State of Alaska
Department of Health and Social Services

Medicaid Section 1115 Behavioral Health Demonstration Application

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Executive Summary

The Alaska Department of Health and Social Services (DHSS) is applying for a Section 1115 Demonstration Waiver from the United States Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) to support the continuing reform of its Medicaid program and of Alaska's behavioral health and substance use disorder (SUD) delivery system as a whole.

The goal of the Alaska Medicaid Section 1115 Behavioral Health Demonstration is to create a data-driven, integrated behavioral health system of care for Alaskans with serious mental illness, severe emotional disturbance, and/or substance use disorders. Because behavioral health challenges often stem from childhood trauma and other adverse experiences and have downstream effects on entire families that translate to higher costs associated with subsequent acute care and chronic health needs, this proposal also aims to establish networks of support for individuals and family members. The state will achieve these goals by creating a more robust continuum of behavioral health care services with emphasis on early interventions, community-based outpatient services, inpatient residential treatment when appropriate, and enhanced peer recovery supports.

This proposal focuses on establishing an enhanced set of benefits for three target populations of Medicaid recipients:

1) Children, Adolescents and their Parents or Caretakers with, or at risk of, Mental Health and Substance Use Disorders;
2) Transitional Age Youth and Adults with Acute Mental Health Needs
3) Adolescents and Adults with Substance Use Disorders

Under the demonstration, Alaska would implement a series of proposed strategies and evidence-based interventions aimed at more effectively addressing the needs of each of the target populations. The benefits for all target populations are designed to decrease use of acute, costly services by conducting universal screenings; intervening early, when symptoms are first identified; utilizing sub-acute, community-based step-up/step-down clinical services as alternatives to residential and inpatient services; and developing community-based supports to maintain recovery, health and wellness. New Medicaid-covered services under the waiver will establish a robust continuum of care designed to anticipate and address the range of behavioral health needs of the target populations.

Through this Section 1115 demonstration proposal, the state will develop and implement an integrated, data-driven fiscally sustainable system of care that achieves the Triple Aim of improved patient experience, improved population health, and reduced costs as well as improved behavioral health outcomes for Alaskans.

Section 1: Program Description and Historical Context

Background and Current State

The Alaska Department of Health and Social Services (DHSS) is requesting authority for a Medicaid Section 1115 Behavioral Health Demonstration Project from the Centers for Medicare & Medicaid Services (CMS) to develop a data-driven, integrated behavioral health system of care for children, youth, and adults with serious mental illness, severe emotional disturbance, and/or substance use disorders. The demonstration also seeks to increase services for at-risk families in order to support the healthy development of children and adults through increased outreach and prevention and early intervention supports. This application is made during a period of dramatic adversity and opportunity in Alaska, and pursuant to a legislative mandate to reform the state's Medicaid health care system.

After years of prosperity resulting from the state's oil wealth, Alaska is facing a fiscal crisis precipitated by the decline of oil prices and levels of production. In just three years, Alaska has reduced its state budget by 22% (with further cuts expected in state fiscal year (SFY) 2019) and cut positions for almost 1,500 state employees (with more proposed for SFY 2019). The state economy is in a recession, creating greater demand for publicly-funded safety net services like Medicaid. The DHSS budget has been reduced by more than $200 million in state general funds over the past three years, restricting the state's ability to address increasing health and social service needs, while demand for safety net services has been increasing.

The challenges in Alaska's behavioral health system extend beyond navigating a fiscal crisis. Important gaps in behavioral health services exist throughout the state due, in large part, to Alaska's complex geographical features including its vast size, rural nature, limited road system, and arctic climate. Significant challenges with recruitment and retention of a qualified behavioral health workforce are impeding access to care; existing behavioral health provider capacities, with long wait times, high staff turnover, and reimbursement rates below that of other medical services, are similarly challenged. The cost of delivering care is very high, leading to the use of technology as a more cost-effective way to provide services where possible. Technology is also an asset for Alaska's behavioral health system and telemedicine has been effectively implemented by Tribal health organizations and some other providers. However, broadband capacity remains limited in rural Alaska and communication between electronic health record (EHR) systems and the nascent health information exchange (HIE) is not sufficient to meet the needs of the provider community.

It was in this climate that, in 2016, the Alaska Legislature passed a monumental Medicaid reform mandate. Senate Bill 74 (SB 74) is a multi-dimensional Medicaid reform package that includes 16 separate and significant initiatives, including direction to apply for a Section 1115 waiver demonstration to enable the state to more efficiently manage a comprehensive and integrated behavioral health system. The system will involve partnerships across a diverse network of providers and clinical disciplines to build a foundation for evidence and data-driven

practices. The bill also directs the state to reduce operational barriers, minimize administrative burden, and improve the effectiveness and efficiency of Alaska's behavioral health system.

The second reform mandate, Senate Bill 91 (SB 91), is a comprehensive criminal justice reform effort aimed at reducing sentencing guidelines for non-violent offenders and reinvesting savings into programs that increase the likelihood of success outside of the correctional system. The mandates in SB 91 are expected to appropriately increase the demand for community-based behavioral health services. An expanded need for mental health and substance use disorder treatment, as well as additional community-based recovery supports, has added pressure to an already strained behavioral health system.

Stakeholder Engagement and 1115 Waiver Concept Paper Development

In response to the passage of SB 74, the Alaska Department of Health and Social Services began a stakeholder engagement process to ensure that residents, providers, Tribal health organizations, and advocates could weigh in on the redesign of the state's behavioral health delivery system. Work groups were created to facilitate discussions of specific elements of a proposed waiver such as benefit design, data needs, and cost and quality goals. Throughout the past two years, dozens of meetings have been held with provider representatives, including Tribal partners.

The early part of the stakeholder engagement process culminated in a draft concept paper that was publicly released in late 2016. Included in the concept paper were five overarching Medicaid reform goals, elements of which can be found throughout this application:

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

The draft 1115 waiver concept paper was submitted to CMS for initial feedback, which resulted in a discussion with staff from the Center for Medicaid and CHIP Services (CMCS) State Demonstrations Group in early 2017.

Martha's Story

Martha is a hypothetical behavioral health consumer whose story is based on the collective experiences of Medicaid enrollees throughout Alaska. This fictional example is being used to describe the combination of challenges that impede access to care in Alaska. Consumers of publicly funded behavioral health services in Alaska can be faced with some, or all, of these barriers in any combination of the described circumstances. Martha's story highlights the multiple factors that may impact health outcomes for individuals in Alaska in both rural and urban settings.

Martha is a 30-year-old Alaskan. She lives in a remote community off the road system. The nearest health care facility is located nearly 300 miles away by plane, and the nearest location for receiving acute behavioral health care is more than 1,000 miles away by plane.

When Martha was 16 years old, she was diagnosed with a fetal alcohol spectrum disorder (FASD). Martha was in and out of foster care and the juvenile justice system while growing up and suffers the long-term effect of trauma, including her parents' addictions, sexual abuse, neglect, domestic violence, separation, and her father's incarceration. Martha entered the adult corrections system after several charges of driving under the influence and domestic violence. Martha's two children are currently in child protective services custody.

Martha experiences a chronic polysubstance use disorder, along with serious and recurring depression and has attempted suicide several times. She has a history of very poor self-care and extensive health issues including obesity, borderline diabetes, chronic migraines, and an overall sense of "not feeling well."

Martha receives individual counseling for her behavioral health disorders via telemedicine – when the equipment is working – along with occasional in-person treatment with her clinician during field visits. Martha has had three different counselors in the past year due to staff turnover, which has impeded her progress. The only health provider in her community is Community Health Aide (CHA)[1] and a village Public Safety Officer is the only local law enforcement official available to respond to crises.

Martha goes to the primary care clinic frequently with somatic complaints of stomach aches and headaches. She says she often feels like she is dying and seeks medical attention, requesting pain medication to cope. Martha eventually travelled to Anchorage and met with a specialist, only to have her somatic complaints be unsubstantiated after bloodwork and invasive procedures. Martha recently disclosed to her new counselor that she has been using opioids for a long time. She shared that she has come close to experimenting with heroin when pills are not available. Martha is ready to take action and admit herself to inpatient treatment, but her counselor is having difficulty finding a withdrawal management and/or residential treatment program to refer her to. Martha will also need quality aftercare and supportive services to help her maintain her sobriety.

Eventually, Martha gives up waiting. She no longer wants to seek treatment. She is avoiding her counselor and continues to use opioids. She has been unable to make the progress needed to enable her to reunite with her children.

Martha's story is all too common in Alaska. The unique geography, diverse population, lack of infrastructure, struggling economy, and limited health care resources make it challenging to

[1] The Community Health Aide Program is a network of about 550 Community Health Aides/Practitioners (CHA/Ps) in more than 170 rural Alaska villages. CHA/Ps are part of an established referral relationship that includes mid-level providers, physicians, regional hospitals, and the Alaska Native Medical Center.

provide a person-centered and culturally responsive system. There were several missed opportunities for Martha that might have led to better outcomes if the right system was in place:

- Timely access to treatment services when child protection services first became involved, could have prevented future harm to Martha and/or her family;
- Screening, Brief Intervention, Referral and Treatment (SBIRT) or similar tools during visits with the Community Health Aide or visiting physician/nurse/practitioner could have identified the need for further assessment and treatment;
- Timely access to appropriate levels of psychiatric and substance use disorder treatment when Martha was ready and willing to seek help; and
- Peer support to help maintain treatment readiness while awaiting admission to treatment and to sustain long-term recovery after treatment.

Alaska's Medicaid Section 1115 Behavioral Health Demonstration Project will support more effective, cost-efficient, integrated care that ensures access to the right services at the right time in the right setting.

Behavioral Health Needs in Alaska

Alaskans have, for many years, manifested behavioral health needs above national averages across several important domains.

Data from the 2015 Behavioral Risk Factor Surveillance Survey (BRFSS) show that 15.3% of Alaskans reported frequent mental distress (14 or more days per month of poor mental health). 18.2% of Alaska Native adults surveyed reported frequent mental distress[2] and Alaska's suicide rate of 27.1/100,000 in 2015 was more than twice the national rate of 12.32/100,000. Our Alaska Native population is 2.4 times likely to complete suicide than non-Alaska Natives.[3]

According to the 2014-2015 National Survey on Drug Use and Health (NSDUH):

- 6.73% of Alaskan adults reported a major depressive episode;
- 4.02% reported a diagnosable mental illness;
- 18.11% reported any mental illness; and
- 4.68% reported serious thoughts of suicide.[4]

Alaska has the 10th highest prevalence rate of adult binge drinking in the country and the fifth highest rate of intensity of binge drinking among adults. Alaskan adults and Alaska Native adults

[2] *AK-IBIS Health Indicator Report of Mental Health – Adults (18+) – Frequent Mental Distre*ss, Alaska Division of Public Health, Department of Health and Social Services (*citing* Alaska Behavioral Risk Factor Surveillance System 2015).
[3] Alaska Health Analytics and Vital Records, Alaska Division of Public Health (provided September 2, 2016).
[4] National Survey on Drug Use and Health, 2014 and 2015, Center for Behavioral Health Statistics and Quality, SAMHSA.

report similar rates of binge drinking in the past month (19.9% and 19.8%, respectively).[5] The rate of alcohol-related mortality for Alaska Natives is more than three times (71.4/100,000) that of all Alaskan adults (20.4/100,000) and is eight times the national rate (8.5/100,000).[6]

Drug use among Alaskans is also prevalent. According to the 2014-2015 NSDUH, 14.38% of Alaskans 12 years and older reported active marijuana use (within the past 30 days). Alaska's BRFSS results reflects similar rates of active marijuana use: 15.7% of all Alaskan adults and 22.6% of Alaska Native adults.[7] Of Alaskans 12 years and older, 1.23% reported heroin use in the past year.[8] Alaska Native youth ages 10-17 years old are 2.7 times more likely to be hospitalized for unintentional alcohol poisoning than a non-Alaska Native peer.[9]

Interestingly, the 2017 Youth Risk Behaviors Survey (YRBS) shows a steady downward trend in underage drinking by traditional high school students[10], and some rates of drug use among high school students have shown the same decline:

- Cocaine use (ever) was 7.8% in 2007 and 4.0% in 2017;
- Inhalant use (ever) was 14.4% in 2007 and 6.7% in 2017;
- Methamphetamine use (ever) was 4.6% in 2007 and 3.0% in 2017; and
- Ecstasy use (ever) was 7.5% in 2007 and 3.9% in 2017.[11]

Youth marijuana use has remained static – 19% in 2007 and 20.5% in 2015.[12] Synthetic marijuana use (ever) was 7.5% in 2015 (first time included in the survey).[13] Heroin use (ever) has increased from 1.6% in 2007 to 2.2% in 2015, while non-medical use of a prescription medication has declined from 20.9% in 2009 (when the YRBS first asked the question) to 14.6% in 2015.[14]

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[5] 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).
[6] AK-IBIS Health Indicator Report of Alcohol-Induced Mortality Rate, Alaska Division of Public Health, Department of Health and Social Services (citing data from the Alaska Health Analytics and Vital Records, Alaska Division of Public Health and US Centers for Disease Control and Prevention).
[7] AK-IBIS Health Indicator Report of Drug Use - Marijuana - Adults (18+), Alaska Division of Public Health, Department of Health and Social Services (*citing* Alaska Behavioral Risk Factor Surveillance System, 2015).
[8] *Id.*
[9] AK-IBIS Health Indicator Report of Alcohol Consumption – Alcohol Poisoning-Hospital - Youth *(10-17),* Alaska Division of Public Health, Department of Health and Social Services (citing Alaska Behavioral Risk Factor Surveillance System, 2015).
[10] The percentage of youth reporting any alcohol consumption ever declined from 73.6% in 2007 to 54.4% in 2015. Current alcohol use (past 30 days) dropped from 39.7% to 22% and binge drinking dropped from 25.8% to 12.5% between 2007 and 2015. Alaska Youth Behavior Survey results, 2007-2015, Alaska Division of Public Health, Department of Health and Social Services.
[11] Alaska Youth Behavior Survey Results, 2007-2015, Alaska Division of Public Health, Department of Health and Social Services.
[12] *Id*.
[13] *Id*.
[14] *Id*.

Alaskans experiencing behavioral health disorders are disproportionately represented in the correctional system: 22% of the SFY 2012 correctional population experienced a mental health disorder and 19% experienced a chronic substance use disorder.[15]

In addition, Alaskans experience significant rates of Adverse Childhood Experiences (ACEs) which translate to more expensive acute care and chronic conditions later in life:

- 66% of Alaskan adults report one or more adverse childhood experiences growing up;
- 21.4% of Alaskan adults report growing up in a household with one or more adults experiencing mental illness;
- 29.7% of Alaskan adults report growing up in a household with one or more adults abusing alcohol and/or other drugs; and
- 19.5% of all Alaskan adults – and 28.4% of Alaska Native adults – report four or more adverse childhood experiences growing up.[16]

Alaska's Medicaid and Behavioral Health Medicaid Program

Alaska's Medicaid Program

Alaska's status as the country's least densely populated and largest geographical state contributes to the fact that Alaska is the fourth most expensive state for health care in the United States. Alaska's total population is approximately 735,600 with 1.2 people per square mile. Alaska Natives, many of whom live in remote areas of the state, have significant health care access issues—Alaska Natives are 12 times more likely than a non-Alaska Native to live in a village that is located more than 100 air or water miles from a hospital.

Alaska ranked 45th in Medicaid spending in 2016, with total expenditures of $1,798,434,564.[17] Medicaid expansion under the Affordable Care Act has accounted for an increase in Medicaid spending of 33.4 percent, with a commensurate enrollee increase of 51%. Alaska's per-enrollee spending is the second highest nationally at over $10,000 per year, reflecting that Alaska has among the highest health care costs in the country, where expensive air ambulance rides are common in emergencies.[18] Twenty-four percent of Alaska's total population is low-income and 18% of the state's residents are covered by Medicaid/CHIP. Alaska has historically had one of

[15] Corrections population data is reported in *Trust Beneficiaries in Alaska's Department of Corrections,* Hornby Zellar Associates, Inc. for the Alaska Department of Corrections, May 2014.
[16] Adverse Childhood Experience data is a three-year average of 2013-2015 Alaska Behavioral Risk Factor Surveillance System responses, reported by the Alaska Division of Public Health.
[17] Kaiser Family Foundation (June 2017), *Medicaid in Alaska.* Found at http://www.kff.org/Medicaid/Medicaid in Alaska
[18] Kaiser Family Foundation (July 21, 2017), *Medicaid's Role in Alaska.* Found at https://www.kff.org/medicaid/fact-sheet/medicaids-role-in-alaska/

the highest uninsured rates in the nation, but that rate has decreased since Medicaid expansion was implemented.[19]

Alaska is the 10th fastest growing state in the country. While the United States is expected to see its population grow by 8.4% by 2025, Alaska is looking at a 12.1% growth rate, or an additional 90,000 people. By 2025, Alaska is expected to see its senior (age 65+) population – a group with high Medicaid costs – grow by 54%, among the fastest growth rates in the country. Alaska's Medicaid enrollment of aged individuals from 2000 - 2011 likewise grew quickly – at an average annual rate of 3.4%, compared to the national average of 2.3%, the 12th fastest growth rate for this Medicaid population in the nation.[20]

Populations with the highest Medicaid eligibility levels in Alaska are children, pregnant women, parents, childless adults, and seniors and people with disabilities. Spending, however, is disproportionately focused on seniors and people with disabilities, who represent 55% of Medicaid spending (individuals with behavioral health disorders are included in the eligibility group of people with disabilities).[21] Like many other state Medicaid spending patterns, 63% of Alaska's Medicaid expenditures are driven by 5% of Medicaid recipients.[22]

Medicaid Enrollees by Group and Expenditures

Category	Percentage of Enrollees	Percentage of Expenditures
Children	57%	29%
Adults	24%	15%
Elderly	5%	16%
Disabled	13%	40%

Alaska's Behavioral Health Medicaid Program

The Behavioral Health Medicaid system, administered through the Division of Behavioral Health, serves the most acutely disabled children, youth, and adults and covers more intense services including residential and inpatient care. Alaska defines Behavioral Health Medicaid services as medically necessary and clinically appropriate active treatment services delivered by eligible providers (acting within their scope of practice) to eligible recipients. Care is delivered in community behavioral health centers, Federally Qualified Health Centers (FQHCs), Tribal health organizations, hospitals, and specialty clinics. The predominant providers in Alaska's behavioral health Medicaid system are community behavioral health centers, hospitals, and specialty clinics. Although primary care providers are an important part of the behavioral health

[19] Kaiser Family Foundation (June 2017), *Medicaid in Alaska.* Found at http://files.kff.org/attachment/fact-sheet-medicaid-state-AK

[20] Robert Wood Johnson Foundation, State Health Reform Assistance Network, *Medicaid Capped Funding: Findings and Implications for Alaska--April 5, 2017*

[21] Kaiser Family Foundation (June 2017), *Medicaid in Alaska.* Found at http://www.kff.org/Medicaid/Medicaid in Alaska

[22] *2015 Alaska Annual Medicaid Report.*

system, the mental health and substance use disorder screening services they provide are often not reimbursed through Medicaid.

Behavioral health redesign and reform is part of the larger Medicaid reform initiative aimed at improving access to behavioral health care, enhance the quality of that care, manage costs and advance the well-being of all Alaskans. These efforts will provide a new business model for comprehensive behavioral health care, including better integration with primary care in an effort to focus on whole-person wellness including the physical, mental and emotional aspects of health. The initiative is looking at how Alaska's behavioral health system is organized; what services are offered; how services are paid for; provider types; provider performance; quality of care; the comprehensive and integrated nature of that care; how to enhance prevention and early intervention services in order to reduce local community reliance on expensive and traumatic psychiatric emergency services; and positive and sustainable outcomes related to the care provided.

Existing Behavioral Health System Capacity and Service Gaps

Historically, Alaska has not provided a comprehensive continuum of behavioral health care. Instead the state has provided a spectrum of services that expand and contract based on time, geography, and funding.

Children and adolescents in the Child Welfare (CW) system are typically cared for in residential, Psychiatric Regional Treatment Facilities (PRTFs), or inpatient hospital services, sometimes in combination with support services. There are a growing number of children (whether in parental or state custody) being placed in out-of-state or out-of-region facilities, making family reunification efforts a challenge.

For those children at risk of coming into the CW system, there are very limited community prevention and early intervention services, which are managed separately from the treatment system, presenting yet another opportunity for service integration and continuum of care expansion. Community coalition efforts do exist in the most populous areas of Alaska to address issues such as fetal alcohol spectrum disorders, suicide, underage drinking, opioid addiction, and other substance abuse related issues. However, early intervention services are virtually non-existent for these "at risk" children.

