The Centers for Medicare & Medicaid Services (CMS) customized the Monitoring Report Template (Version 3.0) to support Alaska's retrospective reporting of monitoring data for its section 1115 substance use disorder (SUD) demonstration. The state should use this customized template to report on retrospective metric trends as requested in the Monitoring Report Instructions (p. 12 of Version 3.0). This template was customized for retrospective reporting in the following ways:

- *Added footnote C to the title page in section 1*
- *The table in section 3 (Narrative information on implementation, by milestone and reporting topics) has been modified to ask the state to report general trends for each Milestone, rather than changes (+ or -) greater than 2 percent for each metric.*
- *The prompts in section 3 that requested implementation updates were removed.*
- *Section 4 (Narrative information on other reporting topics) has been removed entirely.*

1. Title page for the state's SUD demonstration or the SUD component of the broader demonstration

CMS has pre-populated the title page for the state (see blue text). The state should review the pre-populated text and confirm that it is accurate. Definitions for certain rows are below the table.

State	*Alaska*
Demonstration name	*Alaska Substance Use Disorder and Behavioral Health Program (SUD -BHP) (Project Number: 11-W-00318/0)*
Approval period for section 1115 demonstration	*01/01/2019-12/31/2023*
SUD demonstration start date[a]	*01/01/2019*
Implementation date of SUD demonstration, if different from SUD demonstration start date[b]	*07/01/2019*
SUD (or if broader demonstration, then SUD -related) demonstration goals and objectives	• *Increased rates of identification, initiation, and engagement in treatment* • *Increased adherence to and retention in treatment* • *Reduced overdose deaths, particularly those due to opioids* • *Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other more appropriate and focused SUD use/misuse/abuse- related services* • *Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate* • *Improved access to care for physical health conditions among beneficiaries*
SUD demonstration year and quarter[c]	*SUD DY1Q2 – SUD DY2Q3*
Reporting period[c]	*10/01/2019 – 03/31/2021*

[a] **SUD demonstration start date:** For monitoring purposes, CMS defines the start date of the demonstration as the *effective date* listed in the state's STCs at time of SUD demonstration approval. For example, if the state's STCs at the time of SUD demonstration approval note that the SUD demonstration is effective January 1, 2020 – December 31, 2025, the state should consider January 1, 2020 to be the start date of the SUD demonstration. Note that the effective date is considered to be the first day the state may begin its SUD demonstration. In many cases, the effective date is distinct from the approval date of a demonstration; that is, in certain cases, CMS may approve a section 1115 demonstration with an effective date that is in the future. For example, CMS may approve an extension request on 12/15/2020, with an effective date of 1/1/2021 for the new demonstration period. In many cases, the effective date also differs from the date a state begins implementing its demonstration.

[b] **Implementation date of SUD demonstration:** The date the state began claiming federal financial participation for services provided to individuals in institutions for mental disease.

[c] **SUD demonstration year and quarter, and reporting period.** The demonstration year, quarter, and calendar dates associated with the monitoring reports in which the metric trends would have been reported according to the reporting schedule in the state's approved monitoring protocol. For example, if the state's first monitoring report after monitoring protocol approval is its SUD DY2Q4 monitoring report, the retrospective reporting period is considered SUD DY1Q2 through SUD DY2Q3.

2. Executive summary

The executive summary should be reported in the fillable box below. It is intended for summary-level information of metrics trends from the retrospective reporting period. The recommended word count is 500 words or less.

This retrospective report includes all quarters that establish the State of Alaska's 1115 SUD Demonstration Metric count baselines, plus two additional quarters to bridge the gap from inception reporting to the State's 09.30.2021 live submission for DY2Q4. Given the time periods assessed, all retrospective counts align with CMS's Technical Specifications Guidance v3.0. The State anticipates incorporating v4.0 criteria into the live schedule submission for SUD DY3Q1, including all CMS-constructed Quarterly, Annual and CY2021 EQM Metrics

Exhaustive State efforts have resulted in new relationships between historically disparate datasets, allowing the Division of Behavioral Health to report on unique subpopulations of interest that have historically been underrepresented in previous reporting deliverables.

