HEALTH SYSTEMS DIVISION
Kate Brown, Governor

Oregon Health Authority

500 Summer St NE E35
Salem OR 97301
Voice: 503-945-5772 or 800-527-5772
Fax: 503-373-7689
TTY: 711
www.oregon.gov/OHA/HSD

May 29, 2020

Calder Lynch, Deputy Administrator & Director
Judith Cash, Director of the State Demonstrations Group
Center for Medicaid & CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Mr. Lynch and Ms. Cash,

Thank you for your ongoing partnership as we develop and implement Oregon's approach to transforming our Substance Use Disorder (SUD) system. In my capacity as State Medicaid Director, I submit this request for the Centers for Medicare and Medicaid Services (CMS) to approve a SUD demonstration project under Section 1115 of the Social Security Act.

This demonstration project will build on Oregon's efforts to broaden the SUD continuum of care throughout the state. The authority to expand Community Integration Services and Recovery Support Services will allow Oregon to show the impact of the full continuum of care for individuals experiencing SUD, from pretreatment and crisis intervention, through active treatment, and into recovery support, including those in need of intensive residential and withdrawal settings, and post treatment through recovery support services.

Oregon is also requesting approval from CMS through this waiver application to claim Federal Financial Participation for services provided at SUD residential settings that have been designated as Institutions for Mental Disease.

This submission package includes Oregon's 1115 SUD Demonstration Application (with Attachments A-I), and Implementation Plan.

Our process for engaging with Tribes, Coordinated Care Organizations, health care providers, and other stakeholders has been posted publicly on OHA's webpage (https://www.oregon.gov/oha/HSD/Medicaid-Policy/Pages/SUD-Waiver.aspx) and is documented in our application materials.

Thank you for your consideration. Please contact us if you need any additional information.

Sincerely,

[redacted]

Lori Coyner, MA
Medicaid Director
Oregon Health Authority

# Section 1115 Waiver Application

## Oregon Health Plan
## Substance Use Disorder Demonstration

Medicaid and Children's Health Insurance Program

Submitted: May 29, 2020

Oregon Health Authority

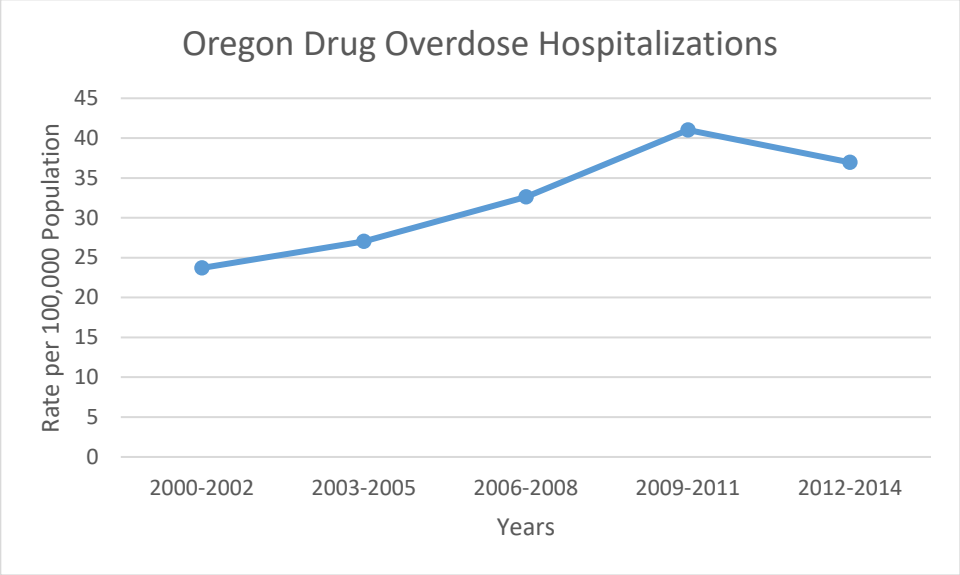
Oregon Health Plan

# Table of contents

## Background

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

**Table 1. Oregon Drug Overdose Hospitalizations**




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

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

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

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

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

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

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

Oregon's patient retention levels remain low across the treatment spectrum and the recovery delivery system; this is especially concerning regarding people with OUD. In early 2017 fewer than 30% of all publicly funded SUD treatment programs nationwide offered Medication Assisted Treatment (MAT) to their clients[3]. Patients who receive MAT have a greater retention rate in treatment. This access gap is most acute within traditional residential and outpatient SUD settings throughout Oregon.

Oregon consistently ranks in the top five states in terms of prevalence and mortality with roughly 5,000 new Hepatitis C (HCV) cases reported annually[4][5]. There is an increase in HCV transmission among young Oregonians. An increase in HCV transmission is an important sentinel of likely HIV transmissions clusters

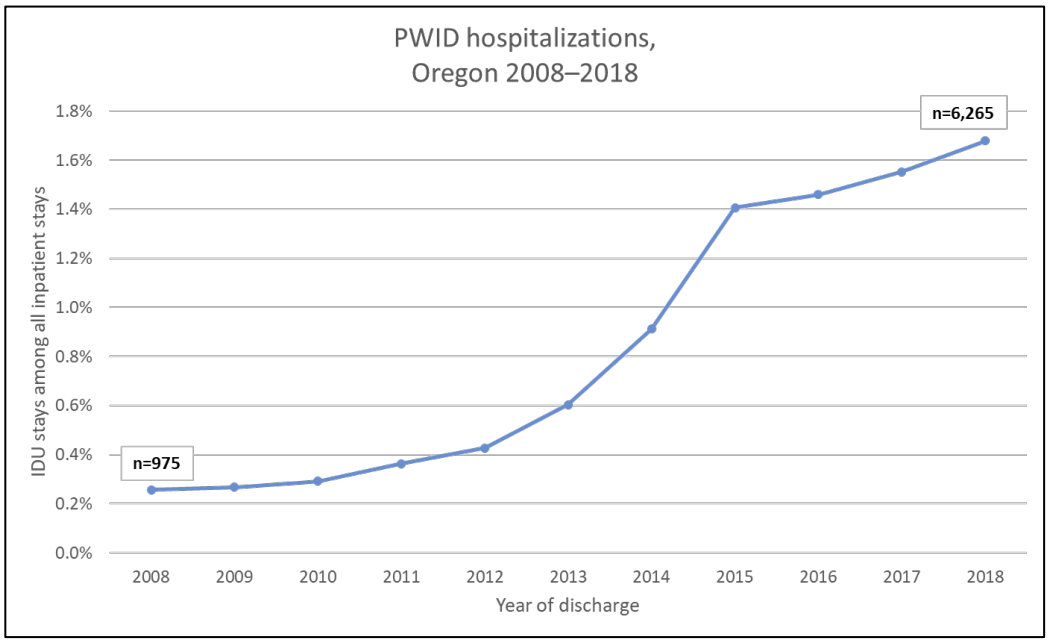
[3] "State and Local Policy Levers for Increasing Treatment and Recovery Capacity to Address the Opioid Epidemic: Final Report." *ASPE*, 13 Aug. 2018, aspe.hhs.gov/basic-report/state-and-local-policy-levers-increasing-treatment-and-recovery-capacity-address-opioid-epidemic-final-report.

[4] Ly, KN, et al, "Deaths Associated With Hepatitis C Virus Infection Among Residents in 50 States and the District of Columbia, 2016–2017," Clin Infect Dis. 2019 Oct 5. pii: ciz976

[5] Bradley H, et el, "Hepatitis C Virus Prevalence in 50 U.S. States and D.C. by Sex, Birth Cohort, and Race: 2013-2016," Hepatol Commun. 2020;4(3):355-370.

among people who inject drugs. Approximately 55% of HCV cases reported in 2019 were people born after 1965, with transmission being predominantly through injection drug use (IDU). The number of IDU related hospitalizations increased from 980 in 2008 to 6, 265 in 2018. The proportion of all hospitalizations that were IDU- related increased from 0.26% in 2008 to 1.58% in 2018, which was more than a 6- fold increase (see Table 3). Injection drug use related hospitalizations due to opioids and stimulants continue to increase.

Table 3: Injection Drug Use Hospitalizations, Oregon 2008-2018




Source: Oregon Hospital Discharge data 2008-2018. In 2019 The National Survey on Drug Use and Health[6] reported that approximately 3.7% of the National population experienced co-occurring mental health and substance use disorders during the past year. Further, over 17% of Oregonians living with SUD attempted to access MH treatment in 2018. SAMHSA also estimates that between 40% and 60% of individuals living with any Mental Illness (AMI) will experience a co-occurring Substance Use Disorder. Further, it is estimated that approximately 6% of people in mental health treatment are living with a co-occurring Gambling Disorder, and 10-15% of people in SUD treatment also experience a Gambling Disorder[7]. Clinically, the relationship between multiple disorders as they manifest within an individual and families creates complex conditions due to the interplay of disorders.

To address this crisis, improve health outcomes, and reduce deaths related to SUDs, Oregon is pursuing multiple approaches, including this waiver, across its state and local agencies, to ensure improved access to SUD treatment, increased provider capacity, and implementation of effective standards of care. Oregon proposes working to transform the SUD delivery system through evidence-based practices, Tribal-Based Practices, and a focus on providing a comprehensive and full continuum of care (Attachment E). Through the SUD waiver, as

6 "The National Survey on Drug Use and Health." *US Department of Health and Human Resources*, Aug. 2019, https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHNationalFindingsReport2018/NSDUHNationalFindingsReport2018.pdf

7 Petry, N. M., Blanco, C., Jin, C., & Grant, B. F. (2014). Concordance between gambling disorder diagnoses in the DSM-IV and DSM-5: Results from the National Epidemiological Survey of Alcohol and Related Disorders. *Psychology of Addictive Behaviors, 28*(2), 586-591. doi:10.1037/a0034661

further described below, the state intends to demonstrate a new way to strengthen the state behavioral health care system by providing SUD services to individuals in intensive residential settings (i.e. Institutions for Mental Disease (IMDs) and maximizing federal funding opportunities to bolster existing programs and initiatives, and implementing new strategies to build comprehensive, recovery-oriented continuum of care services and supports.

## Program Description

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

Oregon is a Medicaid expansion state under the Affordable Care Act, with nearly 975,000 enrolled in Medicaid and CHIP in October 2019[8]. Nearly 90% of individuals are served through the state's fifteen Coordinated Care Organizations (CCO)s. Oregon's CCOs have been operational since 2012 through the state's 1115(a) Medicaid and State Children's Health Insurance Program Demonstration Waiver, "Oregon Health Plan" (OHP).

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

Often, the burden of implementing equity, diversity and inclusion strategies in health systems falls on the shoulders of those who belong to historically marginalized communities. Oregon is committed to ensuring that advancing racial and health equity in the system becomes a collaboration of all regions and sectors in the state, including tribal governments. This waiver provides a unique opportunity to support health equity by increasing recovery supports and other critical services such as crisis intervention to individuals who are disproportionality affected by substance use within historically marginalized communities.

OHA is committed to working with the Nine Federally Recognized Tribes of Oregon, and the Urban Indian Health Program (UIHP) to identify mechanisms to help ensure Tribal health care objectives are achieved while respectfully honoring tribal traditional based practices and upholding the government to government relationship between the sovereign nations and the state. OHA follows agreements and processes set forth in Oregon's existing 1115 Medicaid Demonstration waiver, specifically Attachment I: Tribal Engagement and Collaboration

[8] "HPAM's Medicaid Monthly Population report from SharePoint Business Intelligence Center"; Health Policy & Analytics, OHA. data Source is DSSURS.

Protocol, OHA's Commitment Letter to Oregon Tribes, and the Tribal Consultation and Urban Indian Health Program Confer Policy. There are two Indian Health Services (IHS) clinics and eight Tribal Health Programs enrolled in Oregon Medicaid. The Urban Indian Health Program is enrolled as a Federally Qualified Health Center in the Portland area. Tribal programs provide prevention services, several outpatient treatment programs and two residential treatment programs, one youth and one adult, designated to serve Tribal members with culturally specific services.

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

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

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

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

In 2007, the Centers for Medicare & Medicaid Services (CMS) approved coverage of peer delivered services (PDS) in Oregon's Medicaid State Plan and directed the state to define its training and certification requirements for both mental health and SUD. Peer Support Specialists and Peer Wellness Specialists provide outreach, system navigation, recovery and resiliency promotion, community building for individuals with behavioral health conditions and their families. Depending on where a person is in his or her recovery process, they can receive PDS in a variety of settings. Peer delivered services are being delivered in urban and rural communities to many

different population groups defined by age (adolescents); race or ethnicity (Native American, Latino, African American); gender and sexual orientation; and/or co-existing conditions/status such as incarceration, homelessness, mental illness or HIV/AIDs. In Oregon, Peer Delivered Services are integrated at many levels of SUD treatment provision.

Oregon requires all Outpatient and Residential programs provide HIV and AIDS, tuberculosis, sexually transmitted disease, Hepatitis and other infectious disease information and risk assessment, including any needed referral, within 30 days of entry. It is also required that the following individuals admitted to the program shall be referred for a physical examination and appropriate lab testing within 30 days of entry to the program. Individuals who:

- are currently injecting or intravenously using a drug or have injected; or
- have intravenously used a drug within the past 30 days; or
- are at risk of withdrawal from a drug; or
- may be pregnant.

This requirement may be waived by the medical director if these services have been received within the past 90 days and documentation is provided (OAR Chapter309, Divisions 018 and 019).
In September 2016, Oregon received and began implementing; the Medication Assisted Treatment-Prescription Drug and Opioid Addiction (MAT-PDOA) grant from SAMHSA for a period of three years which continued through September 2019. Through this grant Oregon has been able to:

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

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

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

- Enhancing state and community efforts to advance interventions that reduce prescription drug overdose (PDO) and problematic prescribing of controlled substances. Oregon has implemented PDO coordinators in nine regions of the state. Their focus is to train local prescribers, convene regional pain guidance groups, regional interdisciplinary action teams, and training local partners and providers in the prescription drug training program (PDMP).

- Project ECHO[9] to increase the number of Drug Addiction Treatment Act (DATA) waived providers in Oregon who are actively prescribing MAT.
- Increasing access to MAT by expanding the number of Opioid Treatment Programs (OTP) throughout the rural regions.
- Establishing a robust network of naloxone distribution and training in regions most affected by the opioid epidemic.
- Enhancing a network of recovery support services within the correctional system through peer delivered services.
- Partnering with Oregon's Tribes and Urban Indian Health Program to provide funding for prevention, treatment, and recovery strategies within the individual Tribal health programs.

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

In April 2018, to address the burgeoning opioid crisis, the Oregon Legislature enacted House Bill 4143 (HB 4143) to study barriers to MAT for SUDs, including addictions to opioids and opiates. HB 4143 directed OHA to implement a pilot project through January 2, 2021, placing peer recovery support mentors in emergency departments to support individuals who suffer from opioid and opiate overdoses. HB 4143 required OHA to develop a report and recommendations on the barriers around recovery and treatment of SUD. OHA, within this report, recommended that issues be addressed at all levels. This report was presented to the Oregon State Legislature in July 2018[10].

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

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

[9] "All About ECHO." *Oregon ECHO Network*, 2018, https://www.oregonechonetwork.org/aboutecho

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

## *Oregon Health Authority*

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

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

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

By July 2020, Oregon's ambition is to have over 75% of these licensed and certified providers able to offer MAT services to their clients with OUD. State staff will continue to work with these providers to both deliver training and other technical assistance, as well as remove barriers to billing for these services. Working together, the Tribes and state adjusted the plan for implementation of this OAR to support the accessibility of MAT for the Tribal population. Initially, only one Tribe was implementing MAT and now with support from the state and outside resources, all Tribes and the Urban Indian Health Program are exploring the possibilities of what providing access to MAT could look like in their community. This allows Tribal programs to develop treatment programs that meet the needs of their people/clients, and are consistent with their values and culture, from abstinence-based programs to MAT programs.

In January 2019, Oregon released an RFA for a new CCO contracting cycle for 2020-2024[11], referred to as CCO 2.0. CCO 2.0 implements policies that seek to improve behavioral health, including a focus on enhancing services and supports for individuals with SUD. Previously, administrative and billing barriers impeded integration efforts and created barriers to access and effective care for individuals with Severe and Persistent Mental Illness (SPMI) and SUDs. OHA staff developed policy options to address the issues identified through an extensive community feedback process, with a focus on behavioral health integration, access to services and an adequate provider network.

Specific to SUD, CCOs, beginning in 2020, will require access to a full continuum of care (Attachment E) throughout the state, including detox/withdrawal management, residential, outpatient and recovery support services. CCOs will prioritize access to SUD services for pregnant women, parents, families, and children, including access to MAT, withdrawal management, residential services, outpatient services and ongoing recovery

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

support services for parents, and behavioral health screening and treatment for children. Beginning in 2020, there are enhanced standards for timely access to care for SUD populations, identifying those who are the most vulnerable and need additional support. This includes requiring no wait time for intravenous (IV) drug users, requirement of interim services provided within 72 hours and additional timely access standards for other prioritized populations with SUD. To further improve provider network adequacy, CCO requirements in 2020 include a culturally responsive and linguistically appropriate workforce, which must include Youth Peer Delivered Service Providers, Family Peer Delivered Service Providers, and Peer Delivered Service Provider Supervisors.

