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

March 26, 2024

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

Dear Deputy Commissioner Ricci:

The Centers for Medicare & Medicaid Services (CMS) is approving Alaska's request to extend the demonstration entitled, "Behavioral Health Reform" (Project Number 11-W-00318/0), in accordance with section 1115(a) of the Social Security Act (the Act). This extension authorizes the state to change the title of the demonstration from "Substance Use Disorder Treatment and Behavioral Health Program (SUD-BHP)" to "Behavioral Health Reform." The title change aligns mental health and SUD under a broader behavioral health definition to reflect the state's commitment to program reform and system transformation. Beyond the title change, the state did not request changes with this extension but rather sought to continue the operations of the current demonstration. This extension approval is effective upon the date of this letter through December 31, 2028.

CMS has determined that the Behavioral Health Reform demonstration is likely to assist in promoting the objectives of the Medicaid statute by increasing access to high-quality medical assistance and coverage for behavioral health services through demonstration programs that provide a continuum care of SUD and opioid use disorder (OUD) services for children, youth, and adults with behavioral health needs.

CMS' approval is subject to the limitations specified in the attached waiver and expenditure authorities, 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 Medicaid state plan requirements only to the extent those requirements have been listed as waived or not applicable to expenditures under the demonstration.

Extent and Scope of the Demonstration Extension

With this extension, Alaska will continue to operationalize and refine its behavioral health and SUD demonstration programs. CMS is extending the state's current authority to receive federal financial participation (FFP) for providing clinically appropriate SUD treatment services for short-term residents in residential and inpatient treatment settings that qualify as an institution for mental diseases (IMD), as well as provide additional services to enhance the comprehensive

and integrated behavioral health system for children, youth, and adults with serious mental illness (SMI), severe emotional disturbance (SED), and/or SUDs. This extension will allow the state to continue to improve access to comprehensive behavioral health services by building a Medicaid behavioral health delivery system pointing to integrated and recovery-oriented care that aligns with evidence-based best practices. The state will continue to build on the longstanding authorities granted under this demonstration to enhance the benefit package and continue coverage for a continuum of behavioral health care services that emphasize screening, community-based services, residential treatment when appropriate, and enhanced peer recovery supports. These services promote prevention, early intervention, recovery, and integrated whole-person care, which are the goals of this demonstration.

Budget Neutrality

Under section 1115(a) demonstrations, states can test innovative approaches to operating their Medicaid programs if CMS determines that the demonstration is likely to assist in promoting the objectives of the Medicaid statute. CMS has long required, as a condition of demonstration approval, that demonstrations be "budget neutral," meaning the federal costs of the state's Medicaid program with the demonstration cannot exceed what the federal government's Medicaid costs in that state likely would have been without the demonstration. In requiring demonstrations to be budget neutral, CMS is constantly striving to achieve a balance between its interest in preserving the fiscal integrity of the Medicaid program and its interest in facilitating state innovation through section 1115 approvals. In practice, budget neutrality generally means that the total computable (i.e., both state and federal) costs for approved demonstration expenditures are limited to a certain amount for the demonstration approval period. This limit is called the budget neutrality expenditure limit and is based on a projection of the Medicaid expenditures that could have occurred absent the demonstration, the "without waiver" (WOW) costs. Historically, if a state's "with waiver" (WW) costs for a demonstration approval period were less than the expenditure limit for that period, the unspent funds or "savings" rolled over into the next approval period, which mean that the state could incur higher WW costs during the new approval period.

CMS and states have generally been applying an approach to calculating budget neutrality that CMS described in a 2018 State Medicaid Director Letter (SMDL).[1] The approach described in the 2018 SMDL included certain features that limited the extent to which states could roll over unspent "savings" from one approval period to the next when CMS extended a demonstration, and which were thereby intended to preserve the fiscal integrity of the Medicaid program. Based on CMS' and states' experience implementing the approach described in the 2018 SMDL, it has become apparent to CMS that this approach may limit states' future ability to continue testing and developing innovative demonstration programs that are likely to assist in promoting the objectives of Medicaid. Therefore, in this approval, CMS has reevaluated and is modifying certain aspects of the budget neutrality approach described in the 2018 SMDL in an attempt to better support state innovation, in line with section 1115 of the Act, while maintaining its commitment to fiscal integrity. While CMS evaluates each demonstration proposal on a case-by-

[1] August 22, 2018. SMD#18-009 RE: Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects. https://www.medicaid.gov/federal-policy-guidance/downloads/smd18009.pdf

case basis, CMS anticipates that it will consistently apply these or similar updates in its approach to budget neutrality to all similarly situated states going forward.

