State of Nebraska Department of Health and Human Services

Nebraska Substance Use Disorder (SUD) Demonstration Waiver

Mid-Point Assessment

July 2022

HSAG HEALTH SERVICES ADVISORY GROUP

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Executive Summary

Through Section 1115 of the Social Security Act, states are provided an opportunity to design and test their own methods for providing and funding healthcare services that meet the objectives of the federal Medicaid program and Children's Health Insurance Program (CHIP) but differ from services required by federal statute through Section 1115 Demonstration Waivers. Section 1115 Demonstration waivers also allow states flexibility in how state healthcare is provided, within federal guidelines. The Centers for Medicare & Medicaid Services (CMS) has designed a national evaluation strategy to compare the approaches used by different states in its Section 1115 Medicaid expansion waivers, requiring that each demonstration meet the program objectives. The Mid-Point Assessment (MPA) is a critical requirement of this evaluation strategy. The purposes of the MPA are to examine the progress toward each demonstration milestone outlined in the implementation plan, to identify any risks to meeting those milestones, and to provide recommendations for improving the demonstration program.

The public health crisis caused by the abuse of prescription and illicit opioids has adversely impacted the quality of life of individuals across the United States, including those residing in Nebraska. Based on data collected by the Centers for Disease Control and Prevention (CDC), the drug overdose death rate in Nebraska was 6.9 to 11 per 100,000 people in 2017.[1] Additionally, the rate of newborns exhibiting drug withdrawal symptoms per 1,000 hospital births has risen steadily since 2008. Data collected by Substance Abuse Treatment Centers (SATC) in Nebraska identified alcohol and methamphetamines as the most predominantly used substances in 2016.[2] The Nebraska Department of Health and Human Services (DHHS) took steps to address the needs of its Medicaid population by integrating physical, behavioral, and substance use treatment services provided to enrollees, as well as launching opioid use disorder (OUD) initiatives.

CMS approved Nebraska's Section 1115 Substance Use Disorder (SUD) Demonstration Waiver, on June 28, 2019, effective from July 1, 2019 through June 30, 2024.[3] Through the Section 1115 Demonstration Waiver, the State is authorized to provide high-quality, clinically appropriate treatment including a continuum of services to treat addictions to opioids and other substances, for Medicaid enrollees ages 21–64 primarily diagnosed with OUD and/or other SUDs. The Section 1115 SUD Demonstration Waiver also enables DHHS to implement models focused on increasing community- and home-based support for beneficiaries and to improve access to SUD evidence-based services based on the American Society of Addiction Medicine (ASAM) criteria. Nebraska's Section 1115 SUD Demonstration Waiver was designed to meet milestones required by CMS and set out in the special terms and conditions (STCs) of the Waiver approval. Additionally, with the implementation of the Heritage Health Adult (HHA) expansion on October 1, 2020, Medicaid eligibility was extended to individuals ages 19–64 with income at or below 138 percent of the Federal poverty level, expanding the age range of individuals eligible for coverage by Medicaid, and subsequently expanding the 21–64 population covered under the Section 1115 SUD Demonstration Waiver.[4] As of December 2021, over 55,000 newly eligible members had

1 Centers for Disease Control and Prevention. 2017 Drug Overdose Death Rates. Available at: https://www.cdc.gov/drugoverdose/deaths/2017.html. Accessed on Mar. 30, 2022.

2 Nebraska Department of Health and Human Services. State Initial Application. Available at: ne-sud-demo-pa.pdf (medicaid.gov). Accessed on Mar. 30, 2022.

3 Centers for Medicare and Medicaid Services. Initial Approval. Available at: ne-sud-demo-initial-appvl-20190628.pdf (medicaid.gov). Accessed on Mar. 30, 2022.

4 Centers for Medicare and Medicaid Services. CMS Amendment Update – New Adult Group. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ne-sud-demo-amend-update-new-adult-group-09012020.pdf (medicaid.gov). Accessed on June 1, 2022.

enrolled in Medicaid, substantially increasing the number of members covered under the Section 1115 SUD Demonstration Waiver.

Within Nebraska DHHS, the Division of Medicaid and Long Term Care (MLTC) is responsible for administration of the Section 1115 SUD Demonstration Waiver but is not working in isolation. MLTC is working in collaboration with the Division of Behavioral Health (DBH) and the Division of Public Health (DPH) within DHHS to achieve the demonstration milestones within the context of a broader integration of SUD and behavioral health service definitions and regulations.

Pursuant to the STCs, DHHS contracted with Health Services Advisory Group, Inc. (HSAG) as an independent evaluator to conduct a comprehensive evaluation of Nebraska's Section 1115 SUD Demonstration Waiver program, including an MPA of the program. The purpose of the MPA is to provide CMS and DHHS with an assessment of the state's progress toward meeting its demonstration milestones and monitoring metric targets, as well as providing the opportunity to ensure ongoing progress and inform demonstration planning and quality improvement efforts.

Goals of the Nebraska SUD Program

The SUD program demonstration describes six goals established by Nebraska DHHS for the program:

1. Increased rates of identification, initiation, and engagement in treatment for SUD
2. Increased adherence to and retention in treatment
3. Reductions in overdose deaths, particularly those due to opioids
4. Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services
5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate
6. Improved access to care for physical health conditions among beneficiaries with SUD

Methodology

This MPA relies on data obtained from several sources, as described more fully in Section 2 of this report. The monitoring protocol developed by DHHS and approved by CMS lays out 36 CMS-provided metrics and three state-defined health information technology (HIT) metrics, 26 of which are tracked and reported on by the State in quarterly and annual monitoring reports. The MPA monitors a set of 26 CMS- and state-defined metrics as quantitative evidence of progress in the Section 1115 SUD Demonstration Waiver. DHHS provided claims and encounter data for use in calculating most of the monitoring metrics. A small number of monitoring metrics required acquisition of data from additional sources beyond the claims and encounter data provided by DHHS. The number of providers delivering medication-assisted treatment (MAT) services was obtained from data maintained by the Substance Abuse and Mental Health Services Administration (SAMHSA) on SUD providers delivering medication-assisted treatments. HSAG linked the SAMHSA data on MAT service providers in Nebraska to provider enrollment data supplied by DHHS to identify Medicaid-contracted providers. The availability of providers for SUD treatment and prevention services were obtained from DHHS data, SAMHSA data, and the Mental Health Substance Use (MHSU) facility roster which identified SUD provider facilities throughout the state, including halfway houses, residential treatment facilities, regional centers, residential rehabilitation, Institutions for Mental Diseases (IMDs), secured psychiatric facilitates, and opioid treatment

program (OTP) providers. The claims and encounter data, SAMHSA data on SUD providers delivering MAT, and the MHSU facility roster file are the key quantitative data sources for this MPA.

In addition to the quantitative data described above, HSAG conducted semi-structured interviews with State administrators, providers, managed care organization (MCO) staff, beneficiary representatives, and other non-provider stakeholders involved in the provision of care to Nebraska Medicaid beneficiaries. The interviews collected data on perceptions and experiences during the early stages of the SUD Demonstration Waiver regarding:

- Experiences with access, care coordination and transitions, and quality of care for SUD treatment recipients
- Perceptions of barriers and drivers of success associated with the implementation of the SUD demonstration
- Unintended consequences encountered during the implementation of the SUD demonstration
- Impacts of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) on the implementation of the SUD demonstration

HSAG synthesized the results of these quantitative and qualitative analyses to assess the risk that the state would not be able to meet each milestone, to identify key considerations in that assessment of risk, and to make recommendations for potential improvements for the remainder of the demonstration.

Assessment of Overall Risk of Not Meeting Milestones

The results of the MPA must be interpreted in the context of the HHA expansion implemented on October 1, 2020, which resulted in over 55,000 newly-eligible members enrolling in Medicaid in the following 15 months. A review of the DHHS-submitted monitoring metric reports indicated that several metrics exhibited substantial jumps in numerator counts that coincided with the HHA expansion.

The number of *Medicaid Beneficiaries With SUD Diagnosis* increased from 5,907 and 6,038 in August and September 2020 to 7,105 and 7,710 in October and November 2020, a 17.7 percent increase from September to October. A greater increase was observed in the number of Medicaid beneficiaries receiving *Any SUD Treatment* services, from 1,468 and 1,540 in August and September 2020 to 2,543 and 2,594 in October and November 2020, a 65.1 percent increase between September and October. Similar increases between September and October 2020 in the number of services delivered were observed for several additional monitoring metrics reported by DHHS, including:

- *Intensive Outpatient and Partial Hospitalization Services* (50.9 percent increase)
- *Residential and Inpatient Services* (125.0 percent increase)
- *Withdrawal Management* (218.8 percent increase)
- *Medication-Assisted Treatment* (24.3 percent increase)

The substantial increases in the number of services delivered observed for these measures coincide with the HHA expansion and would be expected as a result of a large increase in Medicaid enrollees within the 21–64 age range. To account for the increase in beneficiaries enrolled and covered under the Section 1115 SUD Demonstration Waiver, the MPA examines the changes in rates of events, or the percentage of Medicaid beneficiaries receiving a service or experiencing an event over time as opposed to assessing the change in the simple counts of events.

There are, however, two monitoring metrics specified as rates that DHHS reported for which there were substantial increases that coincided with HHA expansion. *Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries* increased by 47.9 percent between September and October 2020, from 1.90 to 2.81 per

1,000. During the same period, *Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries* increased by 39.8 percent, from 1.08 to 1.51 per 1,000. Based on the monitoring metrics observed to date, it is clear that HHA expansion coincided with substantial increases in both numerator events and rates as the population of Medicaid beneficiaries covered by the Section 1115 SUD Demonstration Waiver increased. As the Medicaid expansion population size stabilizes, the monitoring metrics are expected to stabilize at rates representative of the newly-expanded Section 1115 SUD Demonstration Waiver population. The purpose of this MPA, however, is not to determine what portion of changes in the monitoring metrics is due to HHA expansion and what portion is due to the Section 1115 SUD Demonstration Waiver impact. The forthcoming interim evaluation report will address the question of demonstration impacts and HHA expansion impacts and will attempt to disentangle the two types of impacts.

Regardless of the causes of changes in the monitoring metrics described to this point, one impact of the Section 1115 SUD Demonstration Waiver is clearly observable. As reported by DHHS, between July 1, 2019 and March 31, 2022, the Section 1115 SUD Demonstration Waiver has covered 1,314 stays in IMDs over 15 days, which accounted for 69.4 percent of the total IMD stays reported during that period, and which previously would not have been covered had the Section 1115 SUD Demonstration Waiver not been in place.

Having set the context around the implementation of the Section 1115 SUD Demonstration Waiver overlapping with HHA expansion, the MPA now focuses on results across the critical monitoring metrics, the state's completion of implementation plan action items, stakeholder input, and provider availability. The results across these data sources were synthesized using the algorithm presented in the Mid-Point Assessment Technical Assistance from CMS[5] to determine the overall level of risk of the demonstration not meeting each milestone. Table 1 presents the risk assessment developed in this MPA report.

Table 1—Assessment of the Level of Risk of Not Meeting Milestones

Milestone	Risk Level	Factors
Milestone 1: Access to Critical Levels of Care for OUD and other SUDs	Low	• Implementation Plan action items complete: 100% • Critical metrics meeting target: 87.5% • Few stakeholders identified risks, and all are being addressed within the planned timeframe • Availability is not yet adequate, largely due to geographic and demographic limitations on the availability of providers at critical levels of care
Milestone 2: Widespread Use of Evidence-Based, SUD-Specific Patient Placement Criteria	Low-Medium	• Implementation Plan action items complete: 50% • Critical metrics meeting target: 50% • Stakeholders identified no risks
Milestone 3: Use of Nationally Recognized, evidence-Based, SUD-specific Program Standards for Residential Treatment Facility Provider Qualifications	Low-Medium	• Implementation Plan action items complete: 50% • Critical metrics meeting Target: NA[a] • Stakeholders identified no risks

5 Centers for Medicare & Medicaid Services. Medicaid Section 1115 Substance Use Disorder (SUD) and Serious Mental Illness and Serious Emotional Disturbance (SMI/SED) Demonstrations, Mid-Point Assessment Technical Assistance, version 1.0 (October 2021). Available at: 1115 SUD and SMI/SED Mid-Point Assessment Technical Assistance Version 1.0 (medicaid.gov). Accessed on Apr. 14, 2022.

Milestone	Risk Level	Factors
Milestone 4: Sufficient Provider Capacity at Each Level of Care, Including MAT	Low	• Implementation Plan action items complete: 100% • Critical metrics meeting Target: 100%[b] • Many stakeholders identified challenges, and all are being addressed within the planned timeframe – Availability is not yet adequate, but DHHS and the MCOs are addressing geographic and demographic limitations to the availability of providers at critical levels of care
Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD	Low	• Implementation Plan action items complete: 100% • Critical metrics meeting target: 66.6% • Stakeholders identified no risks
Milestone 6: Improved Care Coordination and Transitions Between Levels of Care	Low-Medium	• Implementation Plan action items complete: 50% • Critical metrics meeting target: 57.1% • Few stakeholders identified issues, and all are being addressed within the planned timeframe

[a] There are no monitoring metrics attached to Milestone 3.
[b] One of the two monitoring metrics, *SUD Provider Availability – MAT*, could only be calculated for the performance period, precluding the assessment of change over time. The remaining monitoring metric, SUD Provider Availability, exhibited change in the expected direction between the baseline and performance year.

Among the milestones defined in the CMS STCs for the demonstration, the risk of Nebraska not meeting the requirements of the milestones are all either low, or low-to-medium. Assessment of the available data shows that a number of action items have been delayed in part due to the COVID-19 PHE. Additionally, DHHS is engaging in a broader overhaul of its SUD and behavioral health regulations to better align programs, policies, and coverage for Nebraskans across divisions such as DBH and MLTC. This larger effort has required working through the complex set of regulatory definitions surrounding service definitions, qualifications, and other regulatory nuances which extend beyond the scope of the demonstration. DHHS, however, continues to make progress in this area and anticipates completing the reconciliation of these processes by January 2023.

In addition to progress toward completion of the implementation plan action items, the monitoring metrics for many measures are moving in the targeted direction for the demonstration. Of the five milestones that have monitoring metrics assigned, all have at least half of the metrics moving in the targeted direction. Among those metrics that are not changing in the targeted direction, it is possible that the ongoing COVID-19 PHE and/or the Medicaid expansion through the HHA program may be contributing to the observed changes. Additionally, examination of the absolute and relative changes among the monitoring metrics indicates that metrics moving in the targeted direction tend to exhibit larger changes than those moving opposite to the targeted direction. While the MPA cannot speak to the counterfactual of what the monitoring metrics rates would have been without the COVID-19 PHE, it is possible that the demonstration is helping to mitigate some of the negative impacts of the PHE on members with SUD diagnoses.

Finally, among interviews of state administrators, plan staff, and providers, no major risks were identified that pose a threat to the state's ability to meet milestone requirements. The one challenge that was raised by multiple interviewees at all levels, and is a known issue within the state, is the difficulty in providing access to the full continuum of care to members living in rural and frontier counties. While DHHS has added capacity and expanded services to date, there continues to be a geographic gap driven in large part by the discordance between the location of Medicaid members and providers. The state continues to work with MCOs and providers to address this challenge, but further work is needed, as acknowledged by all stakeholders. Fortunately, increases in

telehealth and telemedicine, the use of Project Extension for Community Healthcare Outcomes (ECHO) sessions, and mobile crisis units have helped to mitigate this challenge in the short-term.

Next Steps

Currently, there are no areas where the state is at risk of failing to meet the required milestones. The state should continue, however, to work with the MCOs and providers to address the challenge of improving access to care in less densely populated areas of the state.

1. Background

Through Section 1115 of the Social Security Act, states are provided an opportunity to design and test their own methods for providing and funding healthcare services that meet the objectives of the federal Medicaid program and Children's Health Insurance Program (CHIP) but differ from services required by federal statute through Section 1115 Demonstration Waivers. Section 1115 Demonstration Waivers also allow states flexibility in how state healthcare is provided, within federal guidelines. The Centers for Medicare & Medicaid Services (CMS) has designed a national evaluation strategy to compare the approaches used by different states in its Section 1115 Medicaid expansion waivers, requiring that each demonstration meet the program objectives. The Mid-Point Assessment (MPA) is a critical requirement of this evaluation strategy. The purposes of the MPA are to examine the progress toward each demonstration milestone outlined in the implementation plan, to identify any risks to meeting those milestones, and to provide recommendations for improving the demonstration program.