For children already receiving residential services, there are very few step-up/step-down community-based vehicles for sub-acute services designed to (a) provide services within the child's home or in the child's community and (b) prevent repeated placement in residential and inpatient services far from the child's community and home.

There are currently no residential facilities in Alaska for adults with acute mental health needs, leaving inpatient psychiatric emergency services, inpatient psychiatric hospitals, emergency departments, and inpatient general hospitals as the primary location for services. There is limited availability of crisis intervention/stabilization services designed to identify and

intervene before costlier acute services are necessary.

Existing comprehensive community support services do not meet the continuing service needs of this population, including housing alternatives. There is no coordinated, integrated community-based system of care to allow seamless transitions across levels of care.

There are many gaps in the continuum of substance use disorder (SUD) treatment options for both youth and adults. Although outpatient SUD treatment is available through community and private providers statewide, the wait for treatment services is long for all but the highest priority populations. Referrals from courts, the Department of Corrections, primary care, schools, police, and clergy are bottlenecked in a behavioral health service system that is overloaded and has limited capacity. Prevention and early intervention services, where they exist, are not integrated into the continuum of treatment and recovery support services.

Community-based recovery support services exist only in the most populous regions of the state. There are no ambulatory withdrawal management services across Alaska, making the costlier (but limited) inpatient/residential withdrawal management services the only alternative. For youth, residential treatment is the only service option for almost half of the state. A key strategy for this waiver is to seek and successfully garner an exemption for Alaska Psychiatric Institute (API), Alaska's only public psychiatric hospital, and any adult residential SUD treatment facility in Alaska that exceeds 16 beds, from the Institute for Mental Disease (IMD) exclusion rule, in order to free up state general fund dollars that can then be redirected to community-based mental health and SUD services.

SUD Treatment programs offering Medication Assisted Treatment (MAT) are available in four communities throughout Alaska. MAT is provided by Office Based Opioid Treatment (OBOT) providers, Opioid Treatment Programs (OTPs), Tribal health organizations, and FQHCs. There are four OTP (methadone) providers providing MAT.

There are four methadone providers in Alaska. MAT services are in increased demand both because of the opioid abuse epidemic in Alaska, and because of the SB 91 criminal justice reform efforts for reentering citizens and pre-trial diversion.

A challenge for tracking and unifying the SUD continuum of care is the limited number of private physicians, psychiatrists, psychologists, other licensed clinical professionals, and private substance abuse professionals offering SUD services in the more populous areas of Alaska. Estimates from tracked Alaska court referrals, the only current data available, suggest that upwards of 50-75% of outpatient SUD treatment services are provided by these private provider types, yet these provider types are not coordinated and integrated with other provider types across the SUD system of care. It is unknown what level of counseling or other mental health services they provide. Under the demonstration, services will be coordinated, integrated, closely monitored and carefully managed and the state will work in close collaboration with the provider community.

Telehealth Services & Technology

Telehealth technology is both an asset and an added complexity for Alaska's behavioral health system. Tribal health organizations in Alaska have pioneered telemedicine and tele-behavioral health services. The Alaska Medicaid program currently pays for services through telemedicine if the service is covered under traditional, non-telemedicine methods and is provided by an eligible provider. Unfortunately, broadband capacity is limited in rural Alaska, causing challenges with widespread use of telemedicine. In addition, Electronic Health Record (EHR) systems vary across the state and do not always communicate well with one another. Not all health care providers use the health information exchange (HIE), which the state is actively working to expand. Complicating matters further, state-funded behavioral health providers report data via a separate system which does not communicate with Alaska's Medicaid Management Information System (MMIS). The waiver is proposing additional behavioral health telehealth capacity to build upon the transformative foundation developed by the Tribal health system, as well as seeking to better integrate provider EHR data and data sharing through the expansion of Alaska's HIE.

Alaska's Tribal Behavioral Health System Capacities

One of Alaska's strongest assets for improving the behavioral health of all Alaskans is the Tribal health system. Tribal Health Organizations leverage Indian Health Service funding with state grants, third party billing revenue, Alaska Medicaid billing revenue, and other funds to provide an array of behavioral health services and supports. There are 17 regions that comprise Alaska's Tribal health system, with behavioral health providers located in all but two of the 17 regions. Ten of the 17 behavioral health providers are also community health centers, providing a tremendous opportunity for integration of physical and behavioral health services.

In remote villages/communities throughout Alaska, prevalence rates and behavioral health needs are quite high and quickly overload capacity. The need to seek acute treatment services located outside of the community is the norm and creates even more of a disconnect between culture and treatment. Outpatient services are few and far between and crisis response and transportation services are extremely costly. Adding to this challenge are the limited supports for patients returning to the community, with discharge plans developed in urban, acute-care settings that do not reflect village/community realities.[23]

In small and medium population centers, existing clinicians are overwhelmed by service needs and lack of psychiatric inpatient capacity.[24] Individuals are usually transported out of region, and communication between care providers in villages/communities/small-medium population centers and urban treatment providers is often limited.[25]

[23] Agnew::Beck Consulting, LLC and Hornby Zeller Associates, Inc. Alaska Behavioral Health Systems Assessment Final Report, prepared for the Alaska Mental Health Trust Authority, 2016.
[24] Ibid.
[25] Ibid.

While Tribal Health Organizations offer a variety of services to address the behavioral health and SUD needs of Tribal members, there is a need to build on and enhance the availability of home-based family treatment options and community-based behavioral health and SUD services for all Alaska Natives/American Indians through Tribal Health Organizations. This demonstration proposal seeks to expand those service options for the Medicaid population.

Infrastructure Building Activities

Over the past several years, Alaska has been laying the groundwork for the change in Alaska's behavioral health system and preparing the health care community for the expansion of services and capacity expected through the Medicaid Section 1115 Demonstration Project:

- In 2015-2016, the Division of Behavioral Health (DBH) contracted for two readiness assessments – one for DBH staff and one for community behavioral health providers. These assessments identified capacities and infrastructures necessary to succeed in a transformed system of care. DBH initiated training and technical assistance in May 2017 to prepare Alaska for the impending transformation. Training continues for data and performance management training, working with an Administrative Services Organization (ASO), organizational preparedness and financial management/costing services. Future training topics include integration of physical and behavioral health care, clinical management, telehealth and use of digital/mobile technologies, continuous quality improvement, and systems thinking.

- The Alaska Medicaid Coordinated Care Initiative and the Medicaid Pharmacy and Therapeutics Committee (responsible for the preferred drug list and drug utilization review process) provide experience and guidance for the utilization control efforts planned for by the Section 1115 demonstration project.

- Extensive training and technical assistance has been offered since 2010 to embed trauma-informed practices in community behavioral health, corrections, domestic violence, and juvenile justice settings in support of efforts to integrate systems and improve the quality of services.

- The statewide Early Childhood Comprehensive Systems (ECCS) plan, currently serving Kodiak, Nome and its surrounding villages, and the Matanuska-Susitna Borough, provides research, evidence, and lessons in implementation to support the effort to enhance early intervention services and move towards universal screening for young children.

- The 2016 creation of a Tribal/State comprehensive strategic plan to transform child welfare outcomes for Alaska Native and American Indian children, including the provision of culturally specific services and supports to children in state custody, provides context for aligning behavioral health reform efforts.

- The Alaska Mental Health Board, Advisory Board on Alcoholism and Drug Abuse, and Alaska Behavioral Health Association conducted an in-depth review of reporting and administrative requirements for community behavioral health providers in 2014. Of the eleven concrete recommendations made to alleviate some of the administrative burden on providers, DBH has implemented three and made significant progress on four others.

- The Alaska Opioid Policy Task Force has issued a broad set of recommendations to prevent, treat, and support recovery from opioid misuse and addiction in Alaska. In 2016, DBH applied for and received a SAMHSA grant to expand MAT capacity to address the opioid crisis in Anchorage and Juneau.

Alaska continues to work diligently to prepare for behavioral health transformation. Through this Section 1115 demonstration proposal, the state will develop and implement an integrated, data-driven fiscally sustainable system of care that achieves the Triple Aim of improved patient experience, improved population health, and reduced costs as well as improved behavioral health outcomes for Alaskans.

Section 2: Transforming the Behavioral Health System in Alaska

2.1 Introduction

The goal of the Alaska Medicaid Section 1115 Behavioral Health Demonstration is to create a data-driven, integrated behavioral health system of care for Alaskans with serious mental illness, severe emotional disturbance, and/or substance use disorders. Because behavioral health challenges often stem from childhood trauma and other adverse experiences and have downstream effects on entire families that translate to higher costs associated with subsequent acute care and chronic health needs, this proposal also aims to establish networks of support for individuals and family members. The state will achieve these goals by creating a more robust continuum of behavioral health care services with emphasis on early interventions, community-based outpatient services, inpatient residential treatment when appropriate, and enhanced peer recovery supports. This proposal focuses on establishing an enhanced set of benefits for three target populations of Medicaid recipients: 1) Children and adolescents who are interacting or at risk of interacting with the child welfare system or the Division of Juvenile Justice system (as identified using indicators from the Alaska Longitudinal Child Abuse and Neglect Linkage Project[26]); 2) Individuals with acute mental health needs; and 3) Individuals with substance use disorders. Waiver goals and objectives for each of the populations are described in Section 2.4 below.

2.2 Target Populations and Rationale

This Section 1115 demonstration proposal focuses on enhancing services for individuals in three subpopulations within Alaska's Medicaid and CHIP programs.

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

A significant proportion of Alaska's children and adolescents encounter the child welfare system or juvenile justice system at some point in their upbringing. This waiver would provide an important vehicle for strengthening the support system for these young people in hopes of anticipating and preventing crises and reducing the need for out-of-home placements over time. Individuals in this target population are currently in the custody or under the supervision of the Alaska Department of Health and Social Services' Office of Children's Services, the Division of Juvenile Justice, or in tribal custody; formerly in kinship care, foster care, or residential care; and at risk of an out-of-home placement, and include:

[26] Parrish, J.W., Shanahan, M.E., Schnitzer, P.G. et al. Inj. Epidemiology. (2017) 4:23. Found at https://doi.org/10.1186/s40621-017-0119-6

- Individuals up to age 21 who have a child-specific or parental mental health or substance use disorder that has been treated within the past year; or

- Children and youth who have utilized an inpatient psychiatric hospital, inpatient general hospital mental health or substance use service, or residential treatment episode within the past year; or

- Children and youth who have been identified through positive responses to evidence-based mental health and SUD screening questions indicating an increased likelihood that a mental health and/or SUD symptom exists and needs further assessment and evaluation; and

- Individuals with complicating life circumstances including inadequate housing, negative family circumstances, or other psychosocial complications including unwanted pregnancy, inadequate family and peer support, or history of incarceration.

Rationale: The state is targeting this population as an early intervention strategy, which represents a significant shift in the approach to delivering behavioral health services. Alaska's children are 56% more likely to be abused than the national average and 66% of Alaskan adults report one or more adverse childhood experience growing up. In calendar year 2016, one in 10 Alaska children were reported to child protection services (CPS) regarding child abuse or neglect. Twenty-five percent of births experienced a first screened-in report to the Office of Children's Services (OCS) before age seven and one in every 12 births experienced a first substantiated report to OCS before age seven. Alaska also has high rates of repeat child maltreatment as compared to the national average.[27] In addition:

- Between 2012 and 2017, the number of children in foster care in Alaska increased by 62%, from 1,860 to approximately 3,000;[28]
- The number of Alaska children in out-of-home placements increased 67% between 2012 and 2016, from 2,758 to 4,137;[29] and
- American Indian/Alaska Native children are disproportionately over-represented in Alaska's foster care system, comprising 17.8% of the children in the state and 46.6% of the children in foster care.[30]

[27] Alaska Department of Health and Social Services, Office of Children's Services from dhss.alaska.gov/ocs/Documents/statistics/webdata/mainOohYr.pdf.
[28] Adoption and Foster Care Analysis and Reporting System, United States Department of Health and Human Services' Administration on Children and Families from AFCARS-STATE-DATA-TABLES-FY 2015 and from dhss.alaska.gov/ocs.
[29] Alaska Department of Health and Social Services, Office of Children's Services from dhss.alaska.gov/ocs/Documents/statistics/webdata/mainOohYr.pdf.
[30] National Indian Child Welfare Association. 2017. *Disproportionality Rate of AI/AN Children in Foster Care* from ruralhealthinfo.org.

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

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

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

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

The behavioral health system in Alaska does not sufficiently meet the needs of individuals who experience mental health disorders, particularly for individuals like Martha, with complex co-morbidities or dual diagnoses of intellectual, developmental, or sensory disabilities. This waiver proposal seeks to enhance the availability of mental health treatment and prevention services to transitional age youth and adults enrolled in Medicaid in Alaska. The individuals in this target population are between 18-64 years of age and have:

- A Diagnostic and Statistical Manual of Mental Disorders (DSM-5 or the most current version of the DSM) mental disorder; and
- Utilized three or more of the following acute intensive services in the past year:
    - Inpatient psychiatric hospital stay;
    - Inpatient mental health or substance abuse general hospital stay;
    - Inpatient hospital medical/surgical, non-delivery, inpatient maternity delivery, and other inpatient stay;
    - Outpatient general hospital emergency room visit; or
    - A yet-to-be-determined proxy for villages.

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

- Of the 42,123 Medicaid enrollees served in SFY 2016, 28,937 received treatment for a mental health disorder;
- 20% of Alaskan adults experience a diagnosable mental health disorder each year;
- 21.4% of Alaskan adults report growing up in a household with one or more adults experiencing mental illness;
- 29.7% of Alaskan adults report growing up in a household with one or more adults

abusing alcohol and/or other drugs;

- 19.5% of all Alaskan adults – and 28.4% of Alaska Native adults – report four or more adverse childhood experience growing up;
- Alaska's suicide rate of 27.1/100,000 in 2015 was more than twice the national rate (12.32/100,000);
- 22% of the Alaska Corrections population in SFY 2012 experienced a mental health disorder;
- 18% of individuals with five or more hospitalizations between 2012 and 2015 had a behavioral health diagnosis – the most common disease category across all admissions;[31] and
- Analysis of 2016 Emergency Department Super-Utilizers reveal that the top 1.1% of ED users account for 8.6% of charges and two of the eight most common principal diagnoses among the top 1.1% include alcohol-related disorders and anxiety disorders.[32]

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

Limited access to behavioral health providers and services has led to a fragmented and crisis-driven system of care that frequently misses opportunities to engage adults with behavioral health needs that present in the health care, public safety, judicial, and correctional systems. The result is a system that often pays for behavioral health services at the highest level and cost of care, and where individuals and families often go without needed treatment and recovery services.

<u>Group 3: Adolescents and Adults with Substance Use Disorders</u>

Like all states, Alaska has experienced an uptick in the number of individuals dealing with substance use disorders and the associated rate of deaths due to opioid overdose. Alaska has the 10th highest prevalence rate of adult binge drinking in the country and the 5th highest rate of intensity of binge drinking among adults.[33] Importantly, as noted above, the rate of alcohol-related mortality for Alaska Natives is more than three times (71.4/100,000) that of all Alaskan

[31] The Menges Group. *Assessment of Medicaid Reform Options.* Report for the Alaska Legislative Budget and Audit Committee. March 24, 2016.
[32] Alaska Department of Health and Social Services, Division of Public Health, Health Analytics & Vital Records. *Alaska Facts and Figures—2016 Emergency Department Super-Utilizer Facts.*
[33] 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).

adults (20.4/100,000) and is eight times the national rate (8.5/100,000).[34] Alaska Native youth ages 10-17 years old are 2.7 times more likely to be hospitalized for unintentional alcohol poisoning than a non-Alaska Native peer.[35] While our opioid crisis has emerged relatively recently, our alarming alcohol-related prevalence rates have remained constant over a much longer period of time.

This waiver proposal seeks to enhance the availability of and provide a more comprehensive continuum of substance use disorder treatment for adults, as well as adolescents and children enrolled in Medicaid in Alaska. The waiver will target individuals between 12 and 64 years of age who:

- Have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM-5 or the most current version of the DSM) for substance-related and addictive disorders.

Rationale: Like many states, Alaska continues to experience increases in opioid use and abuse. According to the State of Alaska Epidemiology Section, the rate of heroin poisoning resulting in hospital admissions doubled between 2008 and 2012 and between 2008 and 2013, the number of heroin-associated deaths more than tripled in Alaska. In 2012, the rate of heroin-associated deaths in Alaska was 42% higher than that for the U.S. overall (2.7 per 100,000 vs. 1.9 per 100,000, respectively). Admissions to publicly funded SUD treatment for heroin dependence increased 58% between 2009 and 2013. The majority of those individuals seeking treatment were age 21-29.[36]

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

The state considers SUD treatment to be a key component of behavioral health reform. In a 2017 Alaska Opioid Policy Task Force report, stakeholders pointed to primary prevention

[34] AK-IBIS Health Indicator Report of Alcohol-Induced Mortality Rate, Alaska Division of Public Health, Department of Health and Social Services (*citing* data from the Alaska Health Analytics and Vital Records, Alaska Division of Public Health and Centers for Disease Control and Prevention).
[35] BRFSS-2015-AK IBIS-*Youth (10-17)—Alcohol Poisoning-Hospital*
[36] Alaska Opioid Policy Task Force recommendations, which cited: Health Impacts of Heroin Use in Alaska, State of Alaska Epidemiology Bulletin, July 14, 2015).

policies supporting "upstream" efforts to improve the overall health and wellness of individuals across the lifespan that can help reduce the risk of opioid use, misuse, and abuse at the population level. Access to appropriate levels of treatment when a person seeks help, as close to home as possible, is critical to helping Alaskans move from opioid dependence to recovery.

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

2.3 Intervention Strategies and Benefit Design

Under the demonstration, Alaska would implement a series of proposed strategies and evidence-based interventions aimed at more effectively addressing the needs of each of the target populations. The benefits for all target populations are designed to decrease use of acute, costly services by conducting universal screenings; intervening early, when symptoms are first identified; utilizing sub-acute, community-based step-up/step-down clinical services as alternatives to residential and inpatient services; and developing community-based supports to maintain recovery, health and wellness. New Medicaid-covered services under the waiver will establish a robust continuum of care designed to anticipate and address the range of behavioral health needs of the target populations. Several of the new services will be available for all three target populations (such as standardized screenings, intensive case management, and mobile crisis response services), while some services are unique to the age and needs of specific populations. Please note that wherever possible, the state will support the provision of waiver services by Community Health Aides/Practitioners (CHA/Ps) and Behavioral Health Aides/Practitioners (BHA/Ps) as long as the services are within the CHA/P and BHA/P scope of practice.

At the end of this section, Table 1 summarizes the new services that would be available across all target populations, and Table 2 describes the SUD-specific services.

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

- **Screening and assessment services***. The state will require the use of **standardized mental health and SUD screening instruments**. Services will be reimbursed for all beneficiaries presenting at a service setting for the first time, regardless of setting

*The state will convene a workgroup in coordination with the ASO comprised of Tribal, state, community representatives charged with determining the specific evidence-based screening and assessment tools to be used, including those that are culturally-appropriate.

(this benefit will be accessed through the state plan EPSDT benefit for this population). Universal screening is designed to identify children with behavioral health symptoms that may require clinical assessment and referral to treatment. An **evidence-based clinical assessment** will provide a comprehensive clinical picture of an individual's functioning across multiple domains that integrate results from clinical interviews, behavioral observations, clinical record reviews, and collateral information. Assessments would be used to develop diagnoses and treatment plans in a culturally appropriate manner and include at a minimum, assessment of mental health status, substance use, functional capacity, strengths, and service needs.

- **Community-Based Outpatient Services.** These services are designed to reduce use of inpatient hospitalization and residential services and avert Adverse Childhood Experiences (ACEs) by supporting at-risk families with treatment and wrap-around services in the child's home. These services will be culturally and linguistically appropriate and designed to assist individuals and families in sustaining recovery and promoting family stability. The level of intensity for services will be based on a comprehensive family assessment, which would guide services and supports and is designed to ensure that the child and family have a full understanding of the discharge plan, measure the family's commitment to the discharge plan, evaluate strengths and needs, and create a service plan. Specific community-based outpatient services will include:

    - **Intensive case management services** will be available and include evaluation, outreach, support services, patient advocacy with community agencies, arranging services and supports, teaching community living and problem-solving skills, modeling productive behaviors, and teaching patients to become self-sufficient.

    - **Mental health day treatment** services are outpatient services specifically designed for the diagnosis or active treatment of a mental disorder when there is a reasonable expectation for improvement or when it is necessary to maintain a child's functional level and prevent relapse or full hospitalization.

