DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

December 9, 2025

Emily Ricci
Deputy Commissioner
Alaska Department of Health
3601 C Street
Suite 902
Anchorage, Alaska 99503

Dear Deputy Commissioner Ricci:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the Alaska's Evaluation Design, as required by the Special Terms and Conditions (STCs), specifically, STC #11, of the "Behavioral Health Reform" section 1115 demonstration (Project Number 11-W-00318/0), effective through December 31, 2028. CMS has determined that the Evaluation Design, which was submitted on September 20, 2024 and revised on January 3, 2025 meets the requirements set forth in the STCs and CMS's evaluation design guidance, and therefore approves the Evaluation Design.

CMS has added the approved Evaluation Designs to the demonstration's STCs as Attachment C. A copy of the STCs, which includes the new attachment, is enclosed with this letter. In accordance with 42 CFR 431.424, the approved Evaluation Designs may now be posted to the state's Medicaid website within 30 days. CMS will also post the approved Evaluation Design as a standalone document, separate from the STCs, on Medicaid.gov.

Please note that an Interim Evaluation Report, consistent with the approved Evaluation Designs, is due to CMS one year prior to the expiration of the demonstration, or at the time of the extension application, if the state chooses to extend the demonstration. Likewise, a Summative Evaluation Report, consistent with the approved designs, is due to CMS within 18 months of the end of the demonstration period. In accordance with 42 CFR 431.428 and the STCs, we look forward to receiving updates on evaluation activities in the demonstration monitoring reports.

We appreciate our continued partnership with Alaska on the Behavioral Health Reform section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

DANIELLE DALY -S

Digitally signed by DANIELLE DALY -S
Date: 2025.12.09 11:35:58 -05'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Maria Garza, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

June 25, 2025

Emily Ricci
Deputy Commissioner
Alaska Department of Health
3601 C Street
Suite 902
Anchorage, Alaska 99503

Dear Deputy Commissioner Ricci:

The Centers for Medicare & Medicaid Services (CMS) is updating the section 1115 demonstration monitoring approach to reduce state burden, promote effective and efficient information sharing, and enhance CMS's oversight of program integrity by reducing variation in information reported to CMS.

Federal section 1115 demonstration monitoring and evaluation requirements are set forth in section 1115(d)(2)(D)-(E) of the Social Security Act (the Act), in CMS regulations in 42 CFR 431.428 and 431.420, and in individual demonstration special terms and conditions (STCs). Monitoring provides insight into progress with initial and ongoing demonstration implementation and performance, which can detect risks and vulnerabilities to inform possible course corrections and identify best practices. Monitoring is a complementary effort to evaluation. Evaluation activities assess the demonstration's success in achieving its stated goals and objectives.

Key changes of this monitoring redesign initiative include introducing a structured template for monitoring reporting, updating the frequency and timing of submission of monitoring reports, and standardizing the cadence and content of the demonstration monitoring calls.

Updates to Demonstration Monitoring

Below are the updated aspects of demonstration monitoring for the Behavioral Health Reform (Project Number 11-W-00318/0) demonstration.

Reporting Cadence and Due Date

CMS determined that, when combined with monitoring calls, an annual monitoring reporting cadence will generally be sufficient to monitor potential risks and vulnerabilities in demonstration implementation, performance, and progress toward stipulated goals. Thus, pursuant to CMS's authority under 42 CFR 431.420(b)(1) and 42 CFR 431.428, CMS is updating the cadence for this demonstration to annual monitoring reporting (see also section

1115(d)(2)(D)-(E) of the Act). This transition to annual monitoring reporting is expected to alleviate administrative burden for both the state and CMS. In addition, CMS is extending the due date of the annual monitoring report from 90 days to 180 days after the end of each demonstration year to balance Medicaid claims completeness with the state's work to draft, review, and submit the report timely.

CMS might increase the frequency of monitoring reporting if CMS determines that doing so would be appropriate. The standard for determining the frequency of monitoring reporting will ultimately be included in each demonstration's STCs. CMS expects that this standard will permit CMS to make on-going determinations about reporting frequency under each demonstration by assessing the risk that the state might materially fail to comply with the terms of the approved demonstration during its implementation and/or the risk that the state might implement the demonstration in a manner unlikely to achieve the statutory purposes of Medicaid. *See* 42 CFR 431.420(d)(1)-(2).

The Behavioral Health Reform demonstration will transition to annual monitoring reporting effective June 25, 2025. The next annual monitoring report will be due on June 29, 2026, which reflects the first business day following 180 calendar days after the end of the current demonstration year. The demonstration STCs will be updated in the next demonstration amendment or extension approval to reflect the new reporting cadence and due date.

Structured Monitoring Report Template

As noted in STC 8.6, "Monitoring Reports," monitoring reports "must follow the framework provided by CMS, which is subject to change as monitoring systems are developed / evolve and be provided in a structured manner that supports federal tracking and analysis." Pursuant to that STC, CMS is introducing a structured monitoring report template to minimize variation in content of reports across states, which will facilitate drawing conclusions over time and across demonstrations with broadly similar section 1115 waivers or expenditure authorities. The structured reporting framework will also provide CMS and the state opportunities for more comprehensive and instructive engagement on the report's content to identify potential risks and vulnerabilities and associated mitigation efforts as well as best practices, thus strengthening the overall integrity of demonstration monitoring.

This structured template will include a set of base metrics for all demonstrations. For demonstrations with certain waiver and expenditure authorities, there are additional policy-specific metrics that will be collected through the structured reporting template.

Some of the metrics currently required for Substance Use Disorder (SUD) and Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED) demonstrations will no longer be required.

CMS is also removing the requirement for a Monitoring Protocol deliverable, which has been required under certain types of section 1115 demonstration, including but not limited to the SUD, SMI/SED, Health-Related Social Needs (HRSN), and reentry demonstrations. Removal of the Monitoring Protocol requirement simplifies and streamlines demonstration monitoring activities for states and CMS.

Demonstration Monitoring Calls

As STC 8.10 "Monitoring Calls" describes, CMS may "convene periodic conference calls with the state," and the calls are intended "to discuss ongoing demonstration operation, including (but not limited to) any significant actual or anticipated developments affecting the demonstration." Going forward, CMS envisions implementing a structured format for monitoring calls to provide consistency in content and frequency of demonstration monitoring calls across demonstrations. CMS also envisions convening quarterly monitoring calls with the state and will follow the structure and topics in the monitoring report template. We anticipate that standardizing the expectations for and content of the calls will result in more meaningful discussion and timely assessment of demonstration risks, vulnerabilities, and opportunities for intervention. The demonstration STCs will be updated in the next demonstration amendment or extension approval to reflect that monitoring calls will be held no less frequently than quarterly.

CMS will continue to be available for additional calls as necessary to provide technical assistance or to discuss demonstration applications, pending actions, or requests for changes to demonstrations. CMS recognizes that frequent and regular calls are appropriate for certain demonstrations and at specific points in a demonstration's lifecycle.

In the coming weeks, CMS will reach out to schedule a transition meeting to review templates and timelines outlined above. As noted above, the pertinent Behavioral Health Reform section 1115 demonstration STCs will be updated in the next demonstration amendment or extension approval to reflect these updates.

If you have any questions regarding these updates, please contact Danielle Daly, Director of the Division of Demonstration Monitoring and Evaluation, at Danielle.Daly@cms.hhs.gov.

Sincerely,

[redacted]

Karen LLanos
Acting Director

Enclosure
cc: Maria Garza, State Monitoring Lead, Medicaid and CHIP Operations Group

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00318/0**

TITLE: **Alaska Behavioral Health Reform**

AWARDEE: **Alaska Department of Health**

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Alaska for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period from March 26, 2024 through December 31, 2028, unless otherwise specified, be regarded as expenditures under the state's title XIX.

1. **Residential Treatment for Individuals with Substance Use Disorder (SUD).** Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental diseases (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 (SUD).** 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 as outlined in STC 5.3.4, effective September 3, 2019.

5. **Partial Hospitalization Program (PHP) Services for Substance Use Disorder (SUD).** 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/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 a individual's psychiatric disorder, with a diagnosis of Serious Mental Illness (SMI) or Serious Emotional Disorder (SED) in accordance with an individualized treatment plan as outlined in STC 5.3.10 effective September 3, 2019. 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 as outlined in STC 5.3.17, effective September 3, 2019.

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. This expenditure authority will be effective September 3, 2019.

16. **Children's Residential Treatment Level 1 (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 as outlined in STC 5.3.5, effective September 3, 2019. 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 as outlined in STC 5.3.6, effective September 3, 2019. 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 as outlined in STC 5.3.11 effective September 3, 2019. This authority does not apply to IMDs. Payment for room and board ae prohibited.

20. **Peer-Based Crisis Services.** Expenditures for community-based services, that divert individuals from emergency department and psychiatric hospitalization use, effective September 3, 2019. 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) as outlined in STC 5.3.12.

21. **Intensive Case Management Services for Substance Use Disorder (SUD).** Expenditures for services for adults with substance use disorders (if their needs cannot be met by SUD Care Coordination) as outlined in the approved Implementation Plan in Attachment D.

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, as outlined in STC 5.3.2, effective September 3, 2019.

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 as outlined in STC 5.3.14 effective September 3, 2019.

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 as outlined in STC 5.3.15 effective September 3, 2019.

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 as outlined in STC 5.3.16 effective September 3, 2019. These facilities are not IMDs. Payment for room and board are prohibited.

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY

NUMBER: 11-W-00318/0

TITLE: Alaska Behavioral Health Reform

AWARDEE: Alaska Department of Health

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the demonstration, from date March 26, 2024 through December 31, 2028 unless otherwise specified. In addition, this waiver may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waiver of state plan requirements contained in section 1902 of the Act is granted in order to enable Alaska (the state) to carry out the Alaska Substance Use Disorder and Behavioral Health Program.

1. Amount, Duration, & Scope **Section 1902(a)(10)(B)**

To the extent necessary to enable the state to vary the amount, duration, and scope of services offered to individuals, regardless of eligibility category, in accordance with the recipient criteria set forth in the benefits in STC 5.4.

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CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS (STC)

NUMBER: 11-W-00318/0

TITLE: Alaska Behavioral Health Reform

AWARDEE: Alaska Department of Health

1. PREFACE

The following are the Special Terms and Conditions (STC) for the "Alaska Behavioral Health Reform" (BHR) section 1115(a) Medicaid demonstration (hereinafter BHR or "demonstration"), to enable the Alaska Department of Health (hereinafter DOH or "state") to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waiver authorities and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable (CNOM), which are separately enumerated. These STCs set forth conditions and limitations on those expenditure authorities, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to this demonstration. These STCs neither grant additional waivers or expenditure authorities, nor expand upon those separately granted.

The STCs are effective from March 26, 2024 through December 31, 2028, unless otherwise stated.

The STCs have been arranged into the following subject areas:

1. Preface
2. Program Description and Objectives
3. General Program Requirements
4. Eligibility and Enrollment
5. Demonstration Programs and Benefits
6. Cost Sharing
7. Delivery System
8. Monitoring and Reporting Requirements
9. General Financial requirements
10. Monitoring Budget Neutrality for the Demonstration
11. Evaluation of the Demonstration
12. Schedule of Deliverable

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

1. Attachment A: Developing the Evaluation Design
2. Attachment B: Preparing the Interim and Summative Evaluation Reports
3. Attachment C: Evaluation Design
4. Attachment D: SUD Implementation Plan (approved)
5. Attachment E: SUD Claiming Protocol

6. Attachment F: Monitoring Protocol
7. Attachment G: Quarterly and Annual Progress Report Template and Instructions
8. Attachment H: COVID-19 Personal Care Services Amendment

2. PROGRAM DESCRIPTION AND OBJECTIVES

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 original 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.

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.

The goal of the BHR demonstration is to increase access to a comprehensive continuum of SUD and behavioral health services designed to maintain individuals in community settings and to address long-standing gaps in services and needs related to the state's behavioral health issues. Approval of this demonstration is acknowledgement that, as relayed to CMS, the state faces significant challenges related to infrastructure, provider capacity, and workforce development—which are impediments to addressing the opioid crisis in the state. The activities and services provided through the demonstration will enhance the state's ability to:

- Provide a continuum of SUD services—by both increasing the benefits offered to Medicaid recipients and using evidence-based SUD program standards; and
- Increase capacity by building provider networks and workforce throughout the state.

During the approval period, the state will leverage the authorities provided through this demonstration to achieve the following goals:

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

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

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

4. Reduced utilization of emergency departments and inpatient hospital settings for substance use and behavioral health 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; and

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

On February 27, 2023, the state submitted an extension application to update the 1115 demonstration name from the current title, "Substance Use Disorder Treatment and Behavioral Health Program (SUD BHP)" to "Alaska Behavioral Health Reform". There were no other substantive changes requested with this extension.

3. GENERAL PROGRAM REQUIREMENTS

3.1. Compliance with Federal Non-Discrimination Statutes. The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

3.2. Compliance with Medicaid and Child Health Insurance Program (CHIP) Law, Regulation, and Policy. All requirements of the Medicaid program, or the Children's Health Insurance Program (CHIP) for the separate CHIP population, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3.2. Changes in Medicaid and CHIP Law, Regulation, and Policy. The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

3.4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.

3.4.1. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.

3.4.2. If mandated changes in the federal law require state legislation, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

3.5. **State Plan Amendments**. The state will not be required to submit title XIX or XXI state plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid state plan governs.

3.6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 3.7 below.

3.7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including, but not limited to the failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

3.7.1. An explanation of the public process used by the state, consistent with the requirements of STC 3.12. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

3.7.2. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

3.7.3. An up-to-date CHIP allotment worksheet, if necessary.

3.7.4. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

3.7.5. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as

the oversight, monitoring and measurement of the provisions.

3.8. **Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(e) or 1115(f) of the Act must submit extension applications in accordance with the timelines contained in statute. Otherwise, if the state intends to request a demonstration extension under section 1115(a) of the Act, the state must submit the extension application no later than 12 months prior to the expiration date of the demonstration. The Governor or Chief Executive Officer of the state must submit to CMS either a demonstration extension request that meets federal requirements at CFR section 431.412(c) or a phase-out plan consistent with the requirements of STC 3.9.

3.9. **Demonstration Phase-Out.** The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

3.9.1. Notification of Suspension or Termination. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit a notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 3.12, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and ow the state considered the comments received when developing the revised transition and phase-out plan.

3.9.2. Transition and Phase-Out Plan Requirements. The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct redeterminations of Medicaid or CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible beneficiaries, as well as any community outreach activities the state will undertake to notify affected beneficiaries, including community resources that are available.

3.9.3. Transition and Phase-out Plan Approval. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.

3.9.4. Transition and Phase-out Procedures. The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to making a determination of ineligibility as required under 42 CFR §435.916(f)(1). For individuals determined ineligible for Medicaid and CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR § 435.12.00(e). The state must comply with all applicable notice requirements found in 42 CFR, part 431 subpart E, including sections 431.206 through 431.214. In addition, the state must assure all applicable appeal and hearing rights are afforded to beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including sections 431.220 and

431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR § 431.230.

3.9.5. Exemption from Public Notice Procedures 42 CFR Section 431.416(g). CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR § 431.416(g).

3.9.6. Enrollment Limitation During Demonstration Phase-Out. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

3.9.7. Federal Financial Participation (FFP). If the project is terminated or any relevant waivers are suspended by the state, FFP must be limited to normal closeout costs associated with the termination or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling beneficiaries.

3.10. **Withdrawal of Waiver or Expenditure Authority**. CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associates with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling beneficiaries.

3.11. **Adequacy of Infrastructure**. The state will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility system; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

3.12. **Public Notice, Tribal Consultation, and Consultation with Interested Parties**. The state must comply with the state notice procedures as required in 42 CFR section 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR § 447.205 for changes in statewide methods and standards for setting payment rates.

3.13. **Federal Financial Participation (FFP)**. No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or if later, as expressly stated within these STCs.

3.14. **Administrative Authority**. When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated

functions to operating agencies, MCOs, and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

3.15. **Common Rule Exemption**. The state must ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or services programs, procedures for obtaining Medicaid or CHIP benefits or services, possible changes in or alternatives to Medicaid or CHIP programs and procedures, or possible changes in methods or levels of payment for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR § 46.104(b)(5).

4. ELIGIBILITY AND ENROLLMENT

1. **Eligibility Groups Affected by the Demonstration.** Under the demonstration, there is no change to Medicaid eligibility. Standards for eligibility remain set forth under the state plan.

   All affected groups derive their eligibility through the Medicaid state plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan. All Medicaid eligibility standards and methodologies for these eligibility groups remain applicable.

5. DEMONSTRATION PROGRAMS AND BENEFITS

5.1. Integrated Behavioral Health System- Under the demonstration, the state will create an integrated behavioral health system of care for Alaskan individuals enrolled in Medicaid and CHIP programs with serious mental illness, severe emotional disturbance, mental health disorders, and/or substance use disorders. The Integrated Behavioral Health System aims to establish networks of support for individuals and family members. The state will achieve these goals by creating a more robust continuum of behavioral health care services with emphasis on early interventions, a crisis services infrastructure, community-based outpatient services, residential treatment when appropriate, and enhanced community recovery supports. The Integrated Behavioral Health System will be implemented within 2 different initiatives, described within these STCs:

- Behavioral Health Benefits
- Substance Use Disorder/Opioid Use Disorder Program

5.2. TABLE 1: BEHAVIORAL HEALTH BENEFITS COVERAGE WITH EXPENDITURE AUTHORITY

LBHA Benefit	Medicaid Authority
Home-based Family Treatment	1115 expenditure authority
Intensive Case Management Services (ICM)	1115 expenditure authority

Partial Hospitalization Program Services (PHP)	1115 expenditure authority
Intensive Outpatient Services (IOP)	1115 expenditure authority
Children's Residential Treatment Level 1 (CRT)	1115 expenditure authority
Therapeutic Treatment Homes	1115 expenditure authority
Assertive Community Treatment Services (ACT)	1115 expenditure authority
Adult Mental Health Residential Services (AMHR)	1115 expenditure authority
Peer-based Crisis Services	1115 expenditure authority
Mobile Outreach & Crisis Response Services (MOCR)	1115 expenditure authority
23-Hour Crisis Observation & Stabilization Services (COS)	1115 expenditure authority
Crisis Residential/Stabilization Services	1115 expenditure authority
Community Recovery Support Services (CRSS)	1115 expenditure authority

The services listed in Table 1 can be covered under Medicaid state plan authority.
The state attests that it will continue to provide the Early and Periodic Screening, Diagnostic and Treatment services, EPSDT, to all eligible low-income infants, children and adolescents under age 21, as specified in section 1905(r) of the Social Security Act (the Act).

5.3.Behavioral Health Benefits

5.3.1. The Behavioral Health Benefits will target three groups:

5.3.1.1.Group 1: Children, Adolescents and their Parents or Caretakers with or at risk of Mental Health and Substance Use Disorders (any member of the family, including parents and caretakers, are eligible to receive Group 1 services if they or their children/siblings meet Group 1 eligibility criteria)

5.3.1.2.Group 2: Transition Age Youth and Adults with Acute Mental Health Needs

5.3.1.3.Group 3: Shared Behavioral Health Program Benefits (Shared Group 1 and Group 2)

5.3.2. Group 1- Behavioral Health Program Benefits

5.3.2.1. Home-based Family Treatment- Services to reduce use of child/youth inpatient hospitalization and residential services by providing treatment and wrap-around services in the child/youth's home. Home-based family treatment (HBFT) services are available 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. There will be three progressively intensive levels of HBFT:

5.3.2.1.1. **Level 1** Home-based family treatment services will be provided for children at moderate risk of out-of-home placement

5.3.2.1.2. **Level 2** Home-based family treatment services are provided for children at high risk of out-of-home placement

5.3.2.1.3. **Level 3** Home-based family treatment services will be provided for two types of recipients: children at imminent risk of out-of-home placement or children discharging from residential treatment.

5.3.2.2. Component services include:

- Clinical services:
  - Comprehensive family assessment; and
  - Family, group and individual therapy.

- Medication services—including continuity of medications, medication prescription, review of medication, medication administration, and medication management

- Cognitive, behavioral, and other evidence-based models, reflecting a variety of treatment approaches, provided to the individual on an individual and/ or family basis

- Crisis diversion and intervention planning

- Ongoing monitoring for safety and stability in the home

- Intensive case management

- Skill development including:

  - Parenting skills: assisting parents to utilize developmentally appropriate interventions and strategies to restore functioning and provide structure and support for children with emotional and behavioral problems.
  - Communication, problem solving and conflict resolution skill building, life skills, and social skills required to restore functioning and provide structure and support for children with emotional and behavioral problems; and
  - Self-regulation, anger management, and other mood management skills for children, youth and parents.

- Wraparound facilitation and coordinating to link the family with community services and supports that maintain children with emotional and behavioral problems in the home:

    - Coordinating referrals to community-based social services and supports for basic needs; and
    - Coordinating services with the educational system.

- Medication services for other physical and SUD is provided, as needed, either on-site or through collaboration with other providers

5.3.2.3. Provider Qualifications: Licensed physicians, licensed physician assistants, licensed advanced nurse practitioners, licensed registered nurses supervised by a physician or advanced nurse practitioner, licensed practical nurses supervised by a physician or advanced nurse practitioner, mental health professional clinicians (AK Medicaid provider type including licensed clinical social workers, licensed marriage and family therapists, licensed master's social workers, licensed clinical psychologists, licensed psychological associates, & licensed professional counselors), substance use disorder counselors, behavioral health clinical associates or behavioral health aide, peer support providers (w/ lived experience, working under supervision of a mental health professional clinician w/complete training/certification, w/continuing education).

5.3.2. Intensive Case Management- Services that include evaluation, outreach, support services, advocacy with community agencies, arranging services and supports, teaching community living and problem-solving skills, modeling productive behaviors, and teaching individuals to become self-sufficient. For children/youth at risk of out-of-home placement, community- based wraparound intensive case management service.

5.3.2.1.Component Services include:

- The case manager would serve as the central point of contact for an individual, brokering and/or linking individuals with mental health, SUD, medical, social, educational, vocational, legal, and financial resources in the community.

- Individualized, person-centered assessment and treatment plan with quarterly update assessments.

- Regular (biweekly, at a minimum) monitoring of behavioral health service delivery, safety, and stability.

- Triaging for crisis intervention purposes (e.g., determining need for intervention and referral to appropriate service or authority).

- Assisting individual in being able to better perform activities of daily living—problem-solving skills, self-sufficiency, productive behaviors, conflict resolution.

- Referral for counseling or specialized services; and

- Engaging natural supports (natural supports are family members/close kinship relationships) that enhance the quality of life.

5.3.2.2. Provider Qualifications: Licensed registered nurses, licensed practical nurses, mental health professional clinicians, substance use disorder counselors, behavioral health clinical associates or behavioral health aide, and peer support providers (w/ lived experience, working under supervision of a MH professional, clinician w/complete training / certification, w/continuing education)

5.3.3. Partial Hospitalization Program (PHP) Services - PHP services provide diagnosis or active treatment of a child/youth's psychiatric disorder when there is a reasonable expectation for improvement or when it is necessary to maintain the child/youth's functional level and prevent relapse or full hospitalization. PHP services for children/youth are provided in a highly structured treatment environment and must have the capacity to treat children/youth with substantial medical and SUD problems.

5.3.3.1. Component Services include:

- Individualized, person-centered assessment & clinically directed treatment.

- Cognitive, behavioral, and other mental health disorder-focused therapies, reflecting a variety of treatment approaches, provided to the individual on an individual, group, and/or family basis.

- Psychiatric Evaluation services.

- Nursing services.

- Psycho-education services.

- Medication services—including medication prescription, review of medication, medication administration, and medication management.

- Medication services for other physical and SUD is provided, as needed, either on-site or through collaboration with other providers.

- Crisis Intervention services.

- Occupational, recreational, and play therapy services as appropriate; and

- Recovery Support services focused on skill development for youth and/or family.

5.3.3.2. Provider Qualifications: licensed physicians, licensed physician assistants,

licensed advanced nurse practitioners, licensed registered nurses, licensed practical nurses, mental health professional clinicians, substance use disorder counselors, behavioral health clinical associates, and peer support providers (w/ lived experience, working under supervision of a MH professional clinician, w/complete training / certification, w/continuing education).

5.3.4. Intensive Outpatient (IOP) Services - Intensive outpatient services include structured programming provided to individuals when determined to be medically necessary and in accordance with an individualized treatment plan. Treatment is focused on clinical issues which functionally impair the child/youth's ability to cope with major life tasks.

5.3.4.1. Component Services include:

- Individualized, person-centered assessment and clinically directed treatment.
- Treatment plan development and review.
- Cognitive, behavioral, and other mental health and substance use disorder treatment therapies, reflecting a variety of treatment approaches, provided to the individual on an individual, group, and/ or family basis.
- Psycho-education services.
- Medication Services—including medication prescription, review of medication, medication administration, and medication management.
- Crisis Intervention services; and
- Recovery Support services.

5.3.4.2. Provider Qualifications: Licensed physicians, licensed physician assistants, licensed advanced nurse practitioners, licensed practical nurses, mental health professional clinicians, substance use disorder counselors, and behavioral health clinical associates or Behavioral Health Aides, and peer support providers (w/ lived experience, working under supervision of a MH professional, clinician w/complete training / certification, w/continuing education).

5.3.5. Children's Residential Treatment Level 1 (CRT) - 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.

5.3.5.1. Component Services include:

- A comprehensive evaluation to assess emotional, behavioral, medical, educational, and social needs, and support these needs safely.

- Medication Services—including medication prescription, review of medication, medication administration, and medication management.

- An Individual Plan of Care; and

- Cognitive, behavioral and other therapies, reflecting a variety of treatment approaches, provided to the child/youth on an individual, group, and/or family basis.

5.3.5.2. Provider Qualifications: A mix of providers who meet the requirements for a licensed residential treatment center, which may include: licensed physicians, licensed physician assistants, licensed advanced nurse practitioners, licensed registered nurses supervised by a physician or advanced nurse practitioner, licensed practical nurses supervised by a physician or advanced nurse practitioner, mental health professional clinicians (AK Medicaid provider type including licensed clinical social workers, licensed marriage and family therapists, licensed master's social workers, licensed clinical psychologists, licensed psychological associates, licensed professional counselors), substance use disorder counselors, behavioral health clinical associates or behavioral health aides, peer support providers (w/ lived experience, working under supervision of a MH professional, clinician w/complete training/certification, w/continuing education).

5.3.6. Therapeutic Treatment Homes - Trauma-informed clinical services which include placement in a specifically trained therapeutic treatment home for children/youth who have severe mental, emotional, or behavioral health needs and who cannot be stabilized in their home settings.

5.3.6.1. Component Services include:

- Individualized, person-centered assessment.

- Treatment Plan development.

- Cognitive, behavioral and other trauma-informed therapies, reflecting a variety of treatment approaches, provided to the child/youth on an individual and/or family basis.

- Medication Services—including medication prescription, review of medication, medication administration, and medication management.

- Case Coordination; and

- Crisis Intervention services.

5.3.6.2. Provider Qualifications: A mix of providers who meet the requirements for a licensed foster home, which must include one or more licensed foster parents and which may include: licensed physicians, licensed physician assistants, licensed advanced nurse practitioners, licensed registered nurses supervised by a physician or advanced nurse practitioner, licensed practical nurses supervised by a physician or advanced nurse practitioner, mental health professional clinicians (AK Medicaid provider type including licensed clinical social workers, licensed marriage and family therapists, licensed master's social workers, licensed clinical psychologists, licensed psychological associates, licensed professional counselors), substance use disorder counselors, behavioral health clinical associates or behavioral health aides, peer support providers (w/ lived experience, working under supervision of a MH professional, clinician, w/complete training/certification, w/continuing education).

5.3.7. Group 2- Behavioral Health Program Benefits

5.3.8. Assertive Community Treatment Services (ACT) - 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. The staff-to-recipient ratio is small (one clinician for every ten recipients), and services are provided 24-hours a day, seven days a week, for as long as they are needed.

5.3.8.1. Component Services include:

- Assertive Outreach services- this includes engagement, outside of a clinical setting; including street outreach, visiting the client's home, work, and other community settings.

- Individualized, person-centered assessment and treatment plan with quarterly update assessments.

- Cognitive, behavioral, and other mental health disorder-focused therapies, reflecting a variety of treatment approaches, provided to the individual on an individual, group, and/or family basis.

- Holistic and Integrated services, including health, vocational, and wellness services. This includes, but limited to educating about mental illness, treatment and recovery, teaching wellness skills for health prevention, including coping skills and stress management, developing crisis management and relapse prevention plans, including identification/recognition of early warning signs and rapid intervention strategies, educating clients on their health rights.

- Assisting the individual in being able to better perform activities of daily living— problem-solving skills, self-sufficiency, productive behaviors, conflict resolution.

- Family Education services specific to treatment, rehabilitation and support to individuals who are diagnosed with a severe mental illness.

- Peer support services.

- Medication services—including medication prescription, review of medication, medication administration, and medication management; and

- Recovery Support services focused on skill development regarding how to access community resources and natural supports that could be used to help facilitate individual efficacy, increase functioning, developing communication and social skills, economic. Self-sufficiency and developing healthy coping skills.

5.3.8.2.Provider Qualifications: licensed physicians, licensed physician assistances, licensed advanced nurse practitioners, licensed registered nurses, licensed practical nurses, mental health professional clinicians, substance use disorder counselors, and behavioral health clinical associates or behavioral health aides, peer support providers (w/ lived experience, working under supervision of a MH professional, clinician, w/complete training/certification,

5.3.9. Intensive Case Management - Services that include evaluation, outreach, support services, advocacy with community agencies, arranging services and supports, teaching community living and problem-solving skills, modeling productive behaviors, and teaching individuals to become self- sufficient. Intensive case management is envisioned as a comprehensive case management service for adults with acute mental health needs who require on-going and long-term support but have fewer intensive support needs than ACT.

5.3.9.1. Component Services include:

- Brokering and linking individuals with mental health, SUD, medical, social, educational, vocational, legal, and financial resources in the community.

- Individualized, person-centered assessment and treatment plan with quarterly update assessments.
- Serving as the central point of contact for individual navigating transitions across levels of care.

- Regular (biweekly, at a minimum) monitoring of behavioral health service delivery, safety, and stability.

- Triaging for crisis intervention purposes (e.g., determining need for intervention and referral to appropriate service or authority).

- Assisting individual in being able to better perform activities of daily living—problem-solving skills, self-sufficiency, productive behaviors, conflict resolution.

- Referral for counseling or specialized services; and

- Engaging natural supports (family and/or friends; individuals that are related or have close relationships with the client) in the community that enhance the quality of life.

5.3.9.2. Provider Qualifications: licensed registered nurses, licensed practical nurses, mental health professional clinicians (AK Medicaid provider type including licensed clinical social workers, licensed marriage and family therapists, licensed master's social workers, licensed clinical psychologists, licensed psychological associates, licensed professional counselors), substance use disorder counselors, behavioral health clinical associates or behavioral health aides, and peer support providers (w/ lived experience, working under supervision of a MH professional clinician, w/complete training / certification, w/continuing education).

5.3.10. Partial Hospitalization Program (PHP)—PHP services provide diagnosis or active treatment of an individual's psychiatric disorder when there is a reasonable expectation for improvement or when it is necessary to maintain the individual's functional level and prevent relapse or full hospitalization. In addition to assisting the individual in managing the stress and anxieties of daily life, PHPs must have the capacity to treat individuals with substantial medical and SUD problems.

5.3.10.1. Component Services include:

- Individualized, person-centered assessment & clinically-directed treatment.
- Cognitive, behavioral, and other mental health disorder-focused therapies, reflecting a variety of treatment approaches, provided to the individual on an individual, group, and/or family basis.
- Psychiatric evaluation services.
- Nursing services.
- Psycho-education services.
- Medication services—including medication prescription, review of medication, medication administration, and medication management.
- Medication services for other physical and SUD is provided, as needed, either on-site or through collaboration with other providers.
- Crisis intervention services.
- Occupational, recreational, and play therapy services as appropriate; and
- Recovery Support services focused on skill development for youth and/or family.

5.3.10.2. Provider Qualifications: licensed physicians, licensed physician assistants, licensed advanced nurse practitioners, licensed registered nurses, licensed practical nurses, mental health professional clinicians, substance use disorder

counselors, behavioral health clinical associates, and peer support providers (w/ lived experience, working under supervision of a MH professional clinician, w/complete training / certification, w/continuing education).

5.3.11. Adult Mental Health Residential (AMHR) - AMHR are treatment services provided by an interdisciplinary treatment team in a therapeutically-structured, supervised environment for adults with acute mental health needs whose health is at risk while living in their community. This authority does not apply to IMDs. AMHR services are appropriate for those who have not responded to outpatient treatment, who have therapeutic needs that cannot be met in a less-restrictive setting, or who are in need of further intensive treatment following inpatient psychiatric hospital services. Payment for room and board are prohibited.

5.3.11.1. Component Services include:

- Clinically-directed therapeutic treatment.
- A comprehensive evaluation to assess emotional, behavioral, medical, educational, and social needs, and support these needs safely.
- Medication Services—including medication prescription, review of medication, medication administration, and medication management.
- An Individual Plan of Care that puts into place interventions that help the individual attain goals designed to achieve discharge from AMH at the earliest possible time; and
- Cognitive, behavioral and other therapies, reflecting a variety of treatment approaches, provided to the individual on an individual, group, and/or family basis.

5.3.11.2. Provider Qualifications: A mix of providers who meet the requirements for an AK approved AMHR home, which may include: licensed physicians, licensed physician assistants, licensed advanced nurse practitioners, licensed registered nurses supervised by a physician or advanced nurse practitioner, licensed practical nurses supervised by a physician or advanced nurse practitioner, mental health professional clinicians (AK Medicaid provider type including licensed clinical social workers, licensed marriage and family therapists, licensed master's social workers, licensed clinical psychologists, licensed psychological associates, licensed professional counselors), substance use disorder counselors, behavioral health clinical associates or behavioral health aides, peer support providers (w/ lived experience, working under supervision of a MH professional clinician, w/complete training/certification, w/continuing education).

5.3.12. Peer-based Crisis Services - Services are facilitated by a peer, someone who has lived with a mental illness and/or substance use disorder or has had experience with

substance use disorder (includes parents with experience parenting a child with a mental illness or a substance use disorder). Peer-based crisis services serve as a community-based diversion from emergency department and psychiatric hospitalization use. Peer crisis services delivered in community settings with medical support. These services are coordinated within the context of an individualized person-centered plan.

5.3.12.1. Component Services include:

- Triaging for crisis intervention purposes (e.g., determining need for intervention and referral to appropriate service or authority).
- Crisis support services.
- Facilitation of the transition to community resources and natural supports.
- Crisis diversion services.
- Activation of resiliency strength services; and
- Advocacy services (e.g., services include acting as an advocate for a client regarding preferred treatment, engagement to access services and supports, navigation to bridge services or to access necessary supports).

5.3.12.2. Provider Qualifications: Providers with a lived experience of mental health or substance use disorders (includes parents with experience parenting a child with a mental illness or a substance use disorder), working under the supervision of a mental health professional clinician, who complete training/certification as defined by the state, and who participate in continuing education as required by the state.

5.3.13. Shared Behavioral Health Program Benefits (Shared Group 1 and Group 2)

5.3.14. Mobile Outreach and Crisis Response Services (MOCR) - Services designed to prevent a mental health crisis or to stabilize an individual during or after a mental health crisis or a crisis involving both substance use and mental health disorders. Trained professionals meet face-to-face with the individual experiencing the crisis (and when appropriate their family or support system) wherever the crisis occurs, to assess and de-escalate the situation, provide mediation (if appropriate), refer and if possible, connect to the appropriate services or potentially resolve the crisis. MOCR services may be provided in any location where the provider and the individual can maintain safety.

5.3.14.1. Component Services include:

- Triage and assessment services.
- Crisis Intervention and Stabilization services.

- Referral and linkage with appropriate community services and resources.
- Medication services as needed, either on-site or through collaboration with other providers.
- Mediation services as appropriate; and
- Skills Training services designed to minimize future crisis situations.

5.3.14.2. Provider Qualifications: Licensed physicians, licensed physician assistants, licensed advanced nurse practitioners, licensed registered nurses, licensed practical nurses, licensed psychologists, mental health professional clinicians, substance use disorder counselors, and behavioral health clinical associates, and peer support providers (w/ lived experience, working under supervision of a MH professional, clinician, w/complete training/certification, w/continuing education).

5.3.15. 23-Hour Crisis Observation and Stabilization (COS) - Services for up to 23 hours and 59 minutes of care in a secure and protected environment- an unlocked facility designed to allow staff to stay in close contact with clients (staff are trained in "Suicide Safe" procedures with suicide-safety considerations). The program is medically staffed, psychiatrically supervised and includes continuous nursing services. The primary objective is for prompt evaluation and/or stabilization of individuals presenting with acute symptoms or distress.

5.3.15.1. Component Services include:

- Individualized, person-centered assessment.
- Psychiatric Evaluation services.
- Nursing services.
- Medication Services—including medication prescription, review of medication, medication administration, and medication management.
- Treatment Plan development.
- Crisis Intervention services.
- Crisis Stabilization services designed to stabilize and restore the individual to a level of functioning that does not require inpatient hospitalization; and
- Referral to the appropriate level of treatment services.

5.3.15.2. Provider Qualifications: AK licensed general acute care hospitals, AK licensed psychiatric hospitals, State of Alaska-approved Indian Health Care Providers (IHCPs), AK licensed critical access hospitals, Medicaid enrolled Mental Health Physician Clinics, and AK licensed Crisis Residential/Stabilization Units.

5.3.16. Crisis Residential/Stabilization Services - A medically monitored, short-term, residential program in an approved (10- to 15-bed) facility that provides 24/7 psychiatric stabilization.

5.3.16.1. Component Services include:

- Individualized, person-centered assessment.
- Crisis Intervention services.
- Crisis stabilization services designed to stabilize and restore the individual to a level of functioning that does not require inpatient hospitalization.
- Psychiatric Evaluation services.
- Nursing services.
- Medication Services—including medication prescription, review of medication, medication administration, and medication management.
- Treatment Plan development services; and
- Referral to the appropriate level of treatment services.

5.3.16.2. Provider Qualifications: AK licensed general acute care hospitals, AK licensed psychiatric hospitals, State of Alaska-approved Indian Health Care Providers (IHCPs), AK licensed critical access hospitals, Medicaid enrolled Mental Health Physician Clinics, and AK licensed Crisis Residential/Stabilization Units.

5.3.17. Community Recovery Support Services (CRSS) - Skill building, counseling, coaching, and support services to help prevent relapse and promote recovery from behavioral health disorders (mental health disorders, SUD, or both).

5.3.17.1. Component Services include:

- Recovery coaching- direct services that provide guidance, support and encouragement from the expertise of the trained recovery professional. Recovery coaching is a form of strength-based supports for persons in or seeking recovery from mental disorders and SUD (if co-occurring).
- Social/cognitive/daily living skill building- direct services that assist the individual in being able to better perform his/her own social, cognitive, or

activities of daily living or assist the individual in finding resources to meet those needs. Services include coaching to identify the individual's needs (i.e., social, cognitive, daily living) and to either work with the individual to develop the social, cognitive, or ADL skills to meet those needs or refer the individual to another agency or service.

- Facilitation of level of care transitions.

- Peer-to-peer services, mentoring, & coaching- Peers are defined as: Individuals who provide services in behavioral health settings—both mental health and substance use disorders treatment—based on their own experience of recovery from mental illness or addiction and skills obtained from formal peer provider training. Within the demonstration, family members of people with SED, SMI, SUD or Co-Occurring disorders are applicable to provide services to other family members with similar experiences.

- Beneficiary & Family Education/Training/Support- Psychoeducational services that teach self- help concepts, skills, and strategies which are designed to promote wellness, stability, and recovery for service recipients and their families.

- Psychoeducational services are an important mechanism to assist service recipients and family members in understanding the many aspects of mental disorders and SUD (if co-occurring), including factual data about the mental disorder itself; signs & symptoms; information about how mental disorders affect physical health; medications being used to treat the mental disorder; the consequences that mental disorders can have on the service recipient's mental health, family relationships, and other areas of functioning; and the recovery process.

- Relapse prevention.

- Child therapeutic support services - direct therapeutic services that involve actions or skills relating to the health of a child or multiple children at a time. Services include linking the child and/or parents with supports, services, and resources that support healthy child development; identifying key developmental milestones (ages and stages) in order to improve child health/growth/development; and educating parents about how to support healthy cognitive, emotional, and social child development.

5.3.17.2. Provider Qualifications: Licensed psychologists, mental health professional clinicians, substance use disorder counselors, and behavioral health clinical associates, and peer support providers (w/ lived experience, working under supervision of a Mental Health professional clinician, w/complete training/certification, w/continuing education).

5.4. Substance Use Disorder/Opioid Use Disorder Program. Effective upon CMS' approval of the SUD/OUD Implementation Protocol the demonstration benefit package for the state's Medicaid recipients must include SUD/OUD treatment services, including services provided

in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise matchable expenditures under section 1903 of the Act. The state will be eligible to receive FFP for the state's Medicaid recipients residing in IMDs under the terms of this demonstration for coverage of medical assistance, including SUD/OUD benefits that would otherwise be matchable if the beneficiary were not residing in an IMD. Alaska will aim for a statewide average length of stay of 30 days in residential treatment settings, to be monitored pursuant to the Monitoring Protocol as outlined in STC 8.5 below, to ensure short-term residential treatment stays. Under this demonstration, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions.

The coverage of SUD/OUD treatment services and withdrawal management during short term residential and inpatient stays in IMDs will expand the state's current SUD/OUD benefit package available to all the state's Medicaid recipients as outlined in Table 1. Room and board costs are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

5.4.1. Table 2: SUD/OUD Benefits Coverage with Expenditure Authority

SUD Benefit	Medicaid Authority	Expenditure Authority
Opioid Treatment Services (OTS) for persons experiencing an Opioid Use Disorder (OUD)	1115 expenditure authority	Services provided to individuals in IMDs
Intensive Outpatient Services	1115 expenditure authority	Services provided to individuals in IMDs
Outpatient Services	State plan (Individual services covered)	
Partial Hospitalization Program (PHP)	1115 expenditure authority	Services provided to individuals in IMDs
Early Intervention- Services	State plan	
Residential Treatment	1115 expenditure authority	Services provided to individuals in IMDs
Medically Monitored Intensive Inpatient Services	1115 expenditure authority	Services provided to individuals in IMDs

Medically Managed Intensive Inpatient Services	1115 expenditure authority	Services provided to individuals in IMDs
Ambulatory Withdrawal Management	1115 expenditure authority	Services provided to individuals in IMDs
Clinically Managed Residential Withdrawal Management	1115 expenditure authority	Services provided to individuals in IMDs
Medically Monitored Inpatient Withdrawal Management	1115 expenditure authority	Services provided to individuals in IMDs
Medically Managed Intensive Inpatient Withdrawal Management	1115 expenditure authority	Services provided to individuals in IMDs
Medication-Assisted Treatment (MAT)	State plan	Services provided to individuals in IMDs

The state attests that the services indicated in Table 2, above, as being currently covered under the Medicaid state plan authority are currently covered in Alaska's state plan.

The state will attest that it will provide the Early and Periodic Screening, Diagnostic and Treatment services, EPSDT, to all eligible low-income infants, children and adolescents under age 21, as specified in Section 1905(r) of the Social Security Act (the Act).

The following service definition and provider qualifications are described for the approved SUD demonstration service pilots where separate expenditure authorities have been granted under this section 1115 demonstration.

5.4.2. Opioid Treatment Services (OTS) for persons experiencing an Opioid Use Disorder (OUD) - Physician-supervised daily or several times weekly pharmacotherapy and counseling services provided to maintain multidimensional stability for those with severe opioid use disorder in accordance with an individualized treatment plan determined by a licensed physician or licensed prescriber and approved and authorized according to state requirements.

5.4.2.1. Component services include:

- Linkage to psychological, medical, and psychiatric consultation.
- Access to emergency medical and psychiatric care through connections with more intensive levels of care.
- Access to evaluation and ongoing primary care.
- Ability to conduct or arrange for appropriate laboratory and toxicology tests including urine drug screenings.
- Availability of licensed physicians to evaluate and monitor use of, methadone,

buprenorphine products or naltrexone products and of pharmacists and nurses to dispense and administer these medications.

- Individualized, person-centered assessment and treatment.

- Assessing, ordering, administering, reassessing, and regulating medication and dose levels appropriate to the individual; supervising withdrawal management from opioid analgesics, including buprenorphine products or naltrexone products; overseeing and facilitating access to appropriate treatment for opioid use disorder.

- Medication for other physical and mental health illness is provided, as needed, either on-site or through collaboration with other providers.

- Cognitive, behavioral, and other substance use disorder-focused therapies, reflecting a variety of treatment approaches, provided to the individual on an individual, group, and/ or family basis.

- Optional substance use care coordination provided, including integrating behavioral health into primary care and specialty medical settings through interdisciplinary care planning and monitoring individual progress and tracking individual outcomes; supporting conversations between buprenorphine-waivered practitioners and behavioral health professionals to develop and monitor individualized treatment plans; linking individuals with community resources to facilitate referrals and respond to social service needs; tracking and supporting individuals when they obtain medical, behavioral health, or social services outside the practice; and

- Referral for screening for infectious diseases such as HIV, hepatitis B and C, and tuberculosis at treatment initiation and then at least annually or more often based on risk factors.

5.4.2.2. Provider Qualifications- Providers qualified to be reimbursed for eligible services provided to eligible service recipients include licensed physicians, licensed physician assistants, licensed advanced nurse practitioners, licensed registered nurses supervised by a physician or advanced nurse practitioner, licensed practical nurses supervised by a physician or advanced nurse practitioner, mental health professional clinicians (AK Medicaid provider type including licensed clinical social workers, licensed marriage and family therapists, licensed master's social workers, licensed clinical psychologists, licensed psychological associates, licensed professional counselors), substance use disorder counselors (AK certified Chemical Dependency Counselor I or II and Chemical Dependency Clinical Supervisor), and behavioral health clinical associates.

5.4.3. Intensive Outpatient Services - Intensive outpatient includes structured programming services provided to beneficiaries (a minimum of nine hours with a maximum of 19 hours a week for adults, and a minimum of six hours with a maximum of 19 hours a week for adolescents) when determined to be medically necessary and in accordance with an individualized treatment plan. Treatment is focused on major lifestyle, attitudinal, and

behavior issues which impair the individual's ability to cope with major life tasks without use of substances.

5.4.3.1. Components Services include:

- Individualized, person-centered assessment and clinically-directed treatment.
- Treatment plan development and review.
- Cognitive, behavioral, and other substance use disorder-focused therapies, reflecting a variety of treatment approaches, provided to the individual on an individual, group, and/ or family basis.
- Appropriate drug screening.
- Psychoeducation Services.
- Medication Services.
- Crisis Intervention Services.
- Recovery Support Services; and
- SUD Care Coordination.

5.4.3.2. Provider Qualifications -Providers qualified to be reimbursed for eligible services provided to eligible service recipients include licensed physicians, licensed physician assistants, licensed advanced nurse practitioners, licensed practical nurses, mental health professional clinicians, substance use disorder counselors, and behavioral health clinical associates.

5.4.4. Partial Hospitalization Services (PHP) -PHP services will be specifically designed for the diagnosis or active treatment of a SUD when there is a reasonable expectation for improvement or when it is necessary to maintain the person's functional level and prevent relapse or inpatient hospitalization. Services within the PHP are more clinically intense than IOP and, in addition to addressing major lifestyle, attitudinal, & behavior issues which impair the individual's ability to cope with major life tasks without the addictive use of alcohol and/or other drugs, have the capacity to treat individuals with substantial medical and psychiatric problems.

5.4.4.1. Component Services include:

- Individualized, person-centered assessment and clinically-directed treatment.
- Cognitive, behavioral, and other substance use disorder-focused therapies, reflecting a variety of treatment approaches, provided to the individual on an individual, group, and/ or family basis.

- Appropriate drug screening.
- Psychoeducation services.
- Medication services.
- Crisis Intervention services.
- Recovery Support Services; and
- Occupational and recreational therapy services as appropriate.

5.4.4.2. Provider Qualifications: Providers qualified to be reimbursed for eligible services provided to eligible service recipients include licensed physicians, licensed physician assistants, licensed advanced nurse practitioners, licensed practical nurses, mental health professional clinicians, substance use disorder counselors, and behavioral health clinical associates.

5.4.5. Residential Treatment Services - Treatment services delivered to residents of an institutional care setting, including facilities that meet the definition of an institution for mental diseases (IMD), are provided to Alaska Medicaid recipients with a SUD diagnosis when determined to be medically necessary and in accordance with an individualized treatment plan. Residential treatment services are provided in an Alaska Department of Health and Social Services (DHSS) licensed facility that has been enrolled as a Medicaid provider and assessed/designated/certified by DHSS as delivering care consistent with ASAM or other nationally recognized, SUD-specific program standards for residential treatment facilities. Residential treatment services can be provided in settings of any size. Room and board costs are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

5.4.5.1. Component services include:

- Clinically-directed therapeutic treatment to facilitate recovery skills, facilitate decreasing risk of recurrence of symptoms, and emotional coping strategies.
- Addiction pharmacotherapy and drug screening.
- Motivational enhancement and engagement strategies.
- Counseling and clinical monitoring.
- Withdrawal management and related treatment designed to alleviate acute emotional, behavioral, cognitive, or biomedical distress resulting from, or occurring with, an individual's use of alcohol and other drugs.
- Regular monitoring of the individual's medication adherence.
- Recovery support services.

- Counseling services involving the beneficiary's family and significant others to advance the beneficiary's treatment goals, when (1) the counseling with the family member and significant others is for the direct benefit of the beneficiary, (2) the counseling is not aimed at addressing treatment needs of the beneficiary's family or significant others, and (3) the beneficiary is present except when it is clinically appropriate for the beneficiary to be absent in order to advance the beneficiary's treatment goals; and
- Education on benefits of medication assisted treatment and referral to treatment as necessary.

5.4.5.2. Provider Qualifications - Providers qualified to be reimbursed for eligible services provided to eligible service recipients include AK certified residential treatment facility providers. Until formal certification process undergoes regulatory review and approval process, provisional designation will be in place per AK SUD Implementation Plan Protocol.

5.4.6. Medically Monitored Intensive Inpatient Services - These are services provided in a residential setting or a specialty unit of an acute or psychiatric hospital. Individuals receiving services at this level of care require 24-hour services, professionally directed evaluation, observation, medical monitoring, and addiction treatment in an inpatient setting.

5.4.6.1. Component Services include:

- Individualized, person-centered assessment and medically-monitored treatment.
- Addiction pharmacotherapy and medication services.
- Appropriate drug screening.
- Cognitive behavioral and other substance-use disorder-focused therapies, reflecting a variety of treatment approaches, provided to the individual on an individual, group, or family basis.
- Daily medical and nursing services.
- Counseling and clinical/medical monitoring.
- Daily treatment services focused on managing the individual's acute symptoms; and
- Psychoeducation services.

5.4.6.2. Provider Qualifications - Providers qualified to be reimbursed for eligible services provided to eligible service recipients include AK licensed general acute care, specialized psychiatric, Alaska Native tribal, and critical access hospitals.

5.4.7. Medically Managed Intensive Inpatient - These are services provided during a 24-hour inpatient treatment requiring the full resources of an acute care or psychiatric hospital. Medically Managed Intensive Inpatient services differ from Medically Monitored Intensive Inpatient services due to the requirement of **medically directed** evaluation and treatment services provided in a 24-hour treatment setting under a defined set of policies, procedures, and individualized clinical protocols.

5.4.7.1. Component Services include:

- Individualized, person-centered assessment and medically directed &

managed treatment.

- Addiction pharmacotherapy and medication services.
- Appropriate drug screening.
- Cognitive behavioral and other substance-use disorder-focused therapies, reflecting a variety of treatment approaches, provided to the individual on an individual, group, or family basis.
- Daily medical and nursing services.
- Counseling and clinical/medical monitoring.
- Daily treatment services focused on managing the individual's acute symptoms; and
- Psychoeducation services.

5.4.7.2. Provider Qualifications - Providers qualified to be reimbursed for eligible services provided to eligible service recipients include AK licensed general acute care, specialized psychiatric, Alaska Native tribal, and critical access hospitals.

5.4.8. Ambulatory Withdrawal Management - These are outpatient services that may be delivered in an office setting, a health care facility, an addiction treatment facility, or a patient's home for individuals at mild withdrawal risk and with a high commitment to withdrawal management process. Services delivered by physicians and nurses require training in managing intoxication and withdrawal states and clinical staff knowledgeable about the biopsychosocial dimensions of SUDs. Physicians are available via telephone or in- person for consultation; physician and emergency services consultation are available 24/7.

5.4.8.1. Component Services include:

- Individualized, person-centered Assessment.
- Physician and/or Nurse Monitoring.
- Management of Signs & Symptoms of Intoxication & Withdrawal.
- Medication Services.
- Psychoeducation Services.
- Non-Pharmacological Clinical Support Services.
- Referral for Counseling Services.
- Substance Use Care Coordination; and
- Community Recovery Support Services.

5.4.8.2. Provider Qualifications — Physicians, Physician Assistants, Advanced Nurse Practitioners, Registered Nurses supervised by a Physician or Advanced Nurse Practitioner, or Licensed Practical Nurses Supervised by a Physician or Advanced Nurse Practitioner.

5.4.9. Clinically Managed Residential Withdrawal Management — These are services provided in a residential treatment setting that include supervision, observation, and support for individuals who are intoxicated or experiencing withdrawal and require 24-hour structure and support but do not require the medical and nursing care specified for medically monitored/managed inpatient withdrawal management services.

5.4.9.1. Component Services include:

- Individualized, person-centered Assessment.
- Physician and/or Nurse Monitoring.
- Management of Signs & Symptoms of Intoxication & Withdrawal.
- Medication Services.
- Patient Education Services.
- Non-Pharmacological Clinical Support Services.
- Referral for Counseling Services; and
- Recovery Support Services.

5.4.9.2. Provider Qualifications — providers qualified to be reimbursed for eligible services provided to eligible service recipients include AK certified residential treatment facility providers. Until formal certification process undergoes regulatory review and approval process, provisional designation will be in place per AK SUD Implementation Plan.

5.4.10. Medically Monitored Inpatient Withdrawal Management - Services will consist of severe withdrawal and needs 24-hour nursing care and physician visits as necessary. This service is necessary because the patient is unlikely to complete withdrawal management without medical and nursing monitoring.

5.4.10.1. Component Services include:

- Individualized, person-centered assessment and medically monitored treatment.
- Addiction pharmacotherapy and medication services.
- Appropriate drug screening.

- Cognitive behavioral and other substance-use disorder-focused therapies, reflecting a variety of treatment approaches, provided to the individual on an individual, group, or family basis.

- Daily medical and nursing services and monitoring.

- Management of signs and symptoms of intoxication and withdrawal.

- Counseling and clinical/medical monitoring.

- Daily treatment services focused on managing the individual's acute symptoms; and

- Psychoeducation services.

5.4.10.2. Provider Qualifications - Providers qualified to be reimbursed for eligible services provided to eligible service recipients include AK licensed general acute care, specialized psychiatric, Alaska Native tribal, and critical access hospitals.

5.4.11. Medically Managed Intensive Inpatient Withdrawal Management - Services are for **s**evere, unstable withdrawal needs. This can include 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.

5.4.11.1. Component Services include:

- Individualized, person-centered assessment and medically directed & managed treatment.

- Addiction pharmacotherapy and medication services.

- Appropriate drug screening.

- Cognitive behavioral and other substance-use disorder-focused therapies, reflecting a variety of treatment approaches, provided to the individual on an individual, group, or family basis.

- Daily medical and nursing services.

- Management of signs and symptoms of intoxication and withdrawal.

- Counseling and clinical/medical monitoring.

- Daily treatment services focused on managing the individual's acute symptoms.

- Patient Education services.

5.4.11.2. Provider Qualifications - Providers qualified to be reimbursed for eligible services provided to eligible service recipients include AK licensed general acute

care, specialized psychiatric, Alaska Native tribal, and critical access hospitals.

5.4.12. SUD Implementation Plan and Health IT Plan. The state's SUD Implementation Plan, initially approved for the period from March 21, 2019, through December 31, 2023, remains in effect for the approval period from March 26, 2024, through December 31, 2028, and is affixed to the STCs as Attachment D. Any future modifications to the approved Implementation Plan will require CMS approval. Failure to progress in meeting the milestone goals agreed upon by the state and CMS can result in a funding deferral. The approved SUD Implementation Plan describes the strategic approach and a detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives of this SUD demonstration project.

5.4.12.1. Access to Critical Levels of Care for OUD and other SUDs: Service delivery for new benefits, including residential treatment and withdrawal management, within 12-24 months of SUD program demonstration approval.

5.4.12.2. Use of Evidence-Based SUD-Specific Patient Placement Criteria: Establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other comparable assessment and placement tools that reflect evidence-based clinical treatment guidelines within 12-24 months of SUD program demonstration approval.

5.4.12.3. Patient Placement: Establishment of utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings within 12-24 months of SUD program demonstration approval.

5.4.12.4. Use of Nationally Recognized SUD-Specific Program Standards to set Provider Qualifications for Residential Treatment Facilities: Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities: Currently, residential treatment service providers must be accredited by the Council on Accreditation, the Commission on Accreditation for Rehabilitation Facilities, or the Joint Commission and consequently approved by the state pursuant to Title 7 of the Alaska Administrative Code, Chapter 70.990. The state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other, nationally recognized, SUD-specific program standards regarding, in particular, the types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of OUD/SUD program demonstration approval.

5.4.12.5. Standards of Care: Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program

standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of SUD program demonstration approval.

5.4.12.6. Standards of Care: Establishment of a requirement that residential treatment providers offer Medication-Assisted Treatment (MAT) on-side or facilitate access to MAT off-site within 12-24 months of SUD program demonstration approval.

5.4.12.7. Sufficient Provider Capacity at Each Level of Care Including MAT for OUD: An assessment of the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT within 12 months of SUD program demonstration approval.

5.4.12.8. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD: Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand access to naloxone (and other opioid antagonist).

5.4.12.9. Improved Care Coordination and Transitions between Levels of Care: Establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities within 24 months of SUD program demonstration approval.

5.4.12.10. SUD Health IT Plan: Implementation of the milestones and metrics as detailed in STC 5.4.12.5 and

5.4.13. SUD Health Information Technology Plan ("Health IT Plan"). The SUD Health IT Plan applies to all states where the Health IT functionalities are expected to impact beneficiaries within the demonstration. As outlined in SMDL #17-003 states must submit to CMS the Health IT Plan, to be included as a section of the SUD Implementation Plan (See STC 5.4.12) to develop infrastructure and capabilities consistent with the requirements outlined.

The Health IT Plan should describe how technology can support outcomes through care coordination; linkages to public health and prescription drug monitoring programs establish data and reporting structure to monitor outcomes and support data driven interventions. Such technology should, per 42 CFR §433.112(b), use open interfaces and exposed application programming interfaces and ensure alignment with, and incorporation of, industry standards adopted by the Office of the National Coordinator for Health IT in accordance with 42 CFR part 170, subpart B.

5.4.13.1. The state must include in its Monitoring Protocol (see STC 8.6) an approach to monitoring its SUD Health IT Plan which will include performance metrics to be approved in advance by CMS.

5.4.13.2. The state must monitor progress, each Demonstration Year (DY), on the

implementation of its SUD Health IT Plan in relationship to its milestones and timelines – and report on its progress to CMS in an addendum to its Annual Report (see STC 8.6).

5.4.13.3. As applicable, the state should advance the standards identified in the "Interoperability Standards Advisory – Best Available Standards and Implementation Specifications" (ISA)[1] in developing and implementing the state's SUD Health IT policies and in all related applicable state procurement (e.g., including managed care contracts) that are associated with this demonstration.

