Section 1115 Demonstration Waiver Proposal for Substance Use Disorder Treatment

Submitted by the Alabama Medicaid Agency

Draft – For Public Comment

May 4, 2023

Table of Contents

Demonstration Summary

The Alabama Medicaid Agency (AMA) is requesting an 1115 Substance Use Disorder (SUD) demonstration waiver to cover treatment and recovery services provided to Medicaid-enrolled individuals in Institutions for Mental Diseases (IMDs) for opioid use disorder (OUD) and substance use disorder (SUD) services. This request is in accordance with the opportunity announced by the Centers for Medicare and Medicaid Services (CMS) via State Medicaid Director Letter #17-003. In addition, AMA is requesting the extension of Medicaid coverage to qualified low-income individuals without health insurance screened as meeting the criteria for SUD in specific areas of the State who are currently covered only under non-Medicaid funding sources, including state funding and Federal Block Grant funding.

AMA partners with the Alabama Department of Mental Health (ADMH) to provide comprehensive OUD and SUD treatment services based on the American Society of Addiction Medicine (ASAM) definitions of Levels of Care (LOC). The demonstration builds upon an existing array of covered Medicaid SUD services including early intervention, outpatient treatment, intensive outpatient/partial hospitalization, and opioid use disorder treatment (Methadone, Buprenorphine, and Vivitrol treatment). AMA designed this demonstration to address the following goals:

- Improve outcomes for Medicaid beneficiaries with SUD, by maintaining and adding access to a full continuum of OUD and SUD services,
- Enhance access to physical health services by strengthening linkages between behavioral health and physical health providers,
- Improve care coordination to better integrate SUD services, mental health services, physical health services, and social determinants of health needs,
- Improve the rates of initiation, engagement, and retention in treatment,
- Reduce hospital emergency department use and inpatient admissions, and
- Reduce overdose deaths due to opioids and other substances.

To achieve these goals, the AMA requests to:

- Allow the State to include SUD residential treatment provided in IMDs as part of an essential continuum of care for Medicaid-enrolled individuals with OUD or SUD.
- Extend Medicaid State Plan SUD Medicaid rehabilitation option services and residential treatment in an IMD to qualified low-income individuals without health insurance screened as meeting the criteria for SUD in specific areas of the State.

We further describe these requests below.

SUD Residential Treatment Provided in IMDs

AMA requests that CMS allow the State to include OUD and SUD residential treatment provided in IMDs as part of an essential continuum of care for Medicaid-enrolled individuals with OUD or SUD. Medicaid beneficiaries eligible for full Medicaid coverage under the State Plan will be permitted to access services provided in an IMD regardless of their county of residence. By allowing the State to include residential treatment provided in IMDs, the State seeks to improve outcomes for Alabama residents with SUD by maintaining and increasing access to a full continuum of OUD and SUD services. Coupled with the inclusion of SUD residential treatment services in the continuum of care, the demonstration also aims to enhance the coordination of comprehensive SUD treatment in outpatient and community-based settings as well as in residential and inpatient treatment settings, including improved coordination when individuals transition across LOCs.

Extension of Medicaid State Plan Rehabilitation Option Services and Residential Treatment

AMA also requests that CMS allow the State to extend coverage of SUD treatment services to uninsured individuals in counties experiencing a pronounced need for SUD treatment services. The demonstration will extend access to medically necessary SUD treatment

services in select Alabama counties to low-income adults ages 21-64 who are not currently eligible for enrollment in Alabama Medicaid and meet the criteria for SUD treatment. The individuals who meet the criteria for SUD treatment will be eligible to receive Medicaid State Plan SUD Medicaid Rehabilitation Option (MRO) services and residential treatment services provided in an IMD.

The State proposes to extend coverage of these SUD services to individuals that meet the above criteria in nine high-need counties (Blount, Cullman, Etowah, Jefferson, Madison, Shelby, St. Clair, Tuscaloosa, Walker), as illustrated in Figure 1. We further describe why we selected these nine counties in the following section.

Figure 1: Map of Counties for Extended Coverage

Need for SUD Treatment Services in Alabama

Like most states, Alabama is experiencing a complex public health crisis. Alabama residents are reporting SUDs at an alarming rate and Alabama's system of care is inadequately resourced to address the needs of the State's residents. The 2019 – 2020 National Survey on Drug Use and Health indicated that 14.16 percent of people ages 12 and above (representing approximately 585,000 individuals) in Alabama reported a SUD in the past year and that 12.87 percent of people ages 12 and above (representing approximately 532,000 individuals) reported needing, but not receiving treatment at a specialty facility for substance use in the past year.[1] Further, the survey estimated that approximately 230,000 individuals ages 12 and older reported illicit drug use disorder in the past year, with 220,000 reporting needing but not receiving treatment at a specialty facility for illicit drug use. The prevalence of SUD and the unmet need for treatment in Alabama contributes to deaths among Alabama residents; Alabama has a drug overdose mortality rate of 22.3 deaths per 100,000 total population, with over 1,000 deaths due to drug overdoses in 2020. This drug overdose rate has increased over three-fold since 2005 when the drug overdose rate was 6.3 deaths per 100,000 population.[2]

Through this demonstration, AMA aims to broaden access to critical behavioral health services across the care continuum to help address the need for SUD treatment and connect individuals in need of treatment to the appropriate level of services. While the first component of the demonstration to cover SUD residential treatment in IMDs will be statewide, the second component of the demonstration to extend Medicaid State Plan MRO services will be conducted through a pilot directed at nine counties. These counties surround the cities of Birmingham and Huntsville. These nine counties were selected for the pilot because they represent areas with some of the highest needs for SUD services based on metrics such as drug mortality rates, opioid deaths, and drug overdose emergency room (ER) visits and have adequate provider infrastructure necessary to support the pilot program. For example, in the

[1] Substance Abuse and Mental Health Services Administration, *"2019-2020 National Survey on Drug Use and Health: Model-Based Prevalence Estimates (50 States and the District of Columbia),"* Available online: https://www.samhsa.gov/data/sites/default/files/reports/rpt35339/2020NSDUHsaePercents012422/NSDUHsaePercents2020.pdf

[2] Centers for Disease Control and Prevention, "*Drug Overdose Mortality by State,*" Accessed September 14, 2022. Available online: https://www.cdc.gov/nchs/pressroom/sosmap/drug_poisoning_mortality/drug_poisoning.htm.

Birmingham area (comprised of Jefferson, Blount, Cullman, Etowah, Shelby, St. Clair, Tuscaloosa, and Walker counties):

- Jefferson County has a crucial need:
  - Highest drug mortality rate from 2016-2018 and in the top three highest counties for drug mortality rate in 2019-2020[3]
  - Highest number and crude rate of drug-induced overdose (OD) deaths in 2019-2020[4]
  - Highest number and/or crude rate of alcohol-induced OD deaths in 2019-2020[5]
  - Highest number of drug OD ER visits in 2016-2019[6]
  - Second highest opioid dispensing rate per 100 in 2020[7]
- Surrounding counties (Blount, Cullman, Etowah, Shelby, St. Clair, Tuscaloosa, and Walker) are in the top 12 of at least one of the following metrics for the most recent year of data available:
  - Drug mortality rate
  - Rate of drug-induced OD deaths
  - Rate of alcohol-induced OD deaths
  - Drug OD ER visits
  - EMS drug OD rate
  - Opioid death rate
  - Drug arrests

In addition, in the Huntsville area (comprised of Madison County):

- Ranks sixth among Alabama counties for drug-induced OD deaths and alcohol-induced OD deaths in 2020[8]
- Ranks fifth for drug OD ER visits in 2019[9]
- Top 3 for EMS drug ODs (2019), drug arrests (2019), and opioid deaths (2018)[10]

These counties have representation of a broad range of SUD treatment services in the surrounding areas, making it possible for individuals living in these counties to access a continuum of services within reasonable time and distance standards as determined by the State. Specifically, the Birmingham area has SUD treatment centers across the continuum from Level .05 – Level III.7-D. In most cases, there is more than one center at each level in the Birmingham area. The Huntsville area also has good coverage for most ASAM LOCs, especially when considering provider locations in adjacent counties that may be able to supplement the residential continuum. Through this demonstration, ADMH will work with SUD providers, including providers in the Birmingham and Huntsville areas, to improve the quality and breadth of services they offer.

Focusing on these nine counties will allow Alabama to target resources to the areas of the State with a high need while evaluating outcomes of the pilot post-implementation to determine potential options to add coverage of SUD treatment services to uninsured populations in additional counties in the future.

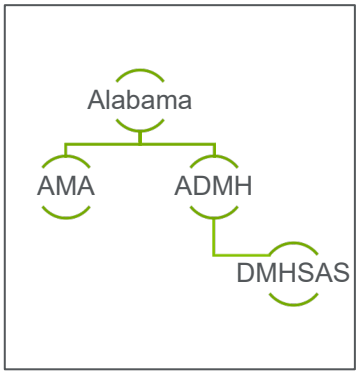
---

[3] Centers for Disease Control and Prevention, "County-Level *Drug Overdose Mortality in the United States, 2003-2020,*" Accessed October 31, 2022. Available online: https://www.cdc.gov/nchs/data-visualization/drug-poisoning-mortality/.
[4] Centers for Disease Control and Prevention, "*CDC Wonder, Underlying Cause of Death, 2018-2020, Single Race Results,*" Accessed October 31, 2022. Available online: https://wonder.cdc.gov/controller/datarequest/D158.
[5] Centers for Disease Control and Prevention, "*CDC Wonder, Underlying Cause of Death, 2018-2020, Single Race Results,*" Accessed October 31, 2022. Available online: https://wonder.cdc.gov/controller/datarequest/D158.
[6] DrugUse.Alabama.Gov. "*Drug Overdose ER Visits in Alabama 2016-2019,"* Accessed October 31, 2022. Available online: https://druguse.alabama.gov/emergencyroom.html.
[7] Centers for Disease Control and Prevention, "*U.S. County Opioid Dispensing Rates, 2020,*" Accessed October 31, 2022. Available online: https://www.cdc.gov/drugoverdose/rxrate-maps/county2020.html.
[8] Centers for Disease Control and Prevention, "*CDC Wonder, Underlying Cause of Death, 2018-2020, Single Race Results,*" Accessed October 31, 2022. Available online: https://wonder.cdc.gov/controller/datarequest/D158.
[9] DrugUse.Alabama.Gov. "*Drug Overdose ER Visits in Alabama 2016-2019,"* Accessed October 31, 2022. Available online: https://druguse.alabama.gov/emergencyroom.html.
[10] DrugUse.Alabama.Gov. "*Drug Use Data,"* Accessed October 31, 2022. Available online: https://druguse.alabama.gov/index.html.

