MILLIMAN REPORT

Assessment of Alaska's Behavioral Health Crisis Services Continuum of Care

Alaska Department of Health, Division of Behavioral Health

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Executive Summary

The Alaska Department of Health (DOH), Division of Behavioral Health (DBH) commissioned Milliman, Inc. to analyze Alaska's behavioral health crisis continuum of care amidst rising suicide rates, overdoses, and increased mental health needs nationwide. This report provides an overview of the current state of behavioral health crisis service delivery in Alaska, highlighting areas of opportunity as the state looks to increase access to behavioral health crisis care in all communities across the state. The report focuses on mobile crisis response and crisis stabilization facilities, as crisis call centers were outside the project's scope.

The project was divided into four phases and conducted by a team including subject matter experts from DBH and Milliman.

- **Phase I.** The first phase of the project involved a comprehensive review of Alaska's regulatory and program documentation to provide an overview of the state's crisis continuum.
- **Phase II.** The second phase focused on researching best practices from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), the National Association of State Mental Health Program Directors' (NASMHPD) Crisis Now initiative, and behavioral health crisis systems in other states.
- **Phase III.** In the third phase, six stakeholder engagement sessions were conducted with tribal organizations, providers, consumer advocates, subject matter experts, and sister agencies to DBH.
- **Phase IV.** The final phase culminated in this report which presents a qualitative and quantitative analysis of the current state of Alaska's behavioral health crisis service delivery system. Leveraging that analysis, it offers actionable options and considerations for Alaska to address these issues and ensure access to behavioral health crisis care for all Alaskans, considering the state's unique challenges related to size, geography, and diverse demographics.

The gaps and options analysis contained in this report identified five opportunity areas and associated options for Alaska to consider:

1. ***Enhancing the crisis service array:*** The responsiveness to community needs could be increased through additional benefits and services, along with increased flexibility in service requirements, licensure, and staffing.
2. ***Streamlining documentation:*** There are opportunities to increase clarity, efficiency, and organization in the documentation and guidance provided to providers and other interested parties.
3. ***Providing additional support for providers and community partners:*** Additional assistance in the form of training, technical support, and workforce programs/incentives is likely needed for providers and community partners.
4. ***Improving sustainable financing:*** The implementation of improved financing mechanisms could support the behavioral health crisis continuum.
5. ***Facilitate Collaboration****:* Promoting, encouraging, and expanding intentional collaboration could support increased alignment across state and community partners.

The final section of this report provides DBH with a strategic roadmap for implementing potential solutions, which may vary based on leadership review and further evaluation. Key implementation activities include planning and design, stakeholder engagement, regulatory authority, payment review and rate development, and updates to internal operations and documentation. In addition to these implementation activities, there are several cross-cutting levers that provide additional opportunities to expand services and supports, address behavioral health access, and more sustainably fund the delivery of crisis services, such as 1115 Demonstration Waiver, Certified Community Behavioral Health Clinics (CCBHC), Health Homes, and managed care and/or administrative service organizations.

Though Alaska faces unique challenges in ensuring access to behavioral health crisis services, this report provides options and potential pathways for addressing these issues. Despite the hurdles, Alaska benefits from a strong foundation of committed individuals and organizations working to ensure access to care for all Alaskans.

I. Introduction

The escalating rates of suicide, overdoses, and overall heightened mental health needs have drawn attention to the nation's behavioral health delivery system, with a particular focus on crisis response.[1,2] In this broader national context, the Alaska Department of Health (DOH), Division of Behavioral Health (DBH) engaged Milliman, Inc. to conduct a thorough analysis of Alaska's behavioral health crisis continuum of care.

Like other states and communities throughout the country, Alaska is striving to ensure that anyone experiencing a behavioral health crisis (inclusive of mental health or substance use disorder crisis) can access support whenever and wherever necessary. To this end, the state has launched several initiatives in recent years to strengthen and expand access to behavioral health crisis services. Alaska grapples with many of the same issues other states face as they work to develop their crisis care delivery systems, such as increased service demand, workforce shortages, and care delivery barriers in rural communities, among others. However, Alaska is distinct in that these challenges can be particularly complicated and daunting due to the state's size, geography, and diverse demographics.

This report aims to offer a concise overview of the current state of behavioral health crisis service delivery in Alaska, acknowledging these challenges and spotlighting key gaps and areas of need in the continuum of care. Most importantly, the report seeks to provide Alaska with tangible options and considerations for addressing these issues moving forward as it works to ensure access to behavioral health crisis care for all Alaskans.

APPROACH

The project team for this report included subject matter experts from DBH and Milliman. The team met on a biweekly basis between January and May of 2024. The work was divided into four general tasks or phases, listed below in the order in which they were carried out.

1. *Documentation review*. The Milliman team initiated the project by conducting a comprehensive review of the available regulatory and program documentation related to the state's crisis service array. The main objective of this review was to establish a solid baseline and provide a comprehensive overview of the current state of Alaska's crisis service delivery system. This included items such as the Medicaid fee schedule, utilization data, service expenditures, Medicaid state plan documents, provider/program manuals, and the Alaska Administrative Code. Appendix A includes a complete list of items reviewed.
2. *Leading practices research*. In addition to reviewing Alaska-specific documentation, the team investigated leading practices and approaches from other regions of the country. At a national level, this primarily involved utilizing resources such as the U.S. Substance Abuse and Mental Health Service Administration's (SAMHSA) *National Guidelines for Behavioral Health Crisis Care* (national guidelines), and the National Association for Mental Health Program Director's (NASMHPD) Crisis Now framework. Furthermore, the team explored unique and innovative approaches to crisis service delivery implemented by other states. Specific attention was paid to approaches in states Arizona, Missouri, Oklahoma, and Washington. The information gathered during this phase of the project specifically supported Sections II and IV of this report.
3. *Interested party engagement*. The entire project was centered around intensive engagement with a variety of interested parties across Alaska's behavioral health crisis delivery system. This involved conducting six focus group discussions with Tribal health organizations, providers, consumer advocates, subject matter experts, and staff from sister agencies of DBH. These discussions delved into the strengths and gaps within Alaska's behavioral health crisis continuum from the perspective of the respective participants, and explored potential solutions suggested by them. The dialogue that occurred during the focus groups was crucial in developing a comprehensive and thorough understanding of the state's crisis care continuum, as seen by the individuals and organizations actively involved in the work. Appendix B provides an overview of the engagement with interested parties, including details on the specific entities involved in the project.
4. *Gaps analysis and options report*. The content of this report is the culmination of information gathered through a review of documentation, research into leading practices, and engagement with interested parties. It provides a comprehensive set of qualitative and quantitative observations, which are explored in Sections

II through IV. Section IV specifically focuses on concrete options and considerations for Alaska as it continues to strengthen its behavioral health crisis system in the future.

II. National Context

As noted in this report's introduction, there has been a growing focus on the need for a robust behavioral health crisis continuum of care in recent years. This has been driven by states' efforts to address heightened behavioral health needs within their communities. Most notably, this led to the creation of a foundational framework, formally published in 2020 by SAMHSA in its national guidelines. This framework was inspired by the Crisis Now recommendations published in 2016.[3] The foundational principle of the national guidelines and Crisis Now framework is that crisis services must be available for *anyone, anywhere,* and at *any time*. The framework lays out a continuum of care composed of three core elements. This continuum is illustrated and described in Figure 1.

FIGURE 1. CRISIS NOW FRAMEWORK

In addition to the three core components depicted in the top-half of Figure 1, the national guidelines emphasize the potential inclusion of other elements in a crisis care system. These elements may either be incorporated within the existing continuum or added to these components. Notably, these include short-term residential facilities for individuals requiring ongoing support post-crisis, without the necessity for an inpatient level of care. The national guidelines also highlight peer-operated respite programs as another example. These programs provide a step-down environment for individuals post-crisis, staffed by peer support workers who themselves have lived experience.

While each of these elements is vital to the crisis continuum of care, the scope of the analysis in this report did not include crisis call centers – i.e., "someone to call." The project primarily focused on mobile crisis response, crisis stabilization, and crisis residential services.

OTHER STATE APPROACHES

The national guidelines and the Crisis Now framework have acted as a beneficial foundation for states as they develop their crisis response systems. However, it is crucial to stress that these national guidelines are a guiding framework, necessitating states to tailor and adapt it to meet their communities' distinct needs. Consequently, numerous examples of innovative strategies have been employed by states to enhance their behavioral health crisis service system. Given the variety of unique approaches by states and the ongoing change and progress at both state and federal levels to expand and strengthen the behavioral health crisis delivery system, this report does not aim to provide a comprehensive list of every innovative strategy implemented nationwide. Nevertheless, the analysis does include examples from states that have successfully implemented leading practices, specifically in relation to the observations and considerations detailed in Sections IV and V. Figure 2 provides two general examples of how states have approached different pieces of their crisis response system.

FIGURE 2. APPROACHES BY OTHER STATES

Tiered approach to place-based crisis care

The national guidelines call for the delivery of crisis receiving and stabilization services in a 23-hour facility that operates 24/7/365 and accepts all referrals, such as walk-ins and first responder drop-offs. However, for many communities, reaching this standard is challenging due to issues like workforce shortages and geographical obstacles, especially in less populated areas. Acknowledging this, some states have established a tiered system of place-based crisis services. For instance, Missouri has developed a network of Behavioral Health Crisis Centers (BHCCs) that function as 23-hour crisis receiving and stabilization facilities in various regions across the state.[4,5] However, Missouri has allowed for *two* types of BHCCs: those with 24/7 operating hours and Urgent Care BHCCs (U-BHCCs) that operate less than 24/7. U-BHCCs must effectively adhere to the same certification standards as regular BHCCs, but without the obligation to maintain 24/7 operating hours – making them a more feasible option in less densely populated areas of the state.[6]

Providing crisis care in rural communities

Like other healthcare services, ensuring access to crisis care in rural communities is a widespread challenge nationwide. Oklahoma has utilized telehealth to enhance care access for individuals undergoing a behavioral health crisis, particularly those residing in areas with limited crisis providers. The state has employed its Certified Community Behavioral Health Clinic (CCBHC) program to distribute tablets to first responders and individuals at risk of crisis, especially in rural regions.[7,8] These first responders have round-the-clock access to behavioral health practitioners for assistance with assessment, evaluation, and treatment connection. The tablets are supplied to first responders and those in need through CCBHCs and city/county health departments. The program has been expanded since its inception beyond usage by first responders and clinics to include emergency rooms, schools, jails, and individual clients providing support in crisis situations, but also with tracking monitoring, and care coordination.[9]

III. Alaska's Crisis Continuum of Care

With the national efforts as a backdrop, Alaska has been undertaking its own initiatives at the state-level to bolster its behavioral health crisis care delivery system. This includes the recent establishment of crisis stabilization and crisis residential facilities in House Bill (HB) 172 – the full implementation of which is ongoing. It also includes the renewal of its Section 1115 Waiver, Alaska's Behavioral Health Reform, authorizing behavioral health crisis services, which are described in additional detail below.

CURRENT CRISIS SERVICE ARRAY

Alaska's current array of crisis services includes seven different crisis services authorized by either the Medicaid State Plan through a state plan amendment (SPA) or the aforementioned 1115 waiver. The evolution of this comprehensive system involved a multi-faceted approval and implementation process over several years, see Figure 3. The Centers for Medicare and Medicaid Services (CMS) first approved Alaska's SPA to authorize two crisis services, short-term crisis stabilization and short-term crisis intervention in April 2010. Alaska codified regulations for these services through the Alaska Administrative Code in October 2011. The continuum of community-based care continued to lack crucial elements in the continuum of community-based care, particularly among substance use disorder (SUD) providers who were funded through private pay or through state and federal grants. These providers were delivering mental health and SUD services but were not enrolled in Medicaid and services often were not available to Medicaid beneficiaries as entitlements. In this climate Senate Bill 74 was passed in 2016, a monumental Medicaid reform package that included a mandate to apply for a Section 1115 demonstration waiver to manage a comprehensive and integrated behavioral health network.

Alaska submitted its 1115 waiver application in January 2018 as a request to authorize a comprehensive continuum of behavioral health services, including four crisis services: mobile outreach and crisis response services, 23-hour crisis stabilization observation, crisis residential stabilization, and peer-based crisis services. However, CMS bifurcated its approval of the waiver into two separate components. CMS initially approved the SUD components of the 1115 Waiver in November 2018 with an approval period of January 1, 2019 through December 31, 2023. This first approval authorized Alaska to receive federal financial participation (FFP) for the provision of a continuum of 13 community-based demonstration services to treat addictions to opioids and other substances for Medicaid enrollees primarily diagnosed with opiate use disorder (OUD) and/or other SUD, including four crisis services. DBH issued emergency regulations outlining provider requirements, as well as service criteria and definitions for the new 1115 SUD services, which went into effect July 1, 2019.

On September 3, 2019, CMS approved the remaining sections of the Alaska waiver which authorized the state to implement 12 additional behavioral health services to enhance the comprehensive service array for children, youth, at risk youth, and adults with serious mental illness (SMI), serious emotional disturbance (SED), and/or SUDs. Alaska again used the state emergency regulation process to make available these new behavioral health services, effective May 21, 2020. This sequential approval led to a staggered operationalization of the services and the establishment of a nuanced framework, delineating distinct billing codes, modifiers, and provider manuals.

