

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S2-01-16  
Baltimore, Maryland 21244-1850



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## State Demonstrations Group

March 21, 2019

Margaret Brodie  
Medicaid Director  
Alaska Department of Health and Social Services  
4501 Business Park Blvd, Bldg. L  
Anchorage, AK 99503-7167

Dear Ms. Brodie:

The state of Alaska submitted its Substance Use Disorder (SUD) Implementation Protocol as required by special terms and condition (STC) 21 of the state's section 1115(a) demonstration (11-W00318/0) entitled "Substance Use Disorder Treatment and Alaska Behavioral Health Program" (SUD - BHP). The Centers for Medicare & Medicaid Services (CMS) has reviewed the SUD Implementation Protocol and determined it is consistent with the requirements outlined in the STCs; therefore, with this letter, the state may begin receiving Federal Financial Participation for Alaska Medicaid recipients residing in the Institutions for Mental Disease setting under the terms of this demonstration for the period starting with the date of this approval letter through December 31, 2023. A copy of this approved protocol is enclosed and is also hereby incorporated into the STCs as Attachment D.

If you have any questions, please contact your project officer, Mrs. Heather Ross, at (410) 786-3666 or by email at [Heather.Ross@cms.hhs.gov](mailto:Heather.Ross@cms.hhs.gov).

We appreciate your cooperation throughout the review process.


Sincerely,

/s/

Mehreen Rashid  
Deputy Director  
Division of System Reform Demonstration

Enclosure

cc: Richard Allen, Director, Division of Medicaid Field Operations West  
Mary Marchioni, Acting Deputy Director, Division of Medicaid Field Operations West  
David Meacham, Deputy Director, Division of Medicaid Field Operations West



ALASKA 1115 SUBSTANCE USE  
DISORDER WAIVER  
IMPLEMENTATION  
PLAN--FINAL

March 13, 2019

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- Alaska Senate Bill 74 (A.S.47.07.036(f))

- Alaska Opioid Policy Task Force Recommendations
- List and location of Waiver regions in Alaska
- The Alcohol Use Disorders Identification Test and the Drug Abuse Screening Test
- Current and Future Capacity for ASAM Levels 3.1, 3.3 and 3.5 Residential Services by Waiver region
- SUD Evidence-based Clinical Assessment Instrument
- ASAM Criteria for Levels of Care 2.1, 2.5, 3.1, 3.3, 3.5, 1-WM & 2-WM
- Chemical Dependency Certification Matrix: Degreed and Non-Degreed Tracks
- Governor of Alaska Administrative Order No. 283
- Alaska Strategic Plan for Responding to Opioid Crisis—Draft
- Alaska Prescription Drug Monitoring Program Report to the 30<sup>th</sup> Alaska State Legislature (2018)
- Alaska Board of Pharmacy Meeting Minutes February 28-March 2, 2018
- Recommendation to Adopt Washington’s Interagency Guideline on Prescribing Opioids for Pain, 3<sup>rd</sup> Edition
- Washington Interagency Guideline on Prescribing Opioids for Pain, 3<sup>rd</sup> Edition
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## Introduction

Like many States, during the past several years Alaska has seen a dramatic increase in opioid use and opioid overdose deaths. In 2017, the rate of opioid-related overdose deaths per 100,000 in Alaska was 13.6, which has steadily increased from a rate of 7.7/100,000 in 2010. This was driven by a dramatic increase in Alaska's number of heroin and fentanyl overdose deaths. Alaska's annual average percentage of adult- past-year-heroin use rate has been well above the national average for many years—for 2015, Alaska's average was 1.23% compared to US average of 0.33%. The increasing use of heroin is also reflected in the 58% increase in treatment admissions for heroin dependence between 2009 and 2013, the majority of which were individuals between 21-29 years of age. Finally, between 2007 and 2016, the number of Neonatal Abstinence Syndrome (NAS) diagnoses among Medicaid-covered infants increased fourfold—from 4.4% to 16.9%. Alaska's Medicaid population has been most impacted by these trends, with substance use disorder (SUD)-related emergency department visits, inpatient hospital stays, and NAS-related hospital costs increasing proportionately.

While Alaska is not too remote to have been spared from the opioid crisis, we have other critical substance use/misuse/abuse-related needs. Alaska has the 10th highest prevalence rate of adult binge drinking in the country and the 5th highest rate of intensity of binge drinking among adults. Importantly, the rate of alcohol-related mortality for Alaska Natives is more than three times (71.4/100,000) that of all Alaskan adults (20.4/100,000) and is eight times the national rate (8.5/100,000). Alaska Native youth ages 10-17 years old are 2.7 times more likely to be hospitalized for unintentional alcohol poisoning than a non-Alaska Native peer. While Alaska's opioid crisis has emerged relatively recently, the State's alarming alcohol-related prevalence rates have remained constant over a much longer period of time.

Alaska find itself with critical treatment infrastructure, provider capacity, and workforce development needs to address these crises. As part of the recommendations in the 2017 report of the Governor's Task Force on Alaska Opioid Policy and the mandates from the Alaska Legislature via Senate Bill 74 (passed in 2016), we are requesting a Section 1115 Demonstration Waiver to transform the behavioral health system of care. The SUD portion of the 1115 Demonstration Waiver will assist us in:

- ◆ Strengthening Alaska's SUD treatment continuum of services—by both increasing the benefits offered to Medicaid recipients and using evidence-based SUD program standards;
- ◆ Building Alaska's provider capacity throughout the State; and
- ◆ Continuing to develop Alaska's SUD workforce capacity and competencies.

Alaska will use this Waiver to achieve the following Centers for Medicare and Medicaid Services (CMS) goals:

1. Increased rates of identification, initiation, and engagement in treatment (AK 1115 Waiver Cross-Cutting Goal #1 and SUD Implementation Plan Goal#3);

2. Increased adherence to and retention in treatment (AK 1115 Waiver Evaluation Hypotheses #5);
3. Reduced overdose deaths, particularly those due to opioids (AK 1115 Waiver Evaluation Hypothesis #4);
4. Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other more appropriate and focused SUD use/misuse/abuse-related services (AK 1115 Waiver Cross-Cutting Goal #1, SUD Implementation Plan Goal #3, and Evaluation Hypothesis #1);
5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate (AK 1115 Waiver SUD Implementation Plan Goal #3 and Evaluation Hypothesis #1); and
6. Improved access to care for physical health conditions among beneficiaries (AK 1115 Waiver Evaluation Hypothesis #2).

Alaska will address five major domains to accomplish these six goals:

- ◆ Universally screen all Medicaid recipients, regardless of setting, using industry-recognized, evidence-based SUD screening instruments to identify symptoms and intervene as early as possible before use becomes dependence.
- ◆ Implement American Society of Addiction Medicine (ASAM) Criteria (3<sup>rd</sup> Edition) to match individuals with SUD with the services and tools necessary for recovery.
- ◆ Increase SUD treatment options for youth (ages 12-17) and adult (18 and over) Medicaid recipients, particularly non-residential, step-up and step-down treatment options.
- ◆ Improve SUD provider infrastructures and capacity utilizing industry-recognized standards for certification and ongoing accountability (with emphasis on residential providers, but across-the-board).
- ◆ Improve SUD workforce by carefully reviewing existing certification requirements and modifying as appropriate to align with Medicaid, Waiver, and industry-recognized credentialing standards.

This Implementation Plan (plan), designed to be implemented during the five years of the Waiver Demonstration, with particular emphasis on the first two years, is organized by the key milestones identified by CMS. Alaska's plan is to phase-in implementation during the first two years, with approximately one-half of the State's population being covered in Waiver Year 1 and the other half in Waiver Year 2 (50/50 schedule).

This plan provides the detail necessary to operationalize Alaska's shared vision: build the treatment infrastructure necessary to improve the outcomes of Alaskans suffering from addiction, while beginning to put in place in all regions the infrastructure and services necessary to make the Waiver's vision of early intervention more than a vision, but a reality.

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

The following table describes each ASAM Level of Care, current Medicaid coverage, and proposed future coverage per the 1115 Waiver. Of the 17 SUD services listed below, one requires a State Plan Amendment to add or change coverage (ASAM 0.5), fourteen are proposed new 1115 Waiver services (one a sub-category of ASAM 3.5), and two require no change (ASAM 1.0 and MAT). For the column entitled “Current Coverage,” “3.1A” refers to Attachment 3.1A of the Alaska State Medicaid Plan, Alcohol and Substance Abuse Rehabilitative Services benefit category, unless otherwise noted.

ASAM Level of Care	Service	Description	Current Coverage	Future Coverage (Under State Plan or Proposed SUD Portion of 1115 Waiver)
OTS	Opioid Treatment Services (OTS) for persons experiencing an Opioid Use Disorder (OUD)	Pharmacological (opioid agonist, partial agonist, & antagonist medications), counseling services (including SUD care coordination services as appropriate) provided in either an Opioid Treatment Program (OTP) or Office-Based Opioid Setting (OBOT).	Not covered	Proposed SUD Portion of 1115 Waiver
0.5	Early Intervention	Services for individuals who are at risk of developing substance-related disorders.	Currently covered in SP, but limited (see section 3.1A)	State Plan
1.0	Outpatient Services (OP)	Outpatient treatment (usually less than 9 hours a week), including counseling, evaluations, and interventions.	Currently Covered in SP, (see section 3.1A)	State Plan
2.1	Intensive Outpatient Services (IOP)	9-19 hours of structured programming per week (counseling and education about addiction-related and mental health problems).	Not covered	Proposed SUD Portion of 1115 Waiver



**Alaska 1115 SUD Waiver Implementation Plan  
March 13, 2019**

<b>ASAM Level of Care</b>	<b>Service</b>	<b>Description</b>	<b>Current Coverage</b>	<b>Future Coverage (Under State Plan or Proposed SUD Portion of 1115 Waiver)</b>
2.5	Partial Hospitalization Program (PHP)	20 or more hours of clinically intensive outpatient programming per week.	Not covered	Proposed SUD Portion of 1115 Waiver
3.1	Clinically Managed Low- Intensity Residential	24-hour supportive living environment; at least 5 hours of low-intensity treatment per week.	Not covered	Proposed SUD Portion of 1115 Waiver
3.3	Clinically Managed population specific, High intensity Residential	24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu for those with cognitive or other impairments.	Not covered	Proposed SUD Portion of 1115 Waiver
3.5	Clinically Managed Medium (Youth) & High (Adult)-Intensity Residential	24-hour living environment, more high-intensity treatment (level 3.7 without intensive medical and nursing component).	Not covered	Proposed SUD Portion of 1115 Waiver
3.7	Medically Monitored Intensive Inpatient Services	24-hour professionally directed evaluation, observation, medical monitoring, and addiction treatment in an inpatient setting (usually hospital-based).	Not covered	Proposed SUD Portion of 1115 Waiver
4.0	Medically Managed Intensive Inpatient	24-hour inpatient treatment requiring the full resources of an acute care or psychiatric hospital.	Not covered	Proposed SUD Portion of 1115 Waiver

**Alaska 1115 SUD Waiver Implementation Plan**  
**March 13, 2019**

<b>ASAM Level of Care</b>	<b>Service</b>	<b>Description</b>	<b>Current Coverage</b>	<b>Future Coverage (Under State Plan or Proposed SUD Portion of 1115 Waiver)</b>
1-WM	Ambulatory Withdrawal Management without Extended On-Site Monitoring	Mild withdrawal with daily or less than daily outpatient supervision.	Not covered	Proposed SUD Portion of 1115 Waiver
2-WM	Ambulatory Withdrawal Management with Extended On-Site Monitoring	Moderate withdrawal with all- day withdrawal management support and supervision; at night, has supportive family or supportive living situation.	Not covered	Proposed SUD Portion of 1115 Waiver
3.2-WM	Clinically Managed Residential Withdrawal Management	Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.	Not covered	Proposed SUD Portion of 1115 Waiver
3.7-WM	Medically Monitored Inpatient Withdrawal Management	Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete withdrawal management without medical, nursing monitoring (usually hospital- based).	Not covered	Proposed SUD Portion of 1115 Waiver
4-WM	Medically Managed Intensive Inpatient Withdrawal Management	Severe, unstable withdrawal and needs (usually hospital-based) 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.	Not covered	Proposed SUD Portion of 1115 Waiver

**Alaska 1115 SUD Waiver Implementation Plan**  
**March 13, 2019**

ASAM Level of Care	Service	Description	Current Coverage	Future Coverage (Under State Plan or Proposed SUD Portion of 1115 Waiver)
Medication-Assisted Treatment	Medication-Assisted Treatment	Pharmacological (opioid agonist, partial agonist, & antagonist medications) services provided in either an Opioid Treatment Program (OTP) or Office-Based Opioid Setting (OBOT).	Currently covered in SP see Attachment 3.1A)	State Plan
Support	Community and Recovery Support	Services to help people overcome personal and environmental obstacles to recovery, assist the newly recovering person into the recovery community, and serve as a personal guide and mentor toward the achievement of goals.	Not covered	Proposed SUD Portion of 1115 Waiver

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

Each of the ASAM Levels of Care will be addressed in more detail by providing current coverage, future coverage, and a timeline for implementation over the next 12-24 months for the proposed Waiver changes.

