Office of the Governor
State of Louisiana

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December 20, 2021

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Washington, D.C. 20201

Dear Secretary Becerra:

The State of Louisiana, through the Louisiana Department of Health (LDH), is pleased to submit the enclosed application to extend the Healthy Louisiana Substance Use Disorder (SUD) 1115 Demonstration (Project Number 11W00311/6) which is scheduled to end on December 31, 2022. With this extension application, Louisiana is requesting approval for a new, five-year demonstration period beginning on January 1, 2023 and ending December 31, 2027.

This demonstration authorizes expenditure authority for otherwise eligible individuals who are short-term residents in facilities that meet the definition of an institution for mental disease to receive treatment and withdrawal management services for SUD. The goal of this demonstration is for Louisiana to maintain critical access to opioid use disorder (OUD) and other SUD services and continue delivery system improvements for these services to provide more coordinated and comprehensive OUD/SUD treatment for Medicaid beneficiaries. Over the course of the initial demonstration period, Louisiana was able to deliver high quality, clinically appropriate treatment services for opioids and other substances. No changes are proposed in this extension request to the provisions currently approved. Louisiana seeks to achieve the following:

- Increase enrollee access to and utilization of appropriate OUD/SUD treatment services based on the ASAM Criteria;
- Decrease use of medically inappropriate and avoidable high-cost emergency department and hospital services by enrollees with OUD/SUD;
- Increase initiation of follow-up after discharge from emergency department for alcohol or other drug dependence; and
- Reduce readmission rates for OUD/SUD treatment.

Louisiana looks forward to its continued collaboration with the Centers for Medicare & Medicaid Services so that we may continue to offer these critical OUD/SUD treatment and

withdrawal services. Should you have any questions or concerns during your review of the State's application, please contact Louisiana Medicaid Executive Director Patrick Gillies at Patrick.Gillies@la.gov.

Sincerely,

[redacted]

John Bel Edwards
Governor

Healthy Louisiana Substance Use Disorder 1115 Demonstration Waiver

Renewal Application

Prepared by:

Bureau of Health Services Financing (BHSF)

Office of Behavioral Health (OBH)

May 16, 2022

LOUISIANA DEPARTMENT OF HEALTH

Contents

Introduction

The Louisiana Department of Health (LDH) Bureau of Health Services Financing (BHSF) and Office of Behavioral Health (OBH) is requesting a five-year renewal of the Healthy Louisiana Opioid Use Disorder/Substance Use Disorder 1115(a) Demonstration Waiver. The current 1115 waiver was approved for the period of February 1, 2018, through December 31, 2022. With this application, Louisiana is seeking to renew the waiver for the period of January 1, 2023, through December 31, 2027.

The Healthy Louisiana SUD 1115 waiver currently authorizes the state to provide for expenditures for otherwise covered substance use disorder (SUD) treatment and withdrawal management services furnished to eligible individuals who are short-term residents in facilities that meet the definition of an institution for mental disease (IMD). This 1115 renewal application seeks authority to continue to operate as approved with no changes.

Section 1 – Overview of the Louisiana Medicaid Health Delivery System

The mission of the Louisiana Department of Health (LDH) is to develop and provide health and medical services for the prevention of disease for the citizens of Louisiana, particularly those individuals who are indigent and uninsured, persons with mental illness, persons with developmental disabilities and those with addictive disorders. The Bureau of Health Services Financing (BHSF) is the single state Medicaid agency responsible for administering the Medicaid program including eligibility, program operations, financial management and policy implementation and support, and the Office of Behavioral Health (OBH) manages and delivers the services and supports necessary to improve the quality of life for citizens with mental illness and addictive disorders.

Subsection 1.1 – Medicaid Managed Care Program

In February 2012, Louisiana Medicaid initiated its transition from the legacy Fee-for-Service (FFS) program to a managed health care delivery system. The Louisiana Medicaid Managed Care Program is a full risk-bearing health care delivery system designed to provide high quality healthcare services statewide to enrollees in the Louisiana Medicaid Managed Care Program, known as Healthy Louisiana. Specialized behavioral health services were integrated into Healthy Louisiana in 2015.

Most Medicaid enrollees receive their healthcare through the managed care delivery model. The managed care programs use a Per-Member-Per-Month (PMPM) payment model, in which Louisiana Medicaid pays the managed care entities (MCEs) a monthly fee to manage the health needs of the Medicaid population. Managed care providers are paid by the MCEs rather than being paid directly by Louisiana Medicaid. All Medicaid recipients of specialized behavioral health services are enrolled with a managed care entity.

Current federal authority for the Louisiana Medicaid Managed Care Program is contained primarily in Section 1932(a) and Section 1915(b) of the Social Security Act and 42 C.F.R. Part 438. The Louisiana Medicaid Managed Care Program is operated under the authority of a Section 1932(a) State Plan Amendment and a Section 1915(b) waiver. The Louisiana Medicaid Managed Care Program is also impacted by the Section 1115 waiver for substance use disorder services.

Subsection 1.2 - Eligibility

Medicaid provides funding for health care to individuals and families who meet the eligibility criteria established by the state and approved by the Centers for Medicare and Medicaid Services (CMS). All individuals who receive Supplemental Security Income (SSI) are automatically enrolled in Medicaid. In addition, families who receive financial assistance through Louisiana's Temporary Aid to Needy Families (TANF) program, also known as Family Independence Temporary Assistance Program (FITAP), are automatically enrolled in Medicaid.

Individuals who are not automatically eligible may qualify for Medicaid coverage if they meet one of the following:

- Are disabled according to the Social Security Administration's definition;
- Have corrected vision no better than 20/200;
- Are a low-income parent of children under age 19;
- Are a child under age 19;
- Are pregnant;
- Have no insurance and need treatment for breast and/or cervical cancer;

- Receive Medicare coverage and are low-income; or
- Are aged 19 to 64 years old, have a household income less than 138% of the federal poverty level, doesn't already qualify for Medicaid or Medicare, and meet citizenship requirement.

Medicaid eligibility is also based upon the family size and relation of monthly income to the Federal Poverty Level income guidelines. For detailed information, the Medicaid Eligibility Manual is available online at http://ldh.la.gov/index.cfm/page/1681.

Subsection 1.3 – Benefits Coverage

The Healthy Louisiana managed care organizations (MCOs) shall provide core benefits and services to Medicaid members. This includes the following list of specialized behavioral health services and practitioners:

- Psychiatrist (all ages)
- Licensed Mental Health Professionals (LMHP)
    - Medical Psychologists
    - Licensed Psychologists
    - Licensed Clinical Social Workers (LCSW)
    - Licensed Professional Counselors (LPC)
    - Licensed Marriage and Family therapists (LMFT)
    - Licensed Addiction Counselors (LAC)
    - Advanced Practice Registered Nurses (must be a nurse practitioner specialist in Adult Psychiatric & mental Health, Family Psychiatric & Mental health, or a Certified Nurse Specialist in Psychosocial, Gerontological Psychiatric Mental Health, Adult Psychiatric & Mental Health, Child Adolescent Mental Health)
- Mental Health Rehabilitation Services
    - Community Psychiatric Support and Treatment (CPST)
    - Community Psychiatric Support and Treatment (CPST), specialized for high-risk populations. This includes:
        - Multi-Systemic Therapy (MST) (under age 21)
        - Functional Family Therapy (FFT) (under age 21)
        - Homebuilders (under age 21)
        - Assertive Community Treatment (limited to 18 years and older)
    - Psychosocial Rehabilitation (PSR)
    - Crisis Intervention
    - Therapeutic Group Homes (under age 21): Therapeutic Group Homes have a non-Medicaid funded room and board component that must be addressed prior to placement.
    - Crisis Stabilization (under age 21)
- Peer Support Services (ages 21 and older), effective February 1, 2021
- Psychiatric Residential Treatment Facilities (under age 21)
- Inpatient hospitalization (age 21 and under; 65 and older) for Behavioral Health Services
- Outpatient and Residential Substance Use Disorder Services in accordance with the American Society of Addiction Medicine (ASAM) levels of care
- Medication-Assisted Treatment (MAT), including Methadone treatment in Opioid Treatment Programs (OTPs)

- Screening for services, including the Coordinated System of Care, may take place while the youth resides in a home and community-based setting and is at risk for hospital levels of care.

Subsection 1.4 – Cost Sharing

Pharmacy copay (cost sharing) is applied uniformly to all pharmacy claims, including mental health or substance use disorder pharmacy claims.

The following pharmacy services are exempt from the copayment requirements:

- Services furnished to pregnant women;
- Emergency services;
- Family planning services; and
- Preventive medications as designated by the US Preventive Services Task Force A and B Recommendations.

The following populations are exempt from copayment requirements:

- Individuals under 21 years of age;
- Individuals living in a long term care facility;
- Individuals receiving hospice care;
- Native Americans;
- Alaskan Eskimos;
- Home and Community Based Waiver recipients; and
- Women whose basis of Medicaid eligibility is breast or cervical cancer.

Cost sharing incurred by all individuals in the Medicaid household shall not exceed an aggregate limit of five (5) percent of the monthly household income.

Section 2 – Healthy Louisiana Opioid Use Disorder/Substance Use Disorder 1115(a) Demonstration

Louisiana received approval of the Healthy Louisiana OUD/SUD 1115 demonstration waiver on February 1, 2018. This waiver opportunity allowed Louisiana to make important changes to the state's SUD system to meet six important milestones, which were described in the approved Implementation Plan Protocol. Louisiana completed the action items from the approved Implementation Plan Protocol within the indicated timelines to fulfill the following milestones requirements:

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 MAT;
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and
6. Improved care coordination and transitions between levels of care.

Louisiana administers its SUD services based on the American Society of Addiction Medicine (ASAM) Patient Placement Criteria. Louisiana continues to offer the full continuum of residential and outpatient

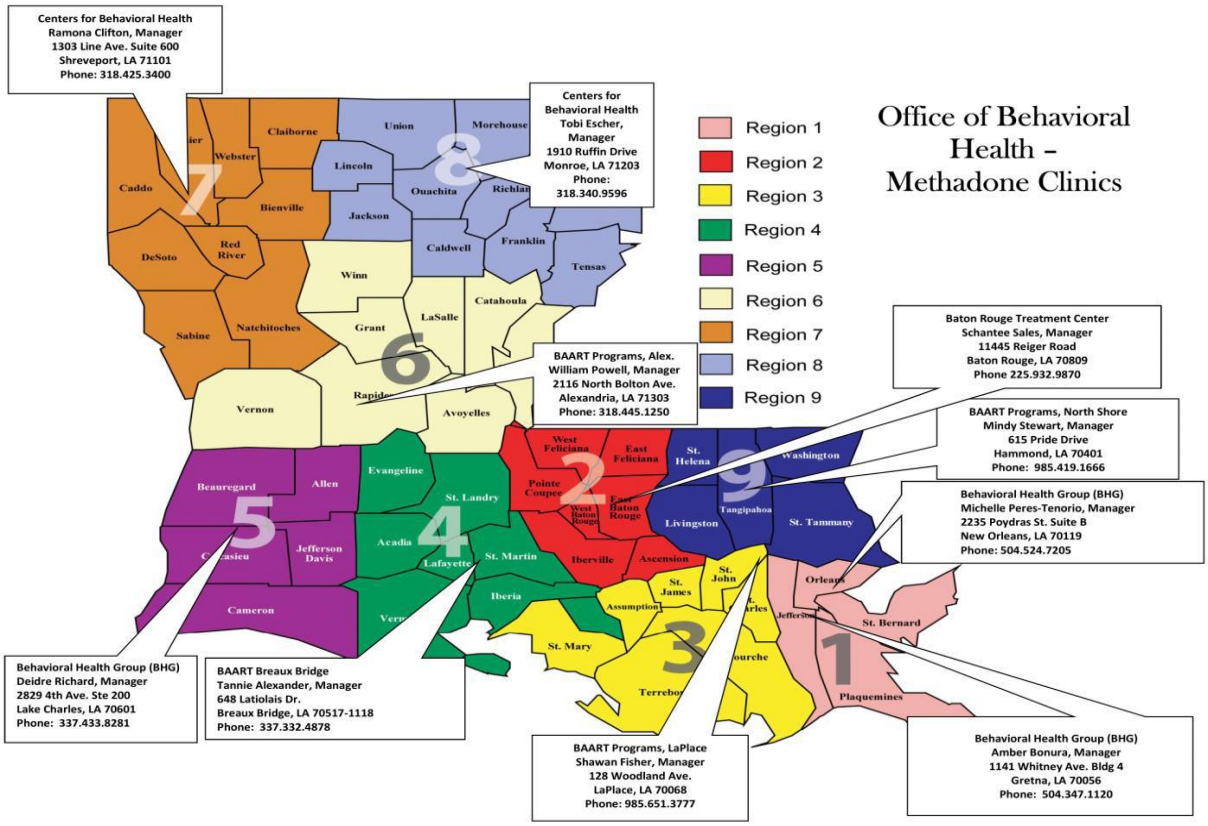
care services set forth by the American Society of Addiction Medicine (ASAM) as included in the Medicaid benefits service array. Two key accomplishments that were realized through the activities of the 1115 waiver were the inclusion of Methadone as a Medicaid covered benefit and the MAT referral requirement on residential providers.

Subsection 2.1 – Methadone and Opioid Treatment Programs (OTPs)

When the 1115 waiver was approved in 2018, Louisiana covered Methadone for the treatment of chronic pain conditions, but not for opioid dependence. Effective January 20, 2020, Methadone was added in the State Plan as an authorized medication for OUD treatment provided by the Opioid Treatment Programs (OTPs). A provider subspecialty code 8V was established for the OTP clinics as sole source providers. Using other states as a model, a bundled rate was developed to reimburse for OTP services. Bundled rates for the OTPs facilitate the practical needs of patient-centered treatment in the administration of MAT to integrate the provision of counseling and medical services. This rate is inclusive of the behavioral health treatment components, physical examinations and laboratory services, and ancillary services offered by the OTPs. Prior to Medicaid coverage, this was a self-pay cash business (or OBH grant funded) for every client.

Louisiana's landscape consists of 10 existing OTPs with one in each region of the state. Each facility is privately owned and operated serving approximately 3,000 – 4,000 patients per month during the last six (6) years.

Image 1: Methadone Clinics in Louisiana



Subsection 2.2 – Medication-Assisted Treatment (MAT)

Milestone 3, which provided for the use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications, included the specification that residential treatment facilities offer Medication-Assisted Treatment (MAT) on-site or facilitate access off-site. Louisiana promulgated rules on April 20, 2019, to provide for this mandate on residential facilities. The following language was included in the Medicaid Behavioral Health Provider Manual:

> "SUD providers, when clinically appropriate, shall:
>
> - Educate members on the proven effectiveness, benefits and risks of Food and Drug Administration approved MAT options for their SUD;
> - Provide on-site MAT or refer to MAT offsite; and
> - Document member education, access to MAT and member response in the progress notes.
>
> Residential SUD providers shall provide MAT onsite or facilitate access to MAT offsite which includes coordinating with the member's health plan for referring to available MAT provider and arranging Medicaid non-emergency medical transportation if other transportation is not available for the patient."

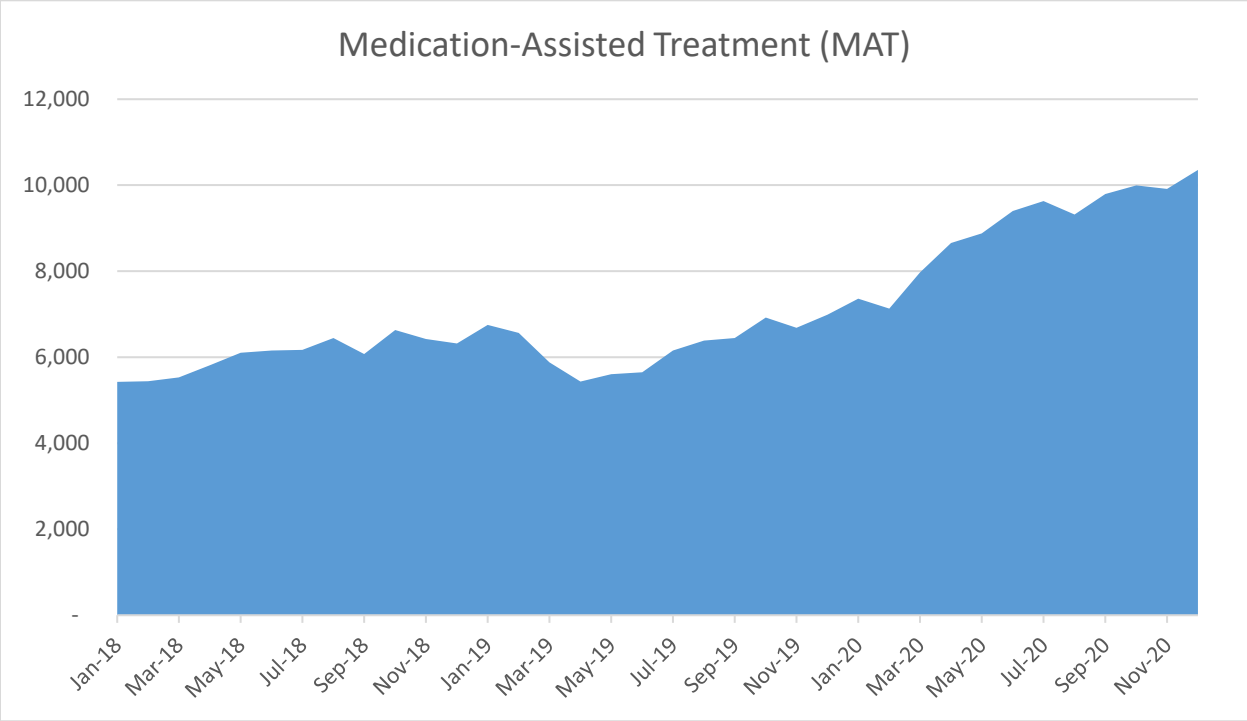
The state has taken measures to increase access to MAT by incorporating language into all behavioral health provider contracts and agreements, whereas providers must provide MAT onsite or initiate a referral to such services, when indicated. This method will ensure that providers move from abstinence based models of care to a no wrong door approach for persons on MAT. The Office of Behavioral Health (OBH) continues to implement workforce development initiatives to provide training and education on MAT to physicians and clinicians statewide.

Particularly, Louisiana has implemented the Extension for Community Health Outcomes (ECHO) Project, which a virtual online professional development series for educators, University Fellow Programs, physicians, clinicians, BH providers and private practitioners. OBH has also partnered with the Office of Public Health to participate in Symposiums across the state to educate stakeholders and the community on the efficacy of MAT and associated stigma.

In tandem with the 1115 waiver, OBH has worked to expand access to MAT via multiple grant awards, targeting expansion of evidence based treatment for persons with opioid use disorder (OUD). The state is implementing a Hub and Spoke model. This model is utilizing Louisiana's current ten opioid treatment programs (OTPs) as the "Hub" and mobilizing Drug Addiction Treatment Act (DATA) Waived Physicians as the "Spokes."

The chart below shows the number of beneficiaries who have a claim for MAT for SUD during a month measurement period, from January 2018 through December 2020. Data was pulled in accordance with CMS-constructed technical specifications.

Chart 1: Medication Assisted Treatment (MAT) for SUD



Section 3 – Renewal Request

The state is requesting a five-year renewal of the Healthy Louisiana Opioid Use Disorder/Substance Use Disorder 1115(a) Demonstration Waiver for the period of January 1, 2023, through December 31, 2027.

The Healthy Louisiana SUD 1115 waiver currently authorizes the state to provide for expenditures for otherwise covered substance use disorder (SUD) treatment and withdrawal management services furnished to eligible individuals who are short-term residents in facilities that meet the definition of an institution for mental disease (IMD). This 1115 renewal application seeks to extend the expenditure authority to continue to operate as approved with no changes.

Section 4 – Goals, Objectives, and Evaluation

The goal of this demonstration is for Louisiana to maintain critical access to opioid use disorder (OUD) and other substance use disorder (SUD) services and continue delivery system improvements for these services to provide more coordinated and comprehensive OUD/SUD treatment for Medicaid beneficiaries. This demonstration will provide the state with authority to provide high-quality, clinically appropriate SUD treatment services for short-term residents in residential and inpatient treatment settings that qualify as an Institution for Mental Diseases (IMD). It will also build on the state's existing efforts to improve models of care focused on supporting individuals in the community and home, outside of institutions and strengthen a continuum of SUD services based on the American Society of Addiction Medicine (ASAM) criteria or other comparable nationally recognized assessment and placement tools that reflect evidence-based clinical treatment guidelines.

During the demonstration period, Louisiana seeks to achieve the following:

- Increase enrollee access to and utilization of appropriate OUD/SUD treatment services based on the ASAM Criteria;
- Decreased use of medically inappropriate and avoidable high-cost emergency department and hospital services by enrollees with OUD/SUD;
- Increased initiation of follow-up after discharge from emergency department for alcohol or other drug dependence; and
- Reduced readmission rates for OUD/SUD treatment.

Subsection 4.1 – Demonstration Goals and Hypotheses

LDH contracted with Tulane University Department of Health Policy and Management as an independent evaluator for purposes of drafting an evaluation design and conducting analyses of the 1115 demonstration waiver. CMS approved Louisiana's evaluation design in July 2019.

The following goals and hypotheses are proposed for the extension period and are unchanged from the initial demonstration approval.

Table 1: LA Healthy LA 1115 SUD Goals and Hypotheses

Goal	Hypothesis	Example Measure	Data Source
Increase access to evidence-based OUD/SUD care	The demonstration will increase the share of beneficiaries who are treated for OUD/SUD in ways that are consistent with evidence-based care	Share of beneficiaries with an OUD/SUD treated in an IMD	Louisiana Medicaid Claims Data
Increase access to and utilization of medication-assisted treatment (MAT) for OUD/Alcohol Use Disorder (AUD)	The demonstration will increase the use of MAT	Share of those with an OUD/AUD diagnosis who are treated using MAT	Louisiana Medicaid Claims Data; Key informant interviews
Ensure efficient provider capacity at each level of care for OUD/SUD	The demonstration will improve provider capacity	Total number of SUD providers	Louisiana Medicaid Claims Data
Decrease use of medically inappropriate care and reduce reliance on emergency department and hospital services for OUD/SUD treatment	The demonstration will reduce visits to the emergency department and the use of hospital services for the treatment of OUD/SUD	Emergency department visits for OUD/SUD	Louisiana Medicaid Claims Data
Reduce readmission rates for OUD/SUD treatment	The demonstration will reduce hospital readmission rates for OUD/SUD	Readmissions for OUD/SUD	Louisiana Medicaid Claims Data
Increase use of evidence-based OUD/SUD patient placement criteria	The demonstration will increase the use of evidence-based OUD/SUD patient placement criteria	Appropriate placement for OUD/SUD treatment	MCO Monitoring Reports
Increase initiation of follow-up after discharge from the emergency department or hospital for OUD/SUD	The demonstration will increase initiation of follow-up after discharge from the	Follow-up after discharge from the ED for OUD/SUD	Louisiana Medicaid Claims Data

	emergency department or hospital for OUD/SUD		
Increase adherence to and retention in treatment	The demonstration will increase adherence to and retention in treatment	Share of those with an OUD/SUD diagnosis who receive follow-up treatment within 35-60 and 61-90 days after initial episode of care	Louisiana Medicaid Claims Data
Reduce instances of drug overdose and overdose deaths	The demonstration will decrease the rate of drug overdose and the number of drug deaths	Number of non-fatal drug overdoses	Louisiana Medicaid Claims Data and Louisiana Office of Public Health Vital Records

Subsection 4.2 – Interim Evaluation Report

Tulane University Department of Health Policy and Management conducted an Interim Evaluation of the 1115 demonstration waiver in accordance with the CMS-approved evaluation design. The evaluation design used a complex methodological approach which varied for each specific goal and hypothesis.

Tulane concluded that that the "ability to continue OUD/SUD treatment in IMDs in Louisiana, through this Demonstration, appears to have resulted in small but important ways that are consistent with evidence-based care." However, the Covid-19 pandemic began in March 2020, and the full impact of the pandemic on the various evaluation measures is unknown. A summary of Tulane's results and findings is provided below, and the full Interim Evaluation Report is included as Appendix 1.

Goal 1.1: Increase access to evidence-based OUD/SUD care.

The number of beneficiaries receiving outpatient and withdrawal management services has not changed, but the number receiving intensive outpatient and partial hospitalization was increasing prior to the demonstration and is still increasing but at a slower rate. The number of beneficiaries receiving residential and inpatient services increased sharply at the start of the waiver but then shows a steady decrease (see Figure 2 in Appendix 1). There is also a sharp decline in the beginning of 2020, which could be caused by the COVID-19 pandemic. Unfortunately, we do not have the data to verify if this is the cause.

Goal 1.2: Increase access to and utilization of medication-assisted treatment (MAT) for OUD/Alcohol Use Disorder (AUD).

The number of beneficiaries with a claim for MAT has been increasing steadily both before and after the intervention, but the rate of increase is greater after the intervention than before. However, we also examined the share of beneficiaries with a claim for MAT and found that it is increasing at a faster rate after the intervention (see Figure 3 in Appendix 1). The number of providers who were enrolled in Medicaid and qualified to deliver SUD services has been steadily increasing at the same rate before and after. Overall, we conclude the demonstration is increasing the use of MAT.

Goal 1.3: Ensure sufficient provider capacity at each level of care for OUD/SUD.

The number of providers has been slowly increasing before and after implementation and the ITS analysis indicates that rate of increase has slowed slightly post implementation (slope change -0.393, $p < 0.05$). We conclude that the demonstration is not yet having a positive impact on provider capacity.

Goal 2.1: Decrease use of medically inappropriate care and reduce reliance on emergency department and hospital services for OUD/SUD treatment.

The ITS analysis shows no change in the number of ED visits per 1,000 beneficiaries. The number of inpatient stays was increasing prior to the intervention and is no longer increasing after the intervention (slope change -0.033, $p < 0.01$) and appears to have leveled off (post-period slope -0.003). These results provide mixed evidence that the demonstration is reducing medically inappropriate care.

Goal 2.2: Reduce readmission rates for OUD/SUD treatment.

ITS analysis indicates that readmissions rates have been slightly increasing before the intervention and that there has been no change post intervention. We conclude that there has been no effect of the demonstration on all-cause readmission rates.

Goal 3.1: Increase initiation of follow-up after discharge from the emergency department or hospital for OUD/SUD.

Quantitatively, we measured this by the percentage of ED visits for beneficiaries aged 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 and within 30 days of the ED visit (Monitoring metric #17). The ITS analysis showed no change in the initiation of follow-up after discharge. Our qualitative analysis of care coordination has not indicated any differences in care coordination among inpatient facilities. We conclude that the demonstration has not yet had an impact on the rates of follow-up after discharge from the ED or inpatient settings.

Goal 3.2: Increase adherence to and retention in treatment.

Goal 3.2 is more complex than most of the other goals. It consists of two measures—one for initiation and one for engagement—for four different cohorts:

1. Alcohol abuse or dependence
2. Opioid abuse or dependence
3. Other drug abuse or dependence
4. Total AOD abuse or dependence

Overall results indicate there has been no increase in adherence to or retention in treatment across all four cohorts.

Goal 4.1: Reduce instances of drug overdose and overdose deaths.

Both descriptive and ITS analysis indicate there has been no change in the number of drug overdoses.

Section 5 – Quality

The state utilizes its existing systems and review processes to support Eligibility quality control for the Healthy LA and SUD 1115 demonstration. Effective November 13, 2018, Louisiana launched a new Medicaid eligibility and enrollment system that uses advanced technology to ensure that benefits go only to those who meet eligibility and program requirements. The system connects with state and federal databases for real-time verification of citizenship, income, disability and lawful presence in the United States. In addition, it enables consistent enforcement of policy, with timely, automated coverage terminations for non-compliance. A standard operating procedure for secondary review tasks is also employed to support quality control at various stages of eligibility case processing. This includes

supervisor reviews for new eligibility workers to ensure that actions taken align with Medicaid policy and case reviews which review eligibility determinations of both new and established staff to confirm accuracy.

Related to SUD treatment, LDH has initiatives aimed at improving SUD quality of care, including:

- LDH requires the Healthy Louisiana MCOs to conduct routine quality monitoring reviews of SUD providers and facilities to ensure provider adherence to requirements and standards pertaining to overall practice/treatment, coordination of care, member health and welfare, documentation, staffing among other areas.
- Performance improvement projects were developed by the MCOs in collaboration with LDH to improve access to SUD care. Validated HEDIS data from the HEDIS measure associated with this project indicates the average statewide Total Initiation rate increased to above the 90th percentile in 2020 and the average statewide Total Engagement rate is above the 75th percentile for Medicaid plans nationally in MY 2020. The new MCO PIP starting in 2022 includes the HEDIS measure: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA).
- Louisiana's free, online LDH SUD treatment locator, ATLAS, was developed with Shatterproof and six other states and launched in July of 2020. ATLAS has structure and process measures on SUD services offered by facilities and captured by a treatment facility survey. ATLAS offers the opportunity for participating providers to compare services to their peers.

LDH is also required to conduct an annual external quality review (EQR) of the services provided by contracted Medicaid managed care entities (MCEs). LDH contracted with IPRO to assess and report the impact of its Medicaid managed care program, the Healthy Louisiana Program, and each of the participating MCEs on the accessibility, timeliness, and quality of services. The 2021 Aggregate EQRO Report is included as Appendix 2.

Section 6 – Budget Neutrality

The following table includes historical enrollment and expenditure totals from the first three years of the initial demonstration period and projected totals for the extension period. Each year listed in the table below represents twelve months of data collected in the months January through December. Expenditures reported represent the capitation payments paid to the Healthy Louisiana and Dental managed care plans for those receiving qualifying SUD services in IMDs.

Table 2: LA Healthy LA 1115 SUD Historical and Projected Enrollment and Expenditures

	Number of Persons Eligible	Total Expenditures
Initial Waiver Period		
2018	2,008	$12,744,753
2019	1,942	$14,291,000
2020	1,944	$16,109,357
Extension Waiver Period (projected)		
2023	1,944	$24,030,297
2024	1,944	$27,457,029
2025	1,944	$31,372,362
2026	1,944	$35,846,062

2027	1,944	$40,957,694

Note: 2021 actual enrollment and expenditure data not finalized and 2022 data not available.

No changes are projected in enrollment for the extension period and expenditures are trended based on historical experience. Enrollment data from the initial waiver period indicates a leveling off during calendar years 2019 and 2020. Because of this, the state included a flat (0%) trend for enrollment.

The complete Budget Neutrality workbook is included as Appendix 4.

Section 7 – Compliance with Public Notice and Tribal Consultation

Subsection 7.1 – Annual Public Forums

Pursuant to 42 CFR 431.420(c), the Louisiana Department of Health (LDH) held annual post-award public forums to allow the public an opportunity to provide comment and to solicit feedback on the progress of the Healthy Louisiana Substance Use Disorder 1115 Demonstration Waiver. These forums were held on June 28, 2018, December 23, 2019, and December 16, 2020. No members of the public attended the annual public forums held on June 28, 2018, and December 23, 2019, and LDH received no questions or comments from the public. Four members of the public attended the December 16, 2020, forum; however, LDH received no questions or comments.

Most recently, due to COVID 19 restrictions, LDH held its annual public forum virtually via Zoom on December 29, 2021, from 1:00 – 2:00 PM CST. Attendees included seven LDH employees. No one from the public attended this forum, and no questions or comments were received.

Subsection 7.2 – Public Notice

In compliance with 42 CFR Section 431.408

Public Notice – October 2021

On Friday, October 15, 2021, an abbreviated public notice was published in the state's major newspapers that included a summary description of the demonstration and the location and times of two public hearings. The public notice included an active link to the abbreviated public notice document on the state's website. Due to COVID-19 and physical distancing guidelines, the public hearings were held via internet and telephone only.

LDH provided a 30-day public notice and comment period from October 29, 2021, to November 28, 2021. On October 29, 2021, the full public notice was published in the state's major newspapers that included a summary description of the demonstration. A web address to the state's 1115 SUD website and instructions for requesting a hardcopy document were included in the notice to allow the public to review the demonstration renewal application. The public notice document also provided instructions to the public for submitting written comments.

The first public hearing was hosted in conjunction with the Louisiana Behavioral Health Advisory Council (LBHAC) on Monday, November 1, 2021, 9:00 a.m. to 10:30 a.m. CST. Attendees included subject matter experts from the Office of Behavioral Health (OBH) and Medicaid; representatives from the state education, rehabilitation, criminal justice, housing, and social services agencies; behavioral health advocates; consumers who receive behavioral health services; family members of children with serious emotional disturbances; and representatives of the managed care organizations (MCOs). No questions or comments were received.

The second public hearing was hosted by the Louisiana Department of Health (LDH) on Tuesday, November 16, 2021, from 3:00 p.m. to 4:30 p.m. CST. Attendees included subject matter experts from the Office of Behavioral Health (OBH) and Medicaid, behavioral health providers, and behavioral health advocates. One individual submitted a question regarding peer services, stating "I know that a while back the state was looking for peer support specialist training providers. Will this waiver include opportunities for peer supports/outpatient services?" LDH responded that "[t]he 1115 waiver does not directly address the peer support specialist program" and the individual was connected with the appropriate OBH subject matter expert for additional information.

The State received no written comments during the public comment period.

Public Notice – April 2022

LDH issued a second public notice on April 5, 2022, regarding intent to seek approval from CMS for a renewal of the Healthy Louisiana Substance Use Disorder 1115 Demonstration Waiver program. This notice revised the prior notice issued on October 29, 2021. The revisions included additional detail related to the demonstration's goals, objectives, hypotheses, health care delivery system, eligibility and cost sharing requirements, expenditure authority, and enrollment and expenditure data.

LDH posted the full public notice, renewal application, and appendices to the 1115 website for public comment from April 6, 2022, through May 6, 2022.

A public hearing was hosted by the Louisiana Department of Health (LDH) on Monday, April 11, 2022, from 2:00 p.m. to 3:00 p.m. CST. Attendees included subject matter experts from the Office of Behavioral Health (OBH) and Medicaid, as well as representatives from the Coalition of Louisiana Addiction Services and Prevention Providers (CLASPP). CLASPP thanked LDH for the work on the 1115 waiver and expressed support for a renewal. No additional questions or comments were received.

OBH also presented to the OBH Kitchen Cabinet on April 18, 2022, and to the Louisiana Behavioral Health Advisory Council (LBHAC) on May 2, 2022, and provided an update on the renewal application and public notice period. The State received no written comments during the public comment period.

Section 7.3 – Tribal Consultation:

In compliance with 42 CFR Section 431.408

On Friday, October 15, 2021, the State sent notification, via electronic mail, to the seven Tribal contacts in Louisiana to inform them of the Healthy Louisiana Substance Use Disorder 1115 Demonstration Waiver renewal. This notification provided a summary description of the demonstration renewal application as well as instructions for sending comments to the State.

The State received no comments from the Tribes.

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TULANE UNIVERSITY
SCHOOL *of* PUBLIC HEALTH
& TROPICAL MEDICINE

Department of Health Policy and Management

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

Interim Report

December 2021

Mark L. Diana, PhD
Kevin Callison, PhD
Janna Wisniewski, PhD
Charles Stoecker, PhD

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Executive Summary

Louisiana, like the rest of the United States, is experiencing an opioid use disorder (OUD) epidemic, resulting in high rates of drug overdose deaths. In response the Louisiana Department of Health (LDH) applied for and received a Section 1115(a) Demonstration in 2017 to allow for the continuation of treatment for OUD/SUD in institutions for mental diseases (IMDs) regardless of the length of stay. In addition, the waiver included several other proposed interventions aimed at improving outcomes for those with an OUD/SUD in areas such as access to critical levels of care for OUD/SUD, the use of evidence-based SUD patient placement criteria, access to medication-assisted treatment (MAT), and care coordination and transition between levels of OUD/SUD care.

The Centers for Medicare and Medicaid Services (CMS) requires an external evaluation of the Healthy Louisiana Substance Use Disorder 1115 Demonstration, and the Tulane University Department of Health Policy and Management received the contract to conduct the Evaluation.

Evaluation Questions and Hypotheses

Evaluation Question 1: Did access to evidence-based OUD/SUD care increase as a result of the demonstration?
Demonstration Goal 1.1: Increase access to evidence-based OUD/SUD care. *Evaluation Hypothesis: The demonstration will increase the share of beneficiaries who are treated for OUD/SUD in ways that are consistent with evidence-based care.*
Demonstration Goal 1.2: Increase access to and utilization of medication-assisted treatment (MAT) for OUD/Alcohol Use Disorder (AUD). *Evaluation Hypothesis: The demonstration will increase the use of MAT.*
Demonstration Goal 1.3: Ensure sufficient provider capacity at each level of care for OUD/SUD. *Evaluation Hypothesis: The demonstration will improve provider capacity.*
Evaluation Question 2: Did use of medically-inappropriate care including emergency department and hospital care for OUD/SUD decline as a result of the demonstration?
Demonstration Goal 2.1: Decrease use of medically inappropriate care and reduce reliance on emergency department and hospital services for OUD/SUD treatment. *Evaluation Hypothesis: The demonstration will reduce visits to the emergency department and the use of hospital services for the treatment of OUD/SUD.*
Demonstration Goal 2.2: Reduce readmission rates for OUD/SUD treatment. *Evaluation Hypothesis: The demonstration will reduce hospital readmission rates for OUD/SUD.*
Demonstration Goal 2.3: Increase use of evidence-based OUD/SUD patient placement criteria. *Evaluation Hypothesis: The demonstration will increase the use of evidence-based OUD/SUD patient placement criteria.*
Evaluation Question 3: Did care-coordination improve as a result of the demonstration?
Demonstration Goal 3.1: Increase initiation of follow-up after discharge from the emergency department or hospital for OUD/SUD. *Evaluation Hypothesis: The demonstration will increase initiation of follow-up after discharge from the emergency department or hospital for OUD/SUD.*

Demonstration Goal 3.2: Increase adherence to and retention in treatment. *Evaluation Hypothesis: The demonstration will increase adherence to and retention in treatment.*
Evaluation Question 4: Did health outcomes for Medicaid beneficiaries with OUD/SUD improve as a result of the demonstration?
Demonstration Goal 4.1: Reduce instances of drug overdose and overdose deaths. *Evaluation Hypothesis: The demonstration will decrease the rate of drug overdose and the number of drug deaths.*

Evaluation Methods

The number of questions, goals, and hypotheses require a complex methodological approach. The specifics of our methods vary. Details are provided for each specific goal and hypotheses in the body of the report. In general, where we were able, we conducted and Interrupted Time Series (ITS) analysis. Where we are unable to do so we provide descriptive analyses. We also include qualitative results for some sections.

