of ITS Analysis (Measure 21: IOP and PH Services)



Similar to utilization of IOP/PH services, utilization of residential and IP services declined during the baseline period but began increasing significantly relative to the baseline trend as displayed in Table 5-20 and Figure 5-13. Following implementation of the demonstration, the odds of a residential or IP service increased by 1.76 percent per month relative to the baseline trend, which was a statistically significant change.

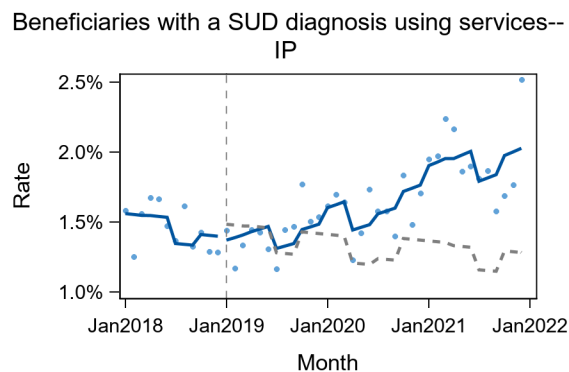
Table 5-20—Primary ITS Results (Measure 21: Residential and IP Services)

Variable	Change in Odds	p-value
Baseline monthly trend	-0.42	0.487
Level change at implementation	-9.33	0.036**
Change in monthly trend	1.76	0.004**

*p < 0.1, **p < 0.05, ***p < 0.001

Note: Full model results are presented in Appendix A.

Figure 5-13—Illustration of ITS Analysis (Measure 21: Residential and IP Services)



ITS analysis shows that the utilization of withdrawal management services—while relatively infrequent at less than 1 percent—increased slightly during the baseline period as seen in Table 5-21 and Figure 5-14. Although ITS showed a significant decrease in the odds of withdrawal management following implementation (18.94 percent decrease in the odds), there was no significant change in the trend.

Table 5-21—Primary ITS Results (Measure 21: Withdrawal Management Services)

Variable	Change in Odds	p-value
Baseline monthly trend	1.14	0.233
Level change at implementation	-18.94	0.004**
Change in monthly trend	-0.36	0.698

*p < 0.1, **p < 0.05, ***p < 0.001

Note: Full model results are presented in Appendix A.

Figure 5-14—Illustration of ITS Analysis (Measure 21: Withdrawal Management Services)

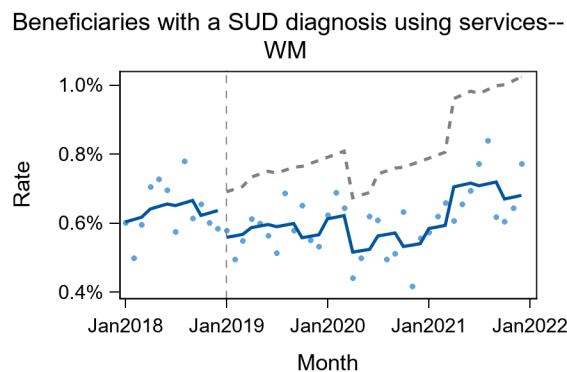


Table 5-22 and Figure 5-15 show the ITS results for medication assisted treatment (MAT). The rate of MAT increased significantly during the baseline, with the odds increasing by 1.43 percent per month. Following implementation, the odds increased by 3.65 percent ($p=0.029$); however, the trend increased by a lower margin, with the odds of MAT decreasing by 0.73 percent per month relative to the baseline trend ($p < 0.001$).

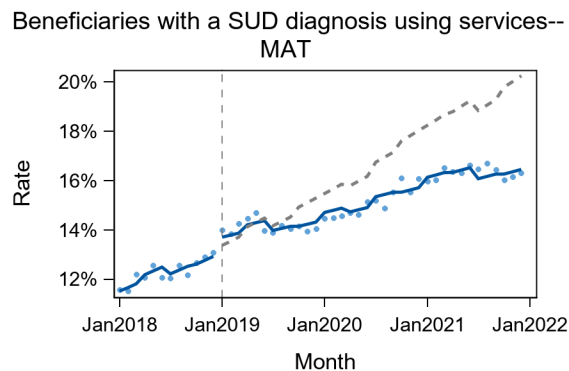
Table 5-22—Primary ITS Results (Measure 21: MAT)

Variable	Change in Odds	p-value
Baseline monthly trend	1.43	<0.001***
Level change at implementation	3.65	0.029**
Change in monthly trend	-0.73	<0.001***

*p < 0.1, **p < 0.05, ***p < 0.001

Note: Full model results are presented in Appendix A.

Figure 5-15—Illustration of ITS Analysis (Measure 21: MAT)



Across all categories of service, the results were mixed and indicate potential substitution effects. There appears to be a shift from OP to residential, IP and IOP/PH. This could be partially because treatment for SUD in the OP setting had been covered under Alaska Medicaid State Plan, and residential, IP, and IOP/PH are new additions under the 1115 waiver.⁵⁻¹¹ If the opening of new services for treating SUD is the primary cause of this shift, then it is an indication that members with a SUD are receiving more appropriate care.

Measure 21 Conclusion: Supports the hypothesis

Number of beneficiaries with a BH diagnosis who used services in the last month or year, by service or benefit type (Measure 22)

An ITS analysis was used to assess the percentage of beneficiaries with a BH diagnosis utilizing relevant treatment services in the year prior to waiver approval and the first three years of the demonstration. Settings included are aligned with the Healthcare Effectiveness Data and Information Set (HEDIS^{®5-12}) measure for mental health utilization:

- IP
- IOP or PH
- OP
- ED
- Telehealth
- Any service

Table 5-23 and Figure 5-16 display the ITS results for IP utilization for those with a BH diagnosis. The percentage of beneficiaries with a BH diagnosis utilizing IP services declined slightly throughout the baseline and evaluation period; however, this decline was not statistically significant, nor was there a statistically significant change following implementation in 2019.

⁵⁻¹¹ Alaska 1115 Waiver Implementation Plan, March 13, 2019. Available at: <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ak/behavioral-health/ak-behavioral-health-demo-appvd-implementation-20190321.pdf>. Accessed on: Oct 24, 2022.

⁵⁻¹² HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

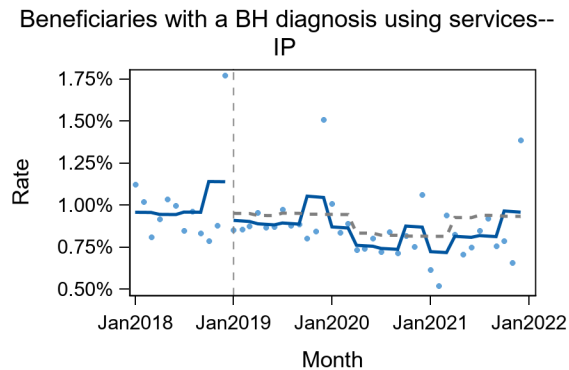
Table 5-23—Primary ITS Results (Measure 22: IP)

Variable	Change in Odds	p-value
Baseline monthly trend	-0.06	0.953
Level change at implementation	-4.15	0.554
Change in monthly trend	-0.31	0.739

*p < 0.1, **p < 0.05, ***p < 0.001

Note: Full model results are presented in Appendix A.

Figure 5-16—Illustration of ITS Analysis (Measure 22: IP)



ITS analysis shows a decline in the utilization of IOP/PH services upon implementation of the waiver with the odds decreasing by 20.21 percent ($p = 0.001$) as shown in Table 5-24 and Figure 5-17. However, the trend after implementation did not change significantly compared to the baseline trend.

Table 5-24—Primary ITS Results (Measure 22: IOP/PH)

Variable	Change in Odds	p-value
Baseline monthly trend	-1.45	0.094*
Level change at implementation	-20.21	0.001**
Change in monthly trend	0.98	0.255

*p < 0.1, **p < 0.05, ***p < 0.001

Note: Full model results are presented in Appendix A.

Figure 5-17—Illustration of IT Analysis (Measure 22: IOP/PH)

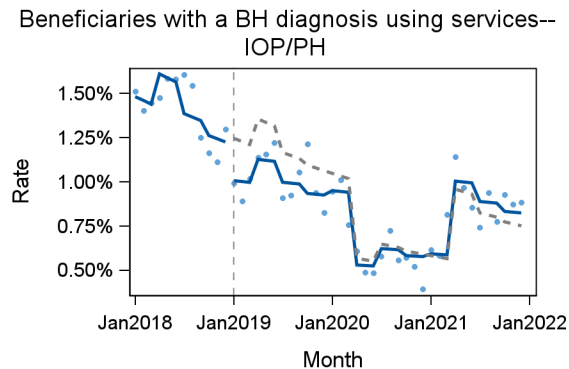


Table 5-25 and Figure 5-18 show the results of the ITS analysis for those with a BH diagnosis utilizing OP services. ITS analysis shows a significant increase in the odds of utilizing OP services at time of implementation

(odds of an OP visit increased by 26.55 percent, $p < 0.001$); however, there was also a significant decrease in the trend following implementation, with the odds of an OP visit declining by 1.81 percent per month ($p < 0.001$).

It is important to note, however, that this may primarily be driven by the COVID-19 PHE, which to date appears to have caused a sustained decrease in the utilization of this setting. Adding a COVID-19 control for the period of Q2 2021–Q4 2021 (not shown) effectively reverses the observed impact. In this model, the trend relative to baseline increased in odds of 0.78 percent per month ($p = 0.012$) and a level change at implementation of 1.48 percent ($p = 0.546$). Although Health Services Advisory Group, Inc.’s (HSAG’s) COVID-19 controls appear to have accounted for the impact of the PHE on most other measures, the sustained decrease in this setting in the latter part of 2021 may bias the findings. HSAG shows results from this analysis for consistency with remaining measures and the uncertainty surrounding the continued impact of the COVID-19 PHE. It is possible that other settings such as telemedicine are serving as a substitute for the OP setting. HSAG anticipates the substitution effect between telemedicine and OP services will be clearer in the Summative Evaluation Report, as additional data are gathered for the remainder of the demonstration period.

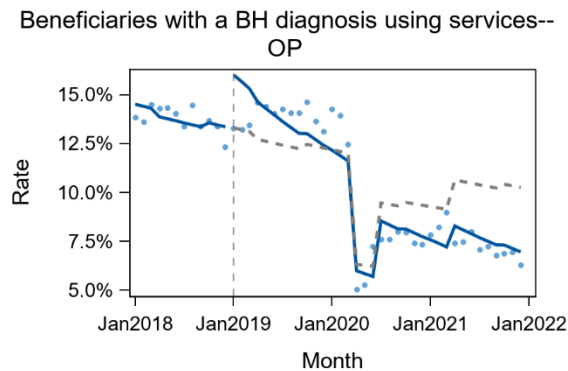
Table 5-25—Primary ITS Results (Measure 22: OP)

Variable	Change in Odds	p-value
Baseline monthly trend	-0.84	0.003**
Level change at implementation	26.55	<0.001***
Change in monthly trend	-1.81	<0.001***

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Note: Full model results are presented in Appendix A.

Figure 5-18—Illustration of ITS Analysis (Measure 22: OP)



ITS analysis shows a significant decrease in the utilization of ED among members with a BH diagnosis during the baseline period as seen in Table 5-26 and Figure 5-19. The odds of such treatment decreased by 12.26 percent per month ($p < 0.001$). Rates increased following implementation (albeit with high variation) compared to projected rates, with the odds of a BH treatment in the ED setting increasing by 216.19 percent ($p < 0.001$). Although rates declined substantially due to the COVID-19 PHE in 2020 and 2021, they were still higher than the near-zero rates projected had the baseline trend continued.

Table 5-26—Primary ITS Results (Measure 22: ED)

Variable	Change in Odds	p-value
Baseline monthly trend	-12.26	<0.001***
Level change at implementation	216.19	<0.001***
Change in monthly trend	8.42	0.025**

*p < 0.1, **p < 0.05, ***p < 0.001

Note: Full model results are presented in Appendix A.

Figure 5-19—Illustration of ITS Analysis (Measure 22: ED)

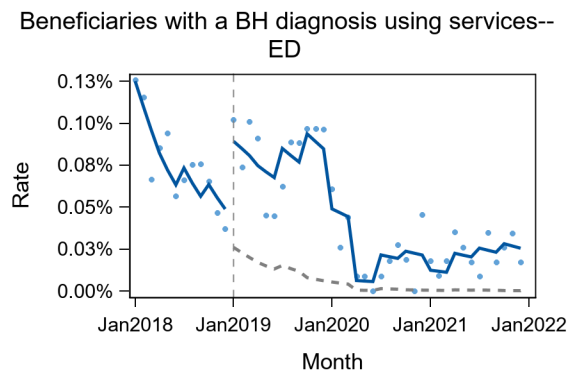


Figure 5-20 demonstrates that prior to the COVID-19 PHE, the rate of BH treatment in the telehealth setting was virtually nonexistent, with rates near zero up until March 2020. ITS analysis displayed in Table 5-27 shows that even after accounting for COVID-impacted quarters, the odds of a telehealth visit among BH members increased on average by 10.25 percent per month ($p < 0.001$), which was driven exclusively by the COVID-19 PHE. Notably, in the year following COVID-19, telehealth visits dropped by approximately 5 percentage points, but remained well above the pre-PHE levels, suggesting a more permanent shift toward this setting following the PHE.

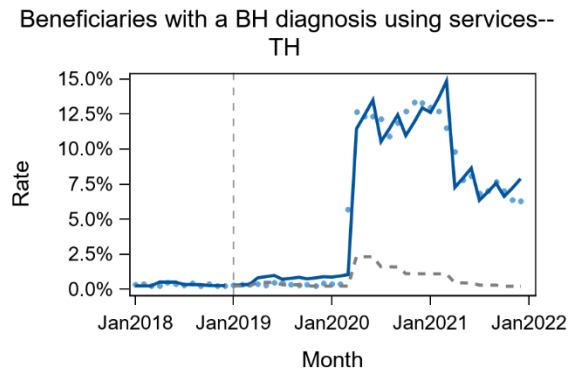
Table 5-27—Primary ITS Results (Measure 22: Telehealth)

Variable	Change in Odds	p-value
Baseline monthly trend	-0.33	0.837
Level change at implementation	14.01	0.230
Change in monthly trend	10.25	<0.001***

*p < 0.1, **p < 0.05, ***p < 0.001

Note: Full model results are presented in Appendix A.

Figure 5-20—Illustration of ITS Analysis (Measure 22: Telehealth)



Although there were significant changes in the trends specific to certain settings, overall, there was no significant change in the trend of members with a BH diagnosis using any of the settings examined in aggregate as demonstrated in Table 5-28. Figure 5-21 shows that the rate of service utilization among members with a BH diagnosis remained between approximately 15 and 16 percent until the COVID-19 PHE began, where it increased to over 18 percent.

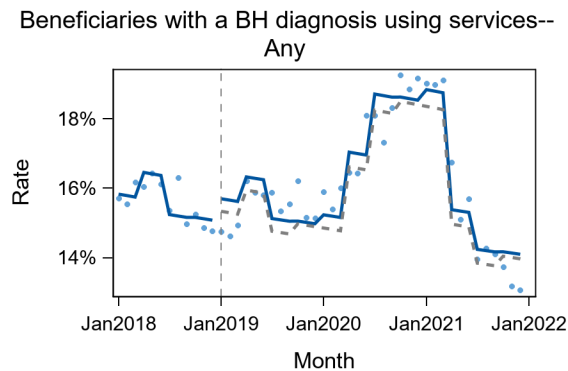
Table 5-28—Primary ITS Results (Measure 22: Any Service)

Variable	Change in Odds	p-value
Baseline monthly trend	-0.31	0.226
Level change at implementation	2.78	0.162
Change in monthly trend	0.02	0.945

*p < 0.1, **p < 0.05, ***p < 0.001

Note: Full model results are presented in Appendix A.

Figure 5-21—Illustration of ITS Analysis (Measure 22: Any Service)



Across all categories, the results were mixed and indicate potential substitution effects. The trend in utilization of OP services among beneficiaries with a BH diagnosis decreased relative to the baseline period, but ED and telehealth increased significantly. The use of telehealth appears to have replaced the OP setting, with an increase to approximately 12.5 percent during the COVID-19 PHE lockdown time frame before falling to approximately 7.5 percent thereafter. Meanwhile, the OP setting decreased from approximately 14 percent prior to the PHE to 7 percent—a decline of 7 percentage points, which is commensurate with the increase in telehealth services. Additionally, utilization of IOP/PH among the BH population did not exhibit a significant increase in 2021 as was seen among the SUD population (Measure 21). Because of these mostly mixed results, the substitution effects

likely attributable to COVID-19, and a decline in overall services following the PHE, evidence does not conclusively support nor fail to support the hypothesis.

Measure 22 Conclusion: Neither supports nor fails to support the hypothesis

Time to treatment, by service type (National Behavioral Health Quality Framework [NBHQF] Goal 1) (Measure 23)

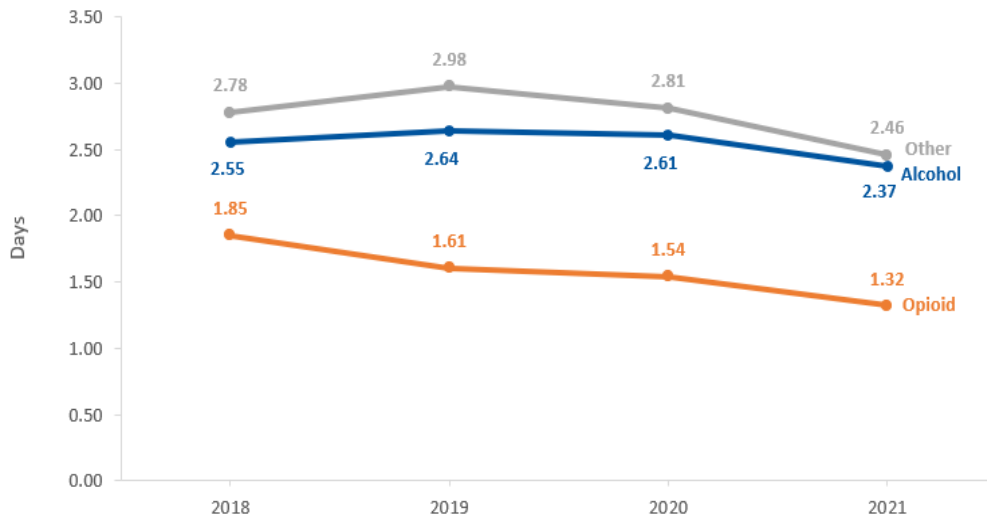
Measure 23 intends to measure the accessibility of alcohol, opioid, and other drug treatment services to the waiver population by evaluating the average time to treatment for members with an alcohol, opioid, or other drug related diagnosis. This measure assesses the time between index episode start date and first date of treatment in alignment with the HEDIS measurement year (MY) 2020 specifications for the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)* measure. For members with an alcohol abuse diagnosis, the average time to treatment was 2.55 days in 2018 and remained relatively stable in 2019 at 2.64 days and in 2020 at 2.61 days before declining slightly to 2.37 days in 2021 as displayed in Table 5-29 and Figure 5-22. The differences in average time to alcohol abuse treatment in the baseline period and the evaluation period were not statistically significant ($p=0.924$). For members with an opioid abuse diagnosis, the average time to treatment started at 1.85 days in 2018 and steadily declined year over year to 1.32 days in 2021. There was a decrease of 0.36 days in average time to opioid abuse treatment between the evaluation period and the baseline period, which was statistically significant ($p<0.001$). For members with a diagnosis for abuse of other drugs, the average time to treatment was 2.78 days in 2018 and rose in 2019 to 2.98 days before falling to 2.81 days in 2020. Rates then declined further to 2.46 days in 2021. The differences in average time to treatment for diagnoses of other drug abuse in the baseline period and the evaluation period were not statistically significant ($p=0.899$).

Table 5-29—Time to Treatment in Days

Service Type	Baseline Period		Evaluation Period			Change in Days	p-value
	2018	2019	2020	2021	Weighted Average		
Alcohol	2.55	2.64	2.61	2.37	2.54	-0.01	0.924
Opioid	1.85	1.61	1.54	1.32	1.49	-0.36	<0.001***
Other	2.78	2.98	2.81	2.46	2.76	-0.02	0.899

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Figure 5-22—Time to Treatment in Days



Although two out of the three indicators were not statistically significant, all exhibited a decline in the time to treatment, and opioid treatment indicated a significant decline in the time to treatment. Therefore, evidence suggests this hypothesis is supported.

Measure 23 Conclusion: Supports the hypothesis

Research Questions 2: Do enrollees receiving SUD services experience improved health outcomes?

Hypothesis 1: The SUD-BH Program will increase the percentage of beneficiaries with SUD or a BH disorder who experience care for comorbid conditions.

Access to physical healthcare (Measure 24)

Measure 24 describes the accessibility of physical healthcare by evaluating adult waiver beneficiaries’ access to preventive/ambulatory services and children and adolescent waiver beneficiaries’ access to primary care practitioners (PCPs).

Table 5-30 shows that overall, adults’ access to physical healthcare slightly decreased year over year from 84.5 percent in 2018 to 81.8 percent in 2021. The average rate of adults’ access to preventive/ambulatory services in the evaluation period was 1.8 percentage points less than the rate in the baseline period, a statistically significant difference ($p < 0.001$). This pattern is similar to the rates of children’s and adolescents’ access to PCPs from 2018–2021. In 2018 and 2019, the rate of children’s access to PCPs was around 94 percent before decreasing in 2020 and 2021 to a low of 89.5 percent. On average, the rate of children’s access to PCPs was 92 percent in the evaluation period, a statistically significant difference ($p < 0.001$) and a decrease of 1.9 percentage points from the rate of 93.9 percent in the baseline period.

Table 5-30—Access to Physical Healthcare

	Baseline Period		Evaluation Period			Percentage Point Change	p-value
	2018	2019	2020	2021	Weighted Average		
Adults' Access to Preventive/Ambulatory Health Services	84.5%	84.3%	82.1%	81.8%	82.7%	-1.8pp	<0.001***
Children and Adolescents' Access to PCPs	93.9%	94.1%	92.2%	89.5%	92.0%	-1.9pp	<0.001***

Note: pp=percentage point
*p< 0.1, **p < 0.05, ***p<0.001

Measure 24 Conclusion: Does not support the hypothesis

Screening for chronic conditions relevant to state Medicaid population (Measure 25)

Measure 25 aims to evaluate whether there has been an increase in waiver members who are receiving care for comorbid conditions by assessing the screening rates for chronic conditions relevant to the State Medicaid population. Appendix A contains the screening codes used for analysis. Overall, waiver members saw a slight decrease in the percentage screened for chronic conditions from 85.7 percent in the baseline period to an average of 83.8 percent in the evaluation period as seen in Table 5-31. This decrease in the average percentage of members screened for chronic conditions (1.9 percentage points) from baseline to evaluation was statistically significant (p<0.001). It is plausible that the COVID-19 PHE played a role in the chronic condition screening rates as the rates were stable from 2018 (85.7 percent) to 2019 (85.6 percent) before falling in 2020 (82.5 percent) and subsequently seeing an uptick in 2021 (83.2 percent).

Table 5-31—Screening for Chronic Conditions Relevant to State Medicaid Population, 2018–2021

	Baseline Period		Evaluation Period			Percentage Point Change	p-value
	2018	2019	2020	2021	Weighted Average		
Screening for chronic conditions relevant to State Medicaid population	85.7%	85.6%	82.5%	83.2%	83.8%	-1.9pp	<0.001***

Note: pp=percentage point
*p< 0.1, **p < 0.05, ***p<0.001

Measure 25 Conclusion: Does not support the hypothesis

Screening for co-morbidity of BH and SUDs within the waiver population compared to the total Medicaid population (Measure 26)

Measure 26 aims to determine whether the demonstration is increasing the percentage of beneficiaries who are receiving care for co-morbidity of BH disorders and SUDs. To assess this, two rates were calculated: first, the percentage of waiver members screened for BH disorders among beneficiaries diagnosed with SUDs; and second, the percentage of waiver members screened for SUDs among beneficiaries diagnosed with BH disorders.

Table 5-32 shows that both diagnosis groups saw significant decreases in their respective population screened between the baseline and evaluation periods. The average rate of waiver beneficiaries screened for BH disorders

among beneficiaries with SUDs fell by 2.3 percentage points between the baseline and evaluation periods, while the rate of screening for SUDs among waiver beneficiaries with BH disorders fell by 1.3 percentage points. Comparisons with the larger Medicaid population were not feasible due to the measure being limited to members diagnosed with either a SUD or a BH disorder, which constitutes a significant portion of the waiver population.

Table 5-32—Screening for Co-Morbidity of BH Disorders and SUDs Within the Waiver Population, 2018–2021

	Baseline Period		Evaluation Period			Percentage Point Change	p-value
	2018	2019	2020	2021	Weighted Average		
Screening for BH disorders among beneficiaries diagnosed with SUDs	21.3%	21.6%	18.8%	16.6%	19.0%	-2.3pp	<0.001***
Screening for SUDs among beneficiaries diagnosed with BH disorders	20.4%	20.4%	18.4%	18.4%	19.1%	-1.3pp	0.002**

Note: pp=percentage point
*p < 0.1, **p < 0.05, ***p < 0.001

Measure 26 Conclusion: Does not support the hypothesis

Percentage of beneficiaries who rate the quality of their healthcare as very good or excellent (Measure 27)

Measure 27 aims to assess satisfaction with healthcare by determining what percentage of survey respondents rated the quality of their healthcare as very good or excellent. Table 5-33 shows that approximately seven of 10 adult respondents reported a high rating of healthcare (8, 9, or 10 on a scale from 0 to 10). This is below the 5th percentile among managed care Medicaid beneficiaries nationally in 2020.⁵⁻¹³ Although the rate among children was higher than among adults (at 79.8 percent), this rate fell well below the 5th percentile nationally. Note that Alaska Medicaid follows an FFS model of care delivery while national percentile data are only available for Medicaid managed care organizations.

Table 5-33—Percentage of Beneficiaries who Rate the Quality of Their Healthcare as Very Good or Excellent

Group	Denominator	Numerator	Rate
Adult	245	170	68.8%
Child	323	251	79.8%

Because these survey results are for a single point in time and no similar comparison group can be found that reflects Alaska Medicaid beneficiaries, data are not sufficient to determine whether the findings support the hypothesis.

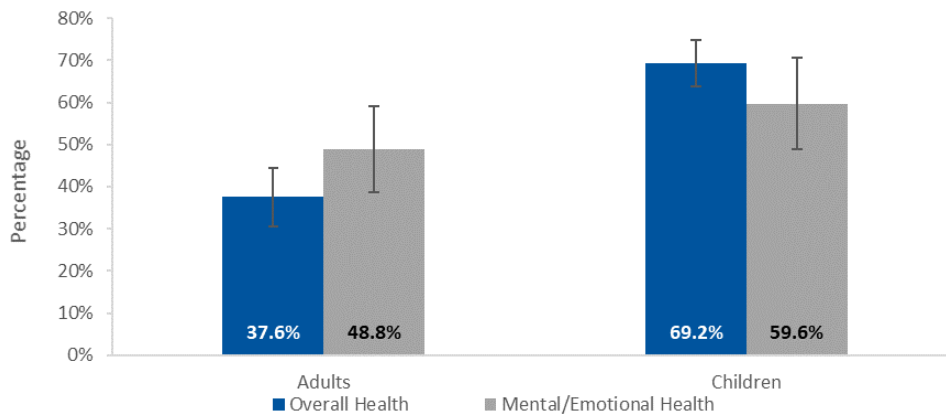
Measure 27 Conclusion: N/A

⁵⁻¹³ Benchmark values for 2021 were not available at the time this report was produced.

Percentage of beneficiaries who rate their overall mental or emotional health as very good or excellent (Measure 28)

Measure 28 aims to assess beneficiaries’ perception of their overall health and mental health by determining what percentage of survey respondents rated their overall health and mental health as very good or excellent. Figure 5-23 shows that overall, 37.6 percent of adults had a high rating of their overall health, while 48.8 percent of adults had a high rating of their mental health. This relationship was reversed among children, where 69.2 percent rated their overall health status highly while 59.6 percent rated their overall mental health status highly. National percentile data are not available for this survey item.

Figure 5-23—Percentage of Beneficiaries who Rate Their Overall Health/Mental Health as Very Good or Excellent



Note: Error bars show 95% confidence intervals.

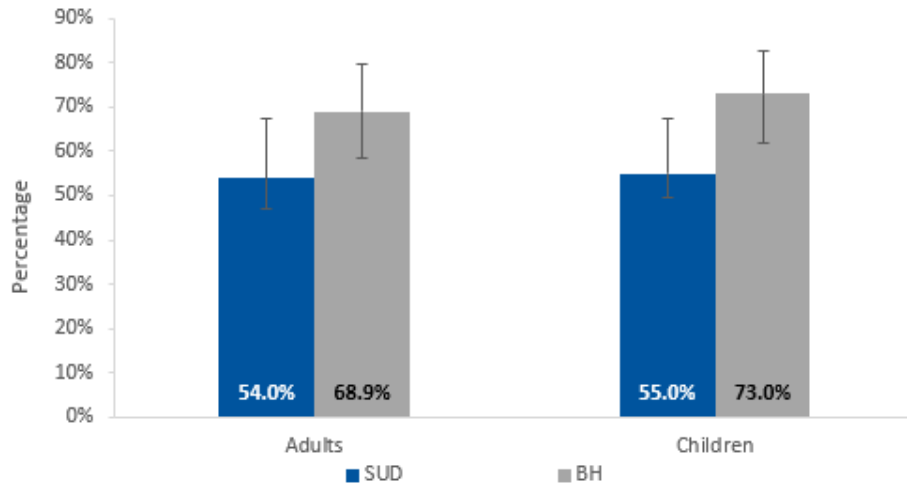
Measure 28 Conclusion: N/A

Percentage of beneficiaries who demonstrate very good or excellent knowledge of available treatment and services (Measure 29)

Measure 29 aims to measure the percentage of Medicaid beneficiaries who demonstrate very good or excellent knowledge of available SUD and BH treatment services through a custom-designed survey instrument.

The first component of this measure assesses the percentage of beneficiaries who responded that they knew where to find SUD or BH treatment services. Figure 5-24 shows that over half of adults (54.0 percent) reported that they knew where to find treatment for substance abuse if needed, while over two-thirds (68.9 percent) reported that they knew where to find treatment for BH disorders if needed. This relationship was similar among children, where 55.0 percent of respondents indicated that they knew where to find treatment for SUD while 73.0 percent knew where to find treatment for a BH disorder for their child.

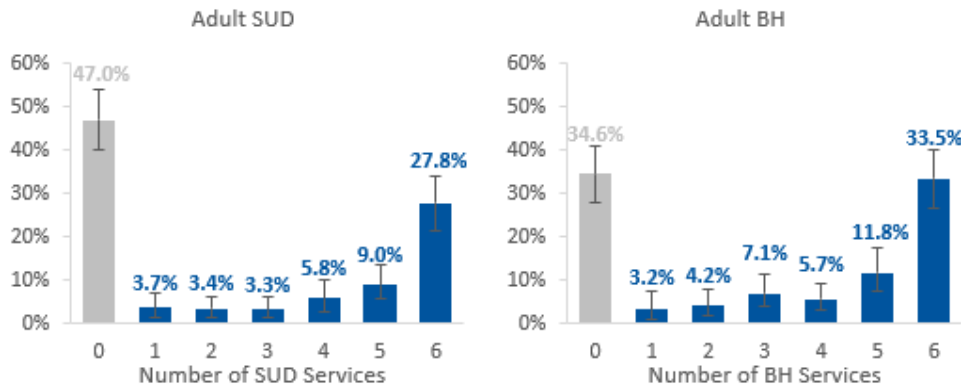
Figure 5-24—Percentage of Beneficiaries who Know Where to find SUD/BH Treatment if Needed



Note: Error bars show 95% confidence intervals.

Figure 5-25 shows that 42.6 percent of adult respondents indicated they knew where to receive four or more different types of treatment for SUD, with just over a quarter (27.8 percent) indicating they knew where to receive all six different types of treatment mentioned in the survey. Over half of adult respondents (51 percent) indicated they knew where to receive four or more different types of BH treatment, with one-third indicating they knew where to receive all six types of BH treatment mentioned.

Figure 5-25—Percentage of Beneficiaries Who Are Knowledgeable of the Number of SUD and BH Services Available for Adults



Note: Error bars show 95% confidence intervals.

Figure 5-26 shows that among those who indicated they knew where to find treatment, group therapy and one-on-one treatment were the most common settings for both SUD and BH treatment. The fewest adult respondents knew where to find treatment through MAT and peer support settings for SUD and BH, respectively.

Figure 5-26—Beneficiary Knowledge of Setting Type—Adults

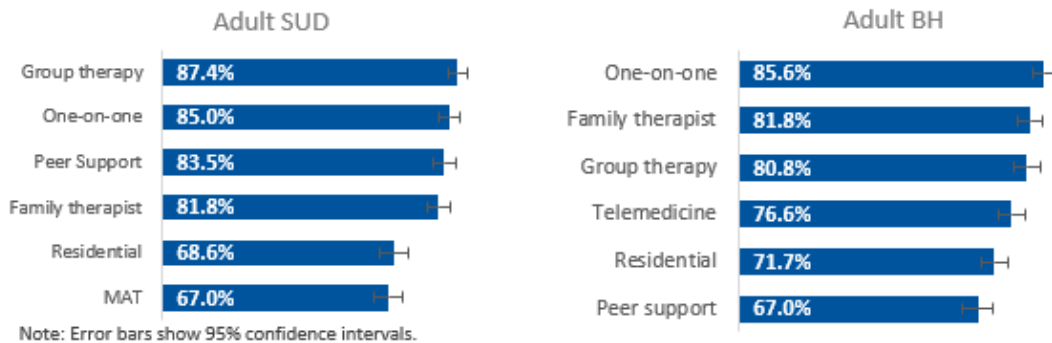


Figure 5-27 shows that among services for children, nearly one-third (31.9 percent) of beneficiaries indicated they knew where to receive all five different types of SUD treatment, and nearly half (48.3 percent) indicated they knew where to receive all four types of treatment for BH mentioned in the survey.

Figure 5-27—Percentage of Beneficiaries Who Are Knowledgeable of the Number of SUD and BH Services Available for Children

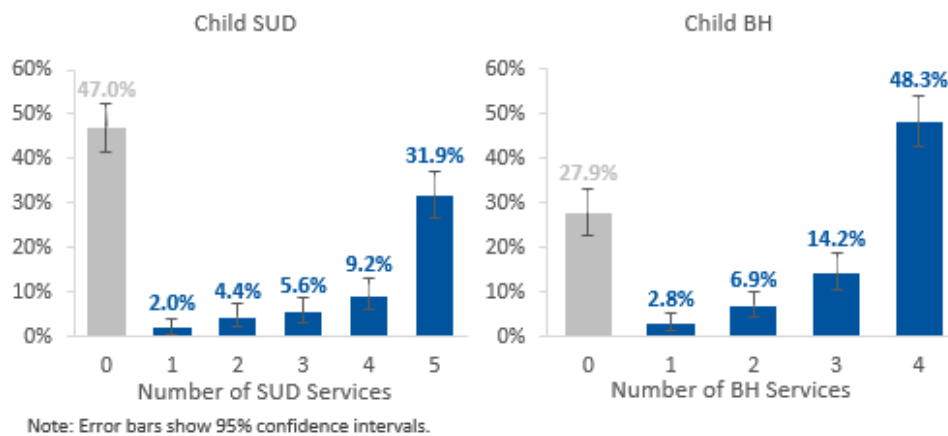
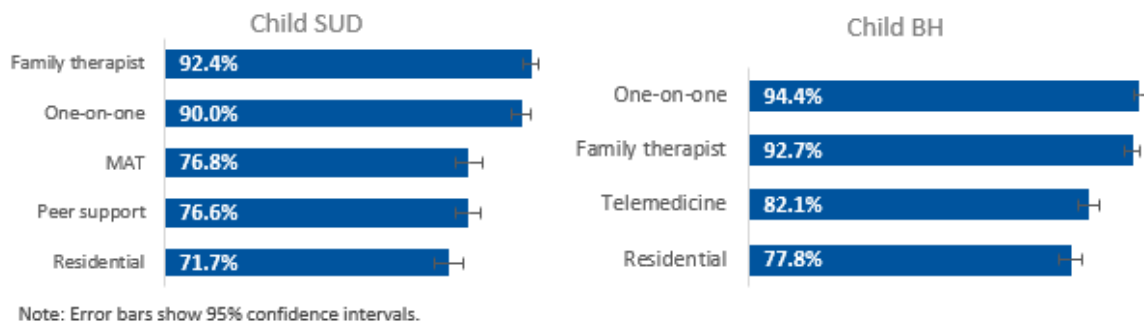


Figure 5-28 shows that, among those who knew where to receive SUD or BH treatment, over nine in 10 respondents knew where to receive family therapy or one-on-one treatment, while more than seven in 10 knew where to receive residential treatment.

Figure 5-28—Beneficiary Knowledge of Setting Type—Children



Because these survey results are for a single point in time and no similar comparison group can be found that reflects Alaska Medicaid beneficiaries, data are not sufficient to determine whether the findings support the hypothesis. Nevertheless, these results indicate that beneficiaries demonstrated a high level of knowledge of treatment for SUD and BH disorders, although there is still room to improve beneficiary knowledge of treatment, particularly for SUD. Just over half of beneficiaries indicated they knew where to receive SUD treatment (for both adults and children), while over two-thirds knew where to receive BH treatment. Among those who did know where to receive treatment, over two-thirds of beneficiaries had knowledge of every treatment setting, and over 70 percent of beneficiaries has knowledge of every child treatment setting.

Measure 29 Conclusion: N/A

Maternal depression (Measure 30)

Measure 30 aims to measure maternal depression by calculating two indicators from the Alaska Childhood Understanding Behaviors Survey (CUBS) survey instrument. The first is a provider discussion indicator that measures the percentage of mothers who are Medicaid beneficiaries and had a discussion with a health care provider in the past 12 months about depression or how they were doing emotionally. The second is a maternal depression composite indicator that asked respondents to rate how often they felt down, depressed, or hopeless, and how often they had little interest or pleasure in doing things they usually enjoyed in the past three months.

As shown in Table 5-34, on average, 30.7 percent of mothers surveyed in the baseline period responded that they had a discussion with a health care professional (HCP) in the past year about how they were doing emotionally, compared to an average of 31.0 percent of mothers surveyed in the evaluation period. Data were available for this question from 2012–2020. Overall, this 0.3 percentage point difference in rates was found not to be statistically significant ($p=0.922$). Results for each year from 2012 to 2020 can be found in Appendix A.

The maternal depression composite indicator was calculated by taking the average of the respondent’s ratings to two questions—how often they felt down, depressed, or hopeless and how often they had little interest in doing things usually enjoyed in the past three months. Possible response values ranged from 1 (Always) to 5 (Never), and data were available for this indicator from 2015-2020. On average, the maternal depression composite indicator was 3.91 among mothers in the baseline period and 3.89 in the evaluation period as demonstrated in Table 5-35. Thus, the difference in means was not found to be statistically significant ($p=0.736$). Results for each year from 2015 to 2020 can be found in Appendix A.

Table 5-34—Maternal Depression—Provider Discussion Indicator

	Baseline Period Weighted Average	Evaluation Period Weighted Average	Percentage Point Change	p-value
Percentage of mothers who had a discussion with a HCP about depression or how they were doing emotionally, past 12 months ¹	30.7%	31.0%	0.3pp	0.922

Note: pp=percentage point

¹ Rates are weighted by survey analysis weight, composed of sampling, nonresponse, and noncoverage components.

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Table 5-35—Maternal Depression—Maternal Depression Indicator (higher is better)

	Baseline Period Weighted Average	Evaluation Period Weighted Average	Change in Means	p-value
Average score-feeling depressed/hopeless/little interest or little pleasure in doing things usually enjoyed, past 3 months ^{1,2,3}	3.91	3.89	-0.02	0.736

¹Counts are weighted by survey analysis weight, composed of sampling, nonresponse, and noncoverage components.

²Average composite score consists of taking the average of the following questions:

During the past 3 months, how often have you felt down, depressed, or hopeless? (1-5)

During the past 3 months, how often have you had little interest or little pleasure in doing things you usually enjoyed? (1-5)

³Scale ranges from 1 (Always) to 5 (Never)

*p < 0.1, **p < 0.05, ***p < 0.001

Measure 30 Conclusion: Neither supports nor fails to support the hypothesis

Maternal domestic abuse (Measure 31)

Measure 31 assesses maternal domestic abuse by calculating how many mothers who completed the CUBS instrument answered that they were physically hurt or made to feel unsafe by their partner in the past year. Data were available from 2012-2020 for this question. Table 5-36 shows that rates were inconsistent throughout both the baseline and evaluation periods. In the baseline period, the rate reached a peak in 2014 at 7.1 percent and began to trend downwards to its lowest point in 2018 at 2.7 percent. During the evaluation period, there was an overall peak in 2019 at 10.4 percent which was followed by a sharp decline to 2.1 percent in the following year 2020. Overall, there was a 1.6 percentage point increase in the rates of reported maternal domestic abuse between the baseline period and evaluation period on average, though this was not a statistically significant difference (p=0.310). Results for each year from 2012 to 2020 can be found in Appendix A.

Table 5-36—Maternal Domestic Abuse

	Baseline Period Weighted Average	Evaluation Period Weighted Average	Percentage Point Change	p-value
Percentage of mothers answering they were physically hurt or made to feel unsafe by their partner, past 12 months ¹	4.8%	6.4%	1.6pp	0.310

Note: pp=percentage point

¹Rates are weighted by survey analysis weight, composed of sampling, nonresponse, and noncoverage components.

*p < 0.1, **p < 0.05, ***p < 0.001

Measure 31 Conclusion: Neither supports nor fails to support the hypothesis

Percentage of beneficiaries who experienced alcoholism or mental health disorder among household members (Measure 32)

Measure 32 aims to evaluate the percentage of child Medicaid beneficiaries who have experienced alcoholism or mental health disorder among household members, as reported by mothers who responded to the CUBS instrument. Data were available from 2012–2020 for this question. Rates were inconsistent during the baseline period from 2012–2018, and the overall average was 8.2 percent as demonstrated in Table 5-37. However, rates

began trending upwards in 2018 from 7.5 percent into the evaluation period to 9.4 percent in 2019 and 13.3 percent in 2020. As a result, the average percentage of youth Medicaid beneficiaries who experienced alcoholism or mental health disorder among household members in the evaluation period was 11.3 percent. This was 3.2 percentage point increase from the average in the baseline period, though this difference was not statistically significant ($p=0.104$). Results for each year from 2012 to 2020 can be found in Appendix A.

Table 5-37—Percentage of Youth Beneficiaries who Have Experienced Alcoholism or Mental Health Disorder Among Household Members

	Baseline Period Weighted Average	Evaluation Period Weighted Average	Percentage Point Change	p-value
Percentage of youth beneficiaries who experienced alcoholism or mental health disorder among household members ¹	8.2%	11.3%	3.2pp	0.104

Note: pp=percentage point

¹Rates are weighted by survey analysis weight, composed of sampling, nonresponse, and noncoverage components.

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Measure 32 Conclusion: Neither supports nor fails to support the hypothesis

Percentage of beneficiaries who witnessed violence or physical abuse between household members (Measure 33)

Measure 33 assesses the percentage of youth Medicaid beneficiaries who have ever witnessed violence or physical abuse between household members, as reported by mothers who responded to the CUBS instrument. Data were available from 2015–2020 for this question. Table 5-38 shows that rates in the baseline period were generally stable, though the 2017 rate dipped to a low point of 5.9 percent. Overall, the average rate of youth Medicaid beneficiaries witnessing violence between household members during the evaluation period was 7.9 percent, which was a 0.4 percentage point increase from the average of 7.5 percent in the baseline period. This difference in averages was not statistically significant ($p=0.833$). Results for each year from 2015 to 2020 can be found in Appendix A.

Table 5-38—Percentage of Youth Beneficiaries who Have Witnessed Violence or Physical Abuse Between Household Members

	Baseline Period Weighted Average	Evaluation Period Weighted Average	Percentage Point Change	p-value
Percentage of youth beneficiaries who witnessed violence or physical abuse between household members ¹	7.5%	7.9%	0.4pp	0.833

Note: pp=percentage point

¹Rates are weighted by survey analysis weight, composed of sampling, nonresponse, and noncoverage components.

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Measure 33 Conclusion: Neither supports nor fails to support the hypothesis

Percentage of youth beneficiaries who have ever been physically hurt by an adult in any way (Measure 34)

Measure 34 assesses the percentage of child Medicaid beneficiaries who have ever been physically hurt by an adult in any way, as reported by mothers who responded to the CUBS instrument. Data were available for this

question from 2015–2019. Overall, the rate of youth Medicaid beneficiaries who were ever physically hurt by an adult in 2019 during the evaluation period was 1.2 percent, which was a 0.3 percentage point increase from the baseline period average of 0.9 percent (Table 5-39). This difference was not statistically significant ($p=0.802$). Results for each year from 2015 to 2019 can be found in Appendix A.

Table 5-39—Percentage of Youth Beneficiaries who Have Been Physically Hurt by an Adult in Any Way

	Baseline Period Weighted Average	Evaluation Period Weighted Average	Percentage Point Change	p-value
Percentage of youth beneficiaries who have ever been physically hurt by an adult in any way ¹	0.9%	1.2%	0.3pp	0.802

Note: pp=percentage point

¹Rates are weighted by survey analysis weight, composed of sampling, nonresponse, and noncoverage components.

