DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

SEP 0 3 2019

Renee Gayhart
Director
Division of Health Care Services
240 Main Street, Suite 202
Juneau, AK 99801

Dear Ms. Gayhart:

Under section 1115 of the Social Security Act (the Act), the Secretary of Health and Human Services (HHS) may approve any experimental, pilot, or demonstration project that, in the judgment of the Secretary, is likely to assist in promoting the objectives of certain Act programs including Medicaid. Congress enacted section 1115 of the Act to ensure that federal requirements did not "stand in the way of experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients." S. Rep. No. 87-1589, at 19 (1962), *as reprinted in* 1962 U.S.C.C.A.N. 1943, 1961. As relevant here, section 1115 of the Act allows the Secretary to waive compliance with the Medicaid program requirements of section 1902 of the Act, to the extent and for the period he finds necessary to carry out the demonstration project. In addition, section 1115 of the Act allows the Secretary to provide federal financial participation for demonstration costs that would not otherwise be considered as federally matchable expenditures under section 1903 of the Act, to the extent and for the period prescribed by the Secretary.

For the reasons discussed below, the Centers for Medicare & Medicaid Services (CMS) is approving your request to amend Alaska's section 1115 demonstration project, titled Substance Use Disorder Treatment and Alaska Behavioral Health Program (SUD-BHP) (Project No. 11-W-00318/0), effective September 3, 2019 through December 31, 2023. Specifically, this approval authorizes the state to implement additional services to enhance the comprehensive services available under the behavioral health system for children, youth, and adults with serious mental illness, severe emotional disturbance, and/or substance use disorders.

CMS's approval of this section 1115(a) demonstration is subject to the limitations specified in the attached expenditure authorities, waivers, Special Terms and Conditions (STCs), and any supplemental attachments defining the nature, character, and extent of federal involvement in this project. The state may deviate from the Medicaid state plan requirements only to the extent those requirements have been specifically listed as waived or as not applicable to expenditures or individuals covered by expenditure authority.

Objectives of the Medicaid Program

As noted above, the Secretary may approve a demonstration project under section 1115 of the Act if, in his judgment, the demonstration is likely to assist in promoting the objectives of title XIX. The purposes of Medicaid include an authorization of appropriation of funds to "enabl[e] each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care." Act § 1901. This provision makes clear that an important objective of the Medicaid program is to furnish medical assistance and other services to vulnerable populations. But, there is little intrinsic value in paying for services if those services are not advancing the health and wellness of the individual receiving them, or otherwise helping the individual attain independence. Therefore, we believe an objective of the Medicaid program, in addition to furnishing services, is to advance the health and wellness needs of its beneficiaries, and that it is appropriate for the state to structure its demonstration project in a manner that prioritizes meeting those needs.

Section 1115 demonstration projects present an opportunity for states to experiment with reforms that go beyond just routine medical care and focus on interventions that drive better health outcomes and quality of life improvements, and that may increase beneficiaries' financial independence. Such policies may include those designed to address certain health determinants and those that encourage beneficiaries to engage in health-promoting behaviors and to strengthen engagement by beneficiaries in their personal health care plans. These tests will necessarily mean a change to the status quo. They may have associated administrative costs, particularly at the initial stage, and section 1115 acknowledges that demonstrations may "result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing." Act § 1115(d)(1). But in the long term, they may create incentives and opportunities that help enable many beneficiaries to enjoy the numerous personal benefits that come with improved health and financial independence.

Section 1115 demonstration projects also provide an opportunity for states to test policies that ensure the fiscal sustainability of the Medicaid program, better "enabling each [s]tate, as far as practicable under the conditions in such [s]tate" to furnish medical assistance, Act § 1901, while making it more practicable for states to furnish medical assistance to a broader range of persons in need. For instance, measures designed to improve health and wellness may reduce the volume of services consumed, as healthier, more engaged beneficiaries tend to consume fewer medical services and are generally less costly to cover. Further, measures that have the effect of helping individuals secure employer-sponsored or other commercial coverage or transition from Medicaid eligibility may decrease the number of individuals who need financial assistance, including medical assistance, from the state. Such measures may enable states to stretch their resources further and enhance their ability to provide medical assistance to a broader range of persons in need, including by expanding the services and populations they cover.[1] By the same

[1] States have considerable flexibility in the design of their Medicaid programs, within federal guidelines. Certain benefits are mandatory under federal law, but many benefits may be provided at state option, such as prescription drug benefits, vision benefits, and dental benefits. Similarly, states have considerable latitude to determine whom their Medicaid programs will cover. Certain eligibility groups must be covered under a state's program, but many

token, such measures may also preserve states' ability to continue to provide the optional services and coverage they already have in place.

Our demonstration authority under section 1115 of the Act allows us to offer states more flexibility to experiment with different ways of improving health outcomes and strengthening the financial independence of beneficiaries. Demonstration projects that seek to improve beneficiary health and financial independence improve the well-being of Medicaid beneficiaries and, at the same time, allow states to maintain the long-term fiscal sustainability of their Medicaid programs and to provide more medical services to more Medicaid beneficiaries. Accordingly, such demonstration projects advance the objectives of the Medicaid program.

Background on Medicaid Coverage in Alaska's SUD-BHP Demonstration

The Alaska Legislature passed a law in 2016 mandating the Alaska Department of Health and Social Services (DHSS) to reform Alaska's Medicaid (Title XIX) program, and to apply for a Section 1115 demonstration. On January 31, 2018, Alaska submitted an application for a new five-year section 1115 demonstration to support the continued effectiveness of Alaska's Medicaid program, with an emphasis on reforming the behavioral health and substance use disorder (SUD) delivery system. The state and CMS agreed to approve the SUD component of the demonstration while the behavioral health component would still be under review. CMS approved the SUD section of the demonstration on November 21, 2018, effective January 1, 2019. The SUD component of this demonstration authorizes Alaska to receive federal financial participation (FFP) for the provision of all Medicaid state plan and approved demonstration services-including a continuum of services to treat addiction to opioids and other substances-for Medicaid enrollees who are primarily receiving treatment and withdrawal management services and are short-term residents in residential and impatient treatment facilities that meet the definition of an Institution for Mental Diseases (IMD).

Extent and Scope of the Demonstration Amendment

The approval of this demonstration amendment authorizes Alaska to provide a comprehensive and integrated set of behavioral health benefits in an effort to reduce operational barriers, minimize administrative burden, and improve the effectiveness and efficiency of Alaska's behavioral health system. The demonstration also seeks to increase and make services more readily available for Medicaid beneficiaries, especially at-risk individuals and families, in order to support the healthy development of children and adults through increased outreach and prevention and early intervention supports.

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states opt to cover additional eligibility groups that are optional under the Medicaid statute. The optional groups include a new, non-elderly adult population (ACA expansion population) that was added to the Act at section 1902(a)(10)(A)(i)(VIII) by the Patient Protection and Affordable Care Act (ACA). Coverage of the ACA expansion population became optional as a result of the Supreme Court's decision in *NFIB v. Sebelius*, 567 U.S. 519 (2012). Accordingly, several months after the *NFIB* decision was issued, CMS informed the states that they "have flexibility to start or stop the expansion." CMS, *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid* at 11 (Dec. 10, 2012). In addition to expanding Medicaid coverage by covering optional eligibility groups and benefits beyond what the Medicaid statute requires, many states also choose to cover benefits beyond what is authorized by statute by using expenditure authority under section 1115(a)(2) of the Act. For example, recently, many states have been relying on this authority to expand the scope of services they offer to address substance use disorders beyond what the statute explicitly authorizes.

CMS is approving expenditure authorities for behavioral health services that could be covered under the state plan. The state will be piloting these services within the demonstration to evaluate their effectiveness and will transition those services found to be effective to state plan authority at the end of the demonstration period. Alaska's complex geographical features, including its vast size, rural nature, limited road system, and arctic climate make it necessary for the state to phase in the services across the state during the 5-year duration of the demonstration with all services available across the state by the end of Demonstration Year 3.

CMS is approving waivers of statewideness and amount, duration, and scope for the behavioral health benefits authorized in this demonstration amendment. Alaska has begun to implement the SUD initiative across the state, in a phase-in approach and will implement the behavioral health services upon approval of the amendment on September 3, 2019. The phase-in approach will begin with approximately one-half of the state's population to be covered during Demonstration Years 1 and 2, and the other half of the state's population covered in Demonstration Year 3.

Many of the services authorized by this demonstration amendment are currently authorized within the state plan, but the state is not able to deliver them in all cases for the reasons described above. Similar to the already approved SUD component of the demonstration, the state has requested that these services be included in the 1115 demonstration so that they can be tested, rigorously evaluated, and monitored within the 1115 demonstration. Alaska intends to use evaluation results from the demonstration in determining whether to include these services in the state plan and will submit appropriate state plan amendments.

Determination that the Demonstration Project is Likely to Assist in Promoting Medicaid's Objectives

In its consideration of Alaska's demonstration amendment, CMS examined whether the demonstration was likely to assist in improving health outcomes, whether it would address health determinants that influence health outcomes, and whether it would incentivize beneficiaries to engage in their own health care and achieve better health outcomes. CMS has determined the demonstration as a whole is likely to promote Medicaid objectives, and the waiver and expenditure authorities sought are necessary and appropriate to carry out the demonstration. The following discusses the authorities approved in the demonstration amendment and how they are likely to promote the objectives of the Medicaid program.

The amendment is likely to assist in improving positive health outcomes for beneficiaries by making available additional behavioral health services for eligible beneficiaries.

CMS has long supported policies that recognize the importance of coordinating care and services to improve the well-being and health of Medicaid beneficiaries. Given the potential health benefits of integrating a comprehensive behavioral health system, CMS believes that state Medicaid programs should be able to support these activities, and test incentives that are appropriate for these populations and are likely to lead to improved health outcomes.

Implementation of the amendment is also likely to assist in promoting the objectives of the Medicaid program by coordinating services for Medicaid beneficiaries to help them receive the necessary care

and treatment for children, youth, and adults with serious mental illness, severe emotional disturbance, and/or substance use disorders. The state expects the implementation of these behavioral health benefits to expand access to these services and to build a transformational comprehensive behavioral health program that will have a positive impact on individuals with SMI, SED, SUD, and co-occurring SMI/SED with SUD, and the state will evaluate the extent to which the provision of these services results in improved integration of all services, increased care coordination effectiveness, increased individual involvement in their care, improved health outcomes, and reductions in unnecessary or inefficient use of health care.

Consideration of Public Comments

To increase the transparency of demonstration projects, sections 1115(d)(1) and (2) of the Act direct the Secretary to issue regulations providing for two periods of public comment on a state's application for a section 1115 demonstration that would result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing. The first comment period occurs at the state level before submission of the section 1115 application, and the second comment period occurs at the federal level after the application is received by the Secretary.

Section 1115(d)(2)(A) & (C) of the Act further specify that comment periods should be "sufficient to ensure a meaningful level of public input," but the statute imposes no additional requirement on the states or the Secretary to address those comments, as might otherwise be required under a general rulemaking. Accordingly, the implementing regulations issued in 2012 provide that CMS will review and consider all comments received by the deadline, but will not provide written responses to public comments.[2] Although CMS is not legally required to provide written responses to the comments, CMS is responding to the comments received during the federal comment period below.

CMS received nine comments during the federal comment period. CMS received several comments expressing recommendations for the behavioral health demonstration and outlining the need for housing supports for individuals with mental health issues. Commenters stated that by integrating housing support services within the demonstration, this approach would create a full continuum of behavioral health care services for Alaskan beneficiaries. During the federal review period, commenters outlined a need for a stronger, more developed behavioral health program for Alaska, noting that the state should focus on increasing the number of beds and evaluating the need to increase the number of days an individual can stay in an inpatient hospital. Commenters also stated that the demonstration will identify behavioral health issues that cannot be managed in a community setting, and therefore the state will need to consider an increase in extending stays and the number of beds within long-term hospitals. The state continues to discuss with CMS how to incorporate housing supports through initiatives that will focus on social determinants of health (SDOH). CMS is in the process of developing guidance that will allow states to address SDOH initiatives within the Medicaid community. The state will also perform an actuarial analysis to identify appropriate resources to increase opportunities to expand the demonstration to accommodate additional needs, including the extension of time and increase in the number of beds in long-term facilities.

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[2] 42 CFR § 431.416(d)(2); see also Medicaid Program; Review and Approval Process for Section 1115 Demonstrations; Application, Review, and Reporting Process for Waivers for State Innovation; Final Rules, 77 Fed. Reg. 11678, 11685 (Feb. 27, 2012) (final rule).

During the federal review process, the Alaska Native Health Board and the Alaska Native Tribal Health Consortium (referred to hereafter as "Tribal Representatives") invoked formal, direct consultation with CMS pursuant to section 8.2.3 of the CMS Tribal Consultation Policy. In response, CMS had two meetings with the Tribal Representatives, the second of which included representatives from the state. During this consultation process, the Tribal Representatives identified a number of concerns, both with the extent and quality of the state's communications with them, and about the degree to which the state made changes in response to the concerns expressed about the demonstration application.

