Alaska Substance Use Disorder and Behavioral Health (SUD-BH) Program Section 1115 Waiver Evaluation

Mid-Point Assessment

Revised – April 2023

HSAG HEALTH SERVICES ADVISORY GROUP

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Executive Summary

Through Section 1115 of the Social Security Act, states are provided an opportunity to design and test their own methods for providing and funding healthcare services that meet the objectives of the federal Medicaid and Children's Health Insurance Programs (CHIP) but differ from services required by federal statute through Medicaid Section 1115 waiver demonstrations. The Centers for Medicare & Medicaid Services (CMS) has designed a national evaluation strategy to compare the approaches used by different states in its Section 1115 Medicaid expansion waivers, requiring that each demonstration meet the program objectives.

Pursuant to the special terms and conditions (STCs) of Alaska's Medicaid Section 1115 waiver demonstration, the Alaska Department of Health and Social Services (DHSS), Division of Behavioral Health (DBH) contracted with Health Services Advisory Group, Inc. (HSAG) as an independent evaluator to conduct a comprehensive evaluation of Alaska's Medicaid Section 1115 waiver demonstration program, including a mid-point assessment of the program. The purpose of the mid-point assessment is to conduct an independent evaluation of the demonstration, ensuring compliance with Medicaid Section 1115 requirements, and providing recommendations to improve program efficacy.

Waiver History

On January 31, 2018, the Alaska DHSS submitted an application for a Medicaid Section 1115 Demonstration Project from CMS to develop a data-driven, integrated behavioral healthcare system for children and adults with serious mental illness (SMI), severe emotional disturbance, and/or substance use disorder (SUD). On November 21, 2018, while the behavioral health component remained under review, CMS approved the SUD component of the Substance Use Disorder and Behavioral Health (SUD-BH) Demonstration, allowing the SUD component to take effect January 1, 2019. On September 3, 2019, CMS approved the SUD-BH in its entirety, with an overall demonstration period of January 1, 2019 through December 31, 2023. In effort to increase access to SUD and behavioral health services to Alaskans, the Demonstration Implementation Plan for the SUD portion of the waiver, approved by CMS on March 21, 2019, outlines the State's strategies to implement throughout the five-year demonstration period. Notably, the SUD component of the Implementation Plan emphasizes implementation during the first two years of the demonstration period.

State of Alaska Response to the Opioid Crisis

While opioid misuse remains a prominent national issue, Alaska's unique population and geography result in a complex substance use environment within the state. Compared to national trends, self-reported opioid misuse is higher in Alaska,[1] and from 2010 to 2017 opioid-related overdose deaths increased from 7.7 to 13.6 per 100,000 persons.[2] Additionally, the highest number of annual opioid-related deaths was highest in 2017, with 108 deaths, of which, 100 (93 percent) were due to overdose. Additionally, from 2012 to 2017, the rate of out-of-hospital

[1] Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2018 on CDC WONDER Online Database released in 2020. Data are from the Multiple Cause of Death Files, 1999-2018, 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: Sept 25, 2020.

[2] Filley J, Hull-Jilly D. Health Impacts of Opioid Misuse in Alaska. *State of Alaska Epidemiology Bulletin*. Alaska Department of Health and Social Services. 2018; 20:3. Available at: http://www.epi.alaska.gov/bulletins/docs/rr2018_03.pdf. Accessed on: April 27, 2022

naloxone administrations by emergency medical service (EMS) personnel more than doubled, from 8.0 to 17.7 administrations per 1,000 EMS calls.[3] Finally, in 2017, total opioid-related inpatient hospitalization charges exceeded $23 million.[4] To address these challenges, Alaska has enacted various coalitions and initiatives that aim to improve substance misuse, addiction treatment, and prevention strategies. For example, Alaska established the Alaska Office of Substance Misuse and Addiction Prevention in July of 2017 to prevent and reduce substance use disorders, support community-based activities across the state, and prevent substance use related harms.[5]Alaska also assembled the Statewide Opioid Action Plan[6] collective to address opioid misuse and improve prevention and control efforts over the course of five years. With collaboration across numerous sectors and community engagement, the plan focuses on environmental controls and improving social determinants of health, screening for and managing addiction, acute health event control and prevention, and a strengthening of public health surveillance and addiction research. Alaska DHSS DBH has also created an Opioid Use Disorders and Medication Assisted Treatment (MAT) fact sheet to educate Alaskans on opioid addiction, treatment, and recovery.[7] These strategies display Alaska's efforts to address the opioid epidemic, and despite the escalating rate of opioid use leading up to 2018, preliminary data suggest a 36 percent reduction in opioid-related overdose deaths in 2018.[3]

In response to the opioid epidemic, the SUD component of the SUD-behavioral health demonstration was fast tracked for approval in November of 2018, as previously mentioned, allowing Alaska to further their substance use initiatives on January 1, 2019.

Overview of Mid-Point Assessment Requirements

In compliance with STC 23,[8] Alaska must conduct an independent mid-point assessment to assess progress toward each of the program milestones and alignment with the timeframe approved in the SUD Implementation Plan. The mid-point assessment requires the independent evaluator, HSAG, to engage with stakeholders, including SUD treatment providers, beneficiaries, and other stakeholders involved in the design, planning, and implementation of the demonstration. The mid-point assessment also includes an analysis of monitoring metrics calculated by DBH and submitted to CMS. Upon determining progress toward implementation milestones and goals, the assessment must also:

- Identify factors impacting progress and performance of the demonstration;
- Recommend adjustments to the state's implementation of the demonstration where appropriate; and,

Finally, the mid-point assessment must include the methodologies used for evaluating progress and assessing risk; and must highlight limitations of the methodology.

3 Alaska Department of Health and Social Services. Opioid Epidemic in Alaska. Available at: http://dhss.alaska.gov/dph/Director/Pages/opioids/home.aspx. Accessed on: Nov 17, 2020.
4 Ibid.
5 Alaska Department of Health and Social Services. Office of Substance Misuse and Addiction Prevention. Homepage. Available at: http://dhss.alaska.gov/osmap/Pages/default.aspx. Accessed on: Nov 17, 2020.
6 Alaska Department of Health and Social Services. 2018-2022 Statewide Opioid Action Plan: Saving lives now and working to prevent future opioid and substance misuse. 2018. Available at: http://dhss.alaska.gov/dph/Director/Documents/opioids/Statewide-Opioid-Action-Plan-2018-2022.pdf Accessed on: Nov 17, 2020.
7 Alaska Department of Health and Social Services. Division of Behavioral Health. Fact Sheet: Opioid Use Disorders and Medication Assisted Treatment. Available at: http://dhss.alaska.gov/dbh/Documents/TreatmentRecovery/Opioids%20FACT%20SHEET.pdf. Accessed on: Nov 17, 2020.
8 Department of Health and Human Services. Centers for Medicare and Medicaid Services. Special Terms and Conditions. 2019.

Mid-Point Assessment Summary

The following outlines key findings from the qualitative and quantitative elements of the mid-point assessment.

Key Informant Interviews

Key informants for the mid-point assessment were composed of state administrators, provider-level informants, and individuals who represented other key stakeholder groups, including major professional associations for behavioral health services and SUD treatment professionals, and state alliances for mental health. An overarching theme throughout all the key informant interviews was that reform of behavioral healthcare services, including SUD, is extremely important to Alaskans and is recognized as key to reforming the state's Medicaid system and achieving the triple aims of quality, access, and budget neutrality. Key informants expressed support and confidence in the Section 1115 waiver demonstration and highlighted successes such as improved access to SUD and behavioral health services via an increase in the number of providers and types of services available, as well as increases in residential treatment facilities that provide safe housing and withdrawal management options. While all key informants were supportive of improving care across the continuum and expanding treatment to meet individuals' specific needs, many expressed concerns that waiver services may not produce measurable results as quickly as required by CMS. In particular, the scope of change, workforce limitations and simultaneous roll-out of Section 1115 waiver demonstration services with the shift to an administrative service organization (ASO) has slowed implementation progress as many providers lack resources and the bandwidth to process all changes efficiently. While DBH has been able to act swiftly to implement the waiver, some providers expressed concerns around a lack of clear guidance on billing for select SUD services and limited ability to provide input in the development of regulations. Lastly, many providers mentioned barriers related to the financial burden associated with the qualification and certification process for individuals who will render expanded services, as well as tracking individual provider qualifications as they move across agencies over time.

Monitoring Metrics

DBH provided HSAG with seven quarterly monitoring reports containing data across 37 measure indicators covering the time period from July 2019 through June 2021 for 10 monthly metrics and 27 annual metrics. Data for monthly metrics in January 2021-March 2021 were not available. Calculation of metric numerators, denominators, and rates were not independently verified by HSAG. The measurement period for annual metrics varied by measure, aligning with either CY 2019-2020 or SFY2020-2021. Two primary analyses were conducted:

1. Trending analysis of monthly metrics
2. Percentage changes

For purpose of evaluation, monitoring metrics that are reported as counts were recalculated as rates to control for changes in the size of the underlying SUD population. However, for completeness and to align with CMS guidance on mid-point assessment, analyses were also conducted on the counts as reported by DBH.

Risk Assessment

The results across the critical monitoring metrics, the state's completion of implementation plan action items, stakeholder input, and provider availability were synthesized using the algorithm presented in the Mid-Point

Assessment Technical Assistance from CMS[9] to determine the overall level of risk of the demonstration not meeting each milestone (Table 1-1).

Table 1-1—Assessment of the Level of Risk of Not Meeting Milestones

Milestone	Level of Risk	Factors
Milestone 1: Access to Critical Levels of Care for OUD and other SUDs	Medium	• Implementation Plan action items complete: 89% • Critical metrics meeting target: 43% • Multiple stakeholders identified challenges around developing the physical infrastructure necessary to provide and expand services, but all are being addressed within the planned timeframe.[10] • Availability is not yet adequate, largely due to geographic and demographic limitations on the availability of physical facilities and providers at critical levels of care but is moving in the expected direction.
Milestone 2: Widespread Use of Evidence-Based, SUD-Specific Patient Placement Criteria	Medium	• Implementation Plan action items complete: 40% • Critical metrics meeting target: 50% • A few stakeholders identified challenges around the logistics of working through new certification and billing processes, especially in view of the broader landscape of change in processes unrelated to the Waiver. All challenges are being addressed within the planned timeframe and moving in the right direction.
Milestone 3: Use of Nationally Recognized, evidence-Based, SUD-specific Program Standards for Residential Treatment Facility Provider Qualifications	Low	• Implementation Plan action items complete: 85% • Critical metrics meeting Target: NA[a] • Few stakeholders identified minor economic and administrative burdens that are being addressed within the planned timeframe.
Milestone 4: Sufficient Provider Capacity at Each Level of Care, Including MAT	Low	• Implementation Plan action items complete: 66% • Critical metrics meeting Target: 100% • Few stakeholders identified challenges around the logistics of working through new certification and billing processes, expressed challenges around the time needed to enroll providers in Medicaid, as well as overall limited provider capacity. DHB is actively addressing these issues within the planned timeframe. • Availability is not yet adequate, largely due to geographic and demographic limitations on the availability of physical facilities and providers at critical levels of care, but is moving in the expected direction.

9 Centers for Medicare & Medicaid Services. Medicaid Section 1115 Substance Use Disorder (SUD) and Serious Mental Illness and Serious Emotional Disturbance (SMI/SED) Demonstrations, Mid-Point Assessment Technical Assistance, version 1.0 (October 2021). Available at: 1115 SUD and SMI/SED Mid-Point Assessment Technical Assistance Version 1.0 (medicaid.gov). Accessed on Apr. 14, 2022.

10 DBH and HSAG agree that not all levels of care require additional infrastructure.

Milestone	Level of Risk	Factors
Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD	Medium	• Implementation Plan action items complete: NA[b] • Critical metrics meeting target: 50% • Stakeholders identified no risks
Milestone 6: Improved Care Coordination and Transitions Between Levels of Care	Medium	• Implementation Plan action items complete: 67% • Critical metrics meeting target: 14% • Most stakeholders felt that new requirements and stricter training and certification were positive overall, although a few indicated that adapting to the new peer recovery certification requirements would take some time.

[a] There are no monitoring metrics attached to Milestone 3.
[b] Due to the State of Alaska rolling out services on a 50/50 schedule, there were no applicable action items for Milestone #5.

All six milestones defined in the CMS STCs for the Alaska demonstration were either low or medium risk of not meeting requirements of the milestones.

An assessment of the available data shows that a number of implementation plan action items have been delayed in part due to the COVID-19 PHE, which caused providers and hospitals to shift their focus elsewhere. For example, implementation of Screening, Brief Intervention and Referral to Treatment (SBIRT), a highly utilized state plan service that has had varied impacts across the system of care, has been delayed due to the pandemic such that hospitals can shift their focus from SBIRT training to elsewhere. However, during the COVID-19 PHE, DBH began providing SBIRT and motivational interviewing training, with a focus on using SBIRT in telehealth settings, to providers other than those originally identified in the SUD-BH wavier implementation milestones. Other action items are only partially completed due to the State of Alaska's 50/50 phase-in approach to the waiver implementation; these activities are ongoing and DHB is actively monitoring their progress.

In addition to the implementation plan action items, the monitoring metrics for many measures are moving in the targeted direction for the demonstration; in fact, approximately half of all monitoring metrics have changed in a favorable direction. Examination of the relative percentage changes among the monitoring metrics indicates that metrics moving in the targeted direction tend to exhibit larger changes (32 percent) compared to those moving opposite of the targeted direction (21 percent). Among those metrics that are not changing in the targeted direction, it is possible that the ongoing COVID-19 PHE may have contributed to the observed changes. While the mid-point assessment cannot speak to the counterfactual of what the monitoring metrics rates would have been without the COVID-19 PHE, it is possible that the demonstration is helping to mitigate some of the negative impacts of the PHE on members with SUD diagnoses.

Among interviews with state administrators and providers, no major risks were identified that pose a threat to the state's ability to meet with milestone requirements. Most described an increase in the number of providers and the types of services available to Alaskans with SUD and behavioral health needs. While the biggest challenge mentioned by key informants was limited financial and personnel resources when making major systemic changes, they also highlighted barriers around limited capacity of workforce available to provide SUD and behavioral health services, high burden of enrolling individual providers into Medicaid, and data collection and reporting.

Recommendations

Key informants were generally pleased with the implementation and progress of the Section 1115 waiver thus far. There were a small number of areas identified where DBH could enhance program performance and maximize the potential impact and reach of the program. These recommendations include:

- Providing additional training to provider agencies to ensure sufficient education and confidence in their ability to maintain service provision and billing practices complaint with Federal and State Medicaid requirements;
- Instituting monthly provider roundtable meetings for the State to address emerging issues and questions;
- Calculating and reporting monitoring metrics regularly in order to facilitate "real time" tracking of the demonstration performance and impact;
- Creating and maintaining a registry of qualified addiction professionals (QAPs) to track individual continuing education hours and requirements to aid provider transitions between agencies; and,
- Updating the "With Waiver" projected costs and membership to reflect the delayed implementation of the SUD portion of the waiver demonstration.

1. Background

Through Section 1115 of the Social Security Act, states are provided an opportunity to design and test their own methods for providing and funding healthcare services that meet the objectives of the federal Medicaid program and Children's Health Insurance Program (CHIP) but differ from services required by federal statute through Section 1115 waiver demonstrations. Section 1115 waiver demonstrations also allow states flexibility in how state healthcare is operated, beyond what is available under law. The Centers for Medicare & Medicaid Services (CMS) has designed a national evaluation strategy to compare the approaches used by different states in its Section 1115 Medicaid expansion waivers, requiring that each demonstration meet the program objectives.

Alaska's Substance Use Disorder Landscape

In line with national trends, opioid use and overdose in Alaska have become significantly more prevalent over the last decade. Since 2008, deaths involving opioids are at historical highs and, while small improvements were made at the turn of the last decade, the most recently available data show that Alaskan opioid death counts have continued to rise since 2013.[1-1] By 2017, opioid-related overdose deaths nearly doubled from 2010, averaging 13.6 per 100,000 deaths.[1-2] In 2018, deaths involving prescription opioids or heroin remained stable; and 60 percent of drug overdose deaths involved opioids.[1-3] While opioid misuse is not exclusive to the State of Alaska, self-reported opioid misuse is higher in Alaska compared to national trends, with 5.7 percent of Alaskans reporting misuse of any opioids and 3.6 percent of Alaskans reporting heroin use, compared to national rates of 4.0 percent and 1.9 percent, respectively, in 2018.[1-4] According to the 2016-2017 National Survey on Drug Use and Health (NSDUH), 24.2 percent of Alaskans age 12 and over reported binge alcohol use in the past month, compared to a national rate of 24.37 percent; 16.81 percent of Alaskans reported illicit drug use in the past month, compared to a national rate of 10.9 percent; and 8.46 percent of Alaskans reported needing but not receiving substance use treatment in the past year, compared with a national rate of 6.82 percent. Self-reported opioid use was also higher among Alaskans, with 0.68 percent reporting pain reliever use disorder in the past year, compared to 0.65 percent nationwide, and 0.44 percent reported heroin use in the past year, compared to 0.34 percent nationally.[1-5] Notably, alcohol misuse is prominent in Alaska, which ranks tenth in the nation for highest prevalence rate of adult binge drinking and has the fifth highest rate of binge drinking intensity.[1-6]

The need for behavioral health services, which often coincide with the need for SUD treatment, is more prominent among Alaskans than the nation as a whole. Data from the 2018 Behavioral Risk Factor Surveillance Survey

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1-1 Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2018 on CDC WONDER Online Database released in 2020. Data are from the Multiple Cause of Death Files, 1999-2018, 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: Sept 25, 2020.

1-2 Filley J, Hull-Jilly D. Health Impacts of Opioid Misuse in Alaska. *State of Alaska Epidemiology Bulletin*. Alaska Department of Health and Social Services. 2018; 20:3. Available at: http://epibulletins.dhss.alaska.gov/Document/Display?DocumentId=1984. Accessed on: Sept 25, 2020

1-3 National Institute on Drug Abuse. Alaska: Opioid-Involved Deaths and Related Harms; Drug-Involved Overdose Deaths. 2020. Available at: https://www.drugabuse.gov/drug-topics/opioids/opioid-summaries-by-state/alaska-opioid-involved-deaths-related-harms. Accessed on: Sept 25, 2020

1-4 National Survey on Drug Use and Health. Homepage. Available at: https://nsduhweb.rti.org/respweb/homepage.cfm. Accessed on: Sept 28, 2020.

1-5 Substance Abuse and Mental Health Services Administration. National Survey on Drug Use and Health.

1-6 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.

(BRFSS) show that 11.3 percent of Alaskans and 15.8 percent of Alaska Natives reported frequent mental distress, defined as 14 or more days per month of poor mental health. In addition, Alaska's 2017 suicide rate of 26.9/100,000 was more than twice the 2015 national rate of 12.32/100,000, and the Alaska Native population is over two times as likely to complete suicide than non-Alaska Natives.[1-7] With rates of mental illness, suicide, illicit and opioid drug use, overdose deaths, and binge drinking stable or on the rise, and in line with or surpassing national trends, Alaskans continue to need services for SUD and behavioral health as well as intervention to address downstream effects that further perpetuate the need for these services.

