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Midpoint Evaluation of the State of Louisiana Substance Use Disorder Section 1115 Demonstration

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Executive Summary

This Mid-Point Assessment evaluates Louisiana's progress toward achieving the six milestones of the Substance Use Disorder (SUD) Section 1115 Medicaid Demonstration during the first two years of the renewal period (January 2023-December 2024). Using Medicaid claims, enrollment, and mortality data, along with stakeholder interviews, the assessment examines changes relative to the baseline period (January-December 2018).

Overall, Louisiana has made significant progress in strengthening its SUD treatment system. Access to services across the American Society of Addiction Medicine (ASAM) continuum has expanded, use of medication for opioid use disorder (MOUD/MAT) has increased markedly, provider capacity has grown, and measures of treatment initiation, engagement, and follow-up have all improved.

Access to SUD Treatment
Compared to baseline, the number of Medicaid beneficiaries receiving any SUD treatment increased by 48%, use of outpatient services nearly doubled, and intensive outpatient/partial hospitalization service use increased by 56%. Most notably, the number of beneficiaries receiving MOUD increased by 127% over the renewal period relative to baseline.

Use of Evidence-Based, SUD-Specific Patient Placement
The number of beneficiaries treated for SUD in an Institution for Mental Diseases (IMD) increased by 29% over the renewal period compared to baseline and the average length of an IMD stay for SUD increased by 75%, consistent with improved identification, referral, and use of standardized placement criteria. Formal requirements for MOUD access and evidence-based program standards are in place, though stakeholder input reflects uneven uptake among some residential providers.

Provider Capacity
The number of providers qualified to deliver SUD services increased by approximately 14% between baseline and the mid-point of the renewal period. Stakeholders nevertheless report workforce shortages and geographic access constraints, particularly in rural areas.

Comprehensive Treatment/Prevention Strategies and Care Coordination
Emergency department utilization for SUD declined by 22% and inpatient stays for SUD declined by 4% from baseline through the mid-point of the renewal period. Treatment initiation and engagement both improved over the renewal period across all four diagnosis cohorts (total AOD, alcohol, opioid, and other drug), and rates of follow-up after emergency department visits more than doubled. The overdose death rate was higher on average over the mid-point period than at baseline, reflecting pandemic-era shocks and the spread of synthetic opioids. However, longitudinal data show that overdose deaths peaked in 2022 and have declined substantially in the most recent period.

Assessor Recommendations
Based on performance across monitoring metrics, implementation plan action items, stakeholder input, and provider capacity, the evaluation team determined that the state was at low risk of

failing to achieve three milestones and at medium risk of failing to achieve three milestones (program standards, overdose prevention, and care coordination) at the mid-point of the renewal period.

For the milestones assessed as medium risk, the independent assessor's recommendations focus on strengthening data-driven targeting of provider education and overdose prevention efforts and supporting more consistent adoption of evidence-based program standards across residential providers.

Summary

In sum, Louisiana has successfully built and expanded a comprehensive SUD treatment system and translated those investments into meaningful gains in access, engagement, and care continuity. Remaining challenges primarily reflect uneven implementation, workforce and geographic constraints, and the inherently lagged nature of downstream outcomes such as overdose mortality.

A. General Background Information

1. Demonstration name, approval date, and time period of data analyzed in the assessment.

The Louisiana Substance Use Disorder (1115) Demonstration was originally approved by the Centers for Medicare & Medicaid Services (CMS) on February 1, 2018 for a period covering February 1, 2018 through December 31, 2022. It was subsequently renewed for a second five-year period covering January 1, 2023 through December 31, 2027.

The demonstration authorizes the Louisiana Department of Health (LDH) to receive federal financial participation for services delivered to Medicaid beneficiaries diagnosed with a substance use disorder (SUD), including short-term residential treatment provided in Institutions for Mental Diseases (IMDs), as part of a continuum of evidence-based care.

This Mid-Point Assessment evaluates demonstration progress approximately halfway through the current approval period, covering activities and data from Demonstration Years 6 and 7 (January 2023 – December 2024)**.** These years correspond to the first two years of Louisiana's extension period.

2. Description of the demonstration's policy goals

Louisiana's SUD 1115 Demonstration was established to strengthen the state's behavioral health system by expanding access to evidence-based treatment for Medicaid beneficiaries with opioid and other substance use disorders. The demonstration aligns with CMS's 2017 SMD #17-003, "*Strategies to Address the Opioid Epidemic*" and is designed to achieve six federal milestones that collectively advance Louisiana's policy goals of improving access, quality, and coordination of SUD services:

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

Together, these milestones are intended to ensure that Louisiana Medicaid beneficiaries have timely access to the full American Society of Addiction Medicine (ASAM) continuum of care and that services delivered in residential and inpatient settings are clinically appropriate, high-quality, and well-integrated with community-based supports.

The demonstration applies to Medicaid-enrolled adults aged 21–64 with a primary or secondary SUD diagnosis. Services are delivered through Louisiana's managed care system, which relies on managed care entities (MCEs) to implement ASAM-aligned network adequacy, utilization management, and care coordination standards. The Louisiana Department of Health (LDH) Office of Behavioral Health (OBH) oversees implementation and monitoring.

During the original 2018–2022 period, Louisiana achieved notable success in advancing demonstration milestones through expanded residential treatment coverage in IMDs, adoption of ASAM-based level-of-care determinations, and improved care coordination protocols between inpatient and outpatient providers. Louisiana also achieved measurable improvements in treatment engagement and outcomes, exceeding the 90th percentile benchmarks established by the National Committee for Quality Assurance (NCQA) for initiation and engagement in SUD treatment and increasing the use of medications for opioid use disorder (MOUD) by more than 50 percent since the waiver's inception.

Building on this success, the demonstration renewal is designed to sustain and deepen system-level reforms through the following specific demonstration goals:

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

Together, these aims reflect Louisiana's transition from establishing the infrastructure for a comprehensive SUD system toward optimizing its performance and sustainability. The renewal period also introduces targeted policy enhancements, such as requiring MCOs to classify members with SUD as *special health care needs populations* eligible for case management, to further promote adherence, retention, and coordination of SUD care.

Finally, the demonstration continues to operate in the context of Louisiana's evolving substance use landscape. Although the state experienced one of the highest rates of overdose deaths in the nation during the COVID-19 public health emergency, mortality rates have since declined by roughly 12 percent as treatment access expanded and MOUD uptake increased. Persistent workforce shortages and shifts toward telehealth-based treatment remain important contextual factors that will shape the state's ability to meet its demonstration milestones over the remainder of the renewal period.

B. Methodology

1. Data Sources

The Mid-Point Assessment and Demonstration Evaluation rely on multiple quantitative and qualitative data sources to evaluate Louisiana's progress toward achieving the six SUD 1115 demonstration milestones and the Phase 2 demonstration goals for DY6-10 established in the state's approved evaluation design. These sources capture service utilization, provider capacity, and progress on implementation milestones from both administrative and stakeholder perspectives.

The primary quantitative data source for this assessment is the state Medicaid claims and enrollment database. These data currently include comprehensive encounter and claims information on the full Medicaid population in Louisiana from January 2018 (for most metrics) through December 2024 and represent the primary source for tracking changes from the baseline period (2018) through the renewal demonstration mid-point. We also used data on overdose deaths supplied by the LDH Bureau of Vital Records and Statistics.

The evaluation team also plans to use Transformed Medicaid Statistical Information System (T-MSIS) data for the Phase 2 evaluation to support difference-in-differences analyses comparing Louisiana to control states without SUD demonstrations. However, because the team is still in the process of obtaining T-MSIS data from CMS, these data were not available for use in the Mid-Point Assessment and were therefore excluded from current analyses.

The primary qualitative data sources for the Mid-Point Assessment include stakeholder interviews and case studies. These data capture perspectives from SUD treatment providers, managed care organizations (MCOs), local health officials, and community stakeholders on the barriers and facilitators to achieving the demonstration's goals. Interviews are conducted in both urban and rural areas, with additional case studies documenting the experiences of individual beneficiaries navigating the SUD treatment continuum. The qualitative data complement the quantitative analyses by providing contextual insight into service delivery challenges, workforce capacity, and the effects of policy and system-level changes during the renewal period.

Table 1 provides a brief description of the datasets used for Mid-Point Assessment and demonstration evaluation.

Table 1: Data Sources for the Mid-Point Assessment

Data Source	Purpose/Application	Primary Demonstration Goals Supported	Data Period	Limitations
A. Quantitative Data Sources				
Louisiana Medicaid Claims and Enrollment Data	Primary quantitative data source used to calculate SUD monitoring metrics and track changes in access, utilization, and treatment outcomes from baseline through the renewal	All renewal demonstration goals	January 2018 – December 2024	Minor lags due to claims adjudication.

	demonstration mid-point.			
LDH Bureau of Vital Records and Statistics	Mortality data used to assess demonstration impact on drug overdose deaths among Medicaid beneficiaries.	Mortality reduction	January 2018 – December 2024	Time lag in mortality reporting.
Transformed Medicaid Statistical Information System (T-MSIS)	Planned data sources for Phase 2 evaluation to enable cross-state difference-in-differences analyses comparing Louisiana with non-demonstration states. Not used in the Mid-Point Assessment.	All renewal demonstration goals	January 2018 – December 2024	Pending acquisition from CMS, so not available for Mid-Point Assessment. Quality and timeliness vary by state.
B. Qualitative Data Sources				
Key informant interviews with system-level stakeholders	Qualitative data capturing perspectives from providers, MCOs, health officials, and community stakeholders on barriers and facilitators to achieving demonstration goals.	Access, retention, and care coordination	2023 – 2025	Due to sample sizes, findings may not be representative of all program stakeholders.
In-depth interviews with beneficiaries receiving SUD treatment	In-depth documentation of beneficiary experiences navigating the SUD treatment continuum in urban and rural settings. Provide context for interpreting quantitative results.	Access, retention	Planned for 2025-2026	Individual case studies do not generalize to the broader SUD population.

For most analyses, the primary target population consists of all Medicaid beneficiaries with full benefits enrolled in Medicaid for any amount of time during the measurement period. Additionally, for several metrics, we analyze outcomes for an alternate population consisting of Medicaid beneficiaries with an SUD diagnosis. The inclusion criterion for this group is Medicaid

beneficiaries enrolled in a specific reporting period (e.g., month or year) with a qualifying claim that uses an OUD/SUD diagnosis code as the primary diagnosis.

2. Analytic Methods

Our preferred methodology for evaluating progress toward meeting the demonstration milestones and Phase 2 demonstration goals is a quasi-experimental research design known as difference-in-differences (DD). The term quasi-experimental refers to approaches like DD that attempt to mimic a randomized controlled trial by assigning individuals to a treatment group or a control group and then measuring changes between the two groups over time. The treatment group is defined by exposure to an intervention, while the control group should ideally be similar to the treatment group but remain unexposed. Under standard assumptions for the DD methodology, changes in outcomes for the treatment group relative to the control group can be interpreted as causal impacts of the intervention.

However, while we still plan to use the DD method for the Phase 2 demonstration evaluation, we were unable to use this method for assessing progress in the Mid-Point Assessment. The DD methodology relies on the evaluation team gaining access to the T-MSIS data and that data acquisition process is still ongoing. Instead, for the Mid-Point Assessment, we rely on an interrupted time series analysis to track the state's progress on several demonstration monitoring metrics.

The interrupted time series (ITS) model can be described as follows and we estimate this model using the ordinary least squares (OLS) technique:

$$Outcome_{it} = \beta_0 + \beta_1 Time_t + \beta_2 Implement_t + \beta_3 Time_t \times Implement_t + \varepsilon_{ist}$$

Where $Time$ is a continuous measure of time denoted in either year, year-quarter, or month depending on sample sizes. $Implement$ is an indicator for the implementation of the SUD demonstration and measures any break in outcome trend associated with the demonstration. The interaction term, $Time_t \times Implement_t$ captures any change in the slope of the outcome trend that occurred after the demonstration was implemented. We focus primarily on the $Time_t \times Implement_t$ term when interpreting results of the model as this term will indicate whether outcome trends have changed concurrently with demonstration implementation. ε is an error term that captures unobserved factors associated with the outcome of interest.

Several of the demonstration evaluations' outcome measures explicitly require retrospective data (typically 30 days) to accurately calculate and interpret results. To capture potential anticipatory activities and ensure the accuracy of the retrospective metrics, we designated January 2018 as the beginning of the implementation period for our ITS analyses.

In addition to reporting results from the ITS analyses, we also conduct more straightforward comparisons of absolute and percentage changes for monitoring metrics from baseline (2018) to the renewal demonstration mid-point. Following CMS guidance, we report these calculations in Table 3 below and report estimates from the ITS models in the appendix.

The COVID-19 Public Health Emergency disrupted all aspects of SUD treatment for Medicaid populations and the associated Continuous Coverage Requirement greatly expanded Medicaid enrollment through mid-2023 when Medicaid redeterminations resumed. As such, rather than reporting only count outcome metrics, we also included outcome rates using the Medicaid population or Medicaid population with an SUD diagnosis as the denominator in an effort to mitigate the potential for distortions in outcome counts caused by enrollment fluctuations and can provide a clearer assessment of waiver impacts.

For the qualitative analysis, interviews will be recorded and transcribed with the interviewee's permission; otherwise, the study team will take detailed notes. Two members of the research staff will code a subset of the data, then develop a common set of codes. Each research staff member will code the full data set and inter-rater reliability will be calculated. Major discrepancies in coding will be resolved between the research staff members.

Data will be coded for themes based on the research questions and triangulated with findings from the quantitative analysis. The analysis will describe areas of consensus among respondents, as well as areas in which there were differing viewpoints.

3. Assessment of overall risk of not meeting milestones

The evaluation team assessed Louisiana's overall risk of not meeting each of the six federal demonstration milestones by examining progress in four domains:

1. Changes in monitoring metrics between the baseline (2018) and renewal mid-point (2023–2024).
2. Completion of implementation plan action items scheduled through Demonstration Year 7.
3. Stakeholder feedback regarding barriers and facilitators to meeting demonstration goals.
4. Provider capacity at each ASAM level of care.

Each milestone is assigned a composite risk level (low, medium, or high) based on Louisiana's progress across these domains.

Table 2: Milestone Risk-Assessment Framework

Domain	Low Risk	Medium Risk	High Risk
Critical Monitoring Metrics	> 75% of critical metrics moving in the expected direction	25 – 75% of critical metrics moving in the expected direction	< 25% of critical metrics moving in the expected direction
Implementation Plan Action Items	> 75% of milestone-specific action items (i.e., specifications) completed or on schedule	25 – 75% of milestone-specific action items (i.e., specifications) completed or on schedule	< 25% of milestone-specific action items (i.e., specifications) completed or on schedule
Stakeholder Feedback	Few or no significant risks identified;	Multiple stakeholders cite challenges that	Stakeholders identify systemic risks that

	concerns can be addressed with existing timelines.	could delay milestone achievement.	threaten milestone achievement.
Provider Availability	Adequate provider capacity across critical ASAM levels of care.	Capacity not yet adequate but improving as expected.	Persistent under-capacity or declining access at one or more ASAM levels.

For each demonstration milestone, the evaluation team:

- Reviewed progress on critical monitoring metrics using absolute and percentage change calculations from 2018 to 2023–2024 along with estimates from ITS models.
- Examined progress on implementation plan action items included in the CMS-approved demonstration implementation plan.
- Analyzed stakeholder interviews and case studies to identify operational barriers, workforce issues, and data-reporting constraints.
- Assessed provider network capacity using LDH provider enrollment and licensure data to evaluate adequacy at each ASAM level.

Milestone risk ratings were then synthesized into a summary table (Table 3, in Section C) showing the percentage of monitoring metrics and action items completed, key stakeholder themes, and the resulting risk classification.