Emergency expansion of Medicaid-reimbursable telehealth services throughout the COVID-19 pandemic played a significant role in supporting continued client access to critical care services. However, reduced counts may be reported during quarters that align with observed peaks in viral transmission rate as a result of individual illness, implementation of mitigation efforts that restricted access to in-person services, and agency infrastructure overhauls to adopt a telehealth service delivery model for eligible categories.

Please note that full claims maturity may not be observed for the DY2Q2 and DY2Q3 reporting periods, as the 1-year timely filing allowance may not have been exhausted at the time of report generation. The State anticipates continued discussions with our CMS partners regarding the reporting impacts of revising the current 6-month claims runout period.

3. Narrative information on implementation, by milestone and reporting topic

The state should provide a general summary of metric trends by milestone and reporting topic for the entire retrospective reporting period. In these general summaries, the state should discuss any relevant trends that the data shows related to each milestone or reporting topic, including trends in state-specific metrics.

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State summary of retrospective reporting period
1. Assessment of need and qualification for SUD services			
1.1 Metric trends			
1.1.1. The state reports the following metric trends related to assessment of need and qualification for SUD services		Metrics 3 and 4	3 – Average quarterly counts of Medicaid Beneficiaries with an SUD Diagnosis remain consistent from baseline period through DY2Q3. 4 – The State reports an annual baseline count of 27,268 distinct Medicaid beneficiaries with an SUD diagnosis.
2. Access to Critical Levels of Care for OUD and other SUDs (Milestone 1)			
2.1 Metric trends			

2.1.1 The state reports the following metric trends related to Milestone 1		Metrics 6, 7, 8, 9, 10, 11, 12 and 22	Emergency expansion of Medicaid-reimbursable telehealth services throughout the COVID-19 pandemic played a significant role in supporting continued client access to critical care services. However, reduced counts may be reported during quarters that align with observed peaks in viral transmission rate as a result of individual illness, implementation of mitigation efforts that restricted access to in-person services, and agency infrastructure overhauls to adopt a telehealth service delivery model for eligible categories. 6 – Average quarterly counts of Medicaid Beneficiaries with any SUD treatment remained consistent from baseline period through DY2Q3. 7 – Reports '0' counts for Medicaid Beneficiaries receiving SUD Early Intervention services until DY1Q4. In the Alaska BH system of care Early Intervention services have traditionally been funded outside of the Medicaid program. The State is actively transitioning away from historical reliance on grant funding opportunities to support a full continuum of care and has since incorporated a more complete array of service offerings as part of its Medicaid billable array. 8 – Reduced counts for DY1Q4 and DY2Q1 for Medicaid Beneficiaries using Outpatient Services may be a result of COVID-19 pandemic mitigation efforts restricting availability of in-person services as well as marking the transition period for agency providers to adopt telehealth delivery. 9 – Reduced counts for DY1Q4 through DY2Q2 for Medicaid Beneficiaries using SUD Intensive Outpatient and Partial Hospitalization may be a result of COVID-19 pandemic mitigation efforts restricting availability of in-person services.

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State summary of retrospective reporting period
			10 – Historically limited bed availability for Medicaid Beneficiaries using SUD Residential and Inpatient services were reduced further by COVID-19 pandemic mitigation efforts restricting availability of in-person services. The growth seen in DY2Q2 aligns with an IMD provider gaining approval to bill Medicaid for services rendered pursuant to the 1115 Waiver exclusion. 11 – Fluctuations in average quarterly counts of Medicaid Beneficiaries using SUD Withdrawal Management services may be a result of COVID-19 pandemic mitigation efforts restricting availability of in-person services and a temporary program closure for one of the State's larger agency's scheduled renovation projects. 12 – Retrospective counts for Medicaid Beneficiaries receiving MAT services for SUD report steady growth in line with annual and demonstration target goals. 22 – The State reports an annual baseline rate of 21.38% of eligible adults 18+ with pharmacotherapy for OUD who have at least 180 days of continuous treatment.
3. Use of Evidence-based, SUD-specific Patient Placement Criteria (Milestone 2)			
3.1 Metric trends			

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State summary of retrospective reporting period
3.1.1 The state reports the following metric trends related to Milestone 2		Metrics 5 and 36	5 and 36 – The State reports an annual baseline count of 68 unique Medicaid beneficiaries with an SUD diagnosis receiving treatment in an IMD, with an average length of stay of 15.22 days. Temporary reductions in bed availability for SUD residential agency providers, including those that would otherwise meet 1115 Demonstration IMD waiver exclusion criteria (16+ beds), were likely a result of COVID-19 pandemic mitigation efforts restricting availability of in-person services.