    - **Home-based family treatment services** are unique services proposed for this target population. Family therapy services would be available for all levels. Other services include individual therapy, crisis intervention, medication services, parenting education, conflict resolution, anger management, and ongoing monitoring for safety and stability in the home. Two different levels of home-based family treatment would be offered: Level 1 home-based family treatment services are provided for children at moderate risk of out-of-home placement, and Level 2 home-based family treatment services are provided for children at high risk of out-of-home placement. Level 3 services would focus on family therapy. These home-based family treatment services are designed for children at high risk for residential placement – pre-residential treatment or post-residential treatment.

- **Acute Intensive Services.** In order to provide a full continuum of services to address child and adolescent behavioral health needs, the state also plans to include acute intensive services in the demonstration. These services are intended to serve children and adolescents in crisis.

    - **Mobile outreach and crisis response services** are designed to effectively and appropriately intervene in a mental health and/or substance use disorder crisis. Clinical professionals will meet face-to-face with the individual experiencing the crisis (and when appropriate, his or her family and/or support system) wherever the crisis occurs, assess, and deescalate the situation, and refer individuals to the appropriate services.

    - **23-hour crisis stabilization services** will also be made available for children and adolescents in crisis. These are services for up to 23 hours and 59 minutes of care in a secure and protected environment. The program is clinically staffed, psychiatrically supervised, and includes continuous nursing services. The primary objective is for prompt evaluation and/or stabilization of individuals presenting with acute symptoms or distress. Services include a comprehensive assessment, treatment plan development, and crisis intervention services necessary to stabilize and restore the individual to a level of functioning that does not require hospitalization.

    - **Residential treatment services** will continue to be provided for children and adolescents, but will be modified based on clinical standards aimed at shortening lengths of stay due to the availability of new step-up and step-down services. This residential component of the continuum of care will also include crisis residential and stabilization services. This includes a medically-monitored, short-term, residential program in a state-approved facility that provides 24/7 psychiatric stabilization services that will also be supplemented by step-up and step-down treatment.

    - **Therapeutic foster care services** are new services unique to this target population that will be made available for youth who are in state custody or foster care. These services are clinical interventions that include placement in specifically trained foster parent homes for children ages 0-18 who are in foster care or in the custody of the juvenile justice system and have severe mental, emotional, or behavioral health needs. Therapeutic foster care includes medically necessary treatment interventions based on an individualized treatment plan guided by a state-selected level of care assessment tool. Services include individual and family therapy, medication services, crisis services, and care coordination.

- **Community and Recovery Support Services.** These new services will be aimed at assisting children and adolescents (and when appropriate, the family and/or support system) to sustain recovery and promote family stability. Services will include recovery

coaching, employment support, social/cognitive/daily living skill building, mentoring, and relapse prevention.

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

- **Screening and Assessment services**. Like Group 1, the state will also offer **standardized mental health and SUD screening instruments** for transitional age youth and adults. Services will be reimbursed for all beneficiaries presenting at a service setting for the first time, regardless of setting. An **evidence-based clinical assessment** will provide a comprehensive clinical picture of an individual's functioning across multiple domains that integrate results from clinical interviews, behavioral observations, clinical record reviews, and collateral information.

- **Community-Based Outpatient Services.** Services in this category for transitional age youth and adults will include **intensive case management services** and **mental health day treatment.** These services are outpatient services specifically designed for the diagnosis or active treatment of a mental disorder when there is a reasonable expectation for improvement or when it is necessary to maintain an adult's functional level and prevent relapse or full hospitalization.

    - **Assertive Community Treatment (ACT)** services are unique to this target population. ACT services are designed to provide treatment, rehabilitation, and support services to individuals who are diagnosed with a severe mental illness and whose needs have not been well met by more traditional mental health services. The ACT team provides services directly to an individual that are tailored to meet his or her specific needs. ACT teams are multi-disciplinary and include members from the fields of psychiatry, nursing, psychology, social work, substance abuse treatment, and vocational rehabilitation. Based on their respective areas of expertise, the team members collaborate to deliver integrated services of the recipients' choice, assist in making progress toward goals, and adjust services over time to meet recipients' changing needs and goals. The staff-to-recipient ratio is low (one clinician for every 10 recipients), and services are provided 24 hours a day, seven days a week, for as long as they are needed.

- **Acute Intensive Services.** Similar to the acute intensive services offered to Group 1, the state plans to offer Group 2 **mobile crisis response services**, **23-hour crisis stabilization services,** and **continue residential treatment services** (modified to clarify clinical standards aimed at shortening lengths of stay due to the new step-up and step-down services). Two new types of acute intensive services will be offered to Group 2:

    - **Peer-based crisis intervention services** are services provided in a calming environment by people who have experienced a mental illness or substance use disorder and are designed for individuals in crisis. They are delivered in community

settings with medical support and can be used in the event that there is a wait list for services.

- **Crisis residential/stabilization services** are medically-monitored, short-term residential programs in a state-approved facility that provides 24/7 psychiatric stabilization services.

- **Community and Recovery Support Services**. Like Group 1, Group 2 will also have access to community and recovery support services aimed at sustaining recovery.

Group 3: Adolescents and Adults with Substance Use Disorders

- **Screening and Assessment services**. Not unlike screening and assessment tools that will be utilized for Groups 1 and 2, Group 3 will be offered **standardized mental health and SUD screening instruments** designed to identify children and adults with SUD symptoms that may require clinical assessment and referral to treatment. SUD screenings would be required and reimbursed for all beneficiaries presenting at a service setting for the first time, regardless of setting. Screening services will include the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model (ASAM Level 0.5), which is a comprehensive, integrated public health approach to early intervention and treatment services for people with SUD, as well as those who are at risk of developing these disorders. It is designed to facilitate integration of SUD and primary care services and includes:

  - Screening to quickly assess the severity of substance use and identify the appropriate level of treatment;
  - Referral to treatment for those identified as needing more extensive treatment; and
  - Brief intervention to focus on increasing insight and awareness regarding substance use and motivation toward behavioral change.

  When necessary, **evidence-based clinical assessments** would be conducted to provide a comprehensive clinical picture of an individual's functioning across multiple domains that integrates results from clinical interviews, behavioral observations, clinical record reviews, and collateral information. Assessments will be used to develop diagnoses and treatment plans in a culturally appropriate manner and include, at a minimum, assessment of mental health status, substance use, functional capacity, strengths, and service needs.

- **Community-Based Outpatient Services.** Like Groups 1 and 2, **intensive case management** services will also be offered to Group 3. New services unique to the Group 3 target population will include:

- **Medication-Assisted Treatment (MAT)** (ASAM Level 1.0) service will include injectable Naltrexone or any other medication that is currently approved. Extended-release injectable Naltrexone is a microsphere formulation of the opioid antagonist (blocker) medication Naltrexone, which blocks the effects of opioid medication, including pain relief or feelings of well-being that can lead to opioid abuse.

  Services would also include **MAT care coordination** services, which is the deliberate organization of patient care activities between two or more participants involved in a patient's care to facilitate the appropriate delivery of integrated SUD and primary health care services. The patient must be in attendance, either in person or telephonically. Care coordination involves a team that provides a wide range of services addressing patients' health needs, including medical, behavioral health, social, and legal services, as well as long-term supports and services, care management, self-management education, and transitional care services.

- **Ambulatory withdrawal management** (ASAM Withdrawal Management Levels 1 and 2) will be offered. ASAM notes that all but the most severe withdrawal symptoms can be managed effectively on an ambulatory (outpatient) basis. Level 1 withdrawal management is an organized outpatient service delivered in an office setting, health care or addiction treatment facility, or in a patient's home by trained clinicians who provide medically-supervised evaluation, withdrawal management, and referral services according to a pre-determined schedule. Level 2 withdrawal management services are provided in an office setting, a general health care or mental health facility, or an addiction treatment facility (not a patient's home) by medical and nursing professionals directly.

- **Intensive outpatient SUD services** (ASAM Level 2.1) will include outpatient services delivered by addiction professionals or addiction-credentialed clinicians, which provide a planned regimen of individual/group/family therapy with regularly scheduled sessions within a structured program.

- **Acute Intensive Services.** Similar to Groups 1 and 2, services in this category for children and adults with SUD will include **mobile crisis response services** (services designed to effectively and appropriately intervene in a SUD crisis, wherever the crisis occurs). Group 3 will also have access to **peer-based crisis services** (services provided by people who have experience living with SUDs).

  - **Adult residential treatment services** (ASAM Level 3.3) will continue to be provided, but will be modified to clarify clinical standards aimed at shortening length of stay due to the step-up and step-down services offered in this benefit. **Adult and youth residential treatment services** (ASAM Level 3.5) are new under the demonstration.

- **Community and Recovery Support Services**. Group 3 will also have access to community and recovery support services aimed at sustaining recovery.

Table 1: New Medicaid Services by Population

This table summarizes the proposed new Medicaid services. Services in yellow are common across multiple target population groups.

	Group 1	Group 2	Group 3
Screening and assessment	Standardized screening instruments	Standardized screening instruments	Standardized screening instruments
	Evidence-based clinical assessment	Evidence-based clinical assessment	Evidence-based clinical assessment
Community-based outpatient services	Intensive case management services	Intensive case management services	Intensive case management services
	Mental health day treatment	Mental health day treatment	
	Home-based family treatment services	Assertive Community Treatment (ACT)	Medication-Assisted Treatment (MAT) and MAT care coordination
			Ambulatory withdrawal management
			Intensive outpatient SUD services
Acute intensive services	Mobile crisis response services	Mobile crisis response services	Mobile crisis response services
	23-hour crisis stabilization services	23-hour crisis stabilization services	
		Peer-based crisis intervention services	Peer-based crisis intervention services
	Residential treatment services	Residential treatment services	Residential treatment services (ASAM Level 3.3)
	Therapeutic foster care services	Crisis residential/ stabilization services	Adult and youth residential treatment

			services (ASAM Level 3.5)
Recovery support services	Community and recovery support services	Community and recovery support services	Community and recovery support services

Table 2: Proposed Alaska SUD Services by ASAM Level of Care

ASAM Level of Care	ASAM Service Title	ASAM Brief Definition	Is this an existing Medicaid service?	Is this a new Medicaid service under the Waiver?	Regulatory Citation for New Services
0.5	Early Intervention	Screening, Brief Intervention, and Referral to Treatment (SBIRT).	No	Yes	42 CFR §440.130
2.1	Intensive Outpatient Services	Nine or more hours of service/week (adults); six or more hours/week (adolescents) to treat multidimensional instability.	No	Yes	42 CFR §440.130
3.5	Clinically Managed High-Intensity Residential Services—Adults; Clinically Managed Medium-Intensity Services--Youth	24-hour care with trained counselors to stabilize multidimensional danger and prepare for OP treatment; able to tolerate and use full active milieu; for youth, have psychoeducational model for conditions such as personality vulnerabilities, disruptive behaviors, educational difficulties, family conflicts and chaotic home situations; requires daily clinical services and at least 10 hours of	No	Yes	42 CFR §440.130

		clinical service/week.			
1-WM	Ambulatory Withdrawal Management Without Extended On-site Monitoring	Mild withdrawal with daily or less than daily outpatient supervision.	No	Yes	42 CFR §440.130 §440.50 §440.60 §440.90
2-WM	Ambulatory Withdrawal Management with Extended On-site Monitoring	Moderate withdrawal with all day withdrawal management/ support and supervision; at night has supportive family or living situation.	No	Yes	42 CFR §440.130 §440.50 §440.60 §440.90

2.4 Waiver Goals and Objectives

The Alaska Behavioral Health Medicaid Section 1115 Demonstration seeks to provide Alaskans with a comprehensive suite of cost-effective, high quality behavioral health services designed to ensure access to the right services at the right time in the right setting.

We have six overarching goals specific to behavioral health reform, three of which are cross-cutting goals across all populations and one population-specific goal for each of our three population groups. These goals, while conceptually consistent with the Medicaid reform goals identified in the stakeholder engagement process (and stated in Section 1 of this application), have been refined with more precise and measurable language.

Cross-Cutting Goals:

1. Rebalance the current behavioral health system of care to reduce Alaska's over-reliance on acute, institutional care and shift to more community- or regionally-based care:
    a. Decrease inpatient hospital and emergency department care episodes;
    b. Decrease use of residential out-of-home placements;
    c. Increase regionally-based capacity for a continuum of intensive outpatient, day treatment, intensive case management, community and recovery support, home-based family supports, assertive community treatment, and ambulatory withdrawal management services; and
    d. Develop community-based, culturally appropriate behavioral health workforce capacity (i.e., implement additional Medicaid-reimbursed behavioral health provider types) to address existing workforce deficits.

2. Intervene as early as possible in the lives of Alaskans to address behavioral health symptoms before they cascade into functional impairments:
    a. Provide universal screening to identify symptoms;
    b. Provide brief, solution-focused interventions to prevent the need for acute care referrals; and
    c. Provide care as close as possible to the homes or regional-hub communities of Alaskans.

3. Improve overall behavioral health system accountability by reforming the existing system of care, including:
    a. Contracting with an Administrative Services Organization (ASO) to manage Alaska's efforts to reform its existing system of behavioral health care based on cost, utilization, and outcomes data;
    b. Improving the consistency of screening, assessment, and service/placement decisions through use of evidence-based and evidence-informed tools;
    c. Standardizing and streamlining documentation requirements to reduce duplication of effort and facilitate coordination of care across all providers;

d. Supporting provider development of infrastructures necessary to coordinate care, report and achieve performance/quality measures, report per capita behavioral health costs, and improve participant outcomes; and
e. Integrating mental health and SUD services and systems.

Population-Specific Goals and Objectives:

1. Group 1: Increase access to robust and sustainable community- or regionally-based and culturally appropriate outpatient treatment services that have been designed to promote family wellness, stability and reunification, and child health and development.
    a. Treat children and their families in their home environment to the maximum extent possible by:
        1) Providing access to family-based and peer-based in-home supports and evidence-based family therapy;
        2) Providing behavioral, developmental, and, when necessary, trauma-informed screenings and monitoring of wellness and development for children and youth at risk of or showing early signs of behavioral health symptoms/needs to ensure timely referrals and improved access to care; and
        3) Providing intensive coordination and wraparound services to develop comprehensive, individualized home-based treatment plans for children, youth, and families who are experiencing serious behavioral health issues.
    b. Reduce the number of out-of-home placements;
    c. Reduce the number of children/youth in Office of Children's Services custody; and
    d. Reduce the number of children/youth under Division of Juvenile Justice supervision.

2. Group 2: Increase access to local crisis and community- and regionally-based sub-acute treatment and wrap-around services designed to prevent over-utilization of deep-end, acute services:
    a. Reduce the number of mental health-related emergency department visits;
    b. Reduce the number of inpatient psychiatric hospital readmissions;
    c. Implement Assertive Community Treatment in those communities with high utilizers of inpatient and emergency department services;
    d. Reduce transportation costs out of the participant's home community or regional hub for behavioral health treatment; and
    e. Develop local and regional psychiatric emergency crisis residential capacity in order to allow the state's only public psychiatric hospital (Alaska Psychiatric Institute) to transition from its current role as a short-term, acute care psychiatric hospital for the entire state back to its intended role as a tertiary care facility. The goal is for API to be able to meet the needs of Alaska's complex,

seriously mentally ill patients who need longer lengths of stay in order to stabilize and return safely to their homes or regions and reducing API's current readmission rates of over 33% within 180 days of discharge.

3. Group 3: Increase access to a comprehensive continuum of SUD services designed to maintain individuals in community settings and to address long-standing gaps in services and needs related to Alaska's opioid crisis:
    a. Implement Screening Brief Intervention Referral Treatment in each regional hub;
    b. Increase MAT capacity to address both the alcohol dependent population and the opioid abusing population;
    c. Provide care coordination services to improve integration of SUD with primary health care;
    d. Increase Alaska's repertoire of community- or regionally-based services designed to promote recovery and resiliency, including ambulatory withdrawal management, SUD intensive outpatient, and community and recovery supports;
    e. Utilize ASAM Criteria to place Medicaid target populations in the right setting at the right time; and
    f. Increase access to peer supports (including peer-based crisis services) designed to sustain recovery in the community.

2.5 Partnership with Administrative Services Organization

Under the waiver, the Department of Health and Social Services (DHSS) will contract with an Administrative Services Organization (ASO) as the service delivery reform effort designed to manage the enhanced behavioral health system. The ASO will be a third-party organization with specialized expertise in integrated behavioral health systems management. DHSS will contract with the ASO through a competitive bidding process to provide certain specified administrative services necessary to manage Alaska's behavioral health system of care on the department's behalf.

The completed Division of Behavioral Health and provider readiness assessments indicate that Alaska does not currently possess the capacity necessary to support the system of care envisioned. An ASO will provide the specialized expertise to manage a comprehensive behavioral health system and to oversee important provider network capacity development. Specific goals for the ASO include:

1. Increasing regional access to appropriate behavioral health services;
2. Improving health outcomes for all publicly funded beneficiaries of behavioral health services (i.e., Medicaid and non-Medicaid (state and federal grant-funded behavioral health programs); and
3. More efficiently and effectively managing the cost of behavioral health service delivery in Alaska.

The state is in the process of finalizing the exact services to be provided by the ASO. The following administrative support services are being considered: Participant Eligibility and Enrollment; Utilization Management; Provider Network Capacity Development and Support; Participant Outreach, Communication, and Support; Quality and Outcomes Management; Data Management; Claims Processing; and IT System Requirements. The ASO will have explicit contractual responsibilities for helping to achieve each demonstration goal.

The ASO's care management infrastructure will ensure cost-effectiveness and accountability across all levels of care. Health outcomes will be improved through earlier interventions and better coordination of care and the system will, by the end of the demonstration, be managed based on health outcomes supported by real-time data collection and reporting.

The state's current data reporting systems do not yet provide the accountability envisioned for a transformed system of care – data, outcomes, and cost management capacities need to be improved. The current data system does not accurately depict services, utilization, cost, and outcomes. Not all providers report data beyond the Division of Behavioral Health's minimum data requirements. This is another important reason to contract with an ASO with established data systems that report service utilization, costs, and outcomes. Data, cost, and outcomes management, like service integration and access management, will be contract requirements of the ASO. The ASO will be required to work closely with Tribal Health Organizations, honoring the unique government-to-government relationship of Tribes with the State of Alaska.

2.6 Workforce Development and Training

The proposed continuum of care for mental health and SUD services is based on a comprehensive set of evidence-based models and interventions. As part of the implementation process, Alaska DHSS will require that all providers of behavioral health and SUD services meet specified criteria, including ASAM requirements, prior to participating in the Medicaid waiver program.

Alaska DHSS will work with the contracted ASO and providers to ensure that licensing, credentialing, and training requirements align with waiver requirements. Because standards of care are continually updated, the state will also work with the ASO and providers to establish and update standards of care for behavioral health and SUD services that incorporate industry benchmarks for defining medical necessity criteria, covered services, and provider qualifications.

Although Alaska has significant challenges with recruitment and retention of a qualified behavioral health and SUD workforce, the state has several resources, coalitions, and initiatives underway focused solely on increasing the capacity of the state's health care workforce.

Alaska is unique in the sense that it has an entity called the Alaska Mental Health Trust Authority (the Trust). The Alaska Mental Health Enabling Act of 1956, legislation passed by Congress during Alaska's transition to statehood, transferred the responsibility of providing mental health services from the federal government to the territory of Alaska (and ultimately the state). The holdings, timber, and mineral rights of one million acres of dedicated Trust land generate income to help pay for a comprehensive and integrated mental health program in Alaska.

In 2010, the Trust developed a health care workforce development plan that addresses the challenge of assuring a well-prepared and sufficient workforce to meet Alaskans' health care needs. The Trust identified four key strategies: engagement, training, recruitment, and workforce retention. The action agendas focus important initiatives towards addressing the need for more behavioral health clinicians in Alaska, as well as expanding the knowledge base of those in and entering practice. The plan includes focusing on the expansion of educational opportunities for health professionals, loan forgiveness programs, and state provider regulation changes.

Recently, the Trust allocated funds to support an initiative aimed at creating a platform for training early childhood mental health providers. The Alaska Association for Infant and Early Childhood Mental Health (AK-AIMH), in partnership with the University of Alaska Anchorage's Center for Human Development and the Alaska Area Health Education Centers, will develop a program plan for a Training Hub that will provide education and training to professionals, paraprofessionals, families and consumers on infant and early childhood mental health (IECMH) approaches and practices. The goal of the Training Hub is to build capacity to work with infants, young children and their families and increase early intervention and resolution of mental health issues in young children and their families. This increased capacity will help to ensure that young children and their families have access to high quality services and supports.