4. Limitations

Several limitations should be considered when interpreting findings from this Mid-Point Assessment. First, the evaluation team has not yet obtained access to the T-MSIS data, precluding the use of a full difference-in-differences analysis to benchmark Louisiana's performance against comparison states. These analyses will be incorporated into the Phase 2 interim and summative evaluations as feasible. Second, the COVID-19 Public Health Emergency and subsequent unwinding of the continuous coverage requirement substantially influenced Medicaid enrollment and service delivery patterns, creating shifts that complicate trend interpretation. To mitigate these effects, the evaluation team relied on rate-based metrics and sensitivity analyses using Medicaid population denominators. Finally, qualitative data from stakeholder interviews and beneficiary case studies, while valuable for contextual understanding, reflect the perspectives of a limited number of respondents and should not be generalized to all program participants.

C. Findings

1. Progress towards demonstration milestones

This section summarizes Louisiana's progress toward meeting each of the six milestones established under the SUD Section 1115 Demonstration. Findings are based on changes in the

critical monitoring metrics identified by CMS, the state's implementation plan action items, and stakeholder feedback collected during Demonstration Years 6 and 7.

Monitoring Metrics

Table 3 presents preliminary findings from the Mid-Point Assessment, showing changes in the critical metrics between the demonstration baseline (2018) and the renewal period mid-point (2023–2024). Each metric includes directionality, absolute and percent change from baseline, whether progress aligns with the state's demonstration targets as defined in the approved monitoring protocol, and milestone risk rating.

Table 3: Findings from mid-point assessment of monitoring metrics

Metric #	Metric Name	At baseline[a]	At midpoint[b]	Absolute change	Percent change	Demonstration target	Directionality at mid-point	Progress	Milestone risk assessment
Milestone 1: Access to critical levels of care for OUD and other SUDs									
6	Any SUD Treatment	18,225.17	26,883.96	8,658.79	47.51%	Consistent or Increase	Increase	Yes	Low
7	Early Intervention	0.75	7.42[c]	6.67	888.89%	Consistent or Increase	Increase	Yes	
8	Outpatient Services	7,059.25	13,919.79	6,860.54	97.19%	Consistent or Increase	Increase	Yes	
9	Intensive Outpatient and Partial Hospitalization Services	1,359.33	2,120.58	761.25	56.00%	Consistent or Increase	Increase	Yes	
10	Residential and Inpatient Services	1,871.42	2,542.75	671.33	35.87%	Consistent or Increase	Increase	Yes	
11	Withdrawal Management	685.50	691.17	5.67	0.83%	Consistent or Increase	Increase	Yes	
12	Medication-Assisted Treatment	6,203.17	14,105.08	7,901.92	127.39%	Increase	Increase	Yes	
Milestone 2: Use of evidence-based, SUD-specific patient placement criteria									
5	Medicaid Beneficiaries Treated in an IMD for SUD	1,708.17	2,208.79	500.63	29.31%	Consistent or Increase	Increase	Yes	Low
36	Average Length of Stay in IMDs	9.16	16.03	6.87	74.95%	Consistent	Increase	Yes	
Milestone 3: Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications									
n/a									n/a
Milestone 4: Sufficient provider capacity at each level of care									
13	Provider Availability	4,182.08	4,755.13	573.04	13.70%	Consistent or Increase	Increase	Yes	Low
Milestone 5: Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD									
23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	2.73	2.14	-0.60	-21.80%	Decrease	Decrease	Yes	Low

24	Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries	1.72	1.66	-0.06	-3.57%	Decrease	Decrease	Yes	
27	Overdose death rate	0.033	0.056	0.023	67.49%	Decrease	Increase	No	
Milestone 6: Improved care coordination and transitions between levels of care									
15	Total AOD Initiation and Engagement	Initiation = 48.77% Engagement = 16.54%	Initiation = 59.21% Engagement = 28.27%	Initiation = 10.44 Engagement = 11.74	Initiation = 21.41% Engagement = 70.97%	Consistent or Increase	Increase	Yes	Low
15	Alcohol Initiation and Engagement	Initiation = 47.36% Engagement = 13.82%	Initiation = 55.77% Engagement = 25.61%	Initiation = 8.40 Engagement = 11.79	Initiation = 17.74% Engagement = 85.28%	Consistent or Increase	Increase	Yes	
15	Opioid Initiation and Engagement	Initiation = 59.91% Engagement = 26.45%	Initiation = 73.59% Engagement = 47.15%	Initiation = 13.68 Engagement = 20.70	Initiation = 22.84% Engagement = 78.24%	Consistent or Increase	Increase	Yes	
15	Other Drug Initiation and Engagement	Initiation = 49.11% Engagement = 16.36%	Initiation = 56.91% Engagement = 24.31%	Initiation = 7.80 Engagement = 7.95	Initiation = 15.88% Engagement = 48.60%	Consistent or Increase	Increase	Yes	
17(1)	Follow-up after Emergency Department Visit for Substance Use	7-day = 6.47% 30-day = 10.55%	7-day = 14.84% 30-day = 24.90%	7-day = 8.37 30-day = 14.35	7-day = 129.46% 30-day = 136.05%	Increase	Increase	Yes	
25	Readmissions Among Beneficiaries with SUD	0.207	0.255	0.048	23.17%	Decrease	Increase	No	
37	Follow-up after High-Intensity Care for Substance Use Disorder	7-day = 61.68% 30-day = 71.83%	n/a	n/a	n/a	Increase	n/a	n/a	

[a] Values averaged over the baseline period (January 2018 through December 2018).

[b] Values averaged over the first two years of the renewal demonstration period (January 2023 through December 2024).

Table 3 summarizes changes in Louisiana's SUD monitoring metrics between the baseline period (January through December 2018) and the mid-point of the renewal demonstration period, and indicates whether observed changes align with the state's expected directionality for each metric. Overall, the results in Table 3 indicate substantial progress on achieving the demonstration milestones.

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

All access-related metrics moved in the expected direction between baseline and mid-point. The number of beneficiaries receiving any SUD treatment, outpatient services, intensive outpatient/partial hospitalization services, residential and inpatient services, and medication-assisted treatment all increased over the demonstration period. Notably, the number of beneficiaries receiving MAT more than doubled relative to baseline, reflecting the combined effects of expanded prescribing authority, elimination of the federal DATA-waiver requirement, and system-level efforts to integrate MAT/MOUD into both outpatient and residential settings.

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

The metrics associated with Milestone 2 show increases in both the number of beneficiaries with an SUD treated in IMDs and the average length of an IMD stay. These changes are consistent with improved identification and referral into residential levels of care and with the use of standardized placement criteria that match patients to appropriate levels of treatment intensity and duration.

Milestone 3: Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications

Milestone 3 does not have associated quantitative monitoring metrics in Table 3. Progress is therefore assessed primarily through implementation activities and stakeholder input rather than changes in utilization patterns.

Milestone 4: Sufficient provider capacity at each level of care

Provider availability increased over the demonstration period, growing by more than 13% from the baseline period. The growth in the supply of providers qualified to deliver SUD services highlights the importance of ongoing workforce development and network expansion efforts, particularly in rural areas where stakeholders have reported access constraints.

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

Metrics related to emergency department utilization and inpatient stays for SUD moved in the expected direction, with modest declines in both outcomes between the baseline and mid-point periods. These reductions are consistent with improved access to outpatient and community-based treatment and with better care coordination following acute episodes.

However, the overdose death rate increased between the baseline and mid-point periods. This increase should be interpreted in the context of broader national and state-level trends during this period, including the COVID-19 pandemic and the proliferation of high-potency synthetic opioids such as fentanyl. Although overdose mortality began to decline in Louisiana after peaking during the pandemic, the mid-point average still reflects elevated mortality relative to the pre-pandemic baseline. Longitudinal data show that the increase in overdose deaths was concentrated during 2020–2022, followed by a period of stabilization and then large declines observed more recently (see Appendix Figure 13).

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

Measures of initiation and engagement in treatment for alcohol and other drug dependence and follow-up after emergency department visits for substance use improved substantially. Overall, the total AOD treatment initiation rate increased from 48.8 percent at baseline to 59.2 percent at the renewal midpoint, a relative increase of 21.4 percent, while the engagement rate increased from 16.5 percent to 28.3 percent, a relative increase of 71.0 percent (see Table 3). Both measures improved across all four diagnosis cohorts. Initiation gains were largest among beneficiaries with opioid abuse or dependence, rising from 59.9 percent to 73.6 percent (22.8 percent relative increase), compared to 17.7 percent for alcohol and 15.9 percent for other drug. Engagement gains were largest for alcohol (13.8 percent to 25.6 percent, an 85.3 percent relative increase) and opioid (26.5 percent to 47.2 percent, a 78.2 percent relative increase) cohorts, with a smaller but still substantial gain for other drug dependence (16.4 percent to 24.3 percent, a 48.6 percent relative increase). 7-day and 30-day follow-up rates after emergency department visits for substance use both more than doubled.

Readmission rates among beneficiaries with SUD increased relative to baseline, likely reflecting a combination of factors, including higher overall treatment engagement among individuals with complex and severe conditions and greater identification of SUD in hospital settings. As such, higher readmission rates may partly reflect increased interaction with the treatment system rather than a deterioration in the quality of care for beneficiaries with SUD.

Finally, follow-up for high intensity care for substance use cannot yet be assessed relative to baseline because this measure was only recently added to the SUD 1115 evaluation framework. However, Louisiana's 7-day and 30-day follow-up rates exceed national averages (34.16% and 54.48%, respectively).

Implementation Plan Action Items

The state's approved Implementation Plan identified a set of milestone-specific action items designed to ensure full implementation of the ASAM continuum of care, strengthen provider capacity, and enhance the quality and coordination of services for Medicaid beneficiaries with SUD. During the initial demonstration period (2018–2022), LDH made substantial progress implementing its approved action items, achieving or initiating nearly all items outlined in the Implementation Plan. Key accomplishments included updating the Behavioral Health Provider Manual to reflect the ASAM continuum of care, extending Medicaid coverage to methadone, implementing the Hub-and-Spoke model for coordinated care, and expanding MAT/MOUD

training through Project ECHO. By mid-point of the initial demonstration period, most infrastructure-related specifications had been completed, with ongoing activities focused on provider education, capacity expansion, and quality monitoring.

Table 4 below summarizes Louisiana's progress on these action items as of the midpoint of the renewal demonstration period (through December 2024).

Table 4: Findings from mid-point assessment of implementation plan action items

Action item description	Date to be completed	Current status (completed, open, suspended)
Milestone 1: Access to critical levels of care for OUD and other SUDs		
Update State Plan and provider manual to reflect current services array and requirements.	February 2019	**Completed**. Provider manual updated in April 2018; State Plan revision not required.
Milestone 2: Use of evidence-based, SUD-specific patient placement criteria		
The Behavioral Health Provider Manual will be updated to clarify that ASAM criteria and levels of care shall be used for each provider's assessment tool.	February 2019	**Completed**. Behavioral Health Provider Manual updated November 2018 to require ASAM criteria; MCOs notified and aligned utilization management policies.
Milestone 3: Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications		
Educated abstinence-based residential providers on benefits of MAT accessibility to begin cultural shift toward acceptance of MAT as a complementary treatment.	February 2020 + ongoing	**Ongoing.** Incremental education strategy implemented through statewide conferences and LDH outreach; gradual shift toward MAT/MOUD acceptance observed.
Review MCO contract language regarding this requirement to determine if changes to the contract to support this milestone are necessary.	February 2019	**Completed.** Contract review determined no revisions needed; existing language met demonstration requirements.
Review provider manual and service description to require access to MAT and any associated provider manual requirements and rate adjustments if needed.	February 2019	**Completed.** Provider Manual revised November 2018 to require residential providers to offer or facilitate access to MAT; rate structure unchanged.
Milestone 4: Sufficient provider capacity at each level of care		
Require MCOs to update their Specialized Behavioral Health network development and management plan to	February 2019	**Completed.** Requirement implemented; first network development plans submitted July 2020.

specifically focus on SUD provider capacity, including MAT.		
Add an indicator if providers are accepting new patients to the quarterly network adequacy reports.	February 2019	**Completed.** Indicator added March 2019; reported in Specialized Behavioral Health network adequacy reviews.
LDH to assess MAT capacity based MCO data or independent review.	February 2019	**Completed/Ongoing.** LDH monitored MAT capacity using MCO data; LDH and Project ECHO trained more than 1,300 providers by 2020.
Milestone 5: Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD		
Coordinate with stakeholders on establishing required reporting for Naloxone administration.	February 2020	**Completed/Ongoing.** Standing order for Naloxone in place since 2016; LDH distributes and tracks kits via grant-funded program; overdose prevention programs are prevalent in the state.
Coordinate with Board of Pharmacy to create Medicaid access to monitor prescribing practices of opioids under the PMP.	February 2020	**Suspended/Determined infeasible.** State law prohibits Medicaid access to PMP; LDH exploring alternative data sources.
Work with Board of Pharmacy to track Naloxone distribution under the PMP.	July 2018	**Completed/Determined infeasible.** Current tracking is limited to LDH-distributed kits as private-sector data remains unavailable. In lieu of PMP tracking, LDH established the State Overdose Prevention and Response Hub to provide information on Naloxone distribution sites.
Milestone 6: Improved care coordination and transitions between levels of care		
n/a		

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

Louisiana's primary Implementation Plan action item under Milestone 1 was to update the State Plan and Behavioral Health Provider Manual to reflect the current services array and associated requirements. This update was completed early in the demonstration period. The Behavioral Health Provider Manual was revised in April 2018 to align Medicaid-covered SUD services with the ASAM continuum of care. These revisions clarified the scope of covered services and

ensured that provider qualifications, documentation standards, and reimbursement guidance were consistent with ASAM criteria. A State Plan amendment was not required because these services were already covered under existing authority.

In addition to this required action item, Louisiana pursued several related system improvements ("future state" activities) that further advanced the intent of Milestone 1 by expanding access to critical levels of care. These included the addition of methadone as a covered medication for opioid use disorder, implemented in January 2020 following CMS approval, and the launch of a Hub-and-Spoke model to strengthen linkages between opioid treatment programs (OTPs) and community-based providers. By the 2020 mid-point, ten OTP "hubs" were operational statewide, each supporting multiple "spoke" providers delivering office-based MOUD. Louisiana also evaluated the need for ambulatory withdrawal management (ASAM Level 1-WM) and determined that the service was not essential for inclusion in the continuum given existing coverage at higher levels of care.

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

Louisiana's Implementation Plan action item under Milestone 2 required the state to update the Behavioral Health Provider Manual to clarify that all providers must use ASAM criteria and levels of care for clinical assessments and service authorization. This update was completed in November 2018, aligning the state's clinical and utilization-management standards with nationally recognized, evidence-based placement practices. MCO contract language was reviewed and found to be consistent with this requirement, and LDH issued technical guidance to reinforce its application across managed-care networks.

Beyond this formal action item, LDH pursued related future state activities to strengthen implementation and oversight of ASAM-based placement. These included the development of standardized utilization-management templates for MCOs, increased auditing of authorization practices, and collaboration with providers to ensure consistent interpretation of placement criteria. By 2020, all MCOs were reporting placement data consistent with ASAM levels of care, and LDH's quarterly reviews confirmed that ASAM criteria were being routinely applied. Ongoing activities in the renewal period focus on enhancing data quality and monitoring adherence through targeted chart audits and staff training.

Milestone 3: Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications

Under Milestone 3, LDH committed to reviewing and updating provider manuals and contracts to ensure residential treatment providers offer or facilitate access to MAT/MOUD and to educating abstinence-based providers on the benefits of MAT/MOUD. Both of these action items were implemented early in the demonstration period. The Behavioral Health Provider Manual was revised in 2018 to codify MAT/MOUD access requirements, and LDH confirmed through contract reviews that existing managed-care provisions were sufficient to support compliance.

