

Section 1115 Waiver Application

Oregon Health Plan

Substance Use Disorder Demonstration

Medicaid and Children's Health Insurance Program

Submitted: <DATE>



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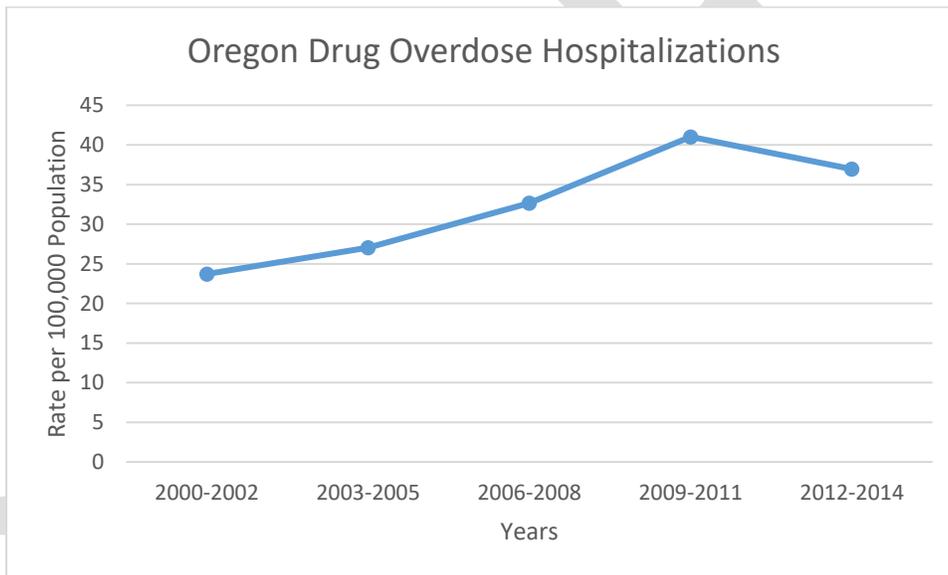
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Background

Oregon is among many states facing a public health crisis relating to substance use disorders (SUD). Of individuals accessing SUD treatment in Oregon, 33.5% (2017) had a primary diagnosis of opioid use disorder (OUD); this rate more than doubled over a four-year period from 2013 to 2017¹. Oregon’s opioid-related overdose deaths have increased during the past decade from 73 total deaths during 2000 to its high at 336 in 2011. In 2017 there were 6.8 deaths per 100,000 Oregon residents (276 total deaths)². All deaths related to all drugs in Oregon have remained high, increasing slightly from 13.760 deaths per 100,000 population in 2009 (529) to 14.18 deaths in 2017 (578)². From this, the need for continued system improvement across all substances of abuse is clear. As seen below in Table 1, analysis of available data of all drug overdose hospitalizations shows that the number of overdose hospitalizations for all drugs has increased significantly since 2000, although it is in a slight decline from its peak in 2011 (not all counties report this data to the state).

Table 1. Oregon Drug Overdose Hospitalizations



For adults in treatment in 2017 as seen in Table 2, Opioids (33.5%) are now the most common drug of choice, followed by Alcohol (30.1%), then Stimulants including: Cocaine, Methamphetamine and misuse of medicines such as Ritalin (25.3%). In 2017, youth in treatment’s most common drug of choice was Cannabis (75.4%), followed by Alcohol (12.8%) and then Stimulants (7.1%). Substance use disorder impacts other high-cost systems as well, including the child welfare system and the criminal justice system.

¹ “Prescribing and Overdose Data for Oregon.” *Oregon Department of Education: 2018 Social Sciences Standards SBE First Reading Draft: Social Sciences: State of Oregon*, 2018, www.oregon.gov/oha/ph/preventionwellness/substanceuse/opioids/pages/data.aspx.

Table 2. Percent of Total Persons in Treatment for a SUD, by Type of Drug

Primary Drug in Treatment ¹	Year in Treatment ²							
	2010	2011	2012	2013	2014	2015	2016	2017
Alcohol	54.6%	52.5%	50.3%	46.7%	39.7%	41.7%	38.4%	32.2%
Amphetamine/Stimulants	13.2%	13.0%	14.7%	17.8%	22.0%	22.8%	22.9%	26.0%
Cannabis	17.8%	18.8%	17.8%	17.1%	17.4%	16.2%	14.6%	10.5%
Cocaine	1.5%	1.4%	1.2%	1.1%	1.2%	1.1%	0.9%	1.2%
Heroin	7.2%	8.3%	9.7%	11.3%	included with opioids			
Opioids	4.9%	5.1%	5.4%	5.3%	29.0%	29.9%	32.9%	35.8%
Other/Unspecified Drugs	0.8%	0.9%	0.8%	0.7%	3.2%	2.2%	0.6%	0.9%
Sedative/hypnotics	0.1%	0.1%	0.1%	0.1%	0.4%	0.5%	0.5%	0.4%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

1. Due to small counts, hallucinogen and inhalants disorders are included in the category "Other/Unspecified Drugs". Beginning 2015 the diagnosis code associated with treatment services is the primary drug of treatment. Heroin is included in the Opioids category as there is no heroin-specific diagnosis code in the International Classification of Diseases 10 (ICD-10).

2. Counts are based on persons that received one or more treatment services during the calendar year. Treatment services include residential, outpatient, methadone maintenance or DUII treatment services. Between 2010 and 2013 the total is the sum of the column. Beginning in 2014 the total is the unique total of persons receiving treatment, not the sum of the column – in a single calendar year some persons may enter treatment for different addiction disorders, but they are counted only once in the total.

3. Data sources: 2010 to 2013 Client Process Monitoring System (CPMS); 2014 CPMS, Measure Outcomes & Tracking System (MOTS), Decision Support Surveillance and Utilization Review System (DSSURS); 2015-2016 MOTS and DSSURS. 2017 DSSURS.

Oregon's patient retention levels remain low across the treatment spectrum and the recovery delivery system; this is especially concerning regarding people with OUD. In early 2017 fewer than 30% of all publicly-funded SUD treatment programs nationwide offered Medication Assisted Treatment (MAT) to their clients³. Patients who receive MAT have a greater retention rate in treatment. This access gap is most acute within traditional residential and outpatient SUD settings throughout Oregon.

To address this crisis, improve health outcomes, and reduce deaths related to SUDs, Oregon is pursuing multiple approaches, including this waiver, across its state and local agencies, to ensure improved access to SUD treatment, increased provider capacity, and implementation of effective standards of care. Oregon proposes working to transform the SUD delivery system through evidence-based practices, Tribal-Based Practices, and a focus on providing a comprehensive and full continuum of care ([Attachment E](#)). Through the SUD waiver, as further described below, the state intends to demonstrate a new way to strengthen the state behavioral health care system by providing SUD services to individuals in intensive residential settings (i.e. Institutions for Mental Disease (IMDs) and maximizing federal funding opportunities to bolster existing programs and initiatives, and implementing new strategies to build comprehensive, recovery-oriented continuum of care services and supports.

³ "State and Local Policy Levers for Increasing Treatment and Recovery Capacity to Address the Opioid Epidemic: Final Report." ASPE, 13 Aug. 2018, aspe.hhs.gov/basic-report/state-and-local-policy-levers-increasing-treatment-and-recovery-capacity-address-opioid-epidemic-final-report.

Program Description

The Oregon Health Authority (OHA) is the Single State Agency that administers the Medicaid and State Children’s Health Insurance Program which includes mental health and substance use services and supports on behalf of Oregonians. OHA also administers the Substance Abuse and Mental Health Systems Administration (SAMHSA) Block Grant and provides funding and services for individuals with behavioral health needs that are either uninsured or underinsured by working with Oregon’s community behavioral health programs and the local alcohol and drug planning committees. With this infrastructure, Oregon is able to deliver SUD services to Medicaid beneficiaries, as well as to the uninsured in a coordinated collaborative structure.

Oregon is a Medicaid expansion state under the Affordable Care Act, with nearly 975,000 enrolled in Medicaid and CHIP in October 2019⁴. Nearly 90% of individuals are served through the state’s fifteen Coordinated Care Organizations (CCO)s. Oregon’s CCOs have been operational since 2012 through the state’s 1115(a) Medicaid and State Children’s Health Insurance Program Demonstration Waiver, “Oregon Health Plan” (OHP).

These CCOs have networks that include many types of health care providers (physical health, substance use disorder, mental health, dental, vision and transportation) who work together within their local communities to serve OHP individuals. To see CCO Service Areas and Oregon’s current SUD residential facilities see [Attachment A](#). Current SUD services are delivered through OHP’s comprehensive benefit package. OHP currently provides outpatient (ASAM 1.0), intensive outpatient (ASAM 2.1), day treatment (ASAM 2.5), residential (ASAM 3.1-3.7), withdrawal management (ASAM 3.2-3.7 WM), MAT, acupuncture, and peer delivered services ([Attachment D](#)).

OHA is committed to working with the Nine Federally Recognized Tribes of Oregon, and the Urban Indian Health Program (UIHP) to identify mechanisms to help ensure Tribal health care objectives are achieved while respectfully honoring tribal traditional based practices and upholding the government to government relationship between the sovereign nations and the state. OHA follows agreements and processes set forth in Oregon’s existing 1115 Medicaid Demonstration waiver, specifically Attachment I: Tribal Engagement and Collaboration Protocol, OHA’s Commitment Letter to Oregon Tribes, and the Tribal Consultation and Urban Indian Health Program Confer Policy. There are two Indian Health Services (IHS) clinics and eight Tribal Health Programs enrolled in Oregon Medicaid. The Urban Indian Health Program is enrolled as a Federally Qualified Health Center in the Portland area. Tribal programs provide prevention services, several outpatient treatment programs and two residential treatment programs, one youth and one adult, designated to serve Tribal members with culturally-specific services.

More than 50% of Medicaid and CHIP -eligible Tribal members in Oregon receive services on a fee-for-service (FFS) basis, rather than enrolling with a CCO. Many Tribal members prefer to receive services from Tribal Health Programs. These programs are crucial to providing culturally-specific services to Tribal members. Tribal Health Care also includes the use of Tribal-Based Practices which many can be reimbursed by the Oregon Health Plan. For more information See [Attachment B](#).

⁴ “HPAM’s Medicaid Monthly Population report from SharePoint Business Intelligence Center”; Health Policy & Analytics, OHA. data Source is DSSURS.

To transform Oregon's SUD system, the state is requesting a five-year waiver demonstration project for its SUD delivery system under section 1115 of the Social Security Act, entitled "Oregon Health Plan SUD Demonstration." Oregon is requesting approval from CMS through this waiver application to claim Federal Financial Participation for services provided at SUD residential settings that have been designated as IMDs. This will ensure continued access to treatment and continuity of care for individuals with the most intensive treatment needs who reside in IMDs.

This demonstration project will build on Oregon's efforts to develop the SUD continuum of care throughout the state and show the impact of the full continuum of care ([Attachment E](#)) for SUD individuals, from pretreatment and crisis intervention, through active treatment, and into recovery support, including those in need of intensive residential and withdrawal settings, and post treatment through recovery support services. The full continuum of care includes the provision of peer support services post treatment and practices on improving SUD outcomes for individuals, while controlling projected Medicaid costs for SUD services in Oregon. This is an integral part of the state's broader efforts to address the opioid and SUD crisis, as well as bolster the efficacy of SUD treatments and services. Over time these efforts will lead to better health outcomes for those individuals with substance use conditions.

Over the last several years, the Oregon Health Authority (OHA) has been exploring opportunities to enhance and improve the state's provider delivery system for SUD treatment with the purpose of addressing the growing opioid crisis and providing a robust person-centered approach that supports long-term recovery with a full continuum of care ([Attachment E](#)) for individuals with SUD. Oregon works to transform its SUD delivery system by creating a full continuum of care, improving access and utilization of high-quality appropriate treatment, increasing rates of identification and engagement in treatment, reducing recurrent visits to equal or higher levels of care including ED and inpatient admissions related to substance use, and improving quality of care and population outcomes for individuals with SUD. These efforts are described below.

In 2007, the Centers for Medicare & Medicaid Services (CMS) approved coverage of peer delivered services in Oregon's Medicaid State Plan and directed the state to define its training and certification requirements for both behavioral health and SUD. Peer Support Specialists and Peer Wellness Specialists provide outreach, system navigation, recovery and resiliency promotion and building community for individuals with behavioral health conditions, families and communities. Depending on where a person is in his or her recovery process, they can receive PDS in a variety of settings. Peer support services are being delivered in urban and rural communities to many different population groups defined by age (adolescents); race or ethnicity (Native American, Latino, African American); gender and sexual orientation; and/or co-existing conditions/status such as incarceration, homelessness, mental illness or HIV/AIDs. In Oregon, Peer Delivered Services are integrated at many levels of SUD treatment provision.

In September 2016, Oregon received and began implementing; the Medication Assisted Treatment-Prescription Drug and Opioid Addiction (MAT-PDOA) grant from SAMHSA for a period of three years which continued through September 2019. Through this grant Oregon has been able to:

- Increase treatment access by funding Opioid Treatment Program (OTP) expansion in Douglas and Coos Counties; underserved, geographically isolated areas with few MAT options previously.

Oregon Health Authority

- Expand office based opioid treatment (OBOT) options in the rural health care/primary care setting in the North Coast region of Oregon, an area with some of the highest overdose (OD), hospitalization and prescribing rates over the last 5-6 years.
- Provide training, education, and case consultation for the addiction medicine workforce statewide through the ECHO Program focusing on MAT and addiction treatment.
- Increase staff at the Bend Treatment Center for improved outreach and intake capacity at Central Oregon's only OTP, additionally, expand partnerships with community stakeholders to develop a comprehensive continuum of care and coordinate with these stakeholders on community wide priorities related to opioid use and misuse in the region.

The MAT-PDOA grant has allowed for system enhancement in areas of critical need across the states especially in underserved, rural and frontier regions.

In May 2017, Oregon was awarded the Opioid State Targeted Response (STR) grant by SAMHSA for a period of 2 years with a one-year, no-cost extension through 2020. Through this grant, Oregon is implementing the following:

- Enhancing state and community efforts to advance interventions that reduce prescription drug overdose (PDO) and problematic prescribing of controlled substances. Oregon has implemented PDO coordinators in nine regions of the state. Their focus is to train local prescribers, convene regional pain guidance groups, regional interdisciplinary action teams, and training local partners and providers in the prescription drug training program (PDMP).
- Project ECHO⁵ to increase the number of Drug Addiction Treatment Act (DATA) waived providers in Oregon who are actively prescribing MAT.
- Increasing access to MAT by expanding the number of Opioid Treatment Programs (OTP) throughout the rural regions.
- Establishing a robust network of naloxone distribution and training in regions most affected by the opioid epidemic.
- Enhancing a network of recovery support services within the correctional system through peer delivered services.
- Partnering with Oregon's Tribes and Urban Indian Health Program to provide funding for prevention, treatment, and recovery strategies within the individual Tribal health programs.

The overall goal of Oregon's STR grant is to enhance and expand access to recovery services especially in rural, frontier, and underserved regions of the state. Oregon has partnered with other state agencies and local communities and providers to implement the grant objectives.

In April 2018, to address the burgeoning opioid crisis, the Oregon Legislature enacted House Bill 4143 (HB 4143) to study barriers to MAT for SUDs, including addictions to opioids and opiates. HB 4143 directed OHA to implement a pilot project through January 2, 2021, placing peer recovery support mentors in emergency departments to support individuals who suffer from opioid and opiate overdoses. HB 4143 required OHA to develop a report and recommendations on the barriers around recovery and treatment of SUD. OHA, within this

⁵ "All About ECHO." *Oregon ECHO Network*, 2018, <https://www.oregonechonetwork.org/aboutecho>

report, recommended that issues be addressed at all levels. This report was presented to the Oregon State Legislature in July 2018⁶.

Oregon received the State Opioid Response grant (SOR), a two-year grant, from SAMHSA, in September 2018. Oregon, in partnership with substance use disorder (SUD) providers and other statewide partners, is focusing on increasing workforce capacity and access to MAT, especially in rural and frontier areas of the state. The SOR grant is focused on OUD (prevention, treatment, and recovery). The SOR grant is building upon the STR grant activities by enhancing and expanding the work being done around OUD and addressing the following targets:

- Increase access to MAT by increasing the DATA waived workforce, and by expanding OTP and MAT services;
- Provide Naloxone distribution and training in counties with high Naloxone rescue and overdose death rates. This includes community mental health programs (CMHP) coordinating with law enforcement and EMS to implement Naloxone training;
- Collaborating with Oregon Tribes and the UIHP to address Tribal-specific needs and gaps;
- Implementing peer delivered services (PDS) in emergency rooms for individuals who undergo Naloxone rescue or overdose.

The OHA is partnering with SUD providers in rural and frontier areas of Oregon, specifically those who are also applying to the National Health Services Corps (NHSC) to be an NHSC site. These rural and frontier NHSC SUD sites will utilize SOR funds to build the infrastructure to provide OUD services to their communities including outreach and wraparound services and combine the NHSC funds to attract and retain the workforce to serve the rural and frontier communities.

In addition, within the SOR grant, Oregon is supporting Tribal partners to expand the work of the STR grant to identify the needed OUD services for each Tribal community and how these systems can work together comprehensively. This includes the use of both evidence-based practices and Tribal Based Practices. Oregon recognizes the importance of being respectful and responsive to the unique needs of Tribal communities.

In July 2018, Oregon amended its Oregon Administrative Rules (OAR) requiring licensed and certified SUD providers to provide MAT services, or access to these services, to clinically appropriate clients. These OARs also prevent facilities from denying access to MAT to clients or requiring them to titrate as a condition of entry or remaining in a program. Often, individuals who are served in these settings are in need of higher levels of care than what primary care providers can provide and may not have access to an Opioid Treatment Program (OTP) within a reasonable distance.

By July 2020, Oregon's ambition is to have over 75% of these licensed and certified providers able to offer MAT services to their clients with OUD. State staff will continue to work with these providers to both deliver training and other technical assistance, as well as remove barriers to billing for these services. Working together, the Tribes and state adjusted the plan for implementation of this OAR to support the accessibility of

⁶ "Report on existing barriers to effective treatment for and recovery from substance use disorders, including additions to opioids and opiates." *Oregon Health Authority*, July 2018. <https://dfr.oregon.gov/business/reg/reports-data/Documents/legislature/2018-hb4143-dfr-legislation-reports.pdf>

MAT for the Tribal population. Initially, only one Tribe was implementing MAT and now with support from the state and outside resources, all Tribes and the Urban Indian Health Program are exploring the possibilities of what providing access to MAT could look like in their community. This allows Tribal programs to develop treatment programs that meet the needs of their people/clients, and are consistent with their values and culture, from abstinence-based programs to MAT programs.

In January 2019, Oregon released an RFA for a new CCO contracting cycle for 2020-2024⁷, referred to as CCO 2.0. CCO 2.0 implements policies that seek to improve behavioral health, including a focus on enhancing services and supports for individuals with SUD. Previously, administrative and billing barriers impeded integration efforts and created barriers to access and effective care for individuals with Severe and Persistent Mental Illness (SPMI) and SUDs. OHA staff developed policy options to address the issues identified through an extensive community feedback process, with a focus on behavioral health integration, access to services and an adequate provider network.

Specific to SUD, CCOs beginning in 2020, require access to a full continuum of care ([Attachment E](#)) throughout the state, including detox/withdrawal management, residential, outpatient and recovery support services. CCOs will prioritize access to SUD services for pregnant women, parents, families, and children, including access to MAT, withdrawal management, residential services, outpatient services and ongoing recovery support services for parents, and behavioral health screening and treatment for children. In CCOs beginning in 2020, there are enhanced standards for timely access to care for SUD populations, identifying those who are the most vulnerable and need additional support. This includes: requiring no wait time for intravenous (IV) drug users, requirement of interim services within 72 hours of being put on a waitlist and additional timely access standards for other prioritized populations with SUD. To further improve provider network adequacy, CCO requirements in 2020 include a culturally responsive and linguistically appropriate workforce, which must include Youth Peer Delivered Service Providers, Family Peer Delivered Service Providers, and Peer Delivered Service Provider Supervisors.

A critical shift in CCOs, includes enhancing intensive care coordination (ICC) standards for vulnerable populations, including individuals with SUD, children of parents with SUD and children with neonatal abstinence syndrome. CCOs will be required to have more frequent contact with individuals, effective care coordination, involvement with interdisciplinary teams (IDTs), and facilitation of IDT meetings to ensure fully integrated care. CCOs are also required to track reassessment triggers for individuals requiring ICC and have contact with individual's post- occurrence of these triggers. For the SUD population, some of these reassessment triggers include: a new hospital visit, a new behavioral health diagnosis (including Opioid drug use and IV drug use), a suicide attempt, severe to high level of self-reported or detected alcohol or benzodiazepine use while enrolled in a MAT program, and two or more readmissions to an acute care psychiatric hospital or an emergency department for psychiatric reason in a six-month period. These standards will ensure CCOs have a greater responsibility to follow the individual as their care needs shift and/or change and provide support as needed based on the individual's health needs, including access to ancillary services and improvement in individual's social determinants of health needs, such as housing. The intensive care

⁷ "Executive Summary CCO 2.0." *Oregon Health Authority*, 2018, <https://www.oregon.gov/oha/OHPB/CCODocuments/2018-OHA-CCO-2.0-Report-Executive-Summary.PDF>.

coordination standards were written to intervene with families at risk for child welfare services prior to involvement with child protective services.

