# Oregon Health Plan 2021-2026 Substance Use Disorder 1115 Demonstration

## MID-POINT ASSESSMENT

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CENTER FOR HEALTH SYSTEMS EFFECTIVENESS

**Prepared for:**
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OHSU

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# Acronyms

| | |
|---|---|
| **AOD** | Alcohol or Other Drug |
| **ASAM** | American Society of Addiction Medicine |
| **CCO** | Coordinated Care Organization |
| **CIS** | Community Integration Services |
| **CMS** | Centers for Medicare and Medicaid Services |
| **EDIE** | Emergency Department Information Exchange |
| **EHR** | Electronic Health Record |
| **HIE** | Health Information Exchange |
| **IMD** | Institutions for Mental Disease |
| **LOS** | Length of Stay |
| **MAT** | Medication-Assisted Treatment |
| **MPA** | Mid-Point Assessment |
| **OAR** | Oregon Administrative Rules |
| **OBOT** | Office-Based Opioid Treatment |
| **OHA** | Oregon Health Authority |
| **OTP** | Opioid Treatment Program |
| **OUD** | Opioid Use Disorder |
| **PDMP** | Prescription Drug Monitoring Program |
| **PHE** | Public Health Emergency |
| **PMPM** | Per Member Per Month |
| **SUD** | Substance Use Disorder |

## Overview

On April 8, 2021, Oregon obtained approval for a Section 1115 waiver designed to help maintain and expand access to treatment for adults with substance use disorder (SUD). The SUD waiver focuses on residential and inpatient treatment, permitting the use of federal matching funds for short-term residential treatment services in Institutions for Mental Disease (IMD) for adults with SUD. Federal funding for services in an IMD is contingent on the state's progress toward a set of six milestones for care delivery. The Centers for Medicare and Medicaid Services (CMS) required Oregon to conduct an independent mid-point assessment (MPA) to examine progress on the six milestones and associated performance targets outlined in the SUD waiver, identify factors affecting their achievement, and provide recommendations for state actions to support improvement.

The Oregon Health Authority (OHA) contracted with the Center for Health Systems Effectiveness at Oregon Health & Science University to complete the mid-point assessment. This report presents assessment findings, cataloging the completion of planned implementation actions and assessing changes in critical metrics associated with each milestone between baseline (2021) and mid-point (2022) years. The assessment also reports feedback from SUD residential treatment providers and coordinated care organizations (CCOs) about the progress of the substance use disorder treatment system and the risks of not meeting the waiver milestones. The findings inform Oregon's continued implementation efforts and highlight how SUD waivers may affect treatment systems in other states.

## Summary of Findings

The state has completed almost all actions in the Implementation Plan. Performance on just over half of critical metrics (15 out of 27) moved in the targeted direction. For example, the state's performance on the Withdrawal Management measure, one of seven metrics for Milestone 1: Access to Critical Levels of Care for Opioid Use Disorder and Other Substance Use Disorders, improved by 4.8%, from 0.63 beneficiaries per 1,000 member months receiving services at baseline (April 2021 to March 2022) to 0.66 at the mid-point (April to December 2022). Conversely, performance on another Milestone 1 metric, Outpatient Services, decreased by 7.1% from 16.46 beneficiaries per 1,000 member months at baseline to 15.29 at the mid-point. Most changes were relatively small. The mid-point assessment is limited by the analysis time frame, measuring differences between 2020 and 2021, during the COVID-19 Public Health Emergency (PHE).

Providers and CCOs perceived progress in several areas across all milestones following recent state policy initiatives. These include increases in Medicaid residential treatment reimbursement rates, reimbursement to providers for engaging with clients before residential treatment and for helping to plan for housing and employment after discharge from treatment, the expansion of telehealth prompted by the PHE, and the increased availability of naloxone, all of which advanced progress toward Milestones 1 and 5. However, barriers did surface for all six milestones. Administrative burdens hindered providers in many ways, such as the need to frequently reauthorize residential treatment and to interact with multiple CCOs with different policies, billing criteria, and billing codes. Providers and CCOs alike saw a nexus of obstacles to improving access to the continuum of SUD care, including a rise in fentanyl use, increased severity of addiction and unmet health-related social needs, still-insufficient treatment reimbursement rates, difficulty hiring and keeping qualified staff, and inadequate capacity at the withdrawal management and residential treatment levels of care. SUD prevention efforts were limited.

Following CMS guidelines, we assessed the state's risk of not meeting each milestone. We assigned the overall risk of not meeting a given milestone by using the highest-risk assessment of the three data sources: progress on critical metrics from baseline to mid-point, completion of implementation action items, and feedback from providers and CCOs. Using these criteria, we assigned Milestones 1 and 6 a high risk based on interview participant feedback. We assigned Milestone 2 a medium risk based on critical metric performance and participant feedback, and Milestone 4 a medium risk based on participant feedback. We assigned Milestones 3 and 5 a low risk.

## Recommendations

Based on our findings, we believe the following actions may improve the potential for the state to meet its goals for milestones at medium or high risk:

### Milestone 1: Access to Critical Levels of Care for Opioid Use Disorder (OUD) and other Substance Use Disorders (SUDs)

- **Consider adding standardization requirements to future CCO contracts** to reduce the administrative burden placed on providers interacting with multiple CCOs. Provider resources spent on maintaining compliance with multiple CCOs and the Division of Medical Assistance Programs requirements could be better allocated to client care delivery. Specifically:
    - Streamline and align service authorization processes across CCOs.
    - Align coding and billing procedures across CCOs.
    - Encourage CCOs to relax restrictions on peer-delivered services to align with best practices for this kind of care, such as allowing providers to bill for drop-in visits.
    - Establish guidelines related to minimum length-of-stay (LOS) authorization for patients, including consideration of CCO quality metrics to ensure LOS determinations are achieving good outcomes.
- **Provide ongoing, robust outreach and technical assistance around:**
    - Behavioral health coding and billing, particularly for community integration services (CIS) and pre-engagement, ideally as a collaboration between OHA and CCOs. Several providers refrained from using the new billing codes because they were unsure of how to use them and didn't want to have claims denied by CCOs.
    - Augmenting the SUD workforce by encouraging the full scope of practice for qualified mental health professionals, in particular for integrating mental health and SUD care. For example, OAR 309-019 allows a qualified mental health professional with an appropriate number of hours of SUD training experience to provide SUD services for a limited time without being a certified alcohol and drug counselor. It was noted that not everyone is aware of this policy, so more effective dissemination and promotion could help expand workforce potential among qualified mental health professionals.
- **Evaluate SUD treatment reimbursement rates,** particularly for residential treatment, and continue to look for ways to ensure they "are sufficient to enlist enough providers so that care and services are available under [Medicaid] at least to the extent that such care and services are available to the general population in the geographic area," as required by Section 1902(a)(30)(A) of the Social Security Act. Participants reported an ongoing need to augment their funding through grants to provide basic services and referred to the greater availability of care for patients with commercial insurance compared to patients with Medicaid.

- **Continue to monitor measures related to Milestone 1 that did not show progress** (Outpatient Services, Medication-Assisted Treatment (MAT), and Continuity of Pharmacotherapy for Opioid Use Disorder (OUD)) and continue the implementation task of engaging with CCOs to improve MAT capacity.

### Milestone 2: Use of Evidence-based, SUD-specific Patient Placement Criteria

- **Consider convening a workgroup of providers** to identify ways OHA and CCOs could reduce the burden on providers to adopt a new assessment, conduct regular training, and research best practices for modifying assessments to account for dual diagnosis or cultural needs.
- **Continue monitoring utilization and LOS for residential treatment facilities.** Rates for the number of Medicaid Beneficiaries Treated in an IMD for SUD improved, but the change was very small and thus classified as "no progress." Average LOS in IMDs was well below the target at the baseline and further decreased at the mid-point. While this development was consistent with the target, which required the average LOS to remain below 30 days, it may raise concerns that LOS could be inadequate for some patients.

### Milestone 4: Sufficient Provider Capacity at Critical Levels of Care including for MAT for OUD

- **Continue outreach to providers to reduce the stigma of MAT** and consider incentives to recruit new providers to become substance use medication prescribers, especially for buprenorphine and other non-methadone options.
- **Focus on how to support MAT access in non-outpatient opioid treatment programs (OTPs) and office-based opioid treatment (OBOT) settings,** including ways to collaborate with MAT providers on wraparound services and care coordination.
- **Continue to allow the use of telehealth in MAT,** especially in rural areas where transportation is a major barrier to access.

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

- **Consider convening a workgroup to assess provider needs to improve information exchange and care coordination**. Providers stated that information-sharing regulations, shifts in Oregon Administrative Rules, and a lack of health information exchange (HIE) infrastructure imposed hurdles when providing care across settings. One participant specifically called out the need for support with electronic signature software, such as DocuSign, that would help speed up the intake and referral process and reduce burdens for clients and providers alike. HIE investments could also help align existing systems and enable the shift from paper to electronic health records to help increase the accessibility of information and facilitate care coordination. Such investments would be a considerable lift for the state and would take a long time to fully implement. While HIE investments should be a consideration for future planning, OHA could seek provider feedback about other difficulties related to information exchange and care coordination and potential remedies actionable in the short term.
- **Clarify and enforce care coordination roles and responsibilities of CCOs.** Participants saw a lack of continuity of care when members of one CCO had to receive services in another region, impeding the likelihood of successful recovery. Clear messaging from OHA to CCOs and providers alike that outlines where the responsibility lies for each aspect of care coordination and transitions between levels of care would support positive outcomes.

- **Continue to monitor measures related to Milestone 6 that did not show progress.** Follow-up after Emergency Department Visit for Alcohol and Other Drug (AOD) Dependence or Mental Illness. Efforts to improve care coordination may aid in moving these metrics in the desired direction.

# Roadmap to the Report

| Chapter | Name | Content |
|---|---|---|
| 1 | Introduction | Introduction to the SUD waiver and its milestones<br>Oregon's Medicaid program and other SUD-related efforts |
| 2 | Methods | Data sources<br>Analytic methods<br>Limitations of the assessment |
| 3 | Findings | Trends in SUD diagnosis<br>Overall feedback from stakeholders<br>Progress on critical metrics by milestone<br>Implementation action items<br>Interviewee assessments<br>Summary of the findings by milestone<br>Assessment of overall risk of not meeting milestones<br>Budget neutrality assessment |
| 4 | Next steps | Independent Assessor recommendations for milestones at moderate to high risk for not being met<br>State responses to findings and recommendations, including any planned modifications to demonstration processes or implementation activities<br>Description of areas at risk of not meeting milestones and list of proposed activities for addressing deficiencies |

# Introduction

## Overview

On April 8, 2021, Oregon obtained approval for its Section 1115 waiver ("Oregon Health Plan Substance Use Disorder 1115 Demonstration, Project Number 11-W00362/10") designed to help maintain and expand access for adults with substance use disorder (SUD), with a focus on residential and inpatient treatment. The SUD waiver permits the use of federal matching funds for short-term residential treatment services in an Institution for Mental Disease (IMD) for these populations, "aim[ing] for a statewide average length of stay (LOS) of 30 days or less."[1]

Since 1965, federal law has prohibited the use of federal Medicaid matching funds for services provided to Medicaid enrollees ages 21 through 64 in facilities with the IMD designation, defined as facilities with more than 16 beds that specialize in mental health or SUD treatment. In 2015, the Centers for Medicare & Medicaid Services (CMS) allowed states to pursue Section 1115 demonstration waivers that removed the IMD exclusion. In 2017, State Medicaid Director letter 17-003, ***Strategies to Address the Opioid Epidemic***, described the new initiative as "aimed at giving states flexibility to design demonstrations that improve access to high quality, clinically appropriate treatment for opioid use disorder (OUD) and other SUDs."

Without an SUD waiver, CMS permits federal matching funds for services provided in an IMD only for individuals under 21 or over 64 years old; however, the SUD waiver allows states to receive federal matching funds for residential treatment services in an IMD for adults ages 21-64 with SUD, on the condition that the statewide average LOS in IMDs is 30 days or less. CMS also requires states with SUD waivers to implement models of care focused on improving access to a continuum of SUD evidence-based services at varied levels of intensity for individuals in the community and outside institutions. The continuum of care must be based on the American Society of Addiction Medicine (ASAM) criteria or other nationally recognized assessment and placement tools that reflect evidence-based clinical treatment guidelines. Most states have since taken advantage of waivers' opportunity to bolster their efforts in tackling substance misuse. As of November 2023, 34 states and the District of Columbia had approved Section 1115 waivers of the IMD payment exclusion for SUD treatment. Four states had such waivers pending.[2]

### BOX 1.1 The IMD exclusion

*An IMD is defined as "a hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services" (Social Security Act §1905(i)). IMDs are generally licensed or accredited facilities that specialize in providing psychiatric, psychological, and/or SUD treatment services.*

*Since 1965, the IMD exclusion has prohibited state Medicaid programs from obtaining federal financial participation to pay for IMD services. The policy was intended to support a shift from institutionalized care to community-based treatment for mental illness while establishing states as the primary payer for inpatient mental health services. The exclusion applies to services provided*

*to Medicaid beneficiaries between the ages of 21 and 64. It does not preclude states from receiving federal Medicaid funding for Medicaid enrollees 21-64 years old who receive services provided in facilities that do not meet the definition of an IMD, such as facilities with 16 or fewer beds, or for Medicaid beneficiaries younger than 21 or older than 64 who receive services in IMDs. In 2016, CMS amended the rules for Medicaid managed care such that state capitation payments to managed care entities for enrollees admitted to an IMD qualified for full federal matching as long as their IMD LOS did not exceed 15 days in a calendar month.*

Approval of Oregon's SUD waiver provided expenditure authority for all Medicaid state plan services, including a continuum of services to treat SUD. The state added to the continuum housing and employment supports for individuals transitioning back into the community from an IMD or other residential setting. Federal funding for services in an IMD is contingent on the state's progress toward a set of milestones for care delivery. Progress will be evaluated based on an implementation plan (SUD Implementation Plan), performance targets on a set of critical metrics (SUD Monitoring Protocol) agreed upon between the state and CMS, and budget neutrality requirements. CMS required Oregon to conduct an independent mid-point assessment (MPA) of the SUD waiver to examine progress on milestones and performance targets, including factors affecting their achievement and the risk of failing to meet them.[1]

The Oregon Health Authority (OHA) contracted with the Center for Health Systems Effectiveness at Oregon Health & Science University to complete the MPA. This report presents its findings.

## Waiver Implementation in the Context of a Shift to Integrated, Accountable Care in Oregon's Medicaid Program

Oregon's implementation of the IMD waiver occurred against the backdrop of other system changes affecting SUD treatment delivery. Some of the changes were specific to Oregon's Medicaid program, while others were broader state initiatives aimed at bolstering the state's response to a widely acknowledged behavioral health crisis.

The IMD waiver came into effect as Oregon was almost 10 years into a major restructuring of its Medicaid systems, one that prioritized behavioral health integration, care coordination, and supports for members' social needs. Before 2012, behavioral health services for Medicaid enrollees were funded and delivered separately from medical services through prepaid behavioral health plans, many of which were operated by counties.[3] This led to a system in which mental health and SUD services were siloed from other health care with little accountability for coordination of services.

Oregon's 2012-2017 Section 1115 waiver inaugurated the coordinated care organization (CCO) model, which featured regional organizations with accountability for members' physical, behavioral, and oral health needs. Some CCOs formed from a single managed care organization, maintaining their contractual relationships with health care providers. Other CCOs formed from partnerships among managed care organizations, health systems, mental health organizations, dental care organizations, and county health departments. Sixteen CCOs were approved in the first round of contracting. Most regions were served by a single CCO, although a few, including the Portland metropolitan area, were served by two CCOs.

While the CCO model had similarities to both managed care organizations and accountable care organizations, it included several distinguishing characteristics that made it unique among Medicaid delivery systems and potentially gave CCOs greater tools to address member SUD needs:

**Local governance with representation from health care providers, Medicaid members, and other community members.** CCOs' governance structures include broad local participation to ensure communities' health needs are being met. Other provisions also ensure that CCOs respond to community needs. CCOs were required to establish agreements with local governments, carry out community health assessments, and develop community health improvement plans based on these assessments.

**Global budgets covering physical, behavioral, and oral health care.** CCOs receive global budgets in the form of per capita payments to cover the cost of members' physical, behavioral, and oral health care. While CCOs are accountable for managing all services covered by the global budget, they have the flexibility to allocate their global budgets to meet the needs of their members and communities. Global budgets place CCOs at risk for all types of health care, creating a financial incentive to coordinate and integrate different types of care.

**Flexibility to use funds to address social determinants of health.** CCO budgets allowed for flexibility to spend funds on services and supports that might not meet the traditional definition of medical necessity. The CCO model allowed for spending on such needs as housing supports, nutrition, and home alterations if such expenses could improve outcomes and reduce spending growth.