Under this approval, CMS is departing from the budget neutrality approach described in the 2018 SMDL in a keyway. CMS is making several changes that are intended to give states greater access to funding, including "savings" from prior approval periods, while still maintaining fiscal integrity. These changes include an updated approach to calculating the WOW baseline, which refers to the projected expenditures that could have occurred absent the demonstration and which, as described above, is the basis for the budget neutrality expenditure limit for each approval period. Under this approval, CMS calculated the WOW baseline by using a *weighted average* of the state's *historical* WOW per-member-per-month (PMPM) baseline and its *recent actual* PMPM costs, rather than taking the approach described in the 2018 SMDL, which was to adjust WOW PMPM cost estimates to reflect only the *recent actual* PMPM costs. This updated approach is expected to result in a slightly higher WOW baseline, while still primarily reflecting the state's most recent expenditures. CMS and states have generally been applying an approach to calculating budget neutrality that CMS described in a 2018 SMDL.

CMS is revising the approach to adjusting the budget neutrality calculation in the middle of a demonstration approval period. Historically, CMS has limited its review of state requests for "mid-course" budget neutrality adjustments to situations that necessitate a corrective action plan, in which projected expenditure data indicated a state is likely to exceed its budget neutrality expenditure limit. CMS has updated its approach to mid-course corrections in this demonstration approval to provide flexibility and stability for the state over the life of a demonstration. This update identifies, in the STCs, a list of circumstances under which a state's baseline may be adjusted based on actual expenditure data to accommodate circumstances that are either out of the state's control (for example, if expensive new drugs that the state is required to cover enter the market); and/or the effect is not a condition or consequence of the demonstration (for example, unexpected costs due to a public health emergency); and/or the new expenditure (while not a new demonstration-covered service or population that would require the state to propose an amendment to the demonstration) is likely to further strengthen access to care (for example, a legislated increase in provider rates). CMS also explains in the STCs what data and other information the state should submit to support a potentially approvable request for an adjustment. CMS considers this a more rational, transparent, and standardized approach to permitting budget neutrality modifications during the course of a demonstration.

Monitoring and Evaluation

Consistent with the demonstration STCs, Alaska submitted its Interim Evaluation Report for the prior demonstration approval period with the extension application.[2] Findings from the evaluation period (January 2019 through December 2021) were promising, and there were positive outcomes in alignment with the demonstration's goals. For example, the report shows that there was an increase in SUD and behavioral health provider capacity, an increase in the availability of new services, and that SUD beneficiaries were transitioning away from emergency department utilization to more appropriate care settings compared to the baseline period (January

[2] The report is approved and available at Medicaid.gov: https://www.medicaid.gov/sites/default/files/2023-09/ak-behavioral-health-sud-interim-evaluton-rpt-09272023.pdf.

2017 through December 2018). The rate of timely initiation of SUD treatment increased and the average length of stay in institutions for mental diseases (IMDs) declined significantly. However, the Interim Evaluation Report results also identified opportunities for improvements, such as reducing the overdose death rate, increasing access to care for individuals with SUD and comorbidities, and improving waitlists and service access for tribal health organizations. With this extension of the Alaska Behavioral Health Reform demonstration, the state is required to continue conducting systematic monitoring and robust evaluation of the demonstration. The state must continue tracking, using quantitative and qualitative data, its progress toward the demonstration's milestones and goals—taking into account the achievements and challenges from the prior approval period. The state must also have an independent entity conduct a mid-point assessment of the extension period. The mid-point assessment will provide the state an opportunity to outline any necessary mitigation strategies to ensure ongoing progress towards the state's demonstration milestones and goals. Additionally, the state is required to develop an Evaluation Design for this demonstration approval period by reframing and refocusing as needed the evaluation hypotheses and research questions to appropriately factor in where it can reasonably expect continued improvements. The state must revisit its analytic approaches, compared to those used in the prior approval period evaluation activities, to ensure that the evaluation accounts for the longer implementation time span to support understanding the demonstration's impact on coverage, access to and quality of care, and health outcomes. The demonstration's Evaluation Design is required to encompass all demonstration components. The state's monitoring and evaluation efforts must facilitate understanding the extent to which the amendment might support reducing existing disparities in access to and quality of care and health outcomes.

Consideration of Public Comments

The federal comment period opened on March 10, 2023, and closed on April 9, 2023. CMS received three public comments during the federal comment period. One comment submission did not contain any feedback relevant to the extension request or information about the commenter, therefore, the comment was not considered. The two remaining comments, received from stakeholder organizations, expressed overwhelming support for the extension proposal. Both organizations are in favor of the state's efforts to expand Alaska's mental health and SUD treatment delivery systems. However, each organization highlighted opportunities to expand the demonstration via amendments. One organization suggested Alaska extend postpartum Medicaid coverage to 12 months[3] while the other organization suggested expanding services around social determinants of health (SDOH) to include housing supports, transition assistance, and nutritional support. CMS supports states in pursuing these types of initiatives and will engage with the state should it pursue such initiatives in the future.