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State summary of retrospective reporting period
4. Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities (Milestone 3)			
4.1 Metric trends			
4.1.1 The state reports the following metric trends related to Milestone 3 *Note: There are no CMS-provided metrics related to Milestone 3. If the state did not identify any metrics for reporting this milestone, the state should indicate it has no update to report.*	X		
5. Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD (Milestone 4)			
5.1 Metric trends			
5.1.1 The state reports the following metric trends related to Milestone 4		Metrics 13 and 14	13 – The State reports an annual baseline count of 398 providers (reliant on QAP methodology) who were enrolled in Medicaid and qualified to deliver SUD services. 14 – The State reports an annual baseline count of 4 (methadone facilities only) provider who were enrolled in Medicaid and qualified to deliver MAT services. At this time, buprenorphine provider information is not available to the State for inclusion in Metric counts.
6. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD (Milestone 5)			
6.1 Metric trends			

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State summary of retrospective reporting period
6.1 The state reports the following metric trends related to Milestone 5		Metrics 18, 21, 23 and 27	18 – The State reports an annual baseline rate of 13.57% of eligible adults 18+ who received Prescriptions for Opioids for SUD with an Average Dosage Equal or Greater than 90 MME over a period of 90+ days. 21 – The State reports an annual baseline rate of 13.50% of eligible adults 18+ with Concurrent Use of Prescription Opioids and Benzodiazepines. 23 – Retrospective counts for Emergency Department Utilization for SUD report a steady rate reduction in line with annual and demonstration target goals. DY2Q2 is an exception to this observed trend. 27 – The State reports an annual baseline rate of 0.38 Overdose Deaths per 1,000 Medicaid beneficiaries.
7. Improved Care Coordination and Transitions between Levels of Care (Milestone 6)			
7.1 Metric trends			
7.1.1 The state reports the following metric trends related to Milestone 6		Metrics 15, 17(1), 17(2) and 25	15 – The State reports a Total AOD population annual baseline rate of 62.04% Initiation and 27.36% Engagement of Alcohol and Drug Abuse Dependence Treatment for Medicaid beneficiaries 18+ with a new episode. 17(1) – The State reports a baseline rate of 27.85% for 30-Day and 18.49% for 7-Day Follow-up for Medicaid beneficiaries 18+ after an Emergency Department Visit for AOD. 17(2) – The State reports a baseline rate of 53.55% for 30-Day and 39.79% for 7-Day Follow-up for Medicaid beneficiaries 18+ after an Emergency Department Visit for Mental Illness.

Prompt	State has no trends/update to report (place an X)	Related metric(s) (if any)	State summary of retrospective reporting period
8. SUD health information technology (health IT)			
8.1 Metric trends			
8.1.1 The state reports the following metric trends related to its health IT metrics		State Health IT Q1, Q2 and Q3	Q1 – The State reports an annual baseline count of 7,736,304 for the Number of Schedule II Prescriptions Dispensed to Medicaid beneficiaries. Q2 – The State reports an annual baseline count of 178 for the Number of Medicaid Professionals Trained in MAT through Alaska's Project Echo. Q3 – The State reports an annual baseline count of 121 for the Number of Organizations on Electronic Referral Platforms Connected to Alaska's Division of Behavioral Health.
9. Other SUD-related metrics			
9.1 Metric trends			
9.1.1 The state reports the following metric trends related to other SUD-related metrics		Metrics 24, 26 and 32	24 – Retrospective counts for Total Inpatient Stays per 1,000 Medicaid beneficiaries report a steady rate reduction in line with annual and demonstration target goals. DY2Q2 is an exception to this observed trend. 26 – The State reports an annual baseline count of 90 total Overdose Deaths among Medicaid beneficiaries. 32 – The State reports an annual baseline rate of 9.67% of Medicaid beneficiaries with SUD who had an Ambulatory or Preventative Care visit.