DBH continues to address service improvements through state policy and regulations; most recently the mobile outreach crisis response (MOCR) service was restructured into two distinct services—MOCR and MOCR crisis service follow up – with the addition of a new billing code.

FIGURE 3. CRISIS SERVICES AUTHORIZATION AND IMPLEMENTATION TIMELINE

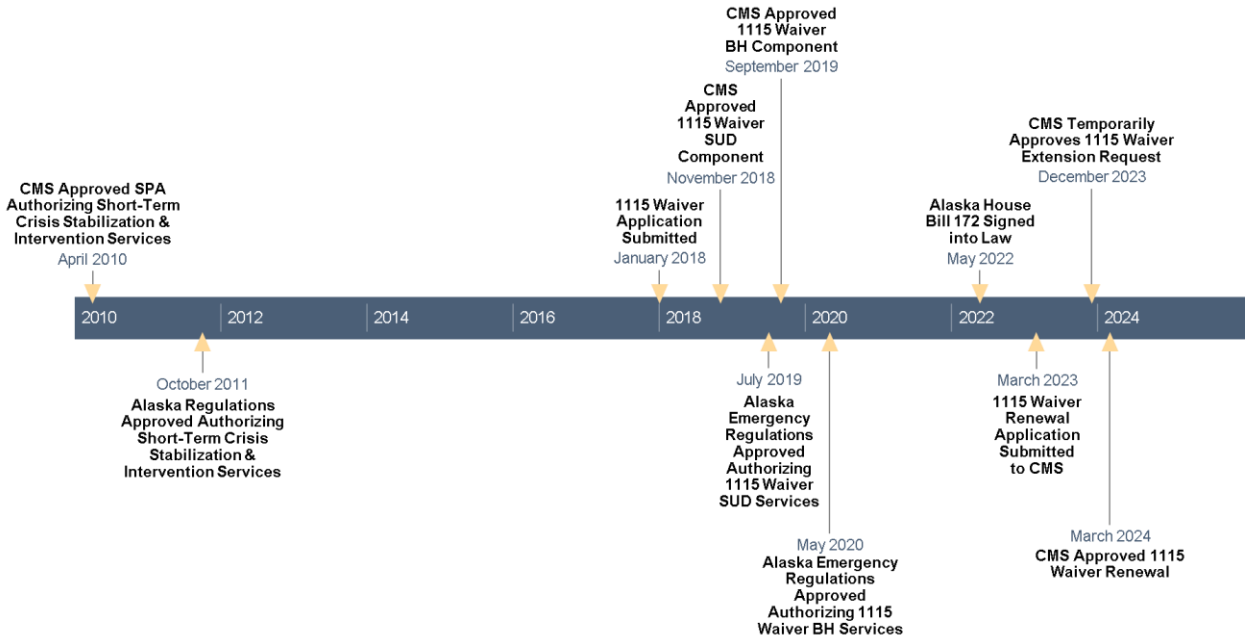


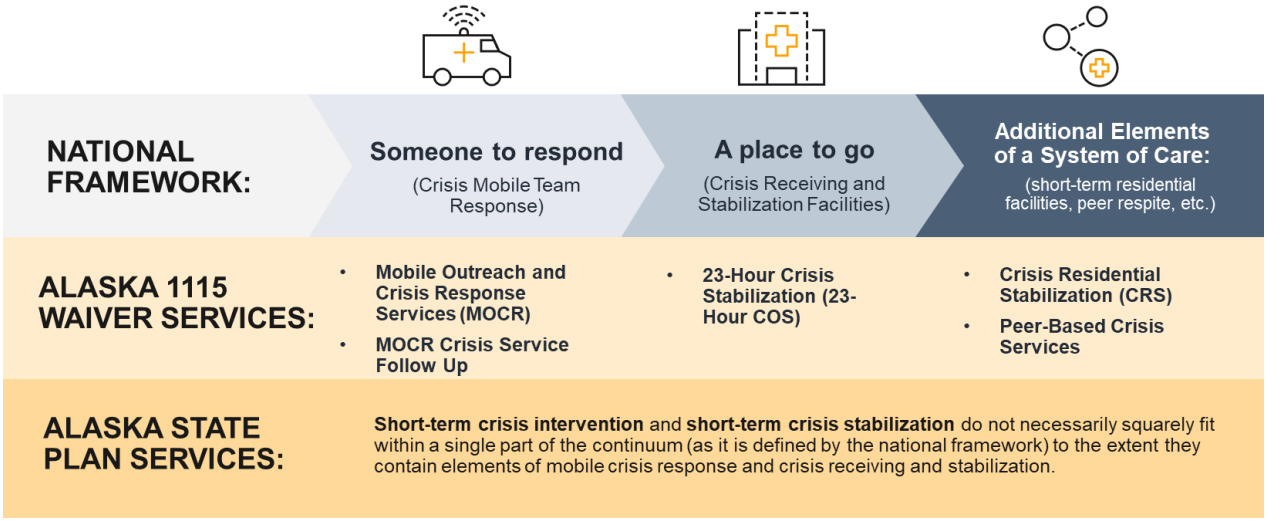
Figure 4 provides a summary of the different services along with the implementation authority and location in the Alaska Administrative code.

FIGURE 4. ALASKA BEHAVIORAL HEALTH CRISIS SERVICES

Authority	Service Name	Description	Administrative Code
State Plan	Short-Term Crisis Intervention	Short-term mental health services provided to a recipient during an acute episode of a mental, emotional, or behavioral disorder	7 AAC 135.160
	Short-Term Crisis Stabilization	Any medically necessary and clinically appropriate behavioral health rehab services necessary to return recipient to the mental, emotional, and behavioral level of functioning before short-term crisis occurred	7 AAC 136.170
1115 Waiver	Mobile Outreach and Crisis Response (MOCR) Services	Provided to prevent a mental health crisis or to stabilize an individual during or after a mental health crisis	7 AAC 138.450 7 AAC 139.350
	MOCR Crisis Service Follow Up	Provided to ensure connection to resources and/or ensure the crisis has stabilized. The follow up continues to assess for safety and confirms linkage with any referrals.	7 AAC 138.450 7 AAC 139.350
	23-Hour Crisis Stabilization Observation	Provide prompt observation and stabilization in a secure environment for individuals at imminent risk of or presently experiencing acute mental health symptoms or emotional distress	7 AAC 138.450 7 AAC 139.350
	Crisis Residential Stabilization	Short-term residential, medically monitored stabilization service for individuals presenting with acute mental or emotional disorders requiring psychiatric stabilization	7 AAC 138.450 7 AAC 139.350
	Peer-Based Crisis Services	Help individual experiencing crisis to avoid need for hospital ED services or psychiatric hospitalization; other therapeutic activities to reduce or eliminate emergent/crisis situation to support individual or family of individual in crisis	7 AAC 138.450 7 AAC 139.350

Figure 5 provides an illustration of how the service array in Figure 4, as defined in the SPA and 1115 waiver, maps to the Crisis Now framework described in Section I of this report.

FIGURE 5. ALASKA CRISIS SERVICE ARRAY AGAINST THE CRISIS NOW FRAMEWORK



CRISIS SERVICE UTILIZATION AND EXPENDITURES

To fully comprehend Alaska's crisis service delivery system, it is not sufficient to merely understand what services Medicaid covers. It is important to examine how these services are utilized and to what extent. As depicted in Figure 5 above, the services covered in Alaska's crisis service array encompass the entire crisis continuum. However, a more thorough understanding of the actual situation can be achieved by analyzing utilization data and expenditures.

Methodology

To identify crisis services for the purpose of understanding utilization and expenditures, we used behavioral health claims experience provided by DBH with runout through February 9th, 2024. We identified July 1, 2021 through June 30, 2023 (SFY 2022-2023) crisis claims based on each Healthcare Common Procedure Coding System (HCPCS) code and associated claim modifiers. Crisis claims were limited and categorized using the following logic:

- **Short-Term Crisis Stabilization**: H2011;
- **Short-Term Crisis Intervention**: S9484 without a V1 or V2 modifier;
- **Mobile Outreach and Crisis Response Services**: T2034 with a V1 or V2 modifier;
- **23-Hour Crisis Stabilization Observation**: S9484 with a V1 or V2 modifier;
- **Crisis Residential Stabilization**: S9485 with a V1 or V2 modifier; and,
- **Peer-Based Crisis Services**: H0038 with a V1 or V2 modifier.

We further classified claims by whether the service was authorized by the state plan or the 1115 waiver by utilizing the modifier field. Claims with a V1 or V2 modifier indicate that the claim was authorized by the 1115 waiver, while claims without the V1 or V2 modifier were authorized by the state plan. We assumed Short-Term Crisis Stabilization services were authorized by the state plan, while the remaining services were authorized by the 1115 waiver. MOCR Crisis Service Follow Up was excluded from this analysis since it only became effective in February 2024.

To gain a more detailed understanding of the crisis claims, we analyzed the claims by their place of service (POS). Common places of service include community mental health centers, emergency rooms, or telehealth. We utilized a POS code variable included on the data provided by DBH along with a publicly available crosswalk from CMS of POS code to POS.[10]

Utilization and expenditures

Generally, over the period analyzed, the crisis services authorized under the SPA had more utilization relative to those authorized by the 1115 waiver. As illustrated in Figure 6, the SPA services accounted for 67% of claims between July 2021 and June 2023.

FIGURE 6. CRISIS SERVICES UTILIZATION BY NUMBER OF CLAIM LINES, JULY 2021 – JUNE 2023

Authority	HCPCS	Modifier	Service	Claim Lines	Percentage
State Plan	H2011	Any	Short-term Crisis Stabilization Service	4,337	67%
	S9484	U6	Short-term Crisis Intervention Service (15 minutes)	11,559	
	S9484	Other	Short-term Crisis Intervention Service (1 Hour)	5,811	
1115 Waiver	S9484	V1	23 Hour Crisis Stabilization Observation (SUD)	3,154	33%
	S9484	V2	23 Hour Crisis Stabilization Observation (BH)	25	
	H0038	V1	Peer-Based Crisis Services (SUD)	1,190	
	H0038	V2	Peer-Based Crisis Services (BH)	79	
	S9485	V1	Crisis Residential Stabilization (SUD)	637	
	S9485	V2	Crisis Residential Stabilization (BH)	5,418	
	T2034	V1	Mobile Outreach and Crisis Response Services (SUD)	64	
	T2034	V2	Mobile Outreach and Crisis Response Services (BH)	255	
Total				**32,529**	**100%**

This is further illustrated when looking at the number of providers delivering each of the services. Figure 7 provides an overview of the number of providers who have billed each of the services. Of the 49 providers who billed any crisis service between July 2021 and June 2023, 85% (42) delivered SPA services, while only 35% (17) delivered 1115 waiver services.

FIGURE 7. PROVIDER COUNT BY CRISIS SERVICE, JULY 2021 – JUNE 2023

Authority	HCPCS	Modifier	Service	Provider Count
State Plan	H2011	Any	Short-term Crisis Stabilization Service	28
	S9484	U6	Short-term Crisis Intervention Service (15 minutes)	33
	S9484	Other	Short-term Crisis Intervention Service (1 Hour)	37
1115 Waiver	S9484	V1	23 Hour Crisis Stabilization Observation (SUD)	2
	S9484	V2	23 Hour Crisis Stabilization Observation (BH)	2
	H0038	V1	Peer-Based Crisis Services (SUD)	6
	H0038	V2	Peer-Based Crisis Services (BH)	4
	S9485	V1	Crisis Residential Stabilization (SUD)	2
	S9485	V2	Crisis Residential Stabilization (BH)	5
	T2034	V1	Mobile Outreach and Crisis Response Services (SUD)	1
	T2034	V2	Mobile Outreach and Crisis Response Services (BH)	2
Any Service				**49**

Notes:
1. Values were developed using the claims data extract titled AK24-053 Claim Extract as of 2023-1002 and provided by DBH.
2. Provider NPI was assigned using the hierarchy Kingfisher NPI->CLPR NPI, ATTR NPI, PRV NPI.
3. Organization names were mapped on using the file Provider Detail Report.csv provided by DBH on March 25, 2022.

To a lesser extent, SPA services also accounted for most expenditures (54%) between June 2021 and July 2023.