The tribal concerns about the demonstration included, but were not limited to, the following major issues:

- *Eligibility Criteria for Demonstration Services*: The state's proposal to make utilization of certain services, such as emergency room visits and inpatient psychiatric hospital stays an eligibility criterion for certain demonstration services;
- *Eligibility for Behavioral Health Services*: Whether behavioral health services outside of an IMD could also be provided to those age 65 and older; and
- *Statewideness*: The phase-in of demonstration services across the state, and tribal concerns that services would be removed from the state plan and not be available to individuals during the phase-in.

Through consultation, Alaska was able to address several issues and committed to continue working with the Tribal Representatives on several others. With respect to the concerns noted above:

- The state removed these eligibility criteria from consideration, and clarified that there will be no change to Medicaid eligibility under the demonstration.
- Alaska removed language that would cap behavioral health services at age 65 and will provide services to those age 65 and older through the existing optional Mediciad State Plan Group (under 42 C.F.R. §§435.232 and 234) for behavioral health services outside of an IMD.
- The state clarified that it will not be removing services from the state plan while the demonstration services are being phased in across the state.

Additionally, as part of this demonstration approval, to help ensure that the state continues to collaborate and engage with the Tribal Representatives and other tribal entities, CMS included a special term and condition (STC) detailing how the state will carry out its Tribal consultation requirements in accordance with approved policy in Alaska's current state plan, with respect to the demonstration project. CMS also will require the state to include information on its tribal consultation activities under the new STC in the quarterly and annual reports related to the implementation of the demonstration for the duration of the demonstration.

Other Information

CMS's approval of this demonstration is conditioned upon compliance with the enclosed list of waiver and expenditure authorities and the STCs defining the nature, character and extent of anticipated federal involvement in the project. The award is subject to our receiving your written

acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter.

A copy of the CMS approved amended STCs and associated waiver and expenditure authorities are enclosed.

Your project officer is Mrs. Heather Ross. Mrs. Ross contact information is as follows:

Heather Ross
Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard
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Baltimore, MD 21244-1850
Telephone: (410) 786-3666
E-mail: heather.ross@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Mrs. Ross and to Mr. David Meacham, Deputy Director, in our Division of Medicaid Field Operations West. Mr. Meacham's address is:

David Meacham
Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
701 Fifth Avenue, Suite 1600
Seattle, WA 98104
E-mail: David.Meacham@cms.hhs.gov

If you have questions regarding this approval, please contact Mrs. Judith Cash, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686. We look forward to continuing to partner with you and your staff throughout the course of Alaska's SUD-BHP demonstration program.

Sincerely,

[redacted]

Calder Lynch
Acting Deputy Administrator and Director

Enclosures

cc: David Meacham, Deputy Director, Division of Medicaid Field Operations West

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: 11-W-00318/0

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

AWARDEE: Alaska Department of Health and Social Services (DHSS)

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable Alaska to operate the above identified section 1115(a) demonstration.

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

2. **Opioid Treatment Services (OTS) for Persons Experiencing an Opioid Use Disorder (OUD).** Expenditures for medication and counseling services to eligible individuals with 5severe opioid use disorder, in accordance with an individualized service plan determined by a licensed physician or licensed prescriber, and approved and authorized according to state requirements.

3. **Intensive Outpatient (IOP) Services for Substance Use Disorder (SUD).** Expenditures for intensive outpatient services and structured programming provided to eligible individuals when determined to be medically necessary and in accordance with an individualized treatment plan.

4. **Intensive Outpatient (IOP) Services for Behavioral Health.** Expenditures for intensive outpatient services and structured programming to individuals determined to be medically necessary and in accordance with an individualized treatment plan as outlined in STC 20a (iv), effective September 3, 2019.

5. **Partial Hospitalization Program (PHP) Services for Substance Use Disorder (SUD).** Expenditures for PHP services provided to eligible individuals including services designed for the diagnosis or active treatment of a SUD to maintain the person's functional level and prevent decrease risk for recurrence of or inpatient hospitalization. Payment for Room and Board are prohibited.

6. **Partial Hospitalization Program (PHP) Services for Behavioral Health**. Expenditures for PHP services provided to individuals, in a highly structured treatment environment for services that will provide diagnosis or active treatment of a individual's psychiatric disorder, with a diagnosis of Serious Mental Illness (SMI) or Serious Emotional Disorder (SED) in accordance with an individualized treatment plan as outlined in STC 20(iii) effective September 3, 2019. Payment for room and board costs are prohibited.

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

8. **Medically Managed Intensive Inpatient Services**. Expenditures for services provided in a hospital setting (acute care or specialty) for individuals with acute medical, behavioral, or cognitive conditions. Medically managed services involve daily medical care and 24-hour nursing requiring the full resources of an acute care or psychiatric hospital.

9. **Ambulatory Withdrawal Management Services.** Expenditures for outpatient services provided to eligible individuals at a mild withdrawal risk with a high commitment to withdrawal management process.

10. **Clinically Managed Residential Withdrawal Management.** Expenditures for services provided in a social setting focusing on peer support programs, including daily individual and group therapies, support and health education services.

11. **Medically Monitored Inpatient Withdrawal Management Services.** Expenditures for services provided in a freestanding withdrawal setting with inpatient beds, specializing in clinical consultation, for individuals experiencing severe withdrawal and needing clinical consultation and supervision for cognitive, biomedical, emotional and behavioral problems.

12. **Medically Managed Intensive Inpatient Withdrawal Management Services.** Expenditures for services provided in an acute care or psychiatric hospital in a patient unit, specializing in medical consultation, full medical acute services and intensive care for individuals experiencing severe, unstable withdrawal needs (usually hospital-based), including 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.

13. **Community Recovery Support Services (CRSS) for Substance Use Disorder.** Expenditures for community recovery support services to help decrease risk for recurrence of symptoms and promote recovery, and to support transition between levels of care for SUD.

14. **Community Recovery Support Services (CRSS) for Behavioral Health.** Expenditures for community recovery support services to help decrease risk for recurrence of symptoms and promote recovery, and to support transition between levels of care for behavioral health services as outlined in STC 20c(iv), effective September 3, 2019.

15. **Home-Based Family Treatment Services.** Expenditures for home-based family treatment (HBFT) services for children/youth ages 0-20 who are at risk for out-of-home placement or detention in a juvenile justice facility and for whom a combination of less intensive outpatient services has not been effective or is deemed likely not to be effective. This expenditure authority will be effective September 3, 2019.

16. **Children's Residential Treatment Level 1 (CRT).** Expenditures for residential treatment services provided by an interdisciplinary treatment team in a therapeutically-structured, supervised environment for children and youth whose health is at risk while living in their community as outlined in STC20a(v), effective September 3, 2019. This authority does not apply to IMDs. Payment for room and board costs are prohibited.

17. **Therapeutic Treatment Homes**. Expenditures for trauma-informed clinical services which include placement in a specifically-trained therapeutic treatment home for children/youth who have severe mental, emotional health needs diagnosed with a SMI or SED or a behavioral health need, and who cannot be stabilized in their home settings as outlined in STCa(vi), effective September 3, 2019. This authority does not apply to IMDs Payment for room and board costs are prohibited.

18. **Assertive Community Treatment (ACT) Services.** Expenditures for an evidence-based practice designed to provide treatment, rehabilitation and support services to individuals who are diagnosed with a severe mental illness and whose needs have not been well met by more traditional mental health services.

19. **Adult Mental Health Residential (AMHR) Services.** Expenditures for AMHR services provided by an interdisciplinary treatment team in a therapeutically-structured, supervised environment for adults with acute mental health needs, diagnosed with a SMI or SED, whose health is at risk while living in their community as outlined in STC 20b(iv) effective September 3, 2019. This authority does not apply to IMDs. Payment for room and board ae prohibited.

20. **Peer-Based Crisis Services.** Expenditures for community-based services, that divert individuals from emergency department and psychiatric hospitalization use, effective September 3, 2019. These services are facilitated by children and adults that have lived with or have experience with a mental illness or a substance disorder (including parents) as outlined in STC 20(b)(v).

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

22. **Intensive Case Management Services for Behavioral Health.** Expenditures for services for children/youth at risk of out-of-home placement, and adults with acute mental health needs, as outlined in STC 20(a)(ii), effective September 3, 2019.

20. **Mobile Outreach and Crisis Response (MOCR) Services**. Expenditures for services which prevent a mental health crisis or stabilize an individual during or after a mental health crisis or a crisis involving both substance use and mental health disorders as outlined in STC20c(i) effective September 3, 2019.

21. **23-Hour Crisis Observation and Stabilization (COS) Services.** Expenditures for evaluation and/or stabilization services for individuals presenting with acute symptoms or distress.

Services are provided for up to 23 hours and 59 minutes of care in a secure and protected environment as outlined in STC 20c(ii) effective September 3, 2019.

23. Crisis Residential/Stabilization Services. Expenditures for medically-monitored, short-term, residential program in an approved 10-15 bed facility that provides 24/7 psychiatric stabilization services as outlined in STC 20c(iii) effective September 3, 2019. These facilities are not IMDs. Payment for room and board are prohibited.

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY

NUMBER: 11-W-00318/0

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

AWARDEE: Alaska Department of Health and Social Services (DHSS)

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the demonstration, from date January 1, 2019 through December 31, 2023 unless otherwise specified. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).
Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of state plan requirements contained in section 1902 of the Act are granted in order to enable Alaska (the state) to carry out the Alaska Substance Use Disorder and Behavioral Health Program.

1. Statewide Operation **Section 1902(a)(1)**

To the extent necessary to enable the state to cover services within residential treatment for individuals with substance use disorder (SUD) and the comprehensive continuum of SUD services designed to maintain individuals in community settings on less than a statewide basis consistent with the phase-in schedule set forth in the approved SUD Implementation Plan Protocol incorporated as Attachment D of the STCs beginning January 1, 2019.

To the extent necessary to enable the state to cover the behavioral health benefits authorized under this demonstration on less than a statewide basis consistent with the phase-in schedule set forth in the "Program Description and Objectives" section of the STCs beginning September 3, 2019.

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

To the extent necessary to enable the state to vary the amount, duration, and scope of services offered to individuals who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD) receiving treatment and withdrawal management services for substance use disorder (SUD) and the comprehensive continuum of SUD services designed to maintain individuals in community settings under this demonstration, regardless of eligibility, consistent with the phase-in schedule set forth in the approved SUD Implementation Plan Protocol incorporated as Attachment D of the STCs beginning January 1, 2019.
To the extent necessary to enable the state to vary the amount, duration, and scope of services of the benefits described in STC 20,consistent with the phase-in schedule set forth in the "Program Description and Objectives" section of the STCs beginning September 3, 2019.

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

NUMBER: 11-W-00318/0

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

AWARDEE: Alaska Department of Health and Social Services (DHSS)

I. PREFACE

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

The STCs are effective from January 1, 2019 through December 31, 2023, unless otherwise stated.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Eligibility and Enrollment
V. Demonstration Programs and Benefits
VI. Cost Sharing
VII. Delivery System
VIII. General Reporting Requirements
IX. Monitoring
X. Evaluation of the Demonstration
XI. General Financial Requirements Under Title XIX
XII. Monitoring Budget Neutrality for the Demonstration
XIII. Schedule of Deliverables for the Demonstration Extension Period

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

- Attachment A: Developing the Evaluation Design
- Attachment B: Preparing the Interim and Summative Evaluation Reports

- Attachment C: Reserved for Evaluation Design
- Attachment D: Reserved for Substance Use Disorder (SUD) Implementation Plan Protocol
- Attachment E: Reserved for SUD Claiming Protocol
- Attachment F: Reserved for SUD Monitoring Protocol
- Attachment G: Reporting Template for Quarterly and Annual Reports

II. PROGRAM DESCRIPTION AND OBJECTIVES

The goal of this demonstration is for Alaska to maintain critical access to opioid use disorder (OUD) and other substance use disorder (SUD) treatment services and continue delivery system improvements for these services to provide more coordinated and comprehensive behavioral health services and OUD/SUD treatment for Medicaid beneficiaries. On November 21, 2018, CMS approved the SUD program component of the demonstration Substance Use Disorder Treatment and Alaska Behavioral Health Program (SUD-BHP) (Project No. 11-W-00318/0). The approved demonstration provides the state with authority to provide high-quality, clinically appropriate SUD treatment services for short-term residents in residential and inpatient treatment settings that qualify as an Institution for Mental Diseases (IMD). It will build on the state's existing efforts to improve models of care focused on supporting individuals in the community and home, outside of institutions and strengthen a continuum of SUD services based on the American Society of Addiction Medicine (ASAM) criteria or other nationally recognized assessment and placement tools that reflect evidence-based clinical treatment guidelines. This current approval also authorizes the state to implement additional services to enhance the comprehensive and integrated behavioral health system for children, youth, and adults with serious mental illness, severe emotional disturbance, and/or substance use disorders.