**Integration of Traditional Health Workers.** Workers include peer support specialists and peer wellness specialists, available to assist Medicaid members in recovery from SUD or living with co-occurring disorders.[4]

**Accountability for health care access and quality.** CCOs served as a single point of accountability for members' health care access and quality. The Oregon-CMS agreement required that quality of care, as defined by 33 measures, would not diminish over time. In addition, OHA publicly reported CCOs' performance on a variety of outcome measures, reinforcing accountability. CCOs could also receive incentive payments from a state Quality Incentive Program ("Quality Pool") for improving specific member outcomes, called CCO incentive measures.

While most Medicaid members were required to enroll in a CCO, members of Oregon's nine Federally Recognized Tribes and Medicare and Medicaid dual-eligible members could choose between CCO enrollment or fee-for-service coverage. Medicaid members with special health needs were required to transition from fee-for-service coverage to a CCO after receiving an individualized transition plan to meet their care needs. By 2014, almost 90% of the state's one million Medicaid enrollees received care through CCOs.

Oregon's 2017-2022 waiver extension built on the strengths of the CCO model while addressing some of its shortcomings. The extension emphasized the following efforts:

**An expanded focus on the integration of physical, behavioral, and oral health care through a performance-driven system.** Integrating the financial and delivery systems of physical, behavioral, and oral health had been a core element of the CCO model. The 2012-2017 experience, while promising, demonstrated that additional time, effort, and coordination among different sectors (e.g., health care, corrections systems, counties, other agencies) would be necessary to achieve full integration. During the demonstration extension period, OHA and CCOs committed to taking the following actions:

- Implementing and supporting models of care that promote integration, such as the Certified Community Behavioral Health Clinic Demonstration project
- Supporting Oregon's Behavioral Health Collaborative workgroups in developing and implementing a behavioral health framework that addresses the systemic and operational barriers to the integration of mental health and substance abuse services

**An enhanced focus on social determinants of health.** The evaluation of Oregon's 2012-2017 waiver found that spending on flexible services was relatively modest. Expenditures on flexible services were inhibited by several factors, including confusion over what was allowable and how expenditures would be treated in assessing medical-loss ratios and setting future rates. The waiver extension addressed several of these issues and also allowed CCOs to earn financial incentives if they improved quality and controlled per capita cost growth through health-related services.

**Increased use of value-based payments.** Oregon committed to developing a value-based payment roadmap for CCOs with targets for value-based payments by the end of the demonstration period. CCOs were also required to create at least one VBP model for behavioral health services.

As OHA prepared to renew CCO contracts in 2020 under the 2017-2022 waiver, Oregon's Health Policy Board assessed ongoing needs for SUD and other behavioral health services. Based on feedback from system partners, the board concluded that the state's behavioral health systems continued to suffer from fragmented financing with de facto carve-outs and siloed delivery systems. For SUD services, the board-issued Medicaid policy recommendations included:

- Improving access to a full continuum of care, including withdrawal management, residential, outpatient, and recovery support services
- Addressing culturally and linguistically appropriate services through network adequacy
- Prohibiting arrangements through which CCOs fully sub-capitated and delegated behavioral health benefits (passing accountability to other organizations)
- Increasing support for health information technology and HIE.

## Oregon's Dynamic SUD Policy Landscape

The SUD waiver in Oregon is just one piece of the state's 2020-2025 Statewide Strategic Plan[5] in which block grants from the Substance Abuse and Mental Health Services Administration, participation in the federal Certified Community Behavioral Health Clinic demonstration program, and policies to increase the capacity of the peer-delivered services workforce continue to play an important role. In recent years, Oregon has greatly ramped up its response to the SUD crisis, driven by high rates of SUD and the recent influx of fentanyl into the state, coupled with inadequate access to services and a severe behavioral health workforce shortage.[6] The state legislature appropriated a $1.35 billion investment in the 2021-2023 biennium to support large-scale improvements to the state's behavioral health system.[7] Additional policies in place up to the time of the MPA include:

- July 2021 – Measure 110 and SB 755 decriminalized unlawful possession of controlled substances, provided access to SUD assessment and treatment, and established Behavioral Health Resource Networks in each county to provide low-barrier access to treatment, housing, and harm reduction services.[8,9]
- July 1, 2022 – HB 5202 allowed OHA to implement a 30% rate increase to the Medicaid behavioral health fee schedule and allowed certain "pre-engagement" codes to be billed before an actual assessment. This occurred in response to provider feedback collected during a rapid assessment and the ability to utilize state general fund money that had previously been used for IMD payments.[10]
- July 27, 2021 – HB 2980 provided funding for peer-run organizations to operate respite centers supporting individuals with mental illness or trauma response symptoms.[11]

- August 6, 2021 – HB 2086 developed recommendations to improve access to services for people with serious mental illness and co-occurring disorders, focusing on culturally specific services.[12]
- August 6, 2021 – HB 2949 established incentives and grants to increase recruitment and retention of culturally responsive behavioral health workers and provided supervised clinical experience pathways.[13]
- March 23, 2022 – HB 4098 established the means to disperse $325 million in National Opioid Settlement funds through 2040.[14]

The state continues to implement new SUD initiatives and programs as part of its larger effort to transform the behavioral health delivery system. The current governor and state legislature have prioritized policies to combat the SUD crisis by expanding access to crisis services, treatment, and housing supports, and creating a robust and diverse behavioral health workforce.[15] Recent policies enacted after the data collection period of the MPA include:

- August 4, 2023 – January 1, 2024 – HB 2395 and HB 1043 were approved, both aimed at increasing access to long-acting opioid antagonists for opioid overdose reversal.[16,17]
- September 24, 2023 – HB 2757 appropriated funds to support and expand the 9-8-8 behavioral health crisis hotline.[18]
- October 1, 2023 – HB 5202 allowed OHA to implement an additional 3.4% rate increase for behavioral health services.[19]
- January 1, 2024 – SB 238 created a drug education and prevention curriculum for public school districts.[20]
- November 2024 – Oregon's 2022-2027 Section 1115 waiver will include health-related social need supports for individuals transitioning out of residential treatment settings, starting November 2024.[21]

As these policies are implemented throughout the waiver period, they will likely affect SUD outcomes.

## Oregon's SUD Waiver Milestones

To obtain federal funding under the SUD waiver, Oregon agreed to demonstrate progress on a set of six milestones.

### *Milestone 1: Access to Critical Levels of Care for OUD and other SUDs*

- Coverage of OUD/SUD treatment services across a comprehensive continuum of care within 12-24 months of demonstration approval including (a) outpatient, (b) intensive outpatient, (c) medication-assisted treatment (MAT, medication as well as counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state), (d) intensive levels of care in residential and inpatient settings, and (e) medically supervised withdrawal management.

### *Milestone 2: Use of Evidence-based, SUD-specific Patient Placement Criteria*

- Implementation of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the ASAM Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines, within 12-24 months of demonstration approval.

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

### *Milestone 3: Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities*

- Implementation of residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval.
- Implementation of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of demonstration approval.
- Requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site within 12-24 months of demonstration approval.

### *Milestone 4: Sufficient Provider Capacity at Critical Levels of Care including for MAT for OUD*

- An assessment of the availability of providers enrolled in Medicaid and accepting new patients in the critical levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT within 12 months of demonstration approval.

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

- Implementation of opioid prescribing guidelines along with other interventions to prevent prescription drug abuse.
- Expanded coverage of and access to naloxone for overdose reversal.
- Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs (PDMP).
    - ***Milestone 5a: SUD Health Information Technology (IT) Plan*** must detail the necessary health IT capabilities in place to support beneficiary health outcomes to address the SUD goals of the demonstration. The plan will also be used to identify areas of health IT system ecosystem improvement.

### *Milestone 6: Improved Care Coordination and Transitions between Levels of Care*

- Implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities within 24 months of demonstration approval.

## MPA Requirements

As part of the waiver, OHA is required to provide CMS with an independent MPA on progress toward the waiver milestones. The assessment must contain the following components:

- An examination of state progress toward meeting each milestone, including whether the state progressed according to the timeframe approved in the demonstration implementation plan, and demonstrated progress toward closing the gap between baseline and target each year in monitoring metrics, as outlined in the state's approved monitoring protocol.
- A determination of factors that affected state achievement towards meeting milestones and monitoring metric targets to date, identification of factors likely to affect future performance in meeting milestones and targets not yet met, and discussion about the risk of possibly missing those milestones and metrics targets.
- An assessment of whether the state is on track to meet its budget neutrality requirements, including recommendations for adjustments in the state's implementation plan or to factors that the state can influence that will support improvement, if necessary.
- If applicable, modifications to the state's implementation plan, financing plan, and monitoring protocols for addressing milestone and metric targets at medium to high risk of not being achieved.
- A description of methodologies used, with justifications, for examining progress and assessing risk, the limitations of the methodologies, and the independent assessor's determinations and any recommendations for the state.

# Methodology

## Overview

In this chapter, we describe how we carried out the MPA. We list the data sources and methods used to collect and analyze data from each source. We present the rubric for assessing the risk of not meeting milestones for each data source and conclude with the limitations of our approach. This project was approved and overseen by the Oregon Health & Science University Institutional Review Board.

## Data Sources

The MPA incorporates data from various sources, detailed in Table 1.

**Table 1. Data Sources**

| Data type | Data source |
|---|---|
| Critical metrics | Medicaid claims provided by OHA |
| Implementation plan action items | Point-in-time update of OHA tracking of implementation plan completeness |
| Feedback from relevant organizations | Presentations to behavioral health organizations and associations on the conduct of the evaluation |
| Qualitative findings from interested parties | Interviews with IMD, SUD program, and CCO staff |

## Analytic Methods

### Critical metrics

#### Metric Selection and Data Sources

CMS selected 19 critical metrics across five of the six demonstration milestones, presented in Table 2. We assessed progress on the metrics between the demonstration baseline and mid-point.

**Table 2. Required Metrics for the MPA**

| # | Milestone[a] | # | Critical Metric | Period | Type |
|---|---|---|---|---|---|
| 1 | Access to Critical Levels of Care for OUD and other SUDs | 7 | Early Intervention | Staggered quarterly | CMS-constructed |
| | | 8 | Outpatient Services | Staggered quarterly | CMS-constructed |
| | | 9 | Intensive Outpatient and Partial Hospitalization Services | Staggered quarterly | CMS-constructed |
| | | 10 | Residential and Inpatient Services | Staggered quarterly | CMS-constructed |
| | | 11 | Withdrawal Management | Staggered quarterly | CMS-constructed |
| | | 12 | MAT | Staggered quarterly | CMS-constructed |
| | | 22 | Continuity of Pharmacotherapy for OUD | Staggered quarterly | Established quality measure |
| 2 | Use of Evidence-based, SUD-Specific Patient Placement Criteria | 5 | Medicaid Beneficiaries Treated in an IMD for SUD | Staggered quarterly | CMS-constructed |
| | | 36 | Average LOS in IMDs | Staggered quarterly | CMS-constructed |
| 3 | Use of Nationally Recognized, Evidence-based SUD Program Standards To Set Residential Treatment Provider Qualifications | NA | NA | NA | NA |
| 4 | Sufficient Provider Capacity at Critical Levels of Care including for MAT for OUD | 13 | Provider Availability | Yearly | CMS-constructed |
| | | 14 | Provider Availability – MAT | Yearly | CMS-constructed |
| 5 | Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD | 18 | Use of Opioids at High Dosage in Persons Without Cancer (NQF #2940) | Staggered quarterly | Established quality measure |
| | | 21 | Concurrent Use of Opioids and Benzodiazepines (NQF #3175) | Staggered quarterly | Established quality measure |
| | | 23 | Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries | Staggered quarterly | CMS-constructed |
| | | 27 | Overdose Death Rate[b] | Yearly | CMS-constructed |

| # | Milestone[a] | # | Critical Metric | Period | Type |
|---|---|---|---|---|---|
| 6 | Improved Care Coordination and Transitions between Levels of Care | 15 | Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF #0004) | Staggered quarterly | Established quality measure |
| | | 17(1) | Follow-up after Emergency Department Visit for Alcohol or Other Drug (AOD) Dependence (NQF #2605) | Staggered quarterly | Established quality measure |
| | | 17(2) | Follow-up after Emergency Department Visit for Mental Illness (NQF #2605) | Staggered quarterly | Established quality measure |
| | | 25 | Readmissions Among Beneficiaries with SUD | Staggered quarterly | CMS-constructed |

*a The milestone groupings for the critical metrics defined in this table align with those included in Version 3.0 of the section 1115 SUD technical specifications manual.*
*b We did not have vital records for the relevant period, so we were not able to calculate Metric #27 Overdose Death Rate.*

We calculated metrics from Medicaid program data, including Medicaid enrollment records with information about each person's demographics, and Medicaid claims/encounters records that identify diagnoses and services each person received. We also used provider enrollment and vital statistics data. Because we did not have Medicare enrollment and claims for the relevant period, we limited the population to beneficiaries under age 65 and to those not dually enrolled in Medicaid and Medicare. See Appendix C for further description of each metric.

## Statistical Analyses

The metrics were developed at the beneficiary level. The quantitative analysis required defining a baseline and mid-point period. Following CMS guidance, which considers the MPA part of states' monitoring efforts, we used baseline and mid-point definitions based on CMS' Technical Specifications for Monitoring Metrics (see Table 3).

**Table 3. Baseline and Mid-Point Measurement Periods by Metric Reporting Category**

| Reporting category[1] | Baseline period | Mid-Point period |
|---|---|---|
| CMS / State-specific metrics | 04/2021 - 03/2022 | 04/2022 - 12/2022 |
| Annual established metrics | 01/2021 - 12/2021 | 01/2022 - 12/2022 |

[1] *See table 2*

For each metric, we calculated the absolute change between baseline and mid-point as well as the percentage change relative to baseline levels.

## Calculating Changes in Monitoring Metrics

Following guidance from CMS's Technical Assistance for MPAs, we provided the following information for each metric:

- Metric number

- Metric name
- Value at baseline
- Value at mid-point
- Absolute change, defined as the value of metric at mid-point - value of metric at baseline
- Percent change, defined as (value of metric at mid-point - value of metric at baseline)/value of metric at baseline
- State's demonstration target (i.e., decrease, increase or compliant)
- Directionality at mid-point (i.e., decrease, increase, no change, or compliant/not compliant). We classified an increase or decrease of less than 2 percent as "no change", consistent with the CMS template for SUD waiver monitoring reports and with OHA reporting practice for the waiver.
- Progress (Yes/No). We categorized progress as "Yes" if the directionality of change aligned with the state's target and "No" otherwise.

Rates reported in this mid-point assessment are based on guidance from CMS and OHA. They may differ from those reported elsewhere due to minor methodological differences, or differences in the way study populations are defined.

### Implementation Plan Action Items

The SUD Implementation Plan lists the tasks Oregon agreed to complete in its efforts to achieve the waiver milestones. OHA provided us with the completion status of implementation plan action items at three points in time. We used the first update, provided at the end of February 2023, to provide context for the development of the draft interview guide. We used the second update, from May 2023, to review current progress in preparation for the qualitative interviews. The third and final update, from January 2024, informed our assessment of the level of risk of not meeting the waiver milestones.

### Feedback from Relevant Organizations

We presented the waiver evaluation plan to three organizations involved in either SUD advocacy or service delivery. Two organizations were professional associations for providers, and the third was for CCO behavioral health staff. We asked attendees to provide any feedback on the plan, such as:

- What does a successful evaluation look like?
- How should we think about SUD treatment in Oregon?
- Are there recent developments we should consider for context?
- Is there anything else we should be thinking about or people we should be talking to?

### Interviews with Interested Parties

We conducted interviews with staff from IMDs and CCOs in June and July 2023. This evaluation focuses on early waiver implementation efforts, so service recipients were not interviewed. Potential interview participants were identified for recruitment from the list of Oregon Medicaid SUD provider organizations as of January 2023. Purposive sampling techniques were employed to maximize representation across geographic region, type and size of organization, population focus, and the role

of the individual within the organization. Sampling variation was limited by the prevalence of relevant organizations in an area who agreed to participate. Of the 33 individuals contacted, 15 individuals from 12 organizations agreed to be interviewed. Upon completion of these interviews, we determined that saturation had been achieved, where no new themes were detected.

Interview participants included directors or similar leadership roles as well as people with direct client contact (Table 4). All participants had past or current direct clinical experience with SUD treatment delivery. All of the state's regions, except for the Oregon Coast, were represented by interview participants. Organizations represented by interview participants included ten IMDs, six serving specialty populations, and two CCOs. Table 4 presents the roles, area of the state, and organizational type of interview participants.