After carefully reviewing the public comments submitted during the federal comment period and information received from the state public comment period, CMS has concluded that the demonstration is likely to assist in promoting the objectives of Medicaid.

Other Information

[3] Effective February 2, 2024, the State of Alaska received approval for a state plan amendment to expand coverage to pregnant women (AK-24-0001). The approval increases income eligibility for pregnant women up to 225 percent of the federal poverty level (FPL) and extends postpartum coverage from 60-days to 12-months.

The award is subject to CMS receiving written acceptance by the state within 30 days of the date of this approval letter. Your project Officer is Mr. Felix Milburn. Mr. Milburn is available to answer any questions concerning implementation of the state's section 1115(a) demonstration and his contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, Maryland 21244-1850
Email: Felix.Milburn@cms.hhs.gov

We appreciate the state's commitment to improving the health of its Medicaid beneficiaries, and we look forward to our continued partnership on the Behavioral Health Reform section 1115(a) demonstration. If you have any questions regarding this approval, please contact Ms. Jacey Cooper, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Sincerely,

Daniel Tsai
Deputy Administrator and Director

Enclosure

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: 11-W-00318/0

TITLE: Alaska Behavioral Health Reform

AWARDEE: Alaska Department of Health

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

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

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

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

4. **Intensive Outpatient (IOP) Services for Behavioral Health.** Expenditures for intensive outpatient services and structured programming to individuals determined to be medically necessary and in accordance with an individualized treatment plan as outlined in STC 5.3.4, effective September 3, 2019.

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

6. **Partial Hospitalization Program (PHP) Services for Behavioral Health**. Expenditures for PHP services provided to individuals, in a highly structured treatment environment for services that will provide diagnosis or active treatment of a individual's psychiatric disorder, with a diagnosis of Serious Mental Illness (SMI) or Serious Emotional Disorder (SED) in accordance with an individualized treatment plan as outlined in STC 5.3.10 effective September 3, 2019. Payment for room and board costs are prohibited.

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

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

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

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

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

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

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

14. **Community Recovery Support Services (CRSS) for Behavioral Health.** Expenditures for community recovery support services to help decrease risk for recurrence of symptoms and promote recovery, and to support transition between levels of care for behavioral health services as outlined in STC 5.3.17, effective September 3, 2019.

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

16. **Children's Residential Treatment Level 1 (CRT).** Expenditures for residential treatment services provided by an interdisciplinary treatment team in a therapeutically-structured, supervised environment for children and youth whose health is at risk while living in their community as outlined in STC 5.3.5, effective September 3, 2019. This authority does not apply to IMDs. Payment for room and board costs are prohibited.

17. **Therapeutic Treatment Homes**. Expenditures for trauma-informed clinical services which include placement in a specifically-trained therapeutic treatment home for children/youth who have severe mental, emotional health needs diagnosed with a SMI or SED or a behavioral health need, and who cannot be stabilized in their home settings as outlined in STC 5.3.6, effective September 3, 2019. This authority does not apply to IMDs Payment for room and board costs are prohibited.

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

19. **Adult Mental Health Residential (AMHR) Services.** Expenditures for AMHR services provided by an interdisciplinary treatment team in a therapeutically-structured, supervised environment for adults with acute mental health needs, diagnosed with a SMI or SED, whose health is at risk while living in their community as outlined in STC 5.3.11 effective September 3, 2019. This authority does not apply to IMDs. Payment for room and board ae prohibited.

20. **Peer-Based Crisis Services.** Expenditures for community-based services, that divert individuals from emergency department and psychiatric hospitalization use, effective September 3, 2019. These services are facilitated by children and adults that have lived with or have experience with a mental illness or a substance disorder (including parents) as outlined in STC 5.3.12.

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

22. **Intensive Case Management Services for Behavioral Health.** Expenditures for services for children/youth at risk of out-of-home placement, and adults with acute mental health needs, as outlined in STC 5.3.2, effective September 3, 2019.

23. **Mobile Outreach and Crisis Response (MOCR) Services**. Expenditures for services which prevent a mental health crisis or stabilize an individual during or after a mental health crisis or a crisis involving both substance use and mental health disorders as outlined in STC 5.3.14 effective September 3, 2019.

24. **23-Hour Crisis Observation and Stabilization (COS) Services.** Expenditures for evaluation and/or stabilization services for individuals presenting with acute symptoms or distress. Services are provided for up to 23 hours and 59 minutes of care in a secure and protected environment as outlined in STC 5.3.15 effective September 3, 2019.