The SUD-BHP demonstration, is designed to be implemented within five years of the demonstration approval period; the SUD component was approved effective January 1, 2019 and the behavioral health component is approved for September 3, 2019. Alaska has begun to implement the SUD initiative across the state, in a phase in approach; during the first two years, approximately one-half of the state's population will be covered during Demonstration Years 1 and 2 and the other half of the state's population covered in Demonstration Year 3. The state plans to pilot services under the SUD initiative in order to test, rigorously evaluate, and monitor the provision of the services under the SUD initiative, and use evaluation results from the demonstration to make strategic decisions prior to providing these services statewide and through the state plan authority.

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

- Provide a continuum of SUD services—by both increasing the benefits offered to Medicaid recipients and using evidence-based SUD program standards; and

- Increase capacity by building provider networks and workforce throughout the state.

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

1. Increased rates of identification, initiation, and engagement in treatment for substance use and behavioral health issues
2. Increased adherence to and retention in treatment for substance use and behavioral health issues
3. Reduced overdose deaths, particularly those due to opioids
4. Reduced utilization of emergency departments and inpatient hospital settings for substance use and behavioral health treatment where the utilization is preventable or medically inappropriate through improved access to other more appropriate and focused services
5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate
6. Improved access to care for physical health conditions among beneficiaries

Under the SUD-BHP demonstration, the state will address major domains to accomplish these six goals:

1. 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
2. Universally screen all Medicaid recipients, regardless of setting, using behavioral health screening instruments to identify symptoms for preventive measures.
3. Implement American Society of Addiction Medicine (ASAM) Criteria (3rd Edition) to match individuals with SUD with the services and tools necessary for recovery
4. Increase SUD and behavioral health treatment options for youth and adult Medicaid recipients, particularly non-residential, step-up and step-down treatment options

III. GENERAL PROGRAM REQUIREMENTS

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

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

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to

amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
   a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.
   b. If mandated changes in the federal law require state legislation, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

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

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in STC 7 below.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including, but not limited to the failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:
   a. An explanation of the public process used by the state, consistent with the requirements of STC 15. Such explanation must include a summary of any public

feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

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

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

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

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

8. **Extension of the Demonstration.** States that intend to request demonstration extensions under sections 1115(e) or 1115(f) of the Act must submit extension applications in accordance with the timelines contained in statute. Otherwise, if the state intends to request a demonstration extension under section 1115(a) of the Act, the state must submit the extension application no later than 12 months prior to the expiration date of the demonstration. The Governor or Chief Executive Officer of the state must submit to CMS either a demonstration extension request that meets federal requirements at CFR section 431.412(c) or a phase-out plan consistent with the requirements of STC 10.
    a. As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR §431.412 and the public notice and tribal consultation requirements outlined in STC 15.
    b. Upon application from the state, CMS reserves the right to temporarily extend the demonstration including making any amendments deemed necessary to effectuate the demonstration extension including but not limited to bringing the demonstration into compliance with changes to federal law, regulation and policy.

9. **Compliance with Transparency Requirements 42 CFR Section 431.412.** As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR Section 431.412 and the public notice and tribal consultation requirements outlined in STC 15, as well as include the following supporting documentation:

    a. Demonstration Summary and Objectives: The state must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.

b. Waiver and Expenditure Authorities: The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.

c. Quality: The state must provide summaries of: External Quality Review Organization (EQRO) reports; managed care organization (MCO) reports; state quality assurance monitoring; and any other documentation that validates the quality of care provided or corrective action taken under the demonstration.

d. Compliance with Budget Neutrality Cap: The state must provide financial data (as set forth in the current STCs) demonstrating the state's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the demonstration. CMS will work with the state to ensure that federal expenditures under the extension of this project do not exceed the federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension. In addition, the state must provide up to date responses to the CMS Financial Management standard questions. If title XXI funding is used in the demonstration, a CHIP Allotment Neutrality worksheet must be included.

e. Evaluation Report: The state must provide an evaluation report reflecting the hypotheses being tested and any results available. For the proposed extension period, the state must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period.

f. Documentation of Public Notice 42 CFR section 431.408: The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR section 431.408 including the post-award public input process described in 431.420(c) with a report of the issues raised by the public during the comment period and how the state considered the comments when developing the demonstration extension application.

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

a. Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 6 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.

The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 calendar days after CMS approval of the phase-out plan.

b. Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

c. Phase-out Procedures: The state must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

d. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP must be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

11. CMS Right to Terminate or Suspend. CMS may suspend or terminate the demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

12. Finding of Non-Compliance. The state does not relinquish its rights to challenge CMS' finding that the state materially failed to comply.

13. Withdrawal of 1115(a) Authority. CMS reserves the right to withdraw waiver or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

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

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

    The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR section 431.408(b), State Medicaid Director Letter #01-024, and contained in the state's approved Medicaid State plan, when any program changes to the demonstration, either through amendment as set out in STC 6 or extension, are proposed by the state.

16. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter, or later date if so identified elsewhere in these STCs or in the list of waiver or expenditure authorities.

17. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies, MCOs and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

18. **Common Rule Exemption.** The state must ensure that the only involvement of human subjects in research activities which may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and which are designed to study, evaluate, or otherwise examine the Medicaid program – including public benefit or service programs; procedures for obtaining Medicaid benefits or services; possible changes in or alternatives to those programs or procedures; or possible changes in methods or level of payment for benefits or services under those programs. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.101(b)(5).

19. **Tribal Engagement and Collaboration Process.** In connection with its implementation of this demonstration project, the state will carry out its existing tribal consultation obligations under section 1902(a)(73) of the Act, and as set forth in Alaska state plan amendment #12-002, as follows:
    a. The state will continue with its activities stated in Alaska's State Plan, including its quarterly meetings with tribal health programs (including tribal behavioral health providers) and/or their designees, the Indian Health Service and/or its designees, the Alaska Native Health Board, and other designated groups such as the State/Tribal Medicaid task force (collectively, "the Alaska Tribal Entities").
    b. At its quarterly meetings with the Alaska Tribal Entities, the state must seek input from the Alaska Tribal Entities on the following specific topics: (1) quality of care

and access to services provided through this demonstration project; (2) implementation of services and activities under this demonstration project, including any barriers or complications the Alaska Tribal Entities encounter or otherwise identify; and (3) progress on execution of the SUD implementation plan under this demonstration project.

c. Consistent with section 2.3 "Committees/Work Groups" of State Plan Amendment #12-002, a special work group will provide targeted guidance and technical assistance to help tribal health programs implement activities under this demonstration project. This work group will report its progress at the quarterly meetings referenced above between the state and Alaska Tribal Entities. The state will report to CMS on the progress of its consultation with Alaska Tribal Entities, including the work group's activities in the quarterly and annual reports for this 1115 demonstration project, as further specified in STC 36f.

IV. ELIGIBILITY AND ENROLLMENT

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

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

V. DEMONSTRATION PROGRAMS AND BENEFITS

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

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

TABLE 1: BEHAVIORAL HEALTH BENEFITS COVERAGE WITH EXPENDITURE AUTHORITY

LBHA Benefit	Medicaid Authority
Home-based Family Treatment	1115 expenditure authority

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

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

The state attests that the services being provided under the demonstration will be implemented through the state's phased in approach over the first two years- Demonstration Year 1 (January 1, 2019-December 31, 2019) and Demonstration Year 2 (January 1, 2020-December 31, 2020).

20. Behavioral Health Benefits

The Behavioral Health Benefits will target three groups:

a. **Group 1: Children, Adolescents and their Parents or Caretakers with or at risk of Mental Health and Substance Use Disorders** (any member of the family, including parents and caretakers, are eligible to receive Group 1 services if they or their children/siblings meet Group 1 eligibility criteria)
b. **Group 2: Transition Age Youth and Adults with Acute Mental Health Needs**
c. **Group 3: Shared Behavioral Health Program Benefits** (Shared Group 1 and Group 2)

a. **Group 1- Behavioral Health Program Benefits**

i. Home-based Family Treatment- Services to reduce use of child/youth inpatient hospitalization and residential services by providing treatment and wrap-around services in the child/youth's home. Home-based family treatment (HBFT) services are available for children/youth ages 0-20 who are at risk for out-of-home placement or detention in a juvenile justice facility and for whom a combination of less intensive outpatient services has not been effective or is deemed likely not to be effective. There will be three progressively intensive levels of HBFT:

- **Level 1** Home-based family treatment services will be provided for children at moderate risk of out-of-home placement
- **Level 2** Home-based family treatment services are provided for children at high risk of out-of-home placement
- **Level 3** Home-based family treatment services will be provided for two types of recipients: children at imminent risk of out-of-home placement or children discharging from residential treatment.

Component services include:

- Clinical services
  - Comprehensive family assessment
  - Family, group and individual therapy
- Medication services—including continuity of medications, medication prescription, review of medication, medication administration, and medication management
- Cognitive, behavioral, and other evidence based models, reflecting a variety of treatment approaches, provided to the individual on an individual and/ or family basis
- Crisis diversion and intervention planning
- Ongoing monitoring for safety and stability in the home
- Intensive case management
- Skill development including:
  - Parenting skills: assisting parents to utilize developmentally appropriate interventions and strategies to restore functioning and provide structure and support for children with emotional and behavioral problems
  - Communication, problem solving and conflict resolution skill building

- Life skills and social skills required to restore functioning and provide structure and support for children with emotional and behavioral problems
- Self-regulation, anger management, and other mood management skills for children, youth and parents

- Wraparound facilitation and coordinating to link the family with community services and supports that maintain children with emotional and behavioral problems in the home:
  - Coordinating referrals to community-based social services and supports for basic needs
  - Coordinating services with the educational system

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

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

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

Component Services include:

- The case manager would serve as the central point of contact for an individual, brokering and/or linking individuals with mental health, SUD, medical, social, educational, vocational, legal, and financial resources in the community
- Individualized, person-centered assessment and treatment plan with quarterly update assessments
- Regular (biweekly, at a minimum) monitoring of behavioral health service delivery, safety, and stability
- Triaging for crisis intervention purposes (e.g., determining need for intervention and referral to appropriate service or authority)
- Assisting individual in being able to better perform activities of daily living—problem-solving skills, self-sufficiency, productive behaviors, conflict resolution

- Referral for counseling or specialized services
- Engaging natural supports (natural supports are family members/close kinship relationships) that enhance the quality of life

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

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

Component Services include:

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

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

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

Component Services include:

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

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

v. **Children's Residential Treatment Level 1 (CRT)**- Treatment services provided by an interdisciplinary treatment team in a therapeutically-structured, supervised environment for children and youth whose health is at risk while living in their community. This authority does not apply to IMDs.

Component Services include:

- A comprehensive evaluation to assess emotional, behavioral, medical, educational, and social needs, and support these needs safely
- Medication Services—including medication prescription, review of medication, medication administration, and medication management
- An Individual Plan of Care
- Cognitive, behavioral and other therapies, reflecting a variety of treatment approaches, provided to the child/youth on an individual, group, and/or family basis

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

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

Component Services include:

- Individualized, person-centered assessment
- Treatment Plan development
- Cognitive, behavioral and other trauma-informed therapies, reflecting a variety of treatment approaches, provided to the child/youth on an individual and/or family basis
- Medication Services—including medication prescription, review of medication, medication administration, and medication management
- Case Coordination
- Crisis Intervention services

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

b. **Group 2- Behavioral Health Program Benefits**

i. **Assertive Community Treatment Services (ACT)**- An evidence-based practice designed to provide treatment, rehabilitation and support services to individuals who are diagnosed with a severe mental illness and whose needs have not been well met by more traditional mental health services. The staff-to-recipient ratio is small (one clinician for every ten recipients), and services are provided 24-hours a day, seven days a week, for as long as they are needed

Component Services include:

- Assertive Outreach services- this includes engagement, outside of a clinical setting; including street outreach, visiting the client's home, work, and other community settings
- Individualized, person-centered assessment and treatment plan with quarterly update assessments
- Cognitive, behavioral, and other mental health disorder-focused therapies, reflecting a variety of treatment approaches, provided to the individual on an individual, group, and/or family basis
- Holistic and Integrated services, including health, vocational, and wellness services. This includes, but limited to educating about mental illness, treatment and recovery, teaching wellness skills for health prevention, including coping skills and stress management, developing crisis management and relapse prevention plans, including identification/recognition of early warning signs and rapid intervention strategies, educating clients on their health rights
- Assisting the individual in being able to better perform activities of daily living— problem-solving skills, self-sufficiency, productive behaviors, conflict resolution
- Family Education services specific to treatment, rehabilitation and support to individuals who are diagnosed with a severe mental illness
- Peer support services
- Medication services—including medication prescription, review of medication, medication administration, and medication management

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

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

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

Component Services include:

- Brokering and linking individuals with mental health, SUD, medical, social, educational, vocational, legal, and financial resources in the community
- Individualized, person-centered assessment and treatment plan with quarterly update assessments
- Serving as the central point of contact for individual navigating transitions across levels of care
- Regular (biweekly, at a minimum) monitoring of behavioral health service delivery, safety, and stability
- Triaging for crisis intervention purposes (e.g., determining need for intervention and referral to appropriate service or authority)
- Assisting individual in being able to better perform activities of daily living—problem-solving skills, self-sufficiency, productive behaviors, conflict resolution
- Referral for counseling or specialized services
- Engaging natural supports (family and/or friends; individuals that are related or have close relationships with the client) in the community that enhance the quality of life

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

supervision of a MH professional clinician, w/complete training / certification, w/continuing education).