Our primary data source is Medicaid claims data. Additional data sources include the Buprenorphine Treatment Practitioner Locator and DATA-Certified Physicians Totals collected by SAMHSA and the National Vital Statistics System Mortality Multiple Cause-of-Death Restricted Use Files.

Results

Goal 1.1: Increase access to evidence-based OUD/SUD care.

The number of beneficiaries receiving outpatient and withdrawal management services has not changed, but the number receiving intensive outpatient and partial hospitalization was increasing prior to the demonstration and is still increasing but at a slower rate. The number of beneficiaries receiving residential and inpatient services increased sharply at the start of the waiver but then shows a steady decrease (see Figure 2). There is also a sharp decline in the beginning of 2020, which could be caused by the COVID-19 pandemic. Unfortunately, we do not have the data to verify if this is the cause.

Goal 1.2: Increase access to and utilization of medication-assisted treatment (MAT) for OUD/Alcohol Use Disorder (AUD).

The number of beneficiaries with a claim for MAT has been increasing steadily both before and after the intervention, but the rate of increase is greater after the intervention than before. However, we also examined the share of beneficiaries with a claim for MAT and found that it is increasing at a faster rate after the intervention (see Figure 3). The number of providers who were enrolled in Medicaid and qualified to deliver SUD services has been steadily increasing at the same rate before and after. Overall, we conclude the demonstration is increasing the use of MAT.

Goal 1.3: Ensure sufficient provider capacity at each level of care for OUD/SUD.

The number of providers has been slowly increasing before and after implementation and the ITS analysis indicates that rate of increase has slowed slightly post implementation (slope change -0.393, $p < 0.05$). We conclude that the demonstration is not yet having a positive impact on provider capacity.

Goal 2.1: Decrease use of medically inappropriate care and reduce reliance on emergency department and hospital services for OUD/SUD treatment.

The ITS analysis shows no change in the number of ED visits per 1,000 beneficiaries. The number of inpatient stays was increasing prior to the intervention and is no longer increasing after the intervention (slope change -0.033, $p < 0.01$) and appears to have leveled off (post-period slope -0.003). These results provide mixed evidence that the demonstration is reducing medically inappropriate care.

Goal 2.2: Reduce readmission rates for OUD/SUD treatment.

ITS analysis indicates that readmissions rates have been slightly increasing before the intervention and that there has been no change post intervention. We conclude that there has been no effect of the demonstration on all-cause readmission rates.

Goal 3.1: Increase initiation of follow-up after discharge from the emergency department or hospital for OUD/SUD.

Quantitatively, we measured this by the percentage of ED visits for beneficiaries aged 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 and within 30 days of the ED visit (Monitoring metric #17). The ITS analysis showed no change in the initiation of follow-up after discharge. Our qualitative analysis of care coordination has not indicated any differences in care coordination among in-patient facilities. We conclude that the demonstration has not yet had an impact on the rates of follow-up after discharge from the ED or inpatient settings.

Goal 3.2: Increase adherence to and retention in treatment.

Goal 3.2 is more complex than most of the other goals. It consists of two measures—one for initiation and one for engagement—for four different cohorts:

1. Alcohol abuse or dependence
2. Opioid abuse or dependence
3. Other drug abuse or dependence
4. Total AOD abuse or dependence

Overall results indicate there has been no increase in adherence to or retention in treatment across all four cohorts.

Goal 4.1: Reduce instances of drug overdose and overdose deaths.

Both descriptive and ITS analysis indicate there has been no change in the number of drug overdoses.

Interpretations, and Policy Implications and Interactions with Other State Initiatives

Overall, we conclude that the demonstration is having a small but positive impact on the treatment of beneficiaries in ways consistent with evidence-based care. The demonstration has clearly increased the access to and utilization of MAT in Louisiana. These results are substantial and consistent across the demonstration whether we look at the number of Medicaid providers and beneficiaries or the share of beneficiaries with an MAT claim.

Our analysis of provider capacity suggests that while there has been a slow steady increase before and after the start of the demonstration, there has not been a change in the rate of increase before and after the demonstration began. This suggest that the demonstration has yet to impact provider capacity.

Our results are mixed on the goal of reducing use of medically inappropriate care and reliance on ED and inpatient services in that we found that inpatient stays were no longer increasing as they were prior to the demonstration, but that there has been no change in ED visits. What we can say is that the number of ED visits and inpatient stays are not increasing. We consider this a positive result, even though we are not able to conclusively attribute this result to the demonstration alone.

Our findings suggest that there has not been an impact on all cause 30-day readmission rates for SUD treatment. We conducted both quantitative and qualitative analyses of care coordination and found no effect of the demonstration to this point. Our evaluation of adherence to and retention in treatment is more complex than many other goals of the demonstration and includes measures of treatment initiation and engagement for four different cohorts. To this point in the demonstration, we do not see any change in these measures.

To this point in the demonstration there has not been a reduction in overdoses in Louisiana. Drivers intended to impact overdoses such as MAT will require time to impact these numbers, and there are delays in reporting these numbers, both of which make it likely there will be a substantial lag between the intervention of the drivers and the ability to observe their impact.

We are cautious in interpreting these results in light of the Covid 19 pandemic.

Lessons Learned and Recommendations

The ability to continue OUD/SUD treatment in IMDs in Louisiana, through this Demonstration, appears to have resulted in small but important ways that are consistent with evidence-based care. Other states may see a similar result.

The Demonstration is effectively using education of abstinence-based residential providers on the benefits of MAT and encouraging physicians and other qualified providers to become certified dispensers to increase the use of MAT. These approaches should be easily transferred to other states and clearly have the potential to achieve similar results.

Introduction

As of 2016, Louisiana had the fifth highest per-capita rate of opioid prescriptions among U.S. states and was above the national average in drug overdose deaths (CDC, 2018). Furthermore, from 2015 to 2016, deaths in Louisiana from opioid overdose increased by 22% (KFF, 2018).

The National Survey of Substance Abuse Treatment Services (N-SSATS) is an annual survey of facilities providing substance use treatment. In Louisiana, 157 substance use treatment facilities were included in the 2016 N-SSATS, which reported a total of 9,628 clients in substance use treatment on March 31, 2016.
(https://www.samhsa.gov/data/sites/default/files/2016_NSSATS.pdf).

Treatment options for patient with SUD include one or more of the following service components:

- Individual and group counseling
- Inpatient and residential treatment
- Intensive outpatient treatment
- Partial hospital programs
- Case or care management
- Medication
- Recovery support services
- 12-Step fellowship
- Peer supports

Source: https://www.samhsa.gov/treatment/substance-use-disorders

Among the treatment options are Institutions for Mental Diseases (IMD). However, from its inception in 1965, Medicaid has excluded IMD coverage for those between the ages of 21 and 64 (Section 1905(a)(B) of the Social Security Act). The IMD exclusion was intended to focus treatment of mental diseases at non-residential settings and leave states with the responsibility for funding inpatient psychiatric services
(https://www.lac.org/assets/files/IMD_exclusion_fact_sheet.pdf).

Since 2012, Louisiana has been able to include coverage of IMD provided services under the Louisiana Behavioral Health Partnership (LBHP) and, later, Healthy Louisiana, since coverage was determined to be "cost-effective" and capitated by the Louisiana Department of Health (LDH). In 2016, the Centers for Medicare and Medicaid Services (CMS) revised regulations and changed capitation policies prohibiting coverage (Federal participation in coverage) for IMD stays beyond 15 days per month.

In response to the growing concern over rates of opioid use disorders (OUDs) and substance use disorders (SUDs) in general, the Louisiana Department of Health applied for a Section 1115(a) Demonstration in 2017 to allow for the continuation of treatment for OUD/SUD in institutions

for mental diseases (IMDs) regardless of the length of stay.[1,2] In addition, the waiver included several other proposed interventions aimed at improving outcomes for those with an OUD/SUD in areas such as access to critical levels of care for OUD/SUD, the use of evidence-based SUD patient placement criteria, access to medication-assisted treatment (MAT), and care coordination and transition between levels of OUD/SUD care. The Healthy Louisiana Substance Use Disorder 1115 Demonstration was approved by CMS on February 1, 2018 and will continue through December 31, 2022. The scope of the demonstration requires no change in Medicaid eligibility; therefore, the affected population will be Medicaid beneficiaries in the state of Louisiana who are treated for an OUD/SUD.

The purpose of the demonstration is to maintain critical access to OUD/SUD services and continue delivery system improvements to provide more coordinated and comprehensive treatment for Medicaid beneficiaries. The demonstration aims to achieve the following goals:

a. Increase access to evidence-based OUD/SUD care
b. Increase access to and utilization of medication-assisted treatment (MAT) for OUD/SUD
c. Ensure sufficient provider capacity at each level of care for OUD/SUD
d. Decrease use of medically inappropriate care and reduced reliance on emergency department and hospital services for OUD/SUD treatment
e. Reduce readmission rates for OUD/SUD treatment
f. Increase use of evidence-based OUD/SUD patient placement criteria
g. Increase initiation of follow-up after discharge from the emergency department or hospital for OUD/SUD
h. Increase adherence to and retention in treatment
i. Reduce instances of drug overdose and overdose deaths

The demonstration implementation plan includes six separate milestones that address various areas of OUD/SUD treatment including access, placement, standards of care, and provider capacity. We develop hypotheses surrounding these milestones and their potential impact on the demonstration goals and describe our proposed methodology for testing these hypotheses below.

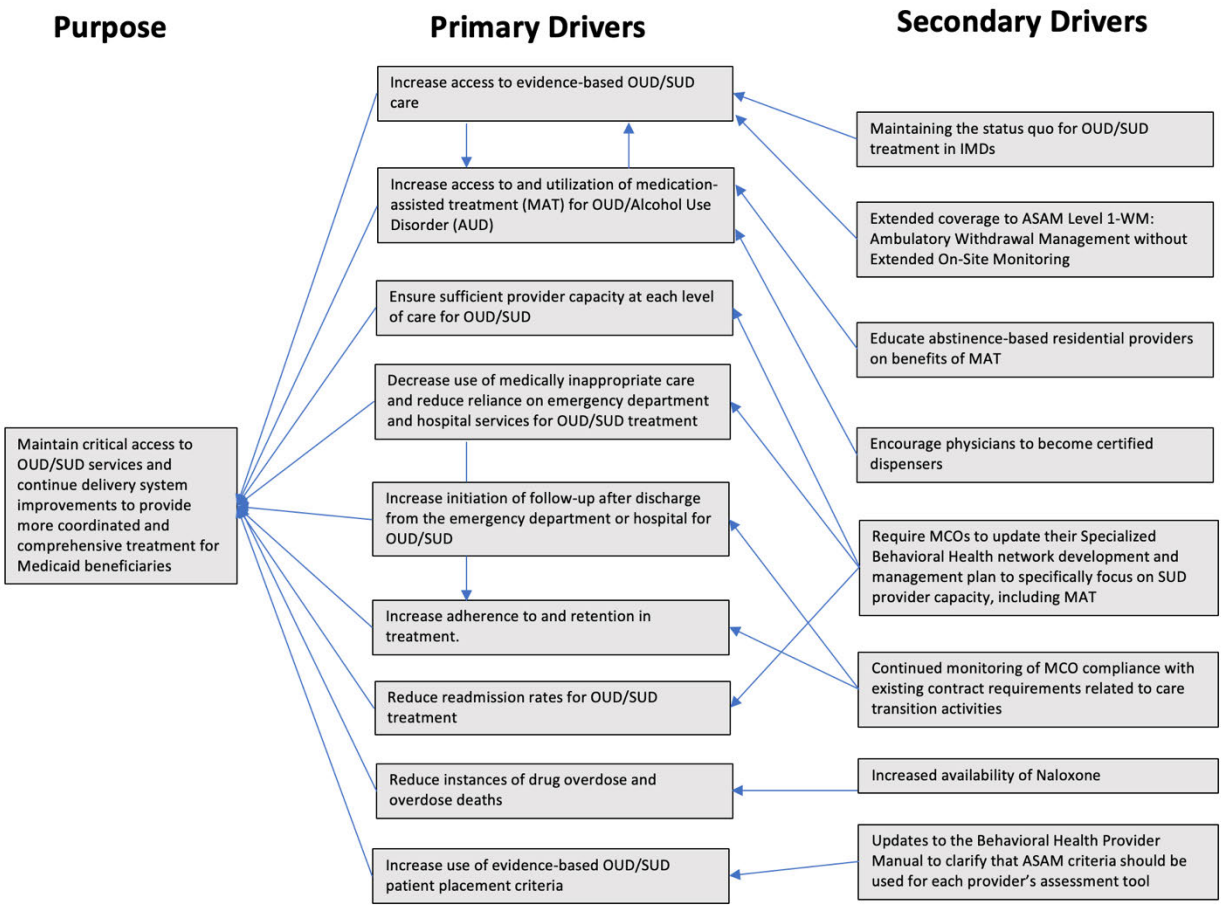
[1] Section 1905 42 of U.S.C. 1396d defines IMDs as "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services."

[2] While IMDs have been excluded from federal financial participation since Medicaid's inception, several states have used an "in lieu of" policy to fund IMD care using federal dollars through capitated payments to managed care organizations (Musumeci, 2018). In May 2016, CMS implemented a policy to limit "in lieu of" payments to IMD stays to 15 days in a calendar month (Priest et al., 2017)

Evaluation Questions and Hypotheses

Driver Diagram and Model Assumptions

Figure 1: Driver diagram



Model Assumptions:

1. Medicaid beneficiaries cannot afford treatment.
2. Providers will read the Louisiana Medicaid Provider manual.
3. Abstinence-only providers will read or participate in education.
4. Cost is a major barrier to evidence-based treatment for providers.
5. Knowledge is a major barrier preventing providers from engaging in evidence-based treatment.
6. Providers will comply with the requirement.
7. MCOs' contract requirements related to linkages to care are appropriate.
8. There is a process in place by which tracking data for opioids and naloxone is acted upon.
9. Community-based services are effective.

Table 1: Evaluation questions, demonstration goals, and evaluation hypotheses.

Evaluation Question 1: Did access to evidence-based OUD/SUD care increase as a result of the demonstration?
Demonstration Goal 1.1: Increase access to evidence-based OUD/SUD care. *Evaluation Hypothesis: The demonstration will increase the share of beneficiaries who are treated for OUD/SUD in ways that are consistent with evidence-based care.*
Demonstration Goal 1.2: Increase access to and utilization of medication-assisted treatment (MAT) for OUD/Alcohol Use Disorder (AUD). *Evaluation Hypothesis: The demonstration will increase the use of MAT.*
Demonstration Goal 1.3: Ensure sufficient provider capacity at each level of care for OUD/SUD. *Evaluation Hypothesis: The demonstration will improve provider capacity.*
Evaluation Question 2: Did use of medically-inappropriate care including emergency department and hospital care for OUD/SUD decline as a result of the demonstration?
Demonstration Goal 2.1: Decrease use of medically inappropriate care and reduce reliance on emergency department and hospital services for OUD/SUD treatment. *Evaluation Hypothesis: The demonstration will reduce visits to the emergency department and the use of hospital services for the treatment of OUD/SUD.*
Demonstration Goal 2.2: Reduce readmission rates for OUD/SUD treatment. *Evaluation Hypothesis: The demonstration will reduce hospital readmission rates for OUD/SUD.*
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Demonstration Goal 3.1: Increase initiation of follow-up after discharge from the emergency department or hospital for OUD/SUD. *Evaluation Hypothesis: The demonstration will increase initiation of follow-up after discharge from the emergency department or hospital for OUD/SUD.*
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Demonstration Goal 4.1: Reduce instances of drug overdose and overdose deaths. *Evaluation Hypothesis: The demonstration will decrease the rate of drug overdose and the number of drug deaths.*

Methods

Evaluation Methodology

We use three methods to evaluate the hypotheses listed in Table 1. When it is possible to designate a control group, our preferred methodology is a differences-in-differences (DD) design. Use of the DD methodology will not be possible when we are unable to identify an appropriate control group who would be plausibly unaffected by an intervention. In this case, we rely on one of two alternative research designs: interrupted time series analysis or a pre/post analysis. The interrupted-time series (ITS) method examines changes over time in an outcome for a treatment group. The evaluation period spans the periods before and after the intervention to capture changes that correspond to the timing of the intervention. An ITS analysis does not require a control group, but instead compares changes within the treatment group over time.

Finally, for a small number of outcomes, both the DD and ITS are not feasible. This occurs when we are unable to identify an appropriate control group and when time-series data on a particular outcome is limited. For example, since ASAM Level 1-WM treatment was not a covered level of care prior to the demonstration, we cannot model the trend in this treatment over time for Medicaid beneficiaries. In these cases, we use a simple pre/post analysis to statistically compare changes in outcomes from the pre-intervention period to the post-intervention period.

Target and Comparison Populations

For most analyses, the target population consists of the Medicaid population with an OUD/SUD. 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.

When examining changes in prescriber certified dispensers, the target population includes all waivered prescribers in the state of Louisiana listed in the SAMHSA Buprenorphine Treatment Practitioner Locator and the DATA-Certified Physician Totals. In some specifications, we compare changes in the number of waivered prescribers in Louisiana to changes in other states. In those instances, our population will expand to include prescribers from non-SUD demonstration states. In addition, we use NPI provider records from the Medicaid claims data to measure active physician treatment for SUD services.

Finally, when examining overdose deaths, our target population will be comprised of those whose cause of death is listed as an “accidental poisoning by and exposure to drugs and other biological substances” in both Louisiana and other control states.

Evaluation Period

The evaluation period for analyses using the Medicaid claims data will begin in January 2014 and will be ongoing through the projected end of the demonstration in December 2022. Though the demonstration was approved in February 2018, we will incorporate data from the 2014 through 2017 in order to establish trends and use-rates in the pre-demonstration period. We will

then measure changes in these outcomes from the pre-demonstration to post-demonstration periods.

Data Sources

The primary data source for our analysis is the Louisiana Medicaid claims database. Additional data sources include the Buprenorphine Treatment Practitioner Locator and DATA-Certified Physicians Totals collected by SAMHSA and the National Vital Statistics System Mortality Multiple Cause-of-Death Restricted Use Files. The Buprenorphine Treatment Practitioner Locator and DATA-Certified Physicians data are freely available through SAMHSA's website. We will apply for access to restricted-use versions of the Mortality Multiple Cause-of-Death files, which is necessary in order to obtain geographic identifiers.

SAMHSA maintains two sources of data on physician certification for treating OUD/SUD through MAT: The Buprenorphine Treatment Practitioner Locator and DATA-Certified Physicians database. Data elements on DATA-Certified Physicians is collected from online submission forms that physicians must complete in order to attain waiver certification. The Buprenorphine Treatment Practitioner Locator data is taken from practitioner profiles maintained by SAMHSA.

Analytic Methods

Quantitative Methods

Our preferred methodology for evaluating the hypotheses listed above is DD. 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.

The DD model can be formally represented as follows:

$$Outcome_{ist} = \beta_0 + \beta_1 Treat_{is} + \beta_2 Post_t + \beta_3 Treat_{is} \times Post_t + \beta_4 X_{ist} + \beta_5 Z_{st} + \delta_s + \tau_t + \varepsilon_{ist}$$

Where $Outcome_{ist}$ represents the outcome of interest to be estimated for individual i living in state or region s at time t. $Treat$ is an indicator for assignment to the treatment group and $Post$ an indicator for the post-intervention period. The interaction term, $Treat_{is} \times Post_t$, is the coefficient of interest and represents the effect of the intervention on the treatment group relative to the control group. Finally, X is a vector of individual characteristics such as age and sex, Z is a vector of state or region characteristics such as unemployment rates, δ and τ are state/region and time fixed effects, and ε is an error term that captures unobserved factors associated with the outcome of interest. Most of the DD models will be estimated using ordinary least squares (OLS), however we may employ nonlinear estimation techniques to account for relatively rare outcomes.

For cases where no appropriate control group can be defined, we will instead rely on either an interrupted time series analysis or a simple pre/post analysis. The interrupted time series model can be described as follows:

$$Outcome_{it} = \beta_0 + \beta_1 Time_t + \beta_2 Implement_t + \beta_3 Time_t \times Implement_t + \beta_4 X_{ist} + \beta_5 Z_{st} + \delta_s + \varepsilon_{ist}$$

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 a demonstration milestone meant to impact the outcome in question and measures any break in trend associated with the intervention. The interaction term, $Time_t \times Implement_t$ captures any change to the slope of the trend that occurred after the intervention. All other variables remain as previously defined.

Finally, in a small number of cases, neither a DD or ITS will be feasible due to a lack of control group and time-series data. In these cases, we will use a simple pre/post comparison of mean changes and test for statistical significance between the pre- and post-period using t-tests or chi-square tests depending on the outcome to be analyzed.

Methodology for analyzing costs of the Louisiana SUD waiver to the Medicaid program

Identify Medicaid beneficiaries with a SUD. Using files obtained from Louisiana Medicaid data warehouse, including inpatient, outpatient, pharmacy, and long-term care claims, we identify beneficiaries with a substance use diagnosis or treatment code during the pre- and post-demonstration periods. We link beneficiaries with a SUD diagnosis or treatment during the specified time periods to Medicaid eligibility data and demographic characteristics, to identify the months a beneficiary was enrolled in Medicaid. The analysis includes the first month where a SUD diagnosis or treatment claim was observed for the beneficiary and for up to eleven additional months that did not include claims for SUD diagnosis or treatment if the beneficiary remained enrolled in Medicaid. Repeated SUD diagnoses or treatment claims extend the observation period included in the analysis.

Organize the data to create a file with an observation for each month a beneficiary is Medicaid-eligible, on or after their first observed SUD-related claim during the analysis period. For each month that an individual is enrolled, the data file contains an observation with their Medicaid costs in that month.

Develop shadow cost prices. As Louisiana Medicaid patients are in managed care, we use the published fee-for-service schedule for Louisiana's Medicaid program. This list maps Current Procedural Terminology (CPT) codes and provider types onto dollar costs. Additionally, there are Healthcare Common Procedure Coding System (HCPCS) codes that define daily charges for SUD IMD stays and these rates are specific to SUD patients. Per guidance from CMS, we exclude room and board from these shadow prices.

Waiver administrative costs. The costs for administering Louisiana's SUD 1115 waiver program are entirely staffing costs. There are 10 staff members involved in administering the waiver program. We ask each staff member to estimate the percentage of their effort spent on administering the SUD waiver, percentage of time spent supporting the waiver evaluation efforts, and percentage of time spent on other duties. This retrospective reporting is performed monthly. We multiply the percentage efforts spent directly on administering the waiver by salaries to obtain administrative costs for the waiver program.

Calculate and trend average monthly spending. From the individual month-level data, we calculate average costs, across the categories presented in Table 2, separated into months before the demonstration and months after. These means are plotted to show trends visually and to verify that month-to-month variation is within expectations and does not indicate an underlying data error. Depending on variance in costs we may collapse data to the quarterly level to smooth out monthly variation in costs.

Table 2: Types of costs and data sources

Level of analysis	Type of costs	Data source
Total costs	Total costs	Louisiana Medicaid Claims Data, IMD costs, administrative costs
	Total federal costs	Total Medicaid costs * federal medical assistance percentage [FMAP] for the state
SUD cost drivers*	SUD-IMD	IMD costs reported by Louisiana Medicaid Claims Data
	SUD-other	Louisiana Medicaid Claims Data
	Non-SUD	Louisiana Medicaid Claims Data
Type or source of care cost drivers*	Outpatient costs – non ED	Louisiana Medicaid Claims Data
	Outpatient costs – ED	
	Inpatient costs	
	Pharmacy costs	
	Long-term care costs	

Our model for identifying the impact of the SUD 1115 waiver program on costs is an interrupted time-series design without a comparison group. This is necessary as there is no geographic or eligibility variation in the Louisiana Medicaid population in who is eligible for these services. For our interrupted time series regression analysis of costs, we include an indicator equal to 1 for months on or after the start date of the demonstration and equal to 0 for the pre-demonstration period months. Our regression model also includes covariates to control for age, race, gender, and dual eligibility status. We model costs in a two-part model where the first part is a logit model where the outcome is whether there are any costs in the person-month and in the second part the outcome is log costs as costs are typically not normally distributed.

For each outcome in Table 2 we will run the following model:

$$\text{Costs} = \beta 0 + \beta 1 * \text{TIME} + \beta 2 * \text{POST} + \beta 3 * (\text{TIME} * \text{POST}) + Bi * \text{CONTROLS} + \varepsilon$$

Where:

TIME is a count variable that starts with the first quarter pre-demonstration period data and ends with the last quarter of post-demonstration period data.

POST is the indicator variable that equals 1 if the month occurred on or after demonstration start date.

CONTROLS are covariates, such as age, gender, race, dual Medicare-Medicaid enrollment, and month.

We report marginal effects and standard errors to assess statistically significant changes in costs. Changes in average costs after the intervention are captured by $\beta 2$. If this is positive and statistically significant it indicates costs are higher in the post-demonstration period.

Changes in trends in costs are captured by $\beta 3$. If this is positive and statistically significant it indicates cost trends have increased in the post period. Together these two coefficients capture potential program impacts on cost. We also report regression adjusted means (either monthly or quarterly), as described previously, to make regression results more easily interpretable for lay audiences.

Results

Demonstration Goal 1.1

Demonstration Goal 1.1 is to increase access to evidence-based OUD/SUD care. The primary driver of this goal is to increase access to evidence-based OUD/SUD care. We used two measures to evaluate this driver:

- Medicaid Beneficiaries Treated in an IMD for SUD (Monitoring metric #5)
- Average Length of Stay in IMDs (Monitoring metric #36)

These measures have remained relatively stable over the demonstration period based on descriptive analysis. We do not have pre-period data and therefore cannot conduct an ITS analysis.

The secondary drivers are:

- Maintaining the status quo for OUD/SUD treatment in IMDs
- Extended coverage to ASAM Level 1-WM: Ambulatory Withdrawal Management without Extended Onsite Monitoring

We used these measures to evaluate the secondary drivers:

- Early intervention (ASAM 0.5; Monitoring metric #7)
- Outpatient Services (ASAM 1; Monitoring metric #8)
- Intensive Outpatient and Partial Hospitalization (ASAM 2; Monitoring metric #9)
- Residential and Inpatient Services (ASAM 3; Monitoring metric #10)
- Withdrawal Management (Monitoring metric #11)

The early intervention measure is not interpretable because of small numbers (there are between 0 – 5 beneficiaries using early services in the period).

ITS results for the number of beneficiaries using outpatient services indicate that there has been no change. An ITS analysis of the share of beneficiaries receiving outpatient services suggests that the share was decreasing prior to the demonstration and that the rate is still decreasing but at a lower rate (slope change 0.34, $p < 0.01$). The number of beneficiaries receiving intensive outpatient and partial hospitalization was increasing prior to the demonstration and is still increasing but at a slower rate (slope change -23.13, $p < 0.01$). There was a large increase in the number of beneficiaries receiving residential and inpatient services at the beginning if the waiver period (level change 1245.14, $p < 0.01$). This number is decreasing on average over the course of the demonstration, but visual inspection suggests this is due to a substantial drop in the first part of 2020. Lastly, the number of beneficiaries receiving withdrawal management services has been increasing at the same rate before and after the start of the demonstration, but there was a small increase in level at the start of the intervention (level change 84.01, $p < 0.05$).

Demonstration Goal 1.2

Demonstration goal 1.2 is to increase access to and utilization of medication-assisted treatment (MAT) for OUD/Alcohol Use Disorder (AUD). The primary driver is measured by the number of beneficiaries who have a claim for MAT for SUD during the measurement period (Monitoring metric #12). The secondary drivers are to educate abstinence-based residential providers on benefits of MAT and to encourage physicians to become certified dispensers. We evaluated the secondary drivers by measuring the number of Medicaid providers who were qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT (Monitoring metric #14).

The ITS analysis of the number of beneficiaries who have a claim for MAT for SUD during the measurement period indicates it is increasing slightly more than before the intervention (slope change 53.71, $p < 0.10$). There also was a decrease in the number of beneficiaries receiving MAT at the beginning of the intervention (level change -1296.99, $p < 0.05$). The number of Medicaid providers who were qualified to deliver MAT services has been steadily increasing at the same rate before and after.

Demonstration Goal 1.3

Demonstration goal 1.3 is to ensure sufficient provider capacity at each level of care for OUD/SUD. The primary driver for goal 1.3 is the number of Medicaid providers who were qualified to deliver SUD services during the measurement period (Monitoring metric #13). The number of providers has been slowly increasing before and after implementation and the ITS analysis indicates that rate of increase has slowed slightly post implementation (slope change -0.393, $p < 0.05$).

Demonstration Goal 2.1

Demonstration goal 2.1 is to decrease the use of medically inappropriate care and reduce reliance on emergency department and hospital services for OUD/SUD treatment. The primary driver for goal 2.1 is the number of OUD/SUD beneficiaries with an emergency department visit per 1,000 beneficiaries (Monitoring metric #23). The secondary driver is the number of inpatient stays for OUD/SUD per 1,000 Medicaid beneficiaries (Monitoring metric #24).

ITS analysis indicates that the number of ED visits has not changed, and that the number of impatient stays was increasing prior to the intervention (pre-period slope 0.031, $p < 0.01$) and that it is has decreased after the intervention (slope change -0.033, $p < 0.01$).

Demonstration Goal 2.2

Demonstration goal 2.2 is to reduce readmission rates for OUD/SUD treatment. We measured this by the rate of all-cause readmissions during the measurement period among beneficiaries with SUD (Monitoring metric #25). ITS analysis indicates that readmissions rates have been slightly increasing before the intervention and that there has been no change post intervention.

Demonstration Goal 3.1

Demonstration goal 3.1 is to increase initiation of follow-up after discharge from the emergency department for Alcohol and Other Drug Abuse or Dependence (AOD). We measured this by the 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 and within 30 days of the ED visit (Monitoring metric #17). The ITS analysis showed no change in the initiation of follow-up after ED visit.

Demonstration Goal 3.1 Survey Methods

The care coordination survey is designed to be a rapid assessment of the ways in which the facility coordinated post-discharge services for inpatients. It covered the types of services coordinated, preauthorization, methods of referral, and patient information transfer.

The sampling frame from this survey was a list of 70 SUD treatment facilities obtained from the SAMHSA website. Facilities classified as inpatient providers that accepted Medicaid. A researcher attempted to reach each facility by telephone to invite them to respond to the survey.

2019 data collection

Of the 70 facilities listed, 22 reported that they provided outpatient care only. Additionally, two were duplicate listings and one reported to not accept Medicaid. Of the remaining 55 facilities, eight completed the survey. The 47 that did not either could not be reached, did not connect the researcher with an appropriate administrator who could respond, or refused.

The facilities that responded to the survey were located in New Orleans (3), Baton Rouge (2), North/Central Louisiana (2), and Southwest Louisiana (1).

2020 data collection

Of the 55 facilities identified as eligible in the first wave of data collection, 10 responded to the survey. The responding facilities were located in New Orleans (4), North/Central Louisiana (2), Southwest Louisiana (2), Baton Rouge (1), and Southeast Louisiana (1).

In an effort to increase the sample size in future waves, researchers will attempt to reach facilities by telephone as well as a mailed or emailed survey with an option to take the survey online.

Results

Between 2019 and 2020, there were no statistically significant differences in care coordination metrics among in-patient facilities. This may be due in part to the small sample size.

In 2019, nearly 13 percent of surveyed facilities did not obtain prior authorization for medications for any patients prior to discharge. In 2020, the percentage had increased to 20.0. However, the percentage of facilities that obtained prior authorization for all patients also increased from 25.0 percent in 2019 to 30.0 percent in 2020.

Table 3. Percentage of your inpatients needing prior authorization for medications who have it at the time of discharge (n=inpatient facilities)

	2019		**2020**	
Percentage	**n**	**%**	**n**	**%**
None	1	12.5	2	20.0
1-24%	0	0.0	0	0.0
25-49%	1	12.5	1	10.0
50-74%	0	0.0	0	0.0
75-99%	1	12.5	1	10.0
100%	2	25.0	3	30.0
Don't know	3	37.5	3	30.0
Total	**8**	**100.0**	**10**	**100.0**

All facilities surveyed indicated that at least some of their patients receive a referral or information about outpatient behavioral health services prior to discharge. The percentage who did so with all patients was relatively unchanged from 2019 to 2020.

Table 4. Percentage of inpatients who have information about or a referral to outpatient behavioral health services prior to discharge (n=inpatient facilities)

	2019		**2020**	
Percentage	**n**	**%**	**n**	**%**
None	0	0.0	0	0.0
1-24%	1	12.5	1	10.0
25-49%	1	12.5	1	10.0
50-74%	0	0.0	1	10.0
75-99%	1	12.5	1	10.0
100%	5	62.5	6	60.0
Don't know	0	0.0	0	0.0
Total	**8**	**100.0**	**10**	**100.0**

In some cases, patients cannot go home or do not have housing after discharge from an inpatient facility. In 2019, 62.5 percent of surveyed facilities indicated that they coordinate with other

organizations to secure housing prior to discharge for these individuals. In 2020, that percentage had risen slightly to 70.0 percent.

Table 5. Percentage of facilities that coordinate with other organizations when a patient cannot go home or has no housing after discharge (n=inpatient facilities)

	2019		2020	
Coordination	**n**	**%**	**n**	**%**
Yes	5	62.5	7	70.0
No	3	37.5	3	30.0
Total	**8**	**100.0**	**10**	**100.0**

In both 2019 and 2020, the majority of inpatient facilities referred or provided information to patients about other services at discharge, most frequently, medical and housing services. Information about social work and employment services were less frequently provided.

Table 6. Other types of health or social services to which facilities refer or provide information to patients (n=inpatient facilities)

	2019		2020	
Services	**n**	**%**	**n**	**%**
Medical	7	87.5	9	90.0
Housing	7	87.5	9	90.0
Dental	6	75.0	8	80.0
Social work/Case management	6	75.0	7	70.0
Employment	5	62.5	6	60.0
Total	**8**	**100.0**	**10**	**100.0**

Facilities were asked to list the organizations to which they refer patients after discharge. In 2019, half of facilities referred to only one organization (40.0 percent in 2020). The highest number of referral organizations was five.

Table 7. Number of organizations to which inpatient facilities refer patients after discharge. (n=inpatient facilities)

	2019		2020	
Organizations	**n**	**%**	**n**	**%**
None/Don't know	1	12.5	1	10.0
1	4	50.0	4	40.0
2	1	12.5	2	20.0
3	0	0.0	1	10.0
4	0	0.0	0	0.0
5	2	25.0	2	20.0
Total	**8**	**100.0**	**10**	**10.0**

Facilities were also asked to characterize the types of relationships they have with referral organizations. In 2019, nearly 44 percent of relationships were informal, and 44 percent were

with organizations under the same parent organization. This was similar in 2020, with 38 percent of relationships being informal and another 38 percent having the same parent organization. Less frequently, relationships were formal (i.e. having a contract in place).

Table 8. Type of relationship with referral organizations (n=organizations to which discharged patients are referred)

	2019		2020	
Relationship	**n**	**%**	**n**	**%**
Informal	7	43.8	8	38.1
Formal	2	12.5	5	23.8
Same parent	7	43.8	8	38.1
Total	**16**	**100.0**	**21**	**100.0**

The degree to which inpatient facilities facilitate referrals varies. In 2019, half of facilities simply gave verbal instructions to patients, and half actually scheduled the appointment for the patient. In 2020, nearly 62 percent of facilities reported scheduling appointments for patients. Other methods, employed by less than 10 percent of facilities, were giving a written referral to the patient and faxing a referral to the provided.

Table 9. Methods which patients are referred (n=organizations to which discharged patients are referred)

	2019		2020	
Referral method (see notes)	**n**	**%**	**n**	**%**
Verbal instruction to patient	8	50.0	8	38.1
Schedule appointment for patient	8	50.0	13	61.9
Written referral given to patient	1	6.3	1	4.8
Referral faxed to provider	1	6.3	1	4.8
Total	**16**	**100.0**	**21**	**100.0**

Notes: Respondents could indicate multiple methods

In 2019, 37.5 percent of facilities reported that they did proactively send patient information with referrals. This percentage decreased to 28.6 percent in 2020.

Table 10. Methods by which patient information is transmitted to the provider with the referral (n=organizations to which discharged patients are referred)

	2019		2020	
Transmission method	**n**	**%**	**n**	**%**
No information proactively sent	6	37.5	6	28.6
Same system	6	37.5	7	33.3
Sent with patient	3	18.8	3	14.3
Telephone	3	18.8	7	33.3
EMR/EHR	3	18.8	4	19.0
Fax	2	12.5	0	0.0
In person	0	0.0	1	4.8
Total	**16**	**100.0**	**21**	**100.0**

Notes: n=organizations to which discharged patients are referred.

Demonstration Goal 3.2

Demonstration goal 3.2 is to increase adherence to and retention in treatment. The measure used to evaluate this goal is the initiation and engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD). This is a complicated measure with numerous breakdowns.

We calculated the percentage of beneficiaries aged 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following:

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

The following diagnosis cohorts are reported for each rate:

1. Alcohol abuse or dependence
2. Opioid abuse or dependence
3. Other drug abuse or dependence
4. Total AOD abuse or dependence

ITS analysis indicates that both initiation (14 days) and engagement (34 days) of treatment for alcohol abuse or dependence has been increasing before and after the intervention, but the rate of increase has slowed slightly after the intervention (initiation slope change -0.240, $p < 0.01$; engagement slope change 0.094, $p < 0.05$).

ITS analysis indicates that both initiation and engagement for opioid abuse or dependence has been rising slowly before and after the intervention with no change post intervention.

ITS analysis of initiation and engagement for other drug abuse or dependence indicates they have been increasing slowly before and after the intervention, but the rate of increase has slowed slightly after the intervention (initiation slope change -0.164, $p < 0.01$; engagement slope change 0.120, $p < 0.05$).

We see a similar pattern with AOD initiation (slope change -0.155, $p < 0.01$) but with a flattening out in the post period.

Demonstration Goal 4.1

Demonstration Goal 4.1 is to reduce instances of drug overdose and overdose deaths.[3] We measured the number of drug overdoses among Medicaid beneficiaries. Drug overdose is defined using the measure proposed by the National Council of State and Territorial Epidemiologists and the National Center for Injury Prevention and Control and includes diagnosis codes in any field starting with T36 through T50, with unintentional, intentional harm, assault, or undetermined intent, and initial, subsequent, or missing encounter type. Instances of adverse effects, underdosing, and sequelae are excluded.

Both descriptive and ITS analysis of the number of drug overdoses indicates there has been no change pre- and post-waiver implementation.

[3] As of December 2021, we do not have a monthly breakdown of drug overdose deaths.

Required Evaluation Topic: Demonstrate patterns and trends in Medicaid costs associated with SUD 1115 demonstration

The evaluation plan includes an analysis of trends in Medicaid costs associated with the SUD 1115 waiver, including total costs, SUD cost drivers, and type or source of care cost drivers. For this report we provide total costs, Federal share of Louisiana SUD waiver, cost of Medicaid beneficiaries treated in an IMD, cost of Medicaid beneficiaries' ED visits, cost of MAT, and cost of ASAM care.