25. Crisis Residential/Stabilization Services. Expenditures for medically-monitored, short-term, residential program in an approved 10-15 bed facility that provides 24/7 psychiatric stabilization services as outlined in STC 5.3.16 effective September 3, 2019. These facilities are not IMDs. Payment for room and board are prohibited.

CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY

NUMBER: 11-W-00318/0

TITLE: Alaska Behavioral Health Reform

AWARDEE: Alaska Department of Health

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

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

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

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

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

NUMBER: 11-W-00318/0

TITLE: Alaska Behavioral Health Reform

AWARDEE: Alaska Department of Health

1. PREFACE

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

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

The STCs have been arranged into the following subject areas:

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

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

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

5. Attachment E: Reserved for SUD Claiming Protocol
6. Attachment F: Monitoring Protocol
7. Attachment H: COVID-19 Personal Care Services Amendment

2. PROGRAM DESCRIPTION AND OBJECTIVES

Historically, Alaska has been significantly challenged in its ability to address the dual crises of opioid addiction and growing behavioral health needs of the population. Ongoing barriers have included issues with infrastructure, provider capacity, and workforce development, among others. With these challenges in mind, the vision of the original Demonstration was to establish a foundation through a comprehensive continuum of cost-effective, high-quality, and evidence-based SUD and behavioral health services to make sure Alaskans have access to the right services at the right time in the right setting. Aligning with evidence-based best practices, this continuum includes services that span each level of care, including early intervention and prevention, outpatient care, intensive outpatient/partial hospitalization, residential treatment/inpatient, and intensive inpatient.

To realize this vision, Alaska's 1115 Waiver has centered around three overarching objectives:

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

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

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

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

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

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

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

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

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

4. Reduced utilization of emergency departments and inpatient hospital settings for substance use and behavioral health treatment where the utilization is preventable or medically inappropriate through improved access to other more appropriate and focused services.

5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and

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

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

3. GENERAL PROGRAM REQUIREMENTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

the oversight, monitoring and measurement of the provisions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. ELIGIBILITY AND ENROLLMENT

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

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

5. DEMONSTRATION PROGRAMS AND BENEFITS

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

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

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

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

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

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

5.3.Behavioral Health Benefits

5.3.1. The Behavioral Health Benefits will target three groups:

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

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

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

5.3.2. Group 1- Behavioral Health Program Benefits

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

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

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

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

5.3.2.2. Component services include:

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

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

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

- Crisis diversion and intervention planning

- Ongoing monitoring for safety and stability in the home

- Intensive case management

- Skill development including:

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

and support for children with emotional and behavioral problems; and
    - Self-regulation, anger management, and other mood management skills for children, youth and parents.

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

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

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

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

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

5.3.2.1.Component Services include:

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

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

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

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

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

- Referral for counseling or specialized services; and

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

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

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

5.3.3.1. Component Services include:

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

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

- Psychiatric Evaluation services.

- Nursing services.

- Psycho-education services.

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

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

- Crisis Intervention services.

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

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

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

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

5.3.4.1. Component Services include:

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

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

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

5.3.5.1. Component Services include:

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

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

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

5.3.6.1.Component Services include:

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

- Case Coordination; and

- Crisis Intervention services.

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

5.3.7. Group 2- Behavioral Health Program Benefits

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

5.3.8.1. Component Services include:

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

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

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

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

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

conflict resolution.

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

- Peer support services.

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

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

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

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

5.3.9.1. Component Services include:

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

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

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

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

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

- Referral for counseling or specialized services; and

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

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

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

5.3.10.1. Component Services include:

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

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

- Nursing services.

- Psycho-education services.

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

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

- Crisis intervention services.

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

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

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

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

5.3.11.1. Component Services include:

- Clinically-directed therapeutic treatment.

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

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

- An Individual Plan of Care that puts into place interventions that help the individual attain goals designed to achieve discharge from AMH at the earliest possible time; and

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

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

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

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

5.3.12.1. Component Services include:

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

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

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

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

5.3.14.1. Component Services include:

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

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

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

5.3.15.1. Component Services include:

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

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

- Referral to the appropriate level of treatment services.

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

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

5.3.16.1. Component Services include:

- Individualized, person-centered assessment.

- Crisis Intervention services.

- Crisis stabilization services designed to stabilize and restore the individual to a level of functioning that does not require inpatient hospitalization.
- Psychiatric Evaluation services.

- Nursing services.

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

- Treatment Plan development services; and

- Referral to the appropriate level of treatment services.

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

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

5.3.17.1. Component Services include:

- Recovery coaching- direct services that provide guidance, support and encouragement from the expertise of the trained recovery professional. Recovery

coaching is a form of strength-based supports for persons in or seeking recovery from mental disorders and SUD (if co-occurring).