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Measure 34 Conclusion: Neither supports nor fails to support the hypothesis

Maternal marijuana or hash use in the past two years (Measure 35)

Measure 35 assesses the percentage of mothers who completed the CUBS instrument and reported using marijuana or hash at any point in the past two years. Data for this measure were available from 2015–2019. Rates began trending upwards slightly in 2018 from 18.0 percent into the evaluation period to 18.2 percent in 2019 (Table 5-40). Though there was a 1.3 percentage point change in average marijuana usage overall from the baseline period and the evaluation period, this difference was not statistically significant ($p=0.712$). Results for each year from 2015 to 2019 can be found in Appendix A.

Table 5-40—Maternal Marijuana or Hash Use in the Past Two Years

	Baseline Period Weighted Average	Evaluation Period Weighted Average	Percentage Point Change	p-value
Percentage of respondents who have used marijuana in the past two years ¹	16.8%	18.2%	1.3pp	0.712

Note: pp=percentage point

¹Rates are weighted by survey analysis weight, composed of sampling, nonresponse, and noncoverage components.

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Measure 35 Conclusion: Neither supports nor fails to support the hypothesis

Frequency of maternal marijuana or hash use (Days per Week) (Measure 36)

Measure 36 assesses the average number of days CUBS respondents used marijuana per week, given that they responded that they have used marijuana in the past two years. Data for this measure were available for 2015–2020. From 2015–2019, this question was asked in terms of average days per week marijuana was used, while in 2020 this question was asked in terms of average days per month that marijuana was used. As a result, responses from 2020 were converted to average days per week of marijuana use for consistency. Table 5-41 shows that mothers who were Medicaid beneficiaries, completed the CUBS instrument, and noted that they have used marijuana reported using marijuana 1.48 days per week on average in the baseline period compared to 0.66 days per week on average in the evaluation period, a decrease of 0.82 days. This difference was found to be statistically

significant ($p < 0.001$), although some of this difference may be due to the change of wording in the 2020 CUBS instrument. Results for each year from 2015 to 2020 can be found in Appendix A.

Table 5-41—Frequency of Maternal Marijuana or Hash Use (Days per Week)

	Baseline Period Weighted Average	Evaluation Period Weighted Average	Change in Means	p-value
Average number of days respondents report using marijuana or hash per week ¹	1.48	0.66	-0.82	<0.001***

¹Counts are weighted by survey analysis weight, composed of sampling, nonresponse, and noncoverage components.

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Measure 36 Conclusion: Supports the hypothesis

Social support—care when sick (Supplemental CUBS Measure 1)

Several additional measures utilizing CUBS data were included after development of the evaluation design plan at the State’s request. These measures relate to social supports and obtaining SUD or BH treatment, the latter being added into the most recent phase of the CUBS instrument beginning in 2020.

Supplemental CUBS Measure 1 aims to assess the social support that mothers who are Medicaid beneficiaries and completed the survey instrument can receive by determining the percentage of respondents who answered they know someone who would help them if they were sick. Data for this measure were available for years 2012–2020. Overall, an average of 82.8 percent of respondents in the baseline period reported that they knew someone who would help if they were sick. In comparison, the average was 78.0 percent of respondents in the evaluation period with a rate of 78.9 percent in 2019 and 77.1 percent in 2020—both of which were lower than any other year in the baseline period (Table 5-42). This was an overall significant decrease of 4.8 percentage points between the averages during baseline period ($p = 0.094$). Results for each year from 2012 to 2020 can be found in Appendix A.

Table 5-42—Social Support—Care When Sick

	Baseline Period Weighted Average	Evaluation Period Weighted Average	Percentage Point Change	p-value
Percentage of respondents who answered they know someone who would help them if they were sick ¹	82.8%	78.0%	-4.8pp	0.094*

¹Rates are weighted by survey analysis weight, composed of sampling, nonresponse, and noncoverage components.

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Supplemental CUBS Measure 1 Conclusion: No associated hypothesis

Desire to SUD/BH treatment options and obtainment of SUD treatment in the past three months (Supplemental CUBS Measure 2)

The CUBS instrument had 2020 data available on the percentage of Medicaid CUBS respondents who desired to obtain SUD treatment or BH treatment, and the percentage of respondents who did obtain SUD treatment or BH treatment in the past three months. Of note, 2.6 percent of respondents stated that they obtained SUD treatment in the past three months while only 2.0 percent of respondents noted that they desired SUD treatment in the past

three months, as shown in Table 5-43. Similarly, 9.6 percent of respondents obtained BH treatment whereas only 7.0 percent of respondents reported that they desired BH treatment in the past three months.

Table 5-43—Desire to SUD/BH Treatment Options and Obtainment of SUD Treatment in the Past Three Months

	Evaluation Period
	2020
Percentage of respondents who desired SUD treatment in the past 3 months ¹	2.0%
Percentage of respondents who obtained SUD treatment in the past 3 months	2.6%
Percentage of respondents who desired mental/behavioral health treatment in the past 3 months	7.0%
Percentage of respondents who obtained mental/behavioral health treatment in the past 3 months	9.6%

¹Rates are weighted by survey analysis weight, composed of sampling, nonresponse, and noncoverage components.
*p < 0.1, **p < 0.05, ***p < 0.001

Supplemental CUBS Measure 2 Conclusion: No associated hypothesis

Hypothesis 2: The SUD-BH Program will decrease the rate of drug overdoses and overdose deaths due to opioids.

Rate of overdose deaths, specifically overdose deaths due to any opioid (Measure 37)

Measure 37 assesses the rate of overdose deaths, both overall and specifically due to opioid overdoses, to determine whether the demonstration has decreased the rate of deaths due to overdoses. For Alaska residents statewide the rate of overdose deaths has been steadily rising from state fiscal year (SFY) 2017 to SFY 2021, with a large increase in the overdose cause-specific mortality rate occurring from SFY 2020 to SFY 2021 (from 18.6 to 27.3 per 100,000 Alaska residents). This increase in the rate of overdose deaths could partially be attributable to effects of the COVID-19 PHE.⁵⁻¹⁴ The average mortality rate for overdose deaths rose by 4.2 per 100,000 Alaska residents between the baseline and evaluation periods, a statistically significant increase ($p=0.006$). The mortality rate associated with opioid-specific overdose deaths remained stable from SFY 2017 to SFY 2019 before seeing a rise in SFY 2020 to 13.0 per 100,000 Alaska residents and a subsequent large jump in SFY 2021 to 21.0 per 100,000 Alaska residents. The average opioid-specific overdose death mortality rate rose by 3.4 per 100,000 Alaska residents between the baseline and evaluation periods, also a statistically significant increase ($p=0.007$). Overdose death data specific to the Medicaid population were not available. Table 5-44 displays the statewide overdose deaths, both overall and opioid-specific, along with the associated mortality rates.

Table 5-44—Rate of Overdose Deaths in Alaska Residents, State Fiscal Year 2017-2021

	Baseline Period			Evaluation Period				Rate Change	p-value
	SFY 2017	SFY 2018	Weighted Average	SFY 2019	SFY 2020	SFY 2021	Weighted Average		
Overdose Deaths, All - Count	125	130		136	137	200			

⁵⁻¹⁴ See, e.g., Walters, S.M., et al, (2022) “Structural and community changes during COVID-19 and their effects on overdose precursors among rural people who use drugs: a mixed-methods analysis,” *Addiction Science & Clinical Practice* 17(24); Available at: <https://ascjournal.biomedcentral.com/articles/10.1186/s13722-022-00303-8>. Accessed on: Oct 28, 2022.

	Baseline Period			Evaluation Period				Rate Change	p-value
	SFY 2017	SFY 2018	Weighted Average	SFY 2019	SFY 2020	SFY 2021	Weighted Average		
Overdose Deaths, All – Cause-Specific Mortality Rate per 100,000	16.9	17.6	17.3	18.5	18.6	27.3	21.5	4.2	0.006**
Overdose Deaths, Opioid	84	89		83	96	154			
Overdose Deaths, Opioid – Cause-Specific Mortality Rate per 100,000	11.4	12.1	11.7	11.3	13.0	21.0	15.1	3.4	0.007**

*p < 0.1, **p < 0.05, ***p < 0.001

Measure 37 Conclusion: Does not support the hypothesis

Non-fatal overdoses (All Cause) (Measure 38)

Measure 38 aims to determine whether the total number of non-fatal overdoses among waiver members has decreased. The trend of non-fatal overdoses among waiver members decreased between 2018 and 2020, falling from 1,450 to 1,176, before seeing a small uptick in the number of non-fatal overdoses in 2021 to 1217. The number of non-fatal overdoses among waiver members saw a significant decrease between the baseline and evaluation periods, falling from 1,450 in 2018 to an average of 1,200 in the evaluation period (a decrease of 250, p=0.010). Table 5-45 shows the number of non-fatal overdoses in the waiver population each year.

Table 5-45—Non-Fatal Overdose (All Causes), 2018-2021

	Baseline Period		Evaluation Period			Count Change	p-value
	2018	2019	2020	2021	Weighted Average		
Non-Fatal Overdoses (all cause)	1,450	1,207	1,176	1,217	1,200	-250	0.010**

*p < 0.1, **p < 0.05, ***p < 0.001

Measure 38 Conclusion: Supports the hypothesis

Use of opioids at high dosage in persons without cancer (NQF 2940) (Measure 39)

Measure 39 utilizes CMS SUD metric 18 data contained in the Alaska SUD Monitoring Metrics to evaluate the use of opioids at high dosage in persons without cancer. The percentage of use of opioids at high dosage in persons without cancer was found to have increased slightly from 2019 to 2020, rising from 13.6 percent to 14.4 percent (a change of 0.8 percentage points, p=0.332). Although no baseline data prior to 2019 were available, the change from 2019 to 2020 was not statistically significant. Limitations in data provided to HSAG for the evaluation prevented the ability to calculate this measure; instead, HSAG relied on rates reported as part of the SUD monitoring reports. Table 5-46 displays the percentage of use of opioids at high dosage in persons without cancer for 2019 and 2020.

Table 5-46—Use of Opioids at High Dosage in Persons Without Cancer, 2019-2020

	2019	2020	Percentage Point Change	p-value
Use of Opioids at High Dosage in Persons Without Cancer (NQF 2940)	13.6%	14.4%	0.8pp	0.332

Note: pp=percentage point
 *p < 0.1, **p < 0.05, ***p < 0.001

Measure 39 Conclusion: Neither supports nor fails to support the hypothesis

Research Question 3: Does the SUD-BH Program reduce the cost of Medicaid for Alaska and the federal government?

Hypothesis 1: The SUD-BH Program will reduce Alaska’s per capita Medicaid BH costs.

To evaluate the costs associated with the SUD-BH demonstration, HSAG followed descriptions specified in CMS Appendix C: Approaches to Analyzing Costs Associated with Section 1115 Demonstrations for Beneficiaries with Serious Mental Illness/Serious Emotional Disturbance or Substance Use Disorders.⁵⁻¹⁵ HSAG identified members with a SUD or BH diagnosis and calculated cost of care for these beneficiaries.

ITS analysis was performed on per-member per-month (PMPM) costs. As described in the Methodology section, to control for seasonality, indicators for each quarter were included in the model. To account for effects of the COVID-19 PHE, two indicator variables were included, one to capture the initial lock-down period of Q2 2020, and another to capture gradual re-opening during Q3 2020 through Q1 2021. A generalized linear model (GLM) was constructed with a log link because costs are positive and not normally distributed. Although this type of model allows for more accurate prediction of costs, interpretation is not as straightforward as a simple linear regression model, which can be interpreted in dollar amount changes. Results in this section are presented as percentage changes in costs.

The following were calculated for the SUD and BH populations

- Total Costs
- IP
- OP
 - ED OP
 - Non-ED OP
- LTC
- Professional
- Dental
- Pharmacy

⁵⁻¹⁵ Centers for Medicare & Medicaid Services. Appendix C: Approaches to Analyzing Costs Associated with Section 1115 Demonstrations for Beneficiaries with Serious Mental Illness/Serious Emotional Disturbance or Substance Use Disorders. Available at: <https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/smi-sed-sud-cost-appendix-c.pdf>. Accessed on: Oct 21, 2022.

The following were calculated for the SUD population only:

- SUD-IMD
- SUD-Other
- Non-SUD

The following were calculated for the BH population only:

- BH-IMD
- BH-Other
- Non-BH

Total costs of health care (sum of parts below), by State and federal share (Measure 40)

Overall, costs among beneficiaries with a SUD diagnosis increased slightly over time with negligible deviations from this trend following the start of the waiver. Table 5-47 and Figure 5-29 show that the COVID-19 PHE led to significantly lower costs, particularly in March and April 2020, with a return to pre-PHE levels afterward. A GLM with a log link was constructed in order to account for the fact that costs are positive and not normally distributed. This model allows for a more accurate analysis of costs; however, interpretation is not as straightforward as a simple linear regression model, which can be interpreted in dollar amount changes. Results are presented as percentage changes in costs.

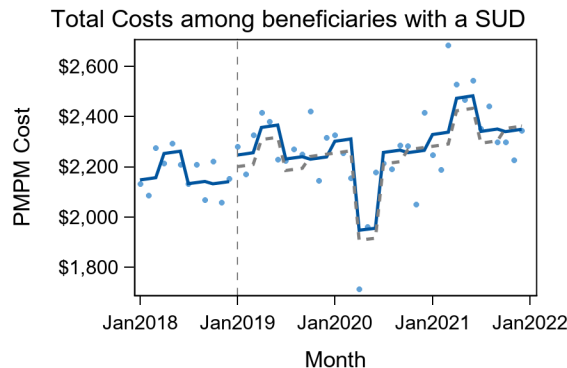
Table 5-47—Primary ITS Results (Measure 40: Total Cost of Care among SUD Beneficiaries)

Variable	Percent Change in Costs	p-value
Baseline monthly trend	0.20%	0.663
Level change	2.11%	0.554
Change in monthly trend	0.00%	0.996

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Note: Full model results are presented in Appendix A.

Figure 5-29—Illustration of ITS Analysis (Measure 40: Total Cost of Care among SUD Beneficiaries)



Similarly, there was no significant change in the total cost of care among beneficiaries with a BH disorder following implementation of the demonstration as displayed in Table 5-48 and Figure 5-30. However, costs among BH beneficiaries declined slightly compared to SUD beneficiaries. A GLM with a log link was constructed in order to account for the fact that costs are positive and not normally distributed. This model allows

for a more accurate analysis of costs; however, interpretation is not as straightforward as a simple linear regression model, which can be interpreted in dollar amount changes. Results are presented as percentage changes in costs.

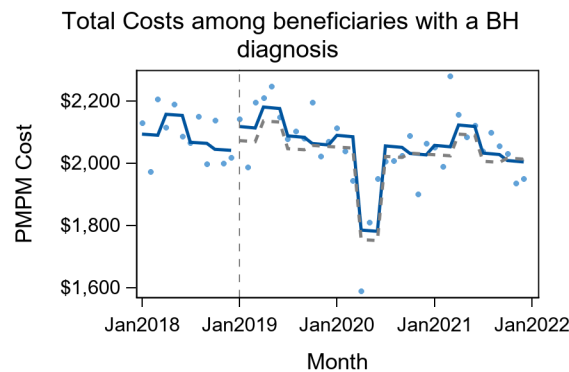
Table 5-48—Primary ITS Results (Measure 40: Total Cost of Care Among BH Beneficiaries)

Variable	Percent Change in Costs	p-value
Baseline monthly trend	-0.08%	0.822
Level change	2.21%	0.439
Change in monthly trend	-0.03%	0.937

*p < 0.1, **p < 0.05, ***p < 0.001

Note: Full model results are presented in Appendix A.

Figure 5-30—Illustration of ITS Analysis (Measure 40: Total Cost of Care Among BH Beneficiaries)



Measure 40 Conclusion: Neither supports nor fails to support the hypothesis

Total cost of SUD, SUD-IMD and SUD-Other and Non-SUD, by setting, including claims data (IP, OP, RX, LTC, and capitated payments to managed care organizations) (Measure 41)

Measure 41 assesses cost drivers among the SUD population. Because Alaska Medicaid follows a FFS model, there are no capitated payments, and total costs represent direct costs to Medicaid.

Total SUD-IMD costs among SUD beneficiaries

Costs associated with a SUD diagnosis or MAT treatment in an IMD increased significantly following approval of the demonstration, with costs more than doubling, with an increase of 165.50 percent ($p=0.003$). This increase is expected since the demonstration allows Medicaid to reimburse IMD stays for individuals ages 21 through 64. An IMD is defined as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

In addition to the increase in average IMD costs after implementation, there was a reversal in the cost trend as displayed in Table 5-49 and Figure 5-31. Prior to the demonstration, IMD costs were decreasing by 3.68 percent, while after implementation they increased by 4.59 percent relative to the baseline trend, although this change was not statistically significant ($p=0.303$). A GLM with a log link was constructed in order to account for the fact that costs are positive and not normally distributed. This model allows for a more accurate analysis of costs; however,

interpretation is not as straightforward as a simple linear regression model, which can be interpreted in dollar amount changes. Results are presented as percentage changes in costs.

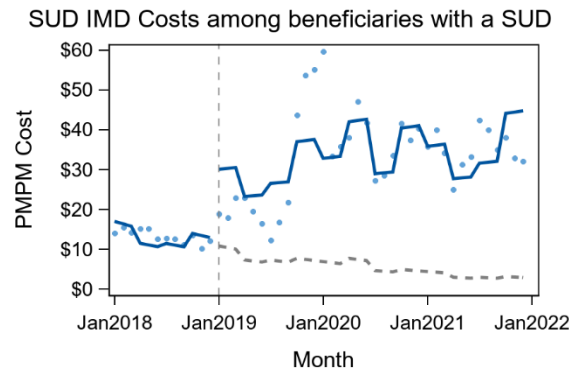
Table 5-49—Primary ITS Results (Measure 41: SUD-IMD Costs Among SUD Beneficiaries)

Variable	Percent Change in Costs	p-value
Baseline monthly trend	-3.68%	0.392
Level change	165.50%	0.003**
Change in monthly trend	4.59%	0.303

*p < 0.1, **p < 0.05, ***p < 0.001

Note: Full model results are presented in Appendix A.

Figure 5-31—Illustration of ITS Analysis (Measure 41: SUD-IMD Costs Among SUD Beneficiaries)



Total SUD-Other costs among SUD beneficiaries

Costs associated with a SUD diagnosis or MAT treatment outside an IMD (non-IMD) increased steadily before and after the demonstration approval period as displayed in Table 5-50 and Figure 5-32. Cost associated with a SUD diagnosis of MAT treatment outside an IMD (non-IMD) increased by 0.56 percent per month (P=0.280) prior to approval. After approval, the trend decreased slightly by 0.24 percent relative to the baseline trend, but this change was not statistically significant (p=0.633) and still represented an increase of 0.32 percentage point per month (0.56 percent–0.24 percent). A GLM with a log link was constructed in order to account for the fact that costs are positive and not normally distributed. This model allows for a more accurate analysis of costs; however, interpretation is not as straightforward as a simple linear regression model, which can be interpreted in dollar amount changes. Results are presented as percentage changes in costs.

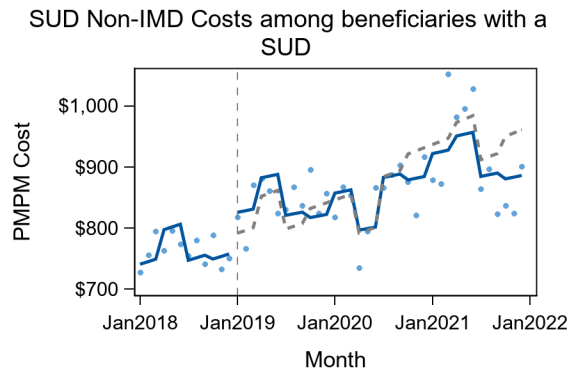
Table 5-50—Primary ITS Results (Measure 41: Other SUD Costs Among SUD Beneficiaries)

Variable	Percent Change in Costs	p-value
Baseline monthly trend	0.56%	0.280
Level change	4.56%	0.244
Change in monthly trend	-0.24%	0.633

*p < 0.1, **p < 0.05, ***p < 0.001

Note: Full model results are presented in Appendix A.

Figure 5-32—Illustration of ITS Analysis (Measure 41: Other SUD Costs Among SUD Beneficiaries)



Costs reported for this measure include those related to SUD diagnosis and MAT. Additional exploratory analysis to assess MAT costs separately showed that on average, MAT comprised approximately 9.0 percent of total SUD and MAT related costs and increased from an average of \$57.96 PMPM in 2018 to \$82.29 in 2021. The use of Vivitrol—a more expensive form of treatment—actually declined slightly between the baseline and demonstration periods, falling from an average of \$14.67 PMPM in 2018 to \$11.56 in 2021. This suggests that the use of this costly treatment did not show a commensurate increase in utilization as other MAT during the evaluation period.

Total Non-SUD costs among SUD beneficiaries

Table 5-51 and Figure 5-33 show costs not associated with a SUD diagnosis or MAT treatment among beneficiaries with a SUD remained mostly flat but highly variable both before and after the demonstration period, with a significant impact from the COVID-19 PHE in Q2 2020. Costs decreased slightly by an average of 0.50 percent following approval of the demonstration, but this was not statistically significant ($p=0.899$). The trend in costs increased slightly by 0.04 percent per month following demonstration approval relative to the baseline trend, but this trend was not statistically significant ($p=0.942$). A GLM with a log link was constructed in order to account for the fact that costs are positive and not normally distributed. This model allows for a more accurate analysis of costs; however, interpretation is not as straightforward as a simple linear regression model, which can be interpreted in dollar amount changes. Results are presented as percentage changes in costs.

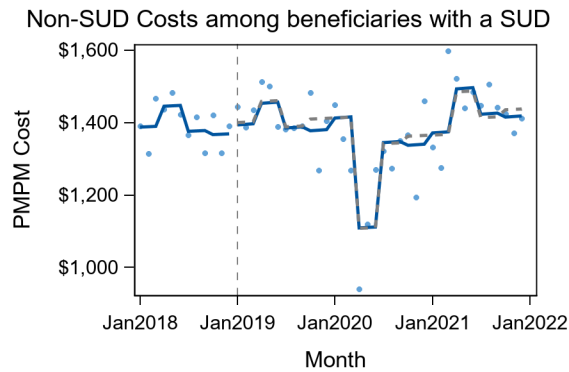
Table 5-51—Primary ITS Results (Measure 41: Non-SUD Costs Among SUD Beneficiaries)

Variable	Percent Change in Costs	p-value
Baseline monthly trend	0.08%	0.884
Level change	-0.50%	0.899
Change in monthly trend	0.04%	0.942

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Note: Full model results are presented in Appendix A.

Figure 5-33—Illustration of ITS Analysis (Measure 41: Non-SUD Costs Among SUD Beneficiaries)



IP costs among SUD beneficiaries

ITS analysis shows the IP costs among SUD beneficiaries were increasing by 1.24 percent per month prior to approval of the demonstration. Table 5-52 and Figure 5-34 show that after approval, the trend decreased by 1.38 percent per month relative to the baseline; however, this trend was not statistically significant ($p=0.139$). Nevertheless, had the baseline trend continued, the projected PMPM IP cost would have been approximately \$860 by the end of 2021 while the actual cost averaged lower at approximately \$570, representing a material difference of roughly \$410 PMPM in costs to the State. A GLM with a log link was constructed in order to account for the fact that costs are positive and not normally distributed. This model allows for a more accurate analysis of costs; however, interpretation is not as straightforward as a simple linear regression model, which can be interpreted in dollar amount changes. Results are presented as percentage changes in costs.

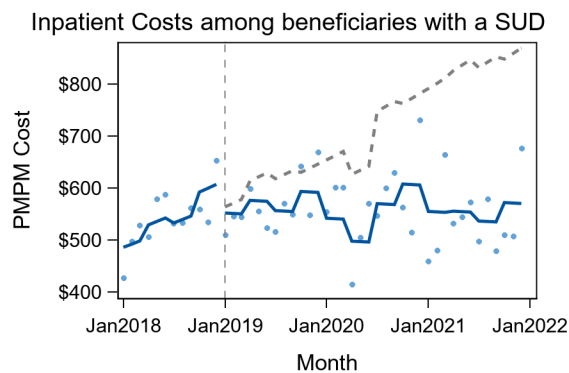
Table 5-52—Primary ITS Results (Measure 41: IP Costs Among SUD Beneficiaries)

Variable	Percent Change in Costs	p-value
Baseline monthly trend	1.24%	0.193
Level change	-0.74%	0.915
Change in monthly trend	-1.38%	0.139

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Note: Full model results are presented in Appendix A.

Figure 5-34—Illustration of ITS Analysis (Measure 41: IP Costs Among SUD Beneficiaries)



OP costs among SUD beneficiaries

Overall, there were no significant changes or trends in OP costs for beneficiaries with a SUD as displayed in Table 5-53 and Figure 5-35. Prior to the demonstration, OP costs were effectively flat, decreasing by 0.01 percent per month. Upon implementation, costs increased on average slightly by 1.83 percent, but this was not statistically significant ($p=0.707$). Similarly, the trend in costs increased slightly by 0.19 percent per month relative to the baseline trend but this was not statistically significant ($p=0.760$). A GLM with a log link was constructed in order to account for the fact that costs are positive and not normally distributed. This model allows for a more accurate analysis of costs; however, interpretation is not as straightforward as a simple linear regression model, which can be interpreted in dollar amount changes. Results are presented as percentage changes in costs.

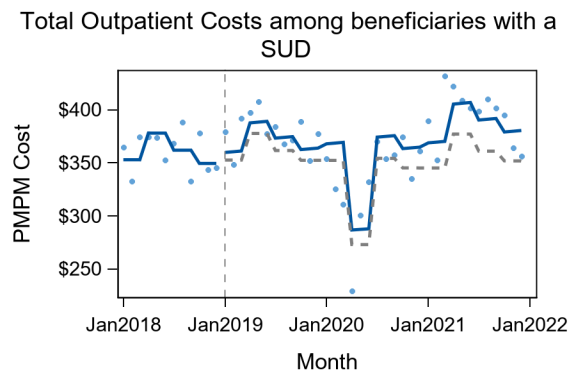
Table 5-53—Primary ITS Results (Measure 41: OP Costs Among SUD Beneficiaries)

Variable	Percent Change in Costs	p-value
Baseline monthly trend	-0.01%	0.991
Level change	1.83%	0.707
Change in monthly trend	0.19%	0.760

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Note: Full model results are presented in Appendix A.

Figure 5-35—Illustration of ITS Analysis (Measure 41: OP Costs Among SUD Beneficiaries)



ED OP costs among SUD beneficiaries

Separating OP costs by ED and non-ED reveals different trends displayed in Table 5-54 and Figure 5-36. ITS analysis of ED costs shows that prior to approval of the demonstration, costs were increasing slightly by 0.34 percent per month ($p=0.598$). After demonstration approval, the trend declined by 0.98 percent per month relative to the baseline trend; however, this change was not statistically significant ($p=0.125$). Similar to the IP trend, however, by the last quarter of 2021, the difference between the actual costs and projected costs had the baseline trend continued was \$42 PMPM (\$183–\$141), or 23 percent lower than projected. A GLM with a log link was constructed in order to account for the fact that costs are positive and not normally distributed. This model allows for a more accurate analysis of costs; however, interpretation is not as straightforward as a simple linear regression model, which can be interpreted in dollar amount changes. Results are presented as percentage changes in costs.

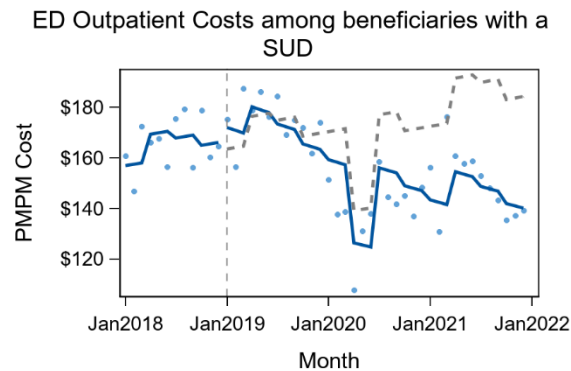
Table 5-54—Primary ITS Results (Measure 41: ED OP Costs Among SUD Beneficiaries)

Variable	Percent Change in Costs	p-value
Baseline monthly trend	0.34%	0.598
Level change	6.22%	0.214
Change in monthly trend	-0.98%	0.125

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Note: Full model results are presented in Appendix A.

Figure 5-36—Illustration of ITS Analysis (Measure 41: ED OP Costs Among SUD Beneficiaries)



Non-ED OP costs among SUD beneficiaries

OP costs not associated with the ED demonstrated an opposite trend when compared to ED costs as displayed in Table 5-55 and Figure 5-37. Prior to the demonstration, costs declined slightly by 0.39 percent per month, while after approval costs began increasing by 1.17 percent per month relative to the baseline trend; however, this change was not statistically significant ($p=0.105$). By the end of 2021, the projected costs were \$163 PMPM while the actual costs averaged \$239, a difference of \$75 PMPM or 47 percent higher than projected. A GLM with a log link was constructed in order to account for the fact that costs are positive and not normally distributed. This model allows for a more accurate analysis of costs; however, interpretation is not as straightforward as a simple linear regression model, which can be interpreted in dollar amount changes. Results are presented as percentage changes in costs.

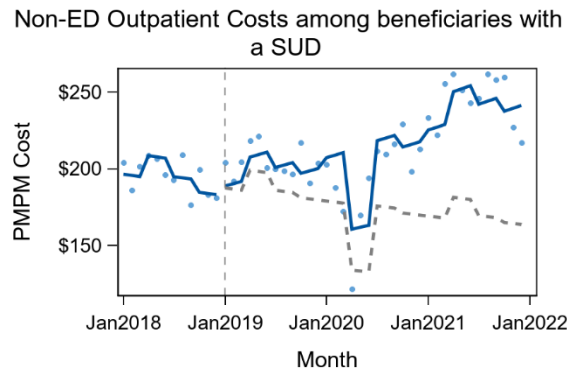
Table 5-55—Primary ITS Results (Measure 41: Non-ED OP Costs Among SUD Beneficiaries)

Variable	Percent Change in Costs	p-value
Baseline monthly trend	-0.39%	0.594
Level change	-0.48%	0.931
Change in monthly trend	1.17%	0.105

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Note: Full model results are presented in Appendix A.

Figure 5-37—Illustration of ITS Analysis (Measure 41: Non-ED OP Costs Among SUD Beneficiaries)



LTC costs among SUD beneficiaries

ITS analysis shows that long-term care (LTC) costs for beneficiaries with a SUD diagnosis were decreasing by 1.58 percent per month during the baseline, which was statistically significant ($p=0.011$). However, Table 5-56 and Figure 5-38 show that following approval of the waiver the average PMPM cost increased significantly by 18.57 percent ($p<0.001$) and increased significantly by 1.43 percent per month on average relative to the baseline trend ($p=0.022$). A GLM with a log link was constructed in order to account for the fact that costs are positive and not normally distributed. This model allows for a more accurate analysis of costs; however, interpretation is not as straightforward as a simple linear regression model, which can be interpreted in dollar amount changes. Results are presented as percentage changes in costs.

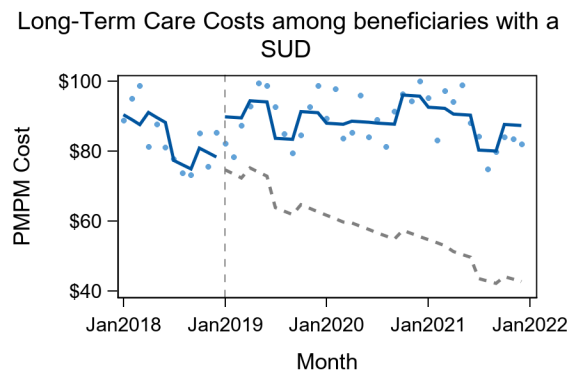
Table 5-56—Primary ITS Results (Measure 41: LTC Costs Among SUD Beneficiaries)

Variable	Percent Change in Costs	p-value
Baseline monthly trend	-1.58%	0.011**
Level change	18.57%	<0.001***
Change in monthly trend	1.43%	0.022**

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Note: Full model results are presented in Appendix A.

Figure 5-38—Illustration of ITS Analysis (Measure 41: LTC Costs Among SUD Beneficiaries)



Professional costs among SUD beneficiaries

ITS analysis shows that controlling for seasonality, professional costs were decreasing slightly at 0.26 percent per month ($p=0.619$) as displayed in Table 5-57 and Figure 5-39. Following implementation, average PMPM costs increased slightly by 4.41 percent ($p=0.282$), and the monthly trend increased by 0.69 percent per month; however, this change was not statistically significant ($p=0.182$). A GLM with a log link was constructed in order to account for the fact that costs are positive and not normally distributed. This model allows for a more accurate analysis of costs; however, interpretation is not as straightforward as a simple linear regression model, which can be interpreted in dollar amount changes. Results are presented as percentage changes in costs.

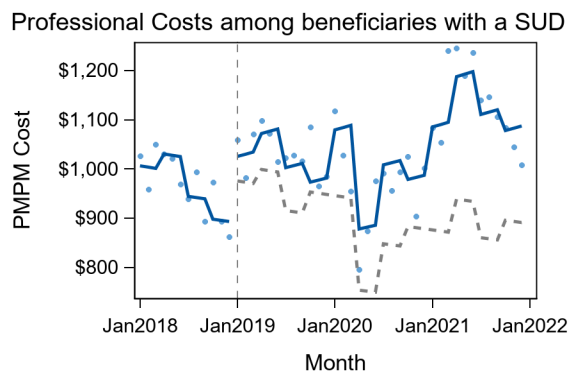
Table 5-57—Primary ITS Results (Measure 41: Professional Costs Among SUD Beneficiaries)

Variable	Percent Change in Costs	p-value
Baseline monthly trend	-0.26%	0.619
Level change	4.41%	0.282
Change in monthly trend	0.69%	0.182

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Note: Full model results are presented in Appendix A.

Figure 5-39—Illustration of ITS Analysis (Measure 41: Professional Costs Among SUD Beneficiaries)



Dental costs among SUD beneficiaries

For completeness, HSAG evaluated dental costs among beneficiaries with a SUD as displayed in Table 5-58 and Figure 5-40. Controlling for seasonality, costs were increasing slightly by 0.45 percent per month prior to approval ($p=0.754$). After demonstration approval, costs decreased by 12.92 percent on average; however, this change was not statistically significant ($p=0.221$). Similarly, the monthly trend decreased by 0.79 percent relative to the baseline trend, which was not statistically significant ($p=0.573$). A GLM with a log link was constructed in order to account for the fact that costs are positive and not normally distributed. This model allows for a more accurate analysis of costs; however, interpretation is not as straightforward as a simple linear regression model, which can be interpreted in dollar amount changes. Results are presented as percentage changes in costs.

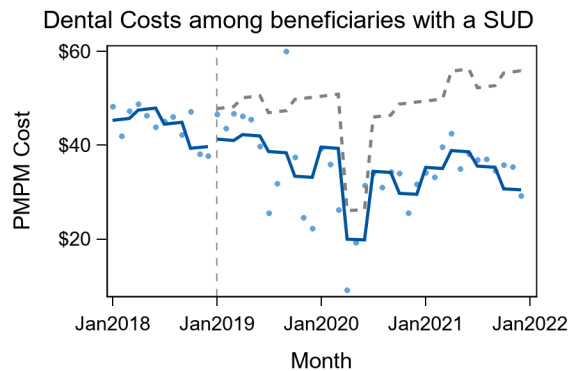
Table 5-58—Primary ITS Results (Measure 41: Dental Costs Among SUD Beneficiaries)

Variable	Percent Change in Costs	p-value
Baseline monthly trend	0.45%	0.754
Level change	-12.92%	0.221
Change in monthly trend	-0.79%	0.573

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Note: Full model results are presented in Appendix A.

Figure 5-40—Illustration of ITS Analysis (Measure 41: Dental Costs Among SUD Beneficiaries)



Pharmacy costs among SUD beneficiaries

ITS analysis shows that pharmacy costs among beneficiaries with a SUD increased slightly by 0.45 percent per month on average ($p=0.363$). After implementation, the upward trend continued, decreasing by only 0.15 percent per month relative to the baseline trend for a net trend of 0.30 percentage point per month (Table 5-59). This change in trend was not statistically significant ($p=0.755$). A GLM with a log link was constructed in order to account for the fact that costs are positive and not normally distributed. This model allows for a more accurate analysis of costs; however, interpretation is not as straightforward as a simple linear regression model, which can be interpreted in dollar amount changes. Results are presented as percentage changes in costs.

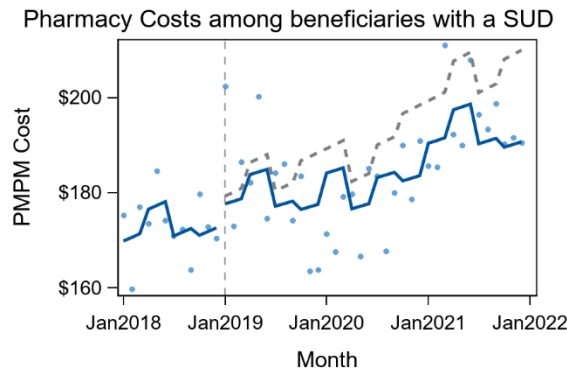
Table 5-59—Primary ITS Results (Measure 41: Pharmacy Costs Among SUD Beneficiaries)

Variable	Percent Change in Costs	p-value
Baseline monthly trend	0.45%	0.363
Level change	-0.75%	0.840
Change in monthly trend	-0.15%	0.755

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Note: Full model results are presented in Appendix A.

Figure 5-41—Illustration of ITS Analysis (Measure 41: Pharmacy Costs Among SUD Beneficiaries)



Although there were no significant changes in total costs among SUD beneficiaries, stratifying by category of service and setting revealed some differing trends. Notably and unsurprisingly, costs associated with a SUD diagnosis in an IMD setting increased significantly upon approval of the demonstration as displayed in Figure 5-41—Illustration of ITS Analysis (Measure 41: Pharmacy Costs Among SUD Beneficiaries). Costs among LTC claims also increased significantly following the approval of the demonstration. Within the OP setting, the trend in ED costs began to decline while non-ED costs began to increase (albeit neither of these changes were statistically significant).

Measure 41 Conclusion: Neither supports nor fails to support the hypothesis

Total cost of BH diagnosis by IMD and Other, by setting (including claims data IP, OP, RX, LTC, and capitated payments to managed care organizations) (Measure 42)

Measure 42 assesses cost drivers among the BH population. Because Alaska Medicaid follows a FFS model, there are no capitated payments and total costs represent direct costs to Medicaid.

Total BH-IMD costs among BH beneficiaries

IMD costs associated with a mental health diagnosis among BH beneficiaries were small relative to total costs at only \$3 PMPM as shown in Table 5-60 and Figure 5-42—Illustration of ITS Analysis (Measure 42: BH-IMD Costs Among BH Beneficiaries). ITS analysis shows that during the baseline period, costs decreased significantly by 7.45 percent per month ($p=0.003$). Following implementation, costs significantly increased by more than doubling (127 percent increase, $p<0.001$). A GLM with a log link was constructed in order to account for the fact that costs are positive and not normally distributed. This model allows for a more accurate analysis of costs; however, interpretation is not as straightforward as a simple linear regression model, which can be interpreted in dollar amount changes. Results are presented as percentage changes in costs.

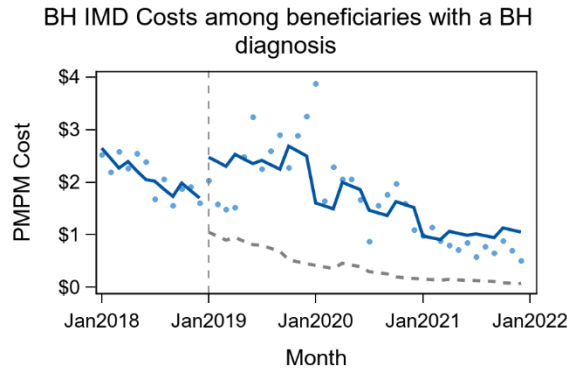
Table 5-60—Primary ITS Results (Measure 42: BH-IMD Costs Among BH Beneficiaries)

Variable	Percent Change in Costs	p-value
Baseline monthly trend	-7.45%	0.003**
Level change	127.02%	<0.001***
Change in monthly trend	4.21%	0.097*

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Note: Full model results are presented in Appendix A.

Figure 5-42—Illustration of ITS Analysis (Measure 42: BH-IMD Costs Among BH Beneficiaries)



Total Other BH costs among BH beneficiaries

ITS analysis shows that costs associated with mental health diagnoses outside an IMD were generally flat throughout both the baseline and evaluation time periods, averaging \$800 as displayed in Table 5-61 and Figure 5-43. There was no discernable trend during the baseline period, with an average increase of only 0.09 percent per month, which was not statistically significant ($p=0.808$), and following demonstration approval, average PMPM costs decreased by 0.26 percent per month relative to the baseline trend, but this change was not statistically significant ($p=0.496$). A GLM with a log link was constructed in order to account for the fact that costs are positive and not normally distributed. This model allows for a more accurate analysis of costs; however, interpretation is not as straightforward as a simple linear regression model, which can be interpreted in dollar amount changes. Results are presented as percentage changes in costs.

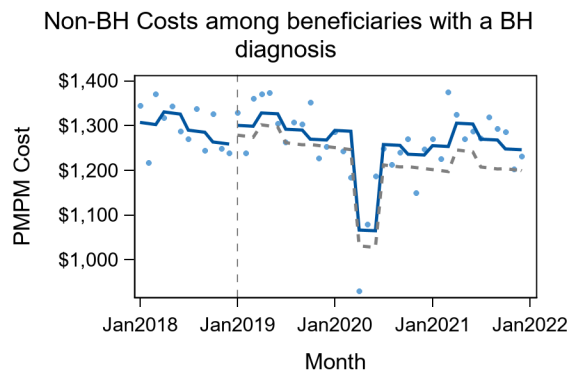
Table 5-61—Primary ITS Results (Measure 42: Other BH Costs Among BH Beneficiaries)

Variable	Percent Change in Costs	<i>p</i> -value
Baseline monthly trend	0.09%	0.808
Level change	3.03%	0.312
Change in monthly trend	-0.26%	0.496

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Note: Full model results are presented in Appendix A.

Figure 5-43—Illustration of ITS Analysis (Measure 42: Other BH Costs Among BH Beneficiaries)



Total Non-BH costs among BH beneficiaries

In addition to claims with a mental health diagnosis, ITS analysis shows that non-mental health related costs among beneficiaries with a BH diagnosis remained generally flat throughout the baseline and evaluation periods as displayed in Table 5-62 and Figure 5-44. In the baseline period, PMPM costs declined slightly by 0.18 percent per month on average, but this was not statistically significant ($p=0.642$). Following approval of the demonstration, this trend increased by 0.11 percent per month relative to the baseline trend but was not statistically significant ($p=0.775$). A GLM with a log link was constructed in order to account for the fact that costs are positive and not normally distributed. This model allows for a more accurate analysis of costs; however, interpretation is not as straightforward as a simple linear regression model, which can be interpreted in dollar amount changes. Results are presented as percentage changes in costs.

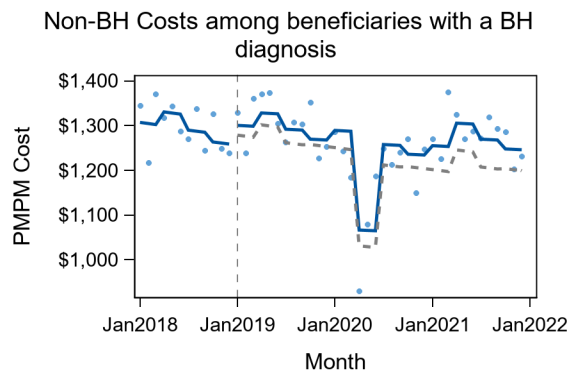
Table 5-62—Primary ITS Results (Measure 42: Non-BH Costs Among BH Beneficiaries)

Variable	Percent Change in Costs	p-value
Baseline monthly trend	-0.18%	0.642
Level change	1.59%	0.601
Change in monthly trend	0.11%	0.775

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Note: Full model results are presented in Appendix A.

Figure 5-44—Illustration of ITS Analysis (Measure 42: Non-BH Costs Among BH Beneficiaries)



IP costs among BH beneficiaries

ITS analysis shows that IP costs among BH beneficiaries were effectively flat throughout the baseline and demonstration periods, averaging \$281. Table 5-63 and Figure 5-45 show there was no discernable change in the level or trend in costs following approval of the demonstration. A GLM with a log link was constructed in order to account for the fact that costs are positive and not normally distributed. This model allows for a more accurate analysis of costs; however, interpretation is not as straightforward as a simple linear regression model, which can be interpreted in dollar amount changes. Results are presented as percentage changes in costs.