**Level of Care: Opioid Treatment Services (OTS)**

**Current State:** Alaska Medicaid provides coverage for pharmacological (opioid agonist, partial agonist, & antagonist) medication administration, counseling services provided in either an opioid treatment program (OTP) or office-based opioid treatment (OBOT), medical evaluation for methadone recipients, and treatment plan review for methadone recipients. Alaska Department of Health and Social Services’ Division of Behavioral Health (DBH) is reviewing and updating both the Healthcare Common Procedure Coding System (HCPCS) codes and the Alaska Administrative Code (AAC) for: 1) The medications, counseling, screening, assessment, treatment planning, and medical evaluation necessary to align with ASAM requirements; 2) To expand use of naltrexone or any currently approved effective pharmacological treatment for substance use disorders; 3) To include treatment plan development in the benefit offered to Waiver recipients; and 4) To define clear standards of care for opioid treatment services.

There are currently four OTPs in Alaska, three of the four OTPs in the Anchorage and Mat-Su regions, where 54% of the state’s population resides, and one in Fairbanks. Alaska has been the recipient of two opioid treatment Substance Abuse and Mental Health Services Administration (SAMHSA) grants. The first, a three-year, \$3 million Medication-Assisted Treatment (MAT) Capacity Expansion grant, is focused on prescription drug and opioid addiction. The grant funds two providers, one OTP in Anchorage and one OBOT in Juneau, and is expected to increase the number of individuals receiving MAT services by 250 over the life of the grant. The grant began 09/01/16 and ends 08/31/19, the proposed Year 1 of the 1115 Waiver Demonstration. The second SAMHSA grant is a two-year, up to \$4 million Opioid State Targeted Response (STR) grant. This grant funds three agencies: one in Kenai (OBOT) and two in Fairbanks (1 OBOT and 1 OTP). The grant is expected to increase the number of individuals receiving MAT by 340 during the life of the grant (05/01/17 through 04/30/19)—again, Year 1 of the 1115 Waiver Demonstration.

**Future State:** Alaska Medicaid/DBH will increase the number of OTPs in Alaska by two for a total of six statewide, including treatment for the 590 grant-funded individuals mentioned above. Proposed locations are included in Appendix 1.

In addition, Alaska Medicaid/DBH will increase MAT services by expanding the use of naltrexone in each of the nine Waiver regions to address both the opioid crisis and continuing alcohol needs. We plan to allow naltrexone or any currently approved effective pharmacological treatment for substance use disorders to be administered in either an OTP, OBOT, out-patient, or residential setting, as long as medical and associated counseling/therapeutic staffing is appropriate. The benefit package for all OTS’s will include evidence-based screening; evidence-based clinical assessment; medication and dose level administration—assessing, ordering, reassessing, and regulating; drug testing for monitoring purposes; treatment plan development and review; SUD care coordination, cognitive-behavioral and other SUD-focused therapies; and a range of Community and Recovery Support Services, which include recovery coaching, relapse prevention, and psychoeducation.

The Alaska Department of Health and Social Services’ Office of Rate Review has developed the rates for screening, clinical assessment, naltrexone, Community and Recovery Support Services, and treatment plan development.

**Actions Needed and Implementation Timeline:**

<b>Action</b>	<b>Timeline</b>
Pursue HCPCS Code modifications for expanded MAT, treatment plan development, and Community and Recovery Support Services.	Target to complete code modifications—April 1, 2019
Pursue Alaska Administrative Code (AAC) modifications accordingly	Target April 1, 2019
Certify two additional OTPs, OBOTs, and Residential providers for appropriate opioid medication (methadone, buprenorphine, or naltrexone)	Will be staggered based on 50/50 schedule. The two additional OTPs will be developed during Demonstration Year 2.

## Level of Care: 0.5—Early Intervention

**Current State:** Alaska Medicaid provides coverage for the Alaska Screening Tool, which is not an evidence-based, SUD-specific instrument. Alaska Medicaid provides coverage for Screening, Brief Intervention, and Referral for Treatment (SBIRT) up to 30 minutes per episode. There is no coverage for brief intervention greater than 30 minutes and no way to track treatment received by SBIRT screens/brief interventions.

**Future State:** Alaska Medicaid will pursue a State Plan Amendment (SPA) to modify the current screening coverage to specify universal use of evidence-based, SUD-specific screening instruments. The plan is to use the Alcohol Use Disorders Identification Test (AUDIT) and the Drug Abuse Screening Test (DAST), two evidence-based, SUD-specific instruments, to identify any person who presents with symptoms indicating possible or potential substance use or misuse requiring further assessment. Universal screening will commence when Waiver services are initiated.

In addition, a SPA will be pursued to modify SBIRT coverage, which will be implemented in the emergency departments of 10 hospitals throughout Alaska as specified in Appendix 1.

The Administrative Services Organization (ASO) will track screenings, brief interventions, and referrals to treatment—where technologically feasible, tablets will be used for screenings, allowing immediate entry into the ASO’s database. We anticipate the use of tablets for approximately 80% of individuals screened (Anchorage, Mat-Su, Fairbanks, Juneau, and Sitka).

### Actions Needed and Implementation Timeline:

Action	Timeline
Pursue SPAs to modify SUD screening and SBIRT services	Target effective date April 1, 2019
Pursue Alaska Administrative Code (AAC) modifications accordingly	Will be filed May 1, 2019
Train hospital ED staff in 10 selected hospitals regarding SBIRT	Will be completed April 30, 2019

For the purpose of the following sections, an “adult” is defined as an individual over 18 years old and a “youth” is defined as an individual between the ages of 12 and 17 years old.

## Level of Care: 1.0—Outpatient Services (OP)

**Current State:** Alaska Medicaid provides coverage for outpatient SUD individual, family, and group therapies. These services are available to all Alaska Medicaid recipients, limited to 10 hours per State Fiscal Year per recipient, with extensions upon authorization.

**Future State:** No changes are expected at this ASAM Level of Care.

**Actions Needed and Implementation Timeline:** None anticipated.

## Level of Care: 2.1—Intensive Outpatient SUD Services (IOP)

**Current State:** Alaska Medicaid does not currently have coverage for intensive outpatient services (IOP). Current practice is to label the need for more than the basic 10 hours of OP services as IOP services; there is presently no Medicaid definition for IOP services.

**Future State:** A new Waiver service will be created to allow reimbursement for SUD IOP services. SUD IOP placement will use the ASAM patient placement criteria, Level 2.1. SUD IOP services will be delivered by qualified addiction professionals (as discussed in Milestone #3, B); and will include a planned regimen of individual/group/family therapy, random drug testing, and skills training, with regularly scheduled sessions within a structured program, for a minimum of nine (9) hours of treatment per week for adults and six (6) hours of treatment per week for youth. All Medicaid recipients eligible to receive Waiver services will have access to this service—strategically, this service is the lynchpin for achieving the positive outcomes we anticipate under the Waiver.

Alaska plans to develop this capacity in 24 locations throughout the State as specified in Appendix 1—14 Adult IOP and 10 Youth IOP.

**Actions Needed and Implementation Timeline:**

Action	Timeline
Develop a new Waiver service to allow reimbursement for IOP services.	Target date for development of new Waiver service—April 2019
Pursue Alaska Administrative Code (AAC) modifications to add coverage of service	Will be filed by May 1, 2019
Develop provider notification/communication regarding new service	Formal notification to be released at least 90 days before initiation of Waiver services
Conduct provider training on ASAM requirements for ASAM 2.1 Level of Care	Based on 50/50 schedule

## Level of Care: 2.5—Partial Hospitalization Program (PHP)

**Current State:** Alaska Medicaid does not currently have coverage for partial hospitalization program services.

**Future State:** Alaska Medicaid will develop a new Waiver service to allow reimbursement for SUD partial hospitalization (PHP) services. SUD PHP services will be specifically designed for the diagnosis or active treatment of a SUD when there is a reasonable expectation for improvement or when it is necessary to maintain the individual’s functional level and prevent relapse or inpatient hospitalization (ASAM Levels 3.7 and 4). Services will include individual, group, and family therapy, medication management, occupational/recreational therapy, and other appropriate therapies. SUD PHP placement will use the ASAM placement criteria, Level 2.5. ASAM has found that, for some individuals, the availability of PHP may shorten the length of stay of full hospitalization or serve as a transition from inpatient to outpatient care. A day of SUD PHP will be defined as six (6) hours of treatment and no less than twenty (20) hours a week of treatment.

We plan to implement SUD partial hospitalization programs, including a minimum of 4 locations throughout the State for youth, targeting those locations with only one adult IOP program, as specified in Appendix 1. We anticipate outpatient settings (including school settings) for this service, not hospital-based settings.

### Actions Needed and Implementation Timeline:

Action	Timeline
Develop a new Waiver service to allow reimbursement for SUD PHP services.	Target effective date April 2019
Pursue Alaska Administrative Code (AAC) modifications to add coverage of service	Will be filed by May 1, 2019
Develop provider notification/communication re new service	Formal notification to be released at least 90 days before initiation of Waiver services
Conduct provider training on ASAM requirements for ASAM 2.5 Level of Care	All training completed Waiver Year 1

## Level of Care: 3.1—Clinically Managed Low-Intensity Residential Services for Youth and Adults

**Current State:** SUD residential treatment is provided within residential treatment facilities, including Institutions for Mental Disease (IMD), which are not currently reimbursed by Medicaid. An IMD is defined as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. The IMD restriction applies to residential treatment programs



with more than 16 beds, whether for SUD or mental health treatment. Federal law prohibits federal financial participation (FFP) from going to IMDs for individuals aged 21 through 64.

One of the primary goals of the SUD portion of the 1115 waiver is to remove this restriction for SUD residential treatment programs and allow such treatment program whose capacity exceeds 16 beds to provide treatment to all Alaska Medicaid recipients receiving hospital-based inpatient and residential treatment services. Providing this service to youth and adults will promote a more robust continuum of care to support youth and adults at all stages of treatment and recovery.

The Alaska Department of Health and Social Services' Office of Rate Review has developed a bundled per diem rate for this ASAM Level of Care. The bundled rate methodology for all Waiver residential services is based on a mix of services that is most appropriate to the particular level of care.

**Future State:** Upon approval of the 1115 waiver, Alaska Medicaid will be able to reimburse for residential stays in all settings, including IMDs, for all eligible youth and adults. Alaska will allow members to seek authorization for residential IMD stays based on a statewide average length of stay of 30 days. Length of stay will be determined by medical necessity.

We plan to increase ASAM 3.1 statewide Residential capacity by 110 beds—90 Adult and 20 Youth—in locations listed in Appendix 1.

This will bring total bed capacity for ASAM 3.1 Residential services to 154 beds. Only a DHSS-approved program that has been designated by the Division of Behavioral Health (DBH) as an ASAM Level 3.1 residential facility (over or under 16 beds) will be eligible to receive Medicaid reimbursement. The development of improved program employee certification requirements and ASAM designation for these facilities will be addressed under a later section of the implementation plan.

Alaska Medicaid will require prior authorization for all SUD residential services provided to Waiver-eligible individuals.

**Actions Needed and Implementation Timeline:**

<b>Action</b>	<b>Timeline</b>
Pursue Alaska Administrative Code (AAC) modifications to add coverage for youth	Will be filed by May 1, 2019
Develop provider notification of IMD status and certification requirements	Formal notification to be released upon CMS approval of SUD Implementation Plan—anticipated date February 1, 2019
Conduct provider training on ASAM requirements for ASAM 3.1 Level of Care	Based on 50/50 schedule



## Level of Care: 3.3—Clinically Managed Population-Specific High-Intensity Residential Services for Adults

**Current State:** SUD residential treatment is provided within residential treatment facilities, including facilities that fall under the IMD, which are not currently reimbursed by Medicaid. As mentioned above, one of the primary goals of the SUD portion of the 1115 Waiver is to remove this restriction as it applies to SUD residential treatment programs with more than 16 treatment beds and allow IMDs to provide treatment to all Alaska Medicaid recipients receiving hospital-based inpatient and residential treatment services.

The Alaska Department of Health and Social Services' Office of Rate Review has developed a bundled per diem rate for this ASAM Level of Care. The bundled rate methodology for all Waiver residential services is based on a mix of services that is most appropriate to the particular level of care.