FIGURE 8. CRISIS SERVICES UTILIZATION BY AMOUNT PAID, JULY 2021 – JUNE 2023

Authority	HCPCS	Modifier	Service	Paid	Cost per Claim Line	Percentage
State Plan	H2011	Any	Short-term Crisis Stabilization Service	$ 2,286,672	$ 527.25	54%
	S9484	U6	Short-term Crisis Intervention Service (15 minutes)	6,558,654	567.41	
	S9484	Other	Short-term Crisis Intervention Service (1 Hour)	2,910,090	500.79	
1115 Waiver	S9484	V1	23 Hour Crisis Stabilization Observation (SUD)	4,368,085	1,384.93	46%
	S9484	V2	23 Hour Crisis Stabilization Observation (BH)	38,698	1,547.92	
	H0038	V1	Peer-Based Crisis Services (SUD)	164,091	137.89	
	H0038	V2	Peer-Based Crisis Services (BH)	9,929	125.69	
	S9485	V1	Crisis Residential Stabilization (SUD)	584,762	917.99	
	S9485	V2	Crisis Residential Stabilization (BH)	4,643,369	857.03	
	T2034	V1	Mobile Outreach and Crisis Response Services (SUD)	11,731	183.29	
	T2034	V2	Mobile Outreach and Crisis Response Services (BH)	45,311	177.69	
Total				**$ 21,621,392**	**$ 664.68**	**100%**

While data limitation prevents reporting crisis services utilization by provider location, Figure 9 provides a summary of crisis service expenditures by member location. Patterns emerge in that members in all regions of the state utilize SPA crisis services; whereas the 1115 waiver services are not utilized by members in every region by their location. Furthermore, the 1115 waiver services have inconsistent utilization by behavioral health or SUD service, even within the same geography.

FIGURE 9. CRISIS SERVICE EXPENDITURES BY MEMBER ELIGIBLITY LOCATION, JULY 2021 – JUNE 2023

Service	Anchorage Municipality	Fairbanks North Star Borough	Southern Southeast Region	Western Region	Northern Southeast Region	MatSu Borough	Kenai Peninsula Borough	Northern & Interior Region	No Mapping Available	Gulf Coast/ Aleutian Region	Out of State	Total
Short-term Crisis Stabilization Service	$ 811,804	$ 121,675	$ 158,384	$ 56,386	$ 420,999	$ 143,635	$ 321,468	$ 14,970	$ 140,148	$ 4,219	$ 92,983	$ 2,286,672
Short-term Crisis Intervention Service (15 minutes)	3,507,959	109,621	537,685	836,688	398,124	300,481	402,139	83,525	253,920	18,808	109,704	6,558,654
Short-term Crisis Intervention Service (1 Hour)	1,294,717	81,304	209,936	321,366	334,683	174,942	240,141	24,447	128,285	5,034	95,236	2,910,090
23 Hour Crisis Stabilization Observation (SUD)	321,179	2,990,340	813	28,969	3,602	14,720	9,180	694,646	51,544	5,810	247,283	4,368,085
23 Hour Crisis Stabilization Observation (BH)	$ 0	$ 0	$ 0	$ 1,724	$ 34,388	$ 0	$ 862	$ 0	$ 862	$ 0	$ 862	$ 38,698
Peer-Based Crisis Services (SUD)	15,418	4,099	-	-	1,608	103,479	20,438	20	1,228	614	17,187	164,091
Peer-Based Crisis Services (BH)	6,138	-	-	-	-	2,615	-	-	164	-	1,013	9,929
Crisis Residential Stabilization (SUD)	245,889	53,262	-	-	-	179,883	35,091	2,700	-	19,800	48,137	584,762
Crisis Residential Stabilization (BH)	420,499	172,386	2,230,659	521,214	398,212	593,871	88,394	96,992	7,560	-	113,584	4,643,369
Mobile Outreach and Crisis Response Services (SUD)	2,386	184	-	-	-	7,709	535	-	-	-	918	11,731
Mobile Outreach and Crisis Response Services (BH)	1,413	34,518	2,635	359	176	1,078	710	2,123	-	703	1,597	45,311
Grand Total	**$ 6,627,403**	**$ 3,567,389**	**$ 3,140,112**	**$ 1,766,706**	**$ 1,591,791**	**$ 1,522,412**	**$ 1,118,958**	**$ 919,423**	**$ 583,711**	**$ 54,987**	**$ 728,501**	**$ 21,621,392**

Expenditure values were developed using the claims data extract titled AK24-143 Claim Extract as of 20240209.csv and provided by DBH.

The potential reasons for the discrepancy in utilization and expenditures between the SPA and 1115 waiver services are multifaceted. Most fundamentally, the SPA services, which have been in existence since 2010, have a longer history compared to the 1115 waiver services, which were authorized in 2019 and 2020. Consequently, providers are likely more familiar with and accustomed to using the SPA services for delivering crisis care. As is explored in further detail in Section IV, there is a potential need for additional clarity and support regarding the 1115 waiver services to encourage and enable providers to leverage these services more in the future. Furthermore, as implementation of HB172 continues and more crisis stabilization centers (CSC) and crisis residential centers (CRC) come online, it is possible that utilization of certain SPA services might increase – e.g., 23-hour crisis stabilization and crisis residential stabilization.

Additionally, to the extent that Short-Term Crisis Intervention (SPA) is seen as equivalent or similar to 23-Hour Crisis Stabilization (1115 waiver), providers are incentivized to use Short-Term Crisis Intervention as the reimbursement rate is 10% higher than that of 23-Hour Crisis Stabilization, $138.34 compared to $121.43 for each one-hour unit. This discrepancy becomes clear when comparing the reimbursement rates in Figure 10 and the claim lines in Figure 6.

FIGURE 10. CRISIS SERVICES PROVIDER REIMBURSEMENT RATES BY UNIT[11,12]

Authority	HCPCS	Service	Unit	Rate
State Plan	H2011	Short-Term Crisis Stabilization	15 minutes	$27.83
	S9484 (U6)	Short-Term Crisis Intervention	15 minutes	$34.59
	S9484	Short-Term Crisis Intervention	1 hour	$138.34
1115 Waiver	T2034	Mobile Outreach and Crisis Response Services	Per Call Out	$183.54
	S9484	23-Hour Crisis Stabilization	1 Hour	$121.43
	S9485	Crisis Residential Stabilization	1 Day	$940.50
	H0038	Peer-Based Crisis Services	15 minutes	$21.38

IV. Assessment of Alaska's Crisis Continuum and Options to Address Potential Gaps

As described in other areas of this report, Alaska has enacted a number of legislative, regulatory, and federal changes to bolster its crisis continuum. To understand the current state of Alaska's crisis system, Milliman conducted a comprehensive review and analysis of formal documentation, utilization data and expenditures, and feedback from interested parties. The following section discusses five opportunity areas that were identified through this assessment and associated solutions for the state's consideration:

1. **Enhancing the crisis service array.** There is potential for increased responsiveness to community needs through possible additional benefits and services along with increased flexibility in service requirements, licensure, and staffing. The considerations within this area include:
    - Increased flexibility in the current service requirements
    - Development of separate services for adults and adolescents
    - Additional options for place-based crisis care
    - Access to wrap-around care and HRSN services
    - Support regional planning and accountability
    - Expansion of services to reimburse traditional healing and health practices
2. **Streamlining documentation.** There are opportunities for increased clarity, efficiency, and organization in the documentation and guidance made publicly available to providers and other interested parties. The considerations within this area include:
    - Organization and accessibility of documentation
    - Consistency and clarity in service descriptions, guidance, and purpose
    - Clarity and certainty in facility licensure
    - Availability of transportation
3. **Providing additional support for providers and community partners.** Further assistance for providers and community partners in the form of training, technical support, and workforce programs/incentives is likely needed. The considerations within this area include:
    - Technical assistance for crisis providers
    - Training for community partners
    - Workforce supports
4. **Improving sustainable financing.** There is an opportunity to implement improved financing mechanisms to support the behavioral health crisis continuum. The considerations within this area include:
    - Provider rate methodology review
    - Rebasing
    - Capital investments
    - Service-specific incentives
    - Temporary Enhanced FMAP for Community-Based Mobile Crisis Intervention Services
5. **Facilitating community collaboration.** There is an opportunity to promote, encourage, and expand intentional collaboration in support of increased alignment across state and community partners. The considerations within this area include:
    - Expanded opportunities for collaboration across state agency partners
    - Expanded opportunities for community collaboration with state partners
    - Shared care planning, closed loop referral platform, and community information exchange

1. ENHANCING THE CRISIS SERVICE ARRAY

Alaska has progressed with the authorization and funding for crucial components of the crisis system continuum through the state plan and the 1115 waiver. However, conversations with interested parties and claims data analyses suggest that services are not equitably distributed across the state. Even when services are available, their utilization varies significantly, especially in relation to the use of SPA services versus 1115 waiver services. To effectively respond to and meet the access demands of all populations and geographical areas, additional services and supports may be required, or existing service requirements may need modification.

Increased flexibility in the current service requirements.

Assessment

Providers and other interested parties universally identified the need for increased flexibility when implementing the 1115 waiver crisis services, especially concerning staffing requirements and the specific difficulties rural providers encounter in meeting these standards. Focus group participants indicated that the 1115 services seem more appropriate for urban settings and do not consider Alaska's unique geographical diversity and the variance in its delivery systems. The assessment determined that providers have also struggled with meeting certain staffing requirements, such as round-the-clock nursing, to set up crisis stabilization centers (CSCs).

Options

The state could contemplate where it can introduce more flexibility in staffing requirements. For instance, the State of Washington is currently implementing a performance program for its mobile crisis response teams.[13] This program sets voluntary performance standards and offers an enhanced rate for teams that meet these standards. Performance metrics vary depending upon whether the individual receiving a response resides in an urban, suburban, or rural area.

There may also be opportunities for the state to adjust staffing requirements specific to CSCs. This could involve setting different standards for CSCs in rural areas compared to urban areas, similar to Washington's approach in its performance program for mobile crisis response. Alternatively, it could involve establishing a tiered system with different levels of CSCs, each with varying rates and requirements, depending on a facility's ability to meet requirements like 24/7 nursing.

Development of separate services for adolescents and adults.

Assessment

During interested parties' interviews, providers shared a number of examples of innovative programs and supports for youth and adolescents. We also heard support for the Behavioral Health Roadmap Project for Alaska Youth efforts and the listening session engagement.[14] Interested parties highlighted that they hope the state will continue to leverage the BH Youth Roadmap effort to help support the youth behavioral health continuum, act upon the recommendations shared and consider opportunities to scale and spread innovative programs. While some interested parties recognized the progress being made in youth behavioral health, there are opportunities to further develop adolescent specific services and supports, further define specific guidance to ensure understanding of expectations and requirements for services and facilities.

Options

Alaska has previously recognized and acted upon the need for enhancements to the behavioral health service array for youth. The steps taken to improve mental health outcomes for youth are documented in that state's 2023 report, "Overview of Alaska's Behavioral Health System of Care for Children.[15] In the report, the state highlights a number of advancements that have been made in the state's crisis system. For example, the report notes the improvements in early-stage outreach, prevention, and intervention services made via the 1115 waiver to reduce reliance on late-stage crisis services. The report also identifies the new subacute crisis centers and the Psychiatric Emergency Services (PES) program as examples of ways the state has expanded service delivery methods and facility types, including for crisis care.

While the report highlights the state's commitment to improving the behavioral health system, it reflects that more can likely be done to customize services and supports for the adolescent population. Alaska has taken steps within its SUD Residential service array to specifically identify adolescent services, codes, and rates, including in ASAM 3.1 and 3.5. However, Alaska may need to further review and consider the rates for SUD residential for ASAM 3.1 to ensure appropriate funding is allocated to support the needs of adolescents. Additionally, DBH may consider if there are other services across the crisis continuum that might benefit from youth and/or adolescent specific service guidance, separate codes, and different rates.

Specifically, DBH may wish to consider implementing a crisis service model targeted at children and adolescents such as Mobile Response and Stabilization Services (MRSS). MRSS is available to any young person under the age of 21 who is experiencing escalating emotional symptoms, behaviors, or traumatic circumstances that have impacted their ability to function within their family, living situation, school, or community.[16] Unlike traditional crisis screening, triage, and referral services, MRSS entails rapid deployment of a team of specialized child and adolescent trained staff that can provide interventions that build on natural support structures in the environment where the crisis occurs.[17] MRSS emphasizes that services and supports should come from providers who are trained in serving children and adolescents and that the crisis need should be defined by the child and their family.[18]

In Ohio, the state provides a suite of resources to train providers and the community on MRSS and its core tenets, including that services are available 24/7, as well as family-oriented, culturally-responsive, and trauma-informed, among other standards.[19] As Alaska considers training and supports for providers and community partners, DBH could build on the work established by the Center for Training and Staff Development, Alaska Child and Family, to support residential care for children and youth agencies, and consider what additional services could benefit from a specific training center to support growth and learning across the community.[20]

Additional options for place-based crisis care.

Assessment

Alaska recently established two sub-acute facility types as part of HB 172: CSCs and crisis residential centers (CRCs). The state issued interim guidance for temporary licensure as it works to establish permanent standards that are clear and ensure quality of care standards. During discussions with interested parties, providers expressed that the interim licensing process has posed challenges and hindered their ability to proceed developing such facilities. Additionally, providers suggested implementing additional step-down approaches to facility-based care and, in some cases, creating a tiered payment methodology to support their capabilities.

The assessment identified that an inability to meet licensing requirements has led to a lack of variety of types of facilities in or through which crisis services are offered. Specifically, stakeholders noted that there is a dearth of place-based crisis care options to support individuals receiving care in their communities.