- Social/cognitive/daily living skill building- direct services that assist the individual in being able to better perform his/her own social, cognitive, or activities of daily living or assist the individual in finding resources to meet those needs. Services include coaching to identify the individual's needs (i.e., social, cognitive, daily living) and to either work with the individual to develop the social, cognitive, or ADL skills to meet those needs or refer the individual to another agency or service.

- Facilitation of level of care transitions.

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

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

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

- Relapse prevention.

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

5.3.17.2. Provider Qualifications: Licensed psychologists, mental health professional clinicians, substance use disorder counselors, and behavioral health clinical associates, and peer support providers (w/ lived experience, working under

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

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

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

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

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

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

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

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

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

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

5.4.2.1. Component services include:

- Linkage to psychological, medical, and psychiatric consultation.
- Access to emergency medical and psychiatric care through connections with more intensive levels of care.

- Access to evaluation and ongoing primary care.

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

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

- Individualized, person-centered assessment and treatment.

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

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

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

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

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

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

behavioral health clinical associates.

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

5.4.3.1. Components Services include:

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

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

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

5.4.4.1. Component Services include:

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

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

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

5.4.5.1. Component services include:

- Clinically-directed therapeutic treatment to facilitate recovery skills, facilitate decreasing risk of recurrence of symptoms, and emotional coping strategies.
- Addiction pharmacotherapy and drug screening.
- Motivational enhancement and engagement strategies.
- Counseling and clinical monitoring.

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

- Regular monitoring of the individual's medication adherence.

- Recovery support services.

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

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

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

5.4.6.1. Component Services include:

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

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

5.4.7. Medically Managed Intensive Inpatient - These are services provided during a 24-hour inpatient treatment requiring the full resources of an acute care or psychiatric hospital.

Medically Managed Intensive Inpatient services differ from Medically Monitored Intensive Inpatient services due to the requirement of **medically directed** evaluation and treatment services provided in a 24-hour treatment setting under a defined set of policies, procedures, and individualized clinical protocols.

5.4.7.1. Component Services include:

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

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

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

5.4.8.1. Component Services include:

- Individualized, person-centered Assessment.
- Physician and/or Nurse Monitoring.
- Management of Signs & Symptoms of Intoxication & Withdrawal.
- Medication Services.
- Psychoeducation Services.

- Non-Pharmacological Clinical Support Services.
- Referral for Counseling Services.
- Substance Use Care Coordination; and
- Community Recovery Support Services.

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

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

5.4.9.1. Component Services include:

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

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

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

5.4.10.1. Component Services include:

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

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

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

5.4.11.1. Component Services include:

- Individualized, person-centered assessment and medically directed & managed treatment.
- Addiction pharmacotherapy and medication services.
- Appropriate drug screening.
- Cognitive behavioral and other substance-use disorder-focused therapies, reflecting a variety of treatment approaches, provided to the individual on an individual, group, or family basis.
- Daily medical and nursing services.
- Management of signs and symptoms of intoxication and withdrawal.

- Counseling and clinical/medical monitoring.
- Daily treatment services focused on managing the individual's acute symptoms.
- Patient Education services.

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

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

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

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

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

5.4.12.4. Use of Nationally Recognized SUD-Specific Program Standards to set Provider Qualifications for Residential Treatment Facilities: Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities: Currently, residential treatment service providers must be accredited by the Council on Accreditation, the Commission on Accreditation for Rehabilitation Facilities, or the Joint Commission and consequently approved by the state pursuant to Title 7 of the Alaska Administrative Code, Chapter 70.990. The state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that

meet program standards in the ASAM Criteria or other, nationally recognized, SUD-specific program standards regarding, in particular, the types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of OUD/SUD program demonstration approval.

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

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

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

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

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

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

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

The Health IT Plan should describe how technology can support outcomes through care coordination; linkages to public health and prescription drug monitoring programs establish data and reporting structure to monitor outcomes and support data driven interventions. Such technology should, per 42 CFR §433.112(b), use open interfaces and exposed application programming interfaces and ensure alignment with, and incorporation of,

industry standards adopted by the Office of the National Coordinator for Health IT in accordance with 42 CFR part 170, subpart B.

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

5.4.13.2. The state must monitor progress, each Demonstration Year (DY), on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines – and report on its progress to CMS in an addendum to its Annual Report (see STC 8.6).

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

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

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

5.4.14. Components of the Health IT Plan Include:

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

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

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

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

[3] *Ibid.*

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

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

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

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

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

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

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

6. COST SHARING:

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

7. DELIVERY SYSTEM:

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

8. MONITORING AND REPORTING REQUIREMENTS

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

8.1.1. The following process will be used: 1) thirty (30) days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in subsection (8.1.3) below; or 2) thirty (30) days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Elements of the Mid-Point Assessment must include:

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

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

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

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

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

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

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

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

8.9.2. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration

approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in STCs 11.7 and 11.8, respectively.