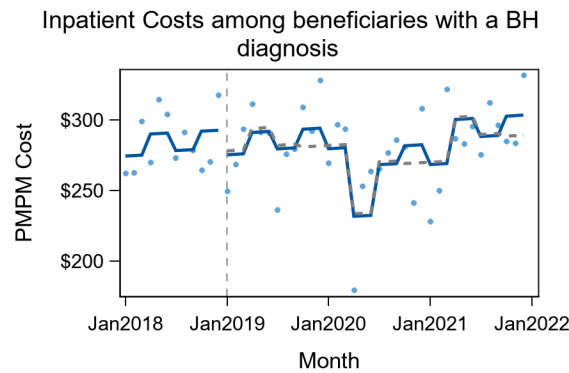
Table 5-63—Primary ITS Results (Measure 42: IP Costs Among BH Beneficiaries)

Variable	Percent Change in Costs	p-value
Baseline monthly trend	0.11%	0.884
Level change	-1.04%	0.856
Change in monthly trend	0.02%	0.981

p* < 0.1, *p* < 0.05, ****p* < 0.001

Note: Full model results are presented in Appendix A.

Figure 5-45—Illustration of ITS Analysis (Measure 42: IP Costs Among BH Beneficiaries)



OP costs among BH beneficiaries

Similar to PMPM IP costs, total OP costs for beneficiaries with a BH diagnosis remained effectively flat throughout the baseline and evaluation periods as displayed in Table 5-64 and Figure 5-46—Illustration of ITS Analysis (Measure 42: OP Costs Among BH Beneficiaries) Figure 5-46. Costs increased slightly by 0.08 percent per month during the baseline period (*p*=0.849) and following approval of the demonstration the trend decreased by 0.20 percent per month relative to the baseline trend, but this change in the trend was not statistically significant (*p*=0.628). A GLM with a log link was constructed in order to account for the fact that costs are positive and not normally distributed. This model allows for a more accurate analysis of costs; however, interpretation is not as straightforward as a simple linear regression model, which can be interpreted in dollar amount changes. Results are presented as percentage changes in costs.

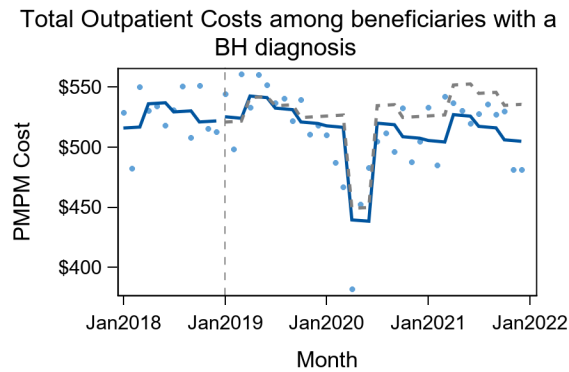
Table 5-64—Primary ITS Results (Measure 42: OP Costs Among BH Beneficiaries)

Variable	Percent Change in Costs	p-value
Baseline monthly trend	0.08%	0.849
Level change	1.05%	0.743
Change in monthly trend	-0.20%	0.628

p* < 0.1, *p* < 0.05, ****p* < 0.001

Note: Full model results are presented in Appendix A.

Figure 5-46—Illustration of ITS Analysis (Measure 42: OP Costs Among BH Beneficiaries)



ED OP costs among BH beneficiaries

Separating OP costs by ED and non-ED revealed slightly more pronounced trends and changes in costs, but results were not statistically significant as displayed in Table 5-65 and Figure 5-47. Prior to implementation, PMPM costs were increasing slightly at 0.38 percent per month ($p=0.525$). Costs increased on average by 6.85 percent after approval of the demonstration, but this was not statistically significant ($p=0.141$), and the trend decreased by 0.82 percent per month relative to the baseline trend, which was not statistically significant ($p=0.163$). A GLM with a log link was constructed in order to account for the fact that costs are positive and not normally distributed. This model allows for a more accurate analysis of costs; however, interpretation is not as straightforward as a simple linear regression model, which can be interpreted in dollar amount changes. Results are presented as percentage changes in costs.

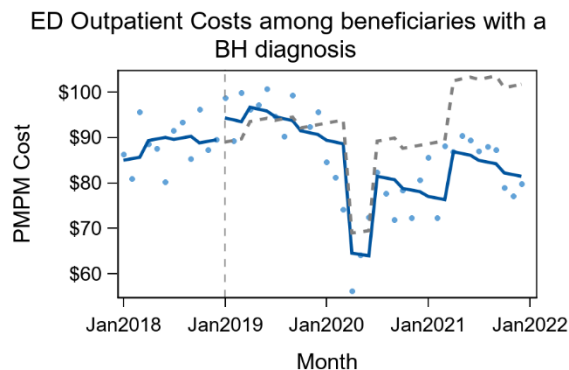
Table 5-65—Primary ITS Results (Measure 42: ED OP Costs Among BH Beneficiaries)

Variable	Percent Change in Costs	p-value
Baseline monthly trend	0.38%	0.525
Level change	6.85%	0.141
Change in monthly trend	-0.82%	0.163

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Note: Full model results are presented in Appendix A.

Figure 5-47—Illustration of ITS Analysis (Measure 42: ED OP Costs Among BH Beneficiaries)



Non-ED OP costs among BH beneficiaries

Non-ED OP costs averaged \$430 PMPM and did not exhibit discernable changes after approval of the demonstration as displayed in Table 5-66 and Figure 5-48. Non-ED OP costs decreased by an average of 0.06 percent ($p=0.985$) and decreased of 0.07 percent per month in the trend relative to the baseline trend ($p=0.869$). A GLM with a log link was constructed in order to account for the fact that costs are positive and not normally distributed. This model allows for a more accurate analysis of costs; however, interpretation is not as straightforward as a simple linear regression model, which can be interpreted in dollar amount changes. Results are presented as percentage changes in costs.

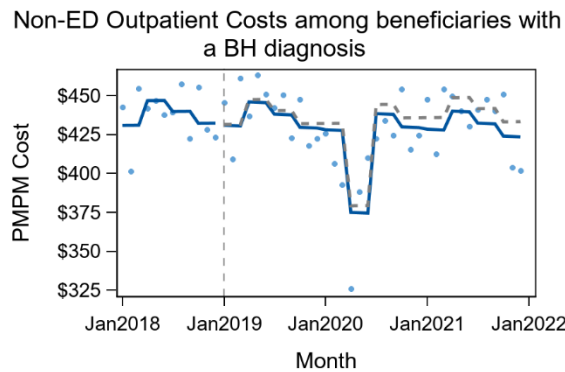
Table 5-66—Primary ITS Results (Measure 42: Non-ED OP Costs Among BH Beneficiaries)

Variable	Percent Change in Costs	p-value
Baseline monthly trend	0.01%	0.977
Level change	-0.06%	0.985
Change in monthly trend	-0.07%	0.869

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Note: Full model results are presented in Appendix A.

Figure 5-48—Illustration of ITS Analysis (Measure 42: Non-ED OP Costs Among BH Beneficiaries)



LTC costs among BH beneficiaries

ITS analysis shows that beneficiaries with a BH diagnosis had a slightly increasing trend in LTC costs during the baseline period, increasing by 0.10 percent per month, but this was not statistically significant ($p=0.710$). However, after approval of the demonstration, costs began to decline by 0.49 percent per month relative to the baseline trend, which was statistically significant at the 0.1 level ($p=0.074$). Table 5-67 and Figure 5-49 display these trends. A GLM with a log link was constructed in order to account for the fact that costs are positive and not normally distributed. This model allows for a more accurate analysis of costs; however, interpretation is not as straightforward as a simple linear regression model, which can be interpreted in dollar amount changes. Results are presented as percentage changes in costs.

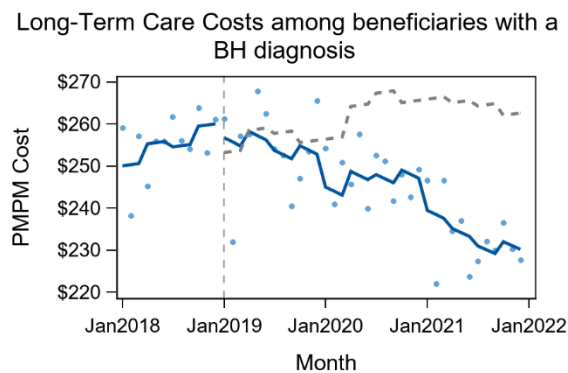
Table 5-67—Primary ITS Results (Measure 42: LTC Costs Among BH Beneficiaries)

Variable	Percent Change in Costs	p-value
Baseline monthly trend	0.10%	0.710
Level change	1.91%	0.374
Change in monthly trend	-0.49%	0.074*

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Note: Full model results are presented in Appendix A.

Figure 5-49—Illustration of ITS Analysis (Measure 42: LTC Costs Among BH Beneficiaries)



Professional costs among BH beneficiaries

ITS analysis shows a slight decrease in professional costs among beneficiaries with a BH diagnosis throughout the baseline period (-0.33 percent per month, $p=0.492$) and this trend did not change significantly after demonstration approval, increasing by 0.08 percent per month relative to the baseline trend ($p=0.872$). Table 5-68 and Figure 5-50 display these trends. A GLM with a log link was constructed in order to account for the fact that costs are positive and not normally distributed. This model allows for a more accurate analysis of costs; however, interpretation is not as straightforward as a simple linear regression model, which can be interpreted in dollar amount changes. Results are presented as percentage changes in costs.

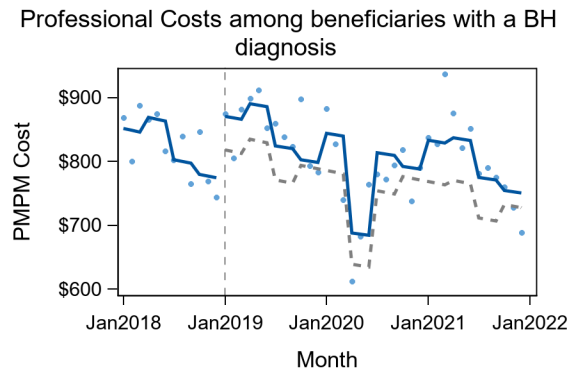
Table 5-68—Primary ITS Results (Measure 42: Professional Costs Among BH Beneficiaries)

Variable	Percent Change in Costs	p-value
Baseline monthly trend	-0.33%	0.492
Level change	6.33%	0.104
Change in monthly trend	0.08%	0.872

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Note: Full model results are presented in Appendix A.

Figure 5-50—Illustration of ITS Analysis (Measure 42: Professional Costs Among BH Beneficiaries)



Dental costs among BH beneficiaries

ITS analysis shows that dental costs among members with a BH diagnosis increased slightly by 0.34 percent per month during the baseline period. Following approval of the demonstration, this trend declined by 1.14 percent per month relative to the baseline, and although this decline was not statistically significant ($p=0.372$), it represented a difference of approximately \$25 PMPM by the end of 2021. Table 5-69 and Figure 5-51 display these trends. A GLM with a log link was constructed in order to account for the fact that costs are positive and not normally distributed. This model allows for a more accurate analysis of costs; however, interpretation is not as straightforward as a simple linear regression model, which can be interpreted in dollar amount changes. Results are presented as percentage changes in costs.

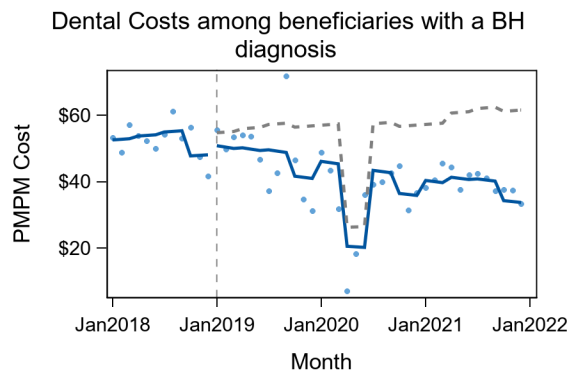
Table 5-69—Illustration of ITS Analysis (Measure 42: Dental Costs Among BH Beneficiaries)

Variable	Percent Change in Costs	p-value
Baseline monthly trend	0.34%	0.796
Level change	-6.09%	0.537
Change in monthly trend	-1.14%	0.372

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Note: Full model results are presented in Appendix A.

Figure 5-51—Illustration of ITS Analysis (Measure 42: Dental Costs Among BH Beneficiaries)



Pharmacy costs among BH beneficiaries

ITS analysis shows that pharmacy costs among beneficiaries with a BH diagnosis increased significantly following approval of the demonstration displayed in Table 5-70 and Figure 5-52. Prior to approval, costs were declining slightly by 0.15 percent per month; after approval, this trend reversed, increasing significantly by 0.98 percent per month relative to the baseline period ($p=0.039$). By the end of 2021, this translated to a difference of approximately \$42 PMPM (\$180 average actual costs compared to projected costs of \$138 PMPM had the baseline trend continued). This increase would not be unexpected if beneficiaries with a BH diagnosis are receiving needed treatment they otherwise were not receiving. A GLM with a log link was constructed in order to account for the fact that costs are positive and not normally distributed. This model allows for a more accurate analysis of costs; however, interpretation is not as straightforward as a simple linear regression model, which can be interpreted in dollar amount changes. Results are presented as percentage changes in costs.

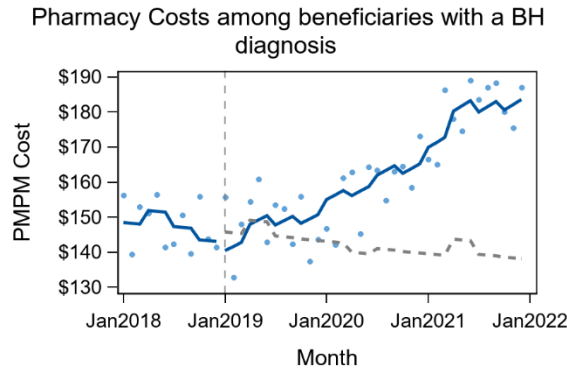
Table 5-70—Illustration of ITS Analysis (Measure 42: Pharmacy Costs Among BH Beneficiaries)

Variable	Percent Change in Costs	p-value
Baseline monthly trend	-0.15%	0.748
Level change	-4.57%	0.200
Change in monthly trend	0.98%	0.039**

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Note: Full model results are presented in Appendix A.

Figure 5-52—Illustration of ITS Analysis (Measure 42: Pharmacy Costs Among BH Beneficiaries)



Overall, costs among beneficiaries with a BH diagnosis did not change by a statistically significant, degree; however, separating by category of service and setting revealed some notable changes in costs. First, similar to beneficiaries with a SUD diagnosis, IMD costs associated with BH diagnoses among the BH population increased significantly following approval of the demonstration. Pharmacy costs also began to increase at a significantly higher rate after the demonstration approval compared to before the approval. LTC costs, however, began to decrease after approval relative to before approval.

Measure 42 Conclusion: Neither supports nor fails to support the hypothesis

6. Conclusions

The Alaska Substance Use Disorder and Behavioral Health (SUD-BH) Program Demonstration Waiver allowed the State to cover a variety of new services to treat SUD and BH disorders including residential, partial hospitalization (PH), intensive outpatient (IOP), withdrawal management, and community recovery support services, among others. Table 6-1 presents the criteria used to determine whether results supported the hypothesis for each measure. Table 6-2 summarizes the conclusions across all measures, organized by research question and hypothesis.

Table 6-1—Measure Conclusion Criteria

Conclusion	Criteria
Supports	<ul style="list-style-type: none"> Statistical testing results are significant in favorable direction.
	<ul style="list-style-type: none"> For measures without statistical testing, there was conclusive evidence of moderate to large, sustained improvements in the results.
Neither support nor fail to support (NS/FS)	<ul style="list-style-type: none"> Statistical testing results are not significant.
	<ul style="list-style-type: none"> For measures without statistical testing, there was no conclusive evidence of moderate to large, sustained increases or decreases in the results.
Does not support	<ul style="list-style-type: none"> Statistical testing results are significant in unfavorable direction.
	<ul style="list-style-type: none"> For measures without statistical testing, there was conclusive evidence of moderate to large, sustained worsening in the results.
N/A	<ul style="list-style-type: none"> The measure does not relate to the hypothesis or no comparison data were available to draw a conclusion.

Table 6-2—Summary of Results by Aim, Hypothesis, and Measure

Measure Number	Measure Name	Results Support Hypothesis
Research Question 1: Does the SUD-BH Program increase access to and utilization of SUD and BH disorder treatment services by increasing access to community-based care?		
Hypothesis 1: The SUD-BH Program will increase the number of beneficiaries in the waiver population who are referred to and engage in treatment for SUD and BH disorders in sub-acute, community, or regionally based OP settings.		
1	Number of beneficiaries screened for symptoms of SUD using industry recognized, evidence-based screening instruments	No
2	Number of beneficiaries screened for symptoms of BH disorders using industry recognized, evidence-based screening instruments	No
3	Number of beneficiaries in the waiver population with SUD or BH diagnosis, by setting	NS/FS
4	Initiation and engagement of AOD abuse or dependence treatment (NQF 0004)	Yes
5	Follow-up after discharge from ED visits for SUD, and specifically for OUD, by setting (NQF 2605)	No
6	Follow-up after discharge from ED visits for a BH disorder, by setting (NQF 2605)	No
7	Number of Medicaid qualified SUD providers (identified by provider ID numbers) who bill for SUD services	Yes
8	Number of Medicaid qualified professionals licensed in the State to provide BH who bill for BH disorder services	Yes

Measure Number	Measure Name	Results Support Hypothesis
9	Providers' reported barriers before, during, and shortly following expansion of BH and SUD services	NS/FS
10	Providers' experience in expanding services	Yes
11	Administrators' reported barriers before, during, and shortly following expansion of BH and SUD services	No
12	Administrators' plan for program sustainability and anticipated challenges	Yes
13	Alaska tribal entities' reported changes in quality of care and access to care following expansion of BH and SUD services	NS/FS
Hypothesis 2: The SUD-BH Program will decrease utilization of ED, IP, or institutional settings within the beneficiary population.		
14	IP admissions for SUD, and specifically for OUD, by setting	NS/FS
15	IP admissions for BH disorders, by setting	NS/FS
16a	ED visits for SUD, by setting	No
16b	ED visits for OUD, by setting	
17	ED visits for BH disorders, by setting	Yes
18	Mean length of stay measured from admission date to discharge date, by setting	Yes
19	30-day readmission rate to IP facilities following hospitalization for a SUD-related diagnosis, by setting	Yes
20	30-day readmission rate to IP facilities following hospitalization for a BH-related diagnosis, by setting	NS/FS
Hypothesis 3: The SUD-BH Program will increase the percentage of beneficiaries who adhere to treatment for SUD and BH disorders.		
21	Number of beneficiaries with a SUD diagnosis including those with OUD who used services in the last month or year, by service or benefit type	Yes
22	Number of beneficiaries with a BH diagnosis who used services in the last month or year, by service or benefit type	NS/FS
23	Time to treatment, by service type (National Behavioral Health Quality Framework [NBHQF] Goal 1)	Yes
Research Question 2: Do enrollees receiving SUD services experience improved health outcomes?		
Hypothesis 1: The SUD-BH Program will increase the percentage of beneficiaries with SUD or a BH disorder who experience care for comorbid conditions.		
24	Access to physical healthcare	No
25	Screening for chronic conditions relevant to state Medicaid population	No
26	Screening for co-morbidity of BH disorders and SUDs within the waiver population compared to the total Medicaid population	No
27	Percentage of beneficiaries who rate the quality of their healthcare as very good or excellent	N/A
28	Percentage of beneficiaries who rate their overall mental or emotional health as very good or excellent	N/A
29	Percentage of beneficiaries who demonstrate very good or excellent knowledge of available treatment and services	N/A
30	Maternal depression	NS/FS
31	Maternal domestic abuse	NS/FS

Measure Number	Measure Name	Results Support Hypothesis
32	Percentage of beneficiaries who experienced alcoholism or mental health disorder among household members	NS/FS
33	Percentage of beneficiaries who witnessed violence or physical abuse between household members	NS/FS
34	Percentage of youth beneficiaries who have ever been physically hurt by an adult in any way	NS/FS
35	Maternal marijuana or hash use in the past two years	NS/FS
36	Frequency of maternal marijuana or hash use (days per week)	Yes
--	Social support— care when sick (Supplemental CUBS Measure 1)	N/A
--	Desire to obtain SUD/BH treatment options and obtainment of SUD treatment in the past three months (Supplemental CUBS Measure 2)	N/A
Hypothesis 2: The SUD-BH Program will decrease the rate of drug overdoses and overdose deaths due to opioids.		
37	Rate of overdose deaths, specifically overdose deaths due to any opioid	No
38	Non-fatal overdoses (<i>all cause</i>)	Yes
39	Use of opioids at high dosage in persons without cancer (NQF 2940)	NS/FS
Research Question 3: Does the SUD-BH Program reduce the cost of Medicaid for Alaska and the federal government?		
Hypothesis 1: The SUD-BH Program will reduce Alaska’s per capita Medicaid BH costs.		
40	Total costs of healthcare (sum of parts below), by State and federal share	NS/FS
41	Total cost of SUD, SUD-IMD and SUD-Other and Non-SUD, by setting, including claims data (IP, OP, RX, LTC, and capitated payments to managed care organizations)	NS/FS
42	Total cost of BH diagnosis by IMD and Other, by setting, including claims data (IP, OP, RX, LTC, and capitated payments to managed care organizations)	NS/FS

Note: AOD: alcohol and other drug use; BH: Behavioral Health; CUBS: Childhood Understanding Behaviors Survey; ED: emergency department; IMD: Institutions for Mental Disease; IP: inpatient; LTC: long-term care; NBHQF: National Behavioral Health Quality Framework; NCQA: National Committee for Quality Assurance; NQF: National Quality Forum; OP: outpatient; OUD: opioid use disorder; RX: pharmacy; SUD: substance use disorder; SUD-BH: Substance Use Disorder-Behavioral Health

Research Question 1

Research Question 1 assesses whether the SUD-BH Program increased access to and utilization of SUD and BH disorder treatment services. Evaluation of this goal was complicated by the coronavirus disease 2019 (COVID-19) public health emergency (PHE), which began one year after the start of the demonstration approval period and coincided with many implementation milestones. As a result, measures that assess utilization of services were adversely impacted by the PHE as lock-down orders were in effect.

Successes and challenges associated with Research Question 1 include the following.

Successes

- Increased number of practitioners providing SUD and BH services.
- Reduced emergency department (ED) visits specifically for opioid use disorder (OUD) and BH disorders.
- Improved rates of service utilization for SUD treatment.
- Timelier initiation of treatment for SUD.

In addition, there were potential successes in a shift of the type of services that beneficiaries utilized. Specifically, among beneficiaries with a SUD, there appeared to be a shift from the outpatient (OP) setting to residential, inpatient (IP) and IOP/PH settings. Because OP services were originally covered under the State plan but IP and IOP/PH were new services provided under the waiver, this may indicate that beneficiaries were not getting an appropriate level of care prior to the demonstration.

Challenges

Notable challenges include:

- Reduced percentage of beneficiaries screened for SUD or BH disorders.
- Lower rates of follow-up after discharge from an ED visit for SUD or BH disorder.

Lower rates of screening for SUD and BH disorders, chronic conditions, and SUD/BH comorbidities were likely driven by the COVID-19 PHE since many residential and withdrawal management facilities were closed or had reduced censuses due to the PHE, as screening rates in 2019 were higher than in 2020 and 2021 and generally similar to 2018 rates; however, screening rates did not increase in 2021 following the reopening and the consequent delays in any routine, nonessential care.

Rates of follow-up visits after discharge from an ED for SUD or BH disorders also declined following approval of the demonstration in 2019, with seven-day follow-up rates declining by nearly 9 percentage points, a 20 percent relative decline, and 30-day follow-up rates declining by 8.4 percentage points, or a 14 percent relative decline. This represents a notable shift that is likely not attributable to the COVID-19 PHE, as rates began to decline in 2019 prior to the PHE.

Research Question 2

Research Question 2 assesses whether enrollees receiving SUD services experienced improved health outcomes. This goal was measured using administrative claims data, beneficiary surveys, the Alaska Childhood Understanding Behaviors Survey (CUBS) instruments, and overdose data to address this research question. Because beneficiary surveys were conducted at a single point in time, no causal conclusions can be drawn, and results are interpreted in a descriptive manner.

Successes

Due in part to data limitations, there were no successes that could be attributed to the demonstration. However, there was a reduction in non-fatal overdoses among Alaska residents statewide (Medicaid and non-Medicaid recipients). Although analysis of the CUBS data indicates a reduction in frequency of maternal marijuana usage after the waiver approval, this decline was observed in 2020 and could be attributable to revisions in the survey instrument that year.

Among survey measures of Medicaid recipients, there were promising signs regarding the number of treatment services that were known to beneficiaries. No statistical testing was conducted because these surveys were conducted at a single point in time after approval of the demonstration and no viable comparison group could be used, but over half of beneficiaries indicated they knew where to receive SUD treatment (for both adults and children), while over two-thirds knew where to receive BH treatment. Among those who did know where to find treatment, every setting for adult treatment was known to over two-thirds of beneficiaries, and every setting for child treatment was known to at least 70 percent of beneficiaries.

Challenges

Notable challenges include:

- Reduced rates of access to preventive and primary care.
- Reduced screening for chronic conditions and SUD/BH comorbidities.
- Higher rates of statewide (including non-Medicaid) overdose deaths, including those from opioids.

Lower rates of access to preventive and primary care are likely attributable to the COVID-19 PHE because rates did not begin to decline until 2020 and 2021; however, there was no rebound in rates in 2021 following the reopening.

Similar to screening for SUD and BH disorders, lower rates of screening for chronic conditions and SUD/BH comorbidities were likely driven by the COVID-19 PHE, as screening rates in 2019 were higher than in 2020 and 2021 and generally similar to 2018 rates; however, screening rates did not increase in 2021 as the healthcare system reopened.

The increased rate of overdose deaths was exacerbated by the COVID-19 PHE, as was seen across the country during this time.⁶⁻¹ Data on Medicaid recipients specifically were not available, and all-cause overdose death rates did not increase substantially until state fiscal year (SFY) 2021. Opioid overdose deaths increased slightly in SFY 2020 and increased substantially in SFY 2021. Studies have shown that COVID-19 had a disproportionate impact on overdoses in rural areas.⁶⁻²

Research Question 3

Research Question 3 assesses the total cost of care for beneficiaries with a SUD and BH disorder. Costs for these beneficiaries did not demonstrably change following implementation of the demonstration.⁶⁻³ Total costs among beneficiaries with a SUD diagnosis increased by 0.20 percent per month both before and after approval of the demonstration. Costs among beneficiaries with a BH diagnosis declined by 0.08 percent per month.

There were two notable increases in costs among the SUD population when examining costs by setting. Unsurprisingly, average institutions for mental disease (IMD) costs increased significantly following approval of

⁶⁻¹ Centers for Disease Control and Prevention. "Overdose Deaths Accelerating During COVID-19," Press Release, December 17, 2020. Available at: <https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html>; Accessed on: Nov 3, 2022.

⁶⁻² Walters, S.M., *et al*, (2022) "Structural and community changes during COVID-19 and their effects on overdose precursors among rural people who use drugs: a mixed-methods analysis," *Addiction Science & Clinical Practice* 17(24); <https://asepjournal.biomedcentral.com/articles/10.1186/s13722-022-00303-8>

⁶⁻³ Note that the cost analyses do not refer to nor attempt to replicate the formal Budget Neutrality test required under the Section 1115 Demonstration Waiver program, which sets a fixed target under which waiver expenditures must fall that was set at the time the waiver was approved.



the demonstration, which allowed Medicaid to reimburse a greater proportion of IMD stays. Long-term care (LTC) costs also increased significantly among the SUD population after approval of the demonstration.

Similar to the SUD population, IMD and LTC costs among the BH population also increased following the approval of the demonstration. Additionally, pharmacy costs saw an increase in costs following approval of the waiver, which may signify that beneficiaries are receiving needed treatment that they had not been receiving prior to the waiver.

7. Interpretations, and Policy Implications, and Interactions with Other State Initiatives

Interpretations

Results suggest that Alaska beneficiaries with a substance use disorder (SUD) or behavioral health (BH) disorder were receiving more appropriate care after approval of the waiver than before approval. Beneficiaries with a SUD began reducing their utilization of outpatient (OP) services following the approval of the waiver and there were noticeable increases among new settings of care for treatment, such as intensive outpatient/partial hospitalization (IOP/PH) and residential inpatient (IP). Similarly, beneficiaries with a BH disorder appeared to transition away from the OP and emergency department (ED) settings more permanently following the coronavirus disease 2019 (COVID-19) public health emergency (PHE) in favor of telehealth. Beneficiaries with a BH disorder also exhibited a significant upward trend in pharmacy costs following the approval of the PHE, potentially indicating these beneficiaries were receiving needed treatment.

There were also improvements in meeting the statewide target for average length of stay in an institution for mental disease (IMD) of 30 days. The average length of stay in an IMD decreased significantly following approval of the demonstration, declining from over 76 days in 2018 to just under 27 days.

Finally, the number of providers billing for SUD services increased substantially following approval of the waiver. In 2018, only 17 providers billed for SUD services, who were located in two regions (Anchorage and Fairbanks). By 2021, 134 providers were billing for SUD services across five regions. The number of providers billing for BH services also increased following the demonstration, but to a lesser extent than SUD providers.

The COVID-19 PHE greatly impacted access to care in 2020 and 2021, which is evidenced by lower rates of SUD and BH screening and access to physical care in both 2020 and 2021. The decline in access to care measures is consistent with what has been seen nationally across Medicaid health plans. Improvements could be made, however, in follow-up visits after discharge from the ED for a SUD or BH disorder. Because follow-up visits after discharge from the ED specifically for opioid use disorder (OUD) increased while they decreased for SUD generally, this implies disproportionate handling of ED visits for OUD compared to alcohol or other drug abuse. Moreover, rates of follow-up visits are not as susceptible to the effects of the COVID-19 PHE as access to care measures, as national rates for Medicaid health plans did not decline substantially in 2020 or 2021.

Costs

It is too early to tell in the demonstration whether this translates to cost savings. The slight increase in costs among the SUD population was primarily driven by costs directly associated with a SUD diagnosis. Increases in cost trends were seen among the non-ED OP, long-term care (LTC), and professional settings. Cost trends declined among the IP, ED OP, dental, and pharmacy settings.

The slight decline in the cost trend among the BH population was primarily driven by a decline in OP (both ED and non-ED), LTC, and dental costs. The trend in costs increased significantly for pharmacy and increased slightly among professional and IP settings.

The cost analysis thus far centered on overall costs to Medicaid. Additional research is needed as more post-implementation data points are gathered to assess the impact at the individual level. It is possible that as the demonstration matures, the impact on overall costs may not result in a reduction, given various stages in SUD or BH treatment among the population. That is, at the individual level, the trajectory of costs increases initially as

members receive treatment before beginning to decline as the lower cost of treatment leads to lower costs over the longer run. In aggregate however, because at any given point in time there are individuals in all stages of treatment, this individual effect is unlikely to translate to an overall reduction in costs (unless the proportion of beneficiaries with a SUD fundamentally decreases). Health Services Advisory Group, Inc. (HSAG) expects that with additional data points being available to assess beneficiary-level costs in the Summative Evaluation Report, a more robust panel analysis can be conducted to evaluate the trajectory of costs at the member level following waiver implementation.

Policy Implications

COVID-19 PHE

The COVID-19 PHE has added layers of complexity to program evaluations, with only a few elements not impacted by the pandemic. Even with the most significant impacts confined mainly to 2020, lingering PHE impacts were identified through 2021. Due to the unprecedented nature of the PHE, very little research is available to reliably predict the trajectory of PHE impacts beyond those accompanying the shutdown and restrictions in 2020. Separating the impacts of the demonstration waiver from those of the PHE will be facilitated by the availability of additional data to identify and control for the trajectory of the PHE and its impacts on the program.

There are likely PHE impacts that have not yet been fully realized, particularly around service needs that were postponed during the PHE and any resurgences of the virus. These impacts will likely continue to impact demonstration waivers for several years. The financial analyses suggest that during the PHE, states faced fiscal pressures of responding to the PHE. However, states may still face fiscal pressures from the demand for services as well as lingering health impacts from COVID-19 on their populations.

The COVID-19 PHE exacerbated already existing workforce shortages in Alaska, particularly for health care workers, creating additional challenges expanding services that require medical staff, such as withdrawal management. Moreover, the COVID-19 PHE significantly impacted the rate of overdose deaths, including those related to opioids. Two findings from this evaluation may assist the State in addressing this issue. First, the State should continue to expand the number of providers who bill for SUD services, particularly in regions 3, 6, 7, and 9 where these providers are not currently available in order to meet the demand in these rural/frontier regions that have been shown to be more disproportionately impacted by COVID-19.⁷⁻¹ Second, the State should encourage providers to screen for SUD and BH disorders in order to identify members who may be at risk of an overdose due to a SUD. The Department of Behavioral Health (DBH) may consider ensuring that reimbursement rates for screening services are comparable to non-Medicaid health plans.

Follow-Up After ED Visit for SUD or BH Disorder

The State should work with providers to improve rates of follow-up visits after an ED visit with a SUD or BH diagnosis. Because ED visits for OUD specifically appeared to show improvements, providers should be encouraged to follow similar follow-up protocols and standards for ED visits for alcohol and other drug abuse and BH disorders as they follow for OUD.

⁷⁻¹ Walters SM, Bolinski RS, *et al.* Structural and community changes during COVID-19 and their effects on overdose precursors among rural people who use drugs: a mixed-methods analysis.” *Addiction Science & Clinical Practice* 17, 24 (2022). Available at: <https://ascjournal.biomedcentral.com/articles/10.1186/s13722-022-00303-8>. Accessed on: Nov 8, 2022.

Interactions With Other State Initiatives

Alaska’s SUD-BH 1115 demonstration is only one tool that the Alaska Department of Health and DBH is using to address SUD and mental illness. The SUD-BH demonstration can augment other State initiatives through leveraging resources provided under the demonstration. Likewise, the demonstration may be able to utilize goals of other initiatives to increase the effectiveness of the SUD-BH Program. For example, one goal of the Statewide Opioid Action Plan is to provide timely access to screening, referral, and treatment of substance misuse.⁰⁻² Actions taken under this initiative to further the goal of screening for SUD could be aligned with the demonstration’s goal of universally screening all Medicaid recipients for SUD using evidence-based screening instruments. This could help address the challenges identified in SUD and BH screening among Medicaid recipients.

Background on Other State Initiatives

Alaska established the Office of Substance Misuse and Addiction Prevention (OSMAP) in July 2017.⁷⁻³ OSMAP utilizes a public health approach to prevent and reduce SUDs, prevent harms caused by substance use (SU), and support community-based activities across Alaska. Activities supported by OSMAP focus on opioid and marijuana misuse, addiction prevention, data and evaluation, and program and system changes to mitigate harm. On February 14, 2017, the Office of the Governor issued a disaster declaration for the opioid epidemic in Alaska. As a result of the declaration, OSMAP, in coordination with the Alaska Department of Health (DOH), the Department of Public Safety (DPS), other State agencies, and community organizations developed the Statewide Opioid Action Plan.⁷⁻⁴ The Statewide Opioid Action Plan, published in November 2018, specificized actions for the State to take to support local, regional, tribal, State, federal, and volunteer agencies and efforts to address opioid misuse in Alaska from 2018 through 2022. In addition, the plan outlined six overarching goals intended to guide and inform future work for the State agencies and partners engaged in the opioid response, listed below:

- Uniting to reduce stigma and change social norms surrounding substance misuse and addiction.
- Communication, coordination, and cooperating on substance misuse efforts.
- Reducing the risks of substance misuse and addiction.
- Having fewer Alaskans experience problems associated with drug abuse.
- Providing timely access to the screening, referral, and treatment services required.
- Building communities of recovery across Alaska.⁷⁻⁵

OSMAP also coordinates Project HOPE. Project HOPE collaborates with community organizations to distribute or administer naloxone in response to opioid overdoses, directly providing naloxone to Alaskans.⁷⁻⁶ To date, Project HOPE has distributed over 12,000 naloxone rescue kits and provided training on their use to first responders. Project HOPE further trained and approved 29 opioid response programs to ensure that distribution of

⁰⁻² Alaska Department of Health and Social Services. Statewide Opioid Action Plan. Available at: <https://health.alaska.gov/osmap/Pages/action.aspx>. Accessed on: Aug 23, 2022.

⁰⁻³ Alaska Department of Health and Social Services. Office of Substance Misuse and Addiction Prevention. Available at: <https://health.alaska.gov/osmap/Pages/default.aspx>. Accessed on: Aug 22, 2022.

⁰⁻⁴ Alaska Department of Health and Social Services. Statewide Opioid Action Plan. Available at: <https://health.alaska.gov/osmap/Pages/action.aspx>. Accessed on: Aug 23, 2022.

⁰⁻⁵ Alaska Department of Health and Social Services. 2018-2022 Statewide Opioid Action Plan. Available at: <https://health.alaska.gov/osmap/Documents/Statewide-Opioid-Action-Plan-2018-2022.pdf>. Accessed on: Sept 14, 2022.

⁰⁻⁶ Alaska Department of Health and Social Services. Project HOPE. Available at: <https://health.alaska.gov/osmap/Pages/hope.aspx>. Accessed on: Aug 23, 2022.

kits and training on their use continues on local levels. Additionally, Project HOPE distributed over 25,000 drug disposal bags across Alaska, providing individuals with safe means to dispose of opioids and unused prescription medication.

DOH developed the Medications for Addiction Treatment Guide to aid providers in Alaska in implementing opioid treatment services.⁷⁻⁷ The guide centered on understanding how to utilize naltrexone and buprenorphine in office-based settings alongside BH treatment and support. The guide contained an evidence-based approach to treating OUD. The most recent version of the guide, the second edition, was published in February 2021.

Alaska operates a Prescription Drug Monitoring Program (PDMP). Alaska's PDMP is designed to improve patient care and encourage cooperation between stakeholders to reduce the misuse, abuse, and diversion of controlled substances by monitoring Schedule II–IV controlled substances dispensed within the State.⁷⁻⁸ The State Opioid Response (SOR) grant partially funds the PDMP. The SOR fundings allows the PDMP to enhance and analyze prescribing accuracy; hire a Principal Investigator to review PDMP violations; and hire additional staff to assist with registration, investigations, and education efforts. Providers who prescribe and dispense these controlled substances are required to register with the PDMP to review and report patient prescription information. By the end of 2020, there were 8,087 registered Alaska PDMP users.⁷⁻⁹

Alaska hosts an increasing number of Project Extension for Community Healthcare Outcomes (ECHO) sites.⁷⁻¹⁰ Alaska Native Tribal Health Consortium (ANTHC), the University of Alaska Anchorage (UAA) Center for Human Development Project, and the Alaska Education Network all host various ECHO projects with different education opportunities. Project ECHO utilizes videoconferencing to connect a team of interdisciplinary specialists with health professionals, educators, and community members. Specialists provide expert advice to aid in building capacity in communities to implement best practices and improve outcomes. ECHO topics covered in the State of Alaska included addiction medicine, behavioral interventions for early childhood, and pain and opioid management.

Alaska places emphasis on programs and initiatives focusing on youth mental health and substance abuse prevention. Youth Mental Health First Aid is a course designed to teach parents, family members, care givers, health and human services workers, and others how to help adolescents experiencing a mental health challenge, an addiction challenge, or who are in crisis.⁷⁻¹¹ Coursework includes a five-step action plan on how to aid youths in crisis and non-crisis situations. Topics covered include anxiety, depression, and SU.

Alaska's Adolescent Health Program established the reduction of youth substance use and abuse as one of its key initiatives.⁷⁻¹² The program supports adolescent SU prevention efforts through programming and resource development in conjunction with work done through community organizations and DBH. One project which is

⁰⁻⁷ Alaska Division of Behavioral Health. Evidence-Based Practices: Medication Addiction Treatment. Available at: <https://health.alaska.gov/dbh/Pages/Initiatives/EvidenceBasedPractices/MAT.aspx>. Accessed on: Aug 22, 2022.

⁰⁻⁸ Alaska Division of Corporations, Business, and Professional Licensing. Prescription Drug Monitoring Program. Available at: <https://www.commerce.alaska.gov/web/cbpl/ProfessionalLicensing/PrescriptionDrugMonitoringProgram.aspx>. Accessed on: Aug 22, 2022.

⁰⁻⁹ NPC Research. Alaska's Prescription Drug Monitoring Program. Available at: https://www.commerce.alaska.gov/web/Portals/5/pub/PDMPNPCAnalysis_2021.pdf. Accessed on: Aug 22, 2022.

⁰⁻¹⁰ Alaska Division of Public Health. Alaska Project ECHO. Available at: <https://health.alaska.gov/dph/Emergency/Pages/healthcare/telehealth/ECHO.aspx>. Accessed on: Aug 22, 2022.

⁰⁻¹¹ Alaska Division of Public Health. Youth Mental Health First Aid. Available at: <https://health.alaska.gov/dph/wcfh/Pages/adolescent/Mental-Health-First-Aid.aspx>. Accessed on: Aug 22, 2022.

⁰⁻¹² Alaska Division of Public Health. Reduce Youth Substance Use & Abuse. Available at: <https://health.alaska.gov/dph/wcfh/Pages/adolescent/substances.aspx#:~:text=The%20Alaska%20Adolescent%20Health%20Program%20supports%20adolescent%20substance,Division%20of%20Behavioral%20Health%20and%20various%20community%20organizations>. Accessed on: Aug 22, 2022.

run through the Adolescent Health Program is the Fourth R program. The Fourth R program was adapted for use in Alaska following its development in Canada.⁷⁻¹³ The Fourth R is a comprehensive school-based program designed to reduce SU, violence, and other risk behaviors through teaching relationship-building and decision-making skills. The program consists of 21 lessons taught by trained teachers in health and physical education classes for students in seventh through ninth grades. By 2017, over 100 schools across 28 districts received the Fourth R curricula, and 400 staff and partners had been trained. The Health Relationships Plus program teaches these subject areas in a non-classroom setting.⁷⁻¹⁴ Healthy Relationships Plus provides instruction to small groups of youth focusing on topics including choice, emotional health and well-being, and communication styles. Healthy Relationships Plus includes an enhanced focus on mental health and suicide prevention, as well as drug and alcohol use.

Workforce Initiatives

DOH, DBH, and other mental health entities created initiatives aimed at addressing health workforce issues created by the general workforce shortage in Alaska. The Alaska Health Workforce Coalition was created in 2010 to address these concerns and has since collaborated with the Alaska Mental Health Trust (the Trust). The goal of this joint effort was to support a statewide system that would help develop a well-qualified healthcare workforce able to meet the needs of the population of Alaska.⁷⁻¹⁵ Specific initiatives included recruiting, developing strategies for programming, creating training programs, and training various BH professions.⁷⁻¹⁶

UAA created the Alaska Training Cooperative to provide non-academic trainings, professional development, and continuing education programs for direct service professionals and BH providers who serve Trust beneficiaries.⁷⁻¹⁷ The goal of the program was to provide more quality training opportunities and generate an enhanced ability by the Alaska workforce to provide culturally attuned services for the Alaska general and Native population.

Alaska's Service to Health Care Practitioners (SHARP) program is a statewide support-for-service effort providing financial support to healthcare providers working in medical, dental, or BH care.⁷⁻¹⁸ SHARP's aim is to improve the recruitment, retention, and distribution of healthcare professionals working in Alaska. Two types of financial support are provided: education loan repayment and direct incentive. SHARP-1, Alaska's main state-operated support-for-service program, is dependent on Alaska's receipt of Health Resources and Services Administration (HRSA) partnership grants from the federal State Loan Repayment Program (SLRP). SHARP-1 only provides education loan repayment to providers specifically practicing in federally designated Health Professional Shortage Areas (HPSAs). In 2021, DOH opened SHARP-3. SHARP-3, named in statute as the Health Care Professionals Workforce Enhancement Program, does not have a sunset date, does not require providers to practice in HPSAs, offers direct incentive in addition to education loan repayment, and broadens the eligible practitioner occupations.

⁰⁻¹³ Alaska Division of Public Health. Fourth R for Healthy Relationships. Available at: <https://health.alaska.gov/dph/wcfh/Pages/adolescent/Fourth-R.aspx>. Accessed on: Aug 22, 2022.

⁰⁻¹⁴ Alaska Division of Public Health. Healthy Relationships Plus. Available at: <https://health.alaska.gov/dph/wcfh/Pages/adolescent/Healthy-Relationships-Plus.aspx>. Accessed on: Aug 22, 2022.

⁰⁻¹⁵ Rural Health Information Hub. Alaska Health Workforce Coalition. Available at: <https://www.ruralhealthinfo.org/project-examples/723>. Accessed on: Aug 30, 2022.

⁰⁻¹⁶ Alaska Health Workforce Coalition. 2017-2021 Action Agenda. Available at: [https://www.alaska.edu/research/wd/plans/health/AHWC-2017-2021-Action-Agenda-September-2017-Final-With-Cover-\(2\).pdf](https://www.alaska.edu/research/wd/plans/health/AHWC-2017-2021-Action-Agenda-September-2017-Final-With-Cover-(2).pdf). Accessed on: Aug 30, 2022.

⁰⁻¹⁷ University of Alaska Anchorage. The Alaska Training Cooperative. Available at: <https://www.uaa.alaska.edu/academics/college-of-health/departments/center-for-human-development/alaska-training-cooperative/index.cshtml>. Accessed on: September 21, 2022.

⁰⁻¹⁸ Alaska Division of Public Health. Alaska's SHARP Program. Available at: <https://health.alaska.gov/dph/Emergency/Pages/healthcare/sharp/default.aspx>. Accessed on: Aug 22, 2022.