By ensuring that individuals receive the right services, in the right place, at the right time, with additional care coordination supports for those with intensive needs, CCOs, beginning in 2020, will further improve behavioral health services for Oregonians impacted by SUD. Oregon Senate Bill 134, passed by the Legislature and signed by the Governor in June 2019, requires Oregon to consider Tribal-Based Practices as equivalent to evidence-based practices for the purposes of meeting standards of care for American Indians and Alaska Natives receiving mental health and substance abuse prevention, counseling, and treatment services, and to reimburse for these Tribal-Based Practices. The State will consult with Oregon's Nine Federally-Recognized Tribes to determine the Tribal-Based Practices that will be available for reimbursement for SUD prevention, counseling, and treatment. Once these Tribal-Based Practices are identified by the Tribes, Oregon will operationalize reimbursement for these practices by updating the claims billing system and issuing policy guidance around appropriate billing codes to use for these practices ([Attachment B](#)).

This waiver will operate in all geographic areas of the state, and services and supports will be available to all Medicaid and CHIP-eligible individuals experiencing SUD. Services provided will be subject to Oregon's Prioritized List of Health Services, as established in Oregon's existing 1115 OHP Demonstration Waiver, and services will be delivered through CCOs or via Fee-for-Service depending on the individual's enrollment.

CCOs, as established in Oregon's existing 1115 OHP Demonstration Waiver, are regionally-based and no single CCO provides coverage throughout the entire state of Oregon. CCOs provide coverage to Medicaid and CHIP-eligible individuals that reside within their service areas and they are contracted to provide coverage of and access to Medicaid and CHIP-covered services according to the Health Evidence Review Commission's Prioritized List of Health Services. CCOs deliver services within the communities they serve.

Summary of Proposed Demonstration Activities

Overall, this demonstration will create a full continuum of care ([Attachment E](#)) that will enable OHA to do the following: effectively reach and engage individuals who may benefit from, but are not currently accessing, SUD services, improve access to high-quality, clinically appropriate levels of care, and improve continuous engagement in treatment with effective care coordination, especially during transitions between levels of care, as well as provide services that effectively support individuals to maintain recovery.

Within this demonstration, Oregon will evaluate whether providing a full continuum of care and support (pre and post treatment across all levels of care, including tenancy and pre-tenancy barrier removal for transition out of treatment housing) will improve health outcomes among the Medicaid and CHIP recipients. Consistent with current Oregon Administrative Rules and Centers of Medicare & Medicaid Services (CMS) guidance to State Medicaid Directors, the levels of care are modeled after those recommended by the American Society of Addiction Medicine's (ASAM) criteria for treating addictive, substance-related and co-occurring conditions. See [Attachment D](#) for Oregon SUD services by ASAMs levels of care.

Proposed Waiver Authority Activities to Support Full Continuum of Care

Community Integration Services

Through this waiver, Oregon seeks to provide community integration services to those with SUD, including transitional housing support services, to support an individual's ability to transition from higher levels of care such as hospital or residential settings to less costly in-home and community-based settings.

Oregon will provide the following housing-related activities and support services to individuals with SUD:

1. **Housing Transition Services:** housing transition services, when not otherwise available, provided by appropriately credentialed professionals including but not limited to, Housing Specialists, Licensed Medical Practitioners (LMP), Qualified Mental Health Practitioner (QMHA), Qualified Mental Health Associate (QMHA), Certified Alcohol and Drug Counselor (CADC), certified peers and interns under appropriate supervision will provide direct support to individuals with SUD needing long-term services and supports and those experiencing chronic homelessness. This service is to enable participants to maintain housing as set forth in their approved plan of care. Those services include:
 - a) Conducting tenant screening and housing assessment. The assessment may include collecting information on potential housing transition barriers, and identification of housing retention barriers creating an initial housing action plan.
 - b) Developing an individualized housing stabilization plan based upon the housing assessment/initial housing action plan that addresses identified barriers, includes short and long-term measurable goals for each issue, establishes approaches to meet the goals, and identifies when other providers or services are needed; making referrals as necessary.
 - c) Assist with housing search process and application process.
 - d) Assist in identifying resources to cover expenses such as security deposit, move in costs, furnishings, adaptive aids, environmental modifications.
 - e) Ensure that the living environment is safe and ready for move-in.
 - f) Assist in arranging and supporting the details of the move.
 - g) Develop a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.
 - h) Initially conducts weekly, biweekly or as needed in-home sessions to identify, link and ensure the receipt of services and resources necessary to support housing stability.
 - i) Ongoing support may be offered as needed with monthly check-ins to monitor housing stability and address merging issues that may threaten housing stability.
2. **Housing & Tenancy Sustaining Services**
 - a) Education and training on the roles, rights, and responsibilities of the tenant and landlord.
 - b) Coaching on developing and maintaining key relationships with landlords/property managers with aim of fostering successful tenancy.
 - c) Assist in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse actions.
 - d) Advocacy and linkage with community resources to prevent eviction when housing is, or may potentially become, jeopardized.
 - e) Assist with the housing recertification process.

- f) Coordination with the tenant to review, update and modify their support and housing retention barriers.
- g) Continued training in being a good tenant and lease compliance, including ongoing support with activities related to household management.

Waiver authority will allow Community Integration Services as a covered benefit for OHP members with SUD. Oregon's Community Integration Services is modeled after similar services approved in other states' 1115 Waivers (e.g., Hawaii, Washington and Washington D.C.). Inclusion of Community Integration Services under the 1115 SUD Waiver authority permits the State to preserve the SUD continuum of care, while alleviating significant administrative burdens of creating and operating a separate Medicaid authority specifically for this service. CMS' approval of this service allows Oregon to move forward with its goals to increase the full continuum of care and improve the social determinants of health of our most vulnerable members.

Institutions for Mental Disease (IMD)

Aligning with CMS guidance for section 1115 waiver demonstrations for SUD reform, the purpose of Oregon's demonstration is to provide Medicaid and CHIP recipients access to the appropriate levels of treatment for SUD from early intervention and crisis intervention services, embedded MAT, high-intensity treatment in residential settings, including IMDs, to a continuum of recovery support services. Oregon is requesting CMS's approval to provide SUD services in SUD residential settings that have been designated as IMDs claiming Federal Financial Participation (FFP) for the duration of treatment deemed clinically necessary. This will enable the state to increase capacity to enhance SUD treatment and create a full continuum of care.

Currently, Oregon has 57 SUD adult residential programs. Twenty-nine of these facilities are licensed and qualify as IMDs. Five of the 7 youth and young adult programs in the state qualify as IMDs. In 2017, SUD adult residential facilities designated as IMDs served 1,897 individuals. Oregon is currently using its general fund dollars to pay 26 of the total 34 designated IMDs to serve OHP members. With the approval of this waiver, Oregon's SUD residential program capacity will increase by allowing Oregon to utilize all designated SUD IMDs, should they choose to participate, to serve the OHP population. Further, with the ability to access FFP, Oregon will be able to develop other non-IMD SUD residential treatment options which further creates capacity.

The ability to claim FFP for the use of IMDs will be an important component of Oregon's Medicaid and CHIP network and its full continuum of care. It is anticipated that claiming FFP for IMDs providing SUD services may reduce waitlists and increase access for individuals.

Oregon believes this waiver will achieve its purpose of increasing capacity to enhance SUD treatment and create a full continuum of care while also respecting the unique nature of Health Care for American Indians and Alaskan Natives in the state. Indian Health Care Providers intertwine traditional and cultural values in their programs, utilizing Tribal Based Practices. Oregon has recognized Tribal Based Practices equivalent to Evidence Based Practices in legislation, HB 3110 (2011) and SB 134 (2019).

Due to the importance of making available high quality and culturally competent services to AI/ANs, Oregon proposes to allow Indian Health Care Providers that qualify as an IMD to offer just one form of medication as part of MAT onsite, either an FDA-approved antagonist or partial agonist. This will allow Indian Health Care

Providers to determine the best fit for their program and demonstrate a pattern of success in treating OUDs in AI/AN communities while not being mandated to offer two types of medication. Spirituality, ceremonies, and cultural practices are used to support those in recovery. There are concerns that a mandate could conflict with these traditional values that are integral to the operations of these programs and we do not want to disrupt this well-established recovery community.

Recovery Support Services

Under Oregon's current Medicaid State Plan authority, Peer Delivered Services (PDS) are provided to individuals with a SUD diagnosis as part of a treatment plan developed and implemented by a licensed SUD treatment provider. Through this waiver, Oregon will expand access to Peer Delivered Services beyond the traditional treatment model to include access to PDS before and after active SUD treatment. Individuals will continue to receive PDS during treatment through the Medicaid State Plan. The individual's treatment plan will delineate services to prevent duplication of services or use of incorrect funding authorities.

Allowing access to peer-delivered services without a treatment plan will remove barriers to treatment and ensure individuals have access to recovery supports throughout the course of their recovery, including before and after active treatment and during transitions of care. Peers are a critical link between individuals and treatment services and enabling peers to work with individuals before they enter treatment may lead to an increased number of individuals engaging in treatment as well as earlier and more sustained engagement in treatment. Allowing individuals in long-term recovery to engage in services on an as-needed basis will allow for earlier intervention to prevent relapse, potentially preventing a return to higher levels of care after completion of treatment.

In addition to providing this expanded covered benefit within its current licensed and/or certified treatment provider network, through this demonstration Oregon will develop certification criteria and begin certification of Peer Run Organizations (PROs) as a new provider type that is independent from outpatient and residential treatment providers.

Peer Run Organizations are community-based organizations that are developed, administered, and led by individuals with lived experience of mental health or addiction challenges, whose boards of directors are comprised of a majority of peers or behavioral health consumers. Supports offered by Peer Run Organizations can complement the entire continuum of care and include education, outreach, prevention, crisis intervention, group, and individual long-term recovery support.

Currently, PDS providers must work and bill under the supervision of a qualified clinical supervisor. This waiver authority will allow peer delivered services to be provided and billed by state certified Peer Support Specialists and Peer Wellness Specialists who are under the supervision of a certified Peer-Run Organization.

Creation of this new provider type will expand the network of available providers and create more choice for behavioral health consumers. Peer-Run Organizations provide a lower-cost, person-centered, and trauma-informed alternative to traditional treatment settings. Peer-Run Organizations deliver services that are more integrated and person-directed than traditional SUD treatment, an approach that is more effective for some service users. Individuals who are less comfortable accessing care in traditional settings may be willing to

engage in services with a Peer-Run Organization, potentially allowing providers to reach individuals who might not otherwise enter treatment or recovery.

Allowing PDS to be utilized outside a treatment plan through a Peer-Run Organization will also allow the same PDS provider to follow an individual through all phases of treatment and recovery. Under the current rules, individuals must often stop working with a peer provider or switch to a new provider when they transition between levels of care. Allowing for more continuity of care will potentially lead to better experiences and better treatment outcomes for individuals.

Not only is there a shortage across the broader provider workforce, there is a distinct shortage of providers in communities of color and those serving Tribal populations. Workforce composition is critical for achieving cultural competence and delivering culturally responsive services. Providers that reflect the local communities are essential for connecting with service users within the community. Oregon seeks to address the unique and specific needs of our population by employing a culturally relevant workforce to work within the traditions and cultures of these diverse communities, so the services are responsive and well received by the community members. An important component of developing a diverse workforce is providing culturally relevant and responsive training. These trainings may also include developing Continuing Education Units and other culturally responsive trainings needed to bolster the existing workers as well as developing those new to the field.

Oregon has partnered with the Tribes in developing a culturally responsive, Tribal-specific Family Support Specialist Training called “Family Preservation” to train Tribal Members to become Family Support Specialists. To continue this work with support from the state, the Tribes wish to develop additional curricula for other types of Peer Support Specialists and Traditional Health Workers, specifically for work in Tribal communities. Oregon will continue to work closely with Tribal partners to determine how SUD prevention, early intervention, crisis intervention and recovery support services can be implemented to improve SUD full continuum of care for tribal members.

Proposed Medicaid State Plan Amendments and Activities to Support Full Continuum of Care

Case Management

Oregon will submit a State Plan Amendment (SPA) following approval of this waiver to expand the covered continuum of care to include case management services for all individuals with SUD on an “as needed” basis. Currently, case management services are offered as a covered benefit under the Medicaid State Plan for those with mental health diagnosis and for substance-abusing pregnant women and substance-abusing parents with children under age 18. This SPA will improve the parity of services between Mental Health and SUD services for OHP members, increasing the continuity of care and appropriate effective care coordination for individuals with SUD.

Case management is an ongoing process to assist individuals to gain timely access to and effectively use necessary health and related social services. Activities include coordination for timely access to care, management of integrated treatment planning, resource identification and linkage, and collaborative development of individualized services that promote continuity of health care. These specialized activities are

intended to improve an individual's experience of care, improve health outcomes and reduce costs by maximizing the benefits of the treatment, and to minimize the risk of unplanned re-admission and to increase the community tenure for the individual. These services will be provided by appropriately credentialed professionals by phone, in outpatient, hospital emergency departments, community, and in-home settings.

Crisis Intervention

Oregon seeks to expand the covered continuum of care to include crisis intervention services for individuals with SUD. Currently, Crisis Intervention Services are offered as a covered benefit under the Medicaid State Plan for those with mental health diagnosis but not for those with SUD. A SPA will be submitted following the approval of this waiver to offer Crisis Intervention Services to those with SUD. This will improve the parity of services between Mental Health and SUD services for OHP members, increasing the continuity of care.

Crisis Intervention is an intensive, short-term, brief service to stabilize an individual to cope with and overcome crisis. Crisis can occur at any time; the priority of crisis intervention is to hasten the process and achieve stabilization. Crisis intervention services must be applied "spur-of-the-moment" and be available 24 hours a day, seven days a week, 365 days per year. These services will be provided by appropriately credentialed professionals by phone, in outpatient, hospital emergency departments, community, and in-home settings. Crisis Services are time-limited and may include screenings, assessments, counseling, supportive services to prevent future crisis, providing services to support the person, address the crisis, look into treatment needs, and provide access to follow-up services.

Community Integration- Skills Training

Oregon seeks to expand SUD services to include a range of integrated and varied life skills training (e.g., housing assistance, employment, health, hygiene, nutritional issues, money management) provided in a wide array of settings, including residential, community, and outpatient, for Medicaid and CHIP enrollees intended to promote improved functioning, treatment retention and to minimize the risk of relapse and to increase the community tenure for the individual. Individuals engage in their treatment as outlined in their treatment and/or recovery plan and these services are restorative in nature. Duration and frequency of this service is determined by the individual's needs and documented in the individual's treatment and/or recovery plan. Providers authorized to deliver these services include CADC, LMP, QMHP, QMHA, Certified Peers and interns under proper supervision.

Early Intervention Services

Oregon will expand the covered continuum of care to include ASAM level 0.5, early intervention services. A SPA will be submitted following the approval of this waiver to offer Early Intervention services to those with SUD, as defined below. This will also improve the parity of services between Mental Health and SUD services for OHP members.

The services or activities are sub-clinical or pre-treatment and designed to explore and address problems or risk factors that appear to be related to substance use, and/or to assist individuals in recognizing the harmful

consequences or unhealthy substance use⁸. This may be done through activities and screenings such as the Screening, Brief Intervention, and Referral to Treatment (SBIRT) that is currently provided within primary care settings⁹. Early intervention services are for individuals whose problems and risk factors appear to be related to substance abuse but do not meet any diagnostic criteria for substance use disorders.

By identifying and engaging individuals in need of SUD services as early as possible, access to appropriate levels of care may be provided at lower levels more frequently. Early intervention by appropriately-credentialed professionals in a variety of settings, by phone, in outpatient, hospital emergency departments, schools, primary care, community, and in-home settings. Early intervention services may include screenings, informal counseling, referrals to supports relevant to the individual, providing access to those at risk of crisis, look in to treatment needs, and provide access to follow-up services. Services are provided to individuals who have problematic use or mild substance use disorders¹⁰. Reducing harms associated with substance misuse and reducing risk behaviors before they lead to injury and prevent progression to a disorder leading to the needed use of SUD services, are the primary goals of early intervention services¹¹.

Prevention Services

Oregon will provide SUD Prevention Services as part of the continuum of care. Although there is limited screening authority allowed through its current Medicaid State Plan, Oregon will submit a SPA following the approval of this waiver to include the services proposed below. This will improve the parity of services between Mental Health and SUD services for OHP members.

Prevention Services or activities are related to screening, education, psycho-education, and outreach designed to assist individuals in discovering and addressing problems or risk factors that are related to substance use, to assist in their recognizing harmful consequences or unhealthy substance use prior to use. Prevention Services are intended for individuals who are at risk of substance abuse but do not meet any diagnostic criteria for substance use disorders.

Providing these services will likely reduce the effects of substance use by identifying and engaging individuals prior to receiving a diagnosis of SUD. Prevention Services will be provided to individuals by appropriately credentialed professionals in a variety of settings by phone, in outpatient setting, hospital emergency departments, schools, community, in licensed mental health settings, and in-home settings. Prevention services

⁸ “Early Intervention, Treatment, and Management of Substance Use Disorders” In Facing Addiction in America: The Surgeon General’s Report on Alcohol, Drugs, and Health, Internet, Substance Abuse and Mental Health Services Administration (US); Office of the Surgeon General (US). Washington (DC): [US Department of Health and Human Services](https://www.ncbi.nlm.nih.gov/books/NBK424859/); November 2016.

⁹ “Screening, Brief Intervention, and Referral to Treatment.” *SAMHSA*, https://www.integration.samhsa.gov/SBIRT_Issue_Brief.pdf

¹⁰ Center for Substance Abuse Treatment. Brief interventions and brief therapies for substance abuse. Rockville, MD: Substance Abuse and Mental Health Services Administration; 1999. (Treatment improvement protocol (TIP) series, No. 34). (HHS Publication No (SMA) 12-3952)

¹¹ “Early Intervention, Treatment, and Management of Substance Use Disorders” In Facing Addiction in America: The Surgeon General’s Report on Alcohol, Drugs, and Health, Internet, Substance Abuse and Mental Health Services Administration (US); Office of the Surgeon General (US). Washington (DC): [US Department of Health and Human Services](https://www.ncbi.nlm.nih.gov/books/NBK424859/); November 2016.

may include information sessions, education, engagement, referrals to supports relevant to the individual’s needs, and provide access to follow-up services.

Some proposed services will require adjustments to CCO rates.

Rationale, Hypothesis and Goals

With Opioids becoming the number one drug of choice for those in treatment and the growing need for a continuum of care from pretreatment through recovery, leveraging of new federal Medicaid funding opportunities for SUD services will be critical to expanding the state’s capacity and to support its Medicaid and CHIP provider system in its efforts over the next five years and beyond. This demonstration will build on Oregon’s efforts to expand its SUD delivery system to a full continuum of care, improve access and utilization of high-quality appropriate treatment, increase rates of identification and engagement in treatment, reduce recitative visits to equal or higher levels of care including ED and inpatient admissions related to substance use, and improve quality of care and population outcomes for individuals with SUD. Over time, Oregon expects that these developments around crisis intervention, expanded peer delivered services and housing transition services will lead to fewer opioid-related deaths and better health outcomes for Medicaid and CHIP-enrolled individuals, including those IMDs.

Through this demonstration, Oregon will demonstrate the impact of having the full continuum of care for those utilizing the SUD service delivery network including those in IMDs. Oregon will evaluate the impact of increasing access to and utilization of appropriate level of treatment at the right time, at all levels of care, improving care transitions while the impacts of these on the quality of care, and the health outcomes of those with SUD within the Oregon services network.

Timeframe

The proposed time-frame for this demonstration is five years, beginning upon CMS’ approval. Oregon’s proposed effective date is July 1, 2020. Each of the strategies proposed have been analyzed according to degree of difficulty to implement and assigned a relative implementation timeframe of: 0 to 6 months; 6 to 12 months; or 12 to 24 months. See Table 3 for the time-frame.

Table 3. Proposed Time-Frame for SUD 1115 Demonstration Strategies

Item	Actions Required	Time Frame
Community Integration Services	Add Services under SUD Covered benefit through Fund Match through Waiver Authority	12 months- 24 months
Institutions for Mental Disease (IMD)	Fund match through waiver authority	0 months -6 months
Recovery Support Services	Add expanded Peer Delivered Services under SUD Covered benefit through Fund Match through Waiver Authority; with PROs as an added provider able to provide said services (defined	12 months- 24 months

Item	Actions Required	Time Frame
	below) through Waiver authority; Develop and support Culturally responsive trainings (Tribal, Latino etc.)	
Recovery Support Services: Peer Run Organizations (PRO) Certification	Add Services under SUD Covered benefit through Fund Match through Waiver Authority; add PRO Provider type Certification;	12 months- 24 months
Prevention Services	Add Services under SUD Covered benefit through SPA	12 months- 24 months
Early intervention Services	Add Services under SUD Covered benefit through SPA	12 months- 24 months
Crisis Intervention Services- Skills Training	Add Services under SUD Covered benefit through SPA	12 months- 24 months
Case Management Services	Add Services under SUD Covered benefit through SPA	12 months- 24 months

Waiver and Expenditure Authority

Below is a list of proposed waiver and expenditure authorities for this demonstration project, under section 1115 of the SSA- the Oregon Health Plan SUD Demonstration.