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

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

Lack of behavioral health providers is a significant issue and need in Tribal Communities. The Northwest Portland Area Indian Health Board and the nine Tribes of Oregon are leading the way in the development of a dental health aide therapy (DHAT) program and are now focusing on the Behavioral Health Aid (BHA) program (modeled after Alaska's Community Health Aide (CHA) Program). The CHA program has been a success in Alaska and includes training and certification for BHAs. BHAs are selected by and for the community they serve which ensures culturally appropriate services. Behavioral Health Aides focus on the following areas;

- Village-based counselors to provide culturally informed, community based, clinical services

### *Oregon Health Authority*

- Provide behavioral health prevention, intervention, aftercare, and postvention
- Training and practicum requirements
- On-the-job training

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

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

## Summary of Proposed Demonstration Activities

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

In Oregon, treatment of co-occurring disorders within behavioral health services has been conducted in a siloed and fragmented way. This fragmented treatment does not adequately address the complex interplay of co-occurring disorders as experienced by individuals and families. Oregon Health Authority has identified a need to address access to treatment of co-occurring disorders within communities in Oregon. This Waiver and related State Plan Amendment (SPA) are the beginning steps necessary to address this need by creating parity among services provided to those with mental health substance use or co-occurring issues system wide.

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

Oregon will continue to collaborate with key stakeholders and partners such as behavioral health consumers and people with lived experience, Community Mental Health Provider (CMHPs)s, Peer Delivered Services providers, CCOs and Tribal Partners to implement and evaluate this demonstration and enhance the full continuum of care for all Oregonians.

# Proposed Waiver Authority Activities to Support Full Continuum of Care

**Community Integration Services**

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

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

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

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

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

**Institutions for Mental Disease (IMD)**

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

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

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

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

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

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

**Recovery Support Services**

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

Allowing access to peer-delivered services outside a treatment plan will remove barriers to ensure individuals have access to recovery supports throughout the course of their recovery, including before and after active treatment and during transitions of care. Peers are a critical link between individuals and treatment services and enabling peers to work with individuals before they enter treatment may lead to an increased number of individuals engaging in treatment as well as earlier and more sustained engagement in treatment. Allowing individuals in long-term recovery to engage in services on an as-needed basis will allow for earlier intervention to prevent relapse, potentially preventing a return to higher levels of care after completion of treatment.

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

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

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

Creation of this new provider type will expand the network of available providers and create more choice for behavioral health consumers. Peer-Run Organizations provide a cost-effective, person-centered, and trauma-informed alternative or supplement to traditional treatment settings. Peer providers are in a unique position to develop a relationship of trust, which is particularly helpful in working with people in trauma recovery. Peer-Run Organizations deliver services that are more integrated and person-directed than traditional SUD treatment, an approach that is more effective for some service users. Individuals who are less comfortable accessing care in

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

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

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

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

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

**Case Management**

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

Case management is an ongoing process to assist individuals to gain timely access to and effectively use necessary health and related social services. Activities include coordination for timely access to care, management of integrated treatment planning, resource identification and linkage, and collaborative development of individualized services that promote continuity of health care. These specialized activities are intended to improve an individual's experience of care, improve health outcomes and reduce costs by maximizing the

benefits of the treatment, and to minimize the risk of unplanned re-admission and to increase the community tenure for the individual. These services will be provided by appropriately credentialed professionals by phone, in outpatient, hospital emergency departments, community, and in-home settings.

**Crisis Intervention**

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

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

**Community Integration- Skills Restoration**

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

**Early Intervention Services**

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

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

consequences or unhealthy substance use[12]. This may be done through activities and screenings such as the Screening, Brief Intervention, and Referral to Treatment (SBIRT) that is currently provided within primary care settings[13]. Early intervention services are for individuals whose problems and risk factors appear to be related to substance abuse but do not meet any diagnostic criteria for substance use disorders.

By identifying and engaging individuals in need of SUD services as early as possible, access to appropriate levels of care may be provided at lower levels more frequently. Early intervention by appropriately credentialed professionals in a variety of settings, by phone, in outpatient, hospital emergency departments, schools, primary care, community, and in-home settings. Early intervention services may include screenings, informal counseling, referrals to supports relevant to the individual, providing access to those at risk of crisis, look into treatment needs, and provide access to follow-up services. Services are provided to individuals who have problematic use or mild substance use disorders[14]. Reducing harms associated with substance misuse and reducing risk behaviors before they lead to injury and prevent progression to a disorder leading to the needed use of SUD services, are the primary goals of early intervention services[15].

**Prevention Services**

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

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

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

---

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

[13] "Screening, Brief Intervention, and Referral to Treatment." *SAMHSA,* https://www.integration.samhsa.gov/SBIRT_Issue_Brief.pdf

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

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

information sessions, education, engagement, referrals to supports relevant to the individual's needs, and provision ofaccess to follow-up services.

Some proposed services will require adjustments to CCO rates.

## Rationale, Hypothesis and Goals

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

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

## Timeframe

The proposed timeframe for this demonstration is five years, beginning upon CMS' approval. Oregon's proposed effective date is July 1, 2020. Each of the strategies proposed have been analyzed according to degree of difficulty to implement and assigned a relative implementation timeframe of 0 to 6 months; 6 to 12 months; or 12 to 24 months. See Table 4 for the timeframe.

**Table 4. Proposed Timeframe for SUD 1115 Demonstration Strategies**

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

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

## Waiver and Expenditure Authority

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

**Table 5. Proposed Expenditure Authorities of the Social Security Act**

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

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

## Demonstration Eligibility

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

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

**Table 6. Summary Chart of Populations Affected by or Eligible Under the Demonstration - SUD 1115 Demonstration**

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

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

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

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

## Demonstration Benefits and Cost-Sharing Requirements

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

1) Indicate whether the benefits provided under the demonstration differ from those provided under the Medicaid and/or CHIP State plan:

   □ Yes

   X No

2) Indicate whether the cost sharing requirements under the demonstration differ from those provided under the Medicaid and/or CHIP State plan:

   □ Yes

   X No

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

## Cost-sharing in Oregon

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

**Table 7. Oregon Co-Payments by service type**

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

## Delivery System and Payment Rates for Services

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

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

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

The SUD Waiver will not alter the current delivery system used for each eligibility group. Table 6 on pages 22-25 outlines the current eligibility groups and corresponding delivery systems that will be used in the demonstration period from 2020-2025.

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

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

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

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

Since September 2012, the OHA has contracted with CCOs to provide coordinated care to its Medicaid and CHIP-eligible population; there are currently 15 CCOs that will cover the population in calendar year 2020. The purpose of the CCO model is to achieve the triple aim of better health, better health care, and lower per capita cost. Over 90% of the OHP individuals are enrolled in CCOs for one or more of Physical Health, Mental Health, and Dental services, with the remaining individuals being enrolled in FFS. The Oregon Health Authority contracts with an actuarial vendor, Optumas, to develop the capitation rates. The rate development process starts with recent historical statewide data on the cost of providing care. Those data are then projected with expected membership changes, trend (inflation), and changes in utilization to the rating year. The process then takes into account geographic, hospital, and member risk factors that impact individual CCOs' expected costs, resulting in CCO-specific payment rates that reflect each CCOs' individual risk. More information on the rate methodology can be found at the following link:
https://www.oregon.gov/oha/HPA/ANALYTICS/OHPRates/Oregon%20CY20%20Rate%20Certification%20-%20CCO%20Rates.pdf"

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

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

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

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

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

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

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

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

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

## Implementation of Demonstration

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

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

Contracting with managed care organizations: In January 2019, Oregon released a new RFA for a new contracting cycle for 2020-2024 [16]. The state is contracted with the 15 CCOs that cover individuals throughout Oregon. CCOs will continue as the state's delivery system for managed care.

## Demonstration Financing and Budget Neutrality

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

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

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

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

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

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

For the purposes of budget neutrality, this application assumes that both services shall be considered hypothetical expenditures and treated as pass-through services for the purposes of budget neutrality. As clarified by CMS guidance,[17] SUD IMD expenditures (Service 1) are deemed as hypothetical as they would have been otherwise allowable under Medicaid were it not for the IMD/settings prohibition. Likewise, expenditures for recovery support services would have been otherwise allowable under Oregon's Medicaid state plan if they were delivered within a treatment plan. Although authority is an option through a 1915i application, community integration services are requested as a CNOM under this 1115 SUD Waiver application to permit the State to preserve the SUD continuum of care while alleviating significant administrative burdens of creating and operating a separate Medicaid authority specifically for this service given it is limited to the targeted SUD population.

The narrative below describes the budget neutrality calculations outlined in Attachment G.

**Overall Approach**

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

**Estimation for the IMD Cost Limit**

To estimate the projected costs for medical assistance during months in which Medicaid eligible enrollees are at an IMD, 5 years of Oregon historical data is provided on overall Medical Assistance (MA) costs for individuals with SUD diagnosis who received inpatient treatment for SUD (or could have received inpatient treatment if such services were available) to determine average cost per user of SUD inpatient services for each historical year.

Oregon's calculations of SUD IMD costs include all approved medical assistance services provided to Medicaid beneficiaries during an IMD member month – both IMD costs and non-IMD Medicaid costs – but do not include

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

costs associated with room and board as specified by CMS. IMD member months are any whole month which a Medicaid eligible is inpatient in an IMD facility at least 1 day.

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

**Estimation of the SUD Hypothetical CNOM Services Limit**

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

**Overview of Medicaid Eligibility Groups Included in Calculations**

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

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

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

This list of MEGs mirror those in the broader Oregon Health Plan Section 1115 demonstration with two exceptions. The Breast and Cervical Cancer Treatment (BCCP) MEG was not included as very little historical data was found for this group currently utilizing SUD IMD and there is insufficient data to warrant including a projection for this group at this time. In the event BCCP individuals begin to utilize SUD IMD services, the BCCP MEG will be included at that time. The Old Age Assistance MEG was only included in the SUD hypothetical CNOM services as the request for SUD IMDs does not apply to individuals over 64 years of age.

**Application of Trends for Projections**

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

The member months under the IMD Cost Limit are trended forward by MEG using Oregon's historical trend. The member months under the SUD hypothetical CNOM services are trended forward by MEG using an annual trend rate projection of 25%.

**Member Month Non-Duplication**

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

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

## Evaluation

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

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

1. **Overview of the Evaluation of the SUD Waiver**

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

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

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

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

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

**3. Expected Observed Outcomes**

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

Using strategies to drive improvement and transformation in services will result in higher initiation and member engagement in SUD treatments, improving the rate of no-shows to referrals and dropouts from treatment. Improvements in linkages to SUD treatment providers after discharges from both hospital inpatient care and emergency department are expected as a result of better work processes and improved provider education. Oregon expects to increased provider training and policy changes lead to a decrease in high dosing of opioids for members without cancer for single and multiple providers.

As a result of access to treatment services including MAT, as well as early case finding and care coordination across the continuum, Oregon expects to observe a decrease in the number of fatal and non-fatal overdoses from opioid use. It is predicted that improvements will likely be seen in overdosing related to greater access to

treatment services including MAT services, as well as early case finding and care coordination across the continuum. Improved hospital based observed outcomes are expected to include lowered inpatient admissions and a low rate of births with neonatal abstinence syndrome because the services will become better integrated and available in the community.

Quality ratings for members with SUD issues are expected to improve on several key questions such as "I'm better able to control my life," "symptoms do not bother me as much," and "I was able to get the services I thought were needed." The members' experience of change attributed to treatment will be represented by their picks from a list of ten improvements, they indicate are due to their care.

Utilization of Peer Delivered Services is expected to increase as education about PDS and its availability is disseminated broadly across the state.

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

**4. Evaluation Design**

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

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

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

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

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

**3. Outcome Measures of Transformation**

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

B. Evaluation Questions and Hypotheses

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

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

| Domain | Research Questions/Hypotheses | Measure Sources | Unit of Measurement |
|---|---|---|---|
| | changes to prescribing patterns in practice? | persons without cancer (PQA); | |
| | | Use of opioids from multiple providers in persons without cancer (PQA); | Health Plan |
| | | Use of opioids at high dosage and from multiple providers in persons without cancer (PQA); and | Health Plan |
| | | Initiation and engagement of SUD treatment (NQF #0004). | Health Plan |
| *Outcomes* | | • Fatal and non-fatal overdoses | Health Plan and County |
| | | • Member quality ratings | Health Plan |
| | | • Neonatal abstinence syndrome prevalence | Health Plan |
| *Acuity* | Do structural and process changes in service delivery result in lowered acuity of care such as inpatient admissions? | Inpatient admissions | Health Plan |
| *Cost* | Does transformation and process improvement result in lowered cost due to fewer inpatient admissions and lower acuity? | Multiple structural and process change variables and hospital admission, ED use and treatment levels | Health Plan and County |

| Domain | Research Questions/Hypotheses | Measure Sources | Unit of Measurement |
|---|---|---|---|
| | Do improvements in structural changes, processes and outcomes result in decreased costs? | • Overall costs to community, health plan and clinic | State, County and Health Plans. |

**4. Data Sources and Evaluation Measures**

Data Sources

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

Evaluation Measures

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

**5. Analytic Plan**

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

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

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

Much of the analyses will fall into three main categories:

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

## Logic Model for Substance Use Disorder Waiver Evaluation

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

| STRUCTURE | PROCESS | OUTCOME |
|---|---|---|
| Increase in trained (MAT, ASAM, CADC) providers | Shorter duration between screening and treatment | Decreased fatal and non-fatal overdoses |
| Improved member access to screening, assessment and treatment | Coordinated care transitions between levels of care | Increased Treatment Engagement |
| Increased MAT services and public education | Increased access to MAT Decreased ED visits | Improved member quality ratings |
| Policy changes and education on prescribing behavior | Reduce SUD readmissions to hospital at same or higher level of care | Decreased unplanned neonatal abstinence syndrome prevalence |
| Certification and License of treatment facilities per ASAM level | Improved care coordination in transitions | Reduced Inpatient admissions |
| Increase recovery support services | Improved integration of physical and behavioral | Improved overall costs to community, health plan and clinic |

| STRUCTURE | PROCESS | OUTCOME |
|---|---|---|
| | health services. Improved recovery retention | |
| Communication networks among health care workers, community leaders, and tribes | Timely engagement at appropriate stages of treatment | |
| Increase peer support programs | | |
| Increase community integration support and services | Improved community integration for improved sustained recovery | Reduce re-admission rates, Improved overall cost to community, health, and SUD |

## Tribal Consultation

Oregon has been engaging Tribal partners throughout the development of the OHP SUD Waiver Application. To continue this, and in alignment with the Tribal Consultation and Urban Indian Health Program Confer Policy, Oregon began the Official Tribal Consultation process on January 13, 2020 with the sending of the Dear Tribal Leader Letter (DTLL), please see Attachment I. The Process concluded on March 13, 2020 with a formal group consultation and confer. The shared goal of the consultation/confer policy is to further the government-to-government relationship between the State and the nine federally recognized Tribes of Oregon (Tribes) as well as strengthen the relationship with the Urban Indian Health Program (UIHP). Further goals of this policy include, but are not limited to: eliminating health and human services disparities of American Indian/Alaskan Natives (AI/AN); ensuring that access to critical health and human services is maximized; advancing and enhancing the social, physical, behavioral and oral health of AI/AN; making accommodations in State programs when possible to account for the unique nature of AI/AN health programs and ensuring that the Tribes are consulted to ensure meaningful and timely tribal input as required under Federal and State law when health and human services policies have an impact on AI/AN individuals and Tribes. To achieve this goal, it is essential that the Tribes and OHA engage in open, continuous, and meaningful consultation. The State specifically acknowledges the State-Tribal consultation process for new and renewal submissions of Medicaid and CHIP 1115 demonstrations waivers; other Medicaid waivers, such as, 191 waivers; and any amendments to the Medicaid State Plan, waivers or demonstrations that are considered to have an impact on AI/A's, Tribes or Urban Indian Health Programs.

An initial SUD 1115 Waiver and State Plan Amendment-Tribal Consultation/UIHP Confer Meeting was held on February 14, 2020.

- **February 14, 2020:** Alcohol & Drug Policy Commission (ADPC); Health Services Building; 500 Summer St room 137 D, Salem, OR 97301;
  Call-in information for the public: Conference Call Number: 1-888-363-4734
  Public Participant Code: 3292468 #
  Input taken in-person and in writing.

Prior to the beginning of the formal Tribal Consultation period, Oregon engaged the Tribes through numerous meetings to develop the concept paper and draft waiver application.

**Summary of Comments**

Overall, the comments on the SUD Waiver were positive and enthusiastically supportive. Many commenters expressed support for the application of the SUD 1115 Waiver demonstration and moving forward the activities it presents, such as expanding peer delivered services and improved access to community integration services such as housing support services. The concerns represented were primarily around prevention and defining the scope of practice. It is important for OHA to continue to work closely with Tribes on SUD, OUD, mental health & suicide issues.

## Public Notice

In alignment with 42 CFR 431.408, Oregon followed the Public Notice Policy prior to submission of OHP SUD Waiver Application to CMS for approval.