Training will emphasize a trans- and inter- disciplinary approach to embedding IECMH expertise in practices across health, behavioral health, education, and social service systems. Reflective supervision, which is foundational in helping practitioners more effectively engage families and implement treatment models, will be included in the plan.

Expansion of Educational Opportunities

Through public and private postsecondary education institutions in the state, Alaskans currently have access to education and training in more than 80 health care occupations. This combination of local jobs, opportunity for advancement and access to in-state training makes the health care industry a primary mover in putting Alaskans to work. For example, the Behavioral Health Career Pathway Program is a statewide program focused on "growing our own" Alaska health care professionals with a specific focus on rural and underserved locations and populations.

Developed in response to industry needs, the Alaska Area Health Education Center (AHEC) began to focus on creating a behavioral health workforce comprised of young Alaskans. AHEC has partnered with the Alaska Native Tribal Health Consortium and local behavioral health providers across the state to develop and run one-week summer camps for students ages 15-19 years old that focus on behavioral health topics including substance abuse, self-care, grief, mental illness, and related career opportunities. Camps have been offered in Utgiagvik (Barrow), Anchorage, Fairbanks, Bethel, Nome, and Ketchikan. Since 2015, the Behavioral Health Career Pathway Program has had 86 participants, 79% of whom have reported an increased interest in behavioral health after the camp and 96% reported an increase in knowledge about BH after the camp. AHECs in Montana & Washington are now modeling similar programs in their states.

In addition, The Alaska Primary Care Association has begun a registered apprenticeship program for Community Health Workers (CHWs). Currently there are 11 apprentices at six sites with six mentors/supervisors. The CHW will be responsible for helping individuals and their families to navigate and access community services, other resources, and adopt healthy behaviors. The CHW supports providers and the care management coordinator through an integrated approach to care coordination and community outreach. CHWs provide social support and informal counseling, advocate for individuals and community health needs, and provide various integrated services as well has community outreach, screenings and home visits.

The Alaska Native Tribal Health Consortium, with assistance from the Trust, has created a Behavioral Health Aide (BHA) training program to promote behavioral health and wellness in Alaska Native individuals, families and communities through culturally relevant training and education for village-based counselors. Behavioral Health Aides work with partners across the state to provide education and assistance for much-needed, community-based behavioral health and wellness services. BHAs are counselors, health educators and advocates who help to address individual and community-based behavioral health needs, including those related to alcohol, drug, and tobacco use as well as mental health issues such as, grief, depression, suicide, and related issues. BHAs seek to achieve balance in the community by integrating their training with a sensitivity to local cultural needs.

Advanced Level Practitioners

Alaska's documented, substantial burden of mental health disorders, substance use disorders, complex trauma and co-occurring disorders is driving the need for an adequate supply of advanced clinical providers. This group includes psychiatrists, psychologists, advanced practice social workers and nurses, licensed counselors, licensed marriage and family therapists, and addiction specialists.

One initiative to expand the workforce was the development of a PhD in Clinical Psychology program at the University of Alaska (UAA), as well as a distance-delivered Master's in Social Work program. In addition, the Alaska Psychology Internship Consortium (AK-PIC) was developed to allow students in the UAA and University of Alaska Fairbanks program, as well as doctoral students from other psychology programs who wish to train and work in Alaska, to

complete an American Psychiatric Association- (APA-) accredited internship program in Alaska. An APA-accredited internship ensures high standards of training for future Alaska psychologists. The Alaska Psychology Internship Consortium obtained APA accreditation in FY 2013.

During AK-PIC's first seven years, a total of 34 UAA/UAF doctoral students have applied for internship positions within AK-PIC, and 23 of those applicants have filled AK-PIC internship slots. Thirty-three of the remaining AK-PIC positions across the first seven years have been filled by out-of-state applicants and two of the positions were filled with applicants returning to their home state of Alaska after studying in a doctoral program outside of the state. Thus, in its first seven years of existence, AK-PIC has provided an opportunity for 68% of the internship-ready UAA-UAF psychology doctoral student applicants to complete their training in state and has recruited 33 new doctoral psychology interns into the state.

AK-PIC maintains data regarding the in-state retention of its graduates. Of the 55 AK-PIC graduates through FY 2016-2017, 40 (73%) accepted their first position in-state to begin their professional careers, obtaining employment in behavioral health agencies (33/83% are still working in Alaska). Eighteen of these interns (55%) are practicing in rural Alaska and all of the interns are focused on serving culturally diverse and underserved populations.

Continuing Education

The Alaska Training Cooperative (AKTC) is a collaborative effort with the Trust, UAA, and providers across the state. The AKTC, administered under the UAA College of Health's Center for Human Development, is responsible for providing non-academic trainings, professional development and continuing education programs to Alaska's behavioral health workforce.

AKTC offers web-based training that promotes career development opportunities for direct support professionals, supervisors, and professionals in the behavioral health and long-term care/community and home-based services workforce by collaborating with Alaskan communities to train rural behavioral health care providers by blending evidence-based practices with traditional wisdom.

The AKTC, in coordination the Division of Behavioral Health and with funding from the Trust, is the entity providing the education and training identified as needed by the readiness assessments conducted by the Division of Behavioral Health in 2016, in preparation for the changes urged by this waiver application and the introduction of an ASO to assist in management of Alaska's reformed behavioral health system of care.

Loan Forgiveness and Repayment Programs

With a 2009 grant from the federal Health Resources and Services Administration (HRSA), Alaska established the Supporting Healthcare Access through loan Repayment Program (SHARP), which is designed to increase the number of primary care providers who are recruited and/or retained to provide service in high-need areas of the state. Behavioral health-related occupations eligible for the program include physicians, nurse practitioners, physician assistants, social workers, counselors, and other Alaska-licensed primary care professionals.

Since the program's inception, 211 practitioners have been awarded SHARP service contracts. Seventy one percent of these work in sites ranging from rural/remote locations where they are the only clinic providers to large urban center hospitals where they are providing specialized care to patients facing some of the rarest illnesses. From SFY 2014 to 2015, the number of patients seen by SHARP providers increased 23.4%, resulting in a 28.8% increase in visits.

2.7 Quality and Performance Measurement

Alaska is involved in a variety of quality and performance improvement activities to ensure both the integrity of the proposed waiver program and that beneficiaries receive the best care possible. The state will collect reliable and valid data through the ASO to enable comprehensive reporting of the mental health and SUD quality and performance measures listed in the table below. Alaska will explore adding other measures and will incorporate new measures as they are developed in order to continue to improve the quality of care delivered through the waiver program. These quality and performance measures will be assessed as part of our program evaluation and will, of course, be reported to CMS.

To ensure data-driven results, the state and the ASO will leverage and expand the existing quality and performance improvement infrastructure as well as process and performance data systems to ensure continuous improvement of the provision of mental health and SUD services.

Quality Measure Source	Measure	Collection Mechanism
(NQF)* #0004 and HEDIS**	Initiation & Engagement of Alcohol & Other Drug Dependence Treatment	Claims/Encounter Data
NQF #2605/HEDIS	Follow-up After Emergency Department Visit for MI or Alcohol & Other Drug Dependence	Claims/Encounter Data
HEDIS	Utilization of Patient Health Questionnaire 9-Question Depression Scale (PHQ-9) to Monitor Depression Symptoms for Adolescents and Adults	Claims/Encounter Data
HEDIS	Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotic Medications	Claims/Encounter Data
HEDIS	Follow-up After Hospitalization for Mental Illness	Claims/Encounter Data

PQA***	Use of Opioids at High Dosage in Persons Without Cancer	Claims/Encounter Data
PQA	Use of Opioids from Multiple Providers in Persons Without Cancer	Claims/Encounter Data
Waiver-Specific—All Groups	Utilization of Inpatient and Residential Services	Claims/Encounter Data
Waiver-Specific—All Groups	Medicaid Spending Per Enrollee	Claims/Encounter Data
Waiver-Specific—All Groups	Transportation Costs	Claims/Encounter Data
Waiver-Specific—All Groups	Number of Individuals Receiving MH or SUD Services	Claims/Encounter Data
Waiver-Specific—Group 1	Number of Out-of-Home Placements	Claims/Encounter Data
Waiver-Specific—Group 1	Utilization of Home-based Services	Claims/Encounter Data
Waiver-Specific—Group 3	Utilization of Inpatient and Residential Withdrawal Management Services	Claims/Encounter Data
Waiver-Specific—Group 3	Use of Alcohol and/or Drugs	Claims/Encounter Data

*NQF = National Quality Forum. The NQF is a not-for-profit, nonpartisan, membership-based organization that works to catalyze improvements in health care. More information can be found at https://www.qualityforum.org/Home.aspx.

**HEDIS = Healthcare Effectiveness Data and Information Set. HEDIS is a widely used set of performance measures utilized by the health care industry, developed and maintained by the National Committee for Quality Assurance (NCQA). More information can be found at http://www.ncqa.org/hedis-quality-measurement.

*** PQA = Pharmacy Quality Alliance (PQA, Inc.) is a consensus-based, multi-stakeholder membership organization committed to improving health care quality and patient safety with a focus on the appropriate use of medications. More information can be found at https://pqaalliance.org/.

Section 3: Impact of 1115 Demonstration on Alaska's Current Medicaid and CHIP Programs

1. **Identify the populations whose eligibility will be affected by the Demonstration.**

   Alaska's proposed Medicaid Section 1115 Demonstration is aimed at a subset of its Medicaid population that is currently covered under the Medicaid State Plan. Individuals that fit into the three target populations will be eligible to receive an enhanced set of services designed to address their clinical and social needs.

2. **Describe the standards and methodologies the state will use to determine eligibility for any populations whose eligibility is changed under the Demonstration, to the extent those standards or methodologies differ from the State plan.**

   The Demonstration will not alter the state's overarching Medicaid eligibility standards. As such, eligibility assessment and determination processes will remain consistent with those outlined in the Medicaid State Plan. Medicaid recipients eligible for services under the waiver will be selected based on the criteria outlined for each target population.

3. **Specify and enrollment limits that apply for expansion populations under the Demonstration.**

   Enrollment limits are not applicable for the demonstration.

4. **Provide the projected number of individuals who would be eligible for the Demonstration, and indicate if the projections are based on current state programs (i.e. Medicaid State plan, or populations covered using other waiver authority, such as 1915c). If applicable, please specify the size of the populations currently served in those programs.**

   As of October 2017, approximately 179,727 individuals are enrolled in Alaska's Medicaid program. We estimate that 24,379 beneficiaries will require access to the enhanced set of benefits that will be offered under the demonstration.

5. **To the extent that long-term services and supports are furnished (either in institutions or in the community), describe how the Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the Demonstration will utilize spousal impoverishment rules under Section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.726 or under 42 CFR 435.735.**

   The demonstration will not affect the provision of long-term services and supports and therefore will not involve use of post-eligibility treatment of income or spousal impoverishment rules.

6. **Describe any changes in eligibility procedures the State will use for populations under the Demonstration, including any eligibility simplifications that require 1115 authority (such as continuous eligibility or express lane eligibility for children.**

   Eligibility procedures will remain consistent with the existing Medicaid State Plan.

7. **If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transition Medicaid or CHIP eligibility standards to the methodologies or standards applicable in 2014 (such as financial methodologies for determining eligibility based on MAGI), or in light of other changes in 2014.**

   Eligibility standards will remain consistent with the existing Medicaid State Plan.

Impact of Demonstration on Benefits and Cost Sharing Requirements

1. **Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan.**

   This 1115 demonstration proposal represents an enhancement of Alaska's state Medicaid benefit package.

2. **Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan.**

   Cost sharing requirements outlined in the Medicaid State Plan will not be impacted by the waiver.

Impact of Demonstration on Delivery System

1. **Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan (if no, skip to question 8).**

   DHSS anticipates contracting with an Administrative Services Organization (ASO) to implement management of the enhanced behavioral health system of care under the waiver. The ASO will be a third-party organization with specialized expertise in integrated behavioral health systems management. The Department will contract with the ASO through a competitive bidding process to provide certain specified administrative services necessary to manage Alaska's behavioral health system of care on the Department's behalf.

8. **If fee-for-service payment will be made for any services, specify any deviation from State plan provider payment rates. If the services are not otherwise covered under the State plan, please specify the rate methodology.**

Payment methodologies under this waiver will be consistent with those approved in the State plan. If any changes are made to State plan payment methodologies, waiver payment methodologies will also be updated.

9. **If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates and any deviations from the payment and contracting requirements under 42 CFR Part 438.**

   Not applicable for the purposes of this demonstration.

10. **If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies, including the quality markers that will be measured and the data that will be collected.**

    The state is considering use of a fixed price incentive contract for the ASO procurement, which would allow the state to quantify ASO performance in terms of costs and services and/or deliverables. If this happens, the ASO will pass those performance incentives on to providers over the course of the waiver, once provider infrastructures are developed.

Section 4: Implementation of Demonstration

1. **Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone.**

   Given the geographical size and remote nature of Alaska, the state will be divided up into regional hubs that will serve as geographical centers for the provision of services. Alaska DHSS is proposing the following regions based on population size (organized so that each region has a population of at least 20,000), Tribal hubs/hospitals, and transport and referral patterns across the state for all providers and hospitals, along with the primary population hub(s) for each region:

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

   The Department is considering a three-year phase in plan to implement services included in this demonstration proposal. The state will work with Tribes, Tribal Health Organizations, stakeholder representatives, and the ASO to further develop the regional approach as part of the waiver implementation plan.

2. **Describe how potential Demonstration participants will be notified/enrolled into the Demonstration.**

   Medicaid recipients will be notified of the new behavioral health and SUD benefits through a public education process and will receive specific information as part of the enrollment/renewal process.

3. **If applicable, describe how the state will contract with managed care organizations to provide Demonstration benefits, including whether the state needs to conduct a procurement action.**

   While Alaska remains a fee-for-service delivery system, the state plans to contract with an ASO to administer the state's Medicaid behavioral health and SUD benefits. A Request for Information (RFI) was released in February of 2017 and ten responses were received. Four health care management organizations submitted responses and

six tribal health organizations, representatives, and governments (tribal entities) submitted recommendations. Drafting of the formal Request for Proposals (RFP) is currently underway and the state anticipates release of the ASO RFP in February of 2018.

Section 5: Demonstration Hypotheses and Evaluation Plan

The State of Alaska will conduct an independent evaluation to measure and monitor the outcomes of the Section 1115 Behavioral Health Demonstration project. The evaluation will focus on five key areas, which are consistent with overarching Medicaid reform goals identified in the stakeholder engagement process: 1) access; 2) service utilization, with steerage to less acute care when appropriate; 3) quality; 4) costs; and 5) integration of care. The evaluators will assess the impact of providing an enriched continuum of local and regional behavioral health services under the proposed waiver, with particular focus on the waiver's impacts over time on the utilization of residential treatment beds, emergency department visits, inpatient hospital stays and hospital readmissions rates. A mid-point evaluation will be completed, along with a final evaluation to be completed at the end of the waiver period.

Hypotheses

Hypothesis 1: The Alaska Section 1115 Behavioral Health Demonstration will result in increased access to sub-acute, community- or regionally-based outpatient treatment services.

Hypothesis 2: Alaskans will achieve improved physical and behavioral health outcomes as a result of the Section 1115 Behavioral Health Demonstration.

Hypothesis 3: The Section 1115 Behavioral Health Demonstration will result in increased access to home-based family treatment and wrap-around services for children and families.

Hypothesis 4: The Section 1115 Behavioral Health Demonstration will result in increased access to Medication Assisted Treatment (MAT) and MAT care coordination services for substance use disorders.

Hypothesis 5: The Section 1115 Behavioral Health Demonstration will result in increased access to appropriate behavioral health care and reduce Alaska's average behavioral health Medicaid per capita costs.

Section 6: Demonstration Financing and Budget Neutrality

Milliman, Inc. (Milliman) was engaged to develop the response to the Budget Neutrality Form section for the Section 1115 Medicaid Demonstration Waiver Application (1115 Waiver). Budget neutrality is a comparison of without waiver expenditures (WoW) to with waiver expenditures (WW). CMS recommends two potential methodologies of demonstrating budget neutrality:

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

Budget neutrality for the Alaska behavioral health (BH) 1115 Waiver will be demonstrated through the use of the per capita method. The budget neutrality projections were developed using CMS budget neutrality requirements. A detailed budget neutrality and supplemental SUD IMD budget neutrality worksheets prepared by Milliman are attached as Appendix D.

Milliman has relied upon certain data and information provided by the State of Alaska Department of Health and Social Services (DHSS) in the development of the estimates contained in the Budget Neutrality Worksheet. Milliman has relied upon the State of Alaska Department of Health and Social Services and their consultants for the accuracy of the data and assumptions and accepted them without audit. To the extent that the data and assumptions provided are not accurate, the results of this analysis may need to be modified to reflect revised information.

Differences between our projections and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience. It should be emphasized that the values in the Budget Neutrality Form are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this analysis.

Appendix D illustrates the 1115 Waiver budget neutrality and supplemental SUD IMD budget neutrality worksheets. The rest of this section documents the supporting data included in the worksheets using guidance provided by CMS in the Budget Neutrality Form.

1. Without- and With-Waiver Projections for Historical Medicaid Populations

A. Recent Historical Actual Data

We have provided actual historical data separately for eight Medicaid populations: ABD, CHIP, Former Foster Care, Medicaid Expansion, Newborn, Parent/Caretaker, Pregnant Woman, TEFRA, Under 21, and Other.

For the Medicaid Expansion population, we have provided historical data for the program's first year, state fiscal year (SFY) 2016. For all other populations, we have provided historical data for SFY 2012 through 2016. For each eligibility group, the historical data includes eligible member months for members who were enrolled in the Medicaid program. We have excluded beneficiary's age 65 and older or living out of state.

Please note that the SFY 2013 and SFY 2014 incurred claims have material defects, based on information provided by DHSS.

B. Bridge Period

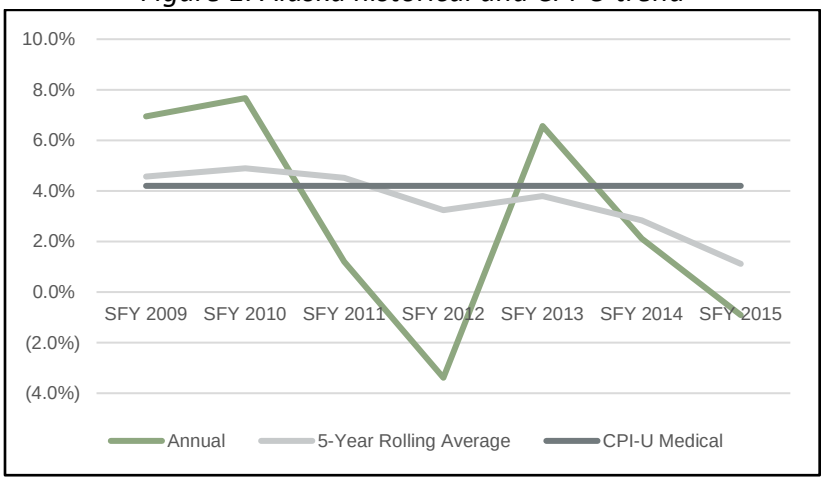
The bridge period is July 1, 2016 to December 31, 2018 (30 months).

C. Without-Waiver Trend Rates, PMPM costs and Member Months with Justification

The WoW scenario reflects the estimated member months and expenditures if DHSS does not implement the 1115. To create the WoW scenario, membership and PMPM trend assumptions were applied to project the historical data forward to the demonstration period. The trend assumptions were applied to the most recent year in the historical data (SFY 2016).

The figure below illustrates the aggregate per capita trend rate based on the Alaska Medicaid 2015 Annual Report and the current CPI-U medical trend. The current CPI-U Medical growth rate projected for the next 5-10 years is 4.2%.

Figure 1: Alaska historical and CPI-U trend



For all MEGs except Expansion, we used the 5-year average historical membership trend from the historical data tab, bounding the trends between 0.0% and 4.5%. For the Expansion population, we used a targeted membership trend rate to account for significant growth in the Expansion population since SFY 2016[37]. After targeting current Expansion membership in DY 0, a 1% membership trend was applied to project Expansion member months for DY 1-5.

DHSS has implemented or is expected to implement several policy and program changes from between the end of the historical data period (June 30, 2016) and to the beginning of the 1115 demonstration (January 1, 2019). Policy and program change adjustments were applied to the DY 0 PMPM cost in both the WoW and WW scenarios. The policy and program changes include the following:

- community behavioral health rate methodology changes;
- residential psychiatric treatment center reimbursement increases;
- tribal lodging reimbursement methodology changes; and,
- applied behavioral analysis (ABA) service implementation.