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

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

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

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

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

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

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

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

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

9. GENERAL FINANCIAL REQUIREMENTS

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

9.2. Standard Medicaid Funding Process. The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance

payments (MAP) and state and local administration costs (ADM). CMS shall make federal funds available based upon the states estimate, as approved by CMS. Within 30 days after the end of each quarter, the state shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on form CMS-64 with federal funding previously made available to the state and include the reconciling adjustment in the finalization of the grant award to the state.

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

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

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

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

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

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

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

9.4.3. The state may use intergovernmental transfer (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under

the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.

9.4.4. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local government, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner in consistent with the requirements in section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9.10. Medicaid Expenditure Groups. Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to the budget neutrality,

components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table providers a master list of MEGs defined for this demonstration.

Table 1: Master MEG Chart					
MEG	Which BN Test Applies	WOW Per Capita	WOW Aggregate	WW	Brief Description
SUD IMD FFS	HYPO 1	X		X	Expenditures for all otherwise-allowable Medicaid services provided, were it not for the IMD prohibition, to otherwise eligible individuals enrolled in fee-for-service during a month in which the beneficiary was a resident in an IMD for a primary diagnosis of SUD.
SUD Non-IMD FFS	HYPO 1	X		X	Expenditures for all otherwise-allowable Medicaid services provided to eligible individuals enrolled in fee-for-service during a month in which the beneficiary was not a resident in an IMD for a primary diagnosis of SUD.
Behavioral Health FFS	HYPO 1	X		X	Expenditures for allowable Medicaid services, outlines within the STCs, provided to eligible individuals enrolled in fee-for-service during a month in which the beneficiary is receiving behavioral health services.

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

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

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

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

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

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

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

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

Table 2: MEG Detail for Expenditure and Member Months Reporting

MEG (Waiver Name)	Detailed Description	Exclusions	CMS 64.9 or 64.10 Line(s) to Use	How Expend Are Assigned to DY	MAP or ADM	Report Member Months	MEG Start Date	MEG End Date
SUD IMD FFS	Expenditures for all otherwise-	N/A	Follow standard CMS-64.9	Date of Services	MAP	Y	03/26/24	12/31/28

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

	for-service during a month in which the beneficiary is receiving behavioral health services.							

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

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

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

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

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

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

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

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

day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

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

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

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

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

10.5. Hypothetical Budget Neutrality. When expenditure authority is provided for coverage of populations or services that the state could have otherwise through its Medicaid state plan or other title XIX authority (such as a waiver under section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be "hypothetical," such that the expenditures are treated as if the state could have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do no necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to refund the FFP to CMS.

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

Table 4: Hypothetical Budget Neutrality Test 1

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

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

Hypothetical Budget Neutrality Test 1 are counted as WW expenditures under the Main Budget Neutrality Test.

Table 5: Hypothetical Budget Neutrality Test 1								
MEG	**PC or Agg.**	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 6**	**DY 7**	**DY 8**	**DY 9**	**DY 10**
Behavioral Health FFS	PC	Both	5.50%	$24.57	$25.92	$27.35	$28.85	$30.44

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

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

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

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

11. EVALUATION OF THE DEMONSTRATION

11.1. Cooperation with Federal Evaluators. As required under 42 CFR § 431.420(f), the state must cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but it not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data

use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they will make such data available for the federal evaluation as is required under 42 CFR § 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 8.1.

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

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

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

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

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

11.6. Evaluation Questions and Hypotheses. Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Reports) of these STCs, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding the demonstration's impact and its effectiveness in achieving the goals.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11.12. Additional Publications and Presentations. For a period of 12 months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports on their findings, including in

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

12. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Deliverable	Timeline	STC Reference
State acceptance of demonstration Waivers, STCs, and Expenditure Authorities	30 calendar days after approval date.	Approval letter
Monitoring Protocol	No later than 150 calendar days after approval date. Revised no later than 60 calendar days after receipt of CMS comments.	STC 8.6
Evaluation Design	No later than 180 calendar days after approval date. Revised no later than 60 calendar days after receipt of CMS comments. Published to state website no later than 30 calendar days after CMS approval.	STC 11.3
Mid-Point Assessment Report	No later than 60 calendar days after December 31, 2026	STC 8.8
Interim Evaluation Report	No later than December 31, 2027, or with extension application. Revised no later than 60 calendar days after receipt of CMS comments.	STC 11.7.3
Summative Evaluation Report	No later than 18 months after the end of the demonstration. Revised no later than 60 calendar days after receipt of CMS comments.	STC 11.8
Close-Out Report	No later than 120 calendar days	STC 8.10