**Table 4. Role, Area of the State, and Organizational Type of Interview Participants**

| Organizational Role of Interview Participants | Number of Interview Participants (n=15) |
|---|---|
| Executive Director/CEO | 5 |
| Residential Services Director | 4 |
| Director of Behavioral Health/SUD Services | 2 |
| Clinical Director | 2 |
| Other Director | 1 |
| Lead Admissions Coordinator | 1 |
| **Characteristics of Interview Participants' Organizations** | **Number of Organizations (n=12)*** |
| **Geography** | |
| Central Oregon | 1 |
| Eastern Oregon | 1 |
| Portland Metro | 4 |
| Southern Oregon | 3 |
| Willamette Valley | 4 |
| **Organization Type** | |
| CCO | 2 |
| IMD (general population) | 8 |
| IMD (specialty population) | 6 |

**Organizations could be in multiple geographic areas; IMDs could serve both general and specialty populations.*

Interviews were conducted via video using a semi-structured interview guide and lasted about 60 minutes [see Appendix B]. All interviews were recorded with permission from the participants. Interviewees were asked about:

- Their professional background
- Their awareness of the waiver, its implementation, and related policy changes
- Any changes they/their organization had made or noticed in response to the waiver
- Their view of the role IMDs play in the continuum of SUD care
- Their perception of how the waiver fits into the state's overall plan to improve SUD care
- Their perception of the likelihood of the state achieving each waiver milestone, including any successes or challenges they have encountered.

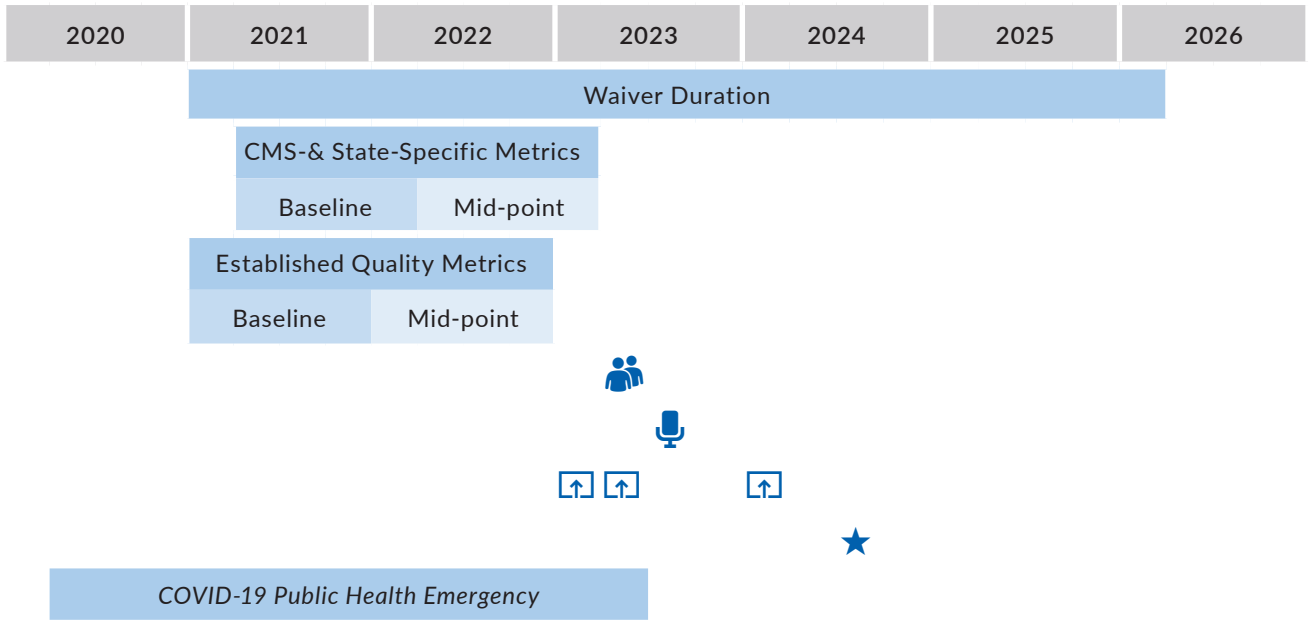
Interviews were transcribed using Otter.ai software and checked for accuracy by evaluation staff. They were then entered into Atlas.ti v. 23 (Scientific Software Development GmbH) qualitative analysis software for data management and analysis. Prior to analysis, a codebook was created based on the interview guide and stated waiver goals. The analysis team met regularly to discuss preliminary coding issues, refine codes, and clarify usage. Two team members separately coded each transcript using the final codebook and met to resolve any discrepancies.

Three team members separately summarized and identified themes for each code which were then discussed as a group to arrive at final themes that emerged during analysis.

## MPA Timeline

As shown in Table 5, quantitative data spanned from before waiver implementation to the early waiver period. Qualitative data collection occurred in 2023 and early 2024.

**Table 5: MPA Timeline**




= Stakeholder feedback
= Interviews
= Update of implementation action items
= Draft report delivered to OHA for review, then to CMS

## Assessment of Overall Risk of Not Meeting Milestones

We considered changes in critical metrics, completion of implementation plan action items, and interview participant feedback to assess the overall risk of not meeting milestones, as described in Table 6. We assigned the overall risk of not meeting a given milestone based on the highest risk indicated out of the three data sources.

**Table 6: Rubric for Assessing the Risk of Not Meeting Milestones**

| Data source | Considerations | Overall Risk of Not Meeting Milestones | | |
|---|---|---|---|---|
| | | Low | Medium | High |
| **Critical metrics (required)** | For each metric associated with the milestone, is the state moving in the direction of the state's annual goal and overall demonstration target? | All or nearly all of the critical metrics were categorized as having achieved progress | Some of the critical metrics were categorized as having achieved progress | Few or none of the critical metrics were categorized as having achieved progress |
| **Implementation plan action items** | Has the state completed each action item associated with the milestone as scheduled to date? | All or nearly all of the action items completed | Some of the action items completed | Few or none of the action items completed |
| **Stakeholder feedback** | Did key stakeholders identify risks related to meeting the milestone? | Few stakeholders identified risks; risks can be easily addressed within the planned timeframe | Multiple stakeholders identified risks that may cause challenges meeting milestone | Stakeholders identified significant risks that may cause challenges meeting milestone |

## Limitations

The assessment had important limitations. First, our ability to measure the quality of life, well-being, and changes in mortality or morbidity was limited in administrative data. Second, the SUD waiver represented one piece of larger statewide and national efforts to address the opioid epidemic, and the pre-post analysis cannot distinguish between changes that occurred because of the waiver and concurrent changes that occurred within the state or across states. Thus, we were not able to attribute changes in this study to the SUD waiver alone. Third, our analysis was limited by the short amount of time between waiver implementation and the mid-point period. Future reports evaluating the waiver will provide additional information on the changes occurring in subsequent years, with some increased ability to discern trends in mortality and overdoses.

Finally, key informant interviews were limited in both sampling and scope. In terms of scope, interview questions focused on the state's Medicaid population as a whole. We did not seek to elicit detailed information on subpopulations, such as incarcerated individuals and persons referred to involuntary

treatment. While some key informants had insights into these populations, our data did not permit a comprehensive discussion of their needs. Our depiction of factors contributing to milestone progress reflected the perspectives of our key informants and should not be interpreted as a complete picture of the SUD treatment system in Oregon.

# Findings

## Overview

In this chapter, we report Oregon's performance in meeting each milestone of the SUD Implementation Plan. We combined quantitative analysis of monitoring metrics and implementation plan completeness with qualitative information collected from key informant interviews.

We first present Oregon Health Plan trends in SUD prevalence, and general perceptions from key informants around the SUD service delivery milieu and waiver implementation. We then present progress on each milestone, drawn from three analyses: changes in each metric from the baseline to the mid-point period of the SUD waiver; which implementation plan action items were complete in the latest update from OHA; and key informants' views on the likelihood of meeting milestones and on factors, whether directly waiver-related or not, that could affect milestone performance.

## How to read metric findings

The first table in each milestone assessment presents metric results and contains the following information:

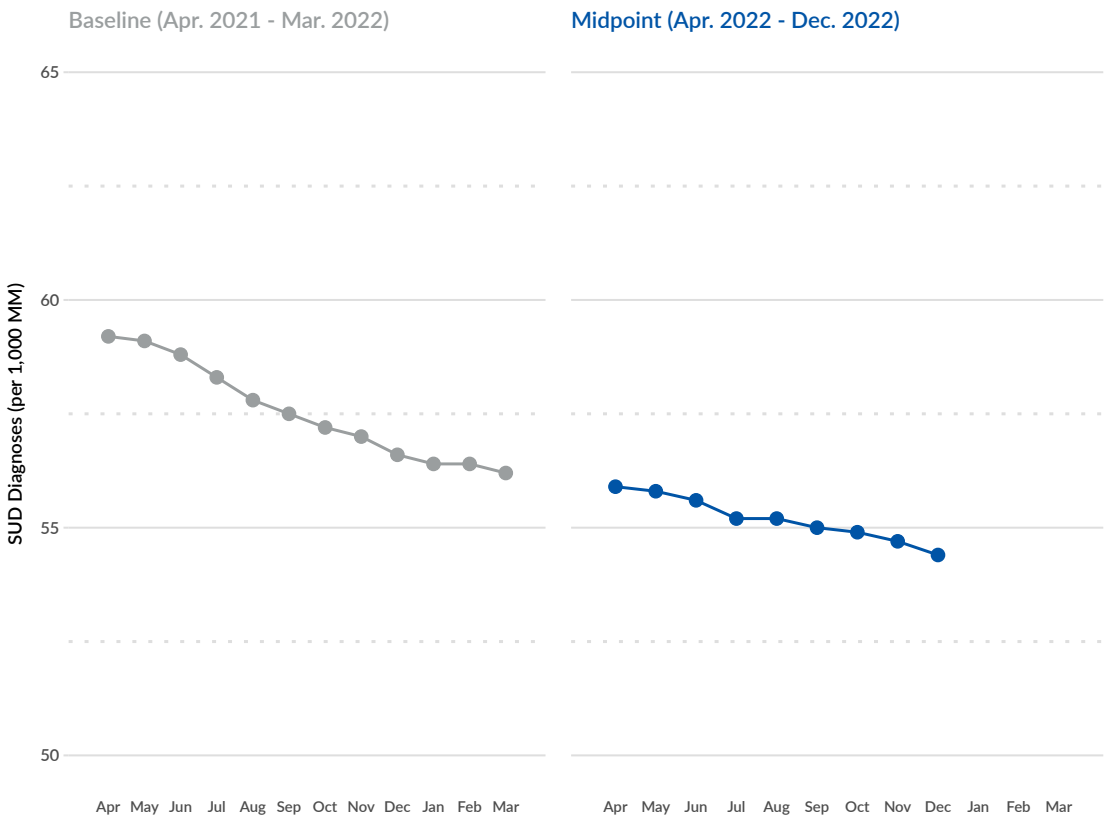
- **Metric name:** Metric name and number as listed in the CMS Technical Specifications Manual, and units of measurement, where "1,000 PMPM" stands for "per 1,000 member months" (e.g., "07. Early Intervention (1,000 PMPM)").
- **Quantitative results:** Levels at baseline and mid-point, absolute change between baseline and mid-point, and relative change between baseline and mid-point expressed as a percent of the baseline level.
- **Target:** *Upward arrow* when the goal is for the metric an increase, or *downward arrow* when the goal is a decrease.
- **Direction:** *Upward arrow* when the baseline to mid-point relative increase exceeded 2 percent, *downward arrow* when the relative decrease exceeded 2 percent, or *equal sign* when the relative change was less than 2 percent in either direction.
- **Progress:** *Y* if the target and direction of change matched; *N* otherwise.

Targets were based on the state's approved monitoring protocol, with some exceptions (noted in tables), for which CMS provided a different target. We color-coded the percent change so that progress is shaded in blue, and lack of progress is shaded in orange. For metric 36 (Average LOS in IMDs), the target was defined as "no more than 30 days," the direction was labeled as "compliant" (average LOS in IMDs did not exceed 30 days) or "not compliant" (average LOS in IMDs exceeded 30 days), and progress was achieved if the metric was compliant.

## SUD prevalence

Annual SUD prevalence was 77.2 per 1,000 member months at baseline and 75.2 at mid-point. Monthly SUD prevalence ranged from 54.4 to 59.2 per 1,000 member months and steadily declined between April 2021 and December 2022 (Figure 1). The calculation of SUD prevalence followed the CMS Technical Specifications for Metric #3/Metric #4: Medicaid beneficiaries with SUD diagnosis (monthly/annual), defined as the number of beneficiaries who receive MAT or a SUD-related treatment service with an associated SUD diagnosis.

**Figure 1. Monthly Beneficiaries with SUD Diagnosis during Baseline and Mid-Point Periods**




## Qualitative perspectives around Oregon's SUD treatment system and waiver implementation

Interview participants shared their experiences and general impressions related to the SUD continuum of care in Oregon. This backdrop provides context for understanding factors that could broadly hinder or facilitate implementation of the waiver and milestone progress.

### *Severity of illness was increasing*

Two factors were identified through interviews as increasing the strain on the SUD treatment delivery system. First, the severity of illness and complexity of treatment had increased with the heightened prevalence of fentanyl. For withdrawal management and residential treatment, fentanyl requires more time before a person can be safely discharged and have a chance at a successful recovery.

*I think people up until now have really been treating [fentanyl detox] like a heroin detox or pain pills. And it's not like that. It's harder, and it's longer.*

Second, people with SUD were presenting with a more severe level of illness. It was hypothesized that this could be due in part to Measure 110 having reduced or eliminated the punitive threat of jail time, which can incentivize people to seek treatment. People were further along in their addiction, causing them to need more intensive services when they sought treatment.

*One of the benefits of pre-Measure 110 was that we had sort of a pathway for folks early on in their addiction, early on in their criminal career, to have a chance at breaking that cycle.*

### *Policymaking was fragmented*

Many challenges were reported in creating and maintaining an effective SUD service delivery system in Oregon. Best practices in the field of SUD treatment are continuously evolving and shifting, but providers felt that policies have historically been a step behind.

Some perceived that Oregon either did not have a strategic plan to improve SUD prevention and treatment or was not following its plan. Shifting goals after leadership changes in the Governor's office and state agencies were cited as a barrier to the focused, cohesive execution of policies. Several participants expressed appreciation for the hard work and dedication of OHA staff in their efforts to improve the state of SUD treatment. They were hopeful about the attention and energy the waiver was bringing. However, disorganization, staff instability, misinformation, and siloed communication within OHA had caused confusion and a lack of trust between OHA and providers.

*…the state of Oregon has such a siloed system, and a disjointed system and who oversees what, and those entities don't communicate. We will have all of these requirements coming down from this side. Yet statute and policy hasn't even been updated on the other side. And our site reviewer is not even aware of the mandate. Nobody at the state level is on the same page, you get different information, different answers, different expectations based on who you talk to. So, you really don't know where you sit, which makes it really hard to deliver a unified system.*

Several providers were concerned that OHA had either not solicited or had ignored their input about improving service delivery.

*What is discouraging is the lack of input acquired from providers to actually ask 'What do we think the problems are? And what are our solutions?' Because we have them, we know how to work better with our partners. And we know money is the restriction. We like the continued effort, we really respect that. I'm not confident that this is going to roll out in a timely manner. And I think it's different for people at OHA who are working on these types of projects. But for us, our patients are dying. They're dying because they can't stay longer. They're dying because they can't get the medication they need.*

### *Residential bed capacity was insufficient*

Oregon was viewed as being severely deficient in residential treatment bed capacity, insufficient to meet the needs of the population. Most of the SUD programs run by interview participants operated at a deficit, tenuously relying on funding streams outside of Medicaid dollars to remain operational.

*I would say the vast majority of residential SUD programs that I have known of over the years have operated in significant deficits. And agencies have had to decide to continue to operate them by utilizing monies from other programs to try and make the books balance. The rate increases that have happened recently have been very helpful, but they're only just finally barely getting us to where we can just maybe make it work.*

All providers underscored the importance of residential treatment in the continuum of SUD care. They universally viewed residential care as offering a unique ability to focus solely on recovery, skill building, and commitment to sobriety without outside distractions and stressors. Appropriate LOS was also cited as critical to successful recovery, but authorizations for 30 days or less were not compatible with long-term recovery, especially for high-acuity clients and with the increase in fentanyl use.

*28 days is barely enough time to just get your head on your shoulders and get through the detox process. There's not a lot of time to really learn the skills you need to maintain sobriety in that.*

### *Hiring and retaining qualified residential staff was a challenge*

Further strain on the system stemmed from the severe behavioral health workforce shortage. Many participants described the hiring environment as the most difficult in decades and saw staff shortages as a continuing and significant challenge to providing care. The challenges spanned across all levels of care and staff types, with shortages noted among certified alcohol and drug counselors, qualified mental health professionals, master's level clinicians, nurses, childcare providers at residential facilities, and residential care facilitators. Expanded options and higher pay for remote work made in-person behavioral health and residential treatment work less appealing for many people, leading to stiff competition in hiring.

*I've never seen it be this hard to hire people in the 28 years that I've been in the field, particularly people who hold certifications. And we've had to significantly increase pay, which then has offset the increase in the code reimbursements that we've gotten. Because now we've bumped up our program costs significantly, just to get and retain the staff that we need.*

While participants acknowledged efforts on the part of OHA and community organizations to recruit and reduce barriers to people entering the behavioral health workforce, difficulty in hiring qualified staff remained. It was also noted that the workforce shortage would affect the state's ability to increase residential treatment capacity due to the high staffing ratios required.