Through this demonstration, Alabama's dual strategies to cover SUD residential treatment in IMDs statewide and to pilot extension of Medicaid State Plan MRO services to enhance access to SUD treatment services in nine high-need counties will allow Alabama to provide an effective SUD treatment continuum of care for a broader set of Alabama residents while enhancing SUD interventions to better address individuals' changing needs across LOCs. In addition, because many individuals with SUD diagnoses often have other chronic physical health conditions, such as cancer, heart disease, and chronic pain, this demonstration will enhance strategies to support demonstration participants' access to physical health services.[11] The demonstration targets an October 2023 effective date.

Alabama Behavioral Health Delivery Structure

AMA administers the State's Medicaid program to provide accessible and appropriate healthcare to Medicaid beneficiaries across Alabama. In 2019, AMA covered over one million Alabama residents, or approximately 25 percent of Alabama's adult population and almost 53 percent of Alabama's children.[12] AMA works in partnership with ADMH to provide comprehensive community-based behavioral health services to more than 200,000 Alabama residents. ADMH's partnership with AMA provides state matching funds for Medicaid payments for certain behavioral health services. Those behavioral health services include mental health rehabilitation, substance use treatment, and targeted case management. Within ADMH, the Division of Mental Health and Substance Abuse Services (DMHSAS) provides funding for a full spectrum of SUD treatment services across Alabama.



Alabama's Medicaid program currently covers non-residential SUD treatment, including ASAM LOCs:

- Level 0.5 Early intervention,
- Level 1 Outpatient services,
- Level 2.1 Intensive outpatient services,
- Level 2.5 Partial hospitalization services,

Alabama Code requires SUD providers to use the most current edition/set of placement criteria for SUD patients/clients published by the American Society of Addiction Medicine. Alabama's Medicaid program also covers all FDA-approved medications for the treatment of OUD and SUD, including Methadone, Buprenorphine, Vivitrol, Acamprosate, Disulfiram, and Naloxone. In addition to in-person services, Alabama's Medicaid program covers access to certain SUD treatment services through telehealth, such as counseling services, peer support services, and medication monitoring. In addition, Alabama law effective July 2022 allows for individuals who possess an active controlled substance certificate or a Qualified Alabama Controlled Substances Registration Certificate to prescribe controlled substances, such as MAT medications, as a result of a telehealth service.[13]

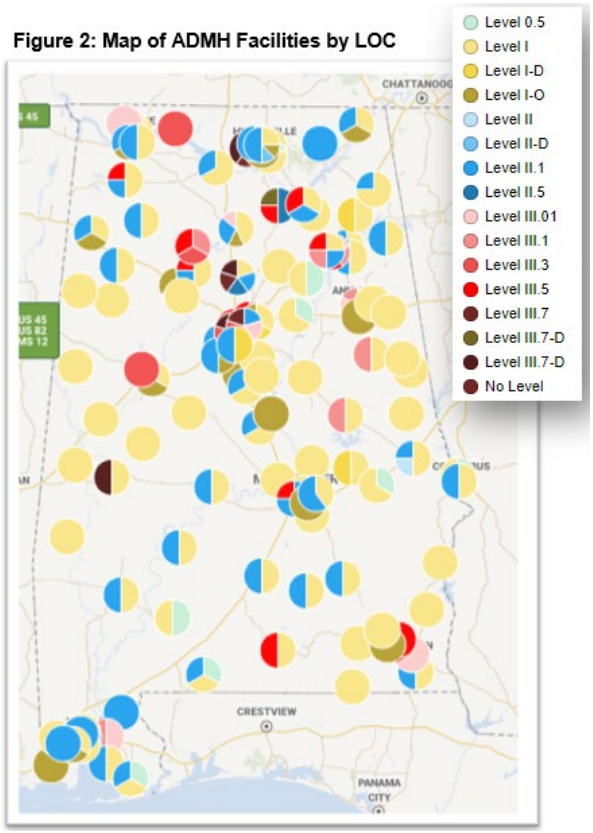
SUD residential treatment services are not currently covered by Alabama's Medicaid program, however residential treatment (ASAM LOCs 3.1, 3.3, 3.5, and 3.7) is accessible through ADMH, paid for with non-Medicaid funding sources, such as state funding and Federal Block Grant funding. Although SUD residential treatment services are not currently covered under

[11] Common Comorbidities with Substance Use Disorders Research Report. Bethesda (MD): National Institutes on Drug Abuse (US); 2020 Apr. Available from: https://www.ncbi.nlm.nih.gov/books/NBK571451/
[12] Alabama Medicaid Agency (2021). *FY 2019 Annual Report* [Report]. Retrieved from: https://medicaid.alabama.gov/documents/2.0_Newsroom/2.3_Publications/2.3.5_Annual_Report_FY19/2.3.5_FY_19_Annual_Report_Bookmarked_6-29-21.pdf
[13] Birmingham Medical News, "Effective July 11 Alabama Has a New Telehealth Rules: What Physicians Need to Know," Available online: https://www.birminghammedicalnews.com/article/8456/effective-july-11-alabama-has-new-telehealth-rules-what-physicians-need-to-know.

Medicaid, ADMH's requirements for SUD residential providers align with ASAM standards for residential services. As discussed above, through this demonstration, AMA is seeking CMS approval to include SUD residential treatment provided in IMDs as part of an essential continuum of care for Medicaid-enrolled individuals, so that SUD residential treatment will be covered by Alabama's Medicaid program.

ADMH does not directly operate any SUD programs, instead, they contract with community providers to deliver evidence-based prevention, treatment, and recovery-based peer support services throughout the State. Alabama's community SUD treatment system has 19 non-profit regional mental health boards (called 310 Boards based on ACT 310 of the 1967 Regular Session of the Alabama Legislature). There are 24 community mental health centers (CMHCs) in the 19 service areas, 19 serve as the 310 Board CMHC and five are CMHCs that operate under a 310 Board CMHC. The Birmingham area has a regional 310 Board and four CMHCs under contract. Outside of the Birmingham area, the CMHCs are organized with a main center in the most populous county or city in their catchment area and satellite offices in outlying counties/areas. In addition to CMHCs, ADMH also contracts with other private and public community and residential providers of SUD services.

Figure 2: Map of ADMH Facilities by LOC



As seen in Figure 2, SUD treatment providers are available throughout the State. The providers offer ASAM defined LOCs 0.5 through III.7. There is at least one SUD treatment option in all but nine of Alabama's 67 counties. ADMH-contracted SUD treatment services include withdrawal management, residential treatment, intensive outpatient treatment, outpatient treatment, and medication-assisted treatment for both adolescents and adults.

Alabama is in the process of transforming its CMHCs across the State into certified community behavioral health clinics (CCBHCs). ADMH conducted a statewide CCBHC readiness assessment with their 310 Boards and a phased CCBHC implementation is scheduled to begin in January 2023. There are already several CCBHC grantees in the State (e.g., WellStone and AltaPointe) and Alabama applied for the SAMHSA CCBHC Planning Grant in December 2022 to support the development and implementation of the CCBHC transformation. CCBHCs will serve both Medicaid and non-Medicaid beneficiaries and will not reject or limit services based on a person's ability to pay. In addition, in alignment with SAMHSA guidance, CCBHCs are expected to promote recovery while fostering resilience and addressing social determinants of health. Alabama's transition to CCBHCs will support the goals of this demonstration to improve access to coordinated SUD treatment services, as well as linkages with mental health and primary care services (either through direct delivery by the CCBHC or through referral relationships with Designated Collaborating Organizations).

ADMH has also been working to increase access to crisis centers, which will improve access to behavioral health services for individuals who are experiencing a substance use or mental health crisis. These crisis center services are available to anyone in the State regardless of

their ability to pay. The crisis centers also aid jails and hospitals throughout Alabama by alleviating the burden to house and care for individuals in need of crisis services. There are currently crisis centers in the Birmingham, Huntsville, Mobile, and Montgomery metro areas with two more crisis centers scheduled to open in the first quarter of 2023. To increase availability of services statewide, AMA and ADMH are also participating in a CMS State Planning Grant to increase 24-hour Mobile Crisis Services throughout the State, strengthening crisis services for all demonstration populations. Currently, ADMH is working with 11 CMHC providers to operate 13 Mobile Crisis Teams (all are in different stages of development and staffing) to offer mobile crisis services in 22 counties throughout Alabama. The Mobile Crisis Services will coordinate with 988, Crisis Centers, and Alabama's Crisis System of Care.

Strategies for Addressing Goals and Milestones

To receive approval for this demonstration, Alabama must agree to meet six programmatic milestones that represent improvements to its SUD delivery system. AMA will address its approach to key system reform milestones in the comprehensive Implementation Plan that will be submitted subsequent to this demonstration request. The Implementation Plan will follow the guidelines outlined by CMS in the 2017 State Medicaid Director's Letter # 17-003. The following section provides a summary of the current environment for each milestone and proposed actions under the demonstration to address each milestone.

Milestone 1: Increase access to LOCs for OUD and other SUDs for individuals in Medicaid

Alabama's SUD treatment systems through AMA and ADMH include coverage of the following ASAM LOCs:

- Level 0.5 Early intervention,
- Level 1 Outpatient services,
- Level 2.1 Intensive outpatient services,
- Level 2.5 Partial hospitalization services,
- Level 3.1 Clinically managed low-intensity residential services,
- Level 3.3 Clinically managed medium-intensity residential services,
- Level 3.5 Clinically managed high-intensity residential services, and
- Level 3.7 Medically monitored intensive residential services.

ADMH does not currently certify providers at ASAM Level 4. However, there are providers in the State that offer hospital-based inpatient detox services, including three hospitals that are registered with ADMH as Level 3.7 facilities and a hospital program that offers inpatient detox services but is not contracted with ADMH.

Alabama received CMS approval in September 2021 for a State Plan Amendment to add MAT as a mandatory benefit in the Medicaid State Plan, in alignment with the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) relating to mandatory coverage of MAT for OUD. MAT is available to individuals across the ASAM LOCs.