Options

As Alaska evaluates its options and finalizes the subacute facility licensure requirements, it can broaden the range of "places to go" during a crisis in a way that provides alternative models or structures for communities where it is not currently feasible to meet the sub-acute facility licensure requirements. Examples include:

- **Behavioral health urgent care.** To the extent that the requirement that CSCs maintain 24/7 operations is an insurmountable barrier for some communities, some states have invested in behavioral health urgent care facilities to supplement 23-hour crisis stabilization facilities. For example, when Missouri recently established certification standards for Behavioral Health Crisis Centers (BHCC) it also established standards for Urgent Care Behavioral Health Crisis Centers (U-BHCC) in the same rule.[21] The primary distinction between U-BHCCs and regular BHCCs is that U-BHCCs are permitted to operate less than 24/7, while BHCCs must maintain 24/7 operations and provide support to individuals for up to 23 consecutive hours. To address concerns from some providers in Alaska about their ability to accept involuntary transfers, an urgent care model supplementing CSCs might offer a more feasible option.
- **Living rooms.** This model provides a crisis respite setting, often staffed by a mix of licensed mental health professionals and peers, including recovery support staff, and offers an alternative to more clinical settings in a more home-like setting. This model has been established in states including Illinois and New York.[22,23]

- **Peer respite facilities.** These facilities are staffed by people with lived experience and offer an alternative to a more clinical setting. Several states have established peer crisis and respite programs, including New York, Massachusetts, and Wisconsin. Wisconsin's peer respite programs prioritize a home-like environment, and in some cases, offer overnight support.[24,25]
- **Short-term residential facilities.** The national guidelines refer to short-term residential facilities as "small, home-like short-term residential facilities [that] can be seen as a strong step-down option to support individuals who do not require inpatient care after this crisis episode." While Alaska's CRCs are intended to provide a residential option capable of accepting involuntary admissions, some facilities might not be able to meet this standard. Similar to behavioral health urgent care, an additional residential facility type that accepts lower acuity individuals might provide an additional step-down option for individuals upon exiting a CSC. Peer respite facilities can also serve such a purpose.

Access to wrap-around care and HRSN services.

Assessment

Focus group participants shared that a well-functioning crisis system includes a comprehensive service array that both identifies individuals at risk prior to a crisis event and continues support after individuals are no longer receiving crisis services. Interested parties also highlighted the importance of pursuing increased access to services to address health-related social needs (HRSN), including housing and housing support services. By addressing the root causes of stress and/or instability that may exacerbate behavioral health issues, the state can proactively serve individuals that have experienced or are at risk of crisis.

Options

Prevention and Post Crisis Wraparound Services

To address the need for behavioral health services that begin and end prior to or after the crisis has occurred, DBH could consider investing in early identification and prevention programs such as community mental health first aid programs and increase school-based behavioral health services. Community mental health first aid programs are programs that teach community members the skills needed to recognize and respond to the signs and symptoms of mental health and substance use challenges and how to provide support to an individual prior to them obtaining professional help.[26] Course participants are taught a five-step action plan to help individuals in crisis access the care they need.[27] Individuals who receive training in community mental health first aid can provide the first intervention for a person in crisis, often far before the individual has the opportunity to seek professional help. Community mental health first aid is also typically rendered by a person who the individual in crisis trusts. This preexisting relationship may increase the likelihood that the person in crisis expresses their needs and has the support to follow through with obtaining care.

DBH may also consider the feasibility of expanding access to school-based behavioral health services. Research has demonstrated that students are more likely to seek necessary behavioral health supports when school-based services are available.[28] By meeting students in an environment where they are comfortable, providers are uniquely positioned to identify opportunities to intervene prior to a crisis occurring or identify if post-crisis services are needed. School-based behavioral health services can vary in scope from school-wide prevention efforts to individualized interventions.[29] Services are funded through multiple sources including district funds, federal grants, partnerships with community organizations, and state funds. Schools can also be reimbursed by Medicaid for health services provided to eligible, enrolled students.[30] DBH may wish to explore what opportunities to further fund school-based behavioral health services and at least ensure that Medicaid is appropriately covering services provided in schools, to all eligible students not just individuals with IEPs.

Progress has already been made toward this goal through a bill spearheaded by DOH to remove the existing caveat that Medicaid services can only be provided to students with Individualized Education Plans (IEPs).[31] House Bill 344 (HB344) was introduced by the Governor and is the result of extensive stakeholder engagement across the DOH, families and children, school systems, and provider communities. The bill continues to move through the legislative process and is expected to be presented to the Governor for signature imminently.

Another approach to providing wraparound services targeted at youth could be through implementing a MRSS program. As described above, MRSS uses a specific team that specializes in supporting children and adolescents to facilitate an immediate response to a crisis. Then, after resolution, the team continues to provide stabilization services, including connections to follow-up services and support and any needed treatment service.[32] While it is important to note that MRSS is different than adult mobile crisis intervention, the approach of leveraging the team to support in post crisis follow up and resource connection is one that could be explored.

Health Related Social Needs

Individuals experiencing homelessness are at increased risk for experiencing a behavioral health crisis due to a number of risk factors, such as high rates of abuse and trauma, untreated physical health conditions, as well as increased likelihood of being arrested and incarcerated, which leads to a cycle of disconnection from the behavioral health system and the potential for recurrent homelessness.[33] Therefore, addressing an individual's HRSNs that may exacerbate their risk of experiencing a crisis is a potential proactive approach to reducing the incidence of crisis.

The federal environment is ripe with opportunity to consider how to incorporate housing and housing support services, as well as other services addressing HRSN, into Medicaid. CMS has recently released guidance highlighting and encouraging state efforts to provide services targeted at HRSN through a number of different Medicaid authorities, including in lieu of services (ILOS) and 1115 waivers.[34] CMS has recently approved 1115 waivers providing services in the areas of housing, nutrition, and case management, as well as infrastructure costs for implementing those services.[35] Infrastructure is considered to be any expenditures that support the implementation and delivery of HRSN services. This may include technology; development of business or operational practices; workforce development; and outreach, education, and stakeholder convening.[36]

Alaska has recently moved one step closer to pursuing this option. In addition to the school-based health care provisions championed by DOH, HB344 also grants authority to pursue a 1115 waiver targeted at HRSNs. Specifically, the bill seeks to "establish one or more demonstration projects focused on addressing health related needs and supportive services...defining those needs as social or economic conditions that contribute to an individual's poor health outcomes and may include nutrition and food security, workforce development, transportation, temporary housing and case management."[37]

Support regional planning and accountability.

Assessment

As previously noted, crisis services are neither equitably available nor used across the various regions of the state. The evaluation process revealed a need for further improvements to the regional crisis system. Given Alaska's geographical disparity, it is crucial to customize crisis systems to suit the unique characteristics of the region in which they operate.

Options

Alaska has already embarked on building out regional system of care approaches and designs to support a robust continuum of behavioral health care for youth.[38] Alaska could consider how this work could expand to the full system and include adults. This work could aim to assess and inform the services needed for the region and/or catchment area and incorporate the need for Alaska to build a crisis continuum that is responsive to both adults and youth. Additionally, some interested parties expressed their appreciation for the facilitation and support provided by the Alaska Mental Health Trust (the Trust) and hope that could be continued and built upon.

Interested parties suggested assessing regional hubs or a hub and spoke approach for crisis care. A regionally based hub and spoke model could allow for increased coordination across the crisis system, especially in deploying mobile crisis services.[39] Some examples of models that have used regional accountability to support crisis system of care coordination include Washington and Arizona, which use regionally based systems to manage and pay for the crisis system continuum. Additionally, Arizona has also developed regionally based tribal behavioral health system to support the tribal communities and providers. When considering a regional hub and spoke approach, the state may also look to the model used to support access to treatment and support for medications for opioid use disorders (MOUD) services. This model is used in several states including Vermont, Washington, New Hampshire, and Colorado and has been leveraged to increase rural access. The hub sites are located regionally, and individuals

receive initial intake and management of services for MOUD, while the spoke sites located through the region/community, individuals receive ongoing treatment, monitoring, and support services.[40,41]

Expand services to reimburse traditional healing and health practices.

Assessment

Through the documentation review and discussion with key interested parties, especially tribal behavioral health providers, it was identified that current crisis service descriptions are centered in a western medical model, which limits providers' abilities to deliver more culturally appropriate services, including tribal health practices. Providers expressed a desire to have more flexibility and clarity on what is possible when delivering traditional healing services.

Options

DBH in partnership with DOH's Tribal Health Program could explore approaches to address the need for crisis services to cover traditional healing services. With any approach, Alaska should center the voices of Alaska natives and tribal behavioral health providers to ensure the solutions are culturally responsive, allow for flexibility, reflect the needs of the population, and honor the sacredness of the traditional healing services.

Create flexibility in service definitions and other requirements to allow for tribal health services to be provided. DBH, working in partnership with Alaska Native Health Board, Tribal Health Organizations, and the Tribal Behavioral Health Directors, could explore specifically what services and supports are needed for Alaska Native communities and how or if these could be delivered within the current crisis services structure. This group could explore what are the real and perceived barriers to providing certain services. Additionally, within the Provider Supports section, we highlight the need for providers to have technical assistance sessions and FAQs to support some of these questions and sort out areas of confusion. Additionally, it may result in updates to the current service guides to provide additional clarity and update language to be more inclusive and culturally appropriate. In Washington state, tribal health providers and communities have sought additional flexibility in service provision. As a result, the state included language in their Medicaid managed care contract to ensure "utilization management practices take into account the greater and particular needs of diverse populations, as reflected in health disparities, risk factors, historical trauma and the need for culturally appropriate care."[42] This has led to increased flexibility in authorization requirements for tribal specific residential services. It has also opened up conversations to investigate how specific service codes and descriptions could support the provision of traditional healing services such as drum circles, beading, sweat lodges, and smudging being considered for group therapy or services provided within residential facilities.

Explore creating traditional healing benefits and supports. While there may be opportunities to make improvements to the current service descriptions and identify how traditional healing services may be able to fit within the current service set, Alaska may need to explore federal flexibilities to support benefits and services. Four states, Arizona, California New Mexico, and Oregon have all pursued covering tribal healing practices through 1115 waiver authority. New Mexico is the only state that has current authority to use Medicaid coverage for traditional healing practices, with Arizona, California, and Oregon proposals still under review. New Mexico's Centennial Care 2.0 waiver provided a self-directed community budget for specialized therapies to members with nursing facility level of care and who receive home and community-based services. Within the list of specialized therapies, "Native American Healers" is included as eligible for coverage under the member managed annual budget.[43] New Mexico's 1115 renewal waiver is still pending and is requesting to continue this current effort and seeks approval for an annual $500 self-directed budget for traditional healing services for individuals enrolled in managed care but not meeting the nursing facility level of care.

On April 3rd during a CMS All Tribes Consultation Webinar focused on Medicaid Coverage of Traditional Health Care Practices, CMS officials shared an initial framework they will use to move forward with approval for these 1115 waiver requests and set forth guidance for other states. The framework outlines eligible beneficiaries, practices and benefits, eligible providers, reimbursement and infrastructure and evaluation.[44] This is important progress and presents an opportunity for Alaska to further expand care options for Alaska Native communities.

Another option exists if Alaska decides to pursue managed care coverage. Managed care plans can leverage" value added benefits or services" to cover traditional healing services. While value added benefits are up to the discretion

of the health plan, most health plans in New Mexico provide a specific amount per calendar year to support traditional healing services.[45]

2. STREAMLINING DOCUMENTATION

A common theme in feedback from interested parties and in Milliman's review of documentation for this assessment was the potential for the state to enhance and overhaul the documentation, guidance, and resources available to providers and other interested parties. Part of this involves better organization of existing materials, while in some instances, it may necessitate the modification of existing documents or the creation of new ones.

Additionally, streamlining documentation may also require training and/or education in authorization and approval for services. For example, individuals experiencing a crisis may have access to services of which they are not aware, or services may not be authorized in necessary circumstances due to lack of clarity in guidance or other documentation. In these instances, ensuring availability and accuracy of guidance is critical.

Organization and accessibility of documentation.

Assessment

The review process of documentation underscored the need to guarantee that documents and materials available online for providers and other interested parties are easy to locate and represent the most recent versions.

Options

Alaska could consider conducting a review of the DOH website, specifically the DBH landing page, to evaluate how information can be located more intuitively and clearly on its website. For example, it could be more clearly indicated that clicking on "Medicaid Provider Assistance Services" will lead to relevant provider manuals, reimbursement rates, and links to appropriate rules and guidance. Additionally, it could be beneficial to remove outdated documents, where possible, and ensure that the most current information and documents are prominently displayed. This could involve moving archived documents to another location as opposed to the landing page and exclusively featuring the most recent versions of documents. While it is appropriate to have archived documentation accessible, issues arise when the top result of a Google search leads to an outdated document. Therefore, ensuring the most recent and relevant information is readily accessible, easily found, and not confused with outdated documents is crucial. When considering reorganization of documentation, leveraging the crisis services continuum as a way to visually organize service-related documentation to reinforce when to use/bill for a specific service along the continuum.

Consistency and clarity in service descriptions, guidance, and purpose.

Assessment

A key issue identified at project initiation was the utilization of the different crisis services, focusing on how extensively and under what circumstance they were being delivered. As described in Section III, the utilization data shows higher usage and expenditures on SPA services compared to the 1115 waiver services. The reasons for this are multifaceted and are further explored in other parts of this section, such as sustainable financing. However, one reason identified during the documentation review and engagement with interested parties was the sometimes-unclear purpose and intent of the different services.