	after the end of the demonstration. Revised no later than 30 calendar days after receipt of CMS comments.	
Monthly		
Monitoring Calls	Monthly	STC 8.11
Quarterly		
Quarterly Monitoring Reports	Due no later than 60 days after end of each quarter, except 4th quarter.	STC 8.7
Quarterly (CMS-64) Expenditure Reports	Due no later than 60 days after end of each quarter, except 4th quarter.	STC 9.2
Quarterly Budget Neutrality Reports	Due no later than 60 days after end of each quarter, except 4th quarter.	STC 9.13
Annually		
Annual Monitoring Reports (including Q4 Expenditure Report and Budget Neutrality Report)	Due 90 days after end of each 4th quarter.	STC 8.7
Post Award Forum	No later than 6 months after the demonstration's implementation and annually thereafter.	STC 8.12

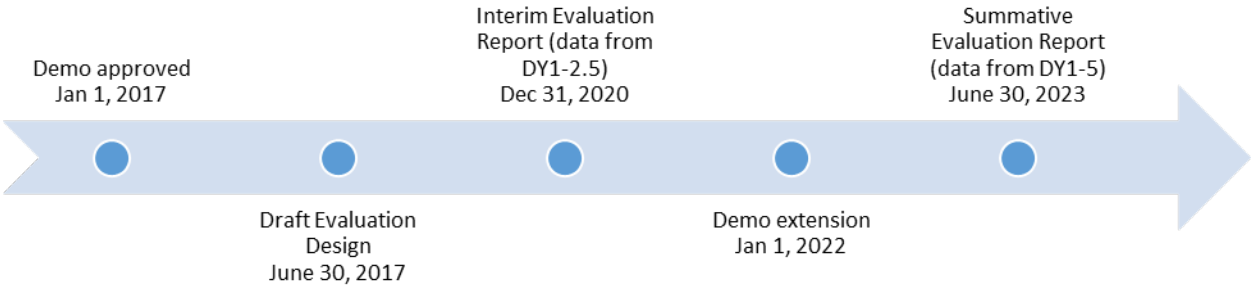
ATTACHMENT A
Developing the Evaluation Design

Introduction

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

Submission Timelines

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



Expectations for Evaluation Designs

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

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

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

The format for the Evaluation Design is as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Specifically, this section establishes:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:

a. Operating smoothly without administrative changes;
b. No or minimal appeals and grievances;
c. No state issues with CMS-64 reporting or budget neutrality; and
d. No Corrective Action Plans for the demonstration.

E. Attachments

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

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

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

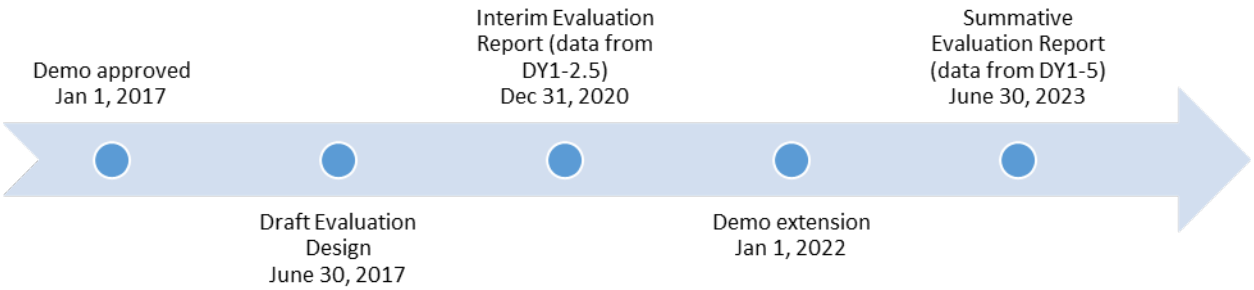
ATTACHMENT B
Preparing the Interim and Summative Evaluation Reports

Introduction

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

Submission Timelines

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



Expectations for Evaluation Reports

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

Evaluation Design. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

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

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

Intent of this Attachment

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

Required Core Components of Interim and Summative Evaluation Reports

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

G. **Conclusions** – In this section, the state will present the conclusions about the evaluation results. Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically, the state should answer the following questions:
   1. In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?
   2. If the state did not fully achieve its intended goals, why not?
   3. What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