*The staffing crisis is really going to be a challenge and opening new beds, particularly for IMDs, just because the staffing ratios are relatively high. So I'm not sure that it's going to see the expansion of residential beds that I think OHA was hoping for.*

### *The impacts of the COVID-19 Public Health Emergency (PHE) lingered*

As with all other areas of healthcare, the COVID-19 PHE had a major impact on SUD service delivery. Provider staffing shortages and safety precautions limited the number of treatment beds available and reduced revenue. While state and federal COVID-related funding programs allowed some providers to remain open even with reduced capacity, the COVID-19 PHE forced some facilities to close. Fear and stress experienced by both staff and clients further hindered the ability to provide effective treatment. Staffing shortages, loss of residential beds, reduced administrative support from OHA and

CCOs, and intensified safety precautions during the COVID-19 PHE continued to linger, delaying some aspects of waiver implementation relating to increasing access.

Almost all interview participants referred to the expansion of telehealth infrastructure and Medicaid reimbursement for telehealth as an unexpected, ongoing benefit of the COVID-19 PHE. The expansion was instrumental in facilitating continuity of care during the pandemic and has since increased access to care, including MAT, particularly in remote areas. With the continued ability to use and be reimbursed by Medicaid for telehealth, improvements were seen in access to specialty providers and culturally specific care, increased patient follow-up post-discharge, and decreased no-show rates. Expanded telehealth also allowed for more equitable access, as it allows individuals without reliable transportation, with young children, or with other challenging circumstances to engage more easily in treatment.

#### *Waiver communications were not ideal*

The study team assessed most participants as having a fair to good understanding of the waiver and its strategic goals. Participants understood that one intent of the waiver is to cover IMD treatment with Medicaid funds, freeing up general revenue funds to be redirected toward increasing the capacity of the continuum of SUD services. However, some had only a vague awareness of the waiver and its associated services. A few participants, some in roles disconnected from billing and reimbursement, had no knowledge of the waiver or confused it with other policies, such as Measure 110 activities.

Communications from OHA to providers and CCOs about waiver activities were generally characterized as unclear, inconsistent, and missing critical target audiences. While a few participants viewed communications as reasonable or sufficient, most said they lacked needed information about new requirements and billing guidelines.

> *Some come out in statewide memos, some come out in memos targeted to providers, some to CCOs… It seems like some of their communication misses on one or both parties. So, it feels like there's just not a lot of consistency of how they communicate a lot of these changes that should be communicated more broadly, and they shoot them to specific audiences and then it gets lost in the translation.*

The lack of clear technical assistance from OHA let CCOs and providers interpret and implement guidance differently. One provider described spending hours investigating how to bill correctly only to receive both an underpayment from the Division of Medical Assistance Programs and an overpayment from a CCO. Many indicated that the most useful and actionable information about the waiver was obtained through sources outside OHA. External provider partners and community organizations, particularly the Oregon Council for Behavioral Health, were instrumental in disseminating and translating communications from OHA.

## Progress Toward Demonstration Milestones

### Milestone 1: Access to Critical Levels of Care for OUD and other SUDs

**Progress on critical metrics.** Table 7 presents progress on the seven metrics associated with Milestone 1. Four metrics (Early Intervention, Intensive Outpatient and Partial Hospitalization, Residential and Inpatient Services, and Withdrawal Management) moved in the desired direction, while three metrics (Outpatient Services, MAT, and Continuity of Pharmacotherapy for OUD) did not. Percent changes were small to moderate in most cases, with the exception of Early Intervention, where a low baseline value resulted in a large percent change despite a small absolute change in the rate. Early

Intervention is defined as the number of member-months during which early intervention services (such as procedure codes associated with screening, brief intervention, and referral to treatment) were received, per 1,000 member months of all beneficiaries with full Medicaid benefits, which may explain the low values.

**Table 7. Critical metric results for Milestone 1**

| Metric | Baseline | Midpoint | Absolute Change | Percent Change | Target | Direction | Progress |
|---|---|---|---|---|---|---|---|
| 07. Early Intervention (10,000 PMPM) | 0.04 | 0.07 | 0.00 | +75.0% | ↑ | ↑ | Y |
| 08. Outpatient Services (1,000 PMPM) | 16.46 | 15.29 | -1.17 | -7.1% | ↑* | ↓ | N |
| 09. Intensive Outpatient and Partial Hospitalization Services (1,000 PMPM) | 1.81 | 1.85 | +0.04 | +2.2% | ↑* | ↑ | Y |
| 10. Residential and Inpatient Services (1,000 PMPM) | 0.30 | 0.31 | +0.01 | +3.3% | ↑ | ↑ | Y |
| 11. Withdrawal Management (1,000 PMPM) | 0.63 | 0.66 | +0.03 | +4.8% | ↑* | ↑ | Y |
| 12. Medication-Assisted Treatment (1,000 PMPM) | 12.57 | 12.57 | 0.00 | 0.0% | ↑ | = | N |
| 22. Continuity of Pharmacotherapy for Opioid Use Disorder (%) | 17.6 | 16.4 | -1.2 | -6.8% | ↑* | ↓ | N |

*Target provided by CMS; differs from target in state Monitoring Protocol

*Target provided by CMS; differs from target in state Monitoring Protocol

**Progress on implementation action items.** All 42 implementation action items associated with Milestone 1 were completed (Table 8).

**Table 8. Implementation action item results for Milestone 1**

| Action item category | Action item description | Date to be completed | Current status |
|---|---|---|---|
| Coverage of outpatient services | Develop robust quarterly report for internal quality improvement strategies for SUD services (All levels) | October 2021 | Completed |
| | Set scope of work for the workforce regarding prevention, early intervention, crisis intervention services and establish reimbursement rate | April 2023 | Completed |
| | Set standards for identification, initiation, and engagement. Educate and engage providers around these standards and implementation | April 2023 | Completed |
| | Develop requirement for CCOs to have a mechanism to ensure that they have adequate capacity to serve those in their region around SUD services | April 2023 | Completed |
| | Develop standard range of client ratio | April 2023 | Completed |
| | Develop provider review process around staffing credentials | April 2023 | Completed |
| | Develop more culturally relevant training for peer-delivered services workers, including a tribal-specific course and Latino-specific course | April 2023 | Completed |
| | Expand the number of diversity of culturally specific peers within the workforce | April 2023 | Completed |
| Coverage of intensive outpatient services | Develop robust quarterly report for internal quality improvement strategies for SUD services (All levels) | October 2021 | Completed |
| | Set scope of work for the workforce regarding prevention, early intervention, crisis intervention services and establish reimbursement rate | April 2023 | Completed |
| | Set standards for identification, initiation, and engagement. Educate and engage providers around these standards and implementation | April 2023 | Completed |
| | Require CCO's to have a mechanism to ensure that they have adequate capacity to serve those in their region around SUD services | April 2023 | Completed |
| | Develop alternative payment methodologies for Day Treatment Services | April 2023 | Completed |
| | Develop standard range of client to clinician ratio | April 2023 | Completed |
| | Develop more culturally relevant training for peer-delivered services workers, including a tribal-specific course and Latino-specific course | April 2023 | Completed |
| | Expand the number of diversity of culturally specific peers within the workforce | April 2023 | Completed |

| Action item category | Action item description | Date to be completed | Current status |
|---|---|---|---|
| Coverage of MAT | Develop robust quarterly report for internal quality improvement strategies for SUD services (All levels) | October 2021 | Completed |
| | Set standards for identification, initiation, and engagement. Educate and engage providers around these standards and implementation | April 2023 | Completed |
| | Develop requirement for CCO's to have a mechanism to ensure that they have adequate capacity to serve those in their region around SUD services | April 2023 | Completed |
| | Engage with CCO's around adequate capacity levels for MAT and their service areas | April 2023 | Completed |
| | Develop standard range of client to clinician ratio | April 2023 | Completed |
| | Develop provider review process around staffing levels | April 2023 | Completed |
| | Develop more culturally relevant training for peer workers, including a tribal-specific course and Latino-specific course | April 2023 | Completed |
| | Expand the number of diversity of culturally specific peers within the workforce | April 2023 | Completed |
| Coverage of intensive levels of care in residential and inpatient settings | Develop robust quarterly report for internal quality improvement strategies for SUD services (All levels) | October 2021 | Completed |
| | Set scope of work for the workforce regarding SUD crisis intervention services and establish reimbursement rate | April 2023 | Completed |
| | Set standards for identification, initiation, and engagement. Educate and engage providers around these standards and implementation | April 2023 | Completed |
| | Develop requirement for CCO's to have a mechanism to ensure that they have adequate capacity to serve those in their region around SUD services | April 2023 | Completed |
| | Develop standard range of client to clinician ratio | April 2023 | Completed |
| | Develop provider review process around staffing credentials | April 2023 | Completed |
| | Develop more culturally relevant training for peer-delivered services workers, including a tribal-specific course and Latino-specific course | April 2023 | Completed |
| | Expand the number of diversity of culturally specific peers within the workforce | April 2023 | Completed |

| Action item category | Action item description | Date to be completed | Current status |
|---|---|---|---|
| Coverage of medically supervised withdrawal management | Develop robust quarterly for internal quality improvement strategies for SUD services (All levels) | October 2021 | Completed |
| | Set scope of work for the workforce regarding SUD crisis intervention services and establish reimbursement rate | April 2023 | Completed |
| | Set standards for identification, initiation, and engagement. Educate and engage providers around these standards and implementation | April 2023 | Completed |
| | Develop standard range of client to clinician ratio | April 2023 | Completed |
| | Develop provider review process around staffing credentials | April 2023 | Completed |
| | Develop requirement for CCO's to have a mechanism to ensure that they have adequate capacity to serve those in their region around SUD services | April 2023 | Completed |
| Parity of Coverage in SUD service array | Oregon will meet with agencies that provide these services (funded through state funds and federal grants) to develop a structure and draft regulations for this service | April 2023 | Completed |
| | Develop reimbursement rates for agencies to provide this service | April 2023 | Completed |
| | The state will pursue a state plan amendment and Oregon Administrative Rule (OAR) changes to expand the use of case management for pre and post treatment and for community-based services and supports, such as housing and employment | April 2023 | Completed |
| | Implement related state plan amendment service | April 2023 | Completed |

**Interview participant assessment.** On a five-point scale, with one being very unlikely and five being very likely, interviewees on average rated the state as a 3.3, ranging from 2 to 4.5, in likeliness to achieve Milestone 1 by the end of the waiver.

### Participant Feedback on Milestone Progress

Many participants saw promising signs of progress towards this milestone. Organizations were able to boost hiring and retention pay as a result of the increase in daily residential payment rates implemented by OHA as part of their Medicaid Behavioral Health fee schedule adjustment in January 2022. The adjustment was in response to providers' expressed need and the availability of general funds previously used for IMD payments. The increase was noted as having a direct positive effect on client care and the ability to provide an array of services.

> *The payments are helping a lot… so by increasing those rates, it has really made a difference in the quality of staff that we can hire, the amount that we can pay the good staff that we have, which also improves their performance. And all of that equates to better service for the client.*

The new ability to bill for time spent engaging with individuals before assessment and treatment, and for community integration services (CIS) was viewed as beneficial to providers' financial viability. Some of the codes (CIS and targeted outreach) were developed to directly address waiver goals, while others were part of OHA's overall strategy to address providers' needs and increase access to treatment. Organizations invested considerable staff time in outreach, building relationships with clients, and integrating services, time that was not previously reimbursable.

> *...we literally spend hours upon hours, just trying to get a woman to walk in the door. And we don't get to bill for any reimbursement until she's actually spent a night.*

> *So our program is only 30 days long. We don't get a lot of time with our people. So she starts working on, you know, finding them clean and sober housing, helping them get squared away with any of their aftercare plans with mental health, primary care, SUD and outpatient, that sort of stuff. It's a busy time for her and it's nice to be able to bill a little bit at the end.*

Other promising signs of progress included improvement in MAT access, increased ability to provide outreach to get people into outpatient treatment, and increased availability and contributions of peer workers. One participant applauded the increased reimbursement for culturally specific facilities and staff.

> *... providing culturally appropriate services ... that's more expensive than a standard residential treatment program. We lost money on that program for [decades], which is exactly what institutional racism looks like in Oregon. And so only in April, in part because of the waiver, did we begin to see improved reimbursements for culturally specific services. So, I think that's a real breakthrough that I certainly want to honor and respect.*

## Participant Feedback on Milestone Barriers

### *Access to withdrawal management and residential treatment facilities was insufficient*

There continued to be a lack of adequate detox and residential beds for Oregon Health Plan clients, creating waitlists of one to two months for many programs and up to nine months for youth Medicaid members. Insufficient reimbursement rates and a lack of funding for capital projects were cited as contributing factors.

> *[With the prevalence of homelessness and the lethality of fentanyl], the stakes are higher than they've ever been for this level of care.*

> *Until they start providing capital funds to actually build new facilities...and until they make SUD [residential] reimbursement rates reflective of what it actually costs to deliver that service, I'm not terribly optimistic.*

Staffing shortages also continued to plague treatment facilities, adding to the lack of access.

> *I think the elephant in the room is going to be the staffing crisis. So that's going to continue to be a problem as we expand these levels of care across the entire continuum. That's not just going to be in the higher levels of care, that staffing crisis is going to continue to be a problem.*

One provider observed a pattern of individuals cycling through unsuccessful bouts of outpatient treatment when unable to access residential treatment. While at least one organization had some success using intensive outpatient for patients waiting for a residential bed, the collateral effects of insufficiently treated addiction were detrimental.

> *People who have not been able to get into residential treatment, cycle in and out of unsuccessful outpatient treatments, and progress further and further and further into their addiction and become more and more and more ill. Then they have children over those years that are born drug affected, that are raised in significantly dysfunctional households, that then are in significantly higher risk of developing addiction and mental health concerns themselves, and are cycling in and out of foster care and all of these other things.*

### *Specialty treatment capacity was insufficient*

The lack of specialty facilities and trained staff for youth, parents, people with co-occurring disorders, and culturally-specific treatment was called out as a barrier on top of the overall shortage of beds. These populations face additional challenges in the recovery process and can be more successful in programs geared to their specific needs.

> *Oregon has zero detox facilities for youth. So it's hard to keep youth in treatment in general, it's just really difficult. It's even harder when you don't get to detox comfortably…*

> *You know, these women have had every conceivable bad thing that can happen to somebody happen to them…Their skill sets are very minimal. Many of them, we're building just sort of basic baby care skill sets here, never mind all of the other sort of activities of daily living sorts of skills. So it's an especially challenging segment of the population.*

A few participants highlighted the failure of the waiver to address co-occurring mental health and substance use disorders. Participants were encouraged by the increase in Certified Community Behavioral Health Clinics as an example of a state trend to improve the integration of mental health and substance use disorder services. Still, organizations rarely found clinicians experienced and qualified to treat co-occurring disorders and cited the lack of administrative integration as a barrier to providing quality coordinated care for this population.

> *I think just about any of our folks that come in have some co-occurring needs.*

> *But the issue continues to be finding master's level clinicians and always ones that actually do SUD and co-occurring, they're rare, relatively rare.*

### *Technical assistance for billing was insufficient*

While the waiver created a new opportunity to bill for pre-engagement and CIS work, many participants had not yet been able to successfully bill for these services. They felt there was a lack of consistent communication, education, and technical assistance from OHA. There was considerable uncertainty and confusion around how to bill the new codes and what services counted. Additional barriers to use included different interpretations and potential claim denials by CCOs, the unfamiliarity of hourly services to providers accustomed to a daily rate, and a level of reimbursement insufficient

to justify the effort needed to bill successfully. Some reported continuing to engage in many hours of unreimbursed work due to these barriers.

> *… looking at that engagement code, and really thinking about what are the logistics for the program administratively to then be able to bill the code? So sometimes how it translates is that what it would take, the lift represents such an effort, that the new reimbursement is actually not worth the lift. And so it's easier to just not try to do it. You can't, it doesn't pencil out.*

### *Administrative burden was overwhelming*

High administrative burden from OHA and CCOs was reported as a considerable barrier to improving access to care across all levels.

> *[OHA is] taking money away from service every time they put another administrative demand on providers or the CCOs.*

One participant questioned whether the continued increase in reporting, additional licensing, and data collection requirements was justified by any improvements in services or outcomes.

> *And that's the fundamental problem with admin burden is they started off with these little pieces of information, and then they've just layered on and layered on and layered on. And no one's really torn it down, saying, 'What do we actually need and what is just extraneous that we're not actually using?' And that's what's created the admin burden.*

All providers characterized the frequency of required authorizations as extremely time-consuming. For smaller organizations without as much administrative infrastructure and support as larger organizations the frequency of authorizations was especially burdensome.

> *But we're seeing the same thing, even at the outpatient level, where we're having to do more frequent authorizations. And oftentimes there could be denial.*

Adding to the burden of frequent authorizations were the differences between CCOs in their requirements and processes.