Nebraska's Substance Use Disorder Landscape

The public health crisis caused by the abuse of prescription and illicit opioids has adversely impacted the quality of life of individuals across the United States, including those residing in Nebraska. Based on data collected by the Centers for Disease Control and Prevention (CDC), the drug overdose death rate in Nebraska was 6.9 to 11 per 100,000 people in 2017. [1-1] Additionally, the rate of newborns exhibiting drug withdrawal symptoms per 1,000 hospital births has risen steadily since 2008. Data collected by Substance Abuse Treatment Centers (SATC) in Nebraska identified alcohol and methamphetamines as the most predominantly used substances in 2016.[1-2] The Nebraska Department of Health and Human Services (DHHS) took steps to address the needs of its Medicaid population by integrating physical, behavioral, and substance use treatment services provided to enrollees, as well as launching opioid use disorder (OUD) initiatives. These OUD initiatives have included expanding the availability of medication assisted treatment (MAT), increasing the number of providers allowed to administer MAT, developing the Prescription Drug Monitoring Program (PDMP), providing training and individual mentoring to new MAT providers, creating a pharmacy network to receive unused prescription opioids, and launching public education campaigns.[1-3]

Background of the Nebraska Substance Use Disorder (SUD) Program

On January 1, 2017, the Nebraska DHHS launched the Heritage Health managed care program to integrate physical health, behavioral health, and pharmacy services for Medicaid enrollees. As part of this program, Nebraska DHHS sought to continue using facilities that qualify as Institutions for Mental Diseases (IMDs) to provide residential SUD treatment services to enrollees ages 21–64 and include IMD stays in the development of capitation payment rates. The Medicaid and CHIP Managed Care Final Rule, implemented by CMS on July 5, 2016, limits capitated payments to IMD stays of 15 or fewer days for residential SUD treatment. Nebraska DHHS

1-1 Centers for Disease Control and Prevention. 2017 Drug Overdose Death Rates. Available at: https://www.cdc.gov/drugoverdose/deaths/2017.html. Accessed on Mar. 30, 2022.

1-2 Nebraska Department of Health and Human Services. State Initial Application. Available at: ne-sud-demo-pa.pdf (medicaid.gov). Accessed on Mar. 30, 2022.

1-3 Nebraska Department of Health and Human Services. Nebraska Coalition to Prevent Opioid Abuse. Available at: Strategic Initiatives Update 2020.pdf (nebraska.gov). Accessed on Mar. 30, 2022.

submitted a Section 1115 SUD Demonstration Waiver on November 27, 2018, to gain the authority to continue making capitated payments for SUD treatment services received at IMDs, regardless of the length of stay.

On June 28, 2019, Nebraska DHHS received CMS' approval to implement the SUD Program from July 1, 2019, through June 30, 2024.[1-4] The SUD program authorizes the State to provide high-quality, clinically appropriate treatment to Medicaid enrollees ages 21–64 primarily diagnosed with OUD and/or other SUDs at IMDs. Additionally, the SUD program enables the State to implement models focused on increasing community- and home-based support for beneficiaries and improve access to SUD evidence-based services based on the American Society of Addiction Medicine (ASAM) criteria.

Goals of the Nebraska SUD Program

The SUD program demonstration describes six goals established by Nebraska DHHS for the program:

1. Increased rates of identification, initiation, and engagement in treatment for SUD
2. Increased adherence to and retention in treatment
3. Reductions in overdose deaths, particularly those due to opioids
4. Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services
5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate
6. Improved access to care for physical health conditions among beneficiaries with SUD

Importantly, effective on October 1, 2020, DHHS expanded Medicaid eligibility to individuals ages 19–64 whose income is at or below 138 percent of the Federal poverty level through its Heritage Health Adult (HHA) expansion program. As of December 2021, more than 55,000 newly-eligible Nebraska residents had enrolled in HHA.[1-5] In September 2020, Nebraska Heritage Health enrollment was 257,589 and increased to 341,985 as of December 2021.[1-6] The timing of the HHA expansion occurred 15 months after the approved implementation date of the Section 1115 SUD Demonstration Waiver, and coincided with the addition of medically monitored inpatient withdrawal (MMIW) and opioid treatment program (OTP) in addition to expanding the 21–64 population targeted by the Section 1115 SUD Demonstration Waiver. Therefore, the impact of these elements of the HHA expansion must be taken into consideration in assessing the Section 1115 SUD Demonstration Waiver, as they were expected to increase the number of Medicaid members, members with SUD diagnoses, and members accessing SUD services.

[1-4] Centers for Medicare and Medicaid Services. Initial Approval. Available at: ne-sud-demo-initial-appvl-20190628.pdf (medicaid.gov). Accessed on Feb. 25, 2022.

[1-5] Nebraska Department of Health and Human Services. Nebraska Medicaid Annual Report State Fiscal Year 2021. December 2021. Available at: https://nebraskalegislature.gov/FloorDocs/107/PDF/Agencies/Health_and_Human_Services__Department_of/107_20211130-091110.pdf. Accessed on June 6, 2022.

[1-6] Nebraska Department of Health and Human Services. Heritage Health Public Dashboard Data. Available at: https://dhhs.ne.gov/Documents/HeritageHealthDashData.pdf. Accessed on June 6, 2022.

Implementation Plan Overview

The SUD program implementation plan, developed by Nebraska DHHS and approved by CMS on July 9, 2019, outlines the strategic approach for meeting the program milestones.

Overview of Milestones

The Nebraska SUD Program demonstration aims to achieve six key milestones:

- **Milestone 1**: Access to critical levels of care for OUD and other SUDs
- **Milestone 2**: Widespread use of evidence-based, SUD-specific patient placement criteria
- **Milestone 3**: Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications
- **Milestone 4**: Sufficient provider capacity at each level of care, including medication assisted treatment (MAT)
- **Milestone 5**: Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD
- **Milestone 6**: Improved care coordination and transitions between levels of care

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

Nebraska DHHS' demonstration waiver was planned to provide coverage for Medicaid members in need of SUD treatment services including outpatient; intensive outpatient services; medication-assisted treatment (medications as well as counseling and other services with sufficient provider capacity to meet the needs of Medicaid beneficiaries in the state); intensive levels of care in residential and inpatient settings; and medically supervised withdrawal management.

Many of these services were already required in the Nebraska Medicaid program, and DHHS planned to continue to monitor contracted managed care organizations (MCOs) for compliance with the existing contract requirements regarding covered services to ensure the full SUD continuum of care is available to members, as well as new services created by proposed changes to the Nebraska Medicaid State Plan and MCO contracts. Nebraska DHHS planned to submit a State Plan Amendment to request the authority to cover medically monitored intensive inpatient withdrawal management for adults at ASAM level 3.7-WM in order to meet the service coverage requirements of Milestone 1. To further align the State's SUD service continuum with CMS' objectives for this program and in recognition of the requirements of Section 1006 of the Support Act,[1-7] Nebraska DHHS also planned to submit a State Plan Amendment to request the authority to cover methadone for MAT. The timeframe for the completion of actions under this milestone was 12 to 24 months following the demonstration approval by CMS.

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

Nebraska DHHS' demonstration waiver was planned to ensure that providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools, or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines; and to require contracted MCOs to have a utilization management

[1-7] 115th United States Congress. SUPPORT for Patients and Communities Act, Section 1006. Available at: https://www.congress.gov/bill/115thcongress/house-bill/6/text#toc-H54D9809005834B7FAEC1764B725A2970. Accessed on Feb. 24, 2022.

approach such that: a) beneficiaries have access to SUD treatment services at the appropriate level of care; b) interventions are appropriate for the diagnosis and level of care; and c) there is an independent process for reviewing placement in residential treatment settings.

Nebraska DHHS recognized that while each of the MCOs had utilization management policies and procedures that might meet this milestone, not all aspects of this milestone are explicitly stated within the contract. Nebraska DHHS therefore planned to update contract language to include a requirement that assessment tools used when authorizing or reviewing inpatient stays be based on evidence-based clinical treatment guidelines in order to ensure that requirements of all service definitions are met. Under the updated contract language, utilization management policies and procedures for each of the contracted MCOs need to specifically address how the requirements of the service definitions are met. Additionally, Nebraska DHHS' strategy included updating the contract language to require that a concurrent review of care provided to members receiving inpatient residential SUD treatment include an evaluation of each case against established criteria such as national clinical guidelines. Nebraska DHHS also proposed including SUD treatment specific requirements in the existing annual audit tool used to review all contracted MCOs' compliance with this new contract language. The timeframe for the completion of actions under Milestone 2 was 12 to 24 months after CMS' approval of the demonstration.

Milestone 3: Use of Nationally Recognized, Evidence-based SUD Program Standards to Set Residential Treatment Provider Qualifications

Nebraska DHHS' demonstration waiver sought to ensure that SUD residential treatment provider qualifications met program standards for evidence-based SUD treatment, including licensing and credentialing standards. To reach that goal, Nebraska DHHS recognized the need to promote a shift in perspective among residential treatment providers from the predominant abstinence-based care models to evidence-based treatment, integrating facilitation of MAT into their programmatic requirements and utilization. DHHS updated contract language to require residential providers to expand their treatment methods by either offering MAT onsite or facilitating access to MAT off-site. This requirement continues to be built into applicable service definitions and rates reviewed based on these updates. The implementation plan acknowledged that this shift in perspective would require extensive outreach and additional education opportunities for providers.

Nebraska DHHS also planned to update contract language to require the MCOs to develop training materials for the Mental Health and Substance Use (MHSU) Treatment Centers to support this perspective shift. These educational initiatives, which were addressed to providers, would seek to reduce stereotyping associated with MAT, and include state and federal guidance associated with MAT as well as materials developed by the Substance Abuse and Mental Health Services Administration (SAMHSA).

Additionally, Nebraska DHHS planned to update contract language to require that MCO reviews of residential treatment providers were updated to ensure that the revised standards regarding service type and expectations, hours of care, and staffing requirements discussed in Milestone 2 are met as part of their current or proposed utilization management procedures. Nebraska DHHS continues to monitor contracted MCOs for their compliance with the existing contract requirements regarding licensure and certification to ensure providers meet standards for SUD provider qualifications. The timeframe for the completion of actions under Milestone 3 was 12 to 24 months after CMS' approval of the demonstration.

Milestone 4: Sufficient Provider Capacity at each Level of Care, including Medication Assisted Treatment (MAT)

To evaluate the availability and capacity of providers throughout the state to enroll in Medicaid and accept patients at the critical levels of care covered by the demonstration waiver, Nebraska DHHS planned to implement new reporting requirements focused on SUD provider capacity for critical ASAM levels of care, including the

number of participating providers accepting new patients by level of care and those that offer MAT. It also mandated that MCOs address improving access to SUD treatment services in their annual network development plans.

Nebraska DHHS required MCOs to increase the use of telehealth as needed to expand their networks' ability to provide needed SUD treatment. Nebraska DHHS has been proactive in recognizing state-level telehealth barriers and worked to expand the availability and utilization of telehealth for physical and behavioral health services. On January 1, 2017, Nebraska DHHS implemented new telehealth regulations that expanded Medicaid covered telehealth services to include billing for telemonitoring and the originating site fee. With this recent regulatory service expansion, Nebraska DHHS believes that the state has laid a policy foundation for increased utilization of telehealth services including tele-SUD. The implementation plan anticipated that actions for Milestone 4 would be completed in the first 12 months of the demonstration.

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

Nebraska DHHS continues to work with internal and external partners to enhance the various existing programing and initiatives to ensure that they evolve as the opioid crisis evolves in Nebraska. One of the longest running initiatives is Nebraska's PDMP. Established in 2011, the PDMP is aimed at preventing the misuse of prescribed controlled substances through monitoring the care of those prescribed controlled substances and reporting all prescription instances. Additionally, Nebraska supports the Drug Utilization Review (DUR) program through the Nebraska Pharmacists Association. In January 2019, the DUR Board implemented a limit on the total daily doses of opioids. The daily limit of opioid doses began at 300 morphine milligram equivalents (MME), and by June 2021 had been further reduced to 90 MME per day. Nebraska DHHS continues to work with MCOs to ensure that policies surrounding opioid prescribing limits and guidelines are being adhered to.

Nebraska DHHS released the Nebraska Pain Management Guidance Document in October 2017. This document serves as a comprehensive resource for prescribers on opioid prescriptions seeking to be compliant with national standards. The guidance aligns with published CDC guidelines as well as best practices. Additionally, Nebraska has recognized the importance of the use of naloxone for overdose reversal. State legislation, such as Neb. Rev. Stat. §28-470, the *Nebraska Naloxone Standing Order*, widely expanded access to naloxone to promote its timely use in overdose situations. The standing order allowed naloxone to be prescribed to those with an OUD who may experience an opioid-related overdose, as well as those who are likely to be in a position to assist in an overdose, such as a first responder or family member. There are no specific action items under Milestone 5, therefore, there is no estimated time frame of completion as the improvement of these programs is ongoing. However, the Division of Medicaid and Long Term Care (MLTC) has developed and published provider resources on opioid prescribing guidelines including a slide deck that was released on April 28, 2022, to support Milestone 5.

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

Nebraska DHHS' demonstration aimed to increase the implementation of policies to ensure residential and inpatient facilities link beneficiaries, especially those with OUD, with community-based services and supports following stays in these facilities, and to improve coordination of care for co-occurring physical and mental health conditions.

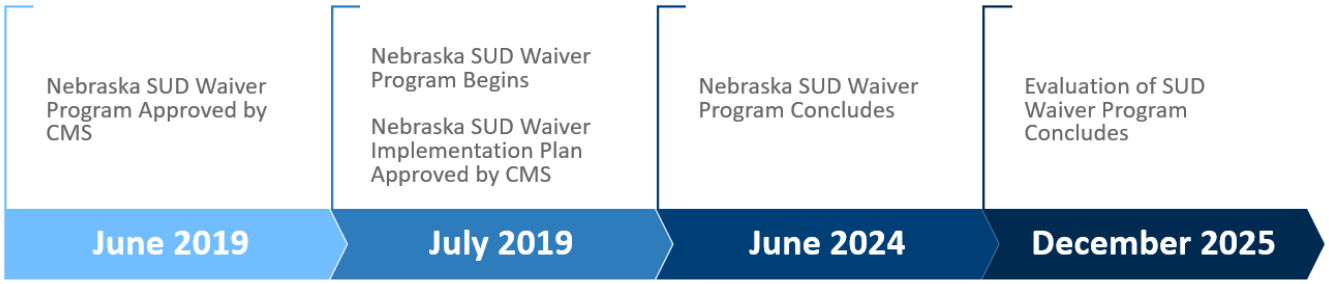
Nebraska DHHS continues to monitor contracted MCOs for compliance with the existing care management contract requirements in order to ensure members' health care issues are being monitored appropriately. Prior to the demonstration, MCO contract requirements did not provide detailed standards for linking beneficiaries, especially those with OUD, with community-based services and supports following inpatient stays in treatment facilities. Over the first 24 months following the demonstration approval, Nebraska DHHS planned to update

contract language to create clear expectations for member follow-up, including specific timeframes for care management contact post discharge from an inpatient stay related to an SUD. These requirements would be incorporated into the existing annual audit tool used to review all contracted MCOs compliance. The implementation plan anticipated that actions for Milestone 6 would be completed in the first 12 to 24 months of the demonstration.

Timeline of the Nebraska SUD Program

The Nebraska Section 1115 SUD Demonstration Waiver was approved in June of 2019 and is anticipated to continue through December of 2025 when the summative evaluation report is submitted to CMS. Figure 1-1 displays a timeline of the major events of the demonstration.