- **Provider manuals.** Currently, the state has two separate provider manuals for the 1115 waiver services, one for "Substance Use Disorders" and another for "Behavioral Health" (i.e., mental health conditions). Also, there is no readily available provider manual for SPA services, outside of the state administrative code.
- **SPA service descriptions.** Again, unlike the 1115 waiver services, there is no readily accessible provider manual outside of the administrative code that provides further clarification for the SPA services. While various approaches have perhaps become customary for how and when these services are utilized in practice, the *written* intent and purpose of short-term intervention services and short-term stabilization services in the Alaska administrative code lack sufficient clarity. This lack of clarity is further compounded when considering the intent of the SPA services within the emerging national framework for behavioral health crisis care. As shown in Figure

5 in Section III, it is not immediately clear or intuitive where within the crisis continuum of care these two services are meant to fit.

- **1115 waiver service locations.** While the purpose and intent of the 1115 waiver services might be clearer relative to the SPA services, certain aspects of the service requirements and standards may not align seamlessly with the intended goal, potentially leading to confusion. Specifically, the location requirements for individual services may not always be intuitive in relation to their purpose. For example, it makes logical sense that MOCR would be provided in almost any location, given its purpose is to offer mobile crisis response in the community. However, it is less clear under what circumstances 23-hour crisis stabilization would be provided at an individual's home, school, or workplace, as opposed to a dedicated crisis receiving and stabilization facility. Appendix C provides a detailed comparison of the location requirements and limitations for the four 1115 waiver services.
- **Crisis coding.** The national guidelines also provide suggested approaches to coding to support billing and reimbursement processes (Figure 11). As illustrated below, the billing codes utilized by Alaska vary from the suggested approaches. Specifically, Alaska uses H2011 for Crisis Stabilization and T2034 for Mobile Outreach and Crisis Response.

FIGURE 11. SAMHSA RECOMMENDED CRISIS CODING[46]

Service	Recommended Coding Approach	Alaska Codes - 1115 Waiver Services
Crisis Line	H0030 – Behavioral Health Hotline Service	*Not in scope*
Mobile Crisis Response	H2011 – Crisis Intervention Service per 15 minutes	T2034
Crisis Stabilization Facility	S9484 – Crisis Intervention Mental Health Services per Hour S9485 – Crisis Intervention Mental Health Services per Diem	S9484 (23-Hour Crisis Stabilization Observation) S4985 (Crisis Residential Stabilization)

Options

Should the state determine a need for enhanced alignment, consistency, and clarity across service descriptions and requirements, there are various options it might consider.

- **Single behavioral health provider manual.** It might be beneficial for the state to create a single, comprehensive provider manual encompassing *both* mental health *and* substance use disorders, 1115 waiver and SPA services. This manual could include all such services, irrespective of the federal or state authority, and feature a detailed crisis services section. Consolidating all necessary information in one location reduces the risk of version control issues and mitigates the potential for confusion for providers and other parties seeking to reference the manuals. Furthermore, it could further assist the state in clearly defining its crisis continuum - that is, determining where, when, and under what circumstances certain services should be utilized and billed.
- **Service location guidance.** Whether or not the state decides to create a comprehensive manual or a single source of guidance for all mental health and substance use disorder services, it might need to consider providing additional clarity specifically related to the service locations for the 1115 waiver services. Ensuring that these service locations are intuitive and aligned with the service's intended purpose could, again, help further define the state's vision for its crisis continuum and identify additional gaps in the continuum. This could involve modifying the permissible service locations or offering further guidance and examples of situations where a service might be suitable for delivery in a specific location – e.g., if/when it is appropriate for 23-hour crisis stabilization to be provided outside of crisis receiving and stabilization setting.
- **Revise and/or remove services.** If the state identifies a need to align service descriptions and requirements across the continuum, while ensuring clarity and consistency in documentation, it may also need to consider the potential redundancy of certain services. In such cases, it might be appropriate to revise (for instance, consolidate or create tiers) and/or eliminate certain services. However, these actions should not be taken in isolation. Instead, they should be implemented in conjunction with relevant financial, policy, and programming

decisions to avoid unintended consequences that could impede providers' ability to deliver services or consumers' ability to access them. For instance, if the state determines a need to remove or consolidate services, it will want to consider the financial implications for both the state and providers and align such an action with a corresponding rate review. Additionally, as the state considers the need to revise and/or remove services, it might wish to review the billing codes it uses for the different crisis services and determine whether it would like to align with the suggestions in the national guidelines (as illustrated above in Figure 11).

Clarity and certainty in facility licensure

Assessment

As highlighted in various sections of this report, providers have expressed a need for enhanced clarity, certainty, and flexibility concerning the licensure requirements for subacute facilities established in HB172, both in public comments and focus groups. Some providers indicated that the uncertainty surrounding potential changes to the interim licensure requirements upon finalization is a contributing factor to their reluctance to invest in the development of these facilities. Moreover, it was not clear that all focus group participants fully appreciated the interim status of the licensure requirements, and thus the potential for further refinement of these requirements. Regardless, some providers, especially those serving rural communities, have stated their inability to meet the current interim licensure requirements and have called for greater flexibility in the requirements themselves. Milliman's analysis of utilization and expenditure data demonstrated a possible relationship between utilization and providers' perceptions of the licensure requirements. Following the release of the interim subacute facility guidance, there was a significant decrease in claims on 23-Hour Crisis Stabilization and Observation and Crisis Residential Stabilization by 45.8% and 77.8%, respectively, between March and June of 2023.

Options

The state should continue to make sure that all providers grasp that the current licensure requirements are in temporary status and have yet to be finalized. If the state is certain that specific requirements will remain unchanged in the final rules, it may be beneficial to communicate this to providers, providing clarity to aid their planning. Also, as previously discussed in relation to additional options for place-based care, the state, while finalizing the interim licensure guidance, could consider potential modifications to the licensure requirements in a manner that enables more providers to meet the requirements without compromising quality and the state's goals. More broadly going forward, the state should also consider the unintended impacts to certain policy changes and consider additional opportunities for education and technical assistance to clarify to provider the impact of the changes and for providers to have a forum to express future impacts.

Availability of transportation.

Assessment

Key informants noted that lack of transportation is a key barrier for members to access crisis services. This is particularly acute for members seeking to obtain facility-based services. While members may be informed about the services available to them, without reliable transportation, they are unable to access the settings in which the requisite level of care is available. There may also be circumstances in which members should qualify for transportation services, but documentation and guidance on eligibility or utilization parameters are unclear, leading to services not being authorized.

Options

Federal policy guidance outlined in the recent State Medicaid Director Letter (SMD #23-006) addresses requirements and flexibilities regarding Medicaid transportation assurance. States are required to assure that members have transportation necessary to access covered medical services and the federal Medicaid transportation requirement does not distinguish emergency medical transportation separately from non-emergency medical transportation (NEMT).[47] Emergency transportation does not need to be limited to emergency room visits; it can cover transport to various appropriate crisis services, such as mental health facilities, crisis stabilization units, or community-based resources.[48] DBH can review the definition of a qualifying emergency for this state plan benefit to either confirm that it does include crisis circumstances or work with the appropriate stakeholders to update the definition and

corresponding guidance to reflect this. Additionally, Alaska's non-emergency transportation benefit has no utilization limits, ensuring that individuals can access transportation as often as needed without restrictions. Therefore, eligible beneficiaries should be able to utilize non-emergency transportation in the event of a crisis. DBH should evaluate this benefit as well to confirm that it is appropriately authorized for eligible beneficiaries in crisis in a timely manner.

Furthermore, the SMD #23-006 guidance allows states to pay for wait time and unloaded mileage. This provision ensures that transportation providers are adequately compensated for the time spent waiting for patients and for the distance traveled without passengers, thereby encouraging more providers to participate in Medicaid transportation services. This could be beneficial in Alaska's rural or underserved areas, where the distances between service locations can be considerable.

Medicaid state plan benefits are managed by the Division of Health Care Services (HSC), another DOH division. HSC is responsible for facilitating access to services and issuing guidance on service eligibility as needed. To obtain additional clarification on transportation benefits available to individuals experiencing a crisis, DBH should consult with HSC regarding these transportation benefits and in what circumstances they are authorized and reimbursed.

3. ADDITIONAL SUPPORTS FOR PROVIDERS AND COMMUNITY PARTNERS

In speaking with providers about ways to improve crisis service delivery, many providers appreciated the level of partnership from DBH. However, they expressed a desire for more support from DBH in understanding the state's expectations and meeting implementation requirements for crisis services, including the 1115 waiver services. Providers identified a lack of technical assistance support and resources as one barrier to service adoption. A number of interested parties also emphasized the importance of building relationships between providers and community partners such as law enforcement. Providers recommended training law enforcement to manage crises in a way that aligns with best practices. Finally, workforce shortages were identified as a key concern. Providers expressed that they continue to struggle to train and retain enough qualified staff to effectively implement comprehensive crisis programs and services. This is of particular concern for providers in Alaska's many rural and frontier areas.

Technical assistance for crisis providers.

Assessment

Providers expressed challenges with implementing the 1115 waiver services, highlighting their desire to offer these services but acknowledging limitations in their capacity and understanding of the required service components. Many commenters described significant administrative burdens experienced in implementing the waiver services and highlighted provider enrollment and data entry requirements as issues exacerbating ongoing workforce shortages. Providers expressed a desire for additional support, transparency, and responsiveness from DBH in navigating the administrative processes to stand up crisis services.

Options

DBH recognizes the need for technical assistance and has issued a draft request for proposals to contract with a behavioral health organization (BHO).[49] The primary role of the BHO will be to facilitate provider technical assistance materials, trainings, and other support needed to implement behavioral health services, including crisis services. DBH intends for the BHO to be responsive to provider concerns and pivot its resources and support based on what is most critically needed.

A core element of the services offered by the BHO will be producing and disseminating guidance documents, including manuals, FAQs, and billing guides, as appropriate. The BHO will seek to make critical information like service standards and provider qualifications easy to access and understand in hopes of mitigating provider confusion or difficulty in understanding expectations. The BHO will also be expected to host technical assistance trainings, task force meetings, and other collaborative sessions in which providers can openly express the challenges they are experiencing and obtain guidance or support in resolving those challenges. Oftentimes, multiple providers may face the same issue concurrently. DBH and the BHO seek to provide a space in which providers can troubleshoot these concerns with other similarly situated individuals and make connections.

Additionally, the state has partnered with the University of Alaska Anchorage (UAA) to implement the Alaska Training Cooperative, which promotes career development opportunities for direct services professionals in the behavioral health workforce. The Training Cooperative offers online and in-person training opportunities such as webinars and conferences. DBH could consider collaborating with UAA to enhance the resources available through the Training Cooperative and ensure that sufficient crisis-specific resources and information exist.

The state of Wisconsin provides a model that DBH, or the BHO, may wish to follow in disseminating crisis services information to providers. The Wisconsin Department of Health Services has a dedicated crisis services landing page with information about meetings, applicable laws and regulations, and opportunities for collaboration in the crisis space.[50] For example, the webpage links to information about monthly virtual meetings between crisis providers and numerous divisions that interact with these providers, including Medicaid. Additionally, the page contains clearly labeled links for program certification, tools, training opportunities, and technical assistance contacts. Furthermore, the state has entered into a behavioral health training partnership with the University of Wisconsin-Green Bay.[51] The partnership offers both a core crisis training to prepare crisis staff to deliver supportive interventions and an advanced crisis training, covering Mobile Crisis Teaming and Harm Reduction training.[52]

Training for community partners.

Assessment

Another additional support requested by interested parties was training for community partners including law enforcement. Providers expressed challenges in coordinating crisis care with community partners who may not have the knowledge or resources to deescalate a crisis. Providers sought additional training, education, and support for law enforcement specifically regarding how to appropriately respond to individuals in crisis and connect them to the appropriate care.

Options

DBH or its state partners may wish to consider broadly implementing a targeted training program for law enforcement to learn about interacting with individuals experiencing behavioral health conditions and/or crises. One option is the Crisis Intervention Team (CIT) program. CIT is a community-based program that brings together multiple partners, including law enforcement, providers, and individuals experiencing behavioral health conditions and/or SUD, to improve community responses to behavioral health crises.[53] The basic goals of CIT are to develop compassionate and effective crisis response systems that are the least intrusive in a person's life and to help persons with behavioral health conditions and/or SUD access medical or behavioral health threat rather than placement in the criminal justice system.[54] In addition to other elements of community support and partnership, CIT programs include trainings through which law enforcement can become a qualified CIT officer who will be dispatched to crisis calls that arise during their regular patrol shift.[55] CIT training is designed in a manner that considers the realities of daily policing and puts officer safety at the forefront.[56] There are examples of CIT already in Alaska, but it may need to scaled and consider specific customization for rural communities and serving Alaska Native communities. The state may consider working with its state agency partners that oversee law enforcement, including state troopers, to ensure this model and other training is disseminated and there are accountability mechanisms in place to ensure law enforcement have received proper trauma informed, harm reduction training.