5.4.13.4. Where there are opportunities at the state-and provider-level (up to and including usage in managed care organizations (MCO) or accountable care organization (ACO) participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state should use the federally recognized standards, barring no other compelling state interest.

5.4.13.5. Where there are opportunities at the state-and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170 but included in the ISA, the state should use the federally recognized ISA standards barring no other compelling state interest.

5.4.14. Components of the Health IT Plan Include:

5.4.14.1. The Health IT Plan must describe the state's alignment with Section 5042 of the SUPPORT Act requiring Medicaid providers to query a Qualified Prescription Drug Monitoring Program (PDMP).[2]

5.4.14.2. The Health IT Plan must address how the state's Qualified PDMP will enhance ease of use for prescribers and other state and federal stakeholders.[3] States should favor procurement strategies that incorporate qualified PDMP data into electronic health records as discrete data without added interface costs to Medicaid providers, leveraging existing federal investments in Rx Check for Interstate data sharing.

5.4.14.3. In developing the Health IT Plan, states should use the following resources:

- States may use federal resources available on Health IT.Gov (https://www.healthit.gov/topic/behavioral-health) including but not limited to "Behavioral Health and Physical Health Integration" and "Section 34: Opioid Epidemic and Health IT" (https://www.healthit.gov/playbook/health-information-exchange/).

- States may also use the CMS 1115 IT resources available on "Medicaid

[1] Available at: https://www.healthit.gov/isa/sites/isa/files/inline-files/2022-ISA-Reference-Edition.pdf

[2] Prescription drug monitoring programs (PDMP) are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the "opioid" epidemic and facilitate a nimble and targeted response.

[3] *Ibid*.

Program Alignment with State-Systems to Advance HIT, HIE and Interoperability" https://www.medicaid.gov/medicaid/data-and-systems//hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.

- States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP interoperability, electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.

- States should review the Office of the National Coordinator's Interoperability Standards Advisory (https://www.healthit.giv/isa/) for information on appropriate standards which may not be required per 45 CFR part 170, subpart N for enhanced funding, but still should be considered industry standards per 42 CFR §433.122(b)(12).

5.4.15. Unallowable Expenditures Under the SUD Expenditure Authority. In addition to the other unallowable costs and caveats already outlined in these STCs, the state may not receive FFP under any expenditure authority approved under this demonstration for any of the following.

5.4.15.1. Room and board costs for residential treatment services providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

6. COST SHARING:

6.1. Cost sharing imposed upon individuals under the demonstration is consistent with the provisions of the approved state plan.

7. DELIVERY SYSTEM:

7.1. No modification to the current Alaska Medicaid delivery system are proposed through this demonstration. Alaska Medicaid beneficiaries will continue to receive services through the current delivery system.

8. MONITORING AND REPORTING REQUIREMENTS

8.1. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in the amount of $5,000,000 (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singly or collectively referred to as "deliverables(s)")) are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

8.1.1. The following process will be used: 1) thirty (30) days after the deliverable was due if the state has not

submitted a written request to CMS for approval of an extension as described in subsection (8.1.3) below; or 2) thirty (30) days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements.

8.1.2. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submission of required deliverable(s).

8.1.3. For each deliverable, the state may submit to CMS a written request for any extension to submit the required deliverable that includes a supporting rationale for the cause(s) of the delay and the state's anticipated date of submission. Should CMS agree to the state's request, a corresponding extension of the deferral process will be provided. CMS may agree to a corrective action plan submitted by the state as an interim step before applying the deferral, if the state proposes a corrective action plan in the state's written extension request.

8.1.4. If CMS agrees to an interim corrective plan in accordance with subsection 8.1.2, and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) with all required contents in satisfaction of the terms of this agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Missouri Substance Use Disorder & Serious Mental Illness Section 1115 Demonstration CMS Approved: December 6, 2023 through December 31, 2028 Page 21 of 54 Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

8.1.5. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement with respect to required deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the requirements specified in these STCs, the deferral(s) will be released.

8.1.6. As the purpose of a section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations and other deliverables will be considered by CMS is reviewing any application for an extension, amendment, or for a new demonstration.

8.2. Deferral of Federal Financial Participation (FFP) from IMD Claiming for Insufficient Progress Toward Milestone. Up to $5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in the Implementation Plan and the required performance measures in the Monitoring Protocol agreed upon by the state and CMS. Once CMS determines that state has not made adequate progress, up to $5,000,000 will be deferred in the next calendar quarter and each calendar thereafter until CMS has determined sufficient progress has been made.

8.3. Submission of Post-Approval Deliverables. The state must submit all deliverables as stipulate by CMS and within the timeframes outlined within these STCs.

8.4. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional section 1115 demonstration reporting and analytics functions, the state will work with CMS to:

8.4.1. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new system.

8.4.2. Ensure all section 1115, Transformed Medicaid Statistical Information System (T-MSIS), and other data elements that have been agreed to for reporting and analytics are provided by the state; and

8.4.3. Submit deliverables to the appropriate system as directed by CMS.

8.5. Monitoring Protocol. The state must submit a Monitoring Protocol for this demonstration within 150 calendar days after approval of the demonstration. The Monitoring Protocol must be developed in cooperation with CMS and is subject to CMS approval. The state must submit a revised Monitoring Protocol with 60 calendar days after receipt of CMS's comments, if any. Once approved, the Monitoring Protocol will be incorporated into the STCs as Attachment D. Progress on the performance measures identified in the Monitoring Protocol must be reported via the Quarterly and Annual Monitoring Reports. Components of the Monitoring Protocol must include:

8.5.1. An assurance of the state's commitment and ability to report information relevant to each of the program implementation areas listed in STC 5.4 and reporting relevant information to the state's Health IT plan described in STC 5.4.12.5.

8.5.2. A description of the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in Section 8 (General Monitoring and Reporting Requirements) of the demonstration; and

8.5.3. A description of baselines and targets to be achieved by the end of the demonstration. Where possible, baselines will be informed by state data, and target will be benchmarked against performance in best practice settings.

8.6. Monitoring Reports. The state must submit three Quarterly Monitoring Reports and one Annual Monitoring Report each DY. The fourth quarter information that would ordinarily be provided in a separate report should be reported as distinct information within the Annual Monitoring Report. The Quarterly Monitoring Reports are due no later than 60 calendar days following the end of each demonstration quarter. The Annual Monitoring Report (including the fourth quarter information) is due no later than 90 calendar days following the end of the DY. The state must submit a revised Monitoring Report within 60 calendar days after receipt of CMS's comments, if any. The reports will include all required elements as per 432 CFR § 432.428 and must not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve and be provided in a structured manner that supports federal tracking and analysis.

8.6.1. Operational Updates: Per 42 CFR § 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key operational and other challenges, underlying causes of challenges, how challenges are being addressed. In addition, Monitoring Reports should describe key achievements, as well as the conditions and efforts to which these successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. Monitoring Reports should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

8.6.2. Performance Metrics. Per applicable CMS guidance and technical assistance, the performance metrics will provide data to support tracking the state's progress toward meeting the demonstration's annual goals and overall targets as will be identified in the approved Monitoring Protocol and will cover key policies under this demonstration. Additionally, per 42 CFR §431.428, the Monitoring Reports must document the impact of the demonstration on beneficiaries' outcomes of care, quality and cost of care, and access to care. Such reporting must also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, primary language, disability status, and geography) and by demonstration component, to the extent feasible. Subpopulation reporting will support identifying any existing shortcomings or disparities in quality of care and health outcomes and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population, including the narrowing of any identified disparities. This may also include the results of beneficiary satisfaction surveys, if conducted, and grievances and appeals. The required monitoring and performance metrics must be included in the Monitoring Reports and will follow the framework provided by CMS to support federal tracking and analysis.

8.6.3. Budget Neutrality and Financial Reporting Requirements. Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data up request. In addition, the state must report quarterly, and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs should be reported separately.

8.6.4. Evaluation Activities and Interim Findings. Per 42 CFR § 431.428, the Monitoring Reports must document 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.

8.6.5. SUD Health IT. The state will include a summary of progress made in regards to SUD Health IT requirements outlined in STC 5.4.14.

8.7. SUD Mid-Point Assessment. The state must contract with an independent entity to conduct a Mid-Point Assessment by December 31, 2026. This timeline will allow for the Mid-Point Assessment to capture approximately the first two-and-a-half years of demonstration program data, accounting for data run-out and data completeness. In the design, planning and conduction of the Mid-Point Assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: representatives of MCO, health care providers (including SUD treatment providers), beneficiaries, community groups, and other key partners

The state must require that the assessor provide a Mid-Point Assessment to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. The state must provide a copy of the report to CMS no later than 60 days after December 31, 2026. If requested, the state must brief CMS on the report. The state must submit a revised Mid-Point Assessment with 60 calendar days after receipt of CMS's comments, if any.

For milestones and measure targets at medium to high risk of not being achieved, the state must submit to CMS proposed modifications to the SUD Implementation Plan and the SUD Monitoring Protocol, for ameliorating these risks. Modifications to any of these plans or protocols are subject to CMS approval.

Elements of the Mid-Point Assessment must include:

8.7.1. An examination of progress toward meeting each milestone and timeframe approved in the SUD Implementation Plan and toward meeting the targets for performance measures as approved in the SUD Monitoring Protocol.

8.7.2. A determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date.

8.7.3. A determination of factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets.

8.7.4. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's SUD Implementation Plans or to other pertinent factors that the state can influence that will support improvement; and

8.7.5. An assessment of whether the state is on track to meet the budget neutrality requirements.

8.8. Corrective Action Plan Related to Demonstration Monitoring. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS will withdraw an authority, as described in STC 3.10 when metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals, and the state has not implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

8.9. Close-Out Report. Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

8.9.1. The Close-Out Report must comply with the most current guidance from CMS.

8.9.2. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in STCs 11.7 and 11.8, respectively.

8.9.3. The state will present to and participate in a discussion with CMS on the Close-Out Report.

8.9.4. The state must take into consideration CMS's comments for incorporation in the Final Close-Out Report.

8.9.5. A revised Close-Out Report is due to CMS no later than 30 calendar days after receipt of CMS's comments.

8.9.6. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 8.1.

8.10. Monitoring Calls. CMS will convene periodic conference calls with the state.

8.10.1. The purpose of these calls is to discuss ongoing demonstration operation, including (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, enrollment and access, budget neutrality, and progress on evaluation activities.

8.10.2. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

8.10.3. The state and CMS will jointly develop the agenda for the calls.

8.11. Post Award Forum. Pursuant to 42 CFR § 431.420(c), within 6 months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 calendar days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent Annual Monitoring Report on its website with the public forum. Pursuant to 42 CFR § 431.420(c), the state must include a summary of the public comments in the Monitoring Report associated with the quarter in which the forum was held, as well as in its Annual Monitoring Report.

9. GENERAL FINANCIAL REQUIREMENTS

9.1. Allowable Expenditures. This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

9.2. Standard Medicaid Funding Process. The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the states estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state and include the reconciling adjustment in the finalization of the grant award to the state.

9.3. Sources of Non-Federal Share. As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

9.3.1. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.

9.3.2. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.

9.3.3. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

9.4. State Certification of Funding Conditions. As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:

9.4.1. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with section 1903(w) of the Act and applicable implementing regulations.

9.4.2. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The federal financial participation paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 435.51(c).

9.4.3. The state may use intergovernmental transfer (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.

9.4.4. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local government, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner in consistent with the requirements in section 1903(w) of the Act and its implementing

regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

9.4.5. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

9.5. Financial Integrity for Managed Care Delivery Systems. As a condition of demonstration approval, the state attests to the following, as applicable:

9.5.1. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR 438.6(b)(2), 438(6)(c), 438.6(d), 438.60, and 438.74.

9.6. Requirements for Health Care-Related Taxes and Provider Donations. As a condition of demonstration approval, the state attests to the following, as applicable:

9.6.1. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).

9.6.2. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

9.6.3. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.

9.6.4. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).

9.6.5. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Social Security Act, 42 CFR 433.66, and 42 CFR 433.54.

9.7. State Monitoring of Non-Federal Share. If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This deliverable is subject to the deferral as described in STC 8.1. This report must include:

9.7.1. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax.

9.7.2. Number of providers in each locality of the taxing entities for each locality tax.

9.7.3. Whether or not all providers in the locality will be paying the assessment for each locality tax.

9.7.4. The assessment rate that the providers will be paying for each locality tax.

9.7.5. Whether any providers that pay the assessment will not be receiving payments funded by the assessment.

9.7.6. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax.

9.7.7. The monitoring plan for the taxing arrangement to ensure that the tax complies within section 1903(w)(4) of the Act and 42 CFR 433.68(f); and

9.7.8. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under section 1903(w) of the Act.

9.8. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in the STCs in Section 10:

9.8.1. Administrative costs, including those associated with the administration of the demonstration.

9.8.2. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan; and

9.8.3. Medical assistance expenditures and prior period adjustments made under section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third-party liability.

9.9. Program Integrity. The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

9.10. Medicaid Expenditure Groups. Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to the budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table providers a master list of MEGs defined for this demonstration.

Table 1: Master MEG Chart

MEG	Which BN Test Applies	WOW Per Capita	WOW Aggregate	WW	Brief Description
SUD IMD FFS	HYPO 1	X		X	Expenditures for all otherwise-allowable Medicaid services provided, were it not for

					the IMD prohibition, to otherwise eligible individuals enrolled in fee-for-service during a month in which the beneficiary was a resident in an IMD for a primary diagnosis of SUD.
SUD Non-IMD FFS	HYPO 1	X		X	Expenditures for all otherwise-allowable Medicaid services provided to eligible individuals enrolled in fee-for-service during a month in which the beneficiary was not a resident in an IMD for a primary diagnosis of SUD.
Behavioral Health FFS	HYPO 1	X		X	Expenditures for allowable Medicaid services, outlines within the STCs, provided to eligible individuals enrolled in fee-for-service during a month in which the beneficiary is receiving behavioral health services.

BN – Budget Neutrality; MEG – Medicaid Expenditure Group; WOW – Without Waiver; WW – With Waiver.

9.11. Report Expenditures and Member Months. The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W-00318/0). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditures. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

9.11.1. Cost Settlements. The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10n (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

9.11.2. Premiums and Cost Sharing Collected by the State. The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet Line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by demonstration year on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

9.11.3. Pharmacy Rebates. Because pharmacy rebates are not included in the base expenditures used to determine the budget neutrality expenditure limit, pharmacy rebates are not included for calculating net expenditures subject to the budget neutrality. The state will report pharmacy rebates on form CMS-64.9 BASE, and not allocate them to any 64.9 OR 64.9P WAIVER.

9.11.4. Administrative Costs. The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the MEG Charts and in the STCs in Section 10, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

9.11.5. Member Months. As part of the Quarterly and Annual Monitoring Reports described in Section 10, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two months each contribute two eligible member months per person, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

9.11.6. Budget Neutrality Specifications Manual. The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table 2: MEG Detail for Expenditure and Member Months Reporting

MEG (Waiver Name)	Detailed Description	Exclusions	CMS 64.9 or 64.10 Line(s) to Use	How Expend Are Assigned to DY	MAP or ADM	Report Member Months	MEG Start Date	MEG End Date
SUD IMD FFS	Expenditures for all otherwise-allowable Medicaid services provided, were it not for the IMD prohibition, to otherwise eligible individuals	N/A	Follow standard CMS-64.9 Category of Service Definition	Date of Services	MAP	Y	03/26/24	12/31/28

	enrolled in fee-for-service during a month in which the beneficiary was a resident in an IMD for a primary diagnosis of SUD.							
SUD Non-IMD FFS	Expenditures for all otherwise-allowable Medicaid services provided to eligible individuals enrolled in fee-for-service during a month in which the beneficiary was not a resident in an IMD for a primary diagnosis of SUD.	N/A	Follow standard CMS-64.9 Category of Service Definition	Date of Services	MAP	Y	03/26/24	12/31/28
Behavioral Health FFS	Expenditures for allowable Medicaid services, outlines within the STCs, provided to eligible individuals enrolled in fee-for-service during a month in which the beneficiary is receiving behavioral health services.		Follow standard CMS-64.9 Category of Service Definition	Date of Services	MAP	Y	03/26/24	12/31/28

ADM – Administration: DY – Demonstration Year; MAP – Medical Assistance Payments; MEG – Medicaid Expenditure Group;

9.12. Demonstration Years. Demonstration Years (DY) for this demonstration are defined in the table below.

Table 3: Demonstration Years		
Demonstration Year 6	January 1, 2024, to December 31, 2024	12 Months
Demonstration Year 7	January 1, 2025, to December 31, 2025	12 Months
Demonstration Year 8	January 1, 2026, to December 31, 2026	12 Months
Demonstration Year 9	January 1, 2027, to December 31, 2027	12 Months
Demonstration Year 10	January 1, 2028, to December 31, 2028	12 Months

9.13. Budget Neutrality Monitoring Tool. The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the performance metrics database and analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing the demonstration's actual expenditures to the budget neutrality expenditure limits described in Section 10. CMS will provide technical assistance, upon request.

9.14. Claiming Period. The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

9.15. Future Adjustments to Budget Neutrality. CMS reserves the right to adjust the budget neutrality expenditure limit:

9.15.1. To be consistent with enforcement of laws and policy statements, including regulations and guidance, regarding impermissible provider payment, health care related taxes, or other payments. CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provision of section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

9.15.2. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

The state certifies that the data if provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations and policies, and that the data are correct to the best of the state's knowledge and belief. The data supplied by the state to det the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

9.16. Budget Neutrality Mid-Course Correction Adjustment Request. No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered services or population and that is likely to further strengthen access to care.

9.16.1. Contents of Request and Process. In its request, the state must provide a description of the expenditures changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 9.16.3. If approved, and adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 3.7 CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to the changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

9.16.2. Types of Allowable Changes. Adjustment will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:

9.16.2.1. Provider rate increases that are anticipated to further strengthen access to care.

9.16.2.2. CMS or State technical errors in the original neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs.

9.16.2.3. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures.

9.16.2.4. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance.

9.16.2.5. When not already accounted for under Emergency Medicaid 1115 demonstration, cost impacts from public health emergencies.

9.16.2.6. High-cost innovative medical treatments that states are required to cover; or

9.16.2.7. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.

9.16.3. Budget Neutrality Update. The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:

9.16.3.1. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and,

9.16.3.2. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration covered service or population and that is likely to further strengthen access to care.

10. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

10.1. Limit on Title XIX Funding. The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit consists of one or more Hypothetical Budget Neutrality Tests as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

10.2. Risk. The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table 1, Master MEG Chart, and Table 2, MEG Detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost of state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions, however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

10.3. Calculation of the Budget Neutrality Limits and How They Are Applied. To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components per capita components, which are calculated as a projected without-waiver Per Member Per Month (PMPM) cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts. The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

10.4. Main Budget Neutrality Test. This demonstration does not include a Main Budget Neutrality Test. Budget neutrality will consist entirely of Hypothetical Budget Neutrality Tests. Any excess spending under the Hypothetical Budget Neutrality Tests must be returned to CMS.

10.5. Hypothetical Budget Neutrality. When expenditure authority is provided for coverage of populations or services that the state could have otherwise through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be "hypothetical," such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they

were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do no necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to refund the FFP to CMS.

10.6. Hypothetical Budget Neutrality Test 1 SUD IMD FFS and SUD Non-IMD FFS. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit form Hypothetical Budget Neutrality Test 1 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 4: Hypothetical Budget Neutrality Test 1

MEG	PC or Agg.	WOW Only, WW Only, or Both	Trend Rate	DY 6	DY 7	DY 8	DY 9	DY 10
SUD IMD FFS	PC	Both	5.50%	$33.27	$35.10	$37.03	$39.07	$41.22
SUD Non-IMD FFS	PC	Both	5.50%	$13,666.38	$14,418.03	$15,211.02	$16,047.63	$16,930.25

10.7. Hypothetical Budget Neutrality Test 2 SUD IMD FFS and SUD Non-IMD FFS. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit form Hypothetical Budget Neutrality Test 1 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 5: Hypothetical Budget Neutrality Test 1

MEG	PC or Agg.	WOW Only, WW Only, or Both	Trend Rate	DY 6	DY 7	DY 8	DY 9	DY 10
Behavioral Health FFS	PC	Both	5.50%	$24.57	$25.92	$27.35	$28.85	$30.44

10.8. Composite Federal Share. The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

10.9. Exceeding Budget Neutrality. CMS will enforce the budget neutrality agreement over the demonstration period, which extends from 03/26/2024 to 12/31/2028. If at the end of the demonstration approval period the Hypothetical Budget Neutrality Test has been exceeded, the excess federal funds will be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

10.10. Corrective Action Plan. If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table 6: Budget Neutrality Test Corrective Action Plan Calculation		
Demonstration Year	**Cumulative Target Definition**	**Percentage**
DY 1 through DY 2	Cumulative Budget Neutrality Limit Plus	2.0 Percent
DY 1 through DY 3	Cumulative Budget Neutrality Limit Plus	1.5 Percent
DY 1 through DY 4	Cumulative Budget Neutrality Limit Plus	1.0 Percent
DY 1 through DY 5	Cumulative Budget Neutrality Limit Plus	0.5 Percent
DY 1 through DY 6	Cumulative Budget Neutrality Limit Plus	0.0 Percent

11. EVALUATION OF THE DEMONSTRATION

11.1. Cooperation with Federal Evaluators. As required under 42 CFR § 431.420(f), the state must cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but it not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they will make such data available for the federal evaluation as is required under 42 CFR § 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 8.1.

11.2. Independent Evaluator: The state must use an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accord with the approved Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved

methodology. However, the state may request, and CMS may agree to, change in the methodology in appropriate circumstances.

11.3. Draft Evaluation Design. The state must submit, for CMS comment and approval, a draft Evaluation Design no later than 180 days after the approval of the demonstration. The draft Evaluation Design must be developed in accordance with Attachment A (Developing the Evaluation Design) of these STCs, CMS's evaluation design guidance for SUD demonstrations, including guidance for approaches to analyzing associated costs, and any other applicable CMS evaluation guidance and technical assistance for the demonstration's other policy components. The Evaluation Design must be also developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations. In addition to these requirements, if determined culturally appropriate for the communities impacted by the demonstration, the state is encouraged to consider implementation approaches involving randomized control trials and staged rollout (for example, across geographic areas, by service setting, or by beneficiary characteristic), as these implementation strategies help create strong comparison groups and facilitate robust evaluation. The state is strongly encouraged to use the expertise of the independent party in the development of the draft Evaluation Design. The draft Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STC 11.7 and 11.8.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design or submit a new Evaluation Design to accommodate the amendment component. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. Depending on the scope and timing of the amendment, in consultation with CMS, the state may provide the details on necessary modifications to the approved Evaluation Design via the monitoring reports. The amended Evaluation Design must also be reflected in the state's Interim (as applicable) and Summative Evaluation Reports, described below.

11.4. Evaluation Budget. A budget for the evaluation must be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

11.5. Evaluation Design Approval and Updates. The state must submit a revised draft Evaluation Design within 60 days after receipt of CMS's comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR § 431.424(c), the state will publish the approved Evaluation Design to the state's website within 30 days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation implementation progress in each of the Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in Monitoring Reports.

11.6. Evaluation Questions and Hypotheses. Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Reports) of these STCs, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the

evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and its effectiveness in achieving the goals.

Hypotheses for the SUD component of the demonstration must support an assessment of the demonstration's success in achieving the core goals of the program through addressing, among other outcomes, initiation and compliance with treatment, utilization of health services in appropriate care settings, and reductions in key outcomes such as deaths due to overdose. Likewise, the state must test appropriate hypotheses focused on utilization and health outcomes for the other demonstration components. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF). CMS underscores the importance of the state undertaking a well-designed beneficiary survey or interviews to assess, for instance, beneficiary understanding of the demonstration policy components and beneficiary experiences with access to and quality of care.

Furthermore, the evaluation must accommodate data collection and analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, and/or geography)—to the extent feasible—to inform a fuller understanding of existing disparities in access and health outcomes, and how the demonstration's various policies might support bridging any such inequities.

11.7. Interim Evaluation Report. The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR § 431.412(c)(2)(vi). When submitting an application for extension of the demonstration, the Interim Evaluation Report should be posted to the state's website with the application for public comment.

11.7.1. The interim evaluation report will discuss evaluation progress and present findings to date as per the approved evaluation design.

11.7.2. For demonstration authority or any components within the demonstration that expire prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.

11.7.3. If the state is seeking a renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted, or one year prior to the end of the demonstration, whichever is sooner. If the state is not requesting an extension for a demonstration, an Interim Evaluation Report is due one year prior to the end of the demonstration.

11.7.4. The state must submit the revised Interim Evaluation Report 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report, if any.

11.7.5. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid website within 30 calendar days.

11.7.6. The Interim Evaluation Report must comply with Attachment B (Preparing the Interim and Summative Evaluation Report) of these STCs.

11.8. Summative Evaluation Report. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in accordance with Attachment B (Preparing the Interim and Summative Evaluation Report) of these STCs, and in alignment with the approved Evaluation Design.

11.8.1. The state must submit the final Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft, if any.

11.8.2. Once approved by CMS, the state must post the final Summative evaluation Report to the state's Medicaid website within 30 calendar days.

11.9. Corrective Action Plan Related to Evaluation. If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. This may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.10. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

11.10. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation Report, and the Summative Evaluation Report.

11.11. Public Access. The state shall post the final documents (e.g., Monitoring Reports, Close-Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 days of approval by CMS.

11.12. Additional Publications and Presentations. For a period of 12 months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports on their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given 30 business days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

12. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Deliverable	Timeline	STC Reference
State acceptance of demonstration Waivers, STCs, and Expenditure Authorities	30 calendar days after approval date.	Approval letter

Monitoring Protocol	No later than 150 calendar days after approval date. Revised no later than 60 calendar days after receipt of CMS comments.	STC 8.6
Evaluation Design	No later than 180 calendar days after approval date. Revised no later than 60 calendar days after receipt of CMS comments. Published to state website no later than 30 calendar days after CMS approval.	STC 11.3
Mid-Point Assessment Report	No later than 60 calendar days after December 31, 2026	STC 8.8
Interim Evaluation Report	No later than December 31, 2027, or with extension application. Revised no later than 60 calendar days after receipt of CMS comments.	STC 11.7.3
Summative Evaluation Report	No later than 18 months after the end of the demonstration. Revised no later than 60 calendar days after receipt of CMS comments.	STC 11.8
Close-Out Report	No later than 120 calendar days after the end of the demonstration. Revised no later than 30 calendar days after receipt of CMS comments.	STC 8.10
Monthly		
Monitoring Calls	Monthly	STC 8.11
Quarterly		
Quarterly Monitoring Reports	Due no later than 60 days after end of each quarter, except 4th quarter.	STC 8.7
Quarterly (CMS-64) Expenditure Reports	Due no later than 60 days after end of each quarter, except 4th quarter.	STC 9.2

Quarterly Budget Neutrality Reports	Due no later than 60 days after end of each quarter, except 4th quarter.	STC 9.13
Annually		
Annual Monitoring Reports (including Q4 Expenditure Report and Budget Neutrality Report)	Due 90 days after end of each 4th quarter.	STC 8.7
Post Award Forum	No later than 6 months after the demonstration's implementation and annually thereafter.	STC 8.12

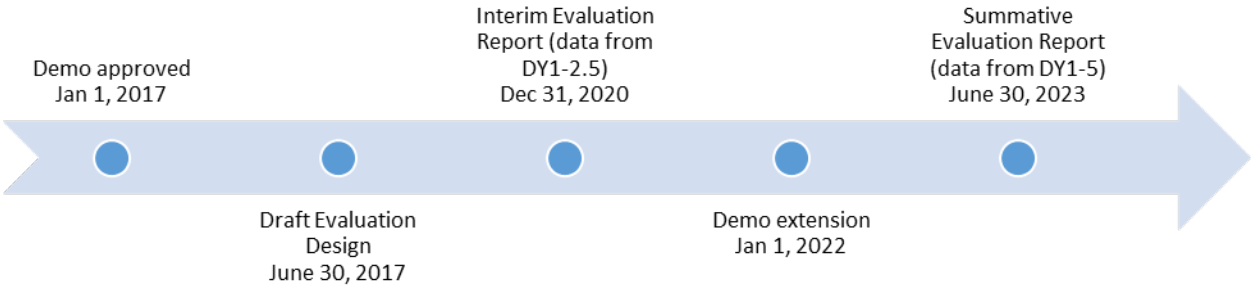
ATTACHMENT A
Developing the Evaluation Design

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the population of focus), and impacts of the demonstration (e.g., whether the outcomes observed in the population of focus differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of its draft Evaluation Design and subsequent evaluation reports. The graphic below depicts an example of this timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within 30 calendar days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Designs

CMS expects Evaluation Designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html. If the state needs technical assistance using this outline or developing the Evaluation Design, the state should contact its demonstration team.

All states with section 1115 demonstrations are required to conduct Interim and Summative Evaluation Reports, and the Evaluation Design is the roadmap for conducting these evaluations. The roadmap begins with the stated

goals for the demonstration, followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

- **A.** General Background Information;
- **B.** Evaluation Questions and Hypotheses;
- **C.** Methodology;
- **D.** Methodological Limitations;
- **E.** Attachments.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1. The issues that the state is trying to address with the approved section 1115 demonstration waivers and expenditure authorities, the potential magnitude of the issues, and why the state selected this course of action to address the issues (e.g., a narrative on why the state submitted a section 1115 demonstration application).

2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.

3. A description of the population groups impacted by the demonstration.

4. A brief description of the demonstration and history of its implementation, and whether the draft Evaluation Design applies to an amendment, extension, or expansion of, the demonstration.

5. For extensions, amendments, and major operational changes: a description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the evaluation questions align with the hypotheses and the goals of the demonstration.

2. Address how the hypotheses and research questions promote the objectives of Titles XIX and XXI.

3. Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets can be measured.

4. Include a Logic Model or Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram, which includes information about the goals and features of the demonstration, is a particularly effective modeling tool when working to improve health and health care through specific interventions. A driver diagram depicts the relationship between the goal, the primary drivers that contribute directly to achieving the goal, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf.

5. Include implementation evaluation questions to inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings. Implementation evaluation research questions can focus on barriers, facilitators, beneficiary and provider experience with the demonstration, the extent to which demonstration components were implemented as planned, and the extent to which implementation of demonstration components varied by setting.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, that the results are statistically valid and reliable, and that it builds upon other published research, using references where appropriate. The evaluation approach should also consider principles of equitable evaluations, and involve partners such as community groups, beneficiaries, health plans, health care providers, social service agencies and providers, and others impacted by the demonstration who understand the cultural context in developing an evaluation approach. The state's Request for Proposal for an independent evaluator, for example, could encourage research teams to partner with impacted groups.

This section also provides evidence that the demonstration evaluation will use the best available data. The state should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discuss the generalizability of results. This section should provide enough transparency to explain what will be measured and how, in sufficient detail so that another party could replicate the results. Table A below is an example of how the state might want to articulate the analytic methods for each research question and measure.

Specifically, this section establishes:

1. *Methodological Design* – Provide information on how the evaluation will be designed. For example, whether the evaluation will utilize pre/post data comparisons, pre-test or post-test only assessments. If qualitative analysis methods will be used, they must be described in detail.

2. *Focus and Comparison Populations* – Describe the characteristics of the focus and comparison populations, incorporating the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups.

Additionally, discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3. *Evaluation Period* – Describe the time periods for which data will be included.

4. *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. The state also should include information about how it will define the numerators and denominators. Furthermore, the state should ensure the measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval. When selecting metrics, the state shall identify opportunities for improving quality of care and health outcomes, and controlling cost of care. The state also should incorporate benchmarking and comparisons to national and state standards, where appropriate.

   Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating, securing, and submitting for endorsement, etc.). Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Core Set of Health Care Quality Measures for Medicaid-Eligible Adults, metrics drawn from the Behavioral Risk Factor Surveillance System (BRFSS) survey, or measures endorsed by National Quality Forum. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology.

5. *Data Sources* – Explain from where the data will be obtained, describe any efforts to validate and clean the data, and discuss the quality and limitations of the data sources. If the state plans to collect primary data (i.e., data collected specifically for the evaluation), include the methods by which the data will be collected, the source of the proposed questions and responses, and the frequency and timing of data collection. Additionally, copies of any proposed surveys must be provided to CMS for approval before implementation.

6. *Analytic Methods* – This section includes the details of the selected quantitative and qualitative analysis measures that will adequately assess the effectiveness of the demonstration. This section should:

   a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression).
   b. Explain how the state will isolate the effects of the demonstration from other initiatives occurring in the state at the same time (e.g., through the use of comparison groups).
   c. Include a discussion of how propensity score matching and difference-in-differences designs may be used to adjust for differences in comparison populations over time, if applicable.
   d. Consider the application of sensitivity analyses, as appropriate.

7. *Other Additions* – The state may provide any other information pertinent to the Evaluation Design for the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-Sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides more detailed information about the limitations of the evaluation. This could include limitations about the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize these limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

CMS also recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. For example, if a demonstration is long-standing, it may be difficult for the state to include baseline data because any pre-test data points may not be relevant or comparable. Other examples of considerations include:

1. When the demonstration is:
    a. Non-complex, unchanged, or has previously been rigorously evaluated and found to be successful; or
    b. Could now be considered standard Medicaid policy (CMS published regulations or guidance).

2. When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
    a. Operating smoothly without administrative changes;
    b. No or minimal appeals and grievances;
    c. No state issues with CMS-64 reporting or budget neutrality; and
    d. No Corrective Action Plans for the demonstration.

E. Attachments

1. **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation and prepare objective Evaluation Reports. The Evaluation Design should include a "No Conflict of Interest" statement signed by the independent evaluator.

2. **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated costs, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design, if CMS finds that the draft Evaluation Design is not sufficiently developed, or if the estimates appear to be excessive.

3. **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The final Evaluation Design shall incorporate milestones for the development and submission of the Interim and Summative Evaluation Reports. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation Report is due.

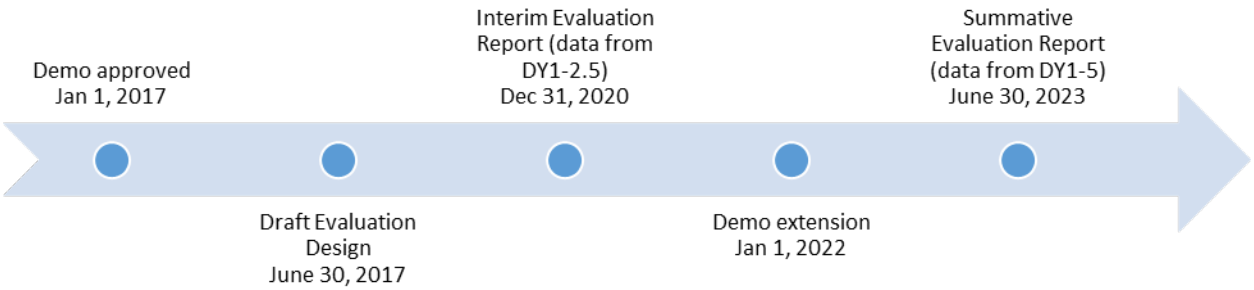
ATTACHMENT B
Preparing the Interim and Summative Evaluation Reports

Introduction

Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions. To that end, for states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate information about these policies. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data. Evaluations should include findings about the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the population of focus), and impacts of the demonstration (e.g., whether the outcomes observed in the population of focus differ from outcomes in similar populations not affected by the demonstration).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). The graphic below depicts an example of a deliverables timeline for a 5-year demonstration. In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the Interim and Summative Evaluation Reports to the state's website within 30 calendar days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Expectations for Evaluation Reports

All states with Medicaid section 1115 demonstrations are required to conduct evaluations that are valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). The already-approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. When conducting analyses and

developing the evaluation reports, every effort should be made to follow the methodology outlined in the approved Evaluation Design. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

When submitting an application for renewal, the Interim Evaluation Report should be posted on the state's website with the application for public comment. Additionally, the Interim Evaluation Report must be included in its entirety with the application submitted to CMS.

CMS expects Interim and Summative Evaluation Reports to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. Technical assistance resources for constructing comparison groups and identifying causal inferences are available on Medicaid.gov: https://www.medicaid.gov/medicaid/section-1115-demonstrations/1115-demonstration-monitoring-evaluation/1115-demonstration-state-monitoring-evaluation-resources/index.html. If the state needs technical assistance using this outline or developing the evaluation reports, the state should contact its demonstration team.

Intent of this Attachment

Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's evaluation report submissions must provide comprehensive written presentations of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

Required Core Components of Interim and Summative Evaluation Reports

The Interim and Summative Evaluation Reports present research and findings about the section 1115 demonstration. It is important that the reports incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. The evaluation reports should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy.

The format for the Interim and Summative Evaluation reports is as follows:

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and,
J. Attachment(s).

A. **Executive Summary** – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. **General Background Information about the Demonstration** – In this section, the state should include basic information about the demonstration, such as:
    1. The issues that the state is trying to address with the approved section 1115 demonstration waivers and expenditure authorities, how the state became aware of the issues, the potential magnitude of the issues, and why the state selected this course of action to address the issues.
    2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation.
    3. A description of the population groups impacted by the demonstration.
    4. A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, or expansion of, the demonstration.
    5. For extensions, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes. Additionally, the state should explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable).

C. **Evaluation Questions and Hypotheses** – In this section, the state should:
    1. Identify the state's hypotheses about the outcomes of the demonstration, and discuss how the goals of the demonstration align with the evaluation questions and hypotheses.
    2. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.
    3. Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
    4. The inclusion of a Logic Model or Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.

D. **Methodology** – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration, consistent with the approved Evaluation Design. The Evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research, (using references), meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An Interim Evaluation Report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an Interim Evaluation Report.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used. The state also should report on, control for, and make appropriate adjustments for the limitations of the data and their effects on results, and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how, in sufficient detail so that another party could replicate the results. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. *Methodological Design* – Whether the evaluation included an assessment of pre/post or post-only data, with or without comparison groups, etc.

2. *Focus and Comparison Populations* – Describe the focus and comparison populations, describing inclusion and exclusion criteria.

3. *Evaluation Period* – Describe the time periods for which data will be collected.

4. *Evaluation Measures* – List the measures used to evaluate the demonstration and their respective measure stewards.

5. *Data Sources* – Explain from where the data were obtained, and efforts to validate and clean the data.

6. *Analytic Methods* – Identify specific statistical testing which was undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).

7. *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. **Methodological Limitations** – This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. **Results** – In this section, the state presents and uses the quantitative and qualitative data to demonstrate whether and to what degree the evaluation questions and hypotheses of the demonstration were addressed. The findings should visually depict the demonstration results, using tables, charts, and graphs, where appropriate. This section should include findings from the statistical tests conducted.

G. **Conclusions** – In this section, the state will present the conclusions about the evaluation results. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically, the state should answer the following questions:

1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
2. If the state did not fully achieve its intended goals, why not?
3. What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. **Interpretations, Policy Implications and Interactions with Other State Initiatives** – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long-range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretations of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels. Interpreting the implications of evaluation findings should include involving partners, such as community groups, beneficiaries, health plans, health care providers, social service agencies and providers, and others impacted by the demonstration who understand the cultural context in which the demonstration was implemented.

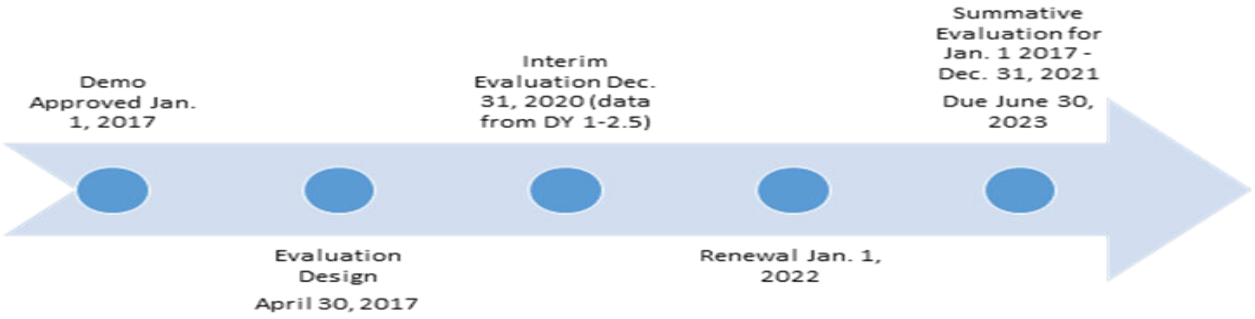
I. **Lessons Learned and Recommendations** – This section of the evaluation report involves the transfer of knowledge. Specifically, it should include potential "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders. Recommendations for improvement can be just as significant as identifying current successful strategies. Based on the evaluation results, the state should address the following questions:
    1. What lessons were learned as a result of the demonstration?
    2. What would you recommend to other states which may be interested in implementing a similar approach?

The format for the Interim and Summative Evaluation reports is as follows:

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and
J. Attachment(s).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish to the state's website the evaluation design within thirty (30) days of CMS approval, and publish reports within thirty (30) days of submission to CMS , pursuant to 42 CFR 431.424. CMS will also publish a copy to Medicaid.gov.



Required Core Components of Interim and Summative Evaluation Reports

The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the state's Driver Diagram (described in the Evaluation Design guidance) must be included with an explanation of the depicted information. The Evaluation Report should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in

hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy. Therefore, the state's submission must include:

A. Executive Summary – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. General Background Information about the Demonstration – In this section, the state should include basic information about the demonstration, such as:

1) The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.

2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;

3) A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;

4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.

5) Describe the population groups impacted by the demonstration.

C. Evaluation Questions and Hypotheses – In this section, the state should:

1) Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.
2) Identify the state's hypotheses about the outcomes of the demonstration;
    a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
    b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and
    c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design.

The evaluation design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An interim report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an interim evaluation.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1. Evaluation Design – Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc.?
2. Target and Comparison Populations – Describe the target and comparison populations; include inclusion and exclusion criteria.
3. Evaluation Period – Describe the time periods for which data will be collected
4. Evaluation Measures – What measures are used to evaluate the demonstration, and who are the measure stewards?
5. Data Sources – Explain where the data will be obtained, and efforts to validate and clean the data.
6. Analytic methods – Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7. Other Additions – The state may provide any other information pertinent to the evaluation of the demonstration.
    - **A) Methodological Limitations -** This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.
    - **B) Results –** In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the demonstration results (tables, charts, graphs). This section should include information on the statistical tests conducted.

C) **Conclusions** – In this section, the state will present the conclusions about the evaluation results.

1) In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?

2) Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:

   a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

D. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

E. Lessons Learned and Recommendations – This section of the Evaluation Report involves the transfer of knowledge. Specifically, the "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:

1. What lessons were learned as a result of the demonstration?

2. What would you recommend to other states which may be interested in implementing a similar approach?

F. Attachment

Evaluation Design: Provide the CMS-approved Evaluation Design

ATTACHMENT C:
Evaluation Design

State of Alaska

Department of Health and Social

Services Division of Behavioral Health

Alaska Substance Use Disorder and Behavioral Health Program (SUD-BHP)

1115 Evaluation Design

For FY2019 Through FY2024

Prepared by Grant J. Rich, PhD and Health Services Advisory Group

TABLE OF CONTENTS AND OUTLINE

A. General Background Information

1. Name of the demonstration, approval date, and time period

Title: Alaska Substance Use Disorder and Behavioral Health Program (SUD-BHP)

Approval Date: September 3rd, 2019 (Special Terms and Conditions/STCs)

Time Period: 01/01/2019 through 12/31/2023

2. The purpose of the section 1115 demonstration and expenditure authorities

The Alaska Department of Health and Social Services (DHSS) has received authority for a Medicaid Section 1115 Demonstration Project from the Centers for Medicare & Medicaid Services (CMS) on September 3, 2019 to develop a data-driven, integrated behavioral health system of care for children, youth, and adults with serious mental illness, severe emotional disturbance, and/or substance use disorders. The demonstration project also seeks to increase services for at-risk families in order to support the healthy development of children and adults through increased outreach and prevention and early intervention supports. The demonstration runs through December 31, 2023 and builds upon the initial Section 1115 Waiver application submitted in January 2018. In brief, the purpose and goal of the Alaska Medicaid Section 1115 Substance Use Disorder and Behavioral Health Program (SUD-BHP) Demonstration is to create a data-driven, integrated behavioral health system of care for Alaskans with serious mental illness, severe emotional disturbance, and/or substance use disorders.

Rationale and Background

Alaskans have, for many years, needed behavioral health (including both substance misuse and mental health) services above national averages across several important domains.

Data from the 2018 Behavioral Risk Factor Surveillance Survey (BRFSS) show that 11.3% of Alaskans reported frequent mental distress (14 or more days per month of poor mental health). 15.8% of Alaska Native adults surveyed reported frequent mental distress[1] and Alaska's 2017 suicide rate of 26.9/100,000 was more than twice the 2015 national rate of 12.32/100,000. The Alaska Native population is over two times likely to complete suicide than non-Alaska Natives.[2]

According to the 2016-2017 National Survey on Drug Use and Health (NSDUH):

- 16.81% of Alaskans (aged 12 and over), compared to 10.9% of respondents in the USA, reported illicit drug use in the past month
- 22.73% of Alaskans (aged 12 and over), compared to 14.5% of respondents in the USA, reported marijuana use in the past year
- 0.44% of Alaskans (aged 12 and over), compared to 0.34% of respondents in the USA, reported heroin use in the past year
- 24.2% of Alaskans (aged 12 and over), compared to 24.37% of respondents in the USA, reported

[1] *AK-IBIS Health Indicator Report of Mental Health – Adults (18+) – Frequent Mental Distres*s, Alaska Division of Public Health, Department of Health and Social Services (*citing* Alaska Behavioral Risk Factor Surveillance System 2018).
[2] Alaska Health Analytics and Vital Records, Alaska Division of Public Health (2013-2017 data: 2017 Annual Report and data).

binge alcohol use in the past month

- 0.68% of Alaskans (aged 18 and over), compared to 0.65% of respondents in the USA, reported pain reliever use disorder in the past year
- 8.46% of Alaskans (aged 12 and over), compared to 6.82% of respondents in the USA, reported needing but not receiving treatment at a specialty facility for substance use in the past year
- 5.02% of Alaskans (aged 18 and over), compared to 4.38% of respondents in the USA, reported serious mental illness in the past year
- 13.02% of Alaskans (aged 18 and over), compared to 14.6% of respondents in the USA, reported receiving mental health services in the past year
- 5.34% of Alaskans (aged 18 and over), compared to 4.19% of respondents in the USA, reported having serious thoughts of suicide in the past year
- 7.69% of Alaskans (aged 18 and over), compared to 6.89% of respondents in the USA, reported having major depressive disorder in the past year.[3]

Alaska has the 10th highest prevalence rate of adult binge drinking in the country and the fifth highest rate of intensity of binge drinking among adults. Alaskan adults and Alaska Native adults report similar rates of binge drinking in the past month (19.9% and 19.8%, respectively).[4] The rate of alcohol-related mortality for Alaska Natives is more than three times (71.4/100,000) that of all Alaskan adults (20.4/100,000) and is eight times the national rate (8.5/100,000).[5] In 2015, Alaska had the 3rd highest rate in the U.S. of alcohol attributed mortality; furthermore, in 2017, 7.6% of all emergency medical service (EMS) transports in Alaska were alcohol-attributable, and in 2016, almost half of the Alaska children in foster care or in "out of home placements" came from a home with parental or guardian alcohol use.[6]

In addition, like all states, Alaska has experienced an uptick in the number of individuals dealing with substance use disorders and the associated rate of deaths due to opioid overdose. Alaska has the 10th highest prevalence rate of adult binge drinking in the country and the 5th highest rate of intensity of binge drinking among adults.[7] Importantly, as noted above, the rate of alcohol-related mortality for Alaska Natives is more than three times (71.4/100,000) that of all Alaskan adults (20.4/100,000) and is eight times the national rate (8.5/100,000).[8] Alaska Native youth ages 10-17 years old are 2.7 times more likely to be hospitalized for unintentional alcohol poisoning than a non-Alaska Native peer.[9] While our opioid crisis has emerged relatively recently, our alarming alcohol-related prevalence rates have remained constant over a much longer period of time. The 2018-2022 Statewide Opioid Action Plan reports alarming statistics regarding opioids in Alaska. From 2010-2017 the opioid death rate increased 77% (from 7.7 per 100,000 to 13.6 in 2017). Furthermore, from 2012-2017, the rate of out-of-hospital naloxone administrations by Emergency Medical Service (EMS) personnel more than doubled from 8.0 to 17.7 administrations per 1,000 EMS calls in 2012 and 2017, respectively. Additionally, the rates of opioid-related inpatient

[3] National Survey on Drug Use and Health, 2016-2017, Center for Behavioral Health Statistics and Quality, SAMHSA.
[4] AK-IBIS Health Indicator Report of Alcohol Consumption - Binge Drinking - Adults *(18+),* Alaska Division of Public Health, Department of Health and Social Services (citing Alaska Behavioral Risk Factor Surveillance System, 2015).
[5] AK-IBIS Health Indicator Report of Alcohol-Induced Mortality Rate, Alaska Division of Public Health, Department of Health and Social Services (citing data from the Alaska Health Analytics and Vital Records, Alaska Division of Public Health and US Centers for Disease Control and Prevention).
[6] Health Impacts of Alcohol Misuse in Alaska (DHSS/DPH/Pachoe, 2018)
[7] AK-IBIS Health Indicator Report of Alcohol Consumption – Binge Drinking – Adults *(18+)*, Alaska Division of Public Health, Department of Health and Social Services (citing Alaska Behavioral Risk Factor Surveillance System 2015).
[8] AK-IBIS Health Indicator Report of Alcohol-Induced Mortality Rate, Alaska Division of Public Health, Department of Health and Social Services (citing data from the Alaska Health Analytics and Vital Records, Alaska Division of Public Health and Centers for Disease Control and Prevention).
[9] BRFSS-2015-AK IBIS-*Youth (10-17)—Alcohol Poisoning-Hospital*

hospitalizations were 28.5 per 100,000 in 2016 and 26.0 in 2017.

Notably, in addition to elevated rates for many behavioral health conditions, both substance misuse and mental health, Alaskans face special challenges related to geography, population, weather, and size, which make it difficult to effectively provide services. Access to services varies widely depending on clients' needs, their location, and their ability to pay. Many of Alaska's remote communities are medically underserved for both primary care and mental health services. Many of these communities are located hundreds of miles from a regional medical center, and individuals travel long distances for services. More specifically, Alaska is geographically the largest state in the United States. Its behavioral health system reaches across a vast area of 570,374 square miles, though its population (710,249) is well under one million persons, the population of a typical mid-sized city in the lower 48 states. In contrast to the high population density in many cities in the contiguous United States, the distance between small villages can range from as few as 15 miles to several hundred miles, while Alaska's largest city, Anchorage has an estimated population of roughly 291,538 (Census.gov, 2018), over approximately forty percent of the state's population. With the exception of the urban communities of Anchorage, Fairbanks, Sitka, and Juneau, all of Alaska's boroughs and census areas are considered "frontier" by the state Office of Rural Health. A rural hub with access to behavioral health professionals is often only accessible from remote villages by plane or boat, and transportation can be unreliable due to extreme weather conditions. Urban areas and rural towns have more access to mental health professionals, yet Alaska statewide is challenged with retention and recruitment of behavioral health professionals. The State of Alaska is roughly two and one half times the size of Texas and represents approximately 1/5 of the landmass of the lower 48, contiguous states, making it extremely challenging to effectively provide services.

In addition to its vast physical size, Alaska's population diversity must also be acknowledged. Alaska is home to 225 recognized Alaskan Native entities and 20 different native languages. There are 31 tribal health organizations in Alaska, many of whom receive grant funding from the Division of Behavioral Health. Alaska also has a growing immigrant population from all over the world, including Ukraine, Russia, Angola, Moldova, Cuba, El Salvador, Yemen, Thailand, Laos, Ethiopia, Kyrgyzstan, Liberia, Sudan, Gambia, Iran, Burma, China, Uzbekistan, Cambodia, and Vietnam. Together, Alaska's elevated rates of behavioral health conditions along with the realities of service provision given the vast and diverse geography and population, present unique challenges for improving care for mental health and substance misuse.

Thus the purpose of the Alaska Medicaid Section 1115 Substance Use Disorder and Behavioral Health Program (SUD-BHP) Demonstration is to create a data-driven, integrated behavioral health system of care for Alaskans with serious mental illness, severe emotional disturbance, and/or substance use disorders. The demonstration seeks to provide Alaskans with a comprehensive suite of cost-effective, high quality behavioral health services designed to ensure access to the right services at the right time in the right setting. Its goals are:

Goal 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 regional-based care

Objectives

- Decrease use of inpatient hospital and emergency department care episodes.
- Decrease use of residential out-of-home placements.

Goal 2: Intervene as early as possible in the lives of Alaskans to address behavioral health symptoms before symptoms cascade into functional impairments:

Objectives

- Provide universal screening to identify symptoms.
- Provide brief, solution-focused interventions to prevent acute care.

Goal 3: Improve the overall behavioral health system accountability by reforming the existing system of care

Objectives

- Contract with an Administrative Services Organization (ASO) to manage Alaska's existing system of behavioral health care.
- Improve the consistency of screening, assessment, and service/placement decisions through use of evidence-based and evidence-informed tools.

3. A brief description of the demonstration and the implementation plan

Current and Proposed New Benefits

Under the demonstration, Alaska will implement a series of proposed strategies and evidence-based interventions aimed at more effectively addressing the needs of each of the selected target populations. A major consideration in designing the waiver is to recognize the anticipated benefits, such as reduced use of acute, costly services, that should result by conducting universal screenings; intervening early, when symptoms are first identified; utilizing sub-acute, community-based step-up/step-down clinical services as alternatives to residential and inpatient services; and developing community-based supports to maintain recovery, health and wellness. Generally speaking, increasing efforts early on, regarding prevention and early intervention, as opposed to greater emphasis on acute, residential, crisis, emergency care, should lead not only to cost savings, but also to improved care for Alaskans. New Medicaid-covered services under the waiver will establish a robust continuum of care designed to anticipate and address the range of behavioral health needs of the target populations. The State of Alaska SUD-BHP Implementation was submitted to CMS in the 1115PMDA website and is in accepted status in the CMS 1115PMDA website as of 3/27/2019; note that per CMS guidance and discussion with the State of Alaska, Alaska does not have a separate behavioral health/mental health implementation plan, rather there is one approved SUD Implementation Plan. This agreement with CMS was decided upon in part due to the timing of the approval of Alaska's SUD Waiver first, prior to CMS approval of the behavioral health/mental health components in the Special Terms and Conditions (STCs, 9/3/2019). The State of Alaska Division of Behavioral Health will work in conjunction with its Administrative Services Organization (ASO), Optum, Inc. to ensure the 1115 Design is implemented as intended, and as per the Special Terms and Conditions (STCs) described by CMS, the state must begin to arrange with an independent party (the Independent Evaluator) (IE) to conduct an evaluation of the demonstration to ensure that the necessary data are collected at an appropriate level of detail sufficient to conduct the research to evaluate the approved hypotheses. Each contract/agreement has or will have language included to describe the process and policies with regard to data sharing and system communication to ensure programs can be appropriately implemented and evaluated. The ASO (and/or Health Care Services- HCS) will provide claims data and other data as required to the Independent Evaluator towards achievement of the deliverables of the evaluation design.

4. Description of the population groups impacted by the demonstration

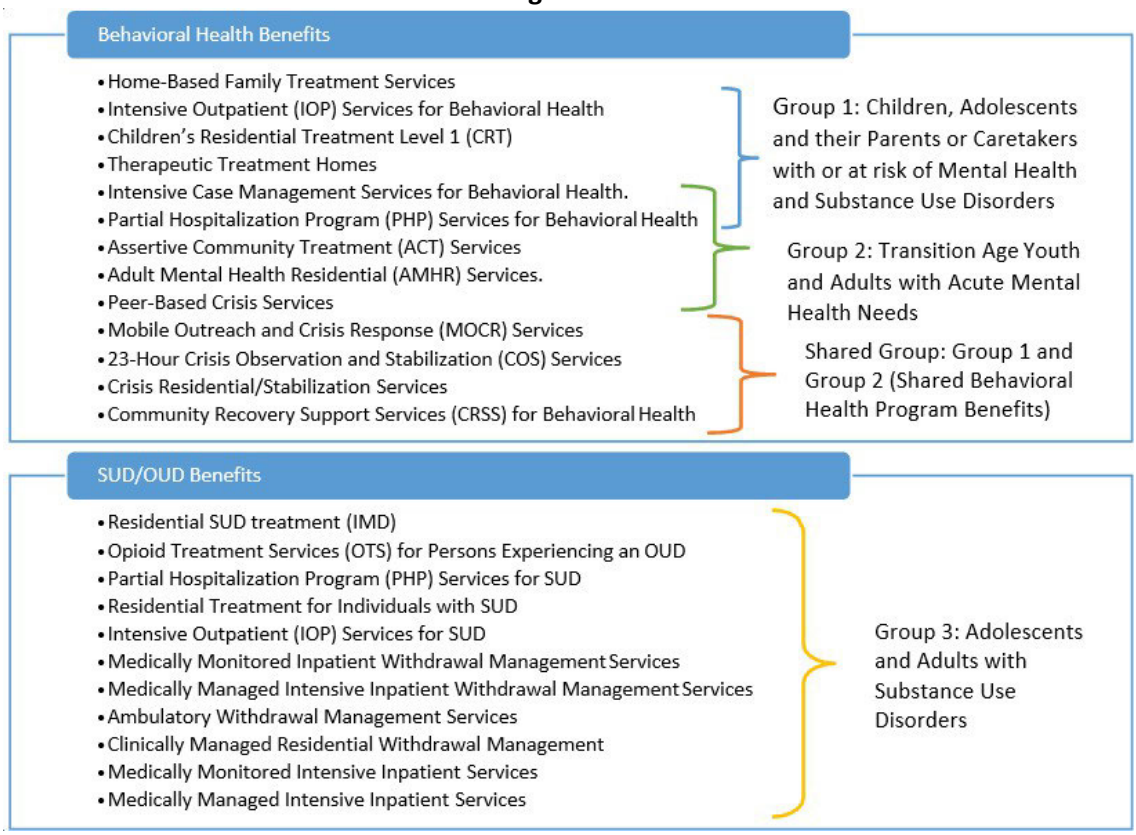
The Integrated Behavioral Health System will be implemented within 2 different initiatives under

1115 expenditure authority:

- Behavioral Health Benefits (STC 20)
- Substance Use Disorder/Opioid Use Disorder Program (STC 21)

Within these initiatives, three distinct groups (and one group that shares behavioral health benefits) are targeted (see Figure 1).

Figure 1:



This Waiver creates an enhanced set of benefits for three target populations (plus one group that shares behavioral health program benefits) of Medicaid recipients:

<u>Group 1: Children, Adolescents and their Parents or Caretakers with, or at risk of, Mental Health and Substance Use Disorders</u>

A significant proportion of Alaska's children and adolescents encounter the child welfare system or juvenile justice system at some point in their upbringing. This waiver provides an important vehicle for strengthening the support system for these young people in hopes of anticipating and preventing crises and reducing the need for out-of-home placements over time. Individuals in this target population are 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; and at risk of an out-of-home placement.

For Group 1, Behavioral Health Program benefits include home-based family treatment, intensive case management, partial hospitalization program (PHP) services, intensive outpatient services

(IOP), children's residential treatment level 1 (CRT), and therapeutic treatment homes.

Rationale: The state is targeting this population as an early intervention strategy, which represents a significant shift in the approach to delivering behavioral health services. Alaska's children are 56% more likely to be abused than the national average and 66% of Alaskan adults report one or more adverse childhood experience growing up. In calendar year 2016, one in 10 Alaska children were reported to child protection services (CPS) regarding child abuse or neglect. Twenty-five percent of births experienced a first screened-in report to the Office of Children's Services (OCS) before age seven and one in every 12 births experienced a first substantiated report to OCS before age seven. Alaska also has high rates of repeat child maltreatment as compared to the national average.[10] In addition:

Each month, an average of 130 children and youth reside in foster care or inpatient psychiatric treatment outside of Alaska. This is due to a combination of factors, including a shortage of available therapeutic foster care placements, a small but very challenging group of complex IDD children with significant behavioral and mental health issues that exceed the current service capacity of in-state providers, and an insufficient capacity of outpatient/step-up and step-down providers available to provide mental health care as an alternative to residential and/or inpatient treatment.