Demonstration Actions to Address Milestone

Under this demonstration, Alabama aims to increase access to medically appropriate SUD treatment services for both the current Medicaid population and the proposed newly eligible population. In 2022, the State conducted a statewide needs assessment of Alabama's continuum of care for SUD services. The goal of this needs assessment was to understand the strengths and gaps in Alabama's SUD prevention and treatment system to inform future

policy, programmatic, and investment decisions to better meet the needs of Alabama's residents and the overall SUD delivery system. The assessment included a review of access to care and capacity, workforce, regulatory barriers, monitoring, and reporting mechanisms to support an effective and high-quality SUD delivery system, and awareness and stigma associated with SUD resources and treatment.

Based on the results of that assessment, the State is creating a phased plan to increase access to additional LOCs across the State, prioritizing the services that will help meet the greatest areas of need. The assessment indicated that Alabama should focus on improving access to SUD residential services, specifically LOC 3.7 (medically monitored intensive residential), 3.7-D (medically monitored intensive residential detox), and 4 (medically managed intensive inpatient). In addition, the assessment indicated that there is an opportunity to improve connection to services as people transition between LOCs by establishing or strengthening referral processes and affiliation agreements with providers for patient referrals to less intensive LOCs and MAT. ASAM is in the process of updating the ASAM continuum of care LOCs, once ASAM releases the 4th edition of the ASAM criteria ADMH will incorporate the revised standards into its approach.

Milestone 2: Widespread use of evidence-based, SUD-specific patient placement criteria

American Society of Addiction Medicine's Patient Placement Criteria

Alabama uses the ASAM criteria to assess and support treatment and LOC decisions statewide. The Alabama Administrative Code for the Department of Mental Health, Substance Abuse Services (Chapter 580-9-44) requires all SUD treatment providers to incorporate the ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders into their overall program framework. The use of the ASAM six assessment dimensions to evaluate patients' level of function and placement is also a requirement for providers and ADMH-certified facilities. As referenced above, once ASAM releases the 4th edition of the ASAM criteria, ADMH will incorporate the revised standards into its approach.

SUD providers must use the ASAM six assessment dimensions to evaluate patients' level of function and placement and develop written policies and procedures on medically necessary client admissions. Alabama code requires physicians to ensure that LOC need is met prior to admission and that continued stays within inpatient settings for adults are clinically appropriate. All SUD providers must keep written placement assessments for all patients containing an evaluation of each patient's level of functioning in the six ASAM dimensions. The placement assessments include an interview with the patient to collect information related to his/her history and needs, preferences, strengths, and abilities to determine the diagnosis, appropriate services, and/or referral. For patients admitted to an inpatient facility, patients receive a thorough mental examination to determine the admitting diagnosis, any contributing factors, and to develop a plan of care that will stabilize the patient and provide for a smooth transition to any post-acute care needed. Alabama code does not require an exam for outpatient treatment except for OTP programs, which require all patients to undergo a thorough mental and physical examination by the attending physician.

To ensure that providers are knowledgeable on ASAM patient placement criteria, Alabama Administrative Code also requires SUD providers to provide clinical and medical program staff training on patient placement criteria within 12 months of their hire date. The training, based on the ASAM criteria, provides a review of ADMH requirements for patient placement at each LOC.

Alabama regularly monitors updates made to evidence-based SUD recommendations and incorporates relevant updates into the Administrative Code. AMA and ADMH are in the process of updating the Alabama Administrative Code to incorporate recent ASAM updates on treatment standards for individuals with co-occurring mental health and SUDs within each ASAM LOC.

SUD Admissions and Placements Review

ADMH has single-state authority to appropriately monitor and require complete contract compliance for treatment services and activities provided by OUD and SUD providers. This includes OUD and SUD providers paid under all funding streams including State, Medicaid, and grant funds.

Currently, state policies require ADMH staff to conduct at least one onsite annual review of all contracted SUD treatment providers. ADMH staff review providers' policies and procedures, program descriptions, clinical records, and patient placements (based on ASAM criteria). As part of the onsite visit, ADMH staff review a representative sample of the providers' client records to ensure individuals are receiving interventions at the SUD LOC appropriate for each individual's diagnosis and individual circumstances, length of stay is aligned with individuals' needs, and that treatment providers are creating individualized treatment plans for patients using multi-dimensional assessments based on the most recent ASAM multi-dimensional assessment. The sample review includes at least one open and one closed file per LOC, and staff ensures that the bulk of the records reviewed belong to clients meeting the special population's criteria (parenting and pregnant women, adolescents, and individuals with co-occurring conditions). If ADMH staff have any concerns or discover issues during the review, then ADMH staff review additional client files as needed. Non-compliant treatment providers must rectify identified issues through a Corrective Action Plan or risk funding loss.

Demonstration Actions to Address Milestone

CMS requires providers to assess patient placement and treatment needs based on SUD-specific patient placement assessment tools that reflect evidence-based clinical treatment guidelines. To strengthen patient placement criteria, the State will update provider agreements and contracts to emphasize the required use of the most current edition of ASAM assessment and placement criteria for providers of SUD treatment services. AMA and ADMH will also update provider manuals to describe providers' responsibilities to use ASAM criteria in all LOCs for screening, assessment, treatment plan review, patient placement, admission, and discharge. To increase provider awareness of ASAM criteria, AMA and ADMH will build on their current ASAM criteria provider training, to ensure that facility staff receives comprehensive training on appropriate patient placement on an ongoing basis. ADMH will also conduct an annual review of provider staff training records on patient placement criteria to confirm staff members are being trained appropriately.

CMS also requires the implementation of a utilization management approach to ensure that beneficiaries have access to SUD services at the appropriate LOC, interventions are appropriate for the diagnosis and LOC, and that there is an independent process for reviewing placement in residential treatment settings. Currently, Alabama performs a quarterly review of facilities records including a review of beneficiaries' prescribed level of care and a determination if their placement is consistent with ASAM LOC guidelines. This audit is completed quarterly and if facilities are found out of compliance they are subject to recoupment of previously paid Medicaid claims, additional monitoring, and/or technical assistance depending on the compliance issue. During the first two years of the demonstration, Alabama will work to enhance the current retrospective utilization management strategy to ensure that Medicaid beneficiaries received SUD services at the appropriate LOC consistent with their symptoms and confirmed SUD diagnosis for an appropriate length of time.

Milestone 3: Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications

Alabama statute and Alabama Administrative Code currently require licensure and certification with ADMH for all facilities operating within the State. Certification requirements and program standards for residential SUD treatment, residential withdrawal management, and inpatient SUD treatment services require compliance with ASAM standards.

Demonstration Actions to Address Milestone

CMS requires the implementation of ASAM or similar criteria for SUD provider program standards and a process for reviewing providers to assure compliance with standards. Alabama's Administrative Code 580-9-44 for Substance Abuse Services already has a high degree of alignment with the ASAM criteria. To strengthen compliance with these criteria, AMA and ADMH will contractually require SUD providers to deliver care consistent with standards found in ADMH provider manuals. AMA and ADMH will implement a review process to confirm compliance with these standards and provide training on SUD program standards to SUD providers on an ongoing basis.

CMS also requires residential treatment facilities to offer MAT onsite or facilitate access off-site. While several Alabama residential treatment facilities currently facilitate access to MAT off-site, none of these facilities offer MAT onsite. To increase access to MAT services, ADMH will update provider contract language to require residential treatment facilities to offer MAT on-site and/or facilitate off-site access. ADMH will also add language to provider contracts to require referral agreements between SUD providers and MAT prescribers to support increased access to MAT treatment services. Finally, AMA and ADMH will provide education and technical assistance to facilities that are not offering MAT services, to help them adhere to new provider standards.

Milestone 4: Improve provider capacity for critical LOCs, including MAT for OUD in Medicaid

ADMH's Division of Mental Health and Substance Abuse Services promotes the development of a comprehensive, coordinated system of community-based services for individuals with SUD. ADMH does not directly operate any SUD programs, instead, they contract with community providers to deliver evidence-based prevention, treatment, and recovery-based peer support services throughout the State, including outpatient and residential services.

Provider Capacity

Alabama conducted a statewide assessment of the State's capacity to address the substance use and opioid crisis. The Alabama Provider Capacity Project (APCP) received a $5.1 million grant from CMS and HHS for collaboration between AMA, ADMH, and VitAL (a behavioral health initiative at The University of Alabama School of Social Work). The project team conducted interviews, focus groups, and surveys with key community members, provider stakeholders, and patients throughout Alabama to gain insight into best practices for increasing community initiatives, provider participation, capacity, and knowledge of resources. The assessment team will use this information, along with data provided by AMA and ADMH, to provide Alabama with a framework to project Medicaid provider participation statewide through 2025 and to develop state goals for increasing the number, willingness, and capacity of Medicaid providers offering SUD treatment services.

As part of their effort to promote access to behavioral health services in Alabama, ADMH provides a web-based searchable SUD Provider Directory. ADMH also publishes the SUD Provider Directory by County, which identifies SUD providers throughout Alabama. The directory designates which providers are state funded, the source of public funds (Block Grant, Medicaid, SOR), as well as if the provider accepts Medicaid patients. ADMH's online provider directory allows individuals to search for providers by category (i.e., prevention, substance use disorder, mental illness, developmental disabilities) and county.

SUD Treatment Providers

SUD treatment providers are located throughout the State with at least one SUD treatment option available in all but nine of Alabama's 67 counties. ADMH contracts with providers to deliver all ASAM LOCs except for Level 4, as ADMH does not currently certify providers at ASAM Level 4. However, there are providers in the State that offer hospital-based inpatient

detox services, including three hospitals that are registered with ADMH as Level 3.7 facilities and a hospital program that offers inpatient detox services but is not contracted with ADMH.