Workforce supports.

Assessment

While much attention has been drawn to building the behavioral health workforce over the last several years, interested parties shared that they continue to struggle to find and retain qualified providers in order to build out and sustain their crisis service capacity. Providers highlighted that key issues include hiring and retaining enough qualified staff, growing capacity, and a staff pipeline in Alaska, and ensuring that all providers are working at the top of their licensure. These issues are especially acute in rural and frontier areas.

Options

Alaska has implemented several targeted workforce enhancements, such as peer guide programs and other supports specifically for the behavioral health provider community. However, DBH could consider what other types of

interventions are appropriate for incentivizing providers to stay in Alaska, and, in the meantime, how to address services gaps.

- **Loan Repayment and Forgiveness.** One type of incentive pursued by a variety of states hoping to bolster their provider workforce is student loan reimbursement and forgiveness programs. Michigan is one state that offers such a program. In Michigan, behavioral health providers who practice in underserved areas of the state can be eligible for up to $300,000 in funds for repaying educational debt over up to 10 years of participation. Participants must enter into two-year agreements with eligible nonprofit practice sites. Services can be provided at state community mental health authority sites, school-based sites, non-profit outpatient behavioral health clinics and non-profit outpatient community health organizations.[57] The Alaska Department of Health provides student loan repayment and incentives to a number of providers, partially with federal funds and employer funding.[58] DBH may consider ways to work with state partners to build additional behavioral health staff specific programs and consider opportunities to support paraprofessional education and support to increase the number of peers and behavioral health aides.
- **Providers working at the top of their license and increasing peer-based services.** DBH may also consider how to incentivize providers to practice "at the top of their license," including working to the full extent of education, training, and competence. Approaches to this may include increasing reciprocity in state licensure requirements and/or pursuing tiered certification approaches.[59] For example, a state could allow tiered certification for critical roles such as nurses and social workers to move providers into practice earlier in their training.[60] Supporting providers at the top of their license also requires a diverse, multidisciplinary staffing model that leverages non-licensed provider types, including peers.[61] Alaska is already on the leading edge of this work in approving and promoting peer-based services and the Behavioral Health Aide position to promote wellness and behavioral health within Alaska Native communities. [62] Alaska could consider opportunities to further incentivize and grow this important component of the workforce, by expanding training opportunities and incentivizing providers who employ and use peer-based services.
- **Use of Technology to Extend Access to Behavioral Health Workforce.** Lastly, Alaska could look to other states that have leveraged technology to create a more immediate connection to behavioral health workforce. In Oklahoma, behavioral health providers have leveraged tablets to facilitate increased connection to their clients and community members in crisis, as well as support community partners responding to someone in crisis, such as law enforcement, EMS, local libraries, and other community centers. The tablets allow for more immediate access to assessments and connection to the crisis helpline. Tablets are also equipped with a connection for the first responders to debrief after a traumatic experience in responding to crisis. This helps decrease the impact of that trauma on the first responder's mental health, which if not addressed, overtime can lead to burnout.[63]

4.SUSTAINABLE FINANCING

As Alaska works to establish a robust, statewide crisis continuum of care, ensuring adequate and suitable funding for this system will be essential. This involves not only setting appropriate and sustainable reimbursement rates, but also making ample capital investments to build the necessary infrastructure to support the system. Additionally, financial incentives should be structured in a way that encourages desired outcomes and utilization. Recognizing that securing adequate financial resources can often be a challenge, the state will likely need to prioritize its needs and consider other policy and programming measures that support financial stability.

Provider rate methodology review.

Assessment

Participants in the focus groups and key informant interviews universally highlighted the overarching need to ensure adequate funding for the behavioral health crisis system. At the service-delivery level, this implied the need for sufficient reimbursement rates – specifically, rates that cover providers' costs and enable them to meet the necessary staffing and service standards for crisis care delivery. There was also widespread recognition of the high costs associated with developing the physical infrastructure required for these programs. Providers in rural areas noted that

there is little room for error in the development of this infrastructure due to the costliness of shipping materials to less densely populated areas and the increased risk for delays in construction.

Options

Milliman did not conduct an analysis of payment rate adequacy to validate these concerns. The Alaska Department of Health is actively procuring a contractor to perform a comprehensive evaluation of Alaska Medicaid payment methodologies,[64] the scope of which includes behavioral health services (state plan and 1115 waiver) and requires a collaborative approach integrating stakeholder engagement into the review and development process. The behavioral health service category draft methodology report is due December 1, 2024, and may identify potential methodologies and/or changes to existing methodologies through the review of the critical assumptions underlying the rate setting (e.g., staff wages, administrative overhead, transportation, etc.), which may alleviate the financial barriers to the expansion of and full implementation of crisis services.

The Medicaid payment methodology evaluation project may also remediate the higher payment rate for the state plan service short-term crisis intervention as compared to the 1115 waiver service 23-hour crisis observation. The state plan service is community-based and does not require 24-hour staffing or a physical infrastructure to be licensed, as does the 1115 service, resulting in higher provider costs.

Two rate setting methodologies that merit further exploration are the **firehouse model** and **total cost of care**. As referenced in Section II, the fundamental principle of behavioral health crisis care is its availability to anyone, anywhere, at any time. Similar to emergency services for physical health, the goal is for crisis providers to be prepared and able to respond whenever a need arises. This means providing a response to an individual 24 hours a day, 7 days a week, 365 days a year, regardless of their insurance status. Given that the demand for crisis services can fluctuate and be unpredictable, especially in the short term, it can pose a challenge for providers to staff their programs in a financially sustainable manner. Consequently, national guidelines have proposed, and some states have started to adopt, a "firehouse" funding model. This model combines multiple funding sources to cover the *actual operating costs* of providers regardless of the utilization provided. Providers are expected to deliver a timely and high-quality response when needed, while being shielded from the financial risk associated with the variability in service utilization inherent to crisis services.

Rebasing.

Assessment

Section 7 AAC 145.580 of the Alaska Administrative Code, behavioral health services payment rates, requires the Chart of Community Behavioral Services Medicaid Rates to be rebased every four years but does not include a rate rebasing schedule for the 1115 waiver services.

Options

Codifying the schedule by which the 1115 waiver services will be reestablished is an opportunity to signal the state's commitment to transparency and provide security to providers regarding a review of the crisis services' financial sustainability. DBH may consider amending Section 7 AAC 145.580 of the Alaska Administrative Code to specify the rebasing timeframe and modeled rate methodology for updating the 1115 waiver services.

Capital investments.

Assessment

As states nationwide work to enhance their crisis care delivery systems, they frequently find themselves needing to invest in additional infrastructure to support these systems. This was a common theme in focus groups with Alaska provider organizations, with the development of CSCs and CRCs being the most frequently cited examples. The extent of what is needed varies based on each provider's starting point - i.e., some providers are further from being able to meet the facility requirements. As previously noted in the context of the rate methodology review, this presents a unique challenge in Alaska, where shipping materials to more rural communities is especially costly, and delays can have significant financial implications.

Options

Capital investments in infrastructure will likely necessitate specific appropriations from the state for this purpose. To make these investments, the state will need to identify which entities and funding streams are capable of providing such support. For instance, in the state of Washington's mobile crisis performance program, the state allocated funding specifically for the creation of establishment grants. These grants are for the purpose of assisting providers in meeting the new standards set forth in law, such as purchasing vehicles for mobile crisis response.

If securing funding for such business investments is currently unfeasible, the state might consider how it can help providers build capacity using alternative mechanisms. This could involve supporting providers with more affordable capital investments, i.e., items that do not necessitate the construction of new buildings but might involve more modest and less costly repurposing of existing spaces or infrastructure. However, if facility licensure requirements currently pose a barrier, the state might need to consider where it can allow flexibility and/or establish additional types of place-based crisis care, as discussed earlier.

Service-specific incentives.

Assessment

As discussed in Section III, in general, the SPA services are utilized more than the 1115 waiver services. Various reasons for this are discussed throughout this report. One reason, mentioned earlier, is the financial incentives that favor the utilization of SPA services. This occurs despite the state's general intention to increase the utilization of the 1115 waiver services as it continues to develop its crisis system. This is particularly noticeable, as shown in Figure 10 in Section III, when comparing the rate of short-term crisis intervention to the rate of 23-hour crisis stabilization and observation, with the former's rate being 10% higher than the latter's. As discussed above, this is the case despite the SPA service having relatively more relaxed staffing and service-location requirements. If the state aims to incentivize greater use of the 1115 waiver services, it might need to consider restructuring financial incentives to favor those services.

Options

As discussed in the context of a potential rate review, the state might consider whether a higher rate for 23-hour crisis stabilization is warranted. If the rate is lower than that of crisis intervention, despite potentially having service requirements that incur higher costs, it remains unclear why the SPA service would have a higher rate.

Beyond merely adjusting the rate for 23-hour stabilization, the state can explore other targeted incentives for the 1115 waiver services. For instance, the state could initiate a value-based payment program for crisis services providers, offering financial incentives specifically tied to the 1115 waiver services.

Request Temporary Enhanced FMAP for Community-Based Mobile Crisis Intervention Services

Assessment

Sustainably financing crisis care is a challenge across the continuum, but it can be particularly difficult in the context of mobile crisis response. The nature of mobile crisis response necessitates that response teams are available 24/7 to provide support wherever a crisis is occurring, regardless of demand at any specific time. This presents a challenge in communities nationwide, and Alaska, with its uniquely expansive geography, is no exception.

Options

One strategy Alaska could consider is leveraging the opportunity for enhanced federal medical assistance percentage (FMAP) under Section 9813 of the American Rescue Plan Act (ARPA). This section provides a temporary option for state Medicaid programs to cover community-based mobile crisis intervention services for individuals undergoing a mental health or substance use disorder crisis.[65] Many states already cover mobile crisis programs through Medicaid, utilizing authorities such as the rehabilitative services option, Home and Community-Based Services (HCBS) under sections 1915(i) and 1915(c) waivers, managed care waivers, and Section 1115 demonstrations.[66] The main difference between the ARPA provision and existing programs is that under ARPA, states can qualify for an 85% Federal Medical Assistance Percentage (FMAP) for mobile crisis services.[67]

To qualify for the enhanced FMAP, states' mobile crisis response systems must be approved by CMS, ensuring they meet the requirements of ARPA, as outlined in the CMS guidance.[68] Services must be provided to Medicaid eligible individuals experiencing a mental health or SUD crisis. Services must be available outside of a hospital or other facility setting. Another notable requirement is that crisis teams must be available 24/7/365.[69] Additionally, teams must be composed of a behavioral health professional and should also include other professionals and paraprofessionals (e.g., peer support worker) who are trained in trauma-informed care, de-escalation strategies, and harm reduction.[70]

If a state's existing benefit under a SPA, a 1915(c) HCBS waiver, a 1915(b) waiver, or a Section 1115 demonstration already meets these requirements, the state may be eligible to obtain the enhanced FMAP.[71] Alternatively, CMS guidance instructs that a state may modify one of the above authorities to ensure that the service is ARPA-compliant. Once approved, states will receive the enhanced FMAP for the first 12 quarters in which a state's program complies with ARPA within the five-year period stipulated in the law, which runs from April 1, 2022, through March, 2027.[72]

Alaska's 1115 waiver currently authorizes Mobile Outreach and Crisis Response services. The service is designed to prevent a mental health crisis or to stabilize an individual during or after a mental health or SUD-related crisis. The service is described in the waiver as consisting of triage and assessment, crisis intervention and stabilization, referral and linkage with community resources, medication services, mediation services, and skills training services.[73] As outlined in the provider manual, the service is available in any location in the community, 24 hours a day and 7 days a week. The service is delivered by a team of at least two staff, a professional clinician, and a qualified behavioral health provider, with an exception in rural areas.[74] Based on this description and initial analysis, this service may qualify for enhanced FMAP.

5.COMMUNITY COLLABORATION

To support increased alignment and coordination across the behavioral health crisis continuum, state agency staff and community partners will need to continue and expand collaboration efforts at all levels of this work. Across the key informant interviews, this came forward as both a strength as well as a continued need.

Expanded opportunities for collaboration across state agency partners.

Assessment

With numerous initiatives moving forward to address the behavioral health crisis continuum and the behavioral health system in general in Alaska, multiple agencies and agency departments within Alaska are responsible for different components of this system. These types of major and on-going systems changes need intentional coordination and communication on a regular cadence. It was evident during the inter-agency key informant interview there was interest in further engagement with their colleagues and even real-time identification of opportunities for increased partnership and coordination.

Options

Facilitation, project management, and state specific collaboration software will be useful to support agency collaboration. Leadership direction and sponsorship is also helpful for reinforcing the need for staff to act together and toward what shared goal or issue. It may be useful for DBH to host regular collaboration spaces across relevant departments and agency staff. Additionally, agencies may consider designating a lead staff person that is responsible for ensuring connection and cross department/agency collaboration.

Expanded opportunities for collaboration with community partners.