Alaska Native children are also over-represented in the state's juvenile justice system. While they comprise less than a quarter of the child and youth population in the state, they account for 33% of referrals made to the juvenile justice system.

With these high rates of Alaska Native children involved in the child welfare and juvenile justice systems, the state places emphasis on the importance of intervention services that are culturally appropriate and trauma-informed.

Group 2: Transitional Age Youth and Adults with Acute Mental Health Needs

This group is composed of transitional age youth and adults who experience mental health disorders with complex co-morbidities or dual diagnoses of intellectual, developmental, or sensory disabilities. This waiver seeks to enhance the availability of mental health treatment and prevention services to this group.

For Group 2, Behavioral Health Program benefits include assertive community treatment services, intensive case management, partial hospitalization program (PHP) services, adult mental health residential (AMHR), and peer-based crisis services.

Shared Behavioral Health Program Benefits (Shared Group 1 and Group 2)

Shared Behavioral Health Program benefits (Shared Group 1 and Group 2) include mobile outreach and crisis response services (MOCR), 23-hour crisis observation and stabilization (COS), crisis residential/stabilization services, and community recovery support services (CRSS).

Rationale: Mental health disorders are very prevalent among Alaska's residents. Data show that:

- Of the 42,123 Medicaid enrollees served in SFY 2016, 28,937 received treatment

[10] Alaska Department of Health and Social Services, Office of Children's Services from dhss.alaska.gov/ocs/Documents/statistics/webdata/mainOohYr.pdf.

for a mental health disorder;

- 20% of Alaskan adults experience a diagnosable mental health disorder each year;
- 21.4% of Alaskan adults report growing up in a household with one or more adults experiencing mental illness;
- 29.7% of Alaskan adults report growing up in a household with one or moreadults abusing alcohol and/or other drugs;
- 19.5% of all Alaskan adults – and 28.4% of Alaska Native adults – report four or more adverse childhood experience growing up;
- Alaska's suicide rate of 27.1/100,000 in 2015 was more than twice the national rate (12.32/100,000);
- 22% of the Alaska Corrections population in SFY 2012 experienced a mental health disorder;
- 18% of individuals with five or more hospitalizations between 2012 and 2015 had a behavioral health diagnosis – the most common disease category across all admissions;[11] and
- Analysis of 2016 Emergency Department Super-Utilizers reveal that the top 1.1% of ED users account for 8.6% of charges and two of the eight most common principal diagnoses among the top 1.1% include alcohol-related disorders and anxiety disorders.[12]

Despite the level of need, behavioral health services are difficult to access due to geography, long wait times, lack of workforce, and the high cost of service. With the exception of the urban communities of Anchorage, Fairbanks, Sitka, and Juneau, all of Alaska's boroughs and census areas are considered frontier by the state Office of Rural Health. Access to services varies widely depending on clients' needs, their location, and their ability to pay. Many of Alaska's remote communities are medically underserved for both primary care and mental health services. Many of these communities are located hundreds of miles from a regional medical center, and individuals travel long distances for services.

Limited access to behavioral health providers and services has led to a fragmented and crisis-driven system of care that frequently misses opportunities to engage adults with behavioral health needs that present in the health care, public safety, judicial, and correctional systems.

The result is a system that often pays for behavioral health services at the highest level and cost of care, and where individuals and families often go without needed treatment and recovery services.

Group 3: Adolescents and Adults with Substance Use Disorders

This waiver seeks to enhance the availability of and provide a more comprehensive continuum of substance use disorder treatment for 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 (DSM-5 or the most current version of the DSM) for substance-related and addictive disorders.

Note that SUD/OUD benefits coverage via 1115 expenditure authority include opioid treatment services for persons experiencing an Opioid Use Disorder (OUD), intensive outpatient services,

[11] The Menges Group. Assessment of Medicaid Reform Options. Report for the Alaska Legislative Budget and Audit Committee. March 24, 2016.
[12] Alaska Department of Health and Social Services, Division of Public Health,

partial hospitalization program (PHP), residential treatment, medically monitored intensive inpatient services, medically managed intensive inpatient services, ambulatory withdrawal management, clinically managed residential withdrawal management, medically monitored inpatient withdrawal management, and medically managed intensive inpatient withdrawal management. In addition, the state plan Medicaid authority offers early intervention services, outpatient services and medication-assisted treatment (MAT).

Rationale: Like many states, Alaska continues to experience increases in opioid use and abuse. According to the State of Alaska Epidemiology Section, the rate of heroin poisoning resulting in hospital admissions doubled between 2008 and 2012 and between 2008 and 2013, the number of heroin-associated deaths more than tripled in Alaska. In 2012, the rate of heroin-associated deaths in Alaska was 42% higher than that for the U.S. overall (2.7 per 100,000 vs. 1.9 per 100,000, respectively). Admissions to publicly funded SUD treatment for heroin dependence increased 58% between 2009 and 2013. The majority of those individuals seeking treatment were age 21-29.[13]

During 2009–2015, 774 drug overdose deaths were entered into the Alaska mortality database. Overall, 512 (66%) decedents had a prescription drug noted as the primary or a contributing cause of death. Of the 311 illicit drug overdose deaths that were recorded in the database, 128 (41%) noted heroin as either the primary or a contributing cause of death. Before receiving a SAMHSA Medication-Assisted Treatment (MAT) Capacity Expansion Grant, Alaska only had MAT capacity to serve 415 individuals, despite having upwards of 1,700 individuals with an Opioid Dependence or SUD diagnosis seeking treatment. Even with Alaska's 2017 SAMHSA MAT Capacity Expansion Grant, the total number of individuals to be served under the grant is only projected to increase by 250. While this is an important capacity development project, further resources are needed to address the 62% of known individuals without access to MAT.

The State considers SUD treatment to be a key component of behavioral health reform. In a 2017 Alaska Opioid Policy Task Force report, stakeholders noted primary prevention policies supporting 'upstream' efforts to improve the overall health and wellness of individuals across the life span that can help reduce the risk of opioid use, misuse, and abuse at the population level. Access to appropriate levels of treatment when a person seeks help, as close to home as possible, is critical to helping Alaskans move from opioid dependence to recovery.

In addition, Alaska's criminal justice reform efforts are expected to increase the demand for SUD treatment services as behavioral health clients are released and/or diverted from the corrections system to treatment. In SFY 2017, 832 citizens returning from Department of Corrections Correctional institutions were successfully enrolled in Medicaid.

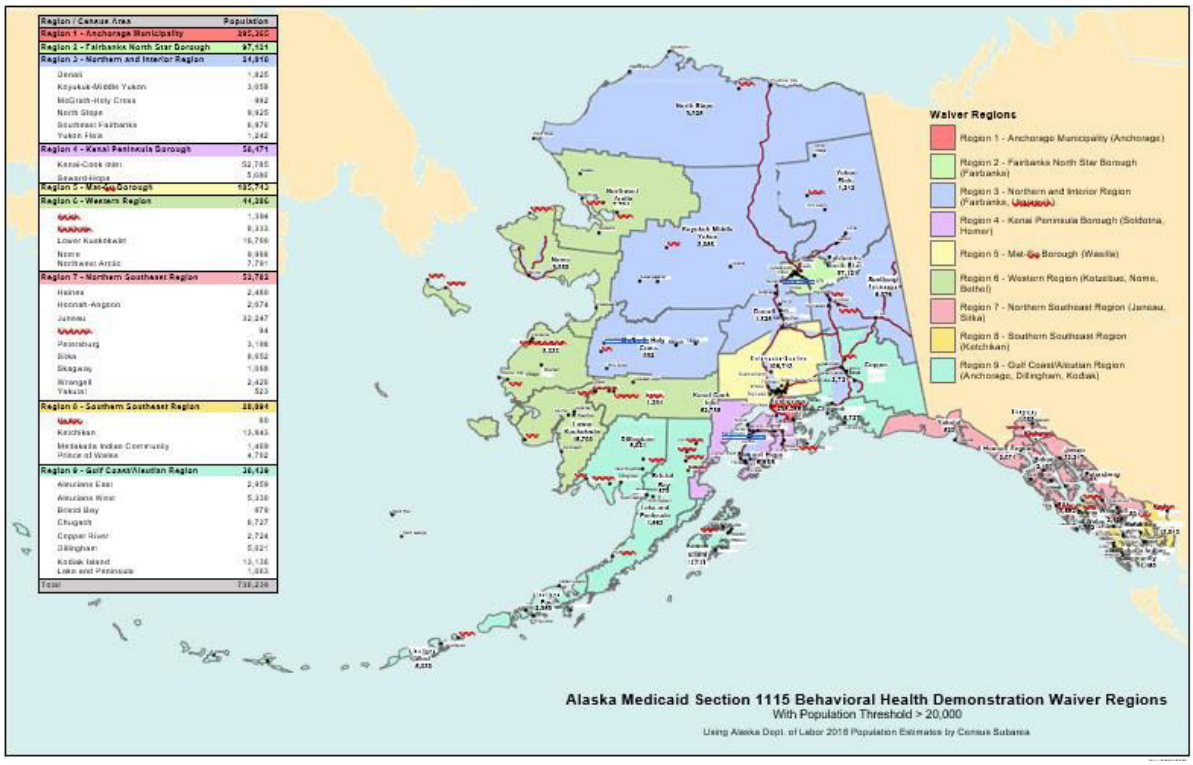
Finally, note that to best serve Alaska's population given the state's vast geography, the Waiver divides the state population into nine regions. Waiver services will be phased in over two years. During year one, region one, region two, region five, and region seven will phase in, along with any agencies in other regions who wish to start early. During year two, the other regions will be phased in. Additional information may be found in the State's CMS approved (3/27/2019) Waiver Implementation Plan.

[13] Alaska Opioid Policy Task Force recommendations, which cited: Health Impacts of Heroin Use in Alaska, State of Alaska Epidemiology Bulletin, July 14, 2015).

Regions are defined as follows:

Region 1 - Anchorage Municipality (Anchorage)
Region 2 - Fairbanks North Star Borough (Fairbanks)
Region 3 - Northern and Interior Region (Fairbanks and Utqiagvik)
Region 4 - Kenai Peninsula Borough (Soldotna and Homer)
Region 5 - MatSu Borough (Wasilla)
Region 6 - Western Region (Kotzebue, Nome, and Bethel)
Region 7 - Northern Southeast Region (Juneau and Sitka)
Region 8 - Southern Southeast Region (Ketchikan)
Region 9 - Gulf Coast/Aleutian Region (Anchorage, Dillingham, and Kodiak)

The following map visually depicts the nine Alaska Medicaid Section 1115 Behavioral Health Demonstration Waiver listed above.



B. Evaluation Questions and Hypotheses

1. Driver Diagram

Per the CMS guidance document 1115 Demonstration Evaluation Design Technical Assistance (3/6/2019), the State of Alaska Division of Behavioral Health has created a Driver Diagram for its 1115 Waiver. This diagram depicts the relationship between the demonstration's goal/purpose/aim, the primary drivers that contribute to realizing that purpose, and the secondary drivers that are necessary to achieve the primary drivers. There are many ways to depict a theory of change, though per CMS guidance, one particularly useful method of doing so is with a driver diagram model, which can represent an organization's current theories regarding change processes (*Defining and using aims and drivers for improvement: A how-to-guide*, CMS, 1/24/2013). As per CMS guidance, State of Alaska Division of Behavioral Health recognizes that there is no single

'correct' way of drawing a driver diagram; driver diagrams are "living" documents that can and should be modified over time as an organization learns what drivers and interventions are important for achieving desired results (*Defining and using aims and drivers for improvement: A how-to-guide*, CMS, 1/24/2013).

The following Driver Diagram was developed via consultation and extended discussions with subject matter experts, clinicians, and researchers at the Alaska Division of Behavioral Health as well as referral to other State of Alaska 1115 documents, including the State's original 1115 Behavioral Health Demonstration Application (1/31/2018), the STCs (Special Terms and Conditions, 9/3/2019), The State's Waiver Implementation Plan (3/27/2019), The State's Monitoring Protocol, and other relevant data, evidence, and information. The Driver Diagram utilizes the 6 CMS goals and is consistent with the three cross-cutting goals and objectives presented in Alaska's initial Waiver Application (1/31/2019):

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 model serves as an informative framework for the Alaska 1115 Evaluation Design and Waiver Demonstration, recognizing that interrelationships between the goals, primary drivers, and secondary drivers may at times be multidirectional. Furthermore, the desired aims may be achieved through an iterative process of change through which a cycle of feedback from interim reporting informs future plans and enhanced implementation as appropriate.

Driver Diagram for State of Alaska 1115 Demonstration Application

6 CMS Goals/Objectives/Aims	Primary Drivers (Major domains through which Alaska may accomplish the six goals, adapted from STCs)	Secondary Drivers (from Alaska's Implementation Plan, utilizing key milestones identified by CMS)
1. Increased rates of identification, initiation, and engagement in treatment for SU and BH issues by end of FY2024	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 American Society of Addiction Medicine (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 (18 and over) Medicaid recipients, particularly non- residential, step-up and step-down treatment options.	Milestone #1: Access to Critical Levels of Care for SUD Treatment Milestone #2: Use of Evidence-Based, SUD- Specific Patient Placement Criteria Milestone #5: Implementation of Comprehensive Treatment & Prevention Strategies to Address Opioids Milestone #6: Improved Care Coordination and Transitions Between Levels of Care

6 CMS Goals/Objectives/Aims	Primary Drivers (Major domains through which Alaska may accomplish the six goals, adapted from STCs)	Secondary Drivers (from Alaska's Implementation Plan, utilizing key milestones identified by CMS)
2. Increased adherence to and retention in SU and BH treatment by end of FY2024	1. Implement American Society of Addiction Medicine (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 (18 and over) Medicaid recipients, particularly non-residential, step-up and step- down treatment options.	Milestone #1: Access to Critical Levels of Care for SUD Treatment Milestone #2: Use of Evidence-Based, SUD- Specific Patient Placement Criteria Milestone #5: Implementation of Comprehensive Treatment & Prevention Strategies to Address Opioids Milestone #6: Improved Care Coordination and Transitions Between Levels of Care
3. Reduced overdose deaths, particularly those due to opioids by end of FY2024	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 American Society of Addiction Medicine (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 (18 and over) 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.	Milestone #1: Access to Critical Levels of Care for SUD Treatment Milestone #2: Use of Evidence-Based, SUD-Specific Patient Placement Criteria Milestone #3: Use of Nationally Recognized SUD-specific Program Standards for Residential Treatment Facility Provider Qualifications Milestone #4: Sufficient Provider Capacity at Critical Levels of Care Milestone #5: Implementation of Comprehensive Treatment & Prevention Strategies to Address Opioids Milestone #6: Improved Care Coordination and Transitions Between Levels of Care

6 CMS Goals/Objectives/Aims	Primary Drivers (Major domains through which Alaska may accomplish the six goals, adapted from STCs)	Secondary Drivers (from Alaska's Implementation Plan, utilizing key milestones identified by CMS)
4. Reduced utilization of emergency departments and inpatient hospital settings for SU and BH treatment where the utilization is preventable or medically inappropriate through improved access to other more appropriate and focused services by end of FY2024	1. Implement American Society of Addiction Medicine (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 (18 and over) 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).	Milestone #1: Access to Critical Levels of Care for SUD Treatment Milestone #2: Use of Evidence-Based, SUD- Specific Patient Placement Criteria Milestone #3: Use of Nationally Recognized SUD-specific Program Standards for Residential Treatment Facility Provider Qualifications Milestone #4: Sufficient Provider Capacity at Critical Levels of Care Milestone #5: Implementation of Comprehensive Treatment & Prevention Strategies to Address Opioids Milestone #6: Improved Care Coordination and Transitions Between Levels of Care
5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate by end of FY2024	1. Implement American Society of Addiction Medicine (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 (18 and over) 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).	Milestone #1: Access to Critical Levels of Care for SUD Treatment Milestone #2: Use of Evidence-Based, SUD- Specific Patient Placement Criteria Milestone #3: Use of Nationally Recognized SUD-specific Program Standards for Residential Treatment Facility Provider Qualifications Milestone #4: Sufficient Provider Capacity at Critical Levels of Care Milestone #5: Implementation of Comprehensive Treatment & Prevention Strategies to Address Opioids Milestone #6: Improved Care Coordination and Transitions Between Levels of Care

6 CMS Goals/Objectives/Aims	Primary Drivers (Major domains through which Alaska may accomplish the six goals, adapted from STCs)	Secondary Drivers (from Alaska's Implementation Plan, utilizing key milestones identified by CMS)
6. Improved access to care for physical health conditions among beneficiaries by end of FY2024	1. 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. 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.	Milestone #1: Access to Critical Levels of Care for SUD Treatment Milestone #2: Use of Evidence-Based, SUD- Specific Patient Placement Criteria Milestone #3: Use of Nationally Recognized SUD-specific Program Standards for Residential Treatment Facility Provider Qualifications Milestone #4: Sufficient Provider Capacity at Critical Levels of Care
← Causality	← Causality	

2. Questions and Hypotheses

Per the CMS guidance document *1115 Demonstration Evaluation Design Technical Assistance* (3/6/2019), the Driver Diagram that the State of Alaska Division of Behavioral Health created in the previous section of this Evaluation Design for its 1115 Waiver is intended as a framework for developing and refining evaluation questions and hypotheses. In this section, the demonstration's core evaluation questions, hypotheses, and recommended data sources and analytic approaches are presented.

Alaska's Evaluation Design includes both outcome measures and interim process measures. Per the CMS guidance document *1115 Demonstration Evaluation Design Technical Assistance* (3/6/2019), when possible, Medicaid specific metrics sets were given preference over other national sets and data, and SUD core monitoring metrics were leveraged in the evaluation as appropriate. To increase the robustness of the design, mixed methods were utilized, including both quantitative and qualitative approaches, as well as both internal pre-post comparisons and, as appropriate, comparisons between Waiver populations and state and national data.

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 behavioral 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.

Measure Description	Data Source	Analytic Approach	Comparison Group[1]	Primary Driver[2]
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?
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).
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).

Measure Description	Data Source	Analytic Approach	Comparison Group[1]	Primary Driver[2]
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.				
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: AUINXXX [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.

Measure Description	Data Source	Analytic Approach	Comparison Group[1]	Primary Driver[2]
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.
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 behavioral health disorders.				

Measure Description	Data Source	Analytic Approach	Comparison Group[1]	Primary Driver[2]
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.
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 behavioral 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.
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.

Measure Description	Data Source	Analytic Approach	Comparison Group[1]	Primary Driver[2]
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.
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				

Measure Description	Data Source	Analytic Approach	Comparison Group[1]	Primary Driver[2]
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
Evaluation Question: Does the demonstration reduce the cost of Medicaid for Alaska and the Federal Government?				
Evaluation Hypothesis: The demonstrations will reduce Alaska's per capita Medicaid behavioral health costs.				
Total costs of healthcare (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.

[1]Comparison 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.
[2]Primary drivers were selected as the most relevant driver for the measure. Multiple primary drivers may relate to the measure.
[3]This 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 please 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?
[4]This 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?

While State of Alaska Division of Behavioral Health believes that overall the above table of evaluation questions, hypotheses, and measures is sufficient, the state will also include additional evaluation measures as appropriate, and in response to stakeholder feedback on emergent issues, themes, and questions that develop during the course of the Waiver period. For instance, in addition to outcome measures, the state will be monitoring Waiver implementation over time as various interim interval points, which may allow for the reporting of process measures.

Furthermore, for a number of the measures in the table above, additional analyses by subpopulations and settings of interest may be warranted. For instance, as appropriate, such sub-populations of interest include children and youth, transitional youth, children existing in therapeutic foster care, children who are in state custody who received behavioral health services through residential child care/therapeutic foster care programs, individuals receiving service through Indian Health Services, individuals admitted to a hospital 90 days after MAT, etc. As an another example, settings of interest for additional sub-analyses may include hospitals, IMDs, residential psychiatric treatment centers, telehealth, Indian Health Services and community-based services also referred to as "other continuum of care services' (e.g., home-based family treatment, wrap-around services for children and family, school-based services, therapeutic foster care, etc.).

State of Alaska Division of Behavioral Health recognizes that program effectiveness and outcomes may vary developmentally in accordance with ample evidence collected by lifespan development researchers (e.g., Berk, 2018; Santrock, 2019). Thus, age graded analyses are appropriate as needed. Another consideration methodologically is the phase-in implementation approach to the Alaska 1115 Waiver services; in terms of its implications for evaluation, this approach affords an opportunity for additional potential comparison groups, as outcomes could be evaluated from the additional perspective of Alaska waiver regions that have implemented their waiver services vs. Alaska waiver regions that have yet to implement their waiver services.

C. Methodology

1. Evaluation Methodology

The Evaluation of Alaska's 1115 Waiver has several goals:

a) Describe progress made on implementation of specific waiver activities (e.g., those noted in Alaska's 1115 Waiver application and STCs)
b) Demonstrate changes and accomplishments regarding the Alaska 1115 Waiver's key milestones and domains (i.e., interim monitoring as required and needed during the Waiver period)
c) Demonstrate progress towards meeting the state and federal goals/objectives/aims of Alaska's 1115 Waiver
d) Evaluate Alaska 1115 Waiver questions and hypotheses with appropriate data, measures, and analyses
e) Design, collect, and analyze sufficient and appropriate data with sound methods for production of required reporting to CMS, such as the Mid-Point Assessment, the Interim Report, and the Summative Draft and Final Evaluation Reports.

Due to the target populations included in the Demonstration, a combination of evaluation design approaches is warranted. Though a true experimental design (Randomized Controlled Trial/RCT) is

considered the "gold standard approach to establishing causality" (Contreary, Bradley, & Chao, 2018), such a design is not feasible or ethical for evaluation of the 1115 Waiver (for example, ethically, one should not deny services to a substance use client by randomly assigning such persons to a control group that receives no therapeutic treatment). Instead, a mixed-methods approach with both quantitative and qualitative components and multiple data types and sources is the most robust and appropriate design to assess the effectiveness of Alaska's 1115 Waiver. Data sources include administrative data such as Medicaid claim and encounter data, electronic health record data (EHR) from AKAIMS (Alaska Automated Information Management System), State Psychiatric Hospital data, and HEDIS-style data. Additionally, data from national data sets such as the BRFSS, YRBSS and NSDUH (SAMHSA) will be utilized as appropriate for additional comparisons between Alaska data and national and other state data. Qualitative data will also be collected and analyzed, including document review and surveys/interviews conducted with beneficiaries, providers, administrators and other stakeholders, such as Tribal Entities/Interests.

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 methodology is selected based on data availability factors relating to: (1) data to measure the outcomes; (2) data for a valid comparison group; and (3) data during the time periods of interest—typically defined as the year prior to implementation and annually thereafter. The Sampling of Analytic Approaches table illustrates a sampling of standard analytic approaches 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.

Sampling of Analytic Approaches

Analytic Approach	Baseline Data	Comparison Group	Allows Causal Inference	Notes
Randomized Controlled Trial		✓	✓	Requires full randomization of intervention and comparison group.
Difference-in-Differences	✓	✓	✓	Trends in outcomes should be similar between comparison and intervention groups at baseline.
Panel Data Analysis	✓		✓	Requires sufficient data points both prior to and after implementation.
Regression Discontinuity		✓	✓	Program eligibility must be determined by a threshold
Interrupted Time Series	✓		✓	Requires sufficient data points prior to and after implementation.
Pre-test/post-test	✓			
Cross-Sectional Analysis		✓		

For most core analyses, a pre-post design will be utilized, using the pre-demonstration period as a baseline when possible, and then using the first year as a baseline for those cases where no

equivalent pre-demonstration data are available due to the nature of the specific target population or other practicalities. In addition to analysis of baseline and endpoint data, interim assessments and evaluations of progress may be conducted at multiple observation points between these two start and end positions. The timing of the data collection periods will vary depending on the data source, the reporting requirements and needs, and information that emerges during the course of the evaluation, such as continuous quality control needs and queries from stakeholders, including from other agencies, divisions, and/or the ASO (Administrative Services Organization).

2. Target and Comparison Populations

The target population for the Evaluation Design is the population served by the Alaska 1115 Waiver for Substance Use Disorder- Behavioral Health Program (SUD-BHP). In particular, the waiver (and thus the evaluation of the waiver) focuses on three groups. Group 1 are Children, Adolescents and their Parents or Caretakers with, or at risk of, Mental Health and Substance Use Disorders. Individuals in this target population include, but are not limited to, those who are 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; and at risk of an out-of-home placement. Group 2 are Transitional Age Youth and Adults with Acute Mental Health Needs. As appropriate, since the Waiver covers some behavioral health program benefits shared by both Group 1 and Group 2, for such analyses, data for these groups may be combined for analysis. Finally, Group 3 are Adolescents and Adults with Substance Use Disorders. These Group 3 individuals are 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 (DSM-5 or the most current version of the DSM) for substance-related and addictive disorders.

As noted by Reschovsky and Bradley (2019) "selecting a valid comparison group is arguably the most critical aspect of planning a quasi-experimental evaluation design" (p. 4). Comparison population groups in the Alaska 1115 Waiver Evaluation Design will vary as appropriate and in keeping with best practices for such evaluation designs. For some analyses the target population will serve as its own comparison group, as in pre-post design analyses, and variations on pre-post analyses that utilize multiple observation points. For other analyses, additional comparison groups will be identified as needed. For example, to increase the robustness of the evaluation design, and to permit analyses when within state comparison groups are not available or feasible, comparisons with national data and data from other states will be utilized.

Among considerations when choosing non-Alaska comparison groups, will be 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 shares sufficient similarities to Alaska, in terms of population size and demographics, rurality, geography, size of Native population, economic and political climate, etc. Additionally, since the Alaska 1115 Waiver (SUD-BHP) utilizes a phased implementation, other opportunities for analysis and comparison are presented with within state data between regions and services that are phased in and those that not yet phased in. As noted in the 3/6/2019 1115 ED Technical Assistance document, "if the implementation is phased in, late implementation groups can be used as comparison groups for early implementation groups" (SUD Section 1115 Demonstration Evaluation Design Technical Assistance, 3/6/2019, p. 13). Together, this broad range of comparative population possibilities provides ample opportunity and sufficient sample sizes for in-depth analysis of the effectiveness of the Alaska 1115 Waiver from multiple

perspectives and approaches.

The following outlines the selection of approaches that will be considered for identifying comparison groups and subsequent analytic methodologies in general order of preference.

1. Utilizing data from other states provided through the national Transformed Medicaid Statistical Information System (T-MSIS) data repository.
2. Out-of-state comparison group, resulting from aggregated data sharing agreement with other states.
3. Beneficiaries in-state residing in regions that have yet to roll-out services.
4. Utilize national survey data to triangulate in-state findings with out-of-state findings.
5. Comparison to pre-demonstration outcomes and/or to national benchmarks where appropriate.

Under all approaches, Year 1 of the demonstration would be treated as a ramp-up period due to the staged roll out.

To best isolate the effects of the demonstration, HSAG will first seek to leverage beneficiary-level data from the Transformed Medicaid Statistical Information System (T-MSIS) maintained and collected by the Centers for Medicare & Medicaid Services (CMS). It is expected that T-MSIS will provide microdata containing information on eligibility, enrollment, demographics, and claims/encounters, which will support individual-level matching to Alaska beneficiaries. However, these data are not yet available, and HSAG is prepared to rely on alternative data sources for the comparison group. If these data become available in time for the summative evaluation report, HSAG will examine the completeness and viability of using these data in the analyses. With robust beneficiary-level data covering the baseline period and multiple years during the demonstration period (if not the entire demonstration period), more robust methods can be employed to estimate the effect of the demonstration on outcomes. Measures that utilize administrative claims/encounter data or enrollment and eligibility data may use methods such as propensity score matching, reweighting, or stratification to construct a valid out-of-state comparison group.

The second strategy utilizes an out-of-state comparison group to serve as the counterfactual for Alaska beneficiaries. The comparison group would be constructed from one or more states as similar to Alaska as possible and does not have a similar SUD 1115 waiver program. Similarity to Alaska will be identified in terms of overall demographics and Medicaid programs and policies. In addition to sharing demographic factors and similar Medicaid policies, comparison state(s) should not have a major change in Medicaid policies during either the baseline or evaluation period. Selection of states will be conducted on a measure-by-measure basis depending on the available data and state willingness to share data. In HSAG's experience, aggregate data sharing agreements are more likely to be concluded than de-identified claim- or individual-level data. In the event that data sharing agreements cannot be concluded with other states or that T-MSIS data is unavailable for the evaluation additional strategies would be employed.

Under the third approach, while comparing the target population to in-state beneficiaries through the staged roll out is a potentially strong design, there are three key limitations to this approach. First, only one year of the demonstration period will be able to leverage this approach, as all regions will have implemented the demonstration activities by the end of Year 2. Second, there are likely to be substantial differences between the various regional populations as the phased roll out is done by region. Specifically, rural/frontier regions would end up serving as the comparison group for more urban municipalities. To mitigate this issue, propensity score matching, or reweighting can be used to construct a valid comparison group based on any existing similarities. For example, individuals living principally in larger cities and towns in regions that have yet to

implement certain phases (e.g., Fairbanks) may be given a higher weight or used exclusively through a match on urbanicity. Finally, not all measures would be impacted uniformly by the phased-in approach, since, according to the SUD implementation plan, some services will be implemented only in one year or only for a certain subset of regions To mitigate this issue, some measures will not benefit from this strategy, and others would be caveated that partial effects are expected. The revised Measure Table includes an option for an in-state comparison group for measures where appropriate.

The fourth comparison strategy involves triangulating results from claims-based measures and beneficiary survey responses to national survey metrics to provide a broader context within which results may be more effectively interpreted. For example, measures of emergency department visits for SUD/OUD using claims data may be compared to rates from the National Survey on Drug Use and Health (variable TXYRERDRG, or NMERTMT2). This would provide a sense as to how rates for Alaska tracked against similar measures nationally over time. Where possible, statistical controls will be employed to account for observable differences between Alaska beneficiaries and beneficiaries nationally. Such controls would include age, gender, and race/ethnicity. The population, where feasible, will be limited to respondents on Medicaid (NSDUH variable CAIDCHIP) with past drug/alcohol use (variable DPPYILLALC).

The final strategy compares changes in rates after implementation of the demonstration to national benchmarks. Similar to national survey data, this will provide a sense as to how rates for Alaska tracked against the same measures nationally. With multiple data points both before and after implementation of the SUD waiver, comparisons can be made in a difference-in-differences framework. HSAG will utilize the most granular data available, such as at the health plan level. The level of granularity will determine the extent to which statistical testing can be performed. Where possible, health plans from states as similar to Alaska as possible will be selected for comparison.

3. Evaluation Period

The 1115 Waiver period covers FY2019 through FY2024. Annual Monitoring Reports are due to CMS on 03/31/2020, 04/01/2021, 04/01/2022, 04/03/2023, and 03/31/2024. The Behavioral Health Demonstration- Draft Interim Report is due 12/30/2022. The SUD Draft Summative Evaluation Report is due 6/30/2025. Data to be used for the evaluation will span the entire Demonstration period from FY2019 through FY2024. As methodologically appropriate and needed, for target population groups where comparable pre-demonstration data are available, retrospective data from prior to the start of the 1115 Waiver period will be used for comparative purposes. Similarly, where comparable target- population specific data from other states may be available and methodologically appropriate, data from the Alaska 1115 Demonstration Waiver period, and as needed, from prior to the onset of the Waiver period, will be analyzed.

4. Data Sources and Collection Plan

Aligned with best practices in research methods, this evaluation will include multiple sources and forms of both qualitative and quantitative research methods and data to effectively and comprehensively evaluate Alaska's 1115 Demonstration hypotheses. Utilizing both types of data, and a range of relevant data sources, will permit a more carefully considered assessment of the impact of Alaska's waiver than reliance on any one type of method or data source alone (Bernard, Wutich, & Ryan, 2012). As Reschovsky, Heeringa, and Colby (2018) astutely note "quantitative evaluation results should be triangulated with results from qualitative analyses, which can validate

and add depth to the interpretation of quantitative impact evaluation results" (p. 19). Thus, among the data sources that will be included in the Alaska Evaluation Design are: administrative data (e.g., Medicaid claims), survey data (including use of national, state, and regional level data sets for comparative purposes), interview data (including semi-structured interviews with providers and beneficiaries designed specifically for this Waiver evaluation), and documentation and data from providers (e.g., quarterly reports and data from AKAIMS, Alaska's Automated Information Management System).

The section below offers detailed descriptions of the various data sources proposed for this 1115 Evaluation Design.

Administrative Data

State of Alaska's 1115 Waiver Evaluation Design will utilize several sources of administrative data to best assess the impact of its Waiver Demonstration on relevant processes and outcomes and to address the stated hypotheses. The major sources of Administrative Data for the Waiver are Medicaid claim and encounter data, electronic health record (EHR) data from AKAIMS (Alaska Automated Information Management System), state psychiatric hospital data, and HEDIS-style data.

Medicaid Management Information System

The Medicaid Management Information System (MMIS) is the repository for all State-based Medicaid claims and encounter data, per CMS standards. Among the information contained therein are service utilization data, types of care provided, payments per service, health care visits, diagnoses, procedures, service setting, service dates, etc. Additionally, MMIS includes information regarding client demographics, such as age, race/ethnicity, eligibility/enrollment and geographic location. Data on provider characteristics such as type, specialty, and geographic location (which will permit identifying location relative to the nine Alaska 1115 Waiver regions), will aid in the Alaska 1115 Evaluation Design. Among the types of measures that can be evaluated utilizing this data source are:

a) Utilization per 1000 beneficiaries in the waiver population of subacute professional services and community settings such as community behavioral health clinics for behavioral health diagnoses
b) Number of unique beneficiaries in the waiver population with SUD or BH diagnosis, by setting
c) Total cost of telehealth claims for beneficiaries in the waiver population with SUD or BH diagnosis
d) Utilization per 1000 beneficiaries in the waiver population of inpatient and institutional settings (including residential psychiatric treatment centers, hospital settings and Institutes for mental disease) for substance use diagnoses
e) Number of individuals in the beneficiaries in the waiver population who are hospitalized for a substance use disorder within 90 days of receiving MAT services
f) Number of children in state custody and receiving behavioral health services through residential child care/therapeutic foster care programs
g) Screening for chronic conditions such as diabetes within the waiver population
h) Total costs of healthcare (behavioral health and non-behavioral health) on a per recipient basis (Waiver vs. non-waiver population)

Data Limitations

While the use of Medicaid claims data has strengths that are desirable to include in the evaluation design, they each have weaknesses as well which are important to understand within the context of the evaluation. For example, the claims/encounter data used to calculate performance metrics are generated as part of the billing process for Medicaid and, as a result, may not be as complete or sensitive for identifying specific healthcare processes and outcomes as may be expected from a thorough review of a patient's medical chart. This weakness may be mitigated in part if the lack of sensitivity in the claims/encounter data remains relatively stable over time and if the measures calculated from these data follow trends consistent with the underlying processes and outcomes of interest. A complete description of the limitations associated with Medicaid claims data is provided in Section D: Methodological Limitations.

HSAG has substantial experience in cleaning, validating, and transforming data suitable for analysis, including using claims data for cost analyses. The exact data validation processes will vary across the specific data sources to be used for the evaluation, depending on the nature of the data being evaluated. Data are generally assessed through:

- **Completeness**: The completeness of data is assessed through the degree to which required fields or measures are fully populated with data. Data that are reported as Not Available or Not Reportable may be considered complete depending on the specific nature of the data fields.
- **Validity**: The validity of data sets is assessed through the degree to which data are clinically and mathematically within required constraints. Data fields will be verified to ensure they are within an appropriate and credible range through a comparison of values to valid value tables as well as national and regional averages as appropriate to the data field.
- **Reliability**: The reliability of the data is assessed through the degree to which equivalent fields in different data sets contain the same information. This will involve performing cross-field checks, ensuring that data fields and data sets contain similar values where appropriate.
- **Comprehensiveness**: The comprehensiveness of data sets is assessed through the degree to which required fields or measures are present in the data. When required measures or data are not present, additional data may be requested.

Alaska Automated Information Management System

The goal of the Alaska Automated Information Management System (AKAIMS) project is to develop, implement, and maintain an evolving, web-based application and database that serve the dual purpose of a management information system (MIS) and an electronic medical record (EMR) . As an MIS reporting tool, the system allows the State of Alaska Division of Behavioral Health to meet current and emerging state and federal reporting requirements, such as state quarterly reporting, Treatment Episode Data Set (TEDS), Government Performance and Results Act (GPRA), both of SAMHSA's Block Grants (Mental Health- MHBG and Substance Abuse- SABG) and the National Outcome Measurements (NOMs). Data collected include data on client diagnoses and clinical conditions/issues, demographics, agency provider and location, types of services (such as special programs or evidence-based practices) provided, and more. AKAIMS will permit the State of Alaska to assess several of the indicators it has proposed as part of its 1115 Waiver Evaluation Design plan. The AKAIMS system is flexible and open- ended by design so that new data fields representing new information of relevance can be added to the system via programming by State of Alaska AKAIMS data team and its subcontractors as needed. Among the types of data relevant to the 1115 Waiver that may be assessed via AKAIMS data include information on:

a) Number of beneficiaries in the community behavioral health clinic population beneficiaries with a positive employment status
b) Number of beneficiaries in the community behavioral health clinic population beneficiaries with a positive housing status
c) Number of beneficiaries in the community behavioral health clinic population beneficiaries with a positive drug use status

National Survey Data

To best evaluate Alaska's 1115 Waiver, national survey data will also be utilized as part of the Evaluation Design. As Daly, Kazi, and Bradley (2019) note "Surveys are the recommended data source for many research questions in CMS's policy-specific evaluation design guidance" (p. 21). Additionally, Reschovsky, Heeringa, & Colby (2019) note the potential value of utilizing national data sets in conjunction with state level subsets from national surveys as part of 1115 Evaluation Designs. The national data sets Alaska anticipates utilizing to conduct state-level analyses include the BRFSS, YRBSS, and NSDUH surveys. Additionally, the Alaska CUBS survey will be leveraged for further data support. Combined with data and evidence from other sources, utilizing these national and state survey sources will help ensure Alaska's 1115 Waiver Evaluation Plan is both cost-effective and robust.

Behavioral Risk Factor Surveillance System

The Behavioral Risk Factor Surveillance System (BRFSS) developed by the CDC (Centers for Disease Control and Prevention) is a health-focused telephone survey that collects state and national data about U.S. residents concerning their health-related risk behaviors, chronic health conditions, and use of preventive services. The BRFSS now collects data in all fifty states, the District of Columbia and three U.S. Territories, permitting comparison across time and between states. Overall, BRFSS completes over 400,000 surveys annually, with approximately a one to two-year lag. CDC supports BRFSS in Alaska, and the potential to add specialty modules, or questions, or to create new Alaska specific questions is provided annually, should the State wish to implement additional data or questions. Categories of BRFSS questions relate to various chronic diseases, including physical conditions (such as diabetes, arthritis, cardiovascular disease, and cancer) and mental health. The Alaska BRFSS also asks questions regarding a range of risk factors, from adverse childhood experiences, alcohol, tobacco, and substance use to issues regarding suicidal ideation, exercise and overweight/obesity and preventive health care. BRFSS data from prior to the implementation of the 1115 Waiver can serve as baseline data to which to compare BRFSS data annually after 1115 Waiver implementation. Additionally, Alaska will find it helpful to compare Alaska BRFSS data with national BRFSS survey data and with BRFSS survey data from select comparison states to offer an additional method by which to assess state progress and potential Waiver impact. BRFSS data currently inform a range of projects at State of Alaska, including SAMHSA grant reporting.

Youth Risk Behavior Factor Surveillance System

The Youth Risk Behavior Factor Surveillance System (YRBSS) developed by the CDC (Centers for Disease Control and Prevention) is a state and national school-based survey developed in 1990 to monitor health behaviors that contribute markedly to the leading causes of death, disability, and social problems among youth and adults in the United States. YRBSS includes a national school-based survey conducted by CDC and state, territorial, tribal, and local surveys conducted by state,

territorial, and local education and health agencies and tribal governments. Every two years, the YRBSS surveys representative samples of 9th through 12th grade students; and from 1991 through 2017, YRBSS has collected data from over 4.4 million high school students. According to the CDC, the Youth Risk Behavior Surveillance System (YRBSS) monitors six categories of health-related behaviors that contribute to the leading causes of death and disability among youth and adults. These behaviors, often established during childhood and early adolescence, include: behaviors that contribute to unintentional injuries and violence; sexual behaviors related to unintended pregnancy and sexually transmitted diseases, including HIV infection; alcohol and other drug use; tobacco use; unhealthy dietary behaviors; and inadequate physical activity. YRBSS also measures the prevalence of obesity and asthma and other health-related behaviors. The YRBSS is typically conducted once every two years (Spring semester of odd-numbered years) and results are released the following year in the Summer. CDC supports YRBSS in Alaska, and the potential to add specialty modules, or questions, or to create new Alaska specific questions is provided every two years, should the State wish to implement additional data or questions. YRBSS data from prior to the implementation of the 1115 Waiver can serve as baseline data to which to compare YRBSS data after 1115 Waiver implementation. Additionally, Alaska will find it helpful to compare Alaska YRBSS data with national YRBSS survey data and with BRFSS survey data from select comparison states to offer an additional method by which to assess state progress and potential Waiver impact. YRBSS data currently inform a range of projects at State of Alaska, including SAMHSA grant reporting, such as indicators for its Block Grant.

National Survey of Drug Use and Health

The National Survey of Drug Use and Health (NSDUH) is a SAMHSA (Substance Abuse and Mental Health Administration) sponsored comprehensive household survey of substance use, substance use disorders, mental health and the receipt of treatment services for those disorders. NSDUH data are collected via face to face interviews and include the civilian, noninstitutionalized population aged 12 and over (including household, university dormitories, sheltered homeless, civilians on military bases but excluding active military, prison populations, unsheltered homeless, and long-term hospital residents). All 50 states and the District of Columbia are surveyed, with over 67,000 interviewed annually. Questions focus on substance use and mental health issues and can help guide policy decisions with evidence-based information regarding problem substances, mental illness prevalence, co-occurring mental health and substance misuse conditions. NSDUH public use data are reported annually, with periodic release of state level data, as well as regional within-a-state level data released as restricted use data files. Restricted data files are released after approximately a two-year lag. Utilizing state-level and regional- level NSDUH data can allow Alaska to better assess the state status and progress in terms of a range of mental health and substance use issues, and can permit comparisons both in time (longitudinal and pre- post data) and in place (such as comparisons between Alaska data and national or selected state data). Selecting a comparison group or state for analysis is an involved, multi-faceted process, including considerations of state demographics (e.g., age distribution, race/ethnicity), overall population size and geography (e.g. rural vs. urban), economic conditions, etc. (e.g., Reschovsky, Heeringa, & Colby, 2019), and a range of comparisons must be made sensibly, each with advantages and disadvantages depending upon the comparison group(s) selected. However, since the NSDUH data are freely accessible, utilizing these data sets is a cost-effective and appropriate method by which to supplement the State's Evaluation Design and several comparison groups can be assessed as needed. NSDUH data currently inform a range of projects at State of Alaska, including SAMHSA grant reporting, such as indicators and information for its Block Grant and specialty grants.

Alaska Childhood Understanding Behaviors Survey (CUBS)

Alaska CUBS is a program designed to find out more about the health and early childhood experiences of young children in Alaska. CUBS collects information by conducting a follow-up survey to the Alaska version of the CDC-developed Alaska Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS sends a survey to approximately one of every six mothers of newborns in Alaska, and CUBS is an Alaska specific program through the Division of Public Health that sends a follow-up survey three years later to all mothers who completed PRAMS and are still living in Alaska. CUBS asks questions about both the mother and her child. The CUBS program began sending out surveys in 2006, and the annual sample size is approximately n=600. There is a question on the survey asking whether or not the participant receives Medicaid or not, which will permit useful comparison data for purposes of evaluating the CMS Alaska 1115 Medicaid Waiver. CUBS program is federally funded by the Title V, MCH Block Grant. CUBS collects information related to toddler behavior, health, health care access, parenting, and school readiness. By using the methodology of re-interviewing mothers who completed a PRAMS survey, CUBS is able to evaluate those factors present at birth or early life that increase risk for later adverse childhood outcomes. The goal of CUBS is to provide data related to the health and well-being of Alaskan toddlers. These data are provided to public health, health-care and education professionals across Alaska to assist them in improving child health. Child-focused topics on CUBS include: current height and weight; nutrition and eating habits; general and specialized health care utilization and access, including dental care; child care and barriers to use of child care; parenting behaviors; immunizations; safety; and development and behaviors.

Other Data Sources

In addition to the BRFSS, YRBSS, NSDUH, and CUBS surveys, Alaska also plans to utilize additional administrative and archival data as needed and appropriate. Examples of other data sources include:

- State of Alaska Division of Public Health, Epidemiology Alaska Violent Death Reporting System (AKVDRS), which tracks violent deaths from multiple sources, including toxicology,
- State of Alaska Division of Public Health, Health Analytics and Vital Records (HAVR), which reports demographics and causes of death for all reported deaths in Alaska, including injury deaths
- Alaska Prescription Drug Monitoring Program (PDMP), which tracks prescribing trends (individual and statewide), including information on each prescription dispensed for a federally scheduled Ii-IV controlled substance
- Alaska's Opioid Data Dashboard, which reports monthly and annual trends in relevant opioid indicators for Alaska from a range of agencies and divisions, including data from Public Health, Behavioral Health, criminal justice, and OSMAP (Office of Substance Misuse and Prevention)
- Department of Commerce, Community and Economic Development, Occupational Licensing Section Database, which will assist Alaska in evaluating trends and anticipated growth regarding workforce development in relevant health-related professions
- Alaska Epidemiological Profile ("Consumption and Consequence"), which is produced each year by the State Epidemiology Workgroup (SEW) and reports on a veritable plethora of data regarding Alaska's behavioral health, including substance use and mental health (Hull-Jilly & Rich, 2019)

Stakeholder Surveys and Interviews

Typically survey and interview data are utilized to gather information that is not possible to be obtained via administrative data (such as Medicaid claims) or observational data (such as fieldwork in naturalistic settings). Thus surveys and interviews are especially valuable in assessing stakeholders' cognitions, perceptions, attitudes, emotions, and satisfaction regarding select topics and issues. Additionally, the nature of surveys and interviews permits semi-structured and open-ended assessment that can reveal stakeholders' views and perceptions more fully, and in more nuanced ways, than forced- choice closed ended questions or administrative data (e.g., Bernard, 2016; Creswell & Creswell, 2018; Rich, 2016).

Three groups of stakeholders will be surveyed or interviewed: 1) Medicaid beneficiaries, 2) Division of Behavioral Health subrecipient providers, and 3) State of Alaska Department and Health and Social Services and Division of Behavioral Health administrators, managers, and employees involved with 1115 Waiver implementation, including individuals representing the ASO (Administrative Services Organization).

Beneficiary Surveys

First, beneficiaries will be surveyed regarding their improvements in care coordination and integration, experiences with ease of access to health care, care quality, health improvements. Interviews will be conducted with a sample of beneficiaries from each of the nine Alaska Waiver regions. Utilizing questions from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)14 as a baseline and supplemented by several additional questions tailored to this 1115 Waiver, beneficiary surveys will assess client satisfaction, access to care, and health. Supplemental questions will be drawn from existing surveys such as the State of Alaska Division of Behavioral Health Consumer Survey, which is Alaska's version of SAMHSA's Mental Health Statistics Improvement Program (MHSIP) survey. Utilizing several of these pre-existing survey questions will permit further ability to examine trends and Waiver impact in a manner that will permit more reliable and valid comparisons and assessments than if entirely new questions were developed. Additionally, State of Alaska proposes to utilize data from Member Satisfaction Surveys provided by DBH's ASO (Administrative Service Organization) regarding quarterly and annual performance targets on client satisfaction with services to further assess beneficiary experiences.

Two rounds of surveys will be conducted during the course of the demonstration. The first will be fielded in Q1 of 2021 and the second will occur in the first half of 2023. Up to 2,000 surveys will be sent each to the child and adult populations in each round. Stratified random sampling will be conducted by region, urbanicity, and other relevant characteristics to construct a statistically valid sample that will allow for valid analyses at a number of demographic and geographic levels, to identify how the impacts of the program may vary across the State. Since stratified random sampling creates stratifications disproportionate to the overall statewide beneficiary demographics, rates will be weighted to adjust for proportionality when calculating aggregate rates. Completed surveys will be evaluated to identify the extent of any response bias across measurable provider demographic characteristics. Weighting will also be used to correct for any identified nonresponse bias. HSAG will work with DBH to streamline survey administration to minimize the number of surveys required, thereby minimizing the burden on beneficiaries and providers as well as maximizing response rates. To maximize response rates, HSAG may employ a

[14] CAHPS is a registered trademark of the Agency for Healthcare Research and Quality.

mixed-mode methodology (e.g., telephone and mail) for survey data collection. The addition of email reminders, when data are available, or pre-notification letters to beneficiaries, has been shown to increase response rates and will be incorporated into survey administration. Mode of administration of survey or interview assessment (such as in-person vs. phone vs. mail) is an important consideration methodologically, with implications for costs, data integrity, response rates, response bias, and attrition (Sudman, Bradburn, & Wasnick, 2004; Tourangeau, Rips, & Rasinski, 2000).

Sample survey items/interview questions/issues may include the following topics:

1. How/Whether the beneficiary rates the quality of their health care as very good or excellent
2. How/Whether the beneficiary rates overall mental or emotional health as very good or excellent
3. How/Whether the beneficiary rates their behavioral health as very good or excellent in each year of the waiver period
4. How/Whether/to what degree the beneficiary demonstrates knowledge of available treatment and services
5. (For children in such settings): How/Whether the child rates their progress as very good or excellent upon exiting therapeutic foster care settings

Provider Focus Groups

Second, provider interviews will be conducted with approximately 30 providers distributed across Alaska's nine 1115 regions, and will focus on documenting providers' experience with care coordination and integration as well as quality of service provision during the Alaska 1115 demonstration. Additionally, provider questions will assess perceptions of the impact of Health Information Technology (HIT) in providing patient care and management. Sample interview questions may include the following topics:

1. Tell me about your experience with some of the new programs and services? How have the new programs and services expanded treatment capacity? How have they improved access to care? How has care quality changed?
2. Are you/your agency using wrap-around services? Evidence-based practices? Home-based care? Describe your experiences.
3. What have been some of the successes regarding these new programs or services? What have been some of the challenges?
4. What have been some of the barriers regarding information sharing between providers?
5. Tell me about your experience with how changes and reforms in the delivery system have impacted your/your agency's efforts?
6. Describe how your system has changed with respect to integration of care?
7. Describe your experience with the changes regarding costs, payment and accountability reforms?
8. What types of assistance/support would be helpful to you as you continue to move forward with your integration efforts?
9. Is there anything else you'd like to mention?

Provider interviews will be conducted either face-to-face or via telephone and will last approximately 45 to 60 minutes. Interviews will be recorded after provider permission, and pseudonyms will be utilized to ensure participant confidentiality. Recordings will be transcribed verbatim. Interviews will be conducted by the independent evaluator and the state will not have access to the recordings, which will be destroyed after transcription.

Key Informant Interviews

Third, in addition to beneficiary and provider interviews, interviews with administration and other stakeholders will also be conducted to best offer a holistic overview of the impact of the 1115 Waiver from a range of perspectives. Semi-structured interviews will be conducted with two DBH program managers per Alaska 1115 region, along with interviews from those representing the State's administration/managerial team, two representing the fiscal implementation, two representing the data/research implementation, and two representing the program/clinical implementation.

The interview will include such questions/topics as:

1. Thus far, what were the successes regarding the 1115 Demonstration Waiver implementation from your perspective? What were the challenges? (For fiscal managers only, also ask this question specifically regarding experiences with cost, provider payment and accountability reform)
2. What are the major changes you see in Alaska's capacity to serve SU and MH populations since the implementation of the 1115 waiver?
3. How have the 1115 Waiver programs impacted care integration, access to services, and treatment capacity in your view? How has care quality changed?
4. From your perspective, what is the plan for program sustainability? What are the challenges associated with ongoing program maintenance and expansion and required policy changes?
5. What strategies were most effective in implementing the 1115 so far in your view?
6. What have been the effects of changes in HIT (Health Information Technology) for patient care, ongoing monitoring, and care coordination as well as for program management?
7. Is there anything else you'd like to mention?

Administrator/Other Stakeholder interviews will be conducted either face-to-face or via telephone and will last approximately 45 to 60 minutes. Interviews will be recorded after participant permission, and pseudonyms will be utilized to ensure participant confidentiality. Recordings will be transcribed verbatim. Interviews will be conducted by the independent evaluator and the state will not have access to the recordings, which will be destroyed after transcription.

5. Analytic Methods

As suggested in the 3/6/2019 1115 ED Technical Assistance document, as recommended by CMS, State of Alaska Division of Behavioral health will utilize a mixed methods evaluation design, collecting both qualitative and quantitative data and applying descriptive and impact analyses (SUD Section 1115 Demonstration Evaluation Design Technical Assistance, 3/6/2019, p. 15). The range of Alaska Waiver goals, aims and objectives and evaluation questions and hypotheses requires the use of both quantitative and qualitative data analytic methods. Alaska's 1115 Waiver Evaluation Design is created to comply with conventional standards for best practices in terms of scientific and academic standards of rigor, with ample attention devoted to ensuring the design is also practical, feasible and appropriate for the Alaska Waiver in terms of design, data analysis, and interpretation and reporting.

a. Qualitative Analyses

Qualitative analyses include a range of non-numerical methods, including interviews, focus groups, field observations, and document review of archival and other materials (Bernard, 2016; Creswell & Creswell, 2018; Rich, 2016). As noted in the 1115 ED Technical Assistance document, "The objective of these types of analyses is to understand and document the demonstration design, implementation and ongoing operations to support the design and interpretation of quantitative descriptive and impact analyses" (SUD Section 1115 Demonstration Evaluation Design Technical

Assistance, 3/6/2019, p. 15). Such type of analyses often permit the type of rich "thick description" described by social anthropologists (e.g., Geertz, 2000, 2013) and allow the presentation of phenomenological data from the perspective of lived experience of the participants, giving voice and empowerment to diverse populations and stakeholders (e.g., Creswell & Creswell, 2018; Rich, 2016; Wertz, Charmaz, McMullen, Josselson, Anderson, & McSpadden, 2011). Qualitative methods are typically the preferred method for collecting in-depth data that cannot be collected or reduced to closed-ended surveys or numeric data or estimates.

For its 1115 Evaluation Design, State of Alaska Division of Behavioral Health will utilize a range of qualitative methods, including interviews, focus groups, and document review. Open-ended questions will be used to maximize the diversity and richness of responses and ensure a more holistic understanding of the subject's experience. Probing follow-up questions will be used as appropriate to elicit additional detail and understanding of critical points, terminology, and perspectives. The sessions will be recorded and transcribed with participant consent. Qualitative methods will also be used to analyze these responses. Interviews are especially valuable in assessing stakeholders' cognitions, perceptions, attitudes, emotions, and satisfaction regarding select topics and issues, and to gather information not possible to be obtained via other means (such as Medicaid claims). Alaska plans interviews with three groups of stakeholders: 1) Medicaid beneficiaries,

2) Division of Behavioral Health subrecipient providers, and 3) State of Alaska Department and Health and Social Services and Division of Behavioral Health administrators, managers, and employees involved with 1115 Waiver implementation. Section C.4 Data Sources of this 1115 Evaluation Design provides additional information on the State's intended process for sample selection and stratification, sample size, qualitative analysis approach, and sample interview questions/topics. Sampling decisions are determined to fit appropriate methodological considerations for qualitative data, and were determined after consideration of other approved State 1115 Waiver Evaluation Designs and best practices for qualitative research, such as qualitative sample sizes proportionally in line with population size, such as relates to the potential to reach saturation points with adequate sampling, and to ensure appropriate representation of intended populations (Creswell & Creswell, 2018).

The information obtained from these focus groups and interviews will be synthesized with the results from other quantitative data analyses providing an in-depth discussion of each of the domains/objectives to be considered. As the key informant interviews are being conducted, HSAG will perform ongoing and iterative review of the interview responses and notes to identify overall themes and common response patterns. Unique responses that are substantively interesting and informative will also be noted and may be used to develop probing questions for future interviews. The results of these preliminary analyses will be used to document the emergent and overarching

themes related to each research question. The documentation of emergent themes will be reviewed in an iterative manner to determine if responses to interview questions are continuing to provide new perspectives and answers, or if the responses are converging on a common set of response patterns indicating saturation on a particular interview question. As additional interview data are collected, the categories, themes, and relationships will be adjusted to reflect the broader set of concepts and different types of relationships identified. The documentation of emergent themes will also be used as an initial starting point for organizing the analysis of the interview data once all interviews are completed.

Following the completion of the focus groups and key informant interviews, the interview notes and transcripts will be reviewed using standard qualitative analysis techniques using MAXQDA software. The data will first be examined through open coding to identify key concepts and themes that may not have been captured as emergent themes during previous analyses. After identifying key concepts, axial coding techniques will be used to develop a more complete understanding of the relationships among categories identified by respondents in the data. The open and axial coding will be performed with a focus on identifying the dimensionality and breadth of responses to the research questions posed for the overall project. If certain outcomes or themes among responses begin to emerge and can be quantified, then these responses may be reported through a mixed methods quantitative approach. It is important to caveat that because data would be gathered through interviews or focus groups among likely small sample sizes, rigorous analytic techniques may not be permitted. Interviewee responses will be identified through the analysis to illustrate and contextualize the conclusions drawn from the research and will be used to support the development of the final report.

b. Quantitative Analyses

Quantitative analyses include a range of numerical methods, including descriptive and inferential statistics, such as correlations, regressions, ANOVAs, chi-squares, factor analyses, meta- analyses, and both parametric and non-parametric statistic (e.g., Bernard, Wutich, & Ryan, 2012; Creswell & Creswell, 2018; Field, 2017). As noted in the 1115 ED Technical Assistance document, "The objective of these types of analyses is to assess measured changes and to determine any impacts – that is, whether the measured changes are attributable to the demonstration intervention" (SUD Section 1115 Demonstration Evaluation Design Technical Assistance, 3/6/2019, p. 15).

The primary challenge to the evaluation is identifying a suitable comparison group. As described in the **Target and Comparison Populations** section, HSAG plans on utilizing five approaches to drawing comparisons. The comparison strategy largely depends on data availability, frequency of data reporting/collection, and level of data provided (unit of analysis). The following analytic approaches will be considered:

1. Difference-in-differences
2. Pre-test/post-test
3. Comparison to national benchmarks and/or historical rates
4. Interrupted time series
5. Panel data analysis

Difference-in-Differences

A DiD analysis covering a single evaluation year will be performed on measures that are linked to

the staged rollout of the expanded SUD services. Specifically, the two years prior to the beginning of the staged rollout will serve as the baseline, and year 1 of the demonstration will serve as the evaluation year. Beneficiaries residing in regions that implemented services in year 1 (implementation regions) will be compared against those in regions that implemented services in year 2 (comparison regions). By subtracting the change in outcomes among beneficiaries in comparison regions from the change in implementation regions, potential biases due to secular trends in outcomes that apply to both groups equally will be removed from the final estimate.[15] The result is a clearer picture of the actual effect of the program on the evaluated outcomes.