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

Component Services include:

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

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

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

Component Services include:

- Clinically-directed therapeutic treatment

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

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

v. **Peer-based Crisis Services**- Services are faclitated by a peer, someone who has lived with a mental illness and/or substance use disorder or has had experience with substance use disorder (includes parents with experience parenting a child with a mental illness or a substance use disorder). Peer-based crisis services serve as a community-based diversion from emergency department and psychiatric hospitalization use. Peer crisis services delivered in community settings with medical support. These services are coordinated within the context of an individualized person-centered plan.

Component Services include:

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

Provider Qualifications: Providers with a lived experience of mental health or substance use disorders (includes parents with experience parenting a child with a mental illness or a substance use disorder), working under the supervision of a mental health professional

clinician, who complete training/certification as defined by the state, and who participate in continuing education as required by the state.

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

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

Component Services include:

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

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

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

Component Services include:

- Individualized, person-centered assessment
- Psychiatric Evaluation services
- Nursing services
- Medication Services—including medication prescription, review of medication, medication administration, and medication management
- Treatment Plan development

- Crisis Intervention services
- Crisis Stabilization services designed to stabilize and restore the individual to a level of functioning that does not require inpatient hospitalization
- Referral to the appropriate level of treatment services

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

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

Component Services include:

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

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

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

Component Services include:

- Recovery coaching- direct services that provide guidance, support and encouragement from the expertise of the trained recovery professional. Recovery coaching is a form of strength-based supports for persons in or seeking recovery from mental disorders and SUD (if co-occurring).
- Social/cognitive/daily living skill building- direct services that assist the individual in being able to better perform his/her own social, cognitive, or activities of daily living or assist the individual in finding resources to meet those needs. Services include coaching to identify the individual's needs (i.e., social, cognitive, daily living) and to either work with the individual to develop the social, cognitive, or ADL skills to meet those needs or refer the individual to another agency or service

- Facilitation of level of care transitions.
- Peer-to-peer services, mentoring, & coaching- Peers are defined as: Individuals who provide services in behavioral health settings—both mental health and substance use disorders treatment—based on their own experience of recovery from mental illness or addiction and skills obtained from formal peer provider training. Within the demonstration, family members of people with SED, SMI, SUD or Co-Occurring disorders are applicable to provide services to other family members with similar experiences.
- Beneficiary & Family Education/Training/Support- Psychoeducational services that teach self- help concepts, skills, and strategies which are designed to promote wellness, stability, and recovery for service recipients and their families. Psychoeducational services are an important mechanism to assist service recipients and family members in understanding the many aspects of mental disorders and SUD (if co-occurring), including factual data about the mental disorder itself; signs & symptoms; information about how mental disorders affect physical health; medications being used to treat the mental disorder; the consequences that mental disorders can have on the service recipient's mental health, family relationships, and other areas of functioning; and the recovery process.
- Relapse prevention
- Child therapeutic support services- direct therapeutic services that involve actions or skills relating to the health of a child or multiple children at a time. Services include linking the child and/or parents with supports, services, and resources that support healthy child development; identifying key developmental milestones (ages and stages) in order to improve child health/growth/development; and educating parents about how to support healthy cognitive, emotional, and social child development.

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

21. Substance Use Disorder/Opioid Use Disorder Program. Effective upon CMS' approval of the SUD/OUD Implementation Protocol the demonstration benefit package for the state's Medicaid recipients must include SUD/OUD treatment services, including services provided in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise matchable expenditures under section 1903 of the Act. The state will be eligible to receive FFP for the state's Medicaid recipients residing in IMDs under the terms of this demonstration for coverage of medical assistance, including SUD/OUD benefits that would otherwise be matchable if the beneficiary were not residing in an IMD. Alaska will aim for a statewide average length of stay of 30 days in residential treatment settings, to be monitored pursuant to the SUD Monitoring Protocol as outlined in STC 21 below, to ensure short-term residential treatment stays. Under this demonstration, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from medically supervised withdrawal management to on-

going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions.

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

Table 2: SUD/OUD Benefits Coverage with Expenditure Authority

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

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

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

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

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

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

Component services include:

i. Linkage to psychological, medical, and psychiatric consultation.

ii. Access to emergency medical and psychiatric care through connections with more intensive levels of care.

iii. Access to evaluation and ongoing primary care.

iv. Ability to conduct or arrange for appropriate laboratory and toxicology tests including urine drug screenings.

v. Availability of licensed physicians to evaluate and monitor use of, methadone, buprenorphine products or naltrexone products and of pharmacists and nurses to dispense and administer these medications.

vi. Individualized, person-centered assessment and treatment.

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

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

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

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

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

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

b. **Intensive Outpatient Services-** Intensive outpatient includes structured programming services provided to beneficiaries (a minimum of nine hours with a maximum of 19 hours a week for adults, and a minimum of six hours with a maximum of 19 hours a week for adolescents) when determined to be medically necessary and in accordance with an individualized treatment plan. Treatment is focused on major lifestyle, attitudinal, and behavior issues which impair the individual's ability to cope with major life tasks without use of substances.

Components Services include:

i. Individualized, person-centered assessment and clinically-directed treatment.

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

iii. Appropriate drug screening

iv. Psychoeducation Services

v. Medication Services
vi. Crisis Intervention Services
vii. Recovery Support Services
viii. SUD Care Coordination

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

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

Component Services include:

i. Individualized, person-centered assessment and clinically-directed treatment
ii. Cognitive, behavioral, and other substance use disorder-focused therapies, reflecting a variety of treatment approaches, provided to the individual on an individual, group, and/ or family basis
iii. Appropriate drug screening
iv. Psychoeducation Services
v. Medication Services
vi. Crisis Intervention Services
vii. Recovery Support Services
viii. Occupational and recreational therapy services as appropriate

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

d. **Residential Treatment Services-** Treatment services delivered to residents of an institutional care setting, including facilities that meet the definition of an institution for mental diseases (IMD), are provided to Alaska Medicaid recipients with a SUD diagnosis

when determined to be medically necessary and in accordance with an individualized treatment plan.

i. Residential treatment services are provided in an Alaska Department of Health and Social Services (DHSS) licensed facility that has been enrolled as a Medicaid provider and assessed/designated/certified by DHSS as delivering care consistent with ASAM or other nationally recognized, SUD-specific program standards for residential treatment facilities.

ii. Residential treatment services can be provided in settings of any size.

iii. Room and board costs are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under section 1905(a) of the Act.

Component services include:

i. Clinically-directed therapeutic treatment to facilitate recovery skills, facilitate decreasing risk of recurrence of symptoms, and emotional coping strategies

ii. Addiction pharmacotherapy and drug screening

iii. Motivational enhancement and engagement strategies

iv. Counseling and clinical monitoring

v. Withdrawal management and related treatment designed to alleviate acute emotional, behavioral, cognitive, or biomedical distress resulting from, or occurring with, an individual's use of alcohol and other drugs

vi. Regular monitoring of the individual's medication adherence

vii. Recovery support services

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

ix. Education on benefits of medication assisted treatment and referral to treatment as necessary.

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

e. **Medically Monitored Intensive Inpatient Services-** These are services provided in a residential setting or a specialty unit of an acute or psychiatric hospital. Individuals receiving services at this level of care require 24-hour services, professionally directed

evaluation, observation, medical monitoring, and addiction treatment in an inpatient setting.

Component Services include:

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

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

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

Component Services include:

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

Provider Qualifications- Providers qualified to be reimbursed for eligible services

provided to eligible service recipients include AK licensed general acute care, specialized psychiatric, Alaska Native tribal, and critical access hospitals.

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

Component Services include:

i. Individualized, person-centered Assessment
ii. Physician and/or Nurse Monitoring
iii. Management of Signs & Symptoms of Intoxication & Withdrawal
iv. Medication Services
v. Psychoeducation Services
vi. Non-Pharmacological Clinical Support Services
vii. Referral for Counseling Services
viii. Substance Use Care Coordination
ix. Community Recovery Support Services

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

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

Component Services include:

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

- Referral for Counseling Services
- Recovery Support Services.

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

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

Component Services include:

i. Individualized, person-centered assessment and medically monitored treatment
ii. Addiction pharmacotherapy and medication services
iii. Appropriate drug screening
iv. Cognitive behavioral and other substance-use disorder-focused therapies, reflecting a variety of treatment approaches, provided to the individual on an individual, group, or family basis
v. Daily medical and nursing services and monitoring
vi. Management of signs and symptoms of intoxication and withdrawal
vii. Counseling and clinical/medical monitoring
viii. Daily treatment services focused on managing the individual's acute symptoms
ix. Psychoeducation services

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

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

Component Services include:

i. Individualized, person-centered assessment and medically directed & managed treatment.
ii. Addiction pharmacotherapy and medication services.
iii. Appropriate drug screening.

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

v. Daily medical and nursing services.

vi. Management of signs and symptoms of intoxication and withdrawal.

vii. Counseling and clinical/medical monitoring.

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

ix. Patient Education services.

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

22. SUD Services Claiming Methodology. Approved SUD Services for which FFP can be claimed solely to support SUD services listed in STC 19. Prior to claiming funding for any of the SUD services, the state must submit a claiming methodology protocol that CMS must approve prior to receiving FFP. The claiming methodology protocol must include expenditures claimed in accordance with CMS-approved claiming and documentation protocols to be specified in Attachment E. The state is not eligible to receive FFP for any of the SUD services until the protocol is approved. Upon CMS approval of the claiming protocol and SUD Implementation Plan Protocol required by STC 21, the state is eligible to receive FFP for the approved SUD services expenditures.

23. SUD Implementation Plan Protocol. The state must submit a SUD/OUD Implementation Protocol within 90 calendar days after approval of this demonstration. The state may not claim FFP for services provided in IMDs until CMS has approved the Implementation Protocol. Once approved, the Implementation Protocol will be incorporated into the STCs, as Attachment D, and once incorporated, may be altered only with CMS approval. After approval of the SUD Implementation Plan Protocol, FFP will be available prospectively, not retrospectively. Failure to submit an Implementation Plan Protocol will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of the OUD/SUD program under this demonstration. Failure to progress in meeting the milestone goals agreed upon by the state and CMS will result in a funding deferral.

At a minimum, the SUD Implementation Plan Protocol must describe the strategic approach and detailed project implementation plan, including timetables and programmatic content where applicable, for meeting the following milestones which reflect the key goals and objectives of the SUD component of this demonstration:

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

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

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

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

e. **Standards of Care:** Establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of SUD program demonstration approval;

f. **Standards of Care:** Establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12-24 months of SUD program demonstration approval;

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

h. **Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD:** Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse and expand coverage of and access to naloxone for overdose reversal as well as implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs;

i. **SUD Health IT Plan:** Implementation of the milestones and metrics as detailed in STC 24 ; and

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

22. SUD Monitoring Protocol. The state must submit a SUD Monitoring Protocol using the CMS SUD Monitoring Protocol template within 150 calendar days after approval of the SUD program under this demonstration. The SUD Monitoring Protocol must be developed in cooperation with CMS and is subject to CMS approval. Once approved, the SUD Monitoring Protocol will be incorporated into the STCs, as Attachment F. At a minimum, the SUD Monitoring Plan Protocol will include reporting relevant to each of the program implementation areas listed in STC 21. The SUD Monitoring Protocol must specify the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in STC 31 of the demonstration. In addition, the SUD Monitoring Protocol must identify a baseline and a target to be achieved by the end of the demonstration. Where possible, baselines must be informed by state data, and targets will be benchmarked against performance in best practice settings. CMS will closely monitor demonstration spending on services in IMDs to ensure adherence to budget neutrality requirements. Progress on the performance measures identified in the SUD Monitoring Protocol must be reported via the quarterly and annual monitoring reports.

23. Mid-Point Assessment. The state must conduct an independent mid-point assessment by November 1, 2020. The state must require that the assessor collaborate with key stakeholders, including representatives of MCOs, SUD treatment providers, beneficiaries, and other key partners in the design, planning and conducting of the mid-point assessment. The state must require that the assessment include an examination of progress toward meeting each milestone and timeframe approved in the SUD Implementation Plan Protocol, and toward meeting the targets for performance measures as approved in the SUD Monitoring Protocol. The state must require that the assessment include a determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date, and a determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and about the risk of possibly missing those milestones and performance targets. The state must require that the mid-point assessment must also provide a status update of budget neutrality requirements. For each milestone or measure target at medium to high risk of not being met, the state must require the assessor provide, for consideration by the state, recommendations for adjustments in the state's implementation plan or to pertinent factors that the state can influence that will support improvement. The state must require the assessor provide a report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. The state must provide a copy of the report to CMS. The state must brief CMS on the report.