Oregon has been engaging Tribal partners, key leaders, and stakeholders by asking for public input on the SUD 1115 Waiver and Implementation Plan. This is an ongoing effort to build upon the state's health system with regard to SUD services and to continue to promote excellence in access, quality, and health outcomes across the state. The notice and input process have allowed Oregon Tribal and Urban Indian populations, consumers, health systems, CCOs, providers, and other key stakeholders and the public the opportunity to comment on the proposed SUD 1115 waiver demonstration. To promote accessibility, printed copies or alternate formats of the application or any information were made available by request by email at sud.waiver@dhsoha.state.or.us, by USPS mail at Oregon Health Authority, Human Services Building, 500 Summer Street NE, Salem, OR, 97301.

Printed copies were made available at:

- The Human Services Building, 500 Summer Street NE, Salem, OR
- The Portland State Office Building, 800 NE Oregon Street, Portland, OR

Additional details were available online at: https://www.oregon.gov/oha/HSD/Medicaid-Policy/Pages/SUD-Waiver.aspx

The Oregon Health Authority staff have intentionally engaged leaders and stakeholders across the state. The application was developed in consultation and collaboration with state, local and other partners, such as Tribal Health Leaders. The Waiver has had input from the Substance Use Disorder Waiver Advisory Committee throughout the development of the Concept Paper and the Application and Implementation Plan.

OHA has met with and received feedback from organizations, groups and individuals, including:

- **Consumer and member advocacy groups**, including Oregon Recovers; Fourth Dimension; Mental Health and Addiction Association of Oregon (MHAAO); Recovery High School; and Oregon Family Support Network (OFSN).
- **Hospitals and Behavioral Health Systems leaders**, including Oregon Council on Behavioral Health; Integrated Health Clinics; The Tri-County Behavioral Health Providers Association (TCHBHPA); and Oregon Health Science University (OHSU)/ Project Echo.

- **Coordinated care organization leaders**, including CCO Behavioral Health Directors and other representatives of CCOs such as Healthshare; Jackson Care Connect & Columbia Pacific; and Trillium.
- **Governments and local government organization**, including Oregon's Nine Federally Recognized Tribes; Several County Mental Health Programs (CMHPS) such as Linn, Benton, and Lane Counties.
- **Health and health care committees**, **advisory groups and work groups, and boards**, including the Oregon Health Policy Board (public meetings); Medicaid Advisory Committee (public meetings); the Oregon Consumer Advisory Council (OCAC), OHA's Peer Delivered Services Core Team; and the Addictions and Mental Health Planning and Advisory Council (AMPHAC).
- **Other community leaders and Medicaid consumer-involved agencies and organizations**, such as, Native American Rehabilitation Association (NARA); the Alano Club; Central City Concern; Wellness Center Klamath Falls; YouthEra; Reconnections Counseling; and Cascadia Behavioral Healthcare.

Prior to the beginning of the public comment period, Oregon engaged stakeholders through numerous meetings to develop the concept paper and the draft waiver posted online on January 14, 2020. Comments and feedback received during the public comment period (January 14 -February 21, 2020) were logged and responses are included in the logs in Attachment H.

**Summary of Comments**

The preponderance of comments on the SUD Waiver request have been immensely positive and helpful. Many commenters expressed support for the application of the SUD 1115 Waiver demonstration and, moving forward, the innovative solutions it presents, such as expanding peer delivered services and improved access to community integration services like housing support services and the need for greater access to transportation.

Constituents and partners presented a number of creative ideas that OHA incorporated throughout the waiver application including emphasizing co-occurring disorders and collaborating with the Community Mental Health Programs (CMHPs). Extensive comments were submitted in support of the IMD exclusion request, several recommendation letters were written, and comments made with enthusiasm to see this as an identified activity within the Waiver. No changes to this provision were requested as a result of public comment.

Through the Public Comment period, Oregon received a number of comments from many judicial jurisdictions in support of the SUD Waiver. In addition to their support, several concerns around substance use treatment and the criminal justice system were highlighted. Among things highlighted were concerns around access to treatment with the loss of Medicaid coverage and difficulty in getting appropriate screenings upon entry to the criminal justice system. The comments make it clear that this is a high priority and need in Oregon. Although beyond the scope of this Waiver project, it is important to acknowledge these concerns and needs for Oregonians. No changes were made as a result of public comment.

As a result of public comment, OHA has incorporated information into the application about the continued effort and work to encourage providers to follow ASAM's National Practice guidelines to address infectious diseases and incorporate testing such as HIV into their processes, although this does not require waiver authority.

## *Oregon Health Authority*

Stakeholders were generally supportive of the proposal to have Peer Run Organizations certified and added as a new Medicaid provider type, yet some concerns were raised related to the implementation of such a proposal. Oregon staff met with Peer Run Organizations for a dialogue session on January 29, 2019 during the development of the SUD Waiver Application. Most of the concerns presented were around billing codes and reimbursement rates, criminal background checks, keeping fidelity with the peer movement in the midst of a clinical system, and loss of other funding sources if billing Medicaid. Some of these same concerns were raised during the public comment period. OHA has addressed those concerns by incorporating a process that would include the Peer Run Organizations in the development of the certification criteria to become a provider type. The plan is to develop a workgroup comprised of Peer Run Organizations and other key community stakeholders to create these criteria. This group would also advise and partner with the state to address billing concerns. Oregon is also emphasizing this is not meant to be the sole source of funding for Peer Run Organizations but would be an option for those who would like to provide a non-clinical service to Oregon's OHP members as a Medicaid provider.

Documentation of Oregon's Public Notice and Comment Process is found below and in Attachment H.

The Oregon Health Authority held five public hearings after the draft waiver application was posted on January 14, 2020.

- **January 23, 2020:** Alcohol & Drug Policy Commission (ADPC); Lines for Life; 5100 SE Macadam Ave Suite 400, Portland, OR 97239;
  Call-in information for the public: Conference Call Number: 1-877-336-1828
  Public Participant Code: 3962169 #
  Input taken in-person and in writing.
- **January 29, 2020:** Medicaid Advisory Committee (MAC); Chemeketa Center for Business & Industry; 626 High St. Rooms 102/103, Salem, OR 97301;
  Call-in information for the public: Conference Call Number: 1-888-398-2342
  Public Participant Code: 5341639 #
  Input taken in-person and in writing.
- **January 31, 2020:** Addictions and Mental Health Planning and Advisory Council (AMHPAC); Cherry Ave Training Center; 3414 Cherry Ave NE, Keizer, OR 97303;
  Call-in information for the public: Conference Call Number: 1-877-336-1828
  Public Participant Code: 3962169 #
  Input taken in-person and in writing.
- **February 04, 2020:** Portland Townhall; Portland State Office Building (PSOB); 800 NE Oregon ST room 1C, Portland, OR 97470;
  Call-in information for the public: Conference Call Number: 1-866-434-5269
  Public Participant Code: 3490709 #
  Input taken in-person and in writing.
- Input taken in-person and in writing.
- **February 12, 2020:** Roseburg Townhall; ADAPT/ COMPASS; 621 W Madrone room 132, Roseburg, OR 97470;
  Call-in information for the public: Conference Call Number: 1-866-434-5269

Public Participant Code: 3490709 #
Input taken in-person and in writing.

- **February 19, 2020:** Redmond Town Hall**;** Redmond Chamber of Commerce & CVB; 446 SW7th ST. Conference Room, Redmond, OR 97756;

Call-in information for the public: Conference Call Number: 1-866-434-5369
Public Participant Code: 3490709#
Input taken in-person and in writing.

Minutes of the townhalls, including the waiver presentation and public input information can be found online at: https://www.oregon.gov/oha/HSD/Medicaid-Policy/Pages/SUD-Waiver.aspx
Written input: Public input was also taken by email (sud.waiver@dhsoha.state.or.us) and USPS mail Joanna Johnson, Oregon Health Authority, The Human Services Building, 500 Summer Street NE, Salem, OR, 97301

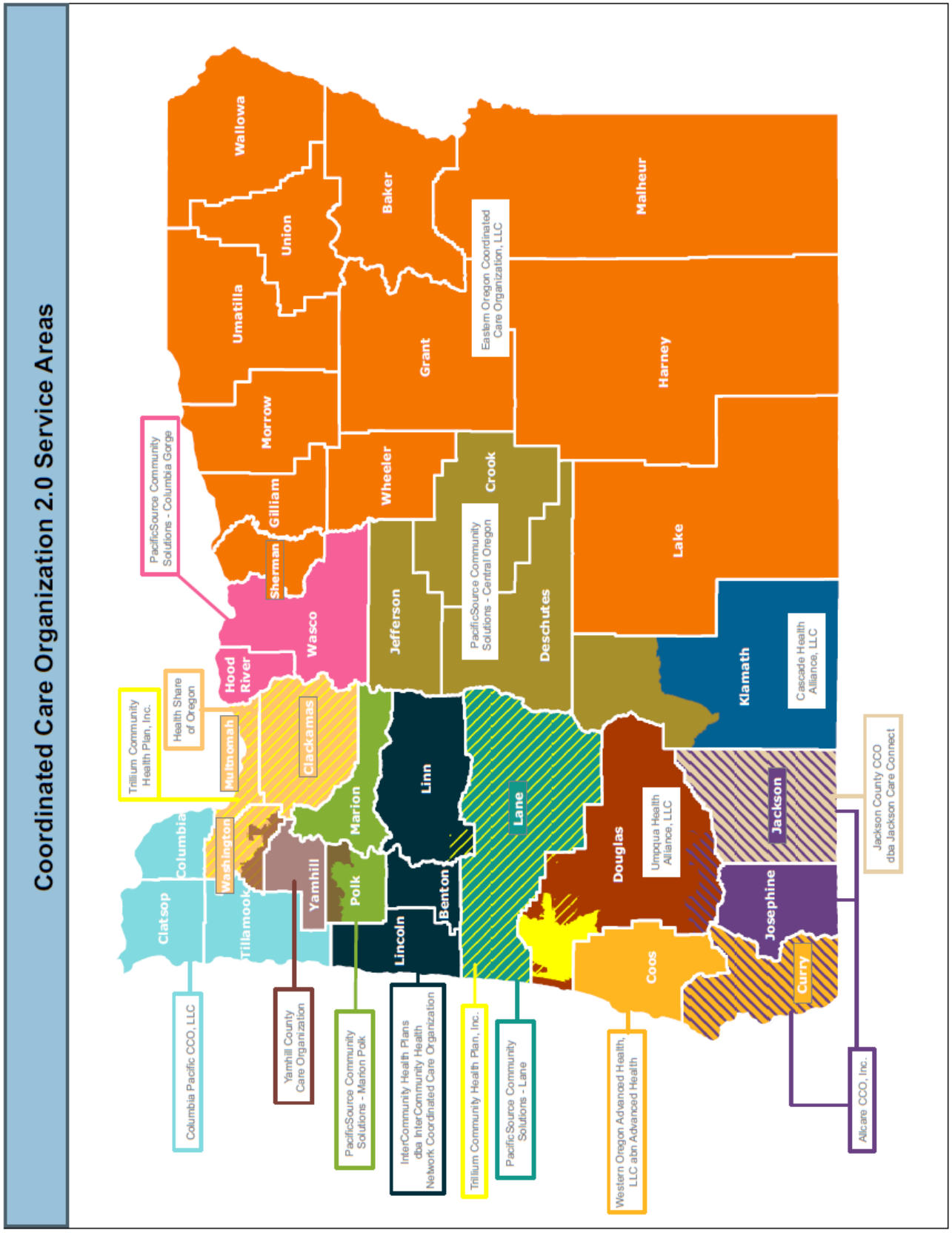
## Demonstration Administration

### Oregon Demonstration Contact

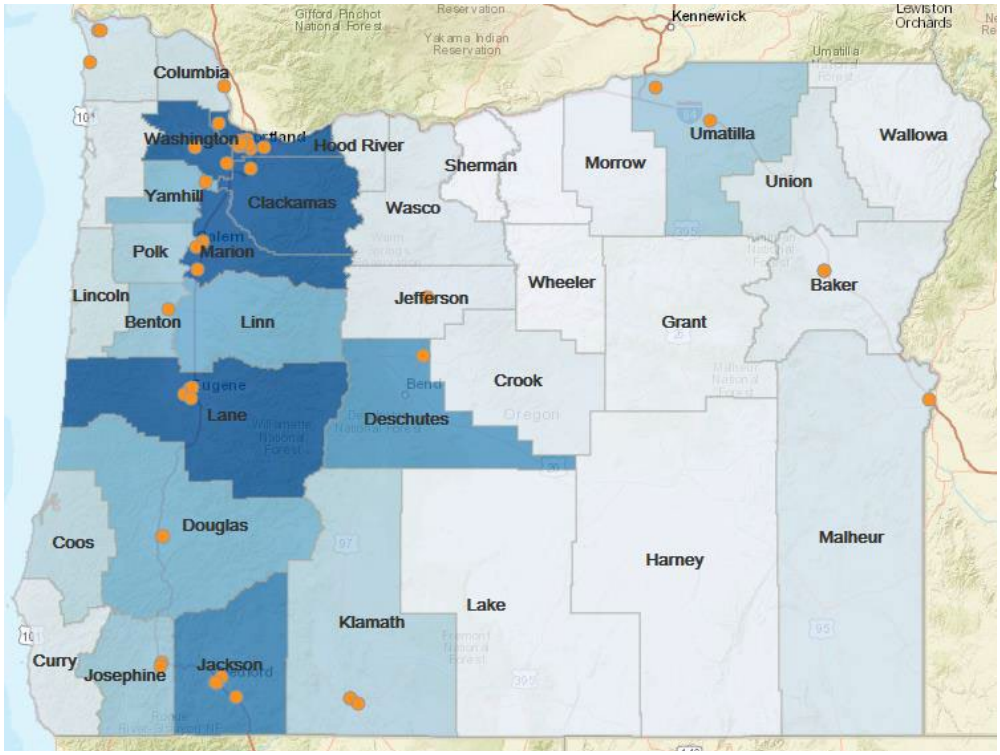
Lori Coyner
Medicaid Director
Health Systems Division
Oregon Health Authority
500 Summer St.
Salem, OR 97301-1079
lori.a.coyner@dhsoha.state.or.us
(503) 947-2340

## Attachment A: CCO Service Areas

### Oregon's Coordinated Care Service Areas



## SUD Residential Treatment Programs (map)



## Attachment B: Tribal Health Care

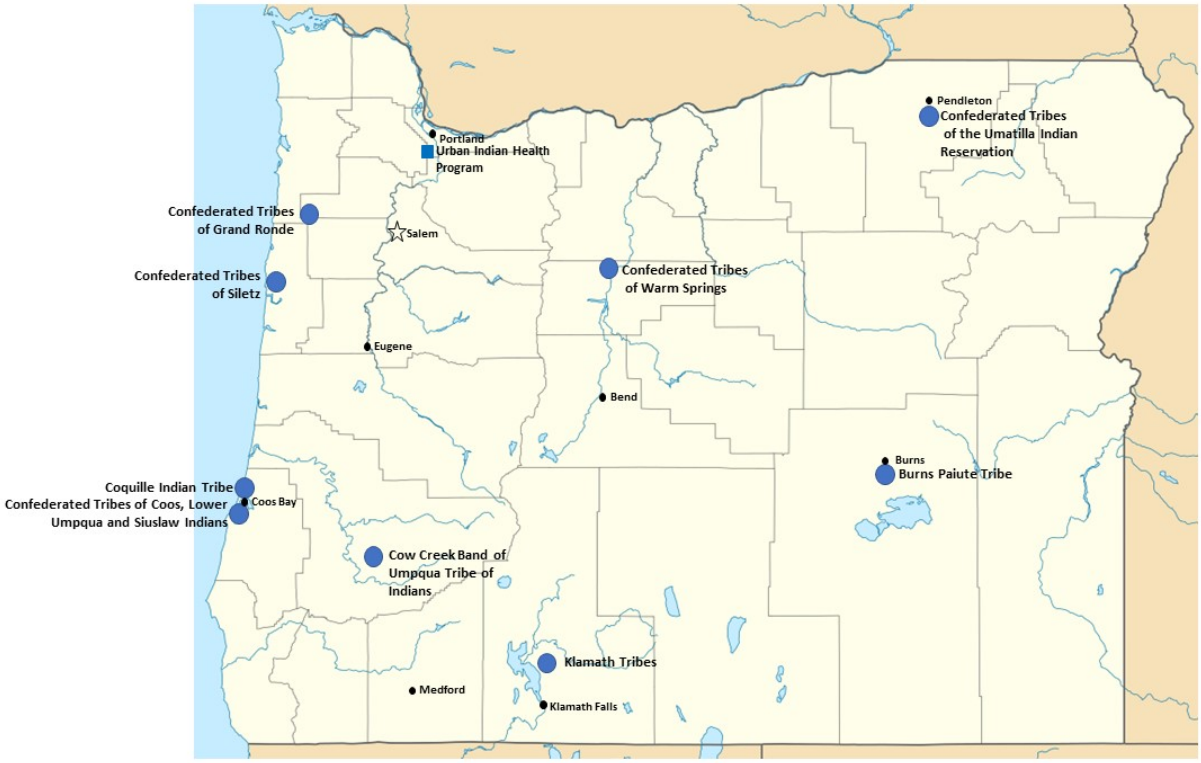
In Oregon there are two Indian Health Services (IHS) clinics and eight Tribal health programs (in accordance with P.L. 93-638 Indian Self-Determination Act) enrolled in Oregon Medicaid. There is also an Urban Indian Health Program (UIHP) enrolled as a Federally Qualified Health Center in the Portland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

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

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

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

## Oregon’s Nine Federally Recognized Tribes



## *Oregon Health Authority*

Oregon's Tribal SUD Programs:

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

Nine Federally Recognized Tribe's Tribal Programs

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

Urban Indian Health Program

- Native American Rehabilitation Association of the Northwest (NARA)

Indian Health Service SUD Program

- Chemawa Behavioral Health Services

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

In 2019 the Oregon Tribes, the Urban Indian Health Program, OHA and additional partners came together to develop the Oregon Tribal Behavioral Health Strategic Plan. The vision includes:
The Oregon Native American Behavioral Health Collaborative envisions healthy Native individuals, families, and communities thriving across Oregon. We envision a shared, continuous alliance between the state and tribal/urban providers that provides a continuum of fully funded, comprehensive, culturally responsive services grounded in tribal-based practices and intertribal collaboration at the administrative and clinical levels. OHA is committed to implementing and supporting this plan for the next 5 years.