Figure 3. Alabama SUD Providers

Level of Care	Number of Provider Locations	Notes
Level 0.5 (Early Intervention)	13	
Level 1 (Outpatient Services)	130	40 locations serve adolescents
Level 2.1 (Intensive Outpatient Services)	63	8 locations serve adolescents
Level 2.5 (Partial Hospitalization Services)	4	
Level 3.01 (Transitional Residential Program [ADMH-specific LOC])	10	Five locations serve men, three serve women, and two serve both genders
Level 3.1 (Clinically Managed Low-Intensity Residential Services)	12	Six locations serve men, five locations serve women, and one location serves both genders
Level 3.3 (Clinically Managed Medium-Intensity Residential)	11	Two locations serve men, five serve women, and four serve both genders
Level 3.5 (Clinically Managed High-Intensity Residential Program - Adults)	13	Six locations serve men, four serve women, and three serve both genders
Level 3.5 (Clinically Managed Medium-Intensity Residential Program - Adolescents)	2	
Level 3.7 (Medically Monitored Intensive Residential)	2	Both locations only serve adults
Level I-O (Opioid Treatment Programs)	21	

Residential Treatment Services

To monitor and support access to residential treatment services, ADMH gathers self-reported data from Alabama residential treatment facilities on the availability of residential beds. ADMH collects this information from both ADMH-contracted and non-contracted providers to offer a more comprehensive picture of bed availability to stakeholders. ADMH compiles this information into a bed availability report and emails these reports on a weekly basis to providers and relevant community organizations. Figure 4 below presents a sample bed availability report for the week starting December 6, 2021. As seen in Figure 4, the SUD bed availability report contains the facility name and LOC, the facility operating agency, the county where the facility is located, and the facility capacity, occupancy, and the number of available beds. The SUD bed availability report is used by AMA, ADMH, and providers throughout the State to access current information on bed availability and help facilitate access to SUD treatment for individuals.

Figure 4: ADMH Weekly SUD Residential Bed Availability Example

SA BED AVAILABILITY 12.06.21

PLEASE FORWARD TO OTHERS IN YOUR ORGANIZATION

TOTAL NUMBER OF CONTRACT RESIDENTIAL BEDS STATEWIDE (includes withdrawal management): 870 beds
TOTAL NUMBER OF NON-CONTRACT RESIDENTIAL BEDS STATEWIDE (includes withdrawal management): 272

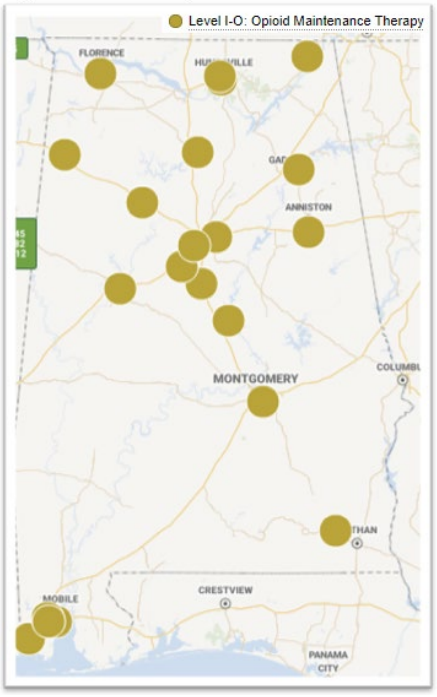
TOTAL CONTRACT RESIDENTIAL BEDS VACANT: __158_ total beds: _83_male __75__female
TOTAL CONTRACT WITHDRAWAL MANAGEMENT BEDS VACANT: _30___ male and female

Facility	Agency	County	Capacity	Enrolled	Availability	Referred Clients	Clients on Waiting List
A Woman's Place (Indian Rivers) Female Level III.3	MHB of Bibb-Pickens-Tuscaloosa Counties	Tuscaloosa	16	11	5	0	1
Aletheia House Male Level III.3	Aletheia House	Jefferson	48	45	3	4	5
Aletheia House Male Level III.5 (currently filling 22 of 24)	Aletheia House	Montgomery	22	23	1	0	0
Aletheia House Special Women's Levels III.01, III.1, & III.3	Aletheia House	Jefferson	16	12	4	0	0
Anniston Fellowship House Male Levels III.01 & III.1	Anniston Fellowship House	Calhoun	19	18	1	0	0
B'ham Fellowship House Female Level III.3 & Female Co-Occurring Level III.3	Fellowship House Inc. (Birmingham)	Jefferson	20	17	3	0	13
B'ham Fellowship House Male Level III.3 & Male Co-Occurring Level III.3	Fellowship House Inc. (Birmingham)	Jefferson	52	47	5	0	18
Bradford Detox Level III.7 D (20 of the 24 beds are self-pay)	Bradford Health Services	Jefferson	24	0	24	0	0

Opioid Treatment Programs

As indicated by Figure 3 above, statewide Alabama has 21 certified opioid treatment programs (OTPs), which combine behavioral therapy and medications, to treat OUDs. As seen in Figure 5, individuals can access OTP services throughout the State, with most providers located near Birmingham, Huntsville, Mobile, and Montgomery. Across Alabama, on a single day in March 2022 approximately 7,885 individuals received medications in OTPs as part of their substance use treatment.[14] OTPs offer MAT and medications used to treat opioid addiction include Buprenorphine, Methadone, and Vivitrol.

Figure 5: Alabama Map of OTP Providers



In addition to receiving medications for OUD from OTPs, individuals may also access buprenorphine from an office-based doctor who has specialized training. As of October 2022, there were 973 active registered Buprenorphine waivered providers throughout the State, a twenty-five percent (25%) increase from January 2021. Individuals can access Vivitrol statewide with a prescription by any doctor.

Medicaid beneficiaries can access medications for OUD from both OTPs and office-based opioid treatment programs.

Demonstration Actions to Address Milestone

CMS requires Alabama to complete an assessment of the availability of providers enrolled in Medicaid and accepting new patients in the critical LOCs throughout the State, including those providers that offer MAT. Alabama is currently conducting a provider assessment through the Alabama Provider Capacity Project, described above. AMA and ADMH will review this assessment to determine if it is adequate to capture information regarding availability and accessibility of SUD providers in Alabama. If the

[14] ADMH provided treatment number for a single day on 3/26/2022

Alabama Provider Capacity Project does not capture the necessary information, AMA and ADMH will conduct a separate provider availability assessment.

To increase community awareness of providers who offer SUD treatment services, ADMH will release regular updates to the "Substance Abuse Provider Directory by County" which identifies SUD providers throughout Alabama. In addition, to improve access to MAT, Alabama will encourage emergency departments throughout Alabama to initiate MAT and offer emergency department staff training on MAT services. In 2019, the University of Alabama at Birmingham (UAB) Department of Emergency Medicine launched an initiative to connect patients with OUD with MAT. ADMH will use lessons learned from this program to encourage the growth of MAT services at emergency departments throughout Alabama.

Milestone 5: Improve comprehensive treatment and prevention strategies to address opioid abuse and OUD

Like the rest of the nation, Alabama is facing a complex public health crisis with the opioid and prescription drug epidemic. In 2020, Alabama experienced 1,029 deaths from drug overdoses.[15] Over half (611) of those deaths were linked to opioid overdoses.[16] This demonstration aims to build on existing State efforts to combat the opioid crisis, including:

- Act 2019-500 (MAT Act of 2019) established guidelines for the use of buprenorphine in non-residential treatment programs.
- Act 2018-552 was enacted to criminalize trafficking fentanyl and fentanyl analogs (controlled substances from a material, mixture, or preparation that contains any chemical structure like that of the chemical structure of any other controlled substance).
- The Governor signed the "Compact to Fight Opioid Addiction" (2016), a commitment to build on State efforts to fight opioid addiction by taking steps to reduce inappropriate opioid prescribing, leading efforts to change Alabama's understanding of opioids and addiction and taking actions to ensure a pathway to recovery for individuals with addiction.

In addition to the actions above, Governor Kay Ivey established the Alabama Opioid Overdose and Addiction Council in August 2017, naming three co-chairs as Council leadership: The Commissioner of ADMH, the State Health Officer of the Alabama Department of Public Health (ADPH), and the State Attorney General. The Governor charged the Council with the task of developing a comprehensive strategic plan to abate the opioid crisis in Alabama. Per the Governor's order, the Council established the following eight sub-committees to explore the multi-faceted problems of Alabama's opioid crisis and make recommendations.

Figure 6. Alabama Opioid Overdose and Addiction Council Sub-Committees

Since its inception, the Council has met regularly to discuss new data, review current actions, and determine future actions. Each year, the Council publishes an annual report that describes the progress made and projects currently being implemented. The most recent annual report

[15] Centers for Disease Control and Prevention. (2020). *Alabama Overdose Prevention Investment Snapshot* [Webpage]. Retrieved from: https://www.cdc.gov/injury/budget/policystatesnapshots/Alabama.html
[16] Kaiser Family Foundation State Health Facts. (2021). *Opioid Overdose Deaths by Age Group* [Webpage]. Retrieved from: https://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-age-group/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

can be found here: Alabama Opioid Overdose and Addiction Council 2021 Annual Report. In this report, the Council outlined several proposed strategies related to its main goals of prevention (e.g., increase the percentage of prescribers using the Alabama Prescription Drug Monitoring Program (PDMP)), intervention (e.g., assess the effectiveness of drug courts in engaging offenders with OUDs in treatment and preventing overdoses), treatment and recovery (e.g., develop, sponsor, and pass comprehensive legislation to provide sustainable funding), community response (e.g., increase general public awareness of naloxone availability), and workforce (e.g., develop strategies to inhibit the effects of the opioid crisis on Alabama's labor participation rate). Figure 7 below outlines some of the Council's proposed strategies that complement and do not supplant the objectives of this demonstration.

Figure 7. Example Strategies from Alabama Opioid Overdose and Addiction Council

Strategy	Objectives
Establish equitable access to OUD treatment in Alabama	• Promote full implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 in Alabama relative to SUD treatment. • Allocate all new state funding received for treatment and recovery support services based on assessed community needs.
Reduce morbidity and mortality from prescription drug overdoses	• Develop and promote statewide guidelines to encourage naloxone co-prescribing for high-risk patients. • Encourage prescribing of naloxone or provide information on naloxone and how to access it to patients who have had prescription opioids discontinued due to concerns about inappropriate use or overuse.

The Commissioner of ADMH is a Council co-chair and will continue to help coordinate with AMA and the Council to ensure that demonstration activities complement and do not supplant other State activities related to SUD/OUD.