For example, with the rising rates of adult SUD between 2007 and 2016, the percentage of Medicaid-covered infants diagnosed with neonatal abstinence syndrome increased nearly fourfold, from 4.4 percent to 16.9 percent.[1-8] In addition, children living with adults with SUD and other behavioral health ailments, are known to have experienced adverse childhood experiences (ACEs), that place 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.[1-9] In Alaska, the prevalence of children living with an adult with SUD is 13.0 percent, and the prevalence of living with an adult with mental illness is 11.3 percent, compared to 8.5 and 7.4 percent nationally, respectively.[1-10] The higher rates of ACEs in Alaska not only coincide with higher rates of adult SUD and behavioral health ailment, but also perpetuate a cycle of high rates of SUD and behavioral health ailment as ACE-affected children age into adulthood with an increased aptitude to partake in risky behaviors. As a result, there is a clear need for intervention across all age groups in Alaska.

Further exacerbating the challenges of providing SUD and behavioral health interventions in Alaska is the unique infrastructure of the State. While Alaska is the largest state in terms of land mass, the comparative population density of Alaskan cities is far less than average cities in the lower 48 states. For example, Alaska's largest city, Anchorage, has an estimated population of 291,538, [1-11] much smaller than many cities in the lower 48 states that have populations upwards of one million. In addition, Alaskan communities are widely distanced, often inaccessible by road, and are medically underserved as a result. Due to the large geographic size and small population size of Alaska, SUD and behavioral health support in many communities is less accessible and healthcare professionals are less numerous than in communities in the contiguous United States (U.S.). Additionally, weather conditions pose a challenge for accessibility, given Alaska's northern and unforgiving climate.

Lastly, Alaska consists of a diverse population with 225 Federally recognized tribes, 20 different native languages, and a growing immigrant population throughout the State. To serve the tribal population, Alaska is home to 31 tribal health organizations, many of which are grant recipients from Alaska's Division of Behavioral

1-7 Alaska Health Analytics and Vital Records, Alaska Division of Public Health (2013-2017 data: 2017 Annual Report and data).

1-8 Department of Health and Human Services. Centers for Medicare & Medicaid Services. State Demonstrations Group [letter]. March 21, 2019. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ak/behavioral-health/ak-behavioral-health-demo-appvd-implementation-20190321.pdf. Accessed on: Feb 12, 2020.

1-9 Felitti VJ, Anda RF, Nordenberg D, et al. *Am. J Prev Med.* Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. 1998;14(4). Available at: https://www.ajpmonline.org/action/showPdf?pii=S0749-3797%2898%2900017-8 Accessed on: Sept 30, 2020.

1-10 United Health Foundation. America's Health Rankings. Adverse Childhood Experiences, Alaska. 2019. Available at: https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/ACEs/state/AK. Accessed on: September 25, 2020.

1-11 United States Census Bureau. Census.gov.

Health (DBH). The diversity of the population presents challenges for providing culturally and regionally appropriate care and services.

Background of Alaska SUD-BH

On January 31, 2018, the Alaska Department of Health and Social Services (DHSS) submitted an application for a Medicaid Section 1115 Demonstration Project from CMS to develop a data-driven, integrated behavioral healthcare system for children and adults with serious mental illness (SMI), severe emotional disturbance, and/or SUD. In addition, the demonstration aims to increase services for at-risk families to support the healthy development of children and adults through various behavioral health interventions. On November 21, 2018, CMS approved the SUD component of the substance use disorder and behavioral health (SUD-BH) program Demonstration while the behavioral health component was under review, allowing the SUD component to take effect January 1, 2019. On September 3, 2019, CMS approved the SUD-BH in its entirety, with an overall demonstration period of January 1, 2019 through December 31, 2023. In brief, the purpose and goal of the SUD-BH Demonstration is to increase access to SUD and behavioral health services to Alaskans to anticipate or eliminate crises and strengthen a continuum of care, including early intervention services and community support. While the demonstration consists of a SUD and behavioral health component, the implementation of both aspects is included under one Implementation Plan (discussed below) for the SUD-BH. The Centers for Medicare & Medicaid Services (CMS) special terms and conditions (STCs) for this Section 1115 waiver relate only to the SUD aspects of the waiver. Therefore, the focus of this report will be primarily on the SUD component of the Section 1115 waiver with some behavioral health elements discussed as they pertain to SUDs.

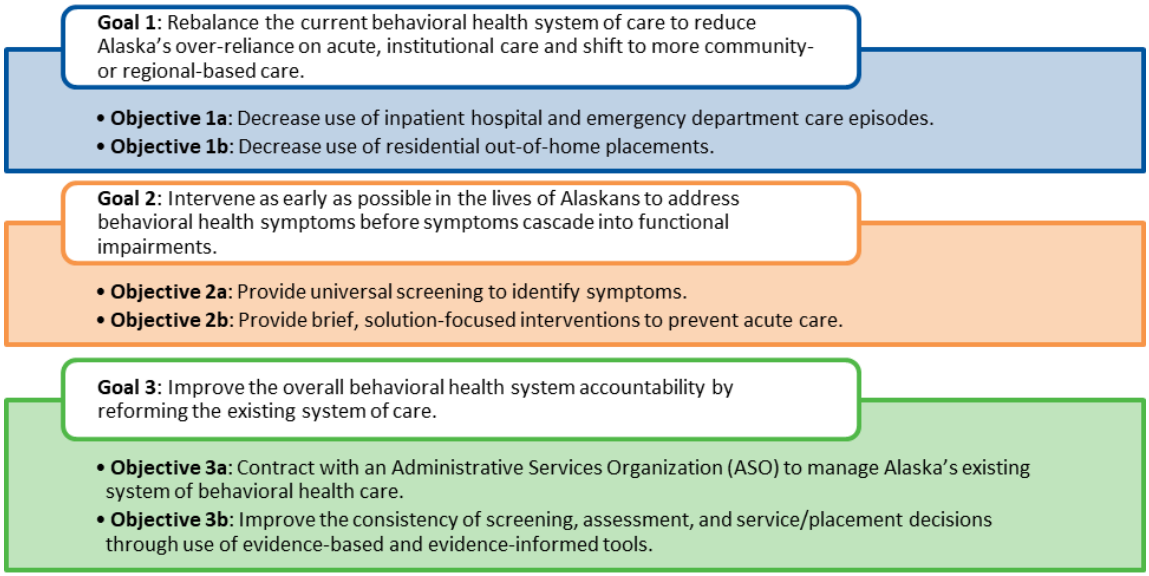
Program Goals and Objectives

The SUD-BH aims to achieve three specific goals:

3. 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.
4. Intervene as early as possible in the lives of Alaskans to address behavioral health symptoms before symptoms cascade into functional impairments.
5. Improve the overall behavioral health system accountability by reforming the existing system of care.

Each of the goals, with their unique objectives, are illustrated in Figure 1-1.

Figure 1-1—SUD-BH Goals and Objectives



Program Population

The waiver is intended to impact three Alaskan Medicaid beneficiary population groups.

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

Group 1: Given that a significant proportion of Alaska's children and adolescents encounter the child welfare system or juvenile justice system at some point in their upbringing, the waiver is intended to strengthen the support system for this group in hopes of preventing crises and reducing the need for out-of-home placements. Beneficiaries in Group 1 are currently under the supervision or in the custody of the Alaska DHSS' Office of Children's Services, the Division of Juvenile Justice, or in tribal custody; formerly in kinship care, foster care, or residential care; or at risk of an out-of-home placement. Waiver services for this population 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: Group 2 is composed of transitional age youth and adults who experience mental health disorders and have co-morbidities or dual diagnoses of intellectual, developmental, or sensory disabilities; making their care needs more complex. For Group 2, waiver services include assertive community treatment services, ICM, PHP services, adult mental health residential (AMHR) services, and peer-based crisis services.

Group 3: Group 3 consists of adults, adolescents, and children between 12 and 64 years of age 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.

Waiver services for this group are aimed at enhancing the availability of and providing a more comprehensive continuum of SUD treatment and include (see Appendix C for additional details):

- Opioid treatment services,

- IOP services,
- PHP services,
- 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.

Implementation Plan Overview

The Implementation Plan, approved by CMS on March 21, 2019, outlines the State's strategies to implement each of the six milestones of the SUD portion of the waiver. During the five-year demonstration period, Alaska intends to have a particular emphasis on the first two years and aims to cover approximately one half of the state population under the SUD portion of the waiver in Demonstration Year 1 and the other half to be phased-in by the end of Demonstration Year 2. The Implementation Plan is organized by key milestones identified by CMS and utilizes nine Alaskan geographic regions to phase-in the waiver implementation in segments.

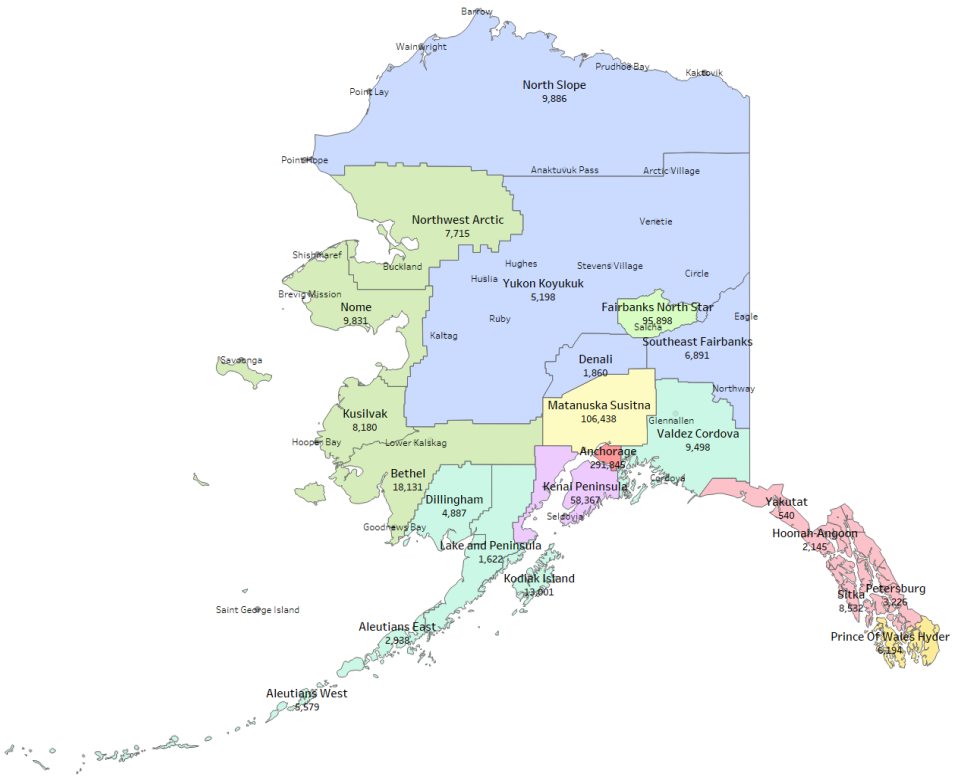
Geographic Map of Phased Implementation

Due to the large geographic area and relatively small population of Alaska, the waiver divides the State into nine geographic regions with phased implementation strategies across each region to allow for each unique region's infrastructural challenges to be addressed, in turn allowing for efficient implementation of the waiver.

Figure 1-2 displays the nine waiver regions along with population size and prominent cities located within each.

Figure 1-2—Alaskan Regional Geographic Service Area

Region / Census Area	Population
Region 1 - Anchorage Municipality	**291,845**
Region 2 - Fairbanks North Star Borough	**95,898**
Region 3 - Northern and Interior Region	**23,835**
Southeast Fairbanks	6,891
Denali	1,860
Yukon Koyukuk	5,198
North Slope	9,886
Region 4 - Kenai Peninsula Borough	**58,367**
Region 5 - MatSu Borough	**106,438**
Region 6 - Western Region	**43,857**
Bethel	18,131
Kusilvak	8,180
Nome	9,831
Northwest Arctic	7,715
Region 7 - Northern Southeast Region	**52,440**
Yakutat	540
Skagway	1,095
Juneau	31,986
Hoonah-Angoon	2,145
Haines	2,516
Sitka	8,532
Petersburg	3,226
Wrangell	2,400
Region 8 - Southern Southeast Region	**19,933**
Prince Of Wales Hyder	6,194
Ketchikan Gateway	13,739
Region 9 - Gulf Coast/Aleutian Region	**38,394**
Aleutians East	2,938
Aleutians West	5,579
Lake and Peninsula	1,622
Valdez Cordova	9,498
Kodiak Island	13,001
Bristol Bay	869
Dillingham	4,887
Total	**731,007**



Implementation Phases

The waiver was scheduled to follow a phase-in approach by geographic region and has two implementation phases with six distinct milestones to achieve:

- **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 and Prevention Strategies to Address Opioid Abuse
- **Milestone 6**: Improved Care Coordination and Transitions Between Levels of Care

In some cases, each of the two implementation phases implement different milestones, or parts of each milestone, in different regions. For example, in one part of Milestone 1, IOP services provider capacity is increased for Region 1 and Region 5 in Demonstration Year 1, whereas IOP provider capacity for Regions 2 through 4 and 6 through 9 is increased in Demonstration Year 2, at the latest. As such, the phase-in approach is applied not only to the Demonstration year, but to the geographic region as well. Furthermore, where applicable, Region 1, Region 2, Region 5, and Region 7 will be phased in during Demonstration Year 1, followed by Region 3, Region 4, Region 6, Region 8, and Region 9 in Demonstration Year 2.

Milestone 1: Access to Critical Levels of Care for SUD Treatment

Improved coverage is proposed to increase access to care under the waiver for each of the American Society of Addiction Medicine (ASAM) levels of SUD care. Refer to the Alaska 1115 Substance Use Disorder Waiver Implementation Plan for specifics on the expansion of services by region for each SUD level of care.[1-12]

Milestone 2: Use of Evidence-Based, SUD-Specific Patient Placement Criteria

A primary purpose of the waiver is to universally screen all Medicaid-eligible individuals for SUD before functional impairments present. Screening protocols will utilize available evidence-based placement and intervention methods, such as the Comprehensive Addictions and Psychological Evaluation (CAAPE-5) and Composite International Diagnostic Interview (CIDI-5). Tools used for screening will undergo prior authorization by the administrative services organization (ASO) and provider training for screening protocols will be given.

For individuals presenting to the emergency department (ED), alcohol use disorders identification test (AUDIT) and drug abuse screening test (DAST) screenings will occur under the waiver and ASAM levels of care will be utilized to place treatment. In addition, the ASO will establish a call center for crisis support anywhere in the State.

Lastly, whenever a qualified addiction professional (QAP) has completed an integrated, comprehensive clinical assessment, the ASO will serve as an independent third party to review the ASAM criteria. All services above ASAM Level 2.5 will require prior authorization by the ASO and the length of stay will be determined by medical necessity. The ASO will be required to have policies and procedures in place to:

- Review instances of over- and under-utilization of emergency department services and other healthcare services.
- Identify aberrant provider practice patterns.
- Evaluate efficiency and appropriateness of service delivery.
- Identify quality of care and treatment issues.

Milestone 3: Use of Nationally Recognized SUD-Specific Program Standards for Residential Treatment Facility Provider Qualifications

Licensure and regulatory changes will occur to help align with ASAM standards for service types and hours of clinical care. 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; or 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 of DBH from either the provider, a recipient, or a family member. Formal rulemaking in Alaska can take anywhere from 12 to 18 months. As such, Alaska will issue guidance on ASAM criteria until promulgation occurs. In addition, workforce development changes will occur to align with the ASAM staffing standards. The waiver will be used to recruit and retain a qualified addiction workforce and to expand the educational requirements for certification. Lastly, Alaska will develop a formal, systematic monitoring protocol to assess ongoing compliance of requirements to ensure provider accountability. The ASO will be utilized for monitoring.

[1-12] Centers for Medicare & Medicaid Services. Alaska 1115 Substance Use Disorder Waiver Implementation Plan—Final. 2019. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ak/behavioral-health/ak-behavioral-health-demo-appvd-implementation-20190321.pdf. Accessed on: Sept 30, 2020.

Milestone 4: Sufficient Provider Capacity at Critical Levels of Care

Due to Alaska's size, number of isolated communities, and health professional shortage areas, the SUD provider capacity at all levels of ASAM care is a tremendous challenge in Alaska. Although recognized as a significant limitation, Alaska DBH intends to increase or develop capacity for ASAM levels 3.5, 3.1, and 3.3 residential; IOP; PHP; opioid treatment program (OTP); medication-assisted treatment (MAT); mobile outreach and crisis; and ambulatory withdrawal management services. In addition, Alaska DBH will conduct a comprehensive assessment of MAT needs across the state as well as increase access to buprenorphine and other pharmacologically appropriate treatments for SUDs.

To increase provider capacities, Alaska has strategized the capacity increases by region, in line with the phase-in implementation approach.[1-13]

Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse

As part of the waiver, various comprehensive treatment and prevention strategies to address opioid abuse will be implemented. Strategies include the creation of an opioid policy task force, a state-specific strategic plan for responding to the opioid crisis, a prescription drug monitoring program, refined opioid prescribing guidelines, and integrating prevention and treatment efforts.

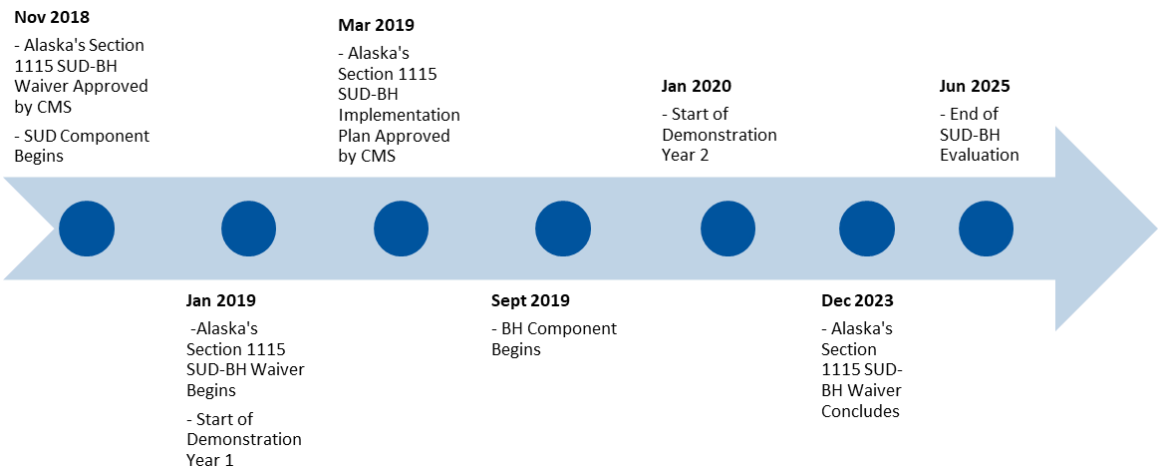
Milestone 6: Improved Care Coordination and Transitions Between Levels of Care

Under the waiver, care coordination services will be available in order to receive Medicaid reimbursement for outpatient MAT. In addition, two new services have been designed: SUD care coordination and ICM. To ensure smooth transitions, Alaska will expand peer recovery coverage for both professionals and non-professionals.

Timeline of the SUD-BH Demonstration

Figure 1-3 illustrates the timeline of the major events of the SUD-BH Demonstration.