In parallel, LDH initiated an education and outreach effort to promote MAT/MOUD acceptance among providers traditionally operating under abstinence-based models. Through statewide

conferences and targeted technical-assistance sessions, LDH and the OBH disseminated evidence regarding the safety and efficacy of MAT/MOUD. By 2020, stakeholder feedback suggested measurable progress toward cultural acceptance of MAT/MOUD, though variation remained among smaller residential programs.

Milestone 4: Sufficient provider capacity at each level of care

Louisiana's Implementation Plan identified several action items under Milestone 4 to expand provider capacity and strengthen monitoring of network adequacy. Specifically, LDH required MCOs to include SUD-specific capacity-building strategies in their network development and management plans and to add an indicator for "accepting new patients" in quarterly network adequacy reports. These requirements were implemented between 2019 and 2020. In addition, LDH committed to assessing MAT/MOUD capacity using MCO data or independent reviews, a process that began in 2019 and continues through the current renewal period.

In addition to these required activities, LDH pursued a number of complementary system-development efforts that advanced the aims of Milestone 4. Through collaboration with Tulane University's Project ECHO, more than 1,300 providers were trained on MAT prescribing and evidence-based behavioral-health practices by 2020. Additionally, more than 50 new office-based opioid treatment providers were recruited through the Louisiana State Opioid Response Program's Office-Based Opioid Treatment (OBOT) initiative. LDH has not yet implemented the centralized provider enrollment and credentialing system. However, the Medicaid Provider Enrollment Portal has been established as an important step toward that broader initiative. Although the overall number of SUD providers increased during the initial demonstration, workforce shortages, particularly in rural areas, remained a key constraint.

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

The Implementation Plan for Milestone 5 included several action items aimed at expanding overdose prevention capacity. Louisiana committed to coordinating with stakeholders on reporting requirements for naloxone administration, working with the Board of Pharmacy to create Medicaid access to Prescription Monitoring Program (PMP) data, and tracking naloxone distribution through the PMP where feasible.

By the 2020 mid-point, LDH had achieved partial or full implementation of these items. The statewide naloxone standing order, originally issued in 2016, remained in effect, and LDH expanded naloxone distribution through grant-funded programs administered by the Office of Public Health. While state law continued to restrict Medicaid access to PMP data, LDH maintained ongoing collaboration with the Board of Pharmacy to explore alternative data-sharing mechanisms. LDH also launched public and provider education campaigns to promote early intervention and reduce stigma surrounding treatment for opioid use disorder.

The state has supported a multi-pronged approach to expanding MAT/MOUD prescribing through the Office-Based Opioid Treatment (OBOT) initiative, the Pharmacy Champion program, and participation in the LA Bridge program to strengthen clinician and pharmacy

engagement. In addition, Louisiana has pursued and implemented a series of legislative and regulatory changes aimed at reducing barriers to MOUD access, including removing the certificate-of-need requirement for opioid treatment programs (OTPs), authorizing pharmacy-based buprenorphine dispensing with minimum stocking requirements, eliminating maximum daily dose limits for buprenorphine, requiring MOUD access in residential and intensive outpatient SUD programs, and permitting emergency buprenorphine fills during disasters.

Finally, while provider quality monitoring reviews were paused from April 2020 through March 2021 due to the COVID-19 public health emergency, they resumed as of April 2021 and have continued on a quarterly basis since that time.

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

Louisiana's approved Implementation Plan did not include a discrete action item for Milestone 6. Rather, progress toward this milestone was expected to occur through implementation of related requirements under other milestones including those addressing use of evidence-based placement criteria, adoption of standardized program standards, and expansion of provider capacity. Collectively, these efforts were intended to ensure that individuals with SUD could move seamlessly across levels of care and remain engaged in treatment during transitions between settings.

During the initial demonstration period, LDH advanced the goals of this milestone through a series of related system-level initiatives. MCOs were required to conduct discharge planning and to coordinate follow-up services for beneficiaries transitioning from residential or withdrawal management programs to community-based treatment. OBH incorporated SUD-specific quality measures into its provider-monitoring reviews and worked with MCOs to address identified gaps in discharge planning and care coordination.

Monitoring activities were temporarily disrupted in 2020 due to the COVID-19 public health emergency and an active hurricane season, but resumed in 2021.

Progress Toward Implementing Secondary Drivers

In addition to the formal Implementation Plan action items, Louisiana continues to advance several secondary drivers identified in the Renewal Evaluation Design as key interventions supporting the demonstration's overarching goal of increasing utilization of SUD services and reducing opioid overdose deaths. These secondary drivers build on the initiatives established during the first demonstration period and reflect ongoing system improvements in MOUD access, provider education, network development, and care management.

Table 5 summarizes progress toward implementing these secondary drivers as of the mid-point of the 2023–2027 renewal period.

Table 5: Progress toward implementation of secondary drivers at midpoint

Secondary Driver	Status

Continue MOUD coverage to include methadone and increase number of OTPs	MCOs continue to cover methadone and other forms of MOUD. In addition, the Louisiana State Opioid Response (LaSOR) Program continues to support MOUD for individuals that do not qualify for Medicaid, but cannot afford their medication. A new OTP opened in Houma in December 2022, bringing the total number of OTPs in the state to 11. An emergency rule was passed in November 2024 allowing OTPs to operate mobile dosing units to expand access to MOUD, including methadone. To make this change permanent, a final rule was published on April 20, 2025.
Maintain requirement that residential treatment providers offer or facilitate access to MOUD	This requirement remains in authority documents for residential providers, including BHSP licensing rule and the Medicaid BHS provider manual.
Continue educating prescribers, pharmacists, and SUD providers on the benefits of MOUD	LDH and the MCOs continue to promote the benefits of MOUD to prescribers, pharmacists and SUD providers.
Continue requiring use of evidence-based SUD-specific patient placement criteria	This requirement continues and remains in authority documents, including the Medicaid BHS provider manual.
Continue requiring MCOs to update their specialized behavioral health network development and management plan to specifically focus on SUD provider capacity, including MOUD	This continues to remain a requirement of the annual network development and management plan submissions.
Continue MCO provider review process to ensure that SUD providers deliver care consistent with the specifications in the ASAM Criteria	This requirement continues with SUD providers included as provider types audited in quarterly MCO provider chart reviews.
Require MCOS to recognize members with SUDs as qualifying as a special health care needs population eligible for case management	This provision has been in place since 2023.

Stakeholder input

The evaluation team is in the process of conducting key informant interviews with stakeholders from across the state who are involved in SUD prevention and treatment. This includes

clinicians, public health professionals, administrators, judges, attorneys, and other support providers. The team will also conduct in-depth interviews with SUD patients generally, and with those who were in treatment while being involved with the criminal justice system, and in treatment while pregnant. The in-depth interviews have not yet begun.

Preliminary analyses of the key informant interviews conducted to date show that stakeholders are generally more positive about the state of the SUD prevention and treatment system in Louisiana compared to the time of the implementation of the 1115 Waiver.

Regarding access to and availability of MOUD services, stakeholders expressed that allowing nurse practitioners to prescribe MOUD has expanded access to services statewide. Barriers to care remain, including limited access to MOUD in rural areas, with some communities depending entirely on local governing entities for MOUD services. Other barriers include limited numbers of methadone clinics, unreliable Medicaid transportation, and pharmacy stock limitations for MOUD medications.

Stakeholders discussed shortages of outpatient MOUD providers who take Medicaid patients, with some areas seeing wait times of weeks-to-months. One stakeholder who provides private, outpatient counseling stated that they would rather treat Medicaid patients for free than go through the process of billing Medicaid. Adolescent addiction services were noted as an area of particular need. In general, stakeholders expressed that having to be credentialed with multiple MCOs created an administrative burden that discouraged providers from treating Medicaid patients.

Capacity of residential and/or inpatient facilities was mixed, with those in urban areas expressing that their wait times are short, while rural inpatient facilities tend to operate at capacity. In at least one case, a rural inpatient facility could not afford an on-staff MOUD provider and had to transport their patients to an outpatient provider for treatment.

Related to program standards and licensing, representatives of several programs discussed with stakeholders apply structured, evidence-informed components such as 12-step programs, CBT group therapy, and curriculum-based counseling. So far, there has been no reference to national accreditation standards (e.g., ASAM levels, CARF, or Joint Commission) or state adoption of such standards for licensing residential facilities.

In terms of coordination and continuity of care, stakeholders were relatively positive about the system by which patients are engaged and retained in care in Louisiana. They cited emergency department-based initiatives that link discharged patients to outpatient MOUD services within 48 hours. The use of peer navigators has also been successful in keeping patients engaged in treatment. A stakeholder from an inpatient facility described how patients are transitioned to outpatient through “warm handoffs” at discharge.

Some gaps in coordination were mentioned. Small facilities may depend on ad hoc research to find the additional services their patients need after discharge. Stakeholders mentioned that it would be useful to have a formal, statewide forum for linking SUD providers, sharing best practices, and communicating policy updates.

Overall, stakeholders felt that the OUD situation in Louisiana had improved in recent years. They attributed this to programs such as community-based overdose prevention and Narcan training, Narcan distribution in communities, jails, and with SUD patients, and peer navigator and outreach programs. Stakeholders called for more outreach to primary care and emergency physicians to decrease the stigma around buprenorphine and increase its uptake.

2. Assessment of overall risk of not meeting milestones

Table 6: Summary of mid-point assessment of overall risk of not achieving demonstration milestones

Milestone	Percentage of fully completed action items (# completed/total)	Percentage of monitoring metrics trending in the desired direction (#metrics/total)	Key themes from stakeholder input	Risk level	For milestones at medium or high risk, independent assessor's recommended modifications	State's responses and planned modifications
Milestone 1: Access to critical levels of care for OUD and other SUDs	100% (1/1)	100% (7/7)	Stakeholders report improved access to SUD treatment and MOUD statewide, including expanded prescribing authority and ED-based linkages. Remaining barriers include transportation challenges, workforce shortages, pharmacy stock limitations, and limited access in rural areas.	Low	n/a	The state agrees with the low risk assessment. No modifications are planned at this time. The state will continue to monitor access challenges identified by stakeholders, including transportation barriers, workforce shortages, pharmacy stock limitations, and rural access gaps, through ongoing data review and stakeholder engagement.
Milestone 2: Use of evidence-based, SUD-specific patient placement criteria	100% (1/1)	100% (2/2)	Stakeholders did not identify concerns related to placement criteria or service authorization, suggesting that ASAM-aligned assessment and placement processes are well integrated into routine practice and do not represent a current implementation barrier.	Low	n/a	The state agrees with the low risk assessment. No modifications are planned at this time. ASAM-aligned assessment and placement processes will continue to be monitored through routine program oversight to ensure sustained alignment with evidence-based standards.
Milestone 3: Use of nationally	67% (2/3)	n/a	Program standards requiring access to MOUD are in place	Medium	Continue and refine the ongoing provider	The state agrees with the medium risk assessment

recognized, evidence-based, SUD program standards to set residential treatment provider qualifications			and generally accepted. However, uptake and cultural alignment vary across residential providers, particularly among smaller or historically abstinence-based programs.		education strategy by using monitoring and utilization data to identify residential providers with low MOUD uptake or referral rates and target technical assistance and outreach to those programs.	and will continue to strengthen provider education and technical assistance related to MOUD requirements in residential settings. The state will use available monitoring and utilization data to identify providers with low MOUD uptake or referral rates and prioritize targeted outreach, education, and technical assistance to support broader cultural alignment and compliance with program standards.
Milestone 4: Sufficient provider capacity at each level of care	100% (3/3)	100% (1/1)	Stakeholder report that provider capacity has increased statewide, particularly for MAT/MOUD, but that workforce shortages and uneven geographic distribution continue to constrain access in rural areas and in certain service lines.	Low	n/a	The state agrees with the low risk assessment. No modifications are planned at this time. LDH will continue monitoring network adequacy as well as continue to collaborate with MCOs to maintain access, address gaps and support network development.
Milestone 5: Implementation of comprehensive treatment and prevention strategies to	33% (1/3)	67% (2/3)	Stakeholders report strong support for overdose prevention, naloxone distribution, and peer-based outreach. However, stigma around MAT/MOUD prescribing persists among some providers.	Medium	Strengthen data-driven targeting of overdose prevention efforts, including focused outreach to high-risk populations and provider groups with low MOUD prescribing or referral rates, and continue close	The state agrees with the medium risk assessment. The state will continue to strengthen data-driven targeting of overdose prevention strategies, including focused outreach to high-risk populations and provider

address opioid abuse and OUD					monitoring of overdose mortality trends, which have begun to decline recently.	groups with low MOUD prescribing or referral rates. Ongoing efforts will include continued support for overdose prevention initiatives, naloxone distribution, and peer-based outreach, as well as monitoring overdose mortality trends to assess progress and inform future adjustments.
Milestone 6: Improved care coordination and transitions between levels of care	n/a	67% (2/3)	Stakeholders report improvements in care coordination through ED-based linkage programs, peer navigation, and warm handoffs at discharge, while noting that coordination remains uneven across providers and that smaller programs tend to rely on informal or ad hoc processes.	Medium	Continue to strengthen and formalize care coordination practices by standardizing discharge planning, warm handoffs, and follow-up workflows across settings; use claims and encounter data to identify facilities or regions with lower rates of 7- and 30-day ED follow-up and target technical assistance accordingly; and monitor 30-day readmissions among SUD beneficiaries to distinguish potentially avoidable readmissions from those reflecting greater identification of need and appropriate system engagement.	The state agrees with the medium risk assessment and will continue efforts to formalize care coordination practices, including standardized discharge planning, warm handoffs, and follow-up workflows. Claims and encounter data will be used to identify facilities or regions with lower 7- and 30-day ED follow-up rates and target technical assistance, and 30-day readmissions will be monitored to assess system performance.

3. Assessment of state's capacity to provide SUD services

Adequacy of the state's capacity at the mid-point

Louisiana continues to strengthen its system capacity to deliver a full continuum of evidence-based SUD treatment services. The state has more than 382 recognized SUD treatment facilities, though much of this capacity remains concentrated in urban centers.[1] Historically, treatment options were limited due to a statewide moratorium on new methadone clinics.[2] However, today, Louisiana maintains a total of 11 Opioid Treatment Programs (OTPs) and at least one residential treatment provider operates in every health service region in the state, reflecting expanded reach across all levels of care.[3]

The Louisiana Substance Abuse Strategic Plan identifies workforce development and credentialing as key priorities for sustaining system capacity.[4] The Addictive Disorder Regulatory Authority (ADRA), in partnership with the Louisiana Association of Substance Abuse Counselors and Trainers (LASACT) and the Louisiana Center for Prevention Resources (LCPR) at Southern University, continues to provide training, licensure, and continuing education for addiction professionals statewide. OBH also supports professional development through partnerships with the Louisiana Addiction Technology Transfer Center (ATTC) and university-based programs such as Tulane University's Project ECHO, which offers clinical consultation and training for providers on MOUD/MAT and co-occurring disorders. Beyond prescribers, OBH has worked to build a peer recovery specialist workforce and has embedded peer support specialists in treatment settings. For instance, each OTP clinic in the state was funded to add a peer support staff member under recent grant programs.[5] Peers in recovery provide mentoring, care navigation, and encouragement to clients, which can improve engagement. Louisiana Medicaid now reimburses peer support services provided by Local Governing Entities (LGEs) and Office of Aging and Adult Services (OAAS) certified permanent supportive housing (PSH) agencies.[6]

These investments in treatment capacity have resulted in improved outcomes for Louisianans with SUD. For example, in 2022, rates of initiation and engagement in SUD treatment for Louisiana Medicaid members exceeded the 90th percentile benchmarks established by the National Committee for Quality Assurance (NCQA). And while national initiation and engagement rates for SUD treatment have remained stagnant over the past decade, rates among Louisiana Medicaid members have experienced significant increases (NCQA, 2024). During the renewal period, initiation and engagement rates improved across all four diagnosis cohorts (total AOD, alcohol, opioid, and other drug). Further, MAT/MOUD use for SUD has increased dramatically in the past decade and remains at an all-time high (see Table 3).