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

24. **SUD Evaluation.** The OUD/SUD Evaluation will be subject to the same requirements as the overall demonstration evaluation, as listed in sections VIII General Reporting Requirements and X Evaluation of the Demonstration of the STCs.

25. **SUD Evaluation Design.** The draft Evaluation Design must be developed in accordance with Attachment A (Developing the Evaluation Design) of these STCs. The state must submit, for CMS comment and approval, the Evaluation Design, including the SUD program with implementation timeline, no later than one hundred eighty (180) days after the effective date of these STCs. Any modifications to an existing approved Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable. The state must use an independent evaluator to develop the draft Evaluation Design.

26. **Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within sixty (60) days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within thirty (30) days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each of the Quarterly and Annual Reports, including any required Rapid Cycle Assessments specified in these STCs. Once CMS approves the evaluation design, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for approval.

27. **Evaluation Questions and Hypotheses Specific to the OUD/SUD Program.** Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Evaluation Report) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component must have at least one evaluation question and hypothesis. The hypothesis testing must include, where possible, assessment of both process and outcome measures. Proposed measures must be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

28. **SUD Health Information Technology (Health IT).** The state must provide CMS with an assurance that it has a sufficient health IT infrastructure/"ecosystem" at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration—or it must submit to CMS a plan to develop the infrastructure/capabilities. This "SUD Health IT Plan," or assurance must be included as a section of the state's "Implementation Plan" (see STC 21) to be approved by CMS. The

SUD Health IT Plan must detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SUD goals of the demonstration. The SUD IT Plan must also be used to identify areas of SUD health IT ecosystem improvement.

a. The SUD Health IT section of the Implementation plan must include implementation milestones and dates for achieving them (see Attachment F).

b. The SUD Health IT Plan must be aligned with the state's broader State Medicaid Health IT Plan (SMHP) and, if applicable, the state's Behavioral Health (BH) "Health IT" Plan.

c. The SUD Health IT Plan must describe the state's goals, each DY, to enhance the state's prescription drug monitoring program's (PDMP).[1]

d. The SUD Health IT Plan must address how the state's PDMP will enhance ease of use for prescribers and other state and federal stakeholders.2 This must also include plans to include PDMP interoperability with a statewide, regional or local Health Information Exchange. Additionally, the SUD Health IT Plan must describe ways in which the state will support clinicians in consulting the PDMP prior to prescribing a controlled substance—and reviewing the patients' history of controlled substance prescriptions—prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription.

e. The SUD Health IT Plan must, as applicable, describe the state's capabilities to leverage a master patient index (or master data management service, etc.) in support of SUD care delivery. Additionally, the SUD Health IT Plan must describe current and future capabilities regarding PDMP queries—and the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP. The state must also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

f. The SUD Health IT Plan must describe how the activities described in (a) through (e) above will support broader state and federal efforts to diminish the likelihood of long-term opioid use directly correlated to clinician prescribing patterns.3

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

    i. States may use resources at Health IT.Gov (https://www.healthit.gov/playbook/opioid-epidemic-and-health-it/) in "Section 4: Opioid Epidemic and Health IT."

    ii. States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE

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

[2] *Ibid*.

[3] Shah, Anuj, Corey Hayes and Bradley Martin. *Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015*. MMWR Morb Mortal Wkly Rep 2017;66.

and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.

iii. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP plans and, more generally, to meet the goals of the demonstration.

h. The state must include in its Monitoring Plan (see STC 22) an approach to monitoring its SUD Health IT Plan which will include performance metrics to be approved in advance by CMS.

i. The state must monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines—and report on its progress to CMS in in an addendum to its Annual Reports (see STC 36).

j. As applicable, the state must advance the standards identified in the 'Interoperability Standards Advisory—Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SUD Health IT policies and in all related applicable State procurements (e.g., including managed care contracts) that are associated with this demonstration.

i. Where there are opportunities at the state- and provider-level (up to and including usage in MCO or ACO participation agreements) to leverage federal funds associated with a standard referenced in 45 CFR 170 Subpart B, the state must use the federally-recognized standards, barring another compelling state interest.

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

VI. COST SHARING

29. **Cost Sharing.** Cost sharing under this demonstration is consistent with the provisions of the approved state plan.

VII. DELIVERY SYSTEM

30. The state's SUD/OUD Medicaid delivery system is based on a fee-for-Service (FFS) model for physical and behavioral health. The state delivers SUD services via a FFS delivery system for beneficiaries. Under the demonstration, Medicaid Section 1115 Behavioral Health Demonstration will continue to operate as approved in Section 1932(a) state plan authority for FFS.

VIII. GENERAL REPORTING REQUIREMENTS

31. **Submission of Post-approval Deliverables.** The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

32. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in the amount of $5,000,000 (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singly or collectively referred to as "deliverable(s)")) are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. Specifically:

    a. Thirty (30) calendar days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.

    b. For each deliverable, the state may submit a written request for an extension to submit the required deliverable. Extension requests that extend beyond the current fiscal quarter must include a Corrective Action Plan (CAP).

        i. CMS may decline the extension request.

        ii. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided.

        iii. If the state's request for an extension includes a CAP, CMS may agree to or further negotiate the CAP as an interim step before applying the deferral.

    c. The deferral would be issued against the next quarterly expenditure report following the written deferral notification.

    d. When the state submits the overdue deliverable(s) that are accepted by CMS, the deferral(s) will be released.

    e. As the purpose of a section 1115 demonstration is to test new methods of operation or services, a state's failure to submit all required deliverables may preclude a state from renewing a demonstration or obtaining a new demonstration.

    f. CMS will consider with the state an alternative set of operational steps for implementing the intended deferral to align the process with the state's existing deferral process, for example, what quarter the deferral applies to and how the deferral is released.

33. **Deferral of Federal Financial Participation (FFP) from IMD claiming for Insufficient Progress Toward Milestones.** Up to $5,000,000 in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones as evidenced by reporting on the milestones in the SUD Implementation Protocol and the required performance measures in the Monitoring Protocol agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to $5,000,000 will be deferred in the next calendar quarter and each

calendar quarter thereafter until CMS has determined sufficient progress has been made.

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

    a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

    b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and

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

35. **Cooperation with Federal Evaluators.** As required under 42 CFR 431.420(f), the state must cooperate fully and timely with CMS and its contractors' in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 32.

IX. MONITORING

36. **Monitoring Reports.** The state must submit three (3) Quarterly Reports and one (1) compiled Annual Report each DY. The information for the fourth quarter should be reported as distinct information within the Annual Report. The Quarterly Reports are due no later than sixty (60 calendar days) following the end of each demonstration quarter. The compiled Annual Report is due no later than ninety (90 calendar days) following the end of the DY. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis. See Attachment G for the reporting template for Quarterly and Annual reports.

    a. Operational Updates - Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by

beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. Performance Metrics – Per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, grievances and appeals. The required monitoring and performance metrics must be included in writing in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

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

d. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

e. SUD Health IT. The state must include a summary of progress made in regards to SUD Health IT requirements outlined in STC 28

f. Tribal Engagement and Collaboration Process. The state must include a summary of its tribal engagement activities with respect to this demonstration, including those outlined in STC 19.

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

a. The draft report must comply with the most current guidance from CMS.

b. The state must present to and participate in a discussion with CMS on the close-out report.

c. The state must take into consideration CMS' comments for incorporation into the final close-out report.

d. The Final Close-Out report is due to CMS no later than 30 calendar days after receipt of CMS' comments.

e. A delay in submitting the draft or final version of the close-out report may subject the state to penalties described in STC 32.

38. Monitoring Calls. CMS will convene periodic conference calls with the states

a. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, enrollment and access, budget neutrality, and progress on evaluation activities.

b. CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration.

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

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

X. EVALUATION OF THE DEMONSTRATION

39. Independent Evaluator. Upon approval of the demonstration, the state must begin to arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accord with the CMS-approved, draft Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

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

41. Draft Evaluation Design. The draft Evaluation Design must be developed in accordance with Attachment A (Developing the Evaluation Design) of these STCs. The state must submit, for CMS comment and approval, a draft Evaluation Design with implementation timeline, no later than one hundred eighty (180) days after the effective date of these STCs. Any modifications to an existing approved Evaluation Design will

not affect previously established requirements and timelines for report submission for the demonstration, if applicable. The state must use an independent evaluator to develop the draft Evaluation Design.

42. **Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within sixty (60) days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design to the state's website within thirty (30) days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each of the Monitoring Reports, including any required Rapid Cycle Assessments specified in theses STCs. Once CMS approves the evaluation design, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for approval.

43. **Evaluation Questions and Hypotheses.** Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Evaluation Report) of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component must have at least one evaluation question and hypothesis. The hypothesis testing must include, where possible, assessment of both process and outcome measures. Proposed measures must be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

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

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

    b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.

    c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design was adapted must be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.

d. The state must submit the final Interim Evaluation Report 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.

e. The Interim Evaluation Report must comply with Attachment B of these STCs.

45. Summative Evaluation Report. The draft Summative Evaluation Report must be developed in accordance with Attachment B of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period, November 1, 2018 – December 31, 2023, within 18 months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

a. Unless otherwise agreed upon in writing by CMS, the state must submit the final Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft.

b. The final Summative Evaluation Report must be posted to the state's Medicaid website within 30 calendar days of approval by CMS.

46. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the interim evaluation, and/or the summative evaluation.

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

48. Additional Publications and Presentations. For a period of twelve (12) months following CMS approval of the final reports, CMS must be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS must be provided a copy including any associated press materials. CMS must be given ten (10) business days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

XI. GENERAL FINANCIAL REQUIREMENTS

This project is approved for title XIX expenditures applicable to services rendered during the demonstration period.

49. Reporting Expenditures under the Demonstration. The following describes the reporting of expenditures subject to the Budget Neutrality agreement:

a. Tracking Expenditures. In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in

section 2500 of the State Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act and subject to the BN expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number (11-W-00304/0) assigned by CMS, including the project number extension which indicates the Demonstration Year (DY) in which services were rendered and by the Waiver Names identified in subparagraph (d).

b. Cost Settlements. For monitoring purposes, cost settlements attributable to the demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any cost settlement not attributable to this demonstration, the adjustments must be reported as otherwise instructed in the State Medicaid Manual.

c. Pharmacy Rebates. Pharmacy rebates must be reported on Form CMS 64.9 Base, and not allocated to any Form 64.0 or 64.9 Waiver

d. Use of Waiver Forms. For each demonstration year, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be completed, using the waiver names listed below. Expenditures must be allocated to these forms based on the guidance which follows.

   i. **SUD IMD FFS:**. *Expenditures for all otherwise-allowable Medicaid services provided, were it not for the IMD prohibition, to otherwise-eligible individuals enrolled in fee-for-service during a month in which the beneficiary was a resident in an IMD for a primary diagnosis of SUD.*

   ii. **SUD Non-IMD FFS:** *Expenditures for all otherwise-allowable Medicaid services provided to eligible individuals enrolled in fee-for-service during a month in which the beneficiary was not a resident in an IMD for a primary diagnosis of SUD.*

   iii. **Behavioral Health FFS:** *Expenditures for allowable Medicaid services, outlines within the STCs, provided to eligible individuals enrolled in fee-for-service during a month in which the beneficiary.*

e. Demonstration Years. The demonstration years are as follows:

Demonstration Year 1	January 1, 2019- December 31, 2019	*12 months*
Demonstration Year 2	January 1, 2020 - December 31, 2020	*12 months*
Demonstration Year 3	January 1, 2021 - December 31, 2021	*12 months*
Demonstration Year 4	January 1, 2022 - December 31, 2022	*12 months*
Demonstration Year 5	January 1, 2023 – December 31, 2023	*12 months*

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

50. Budget Neutrality Monitoring Tool. The state must provide CMS with quarterly budget neutrality status updates using the Budget Neutrality Monitoring Tool provided through the Performance Metrics Database and Analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing demonstration's actual expenditures to the budget neutrality expenditure limits described in Section IX. CMS will provide technical assistance, upon request.

51. Quarterly Annuals: The state must provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided through this under the Medicaid program, including those provided through the demonstration under section 1115 authority that are subject to budget neutrality. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

FFP will be provided for expenditures net of collections in the form of pharmacy rebates, cost sharing, or third party liability.

52. Expenditures Subject to the Budget Neutrality Agreement. For the purpose of this section, the term "expenditures subject to the budget neutrality agreement" means expenditures for the EGs outlined in Section XII, Monitoring Budget Neutrality for the Demonstration, except where specifically exempted. All expenditures that are subject to the budget neutrality agreement are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver. Disproportionate share hospital payments, behavioral health health homes payments, and graduate medical education payments are not expenditures under the demonstration and are therefore excluded from budget neutrality.

