MERCER

1115 Waiver Demonstration

Substance Use Disorder Mid-Point Assessment Report

Commonwealth of Pennsylvania
February 19, 2021

Contents

1 Introduction

The “Pennsylvania Substance Use Disorder 1115(a) Medicaid Demonstration” amendment, which was approved on June 28, 2018, became effective July 1, 2018 and will continue through September 30, 2022 (four years and three months). The amendment is part of the larger Demonstration “Pennsylvania Former Foster Care Youth from a Different State and Substance Use Disorder 1115(a) Medicaid Demonstration” which was originally approved effective October 1, 2017.

The purpose of the Section 1115 Demonstration Substance Use Disorder (SUD) waiver amendment is to afford continued access to high quality, medically necessary treatment for Opioid Use Disorder (OUD) and other SUDs. The mid-point assessment in this document will apply to this SUD Demonstration amendment.

The purpose of the Demonstration is to test a new paradigm for delivering SUD services for Medicaid enrollees. By providing comprehensive, quality SUD treatment, the SUD program will achieve the following goals:

1. Reduce overdose deaths, particularly those due to opioids.
2. Reduce utilization of Emergency Department (ED) and Inpatient hospital settings.
3. Reduce readmissions to the same or higher level of care (LOC).

The Commonwealth of Pennsylvania (Commonwealth or Pennsylvania) believes that these three goals will be achieved through Demonstration activities that increase access to high quality of care across the entire treatment continuum, increase treatment program retention, and improve care transition across the continuum of SUD services. The specific interventions include:

- Continuing federal reimbursement for residential treatment stays beyond the 15-day limit under the Medicaid Managed Care rule.
- Adopting all American Society of Addiction Medicine (ASAM) LOCs and the ASAM patient placement criteria in Medicaid managed care.
- Ensuring provider capacity at critical LOCs including Medication assisted treatment for OUD.
- Implementing nationally recognized SUD-specific program standards to set provider qualifications for Residential Treatment Facilities (RTFs).
- Implementing comprehensive treatment and prevention strategies to address opioid abuse and OUD.
- Improving care coordination and transitions between LOCs.

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Purpose and Process

This report summarizes findings from a mid-point assessment of current progress toward implementing each item in the Demonstration implementation plan, meeting Demonstration milestones, monitoring metric targets, and meeting budget neutrality requirements. In order to conduct this assessment, Mercer Government Human Services Consulting (Mercer), the independent evaluator, conducted the following analysis:

- **Document Reviews**. A content analysis of documentation (policies, procedures, quarterly progress reports) was conducted to summarize the specific actions taken in implementing the Demonstration and to assess implementation progress.

- **Focus Groups**. Focus groups were conducted with the Office of Mental Health and Substance Abuse Services (OMHSAS), Department of Drug and Alcohol Programs (DDAP), Prescription Drug Monitoring Program (PDMP), eHealth leadership and staff, as well as representatives from Primary Contractors (PCs), Behavioral Health Managed Care Organizations (BH-MCOs), county departments and providers (participants in the Drug and Alcohol Committee) to assess current implementation progress and to identify challenges to full implementation.

- **Member Perspectives**. Due to the novel COVID-19 public health emergency (PHE), it was not possible to organize focus groups of members to gather their perspectives on Demonstration implementation. Mercer was able to obtain four published reports from PCs/BH-MCOs/providers with results of member satisfaction with SUD services (based on either surveys or focus groups). This information is limited but provides a general baseline picture of member satisfaction and will be explored further in the interim evaluation report.

- **Monitoring Metrics**. A descriptive, time series analysis was used to document current progress in meeting project goals and milestones.

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Mid-Point Assessment Findings

Milestone 1: Access to Critical Levels of Care for Opioid Use Disorder and other Substance Use Disorders

Description/Goal(s)	Action Items from Implementation Plan	Current Status
Coverage of: • Outpatient • Intensive Outpatient (IOP) Services • Medication-Assisted Treatment (MAT) (medications, as well as counseling and other services with sufficient capacity to meet needs of Medicaid beneficiaries in the Commonwealth) • Intensive LOCs in Residential and Inpatient settings • Medically Supervised Withdrawal Management (WM)	• Crosswalk of the ASAM Criteria with the current system of care.	Completed
	• Begin to utilize The ASAM Criteria for admission determination of LOC on July 1, 2018.	Completed
	• Align Pennsylvania's SUD system of care (services, hours of service, staff credentials, etc.) with the ASAM Criteria is expected to be completed in July 2021.	In progress