Results indicate that total costs dropped significantly after the first intervention in October of 2018, which was to encourage physicians to become certified dispensers. Total costs, the costs of beneficiaries treated in an IMD, and the cost of MAT are increasing after the second intervention, which was to educate abstinence-based residential providers on the benefits of MAT. The increase in total costs appears to be driven primarily by the increase in the cost of MAT.

Conclusions

The Healthy Louisiana Substance Use Disorder 1115 Demonstration was approved by CMS on February 1, 2018. The Evaluation Plan includes nine goals and associated hypotheses. We will discuss each in turn.

Demonstration Goal 1.1: Increase access to evidence-based OUD/SUD care.

Primary Driver: Increase access to evidence-based OUD/SUD care
Secondary Drivers:

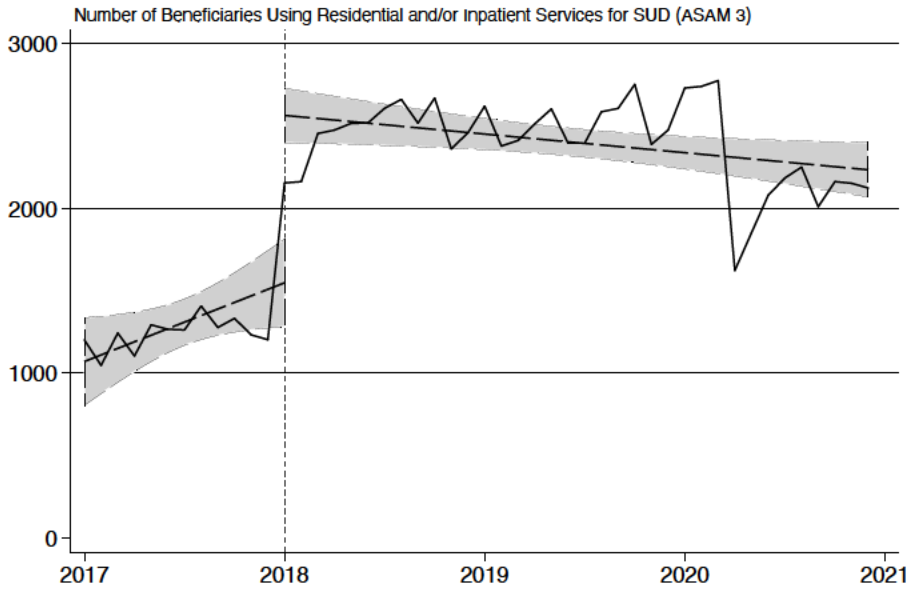
- Maintaining the status quo for OUD/SUD treatment in IMDs
    - Status: Ongoing
    - Details: Treating SUD in IMDs was occurring before the SUD Demonstration with "in lieu of services" provided by the MCOs, and has continued through the start date of February 1, 2018, for approval of the SUD 1115 Demonstration waiver. Maintaining the status quo for SUD treatment in IMDs is ongoing as maintaining the status quo is the intention of the 1115 waiver.
- Extended coverage to ASAM Level 1-WM: Ambulatory Withdrawal Management without Extended Onsite Monitoring
    - Status: Not started
    - Details: ASAM 1-WM is not currently a Medicaid covered service and is dependent upon future funding via Louisiana legislative budget approval.

Evaluation Hypothesis: The demonstration will increase the share of beneficiaries who are treated for OUD/SUD in ways that are consistent with evidence-based care.

We do not have data for many of these measures prior to 2018 and therefore cannot conduct an ITS analysis. Descriptive statistics post implementation for these measures indicates either no change or slight decreases.

We can conduct an ITS analysis on several measures. These results are also generally small but, in some cases, significant. The number of beneficiaries receiving outpatient and withdrawal management services has not changed, but the number receiving intensive outpatient and partial hospitalization was increasing prior to the demonstration and is still increasing but at a slower rate. The number of beneficiaries receiving residential and inpatient services increased sharply at the start of the waiver but then shows a steady decrease (see Figure 2). There is also a sharp decline in the beginning of 2020, which could be caused by the COVID-19 pandemic. Unfortunately, we do not have the data to verify if this is the cause.

Figure 2: Number of Beneficiaries using residential and/or inpatient services for SUD (ASAM 3).



Notes: The total number of unduplicated beneficiaries with a service claim for residential and/or inpatient services for SUD during the measurement period.

Overall, we conclude that the demonstration is having a small but positive impact on the treatment of beneficiaries in ways consistent with evidence-based care.

Demonstration Goal 1.2: Increase access to and utilization of medication-assisted treatment (MAT) for OUD/Alcohol Use Disorder (AUD).

Primary Driver: Increase access to and utilization of medication-assisted treatment (MAT) for SUD

Secondary Drivers:

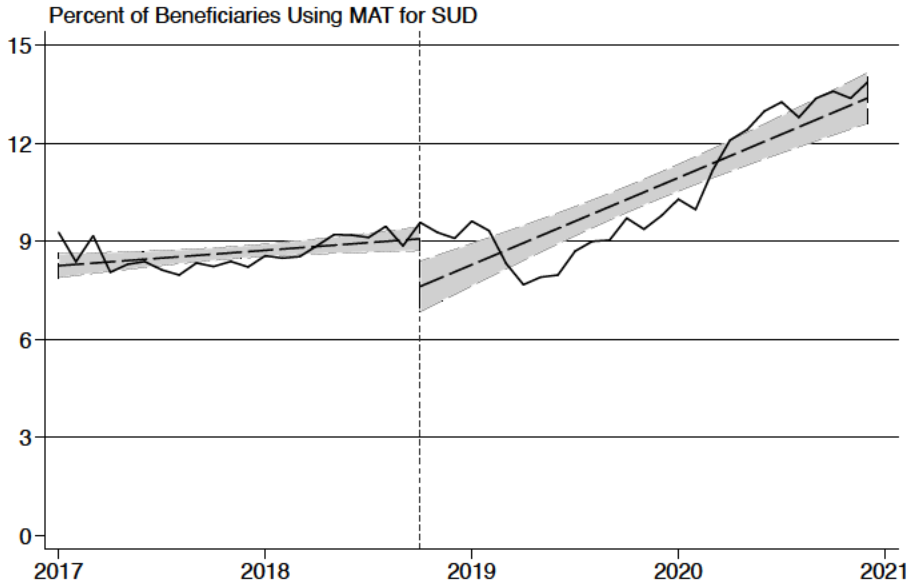
- Educate abstinence-based residential providers on benefits of MAT.
    - Status: Started 4/01/2019
    - Details: Increasing access to MAT or OUD is occurring with the CMS requirement for SUD residential providers to offer MAT onsite or facilitate access to MAT offsite when clinically indicated for patients in their care.
- Encourage physicians to become certified dispensers.
    - Status: Started 10/01/2018
    - Details: FDA approved AUD MAT medications (Disulfiram, Acamprosate and Naltrexone) do not require licensed prescribers to be certified, as are data-waivered to prescribe Buprenorphine. In Louisiana, MDs, APRNs, and PAs are qualified to become data waivered. Prescribers are being recruited through The LaSOR grant to participate in the "Hub and Spoke" model. The LASOR grant timeframe is 10/01/18 to 9/30/2020. LASOR started recruiting in April "officially" when the LSU Contract was completed. As of 9/13/19, 44 new prescribers were prescribing Suboxone. This recruitment will continue through 9/30/2020 with this grant.

Evaluation Hypothesis: The demonstration will increase the use of MAT.

To evaluate this hypothesis, we conducted an ITS analysis on the number of beneficiaries that have a claim for MAT and the number of providers enrolled in Medicaid qualified to deliver SUD services and that meet the standards to provide buprenorphine or methadone as part of MAT.

The number of beneficiaries with a claim for MAT has been increasing steadily both before and after the intervention, but the rate of increase is greater after the intervention than before. However, we also examined the share of beneficiaries with a claim for MAT and found that it is increasing at a faster rate after the intervention (see Figure 3). The number of providers who were enrolled in Medicaid and qualified to deliver SUD services has been steadily increasing at the same rate before and after. Overall, we conclude the demonstration is increasing the use of MAT.

Figure 3: Percent of beneficiaries using MAT for SUD



Notes: The numerator is the total number of unduplicated beneficiaries with a service claim for medication-assisted treatment for SUD during the measurement period. The denominator is the 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.

Demonstration Goal 1.3: Ensure sufficient provider capacity at each level of care for OUD/SUD.

Primary Driver: Ensure sufficient provider capacity at each level of care for SUD
Secondary Drivers:

- Require MCOs to update their Specialized Behavioral Health network development and management plan to specifically focus on SUD provider capacity, including MAT.

- Status: Started 1/30/2019
- Details: The MCOs were required to resubmit their 2019 Network Development and Management Plan to include information on MAT providers. The Network Development and Management Plans are due on January 30th each year. The reporting template for the 2020 submission will be revised emphasizing that the MCOs are to "specifically focus on SUD provider capacity," in addition to the MAT access that we previously requested.

Evaluation Hypothesis: The demonstration will improve provider capacity.

The number of providers has been slowly increasing before and after implementation and the ITS analysis indicates that rate of increase has slowed slightly post implementation (slope change -0.393, $p < 0.05$). We conclude that the demonstration is not yet having a positive impact on provider capacity.

Demonstration Goal 2.1: Decrease use of medically inappropriate care and reduce reliance on emergency department and hospital services for OUD/SUD treatment.

Primary Driver: Decrease use of medically inappropriate care and reduce reliance on emergency department and hospital services for SUD treatment.
Secondary Drivers:

- Require MCOs to update their Specialized Behavioral Health network development and management plan to specifically focus on SUD provider capacity, including MAT.
  - Status: Started 1/30/2019
  - Details: The MCOs were required to resubmit their 2019 Network Development and Management Plan to include information on MAT providers. The Network Development and Management Plans are due on January 30th each year. The reporting template for the 2020 submission will be revised emphasizing that the MCOs are to "specifically focus on SUD provider capacity," in addition to the MAT access that we previously requested.

Evaluation Hypothesis: The demonstration will reduce visits to the emergency department and the use of hospital services for the treatment of OUD/SUD.

The ITS analysis shows no change in the number of ED visits per 1,000 beneficiaries. The number of inpatient stays was increasing prior to the intervention and is no longer increasing after the intervention (slope change -0.033, $p < 0.01$) and appears to have leveled off (post-period slope -0.003). These results provide mixed evidence that the demonstration is reducing medically inappropriate care.

Demonstration Goal 2.2: Reduce readmission rates for OUD/SUD treatment.

Primary Driver: Reduce readmission rates for SUD treatment.
Secondary Drivers:

- Require MCOs to update their Specialized Behavioral Health network development and management plan to specifically focus on SUD provider capacity, including MAT.

- Status: Started 1/30/2019
- Details: The MCOs were required to resubmit their 2019 Network Development and Management Plan to include information on MAT providers. The Network Development and Management Plans are due on January 30th each year. The reporting template for the 2020 submission will be revised emphasizing that the MCOs are to "specifically focus on SUD provider capacity," in addition to the MAT access that we previously requested.

Evaluation Hypothesis: The demonstration will reduce hospital readmission rates for OUD/SUD.

ITS analysis indicates that readmissions rates have been slightly increasing before the intervention and that there has been no change post intervention. We conclude that there has been no effect of the demonstration on all-cause readmission rates.

Demonstration Goal 3.1: Increase initiation of follow-up after discharge from the emergency department or hospital for OUD/SUD.

Primary Driver: Increase initiation of follow-up after discharge from the emergency department or hospital for SUD.
Secondary Drivers:

- Continued monitoring of MCO compliance with existing contract requirements related to care transition activities.
  - Status: Started 6/30/2019
  - Details: SUD specific audit tool elements were added to the MCO monitoring tool for the second quarter reviews in 2019. SUD providers are audited using both the general BH elements and the SUD specific elements. These reports are due 30 days after the end of the quarter being reviewed. "Continuity and Coordination of Care" and discharge planning are tracked components under table 3 of the TRR (Treatment Record Review) tab of the 358 Report. The 358 report template is on the LA – Medicaid website. LDH monitors a report generated by the MCOs who are contractually required to ensure continuity of care. The basis of the report is MCO utilization of the updated audit tool which contains SUD level of care specific elements including discharge planning/transfer planning and referrals.

Evaluation Hypothesis: The demonstration will increase initiation of follow-up after discharge from the emergency department or hospital for OUD/SUD.

Quantitatively, we measured this by the percentage of ED visits for beneficiaries aged 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 and within 30 days of the ED visit (Monitoring metric #17). The ITS analysis showed no change in the initiation of follow-up after discharge. Our qualitative analysis of care coordination has not indicated any differences in care coordination among in-patient facilities. We conclude that the demonstration has not yet had an impact on the rates of follow-up after discharge from the ED or inpatient settings.

Demonstration Goal 3.2: Increase adherence to and retention in treatment.

Primary Driver: Increase adherence to and retention in treatment.
Secondary Drivers:

- Continued monitoring of MCO compliance with existing contract requirements related to care transition activities.
    - Status: Started 6/30/2019
    - Details: SUD specific audit tool elements were added to the MCO monitoring tool for the second quarter reviews in 2019. SUD providers are audited using both the general BH elements and the SUD specific elements. These reports are due 30 days after the end of the quarter being reviewed. "Continuity and Coordination of Care" and discharge planning are tracked components under table 3 of the TRR (Treatment Record Review) tab of the 358 Report. The 358 report template is on the LA – Medicaid website. LDH monitors a report generated by the MCOs who are contractually required to ensure continuity of care. The basis of the report is MCO utilization of the updated audit tool which contains SUD level of care specific elements including discharge planning/transfer planning and referrals.

Evaluation Hypothesis: The demonstration will increase adherence to and retention in treatment.

Goal 3.2 is more complex than most of the other goals. It consists of two measures—one for initiation and one for engagement—for four different cohorts:

1. Alcohol abuse or dependence
2. Opioid abuse or dependence
3. Other drug abuse or dependence
4. Total AOD abuse or dependence

Overall results indicate there has been no increase in adherence to or retention in treatment across all four cohorts.

Demonstration Goal 4.1: Reduce instances of drug overdose and overdose deaths.

Primary Driver: Reduce instances of drug overdose and overdose deaths.
Secondary Drivers:

- Increased availability of Naloxone.
    - Status: Ongoing
    - Details: The secretary of LDH signed a standing order for dispensing Naloxone without a prescription on 1/23/2017. In addition to the standing order, there are grants in place funding distribution of naloxone. These grants include MAT-PDOA, STR, and LASOR.

Evaluation Hypothesis: The demonstration will decrease the rate of drug overdose and the number of drug deaths

Both descriptive and ITS analysis indicate there has been no change in the number of drug overdoses.

Interpretations, and Policy Implications and Interactions with Other State Initiatives

Overall, we conclude that the demonstration is having a small but positive impact on the treatment of beneficiaries in ways consistent with evidence-based care. Metric 6 includes all telehealth services, so this measure combines both telehealth and non-telehealth services. Services provided by telehealth substantially increased in all areas in response to the Covid pandemic, so it is likely that this measure reflects that increase at least in part. Even so, the results here suggest a rapid adaptation to the conversion to telehealth services that may have been aided by the waiver.

The demonstration has clearly increased the access to and utilization of MAT in Louisiana. These results are substantial and consistent across the demonstration whether we look at the number of Medicaid providers and beneficiaries or the share of beneficiaries with an MAT claim. Further, these results are unlikely to have been substantially impacted by the Covid 19 pandemic. Perhaps not surprisingly, the increase in access to and utilization of MAT has also caused an increase in total costs of the demonstration.

Our analysis of provider capacity suggests that while there has been a slow steady increase before and after the start of the demonstration, there has not been a change in the rate of increase before and after the demonstration began. This suggest that the demonstration has yet to impact provider capacity. However, we have two caveats to this interpretation. First, the implementation of the intervention to require MCOs to update their development and management plans to focus on provider capacity began in January of 2019. This may not be sufficient time to observe significant impacts from this intervention, in part because we do not know how long it took the MCOs to update and implement these plans. Second, we have no way to evaluate the potential impact of Covid 19 on provider capacity.

Demonstration Goal 2.1 is to *"decrease use of medically inappropriate care and reduce reliance on emergency department and hospital services for OUD/SUD treatment."* The metrics we used to evaluate this goal were the number of ED visit for SUD (Metric #23) and the number of inpatient visits for SUD (Metric #24). In contrast to Goal 2.1, the evaluation hypothesis is that *"the demonstration will reduce visits to the emergency department and the use of hospital services for the treatment of OUD/SUD."* Our results are mixed in that we found that inpatient stays were no longer increasing as they were prior to the demonstration, but that there has been no change in ED visits. What we can say is that the number of ED visits and inpatient stays are not increasing. We consider this a positive result, even though we are not able to conclusively attribute this result to the demonstration alone. One other caveat to our findings here is that the metrics we used do not directly measure "medically inappropriate care." The underlying implication of the goal is that some portion of care provided in the ED and hospital is not medically necessary, and therefore we would expect to see reductions in these metrics. This issue is most problematic with inpatient stays because SUD beneficiaries are included if there is an SUD diagnosis in any position in the data (i.e., it could be the primary diagnosis, or it could be a secondary or later diagnosis that was not the cause of the specific admission).

Our findings suggest that there has not been an impact on all cause 30-day readmission rates for SUD treatment. This metric has substantial limitations, particularly in the identification of the denominator, that is the number of SUD hospital stays. This is the same limitation described in the preceding paragraph, that is that an inpatient stay with an SUD diagnosis at any position (primary or otherwise) is included. A more general concern with this metric is the "all-cause" nature of the measure. That is any beneficiary that was admitted to the hospital with an SUD diagnosis is included in the number of beneficiaries readmitted regardless of the reason for the readmission.

We conducted both quantitative and qualitative analyses of care coordination and found no effect of the demonstration to this point. The qualitative results provide some context for this finding, but sample sizes are small, and we continue to have difficulty recruiting participants for our qualitative data collection, so we are cautious in our interpretation of the qualitative findings. The quantitative analyses show there has not been a change in the initiation of follow-up after a beneficiary is discharged from the hospital. Once again, we are unable to disentangle any impact COBID-19 and the shift to telehealth may have on these results.

Our evaluation of adherence to and retention in treatment is more complex than many other goals of the demonstration and includes measures of treatment initiation and engagement for four different cohorts. To this point in the demonstration, we do not see any change in these measures. Once again, we must add the caveat that we cannot account for the possible impact of Covid 19 on these results. The Medicaid program saw substantial increases in beneficiaries over the course of the pandemic, and we have no way to account for the prior level of treatment for these beneficiaries and what impact they may have had on the results.

To this point in the demonstration there has not been a reduction in overdoses in Louisiana. Again, we are cautious in interpreting this result in light of the Covid 19 pandemic. Further, drivers intended to impact overdoses such as MAT will require time to impact these numbers, and there are delays in reporting these numbers, both of which make it likely there will be a substantial lag between the intervention of the drivers and the ability to observe their impact.

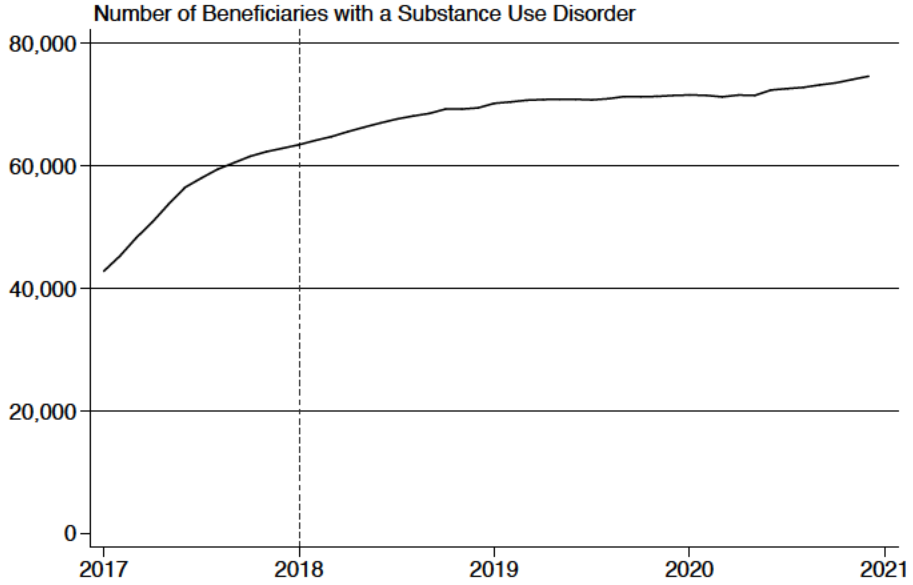
Lessons Learned and Recommendations

The ability to continue OUD/SUD treatment in IMDs in Louisiana, through this Demonstration, appears to have resulted in small but important ways that are consistent with evidence-based care. Other states may see a similar result.

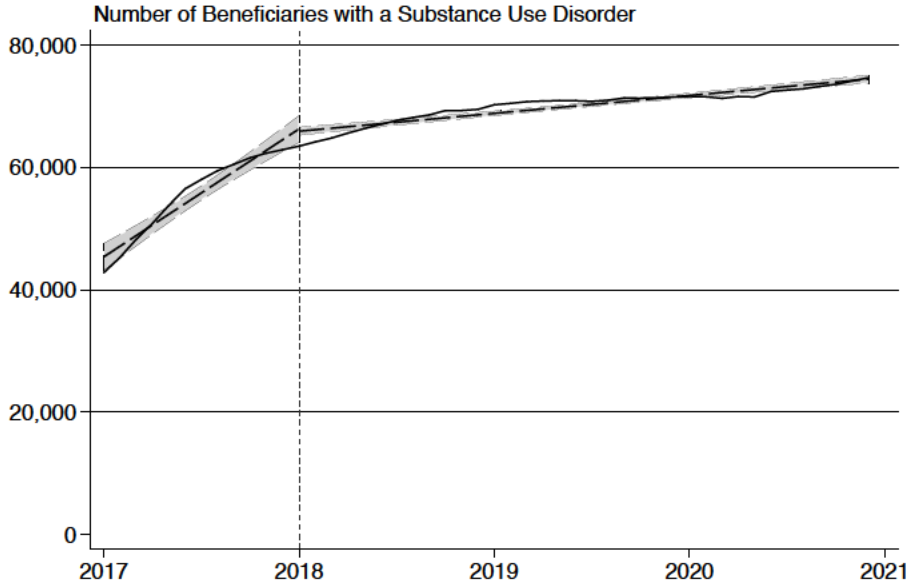
The Demonstration is effectively using education of abstinence-based residential providers on the benefits of MAT and encouraging physicians and other qualified providers to become certified dispensers to increase the use of MAT. These approaches should be easily transferred to other states and clearly have the potential to achieve similar results.

Attachment 1 (Detailed Results)

Evaluation Demonstration Goal 0.0
Monitoring Metric: #3, Count of Medicaid Beneficiaries with an SUD
Description: Medicaid Beneficiaries with SUD Diagnosis (monthly)
Primary Driver: N/A
Secondary Driver: N/A



Notes: 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 OUD/SUD diagnosis code as the primary diagnosis. Intervention date was assigned to the first quarter of the demonstration period.



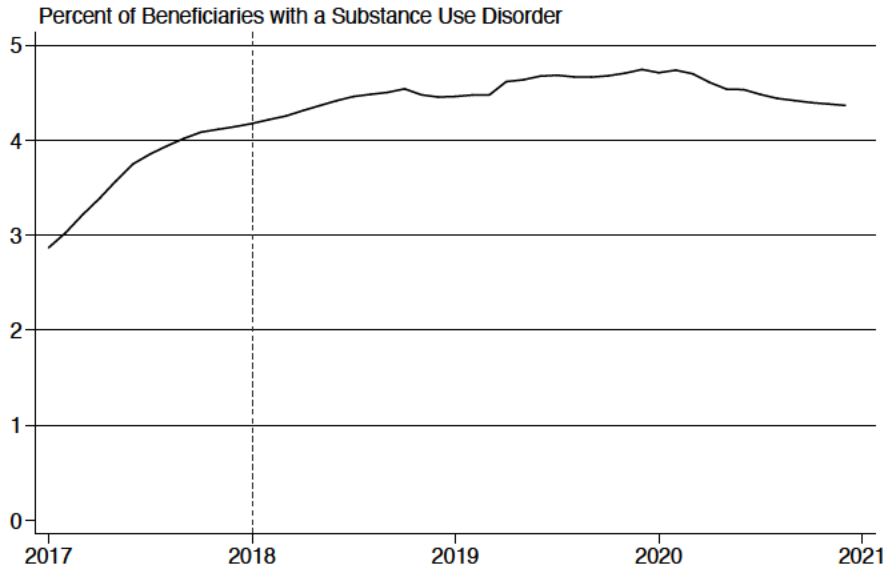
Notes: Number of unduplicated Medicaid beneficiaries enrolled in a reporting month/year with a paid/accepted claim for date of service in reporting month/year that uses an OUD/SUD diagnosis code as the primary diagnosis. Intervention date was assigned to the first quarter of the demonstration period.

ITS Estimates

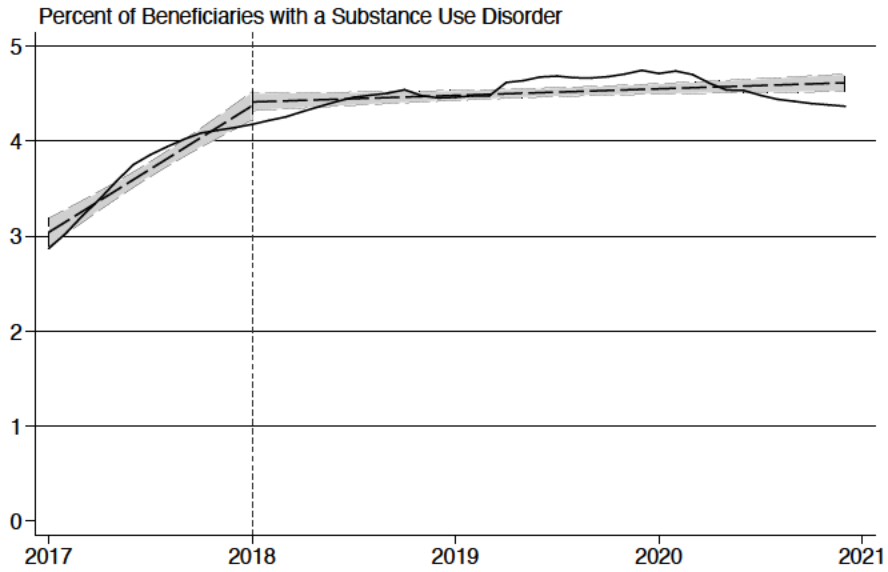
Pre-Period Slope	1867.63*** (188.32) [1488.11, 2247.16]
Level Change	-1420.97 (1347.09) [-4135.84, 1293.91]
Post-Period Slope	243.28*** (31.16) [180.47, 306.08]
Slope Change	-1624.36*** (200.41) [-2028.26, -1220.45]
Pre-Period Mean	55151.25
Pre-Period Min	42763
Pre-Period Max	62847
Post-Period Mean	70127.22
Post-Period Min	63424
Post-Period Max	74610
Observations	48

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

Evaluation Demonstration Goal 0.0 (supplement)
Monitoring Metric: N/A
Description: Percent of Medicaid Beneficiaries with SUD Diagnosis (monthly)
Primary Driver: N/A
Secondary Driver: N/A



Notes: The numerator is the 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 OUD/SUD diagnosis code as the primary diagnosis. 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.



Notes: The numerator is the 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 OUD/SUD diagnosis code as the

primary diagnosis. 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.

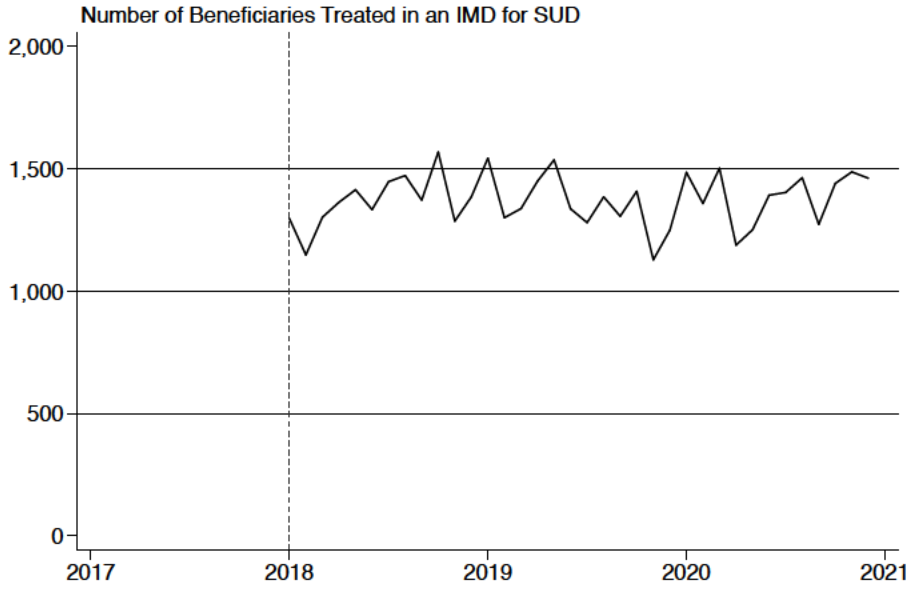
ITS Estimates

Pre-Period Slope	0.120*** (0.013) [0.094, 0.146]
Level Change	-0.033 (0.102) [-0.239, 0.174]
Post-Period Slope	0.006 (0.005) [-0.004, 0.015]
Slope Change	-0.114*** (0.015) [-0.143, -0.085]
Pre-Period Mean	3.67
Pre-Period Min	2.87
Pre-Period Max	4.14
Post-Period Mean	4.51
Post-Period Min	4.18
Post-Period Max	4.74
Observations	48

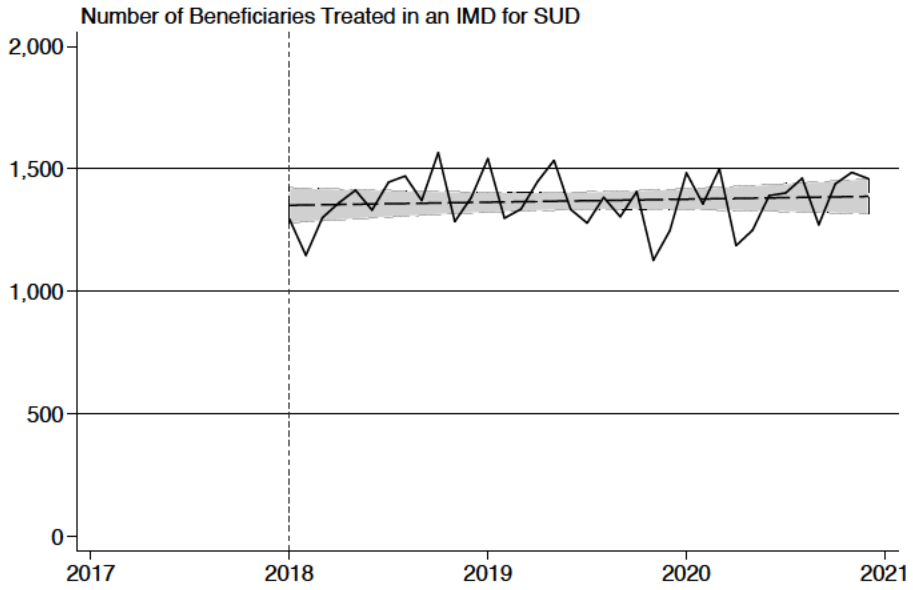
Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets. *p<0.10, **p<0.05, ***p<0.01

Evaluation Demonstration Goal 1.1
Monitoring Metric: #5, Medicaid Beneficiaries Treated in an IMD for SUD
Description: 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.
Primary Driver: Increase access to evidence-based OUD/SUD care
Secondary Drivers:

- Maintaining the status quo for OUD/SUD treatment in IMDs
    - Status: Ongoing
    - Details: Treating SUD in IMDs was occurring before the SUD Demonstration with "in lieu of services" provided by the MCOs, and has continued through the start date of February 1, 2018 for approval of the SUD 1115 Demonstration waiver. Maintaining the status quo for SUD treatment in IMDs is ongoing as maintaining the status quo is the intention of the 1115 waiver.
- Extended coverage to ASAM Level 1-WM: Ambulatory Withdrawal Management without Extended Onsite Monitoring
    - Status: Not started
    - Details: ASAM 1-WM is not currently a Medicaid covered service and is dependent upon future funding via Louisiana legislative budget approval.



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.



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.

ITS Estimates

Pre-Period Slope	N/A
Level Change	N/A
Post-Period Slope	N/A
Slope Change	N/A
Pre-Period Mean	N/A
Pre-Period Min	N/A
Pre-Period Max	N/A
Post-Period Mean	1369.75
Post-Period Min	1127
Post-Period Max	1567
Observations	36

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

Evaluation Demonstration Goal 1.1

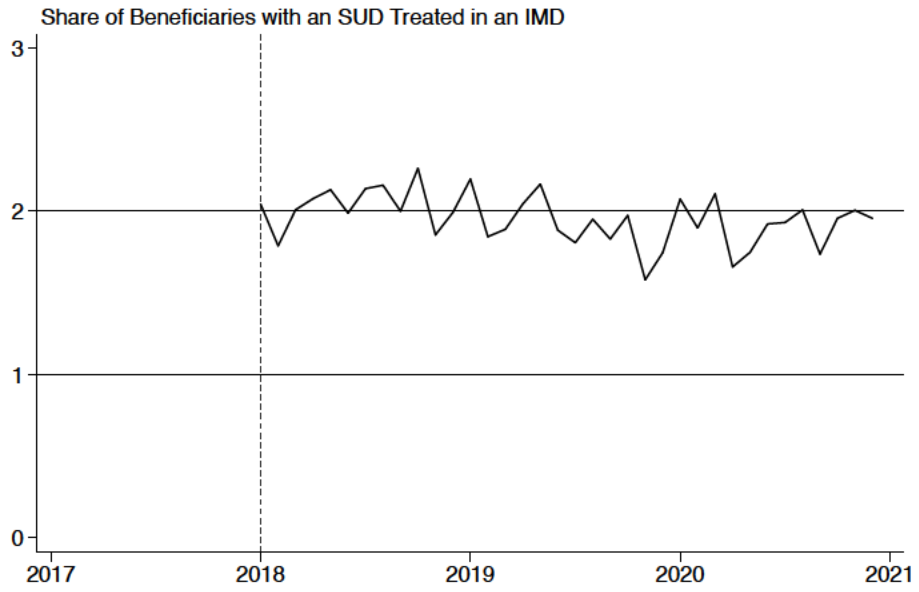
Monitoring Metric: *N/A*

Description: Percent of unduplicated Medicaid Beneficiaries with an SUD 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.

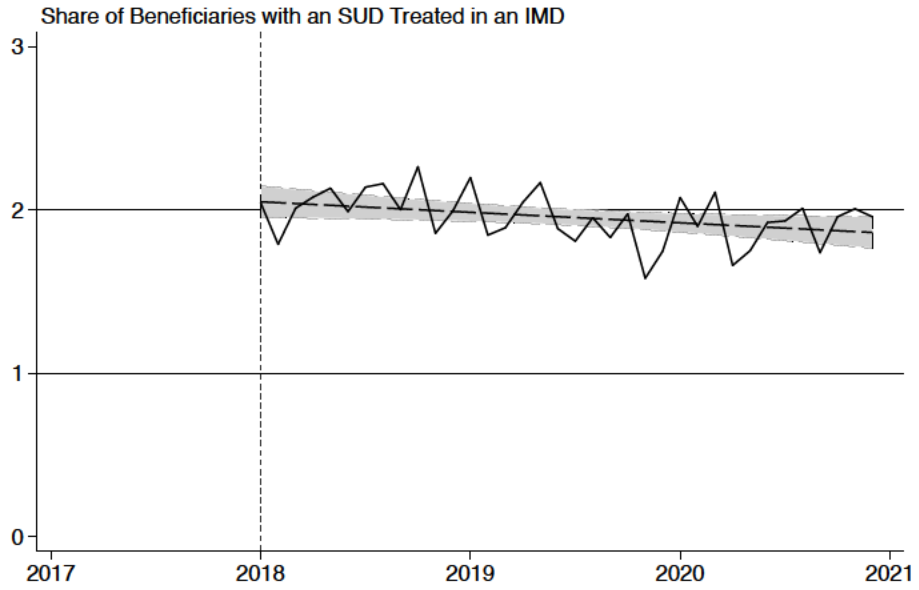
Primary Driver: Increase access to evidence-based OUD/SUD care

Secondary Drivers:

- Maintaining the status quo for OUD/SUD treatment in IMDs
    - Status: Ongoing
    - Details: Treating SUD in IMDs was occurring before the SUD Demonstration with "in lieu of services" provided by the MCOs, and has continued through the start date of February 1, 2018 for approval of the SUD 1115 Demonstration waiver. Maintaining the status quo for SUD treatment in IMDs is ongoing as maintaining the status quo is the intention of the 1115 waiver.
- Extended coverage to ASAM Level 1-WM: Ambulatory Withdrawal Management without Extended Onsite Monitoring
    - Status: Not started
    - Details: ASAM 1-WM is not currently a Medicaid covered service and is dependent upon future funding via Louisiana legislative budget approval.



Notes: The numerator is the 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. The denominator is the 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.



Notes: The numerator is the 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. The denominator is the 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.