Table 4. Proposed Expenditure Authorities of the Social Security Act

Proposed Expenditure Authorities of the Social Security Act (the Act)		
Community Integration Services	Allow the state to operate the 1115 demonstration and to provide federal funding to cover community integration services to include services provided during treatment, transition to/ from treatment, pre/post treatment, and those outside of a treatment plan otherwise ineligible for federal financial participation	Waiver authority of Section 1902(a)(10)(A) and 1902(a)(10)(B), 42 CFR §440.230-250, and 1903(m) and 42 CFR §438.60 CNOM authority requested.
IMD Expenditure Authority & Duration of stay	To the extent necessary to allow the state to operate its section 1115 demonstration and to provide federal funding to cover services,	Waiver authority of Section 1903; 42 CFR §435.1009-10and 1905(a)(29)(B), 42 CFR 438.6(e)

Proposed Expenditure Authorities of the Social Security Act (the Act)		
	otherwise ineligible for federal financial participation, when furnished to Medicaid and CHIP beneficiaries that meet the federal definition of an Institution for Mental Disease (IMD) for the length determined clinically necessary.	If this section is allowing a waiver of the IMD exclusion. CNOM authority requested
Recovery Support Services	Allow the state to operate the 1115 demonstration and to provide federal funding to cover extend Peer Delivered Services to include services provided pre/post treatment, and those in remission, outside of a treatment plan otherwise ineligible for federal financial participation	Waiver authority of Section 42 CFR 8.12(f)(4) CNOM authority Requested

Demonstration Eligibility

The Table below illustrates the populations affected by or eligible under Oregon’s existing 1115 Medicaid and CHIP Demonstration and the eligibility and benefit criteria applied to each. Upon approval, this 1115 SUD waiver will serve the same populations. All groups are eligible under various Title XIX, XXI authorities and subject to the terms and conditions of the approved 1115 Medicaid and CHIP Demonstration. All population groups receive the full OHP Plus benefit package, with enhanced and/or protected benefits for children and pregnant women, and with no benchmark-equivalent coverage currently authorized. There are no enrollment limits on any population and no anticipated changes in eligibility processes or procedures outside of continued implementation of the state’s automated eligibility systems. American Indians and Alaskan Natives are exempt from mandatory managed care enrollment per The American Recovery and Reinvestment Act section 5006.

All OHP individuals will continue to be enrolled into a CCO unless they qualify for an exemption – granted if the individual is an American Indian or Alaska Native, or on a case-by-case basis. All exemptions will remain the same as in the current approved 1115 demonstration.

Table 5. Summary Chart of Populations Affected by or Eligible Under the Demonstration - SUD 1115 Demonstration

Popula tion	Description	Funding	Authority	Income Limits	Resource Limits	Benefit Package	EG Group	Delivery System
1	Pregnant women	Title XIX	Title XIX State Plan and	≤ 185% FPL	None	OHP Plus	Base 1	Managed Care (CCO) or Fee-for- Service

Popula tion	Description	Funding	Authority	Income Limits	Resource Limits	Benefit Package	EG Group	Delivery System
			section 1115					
3	Children 0 through 18	Title XIX	Title XIX state plan and section 1115	Children ages 1 through 18 included in the Medicaid state plan with 0% up to 133% FPL** Infants age 0 to 1 years with no income limit if mother was receiving Medical Assistance at time of birth; or Infants age 0 to 1 years not born to an eligible mother, an income limit of 185% FPL	None	OHP Plus	Base 1	Managed Care (CCO) or Fee- for- Service
4	Children 0 through 18	Title XXI	Title XXI state plan and section 1115	134% up to 300% FPL	None	OHP Plus	Base 1	Managed Care (CCO) or Fee- for- Service

Population	Description	Funding	Authority	Income Limits	Resource Limits	Benefit Package	EG Group	Delivery System
5	Foster Care/Substitute Care Children (youth to age 26, if already in the Oregon foster care; youth to age 18, if in the Oregon Tribal Foster Care)	Title XIX	Title XIX state plan and Section 1115	AFDC income standards and methodology converted to MAGI-equivalent -valet amounts	\$2,000	OHP Plus	Base 2	Managed Care (CCO) or Fee-for- Service
6	Medicaid mandatory section 1931 low income families. (parents, caretaker and other relatives)	Title XIX	Title XIX state plan and Section 1115	AFDC income standards and methodology converted to MAGI-equivalent -valet amounts	\$2,500 for applicants, \$10,000 for recipients actively participating in JOBS for TANF; no asset limit for TANF Extended Medical	OHP Plus	Base 1	Managed Care (CCO) or Fee-for- Service
7	Aged, Blind, & Disabled	Title XIX Medicare	Title XIX state plan and Section 1115; and those Dually Eligible for Medicare and Medicaid	SSI Level	\$2,000 for a single individual, \$3,000 for a couple	OHP Plus	Base 2	Managed Care (CCO) or Fee-for- Service

Population	Description	Funding	Authority	Income Limits	Resource Limits	Benefit Package	EG Group	Delivery System
7	Old Age Assistance (OAA)	Title XIX Medicare	Title XIX state plan and Section 1115; and those Dually Eligible for Medicare and Medicaid	Above SSI Level	\$2,000 single individual, \$3,000 for a couple	OHP Plus	Base 2	Managed Care (CCO) or Fee-for-Service
8	Aged, Blind, & Disabled	Title XIX Medicare	Title XIX state plan and Section 1115; and those Dually Eligible for Medicare and Medicaid	Above SSI Level	\$2,000 single individual, \$3,000 for a couple	OHP Plus	Base 2	Managed Care (CCO) or Fee-for-Service
9	Former Foster Care Youth to age 26	Title XIX	Title XIX state plan and Section 1115	No FPL limit if in Oregon Foster Care at age 18	None	OHP Plus	Base 1	Managed Care (CCO) or Fee-for-Service
21	Uninsured or underinsured women under the age of 65 receiving treatment services under the Breast and Cervical Cancer	Title XIX	Title XIX state plan and Section 1115	0% up to 250% FPL	None	Case-by-case basis	Base 1	Managed Care (CCO) or Fee-for-Service

Population	Description	Funding	Authority	Income Limits	Resource Limits	Benefit Package	EG Group	Delivery System
	Treatment Program (BCCTP)							
23	Low-Income Expansion Adults	Title XIX	Title XIX state plan and Section 1115	0% up to 133% FPL	None	ABP (OHP Plus)	Base 2	Managed Care (CCO) or Fee-for-Service

Demonstration Benefits and Cost-Sharing Requirements

Under this SUD 1115 Waiver request, Oregon intends to maintain all existing benefits and cost sharing requirements outlined in the current 1115 demonstration. Benefits and cost sharing requirements under the renewal demonstration period will not differ from those under the Medicaid and/or CHIP state plan.

- 1) Indicate whether the benefits provided under the demonstration differ from those provided under the Medicaid and/or CHIP State plan:
 - Yes
 - X No
- 2) Indicate whether the cost sharing requirements under the demonstration differ from those provided under the Medicaid and/or CHIP State plan:
 - Yes
 - X No

The following chart details the current benefits and cost sharing requirements that Oregon will maintain under the renewal request submitted to CMS.

Cost-sharing in Oregon

In alignment with the existing 1115 Medicaid demonstration Waiver the OHP has no premiums or other cost-sharing, but eligible individuals may be required to pay small co-payments for some prescription drugs. There are no proposed changes or additional cost sharing requirements.

Table 6. Oregon Co-Payments by service type

Service or benefit	Co-Payment
Substance Use Disorder Services (formerly chemical dependency services)	
• Prevention services	\$0
• Early intervention services (ASAM 0.5)	\$0
• Outpatient services (ASAM 1.0-2.5) and Residential (ASAM 3.1-3.7) services	\$0
• Medication/dosing/dispensing, case management	\$0
• Withdrawal management (ASAM 1-WM- 3.7) (formerly Inpatient hospital detoxification)	\$0
• Inpatient hospital (ASAM 4.0)	\$0
• Crisis intervention services	\$0
• Recovery support services	\$0
• Community integration services	\$0

Delivery System and Payment Rates for Services

No significant changes are being made to the existing CCO delivery system under the SUD 1115 waiver application. Primary changes will be enhancing and expanding services provided. Community Integration services will be an entirely new service. Please refer to the list of covered services described in Oregon’s approved 2017-2022 1115 OHP Demonstration Waiver.

Oregon will use the following delivery system in the SUD 1115 Waiver Application in alignment with the Medicaid and CHIP Demonstration Waiver:

- Coordinated Care Organization (Managed Care Organization)
- Fee-for-service

The SUD Waiver will not alter the current delivery system used for each eligibility group. Table 4 on pages 14-17 outlines the current eligibility groups and corresponding delivery systems that will be used in the demonstration period from 2020-2025.

CCOs and their provider networks are currently under contract with the state of Oregon to provide SUD services. In compliance with state statute and contracting requirements, CCOs will continue as the state’s delivery system to procure SUD services.

Under the SUD Waiver, Oregon will utilize its current 1115 OHP Demonstration Waiver to use its Prioritized List of Health Services to manage benefits under the OHP. The state will continue to use its existing waiver authority to provide services that appear above the funding line established by the Oregon Legislature, including ancillary services for these conditions. The state will also provide medically appropriate diagnostic services required to establish a diagnosis or guide treatment decisions. The funding line can only be moved to a higher position (resulting in fewer services provided) at the request of the Oregon Legislature and as approved by CMS. The state will continue to provide treatment for conditions that do not appear above the funded line when associated with a co-morbid condition which appears in the funded region of the list.

Fee-for-service payments will be made by the OHA for services provided to individuals not enrolled in a CCO or in situations where services are “carved out”, and those payments are made according to the state fee schedules and state plan methodologies.

Oregon Health Authority

Through this waiver, claiming of FFP for IMDs will increase the state's capacity to meet the need for enhanced SUD treatment and full continuum of care.

Since September 2012, the OHA has contracted with CCOs to provide coordinated care to its Medicaid and CHIP-eligible population; there are currently 15 CCOs that will cover the population in calendar year 2020. The purpose of the CCO model is to achieve the triple aim of better health, better health care, and lower per capita cost. Over 90% of the OHP individuals are enrolled in CCOs for one or more of Physical Health, Mental Health, and Dental services, with the remaining individuals being enrolled in FFS. The Oregon Health Authority contracts with an actuarial vendor, Optumas, to develop the capitation rates. The rate development process starts with recent historical statewide data on the cost of providing care. Those data are then projected with expected membership changes, trend (inflation), and changes in utilization to the rating year. The process then takes into account geographic, hospital, and member risk factors that impact individual CCOs' expected costs, resulting in CCO-specific payment rates that reflect each CCOs' individual risk. More information on the rate methodology can be found at the following link:

<https://www.oregon.gov/oha/HPA/ANALYTICS/OHPRates/Oregon%20CY20%20Rate%20Certification%20-%20CCO%20Rates.pdf>

Oregon will continue its incentive programs for both CCOs and hospitals in alignment with the current approved 1115 OHP Demonstration Waiver, utilizing the pay for performance programs as levers to drive focus on quality and access improvement efforts across the health system. Both CCO and hospital incentive programs will continue for the duration of the waiver, which will be guided by the legislatively-appointed public committees to review program performance, select measures and set benchmarks on an annual basis.

Providers in Oregon's Coordinated Care Organization system may receive quality-based supplemental payments in two ways:

CCOs are incentivized to increase quality and access to care through the "Quality Pool" incentive arrangement approved in Oregon's approved 1115 OHP Demonstration Waiver. Oregon's Metrics and Scoring Committee, under the Health Plan Quality Metrics Committee, maintains Oregon's CCO Incentive Measure Set. That set of measures is altered slightly each year to reflect priorities, and alcohol and other drug screening is included in the 2020 measure set.

As per the approved 1115 OHP Demonstration Waiver, STC 24b.ii, OHA will contractually require each CCO to address four of the quality improvements focus areas issues, using rapid cycle improvement methods to:

- Study the extent and unique characteristics of the issue within the population served,
- Plan an intervention that addresses the specific program identified,
- Implement the action plan,
- Study its events, and
- Refine the intervention.

Specifically, CCOs are required to participate in one statewide Performance Improvement Project (PIP) which focuses on integrating primary care, oral and/or behavioral health. During the course of this 1115 SUD Waiver, CCOs will develop a second statewide SUD-specific Performance Improvement Project (PIP). To support a culture of improvement, alignment of resources, while recognizing the burden of change fatigue and reduction in administrative burdens, CCOs will use the statewide SUD-specific PIP to fulfill the requirements of one of the four required PIPs under the approved 1115 OHP Demonstration Waiver.

Therefore, CCOs will be conducting a total of two statewide PIPs as described above and two individual PIPs chosen to address their local community needs and strategies for health transformation and improvement.

A SUD-specific statewide PIP will be developed in accordance within the CMS PIP protocol, as is the current practice for the Integration statewide PIP. A SUD-specific statewide PIP will be developed with CCOs during the current quality structure of meetings; Quality Health Outcome Committee (QHOC) and the Behavioral Health meeting with OHA and CCOs. As the SUD-specific statewide PIP is implemented, discussions relating to interventions, barriers, best practice sharing, and technical assistance will be provided within these meeting structures as well.

Beginning 2021, OHA will work with CCOs to identify SUD value-based-payment models that could be implemented with their providers. Technical assistance and learning collaboratives will focus on contracts that include a value-based payment component as defined by the Health Care Payment Learning and Action Network's (LAN's) "Alternative Payment Model Framework White Paper Refreshed 2017" (<https://hcp-lan.org/apm-refresh-white-paper/>), Pay for Performance category 2C or higher. OHA will broadly share SUD VBP resources so that all CCOs would have the ability to modify and implement VBP models that work best in their communities with their members.

Implementation of Demonstration

Implementation Schedule: All the changes proposed in the SUD demonstration application will be implemented in year 1 and 2 (July 1, 2020- July 2022). Each of the strategies proposed has been analyzed according to degree of difficulty to implement and assigned a relative implementation timeframe of: zero to six months; seven to 12 months; or 12 to 24 months, see Table 2 on page 13.

Notification and Enrollment of demonstration participants: Oregon will continue to use its current notification process under the current 1115 OHP Demonstration Waiver renewal.

Contracting with managed care organizations: In January 2019, Oregon released a new RFA for a new contracting cycle for 2020-2024¹². The state is contracted with the 15 CCOs that cover individuals throughout Oregon. CCOs will continue as the state's delivery system for managed care.

Demonstration Financing and Budget Neutrality

Oregon understands that the state must demonstrate budget neutrality for the OHP SUD demonstration. Please refer to the OHP SUD Budget Neutrality Spreadsheet at [Attachment G](#) for information regarding the basis of the budget neutrality calculations and trend rates.

Budget neutrality for the Oregon behavioral health (BH) 1115 Waiver will be demonstrated through the use of the per capita method outlined in CMS SUD 1115 demonstration budget neutrality template ("CMS template").

¹² "Executive Summary CCO 2.0." *Oregon Health Authority*, 2018, <https://www.oregon.gov/oha/OHPB/CCODocuments/2018-OHA-CCO-2.0-Report-Executive-Summary.PDF>.

Oregon Health Authority

The budget neutrality projections were developed using CMS requirements, with the format adjusted to accommodate the two categories of services outlined in this demonstration request.

As discussed above in this application, Oregon is requesting demonstration authority for the following cost not otherwise matchable (CNOM) expenditures:

1. Expenditures for services furnished to beneficiaries who are residing in an institution for mental diseases (IMD) primarily to receive treatment for a substance use disorder (SUD)
2. Expenditures for community integration and recovery support services. Community integration services provide housing support services to individuals with SUD who experience chronic homelessness or at risk of homelessness. Recovery support services provide peer support services outside of standard treatment to support individuals in their recovery throughout the full continuum of care.

For the purposes of budget neutrality, this application assumes that both services shall be considered hypothetical expenditures and treated as pass-through services for the purposes of budget neutrality. As clarified by CMS guidance,¹³ SUD IMD expenditures (Service 1) are deemed as hypothetical as they would have been otherwise allowable under Medicaid were it not for the IMD/settings prohibition. Likewise, expenditures for recovery support services would have been otherwise allowable under Oregon's Medicaid state plan if they were delivered within a treatment plan. Although authority is an option through a 1915i application, community integration services are requested as a CNOM under this 1115 SUD Waiver application to permit the State to preserve the SUD continuum of care while alleviating significant administrative burdens of creating and operating a separate Medicaid authority specifically for this service given it is limited to the targeted SUD population.

The narrative below describes the budget neutrality calculations outlined in [Attachment G](#).

Overall Approach

Oregon's budget neutrality calculations utilize the approach outlined under Scenario 2 on the CMS template as the state seeks CNOM authority for IMD expenditures as well as additional hypothetical SUD services that can be provided outside the IMD under two budget neutrality limits as directed by CMS. The CMS template has been modified to include six Medicaid eligibility groups (MEGs), as defined below. Tab 2/SUD Historical has been modified under Optional Step 2a for alternative PMPM development when historical data is unavailable. It has been modified to remove reference to IMDs and display the projected base expenditures, member months, and PMPMs by MEG for hypothetical CNOM services for Community Integration and Recovery Support Services.

Estimation for the IMD Cost Limit

To estimate the projected costs for medical assistance during months in which Medicaid eligible enrollees are at an IMD, 5 years of Oregon historical data is provided on overall Medical Assistance (MA) costs for individuals with SUD diagnosis who received inpatient treatment for SUD (or could have received inpatient treatment if

¹³ SMD # 18-009RE: *Budget Neutrality Policies for Section 1115(a) Medicaid Demonstration Projects*. August 22, 2018

such services were available) to determine average cost per user of SUD inpatient services for each historical year.

Oregon's calculations of SUD IMD costs include all approved medical assistance services provided to Medicaid beneficiaries during an IMD member month – both IMD costs and non-IMD Medicaid costs – but do not include costs associated with room and board as specified by CMS. IMD member months are any whole month which a Medicaid eligible is inpatient in an IMD facility at least 1 day.

Data includes capitation payments and all approved fee-for-service payments made to providers in a month when a Medicaid beneficiary was inpatient in a SUD IMD for at least one day. Data excludes beneficiaries over age 64 and facilities with 16 or less beds. An adjustment was added to the IMD Cost Limit for state fiscal year 2019 expenditures for each MEG outlined below to capture in the base an increase to the rates of two procedure codes in October 2019. The procedure codes are provided in the supplemental data worksheet on the IMD cost worksheet.

Estimation of the SUD Hypothetical CNOM Services Limit

Oregon estimated the service limit for the SUD hypothetical CNOM expenditures with a projected average PMPM cost of the additional services for the population eligible to receive them. The PMPM includes the estimated costs of Community Integration and Recovery Support Services (Service 2). As Oregon has not covered these services historically, we do not have historical data for projecting future average expected costs for the individuals who are eligible for receiving the services. We determined the base year PMPM and member months on the current rates for these services while in treatment and the expected utilization based on the utilization of the codes under treatment for Mental Health and Substance Use Disorder. A trend rate, as described below, was applied to the base projections.

Overview of Medicaid Eligibility Groups Included in Calculations

The IMD services will be utilized by Oregon Health Plan beneficiaries from the following Medicaid eligibility groups (MEGs):

- Parent, Caretaker, Relative (PCR)
- Pregnant Women (PWO)
- Children's Medicaid (CMO)
- Aid to Blind & Disabled (ABAD)
- Foster Care/Substitute Adoptive Care (FC/SAC)
- Affordable Care Act (ACA)
- Children's Health Insurance Program (CHIP)
- Citizen-Alien Waived Emergency Medical Prenatal (CAWEM Prenatal)

The SUD hypothetical CNOM services will be utilized by the same MEGs as the IMD services with the addition of Old Age Assistance (OAA).

This list of MEGs mirror those in the broader Oregon Health Plan Section 1115 demonstration with two exceptions. The Breast and Cervical Cancer Treatment (BCCP) MEG was not included as very little historical data was found for this group currently utilizing SUD IMD and there is insufficient data to warrant including a

projection for this group at this time. In the event BCCP individuals begin to utilize SUD IMD services, the BCCP MEG will be included at that time. The Old Age Assistance MEG was only included in the SUD hypothetical CNOM services as the request for SUD IMDs does not apply to individuals over 64 years of age.