Note: Licensee and states must prominently display the following notice on any display of Measure rates:

Measures IET-AD, FUA-AD, FUM-AD, and AAP [Metrics #15, 17(1), 17(2), and 32] are Healthcare Effectiveness Data and Information Set (HEDIS®) measures that are owned and copyrighted by the National Committee for Quality Assurance (NCQA). HEDIS measures and specifications are not clinical guidelines, do not establish a standard of medical care and have not been tested for all potential applications. The measures and specifications are provided "as is" without warranty of any kind. NCQA makes no representations, warranties or endorsements about the quality of any product, test or protocol identified as numerator compliant or otherwise identified as meeting the requirements of a HEDIS measure or specification. NCQA makes no representations, warranties, or

endorsement about the quality of any organization or clinician who uses or reports performance measures and NCQA has no liability to anyone who relies on HEDIS measures or specifications or data reflective of performance under such measures and specifications.

The measure specification methodology used by CMS is different from NCQA's methodology. NCQA has not validated the adjusted measure specifications but has granted CMS permission to adjust. A calculated measure result (a "rate") from a HEDIS measure that has not been certified via NCQA's Measure Certification Program, and is based on adjusted HEDIS specifications, may not be called a "HEDIS rate" until it is audited and designated reportable by an NCQA-Certified HEDIS Compliance Auditor. Until such time, such measure rates shall be designated or referred to as "Adjusted, Uncertified, Unaudited HEDIS rates."

Alaska Medicaid Section 1115 SUD Demonstration Status Report

Operational Updates for SUD Components for Pre-Implementation Period

July 1 – September 30, 2020

I. Transmittal Page for the State's SUD Demonstration or SUD Components of Broader Demonstration

The state should complete this Transmittal Title Page at the beginning of a demonstration and submit as the title page of all SUD Monitoring Reports. The content of this transmittal table should stay consistent over time.

State	Alaska
Demonstration Name	Alaska Medicaid Section 1115 Behavioral Health Demonstration (SUD -BHP) (Project Number: 11-W-00318/0)
Approval Dates	SUD Component: November 28, 2018 BH Component: September 3, 2019
Approval Periods	SUD Component: January 1, 2019 – December 31, 2023 BH Component: September 3, 2019 – December 31, 2023
Demonstration Goals and Objectives	Goal: Create a data-driven, integrated behavioral health system of care for Alaskans with serious mental illness, severe emotional disturbance, and/or substance use disorders. Objectives: • Increased rates of identification, initiation, and engagement in treatment • Increased adherence to and retention in treatment • Reduced overdose deaths, particularly those due to opioids • Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other more appropriate and focused SUD use/misuse/abuse- related services • Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate • Improved access to care for physical health conditions among beneficiaries

II. Operational Updates

Describe all operational updates and activity under the demonstration.

The state has made progress on implementation of the SUD component of the 1115 demonstration waiver. The following is a summary of activities between July 1, 2020 and September 30, 2020:

To date, the Division of Behavioral Health (DBH) has authorized approximately 30 MH agencies and 48 SUD agencies, operating in 206 site locations, with over 818 individual rendering providers to deliver 1115 services within the State of Alaska.

The State continues to revise its Evaluation Design based upon CMS feedback. Notably, the State awarded the contract for an Independent Evaluator (IE) during the review period. Collaboration between the State and the IE is anticipated to contribute significantly to further refinement and implementation of the Evaluation Design.

During the review period, DBH's Research & Analysis (R&A) section made significant progress in validation of the State/Optum automated financial interface. DBH now receives files with 1115 and State Plan Services claims activity reported across multiple fiscal years and has successfully cross walked the ASO's file with the DBH system. It is highly likely that DBH will be able to officially report claims expenditures on the CMS64 beginning in October 2020. These efforts will ensure data elements align with reporting needs and audit policy within the finalized automated production environment. The State eagerly anticipates transitioning administrative burden to our ASO partners.

With live claims processing, Optum launched an information dashboard that provided the State with a suite of pre-built reporting metrics. State plan services claims processing went live on July 1, and DBH R&A section representatives continue conversations with our ASO partner to better define data access and elements of interest for both regular, standardized reporting and ad-hoc data needs.

The 6-part webinar series on Peer Support that DBH hosted continued into this quarter. This series was created in partnership with the SAMHSA-funded technical assistance group BRSS-TACS. Many nationally recognized figures in the field of Peer Support and Recovery contributed to create this one-of-a-kind, excellent series exclusively for Alaska, which showcased the effectiveness of peer support as a part of a behavioral health system and provided insight into how to develop and integrate peer support practices into behavioral health services. The community response to the series

was extremely positive and enthusiastic about continuing to develop Peer Support in Alaska.