**Future State:** Upon approval of the 1115 Waiver, Alaska Medicaid will be able to reimburse for residential stays, including IMDs, for all eligible youth and adults. Alaska will allow members to seek authorization for residential IMD stays based on a statewide average length of stay of thirty (30) days. We plan to implement ASAM Level 3.3 bed capacity in two areas of the state:

- ◆ Region 1—12 beds designated for individuals with Traumatic Brain Injury
- ◆ Region 2—12 beds designated for individuals with SUD-related cognitive impairments

This will develop new capacity (24 beds) for ASAM 3.3—a much-needed service that has been in the State Plan but not utilized. Only facilities that receive DHSS approval and have been designated by the DBH as an ASAM Level 3.3 residential facility will be eligible to receive reimbursement. The development of improved program employee certification requirements and ASAM designation for these facilities will be addressed under a later section of the implementation plan.

Alaska Medicaid will require prior authorization for all SUD residential services provided to Waiver-eligible individuals.

### Actions Needed and Implementation Timeline:

Action	Timeline
Pursue Alaska Administrative Code (AAC) modifications re coverage of service	Will be filed May 1, 2019
Develop provider notification of service and certification requirements	Formal notification to be released at least 90 days before initiation of Waiver services
Conduct provider training on ASAM requirements for ASAM 3.3 Level of Care	Waiver Year 1—Regions 1 & 2

## Level of Care: 3.5—Clinically Managed Medium-Intensity Residential Services for Youth and Clinically Managed High-Intensity Residential Services for Adults

**Current State:** SUD residential treatment is provided within residential treatment facilities, including IMDs, because their treatment capacity exceeds 16 residential SUD treatment beds. IMDs are not currently reimbursed by Medicaid. As noted above, one of the primary goals of the SUD portion of the 1115 Waiver is to remove this restriction on Alaska SUD residential treatment programs and allow its residential IMDs to provide treatment to all Alaska Medicaid recipients receiving hospital-based inpatient and residential treatment services.

The Alaska Department of Health and Social Services' Office of Rate Review has developed a bundled per diem rate for this ASAM Level of Care. The bundled rate methodology for all Waiver residential services is based on a mix of services that is most appropriate to the particular level of care.

**Future State:** Upon approval of the 1115 Waiver, Alaska Medicaid will be able to reimburse for residential stays in all settings, including IMDs, for all eligible youth and adults. Alaska will allow Medicaid recipients to seek authorization for residential IMD stays based on a statewide average length of stay of thirty (30) days. Length of stay determined by medical necessity.

We plan to increase ASAM 3.5 statewide Residential capacity by 66 beds to address existing service gaps.

Of the 66 bed increase, 32 beds will be divided between Adult and Youth providers (26 Adult and 6 Youth). The other 34 beds will become specialized Residential Treatment programs for Pregnant and Postpartum Women and their Children ages 10 and under as detailed in Appendix 1, which are not currently covered in the State Plan and, therefore, will be a new Waiver service.

This will bring total bed capacity for ASAM 3.5 Residential services to 391—252 Adult beds, 52 Youth beds, and 87 Women and Children's beds. Only facilities that have been approved by DHSS and designated by the DBH as an ASAM Level 3.5 residential facility will be eligible to receive reimbursement. The development of improved program employee certification requirements and ASAM designation for these facilities will be addressed under a later section of the implementation plan.

Alaska Medicaid will require prior authorization for all SUD residential services provided to Waiver-eligible individuals.

### Actions Needed and Implementation Timeline:

Action	Timeline
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Pursue Alaska Administrative Code (AAC) modifications re coverage of service	Will be filed by May 1, 2019
Develop provider notification of IMD status, women/children’s requirement, and certification requirements	Formal notification to be released upon CMS approval of SUD Implementation Plan—anticipated date February 1, 2019
Conduct provider training on ASAM requirements for ASAM 3.5 Level of Care	Based on 50/50 schedule

### Level of Care: 3.7—Medically Monitored High-Intensity Inpatient Services for Youth and Adults

**Current State:** Alaska Medicaid provides coverage for Medically Monitored High-Intensity Inpatient Services. These services are available to all Alaska Medicaid recipients.

**Future State:** Alaska Medicaid will require prior authorization for all Inpatient Services provided under the 1115 Waiver.

**Actions Needed and Implementation Timeline:** None anticipated.

### Level of Care: 4.0—Medically Managed Intensive Inpatient Services for Youth and Adults

**Current State:** Alaska Medicaid provides coverage for Medically Managed Intensive Inpatient Services. These services are available to all Alaska Medicaid recipients.

**Future State:** Alaska Medicaid will require prior authorization for all Inpatient Services provided under the 1115 Waiver.

**Actions Needed and Implementation Timeline:** None anticipated.

### Level of Care: 1-WM—Ambulatory Withdrawal Management Without Extended On-Site Monitoring for Youth and Adults

**Current State:** Alaska Medicaid does not provide coverage for ambulatory withdrawal management levels of care based on the ASAM criteria.

**Future State:** Alaska Medicaid will develop ambulatory withdrawal management coverage to align with ASAM 1-WM requirements. Coverage will be provided to all eligible recipients.

We plan to locate at least one AWM provider (AWM-1 or AWM-2) site in each of the nine Waiver regions based on the 50/50 schedule as specified in Appendix 1.

**Actions Needed and Implementation Timeline:**

Action	Timeline
Pursue Alaska Administrative Code (AAC) modifications accordingly	Will be filed April 1, 2019
Develop provider notification of modifications to 1-WM	Formal notification to be released at least 90 days before initiation of Waiver services—anticipated date February 1, 2019
Conduct provider training on ASAM requirements for ASAM 1-WM Level of Care	Based on 50/50 schedule

### Level of Care: 2-WM—Ambulatory Withdrawal Management With Extended On-Site Monitoring for Youth and Adults

**Current State:** Alaska Medicaid does not currently provide coverage for Ambulatory Withdrawal Management with Extended On-Site Monitoring.

**Future State:** Alaska Medicaid will develop a new Waiver service allow reimbursement for ASAM 2-WM. Coverage will be provided to all eligible recipients.

We plan to locate at least one AWM provider (AWM-1 or AWM-2) site in each of the nine Waiver regions based on the 50/50 schedule per Appendix 1.

**Actions Needed and Implementation Timeline:**

Action	Timeline
Develop new Waiver service to allow reimbursement for ASAM 2-WM	Target effective date April 1, 2019
Pursue Alaska Administrative Code (AAC) modifications accordingly	Will be filed May 1, 2019
Develop provider notification of new 2-WM service.	Formal notification to be released at least 90 days before initiation of Waiver services—anticipated date February 1, 2019
Conduct provider training on ASAM requirements for ASAM 2-WM Level of Care	Based on 50/50 schedule

### Level of Care: 3.2-WM—Clinically Managed Residential Withdrawal Management

**Current State:** Alaska Medicaid does not presently provide coverage for Clinically Managed Residential Withdrawal Management.

**Future State:** Alaska Medicaid will create a new Waiver service to allow reimbursement of ASAM 3.2-WM. Coverage will be provided to all eligible recipients. We plan to locate this service in one location during Year 2 of the Waiver as specified in Appendix 1.

Alaska Medicaid will require prior authorization for all Residential Services provided under the 1115 Waiver, including this level of withdrawal management.

**Actions Needed and Implementation Timeline:**

Action	Timeline
Develop new Waiver service to allow reimbursement for ASAM 3.2-WM	Target effective date May 1, 2019
Pursue Alaska Administrative Code (AAC) modifications accordingly	Will be filed June 1, 2019
Develop provider notification of new 3.2- WM service.	Formal notification to be released at least 90 days before initiation of Waiver
Conduct provider training on ASAM requirements for ASAM 3.2-WM Level	Waiver Year 2

## Level of Care: 3.7-WM—Medically Monitored Inpatient Withdrawal Management

**Current State:** Alaska Medicaid presently provides coverage for Clinically Managed Residential Withdrawal Management (ASAM 3.2-WM), but does not provide coverage either for Medically Monitored Inpatient Withdrawal Management (ASAM 3.7-WM) or for Medically Managed Intensive Inpatient Withdrawal Management (ASAM 4-WM).

**Future State:** Alaska Medicaid will create a new Waiver service to allow reimbursement of ASAM 3.7-WM. Coverage will be provided to all eligible recipients. We plan to locate this service in one location during Year 2 of the Waiver as specified in Appendix 1.

Alaska Medicaid will require prior authorization for all Inpatient Services provided under the 1115 Waiver, including this level of withdrawal management.

**Actions Needed and Implementation Timeline:**

Action	Timeline
Develop new Waiver service to allow reimbursement for ASAM 3.7-WM	Target effective date April 1, 2019
Pursue Alaska Administrative Code (AAC) modifications accordingly	Will be filed May 1, 2019
Develop provider notification of new 3.7- WM service.	Formal notification to be released at least 90 days before initiation of Waiver

Conduct provider training on ASAM requirements for ASAM 3.7-WM Level	Waiver Year 2
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## Level of Care: 4-WM—Medically Managed Intensive Inpatient Withdrawal Management

**Current State:** Alaska Medicaid presently provides coverage for Clinically Managed Residential Withdrawal Management (ASAM 3.2-WM), but does not provide coverage either for Medically Monitored Inpatient Withdrawal Management (ASAM 3.7-WM) or for Medically Managed Intensive Inpatient Withdrawal Management (ASAM 4-WM).

**Future State:** Alaska Medicaid will create a new Waiver service to allow reimbursement of ASAM 4-WM. Coverage will be provided to all eligible recipients. We plan to locate this service in three locations during Year 2 of the Waiver as specified in Appendix 1.

Alaska Medicaid will require prior authorization for all Inpatient Services provided under the 1115 Waiver.

### Actions Needed and Implementation Timeline:

Action	Timeline
Develop new Waiver service to allow reimbursement for ASAM 4-WM	Target effective date April 1, 2019
Pursue Alaska Administrative Code (AAC) modifications accordingly	Will be filed May 1, 2019
Develop provider notification of new 4-WM service.	Formal notification to be released at least 90 days before initiation of Waiver services
Conduct provider training on ASAM requirements for ASAM 4-WM Level of Care	Waiver Year 2

## Community Recovery Support Services

**Current State:** Alaska Medicaid currently provides coverage for Comprehensive Community Support Services, Recipient Support Services, and Peer Support Services for both youth and adults. Coverage is provided to all Medicaid recipients.

The services are not focused on those services that specifically initiate, support, and enhance recovery from addiction and that address ASAM criteria considerations for Dimension 6—Recovery and Living Environment.

**Future State:** Alaska Medicaid will pursue a SPA to delete Comprehensive Community Support Services (CCSS) and Recipient Support Services (RSS). We will develop a new Waiver service—Community Recovery Support Services—which addresses the elements of Dimension 6. Coverage will be provided to all eligible recipients under the

proposed 1115 Waiver.

**Actions Needed and Implementation Timeline:**

<b>Action</b>	<b>Timeline</b>
Pursue a SPA to delete CCSS and RSS. Develop new Waiver service to allow reimbursement for Community Recovery Support Services.	Target effective date April 1, 2019
Pursue Alaska Administrative Code (AAC) modifications accordingly	Will be filed May 1, 2019
Develop provider notification of new service	Formal notification to be released at least 90 days before initiation of Waiver services
Phase-out deleted services and phase-in new service	Based on 50/50 schedule
Conduct provider training on ASAM elements of Dimension 6 and requirements for Community Recovery Support Services	Based on 50/50 schedule



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

Alaska has aligned its Medicaid-reimbursable SUD services with previous versions of the ASAM criteria to the extent possible. However, as mentioned in Milestone #3 (C), the DBH does not formally and systematically monitor compliance with these specifications. Alaska plans to require the ASO to develop such a monitoring protocol, in partnership with the DBH. Thus, the Waiver is the primary vehicle for ensuring that use of ASAM placement criteria occurs and is appropriately utilized.

A primary purpose of Alaska's 1115 Waiver is to universally screen all Medicaid-eligible individuals for SUD in order to identify symptoms of misuse or abuse of drugs or alcohol before they become functional impairments. Using available science and research to identify and match the individual with the intervention, treatment, and support tools he/she needs to achieve recovery is imbedded in our approach, beginning with use of evidence-based, SUD-specific screening and ending with evidence-based, SUD-specific Community and Recovery Support Services.

For new SUD services proposed in the 1115 Waiver, and for existing SUD services modified for the Waiver, Alaska will utilize the ASAM criteria for placement, for service types, for staffing, for number of clinical hours per unit, for therapies, and for treatment planning. We will use ASAM standards for certification of residential providers and for ongoing monitoring of compliance. Alaska will accomplish this through its contract with an ASO, a proposed series of SPAs, State administrative regulatory changes, policy manual changes, and Alaska Medicaid provider billing manual changes.