53. Administrative Costs. The state must separately track and report additional administrative costs that are directly attributable to the demonstration, using separate CMS-64.10 waiver and 64.10 waiver forms. Expenditures must be allocated to these forms based on the guidance which follows:

a. ECM Capacity Building: *Expenditures for ECM capacity building payments.*

b. ADM: *All other additional administrative costs that are directly attributable to the demonstration (for information only, excluded from budget neutrality).*.

54. Claiming Period. All claims for expenditures subject to the budget neutrality limit (including any cost settlements) must be made within two (2) years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within two (2) years after the conclusion or termination of the demonstration. During the latter

2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form CMS-64 in order to properly account for these expenditures in determining budget neutrality.

55. Reporting Member Months. The following describes the reporting of member months for demonstration populations.

a. For the purpose of calculating the BN expenditure limit and for other purposes, the state must provide to CMS, as part of the BN Monitoring Tool required under STC 44, the actual number of eligible member months for the each MEG defined in subparagraph D below. The state must submit a statement accompanying the BN Monitoring Tool, which certifies the accuracy of this information. To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revision.

b. The term "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member/months.

c. The state must report separate member month totals for individuals enrolled in the state's Behavioral Health Demonstration and the member months must be subtotaled according to the MEGs defined in STC 55(d)(i).

d. The required member month reporting MEG is:

i. **SUD IMD FFS**: SUD IMD Member Months are months of Medicaid eligibility during which the individual is an inpatient in an IMD under terms of the demonstration for any day during the month.

ii. **SUD Non-IMD FFS**: SUD non-IMD Member Months are months of Medicaid eligibility during which the individual is receiving SUD services outside of an IMD under terms of the demonstration for any day during the month. These services include:

- Intensive Outpatient (IOP)Services for Substance Use Disorder
- Partial Hospitalization Program (PHP) Services for Substance Use Disorder
- Intensive Case Management Services for Substance Use Disorder
- Community Recovery Support Services (CRSS) for Substance Use Disorder
- Medically Monitored Intensive Inpatient Services
- Medically Managed Intensive Inpatient Services
- Ambulatory Withdrawal Management Services
- Clinically Managed Residential Withdrawal Management
- Medically Monitored Inpatient Withdrawal Management Services

- Medically Managed Intensive Inpatient Withdrawal Management Services
- Peer-Based Crisis Services for Substance Use Disorder

iii. **Behavioral Health FFS:** Behavioral Member Months are months of Medicaid eligibility during which the individual is receiving behavioral health services under the terms of the demonstration for any day during the month. These services include:

- Intensive Outpatient (IOP) Services for Behavioral Health
- Partial Hospitalization Program (PHP) Services for Behavioral Health
- Community Recovery Support Services (CRSS)
- Crisis Residential/Stabilization Services.
- 23-Hour Crisis Observation and Stabilization (COS) Services
- Intensive Case Management Services for Behavioral Health
- Mobile Outreach and Crisis Response (MOCR) Services
- Home-Based Family Treatment
- Children's Residential Treatment Level 1 (CRT)
- Therapeutic Treatment Homes
- Assertive Community Treatment (ACT) Services
- Adult Mental Health Residential (AMHR) Services.
- Peer-Based Crisis Services for Behavioral Health

56. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. The state must estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit, and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS shall make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state t

57. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding. CMS will provide FFP at the applicable federal matching rate for the demonstration as a whole for the following, subject to the limits described in Section XII:

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

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

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

58. Sources of Non-Federal Share. The state certifies that the matching non-federal share of funds for the demonstration is state/local monies. The state further certifies that such funds must not be used as the match for any other federal grant or contract, except as permitted by law. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

a. CMS may review at any time the sources of the non-federal share of funding for the demonstration. The state agrees that all funding sources deemed unacceptable by CMS must be addressed within the time frames set by CMS.

b. Any amendments that impact the financial status of the program must require the state to provide information to CMS regarding all sources of the non-federal share of funding.

c. The state assures that all health care-related taxes comport with section 1903(w) of the Act and all other applicable federal statutory and regulatory provision, as well as the approved Medicaid state plan.

59. State Certification of Funding Conditions. Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes—including health care provider-related taxes—fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

60. Program Integrity. The state must have a process in place to ensure that there is no duplication of federal funding for any aspect of the demonstration.

XII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

61. Limit on Title XIX Funding. The state must be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using the per capita cost method described and budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. Actual expenditures subject to the budget neutrality expenditure limit must be reported by the state using the procedures described in Section XII.

62. **Risk.** The state will be at risk for the per capita cost (as determined by the method described below) for state plan and hypothetical populations, but not at risk for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the for all demonstration populations, CMS will not place the state at risk for changing economic conditions. However, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

63. **Calculation of the Budget Neutrality Limit and How It Is Applied.** For the purpose of calculating the overall budget neutrality limit for the demonstration, annual budget limits will be calculated for each DY on a total computable basis, by multiplying the predetermined PMPM cost for each EG (shown on the table in STC 75) by the corresponding actual member months total, and summing the results of those calculations. The annual limits will then be added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality limit by Composite Federal Share, which is defined in STC 67 below.

64. **Impermissible Taxes, or Donations.** CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of laws and policy statements, including regulations and letters regarding impermissible provider payments, health care related taxes, or other payments (if necessary adjustments must be made). CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

65. **Main Budget Neutrality Test.** *The PMPM cost estimates are based on actual 2016 spending for the IMD-stay projections—and historical expenditures from 2012 to 2017 for the non-IMD-stay SUD services, trended forward using trends based on the lower of state historical trends from Calendar Year 2012-2017 and the FFY 2018 President's Budget trends.* The trend rates and per capita cost estimates for each MEG for each year of the demonstration are listed in the table below.

MEG	*TREND*	*DY 1 PMPM*	*DY 2 PMPM*	*DY 3 PMPM*	*DY 4 PMPM*	*DY 5 PMPM*
SUD-IMD FFS	*4.5%*	$13,349	$13,949	$14,577	$15,233	$15,918

SUD Non-IMD FFS	*4.5%*	$18.10	$18.92	$19.77	$20.66	$21.59
BH-FFS	*4.5%*	$55.86	$55.38	$61.00	$63.75	$66.62

66. **Hypothetical Model.** As part of the SUD initiative, the state may receive FFP for the continuum of services to treat OUD and other SUDs, provided to Medicaid enrollees in an IMD. These are state plan services that would be eligible for reimbursement if not for the IMD exclusion. Therefore, they are being treated as hypothetical for the purposes of budget neutrality. Hypothetical services can be treated in budget neutrality in a way that is similar to how Medicaid state plan services are treated, by including them as a "pass through" in both the without-waiver and with-waiver calculations. However, the state will not be allowed to obtain budget neutrality "savings" from these services.

67. **Composite Federal Share Ratios.** The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by Alaska on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method.

68. **Exceeding Budget Neutrality.** The budget neutrality limits calculated in STC 58 will apply to actual expenditures for demonstration services as reported by the state under section XI of these STCs. If at the end of the demonstration period the budget neutrality limit has been exceeded, the excess federal funds must be returned to CMS. If the demonstration is terminated prior to the end of the demonstration period, the budget neutrality test must be based on the time period through the termination date.

69. **Enforcement of Budget Neutrality.** If the state exceeds the calculated cumulative target limit by the percentage identified below for any of the DYs, the state must submit a corrective action plan to CMS for approval.

Demonstration Year	Cumulative Target Definition	Percentage
DY 1	Cumulative budget neutrality limit	2.0 percent
DY 1 through DY 2	Cumulative budget neutrality limit plus:	1.5 percent
DY 1 through DY 3	Cumulative budget neutrality limit plus:	1.0 percent
DY 1 through DY 4	Cumulative budget neutrality limit plus:	0.5 percent
DY 1 through DY 5	Cumulative budget neutrality limit plus:	0.0 percent

XIII. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Date	Deliverable	STC
30 days after approval date	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities	Approval letter
90 days after SUD program approval date	SUD Implementation Plan Protocol	STC 21
150 days after SUD program approval date	SUD Monitoring Protocol	STC 22
180 days after approval date	Draft Evaluation Design	STCs 25 and 41
60 days after receipt of CMS comments	Revised Draft Evaluation Design	STCs 26 and 42
30 days after CMS Approval	Approved Evaluation Design published to state's website	STCs 42
November XX, 2020	Mid-Point Assessment	STC 23
One year prior to the end of the demonstration, or with renewal application	Draft Interim Evaluation Report	STC 44(c)
60 days after receipt of CMS comments	Final Interim Evaluation Report	STC 44(d)
18 months of the end of the demonstration	Draft Summative Evaluation Report	STC 45
60 calendar days after receipt of CMS comments	Final Summative Evaluation Report	STC 45(a)
30 calendar days of CMS approval	Approved Final Summative Evaluation Report published to state's website	STC 45(b)
Monthly Deliverables	Monitoring Calls	STC 38
Quarterly Deliverables Due 60 days after end of each quarter, except 4th quarter	Quarterly Monitoring Reports	STC 36
	Quarterly Expenditure Reports	STC 51
Annual Deliverables - Due 90 days after end of each 4th quarter	Annual Reports	STC 36

ATTACHMENT A
Developing the Evaluation Design

Introduction

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

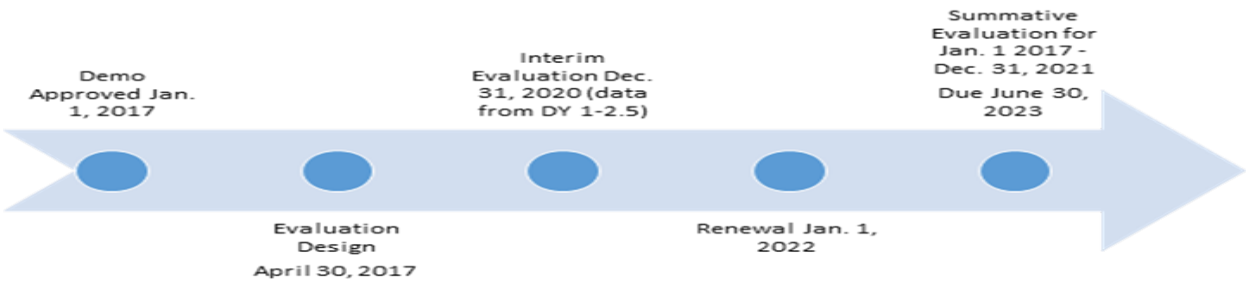
Expectations for Evaluation Designs

All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals**.**

The format for the Evaluation Design is as follows:
General Background Information;
Evaluation Questions and Hypotheses;
Methodology;
Methodological Limitations;
Attachments.

Submission Timelines

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



Required Core Components of All Evaluation Designs
The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the state's Driver Diagram (described in more detail in paragraph B2 below) should be included with an explanation of the depicted information.

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

1. The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).
2. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
3. A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;
4. For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.
5. Describe the population groups impacted by the demonstration.

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

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

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

3. Identify the state's hypotheses about the outcomes of the demonstration:

4. Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;

5. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology.

The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

1) *Evaluation Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?

2) *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

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

4) *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:
    a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
    b. Qualitative analysis methods may be used, and must be described in detail.
    c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.
    d. Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
    e. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).
    f. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.

5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.

    If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).

6) *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:

    a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example

of how the state might want to articulate the analytic methods for each research question and measure.

b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.

c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).

d. The application of sensitivity analyses, as appropriate, should be considered.

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

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

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

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

1) When the state demonstration is:
    a. Long-standing, non-complex, unchanged, or
    b. Has previously been rigorously evaluated and found to be successful, or
    c. Could now be considered standard Medicaid policy (CMS published regulations or guidance)

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

E. Attachments

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

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

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

ATTACHMENT B
Preparing the Interim and Summative Evaluation Reports

Introduction

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

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. As these valid analyses multiply (by a single state or by multiple states with similar demonstrations) and the data sources improve, the reliability of evaluation findings will be able to shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When submitting an application for renewal, the interim evaluation report should be posted on the state's website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

Intent of this Guidance

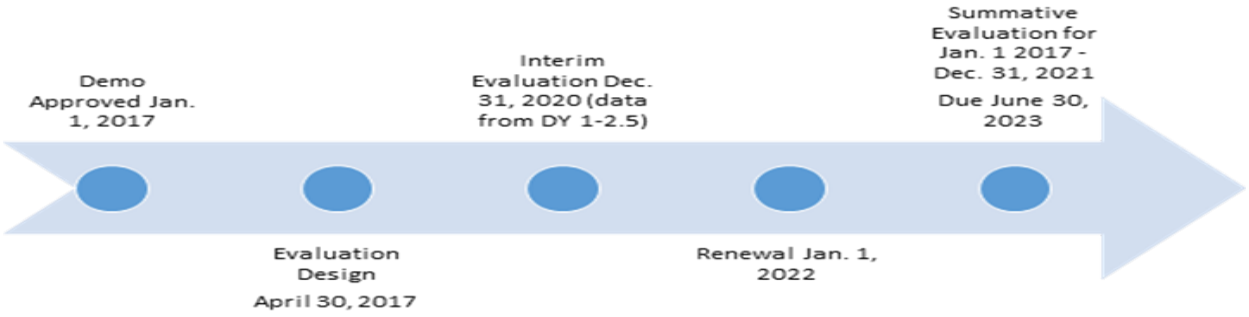
The Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved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

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

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

Submission Timelines

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



Required Core Components of Interim and Summative Evaluation Reports

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

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

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

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

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

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

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

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

5) Describe the population groups impacted by the demonstration.