D. Historical Medicaid Populations: With-Waiver PMPM Cost and Member Month Projections

The WW scenario reflects the estimated member months and expenditures if DHSS implements the 1115 Waiver. The beneficiaries covered by Alaska's Medicaid program are not expected to change under the WW scenario. Additionally, the membership and PMPM cost trends are consistent with the WoW scenario. However, with DHSS' focus on integrating physical and behavioral health treatment for the target populations, both savings and costs associated with the new program have been projected in the WW scenario.

The WW scenario reflects DHSS' implementation of a new integrated physical and behavioral health program for target populations, which are outlined in the Target Population Criteria section of this report. Under the WW scenario, the target populations will receive a behavioral health service array that includes both services that have historically been provided as well as new services that will replace some of the historical benefit. In most cases, the expenditures associated with this new program are projected to be consistent with historical services they are replacing. However, the following items reflect areas in which DHSS expects the WW scenario expenditures to deviate from the WoW expenditures because of the new integrated physical and behavioral health program:

- Savings for medical services from integrated care – high-level savings assumptions were applied to the medical cost of beneficiaries projected to be receiving the new integrated behavioral health program to estimate the WW

[37] http://dhss.alaska.gov/HealthyAlaska/Pages/dashboard.aspx

savings. High-level medical savings estimates were developed based on the integrated physical and behavioral health experience in other state Medicaid programs as well as additional research on similar integrated care programs[38].

- Estimated savings from transitioning behavioral health treatment out of inpatient hospital and residential settings – the historical number of recipients, expected utilization, and cost per day were reviewed for those individuals currently receiving behavioral health care in an inpatient hospital or residential setting. Assumptions for the percentage of recipients shifting to replacement services and the corresponding replacement cost per day were developed with DHSS assistance and modeled to estimate savings associated with care transition.
- Additional expenditures for new entrants and new services – With the 1115 Waiver, DHSS expects to increase the number of beneficiaries receiving behavioral health services relative to the WoW scenario because of physical and behavioral healthcare integration. Additionally, DHSS is adding treatment plan development, treatment plan revisions, and multiple SUD medications. These services were previously not covered and are expected to incur incremental cost relative to the historical benefit.

The WW scenario reflects DHSS' implementation of a new integrated physical and behavioral health program for the following target populations:

- Population 1a – children under age 21 with a behavioral health diagnosis and at risk for out-of-home placement and chronic/acute levels of care
- Population 1b – children under age 21 in Alaska Department of Health and Social Services' Office of Children's Services, Division of Juvenile Justice, or in foster care with a behavioral health diagnosis and at risk for chronic/acute levels of care
- Population 1c – children under age 21 who have utilized a mental health residential treatment service in the past year
- Population 1d – children under age 21 who have been admitted to a general or psychiatric hospital for mental health or substance abuse treatment in the past year
- Population 2 – Medicaid eligible beneficiaries age 18-64 with a mental health or co-occurring mental health and substance abuse diagnosis
- Population 3 – Medicaid eligible beneficiaries age 12-64 with a substance abuse diagnosis
- Population 4 – Medicaid eligible beneficiaries age 12-64 with a substance abuse diagnosis and receiving substance abuse residential treatment services in the past year

[38] https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care

We relied on data and other information provided by DHSS, their consultants, and other research in developing estimated savings for this program.

E. Justification for With-Waiver Trend Rates, PMPM Costs and Member Months

We do not expect membership or PMPM cost trends to deviate from the WoW scenario. The development and justification for these rates is described in *section C* above.

II. Cost Projections for New Populations

Not applicable

III. Disproportionate Share Hospital Expenditure Offset

Not applicable

IV. Summary of Budget Neutrality

Appendix I illustrates the 1115 Waiver budget neutrality spreadsheet as well as the supplemental SUD IMD budget neutrality spreadsheet, which both include the following applicable tabs:

i. Historic Data
ii. WOW (Without-Waiver)
iii. WW (With-Waiver)
iv. Summary (of Budget Neutrality)

DHSS is seeking expenditure authority to provide SUD treatment to individuals residing in facilities that meet the definition of an IMD, and to have those expenditures regarded as expenditures under the State's Title XIX plan. As a result, CMS has provided DHSS with a supplemental budget neutrality form to capture SUD IMD expenditures as well as all other Medicaid expenditures incurred during months where a beneficiary resided in an IMD at least one day during the month. We have completed the supplemental SUD IMD budget neutrality template and included it in Appendix A. Additionally, within the Summary of Budget Neutrality, we have included SUD IMD member months and all associated expenditures.

Similar to the main budget neutrality outlined above, the supplemental SUD IMD budget neutrality projections for the WoW and WW scenarios were developed using SFY 2016 as the base period, with increases for caseload, a medical cost trend of 4.5%, and policy and program changes that occurred or are expected to occur prior to January 2019. However, unlike the main budget neutrality, the WoW and WW scenarios are the same for the SUD IMD budget neutrality.

DHSS has provided information on current and potential SUD IMD providers. These providers were grouped into three categories based on funding. The following lists those categories and how they were reflected in the SUD IMD budget neutrality:

- Medicaid funded providers – these facilities provided Medicaid covered SUD residential treatment to beneficiaries, but were historically not considered IMD facilities. For providers that DHSS indicated were expanded bed capacity above 16 beds, all member months and all (SUD residential and all other behavioral health and medical) expenditures were excluded from the main budget neutrality historical data and included in the SUD IMD budget neutrality historical data. The DY 0 PMPM cost for these providers was adjusted to reflect the estimated average new integrated program reimbursement for substance abuse residential. The expansion in the number of beds was included in the caseload adjustment, which will increase IMD member months over the demonstration.

- Grant funded IMD providers – these providers were historically IMD facilities and funded by DHSS through grants. DHSS provided the historical grant funding for these facilities. The historical grant funding was adjusted in DY 0 to reflect the estimated average new integrated program reimbursement for substance abuse residential. Additionally, given that these SUD IMD treatment facilities have historically received grant funding, we do not have any beneficiary level information to capture all other Medicaid expenditures incurred during months where beneficiaries were in an IMD at least one day. As a result, all non-IMD Medicaid expenditures for months where beneficiaries are in an IMD at least one day were estimated to be the same as non-SUD residential Medicaid expenditures for months where beneficiaries are in a non-IMD SUD residential facility at least one day. The non-IMD Medicaid expenditures were adjusted to reflect the difference in the estimated number of days outside of an IMD between Medicaid funded providers and Grant funded IMD providers. We used SFY 2016 experience to develop this estimate and included it in the historical data tab. The expansion in the number of beds was included in the caseload adjustment, which will increase IMD member months over the demonstration.

- Non-Medicaid reimbursed Non-IMD providers – these providers were historically providing SUD residential treatment without DHSS funding, but are estimated to increase the bed capacity to become an IMD facility and be eligible for Medicaid reimbursement for serving Medicaid beneficiaries under the 1115. The historical expenditures for these providers were not included in the historical data. However, all of the beds were included in the caseload adjustment, which will increase IMD member months over the demonstration.

The caseload was calculated as the expected increase in IMD recipient months based on information provided by DHSS relative to the SFY 2016 base experience, spread across the five-year demonstration.

V. Additional Information to Demonstrate Budget Neutrality

We do not believe there is any other information necessary for CMS to complete its analysis of the budget neutrality submission.

Section 7: List of Proposed Waivers and Expenditure Authorities

7.1 Proposed Waiver Authority Citations

- Proper and Efficient Administration §1902(a)(4):
  Rationale: Mandate Medicaid recipients into a single Administrative Services Organization (ASO).

- Comparability §1902(a)(17):
  Rationale: This demonstration includes benefits specific to eligibility criteria as described in Section II that will not be available to other Medicaid beneficiaries.

- Amount, Duration, and Scope §1902(a)(10)(B)
  Rationale: To enable the state to offer a different benefit package to the demonstration participants that varies in amount, duration, and scope from the benefits offered under the State Plan.

- Freedom of Choice §1902(a)(23)(A)(45)
  Rationale: Individuals enrolled in the program must receive services through the ASO.

- Choice of Coverage §1932(a)(3)
  Rationale: To enable the state to assign demonstration participants to ASO based on geography and to permit participant choice of provider, but not plan.

- Methods of Administration: Transportation §1902(a)(4), insofar as it incorporates 42 CFR 431.53
  Rationale: To enable the state to assure transportation to and from providers for the demonstration participants.

- Eligibility Standards §1902(a)(17)
  Rationale: To enable the state to apply different eligibility methodologies and standards to the demonstration eligible population than are applied under the State Plan.

- Residential SUD treatment services:
  Alaska also seeks expenditure authority under Section 1115(a)(2) of the Social Security Act to claim expenditures made by the state for services not otherwise covered or included as expenditures under Section 1903 of the Act, such as services provided to individuals residing in facilities that meet the definition of an Institution for Mental Disease (IMD), and to have those expenditures regarded as expenditures under the State's Title XIX plan.

- Alaska Psychiatric Institute services:
  Alaska also seeks expenditure authority under Section 1115(a)(2) of the Social Security Act to claim expenditures made by the state for services not otherwise covered or included as expenditures under Section 1903 of the Act, such as services provided to individuals residing in facilities that meet the definition of an Institution for Mental Disease (IMD), and to have those expenditures regarded as expenditures under the State's Title XIX plan.

7.2 Legislative Authority

Through SB 74; **AS 47.07.036** :

(f) Notwithstanding (a) - (c) of this section, and in addition to the projects and services described under (d) and (e) of this section, the department shall apply for a section 1115 waiver under 42 U.S.C. 1315(a) to establish one or more demonstration projects focused on improving the state's behavioral health system for medical assistance recipients. The department shall engage stakeholders and the community in the development of a project or projects under this subsection. The demonstration project or projects must

(1) be consistent with the comprehensive and integrated behavioral health program described under AS 47.05.270(b); and

(2) include continuing cooperation with the grant-funded community mental health clinics and drug and alcohol treatment centers that have historically provided care to recipients of behavioral health services.

Section 8: Stakeholder Engagement and Public Notice

The State of Alaska gathered public input on the Alaska Medicaid Section 1115 Behavioral Health Demonstration application from November 28, 2017 to December 29, 2017 in accordance with the requirements under 42 CFR § 431.408.

Public Notice of Waiver Application
The State of Alaska published public notice on the Alaska Medicaid Section 1115 Behavioral Health Demonstration application at the states' online public notice website located at: https://aws.state.ak.us/OnlinePublicNotices/Notices/Browse.aspx?by=PublishDate.

Links to the public notice were posted on the Alaska Department of Health and Social Services (DHSS) and Division of Behavioral Health (DBH) webpages. Public notice was sent to behavioral health grantees and other stakeholders (such as the Alaska Mental Health Trust and the Alaska Behavioral Health Association) via email, and via social media on Facebook pages managed by the Alaska Mental Health Board (AMHB) and Advisory Board on Alcoholism and Drug Abuse (ABADA).

The public notice contained a comprehensive description of the demonstration application including program description, goals and objectives, proposed delivery system changes, strategies and services, annual enrollment and cost estimates, demonstration hypothesis and evaluation, and the proposed federal authorities requested.

Documentation that certifies that the state provided public notice of the application and published notice in the Anchorage Daily News (Alaska's only city with a population of 100,000 or more) is included in Appendix C.

Public Comment Website
The State developed a webpage for the 1115 Behavioral Health Demonstration application located at:
http://dhss.alaska.gov/HealthyAlaska/Pages/PublicComment/1115waiverComment.aspx. The link to this webpage is accessible via the online public notice and on the DBH, AMHB, and ABADA webpages.

The web page includes a copy of the abbreviated public notice, links to the full public notice and waiver application, dates and locations of public hearings, informational webinar schedule, updated frequently asked questions, information on how the public can comment on the application, and accommodation information.

The link to the full waiver application located at:
http://dhss.alaska.gov/HealthyAlaska/Documents/AK1115_Draft_Application-11-2017.pdf was made available to the public via the full public notice, the abbreviated public notice published in the Anchorage Daily News, and on the 1115 public webpage. Hard copies of the demonstration

application were made available to the public at the Department of Health and Social Services Office of the Commissioner, 3601 C Street, Suite 902, Anchorage, Alaska 99503.

Public Hearings

The State of Alaska follows the public hearing process identified in AS 44.62.190 Procedure for Adopting Regulations.

The State of Alaska convened five public hearings during the public comment period, all of which included toll-free teleconferencing services. These in-person public hearings were held in Juneau (12/8/2017), Fairbanks (12/11/17), Kenai (12/12/17), Wasilla (12/13/17), and Anchorage (12/14/17). During each hearing participants were provided with an overview of the demonstration proposal and given the opportunity to provide public testimony. Three participants provided comments on the demonstration application in person and no comments were submitted by teleconference services.

Other Stakeholder Outreach

DHSS and DBH staff presented information on the Alaska Medicaid Section 1115 Behavioral Health Demonstration application during the 2018 Change Agent conference on December 30, 2017. The Change Agent conference is an annual gathering of DBH grantees and other behavioral health providers. During this presentation participants were provided with an overview of the demonstration proposal, followed by a question and answer session with DHSS and DBH staff. Approx. 240 people attended the presentation.

Two informational webinars on the Alaska Medicaid Section 1115 Behavioral Health Demonstration application were presented on December 6, 2017 and on December 21, 2017. During these webinars participants were provided with an overview of the demonstration proposal, followed by a question and answer session with DHSS and DBH staff. A total of 129 people participated.

The State also convened five informal stakeholder meetings during the public comment period where participants were provided with an overview of the demonstration proposal, followed by a question and answer session with DHSS and DBH staff. Stakeholder meetings were held in Juneau, Fairbanks, Kenai, Palmer and Anchorage. A total of 57 people attended.

Public Comments Received

The State of Alaska received public comments from 34 individuals, organizations and associations during the 30-day public notice period. All public comments received by the State of Alaska are listed in Appendix C.

Tribal Consultation

DHSS maintains an open and transparent process with Tribes, Tribal Health Organizations and entities, and has engaged with Tribal partners throughout all phases of the 1115 Waiver Application development.

Participants from Tribes or Tribal Health Organizations were represented in each of the 1115 Behavioral Health Waiver Development teams including the Policy, Benefit Design, Cost, Data, Quality and Writing teams. The teams often met bi-monthly, carried heavy workloads, and were integral in the early conceptualization and framing of the 1115 Waiver application.

Throughout the calendar year, DHSS maintains a regular meeting schedule in order to maintain ongoing communication with Tribal Leadership on a variety of health care delivery issues. The Department meets with the Alaska Native Health Board twice a year in a forum called the "Mega meeting." The purpose of this meeting is for Department Senior Leadership and Division Directors and Tribal leaders to get together to discuss federal and state legislative priorities and initiatives. The Mega meeting has a designated a subgroup, the State/Tribal Medicaid Task Force (MTF), to focus specifically on programmatic and financial issues. The MTF meets quarterly and includes CEOs, CFOs and higher-level program and finance representatives from Tribal Health Organizations to discuss patient care, policy changes, and billing issues. Additionally, the MTF charters a sub-group that also meet quarterly to discuss Behavioral Health issues and reports back to the quarterly MTF. The 1115 Waiver application has been on every MTF and Behavioral Health Director's meeting agenda since December 2016, offering numerous opportunities for the State to answer questions, provide updates, and receive pre-consultation on items of particular interest to Tribal leadership regarding the 1115 Waiver.

As the result of requests that came out of MTF meetings, the state participated in two "pre-consultation meetings" with Tribal entities related to the state's intention to solicit a contract with an Administrative Service Organization to manage the implementation of the 1115 Waiver. These meetings were held in January 2017 and August 2017. Both meetings involved the state receiving extensive and detailed feedback regarding why Tribal entities have concerns about the state contracting with an ASO. The state is planning in conducting another publicly noticed meeting for Tribal partners and other stakeholders to maintain transparency as allowable under Procurement rules.

The Tribal consultation letter for the 1115 Behavioral Health Medicaid Waiver application was issued November 28, 2017. The state hosted two formal face to face consultation meetings regarding the 1115 Behavioral Health Waiver Application in December 2017 and received numerous oral and written Tribal comments. All correspondence, including state responses and detailed feedback to all written comments, are available at:

http://dhss.alaska.gov/Commissioner/Pages/TribalHealth/Consultations/consultation-letters.aspx

Section 9: Appendices

Appendix A: Alaska Mental Health and SUD Benefits At-A-Glance by Population

Service	Group 1a	Group 1b	Group 1c	Group 2	Group 3	Existing State Plan or New Waiver Service
Evidence-based screenings and assessments (ASAM Level 0.5)	x	x	x	x	x	New waiver service
Alaska-specific screening tool						Existing state plan service; will be retired upon waiver implementation
Screening, Brief Intervention, & Referral to Treatment (SBIRT)					x	Existing state plan service; will be expanded under waiver
Client Status Review						Existing state plan service; will be retired upon waiver implementation
Comprehensive Community Support services						Existing state plan service; will be retired upon waiver implementation
Recipient Support Services						Existing state plan service; will be retired upon waiver implementation
Community and recovery support services	x	x	x	x	x	New waiver service
Home-based family treatment services (Level 1)	x	x				New waiver service

Home-based family treatment services (Level 2)	x	x				New waiver service
Home-based family treatment services (Level 3 – Family therapy)	x	x	x			New waiver service
Intensive case management services	x	x	x	x	x	New waiver service
Mobile crisis response services	x	x	x	x	x	New waiver service
Crisis stabilization & observation services	x	x	x	x		New waiver service
Crisis residential stabilization services	x	x	x	x		New waiver service
Therapeutic foster care services		x				New waiver service
Assertive Community Treatment Services				x		New waiver service
Peer-based crisis services				x	x	New waiver service
Behavioral Rehabilitation Services						Existing state plan service; will be retired upon waiver implementation
Therapeutic Behavioral Health Services						Existing state plan service; will be retired upon waiver implementation
Children's residential treatment (Level 1)			x			New waiver service
Children's residential treatment (Level 2)			x			Existing state plan service
Inpatient psychiatric facility services						Existing state plan service
Mental health day treatment services	x	x	x	x		New waiver service

SUD intensive outpatient services (ASAM Level 2.1)					x	Existing state plan service; will be revised under waiver
Ambulatory withdrawal management (ASAM Levels 1 and 2)					x	New waiver service
Outpatient Medication-Assisted Treatment (MAT)					x	New waiver service
Outpatient MAT Care Coordination					x	New waiver service

Appendix B: Deleted Services/Codes

The following services will be eliminated from the state plan behavioral health services as new services become available. The state will make these decisions in conjunction with Tribes, the ASO, and stakeholder representatives including providers.

Behavioral rehab services H0018
Case Management services T1016
Recipient support services H2017
Comprehensive Community Support Services H2015 & HQ
Therapeutic behavioral services H2019, HR, HQ, HS
Alaska screening tool T1023
Client status review H0046

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$878.99

AFFIDAVIT OF PUBLICATION

STATE OF ALASKA

THIRD JUDICIAL DISTRICT

Joleesa Stepetin
being first duly sworn on oath deposes and says that he/she is a representative of the Alaska Dispatch News, a daily newspaper. That said newspaper has been approved by the Third Judicial Court, Anchorage, Alaska, and it now and has been published in the English language continually as a daily newspaper in Anchorage, Alaska, and it is now and during all said time was printed in an office maintained at the aforesaid place of publication of said newspaper. That the annexed is a copy of an advertisement as it was published in regular issues (and not in supplemental form) of said newspaper on

December 03, 2017

and that such newspaper was regularly distributed to its subscribers during all of said period. That the full amount of the fee charged for the foregoing publication is not in excess of the rate charged private individuals.

Signed Joleesa Stepetin

Subscribed and sworn to before me
this 4th day of December, 2017

Britney Thompson

Notary Public in and for
The State of Alaska.
Third Division
Anchorage, Alaska
MY COMMISSION EXPIRES
2/23/2019

Notary Public
BRITNEY L. THOMPSON
State of Alaska
My Commission Expires Feb 23, 2019

STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
NOTICE OF PUBLIC COMMENT PROCESS FOR MEDICAID SECTION §1115 BEHAVIORAL HEALTH DEMONSTRATION WAIVER

The State of Alaska's Department of Health and Social Services (DHSS) is seeking public comments on an Section 1115 Behavioral Health Demonstration Waiver authority to support the comprehensive reform of Alaska's Medicaid supported behavioral health system.

Public Comment Period Opens: November 28, 2017
Public Comment Period Closes: December 29, 2017 at 5:00 pm AST

To access more information about the public comment process and to read the full waiver application, please go to: http://dhss.alaska.gov/HealthyAlaska/Pages/PublicComment/comment.aspx

Program Summary
The Alaska Department of Health and Social Services (DHSS) is submitting a Section 1115 Behavioral Health Demonstration Waiver application to the Centers for Medicare & Medicaid Services (CMS) to develop a data-driven, integrated behavioral health system of care for children, youth, and adults with serious mental illness, severe emotional disturbance, and/or substance use disorders. The demonstration project also seeks to increase services for at-risk families in order to support the healthy development of children and adults through increased outreach and prevention and early intervention supports.