Figure 1-1—Nebraska Substance Use Disorder Program Timeline of Key Demonstration Events



Impacts of the COVID-19 PHE on the Demonstration

Due to the coronavirus disease (COVID-19) public health emergency (PHE), Nebraska's SUD demonstration experienced delays implementing some of the action items outlined in the implementation plan. Of particular significance, the roll outs of service delivery for the OTPs and MMIW were delayed from an anticipated start on October 1, 2020, to June 1, 2021. In addition to the delayed implementation of these demonstration components, DHHS reported delays in updating MCO contract language to:

- Reflect the specific requirement for utilization management and level of care assessments
- Require provider education regarding the requirements to facilitate MAT
- Require reviews of residential treatment providers to ensure the types of services, hours of clinical care, and credentials for staff for residential treatment settings are performed according to ASAM criteria
- Reflect specific requirements for care management follow-up after SUD treatment discharge

While the COVID-19 PHE has caused delays in the implementation of these specific action items, the state is making distinct progress toward the completion of these items and anticipates a completion date of January 1, 2023. The agency reported they are in the process of reviewing specific language components as part of a larger effort to reconcile and combine SUD and behavioral health service definitions and regulations in the state. DHHS also reported having conducted current state analyses across three different areas while progressing toward completion of the delayed action items. First, DHHS reviewed MCO policies, procedures, and contract language detailing guidance on program standards in the ASAM criteria. Second, the agency reviewed the current state Nebraska DHHS Public Health (DPH) standards regarding MLTC provider screening and enrollment compliance standards and MCO processes for auditing providers to ensure compliance with these standards. Third, DHHS performed an analysis of the current MCO best practices for care and treatment coordination, identifying a widespread model for providing whole person care (WPC), and the role of Integrated Health and Social Services

(IHSS) in care transitions as well as best practices for linking beneficiaries in residential facilities to community-based services and supports. Based on these actions and the ongoing efforts to meet the milestones, the delays caused by the COVID-19 PHE have not prevented the state from continuing significant progress toward meeting the milestones.

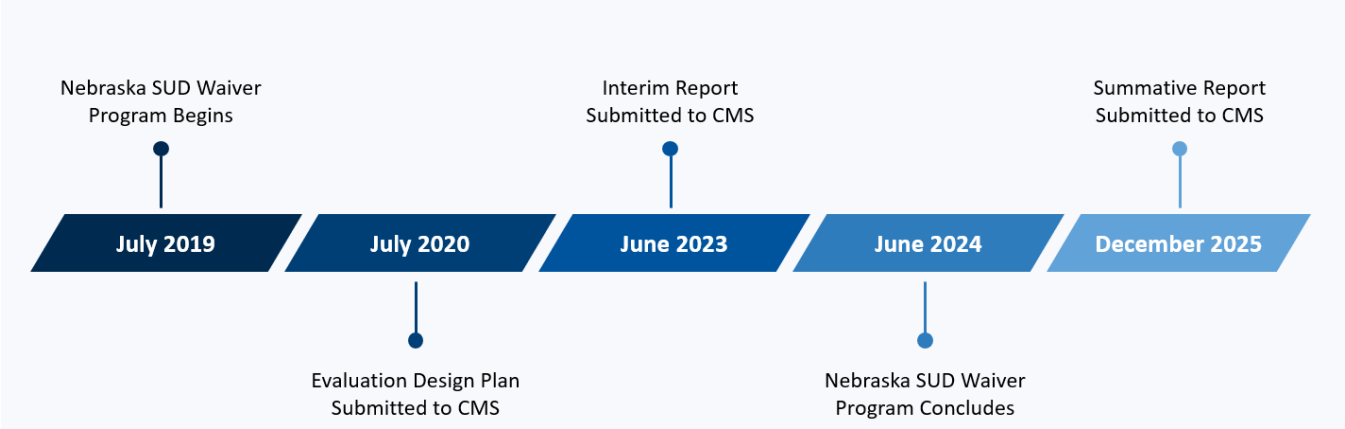
Monitoring Protocol

The monitoring protocol developed by Nebraska DHHS and approved by CMS on November 16, 2020, outlines the State's plan to monitor the demonstration's progress towards meeting the six key milestones. The monitoring protocol lays out 36 CMS-provided metrics and three state-defined health information technology (HIT) metrics, 26 of which are tracked and reported on by the State in quarterly and annual monitoring reports. These reports include the metric trends, updates on the implementation, updates on the evaluation work, and notable achievements. Thus far the State has submitted five State Quarterly Monitoring Reports and one Annual Monitoring Report, describing its progress in Demonstration Year 1.

Evaluation Activities

Health Services Advisory Group, Inc. (HSAG), as the independent evaluator, will conduct a comprehensive evaluation of the Section 1115 SUD Demonstration Waiver, providing the State and CMS a thorough, independent evaluation of the demonstration to estimate the impacts of the program. Figure 1-2 illustrates the timeline of the evaluation activities.

Figure 1-2—Evaluation Activities Timeline



Evaluation Design

The evaluation design outlines how the State has planned to conduct the demonstration evaluation. The evaluation design presents the goals of the demonstration along with the evaluation questions, hypotheses, and methodologies that will be utilized to determine the extent to which the demonstration has achieved its stated goals.

Interim Evaluation Report

The interim evaluation report will discuss the evaluation progress and findings for the completed years of the Section 1115 SUD Demonstration Waiver, complying with the requirements outlined in the Special Terms and Conditions (STCs). The report will include a general background of the demonstration, the goals of the demonstration, and the hypotheses and evaluation questions the demonstration addresses. It will describe the methodology used, including the data sources utilized, the analytic methods, and the methodological limitations of the demonstration. Finally, the interim evaluation report will present interpretations of the analyses, discussion of implications, and recommendations to the State for the remainder of the demonstration period. Importantly, the interim evaluation report will also include the first financial analysis of budget neutrality for the Section 1115 SUD Demonstration Waiver. The interim evaluation report will be submitted to CMS by June 30, 2023.[1-8]

Summative Evaluation Report

The summative evaluation report will follow the same structure as the interim evaluation report, covering the entire demonstration period from July 1, 2019 through June 30, 2024. The summative evaluation report will be submitted to CMS by December 31, 2025.[1-9]

[1-8] Centers for Medicare and Medicaid Services. Special Terms and Conditions Nebraska Substance Use Disorder 11-W-10024/7. Available at: ne-sud-demo-appvd-sud-eval-dsgn-20200828.pdf (medicaid.gov). Accessed on Feb. 24, 2022.

[1-9] Centers for Medicare and Medicaid Services. Evaluation Design Approval. Available at: ne-sud-demo-appvd-sud-eval-dsgn-20200828.pdf (medicaid.gov). Accessed on Mar. 31, 2022.

2. Methodology

The following section describes the data sources and methodologies used to conduct the Nebraska Substance Use Disorder (SUD) Program Mid-Point Assessment (MPA). Approaches include qualitative and quantitative analyses assessing the achievement and progress towards meeting the milestones and assessing the risk of the Demonstration Waiver not meeting milestones, as defined in the Special Terms and Conditions (STCs).

Data Sources

Administrative Claims and Encounter Data

The Nebraska Department of Health and Human Services (DHHS) provided administrative claims and encounter data for the period from January 1, 2016 through September 30, 2021 for use in the evaluation of the SUD Demonstration Waiver and MPA. The claims and encounter data included member enrollment and eligibility files; member demographics; provider files; provider specialty reference data; and institutional, professional, and pharmacy claims data. The administrative claims and encounter data were used to calculate monitoring metrics defined in the Centers for Medicare & Medicaid Services (CMS) technical specifications for Medicaid Section 1115 SUD Demonstrations[2-1], as well as measures defined by the state to establish the availability of SUD providers within the state.

SAMHSA Data

Health Services Advisory Group, Inc. (HSAG) obtained data from the Substance Abuse and Mental Health Services Administration (SAMHSA) on SUD providers delivering medication assisted treatment (MAT) services through the buprenorphine practitioner locator.[2-2, 2-3] HSAG linked the SAMHSA data on MAT service providers in Nebraska to provider enrollment data supplied by DHHS to narrow the list to Medicaid-contracted providers, and used the resulting list of Medicaid-contracted MAT service providers in the calculation of Monitoring Metric 14 *SUD Provider Availability – MAT*.

2-1 Medicaid Section 1115 Substance Use Disorder Demonstrations: Technical Specifications for Monitoring Metrics, Version 4.0. September 2021. Centers for Medicare and Medicaid Services. An overview of the monitoring metrics for Section 1115 Demonstration Waivers is available at https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/sud-monitoring-metrics.pdf, Accessed on Apr. 14, 2022. In the overview document, readers are directed to contact the CMS 1115 monitoring and evaluation email. (1115MonitoringAndEvaluation@cms.hhs.gov) to receive the technical specifications manual.

2-2 Substance Abuse and Mental Health Services Administration. Behavioral Health Treatment Services Locator. Available at: https://www.samhsa.gov/medication-assisted-treatment/find-treatment/treatment-practitioner-locator. Accessed on Apr. 4, 2022.

2-3 Substance Abuse and Mental Health Services Administration. Practitioner and Program Data. Accessed at: https://www.samhsa.gov/medication-assisted-treatment/practitioner-resources/DATA-program-data. Accessed on Apr. 4, 2022.

Qualitative Data

Semi-structured Interviews

HSAG conducted semi-structured interviews with state administrators, providers, managed care organization staff, beneficiary representatives, and other non-provider stakeholders involved in the provision of care to Nebraska Medicaid beneficiaries as part of the SUD Demonstration Waiver. The interviews collected data on perceptions and experiences during the early stages of the SUD Demonstration Waiver regarding:

- Experiences with access, care coordination and transitions, and quality of care for SUD treatment recipients.
- Perceptions of barriers and drivers of success associated with the implementation of the SUD demonstration.
- Unintended consequences encountered during the implementation of the SUD demonstration.
- Impacts of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) on the implementation of the SUD demonstration.

To engage the key informant interviewees, HSAG worked with DHHS to identify a list of providers who have experience delivering services under the SUD demonstration. HSAG recruited interviewees by geographic region, location within each region (e.g., urban versus rural providers), and relevant specialty. After stratifying the provider lists, HSAG sampled providers to maximize variation in provider types and locations so that the data obtained from the interviews represents an informative sample of perspectives from a diverse group of stakeholders. In September 2021, outreach was sent to all identified stakeholders via email and interviews were scheduled accordingly. The interviews were conducted virtually starting in October 2021 through February of 2022. Interviews lasted for approximately 60 minutes to allow time for all participants to voice their detailed perspectives and experiences. The interviews were recorded and transcribed with the permission of the participants to highlight key themes while maintaining the anonymity of participants.

SUD Program Implementation Plan Milestone Progress Report

HSAG requested data from DHHS about their progress to date on each implementation milestone defined in the demonstration STCs. The request for information was stratified by milestone and action item defined in the demonstration implementation plan. DHHS provided a status for each action item as completed, partially-completed, or delayed; and described actions that had been taken to date, as well as the timelines for completion. These data were used to describe the progress on implementation plan action items.

Analytic Methods

Monitoring Metrics

HSAG examined progress toward meeting the demonstration milestones by calculating monitoring metrics specified in the approved monitoring protocol based on appropriate data provided by Nebraska DHHS. In keeping with the evaluation design plan for the Section 1115 SUD Demonstration Waiver and the STCs, HSAG calculated the monitoring metrics for the population of adult Medicaid beneficiaries aged 19 – 64. For metrics described as reporting the number of services/numerator-only in CMS SUD monitoring metric technical specifications, HSAG calculated rates based on the number of beneficiaries with an SUD diagnosis (Monitoring Metric 3 *Medicaid Beneficiaries with SUD Diagnosis* [monthly]). This was to control for any changes in the size of the SUD population over time, which if uncontrolled, could introduce bias in reported numerators and give an inaccurate assessment of the trends.

Multiple Baseline Methodology

HSAG utilized two baseline periods to assess pre-intervention trends. This was necessary in order to address effects of the COVID-19 PHE on both the implementation of the SUD Demonstration Waiver services and its effect on the SUD metrics and rates themselves. The implementation of the demonstration was delayed until approximately June 2021. As shown in Table 2-1 and Table 2-2, the first baseline period *generally* assesses metrics prior to the onset of the COVID-19 PHE. The second baseline period is the twelve months immediately preceding implementation of the demonstration, which were impacted by the COVID-19 PHE, as well as by the Medicaid expansion through the Heritage Health Adult (HHA) program which began October 1, 2020, impacting seven out of the twelve months in this period. Consequently, the change in rates between the two baseline periods largely represents the combination of impacts on measured outcomes from the PHE, HHA expansion, and other structural trends external to the demonstration. The change in rates between the second baseline period (i.e., pre-COVID-19 PHE) and the post-intervention period represents observed differences following implementation. Note, this pre/post analysis does not allow for causal conclusions—that is, the changes in rates between these time periods cannot be necessarily attributed to the demonstration.

Table 2-1—Baseline Periods Utilized in Analysis of Monthly Metrics

Evaluation Period	Calendar Dates	Duration
Pre-Intervention/Pre-COVID-19 PHE	June 1, 2019 – May 31, 2020	12 months
Pre-Intervention/COVID-19 PHE	June 1, 2020 – May 31, 2021	12 months
Post-Intervention	June 1, 2021 – September 30, 2021	4 months

Table 2-2—Baseline Periods Utilized in Analysis of Annual Metrics

Evaluation Period	Calendar Dates	Duration
Pre-Intervention/Pre-COVID-19 PHE	June 1, 2019 – May 31, 2020	12 months
Pre-Intervention/COVID-19 PHE	June 1, 2020 – May 31, 2021	12 months
Post-Intervention	October 1, 2020 – September 30, 2021	12 months

The alignment of baseline rates with the dates described above does not completely remove the impact of the COVID-19 PHE from the earliest baseline time period. The last quarter of that period is likely to exhibit substantial differences in rates associated with disruptions that occurred early in the COVID-19 PHE. To mitigate this concern, HSAG performed a robustness check by removing the peak PHE months of March, April, and May 2020 from the first baseline period for metrics calculated monthly. The results were not materially different after excluding these months. For all but three monitoring metrics, the absolute change in pre-COVID-19 baseline period from removing the months of March, April, and May 2020 was 0.03 percentage points or less. *Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries* exhibited the largest impact from excluding the peak COVID-19 PHE months, reducing the rate from 6.63 to 6.55 per 1,000 (a 1.2 percent decline). In contrast, *Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries* increased when excluding the peak COVID-19 PHE months, as would be expected, from 3.69 to 3.72 per 1,000 (a 0.8 percent increase). Finally, the *Total Number of Telehealth/Telemedicine Visits With an SUD Diagnosis* decreased dramatically with the exclusion of the peak COVID-19 PHE months in the pre-COVID-19 PHE baseline period, dropping from 741 to 61 (a 91.8 percent decline). This dramatic change is the result of telehealth rarely being used for SUD treatment services prior to the COVID-19 PHE. The remaining measures exhibited negligible changes. The remainder of the analysis will focus on results based on the complete set of data, including the peak COVID-19 PHE months.

Analytic Methodology

The trend regression models utilized in the analysis fit a simple linear trend to the monthly data points to estimate the direction of change in performance measure rates. The results are not attributed to program impacts and are only used to assess whether rates are moving in the desired direction.

The general form of the linear regression model is seen in Equation 1:

$$y_t = \beta_0 + \beta_1(Time) + \varepsilon_t$$

Where y_t is the outcome rate in time period *t*, β_0 represents the measure rate at the beginning of the series, conditional on the linear trend, β_1 represents the average change per unit of *Time* (month), *Time* is a linear counter of time periods through the end of the post-intervention period, starting with zero in the first observation, and ε_t is the model residual in time period *t*. In Equation 1, β_1 is the key coefficient that indicates if performance measure rates are changing in an upward or downward direction. Two regression models were run for each monthly metric: one covering all three time periods and another model excluding the pre-COVID-19 PHE baseline period.

For monitoring metrics that could only be calculated on an annual basis, a regression trend model was not fit to the data because of the small number of available data points. Instead, the absolute percentage point and relative percentage changes were calculated between the June 2019 through May 2020 baseline and the October 2020 through September 2021 performance period. The results of these changes were assessed to determine whether the metrics were changing in directions expected given the demonstration.

Assessment of Nebraska SUD Program Demonstration Milestones

The Demonstration Waiver is implemented in phases, with each milestone having distinct intermediate action items and timeframes for completing each action. To assess the progress of the implementation of the waiver, analyses are grouped by milestone, intermediate actions within each milestone, and timeframes for targeted completion of each milestone. An assessment of whether each milestone or intermediate action is completed on schedule was obtained from Nebraska DHHS and includes perceptions from key informant interviews with various key stakeholders, the protocol for which is located in Appendix B. Results are synthesized as the percentage of milestones completed by the specified target date. If accurate quantitative data are available for each of these implementation actions, HSAG has presented results for multiple points in time to provide a sense of the implementation trajectory. If any implementation actions were not completed by the specified date due to the COVID-19 PHE or other reasons, HSAG assessed whether the activities are underway and readjusted the analysis plan accordingly.