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

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

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

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

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

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

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

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

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

2) Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:
   a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

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

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

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

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

F. Attachment

Evaluation Design: Provide the CMS-approved Evaluation Design

ATTACHMENT C:
Reserved for Evaluation Design

ATTACHMENT D: Substance Use Disorder (SUD) Implementation Plan Protocol

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 30th Alaska State Legislature (2018)
- Alaska Board of Pharmacy Meeting Minutes February 28-March 2, 2018
- Recommendation to Adopt Washington's Interagency Guideline on Prescribing Opioids for Pain, 3rd Edition
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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 (3rd Edition) to match individuals with SUD with the services and tools necessary for recovery.
- Increase SUD treatment options for youth (ages 12-17) and adult (18 and over) Medicaid recipients, particularly non-residential, step-up and step-down treatment options.
- Improve SUD provider infrastructures and capacity utilizing industry-recognized standards for certification and ongoing accountability (with emphasis on residential providers, but across-the-board).
- Improve SUD workforce by carefully reviewing existing certification requirements and modifying as appropriate to align with Medicaid, Waiver, and industry-recognized credentialing standards.

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

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

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

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

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

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

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

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

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

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

Level of Care: Opioid Treatment Services (OTS)

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

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

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

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

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

Actions Needed and Implementation Timeline:

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

Level of Care: 0.5—Early Intervention

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

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

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

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

Actions Needed and Implementation Timeline:

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

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

Level of Care: 1.0—Outpatient Services (OP)

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

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

Actions Needed and Implementation Timeline: None anticipated.

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

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

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

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

Actions Needed and Implementation Timeline:

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

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

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

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

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

Actions Needed and Implementation Timeline:

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

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

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

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

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

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

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

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

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

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

Actions Needed and Implementation Timeline:

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

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

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

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

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

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

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

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

Actions Needed and Implementation Timeline:

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

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

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

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

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

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

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

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

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

Actions Needed and Implementation Timeline:

Action	Timeline

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

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

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

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

Actions Needed and Implementation Timeline: None anticipated.

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

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

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

Actions Needed and Implementation Timeline: None anticipated.

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

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

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

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

Actions Needed and Implementation Timeline:

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

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

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

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

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

Actions Needed and Implementation Timeline:

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

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

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

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

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

Actions Needed and Implementation Timeline:

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

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

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

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

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

Actions Needed and Implementation Timeline:

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

Conduct provider training on ASAM requirements for ASAM 3.7-WM Level	Waiver Year 2

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

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

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

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

Actions Needed and Implementation Timeline:

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

Community Recovery Support Services

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

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

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

proposed 1115 Waiver.

Actions Needed and Implementation Timeline:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Service Access and Utilization

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DHSS anticipates having the ASO on board by April of 2019 and beginning SUD 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:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Ongoing Accountability to Ensure Provider Compliance with Standards

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

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

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

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

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

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

A. Existing SUD Provider Capacity

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

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

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

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

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

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

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

B. New Provider Types

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

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

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

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

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

C. Overall Provider Capacity Development Strategy

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

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

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

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

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

A. The Alaska Opioid Policy Task Force

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

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

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

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

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

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

The Governor issued the following agency-specific directives:

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

Several actions resulted from the Governor's Directives:

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

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

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

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

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

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

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

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

- Alaska's 2018 Opioid Action Plan:
  - The purpose is to implement strategies to limit inappropriate access to opioids, prevent and reverse overdoses when necessary, and strengthen treatment system by expanding services.
  - Involved representatives from Office of Governor, Office of Lieutenant Governor, Department of Health and Social Services, Department of Public Safety, Department of Corrections, Department of Commerce Community and Economic Development, Department of Education and Early Development, Department of Law, Department of Military and Veteran Affairs, Alaska Native Tribal Health Consortium, and Local Opioid Task Force Chairs.
  - Recommended five major initiatives:
    1) Expand treatment capacity through funding Medication-Assisted Treatment (MAT) services—primary method to combat crisis.
    2) Use education and stringent regulatory oversight to reduce availability and access to controlled substances (mandate use of the PDMP).
    3) Adopt chronic disease management framework for SUD policies, health care coverage, increase naloxone and buprenorphine availability, and educational outreach.
    4) Collect and analyze cross-sector data to inform decision-making and evaluation of efforts (improve opioid surveillance).
    5) Cross-sector collaboration among State agencies, tribal health care system, and communities.

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

D. Alaska's Prescription Drug Monitoring Program

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

E. Opioid Prescribing Guidelines

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

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

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

F. Integrating Alaska's Prevention and Treatment Efforts

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

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

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

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

Today, Alaska's OUD treatment capacity includes:

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

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

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

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

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

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

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

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

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

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

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

B. Intensive Case Management Services for Individuals with SUD

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

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

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

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

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

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

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

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

C. Additional Step to Ensure Transitions Between Levels of Care

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

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

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

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

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

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

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

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

Level of Care: Opioid Treatment Services (OTS)

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

Level of Care: 0.5—Early Intervention Services

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

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

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

Proposed locations include:

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

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

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

Number of new PHP—4 (all Youth).

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

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

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

Proposed locations include:

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

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

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

Number of additional 3.3 beds—24.

Proposed locations for the 24 beds include:

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

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

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

Proposed locations for the 32 Adult and Youth beds include:

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

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

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

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

All 34 beds will be implemented during Waiver Year 2.

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

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

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

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

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

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

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

Number of new 3.2-WM providers—1.

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

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

Number of new 3.7-WM providers—1.

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

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

Number of new 4-WM providers—3.

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

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

A. SUD Provider Capacity

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

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

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

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

- Waiver Region 3:
  - ASAM Level OTS—1 OBOT & 1 naltrexone provider
  - ASAM Level 0.5—SBIRT in 1 hospital ED
  - ASAM Level 2.1—1 IOP provider (adult)
  - ASAM Level 2.5—1 PHP provider (youth)
  - ASAM Level 3.1—1 Adult provider (10 beds)
  - ASAM Level 3.3—N/A
  - ASAM Level 3.5—1 Women & Children's (W/C) provider (8 beds)
  - ASAM Level 3.7—N/A
  - ASAM Level 4.0—N/A
  - ASAM Level 1-WM—1 provider for 1-WM or 2-WM
  - ASAM Level 2-WM—1 provider for 1-WM or 2-WM
  - ASAM Level 3.2-WM—N/A
  - ASAM Level 3.7-WM—N/A
  - ASAM Level 4-WM—N/A
  - Community Recovery Support-- Phase out deleted services and phase in new services Waiver Year 2
  - Mobile Outreach and Crisis Response—1 provider

- Waiver Region 4:
  - ASAM Level OTS—1 OTP & 1 naltrexone provider
  - ASAM Level 0.5—SBIRT in 1 hospital ED

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

- Waiver Region 5:
  - ASAM Level OTS—1 naltrexone provider
  - ASAM Level 0.5—SBIRT in 1 hospital ED
  - ASAM Level 2.1—2 IOP providers (1 adult and 1 youth)
  - ASAM Level 2.5—N/A
  - ASAM Level 3.1—1 A provider (15 beds)
  - ASAM Level 3.3—N/A
  - ASAM Level 3.5—N/A
  - ASAM Level 3.7—N/A
  - ASAM Level 4.0—N/A
  - ASAM Level 1-WM—1 provider for 1-WM or 2-WM
  - ASAM Level 2-WM—1 provider for 1-WM or 2-WM
  - ASAM Level 3.2-WM—N/A
  - ASAM Level 3.7-WM—N/A
  - ASAM Level 4-WM—1 provider
  - Community Recovery Support—Phase out deleted services and phase in new services Waiver Year 1
  - Mobile Outreach and Crisis Response—1 provider

- Waiver Region 6:
  - ASAM Level OTS—1 naltrexone provider
  - ASAM Level 0.5—SBIRT in 1 hospital ED
  - ASAM Level 2.1—1 IOP provider (adult)
  - ASAM Level 2.5—1 PHP provider (youth)
  - ASAM Level 3.1—1 A provider (5 beds) & 1 Y provider (5 beds)
  - ASAM Level 3.3—N/A
  - ASAM Level 3.5—1 W/C provider (8 beds)
  - ASAM Level 3.7—N/A
  - ASAM Level 4.0—N/A
  - ASAM Level 1-WM—1 provider for 1-WM or 2-WM
  - ASAM Level 2-WM—1 provider for 1-WM or 2-WM
  - ASAM Level 3.2-WM—N/A
  - ASAM Level 3.7-WM—N/A

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

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

- Waiver Region 8:
  - ASAM Level OTS—1 OBOT & 1 naltrexone provider
  - ASAM Level 0.5—SBIRT in 1 hospital ED
  - ASAM Level 2.1—1 IOP provider (adult)
  - ASAM Level 2.5—1 PHP provider (youth)
  - ASAM Level 3.1—1 A provider (5 beds) & 1 Y provider (5 beds)
  - ASAM Level 3.3—N/A
  - ASAM Level 3.5—N/A
  - ASAM Level 3.7—N/A
  - ASAM Level 4.0—N/A
  - ASAM Level 1-WM—1 provider for 1-WM or 2-WM
  - ASAM Level 2-WM—1 provider for 1-WM or 2-WM
  - ASAM Level 3.2-WM—N/A
  - ASAM Level 3.7-WM—N/A
  - ASAM Level 4-WM—N/A
  - Community Recovery Support—Phase out deleted services and phase in new services Waiver Year 2
  - Mobile Outreach and Crisis Response—1 provider

- Waiver Region 9:
  - ASAM Level OTS—1 naltrexone provider

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

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

F. Integrating Alaska's Prevention and Treatment Efforts

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

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

APPENDIX 2— DOCUMENTS

APPENDIX 3— SUD HEALTH INFORMATION TECHNOLOGY PLAN

STATE OF ALASKA SUD HEALTH INFORMATION TECHNOLOGY PLAN AND ATTESTATIONS

MILESTONE CRITERIA	CURRENT STATE	FUTURE STATE	SUMMARY OF ACTIONS NEEDED
Prescription Drug Monitoring Program (PDMP) Functionalities			
Enhanced interstate data sharing in order to better track patient specific prescription data	Alaska's PDMP shares data with 7 other States as part of the PMP InterConnect, in conjunction with our PDMP vendor, Appriss Health and the National Association of Board of Pharmacy. The 7 States are Idaho, Louisiana, Massachusetts, Minnesota, Montana, North Dakota, & Rhode Island. At its February 28-March 2, 2018 Board of Pharmacy meeting, which governs the Alaska PDMP, the Board entertained a regulation project to repeal a section of regulations relating to PDMP access, including the section that would otherwise authorize interstate data sharing. Discussion occurred during Board review of public comments about proposed regarding several proposed PDMP regulations pursuant to 2016 and 2017 statutory changes designed to strengthen Alaska's PDMP.	The State Opioid Treatment Authority and Director of the Division of Behavioral Health will testify at the Board of Pharmacy March 2019 meeting to explain the importance of interstate data sharing in addressing the state's current opioid crisis and to request that the regulation authorizing interstate data sharing be approved by the Board. Alaska's PDMP will continue to engage & participate with the PMP InterConnect in conjunction with Appriss Health & the National Association of Board of Pharmacy unless & until the regulation is repealed. Maintaining the regulation as proposed will require consensus/approval from the Board of Pharmacy.	1. Contact Pharmacy Board members prior to March 2019 meeting (K. Chapman, SOTA & DBH SUD Director). 2. Present at March 2019 Pharmacy Board meeting (K. Chapman, SOTA & DBH SUD Director).
Enhanced "ease of use" for prescribers & other state/federal stakeholders	2016 legislation (SB 74) expanded access to the PDMP for licensed/registered	Alaska's State Opioid Treatment Authority, and Director of the Division of	1. Develop written communication regarding rationale for expanding

	agents/employees of practitioners or pharmacists, who are considered delegates and can review or report actions on behalf of a provider already registered in the database. An online questionnaire was created to satisfy a CDC Data-Driven Prevention Initiative Grant deliverable to solicit input regarding awareness levels of PDMP providers, to solicit feedback on system limitations/improvements, & to gauge client satisfaction/areas for quality improvement of PDMP. The survey was launched Spring, 2018.	Behavioral Health will petition the Board of Pharmacy at its April 2019 meeting to further expand access to the PDMP for Certified Chemical Dependency Clinical Supervisors. Future enhancements will require consensus/approval from the Board of Pharmacy.	access (K. Chapman, SOTA & DBH SUD Director). 2. Work with PDMP Program Manager Laura Carillo to amend 12 Alaska Administrative Code, Section 52.860, to expand access to designated CCD Clinical Supervisors (K. Chapman, SOTA & DBH SUD Director).
Enhanced connectivity between Alaska's PDMP & statewide, regional, or local health information exchange	Alaska's PDMP does not currently have a licensing integration feature to allow access to HIE & EHRs. Alaska is attempting a bidirectional interface between the State's HIE and the PDMP solution. This is designed to: • Enable providers access to real-time, point-of-care prescription data; critical for emergency department providers.	Alaska's SOTA & Director of the Division of Behavioral Health will work with the PDMP Program Manager to examine the cost of a licensing integration feature for the PDMP to facilitate several improvements including the tracking of DEA registrations & connecting with certain EHRs of OTPs/OBOTs/Naltrexone Providers.	1. Monitor Pharmacy Board approval of regulations allowing bidirectional interface between State's HIE & the PDMP (B. Davidson, DHSS HIT Director). 2. Work with PDMP Program Manager to identify cost of licensing integration feature—complete cost estimate by April 2019 (K. Chapman SOTA and L. Carillo, PDMP Program Manager).