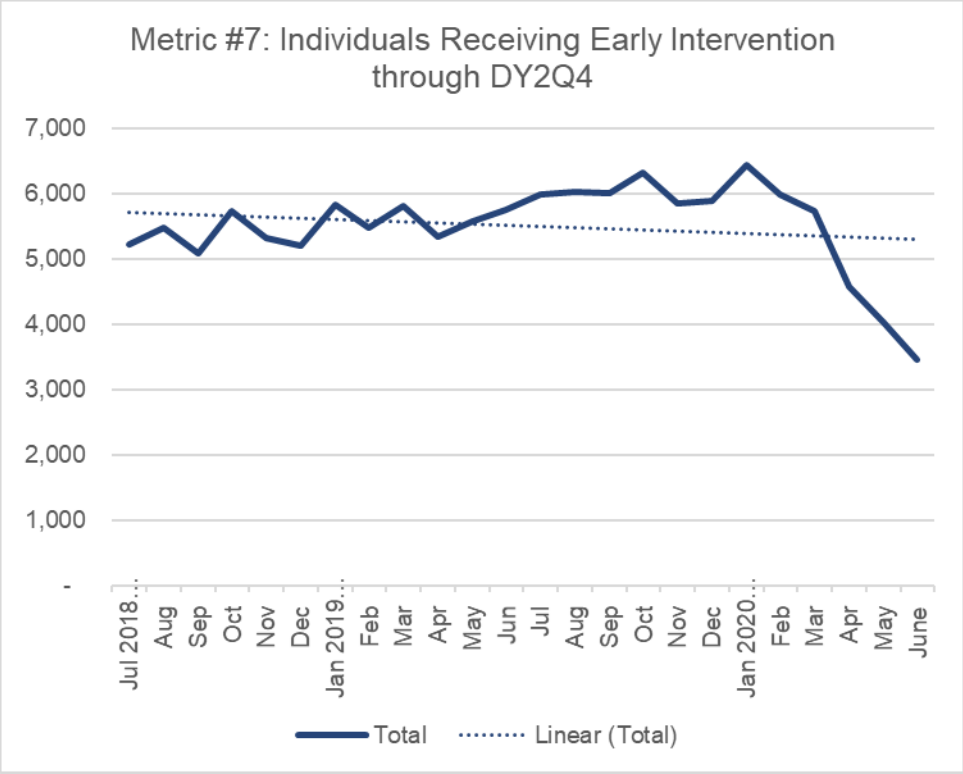
Implementation Progress

Two of the three implementation items have been completed (66%). The Commonwealth completed its crosswalk of ASAM Criteria with the current system of care and providers have begun to use ASAM Criteria for admission to each LOC. Work continues to align service delivery descriptions and expectations. Training for providers continues and the Department of Human Services (DHS) and DDAP have worked together to develop ASAM service descriptions and delivery standards including admission, continuing stay and discharge criteria, the types of services, hours of clinical care, credentials of staff, and implementation of requirements for each LOC. DHS is working to ensure that the coding is consistent with any needed changes. Only WM service descriptions and delivery standards are not developed yet. Providers are expected to align delivery with the new service definitions starting July 1, 2021, with full compliance required by July 1, 2022.

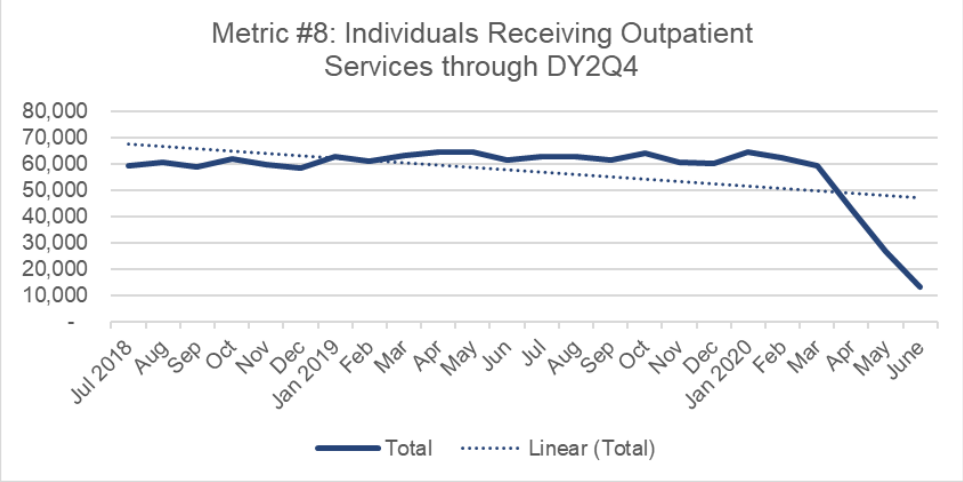
Critical Metrics

Critical metrics for Milestone 1 (Metrics 7–12, 22) show the number of individuals receiving services at critical LOCs. Change over time between baseline (July 2018) and the most recent data available (June 2020) are displayed in the graphs below for metrics 7 through 11. Programming for calculating Metric 22 is still in development.

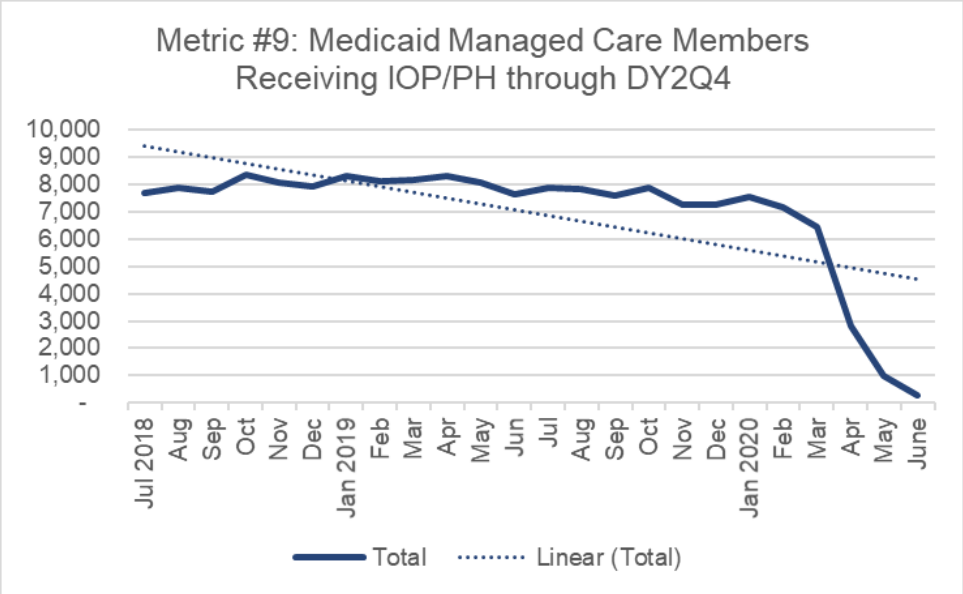
Prior to February 2020, the number of individuals receiving SUD treatment were generally constant. However, the number of individuals receiving any service decreased with the COVID-19 PHE after March 2020.