Area Health Education Centers (AHECs) are federally funded, state-administered offices that work to improve healthcare services across the United States. The Alaska Center for Rural Health and Health Workforce operates six regional AHECs spread across the State.⁷⁻¹⁹ The Alaska AHEC seeks to provide rural areas of the State with qualified health professionals through broadening the training health profession students receive. Specific initiatives include supporting community-based clinic rotations and retaining Alaska's health workforce by providing and increasing access to continuing education opportunities statewide.

DBH-Sponsored Grants

DBH operates several programs, grants, and initiatives outside of the SUD-BH Program to supplement care for Alaska Medicaid members and individuals without insurance. DBH's Behavioral Health Quality Assurance Section provides funding for various BH and SUD programs across its different components. One component is the Community Behavioral Health Grants component. The Community Behavioral Health Grants component provides funding through grants or contracts to local nonprofit or local government agencies to provide an array of OP and residential community mental health services.⁷⁻²⁰ These services include emergency OP and residential crisis/respite services; OP, residential treatment and rehabilitation services for adults with serious mental illness (SMI) and youths with serious emotional disturbance (SED); and OP treatment services for adults and youth with emotional disturbances. The Services to Severely Emotionally Disturbed Youth component provides funding for services to children and youth who suffer from severe emotional disturbances.⁷⁻²¹ Similarly, the Services to Seriously Mentally Ill component provides funding for services for adults with severe and persistent mental illnesses.⁷⁻²² The Services to Seriously Mentally Ill component funds services within Alaska's community support program including case management, peer support services, crisis intervention, and residential services.

DBH operates the Mainstream Voucher program. This program, a partnership between DOH and the Alaska Housing Finance Corporation (AHFC), provides access to rental subsidies in coordination with existing DOH-funded community support services.⁷⁻²³ The goal is to provide support services for individuals with disabilities transitioning from homelessness or institutional settings.

DOH awarded a wide array of grants for BH services throughout the evaluation period.⁷⁻²⁴ Grants each fiscal year (FY) focused on various BH topics including early intervention, medication assisted treatment (MAT), peer support, residential care, and SUD. Grantees were located across Alaska's service areas and DOH regions. In 2019, DOH sponsored 25 BH grants, followed by 27 in 2020. Table 7-1 presents the 22 FY 2021 operating grants for BH sponsored by DOH. While Table 7-1 only presents grants for 2021, similar grants were sponsored in 2019 and 2020.

-
- ⁰⁻¹⁹ Alaska Commission on Postsecondary Education. Alaska Center for Rural Health and Health Workforce. Available at: <https://acpe.alaska.gov/PLANNING/Training-Details/ArticleID/69/Alaska-Center-for-Rural-Health-and-Health-Workforce-Alaska-AHEC>. Accessed on: Aug 31, 2022.
- ⁰⁻²⁰ Alaska Division of Behavioral Health. Community Behavioral Health Grants Component. Available at: <https://health.alaska.gov/dbh/Pages/TreatmentRecovery/MentalHealth/grants.aspx>. Accessed on: Aug 22, 2022.
- ⁰⁻²¹ Alaska Division of Behavioral Health. Services to Severely Emotionally Disturbed Youth. Available at: <https://health.alaska.gov/dbh/Pages/TreatmentRecovery/MentalHealth/severe.aspx>. Accessed on: Aug 22, 2022.
- ⁰⁻²² Alaska Division of Behavioral Health. Services to Seriously Mentally Ill. Available at: <https://health.alaska.gov/dbh/Pages/TreatmentRecovery/MentalHealth/mill.aspx>. Accessed on: Aug 22, 2022.
- ⁰⁻²³ Alaska Division of Behavioral Health. Mainstream Voucher Program. Available at: <https://health.alaska.gov/dbh/Pages/Initiatives/IntegratedHousing/Mainstream-Voucher-Program.aspx>. Accessed on: Aug 22, 2022.
- ⁰⁻²⁴ Alaska Department of Health and Social Services. Annual DHSS Operating Grants Reports. Available at: <https://dhss.alaska.gov/dfcs/fms/grants/Pages/grant-reports.aspx>. Accessed on: Sept 21, 2022.

Table 7-1—FY 2021 Behavioral Health Operating Grants

Grants	
Alcohol Safety Action Program	Recidivism Reduction
Adult Rural Peer Support	Residential Care for Children and Youth
Bethel Community Service Patrol and Sobering Center	Residential Care for Children and Youth Training
Bring the Kids Home	Rural Human Service System
Comprehensive Behavioral Health Treatment and Recovery	Sobering Center, Withdrawal Management, and Residential SUD Treatment Services
Emergency Grants to Address Mental Health and Substance Use Disorders During COVID-19	State Opioid Response: Peer Support Services
First Episode Psychosis	State Opioid Response: Recovery Housing
Independent Case Management and Flexible Supports	State Opioid Response: Supported Employment
Permanent Supportive Housing- ACT	Strategic Prevention Framework Partnerships for Success
Permanent Supportive Housing- PATH	Supported Employment
Pregnant and Parenting Women SUD Services	Therapeutic Court

Note: ACT: Assertive Community Treatment; COVID-19: coronavirus disease 2019; PATH: Projects for Assistance in Transition from Homelessness; SUD: substance use disorder

Cyberattack

On May 5, 2021, DOH received notice of a cyberattack that breached the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Alaska Personal Information Protection Act (APIPA). The attackers may have received information, including protected health information (PHI) on an unknown number of people. A total of 19 DOH systems were taken offline, including the electronic health record (EHR) Alaska’s Automated Information Management System (AKAIMS), the background check system, vital records, and the State’s grants and contracts online system, the Grants Electronic Management System (GEMS).⁷⁻²⁵

AKAIMS remained offline through November 2021, when it was announced on November 5 that the system was in its final phase of testing and became publicly available for organizations with an approved Static IP Address.⁷⁻²⁶ During the offline period, the State provided guidance to providers for temporary processes.⁷⁻²⁷ Guidance included instruction to providers to continue documenting encounter notes, progress notes, and treatment plans via paper forms to be uploaded to AKAIMS upon its return. Providers were given the option to wait for the return of AKAIMS to submit their billing, or they could manually enter their billing into Optum via Provider Express. Providers who manually entered billing into Optum were required to reconcile all billing with AKAIMS when it becomes available.

GEMS remained offline for eight months, during which Alaska was forced to implement manual processes to process grants and contracts. This increased the State’s and providers’ workload and created unique challenges. One such challenge was the loss of GEMS’ automatic system of checks and balances to confirm if tallies and

⁰⁻²⁵ Alaska Department of Health and Social Services. 2021 Cyberattack: Frequently Asked Questions. Available at: https://dhss.alaska.gov/health/News/Documents/press/2021/DHSS_FAQs_FMS_Cyberattack_20210916.pdf. Accessed on: Aug 30, 2022.

⁰⁻²⁶ Alaska Department of Health. AKAIMS Status Update. Available at: <https://content.govdelivery.com/accounts/AKDHSS/bulletins/2fafad0>. Accessed on: Sept 13, 2022.

⁰⁻²⁷ Alaska Department of Health. AKAIMS Agencies. Available at: <https://content.govdelivery.com/accounts/AKDHSS/bulletins/2dacccc>. Accessed on: Sept 13, 2022.

alignments were appropriate. While using manual processes, providers could make errors, submit out-of-compliance documentation, or allow submissions by non-authorized persons that would need to be corrected manually in a lengthy process. These issues caused by the cyber-attack contributed to the delay in the state-level implementation of grant funds received from the federal government.

Block Grants

The Substance Use and Mental Health Services Administration (SAMSHA) awards Alaska annual block grants distributed between the Community Mental Health Services Block Grant (MHBG) and the Substance Abuse Prevention & Treatment Block Grant (SABG). The MHBG funding is to address the needs of adults with SMI and children with serious emotional disturbances⁷⁻²⁸. The SABG funding is to provide primary prevention and non-primary prevention and treatment services to pregnant women, women with dependent children, and intravenous drug users.⁷⁻²⁹

Alaska sought additional grant funding from the federal government to bolster its response to the negative impact resulting from the COVID-19 PHE on Alaskans' mental health, BH, and substance abuse. As a result SAMSHA awarded the COVID-19 Appropriations Act Supplemental Awards (Supplemental Awards) and the American Rescue Plan Act (ARPA) funds to be added to the MHBG and SABG.

COVID-19 Initiatives

DBH recognized the strain placed on the healthcare system, emergency response system, and providers by COVID-19 in Alaska.⁷⁻³⁰ As a result, the Alaska Responder's Relief Line was developed for those at risk of exposure to COVID-19 as a result of their job in a medical setting. This is a confidential hotline available to Alaskans 24 hours a day, and seven days a week. The goal of the Responder's Relief Line is to provide support for the mental, emotional, and physical health of these workers.

As part of the State's response to the ongoing COVID-19 PHE, approximately \$87.9 million in federal funding was awarded to grantees under eight different programs spread across three divisions, including DBH, in FY 2021. Four programs within DBH received COVID-19 funding: the Emergency Grants to Address Mental Health and Substance Use Disorders During COVID-19; the Comprehensive Behavioral Health Prevention and Early Intervention grant; the Sobering Center, Withdrawal Management, and Residential SUD Treatment grant, and the Comprehensive Behavioral Health Treatment and Recovery grant. Grant money for all four programs was distributed with the goal of providing enhanced SUD or BH care throughout the COVID-19 PHE. Specifically, funding was targeted to address the needs of those with SMI, SUD, or co-occurring SMI and SUD.⁷⁻³¹

On April 12, 2021, Alaska submitted a request to SAMSHA to obtain supplemental funds to address the negative impact on mental health, BH, and substance abuse experienced by Alaskans as a result of the COVID-19 PHE. Alaska proposed to utilize these funds to provide services for both mental health and substance abuse as well as co-occurring SMI/SUD disorders for both children and adults. The State planned to provide service hubs in larger

⁷⁻²⁸ Substance Abuse and Mental Health Services Administration. Community Mental Health Services Block Grant. Available at: <https://www.samhsa.gov/grants/block-grants/mhbg>. Accessed on: Dec 2, 2022

⁷⁻²⁹ Substance Abuse and Mental Health Services Administration. Substance Abuse Prevention and Treatment Block Grant. Available at: <https://www.samhsa.gov/grants/block-grants/sabg>. Accessed on: Dec 2, 2022.

⁰⁻³⁰ Alaska Division of Behavioral Health. AK Responder's Relief Line. Available at: <https://health.alaska.gov/dbh/Pages/Initiatives/AK-Responders-Relief-Line.aspx>. Accessed on: Aug 22, 2022.

⁰⁻³¹ Alaska Department of Health and Social Services. Fiscal Year 2021 Operating Grants. Available at: <https://dhss.alaska.gov/dfcs/fms/grants/Documents/Grant-Book/FY21-Grant-Book.pdf>. Accessed on: Aug 23, 2022.

communities and deliver care to clients throughout the State, often utilizing telehealth. Projects that Alaska planned to implement using MHBG supplemental funds are presented in Table 7-2. The period to use MHBG supplemental funds is March 2021 through March 2024.

Table 7-2—MHBG COVID-19 Supplemental Funds Proposed Projects

Project	Description
Technology/Software for delivery of Crisis Services	Provides funding to advance the technology capabilities needed to support shared GPS-enabled communication to support dispatch and location tracking of mobile crisis teams, real-time bed registries, and OP appointment setting through the Crisis Call Center.
TA for the Crisis Call Center	Provides TA to guide the planning and implementation required to expand call center capacity and services.
TA for business planning for Crisis Services	Provides TA for organizations and providers delivering crisis services.
Youth Mental Health First Aid for Crisis Call Center Staff and Child Protection Workers	Trains crisis call center staff in child and adolescent development and BH from Youth Mental Health First Aid.
Living Works ASIST for law enforcement, crisis services staff, and military	Utilizes a T4T model to expand Alaska’s ASIST instructor base to promote opportunities for ASIST training statewide.
Training for BH providers on providing evidence-based treatment for individuals with suicidal ideation and behaviors	Provides CAMS training to BH providers on targeting and treating suicidal ideation and behaviors specifically and in a manner considered culturally appropriate by tribal leadership.
Youth and Young Adult Suicide Prevention Media Campaign	Increases digital outreach that affects young people, provides public health messages of hope and education and links to resources that can support youth and young adult mental health.
Zero Suicide Implementation	Provides TA and training for organizations and providers regarding suicide risk screening and assessment, risk stratification, safety planning, evidence-based clinical interventions and treatment, follow-up, and automating the suicide care pathway within an EHR.
Improving the Child and Adolescent Crisis System	Supports crisis prevention through the development of Mental Health and Social Emotional Learning Lessons for youth.
TA/Training for Crisis Stabilization Services	Provides TA and Training on the development of Crisis Stabilization programs.
Mobile Outreach Grants	Offers smaller communities additional support to develop their mobile outreach programs.
First Episode Psychosis services (10 percent set-aside)	Provides TA to train providers in Fairbanks, Anchorage, and Juneau on the First Episode Psychosis model.
Rural/Remote Emergency Program	Provides financial support to underserved rural and remote children and youth to strengthen access to care.
Safety Net Grants	Provides individuals without insurance access to the same array of services as those with Medicaid or private insurance.

Note: ASIST: Applied Suicide Intervention Skills Training; BH: behavioral health; CAMS: Collaborative Assessment and Management of Suicidality; DBH: Division of Behavioral Health; EHR: electronic health record; GPS: global positioning system; OP: outpatient; T4T: Trainers for Trainers; TA: technical assistance

On April 12, 2021, Alaska also requested funding from SAMHSA for COVID-19 supplemental funds to be used by the SABG. Alaska’s request proposed utilizing SABG funding to provide services for both substance abuse as well as co-occurring SMI/SUD disorders for both children and adults through an array of projects presented in

Table 7-3. The period for the SABG COVID-19 supplemental funds is March 2021 through March 2024.

Table 7-3—SABG COVID-19 Supplemental Awards Proposed Projects

Project	Description
PSS Training	Develops additional professional training to meet the needs of PSS.
Improving the Child and Adolescent Crisis System	Develops Mental Health and Social Emotional Learning Lessons for youth.
TA/Training for Planning and Implementation of Crisis Stabilization Services	Provides TA and Training on the development of Crisis Stabilization programs.
Mobile Outreach Grants	Offers smaller communities additional support to develop their mobile outreach programs.
ACT	Funds the start-up costs necessary for implementing an ACT team.
Sobering Centers	Provides sobering centers additional time to build capacity for long-term financial stability. This includes developing partnerships and expansion that creates opportunities to bill under the 1115 waiver to foster long-term sustainability.
Quarantine Funding for Residential Programs	Serves clients in need of quarantine prior to admitting into a residential SUD program, or needing to leave a program as a result of COVID-19. The program serves potential clients coming from another community presenting for admission.
SBIRT for Behavioral Health Providers	Provides SBIRT training with MATs to support engagement while clients are waiting for treatment.
SBIRT Training for SENI/Perinatal SUD Screening Initiative (collaborate with DPH)	Trains staff in the use of BI and SBIRT.
Prevention of Underage Drinking	Awards 16 CBHPEI grantees to prevent underage drinking.
YRBS & BRFSS	Provides funding to pose Alaska-specific or related questions that are not included in the standard core survey, adding additional value and utility. The Alaska versions of the national surveys continue to be produced and released in formats helpful to DBH, other divisions, stakeholders, and the general public.
TA for Prevention Team and Coalition Grantees	Provides TA to support prevention staff in working with community coalitions to produce programming and environmental interventions that mirror the data-driven needs of the communities while also attending to outcomes.
Substance Misuse Prevention for Seniors and Elders	Promotes substance misuse prevention and harm reduction activities in support of older Alaskans.
Substance Abuse Prevention Skills Certification	Provides funding to participants attending the Substance Abuse Prevention Skills Training course including training cooperative collaboration and cost of travel for in-person training.
Advanced Community Coalition Strategic Planning and Evaluation Capacity and Building a Data Workgroup	Increases local data collection capacity and needs assessment. This requires training, community planning, and assessment support.
Safety Net Grants	Provides individuals without insurance access to the same array of services as those with Medicaid or private insurance.

Note: ACT: assertive community treatment; BI: brief intervention; BRFSS: Alaska Behavioral Risk Factor Surveillance System; CBHPEI: Comprehensive Behavioral Health Prevention and Early Intervention; DBH: Division of Behavioral Health; DPH: Division of Public Health; MAT: Medication Assisted Therapy; SBIRT: Screening, Brief Intervention, and Referral to Treatment; SENI: substance-exposed newborns initiative; SUD: substance use disorder; TA: technical assistance; YRBS: Youth Risk Behavior Survey.

On July 16, 2021, Alaska submitted a request to SAMSHA to obtain supplemental funding available as a part of the American Rescue Plan Act (ARPA) to be added to the MHBG. Projects that Alaska planned to implement using MHBG ARPA supplemental funds are presented in Table 7-4. The period for the MHBG ARPA funds is September 2021 through September 2025.⁷⁻³²

Table 7-4—ARPA MHBG Proposed Projects

Project	Description
Outreach and Linkage for Homeless Population Grants	Creates positions within DBH to outreach to homeless individuals between the ages of 16 and 24 to connect them to BH resources.
Health Program Manager II, Long Term Non-Perm	Creates position within DBH responsible integrating primary care and behavioral health.
Homeless Service Coordinators for SMI populations	Creates positions committed to working with the homeless SMI population with the goal of obtaining permanent supportive housing.
Project Assistant for SMI/MHBG projects	Creates position with project coordination, document management, and office duties to support DBH’s SMI/MHBG projects.
FEP/ESMI- Early Intervention for Serious Mental Illness	Promotes outreach to SMI individuals who may not be ready to engage in services, school, and employment support.
Crisis Stabilization and Crisis Residential Programs	Aids with the development of Crisis Stabilization programs including 23-hour Crisis Stabilization and Short-term Crisis Residential.
Mobile Outreach Grants	Offers smaller communities additional support to develop their mobile outreach programs.
Peer Specialist Training	Trains Peer Specialists based with DBH guidelines and provides focused crisis intervention training.
Safety Net Grants	Provides individuals without insurance access to the same array of services as those with Medicaid or private insurance.
Training for BH providers	Trains BH providers on providing evidence-based treatment for individuals with suicidal ideation and behaviors.
Youth and Young Adult Suicide Prevention Media Campaign	Provides digital outreach for youth and young adult suicide prevention.
Zero Suicide Implementation	Provides TA and training for organizations and providers regarding suicide risk screening and assessment, risk stratification, safety planning, evidence-based clinical interventions and treatment, follow-up, and automating the suicide care pathway within an EHR.
Rural BH Counseling in Schools	Provides resources for rural schools to employ and support counselors.
Crisis Call Center Staffing	Provides staffing required to expand call center capacity and services.

Note: BH: Behavioral Health; DBH: Division of Behavioral Health; EHR: Electronic Health Record; ESMI: Early Serious Mental Illness; FEP: Federal; Employee Program; MHBG: Community Mental Health Services Block Grant; SMI: Serious Mental Illness; TA: Technical Assistance

On July 16, 2021, Alaska submitted a request to SAMSHA to obtain supplemental funding available as a part of the ARPA to be added to the SABG. Projects that Alaska planned to implement using SABG ARPA supplemental funds are presented in Table 7-5. The period to utilize the SABH ARPS funds is September 2021 through September 2025.

⁷⁻³² Substance Abuse and Mental Health Services Administration. FFY 2-22-2023 Block Grant Application. Available at: <https://www.samhsa.gov/sites/default/files/grants/fy22-23-block-grant-application.pdf>. Accessed on: Dec 2, 2022.

Table 7-5—ARPA SABG Proposed Projects

Project	Description
Outreach and Linkage for Homeless Population Grants	Creates positions committed to working with the homeless population with the goal of connecting them to SUD resources.
Residential/Inpatient WM	Provides more residential WM programs and/or an expansion of the number of beds in the existing programs.
Alaska Housing Finance Corporation Vouchers	Provides vulnerable population of homeless mentally ill adults and assist them in making the transition to permanent affordable housing.
SABG Crisis Stabilization and Crisis Residential Programs	Aids with the development of Crisis Stabilization programs including 23-hour Crisis Stabilization and Short-term Crisis Residential.
SABG Mobile Outreach Grants	Offers smaller communities additional support to develop their mobile outreach programs.
Peer Specialist Training	Trains Peer Specialists based with DBH guidelines and provides focused crisis intervention training
ARPA SABG Safety New Grants	Provides individuals without insurance access to the same array of services as those with Medicaid or private insurance.
Narcan Incentive Grants for Business	Trains individuals to administer Narcan and increases the number of people who have access to Narcan.
AKAIMS	Supports the drug test, courts case management, encounter notes restricted access, and confidential client enable access systems.
Academic Detailing	Trains healthcare providers to utilize best prescribing practices and reduce opioid use.
Medication Disposal Bag Distribution	Improves prescribing practices and reduce opioid misuse through medication disposal bag distribution and promotion.
Primary Prevention Projects	Supports primary prevention including the following: accommodations for the deaf and hard of hearing, youth peer screening/SBIRT, rural school substance abuse prevention program coordinator, and preventing underage drinking/substance abuse through promoting Alaska 360.

Note: AKAIMS: AKAIMS: Alaska’s Automated Information Management System; ARPA: American Rescue Plan Act; DBH: The Alaska Division of Behavioral Health; SABG: Substance Abuse Prevention & Treatment Block Grant; SBIRT: Screening, brief intervention, referral to treatment; SUD: Substance Use Disorder; WM: Withdrawal Management

Alaska submitted a request in April 2020 for an emergency grant to address mental health and substance use disorders during the COVID-19 PHE and submitted a supplemental request in December 2020 to receive additional funds through the grant. Awards were used to support those with SUD, those with co-occurring SMI and SUDs, healthcare practitioners requiring mental health care as a result of the COVID-19 PHE, and those with mental disorders less severe than an SMI. The period to use the original emergency COVID-19 grant awards was from April 20, 2020, to August 19, 2022, while the time period to spend the supplemental emergency COVID-19 grant awards runs from February 1, 2021, through May 31, 2023.

8. Lessons Learned and Recommendations

Previous sections in this Interim Evaluation Report provide background on the Substance Use Disorder and Behavioral Health (SUD-BH) Medicaid 1115 Demonstration Waiver; a description of the evaluation research questions, hypotheses, measures, data sources and methodology; results; conclusions; and interpretation. This section of the Interim Evaluation Report presents lessons learned from the evaluation and recommendations for future improvements.

Provider Billing Procedures

ISSUE Providers noted some frustration regarding the changes made to and differences between State plan codes and waiver codes.

RECOMMENDATION The State should assess the State plan codes that were replaced or duplicated by waiver codes to ensure there is not a disincentive for billing waiver codes. For example, one provider noted that the waiver code for peer support services had fewer hours associated with it than the State plan code, which provides a disincentive to bill the waiver code.

Expanding Services

ISSUE Several providers expressed difficulties in obtaining clearance through a background check for peers to provide peer support services.

RECOMMENDATION The State should continue working with the Division of Health Care Services to streamline or expedite the approval process, or provide financial incentives for peers so they are encouraged to remain in the program while their paperwork is being approved.

ISSUE From the evaluation, gaps were found in the number of providers billing for SUD services, particularly in rural/frontier regions.

RECOMMENDATION The State should ensure that the certification process for becoming a Qualified Addiction Professional (QAP) who provides SUD services is simplified to the extent appropriate and that providers are educated on the process to encourage providers to expand the types of services offered.



State of Alaska Department of Health, Division of
Behavioral Health

Alaska Substance Use Disorder and Behavioral Health Program Section 1115 Waiver Evaluation

Interim Evaluation Report, Appendices

December 2022



Table of Contents

A. Appendix A. Supplemental Results and Methodologies	A-1
Supplemental Results	A-1
Screening Codes	A-29
B. Appendix B. Evaluation Design.....	B-1
C. Appendix C. Additional Qualitative Results	C-1
Key Informants.....	C-1
Major Themes	C-2
Successes	C-3
Concerns.....	C-8
Budget Neutrality/Sustainability	C-14
COVID-19.....	C-16
D. Appendix D. Measure Definitions and Specifications	D-1
E. Appendix E. Survey Instruments.....	E-1
Adult Beneficiary Survey Questionnaire.....	E-1
Child Beneficiary Survey Questionnaire.....	E-11

Appendix A. Supplemental Results and Methodologies

Appendix A contains additional results and methodologies used for the Substance Use Disorder and Behavioral Health (SUD-BH) Program Demonstration Waiver evaluation.

Supplemental Results

Table A-1 through Table A-18 contain additional interrupted time series (ITS) results for measures calculated monthly (Measure 14, 15, 16, 21, and 22)

Table A-1—Inpatient (IP) Admissions for SUD (Measure 14)

Variable	Estimate	p-value
Intercept	-4.084 (0.031)	<0.001***
Baseline monthly trend	0.000 (0.005)	0.959
Level Change	-0.047 (0.040)	0.235
Change in monthly trend	0.001 (0.005)	0.856
COVID-19 Lockdown (Q2 2020)	-0.048 (0.036)	0.186
COVID-19 Reopening (Q3 2020 - Q1 2021)	0.004 (0.022)	0.863
Seasonality: Q2	0.075 (0.025)	0.002**
Seasonality: Q3	0.063 (0.024)	0.008**
Seasonality: Q4	0.022 (0.026)	0.404

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$
Standard errors in parentheses.

Table A-2—IP Admissions for Opioid Use Disorder (OUD) (Measure 14)

Variable	Estimate	p-value
Intercept	-5.712 (0.070)	<0.001***
Baseline monthly trend	0.002 (0.012)	0.850
Level Change	0.010 (0.090)	0.909

Variable	Estimate	p-value
Change in monthly trend	-0.002 (0.012)	0.893
COVID-19 Lockdown (Q2 2020)	-0.081 (0.080)	0.315
COVID-19 Reopening (Q3 2020 - Q1 2021)	-0.088 (0.051)	0.081*
Seasonality: Q2	0.019 (0.054)	0.720
Seasonality: Q3	-0.022 (0.053)	0.676
Seasonality: Q4	-0.092 (0.059)	0.118

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$
Standard errors in parentheses.

Table A-3—IP Admissions for a Behavioral Health (BH) Disorder (Measure 15)

Variable	Estimate	p-value
Intercept	-4.443 (0.037)	<0.001***
Baseline monthly trend	0.004 (0.006)	0.516
Level Change	-0.066 (0.049)	0.175
Change in monthly trend	-0.006 (0.006)	0.330
COVID-19 Lockdown (Q2 2020)	-0.111 (0.045)	0.015**
COVID-19 Reopening (Q3 2020 - Q1 2021)	-0.072 (0.028)	0.011**
Seasonality: Q2	0.019 (0.030)	0.527
Seasonality: Q3	0.005 (0.029)	0.866
Seasonality: Q4	-0.077 (0.033)	0.019**

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$
Standard errors in parentheses.

Table A-4—Emergency Department (ED) Visits for SUD (Measure 16)

Variable	Estimate	p-value
Intercept	-2.529 (0.015)	<0.001***
Baseline monthly trend	-0.006 (0.003)	0.025**
Level Change	0.014 (0.020)	0.488
Change in monthly trend	0.006 (0.003)	0.020**
COVID-19 Lockdown (Q2 2020)	-0.208 (0.018)	<0.001***
COVID-19 Reopening (Q3 2020 - Q1 2021)	0.003 (0.011)	0.770
Seasonality: Q2	0.109 (0.012)	<0.001***
Seasonality: Q3	0.026 (0.012)	0.024**
Seasonality: Q4	0.009 (0.013)	0.501

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$
Standard errors in parentheses.

Table A-5—ED Visits for OUD (Measure 16)

Variable	Estimate	p-value
Intercept	-4.945 (0.047)	<0.001***
Baseline monthly trend	0.019 (0.008)	0.016**
Level Change	-0.086 (0.058)	0.139
Change in monthly trend	-0.016 (0.008)	0.044**
COVID-19 Lockdown (Q2 2020)	-0.319 (0.057)	<0.001***
COVID-19 Reopening (Q3 2020 - Q1 2021)	-0.098 (0.033)	0.003**
Seasonality: Q2	0.015 (0.035)	0.674
Seasonality: Q3	-0.066	0.057*

Variable	Estimate	p-value
	(0.034)	
Seasonality: Q4	-0.101 (0.038)	0.007**

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$
Standard errors in parentheses.

Table A-6—ED Visits for a BH Disorder (Measure 17)

Variable	Estimate	p-value
Intercept	-3.298 (0.021)	<0.001***
Baseline monthly trend	0.008 (0.004)	0.028**
Level Change	0.021 (0.027)	0.433
Change in monthly trend	-0.014 (0.004)	<0.001***
COVID-19 Lockdown (Q2 2020)	-0.143 (0.026)	<0.001***
COVID-19 Reopening (Q3 2020 - Q1 2021)	-0.025 (0.016)	0.115
Seasonality: Q2	0.040 (0.017)	0.018**
Seasonality: Q3	0.009 (0.016)	0.578
Seasonality: Q4	-0.003 (0.018)	0.870

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$
Standard errors in parentheses.

Table A-7—Beneficiaries with a SUD Diagnosis Using Early Intervention Services (Measure 21)

Variable	Estimate	p-value
Intercept	-8.359 (0.232)	<0.001***
Baseline monthly trend	0.148 (0.030)	<0.001***
Level Change	0.521 (0.171)	0.002**
Change in monthly trend	-0.157 (0.030)	<0.001***
COVID-19 Lockdown (Q2 2020)	0.180	0.125

Variable	Estimate	p-value
	(0.118)	
COVID-19 Reopening (Q3 2020 - Q1 2021)	0.130 (0.078)	0.096*
Seasonality: Q2	0.024 (0.093)	0.800
Seasonality: Q3	-0.178 (0.086)	0.039**
Seasonality: Q4	-0.028 (0.088)	0.747

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$
Standard errors in parentheses.

Table A-8—Beneficiaries with a SUD Diagnosis Using Intensive Outpatient/Partial Hospitalization (IO/PH) Services (Measure 21)

Variable	Estimate	p-value
Intercept	-4.770 (0.049)	<0.001***
Baseline monthly trend	-0.032 (0.009)	<0.001***
Level Change	-0.331 (0.070)	<0.001***
Change in monthly trend	0.074 (0.009)	<0.001***
COVID-19 Lockdown (Q2 2020)	-0.457 (0.061)	<0.001***
COVID-19 Reopening (Q3 2020 - Q1 2021)	-0.364 (0.034)	<0.001***
Seasonality: Q2	0.136 (0.039)	<0.001***
Seasonality: Q3	-0.051 (0.039)	0.191
Seasonality: Q4	-0.035 (0.041)	0.389

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$
Standard errors in parentheses.

Table A-9—Beneficiaries with a SUD Diagnosis Using IP Services (Measure 21)

Variable	Estimate	p-value
Intercept	-4.144 (0.036)	<0.001***
Baseline monthly trend	-0.004 (0.006)	0.487
Level Change	-0.098 (0.047)	0.036**
Change in monthly trend	0.017 (0.006)	0.004**
COVID-19 Lockdown (Q2 2020)	-0.150 (0.042)	<0.001***
COVID-19 Reopening (Q3 2020 - Q1 2021)	0.017 (0.024)	0.484
Seasonality: Q2	0.004 (0.028)	0.894
Seasonality: Q3	-0.124 (0.027)	<0.001***
Seasonality: Q4	-0.064 (0.028)	0.024**

*p < 0.1, **p < 0.05, ***p < 0.001
Standard errors in parentheses.

Table A-10—Beneficiaries with a SUD Diagnosis Using Medication Assisted Treatment (MAT) Services (Measure 21)

Variable	Estimate	p-value
Intercept	-2.038 (0.014)	<0.001***
Baseline monthly trend	0.014 (0.002)	<0.001***
Level Change	0.036 (0.016)	0.029**
Change in monthly trend	-0.007 (0.002)	<0.001***
COVID-19 Lockdown (Q2 2020)	-0.040 (0.014)	0.005**
COVID-19 Reopening (Q3 2020 - Q1 2021)	0.027 (0.009)	0.002**
Seasonality: Q2	0.021 (0.010)	0.035**
Seasonality: Q3	-0.018	0.052*

Variable	Estimate	p-value
	(0.009)	
Seasonality: Q4	-0.025 (0.010)	0.015**

*p < 0.1, **p < 0.05, ***p < 0.001
Standard errors in parentheses.

Table A-11—Beneficiaries with a SUD Diagnosis Using Outpatient (OP) Services (Measure 21)

Variable	Estimate	p-value
Intercept	-1.146 (0.010)	<0.001***
Baseline monthly trend	0.008 (0.002)	<0.001***
Level Change	0.074 (0.013)	<0.001***
Change in monthly trend	-0.016 (0.002)	<0.001***
COVID-19 Lockdown (Q2 2020)	-0.116 (0.012)	<0.001***
COVID-19 Reopening (Q3 2020 - Q1 2021)	0.078 (0.007)	<0.001***
Seasonality: Q2	0.015 (0.008)	0.057*
Seasonality: Q3	-0.049 (0.008)	<0.001***
Seasonality: Q4	-0.056 (0.008)	<0.001***

*p < 0.1, **p < 0.05, ***p < 0.001
Standard errors in parentheses.

Table A-12—Beneficiaries with a SUD Diagnosis Using Withdrawal Management (WM) (Measure 21)

Variable	Estimate	p-value
Intercept	-5.104 (0.057)	<0.001***
Baseline monthly trend	0.011 (0.010)	0.233
Level Change	-0.210 (0.072)	0.004**
Change in monthly trend	-0.004 (0.009)	0.698
COVID-19 Lockdown (Q2 2020)	-0.222	0.001**

Variable	Estimate	p-value
	(0.069)	
COVID-19 Reopening (Q3 2020 - Q1 2021)	-0.139 (0.041)	<0.001***
Seasonality: Q2	0.026 (0.044)	0.554
Seasonality: Q3	0.008 (0.043)	0.852
Seasonality: Q4	-0.071 (0.048)	0.135

*p < 0.1, **p < 0.05, ***p < 0.001
Standard errors in parentheses.

Table A-13—Beneficiaries with a BH Disorder Using Any Service (Measure 22)

Variable	Estimate	p-value
Intercept	-1.671 (0.015)	<0.001***
Baseline monthly trend	-0.003 (0.003)	0.226
Level Change	0.027 (0.020)	0.162
Change in monthly trend	0.000 (0.003)	0.945
COVID-19 Lockdown (Q2 2020)	0.087 (0.017)	<0.001***
COVID-19 Reopening (Q3 2020 - Q1 2021)	0.291 (0.010)	<0.001***
Seasonality: Q2	0.056 (0.012)	<0.001***
Seasonality: Q3	-0.026 (0.011)	0.023**
Seasonality: Q4	-0.023 (0.012)	0.066*

*p < 0.1, **p < 0.05, ***p < 0.001
Standard errors in parentheses.

Table A-14—Beneficiaries with a BH Disorder Using ED Services (Measure 22)

Variable	Estimate	p-value
Intercept	-6.683 (0.177)	<0.001***
Baseline monthly trend	-0.131 (0.037)	<0.001***
Level Change	1.151 (0.296)	<0.001***
Change in monthly trend	0.081 (0.036)	0.025**
COVID-19 Lockdown (Q2 2020)	-1.875 (0.725)	0.010**
COVID-19 Reopening (Q3 2020 - Q1 2021)	-0.773 (0.266)	0.004**
Seasonality: Q2	-0.027 (0.183)	0.881
Seasonality: Q3	0.251 (0.195)	0.198
Seasonality: Q4	0.499 (0.215)	0.020**

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$
Standard errors in parentheses.

Table A-15—Beneficiaries with a BH Diagnosis Using IO/PH Services (Measure 22)

Variable	Estimate	p-value
Intercept	-4.197 (0.047)	<0.001***
Baseline monthly trend	-0.015 (0.009)	0.094*
Level Change	-0.226 (0.069)	0.001**
Change in monthly trend	0.010 (0.009)	0.255
COVID-19 Lockdown (Q2 2020)	-0.703 (0.082)	<0.001***
COVID-19 Reopening (Q3 2020 - Q1 2021)	-0.417 (0.048)	<0.001***
Seasonality: Q2	0.129 (0.042)	0.002**
Seasonality: Q3	0.020	0.657

Variable	Estimate	p-value
	(0.045)	
Seasonality: Q4	-0.031 (0.051)	0.538

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$
Standard errors in parentheses.

Table A-16—Beneficiaries with a BH Diagnosis Using IP Services (Measure 22)

Variable	Estimate	p-value
Intercept	-4.640 (0.057)	<0.001***
Baseline monthly trend	-0.001 (0.010)	0.953
Level Change	-0.042 (0.072)	0.554
Change in monthly trend	-0.003 (0.009)	0.739
COVID-19 Lockdown (Q2 2020)	-0.113 (0.073)	0.122
COVID-19 Reopening (Q3 2020 - Q1 2021)	-0.143 (0.044)	0.001**
Seasonality: Q2	-0.012 (0.047)	0.805
Seasonality: Q3	0.005 (0.046)	0.921
Seasonality: Q4	0.182 (0.049)	<0.001***

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$
Standard errors in parentheses.

Table A-17—Beneficiaries with a BH Diagnosis Using OP Services (Measure 22)

Variable	Estimate	p-value
Intercept	-1.773 (0.016)	<0.001***
Baseline monthly trend	-0.008 (0.003)	0.003**
Level Change	0.236 (0.022)	<0.001***
Change in monthly trend	-0.018 (0.003)	<0.001***
COVID-19 Lockdown (Q2 2020)	-0.669	<0.001***

Variable	Estimate	p-value
	(0.026)	
COVID-19 Reopening (Q3 2020 - Q1 2021)	-0.205 (0.014)	<0.001***
Seasonality: Q2	-0.028 (0.013)	0.040**
Seasonality: Q3	-0.029 (0.014)	0.034**
Seasonality: Q4	-0.004 (0.015)	0.813

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$
Standard errors in parentheses.

Table A-18—Beneficiaries with a BH Diagnosis Using Telehealth (TH) Services (Measure 22)

Variable	Estimate	p-value
Intercept	-6.072 (0.101)	<0.001***
Baseline monthly trend	-0.003 (0.016)	0.837
Level Change	0.131 (0.109)	0.230
Change in monthly trend	0.098 (0.016)	<0.001***
COVID-19 Lockdown (Q2 2020)	1.633 (0.028)	<0.001***
COVID-19 Reopening (Q3 2020 - Q1 2021)	1.684 (0.019)	<0.001***
Seasonality: Q2	0.789 (0.029)	<0.001***
Seasonality: Q3	0.361 (0.021)	<0.001***
Seasonality: Q4	0.124 (0.021)	<0.001***

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$
Standard errors in parentheses.

Table A-19 through Table A-27 display annual rates for each Childhood Understanding Behaviors Survey (CUBS) measure during the baseline and evaluation period.

Table A-19—Maternal Depression—Provider Discussion Indicator (Measure 30)

	Baseline Period							Evaluation Period	
	2012	2013	2014	2015	2016	2017	2018	2019	2020
Percentage of mothers who had a discussion with a HCP about depression or how they were doing emotionally, past 12 months ¹	32.6%	27.5%	41.1%	26.1%	29.6%	33.4%	24.9%	33.9%	27.9%

Note: pp=percentage point

¹ Rates are weighted by survey analysis weight, comprised of sampling, nonresponse, and noncoverage components.

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Table A-20—Maternal Depression—Maternal Depression Indicator (Higher is Better) (Measure 30)

	Baseline Period				Evaluation Period	
	2015	2016	2017	2018	2019	2020
Average score-feeling depressed/hopeless/little interest or little pleasure in doing things usually enjoyed, past 3 months ^{1,2,3}	3.94	4.03	3.84	3.85	3.88	3.90

Note: pp=percentage point

¹ Counts are weighted by survey analysis weight, comprised of sampling, nonresponse, and noncoverage components.

² Average composite score is comprised of taking the average of the following questions:

During the past 3 months, how often have you felt down, depressed, or hopeless? (1-5)

During the past 3 months, how often have you had little interest or little pleasure in doing things you usually enjoyed? (1-5)

³ Scale ranges from 1 (Always) to 5 (Never)

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Table A-21—Maternal Domestic Abuse (Measure 31)

	Baseline Period							Evaluation Period	
	2012	2013	2014	2015	2016	2017	2018	2019	2020
Percentage of mothers answering they were physically hurt or made to feel unsafe by their partner, past 12 months ¹	6.7%	4.0%	7.1%	5.3%	4.0%	4.2%	2.7%	10.4%	2.1%

Note: pp=percentage point

¹ Rates are weighted by survey analysis weight, comprised of sampling, nonresponse, and noncoverage components.

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Table A-22— Percentage of Youth Beneficiaries who Have Experienced Alcoholism or Mental Health Disorder Among Household Members (Measure 32)

	Baseline Period							Evaluation Period	
	2012	2013	2014	2015	2016	2017	2018	2019	2020
Percentage of youth beneficiaries who experienced alcoholism or mental health disorder among household members ¹	6.2%	8.7%	13.4%	6.9%	5.9%	9.0%	7.5%	9.4%	13.3%

Note: pp=percentage point

¹Rates are weighted by survey analysis weight, comprised of sampling, nonresponse, and noncoverage components.

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Table A-23—Percentage of Youth Beneficiaries who Have Witnessed Violence or Physical Abuse Between Household Members (Measure 33)

	Baseline Period				Evaluation Period	
	2015	2016	2017	2018	2019	2020
Percentage of youth beneficiaries who witnessed violence or physical abuse between household members ¹	7.7%	8.2%	5.9%	8.0%	7.6%	8.1%

Note: pp=percentage point

¹Rates are weighted by survey analysis weight, comprised of sampling, nonresponse, and noncoverage components.

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Table A-24—Percentage of Youth Beneficiaries who Have Been Physically Hurt by an Adult in Any Way

	Baseline Period				Evaluation Period	
	2015	2016	2017	2018	2019	2020
Percentage of youth beneficiaries who have ever been physically hurt by an adult in any way ¹	0.0%	1.4%	0.1%	2.0%	1.2%	--

Note: pp=percentage point

¹Rates are weighted by survey analysis weight, comprised of sampling, nonresponse, and noncoverage components.

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Table A-25—Maternal Marijuana or Hash Use in the Past Two Years (Measure 35)

	Baseline Period				Evaluation Period	
	2015	2016	2017	2018	2019	2020
Percentage of respondents who have used marijuana in the past two years ¹	16.8%	16.5%	15.9%	18.0%	18.2%	--

¹Rates are weighted by survey analysis weight, comprised of sampling, nonresponse, and noncoverage components.

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Table A-26—Frequency of Maternal Marijuana or Hash Use (Days per Week) (Measure 36)

	Baseline Period				Evaluation Period	
	2015	2016	2017	2018	2019	2020
Average number of days respondents report using marijuana or hash per week ¹	1.86	1.27	1.09	1.73	1.45	0.44

¹Counts are weighted by survey analysis weight, comprised of sampling, nonresponse, and noncoverage components.

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Table A-27—Social Support—Care When Sick (Supplemental CUBS Measure 1)

	Baseline Period							Evaluation Period	
	2012	2013	2014	2015	2016	2017	2018	2019	2020
Percentage of respondents who answered they know someone who would help them if they were sick ¹	84.5%	83.7%	84.7%	81.1%	80.6%	81.3%	83.7%	78.9%	77.1%

¹Rates are weighted by survey analysis weight, comprised of sampling, nonresponse, and noncoverage components.

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Table A-28 through Table A-48 contain additional ITS analyses on cost measures (Measures 41 and 42).

Table A-28—Dental Costs Among Beneficiaries with a SUD (Measure 41)

Variable	Estimate	p-value
Intercept	3.814 (0.077)	<0.001***
Baseline monthly trend	0.004 (0.014)	0.754
Level Change	-0.138 (0.113)	0.221
Change in monthly trend	-0.008 (0.014)	0.573
COVID-19 Lockdown (Q2 2020)	-0.708 (0.181)	<0.001***
COVID-19 Reopening (Q3 2020 - Q1 2021)	-0.074 (0.073)	0.315
Seasonality: Q2	0.034 (0.066)	0.611
Seasonality: Q3	-0.045 (0.069)	0.516
Seasonality: Q4	-0.181 (0.082)	0.027**

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$

Standard errors in parentheses.

Table A-29—ED Outpatient Costs Among Beneficiaries with a SUD (Measure 41)

Variable	Estimate	p-value
Intercept	5.056 (0.039)	<0.001***
Baseline monthly trend	0.003 (0.006)	0.598
Level Change	0.060 (0.049)	0.214
Change in monthly trend	-0.010 (0.006)	0.125
COVID-19 Lockdown (Q2 2020)	-0.278 (0.054)	<0.001***
COVID-19 Reopening (Q3 2020 - Q1 2021)	-0.029 (0.030)	0.332
Seasonality: Q2	0.066 (0.030)	0.028**
Seasonality: Q3	0.047 (0.030)	0.120
Seasonality: Q4	0.019 (0.034)	0.571

*p < 0.1, **p < 0.05, ***p < 0.001
Standard errors in parentheses.

Table A-30—IP Costs Among Beneficiaries with a SUD (Measure 41)

Variable	Estimate	p-value
Intercept	6.187 (0.060)	<0.001***
Baseline monthly trend	0.012 (0.010)	0.193
Level Change	-0.007 (0.069)	0.915
Change in monthly trend	-0.014 (0.009)	0.139
COVID-19 Lockdown (Q2 2020)	-0.128 (0.071)	0.073*
COVID-19 Reopening (Q3 2020 - Q1 2021)	0.042 (0.039)	0.284
Seasonality: Q2	0.048 (0.045)	0.293
Seasonality: Q3	0.018	0.687

Variable	Estimate	p-value
	(0.043)	
Seasonality: Q4	0.086 (0.046)	0.063*

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$
Standard errors in parentheses.