	• Enable Opioid Command Center access to real-time, point-of-care prescription data to support their programs and services. • Increase the opportunity to decrease misuse, abuse, and divert the usage of controlled substances. This effort is on hold until the required PDMP regulations are approved by the State Board of Pharmacy.	Future enhancements will require consensus/approval from the Board of Pharmacy.	
Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns	Pursuant to 2018 legislation, prescriber report cards will give prescribers the ability to review their prescription activity & to see how prescribing practices compare to similar practitioners within the same occupation/specialty on a quarterly basis. The first round of report cards were sent 12/6/17. Information includes: 1) The top three medications prescribed, 2) The number of patients receiving a dangerous combination therapy, & 3) The number of patient prescription history queries.	The Commissioner of the Alaska Department of Health & Social Services and Alaska's SOTA will review the need for additional legislation to continue expanding access to the PDMP, including the ability to crosswalk claims data with individual prescriber practices, review of prescriber report cards, & review of inappropriate use or prescribing of controlled substances. This will require consensus from many stakeholders and decision-makers, including the Alaska Legislature,	1. Research other State PDMP information regarding crosswalking of claims data and draft legislation by March 2019—M. Walker, DBH Data Unit Director. 2. Finalize legislative recommendations, including possible interim study, prior to 2020 session (K. Chapman, SOTA and A. Crum, DHSS Commissioner).

	The Alaska Board of Pharmacy has drafted regulations to allow limited data access by designated representatives from the Alaska Medicaid program; the Board will review public comment on this regulation. This will facilitate identifying recipient long-term opioid use but will not allow: • Crosswalking Medicaid claims data with individual prescriber practices • Reviewing prescriber report cards, or • Reviewing inappropriate use or prescribing of controlled substances.	appropriate Licensing Boards and the Board of Pharmacy.	
Current and Future PDMP Query Capabilities			

Facilitate ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e. the Master Patient Index strategy with regard to PDMP query).	Alaska Department of Health & Social Services does not currently have the ability to match patients receiving opioid prescription with patients in the State's PDMP.	However, Alaska's statewide Health Information Exchange is in the final phases of connecting to Alaska's PDMP and also receiving all medication fill information. The statewide HIE is also working with the Alaska Department of Commerce to establish the ability to share bi-directionally PDMP data with at least the states of Washington and Oregon. This information will be able to be shared with the MMIS Decision Support System that is scheduled to be implemented as part of DHSS Division of Health Care Services MMIS modernization project. This final step to connect the HIE to the MMIS Decision Support System will likely need a memorandum of understanding and/or data use agreement(s).	1. Complete system integration work between the statewide HIE and the PDMP. Anticipated timeline: October or November 2019 (B. Davidson, DHSS Director of HIT, K. Chapman, SOTA, and L. Carillo, PDMP Program Manager). 2. Implement a Decision Support System for the MMIS. Anticipated timeline: December 2019 (M. Brody, DHSS Health Care Services Director and K. Chapman, SOTA). 3. Identify any necessary funding sources to support system integration between the HIE and MMIS (B. Davidson, DHSS Director of HIT). 4. Design, develop and implement integration between the HIE and the MMIS Decision Support System (B. Davidson, DHSS Director of HIT).. 5. Identify and implement any necessary memorandums of understanding or data use/sharing agreements (B. Davidson, DHSS Director of HIT)..
Use of PDMP—Supporting Clinicians with Changing Office Workflows/Business Processes			

Develop enhanced provider workflow/business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance to address the issues which follow.	State law requires a prescriber or his delegate (with limited exceptions) to access and review the patient's record in the PDMP prior to initially prescribing any opioid to a patient.	The Division of Behavioral Health is considering requiring Waiver prescribers to use and conduct patient specific queries in the PDMP for behavioral health patients upon writing first prescription for controlled substance and then annually. The physician would print the query and file it as part of the recipient record. The Division would then require the ASO to conduct sample audits to verify compliance.	1. Modify ASO RFP to specify PDMP audits by April 2019 (G. Moreau, Acting DBH Director). 2. Develop SUD MAT Waiver provider notification/communication by May 2019 (G. Moreau, Acting DBH Director and K. Chapman, SOTA).
Develop enhanced supports for clinician review of the patient's history of controlled substance prescriptions provided through the PDMP—prior to the issuance of an opioid prescription.	State law requires a prescriber or his delegate (with limited exceptions) to access and review the patient's record in the PDMP prior to initially prescribing any opioid to a patient.	The Division of Behavioral Health is considering requiring Waiver prescribers to use and conduct patient specific queries in the PDMP for behavioral health patients upon writing first prescription for controlled substance and then annually. The physician would print the query and file it as part of the recipient record. The Division would then require the ASO to conduct sample audits to verify compliance.	1. Modify ASO RFP to specify PDMP audits by April 2019 (G. Moreau, Acting DBH Director) . 2. Develop SUD MAT Waiver provider notification/communication by May 2019 (G. Moreau, Acting DBH Director and K. Chapman, SOTA).
Master Patient Index/Identity Management			
Enhance the Master Patient Index (or master data management service, etc.) in support of SUD care delivery	Alaska Department of Health & Social Services has not utilized its Master Client Index or the statewide HIE Master Patient Index to interface between Alaska's PDMP and the MMIS.	The statewide HIE has a master patient index and robust identity management to allows for different levels of consent including CFR 42 Part 2. The HIE master patient index will be utilized	1. Complete system integration work between the statewide HIE and the PDMP (B. Davidson, DHSS HIT Director and L. Carillo, PDMP Program Manager).

		to support the integration between the PDMP and the MMIS in conjunction with the Alaska Department of Health & Social Services Master Client Index.	2. Implement a Decision Support System for the MMIS (M. Brody, DHSS Director of Health Care Services and K. Chapman, SOTA). 3. Identify any necessary funding sources to support system integration between the HIE and MMIS (B. Davidson, DHSS Director of HIT). 4. Design, develop, and implement integration between the HIE and the MMIS Decision Support System (B. Davidson, DHSS Director of HIT and M. Brody, DHSS Director of Health Care Services). 5. Identify any necessary funding sources to support the syncing of the HIE master patient index to the DHSS Master Client Index to be shared as part of the identity management process for linking PDMP and MMIS data together (B. Davidson, DHSS Director of HIT, M. Brody, DHSS Director of Health Care Services, L. Carillo, PDMP Program Manager, and K. Chapman, SOTA).
Overall Objective for Enhancing PDMP Functionality and Interoperability			
Leverage the above functionalities/capabilities/supports	Alaska's PDMP has the following capabilities to	The issue of Medicaid inappropriately paying for	1. Work with PDMP Program Manager and

(in concert with any other State Health IT, TA or workflow effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing & to ensure that Medicaid does not inappropriately pay for opioids.	minimize the risk of inappropriate opioid overprescribing: • Prescriber report cards • Patient prescription history reports • Required performance measures relating to reductions in inappropriate use or prescription of controlled substances • Required reports relating to number of patients receiving high levels of MME opioids • Monthly reporting of number of newly registered PDMP users, number of patient prescriptions written, & number of patient prescription history requests conducted. This data is a valuable tool to assist demand reduction and law enforcement officials in detecting drug diversion, misuse, and abuse—resulting in a 12.87% decrease in total prescriptions, a 10.12% decrease in the number of patients receiving opioid prescriptions, and a 10.38% decrease in total opioid	opioids continues to be addressed. Data matching per specifications above will be essential. As stated earlier, Alaska's Opioid Incident Command System Chair, State Opioid Treatment Authority, and Director of the Division of Behavioral Health will seek legislative authority during the 2020 legislative session to allow data matching between Medicaid and PDMP data. This will require consensus from many stakeholders and decision-makers, including the Alaska Legislature, appropriate Licensing Boards and the Board of Pharmacy.	Division of Health Care Services to produce reports specifying Medicaid payments for opioid medications by November 2019 (K. Chapman, SOTA, M. Brody, DHSS Director of Health Care Services, and L. Carillo, PDMP Program Manager). 2. Draft authorizing legislation authorizing matching by December 2019 (K. Chapman, SOTA and L. Carillo, PDMP Program Manager). 3. Find legislative sponsor and introduce legislation by February 2020 (K. Chapman, SOTA and L. Carillo, PDMP Program Manager).

	prescriptions between 2016 and 2017. There has been a minimal decrease in the number of opioid prescriptions greater than 100 mg MME per day (.46%) between 2016 and 2017.		

ATTESTATIONS and CONFIRMATIONS:

The State of Alaska has a sufficient health IT infrastructure at every appropriate level including state Medicaid and pharmacy systems, provider service delivery sites, and ASO, to achieve the goals of the SUD portion of Alaska's 1115 Behavioral Health Waiver demonstration.

The State of Alaska's SUD HIT Plan has been developed in coordination and is aligned with the State Medicaid Health IT Plan (SMHP), which will support Alaska's HIE, provider web-based access/connection, infrastructure development, Admission/Discharge/Transfer (ADT) status and data sharing. Alaska does not currently have a Behavioral Health HIT Plan. The DHSS vision for the future of HIT is closely aligned with our SUD HIT vision and is a multi-year vision that leverages implementation of new technologies (e.g., a modernized MMIS, EHRs, HIE networks) to transform Alaska's health care system. An important goal is to ensure data, providers and systems are connected with SUD HIT Plan.

The State of Alaska will ensure that the ASO contract will incorporate the requirement to use health IT standards referenced in 45 CFR 170 Subpart B and the Interoperability Standards Advisory (ISA) as set forth by the Office of the National Coordinator for Health IT (ONC). The State of Alaska currently has statutory authority and the corresponding health IT infrastructure to support **electronic prescribing**, which is currently operable statewide. Prescribers have the obligation check the PDMP before initial prescribing of an opioid, can electronically access a patient's prescription benefit, can electronically access a patient's medication history, and can electronically route the prescription to the patient's choice of pharmacy. Upon signing the ASO contract (anticipated May 2019), we will begin the process of developing **ADT feeds** and documenting and **sharing care plans** using Care Plan Standards (CDA) through our HIE. We will comply with appropriate **direct transport standards**.

Our SOTA will work with the PDMP Program Manager and the DHSS Office of Substance Misuse and Addiction Prevention to review performance metrics from other states for possible adoption within Alaska for **clinical quality measurement**, reporting, and tracking. As part of our overall SUD Monitoring Protocol, we will work with our colleagues in the PDMP and OSMAP to ensure appropriate metrics are identified for ongoing quality monitoring and clinical outcomes monitoring of the SUD HIT Plan. We will work with CMS to ensure that all of our proposed **performance metrics** meet CMS approval criteria. We anticipate that because there are many dynamic features and moving parts to Alaska's SMHP, we will need to carefully monitor ongoing infrastructure and connectivity issues within this broader context. Developing the appropriate performance metrics to measure success within this framework will be an important feature of Alaska's SUD HIT Plan monitoring protocol. While we will heavily rely upon the ASO for this capacity, our obligation does not end. Our SUD HIT monitoring protocol will mirror the overall SUD Monitoring Protocol. We will identify activities/tasks, outcome/success goals, indicators to measure progress in achieving outcome/success goals, reporting timelines, and responsible parties.

ATTACHMENT E:
Reserved for SUD Claiming Protocol

ATTACHMENT F:
Reserved for SUD Monitoring Protocol

ATTACHMENT G – Quarterly and Annual Progress Report Template and Instructions

As stated in Special Terms and Conditions STC 36 the state must submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report template is intended as a framework, and can be modified when CMS and the state agree to the modification.

II. Narrative Report Format

Title Line One - _____ (*Name of Individual State Program*)

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

III. Introduction

Describe the goal of the demonstration, what service it provides, and key dates of approval/operation. ***(This should be the same for each report.)***

IV. Operational Updates

Describe all operational updates and activity under the demonstration.

V. Performance Metrics

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

VI. Evaluation Activities

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

VII. SUD Health IT

Summarize of progress made in regards to SUD Health IT.

VIII. Tribal Engagement and Collaboration Developments/Issues

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

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

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

X. Enclosures/Attachments

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

XI. State Contact(s)

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

XII. Date Submitted to CMS

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

The state may add additional program headings as applicable.