Opioid Prescribing Guidelines

Alabama continues to have one of the highest opioid prescribing rates in the country, nearly twice the national average. In 2020, Alabama providers wrote 80.4 opioid prescriptions for every 100 Alabama residents (the national average in 2020 was 43.3 per 100).[17] To address the opioid crisis, AMA has implemented a number of opioid prescribing policies, including:

- Limited short-acting prescription opioids for beneficiaries with no opioid claims history in the past 180 days.
- Established a maximum supply of seven days for adults and five days for children (Medicaid recipients only, excluding hospice, long-term care, and cancer patients), with a 50-morphine milligram equivalent (MME) limit per day.
- Implemented policy to deny opioid claims that exceed the CDC's recommended threshold of 90 MME per day.
- Adopted a therapeutic duplication policy prohibiting providers from dispensing multiple drugs within the same therapeutic class to the beneficiary.
- Implemented an accumulation policy to prevent beneficiaries from accumulating more than a 14-day supply of opioids.
- Required beneficiaries to use 85 percent of their original opioid prescription before they can receive a refill.
- Mandated prior authorization in a number of situations:
    - For beneficiaries with chronic pain to receive sustained-release oral opioids.
    - For beneficiaries diagnosed with OUD to obtain opioid dependence medication (including buprenorphine and naloxone) and requiring prescribing physicians to attest to reviewing the beneficiary's PDMP record prior to prescribing opioid dependence medication.

[17] Centers for Disease Control and Prevention. *U.S. State Opioid Dispensing Rate, 2020* [Webpage]. Retrieved from: https://www.cdc.gov/drugoverdose/rxrate-maps/state2020.html.

- For certain antidepressants, anxiolytics, sedatives, hypnotics, and narcotic analgesics.

Alabama has also encouraged State healthcare licensing boards that regulate controlled substances to develop and implement mitigation strategies for their licensed providers. This includes formal regulations on opioid prescribing in accordance with CDC guidelines and mandatory opioid prescribing education for licensing board providers. As of 2020, the Alabama Board of Medical Examiners (medical and nursing providers), Board of Dental Examiners, Board of Optometry, and Board of Podiatry have developed and implemented mitigation strategies for their licensed providers.[18]

To support controlled substance education throughout the State, ADMH provides education to Alabama medical professionals through the annual Alabama School on Alcohol and Other Drug Studies on SUD treatment with classes such as How Opioids Hijack the Brain; the Pharmacist's Guide to Opioid Use Disorders; Foundations of Substance Use; Pregnancy and Substance Use; Dealing with Addiction and the Need to Treat Chronic Pain; and Bridging the Gap: Attacking Stigma, Barriers and Patient Centred Treatment.[19]

Naloxone Coverage and Access

Alabama has taken several steps to improve access to and coverage of naloxone. In 2015, Alabama passed HB208 also known as a "Good Samaritan Law." The law authorizes physicians and dentists to prescribe an opioid antagonist, such as naloxone, to individuals at risk of experiencing an opioid-related overdose as well as individuals who are in the position to assist individuals who are at risk of an opioid-related overdose. HB208 provides immunity to prescribing providers and pharmacists who dispense opioid antagonist medications. Finally, the law provides immunity for administering the opioid antagonist. This protects individuals from both civil and criminal liability who administer or attempt to administer an opioid antagonist to an individual believed to be experiencing an opiate-related overdose.

To ensure that naloxone is readily obtainable throughout the State, in 2016, Alabama passed HB379, providing the State Health Officer the authority to write a standing order for dispensing naloxone. The standing order allows pharmacists to prescribe and dispense naloxone directly to customers including individuals at risk of experiencing an opioid-related overdose, family members, friends, or other individuals who may be able to assist individuals experiencing an opioid-related overdose. Medicaid beneficiaries may access naloxone through their pharmacy benefits. The standing order also allows for the bulk distribution of naloxone to first responders including law enforcement agencies, fire departments, rescue squads, and volunteer fire departments.

Naloxone is available statewide through a joint ongoing effort between the Jefferson County Department of Health and the ADMH. The Jefferson County Department of Health offers free, in–person, and online 1-hour trainings on how to recognize, prevent, and respond to an opioid overdose by using naloxone. ADMH in partnership with Jefferson County makes trainings available to first responders (law enforcement, fire departments, volunteer fire departments, etc.), individuals who work with at-risk populations, as well as individuals who are worried that a loved one or community member is at risk for overdosing on opioids. Once training is complete, first responders receive free naloxone kits through ADMH (replacement kits can be requested through a dedicated ADMH email address: narcanadmh@mh.alabama.gov). Community members and individuals receive a free naloxone kit through the Jefferson County Department of Health or ADMH, depending on their county of residence. The kits contain medication and educational material on how to recognize and reverse an opioid overdose. The Jefferson County Department of Health created a dedicated website, Naloxone Training,

[18] The Alabama Opioid Overdose and Addiction Council. (2020). *Alabama Opioid Overdose and Addiction Council 2020 Annual Report* [Report]. Retrieved from: https://mh.alabama.gov/wp-content/uploads/2021/01/2020-Annual-Report-Alabama-Opioid-Overdose-and-Addiction-Council-Report-to-Governor-12.29.2020-FINAL.pdf
[19] Alabama School of Alcohol and Other Drug Studies. (n.d.). *The ASADS Story* [Webpage]. Retrieved from: https://asadsonline.com/about.html

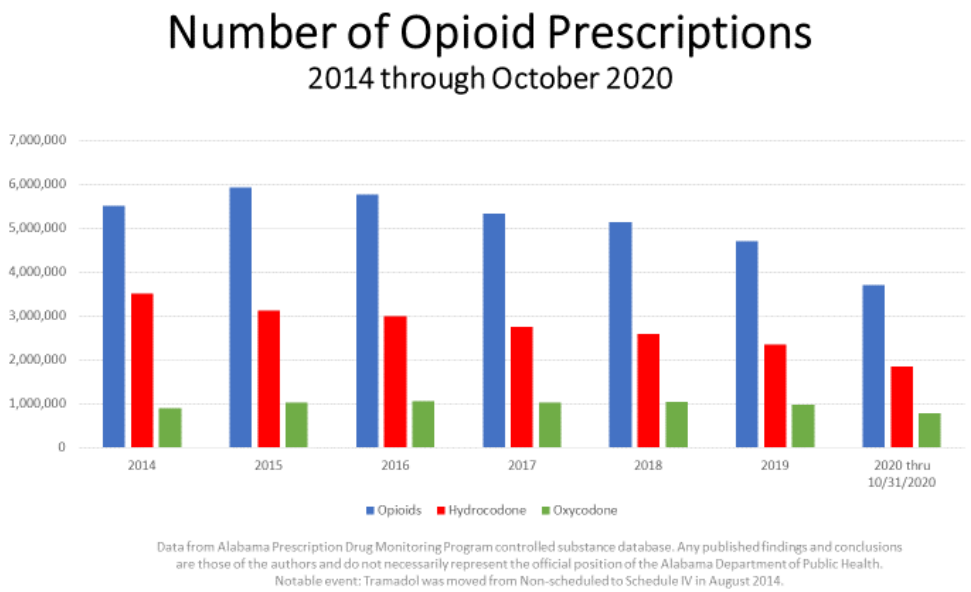
to request training, a naloxone kit, and/or a replacement kit. OTP providers can also request free naloxone kits through ADMH to provide to clients who are deemed at risk for an overdose. These changes have made naloxone more readily available throughout Alabama.

Utilization and Functionality of PDMP

Alabama established its PDMP in 2004 to detect and divert abuse and misuse of prescription medications classified as controlled substances under the Alabama Uniform Controlled Substances Act. In 2014, Alabama updated its regulations, Alabama Public Health Code 420-7-2-.12 to require all entities and practitioners that dispense controlled substances, Class II-V, to report daily controlled substances prescription information to the PDMP. Following recommendations by the Alabama Opioid Overdose and Addiction Council to improve and modernize the PDMP, the Governor and Legislature approved over $1 million each year in operating and improvement budgets for SFY2019, FY2020, and FY2021. Since 2019, the number of PDMP users almost doubled from 122 in 2019 to 238 in 2020, with over 150 more entities working on implementation.[20]

The State's PDMP has documented a drop in the number of opioid prescriptions over the past five years, as depicted below in Figure 8.

Figure 8. Number of Opioid Prescriptions 2014 - 2020[21]



Demonstration Actions to Address Milestone

Under this demonstration, Alabama aims to increase access to medically appropriate SUD treatment services, especially for currently uninsured individuals, with the goal of a reduction in overdose deaths, particularly those related to opioids. For Milestone 5, CMS requires the implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse. The Alabama Opioid Overdose and Addiction Council has a subcommittee focused on prescriber-dispensing. ADMH will build on the work of the Council by providing education for current and newly eligible Medicaid beneficiaries about the availability of opioid treatment programs and access to naloxone.

CMS also requires the amplification of coverage of, and access to, naloxone for overdose reversal. This is also an area of focus for the Alabama Opioid Overdose and Addiction Council,

[20] The Alabama Opioid Overdose and Addiction Council. (2020). *Alabama Opioid Overdose and Addiction Council 2020 Annual Report* [Report]. Retrieved from: https://mh.alabama.gov/wp-content/uploads/2021/01/2020-Annual-Report-Alabama-Opioid-Overdose-and-Addiction-Council-Report-to-Governor-12.29.2020-FINAL.pdf
[21] The Alabama Opioid Overdose and Addiction Council. (2020). *Alabama Opioid Overdose and Addiction Council 2020 Annual Report* [Report]. Retrieved from: https://mh.alabama.gov/wp-content/uploads/2021/01/2020-Annual-Report-Alabama-Opioid-Overdose-and-Addiction-Council-Report-to-Governor-12.29.2020-FINAL.pdf

which has a subcommittee focused on rescue (naloxone). The committee is currently working with ADMH to educate providers and increase access to naloxone. To advance this milestone, AMA and ADMH will create education targeted at current and newly eligible Medicaid beneficiaries about the availability of opioid treatment programs and access to naloxone. They will also update SUD treatment provider agreements and contracts to require facilities to provide patients and their families with information on how and where individuals can access naloxone.

Milestone 6: Improved care coordination and transitions between LOCs for individuals with SUD in Medicaid

AMA and ADMH currently oversee multiple interventions for care coordination and transitions between LOCs for all individuals accessing SUD treatment services, regardless of insurance coverage. Alabama funds care coordination services through a combination of Medicaid dollars, State funds, and Block Grant funds. Interventions include targeted case management and ADMH case management, Assertive Community Treatment Teams, Certified Recovery Support Specialists, and the Alabama Coordinated Health Network (ACHN).

Targeted Case Management and ADMH Case Management

Alabama's Medicaid program offers Targeted Case Management (TCM), a program of services to assist specifically identified groups of persons in gaining access to needed medical, social, educational, and other services. Medicaid beneficiaries with a SUD diagnosis are eligible through Target Group 9: Individuals with a Diagnosed Substance Use Disorder.