However, despite these advances, workforce shortages and uneven geographic distribution continue to constrain access, particularly in rural regions. Individuals in remote parishes often travel long distances to reach an OTP or SUD specialist, and studies show that greater travel distance is associated with lower access to MOUD/MAT.[7] Disparities in care persist as well with recent evidence indicating that younger and non-White patients in Louisiana are less likely to receive MOUD than older or White patients.[8] The Strategic Plan outlines targeted strategies to

address these challenges, including provider incentives, telehealth expansion, and mobile service delivery models.[4]

Overall, Louisiana's capacity to deliver SUD treatment and recovery services at the mid-point of the demonstration is adequate to meet demand across most ASAM levels of care. Continued monitoring of provider participation, workforce distribution, and network adequacy will be critical to maintaining and expanding this capacity over the remainder of the demonstration period.

Changes in the state's capacity

Louisiana's capacity to deliver SUD treatment and recovery services has expanded significantly since the launch of the initial demonstration in 2018. Growth has been driven by increases in enrolled providers, expanded MAT/MOUD availability, and strengthened regional coverage through community-based services.

The most significant gains have occurred in outpatient and MAT/MOUD services. Since the start of the initial demonstration period, the state expanded its Hub-and-Spoke model and opened one additional OTP. As a result, between 2018 and 2024, the number of Medicaid-enrolled SUD providers increased by 13.7 percent. Further, the number of providers delivering MAT/MOUD grew by 81.8 percent over the same period.[1] Access was further enhanced in late 2024 when an emergency rule authorizing OTPs to operate mobile dosing units for methadone and other MOUD. This rule was made permanent in April 2025, allowing OTPs to deliver services in rural and underserved areas, reducing travel barriers for patients.

Policy reforms have also played a central role in the expansion of MAT/MOUD services. In 2019, the Louisiana Legislature passed Act 414, which extended MAT/MOUD prescribing authority to advanced practice nurse practitioners and physician assistants. The 2023 federal elimination of the DATA-waiver requirement further removed barriers to MOUD prescribing. Louisiana Act 425, enacted in January 2020, required all licensed residential addiction treatment facilities in the state to offer buprenorphine and naltrexone (or equivalents) as a condition of licensure.[8] This change helped shift the treatment system away from an abstinence-only model. Following these changes, MAT/MOUD prescribing for Medicaid members more than tripled between 2018 and 2021, and the share of residential treatment patients receiving MOUD rose from 8 percent to 42 percent.[8] Outpatient programs saw similar growth, with utilization increasing from 21 percent to roughly 50 percent over the same period.[8]

At the systems level, OBH strengthened oversight and accountability by requiring annual MCO network development plans, standardized quarterly network adequacy reports, and SUD-specific metrics within performance monitoring. These tools improved the state's ability to track growth, identify gaps, and implement targeted interventions more efficiently than in prior years.

[1] While not reported in Table 3, this 81.8 percent figure is derived from Louisiana Medicaid claims data and compares the average monthly count of MAT/MOUD-qualified providers (Monitoring Metric #14) during 2018 to the average monthly count during the first two years of the renewal demonstration period (January 2023 through December 2024).

Collectively, these reforms have positioned Louisiana to deliver a more comprehensive, accessible, and evidence-based SUD treatment system than at any point in the state's history.

Identified needs for additional capacity

Despite ongoing efforts, stakeholders identified several critical needs for additional SUD treatment capacity in Louisiana. For example, the scarcity of addiction psychiatrists, counselors, social workers, and other professionals is a fundamental barrier to expanding treatment services. With nearly the entire state designated a shortage area for mental health providers and 30% of the population living in rural areas, Louisiana will need continued investment in workforce development.[9]

Capacity limitations are particularly evident in rural regions and in services for adolescents. OBH and its partners are addressing these gaps through strategies outlined in the Strategic Plan, including expanded telehealth, enhanced training programs, and targeted recruitment and retention incentives.[4] The state is also prioritizing access to recovery supports and integrated behavioral and physical health care, recognizing that sustained recovery often depends on coordination across service systems.[4]

Overall, Louisiana's SUD treatment capacity, supported by Medicaid expansion, the 1115 demonstration waiver, targeted funding, workforce initiatives, and recent policy, has made measurable strides in improving access and outcomes for individuals with SUD. The state's ongoing challenge will be to sustain these gains and ensure high-quality, evidence-based treatment and recovery services are available to all who need them, regardless of geography or demographic background.

4. Next steps

Since the launch of Louisiana's Section 1115 SUD Demonstration waiver in 2018, the state has made significant progress toward building a comprehensive, evidence-based system of care for Medicaid beneficiaries with substance use disorders. The state has expanded coverage, increased access to MAT/MOUD, strengthened provider networks, and improved treatment initiation, engagement, and follow-up after acute episodes of care. Many of the core infrastructure elements proposed under the demonstration, including standardized placement criteria, expanded provider capacity, and integration of MAT/MOUD into outpatient and residential settings, are now well-established and functioning as intended.

Despite these successes, this Mid-Point Assessment had identified areas where there is some risk of not fully achieving the demonstration's objectives without continued attention. First, while access to treatment (including MAT/MOUD) and engagement in care have improved, adoption of evidence-based program standards remains uneven across providers. Although formal requirements are in place, variation in update and cultural alignment persists, especially among smaller and historically abstinence-based programs. Without continued efforts to support consistent implementation, there is a risk that these standards will not be uniformly realized statewide.

Second, despite the overall growth in the number of SUD and MAT/MOUD providers, workforce shortages and uneven geographic distribution continue to constrain access in rural areas and in certain service lines. Capacity appears adequate in aggregate, but remains vulnerable to staffing limitations, provider burnout, and other barriers that may impede sustained progress.

Lastly, overdose prevention efforts have expanded, and recent data show encouraging declines in overdose mortality toward the end of the mid-point period. However, continued progress will depend on sustaining and targeting prevention and treatment strategies in high-risk populations and communities.

Louisiana Initiatives

LDH is committed to continuing to improve on demonstration performance and to improving access to overdose prevention and SUD treatment. Some of the state's key initiatives are described below.

Louisiana uses ASAM criteria to establish Medicaid treatment guidelines based on the latest scientific evidence. On October 5, 2023, Hazelden Betty Ford released The ASAM Criteria – 4th Edition, Volume 1 for adults, which revised certain standards and levels of care for serving the adult population. Transition to evidence-based practice standards in the ASAM Criteria – 4th Edition for Adults for various levels of care is scheduled for 2026, with providers required to be in full compliance with revised rules, regulations, and Medicaid policy criteria by July 1, 2026.

LDH will strengthen the MCO corrective action process by developing a Remediation Plan template for MCOs to use to submit their monthly network development plans when network gaps are identified. The plans will include summaries of gaps, a root cause analysis, and a corrective action plan that describes recruitment strategies, proposed incentives, anticipated barriers and expected completion dates.

The Louisiana Bridge Program is a model intervention designed to address overdose deaths by scaling up buprenorphine access, patient navigation programs, overdose prevention services, and take-home naloxone in emergency departments (EDs). The program has been implemented in several regions/LGEs at varying levels of service. In areas where it has been fully implemented with fidelity to the evidenced-based model, dramatic results have been achieved with a 35% reduction in opioid overdose deaths. Adding more Bridge Programs at hospitals and emergency departments statewide will prevent even more deaths and costly ER visits could be reduced on a larger scale. Louisiana Bridge Team is actively working to address current challenges to statewide adoption.

The Louisiana State Opioid Response (LaSOR) Program will continue to address the expansion of access to MAT/MOUD through ongoing and new initiatives:

- Baton Rouge Treatment Center (BRTC), an OTP, will launch its mobile dosing unit once approval for offsite parking is received from the Drug Enforcement Agency (DEA). This will be the first OTP mobile dosing unit to be deployed in Louisiana outside of an emergency declaration.

- Through the Louisiana Primary Care Association (LPCA), LaSOR is expanding the number of Federally Qualified Health Centers/Community Health Centers (FQHC/CHC) that become Office Based Opioid Treatment Providers (OBOT), allowing patients with OUD to access both primary care and behavioral health services, including MOUD, at the same location. Peer recovery support services and group counseling sessions are also being added to the service array offered by participating FQHCs/CHCs, to further support the ongoing recovery of individuals with opioid use disorder.
- LPCA will also continue LaSOR's Project ECHO (Extension for Community Healthcare Outcomes) initiative, establishing a virtual "knowledge network" between an interdisciplinary team of specialists and community provider stakeholders. The live sessions will provide shared case-based learning and mentorship as well as direct support from addiction specialists on de-identified patient cases and other consulting needs.
- LaSOR is partnering with the Louisiana Pharmacy Association (LPA) to contract with pharmacies throughout the state to mitigate the barrier of obtaining prescribed buprenorphine for the under and uninsured while providing drug counseling to patients. LPA will also utilize two pharmacy champions to provide education and advocacy to pharmacists across the state, as a method to increase awareness and comfort level with ordering and dispensing buprenorphine.

LDH is pursuing a Medicaid 1115 waiver to expand access to healthcare services and facilitate enrollment in Medicaid managed care before individuals are released from prison or jail. The Louisiana Reentry Demonstration aims to support transitions back into the community, particularly for those with mental health and substance use needs, to ensure reentering individuals have health coverage, medications, and connections with community-based providers prior to release. LDH plans to cover select services (e.g., case management and MAT) for individuals expecting to release within 90 days from state prison or a participating local jail. Through the Reentry Demonstration, LDH seeks to increase appropriate SUD services uptake, improve continuity of care, reduce ED visits and inpatient hospitalizations among recently incarcerated Medicaid beneficiaries, and reduce overdose deaths.

D. References

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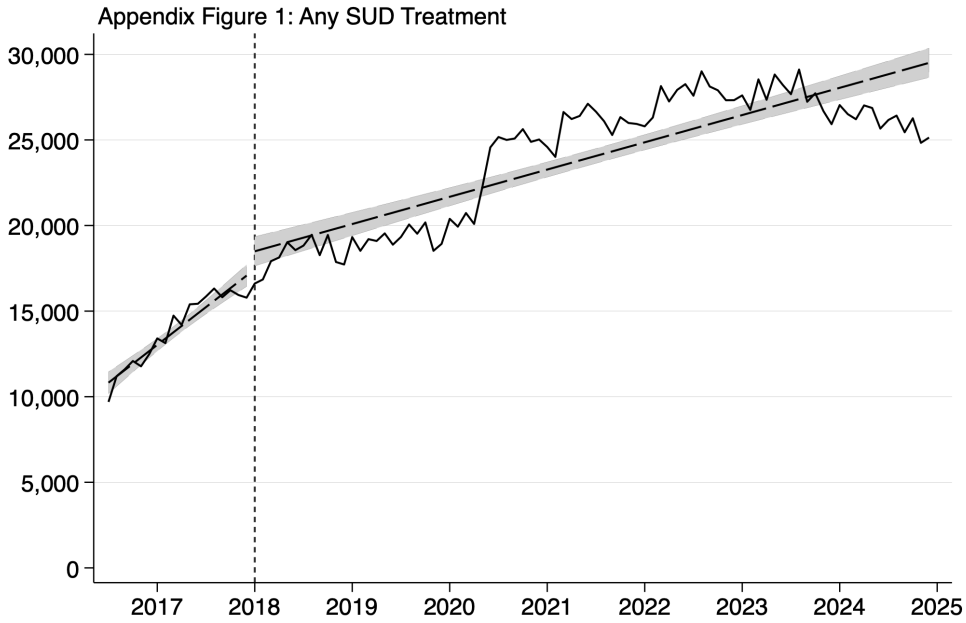
E. Appendix Figure and Tables

Monitoring Metric: #6, Any SUD Treatment

Description: Number of beneficiaries enrolled in the measurement period receiving any SUD treatment service, facility claim, or pharmacy claim during the measurement period.



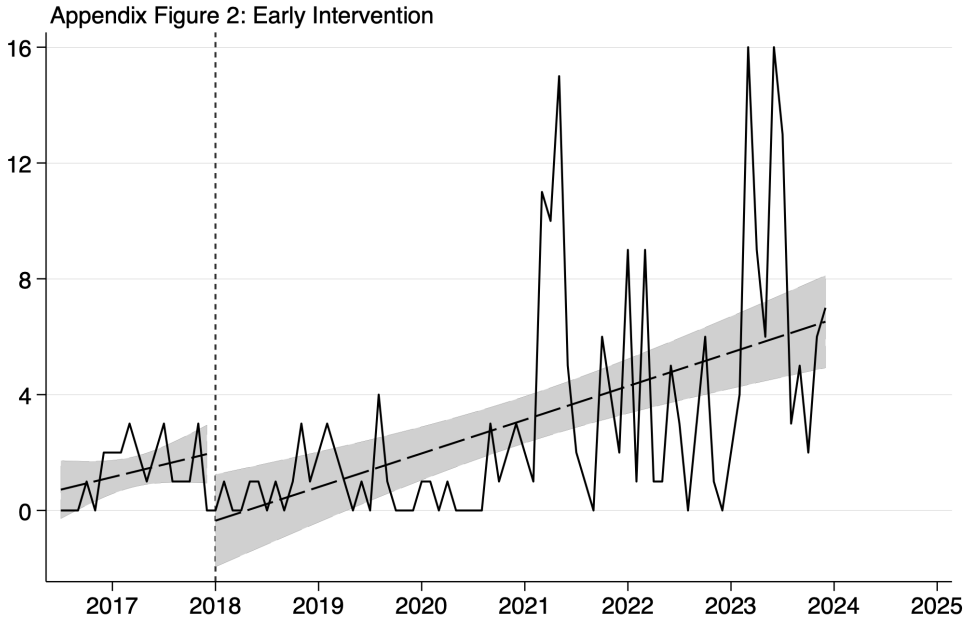
Notes: Number of beneficiaries enrolled in the measurement period receiving any SUD treatment service, facility claim, or pharmacy claim during the measurement period.

Appendix Table 1: Any SUD Treatment

	b/se/ci95
Pre-Period Slope	368.00***
	(40.35)
	[288.91,447.09]
Level Change	1051.33
	(871.33)
	[-656.45,2759.12]
Slope Change	-235.37***
	(47.11)
	[-327.70,-143.05]
Post-Period Slope	132.63***
	(20.03)
	[93.37,171.89]
Pre-Period Mean	13948.67
Pre-Period Min	9697
Pre-Period Max	16321
Post-Period Mean	24000.11
Post-Period Min	16611
Post-Period Max	29113
Observations	102

Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets.
**p<0.10, **p<0.05, ***p<0.01*

Monitoring Metric: #7, Early Intervention
Description: Number of beneficiaries who used early intervention services (such as procedure codes associated with SBIRT) during the measurement period.