A medicine wheel that represents the collaborative's vision

***Peer Run Organizations***:

*"Working Within the Community and Along the Entire Continuum of Care."*

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

***Peer Run Organizations:***

*PRO's work within the community and can fit services across the entire continuum of care . Truly promoting resiliency and Long Term Recovery*

**Individuals with Long Term Recovery Create a resilient PDS Workforce which feeds back into the PRO's.**

*Continuum of Care: Moving Towards Long Term Recovery/ Resiliency*

*Pre-Tx. Community Outreach/ Prevention/ Pre-Contemplation/ Contemplation/ Recovery Peers at PRO's Role Modeling Healthy Resilient Lifestyle and community engagement/ activities relevant to the community.*

*Integration into Tx. Navigation of resources and Tx. Services, Trauma informed response to Behavioral Health SUD/MH/Parenting experiences in culturally relevant community context. PRO's operate **within** the community.*

*Maintained connection and support to promote retention and success throughout Individuals clinical Tx. process.*

*Supportive integration into community. **Re-entry**. Bridging the gap between Tx programs and supportive recovery community.*

*Moving towards maintenance phase of recovery. Maintaining connection to recovery support if relapse phases occur. Promotion of Resiliency Lifestyle. Navigating resources for Long Term Recovery, i.e. 5 yrs. or more. Reduction of costly residential Tx. stays. Sustainable PDS Workforce development to feed back into community systems of support. i.e. PRO's.*

## Attachment D: Oregon Care Services & ASAM Levels of Care

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

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

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

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

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

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

## Substance Use Status

## Substance Use Continuum of Care

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

# Attachment F: Evaluation Budget Projection

**SUD 1115 Waiver Evaluation Key Dates and Payment Amounts:**

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

## Attachment G: Budget Neutrality

Please see attached Excel document

## Attachment H: Public Comments

Please see attached Excel document

## Attachment I: Dear Tribal Leader Letter

TRIBAL AFFAIRS
Kate Brown, Governor

Oregon Health Authority

500 Summer Street NE, E-86
Salem, OR 97301-1118
Desk: 503-945-9703

December 30, 2019

Dear: Tribal Leader

In an ongoing effort to consult with Oregon's Nine Federally Recognized Tribes and confer with the Urban Indian Health Program on issues that may impact the Tribes and the health of their members, this letter is being sent to inform you of an identified critical event- Oregon's Substance Use Disorder (SUD) 1115 Waiver application.

This letter is to provide information and invite you to a consultation meeting to discuss the Oregon Health Authority's (OHA) upcoming application to the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). This SUD 1115 Waiver application and corresponding state plan submission seek to increase the capacity and services available to individuals with a SUD.

**Background:**
OHA believes that substance use disorder is a chronic condition that requires long-term comprehensive care and support. However, Oregon's current Medicaid SUD treatment system faces significant barriers to providing the services that Oregonian need due to limitations in place through federal regulations.

- Currently, Medicaid funds cannot be used to pay for residential treatment provide in facilities with more than 16 beds. A majority of Oregon's residential treatment facilities have more than 16 beds. Oregon currently pays for these services out of the general fund.
- Substance use disorder requires prevention and outreach, treatment, and ongoing maintenance and support. However, only treatment is eligible for Medicaid funding.

**If approved, the waiver would allow OHA to improve Oregon's SUD treatment system in three ways:**

1. Increase access to SUD residential services
2. Expand Recovery Support Services
3. Provide access to transitional Housing Support Services

**Anticipated impact**: we anticipate that this may provide greater access to SUD services statewide including the Tribes or Tribal entities as this may expand services covered as a benefit under the OHP. These changes would apply to individual Tribal member/s who are covered under the OHP.

OHA invites you to review the attached documents for further information.

1. SUD 1115 Waiver application draft
2. SUD SPA draft

If you would like to participate in a formal consultation to discuss the SUD 1115 Waiver application please let me know via email at julie.a.johnson@state.or.us by January 30, 2020 so that we can get it scheduled. If a formal consultation is not needed; we invite you to provide any comments, suggestions or questions to Teri McClain or Joanna Johnson at sud.waiver@dhsoha.state.or.us .

Sincerely,

Julie Johnson
Tribal Affairs Director

# Section 1115 Waiver Implementation Plan

## Oregon Health Plan
## Substance Use Disorder Demonstration

Medicaid and Children's Health Insurance Program

Submitted: May 29, 2020

Oregon Health Authority

Oregon HEALTH PLAN

# Table of contents

## Introduction

Oregon is among many states facing a public health crisis relating to substance use disorders (SUD). Of individuals accessing SUD treatment in Oregon, 33.5% (2017) had a primary diagnosis of opioid use disorder (OUD); this rate more than doubled over a four-year period from 2013 to 2017[1]. Oregon's opioid-related overdose deaths have increased during the past decade from 73 total deaths during 2000 to its high at 336 in 2011. In 2017 there were 6.8 deaths per 100,000 Oregon residents (276 total deaths)[2]. All deaths related to all drugs in Oregon have remained high, increasing slightly from 13.760 deaths per 100,000 population in 2009 (529) to 14.18 deaths in 2017 (578)[2]. The need is clear for continued system improvement across all substances of use.

In order to improve health outcomes and reduce deaths related to substance use disorders, Oregon must improve access to substance use disorder (SUD) treatment, increase provider capacity, and implement effective standards of care. Oregon proposes `to transform the SUD delivery system through evidence-based practices, tribal-based practices, and comprehensive care. Through the SUD waiver, Oregon will bolster existing programs and initiatives and implement new strategies to build comprehensive, continuum of care services and supports.

Specifically, Oregon has requested the waiver authority to:

a) Claim Federal reimbursement for services provided in an Institution for Mental Disease (IMD) with more than 16 beds, for the duration of time clinically deemed necessary.
b) Expand the full SUD continuum of care to include prevention, early intervention, crisis intervention and a full continuum of recovery support services. Recovery services will include certifying Peer Run Organizations (PROs), increasing the workforce and developing culturally relevant trainings (not all these initiatives require waiver authority).
c) Develop housing support services that will provide transition assistance and skill building for individuals with SUD.

This implementation plan provides details on OHA's strategic approach and how this project addresses CMS's goals and required milestones to ensure the full continuum of care succeeds in improving quality, accessibility, and outcomes for SUD/OUD treatment in the most cost-effective manner over the course of the five-year waiver period from July 1, 2020 to June 30, 2025.

[1] "SUD MMIS Treatment Data." *Oregon Health Authority*, November 28, 2018. Internal Data review

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

## Section 1- Milestone Criteria

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

| Milestone 1 Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| Criteria for completion of milestone | Provide an overview of current SUD treatment services covered by the state in each level of care. For services currently covered in the state plan, list the benefit category and page location; for services currently covered in a demonstration, include the program name and Special Term and Condition number. | Provide an overview of planned SUD treatment services to be covered by the state in each level of care: indicate whether planned services will be added to the state plan or authorized through the 1115. | Provide a list of action items needed to be completed to meet milestone requirements, if any. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item. |
| Coverage of outpatient services | Outpatient services are currently covered under Oregon's Medicaid State Plan. (ASAM 1.0)<br><br>State Plan:<br><br>SUD services-Attachment 3.1-A, section 13.d-Rehabilitation, page 6-d.10 thru 6-d.19<br><br>Adult benefit Plan-TN 17-0003 form ABP 5 coverages outpatient hospital | OHA has robust monitoring and evaluation services<br><br>Capacity of the Peer Support Services workforce has been increased (State Plan).<br><br>OHP SUD system benefits provide full continuum of care to include prevention, early intervention, and crisis intervention services (State Plan)<br><br>Each year we will improve rates of | Develop robust quarterly report for internal quality improvement strategies for SUD services (All levels) (0-6 months); Addiction Treatment, Recovery & Prevention Services; Medicaid; and Health Policy & Analytics within OHA. Set scope of work for the workforce regarding prevention, early intervention, and crisis intervention services and establish reimbursement rate. (12-24months); Addiction Treatment Recovery & Prevention unit with Health Systems Division |

| Milestone 1 Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| | SUD services, Physician services.<br><br>TCM- Targeted group: Substance Abusing Pregnant Women and Substance Abusing Parents with Children under Age 18.<br><br>Supplement 1 to Attachment 3.1-A, pages 19-22.a<br><br>Additional services covered under State Plan:<br><br>Individual/Group counseling therapy/Individual family and/or couple counseling: Attachment 3.1-A, section 13.d-SUD rehab, page 6.d.11<br><br>Acupuncture: Attachment 3.1-A, section 13.d-SUD rehab, page 6.d.13.<br><br>Adult benefit Plan-TN 17-0003 form ABP 5 | identification, initiation, and engagement<br><br>Provider capacity has expanded to adequate level for these services<br><br>Develop provider review process around staffing levels<br><br>Each provider will have been reviewed and confirmed has adequate staffing for this level of care | Set standards for identification, initiation, and engagement. Educate and engage providers around these standards and implementation. (12-24 months); Health Systems Division<br><br>Develop requirement for CCOs to have a mechanism to ensure that they have adequate capacity to serve those in their region around SUD services (12-24 months); Health Systems Division<br><br>Develop standard range of client to clinician ratio (12-24 months); Addiction Treatment Recovery & Prevention unit with Health Systems Division<br><br>Develop provider review process around staffing levels; (12-24 months); Addiction Treatment Recovery & Prevention unit with Health Systems Division |
| Coverage of intensive outpatient services | Intensive outpatient services are currently covered under Oregon's | OHA has robust monitoring and evaluation services<br><br>Capacity of the Peer Support Services | Develop robust quarterly report for internal quality improvement strategies for SUD services (All levels) (0-6 months); Addiction Treatment, Recovery & |

| Milestone 1 Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| | Medicaid State Plan. (ASAM 2.1; 2.5)<br><br>State Plan:<br><br>SUD services-Attachment 3.1-A, section 13.d-Rehabilitation, page 6-d.10 thru 6-d.19<br><br>Adult benefit Plan-TN 17-0003 form ABP 5 coverages outpatient hospital SUD services, Physician services.<br><br>TCM- Targeted group: Substance Abusing Pregnant Women and Substance Abusing Parents with Children under Age 18.<br><br>Supplement 1 to Attachment 3.1-A, pages 19-22.a | workforce has been increased (State Plan).<br><br>OHP SUD system benefits provide full continuum of care to include prevention, early intervention, and crisis intervention services (State Plan)<br><br>Each year we will improve rates of identification, initiation, and engagement<br><br>Provider capacity has expanded to adequate level for these services<br><br>Develop provider review process around staffing levels<br><br>Each provider will have been reviewed and confirmed has adequate staffing for this level of care | Prevention Services; Medicaid; and Health Policy & Analytics within OHA. Set scope of work for the workforce regarding prevention, early intervention, and crisis intervention services and establish reimbursement rate. (12-24 months); Health Systems Division<br><br>Set standards for identification, initiation, and engagement. Educate and engage providers around these standards and implementation. (12-24 months); Health Systems Division<br><br>Require CCOs to have a mechanism to ensure that they have adequate capacity to serve those in their region around SUD services (12-24 months); Health Systems Division<br><br>Develop alternative payment methodologies for Day Treatment Services (12-24months); Health Systems Division<br><br>Develop standard range of client to clinician ratio (12-24 months); Health Systems Division |

| Milestone 1 Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| Coverage of Medication Assisted Treatment (medications, as well as counseling and other services with sufficient provider capacity, to meet needs of Medicaid beneficiaries in the state) | Medication Assisted Treatment services are currently covered under Oregon's Medicaid State Plan. (All levels of Care)<br><br>State Plan:<br><br>MAT- Attachment 3.1-A, section 13.d-SUD rehab, page 6.d.12<br><br>Also covered under State Plan:<br><br>Medication management and monitoring: Attachment 3.1-A, section 13.d-SUD rehab, page 6.d.12 | OHA has robust monitoring and evaluation services<br><br>Capacity of the Peer Support Services workforce has been increased (State Plan).<br><br>OHP SUD system benefits provide full continuum of care to include prevention, early intervention, and crisis intervention services (State Plan)<br><br>Each year we will improve rates of identification, initiation, and engagement<br><br>Increase rates of identification, initiation, and engagement<br><br>Provider capacity has been increased adequately at varying clinical settings (such as office-based, Emergency Department, Primary Care, Tele-health, bridge clinics, residential etc.) | Develop robust quarterly report for internal quality improvement strategies for SUD services (All levels) (0-6 months); Addiction Treatment, Recovery & Prevention Services; Medicaid; and Health Policy & Analytics within OHA.<br><br>Set standards for identification, initiation, and engagement. Educate and engage providers around these standards and implementation (12-24 months); Health Systems Division<br><br>Develop requirement for CCOs to have a mechanism to ensure that they have adequate capacity to serve those in their region around SUD services (12-24 months); Health Systems Division<br><br>Develop standard range of client to clinician ratio (12-24 months); Health Systems Division<br><br>Engage with CCOs around adequate capacity levels for MAT and their service areas. (12-24 months); Health Systems Division<br><br>Develop provider review process around staffing levels (12-24 months); Health System Division |

| Milestone 1 Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| | | Increased qualified workforce<br><br>Each provider will have been reviewed and confirmed has adequate staffing for this level of care | |
| Coverage of intensive levels of care in residential and inpatient settings | Residential and inpatient services are currently covered under Oregon's Medicaid State Plan. (ASAM 3.1,3.3,3.5, 3.7, 4)<br><br>Currently, State funding supplements treatment that is not Medicaid-covered due to the IMD exclusion.<br><br>State Plan:<br><br>Attachment 3.1-A, section 13.d-SUD rehab, page 6.d.12 | OHA has robust monitoring and evaluation services<br><br>Increase the Peer Support Services workforce<br><br>Each year we will improve rates of identification, initiation, and engagement<br><br>Increase provider capacity<br><br>Each provider will have been reviewed and confirmed has adequate staffing for this level of care | Develop robust quarterly report for internal quality improvement strategies for SUD services (All levels) (0-6 months); Addiction Treatment, Recovery & Prevention Services; Medicaid; and Health Policy & Analytics within OHA.<br><br>Set scope of work for the workforce regarding SUD crisis intervention services and establish reimbursement rate. (12-24 months); Health Systems Division<br><br>Set standards for identification, initiation, and engagement. Educate and engage providers around these standards and implementation (12-24 months); Health Systems Division<br><br>Develop requirement for CCOs to have a mechanism to ensure that they have adequate capacity to serve those in their region around SUD services (12-24 months); Health Systems Division<br><br>Develop standard range of client to clinician ratio (12-24 |

| Milestone 1 Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| | | | months); Health Systems Division<br><br>Develop provider review process around staffing levels (12-24 months); Health System Division |
| Coverage of medically supervised withdrawal management | Medical Withdrawal services are currently covered under Oregon's Medicaid State Plan. (ASAM 3.7, 4)<br><br>Currently, State funding supplements treatment that is not Medicaid-covered due to the IMD exclusion.<br><br>State Plan:<br><br>Detox- Attachment 3.1-A, section 13.d-SUD rehab, page 6.d.13.<br><br>Adult benefit Plan-TN 17-0003 form ABP 5 | OHA has robust monitoring and evaluation services<br><br>Each year we will improve rates of identification, initiation, and engagement<br><br>Each provider will have been reviewed and confirmed has adequate staffing for this level of care<br><br>Each provider will have been reviewed and confirmed has adequate staffing for this level of care | Develop robust quarterly report for internal quality improvement strategies for SUD services (All levels) (0-6 months); Addiction Treatment, Recovery & Prevention Services; Medicaid; and Health Policy & Analytics within OHA.<br><br>Set scope of work for the workforce regarding SUD crisis intervention services and establish reimbursement rate. (12-24 months); Health Systems Division<br><br>Set standards for identification, initiation, and engagement. Educate and engage providers around these standards and implementation (12-24 months); Health Systems Division<br><br>Develop requirement for CCOs to have a mechanism to ensure that they have adequate capacity to serve those in their region around SUD services (12-24 months); Health Systems Division<br><br>Develop standard range of client to clinician ratio (12-24 |