Goals and Objectives
The Alaska Behavioral Health 1115 Demonstration seeks to provide Alaskans with a comprehensive suite of cost-effective, high quality behavioral health services designed to ensure access to the right services at the right time in the right setting. The goals and objectives of the application are:
Goal 1: Rebalance the current behavioral health system of care to reduce Alaska's over-reliance on acute, institutional care and shift to more community- or regional-based care.

Objectives:
1. Decrease use of inpatient hospital and emergency department care episodes.
2. Decrease use of residential out-of-home placements.
3. Increase regionally-based capacity for a continuum of intensive outpatient, day treatment, intensive case management, community and recovery support, home-based family, assertive community treatment, and ambulatory withdrawal management services
4. Develop community-based, culturally appropriate behavioral health workforce capacity (i.e., implement additional Medicaid-reimbursed behavioral health provider types) to address existing workforce deficits.

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

Objectives:
1. Provide universal screening to identify symptoms.
2. Provide brief, solution-focused interventions to prevent acute care.
3. Provide care as close as possible to the homes or regional-hub communities of Alaskans.

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

Objectives:
1. Contract with an Administrative Services Organization (ASO) to manage Alaska's existing system of behavioral health care.
2. Improve the consistency of screening, assessment, and service/placement decisions through use of evidence-based and evidence-informed tools.
3. Standardize and streamline documentation requirements to reduce duplication of effort and facilitate coordination of care across all providers.
4. Support provider development of infrastructures necessary to coordinate care, report and achieve performance/quality measures, report per capita BH costs, and improve participant outcomes.

Public Comment Process
To submit public comments on the 1115 Waiver, please send them via email to 1115_Public_Comments@alaska.gov or mail them to:

1115 Public Comments
C/O AMHB/ABADA
PO Box 110608
Juneau, AK 99811-0608

Informational Webinar Schedule
The public is welcome to participate in the following online webinars to learn more about the waiver application and ask questions about the project.

Introductory Webinar
Wednesday, December 6th
2:00 pm
Please join the webinar by following this link:
https://stateofalaska.webex.com/stateofalaska/j.php?MTID=m94e0acce3daadf20e8239eb7585122fa
The telephone conference number will be provided when you sign in.

Webinar- Public Comment Process Update and FAQ's
Thursday, December 21st
10:00 am
https://stateofalaska.webex.com/stateofalaska/j.php?MTID=md903694bc98043e98c91e4f72a866b47
The telephone conference number will be provided when you sign in.

Public Meeting Schedule
The public is also welcome to attend or call into the following public meetings to learn more about the waiver application, ask questions, and provide public comment:

Juneau Public Meeting
Friday, December 8th
4:30 pm
Alaska Office Building (350 Main St.)
Conference Room 115
Teleconference #: 1-800-315-6338
Passcode: 58920#

Fairbanks Public Meeting
Monday, December 11th
6:00 pm
Noel Wien Library (1215 Cowles St.)
Teleconference #: 1-800-315-6338
Passcode: 58920#

Kenai Public Meeting
Tuesday, December 12th
6:00 pm
Kenai Chamber of Commerce and Visitors Center (11471 Kenai Spur Hwy.)
Teleconference #: 1-800-315-6338
Passcode: 58920#

Mat-Su Public Meeting
Wednesday, December 13th
6:00 pm
Wasilla Senior Center (1301 S. Century Circle)
Teleconference #: 1-800-315-6338
Passcode: 58920#

Anchorage Public Meeting
Thursday, December 14th
6:00 pm
Frontier Building (3601 C. St.)
Conference Room 880/890
Teleconference #: 1-800-315-6338
Passcode: 58920#

Individuals with disabilities who require special accommodations in order to attend these public meetings, should contact Beverly Schoonover at 907-465-5114, or email at bev.schoonover@alaska.gov to ensure that any necessary accommodations can be provided.

DEPARTMENT OF HEALTH AND SOCIAL SERVICES NOTICE OF PUBLIC COMMENT PROCESS FOR MEDICAID SECTION 1115 BEHAVIORAL HEALTH DEMONSTRATION WAIVER

STATE OF ALASKA DEPARTMENT OF HEALTH AND SOCIAL SERVICES

NOTICE OF PUBLIC COMMENT PROCESS FOR MEDICAID SECTION §1115 BEHAVIORAL HEALTH DEMONSTRATION WAIVER

Public Comment Period Opens: November 28, 2017

Public Comment Period Closes: December 29, 2017 at 5:00 pm AST

Public notice is hereby given that the State of Alaska's Department of Health and Social Services (DHSS) is seeking public comments on a Section 1115 Behavioral Health Demonstration Waiver application to support the comprehensive reform of Alaska's Medicaid supported behavioral health system.

Program Summary

DHSS is requesting approval of a Section 1115 Behavioral Health Demonstration Waiver from the Centers for Medicare & Medicaid Services (CMS) to develop a data-driven, integrated behavioral health system of care for children, youth, and adults with serious mental illness, severe emotional disturbance, and/or substance use disorders. The demonstration project also seeks to increase services for at-risk families in order to support the healthy development of children and adults through increased outreach, prevention and early intervention supports.

Program Background

In 2016 the Alaska Legislature passed Senate Bill 74, a multi-dimensional Medicaid reform package that includes 16 separate and significant initiatives including direction to apply for a Section 1115 Medicaid waiver to enable the state to more efficiently manage a comprehensive and integrated behavioral health system. The bill also directs the state to reduce operational barriers, minimize administrative burden, and improve the effectiveness and efficiency of Alaska's behavioral health system.

In order to proactively address the many goals and expectations of the Alaska legislature and improve the long-term outcomes for Alaskans, DHSS has brought together community members, tribal entities, behavioral health providers, other concerned stakeholders, and contracted with Medicaid experts to develop an 1115 waiver proposal that seeks to address the complex behavioral health needs of Alaskans.

Goals and Objectives

The Alaska 1115 Behavioral Health Demonstration Waiver seeks to provide Alaskans with a comprehensive continuum of cost-effective, high quality behavioral health services designed to ensure access to the right services at the right time in the right setting. The goals and objectives of the application are:

Goal 1: Rebalance the current behavioral health system of care to reduce Alaska's over-reliance on acute, institutional care and shift to more community or regional-based care.

Objectives:

Decrease use of inpatient hospital and emergency department care episodes.

Decrease use of residential out-of-home placements.

Increase regionally-based capacity for a continuum of intensive outpatient, day treatment, intensive case management, community and recovery support, home-based family, assertive community treatment, and ambulatory withdrawal management services.

Develop community-based, culturally appropriate behavioral health workforce capacity to address existing workforce deficits.

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

Objectives:

Provide universal screening to identify symptoms.

Provide brief, solution-focused interventions to prevent acute care.

Provide care as close as possible to the homes or regional-hub communities of Alaskans.

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

Objectives:

Contract with an Administrative Services Organization (ASO) to manage Alaska's existing system of behavioral health care.

Improve the consistency of screening, assessment, and service/placement decisions through use of evidence-based and evidence-informed tools.

Standardize and streamline documentation requirements to reduce duplication of effort and facilitate coordination of care across all providers.

Support provider development of infrastructures necessary to coordinate care, report and achieve performance/quality measures, report per capita BH costs, and improve participant outcomes.

Delivery System Changes

Alaska's proposed Section 1115 Behavioral Health Demonstration Waiver is aimed at a subset of its Medicaid population that is currently covered under the Medicaid State Plan. Individuals who fit into the three target populations will be eligible to receive an enhanced set of services designed to address their clinical and social needs. These three targeted populations of Medicaid recipients include:

1. Children, adolescents and their parents or caretakers with or at risk of mental health and substance-use disorders.

2. Individuals with acute mental health needs.

3. Individuals with substance-use disorders.

As of October 2017, approximately 179,727 individuals were enrolled in Alaska's Medicaid program. The following table estimates the average annual enrollment of beneficiaries for each year of the demonstration project.

State of Alaska, Department of Health and Social Services Estimated Average Monthly Enrollment Projections		
Demonstration Year	Without Waiver	With Wavier
Year 1	175,000	175,000
Year 2	178,000	178,000
Year 3	181,000	181,000
Year 4	184,000	184,000
Year 5	186,000	186,000

The following table estimates the projected expenditures for the 1115 Behavioral Health Demonstration Waiver by program year.

State of Alaska, Department of Health and Social Services Estimated Fiscal Projects				
Expenditures				
Demonstration Year	Without Waiver	With Waiver	Difference	State Share of Expenditure Difference
Year 1	$2,127,895,000	$2,127,677,000	$ (218,000.00)	$ (44,000.00)
Year 2	$2,244,493,000	$2,243,274,000	$ (1,219,000.00)	$ (247,000.00)
Year 3	$2,367,646,000	$2,363,330,000	$ (4,316,000.00)	$ (830,000.00)
Year 4	$2,497,727,000	$2,492,095,000	$ (5,632,000.00)	$ (963,000.00)
Year 5	$2,635,142,000	$2,630,018,000	$ (5,124,000.00)	$ (847,000.00)

Please note: This data in these tables were provided by Milliman, Inc. Their full methodology report is attached as an appendix in the Medicaid Section 1115 Behavioral Health Demonstration Application.

There will be no cost sharing requirement with this demonstration.

Strategies and Services

The following are the proposed strategies and evidence-based interventions aimed at more effectively addressing the needs of each of the target populations. New Medicaid-covered services under the waiver will establish a robust continuum of care designed to anticipate and address the range of behavioral health needs of the target populations. There are no proposed changes in Alaska Medicaid eligibility requirements; however each target population has defining criteria for the waiver's enhanced services.

Targeted Services: Youth At-Risk of Mental Health or Substance Use Disorders

Evidence-based clinical assessments

Standardized mental health and SUD screening

Community-based outpatient services.

Home-based family treatment services

Intensive case management services

Mental health day treatment services

Acute intensive services

Mobile crisis response services

23-hour crisis stabilization services

Therapeutic foster care

Residential treatment services

Community and recovery support services

Targeted Services: Individuals with Acute Mental Health Needs

Standardized screening and assessment

Community-based outpatient treatment options, including the creation and deployment of teams modeled on the Assertive Community Treatment approach

Intensive case management services

Mental health day care treatment

Acute intensive services

23-hour crisis stabilization services

Peer-based crisis stabilization services

Community and recovery support services

Existing crisis residential and stabilization services, including medically-monitored, short-term, residential program in an approved (10-15 bed) facilities that provide 24/7 psychiatric stabilization services

Targeted Services: Individuals with Substance Use Disorders

Standardized screening and assessment

Community and recovery support SUD services

Community-based outpatient SUD treatment and medication services

Medication-Assisted Treatment (MAT) services, including MAT Care Coordination

Intensive SUD case management

Intensive outpatient SUD services

Ambulatory withdrawal management

Acute intensive services will also be made including mobile crisis response services and peer-based crisis services

Adult and youth residential treatment services

Demonstration Project Hypothesis and Evaluation

The State of Alaska will conduct an independent evaluation to measure and monitor the outcomes of the Section 1115 Behavioral Health Demonstration project. The evaluation will focus on five key areas: access, service utilization, quality, costs, and integration of care. The evaluators will assess the impact of providing an enriched continuum of local and regional behavioral health services under the proposed waiver, with particular focus on the waiver's impacts over time on the utilization of residential treatment beds, emergency department visits, inpatient hospital stays and hospital readmissions rates.

Hypothesis 1: Increased access to sub-acute, community- or regionally-based outpatient treatment services will:

Reduce residential lengths of stay

Reduce avoidable Inpatient hospital use

Reduce avoidable Emergency Department use

Reduce readmissions to Inpatient and residential care

Reduce the number of out-of-state residential placements of Alaska's children/youth

Hypothesis 2: Alaskans will achieve improved health outcomes as a result of behavioral health Medicaid reform by:

Reducing the % of readmissions after hospitalization for mental illness

Reducing the number of children utilizing residential treatment services

Increasing the number of physical health referrals, treatment and monitoring for children with behavioral health diagnoses

Early identification of symptoms through universal screening for substance use disorders, mental health disorders, or developmental issues impacting on family stability

Hypothesis 3: Increased access to appropriate behavioral health care will reduce Alaska's average behavioral health Medicaid per capita cost.

Hypothesis 4: Increased access to home-based family treatment and wrap-around services will:

Reduce the number out-of-home placements

Increase the number of family reunifications

Reduce the number of children/youth in Office of Children's Services custody

Reduce the number of children/youth under Division of Juvenile Justice supervision

Reduce the number of children/youth entering or re-entering foster care

Reduce the number of children in residential care

Hypothesis 5: Increased access to Medication Assisted Treatment Care Coordination services will:

Reduce the % of past month alcohol use

Reduce the % of past month adult binge drinking

Reduce the % of past month opioid use

Decrease mortality rate associated with opioid abuse

Improve physical health care by reducing number of inpatient general hospital visits by MAT participants

Reduce the annual cost of physical and behavioral health care for MAT participants

Proposed Federal Authorities Waived

Proper and Efficient Administration §1902(a)(4)

Rationale: Mandate beneficiaries into a single Administrative Services Organization (ASO).

Comparability §1902(a)(17)

Rationale: This waiver program includes benefits specific to eligibility criteria as described in Section II that will not be available to other Medicaid beneficiaries.

Amount, Duration, and Scope §1902(a)(10)(B)

Rationale: To enable the State to offer a different benefit package to the demonstration participants that varies in amount, duration, and scope from the benefits offered under the State Plan.

Freedom of Choice §1902(a)(23)(A)45

Rationale: Beneficiaries enrolled in the program must receive services through the ASO.

Choice of Coverage §1932(a)(3)

Rationale: To enable the state to assign demonstration participants to ASO based on geography and to permit participant choice of provider, but not plan.

Methods of Administration: Transportation §1902(a)(4), insofar as it incorporates 42 CFR 431.53

Rationale: To enable the state to assure transportation to and from providers for the Demonstration participants.

Eligibility Standards §1902(a)(17)

Rationale: To enable the State to apply different eligibility methodologies and standards to the Demonstration eligible population than are applied under the State Plan.

Residential SUD Treatment Services

Alaska also seeks expenditure authority under Section 1115(a)(2) of the Social Security Act to claim expenditures made by the state for services not otherwise covered or included as expenditures under Section 1903 of the Act, such as services provided to individuals residing in facilities that meet the definition of an Institution for Mental Disease (IMD), and to have those expenditures regarded as expenditures under the State's Title XIX plan.

Alaska Psychiatric Institute Services

Alaska also seeks expenditure authority under Section 1115(a)(2) of the Social Security Act to claim expenditures made by the state for services not otherwise covered or included as expenditures under Section 1903 of the Act, such as services provided to individuals residing in facilities that meet the definition of an Institution for Mental Disease (IMD), and to have those expenditures regarded as expenditures under the State's Title XIX plan.

1115 Behavioral Health Demonstration Application

The link to the proposed demonstration application is here:

http://dhss.alaska.gov/HealthyAlaska/Documents/AK1115_Draft_Application-11-2017.pdf

Hard copies of the demonstration application are available at:

Department of Health and Social Services- Office of the Commissioner

3601 C Street, Suite 902, Anchorage, Alaska 99503

Public Comment Process

To submit public comments on the 1115 Waiver, please send them via email to 1115_Public_Comments@alaska.gov or mail them to:

1115 Public Comments

C/O Alaska Mental Health Board/ Advisory Board on Alcoholism and Drug Abuse

PO Box 110608, Juneau, AK 99811-0608

Public comments, FAQ's and additional information will be posted and updated regularly on the web throughout the duration of the public comment period here:

http://dhss.alaska.gov/HealthyAlaska/Pages/PublicComment/1115waiverComment.aspx

Informational Webinar Schedule

The public is welcome to participate in the following online webinars to learn more about the waiver application and ask questions about the project.

Introductory Webinar: Wednesday, December 6th, 2:00 pm

Please join the webinar by following this link: https://stateofalaska.webex.com/stateofalaska/j.php?MTID=m94e0acce3daadf20e8239eb7585122fa

The telephone conference number will be provided when you sign in.

Webinar- Public Comment Process Update and FAQ's: Thursday, December 21st, 10:00 am

Please join the webinar by following this link: https://stateofalaska.webex.com/stateofalaska/j.php?MTID=md903694bc98043e98c91e4f72a866b47

The telephone conference number will be provided when you sign in.

Public Meeting Schedule

The public is also welcome to attend or call into the following public meetings to learn more about the waiver application, ask questions, and provide public comment:

Juneau Public Meeting

Friday, December 8th, 4:30 pm

Alaska Office Building (350 Main St.), Conference Room 115

Teleconference #: 1-800-315-6338 , Passcode: 58920#

Fairbanks Public Meeting

Monday, December 11th, 6:00 pm

Noel Wien Library (1215 Cowles St.)

Teleconference #: 1-800-315-6338, Passcode: 58920#

Kenai Public Meeting

Tuesday, December 12th, 6:00 pm

Kenai Chamber of Commerce and Visitors Center (11471 Kenai Spur Hwy.)

Teleconference #: 1-800-315-6338, Passcode: 58920#

Mat-Su Public Meeting

Wednesday, December 13th, 6:00 pm

Wasilla Senior Center (1301 S. Century Circle)

Teleconference #: 1-800-315-6338, Passcode: 58920#

Anchorage Public Meeting

Thursday, December 14th, 6:00 pm

Frontier Building (3601 C. St.), Conference Room 880/890

Teleconference #: 1-800-315-6338, Passcode: 58920#

Individuals with disabilities who require special accommodations in order to attend these public meetings, should contact Beverly Schoonover at 907-465-5114, or email at bev.schoonover@alaska.gov to ensure that any necessary accommodations can be provided.