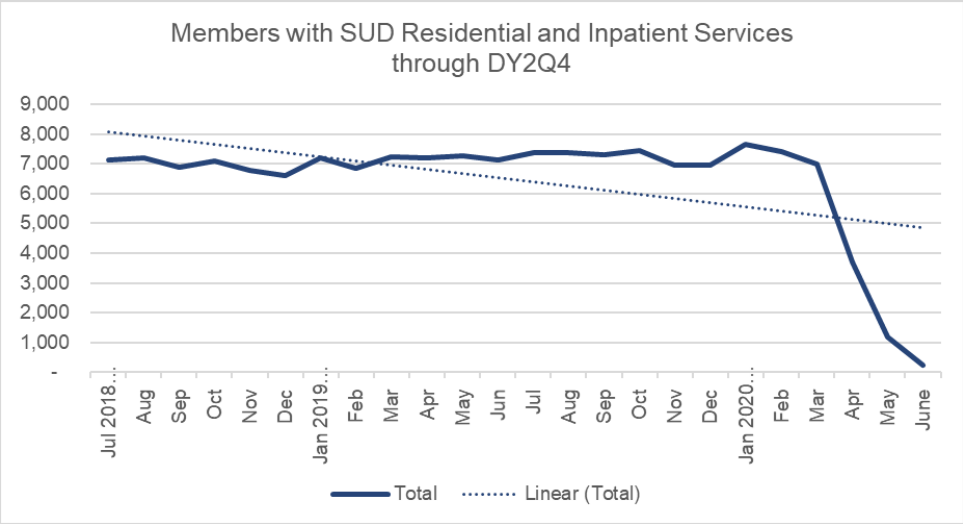
The number of individuals receiving early intervention treatment fluctuated somewhat over the first two Demonstration Years (DYs), but generally increased over time. Increases were seen in both the first and the second year, up until the onset of the PHE.



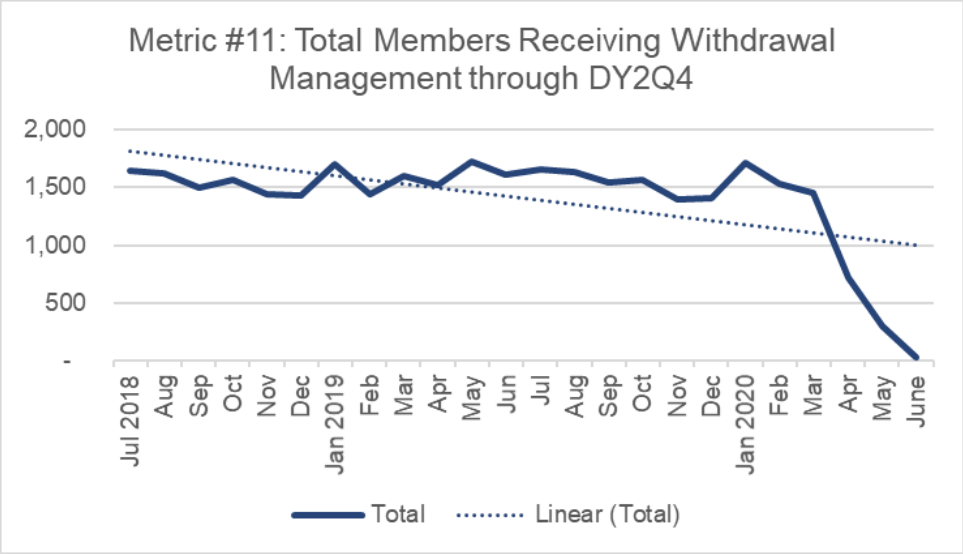
The number of people receiving outpatient services remained relatively stable, increasing only slightly over the first two DYs up until the onset of the PHE.



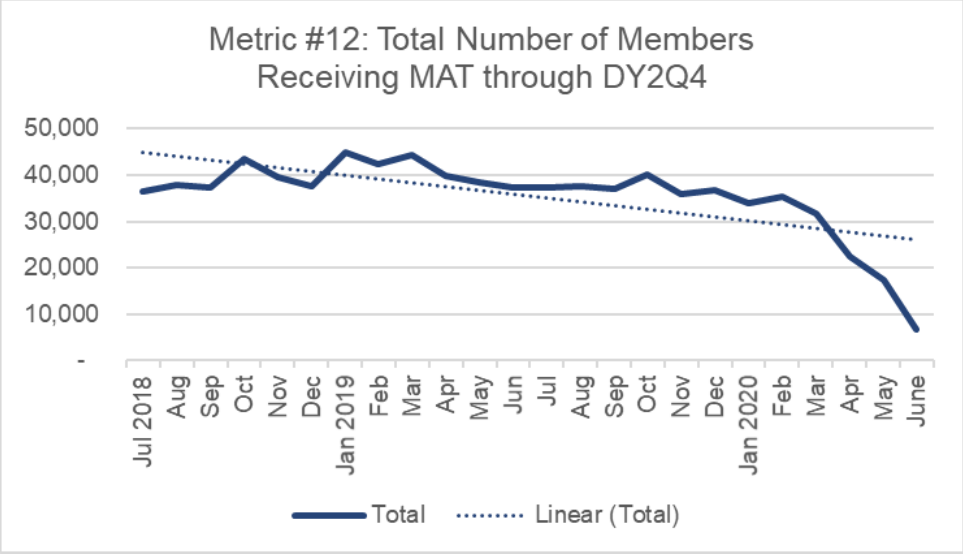
The number of Medicaid managed care members receiving IOP or Partial Hospitalization Program (PHP) services between July 2018 and January 2020 also stayed fairly stable, decreasing slightly over the two years up until the onset of the PHE. Note: the Commonwealth's standards for IOP and PHP have been clarified to better align with ASAM standards and this could account for fewer programs reporting that they provide PHP, which is substantially different under ASAM from the historic Commonwealth service description. Since these services are in congregate settings, almost all utilization dropped off after the beginning of the PHE in March 2020.



Members receiving SUD residential and inpatient treatment also stayed relatively unchanged, decreasing very slightly over the two-year Demonstration period up until the onset of the PHE.



There was a decline in the number of members receiving WM overall across the two years. There was more cyclical variation in the number of individuals receiving withdrawal services and those receiving early intervention than in other outpatient, inpatient, and intensive inpatient LOCs.



Between July 2018 and December of 2019, there was virtually no change in the number of members receiving MAT. There was an initial increase during year one, but the decline during the second year balanced out the initial increases. About 50% of the increase in 2019 was due to the implementation of Centers of Excellence and initiatives in the Commonwealth to increase MAT usage. MAT for dual eligibles dropped starting January 1, 2020 because of Medicare's new coverage of MAT.