Table A-31—Long-Term Care Costs Among Beneficiaries with a SUD (Measure 41)

Variable	Estimate	p-value
Intercept	4.505 (0.036)	<0.001***
Baseline monthly trend	-0.016 (0.006)	0.011**
Level Change	0.170 (0.049)	<0.001***
Change in monthly trend	0.014 (0.006)	0.022**
COVID-19 Lockdown (Q2 2020)	-0.043 (0.042)	0.301
COVID-19 Reopening (Q3 2020 - Q1 2021)	0.071 (0.025)	0.005**
Seasonality: Q2	0.055 (0.028)	0.049**
Seasonality: Q3	-0.061 (0.028)	0.031**
Seasonality: Q4	0.032 (0.029)	0.276

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$
Standard errors in parentheses.

Table A-32—Total Outpatient Costs Among Beneficiaries with a SUD (Measure 41)

Variable	Estimate	p-value
Intercept	5.867 (0.038)	<0.001***
Baseline monthly trend	0.000 (0.006)	0.991
Level Change	0.018 (0.048)	0.707
Change in monthly trend	0.002 (0.006)	0.760
COVID-19 Lockdown (Q2 2020)	-0.324	<0.001***

Variable	Estimate	p-value
	(0.052)	
COVID-19 Reopening (Q3 2020 - Q1 2021)	-0.020 (0.026)	0.447
Seasonality: Q2	0.069 (0.029)	0.016**
Seasonality: Q3	0.026 (0.028)	0.363
Seasonality: Q4	-0.009 (0.031)	0.767

*p < 0.1, **p < 0.05, ***p < 0.001
Standard errors in parentheses.

Table A-33—Pharmacy Costs Among Beneficiaries with a SUD

Variable	Estimate	p-value
Intercept	5.135 (0.030)	<0.001***
Baseline monthly trend	0.005 (0.005)	0.363
Level Change	-0.008 (0.037)	0.840
Change in monthly trend	-0.002 (0.005)	0.755
COVID-19 Lockdown (Q2 2020)	-0.076 (0.034)	0.024**
COVID-19 Reopening (Q3 2020 - Q1 2021)	-0.002 (0.020)	0.909
Seasonality: Q2	0.025 (0.022)	0.264
Seasonality: Q3	-0.021 (0.022)	0.338
Seasonality: Q4	-0.034 (0.024)	0.154

*p < 0.1, **p < 0.05, ***p < 0.001
Standard errors in parentheses.

Table A-34—Professional Costs Among Beneficiaries with a SUD (Measure 41)

Variable	Estimate	p-value
Intercept	6.914 (0.030)	<0.001***
Baseline monthly trend	-0.003 (0.005)	0.619
Level Change	0.043 (0.040)	0.282
Change in monthly trend	0.007 (0.005)	0.182
COVID-19 Lockdown (Q2 2020)	-0.251 (0.038)	<0.001***
COVID-19 Reopening (Q3 2020 - Q1 2021)	-0.046 (0.021)	0.028**
Seasonality: Q2	0.031 (0.022)	0.160
Seasonality: Q3	-0.048 (0.022)	0.031**
Seasonality: Q4	-0.091 (0.025)	<0.001***

*p<0.1, **p<0.05, ***p<0.001
Standard errors in parentheses.

Table A-35—Non-ED Outpatient Costs Among Beneficiaries with a SUD (Measure 41)

Variable	Estimate	p-value
Intercept	5.280 (0.043)	<0.001***
Baseline monthly trend	-0.004 (0.007)	0.594
Level Change	-0.005 (0.056)	0.931
Change in monthly trend	0.012 (0.007)	0.105
COVID-19 Lockdown (Q2 2020)	-0.350 (0.057)	<0.001***
COVID-19 Reopening (Q3 2020 - Q1 2021)	-0.010 (0.027)	0.716
Seasonality: Q2	0.071 (0.032)	0.024**
Seasonality: Q3	0.015	0.623

Variable	Estimate	p-value
	(0.031)	
Seasonality: Q4	-0.027 (0.034)	0.416

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$
Standard errors in parentheses.

Table A-36—Total Costs Among Beneficiaries with a SUD (Measure 41)

Variable	Estimate	p-value
Intercept	7.672 (0.028)	<0.001***
Baseline monthly trend	0.002 (0.005)	0.663
Level Change	0.021 (0.035)	0.553
Change in monthly trend	0.000 (0.005)	0.996
COVID-19 Lockdown (Q2 2020)	-0.215 (0.035)	<0.001***
COVID-19 Reopening (Q3 2020 - Q1 2021)	-0.012 (0.019)	0.512
Seasonality: Q2	0.042 (0.021)	0.046**
Seasonality: Q3	-0.019 (0.020)	0.351
Seasonality: Q4	-0.025 (0.022)	0.253

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$
Standard errors in parentheses.

Table A-37—Non-SUD Costs Among Beneficiaries with a SUD (Measure 41)

Variable	Estimate	p-value
Intercept	7.235 (0.030)	<0.001***
Baseline monthly trend	0.001 (0.005)	0.884
Level Change	-0.005 (0.039)	0.899
Change in monthly trend	0.000 (0.005)	0.942
COVID-19 Lockdown (Q2 2020)	-0.284	<0.001***

Variable	Estimate	p-value
	(0.042)	
COVID-19 Reopening (Q3 2020 - Q1 2021)	-0.043 (0.022)	0.053*
Seasonality: Q2	0.039 (0.024)	0.105
Seasonality: Q3	-0.013 (0.024)	0.584
Seasonality: Q4	-0.022 (0.026)	0.399

*p < 0.1, **p < 0.05, ***p < 0.001
Standard errors in parentheses.

Table A-38—SUD IMD Costs Among Beneficiaries with a SUD (Measure 41)

Variable	Estimate	p-value
Intercept	2.833 (0.267)	<0.001***
Baseline monthly trend	-0.038 (0.044)	0.392
Level Change	0.976 (0.332)	0.003**
Change in monthly trend	0.045 (0.044)	0.303
COVID-19 Lockdown (Q2 2020)	0.504 (0.156)	0.001**
COVID-19 Reopening (Q3 2020 - Q1 2021)	0.000 (0.090)	0.996
Seasonality: Q2	-0.279 (0.143)	0.051*
Seasonality: Q3	-0.169 (0.116)	0.145
Seasonality: Q4	0.142 (0.111)	0.202

*p < 0.1, **p < 0.05, ***p < 0.001
Standard errors in parentheses.

Table A-39—SUD Non-IMD Costs Among Beneficiaries with a SUD (Measure 41)

Variable	Estimate	p-value
Intercept	6.608 (0.031)	<0.001***
Baseline monthly trend	0.006 (0.005)	0.280
Level Change	0.045 (0.038)	0.244
Change in monthly trend	-0.002 (0.005)	0.633
COVID-19 Lockdown (Q2 2020)	-0.140 (0.034)	<0.001***
COVID-19 Reopening (Q3 2020 - Q1 2021)	0.035 (0.019)	0.065*
Seasonality: Q2	0.057 (0.022)	0.010**
Seasonality: Q3	-0.025 (0.021)	0.249
Seasonality: Q4	-0.039 (0.023)	0.096*

*p < 0.1, **p < 0.05, ***p < 0.001
Standard errors in parentheses.

Table A-37—Dental Costs Among Beneficiaries with a BH Diagnosis (Measure 42)

Variable	Estimate	p-value
Intercept	3.963 (0.072)	<0.001***
Baseline monthly trend	0.003 (0.013)	0.796
Level Change	-0.063 (0.102)	0.537
Change in monthly trend	-0.011 (0.013)	0.372
COVID-19 Lockdown (Q2 2020)	-0.796 (0.190)	<0.001***
COVID-19 Reopening (Q3 2020 - Q1 2021)	-0.036 (0.067)	0.590
Seasonality: Q2	0.012 (0.062)	0.848
Seasonality: Q3	0.024	0.701

Variable	Estimate	p-value
	(0.063)	
Seasonality: Q4	-0.126	0.094*
	(0.075)	

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$
Standard errors in parentheses.

Table A-38—ED Outpatient Costs Among Beneficiaries with a BH Diagnosis (Measure 42)

Variable	Estimate	p-value
Intercept	4.443	<0.001***
	(0.036)	
Baseline monthly trend	0.004	0.525
	(0.006)	
Level Change	0.066	0.141
	(0.045)	
Change in monthly trend	-0.008	0.163
	(0.006)	
COVID-19 Lockdown (Q2 2020)	-0.351	<0.001***
	(0.053)	
COVID-19 Reopening (Q3 2020 - Q1 2021)	-0.096	<0.001***
	(0.027)	
Seasonality: Q2	0.038	0.167
	(0.028)	
Seasonality: Q3	0.029	0.285
	(0.028)	
Seasonality: Q4	0.009	0.757
	(0.031)	

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$
Standard errors in parentheses.

Table A-39—Inpatient Costs Among Beneficiaries With a BH Diagnosis (Measure 42)

Variable	Estimate	p-value
Intercept	5.615	<0.001***
	(0.046)	
Baseline monthly trend	0.001	0.884
	(0.008)	
Level Change	-0.010	0.856
	(0.058)	
Change in monthly trend	0.000	0.981
	(0.008)	
COVID-19 Lockdown (Q2 2020)	-0.243	<0.001***

Variable	Estimate	p-value
	(0.062)	
COVID-19 Reopening (Q3 2020 - Q1 2021)	-0.056 (0.033)	0.089*
Seasonality: Q2	0.052 (0.036)	0.150
Seasonality: Q3	0.007 (0.036)	0.837
Seasonality: Q4	0.052 (0.038)	0.175

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$
Standard errors in parentheses.

Table A-40—LTC Costs Among Beneficiaries With a BH Diagnosis (Measure 42)

Variable	Estimate	p-value
Intercept	5.522 (0.017)	<0.001***
Baseline monthly trend	0.001 (0.003)	0.710
Level Change	0.019 (0.021)	0.374
Change in monthly trend	-0.005 (0.003)	0.074*
COVID-19 Lockdown (Q2 2020)	0.009 (0.020)	0.641
COVID-19 Reopening (Q3 2020 - Q1 2021)	0.024 (0.012)	0.055*
Seasonality: Q2	0.018 (0.013)	0.192
Seasonality: Q3	0.012 (0.013)	0.376
Seasonality: Q4	0.028 (0.014)	0.055*

* $p < 0.1$, ** $p < 0.05$, *** $p < 0.001$
Standard errors in parentheses.

Table A-41—Total Outpatient Costs Among Beneficiaries With a BH Diagnosis (Measure 42)

Variable	Estimate	p-value
Intercept	6.246 (0.025)	<0.001***
Baseline monthly trend	0.001 (0.004)	0.849
Level Change	0.010 (0.032)	0.743
Change in monthly trend	-0.002 (0.004)	0.628
COVID-19 Lockdown (Q2 2020)	-0.196 (0.033)	<0.001***
COVID-19 Reopening (Q3 2020 - Q1 2021)	-0.009 (0.018)	0.605
Seasonality: Q2	0.036 (0.020)	0.066*
Seasonality: Q3	0.021 (0.019)	0.276
Seasonality: Q4	0.003 (0.021)	0.902

*p < 0.1, **p < 0.05, ***p < 0.001
Standard errors in parentheses.

Table A-42—Pharmacy Costs Among Beneficiaries With a BH Diagnosis (Measure 42)

Variable	Estimate	p-value
Intercept	5.000 (0.028)	<0.001***
Baseline monthly trend	-0.002 (0.005)	0.748
Level Change	-0.047 (0.037)	0.200
Change in monthly trend	0.010 (0.005)	0.039**
COVID-19 Lockdown (Q2 2020)	-0.045 (0.031)	0.153
COVID-19 Reopening (Q3 2020 - Q1 2021)	-0.007 (0.018)	0.711
Seasonality: Q2	0.027 (0.022)	0.205
Seasonality: Q3	0.001	0.948

Variable	Estimate	p-value
	(0.021)	
Seasonality: Q4	-0.020	0.366
	(0.022)	

*p<0.1, **p<0.05, ***p<0.001
Standard errors in parentheses.

Table A-43—Professional Costs Among Beneficiaries with a BH Diagnosis (Measure 42)

Variable	Estimate	p-value
Intercept	6.747	<0.001***
	(0.028)	
Baseline monthly trend	-0.003	0.492
	(0.005)	
Level Change	0.061	0.104
	(0.038)	
Change in monthly trend	0.001	0.872
	(0.005)	
COVID-19 Lockdown (Q2 2020)	-0.227	<0.001***
	(0.038)	
COVID-19 Reopening (Q3 2020 - Q1 2021)	0.018	0.398
	(0.021)	
Seasonality: Q2	0.030	0.169
	(0.022)	
Seasonality: Q3	-0.039	0.077*
	(0.022)	
Seasonality: Q4	-0.058	0.018**
	(0.025)	

*p< 0.1, **p<0.05, ***p<0.001
Standard errors in parentheses.

Table A-44—Non-ED Outpatient Costs Among Beneficiaries with a BH Diagnosis (Measure 42)

Variable	Estimate	p-value
Intercept	6.066	<0.001***
	(0.024)	
Baseline monthly trend	0.000	0.977
	(0.004)	
Level Change	-0.001	0.985
	(0.031)	
Change in monthly trend	-0.001	0.869
	(0.004)	
COVID-19 Lockdown (Q2 2020)	-0.167	<0.001***

Variable	Estimate	p-value
	(0.032)	
COVID-19 Reopening (Q3 2020 - Q1 2021)	0.007 (0.018)	0.677
Seasonality: Q2	0.036 (0.019)	0.063*
Seasonality: Q3	0.020 (0.019)	0.293
Seasonality: Q4	0.002 (0.021)	0.925

*p < 0.1, **p < 0.05, ***p < 0.001
Standard errors in parentheses.

Table A-45—Total Costs Among Beneficiaries with a BH Diagnosis (Measure 42)

Variable	Estimate	p-value
Intercept	7.646 (0.022)	<0.001***
Baseline monthly trend	-0.001 (0.004)	0.822
Level Change	0.022 (0.028)	0.439
Change in monthly trend	0.000 (0.004)	0.938
COVID-19 Lockdown (Q2 2020)	-0.187 (0.029)	<0.001***
COVID-19 Reopening (Q3 2020 - Q1 2021)	-0.002 (0.016)	0.892
Seasonality: Q2	0.032 (0.017)	0.058*
Seasonality: Q3	-0.008 (0.017)	0.654
Seasonality: Q4	-0.016 (0.019)	0.388

*p < 0.1, **p < 0.05, ***p < 0.001
Standard errors in parentheses.

Table A-46—BH IMD Costs Among Beneficiaries with a BH Diagnosis (Measure 42)

Variable	Estimate	p-value
Intercept	0.973 (0.124)	<0.001***
Baseline monthly trend	-0.077 (0.026)	0.003**
Level Change	0.820 (0.206)	<0.001***
Change in monthly trend	0.041 (0.025)	0.097*
COVID-19 Lockdown (Q2 2020)	0.198 (0.190)	0.298
COVID-19 Reopening (Q3 2020 - Q1 2021)	-0.065 (0.160)	0.682
Seasonality: Q2	0.131 (0.124)	0.291
Seasonality: Q3	0.193 (0.140)	0.167
Seasonality: Q4	0.408 (0.152)	0.007**

*p < 0.1, **p < 0.05, ***p < 0.001
Standard errors in parentheses.

Table A-47—BH Non-IMD Costs Among Beneficiaries with a BH Diagnosis (Measure 42)

Variable	Estimate	p-value
Intercept	6.663 (0.023)	<0.001***
Baseline monthly trend	0.001 (0.004)	0.808
Level Change	0.030 (0.030)	0.312
Change in monthly trend	-0.003 (0.004)	0.496
COVID-19 Lockdown (Q2 2020)	-0.150 (0.029)	<0.001***
COVID-19 Reopening (Q3 2020 - Q1 2021)	0.024 (0.017)	0.155
Seasonality: Q2	0.047 (0.018)	0.008**
Seasonality: Q3	-0.016	0.355

Variable	Estimate	p-value
	(0.018)	
Seasonality: Q4	-0.014	0.463
	(0.019)	

*p < 0.1, **p < 0.05, ***p < 0.001
Standard errors in parentheses.

Table A-48—Non-BH Costs Among Beneficiaries with a BH Diagnosis (Measure 42)

Variable	Estimate	p-value
Intercept	7.176	<0.001***
	(0.023)	
Baseline monthly trend	-0.002	0.642
	(0.004)	
Level Change	0.016	0.601
	(0.030)	
Change in monthly trend	0.001	0.775
	(0.004)	
COVID-19 Lockdown (Q2 2020)	-0.211	<0.001***
	(0.031)	
COVID-19 Reopening (Q3 2020 - Q1 2021)	-0.018	0.289
	(0.017)	
Seasonality: Q2	0.023	0.203
	(0.018)	
Seasonality: Q3	-0.002	0.898
	(0.018)	
Seasonality: Q4	-0.018	0.380
	(0.020)	

*p < 0.1, **p < 0.05, ***p < 0.001
Standard errors in parentheses.

Screening Codes

Table A-49 contains screening codes that were utilized to facilitate calculations on Measure 25, *Screening for Chronic Conditions Relevant to State Medicaid Population*.

Table A-49—Chronic Condition Screening Codes (Measure 25)

Code	Definition
80047	Basic metabolic panel (Calcium, ionized) This panel must include the following: Calcium, ionized (82330) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Potassium (84132) Sodium (84295) Urea Nitrogen (BUN) (84520)
80048	Basic metabolic panel (Calcium, total) This panel must include the following: Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Potassium (84132) Sodium (84295) Urea nitrogen (BUN) (84520)
80050	General health panel This panel must include the following: Comprehensive metabolic panel (80053) Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004) OR Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009) Thyroid stimulating hormone (TSH) (84443)
80053	Comprehensive metabolic panel This panel must include the following: Albumin (82040) Bilirubin, total (82247) Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Phosphatase, alkaline (84075) Potassium (84132) Protein, total (84155) Sodium (84295) Transferase, alanine amino (ALT) (SGPT) (84460) Transferase, aspartate amino (AST) (SGOT) (84450) Urea nitrogen (BUN) (84520)
80061	Lipid panel This panel must include the following: Cholesterol, serum, total (82465) Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718) Triglycerides (84478)
80069	Renal function panel This panel must include the following: Albumin (82040) Calcium, total (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Phosphorus inorganic (phosphate) (84100) Potassium (84132) Sodium (84295) Urea nitrogen (BUN) (84520)
81000	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
81001	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy
81002	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, without microscopy
81003	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy
82040	Albumin (82040)
82042	Albumin; other source, quantitative, each specimen
82043	Albumin; urine (e.g., microalbumin), quantitative
82044	Albumin; urine (e.g., microalbumin), semiquantitative (e.g., reagent strip assay)
82247	Bilirubin, total (82247)
82270	Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided 3 cards or single triple card for consecutive collection)
82274	Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations
82310	Calcium, total (82310)

Code	Definition
82330	Calcium, ionized
82374	Carbon dioxide (bicarbonate) (82374)
82435	Chloride (82435)
82465	Cholesterol, serum or whole blood, total
82565	Creatinine; blood
82570	Creatinine; other source
82947	Glucose (82947)
82950	Glucose; post glucose dose (includes glucose)
82951	Glucose; tolerance test (GTT), 3 specimens (includes glucose)
83036	Hemoglobin; glycosylated (A1C)
83037	Hemoglobin; glycosylated (A1C) by device cleared by FDA for home use
83655	Lead
83700	Lipoprotein, blood; electrophoretic separation and quantitation
83701	Lipoprotein, blood; high resolution fractionation and quantitation of lipoproteins including lipoprotein subclasses when performed (e.g., electrophoresis, ultracentrifugation)
83704	Lipoprotein, blood; quantitation of lipoprotein particle number(s) (e.g., by nuclear magnetic resonance spectroscopy), includes lipoprotein particle subclass(es), when performed
83718	Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)
83721	Lipoprotein, direct measurement; LDL cholesterol
83722	Lipoprotein, direct measurement; small dense LDL cholesterol
84075	Phosphatase, alkaline (84075)
84100	Phosphorus inorganic (phosphate) (84100)
84132	Potassium (84132)
84152	Prostate specific antigen (PSA); complexed (direct measurement)
84153	Prostate specific antigen (PSA); total
84154	Prostate specific antigen (PSA); free
84155	Protein, total (84155)
84156	Protein, total, except by refractometry; urine
84295	Sodium (84295)
84443	Thyroid stimulating hormone (TSH) (84443)
84450	Transferase, aspartate amino (AST) (SGOT) (84450)
84460	Transferase, alanine amino (ALT) (SGPT) (84460)
84478	Triglycerides
84520	Urea Nitrogen (BUN) (84520)
85004	Blood count; automated differential WBC count (85004)
85007	Microscopic examination for white blood cells with manual cell count (85007)
85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC, and platelet count) and automated differential WBC count

Code	Definition
85027	Completed blood count, automated (85027)
87490	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, direct probe technique
87491	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, amplified probe technique
87492	Infectious agent detection by nucleic acid (DNA or RNA); Chlamydia trachomatis, quantification
87624	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), high-risk types (e.g., 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 68)
87625	Infectious agent detection by nucleic acid (DNA or RNA); Human Papillomavirus (HPV), types 16 and 18 only, includes type 45, if performed
88141	Cytopathology, cervical or vaginal (any reporting system), requiring interpretation by physician
88142	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision
88143	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with manual screening and rescreening under physician supervision
88147	Cytopathology smears, cervical or vaginal; screening by automated system under physician supervision
88148	Cytopathology smears, cervical or vaginal; screening by automated system with manual rescreening under physician supervision
88150	Cytopathology, slides, cervical or vaginal; manual screening under physician supervision
88152	Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening under physician supervision
88153	Cytopathology, slides, cervical or vaginal; with manual screening and rescreening under physician supervision
88154	Cytopathology, slides, cervical or vaginal; with manual screening and computer-assisted rescreening using cell selection and review under physician supervision
88164	Cytopathology, slides, cervical or vaginal (the Bethesda System); manual screening under physician supervision
88165	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and rescreening under physician supervision
88166	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening under physician supervision
88167	Cytopathology, slides, cervical or vaginal (the Bethesda System); with manual screening and computer-assisted rescreening using cell selection and review under physician supervision
88174	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision
88175	Cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation; with screening by automated system and manual rescreening or review, under physician supervision
94010	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation
99201	Office or other outpatient visit for the evaluation and management of a new patient
99202	Office or other outpatient visit for the evaluation and management of a new patient
99203	Office or other outpatient visit for the evaluation and management of a new patient
99204	Office or other outpatient visit for the evaluation and management of a new patient
99205	Office or other outpatient visit for the evaluation and management of a new patient

Code	Definition
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician
99212	Office or other outpatient visit for the evaluation and management of an established patient, 10 minutes
99213	Office or other outpatient visit for the evaluation and management of an established patient, 15 minutes
99214	Office or other outpatient visit for the evaluation and management of an established patient, 25 minutes
99215	Office or other outpatient visit for the evaluation and management of an established patient, 40 minutes
99241	Office consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.
99242	Office consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
99243	Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
99244	Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.
99245	Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family.
99251	Inpatient consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 20 minutes are spent at the bedside and on the patient's hospital floor or unit.
99252	Inpatient consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 40 minutes are spent at the bedside and on the patient's hospital floor or unit.

Code	Definition
99253	Inpatient consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 55 minutes are spent at the bedside and on the patient's hospital floor or unit.
99254	Inpatient consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent at the bedside and on the patient's hospital floor or unit.
99255	Inpatient consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 110 minutes are spent at the bedside and on the patient's hospital floor or unit.
99381	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)
99382	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)
99383	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years)
99384	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)
99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years
99386	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years
99387	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older
99391	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year)
99392	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction

Code	Definition
	interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)
99393	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years)
99394	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)
99395	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years
99396	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 40-64 years
99397	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and older
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
99439	Chronic Care Management (CCM)
99487	Chronic Care Management (CCM)
99489	Chronic Care Management (CCM)
99490	Chronic Care Management (CCM)
99491	Chronic Care Management (CCM)
G0506	Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service) (G0506)
H2000	Comprehensive multidisciplinary evaluation (H2000)
P3000	Screening Papanicolaou smear, cervical or vaginal, up to three smears, by technician under physician supervision (P3000)
P3001	Screening Papanicolaou smear, cervical or vaginal, up to three smears, requiring interpretation by physician (P3001)
Q0091	Screening Papanicolaou smear; obtaining, preparing and conveyance of cervical or vaginal smear to laboratory (Q0091)
85610	Prothrombin Time with INR
85730	Partial Thromboplastin Time (PTT)

Appendix B. Evaluation Design

Appendix B contains the Centers for Medicare & Medicaid Services (CMS)-approved evaluation design plan for the Alaska Substance User Disorder and Behavioral Health (SUD-BH) Program Demonstration Waiver.

**[CMS-APPROVED DESIGN PLAN WILL BE INSERTED UPON FINAL PDF
DRAFT]**

Appendix C. Additional Qualitative Results

Health Services Advisory Group, Inc. (HSAG) conducted three rounds of semi-structured interviews with providers, administrators, and Tribal entities to collect qualitative information regarding the impacts of the expansion of substance use disorder and behavioral health (SUD-BH) services between September 2020 and June 2022. These interviews focused on the expansion of services, perceptions and experiences of stakeholders impacted by the SUD-BH Program, barriers encountered, anticipated challenges, successes, impacts on quality of and access to care, and sustainability of the expansion. The interviews also examined how the unexpected burdens of responding to the coronavirus disease 2019 (COVID-19) public health emergency (PHE) impacted the planning and implementation of the SUD-BH Program.

HSAG developed flexible interview protocols using an open-ended questions format to maximize the diversity and richness of responses and ensure a holistic understanding of the subject’s experience. To understand the evolving implementation of the waiver, HSAG returned to many of the same informants in each round of interviews. The responses from the interviews are aggregated and summarized, organized according to the interview protocols.

Key Informants

State administrators, healthcare providers, and non-provider stakeholders were approached for inclusion in all three years of interviews. HSAG was able to speak with most of the state administrators across all three years. The same two non-providers, a professional organization representing BH providers and a group representing Alaskans with mental health and SUDs, were interviewed in all three years. Although many of the providers were included in all three years, The Division of Behavioral Health (DBH) provided HSAG with contact information for several additional providers for year three, and a representative sample of these new providers was also interviewed. Table C-1 displays key informants interviewed throughout the three years of interviews.

Table C-1—Key Informants

Organization Type	Organization
State Administrators	State Medicaid Director Deputy Director Legislative Liaison Chief of Risk and Research Management Behavioral Quality Assurance Section Managers Waiver Research Analyst III
Providers	JAMHI Health and Wellness Central Peninsula Hospital Interior AIDS Association SeaView Community Services Set Free Alaska True North Alaska Cordova Community Medical Center Cook Inlet Council on Alcohol and Drug Abuse Juneau Youth Services Nugen’s Ranch Volunteers of America Alaska

Organization Type	Organization
Tribal Health Organizations	Alaska Native Tribal Health Consortium Aleutian Pribilof Islands Association Cook Inlet Tribal Council Kodiak Area Native Association Maniilaq Association Norton Sound Health Corporation Southcentral Foundation SouthEast Alaska Regional Health Consortium Tanana Chiefs Conference Bristol Bay Area Health Corporation
Consumer Health Advocates	Alaska Behavioral Health Association Alaska Board on Alcohol and Drug Abuse Alaska Mental Health Board Alaska Mental Health Trust Authority

Major Themes

Several major themes emerged from the three rounds of key informant interviews:

- Broad-based support for the ambitious and far-reaching Section 1115 demonstration waiver and a general sentiment that the implementation proceeded as well as could be expected.
- A growing list of examples of the expansion in numbers of providers and types of services available to Alaskans with SUD and BH needs with support from the 1115 waiver.
- A positive attitude toward DBH’s implementation process, despite some expressions of frustration with the level of communication and technical assistance provided.
- Workforce limitations continue to limit the ability to expand services among all stakeholders, as entities struggle to maintain their existing services with the major challenges presented by specific Alaska-related challenges and the issues presented by the COVID-19 PHE.
- All stakeholders continue to work through the details of the qualification and certification processes for providers of new services, notably around qualified addiction professionals (QAPs). Feedback moved from whether these individuals should be certified to specific issues with the process. Several informants mentioned that due to the bifurcation of SUD and BH waiver services, providers of similar services were subject to different enrollment/certification/billing standards depending on where they worked (i.e., in a BH facility or an SUD treatment center) or on the precise nature of the patient’s diagnosis. An issue heard in year three was the barrier to certification of QAPs presented by the difficulty many addiction peers encountered in passing background clearances.
- Administrative burden continues to present a significant challenge to expanding services and to normal billing practices under the wavier.

The following sections provide further detail about the major themes that were mentioned during the key informant interviews, divided into successes and concerns by type of informant.

Successes

All informants were asked to describe their perception of the successes and drivers of success regarding the waiver's expansion of SUD and BH services.

State Administrators

Throughout the evaluation period state administrators felt that the underlying philosophy of the Section 1115 waiver was sound and recognized that a key driver of success has been the dedication of a number of people who worked hard to bring about this significant change in practice, both within the state administrative structure and among other stakeholders. State administrators highlighted several areas of success across all three rounds of interviews and expressed considerable excitement about the growth of services across the continuum of care and early intervention services.

The original waiver plan approved by CMS contemplated a phased rollout of the implementation based on geographic regions, with services expanded first in urban areas followed by rural and frontier areas. However, administrators discovered that acceptance of the need for change and readiness to change were strong in rural and frontier areas as well as urban areas and decided to implement the program statewide from the beginning. Additionally, implementation required a complete rewriting of the state's regulations governing BH and SUD services, which were addressed separately.

As a result, the first round of interviews focused largely on the regulations for BH services, and the second round addressed the regulations governing SUD services and identified some unintended consequences arising from inconsistencies between the two bodies of regulations. During the third round of interviews, state administrators felt they had addressed many of these issues and were still revising processes to implement further improvements. All stakeholders revealed that these issues are still being worked out, although the focus has started to shift to the upcoming renewal of the waiver.

The greatest success of the first year for state administrators was completing the major overhaul of regulations needed to make the waiver a reality. This coincided with significant changes in provider enrollment and billing practices as the State employed an administrative services organization (ASO), Optum, and as many providers enrolled in Medicaid for the first time. Expansion success continued into the second year when interviewees explained that crisis services were successfully billed, mobile outreach was activated in larger cities, and the number of providers and agencies enrolled in Medicaid increased. The number of providers offering services and the variety of services offered continued to grow in year three of the demonstration, especially in rural areas of the state.

State administrators noted that steadily increasing numbers of trainings offered and certifications completed were a success over the first three years of the demonstration. Interviewees noted in the first year of interviews that the waiver raised the bar on staffing qualifications by adding requirements for professional standards and years of experience. By the second year, 35 applications for peer support certification had been processed and approximately 1,200 QAPs had been granted provisional or full certification, and the availability of workforce training had increased. Positive sentiment continued through the end of the evaluation period, especially with respect to increases in the number of training opportunities.

State administrators were continuously engaged with stakeholders throughout the implementation process, communicating waiver direction and timelines and responding to questions. A series of roundtables in each region were held by DBH in the first year to encourage communication. Interviewees reported increased community

engagement from mental health providers, support from law enforcement, and other community stakeholders in the second year.

State administrators viewed relationships within the state government as a driver of success for the waiver. State administrators described a positive engagement with other State agencies in the first year as well as positive leadership changes, specifically noting the leadership skills of the new director of DBH. Informants identified sufficient internal capacity and a successful experience onboarding Optum. State administrators shared positive feedback during the second year surrounding increased bipartisan support from the state legislature. Administrators praised collaboration with other divisions at DHSS and other state agencies throughout the entire evaluation period in the third year.

Other areas of continued success identified by DBH informants included:

- Increased funding in the system, both in general and from the Coronavirus Aid, Relief, and Economic Security (CARES) Act, to build crisis intervention services.
- Relationships and support from the independent evaluator, HSAG, and CMS.
- Familiarization with the process for submitting reports to CMS on time, including quarterly and annual reports.
- Receiving weekly reports from the Medicaid Provider Assistance Services Section (MPASS) about providers and waiver services being offered.

Providers

When asked to share their experience with the demonstration waiver, providers described successes in service quality and accessibility, service expansion, and interactions with DBH. Services expanded steadily across all three years of interviews, as providers were able to offer new services and expand their capabilities to provide a broader continuum of care throughout the evaluation period including the addition or expansion of:

- American Society of Addiction Medicine (ASAM) Level 1.0, 2.1, 2.5, and 3.1 services ^{C-1}
- Broader use of screening, brief intervention, and referral to treatment (SBIRT)
- Crisis intervention
- Withdrawal management
- Improved care planning processes
- Case management and intensive case management services
- Counseling and community support services (CCSS) ^{C-2}
- Peer support services
- Adult mental health residential
- Community recovery support services (CRSS)
- Support for independent living

^{C-1} DBH also expanded 3.3 services along with adolescent SUD services (2.5 and 3.1) although providers did not mention expanding these services.

^{C-2} CCSS has been sunsetted but was mentioned as being expanded by a provider. CCSS was replaced by Community Recovery Support Services.

- Assertive community treatment-based teams working with SMIs

Most services were expanded in the first and second years of the demonstration. Several providers did not add additional services in the third year. Additional areas of action include pioneering the license variance for adult mental health residential, requiring parent involvement in their children's care in a concentrated non-assertive approach, receiving level of care certifications, hiring peer support specialists, and improving awareness and consistency of care through SUD care coordination.

Throughout the course of the evaluation period, providers felt that the waiver had improved service quality and accessibility to serve local individuals, including their abilities to provide the right service at the right time and move patients between levels of care. Specifically, providers noted the implementation of adult mental health residential programs, housing, and stabilization for those in need, and the increase in quantity of care without compromising quality. However, change in quality was not consistent. In the third year, one provider shared that while quality had not decreased, it had not necessarily increased either. Overall, providers felt that their patients were unaware of any changes, which was identified as a success due to continued internal challenges providers faced with billing and reimbursement. Patients continued to receive necessary services with positive outcomes throughout the transition.

Providers shared positive interactions with DBH during the interview process. In the first year, providers thought the round tables held by DBH were helpful, although sometimes unfocused. By year three, providers felt DBH was present in conversations with providers, was transparent, supportive, and responsive with consistent communication. One provider expressed appreciation for DBH's guidance and support through the waiver specifically during COVID-19. Another provider expressed appreciation for the listening sessions hosted by DBH regarding the waiver renewal. A third provider experienced numerous helpful site visits by representatives of DHSS and DBH which helped to identify potential gaps in providing services.

Telehealth improved providers' ability to engage with patients over the course of the waiver. In the first year, a provider shared their enhanced ability to engage with youth and children due to telehealth. In year two, positive experiences with telehealth continued and providers conveyed reduced no-shows and appointment cancellations along with increased patient compliance with treatment regimens.

Individual providers shared additional successes at various points throughout the evaluation period:

- Utilization of ASAM improved service delivery and advocacy through demonstrating medical necessity, structure, and communication in the referral process
- Satisfaction with waiver regulations
- Satisfaction with new case management definitions and defined levels of care
- Excitement for the prospect of expanding peer support group services
- Progress in documentation, coding, and billing practices
- Development of a self-audit checklist by DBH
- Satisfaction with communication and responsiveness by the MPASS unit and Optum among some providers

Successes were not universal. One provider explicitly noted that there were no successes within their organization relating to the waiver.

Tribal Health Organizations

Alaska's Tribal Health Organizations (THOs) are significant providers of and payors for BH and SUD services in Alaska. In the second year of interviews HSAG scheduled and conducted interviews with key informants from five THOs. In the third year of interviews, the number of key THOs informants increased to eight.

THO informants expressed support for the expansion of services across the continuum of care and excitement about the opportunity to provide peer-based services. Specific services that were expanded during the evaluation period included:

- ASAM Level 1.0 (Outpatient) and 2.1 (Intensive Outpatient) services
- Crisis stabilization services
- Same day services
- Women-specific services ^{C-3}

THOs experienced some growth in the number of services expanded during the third year and shared a list of services that they felt were important to their communities and were planning on expanding including:

- ASAM Level 2.1 and 2.5 (Partial Hospitalization Intensive Outpatient Services)
- 23-hour stabilization services
- Medication-assisted treatment (MAT)
- Peer-based support and crisis services
- BH family services

THO informants expressed experiences with early issues with the process of enrolling providers for Medicaid billing but by year three, several THOs shared that they felt the transition to the waiver had been a relatively easy experience and that the waiver was a good framework for providing services they otherwise would not have been able to provide. One THO informant appreciated that the waiver allowed them to think about how SUD integrates with general healthcare and impacts other areas of care. Two THOs commented on improved staff retention after the waiver implementation.

THO informants mentioned that DBH has been responsive to their requests and willing to hear criticism and expressed appreciation for the State's investment in the family services training center and their commitment to infant and early child mental health. One THO appreciated DBH's and Optum's prioritization of liaisons for tribal health and child welfare, two traditionally marginalized groups. The THO indicated that Optum was willing to have these liaisons attend the recurring weekly calls with THO BH directors as needed. In addition to their work through liaisons, some THOs reported that Optum was available to answer questions and was receptive to their suggestions for improvement, such as making provider-specific billing trainings available.

Other notable successes different THOs attributed to the waiver included:

- Investing in the continuum of care, higher levels of care for youth, and early family intervention.
- Utilizing peers and integrated care teams for peer support.

^{C-3} The Alaska 1115 SUD-BH waiver does not provide for any women-specific services; however the services were mentioned by a THO informant with respect to services they have expanded related to SUD and BH care and is included as such.

- Collaborating with other THOs throughout the implementation process via a THO specific learning network of BH directors.
- Utilizing telehealth to provide care.
- Developing and implementing a consistent intake process.
- Standing up a process for receiving referrals from the 988 Suicide and Crisis Lifeline.
- Implementing new assessment and screening tools to place patients in the appropriate level of care.
- Implementing a mobile crisis team operating out of a fire department.
- Doubling residential youth bed numbers.
- Hiring 50 new staff to respond to an increase in patient volume.
- Doubling the number of staff working in intensive care management.
- Contracting with a consulting company to assist in the navigation of waiver challenges.
- Including a cultural competency continuing education unit (CEU) requirement for certification of QAPs, acknowledging the importance of including cultural sensitivity training for providers in certification standards.
- Increasing the quality of care due to enhanced patient engagement as peer support services began.

Non-Provider Stakeholders

Both of the non-provider stakeholders interviewed expressed that while the waiver had its challenges, the underlying principles and goals of the waiver were sound. Across all three years of interviews, these stakeholders highlighted DBH's assistance and communication as a positive. In year one, non-providers cited that DBH pushed out trainings and technical assistance to aid providers in implementing waiver services, specifically MAT and peer support. In the second year, non-providers discussed DHB's continued responsiveness to provider concerns and their flexibility in the transition to the waiver. In year three non-providers provided a mixed reception, with some providers feeling that DBH continues to be helpful, noting the listening sessions, while others feel that communication was confusing and DBH was stepping back.

Non-providers described costs as an area of continued success. In year two, non-providers highlighted lowered costs to the State for Medicaid expenditures and other BH programs compared to pre-waiver. Positive sentiments continued in year three, when non-providers discussed new innovative types of billing they were seeing in the community. One non-provider stakeholder shared how a healthcare provider was providing outpatient services to those in need while simultaneously offering lodging to patients for six to eight weeks for free in a successful, voluntary experiment.

Additional successes noted by non-providers include:

- A surge in new hires and incentives in the third year for providers to remain in Alaska, combatting typical workforce issues.
- A quick transition to patients receiving the appropriate level of care. For example, as of year one, patients were already receiving once a week care rather than residential services when weekly services were more appropriate.

Concerns

All informants were asked to describe barriers or difficulties they had encountered related to the expansion of SUD and BH services during implementation of the waiver, and steps they had taken to address them. The interviews revealed the evolution of the program as all stakeholders shared their experience and collaborated to make necessary course corrections.

State Administrators

When asked to share their concerns about the waiver, state administrators noted several areas of concern including the bifurcation of BH and SUD services, administrative burden, and workforce challenges. State administrators acknowledged that the bifurcation of SUD and BH waiver service regulations had resulted in some unintentional complexity and inconsistencies between the handling of SUD and BH services that may have interfered with their goal of providing integrated care and may have caused confusion among other stakeholders. State administrators found that providers seemed to have had an easier time switching to SUD waiver services compared to BH services. They reported awareness that some provider experienced issues due to SUD and BH QAP certification requirements being different despite QAPs performing the same responsibilities for SUD and BH services. One state administrator also identified that the bifurcation may have resulted in a greater focus on SUD services rather than BH services, resulting perhaps in missed BH opportunities.

State administrators shared awareness of and concern for providers' experience of administrative burden as a result of the waiver, particularly as it related to billing for services and the fears related to potential future Medicaid audits. State administrators understood that some providers found waiver regulations difficult to understand, and that this was perhaps exacerbated by the volume of changes to regulations as well as the differences between the separately released SUD and BH components. Informants recognized there may have been some disconnect between the administrative burden they believed they were imposing with the regulations and that experienced by providers seeking to work under the regulations.

State administrators reported an adjustment period as DBH became accustomed to working with CMS and its regulatory environment, and noted they had faced increased administrative burden internally, as they worked through the waiver process. For example, Alaska's fee-for-service (FFS) environment added complications not present for many states who use managed care entities to provide Medicaid services.

Several state administrators also shared the broader stakeholder community's concerns about billing under the waiver. One informant acknowledged that reimplementing service authorizations will be a challenge when the COVID-19 PHE ends and recognized the need to educate providers on the process. For example, there might be misapprehensions about how authorizations would relate to discharges.

Administrators acknowledged that they heard providers' requests for payment reforms, and concerns about whether they can grow their service array on the current rate trajectory, however the state has limited ability to change rates set or approved by CMS. Another concern was finding a middle ground between for coverage of services that were borderline long-term care (LTC) and might not be able to be billed to Medicaid. Informants were aware of issues related to the sunset of state plan codes, particularly in how rates were impacted by the transition.

One administrator mentioned concern about DHSS' internal restructure that occurred during the third year of interviews. The informant specifically noted there was a split of internal resources between new departments. Most State interviewees, however, believed that the restructure would have limited impact on waiver issues.

State administrators cited lessons learned about the process of onboarding the ASO, Optum. For example, one informant indicated that Optum did not capture National Provider Identifier (NPI) numbers, so DBH had to pull data from other sources. The transition to Optum was described as difficult by several state administrators, who said that many providers had not successfully transitioned as of the second year of interviews; however, this was no longer reported to be an issue by the third year of interviews.

Other delays and challenges noted by state administrators included:

- Significant workforce shortages in Alaska continued to impact waiver expansion and services at the provider and state administrative level.
 - Alaska’s geography, cost of living, and access to broadband contributed to workforce challenges.
 - A volatile economy reflecting reliance on the oil industry.
- Lack of specific guidance from CMS regarding its expectations for engaging in meaningful dialogue with tribal entities.
- An increased urgency of children’s mental health issues with the evolution of the COVID-19 PHE.
- The waiver renewal occurring during an election year.
 - The new administration may not have recognized the importance of the waiver.
 - Negotiations for the waiver occurred during the legislative session, increasing the pressure on the timeframe for renewal.
- Increase in opioid-related overdose deaths prior to the implementation of the waiver.

Providers

Providers highlighted administrative burden as a key concern throughout the three rounds of interviews. Initially, providers experienced long wait times to enroll providers in Medicaid. Once providers were enrolled, they expressed confusion in interpreting and complying with waiver guidelines and what they perceived as restrictions on provider’s abilities to provide services in a specific manner. Many struggled with complying with the certification processes associated with employing QAPs. The certification process was costly and lengthy with no chance for reimbursement; many providers did not feel there was enough time for certification. Many providers also expressed difficulties with paperwork associated with background checks for peer support workers and the variance process. Additionally, one provider mentioned that they experienced increased administrative burden due to having to fill out paperwork for every provider.

Providers noted workforce challenges were a continued concern throughout the three years of interviews. Providers experienced extensive staffing issues and had difficulty hiring and retaining staff. One provider noted a 56 percent turnover among their staff in the preceding 12 months. Another provider noted four clinicians had left their organization in the past year. Workforce challenges shared by providers include difficulty getting workers to move to Alaska, inability to pay relocation fees, difficulty encouraging workers to remain in Alaska, and difficulty in offering competitive wages.

In year one of interviews, providers shared concerns about the sunset of state plan services before the 1115 waiver would be viable. State plan codes were discussed again in year three, when providers expressed frustration that waiver services were not always a direct replacement for state plan services, especially with regard to adult mental health residential services. One provider cited issues with the transition from home-based state plan codes to waiver codes; the provider, in anticipation of the state plan codes being sunset, transitioned their billing to utilize waiver codes. However, DBH delayed the sunsetting a few days before State plan codes were expected to be sunsetted. The provider had already transitioned their systems away from State plan codes and was unable to

reverse in time, causing the provider to stop providing school-based services, and resulting in a major loss in revenue.^{C-4}

There was also discussion about differences between the state plan codes and waiver codes. Specifically, peer support and CRSS had a lower limit of 200 hours on the waiver compared to 840 available hours on the state plan codes. The provider felt that in this situation it would not make sense to bill to the waiver codes. Similarly, an additional provider shared that they continued to bill state plan codes for peer support, case management, assessment, and psychotherapy. Another provider noted that they understand why some providers are continuing to bill to state plan and expressed that they wished 1115 and state plan billing were the same. Medicaid and non-Medicaid services utilize different codes; one provider noted that they would like the State to make these codes match.^{C-5}

Informants expressed additional concerns surrounding billing:

- Inability to bill for arranging travel for case management resulted in providers spending unpaid hours on this process.
- Lack of understanding on the documentation required to bill for peer support. The administrative burden of this billing process was too high, and a provider explained their staff worked weekends to bill for these services.^{C-6}
- Fears over the return of service authorizations after the PHE ends.
- Clarity on bill codes and paybacks.
- Difficulties in providing every location and provider their own NPI.
- Optum not itemizing payments and voids, leaving providers vulnerable in an audit.