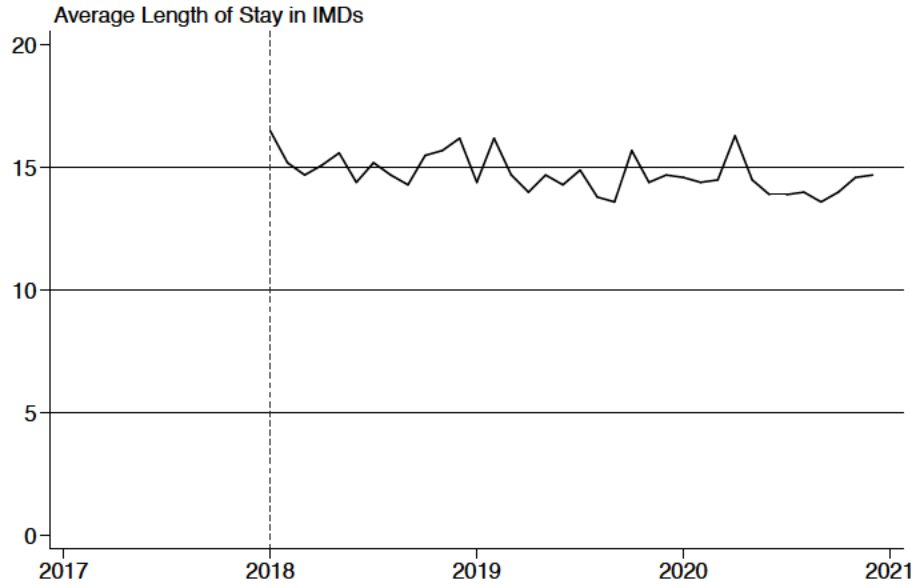
ITS Estimates

Pre-Period Slope	N/A
Level Change	N/A
Post-Period Slope	N/A
Slope Change	N/A
Pre-Period Mean	N/A
Pre-Period Min	N/A
Pre-Period Max	N/A
Post-Period Mean	1.95
Post-Period Min	1.58
Post-Period Max	2.26
Observations	36

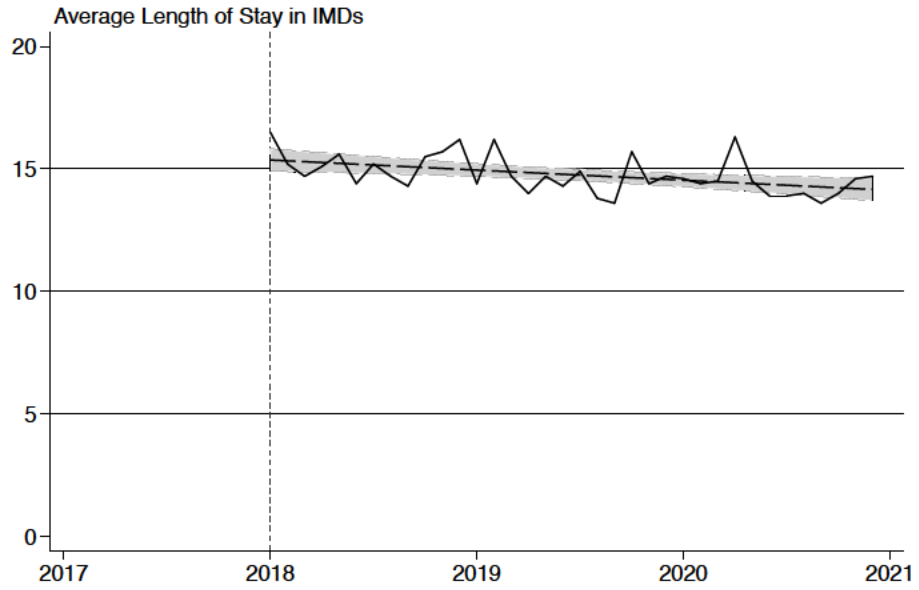
Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets. *p<0.10, **p<0.05, ***p<0.01

Evaluation Demonstration Goal 1.1
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
Primary Driver: Increase access to evidence-based OUD/SUD care
Secondary Drivers:

- Maintaining the status quo for OUD/SUD treatment in IMDs
    - Status: Ongoing
    - Details: Treating SUD in IMDs was occurring before the SUD Demonstration with "in lieu of services" provided by the MCOs, and has continued through the start date of February 1, 2018 for approval of the SUD 1115 Demonstration waiver. Maintaining the status quo for SUD treatment in IMDs is ongoing as maintaining the status quo is the intention of the 1115 waiver.
- Extended coverage to ASAM Level 1-WM: Ambulatory Withdrawal Management without Extended Onsite Monitoring
    - Status: Not started
    - Details: ASAM 1-WM is not currently a Medicaid covered service and is dependent upon future funding via Louisiana legislative budget approval.



Notes: Average length of stay for Medicaid beneficiaries with SUD treated in an IMD.



Notes: Average length of stay for Medicaid beneficiaries with SUD treated in an IMD.

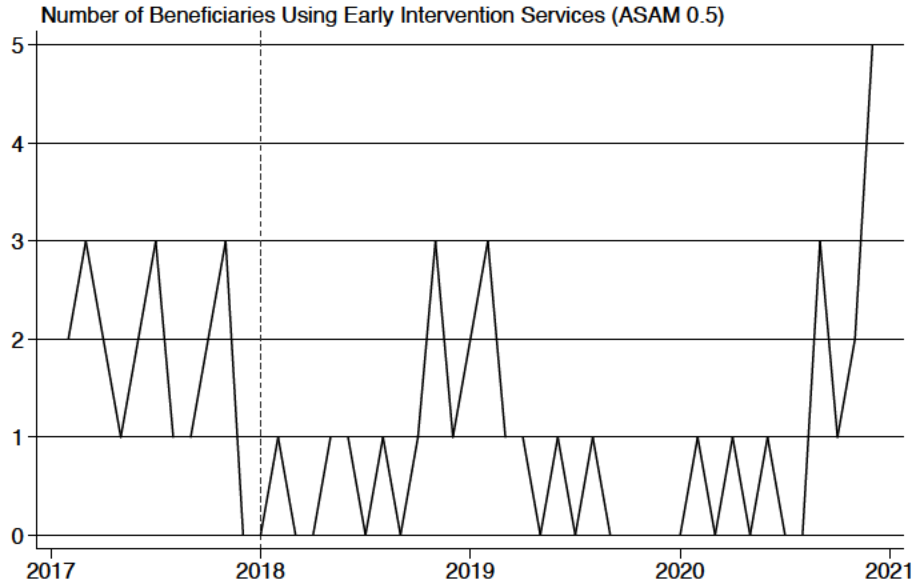
ITS Estimates

Pre-Period Slope	N/A
Level Change	N/A
Post-Period Slope	N/A
Slope Change	N/A
Pre-Period Mean	N/A
Pre-Period Min	N/A
Pre-Period Max	N/A
Post-Period Mean	14.76
Post-Period Min	13.6
Post-Period Max	16.5
Observations	36

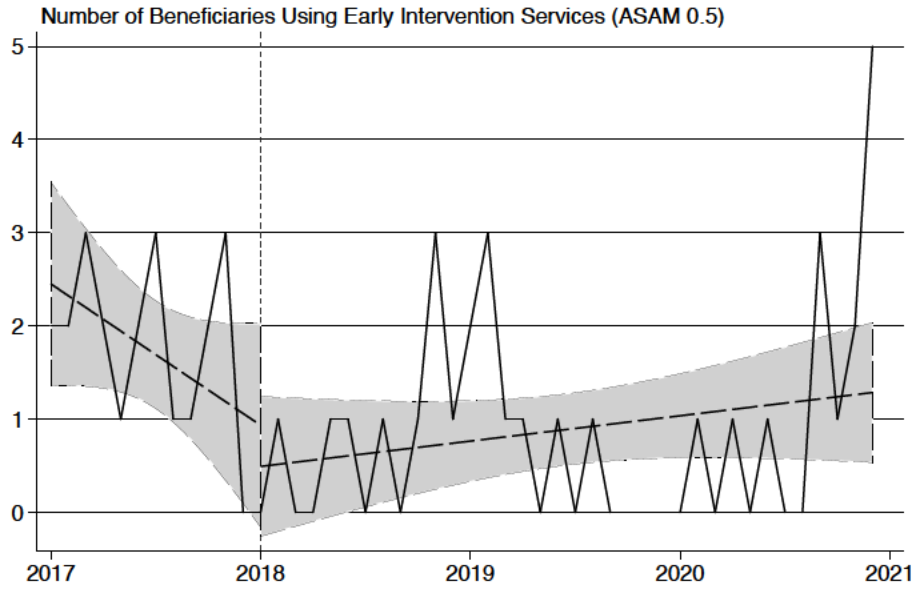
Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets. *p<0.10, **p<0.05, ***p<0.01

Evaluation Demonstration Goal 1.1
Monitoring Metric: #7, Early Intervention (ASAM 0.5)
Description: Number of beneficiaries who used early intervention services (such as procedure codes associated with SBIRT) during the measurement period.
Primary Driver: Increase access to evidence-based OUD/SUD care
Secondary Drivers:

- Maintaining the status quo for OUD/SUD treatment in IMDs
    - Status: Ongoing
    - Details: Treating SUD in IMDs was occurring before the SUD Demonstration with "in lieu of services" provided by the MCOs, and has continued through the start date of February 1, 2018 for approval of the SUD 1115 Demonstration waiver. Maintaining the status quo for SUD treatment in IMDs is ongoing as maintaining the status quo is the intention of the 1115 waiver.
- Extended coverage to ASAM Level 1-WM: Ambulatory Withdrawal Management without Extended Onsite Monitoring
    - Status: Not started
    - Details: ASAM 1-WM is not currently a Medicaid covered service and is dependent upon future funding via Louisiana legislative budget approval.



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



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

ITS Estimates

Pre-Period Slope	-0.084** (0.039) [-0.163, -0.005]
Level Change	-0.795 (0.488) [-1.779, 0.188]
Post-Period Slope	0.023 (0.025) [-0.028, 0.074]
Slope Change	0.107** (0.047) [0.011, 0.202]
Pre-Period Mean	1.83
Pre-Period Min	0
Pre-Period Max	3
Post-Period Mean	0.889
Post-Period Min	0
Post-Period Max	5
Observations	48

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

Evaluation Demonstration Goal 1.1

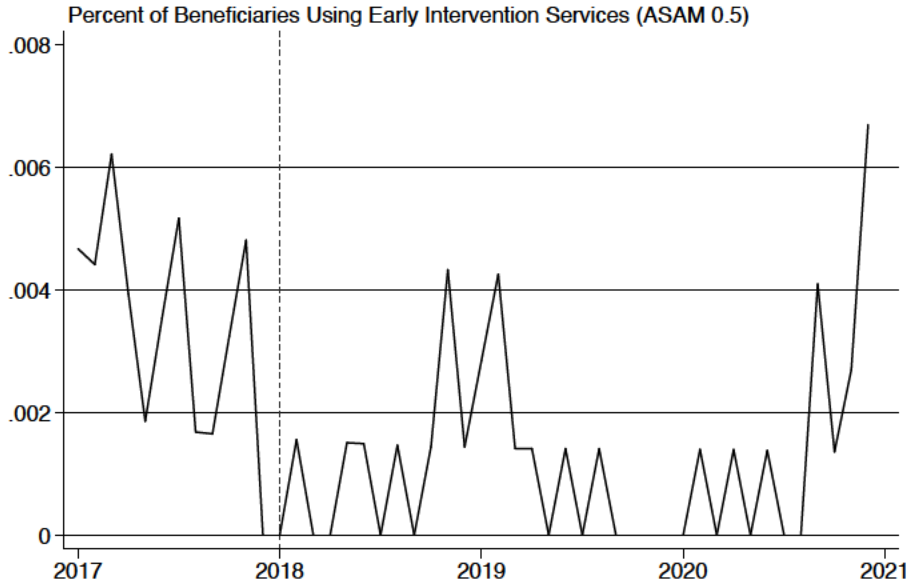
Monitoring Metric: N/A

Description: Percent of beneficiaries who used early intervention services (such as procedure codes associated with SBIRT) during the measurement period.

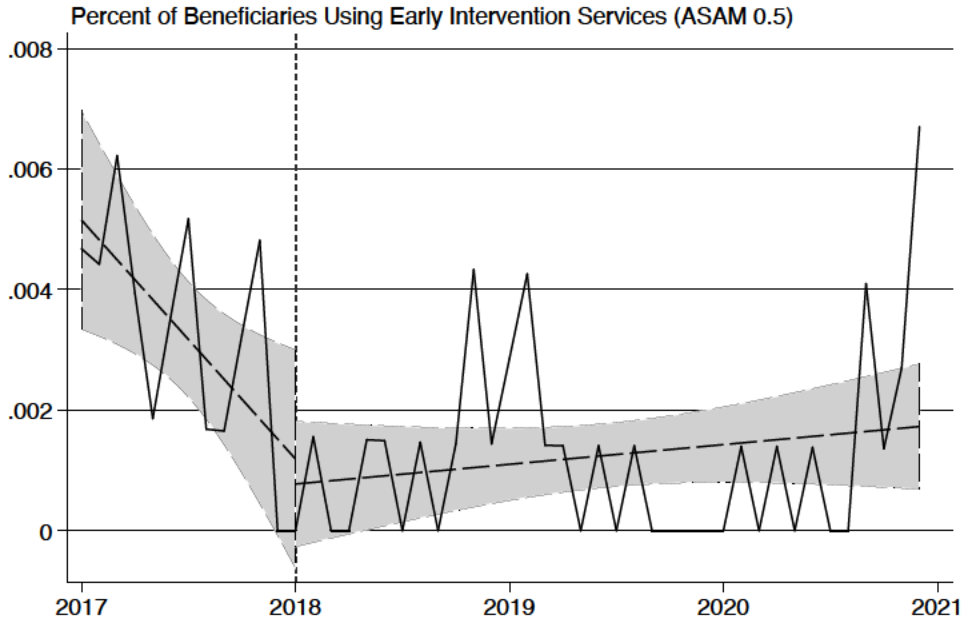
Primary Driver: Increase access to evidence-based OUD/SUD care

Secondary Drivers:

- Maintaining the status quo for OUD/SUD treatment in IMDs
  - Status: Ongoing
  - Details: Treating SUD in IMDs was occurring before the SUD Demonstration with "in lieu of services" provided by the MCOs, and has continued through the start date of February 1, 2018 for approval of the SUD 1115 Demonstration waiver. Maintaining the status quo for SUD treatment in IMDs is ongoing as maintaining the status quo is the intention of the 1115 waiver.
- Extended coverage to ASAM Level 1-WM: Ambulatory Withdrawal Management without Extended Onsite Monitoring
  - Status: Not started
  - Details: ASAM 1-WM is not currently a Medicaid covered service and is dependent upon future funding via Louisiana legislative budget approval.



Notes: The numerator is the total number of unduplicated beneficiaries with a service claim for early intervention services (such as procedure codes associated with SBIRT) during the measurement period. The denominator is the 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.



Notes: The numerator is the total number of unduplicated beneficiaries with a service claim for early intervention services (such as procedure codes associated with SBIRT) during the measurement period. The denominator is the 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.

ITS Estimates

Pre-Period Slope	-0.0003*** (0.0001) [-0.0004, -0.0001]
Level Change	-0.0009 (0.0007) [-0.0023, 0.0006]
Post-Period Slope	0.0000 (0.0000) [-0.0000, 0.0001]
Slope Change	0.0003*** (0.0001) [0.0002, 0.0005]
Pre-Period Mean	0.003
Pre-Period Min	0
Pre-Period Max	0.006
Post-Period Mean	0.001
Post-Period Min	0
Post-Period Max	0.007
Observations	48

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

Evaluation Demonstration Goal 1.1

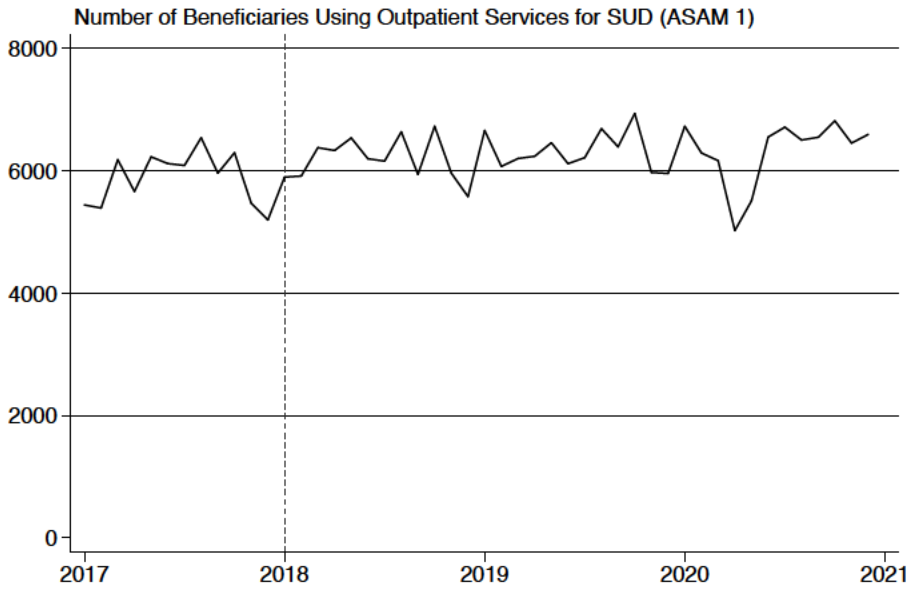
Monitoring Metric: #8, Outpatient Services (ASAM 1)

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.

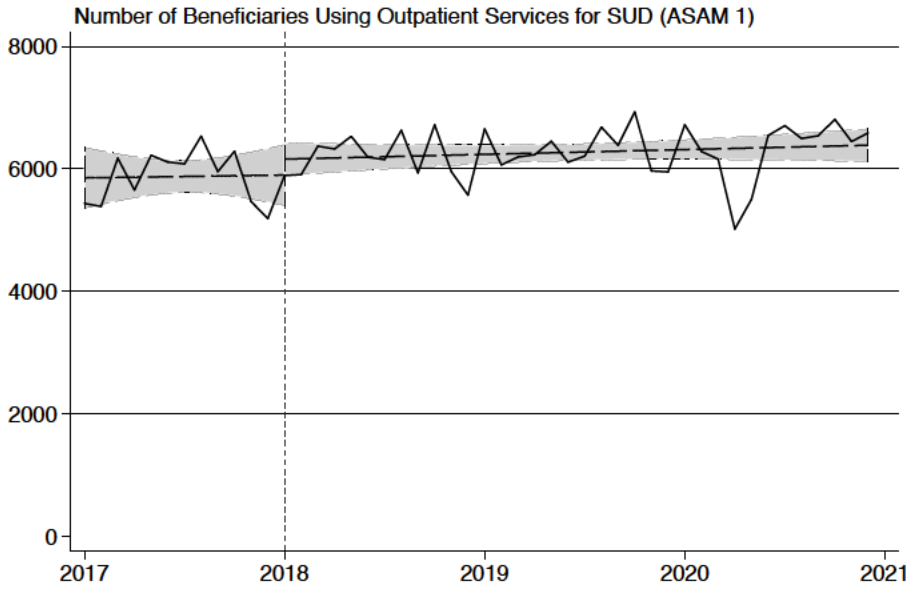
Primary Driver: Increase access to evidence-based OUD/SUD care

Secondary Drivers:

- Maintaining the status quo for OUD/SUD treatment in IMDs
  - Status: Ongoing
  - Details: Treating SUD in IMDs was occurring before the SUD Demonstration with "in lieu of services" provided by the MCOs, and has continued through the start date of February 1, 2018 for approval of the SUD 1115 Demonstration waiver. Maintaining the status quo for SUD treatment in IMDs is ongoing as maintaining the status quo is the intention of the 1115 waiver.
- Extended coverage to ASAM Level 1-WM: Ambulatory Withdrawal Management without Extended Onsite Monitoring
  - Status: Not started
  - Details: ASAM 1-WM is not currently a Medicaid covered service and is dependent upon future funding via Louisiana legislative budget approval.



Notes: The total number of unduplicated beneficiaries with a service claim for outpatient services for SUD (such as outpatient recovery or motivational enhancement therapies, step down care, and monitoring for stable patients) during the measurement period.



Notes: The total number of unduplicated beneficiaries with a service claim for outpatient services for SUD (such as outpatient recovery or motivational enhancement therapies, step down care, and monitoring for stable patients) during the measurement period.

ITS Estimates

Pre-Period Slope	4.19 (44.46) [-85.41, 93.79]
Level Change	257.10 (341.30) [-430.75, 944.95]
Post-Period Slope	6.48 (6.96) [-7.54, 20.51]
Slope Change	2.29 (46.03) [-90.48, 95.07]
Pre-Period Mean	5875.75
Pre-Period Min	5191
Pre-Period Max	6534
Post-Period Mean	6273.58
Post-Period Min	5018
Post-Period Max	6931
Observations	48

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

Evaluation Demonstration Goal 1.1

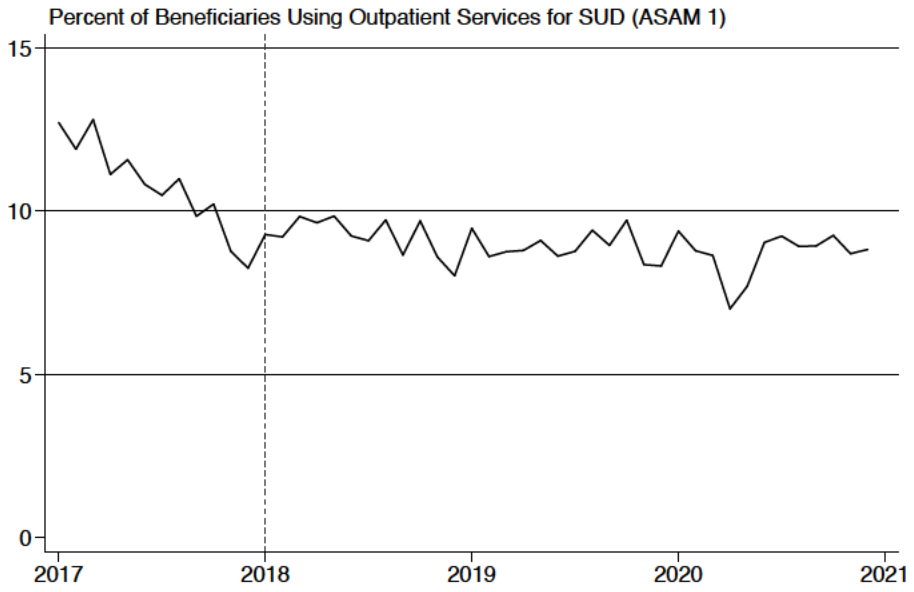
Monitoring Metric: N/A

Description: Percent 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.

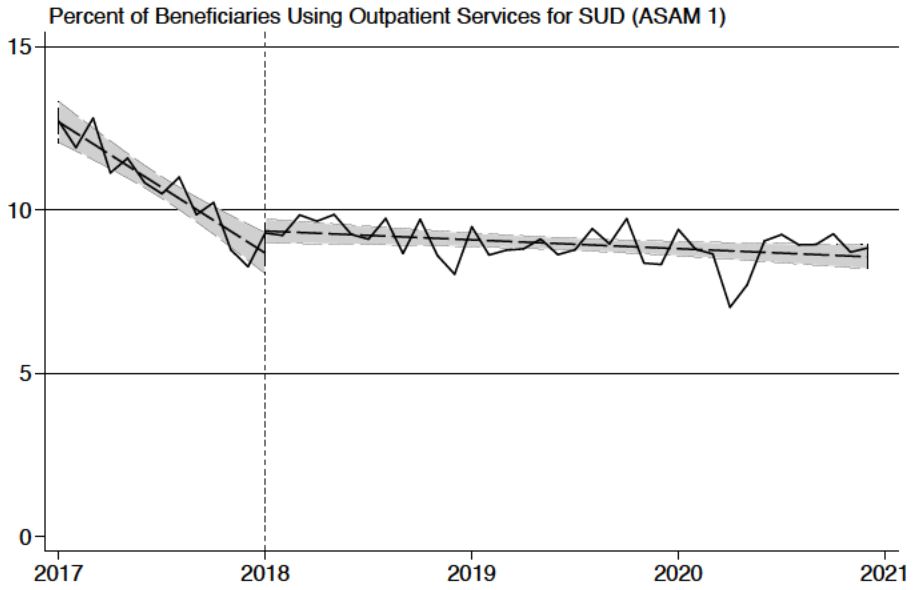
Primary Driver: Increase access to evidence-based OUD/SUD care

Secondary Drivers:

- Maintaining the status quo for OUD/SUD treatment in IMDs
  - Status: Ongoing
  - Details: Treating SUD in IMDs was occurring before the SUD Demonstration with "in lieu of services" provided by the MCOs, and has continued through the start date of February 1, 2018 for approval of the SUD 1115 Demonstration waiver. Maintaining the status quo for SUD treatment in IMDs is ongoing as maintaining the status quo is the intention of the 1115 waiver.
- Extended coverage to ASAM Level 1-WM: Ambulatory Withdrawal Management without Extended Onsite Monitoring
  - Status: Not started
  - Details: ASAM 1-WM is not currently a Medicaid covered service and is dependent upon future funding via Louisiana legislative budget approval.



Notes: The numerator is the total number of unduplicated beneficiaries with a service claim for outpatient services for SUD (such as outpatient recovery or motivational enhancement therapies, step down care, and monitoring for stable patients) during the measurement period. The denominator is the 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.



Notes: The numerator is the total number of unduplicated beneficiaries with a service claim for outpatient services for SUD (such as outpatient recovery or motivational enhancement therapies, step down care, and monitoring for stable patients) during the measurement period. The denominator is the 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.

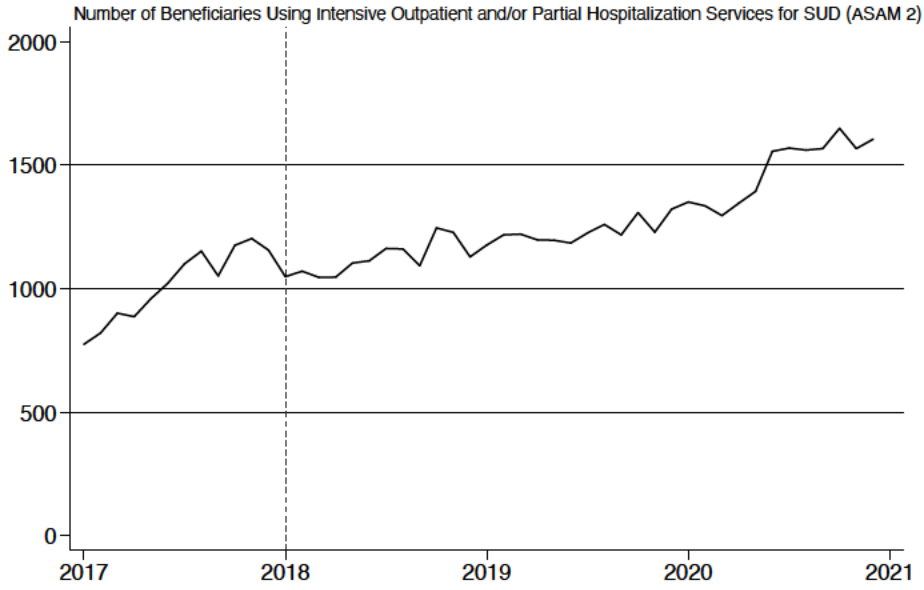
ITS Estimates

Pre-Period Slope	-0.363*** (0.031) [-0.425, -0.300]
Level Change	0.912*** (0.320) [0.267, 1.557]
Post-Period Slope	-0.023** (0.010) [-0.043, -0.002]
Slope Change	0.340*** (0.033) [0.274, 0.406]
Pre-Period Mean	10.80
Pre-Period Min	8.26
Pre-Period Max	12.81
Post-Period Mean	8.95
Post-Period Min	7.01
Post-Period Max	9.85
Observations	48

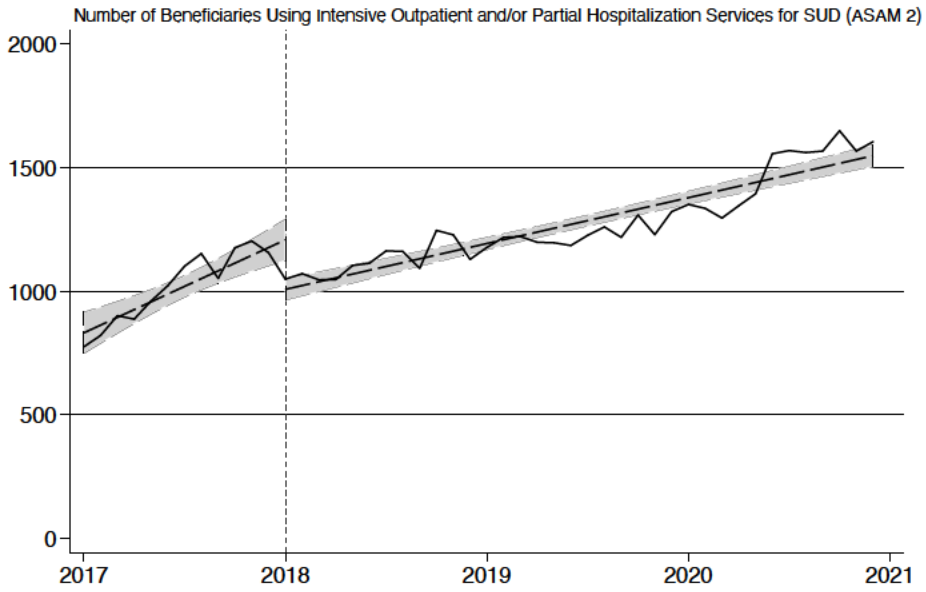
Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets. *p<0.10, **p<0.05, ***p<0.01

Evaluation Demonstration Goal 1.1
Monitoring Metric: #9, Intensive Outpatient and Partial Hospitalization (ASAM 2)
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.
Primary Driver: Increase access to evidence-based OUD/SUD care
Secondary Drivers:

- Maintaining the status quo for OUD/SUD treatment in IMDs
    - Status: Ongoing
    - Details: Treating SUD in IMDs was occurring before the SUD Demonstration with "in lieu of services" provided by the MCOs, and has continued through the start date of February 1, 2018 for approval of the SUD 1115 Demonstration waiver. Maintaining the status quo for SUD treatment in IMDs is ongoing as maintaining the status quo is the intention of the 1115 waiver.
- Extended coverage to ASAM Level 1-WM: Ambulatory Withdrawal Management without Extended Onsite Monitoring
    - Status: Not started
    - Details: ASAM 1-WM is not currently a Medicaid covered service and is dependent upon future funding via Louisiana legislative budget approval.



Notes: The total number of unduplicated beneficiaries with a service claim for intensive outpatient and/or partial hospitalization services for SUD (such as specialized outpatient SUD therapy or other clinical services) during the measurement period.



Notes: The total number of unduplicated beneficiaries with a service claim for intensive outpatient and/or partial hospitalization services for SUD (such as specialized outpatient SUD therapy or other clinical services) during the measurement period.

ITS Estimates

Pre-Period Slope	38.58*** (3.28) [31.96, 45.20]
Level Change	-260.45*** (40.91) [-342.89, -178.01]
Post-Period Slope	15.45*** (1.70) [12.03, 18.87]
Slope Change	-23.13*** (3.51) [-30.20, -16.06]
Pre-Period Mean	1017.17
Pre-Period Min	775
Pre-Period Max	1203
Post-Period Mean	1277.89
Post-Period Min	1046
Post-Period Max	1649
Observations	48

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

Evaluation Demonstration Goal 1.1

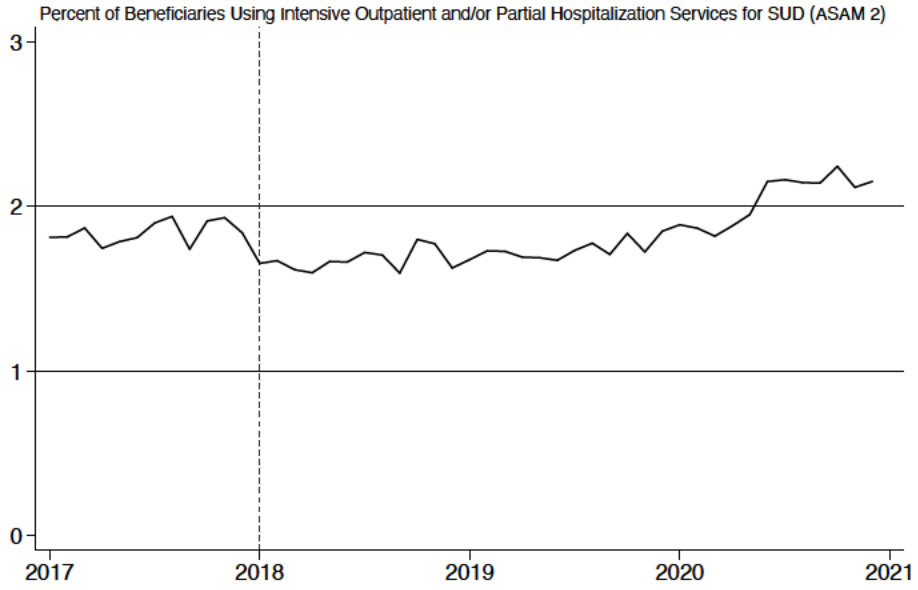
Monitoring Metric: N/A

Description: Percent 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.

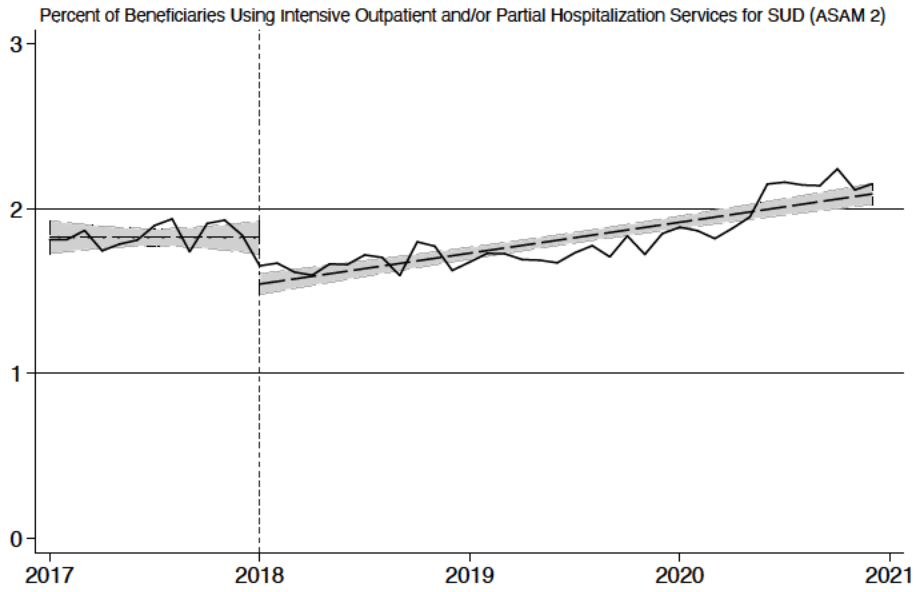
Primary Driver: Increase access to evidence-based OUD/SUD care

Secondary Drivers:

- Maintaining the status quo for OUD/SUD treatment in IMDs
  - Status: Ongoing
  - Details: Treating SUD in IMDs was occurring before the SUD Demonstration with "in lieu of services" provided by the MCOs, and has continued through the start date of February 1, 2018 for approval of the SUD 1115 Demonstration waiver. Maintaining the status quo for SUD treatment in IMDs is ongoing as maintaining the status quo is the intention of the 1115 waiver.
- Extended coverage to ASAM Level 1-WM: Ambulatory Withdrawal Management without Extended Onsite Monitoring
  - Status: Not started
  - Details: ASAM 1-WM is not currently a Medicaid covered service and is dependent upon future funding via Louisiana legislative budget approval.



Notes: The numerator is the total number of unduplicated beneficiaries with a service claim for intensive outpatient and/or partial hospitalization services for SUD (such as specialized outpatient SUD therapy or other clinical services) during the measurement period. The denominator is the 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.



Notes: The numerator is the total number of unduplicated beneficiaries with a service claim for intensive outpatient and/or partial hospitalization services for SUD (such as specialized outpatient SUD therapy or other clinical services) during the measurement period. The denominator is the 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.

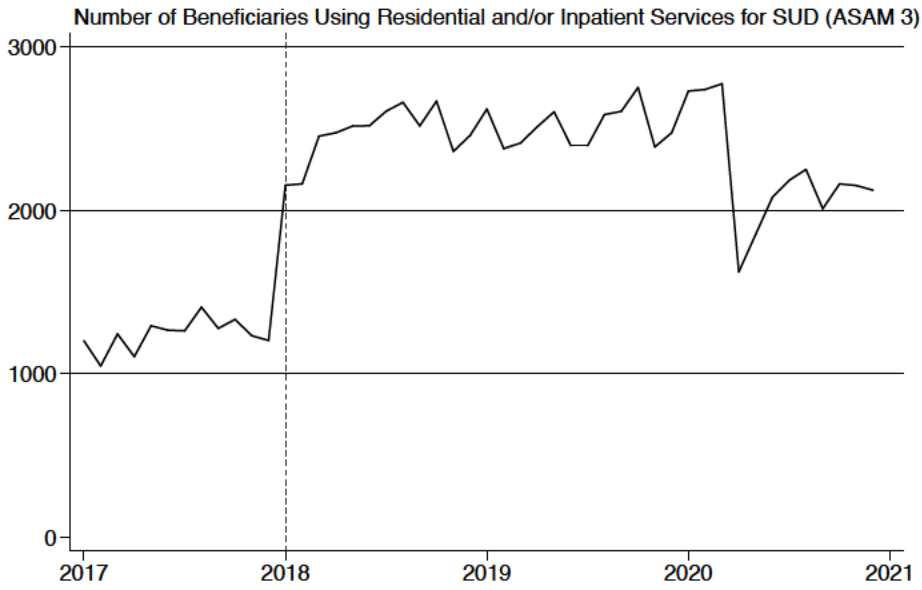
ITS Estimates

Pre-Period Slope	0.008*** (0.002) [0.003, 0.012]
Level Change	-0.347*** (0.047) [-0.441, -0.253]
Post-Period Slope	0.016*** (0.003) [0.010, 0.021]
Slope Change	0.008** (0.003) [0.001, 0.015]
Pre-Period Mean	1.84
Pre-Period Min	1.74
Pre-Period Max	1.94
Post-Period Mean	1.82
Post-Period Min	1.60
Post-Period Max	2.24
Observations	48

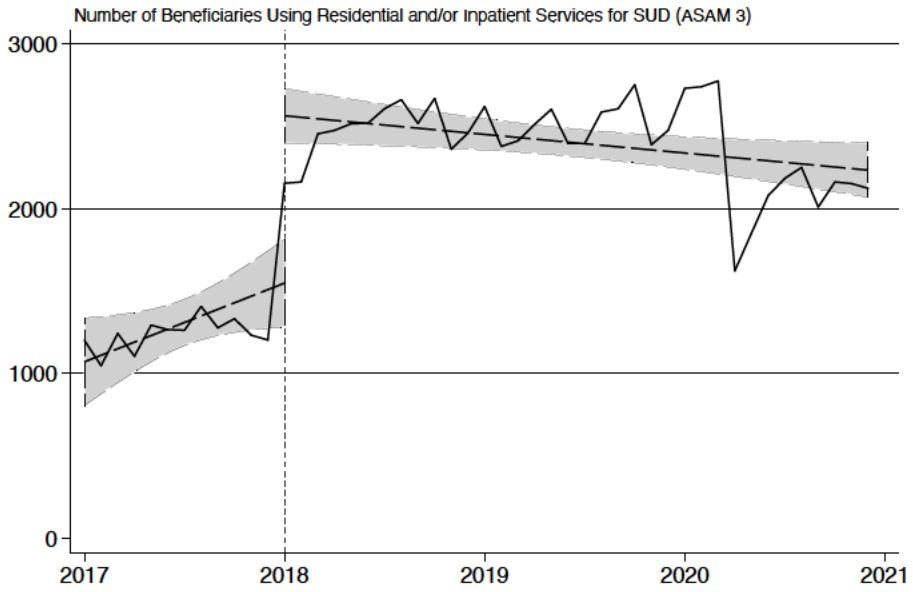
Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets. *p<0.10, **p<0.05, ***p<0.01

Evaluation Demonstration Goal 1.1
Monitoring Metric: #10, Residential and Inpatient Services (ASAM 3)
Description: Number of beneficiaries who used residential and/or inpatient services for SUD during the measurement period.
Primary Driver: Increase access to evidence-based OUD/SUD care
Secondary Drivers:

- Maintaining the status quo for OUD/SUD treatment in IMDs
    - Status: Ongoing
    - Details: Treating SUD in IMDs was occurring before the SUD Demonstration with "in lieu of services" provided by the MCOs, and has continued through the start date of February 1, 2018 for approval of the SUD 1115 Demonstration waiver. Maintaining the status quo for SUD treatment in IMDs is ongoing as maintaining the status quo is the intention of the 1115 waiver.
- Extended coverage to ASAM Level 1-WM: Ambulatory Withdrawal Management without Extended Onsite Monitoring
    - Status: Not started
    - Details: ASAM 1-WM is not currently a Medicaid covered service and is dependent upon future funding via Louisiana legislative budget approval.