Application of Trends for Projections

The PMPM costs under the IMD Cost Limit are trended forward by MEG using the lesser of the President's Budget rate of 4.50% and Oregon's historical trend, with the exception of three MEGs-- Aid to Blind & Disabled (ABAD), Foster Care/Substitute Adoptive Care (FC/SAC), and Children's Health Insurance Program (CHIP), which are trended forward at 4.50%. Calculating the historical trend using data from 2015 reflects a negative PMPM trend for these MEGs which is not expected going forward. The PMPM costs under the SUD hypothetical CNOM services are trended forward by MEG using the President's Budget rate of 4.50%.

Member Month Non-Duplication

As outlined in the CMS template, the IMD Cost Limit member months in Oregon's calculation are non-duplicative of SUD hypothetical CNOM services limit member months. The IMD member month is defined in the calculations as any whole month during which a Medicaid eligible is inpatient in an IMD at least 1 day. The SUD hypothetical CNOM member month is defined as any month of Medicaid eligibility in which a person could receive a SUD hypothetical service that is NOT an IMD member month. These definitions also follow those in the CMS template.

Oregon also understands that the IMD Cost Limit member months will be non-duplicative of member months reported under the state's broader section 1115 Oregon Health Plan demonstration. To avoid duplication between the two demonstrations, explicit adjustments will be included in the broader 1115 demonstration budget neutrality reporting to remove the months from the OHP waiver that are included in the calculation for the SUD demonstration. This adjustment will only be made for the IMD Cost Limit member months as the SUD hypothetical CNOM services member months can be duplicative of general comprehensive demonstration budget neutrality limit member months as clarified in the CMS template.

Evaluation

Oregon has developed a draft evaluation plan to be submitted and approved by CMS. Upon approval of the demonstration and evaluation plan, an independent party will be contracted to conduct an evaluation of the demonstration to ensure the collection and analysis of the demonstration. This evaluation will be done independently and in alignment with the CMS-approved, draft evaluation design. Every effort will be made to follow the design when conducting analyses, evaluations and reporting. The state may request, and CMS may agree to a change in the methodology under specific and appropriate circumstances.

With the draft evaluation design, a draft budget is provided ([Attachment F](#)). It shall include the total estimated cost with breakdowns of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, data collection, cleaning, analyses and report generation.

1. Overview of the Evaluation of the SUD Waiver

Upon approval of the demonstration, an independent third-party evaluator will conduct Oregon's SUD demonstration evaluation. They will examine the expansive goals of the proposal and provide indicators about the effectiveness of strategies to achieve the waiver goals. The evaluation plan will be in alignment with the CMS-approved demonstration waiver. In general, the evaluation follows three global activities: 1. Observe structural and process changes in service delivery transformation, 2. Analyze key outcomes of the waiver strategy and 3. Study the relationship, if any, between the service transformation and the outcomes observed. The evaluation will identify the strength of different drivers for better performance across the state to achieve improved outcomes for Medicaid and CHIP members.

The next several sections will describe the expected changes from the demonstration project, the expected observed outcomes, the design for the evaluation, the measures and data sources, and the proposed analytic plan.

2. Description of Programmatic changes expected to result from the demonstration

The strategies used to achieve the goals of this demonstration are expected to bring service delivery improvements in care. These improvements include an increased trained provider work force (including MAT services,) increased community knowledge of treatment and recovery support services as a result of education, expanded actions from providers to find members with SUD at all levels of care, increased member engagement with timely treatment, and better coordination among all providers of health-related services.

Using strategies to transform service delivery and with improvements in service availability and access, the state expects to improve service capacity for Medicaid beneficiaries. In addition, these strategies could reduce overall relapse rates as well. Improvements to community services and support will result in a corresponding reduction in the need for Inpatient SUD services and Emergency Department visits. Substance-related crises will be treatable at a lower level of care. In turn, increased community support and access should lead to decreased rates of readmission and a lower needed intensity of care. Improvements in care coordination between physical and behavioral health will lead to faster, more effective responses for Medicaid and CHIP members.

3. Expected Observed Outcomes

We will monitor and evaluate SUD-related health services and outcomes through data collection from the Medicaid Management Information System (MMIS) and quality measure and performance improvement projects' reporting from CCOs. In addition to claims measures, some of the data may be extracted from primary care electronic health records as the state is currently implementing a Clinical Quality Metrics Registry. Oregon plans to use standardized quality measures as part of the assessment and evaluation of this demonstration.

Using strategies to drive improvement and transformation in services will result in higher initiation and member engagement in SUD treatments, improving the rate of no-shows to referrals and drop outs from treatment. Improvements in linkages to SUD treatment providers after discharges from both hospital inpatient care as well as emergency department release will be observed because of better work processes and provider education. Over time, Oregon expects to observe a decrease in high dosing of opioids for members without cancer for single and multiple providers due to increased training as well as policy changes.

Oregon expects to observe over time a decreasing trend in the number of fatal and non-fatal overdoses from opioid use. Improvements will be seen in overdosing related to greater access to treatment services including MAT services, as well as early case finding and care coordination across the continuum. Hospital based observed outcomes will include lowered inpatient admissions and a low rate of births with neonatal abstinence syndrome because the services will become better integrated and available in the community.

Quality ratings for members with SUD issues are expected to improve on several key questions such as “I’m better able to control my life,” “symptoms do not bother me as much,” “I was able to get the services I thought were needed.” As well as the members’ experience of change attributed to treatment and their own picks from a list of ten improvements, they think are due to their care. As education about peer services and their availability is disseminated broadly across the state, we think the use of this support will expand. In addition, increases in rates of peer-delivered services are expected as well as ratings of helpfulness for those peer services.

Finally, due to improvements in service transformation, costs to the health plan are expected to decrease as lower acuity services become more widely available.

4. Evaluation Design

- A. Design Plan. Much of the design discussed in this section is observational using advanced statistical models with Oregon as its own historical control. The opportunity may exist to include some components of a quasi-experimental design with another state comparison group. Steps in the design plan include early operational definitions and obtaining the measure specifications, identifying the transformation assessment in delivery of services, measurement of care process changes and investigation into transformation and relationship to observed outcomes.

Operational definitions will include definitions of member coverage periods to assure that beneficiaries have enough exposure to the effects of health plan transformation. Typically, continuous enrollment is defined as six to nine months of coverage in Medicaid and CHIP. Further identifying the time boundaries of the study and obtaining the appropriate claims and electronic health record data and survey information will be done in the early phases of the evaluation.

Equity analyses will include race and ethnicity as well as rural and urban disparities in services and outcomes. Approximately 40% of Oregon beneficiaries are from racial and ethnic minority groups. Rural definitions will be taken from zip codes of last known addresses from beneficiaries as well as Rural-Urban Area Designations as defined by federal programs.

- 1. Observational Measures for Structural Transformation--**
 - a. Number of trained MAT providers within county community
 - b. Density of population to SUD treatment and MAT providers
 - c. Public health education about SUD/MAT
 - d. Changes in provider prescribing patterns for pain
 - e. Number of treatment facility certifications and/or licensed
 - f. Utilization and types of recovery support services
 - g. Meetings and stakeholder interviews with community leaders
 - h. Peer support usage and experiences
 - i. Access and usage of community integration services and supports

- 2. Process Measures for Transformation**

- a. Shorter duration between screening, assessments and treatment
- b. Improved facilitated care transitions between levels of care
- c. Decreased ED visits associated with SUD
- d. Decreased SUD readmissions to hospital at same or lower level of care
- e. Improved integration of physical and behavioral health services
- f. Timely engagement at appropriate stages of treatment

3. Outcome Measures of Transformation

- a. Fatal and non-fatal overdose decline
- b. Improved quality ratings from the member surveys for people with SUD
- c. Low rates of unplanned neonatal abstinence syndrome prevalence
- d. Decline in inpatient admissions for individuals with SUD
- e. Decrease in overall costs for health plan, clinic and community for individuals with SUD

B. Evaluation Questions and Hypotheses

Domain	Research Questions/Hypotheses	Measure Sources	Unit of Measurement
Transformation			
<i>Providers</i>	Does increase in number and density of providers improve quality of care?	Provider work force results and initiation rate, prescribing patterns Screening/treatment gaps	Health Plan and County
	Does increase in number of certified and/or licensed facilities improve initiation and engagement of members?	Counts of facilities and initiation/engage rates of members with SUD	Health Plan and County
	Do structural improvements to access and care transition improve acuity levels of care?	Provider work force results, screening, referral locations	Health Plan and County
	Do changes in provider prescription behaviors (increase prescribing of MAT decrease in Opioid	Prescribing patterns and positive	Health Plan and County

Domain	Research Questions/Hypotheses	Measure Sources	Unit of Measurement
	for pain) improve prevalence outcomes?	screenings for SUD, relapse rates	
<i>Education</i>	Does education of community and providers about SUD/MAT improve member initiation and engagement?	Rates of training exposure in community and with providers, rates of members with SUD initiating treatment and completing treatment	Health Plan and County
	Does peer support improve member ratings of care?	Rates of peer support and ratings of members with SUD	Health Plan and County
Outcomes			
<i>Treatment</i>	Will structural and process changes for services result in improved member participation in treatment?	Initiation and engagement of SUD treatment (NQF #004);	Health Plan and County
	Will better coordination of services result in better care transition at discharge?	SUD treatment provider offered at discharge/ SUB-3a SUD treatment at discharge (NQF #1664);	Health Plan
	Will better coordination of services result in provider follow up after ED use?	Follow-up after discharge from the Emergency Department – SUD (NQF #2605);	Health Plan
<i>Prescribing</i>	Will provider training and policy changes result in	Use of opioids at high dosage in	Health Plan

Domain	Research Questions/Hypotheses	Measure Sources	Unit of Measurement
	changes to prescribing patterns in practice?	persons without cancer (PQA);	
		Use of opioids from multiple providers in persons without cancer (PQA);	Health Plan
		Use of opioids at high dosage and from multiple providers in persons without cancer (PQA); and	Health Plan
		Initiation and engagement of SUD treatment (NQF #0004).	Health Plan
<i>Outcomes</i>		<ul style="list-style-type: none"> Fatal and non-fatal overdoses 	Health Plan and County
		<ul style="list-style-type: none"> Member quality ratings 	Health Plan
		<ul style="list-style-type: none"> Neonatal abstinence syndrome prevalence 	Health Plan
<i>Acuity</i>	Do structural and process changes in service delivery result in lowered acuity of care such as inpatient admissions?	Inpatient admissions	Health Plan
<i>Cost</i>	Does transformation and process improvement result in lowered cost due to fewer inpatient admissions and lower acuity?	Multiple structural and process change variables and hospital admission, ED use and treatment levels	Health Plan and County

Domain	Research Questions/Hypotheses	Measure Sources	Unit of Measurement
	Do improvements in structural changes, processes and outcomes result in decreased costs?	<ul style="list-style-type: none"> Overall costs to community, health plan and clinic 	State, County and Health Plans.

4. Data Sources and Evaluation Measures

Data Sources

We will monitor and evaluate SUD-related health services and outcomes through data collection from our Medicaid Management Information System (MMIS) and quality measure and performance improvement projects’ reporting from CCOs. OHA also will collect surveys from Medicaid and CHIP members who have accessed behavioral health services through the Mental Health Statistical Improvement Project (MHSIP) and through the Consumer Assessment of Health Plan Survey (CAHPS) for members with SUD claims. Oregon Health Authority has current contractors who calculate findings and provide results for several aggregated groups including oversamples of racial groups.

Evaluation Measures

Oregon has a robust data management system and a team of health analysts who perform data querying and abstraction using available claims systems. A separate team oversees the survey data and a third group of health information technology professionals manage the clinical quality metrics registry with electronic health record information. The evaluation measures will make use of these teams who have experience with ongoing quality reporting on an annual basis over sixty (60) measures. The evaluation measures will make use of this existing system by drawing upon existing data and organizing it according to the needs of the waiver evaluation for time points and specifications.

5. Analytic Plan

A primary focus of the quantitative data analysis will be to use the Oregon Medicaid and CHIP Claims data set for the period of the SUD demonstration waiver as well as supplementary data sources such as surveys. The study population of interest will be adults and minors with few exclusion criteria. During the analytic period, we propose several phases of data analysis including univariate, bivariate and multivariate analyses.

During univariate analyses frequency distributions will be created to look for major outliers and decisions regarding validity of the measures based on specifications. In addition, an analysis of missing values will be done to determine their frequency and whether random or in association with certain programs or groups. In bivariate analyses geographic and racial groups will be examined broken out by the different data elements to study data quality and representativeness. Finally, advanced multivariate models will be designed to test hypotheses. At this final analytic stage, the underlying characteristics of the data will be known because of the prior phases of the analyses which will assist in understanding the required assumptions for advanced statistical modeling.

Improvement in rate of drop outs from the SUD treatment programs will be a major outcome in the evaluation (an indicator of client engagement.) One example of success is percentage of members with 90-day retention for outpatient treatment success. Another aspect will be reduction of high utilization and greater intensity treatments. One of the challenges for studying treatment intervention will be clients who choose to leave treatment early. In this situation, findings can be heavily biased for client outcomes since full treatment is not delivered to all participants in these cases. Moreover, severity of the condition can be highly correlated with attrition. During the multivariate analyses, efforts will be made to correct for missing clients by using methods of modeling that account for time duration information where that is possible. Other options for statistically modeling missing clients and service utilization outcomes will be explored to the extent possible.

Much of the analyses will fall into three main categories:

1. Were outcomes improved or maintained over the time of the waiver? These will primarily be univariate in nature using a pre-post analysis looking for historical changes over time and trends in the data.
2. Were variations in improvements observed in outcomes by subgroups such as race-ethnicities or urban-rural subgroups? This analysis will primarily be broken out by subgroups across analytic questions and highest compared to lowest Medicaid health plan SUD outcome. Regression analyses will be used to control for member differences in health status and other demographics.
3. Did the SUD Waiver result in improved outcomes for members? Advanced analytics will be used to model these outcomes. Validity for this question will be strongly improved by adding a comparison group such as another state’s Medicaid data.

Logic Model for Substance Use Disorder Waiver Evaluation

Policy Context: SUD Care Integration – Expanded SUD Services and Access –
Costs

STRUCTURE	PROCESS	OUTCOME
Increase in trained (MAT, ASAM, CADDC) providers	Shorter duration between screening and treatment	Decreased fatal and non-fatal overdoses
Improved member access to screening, assessment and treatment	Coordinated care transitions between levels of care	Increased Treatment Engagement
Increased MAT services and public education	Increased access to MAT Decreased ED visits	Improved member quality ratings
Policy changes and education on prescribing behavior	Reduce SUD readmissions to hospital at same or higher level of care	Decreased unplanned neonatal abstinence syndrome prevalence

STRUCTURE	PROCESS	OUTCOME
Certification and License of treatment facilities per ASAM level	Improved care coordination in transitions	Reduced Inpatient admissions
Increase recovery support services	Improved integration of physical and behavioral health services. Improved recovery retention	Improved overall costs to community, health plan and clinic
Communication networks among health care workers, community leaders, and tribes	Timely engagement at appropriate stages of treatment	
Increase peer support programs		
Increase community integration support and services	Improved community integration for improved sustained recovery	Reduce re-admission rates, Improved overall cost to community, health, and SUD

Tribal Consultation

Oregon has been engaging Tribal partners throughout the development of the OHP SUD Waiver Application. To continue this and in alignment with the Tribal Consultation and Urban Indian Health Program Confer Policy Oregon will begin the Official Tribal Consultation process no less than 60 days prior to the Application’s submission to CMS. The feedback, dates of meetings, etc. received during this period will be included in the application submission to CMS

Public Notice

In alignment with 42 CFR 431.408 Oregon will follow the Public Notice Policy as appropriate prior to final submission of OHP SUD Waiver Application to CMS for approval. The feedback, dates of meetings, etc. received during this period will be included in the final draft’s submission to CMS

Demonstration Administration

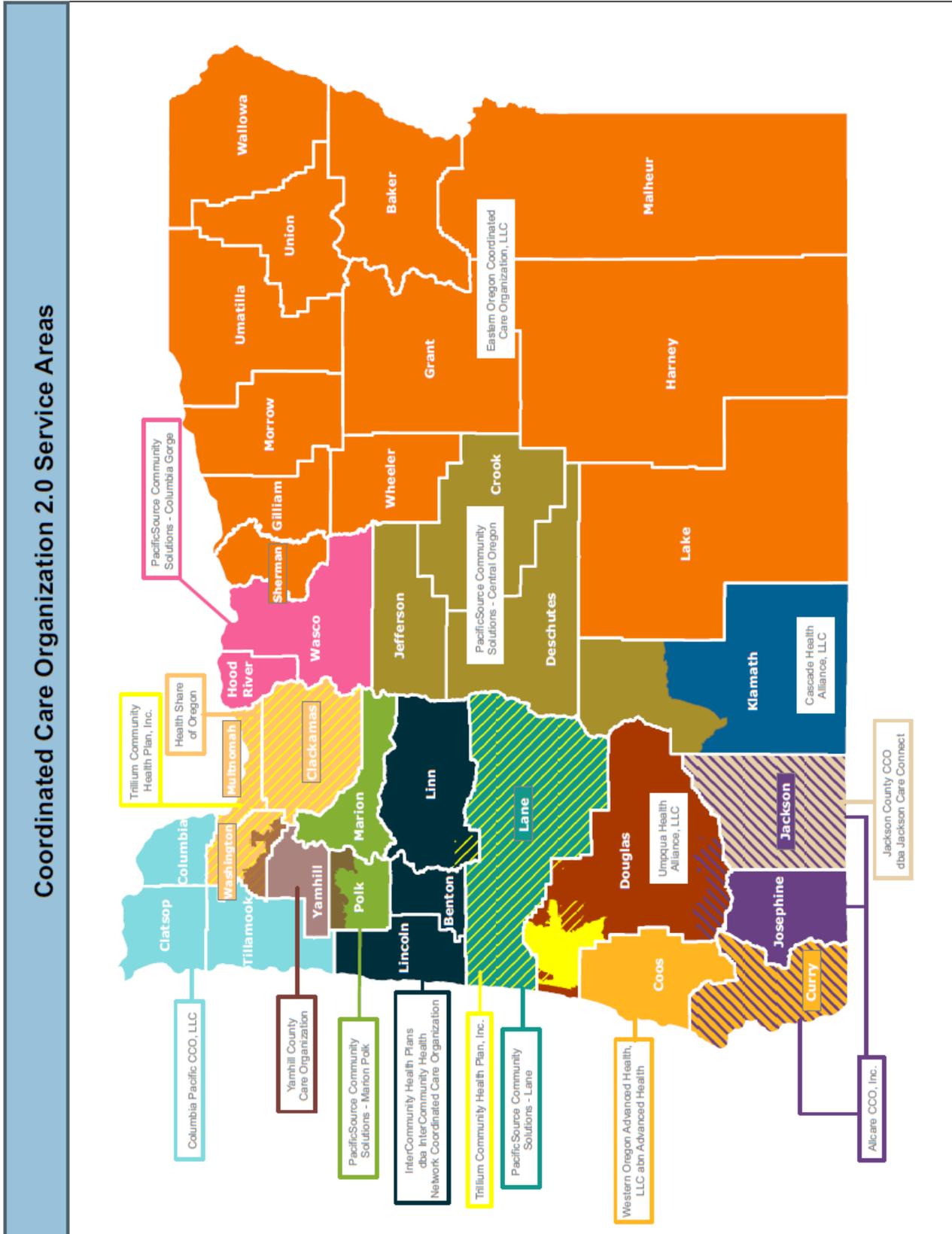
Oregon Demonstration Contact

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Attachment A: CCO Service Areas

Oregon's Coordinated Care Service Areas



Attachment B: Tribal Health Care

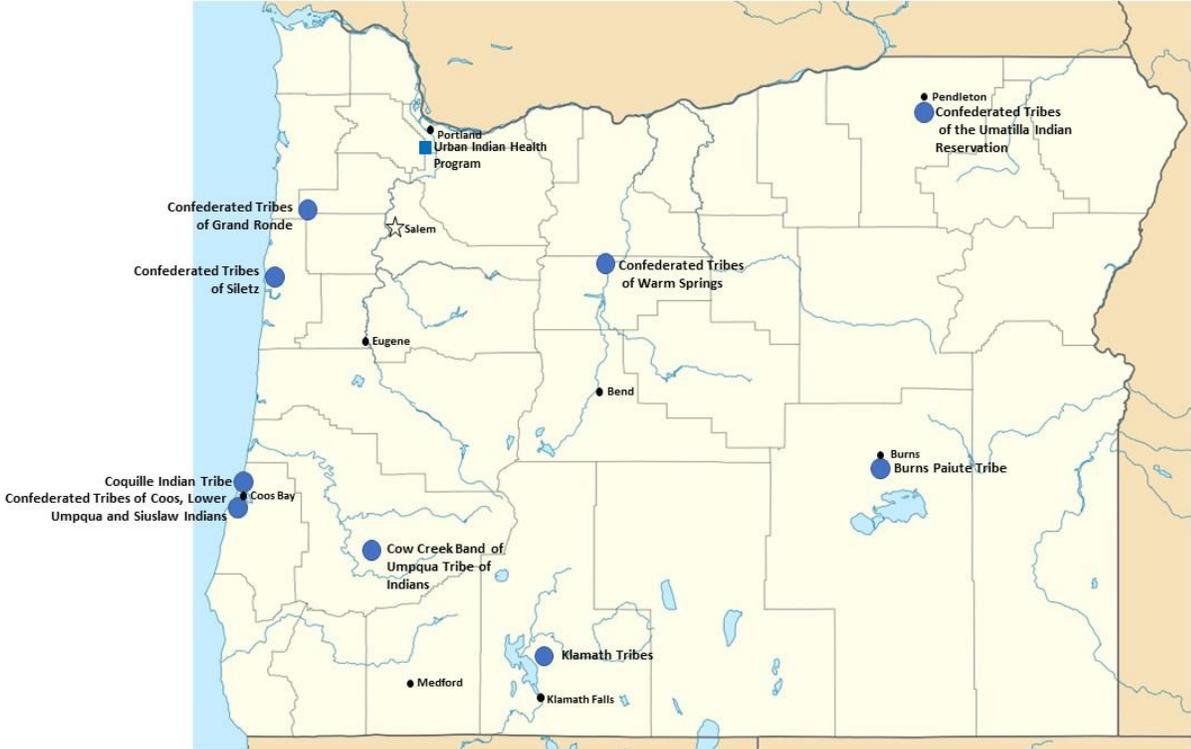
In Oregon there are two Indian Health Services (IHS) clinics and eight Tribal health programs (in accordance with P.L. 93-638 Indian Self-Determination Act) enrolled in Oregon Medicaid. There is also an Urban Indian Health Program (UIHP) enrolled as a Federally Qualified Health Center in the Portland area. IHS clinics are reimbursed through an all-inclusive rate which is published in the Federal Register each year. In 2018, the IHS all-inclusive rate is \$427 per clinic visit. Tribal 638 health centers may choose either the IHS all-inclusive rate or a cost-based Prospective Payment System (PPS) encounter rate developed for their clinic. Two-thirds of Tribal 638 health centers have elected the PPS reimbursement method. The UIHP, by virtue of being enrolled as an FQHC, is also reimbursed through a PPS encounter rate.