ADMH also requires all providers to offer case management services to individuals seeking SUD treatment. These case management services are identical to Medicaid's TCM services and are funded through Federal Block Grant and State funds.

Assertive Community Treatment Teams

Alabama has 15 Assertive Community Treatment (ACT) Teams and two Program for Assertive Community Treatment (PACT) Teams. ACT and PACT teams are multi-disciplinary teams for persons with serious mental illness and co-occurring SUDs. These teams provide case management, mental health, and substance use treatment, basic living skills, vocational rehabilitation, and in some areas of the State, peer support services.

Certified Recovery Support Specialists

ADMH values the power of peers to support individuals with SUD and OUD and promote their recovery. ADMH first established the position of Certified Peer Specialists in 1994 and later moved the peer support program statewide. In May 2016, ADMH certified the first group of substance-use peers and established the position of Certified Recovery Support Specialists (CRSS). CRSSs are credentialed through ADMH and provide services within CMHCs, free-standing Substance Use Treatment providers, and through Peer Support Organizations. Currently, ADMH has 462 active CRSSs.

As part of the certification process, CRSSs must be in recovery and willing to use their personal experience with substance use disorders to assist other individuals in their recovery. They also undergo training to help individuals in recovery to do the following:

- Identify barriers to recovery including individual early warning signs of relapse,
- Develop communication skills, social skills, and healthy social networks,
- Establish self-help and self-advocacy skills,
- Identify personal recovery goals and ways to achieve the goals, and
- Provide information regarding community resources that support goal achievement, including education, recreation, job training, and housing.

In 2016, Alabama merged the Substance Abuse peer programs and Mental Illness peer programs into the Office of Peer Programs. The Office of Peer Programs promotes recovery by coordinating ADMH's support for peer-operated programs, training, and educational programs. ADMH staffs all peer offices with CRSS. Alabama also developed four regional Recovery Community Centers for individuals who have SUDs (with two more centers planned to open soon). The centers are open 12 hours a day (including holidays and weekends) and provide recovery resources in a safe location. Resources offered include support groups, workshops, employment assistance, and recreational activities for consumers and their families.

Alabama Coordinated Health Network

Medicaid beneficiaries also have access to the statewide Alabama Coordinated Health Network (ACHN) program operated through a 1915(b) Waiver. The statewide ACHN program transformed the Alabama Medicaid delivery system by building on the existing case management program structure to create a single care coordination delivery system. ACHNs serve as care coordination entities, with each ACHN responsible for linking Medicaid beneficiaries, providers, and community resources. One of the priority quality improvement areas for the ACHNs is to assist AMA and ADMH in building a sustainable infrastructure to increase the percentage of individuals who initiate and receive timely SUD treatment. To ensure the integration of SUD care into the care coordination model, AMA requires that an ADMH-certified substance use treatment facility representative be a member of each ACHN board. ADMH's Office of Substance Abuse Treatment Services also acts as a quality improvement expert for the ACHNs. The ACHNs are responsible for facilitating care coordination for their assigned members between primary care providers, CMHCs/CCBHCs, and substance use treatment providers and refer individuals with substance use treatment needs to CMHCs/CCBHCs and/or substance use providers, who then connect individuals to treatment services and provide more intensive case management.

Demonstration Actions to Address Milestone

To improve care coordination and transitions between LOCs, CMS requires AMA to implement policies to ensure residential and inpatient facilities link Medicaid beneficiaries with community-based services and supports and higher levels of non-residential SUD services following stays in residential and inpatient facilities. To improve care coordination and hand-offs among SUD providers, AMA and ADMH will require residential providers to have a written referral process and affiliation agreements with other SUD providers for patient referrals to less intensive LOCs. Affiliation agreements should require "warm handoffs" to support individuals' ability to transition between LOCs. ADMH will also require residential facilities to follow up with patients within 7 days of discharge to ensure individuals received information on community-based services and supports and that they were able to access care. During the onsite annual review conducted with all contracted SUD treatment providers, ADMH will audit patient records to monitor that this follow-up is occurring.

In addition to improving care coordination and transitions between ASAM LOCs, Alabama recognizes the importance of assisting demonstration participants to access needed physical health services. Individuals with SUD often have other chronic physical health conditions, such as cancer, heart disease, and chronic pain.[22] The use of certain substances can cause an increased risk for cardiovascular and heart disease. Given the relationship between SUDs and physical health conditions, as well as the overall importance of access to primary care services, this demonstration will enhance strategies to support demonstration participants' access to physical health services.

[22] Common Comorbidities with Substance Use Disorders Research Report. Bethesda (MD): National Institutes on Drug Abuse (US); 2020 Apr. Available from: https://www.ncbi.nlm.nih.gov/books/NBK571451/

Currently, AMA and ADMH contract and/or collaborate with Federally Qualified Health Centers (FQHCs), free clinics, and hospitals to provide services to Medicaid beneficiaries, as well as individuals without Medicaid/other health insurance covering physical health services.

- **FQHCs**. FQHCs deliver Medicaid-covered diagnostic and therapeutic services and supplies provided by a physician, physician assistant, nurse midwife, nurse practitioner, clinical psychologist, registered nurse, or clinical social worker. In addition, as designated FQHCs, these provider types are obligated to provide a set of comprehensive, high-quality primary care and preventive services regardless of individuals' ability to pay. Since Demonstration Population #2 will not receive Medicaid-covered physical health services or supplies as part of their Medicaid targeted benefit package under this demonstration, FQHCs will play an important role in collaborating with SUD providers to help ensure Demonstration Population #2 has well-coordinated access to no-cost/low-cost services provided by FQHCs. FQHCs also offer telehealth services on a sliding fee basis. For example, Cahaba Medical Care, which has multiple locations in Central Alabama, provided over 6,600 telehealth visits in 2021.[23]
- **Free Clinics.** Alabama has free clinics throughout the state that provide physical health services and certain medications to individuals with SUD diagnoses who do not have insurance for such services and supplies. Under this demonstration, these free clinics will continue to provide physical health services and certain medications to Demonstration Population #2 free of charge or at a discount. Free clinics operate in all nine of the Demonstration Population #2 counties. Examples of free clinics in these counties include Bessemer Neighborhood Center and 1916 Clinic in Jefferson County, Community Free Clinic and Community Free Dental Clinic in Madison County, Community of Hope and Southern Family Health in Shelby County, and Fritz and Hope Clinic in Walker County.
- **Hospitals.** Medicaid beneficiaries with full benefits currently receive inpatient hospital services as part of their Medicaid benefit package. In accordance with the Emergency Medical Treatment and Labor Act, Medicare-participating hospitals with emergency departments must screen and treat individuals' emergency medical conditions regardless of their ability or pay or insurance status. Therefore, Demonstration Population #2 will continue to have access to emergency medical screening and treatment at hospital emergency departments until their conditions are resolved or stabilized. Hospitals refer uninsured or underinsured individuals to providers such as FQHCs for ongoing physical health outpatient services. In addition, as discussed under Milestone 4 above, ADMH will use lessons learned from the UAB Department of Emergency Medicine's initiative to connect patients who come to the emergency department with MAT and will encourage the growth of MAT services at emergency departments throughout Alabama. Hospitals in Alabama will continue to receive Medicaid disproportionate share funding for uncompensated care costs incurred by residents who do not have insurance for inpatient services.

To help coordinate services provided by different provider types, Alabama has made efforts to develop and strengthen working relationships between providers offering physical health services (e.g., FQHCs, free clinics, hospitals) and SUD providers. For example, WellStone in Huntsville provides comprehensive behavioral health services and medical support services to individuals in the Huntsville area regardless of their ability to pay. In September 2022 they received a SAMHSA grant to implement a CCBHC model enabling them to provide integrated care for mental healthcare, SUD, and primary care health screenings, 24/7/365 crisis care, and care coordination with hospitals, law enforcement, and schools. In addition, several

[23] Cahaba Medical Care. "*Faces of Resilience: 2021 Annual Report,"* Available at: https://online.fliphtml5.com/ewomg/vnaj/?1647357026581#p=1.

FQHCs (e.g., Cahaba Medical Care, and Franklin Primary Health Center) and CMHCs (e.g., AltaPointe Health and WellStone) already deliver integrated physical health and behavioral health services. Alabama is further building on these efforts to coordinate care through the transformation of Alabama's CMHCs into CCBHCs. In alignment with SAMHSA guidance, CCBHCs are expected to promote recovery while fostering resilience and addressing social determinants of health. Alabama's transition to CCBHCs will support the goals of this demonstration to improve access to coordinated SUD treatment services, as well as linkages with mental health and primary care services (either through direct delivery by the CCBHC or through referral relationships with Designated Collaborating Organizations). Similar to FQHCs, CCBHCs will serve both Medicaid and non-Medicaid beneficiaries and will not reject, or limit services based on a person's ability to pay.

AMA and ADMH will promote Memorandums of Understanding (MOU) between CMHCs/CCBHCs/other SUD providers and FQHCs/other physical health providers to strengthen coordinated care and improve access to services. These MOUs will establish referral relationships between SUD providers and physical health providers and allow for the exchange of information and data sharing for demonstration participants (as permitted by Federal regulations) to increase the integration of care and improve the quality of health care delivery. The MOUs will cover elements such as contact persons at each organization responsible for facilitating access to needed service, responsibilities, and timelines to communicate follow-up care needs, and procedures to maintain the confidentiality of patient information.

Alabama will also require that all demonstration participants are offered a case manager. Case managers will receive training and resources (e.g., local provider lists and contact information) regarding providers that offer physical health services and supplies to Medicaid beneficiaries with full benefits (i.e., Demonstration Population #1) and Medicaid beneficiaries with the Medicaid targeted benefit package covering SUD services (i.e., Demonstration Population #2). Regardless of whether individuals are part of Demonstration Population #1 or Demonstration Population #2, the assigned case managers will be responsible for supporting demonstration participants to receive needed services through referrals and following up to ensure demonstration participants were able to access the referred services.

Through these initiatives, Alabama intends to achieve improved access to care for physical health conditions and better coordination of healthcare services for all individuals participating in the demonstration.

Delivery System

This demonstration will not modify the current Alabama Medicaid fee-for-service or primary care case management entity (through the ACHN program) arrangements. All Medicaid beneficiaries will continue to receive services through their current delivery system.