Attachments, History, Details

Attachments
None

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Summary of Public Comments

CATEGORIES OF COMMENTS	SUMMARY	RATIONALE
Service Array	Add several services, clarify HBFT & ICM, cover residential < 10 beds, culturally appropriate, & expand care coordination	The state agrees that new services would be a positive step and will continue work with the actuarial analysis and cost neutrality to evaluate whether additional services can be added. The state will clarify HBFT, ICM, & peer support in provider billing manuals and regulations accompanying the waiver.
Eligibility	Include functionality matrix, & include many additional eligible populations—particularly the over 65 years of age population	The state agrees that expanding eligibility would be a positive step and will work with the actuarial analysis and cost neutrality to evaluate adding over 65 group. The state will provide a functionality matrix in provider billing manuals and regulations accompanying the waiver.
ASO	Concerns about role, clarify role, exempt tribal populations and tribal health organizations, & include all BH funding	The state understands the concerns about the ASO; any change of this magnitude creates uncertainty. The state will carefully consider the public comments and clarify issues in the ASO RFP to the maximum extent possible. The state does not intend to exempt any behavioral health populations or providers at this time.
Workforce Development	Clarify workforce development items in application, need HIT & data training, & telemedicine is priority	The state will clarify workforce development details in policies/procedures and regulations accompanying the waiver.
Screening/ Assessment	Include trauma screening tool, allow OB/GYN professionals to conduct screening, & include SBIRT in all primary care settings	The state will include a trauma screening tool, will allow OB/GYN professionals to conduct screening & will include SBIRT in as many primary care settings as is financially feasible.
Length of Stay	Medical necessity should determine residential length of stay & must have step-up/step-down services in place before reducing residential length of stay	The state always intended that medical necessity will determine all lengths of stay in any setting, including residential. To the extent possible, the state will have step-up/step-down services accessible prior to accommodate shorter residential lengths of stay.
Regional Phase-in	Concerns re the regions & the regional roll-out of services.	The state has added language to the application that the state will work with Tribes, Tribal Health Organizations,

		stakeholder representatives, and the ASO to further develop the regional approach as part of the waiver implementation plan.
Housing	Concerns that housing is not covered.	The state agrees that new services would be a positive step and will continue work with the actuarial analysis and cost neutrality to evaluate whether additional services can be added.
Therapeutic Foster Care	Clarify & expand TFC as currently defined in waiver; do not limit eligibility for TFC services under waiver.	The state will clarify TFC services in provider billing manuals and regulations accompanying the waiver. The state agrees that new services would be a positive step and will continue work with the actuarial analysis and cost neutrality to evaluate whether additional services can be added.
General questions, clarifications, and comments	Asks for clarification on the criteria for the inclusion of Home and Community Based Services waiver funded individuals for 1115 waiver services.	An individual is receiving 1915(c) services does not preclude them from receiving services through the 1115 if they are eligible. However, if an individual is eligible for 1115 services and is receiving 1915(c) services, limitations and exclusions will apply to prevent duplication of services.
	Asks for clarity on how individuals will transition in and out of waiver services and the determination process.	This level of detail will be addressed through the waiver implementation plan.
	Asks for clarity regarding the requirement for inpatient mental health or substance abuse general hospital stay and does that exclude inpatient substance abuse treatment stays.	Yes, inpatient substance abuse treatment is covered under the category "Inpatient mental health or substance abuse general hospital stay."
	Questions the requirement about peer-based crisis intervention services be 'used in the event that there is a waitlist for services'. Suggests that might be too restrictive and asks for clarity on the waitlist specifically.	This level of detail will be addressed through the waiver implementation plan.
	Asks for more clarity regarding the definition of housing and employment services proposed in the waiver.	This level of detail will be addressed through the waiver implementation plan.
	Asks for more detail on how people transition on and off waiver services, what resources will be available to lower acute settings that are expected	This level of detail will be addressed through the waiver implementation plan.

	to take on higher risk clients, and how clients will navigate the new system.	
	Asks for clarity on what rehabilitations services will be available outside the wavier for individuals not meeting waiver criteria.	Behavioral health-related state plan services will also be available.
	Asks for clarity on the term 'acute'	This level of detail will be addressed through the waiver implementation plan.
	Asks for clarity on the number of providers regarding MAT	Application language is now clarified.
	Asks clarity on if a person qualifies for this level of service, do they ever lose their eligibility.	Continuation of services under the waiver are tied to medical necessity.
	Asks for clarity on what is meant by 'mental health day treatment will be based on the ASAM PPC Level 2.5'.	State agrees that this is confusing. Reference to ASAM has been removed.
	Asks for clarity on referral to treatment for those identified and does that include tobacco use.	This level of detail will be addressed through the waiver implementation plan.
	Asks for clarity about if counseling and/or other recovery services will be included in the proposed services for MAT and Ambulatory Detox.	MAT services include counseling.
	Questions the efficacy of the data in Appendix C, page 3, table 1.	These are preliminary estimates; eligibility and budget considerations are ongoing.
	Asks for clarity on the role that peer-based support services play in a patient's recovery.	This level of detail will be addressed through the waiver implementation plan.
	Asks for clarity on what is included and funded in recovery support services.	This level of detail will be addressed through the waiver implementation plan.
	Asks for clarity on to what extent peer-based crisis services will be offered.	This level of detail will be addressed through the waiver implementation plan.
	Asks for clarity if intensive case management services applied to only the youth, or to others in the family.	This level of detail will be addressed through the waiver implementation plan.
	Asks if 20 hours of service per week is a minimum requirement for mental health day treatment.	This level of detail will be addressed through the waiver implementation plan.
	Asks for clarification for levels of service for home-based treatment, including family therapy.	This level of detail will be addressed through the waiver implementation plan.

	Asks for clarification on how the state will address what types of residential treatment services will be provided by the waiver, and possibly removed in the state plan.	This level of detail will be addressed through the waiver implementation plan.
	Asks for clarification on what components of residential care would be covered and reimbursable under the waiver.	This level of detail will be addressed through the waiver implementation plan.
	Asks for clarity on how often individuals will be assessed for eligibility of waiver services.	This level of detail will be addressed through the waiver implementation plan.
	Supports cost saving measure that will enhance the sustainability of Alaska's long-term services and supports.	Thank you for your comment.
	Comments that the AMHTA and DHSS share a statutory responsibility to prepare and maintain an integrated comprehensive mental health program.	Thank you for your comment.
	Concerns about declining grant dollars, behavioral health billing rates, and proposed services that will be changed or eliminated regarding the financial fragility of BH providers.	Thank you for your comment.
	Supports the request for the waiver of federal authority for the IMD exclusion.	Thank you for your comment.
	Strongly supports the selected target populations.	Thank you for your comment.
	Supports services in the waiver that will provide enhanced services to beneficiaries engaged in the justice system.	Thank you for your comment.
	Recommends reducing the documentation burden for providers and strongly recommends a focus on the alleviation of duplicative and time-intensive documentation where possible.	Thank you for your comment.
	Suggests that good communication, meaningful partnership and collaboration, and a clear vision based on shared values are all essential to the success of behavioral health reform in Alaska.	Thank you for your comment.

	Comments on public comment/provider input during the drafting of the application, questions the opportunities provided by the State for meaningful contribution.	Thank you for your comment.
	Suggests that the draft application focuses on what is hoped to be achieved and lacks critical detail on how it might be achieved.	This level of detail will be addressed through the waiver implementation plan.
	Supports the focus on early intervention.	Thank you for your comment.
	Supports waiver application.	Thank you for your comment.
	Concerns about the existing behavioral health system in Alaska, and specifically in Fairbanks.	Thank you for your comment.
	Concerns about the lack of services for Alaskans with severe mental illness and substance use disorders.	Thank you for your comment.
	Supports the 1115 waiver but concerned the waiver criteria is set too high and excludes people who need services.	Behavioral health-related state plan services will supplement waiver services.
	Concerns that the mental health system in Fairbanks is not adequate.	Thank you for your comment.
	Recommends increased mental health services.	Thank you for your comment.
	Concerns about linking behavioral health and physical health needs in the waiver.	Thank you for your comment.
	Encourages cooperation between DBH and HCS to address behavioral and physical health needs.	Thank you for your comment.
	Recommends wordsmithing the Existing Behavioral Gaps in Services section of the application to note that historically there has not been a systematic approach to developing services or service continuums.	Thank you for your comment.
	Supports the request for the IMD inclusion	Thank you for your comment.
	Supports target group populations #2 and 3	Thank you for your comment.
	Supports the evaluation component of the waiver.	Thank you for your comment.
	Encourages targeted, data-driven decisions that focus on system gaps.	Thank you for your comment.

	Recommends the State mitigate administrative burdens on providers for waiver services.	Thank you for your comment.
	Supports the application and are currently assessing gaps in the Fairbanks system to help advocate for more and improved services.	Thank you for your comment.
	Recommends there is a close relationship between behavioral health and primary care and encourages an integrated system of care.	Thank you for your comment.
	Suggests that the waiver include adoption by reference the work of the Alaska Health Workforce Coalition and include their action agenda as a resource to help achieve the goals of the waiver.	The state is planning periodic updates for Tribes and stakeholders.
	Recommends the State develops a system to track the behavioral health outcomes for those denied care or who otherwise would have been served prior to the implementation of the 1115 waiver.	Thank you for your comment.
	Although generally supportive of the waiver, concerns that the waivers' design elements do not account for the unique challenges faced by Alaska Tribal Health System (ATHS)and would preclude the patients they service from benefiting from wavier services.	Thank you for your comment.
	Recommends that the waiver be structured to support and enhance the existing tribal system.	Thank you for your comment.
	Requests that the State hold monthly teleconferences to update ATHS on waiver negotiations with CMS.	The state is planning periodic updates for Tribes and stakeholders.
	Requests the State continue to meet with Tribal BH Directors and the Tribal Medicaid Task Force to provide updates on the development of the waiver.	The state is planning periodic updates for Tribes and stakeholders.
	Suggests the State should design and implement the waiver to improve access of care for women of reproductive age.	Thank you for your comment.
	Suggests the State recognize and value the role of reproductive health	Thank you for your comment.

	providers in integrated care for women with behavioral health needs.	
	Recommends that the State clarify that OB/GYNs are included in the definitions of primary care providers.	Thank you for your comment.
	Recommends that the ASO be required to engage a sufficient number of reproductive health providers to serve women with participate in behavioral health programs.	Thank you for your comment.
	Recommends that the State consider adding reproductive health care quality measures, such as well-woman visits, to the list of quality and performance measures for the waiver.	Thank you for your comment.
	Concerned about the assumption that cost-neutrality can be achieved through reductions in acute services.	Thank you for your comment.
	Recommends that the State supports and incentivizes lower levels of care, recognizing that lower levels of care include inpatient care at the community hospital level.	Thank you for your comment.
	Concerned about the efficacy of the Milliman data regarding the proposed fiscal impact of the waiver, specifically regarding the integration of physical and behavioral health.	Thank you for your comment.
	Concerned that the waiver does not fully address the integration of physical and behavioral health.	Thank you for your comment.
	Recommends adding alcohol data to the rationale.	Thank you for your comment.
	Recommends wordsmithing the section on Target Group #3 including 'Assessments will be used to develop diagnoses and treatment plans.'	Thank you for your comment.
	Recommends adding 'Reduce number of days of out-of-home placement" under Group 1.b	Thank you for your comment.
	Suggests that instead of shifting care from a more expensive setting to a less costly setting, the focus should be to intervene and address needs early to shift the need level of the populations from more intense to less intense.	Thank you for your comment.

	Recommends that an expansion of the types of providers who can bill for Medicaid will eliminate waiting lists and expand the settings where those with mild and moderate needs can be seen.	Thank you for your comment.
	Suggests that developmental (i.e. assessing the developing system of care) and formative (i.e. focused on evaluating outcomes and impacts of the waiver) evaluation be included in the evaluation process.	Thank you for your comment.
	Encourages coordinated care between BH providers and primary care physicians, specifically including individuals with SMI.	Thank you for your comment.
	Encourages incentive and value-based payments.	Thank you for your comment.
	Encourages collaborative opioid prescription education.	Thank you for your comment.
	Encourages Recovery Oriented Systems of Care (ROSC)	Thank you for your comment.
	Encourages telehealth, smartphone, online, and other health technology.	Thank you for your comment.
	Encourages Alaska to adopt the managed care model.	Thank you for your comment.
	Suggests that focused integration efforts between community behavioral health providers and primary care could increase the capacity to provide the brief solutions outlines.	Thank you for your comment.
	Suggests Alaska Health Care centers have experience with integrating behavioral health and SUD services with their primary care practices, although they acknowledge there are communication barriers.	Thank you for your comment.
	Encourages the state to identify primary care as a key partner in providing coordinated SUD services.	Thank you for your comment.
	Encourages Alaska to adopt the managed care model.	Thank you for your comment.
	Supports an integrated behavioral health system of care for children, youth and adults with SMI and SUD.	Thank you for your comment.
	Suggests that the State include social determinants of health as a core	Thank you for your comment.

	element of the waiver proposal to ensure that the proposed programs support remote, rural and urban settings for providing behavioral health services.	
	Suggests more clarity is needed on how the State will replace the services proposed to be deleted from state plan.	This level of detail will be addressed through the waiver implementation plan.
	Suggests that shortage of access to outpatient care needs to be addressed through regulation and SPA changes, implementation of rate rebasing, and reduction of paperwork burden	Thank you for your comment.
	Recommends that re-basing BH rates occur before the waiver is implemented.	Thank you for your comment.
	Although generally supportive of the waiver, concerns that the waivers' design elements do not account for the unique challenges faced by ATHS and would preclude the patients they service from benefiting from wavier services.	Thank you for your comment.
	Recommends that the waiver be structured to support and enhance the existing tribal system.	Thank you for your comment.
	Requests that the State hold monthly teleconferences to update ATHS on waiver negotiations with CMS.	The state is planning periodic updates for Tribes and stakeholders.
	Requests the State continue to meet with Tribal BH Directors and the Tribal Medicaid Task Force to provide updates on the development of the waiver.	The state is planning periodic updates for Tribes and stakeholders.
	Concerns about removing rehabilitative services.	This level of detail will be addressed through the waiver implementation plan.
	Concerns about the use of psychiatric drugs for mental health treatment.	Thank you for your comment.
	Concerns about the use of standardized psychiatric screenings.	Thank you for your comment.
	Suggests that outreach to other divisions in the state is essential for waiver success.	Thank you for your comment.

	Recommends consideration in the State Plan for individuals who will not qualify for waiver services.	The state agrees.
	Recommends that CMS allows the proposed behavioral health rate adjustments are allowed in the cost neutrality methodology.	Thank you for your comment.
	Recommends the State integrates primary and behavioral health care in regards to cost neutrality.	Thank you for your comment.
	Concern about funding matching the program needs, specifically home and community-based services. Drive time, mileage, no-show rates, sessions overages are given as examples.	Thank you for your comment.

Appendix D: Budget Neutrality and Supplemental SUD IMD Budget Neutrality Worksheets

1/26/2018

Interim Section 1115 Demonstration Application Budget Neutrality Table Shell

	A	B	C	D	E	F	G
1	**5 YEARS OF HISTORIC DATA**						
2							
3	**SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:**						
4							
5	**ABD**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**5-YEARS**
6	**TOTAL EXPENDITURES**	$ 423,135,436	$ 392,493,497	$ 348,649,510	$ 442,344,209	$ 440,604,795	$ 2,047,227,447
7	**ELIGIBLE MEMBER MONTHS**	169,984	172,804	171,336	171,216	169,858	
8	**PMPM COST**	$ 2,489.27	$ 2,271.32	$ 2,034.89	$ 2,583.54	$ 2,593.96	
9	**TREND RATES**						**5-YEAR**
10			**ANNUAL CHANGE**				**AVERAGE**
11	TOTAL EXPENDITURE		-7.24%	-11.17%	26.87%	-0.39%	1.02%
12	ELIGIBLE MEMBER MONTHS		1.66%	-0.85%	-0.07%	-0.79%	-0.02%
13	PMPM COST		-8.76%	-10.41%	26.96%	0.40%	1.04%
14							
15	**CHIP**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**5-YEARS**
16	**TOTAL EXPENDITURES**	$ 82,593,173	$ 76,115,288	$ 69,188,490	$ 105,763,827	$ 117,797,842	$ 451,458,622
17	**ELIGIBLE MEMBER MONTHS**	280,560	269,114	279,653	340,422	361,895	
18	**PMPM COST**	$ 294.39	$ 282.84	$ 247.41	$ 310.68	$ 325.50	
19	**TREND RATES**						**5-YEAR**
20			**ANNUAL CHANGE**				**AVERAGE**
21	TOTAL EXPENDITURE		-7.84%	-9.10%	52.86%	11.38%	9.28%
22	ELIGIBLE MEMBER MONTHS		-4.08%	3.92%	21.73%	6.31%	6.57%
23	PMPM COST		-3.92%	-12.53%	25.58%	4.77%	2.54%
24							
25	**Former Foster Care**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**5-YEARS**
26	**TOTAL EXPENDITURES**	$ -	$ -	$ -	$ 47,391	$ 118,126	$ 165,518
27	**ELIGIBLE MEMBER MONTHS**	-	-	-	100	262	
28	**PMPM COST**	#DIV/0!	#DIV/0!	#DIV/0!	$ 473.91	$ 450.86	
29	**TREND RATES**						**5-YEAR**
30			**ANNUAL CHANGE**				**AVERAGE**
31	TOTAL EXPENDITURE		#DIV/0!	#DIV/0!	#DIV/0!	149.26%	#DIV/0!
32	ELIGIBLE MEMBER MONTHS		#DIV/0!	#DIV/0!	#DIV/0!	162.00%	#DIV/0!
33	PMPM COST		#DIV/0!	#DIV/0!	#DIV/0!	-4.86%	#DIV/0!
34							
35	**Medicaid Expansion**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**5-YEARS**
36	**TOTAL EXPENDITURES**	$ -	$ -	$ -	$ -	$ 182,332,794	$ 182,332,794
37	**ELIGIBLE MEMBER MONTHS**	-	-	-	-	148,828	
38	**PMPM COST**	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	$ 1,225.12	
39	**TREND RATES**						**5-YEAR**
40			**ANNUAL CHANGE**				**AVERAGE**
41	TOTAL EXPENDITURE		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
42	ELIGIBLE MEMBER MONTHS		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
43	PMPM COST		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
44							
45	**Newborn**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**5-YEARS**
46	**TOTAL EXPENDITURES**	$ 74,544,829	$ 68,684,166	$ 36,752,076	$ 85,693,618	$ 98,456,051	$ 364,130,740
47	**ELIGIBLE MEMBER MONTHS**	58,252	57,481	52,741	56,249	68,031	
48	**PMPM COST**	$ 1,279.70	$ 1,194.90	$ 696.84	$ 1,523.48	$ 1,447.23	
49	**TREND RATES**						**5-YEAR**
50			**ANNUAL CHANGE**				**AVERAGE**
51	TOTAL EXPENDITURE		-7.86%	-46.49%	133.17%	14.89%	7.20%
52	ELIGIBLE MEMBER MONTHS		-1.32%	-8.25%	6.65%	20.95%	3.96%
53	PMPM COST		-6.63%	-41.68%	118.63%	-5.01%	3.12%
54							

	A	B	C	D	E	F	G
1	**5 YEARS OF HISTORIC DATA**						
2							
3	**SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:**						
4							
55	**Parent/Caretaker**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**5-YEARS**
56	**TOTAL EXPENDITURES**	$ 114,109,216	$ 110,346,036	$ 105,277,456	$ 186,057,426	$ 201,879,543	$ 717,669,677
57	**ELIGIBLE MEMBER MONTHS**	178,128	188,185	210,579	331,128	354,997	
58	**PMPM COST**	$ 640.60	$ 586.37	$ 499.94	$ 561.89	$ 568.68	
59	**TREND RATES**						**5-YEAR**
60				**ANNUAL CHANGE**			**AVERAGE**
61	TOTAL EXPENDITURE		-3.30%	-4.59%	76.73%	8.50%	15.33%
62	ELIGIBLE MEMBER MONTHS		5.65%	11.90%	57.25%	7.21%	18.82%
63	PMPM COST		-8.47%	-14.74%	12.39%	1.21%	-2.93%
64							
65	**Pregnant Women**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**5-YEARS**
66	**TOTAL EXPENDITURES**	$ 65,164,783	$ 57,561,949	$ 39,749,427	$ 68,981,039	$ 75,708,587	$ 307,165,785
67	**ELIGIBLE MEMBER MONTHS**	38,634	36,790	36,127	41,076	47,885	
68	**PMPM COST**	$ 1,686.72	$ 1,564.61	$ 1,100.27	$ 1,679.35	$ 1,581.05	
69	**TREND RATES**						**5-YEAR**
70				**ANNUAL CHANGE**			**AVERAGE**
71	TOTAL EXPENDITURE		-11.67%	-30.94%	73.54%	9.75%	3.82%
72	ELIGIBLE MEMBER MONTHS		-4.77%	-1.80%	13.70%	16.58%	5.51%
73	PMPM COST		-7.24%	-29.68%	52.63%	-5.85%	-1.60%
74							
75	**TEFRA**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**5-YEARS**
76	**TOTAL EXPENDITURES**	$ 7,993,616	$ 7,392,048	$ 7,519,370	$ 8,597,568	$ 9,089,085	$ 40,591,686
77	**ELIGIBLE MEMBER MONTHS**	8,000	8,512	8,906	9,125	9,326	
78	**PMPM COST**	$ 999.20	$ 868.43	$ 844.30	$ 942.20	$ 974.60	
79	**TREND RATES**						**5-YEAR**
80				**ANNUAL CHANGE**			**AVERAGE**
81	TOTAL EXPENDITURE		-7.53%	1.72%	14.34%	5.72%	3.26%
82	ELIGIBLE MEMBER MONTHS		6.40%	4.63%	2.46%	2.20%	3.91%
83	PMPM COST		-13.09%	-2.78%	11.59%	3.44%	-0.62%
84							
85	**Under 21**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**5-YEARS**
86	**TOTAL EXPENDITURES**	$ 297,831,807	$ 269,690,133	$ 235,136,397	$ 288,378,973	$ 295,330,871	$ 1,386,368,181
87	**ELIGIBLE MEMBER MONTHS**	557,542	571,274	561,832	511,794	523,746	
88	**PMPM COST**	$ 534.19	$ 472.09	$ 418.52	$ 563.47	$ 563.88	
89	**TREND RATES**						**5-YEAR**
90				**ANNUAL CHANGE**			**AVERAGE**
91	TOTAL EXPENDITURE		-9.45%	-12.81%	22.64%	2.41%	-0.21%
92	ELIGIBLE MEMBER MONTHS		2.46%	-1.65%	-8.91%	2.34%	-1.55%
93	PMPM COST		-11.63%	-11.35%	34.63%	0.07%	1.36%
94							
95	**Other**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**	**5-YEARS**
96	**TOTAL EXPENDITURES**	$ 57,771,872	$ 51,371,230	$ 43,019,403	$ 46,161,499	$ 48,127,370	$ 246,451,375
97	**ELIGIBLE MEMBER MONTHS**	62,354	66,073	58,324	40,963	30,641	
98	**PMPM COST**	$ 926.51	$ 777.49	$ 737.59	$ 1,126.91	$ 1,570.67	
99	**TREND RATES**						**5-YEAR**
100				**ANNUAL CHANGE**			**AVERAGE**
101	TOTAL EXPENDITURE		-11.08%	-16.26%	7.30%	4.26%	-4.46%
102	ELIGIBLE MEMBER MONTHS		5.96%	-11.73%	-29.77%	-25.20%	-16.27%
103	PMPM COST		-16.08%	-5.13%	52.78%	39.38%	14.11%