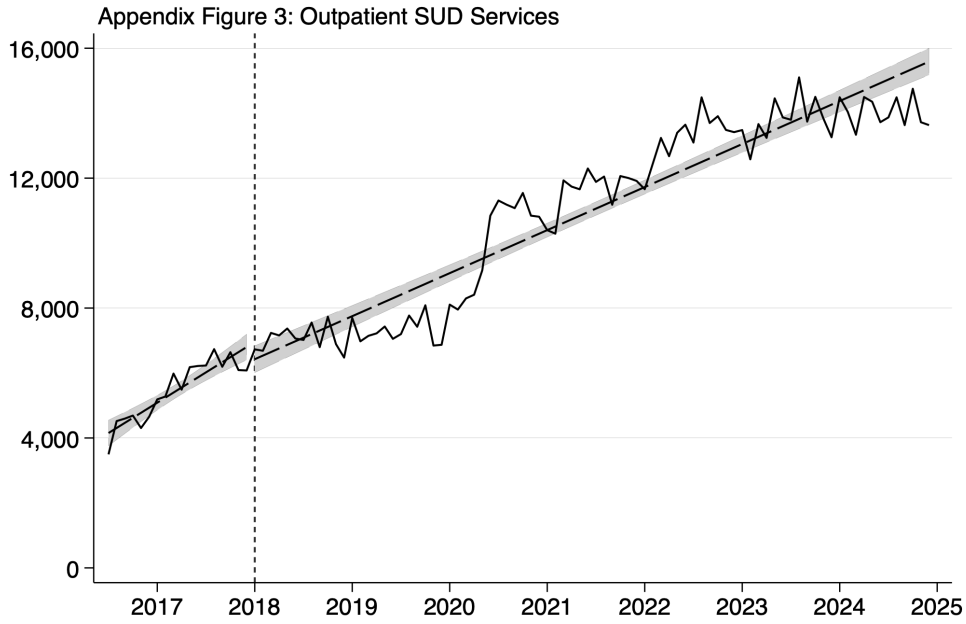
Notes: Total number of unique beneficiaries with a service claim for early intervention services (such as procedure codes associated with SBIRT) during the measurement period.

Appendix Table 2: Early Intervention

	b/se/ci95
Pre-Period Slope	0.07
	(0.05)
	[-0.03,0.17]
Level Change	-2.37***
	(0.88)
	[-4.09,-0.66]
Slope Change	0.02
	(0.05)
	[-0.08,0.13]
Post-Period Slope	0.10***
	(0.02)
	[0.05,0.14]
Pre-Period Mean	1.33
Pre-Period Min	0
Pre-Period Max	3
Post-Period Mean	3.08
Post-Period Min	0
Post-Period Max	16
Observations	90

Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets.
**p<0.10, **p<0.05, ***p<0.01*

Monitoring Metric: #8, Outpatient Services
Description: Number of beneficiaries who used outpatient services for SUD (such as outpatient recovery or motivational enhancement therapies, step down care, and monitoring for stable patients) during the measurement period. (ASAM Level 1).



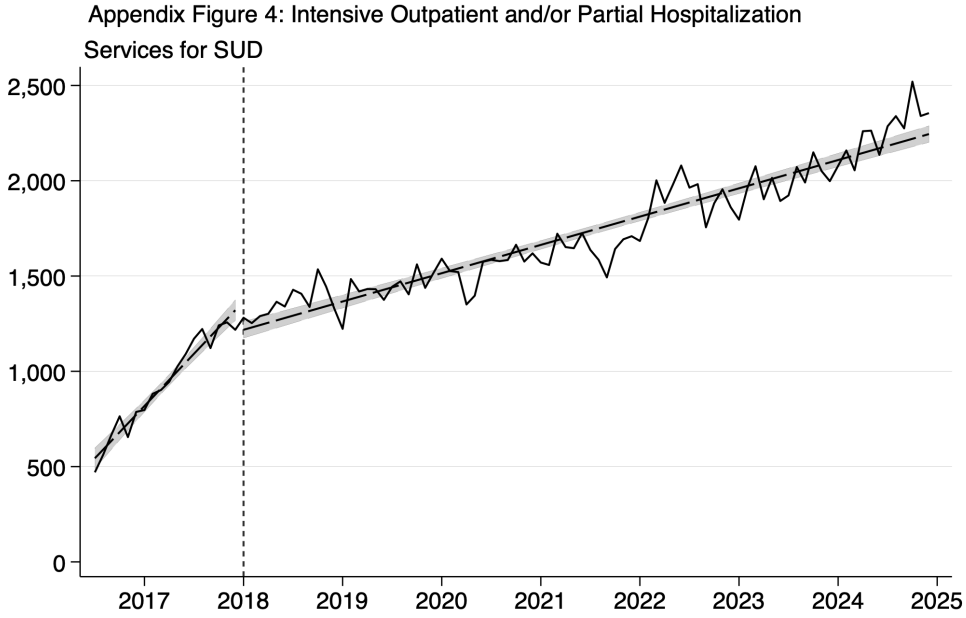
Notes: Number of beneficiaries who used outpatient services for SUD (such as outpatient recovery or motivational enhancement therapies, step down care, and monitoring for stable patients) during the measurement period. (ASAM Level 1). Intervention date was assigned to the first quarter of the demonstration period.

Appendix Table 3: Outpatient Services

	b/se/ci95
Pre-Period Slope	155.69***
	(21.67)
	[113.22,198.15]
Level Change	-529.24
	(499.90)
	[-1509.03,450.55]
Slope Change	-45.28**
	(22.66)
	[-89.69,-0.87]
Post-Period Slope	110.41***
	(8.30)
	[94.13,126.68]
Pre-Period Mean	5475.94
Pre-Period Min	3496
Pre-Period Max	6735
Post-Period Mean	11007.52
Post-Period Min	6476
Post-Period Max	15103
Observations	102

Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets.
**p<0.10, **p<0.05, ***p<0.01*

Monitoring Metric: #9, Intensive Outpatient and Partial Hospitalization Services
Description: Number of beneficiaries who used intensive outpatient and/or partial hospitalization services for SUD (such as specialized outpatient SUD therapy or other clinical services) during the measurement period. (ASAM Level 2).



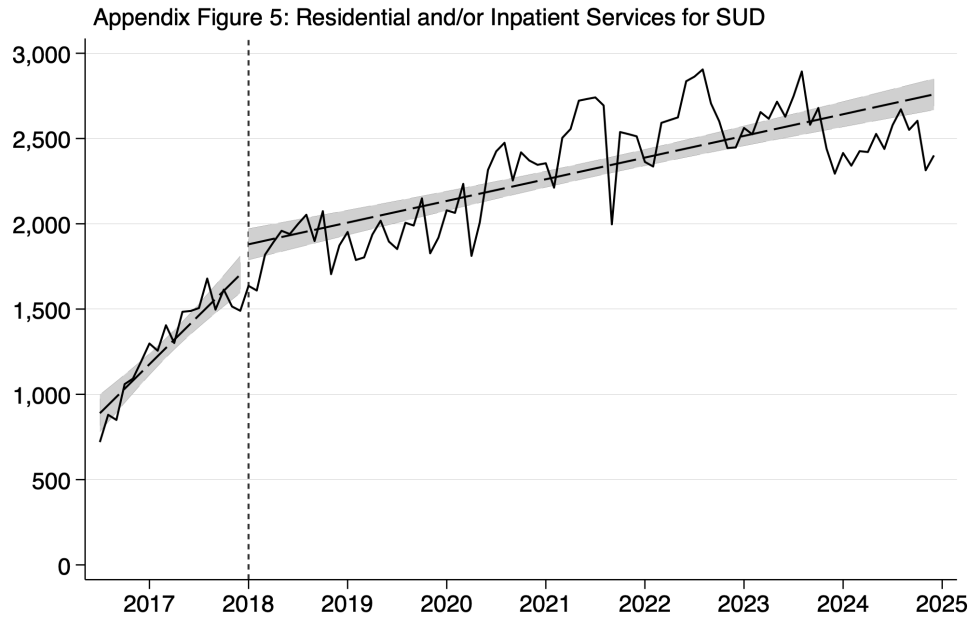
Notes: Number of beneficiaries who used intensive outpatient and/or partial hospitalization services for SUD (such as specialized outpatient SUD therapy or other clinical services) during the measurement period. (ASAM Level 2). Intervention date was assigned to the first quarter of the demonstration period.

Appendix Table 4: Intensive Outpatient and/or Partial Hospitalization Services

	b/se/ci95
Pre-Period Slope	45.69***
	(2.59)
	[40.61,50.77]
Level Change	-148.28***
	(49.18)
	[-244.66,-51.89]
Slope Change	-33.32***
	(2.63)
	[-38.47,-28.17]
Post-Period Slope	12.37***
	(0.78)
	[10.85,13.89]
Pre-Period Mean	932.17
Pre-Period Min	470
Pre-Period Max	1257
Post-Period Mean	1731.40
Post-Period Min	1223
Post-Period Max	2520
Observations	102

Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets.

Monitoring Metric: #10, Residential and Inpatient Services
Description: Number of beneficiaries who use residential and/or inpatient services for SUD during the measurement period. (ASAM Level 3).



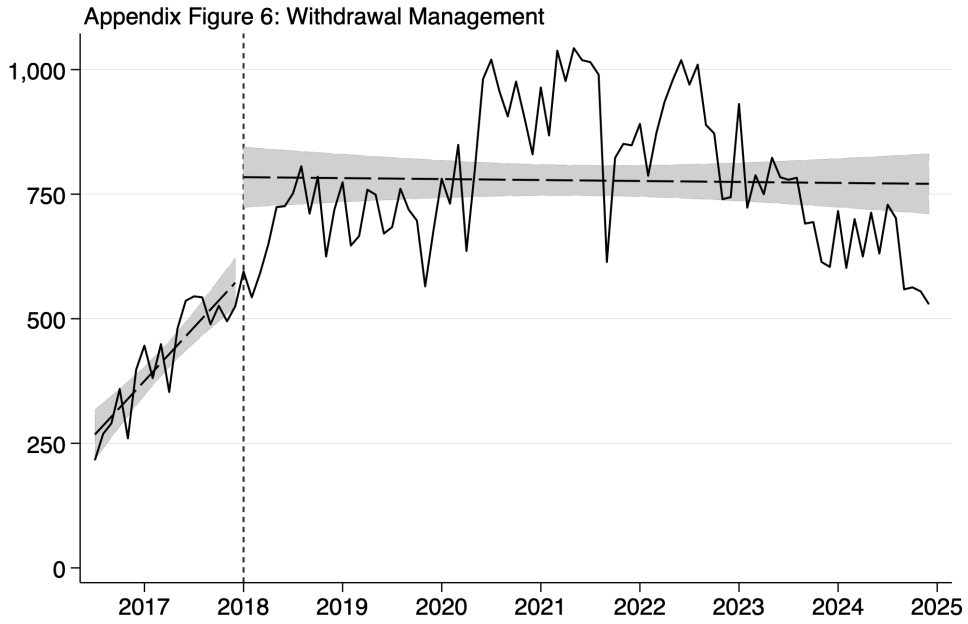
Number of beneficiaries who used residential and/or inpatient services for SUD during the measurement period. (ASAM Level 3). Intervention date was assigned to the first quarter of the demonstration period.

Appendix Table 5: Residential and/or Inpatient Services for SUD

	b/se/ci95
Pre-Period Slope	47.85***
	(7.54)
	[33.06,62.63]
Level Change	129.37
	(92.15)
	[-51.25,309.99]
Slope Change	-37.26***
	(7.99)
	[-52.91,-21.60]
Post-Period Slope	10.59***
	(1.69)
	[7.27,13.91]
Pre-Period Mean	1296.06
Pre-Period Min	720
Pre-Period Max	1679
Post-Period Mean	2319.50
Post-Period Min	1609
Post-Period Max	2905
Observations	102

Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets.
**p<0.10, **p<0.05, ***p<0.01*

Monitoring Metric: #11, Withdrawal Management
Description: Number of beneficiaries who used withdrawal management services (such as outpatient, inpatient, or residential) during the measurement period.
Primary Driver: Increase the rates of identification, initiation, and engagement in treatment.



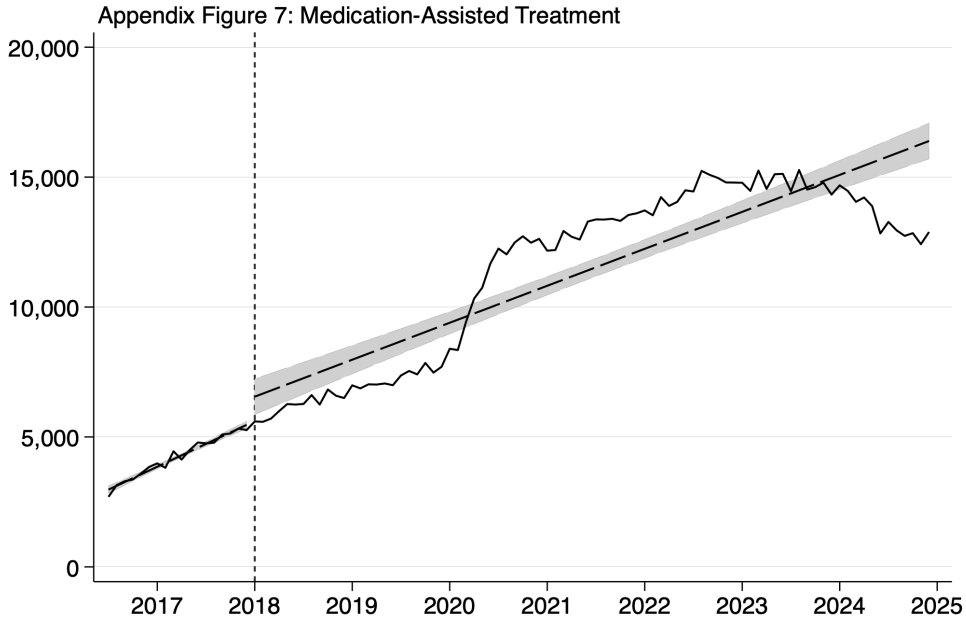
Notes: Number of beneficiaries who use withdrawal management services (such as outpatient, inpatient, or residential) during the measurement period. Intervention date was assigned to the first quarter of the demonstration period.

Appendix Table 6: Withdrawal Management

	b/se/ci95
Pre-Period Slope	17.92***
	(2.33)
	[13.36,22.48]
Level Change	193.93***
	(54.48)
	[87.15,300.71]
Slope Change	-18.08***
	(2.86)
	[-23.69,-12.48]
Post-Period Slope	-0.16
	(1.22)
	[-2.55,2.23]
Pre-Period Mean	420.00
Pre-Period Min	216
Pre-Period Max	545
Post-Period Mean	777.52
Post-Period Min	529
Post-Period Max	1043
Observations	102

Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets.
**p<0.10, **p<0.05, ***p<0.01*

Monitoring Metric: #12, Medication-Assisted Treatment
Description: Number of beneficiaries who have a claim for MAT for SUD during the measurement period.



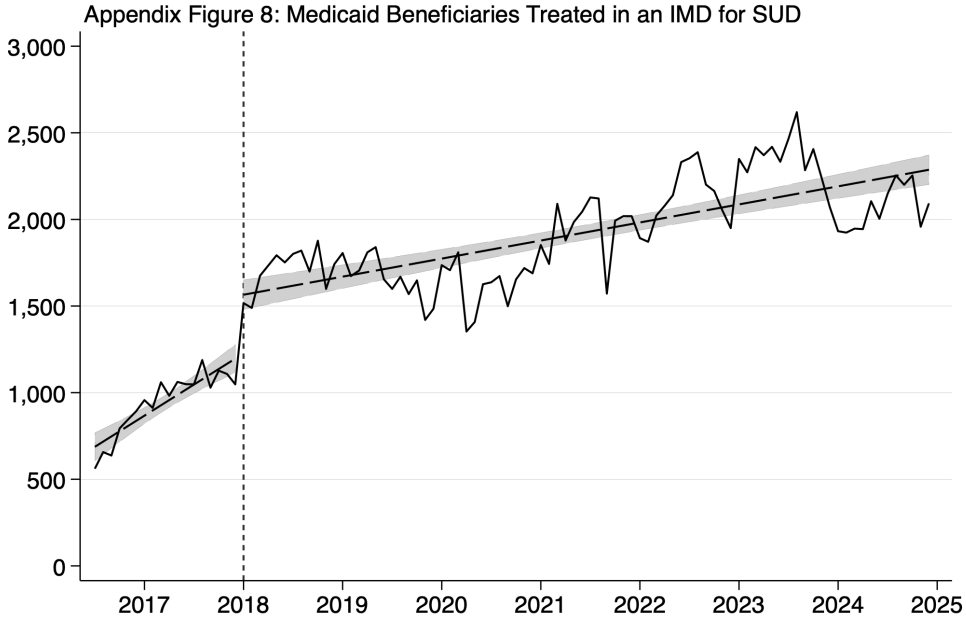
Notes: Number of beneficiaries who have a claim for MAT for SUD during the measurement period. Intervention date was assigned to the first quarter of the demonstration period.