HSAG assessed progress towards the following milestones as outlined in the CMS-approved SUD evaluation design:

- Access to Critical Levels of Care for Opioid Use Disorder (OUD) and other SUDs
- Use of Evidence-based, SUD-specific Patient Placement Criteria
- Use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities
- Sufficient provider capacity at critical levels of care including for medication assisted treatment for OUD
- Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD
- Improved care coordination and transitions between levels of care

The timeframes for each milestone and intermediate action in the evaluation design were utilized when assessing progress towards each milestone in relation to the targeted completion date.

Assessment of Overall Risk

The level of risk (e.g., high risk, medium risk, or low risk) of not meeting each milestone was assessed for each type of analysis (implementation, quantitative, and qualitative). The determination of the level of risk was dependent on the type of analysis conducted. Table 2-3 outlines how the level of risk was determined for each type of analysis.

Table 2-3—Considerations for the Assessment of The Level of Risk of Not Meeting Milestones

Risk Level	Considerations for Assessing the Level of Risk
Low	**Implementation plan action items.** State fully completed most/all (75 percent or more) associated action items as scheduled. **Monitoring metrics.** State is moving in the expected direction relative to its annual goals and overall demonstration targets for all or nearly all (75 percent or more) of the associated monitoring metrics. **Stakeholder feedback.** No stakeholder identified risks related to meeting milestone.
Medium	**Implementation plan action items.** State fully completes some (25–75 percent) of the associated action items as scheduled. **Monitoring metrics.** State is moving in the expected direction relative to its annual goals and overall demonstration targets for many (25–75 percent) of the associated monitoring metrics. **Stakeholder feedback.** Few stakeholders identified risks related to meeting milestone.
High	**Implementation plan action items.** State fully completed few or none (25 percent or less) associated action items as scheduled. **Monitoring metrics.** State is moving in the expected direction relative to its annual goals and overall demonstration targets for few (25 percent or less) of the associated monitoring metrics. **Stakeholder feedback.** Many stakeholders identified risks related to meeting milestone.

Limitations

One primary limitation to the results presented in this report is the inability to draw causal inferences. That is, this assessment did not attempt to isolate the impact of the demonstration on measured outcomes. Two other competing factors are likely to have an as-of-yet undetermined impact on monitoring metric rates during the period from June 1, 2019 and September 30, 2021. First, the COVID-19 PHE began in March 2020. Analyses of measure rates during the pre-COVID-19 PHE baseline period suggest that excluding the COVID-19 PHE months from that baseline does not produce more than minimal changes in the monitoring metric rates. The PHE, however, could have longer-term impacts that extend into the COVID-19 PHE baseline period from June 1, 2020 through May 31, 2021 and into the post-intervention period from June 1, 2021 forward. Second, Medicaid expansion through the HHA program occurred on October 1, 2020, and coincided with notable changes in monitoring metrics rates. The purpose of this MPA is not to disentangle the specific contributions of each of these factors to the monitoring metric trends. Forthcoming interim and summative evaluation reports will seek to establish a causal link between the implementation of the demonstration and changes in outcomes, controlling for these other possible impacts.

A second limitation to the analysis is that the two different baseline periods described do not perfectly align with the onset of the COVID-19 PHE. Rather, the first baseline period includes approximately three months that were impacted by the spread of COVID-19 throughout the world. While the pre-COVID-19 PHE baseline period may have been contaminated in part by the PHE, the impact of the PHE on the monitoring metric rates should have been more extensive during the June 2020 through May 2021 baseline period which was entirely impacted by the

PHE. The purpose of the multiple baselines remains an informative perspective to take with the data for considering the impact that the COVID-19 PHE may have had on monitoring metric rates.

A third limitation is the use of monitoring metrics requiring annual performance periods for their calculation. Specifically, because of the delayed implementation of the opioid treatment program (OTP) and medically monitored inpatient withdrawal (MMIW) services in the demonstration until June 2021, two of the key components of the demonstration were only in effect for the most recent four months of data available for this report. For monitoring metrics calculated on an annual basis, the most recent year of data includes only one-third of the year when these key demonstration components were operational.

3. Findings

Section three of this report presents the findings from the analysis of risk performed for the Mid-Point Assessment (MPA), including the progress toward meeting the demonstration milestones, the assessment of overall risk of not meeting the milestones, and an assessment of the Nebraska Department of Health and Human Services (DHHS) capacity to provide substance use disorder (SUD) treatment services to members.

Progress Towards Demonstration Milestones

Nebraska's Section 1115 SUD Demonstration Waiver uses multiple data sources to assess the progress toward meeting the demonstration milestones. The data sources include quantitative monitoring metrics, descriptions of progress on implementation action plan items, stakeholder input, and a provider availability assessment. The findings from the analysis of each of these data sources is presented below, along with important contextual information to aid in interpreting the results with respect to the milestone progress.

Monitoring Metrics

The results of the MPA must be interpreted in the context of the Heritage Health Adult (HHA) expansion implemented on October 1, 2020, which resulted in over 55,000 newly-eligible members enrolling in Medicaid in the following 15 months. A review of the DHHS-submitted monitoring metric reports indicated that several metrics exhibited substantial jumps in numerator counts that coincided with HHA expansion. The number of *Medicaid Beneficiaries With SUD Diagnosis* increased from 5,907 and 6,038 in August and September 2020 to 7,105 and 7,710 in October and November 2020, a 17.7 percent increase from September to October. A greater increase was observed in the number of Medicaid beneficiaries receiving *Any SUD Treatment*, from 1,468 and 1,540 in August and September 2020 to 2,543 and 2,594 in October and November 2020, a 65.1 percent increase between September and October. Similar increases between September and October 2020 were observed for several additional monitoring metrics reported by DHHS, including:

- *Intensive Outpatient and Partial Hospitalization Services* (50.9 percent increase)
- *Residential and Inpatient Services* (125.0 percent increase)
- *Withdrawal Management* (218.8 percent increase)
- *Medication-Assisted Treatment* (24.3 percent increase)

While many of the metrics specified in the Centers for Medicare & Medicaid Services (CMS) Technical Specifications are defined as counts of members or events (e.g., treatments, diagnoses, or other services), the usefulness of comparing changes in counts over time is limited if the underlying number of beneficiaries, events, or treatments is not constant. For example, the substantial increases in the number of events observed for these measures coincides with HHA expansion and would be expected as a result of a large increase in Medicaid enrollees within the 21–64 age range. For this reason, the Nebraska Section 1115 SUD Demonstration Waiver MPA presents results of the analyses of certain monthly metrics (i.e., metrics 5 through 12) calculated as percentages of the underlying denominator population as defined by Monitoring Metric 3 *Medicaid Beneficiaries With SUD Diagnosis* (monthly). By standardizing the metrics to percentages, any increases or decreases in rates represents a change in standardized performance rather than a function of the change in the underlying population of members or events.

There are, however, two monitoring metrics specified as rates that DHHS reported for which there were substantial increases that coincided with HHA expansion. *Emergency Department Utilization for SUD per 1,000*

Medicaid Beneficiaries increased by 47.9 percent between September and October 2020, from 1.90 to 2.81 per 1,000. During the same time period, *Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries* increased by 39.8 percent, from 1.08 to 1.51 per 1,000. Based on the monitoring metrics observed to date, it is clear that HHA expansion coincided with substantial increases in both numerator events and rates as the population of Medicaid beneficiaries covered by the Section 1115 SUD Demonstration Waiver increased. As the Medicaid expansion population size stabilizes, the monitoring metrics are expected to stabilize at rates representative of the newly-expanded Section 1115 SUD Demonstration Waiver population. The purpose of this MPA, however, is not to determine what portion of changes in the monitoring metrics is due to HHA expansion and what portion is due to the Section 1115 SUD Demonstration Waiver impact. The forthcoming interim evaluation report will address the question of demonstration impacts and attempt to disentangle the impact of HHA expansion in more detail.

Regardless of the causes of changes in the monitoring metrics described to this point, one impact of the Section 1115 SUD Demonstration Waiver is clearly observable. As reported by DHHS, between July 1, 2019 and March 31, 2022, the Section 1115 SUD Demonstration Waiver has covered 1,314 stay in institutions for mental disease (IMDs) over 15 days, which account for 69.4 percent of the total IMD stays reported during that period, and which previously would not have been covered had the Section 1115 SUD Demonstration Waiver not been in place.

Having set the context around the implementation of the Section 1115 SUD Demonstration Waiver overlapping with HHA expansion, the MPA now focuses on results across the critical monitoring metrics, the state's completion of implementation plan action items, stakeholder input, and provider availability. The MPA uses 25 metrics as quantitative evidence of progress. One additional metric, *Medication Adherence for Medication-Assisted Treatment (MAT)* has been specified by the state for future reporting. The metric for *Initiation and Engagement of Alcohol and Other Drug Dependence (AOD) Treatment* includes two components, one for the initiation of treatment, and one for the engagement of treatment. Additionally, the metric for *Follow-up After Emergency Department (ED) Visit* is stratified into two components, one for ED visits for AOD, and one for ED visits for mental illness. Thirteen of these monitoring metrics are calculated on a monthly basis, and 12 are calculated on an annual basis.

Table 3-1 presents results from the analysis of the monitoring metrics. Two sets of baseline rates are presented: the pre-coronavirus disease 2019 (COVID-19) public health emergency (PHE) baseline period represents the period from June 2019 through May 2020, and the post-COVID-19 PHE baseline period represents the period from June 2020 through May 2021. The rate at midpoint reflects the performance of monitoring metrics during the period after the expansion of services to include opioid treatment programs (OTPs) and medically monitored inpatient withdrawal (MMIW) between June 2021 and September 2021. The Demonstration Target is the desired direction of change based on the Section 1115 SUD Demonstration Waiver logic model and hypotheses, regardless of the actual changes observed in each metric. Table 3-1 presents average rates during each study period and results from the trending analysis (applicable to monthly metrics only), stratified by whether the baseline represented the 2019 pre-COVID-19 PHE baseline or the 2020 post-COVID-19 PHE baseline. Changes in the desired direction are indicated with a checkmark, while changes that go against the desired direction are indicated with an 'X'. Table 3-2 presents the absolute and relative percentage changes for all metrics, including those measured annually.

Table 3-1—Monitoring Metric Rates and Trends

#	Metric Name	Monitoring Metric Rate, Count, or Average			Demonstration Target	Direction at Mid-Point (Pre-COVID Baseline)	Direction at Mid-Point (Post-COVID Baseline)
		Pre-COVID Baseline	Post-COVID Baseline	At Mid-Point			
3	Medicaid Beneficiaries With SUD Diagnosis (monthly)	6.6%	7.1%	8.8%	Increase	✓	✓
4	Medicaid Beneficiaries With SUD Diagnosis (annually)	9.1%	10.3%	11.0%	Increase	–	–
5	Medicaid Beneficiaries Treated in an IMD for SUD (per 1,000 SUD Beneficiaries)	4.3	7.9	9.7	Increase	–	–
6	Any SUD Treatment (per 1,000 SUD Beneficiaries)	17.8	24.7	27.3	Increase	✓	✓
7	Early Intervention (per 1,000 SUD Beneficiaries)	0.0	0.0	0.0	Increase	✓	✓
8	Outpatient Services (per 1,000 SUD Beneficiaries)	8.7	14.6	17.0	Increase	✓	✓
9	Intensive Outpatient and Partial Hospitalization Services (per 1,000 SUD Beneficiaries)	0.4	0.7	1.0	Decrease	✗	✗
10	Residential and Inpatient Services (per 1,000 SUD Beneficiaries)	1.4	2.5	2.8	Increase	✓	✓
11	Withdrawal Management (per 1,000 SUD Beneficiaries)	0.5	1.0	1.2	Increase	✓	✓
12	Medication Assisted Treatment (per 1,000 SUD Beneficiaries)	4.5	5.3	5.7	Increase	✓	✓
13	SUD Provider Availability	4,328	4,803	4,884	Increase	–	–
14	SUD Provider Availability – MAT[1]	-	-	102	Increase	–	–
15(a)	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD) – Initiation[a]	42.8%	39.4%	39.5%	Increase	–	–
15(b)	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD) – Engagement[a]	5.4%	8.3%	7.9%	Increase	–	–

#	Metric Name	Monitoring Metric Rate, Count, or Average			Demonstration Target	Direction at Mid-Point (Pre-COVID Baseline)	Direction at Mid-Point (Post-COVID Baseline)
		Pre-COVID Baseline	Post-COVID Baseline	At Mid-Point			
17(1)	Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD): 7-day[a]	6.9%	12.1%	14.5%	Increase	–	–
17(1)	Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD): 30-day[a]	11.1%	19.1%	22.5%	Increase	–	–
17(2)	Follow-up After Emergency Department Visit for Mental Illness (FUM-AD): 7-day[a]	39.0%	29.5%	27.9%	Increase	–	–
17(2)	Follow-up After Emergency Department Visit for Mental Illness (FUM-AD): 30-day[a]	59.6%	48.2%	45.7%	Increase	–	–
18	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)	6.6%	4.4%	3.2%	Decrease	–	–
21	Concurrent Use of Opioids and Benzodiazepines (COB-AD)	23.3%	23.0%	20.9%	Decrease	–	–
22	Continuity of Pharmacotherapy for Opioid Use Disorder	25.7%	29.6%	26.1%	Increase	–	–
23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	6.6	9.1	9.6	Decrease	✗	✗
24	Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries	3.7	4.3	4.0	Decrease	✗	✓
25	Readmissions Among Beneficiaries With SUD	25.6%	24.8%	22.9%	Decrease	–	–
32	Access to Preventative/Ambulatory Health Services for Adult Medicaid Beneficiaries With SUD	95.1%	94.7%	93.3%	Increase	–	–
36	Average Length of Stay in IMDs	11.0	11.1	11.3	Decrease	–	–

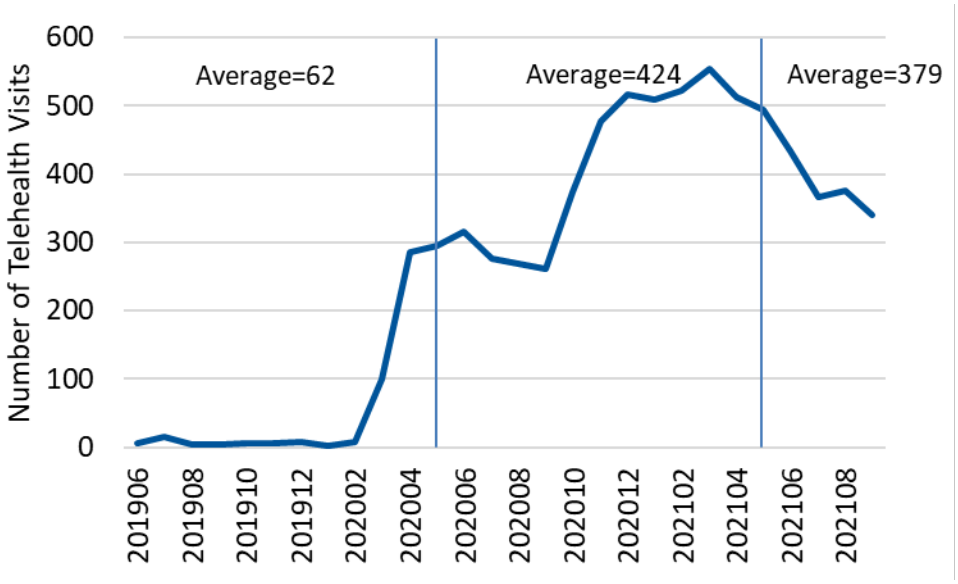
#	Metric Name	Monitoring Metric Rate, Count, or Average			Demonstration Target	Direction at Mid-Point (Pre-COVID Baseline)	Direction at Mid-Point (Post-COVID Baseline)
		Pre-COVID Baseline	Post-COVID Baseline	At Mid-Point			
Q1	Medication Adherence for MAT	–	–	–	Increase	–	–
Q2	Pharmacy Encounters System Improvements[b]	–	99.38%	–	Increase	–	–
Q3	Total Number of Telehealth/Telemedicine Visits With an SUD Diagnosis (monthly average)[c]	62	424	379	Increase	✓	✓

Note: Annual measures were not assessed for trending and are denoted by "–". Metrics 3 through 12 are reported as a percentage of total SUD Medicaid population (aged 19 through 64). This is to control for a changing population size in the reported counts for each metric.
[1]Source: Substance Abuse and Mental Health Services Administration (SAMHSA) Buprenorphine practitioner locator list matched with DHHS provider data.
[a] *Measures IET-AD, FUA-AD, FUM-AD, and AAP [Metrics 15, 17(1), 17(2), and 32] are Healthcare Effectiveness Data and Information Set (HEDIS®) measures that are owned and copyrighted by the National Committee for Quality Assurance (NCQA). HEDIS measures and specifications are not clinical guidelines, do not establish a standard of medical care and have not been tested for all potential applications. The measures and specifications are provided "as is" without warranty of any kind. NCQA makes no representations, warranties, or endorsements about the quality of any product, test or protocol identified as numerator compliant or otherwise identified as meeting the requirements of a HEDIS measure or specification. NCQA makes no representations, warranties, or endorsement about the quality of any organization or clinician who uses or reports performance measures and NCQA has no liability to anyone who relies on HEDIS measures or specifications or data reflective of performance under such measures and specifications. The measure specification methodology used by CMS is different from NCQA's methodology. NCQA has not validated the adjusted measure specifications but has granted CMS permission to adjust. A calculated measure result (a "rate") from a HEDIS measure that has not been certified via NCQA's Measure Certification Program, and is based on adjusted HEDIS specifications, may not be called a "HEDIS rate" until it is audited and designated reportable by an NCQA-Certified HEDIS Compliance Auditor. Until such time, such measure rates shall be designated or referred to as "Adjusted, Uncertified, Unaudited HEDIS rates."*
[b] The pharmacy encounter system improvement measure (Q2) was initially reported for Q2 2020 in the Quarterly Monitoring Report for November and December 2020. Both months exhibited rates over 99 percent, with a small increase from November to December.
[c] The total number of telehealth visits is reported as a monthly average here because the sum of telehealth visits is influenced by the number of months reported during each time period. Because the post-intervention period only includes four months the sum of telehealth visits is artificially smaller than the pre-intervention/COVID-19 PHE baseline period. Examination of the monthly average number of telehealth visits allows for appropriate comparisons. While the average monthly number of telehealth visits at mid-point is lower than for the Post-COVID-19 PHE Baseline, the trending results reported in the Direction at Mid-Point column represent the results from a trend regression fit to the monthly data, which indicate an increasing trend.