### A. Evidence-Based Universal Screening and Evidence-Based Clinical Assessment

Individuals presenting for any Medicaid-funded service in any setting (i.e., primary care, behavioral health care) will receive an AUDIT and a DAST. If the number of "yes" answers indicate the need for further assessment based on quantified scoring criteria, the screener will refer the Medicaid recipient to a behavioral health provider for an integrated, comprehensive clinical assessment conducted by a qualified addiction professional. It is possible that both the screening and the assessment will be conducted by a SUD treatment provider. As part of this assessment, the six dimensions specified by ASAM will be addressed:

- ◆ Dimension 1—acute intoxication and/or withdrawal potential
- ◆ Dimension 2—biomedical conditions and complications
- ◆ Dimension 3—emotional, behavioral, or cognitive conditions and complications
- ◆ Dimension 4—readiness to change
- ◆ Dimension 5—relapse, continued use, or continued problems potential
- ◆ Dimension 6—recovery/living environment



Alaska is in the process of reviewing its current assessment tools and reviewing industry-standard evidence-based assessment instruments to determine which SUD-specific tool to select—whichever instrument is selected, alignment with ASAM criteria is a requirement. Alaska has conducted extensive research and is looking at the Comprehensive Addictions and Psychological Evaluation (CAAPE-5), the Composite International Diagnostic Interview (CIDI-5), the Global Appraisal of Individual Needs (GAIN), the Structured Clinical Interview for DSM-5 (SCID-5) for adults, the Comprehensive Adolescent Severity Inventory (CASI), the Diagnostic Interview Schedule for Children (DISC-IV), and Global Appraisal of Individual Needs (GAIN) for youth. The GAIN may be cost prohibitive and too time-consuming.

Whatever process providers use to complete an assessment (CONTINUUM, or one of the above mentioned tools) they will be required to participate in an electronic submission for to receive prior authorization from the ASO for all residential services. Residential service authorizations will need to be reviewed by the ASO to ensure that information is complete, accurate, filled out correctly, and reflect medical necessity for the level of care that is being requested.

However, depending up on standardized assessment tools that are selected, the ASO process may be a minimal review. One of the roles of the ASO will be to continually adjust the process to reduce barriers to intake and to expedite review processes to reduce the amount of time required for clients to enter treatment.

Alaska recognizes that provider training will be essential for successful implementation of Alaska's new, evidence-based screening and assessment processes. We will work closely with the ASO and ASAM to make certain that all available resources are utilized. The State's contract with the ASO will specify that the ASO's staffing include qualified addiction professionals well-versed in implementing the ASAM criteria.

## B. The Role of Screening, Brief Intervention, and Referral to Treatment

As with universal screening as a way to identify symptomatology, SBIRT will play a critical role for those Waiver-eligible individuals presenting in emergency departments (EDs) of Alaska's 10 busiest hospitals in Alaska. The plan is that everyone presenting in the ED will receive an AUDIT and a DAST.

If the number of "yes" answers indicate low to moderate risk of substance use based on quantified scoring criteria, a trained and qualified specialist will provide a brief intervention while the individual is still at the hospital, once the individual has medical clearance from the primary care provider. Brief intervention will consist of 1-5 sessions (each from 15 to 30 minutes), will occur after screening, and at least one follow-up will be scheduled, either in person, by telephone, or telemedicine.

If the number of "yes" answers indicate moderate to high risk of risky behavior and/or misuse, referral to brief treatment will occur. Brief treatment will consist of 6-10 sessions (most likely on a weekly basis) provided by a qualified addiction professional to focus on reducing the risk of harm from misuse. Individuals may also be referred to a SUD treatment provider for an integrated, comprehensive clinical assessment conducted by a qualified addiction professional if the brief intervention suggests symptoms of addiction.

Individuals requiring more intensive services, whether identified during screening, brief intervention, or brief treatment, will receive an integrated, comprehensive clinical assessment conducted by a qualified addiction professional. Referral to outpatient, intensive outpatient, partial hospitalization, or residential services may occur at that point.

These front-end SUD Waiver services are designed to identify signs and symptoms and intervene with the appropriate ASAM Level of Care as early as possible (i.e., before any untreated SUD escalates into dependence). DHSS believes this is both clinically and economically the most efficient and effective course of action. Included in Alaska's armamentarium of services designed to facilitate access to the appropriate ASAM Levels of Care are crisis response services, particularly mobile crisis response services.

We plan to require the ASO to establish a 1-800 call center that anyone in the State can utilize. Wherever a crisis occurs, clinical professionals will be available in each Waiver region to assess, de-escalate the situation if appropriate, refer to the appropriate services, or make arrangements for emergency services. Alaska is particularly sensitive to youth experiencing SUD-related crises and will make certain that mobile crisis response teams are able to obtain and interpret information, are knowledgeable about the signs and symptoms of alcohol and other drug misuse, dependence, and/or intoxication, and will work closely with families to maintain the youth at home, if possible.

### C. Service Access and Utilization

Whenever a qualified addiction professional has completed an integrated, comprehensive clinical assessment, Alaska plans to use the ASO as an independent third party with the necessary competencies to review the ASAM criteria. All services above ASAM Level 2.5 will require prior authorization by the ASO and length of stay will be determined by medical necessity.

Alaska Medicaid will approve the ASO's evidence-based system for clinical guidelines and will ensure that the ASO's guidelines incorporate the medical necessity criteria required for each ASAM level of care. We plan to require that clinicians use a software system that incorporates evidence-based clinical assessment and ASAM criteria to streamline access to care (e.g., CONTINUUM or a similar system).

The ASO will be required to have policies and procedures in place to:

- 1) review instances of over- and under-utilization of emergency room services and other health care services;
- 2) identify aberrant provider practice patterns;
- 3) evaluate efficiency and appropriateness of service delivery; and
- 4) identify quality of care and treatment issues.

All of these processes are especially critical to the State's efforts around combatting substance use, given Alaska's traditional reliance on more acute levels of care in the absence of sub-acute, community-based services.

A list of action items and expected implementation timeline related to screening, assessment, SBIRT, and service access and utilization are provided in the table below:

<b>Action</b>	<b>Timeline</b>
Conduct provider training on ASAM criteria	Ongoing throughout 2019
Finalize ASAM-aligned assessment instrument	June 1, 2019
Conduct provider training on assessment instrument	Ongoing throughout 2019
Procure contract with ASO	Early Spring 2019
Approve ASO policies and procedures	June 1, 2019

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

### **A. Licensure and Regulatory Changes to Align with ASAM Standards for Service Types and Hours of Clinical Care**

Alaska will use the program standards from ASAM criteria to implement the residential treatment provider qualifications requirement. Because we require that grantees are accredited by the Council on Accreditation (COA), the Commission on Accreditation for Rehabilitation Facilities (CARF), or The Joint Commission, Alaska's providers are well prepared to align their SUD residential programs with ASAM standards for service types and hours of clinical care for adult Residential Services 3.1, 3.3, and 3.5. A major focus for the SUD portion of the Waiver will be developing capacity for Youth SUD services, including residential services 3.1 and 3.5. A breakdown of all Adult and Youth SUD outpatient, residential, and OTP/OBOT providers by ASAM Level of Care and by Waiver region is provided in Appendix 1.

Because of the accreditation requirement, Alaska currently *approves* all SUD residential facilities—whether grantees or not—rather than certify/license. The approval process is governed by Title 7 of the Alaska Administrative Code, Chapter 70.990. The State only approves providers who are accredited by Joint Commission, CARF or COA. They are required to submit their Accreditation Certificate, as well as the Certification Report. If and when the provider is granted full Department approval, the expiration date is aligned with their National Accreditation Expiration date. The State conducts an onsite visit which includes a file review and also requires that the provider's staff receive a full day of documentation training (which DBH provides). Once full Department approval is granted, site visits are not done on a regularly scheduled basis, but are done if complaints are received, concerns expressed by clients, staff or the public, or if there is any indication that something is amiss with their Medicaid billing. Approved providers are required to enter their data into the Alaska Automated Information Management System (AKAIMS) and are required to submit quarterly financial and narrative reports and board meeting minutes, as well as documentation of their participation in Community Action Plan meetings.

DHSS does not presently have published standards in place that specify criteria for service types, clinical care hours, and staff credentials for each ASAM residential treatment setting. DHSS also does not have a formal, systematic monitoring protocol to assess ongoing compliance with Alaska/ASAM requirements; DHSS generally responds to issues and problems as they come to the attention DBH from either the provider, a recipient, or a family member.

For Adult SUD residential, Alaska has a total of 270 ASAM Level 3.1 and 3.5 beds statewide, located in 8 of the 9 Waiver regions. The primary focus for adult residential, other than certification, will be to increase the State's capacity for Women & Children's residential services, which are located in only three of our nine regions. DHSS will

review existing administrative regulations and Medicaid provider billing manuals to update the regulations pursuant to ASAM criteria for service setting, provider types, treatment goals, required therapies, and hours of clinical care. Our Medicaid regulations are governed by Title 47, Alaska Statutes, and are located in Chapter 7 of the Alaska Administrative Code, primarily Sections 135.010-135.990. The regulations specify scope of services requirements for a wide variety of behavioral health services, including residential SUD, detoxification, screening/brief intervention, pharmacologic management, and screening/assessment, but reference to ASAM criteria is not included. However, references to previous ASAM requirements (i.e., 2<sup>nd</sup> edition) do exist in our Community Behavioral Health Services Medicaid Provider Billing Manuals. Both 7 AAC and the Billing Manuals will have to be revised to accommodate changes pursuant to the Waiver. In addition, DBH will establish a formal certification process for SUD providers wishing to receive reimbursement from Alaska Medicaid for adult residential services, which officially designates the provider as either an ASAM Level 3.1, 3.3, or 3.5 facility.

For Youth SUD residential, Alaska has 46 ASAM Level 3.5 beds statewide, located in only 3 of the 9 Waiver regions. There are many service gaps which DHSS plans to address with additional ASAM Level 3.1 and 3.5 beds and, as mentioned in the previous section, with additional IOP and PHP, step-up/step-down services. For youth residential, DBH will also review the State's existing administrative regulations and Medicaid provider billing manuals for Level 3.5 service descriptions, will create Level 3.1 regulations based on ASAM criteria, and, for both levels, will address ASAM criteria for service setting, provider types, treatment goals, required therapies, and hours of clinical care. DBH will establish a formal certification process for SUD providers wishing to receive reimbursement from Alaska Medicaid for Youth residential services which officially designates the provider as either an ASAM Level 3.1 or 3.5 facility.

Like most States, Alaska's formal rulemaking (administrative regulation) process can take anywhere from 1-1 ½ years for promulgation. Alaska is, therefore, requesting to issue provisional ASAM designations until the new residential treatment facility provider qualification certification process have been promulgated. DBH will use the following provisional designation process, with the assistance of the ASO:

- ◆ Review provider capacity by ASAM Level/Waiver region—**January 2019**
- ◆ Develop provider notifications regarding Alaska's provisional designation process (e.g., survey detailing provider setting, types of services, staffing, therapies, hours of clinical care/residential day, etc.)—**February 2019**
- ◆ Review documents and schedule brief, 1-day onsite visit—**February 2019**
- ◆ Develop DBH team of SUD professionals to conduct onsite reviews—**January 2019**
- ◆ Conduct review—**March 2019**
- ◆ Make recommendation for possible provisional designation to DBH Director—**April 2019**

DHSS anticipates having the ASO on board by April of 2019 and beginning SUD services by summer of 2019, at the latest. Assuming that timeline, DBH will be prepared

to issue guidance to the State's currently approved residential providers regarding the requirement of ASAM designation and the formal certification process in March of 2019. DBH will have begun revising relevant sections of the Alaska Administrative Code and DBH Medicaid Provider Billing Manuals to incorporate all required elements of ASAM criteria, including the requirement that residential facilities offer Medication-Assisted Treatment (MAT) in residential facilities (either onsite or through facilitated access off-site). Alaska does not currently have in place a requirement that residential treatment providers offer MAT onsite or facilitate access off-site. To ensure compliance with this requirement, the ASO will maintain a list of all SUD residential providers offering MAT and, for those who facilitate access, will review proximity of that access during the prior authorization process and will monitor service utilization during the course of treatment.

The process we plan to use to develop, review, and monitor the standards includes the following steps:

- ◆ Issuance of a formal letter with attached survey/questionnaire sent to each current residential facility explaining 1115 Waiver requirements for SUD services and requesting facility-specific service/staffing/accreditation information (Month 2 post-CMS approval).
- ◆ Onsite visits to each facility to begin discussions on both the new and revised 1115 Waiver coverages for SUD residential services, the new certification requirements, and follow-up information per provider responses to the questionnaire. The completion of the questionnaire will assist DMHA in assigning a provisional ASAM Level of Care designation to the facility (Months 3-6 post-CMS approval).
- ◆ Issuance of formal guidance regarding the specific requirement of ASAM designation. Will include dates DBH will accept provider applications/documentation for provisional ASAM designation. This will occur simultaneously with DBH revisions of 7 AAC to specify residential certification with all required aspects of the ASAM criteria, including a requirement that residential facilities offer Medication-Assisted Treatment (MAT) on-site or through facilitated access off-site) Month 7 post-CMS approval .
- ◆ Acceptance of requests for provisional designations (Month 8).
- ◆ Approval/disapproval of provisional designation (Month 9).