In response to the ongoing crisis of the COVID-19 pandemic, the State has continued to support utilization of telehealth behavioral health services. Effective 5/21/2020, the list of services that providers can bill for telephonic or telehealth video services has been expanded to include services from the 1115 Waiver service array. As an emergency regulation, the department adopted changes in Title 7 of the Alaska Administrative Code dealing with Medicaid 1115 behavioral health waiver services; the department intends to make this regulation permanent. Additionally, the AK Responders Relief Line that went live May 5 continues to provide crisis counseling and general support for healthcare and behavioral professionals, and their immediate family members, who have been impacted by COVID-19 in their professional and personal lives.

On 9/4/2020, the state filed to make the changes to Alaska Administrative Code Title 7 permanent. These changes were adopted in May as an emergency regulation, but the Department of Health and Social Services always intended to make them permanent. All manuals and rate charts are in the process of being updated with the relevant regulatory and/or rate changes. This permanent package is bringing the 1115 to fruition.

The State continues to host provider outreach opportunities, to address shortfalls in navigating DBH and Optum enrollment site activities, reviewing 1115 Wavier service delivery criteria, and authorization and claim form completion and submission requirements. DBH continues to monitor all claims transactions to support providers throughout the Waiver transition and implementation period.

III. Performance Metrics

Narrative description on the information here regarding the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care.

During the review period 644 unique members received 18,765 units of 1115 SUD treatment services, totaling $2,784,087.89. Broken out by member categories (Tables 1 and 2), the data illustrates that Medicaid Expansion recipients are the primary beneficiaries' of 1115 services during this quarter ($2.3 million, 82.56% total expenditures). In terms of treatment service codes (Table 3), approximately $1.8 million (66.16% total expenditures) was paid to support expanded 1115 residential services.

Table 1. Service Units and Amount Paid Broken Out by Member Eligibility Category

Member Elig Category	Paid Units	Total Paid
Disabled	999	$255,296.13
General MCAID	1827	$230,144.93
Expansion	15939	$2,298,646.83
Grand Total	**18765**	**$2,784,087.89**

Table 2. Service Units and Amount Paid Broken Out by Member Eligibility Code

Medicaid Mem Elig Cd	Paid Units	Paid Amount
AD11SI	15	$6,829.35
AD20DW	3	$342.92
AD20SI	642	$156,169.42
AD20ST	128	$59,485.52
AD69SI	24	$21,349.02
AD69ST	187	$11,119.90
AF11PB	8	$2,367.99
AF11PR	83	$7,042.52
AF20AF	1558	$179,042.56
AF20FF	72	$559.44
AF20MI	57	$25,951.53
AF20MX	15882	$2,272,695.30
AF50TI	30	$13,658.70
AF50TO	76	$27,473.72
Grand Total	**18765**	**$2,784,087.89**

Table 3. Service Units and Amount Paid Broken Out by 1115 SUD Waiver Service code

Procedure Code	Paid Units	Paid Amount
H0001 V1	1	$221.51
H0007 HQ/HB/V1/GT	425	$3,582.75
H0007 V1	65	$1,666.60
H0007 V1/GT	16	$410.24
H0010 TF/V1	1	$710.00
H0010 TG/V1	461	$359,880.00
H0011 V1	98	$147,000.00
H0015 HQ/V1	4602	$35,754.14
H0015 HQ/V1/GT	1357	$13,257.89
H0015 V1	727	$21,289.59
H0015 V1/GT	118	$3,493.98
H0023 V1	1388	$39,643.09
H0023 V1/GT	77	$2,843.32
H0035 V1	483	$241,500.00
H0035 V1/GT	38	$19,000.00
H0047 TG/V1	3042	$1,384,976.27
H0047 V1	15	$4,500.00
H0047 V1/GT	8	$2,400.00
H2015 GT/V1	4	$86.48
H2015 HQ/V1	32	$276.80
H2021 HQ/V1	2662	$14,987.06
H2021 HQ/V1/GT	1292	$7,273.96
H2021 V1	421	$8,734.22
H2021 V1/GT	237	$5,086.02
H2021 V1/HQ/GT	32	$465.38
H2036 HF/V1	1094	$457,058.22
T1007 V1	61	$6,906.93
T1007 V1/GT	8	$1,083.44
Grand Total	**18765**	**$2,784,087.89**