The generic DiD model is:

$$Y_{it} = \beta_0 + \beta_1 X_i + \beta_2 R_t + \beta_3 (R_t * X_i) + \boldsymbol{\gamma} \mathbf{D}'_{\boldsymbol{it}} + u_{it}$$

where Y_{it} is the outcome of interest for individual *i* in time period *t*. R_t is a dummy variable for the remeasurement time period (i.e., evaluation year 1). The dummy variable X_i identifies the intervention group with a 1 and the comparison group with a 0. The vector $\mathbf{D}'$ will include observable covariates to ensure comparability of the groups for any measure-specific subgrouping and $\boldsymbol{\gamma}$ is the related coefficient vector. The coefficient, β_1, identifies the average difference between the groups prior to the effective date of the policy. The time period dummy coefficient, β_2, captures the change in outcome between baseline and remeasurement time periods. The coefficient of interest, β_3, is the coefficient for the interaction term, $R_t * X_i$, which is the same as the dummy variable equal to one for those observations in the intervention group in the remeasurement period. This represents the estimated effect of the waiver on the intervention group, conditional on the included observable covariates. The final DiD estimate is:

$$\beta_3 = (\bar{y}_{T,R} - \bar{y}_{\mathrm{T,B}}) - (\bar{y}_{\mathrm{C,R}} - \bar{y}_{\mathrm{C,B}}) \mid \mathbf{D}'$$

Assuming trends in the outcome between the comparison and intervention groups are approximately parallel during the baseline period, the estimate will provide the expected costs and rates without intervention. If the β_3 coefficient is significantly different from zero, then it is reasonable to conclude that the outcome differed between the intervention and comparison group after the policy went into effect. In addition to assessing the degree of statistical significance for the result, as represented by the p-value associated with β_3, the results will be interpreted in a broader context of clinical and practical significance.

Because this approach in utilizing the staged roll-out for some measures can only evaluate Year 1 of the demonstration, results from this single evaluation year analysis will be combined with additional approaches noted below in order to provide a more comprehensive evaluation of the demonstration. The findings from the Year 1 analysis are likely not generalizable to future years or regions, due to systematic differences in in geographies and population density, unobservable or complex factors, such as learning and practice in implementation, beneficiary knowledge of services, and changes in economic conditions and healthcare landscape following Year 1.

Pre-Test/Post-Test

For measures and time periods for which there is no contemporaneous comparison group and

[15] To the extent trends do not apply to both groups equally, arising from potential differences among data sources, regions, demographic, and differential impact of economic changes over the course of the waiver, results may be biased. Additionally, the DiD approach would be employed to estimate the program impact for year 1 regions in year 1. Therefore, causal inferences should not be extrapolated to other regions or future years. To address this limitation, the DiD approach will be combined with additional approaches to better triangulate program impact.

have too few observations to support an interrupted time series analysis, rates will be calculated and compared both before and after the implementation of the waiver. Statistical testing will be conducted through a chi-square analysis. A chi-square test allows for comparison between two groups that have a categorical outcome, such as survey results or numerator compliance, to determine if the observed counts are different than the expectation.

Comparison to National Benchmarks and/or Historical Rates

To provide additional context of rates and changes in rates after the implementation of the BH/SUD waiver, HSAG will compare post-implementation rates with both historical rates prior to the program and against national benchmarks without necessarily conducting formal statistical testing (e.g., DiD or pre-test/post-test approaches). By combining reference points from historical rates with contemporaneous national benchmarks, rates calculated for the waiver can be reported in the context of historical Alaska-specific performance in addition to performance nationally, thus triangulating an impact of the BH/SUD expansion of benefits on outcomes. Although statistical testing through a DiD or pre-test/post-test approach would be preferable, these comparisons may be necessary if the level of data for the comparison group are not granular enough to support such statistical testing.

Interrupted Time Series

When a suitable contemporaneous comparison group cannot be found but data can be collected at multiple points in time before and after the implementation of the demonstration, such as costs or ED utilization, an ITS methodology can be used to estimate the impact of the demonstration on outcomes. The generic ITS model is:

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

where Y_t is the outcome of interest for the time period *t*, $time_t$ represents a linear time trend, $post_t$ is a dummy variable to indicate the time periods post-implementation, and $time_t \times post_t$ 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 demonstration, β_2 is the change in the outcome immediately following implementation, and β_3 is the change in the slope for the measurements after the demonstration.

Panel Data Analysis

Related to interrupted time series in this context, panel data analysis may be used on outcomes that can be collected on a more frequent basis at the individual level, such as monthly or quarterly costs. The panel data set can exploit differential timing of member interaction and engagement with BH and/or SUD services. The general panel regression model is:

$$Y_{it} = \beta_0 + \sum_{m=1}^{M} \beta_m X_{mit} + \beta_t Time_t + v_i + \varepsilon_{it} \qquad (1)$$

where:

Y_{it} = the value of the dependent variable *Y* for member *i* at time t.

β_0= the average outcome when all covariates are equal to zero.

β_m = a vector of parameter estimates representing the association between the explanatory variables, X_{mit}, and the outcome. The vector, X_{mit}, will include a dummy variable for periods after

implementation of the demonstration. Additional covariates for treatment identification, and time trends will be added as needed.

β_t = the trend in the outcome, net of program impacts and other relevant covariates.

X_{mit} = the value of covariate X_m for member *i* at time *t*.

$Time_t$ = a covariate or set of covariates representing the outcome trend.

v_i= the systematic difference between member i and the average outcome.

ε_{it} = a normally distributed error term.

The model described in equation 1 may take either a fixed effects or random effects form. The fixed effect panel model provides an unbiased estimate of the program impact but has the drawback that time-invariant covariates cannot be included in the model due to the data transformations required by the model (e.g., gender, age, chronic conditions). In contrast, the random effects model allows the inclusion of time-varying and time-invariant covariates. However, the random effects panel regression model may also generate biased results if any of the covariates are correlated with the residual error term, ε_{it}. The appropriateness of the random effects panel regression model will be assessed for outcomes with a normal response distribution using a Hausman test to determine whether the random effects estimates are likely to be biased relative to the fixed effects model results (Kennedy, 2003). For outcomes with a binary or negative binomial response distribution, a Hausman test is not readily available. As a result, HSAG will estimate present the results from a fixed effects specification, as these estimates are unbiased, whereas a random effects model may be biased if an independent covariate is correlated with the error term. Random effects model will still be estimated to serve as a robustness check.

The majority of measures in the Alaska 1115 Evaluation Design are quantitative Medicaid data and follow a pre-post design, with the potential and expectation for multipoint, interim assessment during the course of the Waiver period to monitor progress regarding 1115 activities in terms of Alaska state Waiver goals/objectives/aims, domains and key milestones as indicated in the Driver Diagram as well as described in the summary table of evaluation questions, hypotheses, and measures (see section B. Evaluation Questions and Hypotheses of this Evaluation Design document for additional information and details).

Given the limitations of non-randomized assignment and lack of contemporaneous in-state comparison group, the methods detailed above will be combined with methods that best account for any known of possible external influences and their potential interactions with the Demonstration's goals and activities. For example, since this 1115 Waiver and Evaluation Design aims to assess the effect of the Alaska 1115 Medicaid waiver, other potential sources of influence should be excluded, such as possible effects external to the Waiver programs, such as changes in state or national policy, or state or national economic trends, or socio- cultural cohort changes and trends that exist beyond the waiver services. This evaluation design seeks to isolate effects of the Demonstration Waiver on the observed outcomes through careful design including several considerations: a) when possible, information concerning the context within which the Alaska Waiver exists will be gathered to observe its potential contributions to observed effects in the Waiver, such as documentation regarding legal, regulatory, or policy changes and national/state economic trends; b) when possible, the evaluation will include baseline data collected for the period prior to the start of the Waiver (and when not possible, baseline data from the start of the Waiver period); c) where appropriate, Alaska Waiver populations will be compared to relevant data from other states and the nation to help best assess trends that may exist beyond the Alaska

Waiver activities that may influence Alaska Waiver outcomes. Consideration of such external influences, coupled with Alaska's mixed method, multi data source design, will assist in satisfying many conditions for causal inference, including temporal precedence, association, and elimination when possible of potential confounding factors (Contreary, Bradley, & Chao, 2018).

When appropriate, supplemental analyses will also be conducted to assess issues that emerge during the course of the Waiver period, to respond to stakeholder queries and quality improvement needs, and to delve more deeply into potential differences between Waiver subpopulations, various demographic (e.g., race/ethnicity, age, gender) or geographic variables, and beneficiary types. Additionally, HSAG will collect data for and conduct an actuarial analysis to assess compliance with CMS budget neutrality requirements.

In sum, examination of multiple data sources of both qualitative and quantitative data for Alaska's 1115 Evaluation Design permits an integrative, holistic assessment of the Waiver's effects that is more rigorous and robust that analysis of either quantitative or qualitative data alone.

c. Cost Analyses

Costs of the SUD and BH components to the demonstration will be estimated through three levels, as described in Appendix C to CMS SMI/SED and SUD Evaluation Design Guidance. The first level will estimate total per-member per-month (PMPM) costs across all categories of service (e.g. emergency department, inpatient, outpatient, professional, pharmacy, long-term care). These costs will be computed through reimbursement amounts on fee-for-service Medicaid claims. The analytic team will ensure that only de-duplicated paid claims are considered for the analysis to provide the most accurate picture of costs. Administrative costs will be calculated through identifying state-specific costs associated with the waiver, including a contract with an Administrative Services Organization (ASO) to manage the state's BH system, and costs associated with this evaluation. These costs will be allocated on a PMPM basis.

The second level will stratify total costs by IMD services with a SUD diagnosis, costs associated with other SUD diagnoses, and all other costs not directly related to a SUD diagnosis. It is expected that the SUD-related costs will increase, particularly in the short-term, as additional treatment services are opened and beneficiaries begin utilizing previously absent services.

The third level will stratify total costs by category of service in order to help identify cost drivers and potential cost savings, such as reductions in ED costs.

All cost analysis will be constructed using a panel dataset with the member-month as the unit of analysis. Beneficiaries with a SUD diagnosis during the demonstration period and up to two years prior will be included in the analysis with no enrollment requirements. The first SUD diagnosis during this period will serve as the entry date for beneficiaries in the study and will be followed for up to 11 months after the month of diagnosis. Subsequent SUD diagnoses during this time period will extend the study period. Beneficiaries who have subsequent SUD diagnoses after the initial year will be re-introduced into the study. Indicator flags will denote months in which the member was not enrolled in Medicaid (thereby effectively flagging cases with missing data) and monthly trend variables will be included in the panel dataset relative to each individual's SUD diagnosis. Another indicator variable will flag months after the introduction of the SUD demonstration.

Additional analyses from levels two and three may be conducted to leverage the staged rollout of SUD services. In particular, beneficiaries from regions 2, 3, 4, 6, 7, 8, and 9 may be used as an in-

state contemporaneous comparison group for beneficiaries in regions 1 and 5, which have intended to roll-out most SUD services in demonstration Year 1, according to the state's approved SUD implementation plan.

If data from other states that do not have a SUD demonstration are available, such as through the Transformed Medicaid Statistical Information System (T-MSIS), then analytic methods utilizing a contemporaneous comparison group may be employed. The panel structure of the dataset allows for flexibility in precise analytic technique. For instance, a difference-in-differences approach, with modifications to accommodate the panel nature of the dataset, can be used when a contemporaneous comparison group is available. When not available, an interrupted time series approach will be used. Results will be provided in two stages using a two-part hurdle model where the first stage reports the probability of a beneficiary having any costs in a particular month. The second stage reports the estimated log transformed costs among beneficiary-months in which costs were incurred.

D. Methodological Limitations

Despite many positive aspects, the Alaska SUD-BHP Demonstration evaluation does have several limitations. One limitation likely experienced with all 1115 Demonstration evaluations is the impossibility of utilizing a true experimental design, also known as a randomized controlled trial (RCT), a design which is often referred to as the "gold standard approach to establishing causality" (Contreary, Bradley, & Chao, 2018). RCTs feature random assignment of participants to either an experimental/treatment group or a control group (Creswell & Creswell, 2018), thus permitting it possible to infer that differences in outcomes were caused by the treatment (such as 1115 services). For ethical and practical reasons, such designs are not typically possible for 1115 waivers; for instance, one could not ethically randomly assign one person with a SU or mental health condition to receive therapeutic services and another such person to a control group that received no services. Additionally, RCTs are often better applied to test applications of a single policy, rather than an entire demonstration, since it may not be easily possible to determine which policy or policies impact the outcomes. In recognition of such concerns, State of Alaska Division of Behavioral Health has selected a multifaceted mixed methods design that is appropriate and feasible for evaluating the Alaska 1115 demonstration waiver; for example, both qualitative and quantitative data are utilized, as well as pre-post comparisons, comparisons between phased-in and yet to be phased-in Waiver populations, and comparisons with other state and national data. While not equivalent to a true experimental, RCT design, Alaska's multimodal, mixed methods evaluation design may be considered a robust design in line with best practices in such situations, and taken as a whole, satisfies many conditions for causal inference, including temporal precedence, association, and elimination when possible of potential confounding factors (Contreary, Bradley, & Chao, 2018).

Another limitation of the present evaluation design is the reliance on diagnostic codes (such as for conditions and procedures and prescription drugs) to identify beneficiary populations. The codes may not capture all behavioral health conditions/disorders/issues. Reliance on such codes may reduce outcome differences between beneficiary populations with and without behavioral health conditions, making a fully accurate interpretation of the demonstration's impact more challenging. Nevertheless, the use of coding (such as ICD codes) is in keeping with best practices, and indeed most historians of psychology and psychiatry point to the use of such classification systems as improvements over less evidence-based or less systematic alternatives to diagnosis (e.g., Benjamin, 2019; Porter, 2002; Shorter 1998). State of Alaska Division of Behavioral Health

does recognize that diagnostic codes may sometimes not reflect the full range of SU and BH client/patient experiences, and indeed that sometimes coding practicalities may lead to challenges in data interpretation; for instance, in some cases, a patient prescribed a common psychiatric medication, may be prescribed that medication for a non-BH purpose, leading to data interpretation nuances. In conjunction with State of Alaska Division of Behavioral Health, HSAG will examine carefully best practices in coding and interpretation to ensure the optimal possible evaluation.

A third limitation of Alaska's 1115 Evaluation Plan likely impacts other state evaluation plans as well. Since Alaska, like other states, aims to be responsive to its population in timely fashion, often multiple substance use and mental health initiatives are being developed and implemented by various groups and organizations simultaneously. Furthermore, changes at the state policy level, and federal level, during the Waiver period, may lead to macro-level changes in the substance use and MH/behavioral health system that impact potential to fully interpret all data in terms of their relation to changes effected by the Alaska 1115 Waiver. Ecological models of human development (e.g., Bronfenbrenner, 2009) describe factors beyond individual biology and family/community environment that impact human behavior, such as large scale systemic social or cultural changes, including technological innovations, economic recession, and chronosystem effects such as cohort effects between generations. Despite the practical and methodological challenges of anticipating or predicting all potential macro-level changes that may emerge during the evaluation period, the Alaska multimodal, mixed methods design provides a logical approach to disentangling as many possibly confounding factors as possible.

Finally, one limitation of the Evaluation Design relates to the Waiver period duration FY19 through FY24. State of Alaska Division of Behavioral Health aims to implement its waiver and effect positive, dynamic change for its SU and MH/BH beneficiaries in its SUD-BHP waiver. However, some health changes and outcomes require many years to be apparent or to be detectable via measurement (e.g., Berk, 2018; Santrock, 2019), leading to challenges in assessing all potential impacts of the present Waiver within the Waiver and evaluation period. For instance, prevention and early intervention services for children and youth may potentially lead to health improvements later in the lifespan, such as relating to educational, housing, and employment outcomes and to lifetime involvement with the criminal justice system or with medical professionals for chronic physical conditions related to substance misuse (such as hepatic cirrhosis or Korsakoff syndrome). Nevertheless, Alaska's evaluation design is aimed to assess those changes or precursors to change that may be assessed within the evaluation period, permitting examination to determine which programs and services are most effective. Alaska's proposed evaluation plan, with its mixed quantitative and qualitative methods, and range of data sources and analytic techniques, affords a pragmatic plan that will yield ample evidence of those changes that may be assessed during the evaluation period.

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E. Attachments

1. Independent Evaluator

As part of the Special Terms and Conditions (STCs) described by CMS, the state has contracted with an Independent Evaluator (IE), Health Services Advisory Group, Inc. (HSAG), to conduct an evaluation of the demonstration to ensure that the necessary data are collected at an appropriate level of detail sufficient to conduct the research to evaluate the approved hypotheses. HSAG has signed an agreement attesting it will conduct the demonstration evaluation in an independent manner in accordance with the CMS-approved Evaluation design. In conducting these evaluations and producing these evaluation reports, all efforts will be made to follow approved methodology, though per the STCs, the state may request, and CMS may agree to changes to methods in appropriate circumstances.

The State of Alaska has procured HSAG as the IE and has complied with all federal and state policies regarding making an appropriate selection. The IE's contract objectives are:

- To ensure compliance with State and Federal requirements regarding evaluation of the demonstration project, with specific emphasis on conducting data analysis and to ensure timely reporting
- To review/revise and assist in the development of the Evaluation Design
- Participation in activities related to the CMS-required Monitoring Measures and Evaluation Deliverables (e.g., the Mid Point Assessment, Draft Interim Report, and Draft Summative Evaluation Report)
- To advance data management and analysis capabilities
- To develop effective strategies with Federal, State, and local partners for cross- system, cross-organization coordination

Below are some of the qualifications for the Independent Evaluator (IE) that HSAG has met:

- Experience working with federal programs, especially with 1115 Demonstration Waivers and with Medicaid, and with MMIS data
- Experience and knowledge of behavioral health
- Experience in program evaluation of complex, multifaceted programs
- Experience with CMS federal standards and policies for program evaluation
- Familiarity with national data sources, especially those that may be utilized in this Waiver project, such as NSDUH, BRFSS, YRBSS, Core Set and HEDIS measures
- Skills and experience in quantitative data analysis, including analytic ability regarding statistical methods, including descriptive and inferential statistics, including frequencies, chi-squares, t-Tests, regressions, ANOVAs, and related techniques.
- Skills and experience in qualitative data analysis, including ability regarding creating, conducting and analyzing interview data, provider and beneficiary surveys, focus groups, and field observations, as well as thematic narrative analysis of archival or historical documents.

- Experience with longitudinal and pre-post designs, and in selecting and analyzing appropriate comparison data (such as non-waiver, and national and other state data)
- Experience with quasi-experimental and mixed methods designs, and with both primary and secondary data collection and analysis
- Experience with appropriate sample selection techniques and design of data collection instruments

Additionally, among the desired qualifications HSAG has the following:

- Documented successful experience (preferably at least five years) with assisting state governments with design implementation and evaluation, including management of evaluation teams for projects of similar size and scope
- Knowledge and understanding of Alaska-specific data and of Alaska's unique qualities, such as its geography (rural/urban) and size, and its populations and health systems.
- Demonstrated experience and understanding of Alaska's health delivery system and Medicaid program
- Demonstrated experience conducting Medicaid financial analysis
- Personnel whose resumes reflect appropriate education and experience for this Project; a designated evaluation lead with at least a Master's Degree in Statistics, Social Science (e.g., sociology or psychology), or Public Health, with a Ph.D. preferred.
- Experience working with Tribes, including Tribal Consultation

In selecting HSAG, the State has taken the appropriate steps to ensure HSAG is indeed free of any conflict of interest and that it remains free of conflicts of interest during the contract term. Among the potential conflicts avoided are: 1) the IE must not provide services to any healthcare providers doing business in Alaska under the Medicaid program as per contractual agreements as noted in the contract between the State and the IE and 2) the IE must not provide direct services to individuals in State of Alaska-administered programs as specified in the contractual agreements agreed upon by the State and the IE. If the State discovers such conflicts during the contract term, the State may terminate the contract pursuant to the contract provisions.

Additionally, HSAG will comply with all state and federal laws regarding protecting human subjects and assuring confidentiality of data, including procuring any needed data sharing agreements. The IE will follow generally accepted procedures for safeguarding data, such as password protection and encryption, and HIPAA and 42 CFR Part II regulations.

2. Evaluation Budget

As required by the CMS STCs (Special Terms and Conditions, 9/3/2019), the state must arrange with its IE to conduct an evaluation of the demonstration to ensure that the necessary data are collected at an appropriate level of detail sufficient to conduct the research to evaluate the approved hypotheses. HSAG estimates a cost of $230,119.80 based on its experience with research and evaluation services for the Initial Year of this contact through June 30, 2021. The table below displays the proposed budget that will be utilized during the evaluation.

Deliverable Description	Initial Year thru 6/30/21	Option 1 of 5 Year 2 thru 6/30/22	Option 2 of 5 Year 3 thru 6/30/23	Option 3 of 5 Year 4 thru 6/30/24	Option 4 of 5 Year 5 thru 6/30/25	Option 5 of 5 Year 6 thru 6/30/26	TOTALS
Revise Evaluation Design	$9,682.00						**$9,682.00**
Mid-Point Assessment	$91,009.00						**$91,009.00**
Draft Interim Evaluation Report	$45,280.00	$71,765.00	$54,323.00				**$171,368.00**
Final Interim Evaluation Report			$34,799.00				**$34,799.00**
Draft Summative Report			$58,471.00	$86,069.00	$62,627.00		**$207,167.00**
Final Summative Report						$62,291.00	**$62,291.00**
Draft Close Out Report				$44,143.00			**$44,143.00**
Final Close Out Report					$31,553.00		**$31,553.00**
Semi-Annual progress reports to include all activities with data analysis, reflections and insight on the implementation of projects drawing on key informant interviews, document review, meetings attended, and activity review.	$19,001.60	$19,001.60	$19,001.60	$19,001.60	$19,001.60		**$95,008.00**
Specification for data required from state including a timeline, data gap analysis, and plan to address data gaps.	$3,368.20	$3,368.20	$3,368.20	$3,368.20	$3,368.20		**$16,841.00**
Focus groups and key informant interviews to create baseline information for quantitative analysis	$30,095.00	$25,847.00	$15,216.00				**$71,158.00**

Deliverable Description	Initial Year thru 6/30/21	Option 1 of 5 Year 2 thru 6/30/22	Option 2 of 5 Year 3 thru 6/30/23	Option 3 of 5 Year 4 thru 6/30/24	Option 4 of 5 Year 5 thru 6/30/25	Option 5 of 5 Year 6 thru 6/30/26	TOTALS
Analysis of existing survey results, data, key informant interviews, and focus groups	$21,324.00	$20,402.00	$25,393.00	$37,049.00	$27,190.00		**$131,358.00**
Travel NTE	$10,360.00	$5,180.00	$5,180.00	$5,180.00	$5,180.00		**$31,080.00**
TOTAL COST PER YEAR / PROJECT TOTAL	**$230,119.80**	**$145,563.80**	**$215,751.80**	**$194,810.80**	**$148,919.80**	**$62,291.00**	**$997,457.00**

3. Timeline and Major Milestones (Performance Period 1/01/2019 to 12/31/2023)

Note: The documents labeled SUD/BH below are labeled SUD by CMS in the CMS PMDA1115 website system. With the approved CMS STCs (9/3/2019), that added behavioral health in addition to substance use services, the Alaska Division of Behavioral Health has described the items as SUD/BH below for clarity. Additionally, note that per CMS approval, Alaska's 1115 Waiver has a CMS approved SUD Waiver Implementation Plan (3/27/2019), but Alaska will not have a separate BH Implementation Plan submission.

Task Name	CMS Due Date
SUD Implementation Plan Protocol	4/1/2019 (Accepted 3/27/2019)
SUD Quarterly Monitoring Report April 2019	5/31/2019
Behavioral Health Demonstration/SUD Monitoring Protocol March 2019	6/30/19 (Received 6/26/2019)
SUD/BH Quarterly Monitoring Report July 2019	8/30/2019
SUD/BH Quarterly Monitoring Report October 2019	12/02/2019
SUD/BH Draft Evaluation Design July 2019	03/31/2020
Annual Monitoring Report January 2020	03/31/2020
SUD/BH Quarterly Monitoring Report April 2020	06/01/2020
SUD/BH Quarterly Monitoring Report July 2020	08/31/2020
Mid-Point Assessment November 2020	11/15/2020
SUD/BH Quarterly Monitoring Report October 2020	11/30/2020
Annual Monitoring Report January 2021	04/01/2021
SUD/BH Quarterly Monitoring Report April 2021	05/31/2021
SUD/BH Quarterly Monitoring Report July 2021	08/31/2021

SUD/BH Quarterly Monitoring Report October 2021	11/30/2021
Annual Monitoring Report January 2022	04/01/2022
SUD/BH Quarterly Monitoring Report April 2022	05/31/2022
SUD/BH Quarterly Monitoring Report July 2022	08/30/2022
SUD/BH Quarterly Monitoring Report October 2022	11/30/2022
Behavioral Health Demonstration- Draft Interim Report (12/22)	12/30/2022
Annual Monitoring Report January 2023	04/03/2023
SUD/BH Quarterly Monitoring Report April 2023	05/31/2023
SUD/BH Quarterly Monitoring Report July 2023	08/30/2023
SUD/BH Quarterly Monitoring Report October 2023	11/30/2023
Annual Monitoring Report January 2024	03/31/2024
SUD/BH Quarterly Monitoring Report April 2024	05/31/2024
SUD/BH Draft Summative Evaluation Report June 2025	06/30/2025

State of Alaska Department of Health, Division of Behavioral Health

Alaska Section 1115 Demonstration Waiver – Behavioral Health Reform

Renewal Evaluation Design

January 2025

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Background

The Centers for Medicare & Medicaid Services (CMS) and federal law establish standards for the minimum care that states must provide to Medicaid-eligible populations, while also allowing states to design and test their own strategies for funding and providing healthcare services. Under Section 1115 of the Social Security Act, states can implement innovative demonstration projects and evaluate state-specific policy changes to improve efficiency and reduce costs. On March 26, 2024, CMS approved Alaska's request to extend its Section 1115 Demonstration Waiver, now titled Behavioral Health Reform.[1-1] This extension is approved for five years, from March 26, 2024, through December 31, 2028.

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 reached historical highs. Although there were small improvements at the turn of the last decade, the most recent available data showed that Alaskan opioid death counts continued to rise from 2013 to 2020.[1-2] By 2022, opioid-related overdose deaths nearly quadrupled from 2010, averaging 24.9 deaths per 100,000.[1-3] From 2018 to 2022, 633 of Alaska's 886 drug overdose deaths involved opioids, slightly over 70 percent.[1-4] Opioid misuse was not exclusive to the State of Alaska; rates of self-reported opioid misuse were similar or higher in Alaska compared to national trends, with 3.0 percent of Alaskans reporting misuse of any opioids and 22.8 percent of Alaskans reporting illicit drug use, compared to national rates of 3.3 percent and 15.5 percent, respectively, in 2022.[1-5] According to the 2021–2022 National Survey on Drug Use and Health (NSDUH), 21.1 percent of Alaskan adults reported binge alcohol use in the past month, compared to a national rate of 21.7 percent. Additionally, 23.0 percent of Alaskans had a substance use disorder (SUD), compared to a national rate of 17.0 percent,[1-6] and 6.7 percent of Alaskans reported needing but not receiving treatment for illicit drug use in the past year, compared with a national rate of 4.8 percent.[1-7] Notably, alcohol misuse was prominent in Alaska, which ranked 15th in the nation for highest prevalence rate of adult binge drinking in 2022.[1-8]

1-1 From January 1, 2019, to March 25, 2024, Behavioral Health Reform was called the Substance Use Disorder-Behavioral Health Program.

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 1, 2024.

1-3 Alaska Department of Health. 2022 Drug Overdose Mortality Update. Available at: https://health.alaska.gov/dph/VitalStats/Documents/PDFs/DrugOverdoseMortalityUpdate_2022.pdf. Accessed on: Aug 2, 2024.

1-4 Ibid.

1-5 Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer, Alaska, Volume 6. Available at: https://www.samhsa.gov/data/sites/default/files/reports/rpt45304/2022-nsduh-barometer-region-10.pdf. Accessed on: Aug 2, 2024.

1-6 Ibid.

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 2, 2024.

1-8 Statista. Binge drinking prevalence among adults in the United States as of 2022, by state. Available at: https://www.statista.com/statistics/378966/us-binge-drinking-rate-adults-by-state/#:~:text=U.S.%20binge%20drinking%20among%20adults%20by%20state%202022&text=As%20of%202022%2C%20the%20U.S.,last%2030%20days%20in%202022. Accessed on: Aug 2, 2024.

The need for behavioral health (BH) services, which often coincided with the need for SUD treatment, was more prominent among Alaskans than the rest of the nation. Data from the 2022 Behavioral Risk Factor Surveillance System (BRFSS) showed that 15.2 percent of Alaskans and 17.2 percent of Alaska Natives reported frequent mental distress, defined as experiencing poor mental health (MH) 14 or more days per month.[1-9] In addition, Alaska's 2022 suicide rate of 26.7 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 die by suicide compared to non-Alaska Natives.[1-10] With rates of mental illness, suicide, illicit and opioid drug use, overdose deaths, and binge drinking stable or increasing, and often in line with or surpassing national trends, Alaskans continue to need SUD and BH services, as well as intervention to address downstream effects that further perpetuate the need for these services.

For example, between 2017 and 2021, the number of Medicaid-covered infants diagnosed with neonatal abstinence syndrome (NAS) increased by over 35 percent, from 85.3 per 1,000 births to 116.4 per 1,000 births.[1-11] Additionally, children living with adults with SUD and other BH ailments often experienced adverse childhood experiences (ACEs), placing 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 are more likely to experience physical and mental morbidities including certain cancers, obesity, depression, or premature mortality including suicide, in adulthood.[1-12] In 2021, 16.96 percent of Alaskan children had experienced two or more adverse events,[1-13] compared to 14.0 percent nationally.[1-14] The higher rates of ACEs in Alaska not only coincided with higher rates of adult SUD and BH ailments, they also perpetuated a cycle of high rates of SUD and BH ailments 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.

Further exacerbating the challenges of providing SUD and BH interventions in Alaska is the State's unique infrastructure. While Alaska is the largest state by land mass, its population density is significantly lower than that

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1-9 Centers for Disease Control and Prevention. BRFSS Prevalence & Trends Data. Available at: https://nccd.cdc.gov/BRFSSPrevalence/rdPage.aspx?rdReport=DPH_BRFSS.ExploreByLocation&rdProcessAction=&SaveFileGenerated=1&irbLocationType=States&islLocation=02&islState=&islCounty=&islClass=CLASS20&islTopic=TOPIC71&islYear=2022&hidLocationType=States&hidLocation=02&hidClass=CLASS20&hidTopic=TOPIC71&hidTopicName=Healthy+Days&hidYear=2022&irbShowFootnotes=Show&rdICL-iclIndicators=_PHYS14D%2c_MENT14D&iclIndicators_rdExpandedCollapsedHistory=&iclIndicators=_PHYS14D%2c_MENT14D&hidPreviouslySelectedIndicators=&DashboardColumnCount=2&rdShowElementHistory=divTopicUpdating%3dHide%2cislTopic%3dShow%2cdivYearUpdating%3dHide%2cislYear%3dShow%2c&rdScrollX=0&rdScrollY=200&rdRnd=27721. Accessed on: Aug 2, 2024.

1-10 Alaska Department of Health Division of Public Health. Alaska Vital Statistics 2022 Annual Report. Available at: https://health.alaska.gov/dph/VitalStats/Documents/PDFs/VitalStatistics_Annualreport_2022.pdf. Accessed on: Aug 2, 2024.

[11]Centers for Medicare & Medicaid Services. Number and rate of NAS per 1,000 births in newborns whose deliveries were covered by Medicaid or CHIP, 2017–2021. Available at: https://data.medicaid.gov/dataset/9c9ad0d1-c59b-4a25-9314-8e7e44e7f281?conditions[0][property]=state&conditions[0][value]=Alaska&conditions[0][operator]=%3D. Accessed on: Aug 2, 2024.

1-12 Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. *Am. J Prev Med* 1998;14(4). Available at: https://www.ajpmonline.org/action/showPdf?pii=S0749-3797%2898%2900017-8. Accessed on: Aug 2, 2024.

1-13 An adverse event includes parent divorce or separation; living with someone who had an alcohol or drug problem; neighborhood violence victim or witness; living with someone who was mentally ill, suicidal, or severely depressed; domestic violence witness; parent served jail time; being treated or judged unfairly due to race/ethnicity; or death of a parent.

1-14 United Health Foundation. America's Health Rankings, Adverse Childhood Experiences, Alaska. 2021. Available at: https://www.americashealthrankings.org/explore/measures/ACEs_8. Accessed on: Aug 2, 2024.

of cities in the contiguous United States. For example, Alaska's largest city, Anchorage, had an estimated population of 286,075 in July 2023, much smaller than many cities in the lower 48 states, which have populations exceeding one million.[1-15] In addition, Alaskan communities are widely distanced and inaccessible by road, resulting in them being medically underserved. The large geographic size and small population of Alaska make SUD and BH support less accessible, and there are fewer healthcare professionals compared to communities in the contiguous United States. Moreover, Alaska's northern and unforgiving climate constantly poses a challenge for accessibility and delivery of healthcare services.

Lastly, Alaska has a diverse population that includes 229 federally recognized tribes, 20 different native languages, and a growing immigrant population throughout the State. Alaska is home to 37 tribal health organizations that serve the tribal population, many of which receive grants from the Division of Behavioral Health (DBH). This diversity presents a challenge for providing culturally and regionally appropriate care.

Waiver Background

On March 1, 2023, the Alaska Department of Health (DOH) submitted an application to CMS to renew its Medicaid Section 1115 Demonstration Waiver. The renewal application proposed continuing the SUD-BH Program under a new name, Behavioral Health Reform. The name change reflects the same MH and SUD services as under the previous waiver under the broader term of BH.[1-16] CMS approved Behavioral Health Reform on March 26, 2024, with a demonstration period running from March 26, 2024, to December 31, 2028. Behavioral Health Reform will continue to increase access to SUD and BH services for Alaskans, aiming to anticipate or eliminate crises and strengthen the continuum of care, including early intervention services and community support. The primary objectives of Behavioral Health Reform include:

- Rebalancing 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.
- Intervening as early as possible in the lives of Alaskans to address BH symptoms before symptoms cascade into functional impairments.
- Improving the overall BH system accountability by reforming the existing system of care.

Additionally, the State identified long-term goals for the Behavioral Health Reform:[1-17]

- Increased rates of identification, initiation, and engagement in treatment for substance use and BH issues.
- Increased adherence to and retention in treatment for substance use and BH issues.
- Reduced overdose deaths, particularly those due to opioids.

1-15 United States Census Bureau. Quick Facts. Available at: https://www.census.gov/quickfacts/fact/table/anchoragemunicipalityalaska,US/PST045221. Accessed on: Aug 2, 2024.

1-16 In this evaluation, behavioral health (BH) refers to both substance use disorder (SUD) and mental health (MH) services, while 'SUD' and 'MH' refer specifically to their respective services.

1-17 Centers for Medicare & Medicaid Services. CMS Approval Behavioral Health Reform. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ak-behavioral-health-refm-aprvl-03262024.pdf. Accessed on: Aug 2, 2024.

- 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.
- Fewer readmissions to the same or higher level of care where readmission is preventable or medically inappropriate.
- Improved access to care for physical health (PH) conditions among beneficiaries.

Program Population

Behavioral Health Reform impacts three Alaskan Medicaid beneficiary population groups. Behavioral Health Reform did not impact Medicaid eligibility standards.

Group 1: Children, adolescents, and their parents or caretakers with or at risk of MH disorders and SUD	Group 1 beneficiaries include those 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. Behavioral Health Reform services for this population include 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: Transitional age youth and adults with acute MH needs	Group 2 beneficiaries include transitional age youth and adults between the ages of 18 and 21 as well as between the ages 18 and 25 who experience MH disorders and have comorbidities or dual diagnoses, such as intellectual, developmental, or sensory disabilities, making their care needs more complex. Two different transitional age groups will be analyzed due to variations in the definition of transitional ages in the literature. Individuals in this population are at higher risk of emerging MH issues and SUD.[1-18] Behavioral Health Reform services for Group 2 include assertive community treatment (ACT) services, ICM, PHP services, adult MH residential services, and peer-based crisis services.
Group 3: Adults, adolescents, and children with SUD	Group 3 consists of adults, adolescents, and children between the ages of 12 and 64 years who have 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.[1-19]

Services for this group aim to enhance the availability of care and provide a more comprehensive continuum of treatment for SUD, including:

- Opioid treatment services
- IOP services
- PHP services
- Residential treatment
- Medically monitored intensive IP services

[1-18] Martel A, Fuchs C. Transitional age youth and mental illness – influences on young adult outcomes. *Child and Adolescent Psychiatric Clinics*. 2017; 26(2): XIII–XVII.

[1-19] American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR®). 2022.

- 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 Behavioral Health Reform services replaced existing State plan services, with additional services introduced. Behavioral Health Reform services adhere to the American Society of Addiction Medicine (ASAM) level-of-care criteria to place patients in the right setting at the right time.[1-20]

Previous Report Findings

The March 2023 Interim Evaluation Report, approved by CMS on September 27, 2023,[1-21] provides evidence of Alaska's progress toward its goals. The report suggested that SUD beneficiaries were transitioning away from ED utilization to outpatient (OP) care with the SUD-BH Program implementation. Additionally, SUD and BH provider capacity expanded, and new services became more widely available. Timely initiation of SUD treatment improved, and the average length of stay (LOS) in institutions for mental diseases (IMDs) significantly decreased. However, the coronavirus disease 2019 (COVID-19) public health emergency (PHE) likely impacted utilization, and workforce shortages impacted expansion of services in the State.

The independent evaluator will incorporate a synthesis of results from the prior demonstration period Summative Evaluation Report in the Behavioral Health Reform's Interim Evaluation Report, due to CMS by December 31, 2027.

Additional research questions and measures have been added to this Evaluation Design since the approval of the prior demonstration period's Interim Evaluation Report in September 2023. Table 1-1 lists the research questions that are new to Behavioral Health Reform.

Table 1-1—New Research Questions for Behavioral Health Reform

New Research Questions
1.2: Does Behavioral Health Reform mitigate barriers to maintaining and providing SUD and BH resources?
2.2: Does Behavioral Health Reform reduce the number of beneficiaries who experience or are exposed to adverse events?

1-20 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 2, 2024.

1-21 Centers for Medicare & Medicare Services. SUD Interim Evaluation Report. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ak-behavioral-health-sud-interim-evaluton-rpt-09272023.pdf. Accessed on: Aug 2, 2024.

2. Evaluation Questions and Hypotheses

This section provides the logic model, hypotheses, research questions, and measures which focus on evaluating the impact of the Behavioral Health Reform Section 1115 Demonstration Waiver.

Logic Model

Figure 2-1 displays the logic model for Behavioral Health Reform. The model depicts the relationship between the demonstration's goal/purpose/aim, the primary drivers that contribute to realizing that purpose, and the secondary drivers that are necessary to achieve the primary drivers. Both the secondary and primary drivers will influence each Centers for Medicare & Medicaid Services (CMS Goal), though the relationships between the secondary and primary drivers may be multidirectional.[2-1]

Figure 2-1—Driver Diagram

Primary Drivers[1]	Secondary Drivers[2]
Behavioral Health Reform Goal 1: Increased rates of identification, initiation, and engagement in treatment for substance use and BH issues (Hypotheses 1 and 2)	
Access to Critical Levels of Care for SUD/MH Treatment[2-2]	• Universally screen all beneficiaries, regardless of setting, using industry-recognized, evidence-based SUD and MH screening instruments to identify symptoms for preventive measures and intervene as early as possible • Improve care coordination through the integration of BH into primary care and specialty medical settings • Increase SUD and BH treatment options for youth (ages 12–17) and adult (ages 18 and older) beneficiaries, particularly non-residential, step-up, and step-down treatment options • Increase the number of Medicaid qualified professionals who provide SUD or BH services
Use of Evidence-Based, SUD and MH Patient Placement Criteria	• Implement ASAM Criteria to match beneficiaries with SUD with the services and tools necessary for recovery • Improve beneficiary knowledge of available treatment services

2-1 Centers for Medicare & Medicaid Services. Defining and Using Aims and Drivers for Improvement. January 1, 2013. Available at: https://www.cms.gov/priorities/innovation/files/x/hciatwoaimsdrvrs.pdf. Accessed on Aug 24, 2024.

2-2 In this evaluation, behavioral health (BH) refers to both substance use disorder (SUD) and mental health (MH) services, while 'SUD' and 'MH' refer specifically to their respective services.

Primary Drivers[1]	Secondary Drivers[2]
Behavioral Health Reform Goal 2: Increased adherence to and retention in treatment for substance use and BH issues (Hypotheses 1 and 2)	
Use of Evidence-Based, SUD and MH Patient Placement Criteria	• Improve care coordination through the integration of BH into primary care and specialty medical settings • Increase SUD and MH treatment options for youth (ages 12–17) and adult (ages 18 and older) beneficiaries, particularly non-residential, step-up, and step-down treatment options • Increase access to OP, IOP, and residential treatment for SUD • Ensure patients are satisfied with services • Increase the number of Medicaid qualified professionals who provide SUD or MH services
Use of Evidence-Based, SUD-Specific Patient Placement Criteria	• Implement ASAM Criteria to match beneficiaries with SUD with the services and tools necessary for recovery
Behavioral Health Reform Goal 3: Reduced overdose deaths, particularly those due to opioids (Hypotheses 1 and 2)	
Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioids	• Universally screen all beneficiaries, 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 • Improve SUD provider infrastructures and capacity utilizing industry-recognized standards for certification and ongoing accountability (with emphasis on residential providers, but across-the-board) • Implement ASAM Criteria to match beneficiaries with SUD with the services and tools necessary for recovery
Improve adherence to treatment for OUD and other SUDs	• Improve care coordination and transitions between levels of care, ensuring residential and IP facilities link beneficiaries with community-based services and supports • Increase SUD and MH treatment options for youth (ages 12–17) and adult (ages 18 and older) beneficiaries, particularly non-residential, step-up, and step-down treatment options

Primary Drivers[1]	Secondary Drivers[2]
Behavioral Health Reform Goal 4: Reduced utilization of EDs and IP hospital settings for substance use and MH treatment where the utilization is preventable or medically inappropriate through improved access to other more appropriate and focused services (Hypotheses 1 and 2)	
Increase Access to Continuum of Care	• Improve SUD provider infrastructures and capacity utilizing industry-recognized standards for certification and ongoing accountability (with emphasis on residential providers, but across-the-board) • Improve care coordination through the integration of BH into primary care and specialty medical settings • Promote appropriate service utilization through improved access to care for PH conditions for beneficiaries
Use of Evidence-Based, SUD-Specific Patient Placement Criteria	• Implement ASAM Criteria to match beneficiaries with SUD with the services and tools necessary for recovery • Increase SUD and BH treatment options for youth (ages 12–17) and adult (ages 18 and older) beneficiaries, particularly non-residential, step-up, and step-down treatment options
Behavioral Health Reform Goal 5: Fewer readmissions to the same or higher level of care where readmission is preventable or medically inappropriate (Hypotheses 1 and 2)	
Increase Access to Continuum of Care	• Improve SUD provider infrastructures and capacity utilizing industry-recognized standards for certification and ongoing accountability (with emphasis on residential providers, but across-the-board) • Improve care coordination and transitions between levels of care, ensuring residential and IP facilities link beneficiaries with community-based services and supports • Promote appropriate service utilization through improved access to care for PH conditions for beneficiaries • Ensure patients are satisfied with services
Use of Evidence-Based, SUD-Specific Patient Placement Criteria	• Implement ASAM Criteria to match beneficiaries with SUD with the services and tools necessary for recovery • Increase SUD and MH treatment options for youth (ages 12–17) and adult (ages 18 and older) beneficiaries, particularly non-residential, step-up, and step-down treatment options

Primary Drivers[1]	Secondary Drivers[2]
Behavioral Health Reform Goal 6: Improved access to care for PH conditions among beneficiaries (Hypothesis 2)	
Integrate PH and BH care	• Improve care coordination through the integration of BH into primary care and specialty medical settings • Increase access to preventive health services for beneficiaries overall, and those with comorbid conditions

[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 milestones identified by CMS.
Note: ASAM: American Society of Addiction Medicine; BH: behavioral health; IOP: intensive outpatient; IP: inpatient; MH: mental health; OP: outpatient; PH: physical health; SUD: substance use disorder.

Hypotheses and Research Questions

To comprehensively evaluate Behavioral Health Reform, three hypotheses, listed in Table 2-1, will be assessed using eight research questions.

Table 2-1—Hypotheses

	Hypotheses
1	Behavioral Health Reform will maintain or increase the identification of and access to SUD and MH disorder treatment services by increasing access to community-based care.
2	Beneficiaries receiving BH services will experience maintained or improved health and well-being outcomes.
3	Behavioral Health Reform will maintain or reduce the cost of Medicaid for Alaska and the federal government.

Hypothesis 1 is designed to identify whether Behavioral Health Reform increased community-based care and if the identification of substance use disorder (SUD) and mental health (MH) treatment disorder services increased in response. The measures and research questions associated with Hypothesis 1 are presented in Table 2-2.

Table 2-2—Hypothesis 1 Research Questions and Measures

Hypothesis 1: Behavioral Health Reform will maintain or increase the identification of and access to SUD and MH disorder treatment services by increasing access to community-based care.	
Research Question 1.1: Does Behavioral Health Reform increase the number of beneficiaries in the waiver population who are screened, referred to, and engaged in treatment for SUD and MH disorders?	
1-1	Number of beneficiaries screened for symptoms of SUD using industry-recognized, evidence-based screening instruments
1-2	Number of beneficiaries screened for symptoms of MH disorders using industry recognized, evidence-based screening instruments
1-3	Number of beneficiaries in the waiver population with a SUD or MH diagnosis, by setting

Hypothesis 1: Behavioral Health Reform will maintain or increase the identification of and access to SUD and MH disorder treatment services by increasing access to community-based care.	
1-4	Number of child beneficiaries who are taking medication for ADD/ADHD, ASD, difficulties with emotions, concentration, or behavior
1-5	Percentage of beneficiaries who had initiation of SUD treatment
1-6	Percentage of beneficiaries who had engagement of SUD treatment
1-7	Follow-up after discharge within 7-days and 30-days from ED visits for SUD, and specifically for OUD
1-8	Follow-up after discharge within 7-days and 30-days from ED visits for a MH disorder
1-9	Number of Medicaid qualified SUD providers (identified by provider ID numbers) who bill for SUD services
1-10	Number of Medicaid qualified professionals licensed in the State to provide MH who bill for MH disorder services
1-11	Number of respondents who received substance use treatment
1-12	Number of respondents who were classified as needing substance use treatment
1-13	Number of respondents who received MH treatment
Research Question 1.2: Does Behavioral Health Reform mitigate barriers to maintaining and providing SUD and MH resources?	
1-14	Providers' experience providing SUD and MH services
1-15	Providers' reported barriers maintaining the integration of SUD and MH services
1-16	Provider's reported successes maintaining the integration of SUD and MH services
1-17	Providers' reported changes in the ability to provide care after DBH procurement of a BH organization
1-18	Administrators' reported barriers to maintaining SUD and MH services
1-19	Administrators' reported successes in maintaining SUD and MH services
1-20	Administrators' plan for program sustainability and anticipated challenges
1-21	Alaska tribal entities' reported continued changes in quality of care and access to care in providing SUD and MH services
Research Question 1.3: Does Behavioral Health Reform decrease utilization of ED, IP, or institutional settings within the beneficiary population?	
1-22	IP admissions for SUD, and specifically for OUD
1-23	IP admissions for MH disorders
1-24	ED visits for SUD
1-25	ED visits for OUD
1-26	Number of ED visits among beneficiaries who had at least one ED admission for SUD
1-27	Number of ED visits for SUD among high utilizing beneficiaries
1-28	ED visits for MH disorders
1-29	Number of ED visits among beneficiaries who had at least one ED admission for MH
1-30	Number of ED visits for MH among high utilizing beneficiaries
1-31	Mean length of stay among IMDs measured from admission date to discharge date
1-32	30-day readmission rate to IP facilities following hospitalization for an SUD-related diagnosis
1-33	30-day readmission rate to IP facilities following hospitalization for a MH-related diagnosis

Hypothesis 1: Behavioral Health Reform will maintain or increase the identification of and access to SUD and MH disorder treatment services by increasing access to community-based care.	
Research Question 1.4: Does Behavioral Health Reform increase the percentage of beneficiaries who adhere to treatment for SUD and MH disorders?	
1-34	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
1-35	Number of beneficiaries with a MH diagnosis who used services in the last month or year, by service or benefit type
1-36	Time to treatment among beneficiaries who access SUD treatment

Note: ADD/ADHD: attention deficit disorder/attention deficit hyperactivity disorder; ASD: autism spectrum disorder; BH: behavioral health; DBH: Department of Behavioral Health; ED: emergency department; IMD: Institutions for Mental Disease; IP: inpatient; MH: mental health; OUD: opioid use disorder; SUD: substance use disorder

Hypothesis 2 will evaluate whether Behavioral Health Reform improved health outcomes for beneficiaries. The measures and research questions associated with Hypothesis 2 are presented in Table 2-3.

Table 2-3—Hypothesis 2 Research Questions and Measures

Hypothesis 2: Beneficiaries receiving BH services will experience maintained or improve health and well-being outcomes.	
Research Question 2.1: Does Behavioral Health Reform increase the percentage of beneficiaries with an SUD or a MH disorder who experience care for comorbid conditions?	
2-1	Percentage of adults who accessed preventive/ambulatory health services
2-2	Percentage of beneficiaries 3–21 years of age with a well-care visit with a PCP or OB/GYN
2-3	Screening for chronic conditions relevant to State Medicaid population
2-4	Screening for co-morbidity of BH disorders and SUDs
2-5	Prevention Quality Chronic Composite
2-6	Pediatric Quality Chronic Composite
2-7	Percentage of beneficiaries who have a high rating of their healthcare quality (8, 9, or 10 on a scale of 0–10)
2-8	Percentage of beneficiaries who rate their overall mental or emotional health as “very good” or “excellent”
2-9	Percentage of beneficiaries who demonstrate “very good” or “excellent” knowledge of available SUD/MH treatment and services
2-10	Percentage of beneficiaries who are knowledgeable of the number of SUD and MH services available
2-11	Percentage of mothers who often or always felt depressed since their new baby was born
2-12	Percentage of beneficiaries who indicated poor MH in the last 30 days
2-13	Percentage of mothers who indicate that they have someone who would help them while sick
2-14	Desire to obtain SUD/MH treatment and obtainment of SUD treatment in the past three months
Research Question 2.2: Does Behavioral Health Reform reduce the number of beneficiaries who experience or are exposed to adverse events?	
2-15	Percentage of mothers who reported that during the past 12 months, their husband or partner pushed, hit, slapped, kicked, choked, or physically hurt them in any other way
2-16	Percentage of mothers who reported that in the past 12 months, their husband or partner threatened them, limited their activities against their will, or made them feel unsafe in any other way
2-17	Percentage of respondents whose child lived with someone who had a problem with alcohol or drugs
2-18	Percentage of respondents whose child lived with someone who was mentally ill, suicidal, or severely depressed
2-19	Percentage of respondents whose child witnessed violence or physical abuse between household beneficiaries

Hypothesis 2: Beneficiaries receiving BH services will experience maintained or improve health and well-being outcomes.	
2-20	Percentage of respondents who reported that their child saw or heard parents or adults slap, hit, kick, or punch one another in the home
2-21	Maltreatment types among victims
2-22	Caregiver risk factors among child victims
2-23	Maternal use of marijuana or cannabis in any form
2-24	Frequency of maternal marijuana or cannabis use in the past 30 days
Research Question 2.3: Does Behavioral Health Reform decrease the rate of drug overdoses and overdose deaths due to opioids?	
2-25	Rate of overdose deaths, specifically overdose deaths due to any opioid
2-26	Non-fatal overdoses (all cause)
2-27	Use of opioids at high dosage in persons without cancer
2-28	Use of opioids from multiple providers
2-29	Risk of continued opioid use

Note: BH: behavioral health; OB/GYN: obstetrician/gynecologist; PCP: primary care physician; MH: mental health; SUD: substance use disorder

Hypothesis 3 seeks to measure the cost-effectiveness of Behavioral Health Reform. The measures and research questions associated with Hypothesis 3 are presented in Table 2-4.

Table 2-4—Hypothesis 3 Research Questions and Measures

Hypothesis 3: Behavioral Health Reform will maintain or reduce the cost of Medicaid for Alaska and the federal government.	
Research Question 3.1: Does Behavioral Health Reform maintain or reduce Alaska's per capita Medicaid BH costs?	
3-1	Total costs of healthcare (sum of parts below), by State and federal share
3-2	Total cost of SUD, SUD-IMD, and SUD-Other, and Non-SUD, by setting, including claims data (IP, OP, Rx, LTC)
3-3	Total cost of MH diagnosis by IMD and Other, by setting, including claims data (IP, OP, Rx, LTC)

Note: IMD: Institutions for Mental Diseases; IP: inpatient; LTC: long term care; MH: mental health; OP: outpatient; Rx: prescription medicine; SUD: substance use disorder

3. Methodology

To assess the impact of Alaska's Section 1115 Demonstration Waiver, Behavioral Health Reform, a comparison of outcomes between the intervention group and a valid counterfactual—the intervention group had they 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 comparison group, which would serve as the counterfactual.[3-1] The use of random assignment is limited in healthcare evaluations because it is often infeasible and unethical to provide treatment to an intervention group and deny treatment to those assigned to the comparison group.

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 using at least one of these methodologies. The selected methodology depends on data availability factors relating to: (1) data to measure the outcomes, (2) data for a valid comparison group, and (3) data during the time periods of interest—typically defined as the year prior to implementation and annually thereafter. Table 3-1 illustrates a sampling of standard analytic approaches 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—Sampling of Analytic Approaches

Analytic Approach	Baseline Data	Comparison Group	Allows Causal Inference	Notes
Difference-in-Differences	✓	✓	✓	Trends in outcomes should be similar between comparison and intervention groups at baseline.
Interrupted Time Series	✓		✓	Requires sufficient data points prior to and following implementation.
Pre-Test/Post-Test	✓			

Evaluation Design Summary

Summary of Approach

The SUD-BH Program targeted three populations, beginning in January 2019, and did not undergo substantive changes upon renewal, known as Behavioral Health Reform, in March 2024.[3-2, 3-3] A comprehensive evaluation of

3-1 Contreary K, Bradley K, Chao S. Best Practices in Causal Inference for Evaluations of Section 1115 Eligibility and Coverage Demonstrations. *Mathematica Policy Research*. June 2018. Available at: Best Practices in Causal Inference for Evaluations of Section 1115 Eligibility and Coverage Demonstrations (hhs.gov). Accessed on: Aug 7, 2024.

3-2 Centers for Medicare & Medicaid Services. CMS Approval Substance Use Disorder Treatment and Alaska Behavioral Health Program. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ak/behavioral-health/ak-behavioral-health-demo-no-imp-plan-20190321.pdf. Accessed on: Aug 21, 2024.

3-3 Centers for Medicare & Medicaid Services. CMS Approval Behavioral Health Reform. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ak-behavioral-health-refm-aprvl-03262024.pdf. Accessed on: Aug 21, 2024.

the SUD-BH Program and its impacts among substance use disorder (SUD) and behavioral health (BH) care and outcomes was conducted in the Interim Evaluation Report and will be conducted in the forthcoming Summative Evaluation Report for the January 2019 through March 2024 time period. As such, the evaluation of the renewal will primarily seek to determine whether Behavioral Health Reform, previously known as the SUD-BH Program, goals continue to show promising results during the renewal period. The independent evaluator has made adjustments to further refine the intervention populations and to provide national comparisons when data are available. Quantitative methods will include a pre-test and post-test approach, showing change over time in both counts and rates for specific metrics, or interrupted time series (ITS) analysis to assess whether the Behavioral Health Reform affected changes across specific outcome measures. Beneficiary survey results will be analyzed using a pre-test/post-test approach to assess changes in beneficiaries' rating of their personal doctor and overall healthcare as well as knowledge of available services before and after the renewal of the demonstration. The independent evaluator will use national surveys to construct a difference-in-differences (DiD) or synthetic controls analysis between Alaska and national respondents to compare changes in BH and exposure to adverse events. The independent evaluator may use additional data models to properly identify and control for heterogeneity in outcomes. Non-inferiority testing will determine if Behavioral Health Reform is performing as well or better than the counterfactual group for measures where the hypothesis is framed as maintaining, improving, or reducing. Where data is available, a health equity analyses will compare the relative performance of subgroups to a reference group. The results of these analyses may better inform the ability of members to access care and care outcomes across demographic groups. Finally, the independent evaluator will complete a qualitative component of Behavioral Health Reform to obtain the perspectives of providers, tribal health organizations' (THOs), and State administrators' perspectives regarding the renewal of the Behavioral Health Reform demonstration.

Intervention and Comparison Populations

Behavioral Health Reform targets three groups of Medicaid recipients:

- **Group 1**: Children, adolescents, and their parents or caretakers with or at risk of mental health (MH)[3-4] disorders and SUDs
- **Group 2**: Transitional age youth and adults with acute MH needs
- **Group 3**: Adults, adolescents, and children with SUDs

Since, Behavioral Health Reform covers a majority of Medicaid beneficiaries with SUD or MH diagnoses, the viability of an in-state comparison group is limited. For example, beneficiaries enrolled in Behavioral Health Reform may be fundamentally different from those in the general Medicaid population. The theoretical in-state comparison group may consist of beneficiaries who do not have an SUD or MH diagnosis, which would make these beneficiaries have vastly different health needs and outcomes than the intervention population. It is possible that these groups could serve as a comparison group with a risk-adjustment algorithm applied; however, this approach is unlikely to sufficiently adjust for the substantial differences across subpopulations to produce accurate and reliable results. Since Alaska does not have an all-payer claims database, it is not possible to identify and use an in-state low-income non-Medicaid population as a comparison group.

[3-4] In this evaluation, BH refers to both SUD and MH services, while 'SUD' and 'MH' refer specifically to their respective services.

To evaluate of survey measures in hypotheses 1 and 2, the independent evaluator will compare survey data from Alaskan residents with those nationally. This comparison group will help identify potential program impacts related to SUD, MH, or exposure to adverse events. However, one caveat to the potential survey data sources is that only Behavioral Risk Factor Surveillance System (BRFSS) data includes a mechanism to identify Medicaid recipients. As such, the intervention populations of these surveys will reflect Alaska as a whole, rather than Behavioral Health Reform alone.

Evaluation Periods

Table 3-2 presents the baseline and evaluation periods for Behavioral Health Reform. The Mid-Point Assessment (MPA) is distinct from the Interim and Summative Evaluation Reports. For the MPA, the independent evaluator will work with the Department of Behavioral Health (DBH) to present monitoring metrics data and feedback from key stakeholders, rather than completing a comprehensive evaluation, as described in this Evaluation Design.[3-5] Although Behavioral Health Reform is a renewal of the SUD-BH Program, the baseline period will only cover two years prior to the implementation of the renewal demonstration to allow for an isolated evaluation of the renewal's impact on SUD/MH outcomes in the State. The baseline and evaluation periods will be utilized for all measures where data is available. When appropriate, rates calculated for the SUD-BH Program evaluation reports will be leveraged to provide additional context.

Table 3-2—Evaluation Periods

Deliverable	Baseline Period	Evaluation Period
Mid-Point Assessment	March 26, 2022–March 25, 2024	March 26, 2024–April 30, 2026
Interim Evaluation Report	March 26, 2022–March 25, 2024	March 26, 2024–December 31, 2026
Summative Evaluation Report	March 26, 2022–March 25, 2024	March 26, 2024–December 31, 2028

Evaluation Measures

Table 3-3 presents the evaluation measures along with the respective comparison groups, data sources, and analytic approaches. Please see Appendix A for full measure specifications.

[3-5] Centers for Medicare and Medicaid Services. *Mid-Point Assessment Technical Assistance*. Available at: https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/1115-sud-smised-mid-point-assessment-ta.pdf. Accessed on: Aug 20, 2024.