The action items and expected implementation timeline for the standards for residential treatment facility provider qualification and formal certification are presented in the table below:

<b>Action</b>	<b>Timeline</b>
Finalize process for provisional ASAM designation of qualified residential provider (including MAT requirement)	Will be completed by May of 2019
Modify Alaska Administrative Code to include formal certification process based on the ASAM criteria (Including MAT requirement)	Will be filed by May of 2019
Modify Provider Medicaid Billing Manual to include formal certification process based on The ASAM criteria (including MAT requirement)	Will be completed by May of 2019

## **B. Workforce Development Changes to Align with ASAM Standards for Staffing**

Alaska’s health care system in general has suffered shortages and a mal-distribution of primary care health providers for many years. This situation is exacerbated for Alaska’s addiction workforce. The difficulties in recruiting and retaining a qualified addiction professional workforce in Alaska are complex, but the impact of the extreme geographic isolation of Alaska’s SUD settings cannot be denied. In turn, SUD staff retention challenges destabilize existing work settings and lead to further workforce shortage problems.

The United States Department of Health and Human Services’ Health Resources and Services Administration (HRSA) has designated most of Alaska’s geographic area as Health Professional Shortage Areas (HPSAs) based on the lack of mental health clinicians. HPSAs can apply to geographic areas (HPSAs cover 96% of Alaska’s land mass), population groups (HPSAs cover 39% of Alaska’s population), and health care facilities.

There are 24 geographic areas designated as mental health (MH) HPSAs and 15 MH HPSAs based on Alaska Native or Native American Tribal populations (AN/NA) throughout Alaska. The following Waiver regions are designated by HRSA as MH HPSAs<sup>12</sup>:

- ◆ Region 1—1 HPSA for AN/NA (Anchorage Municipality)
- ◆ Region 2—2 HPSAs for AN/NA (Fairbanks North Star Borough)
- ◆ Region 3—4 HPSAs for geographical areas (Denali and North Slope Boroughs and Southeast Fairbanks and Yukon-Koyukuk Census Areas) and 1 HPSA for AN/NA (North Slope Borough)
- ◆ Region 4—1 HPSA for geographical area (Kenai Peninsula Borough) and 2 HPSAs for AN/NA (Kenai Peninsula Borough—Soldotna and Homer)

- ◆ Region 5—1 HPSA for geographical area (MatSu Borough) and 1 HPSA for AN/NA (MatSu Borough)
- ◆ Region 6—4 HPSAs for geographical areas (Bethel, Kusilvak, Nome Census Areas), (Northwest Arctic Borough) and 3 HPSAs for AN/NA (Nome Census Area)
- ◆ Region 7—6 HPSAs for geographical areas (Haines, Hoonah-Angoon, Petersburg, Skagway, Wrangell, and Yakutat Boroughs) and 1 HPSA for AN/NA (Sitka Borough)
- ◆ Region 8—2 HPSAs for geographical areas (Ketchikan Gateway Borough and Prince of Wales-Hyder Census Area) and 2 HPSAs for AN/NA (Ketchikan Gateway Borough and Prince of Wales-Hyder Census Area)
- ◆ Region 9—6 HPSAs for geographical areas (Aleutians East, Aleutians West, Dillingham, and Valdez-Cordova Census Areas and Bristol Bay and Lake and Peninsula Boroughs) and 2 HPSAs for AN/NA (Dillingham and Valdez-Cordova Census Areas)

Thus, every Waiver region has significant MH and SUD workforce capacity shortages. There are only two Waiver regions that do not have geographical areas designated as HPSA—Anchorage and Fairbanks. We plan to use the Waiver as an opportunity not only to recruit and retain a qualified addiction workforce, but to begin to elevate the level of professionalism in the substance abuse treatment field by expanding the educational requirements for certification. These modifications will bring Alaska's certification requirements into alignment with ASAM over the course of the Waiver. An initial step will be to survey each Waiver region hub to determine the specific SUD workforce needed to provide Waiver services.

Addiction professionals in Alaska are certified by the Alaska Commission for Behavioral Health Certification (ACBHC). Certification is based on coursework, experience, and examination. A college degree is not required, but candidates with degrees in related fields can move through the ranks more quickly; degreed candidates also need to complete fewer contact hours of specific board-mandated coursework. Thus, there are two tracks: a degree track and a non-degree track—for certification as either a Counselor Technician, a Chemical Dependency Counselor I, a Chemical Dependency Counselor II, or a Clinical Supervisor. The framework for the certification process is the National Association of Alcoholism and Drug Abuse Counselors—now called NAADAC, the Association for Addiction Professionals. All Alaska certified addiction professionals must complete Ethics and Confidentiality training; all NAADAC training is deemed approved by ACBHC.

Training is also provided by the Regional Alcohol and Drug Abuse Counselor Training (RADACT) Program. RADACT is a nonprofit organization that coordinates and delivers on-site training to individuals who are in process of pursuing certification. RADACT also provides correspondence courses and offers a three-week intense training academy.

As of January 2018, Alaska has approximately 1022 certificate holders which include 133 Counselor Technicians, 481 Chemical Dependency Counselors I's, 188 Chemical



Dependency Counselors IIs, 69 Chemical Dependency Clinical Supervisors, and 16 Chemical Dependency Administrators.

We will review existing certification standards and requirements and align them with the knowledge, skills, and abilities for staff which are listed in ASAM criteria, Third Edition, for Residential Levels 3.1, 3.3, and 3.5 for adults and Levels 3.1 and 3.5 for youth.

A list of action items and expected implementation timeline related to addiction residential workforce development is provided in the table below:

<b>Action</b>	<b>Timeline</b>
Develop list of certified addiction professionals located in existing SUD residential providers	Will be completed by March of 2019
Work with ACBHC to modify existing certification standards to align with ASAM Levels 3.1, 3.3, and 3.5 staffing requirements	Will be completed by August of 2019

### **C. Ongoing Accountability to Ensure Provider Compliance with Standards**

Alaska does not have a formal, systematic monitoring protocol to assess ongoing compliance with its requirements. However, Alaska will develop a formal monitoring protocol to ensure ongoing provider compliance with ASAM criteria for Residential Levels 3.1, 3.3, and 3.5. The monitoring protocol will align with the provider standards to be included in the Title 7 of the Alaska Administrative Code, the Alaska Medicaid Provider Billing Manual for Community Behavioral Health Services, and the afore-mentioned provisional and permanent SUD residential provider certification process. The monitoring protocols will include both desk reviews of required documents biannually and onsite reviews once a year. DBH will work in concert with the ASO to develop and implement the monitoring protocols. The ASO is DBH’s contractor and, as such, reports directly to DBH. Regarding provider monitoring of these residential standards, DBH envisions working more closely with the ASO to ensure that Waiver requirements are met and will delegate some, but not the majority, of monitoring responsibilities to the ASO—we would envision, for example that desk reviews of documents required for provisional and permanent designation could be conducted by ASO with summaries to DBH. Onsite reviews, however, will be conducted by teams including DBH and ASO. And, of course, final decisions regarding designation lie solely with DBH. Specific responsibilities regarding the ASO’s auditing new providers for the Waiver will be included in the ASO contract.

Generally, the ASO will have responsibility for a variety of provider monitoring activities, including audits and reviews of activities ranging from quality of care to OMB Single Audit report reviews. In addition, the ASO will monitor, aggregate, and report to DBH on provider performance based on DBH-specified performance indicators to be reported by providers to the ASO. The ASO will work in partnership with DBH to monitor fidelity of EBP implementation, co-chairing an EBP Committee to review fidelity of implementation across Alaska. The ASO will have substantial reporting requirements to DBH and will be

required to report to DBH on a daily/weekly/monthly basis on several provider-related activities, including prior authorization, concurrent/retrospective review (as an example, retrospective reviews are planned for services already provided to individuals whose Medicaid eligibility was retroactively approved) , provider capacity, provider recruitment, provider training, provider performance, quality management trends, providers with high volume denials, service utilization & expenditures by provider, length of stay by provider, readmissions by provider, etc. The State recognizes that only the State shares intergovernmental responsibility for the expenditure of these public funds and is by no means abrogating that responsibility.

A list of action items and expected implementation timeline related to Ongoing Compliance is provided in the table below:

<b>Action</b>	<b>Timeline</b>
Develop monitoring protocol	Will be completed by August of 2019
Initiate ongoing monitoring process	Will begin September of 2019

## Milestone #4: Sufficient Provider Capacity at Critical Levels of Care

### A. Existing SUD Provider Capacity

As mentioned in the plans to address Milestone #3, Alaska presents unique challenges in access to and delivery of SUD services most notably because of the state's vast size, number of isolated communities, and the amount of area that is designated as health professional shortage area and medically underserved. Cultural and linguistic variations also lend to this challenge. Many communities are located at considerable distance from SUD providers and are without road access. For many small communities, primary care and other healthcare providers are available on an itinerant basis only; treatment must occur at larger hospitals in urban centers for which air travel is necessary.

This situation presents a tremendous challenge for SUD provider capacity at all ASAM Levels of Care. Currently, there are 80 providers of SUD services in Alaska—including withdrawal management, outpatient, intensive outpatient (non-Medicaid), residential, OTPs, and alcohol safety action program services. 18 providers are residential services providers. These providers include both DBH grantees and non-grantees. A Waiver region breakdown of SUD providers includes the following:

- ◆ Waiver Region 1—29 providers (36% of total)—OTP, OBOT, residential (6 providers), withdrawal management (residential), OP, & IOP.
- ◆ Waiver Region 2—9 providers (11% of total)—OTP, OBOT, residential (2 providers), withdrawal management (residential), OP, & IOP.
- ◆ Waiver Region 3—6 providers (8% of total)—OP.
- ◆ Waiver Region 4—6 providers (8% of total)—OBOT, residential (1 provider), withdrawal management (residential), & OP.
- ◆ Waiver Region 5—6 providers (8% of total)—OBOT, residential (2 providers), OP, & IOP.
- ◆ Waiver Region 6—3 providers (4% of total)—OBOT, residential (1 provider) & OP.
- ◆ Waiver Region 7—9 providers (11% of total)—OBOT, withdrawal management (IP), residential (3 providers), OP, & IOP.
- ◆ Waiver Region 8—5 providers (6% of total)—residential (1 provider) & OP.
- ◆ Waiver Region 9—7 providers (9% of total)—OBOT, residential (1 provider), OP & IOP.

As we are proposing to increase or develop capacity for ASAM Level 3.5, ASAM Level 3.1 and 3.3 residential, intensive outpatient, partial hospitalization, OTP, MAT, mobile outreach and crisis, and ambulatory withdrawal management services throughout the State to address existing service gaps, we recognize that one of the most significant challenges under the Waiver will be to develop qualified and reliable SUD provider capacity. Alaska will require that any willing and qualified provider may enroll to provide Medicaid covered services.

Details regarding proposed increased SUD provider capacity by ASAM Level of Care for each Waiver region are included in Appendix 1.

A list of action items and expected implementation timelines related to Provider Capacity is provided in the table below:

<b>Action</b>	<b>Timeline</b>
Recruit qualified providers to address increased capacity	Based on 50/50 schedule

## B. New Provider Types

To address many of the provider capacity issues listed above, the Waiver will add the following new Medicaid provider types to address existing SUD provider capacity needs: Individual licensed providers that can bill as independent providers, such as licensed psychologists, licensed psychological associates, licensed clinical social workers, registered nurses, licensed practical nurses, advanced nurse practitioners, licensed marriage and family therapists, licensed professional counselors, certified behavioral health aides, certified peers, and Certified Chemical Dependency Counselors.

We anticipate these new mid-level provider types will assist in addressing the new service capacity for IOP (ASAM Level 2.1), PHP (ASAM Level 2.5) and will assist residential treatment facilities in meeting ASAM criteria for staff credentialing referenced in Milestone #3 (ASAM Levels 3.1, 3.3, and 3.5). We will actively recruit additional withdrawal management providers, focusing solely on those that will provide ambulatory services. This is designed to prevent Alaska’s current situation of over-utilization of residential and IP detoxification services—we currently have 2 ASAM Level 3.7-WM providers (1 in Region 1 and 1 in Region 4), 1 ASAM Level 3.7-D provider (Region 2), and 1 ASAM Level 4-WM provider (Region 7). We have no ASAM Level 1-WM or 2-WM in the State.

To address the increase in service capacity for MAT, we already have a list of Alaska OTPs and the number and location of Medicaid providers who have the appropriate buprenorphine training. Increasing use of naltrexone will require training of physicians either already prescribing or wishing to prescribe this MAT. Even though we have a good sense of where MAT providers are located, we will conduct a comprehensive assessment of MAT for Alaska Medicaid recipients and make certain we increase access not only to buprenorphine but, also to any currently approved and effective pharmacological treatment for substance use disorders which we anticipate will be used both for recipients suffering from opioid and alcohol addiction. It is important to note that Alaska has expanded capacity via Medicaid billing by removing the requirement for methadone clinics to have a Comprehensive Community Behavioral health Grant in order to be an enrolled Medicaid provider. This change has allowed two for-profit methadone clinics to enroll in the Medicaid program, expanding capacity for approximately 600 additional recipients.