More than 50% of Medicaid and CHIP-eligible Tribal members in Oregon receive services on an FFS basis, rather than enrolling with a CCO. Many Tribal members prefer to receive culturally-specific treatment from IHS clinics, Tribal health centers, and UIHPs. These specific providers are crucial to providing culturally-sensitive services to Tribal members, and the IHS all-inclusive rate and PPS cost-based rates have led to more robust capacity within Tribal health care for delivering preventative primary care and dental services for the Tribal population.

Tribal Health Care includes use of Tribal-Based practices. Tribal-based practices are one way of restoring elements of Native American cultural practices that were historically limited or prohibited by the federal government. This effort is helping heal the historical traumas and promote positive Native American culture and traditions. Trauma informed care is important for all people with SUD and is especially important for Tribal members due to historical and intergenerational trauma.

Tribes preserve and implement their cultural wisdom as a means to promote health and well-being in their communities through stories, songs, prayers, rituals, and ceremonies and other traditional practices. Tribes' respective traditional wisdom, ceremonies, language, and customs are implemented in their communities to benefit the present and future generations while honoring the ancestral and sacred elements of this knowledge and control its use and dissemination. Cultural wisdom remains authentic to traditional ways of being, knowing and doing. Tribes integrate cultural interventions alongside existing healthcare promotion efforts to ensure a culturally tailored and culturally relevant approach to health promotion and healthcare delivery for Tribal members. (TBHA, p. 5).

Oregon's Nine Federally Recognized Tribes



DRAFT

Oregon Health Authority

Oregon's Tribal SUD Programs:

All tribes provide prevention services, and there are several outpatient treatment programs and two residential treatment programs designated to provide cultural-specific services to Tribal members.

Nine Federally Recognized Tribe's Tribal Programs

- Cow Creek Health and Wellness
- Burns-Paiute Alcohol and Drug Program
- Siletz Tribal Behavioral Health Program
- Klamath Tribal Health & Family Services
- Confederated Tribes of Grand Ronde Health and Wellness Center
- Confederated Tribes of the Umatilla Indian Reservation – Yellowhawk Tribal Health Center
- Confederated Tribes of Warm Springs Behavioral Health Center
- Coquille Indian Tribe Community Health Center
- Confederated Tribes of Coos, Lower Umpqua, and Siuslaw Indians' Health Services Division

Urban Indian Health Program

- Native American Rehabilitation Association of the Northwest (NARA)

Indian Health Service SUD Program

- Chemawa Behavioral Health Services

In addition, social determinants of health represent the largest percentage of the drivers behind many poor health outcomes. There is great potential to improve outcomes by using key strategies of comprehensive risk assessments, identification and tracking of risk factors, and engage vulnerable individuals with proven strategies to improve health equity and outcomes. Cultural competence is an essential factor in the workforce deployed to achieve this aim. One way to accomplish this is by expanding the Traditional Health Worker (THW) model for the Tribal Family Preservation Curriculum expanded into one program.

In 2019 the Oregon Tribes, the Urban Indian Health Program, OHA and additional partners came together to develop the Oregon Tribal Behavioral Health Strategic Plan. The vision includes:

The Oregon Native American Behavioral Health Collaborative envisions healthy Native individuals, families, and communities thriving across Oregon. We envision a shared, continuous alliance between the state and tribal/urban providers that provides a continuum of fully funded, comprehensive, culturally responsive services grounded in tribal-based practices and intertribal collaboration at the administrative and clinical levels. OHA is committed to implementing and supporting this plan for the next 5 years.



A medicine wheel that represents the collaborative's vision

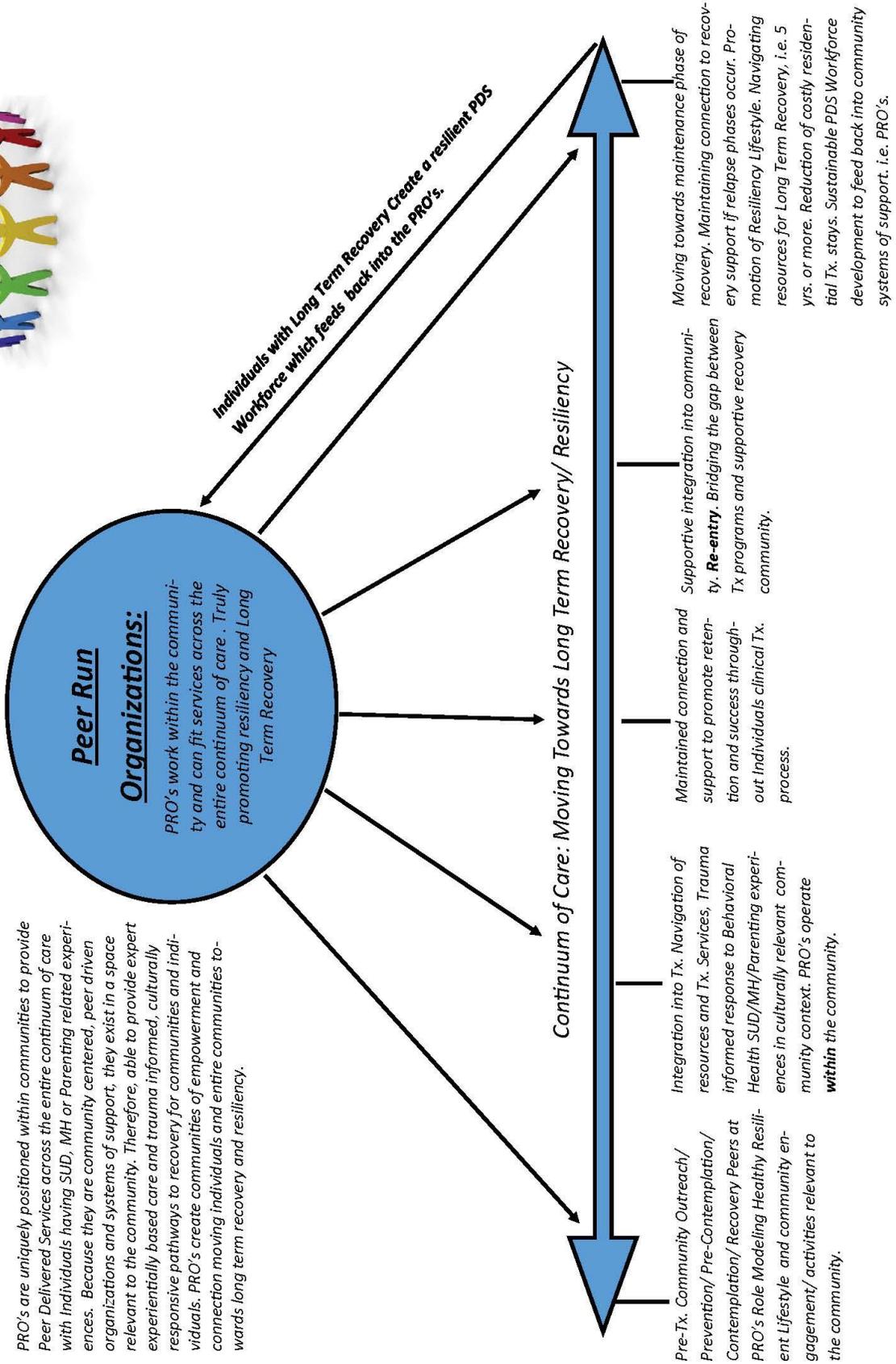
Attachment C: Peer Run Organizations

Peer Run Organizations:

“Working Within the Community and Along the Entire Continuum of Care.”



PRO's are uniquely positioned within communities to provide Peer Delivered Services across the entire continuum of care with Individuals having SUD, MH or Parenting related experiences. Because they are community centered, peer driven organizations and systems of support, they exist in a space relevant to the community. Therefore, able to provide expert experientially based care and trauma informed, culturally responsive pathways to recovery for communities and individuals. PRO's create communities of empowerment and connection moving individuals and entire communities towards long term recovery and resiliency.



Attachment D: Oregon ASAM Levels of Care

ASAM Level of Care	ASAM Service title	ASAM Brief Definition	Existing SUD Medicaid Service?	New SUD Medicaid service under waiver?	Needed Medicaid Authority?
0.0	Prevention	Screening, education & outreach for those at risk for SUD.	No	Yes	440.130
0.5	Early Intervention	Screening, Brief Intervention and Referral to Treatment (SBIRT) Assessment and education for at-risk individuals who do not meet diagnostic criteria for SUD	Yes, SBIRT is an option in primary care; No services covered elsewhere	No	440.130
0.5	Crisis Intervention	Intervention for at risk individuals (substance intoxication, substance withdrawal, SUDs). Linkage to services and supports	No	Yes	440.130
1.0	Outpatient	Less than nine hours of services per week (adults); less than six hours per week (adolescents)	Yes	No	440.130 440.50 440.60 440.90
2.1	Intensive Outpatient	Nine or more hours per week (adults); six or more hours per week (adolescents)	Yes	No	440.130

ASAM Level of Care	ASAM Service title	ASAM Brief Definition	Existing SUD Medicaid Service?	New SUD Medicaid service under waiver?	Needed Medicaid Authority?
2.5	Day Treatment	20 or more hours of services per week	Yes	No	440.130
3.1	Clinically Managed Low-Intensity Residential	24-hour structure with available trained staff at least five hours of clinical services per week and prep for care transition to lower level	Yes (for less than 16 beds)	Yes (for greater than 16 beds)	435.1009 435.1010 440.130 1115(a)(2)
3.3	Clinically Managed High Intensity Residential (population specific)	24-hour structure with available trained staff. Stabilization of multidimensional imminent danger. At least five hours of clinical services per week and prep for care transition to lower level	Yes (for less than 16 beds)	Yes (for greater than 16 beds)	435.1009 435.1010 1115(a)(2)
3.5	Clinically Managed High Intensity Residential	24-hour structure with available trained staff. Stabilization of multidimensional imminent danger. At least five hours of clinical services per week and prep for care transition to lower level	Yes (for less than 16 beds)	Yes (for greater than 16 beds)	435.1009 435.1010 1115(a)(2)

ASAM Level of Care	ASAM Service title	ASAM Brief Definition	Existing SUD Medicaid Service?	New SUD Medicaid service under waiver?	Needed Medicaid Authority?
3.7	Medically Monitored Intensive Inpatient Services	24-hour care with nursing and physician's availability for significant problems in Dimensions 1, 2, or 3. Counseling is available 16 hours per day.	Yes (for less than 16 beds)	Yes (for greater than 16 beds)	435.1009 435.1010 115(a)(2)
1-WM	Ambulatory Withdrawal Management wo/extended on-site Monitoring	Mild WD with daily or less than daily outpatient supervision	Yes	No	440.130 440.50 440.60 440.90
2-WM	Ambulatory Withdrawal w/extended on-site Monitoring	Moderate WD with all day withdrawal management/support and supervision; at night has supportive family or living situation	Yes	No	440.130 440.50 440.60 440.90
3.2-WM	Clinically Managed Residential Withdrawal Management	Moderate WD, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment into recovery	Yes (for less than 16 beds)	Yes (for greater than 16 beds)	435.1009 435.1010 440.130 440.50 440.60 440.90

Oregon Health Plan Waiver Application

ASAM Level of Care	ASAM Service title	ASAM Brief Definition	Existing SUD Medicaid Service?	New SUD Medicaid service under waiver?	Needed Medicaid Authority?
3.7WM	Medically Monitored Inpatient Withdrawal Management	Severe withdrawal, 24-hour nursing care and physician visits; unlikely to complete withdrawal management without medical monitoring and support	Yes (for less than 16 beds)	Yes (for greater than 16 beds)	435.1009 435.1010 440.130 440.50 440.60 440.90
OTS	Opioid Treatment Services	Daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability for those with sever opioid use disorder. Oregon provides Office Based Treatment and Opioid Treatment programs+	Yes	No	440.50 440.60 440.90
Other	Care Management	Services to assist a beneficiary to access needed medical and community support services	Yes	No	440.169
Other	Peer Delivered	Services provided by a Peer/Recovery Coach to support a beneficiary during treatment and into recovery	Yes	No	440.130(c)

ASAM Level of Care	ASAM Service title	ASAM Brief Definition	Existing SUD Medicaid Service?	New SUD Medicaid service under waiver?	Needed Medicaid Authority?
Other	Acupuncture and Acu-detox	Services provided to decrease cravings, withdrawal symptoms and anxiety	Yes	No	440.50 440.130
Other	Transportation	Services provided to transport clients to medical appointments	Yes	No	440.170
Other ASAM Dimension 6 Recovery Environment	Recovery Support Services	Services to support the beneficiary's recovery and wellness after completing their course of treatment.	No	Yes	440.130
Other	Community Integration	Services to support integration into the community including transitional housing support services and employment services.	No	Yes	1903(m) 438.60

Attachment E: Oregon SUD Continuum of Care

<p>Positive Health</p> <p>A state of physical, mental, and social well being, free from substance misuse.</p>	<p>Substance Misuse</p> <p>The use of any substance in a manner, situation, amount or frequency that can cause harm to the user and/or those around them</p>	<p>Substance Use Disorder</p> <p>Clinically and functionally significant impairment caused by substance use. Substance Use disorders are measured on a continuum of mild, moderate, to severe determined by a person's number of symptoms.</p>
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Substance Use Status



Substance Use Continuum of Care

<p>Wellness</p> <p>Promoting physical, mental, and social health and wellbeing, free from substance misuse.</p>	<p>Prevention</p> <p>Addressing individual and environmental risk factors for substance use</p>	<p>Early Intervention</p> <p>Screening and detecting substance use problems at an early stage including crisis intervention (ASAM 0.5)</p>	<p>Treatment</p> <p>Intervention through medication, counseling and other services to eliminate symptoms, achieve and maintain sobriety and maximum function ability Levels of Care include: (ASAM 1.0-3.7) Outpatient services Intensive Outpatient Day Treatment Residential & Inpatient Services Withdrawal management Opioid Treatment Services Medication Assisted Treatment</p>	<p>Recovery Supports & Community Integration</p> <p>Providing Supports to aid in long term recovery process including barrier removal Includes: Housing supports Employment Supports</p>
Peer Delivered Services				

Attachment F: Evaluation Budget Projection

SUD 1115 Waiver Evaluation Key Dates and Payment Amounts:

Body of Work	Date	Payment Amount
Reference Only--Waiver Full Five Years Calendar Date	TBD	Summary in this table
Reference Only--Waiver Half-Way Calendar Date	TBD	Summary in this table
Interim report due	TBD	325,000
Summative report due	TBD	350,000
Ad hoc requests/modifications	Start date – End date	100,000
Total		775,000

Attachment G: Budget Neutrality

How To Use This Spreadsheet:

Consult the tables below for a high level overview of the IMD Cost Limit and SUD Hypothetical CNOM Services Limit in Scenario 1 and Scenario 2. The tables provide basic concepts for establishment of the budget neutrality limits, and reporting requirements for monitoring. The notes below the table provide additional information related to allowable SUD IMD medical assistance services, estimation of the various budget neutrality limits, trend rates and other details of estimation. (see glossary below table for definition of abbreviations)

Scenario 1

Situation: Demonstration CNOM is limited to expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are residents in facilities that meet the definition of an IMD (i.e., IMD exclusion related MA)	IMD Cost Limit	Hypothetical CNOM Services Limit
Without Waiver (i.e., budget neutrality limit)	<p><u>PMPM Cost</u></p> <ul style="list-style-type: none"> Estimated average of all MA costs incurred during IMD MMs. Est. total MA cost in IMD MMs + est. IMD MMs <p><u>Member Months</u></p> <ul style="list-style-type: none"> IMD MM: Any <i>whole</i> month during which a Medicaid eligible is inpatient in an IMD at least 1 day <p><u>BN Expenditure Limit</u></p> <ul style="list-style-type: none"> PMPM cost x IMD MMs 	
With Waiver	<p><u>Expenditures Subject to Limit</u></p> <ul style="list-style-type: none"> All MA costs with dates of service during IMD MMs <p><u>Reporting Requirements</u></p> <p>State must be able to identify and report:</p> <ul style="list-style-type: none"> IMD MMs separate from other Medicaid months of eligibility MA costs during IMD MMs separate from other MA costs 	

Scenario 2

Situation: Demonstration CNOM include both CNOM for IMD exclusion related MA to <i>and</i> CNOM for additional hypothetical services that can be provided outside the IMD.	IMD Cost Limit	Hypothetical CNOM Services Limit
Without Waiver (i.e., budget neutrality limit)	<p><u>PMPM Cost</u></p> <ul style="list-style-type: none"> Estimated average of all MA costs incurred during IMD MMs. Est. total MA cost in IMD MMs + est. IMD MMs <p><u>Member Months</u></p> <ul style="list-style-type: none"> IMD MM: Any <i>whole</i> month during which a Medicaid eligible is inpatient in an IMD at least 1 day <i>Can</i> exclude months with ≤ 15 IMD inpatient days under managed care <p><u>BN Expenditure Limit</u></p> <ul style="list-style-type: none"> PMPM cost x IMD MMs 	<p><u>PMPM Cost</u></p> <ul style="list-style-type: none"> Estimate of average SUD CNOM service cost during Non-IMD MMs Est. total SUD CNOM service cost ÷ est. Non-IMD MMs SUD CNOM service cost can include capitated cost of IMD services <p><u>Member Months</u></p> <ul style="list-style-type: none"> Non-IMD MM: Any month of Medicaid eligibility in which a person <i>could</i> receive a SUD CNOM service that is not an IMD MM <p><u>BN Expenditure Limit</u></p> <ul style="list-style-type: none"> PMPM cost x Non-IMD MMs
With Waiver	<p><u>Expenditures Subject to Limit</u></p> <ul style="list-style-type: none"> All MA costs with dates of service during IMD MMs <p><u>Reporting Requirements</u></p> <p>State must be able to identify and report:</p> <ul style="list-style-type: none"> IMD MMs separate from other Medicaid months of eligibility MA costs during IMD MMs separate from other MA costs 	<p><u>Expenditures Subject to Limit</u></p> <ul style="list-style-type: none"> All SUD CNOM service costs with dates of service during Non-IMD MMs <p><u>Reporting Requirements</u></p> <p>State must be able to identify and report:</p> <ul style="list-style-type: none"> Non-IMD MMs separate from IMD MMs SUD CNOM costs separate from other MA costs

Glossary of Abbreviations

CNOM = expenditure authority (cost not otherwise matchable)

Hypo = hypothetical, i.e., optional services that could be included in the state plan but are instead being authorized in the 1115 using CNOM

IMD = institution for mental diseases

MA = medical assistance

MM = member month

SUD = substance abuse disorder

Notes

1. Date of service for capitation payments is the month of coverage for which the capitation is paid.
2. The IMD Cost Limit and SUD Hypothetical CNOM Services Limit are intended to be two distinct budget neutrality tests separately and independently enforced.
3. SUD IMD Services may include all approved services provided to Medicaid beneficiaries while residing in an IMD; however, they may not include costs associated with room and board payments in those facilities unless they qualify as inpatient facilities under section 1905(a) of the Social Security Act.