Figure 1-3—Timeline of the SUD-BH Demonstration



1-13 Centers for Medicare & Medicaid Services. Alaska 1115 Substance Use Disorder Waiver Implementation Pan—Final. 2019. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ak/behavioral-health/ak-behavioral-health-demo-appvd-implementation-20190321.pdf. Accessed on: Sept 30, 2020.

Impacts of COVID-19

At the State-Level

In response to the ongoing coronavirus disease 2019 (COVID-19) pandemic, the State has expanded telephone and telehealth video services to include services from the Section 1115 waiver service array under Title 7 of the Alaska Administrative Code dealing with Medicaid Section 1115 behavioral health waiver services as emergency regulation, effective May 21, 2020. In addition, a 24/7 anonymous call line, AK Responders Relief Line, went live on May 5, 2020, to provide crisis counseling and general support to healthcare and behavioral health professionals impacted by COVID-19, and includes support to their immediate family members. In addition, a free and confidential crisis call center and 24/7 text line, the CARELINE, was made available for Alaskans who are in a crisis, grieving, a survivor of a suicide attempt or lost someone to suicide, concerned about someone else, or in need of someone to talk to. As an online resource for Alaskans, DBH created Well-Being Alaska, a wellness website page and social media forum to address stress and feelings of isolation during the COVID-19 pandemic.

Increased resources to provide support to Alaskans during the pandemic include additional Coronavirus Aid, Relief, and. Economic Security (CARES) Act and COVID Response Individualized Services Program (CRISP) funding, authorized flexible grant funding for DBH grantees, and homelessness and treatment resources. Specific resources provided through these funding vehicles are outlined below.

- Additional funding through the CARES Act was aimed at suicide prevention and included expanded access to the CARELINE crisis call center. The State developed branding to engage youth and hired dedicated full- and part-time staff to provide in home or telehealth care. In addition, funding was expanded for technical assistance and consultation to assist DBH prevention grantees with suicide prevention, mental health efforts, and substance misuse related to the COVID-19 pandemic and subsequent social isolation. To address suicide healing and prevention of cluster suicides in communities, expanded postvention community planning and training was developed within communities to specifically address their unique resources and needs. Finally, culturally relevant training on specific treatment modalities for suicide was provided to behavioral health providers.
- CRISP funding has been used to divert at-risk populations from higher, residential, or institutional levels of care by providing immediate financial assistance for COVID-19 related expenditures and stabilizing clients through community-based care. CRISP fund awards have been under $500 for an individual or family and have been used to:
  - Cover short-term food costs while waiting for the activation of benefits,
  - Pay for an overdue utility bill, or
  - Purchase internet service or a device that can be used for telehealth services.
- Authorized flexible grant funding for DBH grantees allows agencies who are behavioral health grant recipients to adapt to the needs of clients during the COVID-19 pandemic. This includes but is not limited to:
  - Increasing crisis services for homeless clients,
  - Increasing quarantine housing options for behavioral health clients, and
  - Working with local school districts to obtain additional behavioral health referrals.
- On October 1, 2020, DBH released a grant amendment option, including additional funding, for treatment agencies to provide case management, peer support, psychosocial support, treatment intervention, and withdrawal management to individuals experiencing homelessness.

Finally, in addition to the expansion of funding and services to clients, the State has incorporated administrative flexibilities to better permit services during the COVID-19 Public Health Emergency. For example, DBH has

suspended prior service authorizations, allowing providers to provide care without prior or retrospective billing authorization, and has expanded service types eligible for telehealth.

At the Provider-Level

While continuing to provide inpatient waiver services during the pandemic, handling staffing outbreaks was a cited challenge and lack of personal protective equipment (PPE) was an additional worry for many providers. In addition, providers noted that patient engagement became more difficult in some cases when treatment centers closed, group therapies were cancelled, and services were substituted by telehealth. As a result of the pandemic, numerous providers noted the increase in substance use and, in some communities, alternative substances such as fentanyl have become more prominent.

While COVID-19 has posed significant challenges in receiving healthcare nationwide, the unique, primarily frontier infrastructure of Alaska presented vast barriers to receiving care pre-COVID-19 and emphasized the benefit of the expansion of telehealth services. With telehealth, providers are able to reach populations that they otherwise were unable to reach. Of note, not all Alaskan providers or beneficiaries have the technical infrastructure for telehealth services.

Monitoring Protocol

The State is responsible for tracking the performance of the program in real-time by monitoring various measures pertaining to progress towards the milestones outlined in the Implementation Plan. At the time of the original Mid-Point Assessment, Alaska DBH intended to monitor approximately 35 SUD measures aligned with CMS' SUD Monitoring Metrics Technical Specifications but had not yet finalized implementation of the monitoring metrics. Since that time DBH has begun reporting approximately 35 monitoring metrics and has submitted multiple quarterly monitoring reports to CMS specifying its progress and providing updates on waiver goals, budget neutrality, performance, evaluation activities, collaboration with tribal entities, as well as the monitoring metrics.

Evaluation Activities

As part of the STCs described by CMS, the State has contracted with an independent evaluator, Health Services Advisory Group, Inc. (HSAG), to conduct a comprehensive evaluation of Alaska's Medicaid Section 1115 waiver demonstration. The purpose of this evaluation is to provide CMS and Alaska's DBH with an independent evaluation of the SUD-BH, ensuring compliance with Medicaid Section 1115 requirements and providing recommendations to improve program efficacy along the way. The following sections describe several of the evaluation activities in more detail.

Evaluation Design Plan

The evaluation design plan is the State's plan for how to accomplish the evaluation required by CMS. CMS provides expectations for the contents of the plan, requiring the State to explain how its plan is intended to achieve the goals of the waiver. In addition, the State must outline how components of the evaluation design work together to demonstrate that the approach is working as intended. Alaska's evaluation design plan covers general background information on the SUD-BH and its implementation plan, evaluation questions and hypotheses, evaluation methodology and limitations, and a timeline of CMS deliverables. At the onset of the evaluation, HSAG conducted a thorough review and revised the design plan in accordance with CMS' feedback in May 2020.

Interim Evaluation Report

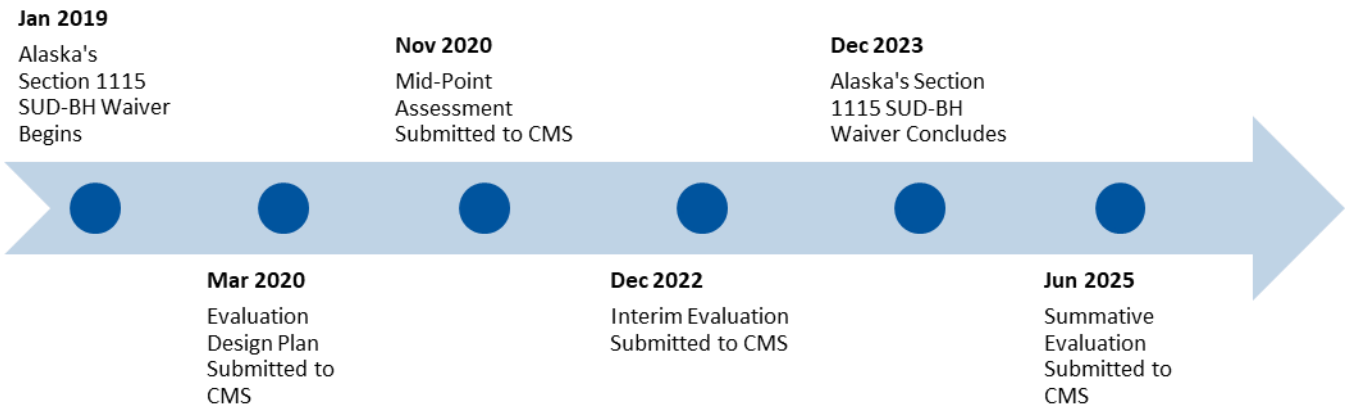
The interim evaluation report will present the impacts of the SUD-BH Demonstration based on analyses conducted in accordance with the CMS-approved evaluation design plan. It will include a discussion about the structure of the evaluation design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. The report will provide all available data to date, with interpretations of the findings; assessments of the outcomes; explanations on the limitations of the design, data, and analyses; and recommendations to the State.

Summative Evaluation Report

Following the same general structure as the interim evaluation report, the State must submit a summative evaluation report for the demonstration's current approval period (September 2019–December 2023).

Figure 1-4 displays the timeline of the evaluation activities.

Figure 1-4—Timeline of Evaluation Activities



COVID-19 Impacts on the Mid-Point Evaluation

As a result of COVID-19, the independent evaluation for the demonstration to produce this mid-point assessment was impacted in several ways. First, all meetings that were intended to occur in-person with DBH in Alaska during 2020 were replaced with virtual meetings. Similarly, all qualitative data collection—including key informant, provider, and non-provider interviews—had to be conducted virtually due to travel restrictions related to COVID-19. Key informants were also specifically asked about how COVID-19 impacted them relative to their provision of demonstration-related services.

2. Methodology

The following section contains the data sources and methodologies used and employed to conduct the Alaska Substance Use Disorder and Behavioral Health (SUD-BH) Program mid-point assessment.

Data Sources

Monitoring Metrics

Alaska Department of Behavioral Health (DBH) supplied HSAG with seven quarterly monitoring reports that were submitted to CMS as part of its regular quarterly reporting. HSAG utilized these workbooks to assess the performance of the SUD demonstration at mid-point. Calculation of metric numerators, denominators, and rates were not independently verified by HSAG. Monthly metrics were calculated for the time periods covering July 2019 through December 2020 and April 2021 through June 2021. The measurement period for annual metrics varied by measure. Metrics 4, 5, 13, 14, 25, 26, 27, and 36 were calculated for SFY 2020 and SFY 2021 (July 2019-June 2020 and July 2020-June 2021, respectively). Metrics 15, 17, 18, 21, 22, and 32 were calculated for CY 2019 and CY 2020.

For purpose of evaluation, monitoring metrics that are reported as counts were recalculated as rates to control for a change in the size of the underlying SUD population. However, for completeness and to align with CMS guidance on mid-point assessment, analyses were also conducted on the counts as reported by DBH.

Provider Availability Assessment Data

Because this assessment was conducted before CMS had published its guidance, provider availability was not explicitly designed into the assessment plan as a specific element to be assessed. However, HSAG asked questions related to the availability of providers and provider appointments as a part of its key informant interviews.

Other Data Sources

Administrative informants for this mid-point assessment were drawn predominantly from Alaska's Division of Behavioral Health (DBH) employees located in the relatively urban areas of Anchorage and Juneau. Provider informants were from Fairbanks, the Seward Peninsula, and Mat-Su Borough. Health Services Advisory Group, Inc. (HSAG) was able to interview two individuals who together represented several other stakeholders, including major professional associations for behavioral health services and SUD treatment professionals, and state alliances for mental health, as indicated in Appendix B.

The mid-point assessment included an analysis of 15 semi-structured interviews with providers and administrators, as well as other non-provider stakeholders that provide care to Alaska Medicaid beneficiaries as part of the SUD-BH Demonstration. The interviews collected data on the perceptions and experiences during the early stages of the demonstration regarding:

- Experiences with care coordination, integration, and quality of care to the SUD-BH recipients.
- Perceptions on barriers and successes associated with integrating the SUD-BH.
- Anticipated challenges on sustaining the implementation of the SUD-BH.

- Impacts of the coronavirus disease 2019 (COVID-19) pandemic on integrating and/or implementing the SUD-BH.

To engage the key informant interviews, Health Services Advisory Group, Inc. (HSAG) worked with Alaska's Division of Behavioral Health (DBH) to identify a list of providers who have experience with the SUD-BH. HSAG recruited participants by geographic region, location within each region (e.g., urban versus rural versus frontier providers), and relevant specialty. After stratifying the provider lists, HSAG recruited additional providers to maximize the variation in provider types and locations, so the data obtained are likely to represent perspectives indicative of the diverse population of Alaska. The interviews lasted approximately 60 minutes to allow time for all participants to voice their perspectives and explore each topic in detail.

List of Organizations Interviewed

Table 2-1 provides a list of the organizations interviewed for the mid-point assessment.

Table 2-1—Organizations Interviewed

Organization Type	Organization
Providers	Akeela Inc.
	Interior AIDS Association
	SeaView Community Services
	Set Free Alaska
	Volunteers of America Alaska
Consumer Advocates	Advisory Board on Alcohol and Drug Abuse (ABADA)
	Alaska Mental Health Board (AMHB)
	Alaska Mental Health Trust Authority (AMHTA)
	Alaska Behavioral Health Association (ABHA)
State-Level Key Informants	State Medicaid Director
	Deputy Director
	Legislative Liaison
	Chief of Risk and Research Management
	Behavioral Quality Assurance Section Managers
	Waiver Research Analyst III

To date, HSAG has not interviewed any of Alaska's 225 tribal authorities or 12 to 15 tribal health organizations, or state boards or consortiums representing them, despite some having been invited to participate in the key informant interviews. It should be noted that since the original publication of this Mid-Point Assessment, HSAG has conducted multiple interviews with multiple tribal entities. The results of these interviews will be included in the Interim and Summative Evaluation Reports. These entities are significant providers of and payors for behavioral health services and SUD services. Tribes may fund social and behavioral health services at a higher rate than CMS and the Section 1115 waiver permits or provide funding in addition to that billable to Medicaid. Some tribes are perceived as more experienced in telehealth. HSAG understands from other non-tribal entity interviewees that some tribes expressed concerns regarding inadequate communication/meaningful dialogue with DBH, and DBH has taken steps to address these concerns.

More than one informant mentioned that the requirement that services funded in a Federally Qualified Health Center (FQHC) be provided within the four walls of the health center may be a barrier to provision of home- and

community-based services (HCBS). It should be noted that this is a Federal requirement and extends beyond the scope of the Section 1115 waiver in Alaska.

Analytic Methods

Monitoring Metrics

The mid-point assessment includes an examination of progress toward meeting the targets specified by the SUD monitoring protocol metrics (Table 2-2).

Table 2-2—Summary of Monitoring Metrics

#	Metric Name	Measurement Period	Desired Direction	Critical Measure Milestone	Overall Demonstration Target
3	Medicaid Beneficiaries with SUD Diagnosis (monthly)	Month	Decrease	—	0% to 3%
4	Medicaid Beneficiaries with SUD Diagnosis (annually)	Year	Decrease	—	0% to 3%
5	Medicaid Beneficiaries Treated in an IMD for SUD	Year	Increase	2	3% to 5%
6	Any SUD Treatment	Month	Increase	—	3% to 5%
7	Early Intervention	Month	Increase	1, 2	3% to 5%
8	Outpatient Services	Month	Increase	1, 2	3% to 5%
9	Intensive Outpatient and Partial Hospitalization Services	Month	Increase	1, 2	1% to 3%
10	Residential and Inpatient Services	Month	Increase	1, 2	3% to 5%
11	Withdrawal Management	Month	Decrease	1, 2	1% to 3%
12	Medication-Assisted Treatment	Month	Increase	1, 2	3% to 5%
13	SUD Provider Availability	Year	Increase	3	0% to 3%
14	SUD Provider Availability (MAT)	Year	Increase	3	0% to 3%
15.a	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: Initiation	Year	Increase	6	0% to 3%
15.b	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: Engagement	Year	Increase	6	0% to 3%
17.1	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence	Year	Increase	6	3% to 5%
17.2	Follow-up after Emergency Department Visit for Mental Illness	Year	Increase	6	3% to 5%

#	Metric Name	Measurement Period	Desired Direction	Critical Measure Milestone	Overall Demonstration Target
18	Use of Opioids at High Dosage in Persons Without Cancer	Year	Decrease	5	3% to 5%
21	Concurrent Use of Opioids and Benzodiazepines	Year	Decrease	5	3% to 5%
22	Continuity of Pharmacotherapy for Opioid Use Disorder	Year	Increase	1	3% to 5%
23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	Month	Decrease	5	0% to 3%
24	Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries	Month	Decrease	—	0% to 3%
25	Readmissions Among Beneficiaries with SUD	Year	Decrease	6	0% to 3%
26	Count of Overdose Deaths	Year	Decrease	—	0% to 3%
27	Rate of Overdose Deaths	Year	Decrease	5	0% to 3%
32	Access to Preventative/Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD	Year	Increase	—	3% to 5%
36	Average Length of Stay in IMDs	Year	Decrease	2	Under 30 Days
Q1	Information Technology Use to Monitor SUD rate via Patient Prescription History Requests	Year	Decrease	—	3% to 5%
Q2	Information Technology Use to Monitor SUD Treatment Effectiveness via Medical Professional Training in MAT Offered	Year	Increase	—	3% to 5%
Q3	Information Technology Use to Monitor “Recovery” Supports and Services for SUD Individuals	Year	Increase	—	3% to 5%

Two analyses were conducted depending on the measurement period of the metric. For all metrics, HSAG calculated the relative percent change and absolute changes between the first and last available data points.

The changes were calculated as follows:

- Absolute Change = Value of metric at mid-point – Value of metric at baseline
- Percent Change = (Value of metric at mid-point – Value of metric at baseline)/Value of metric at baseline

The most recent data point available was used as the value of metric at mid-point, while the first available data point was used as the value of metric at baseline.

For monthly metrics, HSAG also assessed the trend in rates throughout the period of July 2019 through June 2021.

The trend line was calculated through a linear regression expressed as:

$$Y_t = \beta_0 + \beta_1 time_t + \mu_t$$

Where Y_t is the outcome of interest for the time period *t*, *time* represents a linear time trend for each month during the baseline period. The coefficient β_0 identifies the starting level of outcome Y (the rate in July 2019), β_1 is the slope of the outcome over the course of the assessment period. This analysis serves only as a tool to identify any changes or emergence of a trend following the initiation of the waiver to determine whether the measures are on track to meet performance targets, as per the special terms and conditions (STCs). The regression analysis will not purport to attribute changes in rates to the demonstration and will not report results from hypothesis testing.

Assessment of SUD Implementation Plan Milestones

The SUD-BH Demonstration will be implemented in phases across different regions. Each milestone has distinct actions and time frames for completing each action (see Appendix C for details). To assess the progress of the Alaska SUD-BH implementation, actions will be grouped by time frame and by milestone. Most actions have distinct target dates for completion (e.g., April 1, 2019). An assessment of whether each action is completed on schedule will be obtained from key informant interviews with various State staff members. Results may be synthesized as the percentage of actions completed by the specified target date for each milestone, and across all milestones. If quantitative data on each of these actions are available and reliable, HSAG will present results for three time points:

- Prior to Demonstration Year 1 (January 1, 2019–December 31, 2019)
- At the end of Demonstration Year 1
- At the end of Demonstration Year 2 (January 1, 2020–December 31, 2020)

This will provide a sense of trajectory on actions that may be pending or ongoing.

The remaining implementation actions fall within three categories based on their timelines: (1) following the 50/50 phase-in schedule, (2) provider trainings on American Society of Addiction Medicine (ASAM) requirements with targeted completion by Demonstration Year 1 and Demonstration Year 2, and (3) actions requiring the development of provider notifications with a formal notification released 90 days prior to the initiation of waiver services. To assess the progress of these implementation actions, HSAG will again present findings as the percentage of actions that met completion by their target date for each milestone and/or across all milestones where applicable. An assessment of whether each action was completed on schedule will be obtained from key informant interviews with State staff members. If quantitative data on these actions are available and reliable, HSAG will present results for two time points: prior to the start of the demonstration, and after implementation action has been completed.