> *…their rules change from one authorization to the next or from one CCO to the next. For example, they provide a document for us to complete to provide the information and then down the road, they no longer want to use that document, they want us to provide something else… We 100% understand that it's our responsibility to provide the documentation for reauthorization. We also need consistency in what they are looking for and that's not present.*

Participants pointed to onerous regulations surrounding MAT as a barrier to access, inhibiting the expansion of this service. The cost of creating the necessary infrastructure and compliance levels for storing and dispensing medications made it difficult for facilities to provide medication in-house. One participant noted that the speed with which medication dosage may need to be increased for a client was often held up by "red tape," reducing the effectiveness of treatment and leading to an increase in patients leaving treatment early, against medical advice.

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

**Progress on critical metrics.** Table 9 presents progress on the two metrics associated with Milestone 2. Medicaid Beneficiaries Treated in an IMD for SUD (per 1,000 member months) improved slightly but was classified as "no progress" because the improvement relative to baseline was smaller than 2 percent. The Average LOS in IMDs decreased slightly from 17.3 days to 16.6 days and remained consistent with the target (average LOS less than 30 days).

**Table 9. Critical metric results for Milestone 2**

| Metric | Baseline | Midpoint | Absolute Change | Percent Change | Target | Direction | Progress |
|---|---|---|---|---|---|---|---|
| 05. Medicaid Beneficiaries Treated in an IMD for SUD (1,000 PMPM) | 5.20 | 5.23 | +0.03 | +0.6% | ↑ | = | N |
| 36. Average Length of Stay in IMDs (days) | 17.3 | 16.6 | -0.7 | -4.0% | ≤ 30 days | compliant | Y |

**Progress on implementation action items.** All eight action items associated with Milestone 2 were completed (Table 10).

**Table 10. Implementation action item results for Milestone 2**

| Action item category | Action item description | Date to be completed | Current status |
|---|---|---|---|
| Implementation of requirement that providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools that reflect evidence-based clinical treatment guidelines | | April 2023 | Completed |
| Implementation of a utilization management approach such that (a) beneficiaries have access to SUD services at the appropriate level of care | Refine contract language with CCOs to include ASAM | April 2023 | Completed |
| | Monitor CCO's to ensure prior authorization staff are adequately trained in ASAM criteria and SUD treatment services | April 2023 | Completed |
| Implementation of a utilization management approach such that (b) interventions are appropriate for the diagnosis and level of care | Consult with the Department of Justice | October 2021 | Completed |
| | Consult with providers and other stakeholders | April 2022 | Completed |
| | Develop and implement policy and OAR amendments | October 2022 | Completed |
| | Provide training to providers regulated by the new rules (in person, onsite technical assistance and webinar) | April 2023 | Completed |

| Action item category | Action item description | Date to be completed | Current status |
|---|---|---|---|
| Implementation of a utilization management approach such that (c) there is an independent process for reviewing placement in residential treatment settings | Develop requirements for CCOs | April 2022 | Completed |

**Interview participant assessment.** On a five-point scale, with one being very unlikely and five being very likely, interviewees on average rated the state as a 3.5, ranging from 2 to 5, in likeliness to achieve Milestone 2 by the end of the waiver.

## Participant Feedback on Milestone Progress

The idea of standards and uniformity across organizations was generally supported and viewed as necessary to providing uniform and quality care.

> *… there does tend to be just in general, slippage between the criteria of, does this person have an alcohol use disorder, does this person have etc… and what does that even look like? Because I've seen two different providers give two totally different diagnoses.*

There was disagreement with the original decision to require the use of ASAM criteria because of expense, difficulties with system implementation, and its proprietary nature. The shift to requiring "ASAM-like" criteria was seen as a positive step towards easing the burden on many providers. In addition, over half of the participants' organizations were already using ASAM placement criteria so it was not seen as a particularly heavy lift for them.

## Participant Feedback on Milestone Barriers

### *Integration and use of ASAM was time-intensive*

Half of the participants noted that it would still be difficult with ASAM-like requirements to make changes to existing assessments, both functionally and administratively, particularly for smaller organizations. Integrating the criteria in an electronic health record (EHR) could be problematic and time-consuming. On top of low wages, staff shortages, and provider burnout, the labor required to achieve uniformity statewide for patient assessments was described as "salt in a wound." The time and effort it took to persuade OHA to amend the original decision to require ASAM criteria raised a concern that OHA undervalued provider expertise and did not trust providers to do their jobs. Given the variation in clarity, quality, and comprehensiveness of current assessments across the state, participants anticipated a long and arduous process for all providers to adopt ASAM-like assessments. Still, they looked forward to the increase in uniformity. Two participants reflected that the differences in the specific questions or summaries between provider assessments did not facilitate a smooth referral process.

> *I get some that are extremely vague or they don't really have that much info. And some of them have all the information in it. So, it's kind of hard to say, because different agencies have different assessments. And some of them aren't very good.*

### *Evidence-based practices were not always appropriate for all settings*

While encouraged by the support for evidence-based practices in SUD treatment there was concern the practices might not be applied appropriately. Evidence-based practices were not always appropriate or practicable for all settings. For example, the evidence developed in urban settings may not be feasible or effective in rural settings or may not consider different cultural approaches to treatment. There was also concern about the applicability of using ASAM assessments for certain populations.

> *I think they got tied too much to the specific proprietary assessment. And that was not well thought through as to what are the consequences. The ASAM proprietary assessment is not a co-occurring assessment, it's not a culturally appropriate assessment. It's really for a fairly narrow set of folks.*

## Milestone 3: Use of Nationally Recognized SUD-Specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

**Progress on implementation action items.** There were no metrics associated with Milestone 3. All eight action items associated with Milestone 3 were completed (Table 11).

**Table 11. Implementation action item results for Milestone 3**

| Action item category | Action item description | Date to be completed | Current status |
|---|---|---|---|
| Implementation of residential treatment provider qualifications in licensure requirements, policy manuals, managed care contacts, or other guidance. Qualification should meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding, in particular, the types of services, hours of clinical care, and credentials of staff for residential treatment settings | Consult with the Department of Justice | October 2021 | Completed |
| | Consult with providers and other stakeholders | April 2022 | Completed |
| | Provide training to providers regulated by the new rules (in person, onsite technical assistance and webinar) | April 2023 | Completed |
| | Develop and implement policy and OAR amendments | October 2022 | Completed |
| Implementation of a state process for reviewing residential treatment providers to ensure compliance with these standards | Update and implement the process for initial and renewal certification and licensure | April 2022 | Completed |

| Action item category | Action item description | Date to be completed | Current status |
|---|---|---|---|
| Implementation of requirement that residential treatment facilities offer MAT onsite or facilitate access to MAT off-site | Consult with the Department of Justice | October 2021 | Completed |
| | Consult with providers and other stakeholders | April 2022 | Completed |
| | Develop and implement policy and OAR amendments | April 2023 | Completed |

**Interview participant assessment.** On a five-point scale, with one being very unlikely and five being very likely, interviewees on average rated the state as a 3.3, ranging from 2 to 5, in likeliness to achieve Milestone 3 by the end of the waiver.

## Participant Feedback on Milestone Progress

Echoing their sentiments on Milestone 2, participants supported the idea of standards and uniformity across organizations. They viewed the enforcement of standard provider qualifications as critical to ensuring quality care and, equally importantly, the public perception of a competent SUD treatment system. It was seen as beneficial for the field and client care to have "*guardrails around what [a] person can do and how much supervision they would need.*"

Most felt that the pre-waiver status of residential treatment facilities in Oregon would assist the state in meeting Milestone 3. The similarity of existing residential treatment provider qualifications with ASAM provider qualifications, the role of the Mental Health and Addiction Certification Board of Oregon in setting certification standards for SUD professionals, the similarity to the requirements for Commission on Accreditation of Rehabilitation Facilities accreditation combined with the portion of facilities already accredited, and the conduct of regular audits by OHA all led several participants to guess that the milestones should be fairly easy to meet. It was therefore not viewed as truly "transformative" change.

## Participant Feedback on Milestone Barriers

### *Licensing each level of care was perceived as burdensome*

Attention was drawn to the administrative burden of certifying each level of care, especially for small organizations. Providers saw the need for licensing residential and higher levels of care separately. However, for lower levels of care they questioned the value gained in care consistency or improvement on top of regular state audits and certification.

> *So the administrative burden that comes with that is, I'm still shaking my head, I feel like it's insurmountable. We're a pretty small program, I don't have a ton of staff. And now I'm going to have to rewrite all of the rules for each level of care. And then I'm going to have to make a separate application for each level of care. And that's a lot. And that's all on me.*

### *MAT providers were in short supply*

Some participants noted the shortage of MAT providers as a barrier to being able to comply with the residential facility requirement to provide MAT onsite or facilitate offsite access. The workforce shortage was an impediment both to hiring in-house MAT providers and to contracting with external

providers. One participant noted that their facility did not provide MAT in-house and could not accept patients taking MAT as they had no way to ensure the patient could continue their medication.

### *Rulemaking felt disconnected from the field*

Participants pointed to policymakers' apparent lack of understanding of care delivery and provider operations on the ground. They saw a disconnect between the people making the rules and how things function in the real world.

> *I think that the hard part is that the people that write these rules, either have never provided services, or they've been out of it for so long, that they don't get it.*

The lack of understanding had contributed to untenable requirements, such as the requirement to initiate MAT within 72 hours of diagnosing a patient with OUD.

> *In the statute, it says, the second that they are identified as an opioid user, they have to have access to MAT, within 72 hours. It's like, get real. We don't even have the providers that could see somebody in 72 hours available, like it's at least two weeks out… And in what crazy world did that ever seem available, that we have the staffing to do that. And sometimes the person's not even ready to engage in MAT… So, a lot of the rules and mandates around it are insane, and they're never going to be met.*

## Milestone 4: Sufficient Provider Capacity at Critical Levels of Care Including for MAT for OUD

**Progress on critical metrics.** Table 12 presents progress on the two metrics associated with Milestone 4. The number of SUD providers enrolled in Medicaid (Provider Availability) moved in the desired direction, increasing by 11.1% from baseline. The number of MAT providers enrolled in Medicaid (Provider Availability – MAT) similarly increased by 10.6 % from baseline.

**Table 12. Critical metric results for Milestone 4**

| Metric | Baseline | Midpoint | Absolute Change | Percent Change | Target | Direction | Progress |
|---|---|---|---|---|---|---|---|
| 13. Provider Availability (n) | 20287 | 22542 | +2255 | +11.1% | ↑ | ↑ | Y |
| 14. Provider Availability - MAT (n) | 2350 | 2600 | +250 | +10.6% | ↑ | ↑ | Y |

**Progress on implementation action items.** Eleven out of thirteen action items associated with Milestone 4 were completed (Table 13).

**Table 13. Implementation action items for Milestone 4**

| Action item category | Action item description | Date to be completed | Current status |
|---|---|---|---|
| Completion of assessment of the availability of providers enrolled in Medicaid and accepting new patients in the following critical levels of care throughout the state (or at least in participating regions of the state) including those that offer MAT; Outpatient Services; Intensive Outpatient Services; MAT (medication as well as counseling and other services); Intensive Care in Residential and Inpatient settings; Medically Supervised Withdrawal Management | Assess current client to provider ratios for all levels of treatment | October 2021 | Completed |
| | Create action plan to address deficits within the delivery system identify within the capacity study | April 2022 | Completed |
| | Implement the plan to address the delivery system deficits | April 2023 | Open |
| | Develop the appropriate client to provider ratios | April 2022 | Completed |
| | Develop a plan to address any gaps in provider ratio | October 2022 | Completed |
| | Begin to implement changes addressing the gaps in provider ratios that were identified in service area | April 2023 | Completed |
| | Implement the capacity management and referral tracking data base for all SUD residential services (ASAM levels 3-4) including MAT and withdrawal management | April 2023 | Completed |
| | Identify needs for the MAT in OTP and Office-based opioid treatment (OBOT) settings | April 2022 | Completed |
| | Develop plan to meet needs of MAT in OTP and OBOT settings | October 2022 | Completed |
| | Implement plan to address needs of MAT in OTP and OBOT settings | April 2023 | Completed |
| | Assess the number of covered lives, availability of prevalence, incidents and diagnosis rates by region/CCO | April 2023 | Open |
| Increase provider capacity across all levels | Assess the needs of the Healthcare workforce identified in the assessment | April 2023 | Completed |
| | Develop the plan to address workforce issues to include activities such as (focus groups, partnerships with providers and CCOs, etc...) | April 2023 | Completed |

**Interview participant assessment.** On a five-point scale, with one being very unlikely and five being very likely, interviewees on average rated the state as a 3.2, ranging from 2 to 4.3, in likeliness to achieve Milestone 4 by the end of the waiver.

## Participant Feedback on Milestone Progress

Efforts to expand MAT access relatively quickly were viewed as critical to combat the rise in fentanyl use across the state. There was wide variation in provider and client access to services. It was acknowledged that increasing access to MAT in Oregon was going to be a "long haul" that would likely extend beyond the waiver period.

Several participants noted that providers have become more open to the use of SUD medication as stigma and the perception of provider risk has lessened. Some organizations had prioritized expanding MAT services over the last few years with telehealth being an important catalyst. Telehealth capabilities allowed them to work with medication prescribers who did not reside in their region. Changes to federal laws, such as the X Waiver, and Behavioral Health Resource Network funding were also cited as instrumental to recent improvements in MAT access.

## Participant Feedback on Milestone Barriers

### *Hiring and retaining staff were barriers to MAT access*

While two participants described having drastically expanded MAT services through their organizations, most said that the shortage of providers had created a critical lack of access.

Although the stigma around providing SUD medication had lessened, almost half of participants reflected on how some stigma had endured. Some organizations only offered programs predicated on abstinence, and some prescribers still perceived authorizing medication as a liability. Two participants were aware of several potential MAT providers that did not envision ever becoming an OTP, so they did not see much of a pathway for expansion in MAT capacity.

> *There are just not enough bodies to do the work. Ultimately, the biggest issue with MAT is not having the prescribers to give [clients] the medication because of this perception of risk.*

MAT provider capacity and client access to services varied greatly by geographic region and level of care. Some counties had sufficient access to services while others were lacking. Transportation was cited as a main barrier in rural areas, hindering service delivery, especially for methadone and suboxone.

> *I would love to see not only the capacity to increase, but also just the ability to reach out to patients where they're at. For example, we have an MAT clinic in Seaside. But there's one bus a day that goes into Seaside and goes back out to Seaside and a lot of the patients there are from Astoria, and so you've got to get that bus, you've got to make that bus in order to get to the clinic. And so that's a huge barrier for people. Just that one shot a day to be able to get to your medication.*

### *Service delivery was disjointed*

Although telehealth was noted as a facilitator of success for this milestone, one participant noted the limitations of telehealth-only MAT providers.

> *I think the challenge with the telehealth only MAT providers is they're only doing the prescriptions, they're not doing any of the other wraparound care. So if the purpose is only to provide the medication, telehealth does help with that 100%. If it's to provide the whole wraparound services that in my opinion should come with MAT to really have the best likelihood of success, then*

*the telehealth doesn't really change that other than having another prescriber that can see you virtually.*

One participant also reflected that medical providers who were not trained in addiction medicine can create a disconnect in coordinating service delivery and ensuring appropriate access across care settings.

*I think just making sure that we have medical providers who are also very familiar with addiction, so I think that's one thing that we've noticed is, people who are doing physical health in the behavioral health field is great and important. People prescribing MAT obviously, very important. But then also just having medical staff that also have that training in addiction too because it seems like there's going be a big disconnect if we're working with medical providers who don't have that experience.*

## Milestone 5: Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD

**Progress on critical metrics.** Table 14 presents progress on the three metrics associated with Milestone 5, all of which moved in the desired direction. Improvements were substantial for two measures, Use of Opioids at High Dosage in Persons Without Cancer and ED Utilization for SUD.