Notes: The total number of unduplicated beneficiaries with a service claim for residential and/or inpatient services for SUD during the measurement period.



Notes: The total number of unduplicated beneficiaries with a service claim for residential and/or inpatient services for SUD during the measurement period.

ITS Estimates

Pre-Period Slope	12.28* (6.53) [-0.868, 25.434]
Level Change	1245.14*** (90.44) [1062.88, 1427.40]
Post-Period Slope	-9.43* (5.58) [-20.68, 1.81]
Slope Change	-21.72** (9.91) [-41.69, -1.74]
Pre-Period Mean	1239.92
Pre-Period Min	1048
Pre-Period Max	1408
Post-Period Mean	2399.81
Post-Period Min	1624
Post-Period Max	2776
Observations	48

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

Evaluation Demonstration Goal 1.1

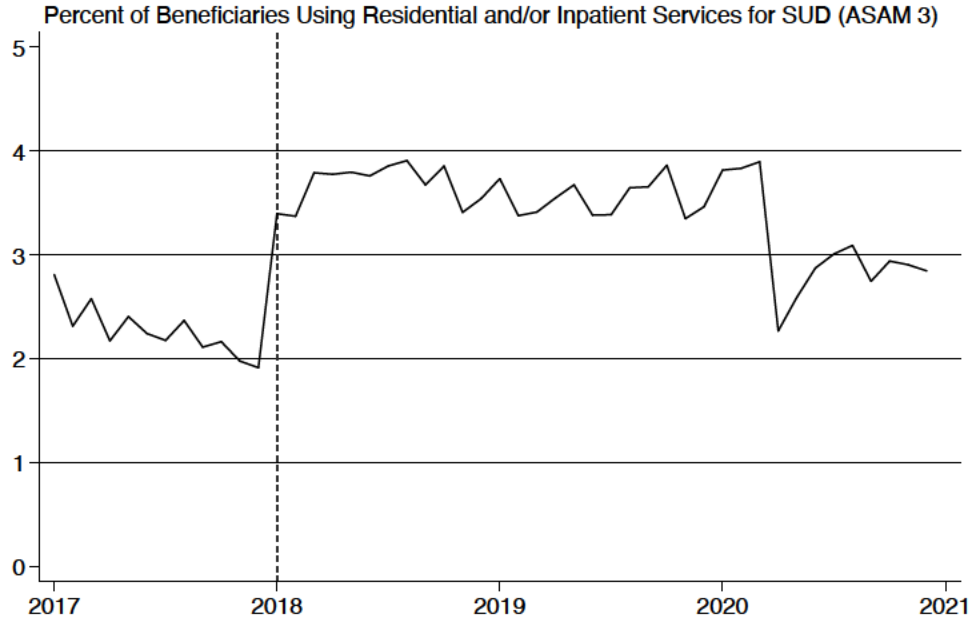
Monitoring Metric: N/A

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

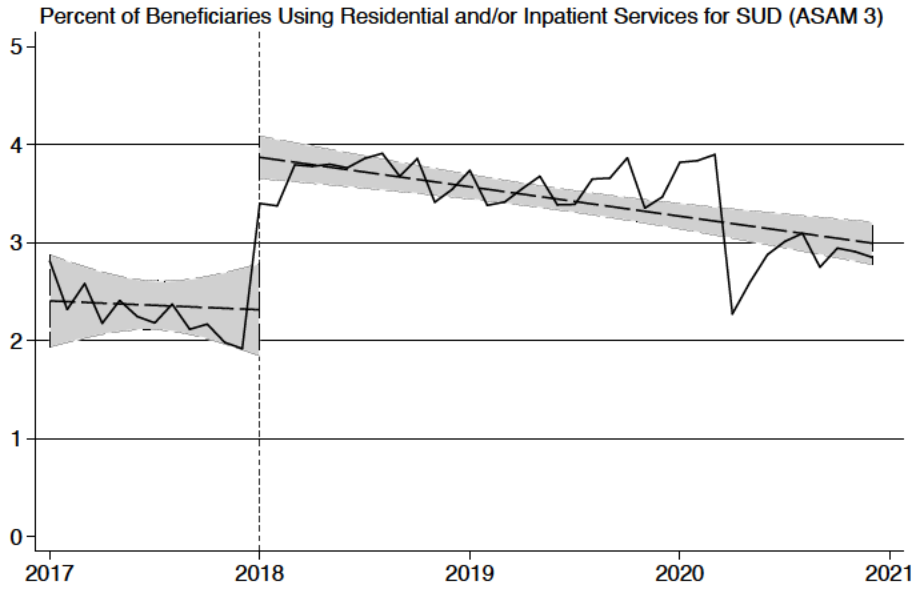
Primary Driver: Increase access to evidence-based OUD/SUD care

Secondary Drivers:

- Maintaining the status quo for OUD/SUD treatment in IMDs
  - Status: Ongoing
  - Details: Treating SUD in IMDs was occurring before the SUD Demonstration with "in lieu of services" provided by the MCOs, and has continued through the start date of February 1, 2018 for approval of the SUD 1115 Demonstration waiver. Maintaining the status quo for SUD treatment in IMDs is ongoing as maintaining the status quo is the intention of the 1115 waiver.
- Extended coverage to ASAM Level 1-WM: Ambulatory Withdrawal Management without Extended Onsite Monitoring
  - Status: Not started
  - Details: ASAM 1-WM is not currently a Medicaid covered service and is dependent upon future funding via Louisiana legislative budget approval.



Notes: The numerator is the total number of unduplicated beneficiaries with a service claim for residential and/or inpatient services for SUD during the measurement period. The denominator is the 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.



Notes: The numerator is the total number of unduplicated beneficiaries with a service claim for residential and/or inpatient services for SUD during the measurement period. The denominator is the 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.

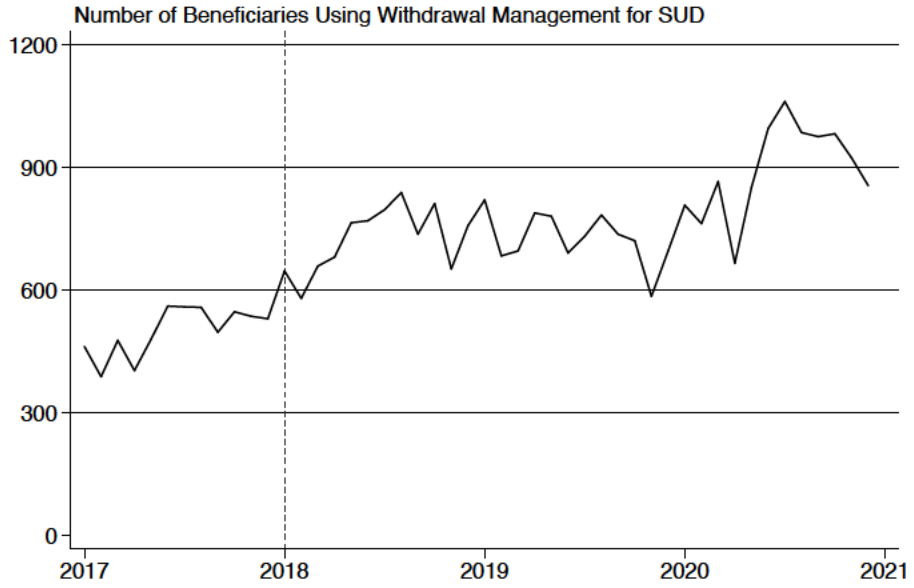
ITS Estimates

Pre-Period Slope	-0.057*** (0.008) [-0.072, -0.041]
Level Change	1.966*** (0.111) [1.743, 2.190]
Post-Period Slope	-0.025*** (0.007) [-0.038, -0.012]
Slope Change	0.032*** (0.011) [0.010, 0.053]
Pre-Period Mean	2.27
Pre-Period Min	1.92
Pre-Period Max	2.81
Post-Period Mean	3.43
Post-Period Min	2.27
Post-Period Max	3.91
Observations	48

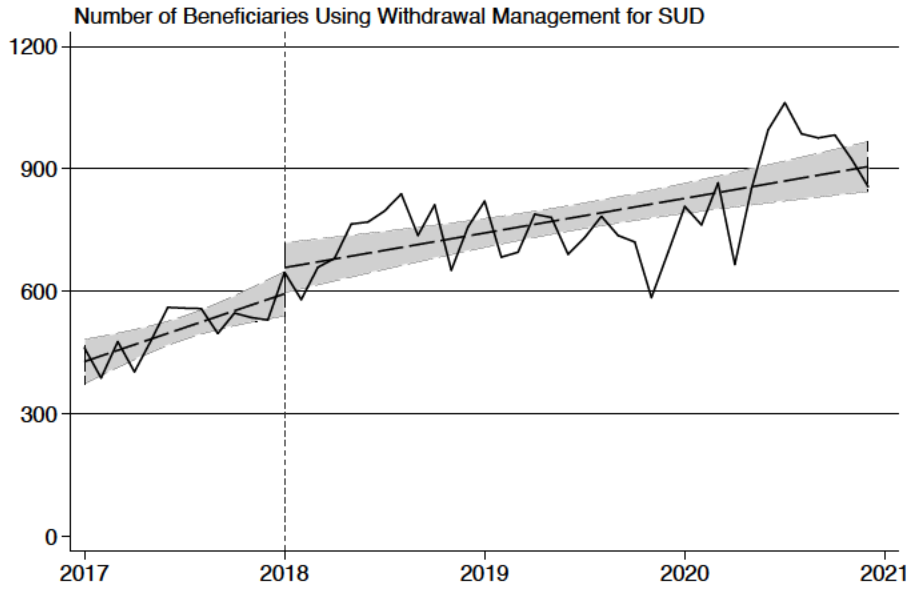
Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets. *p<0.10, **p<0.05, ***p<0.01

Evaluation Demonstration Goal 1.1
Monitoring Metric: #11, Withdrawal Management
Description: Number of beneficiaries who use withdrawal management services (such as outpatient, inpatient, or residential) during the measurement period.
Primary Driver: Increase access to evidence-based OUD/SUD care
Secondary Drivers:

- Maintaining the status quo for OUD/SUD treatment in IMDs
    - Status: Ongoing
    - Details: Treating SUD in IMDs was occurring before the SUD Demonstration with "in lieu of services" provided by the MCOs, and has continued through the start date of February 1, 2018 for approval of the SUD 1115 Demonstration waiver. Maintaining the status quo for SUD treatment in IMDs is ongoing as maintaining the status quo is the intention of the 1115 waiver.
- Extended coverage to ASAM Level 1-WM: Ambulatory Withdrawal Management without Extended Onsite Monitoring
    - Status: Not started
    - Details: ASAM 1-WM is not currently a Medicaid covered service and is dependent upon future funding via Louisiana legislative budget approval.



Notes: The total number of unduplicated beneficiaries with a service claim for withdrawal management for SUD during the measurement period.



Notes: The total number of unduplicated beneficiaries with a service claim for withdrawal management for SUD during the measurement period.

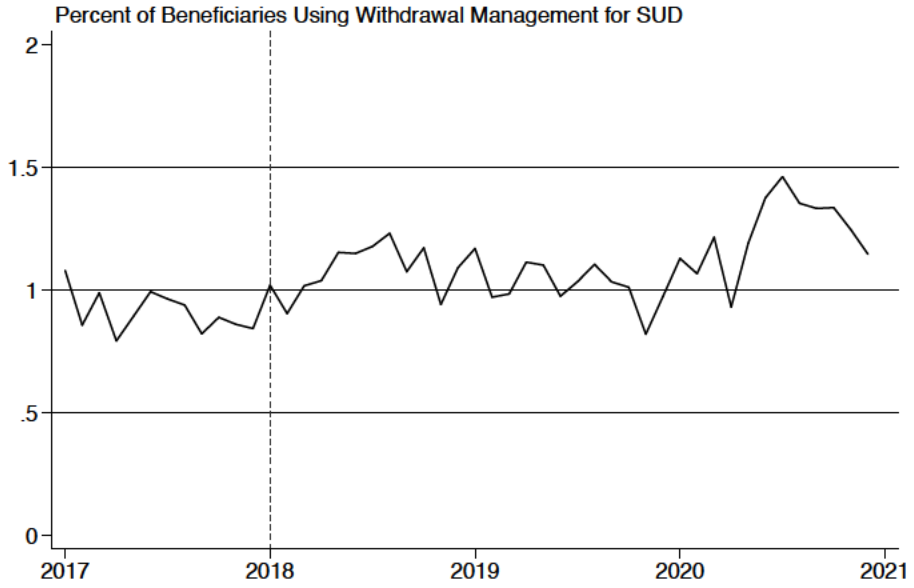
ITS Estimates

Pre-Period Slope	11.44*** (2.66) [6.08, 16.80]
Level Change	84.01** (38.71) [5.98, 162.03]
Post-Period Slope	7.07*** (2.13) [2.78, 11.37]
Slope Change	-4.37 (3.52) [-11.45, 2.72]
Pre-Period Mean	499.83
Pre-Period Min	388
Pre-Period Max	561
Post-Period Mean	782
Post-Period Min	580
Post-Period Max	1062
Observations	48

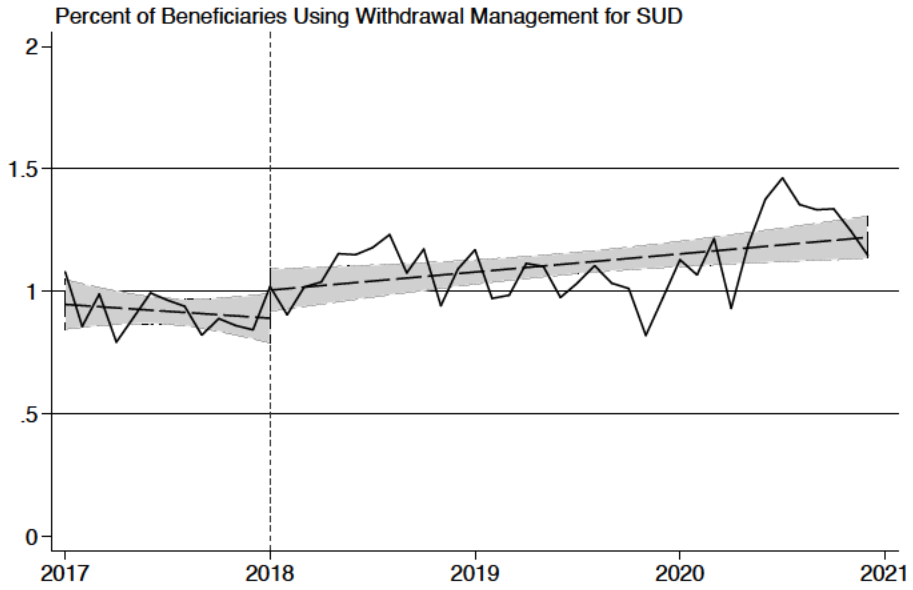
Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets. *p<0.10, **p<0.05, ***p<0.01

Evaluation Demonstration Goal 1.1
Monitoring Metric: N/A
Description: Percent of beneficiaries who use withdrawal management services (such as outpatient, inpatient, or residential) during the measurement period.
Primary Driver: Increase access to evidence-based OUD/SUD care
Secondary Drivers:

- Maintaining the status quo for OUD/SUD treatment in IMDs
    - Status: Ongoing
    - Details: Treating SUD in IMDs was occurring before the SUD Demonstration with "in lieu of services" provided by the MCOs, and has continued through the start date of February 1, 2018 for approval of the SUD 1115 Demonstration waiver. Maintaining the status quo for SUD treatment in IMDs is ongoing as maintaining the status quo is the intention of the 1115 waiver.
- Extended coverage to ASAM Level 1-WM: Ambulatory Withdrawal Management without Extended Onsite Monitoring
    - Status: Not started
    - Details: ASAM 1-WM is not currently a Medicaid covered service and is dependent upon future funding via Louisiana legislative budget approval.



Notes: The numerator is the total number of unduplicated beneficiaries with a service claim for withdrawal management for SUD during the measurement period. The denominator is the 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.



Notes: The numerator is the total number of unduplicated beneficiaries with a service claim for withdrawal management for SUD during the measurement period. The denominator is the 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.

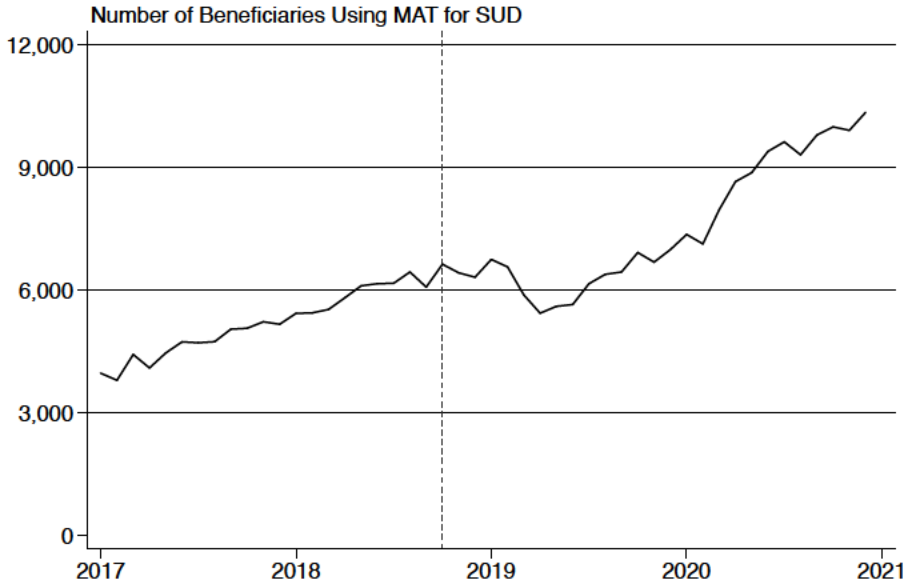
ITS Estimates

Pre-Period Slope	-0.011** (0.004) [-0.019, -0.002]
Level Change	0.164*** (0.053) [0.057, 0.270]
Post-Period Slope	0.006** (0.003) [0.000, 0.012]
Slope Change	0.017*** (0.005) [0.006, 0.027]
Pre-Period Mean	0.910
Pre-Period Min	0.793
Pre-Period Max	1.080
Post-Period Mean	1.113
Post-Period Min	0.820
Post-Period Max	1.463
Observations	48

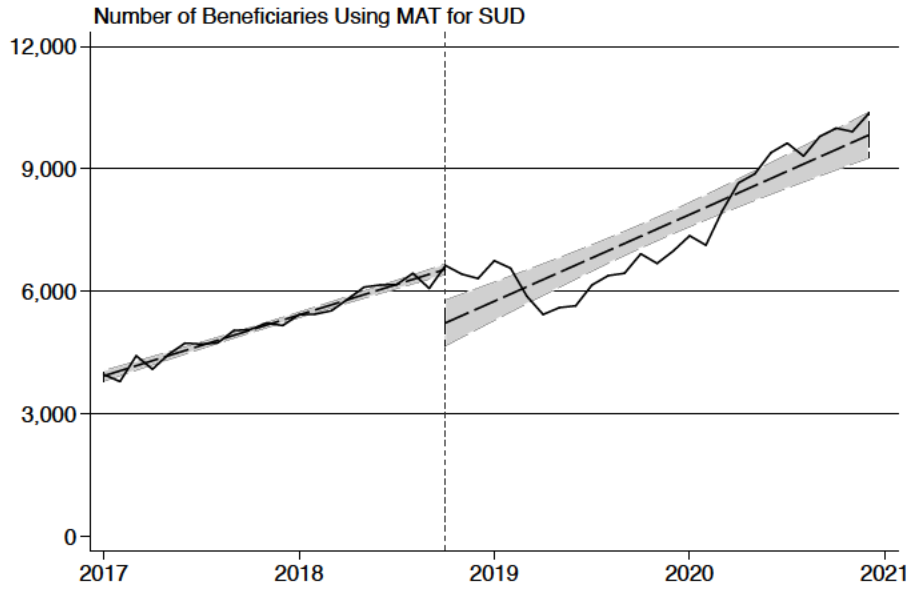
Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets. *p<0.10, **p<0.05, ***p<0.01

Evaluation Demonstration Goal 1.2
Monitoring Metric: #12, Medication-Assisted Treatment
Description: Number of beneficiaries who have a claim for MAT for SUD during the measurement period
Primary Driver: Increase access to and utilization of medication-assisted treatment (MAT) for SUD
Secondary Drivers:

- Educate abstinence-based residential providers on benefits of MAT.
    - Status: Started 4/01/2019
    - Details: Increasing access to MAT or OUD is occurring with the CMS requirement for SUD residential providers to offer MAT onsite or facilitate access to MAT offsite when clinically indicated for patients in their care.
- Encourage physicians to become certified dispensers.
    - Status: Started 10/01/2018
    - Details: FDA approved AUD MAT medications (Disulfiram, Acamprosate and Naltrexone) do not require licensed prescribers to be certified, as are data-waivered to prescribe Buprenorphine. In Louisiana, MDs, APRNs, and PAs are qualified to become data waivered. Prescribers are being recruited through The LaSOR grant to participate in the "Hub and Spoke model. The LASOR grant timeframe is 10/01/18 to 9/30/2020. LASOR started recruiting in April "officially" when the LSU Contract was completed. As of 9/13/19, 44 new prescribers were prescribing Suboxone. This recruitment will continue through 9/30/2020 with this grant.



Notes: The total number of unduplicated beneficiaries with a service claim for medication-assisted treatment for SUD during the measurement period.



Notes: The total number of unduplicated beneficiaries with a service claim for medication-assisted treatment for SUD during the measurement period.

ITS Estimates

Pre-Period Slope	123.19*** (5.08) [112.95, 133.43]
Level Change	-1296.99** (596.41) [-2498.97, -95.01]
Post-Period Slope	176.89*** (32.17) [112.05, 241.73]
Slope Change	53.71* (31.13) [-9.03, 116.44]
Pre-Period Mean	5170.29
Pre-Period Min	3792
Pre-Period Max	6444
Post-Period Mean	7527.96
Post-Period Min	5435
Post-Period Max	10355
Observations	48

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

Evaluation Demonstration Goal 1.2

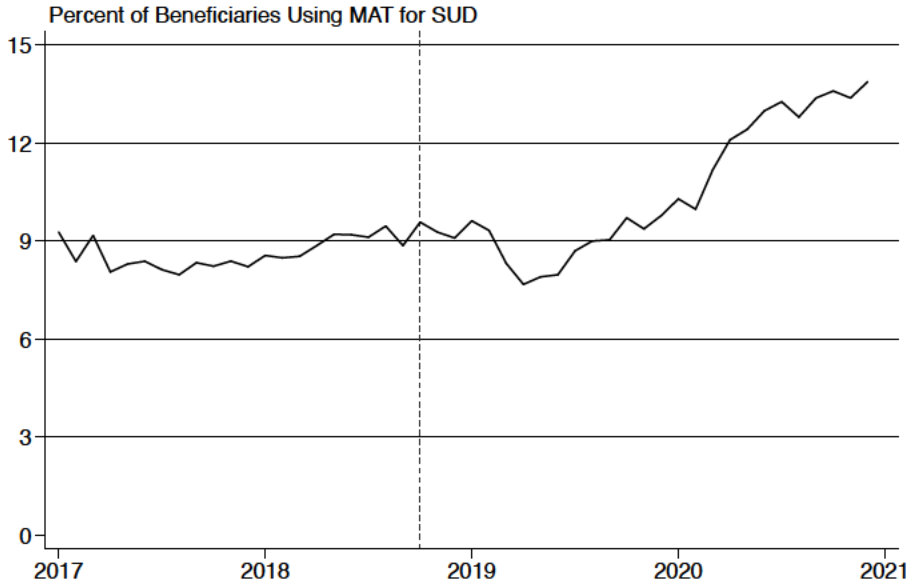
Monitoring Metric: N/A

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

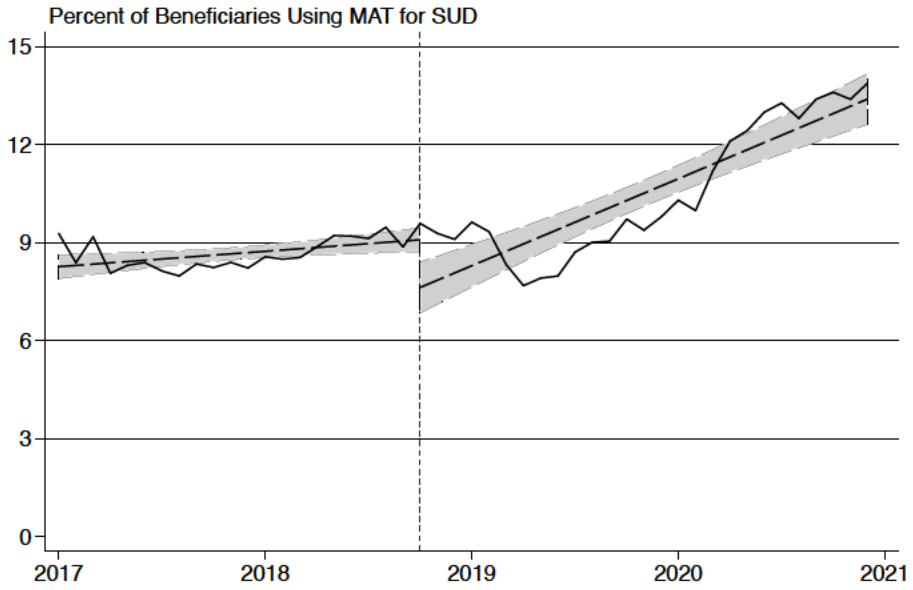
Primary Driver: Increase access to and utilization of medication-assisted treatment (MAT) for SUD

Secondary Drivers:

- Educate abstinence-based residential providers on benefits of MAT.
    - Status: Started 4/01/2019
    - Details: Increasing access to MAT or OUD is occurring with the CMS requirement for SUD residential providers to offer MAT onsite or facilitate access to MAT offsite when clinically indicated for patients in their care.
- Encourage physicians to become certified dispensers.
    - Status: Started 10/01/2018
    - Details: FDA approved AUD MAT medications (Disulfiram, Acamprosate and Naltrexone) do not require licensed prescribers to be certified, as are data-waivered to prescribe Buprenorphine. In Louisiana, MDs, APRNs, and PAs are qualified to become data waivered. Prescribers are being recruited through The LaSOR grant to participate in the "Hub and Spoke model. The LASOR grant timeframe is 10/01/18 to 9/30/2020. LASOR started recruiting in April "officially" when the LSU Contract was completed. As of 9/13/19, 44 new prescribers were prescribing Suboxone. This recruitment will continue through 9/30/2020 with this grant.



Notes: The numerator is the total number of unduplicated beneficiaries with a service claim for medication-assisted treatment for SUD during the measurement period. The denominator is the 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.



Notes: The numerator is the total number of unduplicated beneficiaries with a service claim for medication-assisted treatment for SUD during the measurement period. The denominator is the 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.

ITS Estimates

Pre-Period Slope	0.032 (0.023) [-0.013, 0.078]
Level Change	-1.36 (0.811) [-2.99, 0.278]
Post-Period Slope	0.222*** (0.044) [0.133, 0.311]
Slope Change	0.190*** (0.051) [0.088, 0.292]
Pre-Period Mean	8.63
Pre-Period Min	7.97
Pre-Period Max	9.46
Post-Period Mean	10.51
Post-Period Min	7.68
Post-Period Max	13.88
Observations	48

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

Evaluation Demonstration Goal 1.2

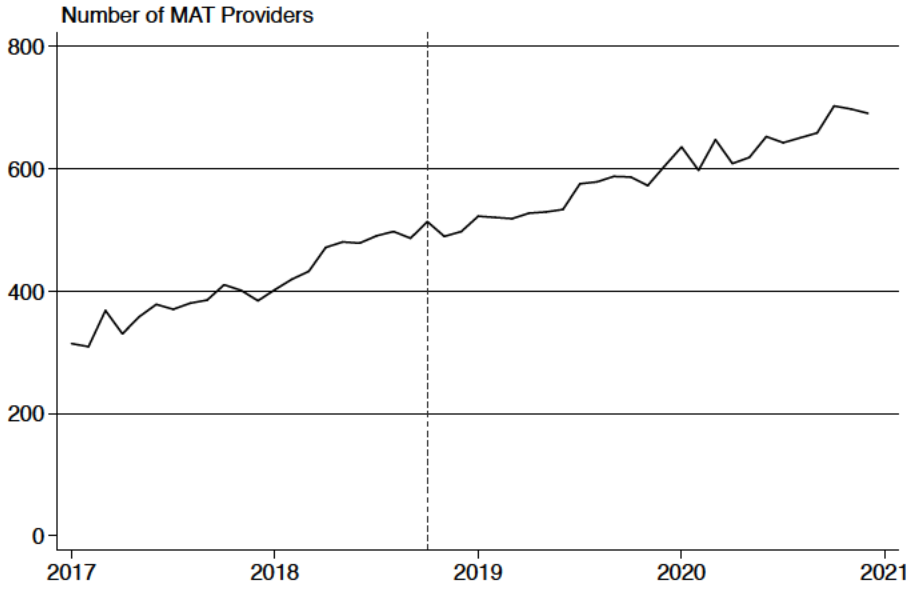
Monitoring Metric: #14, SUD Provider Availability, Medication-Assisted Treatment

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

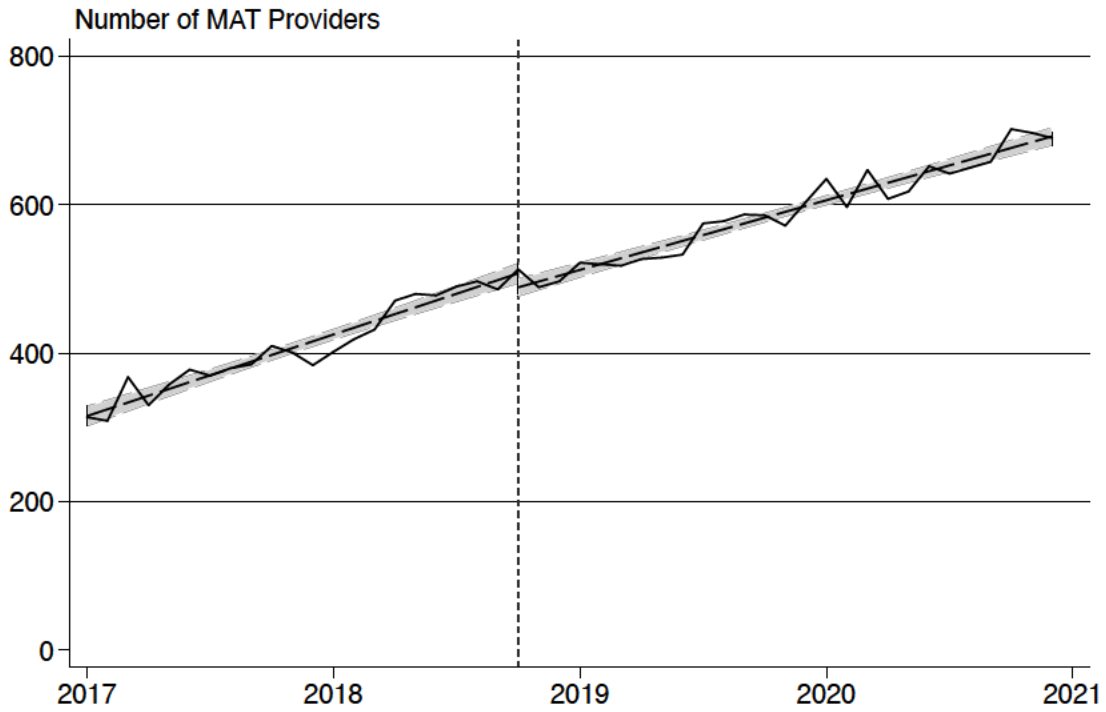
Primary Driver: Increase access to and utilization of medication-assisted treatment (MAT) for SUD

Secondary Drivers:

- Educate abstinence-based residential providers on benefits of MAT.
  - Status: Started 4/01/2019
  - Details: Increasing access to MAT or OUD is occurring with the CMS requirement for SUD residential providers to offer MAT onsite or facilitate access to MAT offsite when clinically indicated for patients in their care.
- Encourage physicians to become certified dispensers.
  - Status: Started 10/01/2018
  - Details: FDA approved AUD MAT medications (Disulfiram, Acamprosate and Naltrexone) do not require licensed prescribers to be certified, as are data-waivered to prescribe Buprenorphine. In Louisiana, MDs, APRNs, and PAs are qualified to become data waivered. Prescribers are being recruited through The LaSOR grant to participate in the "Hub and Spoke model. The LASOR grant timeframe is 10/01/18 to 9/30/2020. LASOR started recruiting in April "officially" when the LSU Contract was completed. As of 9/13/19, 44 new prescribers were prescribing Suboxone. This recruitment will continue through 9/30/2020 with this grant.



Notes: The total number of eligible SUD providers who meet the standards to provide buprenorphine or methadone as part of MAT.



Notes: The total number of eligible SUD providers who meet the standards to provide buprenorphine or methadone as part of MAT.

ITS Estimates

Pre-Period Slope	9.08*** (0.489) [8.10, 10.07]
Level Change	-17.81* (9.39) [-36.73, 1,12]
Post-Period Slope	7.82*** (0.321) [7.18, 8.47]
Slope Change	-1.26** (0.581) [-2.43, -0.088]
Pre-Period Mean	406.76
Pre-Period Min	309
Pre-Period Max	497
Post-Period Mean	590.59
Post-Period Min	489
Post-Period Max	702
Observations	48

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

Evaluation Demonstration Goal 1.2

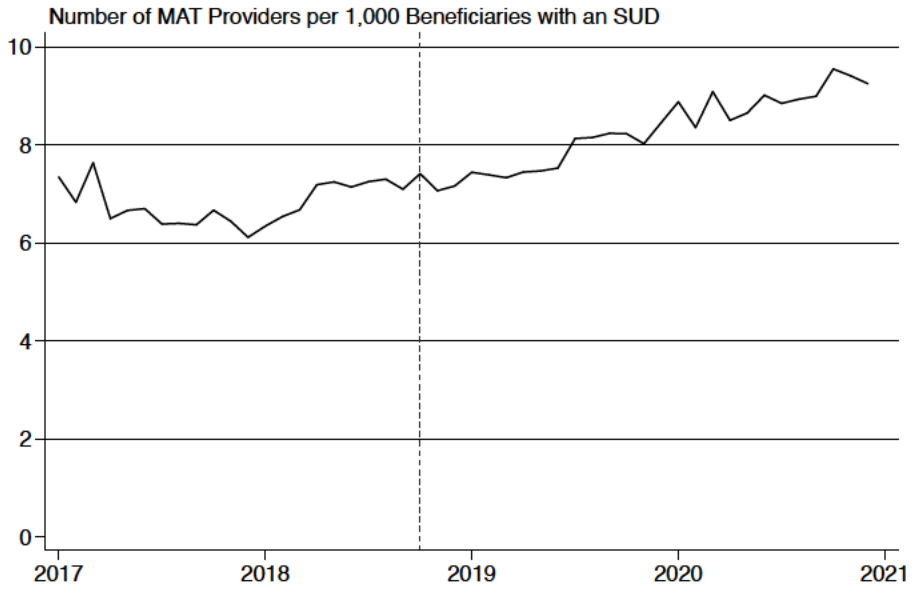
Monitoring Metric: N/A

Description: The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period and who meet the standards to provide buprenorphine or methadone as part of MAT per 1,000 Medicaid Beneficiaries with an SUD Diagnosis.

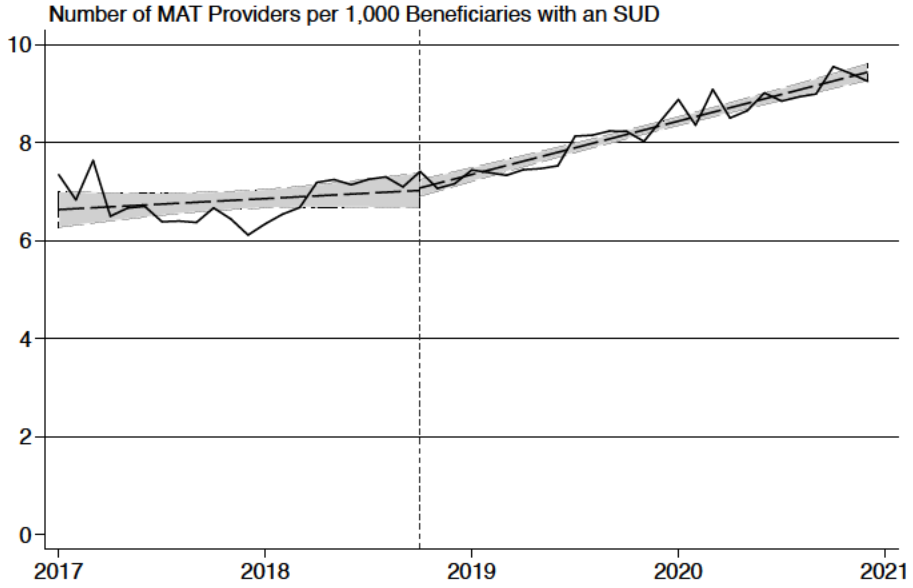
Primary Driver: Increase access to and utilization of medication-assisted treatment (MAT) for SUD

Secondary Drivers:

- Educate abstinence-based residential providers on benefits of MAT.
    - Status: Started 4/01/2019
    - Details: Increasing access to MAT or OUD is occurring with the CMS requirement for SUD residential providers to offer MAT onsite or facilitate access to MAT offsite when clinically indicated for patients in their care.
- Encourage physicians to become certified dispensers.
    - Status: Started 10/01/2018
    - Details: FDA approved AUD MAT medications (Disulfiram, Acamprosate and Naltrexone) do not require licensed prescribers to be certified, as are data-waivered to prescribe Buprenorphine. In Louisiana, MDs, APRNs, and PAs are qualified to become data waivered. Prescribers are being recruited through The LaSOR grant to participate in the "Hub and Spoke model. The LASOR grant timeframe is 10/01/18 to 9/30/2020. LASOR started recruiting in April "officially" when the LSU Contract was completed. As of 9/13/19, 44 new prescribers were prescribing Suboxone. This recruitment will continue through 9/30/2020 with this grant.