Table 3-3—Evaluation Measures

Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach	Frequency	Stratification
Hypothesis 1: Behavioral Health Reform will maintain or increase the identification of and access to SUD and MH disorder treatment services by increasing access to community-based care.					
Research Question 1.1: Does Behavioral Health Reform increase the number of beneficiaries in the waiver population who are screened, referred to, and engaged in treatment for SUD and MH disorders?					
1-1: Number of beneficiaries screened for symptoms of SUD using industry-recognized, evidence-based screening instruments	• N/A	• State eligibility and enrollment data • Claims/encounter data	• Pre-test/post-test	• Annually	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs
1-2: Number of beneficiaries screened for symptoms of MH disorders using industry-recognized, evidence-based screening instruments	• N/A	• State eligibility and enrollment data • Claims/encounter data	• Pre-test/post-test	• Annually	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs
1-3: Number of beneficiaries in the waiver population with a SUD or MH diagnosis, by setting	• N/A	• State eligibility and enrollment data • Claims/encounter data	• Pre-test/post-test	• Annually	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs
1-4: Number of child beneficiaries who are taking medication for ADD/ADHD, ASD, difficulties with emotions, concentration, or behavior	• National benchmarks	• National Survey of Children's Health	• Pre-test/post-test • DiD	• Annually	• N/A

Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach	Frequency	Stratification
1-5: Percentage of beneficiaries who had initiation of SUD treatment	• N/A	• State eligibility and enrollment data • Claims/encounter data	• Pre-test/post-test • ITS	• Annually/ Monthly	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs
1-6: Percentage of beneficiaries who had engagement of SUD treatment	• N/A	• State eligibility and enrollment data • Claims/encounter data	• Pre-test/post-test • ITS	• Annually/ Monthly	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs
1-7: Follow-up after discharge within 7-days and 30-days from ED visits for SUD, and specifically for OUD	• N/A	• State eligibility and enrollment data • Claims/encounter data	• Pre-test/post-test • ITS	• Annually/ Monthly	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs
1-8: Follow-up after discharge within 7-days and 30-days from ED visits for a MH disorder	• N/A	• State eligibility and enrollment data • Claims/encounter data	• Pre-test/post-test • ITS	• Annually/ Monthly	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs

Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach	Frequency	Stratification
1-9: Number of Medicaid qualified SUD providers (identified by provider ID numbers) who bill for SUD services	• N/A	• Provider data • Claims/encounter data	• Pre-test/post-test	• Annually	• N/A
1-10: Number of Medicaid qualified professionals licensed in the State to provide MH who bill for MH disorder services	• N/A	• Provider data • Claims/encounter data	• Pre-test/post-test	• Annually	• N/A
1-11: Number of respondents who received substance use treatment	• Synthetic control group • State/National rates	• NSDUH	• Pre-test/post-test • DiD • Synthetic controls	• Annually	• N/A
1-12: Number of respondents who were classified as needing substance use treatment	• Synthetic control group • State/National rates	• NSDUH	• Pre-test/post-test • DiD • Synthetic controls	• Annually	• N/A
1-13: Number of respondents who received MH treatment	• Synthetic control group • State/National rates	• NSDUH	• Pre-test/post-test • DiD • Synthetic controls	• Annually	• N/A
Research Question 1.2: Does Behavioral Health Reform mitigate barriers to maintaining and providing SUD and MH resources?					
1-14: Providers' experience providing SUD and MH services	• N/A	• Key informant interviews	• Qualitative synthesis	• Two rounds (Interim and Summative)[1]	• N/A
1-15: Providers' reported barriers maintaining the integration of SUD and MH services	• N/A	• Key informant interviews	• Qualitative synthesis	• Two rounds (Interim and Summative)	• N/A
1-16: Provider's reported successes maintaining the integration of SUD and MH services	• N/A	• Key informant interviews	• Qualitative synthesis	• Two rounds (Interim and Summative)	• N/A
1-17: Providers' reported changes in the ability to provide care after DBH procurement of a BH organization	• N/A	• Key informant interviews	• Qualitative synthesis	• Two rounds (Interim and Summative)	• N/A

Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach	Frequency	Stratification
1-18: Administrators' reported barriers to maintaining SUD and MH services	• N/A	• Key informant interviews	• Qualitative synthesis	• Two rounds (Interim and Summative)	• N/A
1-19: Administrators' reported successes in maintaining SUD and MH services	• N/A	• Key informant interviews	• Qualitative synthesis	• Two rounds (Interim and Summative)	• N/A
1-20: Administrators' plan for program sustainability and anticipated challenges	• N/A	• Key informant interviews	• Qualitative synthesis	• Two rounds (Interim and Summative)	• N/A
1-21: Alaska tribal entities' reported continued changes in quality of care and access to care in providing SUD and MH services	• N/A	• Key informant interviews	• Qualitative synthesis	• Two rounds (Interim and Summative)	• N/A
Research Question 1.3: Does Behavioral Health Reform decrease utilization of ED, IP, or institutional settings within the beneficiary population?					
1-22: IP admissions for SUD, and specifically for OUD	• N/A	• State eligibility and enrollment data • Claims/encounter data	• Pre-test/post-test • ITS	• Annually/ Monthly	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs
1-23: IP admissions for MH disorders	• N/A	• State eligibility and enrollment data • Claims/encounter data	• Pre-test/post-test • ITS	• Annually/ Monthly	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs

Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach	Frequency	Stratification
1-24: ED visits for SUD	• N/A	• State eligibility and enrollment data • Claims/encounter data	• Pre-test/post-test • ITS	• Annually/ Monthly	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs
1-25: ED visits for OUD	• N/A	• State eligibility and enrollment data • Claims/encounter data	• Pre-test/post-test • ITS	• Annually/ Monthly	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs
1-26: Number of ED visits among beneficiaries who had at least one ED admission for SUD	• N/A	• State eligibility and enrollment data • Claims/encounter data	• Pre-test/post-test • ITS	• Annually/ Monthly	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs
1-27: Number of ED visits for SUD among high utilizing beneficiaries	• N/A	• State eligibility and enrollment data • Claims/encounter data	• Pre-test/post-test • ITS	• Annually/ Monthly	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs

Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach	Frequency	Stratification
1-28: ED visits for MH disorders	• N/A	• State eligibility and enrollment data • Claims/encounter data	• Pre-test/post-test • ITS	• Annually/ Monthly	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs
1-29: Number of ED visits among beneficiaries who had at least one ED admission for MH	• N/A	• State eligibility and enrollment data • Claims/encounter data	• Pre-test/post-test • ITS	• Annually/ Monthly	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs
1-30: Number of ED visits for MH among high utilizing beneficiaries	• N/A	• State eligibility and enrollment data • Claims/encounter data	• Pre-test/post-test • ITS	• Annually/ Monthly	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs
1-31: Mean length of stay among IMDs measured from admission date to discharge date	• N/A	• State eligibility and enrollment data • Claims/encounter data	• Pre-test/post-test	• Annually/ Monthly	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs

Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach	Frequency	Stratification
1-32: 30-day readmission rate to IP facilities following hospitalization for an SUD-related diagnosis	• N/A	• State eligibility and enrollment data • Claims/encounter data	• Pre-test/post-test	• Annually/ Monthly	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs
1-33: 30-day readmission rate to IP facilities following hospitalization for a MH-related diagnosis	• N/A	• State eligibility and enrollment data • Claims/encounter data	• Pre-test/post-test	• Annually/ Monthly	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs
Research Question 1.4: Does Behavioral Health Reform increase the percentage of beneficiaries who adhere to treatment for SUD and BH disorders?					
1-34: 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	• N/A	• State eligibility and enrollment data • Claims/encounter data	• Pre-test/post-test • ITS	• Annually/ Monthly	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs
1-35: Number of beneficiaries with a MH diagnosis who used services in the last month or year, by service or benefit type	• N/A	• State eligibility and enrollment data • Claims/encounter data	• Pre-test/post-test • ITS	• Annually/ Monthly	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs

Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach	Frequency	Stratification
1-36: Time to treatment among beneficiaries who access SUD treatment	• N/A	• State eligibility and enrollment data • Claims/encounter data	• Pre-test/post-test • ITS	• Annually/ Monthly	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs
Hypothesis 2: Beneficiaries receiving BH services will experience maintained or improve health and well-being outcomes.					
Research Question 2.1: Does Behavioral Health Reform increase the percentage of beneficiaries with an SUD or a MH disorder who experience care for comorbid conditions?					
2-1: Percentage of adults who accessed preventive/ambulatory health services	• N/A	• State eligibility and enrollment data • Claims/encounter data	• Pre-test/post-test	• Annually	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs
2-2: Percentage of beneficiaries 3–21 years of age with a well-care visit with a PCP or OB/GYN	• N/A	• State eligibility and enrollment data • Claims/encounter data	• Pre-test/post-test	• Annually	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs

Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach	Frequency	Stratification
2-3: Screening for chronic conditions relevant to State Medicaid population	• N/A	• State eligibility and enrollment data • Claims/encounter data	• Pre-test/post-test	• Annually	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs
2-4: Screening for co-morbidity of MH disorders and SUDs	• N/A	• State eligibility and enrollment data • Claims/encounter data	• Pre-test/post-test	• Annually	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs
2-5: Prevention Quality Chronic Composite	• N/A	• State eligibility and enrollment data • Claims/encounter data	• Pre-test/post-test	• Annually	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs
2-6: Pediatric Quality Chronic Composite	• N/A	• State eligibility and enrollment data • Claims/encounter data	• Pre-test/post-test	• Annually	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs

Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach	Frequency	Stratification
2-7: Percentage of beneficiaries who have a high rating of their healthcare quality (8, 9, or 10 on a scale of 0–10)	• National benchmarks	• Beneficiary survey	• Pre-test/post-test	• N/A	• Gender • Age • Race/ethnicity
2-8: Percentage of beneficiaries who rate their overall mental or emotional health as "very good" or "excellent"	• National benchmarks	• Beneficiary survey	• Pre-test/post-test	• N/A	• Gender • Age • Race/ethnicity
2-9: Percentage of beneficiaries who demonstrate "very good" or "excellent" knowledge of available SUD/MH treatment and services	• N/A	• Beneficiary survey	• Pre-test/post-test	• N/A	• Gender • Age • Race/ethnicity
2-10: Percentage of beneficiaries who are knowledgeable of the number of SUD and MH services available	• N/A	• Beneficiary survey	• Pre-test/post-test	• N/A	• Gender • Age • Race/ethnicity
2-11: Percentage of mothers who often or always felt depressed since their new baby was born	• Synthetic control group • State/National rates	• PRAMS	• Pre-test/post-test • DiD • Synthetic controls	• Annually	• N/A
2-12: Percentage of beneficiaries who indicated poor MH in the last 30 days	• Synthetic control group • State/National rates	• BRFSS	• Pre-test/post-test • DiD • Synthetic controls	• Annually	• N/A
2-13: Percentage of mothers who indicate that they have someone who would help them while sick	• N/A	• CUBS	• Pre-test/post-test	• Annually	• N/A
2-14: Desire to obtain SUD/MH treatment and obtainment of SUD/MH treatment in the past three months	• N/A	• CUBS	• Pre-test/post-test	• Annually	• N/A
Research Question 2.2: Does Behavioral Health Reform reduce the number of beneficiaries who experience or are exposed to adverse events?					
2-15: Percentage of mothers who reported that during the past 12 months, their husband or partner pushed, hit, slapped, kicked, choked, or physically hurt them in any other way	• Synthetic control group • State/National rates	• CUBS • PRAMS	• Pre-test/post-test • DiD • Synthetic controls	• Annually	• N/A

Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach	Frequency	Stratification
2-16: Percentage of mothers who reported that in the past 12 months, their husband or partner threatened them, limited their activities against their will, or made them feel unsafe in any other way	• Single state comparison: New York	• CUBS • PRAMS	• Pre-test/post-test • DiD	• Annually	• N/A
2-17: Percentage of respondents whose child lived with someone who had a problem with alcohol or drugs	• National benchmarks	• CUBS • National Survey of Children's Health	• Pre-test/post-test • DiD	• Annually	• N/A
2-18: Percentage of respondents whose child lived with someone who was mentally ill, suicidal, or severely depressed	• National benchmarks	• CUBS • National Survey of Children's Health	• Pre-test/post-test • DiD	• Annually	• N/A
2-19: Percentage of respondents whose child witnessed violence or physical abuse between household beneficiaries	• N/A	• CUBS	• Pre-test/post-test	• Annually	• N/A
2-20: Percentage of respondents who reported that their child saw or heard parents or adults slap, hit, kick, or punch one another in the home	• National benchmarks	• National Survey of Children's Health	• Pre-test/post-test • DiD	• Annually	• N/A
2-21: Maltreatment types among victims	• National benchmarks	• Children's Bureau	• Pre-test/post-test • DiD	• Annually	• N/A
2-22: Caregiver risk factors among child victims	• National benchmarks	• Children's Bureau	• Pre-test/post-test • DiD	• Annually	• N/A
2-23: Maternal use of marijuana or cannabis in any form	• Synthetic control group • State/National rates	• PRAMS	• Pre-test/post-test • DiD • Synthetic controls	• Annually	• N/A
2-24: Frequency of maternal marijuana or cannabis use in the past 30 days	• N/A	• CUBS	• Pre-test/post-test	• Annually	• N/A

Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach	Frequency	Stratification
Research Question 2.3: Does Behavioral Health Reform decrease the rate of drug overdoses and overdose deaths due to opioids?					
2-25: Rate of overdose deaths, specifically overdose deaths due to any opioid	• Synthetic control group • State/National rates	• State eligibility and enrollment data • Claims/encounter data • Vital Records • CDC WONDER	• Pre-test/post-test • DiD • Synthetic Controls	• Annually	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs
2-26: Non-fatal overdoses (all cause)	• N/A	• State eligibility and enrollment data • Claims/encounter data	• Pre-test/post-test	• Annually	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs
2-27: Use of opioids at high dosage in persons without cancer	• N/A	• State eligibility and enrollment data • Claims/encounter data	• Pre-test/post-test	• Annually	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs
2-28: Use of opioids from multiple providers	• N/A	• State eligibility and enrollment data • Claims/encounter data	• Pre-test/post-test	• Annually	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs

Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach	Frequency	Stratification
2-29: Risk of continued opioid use	• N/A	• State eligibility and enrollment data • Claims/encounter data	• Pre-test/post-test	• Annually	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs
Hypothesis 3: Behavioral Health Reform will maintain or reduce the cost of Medicaid for Alaska and the federal government.					
Research Question 3.1: Does Behavioral Health Reform maintain or reduce Alaska's per capita Medicaid BH costs?					
3-1: Total costs of healthcare (sum of parts below), by State and federal share	• N/A	• State eligibility and enrollment data • Claims/encounter data	• ITS	• Annually/ Monthly	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs
3-2: Total cost of SUD, SUD-IMD, and SUD-Other, and Non-SUD, by setting, including claims data (IP, OP, Rx, LTC)	• N/A	• State eligibility and enrollment data • Claims/encounter data	• ITS	• Annually/ Monthly	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs

Measure(s)	Comparison Group(s)	Data Source(s)	Analytic Approach	Frequency	Stratification
3-3: Total cost of MH diagnosis by IMD and Other, by setting, including claims data (IP, OP, Rx, LTC)	• N/A	• State eligibility and enrollment data • Claims/encounter data	• ITS	• Annually/ Monthly	• Gender • Age • Race/ethnicity • Geography • Criminal justice involvement • High-cost high needs

[1] For each of the key informant interviews, two rounds of interviews will take place to assess change in responses throughout key intervals of the evaluation period.
Note: ADD: attention deficit disorder; ADHD: attention deficit hyperactivity disorder; ASD: autism spectrum disorder; BRFSS: Behavioral Risk Factor Surveillance System; CDC: Centers for Disease Control; CUBS: Childhood Understanding Behaviors Survey; DBH: Department of Behavioral Health; DiD: difference-in-difference; ED: emergency department; ID: identification; IMD: Institutions for Mental Diseases; IP: inpatient; ITS: interrupted time series; LTC: long term care; MH: mental health; NQF: National Quality Forum; NSDUH: National Survey on Drug Use and Health; OB/GYN: obstetrician/gynecologist; OP: outpatient; OUD: opioid use disorder; PCP: primary care practitioner; PRAMS: Pregnancy Risk Assessment Monitoring System; Rx: medical prescription; SUD: substance use disorder; WONDER: Wide-ranging Online Data for Epidemiologist Research

Data Sources

Multiple data sources will be used to evaluate the eight research questions for the evaluation.

- Administrative Data
  - Medicaid claims and eligibility data
  - Provider enrollment data
  - Vital records
- National, State, and Beneficiary Surveys
  - Survey of Alaska Medicaid members
  - BRFSS data
  - Alaska Childhood Understanding Behaviors Survey (CUBS) data
  - National Survey of Children's Health
  - National Survey on Drug Use and Health (NSDUH) data
  - Pregnancy Risk Assessment Monitoring System (PRAMS) data
- Additional Data Sources
  - Centers for Disease Control and Prevention (CDC) Wide-Ranging Online Data for Epidemiologist Research (WONDER)
  - Children's Bureau
- Key Informant Interviews

Data will be 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)®[3-1] survey and will include additional questions customized to assess beneficiary knowledge of SUD and BH services in the State. Additional data will be collected from interviews with provider stakeholder, non-provider stakeholders, and THOs regarding interviewees' perspectives on the continuation of SUD and BH services, program sustainability, and program successes and challenges.

Administrative Data

Administrative data supplied by DBH will be utilized to calculate most measures identified in the evaluation design. 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 may be combined to provide the most complete picture of Alaska Medicaid claims possible.[3-2] For the Interim Evaluation Report, DBH supplied three primary data sources: data used for the legislative audit; quarterly data from the State's administrative services organization (ASO), Optum, and weekly financial data. Beginning on January 1, 2025, DBH will manage all in a single Medicaid Management Information System (MMIS) data source.

3-1 CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

3-2 Alaska Medicaid Section 1115 SUD Demonstration Status Report. 2020. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/state-annual-report-demostration-yr2-deliverable.pdf. Accessed on: Jul 31, 2024.

Administrative data will be cleaned, validated, and transformed to be suitable for each analysis. The exact data validation processes will vary across the specific data sources to be used for the evaluation, depending on the nature of the data being evaluated as well as the analysis for which the data are being prepared. Data quality will be assessed through:

- **Completeness**: The completeness of data is assessed through the degree to which required fields or measures are fully populated with data. Data that are reported as Not Available or Not Reportable may be considered complete depending on the specific nature of the data fields.
- **Validity**: The validity of data sets is assessed through the degree to which data are clinically and mathematically within required constraints. Data fields will be verified to ensure they are within an appropriate and credible range through a comparison of values to valid value tables as well as national and regional averages as appropriate to the data field.
- **Reliability**: The reliability of the data is assessed through the degree to which equivalent fields in different data sets contain the same information. This will involve performing cross-field checks, ensuring that data fields and data sets contain similar values where appropriate.
- **Comprehensiveness**: The comprehensiveness of data sets is assessed through the degree to which required fields or measures are present in the data. When required measures or data are not present, additional data may be requested.

National and Beneficiary Surveys

Beneficiary Surveys

State beneficiary surveys will be used to assess beneficiaries' ability to obtain timely appointments, satisfaction and experience with healthcare, and perception that their personal doctor seemed informed about the care they received from other providers. CAHPS surveys are often used to assess satisfaction with provided healthcare services and are adapted to elicit information addressing the research hypotheses related to beneficiaries' continuity of healthcare coverage, and overall health status and utilization. Results will be compared against national benchmarks where available. The survey sampling frame will be identified through eligibility and enrollment data, with specific enrollment requirements being finalized upon inspection of the data. Typically, beneficiaries are drawn from those enrolled continuously during the last six months of the measurement period, with no more than a one-month gap in enrollment.

To the extent possible, the independent evaluator will align multiple surveys to be conducted concurrently to increase response rates across all programs with overlapping populations. A range of sampling protocols will be considered including simple random samples; stratified random samples; multistage stratifications (i.e., cluster); and targeted oversamples.

The State and its independent evaluator will seek to streamline survey administration to minimize the number of separate survey rounds required, thereby minimizing the burden on beneficiaries and maximizing the response rate. Due to Alaska's frontier geography and seasonal factors, a telephone survey will be completed in May and June 2026 and 2028, to maximize the response rate.[3-3,3-4] The sampling strategy described above may be revised

[3-3] Bradburn NM, Sudman, S, Wansink B. *Asking Questions: The Definitive Guide to Questionnaire Design*. San Francisco, CA, Jossey-Bass; 2004.

[3-4] Tourangeau, R, Rips, LJ, Rasinski, K. *The Psychology of Survey Response*. New York: Cambridge University Press; 2000.

based on enrollment. Two survey instruments will utilize questions from CAHPS surveys and will include additional questions customized to assess beneficiary knowledge of SUD and BH services within the State. The expected sample will provide sufficient statistical power to detect a difference in a rate of at least 10.2 percentage points with 95 percent confidence and 80 percent power. Assuming a response rate of approximately 15 percent with a 10 percent oversample, the maximum number of surveys to be sent is 2,500.

BRFSS

The independent evaluator will utilize the BRFSS as an out-of-state comparison group using member-level data if data are available and complete enough to support rigorous statistical testing of outcomes. BRFSS is a health-focused telephone survey developed by the Centers for Disease Control and Prevention (CDC) that collects data from approximately 400,000 adults annually across all 50 states, Washington D.C., and three territories.[3-5] The questionnaire generally consists of two components: a core component and an optional component. Beneficiary surveys will be used to assess Measure 2-8 (*Percentage of beneficiaries who rate their overall mental or emotional health as "very good" or "excellent"*) among the Waiver population; however, Measure 2-12 (*Percentage of beneficiaries who indicated poor mental health in the last 30 days*) will allow the independent evaluator to benchmark rates of Alaska Medicaid members against statewide and national rates from the BRFSS core module. The Medicaid coverage indicator from the optional/core (depending on the year) Healthcare Access module may be used to identify responses among individuals similar to Alaska Medicaid members. However, fewer than a dozen states included the optional Healthcare Access module in a given year historically, which may limit the availability and selection of potential benchmark states. This survey is further limited by the inability to identify Waiver-specific beneficiaries, meaning that the rate for the entire Medicaid population will be reported. For these measures, BRFSS results from other states will be used as a benchmark to provide context and triangulate findings to other states' Medicaid populations. Contingent on the availability of data, respondents to the BRFSS survey from all other states may serve as a comparison group to Waiver members.

To provide an understanding of the capabilities of the data for performing statistical analyses, the independent evaluator will calculate the statistical power associated with any out-of-state comparison group data and report the results.

CUBS

Data from the CUBS instrument will be 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 PRAMS of mothers who completed PRAMS and are still living in Alaska. The independent evaluator will request to obtain anonymized beneficiary-level information using current and prior survey phases, as data are available, and questionnaires are consistent. Due to periodic changes in the survey instrument, some survey items will be added, removed, or the language will be substantively revised, which limits the ability to assess these items for the full time frame.[3-6] An advantage of the CUBS survey is that it includes an indicator for Medicaid coverage, which allows the independent evaluator to limit survey results to the Medicaid population, if the sample size is large enough to produce reliable estimates.

3-5 Centers for Disease Control and Prevention. About BRFSS. Available at: https://www.cdc.gov/brfss/about/index.htm. Accessed on: Aug 21, 2024.

3-6 Alaska Department of Health. Alaska Childhood Understanding Behaviors Survey (CUBS). Available at: https://health.alaska.gov/dph/wcfh/Pages/mchepi/cubs/default.aspx; Accessed on: Aug 21, 2024.

Some CUBS survey measures included in the evaluation design indicate that PRAMS or the National Survey of Children's Health (NSCH) data will also be utilized. In these instances, PRAMS or NSCH data will be preferred; however, due to lags in reporting or the availability of optional modules, CUBS data may be used if national data sources are not available.

NSCH

The NSCH produces data relating to children who are exposed to adverse events, such as drug abuse or domestic violence. This survey will provide insight into the change in rates of adverse events among Alaska children as well as provide national rates as a comparison.

NSDUH

The NSDUH surveys individuals regarding drug use and treatment among adults nationally. Data from this survey will be used to identify rates of substance use disorder treatment by treatment setting among Alaska respondents and those nationally, where other state-level data are available.

PRAMS

Data from the PRAMS instrument will be utilized to assess depression, domestic violence, and drug use among new mothers in Alaska. The survey is administered through the CDC and allows for the identification of Alaska residents as well as comparisons to national rates. The independent evaluator will work with the State to obtain anonymized beneficiary-level information for Alaska and obtain beneficiary-level information for other states, if feasible. Although the independent evaluator will work to develop state or national comparison groups using the PRAMS data, this effort may be limited by the extensive process required to request PRAMS data for multiple states.

Additional Data Sources

CDC WONDER

In the event that vital records data from ADOH is not available, or in the case that the independent evaluator wants to compare results among Alaska residents to those nationally, data from CDC Wonder may be used. CDC Wonder provides county and state-level data on overdose mortality. This data will be used to support the calculation of Measure 2-25, *Rate of overdose deaths, specifically overdose deaths due to any opioid* by identifying overdose deaths overall, and those attributable to opioids.

Children's Bureau

The Children's Bureau, acting under the authority of the Department of Health and Human Services (HHS), develops annual child maltreatment reports, which include state-level data on the types of maltreatment perpetrated against child victims and the risk factors among primary caregivers of child victims. These data may be available in an individual-level file; however, due to the sensitivity of the information and the inability to link children to Medicaid members, the aggregate rates included in the annual maltreatment reports will likely be utilized.

Vital Records

Vital Records data from Alaska Department of Health (ADOH) will be used to calculate Measure 2-25 *Rate of overdose deaths, specifically overdose deaths due to any opioid* by identifying overdose deaths overall, and those attributable to opioids.

Key Informant Interviews

Key informant interviews will be conducted with State administrators, providers, THOs, and consumer advocates to add depth to the quantitative results and to gather information that would otherwise be unavailable through administrative data.[3-7,3-8, 3-9] Specifically, data will be collected from interviews with provider stakeholders, non-provider stakeholders, and THOs regarding interviewees' perspectives on the continuation of SUD and BH services, program sustainability, and program successes and challenges. Key informant interviews will be conducted using a semi-structured interview protocol to allow informants the ability to provide open-ended feedback on Behavioral Health Reform.[3-10] Key informant interviews will be transcribed and imported into MAXQDA where the data will be coded to permit qualitative analysis. The transcripts, coding methodologies, and coded data will be used to answer the appropriate Hypotheses.

Analytic Methods

DiD

A DiD analysis will be performed on all non-claims based measures for which a suitable comparison group can be identified. The analysis will compare rates to the weighted national average of participating states to rates among Alaska beneficiaries. Further, rates will be compared to national rates and the rates of eligible beneficiaries who are not participating in Behavioral Health Reform, where possible. For example, this analysis may be utilized to compare Medicaid beneficiaries to the statewide average or to make comparisons among Medicaid beneficiaries. This approach will compare the changes in outcome rates between the baseline period and the evaluation period, across the intervention and comparison groups. For the DiD analysis to be valid, the comparison group must accurately represent the change in outcomes that would have been experienced by the intervention group in the absence of the program. The DiD analysis will be conducted with beneficiary-level rates, using a logistic regression model for measures with binary outcomes.

The logistic regression form of the DiD model is:

$$\ln\left(\frac{Y_{it}}{1-Y_{it}}\right) = \beta_0 + \beta_1 T + \beta_2\, post + \beta_3(post \times T) + \gamma \mathrm{D'}_{it} + \varepsilon$$

3-7 Neuman WL. *Social Research Methods: Qualitative and Quantitative Approaches.* 7th ed. Edinburgh Gate: Pearson Education Limited. 2014.

3-8 Bradley K, Heeringa J, Pohl V, et al. Selecting the Best Comparison Group and Evaluation Design: A Guidance Document for State Section 1115 Demonstration Evaluations. *Centers for Medicare & Medicaid Services* and *Mathematica Policy Research.* 2020.

3-9 Creswell JW, Creswell JD. *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*. 5th ed. Thousand Oaks, CA: SAGE; 2018.

3-10 Ibid.

where Y is the probability of an outcome for group *i* in year *t*, *T* is a binary indicator of the intervention group, *post* is a binary indicator for the evaluation period, the vector D' represents any observed confounding variables that may account for differences between the intervention and comparison groups (described in additional detail below), γ is a coefficient vector, and ε is an error term. The intercept β_0 represents the log-odds of an outcome for the comparison group during the baseline. The coefficient β_1 identifies the average difference in the log-odds of an outcome between the groups during the baseline period prior to Waiver implementation. The time period dummy coefficient β_2 captures the change in the log-odds of an outcome between the baseline and evaluation time periods for the non-intervention group. The coefficient on the interaction term β_3 represents the DiD estimate of interest in this evaluation. In other words, it is how the log-odds of an outcome for the intervention group is changed in the implementation period compared to the pre-implementation period.

The DiD approach will be used where possible, as it controls for any factors external to the program that are applied equally to both groups. When data from 2020–2021 are utilized, controls for the coronavirus disease 2019 (COVID-19) public health emergency (PHE) will be utilized. However, the method is still susceptible to external factors that may have differentially impacted one group and not the other. If sufficient pre-intervention data are available, it is possible to test whether external factors are applied equally to the intervention and comparison groups by visually verifying that both groups exhibit parallel trends in the baseline period. In the absence of treatment, the intervention and comparison groups used in DiD should experience similar changes, manifested as parallel lines during the baseline period. If the parallel trend assumption does not hold, the two-period DiD may still be useful as data during the baseline and evaluation periods will be aggregated into a single pre-intervention and post-intervention average, respectively. Furthermore, the proposed DiD model estimates a single average treatment effect, under the assumption that any heterogeneity in the treatment effect is due to random variation. This assumption is explicit in the model set-up as the DiD treatment effect is represented by a single coefficient (β_3), and therefore any heterogeneity in treatment effects between individuals cannot be modeled. The independent evaluator recognizes the limitations of this approach and will therefore consider estimating additional models such as panel data models, fixed and random effects models, or hierarchical models. Results from adjusted models will be presented and interpreted, keeping in mind the limitations of each approach. Sensitivity testing will allow the independent evaluator to better estimate program impacts by assessing a variety of logistic regression specifications, including control variables as needed to improve the model fit or assess changes in key variables of interest.

If a valid comparison group cannot be constructed, the most rigorous method supported by the data will be utilized.

ITS

When a suitable comparison group cannot be found and data can be collected at multiple points in time before and after the implementation of the program, an ITS methodology can be used. This analysis is quasi-experimental in design and will compare a trend in outcomes between the baseline period and the evaluation period for those who were subject to the program.

In ITS, the measurements taken before a demonstration was initiated are used to predict the outcome if the demonstration did not occur. The measurements collected after the demonstration are then compared to the predicted outcome to evaluate the impact the demonstration had on the outcome.

The ITS model is:

$$Y_t = \beta_0 + \beta_1\, time + \beta_2\, post + \beta_3\, time \times post + \gamma \mathbf{D'}_{it} + \mu_t$$

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, $time \times post$ is the linear time trend variable for the post-implementation time period, the matrix **D'** represents any observed confounding variables that may account for differences between the intervention and comparison groups, and γ is a coefficient vector. For ITS analyses utilizing aggregate-level data, confounding variables will take the form of average values in the population, such as average age, average risk score, or percent female. For analysis utilizing individual-level data, control variables may include age, sex, race/ethnicity, county of residence, Chronic Illness and Disability Payment System (CDPS) risk score, dual eligibility status, or duration of Medicaid enrollment. The intercept, 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 change in the outcome when the program began, β_3 is the change in the slope for the measurements after the program, and μ_t is the error term.

Comparative ITS may be used to assess measures where there are sufficient pre-implementation data points and a valid comparison group. This analysis will be estimated using linear regression modeling of the following comparative ITS equation:

$$Y_t = \beta_0 + \beta_1 T + \beta_2 X_t + \beta_3 T X_t + \beta_4 Z + \beta_5 ZT + \beta_6 Z X_t + \beta_7 Z X_t T + \varepsilon$$

Where *Y* is the measure rate, *T* is time, *X* is study phase (pre- or post-interruption), *XT* is time after interruption, *Z* is treatment or control, *ZT* is time for treatment, *ZX* is study phase for treatment, and *ZXT* is time after interruption for treatment.

Assuming that the measurements taken after the implementation of Behavioral Health Reform would have been equal to the expectation predicted from the measurements taken before Behavioral Health Reform in the absence of the intervention, any changes in the observed rates after implementation can be attributed to the program. However, as the ITS approach relies on a pre- and post-period, it is unable to differentiate between mechanisms that may have impacted observed changes; it is possible that external events could have occurred simultaneously with Behavioral Health Reform and influenced the outcomes of interest. When data from 2020–2021 are utilized, the independent evaluator will rely on best practices to mitigate the potentially confounding effect of simultaneously occurring confounding events such as the coronavirus 2019 (COVID-19) public health emergency (PHE) as well as post-PHE Medicaid "unwinding" by including the use of dummy variables for each time period. In the context of SUD/MH services, the COVID-19 PHE made access to care more difficult due to the strain on the SUD/MH system. Specifically, MH and substance use disorders worsened during this time period due to increased isolation, depression, and anxiety.[3-11] The increased need of SUD/MH services coupled with physical distancing measures, complicated treatment delivery. To account for the impact of the COVID-19 PHE, ITS models will incorporate dummy variables to adjust for the confounding effects if sufficient data are available. An indicator variable for quarter 2 (Q2) 2020 will represent the initial wave of the COVID-19 PHE-related shutdowns and stay-at-home orders, and a separate indicator variable for Q3 2020 through the end of Q1 2021 will reflect subsequent Alaska-specific public health orders. For measures calculated annually, an indicator variable for 2020 will be included in the model to adjust for the COVID-19 PHE. As Behavioral Health Reform overlaps with the COVID-19 PHE as well as post-PHE Medicaid "unwinding," the independent evaluator will explore how the results change when excluding the years most impacted by these external events, or when estimating program effects separately by each year, rather than aggregating baseline years and evaluation years. A

[3-11] Lin, C., Clingan, S., Valdez, J., Mooney, L., and Hser, Y. (2022). The impact of COIVD-19 on substance use disorder treatment in California: Service providers' perspectives. *Journal of Substance Abuse Treatment*, 133:108544. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8702565/. Accessed on September 9, 2024.

similar approach will be taken to account for the "unwinding" period during which the authorized Medicaid continuous enrollment condition ended and Alaska's Department of Health (DOH) began redeterminations of eligibility. Furthermore, the independent evaluator will consider several sensitivity analyses to test the robustness of the main model results. These tests may include modifying regression specifications and control variables to better estimate program impact and/or assess the degree to which findings materially change given alternative specifications. One example of sensitivity testing is the inclusion and specification of COVID-19 controls, where applicable. The most appropriate controls for each analysis utilizing an ITS approach will be identified.

A second assumption of the proposed ITS model is that the expected mean of the error term is zero; however, if current observations are correlated with prior observations, this regression assumption would be violated. The independent evaluator will test this assumption by examining error autocorrelation; if subsequent error terms are highly correlated, then parameter estimates and variance obtained from the model may be biased, resulting in misleading conclusions. During analyses, the independent evaluator will take steps to test for autocorrelation and assess the model fit. If the model is a poor fit for the data, additional procedures will be explored such as transforming the model to remove autocorrelation or estimating an autoregressive model.

A limitation of ITS is the need for sufficient data points both before and after program implementation.[3-12, 3-13, 3-14] To facilitate this methodology, the independent evaluator may consider additional baseline data points using prior year calculations, and/or calculating quarterly rates where feasible, if multiple years both pre- and post-implementation are available to control for seasonality.

Synthetic Controls

The synthetic control method will compare changes in outcome rates between the baseline and evaluation periods for both the intervention and synthetic comparison group. This method allows the independent evaluator to construct a comparison group from states with similar pre-implementation outcomes that did not implement similar policies during the post-implementation period. States are selected as "donors" based on their observed outcomes and are assigned weights according to how closely their pre-implementation outcomes align with those of the intervention state.

The form of the synthetic control model is:

$$\hat{\tau}_{1t} = Y_{1t} - \sum_{j=2}^{J+1} w_j * Y_{jt}$$

Where $\hat{\tau}_{1t}$ represents the difference between the estimate of outcome on the treated unit and the synthetic unit at year *t*. Y_{jt} represents the outcome for the intervention state *j* at in year *t*. The model then estimates the outcome for

3-12 Baicker K, Svoronos, T, (2019) Testing the Validity of the Single ITS Design. *NBER Working Paper 26080.* Available at: https://www.nber.org/papers/w26080.pdf. Accessed on: Aug 21, 2024.

3-13 Bernal JL, Cummins S, Gasparrini A. (2017) Interrupted time series regression for the evaluation of public health interventions: a tutorial. *International Journal of Epidemiology,* 46(1): 348-355. Available at: https://doi.org/10.1093/ije/dyw098. Accessed on: Aug 21, 2024.

3-14 Penfold RB, Zhang F. (2013) Use of Interrupted Time Series Analysis in Evaluating Health Care Quality Improvements. *Academic Pediatrics*, 13(6): S38 - S44. Available at: https://doi.org/10.1016/j.acap.2013.08.002. Accessed on: Aug 21, 2024.

"donor" states in the analysis, represented as the sum of $J + 1$, assuming j=1 represents the intervention state. The weight for "donor" state j is then multiplied by the outcome for the "donor" state at year t.[3-15]

This model requires that donor states did not implement a similar intervention and that there is sufficient pre-implementation data to construct a reliable counterfactual. However, meeting this assumption may be challenging, as other states with a relatively high prevalence of SUD, MH disorders, or other outcomes of interest, such as opioid deaths, may also enact a SUD/MH Medicaid waiver or other similar policies to increase identification of and access to treatment services. Additionally, for measures that rely on survey data, survey instruments can change over time and may not always be comparable with prior years. This may limit the pre and post implementation data that can be included in the analysis, and therefore, the viability of the synthetic control method. To further refine the synthetic control model, the independent evaluator may conduct sensitivity analyses to identify and include appropriate control variables.

The synthetic control method may be used on measures that utilize national survey data and Measure 2-25 *Rate of overdose deaths, specifically overdose deaths due to any opioid*, to compare the rate of overdoses among Alaska residents to those included in the synthetic control group.

To develop a control that reflects Alaska's trend prior to the implementation of Behavioral Health Reform, the independent evaluator will select and weigh "donor" states that closely align with pre-implementation outcomes for the state of Alaska. These states will be weighted based on observed characteristics such as rates of substance use and BH disorders, demographic composition, and the absence of similar policies during the post-implementation period.

Pre-test/post-test

For measures with consistent specifications over time for which national or regional benchmarks are not available, and which have too few observations to support an ITS analysis, rates will be calculated and compared both before and after waiver renewal.[3-16] Statistical testing will be conducted through a Chi-square analysis. A Chi-square test allows for comparison between two groups that have a categorical outcome, such as survey results or numerator compliance, to determine if the observed counts differ from the expectation. Specifically, comparisons will be 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. For measures that utilized pre/post-testing, a weighted average of the evaluation period is also presented and represents a pooled average of the numerator and denominator counts across all three evaluation years.

3-15 Abadie, A, (2021). Using Synthetic Controls: Feasibility, Data Requirements, and Methodological Aspects. *Journal of Economic Literature*, 59(2), 391-425. Available at: Using Synthetic Controls: Feasibility, Data Requirements, and Methodological Aspects (aeaweb.org). Accessed on Aug 20, 2024.

3-16 Because measures are calculated on an annual reporting period, the post-implementation period during the current demonstration approval period of three years is insufficient to support an ITS analysis.

Binomial logistic regression may be utilized to evaluate measures that are binary outcomes or presented as rates. Due to limited options for comparison groups, 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. When possible, control variables will be utilized to better isolate program impact. These variables may include controls for confounding events, such as the COVID-19 PHE.

Non-Inferiority Testing

To support testing of hypotheses that suggest program impacts will "maintain or improve" or "maintain or reduce," the independent evaluator may consider employing noninferiority statistical testing. Specifically, this approach can be utilized for measures that employ a pre-test/post-test, ITS, or DiD framework.

For measures that include a pre/post or ITS framework, non-inferiority testing can be performed to determine whether measure rates in the evaluation period were meaningfully different from rates in the baseline period (i.e., to statistically test whether rates were "the same or better" than baseline rates). Non-inferiority testing allows for an assessment of meaningful difference in rates by comparing the change in rates between the baseline and evaluation period to a predetermined threshold. This threshold represents the greatest difference between the baseline and evaluation period that can exist while still being considered "equivalent." Specifically, the predetermined threshold (δ) will be calculated using the following variation of the Cohen's *h* equation:

$$\delta = P_2 - \sin\left(\frac{2 * \arcsin(\sqrt{P_2}) \pm h}{2}\right)^2$$

Where P_2 is the baseline average rate and *h* is the chosen Cohen's *h* effect size. While an effect size of 0.20 has commonly been deemed to represent a "small" effect as originally suggested by Cohen, Cohen writes, "the terms 'small,' 'medium,' and 'large' are relative, not only to each other, but to the area of behavioral science or even more particularly to the specific content and research method being employed in any given investigation" (p. 25).[3-17] Because the application of effect size in this context is to identify a minimum acceptable difference between proportions while still considering them "equal" for practical purposes, a stricter threshold than what may be typically used is appropriate. Therefore, δ for each measure was calculated based off Cohen's *h* of 0.05 (differences between proportions).

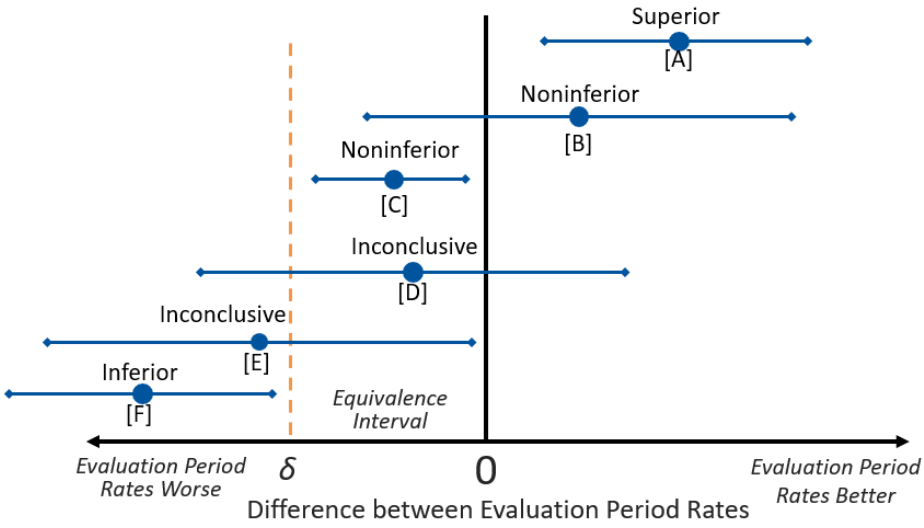
Statistical testing will be conducted by assessing whether the observed difference between the average baseline and evaluation period rates is different from δ. The calculated change in rate threshold will be compared to the 95 percent confidence intervals (CI) from performed pre-test/post-test results to determine whether rates were meaningfully different in the demonstration period.

Non-inferiority testing characterizes results in one of four ways as shown in Figure 3-1: superior, non-inferior, inconclusive, or inferior. Superior results [A] indicate the CI from the pre-test/post-test is entirely above both the predefined threshold value and zero (i.e., the pre-test/post-test is found to be statistically significant). Non-inferior findings [B/C] indicate that while results from statistical testing may be inconclusive or significantly worsening, non-inferiority testing shows any worsening in rates are not practically/clinically significant and therefore can be characterized as being not inferior to baseline rates. Inconclusive findings [D/E] occur when the 95 percent CI

[3-17] Cohen, J. (1988). Statistical Power Analysis for the Behavioral Sciences.

captures the non-inferiority threshold value. Inferior results [F] indicate the CI from the pre-test/post-test is entirely below the predefined threshold value. Figure 3-1 presents both the technical terms and the simplified terms utilized to interpret non-inferiority findings. The results utilize the simplified terms for ease of interpretability.

Figure 3-1—Non-Inferiority Testing



For measures that use a DiD framework and are hypothesized to perform at least as well as or better than a comparison group, a prespecified fraction (δ) of the change in the comparison group (coefficient on time, β_2) is used to define an "equivalence range" which would conclude that the treatment group performed as well as the comparison group. The equivalence range is bounded by the change in rates for the comparison group, plus or minus 10 percent of the change in the comparison group. The change in the treatment group will be compared against this equivalence range using a 95 percent confidence interval. Figure 3-2 illustrates how the equivalence window will be calculated and how statistical significance will be determined.

Figure 3-2—Illustration of Non-Equivalence Testing Procedure

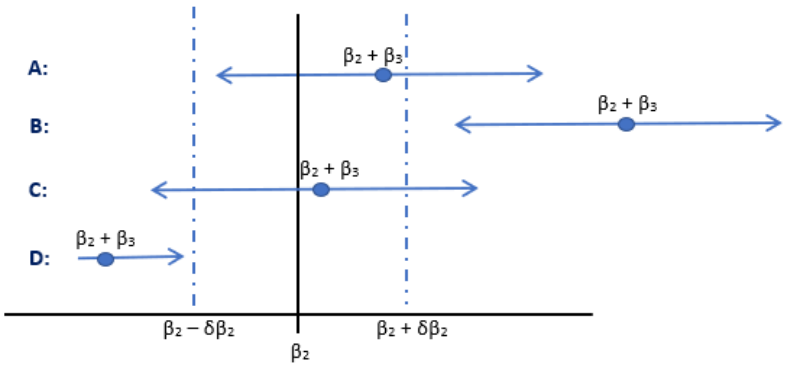


Table 3-4 defines the equivalence intervals used for each scenario in Figure 3-2.

Table 3-4—Noninferiority Equivalence Intervals

Desired Direction	Equivalence Interval	Noninferiority Threshold
Higher is better and $\beta_2 > 0$ OR Lower is better and $\beta_2 < 0$	$(\beta_2 - \delta\beta_2)$ to β_2	$(\beta_2 - \delta\beta_2)$
Lower is better and $\beta_2 > 0$ OR Higher is better and $\beta_2 < 0$	β_2 to $(\beta_2 + \delta\beta_2)$	$(\beta_2 + \delta\beta_2)$

In Figure 3-2, given a measure in which higher is better, the confidence interval in Scenario A, denoted by the arrows, includes β_2 but not the noninferiority threshold, $(\beta_2 - \delta\beta_2)$. Therefore, evidence supports the finding that the treatment group is not inferior to the comparison group. The confidence interval in Scenario B is above β_2, which suggests that the treatment group is superior to the comparison group. The confidence interval in scenario C spans both β_2 and $(\beta_2 - \delta\beta_2)$. Therefore, there is insufficient evidence to establish noninferiority and the results are inconclusive. The confidence interval in Scenario D falls below the noninferiority threshold $(\beta_2 - \delta\beta_2)$ and supports the finding that the treatment group is inferior to the comparison group.

Health Equity Analysis

To provide a more comprehensive view of the difference in rates among demographic groups, a health equity analysis will be conducted. A detailed assessment of changes in health disparities across time will be the primary analytic approach for assessing health equity. Outcome measures for relevant demographic subgroups (e.g., age, sex, race, ethnicity, etc.) will be compared to a reference group and assessed for statistically significant differences as well as clinically meaningful differences in relative percentages and effect sizes. Statistical significance will be calculated through a two-tailed t-test among the reference and comparison groups, while clinically meaningful outcomes will be assessed through effect sizes and relative percentage differences between the groups of interest.

Cohen's *h* or Hedge's *g* will be utilized to determine the effect size between comparison and reference group rates. Effect sizes can fall into small, medium, or large categories.[3-18] This method is applicable to measures where the rate is bounded between 0 and 1.

The formula for Cohen's *h* is given by:

$$h = \left(2 * arcsin\sqrt{P_1}\right) - \left(2 * arcsin\sqrt{P_2}\right)$$

Where P_1 is the annual rate for the comparison group and P_2 is the annual rate for the reference group. The effect size will be displayed with shaded boxes indicating the magnitude and direction of the results.

The formula for Hedge's *g* is given by:

[3-18] Cohen, J. Statistical Power Analysis for the Behavioral Sciences, 2nd Ed. Hillsdale, N.J.: L. Erlbaum Associates; 1988:25

$$g = \frac{\bar{y}_1 - \bar{y}_2}{s_p}$$

$$s_p = \sqrt{\frac{(n_1 - 1)s_1^2 + (n_2 - 1)s_2^2}{(n_1 - 1) + (n_2 - 1)}}$$

Where g represents the effect size between two group means, calculated as the mean of the comparison and reference group, $\bar{y}_1$ and $\bar{y}_2$, respectively, divided by the pooled standard deviation, s_p.[3-19]

For measures where the rates are not bounded between 0 and 1, the relative percent difference between each demographic stratification and the appropriate reference category will be calculated. The relative percent difference is calculated by subtracting the reference group rate from the comparison group rate and then dividing by the reference group rate. The relative percent difference will be displayed using arrows indicating the magnitude and direction of the results.

For each measure that supports a health equity analysis approach, the rates will be compared across reference and comparison demographic groups where data are available, accurate, and relevant. The independent evaluator may limit reporting to groups that have either statistically significant or clinically meaningful differences. At the time of writing this Evaluation Design it is anticipated that demographic data will be available for the following: gender, age, race, ethnicity, and geography. The independent evaluator will work with the DBH to develop a method to identify and report results by criminal justice involvement and high-cost high needs.[3-20] The measure specifications identify the demographic stratification groups for each measure, based on the anticipated available demographic data fields. Subgroup analyses will be conducted to assess program impacts by each demographic group. This allows the independent evaluator to take an exploratory approach in identifying disparities.

In accordance with the Centers for Medicare & Medicaid Services (CMS) suppression guidance, rates with a numerator or denominator greater than 1, but less than 10 will be suppressed due to potentially unreliable rate calculation and to ensure anonymity.[3-21] Furthermore, rates may be suppressed in accordance with the Healthcare Effectiveness Data and Information Set (HEDIS) general guidelines, which requires rates with denominator counts less than 30 to be suppressed to ensure reliability of reporting.[5-22] The most stringent suppression method will be used when suppressing each rate. Sample sizes will reflect the denominator counts for each subgroup by measure. The feasibility of reporting each subgroup will be dependent on numerator and denominator counts meeting suppression criteria and overall sample size.

3-19 National Institute of Standards and Technology. Available at: https://www.itl.nist.gov/div898/software/dataplot/refman2/auxillar/hedgeg.htm#:~:text=Description%3A%20The%20Hedge's%20g%20statistic,the%20pooled%20standard%20deviation%2C%20respectively. Accessed on Sept 9, 2024.

3-20 DBH and the State's criminal justice system operate as distinct entities, which complicates data-sharing to identify Behavioral Health Reform beneficiaries who are also involved with the criminal justice system.

3-21 U.S. Department of Health & Human Services. CMS Cell Suppression Policy. Available at: https://www.hhs.gov/guidance/document/cms-cell-suppression-policy. Accessed on Nov 15, 2024.

5-22 HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Comparison to National Benchmarks

To provide additional context around rates and changes in rates due to Behavioral Health Reform, the independent evaluator will compare post-implementation rates with both historical rates prior to the program and against national benchmarks without necessarily conducting formal statistical testing (e.g., DiD or pre-test/post-test approaches). By combining reference points from historical rates with contemporaneous national benchmarks, rates calculated for Behavioral Health Reform can be reported in the context of historical Alaska-specific performance in addition to performance nationally, thus triangulating an impact of Behavioral Health Reform on outcomes. Although statistical testing through a DiD or pre-test/post-test approach would be preferable, these comparisons may be necessary if the level of data for the comparison group is not granular enough to support such statistical testing.

Qualitative Synthesis

To evaluate the successes, challenges, unintended consequences, and changes to the quality of and access to care, a series of semi-structured key informant interviews with representatives of DOH, providers, and THOs will be conducted to obtain qualitative results. A qualitative synthesis will be utilized to evaluate Behavioral Health Reform.

An informative sample of key informant interviewees will be recruited from nominees identified by DBH. Interviews will invite input from appropriate individuals identified by DBH as having experience and subject matter expertise regarding the development and implementation of SUD and MH services. Each of these individuals will be requested to participate in a 60-minute interview session to provide insights into Behavioral Health Reform. Respondents from DOH, providers, and THOs will provide coverage for a comprehensive assessment across all the stakeholders involved in the planning and implementation of Behavioral Health Reform. The interviews will be conducted in two waves, in state fiscal year (SFY) 2027 and SFY 2029. 15 providers, seven State administrators, and 12 THOs will be interviewed in each wave. The number of interviews conducted is subject to change based on the saturation of feedback obtained during the interim evaluation. These proposed numbers are based on past evaluations conducted. For the second wave of interviews, the independent evaluator will attempt to re-interview the same person. If the same providers are unavailable, the independent evaluator will seek to interview another provider from the same facility or providers from a similar facility. Interviews with State administrators will cover the same administrative roles in the two waves, recognizing that these roles may or may not be filled by the same individuals.

A flexible protocol will be developed for semi-structured interviews with a sample of subjects with knowledge of the specific strategies developed and implemented as a result of Behavioral Health Reform, as well as the successes and barriers encountered during the implementation of SUD and MH services. Interview questions will be developed to seek information about stakeholders' experiences with the implementation of Behavioral Health Reform, including:

- Providers' reported successes and barriers to maintaining the integration of SUD and MH services.
- Administrators' reported successes and barriers to maintaining SUD and MH services.
- THOs' reported continued changes in quality of care and access to care in providing SUD and MH services.

Early interviews will inform the development and choice of topics and help inform the selection of additional interview subjects to round out the list of individuals to be interviewed for this project. Open-ended questions will be used to maximize the diversity and richness of responses and ensure a more holistic understanding of the

subject's experience. Probing follow-up questions will be used as appropriate to elicit additional detail and understanding of critical points, terminology, and perspectives. The sessions will be recorded and transcribed with participant consent.

The information obtained from these interviews will be synthesized with the results from other quantitative data analyses providing an in-depth discussion of each of the domains/objectives to be considered. As the key informant interviews are being conducted, the independent evaluator will perform ongoing and iterative review of the interview responses and notes to identify overall themes and common response patterns. Unique responses that are substantively interesting and informative will also be noted and may be used to develop probing questions for future interviews. The results of these preliminary analyses will be used to document the emergent and overarching themes related to each hypothesis. The documentation of emergent themes will be reviewed iteratively to determine if responses to interview questions are continuing to provide new perspectives and answers, or if the responses are converging on a common set of response patterns indicating saturation on a particular interview question. As additional interview data are collected, the categories, themes, and relationships will be adjusted to reflect the broader set of concepts and different types of relationships identified. The documentation of emergent themes will also be used as an initial starting point for organizing the analysis of the interview data once all interviews are completed.

Following the completion of the key informant interviews, the interview notes and transcripts will be reviewed using standard qualitative analysis techniques. The data will first be examined through open coding to identify key concepts and themes that may not have been captured as emergent themes during previous analyses. After identifying key concepts, axial coding techniques will be used to develop a more complete understanding of the relationships among categories identified by respondents in the data. The result of the open and axial coding analysis will be an account of the scope of issues raised by respondents, and a synthesis of how those concepts are related as presented in the participants' own words and experiences. This thematic coding process will ensure a thorough qualitative analysis with direct links to respondents' exact responses. The open and axial coding will be performed with a focus on identifying the dimensionality and breadth of responses to the hypothesis posed for the overall project. The open and axial coding will aim to identify additional themes and develop a more complete understanding of the themes and relationships among categories identified by respondents. Interviewee responses will be identified through the analysis to illustrate and contextualize the conclusions drawn from the research and will be used to support the development of the final report. The responses to questions related to mitigating barriers to maintaining and providing SUD and MH resources will be used to add context to the quantitative findings regarding those subjects. Opinions identifying opportunities for improving the efficacy of the Behavioral Health Reform more effective in increasing access and quality will inform the *Lessons Learned and Recommendations* chapter in the evaluation reports.

Cost Effectiveness Analysis

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

Behavioral Health Reform is adapted from CMS' guidance for assessing the costs of SUD or serious mental illness (SMI) evaluations.[3-23]

Cost of care for Behavioral Health Reform beneficiaries based on FFS reimbursement amounts will be calculated for each beneficiary in each month. To identify the source of treatment cost drivers for beneficiaries, total costs will be stratified by the categories of service presented in Table 3-5 for SUD and MH beneficiaries, SUD only beneficiaries, and MH only beneficiaries. Data will be aggregated across all beneficiaries to calculate per-member per-month (PMPM) costs for each month of Behavioral Health Reform and 24 months prior.[3-24] ITS analyses will be conducted for total cost of care, as well as for each of the three levels of cost stratification mentioned above. This method will project the costs incurred by the Behavioral Health Reform population during the baseline period, prior to Behavioral Health Reform, and during the evaluation period. The projected costs will represent a counterfactual estimate of the costs of the Behavioral Health Reform population during the evaluation period as if Behavioral Health Reform had never been renewed. Thus, the method will compare the actual costs of the Behavioral Health Reform population in the evaluation period to the projected counterfactual costs of this population in the evaluation period. Seasonality indicators and variables indicating time periods affected by the COVID-19 PHE and post-pandemic Medicaid "unwinding" will be included in the model to control for these factors.

Table 3-5—Categories of Service

SUD and MH Beneficiaries	• Total • IP • OP (ED and Non-ED) • LTC	• Professional • Dental • Pharmacy
SUD Only Beneficiaries	• SUD IMD • SUD Other	• Non-SUD
MH Only Beneficiaries	• MH IMD • MH Other	• Non-MH

Note: ED: emergency department; IMD: Institutions for Mental Disease; IP: inpatient; LTC: long-term care; MH: mental health; OP: outpatient; SUD: substance use disorder

As Behavioral Health Reform will provide additional coverage and services to beneficiaries, it is possible that initial costs will increase. The independent evaluator will also review the overall cost-effectiveness of the program, contrasting and comparing any additional costs incurred through the program to observed benefits of the program. The cost-effectiveness analysis will not involve a direct comparison of costs and savings as benefits of the program may be non-pecuniary in nature, such as provision of new services that previously were unavailable, increased employment opportunities leading to improved financial well-being, lower mortality rates, and

3-23 United States Department of Health and Human 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.hhs.gov/guidance/document/appendix-c-analyzing-costs-associated-demonstrations-smised-or-sud-0. Accessed on: Aug 21, 2024.

3-24 CMS guidance describes constructing an ITS with member-level controls. However, due to a low prevalence of costs for most beneficiaries—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.

improved health outcomes overall. Furthermore, benefits may manifest over the long term and may not be measurable at the time of the evaluation.

When appropriate, supplemental analyses will also be conducted to assess issues that emerge during the course of the evaluation period and respond to stakeholder queries and quality improvement needs.

Disentangling Confounding Events

It is possible that co-interventions or other events coinciding with 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. These effects may include policy changes at the State or federal level or changes to the substance use or the MH system. Known confounding effects will be controlled for using appropriate methods during the analysis of the demonstration.

4. Methodological Limitations

Despite the planned rigor of the evaluation, several limitations may impact the ability of the evaluation to attribute changes in performance metrics to the Behavioral Health Reform Section 1115 Demonstration Waiver.

Data Source Limitations

During the prior evaluation, claims data were provided through multiple avenues and did not always include consistent data. Beginning in January 2025, Alaska will enter into an agreement with a new claims vendor who will report all claims in a single data source. This change to administrative claims data may come with challenges for standardizing the data across prior years but will assist in the consolidation of data sources. The weekly financial claims data provided for the previous demonstration's Interim Evaluation Report did not include the data elements necessary for measure calculation. Nearly 20 percent of the Optum substance use disorder (SUD) claims were missing, resulting in issues with referential integrity between the Optum and weekly financial files. The independent evaluator will work with the Department of Behavioral Health (DBH) to validate data quality, including determining the frequency and accuracy of required fields (i.e., diagnosis code or member identification number). The independent evaluator and DBH will resolve discrepancies and report limitations in the data when applicable.