A list of action items and expected implementation timelines related to New Provider Types is provided in the table below:

<b>Action</b>	<b>Timeline</b>
Identify new provider types by region	Will be completed by February of 2019
Develop notification/communication re Waiver and ASAM requirements	Will be completed by March of 2019
Pursue AAC and Provider Billing Manual changes	Will be completed by May of 2019
Enroll new provider types as independent Medicaid billing providers	Will be completed by April of 2019

### C. Overall Provider Capacity Development Strategy

The state of Alaska requires that any willing and qualified provider may enroll to provide Medicaid covered services. Participant access to behavioral health services is highly dependent on reliable provider capacity. We recognize the importance of developing and maintaining an effective and efficient program for growing regional provider capacity and support with any willing and qualified providers throughout the statewide SUD system of care. We plan to work with the ASO regarding provider capacity development and support to include strategies to address barriers to provider participation throughout Alaska and to target efforts for the rural and remote areas of the state, including additional use of telemedicine. Service analysis will include service gaps and areas in which there is provider saturation in each of the nine waiver regions. As can be determined from the list of SUD providers by Waiver region, we already know which regions are saturated and which regions have extremely limited provider capacity. Alaska also knows, by Waiver region, where the State wants to locate increased capacity. This gives Alaska a good start for developing the necessary capacity. Alaska will coordinate efforts with both Tribal and non-Tribal behavioral health provider communities in these regions, in addition to coordinating with other health care, social, and educational systems involved in participant service provision. Telemedicine will play an important part in providing access to our more isolated communities. Currently, Medicaid will reimburse for the following telemedicine services: initial or one follow-up office visit; consultation made to confirm diagnosis; a diagnostic, therapeutic or interpretive service; psychiatric or substance abuse assessments; individual psychotherapy; and pharmacological management services.

Alaska’s overall strategies for developing regional provider capacities are to 1) promote rapid access to willing and qualified providers, peer supports, and other community-based resources that offer effective services and supports, 2) support providers in the integration of recipients into their communities, utilizing community supports and resources, consistent with the recipient’s needs, preferences, choices, and informed consent, and 3) improve provider performance through streamlined administrative requirements, data descriptions of provider services, and outcomes data collection and management.

A list of action items and expected implementation timelines related to Overall Provider Capacity Development is provided in the table below:

<b>Action</b>	<b>Timeline</b>
Assess ASAM providers and services by region	March of 2019
Work with ASO to provide training on ASAM criteria and requirements for Waiver reimbursement	Ongoing, beginning May 1, 2019
Develop notification/communication re formal designation	May of 2019
Implement formal designation process	June of 2019

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

### A. The Alaska Opioid Policy Task Force

The Alaska Opioid Policy Task Force was convened in 2016 by the Advisory Board on Alcoholism and Drug Abuse, Alaska Mental Health Trust Authority, and Alaska Department of Health and Social Services at Governor Bill Walker’s request. The 20-member Task Force, representing diverse constituencies from across Alaska, held 12 public meetings to explore the public health dimensions of opioid misuse and abuse in Alaska. The Task Force heard testimony from national experts, received public comment at all task force meetings and other forums around the state, received input from local community heroin/opioid coalitions, and conducted research to understand the latest science and evidence-based practices.

The Alaska Opioid Policy Task Force organized their 32 recommendations according to a public health framework developed by the Association of State and Territorial Health Officials (ASTHO). A summary of the recommendations in each area are as follows:

- ◆ Environmental Controls and Social Determinants of Health—Nine recommendations relating to reducing & controlling access to opioids (full utilization of Alaska’s Prescription Drug Monitoring Program and more “nimble” regulation of opioid substances of abuse) and reducing risk of opioid misuse/abuse/dependence (screening and community prevention programs)
- ◆ Chronic Disease Screening, Treatment and Management—13 recommendations relating to screening & referral (SBIRT in all health care settings) and treatment (adopt chronic disease management framework for SUD treatment, implement state opioid prescribing guidelines, conduct, addiction medicine training for all state licensed/certified/registered health care professionals, increase withdrawal management options, decrease use of hospitals, & increase non-residential SUD treatment capacity)
- ◆ Harm Reduction—Four recommendations relating to overdose prevention (increase access to naloxone) and syringe exchange
- ◆ Recovery—Three recommendations relating to peer support reimbursement, “second chance” employers & Community Recovery Support for those receiving MAT
- ◆ Collaboration—Three recommendations relating to interagency collaboration, public safety and community prevention efforts, and mitigating incarceration for drug- related offenses/re-entry.

### B. The Governor’s Administrative Order # 283—The Plan

After reviewing the Task Force’s recommendations in early 2017, the Governor issued Administrative Order (AO) # 283 to address “the urgent need to raise awareness and develop solutions regarding the prevention, treatment, and recovery from opioid misuse and heroin addiction in Alaska.” AO #283 outlines the Governor’s Plan to combat the



heroin and opioid epidemic and overdose-related deaths in Alaska. The Governor directed the Departments of Health and Social Services, Corrections, and Public Safety to evaluate and apply for grants (including Federal grants) available to assist Alaska in combating heroin and opioid abuse.

The Governor issued the following agency-specific directives:

- ◆ Directed the State's Chief Medical Officer to establish an incident command structure to respond to the epidemic
- ◆ Directed the Department of Corrections to implement MAT
- ◆ Directed the Department of Corrections to coordinate with Department of Health and Social Services to ensure availability of MAT after withdrawal
- ◆ Directed the Department of Public Safety to develop options to identify the pathways through which illegal drugs are brought into Alaska and to restrict the entry of illegal drugs through improved screening and enforcement measures.

Several actions resulted from the Governor's Directives:

- ◆ Project HOPE was launched—a statewide program to get the drug naloxone rescue kits into the hands of emergency first responders, family members and friends, and opioid users as well as individuals who are at risk for opioid overdose. DHSS authorizes private or public entities to distribute Project HOPE Narcan rescue kits and conducts educational programs using a core curriculum that includes information and training on how to recognize an opioid overdose, use the proper rescue breathing technique, and properly administer naloxone for the individual until emergency medical help arrives. Regional Overdose Response Programs (ORP's) have been identified in the communities of high need, regional ORPs will have the authority to authorize local ORP's, provide Project HOPE education and training, and equip local ORP's and the community with Project HOPE Heroin/Opioid Overdose Rescue Kits.
- ◆ An Alaska Opioid Command System was developed within the Governor's Office with cabinet-level presentation from 11 departments of state government: Health and Social Services, Law, Public Safety, Commerce, Corrections, Education, Transportation, Fish and Game, Military and Veteran's Affairs, Labor, and Administration. The Department of Health and Social Services' Chief Medical Officer services as Incident Commander (IC) and the Director of the Office of Substance Misuse and Addiction Prevention is Deputy (IC). The group has meet as frequently as weekly with the Governor to provide updates and for strategic and tactical planning. Execution of the response is driven by a multi-departmental team, organized in tradition IC structure into sections for operations, logistics, planning, and finance. The response teams include community outreach, data, criminal justice, education, and media relations, to name a few (see below). The response teams meet biweekly to discuss updates, data, and strategies to combat the opioid crisis.
- ◆ Creation of a Data Team that monitors a number of metrics to generate situational reports to the Governor and to populate a public-facing opioid data dashboard (<http://dhss.alaska.gov/dph/Director/Pages/heroin-opioids/data.aspx>) containing a summary of Alaska opioid statistics, emergency department visits, overdose



deaths, naloxone statistics, prescription drug monitoring program, and neonatal abstinence syndrome.

- ◆ The prescription drug monitoring program (PDMP) Awareness and Feedback Questionnaire Team was developed to create an online questionnaire/survey to solicit input from practitioners on interacting with the PDMP.

### C. State of Alaska Strategic Plan for Responding to the Opioid Crisis

As a result of the Governor's Administrative Order, the Alaska Department of Health and Social Services' Division of Behavioral Health (DBH), where Alaska's State Opioid Treatment Authority resides, applied for and received two SAMHSA grants relating to combating the opioid crisis—The Medication-Assisted Treatment Prescription Drug and Opioid Addiction Capacity Expansion Grant (MAT PDOA: 9/1/16-8/31/19) and the Opioid State Targeted Response Grant (STR: 5/1/17-4/30/19). DBH also developed a comprehensive strategic plan to respond to the opioid crisis.

#### ◆ MAT PDOA Grant:

- \$3 million over three years.
- Funds two DBH providers--Narcotic Drug Treatment Center (NDTC) in Anchorage and Bartlett Rainforest Recovery Center (RRC) in Juneau.
- NDTC received \$450,000 for 2 ½ years after start-up. It is located in downtown Anchorage and provides Opioid Treatment Program (OTP) services involving full psychosocial rehabilitative services while incorporating methadone medication—goal was to increase capacity by 200 total.
- NDTC has reached the goal of an additional 200 persons serve with MAT PDOA funding.
- RRC received \$350,000 for 2 ½ years after start-up. Bartlett is using the Office Based Opioid Treatment (OBOT) model that involves buprenorphine medication and psychosocial treatment—goal was to increase capacity by 75 persons per year.
- Projected outcomes: increase access to MAT services in Alaska, increase in number of persons receiving integrated care, decrease in illicit opioid drug use, and decrease in prescription drug use in a non-prescribed manner.

#### ◆ STR Grant:

- Up to \$4 million over two years.
- Funds three DBH providers using Hub and Spoke model—Cook Inlet Council on Alcohol and Drug Abuse (CICADA) in Kenai, Fairbanks Native Association (FNA) in Fairbanks, and Interior Aids Association (IAA) in Fairbanks.
- Goals: increase MAT provider capacity, increase the number of persons receiving appropriate OUD/MAT treatment, and decrease the negative impacts of opioid use.

- Objectives: increase the number of trained OUD prescribers, increase the number of OUD prescribers receiving buprenorphine waivers, increase the number of OUD prescribers implementing MAT, increase the number of behavioral health providers with OUD training, increase the number of people who receive OUD treatment, increase the number of people who receive OUD recovery services, decrease the number and rate of opioid use, increase access to Naloxone, and decrease the number and rate of opioid overdose-related deaths.
- The Department plans to form a small workgroup this year to discuss options to ensure the sustainability of Naloxone after federal funds lapse. Currently many of Alaska's pharmacies are carrying numerous versions of naloxone for purchase. It is the State's goal to have all pharmacies carry this produce in the future so individual can still directly go to a pharmacy without a prescription and receive naloxone and at their insurance/Medicaid/Medicare/ IHS rates.
- Total projected increase in unduplicated numbers served = 340.
- Total number of naloxone/overdose kits distributed = Over 10,000

◆ Alaska's 2018 Opioid Action Plan:

- The purpose is to implement strategies to limit inappropriate access to opioids, prevent and reverse overdoses when necessary, and strengthen treatment system by expanding services.
- Involved representatives from Office of Governor, Office of Lieutenant Governor, Department of Health and Social Services, Department of Public Safety, Department of Corrections, Department of Commerce Community and Economic Development, Department of Education and Early Development, Department of Law, Department of Military and Veteran Affairs, Alaska Native Tribal Health Consortium, and Local Opioid Task Force Chairs.
- Recommended five major initiatives:
  - 1) Expand treatment capacity through funding Medication-Assisted Treatment (MAT) services—primary method to combat crisis.
  - 2) Use education and stringent regulatory oversight to reduce availability and access to controlled substances (mandate use of the PDMP).
  - 3) Adopt chronic disease management framework for SUD policies, health care coverage, increase naloxone and buprenorphine availability, and educational outreach.
  - 4) Collect and analyze cross-sector data to inform decision-making and evaluation of efforts (improve opioid surveillance).
  - 5) Cross-sector collaboration among State agencies, tribal health care system, and communities.

In order to remain focused on strategic policy-making regarding the opioid crisis across State agencies, DHHS' Office of Substance Misuse and Addiction Prevention is convening an interagency work group to review the Opioid Action Plan and formalize/expand content.