**Table 14. Critical metric results for Milestone 5**

| Metric | Baseline | Midpoint | Absolute Change | Percent Change | Target | Direction | Progress |
|---|---|---|---|---|---|---|---|
| 18. Use of Opioids at High Dosage in Persons Without Cancer (%) | 2.4 | 2.1 | -0.3 | -12.5% | ↓* | ↓ | Y |
| 21. Concurrent Use of Opioids and Benzodiazepines (%) | 7.1 | 6.9 | -0.2 | -2.8% | ↓* | ↓ | Y |
| 23. ED Utilization for SUD per 1,000 Medicaid Beneficiaries | 2.37 | 2.04 | -0.33 | -13.9% | ↓ | ↓ | Y |

*Target provided by CMS; differs from target in state Monitoring Protocol

**Progress on implementation action items.** All action items associated with Milestone 5 were completed (Table 15).

**Table 15. Implementation action item results for Milestone 5**

| Action item category | Action item description | Date to be completed | Current status |
|---|---|---|---|
| Implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse | Health Evidence Review Commission to align payment structure with prescribing guidelines | April 2023 | Completed |
| | Provide greater behavioral health supports (technical assistance, education, etc.) for opioid prescribers and health systems. Especially in primary care and emergency settings to both assist patients in reducing total Morphine equivalent doses and identify SUD/OUD cases which may need individualized care | April 2023 | Completed |
| Expanded coverage of, and access to, Naloxone for overdose reversal | Continue to distribute Naloxone in areas of high need | October 2021 | Completed |
| | Continue cross-divisional collaboration at state and local level | April 2023 | Completed |
| | Increase communication between partners around the alignment of payment structure as it relates to Naloxone to increase access to and penetration of the population at greatest risk and need | April 2022 | Completed |
| | Continue to encourage use and provide technical assistance around Naloxone access, use and distribution to CCOs through the Transformation Center | October 2021 | Completed |
| Implementation of strategies to increase utilization and improve functionality of PDMPs | Continue to collaborate with provider licensing boards | April 2023 | Completed |
| | Educate and engage with provider organizations, CCOs, and healthcare prescribers to increase the number of registered individuals who utilize the system | April 2023 | Completed |
| Other | Increase capacity of culturally-relevant peer-delivered services workforce | April 2023 | Completed |
| | Increase the number of culturally-relevant trainings (including tribal) to be developed and provided statewide | April 2023 | Completed |
| | Leverage opportunities to secure more funding (federal grants, federal opioid project funding, state funds etc.) to expand Opioid Rapid Response Project statewide | April 2023 | Completed |
| | Workforce development efforts around community integration/ housing support specialists as Medicaid participating providers | April 2023 | Completed |

| Action item category | Action item description | Date to be completed | Current status |
|---|---|---|---|
| **Milestone 5a** | | | |
| **Section I** | | | |
| **PDMP Functionalities** | | | |
| Implementation of comprehensive treatment and prevention strategies to address Opioid Abuse and OUD that is: 1) Enhance the state's health IT functionality to support its PDMP; and 2) Enhance and/or support clinicians in their usage of the state's PDMP | Specify a list of action items needed to be completed to meet health IT/PDMP milestones identified. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item | April 2023 | Completed |
| Enhanced interstate data sharing to provide prescribers a more comprehensive prescription history for patients with prescriptions across state lines | Oregon PDMP will continue conversations states as needed and continue to participate in data hub meetings. At least once a year contact will be made, more as needed and available. | April 2023 | Completed |
| | At least once a year contact will be made, more as needed and available. | April 2023 | Completed |
| Enhanced "ease of use" for prescribers and other state and federal stakeholders | PDMP will collaborate with health IT Commons and other stakeholders to: Educate on certain registration and technical thresholds required for integration of prescriber health IT systems with PDMP | April 2023 | Completed |
| | Integrate most prescriber systems (representing 16K prescribers and 4 pharmacy chains) with PDMP. Contact will be made no less than annually but will be done as needed | April 2023 | Completed |
| | PDMP will engage with the PDMP Advisory Council and PDMP Integration Steering Committee, no less than annually but are scheduled quarterly and as needed, to develop "ease of use" strategies (enhancements, education, etc.) for prescribers | April 2023 | Completed |
| Enhanced connectivity between the state's PDMP and any statewide, regional or local HIE | PDMP and health IT Commons will continue to work with Oregon's Community HIEs to integrate with PDMP | April 2023 | Completed |
| | PDMP will work with the health IT Commons, PDMP Integration Steering Committee, and HIE stakeholders to continue to assess enhancements which support clinicians use of HIE to access PDMP data (delegates, training, etc.); contact will be made no less than annually but will be done as needed | April 2023 | Completed |

| Action item category | Action item description | Date to be completed | Current status |
|---|---|---|---|
| Enhanced identification of long-term opioid uses directly correlated to clinician prescribing patterns | PDMP will convene the Clinical Review Subcommittee with a quorum to redefine and update thresholds for risky prescribing at minimum once per year | April 2023 | Completed |
| | PDMP will continue to work with licensing boards to ensure that licensees are registered with the PDMP as mandated by statute; contact will be made no less than annually but will be done as needed and reviewed by the PDMP Advisory Committee quarterly | April 2023 | Completed |
| | The PDMP will continue to promote the continuing medical education resource to stakeholders and enhance education and resources provided to the highest prescribers | April 2023 | Completed |
| **Current and Future PDMP Query Capabilities** | | | |
| Facilitate the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e. the state's master patient index strategy with regard to PDMP query) | Oregon State Statute does not currently allow for this exchange of information – OHA Government Relations and PDMP staff continue to monitor legislation as it emerges – all potential legislative action monitored as a course of business through the PDMP Advisory Committee, quarterly | April 2023 | Completed |
| | The PDMP will continue to engage with the Governor's Opioid Epidemic Taskforce, around the topic of allowing data sharing with the Medicaid program or collection of additional fields. As appropriate and in alignment with meeting agendas and topics | April 2023 | Completed |
| | PDMP will follow any future statute changes from the legislature to enable matching of PDMP and Medicaid data or to allow submission of additional data fields, as available | April 2023 | Completed |
| | The Oregon PDMP master patient index strategy is developed by the AWARxE platform vendor (Appriss) and is primarily the responsibility of the vendor. PDMP staff will work with the vendor to incorporate additional data fields required by any statute changes, as required and available | April 2023 | Completed |

| Action item category | Action item description | Date to be completed | Current status |
|---|---|---|---|
| **Use of PDMP – Supporting Clinicians with Changing Office Workflows / Business Processes** | | | |
| Develop enhanced provider workflow / business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance to address the issues which follow | PDMP will collaborate with health IT Commons, PDMP Integration Steering Committee, and other stakeholders as needed to: 1) Educate on certain registration and technical thresholds required for integration of prescriber health IT systems with PDMP; 2) Integrate most prescriber systems (representing 16K prescribers and 4 pharmacy chains) with PDMP; 3) Share best practices and provide education on leveraging integrated workflows to support informed prescribing of controlled substances; Contact will be made no less than annually but will be done as needed and reviewed by the PDMP Advisory Committee quarterly | April 2023 | Completed |
| Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions provided through the PDMP—prior to the issuance of an opioid prescription | PDMP staff will collaborate with health IT Commons, PDMP Integration Steering Committee, and other stakeholders as needed to: 1) Enable PDMP to be pushed through the emergency department information exchange (EDIE) for hospitals who have already integrated the EDIE solution into their EHR; 2) Support rural hospitals who wish to integrate EDIE into their EHR through a grant provided by OHA and the Oregon Association for Hospitals and Health Systems; Contact will be made no less than annually but will be done as needed and reviewed by the PDMP Advisory Committee quarterly | April 2023 | Completed |
| **Master Patient Index / Identity Management** | | | |
| Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery | Oregon State Statute does not currently allow for this exchange of information – OHA Government Relations and PDMP staff continue to monitor legislation as it emerges – all potential legislative action monitored as a course of business through the PDMP Advisory Committee, quarterly | April 2023 | Completed |
| | The PDMP will continue engagement with the Governor's Opioid Epidemic Taskforce, around statute changes required to allow data sharing with the Medicaid program or collection of additional fields, as available | April 2023 | Completed |
| | The PDMP will follow any future statute changes that allow data sharing between PDMP and Medicaid to enhance the state master patient index in support of SUD care delivery, as available | April 2023 | Completed |
| | PDMP staff will work with the vendor to incorporate additional data fields required by any statute changes, as available | April 2023 | Completed |

| Action item category | Action item description | Date to be completed | Current status |
|---|---|---|---|
| **Overall Objective for Enhancing PDMP Functionality & Interoperability** | | | |
| Leverage the above functionalities / capabilities / supports (in concert with any other state health IT, technical assistance or workflow effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing—and to ensure that Medicaid does not inappropriately pay for opioids | PDMP will collaborate with health IT Commons, PDMP Integration Steering Committee, and other stakeholders as needed to: 1) Register CCO Medical Directors and Dental Directors if legislation is passed; 2) Educate on certain registration and technical thresholds required for integration of prescriber health IT systems with PDMP; 3) Integrate a majority of prescriber systems (representing 16K prescribers and 4 pharmacy chains) with PDMP; 4) Share best practices and provide education on leveraging integrated workflows to support informed prescribing of controlled substances. Contact will be made no less than annually but will be done as needed and reviewed by the PDMP Advisory Committee quarterly | April 2023 | Completed |
| **Section II** | | | |
| Oregon has enough health IT infrastructure and ecosystem at every appropriate level to achieve the goals of the demonstration | | October 2021 | Completed |
| Oregon's SUD Health IT Plan is aligned with the state's Medicaid Health IT Plan and is a component of Oregon's Behavioral Health IT Plan. Oregon is currently initiating modernization efforts on its Behavioral Health IT systems, including SUD IT systems, and will be building a cloud data warehouse, inbound and outbound data interfaces, and longitudinal assessment platforms. This work is a component of the broader Medicaid Health IT Plan which includes Medicaid Modularity and migration of HITECH Act funded systems into the Medicaid Enterprise System. | | April 2023 | Completed |

| Action item category | Action item description | Date to be completed | Current status |
|---|---|---|---|
| **Section III** | | | |
| Oregon will include the applicable standards referenced in the Office of the National Coordinator for Health Information Technology Interoperability Standards Advisory (ISA) and 45 CFR 170 Subpart B in a future amendment to the CCO contract. The opportunities to add the SUD waiver requirements to the CCO contract are through an optional amendment in mid-2021 for CCOs that choose early implementation and through the annual restatement for contract year 2022 whereby implementation will be mandatory for all CCOs. Oregon's most recent procurement for CCO contracts occurred in 2019, with contracts awarded for the period of 2020-2024; Oregon does not anticipate any need to reprocure CCO contracts during the SUD waiver implementation period. | | October 2021 | Completed |

**Interview participant assessment.** On a five-point scale, with one being very unlikely and five being very likely, interviewees on average rated the state as a 3.9, ranging from 2.5 to 5, in the likelihood of achieving Milestone 5 by the end of the waiver period.

## Participant Feedback on Milestone Progress

Most participants shared at least one example of progress related to this milestone. They acknowledged state successes in supporting access to an array of services, specifically peer support workers, medication prescriptions, and culturally relevant services. Half of all participants mentioned that their organizations could supply more Naloxone to clients than in the past, with two specifically mentioning that the waiver had improved the ability to obtain Naloxone and reduced the administrative burden of providing it to clients.

> *I can see improvements in the system. Naloxone has been much more accessible and available. Before there were a lot of requirements on tracking who it's going to and how many people are taking it, whereas now it feels like there's less administrative burden to pass it out to somebody.*

## Participant Feedback on Milestone Barriers

### *Prevention efforts were minimal*

Two participants expressed concern about the scarcity of prevention activities oriented towards primary or secondary strategies. Such activities were viewed as vital to the state's success in decreasing the prevalence of SUD.

> *That's where we're missing the boat, is doing some upstream, either primary or secondary prevention. Because all of those tasks that are listed are at the very best tertiary prevention, but moving into intervention phases. And while I think that's important, we're not going to address the opioid crisis, or really the substance use disorder crisis generally, until we can figure out how to fund actual prevention services. And that's going to continue to be a problem, because there's no Medicaid mechanism to fund prevention.*

### *Restrictions on coverage for Naloxone persisted*

Despite observed gains in Naloxone access and distribution, medication remained expensive, and organizations could not bill for the Naloxone distributed at their facilities. Requiring clients to physically go to a pharmacy to fill a Naloxone prescription was noted as a barrier to access.

> *…every person on Oregon Health Plan can get on naloxone free of charge and they just need to go to the pharmacy. Our clients won't do that. Very few of them will actually go to the pharmacy just to request naloxone, wait, out themselves as somebody that needs naloxone. It's just not going to happen.*

### *Fentanyl and polysubstance use were on the rise*

Five participants called attention to recent increases in fentanyl and polysubstance use, which had made treatment and recovery longer and more difficult for many clients.

*One problem that we see, you know, like our OTP, for example, is that we provide methadone or buprenorphine on a daily basis to folks that come in there. But there's still so much use that takes place on top of that, fentanyl included. But also, we still see a lot of meth that's being used and sold in amongst that population that goes into our OTP. And that's discouraging. That's pretty tough to see that happen.*

Three participants reflected that focusing on a specific drug could detract from attention and efforts to improve prevention and treatment for abuse of other drugs. They believed the intense focus on opioids in the past decade had masked a rise in abuse of other substances.

*We have a thing that we do in this country where we chase the drug. So whatever drug is the drug that's creating the most havoc in our country, that's the drug we prioritize. And when we do that, we don't look at all the other drug abuse that's happening. And we've been doing that for a long time, which is why methamphetamine and cocaine abuse in our country are on the rise. And so I guess, if I wished anything, I wish that we would stop doing that. And prioritize making sure that there's access to care and care available for all of the drugs of abuse.*

### Milestone 6: Improved care coordination and transitions between levels of care

**Progress on critical metrics.** Table 16 presents progress on the four metrics associated with Milestone 6. The four metrics are divided into 13 sub-metrics. Six metrics moved in the desired direction, while seven metrics did not. Of those that did not, one metric (Readmissions Among Beneficiaries with SUD) improved slightly, but less than 2 percent. The other six metrics moved in the opposite direction of the target. Changes were small to moderate for all measures.

**Table 16. Critical metric results for Milestone 6**

| Metric | Baseline | Midpoint | Absolute Change | Percent Change | Target | Direction | Progress |
|---|---|---|---|---|---|---|---|
| 15.1. Initiation of Treatment for Alcohol Abuse or Dependence (%) | 35.4 | 36.7 | +1.3 | +3.7% | ↑ | ↑ | Y |
| 15.2. Engagement of Treatment for Alcohol Abuse or Dependence (%) | 18.9 | 19.5 | +0.6 | +3.2% | ↑ | ↑ | Y |
| 15.3. Initiation of Treatment for Opioid Abuse or Dependence (%) | 56.0 | 59.1 | +3.1 | +5.5% | ↑ | ↑ | Y |
| 15.4. Engagement of Treatment for Opioid Abuse or Dependence (%) | 35.0 | 35.7 | +0.7 | +2.0% | ↑ | ↑ | Y |
| 15.5. Initiation of Treatment for Other Drug Abuse or Dependence (%) | 30.4 | 30.2 | -0.2 | -0.7% | ↑ | = | N |
| 15.6. Engagement of Treatment for Other Drug Abuse or Dependence (%) | 14.5 | 14.2 | -0.3 | -2.1% | ↑ | ↓ | N |
| 15.7. Initiation of Treatment for Total AOD Abuse or Dependence (%) | 36.2 | 37.7 | +1.5 | +4.1% | ↑ | ↑ | Y |
| 15.8. Initiation of Treatment for Total AOD Abuse or Dependence (%) | 19.2 | 19.6 | +0.4 | +2.1% | ↑ | ↑ | Y |
| 17.1. Follow-up after ED Visit for AOD: Age 18 and older (7 days) (%) | 14.7 | 13.9 | -0.8 | -5.4% | ↑ | ↓ | N |
| 17.1. Follow-up after ED Visit for AOD: Age 18 and older (30 days) (%) | 25.6 | 25.4 | -0.2 | -0.8% | ↑ | = | N |
| 17.2. Follow-up after ED Visit for Mental Illness: Age 18 and older (7 days) (%) | 44.1 | 41.8 | -2.3 | -5.2% | ↑ | ↓ | N |
| 17.2. Follow-up after ED Visit for Mental Illness: Age 18 and older (30 days) (%) | 60.1 | 58.0 | -2.1 | -3.5% | ↑ | ↓ | N |
| 25. Readmissions Among Beneficiaries with SUD (%) | 16.5 | 16.4 | -0.1 | -0.6% | ↓ | = | N |

**Progress on implementation action items.** All three action items associated with Milestone 6 were completed (Table 17).

**Table 17. Implementation action item results for Milestone 6**

| Action item category | Action item description | Date to be completed | Current status |
|---|---|---|---|
| Implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities | Specify a list of action items needed to be completed to meet milestone requirements. Include persons or entities responsible for completion of each action item. Include timeframe for com-pletion of each action item | April 2023 | Completed |
| Creation and implementation of additional policies to ensure coor-dination of care for co-occurring physical and mental health condi-tions | Provide support to CCOs through technical assistance and train-ing to increase capacity and quality of SUD care transitions | April 2023 | Completed |
| | CCO 2.0 includes language requiring CCOs use hospital event notifications and make them - and HIE for care coordinating - accessible to primary care, behavioral health, and dental organi-zations | April 2023 | Completed |

**Interview participant assessment.** On a five-point scale with one being very unlikely and five being very likely, interviewees on average rated the state as a 3.5, ranging from 2 to 5, in likeliness to achieve Milestone 6 by the end of the waiver.

## Participant Feedback on Milestone Progress

Most participants underscored the importance of care coordination to a client's successful recovery. Care coordination was especially important for clients with co-occurring disorders, who may be more likely to need services across numerous providers and clinics. Four participants shared examples of how their organizations incorporated more integrative services and worked with various external partners to increase access to services. They had seen more collaboration between organizations and community engagement during the waiver period.