Another limitation is the use of claims data to identify screening among Behavioral Health Reform beneficiaries. Screening data may be difficult to identify in claims due to low reporting among providers. As such, the rates identified through screening may not be an accurate representation of program performance. When these limitations are present, the independent evaluator will describe them in the results.

Analytic Methods Limitations

No in-state comparison groups are available for claims-based measures because the renewal demonstration, Behavioral Health Reform, was implemented for all targeted beneficiaries in the State simultaneously and will continue to operate for all Alaska beneficiaries diagnosed with an SUD or mental health (MH) disorder.[4-1] Alaska does not operate an all-payer claims database, which eliminates the possibility of comparing Medicaid beneficiaries to other low-income beneficiaries in the State who were ineligible for Medicaid. Additionally, data from another state with similar population characteristics and Medicaid policies and procedures in place is unlikely to be available due limitations in interstate data sharing.[4-2] While Transformed Medicaid Statistical Information System (T-MSIS) data from the Centers for Medicare & Medicaid Services (CMS) has been suggested to create a viable comparison group, use of these data were not feasible at the time of this evaluation design. T-MSIS data may become available for use in forming a counterfactual comparison group for the waiver population by the time the Interim Evaluation Reports or the Summative Evaluation Report are developed. Therefore, the counterfactual comparison identified is the comparison of measure rates across the baseline and evaluation periods. For many measures, only a pre-post comparison of outcomes prior to the renewal of the

[4-1] In this evaluation, BH refers to both SUD and MH services, while 'SUD' and 'MH' refer specifically to their respective services.

[4-2] HSAG has approached other states regarding mutual data exchanges for the purposes of Section 1115 Waiver evaluations. No state has expressed interest in any such arrangement.

Behavioral Health Reform to outcomes post-demonstration implementation will be possible. However, a pre-post comparison of rates does not allow for causal inference of program effects.

Where sufficient data points are available, the independent evaluator will utilize an interrupted times series (ITS) analysis to make comparisons while accounting for underlying seasonal trends in the outcome. The results will indicate whether the measure rates increased or decreased, and whether the results represented statistically significant changes in performance. Furthermore, it is possible that co-interventions or other events coinciding with the demonstration may have confounded measure rates; as such, a comparison of rates during the baseline period to rates during the evaluation period would not be able to disentangle those effects from demonstration effects.

Comparisons to similarly situated out-of-state beneficiaries will be identified through national surveys. These national surveys include the Behavioral Risk Factor Surveillance System (BRFSS), National Survey of Drug Use and Health (NSDUH), Pregnancy Risk Assessment Monitoring System (PRAMS), and the National Survey of Children's Health (NSCH). A drawback of these surveys is that the instruments can change over time, which can complicate comparisons across years and there may be significant delays in data availability. Additionally, receiving beneficiary-level data for all states may not be feasible. The independent evaluator will present results from these surveys when the data are consistent. Furthermore, for all national data sources other than BRFSS, there is no mechanism to identify Medicaid-specific populations; therefore, the statewide rate for Alaska will be presented. BRFSS results will be limited to Medicaid respondents if the sample size is large enough for accurate reporting and if sufficient comparison states include the survey question. All surveys will be reported in the context that data collection is reliant on self-reported responses, therefore, the data derived from surveys may not always be accurate. Finally, for survey measures to utilize a synthetic control method, sufficient pre-implementation time periods must be available, and the independent evaluator must be able to identify comparison states that have similar pre-implementation outcomes, but do not implement a similar policy in the post-implementation period. Another limitation pertains to the health equity analysis. The independent evaluator recognizes that health equity is a complex subject, with significant ongoing discussions in the broader scientific community about how to measure it effectively. Since no single approach to evaluating health equity is without limitations, this evaluation utilizes multiple methods to address health equity. The proposed analysis is designed to provide an overview of changes in health disparities during the Behavioral Health Reform study period. However, it acknowledges the primary limitation that any observed changes in disparities cannot be causally attributed to the Behavioral Health Reform, as external factors may also impact the outcomes.

Finally, the evaluation of the Behavioral Health Reform is also limited by the relatively short time frame available to assess the program's long-term impact. For example, the ability of beneficiaries to access needed care may lead to health improvements in future years and tangential outcomes such as improvements in education, housing, employment, and involvement with the criminal justice system.[4-3] Although some outcomes, such as a reduction in emergency department visits, may experience an immediate decline, outcomes related to treatment adherence, SUD/MH-related health outcomes, and declines in mortality may not be evident until decade(s) later. For example, individuals with cirrhosis have been found to experience a higher likelihood of survival upon abstinence from alcohol, when compared to their counterparts who did not abstain. These outcomes may not be present for years after exposure to Behavioral Health Reform, complicating the ability to track and attribute these successes

[4-3] Berk LE. *Development Through the Lifespan*. 7th Ed. Hoboken, NJ: Pearson; 2018.

to the demonstration.[4-4] Additionally, a study conducted by Substance Abuse and Mental Health Services (SAMSHA) found that, on average, it takes nine years from the first treatment before individuals experience a full year of abstinence from substance use, which may indicate that active engagement in a SUD program may take years to achieve the desired outcome.[4-5] This further limits the ability to capture improvements in treatment adherence and health outcomes. While the renewal extends the evaluation period by five years, some outcomes may actualize on a longer time frame or may fall outside of the scope of this demonstration. To address these limitations, the independent evaluator will leverage quantitative and qualitative methods to assess changes in outcomes during the evaluation period.

4-4 Vuittonet CL, Halse M, Leggio L, Fricchione SB, Brickley M, Haass-Koffler CL, Tavares T, Swift RM, Kenna GA. (2014). Pharmacotherapy for alcoholic patients with alcoholic liver disease. *Am J Health Syst Pharm* 71(15):1265-76. Available at: 10.2146/ajhp140028. PMID: 25027533; PMCID: PMC4170837. Accessed on: Sep 6, 2024.

4-5 Beaulieu, M., Tremblay, J., Baudry, C., Pearson, J., and Bertrand, K. (2021). A systematic review and meta-analysis of the efficacy of the long-term treatment and support of substance use disorders. *Social Science and Medicine* (285): 114289. A systematic review and meta-analysis of the efficacy of the long-term treatment and support of substance use disorders - ScienceDirect. Accessed on: Sep 5, 2024.

Appendix A. Attachments

Independent Evaluator

The Department of Behavioral Health (DBH) will select an independent evaluator with experience and expertise to conduct a scientifically and rigorous Medicaid Section 1115 waiver evaluation that meets all the requirements specified in the Special Terms and Conditions (STCs).[A-1] The independent evaluator will be required to have the following qualifications:

- Knowledge of public health programs and policy
- Experience in healthcare research and evaluation
- Understanding of Alaska's programs and populations
- Expertise with conducting complex program evaluations
- Relevant work experience
- Skills in data management and analytic capacity
- Medicaid experience and technical knowledge

Based on State protocols, DBH will follow established policies and procedures to acquire an independent entity or entities to conduct the waiver evaluation. In addition, DBH will ensure that the selected independent evaluator does not have any conflicts of interest and will require the independent evaluator to sign a "No Conflict of Interest" statement.

Evaluation Budget

Table A-1 presents the cost estimate for the evaluation of the Behavioral Health Reform.

Table A-1—Evaluation Budget

Task	SFY26	SFY27	SFY28	SFY29	SFY30	SFY31	Total
Project Management (Semi-Annual Progress Reports)	$ 18,911	$ 20,046	$ 21,248	$ 22,523	$ 23,875	$ 11,777	**$ 118,380**
Key Informant Interviews (Instrument, Administration, Analysis)	$ 34,665	$ 36,742	$ -	$ 41,394	$ -	$ -	**$ 112,801**
Beneficiary Surveys (Instrument, Administration, Analysis)	$ 32,329	$ 25,652	$ -	$ 35,000	$ 30,552	$ -	**$ 123,533**
Mid-Point Assessment, Draft	$ -	$ 68,572	$ -	$ -	$ -	$ -	**$ 68,572**
Mid-Point Assessment, Final	$ -	$ 25,040	$ -	$ -	$ -	$ -	**$ 25,040**
Interim Evaluation Report, Draft	$ 23,505	$ 87,311	$ 80,009	$ -	$ -	$ -	**$ 190,825**
Interim Evaluation Report, Final	$ -	$ -	$ 54,116	$ -	$ -	$ -	**$ 54,116**
Summative Evaluation Report, Draft	$ -	$ -	$ -	$ 102,163	$ 104,757	$ -	**$ 206,920**
Summative Evaluation Report, Final	$ -	$ -	$ -	$ -	$ -	$ 69,071	**$ 69,071**
Total	**$ 109,410**	**$ 263,363**	**$ 155,373**	**$ 201,080**	**$ 159,184**	**$ 80,848**	**$ 969,258**

A-1 Centers for Medicare & Medicaid Services. Special Terms and Conditions. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ak-behavioral-health-refm-aprvl-03262024.pdf. Accessed on: Aug 21, 2024.

Timeline and Major Milestones

Table A-2 is the proposed evaluation timeline for the Behavioral Health Reform Demonstration Waiver. This timeline is preliminary and subject to change based on approval of the Evaluation Design.

Table A-2—Evaluation Timeline

Task	SFY2025		SFY2026				SFY2027				SFY2028				SFY2029				SFY2030	
	CY2025			CY2026				CY2027				CY2028				CY2029				CY2030	
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Prepare and Implement Study Design																					
Conduct kick-off meeting																					
Prepare workplan																					
Data Collection																					
Obtain claims/encounters																					
Obtain member, provider, and eligibility/enrollment data																					
Obtain financial data																					
Perform gap analysis and other data quality checks																					
Conduct Analysis																					
Key Informant Interviews																					
Develop protocols																					
Conduct interviews																					
Conduct analyses																					
Non-Survey Analyses																					
Prepare and calculate metrics																					
Conduct statistical testing and comparison																					
Survey Analyses																					
Develop survey instrument																					
Field survey																					
Conduct survey analyses																					
Reporting																					
Draft Mid-Point Assessment																					
Final Mid-Point Assessment																					
Draft Interim Evaluation Report																					
Final Interim Evaluation Report																					
Draft Summative Evaluation Report																					
Final Summative Evaluation Report																					

Note: CY: calendar year; SFY: state fiscal year; Q: quarter

Proposed Measure Specifications

The tables in this section provide the detailed measure specifications for the Behavioral Health Reform evaluation.

Hypothesis 1: Behavioral Health Reform will maintain or increase the identification of and access to substance use disorder (SUD) and mental health (MH) disorder treatment services by increasing access to community-based care.

Research Question 1.1: Does Behavioral Health Reform increase the number of beneficiaries in the waiver population who are screened, referred to, and engaged in treatment for SUD and MH disorders?

Number of beneficiaries screened for symptoms of SUD using industry-recognized, evidence-based screening instruments (Measure 1-1)	
Numerator/Denominator	Numerator: Number of waiver recipients screened for symptoms of SUD Denominator: Number of waiver recipients
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs

Number of beneficiaries screened for symptoms of SUD using industry-recognized, evidence-based screening instruments (Measure 1-1)	
Measure Steward	N/A
Measure Name	N/A
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	Higher is better
Analytic Approach	Pre-test/post-test
Frequency	Annual

Number of beneficiaries screened for symptoms of MH disorders using industry recognized, evidence-based screening instruments (Measure 1-2)	
Numerator/Denominator	Numerator: Number of waiver recipients screened for symptoms of MH disorders Denominator: Number of waiver recipients
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs
Measure Steward	N/A
Measure Name	N/A
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	Higher is better
Analytic Approach	Pre-test/post-test
Frequency	Annual

Number of beneficiaries in the waiver population with a SUD or BM diagnosis, by setting (Measure 1-3)	
Numerator/Denominator	Numerator: Number of waiver recipients diagnosed with a SUD or MH disorder, stratified by the following settings for SUD: Any setting, Early Intervention, Outpatient, Intensive Inpatient, Residential and Inpatient. Stratified by the following settings for MH: Any setting, IOP or PH, IP, OP, ED, Telehealth. Denominator: Number of waiver recipients
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs
Measure Steward	N/A
Measure Name	N/A
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No desired direction
Analytic Approach	Pre-test/post-test
Frequency	Annual

Number of child beneficiaries who are taking medication for ADD/ADHD, ASD, difficulties with emotions, concentration, or behavior (Measure 1-4)	
Numerator/Denominator	Numerator: Number of respondents indicating that they are taking medication for ADD/ADHD, ASD, difficulties with emotions, concentration, or behavior Denominator: Number of respondents to the survey age 3-17 years old
Comparison Population	National/state rates
Stratification	N/A
Measure Steward	National Survey of Children's Health
Measure Name	N/A
Data Source	National Survey of Children's Health
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Pre-test/post-test • DiD • Synthetic Controls
Frequency	Annual

Percentage of beneficiaries who had initiation of SUD treatment (Measure 1-5)	
Numerator/Denominator	Numerator: Number of waiver recipients in the denominator who had initiation of SUD treatment within 14 days of the index episode. Stratified by: Alcohol, Opioid, Other Denominator: Number of waiver recipients aged 13 and over during the measurement year with an SUD diagnosis and 194 days continuous enrollment prior to the episode and 47 days after the index episode.
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs
Measure Steward	CMS Adult Core Set
Measure Name	IET
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Percentage of beneficiaries who had engagement of SUD treatment (Measure 1-6)	
Numerator/Denominator	Numerator: Number of waiver recipients in the denominator who had initiation of SUD treatment within 14 days of the index episode and two or more engagement episodes within 34 days of the initiation episode. Stratified by: Alcohol, Opioid, Other Denominator: Number of waiver recipients aged 13 and over during the measurement year with an SUD diagnosis and 194 days continuous enrollment prior to the episode and 47 days after the index episode
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs

Percentage of beneficiaries who had engagement of SUD treatment (Measure 1-6)	
Measure Steward	CMS Adult Core Set
Measure Name	IET
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Follow-up after discharge within 7-days and 30-days from ED visits for SUD, and specifically for OUD (Measure 1-7)	
Numerator/Denominator	Numerator: Number of ED visits in the denominator with a follow-up visit for SUD. Rates are reported for follow-up visits within 7 and 30 days of the ED visit. Denominator: Number of ED visits for waiver recipients 18 years of age and older with a principal diagnosis of SUD and were continuously enrolled from the date of the ED visit through 30 days after the ED visit
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs
Measure Steward	CMS Adult Core Set
Measure Name	FUA-AD
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Follow-up after discharge within 7-days and 30-days from ED visits for a MH disorder (Measure 1-8)	
Numerator/Denominator	Numerator: Number of ED visits in the denominator with a follow-up visit for mental illness. Rates are reported for follow-up visits within 7 and 30 days of an ED visit for mental illness. Denominator: Number of ED visits for waiver recipients 18 years of age and older with a principal diagnosis of mental illness or intentional self-harm with continuous enrollment from the date of the ED visit through 30 days after the ED visit
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs
Measure Steward	CMS Adult Core Set
Measure Name	FUM-AD
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No change or an increase in the rate supports the hypothesis

Follow-up after discharge within 7-days and 30-days from ED visits for a MH disorder (Measure 1-8)	
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Number of Medicaid qualified SUD providers (identified by provider ID numbers) who bill for SUD services (Measure 1-9)	
Numerator/Denominator	Numerator: Number of providers billing for SUD services, stratified by region Denominator: N/A
Comparison Population	N/A
Stratification	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	• Provider data • Claims/encounter data
Desired Direction	Higher is better
Analytic Approach	Pre-test/post-test
Frequency	Annual

Number of Medicaid qualified professionals licensed in the State to provide MH who bill for MH disorder services (Measure 1-10)	
Numerator/Denominator	Numerator: Number of providers billing for MH services, stratified by region Denominator: N/A
Comparison Population	N/A
Stratification	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	• Provider data • Claims/encounter data
Desired Direction	Higher is better
Analytic Approach	Pre-test/post-test
Frequency	Annual

Number of respondents who received substance use treatment (Measure 1-11)	
Numerator/Denominator	Numerator: Number of respondents who indicated that they received substance use treatment Denominator: Number of respondents to the survey
Comparison Population	• State/National rates • Synthetic control group
Stratification	N/A
Measure Steward	NSDUH
Measure Name	N/A

Number of respondents who received substance use treatment (Measure 1-11)	
Data Source	National Survey on Drug Use and Health (NSDUH)
Desired Direction	No desired direction
Analytic Approach	• Pre-test/post-test • DiD • Synthetic Controls
Frequency	Annual

Number of respondents who were classified as needing substance use treatment (Measure 1-12)	
Numerator/Denominator	Numerator: Number of respondents that indicated that they needed substance use treatment if they met Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5) criteria for a drug or alcohol use disorder or received treatment for a drug or alcohol use Denominator: Number of respondents to the survey
Comparison Population	• State/National rates • Synthetic control group
Stratification	N/A
Measure Steward	NSDUH
Measure Name	N/A
Data Source	National Survey on Drug Use and Health (NSDUH)
Desired Direction	No desired direction
Analytic Approach	• Pre-test/post-test • DiD • Synthetic Controls
Frequency	Annual

Number of respondents who received mental health treatment (Measure 1-13)	
Numerator/Denominator	Numerator: Number of respondents who indicated that they received mental health treatment Denominator: Number of respondents to the survey
Comparison Population	• State/National rates • Synthetic control group
Stratification	N/A
Measure Steward	NSDUH
Measure Name	N/A
Data Source	National Survey on Drug Use and Health (NSDUH)
Desired Direction	No desired direction
Analytic Approach	• Pre-test/post-test • DiD • Synthetic Controls
Frequency	Annual

Research Question 1.2: Does Behavioral Health Reform mitigate barriers to maintaining and providing SUD and BH resources?

Providers' experience providing SUD and MH services (Measure 1-14)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Stratification	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Key informant interviews
Desired Direction	N/A
Analytic Approach	Qualitative Synthesis
Frequency	Two rounds (Interim Evaluation Report, Summative Evaluation Report)

Providers' reported barriers maintaining the integration of SUD and MH services (Measure 1-15)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Key informant interviews
Desired Direction	N/A
Analytic Approach	Qualitative Synthesis
Frequency	Two rounds (Interim Evaluation Report, Summative Evaluation Report)

Provider's reported successes maintaining the integration of SUD and MH services (Measure 1-16)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Stratification	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Key informant interviews
Desired Direction	N/A
Analytic Approach	Qualitative Synthesis
Frequency	Two rounds (Interim Evaluation Report, Summative Evaluation Report)

Providers' reported changes in ability to provide care after DBH procurement of a BH organization (Measure 1-17)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Stratification	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Key informant interviews
Desired Direction	N/A
Analytic Approach	Qualitative Synthesis
Frequency	Two rounds (Interim Evaluation Report, Summative Evaluation Report)

Administrators' reported barriers maintaining SUD and MH services (Measure 1-18)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Stratification	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Key informant interviews
Desired Direction	N/A
Analytic Approach	Qualitative Synthesis
Frequency	Two rounds (Interim Evaluation Report, Summative Evaluation Report)

Administrators' reported successes maintaining SUD and MH services (Measure 1-19)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Stratification	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Key informant interviews
Desired Direction	N/A
Analytic Approach	Qualitative Synthesis
Frequency	Two rounds (Interim Evaluation Report, Summative Evaluation Report)

Administrators' plan for program sustainability and anticipated challenges (Measure 1-20)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Stratification	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Key informant interviews
Desired Direction	N/A
Analytic Approach	Qualitative Synthesis
Frequency	Two rounds (Interim Evaluation Report, Summative Evaluation Report)

Alaska tribal entities' reported continued changes in quality of care and access to care providing SUD and MH services (Measure 1-21)	
Numerator/Denominator	Numerator: N/A Denominator: N/A
Comparison Population	N/A
Stratification	N/A
Measure Steward	N/A
Measure Name	N/A
Data Source	Key informant interviews
Desired Direction	N/A
Analytic Approach	Qualitative Synthesis
Frequency	Two rounds (Interim Evaluation Report, Summative Evaluation Report)

Research Question 1.3: Does Behavioral Health Reform decrease utilization of ED, IP, or institutional settings within the beneficiary population?

IP admissions for SUD, and specifically for OUD (Measure 1-22)	
Numerator/Denominator	Numerator: Total number of SUD inpatient stays, stratified by Any SUD and OUD Denominator: Number of beneficiary months among waiver recipients in the waiver population, divided by 1,000
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs
Measure Steward	N/A
Measure Name	Modified IPU
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No desired direction
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

IP admissions for MH disorders (Measure 1-23)	
Numerator/Denominator	Numerator: Total number of MH inpatient stays Denominator: Number of beneficiary months among waiver recipients in the waiver population, divided by 1,000
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs
Measure Steward	N/A
Measure Name	Modified IPU
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No desired direction
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

ED visits for SUD (Measure 1-24)	
Numerator/Denominator	Numerator: Total number of SUD ED admissions Denominator: Number of beneficiary months among waiver recipients in the waiver population, divided by 1,000
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs
Measure Steward	N/A
Measure Name	Modified AMB-ED
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No desired direction
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

ED visits for OUD (Measure 1-25)	
Numerator/Denominator	Numerator: Total number of OUD ED admissions Denominator: Number of beneficiary months among waiver recipients in the waiver population, divided by 1,000
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs
Measure Steward	N/A
Measure Name	Modified AMB-ED

ED visits for OUD (Measure 1-25)	
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No desired direction
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Number of ED visits among beneficiaries who had at least one ED admission for SUD (Measure 1-26)	
Numerator/Denominator	Numerator: Total number of SUD ED admissions Denominator: Number of beneficiary months among waiver recipients in the waiver population with at least one ED admission for SUD, divided by 1,000
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs
Measure Steward	N/A
Measure Name	Modified AMB-ED
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No desired direction
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/monthly

Number of ED visits for SUD among high utilizing beneficiaries (Measure 1-27)	
Numerator/Denominator	Numerator: Total number of SUD ED admissions Denominator: Number of beneficiary months among waiver recipients in the waiver population who fall above the 95th percentile of ED admissions for SUD, divided by 1,000
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs
Measure Steward	N/A
Measure Name	Modified AMB-ED
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No desired direction
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/monthly

ED visits for MH disorders (Measure 1-28)	
Numerator/Denominator	Numerator: Total number of MH ED admissions Denominator: Number of beneficiary months among waiver recipients in the waiver population, divided by 1,000
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs
Measure Steward	N/A
Measure Name	Modified AMB-ED
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No desired direction
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/monthly

Number of ED visits among beneficiaries who had at least one ED admission for MH (Measure 1-29)	
Numerator/Denominator	Numerator: Total number of MH ED admissions Denominator: Number of beneficiary months among waiver recipients in the waiver population with at least one ED admission for MH, divided by 1,000
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs
Measure Steward	N/A
Measure Name	N/A
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No desired direction
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/monthly

Number of ED visits for MH among high utilizing beneficiaries (Measure 1-30)	
Numerator/Denominator	Numerator: Total number MH SUD ED admissions Denominator: Number of beneficiary months among waiver recipients in the waiver population who fall above the 95th percentile of ED admissions for MH, divided by 1,000
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs
Measure Steward	N/A
Measure Name	N/A

Number of ED visits for MH among high utilizing beneficiaries (Measure 1-30)	
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No desired direction
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/monthly

Mean length of stay among IMDs measured from admission date to discharge date (Measure 1-31)	
Numerator/Denominator	Numerator: Number of days before discharge Denominator: Number of waiver recipients admitted to an IMD
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs
Measure Steward	N/A
Measure Name	N/A
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	Lower is better
Analytic Approach	Pre-test/post-test
Frequency	Annual

30-day readmission rate to IP facilities following hospitalization for an SUD-related diagnosis (Measure 1-32)	
Numerator/Denominator	Numerator: Number of hospitalizations for an SUD-related diagnosis during measurement year that were followed by an unplanned readmission to an inpatient facility Denominator: Number of waiver recipients 18 years old and older in the waiver population who were continuously enrolled with no more than one gap in enrollment of up to 45 days during the year prior to the discharge date and no gap during the 30 days following the discharge date
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs
Measure Steward	N/A
Measure Name	Modified PCR
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	Lower is better
Analytic Approach	Pre-test/post-test
Frequency	Annual

30-day readmission rate to IP facilities following hospitalization for a MH-related diagnosis (Measure 1-33)	
Numerator/Denominator	Numerator: Number of hospitalizations for an MH-related diagnosis during measurement year that were followed by an unplanned readmission to an inpatient facility Denominator: Number of waiver recipients 18 years old and older in the waiver population who were continuously enrolled with no more than one gap in enrollment of up to 45 days during the year prior to the discharge date and no gap during the 30 days following the discharge date
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs
Measure Steward	N/A
Measure Name	Modified PCR
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	Lower is better
Analytic Approach	Pre-test/post-test
Frequency	Annual

Research Question 1.4: Does Behavioral Health Reform increase the percentage of beneficiaries who adhere to treatment for SUD and MH 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 1-34)	
Numerator/Denominator	Numerator: Waiver recipients in the denominator, stratified by the following settings: Any setting, Early Intervention, Outpatient, Intensive Inpatient, Residential and Inpatient, Withdrawal Management, MAT Denominator: Number of waiver recipients with an SUD diagnosis
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs
Measure Steward	N/A
Measure Name	N/A
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No desired direction
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Number of beneficiaries with a MH diagnosis who used services in the last month or year, by service or benefit type (Measure 1-35)	
Numerator/Denominator	Numerator: Waiver recipients in the denominator, stratified by the following settings: Any service, IOP or PH, IP, OP, ED, Telehealth Denominator: Number of waiver recipients with a MH diagnosis
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs

Number of beneficiaries with a MH diagnosis who used services in the last month or year, by service or benefit type (Measure 1-35)	
Measure Steward	N/A
Measure Name	N/A
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No desired direction
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Time to treatment among beneficiaries who access SUD treatment (Measure 1-36)	
Numerator/Denominator	Numerator: Number of days between the index episode start date and first date of treatment. Rates stratified by: Alcohol, Opioid, Other Denominator: Number of waiver recipients aged 13 and over during the measurement year with an SUD diagnosis and 194 days continuous enrollment prior to the episode and 47 days after the index episode
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs
Measure Steward	N/A
Measure Name	Modified IET
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No change or an increase in the rate supports the hypothesis
Analytic Approach	• Pre-test/post-test • ITS
Frequency	Annually/Monthly

Hypothesis 2: Beneficiaries receiving BH services will experience maintained or improve health and well-being outcomes.

Research Question 2.1: Does Behavioral Health Reform increase the percentage of beneficiaries with SUD or a MH disorder who experience care for comorbid conditions?

Percentage of adults who accessed preventive/ambulatory health services (Measure 2-1)	
Numerator/Denominator	Numerator: Number of waiver recipients with an ambulatory or preventive care visit Denominator: Number of waiver recipients 20 years and older continuously enrolled throughout the measurement year with no more than one gap in enrollment of up to 45 days
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs

Percentage of adults who accessed preventive/ambulatory health services (Measure 2-1)	
Measure Steward	HEDIS[A-1]
Measure Name	AAP
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	Higher is better
Analytic Approach	Pre-test/post-test
Frequency	Annual

Percentage of beneficiaries 3–21 years of age with a well-care visit with a PCP or OB/GYN (Measure 2-2)	
Numerator/Denominator	Numerator: Waiver recipients with one or more well-care visit during the measurement year. Denominator: Number of waiver recipients aged 3-21 years who are continuously enrolled during the measurement year with no more than one gap in enrollment of up to 45 days
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs
Measure Steward	HEDIS
Measure Name	WCV
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	Higher is better
Analytic Approach	Pre-test/post-test
Frequency	Annual

Screening for chronic conditions relevant to State Medicaid population (Measure 2-3)	
Numerator/Denominator	Numerator: Number of waiver recipients screened for chronic conditions Denominator: Number of waiver recipients
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs
Measure Steward	N/A
Measure Name	N/A
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	Higher is better
Analytic Approach	Pre-test/post-test
Frequency	Annual

A-1 HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Screening for co-morbidity of MH disorders and SUDs (Measure 2-4)	
Numerator/Denominator	Numerator: Number of waiver recipients screened for chronic conditions. Two numerators are reported: 1. Number of waiver recipients with MH disorder who also have SUD 2. Number of waiver recipients with SUD who also have MH disorder Denominator: Two denominators are reported: 1. Number of waiver recipients with MH disorder 2. Number of waiver recipients with SUD
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs
Measure Steward	N/A
Measure Name	N/A
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	Higher is better
Analytic Approach	Pre-test/post-test
Frequency	Annual

Prevention Quality Chronic Composite (Measure 2-5)	
Numerator/Denominator	Numerator: Hospital discharges for long and short-term diabetes complications, COPD, hypertension, heart failure, uncontrolled diabetes, asthma, and lower-extremity amputation among waiver recipients with diabetes Denominator: Population age 18 years and older in metropolitan area or county among waiver recipients
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs
Measure Steward	AHRQ
Measure Name	PQI 92
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	Higher is better
Analytic Approach	Pre-test/post-test
Frequency	Annual

Pediatric Quality Chronic Composite (Measure 2-6)	
Numerator/Denominator	Numerator: Hospital discharges for asthma or diabetes complications Denominator: Population ages 6 to 17 years in metropolitan area or county among waiver recipients
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs
Measure Steward	AHRQ
Measure Name	PDI 92

Pediatric Quality Chronic Composite (Measure 2-6)	
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	Higher is better
Analytic Approach	Pre-test/post-test
Frequency	Annual

Percentage of beneficiaries who have a high rating of their healthcare quality (8, 9, or 10 on a scale of 0–10) (Measure 2-7)	
Numerator/Denominator	Numerator: Two rates are reported: 1. Adults rating the quality of their healthcare as very good or excellent 2. Children rating the quality of their healthcare as very good or excellent Denominator: Two denominators are calculated: 1. Adult survey question respondents 2. Child survey question respondents
Comparison Population	National benchmarks
Stratification	Gender, age, race/ethnicity[A-2]
Measure Steward	CAHPS[A-3]
Measure Name	N/A
Data Source	Beneficiary survey
Desired Direction	Higher is better
Analytic Approach	Pre-test/post-test
Frequency	Two rounds of surveys (Interim Evaluation Report, Summative Evaluation Report)

Percentage of beneficiaries who rate their overall mental or emotional health as "very good" or "excellent" (Measure 2-8)	
Numerator/Denominator	Numerator: Two rates are reported: 1. Adults rating their mental health as very good or excellent 2. Children rating their mental health as very good or excellent Denominator: Two denominators are calculated: 1. Adult survey question respondents 2. Child survey question respondents
Comparison Population	National benchmarks
Stratification	Gender, age, race/ethnicity
Measure Steward	CAHPS
Measure Name	N/A
Data Source	Beneficiary survey
Desired Direction	Higher is better
Analytic Approach	Pre-test/post-test

A-2 To minimize survey burden and ensure that stratified rates are high enough to meet reporting standards, survey measures will be limited to stratifications by gender, age, and race/ethnicity.

A-3 CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Percentage of beneficiaries who rate their overall mental or emotional health as "very good" or "excellent" (Measure 2-8)	
Frequency	Two rounds of surveys (Interim Evaluation Report, Summative Evaluation Report)

Percentage of beneficiaries who demonstrate "very good" or "excellent" knowledge of available SUD/MH treatment and services (Measure 2-9)	
Numerator/Denominator	Numerator: Two rates are reported: 1. Adults indicating that they know where to find SUD or BH services if needed 2. Children indicating that they know where to find Sud or BH services if needed Denominator: Two denominators are calculated: 1. Adult survey question respondents 2. Child survey question respondents
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity
Measure Steward	N/A
Measure Name	N/A
Data Source	Beneficiary survey
Desired Direction	Higher is better
Analytic Approach	Pre-test/post-test
Frequency	Two rounds of surveys (Interim Evaluation Report, Summative Evaluation Report)

Percentage of beneficiaries who are knowledgeable of the number of SUD and MH services available (Measure 2-10)	
Numerator/Denominator	Numerator: Rates for two groups are reported: Adults, Children Among these groups rates are reported among respondents indicating that they knew where to receive all types of treatments mentioned in the survey. Stratified by the following: SUD services, MH services SUD services listed include: Group therapy, One on one, Peer support, Family therapist, Residential, MAT MH services listed include: Group therapy, One on one, Telemedicine, Family therapist, Residential, Peer support Denominator: Two denominators are calculated: 1. Adult survey respondents 2. Child survey respondents
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity
Measure Steward	N/A
Measure Name	N/A
Data Source	Beneficiary survey
Desired Direction	Higher is better
Analytic Approach	Pre-test/post-test
Frequency	Two rounds of surveys (Interim Evaluation Report, Summative Evaluation Report)

Percentage of mothers who often or always felt depressed since their new baby was born (Measure 2-11)	
Numerator/Denominator	Numerator: Number of respondents indicating they are often or always depressed Denominator: Number of survey question respondents
Comparison Population	• State/National rates • Synthetic control group
Stratification	N/A
Measure Steward	PRAMS
Measure Name	N/A
Data Source	PRAMS
Desired Direction	• Pre-test/post-test • DiD • Synthetic Controls
Analytic Approach	Pre-test/post-test
Frequency	Annual

Percentage of beneficiaries who indicated poor mental health in the last 30 days (Measure 2-12)	
Numerator/Denominator	Numerator: Number of respondents that their mental health was not good in the past 30 days Denominator: Number of survey question respondents
Comparison Population	• Synthetic control group • State/National rates
Stratification	N/A
Measure Steward	BRFSS
Measure Name	N/A
Data Source	BRFSS
Desired Direction	Lower is better
Analytic Approach	• Pre-test/post-test • DiD • Synthetic Controls
Frequency	Annual

Percentage of mothers who indicate that they have someone who would help them while sick (Measure 2-13)	
Numerator/Denominator	Numerator: Number of respondents indicating they have someone who would help them while sick Denominator: Number of survey question respondents
Comparison Population	N/A
Stratification	N/A
Measure Steward	CUBS
Measure Name	N/A
Data Source	CUBS
Desired Direction	Higher is better

Percentage of mothers who indicate that they have someone who would help them while sick (Measure 2-13)	
Analytic Approach	Pre-test/post-test
Frequency	Annual

Desire to obtain SUD/MH treatment and obtainment of SUD/MH treatment in the past three months (Measure 2-14)	
Numerator/Denominator	Numerator: Number of respondents who indicated they sought SUD/MH treatment. Stratified by the following: – Those who desired to obtain treatment – Those who obtained treatment Denominator: Number of survey question respondents
Comparison Population	N/A
Stratification	N/A
Measure Steward	CUBS
Measure Name	N/A
Data Source	CUBS
Desired Direction	Higher is better
Analytic Approach	Pre-test/post-test
Frequency	Annual

Research Question 2.2: Does Behavioral Health Reform reduce the number of beneficiaries who experience or are exposed to adverse events?

Percentage of mothers who reported that during the past 12 months, their husband or partner pushed, hit, slapped, kicked, choked, or physically hurt them in any other way (Measure 2-15)	
Numerator/Denominator	Numerator: Number of respondents indicating that their husband or partner pushed, hit, slapped, kicked, choked, or physically hurt them in any other way Denominator: Number of survey question respondents
Comparison Population	• Synthetic control group • State/National rates
Stratification	N/A
Measure Steward	• CUBS • PRAMS
Measure Name	N/A
Data Source	• CUBS • PRAMS
Desired Direction	Lower is better
Analytic Approach	• Pre-test/post-test • DiD • Synthetic Controls
Frequency	Annual

Percentage of mothers who reported that in the past 12 months, their husband or partner threatened them, limited their activities against their will or made them feel unsafe in any other way (Measure 2-16)	
Numerator/Denominator	Numerator: Number of respondents indicating that their husband or partner threatened them, limited their activities against their will or make them feel unsafe in any other way Denominator: Number of survey question respondents
Comparison Population	Single state comparison: New York[A-4]
Stratification	N/A
Measure Steward	• CUBS • PRAMS
Measure Name	N/A
Data Source	• CUBS • PRAMS
Desired Direction	Lower is better
Analytic Approach	• Pre-test/post-test • DiD • Synthetic Controls
Frequency	Annual

Percentage of respondents whose child lived with someone who had a problem with alcohol or drugs (Measure 2-17)	
Numerator/Denominator	Numerator: Number of respondents who indicated their child lived with someone who had a problem with alcohol or drugs Denominator: Number of survey question respondents
Comparison Population	National benchmarks
Stratification	N/A
Measure Steward	• CUBS • NSCH
Measure Name	N/A
Data Source	• CUBS • NSCH
Desired Direction	Lower is better
Analytic Approach	• Pre-test/post-test • DiD
Frequency	Annual

[A-4] This is a supplemental PRAMS question that is included in the Alaska and New York surveys. The independent evaluator may elect to report the New York rate for context.

Percentage of respondents whose child lived with someone who was mentally ill, suicidal, or severely depressed (Measure 2-18)	
Numerator/Denominator	Numerator: Number of respondents who indicated their child lived with someone who was mentally ill, suicidal, or severely depressed Denominator: Number of survey question respondents
Comparison Population	National benchmarks
Stratification	N/A
Measure Steward	• CUBS • NSCH
Measure Name	N/A
Data Source	• CUBS • NSCH
Desired Direction	Lower is better
Analytic Approach	• Pre-test/post-test • DiD
Frequency	Annual

Percentage of respondents whose child witnessed violence or physical abuse between household beneficiaries (Measure 2-19)	
Numerator/Denominator	Numerator: Number of respondents who indicated their child witnessed violence or physical abuse between household members Denominator: Number of survey question respondents
Comparison Population	N/A
Stratification	N/A
Measure Steward	CUBS
Measure Name	N/A
Data Source	CUBS
Desired Direction	Lower is better
Analytic Approach	Pre-test/post-test
Frequency	Annual

Percentage of respondents who reported that their child saw or heard parents or adults slap, hit, kick, punch one another in the home (Measure 2-20)	
Numerator/Denominator	Numerator: Number of respondents who their child saw or heard parents or adults slap, hit, kick, punch one another in the home Denominator: Number of survey question respondents
Comparison Population	National/State rates
Stratification	N/A
Measure Steward	NSCH
Measure Name	N/A
Data Source	NSCH
Desired Direction	Lower is better

Percentage of respondents who reported that their child saw or heard parents or adults slap, hit, kick, punch one another in the home (Measure 2-20)	
Analytic Approach	• Pre-test/post-test • DiD
Frequency	Annual

Maltreatment types among victims (Measure 2-21)	
Numerator/Denominator	Numerator: Number of child victims, reported by maltreatment type: Medical neglect, Neglect, Other, Physical Abuse, Psychological maltreatment, Sexual abuse, Sex trafficking, Unknown Denominator: Number of child victims
Comparison Population	National/state rates
Stratification	N/A
Measure Steward	Children's Bureau
Measure Name	N/A
Data Source	Children's Bureau
Desired Direction	No desired direction
Analytic Approach	• Pre-test/post-test • DiD
Frequency	Annual

Caregiver risk factors among child victims (Measure 2-22)	
Numerator/Denominator	Numerator: Number of child victims, reported by risk factor: Alcohol Abuse, Domestic Violence, Drug Abuse, Inadequate housing Denominator: Number of child victims
Comparison Population	National/state rates
Stratification	N/A
Measure Steward	Children's Bureau
Measure Name	N/A
Data Source	Children's Bureau
Desired Direction	No desired direction
Analytic Approach	• Pre-test/post-test • DiD
Frequency	Annual

Maternal use of marijuana or cannabis in any form (Measure 2-23)	
Numerator/Denominator	Numerator: Number of respondents indicating that they used marijuana or hash. Stratified by time: – During the 12 months before I got pregnant – During my most recent pregnancy – Since my new baby was born Denominator: Number of survey question respondents
Comparison Population	• Synthetic control group • National/state rates
Stratification	N/A
Measure Steward	PRAMS
Measure Name	N/A
Data Source	PRAMS
Desired Direction	Lower is better
Analytic Approach	• Pre-test/post-test • DiD • Synthetic Controls
Frequency	Annual

Frequency of maternal marijuana or cannabis use in the past 30 days (Measure 2-24)	
Numerator/Denominator	Numerator: Number of days Denominator: Number of survey question respondents
Comparison Population	N/A
Stratification	N/A
Measure Steward	CUBS
Measure Name	N/A
Data Source	CUBS
Desired Direction	Lower is better
Analytic Approach	Pre-test/post-test
Frequency	Annual

Research Question 2.3: Does Behavioral Health Reform decrease the rate of drug overdoses and overdose deaths due to opioids?

Rate of overdose deaths, specifically overdose deaths due to any opioid (Measure 2-25)	
Numerator/Denominator	Numerator: Number of overdose deaths attributable to opioids Denominator: Number of Alaska residents
Comparison Population	• Synthetic control group • State/National rates

Rate of overdose deaths, specifically overdose deaths due to any opioid (Measure 2-25)	
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs[A-5]
Measure Steward	N/A
Measure Name	N/A
Data Source	• State eligibility and enrollment data • Claims/encounter data • Vital stats • CDC WONDER
Desired Direction	Lower is better
Analytic Approach	• Pre-test/post-test • DiD • Synthetic Controls
Frequency	Annual

Non-fatal overdoses (all cause) (Measure 2-26)	
Numerator/Denominator	Numerator: Number of non-fatal overdoses Denominator: Number of Alaska residents
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs
Measure Steward	N/A
Measure Name	N/A
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	Lower is better
Analytic Approach	Pre-test/post-test
Frequency	Annual

Use of opioids at high dosage in persons without cancer (Measure 2-27)	
Numerator/Denominator	Numerator: Number of waiver recipients in the denominator 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. Denominator: Number of waiver recipients aged 18 and older with two or more prescriptions for opioids on different days with a cumulative days' supply of 15 or more
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs
Measure Steward	HEDIS
Measure Name	OHD

[A-5] This measure will only be stratified if vital statistics data are available. Data from CDC Wonder cannot be stratified.

Use of opioids at high dosage in persons without cancer (Measure 2-27)	
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	Lower is better
Analytic Approach	Pre-test/post-test
Frequency	Annual

Use of opioids from multiple providers (Measure 2-28)	
Numerator/Denominator	Numerator: Number of waiver recipients receiving prescription opioids for => 15 days during the measurement year, who received opioids from multiple providers. Stratified by the following: – Multiple prescribers – Multiple pharmacies – Multiple prescribers and multiple pharmacies Denominator: Number of waiver recipients aged 18 and older with no more than one gap in continuous enrollment of up to 45 days and have two or more opioid dispensing events on different dates of service with => 15 total days covered by opioids
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs
Measure Steward	HEDIS
Measure Name	UOP
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	Lower is better
Analytic Approach	Pre-test/post-test
Frequency	Annual

Risk of continued opioid use (Measure 2-29)	
Numerator/Denominator	Numerator: Number of waiver recipients who have a new episode of opioid use that puts them at risk for continued opioid use. Stratified by the following: – At least 15 days of prescription opioids in a 30-day period – At least 31 days of prescription opioids in a 62-day period Denominator: Number of waiver recipients aged 18 and older with no more than one gap in continuous enrollment of up to 45 days who were enrolled at least 180 days prior to their index prescription start date (IPSD) and 61 days after the IPSD
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs
Measure Steward	HEDIS
Measure Name	COU
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	Lower is better

Risk of continued opioid use (Measure 2-29)	
Analytic Approach	Pre-test/post-test
Frequency	Annual

Hypothesis 3: Behavioral Health Reform will maintain or reduce the cost of Medicaid for Alaska and the federal government.

Research Question 3.1: Does Behavioral Health Reform maintain or reduce Alaska's per capita Medicaid BH costs?

Total costs of healthcare (sum of parts below), by State and federal share (Measure 3-1)	
Numerator/Denominator	Numerator: Total costs of healthcare. Stratified by the following: Total costs, IP, OP (ED OP and non-ED OP), LTC, Professional, Dental, Pharmacy Denominator: Total number of beneficiary months, divided by 1,000
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs
Measure Steward	N/A
Measure Name	N/A
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No change or lower is better
Analytic Approach	ITS
Frequency	Annually/monthly

Total cost of SUD, SUD-IMD and SUD-Other and Non-SUD, by setting, including claims data (IP, OP, Rx, LTC) (Measure 3-2)	
Numerator/Denominator	Numerator: Total cost of SUD services. Stratified by: SUD-IMD, SUD-Other, Non-SUD Denominator: Total number of beneficiary months, divided by 1,000
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs
Measure Steward	N/A
Measure Name	N/A
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No change or lower is better
Analytic Approach	ITS
Frequency	Annually/monthly

Total cost of MH diagnosis by IMD and Other, by setting, including claims data (IP, OP, Rx, LTC) (Measure 3-3)	
Numerator/Denominator	Numerator: Total cost of BH services. Stratified by: MH-IMD, MH- Other, Non-MH Denominator: Total number of beneficiary months, divided by 1,000
Comparison Population	N/A
Stratification	Gender, age, race/ethnicity, geography, criminal justice involvement, and high-cost high needs
Measure Steward	N/A
Measure Name	N/A
Data Source	• State eligibility and enrollment data • Claims/encounter data
Desired Direction	No change or lower is better
Analytic Approach	ITS
Frequency	Annually/monthly

ATTACHMENT D:
SUD Implementation Plan Protocol

ALASKA 1115 SUBSTANCE USE DISORDER WAIVER IMPLEMENTATION PLAN--FINAL

March 13, 2019

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- Governor of Alaska Administrative Order No. 283
- Alaska Strategic Plan for Responding to Opioid Crisis—Draft
- Alaska Prescription Drug Monitoring Program Report to the 30th Alaska State Legislature (2018)
- Alaska Board of Pharmacy Meeting Minutes February 28-March 2, 2018
- Recommendation to Adopt Washington's Interagency Guideline on Prescribing Opioids for Pain, 3rd Edition
- Washington Interagency Guideline on Prescribing Opioids for Pain, 3rd Edition
- Alaska's Proposed Definition—SUD Care Coordination

Introduction

Like many States, during the past several years Alaska has seen a dramatic increase in opioid use and opioid overdose deaths. In 2017, the rate of opioid-related overdose deaths per 100,000 in Alaska was 13.6, which has steadily increased from a rate of 7.7/100,000 in 2010. This was driven by a dramatic increase in Alaska's number of heroin and fentanyl overdose deaths. Alaska's annual average percentage of adult- past-year-heroin use rate has been well above the national average for many years—for 2015, Alaska's average was 1.23% compared to US average of 0.33%. The increasing use of heroin is also reflected in the 58% increase in treatment admissions for heroin dependence between 2009 and 2013, the majority of which were individuals between 21-29 years of age. Finally, between 2007 and 2016, the number of Neonatal Abstinence Syndrome (NAS) diagnoses among Medicaid-covered infants increased fourfold—from 4.4% to 16.9%. Alaska's Medicaid population has been most impacted by these trends, with substance use disorder (SUD)-related emergency department visits, inpatient hospital stays, and NAS-related hospital costs increasing proportionately.

While Alaska is not too remote to have been spared from the opioid crisis, we have other critical substance use/misuse/abuse-related needs. Alaska has the 10th highest prevalence rate of adult binge drinking in the country and the 5th highest rate of intensity of binge drinking among adults. Importantly, the rate of alcohol-related mortality for Alaska Natives is more than three times (71.4/100,000) that of all Alaskan adults (20.4/100,000) and is eight times the national rate (8.5/100,000). Alaska Native youth ages 10-17 years old are 2.7 times more likely to be hospitalized for unintentional alcohol poisoning than a non-Alaska Native peer. While Alaska's opioid crisis has emerged relatively recently, the State's alarming alcohol-related prevalence rates have remained constant over a much longer period of time.

Alaska find itself with critical treatment infrastructure, provider capacity, and workforce development needs to address these crises. As part of the recommendations in the 2017 report of the Governor's Task Force on Alaska Opioid Policy and the mandates from the Alaska Legislature via Senate Bill 74 (passed in 2016), we are requesting a Section 1115 Demonstration Waiver to transform the behavioral health system of care. The SUD portion of the 1115 Demonstration Waiver will assist us in:

- Strengthening Alaska's SUD treatment continuum of services—by both increasing the benefits offered to Medicaid recipients and using evidence-based SUD program standards;
- Building Alaska's provider capacity throughout the State; and
- Continuing to develop Alaska's SUD workforce capacity and competencies.

Alaska will use this Waiver to achieve the following Centers for Medicare and Medicaid Services (CMS) goals:

1. Increased rates of identification, initiation, and engagement in treatment (AK 1115 Waiver Cross-Cutting Goal #1 and SUD Implementation Plan Goal #3);

2. Increased adherence to and retention in treatment (AK 1115 Waiver Evaluation Hypotheses #5);
3. Reduced overdose deaths, particularly those due to opioids (AK 1115 Waiver Evaluation Hypothesis #4);
4. 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 (AK 1115 Waiver Cross-Cutting Goal #1, SUD Implementation Plan Goal #3, and Evaluation Hypothesis #1);
5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate (AK 1115 Waiver SUD Implementation Plan Goal #3 and Evaluation Hypothesis #1); and
6. Improved access to care for physical health conditions among beneficiaries (AK 1115 Waiver Evaluation Hypothesis #2).

Alaska will address five major domains to accomplish these six goals:

- Universally screen all Medicaid recipients, regardless of setting, using industry-recognized, evidence-based SUD screening instruments to identify symptoms and intervene as early as possible before use becomes dependence.
- Implement American Society of Addiction Medicine (ASAM) Criteria (3rd Edition) to match individuals with SUD with the services and tools necessary for recovery.
- Increase SUD 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 utilizing industry-recognized standards for certification and ongoing accountability (with emphasis on residential providers, but across-the-board).
- Improve SUD workforce by carefully reviewing existing certification requirements and modifying as appropriate to align with Medicaid, Waiver, and industry-recognized credentialing standards.

This Implementation Plan (plan), designed to be implemented during the five years of the Waiver Demonstration, with particular emphasis on the first two years, is organized by the key milestones identified by CMS. Alaska's plan is to phase-in implementation during the first two years, with approximately one-half of the State's population being covered in Waiver Year 1 and the other half in Waiver Year 2 (50/50 schedule).

This plan provides the detail necessary to operationalize Alaska's shared vision: build the treatment infrastructure necessary to improve the outcomes of Alaskans suffering from addiction, while beginning to put in place in all regions the infrastructure and services necessary to make the Waiver's vision of early intervention more than a vision, but a reality.

Milestone #1: Access to Critical Levels of Care for SUD Treatment

The following table describes each ASAM Level of Care, current Medicaid coverage, and proposed future coverage per the 1115 Waiver. Of the 17 SUD services listed below, one requires a State Plan Amendment to add or change coverage (ASAM 0.5), fourteen are proposed new 1115 Waiver services (one a sub-category of ASAM 3.5), and two require no change (ASAM 1.0 and MAT). For the column entitled "Current Coverage," "3.1A" refers to Attachment 3.1A of the Alaska State Medicaid Plan, Alcohol and Substance Abuse Rehabilitative Services benefit category, unless otherwise noted.

ASAM Level of Care	Service	Description	Current Coverage	Future Coverage (Under State Plan or Proposed SUD Portion of 1115 Waiver)
OTS	Opioid Treatment Services (OTS) for persons experiencing an Opioid Use Disorder (OUD)	Pharmacological (opioid agonist, partial agonist, & antagonist medications), counseling services (including SUD care coordination services as appropriate) provided in either an Opioid Treatment Program (OTP) or Office-Based Opioid Setting (OBOT).	Not covered	Proposed SUD Portion of 1115 Waiver
0.5	Early Intervention	Services for individuals who are at risk of developing substance-related disorders.	Currently covered in SP, but limited (see section 3.1A)	State Plan
1.0	Outpatient Services (OP)	Outpatient treatment (usually less than 9 hours a week), including counseling, evaluations, and interventions.	Currently Covered in SP, (see section 3.1A)	State Plan
2.1	Intensive Outpatient Services (IOP)	9-19 hours of structured programming per week (counseling and education about addiction-related and mental health problems).	Not covered	Proposed SUD Portion of 1115 Waiver

ASAM Level of Care	Service	Description	Current Coverage	Future Coverage (Under State Plan or Proposed SUD Portion of 1115 Waiver)
2.5	Partial Hospitalization Program (PHP)	20 or more hours of clinically intensive outpatient programming per week.	Not covered	Proposed SUD Portion of 1115 Waiver
3.1	Clinically Managed Low- Intensity Residential	24-hour supportive living environment; at least 5 hours of low-intensity treatment per week.	Not covered	Proposed SUD Portion of 1115 Waiver
3.3	Clinically Managed population specific, High intensity Residential	24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu for those with cognitive or other impairments.	Not covered	Proposed SUD Portion of 1115 Waiver
3.5	Clinically Managed Medium (Youth) & High (Adult)-Intensity Residential	24-hour living environment, more high-intensity treatment (level 3.7 without intensive medical and nursing component).	Not covered	Proposed SUD Portion of 1115 Waiver
3.7	Medically Monitored Intensive Inpatient Services	24-hour professionally directed evaluation, observation, medical monitoring, and addiction treatment in an inpatient setting (usually hospital-based).	Not covered	Proposed SUD Portion of 1115 Waiver
4.0	Medically Managed Intensive Inpatient	24-hour inpatient treatment requiring the full resources of an acute care or psychiatric hospital.	Not covered	Proposed SUD Portion of 1115 Waiver

ASAM Level of Care	Service	Description	Current Coverage	Future Coverage (Under State Plan or Proposed SUD Portion of 1115 Waiver)
1-WM	Ambulatory Withdrawal Management without Extended On-Site Monitoring	Mild withdrawal with daily or less than daily outpatient supervision.	Not covered	Proposed SUD Portion of 1115 Waiver
2-WM	Ambulatory Withdrawal Management with Extended On-Site Monitoring	Moderate withdrawal with all- day withdrawal management support and supervision; at night, has supportive family or supportive living situation.	Not covered	Proposed SUD Portion of 1115 Waiver
3.2-WM	Clinically Managed Residential Withdrawal Management	Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.	Not covered	Proposed SUD Portion of 1115 Waiver
3.7-WM	Medically Monitored Inpatient Withdrawal Management	Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete withdrawal management without medical, nursing monitoring (usually hospital- based).	Not covered	Proposed SUD Portion of 1115 Waiver
4-WM	Medically Managed Intensive Inpatient Withdrawal Management	Severe, unstable withdrawal and needs (usually hospital-based) 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.	Not covered	Proposed SUD Portion of 1115 Waiver

ASAM Level of Care	Service	Description	Current Coverage	Future Coverage (Under State Plan or Proposed SUD Portion of 1115 Waiver)
Medication-Assisted Treatment	Medication-Assisted Treatment	Pharmacological (opioid agonist, partial agonist, & antagonist medications) services provided in either an Opioid Treatment Program (OTP) or Office-Based Opioid Setting (OBOT).	Currently covered in SP see Attachment 3.1A)	State Plan
Support	Community and Recovery Support	Services to help people overcome personal and environmental obstacles to recovery, assist the newly recovering person into the recovery community, and serve as a personal guide and mentor toward the achievement of goals.	Not covered	Proposed SUD Portion of 1115 Waiver

The State attests that Alaska will provide the Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) to all eligible low-income infants, children and adolescents under age 21, as specified in Section 1905(r) of the Social Security Act.

Each of the ASAM Levels of Care will be addressed in more detail by providing current coverage, future coverage, and a timeline for implementation over the next 12-24 months for the proposed Waiver changes.

Level of Care: Opioid Treatment Services (OTS)

Current State: Alaska Medicaid provides coverage for pharmacological (opioid agonist, partial agonist, & antagonist) medication administration, counseling services provided in either an opioid treatment program (OTP) or office-based opioid treatment (OBOT), medical evaluation for methadone recipients, and treatment plan review for methadone recipients. Alaska Department of Health and Social Services' Division of Behavioral Health (DBH) is reviewing and updating both the Healthcare Common Procedure Coding System (HCPCS) codes and the Alaska Administrative Code (AAC) for: 1) The medications, counseling, screening, assessment, treatment planning, and medical evaluation necessary to align with ASAM requirements; 2) To expand use of naltrexone or any currently approved effective pharmacological treatment for substance use disorders; 3) To include treatment plan development in the benefit offered to Waiver recipients; and 4) To define clear standards of care for opioid treatment services.

There are currently four OTPs in Alaska, three of the four OTPs in the Anchorage and Mat-Su regions, where 54% of the state's population resides, and one in Fairbanks. Alaska has been the recipient of two opioid treatment Substance Abuse and Mental Health Services Administration (SAMHSA) grants. The first, a three-year, $3 million Medication-Assisted Treatment (MAT) Capacity Expansion grant, is focused on prescription drug and opioid addiction. The grant funds two providers, one OTP in Anchorage and one OBOT in Juneau, and is expected to increase the number of individuals receiving MAT services by 250 over the life of the grant. The grant began 09/01/16 and ends 08/31/19, the proposed Year 1 of the 1115 Waiver Demonstration. The second SAMHSA grant is a two-year, up to $4 million Opioid State Targeted Response (STR) grant. This grant funds three agencies: one in Kenai (OBOT) and two in Fairbanks (1 OBOT and 1 OTP). The grant is expected to increase the number of individuals receiving MAT by 340 during the life of the grant (05/01/17 through 04/30/19)—again, Year 1 of the 1115 Waiver Demonstration.

Future State: Alaska Medicaid/DBH will increase the number of OTPs in Alaska by two for a total of six statewide, including treatment for the 590 grant-funded individuals mentioned above. Proposed locations are included in Appendix 1.

In addition, Alaska Medicaid/DBH will increase MAT services by expanding the use of naltrexone in each of the nine Waiver regions to address both the opioid crisis and continuing alcohol needs. We plan to allow naltrexone or any currently approved effective pharmacological treatment for substance use disorders to be administered in either an OTP, OBOT, out-patient, or residential setting, as long as medical and associated counseling/therapeutic staffing is appropriate. The benefit package for all OTS's will include evidence-based screening; evidence-based clinical assessment; medication and dose level administration—assessing, ordering, reassessing, and regulating; drug testing for monitoring purposes; treatment plan development and review; SUD care coordination, cognitive-behavioral and other SUD-focused therapies; and a range of Community and Recovery Support Services, which include recovery coaching, relapse prevention, and psychoeducation.

The Alaska Department of Health and Social Services' Office of Rate Review has developed the rates for screening, clinical assessment, naltrexone, Community and Recovery Support Services, and treatment plan development.

Actions Needed and Implementation Timeline:

Action	Timeline
Pursue HCPCS Code modifications for expanded MAT, treatment plan development, and Community and Recovery Support Services.	Target to complete code modifications—April 1, 2019
Pursue Alaska Administrative Code (AAC) modifications accordingly	Target April 1, 2019
Certify two additional OTPs, OBOTs, and Residential providers for appropriate opioid medication (methadone, buprenorphine, or naltrexone)	Will be staggered based on 50/50 schedule. The two additional OTPs will be developed during Demonstration Year 2.

Level of Care: 0.5—Early Intervention

Current State: Alaska Medicaid provides coverage for the Alaska Screening Tool, which is not an evidence-based, SUD-specific instrument. Alaska Medicaid provides coverage for Screening, Brief Intervention, and Referral for Treatment (SBIRT) up to 30 minutes per episode. There is no coverage for brief intervention greater than 30 minutes and no way to track treatment received by SBIRT screens/brief interventions.

Future State: Alaska Medicaid will pursue a State Plan Amendment (SPA) to modify the current screening coverage to specify universal use of evidence-based, SUD-specific screening instruments. The plan is to use the Alcohol Use Disorders Identification Test (AUDIT) and the Drug Abuse Screening Test (DAST), two evidence-based, SUD-specific instruments, to identify any person who presents with symptoms indicating possible or potential substance use or misuse requiring further assessment. Universal screening will commence when Waiver services are initiated.

In addition, a SPA will be pursued to modify SBIRT coverage, which will be implemented in the emergency departments of 10 hospitals throughout Alaska as specified in Appendix 1.

The Administrative Services Organization (ASO) will track screenings, brief interventions, and referrals to treatment—where technologically feasible, tablets will be used for screenings, allowing immediate entry into the ASO's database. We anticipate the use of tablets for approximately 80% of individuals screened (Anchorage, Mat-Su, Fairbanks, Juneau, and Sitka).