	A	B	C	D	E	F	G	H	I	J	K
1	**DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS**										
2											
3											
4	**ELIGIBILITY**	**TREND**	**MONTHS**	**BASE YEAR**	**TREND**	**DEMONSTRATION YEARS (DY)**					**TOTAL**
5	**GROUP**	**RATE 1**	**OF AGING**	**DY 00**	**RATE 2**	**DY 01**	**DY 02**	**DY 03**	**DY 04**	**DY 05**	**WOW**
6											
7	**ABD**										
8	**Pop Type:**	**Medicaid**									
9	Eligible Member Months	0.0%	30	169,858	0.0%	169,858	169,858	169,858	169,858	169,858	
10	PMPM Cost	3.5%	30	$ 2,888.01	3.5%	$ 2,989.09	$ 3,093.71	$ 3,201.99	$ 3,314.06	$ 3,430.05	
11	Total Expenditure					$ 507,720,849	$ 525,491,393	$ 543,883,617	$ 562,919,603	$ 582,621,433	$ 2,722,636,896
12											
13	**CHIP**										
14	**Pop Type:**	**Medicaid**									
15	Eligible Member Months	4.5%	30	403,993	4.5%	422,173	441,170	461,023	481,769	503,449	
16	PMPM Cost	3.5%	30	$ 455.08	3.5%	$ 471.01	$ 487.50	$ 504.56	$ 522.22	$ 540.50	
17	Total Expenditure					$ 198,847,556	$ 215,070,597	$ 232,613,829	$ 251,589,494	$ 272,114,065	$ 1,170,235,542
18											
19	**Former Foster Care**										
20	**Pop Type:**	**Medicaid**									
21	Eligible Member Months	4.5%	30	292	4.5%	305	319	333	348	364	
22	PMPM Cost	3.5%	30	$ 491.46	3.5%	$ 508.66	$ 526.46	$ 544.89	$ 563.96	$ 583.70	
23	Total Expenditure					$ 155,213	$ 167,873	$ 181,569	$ 196,380	$ 212,400	$ 913,433
24											
25	**Medicaid Expansion**										
26	**Pop Type:**	**Expansion**									
27	Eligible Member Months	60.0%	30	481,931	1.0%	486,750	491,618	496,534	501,499	506,514	
28	PMPM Cost	3.5%	30	$ 1,352.15	3.5%	$ 1,399.48	$ 1,448.46	$ 1,499.16	$ 1,551.63	$ 1,605.94	
29	Total Expenditure					$ 681,197,324	$ 712,088,738	$ 744,383,898	$ 778,141,407	$ 813,431,614	$ 3,729,242,981
30											
31	**Newborn**										
32	**Pop Type:**	**Medicaid**									
33	Eligible Member Months	4.0%	30	75,039	4.0%	78,041	81,162	84,409	87,785	91,296	
34	PMPM Cost	3.5%	30	$ 1,636.69	3.5%	$ 1,693.97	$ 1,753.26	$ 1,814.62	$ 1,878.13	$ 1,943.86	
35	Total Expenditure					$ 132,198,367	$ 142,298,408	$ 153,169,660	$ 164,871,673	$ 177,467,453	$ 770,005,562
36											
37	**Parent/Caretaker**										
38	**Pop Type:**	**Medicaid**									
39	Eligible Member Months	4.5%	30	396,292	4.5%	414,125	432,761	452,235	472,586	493,852	
40	PMPM Cost	3.5%	30	$ 646.78	3.5%	$ 669.42	$ 692.85	$ 717.10	$ 742.20	$ 768.18	
41	Total Expenditure					$ 277,223,651	$ 299,838,300	$ 324,297,723	$ 350,753,018	$ 379,367,177	$ 1,631,479,870
42											

	A	B	C	D	E	F	G	H	I	J	K
1	**DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS**										
2											
3											
4	**ELIGIBILITY**	**TREND**	**MONTHS**	**BASE YEAR**	**TREND**	**DEMONSTRATION YEARS (DY)**					**TOTAL**
5	**GROUP**	**RATE 1**	**OF AGING**	**DY 00**	**RATE 2**	**DY 01**	**DY 02**	**DY 03**	**DY 04**	**DY 05**	**WOW**
6											
43	**Pregnant Women**										
44	**Pop Type:**	**Medicaid**									
45	Eligible Member Months	4.5%	30	53,455	4.5%	55,860	58,374	61,001	63,746	66,615	
46	PMPM Cost	3.5%	30	$ 1,768.25	3.5%	$ 1,830.14	$ 1,894.19	$ 1,960.49	$ 2,029.11	$ 2,100.13	
47	Total Expenditure					$ 102,232,490	$ 110,571,819	$ 119,591,920	$ 129,347,812	$ 139,899,436	$ 601,643,477
48											
49	**TEFRA**										
50	**Pop Type:**	**Medicaid**									
51	Eligible Member Months	3.9%	30	10,262	3.9%	10,662	11,078	11,510	11,959	12,425	
52	PMPM Cost	3.5%	30	$ 1,125.49	3.5%	$ 1,164.88	$ 1,205.65	$ 1,247.85	$ 1,291.52	$ 1,336.72	
53	Total Expenditure					$ 12,420,205	$ 13,356,244	$ 14,362,864	$ 15,445,264	$ 16,609,257	$ 72,193,833
54											
55	**Under 21**										
56	**Pop Type:**	**Medicaid**									
57	Eligible Member Months	0.0%	30	523,746	0.0%	523,746	523,746	523,746	523,746	523,746	
58	PMPM Cost	3.5%	30	$ 688.07	3.5%	$ 712.15	$ 737.08	$ 762.88	$ 789.58	$ 817.22	
59	Total Expenditure					$ 372,985,714	$ 386,042,702	$ 399,555,348	$ 413,539,367	$ 428,015,706	$ 2,000,138,837
60											
61	**Other**										
62	**Pop Type:**	**Medicaid**									
63	Eligible Member Months	0.0%	30	30,641	0.0%	30,641	30,641	30,641	30,641	30,641	
64	PMPM Cost	3.5%	30	$ 1,715.29	3.5%	$ 1,775.33	$ 1,837.47	$ 1,901.78	$ 1,968.34	$ 2,037.23	
65	Total Expenditure					$ 54,397,887	$ 56,301,918	$ 58,272,441	$ 60,311,906	$ 62,422,764	$ 291,706,916

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

RESULT

ELIGIBILITY GROUP	DY 00	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WW
ABD								
Pop Type:	**Medicaid**							
Eligible Member Months	169,858	0.0%	169,858	169,858	169,858	169,858	169,858	
PMPM Cost	$ 2,888.01	3.50%	$ 2,988.75	$ 3,090.68	$ 3,193.37	$ 3,299.12	$ 3,409.30	
Total Expenditure			$ 507,663,511	$ 524,976,866	$ 542,420,029	$ 560,381,205	$ 579,096,916	$ 2,714,538,527
CHIP								
Pop Type:	**Medicaid**							
Eligible Member Months	403,993	4.5%	422,173	441,170	461,023	481,769	503,449	
PMPM Cost	$ 455.08	3.50%	$ 471.11	$ 487.40	$ 503.49	$ 519.95	$ 537.43	
Total Expenditure			$ 198,888,768	$ 215,027,816	$ 232,118,258	$ 250,496,272	$ 270,567,911	$ 1,167,099,024
Former Foster Care								
Pop Type:	**Medicaid**							
Eligible Member Months	292	4.5%	305	319	333	348	364	
PMPM Cost	$ 491.46	3.50%	$ 510.63	$ 524.10	$ 535.86	$ 540.04	$ 549.27	
Total Expenditure			$ 155,815	$ 167,122	$ 178,559	$ 188,052	$ 199,871	$ 889,419
Medicaid Expansion								
Pop Type:	**Medicaid**							
Eligible Member Months	481,931	1.0%	486,750	491,618	496,534	501,499	506,514	
PMPM Cost	$ 1,352.15	3.50%	$ 1,400.37	$ 1,448.82	$ 1,496.89	$ 1,545.06	$ 1,594.43	
Total Expenditure			$ 681,631,923	$ 712,266,937	$ 743,258,194	$ 774,846,562	$ 807,601,719	$ 3,719,605,335
Newborn								
Pop Type:	**Medicaid**							
Eligible Member Months	75,039	4.0%	78,041	81,162	84,409	87,785	91,296	
PMPM Cost	$ 1,636.69	3.50%	$ 1,693.96	$ 1,753.09	$ 1,813.93	$ 1,876.87	$ 1,942.19	
Total Expenditure			$ 132,197,561	$ 142,284,238	$ 153,111,735	$ 164,761,294	$ 177,314,994	$ 769,669,822
Parent/Caretaker								
Pop Type:	**Medicaid**							
Eligible Member Months	396,292	4.5%	414,125	432,761	452,235	472,586	493,852	
PMPM Cost	$ 646.78	3.50%	$ 670.26	$ 694.38	$ 718.53	$ 742.69	$ 766.99	
Total Expenditure			$ 277,572,548	$ 300,499,122	$ 324,946,424	$ 350,985,692	$ 378,780,049	$ 1,632,783,835

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

RESULT

ELIGIBILITY GROUP	DY 00	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WW
Pregnant Women								
Pop Type:	**Medicaid**							
Eligible Member Months	53,455	4.5%	55,860	58,374	61,001	63,746	66,615	
PMPM Cost	$ 1,768.25	3.50%	$ 1,830.82	$ 1,894.99	$ 1,959.38	$ 2,024.84	$ 2,092.10	
Total Expenditure			$ 102,270,609	$ 110,618,487	$ 119,524,151	$ 129,075,887	$ 139,364,372	$ 600,853,506
TEFRA								
Pop Type:	**Medicaid**							
Eligible Member Months	10,262	3.9%	10,662	11,078	11,510	11,959	12,425	
PMPM Cost	$ 1,125.49	3.50%	$ 1,165.66	$ 1,205.78	$ 1,244.18	$ 1,283.82	$ 1,326.39	
Total Expenditure			$ 12,428,513	$ 13,357,645	$ 14,320,569	$ 15,353,129	$ 16,480,916	$ 71,940,772
Under 21								
Pop Type:	**Medicaid**							
Eligible Member Months	523,746	0.0%	523,746	523,746	523,746	523,746	523,746	
PMPM Cost	$ 688.07	3.50%	$ 711.09	$ 731.98	$ 749.82	$ 768.33	$ 790.70	
Total Expenditure			$ 372,429,431	$ 383,370,466	$ 392,714,818	$ 402,412,153	$ 414,127,115	$ 1,965,053,982
Other								
Pop Type:	**Medicaid**							
Eligible Member Months	30,641	0.0%	30,641	30,641	30,641	30,641	30,641	
PMPM Cost	$ 1,715.29	3.50%	$ 1,775.33	$ 1,837.47	$ 1,901.78	$ 1,968.34	$ 2,037.23	
Total Expenditure			$ 54,397,887	$ 56,301,813	$ 58,272,376	$ 60,311,909	$ 62,422,826	$ 291,706,810

Budget Neutrality Summary

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Medicaid Populations						
ABD	$ 507,720,849	$ 525,491,393	$ 543,883,617	$ 562,919,603	$ 582,621,433	$ 2,722,636,896
CHIP	$ 198,847,556	$ 215,070,597	$ 232,613,829	$ 251,589,494	$ 272,114,065	$ 1,170,235,542
Former Foster Care	$ 155,213	$ 167,873	$ 181,569	$ 196,380	$ 212,400	$ 913,433
Medicaid Expansion	$ 681,197,324	$ 712,088,738	$ 744,383,898	$ 778,141,407	$ 813,431,614	$ 3,729,242,981
Newborn	$ 132,198,367	$ 142,298,408	$ 153,169,660	$ 164,871,673	$ 177,467,453	$ 770,005,562
Parent/Caretaker	$ 277,223,651	$ 299,838,300	$ 324,297,723	$ 350,753,018	$ 379,367,177	$ 1,631,479,870
Pregnant Women	$ 102,232,490	$ 110,571,819	$ 119,591,920	$ 129,347,812	$ 139,899,436	$ 601,643,477
TEFRA	$ 12,420,205	$ 13,356,244	$ 14,362,864	$ 15,445,264	$ 16,609,257	$ 72,193,833
Under 21	$ 372,985,714	$ 386,042,702	$ 399,555,348	$ 413,539,367	$ 428,015,706	$ 2,000,138,837
Other	$ 54,397,887	$ 56,301,918	$ 58,272,441	$ 60,311,906	$ 62,422,764	$ 291,706,916
DSH Allotment Diverted	$ -	$ -	$ -	$ -	$ -	$ -
Other WOW Categories						
SUD IMD	$ 20,592,737	$ 23,981,578	$ 27,928,100	$ 32,524,082	$ 37,876,401	$ 142,902,898
Category 2						$ -
TOTAL	$ 2,359,971,993	$ 2,485,209,571	$ 2,618,240,968	$ 2,759,640,006	$ 2,910,037,708	$ 13,133,100,246

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Medicaid Populations						
ABD	$ 507,663,511	$ 524,976,866	$ 542,420,029	$ 560,381,205	$ 579,096,916	$ 2,714,538,527
CHIP	$ 198,888,768	$ 215,027,816	$ 232,118,258	$ 250,496,272	$ 270,567,911	$ 1,167,099,024
Former Foster Care	$ 155,815	$ 167,122	$ 178,559	$ 188,052	$ 199,871	$ 889,419
Medicaid Expansion	$ 681,631,923	$ 712,266,937	$ 743,258,194	$ 774,846,562	$ 807,601,719	$ 3,719,605,335
Newborn	$ 132,197,561	$ 142,284,238	$ 153,111,735	$ 164,761,294	$ 177,314,994	$ 769,669,822
Parent/Caretaker	$ 277,572,548	$ 300,499,122	$ 324,946,424	$ 350,985,692	$ 378,780,049	$ 1,632,783,835
Pregnant Women	$ 102,270,609	$ 110,618,487	$ 119,524,151	$ 129,075,887	$ 139,364,372	$ 600,853,506
TEFRA	$ 12,428,513	$ 13,357,645	$ 14,320,569	$ 15,353,129	$ 16,480,916	$ 71,940,772
Under 21	$ 372,429,431	$ 383,370,466	$ 392,714,818	$ 402,412,153	$ 414,127,115	$ 1,965,053,982
Other	$ 54,397,887	$ 56,301,813	$ 58,272,376	$ 60,311,909	$ 62,422,826	$ 291,706,810
Excess Spending From Hypotheticals						$ -
Other WW Categories						
SUD IMD	$ 20,592,737	$ 23,981,578	$ 27,928,100	$ 32,524,082	$ 37,876,401	$ 142,902,898
Category 4						$ -
TOTAL	$ 2,360,229,304	$ 2,482,852,089	$ 2,608,793,212	$ 2,741,336,236	$ 2,883,833,089	$ 13,077,043,930

VARIANCE	$ (257,311)	$ 2,357,482	$ 9,447,756	$ 18,303,770	$ 26,204,619	$ 56,056,316

SUD Historical Spending Data - 5 Years

	Historical Years Definition:		State Fiscal Year			
SUD IMD Services MEG 1	**2012**	**2013**	**2014**	**2015**	**2016**	**5-YEARS**
TOTAL EXPENDITURES	$ 0	$ 0	$ 0	$ 0	$ 14,387,511	$ 14,387,511
ELIGIBLE MEMBER MONTHS	-	-	-	-	1,621	1,621
PMPM COST	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	$ 8,877.89	$ 8,877.89
TREND RATES						
TOTAL EXPENDITURE		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
ELIGIBLE MEMBER MONTHS		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
PMPM COST		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	4.50%

SUD IMD Services MEG 2

TOTAL EXPENDITURES						
ELIGIBLE MEMBER MONTHS						
PMPM COST	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
TREND RATES						
TOTAL EXPENDITURE		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
ELIGIBLE MEMBER MONTHS		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
PMPM COST		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

SUD IMD Services MEG 3

TOTAL EXPENDITURES						
ELIGIBLE MEMBER MONTHS						
PMPM COST	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
TREND RATES						
TOTAL EXPENDITURE		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
ELIGIBLE MEMBER MONTHS		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	
PMPM COST		#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

			PB Trend:	4.5%						
ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR DY 00	TREND RATE 2	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WOW
SUD IMD Services MEG 1										
Eligible Member Months	n.a.	n.a.	1621	n.a.	1,621	1,806	2,013	2,243	2,500	
PMPM Cost	4.5%	30	$12,159.67	4.5%	$12,707	$13,279	$13,876	$14,501	$15,153	
Total Expenditure					$20,592,737	$23,981,578	$27,928,100	$32,524,082	$37,876,401	$142,902,898
SUD IMD Services MEG 2										
Eligible Member Months	n.a.	n.a.	0	n.a.	0	0	0	0	0	
PMPM Cost	n.a.	0	$0.00	4.5%	$0	$0	$0	$0	$0	
Total Expenditure					$0	$0	$0	$0	$0	$0
SUD IMD Services MEG 3										
Eligible Member Months	n.a.	n.a.	0	n.a.	0	0	0	0	0	
PMPM Cost	n.a.	0	$0.00	4.5%	$0	$0	$0	$0	$0	
Total Expenditure					$0	$0	$0	$0	$0	$0
SUD IMD Hypothetical Services CNOM MEG										
Eligible Member Months	n.a.	n.a.	n.a.	n.a.	0	0	0	0	0	
PMPM Cost	n.a.		$0.00	4.5%	$0	$0	$0	$0	$0	
Total Expenditure					$0	$0	$0	$0	$0	$0

ELIGIBILITY GROUP	DY 00	TREND RATE	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WW
SUD IMD Services MEG 1								
Eligible Member Months			1,621	1,806	2,013	2,243	2,500	
PMPM Cost	$12,160	4.5%	$12,707	$13,279	$13,876	$14,501	$15,153	
Total Expenditure			$20,592,737	$23,981,578	$27,928,100	$32,524,082	$37,876,401	$142,902,898
SUD IMD Services MEG 2								
Eligible Member Months			0	0	0	0	0	
PMPM Cost	$0	4.5%	0	0	0	0	$0	
Total Expenditure			0	0	0	0	$0	$0
SUD IMD Services MEG 3								
Eligible Member Months			0	0	0	0	0	
PMPM Cost	$0	4.5%	0	0	0	0	0	
Total Expenditure			0	0	0	0	0	$0
SUD IMD Hypothetical Services CNOM MEG								
Eligible Member Months	n.a.		0	0	0	0	0	
PMPM Cost	$0	4.5%	0	0	0	0	0	
Total Expenditure			0	0	0	0	0	$0
SUD IMD Non-Hypothetical Services CNOM MEG								
Eligible Member Months			0	0	0	0	0	
PMPM Cost	$0	4.5%	$0	$0	$0	$0	$0	
Total Expenditure			$0	$0	$0	$0	$0	$0

SUD IMD Supplemental BN Tests

IMD Cost Limit
Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
SUD IMD Services MEG 1	$20,592,737	$23,981,578	$27,928,100	$32,524,082	$37,876,401	$142,902,898
SUD IMD Services MEG 2	$0	$0	$0	$0	$0	$0
SUD IMD Services MEG 3	$0	$0	$0	$0	$0	$0
TOTAL	$20,592,737	$23,981,578	$27,928,100	$32,524,082	$37,876,401	$142,902,898

With-Waiver Total Expenditures

	DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL
SUD IMD Services MEG 1	$20,592,737	$23,981,578	$27,928,100	$32,524,082	$37,876,401	$142,902,898
SUD IMD Services MEG 2	$0	$0	$0	$0	$0	$0
SUD IMD Services MEG 3	$0	$0	$0	$0	$0	$0
TOTAL	$20,592,737	$23,981,578	$27,928,100	$32,524,082	$37,876,401	$142,902,898
Net Overspend	$0	$0	$0	$0	$0	**$0**

Projected SUD IMD Member Months/Caseloads		DEMONSTRATION YEARS (DY)				
	Trend Rate	DY 01	DY 02	DY 03	DY 04	DY 05
SUD IMD Services MEG 1	11.4%	1,621	1,806	2,013	2,243	2,500
SUD IMD Services MEG 2			0	0	0	0
SUD IMD Services MEG 3			0	0	0	0
SUD IMD Hypothetical Services CNOM MEG			0	0	0	0
SUD IMD Non-Hypothetical Services CNOM MEG			0	0	0	0