If any these implementation actions are not completed by the specified date due to COVID-19 or other reasons, HSAG will assess whether the activities are underway and readjust the analysis plan to align with the anticipated completion date.

Provider Availability Assessment

Because this assessment was conducted before CMS had published its guidance, provider availability was not explicitly designed into the assessment plan as a specific element to be assessed. However, HSAG did ask questions related to the availability of providers and provider appointments as a part of its key informant interviews. Information provided by stakeholders related to provider availability as a part of the key informant interviews were extracted and synthesized to provide an assessment of provider availability.

Assessment of Overall Risk of Not Meeting Milestones

The level of risk (e.g., high risk, medium risk, or low risk) associated with not meeting each milestone for each type of analysis (implementation, quantitative, and qualitative) was assessed. The determination of the level of risk was dependent on the type of analysis conducted. Table 2-3 outlines how the level of risk is determined for each type of analysis.

Table 2-3—Considerations for the Assessment of The Level of Risk of Not Meeting Milestones

Risk Level	Considerations for Assessing the Level of Risk
Low	**Implementation plan action items.** State fully completed most/all (75 percent or more) associated action items as scheduled. **Monitoring metrics.** State is moving in the expected direction relative to its annual goals and overall demonstration targets for all or nearly all (75 percent or more) of the associated monitoring metrics. **Stakeholder feedback.** No stakeholder identified risks related to meeting milestone.
Medium	**Implementation plan action items.** State fully completes some (25–75 percent) of the associated action items as scheduled. **Monitoring metrics.** State is moving in the expected direction relative to its annual goals and overall demonstration targets for many (25–75 percent) of the associated monitoring metrics. **Stakeholder feedback.** Few stakeholders identified risks related to meeting milestone.
High	**Implementation plan action items.** State fully completed few or none (25 percent or less) associated action items as scheduled. **Monitoring metrics.** State is moving in the expected direction relative to its annual goals and overall demonstration targets for few (25 percent or less) of the associated monitoring metrics. **Stakeholder feedback.** Many stakeholders identified risks related to meeting milestone.

Limitations

There are several limitations to the results presented in this report. The first limitation relates to the time period of the data available. This report covers the baseline period, which is prior to or concurrent with implementation of many of the activities described in the SUD implementation protocol. As a result, immediate changes in measured outcomes may not be apparent or expected. Some health changes and outcomes require many years to be apparent or to be detectable via measurement, leading to challenges in assessing all potential impacts of the demonstration even during the evaluation period.[2-24] While trends in the metrics have been assessed for measures that are

[2-24] Berk, L. E. (2018). *Development through the lifespan* (7th Ed.). Hoboken, NJ: Pearson.; Santrock, J. W. (2019). *Lifespan development* (17th Ed.). New York, NY: McGraw-Hill.

reported monthly, this trend does not purport to illustrate the performance of the demonstration but rather provide an assessment of level and direction for the selected metrics prior to implementation.

A second, related, limitation pertains to the methodology employed. The data have not been analyzed using statistical methods that would allow making statements about the program impact. The reported trends may be influenced by factors external to the implementation of the demonstration, such as seasonal variation that have not been statistically controlled for. Additional years of baseline data would help assess the impact of seasonality and future evaluation reports will provide the results of whether these changes are associated with program impacts.

A third limitation is the availability of certain fields in the data used in this analysis. Some fields were necessary in order to calculate metrics as fully specified in the SUD Monitoring Metrics Technical Specifications or Healthcare Effectiveness Data and Information Set (HEDIS®)[2-25] Volume 2 technical specifications. For example, type of bill can be used to confirm that a community mental health center visits was in an intensive outpatient or partial hospitalization setting; however, this field was not available in the data extract (used in the priority assignment for SUD Metric #8). Future evaluation reports will contain additional data used to calculate metrics as specified.

[2-25] HEDIS® is a registered trademark of the National Committee of Quality Assurance (NCQA).

3. Findings

The following section details the qualitative and quantitative results for the Alaska Substance Use Disorder and Behavioral Health (SUD-BH) Program Section 1115 waiver demonstration.

Progress Towards Demonstration Milestones

Background Described by Key Informants

Alaska's Section 1115 waiver demonstration and its implementation must be evaluated within the context of the State's unique environment. As discussed previously, this includes the State's huge physical/geographical size, its relatively small population, and low population density. Access to healthcare is complicated by lack of access to an integrated highway system, with more than 80 percent of Alaskans living away from major roads, many in remote areas, small villages, and tribal areas accessible only by air or sea. There is limited access to public transportation or reliable personal vehicles able to safely travel into town for care during the winter months. One provider explained that, in winter, their client base was limited to individuals who owned dependable vehicles and lived within 15–20 miles of their office.

Alaska has the largest number of separate Native American tribal associations of any state, with 225 separate Federally recognized tribes engaged in a variety of alliances at different healthcare levels (federal, state, and tribal). This presents substantial challenges to the effective communication and collaboration necessary as a part of the extensive changes to the State's behavioral health system envisioned in the Section 1115 waiver, as well as to the selection and provision of culturally appropriate outreach, screening, assessment, and treatment. At the same time, many key informants praised the tribes' preexisting expertise in telemedicine, supported housing, and community-based services.

Workforce shortages are the norm in Alaska, with much of its non-native population being more transient compared to the lower 48 states. Many people are only willing to work seasonally and leave the State to avoid the harshest winter conditions. Many others leave after a few years. More than one informant mentioned a net negative population growth in many parts of the State. The high cost of living and the shortage of physical housing stock in Alaska also contribute to workforce shortages.

Alaskans experience rates of SUDs and behavioral health issues at rates much higher than residents of the lower 48 states, yet the state has a limited pool of providers to meet these needs. This results in delays in treatment and the need to travel out of state for many forms of residential treatment, which in turn puts additional strain on the patient and family that may prevent them from seeking care until the situation has become dire.

According to informants, the Alaskan economy has been traditionally based on two industries that have suffered major downturns in the recent past—the oil and gas industry, which has seen worldwide decreases in oil prices, and has been decimated by the coronavirus disease 2019 (COVID-19) pandemic. There is a perception that these conditions have resulted in large cuts to state Medicaid funding at a time when people's lack of work and higher stress levels are likely to create increased demand for behavioral health and SUD services. It is important to note that there have been no cuts to the Alaska Medicaid budget since the beginning of the COVID-19 pandemic.

Another critical factor differentiating Alaska Medicaid from many other states is that Alaska has not adopted managed care for its Medicaid populations. The waiver encourages coordination of care and early intervention, tools that are often part of a bundled or capitated approach in a managed care environment but are difficult to incentivize and finance in a fee-for-service (FFS) environment. Several key informants noted that the lack of

funding for expanded services, when combined with a perceived Centers for Medicare & Medicaid Services (CMS) mandate to keep reimbursement rates low, may slow the implementation of the program for some providers.

Finally, several informants pointed out that most SUD services have historically been funded by grants in Alaska. This meant that programs were limited by grant terms and durations and were characterized by interruptions in continuity of services and lack of certainty about long-term commitments. The state sought a more permanent (and external) funding source in Medicaid, but that has required broad-based systemic changes that were perhaps more complex or more difficult than administrators or providers anticipated.

All key informants acknowledged some or all of these realities and pointed out several specific ways in which these factors interacted to complicate the planning and implementation of the Section 1115 waiver demonstration. However, a predominant theme throughout the key informant interviews was the recognition that reform of behavioral healthcare, including SUD, were extremely important to Alaskans, and reform of this system was seen as a key to reforming the state's Medicaid system and achieving the triple aims of quality, access, and budget neutrality. Both administrators and providers cautioned against expecting immediate results and discussed why it might take some time to make the broad systemic changes required by the Section 1115 waiver demonstration structure and to see successful outcomes.

Key informants expressed broad-based support for the Section 1115 waiver demonstration, and confidence that it would expand care, although there was also a concern that the waiver services may not produce measurable results as quickly as CMS would like to see. All were supportive of the concept of improving care across the continuum and expanding the ability to step up/step down treatment levels to correspond to individuals' specific needs.

Monitoring Metrics

The mid-point assessment uses 31 metrics to indicate progress made on the demonstration.[3-1] The monitoring metrics include 10 metrics calculated on a monthly basis, and 20 metrics calculated on an annual basis.

While SUD treatment metrics (i.e., metrics 6 through 12) specified in the Centers for Medicare & Medicaid Services (CMS) Technical Specifications are generated as counts of members or events, the analysis of changes in counts over time can be limited if the underlying number of beneficiaries is not constant. For this reason, the Alaska 1115 SUD waiver demonstration mid-point assessment presents results from the analyses of these metrics calculated as percentages of the underlying population based on Monitoring Metric 3: Medicaid Beneficiaries with SUD Diagnosis (monthly). Because the metrics are standardized to percentages, any increases or decreases in metric rates represents a change in standardized performance and is not a function of the change in the size of the underlying population of members or events. For completeness, analyses were also conducted on the counts as reported by DBH. These results are presented in Appendix D.

Analysis of mid-point monitoring metrics generated mixed results. Approximately half of all monitoring metrics had changed in a favorable direction, as shown in Table 3-1. However, the metrics that did change in the desired direction had a relative percentage change of 32 percent compared to a change of 21 percent for metrics changing in an unfavorable direction.

3-1 The metric for initiation and engagement of alcohol and other drug dependence (AOD) treatment includes two components, one for the initiation of treatment, and one for the engagement of treatment. HSAG counted the two components as separate metrics. Additionally, the metric for follow-up after emergency department (ED) visit is stratified into two components, one for ED visits for Alcohol or Other Drug Dependence (AOD), and one for ED visits for mental illness. The two components are further reported by 7-day and 30-day follow-up periods. HSAG reported each as a separate metric.

Table 3-1—Summary of Changes in Metrics

Summary Stats	Percent or Number
Number of Metrics[1]	30
Number with Favorable Change	14
Average Relative Change in Favorable Direction	32%
Average Relative Change in Unfavorable Direction	21%

[1]One metric (Metric #14: SUD Provider Availability - MAT) did not change and is not included in this summary. Additionally, only the Total indicator is included for Metric #15 (Initiation and Engagement of Alcohol and Other Drug Dependence Treatment) to avoid double counting indicators.

Table 3-2 presents average rates or counts during the baseline period and the midpoint period, and results from the trending analysis (applicable to monthly metrics only). Changes in the desired direction are indicated with a checkmark, while changes that go against the desired direction are indicated with an 'X'. Also included are the results of absolute and relative changes between the baseline and midpoint data point for each metric, key findings include:

Successes

- Beneficiaries treated in an IMD for SUD increased by over 50 percent.
- Availability of SUD providers more than doubled.
- ED visits and inpatient stays for SUD declined by 63 percent and 86 percent, respectively.
- Readmissions among beneficiaries with an SUD declined by 10 percent.
- Access to preventative/ambulatory services increased by nearly 5 percent

Challenges

- Treatment for SUD in any setting declined by 23 percent.
- Engagement of alcohol and other drug treatment declined by 36 percent.
- Overdose deaths increased nearly 50 percent.

Table 3-2—Monitoring Metric Rates and Trends

				Rate Changes				
	Monitoring Metric	Baseline Rate/ Count	Mid-Point Rate/ Count	Absolute	Relative Percent	In Desired Direction	Monthly Trend	Monthly Trend in Desired Direction
3	Medicaid Beneficiaries with SUD Diagnosis (monthly)	18,650	18,175	-475	-2.5%	✓	-17	✓
4	Medicaid Beneficiaries with SUD Diagnosis (annually)	27,268	26,671	-597	-2.2%	✓	-	-
5	Medicaid Beneficiaries Treated in an IMD for SUD	68.0	106.0	38.0	55.9%	✓	-	-
6	Any SUD Treatment (per 1,000 SUD beneficiaries)	342.0	261.8	-80.2	-23.4%	✗	-1.76	✗
7	Early Intervention (per 1,000 SUD beneficiaries)	0.0	0.1	0.1	0.0%	✓	0.04	✓

	Monitoring Metric	Baseline Rate/ Count	Mid-Point Rate/ Count	Rate Changes				
				Absolute	Relative Percent	In Desired Direction	Monthly Trend	Monthly Trend in Desired Direction
8	Outpatient Services (per 1,000 SUD beneficiaries)	249.1	143.1	-106.1	-42.6%	✗	-3.09	✗
9	Intensive Outpatient and Partial Hospitalization Services (per 1,000 SUD beneficiaries)	15.8	14.4	-1.3	-8.6%	✗	-0.43	✗
10	Residential and Inpatient Services (per 1,000 SUD beneficiaries)	7.8	7.3	-0.5	-6.6%	✗	0.00	✗
11	Withdrawal Management (per 1,000 SUD beneficiaries)	4.9	6.3	1.3	27.2%	✗	0.02	✗
12	Medication Assisted Treatment (per 1,000 SUD beneficiaries)	141.0	164.5	23.5	16.7%	✓	1.23	✓
13	SUD Provider Availability	398.0	906.0	508.0	127.6%	✓	-	-
14	SUD Provider Availability - MAT	4.0	4.0	0.0	0.0%	-	-	-
15.a	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD): Initiation (Total)	62.0%	61.5%	-0.5p.p.	-0.8%	✗	-	-
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD): Initiation (Alcohol)	63.5%	63.1%	-0.4p.p.	-0.6%	✗	-	-
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD): Initiation (Opioid)	62.5%	60.2%	-2.3 p.p.	-3.7%	✗	-	-
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD): Initiation (Other drug)	54.0%	52.8%	-1.2 p.p.	-2.3%	✗	-	-
15.b	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD): Engagement (Total)	27.4%	17.5%	-9.9 p.p.	-36.0%	✗	-	-
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD): Engagement (Alcohol)	28.7%	17.8%	-10.9 p.p.	-37.8%	✗	-	-
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD): Engagement (Opioid)	24.4%	17.7%	-6.7 p.p.	-27.4%	✗	-	-

	Monitoring Metric	Baseline Rate/ Count	Mid-Point Rate/ Count	Rate Changes				
				Absolute	Relative Percent	In Desired Direction	Monthly Trend	Monthly Trend in Desired Direction
	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD): Engagement (Other drug)	22.9%	14.2%	-8.8 p.p.	-38.2%	✗	-	-
17.1.a	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD): 7-day	18.5%	15.5%	-3.0 p.p.	-16.0%	✗	-	-
17.1.b	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD): 30-day	27.9%	24.5%	-3.3 p.p.	-12.0%	✗	-	-
17.2.a	Follow-up after Emergency Department Visit for Mental Illness (FUM-AD): 7-day	39.8%	34.9%	-4.9 p.p.	-12.3%	✗	-	-
17.2.b	Follow-up after Emergency Department Visit for Mental Illness (FUM-AD): 30-day	53.6%	48.6%	-5.0 p.p.	-9.3%	✗	-	-
18	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)	13.6%	14.4%	0.8 p.p.	6.1%	✗	-	-
21	Concurrent Use of Opioids and Benzodiazepines (COB-AD)	13.5%	12.4%	-1.1 p.p.	-8.4%	✓	-	-
22	Continuity of Pharmacotherapy for Opioid Use Disorder	21.4%	21.6%	0.2 p.p.	1.1%	✓	-	-
23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	7.7	2.8	-4.9	-63.3%	✓	-0.11	✓
24	Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries	2.1	0.3	-1.8	-86.1%	✓	-0.04	✓
25	Readmissions Among Beneficiaries with SUD	21.4%	19.1%	-2.2 p.p.	-10.4%	✓	-	-
26	Overdose Deaths (count)	90	134	44	48.9%	✗	-	-
27	Overdose Deaths (rate per 1,000)	0.38	0.56	0.19	49.3%	✗	-	-
32	Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD (AAP)	88.6%	92.9%	4.3p.p.	4.9%	✓	-	-
36	Average Length of Stay in IMDs	15.2	19.5	4.3	28.0%	✗	-	-
Q1	Information Technology Use to Monitor SUD rate via Patient Prescription History Requests	7,736,304	5,184,842	-2,551,462	-33.0%	✓	-	-

	Monitoring Metric	Baseline Rate/ Count	Mid-Point Rate/ Count	Rate Changes				
				Absolute	Relative Percent	In Desired Direction	Monthly Trend	Monthly Trend in Desired Direction
Q2	Information Technology Use to Monitor SUD Treatment Effectiveness via Medical Professional Training in MAT Offered	178	188	10	5.6%	✓	-	-
Q3	Information Technology Use to Monitor "Recovery" Supports and Services for SUD Individuals	121	125	4	3.3%	✓	-	-

Metrics 6 through 12 were calculated as rates to control for a changing size of the SUD population throughout the study period. Overall, conclusions remain unchanged when assessing the directionality of the metric trends. These results are presented in Appendix D.

Monitoring metrics 5, 6, 7, 8, 9, 10, 12, 13, 14, 15.a, 15.b, 17.1.a, 17.1.b, 17.2.a, 17.2.b, 22, 32, Q2 and Q3 are expected to increase as a result of the demonstration (Table 3-2). Seven of these measures have trended in the desired direction in the MPA evaluation period relative to baseline rates. Results indicate that there has been a greater than 50 percent increase in the treatment of Medicaid beneficiaries in an IMD for SUD. In addition, there have been increases in medication assisted treatment (+ 23.5 per 1,000 SUD beneficiaries) and pharmacotherapy for opioid use disorder (+ 0.2 percentage points). The provision of early intervention for SUD has remained steady (+ 0.1 per 1,000 SUD beneficiaries). Notably, SUD provider availability more than doubled during this period from 398 providers during the baseline period to 906 providers during the mid-point period. Furthermore, these results indicate increases in the use of information technology use for monitoring SUD treatment effectiveness via medical professional training in MAT (+ 5.6 percent) and for monitoring "recovery" supports and services for SUD individuals (+ 3.3 percent). Access to preventive/ambulatory health services for members with an SUD diagnosis increased by 4.9 percent, which were in-line with the demonstration target of 3–5 percent.

The remaining measures have not reflected the desired increase thus far. These measures include any SUD treatment (-80.2 per 1,000 SUD beneficiaries); outpatient (-106.1 per 1,000 SUD beneficiaries), intensive outpatient and partial hospitalization (-1.3 per 1,000 SUD beneficiaries), residential and inpatient services (-0.5 per 1,000 SUD beneficiaries); initiation and engagement of alcohol and other drug dependence treatment (-0.5 percentage points and -9.9 percentage points, respectively); follow-up after emergency department visits for AOD within seven days and 30 days after discharge (-3.0 percentage points and -3.3 percentage points, respectively), follow-up after emergency department visits for mental illness within seven days and 30 days after discharge (-4.9 percentage points and -5.0 percentage points, respectively).