Of the monitoring metrics with monthly data and for which a trend analysis was performed, metrics 3, 6, 7, 8, 10, 11, 12, and Q3 are expected to increase as a result of the demonstration. All eight of these measures have increased in the performance period relative to baseline rates. These results hold across comparisons of the mid-point rates to either the pre-COVID-19 PHE or post-COVID-19 PHE baseline periods. These results indicate that there have been increases in the identification of Nebraska *Medicaid Beneficiaries With SUD Diagnosis*, as well as increases in the provision of *Early Intervention* for SUD, *Any SUD Treatment*, and *Outpatient Services* for SUD treatment. Furthermore, the results indicate increases in the use of *Residential and Inpatient Services* for SUD treatment, as well as in the use of *Withdrawal Management* and *Medication-Assisted Treatment*. Finally, these results indicate a substantial increase in the use of telehealth visits for members with an SUD diagnosis. The result in Table 3-1 for the *Total Number of Telehealth/Telemedicine Visits With an SUD Diagnosis* is reported using a monthly average to make the two baseline and mid-point data values comparable. While the results show that the average monthly count in the post-COVID-19 PHE baseline period is 424 and the average monthly count in the post-intervention period at mid-point is 379—an apparent reduction in telehealth utilization—the results of the trend analysis indicate an upward trend. A comparison of the same four months in the post-COVID-19 PHE

baseline period and the post-intervention period at mid-point (i.e., June through September of 2020 and 2021, respectively) shows that the average monthly number of telehealth visits in 2020 was 281, while in 2021 this increased to 379. The higher average monthly count of telehealth visits across the entirety of the post-COVID-19 PHE as compared to the post-intervention mid-point is due to an increase in utilization from 261 visits in September 2020 to 555 visits in March 2021, remaining approximately at or above 500 visits per month between December 2020 and May 2021 as shown in Figure 3-1.

Figure 3-1—Monthly Telehealth Visits for Medicaid Beneficiaries with an SUD Diagnosis



In contrast to the increases in the identification of members with SUD and the use of early interventions, SUD treatments, outpatient services, and telehealth, Monitoring Metrics 9, 23, and 24 are expected to decrease as a result of the demonstration. All three of these measures have increased, however, between the baseline and performance period. These results also hold across comparisons of the mid-point rates to either the pre-COVID-19 PHE or post-COVID-19 PHE baseline periods, except for metric 24 which decreased in the expected direction between the post-COVID-19 PHE baseline period and the post-intervention period. For the metrics 9 and 23, the largest increases in rates were between the pre-COVID-19 PHE and post-COVID-19 PHE periods. These results indicate that *Intensive Outpatient and Partial Hospitalization Services*, *Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries*, and *Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries* rose during the initial implementation of the demonstration, rather than declining. While these changes are not in the expected direction targeted by the demonstration, these results may reflect the initial expansion and growth of service utilization, and may also reflect increases in negative outcomes for individuals with SUD in response to the ongoing COVID-19 PHE.

Table 3-2 presents the results from the analysis of absolute and relative changes between the first and last data point for each metric. For annual measures, the analysis compared the pre-COVID-19 PHE baseline rates between June 2019 and May 2020 to the performance period rates between October 2020 and September 2021, the latest data available for inclusion in the report. Given the time frame of the performance period, there is a substantial degree of overlap with the post-COVID-19 PHE baseline: from October 2020 through May 2021, or eight months. Because of this overlap, the MPA does not compare the post-COVID-19 PHE baseline rates to the mid-point performance rates for annual metrics. For monthly metrics, the absolute and relative differences between the pre-COVID-19 PHE and post-COVID-19 PHE baselines and the mid-point performance period were calculated

using the first data point available in each of the baseline periods (i.e., June 2019 or June 2020), and the last data point available in the mid-point performance period (i.e., September 2021).

Table 3-2—Absolute and Relative Differences for All Monitoring Metrics

#	Metric Name	Monitoring Metric Rate or Count			Pre-COVID Baseline to Mid-Point		Post-COVID Baseline to Mid-Point	
		Pre-COVID Baseline	Post-COVID Baseline	At Mid-Point	Absolute Difference	Relative Difference	Absolute Difference	Relative Difference
3	Medicaid Beneficiaries With SUD Diagnosis (monthly)	6.5%	6.6%	9.0%	2.4pp	37.6%	2.3pp	35.2%
4	Medicaid Beneficiaries With SUD Diagnosis (annually)	9.1%	10.3%	11.0%	1.9pp	21.3%	–	–
5	Medicaid Beneficiaries Treated in an IMD for SUD (per 1,000 SUD Beneficiaries)	4.3	–	9.7	5.5pp	128.2%	–	–
6	Any SUD Treatment (per 1,000 SUD Beneficiaries)	17.2	17.8	25.5	8.3pp	48.2%	7.7pp	43.3%
7	Early Intervention (per 1,000 SUD Beneficiaries)	0.0	0.0	0.0	0.0pp	0.0%	0.0pp	-100.0%
8	Outpatient Services (per 1,000 SUD Beneficiaries)	8.5	8.0	16.1	7.6pp	90.0%	8.1pp	101.0%
9	Intensive Outpatient and Partial Hospitalization Services (per 1,000 SUD Beneficiaries)	0.3	0.4	0.8	0.5pp	158.1%	0.4pp	106.0%
10	Residential and Inpatient Services (per 1,000 SUD Beneficiaries)	1.3	1.2	2.3	1.0pp	78.5%	1.2pp	102.1%
11	Withdrawal Management (per 1,000 SUD Beneficiaries)	0.3	0.5	1.1	0.8pp	254.7%	0.6pp	126.9%

#	Metric Name	Monitoring Metric Rate or Count			Pre-COVID Baseline to Mid-Point		Post-COVID Baseline to Mid-Point	
		Pre-COVID Baseline	Post-COVID Baseline	At Mid-Point	Absolute Difference	Relative Difference	Absolute Difference	Relative Difference
12	Medication Assisted Treatment (per 1,000 SUD Beneficiaries)	4.0	4.9	5.7	1.7pp	43.0%	0.9pp	17.8%
13	SUD Provider Availability	4,328	4,803	4,884	556	12.8%	–	–
14	SUD Provider Availability – MAT[1]	–	–	102	–	–	–	–
15(a)	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD): Initiation[a]	42.8%	39.4%	39.5%	-3.4pp	-7.8%	–	–
15(b)	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-AD): Engagement[a]	5.4%	8.3%	7.9%	2.6pp	47.7%	–	–
17(1)	Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD): 7-day[a]	6.9%	12.1%	14.5%	7.6pp	110.7%	–	–
17(1)	Follow-up After Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD): 30-day[a]	11.1%	19.1%	22.5%	11.4pp	103.0%	–	–
17(2)	Follow-up After Emergency Department Visit for Mental Illness (FUM-AD): 7-day[a]	39.0%	29.5%	27.9%	-11.2pp	-28.6%	–	–

#	Metric Name	Monitoring Metric Rate or Count			Pre-COVID Baseline to Mid-Point		Post-COVID Baseline to Mid-Point	
		Pre-COVID Baseline	Post-COVID Baseline	At Mid-Point	Absolute Difference	Relative Difference	Absolute Difference	Relative Difference
17(2)	Follow-up After Emergency Department Visit for Mental Illness (FUM-AD): 30-day[a]	59.6%	48.2%	45.7%	-13.9pp	-23.4%	–	–
18	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)	6.6%	4.4%	3.2%	-3.4pp	-51.1%	–	–
21	Concurrent Use of Opioids and Benzodiazepines (COB-AD)	23.3%	23.0%	20.9%	-2.4pp	-10.4%	–	–
22	Continuity of Pharmacotherapy for Opioid Use Disorder	25.7%	29.6%	26.1%	0.4pp	1.4%	–	–
23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	6.4	7.2	8.3	1.9	29.9%	1.1	15.9%
24	Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries	3.3	3.6	3.4	0.0	1.5%	-0.3	-7.0%
25	Readmissions Among Beneficiaries With SUD	25.6%	24.8%	22.9%	-2.7pp	-10.5%	–	–
32	Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries With SUD (AAP)	95.1%	94.7%	93.3%	-1.8pp	-1.9%	–	–
36	Average Length of Stay in IMDs	11.0	11.1	11.3	0.3	2.6%	–	–
Q1	Medication Adherence for MAT	–	–	–	–	–	–	–

#	Metric Name	Monitoring Metric Rate or Count			Pre-COVID Baseline to Mid-Point		Post-COVID Baseline to Mid-Point	
		Pre-COVID Baseline	Post-COVID Baseline	At Mid-Point	Absolute Difference	Relative Difference	Absolute Difference	Relative Difference
Q2	Pharmacy Encounters System Improvements[b]	–	99.38%	–	–	–	–	–
Q3	Total Number of Telehealth/Telemedicine Visits With an SUD Diagnosis	6	316	340	334	5,566.7%	24	7.6%

Note: Annual measures were not assessed for trending and are denoted by "–". Metrics 3 through 12 are reported as a percentage of total SUD Medicaid population (aged 19 through 64). This is to control for a changing population size in the reported counts for each metric. pp=percentage point.

[1]Source: SAMHSA Buprenorphine practitioner locator list matched with DHHS provider data.

[a] *Measures IET-AD, FUA-AD, FUM-AD, and AAP [Metrics 15, 17(1), 17(2), and 32] are Healthcare Effectiveness Data and Information Set (HEDIS®) measures that are owned and copyrighted by the National Committee for Quality Assurance (NCQA). HEDIS measures and specifications are not clinical guidelines, do not establish a standard of medical care and have not been tested for all potential applications. The measures and specifications are provided "as is" without warranty of any kind. NCQA makes no representations, warranties, or endorsements about the quality of any product, test or protocol identified as numerator compliant or otherwise identified as meeting the requirements of a HEDIS measure or specification. NCQA makes no representations, warranties, or endorsement about the quality of any organization or clinician who uses or reports performance measures and NCQA has no liability to anyone who relies on HEDIS measures or specifications or data reflective of performance under such measures and specifications. The measure specification methodology used by CMS is different from NCQA's methodology. NCQA has not validated the adjusted measure specifications but has granted CMS permission to adjust. A calculated measure result (a "rate") from a HEDIS measure that has not been certified via NCQA's Measure Certification Program, and is based on adjusted HEDIS specifications, may not be called a "HEDIS rate" until it is audited and designated reportable by an NCQA-Certified HEDIS Compliance Auditor. Until such time, such measure rates shall be designated or referred to as "Adjusted, Uncertified, Unaudited HEDIS rates."*

[b] The pharmacy encounter system improvement measure (Q2) was initially reported for Q2 2020 in the Quarterly Monitoring Report for November and December 2020. Both months exhibited rates over 99 percent, with a small increase from November to December.

Only four indicators where an increase was desired were trending in the opposite direction. Those measures were the *Initiation and Engagement of AOD Treatment – Initiation* (-3.4 percentage points), *Follow-up After ED Visits for Mental Illness* within both seven days and 30 days after discharge (-11.2 and -13.9 percentage points, respectively), and *Access to Preventive/Ambulatory Health Services for Adult Medicaid Beneficiaries With SUD* (-1.8 percentage points).

Among the 19 measures where an increase was targeted, the average relative change in measure rates was 341 percent between the pre-COVID-19 PHE baseline and the mid-point performance period; however, the dramatic increase in telehealth visits with an SUD diagnosis (5,566.7 percent) is a clear, but not unexpected, outlier. The significant shift to using telehealth visits between 2019 and 2020 to cope with the COVID-19 PHE was observed throughout the healthcare industry on a national basis. Excluding the increase in telehealth visits, the average relative change between the pre-COVID-19 PHE baseline and mid-point period was a 50 percent increase. The average relative percent change in monitoring metric rates where an increase was expected between the post-COVID-19 PHE baseline and mid-point performance period was 37 percent, including the increase in telehealth,

which exhibited a more modest increase between the post-COVID-19 PHE baseline period and the mid-point performance period.[3-1]

Three out of seven indicators in which a decrease was targeted were trending in a downward direction. The four metrics where a decrease was targeted but not realized included *Intensive Outpatient and Partial Hospitalization Services* (increase of 0.5 per 1,000 SUD beneficiaries), *Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries* (increase of 1.9 per 1,000), *Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries* (increase of 0.05 per 1,000) and the *Average Length of Stay in IMDs* (increase of 0.3 days). Among all measures where a decrease was targeted (i.e., measures 9, 18, 21, 23, 24, 25, and 36), the average relative change in measure rates was a 17.2 percent increase between the pre-COVID-19 PHE baseline and the mid-point performance period. Among these metrics, the relative increase in *Intensive Outpatient and Partial Hospitalization services* (158.1 percent) stands as an outlier change, but masks the very small absolute change of 0.5 per 1,000 SUD beneficiaries. This measure is close to zero in all periods, causing small changes to appear disproportionately large. Excluding this measure, the average relative change between the pre-COVID-19 PHE baseline and the mid-point performance period was -6.3 percent. The average relative percent change in monitoring metrics rates where a decease was expected between the post-COVID-19 PHE baseline and mid-point performance period could only be calculated for three metrics, *Intensive Outpatient and Partial Hospitalization Services*, *Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries*, and *Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries*, and was 38.3 percent. Again, the *Intensive Outpatient and Partial Hospitalization Services* metric increased by 106 percent relative to the post-COVID-19 PHE baseline period, and is influenced by the rate being very close to zero in all periods.

Monitoring Metrics and Implementation Plan Action Item Results by Milestone

The result from analysis of the monitoring metrics is one element in the assessment of risk and progress for the Nebraska Medicaid Section 1115 SUD Demonstration Waiver. Specifically, the monitoring metrics provide indications of whether key measures anticipated to be impacted by the demonstration are changing in directions anticipated by the demonstration logic model. In addition to the monitoring metrics, elements of the implementation action plan must also exhibit progress to provide the mechanisms linking the Section 1115 SUD Demonstration Waiver to the monitoring metrics it is intended to impact. The CMS Special Terms and Conditions (STCs) for the demonstration outline six milestones the state is expected to meet in a timely manner, defined as occurring within 12 to 24 months after the demonstration approval. While the COVID-19 PHE has delayed some elements of the demonstration action items, DHHS is actively pursuing the completion of the implementation plan action items. This section of the MPA combines a brief summary of the monitoring metric results by milestone with the progress made to date in executing items from the implementation action plan for each milestone of the Section 1115 SUD Demonstration Waiver.