Many providers experienced concerns specifically with Optum. In years one and two, the majority of interviewed providers highlighted the difficulty of the transition from Conduent to Optum. Issues in this transition included billing issues (denied claims, providers not in the billing system), inconsistent instructions, lack of communication, and a reduction in information technology (IT) and technical support. Providers felt that the transition to Optum at the same time as rolling out the waiver and during the COVID-19 PHE was too much. Additionally, providers felt that Optum did not provide the cost reduction and support that was originally indicated. By the third year, interviewed providers did not express concerns regarding Optum.

Providers also expressed a similar lack of support, training, and guidance from DBH in the billing and documentation processes in the first year of interviews. Some interviewees felt that DBH's responses were inconsistent. By the third-year, similar feelings remained. Providers noted that DBH was not responsive to questions, and that different DBH representatives gave different answers to the same question. Providers who did feel that DBH was responsive maintained that answers were unclear. Informants expressed the need for more transparency from DBH. Several providers shared that they were looking forward to meeting with DBH in person to get their questions answered.

^{C-4} School-based services provided by the Tribal Behavioral Health System (TBHS) remain in the Alaska state plan.

^{C-5} If the recipient is ineligible for Medicaid, then neither State plan nor 1115 billing codes should be used. For those ineligible for Medicaid, State grants are used to support provider organizations that serve non-resourced service recipients; funding for this population has continued during the demonstration period to ensure access to services via grants. Providers are only required to provide services to non-Medicaid recipients as a component of their grant requirements.

^{C-6} There may be confusion among providers between peer support services and peer-based crisis services. Peer support services are provided under the Alaska state plan, while peer-based crisis services have not been implemented.

Several providers experienced difficulties providing services in 2021 due to a cybersecurity attack on the Alaska's Automated Information Management System (AKAIMS) system. Prior to the incident, providers billed Medicaid through the AKAIMS system and were forced to switch to Optum's provider express system online. One provider missed timely filing when AKAIMS was taken offline and were not given a grace period under the waiver or the state plan; the provider estimates a loss of approximately \$40,000 over seven months.

Lastly, providers reported experiencing difficulties expanding services, namely in providing peer support services. Peers had difficulties gaining clearance via a background check to perform peer support services because many peers had an issue appear on the background check. Providers had to complete a variance to allow the peer to work which could take up to eight weeks to gather all the correct paperwork. Many peers dropped out of the program because they could not wait unpaid.^{C-7} Additionally, providers felt there was not enough funding and resources for proper implementation. One provider required grant funds to operate for the first six months of implementation.

There were additional areas of concern highlighted throughout the evaluation period:

- The geography of Alaska limited providers' ability to provide services within a safe driving distance.
- Difficulty in providing services to youth with BH needs due to the limited number of beds, especially residential psychiatric treatment beds for youth.
- Community stigma against SUD residential providers.
- Some providers felt that access to care had not changed, some feel it had increased, and others felt that access decreased. Reasons that providers believe access decreased include:
 - One provider was forced to stop providing school-based youth services and closed an entire clinic due to waiver billing issues.
 - Patients must wait for service authorizations while in crisis. This was identified as burdensome and clinically unhealthy.
- Providers struggled to continue providing services to non-Medicaid patients.
 - Prior to the waiver, same services were available to Medicaid and non-Medicaid patients. The waiver created a gap in services available between groups.
 - The State maintained a heavy focus on Medicaid and, according to one provider, forgot that providers must serve non-Medicaid patients to stay in business.
- The waiver's focus on early intervention and prevention was not conducive to adults with long-term serious mental illness (SMI).
- Providers had to identify what setting clients are in when they receive telehealth services (i.e., at home or another setting).
- Agencies had to become licensed as an assisted living facility to provide adult mental health residential services.

Tribal Health Organizations

During the second year of interviews, informants' major concerns were the administrative burden, the evolving process of development and revision of the new regulatory system, confusion over which services were billable

^{C-7} Background checks and clearances are under the purview of the Division of Health Care Services (HCS). DBH is collaborating with HCS to reduce the process time to enroll peer support staff.

and which were not, and the long processing time for applications to enroll with CMS for billing. Interviews conducted in the third year showed that administrative burden continued to be a concern amongst THOs, and their feedback was quite similar to that provided in the prior two years by THOs and other stakeholders, centering on licensure requirements, certification of QAPs, and enrollment of providers. Informants did not raise previously unidentified issues and acknowledged DBH's continuing efforts to address their concerns. However, there was a perception of change fatigue due to the cumulative effects of a lot of change over time.

THOs identified some concerns about the regulatory scheme itself; one THO felt the waiver eliminated flexibility and did not allow for programs to grow and develop naturally. Another perceived that the waiver focused on ASAM level 1.0 and 2.1 services while disregarding others. A third mentioned the need to address coverage for involuntary care.

Several THOs highlighted the bifurcation of SUD and BH regulations and services as a concern in year three. Since many SUD and BH patients present with co-occurring issues, the waiver's bifurcation resulted in issues with billing, created potential problems for audits, and impacted the treatment of patients. THOs hoped that this confusion would be alleviated in the renewal of the waiver.

The lack of resources for early intervention and service for youth and families was one of the main drivers of the design of the waiver and remains an acute concern among THOs across the continuum of care. This situation was described in the second year of interviews as especially acute for youth with BH needs due to the limited number of inpatient/residential psychiatric treatment beds for youth. The shortage was exacerbated by the lengthy process to get approval or authorization for placements in state and even lengthier for placements out of state. Informants felt that early screening and intervention had begun to improve with the adoption of the SBIRT screening tool. However, during the third year one informant observed that the intake paperwork for BH was still much longer than the paperwork required for physical health visits or that required in federally qualified health centers (FQHCs), presenting an overwhelming burden for providers and a barrier to patients' engagement in care.

In the third year, THOs also noted that home-based family treatment billing codes did not always match the work THOs were doing and seemed designed to support reactive rather than preventative care. Ultimately, the services seemed to be geared toward older youth in an effort to prevent them from incarceration rather than supplying true early intervention care, as originally intended. Informants felt they had not been able to translate the opportunities presented by the new codes in the waiver into actual growth in youth programming. One THO highlighted this as an area of opportunity for DBH to translate what code sets mean in practice and explain how organizations could build capacity to support families.

In the third year of interviews, billing issues continued to present concerns. Many THOs were especially concerned about the impending return of service authorizations, which were not required during the COVID-19 PHE. Several THOs believed there appeared to be inconsistency in guidance from Optum and DBH regarding when service authorizations would return and noted there were many other unknowns surrounding their return. One informant described that they would need to manually track all service authorizations since their electronic health record (EHR) system did not automatically do so.

In the second year of interviews THOs wondered whether smaller providers would be driven out of business due to the waiver. In year three, there were anecdotal reports by THOs of the loss of services that they attributed to complications of the waiver. One informant was unable to alter its children's home service to fit the waiver bill codes and withdrew the service from Medicaid billing. One THO was considering enrolling as a tribal FQHC instead of providing services through the waiver due to the administrative burden associated with the waiver. Multiple THOs noted that waiver billing rates were too low to both continue existing state plan services and support the expansion of several waiver services, especially rates for residential services for youth, and 24-hour multidisciplinary, and assertive community treatment (ACT) services.

Several THOs in year three mentioned additional workforce challenges, including a limited pool of prospective employees and high rates of unfilled vacancies within their organizations. THOs lacked administrative staff, case managers, and paraprofessionals. One informant's workforce fears centered around the concern that masters' levels providers would leave for the private sector to avoid administrative burden.

THOs shared that funding challenges limited expansion in year three. The high cost to staff new programs was named as a chief friction point. The recent economy was also a factor, with increasing general costs negatively impacting already thin margins. Additional limiting factors in expansion mentioned by THOs in the third year included limited infrastructure and lacking knowledge of how to implement new services in practice. One THO noted that they were only able to shift the bill codes of its pre-existing services and did not add any new waiver services to its service array. THOs also felt that the service definitions and requirements were designed for an urban population and were not easily adaptable to rural tribal areas due to the unique rural lifestyles of these groups. One THO shared that strict program and engagement requirements were difficult for rural populations to align with while trying to provide for their families in a remote setting. For example, the patient population in Alaska may leave treatment depending on the season due to the unique lifestyles of some Alaskans.

While some THOs expressed positive sentiments around their interactions with DBH and Optum, others felt that communication could be improved. THOs would like an easily available resource on up-to-date information on regulations, fee schedules, and manuals. While they conceded there was information available online, THOs pointed out that much of this information was outdated, creating significant potential ramifications in the case of an audit.

Several THOs expressed difficulties performing their typical duties for several months in 2021 due to a Statewide cyberattack that impacted AKAIMS. During the cyberattack, THOs were forced to switch to a paper-based record systems instead of an electronic version. This caused one THO to have to spend time away from patients and physically move records around the facility each day, impacting the quality of care they were able to provide. During the cyberattack, progress towards expanding services and implementing key waiver functions halted as THOs focused on providing care while using cumbersome paper methods. One THO mentioned that having to deal with the cyberattack and the COVID-19 PHE simultaneously was a challenge and there continues to be a need to provide early intervention and prevention services. One THO was concerned that DBH had been unable to meet with tribal behavioral health directors to discuss the administrative burden of the waiver. One THO recommended that DBH help Optum with documentation requirements associated with the waiver because Optum experienced difficulties working with THOs on documentation requirements due to stringent regulations. One informant also felt that the Optum conferences were unproductive; in the future, they would like to spend more time at conferences on what services are supposed to look like in practice when implemented.

Non-Provider Stakeholders

Non-provider stakeholders (one BH professional association and one consumer advocate organization) raised various concerns over the three years of interviews, generally centered around the level of communication between DBH and stakeholders. Primary concerns were the level of DBH interactions with providers, lack of transparency, and transition planning for phasing-out state plan services. However, as mentioned earlier, the consensus was that DBH had done a fairly good job at responding to issues and learning from challenges.

In all three years, non-providers felt DBH may have missed an opportunity to work more closely with providers. The consumer advocate informant discussed a need for more active change management and waiver education for other State agencies/departments, especially because informants had observed other departments pass out incorrect information about covered services to community members. In year one, the professional association felt that DBH had started major system changes with little to no follow up, leaving providers with inadequate

information to commit to new changes and initiatives. By the third year, both of these stakeholder groups reported that communication had improved, although mixed responses on the subject persisted. One non-provider indicated that DBH was cutting back on their communication in year three, while another noted that DBH was helpful in getting services stood up.

Both non-provider stakeholders shared a common concern regarding a lack of transparency with the waiver. One informant during the second year of interviews recommended that more data, including the number of Medicaid enrollees or the number or types or service claims, should be more public facing. By the third year, the same informant indicated that a quality assurance (QA) review was going to be performed by providers and consumer advocates to review data and make recommendations to the ASO, Optum, but planning was discontinued due to lack of funding and other resources.

Non-providers felt as though there had been inadequate transition planning for the phase-out of state plan services and were concerned that patients might have been injured during the transition of state plan services to waiver services due to disruptions in their continuum of care. State plan services were phased-out before many providers were ready to complete the transition to waiver services, and waiver services were not always a clear replacement for existing state plan services.

Other concerns offered by these stakeholders included:

- The cyberattack on DOH website that occurred in May 2019 impacted the ability of providers to transition to new EHR systems and lengthened the amount of time it took to perform background checks for new employees.
- Parts of the waiver were rolled out under COVID-19 emergency regulations causing the public commenting period to occur after the waiver was implemented.^{C-8}
- There was a possible loss of small BH providers who were unwilling or unable to meet the requirements of the waiver.
- There was a possible loss of funding streams due to not utilizing unrestricted general funds in addition to waiver funds.
- Providers had to alter their workplace to incorporate trainings, modify their EHR, and redesigned infrastructure, all of which created burdens that were not compensated.
- Regulations were overly flexible, causing confusion about service requirements.
- There were frequent changes in service requirements causing disruptions for providers who were in active implementation processes.
- There was confusion with new QAP credentialing requirements and how long training should take for degreed and non-degreed employees.

Budget Neutrality/Sustainability

State Administrators

State administrators highlighted a variety of topics related to budget neutrality and sustainability. During the first year, interviewees cited the need to understand how to establish and measure budget neutrality, explaining there

^{C-8} In fact, the regulations relating to the Alaska 1115 SUD-BH Waiver were put into place using the state's emergency regulation process, but the use of the emergency regulation process was unrelated to the COVID-19 PHE.

was much to learn about the new processes for the waiver. COVID-19 greatly threatened the core sustainability of waiver services during the first year.

The second year of interviews highlighted several new topics related to budget neutrality and sustainability. Interviewees reiterated the need to look at improved outcomes from providing early intervention in the long term when judging sustainability. Several state administrators described difficulty obtaining the data from Optum that was needed to demonstrate sustainability, while acknowledging that some of these difficulties might be due to the COVID-19 PHE rather than the waiver. State administrators expressed at that time a clear view of the waiver's financial impact which included \$200 million entering Alaska to pay BH providers' Medicaid claims. Most state agencies received more Medicaid revenue than state plan revenue.

State administrators identified the waiver as generally stable in year three, although sustainability planning continued to be an ongoing process. Interviewees shared concerns about funding and shared that they were seeking additional grant dollars to support waiver services. One informant highlighted that grant funding, specifically COVID-19-related funding, may have caused a general decline in the Medicaid budget due to a line veto performed by the state legislature. State administrators also discussed issues regarding select reimbursement rates. Youth crisis residential services were noted as being too low and not cost effective while mobile crisis services were identified as difficult to implement without proper staffing. Additionally, one informant shared that Milliman, the contractor who performs Alaska's budget neutrality work related to the waiver, aligned the CMS 64 reports and XML files from Optum to determine budget neutrality; the contract is ending after 2022. Work related to budget neutrality will need to be moved in-house at DBH if that contract is not extended.

Providers

The chief sustainability topic area identified in all three years by providers was the billing rates set for waiver services. Providers expressed that they believed rates were mostly reasonable and that services would be sustainable once they were up and running in year one. However, several areas of concern with service rates were identified:

- Unhappiness with the rate approved by CMS for ACT.
- Decreases in rates for several services including group services and community support.
- Insufficient rates for mobile outreach to support the service.

In year two, providers expressed concern about the rates set for children's services. Providers felt that the rates, set at half that of adults for similar services, failed to consider that children's needs are more complex and more urgent than those of adults. As a result, providers struggled financially to provide these services, noting that they were losing money on every patient served due to the way the regulations were written. In round three these sentiments continued. Again, providers specifically identified mobile outreach rates as being insufficient to support the service. One provider shared that they were only able to bill for \$125,000 while accumulating \$800,000 in costs to run the service. Providers also noted home-based service rates as insufficient to support the service.

Individual providers made additional comments on sustainability or budget neutrality during the third year of interviews:

- The separation of ASAM level 1.0 and 2.1 services contributed to increased sustainability.
- Separating waiver services and state plan billing did not allow providers to see budget neutrality.
- Billing rates may not keep pace with salary increases.

- Adult mental health residential services were not sustainable in the long term; however, ending this service would displace 40–50 patients.

Non-Provider Stakeholders

The non-provider stakeholders highlighted several areas of importance in sustainability. Interviewees agreed that billing rates were insufficient to sustain waiver services and were concerned that providers would cease operations. They agreed that rates for children’s services had been set too low compared to adult rates for services, despite a need for more intensive care. Informants also expressed concern with the rates for mobile crisis services, citing that these rates were a quarter of the true cost of the service. According to interviewees, DBH was made aware of the issues with the rates and made promises to increase them, however, they did not seem to have been addressed in the budget.

Other issues on the minds of these stakeholders included:

- The need for the state and providers to diversify funding to continue operations after funding from grants decreased.
- Providers were unable to take on additional grants due to their staff’s limited capacity.
- An ongoing attempt to use funding from the Family First Prevention Services Act in conjunction with the waiver to increase sustainability.

COVID-19

All of the key informants recognized the stress on themselves, their patients, and on the healthcare system as a whole from the COVID-19 PHE. For example, many residential and withdrawal management facilities were closed or had reduced census due to PHE. All recognized that increased telehealth services were helpful in dealing with the needs of patients and staff. Response to the pandemic also led stakeholders to work together in creative ways that brought a spirit of innovation that will continue as the pandemic becomes less acute. For example, providers who normally did not work together collaborated to provide joint access to 23-hour crisis stabilization for quarantined individuals that they hoped would last beyond the needs of the pandemic.

In the third year of interviews, informants continued to share the impacts of increased telehealth services including increased flexibility, higher attendance rates in rural areas, and better provider retention. However, they also reported difficulty providing telehealth services to rural areas and identifying how to utilize telehealth while simultaneously expanding services.

The COVID-19 PHE was also perceived as creating a back log for higher levels of service as more patients and staff were impacted by mental health crises. Informants, particularly THOs observed an increase in alcohol use and the number of deaths in rural populations unengaged in care. One THO experienced multiple staff suicides within its organization during the pandemic. THOs described experiencing challenges with employee recruitment and retention attributed to the pandemic. Staff members became exhausted when dealing with COVID-19, leading to high staff turnover which was further exacerbated by a lack of staff housing.

Appendix D. Measure Definitions and Specifications

Health Services Advisory Group, Inc. (HSAG) identified the waiver population according to the three target groups specified in the Centers for Medicare & Medicaid Services (CMS)-approved evaluation design plan.

- **Group 1:** Children, adolescents, and their parents or caretakers with or at risk of mental health disorders and substance use disorders (SUDs)
 - COE 51 – Child Under 21 and in state custody (including Title IV-E Foster Care)
- **Group 2:** Transition age youth and adults with acute mental health needs
 - Beneficiaries 16–24 years old
 - COE 31, 71 or 81
 - COE 31 – Adults with Physical and Developmental Disabilities Waiver
 - COE 71 – Intellectual and Developmental Disability Waiver
 - COE 81 – Complex Medical Condition Waiver
 - Claim with a diagnosis code listed in the HEDIS MY 2020 Mental Health diagnosis value set
- **Group 3:** Adults, adolescents, and children with SUDs
 - Beneficiaries 12–64 years old
 - Claim with a diagnosis code listed under one of the following HEDIS MY 2020 Value Sets:
 - Alcohol Abuse and Dependence Value Set
 - Opioid Abuse and Dependence Value Set
 - Other Drug Abuse and Dependence Value Set

Beneficiaries screened for symptoms of SUD using industry recognized, evidence-based screening instruments (Measure 1)

Numerator	The number of unique beneficiaries screened for symptoms of SUD
Denominator	The total number of unique waiver beneficiaries
Comparison Population	N/A
Analytic Approach	Pre/post analysis
Measure Steward	N/A
Data Source	MMIS
Frequency	Annual
Desired Direction	Higher is better
Notes for measure calculation	The following HCPCS/CPT codes were used to identify SUD screening: H0049 H2000 H0001 Alcohol and/or Drug Assessment H0002 H0031 - HH Integrated MH and SU intake assessment*

* The H0031 – HH code does not disaggregate SUD from MH

Beneficiaries screened for symptoms of behavioral health disorders using industry recognized, evidence-based screening instruments (Measure 2)	
Numerator	The number of unique beneficiaries screened for symptoms of BH
Denominator	The total number of unique waiver beneficiaries
Comparison Population	N/A
Analytic Approach	Pre/post analysis
Measure Steward	N/A
Data Source	MMIS
Frequency	Annual
Desired Direction	Higher is better
Notes for measure calculation	The following HCPCS/CPT codes were used to identify BH screening: T1023 90791 H0031 Mental Health Assessment H0031 - HH Integrated MH and SU intake assessment

Number of beneficiaries in the waiver population with SUD or behavioral health diagnosis, by setting (Measure 3)	
Numerator	The number of unique beneficiaries (de-duplicated total) enrolled in the measurement period who receive MAT or have qualifying facility, provider, or pharmacy claims with a SUD diagnosis and a SUD-related treatment service during the measurement period and/or in the 11 months before the measurement period
Denominator	The total number of unique waiver beneficiaries
Comparison Population	N/A
Analytic Approach	Pre/post analysis
Measure Steward	CMS
Data Source	MMIS
Frequency	Annual
Desired Direction	Higher is better
Notes for measure calculation	Measure specifications rely on <i>Medicaid Section 1115 SUD Demonstrations: Technical Specifications for Monitoring Metrics, version 4.0</i> , Metric #4: Medicaid Beneficiaries with SUD Diagnosis (annually).

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Measure 4)	
Numerator	<i>Initiation of AOD Treatment:</i> the number of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis. <i>Engagement of AOD Treatment:</i> the number of members who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit.
Denominator	The total number of waiver beneficiaries with a new diagnosis of AOD abuse or dependence
Comparison Population	N/A

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Measure 4)	
Analytic Approach	Pre/post analysis
Measure Steward	NCQA (NQF 0004)
Data Source	MMIS
Frequency	Annual
Desired Direction	Higher is better
Notes for measure calculation	This measure follows NCQA specifications for Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET).

Follow up after discharge from emergency department visits for SUD, and specifically for OUD, by setting (Measure 5)	
Numerator	<p>Of the visits identified in the denominator, the number of follow-up visits with any practitioner, with a principal diagnosis of AOD within 7 days after the ED visit (8 total days).</p> <p>Of the visits identified in the denominator, the total number of follow-up visits with any practitioner, with a principal diagnosis of AOD within 30 days after the ED visit (31 total days).</p>
Denominator	The total number of emergency department visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence.
Comparison Population	N/A
Analytic Approach	Pre/post analysis
Measure Steward	NCQA (NQF 2605)
Data Source	MMIS
Frequency	Annual
Desired Direction	Higher is better
Notes for measure calculation	This measure follows NCQA specifications for Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA).

Follow up after discharge from emergency department visits for a behavioral health disorder, by setting (Measure 6)	
Numerator	<p>7-day follow-up: Of the visits identified in the denominator, the total number of follow-up visits with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 7 days after the ED visit (8 total days).</p> <p>30-day follow-up: Of the visits identified in the denominator, the total number of follow-up visits with any practitioner, with a principal diagnosis of a mental health disorder or with a principal diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 30 days after the ED visit (31total days).</p>
Denominator	The total number of emergency department visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm.
Comparison Population	N/A
Analytic Approach	Pre/post analysis
Measure Steward	NCQA (NQF 2605)

Follow up after discharge from emergency department visits for a behavioral health disorder, by setting (Measure 6)	
Data Source	MMIS
Frequency	Annual
Desired Direction	Higher is better
Notes for measure calculation	This measure follows NCOA specifications for Follow-Up After Emergency Department Visit for Mental Illness (FUM).

Number of Medicaid qualified SUD providers (identified by provider ID numbers) who bill for SUD services (Measure 7)	
Numerator	The number of Qualified Addiction Specialists with a claim for a SUD service.
Denominator	N/A
Comparison Population	N/A
Analytic Approach	Descriptive analysis
Measure Steward	N/A
Data Source	Administrative/provider enrollment records/MMIS
Frequency	Annual
Desired Direction	N/A
Notes for measure calculation	SUD service is defined as a claim meeting any of the following criteria: Diagnosis code in any of the following HEDIS MY 2020: Alcohol Abuse and Dependence Value Set Opioid Abuse and Dependence Value Set Other Drug Abuse and Dependence Value Set HEDIS MY 2020AOD Medication Treatment Value Set CPT H0009, H0010, H0011, H2036, H0047, H0023, H0014, H2021, H0015, T1007, H0035

Number of Medicaid qualified professionals licensed in the state to provide behavioral health who bill for behavioral health disorder services (Measure 8)	
Numerator	The number of behavioral health providers with a claim for behavioral health disorder services.
Denominator	N/A
Comparison Population	N/A
Analytic Approach	Descriptive analysis
Measure Steward	N/A
Data Source	Administrative/provider enrollment records/MMIS
Frequency	Annual
Desired Direction	N/A
Notes for measure calculation	BH service is defined as a claim with a diagnosis code in the Mental Health Diagnosis Value Set.

Providers' reported barriers before, during, and shortly following expansion of BH and SUD services (Measure 9)	
Numerator	N/A
Denominator	N/A
Comparison Population	N/A
Analytic Approach	Qualitative Analysis
Measure Steward	N/A
Data Source	Provider key informant interviews
Frequency	N/A
Desired Direction	N/A
Notes for measure calculation	Interviews were conducted annually from 2020-2022.

Providers' experience in expanding services (Measure 10)	
Numerator	N/A
Denominator	N/A
Comparison Population	N/A
Measure Steward	N/A
Data Source	Provider key informant interviews
Frequency	N/A
Desired Direction	N/A
Analytic Approach	Qualitative Analysis
Notes for measure calculation	Interviews were conducted annually from 2020-2022.

Administrators' reported barriers before, during, and shortly following expansion of BH and SUD services (Measure 11)	
Numerator	N/A
Denominator	N/A
Comparison Population	N/A
Measure Steward	N/A
Data Source	Administrator key informant interview
Frequency	N/A
Desired Direction	N/A
Analytic Approach	Qualitative Analysis
Notes for measure calculation	Interviews were conducted annually from 2020-2022.

Administrators' plan for program sustainability and anticipated challenges (Measure 12)	
Numerator	N/A
Denominator	N/A
Comparison Population	N/A

Administrators' plan for program sustainability and anticipated challenges (Measure 12)	
Measure Steward	N/A
Analytic Approach	Qualitative Analysis
Data Source	Administrator key informant interview
Frequency	N/A
Desired Direction	N/A
Notes for measure calculation	Interviews were conducted annually from 2020-2022.

Alaska tribal entities reported changes in quality of care and access to care following expansion of BH and SUD services (Measure 13)	
Numerator	N/A
Denominator	N/A
Comparison Population	N/A
Measure Steward	N/A
Data Source	Tribal Health Organization key informant interviews.
Frequency	N/A
Desired Direction	N/A
Analytic Approach	Qualitative Analysis
Notes for measure calculation	Interviews were conducted annually from 2020-2022.

Inpatient admissions for SUD, and specifically for OUD, by setting (Measure 14)	
Numerator	The number of inpatient discharges related to a SUD stay during the measurement period.
	The number of inpatient discharges related to an OUD stay during the measurement period. OUD is defined as having an ICD-10-CM diagnosis code in the Opioid Abuse and Dependence Value Set.
Denominator	The total number of unique waiver beneficiaries
Comparison Population	N/A
Analytic Approach	Interrupted time series analysis
Measure Steward	CMS
Data Source	MMIS
Frequency	Monthly
Desired Direction	Lower is better
Notes for measure calculation	Measure specifications rely on <i>Medicaid Section 1115 SUD Demonstrations: Technical Specifications for Monitoring Metrics, version 4.0</i> , Metric #24: Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries.

Inpatient admissions for behavioral health disorders, by setting (Measure 15)	
Numerator	The number of inpatient discharges related to a BH stay during the measurement period.
Denominator	The total number of unique waiver beneficiaries
Comparison Population	N/A
Analytic Approach	Interrupted time series analysis
Measure Steward	CMS
Data Source	MMIS
Frequency	Monthly
Desired Direction	Lower is better
Notes for measure calculation	Measure specifications rely on a modified <i>Medicaid Section 1115 SUD Demonstrations: Technical Specifications for Monitoring Metrics, version 4.0</i> , Metric #24: Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries. Instead of the Alcohol Abuse and Dependence, Opioid Abuse and Dependence, and Other Drug Abuse and Dependence value sets to identify SUD, this measure is modified to use the Mental Health diagnosis value set to identify BH disorders.

Emergency department visits for SUD, and specifically for OUD, by setting (Measure 16)	
Numerator	The number of ED visits for SUD during the measurement period.
Denominator	The number of ED visits for OUD during the measurement period. OUD is defined as having an ICD-10-CM in the Opioid Abuse and Dependence Value Set.
Comparison Population	N/A
Analytic Approach	Interrupted time series analysis
Measure Steward	CMS
Data Source	MMIS
Frequency	Monthly
Desired Direction	Lower is better
Notes for measure calculation	Measure specifications rely on <i>Medicaid Section 1115 SUD Demonstrations: Technical Specifications for Monitoring Metrics, version 4.0</i> , Metric #23: Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries.

Emergency department visits for a behavioral health disorder, by setting (Measure 17)	
Numerator	The number of ED visits for BH during the measurement period.
Denominator	The total number of unique waiver beneficiaries
Comparison Population	N/A
Analytic Approach	Interrupted time series analysis
Measure Steward	CMS
Data Source	MMIS
Frequency	Monthly

Emergency department visits for a behavioral health disorder, by setting (Measure 17)

Desired Direction	Lower is better
Notes for measure calculation	Measure specifications rely on modified <i>Medicaid Section 1115 SUD Demonstrations: Technical Specifications for Monitoring Metrics, version 4.0</i> , Metric #23: Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries. Instead of the Alcohol Abuse and Dependence, Opioid Abuse and Dependence, and Other Drug Abuse and Dependence value sets to identify SUD, this measure is modified to use the Mental Health diagnosis value set to identify BH disorders instead.

Mean length of stay measured from admission date to discharge date, by setting (Measure 18)

Numerator	The total number of days in an IMD for inpatient/residential discharges for SUD.
Denominator	The total number of discharges from an IMD for beneficiaries with an inpatient or residential treatment stay for SUD.
Comparison Population	N/A
Analytic Approach	Pre/post analysis
Measure Steward	CMS
Data Source	MMIS
Frequency	Annual
Desired Direction	Statewide goal of 30 days average length of stay.
Notes for measure calculation	Measure specifications rely on modified <i>Medicaid Section 1115 SUD Demonstrations: Technical Specifications for Monitoring Metrics, version 4.0</i> , Metric #36: Average Length of Stay in IMDs.

30-day readmission rate to inpatient facilities following hospitalization for an SUD related diagnosis, by setting (Measure 19)

Numerator	30-day inpatient and residential readmission rates for beneficiaries discharged with SUD diagnosis and readmitted to either inpatient or residential treatment facilities. The number of inpatient discharges with a principal diagnosis of SUD. Step 1: Calculate the Denominator: Count of Index Hospital Stays
Denominator	<u>Step 1a.</u> Identify all acute inpatient discharges with any diagnosis in the first 11 months of the measurement year. To identify acute inpatient discharges: Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>). Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>). Determine whether the discharge date for the stay falls in the first 11 months of the measurement year. Inpatient stays where the discharge date from the first setting and the admission date to the second setting are two or more calendar days apart must be considered distinct inpatient stays. This measure includes acute discharges from any type of acute facility (including behavioral healthcare facilities). <u>Step 1b.</u> Address acute-to-acute direct transfers. Exclude the hospital stay if the direct transfer’s discharge date occurs in the last 30 days of the measurement year.

30-day readmission rate to inpatient facilities following hospitalization for an SUD related diagnosis, by setting (Measure 19)

Step 1c. Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date.

Step 1d. Exclude hospital stays for the following reasons:
 The beneficiary died during the stay.
 Female beneficiaries with a principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim.
 A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim.

Note: For hospital stays where there was an acute-to-acute direct transfer (identified in Step 1), use both the original stay and the direct transfer stay to identify exclusions in this step.

Step 1e. Identify stays with a principal diagnosis for SUD (AOD Abuse and Dependence Value Set).

Step 1f. To calculate the count of Index Hospital Stays (i.e., the denominator), count the number of Index Hospital Stays that meet the criteria in Steps 1a-1e.

Comparison Population	N/A
Analytic Approach	Pre/post analysis
Measure Steward	N/A
Data Source	MMIS
Frequency	Annual
Desired Direction	Lower is better
Notes for measure calculation	Specifications for this measure were developed following modified <i>Medicaid Section 1115 SUD Demonstrations: Technical Specifications for Monitoring Metrics, version 4.0, Metric #25: Readmissions Among Beneficiaries with SUD v4.0.</i>

30-day readmission rate to inpatient facilities following hospitalization for a behavioral health related diagnosis, by setting (Measure 20)

Numerator	30-day inpatient and residential readmission rates for beneficiaries discharged with BH diagnosis and readmitted to either inpatient or residential treatment facilities. The number of inpatient discharges with a principal diagnosis of BH.
Denominator	Step 1: Calculate the Denominator: Count of Index Hospital Stays <u>Step 1a.</u> Identify all acute inpatient discharges with any diagnosis in the first 11 months of the measurement year. To identify acute inpatient discharges: Identify all acute and nonacute inpatient stays (<u>Inpatient Stay Value Set</u>). Exclude nonacute inpatient stays (<u>Nonacute Inpatient Stay Value Set</u>). Determine whether the discharge date for the stay falls in the first 11 months of the measurement year. Inpatient stays where the discharge date from the first setting and the admission date to the second setting are two or more calendar days apart must be considered distinct inpatient stays. This measure includes acute discharges from any type of acute facility (including behavioral healthcare facilities).

30-day readmission rate to inpatient facilities following hospitalization for a behavioral health related diagnosis, by setting (Measure 20)

Step 1b. Address acute-to-acute direct transfers. Exclude the hospital stay if the direct transfer’s discharge date occurs in the last 30 days of the measurement year.

Step 1c. Exclude hospital stays where the Index Admission Date is the same as the Index Discharge Date.

Step 1d. Exclude hospital stays for the following reasons:
 The beneficiary died during the stay.
 Female beneficiaries with a principal diagnosis of pregnancy (Pregnancy Value Set) on the discharge claim.
 A principal diagnosis of a condition originating in the perinatal period (Perinatal Conditions Value Set) on the discharge claim.

Note: For hospital stays where there was an acute-to-acute direct transfer (identified in Step 1), use both the original stay and the direct transfer stay to identify exclusions in this step.

Step 1e. Identify stays with a principal diagnosis for BH (Mental Health Diagnosis Value Set).

Step 1f. To calculate the count of Index Hospital Stays (i.e., the denominator), count the number of Index Hospital Stays that meet the criteria in Steps 1a-1e.

Comparison Population	N/A
Analytic Approach	Pre/post analysis
Measure Steward	N/A
Data Source	MMIS
Frequency	Annual
Desired Direction	Lower is better
Notes for measure calculation	Specifications for this measure were developed following modified <i>Medicaid Section 1115 SUD Demonstrations: Technical Specifications for Monitoring Metrics, version 4.0</i> , Metric #25: Readmissions Among Beneficiaries with SUD v4.0.

Number of beneficiaries with a SUD diagnosis including those with OUD who used services in the last month or year, by service or benefit type (Measure 21)

Numerator	The number of beneficiaries using the following services defined by <i>Medicaid Section 1115 SUD Demonstrations: Technical Specifications for Monitoring Metrics, version 4.0</i> : Metric #7: Early Intervention Metric #8: Outpatient Metric #9: Intensive Outpatient and Partial Hospitalization Metric #10: Residential and Inpatient Metric #11: Withdrawal Management Metric #12: Medication Assisted Treatment
Denominator	The total number of unique waiver beneficiaries with a SUD diagnosis (HEDIS MY 2020 AOD Abuse and Dependence Value Set)
Comparison Population	N/A
Analytic Approach	Interrupted time series analysis
Measure Steward	N/A

Number of beneficiaries with a SUD diagnosis including those with OUD who used services in the last month or year, by service or benefit type (Measure 21)

Data Source	MMIS
Frequency	Monthly
Desired Direction	Higher is better
Notes for measure calculation	

Number of beneficiaries with a behavioral health diagnosis who used services in the last month or year, by service or benefit type (Measure 22)

Numerator	The number of beneficiaries using the following services defined by HEDIS MY 2020 Specifications of Mental Health Utilization (MPT): Inpatient Intensive Outpatient or Partial Hospitalization Outpatient ED Telehealth Any service
Denominator	The total number of unique waiver beneficiaries with a BH diagnosis (HEDIS MY 2020 Mental Health Diagnosis Value Set)
Comparison Population	N/A
Analytic Approach	Interrupted time series analysis
Measure Steward	N/A
Data Source	MMIS
Frequency	Monthly
Desired Direction	Higher is better
Notes for measure calculation	

Time to treatment, by service type (National Behavioral Health Quality Framework [NBHQF] Goal 1) (Measure 23)

Numerator	Index episode start date (IESD) definition is aligned with HEDIS MY 2020 IET specifications for initiation of treatment. The total number of days from IESD, i.e., the earliest date of service for an eligible encounter with a diagnosis of alcohol, opioid, or other drug-related abuse or dependence, through an inpatient alcohol-related admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days.
Denominator	The total number of claims for initiation of alcohol, opioid, or other drug-related abuse treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis among waiver beneficiaries.
Comparison Population	N/A

Time to treatment, by service type (National Behavioral Health Quality Framework [NBHQF] Goal 1) (Measure 23)	
Analytic Approach	Pre/post analysis
Measure Steward	N/A
Data Source	MMIS
Frequency	Annual
Desired Direction	Lower is better
Notes for measure calculation	For an ED, inpatient stay, observation visits that result in an inpatient stay, or for detoxification that occurred during an inpatient stay, the index episode start date is considered the initiation of treatment. Time to treatment is set to 0 for these claims.

Access to physical health care (Measure 24)	
Numerator	The number of adult waiver members aged 20 and older who had an ambulatory or preventative care visit during the measurement year. The number of children and young adults 12 months – 19 years of age who had a visit with a primary care practitioner during the measurement year.
Denominator	The total number of unique adult waiver beneficiaries aged 20 and older. The total number of unique child waiver beneficiaries aged 12 months – 19 years.
Comparison Population	N/A
Analytic Approach	Pre/post analysis
Measure Steward	NCQA
Data Source	MMIS
Frequency	Annual
Desired Direction	Higher is better
Notes for measure calculation	This measure follows NCQA specifications for Adults’ Access to Preventive/Ambulatory Health Services (AAP) and Children and Adolescents’ Access to Primary Care Practitioners (CAP).

Screening for chronic conditions relevant to state Medicaid population (Measure 25)	
Numerator	The number of unique waiver beneficiaries screened for a chronic condition (Appendix Table A-19).
Denominator	The total number of unique waiver beneficiaries
Comparison Population	N/A
Analytic Approach	Pre/post analysis
Measure Steward	N/A
Data Source	MMIS
Frequency	Annual
Desired Direction	Higher is better
Notes for measure calculation	

Screening for co-morbidity of behavioral health and substance use disorders within the waiver population compared to the total Medicaid population (Measure 26)

Numerator	<p><u>Rate Indicator 1:</u> The number of unique beneficiaries with a SUD diagnosis (denominator rate indicator 1) screened for symptoms of BH, as defined by Measure 2 (Beneficiaries screened for symptoms of BH using industry recognized, evidence-based screening instruments).</p> <p><u>Rate Indicator 2:</u> The number of unique beneficiaries with a BH diagnosis (denominator rate indicator 2) screened for symptoms of SUD, as defined by Measure 1 (Beneficiaries screened for symptoms of SUD using industry recognized, evidence-based screening instruments).</p>
Denominator	<p><u>Rate Indicator 1:</u> The number of unique beneficiaries (de-duplicated total) enrolled in the measurement period who receive MAT or have qualifying facility, provider, or pharmacy claims with a SUD diagnosis and a SUD-related treatment service during the measurement period and/or in the 11 months before the measurement period</p> <p><u>Rate Indicator 2:</u> The number of unique beneficiaries (de-duplicated total) enrolled in the measurement period diagnosed with a BH disorder.</p>
Comparison Population	N/A
Analytic Approach	Pre/post analysis
Measure Steward	N/A
Data Source	MMIS
Frequency	Annual
Desired Direction	Higher is better
Notes for measure calculation	Two rate indicators were combined to provide a composite rate score of screening for co-morbid BH and SUD conditions.

Percentage of beneficiaries who rate the quality of their of health care as very good or excellent (Measure 27)

Summary rates are evaluated based on an 8+9+10 top-box rating system as indicated in the table below. The response score value or numerator compliance for each member answering the following question:

“Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?”

Responses and their corresponding score values and numerator compliance are as follows:

Numerator

Response Choices	Score Value
0 – Worst health care possible	0
1	0
2	0
3	0
4	0
5	0
6	0
7	0

Percentage of beneficiaries who rate the quality of their of health care as very good or excellent (Measure 27)							
	<table border="1"> <tr> <td>8</td> <td>1</td> </tr> <tr> <td>9</td> <td>1</td> </tr> <tr> <td>10 – Best health care possible</td> <td>1</td> </tr> </table>	8	1	9	1	10 – Best health care possible	1
8	1						
9	1						
10 – Best health care possible	1						
Denominator	The number of respondents who had a valid response to the question indicated in the numerator.						
Comparison Population	N/A						
Analytic Approach	Descriptive analysis						
Measure Steward	CAHPS						
Data Source	Beneficiary survey						
Frequency	Once						
Desired Direction	Higher is better						
Notes for measure calculation	Rates for calculated for both adult respondents and child respondents.						

Percentage of beneficiaries who rate overall mental or emotional health as very good or excellent (Measure 28)													
Numerator	<p>Summary rates will be evaluated based on a very good + excellent top-box rating system indicated in the table below. The numerator will be defined as the response score value or numerator compliance for each member answering the following question:</p> <p>“In general, how would you rate your overall mental or emotional health?</p> <p>Responses and their corresponding score values and numerator compliance are as follows:</p> <table border="1"> <thead> <tr> <th>Response Choices</th> <th>Score Value</th> </tr> </thead> <tbody> <tr> <td>Excellent</td> <td>1</td> </tr> <tr> <td>Very good</td> <td>1</td> </tr> <tr> <td>Good</td> <td>0</td> </tr> <tr> <td>Fair</td> <td>0</td> </tr> <tr> <td>Poor</td> <td>0</td> </tr> </tbody> </table>	Response Choices	Score Value	Excellent	1	Very good	1	Good	0	Fair	0	Poor	0
Response Choices	Score Value												
Excellent	1												
Very good	1												
Good	0												
Fair	0												
Poor	0												
Denominator	The number of respondents who had a valid response to the question indicated in the numerator.												
Comparison Population	N/A												
Analytic Approach	Descriptive analysis												
Measure Steward	CAHPS												
Data Source	Beneficiary survey												
Frequency	Once												
Desired Direction	Higher is better												
Notes for measure calculation	Rates for calculated for both adult respondents and child respondents.												

Percentage of beneficiaries who demonstrate very good or excellent knowledge of available treatment and services (Measure 29)

Numerator

Two indicators for this measure were calculated:
The number of beneficiaries who responded yes to the following questions:
“If you needed treatment for substance abuse, do you know how you can receive this treatment?”
“If you needed treatment for behavioral or mental health concerns, do you know how you can receive this treatment?”

The total number of “Yes” responses per beneficiary to each of the following questions:

For SUD:

Do you know how you can receive one-on-one help from a person who has training to help treat substance abuse?

Do you know how you can get group therapy treatment for substance abuse in your community, such as rehab or recovery therapy in a group setting led by a licensed health professional?

Do you know how you can receive help from a person who has training to treat substance abuse, who would meet with you and your family (family therapist or counselor)?

Do you know how you can get treatment or support for substance abuse from someone who has already recovered from substance abuse (for example, peer mentoring or coaching)?

Are you aware of any place you can stay to receive treatment 24 hours a day, seven days a week for substance abuse?

If you wanted to get medication-assisted treatment (MAT) for substance abuse, do you know where to go? MAT refers to the use of medicines such as methadone, Suboxone, or buprenorphine to treat opioid addiction and reduce withdrawal symptoms.

For BH:

Do you know how you can receive one-on-one help from a person who has training to help treat behavioral or mental health concerns?

Do you know how you can get group therapy treatment for behavioral or mental health programs in your community, such as therapy in a group setting led by a counselor? Examples include group therapy for anxiety, depression, panic disorders, family concerns, etc.

Do you know how you can receive help from a person who has training to treat behavioral and mental health concerns, who would meet with you and your family (family therapist or counselor)?

Do you know how you can get treatment or support for behavioral or mental health concerns offered by someone who has already recovered from mental or behavioral health concerns (for example, peer mentoring or coaching)?

Are you aware of any place you can stay to receive treatment 24 hours a day, seven days a week for behavioral or mental health concerns?

Do you know if there are options for you to meet with a person who has training to help treat behavioral or mental health concerns through the phone or computer?

Denominator

Percentage of beneficiaries who demonstrate very good or excellent knowledge of available treatment and services (Measure 29)

The number of respondents who had a valid response to the question indicated in the numerator.
Results presented as a histogram for number of SUD/BH services known indicator.

Comparison Population	N/A
Analytic Approach	Descriptive analysis
Measure Steward	CAHPS
Data Source	Beneficiary survey
Frequency	Once
Desired Direction	Higher is better
Notes for measure calculation	Rates for calculated for both adult respondents and child respondents.

Maternal depression (Measure 30)

Two indicators of maternal depression were calculated:
Maternal depression composite indicator
Sum the number of respondents’ answers to the following questions:
During the past 3 months, how often have you felt down, depressed, or hopeless? (1-5)
During the past 3 months, how often have you had little interest or little pleasure in doing things you usually enjoyed? (1-5)
Responses are coded as follows:

1	Always
2	Often
3	Sometimes
4	Rarely
5	Never

Numerator

Then, divide by two to get an average composite score.
Provider discussion indicator
During the past 12 months, did a doctor, nurse or other health care or mental health provider talk to you about depression or how you are feeling emotionally? (Yes/No)
Sum the number of respondents who answered “Yes” to this question.