In contrast, monitoring metrics 3, 4, 11, 18, 21, 23, 24, 25, 26, 27, 36, and Q1 are expected to decrease as a result of the demonstration.[3-2] Seven of those measures decreased in the mid-point evaluation period relative to baseline rates. These results indicate that the overall number of Medicaid beneficiaries diagnosed with SUD decreased from the baseline period (-2.2 percent annually). Additionally, emergency department utilization for SUD (-4.9 per 1,000 Medicaid beneficiaries), inpatient stays for SUD (-1.8 per 1,000 Medicaid beneficiaries), and readmissions among beneficiaries with SUD (-2.2 percentage points). The use of information technology to monitor SUD rates via Patient Prescription History Requests also decreased by 33 percent. Among the measures

[3-2] Although Metric 36 is expected to decrease, the overall goal is to maintain an average LOS of less than 30 days.

where a decrease was targeted, the average relative change in measure rates was a 3.8 percent decrease between the baseline and mid-point performance period. There were four metrics where a decrease was targeted but not realized included the use of withdrawal management (+1.3 per 1,000 SUD beneficiaries), use of opioids at high dosage among persons without cancer (+ 0.8 percentage points), and overdose deaths (+ 0.19 per 1,000 and 44 more overdose deaths in the mid-point evaluation period compared to the baseline period). Although the average length of stay in an IMD increased by 4.3 days when a decrease is expected, the average LOS at mid-point was 19.5 days, which is in line with the goal of an average LOS under 30 days. As such, unless this trend materially increases throughout the demonstration period, these results are consistent with the goals of the waiver.

The assessment of trends among monthly metrics was similarly mixed, with exactly half (five out of ten) trending in the desired direction.

Implementation Plan Action Items

The Implementation Plan identifies key action items for each Milestone for the State to complete as required by CMS. The number of complete action items in each Milestone will help determine the risk level of the State not meeting each Milestone. Milestones that are at a medium or high-risk level of not being completed will need to be reassessed and a new Implementation Plan with new action items may need to be completed. See Appendix C for the Implementation Plan key action items.

Additionally, state administrators and providers each provided feedback during their key informant interviews regarding general implementation. Feedback was generally positive, however, there were some frustrations surrounding the lack of communication and phased implementation attempts. As of this mid-point assessment, many phases have not yet been implemented and COVID-19 has resulted in slowed implementation overall.

Milestones

Milestone #1, Access to Critical Levels of Care for SUD Treatment, stratifies the milestone across several different types of services including opioid treatment services, early intervention, outpatient services, and various intensities of inpatient and residential care for adults and children. Each type of service has action items related to training staff appropriately, creating a provider notification/communication system to align with the new types of services, and pursuing Alaska Administrative Code (AAC) modifications for increased coverage of services. Alaska completed a large percentage (89 percent) of action items in Milestone #1.

Informants expressed appreciation for the new services that have become available but voiced concerns that the rates for services were inadequate for developing the physical space needed to provide and expand new services. Additionally, while many new services were provided as written in the implementation plan, providers noted that the COVID-19 pandemic caused them to focus on maintaining existing services instead of expanding on these new services.

Action items that were delayed include all items under the category ‘0.5 – Early Intervention’ due to having to delay the implementation of Screening, Brief Intervention and Referral to Treatment (SBIRT). SBIRT is a highly utilized state plan service and has varied impacts across the system of care. DBH thus decided to delay the implementation of SBIRT into the Section 1115 Waiver Demonstration. Additionally, the COVID-19 pandemic caused hospitals to shift their focus from SBIRT training to elsewhere.

Two elements were marked as ‘Partially Complete/Delayed’ in relation to services in community recovery support services. Both items involve deleting or phasing out old services or deleting comprehensive community support services (CCSS) and recovery support services (RSS) while phasing in new services and developing new waiver services to allow reimbursement for CCSS and RSS. DBH is working to ensure smooth transition as services are phased-in and -out.

The State has successfully conducted provider training on American Society of Addiction Medicine (ASAM) standards criteria and procured a contract with an ASO as part of the tasks required for Milestone #2, Use of Evidence-Based, SUD-Specific Patient Placement Criteria. The State has partially completed the process of approving ASO policies and procedures and has not yet finalized ASAM-aligned assessment instruments or conducted provider training on the assessment instruments resulting in a 40 percent completion rate for Milestone #2. Stakeholder feedback mostly lacked in reference to Milestone #2 action items, however, stakeholders did note that rolling out the SUD-BH waiver demonstration concurrently with the shift to an ASO was overly ambitious and resulted in complex issues that took several months for the providers to address. Providers lacked the time and ability to process both major systematic changes occurring at the same time.

All but one action item was marked as 'Complete' for Milestone #3, Use of Nationally Recognized SUD-specific Program Standards for Residential Treatment Facility Provider Qualifications. Action items for this Milestone include incorporating formal certification processes, trainings, and standards for providers to complete to continue to provide services. Many providers reported benefits of having new standards of certification but felt as though they came with extra economic and administrative burden. Additionally, having stricter standards for training and certification have led to a greater ability to provide addiction support services. The one item marked as 'Partially Complete,' to initiate ongoing monitoring process, is currently ongoing.

Thus far, notification and communication regarding waiver and ASAM requirements has been developed to complete action items for Milestone #4, Sufficient Provider Capacity at Critical Levels of Care. DBH has pursued AAC and Provider Medicaid Billing Manual changes; enrolled new provider types as independent Medicaid billing providers; collaborated with the ASO to provide training on ASAM criteria; developed requirements for waiver reimbursement, notification, and communication systems regarding formal designation; and implemented formal designation processes to result in 66 percent of action items being fully completed. Though the Milestone has seen overall success, stakeholders expressed frustration with the amount of time needed to enroll individual providers; some stakeholders needed several months to a year to fully complete the numerous required steps. Stakeholders did confirm that DBH provided important training and educational resources on the topic. DBH is still recruiting qualified providers to address increased capacity, identifying new provider types by region, and assessing ASAM providers and services by region. Feedback suggests that provider capacity remains an issue, citing a general limited workforce and specifically recognizing a lack of providers for adult residential behavioral healthcare and ambulatory withdrawal management programs.

Due to the State of Alaska rolling out services on a 50/50 schedule, there were no applicable action items for Milestone #5, Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse, in terms of status. There were two possible items action items for this Milestone, both related to expansion of services and providers with the goal to help address opioid and other substance abuse. On the educational front, many providers mentioned that they have been learning quickly and appropriately, expanding their own knowledge of how to properly provide care. The State does not have a mechanism to require existing providers to expand due to providing services on a fee-for-service basis, but DBH has managed to expand its capacity with grant funds and has established enhanced rates to encourage the act of expansion.

To complete Milestone #6, Improved Care Coordination and Transitions Between Levels of Care, DBH successfully developed SUD care coordination guidelines for transitions from residential to non-residential settings and developed intensive case management (ICM) guidelines to clarify the difference from SUD care coordination services and circumstances for concurrent use in July of 2019. The development and implementation of peer recovery certification requirements is partially completed. Stakeholders suggested that the new peer recovery certification requirements would place a large burden on employees who only hold a bachelor's degree, as these degree holders did not have prior experience meeting the significant continuing education requirements being implemented. Despite these worries, an appreciation for the three-year grace-period to become up to date

with the new requirements was expressed, and stakeholders felt that the stricter training and certification were an overall positive in bettering the provision of addiction support services.

State Administrators

The biggest challenge mentioned by DBH was its limited financial and personnel resources when faced with the need to make major systemic changes. It worked as quickly as it could within those constraints, but it took more time than it would have liked to implement all of the changes necessary to make the huge systemic changes required by the Section 1115 waiver.

DBH informants felt that much of the confusion providers presented to them was a result of the decision to implement SUD services without the behavioral health component and they believed that those issues have largely subsided with the additional regulations.

One of the barriers to successful implementation of the Section 1115 waiver mentioned by DBH was the fact that some services that are critical to the success of the overall approach of the waiver, such as crisis stabilization services, are currently virtually non-existent in Alaska. Recent legislation (Senate Bill [S.B.] 120[3-3]) allows police officers to refer people to diversion in 23-hour stabilization centers, but there are still not enough providers providing those services to meet the need, and the issue has become a bottleneck. DBH informants also recognized a lack of providers for adult residential behavioral healthcare and ambulatory withdrawal management programs.

The enrollment of individual providers in Medicaid has been a major challenge to the implementation of the Section 1115 waiver. To be able to bill for these services, each individual rendering covered services, not the agency that employed them, had to be enrolled in Medicaid with an individual billing number. This changed prior practice in Alaska, and the transition required a lot of support. One informant stated that it took from six months to a year to get providers into the Medicaid system and help them build capacity to bill Medicaid on a wide scale. DBH provided key training and education to providers, and support for a major shift in point of view from grant funding, which is a flat amount per year, to a Medicaid FFS payment scheme.

Data collection and reporting has also been a significant challenge for administrators and providers alike. Some of the challenges mentioned by DBH employees included issues with data sharing and compatibility, Health Insurance Portability and Accountability Act (HIPAA) privacy concerns and understanding and which elements of legacy data systems contain information needed to meet new CMS requirements. Informants struggled with creating formats to collect the data required by CMS, such as tracking data by individual provider basis, not location.

DBH informants stated that there seems to be an uptick in the number of people seeking SUD services, but it is too early to tell whether that will translate to better outcomes or cost savings.

DBH informants described their attempts at communication with providers and were aware of dissatisfaction around rolling out the program in phases. Some felt that many of the early questions were answered when the second phase of regulations relating to behavioral health services was published. In addition, DBH named a single point of contact at DBH for providers.

[3-3] An Act establishing an alternative to arrest procedure for persons suffering from an acute behavioral health crisis; relating to emergency detention for mental health evaluation; relating to administration of psychotropic medication to a patient without the patient's informed consent; relating to licensure of crisis stabilization centers; and providing for an effective date. S.B. 120, 31st Cong. 2020. http://www.akleg.gov/basis/Bill/Detail/31?Root=SB%20120

Providers

With respect to the expansion of services under the Section 1115 waiver, providers expressed significant concern about the limited work force, the limited number of QAPs in the state, and the concern that higher standards would only exacerbate that shortage. Providers were concerned about the resources they would have to devote to supervision of staff members. Initially, some individual professionals objected to additional continuing education requirements in American Society of Addiction Medicine (ASAM) standards, ethics, and cultural competency but realized that most of those could be met by their current continuing medical education (CME) requirements. While the finalized system works fairly well for the higher professionally qualified (i.e., Doctor of Medicine [MD], Doctor of Philosophy [PhD], Registered Nurse [RN]), who already had significant continuing education requirements, that was not so for bachelor's-level employees who would become QAPs or certified peers. Providers appreciated the grace period added for attaining certification but noted that record-keeping problems were created by the fact that the grace period runs for each employee independently, so it is difficult for employers to plan, and hampers their ability to accept employees moving between providers. One informant mentioned that providers would still appreciate a clear roadmap for how to get individuals through the qualification process to certification. Informants pointed out that the lack of clear recommendations on what screening tools to use or which practices are evidence-based processes will place a heightened burden on smaller agencies without the resources to evaluate them independently.

Informants also spoke of the difficulty of getting individual providers enrolled in Medicaid. One provider had identified 16 specific steps necessary to get a billing number for each new employee.

Providers perceived a lack of communication from DBH in implementing the regulations and billing for services. Informants mentioned challenges including a lack of clarity, regulations that could be interpreted different ways, and the fact that they came out in stages. Some informants expressed that their questions were not answered, although regulations were revised multiple times. Some mentioned receiving inconsistent information from DBH and Optum on how to bill services under Medicaid, particularly where there is potential overlap between services still billed under the State Plan as well, and reconciliation of multiple billing streams.

Provider and professional associations described a wide range in sophistication and care practices between providers. Most behavioral health providers who provide SUD services under the waiver in Alaska were not individually enrolled in Medicaid prior to the Section 1115 waiver, when it became necessary to have every individual providing care enroll with a separate Medicaid provider number. Prior to the waiver, many worked for groups, or were paid solely through non-Medicaid sources, and had limited understanding of the Medicaid coding/claims process. Providers ranged from single counselors in practice by themselves, to tribal communities offering drumming circles or sweat lodges, to inpatient hospitals. Many were handwriting paper forms. Even among providers with EHRs, the implementation required conversion to multiple data requirements not widely used in the past—Medicaid Management Information System (MMIS) data, Medicaid claims forms, and standards for measure collection and submission.

Prior experience with Medicaid billing did not insulate providers from challenges presented by implementation. One large provider with a history of billing Medicaid reported issues with the transition from Conduent to Optum including large numbers of denied claims, providers enrolled in Medicaid under Conduent system were not uploaded into the Optum system, and bills that were paid being credited to the wrong provider number. This has led to frequent duplications of effort and providers who are uncertain how their records will fare in a CMS audit.

Some providers felt they received insufficient technical and information technology (IT) support from Optum.

Some expressed confusion as to why some codes are available under behavioral health services, but not for SUD services or vice versa. Therapeutic foster care seems to have been available for behavioral health, but not SUD.

There is an incorrect perception among some providers that child mental health providers do not presently have a code for most of their services. Since the previous codes for children services remain in effect, this represents an opportunity for additional provider education.

Stakeholder Input

As part of the overall mid-point assessment process, Health Services Advisory Group, Inc. (HSAG) was required to solicit feedback from a variety of key stakeholders and consumer advocates on the design and approach of the mid-point assessment. HSAG developed a document detailing the intent of the assessment, along with an outline of the components included. The outreach was facilitated via electronic format to 14 stakeholders (Table 3-3), requesting feedback on the mid-point assessment's design and approach to ensure that HSAG was capturing the most valuable information to help stakeholders and Alaska's Division of Behavioral Health (DBH) with the performance and progress of the Substance Use Disorder and Behavioral Health (SUD-BH) Program.

HSAG received the following feedback on the mid-point assessment's design and approach from three stakeholders:

- One stakeholder requested adding additional information regarding the changes that providers have had to make due to the coronavirus disease 2019 (COVID-19) pandemic during Demonstration Year 2 while implementing the components of the SUD-BH.
- Another stakeholder provided a general overview of the waiver process; how providers are receiving guidance from DBH; and the processes required for the waiver, such as billing.
- Another stakeholder indicated that the design and approach was good as it was presented and did not recommend any changes.

HSAG reviewed all feedback received from stakeholders and determined that each was already addressed in either future evaluations or through the data collection efforts for the qualitative key informant and provider interviews.

List of Organizations Contacted

Table 3-3 provides a list of organizational types and organizations that HSAG solicited feedback from for the design and approach of the mid-point assessment.

Table 3-3—Organizations Contacted

Entity Type	Entity
Providers	Akeela Inc. Bartlett Regional Hospital Bristol Bay Area Health Corporation Fairbanks Native Association Frontline Hospital (Artic Recovery) Interior AIDS Association Restore SeaView Community Services Set Free Alaska The Salvation Army
Consumer Advocates	Advisory Board on Alcohol and Drug Abuse (ABADA) Alaska Mental Health Board (AMHB) Alaska Mental Health Trust Authority (AMHTA) Alaska Behavioral Health Association (ABHA)

Provider Availability Assessment

Key informants described an increase in the number of providers and the types of services available to Alaskans with SUD and behavioral health needs. This has resulted in access to a greater number of services as well as services that are more effective as they are tailored to the specific needs of individual patients. Providers have increased residential treatment facility capacities, providing safe housing, and withdrawal management options. Some informants said that they have already observed improved patient outcomes. Despite these clear improvements, key informants presented several issues in capacity, including concerns about the limited workforce to provide SUD and behavioral health care, burdens placed on providers by expanded certification processes, and high turnover rates among staff.

Assessment of Overall Risk of Not Meeting Milestones

The results across the critical monitoring metrics, the state's completion of implementation plan action items, stakeholder input, and provider availability were synthesized using the algorithm presented in the Mid-Point Assessment Technical Assistance from CMS[3-4] to determine the overall level of risk of the demonstration not meeting each milestone (Table 3-4).

Table 3-4—Assessment of the Level of Risk of Not Meeting Milestones

Milestone	Level of Risk	Factors
Milestone 1: Access to Critical Levels of Care for OUD and other SUDs	Medium	• Implementation Plan action items complete: 89% • Critical metrics meeting target: 43% • Multiple stakeholders identified challenges around developing the physical infrastructure necessary to provide and expand services, but all are being addressed within the planned timeframe. [3-5] • Availability is not yet adequate, largely due to geographic and demographic limitations on the availability of physical facilities and providers at critical levels of care but is moving in the expected direction.
Milestone 2: Widespread Use of Evidence-Based, SUD-Specific Patient Placement Criteria	Medium	• Implementation Plan action items complete: 40% • Critical metrics meeting target: 50% • A few stakeholders identified challenges around the logistics of working through new certification and billing processes, especially in view of the broader landscape of change in processes unrelated to the Waiver. All challenges are being addressed within the planned timeframe and moving in the right direction.

3-4 Centers for Medicare & Medicaid Services. Medicaid Section 1115 Substance Use Disorder (SUD) and Serious Mental Illness and Serious Emotional Disturbance (SMI/SED) Demonstrations, Mid-Point Assessment Technical Assistance, version 1.0 (October 2021). Available at: 1115 SUD and SMI/SED Mid-Point Assessment Technical Assistance Version 1.0 (medicaid.gov). Accessed on Apr. 14, 2022.

3-5 DBH and HSAG agree that not all levels of care require additional infrastructure.

Milestone	Level of Risk	Factors
Milestone 3: Use of Nationally Recognized, evidence-Based, SUD-specific Program Standards for Residential Treatment Facility Provider Qualifications	Low	• Implementation Plan action items complete: 85% • Critical metrics meeting Target: NA[a] • Few stakeholders identified minor economic and administrative burdens that are being addressed within the planned timeframe
Milestone 4: Sufficient Provider Capacity at Each Level of Care, Including MAT	Low	• Implementation Plan action items complete: 66% • Critical metrics meeting Target: 100% • Few stakeholders identified challenges around the logistics of working through new certification and billing processes, expressed challenges around the time needed to enroll providers in Medicaid, as well as overall limited provider capacity. DHB is actively addressing these issues within the planned timeframe. • Availability is not yet adequate, largely due to geographic and demographic limitations on the availability of physical facilities and providers at critical levels of care, but is moving in the expected direction.
Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD	Medium	• Implementation Plan action items complete: NA[b] • Critical metrics meeting target: 50% • Stakeholders identified no risks
Milestone 6: Improved Care Coordination and Transitions Between Levels of Care	Medium	• Implementation Plan action items complete: 67% • Critical metrics meeting target: 14% • Most stakeholders felt that new requirements and stricter training and certification were positive overall, although a few indicated that adapting to the new peer recovery certification requirements would take some time.

[a] There are no monitoring metrics attached to Milestone 3.
[b] Due to the State of Alaska rolling out services on a 50/50 schedule, there were no applicable action items for Milestone #5.

All six milestones defined in the CMS STCs for the Alaska demonstration were either low or medium risk of not meeting requirements of the milestones.

An assessment of the available data shows that a number of implementation plan action items have been delayed in part due to the COVID-19 PHE, which caused providers and hospitals to shift their focus elsewhere. For example, implementation of Screening, Brief Intervention and Referral to Treatment (SBIRT), a highly utilized state plan service that has had varied impacts across the system of care, has been delayed due to the pandemic such that hospitals can shift their focus from SBIRT training to elsewhere. However, during the COVID-19 PHE, DBH began providing SBIRT and motivational interviewing training, with a focus on using SBIRT in telehealth settings, to providers other than those originally identified in the SUD-BH wavier implementation milestones. Other action items are only partially completed due to the State of Alaska's 50/50 phase-in approach to the waiver implementation; these activities are ongoing and DHB is actively monitoring their progress.