Metric Number	Metric Name	Baseline Total (Jul 2018)	DY2Q2 Total (Dec 2019)	Change from Baseline Total	DY2Q3 Total (Mar 2020)	Change from Baseline Total
7	Early Intervention	5,218	5,891	12.90%	5,732	9.85%
8	Outpatient Services	59,508	60,153	1.08%	59,415	-0.16%
9	IOP and PHP Services	7,687	7,281	-5.28%	6,458	-15.99%
10	Residential and Inpatient Services	7,142	6,961	-2.53%	6,984	-2.21%
11	WM	1,649	1,405	-14.80%	1,449	-12.13%
12	MAT	36,338	36,690	0.97%	31,647	-12.91%

Note: Mercer is comparing with DY2Q2 and DY2Q3 rather than DY2Q4 due to the PHE's effect on utilization.

The Commonwealth anticipated, generally, only small increases in the numbers of individuals served in each LOC, and set annual targets for improvement of 1% in the rate of individuals with a SUD diagnosis in each LOC. Because the number of members with a SUD diagnosis remained very stable across the two-year period examined here, prior to the PHE onset, it is likely that this rate increase was not realized for the most intensive LOCs.

The least restrictive LOCs (early intervention, outpatient, and MAT or three of six metrics) did show an overall increase, while the metrics for the most intensive LOCs (IOP/PHP, residential, WM or three of six metrics) showed declines. The most notable changes were the 12.9% increase in the number of individuals receiving early intervention services and the 14.8% decrease in members receiving WM. It is not clear if the implementation of ASAM assessment requirements and the use of ASAM placement criteria for ASAM admission are resulting in individuals being treated at more appropriate and lower LOCs or if there are other factors at work. While most administrative work has been done to make progress on action items associated with the ASAM placement criteria, the full use of ASAM for determining LOCs and guiding service delivery have not been fully implemented at the provider level concurrent with the alignment of service definitions to ASAM. Contractual requirements for the use of ASAM service definitions will begin July 2021 and compliance will be required July 2022.

Stakeholder Feedback

OMHSAS and DDAP leadership and staff expressed confidence in the current progress being made toward implementing all action items from Milestone 1; these groups cautioned that as full implementation is still underway, it is too early to fully assess the impact to access for each LOC. Most stakeholders acknowledged that providers will need more time than originally anticipated for full compliance and while much progress has been made, there is still a great deal of work to do. Because DDAP is continuing to roll out service descriptions, but has not yet completed the process for WM, services are not yet aligned at the provider level. It is too soon to fully assess how transition to the criteria is impacting access.

There was initially a disruption in training, around ASAM assessment criteria for admission to and service delivery characteristics in each LOC, due to the requirement of a two-day, in-person training. DDAP implemented on-line training for payers and providers to address this issue.

There was consensus among OMHSAS and DDAP leadership and staff that providers overall seemed to be doing well in initial ASAM assessment and treatment plan training, and have begun to use the criteria for admissions, but have not yet aligned service delivery as definitions and guidance continue to transition. This assessment of progress was echoed by PC/BH-MCO representatives who expressed the view that providers overall were doing well in the ongoing implementation of ASAM. Some providers were less certain of how far Single County Authorities (SCAs) and PC/BH-MCOs have gotten into the transition and whether or not considerations are being (or will be) made for new service delivery requirements and the rates set.

The primary challenges discussed were around distinctions in ASAM LOCs in residential and intensive inpatient treatment. Specifically, participants described challenges determining which organizations can provide clinically managed High-Intensity Residential Services (ASAM LOC 3.5) versus medically monitored Intensive Inpatient Services (ASAM LOC 3.7) and what specifically should be offered at each level. The participants also described confusion on the part of providers around whether providers can mix individuals in the two LOCs. This challenge arises because LOC 3.7 is new to the Commonwealth and was mentioned among all of the groups included in this assessment.

Payment for these two LOCs were also discussed, with concern being raised about whether or not payers have fully recognized the increased staffing demands of LOC 3.7 and if the variances had been factored into differential rates between the two LOCs. While this concern is most pressing for LOCs 3.5 and 3.7, the increased number of service hours across all ASAM LOCs may create staffing challenges for providers. Providers specifically noted that the current payment system is not aligned to the LOC 3.7 requirements. Providers also noted that all of the new qualifications could impact staffing; this includes concerns over workforce sufficiency, as there will be a need to hire more licensed practitioners and meeting staffing requirements as private practices can generally offer greater compensation. OMHSAS and DDAP leaders said they recognize this challenge and continue communicating with PCs/BH-MCOs, SCAs and providers around the new criteria.

The Commonwealth also anticipates challenges with PHP (ASAM LOC 2.5), due to current regulatory requirements and the current service misalignment with the ASAM Criteria. OMHSAS and DDAP continue to work together on this LOC including assessing the provider network capacity for this level.

Leadership and agency staff stakeholders also indicated that WM capacity within the Commonwealth might also be a challenge. For outpatient service capacity, providers noted that maintaining the current procedures for telehealth service delivery and reimbursement would be vital to maintain adequate capacity for those LOCs.

As noted above, PCs/BH-MCOs and SCAs have begun using the ASAM for screening and assessment monitoring and providers have begun using the ASAM for placement. This first stage seems to be going well, but since service delivery and expectation definitions are still being released, it is difficult for the ASAM to significantly impact treatment.

As implementation activities have been ongoing, there have been few recommendations for policy or regulatory changes. DDAP and OMHSAS will continue to monitor this and use contracts and amendments to make changes, where possible. It is likely that conversations around rate setting, definitive distinctions in service delivery across ASAM LOCs (particularly around WM, 2.5, 3.5, and 3.7), and workforce needs will need to continue during the next year of Demonstration implementation.

Review of member survey reports provided to Mercer showed general high levels of satisfaction of survey respondents. However, few surveys directly addressed whether a member has perceived their LOC as "appropriate" or whether they experienced a lack of access to a particular LOC. This issue will be a priority in member focus groups for the interim evaluation report.