Notes: The numerator is the total number of eligible SUD providers who meet the standards to provide buprenorphine or methadone as part of MAT. The denominator is the 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 (in thousands).



Notes: The numerator is the total number of eligible SUD providers who meet the standards to provide buprenorphine or methadone as part of MAT. The denominator is the 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 (in thousands).

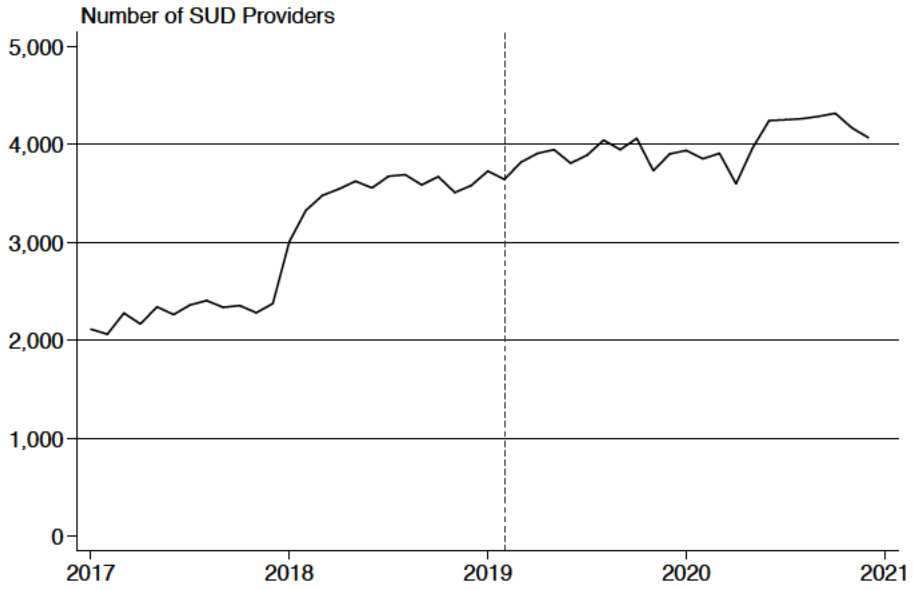
ITS Estimates

Pre-Period Slope	0.013 (0.022)
Level Change	0.131 (0.267)
Post-Period Slope	0.091*** (0.004)
Slope Change	0.078*** (0.023)
Pre-Period Mean	6.80
Pre-Period Min	6.11
Pre-Period Max	7.63
Post-Period Mean	8.25
Post-Period Min	7.06
Post-Period Max	9.55
Observations	48

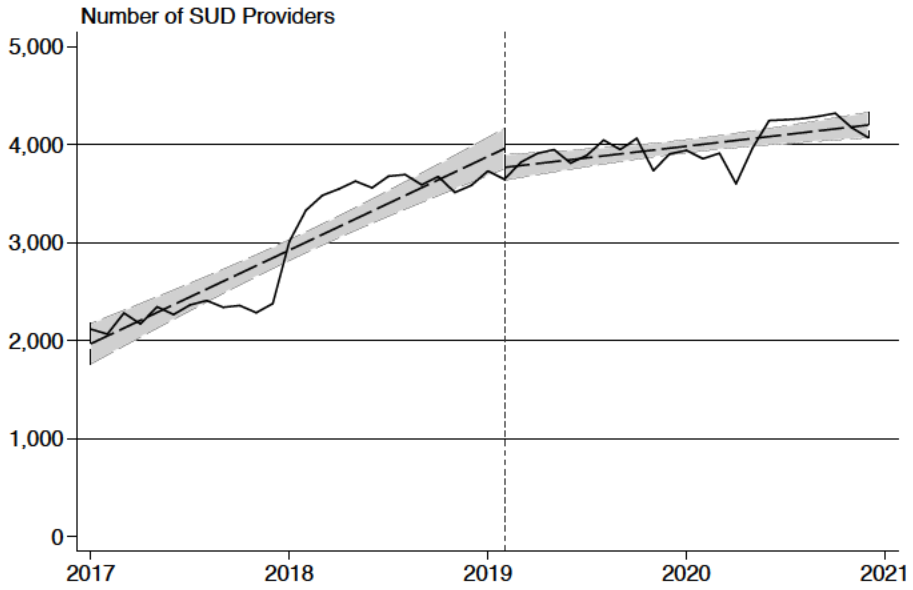
Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets. *p<0.10, **p<0.05, ***p<0.01

Evaluation Demonstration Goal 1.3
Monitoring Metric: #13, SUD Provider Availability
Description: The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period.
Primary Driver: Ensure sufficient provider capacity at each level of care for SUD
Secondary Drivers:

- Require MCOs to update their Specialized Behavioral Health network development and management plan to specifically focus on SUD provider capacity, including MAT.
    - Status: Started 1/30/2019
    - Details: The MCOs were required to resubmit their 2019 Network Development and Management Plan to include information on MAT providers. The Network Development and Management Plans are due on January 30th each year. The reporting template for the 2020 submission will be revised emphasizing that the MCOs are to "specifically focus on SUD provider capacity," in addition to the MAT access that we previously requested.



Notes: Total number of eligible SUD providers.



Notes: Total number of eligible SUD providers.

ITS Estimates

Pre-Period Slope	82.74*** (8.09) [66.43, 99.06]
Level Change	-244.36 (154.19) [-555.11, 66.38]
Post-Period Slope	19.68*** (4.80) [10.01, 29.34]
Slope Change	-63.07*** (9.75) [-82.71, -43,42]
Pre-Period Mean	2933.92
Pre-Period Min	2064
Pre-Period Max	3729
Post-Period Mean	3981.65
Post-Period Min	3599
Post-Period Max	4318
Observations	48

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

Evaluation Demonstration Goal 1.3

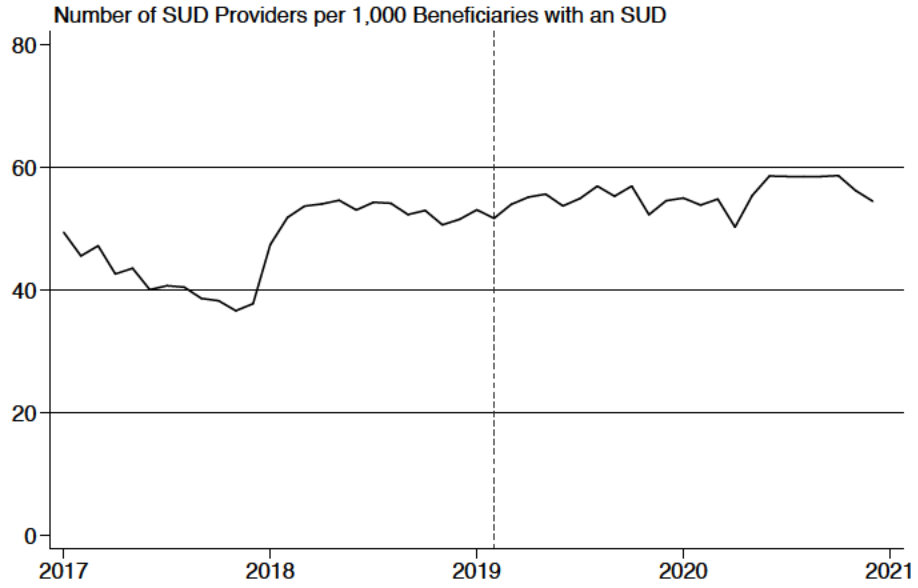
Monitoring Metric: N/A

Description: The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period per 1,000 Medicaid Beneficiaries with an SUD Diagnosis.

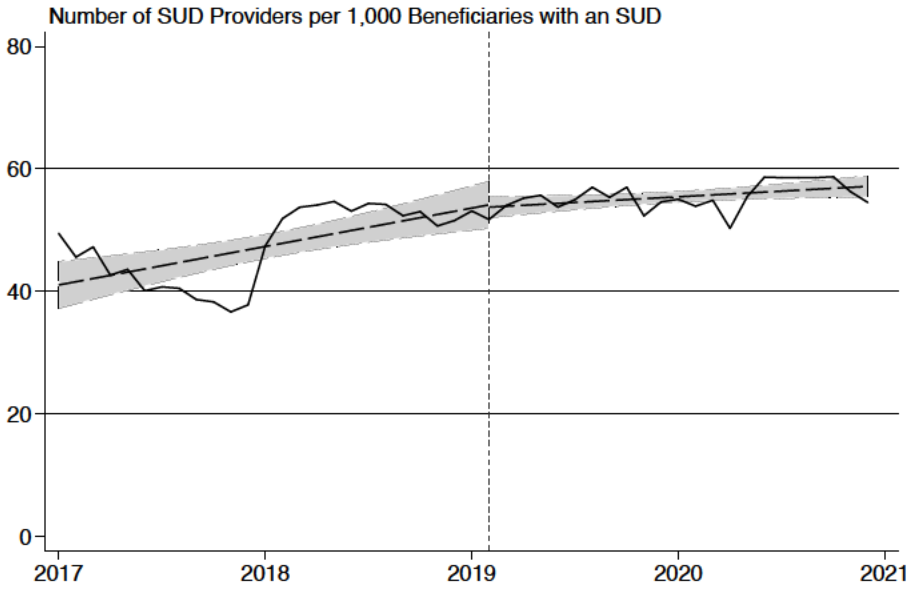
Primary Driver: Ensure sufficient provider capacity at each level of care for SUD

Secondary Drivers:

- Require MCOs to update their Specialized Behavioral Health network development and management plan to specifically focus on SUD provider capacity, including MAT.
    - Status: Started 1/30/2019
    - Details: The MCOs were required to resubmit their 2019 Network Development and Management Plan to include information on MAT providers. The Network Development and Management Plans are due on January 30th each year. The reporting template for the 2020 submission will be revised emphasizing that the MCOs are to "specifically focus on SUD provider capacity," in addition to the MAT access that we previously requested.



Notes: The numerator is the total number of eligible SUD providers. The denominator is the 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 (in thousands).



Notes: The numerator is the total number of eligible SUD providers. The denominator is the 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 (in thousands).

ITS Estimates

Pre-Period Slope	0.547*** (0.179) [0.185, 0.908]
Level Change	-0.780 (2.207) [-5.23, 3.67]
Post-Period Slope	0.154** (0.066) [0.022, 0.286]
Slope Change	-0.393** (0.193) [-0.782, -0.004]
Pre-Period Mean	47.43
Pre-Period Min	36.65
Pre-Period Max	54.69
Post-Period Mean	55.45
Post-Period Min	50.31
Post-Period Max	58.72
Observations	48

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

Evaluation Demonstration Goal 2.1

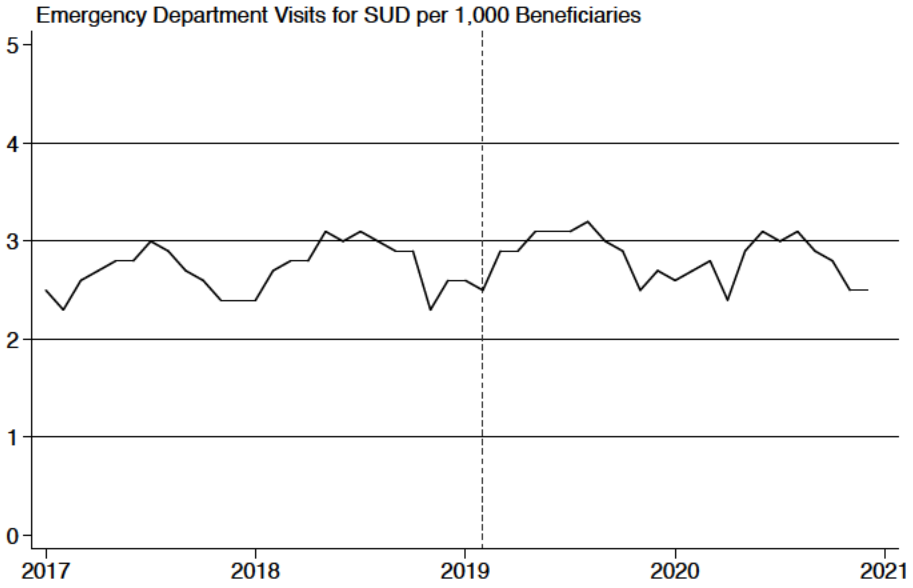
Monitoring Metric: #23, Emergency Department Visits for SUD

Description: The number of ED visits for SUD per 1,000 beneficiaries in the measurement period.

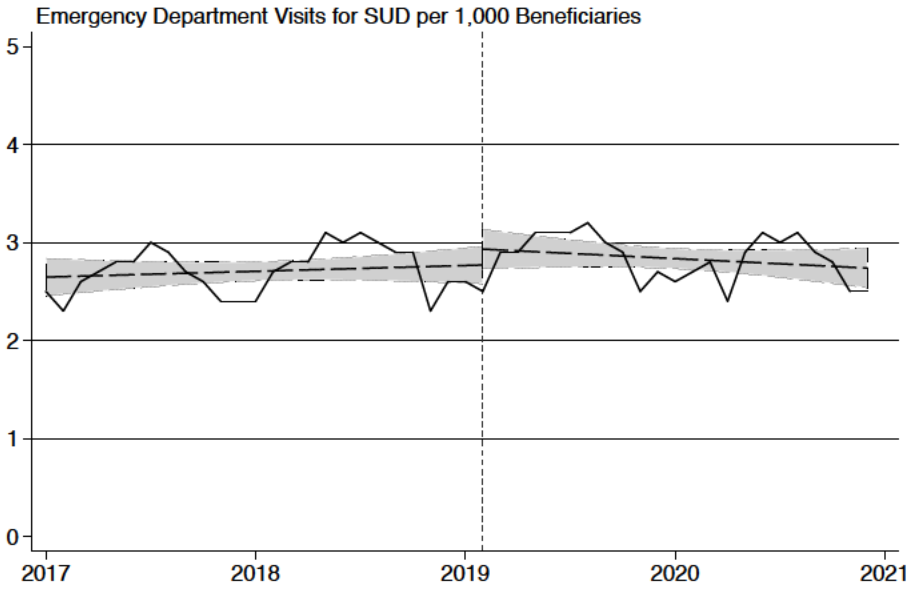
Primary Driver: Decrease use of medically inappropriate care and reduce reliance on emergency department and hospital services for SUD treatment.

Secondary Drivers:

- Require MCOs to update their Specialized Behavioral Health network development and management plan to specifically focus on SUD provider capacity, including MAT.
    - Status: Started 1/30/2019
    - Details: The MCOs were required to resubmit their 2019 Network Development and Management Plan to include information on MAT providers. The Network Development and Management Plans are due on January 30th each year. The reporting template for the 2020 submission will be revised emphasizing that the MCOs are to "specifically focus on SUD provider capacity," in addition to the MAT access that we previously requested.



Notes: The numerator is the total number of emergency department visits for SUD during the measurement period. The denominator is the total number of unduplicated Medicaid beneficiaries (in thousands).



Notes: The numerator is the total number of emergency department visits for SUD during the measurement period. The denominator is the total number of unduplicated Medicaid beneficiaries (in thousands).

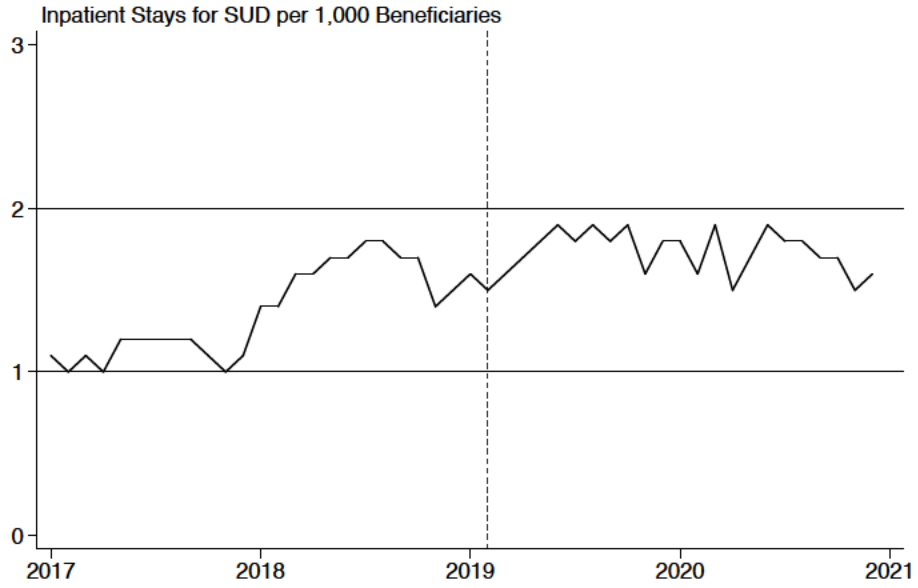
ITS Estimates

Pre-Period Slope	0.008 (0.009) [-0.011, 0.026]
Level Change	0.117 (0.179) [-0.243, 0.476]
Post-Period Slope	-0.009 (0.010) [-0.028, 0.011]
Slope Change	-0.016 (0.015) [-0.046, 0.013]
Pre-Period Mean	2.72
Pre-Period Min	2.3
Pre-Period Max	3.1
Post-Period Mean	2.83
Post-Period Min	2.4
Post-Period Max	3.2
Observations	48

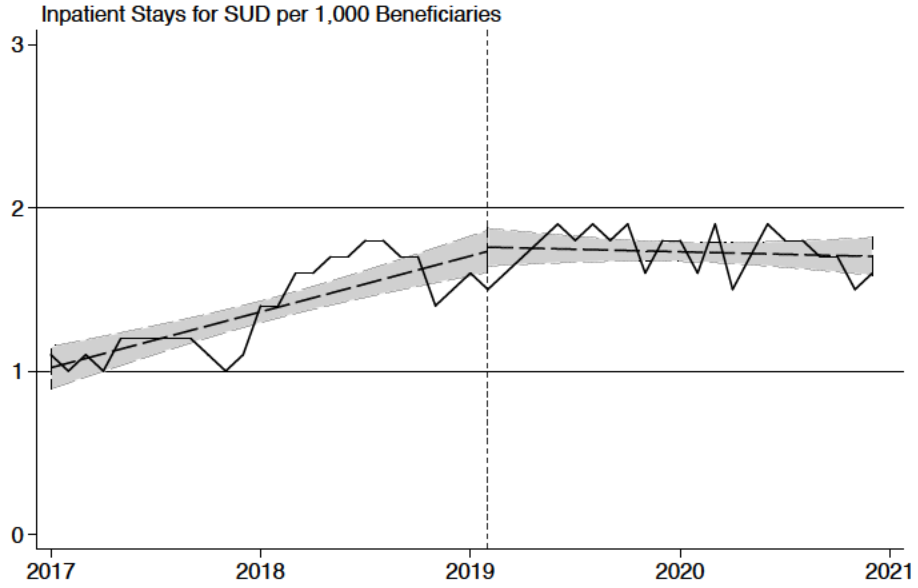
Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets. *p<0.10, **p<0.05, ***p<0.01

Evaluation Demonstration Goal 2.1
Monitoring Metric: #24, Inpatient Stays for SUD
Description: The number of inpatient stays for SUD per 1,000 beneficiaries in the measurement period.
Primary Driver: Decrease use of medically inappropriate care and reduce reliance on emergency department and hospital services for SUD treatment.
Secondary Drivers:

- Require MCOs to update their Specialized Behavioral Health network development and management plan to specifically focus on SUD provider capacity, including MAT.
    - Status: Started 1/30/2019
    - Details: The MCOs were required to resubmit their 2019 Network Development and Management Plan to include information on MAT providers. The Network Development and Management Plans are due on January 30th each year. The reporting template for the 2020 submission will be revised emphasizing that the MCOs are to "specifically focus on SUD provider capacity," in addition to the MAT access that we previously requested.



Notes: The numerator is the total number of inpatient stays for SUD during the measurement period. The denominator is the total number of unduplicated Medicaid beneficiaries (in thousands).



Notes: The numerator is the total number of inpatient stays for SUD during the measurement period. The denominator is the total number of unduplicated Medicaid beneficiaries (in thousands).

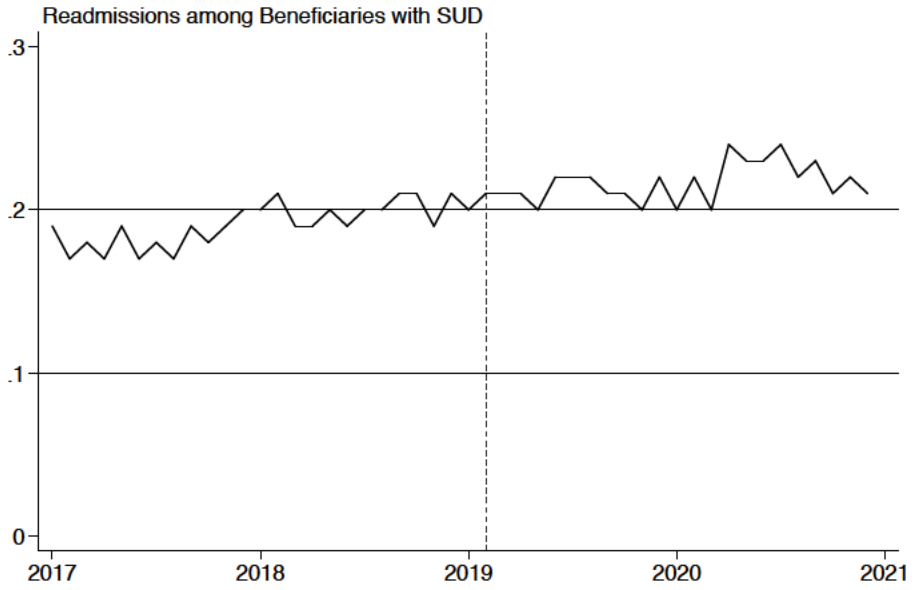
ITS Estimates

Pre-Period Slope	0.031*** (0.006) [0.019, 0.043]
Level Change	-0.014 (0.122) [-0.260, 0.231]
Post-Period Slope	-0.003 (0.006) [-0.015, 0.010]
Slope Change	-0.033*** (0.009) [-0.053, -0.014]
Pre-Period Mean	1.37
Pre-Period Min	1
Pre-Period Max	1.8
Post-Period Mean	1.73
Post-Period Min	1.5
Post-Period Max	1.9
Observations	48

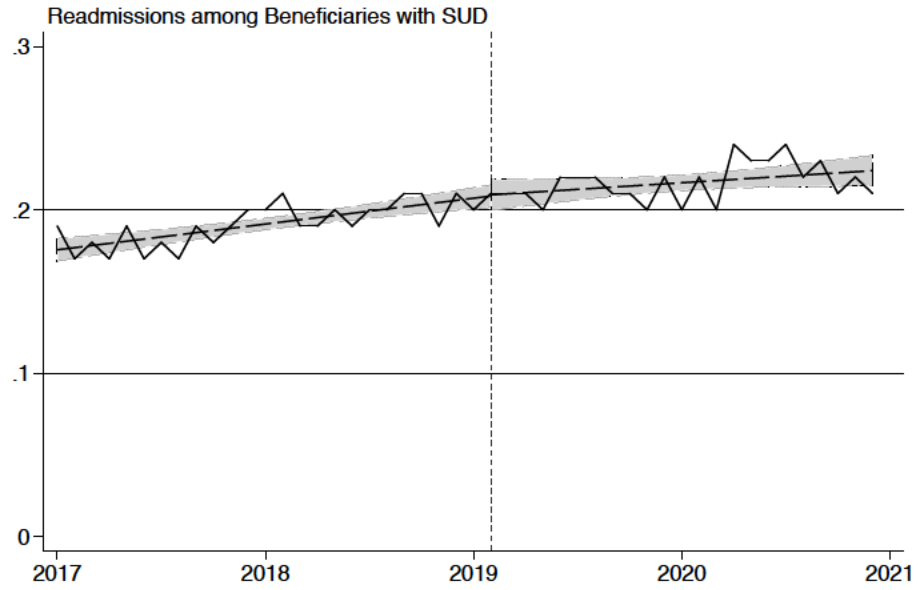
Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets. *p<0.10, **p<0.05, ***p<0.01

Evaluation Demonstration Goal 2.2
Monitoring Metric: #25, Readmissions among Beneficiaries with SUD
Description: The rate of all-cause readmissions during the measurement period among beneficiaries with SUD.
Primary Driver: Reduce readmission rates for SUD treatment.
Secondary Drivers:

- Require MCOs to update their Specialized Behavioral Health network development and management plan to specifically focus on SUD provider capacity, including MAT.
    - Status: Started 1/30/2019
    - Details: The MCOs were required to resubmit their 2019 Network Development and Management Plan to include information on MAT providers. The Network Development and Management Plans are due on January 30th each year. The reporting template for the 2020 submission will be revised emphasizing that the MCOs are to "specifically focus on SUD provider capacity," in addition to the MAT access that we previously requested.



Notes: The numerator is the total number of 30-day readmissions (at least one acute readmission for any diagnosis within 30 days of the index discharge date). The denominator is the total number of index hospital stays.



Notes: The numerator is the total number of 30-day readmissions (at least one acute readmission for any diagnosis within 30 days of the index discharge date). The denominator is the total number of index hospital stays.

ITS Estimates

Pre-Period Slope	0.0013*** (0.0002) [0.0009, 0.0017]
Level Change	0.0010 (0.0038) [-0.0067, 0.0088]
Post-Period Slope	0.0007* (0.0003) [-0.0000, 0.0014]
Slope Change	-0.0006 (0.0004) [-0.0014, 0.0001]
Pre-Period Mean	0.191
Pre-Period Min	0.17
Pre-Period Max	0.21
Post-Period Mean	0.217
Post-Period Min	0.20
Post-Period Max	0.24
Observations	48

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

Evaluation Demonstration Goal 3.1

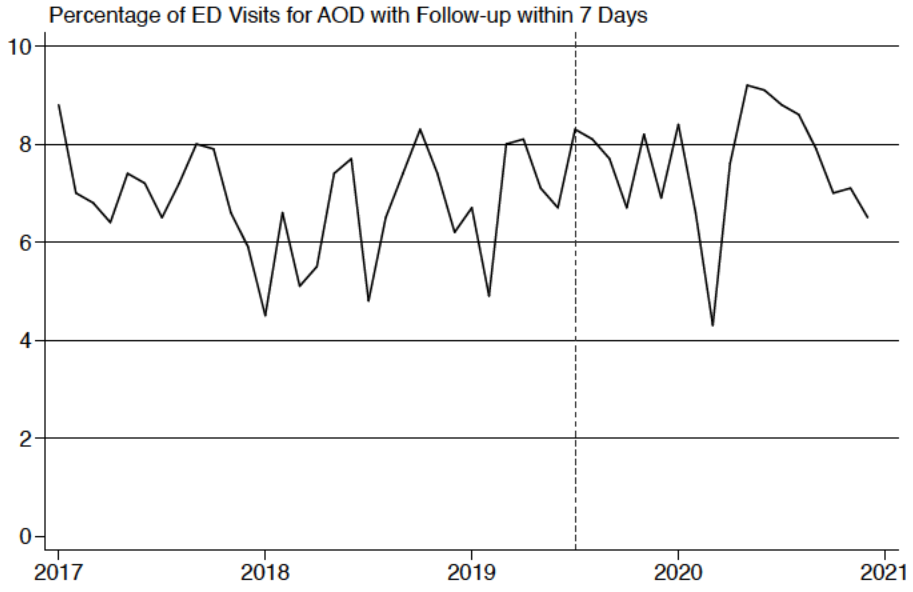
Monitoring Metric: #17(1), Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence

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.

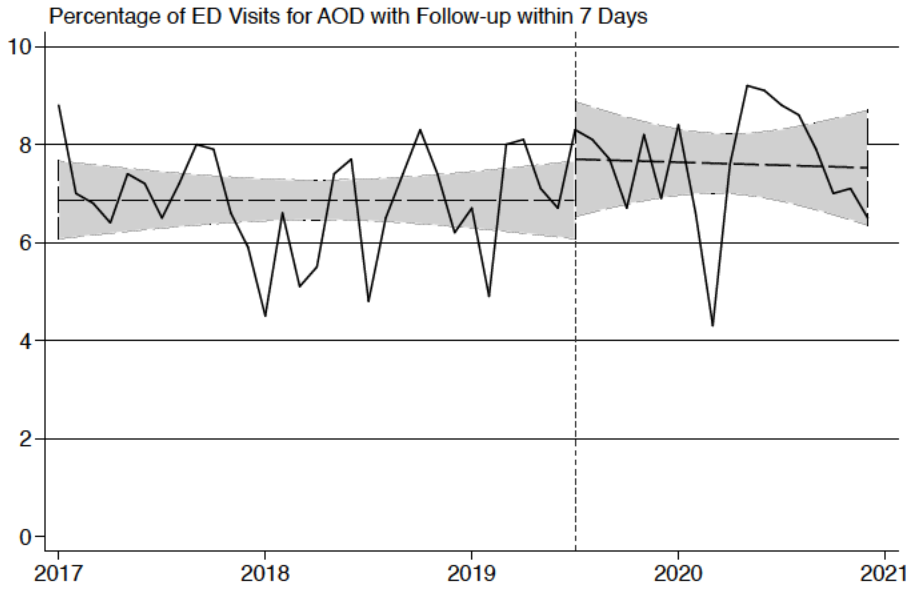
Primary Driver: Increase initiation of follow-up after discharge from the emergency department or hospital for SUD.

Secondary Drivers:

- Continued monitoring of MCO compliance with existing contract requirements related to care transition activities.
    - Status: Started 6/30/2019
    - Details: SUD specific audit tool elements were added to the MCO monitoring tool for the second quarter reviews in 2019. SUD providers are audited using both the general BH elements and the SUD specific elements. These reports are due 30 days after the end of the quarter being reviewed. "Continuity and Coordination of Care" and discharge planning are tracked components under table 3 of the TRR (Treatment Record Review) tab of the 358 Report. The 358 report template is on the LA – Medicaid website. LDH monitors a report generated by the MCOs who are contractually required to ensure continuity of care. The basis of the report is MCO utilization of the updated audit tool which contains SUD level of care specific elements including discharge planning/transfer planning and referrals.



Notes: The numerator is the total number of follow-up visits with any practitioner, with a principal diagnosis of AOD abuse or dependence within 7 days after the ED visit (8 total days), including visits that occur on the date of the ED visit. The denominator is the total number of index ED visits.



Notes: The numerator is the total number of follow-up visits with any practitioner, with a principal diagnosis of AOD abuse or dependence within 7 days after the ED visit (8 total days), including visits that occur on the date of the ED visit. The denominator is the total number of index ED visits.

ITS Estimates

Pre-Period Slope	-0.010 (0.019) [-0.049, 0.029]
Level Change	1.032** (0.479) [0.066, 1.998]
Post-Period Slope	-0.010 (0.043) [-0.096, 0.076]
Slope Change	-0.000 (0.048)
Pre-Period Mean	6.82
Pre-Period Min	4.5
Pre-Period Max	8.8
Post-Period Mean	7.61
Post-Period Min	4.3
Post-Period Max	9.2
Observations	48

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

Evaluation Demonstration Goal 3.1

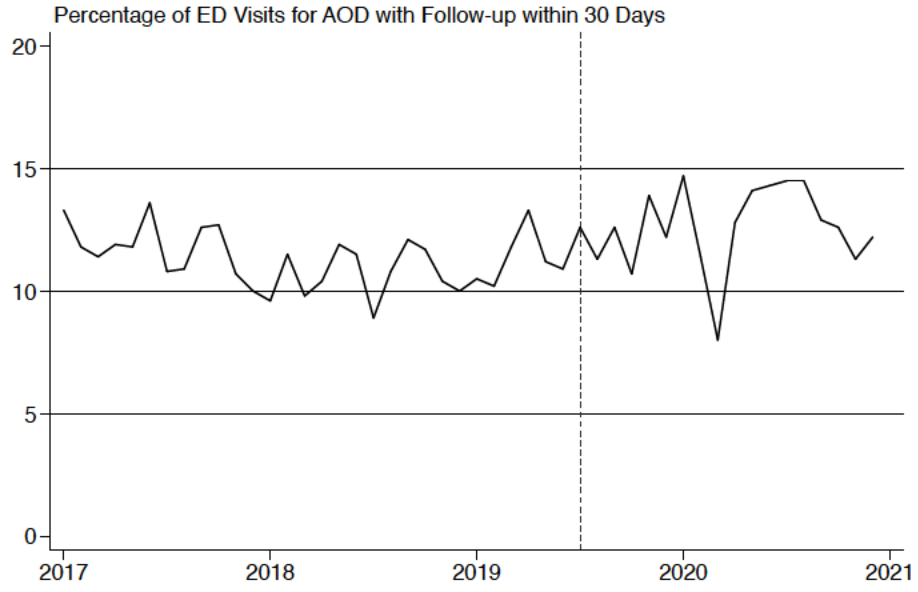
Monitoring Metric: #17(1), Follow-up After ED Visit for Alcohol and Other Drug Abuse or Dependence

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.

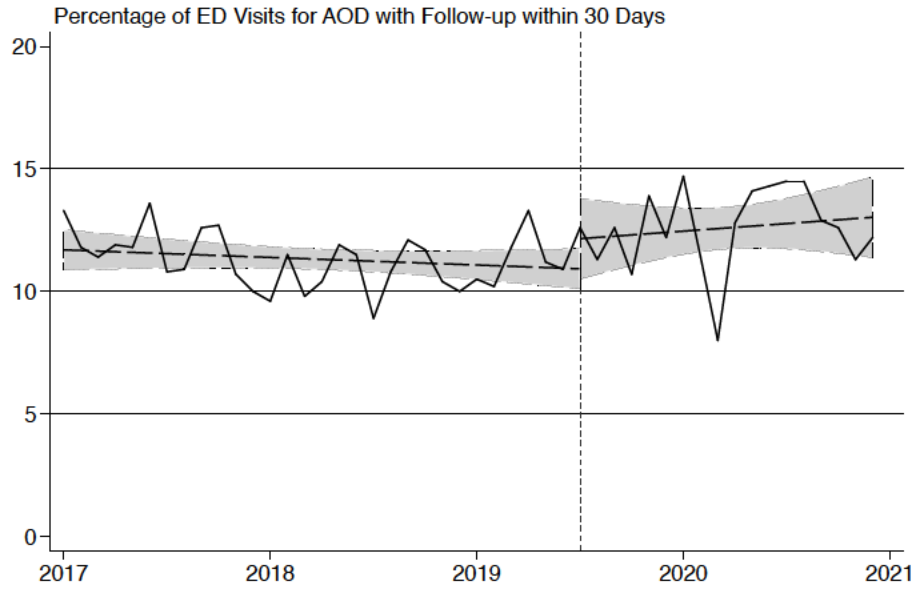
Primary Driver: Increase initiation of follow-up after discharge from the emergency department or hospital for SUD.

Secondary Drivers:

- Continued monitoring of MCO compliance with existing contract requirements related to care transition activities.
    - Status: Started 6/30/2019
    - Details: SUD specific audit tool elements were added to the MCO monitoring tool for the second quarter reviews in 2019. SUD providers are audited using both the general BH elements and the SUD specific elements. These reports are due 30 days after the end of the quarter being reviewed. "Continuity and Coordination of Care" and discharge planning are tracked components under table 3 of the TRR (Treatment Record Review) tab of the 358 Report. The 358 report template is on the LA – Medicaid website. LDH monitors a report generated by the MCOs who are contractually required to ensure continuity of care. The basis of the report is MCO utilization of the updated audit tool which contains SUD level of care specific elements including discharge planning/transfer planning and referrals.



Notes: The numerator is the total number of follow-up visits with any practitioner, with a principal diagnosis of AOD abuse or dependence within 30 days after the ED visit (31 total days), including visits that occur on the date of the ED visit. The denominator is the total number of index ED visits.



Notes: The numerator is the total number of follow-up visits with any practitioner, with a principal diagnosis of AOD abuse or dependence within 30 days after the ED visit (31 total days), including visits that occur on the date of the ED visit. The denominator is the total number of index ED visits.