| Milestone 1 Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| | | | months); Health Systems Division<br><br>Develop provider review process around staffing levels (12-24 months); Health System Division |
| Coverage of Peer Delivered Services across the continuum. | Peer Support Services are a covered available benefit. (All levels of Care)<br><br>Oregon is currently pursuing a Medicaid State Plan Amendment (SPA) to allow certification of Peer Run Organizations (PRO)<br><br>Oregon and The Nine Federally Recognized Tribes of Oregon and the Urban Indian Program developed Tribal- Specific Curriculum for the Family Support Peers including some SUD work. | Peer Delivered Support Services have been adequately expanded for SUD services. (12-24 months)<br><br>SPA to certify PROs is completed<br><br>Expand peer service array beyond current "in-treatment only" model to include crisis intervention, prevention, and recovery support services. (12-24 months)<br><br>The number and diversity of culturally specific peers within the workforce has been expanded | Measure long-term operational outcomes and abilities for PROs. Provide state support for administrative development as needed (12-24 months); Addiction Treatment, Recovery & Prevention Services; Medicaid; and Health Policy & Analytics within OHA.<br><br>Pursue SPA to certify Peer Run Organizations (12-24 Months); Health Systems Division<br><br>Oregon will meet with PROs and agencies that currently provide Peer Support Services (funded through state funds and federal grants) to develop a structure and draft regulations for this service. (6-12 months); Behavioral Health<br><br>Develop reimbursement rates for PROs to provide this service (12-24 months); Actuarial Services, Medicaid & Addiction Treatment, Recovery & Prevention Services. |

| Milestone 1 Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| | | | Implement services within 24 months from Agreement (12-24 months); Health Systems<br><br>Develop more culturally relevant training for peer workers, including a tribal-specific course and Latino-specific course (12-24 months); Office of Equity & Inclusion & Behavioral Health<br><br>Expand the number and diversity of culturally specific peers within the workforce (12-24 months); Health Systems division & Office of Equity and Inclusion |
| Parity of Coverage in SUD service array. | Case Management Services for individuals with only SUD are not a covered Oregon Medicaid State Plan benefit.<br><br>State Plan:<br><br>Peer Support Services: Attachment 3.1-A, section 13.d-SUD rehab, page 6.d.14.<br><br>Case Management Services (listed as care coordination)<br><br>3.1-A, section 13.d-SUD rehab, page 6.d.12 | A SPA and OAR changes are completed to expand the use of case management for pre and post treatment and for community-based services and supports such as housing and employment | Oregon will meet with agencies that provide these services (funded through state funds and federal grants) to develop a structure and draft regulations for this service. (12-24 months); Behavioral Health & Medicaid<br><br>Develop reimbursement rates for agencies to provide this service (12-24 months; Actuarial Services & Addiction Treatment, Recovery & Prevention Services<br><br>Implement service by 24 months past start (12-24 months); Health Systems Division<br><br>The state will pursue a SPA and OAR changes to expand |

| Milestone 1 Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| | | | the use of case management for pre and post treatment and for community-based services and supports such as housing and employment (12-24 months); Health Systems Division |

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

| Milestone 2 Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| Criteria for completion of milestone | Provide an overview of current state use of evidence-based, SUD-specific patient placement criteria and utilization management approach to ensure placement in appropriate level of care and receipt of services recommended for that level of care | Provide an overview of planned state implementation of requirement that providers use an evidence-based, SUD-specific patient placement criterion and use of utilization management to ensure placement in appropriate level of care and receipt of services recommended for that level of care. | Specify a list of action items needed to be completed to meet milestone requirements. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item |
| Implementation of requirement that providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools that reflect evidence-based clinical treatment guidelines | Current State OARs 309-018 and 309-019 require SUD outpatient (O/P) and residential assessments to include all ASAM PPC dimensions. | State OARs 309-018 and 309-019 continue to require SUD O/P and residential assessments to include all ASAM PPC dimensions. | None |
| Implementation of a utilization management | For over 20 years Oregon has required, | CCOs will be monitored to ensure | Refine contract language with CCOs to include ASAM (12-24 |

| Milestone 2 Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| approach such that (a) beneficiaries have access to SUD services at the appropriate level of care | and continues to require, SUD Providers to assess treatment needs based on multi-dimensional ASAM assessment tools that reflect evidence-based clinical guidelines for all levels of care, per licensing regulation and state contracts<br><br>Within contracts, the CCOs are required to ensure prior authorization staff are adequately trained in ASAM Criteria and SUD treatment services | prior authorization staff are adequately trained in ASAM criteria and SUD treatment services | months); Health Systems Division<br><br>Monitor CCOs to ensure prior authorization staff are adequately trained in ASAM criteria and SUD treatment services |
| Implementation of a utilization management approach such that (b) interventions are appropriate for the diagnosis and level of care | Current State OARs 309-018 and 309-019 require SUD outpatient and residential service plans to reflect information included in the assessment. Health Services Division (HSD) reviews a sample of the plans for compliance during renewal reviews. | State OARs 309-018 and 309-019 will be revised to specify services that must be provided for each ASAM level of care. State licensing/certification site reviews will include assessment of compliance with this requirement to ensure that service plans reflect appropriate interventions for the diagnosis and the ASAM level of care. | Consult with DOJ – (3-6 months); Health Systems Division<br><br>Consult with providers and other stakeholders – (6-12 months); Health Systems Division<br><br>Develop and implement policy and OAR amendments – (12-18 months); Health Systems Division<br><br>Provide training to providers regulated by the new rules (in person, onsite technical assistance and webinar.) – (12-24 months); Health Systems Division |
| Implementation of a utilization management | HSD's Licensing and Compliance Unit | Continue to monitor placement criteria | None |

| Milestone 2 Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| approach such that (c) there is an independent process for reviewing placement in residential treatment settings | conducts site visits and clinical review of charts and notes every 2 years to determine compliance with OARs. | within the site and clinical reviews. | |

## 3. Use of Nationally recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

| Milestone 3 Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| Criteria for completion of milestone | Provide an overview of current provider qualifications for residential treatment facilities and how these compare to nationally recognized SUD-specific program standards, e.g., the ASAM Criteria | An overview of planned use of nationally recognized SUD-specific program standards in improving provider qualifications for residential treatment facilities is provided. | Specify a list of action items needed to be completed to meet milestone requirements. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item |
| Implementation of residential treatment provider qualifications in licensure requirements, policy manuals, managed care contracts, or other guidance. Qualification should meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding, in particular, the types of services, hours of clinical care, | Current Oregon OARs 309-018 and 309-019 specify qualifications and competencies that must be met to qualify to provide SUD treatment. There is no distinction in the qualifications or competencies pertaining to levels of care. | State OARs 309-018 and 309-019 will be revised to specify requirements for qualifications and competencies for individuals providing treatment services in each level of care, consistent with ASAM.<br><br>OAR 309-018 and 309-019 will be revised to specify | Consult with DOJ – (3-6 months)); Health Systems Division<br><br>Consult with providers and other stakeholders – (6-12 months); Health Systems Division<br><br>Develop and implement policy and OAR amendments – (12-18 months); Health Systems Division |

| Milestone 3 Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| and credentials of staff for residential treatment settings | Current Oregon OAR 309-018 identifies some types of services in residential settings including smoking cessation, parenting and some life skills. There are no staffing ratios, or number of hours specified. | requirements and standards for clinical care including comprehensive services that address clinical needs and social determinants of health, staffing ratios and total hours of care provided in each level of care, consistent with ASAM. | Provide training to providers regulated by the new rules (in person, onsite technical assistance and webinar.) – (18-24 months); Health Systems Division |
| Implementation of a state process for reviewing residential treatment providers to ensure compliance with these standards | OARs 309-008 and 415-012 specify processes and standards for certification and licensure of SUD O/P and residential programs. Current licensure allows programs to provide all levels of residential services. Current certification allows programs to provide all levels of outpatient services. | OARs 309-008 and 415-012 will be revised to specify the process and standards for certification and licensure of each ASAM level of care in both O/P and residential programs. OHA/HSD-issued certificates and licenses will identify specific levels of care for each provider. | Update and implement the process for initial and renewal certification and licensure – (6-12 months); Licensing and Certification Unit<br>• Licensing and Certification Unit: Develop certificate and license types for each level of care – (6-12 months)<br><br>Update licensing and certification data base – (6-12 months); Licensing and Certification Unit: |
| Implementation of requirement that residential treatment facilities offer MAT on-site or facilitate access to MAT off-site | In residential programs, current OAR requires that providers assist individuals to access MAT by coordinating services and making transportation available. O/P | OAR will be revised to require that residential providers make MAT available on-site or provide coordination services to off-site MAT services including assisting with access, payment issues, | Consult with DOJ – (3-6 months); Health Systems Division<br><br>Consult with providers and other stakeholders – (6-12 months); Health Systems Division<br><br>Develop and implement policy and OAR |

| Milestone 3 Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| | programs are not required to provide this service, although they are not permitted to deny entry to individuals who currently receive MAT. | transportation and daycare. | amendments – (12-25 months); Health Systems Division |

## 4. Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment of OUD

| Milestone 4 Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| Criteria for completion of milestone | Provide an overview of current provider capacities throughout the state to provide SUD treatment at each of the critical levels of care listed in Milestone 1. | An overview of planned improvements to provider availability and capacity intended to improve Medicaid beneficiary access to treatment throughout the State at each of the critical levels of care listed in Milestone 1 is provided. | Specify a list of action items needed to be completed to meet milestone requirements. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item |
| Completion of assessment of the availability of providers enrolled in Medicaid and accepting new patients in the following critical levels of care throughout the state (or at least in participating regions | Oregon is conducting a provider capacity study for key levels of care in the state.<br><br>A capacity management and referral tracking data base is currently being implemented through a contract with a vendor: Lines | Provider capacity study will be completed and used to identify areas of high need.<br><br>SUD services are available at appropriate client to provider ratios including reasonable access, admittance | Create action plan to address deficits within the delivery system identify within the capacity study. (6- 12 Months); Health Systems Division<br><br>Implement the plan to address the delivery system deficits (12-24 months); Health Systems Division<br><br>Assess current client to provider ratios for all levels of treatment (0- |

| Milestone 4 Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| of the state) including those that offer MAT;<br><br>Outpatient Services;<br><br>Intensive Outpatient Services;<br><br>Medication Assisted Treatment (medications as well as counseling and other services);<br><br>Intensive Care in Residential and Inpatient Settings;<br><br>Medically Supervised Withdrawal Management. | for Life. In 2019 the focus will be on SUD Outpatient services including Office Based Opioid Treatment (OBOT) settings and Opioid Treatment Program (OTP) as well as MAT services<br><br>Oregon has identified statewide Opioid Use Disorder treatment capacity in both OBOT settings and OTP settings. | times, and reasonable geographic distances for patients to travel to clinically appropriate services.<br><br>The capacity management and referral tracking data base will be implemented statewide for all critical levels of care<br><br>Regional needs have been identified and addressed for MAT in both OTP and OBOT treatments. | 6 months); Health Systems Division<br><br>Develop the appropriate client to provider ratios (6-12 months); Health Systems Division<br><br>Develop a plan to address any gaps in provider ratio (12-18 months); Health System Division<br><br>Begin to implement changes addressing the gaps in provider ratios that were identified in service areas (18-24 months); Health Systems Division<br><br>Implement the capacity management and referral tracking data base for all SUD residential services (ASAM levels 3-4) including MAT and withdrawal management (12-24); vendor: Lines for Life.<br><br>Identify needs for MAT in OTP and OBOT settings. (6-12 months); Health Systems Division<br><br>Develop plan to meet needs of MAT in OTP and OBOT settings (12-18 months); Health Systems Division<br><br>Implement plan to address needs of MAT in OTP and OBOT settings (18-24 months); Health Systems Division<br><br>Assess the number of covered lives, availability of prevalence, incidents and diagnosis rates by region/ CCO (12-24 months); Health Systems Division |

| Milestone 4 Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| Increase provider capacity across all levels | Oregon has contracted with the Farley Center to conduct a Healthcare Workforce Assessment was completed March 2019 | The Healthcare workforce needs will be identified and addressed. | Asses the needs of the Healthcare workforce identified in the assessment. (12-24 Months); Health Systems Division<br><br>Develop the plan to address workforce issues to include activities such as (focus groups, partnerships with providers and CCOs, etc…) (12-24 months); Health Systems Division |

## 5. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

| Milestone 5 Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| Criteria for completion of milestone | Provide an overview of current treatment and prevention strategies to reduce opioid abuse and OUD in the state. | Provide an overview of planned strategies to prevent and treat opioid abuse and OUD. | Specify a list of action items needed to be completed to meet milestone requirements as detailed above. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item |
| Implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse | In 2016, the Oregon Health Authority (OHA) convened a task force to develop opioid prescribing guidelines around chronic pain and for dentists. These guidelines include recommendations for working directly with patients on treatment planning, emphasis on non-pharmacologic and | OHA will continue to emphasize individualized patient care, non-pharmacologic treatment options, and awareness around OUD in the primary care as well as ED settings.<br><br>Educated providers and implemented new guidelines and best practices around opioid use and prescribing. | Provide greater behavioral health supports (TA, education, etc.) for opioid prescribers and health systems. Especially in primary care and emergency settings to both assist patients in reducing total Morphine equivalent doses (MED) and identify SUD/OUD cases which may need individualized care. (12-24 months); Transformation Center & Health Systems Division<br><br>Health Evidence Review Commission to align payment structure with prescribing |

| Milestone 5 Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| | non-opioid pharmacolites.<br><br>OHA adopted the opioid prescribing guidelines around chronic pain and dentistry[3]. These were implemented November 17, 2016<br><br>In 2018, OHA convened a task force to develop guidelines around Acute pain and prescribing.<br><br>The opioid prescribing guidelines[4] around Acute pain were adopted by Oregon Health Authority on October 20, 2018 | Evaluated Chronic and Acute pain prescribing guidelines for updates to treatment recommendations, if required.<br><br>Current payment structure is aligned with recommended chronic and Acute prescribing guidelines | guidelines. (0-12 months); Health Systems Division |
| Expanded coverage of, and access to, naloxone for overdose reversal | Per HB3440 (2017) passage, all training requirements, special conditions, including access by social service agencies to Naloxone, and the usage of it have been removed. All Oregonians in any settings can utilize | Federal grants (STR/SOR) and other initiatives will continue to fund and increase access to naloxone statewide, especially in areas where there are gaps including rural, | Continue to distribute Naloxone in areas of high need. (0-6 Months); Health Systems Division<br><br>Continue cross-divisional collaboration at state and local level (0-24 Months); Health Systems Division<br><br>Increase communication between partners around the |

[3] "Oregon Opioid Prescribing Guidelines (Chronic)." *OHA*. November 2016. https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Documents/taskforce/oregon-opioid-prescribing-guidelines.pdf

[4] "Oregon Acute Opioid Prescribing Guidelines." *OHA*. October 2018. https://www.oregon.gov/OSBN/pdfs/Resource_OregonAcuteOpioidPrescribingGuidelines.pdf

| Milestone 5 Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| | Naloxone without prior training for other conditions. Pharmacists may dispense Naloxone at the point of sale. Oregon Health Plan fee-for-service program (directly administered by OHA) has no prior authorization for Naloxone; CCO coverage varies.<br><br>Cross-division partnerships with OHA, Public Health and Health Systems Divisions as well as partnerships with local health departments to fund the Prescription Drug Overdose coordinator(s) (PDO). PDOs will continue to assist in coordinating local naloxone distribution efforts. | frontier and coastal areas.<br><br>Continue cross-division partnerships and funding for the PDO position(s). Work together on opioid crisis response collectively to activities such as overdose outbreaks.<br><br>Continue to support CCO engagement with the Transformation Center and other resources for technical assistance (TA) around Naloxone distribution and utilization. | alignment of payment structure as it relates to Naloxone to increase access to and penetration of the population at greatest risk and need. (6-12 Months); Health Systems Division<br><br>Continue to encourage use and provide TA around Naloxone access, use and distribution to CCOs through the Transformation Center. (0-6 months); Transformation Center & Health Systems Division |
| Implementation of strategies to increase utilization and improve functionality of Prescription Drug Monitoring Programs (PDMP) | As of January 2018, medical and pharmacy directors will be allowed access to the PDMP in regard to their respective entities.<br><br>As of February 2018, through HB 4143, the PDMP | Continue funding the PDMP program to data access, analysis, and improve upon the surveillance potential. Utilize this data to assess the impact of opioid use statewide and engage those communities | Continue to collaborate with provider licensing boards (continuous); Health Systems Division<br><br>Educate and engage with provider organizations, CCOs, and healthcare prescribers to increase the number of registered individuals who utilize the system (12-24 |

| Milestone 5 Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| | registration is mandatory for healthcare practitioners who are authorized to prescribe schedule II through IV controlled medications.<br><br>Public health and education regarding the value of PDMP registration and utilization are ongoing to providers and organizations. | most impacted by the effects of the opioid crisis.<br><br>Continue to collaborate with healthcare licensing boards within Oregon to encourage safe and appropriate controlled substance prescribing.<br><br>The number of healthcare prescribers who use the PDMP beyond the required registration increased. | months); Health Systems Division |
| Other | In February 2018 the passage of HB 4143 passed the (Opioid Rapid Response Project), provided resources to create more direct links between ED and appropriate treatment and resources including increased availability of MAT in the ED and using peer recovery support mentors to facilitate the link between ED and appropriate treatment/ resources. This two-year pilot project starting in January 2019 will | The Opioid Rapid Response Project was expanded statewide to other high risk and high burden counties.<br><br>The scope of peer delivered services via a Medicaid benefit through prevention, early intervention, crisis intervention etc. prior to treatment and recovery services post treatment was expanded.<br><br>Coverage of community | Leverage opportunities to secure more funding (federal grants, Federal opioid project funding, state funds etc.) to expand Opioid Rapid Response project statewide. (12-24 months); Health Systems Division<br><br>Increase PDS workforce capacity through the certification of Peer Run Organizations (PRO) (12-24 months); Health Systems Division<br><br>Increase capacity of culturally-relevant PDS workforce (12-24 months); Health Systems Division<br><br>Increase the number of culturally-relevant trainings (including tribal) to be |

| Milestone 5 Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| | begin in four Oregon counties.<br><br>2. Under the Oregon State Plan currently peer delivered services are covered when delivered as part of a treatment plan under the supervision of a licensed program or provider | integration services and supports specifically for housing are implemented; ensuring safe housing in an appropriate recovery environment, special attention and effort around MAT housing | developed and provided statewide (12-24 months); Office of Equity & inclusion & Health Systems Division<br><br>Increase the development of PROs and individuals to meet PDS requirements to meet the long-term recovery needs (12-24 months); Health Systems Division<br><br>Workforce development efforts around community integration/ housing support specialists as Medicaid participating providers (12-24 months); Health Systems Division<br><br>Development of reimbursement rates and coding for community integration housing support services (12-24 months); Actuarial Services & Behavioral Health |