## D. Alaska's Prescription Drug Monitoring Program

Alaska established a controlled substance prescription database in 2008 (Senate Bill 196), which was operated by the Board of Pharmacy under the name of "Alaska Prescription Drug Monitoring Program" (PDMP). The Board of Pharmacy is located within the Alaska Department of Commerce, Community and Economic Development Division of Corporations, Business and Professional Licensing. Since its inception, several statutory changes have impacted the database and the PDMP, the most important of which was in 2017, requiring mandatory registration, review, and reporting for dentists, physicians, nurses, optometrists, pharmacists, veterinarians, physician assistants, and advanced practice registered nurses. These important expanded requirements have resulted in Alaska's ability to collect, analyze, and report on controlled substance usage at a level that is both quantitatively and qualitatively much more detailed than in previous years. The PDMP must report certain performance measures to the Alaska Legislature, including security of the PDMP, reductions in inappropriate use or prescription of controlled substances as a result of the PDMP, coordination among PDMP partners, and stakeholder involvement in planning. Other data reported includes number of practitioners registered by discipline, patient prescription history requests, number of patients receiving an opioid prescription, number of total prescriptions and dispensations, top drugs dispensed, and the number of patients receiving high levels of morphine milligram equivalent (MMEs) opioids.

## E. Opioid Prescribing Guidelines

Historically, Alaska was one of just a couple of states that lacked a formal medical board position statement on the use of controlled medications to treat pain. That, however, has changed due to the State's opioid crisis and the resulting gubernatorial and legislative actions, beginning in 2016. The Alaska Legislature passed Senate Bill 74 during the 2016 session. In addition to requiring that the Department of Health and Social Services apply for an 1115 Behavioral Health Waiver to reform Alaska's behavioral health delivery system, SB 74 directed the Boards of Dental Examiners, Medicine, Nursing, Examiners in Optometry, and Pharmacy to recommend guidelines for the prescription of Schedule II controlled substances listed under Federal law. On December 30, 2016, the Boards recommended that the State of Washington's *Interagency Guideline on Prescribing Opioids for Pain, 3<sup>rd</sup> edition* be adopted with minor modification to incorporate the 2016 Centers for Disease Control and Prevention pain management guidelines.

The Alaska Medical Board issued revised policies and procedures adopting the guidelines in 2017. In addition, the Board has posted the requirements for mandatory registration in the PDMP and its proposed regulations regarding the PDMP.

While we are in the beginning phases of prescribing guidelines and mandatory registration/reporting under Alaska's PDMP, we believe this status will provide a solid foundation for addressing the opioid crisis. To assist the State in comprehensively addressing the crisis, however, Alaska expects to expand MAT services even further under the Waiver.

## F. Integrating Alaska's Prevention and Treatment Efforts

Clearly Alaska has invested a considerable amount of time and energy in addressing the opioid crisis. The Waiver will play an important role in continuing and improving upon these treatment-related efforts. Before 2016, Alaska's services to address OUD included the following prevention and treatment efforts:

- ◆ Substance Abuse Prevention and Treatment Block Grant funding of methadone services in Anchorage and Fairbanks
- ◆ Strategic Prevention Framework-Partnership for Success funding for opioid prevention efforts in 6 communities.

The two capacity expansion grants have allowed the State to build upon this foundation and pursue a three-pronged strategy to address this crisis:

- ◆ Increased access to methadone vis-à-vis regulatory changes—increased number served by 600
- ◆ Increased access to buprenorphine and methadone vis-à-vis MAT PDOA and STR grants
- ◆ Increased access to naloxone vis-à-vis STR grant
- ◆ Proposed increased access to buprenorphine and naltrexone vis-à-vis Waiver
- ◆ Proposed modification of SBIRT to identify and intervene early with OUD vis-à-vis Waiver
- ◆ Proposed new service MAT Care Coordination under Waiver to integrate MAT with primary care services vis-à-vis Waiver.

Today, Alaska's OUD treatment capacity includes:

- ◆ 4 OTPs (Anchorage Treatment Solutions—Anchorage/Region 1, Community Medical Services—Wasilla/Region 5, Interior Aids Association—Fairbanks/Region 2, and Narcotic Drug Treatment Center—Anchorage/Region 1)
- ◆ Approximately 319 DATA Waivered Practitioners.

The State does not want to lose the momentum gained from these statewide efforts; both grants expire during Waiver Year 1 and Alaska has crafted the Waiver MAT services to sustain these services. Alaska plans to expand access to both buprenorphine and naltrexone or any currently approved effective pharmacological treatment for substance use disorders to further enhance its statewide MAT capacity.

Alaska Medicaid provides reimbursement for naltrexone, but the medication is under-utilized. DBH staff have studied the research and have observed naltrexone's record with individuals suffering from both alcohol and OUD. The plan is to have MAT providers in each of the nine Waiver regions, to require Care Coordination to accompany MAT in each region, and to implement SBIRT in one hospital in each region. Alaska expects to treat 50 individuals per Waiver year with naltrexone, totaling 250 over the course of the Waiver.

Proposed increased treatment capacity for OUD is specified in Appendix 1.

A list of action items and expected implementation timelines related to Integrating Prevention and Treatment Efforts is provided in the table below:

<b>Action</b>	<b>Timeline</b>
Recruit qualified buprenorphine and naltrexone providers to address expanded capacity	Based on 50/50 schedule
Expand use of buprenorphine or any currently approved effective pharmacological treatment for substance use disorders to address OUD and expand use of naltrexone to address alcohol and OUD	Based on 50/50 schedule

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

### A. SUD Care Coordination to Facilitate SUD Integration with Physical Health Care

Currently Alaska Medicaid does not reimburse for Care Coordination for SUD services. Under the Waiver, however, Alaska plans to require Care Coordination services specifically focused on integration with physical health care<sup>15</sup>. DBH plans to define the service as facilitating the appropriate delivery of integrated behavioral and primary health care services. Alaska recognizes that Care Coordination involves a wide range of services addressing patients' health needs--including medical, behavioral health, social, and legal services; as well as long-term supports and services, care management, self-management education, and transitional care services. Our definition of SUD Care Coordination includes:

- ◆ Integrating behavioral health services into primary care and specialty medical settings through interdisciplinary care planning, monitoring individual progress, and tracking individual outcomes;
- ◆ Facilitating smooth transitions from inpatient and residential care settings to community-based care settings;
- ◆ Supporting conversations between buprenorphine-waivered practitioners and behavioral health professionals to develop and monitor individual service plans;
- ◆ Linking individuals with community resources to facilitate referrals and respond to social service needs; and
- ◆ Tracking and supporting individuals when they obtain medical, behavioral health, or social services.

Care Coordination services will be required in order to receive Medicaid reimbursement for OP MAT services under the Waiver. Alaska's goal is to expand this service throughout the course of the Waiver, but the State does not have a specific timeline to do so. We want to gain the service experience during Year 1 of the Demonstration to better understand whether SUD Care Coordination services meet the case management needs of this population or if additional intensive case management services are required.

### B. Intensive Case Management Services for Individuals with SUD

We recognize that there may be waiver-eligible individuals with SUD who may require case management services beyond the SUD Care Coordination services described above. Due to the challenges with the two behavioral health case management services defined in our State Plan, we have proposed two new Waiver services (SUD Care Coordination and Intensive Case Management/ICM) to address the broad case management needs of our Waiver populations. We designed ICM services primarily for Waiver eligibility groups 1 and 2, but we are prepared to utilize these services for the SUD waiver population if necessary and clinically appropriate. We have crafted each definition in an attempt to avoid duplication across similar community-based services that do not currently exist. Generally speaking, SUD Care Coordination is envisioned as more systems collaboration-oriented, specifically primary care coordination and collaboration.



ICM, however, is envisioned as a more client-specific, wrap around model where the intensive case manager begins with the behavioral health service needs of the client and identifies other resources as appropriate.

As we have discussed during the negotiation process, we define ICM services differently than SUD Care Coordination services:

- ◆ Broad focus on community-based behavioral health provider-specific services which may include engaging resources beyond that provider (e.g., schools, housing, employment, etc.);
- ◆ Advocacy and engaging natural supports;
- ◆ Assisting with activities of daily living, problem-solving skills, self-sufficiency, conflict resolution, & productive behaviors;
- ◆ Monitoring behavioral health service delivery, safety, and stability;
- ◆ Brokering and linking individuals with resources; and
- ◆ Triaging for crisis intervention purposes (e.g., determining need to intervention and referral to appropriate authorities).

Most importantly, we simply do not envision ICM services as focused on primary care interventions; however, primary care is at the heart of how we envision SUD Care Coordination services.

At this point, we do not anticipate that Waiver recipients will concurrently utilize both SUD Care Coordination and intensive case management (ICM) services; however, clients with intensive needs may require SUD Care Coordination to access Medication-Assisted Treatment, and ICM to obtain housing and/or to engage natural supports. This is why the most reasonable approach is to gain the service experience during Year 1 of the Demonstration to better understand whether SUD Care Coordination services meet the case management needs of this population or if additional intensive case management services are required. If additional case management services are required, we will require careful scrutiny on the part of the Administrative Services Organization (ASO) before agreeing to both services at the same time.

Our existing State Plan case management services do not meet the needs we have identified above. Our rationale by State Plan case management services is as follows:

- ◆ Targeted Case Management--SUD case management services per TN # 92-14, State Plan Supplement 1 to Attachment 3.1-A, which is currently **not utilized**--no HCPCS code and services limited to 4 hours in a 6-month period, with 20-30 minute/contact/service; and
- ◆ Behavioral Health Case Management services--a rehabilitation service that will be **removed** from the State Plan per previous CMS direction.

### C. Additional Step to Ensure Transitions Between Levels of Care

Alaska plans to take an additional step to ensure smooth transitions for individuals with SUD who are moving between levels of care:

- ◆ Alaska will expand coverage of peer recovery coaches to assist SUD recipients in connecting with community services and resources—both professional and nonprofessional.



A list of action items and expected implementation timelines related to Improved Care Coordination and Transitions between Levels of Care is provided in the table below:

<b>Action</b>	<b>Timeline</b>
Develop SUD care coordination guidelines for transitions from residential to non-residential settings.	March 2019
Develop ICM guidelines to clarify difference from SUD Care Coordination services and circumstances for concurrent use	May 2019
Develop and implement peer recovery certification requirements.	Begin certification process—Summer of 2018  Implement Demonstration Year 2

## APPENDIX 1— CURRENT ESTIMATE OF NUMBER AND LOCATIONS OF WAIVER SERVICES

The following information provides details regarding the proposed number of Waiver services and the proposed locations of services by Waiver region and by ASAM Level of Care (**Milestone #1**). In addition, increased SUD provider capacity by Waiver region (**Milestone #4**) and increased OUD provider capacity by Waiver region (**Milestone #5**) are provided. A map of Waiver regions is included in Appendix 2.

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

The following specifies Alaska's proposed SUD Waiver services by regional location.

#### Level of Care: Opioid Treatment Services (OTS)

**Number of additional OTP—2.** Proposed locations include Region 4 and Region 7 (both in Waiver Year 2).

#### Level of Care: 0.5—Early Intervention Services

**Number of additional SBIRT Hospital ED locations—10.** Proposed locations include 1 each in Regions 2-9 and two in Region 1 (all in Waiver Year 1).

#### Level of Care: 2.1—Intensive Outpatient Services (IOP)

**Number of new IOP—24 (14 Adult and 10 Youth).**

Proposed locations include:

- ◆ Region 1—8 IOP locations (4A and 4Y)
- ◆ Region 2—4 IOP locations (2A and 2Y)
- ◆ Region 3—1 IOP location
- ◆ Region 4—2 IOP locations (1A and 1Y)
- ◆ Region 5—4 IOP locations (2A and 2Y)
- ◆ Region 6—1 IOP location
- ◆ Region 7—2 IOP locations (1A and 1Y)
- ◆ Region 8—1 IOP location
- ◆ Region 9—1 IOP location

Regions 1 and 5 will develop IOPs in 12 locations during Waiver Year 1 and Regions 2-4 and 6-9 will develop IOPs in 12 locations during Waiver Year 2, at the latest.

## **Level of Care: 2.5—Partial Hospitalization Services (PHP)**

**Number of new PHP—4 (all Youth).**

Proposed locations include those 4 regions with only one IOP program—Regions 3, 6, 8, & 9 (all in Waiver Year 2).

## **Level of Care: 3.1—Clinically Managed Low-Intensity Residential Services**

**Number of additional 3.1 beds—110 (90 Adult and 20 Youth).**

Proposed locations include:

- ◆ Region 1—↑ 20 beds (15 A & 5 Y)
- ◆ Region 2—↑ 20 A beds
- ◆ Region 3-- ↑ 10 A beds
- ◆ Region 4—↑ 10 beds (5 A & 5 Y)
- ◆ Region 5—↑ 15 A beds
- ◆ Region 6—↑ 10 beds (5 A & 5 Y)
- ◆ Region 8—↑ 10 beds (5 A & 5 Y)
- ◆ Region 9—↑ 15 A beds

Regions 1 and 5 will implement during Waiver Year 1 and Regions 2-4 and 6-9 will implement during Waiver Year 2.