Estimation for the IMD Cost Limit

The IMD Cost Limit represents the projected cost of medical assistance during months in which Medicaid eligible are patients at the IMD. These are the acceptable ways for the state to determine the PMPMs for the IMD Cost Limit.

- States should present 5 years of historical data on overall MA costs for individuals with a SUD diagnosis (or proxy) who received inpatient treatment for SUD (or could have received inpatient treatment if such services were available), to determine average MA cost per user of SUD inpatient services for each historical year. The per user per month costs are then projected forward using the lower of historical per user month cost trend or the President's Budget PMPM cost trend. The projected per user per month costs will become the PMPMs for the IMD Cost Limit.
- If the state has an existing comprehensive Medicaid demonstration with already calculated without waiver PMPMs, the state should incorporate those PMPMs in the IMD Cost Limit PMPMs (see Historical tab).
- State can top off IMD Cost Limit PMPMs with an additional estimated amount representing any additional CNOM services that affected individuals may also receive during IMD months.
- State may use Alternate PMPM Development in Historical tab for estimating expenditures to be included in the PMPM(s)/IMD Cost Limit (see 'Supplemental Methodology Document' requirement below).

Estimation of the SUD Hypothetical CNOM Services Limit

The SUD Hypothetical CNOM Services Limit represents the projected average PMPM cost of additional expenditure authority services for the population eligible to receive them. This can include the estimated average cost of IMD services, if these costs are being averaged out across an entire covered population through inclusion in capitated payment rates to Medicaid managed care plans.

- Since states are unlikely to have actually covered these services in the past, they will not have historical data for projecting future costs.
- The PMPM cost estimate should be an average expected cost of hypothetical additional expenditure authority services for individuals who are eligible to receive those services. It should not be a cost per month of service use.

Supplemental Methodology Document

- The 'Historical Spending Data' and/or 'Alternate PMPM Development' in the SUD Historical tab must be accompanied by a supplemental methodology and data sources document that fully describes, for each MEG, a full breakout of all SUD services - with descriptions of accompanying expenditures and caseloads. There should also be sections/headings in the methodology document which describe all other state data inputs (see 'State Data Inputs' below).

Trends

PMPM trends should be the lower of the state's historical trend and the smoothed trend from the 2018 President's Budget (in the absence of historical data, CMS will apply the President's Budget trend). The President's Budget trends should be for the eligibility groups that are participating in the SUD demonstration. Most often, these will be the Current Adults, New Adults, or a blend of Current Adults and New Adults.

Multiple MEGs

There should be one set of MEGs for the current Medicaid state plan IMD Cost Limit(s) with associated PMPMs and member months, and one for the SUD Hypothetical CNOM Services Limit (and *non*-Hypothetical CNOM), as applicable.

Member Month Non-Duplication

IMD Cost Limit member month must be non-duplicative of SUD Hypothetical CNOM Services Limit member months, and must also be non-duplicative of general comprehensive demonstration budget neutrality limit member months. This means that month of Medicaid eligibility for an individual cannot appear as both an IMD Cost Limit member month and a SUD Hypothetical CNOM Services Limit member month; it has to be one or the other, and likewise for IMD Cost Limit member month and general comprehensive demonstration budget neutrality limit member months. SUD Hypothetical CNOM Services Limit member months can be duplicative of general comprehensive demonstration budget neutrality limit member months.

State Data Inputs

States must add their data to the yellow highlighted cells for CMS review and discussion - and choose the appropriate drop-downs corresponding to their data inputs. CMS will provide template instructions with this spreadsheet.

SUD Historical Spending Data - 5 Years

SUD IMD Services	Historical Years Definition:		State Fiscal Year			
	2015	2016	2017	2018	2019	5-YEARS
SUD IMD Services PCR						
TOTAL EXPENDITURES	\$1,115,246	\$1,151,941	\$2,345,240	\$1,199,615	\$1,541,230	
ELIGIBLE MEMBER MONTHS	1,267	1,106	1,474	1,250	1,362	
PMPM COST	\$880.23	\$1,041.54	\$1,591.07	\$959.69	\$1,131.59	
TREND RATES						
TOTAL EXPENDITURE		3.29%	103.59%	-48.85%	28.48%	
ELIGIBLE MEMBER MONTHS		-12.71%	33.27%	-15.20%	8.96%	1.80%
PMPM COST		18.33%	52.76%	-39.68%	17.91%	6.50%
SUD IMD Services PWO						
TOTAL EXPENDITURES	\$696,912	\$677,577	\$1,000,998	\$297,499	\$405,472	
ELIGIBLE MEMBER MONTHS	606	543	346	238	260	
PMPM COST	\$1,150.02	\$1,247.84	\$2,893.06	\$1,249.99	\$1,559.51	
TREND RATES						
TOTAL EXPENDITURE		-2.77%	47.73%	-70.28%	36.29%	
ELIGIBLE MEMBER MONTHS		-10.40%	-36.28%	-31.21%	9.24%	-19.10%
PMPM COST		8.51%	131.85%	-56.79%	24.76%	7.90%
SUD IMD Services CMO						
TOTAL EXPENDITURES	\$458,044	\$713,004	\$839,740	\$399,317	\$610,939	
ELIGIBLE MEMBER MONTHS	705	828	712	615	487	
PMPM COST	\$649.71	\$861.12	\$1,179.41	\$649.30	\$1,254.49	
TREND RATES						
TOTAL EXPENDITURE		55.66%	17.77%	-52.45%	53.00%	
ELIGIBLE MEMBER MONTHS		17.45%	-14.01%	-13.62%	-20.81%	-8.80%
PMPM COST		32.54%	36.96%	-44.95%	93.21%	17.90%
SUD IMD Services ABAD						
TOTAL EXPENDITURES	\$1,246,617	\$1,090,746	\$1,310,929	\$1,062,604	\$1,255,071	
ELIGIBLE MEMBER MONTHS	421	492	451	620	524	
PMPM COST	\$2,961.09	\$2,216.96	\$2,906.72	\$1,713.88	\$2,395.17	
TREND RATES						
TOTAL EXPENDITURE		-12.50%	20.19%	-18.94%	18.11%	
ELIGIBLE MEMBER MONTHS		16.86%	-8.33%	37.47%	-15.48%	5.60%
PMPM COST		-25.13%	31.11%	-41.04%	39.75%	-5.20%
SUD IMD Services FC/SAC						
TOTAL EXPENDITURES	\$235,783	\$437,754	\$549,980	\$238,913	\$203,214	
ELIGIBLE MEMBER MONTHS	150	159	171	200	152	
PMPM COST	\$1,571.89	\$2,753.17	\$3,216.26	\$1,194.56	\$1,336.94	
TREND RATES						
TOTAL EXPENDITURE		85.66%	25.64%	-56.56%	-14.94%	
ELIGIBLE MEMBER MONTHS		6.00%	7.55%	16.96%	-24.00%	0.30%
PMPM COST		75.15%	16.82%	-62.86%	11.92%	-4.00%
SUD IMD Services ACA						
TOTAL EXPENDITURES	\$7,764,861	\$8,231,164	\$13,095,785	\$8,281,270	\$13,255,572	
ELIGIBLE MEMBER MONTHS	5,696	6,216	6,461	7,521	7,677	
PMPM COST	\$1,363.21	\$1,324.19	\$2,026.90	\$1,101.09	\$1,726.66	
TREND RATES						
TOTAL EXPENDITURE		6.01%	59.10%	-36.76%	60.07%	
ELIGIBLE MEMBER MONTHS		9.13%	3.94%	16.41%	2.07%	7.70%
PMPM COST		-2.86%	53.07%	-45.68%	56.81%	6.10%
SUD IMD Services CHIP						
TOTAL EXPENDITURES	\$74,707	\$88,932	\$101,400	\$64,438	\$98,405	
ELIGIBLE MEMBER MONTHS	162	151	206	249	219	
PMPM COST	\$461.15	\$588.96	\$492.23	\$258.79	\$449.34	
TREND RATES						
TOTAL EXPENDITURE		19.04%	14.02%	-36.45%	52.71%	
ELIGIBLE MEMBER MONTHS		-6.79%	36.42%	20.87%	-12.05%	7.80%
PMPM COST		27.71%	-16.42%	-47.43%	73.63%	-0.60%
SUD IMD Services CAWEM Prenatal						
TOTAL EXPENDITURES	\$0	\$0	\$0	\$18,027	\$23,205	
ELIGIBLE MEMBER MONTHS	0	0	0	2	2	
PMPM COST	\$0.00	\$0.00	\$0.00	\$9,013.26	\$11,602.36	
TREND RATES						
TOTAL EXPENDITURE		0.00%	0.00%	0.00%	28.73%	
ELIGIBLE MEMBER MONTHS		0.00%	0.00%	0.00%	0.00%	0.00%
PMPM COST		0.00%	0.00%	0.00%	28.73%	28.70%

Choose "Included" from Drop-Down(s) to Link Services with MEG(s)

Hypothetical Services Base Year Totals. To start in DY2:

CNOM - Community Integration & Recovery Support Services PCR

Community Integration & Recovery Support Services	Estimated Total Expenditures for Community Integration & Recovery Support Services	n/a	Estimated Eligible Member Months for Community Integration & Recovery Support Services	Estimated PMPM Cost	CURRENT State Plan Service(s)			NOT CURRENT State Plan Svc(s)	
								Hypothetical CNOM - Community Integration & Recovery Support Services PCR	Non-Hypothetical Services CNOM
H0043 - Supported Housing	\$4,779		18	\$260.44				Included	
H2014 - Skills Training & Development	\$11,193		73	\$152.50				Included	
H2023 - Supported Employment	\$32,645		214	\$152.50				Included	
H2023 - Supported Education	\$32,645		214	\$152.50				Included	
H0038 - Self-Help/Peer Services	\$580,131		1,713	\$338.76				Included	
Totals					\$0.00	\$0.00	\$0.00	296.27	\$0.00

CNOM - Community Integration & Recovery Support Services PWO

Community Integration & Recovery Support Services	Estimated Total Expenditures for Community Integration & Recovery Support Services	n/a	Estimated Eligible Member Months for Community Integration & Recovery Support Services	Estimated PMPM Cost	CURRENT State Plan Service(s)			NOT CURRENT State Plan Svc(s)	
								Hypothetical CNOM - Community Integration & Recovery Support Services PWO	Non-Hypothetical Services CNOM
H0043 - Supported Housing	\$1,475		6	\$260.44				Included	
H2014 - Skills Training & Development	\$3,454		23	\$152.50				Included	
H2023 - Supported Employment	\$10,073		66	\$152.50				Included	
H2023 - Supported Education	\$10,073		66	\$152.50				Included	
H0038 - Self-Help/Peer Services	\$179,006		528	\$338.76				Included	
Totals					\$0.00	\$0.00	\$0.00	296.27	\$0.00

CNOM - Community Integration & Recovery Support Services CMO

Community Integration & Recovery Support Services	Estimated Total Expenditures for Community Integration & Recovery Support Services	n/a	Estimated Eligible Member Months for Community Integration & Recovery Support Services	Estimated PMPM Cost	CURRENT State Plan Service(s)			NOT CURRENT State Plan Svc(s)	
								Hypothetical CNOM - Community Integration & Recovery Support Services CMO	Non-Hypothetical Services CNOM
H0043 - Supported Housing	\$2,476		10	\$260.44				Included	
H2014 - Skills Training & Development	\$5,800		38	\$152.50				Included	
H2023 - Supported Employment	\$16,916		111	\$152.50				Included	
H2023 - Supported Education	\$16,916		111	\$152.50				Included	
H0038 - Self-Help/Peer Services	\$300,619		887	\$338.76				Included	
Totals					\$0.00	\$0.00	\$0.00	296.27	\$0.00

CNOM - Community Integration & Recovery Support Services ABAD

Community Integration & Recovery Support Services	Estimated Total Expenditures for Community Integration & Recovery Support Services	n/a	Estimated Eligible Member Months for Community Integration & Recovery Support Services	Estimated PMPM Cost	CURRENT State Plan Service(s)			NOT CURRENT State Plan Svc(s)	
								Hypothetical CNOM - Community Integration & Recovery Support Services ABAD	Non-Hypothetical Services CNOM
H0043 - Supported Housing	\$1,856		7	\$260.44				Included	
H2014 - Skills Training & Development	\$4,346		28	\$152.50				Included	
H2023 - Supported Employment	\$12,676		83	\$152.50				Included	
H2023 - Supported Education	\$12,676		83	\$152.50				Included	
H0038 - Self-Help/Peer Services	\$225,262		665	\$338.76				Included	
Totals					\$0.00	\$0.00	\$0.00	296.27	\$0.00

CNOM - Community Integration & Recovery Support Services OAA

Community Integration & Recovery Support Services	Estimated Total Expenditures for Community Integration & Recovery Support Services	n/a	Estimated Eligible Member Months for Community Integration & Recovery Support Services	Estimated PMPM Cost	CURRENT State Plan Service(s)			NOT CURRENT State Plan Svc(s)	
								Hypothetical CNOM - Community Integration & Recovery Support Services OAA	Non-Hypothetical Services CNOM
H0043 - Supported Housing	\$368		1	\$260.44				Included	
H2014 - Skills Training & Development	\$861		6	\$152.50				Included	
H2023 - Supported Employment	\$2,512		16	\$152.50				Included	
H2023 - Supported Education	\$2,512		16	\$152.50				Included	
H0038 - Self-Help/Peer Services	\$44,637		132	\$338.76				Included	
Totals					\$0.00	\$0.00	\$0.00	296.27	\$0.00

CNOM - Community Integration & Recovery Support Services FC/SAC

					CURRENT State Plan Service(s)			NOT CURRENT State Plan Svc(s)	

Community Integration & Recovery Support Services	Estimated Total Expenditures for Community Integration & Recovery Support Services	n/a	Estimated Eligible Member Months for Community Integration & Recovery Support Services	Estimated PMPM Cost		n/a		Hypothetical CNOM - Community Integration & Recovery Support Services FC/SAC	Non-Hypothetical Services CNOM
H0043 - Supported Housing	\$616		2	\$260.44				Included	
H2014 - Skills Training & Development	\$1,442		9	\$152.50				Included	
H2023 - Supported Employment	\$4,205		28	\$152.50				Included	
H2023 - Supported Education	\$4,205		28	\$152.50				Included	
H0038 - Self-Help/Peer Services	\$74,728		221	\$338.76				Included	
Totals					\$0.00	\$0.00	\$0.00	296.27	\$0.00

CNOM - Community Integration & Recovery Support Services ACA					CURRENT State Plan Service(s)			NOT CURRENT State Plan Svc(s)	
Community Integration & Recovery Support Services	Estimated Total Expenditures for Community Integration & Recovery Support Services	n/a	Estimated Eligible Member Months for Community Integration & Recovery Support Services	Estimated PMPM Cost		n/a		Hypothetical CNOM - Community Integration & Recovery Support Services ACA	Non-Hypothetical Services CNOM
H0043 - Supported Housing	\$24,837		95	\$260.44				Included	
H2014 - Skills Training & Development	\$58,174		381	\$152.50				Included	
H2023 - Supported Employment	\$169,673		1,113	\$152.50				Included	
H2023 - Supported Education	\$169,673		1,113	\$152.50				Included	
H0038 - Self-Help/Peer Services	\$3,015,264		8,901	\$338.76				Included	
Totals					\$0.00	\$0.00	\$0.00	296.27	\$0.00

CNOM - Community Integration & Recovery Support Services CHIP					CURRENT State Plan Service(s)			NOT CURRENT State Plan Svc(s)	
Community Integration & Recovery Support Services	Estimated Total Expenditures for Community Integration & Recovery Support Services	n/a	Estimated Eligible Member Months for Community Integration & Recovery Support Services	Estimated PMPM Cost		n/a		Hypothetical CNOM - Community Integration & Recovery Support Services CHIP	Non-Hypothetical Services CNOM
H0043 - Supported Housing	\$730		3	\$260.44				Included	
H2014 - Skills Training & Development	\$1,710		11	\$152.50				Included	
H2023 - Supported Employment	\$4,988		33	\$152.50				Included	
H2023 - Supported Education	\$4,988		33	\$152.50				Included	
H0038 - Self-Help/Peer Services	\$88,650		262	\$338.76				Included	
Totals					\$0.00	\$0.00	\$0.00	296.27	\$0.00

CNOM - Community Integration & Recovery Support Services CAWEM Prenatal					CURRENT State Plan Service(s)			NOT CURRENT State Plan Svc(s)	
Community Integration & Recovery Support Services	Estimated Total Expenditures for Community Integration & Recovery Support Services	n/a	Estimated Eligible Member Months for Community Integration & Recovery Support Services	Estimated PMPM Cost		n/a		Hypothetical CNOM - Community Integration & Recovery Support Services CAWEM Prenatal	Non-Hypothetical Services CNOM
H0043 - Supported Housing	\$368		1	\$260.44				Included	
H2014 - Skills Training & Development	\$861		6	\$152.50				Included	
H2023 - Supported Employment	\$2,512		16	\$152.50				Included	
H2023 - Supported Education	\$2,512		16	\$152.50				Included	
H0038 - Self-Help/Peer Services	\$44,637		132	\$338.76				Included	
Totals					\$0.00	\$0.00	\$0.00	296.27	\$0.00

ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	PB Trend: 4.5%		DEMONSTRATION YEARS (DY)					TOTAL WOW
			BASE YEAR DY 00	TREND RATE 2	DY 01	DY 02	DY 03	DY 04	DY 05	
SUD IMD Services PCR										
Eligible Member Months	n.a.	n.a.	1,362	n.a.	1,411	1,437	1,463	1,489	1,516	
PMPM Cost	6.5%	12	\$1,205.15	4.5%	\$1,259	\$1,316	\$1,375	\$1,437	\$1,502	
Total Expenditure					\$1,777,581	\$1,891,006	\$2,011,667	\$2,140,036	\$2,276,589	\$10,096,879
SUD IMD Services PWO										
Eligible Member Months	n.a.	n.a.	260	n.a.	170	138	111	90	73	
PMPM Cost	7.9%	12	\$1,682.71	4.5%	\$1,758	\$1,838	\$1,920	\$2,007	\$2,097	
Total Expenditure					\$299,223	\$252,965	\$213,858	\$180,796	\$152,846	\$1,099,689
SUD IMD Services CMO										
Eligible Member Months	n.a.	n.a.	487	n.a.	405	369	337	307	280	
PMPM Cost	17.9%	12	\$1,479.05	4.5%	\$1,546	\$1,615	\$1,688	\$1,764	\$1,843	
Total Expenditure					\$626,064	\$596,663	\$568,643	\$541,939	\$516,489	\$2,849,797
SUD IMD Services ABAD										
Eligible Member Months	n.a.	n.a.	524	n.a.	584	617	652	688	727	
PMPM Cost	-5.2%	12	\$2,270.62	4.5%	\$2,373	\$2,480	\$2,591	\$2,708	\$2,830	
Total Expenditure					\$1,386,501	\$1,530,034	\$1,688,423	\$1,863,207	\$2,056,086	\$8,524,251
SUD IMD Services FC/SAC										
Eligible Member Months	n.a.	n.a.	152	n.a.	153	153	154	154	155	
PMPM Cost	-4.0%	12	\$1,283.46	4.5%	\$1,341	\$1,402	\$1,465	\$1,531	\$1,599	
Total Expenditure					\$205,090	\$214,962	\$225,309	\$236,154	\$247,521	\$1,129,036
SUD IMD Services ACA										
Eligible Member Months	n.a.	n.a.	7,677	n.a.	8,905	9,590	10,329	11,124	11,981	
PMPM Cost	6.1%	12	\$1,831.99	4.5%	\$1,914	\$2,001	\$2,091	\$2,185	\$2,283	
Total Expenditure					\$17,047,568	\$19,186,448	\$21,593,716	\$24,302,999	\$27,352,163	\$109,482,894
SUD IMD Services CHIP										
Eligible Member Months	n.a.	n.a.	219	n.a.	254	274	296	319	344	
PMPM Cost	-0.6%	12	\$446.64	4.5%	\$467	\$488	\$510	\$533	\$557	
Total Expenditure					\$118,784	\$133,810	\$150,739	\$169,810	\$191,293	\$764,436
SUD IMD Services CAWEM Prenatal										
Eligible Member Months	n.a.	n.a.	2	n.a.	2	2	2	2	2	
PMPM Cost	28.7%	12	\$14,932.24	4.5%	\$15,604	\$16,306	\$17,040	\$17,807	\$18,608	
Total Expenditure					\$31,208	\$32,613	\$34,080	\$35,614	\$37,217	\$170,732
Hypothetical CNOM - Community Integration & Recovery Support Services PCR										
Eligible Member Months	n.a.	n.a.	n.a.	n.a.	0	2,790	3,488	4,360	5,450	
PMPM Cost	n.a.	0	\$296.27	4.5%	\$0	\$310	\$324	\$338	\$353	
Total Expenditure					\$0	\$863,933	\$1,428,505	\$1,474,115	\$1,925,541	\$5,392,094
Hypothetical CNOM - Community Integration & Recovery Support Services PWO										
Eligible Member Months	n.a.	n.a.	n.a.	n.a.	0	861	1,076	1,345	1,682	
PMPM Cost	n.a.	0	\$296.27	4.5%	\$0	\$310	\$324	\$338	\$353	
Total Expenditure					\$0	\$266,577	\$348,214	\$484,855	\$594,148	\$1,663,794
Hypothetical CNOM - Community Integration & Recovery Support Services CMO										
Eligible Member Months	n.a.	n.a.	n.a.	n.a.	0	1,446	1,808	2,259	2,824	
PMPM Cost	n.a.	0	\$296.27	4.5%	\$0	\$310	\$324	\$338	\$353	
Total Expenditure					\$0	\$447,683	\$584,782	\$763,874	\$997,799	\$2,794,138
Hypothetical CNOM - Community Integration & Recovery Support Services ABAD										
Eligible Member Months	n.a.	n.a.	n.a.	n.a.	0	1,084	1,354	1,693	2,116	
PMPM Cost	n.a.	0	\$296.27	4.5%	\$0	\$310	\$324	\$338	\$353	
Total Expenditure					\$0	\$335,461	\$438,193	\$572,392	\$747,679	\$2,093,725
Hypothetical CNOM - Community Integration & Recovery Support Services OAA										
Eligible Member Months	n.a.	n.a.	n.a.	n.a.	0	215	268	335	419	
PMPM Cost	n.a.	0	\$296.27	4.5%	\$0	\$310	\$324	\$338	\$353	
Total Expenditure					\$0	\$66,473	\$86,830	\$113,422	\$148,155	\$414,880
Hypothetical CNOM - Community Integration & Recovery Support Services FC/SAC										
Eligible Member Months	n.a.	n.a.	n.a.	n.a.	0	359	449	562	702	
PMPM Cost	n.a.	0	\$296.27	4.5%	\$0	\$310	\$324	\$338	\$353	
Total Expenditure					\$0	\$111,285	\$145,366	\$189,884	\$248,034	\$694,569
Hypothetical CNOM - Community Integration & Recovery Support Services ACA										
Eligible Member Months	n.a.	n.a.	n.a.	n.a.	0	14,504	18,130	22,662	28,327	
PMPM Cost	n.a.	0	\$296.27	4.5%	\$0	\$310	\$324	\$338	\$353	
Total Expenditure					\$0	\$4,490,338	\$5,865,467	\$7,661,793	\$10,008,102	\$28,025,700
Hypothetical CNOM - Community Integration & Recovery Support Services CHIP										
Eligible Member Months	n.a.	n.a.	n.a.	n.a.	0	426	533	666	833	
PMPM Cost	n.a.	0	\$296.27	4.5%	\$0	\$310	\$324	\$338	\$353	
Total Expenditure					\$0	\$132,018	\$172,447	\$225,260	\$294,242	\$823,966
Hypothetical CNOM - Community Integration & Recovery Support Services CAWEM Prenatal										
Eligible Member Months	n.a.	n.a.	n.a.	n.a.	0	215	268	335	419	
PMPM Cost	n.a.	0	\$296.27	4.5%	\$0	\$310	\$324	\$338	\$353	
Total Expenditure					\$0	\$66,473	\$86,830	\$113,422	\$148,155	\$414,880