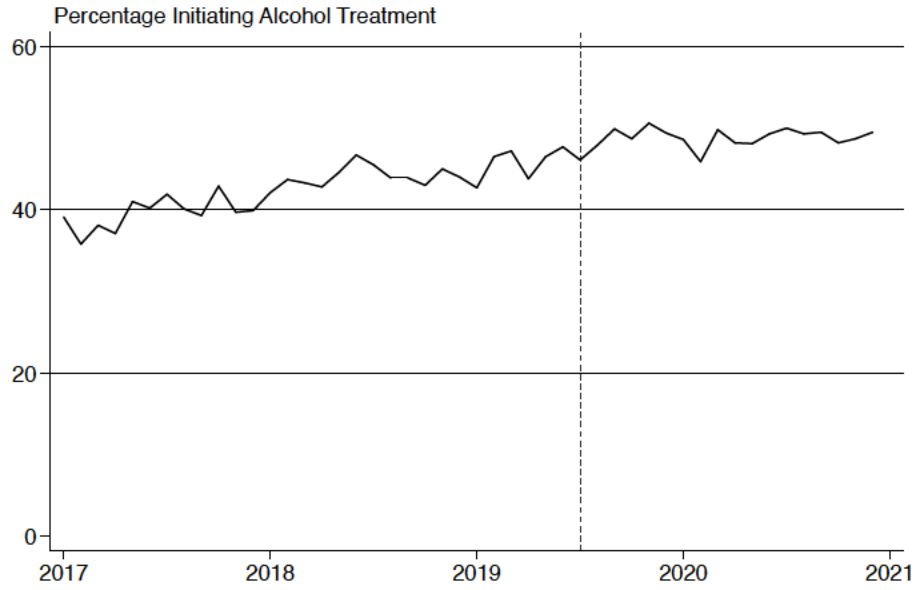
ITS Estimates

Pre-Period Slope	-0.037 (0.024) [-0.086, 0.011]
Level Change	1.465** (0.612) [0.232, 2.697]
Post-Period Slope	0.051 (0.057) [-0.063, 0.166]
Slope Change	0.089 (0.063) [-0.037, 0.214]
Pre-Period Mean	11.27
Pre-Period Min	8.9
Pre-Period Max	13.6
Post-Period Mean	12.59
Post-Period Min	8
Post-Period Max	14.7
Observations	48

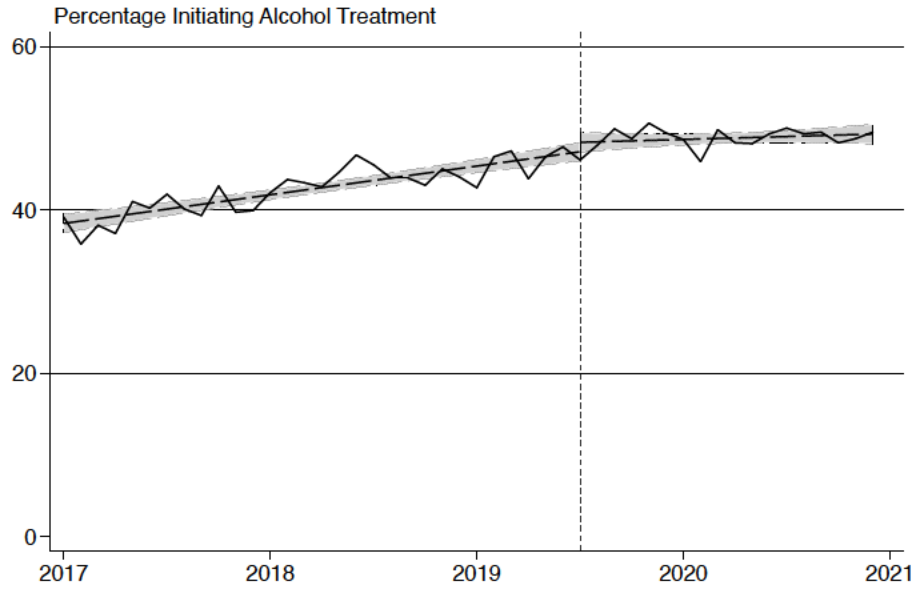
Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets. *p<0.10, **p<0.05, ***p<0.01

Evaluation Demonstration Goal 3.2
Monitoring Metric: #15, Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)
Description: Percentage of beneficiaries age 18 and older with a new episode of alcohol abuse or dependence who initiated treatment within 14 days of the diagnosis.
Primary Driver: Increase adherence to and retention in treatment.
Secondary Drivers:

- Continued monitoring of MCO compliance with existing contract requirements related to care transition activities.
    - Status: Started 6/30/2019
    - Details: SUD specific audit tool elements were added to the MCO monitoring tool for the second quarter reviews in 2019. SUD providers are audited using both the general BH elements and the SUD specific elements. These reports are due 30 days after the end of the quarter being reviewed. "Continuity and Coordination of Care" and discharge planning are tracked components under table 3 of the TRR (Treatment Record Review) tab of the 358 Report. The 358 report template is on the LA – Medicaid website. LDH monitors a report generated by the MCOs who are contractually required to ensure continuity of care. The basis of the report is MCO utilization of the updated audit tool which contains SUD level of care specific elements including discharge planning/transfer planning and referrals.



Notes: The numerator is the total number beneficiaries age 18 and older with a new episode of alcohol abuse or dependence who initiated treatment within 14 days of the diagnosis. The denominator is the total number of index visits for alcohol abuse or dependence.



Notes: The numerator is the total number beneficiaries age 18 and older with a new episode of alcohol abuse or dependence who initiated treatment within 14 days of the diagnosis. The denominator is the total number of index visits for alcohol abuse or dependence.

ITS Estimates

Pre-Period Slope	0.300*** (0.030) [0.238, 0.361]
Level Change	1.013 (0.866) [-0.733, 2.759]
Post-Period Slope	0.059 (0.053) [-0.048, 0.166]
Slope Change	-0.240*** (0.062) [-0.364, -0.116]
Pre-Period Mean	42.6
Pre-Period Min	35.8
Pre-Period Max	47.7
Post-Period Mean	48.76
Post-Period Min	45.9
Post-Period Max	50.6
Observations	48

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

Evaluation Demonstration Goal 3.2

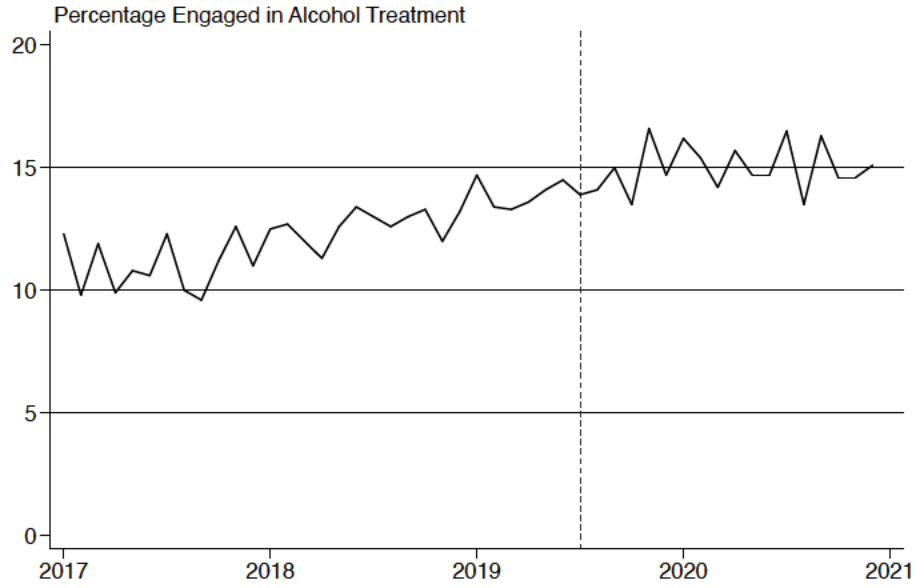
Monitoring Metric: #15, Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)

Description: Percentage of beneficiaries age 18 and older with a new episode of alcohol abuse or dependence who initiated treatment and who were engaged in ongoing treatment within 34 days of the initiation visit.

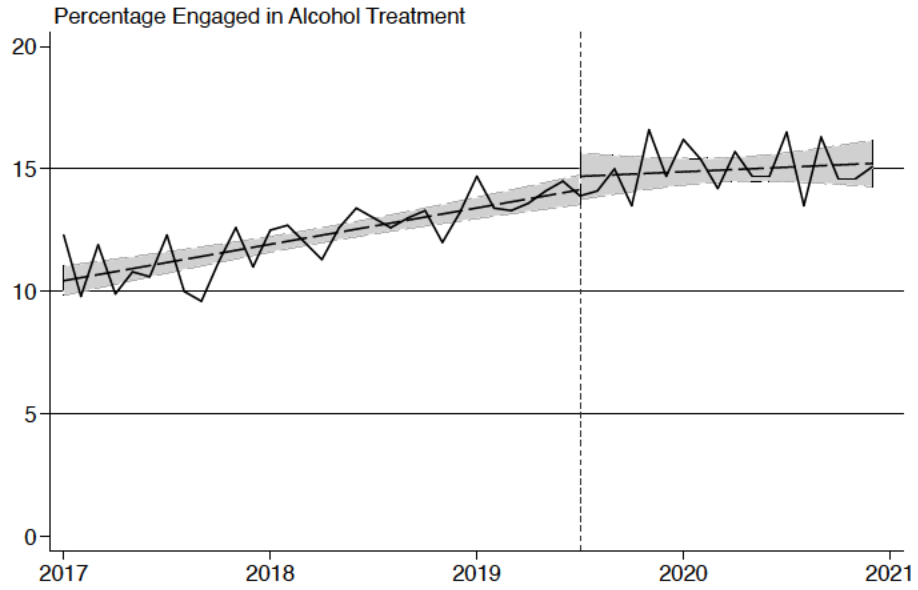
Primary Driver: Increase adherence to and retention in treatment.

Secondary Drivers:

- Continued monitoring of MCO compliance with existing contract requirements related to care transition activities.
    - Status: Started 6/30/2019
    - Details: SUD specific audit tool elements were added to the MCO monitoring tool for the second quarter reviews in 2019. SUD providers are audited using both the general BH elements and the SUD specific elements. These reports are due 30 days after the end of the quarter being reviewed. "Continuity and Coordination of Care" and discharge planning are tracked components under table 3 of the TRR (Treatment Record Review) tab of the 358 Report. The 358 report template is on the LA – Medicaid website. LDH monitors a report generated by the MCOs who are contractually required to ensure continuity of care. The basis of the report is MCO utilization of the updated audit tool which contains SUD level of care specific elements including discharge planning/transfer planning and referrals.



Notes: The numerator is the total number beneficiaries age 18 and older with a new episode of alcohol abuse or dependence who initiated treatment and who were engaged in ongoing treatment within 34 days of the initiation visit. The denominator is the total number of index visits for alcohol abuse or dependence.



Notes: The numerator is the total number beneficiaries age 18 and older with a new episode of alcohol abuse or dependence who initiated treatment and who were engaged in ongoing treatment within 34 days of the initiation visit. The denominator is the total number of index visits for alcohol abuse or dependence.

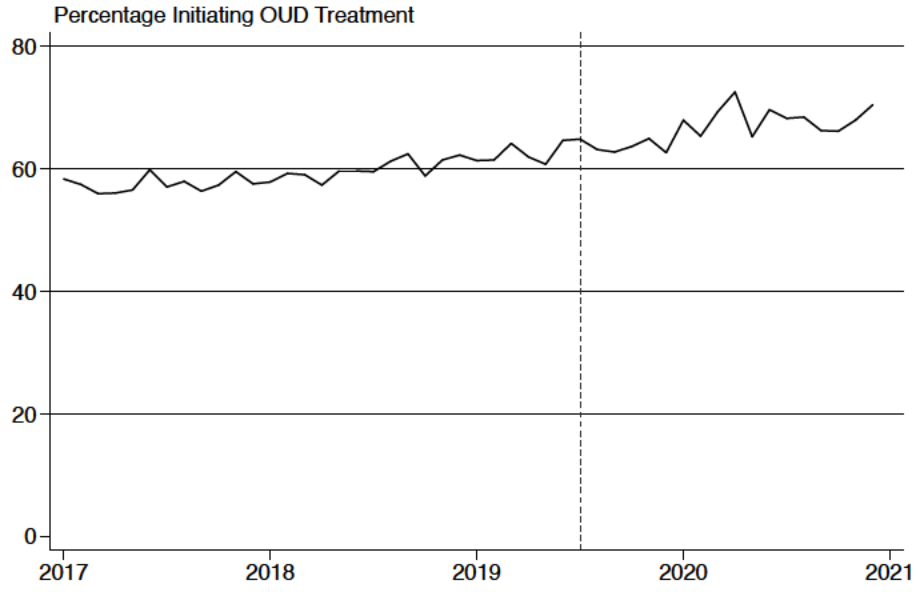
ITS Estimates

Pre-Period Slope	0.125*** (0.015) [0.095, 0.155]
Level Change	0.513 (0.464) [-0.423, 1.449]
Post-Period Slope	0.031 (0.034) [-0.037, 0.099]
Slope Change	-0.094** (0.036) [-0.166, -0.023]
Pre-Period Mean	12.24
Pre-Period Min	9.6
Pre-Period Max	14.7
Post-Period Mean	14.96
Post-Period Min	13.5
Post-Period Max	16.6
Observations	48

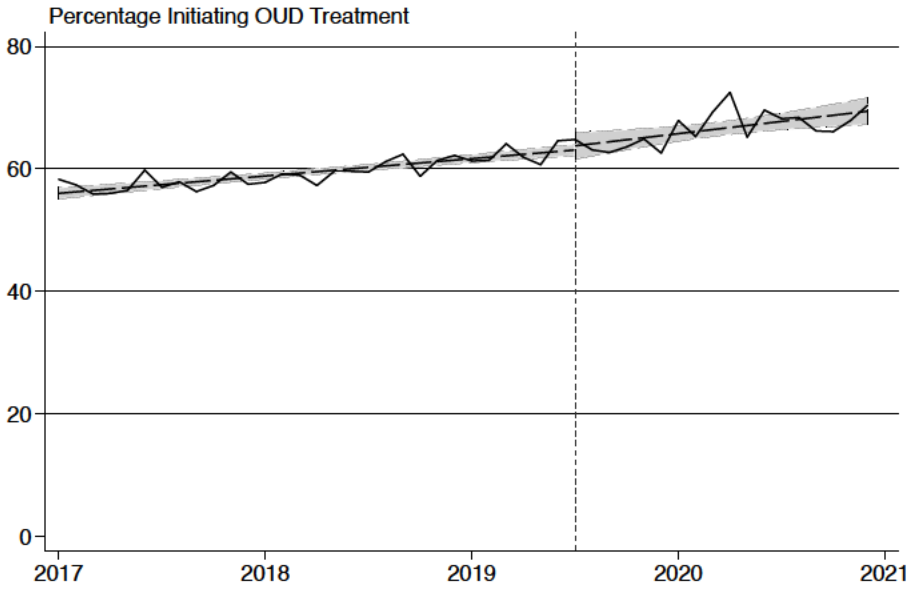
Notes: Standard errors are in parentheses and 95% confidence intervals are in brackets. *p<0.10, **p<0.05, ***p<0.01

Evaluation Demonstration Goal 3.2
Monitoring Metric: #15, Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)
Description: Percentage of beneficiaries age 18 and older with a new episode of opioid abuse or dependence who initiated OUD treatment within 14 days of the diagnosis.
Primary Driver: Increase adherence to and retention in treatment.
Secondary Drivers:

- Continued monitoring of MCO compliance with existing contract requirements related to care transition activities.
    - Status: Started 6/30/2019
    - Details: SUD specific audit tool elements were added to the MCO monitoring tool for the second quarter reviews in 2019. SUD providers are audited using both the general BH elements and the SUD specific elements. These reports are due 30 days after the end of the quarter being reviewed. "Continuity and Coordination of Care" and discharge planning are tracked components under table 3 of the TRR (Treatment Record Review) tab of the 358 Report. The 358 report template is on the LA – Medicaid website. LDH monitors a report generated by the MCOs who are contractually required to ensure continuity of care. The basis of the report is MCO utilization of the updated audit tool which contains SUD level of care specific elements including discharge planning/transfer planning and referrals.



Notes: The numerator is the total number beneficiaries age 18 and older with a new episode of opioid abuse or dependence who initiated OUD treatment within 14 days of the diagnosis. The denominator is the total number of index OUD visits.



Notes: The numerator is the total number beneficiaries age 18 and older with a new episode of opioid abuse or dependence who initiated OUD treatment within 14 days of the diagnosis. The denominator is the total number of index OUD visits.

ITS Estimates

Pre-Period Slope	0.224*** (0.022) [0.179, 0.269]
Level Change	0.917 (0.930) [-0.958, 2.792]
Post-Period Slope	0.332*** (0.081) [0.169, 0.495]
Slope Change	0.108 (0.083) [-0.059, 0.276]
Pre-Period Mean	59.38
Pre-Period Min	55.9
Pre-Period Max	64.6
Post-Period Mean	66.59
Post-Period Min	62.6
Post-Period Max	72.5
Observations	48

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

Evaluation Demonstration Goal 3.2

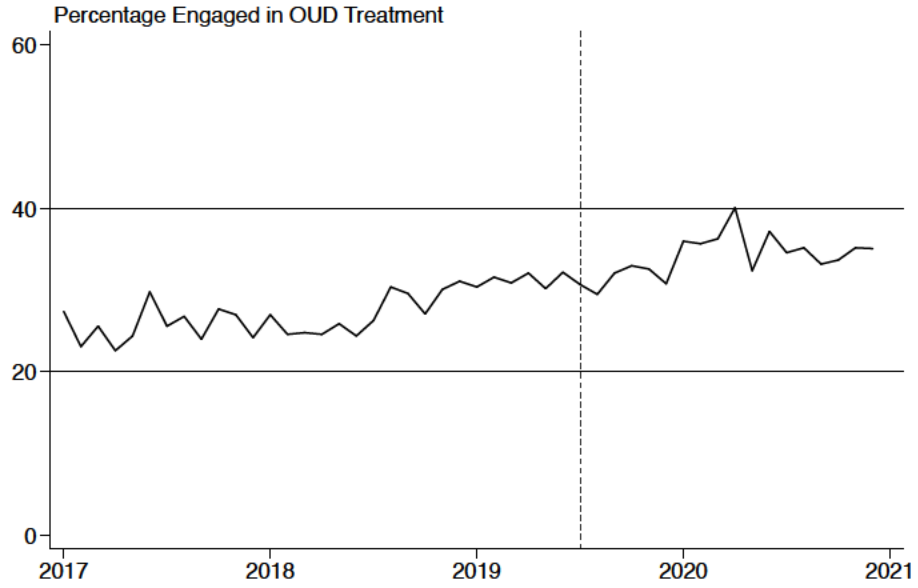
Monitoring Metric: #15, Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)

Description: Percentage of beneficiaries age 18 and older with a new episode of opioid abuse or dependence who initiated treatment and who were engaged in ongoing OUD treatment within 34 days of the initiation visit.

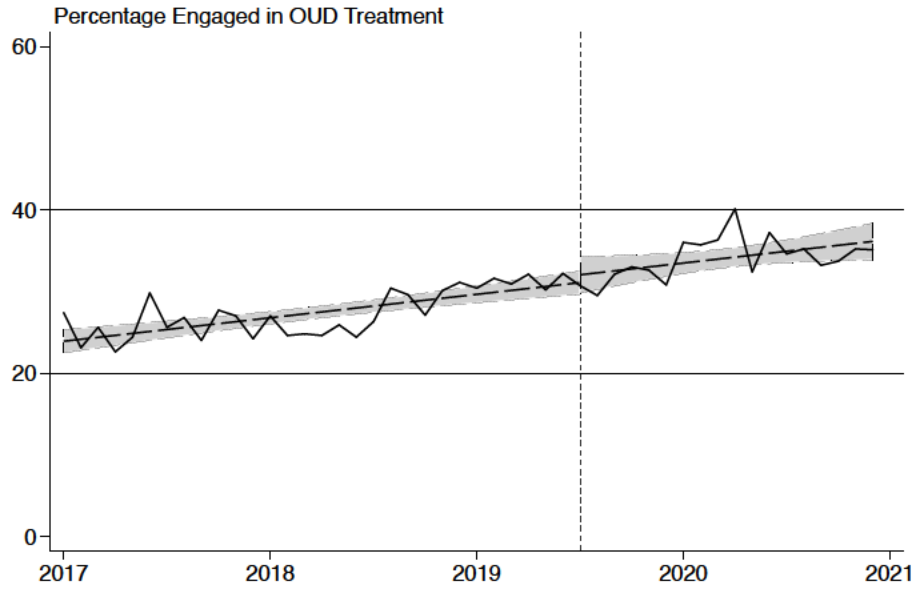
Primary Driver: Increase adherence to and retention in treatment.

Secondary Drivers:

- Continued monitoring of MCO compliance with existing contract requirements related to care transition activities.
    - Status: Started 6/30/2019
    - Details: SUD specific audit tool elements were added to the MCO monitoring tool for the second quarter reviews in 2019. SUD providers are audited using both the general BH elements and the SUD specific elements. These reports are due 30 days after the end of the quarter being reviewed. "Continuity and Coordination of Care" and discharge planning are tracked components under table 3 of the TRR (Treatment Record Review) tab of the 358 Report. The 358 report template is on the LA – Medicaid website. LDH monitors a report generated by the MCOs who are contractually required to ensure continuity of care. The basis of the report is MCO utilization of the updated audit tool which contains SUD level of care specific elements including discharge planning/transfer planning and referrals.



Notes: The numerator is the total number beneficiaries age 18 and older with a new episode of opioid abuse or dependence who initiated treatment and who were engaged in ongoing OUD treatment within 34 days of the initiation visit. The denominator is the total number of index OUD visits.



Notes: The numerator is the total number beneficiaries age 18 and older with a new episode of opioid abuse or dependence who initiated treatment and who were engaged in ongoing OUD treatment within 34 days of the initiation visit. The denominator is the total number of index OUD visits.

ITS Estimates

Pre-Period Slope	0.242*** (0.039) [0.163, 0.321]
Level Change	0.900 (1.395) [-1.911, 3.712]
Post-Period Slope	0.241** (0.099) [0.042, 0.439]
Slope Change	-0.001 (0.103) [-0.208, 0.206]
Pre-Period Mean	27.38
Pre-Period Min	22.6
Pre-Period Max	32.2
Post-Period Mean	34.08
Post-Period Min	29.5
Post-Period Max	40.1
Observations	48

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

Evaluation Demonstration Goal 3.2

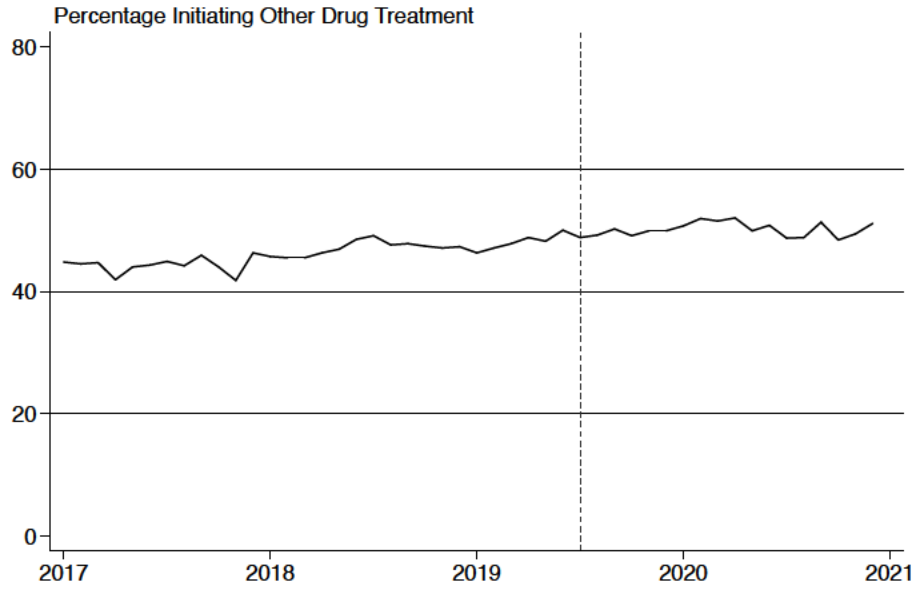
Monitoring Metric: #15, Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)

Description: Percentage of beneficiaries age 18 and older with a new episode of other drug abuse or dependence who initiated treatment within 14 days of the diagnosis.

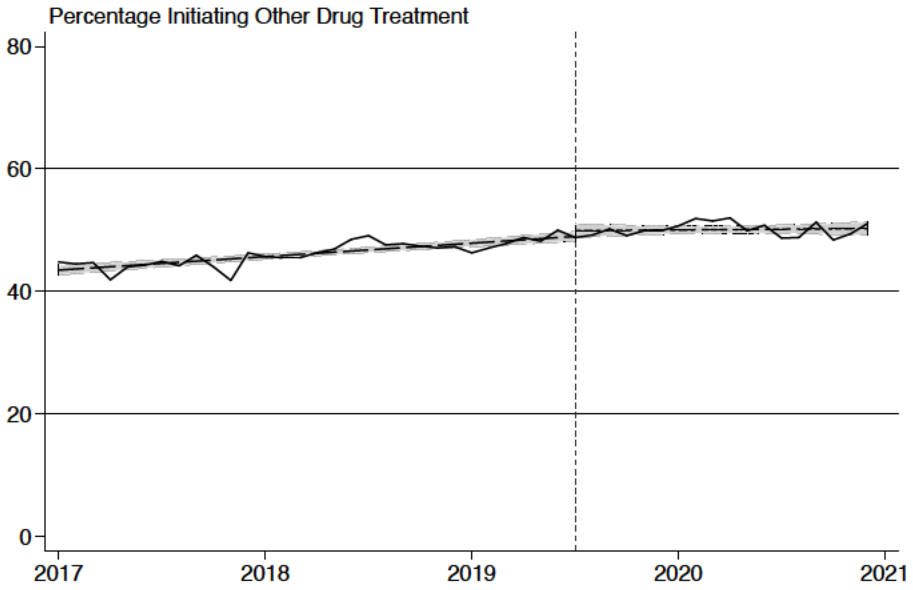
Primary Driver: Increase adherence to and retention in treatment.

Secondary Drivers:

- Continued monitoring of MCO compliance with existing contract requirements related to care transition activities.
    - Status: Started 6/30/2019
    - Details: SUD specific audit tool elements were added to the MCO monitoring tool for the second quarter reviews in 2019. SUD providers are audited using both the general BH elements and the SUD specific elements. These reports are due 30 days after the end of the quarter being reviewed. "Continuity and Coordination of Care" and discharge planning are tracked components under table 3 of the TRR (Treatment Record Review) tab of the 358 Report. The 358 report template is on the LA – Medicaid website. LDH monitors a report generated by the MCOs who are contractually required to ensure continuity of care. The basis of the report is MCO utilization of the updated audit tool which contains SUD level of care specific elements including discharge planning/transfer planning and referrals.



Notes: The numerator is the total number beneficiaries age 18 and older with a new episode of other drug abuse or dependence who initiated treatment within 14 days of the diagnosis. The denominator is the total number of index other drug visits.



Notes: The numerator is the total number beneficiaries age 18 and older with a new episode of other drug abuse or dependence who initiated treatment within 14 days of the diagnosis. The denominator is the total number of index other drug visits.

ITS Estimates

Pre-Period Slope	0.184*** (0.024) [0.135, 0.233]
Level Change	0.920 (0.768) [-0.628, 2.468]
Post-Period Slope	0.020 (0.048) [-0.076, 0.116]
Slope Change	-0.164*** (0.051) [-0.267, -0.062]
Pre-Period Mean	46.14
Pre-Period Min	41.8
Pre-Period Max	50
Post-Period Mean	50.09
Post-Period Min	48.4
Post-Period Max	52
Observations	48

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

Evaluation Demonstration Goal 3.2

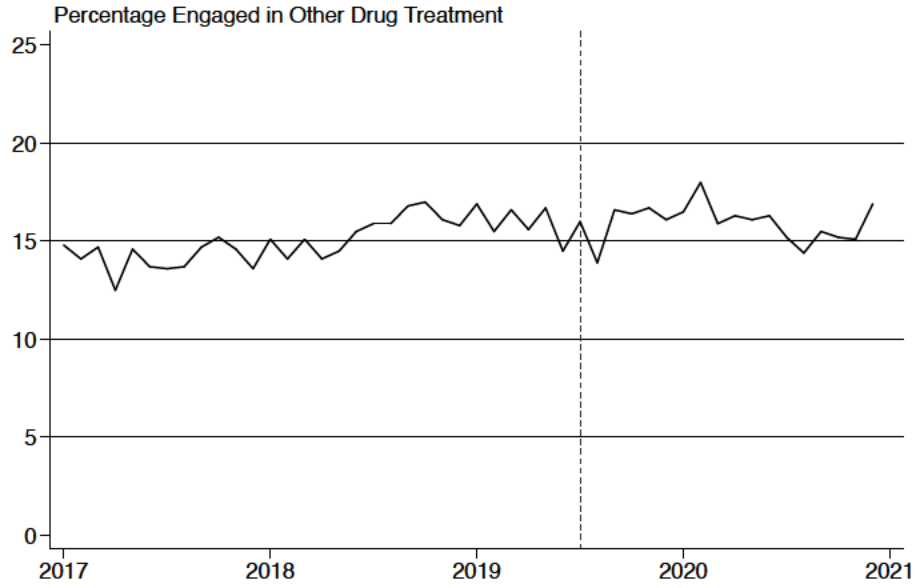
Monitoring Metric: #15, Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)

Description: Percentage of beneficiaries age 18 and older with a new episode of other drug abuse or dependence who initiated treatment and who were engaged in ongoing treatment within 34 days of the initiation visit.

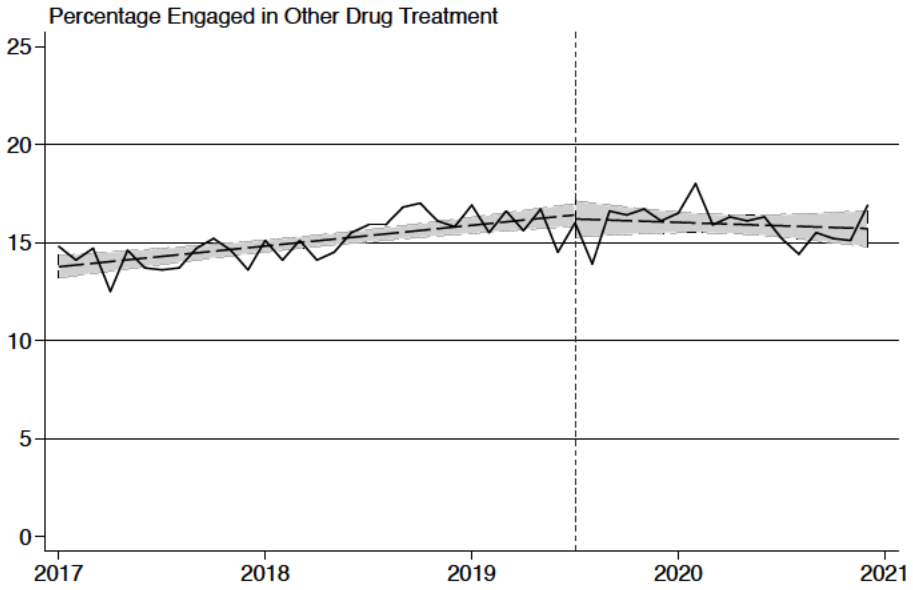
Primary Driver: Increase adherence to and retention in treatment.

Secondary Drivers:

- Continued monitoring of MCO compliance with existing contract requirements related to care transition activities.
    - Status: Started 6/30/2019
    - Details: SUD specific audit tool elements were added to the MCO monitoring tool for the second quarter reviews in 2019. SUD providers are audited using both the general BH elements and the SUD specific elements. These reports are due 30 days after the end of the quarter being reviewed. "Continuity and Coordination of Care" and discharge planning are tracked components under table 3 of the TRR (Treatment Record Review) tab of the 358 Report. The 358 report template is on the LA – Medicaid website. LDH monitors a report generated by the MCOs who are contractually required to ensure continuity of care. The basis of the report is MCO utilization of the updated audit tool which contains SUD level of care specific elements including discharge planning/transfer planning and referrals.



Notes: The numerator is the total number beneficiaries age 18 and older with a new episode of other drug abuse or dependence who initiated treatment and who were engaged in ongoing treatment within 34 days of the initiation visit. The denominator is the total number of index other drug visits.



Notes: The numerator is the total number beneficiaries age 18 and older with a new episode of other drug abuse or dependence who initiated treatment and who were engaged in ongoing treatment within 34 days of the initiation visit. The denominator is the total number of index other drug visits.

ITS Estimates

Pre-Period Slope	0.091*** (0.019) [0.052, 0.130]
Level Change	-0.264 (0.530) [-1.332, 0.805]
Post-Period Slope	-0.029 (0.046) [-0.121, 0.063]
Slope Change	-0.120** (0.054) [-0.229, -0.011]
Pre-Period Mean	15.05
Pre-Period Min	12.5
Pre-Period Max	17
Post-Period Mean	15.95
Post-Period Min	13.9
Post-Period Max	18
Observations	48

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

Evaluation Demonstration Goal 3.2

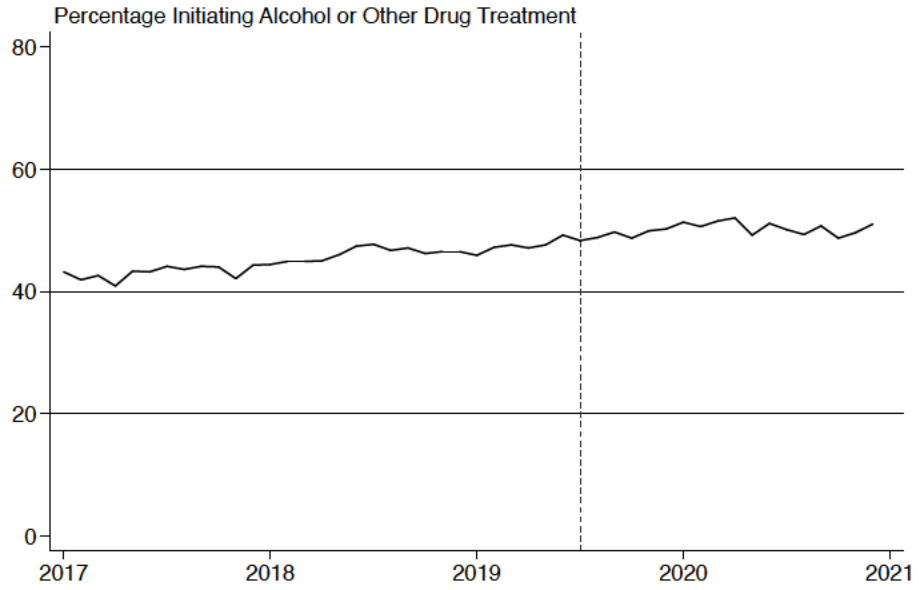
Monitoring Metric: #15, Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)

Description: Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug abuse or dependence (AOD) who initiated treatment within 14 days of the diagnosis.

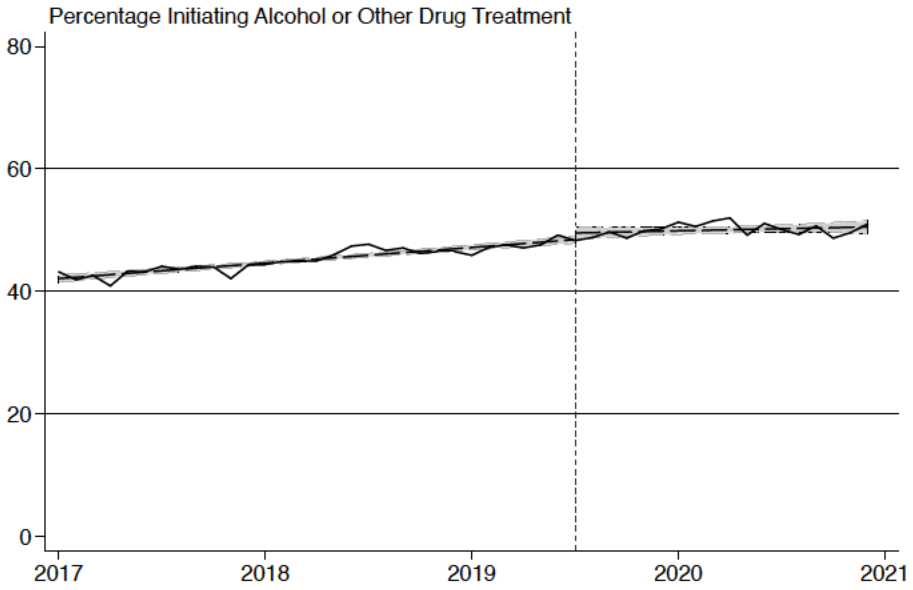
Primary Driver: Increase adherence to and retention in treatment.

Secondary Drivers:

- Continued monitoring of MCO compliance with existing contract requirements related to care transition activities.
    - Status: Started 6/30/2019
    - Details: SUD specific audit tool elements were added to the MCO monitoring tool for the second quarter reviews in 2019. SUD providers are audited using both the general BH elements and the SUD specific elements. These reports are due 30 days after the end of the quarter being reviewed. "Continuity and Coordination of Care" and discharge planning are tracked components under table 3 of the TRR (Treatment Record Review) tab of the 358 Report. The 358 report template is on the LA – Medicaid website. LDH monitors a report generated by the MCOs who are contractually required to ensure continuity of care. The basis of the report is MCO utilization of the updated audit tool which contains SUD level of care specific elements including discharge planning/transfer planning and referrals.



Notes: The numerator is the total number beneficiaries age 18 and older with a new episode of AOD abuse or dependence who initiated treatment within 14 days of the diagnosis. The denominator is the total number of index AOD visits.



Notes: The numerator is the total number beneficiaries age 18 and older with a new episode of AOD abuse or dependence who initiated treatment within 14 days of the diagnosis. The denominator is the total number of index AOD visits.

ITS Estimates

Pre-Period Slope	0.213*** (0.017) [0.179, 0.246]
Level Change	1.073 (0.719) [-0.375, 2.522]
Post-Period Slope	0.058 (0.052) [-0.048, 0.164]
Slope Change	-0.155*** (0.053) [-0.263, -0.047]
Pre-Period Mean	45.17
Pre-Period Min	40.9
Pre-Period Max	49.2
Post-Period Mean	50.04
Post-Period Min	48.3
Post-Period Max	52
Observations	48

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

Evaluation Demonstration Goal 3.2

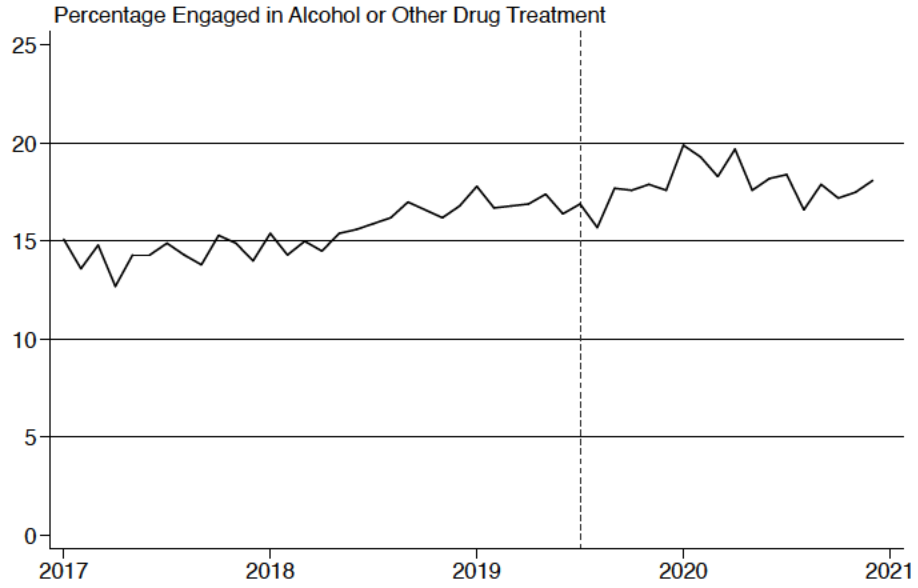
Monitoring Metric: #15, Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)

Description: Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug abuse or dependence (AOD) who initiated treatment and who were engaged in ongoing treatment within 34 days of the initiation visit.