> *There's been more people collectively working on problems outside of organizations. Now we have more community engagement, and we're not trying to solve problems in a silo.*

Participants from six of the organizations interviewed were actively billing for the new CIS. They emphasized the value of the additional reimbursement to fund operations and free up money to be used elsewhere in their organizations. For example, the additional reimbursement allowed organizations to hire more staff, return to full capacity post-COVID, provide better support for client transitions, and help cover the costs of care for uninsured clients.

## Participant Feedback on Milestone Barriers

### *Care coordination required time outside of care delivery that participants did not have*

There was a desire to balance administrative demand with effective care coordination. Large caseloads, understaffing, and lack of clinician training made coordination across facilities challenging. Two participants reflected that care coordination, even within the same organization, required intentional work such as proactive care team communications and supervision.

Three participants reflected on whether providers or CCOs should ultimately be responsible for care coordination. CCOs did not always conduct care coordination for clients, particularly when cross-county coordination was required. OHA was encouraged to hold CCOs more accountable to the care coordination mandates in their contracts.

### *Interoperability between different EHR systems was limited*

Three participants said that information sharing was difficult between organizations that used different electronic health record systems or that primarily used paper-based records.

> *One of the struggles between levels of care is that we use different EHRs and different systems. Some SUD programs are still paper. We only recently got our outpatient program to start charting in the EHR two months ago.*

In the context of limited state capacity, it was noted that care coordination was often hampered by a lack of appropriate levels of care for clients to move into. Three participants reported that they would appreciate a concerted effort from the state on the milestone, specifically for HIE and intensive care coordination. One participant noted the problems caused by referring a patient from one provider to another.

> *Can the state just not say like, 'Hey, here's the EHR y'all are gonna use, here's the forms y'all are gonna use.' So that all of us are getting the same information, we all know the process, because we're getting an assessment for residential from one entity, and it's like total crap, you can't really tell anything from it. And then you'll get a 20-page referral from another entity.*

### *Technical assistance on qualifying services for the new CIS codes was scarce*

Regardless of whether their organizations had leveraged the new CIS billing codes, there was still uncertainty and confusion around how to bill the new codes and what services qualified. Five participants lamented the limited technical assistance and guidance from OHA. Varying interpretations across CCOs of what was allowable under the codes posed administrative burdens for seeing patients from more than one CCO.

> *The biggest issue with being able to utilize those [CIS] codes is getting fair and accurate information. [With various OHA departments and CCOs] it's like we have three different entities giving three different variations of what their interpretation of the code is. These codes do not feel available to us because when we inquire and request technical assistance, we do not receive it. We provide those services for free and avoid billing because we just don't have that technical assistance guidance manual that would give us the confidence to bill.*

There were additional limitations around billing for peer providers, like being unable to bill for drop-in hours, that did not always align with best practices.

### *Information-sharing regulations impeded efficient care coordination*

Information-sharing regulations and lack of HIE infrastructure added to the administrative burden for provider staff. Two participants mentioned the Code of Federal Regulations Title 42 Part 2, which put constraints on information sharing with required releases of information. The requirement to sign these releases in person could pose barriers for clients and inhibit timely care coordination. One participant said that a language change in the OAR necessitated a language change in the organization's EHR system, which was time-consuming.

## Assessment of Overall Risk of Not Meeting Milestones

For each milestone, we used the criteria presented in Table 6 to assess the risk, by data source, of not meeting the milestone. We assigned the overall risk of not meeting a given milestone based on the highest risk indicated out of the three data sources. Based on these criteria, we assigned Milestones 1 and 6 a high risk of not meeting the milestone based on interview participant feedback. We assigned Milestone 2 a medium risk based on critical metric performance and participant feedback, and Milestone 4 a medium risk based on participant feedback. We assigned Milestones 3 and 5 a low risk.

Table 18 summarizes the findings for each milestone from each data source and presents our risk assessments.

**Table 18: Summary of overall risk of not achieving demonstration milestones**

| Milestone | Metric goals met | Action items complete | Average rating* | Key themes from stakeholder feedback | Risk level |
|---|---|---|---|---|---|
| 1 | 4/7 | 100%<br><br>42/42 | 3.3 | • Progress seen in increased reimbursement for residential treatment, engagement before residential treatment, culturally specific services, and telehealth<br>• Access to withdrawal management and residential treatment facilities was insufficient<br>• Specialty treatment capacity was insufficient<br>• Technical assistance for billing was insufficient<br>• Administrative burden was overwhelming<br><br>*General perspectives around Oregon's SUD treatment system and waiver implementation*<br><br>• Severity of illness was increasing<br>• Policymaking was fragmented<br>• Residential bed capacity was insufficient<br>• Hiring and retaining qualified residential staff was a challenge<br>• The impacts of the COVID-19 PHE lingered<br>• Waiver communications were not ideal | High |

| Milestone | Metric goals met | Action items complete | Average rating* | Key themes from stakeholder feedback | Risk level |
|---|---|---|---|---|---|
| 2 | 1/2 | 100%<br>8/8 | 3.5 | • Support for uniform standards<br>• Integration and use of ASAM was time-intensive<br>• Evidence-based practices were not always appropriate for all settings | Med |
| 3 | NA | 100%<br>8/8 | 3.3 | • Support for uniform standards<br>• ASAM-like preferred over ASAM<br>• Licensing each level of care was perceived as burdensome<br>• MAT providers were in short supply<br>• Rulemaking felt disconnected from the field | Low |
| 4 | 2/2 | 85%<br>11/13 | 3.2 | • MAT access and availability vary widely across counties<br>• Stigma and perception of risk around providing MAT had decreased but persisted<br>• Hiring and retaining staff were barriers to MAT access<br>• Service delivery was disjointed | Med |
| 5 | 3/3 | 100%<br>36/36 | 3.9 | • Organizations have been able to provide more Naloxone<br>• Prevention efforts were minimal<br>• Restrictions on coverage for Naloxone persisted<br>• Fentanyl and polysubstance use were on the rise | Low |
| 6 | 6/13 | 100%<br>3/3 | 3.5 | • Appreciation for new CIS codes<br>• Care coordination required time outside of care delivery that participants did not have<br>• Interoperability between different EHR systems was limited<br>• Technical assistance on qualifying services for the new CIS codes was scarce<br>• Information-sharing regulations impeded efficient care coordination. | High |

** Average participant rating of the likelihood of the state achieving the milestone. 1 = very unlikely; 5 = very likely*

## Budget neutrality assessment

Currently, CMS requires all section 1115(a) demonstrations to be budget neutral to the federal government. This condition is met if spending under the waiver demonstration ("with waiver" expenditures) does not exceed projected hypothetical spending in the absence of the waiver demonstration ("without waiver" expenditures).

To assess budget neutrality, we requested the budget neutrality workbook from OHA, which is part of their monitoring requirements, and which reports on "with waiver" and "without waiver" expenditures.

OHA communicated with us that it was currently not able to provide us with the budget neutrality workbook. Therefore, it was not feasible for us to conduct a budget neutrality assessment for this Mid-Point Assessment.

# Next Steps

## Overview

In this chapter, we describe our recommendations for the areas in which Oregon is at medium or high risk of not meeting milestones and any planned modifications by the Oregon Health Authority (OHA) to their waiver implementation plan. Recommendations are for OHA and coordinated care organizations (CCOs), by milestone, based on metric findings and interview participant input.

## Independent Assessor Recommendations for Moderate or High-Risk Milestones

### Milestone 1: Access to Critical Levels of Care for Opioid Use Disorder (OUD) and other Substance Use Disorders (SUDs)

- **Consider adding standardization requirements to future CCO contracts** to reduce the administrative burden placed on providers interacting with multiple CCOs. Provider resources spent on maintaining compliance with multiple CCOs and the Division of Medical Assistance Programs requirements could be better allocated to client care delivery. Specifically:
  - Streamline and align service authorization processes across CCOs.
  - Align coding and billing procedures across CCOs.
  - Encourage CCOs to relax restrictions on peer-delivered services to align with best practices for this kind of care, such as allowing providers to bill for drop-in visits.
  - Establish guidelines related to minimum length-of-stay (LOS) authorization for patients, including consideration of CCO quality metrics to ensure LOS determinations are achieving good outcomes.
- **Provide ongoing, robust outreach and technical assistance around:**
  - Behavioral health coding and billing, particularly for community integration services (CIS) and pre-engagement, ideally as a collaboration between OHA and CCOs. Several providers refrained from using the new billing codes because they were unsure of how to use them and didn't want to have claims denied by CCOs.
  - Augmenting the SUD workforce by encouraging the full scope of practice for qualified mental health professionals, in particular for integrating mental health and SUD care. For instance, OAR 309-019 allows a qualified mental health professional with an appropriate number of hours of SUD training to provide SUD services for a limited time without being a certified alcohol and drug counselor. It was noted that not everyone was aware of this policy, so more effective dissemination and promotion could help expand workforce potential among qualified mental health professionals.

- **Evaluate SUD treatment reimbursement rates,** particularly for residential treatment, and continue to look for ways to ensure they "are sufficient to enlist enough providers so that care and services are available under [Medicaid] at least to the extent that such care and services are available to the general population in the geographic area," as required by Section 1902(a)(30)(A) of the Social Security Act. Participants reported an ongoing need to augment their funding through grants to provide basic services and referred to the greater availability of care for patients with commercial insurance compared to patients with Medicaid.
- **Continue to monitor measures related to Milestone 1 that did not show progress** (Outpatient Services, Medication-Assisted Treatment (MAT), and Continuity of Pharmacotherapy for Opioid Use Disorder (OUD)) and continue the implementation task of engaging with CCOs to improve MAT capacity.

### Milestone 2: Use of Evidence-based, SUD-specific Patient Placement Criteria

- **Consider convening a workgroup of providers** to identify ways OHA and CCOs could reduce the burden on providers to adopt a new assessment, conduct regular training, and research best practices for modifying assessments to account for dual diagnosis or cultural needs.
- **Continue monitoring utilization and LOS for residential treatment facilities.** Rates for the number of Medicaid Beneficiaries Treated in an IMD for SUD improved, but the change was very small and thus classified as "no progress." Average LOS in IMDs was well below the target at the baseline and further decreased at the mid-point. While this development was consistent with the target, which required the average LOS to remain below 30 days, it may raise concerns that LOS could be inadequate for some patients.

### Milestone 4: Sufficient Provider Capacity at Critical Levels of Care including for MAT for OUD

- **Continue outreach to providers to reduce the stigma of MAT** and consider incentives to recruit new providers to become substance use medication prescribers, especially for buprenorphine and other non-methadone options.
- **Focus on how to support MAT access in non-outpatient opioid treatment programs (OTPs) and office-based opioid treatment (OBOT) settings,** including ways to collaborate with MAT providers on wraparound services and care coordination.
- **Continue to allow the use of telehealth in MAT,** especially in rural areas where transportation is a major barrier to access.

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

- **Consider convening a workgroup to assess provider needs to improve information exchange and care coordination**. Providers stated that information-sharing regulations, shifts in Oregon Administrative Rules, and a lack of health information exchange (HIE) infrastructure imposed hurdles when providing care across settings. One participant specifically called out the need for support with electronic signature software, such as DocuSign, that would help speed up the intake and referral process and reduce burdens for clients and providers alike. HIE investments could also help align existing systems and enable the shift from paper to electronic health records to help increase the accessibility of information and facilitate care coordination. Such investments would be a considerable lift for the state and would take a long time to fully implement. While HIE investments should be a consideration for future planning, OHA could seek provider feedback about other difficulties related to information exchange and care coordination and potential remedies actionable in the short term.

- **Clarify and enforce care coordination roles and responsibilities of CCOs.** Participants saw a lack of continuity of care when members of one CCO had to receive services in another region, impeding the likelihood of successful recovery. Clear messaging from OHA to CCOs and providers alike that outlines where the responsibility lies for each aspect of care coordination and transitions between levels of care would support positive outcomes.
- **Continue to monitor measures related to Milestone 6 that did not show progress,** such as Follow-up after Emergency Department Visit for Alcohol and Other Drug (AOD) Dependence or Mental Illness. Efforts to improve care coordination may aid in moving these metrics in the desired direction.

Table 19 summarizes our recommendations for medium- and high-risk milestones. The Table also includes state responses and planned modifications to waiver implementation.

**Table 19: Summary of recommendations for medium-and high-risk milestones and state responses**

| Milestone | For milestones at medium or high risk, independent assessor's recommended modifications | State responses and planned modifications |
|---|---|---|
| 1 | • Add standardization requirements to future CCO contracts to reduce the provider administrative burden when interacting with multiple CCOs.<br>• Provide ongoing, robust outreach and technical assistance around behavioral health coding and billing, and augmenting the SUD workforce by encouraging the full scope of practice for qualified mental health professionals as providers.<br>• Evaluate SUD reimbursement rates and continue to look for ways to ensure they meet statutory requirements.<br>• Continue to monitor measures related to Milestone 1 that did not show progress. | The state has taken the following actions to support the recommendations:<br>• Engaged providers and CCOs in a statewide tackling administrative burden workgroup, initiated summer of 2023<br>• OHA has engaged providers in quarterly technical assistance sessions<br>• OHA implemented a 30% increase to SUD providers in January 2022, a net 30% increase for all providers of SUD and mental health services, implemented a 3.4% increase for providers in October 2023, and will complete a 3.4% increase in July 2024.<br>• OHA also opened up ASAM 3.7R LOC for fee-for-service<br>• OHA provided over $100 Million in vacancy payments to SUD and Mental Health residential providers starting in Q4 of 2020 and ending in Q2 2023<br>• OHA continues to monitor claims and encounter data to support Milestone |
| 2 | • Convene a workgroup of providers to identify ways OHA and CCOs could reduce burden on providers.<br>• Continue monitoring IMD utilization and LOS. | • OHA has engaged providers in a tackling administrative burden workgroup, initiated in the summer of 2023<br>• OHA monitors claims and encounter data, including LOS requirements and reports to CMS on a demonstration year basis |

| Milestone | For milestones at medium or high risk, independent assessor's recommended modifications | State responses and planned modifications |
|---|---|---|
| 4 | • Continue outreach to providers to reduce the stigma of MAT and consider incentives to recruit new providers to become medication prescribers.<br>• Focus on how to support MAT access in non-OTP programs, OBOT settings.<br>• Continue to allow the use of telehealth in MAT. | • OHA will continue supporting MAT in non-OTP and OBOT settings<br>• OHA has implemented telehealth as a viable permanent option, paying at parity with in-person services<br>• OHA will continue to host provider engagement technical assistance opportunities for providers to ease the burden of billing for Medicaid Services |
| 6 | • Convene a workgroup to assess provider needs to improve information exchange and care coordination.<br>• Clarify and enforce care coordination roles and responsibilities of CCOs.<br>• Continue to monitor measures related to Milestone 6 that did not show progress. | • OHA will continue to monitor the measures in Milestone 6 that did not show improvement between Year 1 and Year 2 of the waiver<br>• OHA will consider provider workgroups in a meaningful way, given providers concerns with administrative burden<br>• OHA has recently revised care coordination rules and responsibilities for CCOs, and will monitor effectiveness through CCO quality assurance activities |

## Description of areas at risk of not meeting milestones and list of proposed activities for addressing deficiencies

Based on our findings we identified two areas at high risk of not meeting targets: access to critical levels of care for OUD and other SUDs (Milestone 1) and improved care coordination and transition between levels of care (Milestone 6). For Milestone 1, the state has convened a workgroup for providers and CCOs to address administrative burden, offered technical assistance sessions for providers, increased reimbursement rates, opened up ASAM level of care 3.7 for fee-for-service payments, and provided vacancy payments to SUD and mental health residential providers. The state further plans another reimbursement increase in 2024. For milestone 6, the state proposes to monitor effectiveness of revised care coordination rules and responsibilities for CCOs, and to consider offering provider workgroups. The state also proposes to monitor data and measures relevant for these two milestones.

We identified two areas at medium risk of not meeting targets: use of evidence-based, SUD-specific patient placement criteria (Milestone 2), and sufficient provider capacity at critical levels of care, including for MAT for OUD (Milestone 4). To address these deficiencies, the state has engaged providers in a workgroup to reduce administrative burden and implemented telehealth as a permanent option for MAT. The state will also continue its support for MAT in non-OTP and OBOT settings, monitor relevant data and measures, and continue hosting provider engagement technical assistance opportunities.

# Independent Assessor Description

The Center for Health Systems Effectiveness at Oregon Health & Science University is a research organization that uses economic approaches and big data to answer pressing questions about health care delivery. Our mission is to provide the analyses, evidence, and economic expertise to build a more sustainable health care system. Our publications do not necessarily reflect the opinions of its clients and funders.