## 6. Improved Care Coordination and Transitions between Levels of Care

| Milestone 6 Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| Implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities | Provide an overview of current care coordination services and transition services across levels of care. | Provide an overview of planned improvements to care coordination services and transition services across levels of care. | Specify a list of action items needed to be completed to meet milestone requirements. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item |

| Milestone 6 Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| Creation and implementation of additional policies to ensure coordination of care for co-occurring physical and mental health conditions | Under Oregon's current structure, SUD services are covered under physical health services and behavioral health care coordination are the responsibility of the CCOs<br><br>To support OHA's ED Disparity Measure for CCOs, the hospital notifications product, The Collective (formerly called Pre-Manage), has added a flag for CCOs and their contracted clinics to alert when a Medicaid member with Severe and Persistent Mental Illness (SPMI) has a hospital event for a physical reason for coordination of care among CCOs and providers. | CCOs increased their capacity to provide warmer hand offs between levels of care through enhanced coordinated care for SUD services<br><br>Those in Medication Assisted Treatment for SUD, IV drug users, and individuals with SUD in need of withdrawal management were added as prioritized population (2020) for the CCOs in 2020<br><br>OHA will continue to work on optimization and education on the ED disparity measure flags provided through The Collective. | Provide support to CCOs through TA and training to increase capacity and quality of SUD care transitions (12-24 months)<br><br>An educational series, specifically for CCOs, is planned for early 2019 in support of improving care coordination services. (0-6 months)<br><br>CCO 2.0 includes language requiring CCOs use hospital event notifications and make them- and health information exchange for care coordinating- accessible to primary care, behavioral health and dental organizations. (12-24 months)<br><br>Those in Medication Assisted Treatment for SUD, IV drug users, and individuals with SUD in need of withdrawal management will be added as prioritized population (2020) for the CCOs in 2020 (12-24 months); Health Systems Division |

## Section II- Implementation Administration

### Oregon Demonstration Contact

Lori Coyner
Medicaid Director
Health Systems Division
Oregon Health Authority
500 Summer St.
Salem, OR 97301-1079

*Oregon Health Authority*
lori.a.coyner@dhsoha.state.or.us
(503) 947-2340

## Section III- Relevant Documents

*Please provide any additional Documentation or information that the state deems relevant to successful execution of the implementation plan.*

## Attachment A- Milestone 5a- SUD Health Information Technology (IT) Plan

***Section I.***

| Milestone 5a Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| *5. Implementation of comprehensive treatment and prevention strategies to address Opioid Abuse and OUD, that is:*<br>*--Enhance the state's health IT functionality to support its PDMP; and*<br>*--Enhance and/or support clinicians in their usage of the state's PDMP.* | *Provide an overview of current PDMP capabilities, health IT functionalities to support the PDMP, and supports to enhance clinicians' use of the state's health IT functionality to achieve the goals of the PDMP.* | *Provide an overview of plans for enhancing the state's PDMP, related enhancements to its health IT functionalities, and related enhancements to support clinicians' use of the health IT functionality to achieve the goals of the PDMP.* | *Specify a list of action items needed to be completed to meet the HIT/PDMP milestones identified in the first column. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item* |
| **Prescription Drug Monitoring Program (PDMP) Functionalities** | | | |
| Enhanced interstate data sharing to provide prescribers a more comprehensive prescription history for patients with prescriptions across state lines. | Oregon PDMP can share data with states that meet privacy and security standards.<br><br>Oregon has circulated Memoranda of Understanding (MOUs) to western states.<br><br>Interstate data sharing agreements are in place with Idaho, Kansas, Nevada, | Connection of Oregon's PDMP with contiguous states to allow secure sharing of PDMP data. | (6-24 months)<br>Oregon PDMP will continue conversations with contiguous states to resolve legal and technical barriers for interstate data sharing.<br>This may include Oregon PDMP joining the data sharing hub Rx Check in addition to |

| Milestone 5a Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| | Texas, and North Dakota. | | the current data sharing hub.<br><br>Dependencies to this include:<br>- Washington State is not leveraging the same vendor as Oregon for interstate exchange.<br>- California passed legislation in 2018 which will enable interstate exchange, but that legislation is not enacted until July 2020. It is also not known which vendor California will use for interstate data sharing |
| Enhanced "ease of use" for prescribers and other state and federal stakeholders | Prescribers (physicians (MD, PA, DO), Pharmacists (RPh), Nurse Practitioners (NP/CNS-PP), Dentists (DDS/DMD), and Naturopaths (ND), across Oregon, are allowed access to the PDMP system after registration.<br><br>Medical and Pharmacy Directors are allowed access for the purpose of overseeing | PDMP integration with most prescriber systems. Integrated PDMP supports clinician ease of use by pulling PDMP data into their electronic workflow for "one-click" access. | (6-24 months), the PDMP will collaborate with HIT Commons and other stakeholders to:<br><br>– Educate on certain registration and technical thresholds required for integration of prescriber health IT systems with PDMP.<br>– Integrate most prescriber systems |

| Milestone 5a Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| | prescribing and dispensing within their respective entities.<br><br>Prescribers and Medical and Pharmacy Directors are allowed delegates.<br><br>Oregon has a statewide initiative to integrate PDMP into health IT systems, including: EHRs, HIEs, pharmacy management systems, and the statewide hospital event notification system Edie.<br><br>Oregon PDMP has partnered with the HIT Commons (public/private partnership) to help subsidize this connection. | | (representing 16K prescribers and 4 pharmacy chains) with PDMP.<br><br>PDMP will engage with the PDMP Advisory Council and PDMP Integration Steering Committee, as needed, to develop "ease of use" strategies (enhancements, education, etc.) for prescribers |
| Enhanced connectivity between the state's PDMP and any statewide, regional or local health information exchange | Under the statewide initiative to integrate PDMP into health IT systems, Community Health Information Exchanges (HIEs) can integrate with PDMP.<br><br>Two of Oregon's HIEs are working towards integration. | Integration of Oregon's Community Health Information Exchanges with PDMP | (6-24 months) PDMP and HIT Commons will continue to work with Oregon's Community HIEs to integrate with PDMP.<br><br>(6-24 months) PDMP will work with the HIT Commons, PDMP Integration |

| Milestone 5a Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| | Oregon PDMP is working with the HIT Commons (public/private partnership) to help subsidize this connection. | | Steering Committee, and HIE stakeholders to continue to assess enhancements which support clinicians use of HIE to access PDMP data (delegates, training, etc.). |
| Enhanced identification of long-term opioid uses directly correlated to clinician prescribing patterns[5] (see also "Use of PDMP" #2 below) | According to statute, the Oregon PDMP may not evaluate professional practice except through licensing boards or the PDMP Advisory Commission Prescribing Practice Review Subcommittee. The subcommittee provides education and resources to the highest prescribers.<br><br>The PDMP has collaborated with the Oregon Pain Management Commission to develop a free Continuous Medical Education (CME) module on pain management; so far more than 5,000 | Continued leveraging of the PDMP Advisory Commission Clinics Review Subcommittee and continued collaboration with Oregon Pain Management Commission to educate prescribers for informed prescribing choices. | (0-12 months) PDMP will convene the Clinical Review Subcommittee with a quorum to redefine and update thresholds for risky prescribing at minimum once per year.<br><br>(6-24 months) PDMP will continue to work with licensing boards to ensure that licensees are registered with the PDMP as mandated by statute.<br><br>(0-24 months) The PDMP will continue to promote the CME resource to stakeholders and enhance education and resources provided to the highest prescribers. |

[5] Shah A, Hayes CJ, Martin BC. Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015. MMWR Morb Mortal Wkly Rep 2017;66:265–269. DOI: http://dx.doi.org/10.15585/mmwr.mm6610a1.

| Milestone 5a Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| | providers have taken the course. | | |
| **Current and Future PDMP Query Capabilities** | | | |
| Facilitate the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e. the state's master patient index (MPI) strategy with regard to PDMP query) | States on the AWARxE platform share the same patient matching algorithm which uses the available data fields to determine which records should be consolidated to unique individuals. The proprietary vendor (Appriss) algorithm allows for certain non-exact matches such as common misspellings, nicknames, or changes in address. | The PDMP will share information with the Governor's Opioid Epidemic Taskforce to consider future changes to statute which allow data sharing in support of patient matching.<br><br>Continue PDMP data quality improvement efforts with propriety vendor for patient data matching processes and analytics. | (0-24 months) The PDMP will continue engagement with the Governor's Opioid Epidemic Taskforce, including around the topic of allowing data sharing with the Medicaid program or collection of additional fields.<br><br>(0-24 months) PDMP will follow any future statute changes from the legislature to enable matching of PDMP and Medicaid data or to allow submission of additional data fields.<br><br>(0-24 months) The Oregon PDMP MPI strategy is developed by the AWARxE platform vendor (Appriss) and is primarily the responsibility of the vendor. PDMP staff will work with the vendor to incorporate additional data fields required by any statute changes. |

| Milestone 5a Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| | | | |
| **Use of PDMP – Supporting Clinicians with Changing Office Workflows / Business Processes** | | | |
| Develop enhanced provider workflow / business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance to address the issues which follow | Prescribers are allowed access to the PDMP system through a web portal after registration.<br><br>Prescribers are allowed delegates to support clinician workflows.<br><br>Oregon is in the second year of a three-year statewide initiative to integrate PDMP into health IT systems, including: EHRs, HIEs, pharmacy management systems, and the statewide hospital event notification system Edie.<br><br>Oregon PDMP has partnered with the HIT Commons (public/private partnership) to help subsidize this connection. | PDMP integration with most prescriber systems. Integrated PDMP supports clinician ease of use by pulling PDMP data into their electronic workflow for "one-click" access. | (0-24 months)<br>PDMP will collaborate with HIT Commons, PDMP Integration Steering Committee, and other stakeholders as needed to:<br><br>– Educate on certain registration and technical thresholds required for integration of prescriber health IT systems with PDMP.<br>– Integrate most prescriber systems (representing 16K prescribers and 4 pharmacy chains) with PDMP.<br>– Share best practices and provide education on leveraging integrated workflows to support informed prescribing of |

| Milestone 5a Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| | | | controlled substances. |
| Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions provided through the PDMP—prior to the issuance of an opioid prescription | Prescribers can review individual patient records, their own prescribing history, or a threshold report listing all patients that meet certain risky prescribing thresholds (high dose, co-prescribing, etc.).<br><br>Emergency Department (ED) physicians who have the Emergency Department Information Exchange (EDIE) integrated into their ED track boards may receive PDMP data pushed to them when a patient meets certain criteria, prompting review of patient's history before prescribing.<br><br>Additionally, the PDMP allows prescribers and pharmacists to enable delegates to search the PDMP on their behalf in order to support clinician review of | PDMP integration with most prescriber health IT systems.<br><br>PDMP pushed to all ED physicians in Oregon with integrated EDIE in their EHR.<br><br>PDMP stakeholders are educated and receive assistance. | (0-24 months) PDMP staff will collaborate with HIT Commons, PDMP Integration Steering Committee, and other stakeholders as needed to:<br><br>– Enable PDMP to be pushed through EDIE for hospitals who have already integrated the EDIE solution into their EHR<br>– Support rural hospitals who wish to integrate EDIE into their EHR through a grant provided by OHA and the Oregon Association for Hospitals and Health Systems |

| Milestone 5a Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| | PDMP prior to an opioid prescription issuance. | | |
| **Master Patient Index / Identity Management** | | | |
| Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery. | Oregon's PDMP collection of data fields is defined by state law.<br>The Oregon PDMP MPI strategy is developed by the AWARxE platform vendor (Appriss). The AWARxE platform uses a proprietary patient matching algorithm which uses the available data fields to determine which records should be consolidated to unique individuals. The proprietary algorithm allows for certain non-exact matches such as common misspellings, nicknames, or changes in address to achieve an acceptable sensitivity and specificity.<br><br>The EDIE vendor, used by hospitals to receive pushed PDMP notifications when a patient enters the ED who meets certain criteria, also has a defined algorithm MPI | PDMP utilizes Appriss AWARExE platform effectively to support SUD care delivery.<br><br>PDMP data is pushed through EDIE notifications where hospitals have integrated EDIE into their HER. | (0-24 months) the PDMP will continue engagement with the Governor's Opioid Epidemic Taskforce, around statute changes required to allow data sharing with the Medicaid program or collection of additional fields.<br><br>The PDMP will follow any future statute changes that allow data sharing between PDMP and Medicaid to enhance the state MPI in support of SUD care delivery.<br><br>PDMP staff will work with the vendor to incorporate additional data fields required by any statute changes. |

| Milestone 5a Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| | that provides match and patient record merging. This supports SUD care delivery as ED physicians are notified of PDMP data, as well as historical hospital data on the patient at the point of care. | | |
| **Overall Objective for Enhancing PDMP Functionality & Interoperability** | | | |
| Leverage the above functionalities / capabilities / supports (in concert with any other state health IT, TA or workflow effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing—and to ensure that Medicaid does not inappropriately pay for opioids | Oregon PDMPs mission is primarily to support clinical decision-making. Medical Directors and Pharmacy Directors are allowed access to the PDMP to perform clinical quality assurance activities for the providers they supervise.<br><br>Oregon is in year two of a three-year statewide initiative to integrate PDMP into health IT systems, including: EHRs, HIEs, pharmacy management systems, and the statewide hospital event notification system EDie.<br><br>– Legislation in 2019 added Dental Directors and CCO | Dental Directors and CCO Medical Directors access PDMP data in support of clinical quality assurance activities.<br><br>PDMP integration with a majority of prescriber systems supports effective controls to minimize the risk of inappropriate opioid overprescribing by leveraging system functionalities (HIE, EDIE) | (6-24 months) PDMP will collaborate with HIT Commons, PDMP Integration Steering Committee, and other stakeholders as needed to:<br><br>– Register CCO Medical Directors and Dental Directors if legislation is passed.<br>– Educate on certain registration and technical thresholds required for integration of prescriber health IT systems with PDMP.<br>– Integrate a majority of prescriber systems (representing 16K |

| Milestone 5a Criteria | Current State | Future State | Summary of Actions Needed |
|---|---|---|---|
| | Medical Directors to list of authorized users of PDMP | | prescribers and 4 pharmacy chains) with PDMP.<br>– Share best practices and provide education on leveraging integrated workflows to support informed prescribing of controlled substances. |