Milestone 2: Use of Evidence-Based, Substance Use Disorder-Specific Patient Placement Criteria

Description/Goal(s)	Action Items from Implementation Plan	Current Status
• Require that providers assess treatment needs based on SUD-specific, multidimensional assessment tools that reflect evidence-based clinical treatment guidelines. • Implementation of a Utilization Management approach such that: — Beneficiaries have access to SUD services at the appropriate LOC, — Interventions are appropriate for the diagnosis and LOC, and — There is an independent process for reviewing placement in Residential treatment settings.	• Support providers in the transition to the use of ASAM assessments (recommending training funding sources, identifying staff to be trained and collaborating regionally to schedule trainings for cost effectiveness).	Completed
	• Begin to utilize The ASAM Criteria's for admission determination of LOC on July 1, 2018.	Completed
	• Guidance for application of ASAM placement criteria in Pennsylvania released May 2018.	Completed
	• Target date for transition to ASAM placement criteria, July 1, 2018.	Completed

Implementation Progress

All implementation action items (100%) for this milestone have been completed. OMHSAS required PCs/BH-MCOs to use ASAM patient placement criteria for Medicaid utilization review and admission prior authorization to residential facilities on January 1, 2019. DDAP issued guidance to the counties to use ASAM admission criteria as of May 1, 2018. DDAP began requiring ASAM Criteria for treatment plans, continued stay and discharge criteria as of May 2019. While this action item has been completed, some stakeholders report that use of the ASAM for admission criteria is consistent, but that it is not regularly being used in treatment plans; continued stay and discharge criteria (see stakeholder feedback section below).

As of the end of DY2Q4, nearly 9,800 Pennsylvania professionals have been trained in the use of *The ASAM Criteria, 2013* via two-day, in-person training events. On January 1, 2020, DDAP added an online option to its approved training curriculum, in order to address training delays caused by the COVID-19 PHE.

Critical Metrics

Measure Number	Measure Name	Time Period	Demonstration Denominator	Demonstration Numerator or Count	Demonstration Rate/Percentage
6	Medicaid Beneficiaries Treated in an Institution for Mental Disease (IMD) for SUD	07/01/2018–06/30/2019	-	31,416	-
36	Average Length of Stay in IMDs	07/01/2018–06/30/2019	1,778,883	3,115,131	1.75

Metrics for Milestone 2 are annual measures. To date, only baseline measures are available. Therefore, there are not changes over time to report.

Stakeholder Feedback

The use of ASAM placement criteria has become universal in Pennsylvania, according to all stakeholder groups. PCs/BH-MCOs report completion of converting their utilization review systems to ASAM. Provider staff have been trained and appear to be complying with use of the criteria for placement decisions. However, as there has been a delay in the rollout of service descriptions and definitions the ASAM service alignment at the provider service delivery level is not complete. For example, a member may be assessed at a LOC 3.7, but may receive services at a LOC 3.5 because of a lack of available services at LOC 3.7. This mismatch of services to placement criteria is related to the new LOC 3.7 service level definition. Providers are just developing this newly aligned ASAM LOC 3.7. Providers also reported that coding and rates to provide MAT in more intense LOCs such as IOP or residential are not implemented yet.

The OMHSAS and DDAP indicated that providers are generally supportive of the system transformation; they believe existing challenges are related to issues created by a major transition in a large system. Pennsylvania has over 900 providers and two sister agencies within the Commonwealth that are working to forge a fundamental system transformation across the Commonwealth. An extremely positive result of the Demonstration is the increased collaboration between OMHSAS and DDAP. Although there have been delays in implementation, agency staff expresses confidence that the remaining implementation should be completed timely and the implementation timeline can be accomplished as scheduled.

All stakeholders report that the system has transitioned well to using ASAM LOC as a placement tool. Specifically, PCs/BH-MCOs were very complimentary and appreciative of the work providers have done to make progress to this point. The next step will be to ensure service alignment with ASAM LOC. This will likely progress more quickly once there has been a full transition to the service descriptions and will be revisited in the fall 2021 interim evaluation report.

There has been a suspension of prior authorizations for services during the COVID-19 PHE, but the need for appropriate prior authorizations will be revisited once the PHE ends.

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

Description/Goal(s)	Action Items from Implementation Plan	Current Status
• 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. • Implementation of Commonwealth process for reviewing Residential treatment providers to ensure compliance with these standards. • Requirement that RTFs offer MAT onsite or facilitate access offsite.	• Release of service definitions and provider checklists and addendums for ASAM residential and residential withdrawal services in summer and fall 2020.	In progress
	• Implementation of a Commonwealth process for reviewing Residential treatment providers to ensure compliance with these standards.	In progress
	• Implementation of requirement that RTFs offer MAT onsite or facilitate access offsite.	Completed

Implementation Progress

One of the three (33%) action items for Milestone 3 has been completed. OMHSAS and DDAP have had challenges implementing residential and residential WM provider alignment with ASAM. As mentioned previously, the size of the system transformation effort has been the primary challenge. The delay in the full release of service definitions and provider checklists and addendums has delayed the implementation of a Commonwealth review process for compliance with the standards. Release of the service definitions is, however, nearly complete with only definitions for WM outstanding; this will be revisited in the interim evaluation report.

The Commonwealth is currently taking the following steps to progress toward greater alignment of ASAM with the current continuum of care:

- In 2020, DDAP and DHS aligned service delivery (hours, service descriptions, staff qualifications) to *The ASAM Criteria, 2013*.

- Preliminary designations for residential services were issued based on provider reported staffing. However, staffing alone does not assure that the services described by the criteria are being delivered in residential or ambulatory treatment settings.

- A systematic “roll out” of service delivery descriptions and expectations occurred during 2020, with only WM service descriptions outstanding in 2021. DDAP and DHS communicated details through in-person discussions (as possible during the PHE), webinars, online trainings, listserv communications, web postings, etc.

Critical Metrics

There are no critical metrics for Milestone 3.

Stakeholder Feedback

A common theme in the difficulty in alignment with the ASAM Criteria, which has been discussed previously in this report, is the challenge in implementing such a significant change over such a large system. The Commonwealth has extended timeframes to reach milestones and now anticipates all services to be aligned with ASAM standards July 1, 2021, with provider compliance required July 1, 2022.