The Center for Health Systems Effectiveness conducted a fair and impartial assessment and prepared an objective assessment report. We relied on the following resources to guide the assessment:

- Medicaid Section 1115 Substance Use Disorder (SUD) and Serious Mental Illness and Serious Emotional Disturbance (SMI/SED) Demonstrations MPA Technical Assistance Version 1.0 (October 2021);
- Oregon Health Plan Substance Use Disorder 1115 Demonstration, Approval Period: April 8, 2021 through March 31, 2026, Attachment E SUD Evaluation Design;
- Medicaid Section 1115 Substance Use Disorder Demonstrations: Technical Specifications for Monitoring Metrics Version 5.0, September 2022;
- Responses from the CMS 1115 Waiver Technical Assistance team (1115MonitoringandEvaluation@cms.hhs.gov) to clarification questions regarding MPA requirements; and
- Consultation with OHA limited to:
    - Requests for and receipt of data such as Medicaid claims, list of Medicaid-enrolled IMDs, contact information for behavioral health directors of CCOs, or implementation updates,
    - Receipt of policy documents, fee schedules, training sessions, or other resources available regarding Medicaid SUD services,
    - Dialogue to ensure the calculation of metrics was as similar as possible between OHA monitoring reports and the MPA,
    - Responses to clarification questions regarding interviewee statements or references, and
    - Dialogue to establish the method and timing of the delivery of the report drafts.

The Center for Health Systems Effectiveness has no conflict of interest regarding the evaluation overall or this report specifically.

Stephan Lindner

# Interview Guide

## Oregon SUD Waiver Evaluation – Round 1 Interview Guide

*The questions below are the general topic areas we will explore with interview participants. Not all of these questions will be asked of all participants.*

### Introduction

Thank you for agreeing to participate in this interview. My name is ***[state name]*** from the Oregon Health & Science University Center for Health Systems Effectiveness. My colleague ***[state name]*** is also here to observe and take notes. We are working with the Oregon Health Authority to understand the Medicaid 1115 Substance Use Disorder Waiver's early implementation successes and challenges, as well as progress towards the achievement of Waiver milestones. We're speaking with people around the state to understand experiences from different organizational and professional perspectives. The information we gather will be used to inform our evaluation of OHA's progress with waiver implementation, as well as provide insight and context to the quantitative analysis.

- Did you have a chance to review the information sheet? Do you have any questions?
- Interview recordings will be professionally transcribed, and any information in the interview that could be used to identify you will be removed from the transcripts. These transcripts will only be seen by the research team.
- Start recording: Do I have your permission to record this interview?

### Questions

*The waiver was implemented in April 2021. These questions are related to your experiences after the implementation date.*

1. **Please tell me about yourself.**
    a. What is your role and title?
    b. What is your background in SUD service delivery?
2. **In general, what is your awareness of the Oregon SUD waiver, its goals, and the related policy changes?**
    a. What has been your experience with state communications and outreach about the waiver?
    b. What form did they take? (e.g., group email, individual outreach, webinar)
    c. Were they helpful and relevant for your organization?
3. **Have you or your organization utilized any of the new policies related to billing codes and Medicaid payments for IMD stays?**

a If not, why? (e.g., weren't aware of them, insufficient infrastructure, etc.)

4 **What effects, if any, have you seen from the waiver so far? For example:**

a How has the waiver affected organizational operations or your daily work?

b How has it affected clients and access to care?

5 **What is your experience with the role that IMDs play in the continuum of SUD care, and what is the significance of this role?**

6 **How do you see the waiver fitting into Oregon's overall plan to improve access to SUD treatment?**

a Specifically related to IMD reimbursement and CIS

7 **Relating to COVID and how the public health emergency impacted your work:**

a How did COVID affect the roll out of the waiver?

b What was your biggest challenge during COVID; any main takeaways; any lingering effects?

8 **We would like to discuss the six individual milestones of the waiver and activities OHA is conducting to achieve them. I'll ask the same follow-up questions after describing each milestone and give you space to provide additional context or detail.** *[Bulleted items under each milestone activity are for interviewer reference and to provide additional context for key informants if necessary]*

**Milestone 1** – Access to critical levels of care for OUD and other SUDs (this includes outpatient services, intensive outpatient services, coverage of MAT, coverage of medically supervised withdrawal management, parity of coverage in SUD service array). This includes activities such as [read activity listed after each letter]:

a Changes to reimbursement and standards for identification, initiation, and engagement of patients.

- Set scope of work for the workforce regarding prevention, early intervention, and crisis intervention services and establish reimbursement rate.
- Develop alternative payment methodologies for Day Treatment Services
- Set standards for identification, initiation, and engagement. Educate and engage providers around these standards and implementation.

b Requirements for and engagement with CCOs around their staffing levels and capacity to provide SUD services including MAT.

- Develop requirement for CCOs to have a mechanism to ensure that they have adequate capacity to serve those in their region around SUD services
- Engage with CCOs around adequate capacity levels for MAT and their service areas.
- Develop standard range of client to clinician ratio
- Develop provider review process around staffing levels

c Increase availability of culturally relevant training and diversity within the workforce.

- Develop more culturally relevant training for peer-delivered services workers, including a tribal- specific course and Latino- specific course

- Expand the number and diversity of culturally specific peers within the workforce

**d** Develop structure and reimbursement rates for agencies to provide case management for CIS.

- Pursue state plan amendment and OAR changes to expand the use of case management for pre- and post-treatment and for community-based services and supports such as housing and employment. Meet with agencies that provide case management for pre- and post-treatment and for community-based services (funded through state funds and federal grants) to develop a structure and draft regulations for this service. Develop reimbursement rates for agencies to provide this service (These are OHA activities directly related to parity of coverage in SUD service array)

**i** Have you encountered any successes or challenges related to this milestone?

**ii** Do you have anything to add/thoughts regarding this milestone?

**iii** How would you rate Oregon's likeliness to achieve this milestone on a scale of 1-5, with 1 being very unlikely and 5 being very likely?

**Milestone 2** – Use of evidence-based, SUD-specific patient placement criteria. This includes activities such as *[read activity listed after each letter]:*

**a** New regulations around inclusion of ASAM criteria, licensing and certification, and staff training for new rules.

- Refine contract language with CCOs to include ASAM criteria
- Monitor CCOs to ensure prior authorization staff are adequately trained in ASAM criteria and SUD treatment services
- Revise state OARs 309-018 and 309-019 to specify services that must be provided for each ASAM level of care. State licensing/certification site reviews will include assessment of compliance with this requirement to ensure that service plans reflect appropriate interventions for the diagnosis and the ASAM level of care.
    - Consult with the Department of Justice
    - Consult with providers and other stakeholders
    - Develop and implement policy and OAR amendments
    - Provide training to providers regulated by the new rules (in person, onsite technical assistance and webinar)

**i** Have you encountered any successes or challenges related to this milestone?

**ii** Do you have anything to add/thoughts regarding this milestone?

**iii** How would you rate Oregon's likeliness to achieve this milestone on a scale of 1-5, with 1 being very unlikely and 5 being very likely?

**Milestone 3** – Use of nationally-recognized SUD-specific program standards to set provider qualifications for residential treatment facilities. This includes activities such as *[read activity listed after each letter]:*

**a** New ASAM criteria regulations and licensing, including access to MAT.

- Revise state rules to specify services that must be provided for each ASAM level of care. (Repeated from Milestone 2)
- Revise OARs 309-008 and 415-012 to specify the process and standards for certification and licensure of each ASAM level of care in both outpatient and residential programs. OHA/Health Services Division-issued certificates and licenses will identify specific levels of care for each provider.
- Revise OAR to require that residential providers make MAT available onsite or provide coordination services to off-site MAT services including assisting with access, payment issues, transportation, and daycare.

**i** Have you encountered any successes or challenges related to this milestone?

**ii** Do you have anything to add/thoughts regarding this milestone?

**iii** How would you rate Oregon's likeliness to achieve this milestone on a scale of 1-5, with 1 being very unlikely and 5 being very likely?

**Milestone 4** – Sufficient provider capacity at critical levels of care for MAT of OUD. This includes activities such as *[read activity listed after each letter]:*

**a** Assessing provider capacity in all levels of care and implementing changes to address gaps in provider ratios.

- Complete provider capacity study and use to identify areas of high need.
  - Create action plan to address deficits within the delivery system identify within the capacity study
  - Implement the plan to address the delivery system deficits
  - Assess current client to provider ratios for all levels of treatment
  - Develop the appropriate client to provider ratios
  - Develop a plan to address any gaps in provider ratio
  - Begin to implement changes addressing the gaps in provider ratios that were identified in service areas

**b** Ensuring access to MAT in various settings.

- Implement the capacity management and referral tracking database for all SUD residential services (ASAM levels 3-4) including MAT and withdrawal management
- Identify needs for MAT in OTP and OBOT settings
- Develop plan to meet needs of MAT in OTP and OBOT settings
- Implement plan to address needs of MAT in OTP and OBOT settings

**c** Identifying areas of high need.

- Assess the number of covered lives, availability of prevalence, incidents and diagnosis rates by region/ CCO

**d** Addressing the workforce shortage.

- Assess the needs of the Healthcare workforce identified in the assessment.
- Develop the plan to address workforce issues to include activities such as (focus groups, partnerships with providers and CCOs, etc.…)

**i** Have you encountered any successes or challenges related to this milestone?

**ii** Do you have anything to add/thoughts regarding this milestone?

**iii** How would you rate Oregon's likeliness to achieve this milestone on a scale of 1-5, with 1 being very unlikely and 5 being very likely?

**Milestone 5** – Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD. This includes activities such as ***[read activity listed after each letter]***:

**a** Provider education and TA around identifying and treating SUD/OUD, and reducing Morphine Equivalent Doses.

- Provide greater behavioral health supports (TA, education, etc.) for opioid prescribers and health systems. Especially in primary care and emergency settings to both assist patients in reducing total Morphine equivalent doses and identify SUD/OUD cases which may need individualized care.

**b** Aligning payment structure with prescribing guidelines.

- Health Evidence Review Commission to align payment structure with prescribing guidelines.

**c** Distribution, training, and promotion of naloxone access

- Continue to distribute Naloxone in areas of high need.
- Continue cross-divisional collaboration at state and local level
- Increase communication between partners around the alignment of payment structure as it relates to Naloxone to increase access to and penetration of the population at greatest risk and need.
- Continue to encourage use and provide TA around Naloxone access, use and distribution to CCOs through the Transformation Center.

**d** Collaboration with organizations and providers for licensure and funding opportunities

- Continue to collaborate with provider licensing boards
- Educate and engage with provider organizations, CCOs, and healthcare prescribers to increase the number of registered individuals who utilize the system
- Leverage opportunities to secure more funding (federal grants, Federal opioid project funding, state funds etc.) to expand Opioid Rapid Response project statewide.

**e** Increase culturally-relevant capacity and workforce development for CIS specialists.

- Increase capacity of culturally-relevant peer-delivered services workforce
- Increase the number of culturally-relevant trainings (including tribal) to be developed and provided statewide

- Workforce development efforts around community integration/ housing support specialists as Medicaid participating providers

i Have you encountered any success or challenges related to this milestone?

ii Do you have anything to add/thoughts regarding this milestone

iii How would you rate Oregon's likeliness to achieve this milestone on a scale of 1-5, with 1 being very unlikely and 5 being very likely?

**Milestone 6** – Improved care coordination and transitions between levels of care. This includes activities such as *[read activity listed after each letter]:*

a Increasing capacity for care coordination and health information exchange

- Provide support to CCOs through TA and training to increase capacity and quality of SUD care transitions
- CCO 2.0 includes language requiring CCOs use hospital event notifications and make them- and health information exchange for care coordinating accessible to primary care, behavioral health and dental organizations

i Have you encountered any successes or challenges related to this milestone?

ii Do you have anything to add/thoughts regarding this milestone?

iii How would you rate Oregon's likeliness to achieve this milestone on a scale of 1-5, with 1 being very unlikely and 5 being very likely?

9 Do you have any questions for us or any other thoughts that you would like to share?

Thank you very much for your time.

# Measure Definitions

## Critical SUD metrics for assessing milestone progress at the mid-point

All metrics courtesy of CMS Medicaid Section 1115 Substance Use Disorder Demonstrations: Technical Specifications for Monitoring Metrics Manual, Version 5.0, September 2022.

### Milestone 1. Access to critical levels of care for OUD and other SUDs

#### *Metric #7 Early Intervention*

Description: Number of beneficiaries who used early intervention services (such as procedure codes associated with screening, brief intervention, and referral to treatment) during the measurement period.

Source: Medicaid claims

#### *Metric #8 Outpatient Service*

Description: Number of beneficiaries who used outpatient services for SUD (such as outpatient recovery or motivational enhancement therapies, step-down care, and monitoring for stable patients) during the measurement period.

Source: Medicaid claims

#### *Metric #9 Intensive Outpatient and Partial Hospitalization Services*

Description: Number of beneficiaries who used intensive outpatient and/or partial hospitalization services for SUD (such as specialized outpatient SUD therapy or other clinical services) during the measurement period.

Source: Medicaid claims

#### *Metric #10 Residential and Inpatient Services*

Description: Number of beneficiaries who use residential and/or inpatient services for SUD during the measurement period.

Source: Medicaid claims

#### *Metric #11 Withdrawal Management*

Description: Number of beneficiaries who use withdrawal management services (such as outpatient, inpatient, or residential) during the measurement period.

Source: Medicaid claims

### *Metric #12 MAT*

Description: Number of beneficiaries who have a claim for MAT for SUD during the measurement period.

Source: Medicaid claims

### *Metric #22 Continuity of Pharmacotherapy for OUD*

Description: Percentage of adults age 18 and older with pharmacotherapy for OUD who have at least 180 days of continuous treatment.

Source: Medicaid claims

## Milestone 2. Use of evidence-based, SUD-specific patient placement criteria

### *Metric #5 Medicaid Beneficiaries Treated in and IMD for SUD*

Description: Number of beneficiaries with a claim for inpatient/residential treatment for SUD in an IMD during the measurement period.

Source: Medicaid claims

### *Metric #36 Average LOS in IMDs*

Description: The average LOS for beneficiaries discharged from IMD inpatient/residential treatment for SUD.

Source: Medicaid Claims; State-specific IMD database

## Milestone 3. Use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities

### *n/a*

There are no critical metrics identified for Milestone 3 (Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications). CMS will assess progress on this milestone based on other data described in Sections III and IV.

## Milestone 4. Sufficient provider capacity at each level of care

### *Metric #13 Provider Availability*

Description: The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period.

Source: Provider enrollment database; Medicaid claims (if necessary)

### *Metric #14 Provider Availability – MAT*

Description: The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT.

Source: Provider enrollment database; Medicaid claims (if necessary); Substance Abuse and Mental Health Services Administration Opioid Treatment Program Directory (if necessary); Substance Abuse

and Mental Health Services Administration Number of DATA-Waived Practitioners Newly Certified by Year (if necessary); Substance Abuse and Mental Health Services Administration Buprenorphine Treatment Practitioner Locator (if necessary)

## Milestone 5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD

### *Metric #18 Use of Opioids at High Dosage in Persons Without Cancer*

Description: Percentage of beneficiaries age 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents over a period of 90 days or more. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice or palliative care are excluded.

Source: Medicaid claims

### *Metric #21 Concurrent Use of Opioids and Benzodiazepines*

Description: Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice or palliative care are excluded.

Source: Medicaid claims

### *Metric #23 Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries*

Description: Total number of emergency department visits for SUD per 1,000 beneficiaries in the measurement period.

Source: Medicaid claims

### *Metric #27 Overdose death rate*

Description: Rate of overdose deaths during the measurement period among adult Medicaid beneficiaries living in a geographic area covered by the demonstration.

Source: State data on cause of death

## Milestone 6. Improved care coordination and transitions between levels of care

### *Metric #15 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment*

Description: Percentage of beneficiaries age 18 and older with a new episode of AOD abuse or dependence who received the following:

- Initiation of AOD Treatment—percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis.
- Engagement of AOD Treatment—percentage of beneficiaries who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit.

The following diagnosis cohorts are reported for each rate: (1) Alcohol abuse or dependence, (2) Opioid abuse or dependence, (3) Other drug abuse or dependence, and (4) Total AOD abuse or dependence. A total of 8 separate rates are reported for this measure.

Source: Medicaid claims or EHR

### *Metric #17(1) Follow-up after Emergency Department Visit for Alcohol and Drug Dependence*

Description: Percentage of emergency department visits for beneficiaries age 18 and older with a principal diagnosis of AOD abuse or dependence who had a follow-up visit for AOD abuse or dependence. Two rates are reported:

- Percentage of emergency department visits for which the beneficiary received follow-up within 30 days of the emergency department visit (31 total days).
- Percentage of emergency department visits for which the beneficiary received follow-up within 7 days of the emergency department visit (8 total days).

Source: Medicaid claims

### *Metric #17(2) Follow-up after Emergency Department Visit for Mental Illness*

Description: Percentage of emergency department visits for beneficiaries age 18 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported:

- Percentage of emergency department visits for mental illness for which the beneficiary received follow-up within 30 days of the emergency department visit (31 total days).
- Percentage of emergency department visits for mental illness for which the beneficiary received follow-up within 7 days of the emergency department visit (8 total days).

Source: Medicaid claims

### *Metric #25 Readmissions Among Beneficiaries with SUD*

Description: The rate of all-cause readmissions during the measurement period among beneficiaries with SUD.

Source: Medicaid claims

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