Eligibility

Demonstration Population #1: All Alabama Medicaid beneficiaries between the ages of 21-64, who are eligible for a mandatory or optional eligibility group approved for full Medicaid coverage under the State Plan will be eligible for IMD SUD services under the demonstration. Medicaid beneficiaries who are eligible for limited Medicaid services (limited services beneficiary groups outlined in Figure 9 below) will not be eligible for IMD SUD services.

Figure 9. Eligibility Groups Excluded from the Demonstration

Eligibility Group Name	Social Security Act & CFR Citations
Limited Services Available to Certain Aliens	42 CFR §435.139
Qualified Medicare Beneficiaries (QMB)	1902(a)(10)(E)(i) 1905(p)
Specified Low-Income Medicare Beneficiaries (SLMB)	1902(a)(10)(E)(iii)
Qualified Individual (QI) Program	1902(a)(19)(E)(iv)
Qualified Disabled Working Individual (QDWI) Program	1902(a)(10)(E)(ii) 1905(s)
Family Planning – Authorized through Alabama's Plan First §1115 Family Planning Demonstration	1902(a)(10)(A)(ii)(XXI)

Demonstration Population #2: Alabama will also extend Medicaid eligibility to low-income, uninsured individuals who are not otherwise enrolled in Medicaid and who meet eligibility parameters resulting from a diagnosis related to SUD and the following criteria.

- Adult ages 21 through 64 years old,
- U. S. Citizen or lawfully residing immigrant,
- Uninsured and not eligible for any state or federal full benefits program including Medicaid, Children's Health Insurance Program (CHIP/FAMIS), or Medicare,
- Resident of Alabama,
- Resides in one of nine identified counties: Blount, Cullman, Etowah, Jefferson, Madison, Shelby, St. Clair, Tuscaloosa, Walker,
- Household income that is below 20 percent (20%) of the Federal Poverty Level (FPL) plus 5 percent (5%) income disregard (Alabama Medicaid may increase or decrease FPL limit to manage program resources),
- Not residing in a long-term care facility, mental health facility, long-stay hospital, intermediate care facility for individuals with developmental disabilities, or penal institution.

Individuals who meet these criteria will be eligible to receive a limited Medicaid benefit package that includes Medicaid State Plan Medicaid Rehabilitation Option services and residential treatment in an IMD.

Benefits

Demonstration Population #1: Currently, Medicaid-enrolled individuals between the ages of 21-65 do not have access to residential SUD services in IMDs through Medicaid. Through this demonstration, AMA will begin reimbursement of SUD residential treatment provided in IMDs as part of a full array of SUD services, after the effective date of the demonstration.

Demonstration Population #2: Demonstration Population #2 will receive a targeted benefit package consisting of Medicaid State Plan SUD Medicaid Rehabilitation Option services and residential SUD treatment in an IMD.

The targeted benefit package will cover all ASAM LOCs and is designed to provide low-income beneficiaries in high-need counties with access to critical OUD and SUD services.

While the targeted benefit package for Demonstration Population #2 does not include physical health services, this population will have access to physical health services through partnerships with FQHCs, free clinics, and hospitals. In addition, to help beneficiaries access covered and non-covered services, all demonstration participants, including Demonstration Population #2 participants, will be offered a case manager.

All beneficiaries receiving services through this demonstration must meet medical necessity criteria.

Cost-Sharing

No modifications to beneficiary cost-sharing are proposed under this demonstration.

List of Waiver and Expenditure Authorities

Waiver Authority:

To the extent necessary to implement the proposal, the demonstration application requests that CMS, under the authority of section 1115(a)(1) of the Social Security Act (42 U.S.C. § 1315), waive the following requirements of Title XIX of the Social Security Act (42 U.S.C. § 1396) to enable the State of Alabama to implement this demonstration for enhanced SUD treatment.

1. **Statewideness**: Section 1902(a)(1)
   To the extent necessary to allow the State to limit enrollment in the demonstration for population #2 to persons residing in the following nine counties:
   - Blount
   - Cullman
   - Etowah
   - Jefferson
   - Madison
   - Shelby
   - St. Clair
   - Tuscaloosa
   - Walker

2. **Amount, Duration, and Scope of Services**: Section 1902(a)(10)(B)
   To the extent necessary to permit the State to offer benefits to Demonstration Population #2 that differ from the benefits offered under the Medicaid state plan.

3. **Reasonable Promptness**: Section 1902(a)(8)
   To the extent necessary to allow the State to limit enrollment via modification to eligibility thresholds for Demonstration Population #2.

Expenditure Authority:

AMA is requesting expenditure authority under Section 1115 to claim as medical assistance.

1. **Residential Treatment for Individuals with SUDs**
   The State requests expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management

services for SUD who are short-term residents in facilities that meet the definition of an IMD.

2. **Expenditures for Limited Benefit Package for Demonstration Population #2:** The State requests expenditure authority for coverage of Medicaid State Plan Rehabilitation Option services and residential treatment services provided in an IMD for individuals qualifying for Demonstration Population #2.

Budget Neutrality and Estimate of Expected Impact on Annual Enrolment and Annual Aggregate Expenditures

The following presents the Alabama Medicaid Agency's (AMA) approach to developing budget neutrality. The five-year demonstration is proposed to begin October 1, 2023, and end September 30, 2028, Table 1 outlines each demonstration year (DY).

Table 1 – Demonstration Years

Demonstration Year	DY1	DY2	DY3	DY4	DY5
Begin and End Dates	10/1/2023 – 9/30/2024	10/1/2024 – 9/30/2025	10/1/2025 – 9/30/2026	10/1/2026 – 09/30/2027	10/1/2027 – 09/30/2028

This demonstration will not reduce or negatively impact current Medicaid enrollment. Estimates of the member months are included in the Without and With Waiver Caseload estimates.

The budget neutrality caseload and per capita and expenditure projections were developed for the following two Medicaid Eligibility Groups (MEGs):

- **MEG 1 – Demonstration Population 1** – This MEG includes all Alabama Medicaid-eligible beneficiaries receiving services in an Institution for Mental Disease (IMD).

- **MEG 2 – Demonstration Population 2** – This MEG includes low-income, uninsured individuals who are not otherwise enrolled in Medicaid, whose household income is below 20 percent (20%) of the Federal Poverty Level (FPL) plus 5 percent (5%) income disregard, and who meet eligibility parameters resulting from a diagnosis related to substance use disorder (SUD) and the criteria outlined in the eligibility section for Demonstration Population 2. The beneficiaries enrolled in this MEG are eligible to receive Medicaid State Plan Rehabilitation Option services and residential treatment in an IMD.

Demonstration Population 1: Medicaid Inpatient Substance Abuse Users

To develop the With and Without cost and caseload projections illustrated in Table 2, AMA selected five years of historical data for inpatient hospital SUD admissions on a statewide basis as outlined below. Data was evaluated statewide to ensure an adequate number of individuals and data were represented and to develop a credible average per capita cost.

1. The five-year historical period used enrollment and claims expenditures between October 1, 2015, through September 30, 2020.
2. Historical enrollment reflects Medicaid beneficiaries who used an acute inpatient hospital admission for SUD.

3. The data selection process includes all acute inpatient hospital admissions that included two criteria:
    a. Acute inpatient SUD stays were flagged where the claim reflected a substance abuse disorder diagnosis in the admitting, first or second diagnosis codes.
    b. The inpatient admission included at least one inpatient day classified as detoxification.
4. Individuals with an acute inpatient substance abuse hospital stay as described in 3.a and 3.b were flagged for the month(s) of their inpatient stay.
5. Member months and claims data expenditures, including the acute inpatient substance abuse stays discussed in the prior steps, were selected for the month(s) the inpatient stay occurred.
6. This information was analyzed to develop the average per member per month (PMPM) expenditures and historical trends.

5-Year Historical Data

	SFY2016 (10/1/15-9/30/16)	SFY2017 (10/1/16-9/30/17)	SFY2018 (10/1/17-9/30/18)	SFY2019 (10/1/18-9/30/19)	SFY2020 (10/1/19-9/30/20)	5-Year Total
Member Months	834	709	838	1,079	981	4,441
Service Expenditures [1]	$4,207,349	$3,684,061	$4,307,225	$5,856,995	$6,701,168	24,756,799
Per Capita	$5,044.78	$5,196.14	$5,139.89	$5,428.17	$6,830.96	5,575
4-Year Trend *(Annualized)*						7.9%

1 - Service expenditures include inpatient substance use and all state plan services.

Trend Factor and Projection

The five-year historical data reflected an average annual per capita trend of 7.9%. This trend exceeded the anticipated President's budget trend factor of 6.6%; therefore, the lower trend factor of 6.6% was used to project the base period Alabama State Fiscal Year 2020 (October 1, 2019 – September 30, 2020) to each demonstration year (outlined in Table 1) for Without and With Waiver.

Demonstration Population 2: Low-Income Uninsured Adults Not Eligible for Medicaid with a Substance Use Disorder

Three years of historical enrollment and claims expenditures for SUD rehabilitation services from the Alabama Department of Mental Health (ADMH) were used to develop the per capita estimates for this demonstration group. Historical data included calendar years 2018 through 2020 by county of residence, and major service category, and are representative of the demonstration population. This data was limited to individuals who received SUD rehabilitation services for select counties (Blount, Cullman, Etowah, Jefferson, Madison, Shelby, St. Clair, Tuscaloosa, and Walker).

Historical data

	CY2018 (1/1/18-12/31/18	CY2019 (1/1/18-12/31/18	CY2020 (1/1/18-12/31/18
Member Months (Non-Residential Setting)	22,809	25,346	21,886
Member Months (Residential Setting)	4,322	4,488	3,694
Enrollees (Non-Residential Setting)	9,499	9,325	7,017
Enrollees (Residential Setting)	2,038	2,086	1,658
SUD Expenditures (Non-Residential Setting) [1]	$4,483,058	$5,867,806	$6,115,901
SUD Expenditures (Residential Setting) [1]	$6,791,570	$7,465,132	$7,547,183
Per Capita (Non-Residential Setting)	$196.55	$231.51	$279.44
Per Capita (Residential)	$1,571.40	$1,663.35	$2,043.09

1 - Service expenditures include substance use rehabilitation.

Trend Factor and Projection

To develop the projected Without and With the waiver, the per capita value for the calendar year 2019 (January 1, 2019 – December 31, 2019) was aggregated based on projected member month mix and trended at 5.1%, consistent with the increased adult trend, to each demonstration year (outlined in Table 1).