In addition to the implementation plan action items, the monitoring metrics for many measures are moving in the targeted direction for the demonstration; in fact, approximately half of all monitoring metrics have changed in a favorable direction. Examination of the relative percentage changes among the monitoring metrics indicates that metrics moving in the targeted direction tend to exhibit larger changes (32 percent) compared to those moving

opposite of the targeted direction (21 percent). Among those metrics that are not changing in the targeted direction, it is possible that the ongoing COVID-19 PHE may be contributing to the observed changes. While the mid-point assessment cannot speak to the counterfactual of what the monitoring metrics rates would have been without the COVID-19 PHE, it is possible that the demonstration is helping to mitigate some of the negative impacts of the PHE on members with SUD diagnoses.

Among interviews with state administrators and providers, no major risks were identified that pose a threat to the state's ability to meet with milestone requirements. Most described an increase in the number of providers and the types of services available to Alaskans with SUD and behavioral health needs. While the biggest challenge mentioned by key informants was limited financial and personnel resources when making major systemic changes, they also highlighted barriers around limited capacity of workforce available to provide SUD and behavioral health services, high burden of enrolling individual providers into Medicaid, and data collection and reporting.

State's Response to Risk Assessment

On Implementation

Through the demonstration, Alaska designed a system to decrease the use of acute services through the use of universal screenings, early intervention, utilization of subacute crisis services, and ancillary community-based step-up and step-down services as alternatives to residential and inpatient services. However, less than one year into the implementation of the SUD component of the waiver, the COVID-19 pandemic emerged and rocked the fragile behavioral health infrastructure of Alaska. As a result, behavioral health providers across the state had to quickly pivot best-laid plans for growth and expansion and focus their attention on the health and safety of their staff and the individuals they serve. For many, this meant transitioning many services to a telehealth platform and reallocating space to accommodate for safe social distancing and reducing face-to-face group size/frequency for safety. Simultaneously agencies also began to see the prevalence of behavioral health conditions rise and the demand for treatment soar. As such, the critical first step for agencies was meeting the community's needs and addressing the needs of their workforce while trying to understand the full scope of new services made available under the waiver. The Division recognized the challenges facing the nation and the state and committed to supporting providers through implementing Medicaid flexibilities made available by CMS and by relaxing several state regulations made available through the State Declaration of Emergency.

On Metrics

The pandemic fundamentally changed how behavioral health care systems delivered services. A shift from the traditional face-to-face office visits to the implementation and proliferation of telehealth services ensured critical behavioral health services remained available and, in some areas, expanded. However, the pandemic emerged during the state's most extensive behavioral health reform effort – expanding Medicaid-covered services (through 1115 Demonstration Waiver), transitioning to a new fiscal agent, and sunsetting outmoded services. These changes, coupled with the subsequent quarantine, lockdown, and reduced face-to-face engagement because of the pandemic, negatively impacted "normal life." Individuals found themselves isolated, juggling work from home dynamics, home-schooling, and for many individuals, substantial economic loss. These changes, for some, occurred without warning and almost overnight, tremendously increasing feelings of stress, anxiety, depression, and maladaptive patterns of coping (i.e., binge drinking and substance use). Unfortunately, these impacts exacerbated the longstanding behavioral health systems capacity and service gaps the demonstration was designed to address. The metrics reflect and emphasize the pandemic's toll on the state; however, DBH remains optimistic that pandemic-related impacts can be lessened as the state partners with providers to reinvest in onboarding the ancillary services made available under the waiver, to change the trajectory of Alaska.

On SBIRT

An assessment of the available data shows that a number of implementation plan action items have been delayed in part due to the COVID-19 PHE, which caused providers and hospitals to shift their focus elsewhere. For example, implementation of Screening, Brief Intervention and Referral to Treatment (SBIRT), a highly utilized state plan service that has had varied impacts across the system of care, has been delayed due to the pandemic such that hospitals can shift their focus from SBIRT training to elsewhere. Other action items are only partially completed due to the State of Alaska's 50/50 phase-in approach to the waiver implementation; these activities are ongoing and DHB is actively monitoring their progress.

While the plan to disseminate SBIRT training and technical assistance to hospital emergency departments was put on hold, DBH has been able to continue many SBIRT activities in Alaska in the interim that support the implementation of SBIRT overall, while not burdening EDs at a time when medical providers, particularly those in EDs, were so overwhelmed. With the proliferation of telehealth services as a result of the COVID-19 PHE, DBH began providing SBIRT and Motivational Interviewing training to medical and behavioral health providers via distance delivery, with a focus on the use of SBIRT in telehealth settings. This training series has been offered six times since March of 2020.

Furthermore, DBH has provided technical assistance around the implementation of SBIRT to sites/organizations that exhibit a high level of readiness for SBIRT. These services were offered to two State of Alaska partner agencies: the Division of Juvenile Justice (DJJ) and the Division of Public Health (DPH). DBH offered SBIRT training to residential counselors and probation officers working with youth who have been incarcerated. The SBIRT initiative is also continuing to partner with the DHP, perinatal screening program operated through Women, Child, Family Health. Additionally, four integrated physical and behavioral health care provider sites were given intensive training and implementation services. DBH also made use of the time available, as a result of the COVID-19 PHE, to prepare training materials for use throughput the project. DBH has maintained its SBIRT implementation work with one hospital, Fairbanks Memorial, throughout the COVID-19 PHE. As Alaska moves forward into this new phase of the pandemic, DBH is returning to its focus to offering SBIRT training and technical assistance to EDs in Alaska, in keeping with the Early Intervention Milestones.

Assessment of State's Capacity to Provide SUD and/or SMI/SED Services

When asked specifically to identify successes of the Section 1115 waiver, administrators and providers felt that the underlying basic philosophy of the Section 1115 waiver is sound, and many people have worked hard to bring about this significant change in practice. Providers expressed that the positives significantly outweigh the challenges, allowing an expanded continuum of care that better meets clients' needs, more opportunities to support clients locally and help them access treatment faster, and the ability to implement more evidence-based practices.

DBH was able to achieve this success despite a high rate of turnover in leadership and personnel within the agency. Although the current director has been involved from the beginning of the process, the agency's ability to continue to move the process forward in the face of multiple challenges was made possible by the commitment and flexibility of the team. They have repeatedly shown the ability to respond to changing circumstances by modifying their approach and are taking steps in training to limit disruptions caused by future turnover.

Actual expansion of SUD and behavioral health services has happened. There are new providers offering services, and several providers described providing additional beds and additional services to Alaskans as a result of the Section 1115 waiver demonstration. There are providers offering behavioral health services in regions that had no such services in the past. One provider reported 18 additional beds in residential SUD treatment, with more in the

planning stages. Others reported the addition of different levels of residential facilities, as well as expansion to include many of the other services funded by the Section 1115 waiver demonstration.

Onboarding with Optum seems to have been largely viewed as successful.

When asked to identify any major concerns or unintended consequences they had observed, the following stood out:

- There are discrepancies between the regulations and guidance issued under the SUD phase and the behavioral health phase, that may or may not be intentional, but are creating confusion and other barriers for providers. For example, payment rates for group services and community support differ between SUD and behavioral health services, but many patients are likely to have co-occurring conditions and require both types of services. The lack of clear guidelines for billing the intensive treatment needed in early SUD recovery, such as connecting with peers in their homes or in groups as they learn to develop healthy and safe habits and relationships, is a limit on the care providers can offer. Some providers indicated that they believed there is no clear method of payment for family counseling, an important element of SUD care. However, there has been no change to covered state plan services, which include family counseling payment, suggesting an opportunity for DBH to better communicate service availability to providers.
- The requirement that a provider have a behavioral health assessment and treatment plan for a patient in place in order to bill for waiver services is seen by some providers as a major stumbling block for early intervention services, crisis services, and mobile outreach teams. Some providers are under the impression that mobile outreach services are limited to one hour which would result in insufficient funding for mobile outreach to make it affordable for providers to offer. However, there are no such limits associated with the Section 1115 waiver, suggesting an additional opportunity for DBH to communicate service availability. The adoption of a minimum adverse childhood experience (ACE) score of "4" to justify payment for early intervention is not early enough. Providers mentioned they would like to go further upstream for intervention. Providers stated that some elements of bundled payments are inconsistent with the goal of early intervention and expanded services across the continuum of care, and that they do not know how they will bill for family services, as opposed to individual services.
- Some providers are concerned that the state will sunset payment for behavioral health or SUD services under the State Medicaid Plan or other funding, such as grants, before the Section 1115 waiver demonstration's expanded services are fully operational. It should be noted that implementation of the Section 1115 waiver does not impact the ability of DBH to apply for and utilize grants from outside sources and that Medicaid funding will provide a stable and predictable source of funding for providers. At least one provider had already experienced a reduction in grant funding from prior years on the expectation of Section 1115 funding that has not yet materialized due to delays in developing the regulations and billing system. This presents an opportunity for DBH to educate providers on the benefits of Medicaid funding in conjunction with future grant opportunities. Providers supported the decision to transition from the older standardized screenings status review tools used by Alaska, to evidence-based screening tools. At least one provider expressed concern about the timing to "sunset" older programs. They were concerned the older programs would end before providers were comfortable with billing services under the new regulations provided with the Section 1115 waiver demonstration.
- There is no mechanism to track and maintain individual employees' progress toward certifications for qualified addiction professionals (QAPs). Providers suggested the state should maintain a registry of QAPs and a more coordinated continuing education plan.
- Key Informants, some of whom are first-time Medicaid providers as a result of the waiver, identified a few additional areas of concern.
  - Crisis services in dedicated facilities. It is difficult to harmonize with the existing "no wrong door" policy.

- Unclear guidance around billing for 24-hour observation periods.
- Mobile response units—behavioral health service regulations are inconsistent with SUD regulations; these services require assessment and plan to bill, which are not meaningfully available in an emergency situation. This presents an opportunity for DBH to provide additional education to providers to clarify the role of mobile response units within the Section 1115 waiver.

State Administrators

HSAG was able to interview several current employees of DBH, including individuals who had led the program from its inception and were key participants in drafting the legislation, the Section 1115 waiver request, and the enabling regulations and practice manual. HSAG spoke with informants who handled stakeholder engagement and data transitions, and who oversaw and participated in the rollout of the program. Another informant was involved in preparation for the ASO/Optum contract. These interviews revealed a department populated with diverse backgrounds and points of view, including professionals with backgrounds in clinical care, SUD treatment, research, peer mentoring, and housing support in Alaska; information technology (IT) and data science; and with liaisons to the public safety and prison systems and to the state legislators. Staff members were united in their support for the Section 1115 waiver demonstration process and dedicated to its implementation.

Alaska's Section 1115 waiver development has crossed several administrations and seen multiple changes in leadership and shifts in economic conditions. The current Director of the Alaska Department of Health Services' DBH has been involved in the process from the design of the State's Section 1115 waiver application up to the present. She described a common perception among stakeholders that Medicaid reform in Alaska must begin with behavioral health reform. She felt that no one argued that the approach taken by the Section 1115 waiver was wrong or not well-taken, everyone agreeing that the philosophies of early intervention and comprehensive treatment across the continuum of care were not only the best way to improve outcomes in the long run, but they were also the humane and compassionate way to reform the system and have been adopted across the stakeholder communities.

In preparation for the expansion of services, DBH performed an environmental scan of the treatment options in Alaska, identifying existing capacity and gaps. The agency described its work with Optum and Milliman to transition billing systems from Conduent, Inc. to Optum, including weekly meetings for several years to support the transition.

DBH engaged with working groups to develop peer support training, identify appropriate standards, and build interest and support in a certification program. The proposed standards for providers included higher professional standards and minimum years of experience. There was widespread discussion about exactly what the standards should be and how the certification process would take place, and DBH made changes to its initial approach in response to provider concerns.

DBH planned to engage the stakeholder community through a program of multiple roundtables in regions of the State to explore areas of interest to providers. Other outreach included telephone calls, creation of an email contact list, and multiple presentations at state conferences. The division also conducted public comment activities with the draft regulations.

DBH planned to implement the Section 1115 waiver demonstration in two phases based on geography but changed course in response to providers' expressed desire to implement the waiver as soon as they were ready, i.e., able to bill under the new system. DBH revised its initial plan, finding that more technologically sophisticated providers were ready and willing to adopt the system sooner, while those who were not would require additional training to be brought up to the level of readiness. As mentioned previously, the SUD portion of the plan for the

Section 1115 waiver demonstration was operational for several months before the behavioral health services portion was finalized. Both are "live" and operational now.

Providers

Key informant providers described their main challenge in preparing for the waiver was uncertainty about what changes they would have to make. They were aware that major changes were coming but did not know what those changes would consist of. Individuals expressed frustration that the State responded to their questions with references to regulations, but without concrete answers.

One agency with an established history of providing behavioral health and SUD services described a strategic planning process that produced a three-year implementation plan to expand its services. It expanded first into adult partial hospitalization services for SUD and is currently in the process of implementing intensive case management (ICM) Certified Recovery Support Specialist (CRSS) services. The informant observed an increase in the number of local residential beds, which resulted in improved capacity to serve individuals locally without the need to travel for care, and in shortened waiting lists. The provider is tracking client outcomes and believes they are improving. Importantly, their strategic analysis found that, for many of the expanded services, approved rates would be sufficient for long-term sustainability.

Key informants described delays in receiving payment for services rendered. They reported claims being denied or paid at a different rate or for a different provider number than submitted. One provider described having to work out of their cash reserves because of delays they were experiencing with the State's billing interface.

Concerns About Sustainability

State Administrators

DBH informants expressed the difficulty of measuring the long-term results of improved behavioral health and SUD treatment, specifically that the impacts of the program may well not be measurable within the time frame of the waiver evaluation.

One DBH informant was concerned that high intensity programs may have been quicker to take advantage of the opportunity to expand services and utilize new bill codes than HCBS. They worried that there will be a delay in developing community service supports, HCBS, support groups, etc., which were designed to be the first line of defense (and were less expensive). Instead, after a huge response from providers of Institution for Mental Disease (IMD) treatment, the most expensive services, the DBH informant fears the budget will be expended on those services before cost savings from early intervention can be realized.

One DBH informant was concerned that the agency had been slow in getting early intervention off the ground, which was attributed to difficulty in building consensus on screening tools across professional groups, agencies, and tribal authorities on methodologically sound and culturally appropriate grounds for universal screening. Screening, Brief Intervention and Referral to Treatment (SBIRT) has been rolling out more slowly than hoped. The informant recognized the anomaly in billing that requires formal assessment and diagnosis, which would not be present at a stage people would like to conduct early intervention.

Providers

One informant emphasized that expansion should be measured in the number of new providers, as opposed to newly enrolled providers, since the change from the agency supervising staff members to the individual rendering care for billing will result in many more professionals billing services.

Some providers objected to the lack of adequacy of rates approved for assertive community treatment, a treatment model for the most vulnerable individuals, those at risk of incarceration or hospitalization, that creates a multidisciplinary team to wrap needed outpatient and community-based services around the individual. One informant described their agency's formal financial analysis which concluded it could not offer the ASAM level 3.5 services because rates were set at a level that would not be sustainable for it.

It is possible that the funding for office based opioid treatment (OBOT), combined with relatively recent expansion of providers to include for profit corporations has resulted, and will continue to result, in funneling money to large national corporations outside Alaska at the expense of Medicaid.

Adequacy of the State's Capacity

A number of key informants discussed areas of concern in the ability of the State's workforce to provide adequate services to its population. A chief concern was the limited workforce, specifically, the limited number of qualified professionals active in the field of SUD and behavioral health services. Informants shared that there is a complete lack of providers for certain levels of care. The limited workforce results in the lack of resources necessary for those in management positions to be devoted to the sufficient supervision of staff and exacerbates issues in the retention of the current workforce.

Issues resulting from the workforce shortage were also clear for qualified addiction professionals (QAPs) staff members. Providers are only given a two-year period in which to become up to date with QAP standards; this, combined with the current limited workforce, created an environment in which agencies are poaching QAPs from each other to fill their own staffing needs. In addition, informants viewed the new continuing education standards for QAPs and certified peers as placing a new burden on employees with a bachelor's degree. In the past, these employees did not have to meet significant continuing education requirements. Providers are not reimbursed for these continuing education trainings, and until the implementation of the waiver, they were not planned for. Informants expressed an appreciation for the extended grace period given to become compliant with the standards, however, found it difficult to track every employee's individual progress. This confusion resulted in increased concerns about provider capacity through the fear of not knowing how far into the standardization process new employees hired from other agencies were, and whether they would be certified in time to be able to bill for their services. Informants shared that they have expressed their concerns about this new certification process and its potential to exacerbate the existing workforce shortage and have been met with a lack of response from the State.

Key informants also expressed that inadequate provider capacity creates circumstances in which providers have difficulty expanding their service portfolio due to a lack of employees available to staff any added services and limited time available to onboard new staff members. Informants spoke of the fact that it takes six to twelve months to enroll providers into the Medicaid system and build their capacity to bill for Medicaid on a wide scale. Brand new providers also need to learn and become familiar with how to use the system. For BH providers, additional steps are required as their field is considered high risk. This extended time period further delays the ability to add to the workforce. An additional barrier to capacity expansion is the lack of infrastructure available. Providers do not have the physical space in which to expand their service delivery; communities not only lack the space for providers to operate from, but often also lack the space to house new-to-the-area providers. In Alaska, providers are competing with the tourism industry that promotes short-term rentals over long-term tenants, causing providers to struggle to find personal housing.

Any Changes in the State's Capacity

The number of agencies providing SUD and SMI/SED services in Alaska has increased throughout the course of the demonstration thus far. This is consistent with the actions taken by the State as it has progressed through the key action items of the Implementation Plan and worked towards the completion of the Milestones. Due to

Alaska's unique geography, the ability of providers to deliver services is often limited to safe driving distances. The waiver demonstration has been able to improve upon the capacity to serve individuals locally and has increased the number of local residential beds. This directly increases the capacity to provide services to local community members who are now able to receive care within safe driving distances from their home. Access to care has been improved regardless of geography, as the waiver demonstration has impacted communities across the diverse regions of Alaska. The new qualification requirements have increased the quality of staff, ensuring that sufficient experience and professional standards are met across the board.

Several changes have occurred that were not anticipated by the Implementation Plan. Namely, DBH's decision to phase in the waiver program based on the technological sophistication of providers. The more technologically sophisticated providers were ready to adopt and implement the waiver program sooner than their counterparts while simultaneously requiring less training to become up to date on the new practices. Also unforeseen in the planning was the varying levels of response from different areas of providers. The response from IMD treatment providers, generally delivering a more expensive service, was large. Informants expressed fear that this would result in decreased budgeting for HCBS, support groups, and community service supports; groups who provide the front-line services that are less expensive and failed to exhibit the same level of response to the waiver demonstration.

The COVID-19 PHE was the driving force behind a major shift in the medium through which care was provided, kickstarting the change from primarily in-person delivery of care to providing care through telehealth. It is important to note that this shift, though significant for the method of care, generally did not impact the capacity to provide services. One exception was methadone clinics' ability to provide services to incarcerated populations. Additionally, the COVID-19 PHE slowed the progress on waiver program implementation. Providers lacked the bandwidth to address the pandemic's impact on their ability to deliver traditional services while simultaneously implementing new programs as dictated by the waiver. This was exacerbated by the large staffing shortages that plagued the industry as providers remained out of work for quarantine periods and many other employees relocated out of state to be closer to family members.