## SUD IMD Facilities

5 Year Historical Costs & Future Projections Based on Trends

**Inflation:** **4.50%**

| 5 year History | 2015 | 2016 | 2017 | 2018 | 2019 w/ Adjustment |
|---|---|---|---|---|---|
| **PCR** | | | | | |
| FFS SUD IMD Services | 397,200 | 429,270 | 888,606 | 405,594 | 648,947 |
| FFS Non-SUD IMD Services | 219,741 | 300,277 | 879,214 | 263,649 | 282,813 |
| CCO Cap Payments | 498,305 | 422,394 | 577,420 | 530,372 | 609,469 |
| Total Expenditure | 1,115,246 | 1,151,941 | 2,345,240 | 1,199,615 | 1,541,230 |
| Member Months | 1,267 | 1,106 | 1,474 | 1,250 | 1,362 |
| PMPM | 880 | 1,042 | 1,591 | 960 | 1,132 |
| **PWO** | | | | | |
| FFS SUD IMD Services | 243,000 | 174,465 | 344,900 | 78,900 | 173,993 |
| FFS Non-SUD IMD Services | 219,438 | 268,446 | 534,715 | 131,981 | 134,850 |
| CCO Cap Payments | 234,474 | 234,666 | 121,383 | 86,618 | 96,629 |
| Total Expenditure | 696,912 | 677,577 | 1,000,998 | 297,499 | 405,472 |
| Member Months | 606 | 543 | 346 | 238 | 260 |
| PMPM | 1,150 | 1,248 | 2,893 | 1,250 | 1,560 |
| **CMO** | | | | | |
| FFS SUD IMD Services | 278,601 | 461,190 | 624,304 | 231,780 | 444,217 |
| FFS Non-SUD IMD Services | 77,371 | 131,764 | 111,509 | 68,707 | 85,085 |
| CCO Cap Payments | 102,071 | 120,051 | 103,927 | 98,830 | 81,636 |
| Total Expenditure | 458,044 | 713,004 | 839,740 | 399,317 | 610,939 |
| Member Months | 705 | 828 | 712 | 615 | 487 |
| PMPM | 650 | 861 | 1,179 | 649 | 1,254 |
| **ABAD** | | | | | |
| FFS SUD IMD Services | 418,469 | 278,631 | 472,280 | 197,760 | 442,343 |
| FFS Non-SUD IMD Services | 370,070 | 261,531 | 312,788 | 146,568 | 251,088 |
| CCO Cap Payments | 458,078 | 550,584 | 525,861 | 718,276 | 561,640 |
| Total Expenditure | 1,246,617 | 1,090,746 | 1,310,929 | 1,062,604 | 1,255,071 |
| Member Months | 421 | 492 | 451 | 620 | 524 |
| PMPM | 2,961 | 2,217 | 2,907 | 1,714 | 2,395 |
| **FC/SAC** | | | | | |
| FFS SUD IMD Services | 137,035 | 155,810 | 187,502 | 108,514 | 97,047 |
| FFS Non-SUD IMD Services | 28,107 | 202,431 | 269,201 | 43,647 | 31,457 |
| CCO Cap Payments | 70,641 | 79,513 | 93,277 | 86,752 | 74,710 |
| Total Expenditure | 235,783 | 437,754 | 549,980 | 238,913 | 203,214 |
| Member Months | 150 | 159 | 171 | 200 | 152 |
| PMPM | 1,572 | 2,753 | 3,216 | 1,195 | 1,337 |

| Projections | SFY20 Base Year | SFY21 DY 1 | SFY22 DY 2 | SFY23 DY 3 | SFY24 DY 4 | SFY25 DY 5 | 5 year Total | |
|---|---|---|---|---|---|---|---|---|
| **PCR Combined Costs** | | | | | | | | |
| Member Month Trend Rate | 1.80% | | | | | | | |
| PMPM Cost Trend | 6.50% | | | | | | | |
| Total Expenditure | 1,670,960 | 1,777,581 | 1,891,006 | 2,011,667 | 2,140,036 | 2,276,589 | 10,096,879 | - |
| Member Months | 1,387 | 1,411 | 1,437 | 1,463 | 1,489 | 1,516 | 7,316 | |
| PMPM | 1,205 | 1,259 | 1,316 | 1,375 | 1,437 | 1,502 | 1,380 | |
| **PWO Combined Costs** | | | | | | | | |
| Member Month Trend Rate | -19.10% | | | | | | | |
| PMPM Cost Trend | 7.90% | | | | | | | |
| Total Expenditure | 353,941 | 299,223 | 252,965 | 213,858 | 180,796 | 152,846 | 1,099,689 | - |
| Member Months | 210 | 170 | 138 | 111 | 90 | 73 | 582 | |
| PMPM | 1,683 | 1,758 | 1,838 | 1,920 | 2,007 | 2,097 | 1,889 | |
| **CMO Combined Costs** | | | | | | | | |
| Member Month Trend Rate | -8.80% | | | | | | | |
| PMPM Cost Trend | 17.90% | | | | | | | |
| Total Expenditure | 656,911 | 626,063.75 | 596,662.89 | 568,642.86 | 541,938.53 | 516,488.94 | 2,849,797 | - |
| Member Months | 444 | 405 | 369 | 337 | 307 | 280 | 1,699 | |
| PMPM | 1,479 | 1,545.61 | 1,615.16 | 1,687.84 | 1,763.79 | 1,843.16 | 1,677 | |
| **ABAD Combined Costs** | | | | | | | | |
| Member Month Trend Rate | 5.60% | | | | | | | |
| PMPM Cost Trend | -5.20% | | | | | | | |
| Total Expenditure | 1,256,434 | 1,386,501 | 1,530,034 | 1,688,423 | 1,863,207 | 2,056,086 | 8,524,251 | - |
| Member Months | 553 | 584 | 617 | 652 | 688 | 727 | 3,268 | |
| PMPM | 2,271 | 2,373 | 2,480 | 2,591 | 2,708 | 2,830 | 2,609 | |
| **FC/SAC Combined Costs** | | | | | | | | |
| Member Month Trend Rate | 0.30% | | | | | | | |
| PMPM Cost Trend | -4.00% | | | | | | | |
| Total Expenditure | 195,671 | 205,090 | 214,962 | 225,309 | 236,154 | 247,521 | 1,129,036 | - |
| Member Months | 152 | 153 | 153 | 154 | 154 | 155 | 769 | |
| PMPM | 1,283 | 1,341 | 1,402 | 1,465 | 1,531 | 1,599 | 1,468 | |

| ACA | | | | | | ACA Combined Costs | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FFS SUD IMD Services | 3,175,383 | 3,025,690 | 6,448,832 | 3,096,394 | 6,969,182 | Member Month Trend Rate | 7.70% | | | | | | | |
| FFS Non-SUD IMD Services | 1,964,657 | 2,748,988 | 4,247,028 | 2,141,069 | 2,978,688 | PMPM Cost Trend | 6.10% | | | | | | | |
| CCO Cap Payments | 2,624,822 | 2,456,486 | 2,399,926 | 3,043,807 | 3,307,702 | | | | | | | | | |
| Total Expenditure | 7,764,861 | 8,231,164 | 13,095,785 | 8,281,270 | 13,255,572 | Total Expenditure | 15,147,130 | 17,047,568 | 19,186,448 | 21,593,716 | 24,302,999 | 27,352,163 | 109,482,894 | - |
| Member Months | 5,696 | 6,216 | 6,461 | 7,521 | 7,677 | Member Months | 8,268 | 8,905 | 9,590 | 10,329 | 11,124 | 11,981 | 51,929 | |
| PMPM | 1,363 | 1,324 | 2,027 | 1,101 | 1,727 | PMPM | 1,832 | 1,914 | 2,001 | 2,091 | 2,185 | 2,283 | 2,108 | |

| CHIP | | | | | | CHIP Combined Costs | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FFS SUD IMD Services | 41,427 | 45,760 | 58,307 | 17,600 | 40,788 | Member Month Trend Rate | 7.80% | | | | | | | |
| FFS Non-SUD IMD Services | 10,247 | 22,413 | 10,062 | 4,501 | 16,177 | PMPM Cost Trend | -0.60% | | | | | | | |
| CCO Cap Payments | 23,033 | 20,759 | 33,030 | 42,337 | 41,440 | | | | | | | | | |
| Total Expenditure | 74,707 | 88,932 | 101,400 | 64,438 | 98,405 | Total Expenditure | 105,444 | 118,784 | 133,810 | 150,739 | 169,810 | 191,293 | 764,436 | - |
| Member Months | 162 | 151 | 206 | 249 | 219 | Member Months | 236 | 254 | 274 | 296 | 319 | 344 | 1,487 | |
| PMPM | 461 | 589 | 492 | 259 | 449 | PMPM | 447 | 467 | 488 | 510 | 533 | 557 | 514 | |

| CAWEM Prenatal | | | | | | CAWEM Prenatal Combined Costs | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FFS SUD IMD Services | - | - | - | 14,910 | 2,604 | Member Month Trend Rate | 0.00% | | | | | | | |
| FFS Non-SUD IMD Services | - | - | - | 3,117 | 20,601 | PMPM Cost Trend | 28.70% | | | | | | | |
| CCO Cap Payments | - | - | - | - | - | | | | | | | | | |
| Total Expenditure | - | - | - | 18,027 | 23,205 | Total Expenditure | 29,864 | 31,208 | 32,613 | 34,080 | 35,614 | 37,217 | 170,732 | - |
| Member Months | - | - | - | 2 | 2 | Member Months | 2 | 2 | 2 | 2 | 2 | 2 | 10 | |
| PMPM | | | | 9,013 | 11,602 | PMPM | 14,932 | 15,604 | 16,306 | 17,040 | 17,807 | 18,608 | 17,073 | |

| Combined History | | | | | | Combined Projections | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total Fund | 11,592,171 | 12,391,118 | 19,244,073 | 11,552,669 | 17,381,505 | Total Fund | 19,416,355 | 21,492,020 | 23,838,500 | 26,486,435 | 29,470,556 | 32,830,204 | 134,117,714 |

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

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

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

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

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

## Community Integration & Recovery Support Services - Projections by MEG - Beginning DY 2

Assumes annual MM Trend of 25%

Program Estimates | -4.50% | 4.50%

| PMPM's | | Base Year | SFY22 DY 2 | SFY23 DY 3 | SFY24 DY 4 | SFY25 DY 5 | 4 Year Total - Solved for |
|---|---|---|---|---|---|---|---|
| **PCR** | **13%** | | | | | | |
| H0043 | Supported Housing | $260.44 | $272.16 | $284.41 | $297.21 | $310.58 | $294.62 |
| H2014 | Skills training and development, per 15 min | $152.50 | $159.36 | $166.53 | $174.02 | $181.85 | $172.51 |
| H2023 | Supported Employment, per 15 min | $152.50 | $159.36 | $166.53 | $174.02 | $181.85 | $172.51 |
| H2023 | Supported Education, per 15 min | $152.50 | $159.36 | $166.53 | $174.02 | $181.85 | $172.51 |
| H0038 | Self-help/peer services, per 15 min | $338.76 | $354.00 | $369.93 | $386.58 | $403.98 | $383.21 |
| | **Total (Solved for)** | **$296.27** | **$309.60** | **$323.53** | **$338.09** | **$353.31** | **$335.15** |
| **PWO** | **4%** | | | | | | |
| H0043 | Supported Housing | $260.44 | $272.16 | $284.41 | $297.21 | $310.58 | $294.62 |
| H2014 | Skills training and development, per 15 min | $152.50 | $159.36 | $166.53 | $174.02 | $181.85 | $172.51 |
| H2023 | Supported Employment, per 15 min | $152.50 | $159.36 | $166.53 | $174.02 | $181.85 | $172.51 |
| H2023 | Supported Education, per 15 min | $152.50 | $159.36 | $166.53 | $174.02 | $181.85 | $172.51 |
| H0038 | Self-help/peer services, per 15 min | $338.76 | $354.00 | $369.93 | $386.58 | $403.98 | $383.21 |
| | **Total (Solved for)** | **$296.27** | **$309.60** | **$323.53** | **$338.09** | **$353.31** | **$335.15** |
| **CMO** | **7%** | | | | | | |
| H0043 | Supported Housing | $260.44 | $272.16 | $284.41 | $297.21 | $310.58 | $294.62 |
| H2014 | Skills training and development, per 15 min | $152.50 | $159.36 | $166.53 | $174.02 | $181.85 | $172.51 |
| H2023 | Supported Employment, per 15 min | $152.50 | $159.36 | $166.53 | $174.02 | $181.85 | $172.51 |
| H2023 | Supported Education, per 15 min | $152.50 | $159.36 | $166.53 | $174.02 | $181.85 | $172.51 |
| H0038 | Self-help/peer services, per 15 min | $338.76 | $354.00 | $369.93 | $386.58 | $403.98 | $383.21 |
| | **Total (Solved for)** | **$296.27** | **$309.60** | **$323.53** | **$338.09** | **$353.31** | **$335.15** |
| **ABAD** | **5%** | | | | | | |
| H0043 | Supported Housing | $260.44 | $272.16 | $284.41 | $297.21 | $310.58 | $294.62 |
| H2014 | Skills training and development, per 15 min | $152.50 | $159.36 | $166.53 | $174.02 | $181.85 | $172.51 |
| H2023 | Supported Employment, per 15 min | $152.50 | $159.36 | $166.53 | $174.02 | $181.85 | $172.51 |
| H2023 | Supported Education, per 15 min | $152.50 | $159.36 | $166.53 | $174.02 | $181.85 | $172.51 |
| H0038 | Self-help/peer services, per 15 min | $338.76 | $354.00 | $369.93 | $386.58 | $403.98 | $383.21 |
| | **Total (Solved for)** | **$296.27** | **$309.60** | **$323.53** | **$338.09** | **$353.31** | **$335.15** |

-25.00% | 25.00%

| MM's | | Base Year | SFY22 DY 2 | SFY23 DY 3 | SFY24 DY 4 | SFY25 DY 5 | 4 Year Total | MM Trend DY2-DY4 |
|---|---|---|---|---|---|---|---|---|
| **PCR** | | | | | | | | |
| H0043 | Supported Housing | 18 | 23 | 29 | 36 | 45 | 132 | 25.00% |
| H2014 | Skills training and development, per 15 min | 73 | 92 | 115 | 143 | 179 | 529 | 25.00% |
| H2023 | Supported Employment, per 15 min | 214 | 268 | 334 | 418 | 523 | 1,543 | 25.00% |
| H2023 | Supported Education, per 15 min | 214 | 268 | 334 | 418 | 523 | 1,543 | 25.00% |
| H0038 | Self-help/peer services, per 15 min | 1,713 | 2,141 | 2,676 | 3,345 | 4,181 | 12,342 | 25.00% |
| | **Total** | **2,232** | **2,790** | **3,488** | **4,360** | **5,450** | **16,089** | **25.00%** |
| **PWO** | | | | | | | | |
| H0043 | Supported Housing | 6 | 7 | 9 | 11 | 14 | 41 | 25.00% |
| H2014 | Skills training and development, per 15 min | 23 | 28 | 35 | 44 | 55 | 163 | 25.00% |
| H2023 | Supported Employment, per 15 min | 66 | 83 | 103 | 129 | 161 | 476 | 25.00% |
| H2023 | Supported Education, per 15 min | 66 | 83 | 103 | 129 | 161 | 476 | 25.00% |
| H0038 | Self-help/peer services, per 15 min | 528 | 661 | 826 | 1,032 | 1,290 | 3,808 | 25.00% |
| | **Total** | **689** | **861** | **1,076** | **1,345** | **1,682** | **4,964** | **25.00%** |
| **CMO** | | | | | | | | |
| H0043 | Supported Housing | 10 | 12 | 15 | 19 | 23 | 69 | 25.00% |
| H2014 | Skills training and development, per 15 min | 38 | 48 | 59 | 74 | 93 | 274 | 25.00% |
| H2023 | Supported Employment, per 15 min | 111 | 139 | 173 | 217 | 271 | 799 | 25.00% |
| H2023 | Supported Education, per 15 min | 111 | 139 | 173 | 217 | 271 | 799 | 25.00% |
| H0038 | Self-help/peer services, per 15 min | 887 | 1,109 | 1,387 | 1,733 | 2,167 | 6,396 | 25.00% |
| | **Total** | **1,157** | **1,446** | **1,808** | **2,259** | **2,824** | **8,337** | **25.00%** |
| **ABAD** | | | | | | | | |
| H0043 | Supported Housing | 7 | 9 | 11 | 14 | 17 | 51 | 25.00% |
| H2014 | Skills training and development, per 15 min | 28 | 36 | 45 | 56 | 70 | 205 | 25.00% |
| H2023 | Supported Employment, per 15 min | 83 | 104 | 130 | 162 | 203 | 599 | 25.00% |
| H2023 | Supported Education, per 15 min | 83 | 104 | 130 | 162 | 203 | 599 | 25.00% |
| H0038 | Self-help/peer services, per 15 min | 665 | 831 | 1,039 | 1,299 | 1,623 | 4,792 | 25.00% |
| | **Total** | **867** | **1,084** | **1,354** | **1,693** | **2,116** | **6,247** | **25.00%** |