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

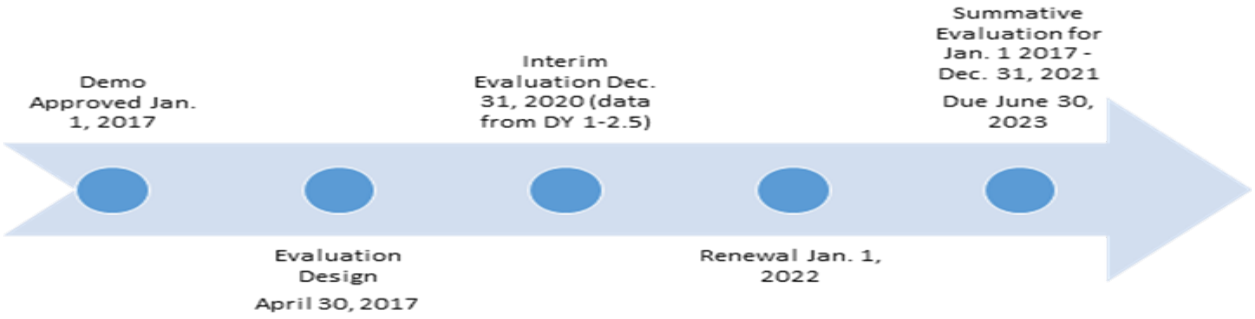
I. **Lessons Learned and Recommendations** – This section of the evaluation report involves the transfer of knowledge. Specifically, it should include potential "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders. Recommendations for improvement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

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

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

Submission Timelines

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



Required Core Components of Interim and Summative Evaluation Reports

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

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

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

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

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

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

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

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

5) Describe the population groups impacted by the demonstration.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

F. Attachment

Evaluation Design: Provide the CMS-approved Evaluation Design

ATTACHMENT C:
Evaluation Design
(Reserved)

ATTACHMENT D:
SUD Implementation Plan Protocol

ALASKA 1115 SUBSTANCE USE DISORDER WAIVER IMPLEMENTATION PLAN--FINAL

March 13, 2019

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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

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

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

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

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

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

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

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

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

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

ATTESTATIONS and CONFIRMATIONS:

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

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

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

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

ATTACHMENT E:
Reserved for SUD Claiming Protocol

ATTACHMENT F: SUD Monitoring Protocol

(Reserved)

ATTACHMENT G – Quarterly and Annual Progress Report Template and Instructions

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

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

II. Narrative Report Format

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

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

III. Introduction

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

IV. Operational Updates

Describe all operational updates and activity under the demonstration.

V. Performance Metrics

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

VI. Evaluation Activities

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

VII. SUD Health IT

Summarize of progress made in regards to SUD Health IT.

VIII. Tribal Engagement and Collaboration Developments/Issues

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

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

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

X. Enclosures/Attachments

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

XI. State Contact(s)

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

XII. Date Submitted to CMS

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

The state may add additional program headings as applicable.

Attachment H

Time-limited Expenditure Authority and Associated Requirements for the COVID-19 Public Health Emergency (PHE) Demonstration Amendment

Expenditure Authority

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the state for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for state plan populations, for the period from May 12, 2023, to November 11, 2023, unless otherwise specificized, be eligible for federal financial participation under the state's title XIX plan.

1. **Use of Legally Responsible Individuals to Render Personal Care Services (PCS).** To allow temporary payment for 1905(a) PCS rendered by legally responsible individuals (which could be inclusive of legally responsible family caregivers) provided that the state meets all existing requirements as described under the Medicaid state plan, including Electronic Visit Verification requirements.

Monitoring and Evaluation Requirements

1. **Evaluation Design.** The state must submit an Evaluation Design that is encapsulated in a Final Report to CMS no later than 12 months after the expiration of this amendment approval period. In developing the Evaluation Design, the state can focus on qualitative methods and descriptive data to address evaluation questions that will support understanding the successes, challenges, and lessons learned in implementing the demonstration amendment. The state must also describe its plans to collect and report data on the size of the populations served under this demonstration amendment, and a summary of service utilization.

2. **Final Report.** The state is required to submit to CMS for review and approval a Final Report, which will consolidate the monitoring and evaluation reporting requirements for this demonstration amendment. The Final Report is due no later than 12 months after the end of the expenditure authority. In addition to capturing data on the number of individuals served and utilization of services under this amendment, the Final Report must undertake qualitative and descriptive assessment on the demonstration implementation, lessons learned, and best practices for similar situations. The state is required to track expenditures associated with this demonstration, as applicable, and may include but not be limited to, administrative costs and program expenditures. CMS's section 1115 demonstration evaluation guidance, "Preparing the Evaluation Report"[4] provides pertinent instructions that would be helpful in preparing the consolidated Final Report. The state should customize the content of the Final Report to align with the specific scope of the demonstration amendment. Once approved, the state is required to post its consolidated Evaluation Design and Final Report to the state's website within 30 days of CMS approval.

[4] Available at https://www.medicaid.gov/medicaid/downloads/preparing-the-evaluation-report.pdf.