## **Level of Care: 3.3—Clinically Managed Population-Specific High-Intensity Residential Services for Adults**

**Number of additional 3.3 beds—24.**

Proposed locations for the 24 beds include:

- ◆ Region 1—12 beds—Waiver Year 1
- ◆ Region 2—12 beds—Waiver Year 2

## **Level of Care: 3.5—Clinically Managed Medium-Intensity Residential Services (Youth) and Clinically Managed High-Intensity Residential Services (Adult)**

**Number of additional 3.5 beds—66 (26 Adult, 6 Youth, 34 Pregnant and Postpartum Women with Children).**

Proposed locations for the 32 Adult and Youth beds include:

- ◆ Region 1—↑ 12 A beds
- ◆ Region 2—↑ 6 Y beds
- ◆ Region 4—↑ 8 A beds
- ◆ Region 7—↑ 6 A beds

Region 1 beds will be implemented during Waiver Year 1; Regions 2, 4, and 7 beds will be implemented during Waiver Year 2.

The other 34 beds will become specialized Residential Treatment programs for Pregnant and Postpartum Women and their Children ages 10 and under. Proposed locations include:

- ◆ Region 3—↑ 8 beds Region
- ◆ 4—↑ 8 beds Region 6—↑ 8
- ◆ beds Regions 7 & 8--↑10
- ◆ beds

All 34 beds will be implemented during Waiver Year 2.

## **Level of Care: 1-WM—Ambulatory Withdrawal Management Without Extended On-Site Monitoring**

**Number of additional 1-WM providers—9 (1 per region).**

Proposed locations include Waiver Year 1 for Regions 1 and 5 and Waiver Year 2 for Regions 2-4 and 6-9.

## **Level of Care: 2-WM—Ambulatory Withdrawal Management With Extended On-Site Monitoring**

**Number of new 2-WM providers—9 (1 per region).**

Proposed locations include Waiver Year 1 for Regions 1 and 5 and Waiver Year 2 for Regions 2-4 and 6-9.

## Level of Care: 3.2-WM—Clinically Managed Residential Withdrawal Management

Number of new 3.2-WM providers—1.

Proposed location includes 1 in Region 1 (Waiver Year 2).

## Level of Care: 3.7-WM—Medically Monitored Intensive Inpatient Withdrawal Management

Number of new 3.7-WM providers—1.

Proposed location includes 1 in Region 1 (Waiver Year 2).

## Level of Care: 4-WM—Medically Managed Intensive Inpatient Withdrawal Management

Number of new 4-WM providers—3.

Proposed locations include 1 in Region 1 (Waiver Year 1), 1 in Region 2 (Waiver Year 2), and 1 in Region 5 (Waiver Year 1).

## Milestone #4: Sufficient Provider Capacity at Critical Levels of Care

### A. SUD Provider Capacity

Details regarding **proposed increased SUD provider capacity** by ASAM Level of Care for each Waiver region include:

- ◆ Waiver Region 1:
  - ASAM Level OTS—3 naltrexone providers
  - ASAM Level 0.5— SBIRT in 2 hospital ED
  - ASAM Level 2.1—8 IOP providers (4 adult and 4 youth)
  - ASAM Level 2.5—N/A
  - ASAM Level 3.1—1 Adult (A) provider (15 beds) & 1 Youth (Y) provider (5 beds)
  - ASAM Level 3.3—1 TBI provider (12 beds)
  - ASAM Level 3.5—1 A provider (12 beds)
  - ASAM Level 3.7—N/A
  - ASAM Level 4.0—N/A
  - ASAM Level 1-WM—1 provider for 1-WM or 2-WM
  - ASAM Level 2-WM—1 provider for 1-WM or 2-WM
  - ASAM Level 3.2-WM—N/A

- ASAM Level 3.7-WM—N/A
- ASAM Level 4-WM—1 provider
- Community Recovery Support—Phase out deleted services and phase in new services Waiver Year 1
- Mobile Outreach and Crisis Response—1 provider

◆ Waiver Region 2:

- ASAM Level OTS—1 naltrexone provider
- ASAM Level 0.5—SBIRT in 1 hospital ED
- ASAM Level 2.1—4 IOP providers (2 adult and 2 youth)
- ASAM Level 2.5—N/A
- ASAM Level 3.1—1-2 A provider(s) (20 beds)
- ASAM Level 3.3—1 SUD-related cognitive impairment provider (12 beds)
- ASAM Level 3.5—1 Y provider (6 beds)
- ASAM Level 3.7—N/A
- ASAM Level 4.0—N/A
- ASAM Level 1-WM—1 provider for 1-WM or 2-WM
- ASAM Level 2-WM—1 provider for 1-WM or 2-WM
- ASAM Level 3.2-WM—N/A
- ASAM Level 3.7-WM—N/A
- ASAM Level 4-WM—1 provider
- Community Recovery Support--Phase out deleted services and phase in new services Waiver Year 2
- Mobile Outreach and Crisis Response—1 provider

◆ Waiver Region 3:

- ASAM Level OTS—1 OBOT & 1 naltrexone provider
- ASAM Level 0.5—SBIRT in 1 hospital ED
- ASAM Level 2.1—1 IOP provider (adult)
- ASAM Level 2.5—1 PHP provider (youth)
- ASAM Level 3.1—1 Adult provider (10 beds)
- ASAM Level 3.3—N/A
- ASAM Level 3.5—1 Women & Children's (W/C) provider (8 beds)
- ASAM Level 3.7—N/A
- ASAM Level 4.0—N/A
- ASAM Level 1-WM—1 provider for 1-WM or 2-WM
- ASAM Level 2-WM—1 provider for 1-WM or 2-WM
- ASAM Level 3.2-WM—N/A
- ASAM Level 3.7-WM—N/A
- ASAM Level 4-WM—N/A
- Community Recovery Support-- Phase out deleted services and phase in new services Waiver Year 2
- Mobile Outreach and Crisis Response—1 provider

◆ Waiver Region 4:

- ASAM Level OTS—1 OTP & 1 naltrexone provider
- ASAM Level 0.5—SBIRT in 1 hospital ED

- ASAM Level 2.1—2 IOP providers (1 adult and 1 youth)
- ASAM Level 2.5—N/A
- ASAM Level 3.1—1 A provider (5 beds) & 1 Y provider (5 beds)
- ASAM Level 3.3—N/A
- ASAM Level 3.5—1 A provider (8 beds) & 1 W/C provider (8 beds)
- ASAM Level 3.7—N/A
- ASAM Level 4.0—N/A
- ASAM Level 1-WM—1 provider for 1-WM or 2-WM
- ASAM Level 2-WM—1 provider for 1-WM or 2-WM
- ASAM Level 3.2-WM—N/A
- ASAM Level 3.7-WM—N/A
- ASAM Level 4-WM—N/A
- Community Recovery Support—Phase out deleted services and phase in new services Waiver Year 2
- Mobile Outreach and Crisis Response—1 provider

◆ Waiver Region 5:

- ASAM Level OTS—1 naltrexone provider
- ASAM Level 0.5—SBIRT in 1 hospital ED
- ASAM Level 2.1—2 IOP providers (1 adult and 1 youth)
- ASAM Level 2.5—N/A
- ASAM Level 3.1—1 A provider (15 beds)
- ASAM Level 3.3—N/A
- ASAM Level 3.5—N/A
- ASAM Level 3.7—N/A
- ASAM Level 4.0—N/A
- ASAM Level 1-WM—1 provider for 1-WM or 2-WM
- ASAM Level 2-WM—1 provider for 1-WM or 2-WM
- ASAM Level 3.2-WM—N/A
- ASAM Level 3.7-WM—N/A
- ASAM Level 4-WM—1 provider
- Community Recovery Support—Phase out deleted services and phase in new services Waiver Year 1
- Mobile Outreach and Crisis Response—1 provider

◆ Waiver Region 6:

- ASAM Level OTS—1 naltrexone provider
- ASAM Level 0.5—SBIRT in 1 hospital ED
- ASAM Level 2.1—1 IOP provider (adult)
- ASAM Level 2.5—1 PHP provider (youth)
- ASAM Level 3.1—1 A provider (5 beds) & 1 Y provider (5 beds)
- ASAM Level 3.3—N/A
- ASAM Level 3.5—1 W/C provider (8 beds)
- ASAM Level 3.7—N/A
- ASAM Level 4.0—N/A
- ASAM Level 1-WM—1 provider for 1-WM or 2-WM
- ASAM Level 2-WM—1 provider for 1-WM or 2-WM
- ASAM Level 3.2-WM—N/A
- ASAM Level 3.7-WM—N/A



- ASAM Level 4-WM—N/A
- Community Recovery Support—Phase out deleted services and phase in new services Waiver Year 2
- Mobile Outreach and Crisis Response—1 provider

◆ Waiver Region 7:

- ASAM Level OTS—1 OTP & 1 naltrexone provider
- ASAM Level 0.5—SBIRT in 1 hospital ED
- ASAM Level 2.1—2 IOP providers (1 adult & 1 youth)
- ASAM Level 2.5—N/A
- ASAM Level 3.1—N/A
- ASAM Level 3.3—N/A
- ASAM Level 3.5—1 A provider (6 beds) & 1 W/C provider for Regions 7 & 8 (10 beds)
- ASAM Level 3.7—N/A
- ASAM Level 4.0—N/A
- ASAM Level 1-WM—1 provider for 1-WM or 2-WM
- ASAM Level 2-WM—1 provider for 1-WM or 2-WM
- ASAM Level 3.2-WM—N/A
- ASAM Level 3.7-WM—N/A
- ASAM Level 4-WM—N/A
- Community Recovery Support—Phase out deleted services and phase in new services Waiver Year 2
- Mobile Outreach and Crisis Response—1 provider

◆ Waiver Region 8:

- ASAM Level OTS—1 OBOT & 1 naltrexone provider
- ASAM Level 0.5—SBIRT in 1 hospital ED
- ASAM Level 2.1—1 IOP provider (adult)
- ASAM Level 2.5—1 PHP provider (youth)
- ASAM Level 3.1—1 A provider (5 beds) & 1 Y provider (5 beds)
- ASAM Level 3.3—N/A
- ASAM Level 3.5—N/A
- ASAM Level 3.7—N/A
- ASAM Level 4.0—N/A
- ASAM Level 1-WM—1 provider for 1-WM or 2-WM
- ASAM Level 2-WM—1 provider for 1-WM or 2-WM
- ASAM Level 3.2-WM—N/A
- ASAM Level 3.7-WM—N/A
- ASAM Level 4-WM—N/A
- Community Recovery Support—Phase out deleted services and phase in new services Waiver Year 2
- Mobile Outreach and Crisis Response—1 provider

◆ Waiver Region 9:

- ASAM Level OTS—1 naltrexone provider

- ASAM Level 0.5—SBIRT in 1 hospital ED
- ASAM Level 2.1—1 IOP provider (adult)
- ASAM Level 2.5—1 PHP provider (youth)
- ASAM Level 3.1—1 A provider (15 beds)
- ASAM Level 3.3—N/A
- ASAM Level 3.5—N/A
- ASAM Level 3.7—N/A
- ASAM Level 4.0—N/A
- ASAM Level 1-WM—1 provider for 1-WM or 2-WM
- ASAM Level 2-WM—1 provider for 1-WM or 2-WM
- ASAM Level 3.2-WM—N/A
- ASAM Level 3.7-WM—N/A
- ASAM Level 4-WM—N/A
- Community Recovery Support—Phase out deleted services and phase in new services Waiver Year 2
- Mobile Outreach and Crisis Response—1 provider

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

### F. Integrating Alaska’s Prevention and Treatment Efforts

With the Waiver, Alaska’s **proposed increased OUD treatment capacity** will include the following by Waiver region (increased capacity vis-à-vis Waiver in red):

- ◆ Region 1—2 OTPs, 5 OBOTs, 3 naltrexone providers, MAT Care Coordination, SBIRT in 2 hospitals
- ◆ Region 2—1 OTP, 3 OBOTs, 1 naltrexone provider, MAT Care Coordination, SBIRT in 1 hospital
- ◆ Region 3—1 OBOT, 1 naltrexone provider, MAT Care Coordination, SBIRT in 1 hospital
- ◆ Region 4—1 OBOT, 1 OTP, 1 naltrexone provider, MAT Care Coordination, SBIRT in 1 hospital
- ◆ Region 5—2 OBOTs, 1 naltrexone provider, MAT Care Coordination, SBIRT in 1 hospital
- ◆ Region 6—1 OBOT, 1 naltrexone provider, MAT Care Coordination, SBIRT in 1 hospital
- ◆ Region 7—2 OBOTS, 1 OTP, 1 naltrexone provider, MAT Care Coordination, SBIRT in 1 hospital
- ◆ Region 8—1 OBOT, 1 naltrexone provider, MAT Care Coordination, SBIRT in 1 hospital
- ◆ Region 9—1 OBOT, 1 naltrexone provider, MAT Care Coordination, SBIRT in 1 hospital.

**APPENDIX 2— DOCUMENTS**

## **APPENDIX 3— SUD HEALTH INFORMATION TECHNOLOGY PLAN**