Any Identified Needs for Additional Capacity

Despite the overall increase in the State's capacity to provide SUD and SMI/SED services, there are areas of identified need where actions can be taken to improve capacity. The development of a roadmap or alternative official manner through which to document an individual's progress through the qualification process for QAP and peer support certification would be beneficial. Additionally, providers suggested the development of a registry through which the State can maintain a database of information on QAPs' status. These actions will support cross-agency hiring and ease of successfully completing the qualification process, therefore facilitating increases to provider capacity.

Additionally, DBH should continue in its progress towards the completion of Milestone #4, Sufficient Provider Capacity at Critical Levels of Care. Specifically, the action items to recruit qualified providers to address increased capacity and identify new provider types by region. These actions will require the ASO to move forward with new provider recruitment and the identification of new specialties that will aid in expanding provider capacity. Milestone #5, Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse also looks to expand capacity through recruiting qualified buprenorphine or naltrexone providers to address expended capacity. It is important to note that there is no existing mechanism within the Alaska Medicaid system to mandate existing providers to expand due to the fee-for-service systems structure. DBH has instead expanded capacity through the procurement of grant funding.

COVID-19 Impacts on Implementation and Performance

For all providers, COVID-19 has resulted in a dramatic impact on day-to-day operations as healthcare service delivery changed to accommodate social distancing. One member of the DBH team said that the Federal Emergency Management Agency (FEMA) crisis center in Alaska had a many thousand-fold increase in calls. This increase reflects the increased stress to individual beneficiaries, as well as to the staff members who must meet the increasing need for services. With social distancing protocols shifting as much as 75 percent of services to telehealth, some services, such as administration of MAT, required frequent in-person visits, and a different set of logistical changes. In addition, both administrators and providers acknowledged that the loss of face-to-face and peer engagement with beneficiaries has impacted treatment outcomes as well as provider revenue. While it is unclear whether telehealth is reaching individuals who would not have been served otherwise, benefits of telehealth were noted by several respondents as an unintended, beneficial consequence of COVID-19. For example, one administrator described the positives of increased telehealth as increased patient engagement, fewer no shows, fewer patients dropping out of treatment, and more completion of treatment. They also reported increased peer-to-peer engagement. One population particularly hard-hit by the changes necessary to combat COVID-19 has been the incarcerated population, as providers are prevented from going into jails to perform in-person assessments. To further evaluate the impact of telehealth on SUD-BHP services, the State will be adding questions about telehealth to its Consumer Health Survey.

In addition to social distancing protocols, some agencies faced challenges with staffing concerns due to quarantines and infection. With the state of the pandemic, time to replace staff members increased from 6 to 12 weeks, in an environment already affected by staffing shortages. The pandemic may have also impacted the evaluation of budget neutrality and sustainability, since some allowable modifications have been made for providers receiving Section 1115 funds to their procedures for documenting and separating out funding streams. This may have impacts on the data providers are expected to report.

Finally, impacts to waiver services implementation were consistent across all informants; the pandemic slowed progress on waiver issues because agencies and providers may have lacked the bandwidth to deal with new programs at a time they were scrambling to deliver traditional services, leading to a feeling of being in crisis stabilization mode. While initially unsure if they were able to stay open, providers were unlikely to expand waiver services. Conversely, while expanding services was delayed, administrators noted that an unintended benefit was the ability to get regulations through in a compressed time frame, due to the use of emergency regulations. Additionally, under the emergency regulation, one informant noted that the ASO, Optum, paid claims without requiring a pre-authorization of services, which may have created an unknown long-term financial impact.

Next Steps and Recommendations

Despite some technical challenges and coronavirus disease 2019 (COVID-19) pandemic-related challenges, key informants were generally pleased with the implementation and progress of the Section 1115 waiver. Key informants identified several positive impacts, notably an expansion of services being provided as a result of the waiver, both in the types of services being provided and the number of patients receiving the services. There were a small number of areas identified by multiple key informants in which the Alaska Department of Health and Social Services (DHSS) and Division of Behavioral Health (DBH) can make some changes that will serve to enhance the performance of the program and help to ensure that the program maximizes its potential impact and reach. The bulk of the issues identified by providers would be best addressed by additional education and communication with the provider community. Specific recommendations include:

- A number of providers reported confusion regarding billing practices and allowable services through the demonstration. As many of the providers within the demonstration are new to Medicaid, DBH should consider providing additional training to provider agencies to ensure that the agencies are educated and confident in their ability to ensure their service provision and billing practices are compliant with all Federal and State Medicaid requirements.
- To ensure that as provider agencies questions arise, DBH should consider instituting monthly provider roundtable meetings for the State to address emerging issues and questions. DBH should aim to provide clear answers to questions raised in the group no later than the following month's meeting.
- DBH should consider calculating and reporting the monitoring metrics regularly, based on the frequency of the specific metric, to create "real time" tracking of the performance and impact of the demonstration.
- DBH should consider creating and maintaining a registry of qualified addiction professionals (QAPs) tracking individual continuing education hours and requirements to smooth the transition of providers between agencies.
- With the delayed implementation of the substance use disorder (SUD) portion of the waiver demonstration, the "With Waiver" projected costs and membership should be updated to reflect the impact of the program not starting until July 1, 2019.

Appendix A. Independent Assessor

The Alaska Department of Health and Human Services (DHHS) Division of Behavior Health (DBH) contracted with an independent assessor, Health Services Advisory Group, Inc. (HSAG), to conduct an independent evaluation of the Section 1115 waiver demonstration including the Mid-Point Assessment.[A-1] Since 1979, HSAG has provided state and federal government agencies, health plans, and providers assistance in delivering healthcare quality improvement support and evaluation services. HSAG's work has impacted 45 percent of the Medicaid members and 12 percent of Medicare members across the United States. Prior work in Section 1115 waiver demonstrations have involved large-scale evaluations utilizing advanced qualitative and quantitative techniques for several state Medicaid and federal agencies. HSAG's extensive experience and expertise has proven their capacity and technical ability to conduct the waiver evaluation for the Alaska Substance Use Disorder and Behavioral Health Program.

HSAG conducted a fair and impartial demonstration evaluation in accordance with the Special Terms and Conditions (STCs) and the Evaluation Design approved by the Centers for Medicare & Medicaid Services.[A-2] To mitigate any potential conflict of interest within DBH, HSAG assumed sole responsibility for the analysis of data collected for monitoring purposes, benchmarking of demonstration performance to national standards, evaluation of changes over time, interpretation of results, and production of evaluation reports and deliverables. DBH provided pre-calculated metric numerators, denominators, and rates to HSAG to conduct the assessment. The calculation of the metric numerators, denominators, and rates were not independently verified by HSAG. While independently conducting the evaluation and preparing this mid-point assessment, HSAG maintained professional independence from DBH while adhering to the CMS-approved evaluation design plan. DBH has confirmed that HSAG has no conflicts of interest to report and will remain free of interests that would conflict with fulfilling its contractual obligations to DBH for the duration of their involvement in the demonstration evaluation.

A-1 Centers for Medicare & Medicaid Services. State Initial Application. Available at: ak-behavioral-health-demo-pa.pdf (medicaid.gov). Accessed Mar. 15, 2022.

A-2 Centers for Medicare & Medicaid Services. Special Terms and Conditions. Available at: ak-behavioral-health-demo-benefits-amend-appvl-09032019.pdf (medicaid.gov). Accessed Mar. 15, 2022.

Appendix B. Data Collection Tools

HSAG developed a flexible interview protocol using an open-ended questions format to maximize the diversity and richness of responses and ensure a more holistic understanding of the subjects' experience. The interview protocol was provided to interviewees via email in advance of the interview. Solely for the purpose of notetaking and accurate development of this assessment, subjects were asked for verbal consent to interview recording. All subjects consented. As the interview developed, the interviewer followed up answers by probing for details to ensure a complete understanding of critical points, terminology, and perspectives of the participants, giving voice and empowerment to diverse populations and shareholders. The protocol is provided below for reference.

Alaska Substance Use Disorder and Behavioral Health Program (SUD-BHP) Semi-Structured Interview Guide

Health Services Advisory Group, Inc. (HSAG) is conducting an independent evaluation of the Alaska Department of Health and Social Services, Division of Behavioral Health (DBH) Substance Use Disorder and Behavioral Health Program (SUD-BHP) demonstration waiver as a required element of the Centers for Medicaid & Medicare Services (CMS) Standard Terms and Conditions of Alaska's Section 1115 waiver. The demonstration seeks to develop a data-driven, integrated behavioral health system of care for children, youth, and adults with serious mental illness (SMI), severe emotional disturbance, and/or SUDs.[1] To develop a robust evaluation of the waiver, HSAG will conduct several semi-structured interviews and focus groups with providers and administrators, as well as Tribal entities and other non-provider stakeholders that provide care to or represent Alaska's Medicaid population. The interviews will collect qualitative information regarding the perceptions and experiences of stakeholders impacted by the SUD-BHP, focusing on barriers encountered, anticipated challenges, impacts on quality of and access to care, and sustainability of the expansion. HSAG will also examine how the unexpected burdens of responding to the coronavirus disease 2019 (COVID-19) pandemic has impacted the planning and implementation of the SUD-BHP demonstration.

The following sections contain sets of open-ended questions to guide semi-structured interviews and/or focus groups for the identified entities. This is not intended to be an exhaustive list of questions or a verbatim script for conversations, rather, this guide is intended to facilitate conversation by providing primary questions and key follow-up questions that HSAG staff will use to elicit further information. HSAG expects that each interview will be unique. As it develops, the interviewer or facilitator will follow up answers by probing for details to ensure complete understanding of critical points, terminology, and perspectives of the participants, giving voice and empowerment to diverse populations and shareholders.

Proposed Protocol for Semi-Structured Interviews and Focus Groups

Proposed Interview Introductory Language

The following language, along with a copy of the proposed questions will be sent to the appropriate interview subject in advance of the interview and/or focus group. This will provide subjects with an opportunity to give some advance thought to the issues to be raised.

"Thank you for agreeing to take part in this interview. As you know, HSAG is conducting an independent evaluation of the Alaska Section 1115 waiver, Substance Use Disorder and Behavioral Health Program (SUD-BHP) demonstration, as required by the Centers for Medicaid & Medicare Services (CMS). This interview is part of that evaluation and is designed to capture critical qualitative information regarding your experience with the pre-implementation of SUD-BHP expansion; implementation; and post-implementation care coordination, integration, and quality of services provided to Medicaid beneficiaries. Since the response to the coronavirus disease 2019 (COVID-19) pandemic has disrupted many aspects of the healthcare system, your experience with|

[1] Alaska Department of Health and Social Services Division of Behavioral Health. 1115 Behavioral Health Medicaid Waiver. 2019. Available at: http://dhss.alaska.gov/dbh/Pages/1115/default.aspx. Accessed on: Jul 29, 2020.

how the pandemic has impacted the ability to provide for Medicaid beneficiaries in need of SUD-BHP services is also important.

The information and insights you provide will be aggregated and shared in general terms. Nothing you say will be attributed to you or your organization; only the general themes and commentary provided will be reported.

We hope you will take this opportunity to participate in the evaluation and give us your feedback on whether the SUD-BHP demonstration is working as expected, how the demonstration has been influenced by barriers and drivers of success, and what unanticipated barriers were presented by the COVID-19 response. We would also like your insight into how similar programs could be improved in the future."

Questions Addressed to Providers

Provider experience with care coordination, integration, and quality of services provided with the SUD-BHP demonstration

- Have you participated in any of the newly expanded SUD-BHP services? Which ones? What barriers or difficulties did you encounter related to the expansion of SUD-BHP services?
  - Leading up to the transition
  - During the transition
  - After the transition
- What have been some of the successes regarding newly expanded programs or services? What drivers of success have you noticed (i.e., anything that made the task easier than you thought it would be)?
  - Was there anything that worked particularly well?
  - How did you identify or notice drivers of success?
- How has your practice changed as a result of the SUD-BHP?
  - Could you describe any changes you have made to how you handle Health Information Technology (HIT) in providing patient care and management? In how you communicate with or integrate care with other providers? With patients?
  - What have been some of the barriers regarding sharing information between providers?
  - How has SUD-BHP changed your treatment capacity or case load?
  - Tell me about your experience with beneficiaries' access to care after SUD-BHP.
  - Tell me about your experience with whether the overall quality of care your patients are receiving has changed as a result of SUD-BHP.
  - Are there other changes you have noticed as a result of SUD-BHP?
  - Are there other changes you have noticed that you do not believe are related to SUD-BHP?
- In what ways, if any, has the expansion of SUD-BHP services impacted the types of beneficiaries referred to and seeking treatment in your practice?
  - Services sought by beneficiaries
  - Beneficiary adherence
  - Continuum of care capacities
- Have your practices for caring for beneficiaries changed as a result of SUD-BHP?

- What screening instruments or evidence-based practices do you use to identify potential SUD-BHP issues and appropriate treatment options?
  - What about prevention strategies, specifically as it pertains to SUD?
- Where did you learn about them?
- What changes have worked especially well?
- What barriers have you encountered?

- Please describe any difficulties or successes you have encountered in helping your patients get expanded SUD-BHP services such as non-residential care? Step-up and step-down treatment options? Other home and community-based services?
- Describe your experience with the SUD-BHP changes regarding costs, payment, and accountability reforms.
- What types of assistance/support would be helpful to you as you continue to move forward with your integration efforts?
- What unintended consequences (positive or negative) of the expansion of SUD-BHP services have you noticed?

COVID-19 Impact

- What specific challenges have you observed associated with the COVID-19 pandemic pertaining to the:
  - Expansion of services
  - Delivery of services
  - Utilization of services by beneficiaries
- Are there particular successes you have had in changing practices to meet the challenges of the COVID-19 pandemic?
- What types of assistance/support would be helpful to you as you continue to move forward with providing SUD-BHP services during the COVID-19 pandemic?
- Is there anything else you would like to mention?

Questions Addressed to Non-provider Stakeholder Entities

Non-provider stakeholder entity perspective on changes in access to care following expansion of BH and SUD services

- Please describe your role in planning for and implementing the expansion of SUD-BHP services for your entity?
- Have you or your entity participated in any of the newly expanded programs or initiatives? Which ones? What barriers or difficulties did you encounter, or do you anticipate related to the newly expanded programs or initiatives?
  - Leading up to the transition
  - During the transition
  - After the transition
- Thus far, what have been the successes regarding the SUD-BHP implementation from your perspective?
  - What are the challenges you face in obtaining SUD-BHP services for your members?
  - What aspects of the SUD-BHP could be improved to address these challenges?

- Can you describe any strategies for implementing changes in SUD-BHP services by providers or administrators that have worked particularly well?
- Can you describe any characteristics of providers that made them more or less likely to succeed in implementing the changes?
- Can you describe characteristics of members, families, or communities that may make them more or less likely to benefit from the changes to SUD-BHP services? Are there strategies you think would improve implementation for these individuals?

- How has the expansion of SUD-BHP services impacted beneficiaries' access to care?
  - Regarding provider and provider appointment availability
  - Regarding geographical access
  - Regarding access related to affordability of care
  - Regarding early interventions and support for families
  - Regarding availability of appropriate treatment settings
- What types of assistance/support would be helpful to you as you continue to move forward with your integration efforts?
- What unintended consequences (positive or negative) of the expansion of SUD-BHP services have you noticed?

Non-provider stakeholder entity perspective on changes in quality of care following expansion of BH and SUD services

- How has the expansion of BH and SUD services impacted beneficiary quality of care?
  - Regarding variety of services
  - Regarding consistency of screening and assessments
  - Regarding delivery of appropriate and timely services
  - Regarding improved outcomes

COVID-19 Impact

- What specific challenges have you observed associated with the COVID-19 pandemic pertaining to the:
  - Expansion of SUD-BHP services
  - Delivery of SUD-BHP services
  - Utilization of SUD-BHP services by beneficiaries
- Are there particular successes you have had in changing practices to meet the challenges of the COVID-19 pandemic?
- What types of assistance/support would be helpful to you as you continue to move forward with providing SUD-BHP services during the COVID-19 pandemic?
- Is there anything else you would like to mention?

Questions Addressed to Administration Key Informants

Administrator perspective on the barriers associated with the expansion of SUD-BHP services

- Please describe your role in planning for and implementing the expansion of SUD-BHP services.

- Thus far, what have been the successes regarding the SUD-BHP implementation from your perspective?
  - For BH program managers, if your experience is limited to a particular Alaska 1115 region, what have you found to be the special challenges presented by the region?
  - For fiscal managers, have there been successes or challenges regarding costs, provider payments and accountability reform?
- What barriers or difficulties have you encountered related to the implementation of the expansion of SUD-BHP services; or, if expansion has not occurred, what barriers do you anticipate?
  - Leading up to expansion
  - During expansion
- What approaches have been taken to address barriers?
  - Were they successful?
- What drivers of success have you noticed related to the implementation of the SUD-BHP expansion of services (i.e., anything that made the task easier than you thought it would be)?
  - Can you please describe any strategies that worked particularly well?
  - Can you describe any characteristics of providers that make them more or less likely to succeed in implementing the changes?
  - How did you identify or notice drivers of success?
- What are the major changes you see in use of HIT (Health Information Technology) for patient care, ongoing monitoring, and care coordination as well as program management? Have you noticed barriers or drivers of success for different providers? Regions? What strategies do you think would improve use of HIT?

Administrator perspective on program sustainability and anticipated challenges

- From your perspective, what is the plan for program sustainability of expanded SUD-BHP services?
  - Regarding provider accessibility with higher beneficiary volumes
  - Regarding infrastructure
  - Regarding continuum of care
- What challenges do you anticipate in ensuring the sustainability of the expansion?

COVID-19 Impact

- What specific challenges have you observed, or do you anticipate associated with the COVID-19 pandemic pertaining to the expansion of SUD-BHP services?
  - Expansion of services
  - Delivery of services
  - Utilization of services by beneficiaries
- Are there particular successes you have had in changing practices to meet the challenges of the COVID-19 pandemic as it relates to the implementation of SUD-BHP expansion of services?
- What types of assistance/support would be helpful to you as you continue to move forward with providing SUD-BHP expanded services during the COVID-19 pandemic?
- Is there anything else you would like to mention?

Appendix C. SUD-BH Implementation Milestones

Appendix C provides the State's response to the Substance Use Disorder and Behavioral Health (SUD-BH) Program milestone actions and timeframes (Table C-1).

Table C-1—Milestone Actions and Timeframes

Level of Care	Action	Timeline	Status (e.g., complete, partially complete, delayed)	Completion Date (if applicable)	State Notes
Milestone #1: Access to Critical Levels of Care for SUD Treatment					
OTS	Pursue HCPCS code modifications for expanded MAT, treatment plan development, and Community services and RSS	Target to complete code modifications—4/1/2019	Complete	7/1/2019 for SUD and 5/21/2020 for the BH	
	Pursue AAC modifications accordingly	Target 4/1/2019	Complete	7/1/2019 for SUD and 5/21/2020 for the BH	
	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	N/A	Enhanced services 7/1/2019 were onboarded per the SUD STCs component	Note that Alaska Medicaid is FFS, so there is a not a mechanism for the State to require existing providers to expand. There is no special funding to start a new OTP, but DBH has expanded its capacity with SAMHSA SOR grant funds and has established enhanced rates.
0.5 – Early Intervention	Pursue SPAs to modify SUD screening and SBIRT services	Target effective date 4/1/2019	Delayed		Alaska is not moving SBIRT into the Section 1115 waiver demonstration at present. Currently SBIRT is a highly utilized state plan service. This activity has had varied impacts across the system of care, including financial, so in an abundance of caution, this item has been delayed.