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

Monitoring Metrics

Examining the results for each milestone, the percentage of measures moving in the target direction for the demonstration is promising. The measures aligned with Milestone 1 include 6, 7, 8, 9, 10, 11, 12, and 22. Among these eight measures, seven (87.5 percent) are moving in the targeted direction. While the absolute percentage

[3-1] Annual metrics were excluded from this comparison due to the overlap between the post-COVID-19 PHE baseline and mid-point performance period.

point changes are generally less than one percentage point, because the metric rates are small in the baseline periods, there have been larger relative changes, averaging 84.2 percent.

Implementation Plan Action Items

The criteria for Milestone 1 include providing coverage for the following settings:

- Outpatient services
- Intensive outpatient services
- Medication-assisted treatment (i.e., medications as well as counseling and other services with sufficient provider capacity to meet the needs of Medicaid beneficiaries in the state)
- Intensive levels of care in residential and inpatient settings
- Medically supervised withdrawal management

To facilitate meeting the criteria for Milestone 1, two action items were defined in the CMS-approved DHHS implementation plan:

1. Submit a State Plan Amendment to request authority to cover medically monitored intensive inpatient withdrawal management for adults at American Society of Addiction Medicine (ASAM) level 3.7-WM.
2. Submit a State Plan Amendment to request authority to cover methadone for MAT.

The time frame to complete both of these actions was within 12 to 24 months after demonstration approval by CMS on June 28, 2019. Both of these actions were completed on November 30, 2020, approximately 17 months after receiving approval.[3-2, 3-3, 3-4] Based on the completion of these actions, DHHS' criteria for Milestone 1 have been met.

Milestone 2: Widespread Use of Evidence-Based, SUD-Specific Patient Placement Criteria

Monitoring Metrics

There are two monitoring metrics aligned with Milestone 2, providing for widespread use of evidence-based, SUD-specific patient placement criteria: *Medicaid Beneficiaries Treated in an IMD for SUD*, and the *Average Length of Stay in IMDs*. *Medicaid Beneficiaries Treated in an IMD for SUD* increased, as expected during the performance period, nearly doubling from 0.4 percent in the pre-COVID-19 PHE baseline to 1.0 percent in the mid-point period. The *Average Length of Stay in IMDs* was expected to decrease in the long term, however, during the initial period of performance it has increased instead by 2.6 percent since baseline, or approximately one-third of a day. For Milestone 2, 50 percent of the monitoring metrics indicate movement in the expected direction.

3-2 Nebraska Department of Health and Human Services. State Plan Amendment for Medically Monitored Inpatient Withdrawal Management. Available at: Attachment 4.19b Item 28 - Rehabilitation Substance Use Disorder Services; MMIW.pdf (ne.gov). Accessed Apr. 4, 2022.

3-3 Nebraska Department of Health and Human Services. State Plan Amendment for Medication-Assisted Treatment Attachment 4. Available at: Supplement to Attachment 3.1 A 1905(a)(29) Medication-Assisted Treatment (MAT) (ne.gov). Accessed on Apr. 4, 2022.

3-4 Nebraska Department of Health and Human Services. State Plan Amendment for Medication-Assisted Treatment Supplement 5 to Attachment 3. Available at: Supplement to Attachment 3.1 B 1905(a)(29) Medication-Assisted Treatment (MAT) (ne.gov). Accessed on Apr. 4, 2022.

Implementation Plan Action Items

The criteria for Milestone 2 require providers assessing treatment needs based on SUD-specific, multi-dimensional assessment tools, or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines. Additionally, the criteria require that contracted managed care organizations (MCOs) have a utilization management approach such that:

1. Beneficiaries have access to SUD services at the appropriate level of care;
2. Interventions are appropriate for the diagnosis and level of care; and
3. There is an independent process for reviewing the placement in residential treatment settings.

The CMS-approved implementation plan described updating contract language to reflect the specific requirements listed above. The time frame for this action items was 12 to 24 months after demonstration approval.

Because of the COVID-19 PHE, updating contract language was delayed by DHHS as priorities shifted to address the urgent healthcare needs associated with the PHE. DHHS has, however, developed explicit components pertaining to this milestone as part of a larger scope of work combining SUD and behavioral health (BH) service definitions and regulations. DHHS anticipates completing this action item by January 1, 2023.

Administrative staff across DHHS, both in the Division of Medicaid and Long-Term Care (MLTC) and the Division of Behavioral Health (DBH) indicated during interviews that public policies across both divisions have been undergoing efforts to reconcile the regulatory environment and ensure that the care being provided by the state is consistent and appropriate, whether being covered under Medicaid expenditure authority or state behavioral health regions under the authority of DBH. State staff also described ongoing efforts to identify and resolve regulatory and coverage differences, with the understanding that there are different historical contexts and divisional perspectives among providers that need to be addressed and harmonized. Because the state understands these issues and is actively working to create systemic improvements, there is no clear evidence indicating the state is at-risk of not completing this action item. The delays created by the COVID-19 PHE do not stand as a permanent impediment to meeting the criteria for Milestone 2.

Milestone 3: Use of Nationally Recognized, evidence-Based, SUD-specific Program Standards for Residential Treatment Facility Provider Qualifications

Monitoring Metrics

There are no specific monitoring metrics associated with Milestone 3 in the Section 1115 SUD Demonstration Waiver Implementation Plan.

Implementation Plan Action Items

The criteria for Milestone 3 include the implementation of residential treatment provider qualifications in licensure requirements, program authorities, policy manuals, managed care contracts, and other guidance. The qualifications are required to meet the ASAM criteria, or other nationally recognized, evidence-based SUD-specific program standards regarding particular types of services, hours of clinical care, and credentials of staff for residential treatment settings. Additionally, the criteria for Milestone 3 require implementation of a state process for reviewing residential treatment providers to ensure compliance with these standards. The CMS-approved implementation plan included an action item to update contract language requiring provider education pertaining to the benefits of MAT as a complementary treatment and providing MAT either on or off site. The timeframe for this action items was 12 to 24 months after demonstration approval.

Because of the COVID-19 PHE, the execution of this action item was delayed by DHHS as priorities shifted to address healthcare needs during the pandemic; however, as of this MPA the action items have been partially completed. DHHS identified the following areas where state is supporting SUD-specific program standards for residential treatment facility providers:

- Nebraska residential levels of care are required to accept all forms of Food and Drug Administration (FDA) approved MAT.
- DHHS expanded the availability of MAT by authorizing mid-level nurse practitioners and physician assistants to dispense medications used to treat opioid use disorder (OUD).
- In such cases where distance would be prohibitive for the residential provider to obtain a take-home medication every two weeks (e.g., for MAT), if the member is in agreement, the provider may refer the member to an alternate nearby facility that can provide guest dosing.
- Project Extension for Community Healthcare Outcomes (ECHO) engages a range of provider environments and professionals – from the prescribers to social service staff, to licensed alcohol and drug abuse counselors, to clinic administrators and beyond. Addiction and pain management experts deliver education and case review for providers statewide, increasing access to individuals in rural and frontier counties within the state.

In addition to these activities, the state is reviewing explicit components of ASAM criteria and as part of a broader effort to combine SUD and behavioral health service definitions and regulations. DHHS anticipates completing this action item by January 1, 2023. DHHS is developing appropriate provider/MCO engagement materials and communications plans to ensure the requirement of MAT access is communicated and can be successfully met.

While the demonstration has yet to address all components of the Milestone 3 criteria around licensure requirements, program authorities, and policy manuals, the state has adopted the ASAM criteria as the evidence-based, nationally recognized SUD-specific program standards. During qualitative interviews, with state administrators and provider, there was widespread agreement that the ASAM criteria are the gold-standards for appropriate treatment. Currently DHHS, and other administrators in the state are working toward clarifying the licensure requirements associated with the ASAM criteria across providers and other stakeholders, and implementing a system to ensure appropriate review of compliance with the ASAM criteria.

Based on the progress described by DHHS on meeting these criteria, and the policies and procedures already in place, the demonstration is positioned to meet the required criteria with contract language updates associated with combining SUD and behavioral health service definitions and regulations by January 1, 2023.

Milestone 4: Sufficient Provider Capacity at Each Level of Care, Including MAT

Monitoring Metrics

Two metrics are associated with Milestone 4: *SUD Provider Availability*, and *SUD Provider Availability – MAT*. *SUD Provider Availability* increased by 12.8 percent as expected from the pre-COVID-19 PHE baseline period to the performance period at mid-point. The monitoring metric for *SUD Provider Availability – MAT* could only be calculated for the mid-point period due to the availability of data on MAT providers. At the mid-point, there were 102 SUD providers delivering MAT. Future evaluation reports will examine updated data for this metric to establish trends. For the one monitoring metric where a change could be calculated, the rate changed in the expected direction.

Implementation Plan Action Items

The criteria for Milestone 4 include an assessment of the availability and capacity of providers throughout the state, enrolled in Medicaid and who accept patients in the Milestone 1 critical levels of care.[3-5] The CMS-approved implementation plan included an action item to add SUD-specific provider capacity reporting requirements which include the number of participating providers accepting new patients by level of care and those that offer MAT. A second action item includes expanding telehealth reporting requirements. The timeframes to meet both action items for Milestone 4 were within 12 months of the demonstration approval.

DHHS has completed both of these action items. On August 15, 2021, DHHS updated provider capacity reporting requirements for SUD providers, and have made those data available to the agency's Health Services, Data & Analytics, and Plan Management teams to use the data on an ongoing basis for planning, quality improvement, and other efforts. Additionally, on December 16, 2021, CMS notified DHHS that the state's substantial increase in the *Total Number of Telehealth/Telemedicine Visits With an SUD Diagnosis* since the first half of the demonstration meets the targeted direction and satisfied the action requirement with respect to the milestone.[3-6]

While the completion of these two action items was delayed by the COVID-19 PHE, DHHS has updated requirements for reporting and are collecting the required data, and has expanded telehealth utilization substantially during the demonstration, in part due to the impacts of the COVID-19 PHE. Therefore, the risk is low that the demonstration does not meet this milestone.

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

Monitoring Metrics

Metrics 18, 21, and 23 are used to assess Milestone 5. Two of the three are decreasing as targeted. *Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries* is the one metric that is increasing. The increase observed in ED utilization, however, may be a partial reflection of increases in SUD as a response to the COVID-19 PHE, rather than a failure on the part of the demonstration. It remains promising that this rate is increasing given there has been at least a 21.3 percent relative increase in the percentage of Medicaid members diagnosed with SUD between the pre-COVID-19 PHE baseline period and the mid-point period.

Implementation Plan Action Items

The criteria for Milestone 5 include:

- The implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse;
- The expansion of coverage and access to naloxone for overdose reversal; and
- The implementation of strategies to increase the utilization and improve functionality of prescription drug monitoring programs. This is accomplished through enhancing health information technology (IT) functionality to support prescription drug monitoring program (PDMP) interoperability and supporting clinicians in their usage of the state's PDMP.

3-5 These include outpatient services, intensive outpatient services, medication-assisted treatment (i.e., medications as well as counseling and other services with sufficient provider capacity to meet the needs of Medicaid beneficiaries in the state), intensive levels of care in residential and inpatient settings, and medically supervised withdrawal management.

3-6 Email communication on December 16, 2021 from Shelby Higgins, Project Officer to Malisa McCown, Medicaid Program Coordinator, Demonstration Waivers.

Nebraska DHHS already has a multi-point approach for the treatment and prevention of SUD. The strategy includes several key elements, including:

- Daily dosage limits[3-7]
- A preferred drug list with prior authorization criteria[3-8]
- Summary of Drug Limitations[3-9]
- A formalized Nebraska Pain Management Guidance document[3-10]
- Statutory protections for health professionals to prescribe, administer or dispense naloxone to individuals likely to experience opioid overdose[3-11]
- A PDMP requiring reporting of all dispensed prescription drugs[3-12]

In addition to the ongoing strategies implemented by the state to treat and prevent opioid abuse and OUD, DHHS MLTC is developing a Prescribing Guidance slide deck outlining all three criteria for Milestone 5. MLTC has also partnered with the Nebraska Medical Association to address opioid prescribing guidelines and disseminated the slide deck publicly on April 28, 2022.[3-13]

Despite the absence of specific action items required to meet the criteria of Milestone 5, the ongoing strategies implemented by DHHS to treat and prevent opioid abuse and OUD target the various aspects of the milestone to create a comprehensive strategy. Based on these findings, there is no substantive concern that the state will not continue to meet the milestone criteria.

Milestone 6: Improved Care Coordination and Transitions Between Levels of Care

Monitoring Metrics

Seven monitoring metrics are used to assess Milestone 6: 15(a), 15(b), 17(1) seven- and 30-day, 17(2) seven- and 30-day, and 25. Four out of seven exhibited changes in the direction targeted by the demonstration. *Initiation and Engagement of AOD Treatment - Initiation* has declined by 7.8 percent relative to the pre-COVID-19 PHE baseline period, which could reflect the higher proportion of *Medicaid Beneficiaries With SUD Diagnosis* since the beginning of the COVID-19 PHE. The rate of *Follow-up After ED Visit for Mental Illness* has also declined by 28.6 percent and 23.4 percent for the seven- and 30-day follow-up periods, respectively, and relative to the pre-COVID-19 PHE baseline period. Again, despite an increase in the number of members diagnosed with an SUD

3-7 Nebraska Department of Health and Human Services. Opioid Limits Recommended by the DUR Board. Available at: https://dhhs.ne.gov/Documents/DUR%20Newsletter%20July%202018.pdf. Accessed on Apr. 4, 2022.

3-8 Nebraska Department of Health and Human Services. Medicaid Preferred Drug List with Prior Authorization Criteria. Available at https://nebraska.fhsc.com/downloads/PDL/NE_PDL-20220401.pdf. Accessed on Apr. 4, 2022.

3-9 Nebraska Department of Health and Human Services. Summary of Drug Limitations. Available at https://nebraska.fhsc.com/Downloads/neclaimlimitations.pdf. Accessed on Apr. 4, 2022.

3-10 Nebraska Department of Health and Human Services. Nebraska Pain Management Guidance Document. Available at https://dhhs.ne.gov/DOP%20document%20library/Pain%20Management%20Pain%20Guidance.pdf. Accessed on Apr. 4, 2022.

3-11 Nebraska Legislature. Nebraska Revised Statute §28-470 Available at: https://nebraskalegislature.gov/laws/statutes.php?statute=28-470 Accessed on Apr. 4, 2022.

3-12 Nebraska Department of Health and Human Services. Drug Overdose Prevention – PDMP Access. Available at: Drug Overdose Prevention-PDMP Access (ne.gov). Accessed on Apr. 4, 2022.

3-13 Nebraska Medicaid Policy on Opioid Prescribing. Available at: https://dhhs.ne.gov/Documents/Nebraska%20Medicaid%20Policy%20on%20Opioid%20Prescribing.pdf. Accessed on June 10, 2022.

during the COVID-19 PHE, there were concomitant restrictions in accessibility and staffing across the healthcare industry in 2021, and it is not surprising that the follow-up rates declined by more than 10 percentage points, indicating challenges in meeting timely follow-up appointments.

Implementation Plan Action Items

The criteria for Milestone 6 include the implementation of policies to ensure residential treatment facilities and inpatient facilities link beneficiaries, and especially those with OUD, with community-based services and supports following facility stays. Additionally, the Milestone 6 criteria include coordination of care for co-occurring physical and mental health conditions. To facilitate meeting the criteria for Milestone 6, one action item defined in the CMS-approved, DHHS implementation plan was to update contract language to reflect specific requirements for care management follow-up after SUD treatment discharge. The timeframe to meet this action item for Milestone 6 is 12 to 24 months after demonstration approval.

As has occurred with other milestones in the demonstration, Milestone 6 was delayed due to the COVID-19 PHE as priorities shifted to address urgent healthcare needs associated with the PHE; however, the action items have been partially completed as of this MPA. DHHS conducted a current state analysis and collected information from the MCOs about current policies and procedures associated with care coordination and transitions between levels of care. The current state analysis identified several relevant practices already established by Nebraska MCOs.

All of the MCOs are engaged in the whole person care (WPC) model of care, wherein members are provided care coordination services and increased access to social services. Additionally, the WPC model used by the MCOs focuses on person-centered strategies, and managing comorbidities, rather than focusing only on the member's primary diagnosis.

One MCO, UnitedHealthcare Community Plan, uses Integrated Health Services Staff (IHSS) in care transitions. The IHSS staff coordinate care for both planned and unplanned transitions of care. The IHSS staff assist members, their legal representatives or designees, and caregivers across settings when any transition occurs. The care manager will notify the integrated care team (ICT), which includes the Primary Care Physician (PCP) of any changes to the member within two business days of the change. The IHSS will communicate with the member about the process for transition for both planned and unplanned transitions of care.