Actions Needed and Implementation Timeline:

Action	Timeline
Pursue SPAs to modify SUD screening and SBIRT services	Target effective date April 1, 2019
Pursue Alaska Administrative Code (AAC) modifications accordingly	Will be filed May 1, 2019
Train hospital ED staff in 10 selected hospitals regarding SBIRT	Will be completed April 30, 2019

For the purpose of the following sections, an "adult" is defined as an individual over 18 years old and a "youth" is defined as an individual between the ages of 12 and 17 years old.

Level of Care: 1.0—Outpatient Services (OP)

Current State: Alaska Medicaid provides coverage for outpatient SUD individual, family, and group therapies. These services are available to all Alaska Medicaid recipients, limited to 10 hours per State Fiscal Year per recipient, with extensions upon authorization.

Future State: No changes are expected at this ASAM Level of Care.

Actions Needed and Implementation Timeline: None anticipated.

Level of Care: 2.1—Intensive Outpatient SUD Services (IOP)

Current State: Alaska Medicaid does not currently have coverage for intensive outpatient services (IOP). Current practice is to label the need for more than the basic 10 hours of OP services as IOP services; there is presently no Medicaid definition for IOP services.

Future State: A new Waiver service will be created to allow reimbursement for SUD IOP services. SUD IOP placement will use the ASAM patient placement criteria, Level 2.1. SUD IOP services will be delivered by qualified addiction professionals (as discussed in Milestone #3, B); and will include a planned regimen of individual/group/family therapy, random drug testing, and skills training, with regularly scheduled sessions within a structured program, for a minimum of nine (9) hours of treatment per week for adults and six (6) hours of treatment per week for youth. All Medicaid recipients eligible to receive Waiver services will have access to this service—strategically, this service is the lynchpin for achieving the positive outcomes we anticipate under the Waiver.

Alaska plans to develop this capacity in 24 locations throughout the State as specified in Appendix 1—14 Adult IOP and 10 Youth IOP.

Actions Needed and Implementation Timeline:

Action	Timeline
Develop a new Waiver service to allow reimbursement for IOP services.	Target date for development of new Waiver service—April 2019
Pursue Alaska Administrative Code (AAC) modifications to add coverage of service	Will be filed by May 1, 2019
Develop provider notification/communication regarding new service	Formal notification to be released at least 90 days before initiation of Waiver services
Conduct provider training on ASAM requirements for ASAM 2.1 Level of Care	Based on 50/50 schedule

Level of Care: 2.5—Partial Hospitalization Program (PHP)

Current State: Alaska Medicaid does not currently have coverage for partial hospitalization program services.

Future State: Alaska Medicaid will develop a new Waiver service to allow reimbursement for SUD partial hospitalization (PHP) services. SUD PHP services will be specifically designed for the diagnosis or active treatment of a SUD when there is a reasonable expectation for improvement or when it is necessary to maintain the individual's functional level and prevent relapse or inpatient hospitalization (ASAM Levels 3.7 and 4). Services will include individual, group, and family therapy, medication management, occupational/recreational therapy, and other appropriate therapies. SUD PHP placement will use the ASAM placement criteria, Level 2.5. ASAM has found that, for some individuals, the availability of PHP may shorten the length of stay of full hospitalization or serve as a transition from inpatient to outpatient care. A day of SUD PHP will be defined as six (6) hours of treatment and no less than twenty (20) hours a week of treatment.

We plan to implement SUD partial hospitalization programs, including a minimum of 4 locations throughout the State for youth, targeting those locations with only one adult IOP program, as specified in Appendix 1. We anticipate outpatient settings (including school settings) for this service, not hospital-based settings.

Actions Needed and Implementation Timeline:

Action	Timeline
Develop a new Waiver service to allow reimbursement for SUD PHP services.	Target effective date April 2019
Pursue Alaska Administrative Code (AAC) modifications to add coverage of service	Will be filed by May 1, 2019
Develop provider notification/ communication re new service	Formal notification to be released at least 90 days before initiation of Waiver services
Conduct provider training on ASAM requirements for ASAM 2.5 Level of Care	All training completed Waiver Year 1

Level of Care: 3.1—Clinically Managed Low-Intensity Residential Services for Youth and Adults

Current State: SUD residential treatment is provided within residential treatment facilities, including Institutions for Mental Disease (IMD), which are not currently reimbursed by Medicaid. 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. The IMD restriction applies to residential treatment programs

with more than 16 beds, whether for SUD or mental health treatment. Federal law prohibits federal financial participation (FFP) from going to IMDs for individuals aged 21 through 64.

One of the primary goals of the SUD portion of the 1115 waiver is to remove this restriction for SUD residential treatment programs and allow such treatment program whose capacity exceeds 16 beds to provide treatment to all Alaska Medicaid recipients receiving hospital-based inpatient and residential treatment services. Providing this service to youth and adults will promote a more robust continuum of care to support youth and adults at all stages of treatment and recovery.

The Alaska Department of Health and Social Services' Office of Rate Review has developed a bundled per diem rate for this ASAM Level of Care. The bundled rate methodology for all Waiver residential services is based on a mix of services that is most appropriate to the particular level of care.

Future State: Upon approval of the 1115 waiver, Alaska Medicaid will be able to reimburse for residential stays in all settings, including IMDs, for all eligible youth and adults. Alaska will allow members to seek authorization for residential IMD stays based on a statewide average length of stay of 30 days. Length of stay will be determined by medical necessity.

We plan to increase ASAM 3.1 statewide Residential capacity by 110 beds—90 Adult and 20 Youth—in locations listed in Appendix 1.

This will bring total bed capacity for ASAM 3.1 Residential services to 154 beds. Only a DHSS-approved program that has been designated by the Division of Behavioral Health (DBH) as an ASAM Level 3.1 residential facility (over or under 16 beds) will be eligible to receive Medicaid reimbursement. The development of improved program employee certification requirements and ASAM designation for these facilities will be addressed under a later section of the implementation plan.

Alaska Medicaid will require prior authorization for all SUD residential services provided to Waiver-eligible individuals.

Actions Needed and Implementation Timeline:

Action	Timeline
Pursue Alaska Administrative Code (AAC) modifications to add coverage for youth	Will be filed by May 1, 2019
Develop provider notification of IMD status and certification requirements	Formal notification to be released upon CMS approval of SUD Implementation Plan—anticipated date February 1, 2019
Conduct provider training on ASAM requirements for ASAM 3.1 Level of Care	Based on 50/50 schedule

Level of Care: 3.3—Clinically Managed Population-Specific High-Intensity Residential Services for Adults

Current State: SUD residential treatment is provided within residential treatment facilities, including facilities that fall under the IMD, which are not currently reimbursed by Medicaid. As mentioned above, one of the primary goals of the SUD portion of the 1115 Waiver is to remove this restriction as it applies to SUD residential treatment programs with more than 16 treatment beds and allow IMDs to provide treatment to all Alaska Medicaid recipients receiving hospital-based inpatient and residential treatment services.

The Alaska Department of Health and Social Services' Office of Rate Review has developed a bundled per diem rate for this ASAM Level of Care. The bundled rate methodology for all Waiver residential services is based on a mix of services that is most appropriate to the particular level of care.

Future State: Upon approval of the 1115 Waiver, Alaska Medicaid will be able to reimburse for residential stays, including IMDs, for all eligible youth and adults. Alaska will allow members to seek authorization for residential IMD stays based on a statewide average length of stay of thirty (30) days. We plan to implement ASAM Level 3.3 bed capacity in two areas of the state:

- Region 1—12 beds designated for individuals with Traumatic Brain Injury
- Region 2—12 beds designated for individuals with SUD-related cognitive impairments

This will develop new capacity (24 beds) for ASAM 3.3—a much-needed service that has been in the State Plan but not utilized. Only facilities that receive DHSS approval and have been designated by the DBH as an ASAM Level 3.3 residential facility will be eligible to receive reimbursement. The development of improved program employee certification requirements and ASAM designation for these facilities will be addressed under a later section of the implementation plan.

Alaska Medicaid will require prior authorization for all SUD residential services provided to Waiver-eligible individuals.

Actions Needed and Implementation Timeline:

Action	Timeline
Pursue Alaska Administrative Code (AAC) modifications re coverage of service	Will be filed May 1, 2019
Develop provider notification of service and certification requirements	Formal notification to be released at least 90 days before initiation of Waiver services
Conduct provider training on ASAM requirements for ASAM 3.3 Level of Care	Waiver Year 1—Regions 1 & 2

Level of Care: 3.5—Clinically Managed Medium-Intensity Residential Services for Youth and Clinically Managed High-Intensity Residential Services for Adults

Current State: SUD residential treatment is provided within residential treatment facilities, including IMDs, because their treatment capacity exceeds 16 residential SUD treatment beds. IMDs are not currently reimbursed by Medicaid. As noted above, one of the primary goals of the SUD portion of the 1115 Waiver is to remove this restriction on Alaska SUD residential treatment programs and allow its residential IMDs to provide treatment to all Alaska Medicaid recipients receiving hospital-based inpatient and residential treatment services.

The Alaska Department of Health and Social Services' Office of Rate Review has developed a bundled per diem rate for this ASAM Level of Care. The bundled rate methodology for all Waiver residential services is based on a mix of services that is most appropriate to the particular level of care.

Future State: Upon approval of the 1115 Waiver, Alaska Medicaid will be able to reimburse for residential stays in all settings, including IMDs, for all eligible youth and adults. Alaska will allow Medicaid recipients to seek authorization for residential IMD stays based on a statewide average length of stay of thirty (30) days. Length of stay determined by medical necessity.

We plan to increase ASAM 3.5 statewide Residential capacity by 66 beds to address existing service gaps.

Of the 66 bed increase, 32 beds will be divided between Adult and Youth providers (26 Adult and 6 Youth). The other 34 beds will become specialized Residential Treatment programs for Pregnant and Postpartum Women and their Children ages 10 and under as detailed in Appendix 1, which are not currently covered in the State Plan and, therefore, will be a new Waiver service.

This will bring total bed capacity for ASAM 3.5 Residential services to 391—252 Adult beds, 52 Youth beds, and 87 Women and Children's beds. Only facilities that have been approved by DHSS and designated by the DBH as an ASAM Level 3.5 residential facility will be eligible to receive reimbursement. The development of improved program employee certification requirements and ASAM designation for these facilities will be addressed under a later section of the implementation plan.

Alaska Medicaid will require prior authorization for all SUD residential services provided to Waiver-eligible individuals.

Actions Needed and Implementation Timeline:

Action	Timeline

Pursue Alaska Administrative Code (AAC) modifications re coverage of service	Will be filed by May 1, 2019
Develop provider notification of IMD status, women/children's requirement, and certification requirements	Formal notification to be released upon CMS approval of SUD Implementation Plan—anticipated date February 1, 2019
Conduct provider training on ASAM requirements for ASAM 3.5 Level of Care	Based on 50/50 schedule

Level of Care: 3.7—Medically Monitored High-Intensity Inpatient Services for Youth and Adults

Current State: Alaska Medicaid provides coverage for Medically Monitored High-Intensity Inpatient Services. These services are available to all Alaska Medicaid recipients.

Future State: Alaska Medicaid will require prior authorization for all Inpatient Services provided under the 1115 Waiver.

Actions Needed and Implementation Timeline: None anticipated.

Level of Care: 4.0—Medically Managed Intensive Inpatient Services for Youth and Adults

Current State: Alaska Medicaid provides coverage for Medically Managed Intensive Inpatient Services. These services are available to all Alaska Medicaid recipients.

Future State: Alaska Medicaid will require prior authorization for all Inpatient Services provided under the 1115 Waiver.

Actions Needed and Implementation Timeline: None anticipated.

Level of Care: 1-WM—Ambulatory Withdrawal Management Without Extended On-Site Monitoring for Youth and Adults

Current State: Alaska Medicaid does not provide coverage for ambulatory withdrawal management levels of care based on the ASAM criteria.

Future State: Alaska Medicaid will develop ambulatory withdrawal management coverage to align with ASAM 1-WM requirements. Coverage will be provided to all eligible recipients.

We plan to locate at least one AWM provider (AWM-1 or AWM-2) site in each of the nine Waiver regions based on the 50/50 schedule as specified in Appendix 1.

Actions Needed and Implementation Timeline:

Action	Timeline
Pursue Alaska Administrative Code (AAC) modifications accordingly	Will be filed April 1, 2019
Develop provider notification of modifications to 1-WM	Formal notification to be released at least 90 days before initiation of Waiver services—anticipated date February 1, 2019
Conduct provider training on ASAM requirements for ASAM 1-WM Level of Care	Based on 50/50 schedule

Level of Care: 2-WM—Ambulatory Withdrawal Management With Extended On-Site Monitoring for Youth and Adults

Current State: Alaska Medicaid does not currently provide coverage for Ambulatory Withdrawal Management with Extended On-Site Monitoring.

Future State: Alaska Medicaid will develop a new Waiver service allow reimbursement for ASAM 2-WM. Coverage will be provided to all eligible recipients.

We plan to locate at least one AWM provider (AWM-1 or AWM-2) site in each of the nine Waiver regions based on the 50/50 schedule per Appendix 1.

Actions Needed and Implementation Timeline:

Action	Timeline
Develop new Waiver service to allow reimbursement for ASAM 2-WM	Target effective date April 1, 2019
Pursue Alaska Administrative Code (AAC) modifications accordingly	Will be filed May 1, 2019
Develop provider notification of new 2-WM service.	Formal notification to be released at least 90 days before initiation of Waiver services—anticipated date February 1, 2019
Conduct provider training on ASAM requirements for ASAM 2-WM Level of Care	Based on 50/50 schedule

Level of Care: 3.2-WM—Clinically Managed Residential Withdrawal Management

Current State: Alaska Medicaid does not presently provide coverage for Clinically Managed Residential Withdrawal Management.

Future State: Alaska Medicaid will create a new Waiver service to allow reimbursement of ASAM 3.2-WM. Coverage will be provided to all eligible recipients. We plan to locate this service in one location during Year 2 of the Waiver as specified in Appendix 1.

Alaska Medicaid will require prior authorization for all Residential Services provided under the 1115 Waiver, including this level of withdrawal management.

Actions Needed and Implementation Timeline:

Action	Timeline
Develop new Waiver service to allow reimbursement for ASAM 3.2-WM	Target effective date May 1, 2019
Pursue Alaska Administrative Code (AAC) modifications accordingly	Will be filed June 1, 2019
Develop provider notification of new 3.2- WM service.	Formal notification to be released at least 90 days before initiation of Waiver
Conduct provider training on ASAM requirements for ASAM 3.2-WM Level	Waiver Year 2

Level of Care: 3.7-WM—Medically Monitored Inpatient Withdrawal Management

Current State: Alaska Medicaid presently provides coverage for Clinically Managed Residential Withdrawal Management (ASAM 3.2-WM), but does not provide coverage either for Medically Monitored Inpatient Withdrawal Management (ASAM 3.7-WM) or for Medically Managed Intensive Inpatient Withdrawal Management (ASAM 4-WM).

Future State: Alaska Medicaid will create a new Waiver service to allow reimbursement of ASAM 3.7-WM. Coverage will be provided to all eligible recipients. We plan to locate this service in one location during Year 2 of the Waiver as specified in Appendix 1.

Alaska Medicaid will require prior authorization for all Inpatient Services provided under the 1115 Waiver, including this level of withdrawal management.

Actions Needed and Implementation Timeline:

Action	Timeline
Develop new Waiver service to allow reimbursement for ASAM 3.7-WM	Target effective date April 1, 2019
Pursue Alaska Administrative Code (AAC) modifications accordingly	Will be filed May 1, 2019
Develop provider notification of new 3.7- WM service.	Formal notification to be released at least 90 days before initiation of Waiver

Conduct provider training on ASAM requirements for ASAM 3.7-WM Level	Waiver Year 2

Level of Care: 4-WM—Medically Managed Intensive Inpatient Withdrawal Management

Current State: Alaska Medicaid presently provides coverage for Clinically Managed Residential Withdrawal Management (ASAM 3.2-WM), but does not provide coverage either for Medically Monitored Inpatient Withdrawal Management (ASAM 3.7-WM) or for Medically Managed Intensive Inpatient Withdrawal Management (ASAM 4-WM).

Future State: Alaska Medicaid will create a new Waiver service to allow reimbursement of ASAM 4-WM. Coverage will be provided to all eligible recipients. We plan to locate this service in three locations during Year 2 of the Waiver as specified in Appendix 1.

Alaska Medicaid will require prior authorization for all Inpatient Services provided under the 1115 Waiver.

Actions Needed and Implementation Timeline:

Action	Timeline
Develop new Waiver service to allow reimbursement for ASAM 4-WM	Target effective date April 1, 2019
Pursue Alaska Administrative Code (AAC) modifications accordingly	Will be filed May 1, 2019
Develop provider notification of new 4-WM service.	Formal notification to be released at least 90 days before initiation of Waiver services
Conduct provider training on ASAM requirements for ASAM 4-WM Level of Care	Waiver Year 2

Community Recovery Support Services

Current State: Alaska Medicaid currently provides coverage for Comprehensive Community Support Services, Recipient Support Services, and Peer Support Services for both youth and adults. Coverage is provided to all Medicaid recipients.

The services are not focused on those services that specifically initiate, support, and enhance recovery from addiction and that address ASAM criteria considerations for Dimension 6—Recovery and Living Environment.

Future State: Alaska Medicaid will pursue a SPA to delete Comprehensive Community Support Services (CCSS) and Recipient Support Services (RSS). We will develop a new Waiver service—Community Recovery Support Services—which addresses the elements of Dimension 6. Coverage will be provided to all eligible recipients under the

proposed 1115 Waiver.

Actions Needed and Implementation Timeline:

Action	Timeline
Pursue a SPA to delete CCSS and RSS. Develop new Waiver service to allow reimbursement for Community Recovery Support Services.	Target effective date April 1, 2019
Pursue Alaska Administrative Code (AAC) modifications accordingly	Will be filed May 1, 2019
Develop provider notification of new service	Formal notification to be released at least 90 days before initiation of Waiver services
Phase-out deleted services and phase-in new service	Based on 50/50 schedule
Conduct provider training on ASAM elements of Dimension 6 and requirements for Community Recovery Support Services	Based on 50/50 schedule

Milestone #2: Use of Evidence-Based, SUD-Specific Patient Placement Criteria

Alaska has aligned its Medicaid-reimbursable SUD services with previous versions of the ASAM criteria to the extent possible. However, as mentioned in Milestone #3 (C), the DBH does not formally and systematically monitor compliance with these specifications. Alaska plans to require the ASO to develop such a monitoring protocol, in partnership with the DBH. Thus, the Waiver is the primary vehicle for ensuring that use of ASAM placement criteria occurs and is appropriately utilized.

A primary purpose of Alaska's 1115 Waiver is to universally screen all Medicaid-eligible individuals for SUD in order to identify symptoms of misuse or abuse of drugs or alcohol before they become functional impairments. Using available science and research to identify and match the individual with the intervention, treatment, and support tools he/she needs to achieve recovery is imbedded in our approach, beginning with use of evidence-based, SUD-specific screening and ending with evidence-based, SUD-specific Community and Recovery Support Services.

For new SUD services proposed in the 1115 Waiver, and for existing SUD services modified for the Waiver, Alaska will utilize the ASAM criteria for placement, for service types, for staffing, for number of clinical hours per unit, for therapies, and for treatment planning. We will use ASAM standards for certification of residential providers and for ongoing monitoring of compliance. Alaska will accomplish this through its contract with an ASO, a proposed series of SPAs, State administrative regulatory changes, policy manual changes, and Alaska Medicaid provider billing manual changes.

A. Evidence-Based Universal Screening and Evidence-Based Clinical Assessment

Individuals presenting for any Medicaid-funded service in any setting (i.e., primary care, behavioral health care) will receive an AUDIT and a DAST. If the number of "yes" answers indicate the need for further assessment based on quantified scoring criteria, the screener will refer the Medicaid recipient to a behavioral health provider for an integrated, comprehensive clinical assessment conducted by a qualified addiction professional. It is possible that both the screening and the assessment will be conducted by a SUD treatment provider. As part of this assessment, the six dimensions specified by ASAM will be addressed:

- Dimension 1—acute intoxication and/or withdrawal potential
- Dimension 2—biomedical conditions and complications
- Dimension 3—emotional, behavioral, or cognitive conditions and complications
- Dimension 4—readiness to change
- Dimension 5—relapse, continued use, or continued problems potential
- Dimension 6—recovery/living environment

Alaska is in the process of reviewing its current assessment tools and reviewing industry-standard evidence-based assessment instruments to determine which SUD- specific tool to select—whichever instrument is selected, alignment with ASAM criteria is a requirement. Alaska has conducted extensive research and is looking at the Comprehensive Addictions and Psychological Evaluation (CAAPE-5), the Composite International Diagnostic Interview (CIDI-5), the Global Appraisal of Individual Needs (GAIN), the Structured Clinical Interview for DSM-5 (SCID-5) for adults, the Comprehensive Adolescent Severity Inventory (CASI), the Diagnostic Interview Schedule for Children (DISC-IV), and Global Appraisal of Individual Needs (GAIN) for youth. The GAIN may be cost prohibitive and too time-consuming.

Whatever process providers use to complete an assessment (CONTINUUM, or one of the above mentioned tools) they will be required to participate in an electronic submission for to receive prior authorization from the ASO for all residential services. Residential service authorizations will need to be reviewed by the ASO to ensure that information is complete, accurate, filled out correctly, and reflect medical necessity for the level of care that is being requested.

However, depending up on standardized assessment tools that are selected, the ASO process may be a minimal review. One of the roles of the ASO will be to continually adjust the process to reduce barriers to intake and to expedite review processes to reduce the amount of time required for clients to enter treatment.

Alaska recognizes that provider training will be essential for successful implementation of Alaska's new, evidence-based screening and assessment processes. We will work closely with the ASO and ASAM to make certain that all available resources are utilized. The State's contract with the ASO will specify that the ASO's staffing include qualified addiction professionals well-versed in implementing the ASAM criteria.

B. The Role of Screening, Brief Intervention, and Referral to Treatment

As with universal screening as a way to identify symptomatology, SBIRT will play a critical role for those Waiver-eligible individuals presenting in emergency departments (EDs) of Alaska's 10 busiest hospitals in Alaska. The plan is that everyone presenting in the ED will receive an AUDIT and a DAST.

If the number of "yes" answers indicate low to moderate risk of substance use based on quantified scoring criteria, a trained and qualified specialist will provide a brief intervention while the individual is still at the hospital, once the individual has medical clearance from the primary care provider. Brief intervention will consist of 1-5 sessions (each from 15 to 30 minutes), will occur after screening, and at least one follow-up will be scheduled, either in person, by telephone, or telemedicine.

If the number of "yes" answers indicate moderate to high risk of risky behavior and/or misuse, referral to brief treatment will occur. Brief treatment will consist of 6-10 sessions (most likely on a weekly basis) provided by a qualified addiction professional to focus on reducing the risk of harm from misuse. Individuals may also be referred to a SUD treatment provider for an integrated, comprehensive clinical assessment conducted by a qualified addiction professional if the brief intervention suggests symptoms of addiction.

Individuals requiring more intensive services, whether identified during screening, brief intervention, or brief treatment, will receive an integrated, comprehensive clinical assessment conducted by a qualified addiction professional. Referral to outpatient, intensive outpatient, partial hospitalization, or residential services may occur at that point.

These front-end SUD Waiver services are designed to identify signs and symptoms and intervene with the appropriate ASAM Level of Care as early as possible (i.e., before any untreated SUD escalates into dependence). DHSS believes this is both clinically and economically the most efficient and effective course of action. Included in Alaska's armamentarium of services designed to facilitate access to the appropriate ASAM Levels of Care are crisis response services, particularly mobile crisis response services.

We plan to require the ASO to establish a 1-800 call center that anyone in the State can utilize. Wherever a crisis occurs, clinical professionals will be available in each Waiver region to assess, de-escalate the situation if appropriate, refer to the appropriate services, or make arrangements for emergency services. Alaska is particularly sensitive to youth experiencing SUD-related crises and will make certain that mobile crisis response teams are able to obtain and interpret information, are knowledgeable about the signs and symptoms of alcohol and other drug misuse, dependence, and/or intoxication, and will work closely with families to maintain the youth at home, if possible.

C. Service Access and Utilization

Whenever a qualified addiction professional has completed an integrated, comprehensive clinical assessment, Alaska plans to use the ASO as an independent third party with the necessary competencies to review the ASAM criteria. All services above ASAM Level 2.5 will require prior authorization by the ASO and length of stay will be determined by medical necessity.

Alaska Medicaid will approve the ASO's evidence-based system for clinical guidelines and will ensure that the ASO's guidelines incorporate the medical necessity criteria required for each ASAM level of care. We plan to require that clinicians use a software system that incorporates evidence-based clinical assessment and ASAM criteria to streamline access to care (e.g., CONTINUUM or a similar system).

The ASO will be required to have policies and procedures in place to:

1) review instances of over- and under-utilization of emergency room services and other health care services;
2) identify aberrant provider practice patterns;
3) evaluate efficiency and appropriateness of service delivery; and
4) identify quality of care and treatment issues.

All of these processes are especially critical to the State's efforts around combatting substance use, given Alaska's traditional reliance on more acute levels of care in the

absence of sub-acute, community-based services.

A list of action items and expected implementation timeline related to screening, assessment, SBIRT, and service access and utilization are provided in the table below:

Action	Timeline
Conduct provider training on ASAM criteria	Ongoing throughout 2019
Finalize ASAM-aligned assessment instrument	June 1, 2019
Conduct provider training on assessment instrument	Ongoing throughout 2019
Procure contract with ASO	Early Spring 2019
Approve ASO policies and procedures	June 1, 2019

Milestone #3: Use of Nationally Recognized SUD-specific Program Standards for Residential Treatment Facility Provider Qualifications

A. Licensure and Regulatory Changes to Align with ASAM Standards for Service Types and Hours of Clinical Care

Alaska will use the program standards from ASAM criteria to implement the residential treatment provider qualifications requirement. Because we require that grantees are accredited by the Council on Accreditation (COA), the Commission on Accreditation for Rehabilitation Facilities (CARF), or The Joint Commission, Alaska's providers are well prepared to align their SUD residential programs with ASAM standards for service types and hours of clinical care for adult Residential Services 3.1, 3.3, and 3.5. A major focus for the SUD portion of the Waiver will be developing capacity for Youth SUD services, including residential services 3.1 and 3.5. A breakdown of all Adult and Youth SUD outpatient, residential, and OTP/OBOT providers by ASAM Level of Care and by Waiver region is provided in Appendix 1.

Because of the accreditation requirement, Alaska currently *approves* all SUD residential facilities—whether grantees or not--rather than certify/license. The approval process is governed by Title 7 of the Alaska Administrative Code, Chapter 70.990. The State only approves providers who are accredited by Joint Commission, CARF or COA. They are required to submit their Accreditation Certificate, as well as the Certification Report. If and when the provider is granted full Department approval, the expiration date is aligned with their National Accreditation Expiration date. The State conducts an onsite visit which includes a file review and also requires that the provider's staff receive a full day of documentation training (which DBH provides). Once full Department approval is granted, site visits are not done on a regularly scheduled basis, but are done if complaints are received, concerns expressed by clients, staff or the public, or if there is any indication that something is amiss with their Medicaid billing. Approved providers are required to enter their data into the Alaska Automated Information Management System (AKAIMS) and are required to submit quarterly financial and narrative reports and board meeting minutes, as well as documentation of their participation in Community Action Plan meetings.

DHSS does not presently have published standards in place that specify criteria for service types, clinical care hours, and staff credentials for each ASAM residential treatment setting. DHSS also does not have a formal, systematic monitoring protocol to assess ongoing compliance with Alaska/ASAM requirements; DHSS generally responds to issues and problems as they come to the attention DBH from either the provider, a recipient, or a family member.

For Adult SUD residential, Alaska has a total of 270 ASAM Level 3.1 and 3.5 beds statewide, located in 8 of the 9 Waiver regions. The primary focus for adult residential, other than certification, will be to increase the State's capacity for Women & Children's residential services, which are located in only three of our nine regions. DHSS will

review existing administrative regulations and Medicaid provider billing manuals to update the regulations pursuant to ASAM criteria for service setting, provider types, treatment goals, required therapies, and hours of clinical care. Our Medicaid regulations are governed by Title 47, Alaska Statutes, and are located in Chapter 7 of the Alaska Administrative Code, primarily Sections 135.010-135.990. The regulations specify scope of services requirements for a wide variety of behavioral health services, including residential SUD, detoxification, screening/brief intervention, pharmacologic management, and screening/assessment, but reference to ASAM criteria is not included. However, references to previous ASAM requirements (i.e., 2nd edition) do exist in our Community Behavioral Health Services Medicaid Provider Billing Manuals. Both 7 AAC and the Billing Manuals will have to be revised to accommodate changes pursuant to the Waiver. In addition, DBH will establish a formal certification process for SUD providers wishing to receive reimbursement from Alaska Medicaid for adult residential services, which officially designates the provider as either an ASAM Level 3.1, 3.3, or 3.5 facility.

For Youth SUD residential, Alaska has 46 ASAM Level 3.5 beds statewide, located in only 3 of the 9 Waiver regions. There are many service gaps which DHSS plans to address with additional ASAM Level 3.1 and 3.5 beds and, as mentioned in the previous section, with additional IOP and PHP, step-up/step-down services. For youth residential, DBH will also review the State's existing administrative regulations and Medicaid provider billing manuals for Level 3.5 service descriptions, will create Level 3.1 regulations based on ASAM criteria, and, for both levels, will address ASAM criteria for service setting, provider types, treatment goals, required therapies, and hours of clinical care. DBH will establish a formal certification process for SUD providers wishing to receive reimbursement from Alaska Medicaid for Youth residential services which officially designates the provider as either an ASAM Level 3.1 or 3.5 facility.

Like most States, Alaska's formal rulemaking (administrative regulation) process can take anywhere from 1-1 ½ years for promulgation. Alaska is, therefore, requesting to issue provisional ASAM designations until the new residential treatment facility provider qualification certification process have been promulgated. DBH will use the following provisional designation process, with the assistance of the ASO:

- Review provider capacity by ASAM Level/Waiver region—***January 2019***
- Develop provider notifications regarding Alaska's provisional designation process (e.g., survey detailing provider setting, types of services, staffing, therapies, hours of clinical care/residential day, etc.)—***February 2019***
- Review documents and schedule brief, 1-day onsite visit—***February 2019***
- Develop DBH team of SUD professionals to conduct onsite reviews—***January 2019***
- Conduct review—***March 2019***
- Make recommendation for possible provisional designation to DBH Director—***April 2019***

DHSS anticipates having the ASO on board by April of 2019 and beginning SUD

to issue guidance to the State's currently approved residential providers regarding the requirement of ASAM designation and the formal certification process in March of 2019. DBH will have begun revising relevant sections of the Alaska Administrative Code and DBH Medicaid Provider Billing Manuals to incorporate all required elements of ASAM criteria, including the requirement that residential facilities offer Medication-Assisted Treatment (MAT) in residential facilities (either onsite or through facilitated access off-site). Alaska does not currently have in place a requirement that residential treatment providers offer MAT onsite or facilitate access off- site. To ensure compliance with this requirement, the ASO will maintain a list of all SUD residential providers offering MAT and, for those who facilitate access, will review proximity of that access during the prior authorization process and will monitor service utilization during the course of treatment.

The process we plan to use to develop, review, and monitor the standards includes the following steps:

- Issuance of a formal letter with attached survey/questionnaire sent to each current residential facility explaining 1115 Waiver requirements for SUD services and requesting facility-specific service/staffing/accreditation information (Month 2 post-CMS approval).
- Onsite visits to each facility to begin discussions on both the new and revised 1115 Waiver coverages for SUD residential services, the new certification requirements, and follow-up information per provider responses to the questionnaire. The completion of the questionnaire will assist DMHA in assigning a provisional ASAM Level of Care designation to the facility (Months 3-6 post-CMS approval).
- Issuance of formal guidance regarding the specific requirement of ASAM designation. Will include dates DBH will accept provider applications/documentation for provisional ASAM designation. This will occur simultaneously with DBH revisions of 7 AAC to specify residential certification with all required aspects of the ASAM criteria, including a requirement that residential facilities offer Medication-Assisted Treatment (MAT) on-site or through facilitated access off-site) Month 7 post-CMS approval .
- Acceptance of requests for provisional designations (Month 8).
- Approval/disapproval of provisional designation (Month 9).

The action items and expected implementation timeline for the standards for residential treatment facility provider qualification and formal certification are presented in the table below:

Action	Timeline
Finalize process for provisional ASAM designation of qualified residential provider (including MAT requirement)	Will be completed by May of 2019
Modify Alaska Administrative Code to include formal certification process based on the ASAM criteria (Including MAT requirement)	Will be filed by May of 2019
Modify Provider Medicaid Billing Manual to include formal certification process based on The ASAM criteria (including MAT requirement)	Will be completed by May of 2019

B. Workforce Development Changes to Align with ASAM Standards for Staffing

Alaska's health care system in general has suffered shortages and a mal-distribution of primary care health providers for many years. This situation is exacerbated for Alaska's addiction workforce. The difficulties in recruiting and retaining a qualified addiction professional workforce in Alaska are complex, but the impact of the extreme geographic isolation of Alaska's SUD settings cannot be denied. In turn, SUD staff retention challenges destabilize existing work settings and lead to further workforce shortage problems.

The United States Department of Health and Human Services' Health Resources and Services Administration (HRSA) has designated most of Alaska's geographic area as Health Professional Shortage Areas (HPSAs) based on the lack of mental health clinicians. HPSAs can apply to geographic areas (HPSAs cover 96% of Alaska's land mass), population groups (HPSAs cover 39% of Alaska's population), and health care facilities.

There are 24 geographic areas designated as mental health (MH) HPSAs and 15 MH HPSAs based on Alaska Native or Native American Tribal populations (AN/NA) throughout Alaska. The following Waiver regions are designated by HRSA as MH HPSAs[12]:

- Region 1—1 HPSA for AN/NA (Anchorage Municipality)
- Region 2—2 HPSAs for AN/NA (Fairbanks North Star Borough)
- Region 3—4 HPSAs for geographical areas (Denali and North Slope Boroughs and Southeast Fairbanks and Yukon-Koyukuk Census Areas) and 1 HPSA for AN/NA (North Slope Borough)
- Region 4—1 HPSA for geographical area (Kenai Peninsula Borough) and 2 HPSAs for AN/NA (Kenai Peninsula Borough—Soldotna and Homer)

- Region 5—1 HPSA for geographical area (MatSu Borough) and 1 HPSA for AN/NA (MatSu Borough)
- Region 6—4 HPSAs for geographical areas (Bethel, Kusilvak, Nome Census Areas), (Northwest Arctic Borough) and 3 HPSAs for AN/NA (Nome Census Area)
- Region 7—6 HPSAs for geographical areas (Haines, Hoonah-Angoon, Petersburg, Skagway, Wrangell, and Yakutat Boroughs) and 1 HPSA for AN/NA (Sitka Borough)
- Region 8—2 HPSAs for geographical areas (Ketchikan Gateway Borough and Prince of Wales-Hyder Census Area) and 2 HPSAs for AN/NA (Ketchikan Gateway Borough and Prince of Wales-Hyder Census Area)
- Region 9--6 HPSAs for geographical areas (Aleutians East, Aleutians West, Dillingham, and Valdez-Cordova Census Areas and Bristol Bay and Lake and Peninsula Boroughs) and 2 HPSA for AN/NA (Dillingham and Valdez-Cordova Census Areas)

Thus, every Waiver region has significant MH and SUD workforce capacity shortages. There are only two Waiver regions that do not have geographical areas designated as HPSA—Anchorage and Fairbanks. We plan to use the Waiver as an opportunity not only to recruit and retain a qualified addiction workforce, but to begin to elevate the level of professionalism in the substance abuse treatment field by expanding the educational requirements for certification. These modifications will bring Alaska's certification requirements into alignment with ASAM over the course of the Waiver. An initial step will be to survey each Waiver region hub to determine the specific SUD workforce needed to provide Waiver services.

Addiction professionals in Alaska are certified by the Alaska Commission for Behavioral Health Certification (ACBHC). Certification is based on coursework, experience, and examination. A college degree is not required, but candidates with degrees in related fields can move through the ranks more quickly; degreed candidates also need to complete fewer contact hours of specific board-mandated coursework. Thus, there are two tracks: a degree track and a non-degree track--for certification as either a Counselor Technician, a Chemical Dependency Counselor I, a Chemical Dependency Counselor II, or a Clinical Supervisor. The framework for the certification process is the National Association of Alcoholism and Drug Abuse Counselors—now called NAADAC, the Association for Addiction Professionals. All Alaska certified addiction professionals must complete Ethics and Confidentiality training; all NAADAC training is deemed approved by ACBHC.

Training is also provided by the Regional Alcohol and Drug Abuse Counselor Training (RADACT) Program. RADACT is a nonprofit organization that coordinates and delivers on-site training to individuals who are in process of pursuing certification. RADACT also provides correspondence courses and offers a three-week intense training academy.

As of January 2018, Alaska has approximately 1022 certificate holders which include 133 Counselor Technicians, 481 Chemical Dependency Counselors I's, 188 Chemical

Dependency Counselors IIs, 69 Chemical Dependency Clinical Supervisors, and 16 Chemical Dependency Administrators.

We will review existing certification standards and requirements and align them with the knowledge, skills, and abilities for staff which are listed in ASAM criteria, Third Edition, for Residential Levels 3.1, 3.3, and 3.5 for adults and Levels 3.1 and 3.5 for youth.

A list of action items and expected implementation timeline related to addiction residential workforce development is provided in the table below:

Action	Timeline
Develop list of certified addiction professionals located in existing SUD residential providers	Will be completed by March of 2019
Work with ACBHC to modify existing certification standards to align with ASAM Levels 3.1, 3.3, and 3.5 staffing requirements	Will be completed by August of 2019

C. Ongoing Accountability to Ensure Provider Compliance with Standards

Alaska does not have a formal, systematic monitoring protocol to assess ongoing compliance with its requirements. However, Alaska will develop a formal monitoring protocol to ensure ongoing provider compliance with ASAM criteria for Residential Levels 3.1, 3.3, and 3.5. The monitoring protocol will align with the provider standards to be included in the Title 7 of the Alaska Administrative Code, the Alaska Medicaid Provider Billing Manual for Community Behavioral Health Services, and the afore-mentioned provisional and permanent SUD residential provider certification process. The monitoring protocols will include both desk reviews of required documents biannually and onsite reviews once a year. DBH will work in concert with the ASO to develop and implement the monitoring protocols. The ASO is DBH's contractor and, as such, reports directly to DBH. Regarding provider monitoring of these residential standards, DBH envisions working more closely with the ASO to ensure that Waiver requirements are met and will delegate some, but not the majority, of monitoring responsibilities to the ASO—we would envision, for example that desk reviews of documents required for provisional and permanent designation could by conducted by ASO with summaries to DBH. Onsite reviews, however, will be conducted by teams including DBH and ASO. And, of course, final decisions regarding designation lie solely with DBH. Specific responsibilities regarding the ASO's auditing new providers for the Waiver will be included in the ASO contract.

Generally, the ASO will have responsibility for a variety of provider monitoring activities, including audits and reviews of activities ranging from quality of care to OMB Single Audit report reviews. In addition, the ASO will monitor, aggregate, and report to DBH on provider performance based on DBH-specified performance indicators to be reported by providers to the ASO. The ASO will work in partnership with DBH to monitor fidelity of EBP implementation, co-chairing an EBP Committee to review fidelity of implementation across Alaska. The ASO will have substantial reporting requirements to DBH and will be

required to report to DBH on a daily/weekly/monthly basis on several provider-related activities, including prior authorization, concurrent/retrospective review (as an example, retrospective reviews are planned for services already provided to individuals whose Medicaid eligibility was retroactively approved) , provider capacity, provider recruitment, provider training, provider performance, quality management trends, providers with high volume denials, service utilization & expenditures by provider, length of stay by provider, readmissions by provider, etc. The State recognizes that only the State shares intergovernmental responsibility for the expenditure of these public funds and is by no means abrogating that responsibility.

A list of action items and expected implementation timeline related to Ongoing Compliance is provided in the table below:

Action	Timeline
Develop monitoring protocol	Will be completed by August of 2019
Initiate ongoing monitoring process	Will begin September of 2019

Milestone #4: Sufficient Provider Capacity at Critical Levels of Care

A. Existing SUD Provider Capacity

As mentioned in the plans to address Milestone #3, Alaska presents unique challenges in access to and delivery of SUD services most notably because of the state's vast size, number of isolated communities, and the amount of area that is designated as health professional shortage area and medically underserved. Cultural and linguistic variations also lend to this challenge. Many communities are located at considerable distance from SUD providers and are without road access. For many small communities, primary care and other healthcare providers are available on an itinerant basis only; treatment must occur at larger hospitals in urban centers for which air travel is necessary.

This situation presents a tremendous challenge for SUD provider capacity at all ASAM Levels of Care. Currently, there are 80 providers of SUD services in Alaska—including withdrawal management, outpatient, intensive outpatient (non-Medicaid), residential, OTPs, and alcohol safety action program services. 18 providers are residential services providers. These providers include both DBH grantees and non-grantees. A Waiver region breakdown of SUD providers includes the following:

- Waiver Region 1—29 providers (36% of total)—OTP, OBOT, residential (6 providers), withdrawal management (residential), OP, & IOP.
- Waiver Region 2—9 providers (11% of total)—OTP, OBOT, residential (2 providers), withdrawal management (residential), OP, & IOP.
- Waiver Region 3—6 providers (8% of total)—OP.
- Waiver Region 4—6 providers (8% of total)—OBOT, residential (1 provider), withdrawal management (residential), & OP.
- Waiver Region 5—6 providers (8% of total)—OBOT, residential (2 providers), OP, & IOP.
- Waiver Region 6—3 providers (4% of total)—OBOT, residential (1 provider) & OP.
- Waiver Region 7—9 providers (11% of total)—OBOT, withdrawal management (IP), residential (3 providers), OP, & IOP.
- Waiver Region 8—5 providers (6% of total)—residential (1 provider) & OP.
- Waiver Region 9—7 providers (9% of total)—OBOT, residential (1 provider), OP & IOP.

As we are proposing to increase or develop capacity for ASAM Level 3.5, ASAM Level 3.1 and 3.3 residential, intensive outpatient, partial hospitalization, OTP, MAT, mobile outreach and crisis, and ambulatory withdrawal management services throughout the State to address existing service gaps, we recognize that one of the most significant challenges under the Waiver will be to develop qualified and reliable SUD provider capacity. Alaska will require that any willing and qualified provider may enroll to provide Medicaid covered services.

Details regarding proposed increased SUD provider capacity by ASAM Level of Care for each Waiver region are included in Appendix 1.

A list of action items and expected implementation timelines related to Provider Capacity is provided in the table below:

Action	Timeline
Recruit qualified providers to address increased capacity	Based on 50/50 schedule

B. New Provider Types

To address many of the provider capacity issues listed above, the Waiver will add the following new Medicaid provider types to address existing SUD provider capacity needs: Individual licensed providers that can bill as independent providers, such as licensed psychologists, licensed psychological associates, licensed clinical social workers, registered nurses, licensed practical nurses, advanced nurse practitioners, licensed marriage and family therapists, licensed professional counselors, certified behavioral health aides, certified peers, and Certified Chemical Dependency Counselors.

We anticipate these new mid-level provider types will assist in addressing the new service capacity for IOP (ASAM Level 2.1), PHP (ASAM Level 2.5) and will assist residential treatment facilities in meeting ASAM criteria for staff credentialing referenced in Milestone #3 (ASAM Levels 3.1, 3.3, and 3.5). We will actively recruit additional withdrawal management providers, focusing solely on those that will provide ambulatory services. This is designed to prevent Alaska's current situation of over-utilization of residential and IP detoxification services—we currently have 2 ASAM Level 3.7-WM providers (1 in Region 1 and 1 in Region 4), 1 ASAM Level 3.7-D provider (Region 2), and 1 ASAM Level 4-WM provider (Region 7). We have no ASAM Level 1-WM or 2-WM in the State.

To address the increase in service capacity for MAT, we already have a list of Alaska OTPs and the number and location of Medicaid providers who have the appropriate buprenorphine training. Increasing use of naltrexone will require training of physicians either already prescribing or wishing to prescribe this MAT. Even though we have a good sense of where MAT providers are located, we will conduct a comprehensive assessment of MAT for Alaska Medicaid recipients and make certain we increase access not only to buprenorphine but, also to any currently approved and effective pharmacological treatment for substance use disorders which we anticipate will be used both for recipients suffering from opioid and alcohol addiction. It is important to note that Alaska has expanded capacity via Medicaid billing by removing the requirement for methadone clinics to have a Comprehensive Community Behavioral health Grant in order to be an enrolled Medicaid provider. This change has allowed two for-profit methadone clinics to enroll in the Medicaid program, expanding capacity for approximately 600 additional recipients.

A list of action items and expected implementation timelines related to New Provider Types is provided in the table below:

Action	Timeline
Identify new provider types by region	Will be completed by February of 2019
Develop notification/communication re Waiver and ASAM requirements	Will be completed by March of 2019
Pursue AAC and Provider Billing Manual changes	Will be completed by May of 2019
Enroll new provider types as independent Medicaid billing providers	Will be completed by April of 2019

C. Overall Provider Capacity Development Strategy

The state of Alaska requires that any willing and qualified provider may enroll to provide Medicaid covered services. Participant access to behavioral health services is highly dependent on reliable provider capacity. We recognize the importance of developing and maintaining an effective and efficient program for growing regional provider capacity and support with any willing and qualified providers throughout the statewide SUD system of care. We plan to work with the ASO regarding provider capacity development and support to include strategies to address barriers to provider participation throughout Alaska and to target efforts for the rural and remote areas of the state, including additional use of telemedicine. Service analysis will include service gaps and areas in which there is provider saturation in each of the nine waiver regions. As can be determined from the list of SUD providers by Waiver region, we already know which regions are saturated and which regions have extremely limited provider capacity. Alaska also knows, by Waiver region, where the State wants to locate increased capacity. This gives Alaska a good start for developing the necessary capacity. Alaska will coordinate efforts with both Tribal and non-Tribal behavioral health provider communities in these regions, in addition to coordinating with other health care, social, and educational systems involved in participant service provision. Telemedicine will play an important part in providing access to our more isolated communities. Currently, Medicaid will reimburse for the following telemedicine services: initial or one follow-up office visit; consultation made to confirm diagnosis; a diagnostic, therapeutic or interpretive service; psychiatric or substance abuse assessments; individual psychotherapy; and pharmacological management services.

Alaska's overall strategies for developing regional provider capacities are to 1) promote rapid access to willing and qualified providers, peer supports, and other community-based resources that offer effective services and supports, 2) support providers in the integration of recipients into their communities, utilizing community supports and resources, consistent with the recipient's needs, preferences, choices, and informed consent, and 3) improve provider performance through streamlined administrative requirements, data descriptions of provider services, and outcomes data collection and management.

A list of action items and expected implementation timelines related to Overall Provider Capacity Development is provided in the table below:

Action	Timeline
Assess ASAM providers and services by region	March of 2019
Work with ASO to provide training on ASAM criteria and requirements for Waiver reimbursement	Ongoing, beginning May 1, 2019
Develop notification/communication re formal designation	May of 2019
Implement formal designation process	June of 2019

Milestone #5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse

A. The Alaska Opioid Policy Task Force

The Alaska Opioid Policy Task Force was convened in 2016 by the Advisory Board on Alcoholism and Drug Abuse, Alaska Mental Health Trust Authority, and Alaska Department of Health and Social Services at Governor Bill Walker's request. The 20-member Task Force, representing diverse constituencies from across Alaska, held 12 public meetings to explore the public health dimensions of opioid misuse and abuse in Alaska. The Task Force heard testimony from national experts, received public comment at all task force meetings and other forums around the state, received input from local community heroin/opioid coalitions, and conducted research to understand the latest science and evidence-based practices.

The Alaska Opioid Policy Task Force organized their 32 recommendations according to a public health framework developed by the Association of State and Territorial Health Officials (ASTHO). A summary of the recommendations in each area are as follows:

- Environmental Controls and Social Determinants of Health—Nine recommendations relating to reducing & controlling access to opioids (full utilization of Alaska's Prescription Drug Monitoring Program and more "nimble" regulation of opioid substances of abuse) and reducing risk of opioid misuse/abuse/dependence (screening and community prevention programs)
- Chronic Disease Screening, Treatment and Management—13 recommendations relating to screening & referral (SBIRT in all health care settings) and treatment (adopt chronic disease management framework for SUD treatment, implement state opioid prescribing guidelines, conduct, addiction medicine training for all state licensed/certified/registered health care professionals, increase withdrawal management options, decrease use of hospitals, & increase non-residential SUD treatment capacity)
- Harm Reduction—Four recommendations relating to overdose prevention (increase access to naloxone) and syringe exchange
- Recovery—Three recommendations relating to peer support reimbursement, "second chance" employers & Community Recovery Support for those receiving MAT
- Collaboration—Three recommendations relating to interagency collaboration, public safety and community prevention efforts, and mitigating incarceration for drug- related offenses/re-entry.

B. The Governor's Administrative Order # 283—The Plan

After reviewing the Task Force's recommendations in early 2017, the Governor issued Administrative Order (AO) # 283 to address "the urgent need to raise awareness and develop solutions regarding the prevention, treatment, and recovery from opioid misuse and heroin addiction in Alaska." AO #283 outlines the Governor's Plan to combat the

heroin and opioid epidemic and overdose-related deaths in Alaska. The Governor directed the Departments of Health and Social Services, Corrections, and Public Safety to evaluate and apply for grants (including Federal grants) available to assist Alaska in combating heroin and opioid abuse.

The Governor issued the following agency-specific directives:

- Directed the State's Chief Medical Officer to establish an incident command structure to respond to the epidemic
- Directed the Department of Corrections to implement MAT
- Directed the Department of Corrections to coordinate with Department of Health and Social Services to ensure availability of MAT after withdrawal
- Directed the Department of Public Safety to develop options to identify the pathways through which illegal drugs are brought into Alaska and to restrict the entry of illegal drugs through improved screening and enforcement measures.

Several actions resulted from the Governor's Directives:

- Project HOPE was launched—a statewide program to get the drug naloxone rescue kits into the hands of emergency first responders, family members and friends, and opioid users as well as individuals who are at risk for opioid overdose.
  DHSS authorizes private or public entities to distribute Project HOPE Narcan rescue kits and conducts educational programs using a core curriculum that includes information and training on how to recognize an opioid overdose, use the proper rescue breathing technique, and properly administer naloxone for the individual until emergency medical help arrives. Regional Overdose Response Programs (ORP's) have been identified in the communities of high need, regional ORPs will have the authority to authorize local ORP's, provide Project HOPE education and training, and equip local ORP's and the community with Project HOPE Heroin/Opioid Overdose Rescue Kits.
- An Alaska Opioid Command System was developed within the Governor's Office with cabinet-level presentation from 11 departments of state government: Health and Social Services, Law, Public Safety, Commerce, Corrections, Education, Transportation, Fish and Game, Military and Veteran's Affairs, Labor, and Administration. The Department of Health and Social Services' Chief Medical Officer services as Incident Commander (IC) and the Director of the Office of Substance Misuse and Addiction Prevention is Deputy (IC). The group has meet as frequently as weekly with the Governor to provide updates and for strategic and tactical planning. Execution of the response is driven by a multi-departmental team, organized in tradition IC structure into sections for operations, logistics, planning, and finance. The response teams include community outreach, data, criminal justice, education, and media relations, to name a few (see below). The response teams meet biweekly to discuss updates, data, and strategies to combat the opioid crisis.
- Creation of a Data Team that monitors a number of metrics to generate situational reports to the Governor and to populate a public-facing opioid data dashboard (http://dhss.alaska.gov/dph/Director/Pages/heroin-opioids/data.aspx) containing a summary of Alaska opioid statistics, emergency department visits, overdose

deaths, naloxone statistics, prescription drug monitoring program, and neonatal abstinence syndrome.

- The prescription drug monitoring program (PDMP) Awareness and Feedback Questionnaire Team was developed to create an online questionnaire/survey to solicit input from practitioners on interacting with the PDMP.

C. State of Alaska Strategic Plan for Responding to the Opioid Crisis

As a result of the Governor's Administrative Order, the Alaska Department of Health and Social Services' Division of Behavioral Health (DBH), where Alaska's State Opioid Treatment Authority resides, applied for and received two SAMHSA grants relating to combating the opioid crisis—The Medication-Assisted Treatment Prescription Drug and Opioid Addiction Capacity Expansion Grant (MAT PDOA: 9/1/16-8/31/19) and the Opioid State Targeted Response Grant (STR: 5/1/17-4/30/19). DBH also developed a comprehensive strategic plan to respond to the opioid crisis.

- MAT PDOA Grant:
  - $3 million over three years.
  - Funds two DBH providers--Narcotic Drug Treatment Center (NDTC) in Anchorage and Bartlett Rainforest Recovery Center (RRC) in Juneau.
  - NDTC received $450,000 for 2 ½ years after start-up. It is located in downtown Anchorage and provides Opioid Treatment Program (OTP) services involving full psychosocial rehabilitative services while incorporating methadone medication—goal was to increase capacity by 200 total.
  - NDTC has reached the goal of an additional 200 persons serve with MAT PDOA funding.
  - RRC received $350,000 for 2 ½ years after start-up. Bartlett is using the Office Based Opioid Treatment (OBOT) model that involves buprenorphine medication and psychosocial treatment—goal was to increase capacity by 75 persons per year.
  - Projected outcomes: increase access to MAT services in Alaska, increase in number of persons receiving integrated care, decrease in illicit opioid drug use, and decrease in prescription drug use in a non- prescribed manner.

- STR Grant:
  - Up to $4 million over two years.
  - Funds three DBH providers using Hub and Spoke model—Cook Inlet Council on Alcohol and Drug Abuse (CICADA) in Kenai, Fairbanks Native Association (FNA) in Fairbanks, and Interior Aids Association (IAA) in Fairbanks.
  - Goals: increase MAT provider capacity, increase the number of persons receiving appropriate OUD/MAT treatment, and decrease the negative impacts of opioid use.

- Objectives: increase the number of trained OUD prescribers, increase the number of OUD prescribers receiving buprenorphine waivers, increase the number of OUD prescribers implementing MAT, increase the number of behavioral health providers with OUD training, increase the number of people who receive OUD treatment, increase the number of people who receive OUD recovery services, decrease the number and rate of opioid use, increase access to Naloxone, and decrease the number and rate of opioid overdose-related deaths.
- The Department plans to form a small workgroup this year to discuss options to ensure the sustainability of Naloxone after federal funds lapse. Currently many of Alaska's pharmacies are carrying numerous versions of naloxone for purchase. It is the State's goal to have all pharmacies carry this produce in the future so individual can still directly go to a pharmacy without a prescription and receive naloxone and at their insurance/Medicaid/Medicare/ IHS rates.
- Total projected increase in unduplicated numbers served = 340.
- Total number of naloxone/overdose kits distributed = Over 10,000

- Alaska's 2018 Opioid Action Plan:
  - The purpose is to implement strategies to limit inappropriate access to opioids, prevent and reverse overdoses when necessary, and strengthen treatment system by expanding services.
  - Involved representatives from Office of Governor, Office of Lieutenant Governor, Department of Health and Social Services, Department of Public Safety, Department of Corrections, Department of Commerce Community and Economic Development, Department of Education and Early Development, Department of Law, Department of Military and Veteran Affairs, Alaska Native Tribal Health Consortium, and Local Opioid Task Force Chairs.
  - Recommended five major initiatives:
    1) Expand treatment capacity through funding Medication-Assisted Treatment (MAT) services—primary method to combat crisis.
    2) Use education and stringent regulatory oversight to reduce availability and access to controlled substances (mandate use of the PDMP).
    3) Adopt chronic disease management framework for SUD policies, health care coverage, increase naloxone and buprenorphine availability, and educational outreach.
    4) Collect and analyze cross-sector data to inform decision-making and evaluation of efforts (improve opioid surveillance).
    5) Cross-sector collaboration among State agencies, tribal health care system, and communities.

In order to remain focused on strategic policy-making regarding the opioid crisis across State agencies, DHHS' Office of Substance Misuse and Addiction Prevention is convening an interagency work group to review the Opioid Action Plan and formalize/expand content.

D. Alaska's Prescription Drug Monitoring Program

Alaska established a controlled substance prescription database in 2008 (Senate Bill 196), which was operated by the Board of Pharmacy under the name of "Alaska Prescription Drug Monitoring Program" (PDMP). The Board of Pharmacy is located within the Alaska Department of Commerce, Community and Economic Development Division of Corporations, Business and Professional Licensing. Since its inception, several statutory changes have impacted the database and the PDMP, the most important of which was in 2017, requiring mandatory registration, review, and reporting for dentists, physicians, nurses, optometrists, pharmacists, veterinarians, physician assistants, and advanced practice registered nurses. These important expanded requirements have resulted in Alaska's ability to collect, analyze, and report on controlled substance usage at a level that is both quantitatively and qualitatively much more detailed than in previous years. The PDMP must report certain performance measures to the Alaska Legislature, including security of the PDMP, reductions in inappropriate use or prescription of controlled substances as a result of the PDMP, coordination among PDMP partners, and stakeholder involvement in planning. Other data reported includes number of practitioners registered by discipline, patient prescription history requests, number of patients receiving an opioid prescription, number of total prescriptions and dispensations, top drugs dispensed, and the number of patients receiving high levels of morphine milligram equivalent (MMEs) opioids.

E. Opioid Prescribing Guidelines

Historically, Alaska was one of just a couple of states that lacked a formal medical board position statement on the use of controlled medications to treat pain. That, however, has changed due to the State's opioid crisis and the resulting gubernatorial and legislative actions, beginning in 2016. The Alaska Legislature passed Senate Bill 74 during the 2016 session. In addition to requiring that the Department of Health and Social Services apply for an 1115 Behavioral Health Waiver to reform Alaska's behavioral health delivery system, SB 74 directed the Boards of Dental Examiners, Medicine, Nursing, Examiners in Optometry, and Pharmacy to recommend guidelines for the prescription of Schedule II controlled substances listed under Federal law. On December 30, 2016, the Boards recommended that the State of Washington's *Interagency Guideline on Prescribing Opioids for Pain, 3rd edition* be adopted with minor modification to incorporate the 2016 Centers for Disease Control and Prevention pain management guidelines.

The Alaska Medical Board issued revised policies and procedures adopting the guidelines in 2017. In addition, the Board has posted the requirements for mandatory registration in the PDMP and its proposed regulations regarding the PDMP.

While we are in the beginning phases of prescribing guidelines and mandatory registration/reporting under Alaska's PDMP, we believe this status will provide a solid foundation for addressing the opioid crisis. To assist the State in comprehensively addressing the crisis, however, Alaska expects to expand MAT services even further under the Waiver.

F. Integrating Alaska's Prevention and Treatment Efforts

Clearly Alaska has invested a considerable amount of time and energy in addressing the opioid crisis. The Waiver will play an important role in continuing and improving upon these treatment-related efforts. Before 2016, Alaska's services to address OUD included the following prevention and treatment efforts:

- Substance Abuse Prevention and Treatment Block Grant funding of methadone services in Anchorage and Fairbanks
- Strategic Prevention Framework-Partnership for Success funding for opioid prevention efforts in 6 communities.

The two capacity expansion grants have allowed the State to build upon this foundation and pursue a three-pronged strategy to address this crisis:

- Increased access to methadone vis-à-vis regulatory changes—increased number served by 600
- Increased access to buprenorphine and methadone vis-à-vis MAT PDOA and STR grants
- Increased access to naloxone vis-à-vis STR grant
- Proposed increased access to buprenorphine and naltrexone vis-à-vis Waiver
- Proposed modification of SBIRT to identify and intervene early with OUD vis-à-vis Waiver
- Proposed new service MAT Care Coordination under Waiver to integrate MAT with primary care services vis-à-vis Waiver.