Level of Care	Action	Timeline	Status (e.g., complete, partially complete, delayed)	Completion Date (if applicable)	State Notes
	Pursue AAC modifications accordingly	Will be filed 5/1/2019	Delayed		See notes concerning SBIRT above.
	Train hospital ED staff members in 10 selected hospitals regarding SBIRT	Will be completed 4/30/2019	Partially Complete/Delayed		DBH has worked with two hospitals, but when the COVID-19 pandemic began, focus shifted elsewhere, and hospitals' ability to engage was impacted.
1.0 – Outpatient Services	Develop a new waiver service to allow reimbursement for IOP services	Target date for development of new waiver service—April 2019	Complete	10/2019	This was completed with the SUD roll out.
	Pursue AAC modifications to add coverage of service	Will be filed by 5/1/2019	Complete	10/7/2019	
	Develop provider notification/communication regarding new service	Formal notification to be released at least 90 days before initiation of waiver services	Complete	10/7/2019	Using existing communication mechanisms, provider communication is ongoing, including technical assistance and support from the ASO (Optum).
	Conduct provider training on ASAM requirements for ASAM 1.0 Level of Care	Based on 50/50 schedule	Complete	10/7/2019	
2.5 – PHP	Develop a new waiver service to allow reimbursement for SUD PHP services	Target effective date April 2019	Complete	7/1/2019	Using existing communication mechanisms, provider communication is ongoing, including technical assistance and support from the ASO (Optum).
	Pursue AAC modifications to add coverage of service	Will be filed by 5/1/2019	Complete	7/1/2019	
	Develop provider notification/ communication regarding new service	Formal notification to be released at least 90 days before initiation of waiver services	Complete	7/1/2019	
	Conduct provider training on ASAM requirements for ASAM 2.5 Level of Care	All training completed waiver Year 1	Complete	7/1/2019	

Level of Care	Action	Timeline	Status (e.g., complete, partially complete, delayed)	Completion Date (if applicable)	State Notes
3.1 – Clinically Managed Low-Intensity Residential Services for Youth and Adults	Pursue AAC modifications to add coverage for youth	Will be filed 5/1/2019	Complete	7/1/2019	
	Develop provider notification of IMD status and certification requirements	Formal notification to be released upon CMS approval of SUD implementation plan, anticipated date 2/1/2019	Complete	7/1/2019	
	Conduct provider training on ASAM requirements for ASAM 3.1 Level of Care	Based on 50/50 schedule	Complete	7/1/2019	
3.3 – Clinically Managed Population—Specific High Intensity Residential Services for Adults	Pursue AAC modifications regarding coverage of service	Will be filed 5/1/2019	Complete	7/1/2019	
	Develop provider notification of service and certification requirements	Formal notification to be released at least 90 days before initiation of waiver services	Complete	7/1/2019	
	Conduct provider training on ASAM requirements for ASAM 3.3 Level of Care	Waiver Year 1—Regions 1 and 2	Complete	7/1/2019	
3.5 – Clinically Managed Medium-Intensity Residential Services for Youth and Clinically Managed High-Intensity Residential Services for Adults	Pursue AAC modifications regarding coverage of service	Will be filed 5/1/2019	Complete	7/1/2019	
	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 2/1/2019	Complete	7/1/2019	
	Conduct provider training on ASAM requirements for ASAM 3.5 Level of Care	Based on 50/50 schedule	Complete	7/1/2019	
3.7 – Medically Monitored High Intensity Inpatient	N/A	N/A	Complete	7/1/2019	

Level of Care	Action	Timeline	Status (e.g., complete, partially complete, delayed)	Completion Date (if applicable)	State Notes
Services for Youth and Adults					
4.0 – Medically Managed Intensive Inpatient Services for Youth and Adults	N/A	N/A	Complete	7/1/2019	
1 – WM—Ambulatory WM Without Extended On-Site Monitoring for Youth and Adults	Pursue AAC modifications accordingly	Will be filed 4/1/2019	Complete	7/1/2019	
	Develop provider notification of modifications to 1-WM	Formal notification to be released at least 90 days before initiation of waiver services, anticipated date 2/1/2019	Complete	7/1/2019	
	Conduct provider training on ASAM requirements for ASAM 1-WM Level of Care	Based on 50/50 schedule	Complete	7/1/2019	
2 – WM—Ambulatory WM with Extended On-Site Monitoring for Youth and Adults	Develop new waiver service to allow reimbursement for ASAM 2- WM	Target effective date 4/1/2019	Complete	7/1/2019	
	Pursue AAC modifications accordingly	Will be filed 5/1/2019	Complete	7/1/2019	
	Develop provider notification of new 2-WM service.	Formal notification to be released at least 90 days before initiation of waiver services, anticipated date 2/1/2019	Complete	7/1/2019	
	Conduct provider training on ASAM requirements for ASAM 2-WM Level of Care	Based on 50/50 schedule	Complete	7/1/2019	
3.2 – WM—Clinically	Develop new waiver service to allow reimbursement for ASAM 3.2- WM	Target effective date 5/1/2019	Complete	7/1/2019	

Level of Care	Action	Timeline	Status (e.g., complete, partially complete, delayed)	Completion Date (if applicable)	State Notes
Managed Residential WM	Pursue AAC modifications accordingly	Will be filed 6/1/2019	Complete	7/1/2019	
	Develop provider notification of new 3.2-WM service.	Formal notification to be released at least 90 days before initiation of waiver	Complete	7/1/2019	
	Conduct provider training on ASAM requirements for ASAM 3.2-WM Level of Care	Waiver Year 2	Complete	7/1/2019	
3.7 – WM— Medically Monitored Inpatient WM	Develop new waiver service to allow reimbursement for ASAM 3.7- WM	Target effective date 4/1/2019	Complete	7/1/2019	
	Pursue AAC modifications accordingly	Will be filed 5/1/2019	Complete	7/1/2019	
	Develop provider notification of new 3.7-WM service.	Formal notification to be released at least 90 days before initiation of waiver services	Complete	7/1/2019	
	Conduct provider training on ASAM requirements for ASAM 3.7-WM Level of Care	Waiver Year 2	Complete	7/1/2019	
4 – WM— Medically Managed Intensive Inpatient WM	Develop new waiver service to allow reimbursement for ASAM 4- WM	Target effective date 4/1/2019	Complete	7/1/2019	
	Pursue AAC modifications accordingly	Will be filed 5/1/2019	Complete	7/1/2019	
	Develop provider notification of new 4-WM service.	Formal notification to be released at least 90 days before initiation of waiver services	Complete	7/1/2019	
	Conduct provider training on ASAM requirements for ASAM 4-WM Level of Care	Waiver Year 2	Complete	7/1/2019	
Community Recovery Support Services	Pursue a SPA to delete CCSS and RSS	Target effective date 4/1/2019	Partially Complete/Delayed		The State has rolled out CRSS and are tentatively engaged in conversation with tribes for

Level of Care	Action	Timeline	Status (e.g., complete, partially complete, delayed)	Completion Date (if applicable)	State Notes
	Develop new Waiver service to allow reimbursement for Community services and RSS				consultation. The State is following appropriate sequencing to ensure a smooth transition.
	Pursue AAC modifications accordingly	Will be filed 5/1/2019	Complete	7/1/2019	Completed specific to CRSS (7/1/2019).
	Develop provider notification of new service	Formal notification to be released at least 90 days before initiation of waiver services	Complete	7/1/2019	
	Phase-out deleted services and phase-in new service	Based on 50/50 schedule	Partially Complete/Delayed		The state plan services cannot be deleted as they impact the waiver. Further this element was not rolled out until May 2020. DBH is working to ensure appropriate sequencing and a smooth transition.
	Conduct provider training on ASAM elements of Dimension 6 and requirements for Community services and RSS	Based on 50/50 schedule	Complete	7/1/2019	Training remains ongoing and technical assistance is also available.
Milestone #2: Use of Evidence-Based, SUD-Specific Patient Placement Criteria					
N/A	Conduct provider training on ASAM criteria	Ongoing throughout 2019	Complete	7/1/2019	Training remains ongoing and technical assistance is also available.
	Finalize ASAM-aligned assessment instrument	6/1/2019	Delayed		
	Conduct provider training on assessment instrument	Ongoing throughout 2019	Delayed		
	Procure contract with ASO	Early Spring 2019	Complete	November 2019	
	Approve ASO policies and procedures	6/1/2019	Partially Complete		Ongoing
Milestone #3: Use of Nationally Recognized SUD-specific Program Standards for Residential Treatment Facility Provider Qualifications					
N/A	Finalize process for provisional ASAM designation of qualified residential provider (including MAT requirement)	Will be completed by May 2019	Complete	7/1/2019	

Level of Care	Action	Timeline	Status (e.g., complete, partially complete, delayed)	Completion Date (if applicable)	State Notes
	Modify AAC to include formal certification process based on the ASAM criteria (including MAT requirement)	Will be filed by May 2019	Complete	7/1/2019	
	Modify Provider Medicaid Billing Manual to include formal certification process based on the ASAM criteria (including MAT requirement)	Will be completed by May 2019	Complete	7/1/2019	For details, see the Administrative and Procedures Manual for SUD, preamble which discusses ASAM and QAP issues.
	Develop loss of certified addiction professionals located in existing SUD residential providers	Will be completed by March 2019	Complete	7/1/2019	Ongoing as individuals enroll.
	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 2019	Complete	7/1/2019	
	Develop monitoring protocol	Will be completed by August 2019	Complete	7/1/2019	Original Monitoring Protocol submitted in June 2019; Revised Monitoring Protocol submitted in May/June 2020.
	Initiate ongoing monitoring process	Will begin September 2019	Partially Complete		Ongoing
Milestone #4: Sufficient Provider Capacity at Critical Levels of Care					
N/A	Recruit qualified providers to address increased capacity	Based on 50/50 schedule	Partially Complete		Note that Alaska Medicaid is FFS, so there is a not a mechanism for the State to require existing providers to expand. However, DBH has established enhanced rates.
	Identify new providers types by region	Will be completed by February 2019	Partially Complete		Ongoing; the ASO (Optum) is continuously monitoring the issue. Initial efforts focused on claims processing and education but

Level of Care	Action	Timeline	Status (e.g., complete, partially complete, delayed)	Completion Date (if applicable)	State Notes
					moving forward the ASO will begin to focus on recruitment.
	Develop notification/communication regarding waiver and ASAM requirements	Will be completed by March 2019	Complete	7/1/2019	Ongoing
	Pursue AAC and Provider Medicaid Billing Manual changes	Will be completed by May 2019	Complete	7/1/2019	Since the Section 1115 is a demonstration, the provider billing manual will have multiple iterations with updated information; 10/7/2019 being the latest revision.
	Enroll new provider types as independent Medicaid billing providers	Will be completed by April 2019	Complete	7/1/2019	Ongoing
	Assess ASAM providers and services by region	March of 2019	Partially Complete		Ongoing. Note that the Section 1115 rolled out regionally impacting assessment and implementation.
	Work with ASO to provide training on ASAM criteria and requirements for waiver reimbursement	Ongoing, beginning 5/1/2019	Complete	7/1/2019	Ongoing; the ASO began working with providers February 2020; prior to that DBH staff worked on this issue.
	Develop notification/communication regarding formal designation	May 2019	Complete	7/1/2019	Ongoing as new services are onboarded that require ASAM (this item is specific to residential services).
	Implement formal designation process	June 2019	Complete	7/1/2019	Ongoing as new services are onboarded that require ASAM (this item is specific to residential services).
Milestone #5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse					
N/A	Recruit qualified buprenorphine and naltrexone providers to address expanded capacity	Based on 50/50 schedule	N/A		Note that Alaska Medicaid is FFS, so there is a not a mechanism for the State to require existing providers to expand. There is no

Level of Care	Action	Timeline	Status (e.g., complete, partially complete, delayed)	Completion Date (if applicable)	State Notes
					special funding to start a new OTP, but DBH has expanded its capacity with SAMHSA SOR grant funds and has established enhanced rates.
	Expand use of buprenorphine or any currently approved effective pharmacological treatment for SUDs to address OUD and expand use of naltrexone to address alcohol use disorders and OUDs	Based on 50/50 schedule	N/A		Note that Alaska Medicaid is FFS, so there is a not a mechanism for the State to require existing providers to expand. There is no special funding to start a new OTP, but DBH has expanded its capacity with SAMHSA SOR grant funds and has established enhanced rates. This item is primarily an educational activity. DBH expects the ASO (Optum) will engage in more now that claims processing has moved forward.
Milestone #6: Improved Care Coordination and Transitions Between Levels of Care					
N/A	Develop SUD care coordination guidelines for transitions from residential to non-residential settings	March 2019	Complete	7/1/2019	See Administrative and Procedures Manual for SUD for details.
	Develop ICM guidelines to clarify difference from SUD care coordination services and circumstances for concurrent use	May 2019	Complete	7/1/2019	See Administrative and Procedures Manual for SUD for details.
	Develop and implement peer recovery certification requirements	Begin certification process – summer of 2018; implement Demonstration Year 2	Partially Complete		Expected to go live in January 2021.

AAC: Alaska Administrative Code; ACBHC: Alaska Commission for Behavioral Health Certification; ASAM: American Society of Addiction Medicine; ASO: administrative services organization; CCSS: comprehensive community support services; CMS: Centers for Medicare & Medicaid Services; COVID-19: coronavirus disease 2019; ED: emergency department; FFS: fee-for-service; HCPCS: healthcare common procedure coding system; ICM: intensive case management; IMD: Institution for Mental Disease; IOP: intensive outpatient; MAT: medication assisted treatment; OBOT: office-based opioid treatment; OTP: opioid treatment program; OTS: opioid treatment service; OUD: opioid use disorder; PHP: Partial Hospitalization Program; QAP: qualified addiction professional; RSS: recovery support services; SBIRT: screening, brief intervention and referral to treatment; SOR: state opioid response; SPA: state plan amendment; STCs: special terms and conditions; SUD: substance use disorder; WM: withdrawal management.

Appendix D. Monitoring Metrics

Appendix D provides additional details on the monitoring metrics included in the Mid-Point Assessment for the Alaska Substance Use Disorder and Behavioral Health (SUD-BH) Program (Table D-1).

Table D-1—Monitoring Metrics

	Monitoring Metric	Baseline Rate/Count	Mid-Point Rate/Count	Absolute	Relative Percent	In Desired Direction	Monthly Trend	Monthly Trend in Desired Direction
3	Medicaid Beneficiaries with SUD Diagnosis (monthly)	18,650	18,175	-475	-2.5%	✓	-17.27	✓
4	Medicaid Beneficiaries with SUD Diagnosis (annually)	27,268	26,671	-597	-2.2%	✓		
5	Medicaid Beneficiaries Treated in an IMD for SUD	68	106	38	55.9%	✓		
6	Any SUD Treatment (per 1,000 SUD beneficiaries)	6,379	4,759	-1,620	-25.4%	✗	-38.20	✗
7	Early Intervention (per 1,000 SUD beneficiaries)	0	1	1	0.0%	✓	0.76	✓
8	Outpatient Services (per 1,000 SUD beneficiaries)	4,646	2,600	-2,046	-44.0%	✗	-61.17	✗
9	Intensive Outpatient and Partial Hospitalization Services (per 1,000 SUD beneficiaries)	294	262	-32	-10.9%	✗	-8.31	✗
10	Residential and Inpatient Services (per 1,000 SUD beneficiaries)	145	132	-13	-9.0%	✗	-0.20	✗
11	Withdrawal Management (per 1,000 SUD beneficiaries)	92	114	22	23.9%	✗	0.22	✗
12	Medication Assisted Treatment (per 1,000 SUD beneficiaries)	2,629	2,990	361	13.7%	✓	20.28	✓
13	SUD Provider Availability	398	906	508	127.6%	✓		

	Monitoring Metric	Baseline Rate/Count	Mid-Point Rate/Count	Absolute	Relative Percent	In Desired Direction	Monthly Trend	Monthly Trend in Desired Direction
14	SUD Provider Availability - MAT	4	4	0	0.0%			
15	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD): Initiation (Total)	62.0%	61.5%	-0.5%	-0.8%	✗		
15	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD): Initiation (Alcohol)	63.5%	63.1%	-0.4%	-0.6%	✗		
15	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD): Initiation (Opioid)	62.5%	60.2%	-2.3%	-3.7%	✗		
15	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD): Initiation (Other Drug)	54.0%	52.8%	-1.2%	-2.3%	✗		
15	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD): Engagement (Total)	27.4%	17.5%	-9.9%	-36.0%	✗		
15	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD): Engagement (Alcohol)	28.7%	17.8%	-10.9%	-37.8%	✗		
15	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD): Engagement (Opioid)	24.4%	17.7%	-6.7%	-27.4%	✗		
15	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD): Engagement (Other Drug)	22.9%	14.2%	-8.8%	-38.2%	✗		

	Monitoring Metric	Baseline Rate/Count	Mid-Point Rate/Count	Absolute	Relative Percent	In Desired Direction	Monthly Trend	Monthly Trend in Desired Direction
17(1)	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD): 7-day	18.5%	15.5%	-3.0%	-16.0%	✗		
17(1)	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD): 30-day	27.9%	24.5%	-3.3%	-12.0%	✗		
17(2)	Follow-up after Emergency Department Visit for Mental Illness (FUM-AD): 7-day	39.8%	24.9%	-4.9%	-12.3%	✗		
17(2)	Follow-up after Emergency Department Visit for Mental Illness (FUM-AD): 30-day	53.6%	48.6%	-5.0%	-9.3%	✗		
18	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)	13.6%	14.4%	0.8%	6.1%	✗		
21	Concurrent Use of Opioids and Benzodiazepines (COB-AD)	13.5%	12.4%	-1.1%	-8.4%	✓		
22	Continuity of Pharmacotherapy for Opioid Use Disorder	21.4%	21.6%	0.2%	1.1%	✓		
23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	1,629.0	644.0	-985.0	-60.5%	✓	-19.49	✓
24	Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries	449.0	67.0	-382.0	-85.1%	✓	-8.44	✓
25	Readmissions Among Beneficiaries with SUD	21.4%	19.1%	-2.2%	-10.4%	✓		
26	Overdose Deaths (count)	90	134	44	48.9%	✗		

	Monitoring Metric	Baseline Rate/Count	Mid-Point Rate/Count	Absolute	Relative Percent	In Desired Direction	Monthly Trend	Monthly Trend in Desired Direction
27	Overdose Deaths (rate per 1,000)	0.38	0.56	0.19	49.3%	✗		
32	Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD (AAP)	88.6%	92.9%	4.3%	4.9%	✓		
36	Average Length of Stay in IMDs	15.2	19.5	4.3	28.0%	✗		
Q1	Information Technology Use to Monitor SUD rate via Patient Prescription History Requests	7,736,304	5,184,842	-2,551,462	-33.0%	✓		
Q2	Information Technology Use to Monitor SUD Treatment Effectiveness via Medical Professional Training in MAT Offered	178	188	10	5.6%	✓		
Q3	Information Technology Use to Monitor "Recovery" Supports and Services for SUD Individuals	121	125	4	3.3%	✓		