Assessment

In addition to state agency specific collaboration, state agency partnership and collaboration with the community partners is critical. Within the key informant interviews, DBH staff were commended for their community outreach and partnership. Community partners highlighted opportunities for this type of state collaboration to expand. There is a desire to create more spaces with DBH and other state staff and community partners. Key informants specifically

mentioned the DOH and DCFS Complex Care Initiatives committee structure as one that could be leveraged to support other cross-agency and community collaboration.[75]

Collaboration is also imperative across communities and sectors. The Alaska Mental Health Trust has taken a leadership role in investing in region/local community collaboration to address improvements in the crisis system. Key informant interviews suggested this work had been very supportive in aligning community approaches to crisis care and should continue. There are already strong examples of this in a number of communities, including Fairbanks, Anchorage, Mat-Su, Ketchikan, and Juneau. In Fairbanks, the community collaboration has included the fire department, public library, and homeless shelters partnering to support crisis implementation efforts. The Crisis Now monthly newsletters funded by the Trust share important updates regarding the local crisis system planning and are excellent evidence of on-going collaboration.

Options

Alaska could build on the strong foundation already set forth by DBH and the Trust and could work to further formalize the Crisis Now community collaborative structures that have formed. With a more formalized approach across community partners established, communities may be able to align more strategically to build out needed components of the crisis continuum and consider opportunities for the individual parts to work better together. The state could reinforce this structure through engagement and/or funding opportunities to incentivize further partnership. Like some of the early examples shared in the assessment, the crisis collaboration structure could hold regular meetings and those meetings could be attended by multiple sectors that participate in and/or engage with community members experiencing crisis beyond behavioral health providers, such as first responders, law enforcement, housing providers, advocates, and those with lived experience. This structure would facilitate further collaboration across community partners and could also create a central engagement point for state partners. [76]

Shared care planning, closed loop referral platform, and community information exchange.

Assessment

Interested parties elevated the need for shared care planning and closed loop referral software and other examples of community resource referral platforms. They shared that it would be beneficial to have such tools to help support connection and collaboration across providers and community-based organization to ensure individuals are receiving the necessary care and getting connected to needed services without supports and efforts being duplicated.

Options

The goal of shared care planning, closed loop referral platforms, community information exchange, and other similar means of communication is to ensure that all providers involved in an individual's care are receiving critical information about that person's progress and treatment, including connection to social and community services. In many cases, when providers refer individuals for health-related social needs services, such as housing and/or nutrition supports, the referring providers have no way of knowing if the individuals made the connections and received the support services. These technology platforms can support tracking connections as well as provide resource directories for available support services in the area. There are some statewide examples of using shared care planning, closed loop referral systems and community information exchange systems, whereas in other cases, local communities or even individual health plans and provider systems will choose to use a system. Alaska could consider selecting a statewide system and directing its use like North Carolina.[77] This could support standardization across the state and address some barriers to interoperability across systems. Also, Alaska could also set forth standards for communities and providers to use a shared care planning template or tool to support increased coordination. Oregon developed a shared care plan tool and required its use to support cross system coordination for children with special health care needs. [78]

Alaska's 2023 State Health Improvement plan proposed to achieve health-related goals in part through developing "a statewide closed loop referral management system that includes healthcare, public health, and social services." Partners identified for the initiative included the Division of Public Health (DPH). As DPH continues to pursue this goal, DBH should provide its input on how to best integrate crisis providers.[79]

V. Implementation Considerations

This section is intended to provide DBH with a strategic roadmap for successfully implementing the potential solutions outlined in Section IV. We recognize that DBH may not pursue all these options simultaneously or even at all, as the decision to implement a specific solution will depend on leadership review and further evaluation. Given the diverse implementation requirements of each option, these considerations are designed to provide a flexible yet thorough approach, permitting adjustments as the selected activities are finalized.

Overarching implementation activities are described below. In addition to these overarching implementation activities, there are several implementation levers supportive of multiple solutions outlined in Section IV. These are described below as “cross-cutting levers.” Figure 12 contains a table indicating the necessary activities for implementing each potential option, along with its possible timing.

1. OVERARCHING IMPLEMENTATION ACTIVITIES

Planning and Design.

Regardless of the options selected, a thorough planning and design process is essential for implementation. DBH might consider conducting further evaluations of solutions, assessing potential combinations of options, and performing feasibility studies to determine the practicality and effectiveness of various strategies. Simultaneously, DBH will need to identify and allocate the necessary financial and human resources to support implementation. Understanding the state budget and fiscal impact is crucial for ensuring sustainable funding. DBH could opt to establish a workgroup for each of the five opportunity areas or create workstreams based on selected groups of solutions to pursue.

Once DBH finalizes the design, the planning process involves developing detailed work plans that delineate specific activities, timelines, and milestones for implementation. This includes defining the project's scope, setting clear objectives, and identifying key stakeholders and their roles in the process. Establishing a timeline is critical to monitor progress and ensure activities are completed on time. Essential activities, such as staff training, infrastructure development, and policy adjustments, must be clearly delineated and incorporated into the project plan.

Stakeholder Engagement.

Stakeholder engagement is crucial for the success of any initiative that DBH opts to implement, as it ensures the solutions are responsive to the needs and perspectives of those they impact. While key informant interviews provided significant input into the findings of this assessment, further engagement is essential for informed decision-making, trust, and support building, identifying needs and priorities, enhancing transparency, and fostering collaboration and ownership. This is particularly true when engaging with DBH's sister agencies and Tribal health organizations.

While procedures for updating regulatory authorities require opportunities for public comment, DBH might consider developing additional mechanisms to solicit and collect feedback across all proposed options.

Regulatory Authority

Implementation of the proposed solutions may require DBH to update or secure a new regulatory authority. Currently, both state and federal authorities govern Alaska’s crisis services and enhancements to the service array will likely require revisions to the state administrative code, Medicaid State Plan, and/or 1115 waiver. These processes are time and resource intensive and must be a consideration when determining the available level of effort and implementation timeline.

States have broad flexibility to create benefit packages and provide coverage for optional services to Medicaid beneficiaries insofar as they meet federal guidelines. When adding a new benefit to the Medicaid state plan, a state generally must provide the benefit in the same amount, duration, and scope to all enrollees (Section 1902(a)(10)(B) of the Social Security Act) and make that service available statewide (Section 1902(a)(1)). In order to “waive” these requirements, states must use another authority, typically a 1915(c), 1915(b), or 1115 demonstration waiver.

As described above, Alaska’s Medicaid State Plan specifies short-term crisis stabilization and short-term crisis intervention services as optional services the state has chosen to provide and seeks federal expenditures to cover. If

DBH seeks to add a new service through the state plan and make it available statewide to all enrollees, it must submit a SPA to CMS for approval, at which point CMS has 90 days to approve.[80]

Section 1115 demonstration waivers permit federal financial participation for costs not otherwise matchable, allowing states to cover services and populations not included in the state plan.[81] Implementation of new services on a limited geographic basis or targeted to certain populations would require authorization through an 1115 waiver. Additionally, federal financing for services to address certain HRSNs would also be contingent on 1115 waiver approval. Depending on the degree of flexibility sought, changes to the crisis services currently authorized through Alaska's 1115 waiver will necessitate the submission of an amendment for CMS approval. The standard terms and conditions (STCs) in Alaska's 1115 waiver outline the process Alaska must follow to request an amendment to change the current services and/or implement new services. Notably, Alaska must comply with the public notice, tribal consultation, and consultation with interested parties' procedures as required in 42 CFR 431.408, include a data analysis of the amendment's impact on the current budget neutrality agreement, and provide updates to existing demonstration reporting and quality and evaluation plans to incorporate the amendment provisions.[82]

Once DBH secures federal approval, Alaska will need to update or create new state regulations. Updates to the administrative code would first require identification of the areas of the code that need updates, revisions, or new regulations and then the drafting of new provisions. After review and approval by the Department of Law, the proposed changes must be published for public comment and revised after considering external input. After revision and finalization, the regulations are filed with the Lieutenant Governor's office for official publication.

Payment Review and Rate Development

While rate methodology review is its own proposed solution regardless of any other options implemented, making changes to the existing crisis services, and/or developing new services will necessitate payment review and rate development. To the extent possible, leveraging the Medicaid payment methodology evaluation project to determine which adjustments to provider reimbursement rates may be needed will streamline the process. In some cases, payment rate adjustments to adequately reflect the costs of program requirements may require additional funding to implement, which may require state legislative action.

Updates to Internal Operations and Documentation

DBH will need to review their communication materials, member and provider resources, as well as billing and reimbursement policies. Updates will be necessary to ensure these align with the changes they aim to implement. Communication materials – including FAQs, newsletters, training materials, and the DBH website – may need updates. Similarly, member and provider materials like the member handbook, provider manuals, and billing and reimbursement policies may require revisions to incorporate service enhancements, changes to billing codes, and adjustments to provider certification/licensure requirements, among other things.

2. CROSS-CUTTING LEVERS

When considering the implementation activities, there are some cross-cutting levers that may be able to address the options highlighted in the assessment section collectively rather than through individual policy changes. While each of these levers are major initiatives, they could make a major impact on the full continuum of health and healthcare that can ultimately support the needs identified within the crisis system.

1115 Demonstration Waiver

Alaska has already leveraged the flexibility of an 1115 demonstration waiver to expand services and supports to address behavioral health access including crisis services. This report identifies a number of opportunities that could be pursued through an 1115 waiver including creating additional options for place-based crisis care, pursuing services that address HRSNs, and expanding services to reimburse traditional healing practices for Alaska Native populations. Within the HRSN 1115 waiver guidance, CMS also provides opportunities for states to support new health related social needs case management services. Not only does this provide additional resources and support to connect individuals with health-related social needs services, but these services also provide an additional avenue for outreach and engagement with individuals in need of care. Beyond new services, these 1115 options also present an opportunity for infrastructure investment to support both state, provider, and community capacity needs, including

a number of other items that have been elevated in this report, such as training and technical assistance, community collaboration, workforce, and IT and data systems, including the development of community information exchange and/or closed loop referral systems. The purpose of this infrastructure funding is to support providers who are not traditionally engaged within the Medicaid system, and thus could be an opportunity to grow provider capacities, especially those from underrepresented communities. While not mentioned in the body of the report, Alaska may also want to consider leveraging an 1115 waiver to support paying for pre-release services for up to 90 days for individuals in carceral settings. Additional care and support for individuals within and transitioning out of carceral settings may create opportunities to prevent crisis upon release. The reentry waivers also come with additional support to improve services and connection across carceral settings and community-based providers.

Certified Community Behavioral Health Clinics (CCBHC)

As underscored throughout this report, there has been a nationwide push to enhance the behavioral health crisis system across the country. This effort has coincided with the establishment and expansion of Certified Community Behavioral Health Clinics (CCBHC). These two initiatives are closely connected, with states and individual providers using the CCBHC model to develop and more sustainably fund the delivery of crisis services.[83]

CCBHCs are required to provide nine core services, which includes the provision of crisis care. Specifically, CCBHCs must guarantee the delivery of the three core components of the crisis continuum: coordination with telephonic/text/chat crisis call centers, round-the-clock mobile crisis response teams, and crisis receiving/stabilization services.[84] CCBHCs are permitted to deliver these services directly or through a formal partnership with another provider organization. This requirement has served as an additional impetus to enhance the crisis continuum of care.

Alaska was one of the 24 states selected to participate in the 2015 Planning Phase of the CCBHC State Demonstration operated by SAMHSA and received $769,015 to design and implement system changes to certify two CCBHCs. The state planned to use the PPS-1 rate methodology and require Motivational Interviewing (MI), Integrated Dual Diagnosis Treatment (IDDT), and Medication Assisted Treatment (MAT) to be provided at all CCBHCs. Populations of focus were adults with SMI, children and youth with serious emotional disturbance (SED), and individuals experiencing chronic or serious SUD, particularly pregnant and parenting women with substance use disorders and people actively using IV drugs.[85] After issuing an RFP and selecting two provider groups to help develop and pilot the demonstration, Alaska later decided not to pursue the CCBHC State Demonstration.[86] Three clinics, Alaska Behavioral Health, Fairbanks Native Association Behavioral Health Services, and JAMHI Health & Wellness, Inc., have received a total of four CCBHC grants to meet the CCBHC criteria and provide support for uncompensated care.[87]

If Alaska decides to establish a state CCBHC program in the future - either through a SPA or the federal demonstration program[88] - it could consider how to utilize the CCBHC model to bolster its crisis service delivery system. This model presents a potential opportunity to finance the cost of the crisis care delivery system more sustainably, within a broader effort to strengthen the community behavioral health system. As has been done in other states, CCBHCs could be particularly leveraged to support mobile crisis response and 23-hour crisis stabilization.

Health Homes

Health homes as created under Section 2703 of the Patient Protection and Affordable Care Act of 2010 (ACA) entitled, “State Option to Provide Health Homes for Enrollees with Chronic Conditions” are a Medicaid state plan option that offer states a strategic opportunity to provide comprehensive care coordination and increase physical and behavioral health integration for individuals with chronic conditions. Health homes are not a place, but a care model. The term is used to refer to a system through which one receives services, not a specific location of care. As described in the Social Security Act, health homes are an arrangement that allows eligible individuals with chronic conditions to select a designated provider, team of health care professionals operating with such a provider, or a health team as the individual’s health home for the purposes of providing the individual with health home services: comprehensive care management, care coordination, health promotion, comprehensive transitional care/follow-up, patient and family support, and referral to community and social support services.[89] Providers or groups of providers must offer these six required services and report quality measures.