Today, Alaska's OUD treatment capacity includes:

- 4 OTPs (Anchorage Treatment Solutions—Anchorage/Region 1, Community Medical Services—Wasilla/Region 5, Interior Aids Association—Fairbanks/Region 2, and Narcotic Drug Treatment Center—Anchorage/Region 1)
- Approximately 319 DATA Waivered Practitioners.

The State does not want to lose the momentum gained from these statewide efforts; both grants expire during Waiver Year 1 and Alaska has crafted the Waiver MAT services to sustain these services. Alaska plans to expand access to both buprenorphine and naltrexone or any currently approved effective pharmacological treatment for substance use disorders to further enhance its statewide MAT capacity.

Alaska Medicaid provides reimbursement for naltrexone, but the medication is under-utilized. DBH staff have studied the research and have observed naltrexone's record with individuals suffering from both alcohol and OUD. The plan is to have MAT providers in each of the nine Waiver regions, to require Care Coordination to accompany MAT in each region, and to implement SBIRT in one hospital in each region. Alaska expects to treat 50 individuals per Waiver year with naltrexone, totaling 250 over the course of the Waiver.

Proposed increased treatment capacity for OUD is specified in Appendix 1.

A list of action items and expected implementation timelines related to Integrating Prevention and Treatment Efforts is provided in the table below:

Action	Timeline
Recruit qualified buprenorphine and naltrexone providers to address expanded capacity	Based on 50/50 schedule
Expand use of buprenorphine or any currently approved effective pharmacological treatment for substance use disorders to address OUD and expand use of naltrexone to address alcohol and OUD	Based on 50/50 schedule

Milestone #6: Improved Care Coordination and Transitions Between Levels of Care

A. SUD Care Coordination to Facilitate SUD Integration with Physical Health Care

Currently Alaska Medicaid does not reimburse for Care Coordination for SUD services. Under the Waiver, however, Alaska plans to require Care Coordination services specifically focused on integration with physical health care[15]. DBH plans to define the service as facilitating the appropriate delivery of integrated behavioral and primary health care services. Alaska recognizes that Care Coordination involves a wide range of services addressing patients' health needs--including medical, behavioral health, social, and legal services; as well as long-term supports and services, care management, self-management education, and transitional care services. Our definition of SUD Care Coordination includes:

- Integrating behavioral health services into primary care and specialty medical settings through interdisciplinary care planning, monitoring individual progress, and tracking individual outcomes;
- Facilitating smooth transitions from inpatient and residential care settings to community-based care settings;
- Supporting conversations between buprenorphine-waivered practitioners and behavioral health professionals to develop and monitor individual service plans;
- Linking individuals with community resources to facilitate referrals and respond to social service needs; and
- Tracking and supporting individuals when they obtain medical, behavioral health, or social services.

Care Coordination services will be required in order to receive Medicaid reimbursement for OP MAT services under the Waiver. Alaska's goal is to expand this service throughout the course of the Waiver, but the State does not have a specific timeline to do so. We want to gain the service experience during Year 1 of the Demonstration to better understand whether SUD Care Coordination services meet the case management needs of this population or if additional intensive case management services are required.

B. Intensive Case Management Services for Individuals with SUD

We recognize that there may be waiver-eligible individuals with SUD who may require case management services beyond the SUD Care Coordination services described above. Due to the challenges with the two behavioral health case management services defined in our State Plan, we have proposed two new Waiver services (SUD Care Coordination and Intensive Case Management/ICM) to address the broad case management needs of our Waiver populations. We designed ICM services primarily for Waiver eligibility groups 1 and 2, but we are prepared to utilize these services for the SUD waiver population if necessary and clinically appropriate. We have crafted each definition in an attempt to avoid duplication across similar community-based services that do not currently exist. Generally speaking, SUD Care Coordination is envisioned as more systems collaboration-oriented, specifically primary care coordination and collaboration.

ICM, however, is envisioned as a more client-specific, wrap around model where the intensive case manager begins with the behavioral health service needs of the client and identifies other resources as appropriate.

As we have discussed during the negotiation process, we define ICM services differently than SUD Care Coordination services:

- Broad focus on community-based behavioral health provider-specific services which may include engaging resources beyond that provider (e.g., schools, housing, employment, etc.);
- Advocacy and engaging natural supports;
- Assisting with activities of daily living, problem-solving skills, self-sufficiency, conflict resolution, & productive behaviors;
- Monitoring behavioral health service delivery, safety, and stability;
- Brokering and linking individuals with resources; and
- Triaging for crisis intervention purposes (e.g., determining need to intervention and referral to appropriate authorities).

Most importantly, we simply do not envision ICM services as focused on primary care interventions; however, primary care is at the heart of how we envision SUD Care Coordination services.

At this point, we do not anticipate that Waiver recipients will concurrently utilize both SUD Care Coordination and intensive case management (ICM) services; however, clients with intensive needs may require SUD Care Coordination to access Medication-Assisted Treatment, and ICM to obtain housing and/or to engage natural supports. This is why the most reasonable approach is to gain the service experience during Year 1 of the Demonstration to better understand whether SUD Care Coordination services meet the case management needs of this population or if additional intensive case management services are required. If additional case management services are required, we will require careful scrutiny on the part of the Administrative Services Organization (ASO) before agreeing to both services at the same time.

Our existing State Plan case management services do not meet the needs we have identified above. Our rationale by State Plan case management services is as follows:

- Targeted Case Management--SUD case management services per TN # 92-14, State Plan Supplement 1 to Attachment 3.1-A, which is currently **not utilized**--no HCPCS code and services limited to 4 hours in a 6-month period, with 20-30 minute/contact/service; and
- Behavioral Health Case Management services--a rehabilitation service that will be **removed** from the State Plan per previous CMS direction.

C. Additional Step to Ensure Transitions Between Levels of Care

Alaska plans to take an additional step to ensure smooth transitions for individuals with SUD who are moving between levels of care:

- Alaska will expand coverage of peer recovery coaches to assist SUD recipients in connecting with community services and resources—both professional and nonprofessional.

A list of action items and expected implementation timelines related to Improved Care Coordination and Transitions between Levels of Care is provided in the table below:

Action	Timeline
Develop SUD care coordination guidelines for transitions from residential to non-residential settings.	March 2019
Develop ICM guidelines to clarify difference from SUD Care Coordination services and circumstances for concurrent use	May 2019
Develop and implement peer recovery certification requirements.	Begin certification process—Summer of 2018 Implement Demonstration Year 2

APPENDIX 1— CURRENT ESTIMATE OF NUMBER AND LOCATIONS OF WAIVER SERVICES

The following information provides details regarding the proposed number of Waiver services and the proposed locations of services by Waiver region and by ASAM Level of Care **(Milestone #1).** In addition, increased SUD provider capacity by Waiver region **(Milestone #4)** and increased OUD provider capacity by Waiver region **(Milestone #5)** are provided. A map of Waiver regions is included in Appendix 2.

Milestone #1: Access to Critical Levels of Care for SUD Treatment

The following specifies Alaska's ***proposed SUD Waiver services*** by regional location.

Level of Care: Opioid Treatment Services (OTS)

Number of additional OTP—2. Proposed locations include Region 4 and Region 7 (both in Waiver Year 2).

Level of Care: 0.5—Early Intervention Services

Number of additional SBIRT Hospital ED locations—10. Proposed locations include 1 each in Regions 2-9 and two in Region 1 (all in Waiver Year 1).

Level of Care: 2.1—Intensive Outpatient Services (IOP)

Number of new IOP—24 (14 Adult and 10 Youth).

Proposed locations include:

- Region 1—8 IOP locations (4A and 4Y)
- Region 2—4 IOP locations (2A and 2Y)
- Region 3—1 IOP location
- Region 4—2 IOP locations (1A and 1Y)
- Region 5—4 IOP locations (2A and 2Y)
- Region 6—1 IOP location
- Region 7—2 IOP locations (1A and 1Y)
- Region 8—1 IOP location
- Region 9—1 IOP location

Regions 1 and 5 will develop IOPs in 12 locations during Waiver Year 1 and Regions 2-4 and 6-9 will develop IOPs in 12 locations during Waiver Year 2, at the latest.

Level of Care: 2.5—Partial Hospitalization Services (PHP)

Number of new PHP—4 (all Youth).

Proposed locations include those 4 regions with only one IOP program—Regions 3, 6, 8, & 9 (all in Waiver Year 2).

Level of Care: 3.1—Clinically Managed Low-Intensity Residential Services

Number of additional 3.1 beds—110 (90 Adult and 20 Youth).

Proposed locations include:

- Region 1—↑ 20 beds (15 A & 5 Y)
- Region 2—↑ 20 A beds
- Region 3-- ↑ 10 A beds
- Region 4—↑ 10 beds (5 A & 5 Y)
- Region 5—↑ 15 A beds
- Region 6—↑ 10 beds (5 A & 5 Y)
- Region 8—↑ 10 beds (5 A & 5 Y)
- Region 9—↑15 A beds

Regions 1 and 5 will implement during Waiver Year 1 and Regions 2-4 and 6-9 will implement during Waiver Year 2.

Level of Care: 3.3—Clinically Managed Population-Specific High-Intensity Residential Services for Adults

Number of additional 3.3 beds—24.

Proposed locations for the 24 beds include:

- Region 1—12 beds—Waiver Year 1
- Region 2—12 beds—Waiver Year 2

Level of Care: 3.5—Clinically Managed Medium-Intensity Residential Services (Youth) and Clinically Managed High-Intensity Residential Services (Adult)

Number of additional 3.5 beds—66 (26 Adult, 6 Youth, 34 Pregnant and Postpartum Women with Children).

Proposed locations for the 32 Adult and Youth beds include:

- Region 1—↑ 12 A beds
- Region 2—↑ 6 Y beds
- Region 4—↑ 8 A beds
- Region 7—↑ 6 A beds

Region 1 beds will be implemented during Waiver Year 1; Regions 2, 4, and 7 beds will be implemented during Waiver Year 2.

The other 34 beds will become specialized Residential Treatment programs for Pregnant and Postpartum Women and their Children ages 10 and under. Proposed locations include:

- Region 3—↑ 8 beds Region
- 4—↑ 8 beds Region 6—↑ 8
- beds Regions 7 & 8--↑10
- beds

All 34 beds will be implemented during Waiver Year 2.

Level of Care: 1-WM—Ambulatory Withdrawal Management Without Extended On-Site Monitoring

Number of additional 1-WM providers—9 (1 per region).

Proposed locations include Waiver Year 1 for Regions 1 and 5 and Waiver Year 2 for Regions 2-4 and 6-9.

Level of Care: 2-WM—Ambulatory Withdrawal Management With Extended On-Site Monitoring

Number of new 2-WM providers—9 (1 per region).

Proposed locations include Waiver Year 1 for Regions 1 and 5 and Waiver Year 2 for Regions 2-4 and 6-9.

Level of Care: 3.2-WM—Clinically Managed Residential Withdrawal Management

Number of new 3.2-WM providers—1.

Proposed location includes 1 in Region 1 (Waiver Year 2).

Level of Care: 3.7-WM—Medically Monitored Intensive Inpatient Withdrawal Management

Number of new 3.7-WM providers—1.

Proposed location includes 1 in Region 1 (Waiver Year 2).

Level of Care: 4-WM—Medically Managed Intensive Inpatient Withdrawal Management

Number of new 4-WM providers—3.

Proposed locations include 1 in Region 1 (Waiver Year 1), 1 in Region 2 (Waiver Year 2), and 1 in Region 5 (Waiver Year 1).

Milestone #4: Sufficient Provider Capacity at Critical Levels of Care

A. SUD Provider Capacity

Details regarding ***proposed increased SUD provider capacity*** by ASAM Level of Care for each Waiver region include:

- Waiver Region 1:
  - ASAM Level OTS—3 naltrexone providers
  - ASAM Level 0.5— SBIRT in 2 hospital ED
  - ASAM Level 2.1—8 IOP providers (4 adult and 4 youth)
  - ASAM Level 2.5—N/A
  - ASAM Level 3.1—1 Adult (A) provider (15 beds) & 1 Youth (Y) provider (5 beds)
  - ASAM Level 3.3—1 TBI provider (12 beds)
  - ASAM Level 3.5—1 A provider (12 beds)
  - ASAM Level 3.7—N/A
  - ASAM Level 4.0—N/A
  - ASAM Level 1-WM—1 provider for 1-WM or 2-WM
  - ASAM Level 2-WM—1 provider for 1-WM or 2-WM
  - ASAM Level 3.2-WM—N/A

- ASAM Level 3.7-WM—N/A
- ASAM Level 4-WM—1 provider
- Community Recovery Support—Phase out deleted services and phase in new services Waiver Year 1
- Mobile Outreach and Crisis Response—1 provider

- Waiver Region 2:
  - ASAM Level OTS—1 naltrexone provider
  - ASAM Level 0.5—SBIRT in 1 hospital ED
  - ASAM Level 2.1—4 IOP providers (2 adult and 2 youth)
  - ASAM Level 2.5—N/A
  - ASAM Level 3.1—1-2 A provider(s) (20 beds)
  - ASAM Level 3.3—1 SUD-related cognitive impairment provider (12 beds)
  - ASAM Level 3.5—1 Y provider (6 beds)
  - ASAM Level 3.7—N/A
  - ASAM Level 4.0—N/A
  - ASAM Level 1-WM—1 provider for 1-WM or 2-WM
  - ASAM Level 2-WM—1 provider for 1-WM or 2-WM
  - ASAM Level 3.2-WM—N/A
  - ASAM Level 3.7-WM—N/A
  - ASAM Level 4-WM—1 provider
  - Community Recovery Support--Phase out deleted services and phase in new services Waiver Year 2
  - Mobile Outreach and Crisis Response—1 provider

- Waiver Region 3:
  - ASAM Level OTS—1 OBOT & 1 naltrexone provider
  - ASAM Level 0.5—SBIRT in 1 hospital ED
  - ASAM Level 2.1—1 IOP provider (adult)
  - ASAM Level 2.5—1 PHP provider (youth)
  - ASAM Level 3.1—1 Adult provider (10 beds)
  - ASAM Level 3.3—N/A
  - ASAM Level 3.5—1 Women & Children's (W/C) provider (8 beds)
  - ASAM Level 3.7—N/A
  - ASAM Level 4.0—N/A
  - ASAM Level 1-WM—1 provider for 1-WM or 2-WM
  - ASAM Level 2-WM—1 provider for 1-WM or 2-WM
  - ASAM Level 3.2-WM—N/A
  - ASAM Level 3.7-WM—N/A
  - ASAM Level 4-WM—N/A
  - Community Recovery Support-- Phase out deleted services and phase in new services Waiver Year 2
  - Mobile Outreach and Crisis Response—1 provider

- Waiver Region 4:
- ASAM Level OTS—1 OTP & 1 naltrexone provider
    - ASAM Level 0.5—SBIRT in 1 hospital ED
    - ASAM Level 2.1—2 IOP providers (1 adult and 1 youth)
    - ASAM Level 2.5—N/A
    - ASAM Level 3.1—1 A provider (5 beds) & 1 Y provider (5 beds)
    - ASAM Level 3.3—N/A
    - ASAM Level 3.5—1 A provider (8 beds) & 1 W/C provider (8 beds)
    - ASAM Level 3.7—N/A
    - ASAM Level 4.0—N/A
    - ASAM Level 1-WM—1 provider for 1-WM or 2-WM
    - ASAM Level 2-WM—1 provider for 1-WM or 2-WM
    - ASAM Level 3.2-WM—N/A
    - ASAM Level 3.7-WM—N/A
    - ASAM Level 4-WM—N/A
    - Community Recovery Support—Phase out deleted services and phase in new services Waiver Year 2
    - Mobile Outreach and Crisis Response—1 provider
- Waiver Region 5:
    - ASAM Level OTS—1 naltrexone provider
    - ASAM Level 0.5—SBIRT in 1 hospital ED
    - ASAM Level 2.1—2 IOP providers (1 adult and 1 youth)
    - ASAM Level 2.5—N/A
    - ASAM Level 3.1—1 A provider (15 beds)
    - ASAM Level 3.3—N/A
    - ASAM Level 3.5—N/A
    - ASAM Level 3.7—N/A
    - ASAM Level 4.0—N/A
    - ASAM Level 1-WM—1 provider for 1-WM or 2-WM
    - ASAM Level 2-WM—1 provider for 1-WM or 2-WM
    - ASAM Level 3.2-WM—N/A
    - ASAM Level 3.7-WM—N/A
    - ASAM Level 4-WM—1 provider
    - Community Recovery Support—Phase out deleted services and phase in new services Waiver Year 1
    - Mobile Outreach and Crisis Response—1 provider
- Waiver Region 6:
    - ASAM Level OTS—1 naltrexone provider
    - ASAM Level 0.5—SBIRT in 1 hospital ED
    - ASAM Level 2.1—1 IOP provider (adult)
    - ASAM Level 2.5—1 PHP provider (youth)
    - ASAM Level 3.1—1 A provider (5 beds) & 1 Y provider (5 beds)
    - ASAM Level 3.3—N/A
    - ASAM Level 3.5—1 W/C provider (8 beds)
    - ASAM Level 3.7—N/A
    - ASAM Level 4.0—N/A

- ASAM Level 1-WM—1 provider for 1-WM or 2-WM
- ASAM Level 2-WM—1 provider for 1-WM or 2-WM
- ASAM Level 3.2-WM—N/A
- ASAM Level 3.7-WM—N/A

- ASAM Level 4-WM—N/A
- Community Recovery Support—Phase out deleted services and phase in new services Waiver Year 2
- Mobile Outreach and Crisis Response—1 provider

- Waiver Region 7:
  - ASAM Level OTS—1 OTP & 1 naltrexone provider
  - ASAM Level 0.5—SBIRT in 1 hospital ED
  - ASAM Level 2.1—2 IOP providers (1 adult & 1 youth)
  - ASAM Level 2.5—N/A
  - ASAM Level 3.1—N/A
  - ASAM Level 3.3—N/A
  - ASAM Level 3.5—1 A provider (6 beds) & 1 W/C provider for Regions 7 & 8 (10 beds)
  - ASAM Level 3.7—N/A
  - ASAM Level 4.0—N/A
  - ASAM Level 1-WM—1 provider for 1-WM or 2-WM
  - ASAM Level 2-WM—1 provider for 1-WM or 2-WM
  - ASAM Level 3.2-WM—N/A
  - ASAM Level 3.7-WM—N/A
  - ASAM Level 4-WM—N/A
  - Community Recovery Support—Phase out deleted services and phase in new services Waiver Year 2
  - Mobile Outreach and Crisis Response—1 provider

- Waiver Region 8:
  - ASAM Level OTS—1 OBOT & 1 naltrexone provider
  - ASAM Level 0.5—SBIRT in 1 hospital ED
  - ASAM Level 2.1—1 IOP provider (adult)
  - ASAM Level 2.5—1 PHP provider (youth)
  - ASAM Level 3.1—1 A provider (5 beds) & 1 Y provider (5 beds)
  - ASAM Level 3.3—N/A
  - ASAM Level 3.5—N/A
  - ASAM Level 3.7—N/A
  - ASAM Level 4.0—N/A
  - ASAM Level 1-WM—1 provider for 1-WM or 2-WM
  - ASAM Level 2-WM—1 provider for 1-WM or 2-WM
  - ASAM Level 3.2-WM—N/A
  - ASAM Level 3.7-WM—N/A
  - ASAM Level 4-WM—N/A
  - Community Recovery Support—Phase out deleted services and phase in new services Waiver Year 2
  - Mobile Outreach and Crisis Response—1 provider

- Waiver Region 9:
  - ASAM Level OTS—1 naltrexone provider

- ASAM Level 0.5—SBIRT in 1 hospital ED
- ASAM Level 2.1—1 IOP provider (adult)
- ASAM Level 2.5—1 PHP provider (youth)
- ASAM Level 3.1—1 A provider (15 beds)
- ASAM Level 3.3—N/A
- ASAM Level 3.5—N/A
- ASAM Level 3.7—N/A
- ASAM Level 4.0—N/A
- ASAM Level 1-WM—1 provider for 1-WM or 2-WM
- ASAM Level 2-WM—1 provider for 1-WM or 2-WM
- ASAM Level 3.2-WM—N/A
- ASAM Level 3.7-WM—N/A
- ASAM Level 4-WM—N/A
- Community Recovery Support—Phase out deleted services and phase in new services Waiver Year 2
- Mobile Outreach and Crisis Response—1 provider

Milestone #5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse

F. Integrating Alaska's Prevention and Treatment Efforts

With the Waiver, Alaska's ***proposed increased OUD treatment capacity*** will include the following by Waiver region (increased capacity vis-à-vis Waiver in red):

- Region 1—2 OTPs, 5 OBOTs, 3 naltrexone providers, MAT Care Coordination, SBIRT in 2 hospitals
- Region 2—1 OTP, 3 OBOTs, 1 naltrexone provider, MAT Care Coordination, SBIRT in 1 hospital
- Region 3—1 OBOT, 1 naltrexone provider, MAT Care Coordination, SBIRT in 1 hospital
- Region 4—1 OBOT, 1 OTP, 1 naltrexone provider, MAT Care Coordination, SBIRT in 1 hospital
- Region 5—2 OBOTs, 1 naltrexone provider, MAT Care Coordination, SBIRT in 1 hospital
- Region 6—1 OBOT, 1 naltrexone provider, MAT Care Coordination, SBIRT in 1 hospital
- Region 7—2 OBOTS, 1 OTP, 1 naltrexone provider, MAT Care Coordination, SBIRT in 1 hospital
- Region 8—1 OBOT, 1 naltrexone provider, MAT Care Coordination, SBIRT in 1 hospital
- Region 9—1 OBOT, 1 naltrexone provider, MAT Care Coordination, SBIRT in 1 hospital.

APPENDIX 2— DOCUMENTS

MILESTONE CRITERIA	CURRENT STATE	FUTURE STATE	SUMMARY OF ACTIONS NEEDED
Prescription Drug Monitoring Program (PDMP) Functionalities			
Enhanced interstate data sharing in order to better track patient specific prescription data	Alaska's PDMP shares data with 7 other States as part of the PMP InterConnect, in conjunction with our PDMP vendor, Appriss Health and the National Association of Board of Pharmacy. The 7 States are Idaho, Louisiana, Massachusetts, Minnesota, Montana, North Dakota, & Rhode Island. At its February 28-March 2, 2018 Board of Pharmacy meeting, which governs the Alaska PDMP, the Board entertained a regulation project to repeal a section of regulations relating to PDMP access, including the section that would otherwise authorize interstate data sharing. Discussion occurred during Board review of public comments about proposed regarding several proposed PDMP regulations pursuant to 2016 and 2017 statutory changes designed to strengthen Alaska's PDMP.	The State Opioid Treatment Authority and Director of the Division of Behavioral Health will testify at the Board of Pharmacy March 2019 meeting to explain the importance of interstate data sharing in addressing the state's current opioid crisis and to request that the regulation authorizing interstate data sharing be approved by the Board. Alaska's PDMP will continue to engage & participate with the PMP InterConnect in conjunction with Appriss Health & the National Association of Board of Pharmacy unless & until the regulation is repealed. Maintaining the regulation as proposed will require consensus/approval from the Board of Pharmacy.	1. Contact Pharmacy Board members prior to March 2019 meeting (K. Chapman, SOTA & DBH SUD Director). 2. Present at March 2019 Pharmacy Board meeting (K. Chapman, SOTA & DBH SUD Director).
Enhanced "ease of use" for prescribers & other state/federal stakeholders	2016 legislation (SB 74) expanded access to the PDMP for licensed/registered	Alaska's State Opioid Treatment Authority, and Director of the Division of	1. Develop written communication regarding rationale for expanding

	agents/employees of practitioners or pharmacists, who are considered delegates and can review or report actions on behalf of a provider already registered in the database. An online questionnaire was created to satisfy a CDC Data-Driven Prevention Initiative Grant deliverable to solicit input regarding awareness levels of PDMP providers, to solicit feedback on system limitations/improvements, & to gauge client satisfaction/areas for quality improvement of PDMP. The survey was launched Spring, 2018.	Behavioral Health will petition the Board of Pharmacy at its April 2019 meeting to further expand access to the PDMP for Certified Chemical Dependency Clinical Supervisors. Future enhancements will require consensus/approval from the Board of Pharmacy.	access (K. Chapman, SOTA & DBH SUD Director). 2. Work with PDMP Program Manager Laura Carillo to amend 12 Alaska Administrative Code, Section 52.860, to expand access to designated CCD Clinical Supervisors (K. Chapman, SOTA & DBH SUD Director).
Enhanced connectivity between Alaska's PDMP & statewide, regional, or local health information exchange	Alaska's PDMP does not currently have a licensing integration feature to allow access to HIE & EHRs. Alaska is attempting a bidirectional interface between the State's HIE and the PDMP solution. This is designed to: • Enable providers access to real-time, point-of-care prescription data; critical for emergency department providers.	Alaska's SOTA & Director of the Division of Behavioral Health will work with the PDMP Program Manager to examine the cost of a licensing integration feature for the PDMP to facilitate several improvements including the tracking of DEA registrations & connecting with certain EHRs of OTPs/OBOTs/Naltrexone Providers.	1. Monitor Pharmacy Board approval of regulations allowing bidirectional interface between State's HIE & the PDMP (B. Davidson, DHSS HIT Director). 2. Work with PDMP Program Manager to identify cost of licensing integration feature—complete cost estimate by April 2019 (K. Chapman SOTA and L. Carillo, PDMP Program Manager).

	• Enable Opioid Command Center access to real-time, point-of-care prescription data to support their programs and services. • Increase the opportunity to decrease misuse, abuse, and divert the usage of controlled substances. This effort is on hold until the required PDMP regulations are approved by the State Board of Pharmacy.	Future enhancements will require consensus/approval from the Board of Pharmacy.	
Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns	Pursuant to 2018 legislation, prescriber report cards will give prescribers the ability to review their prescription activity & to see how prescribing practices compare to similar practitioners within the same occupation/specialty on a quarterly basis. The first round of report cards were sent 12/6/17. Information includes: 1) The top three medications prescribed, 2) The number of patients receiving a dangerous combination therapy, & 3) The number of patient prescription history queries.	The Commissioner of the Alaska Department of Health & Social Services and Alaska's SOTA will review the need for additional legislation to continue expanding access to the PDMP, including the ability to crosswalk claims data with individual prescriber practices, review of prescriber report cards, & review of inappropriate use or prescribing of controlled substances. This will require consensus from many stakeholders and decision-makers, including the Alaska Legislature,	1. Research other State PDMP information regarding crosswalking of claims data and draft legislation by March 2019—M. Walker, DBH Data Unit Director. 2. Finalize legislative recommendations, including possible interim study, prior to 2020 session (K. Chapman, SOTA and A. Crum, DHSS Commissioner).

	The Alaska Board of Pharmacy has drafted regulations to allow limited data access by designated representatives from the Alaska Medicaid program; the Board will review public comment on this regulation. This will facilitate identifying recipient long-term opioid use but will not allow: • Crosswalking Medicaid claims data with individual prescriber practices • Reviewing prescriber report cards, or • Reviewing inappropriate use or prescribing of controlled substances.	appropriate Licensing Boards and the Board of Pharmacy.	
Current and Future PDMP Query Capabilities			

Facilitate ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e. the Master Patient Index strategy with regard to PDMP query).	Alaska Department of Health & Social Services does not currently have the ability to match patients receiving opioid prescription with patients in the State's PDMP.	However, Alaska's statewide Health Information Exchange is in the final phases of connecting to Alaska's PDMP and also receiving all medication fill information. The statewide HIE is also working with the Alaska Department of Commerce to establish the ability to share bi-directionally PDMP data with at least the states of Washington and Oregon. This information will be able to be shared with the MMIS Decision Support System that is scheduled to be implemented as part of DHSS Division of Health Care Services MMIS modernization project. This final step to connect the HIE to the MMIS Decision Support System will likely need a memorandum of understanding and/or data use agreement(s).	1. Complete system integration work between the statewide HIE and the PDMP. Anticipated timeline: October or November 2019 (B. Davidson, DHSS Director of HIT, K. Chapman, SOTA, and L. Carillo, PDMP Program Manager). 2. Implement a Decision Support System for the MMIS. Anticipated timeline: December 2019 (M. Brody, DHSS Health Care Services Director and K. Chapman, SOTA). 3. Identify any necessary funding sources to support system integration between the HIE and MMIS (B. Davidson, DHSS Director of HIT). 4. Design, develop and implement integration between the HIE and the MMIS Decision Support System (B. Davidson, DHSS Director of HIT).. 5. Identify and implement any necessary memorandums of understanding or data use/sharing agreements (B. Davidson, DHSS Director of HIT)..
Use of PDMP—Supporting Clinicians with Changing Office Workflows/Business Processes			

Develop enhanced provider workflow/business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance to address the issues which follow.	State law requires a prescriber or his delegate (with limited exceptions) to access and review the patient's record in the PDMP prior to initially prescribing any opioid to a patient.	The Division of Behavioral Health is considering requiring Waiver prescribers to use and conduct patient specific queries in the PDMP for behavioral health patients upon writing first prescription for controlled substance and then annually. The physician would print the query and file it as part of the recipient record. The Division would then require the ASO to conduct sample audits to verify compliance.	1. Modify ASO RFP to specify PDMP audits by April 2019 (G. Moreau, Acting DBH Director). 2. Develop SUD MAT Waiver provider notification/communication by May 2019 (G. Moreau, Acting DBH Director and K. Chapman, SOTA).
Develop enhanced supports for clinician review of the patient's history of controlled substance prescriptions provided through the PDMP—prior to the issuance of an opioid prescription.	State law requires a prescriber or his delegate (with limited exceptions) to access and review the patient's record in the PDMP prior to initially prescribing any opioid to a patient.	The Division of Behavioral Health is considering requiring Waiver prescribers to use and conduct patient specific queries in the PDMP for behavioral health patients upon writing first prescription for controlled substance and then annually. The physician would print the query and file it as part of the recipient record. The Division would then require the ASO to conduct sample audits to verify compliance.	1. Modify ASO RFP to specify PDMP audits by April 2019 (G. Moreau, Acting DBH Director) . 2. Develop SUD MAT Waiver provider notification/communication by May 2019 (G. Moreau, Acting DBH Director and K. Chapman, SOTA).
Master Patient Index/Identity Management			
Enhance the Master Patient Index (or master data management service, etc.) in support of SUD care delivery	Alaska Department of Health & Social Services has not utilized its Master Client Index or the statewide HIE Master Patient Index to interface between Alaska's PDMP and the MMIS.	The statewide HIE has a master patient index and robust identity management to allows for different levels of consent including CFR 42 Part 2. The HIE master patient index will be utilized	1. Complete system integration work between the statewide HIE and the PDMP (B. Davidson, DHSS HIT Director and L. Carillo, PDMP Program Manager).

		to support the integration between the PDMP and the MMIS in conjunction with the Alaska Department of Health & Social Services Master Client Index.	2. Implement a Decision Support System for the MMIS (M. Brody, DHSS Director of Health Care Services and K. Chapman, SOTA). 3. Identify any necessary funding sources to support system integration between the HIE and MMIS (B. Davidson, DHSS Director of HIT). 4. Design, develop, and implement integration between the HIE and the MMIS Decision Support System (B. Davidson, DHSS Director of HIT and M. Brody, DHSS Director of Health Care Services). 5. Identify any necessary funding sources to support the syncing of the HIE master patient index to the DHSS Master Client Index to be shared as part of the identity management process for linking PDMP and MMIS data together (B. Davidson, DHSS Director of HIT, M. Brody, DHSS Director of Health Care Services, L. Carillo, PDMP Program Manager, and K. Chapman, SOTA).
Overall Objective for Enhancing PDMP Functionality and Interoperability			
Leverage the above functionalities/capabilities/supports	Alaska's PDMP has the following capabilities to	The issue of Medicaid inappropriately paying for	1. Work with PDMP Program Manager and

(in concert with any other State Health IT, TA or workflow effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing & to ensure that Medicaid does not inappropriately pay for opioids.	minimize the risk of inappropriate opioid overprescribing: • Prescriber report cards • Patient prescription history reports • Required performance measures relating to reductions in inappropriate use or prescription of controlled substances • Required reports relating to number of patients receiving high levels of MME opioids • Monthly reporting of number of newly registered PDMP users, number of patient prescriptions written, & number of patient prescription history requests conducted. This data is a valuable tool to assist demand reduction and law enforcement officials in detecting drug diversion, misuse, and abuse—resulting in a 12.87% decrease in total prescriptions, a 10.12% decrease in the number of patients receiving opioid prescriptions, and a 10.38% decrease in total opioid	opioids continues to be addressed. Data matching per specifications above will be essential. As stated earlier, Alaska's Opioid Incident Command System Chair, State Opioid Treatment Authority, and Director of the Division of Behavioral Health will seek legislative authority during the 2020 legislative session to allow data matching between Medicaid and PDMP data. This will require consensus from many stakeholders and decision-makers, including the Alaska Legislature, appropriate Licensing Boards and the Board of Pharmacy.	Division of Health Care Services to produce reports specifying Medicaid payments for opioid medications by November 2019 (K. Chapman, SOTA, M. Brody, DHSS Director of Health Care Services, and L. Carillo, PDMP Program Manager). 2. Draft authorizing legislation authorizing matching by December 2019 (K. Chapman, SOTA and L. Carillo, PDMP Program Manager). 3. Find legislative sponsor and introduce legislation by February 2020 (K. Chapman, SOTA and L. Carillo, PDMP Program Manager).

	prescriptions between 2016 and 2017. There has been a minimal decrease in the number of opioid prescriptions greater than 100 mg MME per day (.46%) between 2016 and 2017.		

ATTESTATIONS and CONFIRMATIONS:

The State of Alaska has a sufficient health IT infrastructure at every appropriate level including state Medicaid and pharmacy systems, provider service delivery sites, and ASO, to achieve the goals of the SUD portion of Alaska's 1115 Behavioral Health Waiver demonstration.

The State of Alaska's SUD HIT Plan has been developed in coordination and is aligned with the State Medicaid Health IT Plan (SMHP), which will support Alaska's HIE, provider web-based access/connection, infrastructure development, Admission/Discharge/Transfer (ADT) status and data sharing. Alaska does not currently have a Behavioral Health HIT Plan. The DHSS vision for the future of HIT is closely aligned with our SUD HIT vision and is a multi-year vision that leverages implementation of new technologies (e.g., a modernized MMIS, EHRs, HIE networks) to transform Alaska's health care system. An important goal is to ensure data, providers and systems are connected with SUD HIT Plan.

The State of Alaska will ensure that the ASO contract will incorporate the requirement to use health IT standards referenced in 45 CFR 170 Subpart B and the Interoperability Standards Advisory (ISA) as set forth by the Office of the National Coordinator for Health IT (ONC). The State of Alaska currently has statutory authority and the corresponding health IT infrastructure to support **electronic prescribing**, which is currently operable statewide. Prescribers have the obligation check the PDMP before initial prescribing of an opioid, can electronically access a patient's prescription benefit, can electronically access a patient's medication history, and can electronically route the prescription to the patient's choice of pharmacy. Upon signing the ASO contract (anticipated May 2019), we will begin the process of developing **ADT feeds** and documenting and **sharing care plans** using Care Plan Standards (CDA) through our HIE. We will comply with appropriate **direct transport standards**.

Our SOTA will work with the PDMP Program Manager and the DHSS Office of Substance Misuse and Addiction Prevention to review performance metrics from other states for possible adoption within Alaska for **clinical quality measurement**, reporting, and tracking. As part of our overall SUD Monitoring Protocol, we will work with our colleagues in the PDMP and OSMAP to ensure appropriate metrics are identified for ongoing quality monitoring and clinical outcomes monitoring of the SUD HIT Plan. We will work with CMS to ensure that all of our proposed **performance metrics** meet CMS approval criteria. We anticipate that because there are many dynamic features and moving parts to Alaska's SMHP, we will need to carefully monitor ongoing infrastructure and connectivity issues within this broader context. Developing the appropriate performance metrics to measure success within this framework will be an important feature of Alaska's SUD HIT Plan monitoring protocol. While we will heavily rely upon the ASO for this capacity, our obligation does not end. Our SUD HIT monitoring protocol will mirror the overall SUD Monitoring Protocol. We will identify activities/tasks, outcome/success goals, indicators to measure progress in achieving outcome/success goals, reporting timelines, and responsible parties.

ATTACHMENT E:
Reserved for SUD Claiming Protocol

ATTACHMENT F: SUD Monitoring Protocol

1. Title page for the state's substance use disorder (SUD) demonstration or the SUD component of the broader demonstration

The state should complete this title page as part of its monitoring protocol. This form should be submitted as the title page for all monitoring reports. The content of this table should stay consistent over time. Definitions for certain rows are below the table.

State	Alaska
Demonstration name	Alaska Substance Use Disorder and Behavioral Health Program (SUD-BHP)
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

[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.

2. Acknowledgement of narrative reporting requirements

☒ The state has reviewed the narrative questions in the Monitoring Report Template provided by CMS and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested narrative information (with no modifications).

3. Acknowledgement of budget neutrality reporting requirements

☒ The state has reviewed the Budget Neutrality Workbook provided by the CMS demonstration team and understands the expectations for quarterly and annual monitoring reports. The state will provide the requested budget neutrality information (with no modifications).

4. Retrospective reporting

The state is not expected to submit metrics data until after protocol approval, to ensure that data reflects the monitoring plans agreed upon by CMS and the state. Prior to monitoring protocol approval, the state should submit quarterly and annual monitoring reports with narrative updates on implementation progress and other information that may be applicable, according to the requirements in its STCs.

For a state that has monitoring protocols approved after one or more initial quarterly monitoring report submissions, it should report metrics data to CMS retrospectively for any prior quarters of the section 1115 SUD demonstration that precede the monitoring protocol approval date. A state is expected to submit retrospective metrics data—provided there is adequate time for preparation of these data— in its second monitoring report submission that contains metrics. The retrospective report for a state with a first SUD DY of less than 12 months, should include data for any baseline period quarters preceding the demonstration, as described in Part A of the state's monitoring protocols (see Appendix B of the instruction for further guidance determining baseline periods for first SUD DYs that are less than 12 months.) If a state needs additional time for preparation of these data, it should propose an alternative plan (i.e., specify the monitoring report that would capture the data) for reporting retrospectively on its section 1115 SUD demonstration.

In the monitoring report submission containing retrospective metrics data, the state should also provide a general assessment of metrics trends from the start of its demonstration through the end of the current reporting period. The state should report this information in Part B of its report submission (Section 3: Narrative information on implementation, by milestone and reporting topic). This general assessment is not intended to be a comprehensive description of every trend observed in the metrics data. Unlike other monitoring report submissions, for instance, the state is not required to describe all metric changes (+ or - greater than 2 percent). Rather, the assessment is an opportunity for a state to provide context on its retrospective metrics data and to support CMS's review and interpretation of these data. For example, consider a state that submits data showing an increase in the number of medication-assisted treatment (MAT) providers (Metric #14) over the course of the retrospective reporting period. This state may decide to highlight this trend for CMS in Part B of its report (under Milestone 4) by briefly summarizing the trend and explaining that during this period, a grant supporting training for new MAT providers throughout its state was implemented.

For further information on how to compile and submit a retrospective report, the state should review Section B of the Monitoring Report Instructions document.

☒ The state will report retrospectively for any quarters prior to monitoring protocol approval as described above, in the state's second monitoring report submission that contains metrics after protocol approval.

☐ The state proposes an alternative plan to report retrospectively for any quarters prior to monitoring protocol approval: *Insert narrative description of proposed alternative plan for retrospective reporting. The state should provide justification for its proposed alternative plan.*

Medicaid Section 1115 SUD Demonstrations Monitoring Protocol (Part A) - Planned Metrics (Version 5.0)
State Alaska
Demonstration Name Alaska Substance Use Disorder and Behavioral Health Program (SUD-BHP)

Substance Use Disorder (SUD) Planned Metrics

Standard information on CMS-provided metrics											Baseline, annual goals, and demonstration target			Alignment with CMS-provided technical specifications manual		Phased-in metrics reporting		
#	Metric name	Metric description	Milestone or reporting topic[a]	Metric type	Reporting category	Data source	Measurement period	Reporting frequency	Reporting priority	State will report (Y/N)	Baseline reporting period (MM/DD/YYYY-MM/DD/YYYY)	Annual goal	Overall demonstration target	Attest that planned reporting matches the CMS-provided technical specifications manual (Y/N)	Explanation of any deviations from the CMS-provided technical specifications manual (different data source, definition, codes, target population, etc.)	State plans to phase in reporting (Y/N)	Report in which metric will be phased in (Format SUD DYQ; Ex. DY1Q3)	Explanation of any plans to phase in reporting over time
*EXAMPLE: 1 **(Do not delete or edit this row)***	*EXAMPLE: Assessed for SUD Treatment Needs Using a Standardized Screening Tool*	*EXAMPLE: Number of beneficiaries screened for SUD treatment needs using a standardized screening tool during the measurement period*	*EXAMPLE: Assessment of need and qualification for SUD treatment services*	*EXAMPLE: CMS-constructed*	*EXAMPLE: Other monthly and quarterly metric*	*EXAMPLE: Medical record review or claims*	*EXAMPLE: Month*	*EXAMPLE: Quarterly*	*EXAMPLE: Recommended*	*EXAMPLE: Y*	*EXAMPLE: 07/1/2018-06/30/2019*	*EXAMPLE: Increase*	*EXAMPLE: Increase*	*EXAMPLE: N*	*EXAMPLE: The Department will use state-defined procedure codes (list specific codes) to calculate this metric.*	*EXAMPLE: Y*	*EXAMPLE: DY2Q1*	*EXAMPLE: This measure requires an update to the Adult Needs and Strengths Assessment tool that reflects an ASAM level of treatment. The work is in the testing phase with anticipated go live in mid to late 2021.*
1	Assessed for SUD Treatment Needs Using a Standardized Screening Tool	Number of beneficiaries screened for SUD treatment needs using a standardized screening tool during the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other monthly and quarterly metric	Medical record review or claims	Month	Quarterly	Recommended	N								
2	Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis	Number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period but not in the three months before the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Recommended	N								
3	Medicaid Beneficiaries with SUD Diagnosis (monthly)	Number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period and/or in the 11 months before the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	07/01/2019 - 06/30/2020	0% to 1% Decrease	0% to 3% Decrease	Y		N		
4	Medicaid Beneficiaries with SUD Diagnosis (annually)	Number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period and/or in the 12 months before the measurement period	Assessment of need and qualification for SUD treatment services	CMS-constructed	Other annual metric	Claims	Year	Annually	Required	Y	07/01/2019 - 06/30/2020	0% to 1% Decrease	0% to 3% Decrease	Y		N		
5	Medicaid Beneficiaries Treated in an IMD for SUD	Number of beneficiaries with a claim for inpatient/residential treatment for SUD in an IMD during the measurement period.	Milestone 2	CMS-constructed	Other annual metric	Claims	Year	Annually	Required	Y	07/01/2019 - 06/30/2020	1% to 3% Increase	3% to 5% Increase	N	There are no state specific-definitions regarding IMD for metrics #5 and #36. D	N		
6	Any SUD Treatment	Number of beneficiaries enrolled in the measurement period receiving any SUD treatment service, facility claim, or pharmacy claim during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	07/01/2019 - 06/30/2020	0% to 3% Increase	3% to 5% Increase	Y		N		
7	Early Intervention	Number of beneficiaries who used early intervention services (such as procedure codes associated with SBIRT) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	07/01/2019 - 06/30/2020	3% to 5% Increase	3% to 5% Increase	Y		N		
8	Outpatient Services	Number of beneficiaries who used outpatient services for SUD (such as outpatient recovery or motivational enhancement therapies, step down care, and monitoring for stable patients) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	07/01/2019 - 06/30/2020	0% to 3% Increase	3% to 5% Increase	Y		N		
9	Intensive Outpatient and Partial Hospitalization Services	Number of beneficiaries who used intensive outpatient and/or partial hospitalization services for SUD (such as specialized outpatient SUD therapy or other clinical services) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	07/01/2019 - 06/30/2020	0% to 1% Increase	1% to 3% Increase	Y		N		
10	Residential and Inpatient Services	Number of beneficiaries who use residential and/or inpatient services for SUD during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	07/01/2019 - 06/30/2020	1% to 3% Increase	3% to 5% Increase	Y		N		
11	Withdrawal Management	Number of beneficiaries who use withdrawal management services (such as outpatient, inpatient, or residential) during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	07/01/2019 - 06/30/2020	0% to 1% Decrease	1% to 3% Decrease	Y		N		
12	Medication-Assisted Treatment	Number of beneficiaries who have a claim for MAT for SUD during the measurement period	Milestone 1	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	07/01/2019 - 06/30/2020	0% to 3% Increase	3% to 5% Increase	Y		N		
13	SUD Provider Availability	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period	Milestone 4	CMS-constructed	Other annual metric	Provider enrollment database; Claims	Year	Annually	Required	Y	07/01/2019 - 06/30/2020	0% to 1% Increase	0% to 3% Increase	N	For this metric, DBH will utilize an operational definition of provider "qualified to deliver SUD services" as an individual who is counted as a QAP (qualified addictions professional), in our system. Duplicate names of QAPs will only be counted once.	N		
14	SUD Provider Availability - MAT	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT	Milestone 4	CMS-constructed	Other annual metric	Provider enrollment database; Claims; SAMHSA datasets	Year	Annually	Required	Y	07/01/2019 - 06/30/2020	0% to 1% Increase	0% to 3% Increase	N	For this metric, DBH will utilize organization level provider, and will report the number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide methadone as part of MAT leveraging SAMHSA's organization level public approved methadone list; DBH cannot report number of practitioners who have a waiver to dispense buprenorphine, as SAMHSA indicates the list	N		
15	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD) [NCQA; NQF #0004; Medicaid Adult Core Set; Adjusted HEDIS measure]	Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: • Initiation of AOD Treatment—percentage of beneficiaries 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 • Engagement of AOD Treatment—percentage of beneficiaries who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit The following diagnosis cohorts are reported for each rate: (1) Alcohol abuse or dependence, (2) Opioid abuse or dependence, (3) Other drug abuse or dependence, and (4) Total AOD abuse or dependence. A total of 8 separate rates are reported for this measure.	Milestone 6	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2019 - 12/31/2019	0% to 1% Increase	0% to 3% Increase	Y		N		
16	SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge [Joint Commission]	SUB-3: Patients who are identified with alcohol or drug use disorder who receive or refuse at discharge a prescription for FDA-approved medications for alcohol or drug use disorder, OR who receive or refuse a referral for addictions treatment. SUB-3a: Patients who are identified with alcohol or drug disorder who receive a prescription for FDA-approved medications for alcohol or drug use disorder OR a referral for addictions treatment.	Milestone 6	Established quality measure	Annual metric that is an established quality measure	Medical record review or claims	Year	Annually	Recommended	N						N		
17(1)	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD) [NCQA; NQF #3488; Medicaid Adult Core Set; Adjusted HEDIS measure][b]	Percentage of ED visits for beneficiaries age 18 and older with a principal diagnosis of AOD abuse or dependence who had a follow-up visit for AOD abuse or dependence. Two rates are reported: - Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days). - Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	Milestone 6	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2019 - 12/31/2019	1% to 3% Increase	3% to 5% Increase	Y		N		
17(2)	Follow-up after Emergency Department Visit for Mental Illness (FUM-AD) [NCQA; NQF #0576; Medicaid Adult Core Set; Adjusted HEDIS measure][c]	Percentage of ED visits for beneficiaries age 18 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported: - Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days) - Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	Milestone 6	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2019 - 12/31/2019	1% to 3% Increase	3% to 5% Increase	Y		N		
18	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD) [PQA, NQF #2940; Medicaid Adult Core Set]	Percentage of beneficiaries age 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.	Milestone 5	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2019 - 12/31/2019	0% to 3% Decrease	3% to 5% Decrease	Y		N		
19	Use of Opioids from Multiple Providers in Persons without Cancer (OMP) [PQA; NQF #2950]	The percentage of individuals ≥18 years of age who received prescriptions for opioids from ≥4 prescribers AND ≥4 pharmacies within ≤180 days.	Milestone 5	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Recommended	N								
20	Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (OHDMP) [PQA, NQF #2951]	The percentage of individuals ≥18 years of age who received prescriptions for opioids with an average daily dosage of ≥90 morphine milligram equivalents (MME) AND who received prescriptions for opioids from ≥4 prescribers AND ≥4 pharmacies.	Milestone 5	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Recommended	N								
21	Concurrent Use of Opioids and Benzodiazepines (COB-AD) [PQA, NQF #3389; Medicaid Adult Core Set]	Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice are excluded.	Milestone 5	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2019 - 12/31/2019	0% to 3% Decrease	3% to 5% Decrease	Y		N		
22	Continuity of Pharmacotherapy for Opioid Use Disorder [USC; NQF #3175]	Percentage of adults 18 years of age and older with pharmacotherapy for OUD who have at least 180 days of continuous treatment	Milestone 1	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2018 - 12/31/2019	1% to 3% Increase	3% to 5% Increase	Y		N		
23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	Total number of ED visits for SUD per 1,000 beneficiaries in the measurement period	Milestone 5	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	07/01/2019 - 06/30/2020	0% to 1% Decrease	0% to 3% Decrease	Y		N		
24	Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries	Total number of inpatient stays per 1,000 beneficiaries in the measurement period	Other SUD-related metrics	CMS-constructed	Other monthly and quarterly metric	Claims	Month	Quarterly	Required	Y	07/01/2019 - 06/30/2020	0% to 1% Decrease	0% to 3% Decrease	Y		N		
25	Readmissions Among Beneficiaries with SUD	The rate of all-cause readmissions during the measurement period among beneficiaries with SUD	Milestone 6	CMS-constructed	Other annual metric	Claims	Year	Annually	Required	Y	07/01/2019 - 06/30/2020	0% to 1% Decrease	0% to 3% Decrease	Y		N		
26	Overdose Deaths (count)	Number of overdose deaths during the measurement period among Medicaid beneficiaries living in a geographic area covered by the demonstration. The state is encouraged to report the cause of overdose death as specifically as possible (for example, prescription vs. illicit opioid).	Other SUD-related metrics	CMS-constructed	Other annual metric	State data on cause of death	Year	Annually	Required	Y	07/01/2019 - 06/30/2020	0% to 1% Decrease	0% to 3% Decrease	Y		N		
27	Overdose Deaths (rate)	Rate of overdose deaths during the measurement period among adult Medicaid beneficiaries living in a geographic area covered by the demonstration. The state is encouraged to report the cause of overdose death as specifically as possible (for example, prescription vs. illicit opioid).	Milestone 5	CMS-constructed	Other annual metric	State data on cause of death	Year	Annually	Required	Y	07/01/2019 - 06/30/2020	0% to 1% Decrease	0% to 3% Decrease	Y		N		
28	SUD Spending	Total Medicaid SUD spending during the measurement period.	Other SUD-related metrics	CMS-constructed	Other annual metric	Claims	Year	Annually	Recommended	N								
29	SUD Spending Within IMDs	Total Medicaid SUD spending on inpatient/residential treatment within IMDs during the measurement period	Other SUD-related metrics	CMS-constructed	Other annual metric	Claims	Year	Annually	Recommended	N								
30	Per Capita SUD Spending	Per capita SUD spending during the measurement period	Other SUD-related metrics	CMS-constructed	Other annual metric	Claims	Year	Annually	Recommended	N								
31	Per Capita SUD Spending Within IMDs	Per capita SUD spending within IMDs during the measurement period	Other SUD-related metrics	CMS-constructed	Other annual metric	Claims	Year	Annually	Recommended	N								
32	Access to Preventive/ Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD [Adjusted HEDIS measure]	The percentage of Medicaid beneficiaries with SUD who had an ambulatory or preventive care visit during the measurement period.	Other SUD-related metrics	Established quality measure	Annual metric that is an established quality measure	Claims	Year	Annually	Required	Y	01/01/2019 - 12/31/2019	1% to 3% Increase	3% to 5% Increase	Y		N		
33	Grievances Related to SUD Treatment Services	Number of grievances filed during the measurement period that are related to SUD treatment services	Other SUD-related metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Recommended	N								
34	Appeals Related to SUD Treatment Services	Number of appeals filed during the measurement period that are related to SUD treatment services	Other SUD-related metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Recommended	N								
35	Critical Incidents Related to SUD Treatment Services	Number of critical incidents filed during the measurement period that are related to SUD treatment services	Other SUD-related metrics	CMS-constructed	Grievances and appeals	Administrative records	Quarter	Quarterly	Recommended	N								
36	Average Length of Stay in IMDs	The average length of stay for beneficiaries discharged from IMD inpatient/residential treatment for SUD.	Milestone 2	CMS-constructed	Other annual metric	Claims; State-specific IMD database	Year	Annually	Required	Y	07/01/2019 - 06/30/2020	Decrease	No more than 30 days	N	There are no state specific-definitions regarding IMD for metrics #5 and #36. D	N		
Q1	Information Technology Use to Monitor SUD rate via Patient Prescription History Requests	Number of Schedule II prescriptions by schedule dispensed to CMS beneficiaries	Health IT	State-specific	Other annual metric	Prescription Drug Monitoring Protocol Database (PDMP)	Year	Annually	Required	Y	07/01/2019 - 06/30/2020	1% to 3% Decrease	3% to 5% Decrease			N		
Q2	Information Technology Use to Monitor SUD Treatment Effectiveness via Medical Professional Training in MAT Offered	Number of medical professionals trained in MAT through Alaska's Project Echo	Health IT	State-specific	Other annual metric	Administrative Records from Alaska's Project Echo	Year	Annually	Required	Y	07/01/2019 - 06/30/2020	1% to 3% Increase	3% to 5% Increase			N		
Q3	Information Technology Use to Monitor "Recovery" Supports and Services for SUD Individuals	Number of organizations connected to Alaska's Division of Behavioral Health	Health IT	State-specific	Other annual metric	AKAIMS (Alaska's Automated Information Management System) or Reporting Database	Year	Annually	Required	Y	07/01/2019 - 06/30/2020	1% to 3% Increase	3% to 5% Increase			N		
State-Specific Metrics																		
Add rows for any additional state-specific metrics																		

[a] There are no CMS-provided metrics related to milestone 3
[b] Rates 1 and 2 reported for Metric #17(1) correspond to rates 2 and 3 for Metric #17 from Version 1.1 of the the Medicaid Section 1115 Substance Use Disorder Demonstrations: Technical Specifications for Monitoring Metrics
[c] Rates 1 and 2 reported for Metric #17(2) correspond to rates 1 and 2 for Metric #17 from Version 1.1 of the the Medicaid Section 1115 Substance Use Disorder Demonstrations: Technical Specifications for Monitoring Metrics

The SUD Monitoring Protocol Workbook (Part A) is also available in spreadsheet format on Medicaid.gov

This attachment is part of the monitoring protocol for Alaska's section 1115 substance use disorder (SUD) demonstration and contains additional information regarding how the state is reporting/defining certain metrics.

Table 1. Alaska's comments regarding the reporting of Metrics #5, 10, 18, and Q1 – Q3

Metric number	Metric name	State's comments on reporting
5	Medicaid Beneficiaries Treated in an IMD for SUD	Lifting the 16 bed IMD limit for SUD will increase the number of beds available. As a result, the number of people served will increase.
10	Residential and Inpatient Services	Per 3/24/2020 CMS guidance, and Technical Specifications Manual (2.0), this metric will capture both inpatient and residential treatment services, and this note serves to clarify that both service types are included
18	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD) [PQA, NQF #2940; Medicaid Adult Core Set]	ASO will have to use Medicaid prescription claims data as state law cannot disclose Prescription Drug Monitoring Protocol (PDMP) client specific data to the Department of Health and Social Services (see AS 17.30.200). To meet the Medicaid Adult Core Set Manual (Pg 106-109) https://www.medicaid.gov/medicaid/quality-of- care/downloads/medicaid-adult-core-set-manual.pdf, the ASO will need to match the National Drug Code (NDC) from claims data to clients in dataset.
Q1	Information Technology Use to Monitor SUD rate via Patient Prescription History Requests	No comment
Q2	Information Technology Use to Monitor SUD Treatment Effectiveness via Medical Professional Training in MAT Offered	The number of participants that attend MAT training through Alaska's Project Echo.
Q3	Information Technology Use to Monitor "Recovery" Supports and Services for SUD Individuals	No comment

ATTACHMENT G – Quarterly and Annual Progress Report Template and Instructions

As stated in Special Terms and Conditions STC 36 the state must submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report template is intended as a framework, and can be modified when CMS and the state agree to the modification.

II. Narrative Report Format

Title Line One - _____ (*Name of Individual State Program*)

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

III. Introduction

Describe the goal of the demonstration, what service it provides, and key dates of approval/operation. ***(This should be the same for each report.)***

IV. Operational Updates

Describe all operational updates and activity under the demonstration.

V. 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.

VI. 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.

VII. SUD Health IT

Summarize of progress made in regards to SUD Health IT.

VIII. Tribal Engagement and Collaboration Developments/Issues

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

IX. 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.

X. Enclosures/Attachments

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

XI. State Contact(s)

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

XII. Date Submitted to CMS

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

The state may add additional program headings as applicable.

ATTACHMENT G – Quarterly and Annual Progress Report Template and Instructions

As stated in Special Terms and Conditions STC 36 the state must submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report template is intended as a framework, and can be modified when CMS and the state agree to the modification.

II. Narrative Report Format

Title Line One - _____ (*Name of Individual State Program*)

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

III. Introduction

Describe the goal of the demonstration, what service it provides, and key dates of approval/operation. ***(This should be the same for each report.)***

IV. Operational Updates

Describe all operational updates and activity under the demonstration.

V. 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.

VI. 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.

VII. SUD Health IT

Summarize of progress made in regards to SUD Health IT.

VIII. Tribal Engagement and Collaboration Developments/Issues

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

IX. 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.

X. Enclosures/Attachments

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

XI. State Contact(s)

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

XII. Date Submitted to CMS

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

The state may add additional program headings as applicable.

Attachment H

Time-limited Expenditure Authority and Associated Requirements for the COVID-19 Public Health Emergency (PHE) Demonstration Amendment

Expenditure Authority

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for state plan populations, for the period from May 12, 2023, to November 11, 2023, unless otherwise specificized, be eligible for federal financial participation under the state's title XIX plan.

1. **Use of Legally Responsible Individuals to Render Personal Care Services (PCS).** To allow temporary payment for 1905(a) PCS rendered by legally responsible individuals (which could be inclusive of legally responsible family caregivers) provided that the state meets all existing requirements as described under the Medicaid state plan, including Electronic Visit Verification requirements.

Monitoring and Evaluation Requirements

1. **Evaluation Design.** The state must submit an Evaluation Design that is encapsulated in a Final Report to CMS no later than 12 months after the expiration of this amendment approval period. In developing the Evaluation Design, the state can focus on qualitative methods and descriptive data to address evaluation questions that will support understanding the successes, challenges, and lessons learned in implementing the demonstration amendment. The state must also describe its plans to collect and report data on the size of the populations served under this demonstration amendment, and a summary of service utilization.

2. **Final Report.** The state is required to submit to CMS for review and approval a Final Report, which will consolidate the monitoring and evaluation reporting requirements for this demonstration amendment. The Final Report is due no later than 12 months after the end of the expenditure authority. In addition to capturing data on the number of individuals served and utilization of services under this amendment, the Final Report must undertake qualitative and descriptive assessment on the demonstration implementation, lessons learned, and best practices for similar situations. The state is required to track expenditures associated with this demonstration, as applicable, and may include but not be limited to, administrative costs and program expenditures. CMS's section 1115 demonstration evaluation guidance, "Preparing the Evaluation Report"[4] provides pertinent instructions that would be helpful in preparing the consolidated Final Report. The state should customize the content of the Final Report to align with the specific scope of the demonstration amendment. Once approved, the state is required to post its consolidated Evaluation Design and Final Report to the state's website within 30 days of CMS approval.

[4] Available at https://www.medicaid.gov/medicaid/downloads/preparing-the-evaluation-report.pdf.