While consistent across all stakeholders that participated in focus groups, there was specific concern among providers about staff to client ratios and credentialing enough staff to accommodate shifts in service delivery requirements. Providers raised an associated concern about reimbursement rates and the costs to providers for the transition (both training costs and increased staffing needs). Providers are concerned with the ongoing difficulty in recruiting and retaining competent staff. These providers experienced high staff turnover prior to the Demonstration and the concern has not abated. However, stakeholders did caution that it is still very early in the process and many of the challenges being reported are those being anticipated, rather those that have been observed.

DDAP and OMHSAS staff reported high levels of provider buy-in with training and webinars that have been provided regarding the transition to ASAM. Providers and PCs/BH-MCOs confirmed their general support of moving toward alignment in services with the ASAM Criteria. Given some of the concerns that have been outlined in this report, it is predictable that there is significant interest in further dialog around the alignment process. Providers also indicated a strong partnership with SCAs throughout the process.

The use of MAT within the ASAM Criteria has some lingering challenges across the provider network. Some degree of stigma remains regarding the use of MAT and philosophical barriers with some providers. Stakeholders reported that the number of opposed providers has been steadily decreasing over the course of the first two years of the Demonstration. The Commonwealth continues to address philosophical concerns about MAT through educational opportunities and awareness campaigns. The Commonwealth has created an online MAT 101 training and is conducting an anti-stigma campaign that uses individuals with lived experience who successfully used MAT as part of their treatment and recovery experience. MAT availability has been addressed with SCAs and PCs/BH-MCOs in recent

contracts. There was additional concern about the consistent availability of MAT in some geographical areas. This issue should be more closely examined once the transition has been completed.

Surveys and focus groups conducted with members (provided to Mercer via published reports) indicated that members perceive stigma around the use of MAT. Members were most concerned about the lack of MAT in criminal justice settings and that when an individual is removed from an MAT program for non-compliance there is no ability to "taper" off medications.

The two sister agencies have been developing a strategy for onsite provider monitoring for compliance with the newly aligned ASAM service definitions. The two agencies anticipate using the same tools to monitor provider compliance with the ASAM requirements beginning in July 2022. Because all 900 providers will require monitoring, the size and complexity of the transformation will once again pose a potential challenge; OMHSAS and DDAP will need both financial and staffing resources to do this well. However, both OMHSAS and DDAP leadership and staff expressed confidence in the process that has been outlined and stressed that the strengthened partnership between the two agencies will be a significant asset moving forward. Because monitoring procedures for ASAM have not yet begun, BH-MCOs, SCAs, and providers did not report any current challenges.

Milestone 4: Sufficient Provider Capacity at Critical Levels of Care including Medication-Assisted Treatment for Opioid Use Disorder

Description/Goal(s)	Action Items from Implementation Plan	Current Status
• Coverage of: — Outpatient — IOP services — MAT (medications, as well as counseling and other services with sufficient capacity to meet needs of Medicaid beneficiaries in the Commonwealth) — Intensive LOCs in Residential and Inpatient settings — Medically supervised WM	• The original provider capacity assessment was completed according to former non-ASAM standards, the provider assessment according to ASAM standards is being planned, continue to ensure that access standards are met and required capacity is available.	In Progress

Implementation Progress

The one action item for Milestone 4 was initially completed at the start of the Demonstration project using non-ASAM service definitions. Once the Commonwealth determines compliance with each ASAM LOC, the Commonwealth will conduct another provider capacity assessment consistent with the updated service definitions. The need for this assessment is clear in some of the concerns across all stakeholder groups (see the Stakeholder Feedback section below) about capacity and workforce shortages.

Critical Metrics

Measure Number	Measure Name	Time Period	Demonstration Denominator	Demonstration Numerator or Count	Demonstration Rate/Percentage
13	SUD Provider Availability	07/01/2018–06/30/2019	-	6,575	-
14	SUD Provider Availability — MAT	07/01/2018–06/30/2019	-	3,753	-

The two critical metrics for Milestone 4 are annual measures. Therefore, only baseline data are available at this time, trends over time cannot be analyzed.

Stakeholder Feedback

As the alignment of provider standards to ASAM is completed, DDAP, and OMHSAS believe there will be sufficient outpatient and IOP capacity as well as capacity at most of the residential ASAM LOCs. However, it is unclear if there will be sufficient PHP access given the breadth of changes needed in the industry. In addition, ASAM LOC 3.7 capacity will present a challenge to full implementation because this LOC is new to the provider network and is also undergoing major changes from previous system of care definitions. The WM roll out has not started yet so capacity issues are largely unknown. This is an area where there may be a fair amount of work to do to build capacity.

As already mentioned in this report, workforce issues, as is the case in most other states, continues to be a barrier to overall system capacity. This issue will likely be a point of on ongoing discussion for the next several years. Providers emphasized that the use of telehealth is a solution to some capacity challenges and that changes to billing and authorization regulations made during the COVID-19 PHE should be maintained after the PHE is over.

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

Description/Goal(s)	Action Items from Implementation Plan	Current Status
• Implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse.	• No new action, the Commonwealth will continue to ensure the efficacy of the opioid prescribing guidelines.	Completed
• Expanded coverage of and access to, Naloxone for overdose reversal. • Implementation of strategies to increase utilization and improve functionality of PDMP.	• The standing order (Pennsylvania's General Assembly Act 139, issued in 2014) allowing for Naloxone administration will be reviewed and updated if needed, in at least four years from the effective date of January 10, 2018 (January 2022).	Completed (as needed to date) Future action to be taken, if needed