Health homes can be targeted by type or severity of condition[90] and/or location.[91] Programs are categorized based on conditions they focus on. Categories include individuals with chronic conditions, SMI, intellectual and developmental disabilities (IDD), SED, SUD, and/or HIV/AIDS. States receive a 90% enhanced federal match rate for health home services for the first eight fiscal quarters. Enhanced funding is available for the first 10 fiscal quarters for SUD health homes.

Beyond the initial enhanced funding opportunity, Alaska may find these health home services beneficial in meeting the needs of individuals in crises by coordinating seamless and holistic care across systems. By integrating healthcare, social services, and mental health support, health homes can address the multifaceted needs of individuals, providing timely and appropriate interventions, and ongoing care coordination support.

Managed Care and Administrative Service Organizations

Alaska operates a fee-for-service (FFS) Medicaid delivery system, which creates barriers to implementing and administering large-scale delivery system innovations like 1115 demonstration waivers. The FFS payment system, as it is currently organized, lacks care coordination and financing tools to shift incentives and accountabilities toward population health outcomes and cost efficiencies. Because the FFS system itself cannot meet this challenge on its own, the operational lift of implementing large scale program changes falls largely on the state and behavioral health providers, whereas in other states, the infrastructure and capacities offered by managed care and/or administrative service organizations can support the operational changes, administration, and expertise needed to effectuate delivery system reform. By leveraging the comprehensive infrastructure and administrative capabilities of these organizations, Alaska could address multiple opportunity areas identified in this report to enhance the state's crisis continuum and behavioral health delivery system.

In addition to having financial responsibility for the provision of covered services, managed care organizations can provide optional value-added benefits that address the immediate needs of individuals in crisis. States can also utilize the in-lieu-of services authority available through managed care to deliver essential services that address HRSNs, such as housing support, food security, and transportation, thus preventing crises and stabilizing individuals' situations more effectively.

Both managed care and administrative service organizations can support crisis service providers through contracting, training, billing, and reimbursement assistance. By delegating these administrative tasks, states can streamline operations and focus on strategic oversight. Moreover, these organizations can facilitate community collaboration and provide enhanced care coordination for individuals, linking various providers and community partners, thus fostering a crisis response system that is integrated into broader systems of care. States benefit financially by receiving the medical FMAP for these services when included in the managed care contract, as opposed to the administrative federal financial participation (FFP) rate.

Alaska has analyzed several managed care reform initiatives, however, despite the advantages, Alaska's demographic composition and geography likely present barriers to successful managed care implementation. The state's vast rural regions and low population density are challenges to managed care organizations establishing sufficient provider networks and reaching standard economies of scale for profitability. Even if Alaska were to pilot managed care in the more populated areas, such as Anchorage or Fairbanks, the state would still be responsible to build a full administrative structure to meet the federal requirements for managed care oversight. Furthermore, many managed care organizations do not understand Tribal sovereignty, are not familiar with the Indian managed care protections at 42 CFR 438.14, and do not have experience working with and reimbursing Tribal health infrastructures. States cannot use a state plan amendment to require American Indian and Alaskan Native individuals to enroll in managed care unless the managed care entity is an Indian health entity.[92] Exempting Alaska Natives from managed care would further limit the scale and potential advantages of managed care.

FIGURE 12. IMPLEMENTATION ACTIVITIES BY POTENTIAL SOLUTION

Areas of Opportunity	Potential Solutions	Required Implementation Activities							Potential Timing
		Planning/ Design	Stakeholder Engagement	Regulatory Authority[1]			Payment Review & Rate Development	Operations & Documentation	
				Administrative Code Revisions	State Plan Amendment	1115 Waiver Amendment			
1) Enhancing the Crisis Service Array	Increased flexibility in the current service requirements	✓	✓	✓	✓	✓	✓	✓	1-2 years
	Develop separate services for adolescents and adults	✓	✓	✓	✓	✓	✓	✓	1-2 years
	Additional options for place-based crisis care	✓	✓	✓	tbd	tbd	✓	✓	1-2 years
	Access to wrap-around care and HRSN services	✓	✓	✓	tbd	✓	✓	✓	1-2 years
	Support regional planning and accountability	✓	✓			✓	✓	✓	6 months-2 years
	Expand services to reimburse Tribal healing practices	✓	✓	✓	tbd	✓	✓	✓	1-2 years
2) Streamlining Documentation	Organization and accessibility of documentation	✓	✓					✓	3-12 months
	Consistency and clarity in provider guidance and service definitions	✓	✓	tbd				✓	3-12 months
	Clarity and certainty in facility licensure	✓	✓	tbd				✓	3-12 months
	Availability of transportation	✓		tbd	tbd		✓	✓	3-6 months
3) Additional Supports for Providers and Community Partners	Technical assistance for crisis providers	✓	✓					✓	3-12 months
	Training for community partners	✓	✓					✓	3-12 months
	Workforce supports	✓	✓	tbd		✓		✓	1-2 years
4) Sustainable Financing	Rate methodology review	✓	✓	✓	tbd		✓	✓	1-2 years
	Rebasing	✓	✓	✓				✓	1-2 years
	Capital investment	✓	✓					✓	1-2 years
	Service specific incentives	✓	✓	✓	✓		✓	✓	1-2 years
	Enhanced FMAP for Mobile Crisis	✓						✓	3-6 months
5) Community Collaboration	Expanded opportunities for collaboration with state partners	✓	✓					✓	3-12 months
	Expanded opportunities for collaboration with community partners	✓	✓					✓	3-12 months
	Shared care planning and closed loop referral platform	✓	✓			✓		✓	3-12 months

[1] Services not currently authorized under Alaska Statute Chapter 47.07 Medical Assistance for Needy Persons would require legislative approval to implement.

VI. Conclusion

Like other states and communities nationwide, Alaska is wrestling with the challenge of providing adequate behavioral health crisis services to all its residents. The state faces common hurdles in the development of their crisis care delivery systems, such as increased service demand, workforce shortages, and obstacles in delivering care in rural areas. However, these challenges are magnified in Alaska due to its size, geographical characteristics, and diverse population.

While Alaska's service array is comprehensive and reflective of the continuum of crisis services, the utilization of these services fluctuates and is inconsistent across the state, especially in rural communities. This report offers a thorough set of considerations and options for Alaska as it strives to ensure the crisis service array caters to the needs of all Alaskans and is accessible to them. The objective is not for the state to necessarily address every consideration or pursue every option detailed in this report. Instead, as the state progresses, it should consider prioritizing certain items for potential implementation and identify areas that require further exploration and consideration before pursuing any single option.

A consistent theme across engagements with interested parties was the appreciation individuals and organizations had for the state's sincere efforts to improve access to behavioral health crisis care and engage community partners in the process. This is important to note because, although Alaska faces many potential challenges and frustrations in building its crisis continuum of care, it is doing so with a strong foundation of individuals within various state agencies and community partners who share a commitment to ensuring that all Alaskans can access behavioral health crisis care.

Appendix A

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- 7AAC 138.450. Crisis response services. https://www.akleg.gov/basis/aac.asp#7.138.450
- 7 AAC 139.350. Crisis response services. https://www.akleg.gov/basis/aac.asp#7.139.350

Documents shared by Alaska Department of Behavioral Health:

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- Overview of SUD Manual changes 10.9.23. (Date shared: December 18, 2023)
- Alaska BH Provider Standards Administrative Procedures for BH Provider Services 10.9.23_v4. (Date shared: December 18, 2023)
- Alaska BH Provider Service Standards Administrative Procedures for SUD Provider Services 10.9.23)_v4. (Date shared: December 18, 2023)
- 2023 cross walk of crisis 23 and residential services 10.9.23. (Date shared: February 1, 2024)
- DBH compiled notes about crisis services (Date shared: February 1, 2024)
- Crisis issues based on 1115 public comment summary (Date shared: February 1, 2024)
- Crisis Services Summary from BH Roadmap (Date shared: February 1, 2024)
- SCF Comments on Crisis Facilities Regulations Public Scoping 01.03.2023 (Date shared: February 1, 2024)
- HB 172 Regulations final version (Date shared: February 1, 2024)
- DOH Subacute Licensing Regulations FCSA Comments 1-4-2023 (Date shared: February 1, 2024)

Appendix B

Overview of the engagement conducted with interested parties.

Date	Meeting Group	Organization	Name
March 21, 2024	Sister Agencies	Department of Family and Community Services	▪ Kim Kovol ▪ Julia McMullan ▪ Chrissy Vogeley
		Department of Law	▪ Kimberly Allen
		Department of Health	▪ Matthew Thomas ▪ Ana Thompson ▪ Tricia Skitt
March 28, 2024	Community Providers	Alaska Behavioral Health	▪ Jim Myers
		True North	▪ Karl Soderstrom
March 28, 2024	Tribal Health Organizations	Alaska Native Tribal Health Consortium	▪ Jim Roberts ▪ Gennifer Moreau-Johnson ▪ Leah Van Kirk
		Alaska Native Health Board	▪ Alberta Unok ▪ Grace Heglund Lohman
		Maniilaq Association	▪ Ronto Roney ▪ Bree Swanson ▪ Anthony Cravalho
		South Central Foundation	▪ Michelle Baker ▪ Chris Bragg ▪ Brian McCutcheon ▪ Ted Madsen
		Southeast Alaska Regional Health Consortium	▪ Jessica Whitaker
		Yukon-Kuskokwim Health Corporation	▪ Adrienne Gregory
		Sonosky, Chambers, Sachse, Enderson & Perry, LLP (Alaska Native Law)	▪ Nathaniel Amdur-Clark
March 29, 2024	Facility-Based Providers	Providence	▪ Laura Anderson
		South Central Foundation	▪ Michelle Baker
		Bartlett	▪ Jennifer Carson
April 3, 2024	Other advisors and subject matter experts	Pugsley Consulting	▪ Amy Pugsley
		Agnew Beck Consulting	▪ Thea Agnew Bemben
		Alaska Mental Health Trust	▪ Eric Boyer ▪ Katie Baldwin-Johnson ▪ Tina Voelker-Ross
April 4, 2024	Provider Organizations	Alaska Hospital and Healthcare Association	▪ Jared Kosin ▪ Elizabeth King
		Alaska Behavioral Health Association	▪ Lance Johnson ▪ John Solomon

Appendix C

Comparison of the location requirements and limitations for the four 1115 waiver crisis services.

Place of Service		Peer-Based Crisis Services	23-Hour Crisis Stabilization Observation	Mobile Outreach and Crisis Response	Crisis Residential Stabilization
02	Telehealth, patient not located at home	*	*	X	*
03	School	X	X	X	
04	Homeless Shelter	X	X	X	
05	Indian Health Service Free-standing Facility	X	X	X	X
06	Indian Health Service Provider-based Facility	X	X	X	X
07	Tribal 638 Free-standing Facility	X	X	X	X
08	Tribal 638 Provider-based Facility	X	X	X	X
10	Telehealth, patient located at home		*	X	
11	Office	X	X	X	
12	Home	X	X	X	
13	Assisted Living Facility	X	X	X	
14	Group Home	X	X	X	
15	Mobile Unit	X	X	X	
16	Temporary Lodging	X	X	X	
18	Place of Employment	X	X	X	
19	Off Campus-Outpatient Hospital	X	X	X	
20	Urgent Care Facility		X	X	
21	Inpatient Hospital		X	X	
22	On Campus-Outpatient Hospital	X	X	X	
23	Emergency Room	X	X	X	X
26	Military Treatment Center	X	X	X	
34	Hospice		X	X	
49	Independent Clinic	X	X	X	
50	Federally Qualified Health Center	X	X	X	
51	Inpatient Psychiatric Facility		X	X	
52	Partial Hospitalization Program	X	X	X	
53	Community Mental Health Center	X	X	X	X
54	Intermediate Care Facility/ Individuals with Intellectual Disabilities	X	X	X	
55	Residential Substance Abuse Treatment Facility	X	X	X	
56	Psychiatric Residential Treatment Center	X	X	X	
57	Non-residential Substance Abuse Treatment Center	X	X	X	
58	Non-residential Opioid Treatment Facility	X	X	X	
61	Comprehensive Inpatient Rehabilitation Facility	X	X	X	
71	State or local Public Health Clinic	X	X	X	
72	Rural Health Clinic	X	X	X	
99	Other appropriate place of service	X	X	X	X

*Telehealth may be allowable for 23-Hour Crisis Observation and Stabilization if prior authorization is obtained.

Limitations

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Milliman has developed certain models to estimate the values included in this summary. The intent of the models is to summarize crisis experience. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP). The models rely on data and information as input to the models. We have relied upon certain data and information provided by DOH for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this correspondence may likewise be inaccurate or incomplete. The models, including all input, calculations, and output may not be appropriate for any other purpose. Any user of the data and information contained within this presentation must possess a certain level of expertise in service utilization and behavioral health services that will allow appropriate use of the data and information presented.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Tyler Schulze is a member of the American Academy of Actuaries and meets the qualification standards for performing the analyses in this summary.

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