DHHS is also currently performing outreach with the MCOs to identify the value and potential barriers in having residential facilities ensure that beneficiaries are linked to community-based services and supports. Because this is likely to entail a significant administrative burden to update and refine regulations requiring linkage, DHHS is soliciting information about the burden in advance to best accommodate the requirement. Finally, DHHS is inquiring with the MCOs whether they provide care managers training on ASAM for the SUD treatment services provided under the Section 1115 SUD Demonstration Waiver. One MCO, UnitedHealthcare Community Plan confirmed that they are already providing this training.

Despite delays in the implementation of action items toward meeting the criteria of Milestone 6, DHHS is collecting data on the current state of policies among the MCOs for care coordination and is performing outreach to identify potential barriers to ensuring seamless transitions of care. DHHS has yet to define the contract language required to have care management staff follow-up after discharge from treatment for SUD, but is in the process of reviewing potential revisions. Given the current strategy of reconciling and integrating the SUD and behavioral health services regulations and policies, anticipated to be completed by January 1, 2023, and the progress that DHHS is currently making, it is likely that DHHS includes the language for care coordination strategies in the revised regulations and policies. There is a low risk that DHHS will not meet this milestone.

Stakeholder Input

Health Services Advisory Group, Inc. (HSAG) identified several major themes brought up by interviewees across all stakeholder groups, revealing that although their points of view might differ, they shared a common understanding and experience with the waiver. Several of these themes are related to multiple milestones. Overall, the interviews confirmed that the challenges to reaching the program milestones are well known and being addressed by DHHS with stakeholder input. No major risks to the success of the demonstration were identified. The challenges identified by stakeholders are discussed below and related to a handful of major themes.

Interviewees understood that the Section 1115 SUD Demonstration Waiver opened up the possibility of billing Medicaid for SUD and BH services, and that this presented an important opportunity for individuals to access treatment previously not covered by Medicaid, and for providers to develop a means for providing services under the new expenditure authority. The following sections provide a discussion of the major themes that emerged across stakeholder groups.

The COVID-19 Public Health Emergency

There was a common acknowledgement that the COVID-19 PHE presented unexpected challenges to the schedule for implementing Section 1115 SUD Demonstration Waiver services. Stakeholders at all levels described pivoting to deal with the immediate health crisis and prioritizing the immediate health and safety needs of individuals over other concerns. Some providers who had to meet safe space requirements reported reduced treatment capacity. All interviewees discussed negative impacts on their workforce. Providers acknowledged they may have been somewhat slower to develop new services than they would have been absent the PHE, and more cautious about adapting to demand under these circumstances. There was also a general consensus that there will be lingering after-effects of the PHE which will likely include an increased need for SUD and BH services. The COVID-19 PHE response has delayed meeting some of the projected milestones temporarily, as understood and expected by CMS. Stakeholder input, however, indicated the Demonstration Waiver is moving forward and on track to meet its milestones.

Regulatory Definition Issues

Most interviewees were aware that there has been an ongoing process to develop and revise the definitions used in regulations and service categories governing SUD treatment services under the Section 1115 SUD Demonstration Waiver. The definitions of service categories including specifying what services must be covered and the qualifications of the people who must provide them have been major topics of concern for everyone, and DHHS has worked iteratively with the plans to build a common understanding of what is covered. Providers have been challenged by mastering new codes for billing as well as different processes and standards for submitting bills and obtaining authorizations for treatment from multiple plans. They are still learning which services are covered and how they can be billed. All stakeholders are dedicating substantial resources to achieve a common understanding of these definitions, and the situation is improving.

These definitional issues are integral to Milestones 1, 2, and 3, since the definitions drive coverage, treatment options, and professional standards, which in turn drive access and availability of services for members. Although interviewees identified several challenges related to building commonly understood definitions and vocabularies across the stakeholder community, none indicated any issues that are likely to cause further delay in reaching milestones.

Access to SUD and Behavioral Health Services in Rural and Frontier Counties is a Well-known Challenge

Interviewees representing a wide range of stakeholders revealed that, while access to services is greatly encouraged by the expanded coverage of services, rural and frontier areas may not have the population base to attract providers for some services, even if they are covered. These particular challenges are outside the control of DHHS or the MCOs. DHHS, MCO representatives, and providers were aware of this issue, with many commenting that a significant barrier to access to SUD and BH services across the continuum of care was the lack of providers of specific services in particular areas. At the same time, DHHS has been conducting activities designed to build the provider base while exploring other options for improving access such as requiring telehealth where access standards cannot be met or deploying an increased number of mobile crisis units. Similarly, the state has permitted residential facilities to refer residents to other providers for MAT.

Capacity and access are of course interrelated and both impact Milestones 1 through 4. DHHS understands the situation and is taking reasonable actions to improve access. HSAG did not identify any risks to reaching milestones that were not well understood by DHHS and the subject of improvement efforts.

Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse, and OUD

Nebraska DHHS has compiled a comprehensive strategy to address and coordinate opioid use disorder and substance use disorder programs and has implemented and executed that strategy statewide. Interviewees from all stakeholder groups were well aware of the nationwide impact of the opioid epidemic, and several remarked that thus far Nebraska has been spared some of the worst impacts. Alcohol and methamphetamine abuse are far more frequently seen among residents of Nebraska than opiates. While this relative lack of OUD patients is certainly a good thing, the small population has presented a challenge to attracting new providers to offer the services such as intensive medically monitored withdrawal and/or MAT. DHHS is working with the Nebraska Medical Association, its MCOs, and other stakeholders to further clarify prescribing guidance. The implementation of a comprehensive treatment and prevention strategy to address opioid abuse and OUD is the foundation for Milestone 5. Interviewees did not express any concerns that the situation presents an appreciable risk that milestones will not be met.

Improved Coordination of Care and Transitions between Levels of Care

Coordination of care and transitions between levels of care present a challenge recognized by stakeholders across the board. These are being handled primarily at the local level by providers, with varying degrees of success. Warm handoffs between levels of care, particularly as members step down from more restrictive to less restrictive levels of care were perceived as lacking by some providers, despite the clear support of DHHS for person-centered care across the continuum of care, and improved care coordination. Plans reported implementing care management teams and some are working to build bridges with providers. This situation is exacerbated in rural and frontier areas, where providers may be few and far between. Plans may need to build more outreach and better relationships among providers to facilitate coordination of care and DHHS may need to find ways to further provide incentives to plans to have truly coordinated networks. Stakeholders shared a common view of these challenges and acknowledged the need to do more to achieve improved care coordination and transition between levels of care. While the geographic distribution of providers presents a real challenge, the challenge is known and is being addressed by the state in partnership with the MCOs and providers alike. The improvement of care coordination and transitions between levels of care is central to Milestone 6. Stakeholders did not identify a risk that the demonstration will fail to meet the goal of this milestone.

Unintended Consequences

HSAG identified two potential unintended consequences from the implementation of the Section 1115 SUD Demonstration Waiver, as described by the providers interviewed for this MPA. These items are raised in the MPA to provide the opportunity for possible future consideration by DHHS.

Several providers of residential treatment sites observed that the transition from regional funding to Medicaid payment for services has had some unexpected impacts on their traditional treatment models. A key ingredient in supporting the successful recovery from substance abuse is reintroducing residents to their normal lives. This has traditionally been accomplished in part by allowing "passes" for the resident to return home for a limited number of days. If a patient's stay is covered by Medicaid, they can no longer be allowed these opportunities. These passes are not funded by Medicaid although they are a key part of the treatment model for those residents funded by the regional authority or other payers and may be available to other individuals in treatment with Medicaid members. This may feel punitive to Medicaid members.

Another traditional requirement of residential centers impacted by Medicaid is that residents frequently prepare for reentry into the real world by working. Providers have viewed patients' taking responsibility for partial payment of their treatment as helpful to their recovery, providing them a personal stake in treatment. Medicaid funding prohibits providers from charging anything over what Medicaid allows, and patients may also be discouraged from looking for work for fear of losing benefits.

Provider Availability Assessment

Three data sources are available for determining the availability of providers for SUD treatment and prevention: Mental Health Substance Use (MHSU) Facility Roster, the Substance Abuse and Mental Health Services Administration (SAMHSA) behavioral health treatment services locator, and the set of providers identified in the administrative claim/encounter data. All three sources show increases in capacity in terms of numbers of providers and/or bed counts.

At the outset of the demonstration, MLTC did not have a methodology for tracking the number of IMDs and bed capacity of SUD provider facilities. The Division of Public Health (DPH) maintains a monthly Roster of Mental Health and Substance Use Treatment Centers within the state, including providers that are not Medicaid enrolled.[3-14] The DPH MHSU Roster is updated on a monthly basis and provided the foundation for the MLTC MHSU Facility Roster that was implemented in February 2020. At that time, there were 54 facilities identified by MLTC, with a bed count of 1,223. By February of 2022, these numbers had grown to 62 facilities identified by MLTC and 1,358 beds. The change between February 2020 and February 2022 indicates that the number of facilities has grown by eight, a 14.8 percent increase in facilities; and that the number of beds has grown by 135 beds, an 11.0 percent increase in beds.

Between June and July 2021, DHHS also enrolled four OTP providers to provide services to Medicaid members throughout the state. Additionally, there were 25 IMD providers across the state, representing a total of 897 beds, or 66.1 percent of the beds identified in the MHSU Facility Roster. As of February 2022, one MMIW provider was enrolled as well.

[3-14] The Nebraska Roster of Mental Health & Substance Use Treatment Centers maintained by DPH is accessible at: https://dhhs.ne.gov/licensure/Documents/MHSU%20Roster.pdf. Accessed on June 6, 2022.

The *SUD Provider Availability* identified in the claims and encounter data increased from 4,328 in June 2019 to 4,884 in September 2021, representing a 12.8 percent increase. Additionally, the *SUD Providers Availability – MAT* in the SAMHSA provider database was 102 at the time of writing this report.[3-15]

Assessment of Overall Risk of Not Meeting Milestones

The results presented across the monitoring metrics, implementation milestones, stakeholder input, and provider availability were synthesized using the algorithm shown in the Analytic Methods section to determine the overall level of risk of the demonstration not meeting each milestone. Table 3-3 presents the synthesis of risk developed in this MPA report.

Table 3-3—Assessment of the Level of Risk of Not Meeting Milestones

Milestone	Risk Level	Considerations
Milestone 1: Access to Critical Levels of Care for OUD and other SUDs	Low	• Implementation Plan action items complete: 100% • Critical metrics meeting target: 87.5% • Few stakeholders identified risks, and all are being addressed within the planned timeframe • Availability is not yet adequate, largely due to geographic and demographic limitations on the availability of providers at critical levels of care
Milestone 2: Widespread Use of Evidence-Based, SUD-Specific Patient Placement Criteria	Low-Medium	• Implementation Plan action items complete: 50% • Critical metrics meeting target: 50% • Stakeholders identified no risks
Milestone 3: Use of Nationally Recognized, evidence-Based, SUD-specific Program Standards for Residential Treatment Facility Provider Qualifications	Low-Medium	• Implementation Plan action items complete: 50% • Critical metrics meeting Target: NA[a] • Stakeholders identified no risks
Milestone 4: Sufficient Provider Capacity at Each Level of Care, Including MAT	Low	• Implementation Plan action items complete: 100% • Critical metrics meeting Target: 100%[b] • Many stakeholders identified challenges and all are being addressed within the planned timeframe – Availability is not yet adequate, but DHHS and the MCOs are addressing geographic and demographic limitations to the availability of providers at critical levels of care
Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD	Low	• Implementation Plan action items complete: 100% • Critical metrics meeting target: 66.6% • Stakeholders identified no risks
Milestone 6: Improved Care Coordination and Transitions Between Levels of Care	Low-Medium	• Implementation Plan action items complete: 50% • Critical metrics meeting target: 57.1% • Few stakeholders identified issues, and all are being addressed within the planned timeframe

[a] There are no monitoring metrics attached to Milestone 3.
[b] One of the two monitoring metrics, *SUD Provider Availability – MAT*, could only be calculated for the performance period, precluding the assessment of change over time. The remaining monitoring metric, *SUD Provider Availability*, exhibited change in the expected direction between the baseline and performance year.

3-15 Substance Abuse and Mental Health Services Administration. Buprenorphine Practitioner Locator. Available at: https://www.samhsa.gov/medication-assisted-treatment/find-treatment/treatment-practitioner-locator. Accessed on June 6, 2022.

The risk of Nebraska not meeting the requirements of its milestones are either low, or low-to-medium. Assessment of the available data shows that a number of action items have been delayed in part due to the COVID-19 PHE. Additionally, DHHS is engaging in a broader overhaul of its SUD and behavioral health regulations to better align programs, policies, and coverage for Nebraskans across divisions such as DBH, DPH, and MLTC. This larger effort has required working through the complexities extending beyond the scope of the demonstration. DHHS, however, continues to make progress in this area and anticipates completing these processes by January 2023.

In addition to the implementation plan action items, the monitoring metrics for many measures are moving in the targeted direction for the demonstration. Of the five milestones that have monitoring metrics assigned, all have at least half of the metrics moving in the targeted direction. Among those metrics not trending in the targeted direction, it is possible that the ongoing COVID-19 PHE may be contributing to the observed changes. Additionally, examination of the absolute and relative changes among the monitoring metrics indicates that metrics moving in the targeted direction tend to exhibit larger changes than those moving opposite of the targeted direction. While the MPA cannot speak to the counterfactual of what the monitoring metrics rates would be without the COVID-19 PHE, it is possible that the demonstration is helping to mitigate some of the negative impacts of the PHE on members with SUD diagnoses.

Finally, among interviews of state administrators, plan staff, or providers, no major risks were identified that pose a threat to the state's ability to meet with milestone requirements. The one challenge that was raised by multiple interviewees at all levels, and is a known issue within the state, is the difficulty in providing access to the full continuum of care to members living in rural and frontier counties. While DHHS has added capacity and expanded services to date, there continues to be a geographic gap driven in large part by the discordance between the location of Medicaid members and providers. The state continues to work with MCOs and providers to address this challenge, but further work is needed, as acknowledged by all stakeholders. Fortunately, increases in telehealth and telemedicine, the use of Project ECHO sessions, and mobile crisis units have helped to mitigate this challenge in the short-term.

State's Response to Risk Assessment

Nebraska concurs with the assessment conducted by HSAG. The COVID-19 PHE posed several implications for demonstration implementation; however, in terms of rolling out tele-SUD treatment services, the pandemic expedited the rollout and allowed the State to successfully complete Milestone 4. Regarding Milestones 2, 3 and 6, with a risk level of low-medium, the State is confident in the ability to meet these milestones and is actively working towards the completion of implementation plan action items. As the Independent Evaluator indicated, the State is collaborating closely with sister divisions, Departments of Behavioral Health and Public Health, to update regulations and Medicaid service definitions as part of meeting Milestone 2. The initial rounds of monitoring and reporting were impacted by the HHA Expansion in October of 2020, resulting in a noticeable increase in metrics that are beginning to level out to a better representation of the prevalence of SUD in NE Medicaid beneficiaries.

Assessment of State's Capacity to Provide SUD Treatment Services

The Nebraska Medicaid Section 1115 SUD Demonstration Waiver is designed to increase the capacity and comprehensiveness of prevention and treatment services across the state. Additionally, the demonstration is intended to ensure that a full continuum of care, defined by the ASAM criteria, is available for members with an SUD diagnosis, including IMD stays greater than 15 days, MAT, MMIW, and OTP services. To achieve the capacity goals, DHHS and the MCOs serving Nebraska need to do the following:

1. Increase the size of the provider network available for members to access
2. Enroll providers that deliver services previously not covered by Medicaid, including MAT and OTP
3. Ensure that members with SUD diagnoses across the state have the necessary access to care

The results of the MPA analysis indicate that DHHS has increased provider enrollments for Medicaid, including the addition of OTPs and providers delivering MAT. The number of provider facilities grew by approximately 14.8 percent, with an 11.0 percent increase in bed capacity. Additionally, DHHS enrolled four existing OTP providers that has been serving Nebraskans with OUD diagnoses and will now serve the state's Medicaid population.