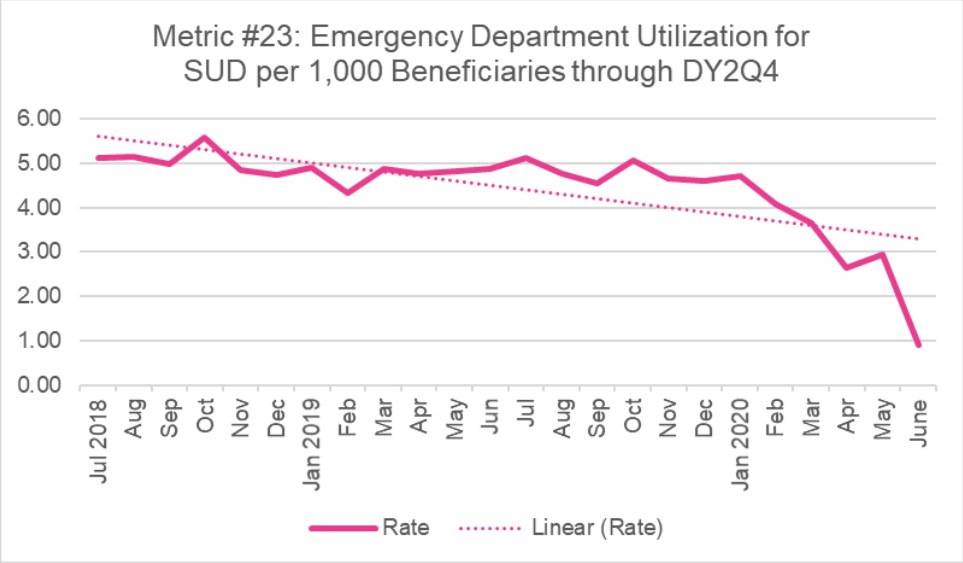
Description/Goal(s)	Action Items from Implementation Plan	Current Status
	• Training available early Q1 2018 for prescriber and dispenser face-to-face education as well as through online training, and Continuing Medical Education (CME) units will be provided.	Completed

Implementation Progress

All (100%) of action items planned to date have been completed for Milestone 5. The Commonwealth will continue to monitor the standing order for Naloxone administration as the Demonstration continues.

PDMP system alerts were implemented in 2018 and hundreds of thousands of alerts have been generated since then.

Critical Metrics



ED utilization fluctuated somewhat during the period, but ultimately declined during the first two DYs, even prior to the onset of the PHE.

Metric Number	Metric Name	Baseline Rate (Jul 2018)	DY2Q2 Rate (Dec 2019)	Change from Baseline Rate	DY2Q3 Rate (Mar 2020)	Change from Baseline Rate
23	ED Utilization for SUD per 1,000 Medicaid Beneficiaries	5.12	4.62	-9.81%	3.65	-28.59%

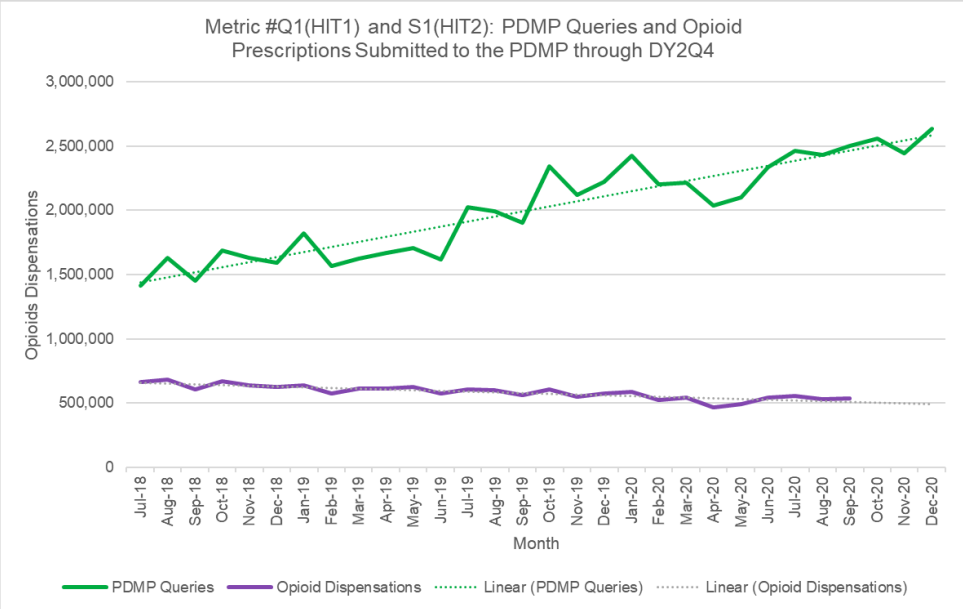
Other critical metrics for Milestone 5 (18, 21, and 27) are annual measures. Coding to calculate these measures is ongoing, as the Commonwealth has prioritized changes to quarterly measures. These measures will be available for the interim evaluation report, which will be submitted fall 2021.

The one metric for which trend data is available (100%) shows a change in the anticipated direction, based on Demonstration goals and objectives.

Stakeholder Feedback

Stakeholders in the PC/BH-MCO and provider group reported a notable drop in the prescription of opioids since the start of the Demonstration. Some participants indicated that changes to policy might be having an impact on the number of patients with new opioid addictions, although it was noted that this was largely an anecdotal observation. Providers noted that they are seeing more returning patients and fewer new ones.

The anecdotal observation was consistent with the decreasing number of opioid prescriptions reported to the PDMP. In the Commonwealth-defined Health Information Technology (HIT) metrics, the Commonwealth found that prescribers are using the PDMP increasingly more and the number of opioid prescriptions dispensed are continuing to decrease since the beginning of the Demonstration.



There was consensus across stakeholder groups that the relaxing of standards for prescribing Naloxone, Suboxone®, and Buprenorphine has had an overall positive impact on treatment. Providers expressed a belief that exemptions for face-to-face contact for Suboxone® and Buprenorphine should apply to Methadone as well.

Across stakeholder groups, there was consensus that outpatient capacity to prescribe is currently adequate. Providers expressed concerns that new ASAM requirements could force some providers to

close because staffing requirements do not align with reimbursement rates. Stakeholders, in general, said that current Naloxone access is adequate.

PDMP staff have created seven continuing education modules titled, “Evidence-Based Prescribing: Tools You Can Use to Fight the Opioid Epidemic”. Over 2,900 health care professionals were educated onsite through a face-to-face education session, 474 health care professionals educated through live webinar, and 17,125 courses have been completed across 5,446 unique participants. Additionally, the PDMP are conducting Academic Detailing (targeted one-on-one sessions with prescribers) and have completed 548 sessions with healthcare professionals to date.