Appendix Table 7: Medication-Assisted Treatment

	b/se/ci95
Pre-Period Slope	146.62***
	(6.12)
	[134.63,158.62]
Level Change	937.29
	(707.73)
	[-449.84,2324.41]
Slope Change	-28.08
	(19.42)
	[-66.14,9.98]
Post-Period Slope	118.54***
	(18.01)
	[83.25,153.84]
Pre-Period Mean	4220.22
Pre-Period Min	2696
Pre-Period Max	5324
Post-Period Mean	11469.92
Post-Period Min	5583
Post-Period Max	15273
Observations	102

Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets.
**p<0.10, **p<0.05, ***p<0.01*

Monitoring Metric: #5, Number of Medicaid Beneficiaries Treated in an IMD for SUD
Description: Number of unduplicated Medicaid beneficiaries enrolled in a reporting month/year with a paid/accepted claim for date of service in reporting month/year that uses an SUD diagnosis code as the primary diagnosis from an IMD provider.



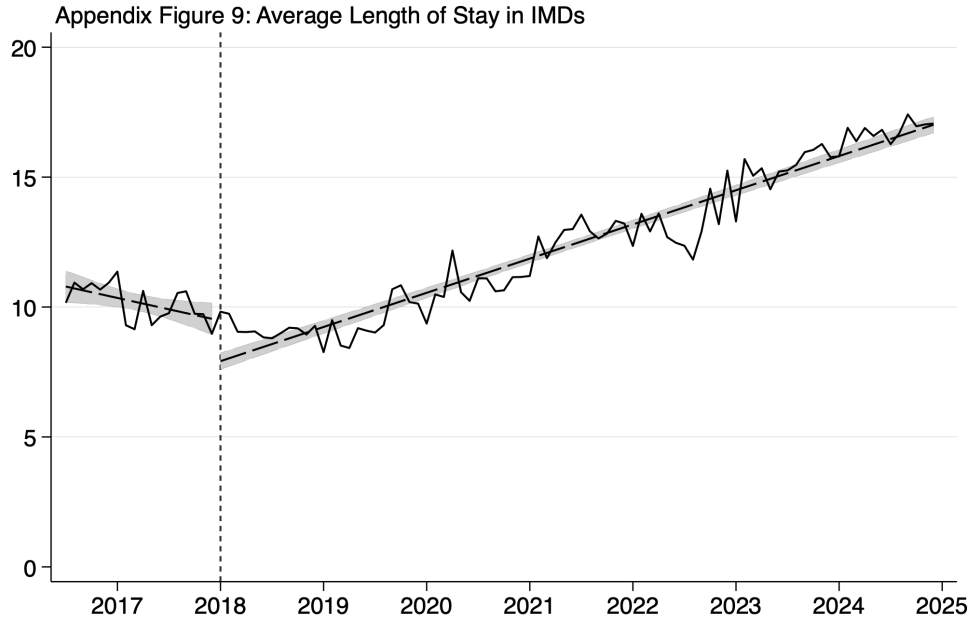
Notes: Number of unduplicated beneficiaries enrolled in a reporting month/year with a paid/accepted claim for date of service in reporting month/year that uses an SUD diagnosis code as the primary diagnosis from an IMD provider. Intervention date was assigned to the first quarter of the demonstration period.

Appendix Table 8: Medicaid Beneficiaries Treated in an IMD for SUD

	b/se/ci95
Pre-Period Slope	29.94***
	(5.47)
	[19.21,40.67]
Level Change	338.91***
	(89.29)
	[163.90,513.92]
Slope Change	-21.25***
	(5.71)
	[-32.44,-10.06]
Post-Period Slope	8.69***
	(1.63)
	[5.50,11.88]
Pre-Period Mean	942.00
Pre-Period Min	561
Pre-Period Max	1188
Post-Period Mean	1925.99
Post-Period Min	1353
Post-Period Max	2619
Observations	102

Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets.
**p<0.10, **p<0.05, ***p<0.01*

Monitoring Metric: #36, Average Length of Stay in IMDs
Description: The average length of stay for beneficiaries discharged from IMD inpatient/residential treatment for SUD.



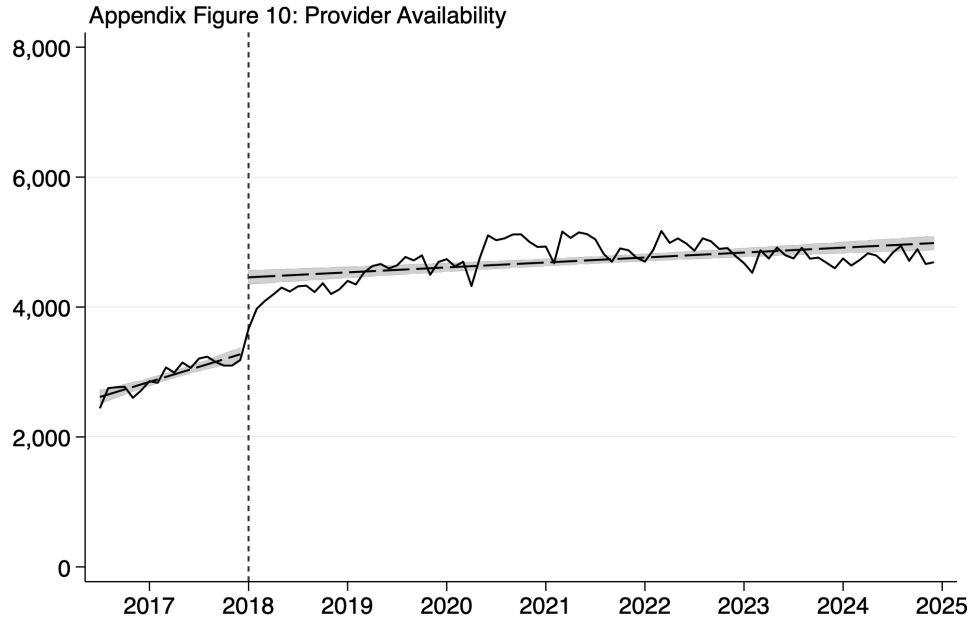
Notes: Average length of stay for Medicaid beneficiaries with SUD treated in an IMD. Intervention date was assigned to the first quarter of the demonstration period.

Appendix Table 9: Average Length of Stay in IMDs

	b/se/ci95
Pre-Period Slope	-0.073***
	(0.018)
	[-0.108,-0.038]
Level Change	-1.557***
	(0.399)
	[-2.339,-0.774]
Slope Change	0.183***
	(0.018)
	[0.148,0.217]
Post-Period Slope	0.110***
	(0.006)
	[0.098,0.121]
Pre-Period Mean	10.17
Pre-Period Min	9
Pre-Period Max	11
Post-Period Mean	12.47
Post-Period Min	8
Post-Period Max	17
Observations	102

Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets.
**p<0.10, **p<0.05, ***p<0.01*

Monitoring Metric: #13, SUD Provider Availability
Description: Number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period.



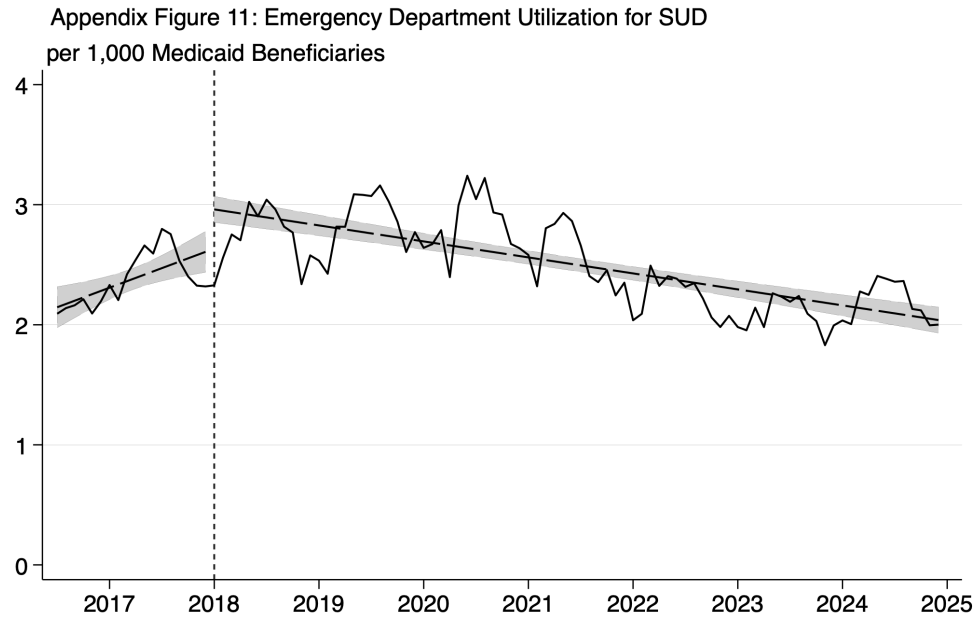
Notes: Number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period.

Appendix Table 10: Number of SUD Providers

	b/se/ci95
Pre-Period Slope	38.63***
	(4.87)
	[29.09,48.17]
Level Change	1146.43***
	(120.95)
	[909.37,1383.49]
Slope Change	-32.28***
	(6.11)
	[-44.25,-20.30]
Post-Period Slope	6.35***
	(2.38)
	[1.69,11.02]
Pre-Period Mean	2944.11
Pre-Period Min	2441
Pre-Period Max	3236
Post-Period Mean	4721.15
Post-Period Min	3664
Post-Period Max	5170
Observations	102

Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets.
**p<0.10, **p<0.05, ***p<0.01*

Monitoring Metric: #23, Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries. *Description*: The number of ED visits for SUD during the measurement period per 1,000 Medicaid beneficiaries.



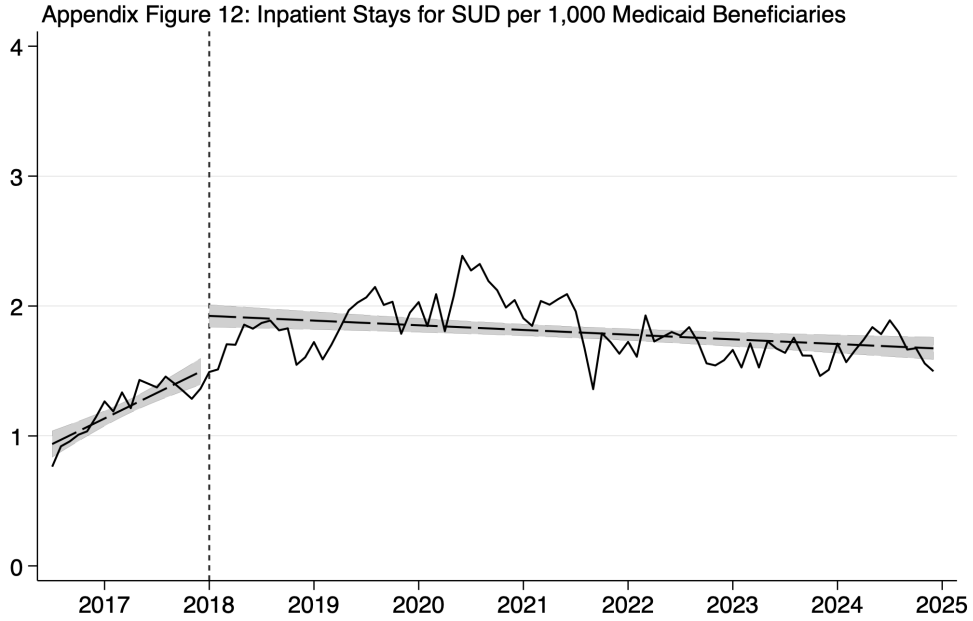
Notes: The numerator is the number of ED visits for SUD during the measurement period. The denominator is the number of unduplicated Medicaid beneficiaries eligible for the demonstration divided by 1,000. Intervention date was assigned to the first quarter of the demonstration period.

Appendix Table 11: Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries

	b/se/ci95
Pre-Period Slope	0.027**
	(0.011)
	[0.006,0.048]
Level Change	0.326**
	(0.148)
	[0.036,0.617]
Slope Change	-0.038***
	(0.012)
	[-0.061,-0.016]
Post-Period Slope	-0.011***
	(0.002)
	[-0.015,-0.007]
Pre-Period Mean	2.38
Pre-Period Min	2.09
Pre-Period Max	2.80
Post-Period Mean	2.50
Post-Period Min	1.83
Post-Period Max	3.24
Observations	102

Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets.
**p<0.10, **p<0.05, ***p<0.01*

Monitoring Metric: #24, Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries
Description: Total number of inpatient stays per 1,000 beneficiaries in the measurement period.



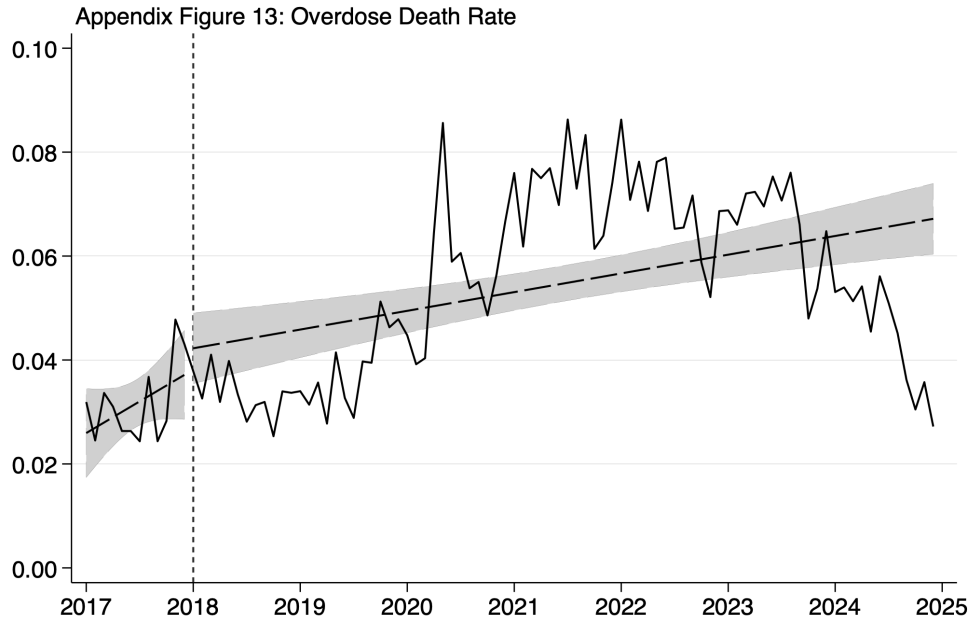
Notes: The numerator is the number of inpatient discharges related to SUD during the measurement period. The denominator is the count of index hospital stays among the eligible population divided by 1,000. Intervention date was assigned to the first quarter of the demonstration period.