ELIGIBILITY GROUP	DY 00	TREND RATE	DEMONSTRATION YEARS (DY)					TOTAL WW
			DY 01	DY 02	DY 03	DY 04	DY 05	
SUD IMD Services PCR								
Eligible Member Months			1,411	1,437	1,463	1,489	1,516	
PMPM Cost	\$1,205	4.5%	\$1,259	\$1,316	\$1,375	\$1,437	\$1,502	
Total Expenditure			\$1,777,581	\$1,891,006	\$2,011,667	\$2,140,036	\$2,276,589	\$10,096,879
SUD IMD Services PWO								
Eligible Member Months			170	138	111	90	73	
PMPM Cost	\$1,683	4.5%	\$1,758	\$1,838	\$1,920	\$2,007	\$2,097	
Total Expenditure			\$299,223	\$252,965	\$213,858	\$180,796	\$152,846	\$1,099,689
SUD IMD Services CMO								
Eligible Member Months			405	369	337	307	280	
PMPM Cost	\$1,479	4.5%	\$1,546	\$1,615	\$1,688	\$1,764	\$1,843	
Total Expenditure			\$626,064	\$596,663	\$568,643	\$541,939	\$516,489	\$2,849,797
SUD IMD Services ABAD								
Eligible Member Months			584	617	652	688	727	
PMPM Cost	\$2,271	4.5%	\$2,373	\$2,480	\$2,591	\$2,708	\$2,830	
Total Expenditure			\$1,386,501	\$1,530,034	\$1,688,423	\$1,863,207	\$2,056,086	\$8,524,251
SUD IMD Services FC/SAC								
Eligible Member Months			153	153	154	154	155	
PMPM Cost	\$1,283	4.5%	\$1,341	\$1,402	\$1,465	\$1,531	\$1,599	
Total Expenditure			\$205,090	\$214,962	\$225,309	\$236,154	\$247,521	\$1,129,036
SUD IMD Services ACA								
Eligible Member Months			8,905	9,590	10,329	11,124	11,981	
PMPM Cost	\$1,832	4.5%	\$1,914	\$2,001	\$2,091	\$2,185	\$2,283	
Total Expenditure			\$17,047,568	\$19,186,448	\$21,593,716	\$24,302,999	\$27,352,163	\$109,482,894
SUD IMD Services CHIP								
Eligible Member Months			254	274	296	319	344	
PMPM Cost	\$447	4.5%	\$467	\$488	\$510	\$533	\$557	
Total Expenditure			\$118,784	\$133,810	\$150,739	\$169,810	\$191,293	\$764,436
SUD IMD Services CAWEM Prenatal								
Eligible Member Months			2	2	2	2	2	
PMPM Cost	\$14,932	4.5%	\$15,604	\$16,306	\$17,040	\$17,807	\$18,608	
Total Expenditure			\$31,208	\$32,613	\$34,080	\$35,614	\$37,217	\$170,732
Hypothetical CNOM - Community Integration & Recovery Support Services PCR								
Eligible Member Months	n.a.		0	2,790	3,488	4,360	5,450	
PMPM Cost	\$296	4.5%	\$0	\$310	\$324	\$338	\$353	
Total Expenditure			\$0	\$863,933	\$1,128,505	\$1,474,115	\$1,925,541	\$5,392,094
Hypothetical CNOM - Community Integration & Recovery Support Services PWO								
Eligible Member Months	n.a.		0	861	1,076	1,345	1,682	
PMPM Cost	\$296	4.5%	\$0	\$310	\$324	\$338	\$353	
Total Expenditure			\$0	\$266,577	\$348,214	\$454,855	\$594,148	\$1,663,794
Hypothetical CNOM - Community Integration & Recovery Support Services CMO								
Eligible Member Months	n.a.		0	1,446	1,808	2,259	2,824	
PMPM Cost	\$296	4.5%	\$0	\$310	\$324	\$338	\$353	
Total Expenditure			\$0	\$447,683	\$584,782	\$763,874	\$997,799	\$2,794,138
Hypothetical CNOM - Community Integration & Recovery Support Services ABAD								
Eligible Member Months	n.a.		0	1,084	1,354	1,693	2,316	
PMPM Cost	\$296	4.5%	\$0	\$310	\$324	\$338	\$353	
Total Expenditure			\$0	\$335,461	\$438,193	\$572,392	\$747,679	\$2,093,725
Hypothetical CNOM - Community Integration & Recovery Support Services OAA								
Eligible Member Months	n.a.		0	215	268	335	419	
PMPM Cost	\$296	4.5%	\$0	\$310	\$324	\$338	\$353	
Total Expenditure			\$0	\$66,473	\$86,830	\$113,422	\$148,155	\$414,880
Hypothetical CNOM - Community Integration & Recovery Support Services FC/SAC								
Eligible Member Months	n.a.		0	359	449	562	702	
PMPM Cost	\$296	4.5%	\$0	\$310	\$324	\$338	\$353	
Total Expenditure			\$0	\$111,285	\$145,366	\$189,884	\$248,034	\$694,569
Hypothetical CNOM - Community Integration & Recovery Support Services ACA								
Eligible Member Months	n.a.		0	14,504	18,130	22,662	28,327	
PMPM Cost	\$296	4.5%	\$0	\$310	\$324	\$338	\$353	
Total Expenditure			\$0	\$4,490,338	\$5,865,467	\$7,661,793	\$10,008,102	\$28,025,700
Hypothetical CNOM - Community Integration & Recovery Support Services CHIP								
Eligible Member Months	n.a.		0	426	533	666	833	
PMPM Cost	\$296	4.5%	\$0	\$310	\$324	\$338	\$353	
Total Expenditure			\$0	\$132,018	\$172,447	\$225,260	\$294,242	\$823,966
Hypothetical CNOM - Community Integration & Recovery Support Services CAWEM Prenatal								
Eligible Member Months	n.a.		0	215	268	335	419	
PMPM Cost	\$296	4.5%	\$0	\$310	\$324	\$338	\$353	
Total Expenditure			\$0	\$66,473	\$86,830	\$113,422	\$148,155	\$414,880

SUD IMD Supplemental BN Tests

IMD Cost Limit
Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
SUD IMD Services PCR	\$1,777,581	\$1,891,006	\$2,011,667	\$2,140,036	\$2,276,589	\$10,096,879
SUD IMD Services PWO	\$299,223	\$252,965	\$213,858	\$180,796	\$152,846	\$1,099,689
SUD IMD Services CMO	\$626,064	\$596,663	\$568,643	\$541,939	\$516,489	\$2,849,797
SUD IMD Services ABAD	\$1,386,501	\$1,530,034	\$1,688,423	\$1,863,207	\$2,056,086	\$8,524,251
SUD IMD Services FC/SAC	\$205,090	\$214,962	\$225,309	\$236,154	\$247,521	\$1,129,036
SUD IMD Services ACA	\$17,047,568	\$19,186,448	\$21,593,716	\$24,302,999	\$27,352,163	\$109,482,894
SUD IMD Services CHIP	\$118,784	\$133,810	\$150,739	\$169,810	\$191,293	\$764,436
SUD IMD Services CAWEM Prenatal	\$31,208	\$32,613	\$34,080	\$35,614	\$37,217	\$170,732
TOTAL	\$21,492,020	\$23,838,500	\$26,486,435	\$29,470,556	\$32,830,204	\$134,117,714

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
SUD IMD Services PCR	\$1,777,581	\$1,891,006	\$2,011,667	\$2,140,036	\$2,276,589	\$10,096,879
SUD IMD Services PWO	\$299,223	\$252,965	\$213,858	\$180,796	\$152,846	\$1,099,689
SUD IMD Services CMO	\$626,064	\$596,663	\$568,643	\$541,939	\$516,489	\$2,849,797
SUD IMD Services ABAD	\$1,386,501	\$1,530,034	\$1,688,423	\$1,863,207	\$2,056,086	\$8,524,251
SUD IMD Services FC/SAC	\$205,090	\$214,962	\$225,309	\$236,154	\$247,521	\$1,129,036
SUD IMD Services ACA	\$17,047,568	\$19,186,448	\$21,593,716	\$24,302,999	\$27,352,163	\$109,482,894
SUD IMD Services CHIP	\$118,784	\$133,810	\$150,739	\$169,810	\$191,293	\$764,436
SUD IMD Services CAWEM Prenatal	\$31,208	\$32,613	\$34,080	\$35,614	\$37,217	\$170,732
TOTAL	\$21,492,020	\$23,838,500	\$26,486,435	\$29,470,556	\$32,830,204	\$134,117,714

Net Overspend

	\$0	\$0	\$0	\$0	\$0	\$0
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Hypothetical CNOM Services Limit

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Hypothetical CNOM - Community Integration & Recovery Support Services PCR	\$0	\$862,933	\$1,128,505	\$1,474,115	\$1,925,541	\$5,392,094
Hypothetical CNOM - Community Integration & Recovery Support Services PWO	\$0	\$266,577	\$348,214	\$454,855	\$594,148	\$1,663,794
Hypothetical CNOM - Community Integration & Recovery Support Services CMO	\$0	\$447,683	\$584,782	\$763,874	\$997,799	\$2,794,138
Hypothetical CNOM - Community Integration & Recovery Support Services ABAD	\$0	\$335,461	\$438,193	\$572,392	\$747,679	\$2,093,725
Hypothetical CNOM - Community Integration & Recovery Support Services OAA	\$0	\$66,473	\$86,830	\$113,422	\$148,155	\$414,880
Hypothetical CNOM - Community Integration & Recovery Support Services FC/SAC	\$0	\$111,285	\$145,366	\$189,884	\$248,034	\$694,569
Hypothetical CNOM - Community Integration & Recovery Support Services ACA	\$0	\$4,490,338	\$5,865,467	\$7,661,793	\$10,008,102	\$28,025,700
Hypothetical CNOM - Community Integration & Recovery Support Services CHIP	\$0	\$132,018	\$172,447	\$225,260	\$294,242	\$823,966
Hypothetical CNOM - Community Integration & Recovery Support Services CAWEM Prenatal	\$0	\$66,473	\$86,830	\$113,422	\$148,155	\$414,880
TOTAL	\$0	\$6,713,767	\$8,769,804	\$11,455,595	\$14,963,700	\$41,902,867

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Hypothetical CNOM - Community Integration & Recovery Support Services PCR	\$0	\$862,933	\$1,128,505	\$1,474,115	\$1,925,541	\$5,392,094
Hypothetical CNOM - Community Integration & Recovery Support Services PWO	\$0	\$266,577	\$348,214	\$454,855	\$594,148	\$1,663,794
Hypothetical CNOM - Community Integration & Recovery Support Services CMO	\$0	\$447,683	\$584,782	\$763,874	\$997,799	\$2,794,138
Hypothetical CNOM - Community Integration & Recovery Support Services ABAD	\$0	\$335,461	\$438,193	\$572,392	\$747,679	\$2,093,725
Hypothetical CNOM - Community Integration & Recovery Support Services OAA	\$0	\$66,473	\$86,830	\$113,422	\$148,155	\$414,880
Hypothetical CNOM - Community Integration & Recovery Support Services FC/SAC	\$0	\$111,285	\$145,366	\$189,884	\$248,034	\$694,569
Hypothetical CNOM - Community Integration & Recovery Support Services ACA	\$0	\$4,490,338	\$5,865,467	\$7,661,793	\$10,008,102	\$28,025,700
Hypothetical CNOM - Community Integration & Recovery Support Services CHIP	\$0	\$132,018	\$172,447	\$225,260	\$294,242	\$823,966
Hypothetical CNOM - Community Integration & Recovery Support Services CAWEM Prenatal	\$0	\$66,473	\$86,830	\$113,422	\$148,155	\$414,880
TOTAL	\$0	\$6,713,767	\$8,769,804	\$11,455,595	\$14,963,700	\$41,902,867

Net Overspend

	\$0	\$0	\$0	\$0	\$0	\$0
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Add Trend Rates & PMPMs from Table Below to 'SUD IMD Supplemental Budget Neutrality Test(s)' STC

SUD MEG(s)	Trend Rate	DY 01	DY 02	DY 03	DY 04	DY 05
SUD IMD Services PCR	4.5%	\$1,259	\$1,316	\$1,375	\$1,437	\$1,502
SUD IMD Services PWO	4.5%	\$1,758	\$1,838	\$1,920	\$2,007	\$2,097
SUD IMD Services CMO	4.5%	\$1,546	\$1,615	\$1,688	\$1,764	\$1,843
SUD IMD Services ABAD	4.5%	\$2,373	\$2,480	\$2,591	\$2,708	\$2,830
SUD IMD Services FC/SAC	4.5%	\$1,341	\$1,402	\$1,465	\$1,531	\$1,599
SUD IMD Services ACA	4.5%	\$1,914	\$2,001	\$2,091	\$2,185	\$2,283
SUD IMD Services CHIP	4.5%	\$467	\$488	\$510	\$533	\$557
SUD IMD Services CAWEM Prenatal	4.5%	\$118,784	\$133,810	\$150,739	\$169,810	\$191,293
Hypothetical CNOM - Community Integration & Recovery Support Services PCR	4.5%	\$0	\$310	\$324	\$338	\$353
Hypothetical CNOM - Community Integration & Recovery Support Services PWO	4.5%	\$0	\$310	\$324	\$338	\$353
Hypothetical CNOM - Community Integration & Recovery Support Services CMO	4.5%	\$0	\$310	\$324	\$338	\$353
Hypothetical CNOM - Community Integration & Recovery Support Services ABAD	4.5%	\$0	\$310	\$324	\$338	\$353
Hypothetical CNOM - Community Integration & Recovery Support Services OAA	4.5%	\$0	\$310	\$324	\$338	\$353
Hypothetical CNOM - Community Integration & Recovery Support Services FC/SAC	4.5%	\$0	\$310	\$324	\$338	\$353
Hypothetical CNOM - Community Integration & Recovery Support Services ACA	4.5%	\$0	\$310	\$324	\$338	\$353
Hypothetical CNOM - Community Integration & Recovery Support Services CHIP	4.5%	\$0	\$310	\$324	\$338	\$353
Hypothetical CNOM - Community Integration & Recovery Support Services CAWEM Prenatal	4.5%	\$0	\$310	\$324	\$338	\$353

Projected SUD Member Months/Caseloads

	Trend Rate	DEMONSTRATION YEARS (DY)				
		DY 01	DY 02	DY 03	DY 04	DY 05
SUD IMD Services PCR	1.8%	1,411	1,437	1,463	1,489	1,516
SUD IMD Services PWO	-19.1%	170	138	111	90	73
SUD IMD Services CMO	-8.8%	405	369	337	307	280
SUD IMD Services ABAD	5.6%	584	617	652	688	727
SUD IMD Services FC/SAC	0.3%	153	153	154	154	155
SUD IMD Services ACA	7.7%	8,905	9,590	10,329	11,124	11,981
SUD IMD Services CHIP	7.8%	254	274	296	319	344
SUD IMD Services CAWEM Prenatal	0.0%	2	2	2	2	2
Hypothetical CNOM - Community Integration & Recovery Support Services PCR	25.0%	n/a	2,790	3,488	4,360	5,450
Hypothetical CNOM - Community Integration & Recovery Support Services PWO	25.0%	n/a	861	1,076	1,345	1,682
Hypothetical CNOM - Community Integration & Recovery Support Services CMO	25.0%	n/a	1,446	1,808	2,259	2,824
Hypothetical CNOM - Community Integration & Recovery Support Services ABAD	25.0%	n/a	1,084	1,354	1,693	2,116
Hypothetical CNOM - Community Integration & Recovery Support Services OAA	25.0%	n/a	215	268	335	419
Hypothetical CNOM - Community Integration & Recovery Support Services FC/SAC	25.0%	n/a	359	449	562	702
Hypothetical CNOM - Community Integration & Recovery Support Services ACA	25.0%	n/a	14,504	18,130	22,662	28,327
Hypothetical CNOM - Community Integration & Recovery Support Services CHIP	25.0%	n/a	426	533	666	833
Hypothetical CNOM - Community Integration & Recovery Support Services CAWEM Prenatal	25.0%	n/a	215	268	335	419