The PDMP has also contracted with the University of Pittsburgh to link PDMP data with overdose data and to identify variables associated with increased risk of long-term opioid use and overdose.

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

Description/Goal(s)	Action Items from Implementation Plan	Current Status
• Implementation of policies to ensure residential and inpatient facilities link beneficiaries, especially those with OUD, with community-based services and supports following stays in these facilities.	• No specific action items. The Commonwealth already has these policies in place. • The Commonwealth will review data from Certified Community Behavioral Health Clinics (CCBHCs) and decide on any future steps. CCBHCs will submit data on three identified care coordination goals.	Completed

Implementation Progress

Within the Demonstration, the ASAM alignment will emphasize the required provider standards for transition between LOCs. Because of the intense focus on transition to ASAM criteria, this work is ongoing, still in early stages, and continues in parallel to ASAM implementation. Improvements to care coordination will benefit the ASAM transition as well.

The DDAP treatment team is continuing to work on improving care coordination across the system. For example, DDAP is planning to provide Care Coordination services separate from the clinical counselors by distinct teams/individuals including ancillary services. DDAP is working on a separate five-year strategic plan for improving Care Coordination services. Any individual with SUD in the Commonwealth regardless of funding who needs Care Coordination will be able to receive it.

Critical Metrics

Other critical metrics for Milestone 5 (15, 17, 18, 21, 22, and 25) are annual measures. Coding to calculate these measures is ongoing, as the Commonwealth has prioritized changes to quarterly measures. These measures will be available for the interim evaluation report, which will be submitted fall 2021.

Stakeholder Feedback

Stakeholders are currently focused on details around full alignment with ASAM service definitions across the system of care. Within these service definitions are changes to care coordination approaches. As the Commonwealth proceeds with implementation, this area may require greater focus. Using ASAM Criteria for admissions has been well established. The system is in the process of using the criteria for determining LOCs and transitions between them.

Stakeholders noted that the system has a particular strength in having developed performance measures for care coordination that can guide future planning and assessment.

Some stakeholders noted the importance of Communities of Excellence (COEs) in Care Management and using this model for care coordination. This point was underscored by member survey results that showed very high levels of satisfaction with COE services.

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Budget Neutrality

While initially facing some challenges with cost reporting, the Commonwealth is now providing reports on the 1115 waiver schedules by Date of Payment. The Commonwealth is using the correct BN forms for the SUD 1115 quarterly report.

As noted in the latest DY2Q4 BN reports, the Demonstration is below the Cumulative Budget Neutrality Limit (CBNL) for both of the first two years of the Demonstration ($18.5 million below the target for DY1 and $33.9 million below the target for DY2). For the Supplemental Security Income (SSI) Dual Medicaid Eligibility Group (MEG) the actual expenditures are $991,040 and the limit was $933,174. However, the expenditures for all other MEGs were under the BN limits.

Hypotheticals Test 1 Cumulative Target Limit		
	Demonstration Years	
	1	2
Cumulative Budget Neutrality Limit (CBNL)	$ 75,037,778	$ 137,299,638
Allowed Cumulative Variance (= CTP X CBNL)	$ 1,500,756	$ 2,059,495
Actual Cumulative Variance (Positive = Overspending)	$ (18,511,949)	$ (33,950,475)

The Commonwealth is below the CBNL test for each MEG except for the SSI Dual eligible MEG in DY2.

Without-Waiver Total Expenditures			
Hypothetical 1 Per Capita		Demonstration Years	
		1	2
SUD IMD Temporary Assistance for Needy Families (TANF)	1	$ 4,426,267	$ 3,302,640
SUD IMD SSI Duals	2	$ 1,053,263	**$ 933,174**
SUD IMD SSI Non-Duals	3	$ 18,695,873	$ 15,342,423
SUD IMD Home Care for the Elderly (HCE)	4	$ 50,862,375	$ 42,683,624
	Total	**$ 75,037,778**	**$ 62,261,860**

With-Waiver Total Expenditures			
Hypothetical 1 Per Capita		Demonstration Years	
		1	2
SUD IMD TANF	1	$ 4,071,830	$ 3,005,215
SUD IMD SSI Duals	2	$ 508,708	**$ 991,040**
SUD IMD SSI NON-Duals	3	$ 15,745,807	$ 12,940,686
SUD IMD HCE	4	$ 36,199,484	$ 29,886,393
Total		**$ 56,525,829**	**$ 46,823,334**
Hypotheticals Variance 1		**$ 18,511,949**	**$ 15,438,526**

Assessment of Level of Risk

Milestone	Implementation Plan Action Items	Monitoring Metrics	Stakeholder Feedback	Risk Level
Milestone 1	66%	50%	Stakeholders identified a few concerns, particularly around specific ASAM LOCs (2.5, 3.5, and 3.7)	Medium
Milestone 2	100%	N/A (baseline only)	No stakeholders identified risks. However, ASAM service definitions are not fully implemented and aligned with ASAM placement criteria.	Low
Milestone 3	33%	N/A	Stakeholders expressed some concerns regarding staffing and MAT acceptance and availability.	Medium
Milestone 4	In progress	N/A (baseline only)	Stakeholders are concerned with capacity around new LOCs and workforce availability.	Medium
Milestone 5	100%	100% (of available)	Stakeholders reported consistently positive views of opioid prescribing guidelines, Naloxone availability and the PDMP.	Low
Milestone 6	100%	Completed	Stakeholders reported that the ASAM alignment would emphasize the new required provider standards for transition between LOCs.	Low

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Recommendations

As a result of the Midpoint Assessment, Mercer has the following recommendations for addressing the medium risk items identified:

- After the Commonwealth rolls out all service delivery definitions and expectations, staff should engage providers and PCs/BH-MCOs to identify areas of remaining uncertainty and prioritize creating opportunities for additional learning and communication relating to implementing Milestone 1 and 3.

- The Commonwealth should have open discussions around service capacity under the new ASAM service definitions once the system is fully transitioned to the ASAM LOC service delivery definitions and there is greater clarity around expectations. The Commonwealth might consider an SUD workforce study surrounding new staffing requirements. This Milestone 4 analysis should be a large focus of the interim evaluation report.

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