IV. Evaluation Activities

Narrative description of any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

In terms of progress and developments regarding evaluation activities:

Per CMS's STC's, State of Alaska is required to have an Independent Evaluator (IE) to revise and conduct its 1115 Evaluation Design. Since May 18th, 2020, DBH has worked with our Independent Evaluator (Health Services Advisory Group) HSAG per the 9/3/19 STCs to ensure that HSAG has the information they have requested to complete the Mid Point Assessment (MPA) due 11/15/2020 in PMDA. Previously HSAG revised the Draft Evaluation Design (12/5/2019) and the Revised ED has been submitted (5/29/2020) as noted in a previous Quarterly Monitoring Report.

Weekly calls between DBH and HSAG ensure that the Independent Evaluator remains on track for successful completion of the work, including preparation and planning for the Mid-Point Assessment. DBH provided contact information to facilitate interviews and qualitative data collection, as well as provided copious amounts of materials regarding Medicaid data, including data files, audit files, provider information, data dictionaries and information on value and variable labels/definitions. DBH also provided other guidance documents needed for the MPA, including copies of other DBH submitted deliverables such as Budget Neutrality information and manuals and previously submitted Monitoring Reports, and documents regarding monitoring protocols and manuals, such as technical specification manuals. In addition, DBH provided information as to the status of completed and in-progress milestones so that HSAG could populate its MPA. DBH/SOA provided information via ample attachments as well as when warranted via FTP. Technical assistance such as demonstrations of AK's AKAIMS system and opportunities for communication with interdivisional SOA Medicaid staff was also provided.

HSAG has completed a range of qualitative interviews for the mixed methods MPA and is in the process of calculating a range of quantitative measures for the MPA. Presently, HSAG has created a draft MPA which is under review at DBH before its submission in PMDA by 11/15/2020, which falls under the next Quarterly Monitoring Report period. CMS has indicated an approval letter for the Revised Monitoring Protocol and Revised Evaluation Design will be arriving in the coming days or so.

V. SUD Health IT

Summarize of progress made regarding SUD Health IT.

Supporting expansion of the State's Health IT infrastructure remains a critical component of the State's contract with our Administrative Services Organization (ASO) partner, Optum. The State seeks an integrated primary and behavioral health care and case management system which complements a more holistic focus on client treatment and recovery support, especially for those with chronic behavioral and medical health conditions. DBH representatives are still in conversation with our ASO partner to define data access and elements of interest to the division for regular, standardized reporting.

From the monitoring protocol/metrics workbook:

Alaska Opioid Data Dashboard, DPH – *No update during the review period.* DBH eagerly anticipates the next scheduled upload of PDMP data in DY2 Q4.

Project ECHO (AK-ECHO), University of Alaska Anchorage Center for Human Development – AK-ECHO continues to provide a virtual learning network for interdisciplinary providers to discuss best practices and strategies to improve treatment outcomes for target clients. The AK-ECHO team has announced a third series launch of the successful "Pain & Opioid Management" program in October 2020, as well as a related November series entitled "Co-Occurring Behavioral Health, Opioid, and Stimulant Use Disorders". Building on programmatic success and stakeholder interest, several additional pilot ECHO series are scheduled to address a wide range of key behavioral and mental health topics.

The Alaska Behavioral Health Referral Network – TreatmentConnections continues to explore additional opportunities to create a more robust network, especially in targeted areas where Crisis Now will be operating. As of September 30, 2020, there are 27 receiving providers and 9 referring entities on network, including state sponsored providers and those with independent memberships. Several other providers statewide are currently in conversation with the TreatmentConnections team as well. Promotion of the platform as a valuable means of connecting vulnerable individuals across the state with behavioral health services is ongoing. A Telehealth campaign was instituted by TreatmentConnections to assist providers with the unique challenges associated with providing telehealth services. Recently, TreatmentConnections presented their platform to Optum as a potential sub-contractor after State sponsorship expires. The

TreatmentConnections team also presented their product platform to another community stakeholder (Alaska Mental Health Trust); they are currently reviewing partnerships/models/platforms/etc. that will help them implement the Crisis Now framework.