While the state's capacity to provide SUD treatment services has increased both in the total number of providers and the comprehensiveness of available levels of care following the ASAM guidelines, Nebraska DHHS continues to experience challenges in ensuring complete coverage for members living in all parts of the state. Nebraska's unique geographic population distribution includes large population centers and resources located in the eastern portion of the state around the Omaha and Lincoln metropolitan areas. The remainder of the state is much more sparsely populated, where rural and frontier counties pose significant challenges for members needing to access different levels of care.

The geographic challenge to accessing care is a known issue within the state, among state administrators, health plans, and providers alike. DHHS and the MCOs continue to work on solutions to improve access to care through the use of mobile crisis teams and the implementation of Project ECHO sessions coordinated by the University of Nebraska Medical Center and focusing on both SUD and behavioral health issues. Providers continue to maintain local networks of communication to help residents access available care. Additional work is needed to achieve continued improvement in accessing care across the geographic continuum of the state; however, this is a challenge that all stakeholders continue to work toward improving.

Next Steps

Currently, there are no areas where the state is at significant risk of not meeting the required milestones. The state should continue, however, to work with the MCOs and providers to address the challenge of improving access to care in less densely populated areas of the state.

Appendix A. Independent Assessor Description

The Nebraska Department of Health and Human Services (DHHS) contracted with an independent assessor, Health Services Advisory Group, Inc. (HSAG), to conduct an independent evaluation of the Section 1115 Substance Use Disorder (SUD) Demonstration Waiver including the Mid-Point Assessment (MPA).[A-1] Since 1979, HSAG has provided state and federal government agencies, health plans, and providers assistance in delivering healthcare quality improvement support and evaluation services. HSAG's work has impacted 45 percent of the Medicaid members and 12 percent of Medicare members across the United States. Prior work in Section 1115 SUD Demonstration Waivers has involved large-scale evaluations utilizing advanced qualitative and quantitative techniques for several state Medicaid and federal agencies. HSAG's extensive experience and expertise has proven their capacity and technical ability to conduct the waiver evaluation for the Nebraska SUD demonstration.

HSAG conducted a fair and impartial demonstration evaluation in accordance with the Special Terms and Conditions (STCs) and the Evaluation Design approved by the Centers for Medicare & Medicaid Services (CMS).[A-2] To mitigate any potential conflict of interest within Nebraska DHHS, HSAG assumed sole responsibility for the analysis of data collected for monitoring purposes, benchmarking of demonstration performance to national standards, evaluation of changes over time, interpretation of results, and production of evaluation reports and deliverables. While independently conducting the evaluation and preparing this MPA, HSAG maintained professional independence from Nebraska DHHS while adhering to the CMS-approved evaluation design. Nebraska DHHS has confirmed that HSAG has no conflicts of interest to report and will remain free of interests that would conflict with fulfilling its contractual obligations to Nebraska DHHS for the duration of their involvement in the demonstration evaluation.

A-1 Centers for Medicare & Medicaid Services. State Initial Application. Available at: ne-sud-demo-pa.pdf (medicaid.gov). Accessed on Mar. 15, 2022.

A-2 Centers for Medicare & Medicaid Services. Special Terms and Conditions Nebraska Substance Use Disorder 11-W10024/7. Available at: ne-sud-demo-appvd-sud-eval-dsgn-20200828.pdf (medicaid.gov). Accessed on Mar. 15, 2022.

Appendix B. Data Collection Tools

Interview Protocol

Health Services Advisory Group, Inc. (HSAG) developed a semi-structured interview protocol of open-ended questions to maximize the diversity and depth of subject responses and ensure a complete understanding of the subjects' experience with the substance use disorder (SUD) program demonstration. Prior to the interview, the subjects were provided a copy of the interview protocol. The interviewees were asked for permission to record the interview to aid in the notetaking and accurate record keeping for the development of the Mid-Point Assessment. Over the course of the interview, the interviewer expanded on subjects' responses by asking for additional details to ensure a holistic understanding of their perspectives and critical points, empowering the diverse populations and shareholders to meaningfully share their experience. The interview protocol for both provider interviews and administrator interviews are provided below.

HSAG HEALTH SERVICES ADVISORY GROUP

Introduction

Health Services Advisory Group, Inc. (HSAG) is contracted with the Nebraska Department of Health and Human Services (DHHS) to perform an independent evaluation of the state's Medicaid Section 1115 Waiver program for Substance Use Disorder (SUD) Treatment. As a part of the evaluation, HSAG will be conducting a series of key informant interviews with administrators and providers.

The purpose of conducting the interviews is to collect data related to experiences during the implementation of the demonstration, to understand the barriers and facilitators to successful implementation, and to identify any unintended consequences associated with program implementation. The respondents from DHHS and providers will provide coverage for a comprehensive assessment across all the stakeholders involved in the planning and implementation of the program. Semi-structured interview guides will be used to focus inquiries for each group of respondents. The guides include primary questions that HSAG staff will use to elicit information on program experiences. Additional follow-up questions may be used to probe specific topics or issues raised during an interview or focus group.

This document contains the key informant interview guide for providers that HSAG will use for the data collection. Key informant interviews are planned to last no longer than 60 minutes; therefore, the number of questions have been limited to fit within that time frame and remain focused on key topics surrounding the implementation of the demonstration.

1. Administrators

1. How has the demonstration impacted the following?
    - Patient placement
    - The growth in capacity for SUD treatment
    - The availability of a full continuum of care for SUD
2. What strategies/policies were used to improve care coordination between residential/inpatient facilities and community-based services for treating SUD?
3. How was the provider review process designed to ensure consistent delivery of specifications in American Society of Addiction Medicine (ASAM) Criteria or other standards of care?
4. The comprehensive treatment and prevention strategy for SUD in Nebraska includes a number of elements:
    - Daily dosage limits
    - A preferred drug list with prior authorization criteria
    - The Drug Limitations document
    - Nebraska Pain Management Guidance document
    - Statutory protections for health professionals to prescribe, administer or dispense naloxone to individuals likely to experience opioid overdose
    - A prescription drug monitoring program (PDMP) requiring reporting of all dispensed prescription drugs

    What barriers to implementing this strategy are you aware of?
5. Outside of the comprehensive treatment and prevention strategy, what other barriers to success did you identify during the implementation process?
6. What drivers of success, or the factors that made the demonstration easier to implement, did you identify during the implementation process?
7. What unintended consequences, either positive or negative, did you encounter during the demonstration?
8. Have you identified any impacts of the COVID-19 public health emergency that are specific to the SUD treatment demonstration?

2. Providers

1. How has the demonstration changed access to care for beneficiaries diagnosed with SUD?
2. What impact has the change in coverage by the demonstration had on your day-to-day practices (e.g., care delivery, administrative requirements, etc.)?
3. How has the demonstration changed the identification, initiation, and engagement in treatment of beneficiaries diagnosed with SUD?
4. What barriers to success did you identify during the implementation process ?
5. What drivers of success, or the factors that made the implementation easier, did you identify during the implementation process?
6. What unintended consequences, either positive or negative, did you encounter during the implementation of the demonstration?
7. Have you identified any impacts of the COVID-19 public health emergency that are specific to the SUD treatment demonstration?

SUD Program Implementation Milestones

The following table presents the State's response to the SUD Program implementation milestone actions and timeframes (Table B-1).

Table B-1—Implementation Milestones and Timeframes

Criteria	Action	Timeline	Status (e.g., complete, partially complete, delayed)	Completion Date (if applicable)	State Notes
Milestone 1: Access to Critical Levels of Care for OUD and Other SUDs					
1. Coverage of: a) outpatient; b) intensive outpatient services; c) medication-assisted treatment (medications as well as counseling and other services with sufficient provider capacity to meet the needs of Medicaid beneficiaries in the state); d) intensive levels of care in residential and inpatient settings; and e) medically supervised withdrawal management.	Submit a State Plan Amendment to request authority to cover medically monitored intensive inpatient withdrawal management for adults at ASAM Level 3.7-WM	12–24 months after demonstration approval	Complete	11/30/2020	https://dhhs.ne.gov/Medicaid%20State%20Plan/Attachment%204.19b%20Item%2028%20-%20Rehabilitation%20Substance%20Use%20Disorder%20Services;%20MMIW.pdf
	Submit a State Plan Amendment to request authority to cover methadone for MAT	12–24 months after demonstration approval	Complete	11/30/2020	https://dhhs.ne.gov/Medicaid%20State%20Plan/Supplement%205%20-%20MAT.pdf https://dhhs.ne.gov/Medicaid%20State%20Plan/Supplement%206%20-%20MAT.pdf
Milestone 2: Use of Evidence-Based, SUD-Specific Patient Placement Criteria					
1. Providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools, or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines. **2. Contracted MCOs must have a utilization management approach such that: a) beneficiaries have access to SUD services at the appropriate level of care; b) interventions are appropriate for the diagnosis and level of care; and c) there is an independent process for reviewing the placement in residential treatment settings.**	Update contract language to reflect specific requirements for utilization management and level of care assessments	12–24 months after demonstration approval	Delayed		Action progress is delayed due to the COVID-19 PHE. Explicit components are being reviewed as part of the larger scope of the combined SUD and BH service definitions and regulations project. The action is anticipated to be completed on January 1, 2023.

Criteria	Action	Timeline	Status (e.g., complete, partially complete, delayed)	Completion Date (if applicable)	State Notes
Milestone 3: Use of Nationally Recognized, Evidence-Based, SUD-specific Program Standards for Residential Treatment Facility Provider Qualifications					
1. Implementation of residential treatment provider qualifications in licensure requirements, program authorities and policy manuals, managed care contracts, and other guidance. Qualifications should meet program standards in the ASAM criteria, or other nationally recognized, evidence-based SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings. **2. Implementation of state process for reviewing residential treatment providers to ensure compliance with these standards.** **3. Residential treatment facilities offer MAT on-sire or facilitate access off-site.**	Update contract language to require provider education regarding the requirements to facilitate MAT onsite or off site, and on benefits of MAT accessibility, to begin a shift in perspective toward acceptance of MAT as a complementary treatment.	12–24 months after demonstration approval	Partially Complete/Delayed		Action progress is delayed due to the COVID-19 PHE. Explicit components are being reviewed as part of the larger scope of the combined SUD and BH service definitions and regulations project. The action is anticipated to be completed on January 1, 2023. The next step towards action completion is to determine the appropriate provider and MCO engagement and communication plan to ensure requirement of MAT access is clearly communicated and can be successfully met. A current state analysis of practices was conducted, and the following examples were gathered: – RLOCs are required to accept all forms of FDA approved MAT – Expanded the availability of MAT by authorizing mid-level NPs and PAs to dispense medications used to treat OUD – In cases where distance would be prohibitive for the residential provider to obtain the take-home medication every two weeks, if the individual is in agreement, the provider can refer to an alternate facility in proximity that can provide guest dosing – Project ECHO engages a range of provider environments and professionals, including prescribers, social service staff, licensed alcohol and drug abuse counselors, and clinic administrators

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	Update service definitions to require access to MAT.	12–24 months after demonstration approval	Delayed		Action progress is delayed due to the COVID-19 PHE. Explicit components are being reviewed as part of the larger scope of the combined SUD and BH service definitions and regulations project. The action is anticipated to be completed on January 1, 2023.
	Update contract language to require reviews of residential treatment providers to ensure the types of services, hours of clinical care, and credentials of staff for residential treatment settings are performed according to ASAM criteria, or other nationally recognized, evidence-based SUD-specific program standards.	12–24 months after demonstration approval	Partially Complete/Delayed		Action progress is delayed due to the COVID-19 PHE. Explicit components are being reviewed as part of the larger scope of the combined SUD and BH service definitions and regulations project. The action is anticipated to be completed on January 1, 2023. A current state analysis was conducted by requesting from MCOs information on policies, procedures, and MCO contracts detailing guidance on program standards in the ASAM criteria, or other nationally recognized evidence-based SUD-specific program standards. A current state analysis was conducted on State Public Health standards which do not currently have a robust audit for compliance as well as the MLTC Provider Screening & Enrollment process which conducts screening upon Medicaid enrollment and five years after enrollment with no periodic audit. Information on the MCO process for auditing providers to ensure compliance with these standards was requested from the MCOs. The immediate next step towards action completion is to create a process and

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					communication plan requiring MCOs conduct a periodic audit on providers
Milestone 4: Sufficient Provider Capacity at Each Level of Care, Including MAT					
1. Assess the availability and capacity of providers throughout the state, enrolled in Medicaid, who accept patients in the Milestone 1 critical levels of care: a) outpatient; b) intensive outpatient services; c) medication-assisted treatment (medications as well as counseling and other services); d) intensive levels of care in residential and inpatient settings and e) medically supervised withdrawal management.	Add SUD specific provider capacity reporting requirements which include the number of participating providers accepting new patients by level of care and those that offer MAT.	Within 12 months of demonstration approval	Complete	8/15/2021	Health Services, Data Analytics, and Plan Management have the discretion to use this data for other ongoing purposes.
	Expand telehealth reporting requirements	Within 12 months of demonstration approval	Complete	12/16/2021	Confirmation was received via email from CMS on December 16, 2021 that Milestone 2 and this action item are completed. The email reads: "We agree that the state's reported metrics data indicate progress in telehealth usage in the past 12 months. Given that the annual goal for Metric Q3 (Total number of telehealth/telemedicine visits with an SUD diagnosis) in the approved SUD monitoring protocol was only directional to increase telehealth usage, the state surely has met that criteria. In the state's SUD mid-point assessment report, the independent assessor might still be able to look into the performance metrics by some stratifications and may be able to recommend for the state specific areas of focus, for example, if there are any geographic disparities in telehealth usage. Overall, though we would consider the metric target satisfied for the reporting period of 07/01/2019 through 06/30/2020, and also to the extent it is a milestone the state expected to meet per its approved SUD Implementation Plan."
Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD					
1. Implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse.	No actions required	N/A	Partially Complete	N/A	The process of creating a MLTC OUD Prescribing Guidance deck which outlines all three criteria with the plan to partner with Nebraska Medical Association is ongoing.

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2. Expanded coverage of, and access to, naloxone for overdose reversal. **3. Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs. This includes enhancing the health IT functionality to support PDMP interoperability and enhancing and/or supporting clinicians in their usage of the state's PDMP.**					This guidance is anticipated to be posted publicly in March 2022.
Milestone 6: Improved Care Coordination and Transitions Between Levels of Care					
1. Implementation of policies to ensure residential treatment facilities and inpatient facilities link beneficiaries, especially those with OUD, with community-based services and supports following stays in these facilities, and coordination of care for co-occurring physical and mental health conditions.	Update contract language to reflect specific requirements for Care Management follow-up after SUD treatment discharge.	12–24 months after demonstration approval	Partially Complete/Delayed		Action progress is delayed due to the COVID-19 PHE. A current state analysis was conducted to gather information from MCOs about current policies, procedures, and researched best practices among other states. The analysis confirmed the following established practices: – All three MCOs provide whole person care, the provision of care coordination services and increased access to social services. The MCOs' CMPs focus on person-centered strategies, managing co-morbidities and addressing the whole person, rather than simply on the individuals' primary condition. – UHC shared the role of IHSS staff in care transitions. IHSS staff coordinate care for planned and unplanned care transitions that include explaining the process for the preparation of planned and unplanned transitions, communication among all providers, communication to the member and/or his or her designee/legal representative, and communication between caregivers across settings

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					and the ICT, within the first month of the transition. The care manager will notify the ICT, which includes the PCP, of any changes to the member's health within two business days of notification of the change. This will be documented in the care management documentation system. The IHSS staff will communicate with the member about the transition process within two business days for planned transitions and within three business days of notification for unplanned transitions and will document in the care management documentation system. The process of confirming the following information with MCOs is ongoing: – Is there value in having residential facilities ensure that beneficiaries are linked with community-based services and supports? This would require updates in administrative rules requiring linkage. – Do the MCOs provide care managers training on ASAM for the SUD services provided under the 1115 Demonstration Waiver to ensure a seamless transition between LOCs? This action has been confirmed by one MCO.

ASAM: American Society of Addiction Medicine; BH: behavioral health; CMP: Care management program; CMS: Centers for Medicare & Medicaid Services; COVID-19: coronavirus disease 2019; IHSS: Integrated Health Social Services; FDA: United States Food and Drug Administration; LOC: level of care; MAT: medication assisted treatment; MCO: managed care organization; MLTC: managed long-term care; NP: nurse practitioner; OUD: opioid use disorder; PA: physician's assistant; PCP: primary care physician; PDMP: prescription drug monitoring program; PHE: public health emergency; RLOC: residential level of care; SUD: substance use disorder; UHC: United Health Care