DRAFT

SUD IMD Facilities

5 Year Historical Costs & Future Projections Based on Trends

Inflation: 4.50%

5 year History	2015	2016	2017	2018	2019 w/ Adjustment	Projections						5 year Total	
						Base Year	DY 1	DY 2	DY 3	DY 4	DY 5		
PCR						PCR Combined Costs							
FFS SUD IMD Services	397,200	429,270	888,606	405,594	648,947	Member Month Trend Rate	1.80%						
FFS Non-SUD IMD Services	219,741	300,277	879,214	263,649	282,813	PMPM Cost Trend	6.50%						
CCO Cap Payments	498,305	422,394	577,420	530,372	609,469	Total Expenditure	1,670,960	1,777,581	1,891,006	2,011,667	2,140,036	2,276,589	10,096,879
Total Expenditure	1,115,246	1,151,941	2,345,240	1,199,615	1,541,230	Member Months	1,387	1,411	1,437	1,463	1,489	1,516	7,316
Member Months	1,267	1,106	1,474	1,250	1,362	PMPM	1,205	1,259	1,316	1,375	1,437	1,502	1,380
PMPM	880	1,042	1,591	960	1,132								
PWO						PWO Combined Costs							
FFS SUD IMD Services	243,000	174,465	344,900	78,900	173,993	Member Month Trend Rate	-19.10%						
FFS Non-SUD IMD Services	219,438	268,446	534,715	131,981	134,850	PMPM Cost Trend	7.90%						
CCO Cap Payments	234,474	234,666	121,383	86,618	96,629	Total Expenditure	353,941	299,223	252,965	213,858	180,796	152,846	1,099,689
Total Expenditure	696,912	677,577	1,000,998	297,499	405,472	Member Months	210	170	138	111	90	73	582
Member Months	606	543	346	238	260	PMPM	1,683	1,758	1,838	1,920	2,007	2,097	1,889
PMPM	1,150	1,248	2,893	1,250	1,560								
CMO						CMO Combined Costs							
FFS SUD IMD Services	278,601	461,190	624,304	231,780	444,217	Member Month Trend Rate	-8.80%						
FFS Non-SUD IMD Services	77,371	131,764	111,509	68,707	85,085	PMPM Cost Trend	17.90%						
CCO Cap Payments	102,071	120,051	103,927	98,830	81,636	Total Expenditure	656,911	626,063.75	596,662.89	568,642.86	541,938.53	516,488.94	2,849,797
Total Expenditure	458,044	713,004	839,740	399,317	610,939	Member Months	444	405	369	337	307	280	1,699
Member Months	705	828	712	615	487	PMPM	1,479	1,545.61	1,615.16	1,687.84	1,763.79	1,843.16	1,677
PMPM	650	861	1,179	649	1,254								
ABAD						ABAD Combined Costs							
FFS SUD IMD Services	418,469	278,631	472,280	197,760	442,343	Member Month Trend Rate	5.60%						
FFS Non-SUD IMD Services	370,070	261,531	312,788	146,568	251,088	PMPM Cost Trend	-5.20%						
CCO Cap Payments	458,078	550,584	525,861	718,276	561,640	Total Expenditure	1,256,434	1,386,501	1,530,034	1,688,423	1,863,207	2,056,086	8,524,251
Total Expenditure	1,246,617	1,090,746	1,310,929	1,062,604	1,255,071	Member Months	553	584	617	652	688	727	3,268
Member Months	421	492	451	620	524	PMPM	2,271	2,373	2,480	2,591	2,708	2,830	2,609
PMPM	2,961	2,217	2,907	1,714	2,395								
FC/SAC						FC/SAC Combined Costs							
FFS SUD IMD Services	137,035	155,810	187,502	108,514	97,047	Member Month Trend Rate	0.30%						
FFS Non-SUD IMD Services	28,107	202,431	269,201	43,647	31,457	PMPM Cost Trend	-4.00%						
CCO Cap Payments	70,641	79,513	93,277	86,752	74,710	Total Expenditure	195,671	205,090	214,962	225,309	236,154	247,521	1,129,036
Total Expenditure	235,783	437,754	549,980	238,913	203,214	Member Months	152	153	153	154	154	155	769
Member Months	150	159	171	200	152	PMPM	1,283	1,341	1,402	1,465	1,531	1,599	1,468
PMPM	1,572	2,753	3,216	1,195	1,337								

ACA						ACA Combined Costs								
FFS SUD IMD Services	3,175,383	3,025,690	6,448,832	3,096,394	6,969,182	Member Month Trend Rate	7.70%							
FFS Non-SUD IMD Services	1,964,657	2,748,988	4,247,028	2,141,069	2,978,688	PMPM Cost Trend	6.10%							
CCO Cap Payments	2,624,822	2,456,486	2,399,926	3,043,807	3,307,702	Total Expenditure	15,147,130	17,047,568	19,186,448	21,593,716	24,302,999	27,352,163	109,482,894	-
Total Expenditure	7,764,861	8,231,164	13,095,785	8,281,270	13,255,572	Member Months	8,268	8,905	9,590	10,329	11,124	11,981	51,929	
Member Months	5,696	6,216	6,461	7,521	7,677	PMPM	1,832	1,914	2,001	2,091	2,185	2,283	2,108	
PMPM	1,363	1,324	2,027	1,101	1,727									
CHIP						CHIP Combined Costs								
FFS SUD IMD Services	41,427	45,760	58,307	17,600	40,788	Member Month Trend Rate	7.80%							
FFS Non-SUD IMD Services	10,247	22,413	10,062	4,501	16,177	PMPM Cost Trend	-0.60%							
CCO Cap Payments	23,033	20,759	33,030	42,337	41,440	Total Expenditure	105,444	118,784	133,810	150,739	169,810	191,293	764,436	-
Total Expenditure	74,707	88,932	101,400	64,438	98,405	Member Months	236	254	274	296	319	344	1,487	
Member Months	162	151	206	249	219	PMPM	447	467	488	510	533	557	514	
PMPM	461	589	492	259	449									
CAWEM Prenatal						CAWEM Prenatal Combined Costs								
FFS SUD IMD Services	-	-	-	14,910	2,604	Member Month Trend Rate	0.00%							
FFS Non-SUD IMD Services	-	-	-	3,117	20,601	PMPM Cost Trend	28.70%							
CCO Cap Payments	-	-	-	-	-	Total Expenditure	29,864	31,208	32,613	34,080	35,614	37,217	170,732	-
Total Expenditure	-	-	-	18,027	23,205	Member Months	2	2	2	2	2	2	10	
Member Months	-	-	-	2	2	PMPM	14,932	15,604	16,306	17,040	17,807	18,608	17,073	
PMPM	-	-	-	9,013	11,602									
Combined History						Combined Projections								
Total Fund	11,592,171	12,391,118	19,244,073	11,552,669	17,381,505	Total Fund	19,416,355	21,492,020	23,838,500	26,486,435	29,470,556	32,830,204	134,117,714	

SUD IMD Services : Costs billed by IMD providers for the SUD treatment while in the SUD IMD. The 2019 expenditure total includes an adjustment to increase the Base Year based on an estimate for the behavioral health rate increase of 38% on H0018 and H0019 effective October 2019, which is not in the historical data. The adjustment adds \$1.7m to the 2019 expenditures.

Non-SUD IMD Services: Costs billed for services performed outside of the SUD IMD in any whole month while the client received SUD treatment in an IMD for at least 1 day.

CCO Cap Payments: Cost of capitation payments made to a managed care organization if an enrollee was in an IMD facility at least one day.

Member Months: Count of Oregon Health Plan members (enrollees & non-enrollees) who received care in an IMD at least 1 day in a month.

Projections of PMPM Cost Trend: Beginning in DY 1, using the lessor of the inflation rate of 4.50% or the historical average, with the exception of ABAD, FC/SAC, and CAWEM Prenatal. The average annual historical trend using data from 2015 reflect a negative PMPM trend which is not expected going forward.

H0043	Supported Housing	\$260.44	\$272.16	\$284.41	\$297.21	\$310.58	\$294.62
H2014	Skills training and development, per 15 min	\$152.50	\$159.36	\$166.53	\$174.02	\$181.85	\$172.51
H2023	Supported Employment, per 15 min	\$152.50	\$159.36	\$166.53	\$174.02	\$181.85	\$172.51
H2023	Supported Education, per 15 min	\$152.50	\$159.36	\$166.53	\$174.02	\$181.85	\$172.51
H0038	Self-help/peer services, per 15 min	\$338.76	\$354.00	\$369.93	\$386.58	\$403.98	\$383.21
Total (Solved for)		\$296.27	\$309.60	\$323.53	\$338.09	\$353.31	\$335.15

H0043	Supported Housing	1	2	2	3	3	10	25.00%
H2014	Skills training and development, per 15 min	6	7	9	11	14	41	25.00%
H2023	Supported Employment, per 15 min	16	21	26	32	40	119	25.00%
H2023	Supported Education, per 15 min	16	21	26	32	40	119	25.00%
H0038	Self-help/peer services, per 15 min	132	165	206	257	322	950	25.00%
Total		172	215	268	335	419	1,238	25.00%

H0043	Supported Housing	\$368	\$480	\$627	\$820	\$1,070	\$2,998
H2014	Skills training and development, per 15 min	\$861	\$1,125	\$1,469	\$1,919	\$2,507	\$7,021
H2023	Supported Employment, per 15 min	\$2,512	\$3,281	\$4,286	\$5,598	\$7,312	\$20,477
H2023	Supported Education, per 15 min	\$2,512	\$3,281	\$4,286	\$5,598	\$7,312	\$20,477
H0038	Self-help/peer services, per 15 min	\$44,637	\$58,306	\$76,162	\$99,488	\$129,957	\$363,912
Total		\$50,889	\$66,473	\$86,830	\$113,422	\$148,159	\$414,885

FC/SAC		2%					
H0043	Supported Housing	\$260.44	\$272.16	\$284.41	\$297.21	\$310.58	\$294.62
H2014	Skills training and development, per 15 min	\$152.50	\$159.36	\$166.53	\$174.02	\$181.85	\$172.51
H2023	Supported Employment, per 15 min	\$152.50	\$159.36	\$166.53	\$174.02	\$181.85	\$172.51
H2023	Supported Education, per 15 min	\$152.50	\$159.36	\$166.53	\$174.02	\$181.85	\$172.51
H0038	Self-help/peer services, per 15 min	\$338.76	\$354.00	\$369.93	\$386.58	\$403.98	\$383.21
Total (Solved for)		\$296.27	\$309.60	\$323.53	\$338.09	\$353.31	\$335.15

FC/SAC		2%						
H0043	Supported Housing	2	3	4	5	6	17	25.00%
H2014	Skills training and development, per 15 min	9	12	15	18	23	68	25.00%
H2023	Supported Employment, per 15 min	28	34	43	54	67	199	25.00%
H2023	Supported Education, per 15 min	28	34	43	54	67	199	25.00%
H0038	Self-help/peer services, per 15 min	221	276	345	431	539	1,590	25.00%
Total		288	359	449	562	702	2,072	25.00%

FC/SAC		2%					
H0043	Supported Housing	\$616	\$804	\$1,050	\$1,372	\$1,792	\$5,018
H2014	Skills training and development, per 15 min	\$1,442	\$1,883	\$2,460	\$3,213	\$4,197	\$11,754
H2023	Supported Employment, per 15 min	\$4,205	\$5,493	\$7,175	\$9,372	\$12,242	\$34,282
H2023	Supported Education, per 15 min	\$4,205	\$5,493	\$7,175	\$9,372	\$12,242	\$34,282
H0038	Self-help/peer services, per 15 min	\$74,728	\$97,613	\$127,506	\$166,557	\$217,567	\$609,242
Total		\$85,196	\$111,285	\$145,366	\$189,886	\$248,040	\$694,578

ACA		66%					
H0043	Supported Housing	\$260.44	\$272.16	\$284.41	\$297.21	\$310.58	\$294.62
H2014	Skills training and development, per 15 min	\$152.50	\$159.36	\$166.53	\$174.02	\$181.85	\$172.51
H2023	Supported Employment, per 15 min	\$152.50	\$159.36	\$166.53	\$174.02	\$181.85	\$172.51
H2023	Supported Education, per 15 min	\$152.50	\$159.36	\$166.53	\$174.02	\$181.85	\$172.51
H0038	Self-help/peer services, per 15 min	\$338.76	\$354.00	\$369.93	\$386.58	\$403.98	\$383.21
Total (Solved for)		\$296.27	\$309.60	\$323.53	\$338.09	\$353.31	\$335.15

ACA		66%						
H0043	Supported Housing	95	119	149	186	233	687	25.00%
H2014	Skills training and development, per 15 min	381	477	596	745	931	2,749	25.00%
H2023	Supported Employment, per 15 min	1,113	1,391	1,738	2,173	2,716	8,019	25.00%
H2023	Supported Education, per 15 min	1,113	1,391	1,738	2,173	2,716	8,019	25.00%
H0038	Self-help/peer services, per 15 min	8,901	11,126	13,908	17,385	21,731	64,149	25.00%
Total		11,603	14,504	18,130	22,662	28,327	83,623	25.00%

ACA		66%					
H0043	Supported Housing	\$24,837	\$32,444	\$42,380	\$55,359	\$72,312	\$202,495
H2014	Skills training and development, per 15 min	\$58,174	\$75,988	\$99,259	\$129,654	\$169,360	\$474,260
H2023	Supported Employment, per 15 min	\$169,673	\$221,632	\$289,505	\$378,157	\$493,965	\$1,383,259
H2023	Supported Education, per 15 min	\$169,673	\$221,632	\$289,505	\$378,157	\$493,965	\$1,383,259
H0038	Self-help/peer services, per 15 min	\$3,015,264	\$3,938,642	\$5,144,851	\$6,720,516	\$8,778,759	\$24,582,767
Total		\$3,437,621	\$4,490,338	\$5,865,499	\$7,661,844	\$10,008,361	\$28,026,042

CHIP		2%					
H0043	Supported Housing	\$260.44	\$272.16	\$284.41	\$297.21	\$310.58	\$294.62
H2014	Skills training and development, per 15 min	\$152.50	\$159.36	\$166.53	\$174.02	\$181.85	\$172.51
H2023	Supported Employment, per 15 min	\$152.50	\$159.36	\$166.53	\$174.02	\$181.85	\$172.51
H2023	Supported Education, per 15 min	\$152.50	\$159.36	\$166.53	\$174.02	\$181.85	\$172.51
H0038	Self-help/peer services, per 15 min	\$338.76	\$354.00	\$369.93	\$386.58	\$403.98	\$383.21
Total (Solved for)		\$296.27	\$309.60	\$323.53	\$338.09	\$353.31	\$335.15

CHIP		2%						
H0043	Supported Housing	3	4	4	5	7	20	25.00%
H2014	Skills training and development, per 15 min	11	14	18	22	27	81	25.00%
H2023	Supported Employment, per 15 min	33	41	51	64	80	236	25.00%
H2023	Supported Education, per 15 min	33	41	51	64	80	236	25.00%
H0038	Self-help/peer services, per 15 min	262	327	409	511	639	1,886	25.00%
Total		341	426	533	666	833	2,459	25.00%

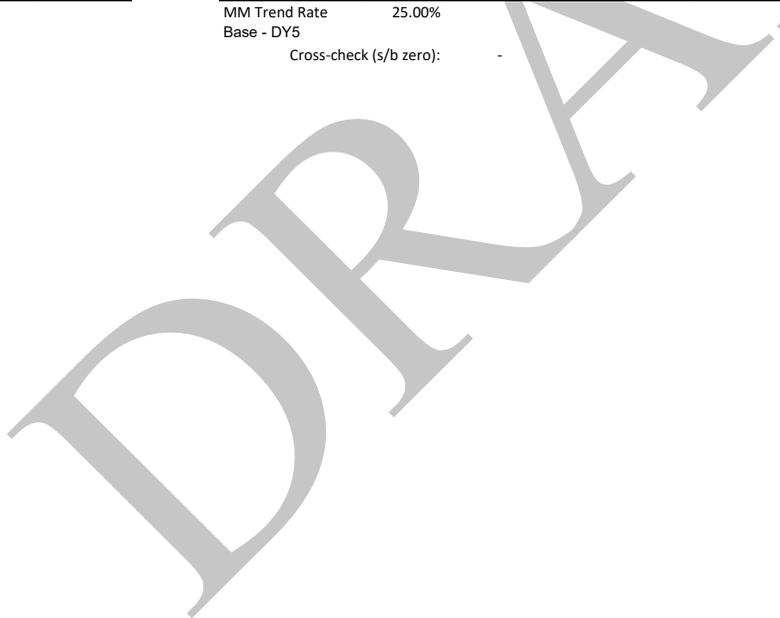
CHIP		2%					
H0043	Supported Housing	\$730	\$954	\$1,246	\$1,628	\$2,126	\$5,953
H2014	Skills training and development, per 15 min	\$1,710	\$2,234	\$2,918	\$3,812	\$4,979	\$13,943
H2023	Supported Employment, per 15 min	\$4,988	\$6,516	\$8,512	\$11,118	\$14,523	\$40,668
H2023	Supported Education, per 15 min	\$4,988	\$6,516	\$8,512	\$11,118	\$14,523	\$40,668
H0038	Self-help/peer services, per 15 min	\$88,650	\$115,798	\$151,261	\$197,586	\$258,099	\$722,743
Total		\$101,067	\$132,018	\$172,448	\$225,261	\$294,250	\$823,976

CAWEM Prenatal 1%								CAWEM Prenatal								CAWEM Prenatal								
H0043	Supported Housing	\$260.44	\$272.16	\$284.41	\$297.21	\$310.58	\$294.62	H0043	Supported Housing	1	2	2	3	3	10	25.00%	H0043	Supported Housing	\$368	\$480	\$627	\$820	\$1,070	\$2,998
H2014	Skills training and development, per 15 min	\$152.50	\$159.36	\$166.53	\$174.02	\$181.85	\$172.51	H2014	Skills training and development, per 15 min	6	7	9	11	14	41	25.00%	H2014	Skills training and development, per 15 min	\$861	\$1,125	\$1,469	\$1,919	\$2,507	\$7,021
H2023	Supported Employment, per 15 min	\$152.50	\$159.36	\$166.53	\$174.02	\$181.85	\$172.51	H2023	Supported Employment, per 15 min	16	21	26	32	40	119	25.00%	H2023	Supported Employment, per 15 min	\$2,512	\$3,281	\$4,286	\$5,598	\$7,312	\$20,477
H2023	Supported Education, per 15 min	\$152.50	\$159.36	\$166.53	\$174.02	\$181.85	\$172.51	H2023	Supported Education, per 15 min	16	21	26	32	40	119	25.00%	H2023	Supported Education, per 15 min	\$2,512	\$3,281	\$4,286	\$5,598	\$7,312	\$20,477
H0038	Self-help/peer services, per 15 min	\$338.76	\$354.00	\$369.93	\$386.58	\$403.98	\$383.21	H0038	Self-help/peer services, per 15 min	132	165	206	257	322	950	25.00%	H0038	Self-help/peer services, per 15 min	\$44,637	\$58,306	\$76,162	\$99,488	\$129,957	\$363,912
Total (Solved for)		\$296.27	\$309.60	\$323.53	\$338.09	\$353.31	\$335.15	Total		172	215	268	335	419	1,238	25.00%	Total		\$50,889	\$66,473	\$86,830	\$113,422	\$148,159	\$414,885
Total 100% (Should be 100%)								Total 25.00%								Total 25.00%								
H0043	Supported Housing	\$260.44	\$272.16	\$284.41	\$297.21	\$310.58	\$294.62	H0043	Supported Housing	144	180	225	281	352	1,038	25.00%	H0043	Supported Housing	\$37,503	\$48,989	\$63,992	\$83,590	\$109,188	\$305,760
H2014	Skills training and development, per 15 min	\$152.50	\$159.36	\$166.53	\$174.03	\$181.86	\$172.51	H2014	Skills training and development, per 15 min	576	720	900	1,125	1,406	4,151	25.00%	H2014	Skills training and development, per 15 min	\$87,840	\$114,739	\$149,877	\$195,773	\$255,727	\$716,115
H2023	Supported Employment, per 15 min	\$152.50	\$159.36	\$166.53	\$174.03	\$181.86	\$172.51	H2023	Supported Employment, per 15 min	1,680	2,100	2,625	3,281	4,102	12,108	25.00%	H2023	Supported Employment, per 15 min	\$256,200	\$334,656	\$437,141	\$571,003	\$745,869	\$2,088,670
H2023	Supported Education, per 15 min	\$152.50	\$159.36	\$166.53	\$174.03	\$181.86	\$172.51	H2023	Supported Education, per 15 min	1,680	2,100	2,625	3,281	4,102	12,108	25.00%	H2023	Supported Education, per 15 min	\$256,200	\$334,656	\$437,141	\$571,003	\$745,869	\$2,088,670
H0038	Self-help/peer services, per 15 min	\$338.76	\$354.00	\$369.93	\$386.58	\$403.97	\$383.21	H0038	Self-help/peer services, per 15 min	13,440	16,800	21,000	26,250	32,813	96,863	25.00%	H0038	Self-help/peer services, per 15 min	\$4,552,934	\$5,947,200	\$7,768,530	\$10,147,725	\$13,255,594	\$37,119,049
Total (Solved for)		\$296.27	\$309.60	\$323.53	\$338.09	\$353.31	\$335.15	Total		17,520	21,900	27,375	34,219	42,773	126,267	25.00%	Total		\$5,190,678	\$6,780,240	\$8,856,682	\$11,569,094	\$15,112,247	\$42,318,263

PMPM Cost Trend Base - DY5 4.50%

MM Trend Rate Base - DY5 25.00%

Cross-check (s/b zero): -



Community Integration & Recovery Support Services

Program projections, beginning in DY2

DY2

Code		Description	Rate	Unit	Approx Units Per Month Per Person	Approx Persons per month	Total Fund Monthly Costs	Total Fund Annual Costs	PMPM	MM's
H0043	Community Integration Services	Supported Housing	\$68.04	Per Day	4	15	\$4,082	\$48,989	\$272.16	180
H2014	Recovery Support Services	Skills training and development, per 15 min	\$19.92	15 MINUTES	8	60	\$9,562	\$114,739	\$159.36	720
H2023	Recovery Support Services	Supported Employment, per 15 min	\$19.92	15 MINUTES	8	175	\$27,888	\$334,656	\$159.36	2,100
H2023	Recovery Support Services	Supported Education, per 15 min	\$19.92	15 MINUTES	8	175	\$27,888	\$334,656	\$159.36	2,100
H0038	Recovery Support Services	Self-help/peer services, per 15 min	\$17.70	15 MINUTES	20	1,400	\$495,600	\$5,947,200	\$354.00	16,800
Total						1,825	\$565,020	\$6,780,240	\$309.60	21,900

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