| Expenditures | | Base Year | SFY22 DY 2 | SFY23 DY 3 | SFY24 DY 4 | SFY25 DY 5 | 4 Year Total |
|---|---|---|---|---|---|---|---|
| **PCR** | | | | | | | |
| H0043 | Supported Housing | $4,779 | $6,242 | $8,154 | $10,651 | $13,913 | $38,960 |
| H2014 | Skills training and development, per 15 min | $11,193 | $14,620 | $19,097 | $24,945 | $32,584 | $91,247 |
| H2023 | Supported Employment, per 15 min | $32,645 | $42,642 | $55,700 | $72,757 | $95,038 | $266,137 |
| H2023 | Supported Education, per 15 min | $32,645 | $42,642 | $55,700 | $72,757 | $95,038 | $266,137 |
| H0038 | Self-help/peer services, per 15 | $580,131 | $757,788 | $989,860 | $1,293,015 | $1,689,017 | $4,729,680 |
| | **Total** | **$661,392** | **$863,933** | **$1,128,511** | **$1,474,125** | **$1,925,591** | **$5,392,160** |
| **PWO** | | | | | | | |
| H0043 | Supported Housing | $1,475 | $1,926 | $2,516 | $3,286 | $4,293 | $12,021 |
| H2014 | Skills training and development, per 15 min | $3,454 | $4,511 | $5,893 | $7,697 | $10,054 | $28,155 |
| H2023 | Supported Employment, per 15 min | $10,073 | $13,158 | $17,187 | $22,450 | $29,325 | $82,120 |
| H2023 | Supported Education, per 15 min | $10,073 | $13,158 | $17,187 | $22,450 | $29,325 | $82,120 |
| H0038 | Self-help/peer services, per 15 | $179,006 | $233,824 | $305,433 | $398,975 | $521,166 | $1,459,398 |
| | **Total** | **$204,080** | **$266,577** | **$348,215** | **$454,858** | **$594,164** | **$1,663,814** |
| **CMO** | | | | | | | |
| H0043 | Supported Housing | $2,476 | $3,235 | $4,225 | $5,519 | $7,209 | $20,189 |
| H2014 | Skills training and development, per 15 min | $5,800 | $7,576 | $9,896 | $12,926 | $16,885 | $47,283 |
| H2023 | Supported Employment, per 15 min | $16,916 | $22,097 | $28,863 | $37,702 | $49,248 | $137,910 |
| H2023 | Supported Education, per 15 min | $16,916 | $22,097 | $28,863 | $37,702 | $49,248 | $137,910 |
| H0038 | Self-help/peer services, per 15 | $300,619 | $392,679 | $512,937 | $670,030 | $875,235 | $2,450,881 |
| | **Total** | **$342,728** | **$447,683** | **$584,785** | **$763,879** | **$997,825** | **$2,794,172** |
| **ABAD** | | | | | | | |
| H0043 | Supported Housing | $1,856 | $2,424 | $3,166 | $4,136 | $5,402 | $15,128 |
| H2014 | Skills training and development, per 15 min | $4,346 | $5,677 | $7,415 | $9,686 | $12,652 | $35,431 |
| H2023 | Supported Employment, per 15 min | $12,676 | $16,558 | $21,628 | $28,251 | $36,903 | $103,340 |
| H2023 | Supported Education, per 15 min | $12,676 | $16,558 | $21,628 | $28,251 | $36,903 | $103,340 |
| H0038 | Self-help/peer services, per 15 | $225,262 | $294,245 | $384,358 | $502,072 | $655,838 | $1,836,513 |
| | **Total** | **$256,816** | **$335,461** | **$438,196** | **$572,396** | **$747,698** | **$2,093,751** |

| OAA | 1% | | | | | | |
|---|---|---|---|---|---|---|---|
| H0043 | Supported Housing | $260.44 | $272.16 | $284.41 | $297.21 | $310.58 | $294.62 |
| H2014 | Skills training and development, per 15 min | $152.50 | $159.36 | $166.53 | $174.02 | $181.85 | $172.51 |
| H2023 | Supported Employment, per 15 min | $152.50 | $159.36 | $166.53 | $174.02 | $181.85 | $172.51 |
| H2023 | Supported Education, per 15 min | $152.50 | $159.36 | $166.53 | $174.02 | $181.85 | $172.51 |
| H0038 | Self-help/peer services, per 15 min | $338.76 | $354.00 | $369.93 | $386.58 | $403.98 | $383.21 |
| | **Total (Solved for)** | **$296.27** | **$309.60** | **$323.53** | **$338.09** | **$353.31** | **$335.15** |
| **FC/SAC** | **2%** | | | | | | |
| H0043 | Supported Housing | $260.44 | $272.16 | $284.41 | $297.21 | $310.58 | $294.62 |
| H2014 | Skills training and development, per 15 min | $152.50 | $159.36 | $166.53 | $174.02 | $181.85 | $172.51 |
| H2023 | Supported Employment, per 15 min | $152.50 | $159.36 | $166.53 | $174.02 | $181.85 | $172.51 |
| H2023 | Supported Education, per 15 min | $152.50 | $159.36 | $166.53 | $174.02 | $181.85 | $172.51 |
| H0038 | Self-help/peer services, per 15 min | $338.76 | $354.00 | $369.93 | $386.58 | $403.98 | $383.21 |
| | **68%** | **$296.27** | **$309.60** | **$323.53** | **$338.09** | **$353.31** | **$335.15** |
| **ACA** | **66%** | | | | | | |
| H0043 | Supported Housing | $260.44 | $272.16 | $284.41 | $297.21 | $310.58 | $294.62 |
| H2014 | Skills training and development, per 15 min | $152.50 | $159.36 | $166.53 | $174.02 | $181.85 | $172.51 |
| H2023 | Supported Employment, per 15 min | $152.50 | $159.36 | $166.53 | $174.02 | $181.85 | $172.51 |
| H2023 | Supported Education, per 15 min | $152.50 | $159.36 | $166.53 | $174.02 | $181.85 | $172.51 |
| H0038 | Self-help/peer services, per 15 min | $338.76 | $354.00 | $369.93 | $386.58 | $403.98 | $383.21 |
| | **Total (Solved for)** | **$296.27** | **$309.60** | **$323.53** | **$338.09** | **$353.31** | **$335.15** |
| **CHIP** | **2%** | | | | | | |
| H0043 | Supported Housing | $260.44 | $272.16 | $284.41 | $297.21 | $310.58 | $294.62 |
| H2014 | Skills training and development, per 15 min | $152.50 | $159.36 | $166.53 | $174.02 | $181.85 | $172.51 |
| H2023 | Supported Employment, per 15 min | $152.50 | $159.36 | $166.53 | $174.02 | $181.85 | $172.51 |
| H2023 | Supported Education, per 15 min | $152.50 | $159.36 | $166.53 | $174.02 | $181.85 | $172.51 |
| H0038 | Self-help/peer services, per 15 min | $338.76 | $354.00 | $369.93 | $386.58 | $403.98 | $383.21 |
| | **Total (Solved for)** | **$296.27** | **$309.60** | **$323.53** | **$338.09** | **$353.31** | **$335.15** |

| OAA | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| H0043 | Supported Housing | 1 | 2 | 2 | 3 | 3 | 10 | 25.00% |
| H2014 | Skills training and development, per 15 min | 6 | 7 | 9 | 11 | 14 | 41 | 25.00% |
| H2023 | Supported Employment, per 15 min | 16 | 21 | 26 | 32 | 40 | 119 | 25.00% |
| H2023 | Supported Education, per 15 min | 16 | 21 | 26 | 32 | 40 | 119 | 25.00% |
| H0038 | Self-help/peer services, per 15 min | 132 | 165 | 206 | 257 | 322 | 950 | 25.00% |
| | **Total** | **172** | **215** | **268** | **335** | **419** | **1,238** | **25.00%** |
| **FC/SAC** | | | | | | | | |
| H0043 | Supported Housing | 2 | 3 | 4 | 5 | 6 | 17 | 25.00% |
| H2014 | Skills training and development, per 15 min | 9 | 12 | 15 | 18 | 23 | 68 | 25.00% |
| H2023 | Supported Employment, per 15 min | 28 | 34 | 43 | 54 | 67 | 199 | 25.00% |
| H2023 | Supported Education, per 15 min | 28 | 34 | 43 | 54 | 67 | 199 | 25.00% |
| H0038 | Self-help/peer services, per 15 min | 221 | 276 | 345 | 431 | 539 | 1,590 | 25.00% |
| | **Total** | **288** | **359** | **449** | **562** | **702** | **2,072** | **25.00%** |
| **ACA** | | | | | | | | |
| H0043 | Supported Housing | 95 | 119 | 149 | 186 | 233 | 687 | 25.00% |
| H2014 | Skills training and development, per 15 min | 381 | 477 | 596 | 745 | 931 | 2,749 | 25.00% |
| H2023 | Supported Employment, per 15 min | 1,113 | 1,391 | 1,738 | 2,173 | 2,716 | 8,019 | 25.00% |
| H2023 | Supported Education, per 15 min | 1,113 | 1,391 | 1,738 | 2,173 | 2,716 | 8,019 | 25.00% |
| H0038 | Self-help/peer services, per 15 min | 8,901 | 11,126 | 13,908 | 17,385 | 21,731 | 64,149 | 25.00% |
| | **Total** | **11,603** | **14,504** | **18,130** | **22,662** | **28,327** | **83,623** | **25.00%** |
| **CHIP** | | | | | | | | |
| H0043 | Supported Housing | 3 | 4 | 4 | 5 | 7 | 20 | 25.00% |
| H2014 | Skills training and development, per 15 min | 11 | 14 | 18 | 22 | 27 | 81 | 25.00% |
| H2023 | Supported Employment, per 15 min | 33 | 41 | 51 | 64 | 80 | 236 | 25.00% |
| H2023 | Supported Education, per 15 min | 33 | 41 | 51 | 64 | 80 | 236 | 25.00% |
| H0038 | Self-help/peer services, per 15 min | 262 | 327 | 409 | 511 | 639 | 1,886 | 25.00% |
| | **Total** | **341** | **426** | **533** | **666** | **833** | **2,459** | **25.00%** |

| OAA | | | | | | | |
|---|---|---|---|---|---|---|---|
| H0043 | Supported Housing | $368 | $480 | $627 | $820 | $1,070 | $2,998 |
| H2014 | Skills training and development, per 15 min | $861 | $1,125 | $1,469 | $1,919 | $2,507 | $7,021 |
| H2023 | Supported Employment, per 15 min | $2,512 | $3,281 | $4,286 | $5,598 | $7,312 | $20,477 |
| H2023 | Supported Education, per 15 min | $2,512 | $3,281 | $4,286 | $5,598 | $7,312 | $20,477 |
| H0038 | Self-help/peer services, per 15 | $44,637 | $58,306 | $76,162 | $99,488 | $129,957 | $363,912 |
| | **Total** | **$50,889** | **$66,473** | **$86,830** | **$113,422** | **$148,159** | **$414,885** |
| **FC/SAC** | | | | | | | |
| H0043 | Supported Housing | $616 | $804 | $1,050 | $1,372 | $1,792 | $5,018 |
| H2014 | Skills training and development, per 15 min | $1,442 | $1,883 | $2,460 | $3,213 | $4,197 | $11,754 |
| H2023 | Supported Employment, per 15 min | $4,205 | $5,493 | $7,175 | $9,372 | $12,242 | $34,282 |
| H2023 | Supported Education, per 15 min | $4,205 | $5,493 | $7,175 | $9,372 | $12,242 | $34,282 |
| H0038 | Self-help/peer services, per 15 | $74,728 | $97,613 | $127,506 | $166,557 | $217,567 | $609,242 |
| | **Total** | **$85,196** | **$111,285** | **$145,366** | **$189,886** | **$248,040** | **$694,578** |
| **ACA** | | | | | | | |
| H0043 | Supported Housing | $24,837 | $32,444 | $42,380 | $55,359 | $72,312 | $202,495 |
| H2014 | Skills training and development, per 15 min | $58,174 | $75,988 | $99,259 | $129,654 | $169,360 | $474,260 |
| H2023 | Supported Employment, per 15 min | $169,673 | $221,632 | $289,505 | $378,157 | $493,965 | $1,383,259 |
| H2023 | Supported Education, per 15 min | $169,673 | $221,632 | $289,505 | $378,157 | $493,965 | $1,383,259 |
| H0038 | Self-help/peer services, per 15 | $3,015,264 | $3,938,642 | $5,144,851 | $6,720,516 | $8,778,759 | $24,582,767 |
| | **Total** | **$3,437,621** | **$4,490,338** | **$5,865,499** | **$7,661,844** | **$10,008,361** | **$28,026,042** |
| **CHIP** | | | | | | | |
| H0043 | Supported Housing | $730 | $954 | $1,246 | $1,628 | $2,126 | $5,953 |
| H2014 | Skills training and development, per 15 min | $1,710 | $2,234 | $2,918 | $3,812 | $4,979 | $13,943 |
| H2023 | Supported Employment, per 15 min | $4,988 | $6,516 | $8,512 | $11,118 | $14,523 | $40,668 |
| H2023 | Supported Education, per 15 min | $4,988 | $6,516 | $8,512 | $11,118 | $14,523 | $40,668 |
| H0038 | Self-help/peer services, per 15 | $88,650 | $115,798 | $151,261 | $197,586 | $258,099 | $722,743 |
| | **Total** | **$101,067** | **$132,018** | **$172,448** | **$225,261** | **$294,250** | **$823,976** |

| CAWEM Prenatal | 1% | | | | | | | CAWEM Prenatal | | | | | | | | | CAWEM Prenatal | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| H0043 | Supported Housing | $260.44 | $272.16 | $284.41 | $297.21 | $310.58 | $294.62 | H0043 | Supported Housing | 1 | 2 | 2 | 3 | 3 | 10 | 25.00% | H0043 | Supported Housing | $368 | $480 | $627 | $820 | $1,070 | $2,998 |
| H2014 | Skills training and development, per 15 min | $152.50 | $159.36 | $166.53 | $174.02 | $181.85 | $172.51 | H2014 | Skills training and development, per 15 min | 6 | 7 | 9 | 11 | 14 | 41 | 25.00% | H2014 | Skills training and development, per 15 min | $861 | $1,125 | $1,469 | $1,919 | $2,507 | $7,021 |
| H2023 | Supported Employment, per 15 min | $152.50 | $159.36 | $166.53 | $174.02 | $181.85 | $172.51 | H2023 | Supported Employment, per 15 min | 16 | 21 | 26 | 32 | 40 | 119 | 25.00% | H2023 | Supported Employment, per 15 min | $2,512 | $3,281 | $4,286 | $5,598 | $7,312 | $20,477 |
| H2023 | Supported Education, per 15 min | $152.50 | $159.36 | $166.53 | $174.02 | $181.85 | $172.51 | H2023 | Supported Education, per 15 min | 16 | 21 | 26 | 32 | 40 | 119 | 25.00% | H2023 | Supported Education, per 15 min | $2,512 | $3,281 | $4,286 | $5,598 | $7,312 | $20,477 |
| H0038 | Self-help/peer services, per 15 min | $338.76 | $354.00 | $369.93 | $386.58 | $403.98 | $383.21 | H0038 | Self-help/peer services, per 15 min | 132 | 165 | 206 | 257 | 322 | 950 | 25.00% | H0038 | Self-help/peer services, per 15 | $44,637 | $58,306 | $76,162 | $99,488 | $129,957 | $363,912 |
| | **Total (Solved for)** | **$296.27** | **$309.60** | **$323.53** | **$338.09** | **$353.31** | **$335.15** | | **Total** | **172** | **215** | **268** | **335** | **419** | **1,238** | **25.00%** | | **Total** | **$50,889** | **$66,473** | **$86,830** | **$113,422** | **$148,159** | **$414,885** |
| **Total** | **100%** | **(Should be 100%)** | | | | | | | | | | | | | | | | | | | | | | |
| H0043 | Supported Housing | $260.44 | $272.16 | $284.41 | $297.21 | $310.58 | $294.62 | H0043 | Supported Housing | 144 | 180 | 225 | 281 | 352 | 1,038 | 25.00% | H0043 | Supported Housing | $37,503 | $48,989 | $63,992 | $83,590 | $109,188 | $305,760 |
| H2014 | Skills training and development, per 15 min | $152.50 | $159.36 | $166.53 | $174.03 | $181.86 | $172.51 | H2014 | Skills training and development, per 15 min | 576 | 720 | 900 | 1,125 | 1,406 | 4,151 | 25.00% | H2014 | Skills training and development, per 15 min | $87,840 | $114,739 | $149,877 | $195,773 | $255,727 | $716,115 |
| H2023 | Supported Employment, per 15 min | $152.50 | $159.36 | $166.53 | $174.03 | $181.86 | $172.51 | H2023 | Supported Employment, per 15 min | 1,680 | 2,100 | 2,625 | 3,281 | 4,102 | 12,108 | 25.00% | H2023 | Supported Employment, per 15 min | $256,200 | $334,656 | $437,141 | $571,003 | $745,869 | $2,088,670 |
| H2023 | Supported Education, per 15 min | $152.50 | $159.36 | $166.53 | $174.03 | $181.86 | $172.51 | H2023 | Supported Education, per 15 min | 1,680 | 2,100 | 2,625 | 3,281 | 4,102 | 12,108 | 25.00% | H2023 | Supported Education, per 15 min | $256,200 | $334,656 | $437,141 | $571,003 | $745,869 | $2,088,670 |
| H0038 | Self-help/peer services, per 15 min | $338.76 | $354.00 | $369.93 | $386.58 | $403.97 | $383.21 | H0038 | Self-help/peer services, per 15 min | 13,440 | 16,800 | 21,000 | 26,250 | 32,813 | 96,863 | 25.00% | H0038 | Self-help/peer services, per 15 | $4,552,934 | $5,947,200 | $7,768,530 | $10,147,725 | $13,255,594 | $37,119,049 |
| | **Total (Solved for)** | **$296.27** | **$309.60** | **$323.53** | **$338.09** | **$353.31** | **$335.15** | | **Total** | **17,520** | **21,900** | **27,375** | **34,219** | **42,773** | **126,267** | **25.00%** | | **Total** | **$5,190,678** | **$6,780,240** | **$8,856,682** | **$11,569,094** | **$15,112,247** | **$42,318,263** |
| | PMPM Cost Trend Base - DY5 | 4.50% | | | | | | | MM Trend Rate Base - DY5 | 25.00% | | | | | | | | | | | | | | |
| | | | | | | | | | Cross-check (s/b zero): | - | | | | | | | | | | | | | | |

## Community Integration & Recovery Support Services

Program projections, beginning in DY2

DY2

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