VI. Tribal Engagement and Collaboration Developments/Issues

A summary of the state's tribal engagement activities with respect to this demonstration.

State of Alaska representatives regularly participate in Alaska Tribal Health System (ATHS) meetings, ensuring attendance in the 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. Within the reporting period the State participated in MTF meeting on August 21st and TBHD meeting on September 18th. These meetings related to Tribal Engagement and Collaboration are ongoing and routine. The state remains open to Tribal BH Directors to schedule extra time during the already established TBHD meetings to discuss specific inquiry or concerns. During the quarter the Division actively engaged with Tribal partners in a series of workgroups aimed at solutioning through the 4-walls provision as identified in 42 CFR 440.90-Clinci Services.

- As part of the MEGA and MTF meetings the Division and tribal partners maintain open, direct conversation on the status of the implementation of the Alaska 1115 Medicaid Demonstration Waiver for substance use and behavioral health treatment services and the implementation of claims processing through the administrative services organization, Optum. As the pandemic continues to rage across the nation, and the state, the Division and Tribal partners maintain dialogue about the success and challenges of serving behavioral health clients during unprecedented times ensuring all available telehealth flexibilities are utilized.
- As part of the TBHD meeting the Division maintains open, direct conversation with the tribal directors on their success, challenges, and barriers implementing 1115 SUD and behavioral health services. The tribal liaison position remains vacant. The Division continues to rank open and direct communication between our tribal partners and Optum as key to productive feedback regarding the claims processing implementation and long-term outcomes.
    - TBHD feedback included comments and questions about the future sunset services and the relationship with new 1115 waiver services. The state also discussed the functions of the new Medicaid section manager and reiterated this position will continue to serve as the States tribal

liaison. Tribal partners provided feedback and concerns about enrollment and the administrative burden enrolling multiple facilities entails before they can begin implement 1115 behavioral health services.

- The state and behavioral health providers meet monthly during the Alaska Behavioral Health Association teleconference. Tribal providers participate in ABHA and serve on the executive committee. The 1115 waiver and other topics are discussed as standing agenda items during each monthly ABHA teleconference.
    - Based on feedback from ABHA the Division scheduled a series of 1115 waiver service training sessions to begin in October.
- The State of Alaska continues to invite ATHS representatives to participate in workgroups and policy meetings.
    - During this quarter, July 2020, representatives from ATHS participated as panelist during the annual Mental Health Block Grant site review, held virtually.
    - The Division and tribal partners meet bi-weekly for continued discussion on current services provided outside the 4-walls of a tribal clinic, the provision of 1115 behavioral health services, and the use of telehealth services.

VII. Financial/Budget Neutrality Developments/Allotment Neutrality Developments/Issues

Identify all significant developments/issues/problems with financial accounting, budget neutrality. Identify the State's actions to address these issues.

The BN Report continued this quarter in similar fashion as last quarter. The central issue currently is the BH and IMD that are not being programmed into the CMS 64 and therefore not being submitted to CMS. The bifurcated deployment of the 1115 Waiver's SUD and BH components created these challenges in fulfilling the STC's (IMD&BH) criteria.

In response, we continued the integration of the data collection and analysis on the SUD-IMD and the associated Optum, MMIS and DSS expenditures. Next, we executed DY 2 QTR 3 expenditures with our actuarial partner, then prepped Optum and MMIS expenditures for this quarter's BN. To accomplish this, we conducted meetings with DSS, Milliman and Research that focused on IRIS uploads/XML file that is specific to the IMD/Non IMD expenditures.

Through this manual analysis, Research can track when a provider that is not an IMD becomes an IMD (via expenditures). Though the data isn't transmitted via the MBES/CMS 64, we are including this data in the BN workbook. In addition, we outlined

plans for future Optum data to be programmed to produce IMD expenditures. These challenges are meticulously documented in our Budget Neutrality files.

VIII. Enclosures/Attachments

Identify by title any attachments along with a brief description of the information contained in the document.

There are no attachments for this status update.

IX. State Contact(s)

Identify individuals by name, title, telephone, fax, and address so that CMS may contact individuals directly with any questions.

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Enter the date submitted to CMS in the following format: (mm/dd/yyyy).

11/30/2020