Denominator

The maternal depression composite indicator does not have a denominator, as we are calculating average composite score.
The denominator for the provider discussion indicator is the number of respondents who self-reported that their child was covered by Medicaid and had a valid response to the questions indicated in the numerator.

Comparison Population	N/A
Analytic Approach	Pre/post analysis
Measure Steward	N/A
Data Source	CUBS

Maternal depression (Measure 30)	
Frequency	Annual
Desired Direction	For the maternal depression composite indicator, higher is better. For the provider discussion indicator, lower is better.
Notes for measure calculation	Data for the maternal depression composite indicator was available for 2012-2020. Data for the provider discussion indicator was available for 2015-2020.

Maternal domestic abuse (Measure 31)	
Numerator	The number of respondents answering they were physically hurt or made to feel unsafe by their partner from one of the following questions: During the past 12 months, did your husband or partner push, hit, slap, kick, choke or physically hurt you in any other way? (Yes/No); <i>or</i> During the past 12 months, did your husband or partner threaten you, limit your activities against your will or make you feel unsafe in any other way? (Yes/No) Respondents who answered “Yes” to at least one of the above questions will be assigned a “1” for this measure overall. Respondents not answering “Yes” both of the above questions will be assigned a “0” for this measure overall.
Denominator	The number of respondents who self-reported that their child was covered by Medicaid and had a valid response to the questions indicated in the numerator.
Comparison Population	N/A
Analytic Approach	Pre/post analysis
Measure Steward	N/A
Data Source	CUBS
Frequency	Annual
Desired Direction	Lower is better
Notes for measure calculation	Data for this measure was available for 2012-2020.

Percentage of beneficiaries who experienced alcoholism or mental health disorder among household members (Measure 32)	
Numerator	The number of respondents who self-reported that their child was enrolled in Medicaid and who answered that the child experienced alcoholism or mental health disorder among household members. Has your child ever experienced any of the following events or situations? For each event circle Y(Yes) or circle N(No). Phase 4 – Alcoholism or mental health disorder in family Phase 5 – Alcoholism or mental health disorder among household members Phase 6 (a ‘Yes’ for either of these questions constitutes a ‘Yes’ for the numerator) Living with someone who had a problem with alcohol or drugs Living with someone who was mentally ill, suicidal, or severely depressed

Percentage of beneficiaries who experienced alcoholism or mental health disorder among household members (Measure 32)

Denominator	The number of respondents who self-reported that their child was covered by Medicaid and had a valid response to the questions indicated in the numerator.
Comparison Population	N/A
Analytic Approach	Pre/post analysis
Measure Steward	N/A
Data Source	CUBS
Frequency	Annual
Desired Direction	Lower is better
Notes for measure calculation	Data for this measure was available for 2012-2020.

Percentage of beneficiaries who witnessed violence or physical abuse between household members (Measure 33)

Numerator	The number of respondents who self-reported that their child was enrolled in Medicaid and who answered that the child witnessed violence or physical abuse between household members.
Denominator	The number of respondents who self-reported that their child was covered by Medicaid and had a valid response to the question indicated in the numerator.
Comparison Population	N/A
Analytic Approach	Pre/post analysis
Measure Steward	N/A
Data Source	CUBS
Frequency	Annual
Desired Direction	Lower is better
Notes for measure calculation	Data for this measure was available for 2015-2020.

Percentage of youth beneficiaries who have ever been physically hurt by an adult in any way (Measure 34)

Numerator	The number of respondents who self-reported that their child was enrolled in Medicaid and who answered that their child has ever been physically hurt by an adult in any way.
Denominator	The number of respondents who self-reported that their child was covered by Medicaid and had a valid response to the question indicated in the numerator.
Comparison Population	N/A
Analytic Approach	Descriptive
Measure Steward	N/A
Data Source	CUBS
Frequency	Annual
Desired Direction	Lower is better
Notes for measure calculation	Data for this measure was available for 2015-2020.

Maternal marijuana or hash use in the past two years (Measure 35)	
Numerator	The number of respondents who answered they have used marijuana or hash in the past 2 years.
Denominator	The number of respondents who self-reported that their child was covered by Medicaid and had a valid response to the question indicated in the numerator.
Comparison Population	N/A
Analytic Approach	Descriptive
Measure Steward	N/A
Data Source	CUBS
Frequency	Annual
Desired Direction	Lower is better
Notes for measure calculation	Data for this measure was available for 2015-2020.

Frequency of maternal marijuana or hash use (days per week) (Measure 36)	
Numerator	The sum of the average number of days respondents report using marijuana or hash per week.
Denominator	The number of respondents who self-report that their child was enrolled in Medicaid and had a valid response to the question indicated in the numerator.
Comparison Population	N/A
Analytic Approach	Pre/post analysis
Measure Steward	N/A
Data Source	CUBS
Frequency	Annual
Desired Direction	Lower is better
Notes for measure calculation	Data for this measure was available for 2015-2020. From 2015-2019 this question was asked in terms of average days per week marijuana was used. In 2020, this question was asked in terms of average days per month that marijuana was used. Responses from 2020 were converted to average days per week of marijuana use for consistency.

Social support – care when sick (Supplemental CUBS Measure 1)	
Numerator	The number of respondents who answered they know someone who would help them if they were sick.
Denominator	The number of respondents who self-reported that their child was covered by Medicaid and had a valid response to the question indicated in the numerator.
Comparison Population	N/A
Analytic Approach	Descriptive
Measure Steward	N/A
Data Source	CUBS
Frequency	Annual
Desired Direction	Higher is better

Social support – care when sick (Supplemental CUBS Measure 1)

Notes for measure calculation Data for this measure was available for 2012-2020.

Desire to Obtain SUD/BH Treatment Options and Obtainment of SUD Treatment in the Past 3 Months (Supplemental CUBS Measure 2)

	<u>Three individual indicators of desire to obtain SUD/BH treatment and obtainment of SUD treatment were calculated:</u>
Numerator	<p>The number of respondents who answered they had a desire to obtain SUD treatment in the past 3 months.</p> <p>The number of respondents who answered they had a desire to obtain BH treatment in the past 3 months.</p> <p>The number of respondents who answered they had obtained SUD treatment in the past 3 months.</p>
Denominator	The number of respondents who self-reported that their child was covered by Medicaid and had a valid response to the respective question indicated in the numerator.
Comparison Population	N/A
Analytic Approach	Descriptive
Measure Steward	N/A
Data Source	CUBS
Frequency	Annual
Desired Direction	Higher is better
Notes for measure calculation	Data for this measure was only available for 2020.

Rate of overdose deaths, specifically overdose deaths due to any opioid (Measure 37)

Numerator	The number of overdose deaths among Alaska residents.
Denominator	The number of Alaska residents.
Comparison Population	N/A
Analytic Approach	Pre/post analysis
Measure Steward	N/A
Data Source	Alaska Health Analytics and Vital Records/American Community Survey
Frequency	Annual
Desired Direction	Lower is better
Notes for measure calculation	

Non-fatal Overdoses (all cause) (Measure 38)

Numerator	The number of non-fatal overdoses among waiver beneficiaries.
Denominator	N/A

Non-fatal Overdoses (all cause) (Measure 38)	
Comparison Population	N/A
Analytic Approach	Pre/post analysis
Measure Steward	N/A
Data Source	MMIS
Frequency	Annual
Desired Direction	Lower is better
Notes for measure calculation	Drug overdoses were defined as having a principal or secondary diagnosis ICD-10-CM code in T36–T50, encounter=A, intent = 1-4. Only one non-fatal overdose is counted per waiver beneficiary stay.

Use of Opioids at High Dosage in Persons Without Cancer (NQF 2940) (Measure 39)	
Numerator	The number beneficiaries aged 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice are excluded.
Denominator	All Medicaid beneficiaries within the eligible population defined in the measure steward's specifications.
Comparison Population	N/A
Analytic Approach	Pre/post analysis
Measure Steward	CMS SUD Monitoring Metrics, CMS Adult Core Set
Data Source	DBH
Frequency	Annual
Desired Direction	Lower is better
Notes for measure calculation	Measure specifications rely on <i>Medicaid Section 1115 SUD Demonstrations: Technical Specifications for Monitoring Metrics, version 4.0</i> , Metric #18: Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD).

Total costs of healthcare (sum of parts below), by state and federal share (Measure 40)	
Numerator	<p>The sum of total paid claim amounts for all inpatient, long-term care, outpatient, professional, dental and pharmacy categories of service for members flagged with an SUD or BH diagnosis.</p> <p>Members flagged with an SUD diagnosis are those enrolled in the measurement period and who receive MAT or have qualifying facility, provider, or pharmacy claims with a SUD diagnosis and a SUD-related treatment service during the measurement period.</p> <p>Step 1. Identify claims for MAT, defined in one of the following HEDIS MY 2020 IET Value Sets or Medications Lists:</p> <ul style="list-style-type: none"> AOD Medication Treatment Value Set Alcohol Use Disorder Treatment Medication Lists Opioid Use Disorder Treatment Medication Lists

Total costs of healthcare (sum of parts below), by state and federal share (Measure 40)	
	<p>Step 2. Identify claims with a diagnosis code (any diagnosis on the claim) listed under one of the following HEDIS MY 2020 Value Sets:</p> <p><u>Alcohol Abuse and Dependence</u></p> <p><u>Opioid Abuse and Dependence</u></p> <p><u>Other Drug Abuse and Dependence</u></p> <p>Members flagged with a BH diagnosis are those enrolled in the measurement period and who have a claim with a diagnosis code from the HEDIS MY 2020 <u>Mental Health Diagnosis Value Set</u> during the measurement period.</p> <p><u>Members are considered a part of the SUD/BH cost analysis group beginning the first month in which they have a relevant diagnosis or treatment claim for either SUD or BH, and up to 11 additional months that did not include relevant claims, if the beneficiary remained enrolled in Medicaid. If a member has additional claims with a relevant diagnosis or treatment code, their inclusion in the SUD/BH cost analysis group is extended to include up to 11 additional months following the subsequent claim, if the member remained enrolled in Medicaid.</u></p>
Denominator	The total number of member months among beneficiaries in the SUD/BH cost analysis group.
Comparison Population	
Analytic Approach	Interrupted time series analysis
Measure Steward	CMS
Data Source	MMIS
Frequency	Monthly
Desired Direction	Lower is better
Notes for measure calculation	Methodology for assessing costs follows CMS SMI/SED Evaluation Design Guidance: Appendix C, https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/smi-sed-sud-cost-appendix-c.pdf ; last accessed November 1, 2022.

Total cost of SUD, SUD-IMD and SUD-Other and Non-SUD, by setting (including claims data (inpatient (IP), outpatient (OT), pharmacy (RX), long-term care (LT), and capitated payments to managed care organizations) (Measure 41)	
Numerator	<p>The sum of total paid claim amounts stratified by SUD-IMD, SUD-Other, Non-SUD, inpatient, long-term care, outpatient, professional, dental and pharmacy categories of service for members flagged with an SUD diagnosis. Outpatient costs were further stratified into ED and non-ED categories of service.</p> <p>Members flagged with an SUD diagnosis are those enrolled in the measurement period and who receive MAT or have qualifying facility, provider, or pharmacy claims with a SUD diagnosis and a SUD-related treatment service during the measurement period.</p> <p>Step 1. Identify claims for MAT, defined in one of the following HEDIS MY 2020 IET Value Sets or Medications Lists:</p> <p><u>AOD Medication Treatment Value Set</u></p> <p><u>Alcohol Use Disorder Treatment Medication Lists</u></p> <p><u>Opioid Use Disorder Treatment Medication Lists</u></p>

Total cost of SUD, SUD-IMD and SUD-Other and Non-SUD, by setting (including claims data (inpatient (IP), outpatient (OT), pharmacy (RX), long-term care (LT), and capitated payments to managed care organizations) (Measure 41)

Step 2. Identify claims with a diagnosis code (any diagnosis on the claim) listed under one of the following HEDIS MY 2020 Value Sets:

Alcohol Abuse and Dependence

Opioid Abuse and Dependence

Other Drug Abuse and Dependence

Members are considered a part of the SUD cost analysis group beginning the first month in which they have a relevant diagnosis or treatment claim for SUD, and up to 11 additional months that did not include relevant claims, if the beneficiary remained enrolled in Medicaid. If a member has additional claims with a relevant diagnosis or treatment code, their inclusion in the SUD cost analysis group is extended to include up to 11 additional months following the subsequent claim, if the member remained enrolled in Medicaid.

SUD-IMD and SUD-Other costs included costs from:

Claims with a diagnosis code from one of the following MAT medications lists:

Alcohol Abuse and Dependence

Opioid Abuse and Dependence

Other Drug Abuse and Dependence value sets.

Claims for MAT defined by:

AOD Medication Treatment value Set

Alcohol Use Disorder Treatment Medication Lists

Opioid Use Disorder Treatment Medication Lists

Claims with SUD /MAT treatment codes

H0009, H0010, H0011, H2036, H0047, H0023, H0014, H2021, H0015, T1007, H0035

SUD-IMD costs were costs incurred from claims with an IMD provider. SUD-Other

costs are all other SUD costs from claims for a non-IMD provider. HSAG used the DBH provided list of Billing Provider NPIs and Billing provider IDs to flag IMD providers.

Non-SUD costs included all other costs from non-SUD claims for the member.

Denominator	The total number of member months among beneficiaries in the SUD cost analysis group.
Comparison Population	N/A
Analytic Approach	Interrupted time series analysis
Measure Steward	CMS
Data Source	MMIS
Frequency	Monthly
Desired Direction	Lower is better
Notes for measure calculation	Methodology for assessing costs follows CMS SMI/SED Evaluation Design Guidance: Appendix C, https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/smi-sed-sud-cost-appendix-c.pdf ; last accessed November 1, 2022.

Total cost of behavioral health diagnosis by IMD and Other, by setting (including claims data (inpatient (IP), outpatient (OT), pharmacy (RX), long-term care (LT), and capitated payments to managed care organizations) (Measure 42)	
Numerator	<p>The sum of total paid claim amounts stratified by BH-IMD, BH-Other, Non-BH, inpatient, long-term care, outpatient, professional, dental and pharmacy categories of service for members flagged with an BH diagnosis.</p> <p>Members flagged with a BH diagnosis are those enrolled in the measurement period and who have a claim with a diagnosis code from the HEDIS MY 2020 <u>Mental Health Diagnosis Value Set</u> during the measurement period.</p> <p><u>Members are considered a part of the BH cost analysis group beginning the first month in which they have a relevant diagnosis or treatment claim for BH, and up to 11 additional months that did not include relevant claims, if the beneficiary remained enrolled in Medicaid. If a member has additional claims with a relevant diagnosis or treatment code, their inclusion in the BH cost analysis group is extended to include up to 11 additional months following the subsequent claim, if the member remained enrolled in Medicaid.</u></p> <p>BH-IMD and BH-Other costs included costs from: Claims with a diagnosis code from the HEDIS MY 2020 Mental Health Diagnosis Value Set Claims from medication lists for BH put together by HSAG’s clinical experts BH-IMD costs were costs incurred from claims with an IMD provider. BH-Other costs are all other BH costs from claims for a non-IMD provider. HSAG used the DBH-provided list of Billing Provider NPIs and Billing provider IDs to flag IMD providers. Non-BH costs included all other costs from non-BH claims for the member.</p>
Denominator	The total number of member months among beneficiaries in the BH cost analysis group.
Comparison Population	N/A
Analytic Approach	Interrupted time series analysis
Measure Steward	CMS
Data Source	MMIS
Frequency	Monthly
Desired Direction	Lower is better
Notes for measure calculation	Methodology for assessing costs follows CMS SMI/SED Evaluation Design Guidance: Appendix C, https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/smi-sed-sud-cost-appendix-c.pdf ; last accessed November 1, 2022.

Appendix E. Survey Instruments

Health Services Advisory Group, Inc. (HSAG) utilized a questionnaire to facilitate a beneficiary phone survey for adults and children. The questionnaires are provided below for reference.

Adult Beneficiary Survey Questionnaire

Introduction		
<p>This document contains telephone interviewing instructions for the Adult 2021 Alaska Department of Behavioral Health knowledge assessment survey. This survey is conducted as part of the evaluation of the Substance Use Disorder 1115 Waiver Demonstration.</p>		
Survey Question	Telephone Interviewing Specifications	Comments
	<p>>Intro< Hello, I'm calling on behalf of the Alaska Department of Health and Social Services to conduct an important study and would like your feedback. We are conducting this study to find out members' knowledge of services that Alaska Medicaid offers. The results of the study will help the Department improve the care they provide. If at any time you wish to end the survey you may do so.</p> <p>The interview is completely confidential and voluntary and will not affect your health care or benefits in any way. This call will be recorded and may be monitored for quality and training purposes.</p> <p>[Q1]</p>	
	<p>Survey vendors with different Telephone Interviewing systems may have their own preferred "path" for establishing contact with a respondent and beginning the interview. The screen shown above assumes that the interviewer is already speaking to the sampled respondent.</p> <p>The interviewer should only read or clarify response choices if necessary. For questions with a Yes/No answer, only read the answer choices "YES" and "NO" if necessary. For all questions, do not read response options for UNCERTAIN/UNSURE, NOT ASCERTAINED or DECLINED TO DISCLOSE.</p>	

Survey Question	Telephone Interviewing Specifications	Comments
<p>1. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months? Do <u>not</u> include care you got when you stayed overnight in a hospital. Do <u>not</u> include the times you went for dental care visits.</p> <p> <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 Worst health care Best health care </p>	<p>Now I'm going to ask you some questions about your own health care from a clinic, emergency room, or doctor's office. This includes care you got in person, by phone, or by video. When you answer these questions, please provide one answer for each question, unless otherwise instructed.</p> <p>Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months? Do <u>not</u> include care you got when you stayed overnight in a hospital. Do <u>not</u> include the times you went for dental care visits.</p> <p>{READ RESPONSE CHOICES ONLY IF NECESSARY}</p> <p><00> 0 [Q2] <01> 1 [Q2] <02> 2 [Q2] <03> 3 [Q2] <04> 4 [Q2] <05> 5 [Q2] <06> 6 [Q2] <07> 7 [Q2] <08> 8 [Q2] <09> 9 [Q2] <10> 10 [Q2]</p> <p><99> DECLINED TO DISCLOSE [Q2]</p>	
<p>2. In general, how would you rate your overall health?</p> <p> <input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor </p>	<p>In general, how would you rate your overall health? Would you say it is...</p> <p> <1> Excellent, [Q3] <2> Very Good, [Q3] <3> Good, [Q3] <4> Fair, or [Q3] <5> Poor? [Q3] </p> <p><9> DECLINED TO DISCLOSE [Q3]</p>	
<p>3. In general, how would you rate your overall <u>mental or emotional</u> health?</p>	<p>In general, how would you rate your overall <u>mental or emotional</u> health? Would you say it is...</p> <p> <1> Excellent, [Q4] <2> Very Good, [Q4] <3> Good, [Q4] <4> Fair, or [Q4] <5> Poor? [Q4] </p> <p><9> DECLINED TO DISCLOSE [Q4]</p>	

Survey Question	Telephone Interviewing Specifications	Comments
	<p>These next questions ask you about your knowledge and awareness of treatment services that may be available to you and covered through Medicaid. These services are about treatment for substance abuse. Substance abuse refers to an inability to control the use of legal or illegal drugs or medications, such as alcohol, marijuana, nicotine, opioids, or pain killers.</p> <p>For each of the following questions, please consider where you might go to obtain these services if you needed them, even if you do not need them right now.</p>	
<p>4. If you needed treatment for substance abuse, do you know how you can receive this treatment?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No → If NO, SKIP to Question 11</p>	<p>If you needed treatment for substance abuse, do you know how you can receive this treatment?</p> <p><1> YES [Q5]</p> <p><2> NO [Q11]</p> <p><3> UNCERTAIN/UNSURE [Q5]</p> <p><8> NOT ASCERTAINED [Q5]</p> <p><9> DECLINED TO DISCLOSE [Q11]</p>	
<p>5. Do you know how you can receive <u>one-on-one</u> help from a person who has training to help treat substance abuse?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>Do you know how you can receive one-on-one help from a person who has training to help treat substance abuse?</p> <p><1> YES [Q6]</p> <p><2> NO [Q6]</p> <p><3> UNCERTAIN/UNSURE [Q6]</p> <p><8> NOT ASCERTAINED [Q6]</p> <p><9> DECLINED TO DISCLOSE [Q6]</p>	
<p>6. Do you know how you can get <u>group therapy treatment</u> for substance abuse in your community, such as rehab or recovery therapy in a group setting led by a licensed health professional?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>Do you know how you can get group therapy treatment for substance abuse in your community, such as rehab or recovery therapy in a group setting led by a licensed health professional?</p> <p><1> YES [Q7]</p> <p><2> NO [Q7]</p> <p><3> UNCERTAIN/UNSURE [Q7]</p> <p><8> NOT ASCERTAINED [Q7]</p> <p><9> DECLINED TO DISCLOSE [Q7]</p>	

Survey Question	Telephone Interviewing Specifications	Comments
<p>7. Do you know how you can receive help from a person who has training to treat substance abuse, who would meet with you and your family (family therapist or counselor)?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>Do you know how you can receive help from a person who has training to treat substance abuse, who would meet with you and your family, also called a family therapist or counselor?</p> <p><1> YES [Q8]</p> <p><2> NO [Q8]</p> <p><3> UNCERTAIN/UNSURE [Q8]</p> <p><8> NOT ASCERTAINED [Q8]</p> <p><9> DECLINED TO DISCLOSE [Q8]</p>	
<p>8. Do you know how you can get treatment or support for substance abuse from someone who has <u>already recovered from substance abuse</u> (for example, peer mentoring or coaching)?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>Do you know how you can get treatment or support for substance abuse from someone who has already recovered from substance abuse (for example, peer mentoring or coaching)?</p> <p><1> YES [Q9]</p> <p><2> NO [Q9]</p> <p><3> UNCERTAIN/UNSURE [Q9]</p> <p><8> NOT ASCERTAINED [Q9]</p> <p><9> DECLINED TO DISCLOSE [Q9]</p>	
<p>9. Are you aware of any place you can stay to receive treatment 24 hours a day, seven days a week for substance abuse?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>Are you aware of any place you can stay to receive treatment 24 hours a day, seven days a week for substance abuse?</p> <p><1> YES [Q10]</p> <p><2> NO [Q10]</p> <p><3> UNCERTAIN/UNSURE [Q10]</p> <p><8> NOT ASCERTAINED [Q10]</p> <p><9> DECLINED TO DISCLOSE [Q10]</p>	
<p>10. If you wanted to get medication-assisted treatment (MAT) for substance abuse, do you know where to go? MAT refers to the use of medicines such as methadone, Suboxone, or buprenorphine to treat opioid addiction and reduce withdrawal symptoms.</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>If you wanted to get medication-assisted treatment or M.A.T. for substance abuse, do you know where to go? MAT refers to the use of medicines such as methadone, Suboxone, or buprenorphine to treat opioid addiction and reduce withdrawal symptoms.</p> <p><1> YES [Q11]</p> <p><2> NO [Q11]</p> <p><3> UNCERTAIN/UNSURE [Q11]</p> <p><8> NOT ASCERTAINED [Q11]</p> <p><9> DECLINED TO DISCLOSE [Q11]</p>	

Survey Question	Telephone Interviewing Specifications	Comments
	<p>Now I'm going to ask you about the same type of services but for mental or behavioral health concerns. Mental or behavioral health concerns refer to concerns like stress, anxiety, depression and other mood disorders, personality disorders, psychotic disorders such as Schizophrenia, eating disorders, obsessive-compulsive disorder or OCD, or post-traumatic stress disorder or PTSD. This does not include substance abuse/misuse.</p> <p>Again, please provide one answer for each question, unless otherwise instructed.</p>	
<p>11. If you needed treatment for behavioral or mental health concerns, do you know how you can receive this treatment?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No → If NO, SKIP to Question 18</p>	<p>If you needed treatment for behavioral or mental health concerns, do you know how you can receive this treatment?</p> <p><1> YES [Q12]</p> <p><2> NO [Q18]</p> <p><3> UNCERTAIN/UNSURE [Q12]</p> <p><8> NOT ASCERTAINED [Q12]</p> <p><9> DECLINED TO DISCLOSE [Q18]</p>	
<p>12. Do you know how you can receive <u>one-on-one</u> help from a person who has training to help treat behavioral or mental health concerns?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>Do you know how you can receive one-on-one help from a person who has training to help treat behavioral or mental health concerns?</p> <p><1> YES [Q13]</p> <p><2> NO [Q13]</p> <p><3> UNCERTAIN/UNSURE [Q13]</p> <p><8> NOT ASCERTAINED [Q13]</p> <p><9> DECLINED TO DISCLOSE [Q13]</p>	

Survey Question	Telephone Interviewing Specifications	Comments
<p>13. Do you know how you can get group therapy treatment for behavioral or mental health programs in your community, such as therapy in a group setting led by a counselor? Examples include group therapy for anxiety, depression, panic disorders, family concerns, etc.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Do you know how you can get group therapy treatment for behavioral or mental health programs in your community? Group therapy is treatment you can get in a group setting led by a counselor.? Examples include group therapy for anxiety, depression, panic disorders, family concerns.</p> <p><1> YES [Q14] <2> NO [Q14] <3> UNCERTAIN/UNSURE [Q14]</p> <p><8> NOT ASCERTAINED [Q14] <9> DECLINED TO DISCLOSE [Q14]</p>	
<p>14. Do you know how you can receive help from a person who has training to treat behavioral and mental health concerns, who would meet with you and your family (family therapist or counselor)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Do you know how you can receive help from a person who has training to treat behavioral or mental health concerns, who would meet with you and your family, also known as a family therapist or counselor?</p> <p><1> YES [Q15] <2> NO [Q15] <3> UNCERTAIN/UNSURE [Q15]</p> <p><8> NOT ASCERTAINED [Q15] <9> DECLINED TO DISCLOSE [Q15]</p>	
<p>15. Do you know how you can get treatment or support for behavioral or mental health concerns offered by someone who has <u>already recovered from mental or behavioral health concerns</u> (for example, peer mentoring or coaching)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Do you know how you can get treatment or support for behavioral or mental health concerns offered by someone who has <u>already recovered from mental or behavioral health concerns</u> (for example, peer mentoring or coaching)?</p> <p><1> YES [Q16] <2> NO [Q16] <3> UNCERTAIN/UNSURE [Q16]</p> <p><8> NOT ASCERTAINED [Q16] <9> DECLINED TO DISCLOSE [Q16]</p>	

Survey Question	Telephone Interviewing Specifications	Comments
<p>16. Are you aware of any place you can stay to receive treatment <u>24 hours a day, seven days a week</u> for behavioral or mental health concerns?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>Are you aware of any place you can stay to receive treatment 24 hours a day, seven days a week for behavioral or mental health concerns?</p> <p><1> YES [Q17]</p> <p><2> NO [Q17]</p> <p><3> UNCERTAIN/UNSURE [Q17]</p> <p><8> NOT ASCERTAINED [Q17]</p> <p><9> DECLINED TO DISCLOSE [Q17]</p>	
<p>17. Do you know if there are options for you to meet with a person who has training to help treat behavioral or mental health concerns through the phone or computer?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>Do you know if there are options for you to meet with a person who has training to help treat behavioral or mental health concerns through the phone or computer?</p> <p><1> YES [Q18]</p> <p><2> NO [Q18]</p> <p><3> UNCERTAIN/UNSURE [Q18]</p> <p><8> NOT ASCERTAINED [Q18]</p> <p><9> DECLINED TO DISCLOSE [Q18]</p>	
<p>18. What is your age?</p> <p><input type="checkbox"/> 18 to 24</p> <p><input type="checkbox"/> 25 to 34</p> <p><input type="checkbox"/> 35 to 44</p> <p><input type="checkbox"/> 45 to 54</p> <p><input type="checkbox"/> 55 to 64</p> <p><input type="checkbox"/> 65 to 74</p> <p><input type="checkbox"/> 75 or older</p>	<p>What is your age?</p> <p>{IF NECESSARY: "Are you..." THEN READ RESPONSE CHOICES}</p> <p><1> 18 to 24, [Q19]</p> <p><2> 25 to 34, [Q19]</p> <p><3> 35 to 44, [Q19]</p> <p><4> 45 to 54, [Q19]</p> <p><5> 55 to 64, [Q19]</p> <p><6> 65 to 74, or [Q19]</p> <p><7> 75 or older. [Q19]</p> <p><9> DECLINED TO DISCLOSE [Q19]</p>	
	<p>The respondent should report age as of his or her last birthday. Do not round. Reading response choices is optional.</p>	
<p>19. What is your gender?</p> <p><input type="checkbox"/> Male</p> <p><input type="checkbox"/> Female</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> Decline to disclose</p>	<p>What is your gender?</p> <p><1> MALE [Q20]</p> <p><2> FEMALE [Q20]</p> <p><3> OTHER [Q20]</p> <p><9> DECLINED TO DISCLOSE [Q20]</p>	

Survey Question	Telephone Interviewing Specifications	Comments
<p>20. What is the highest grade or level of school that you have completed?</p> <p><input type="checkbox"/> 8th grade or less</p> <p><input type="checkbox"/> Some high school, but did not graduate</p> <p><input type="checkbox"/> High school graduate or GED</p> <p><input type="checkbox"/> Some college or 2-year degree</p> <p><input type="checkbox"/> 4-year college graduate</p> <p><input type="checkbox"/> More than 4-year college degree</p>	<p>What is the highest grade or level of school that you have completed? Did you complete...</p> <p><1> 8th grade or less, [Q21]</p> <p><2> Some high school, but did not graduate, [Q21]</p> <p><3> High school graduate or GED, [Q21]</p> <p><4> Some college or 2-year degree, [Q21]</p> <p><5> 4-year college graduate, or [Q21]</p> <p><6> More than 4-year college degree? [Q21]</p> <p><9> DECLINED TO DISCLOSE [Q21]</p>	
	<p>Code academic training beyond a high school diploma that does not lead to a bachelor's degree as 4. This includes business school training or a three-year nursing degree.</p> <p>If the respondent describes non-academic training, such as trade school, probe to find out if he or she has a high school diploma and code 2 or 3, as appropriate.</p>	
<p>21. Are you of Hispanic or Latino origin or descent?</p> <p><input type="checkbox"/> Yes, Hispanic or Latino</p> <p><input type="checkbox"/> No, Not Hispanic or Latino</p>	<p>Are you of Hispanic or Latino origin or descent?</p> <p><1> YES, HISPANIC OR LATINO [Q22]</p> <p><2> NO, NOT HISPANIC OR LATINO [Q22]</p> <p><9> DECLINED TO DISCLOSE [Q22]</p>	
<p>22. What is your race? Mark one or more.</p> <p><input type="checkbox"/> White</p> <p><input type="checkbox"/> Black or African-American</p> <p><input type="checkbox"/> Asian</p> <p><input type="checkbox"/> Native Hawaiian or other Pacific Islander</p> <p><input type="checkbox"/> American Indian</p> <p><input type="checkbox"/> Alaska Native</p> <p><input type="checkbox"/> Other</p>	<p>[FOR TELEPHONE INTERVIEWING THIS QUESTION IS BROKEN INTO PARTS A-G]</p> <p>>22a<</p> <p>I am going to read a list of race categories. For each category, please say yes or no if it describes your race. I must ask you about all categories in case more than one applies.</p> <p>Are you white?</p> <p><1> YES [Q22b]</p> <p><9> NO OR DECLINED TO DISCLOSE [Q22b]</p>	

Survey Question	Telephone Interviewing Specifications	Comments
	<p>If the respondent replies "Why are you asking my race?" say: "We ask about your race for demographic purposes only. We want to be sure that the people we survey accurately represent the racial diversity of Medicaid enrollees in Alaska."</p> <p>If the respondent answers with a category not listed here, such as "Hispanic" or "American" or "Mixed race", the interviewer can probe using the category "Other."</p>	
	<p>>22b< Black or African-American?</p> <p><1> YES [Q22c]</p> <p><9> NO OR DECLINED TO DISCLOSE [Q22c]</p>	
	<p>>22c< Asian?</p> <p><1> YES [Q22d]</p> <p><9> NO OR DECLINED TO DISCLOSE [Q22d]</p>	
	<p>>22d< Native Hawaiian or other Pacific Islander?</p> <p><1> YES [Q22e]</p> <p><9> NO OR DECLINED TO DISCLOSE [Q22e]</p>	
	<p>>22e< American Indian?</p> <p><1> YES [Q22f]</p> <p><9> NO OR DECLINED TO DISCLOSE [Q22f]</p>	
	<p>>22f< Alaska Native?</p> <p><1> YES [Q22g]</p> <p><9> NO OR DECLINED TO DISCLOSE [Q22g]</p>	

Survey Question	Telephone Interviewing Specifications	Comments
	>22g< Other? <1> YES [Q23] <9> NO OR DECLINED TO DISCLOSE [Q23]	
23. If you are uncertain about how to find services, you can find a provider online at Alaska.Optum.com.	{ASK IF Q4="NO" OR Q11="NO"} If you are uncertain about how to find services, you can find a provider online at Alaska (dot) Optum (dot) com. Do you have any additional comments?	
24. Do you have any additional comments?	[RECORD ANY RESPONSES HERE] [close]	
	>close< Those are all the questions I have. If you feel like you need support on any of the concerns we discussed today, you may call Alaska Careline at 1-877-266-HELP, or 1-877-266-4357 any time. You may also visit CareLine Alaska (dot) com. Thank you for taking part in this important interview.	

Child Beneficiary Survey Questionnaire

Introduction

This document contains telephone interviewing instructions for the Child 2021 Alaska Department of Behavioral Health knowledge assessment survey, child version. This survey is conducted as part of the evaluation of the Substance Use Disorder 1115 Waiver Demonstration.

Survey Question	Telephone Interviewing Specifications	Comments
	<p>>Intro<</p> <p>Hello, I'm calling on behalf of the Alaska Department of Health and Social Services to conduct an important study and would like your feedback. We are conducting this study to find out members' knowledge of services that Alaska Medicaid offers. The results of the study will help the Department improve the care they provide. If at any time you wish to end the survey you may do so.</p> <p>The interview is completely confidential and voluntary and will not affect your health care or benefits in any way. This call will be recorded and may be monitored for quality and training purposes.</p> <p>I would like to speak to the person who knows the most about [CHILD NAME]'s health care. Is that you?</p> <p>[Q1]</p>	

Survey Question	Telephone Interviewing Specifications	Comments
	<p>Survey vendors with different Telephone Interviewing systems may have their own preferred "path" for establishing contact with a respondent and beginning the interview. The screen shown above assumes that the interviewer is already speaking to the sampled respondent.</p> <p>This screen should be adapted to ask for a better respondent if the parent on the phone is not the person who knows the most about the sampled child's health care, and to collect that person's telephone number, if necessary. This person will usually be a parent, but might be a grandparent or other guardian.</p> <p>The interviewer should only read or clarify response choices if necessary. For questions with a Yes/No answer, only read the answer choices "YES" and "NO" if necessary. For all questions, do not read response options for UNCERTAIN/UNSURE, NOT ASCERTAINED or DECLINED TO DISCLOSE.</p>	

Survey Question	Telephone Interviewing Specifications	Comments
<p>1. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your child's health care in the last 6 months? Do <u>not</u> include care your child got when he or she stayed overnight in a hospital. Do <u>not</u> include the times your child went for dental care visits.</p> <p> <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 Worst health care Best health care </p>	<p>I will be asking you about [CHILD NAME]'s health care. Please answer these questions based on the experiences you have had in getting health care for [CHILD NAME] and not on any experiences you may have had getting care for yourself or other members of your family.</p> <p>When you answer these questions, please provide one answer for each question, unless otherwise instructed.</p> <p>Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your child's health care in the last 6 months? Do <u>not</u> include care your child got when he or she stayed overnight in a hospital. Do <u>not</u> include the times your child went for dental care visits.</p> <p>{READ RESPONSE CHOICES ONLY IF NECESSARY}</p> <p><00> 0 [Q2] <01> 1 [Q2] <02> 2 [Q2] <03> 3 [Q2] <04> 4 [Q2] <05> 5 [Q2] <06> 6 [Q2] <07> 7 [Q2] <08> 8 [Q2] <09> 9 [Q2] <10> 10 [Q2]</p> <p><99> DECLINED TO DISCLOSE [Q2]</p>	
<p>2. In general, how would you rate your child's overall health?</p> <p> <input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor </p>	<p>In general, how would you rate your child's overall health? Would you say it is...</p> <p><1> Excellent, [Q3] <2> Very Good, [Q3] <3> Good, [Q3] <4> Fair, or [Q3] <5> Poor? [Q3]</p> <p><9> DECLINED TO DISCLOSE [Q3]</p>	

Survey Question	Telephone Interviewing Specifications	Comments
<p>3. In general, how would you rate your child's overall <u>mental or emotional</u> health?</p>	<p>In general, how would you rate your child's overall <u>mental or emotional</u> health? Would you say it is...</p> <p><1> Excellent, [Q4] <2> Very Good, [Q4] <3> Good, [Q4] <4> Fair, or [Q4] <5> Poor? [Q4]</p> <p><9> DECLINED TO DISCLOSE [Q4]</p> <p>These next questions ask you about your knowledge and awareness of treatment services that may be available to your child and covered through Medicaid. These services are about treatment for substance abuse. Substance abuse refers to an inability to control the use of legal or illegal drugs or medications, such as alcohol, marijuana, nicotine, opioids, or pain killers.</p> <p>For each of the following questions, please consider where you might go to obtain these services if your child needed them, even if your child does not need them right now.</p>	
<p>4. If your child needed treatment for substance abuse, do you know how they can receive this treatment?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No → If NO, SKIP to Question 10</p>	<p>If your child needed treatment for substance abuse, do you know how they can receive this treatment?</p> <p><1> YES [Q5] <2> NO [Q10] <3> UNCERTAIN/UNSURE [Q5]</p> <p><8> NOT ASCERTAINED [Q5] <9> DECLINED TO DISCLOSE [Q10]</p>	
<p>5. Do you know how your child can receive <u>one-on-one</u> help from a person who has training to help treat substance abuse?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Do you know how your child can receive one-on-one help from a person who has training to help treat substance abuse?</p> <p><1> YES [Q6] <2> NO [Q6] <3> UNCERTAIN/UNSURE [Q6]</p> <p><8> NOT ASCERTAINED [Q6] <9> DECLINED TO DISCLOSE [Q6]</p>	

Survey Question	Telephone Interviewing Specifications	Comments
<p>6. Do you know how your child can receive help from a person who has training to treat substance abuse, who would meet with you and your family (family therapist or counselor)?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>Do you know how your child can receive help from a person who has training to treat substance abuse, who would meet with you and your family, also called a family therapist or counselor?</p> <p><1> YES [Q7]</p> <p><2> NO [Q7]</p> <p><3> UNCERTAIN/UNSURE [Q7]</p> <p><8> NOT ASCERTAINED [Q7]</p> <p><9> DECLINED TO DISCLOSE [Q7]</p>	
<p>7. Do you know how your child can get treatment or support for substance abuse from someone who has <u>already recovered from substance abuse</u> (for example, peer mentoring or coaching)?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>Do you know how your child can get treatment or support for substance abuse from someone who has already recovered from substance abuse (for example, peer mentoring or coaching)?</p> <p><1> YES [Q8]</p> <p><2> NO [Q8]</p> <p><3> UNCERTAIN/UNSURE [Q8]</p> <p><8> NOT ASCERTAINED [Q8]</p> <p><9> DECLINED TO DISCLOSE [Q8]</p>	
<p>8. Are you aware of any place your child can stay to receive treatment 24 hours a day, seven days a week for substance abuse?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>Are you aware of any place your child can stay to receive treatment 24 hours a day, seven days a week for substance abuse?</p> <p><1> YES [Q9]</p> <p><2> NO [Q9]</p> <p><3> UNCERTAIN/UNSURE [Q9]</p> <p><8> NOT ASCERTAINED [Q9]</p> <p><9> DECLINED TO DISCLOSE [Q9]</p>	

Survey Question	Telephone Interviewing Specifications	Comments
<p>9. If you wanted to get medication-assisted treatment (MAT) for substance abuse for your child, do you know where to take them? MAT refers to the use of medicines such as methadone, Suboxone, or buprenorphine to treat opioid addiction and reduce withdrawal symptoms.</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>If you wanted to get medication-assisted treatment or M.A.T. for substance abuse for your child, do you know where to take them? MAT refers to the use of medicines such as methadone, Suboxone, or buprenorphine to treat opioid addiction and reduce withdrawal symptoms.</p> <p><1> YES [Q10] <2> NO [Q10] <3> UNCERTAIN/UNSURE [Q10]</p> <p><8> NOT ASCERTAINED [Q10] <9> DECLINED TO DISCLOSE [Q10]</p>	
	<p>Now I'm going to ask you about the same type of services but for mental or behavioral health concerns. Mental or behavioral health concerns refer to concerns like stress, anxiety, depression and other mood disorders, personality disorders, psychotic disorders such as Schizophrenia, eating disorders, obsessive-compulsive disorder or OCD, or post-traumatic stress disorder or PTSD. This does not include substance abuse/misuse.</p> <p>Again, please provide one answer for each question, unless otherwise instructed.</p>	
<p>10. If your child needed treatment for behavioral or mental health concerns, do you know how they can receive this treatment?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No → If NO, SKIP to Question 15</p>	<p>If your child needed treatment for behavioral or mental health concerns, do you know how they can receive this treatment?</p> <p><1> YES [Q11] <2> NO [Q15] <3> UNCERTAIN/UNSURE [Q11]</p> <p><8> NOT ASCERTAINED [Q11] <9> DECLINED TO DISCLOSE [Q15]</p>	

Survey Question	Telephone Interviewing Specifications	Comments
<p>11. Do you know how your child can receive <u>one-on-one</u> help from a person who has training to help treat behavioral or mental health concerns?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>Do you know how your child can receive one-on-one help from a person who has training to help treat behavioral or mental health concerns?</p> <p><1> YES [Q12]</p> <p><2> NO [Q12]</p> <p><3> UNCERTAIN/UNSURE [Q12]</p> <p><8> NOT ASCERTAINED [Q12]</p> <p><9> DECLINED TO DISCLOSE [Q12]</p>	
<p>12. Do you know how your child can receive help from a person who has training to treat behavioral and mental health concerns, who would meet with you and your family (family therapist or counselor)?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>Do you know how your child can receive help from a person who has training to treat behavioral and mental health concerns, who would meet with you and your family, also known as a family therapist or counselor?</p> <p><1> YES [Q13]</p> <p><2> NO [Q13]</p> <p><3> UNCERTAIN/UNSURE [Q13]</p> <p><8> NOT ASCERTAINED [Q13]</p> <p><9> DECLINED TO DISCLOSE [Q13]</p>	
<p>13. Are you aware of any place your child can stay to receive treatment <u>24 hours a day, seven days a week</u> for behavioral or mental health concerns?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>Are you aware of any place your child can stay to receive treatment 24 hours a day, seven days a week for behavioral or mental health concerns?</p> <p><1> YES [Q14]</p> <p><2> NO [Q14]</p> <p><3> UNCERTAIN/UNSURE [Q14]</p> <p><8> NOT ASCERTAINED [Q14]</p> <p><9> DECLINED TO DISCLOSE [Q14]</p>	
<p>14. Do you know if there are options for your child to meet with a person who has training to help treat behavioral or mental health concerns through the phone or computer?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>Do you know if there are options for your child to meet with a person who has training to help treat behavioral or mental health concerns through the phone or computer?</p> <p><1> YES [Q15]</p> <p><2> NO [Q15]</p> <p><3> UNCERTAIN/UNSURE [Q15]</p> <p><8> NOT ASCERTAINED [Q15]</p> <p><9> DECLINED TO DISCLOSE [Q15]</p>	

Survey Question	Telephone Interviewing Specifications	Comments
	<p>Now I will ask you a series of questions about your child and you.</p> <p>Please provide only one answer unless otherwise instructed.</p>	
<p>15. What is your child's age?</p> <p>_____</p>	<p>What is your child's age?</p> <p>_____ [Q16]</p> <p><99> DECLINED TO DISCLOSE [Q16]</p>	
	<p>The respondent should report the child's age as of his or hers last birthday. Do not round.</p>	
<p>16. What is your child's gender?</p> <p><input type="checkbox"/> Male</p> <p><input type="checkbox"/> Female</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> Decline to disclose</p>	<p>What is your child's gender?</p> <p><1> MALE [Q17]</p> <p><2> FEMALE [Q17]</p> <p><3> OTHER [Q17]</p> <p><9> DECLINED TO DISCLOSE [Q17]</p>	
<p>17. Is your child of Hispanic or Latino origin or descent?</p> <p><input type="checkbox"/> Yes, Hispanic or Latino</p> <p><input type="checkbox"/> No, Not Hispanic or Latino</p>	<p>Is your child of Hispanic or Latino origin or descent?</p> <p><1> YES, HISPANIC OR LATINO [Q18]</p> <p><2> NO, NOT HISPANIC OR LATINO [Q18]</p> <p><9> DECLINED TO DISCLOSE [Q18]</p>	
<p>18. What is your child's race? Mark one or more.</p> <p><input type="checkbox"/> White</p> <p><input type="checkbox"/> Black or African-American</p> <p><input type="checkbox"/> Asian</p> <p><input type="checkbox"/> Native Hawaiian or other Pacific Islander</p> <p><input type="checkbox"/> American Indian</p> <p><input type="checkbox"/> Alaska Native</p> <p><input type="checkbox"/> Other</p>	<p>[FOR TELEPHONE INTERVIEWING THIS QUESTION IS BROKEN INTO PARTS A-G]</p> <p>>18a<</p> <p>I am going to read a list of race categories. For each category, please say yes or no if it describes your child's race. I must ask you about all categories in case more than one applies.</p> <p>Is your child white?</p> <p><1> YES [Q18b]</p> <p><9> NO OR DECLINED TO DISCLOSE [Q18b]</p>	