Appendix Table 12: Inpatient Stays for SUD per 1,000 Medicaid Beneficiaries

	b/se/ci95
Pre-Period Slope	0.033***
	(0.007)
	[0.019,0.047]
Level Change	0.396***
	(0.104)
	[0.193,0.599]
Slope Change	-0.036***
	(0.008)
	[-0.051,-0.021]
Post-Period Slope	-0.003*
	(0.002)
	[-0.006,0.000]
Pre-Period Mean	1.22
Pre-Period Min	0.76
Pre-Period Max	1.46
Post-Period Mean	1.80
Post-Period Min	1.36
Post-Period Max	2.39
Observations	102

Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets.
**p<0.10, **p<0.05, ***p<0.01*

Monitoring Metric: #27, Drug overdose deaths (rate)
Description: Number of overdose deaths during the measurement period among Medicaid beneficiaries living in a geographic area covered by the demonstration per 1,000 Medicaid beneficiaries.
Primary Driver: Reduce opioid-related overdose deaths.



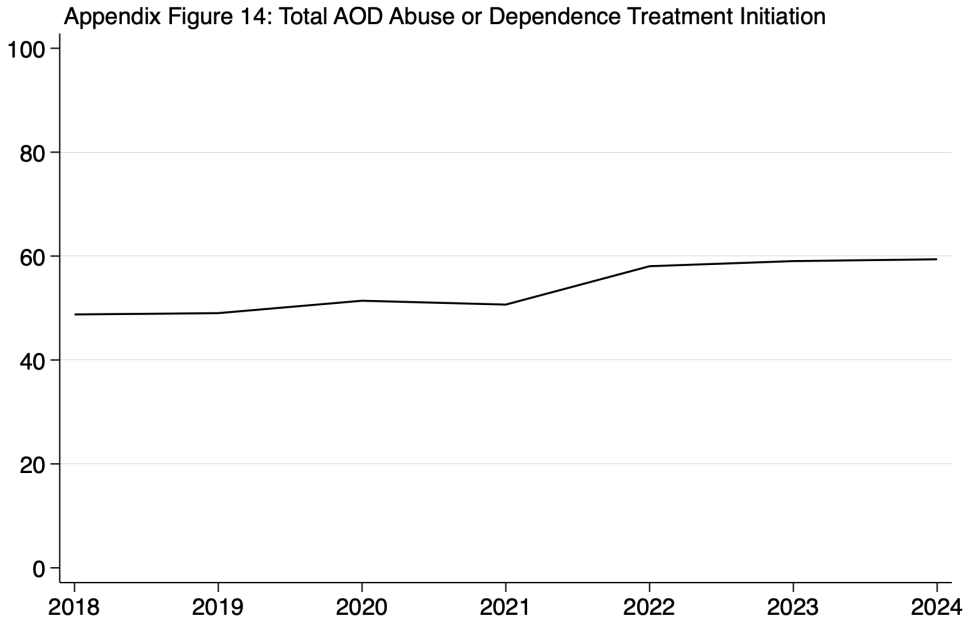
Notes: The numerator is the number of overdose deaths during the measurement period among Medicaid beneficiaries living in a geographic area covered by the demonstration. The denominator is the number of unduplicated Medicaid beneficiaries eligible for the demonstration. Intervention date was assigned to the first quarter of the demonstration period.

Appendix Table 13: Number of Overdose Deaths per 1,000 SUD Beneficiaries

	b/se/ci95
Pre-Period Slope	0.001**
	(0.000)
	[0.000,0.002]
Level Change	0.004
	(0.008)
	[-0.011,0.020]
Slope Change	-0.001
	(0.001)
	[-0.002,0.000]
Post-Period Slope	0.000*
	(0.000)
	[-0.000,0.001]
Pre-Period Mean	0.03
Pre-Period Min	0.02
Pre-Period Max	0.05
Post-Period Mean	0.05
Post-Period Min	0.03
Post-Period Max	0.09
Observations	96

Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets.
**p<0.10, **p<0.05, ***p<0.01*

Monitoring Metric: #15, Total AOD Abuse or Dependence Treatment Initiation
Description: Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis – total AOD abuse or dependence diagnosis cohort.



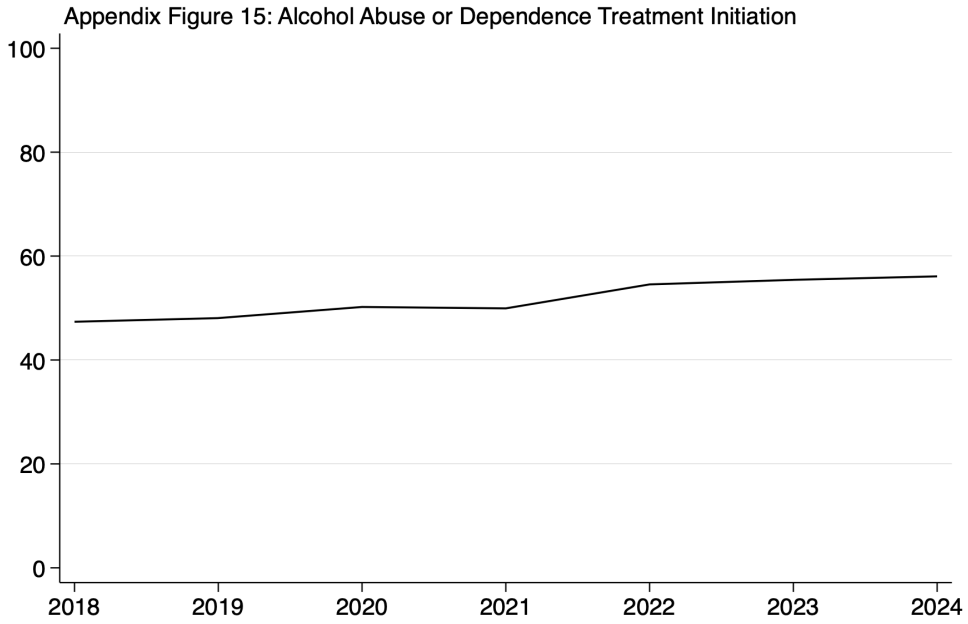
Notes: Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis – total AOD abuse or dependence cohort.

Appendix Table 14: Total AOD Abuse or Dependence Treatment Initiation

	b/se/ci95
Post-Period Slope	2.090***
	(0.359)
	[1.168,3.013]
Pre-Period Max	
Post-Period Mean	53.76
Post-Period Min	48.77
Post-Period Max	59.39
Observations	7

Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets.
**p<0.10, **p<0.05, ***p<0.01*

Monitoring Metric: #15, Alcohol Abuse and Dependence Treatment Initiation
Description: Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis – alcohol abuse or dependence diagnosis cohort.



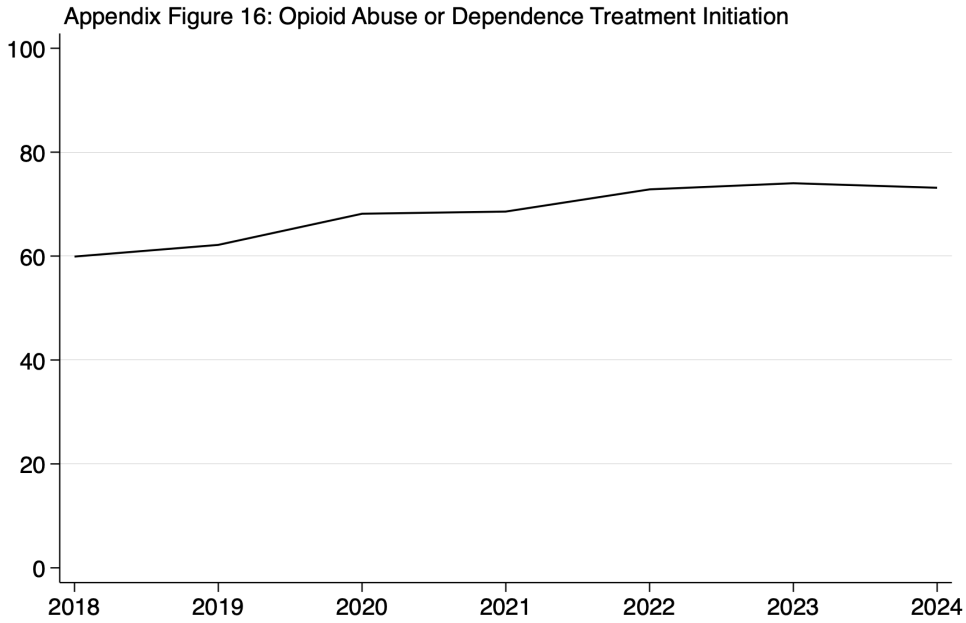
Notes: Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis – alcohol abuse or dependence cohort.

Appendix Table 15: Alcohol Abuse or Dependence Treatment Initiation

	b/se/ci95
Post-Period Slope	1.617***
	(0.198)
	[1.107,2.127]
Pre-Period Max	
Post-Period Mean	51.67
Post-Period Min	47.36
Post-Period Max	56.10
Observations	7

Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets.
**p<0.10, **p<0.05, ***p<0.01*

Monitoring Metric: #15, Opioid Abuse and Dependence Treatment Initiation
Description: Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis – opioid abuse or dependence diagnosis cohort.



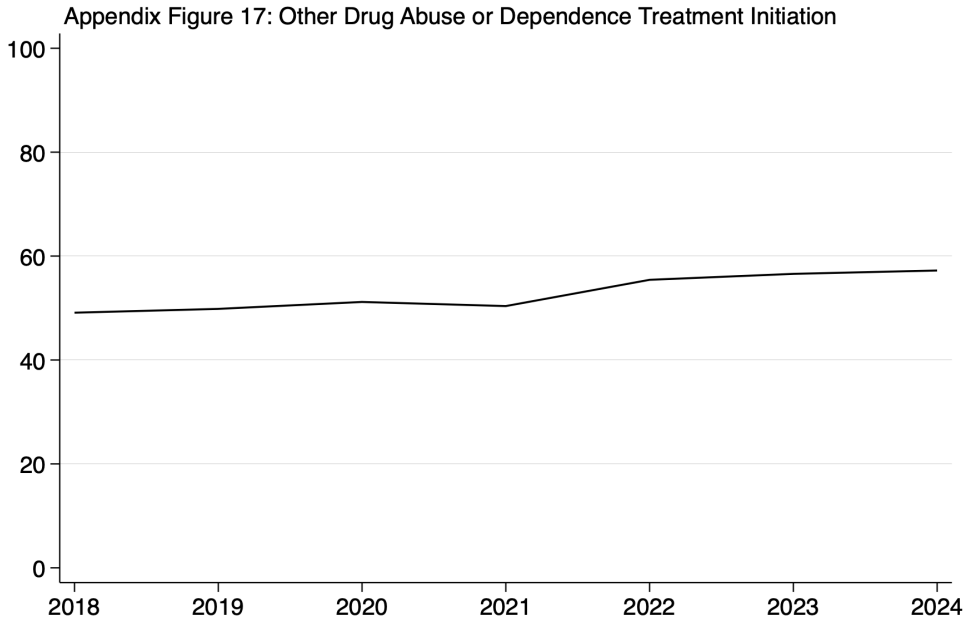
Notes: Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis – opioid abuse or dependence cohort.

Appendix Table 16: Opioid Abuse or Dependence Treatment Initiation

	b/se/ci95
Post-Period Slope	2.434***
	(0.371)
	[1.480,3.388]
Pre-Period Max	
Post-Period Mean	68.40
Post-Period Min	59.91
Post-Period Max	74.03
Observations	7

Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets.
**p<0.10, **p<0.05, ***p<0.01*

Monitoring Metric: #15, Other Drug Abuse and Dependence Treatment Initiation
Description: Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis – other drug abuse or dependence diagnosis cohort.



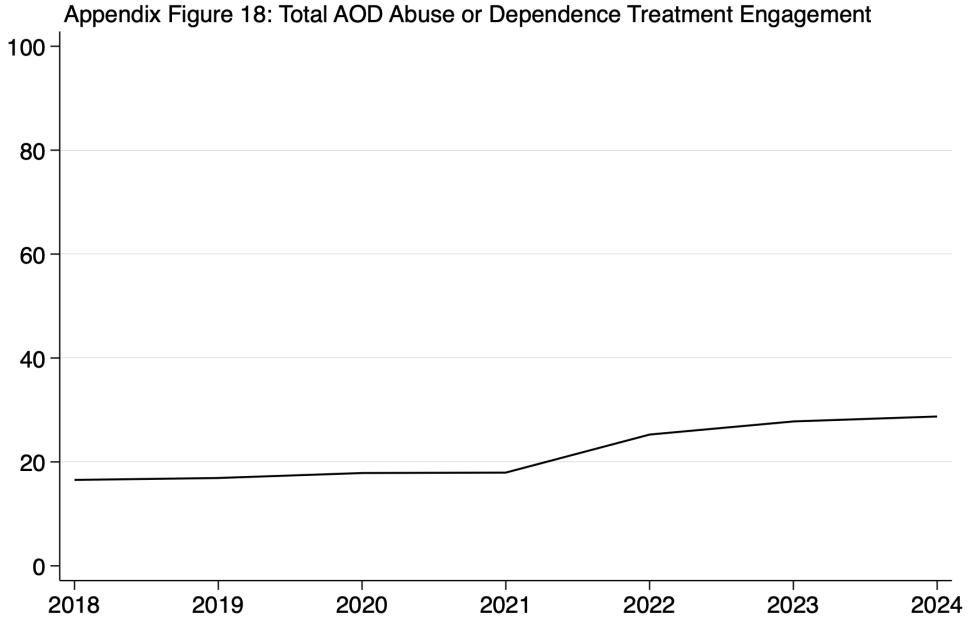
Notes: Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis – other drug abuse or dependence cohort

Appendix Table 17: Other Drug Abuse or Dependence Treatment Initiation

	b/se/ci95
Post-Period Slope	1.504***
	(0.245)
	[0.874,2.135]
Pre-Period Max	
Post-Period Mean	52.82
Post-Period Min	49.11
Post-Period Max	57.23
Observations	7

Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets.
**p<0.10, **p<0.05, ***p<0.01*

Monitoring Metric: #15, Total AOD Abuse and Dependence Treatment Engagement
Description: Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of diagnosis and who were engaged in ongoing AOD treatment within 34 days of the initiation visit – other drug abuse or dependence diagnosis cohort.



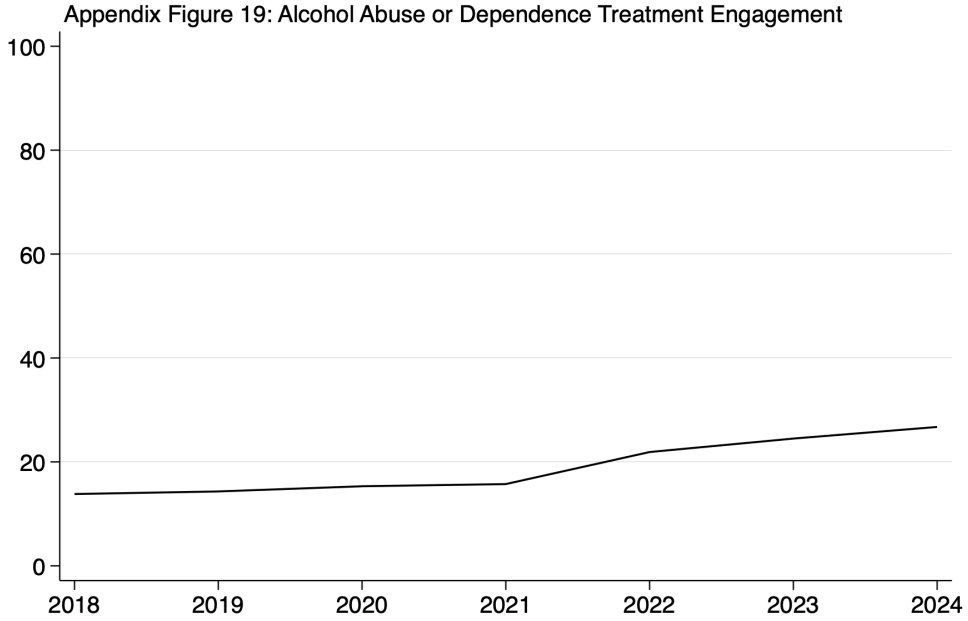
Notes: Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis and who were engaged in ongoing AOD treatment within 34 days of the initiation visit – other drug abuse or dependence cohort

Appendix Table 18: Total AOD Abuse or Dependence Treatment Engagement

	b/se/ci95
Post-Period Slope	2.350***
	(0.407)
	[1.303,3.397]
Pre-Period Max	
Post-Period Mean	21.58
Post-Period Min	16.54
Post-Period Max	28.75
Observations	7

Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets.
**p<0.10, **p<0.05, ***p<0.01*

Monitoring Metric: #15, Alcohol Abuse and Dependence Treatment Engagement
Description: Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of diagnosis and who were engaged in ongoing AOD treatment within 34 days of the initiation visit – alcohol abuse or dependence diagnosis cohort.