Without and With Waiver Caseload Estimates

Table 2 presents the without and with waiver caseload and expenditure Projections for the Medicaid SUD-IMD (Demonstration Population 1) and Adults (Demonstration Population 2) separately. The Without and With Waiver are equivalent and treated as “Hypothetical” because Alabama could otherwise have covered these populations and costs under a state plan amendment or a waiver.

As previously noted, this demonstration will not reduce or negatively impact current Medicaid enrollment. Estimates of the member months are included in the Without and With Waiver Caseload estimates.

Budget Neutrality Assumptions

Alabama makes the following assumptions about the projected budget neutrality:

- State administrative costs are not included in the budget neutrality calculations;
- Per capita expenditures are not adjusted for historical pharmacy rebates. Under the demonstration, the State will continue to report pharmacy rebates on Form CMS-64.9 Base, and not allocate to any Form 64.9 or 64.9P Waiver.
- Nothing in this demonstration application precludes Alabama from applying for enhanced Medicaid funding as CMS issues new opportunities or policies; and
- The budget neutrality agreement is in terms of total computable so that Alabama is not adversely affected by future changes to federal medical assistance percentages.

MEG 1 – Demonstration Population 1

- Alabama proposes a per capita budget limit for MEG 1.
- Approved state plan hospital access supplemental payments are excluded from the per capita amounts included in MEG 1. Hospital access payments will continue to be made in accordance with Alabama’s approved SPA.

MEG 2 – Demonstration Population 2

- Alabama proposes an annual and total expenditure limit for MEG 2.

Table 2 - Without and With Waiver Caseload and Expenditure Projections

MEG 1 – Demonstration Population 1					
Member Months	1,154	1,202	1,251	1,303	1,357
Enrollment [1]	1,154	1,202	1,251	1,303	1,357
Per Capita (PMPM)	$8,820.85	$9,403.02	$10,023.62	$10,685.18	$11,390.40
Projected (Total Computable) Expenditures	$10,178,465	$11,299,656	$12,544,350	$13,926,151	$15,460,162
Annual Trend Factor	*6.6%*	*6.6%*	*6.6%*	*6.6%*	*6.6%*

1 – MEG 1 represents substance use disorder in an IMD, the member months are equivalent to the enrolment.

MEG 2 – Demonstration Population 2					
Member Months	30,788	30,788	30,788	30,788	30,788
Enrollment	5,398	5,398	5,398	5,398	5,398
Per Capita (PMPM)	$481.67	$506.23	$532.05	$559.18	$587.70
Projected (Total Computable) Expenditures	$14,829,562	$15,585,870	$16,380,749	$17,216,167	$18,094,192
Annual Trend Factor	*5.1%*	*5.1%*	*5.1%*	*5.1%*	*5.1%*

Please reference Attachment A for more information on the budget neutrality calculations.

Public Notice and Tribal Consultation

Public Notice Process

In accordance with 42 CFR §431.408, Alabama used the following process to provide notice to the public about the opportunity to comment on the proposed SUD 1115 demonstration waiver. The public notice and comment period ran from DATE to DATE.

- Office Posting
  - On DATE, Alabama posted the public notice and made all waiver documents available for review in each county office of the Department of Human Resources, the State Office of the Alabama Department of Mental Health, and the State Office of the Alabama Medicaid Agency.
- Web Posting
  - On DATE, Alabama posted a public notice summary with the draft waiver on ADMH and AMA website at Web URL
  - On DATE, Alabama published an abbreviated notice in the State's administrative record, the Alabama Administrative Monthly.
- Provider Notice
  - On DATE, Alabama Medicaid sent electronic notice to Medicaid enrolled providers via its provider notice process.
- Electronic Mailing – Individuals requesting the waiver were emailed a copy of the waiver.

Alabama provided the following methods for the public to provide input on the draft waiver:

- Email inbox – Alabama established a dedicated email box: Email Address. Alabama received a total of X emails by the DATE deadline.
- Mail – Alabama provided a US Postal Service address for submission of public comments: Address. Alabama received a total of X letters by the DATE deadline.
- Fax– Alabama provided a fax number: Number. Alabama received a total of X faxes by the DATE deadline.
- Public Hearings –
    - Alabama held two public hearings on DATE and DATE and invited the public to provide comments on the draft waiver. At the public hearings, ADMH and AMA gave a presentation on the proposed SUD 1115 demonstration. Approximately X individuals attended the first hearing and X individuals attended the second hearing.

Summary of Public Comments

Please reference Attachment B for a summary of the public comments received.

Tribal Consultation

In accordance with 42 CFR §431.408, Alabama provided notice of the waiver application to Alabama's federally recognized tribe, the Poarch Band of Creeks, on DATE. Alabama received a total of X comments.

Evaluation

The demonstration will evaluate whether AMA and ADMH can improve outcomes for Medicaid beneficiaries with SUDs. This will be achieved by maintaining and increasing access to a full continuum of OUD and SUD services, including outpatient and community-based settings as well as in residential and inpatient treatment settings including settings that are identified as an IMD.

Through a contract with an independent evaluator, Alabama will conduct an independent evaluation to measure and monitor the outcomes of the demonstration. The evaluation will focus on the key goals and a subset of milestones of the demonstration with performance measures as outlined below.

The evaluation is planned to include the following milestones, research questions, hypotheses, and performance measures. Alabama will collaborate with its independent evaluator to refine the research questions, hypotheses, performance measures, data sources, and analytic methods.

Milestone 1: Increase access to LOCs for OUD and other SUDs for individuals in Medicaid.
Research Question: Has access to critical LOCs as defined below improved under the demonstration?
Hypothesis: The demonstration will increase access to the specified LOCs for Alabama Medicaid beneficiaries compared to prior to the demonstration.
Performance Measures:

• Number and percentage of individuals enrolled in Medicaid with a SUD diagnosis as well as those with an OUD diagnosis (monthly and annually) • Number and percentage of individuals enrolled in Medicaid receiving any SUD treatment • Number and percentage of individuals enrolled in Medicaid using each of the critical LOCs—early intervention, outpatient services, intensive outpatient and partial hospitalization services, residential and inpatient services, withdrawal management and medication assisted treatment (MAT) • Number and percentage of individuals enrolled in Medicaid treated in an IMD for SUD and the average length of stay in the IMD

Data Sources:	Analytic Approach:
• Medicaid claims	• Difference-in-differences • Descriptive time series

Milestone 2: Achieve widespread use of evidence-based, SUD-specific patient placement criteria
Research Question: Has widespread use of ASAM patient placement criteria been implemented?
Hypothesis: The demonstration will lead to increased use of evidence-based, SUD-specific patient placement criteria.
Performance Measures: • Number and percentage of providers licensed at each ASAM level of care • Number and rate of providers reviewed for compliance • Description of training and technical assistance activities to align providers with ASAM standards

Data Sources:	Analytic Approach:
• ADMH licensing records • ADMH auditing records • Key informant interviews and documentation review	• Descriptive time series • Thematic analysis

Milestone 3: Use nationally recognized, evidence-based SUD program standards to set residential provider qualifications
Research Question: Have evidence-based SUD program standards been used in evaluating residential treatment provider qualifications?
Hypothesis: The demonstration will lead to increased use of nationally recognized, evidence-based SUD program standards.
Performance Measures: • Number and percentage of providers licensed at each ASAM level of care

• Number and rate of providers reviewed for compliance	
Data Sources: • ADMH licensing records • ADMH auditing records	Analytic Approach: • Descriptive time series

Milestone 4: Improve provider capacity for critical LOCs, including MAT for OUD in Medicaid	
Research Question: Has the availability of SUD treatment providers (including MAT providers) enrolled in Medicaid and accepting new patients, improved under the demonstration?	
Hypothesis: The demonstration will increase provider capacity for SUD treatment in critical LOCs for Alabama Medicaid beneficiaries.	
Performance Measures: • Number of SUD treatment providers enrolled in Medicaid for each of the critical LOCs—early intervention, outpatient services, intensive outpatient and partial hospitalization services, residential and inpatient services, withdrawal management and medication assisted treatment (MAT) • Number of SUD residential treatment providers enrolled in Medicaid to provide Medications for OUD (MOUD)	
Data Sources: • Medicaid provider enrollment data	Analytic Approach: • Descriptive time series

Milestone 5: Improve comprehensive treatment and prevention strategies to address opioid abuse and OUD
Research Question: Has the demonstration improved outcomes for Alabama Medicaid beneficiaries with SUD through more appropriate use of opioids, improved adherence to treatment and decreased use of emergency departments and inpatient hospital settings, and decreased overdose deaths?
Hypothesis: The demonstration will improve outcomes for Alabama Medicaid beneficiaries with SUD on a variety of measures.
Performance Measures: • Rates of identification, initiation, and engagement in SUD treatment (NQF #0004) • Use of opioids at high dosages in persons without cancer (NQF #2940) • Concurrent use of opioids and benzodiazepines [PQA] • Continuity of pharmacotherapy (NQF #3175) • ED visits for SUD (and specifically OUD) among Medicaid beneficiaries/1000 member months • Inpatient admissions for SUD (and specifically OUD) among Medicaid beneficiaries/1000 member months

• Number of overdose deaths/1000 Medicaid beneficiaries/month and specifically overdose deaths due to any opioid	
Data Sources: • Medicaid claims • Public Health mortality data	Analytic Approach: • Difference-in-differences • Descriptive time series

Milestone 6: Improve care coordination and transitions between LOCs for individuals with SUD in Medicaid	
Research Question: Has the demonstration improved linkages between emergency department/ inpatient treatment and follow-up care and increased access to physical healthcare?	
Hypothesis: The demonstration will improve follow-up after emergency department and inpatient treatment and increase access to physical care among beneficiaries with an SUD.	
Performance measures: • Follow up after emergency department visit for alcohol and other drug abuse or dependence (NQF #2605) • 30-day readmission rate following hospitalization for an SUD-related diagnosis and specifically for OUD • Percent of beneficiaries, who access preventive and ambulatory health services. (HEDIS measure: Adults' access to preventive/ambulatory health services)	
Data Sources: • Medicaid claims • Interviews or focus groups	Analytic Approach: • Difference-in-differences • Descriptive time series • Qualitative analysis

Attachment A: Budget Neutrality

Detailed Budget Neutrality files will be included for final submission

Attachment B: Summary of Public Comments

Summary of public comments will be included for final submission