Survey Question	Telephone Interviewing Specifications	Comments
	<p>If the respondent replies "Why are you asking about my child's race?" say: "We ask about your child's race for demographic purposes only. We want to be sure that the people we survey accurately represent the racial diversity of Medicaid enrollees in this country."</p> <p>If the respondent answers with a category not listed here, such as "Hispanic" or "American" or "Mixed race", the interviewer can probe using the category "Other."</p>	
	<p>>18b< Black or African-American?</p> <p><1> YES [Q18c] <9> NO OR DECLINED TO DISCLOSE [Q18c]</p>	
	<p>>18c< Asian?</p> <p><1> YES [Q18d] <9> NO OR DECLINED TO DISCLOSE [Q18d]</p>	
	<p>>18d< Native Hawaiian or other Pacific Islander?</p> <p><1> YES [Q18e] <9> NO OR DECLINED TO DISCLOSE [Q18e]</p>	
	<p>>18e< American Indian?</p> <p><1> YES [Q18f] <9> NO OR DECLINED TO DISCLOSE [Q18f]</p>	
	<p>>18f< Alaska Native?</p> <p><1> YES [Q18g] <9> NO OR DECLINED TO DISCLOSE [Q18g]</p>	

Survey Question	Telephone Interviewing Specifications	Comments
	>18g< Other? <1> YES [Q19] <9> NO OR DECLINED TO DISCLOSE [Q19]	
19. What is your age? <input type="checkbox"/> 18 to 24 <input type="checkbox"/> 25 to 34 <input type="checkbox"/> 35 to 44 <input type="checkbox"/> 45 to 54 <input type="checkbox"/> 55 to 64 <input type="checkbox"/> 65 to 74 <input type="checkbox"/> 75 or older <input type="checkbox"/> Declined to disclose	What is your age? {IF NECESSARY: "Are you..." THEN READ RESPONSE CHOICES} <1> 18 to 24, [Q20] <2> 25 to 34, [Q20] <3> 35 to 44, [Q20] <4> 45 to 54, [Q20] <5> 55 to 64, [Q20] <6> 65 to 74, [Q20] <7> 75 or older, or [Q20]<9> DECLINED TO DISCLOSE [Q20]	
20. What is your gender? <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Declined to disclose	What is your gender? <1> MALE [Q21] <2> FEMALE [Q21] <3> OTHER [Q21] <9> DECLINED TO DISCLOSE [Q21]	
21. Are you of Hispanic or Latino origin or descent? <input type="checkbox"/> Yes, Hispanic or Latino <input type="checkbox"/> No, Not Hispanic or Latino	Are you of Hispanic or Latino origin or descent? <1> YES, HISPANIC OR LATINO [Q22] <2> NO, NOT HISPANIC OR LATINO [Q22] <9> DECLINED TO DISCLOSE [Q22]	
22. What is your race? Mark one or more. <input type="checkbox"/> White <input type="checkbox"/> Black or African-American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or other Pacific	[FOR TELEPHONE INTERVIEWING THIS QUESTION IS BROKEN INTO PARTS A-G] >22a< I am going to read a list of race categories. For each category, please say yes or no if it describes your race. I must ask you about all categories in case more than one applies. Are you white? <1> YES [Q22b] <9> NO OR DECLINED TO DISCLOSE [Q22b]	

Survey Question	Telephone Interviewing Specifications	Comments
Islander <input type="checkbox"/> American Indian <input type="checkbox"/> Alaska Native <input type="checkbox"/> Other	<p>If the respondent replies "Why are you asking my race?" say: "We ask about your race for demographic purposes only. We want to be sure that the people we survey accurately represent the racial diversity of Medicaid enrollees in Alaska."</p> <p>If the respondent answers with a category not listed here, such as "Hispanic" or "American" or "Mixed race", the interviewer can probe using the category "Other."</p>	
	>22b< Black or African-American? <1> YES [Q22c] <9> NO OR DECLINED TO DISCLOSE [Q22c]	
	>22c< Asian? <1> YES [Q22d] <9> NO OR DECLINED TO DISCLOSE [Q22d]	
	>22d< Native Hawaiian or other Pacific Islander? <1> YES [Q22e] <9> NO OR DECLINED TO DISCLOSE [Q22e]	
	>22e< American Indian? <1> YES [Q22f] <9> NO OR DECLINED TO DISCLOSE [Q22f]	
	>22f< Alaska Native? <1> YES [Q22g] <9> NO OR DECLINED TO DISCLOSE [Q22g]	

Survey Question	Telephone Interviewing Specifications	Comments
	>22g< Other? <1> YES [Q23] <9> NO OR DECLINED TO DISCLOSE [Q23]	
23. What is the highest grade or level of school that you have completed? <input type="checkbox"/> 8th grade or less <input type="checkbox"/> Some high school, but did not graduate <input type="checkbox"/> High school graduate or GED <input type="checkbox"/> Some college or 2-year degree <input type="checkbox"/> 4-year college graduate <input type="checkbox"/> More than 4-year college degree	What is the highest grade or level of school that you have completed? Did you complete... <1> 8th grade or less, [Q24] <2> Some high school, but did not graduate, [Q24] <3> High school graduate or GED, [Q24] <4> Some college or 2-year degree, [Q24] <5> 4-year college graduate, or [Q24] <6> More than 4-year college degree? [Q24] <9> DECLINED TO DISCLOSE [Q24] Code academic training beyond a high school diploma that does not lead to a bachelor's degree as 4. This includes business school training or a three-year nursing degree. If the respondent describes non-academic training, such as trade school, probe to find out if he or she has a high school diploma and code 2 or 3, as appropriate.	
24. How are you related to the child? <input type="checkbox"/> Mother or father <input type="checkbox"/> Grandparent <input type="checkbox"/> Aunt or uncle <input type="checkbox"/> Older brother or sister <input type="checkbox"/> Other relative <input type="checkbox"/> Legal guardian <input type="checkbox"/> Someone else	How are you related to the child? <1> Mother or father, [Q25] <2> Grandparent, [Q25] <3> Aunt or uncle, [Q25] <4> Older brother or sister, [Q25] <5> Other relative, [Q25] <6> Legal guardian, [Q25] <7> Someone else, [Q25] <9> DECLINED TO DISCLOSE [Q25]	

Survey Question	Telephone Interviewing Specifications	Comments
25. If you are uncertain about how to find services, you can find a provider online at Alaska.Optum.com.	{ASK IF Q4="NO" OR Q10="NO"} If you are uncertain about how to find services, you can find a provider online at Alaska (dot) Optum (dot) com. Do you have any additional comments?	
26. Do you have any additional comments?	[RECORD ANY RESPONSES HERE] [close]	
	>close< Those are all the questions I have. If you feel like you need support on any of the concerns we discussed today, you may call Alaska Careline at 1-877-266-HELP, or 1-877-266-4357 any time. You may also visit CareLine Alaska (dot) com. Thank you for taking part in this important interview.	

Appendix D: Formal Public Notice



Alaska Department of Health
Division of Behavioral Health

**STATE OF ALASKA DEPARTMENT OF HEALTH
NOTICE OF PUBLIC COMMENT PROCESS FOR MEDICAID SECTION 1115 SUBSTANCE USE
DISORDER TREATMENT AND BEHAVIORAL HEALTH PROGRAM DEMONSTRATION WAIVER**

Public Comment Period Opens: January 9, 2023

Public Comment Period Closes: February 8, 2023, at 5:00 pm AKST

PUBLIC NOTICE

In accordance with 42 §CFR 431.408, public notice is hereby given that the State of Alaska Department of Health (DOH) proposes to submit to the Centers for Medicare and Medicaid Services (CMS) its request to extend Alaska's 1115 Substance Use Disorder Treatment and Behavioral Health Program Demonstration Waiver for a period of five years from January 1, 2024 through December 31, 2028. DOH seeks public comments on the waiver renewal application to continue the comprehensive reform of Alaska's behavioral health delivery system.

This notice provides details about the waiver extension request and serves to formally open the 30-day public comment period, which will conclude on **February 8, 2023**. During the public comment period, the public will be able to provide written comments to DOH via US postal service or electronic mail, as well as make comments verbally during virtual public hearings.

LOCATION OF APPLICATION

The proposed extension request is accessible for public review on the DOH website at:

<https://health.alaska.gov/dbh/Pages/1115/default.aspx>

In addition, the draft documents are also available in hard copy at:

Alaska Department of Health, Division of Behavioral Health
3601 C Street, Suite 878
Anchorage, Alaska 99503

Hard copies are also available upon request by calling:

(907) 269-3600

COMMENT SUBMISSION PROCESS

Interested persons should submit public comments to DOH on the proposed extension on or before February 8, 2023, at 5:00 pm AKST. Written comments on the application can be submitted through three channels:

1. Email to doh.dbh.public.comments@alaska.gov, referencing "1115 Renewal" in the subject line
2. Electronic submission through the Alaska Online Public Notices System located at <https://aws.state.ak.us/OnlinePublicNotices/> and using the "Leave a Comment" link



3. U.S. Mail to:

Alaska Department of Health, Division of Behavioral Health
Re: 1115 Waiver Renewal Application Comments
3601 C Street, Suite 878
Anchorage, Alaska 99503

PUBLIC HEARINGS

The public is welcome to attend virtual meetings to learn more about the waiver renewal application, ask questions, and provide public comments. Two public hearings will be held virtually on the following dates, times, and locations. Individuals with disabilities who require special accommodations in order to attend these public meetings, should contact Heather Phelps at (907) 269-3616 or email at heather.phelps@alaska.gov to ensure that any necessary accommodations can be provided.

<u>Public Hearing #1</u>	<u>Public Hearing #2</u>
January 20, 2023 9:30am – 11:30am Please join the public hearing by following this link: https://us02web.zoom.us/j/83576266762?pwd=U1oxbUJMR0pDSIBURnFmSTNGaFA4UT09	January 27, 2023 9:30am – 11:30am Please join the public hearing by following this link: https://us02web.zoom.us/j/87373191962?pwd=OWF0Z3pZL2lxOFIPZmMzVUpHaDRVQT09

PROGRAM DESCRIPTION

Alaska’s 1115 waiver, called the Substance Use Disorder and Behavioral Health Program (SUD-BHP) Demonstration (“the Demonstration”), has shown substantial progress in building a more robust, coordinated behavioral health system across the state. The SUD-BHP Demonstration was designed to centralize Alaska’s behavioral health system under a sustainable financing model to ensure access to the full continuum of mental health and substance use disorder (SUD) services. The initial waiver authorized 25 services, including residential and inpatient treatment in Institutions for Mental Diseases (IMDs), with emphasis on early interventions, a crisis services infrastructure, community-based outpatient services, residential treatment when appropriate, and enhanced community recovery supports. Alaska is seeking an extension of the Demonstration to continue the progress made under the program. Current beneficiaries will maintain existing access to services.

Through the approval of this renewal request, Alaska proposes to update the 1115 Demonstration name from the current Substance Use Disorder Treatment and Behavioral Health Program (SUD-BHP) title to the Behavioral Health Reform Waiver, with the broader behavioral health term encompassing both mental health and substance use disorder and reflecting Alaska’s ongoing commitment to program reform and system transformation.

Goal and Objectives

Alaska’s Demonstration has centered around three overarching objectives:

1. Rebalance the current behavioral health system of care to reduce Alaska’s over-reliance on acute, institutional care and shift to more community- or regionally based care.



2. Intervene as early as possible in the lives of Alaskans to address behavioral health symptoms before they cascade into functional impairments.
3. Improve overall behavioral health system accountability by reforming the existing system of care.

The state has identified long-term goals for the Demonstration:

1. Increased rates of identification, initiation, and engagement in treatment for SUD and BH issues.
2. Increased adherence to and retention in treatment for SUD and BH issues.
3. Reduced overdose deaths, particularly those due to opioids.
4. Reduced utilization of emergency departments and inpatient hospital settings for SUD and BH treatment where the utilization is preventable or medically inappropriate through improved access to other more appropriate and focused services.
5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate.
6. Improved access to care for physical health conditions among beneficiaries.

Alaska has demonstrated progress toward achieving several of these goals. The state has authorized numerous behavioral health and SUD agencies to provide care, increased access to telehealth, and made progress in aligning with nationally recognized criteria for behavioral health and SUD providers. The state will use this extension to continue to work toward achieving its goals to increase access to services and improve outcomes.

ELIGIBILITY REQUIREMENTS, COST SHARING, BENEFIT COVERAGE, AND HEALTH CARE DELIVERY SYSTEM

Alaska is seeking to maintain the existing delivery system, eligibility requirements, benefit coverage, and cost sharing as established by the prior Demonstration application.

Health Care Delivery System

While the state's Medicaid program continues to operate through a fee-for-service system, the state has engaged an Administrative Services Organization (ASO) to facilitate the provision of services. The state seeks to use this renewal period to work through operational changes associated with the continuing adoption of the ASO model and to support providers with technical assistance as they onboard the 1115 services.

Eligibility

To qualify for waiver services individuals must derive their eligibility through the Alaska Medicaid State Plan and are subject to all applicable Medicaid laws and regulations regarding initial and ongoing eligibility. Alaska continues to target the services under the 1115 waiver Demonstration to only those who meet the following eligibility requirements:

Section 7 Alaska Administrative Code (AAC) 139.010 outlines the recipient eligibility requirements for the behavioral health services:

- An eligible youth under age 21 who
 - is diagnosed with a mental health or substance use disorder



- is at risk of developing a mental health or substance use disorder based upon a screening conducted according to 7 AAC 135.100
- is at risk of out of home placement
- is currently in the custody of the state, or
- has been detained in a juvenile justice facility or treated in a residential treatment program or psychiatric hospital within the past year
- An eligible individual who meets the criteria under 7 AAC 135.055 for experiencing a serious mental illness.
- An individual who is experiencing a mental disorder who meets the diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders, adopted by reference in 7 AAC 70.910, or the International Classification of Diseases - 10th Revision, Clinical Modification, (ICD-10-CM), adopted by reference in 7 AAC 70.910.

Section 7 AAC 138.010 outlines the eligibility requirements for the substance use disorder waiver services:

- A child at least 12 years of age and under 18 years of age who may have a substance use disorder or may be at risk to develop a substance use disorder as determined through a screening conducted according to 7 AAC 135.100.
- A youth at least 18 years of age and under 22 years of age who may have a substance use disorder or may be at risk to develop a substance use disorder as determined through a screening conducted according to 7 AAC 135.100.
- An adult who is diagnosed with a substance use disorder or is at risk of developing a substance use disorder as determined through a screening conducted according to 7 AAC 135.100.

Cost Sharing

There are no cost-sharing requirements under the Demonstration.

Benefits

Alaska will rigorously evaluate and monitor the provision of services under the renewal period and use these learnings to inform the state's future approach to providing behavioral health services through state plan authority.

1. **Residential Treatment for Individuals with Substance Use Disorder.** Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder who are short-term residents in facilities that meet the definition of an IMD.
2. **Opioid Treatment Services (OTS) for Persons Experiencing an Opioid Use Disorder (OUD).** Expenditures for medication and counseling services to eligible individuals with severe opioid use disorder, in accordance with an individualized service plan determined by a licensed physician or licensed prescriber and approved and authorized according to state requirements.
3. **Intensive Outpatient (IOP) Services for Substance Use Disorder.** Expenditures for intensive outpatient services and structured programming provided to eligible individuals when determined to be medically necessary and in accordance with an individualized treatment plan.



4. **Intensive Outpatient (IOP) Services for Behavioral Health.** Expenditures for intensive outpatient services and structured programming to individuals determined to be medically necessary and in accordance with an individualized treatment plan.
5. **Partial Hospitalization Program (PHP) Services for Substance Use Disorder.** Expenditures for PHP services provided to eligible individuals including services designed for the diagnosis or active treatment of a SUD to maintain the person's functional level and prevent or decrease risk for recurrence of or inpatient hospitalization. Payment for Room and Board are prohibited.
6. **Partial Hospitalization Program (PHP) Services for Behavioral Health.** Expenditures for PHP services provided to individuals, in a highly structured treatment environment for services that will provide diagnosis or active treatment of an individual's psychiatric disorder, with a diagnosis of Serious Mental Illness (SMI) or Serious Emotional Disorder (SED) in accordance with an individualized treatment plan. Payment for room and board costs are prohibited.
7. **Medically Monitored Intensive Inpatient Services.** Expenditures for services provided in a residential setting or a specialty unit of an acute or psychiatric hospital. Individuals receiving Medicaid coverable services at this level of care require 24-hour services, professionally directed evaluation, observation, medical monitoring, and addiction treatment in an inpatient setting.
8. **Medically Managed Intensive Inpatient Services.** Expenditures for services provided in a hospital setting (acute care or specialty) for individuals with acute medical, behavioral, or cognitive conditions. Medically managed services involve daily medical care and 24-hour nursing requiring the full resources of an acute care or psychiatric hospital.
9. **Ambulatory Withdrawal Management Services.** Expenditures for outpatient services provided to eligible individuals at a mild withdrawal risk with a high commitment to withdrawal management process.
10. **Clinically Managed Residential Withdrawal Management.** Expenditures for services provided in a social setting focusing on peer support programs, including daily individual and group therapies, support, and health education services.
11. **Medically Monitored Inpatient Withdrawal Management Services.** Expenditures for services provided in a freestanding withdrawal setting with inpatient beds, specializing in clinical consultation, for individuals experiencing severe withdrawal and needing clinical consultation and supervision for cognitive, biomedical, emotional, and behavioral problems.
12. **Medically Managed Intensive Inpatient Withdrawal Management Services.** Expenditures for services provided in an acute care or psychiatric hospital in a patient unit, specializing in medical consultation, full medical acute services and intensive care for individuals experiencing severe, unstable withdrawal needs (usually hospital-based), including 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.
13. **Community Recovery Support Services (CRSS) for Substance Use Disorder.** Expenditures for community recovery support services to help decrease risk for recurrence of symptoms and promote recovery, and to support transition between levels of care for SUD.
14. **Community Recovery Support Services (CRSS) for Behavioral Health.** Expenditures for community recovery support services to help decrease risk for recurrence of symptoms and promote recovery, and to support transition between levels of care for behavioral health services.



15. **Home-Based Family Treatment Services.** Expenditures for home-based family treatment (HBFT) services for children/youth ages 0-20 who are at risk for out-of-home placement or detention in a juvenile justice facility and for whom a combination of less intensive outpatient services has not been effective or is deemed likely not to be effective.
16. **Children's Residential Treatment (CRT).** Expenditures for residential treatment services provided by an interdisciplinary treatment team in a therapeutically structured, supervised environment for children and youth whose health is at risk while living in their community. This authority does not apply to IMDs. Payment for room and board costs are prohibited.
17. **Therapeutic Treatment Homes.** Expenditures for trauma-informed clinical services which include placement in a specifically trained therapeutic treatment home for children/youth who have severe mental, emotional health needs diagnosed with a SMI or SED or a behavioral health need, and who cannot be stabilized in their home settings. This authority does not apply to IMDs Payment for room and board costs are prohibited.
18. **Assertive Community Treatment (ACT) Services.** Expenditures for an evidence-based practice designed to provide treatment, rehabilitation and support services to individuals who are diagnosed with a severe mental illness and whose needs have not been well met by more traditional mental health services.
19. **Adult Mental Health Residential (AMHR) Services.** Expenditures for AMHR services provided by an interdisciplinary treatment team in a therapeutically structured, supervised environment for adults with acute mental health needs, diagnosed with a SMI or SED, whose health is at risk while living in their community. This authority does not apply to IMDs. Payment for room and board are prohibited.
20. **Peer-Based Crisis Services.** Expenditures for community-based services, that divert individuals from emergency department and psychiatric hospitalization use. These services are facilitated by children and adults that have lived with or have experience with a mental illness or a substance disorder (including parents).
21. **Intensive Case Management Services for Substance Use Disorder.** Expenditures for services for adults with substance use disorders (if their needs cannot be met by SUD Care Coordination).
22. **Intensive Case Management Services for Behavioral Health.** Expenditures for services for children/youth at risk of out-of-home placement, and adults with acute mental health needs.
23. **Mobile Outreach and Crisis Response (MOCR) Services.** Expenditures for services which prevent a mental health crisis or stabilize an individual during or after a mental health crisis or a crisis involving both substance use and mental health disorders.
24. **23-Hour Crisis Observation and Stabilization (COS) Services.** Expenditures for evaluation and/or stabilization services for individuals presenting with acute symptoms or distress. Services are provided for up to 23 hours and 59 minutes of care in a secure and protected environment.
25. **Crisis Residential/Stabilization Services.** Expenditures for medically monitored short-term, residential program in an approved 10-15 bed facility that provides 24/7 psychiatric stabilization services. These facilities are not IMDs. Payment for room and board are prohibited.



ENROLLMENT AND EXPENDITURES

As part of the 1115 waiver renewal application, the state is responsible for a budget neutrality demonstration that includes projected experience from demonstration year (DY) 6 through 10, defined as January 1, 2024 through December 31, 2028. Budget neutrality is a comparison of without waiver expenditures (WoW) to with waiver expenditures (WW). Budget neutrality for this 1115 Waiver, which was developed using CMS budget neutrality requirements, will be demonstrated using the per capita method: an assessment of the per member per month (PMPM) cost of the Demonstration.

To develop the budget neutrality projections, the state relied on historical incurred experience under the previous demonstration adjusted for the impact of enrollment and PMPM cost changes anticipated to occur between the historical period and the renewal Demonstration period. Table 1 below contains a summary of this information, where DY 03 represents the most recent calendar year of incurred experience (calendar year 2021) and DY 06 through 10 represent the renewal Demonstration period.

TABLE 1 - 1115 BUDGET NEUTRALITY PROJECTIONS BY GROUPING

GROUPING	DY 03	DY 06	DY 07	DY 08	DY 09	DY 10
SUD IMD						
Persons Eligible: Avg Monthly	122	125	127	128	129	131
PMPM Cost	\$ 12,548.15	\$ 14,922.75	\$ 15,594.27	\$ 16,296.01	\$ 17,029.33	\$ 17,795.65
Expenditures	\$18,332,845	\$22,462,823	\$23,708,381	\$25,023,007	\$26,410,532	\$27,874,997
SUD Non-IMD						
Persons Eligible: Avg Monthly	238,993	222,922	225,152	227,403	229,677	231,974
PMPM Cost	\$ 19.94	\$ 33.47	\$ 34.98	\$ 36.55	\$ 38.19	\$ 39.91
Expenditures	\$ 57,193,269	\$ 89,534,506	\$ 94,509,596	\$ 99,738,965	\$ 105,256,399	\$ 111,096,903
BH Non-IMD						
Persons Eligible: Avg Monthly	238,993	222,922	225,152	227,403	229,677	231,974
PMPM Cost	\$ 24.17	\$ 51.09	\$ 53.39	\$ 55.79	\$ 58.30	\$ 60.92
Expenditures	\$69,329,383	\$136,669,193	\$144,250,067	\$152,241,774	\$160,682,065	\$169,582,143
Total Expenditures	\$144,855,497	\$248,666,522	\$262,468,044	\$277,003,747	\$292,348,996	\$308,554,042

Notes:

1. Values reflect state and federal expenditures.
2. DY 06 - DY 10 represent the waiver demonstration period of January 1, 2024 through December 31, 2028.
3. SUD IMD persons eligible are based on service recipients, while persons eligible for the Non-IMD groupings include all Medicaid eligible members under age 65.
4. PMPM cost for the SUD IMD grouping reflects expenditures for all services. For the Non-IMD groupings, PMPM cost reflects 1115 services only.
5. Persons eligible for both the SUD Non-IMD and BH Non-IMD groupings represent total eligible members.

Table 1 indicates a material increase in PMPM cost particularly for the SUD Non-IMD and BH Non-IMD groupings when moving from DY 03 through the waiver renewal period. A key driver of this result is observed and anticipated shifting from state plan to 1115 behavioral health services. Since the SUD Non-IMD and BH Non-IMD groupings in the budget neutrality demonstration include expenditures only for 1115 waiver services, this shifting of utilization from state plan to 1115 waiver services results in material projected cost increases under that limited definition. To reflect the impact of state plan to 1115 waiver shifting that has already occurred, plus the potential impact of further shifting during the next demonstration period, we developed the budget neutrality projections to reflect the anticipated distribution of state plan and 1115 service cost during the demonstration.

The state does not anticipate a material financial impact related to changes in this waiver renewal relative to the previous demonstration, including the provision of making services available statewide. Under the



previous demonstration, the budget neutrality projections were developed such that the historical and projected experience reflected Medicaid enrollees in all regions of the state.

HYPOTHESES AND EVALUATION PARAMETERS

Alaska will conduct an independent evaluation to measure and monitor the outcomes of the Demonstration. Evaluators will assess utilization, health outcomes, and costs. The state proposes to evaluate this extension of the Demonstration utilizing the following questions, hypotheses, and measures.

Evaluation Question 1: Does the Demonstration increase access to and utilization of substance use disorder and mental health disorder treatment services by increasing access to community based care?

Evaluation Hypothesis: The Demonstration will increase the number of beneficiaries in the waiver population who are referred to and engage in treatment for substance use disorder and behavioral health disorder in sub-acute, community- or regionally-based outpatient settings.

Measures

- Number of beneficiaries screened for symptoms of SUD using industry recognized, evidence- based screening instruments.
- Number of beneficiaries screened for symptoms of behavioral health disorders using industry recognized, evidence- based screening instruments.
- Number of beneficiaries in the waiver population with SUD or behavioral health diagnosis, by setting.
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF 0004).
- Follow up after discharge from emergency department visits for SUD, and specifically for Opioid Use Disorder (OUD), by setting (NQF 2605).
- Follow up after discharge from emergency department visits for a behavioral health disorder, by setting (NQF 2605).
- Number of Medicaid qualified SUD providers (identified by provider ID numbers) who bill for SUD services.
- Number of Medicaid qualified professionals licensed in the state to provide behavioral health who bill for behavioral health disorder services.
- Providers' reported barriers before, during, and shortly following expansion of BH and SUD services.
- Providers' experience in expanding services.
- Administrators' reported barriers before, during, and shortly following expansion of BH and SUD services.
- Administrators' plan for program sustainability and anticipated challenges.
- Alaska tribal entities reported changes in quality of care and access to care following expansion of BH and SUD services.

Evaluation Hypothesis: The Demonstration will decrease utilization of emergency department, inpatient, or institutional settings within the beneficiary population.

Measures

- Inpatient admissions for SUD, and specifically for OUD, by setting.
- Inpatient admissions for behavioral health disorders, by setting.



- Emergency department visits for SUD, and specifically for OUD, by setting.
- Emergency department visits for a behavioral health disorder, by setting.
- Mean length of stay measured from admission date to discharge date, by setting.
- 30-day readmission rate to inpatient facilities following hospitalization for an SUD related diagnosis, by setting.
- 30-day readmission rate to inpatient facilities following hospitalization for a behavioral health related diagnosis, by setting.

Evaluation Hypothesis: The Demonstration will increase the percentage of beneficiaries who adhere to treatment for substance use disorders and mental health disorders.

Measures

- Number of beneficiaries with a SUD diagnosis including those with OUD who used services in the last month or year, by service or benefit type.
- Number of beneficiaries with a behavioral health diagnosis who used services in the last month or year, by service or benefit type.
- Time to treatment, by service type (National Behavioral Health Quality Framework [NBHQF] Goal 1).

Evaluation Question 2: Do enrollees receiving substance use disorder services experience improved health outcomes?

Evaluation Hypothesis: The Demonstration will increase the percentage of beneficiaries with substance use disorder or a mental health disorder who experience care for comorbid conditions.

Measures

- Access to physical health care.
- Screening for chronic conditions relevant to state Medicaid population.
- Screening for co- morbidity of behavioral health and substance use disorders within the waiver population compared to the total Medicaid population.
- Percentage of beneficiaries who rate the quality of their health care as very good or excellent.
- Percentage of beneficiaries who rate overall mental or emotional health as very good or excellent.
- Percentage of beneficiaries who demonstrate very good or excellent knowledge of available treatment and services.
- Maternal depression
- Maternal domestic abuse
- Percentage of beneficiaries who experienced alcoholism or mental health disorder among household members.
- Percentage of beneficiaries who witnessed violence or physical abuse between household members.
- Percentage of youth beneficiaries who have ever been physically hurt by an adult in any way.
- Maternal marijuana or hash use in the past two years.
- Frequency of maternal marijuana or hash use (days per week).

Evaluation Hypothesis: The Demonstration will decrease the rate of drug overdoses and overdose deaths due to opioids.



Measures

- Rate of overdose deaths, specifically overdose deaths due to any opioid
- Non-fatal Overdoses (all cause).
- Use of Opioids at High Dosage in Persons Without Cancer (NQF 2940).

Evaluation Question 3: Does the Demonstration reduce the cost of Medicaid for Alaska and the Federal Government?

Evaluation Hypothesis: The Demonstration will reduce Alaska's per capita Medicaid behavioral health costs.

Measures

- Total costs of healthcare (sum of parts below), by state and federal share.
- Total cost of SUD, SUD- IMD and SUD-Other and Non-SUD, by setting (including claims data (inpatient (IP), outpatient (OT), pharmacy (RX), long-term care (LT), and capitated payments to managed care organizations).
- Total cost of behavioral health diagnosis by IMD and Other, by setting (including claims data (inpatient (IP), outpatient (OT), pharmacy (RX), long-term care (LT), and capitated payments to managed care organizations).

WAIVER AND EXPENDITURE AUTHORITIES

Alaska continues to target the services under the 1115 waiver Demonstration and requests extended waiver of comparability under section 1902(a)(10)(B) of the act to vary the amount, duration, and scope of services to eligible beneficiaries only.

The phased-in schedule to cover the behavioral health benefits and continuum of SUD services as set forth in the approved STCs and SUD Implementation Plan Protocol, beginning January 1, 2019, and September 3, 2019, under the original waiver applications is complete. As such, the waiver services are available on a statewide basis and Alaska no longer seeks to waive section 1902(a)(1) of the Social Security Act.

Alaska requests a renewal of the expenditure authorities granted in the original Demonstration. A list of the already approved expenditure authorities can be found in the benefits section on pages 4 through 6 of this document. Alaska intends to continue to pilot the service array authorized by the waiver, given initial disruptions in implementation due to staggered start dates of waiver programs, the COVID-19 pandemic, and transition to ASO administration of core functions.

Appendix E: Abbreviated Public Notice



Abbreviated Public Notice

This abbreviated public notice provides information regarding the State of Alaska Department of Health (DOH) seeking public comments on a Section 1115 Behavioral Health Demonstration Waiver (the SUD-BHP Demonstration) extension application. The Demonstration was designed to centralize Alaska’s behavioral health system under a sustainable financing model to ensure access to the full continuum of behavioral health and SUD services. The initial waiver authorized 25 services, including residential and inpatient treatment in Institutions for Mental Diseases (IMDs), with emphasis on early interventions, a crisis services infrastructure, community-based outpatient services, residential treatment when appropriate, and enhanced community recovery supports. Alaska is seeking an extension of the Demonstration to continue the progress made under the program as currently authorized. Current beneficiaries will maintain existing access to services. Through the approval of this renewal request, Alaska proposes to update the 1115 Demonstration name from the current Substance Use Disorder Treatment and Behavioral Health Program (SUD-BHP) title to the Behavioral Health Reform Waiver, with the broader behavioral health term encompassing both mental health and substance use disorder and reflecting Alaska’s ongoing commitment to program reform and system transformation.

The proposed Demonstration extension application and full public notice are available online at: <https://health.alaska.gov/dbh/Pages/1115/default.aspx>.

In addition, the draft documents are also available in hard copy at:

Alaska Department of Health, Division of Behavioral Health
3601 C Street, Suite 878
Anchorage, Alaska 99503

Hard copies are also available upon request by calling: (907) 269-3600.

Interested persons should submit comments to DOH on the proposed extension during the public comment period beginning **January 9, 2023** and ending **February 8, 2023** at **5:00 p.m. AKST**. Written comments on the proposed can be submitted via three channels:

1. Email to doh.dbh.public.comments@alaska.gov, referencing “1115 Renewal” in the subject line
2. Electronic submission through the Alaska Online Public Notices System located at <https://aws.state.ak.us/OnlinePublicNotices/> and using the “Leave a Comment” link
3. U.S. Mail to:

Alaska Department of Health, Division of Behavioral Health
Re: 1115 Waiver Renewal Application Comments
3601 C Street, Suite 878
Anchorage, Alaska 99503

The state will hold two public hearings for interest parties to learn more about the waiver renewal application, ask questions, and provide public comments. The public hearings will be held virtually at the following dates, times, and locations. Individuals with disabilities who require special accommodations in order to attend these public meetings, should contact Heather Phelps at (907) 269-3616 or email at heather.phelps@alaska.gov to ensure that any necessary accommodations can be provided.

<u>Public Hearing #1</u>	<u>Public Hearing #2</u>
January 20, 2023 9:30am – 11:30am Please join the public hearing by following this link: https://us02web.zoom.us/j/83576266762?pwd=U1oxbUJMR0pDSIBURnFmSTNGaFA4UT09	January 27, 2023 9:30am – 11:30am Please join the public hearing by following this link: https://us02web.zoom.us/j/87373191962?pwd=OWF0Z3pZL2lxOFIPZmMzVUpHaDRVQT09

Appendix F: CMS Approval to Hold Virtual Public Hearings

From: Walaszek, Edwin (CMS/CMCS) <[REDACTED]>
Sent: Thursday, September 22, 2022 4:46 AM
To: Brown, Farina E (DOH) <[REDACTED]>; Moreau-Johnson, Gennifer L (DOH) <[REDACTED]>; Garza, Maria (CMS/CMCS) <[REDACTED]>
Cc: King, Courtney O (DOH) <[REDACTED]>
Subject: 1115 public hearing

Good morning Alaska:

I just wanted to reach out regarding some guidance that was confirmed by CMS regarding options available for the 1115 public hearing format.

Our SDG group have confirmed the state can use the virtual alternative formats while we're in the PHE status.

Please let me know if there are additional questions or concerns.

Thank you,

Edwin Walaszek

Washington State Lead

Division of Program Operations – West | Medicaid & CHIP Operations Group

Center for Medicaid & CHIP Services | Centers for Medicare & Medicaid Services

Email: [REDACTED]

Appendix G: Tribal Notice

From: Beaulieu, Emily A (DOH) <[REDACTED]>

Sent: Wednesday, December 28, 2022 4:17 PM

To: [REDACTED]

Cc: King, Courtney O (DOH) <[REDACTED]>; Robb, Sylvan S (DOH) <[REDACTED]>; Ricci, Emily K (DOH) <[REDACTED]>; Carpenter, Heather R (DOH) <[REDACTED]>; Russell, Laura O (DOH) <[REDACTED]>; Moreau-Johnson, Gennifer L (DOH) <[REDACTED]>; Brown, Farina E (DOH) <[REDACTED]>

Subject: Opportunity for Consultation - Substance Use Disorder Treatment and Behavioral Health Program 1115 Demonstration Waiver Renewal

Good afternoon,

Attached to this email is a letter describing an opportunity for consultation.

Please distribute this information to all interested parties within the tribal health system and include both Courtney O’Byrne King ([REDACTED]) and me ([REDACTED]) on all responses.

Respectfully,

Emily

Emily Beaulieu
Medicaid State Plan Coordinator
Department of Health – Commissioner’s Office
3601 C Street, Suite 902
Anchorage, AK 99503
Phone: 907-538-7665
Work Hours: 7:30 AM – 4:00 PM

[Medicaid State Plan](#)



THE STATE
of **ALASKA**
GOVERNOR MIKE DUNLEAVY

Department of Health

OFFICE OF THE COMMISSIONER

Anchorage

3601 C Street, Suite 902
Anchorage, Alaska 99503-5923
Main: 907.269.7800
Fax: 907.269.0060

Juneau

350 Main Street, Suite 404
Juneau, Alaska 99801
Main: 907.465.3030
Fax: 907.465.3068

December 28, 2022

Dear Tribal Health Leaders,

On behalf of the Department of Health and in keeping with the responsibility to conduct tribal consultation, I am writing to inform you of the proposed renewal application for the Substance Use Disorder Treatment and Behavioral Health Program 1115 demonstration waiver ("Demonstration"). As Alaska's current authority for the Demonstration ends in December 2023, the Division of Behavioral Health (DBH) is developing a waiver renewal request to the Centers for Medicare and Medicaid Services (CMS). Approval of this extension request will support the continued transformation of Alaska's behavioral health (BH) and substance use disorder (SUD) delivery system. DBH recognizes that achieving the state's vision is a long-term path. The collaboration of the Demonstration between the state, tribal health organizations, and other stakeholders has been instrumental in achieving significant steps of this path.

While progress has been made over the course of the original Demonstration period, the waiver implementation has faced some significant challenges including the COVID-19 pandemic and rise in fentanyl use. This impacted progress, creating unforeseen barriers to implementation and simultaneously contributing to higher behavioral health morbidity and mortality. There has not been sufficient time to completely implement waiver programs and realize the fully anticipated outcomes. As such, DBH envisions the Demonstration renewal as a continuation of efforts toward a consistent vision and set of strategic goals for behavioral health service delivery in Alaska.

This letter is to give Tribal Health Organizations and eligible tribal beneficiaries an overview of the renewal application and an opportunity to request a meeting on the state's upcoming request to CMS. To access the renewal application and additional information, please go to the following webpage - <https://health.alaska.gov/dbh/Pages/1115/default.aspx> on or after January 9, 2023 when the application will be released for public notice.

Renewal Application Overview and Crosswalk to Original Application

DBH seeks to maintain the current waiver with minimal changes. The renewal goal is to satisfy CMS requirements to extend the waiver for another five years (January 2024 – December 2028) and continue efforts towards full implementation. Through the approval of this renewal request, Alaska proposes to update the 1115 Demonstration name from the current Substance Use Disorder Treatment and Behavioral Health Program (SUD-BHP) title to the Behavioral Health Reform Waiver, with the broader behavioral health term encompassing both mental health and substance use disorder and reflecting Alaska’s ongoing commitment to program reform and system transformation.

Goals and Objectives – Unchanged from Original Application

Alaska’s Demonstration has centered around three overarching objectives:

1. Rebalance the current behavioral health system of care to reduce Alaska’s over-reliance on acute, institutional care and shift to more community- or regionally based care.
2. Intervene as early as possible in the lives of Alaskans to address behavioral health symptoms before they cascade into functional impairments.
3. Improve overall behavioral health system accountability by reforming the existing system of care.

The state has identified long-term goals, also unchanged, for the Demonstration:

1. Increased rates of identification, initiation, and engagement in treatment for SUD and BH issues.
2. Increased adherence to and retention in treatment for SUD and BH issues.
3. Reduced overdose deaths, particularly those due to opioids.
4. Reduced utilization of emergency departments and inpatient hospital settings for SUD and BH treatment where the utilization is preventable or medically inappropriate through improved access to other more appropriate and focused services.
5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate.
6. Improved access to care for physical health conditions among beneficiaries.

Alaska has demonstrated progress toward achieving several of these goals. The state has authorized numerous BH and SUD agencies to provide care, increased access to telehealth, and made progress in aligning with nationally recognized criteria for BH and SUD providers. The state will use this extension to continue to work toward achieving its goals to increase access to services and improve outcomes.

Eligibility, Cost Sharing, Benefits, and Delivery System – Unchanged from Original Application

Alaska seeks to maintain the existing delivery system, eligibility requirements, benefit coverage, and cost sharing as established by the prior Demonstration application.

Hypothesis and Evaluation Parameters – Unchanged from Original Application

The state proposes to evaluate this extension of the Demonstration utilizing the evaluation questions, hypotheses, and measures from the original application.

Waiver and Expenditure Authorities Requested – Minor Change from Original Application

Alaska continues to target the services under the 1115 waiver Demonstration and requests extended waiver of comparability under section 1902(a)(10)(B) of the act to vary the amount, duration, and scope of services to eligible beneficiaries only.

The phased-in schedule to cover the behavioral health benefits and continuum of SUD services as set forth in the approved STCs and SUD Implementation Plan Protocol, beginning January 1, 2019, and September 3, 2019, under the original waiver applications is complete. As such, the waiver services are available on a statewide basis and Alaska no longer seeks to waive section 1902(a)(1) of the Social Security Act.

Alaska requests a renewal of the expenditure authorities granted in the original Demonstration. Alaska intends to continue to pilot the service array authorized by the waiver, given initial disruptions in implementation due to staggered start dates of waiver programs, the COVID-19 pandemic, and transition to Administration Services Organization (ASO) administration of core functions.

Enrollment and Expenditures – Updated from Original Application

As part of the 1115 waiver renewal application, the state is responsible for a budget neutrality demonstration that includes projected experience from demonstration year (DY) 6 through 10, defined as January 1, 2024 through December 31, 2028. Budget neutrality is a comparison of without waiver expenditures (WoW) to with waiver expenditures (WW). Budget neutrality for this 1115 Waiver, which was developed using CMS budget neutrality requirements, will be demonstrated using the per capita method: an assessment of the per member per month (PMPM) cost of the Demonstration.

To develop the budget neutrality projections, the state relied on historical incurred experience under the previous demonstration adjusted for the impact of enrollment and PMPM cost changes anticipated to occur between the historical period and the renewal Demonstration period. Table 1 below contains a summary of this information, where DY 03 represents the most recently calendar year of incurred experience (calendar year 2021) and DY 06 through 10 represent the renewal Demonstration period.

TABLE 1 - 1115 BUDGET NEUTRALITY PROJECTIONS BY GROUPING

GROUPING	DY 03	DY 06	DY 07	DY 08	DY 09	DY 10
SUD IMD						
Eligible Member Months	1,461	1,505	1,520	1,536	1,551	1,566
PMPM Cost	\$ 12,548.15	\$ 14,922.75	\$ 15,594.27	\$ 16,296.01	\$ 17,029.33	\$ 17,795.65
Expenditures	\$18,332,845	\$22,462,823	\$23,708,381	\$25,023,007	\$26,410,532	\$27,874,997
SUD Non-IMD						
Eligible Member Months	2,867,917	2,675,067	2,701,818	2,728,836	2,756,125	2,783,686
PMPM Cost	\$ 19.94	\$ 33.47	\$ 34.98	\$ 36.55	\$ 38.19	\$ 39.91
Expenditures	\$ 57,193,269	\$ 89,534,506	\$ 94,509,596	\$ 99,738,965	\$ 105,256,399	\$ 111,096,903
BH Non-IMD						
Eligible Member Months	2,867,917	2,675,067	2,701,818	2,728,836	2,756,125	2,783,686
PMPM Cost	\$ 24.17	\$ 51.09	\$ 53.39	\$ 55.79	\$ 58.30	\$ 60.92
Expenditures	\$69,329,383	\$136,669,193	\$144,250,067	\$152,241,774	\$160,682,065	\$169,582,143
Total Expenditures	\$144,855,497	\$248,666,522	\$262,468,044	\$277,003,747	\$292,348,996	\$308,554,042

Notes:

1. Values reflect state and federal expenditures.
2. DY 06 - DY 10 represent the waiver demonstration period of January 1, 2024 through December 31, 2028.
3. SUD IMD eligible member months are based on service recipient months, while eligible member months for the Non-IMD groupings include all Medicaid eligible members under age 65.
4. PMPM cost for the SUD IMD grouping reflects expenditures for all services. For the Non-IMD groupings, PMPM cost reflects 1115 services only.

Table 1 indicates a material increase in PMPM cost particularly for the SUD Non-IMD and BH Non-IMD groupings when moving from DY 03 through the waiver renewal period. A key driver of this result is observed and anticipated shifting from state plan to 1115 behavioral health services. Since the SUD Non-IMD and BH Non-IMD groupings in the budget neutrality demonstration include expenditures only for 1115 waiver services, this shifting of utilization from state plan to 1115 waiver services results in material projected cost increases under that limited definition. To reflect the impact of state plan to 1115 waiver shifting that has already occurred, plus the potential impact of further shifting during the next demonstration period, we developed the budget neutrality projections to reflect the anticipated distribution of state plan and 1115 service cost during the demonstration.

The state does not anticipate a material financial impact related to changes in this waiver renewal relative to the previous demonstration, including the provision of making services available statewide. Under the previous demonstration, the budget neutrality projections were developed such that the historical and projected experience reflected Medicaid enrollees in all regions of the state.

Written comments or questions regarding the proposed extension are due no later than the close of business, February 8, 2022. If seeking an in-person meeting regarding the proposed changes, please provide a written request within 15-days of the date of this letter. Please direct all written correspondence to Courtney O'Byrne King and Emily Beaulieu, Alaska Department of Health, 3601 C Street, Suite 902, Anchorage, AK 99503, or courtney.king@alaska.gov and emily.beaulieu@alaska.gov.

Sincerely,

/s/

Courtney O'Byrne King, MS and Emily Beaulieu

Medicaid State Plan Coordinators