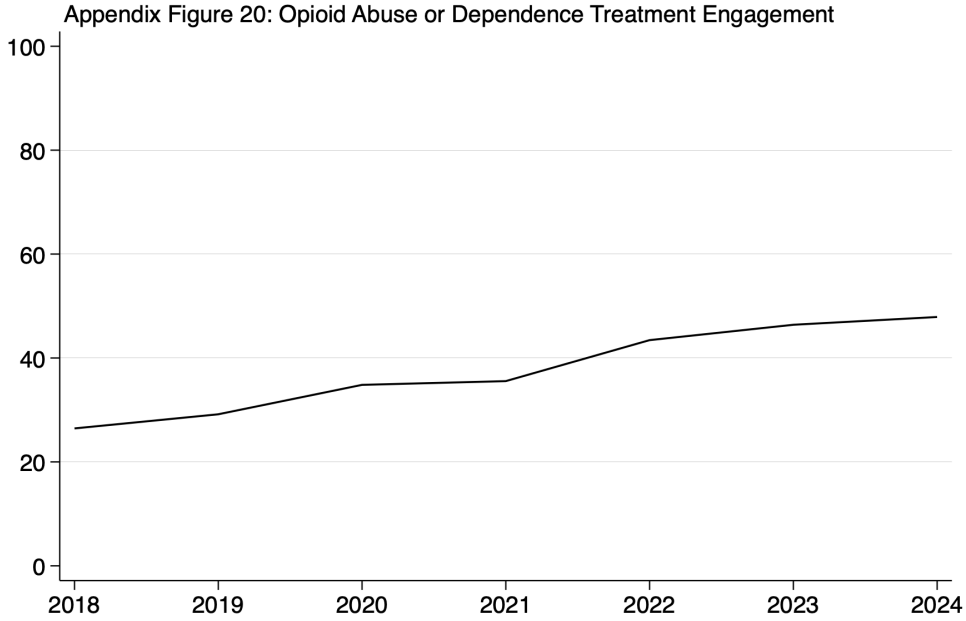
Notes: Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis and who were engaged in ongoing AOD treatment within 34 days of the initiation visit – alcohol abuse or dependence cohort

Appendix Table 19: Alcohol Abuse or Dependence Treatment Engagement

	b/se/ci95
Post-Period Slope	2.345***
	(0.351)
	[1.442,3.247]
Pre-Period Max	
Post-Period Mean	18.91
Post-Period Min	13.82
Post-Period Max	26.73
Observations	7

Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets.
**p<0.10, **p<0.05, ***p<0.01*

Monitoring Metric: #15, Opioid Abuse and Dependence Treatment Engagement
Description: Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of diagnosis and who were engaged in ongoing AOD treatment within 34 days of the initiation visit – opioid abuse or dependence diagnosis cohort.



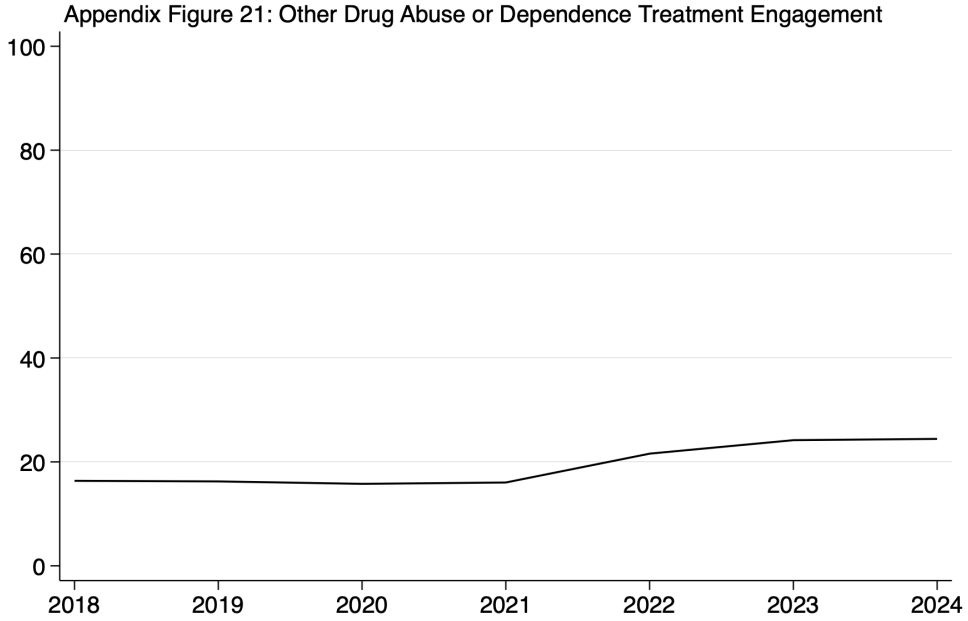
Notes: Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis and who were engaged in ongoing AOD treatment within 34 days of the initiation visit – opioid abuse or dependence cohort

Appendix Table 20: Opioid Abuse or Dependence Treatment Engagement

	b/se/ci95
Post-Period Slope	3.835***
	(0.302)
	[3.060,4.611]
Pre-Period Max	
Post-Period Mean	37.68
Post-Period Min	26.45
Post-Period Max	47.90
Observations	7

Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets.
**p<0.10, **p<0.05, ***p<0.01*

Monitoring Metric: #15, Other Drug Abuse and Dependence Treatment Engagement
Description: Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of diagnosis and who were engaged in ongoing AOD treatment within 34 days of the initiation visit – other drug abuse or dependence diagnosis cohort.



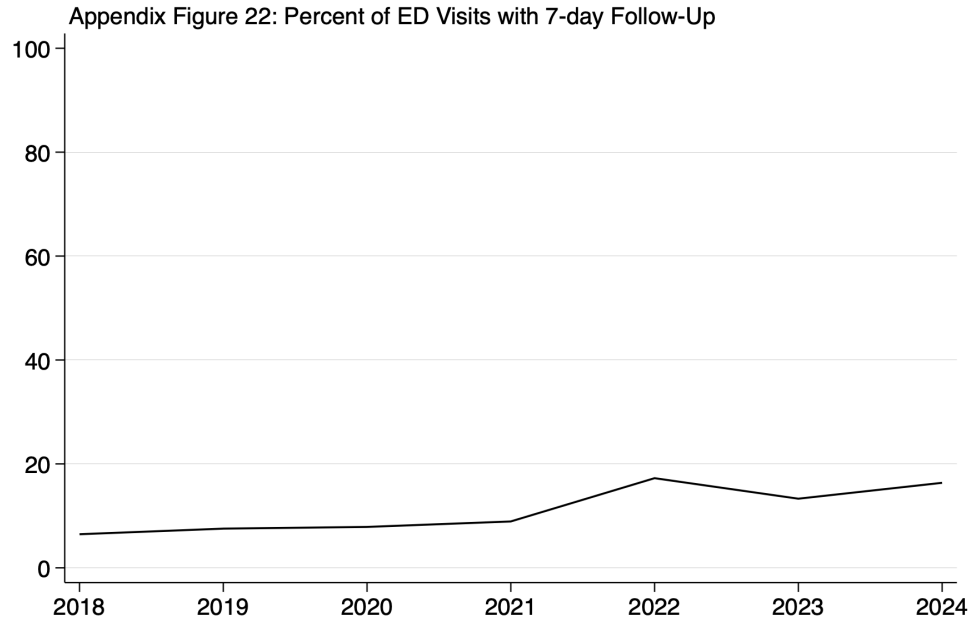
Notes: Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis and who were engaged in ongoing AOD treatment within 34 days of the initiation visit – other drug abuse or dependence cohort

Appendix Table 21: Other Drug Abuse or Dependence Treatment Engagement

	b/se/ci95
Post-Period Slope	1.640***
	(0.389)
	[0.641,2.639]
Pre-Period Max	
Post-Period Mean	19.24
Post-Period Min	15.78
Post-Period Max	24.44
Observations	7

Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets.
**p<0.10, **p<0.05, ***p<0.01*

Monitoring Metric: #17(1), Follow-up after Emergency Department Visit for Substance Use.
Description: Percentage of ED visits for beneficiaries age 18 and older with a principal diagnosis of AOD abuse or dependence who had a follow-up visit for AOD abuse or dependence within 7 days of the ED visit (8 total days).



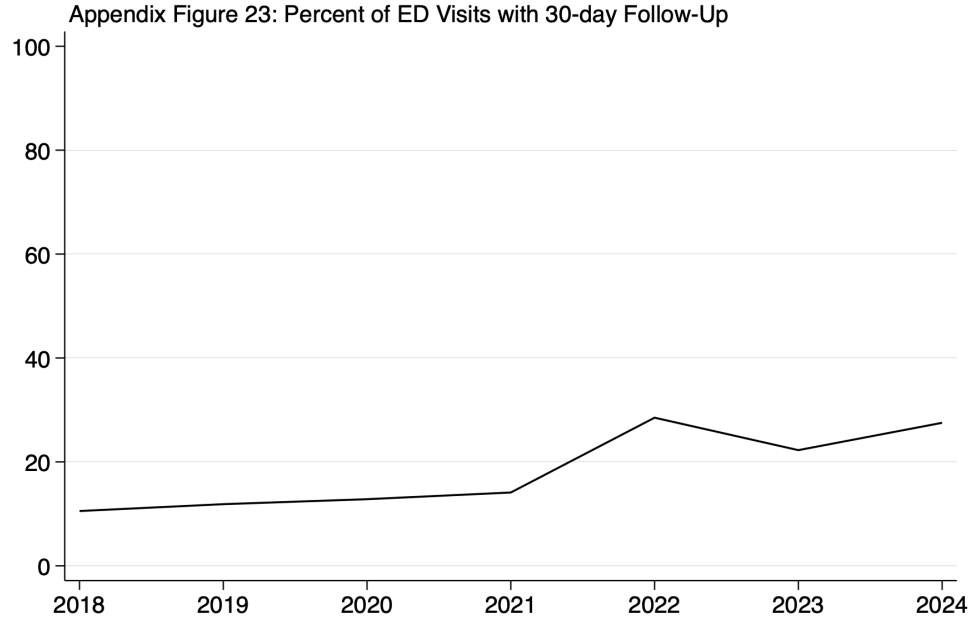
Notes: Percentage of ED visits for beneficiaries age 18 and older with a principal diagnosis of AOD abuse or dependence who had a follow-up visit for AOD abuse or dependence within 7 days of the ED visit (8 total days).

Appendix Table 22: Percent of ED Visits with 7-day Follow-Up

	b/se/ci95
Post-Period Slope	1.807**
	(0.449)
	[0.652,2.962]
Pre-Period Max	
Post-Period Mean	11.11
Post-Period Min	6.47
Post-Period Max	17.26
Observations	7

Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets.
**p<0.10, **p<0.05, ***p<0.01*

Monitoring Metric: #17(1), Follow-up after Emergency Department Visit for Substance Use.
Description: Percentage of ED visits for beneficiaries age 18 and older with a principal diagnosis of AOD abuse or dependence who had a follow-up visit for AOD abuse or dependence within 30 days of the ED visit (31 total days).



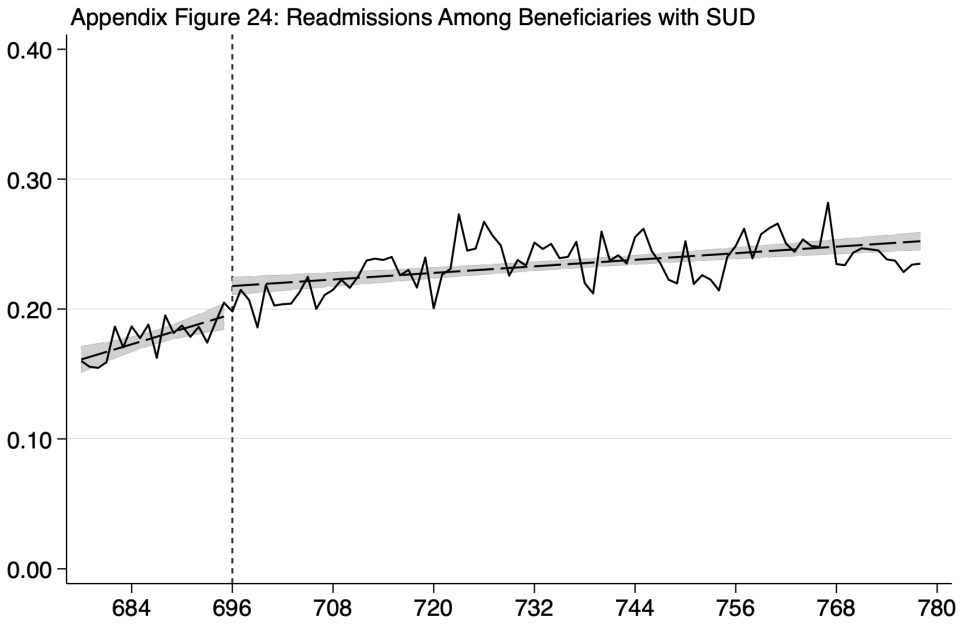
Notes: Percentage of ED visits for beneficiaries age 18 and older with a principal diagnosis of AOD abuse or dependence who had a follow-up visit for AOD abuse or dependence within 30 days of the ED visit (31 total days).

Appendix Table 23: Percent of ED Visits with 30-day Follow-Up

	b/se/ci95
Post-Period Slope	3.122***
	(0.761)
	[1.165,5.080]
Pre-Period Max	
Post-Period Mean	18.24
Post-Period Min	10.55
Post-Period Max	28.51
Observations	7

Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets.
**p<0.10, **p<0.05, ***p<0.01*

Monitoring Metric: #25, Readmissions among beneficiaries with SUD.
Description: Percent of all-cause 30-day readmissions during the measurement period among beneficiaries with SUD.



Notes: The numerator is the count of all-cause 30-day readmissions during the measurement period among beneficiaries with SUD. The denominator is the count of index hospital stays among all beneficiaries with full benefits enrolled in Medicaid for at least one month (30 consecutive days) during the measurement period. Intervention date was assigned to the first quarter of the demonstration period.

Appendix Table 24: Readmissions Among Beneficiaries with SUD

	b/se/ci95
Pre-Period Slope	*0.002***
	(0.000)
	[0.001,0.003]
Level Change	*0.023***
	(0.007)
	[0.010,0.037]
Slope Change	*-0.002***
	(0.000)
	[-0.002,-0.001]
Post-Period Slope	*0.000***
	(0.000)
	[0.000,0.001]
Pre-Period Mean	*0.18*
Pre-Period Min	*0*
Pre-Period Max	*0*
Post-Period Mean	*0.24*
Post-Period Min	*0*
Post-Period Max	*0*
Observations	*114*

Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets.
**p<0.10, **p<0.05, ***p<0.01*