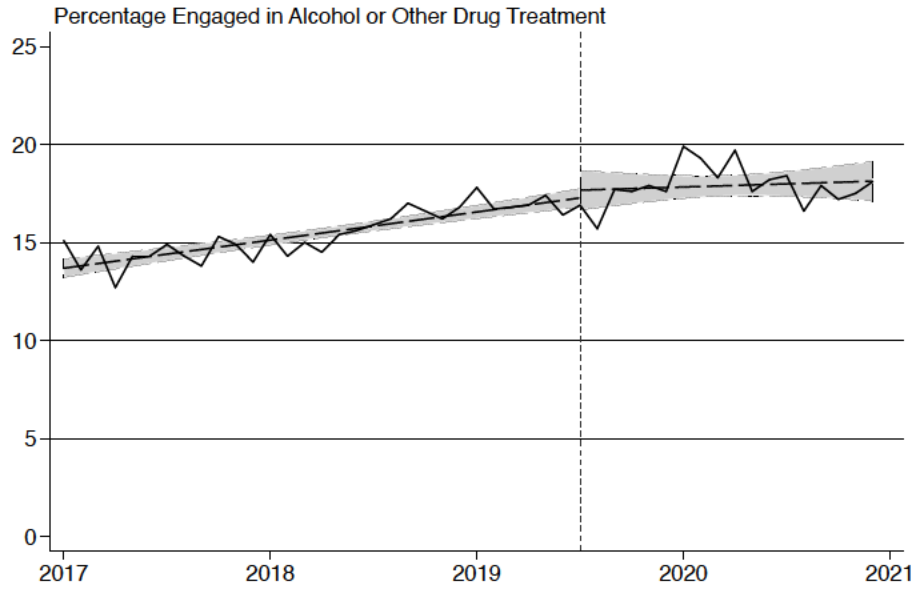
Primary Driver: Increase adherence to and retention in treatment.

Secondary Drivers:

- Continued monitoring of MCO compliance with existing contract requirements related to care transition activities.
    - Status: Started 6/30/2019
    - Details: SUD specific audit tool elements were added to the MCO monitoring tool for the second quarter reviews in 2019. SUD providers are audited using both the general BH elements and the SUD specific elements. These reports are due 30 days after the end of the quarter being reviewed. "Continuity and Coordination of Care" and discharge planning are tracked components under table 3 of the TRR (Treatment Record Review) tab of the 358 Report. The 358 report template is on the LA – Medicaid website. LDH monitors a report generated by the MCOs who are contractually required to ensure continuity of care. The basis of the report is MCO utilization of the updated audit tool which contains SUD level of care specific elements including discharge planning/transfer planning and referrals.



Notes: The numerator is the total number beneficiaries age 18 and older with a new episode of AOD abuse or dependence who initiated treatment and who were engaged in ongoing treatment within 34 days of the initiation visit. The denominator is the total number of index AOD visits.



Notes: The numerator is the total number beneficiaries age 18 and older with a new episode of AOD abuse or dependence who initiated treatment and who were engaged in ongoing treatment within 34 days of the initiation visit. The denominator is the total number of index AOD visits.

ITS Estimates

Pre-Period Slope	0.122*** (0.013) [0.095, 0.149]
Level Change	0.345 (0.659) [-0.983, 1.673]
Post-Period Slope	0.027 (0.055) [-0.084, 0.138]
Slope Change	-0.095 (0.059) [-0.214, 0.023]
Pre-Period Mean	15.43
Pre-Period Min	12.7
Pre-Period Max	17.8
Post-Period Mean	17.89
Post-Period Min	15.7
Post-Period Max	19.9
Observations	48

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

Evaluation Demonstration Goal 4.1

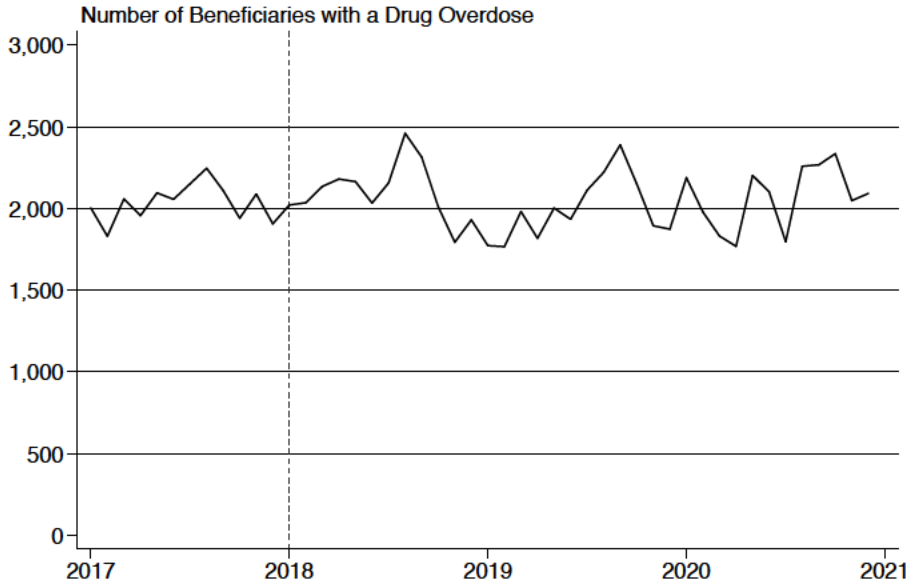
Monitoring Metric: N/A

Description: The number of drug overdoses among Medicaid beneficiaries. Drug overdose is defined using the measure proposed by the National Council of State and Territorial Epidemiologists and the National Center for Injury Prevention and Control and includes diagnosis codes in any field starting with T36 through T50, with unintentional, intentional harm, assault, or undetermined intent, and initial, subsequent, or missing encounter type. Instances of adverse effects, underdosing, and sequelae are excluded.

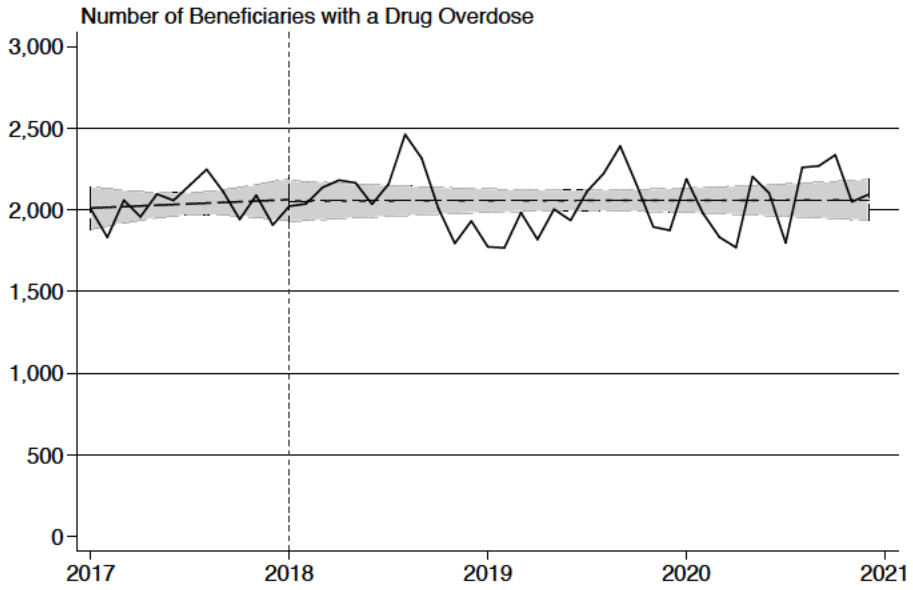
Primary Driver: Reduce instances of drug overdose and overdose deaths.

Secondary Drivers:

- Increased availability of Naloxone.
    - Status: Ongoing
    - Details: The secretary of LDH signed a standing order for dispensing Naloxone without a prescription on 1/23/2017. In addition to the standing order, there are grants in place funding distribution of naloxone. These grants include MAT-PDOA, STR, and LASOR.



Notes: The total number of Medicaid beneficiaries with a diagnosis code in any field starting with T36 through T50, with unintentional, intentional harm, assault, or undetermined intent, and initial, subsequent, or missing encounter type. Instances of adverse effects, underdosing, and sequelae are excluded.



Notes: The total number of Medicaid beneficiaries with a diagnosis code in any field starting with T36 through T50, with unintentional, intentional harm, assault, or undetermined intent, and initial, subsequent, or missing encounter type. Instances of adverse effects, underdosing, and sequelae are excluded.

ITS Estimates

Pre-Period Slope	6.11 (9.42) [-12.87, 25.09]
Level Change	-23.76 (111.22) [-247.91, 200.39]
Post-Period Slope	0.183 (3.39) [-6.65, 7.02]
Slope Change	-5.93 (10.06) [-26.20, 14.34]
Pre-Period Mean	2,037.58
Pre-Period Min	1,831
Pre-Period Max	2,247
Post-Period Mean	2,056.72
Post-Period Min	1,767
Post-Period Max	2,461
Observations	48

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

Evaluation Demonstration Goal 4.1

Monitoring Metric: N/A

Description: The percentage of Medicaid beneficiaries with a drug overdose among Medicaid beneficiaries with an SUD diagnosis. Drug overdose is defined using the measure proposed by the National Council of State and Territorial Epidemiologists and the National Center for Injury Prevention and Control and includes diagnosis codes in any field starting with T36 through T50, with unintentional, intentional harm, assault, or undetermined intent, and initial, subsequent, or missing encounter type. Instances of adverse effects, underdosing, and sequelae are excluded.

Primary Driver: Reduce instances of drug overdose and overdose deaths.

Secondary Drivers:

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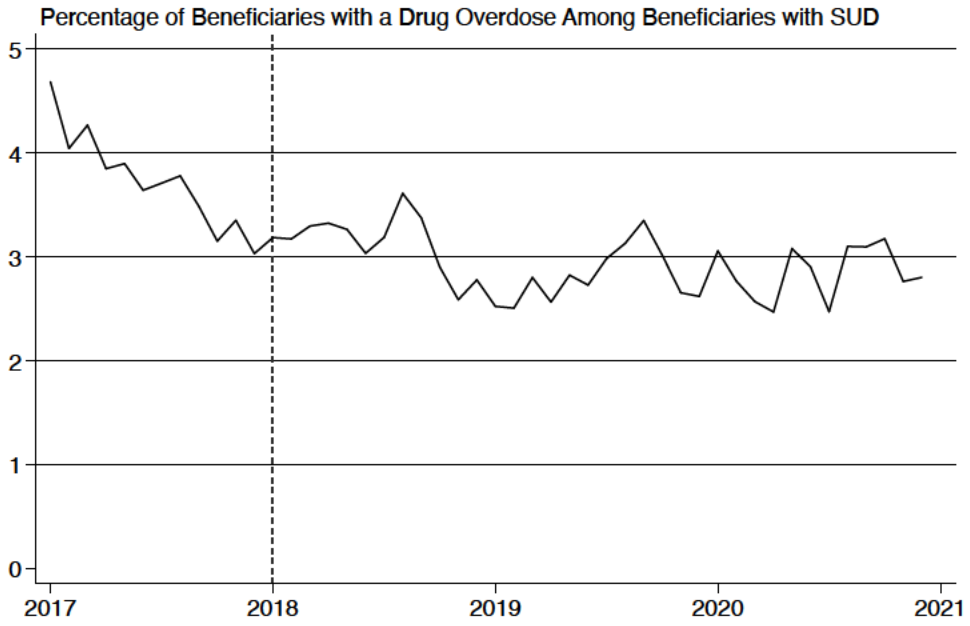
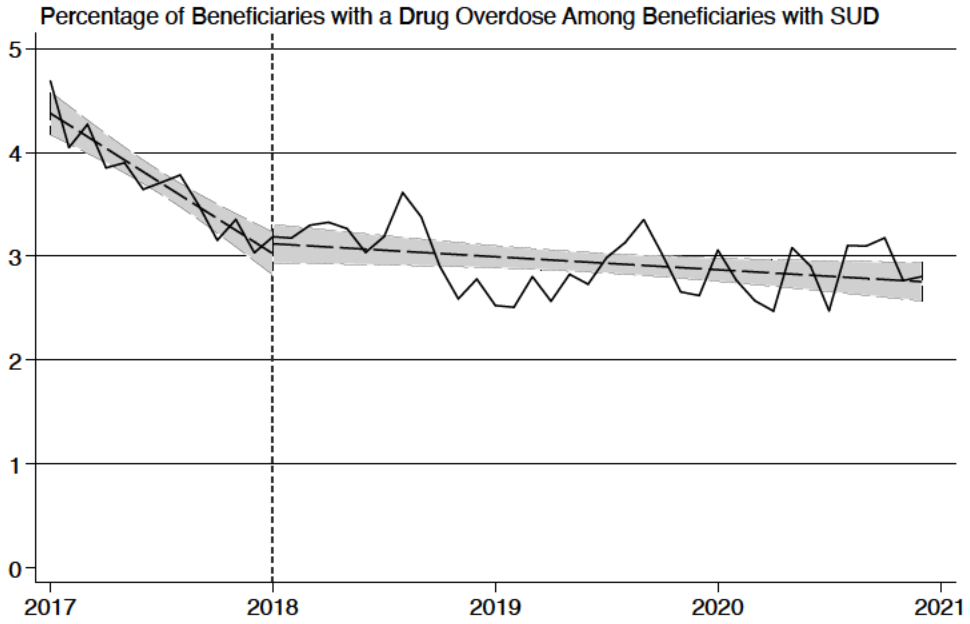
    - Status: Ongoing
    - Details: The secretary of LDH signed a standing order for dispensing Naloxone without a prescription on 1/23/2017. In addition to the standing order, there are grants in place funding distribution of naloxone. These grants include MAT-PDOA, STR, and LASOR.



Notes: The numerator is the total number of Medicaid beneficiaries with a diagnosis code in any field starting with T36 through T50, with unintentional, intentional harm, assault, or undetermined intent, and initial, subsequent, or missing encounter type. Instances of adverse effects, underdosing, and sequelae are excluded. The denominator is the 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 (in thousands).



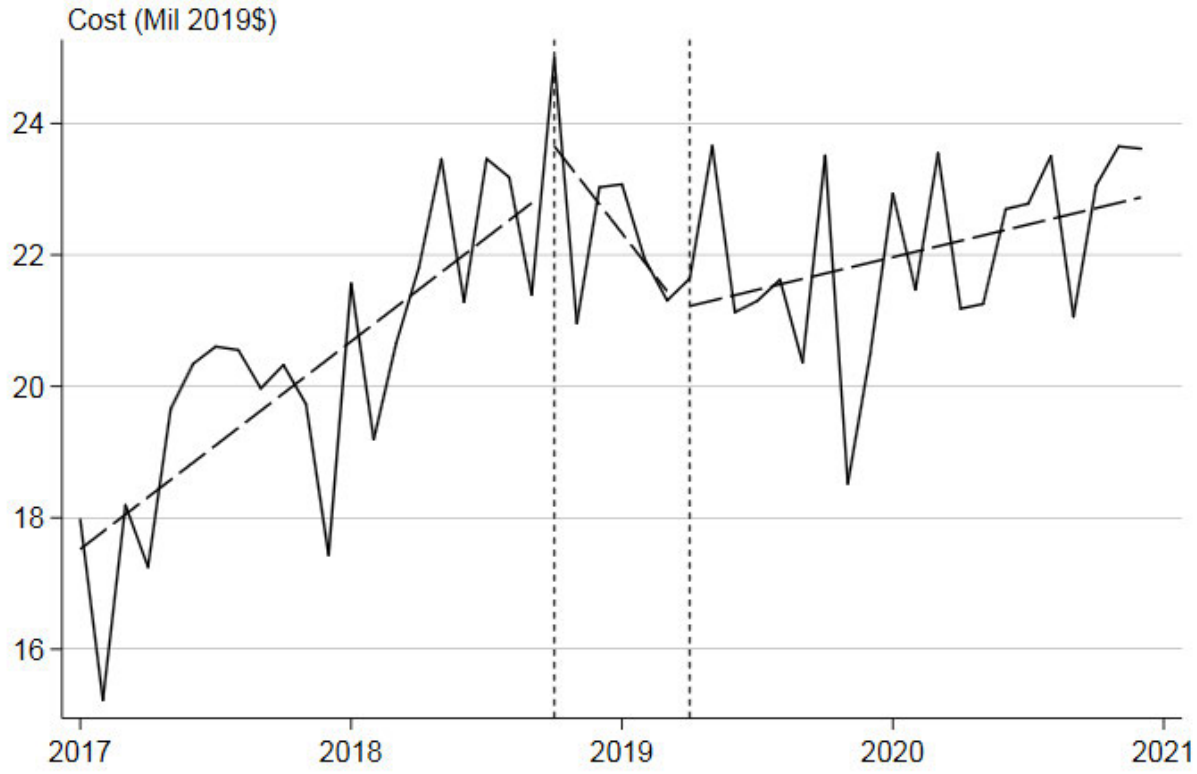
ITS Estimates

Pre-Period Slope	-0.120*** (0.009) [-0.139, -0.101]
Level Change	0.156 (0.140) [-0.125, 0.438]
Post-Period Slope	-0.010* (0.005) [-0.021, 0.000]
Slope Change	0.109*** (0.011) [0.088, 0.131]
Pre-Period Mean	3.74
Pre-Period Min	3.03
Pre-Period Max	4.69
Post-Period Mean	2.94
Post-Period Min	2.47
Post-Period Max	3.61
Observations	48

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

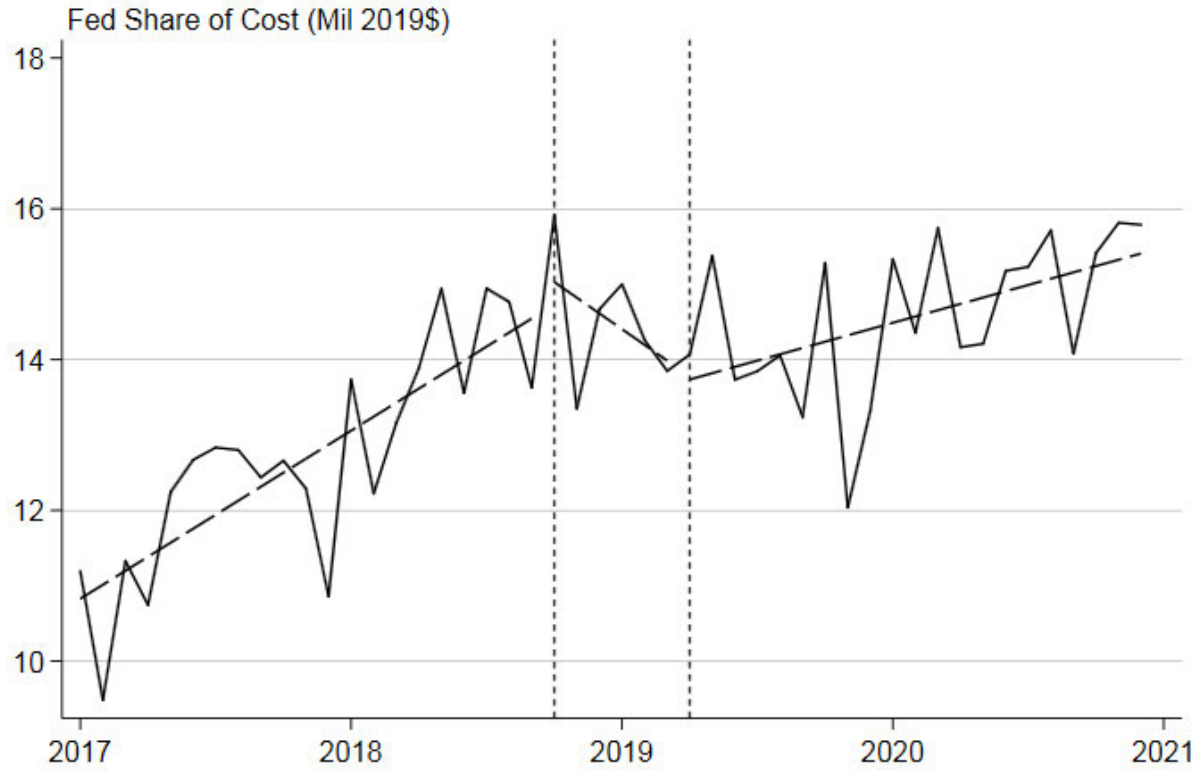
Required Evaluation Topic: Demonstrate patterns and trends in Medicaid costs associated with SUD 1115 demonstration

Total Cost Louisiana Substance Use Disorder Waiver – Interrupted Time Series



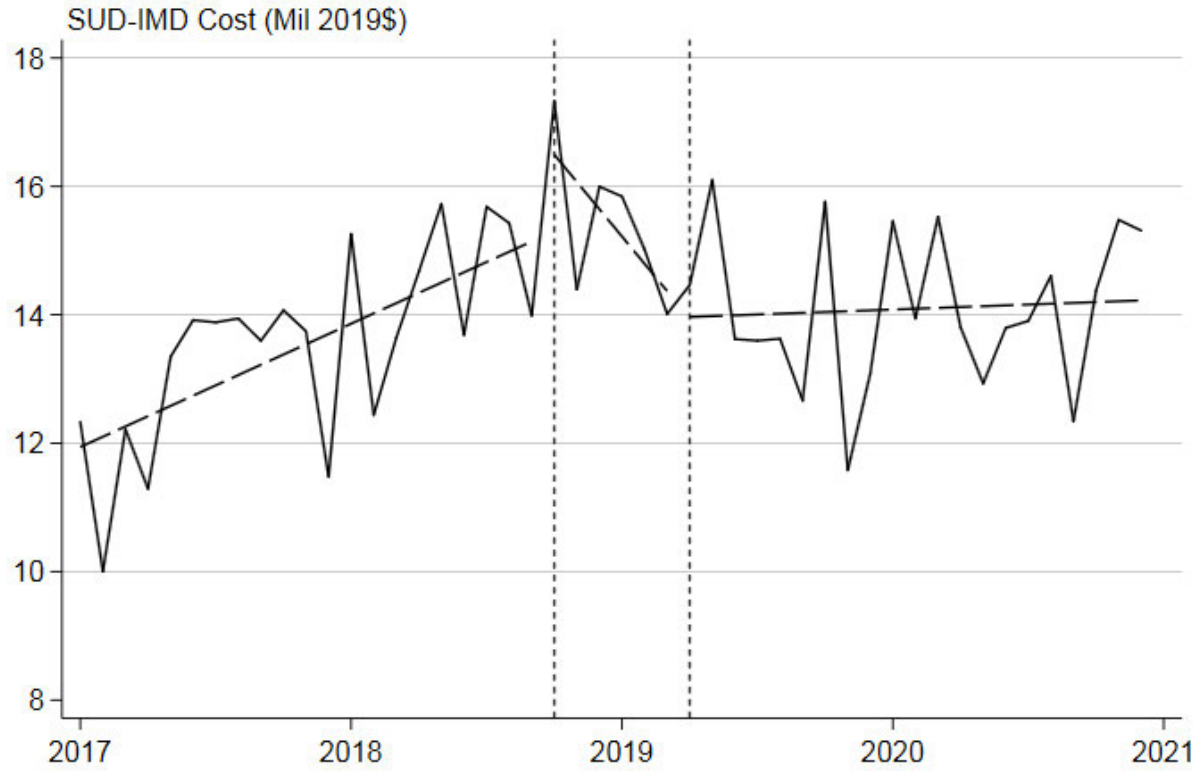
Definition: Total cost consists of waiver administration costs, Emergency Department visits, stays in an Institution for Mental Disease, treatment costs by American Society of Addiction Medicine Level, and medication assisted therapy costs. Data source: Louisiana Department of Health time use survey, Louisiana Medicaid claims, Louisiana Medicaid Fee Schedule, Federal Supply Schedule.

Federal Share of Louisiana Substance Use Disorder Waiver Cost – Interrupted Time Series



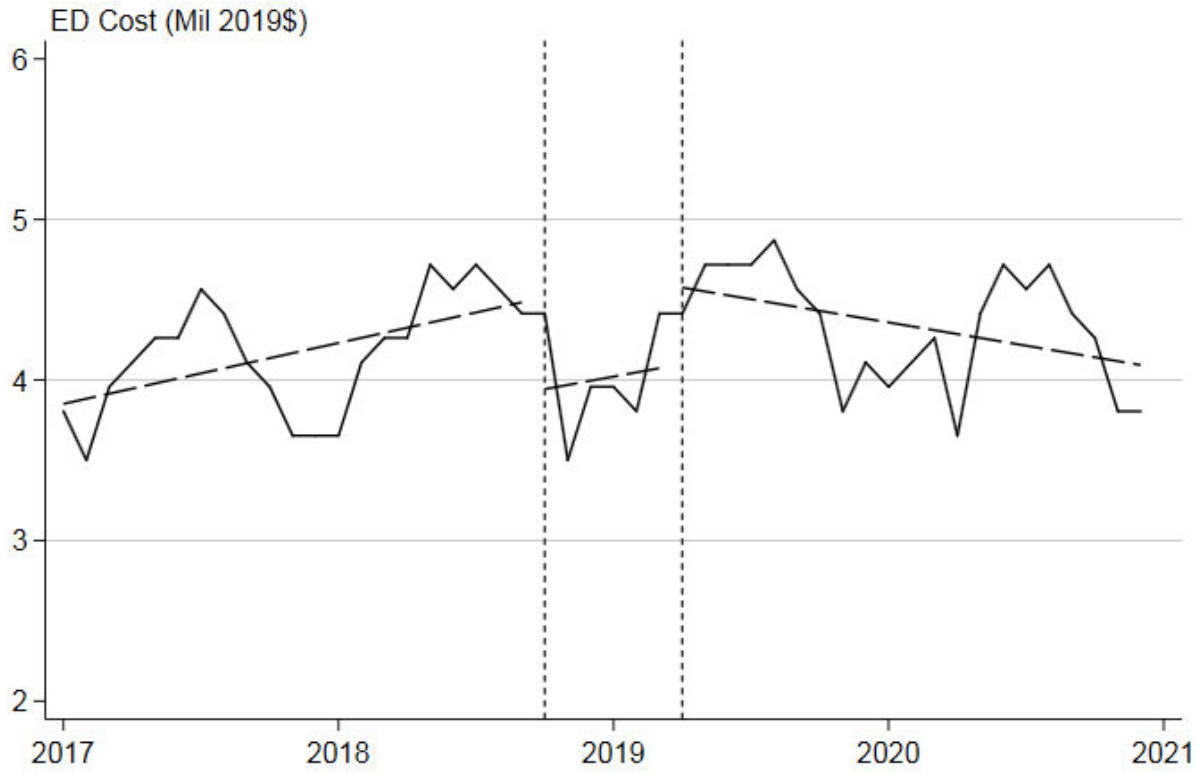
Definition: Total cost multiplied by annual Federal Medical Assistance Percentage (FMAP) for Louisiana. Data source: Louisiana Department of Health time use survey, Louisiana Medicaid claims, Louisiana Medicaid Fee Schedule, Federal Supply Schedule, Kaiser Family Foundation.

Cost of Medicaid Beneficiaries Treated in an Institution for Mental Diseases – Interrupted Time Series



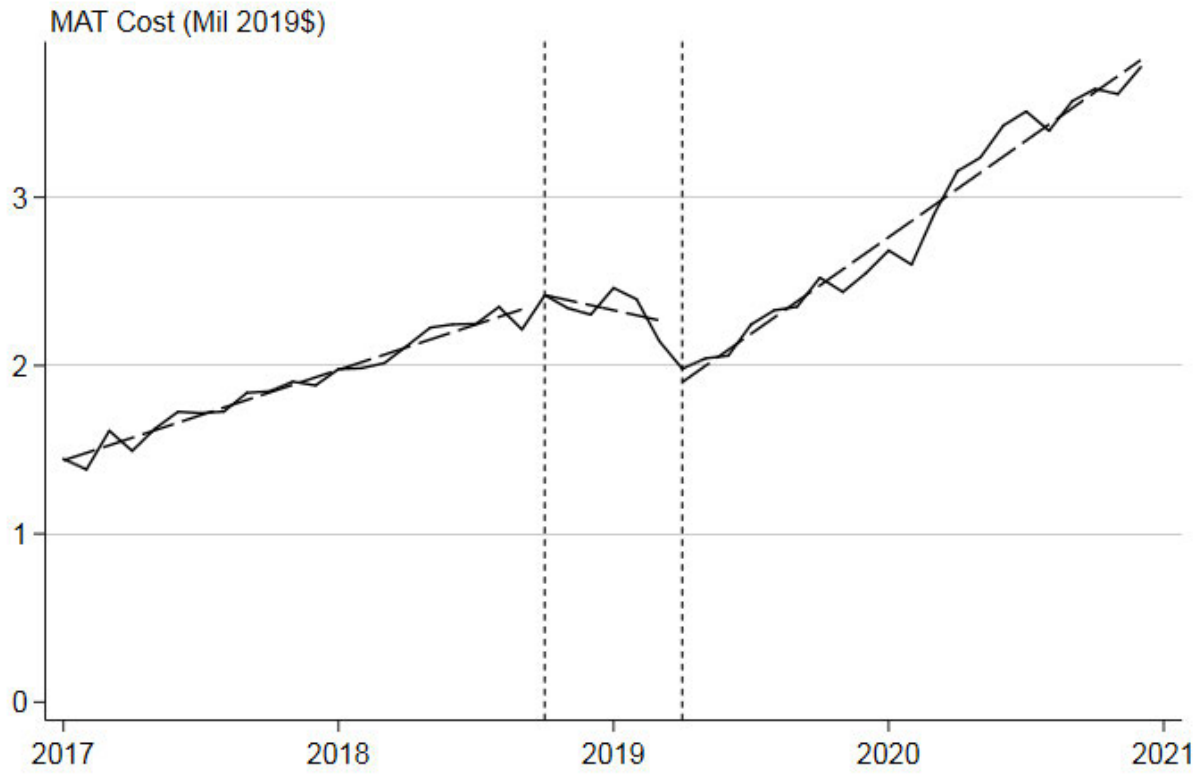
Definition: The product of the number of beneficiaries that stay in an IMD, the average length of stay, and daily cost. Data source: Louisiana Medicaid claims, Louisiana Medicaid Fee Schedule.

Cost of Medicaid Beneficiaries' Emergency Department Visits – Interrupted Time Series



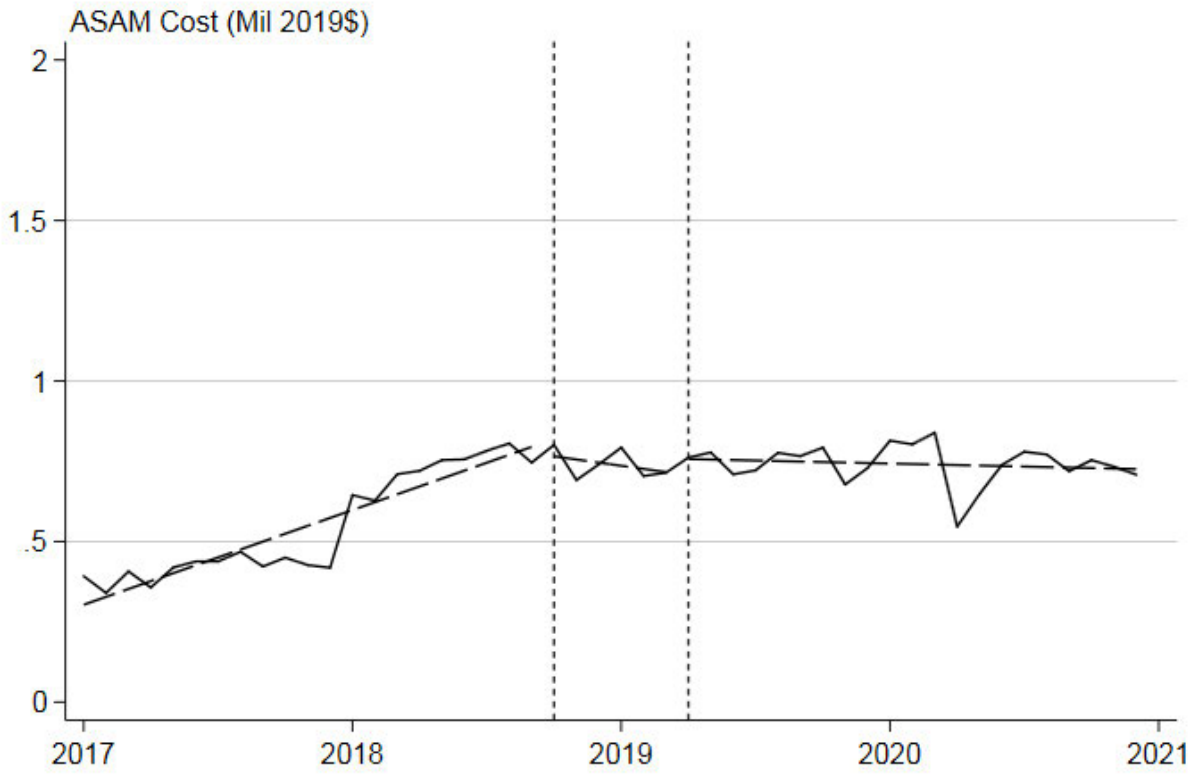
Definition: The product of the number of beneficiaries that visit an ED and cost. Data source: Louisiana Medicaid claims, Louisiana Medicaid Fee Schedule.

Cost of Medication-Assisted Treatment– Interrupted Time Series



Definition: The product of the number of beneficiaries that use MAT, duration of treatment, and daily cost. Data source: Louisiana Medicaid claims, Federal Supply Schedule.

Cost of ASAM Care – Interrupted Time Series



Definition: The product of each level of care and cost for that level of care. Data source: Louisiana Medicaid claims, Louisiana Medicaid Fee Schedule.

Interrupted Time Series Estimates of Cost

	Total Cost	Federal Share of Total Cost	SUD-IMD Cost	ED Cost	MAT Cost	ASAM Cost
Trend	0.263***	0.186***	0.160***	0.032***	0.045***	0.025***
	(0.049)	(0.031)	(0.041)	(0.009)	(0.003)	(0.002)
Post1	16.119**	8.971*	14.069**	-0.451	1.691***	0.703***
	(7.636)	(5.043)	(5.434)	(2.538)	(0.508)	(0.218)
Post2	-14.473*	-8.215	-12.244**	1.882	-3.861***	-0.18
	(7.812)	(5.163)	(5.683)	(2.564)	(0.517)	(0.221)
Post x Trend1	-0.705**	-0.394*	-0.585***	-0.006	-0.075***	-0.034***
	(0.297)	(0.196)	(0.213)	(0.101)	(0.022)	(0.009)
Post x Trend2	0.525*	0.292	0.438**	-0.05	0.126***	0.008
	(0.296)	(0.196)	(0.214)	(0.102)	(0.022)	(0.009)
Baseline Mean	20.2	12.7	13.5	4.2	1.9	0.5
R^2	0.589	0.689	0.407	0.275	0.982	0.843
Observations	48	48	48	48	48	48

Notes: All costs are in millions of 2019$. Coefficient definitions are as follows: *Trend* represents the pre-intervention estimate of the slope of the linear trend in the outcome variable; *Post1* and *Post2* are indicators for level changes in outcomes coinciding with the intervention periods; *Post x Trend1* and *Post X Trend2* represent the post-intervention change in the slope of the linear trend compared to the pre-intervention period. The baseline mean is calculated as the mean of the outcome variable in the pre-intervention period. Heteroskedasticity-robust standard errors are presented in parentheses below the coefficient estimates. *$p<0.10$, **$p<0.05$, ***$p<0.01$

Notes about imputation of 2017 IMD values:

All values are based on values reported as part of the monitoring protocol except for values relating to beneficiaries treated in an institution of mental disease. Lists of institutions of mental disease were not preserved for 2017, so this metric is not reported in the utilization metrics. But IMD stays are a component of total costs, so we use the 2018 list of institutions of mental disease and calculate the number of patients staying in IMDs in 2017 and 2018 using the 2018 facility definition. We then scale our 2017 monthly calculations by the ratio between the Louisiana Department of Health's 2018 annual total and Tulane's 2018 annual total. We also repeat this imputation process to obtain 2017 estimates of the length of stay in an IMD. This procedure applies to the number of patients in an IMD (Monitoring Metric 5) and the length of stay in an IMD (Monitoring Metric 36).

State of Louisiana Department of Health
Aggregate Report
Annual External Quality Review Technical Report

FINAL REPORT

Review Period: July 1, 2019 – June 30, 2020
Report Issued: April 2021

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Better healthcare, realized.

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I. Introduction

The Centers for Medicare and Medicaid Services (CMS) require that state agencies contract with an external quality review organization (EQRO) to conduct an annual external quality review (EQR) of the services provided by contracted Medicaid managed care organizations, prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), and primary care case management plans (managed care entities [MCEs]). This EQR must include an analysis and evaluation of aggregated information on quality, timeliness, and access to the health care services that an MCE furnishes to Medicaid recipients. Quality is defined in 42 Code of Federal Regulations (CFR) 438.320 as "the degree to which an MCO or PIHP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge."

In order to comply with these requirements, the Louisiana Department of Health (LDH) contracted with IPRO to assess and report the impact of its Medicaid managed care program, the Healthy Louisiana Program, and each of the participating MCEs on the accessibility, timeliness, and quality of services.

The framework for IPRO's assessment is based on the guidelines and protocols established by CMS, as well as Louisiana state requirements. IPRO's assessment included an evaluation of the mandatory activities, which encompass: performance measure (PM) validation, performance improvement project (PIP) validation, and compliance audits. Results of the most current Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys are presented and are evaluated in comparison to the National Committee for Quality Assurance (NCQA)'s *Quality Compass®* National – All Lines of Business ([LOBs] Excluding Preferred-Provider Organizations [PPOs] and Exclusive Provider Organizations [EPOs]) Medicaid benchmarks.

To meet 42 CFR 438.364(a)(5) requiring comparative information about all MCEs, this aggregate compares Louisiana managed care entities (MCEs) on EQR tasks. Detailed methodology, review, and assessment of quality, timeliness, and access to healthcare services furnished to Medicaid enrollees can be found in the individual MCE annual technical review reports.

The review period for this report is July 1, 2019 – June 30, 2020.

During the review period, the following five MCOs had enrolled Medicaid members in Louisiana:

- Aetna
- AmeriHealth Caritas Louisiana (ACLA)
- Healthy Blue
- Louisiana Healthcare Connections (LHCC)
- United Healthcare Community Plan (UHC)

Two PAHPs are also included in this aggregate report:

- Magellan of Louisiana CSoC Program (Magellan)
- MCNA Dental (MCNA)

For the review period, Magellan was the only behavioral health PAHP and MCNA was the only dental PAHP. The PAHPs report different PMs, conduct separate PIPs, and have different compliance requirements than the MCOs and so are not compared directly to the MCOs in this aggregate report.

II. Performance Improvement Projects

Full reviews of each MCE's PIP can be found in the individual ATR reports. Reported here are the final assessments of credibility of results and conclusions.

PIP: Improving Rates for (1) Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) and (2) Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

ACLA

Overall Credibility of Results: The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution due to data correction needed for Indicator 8.

Conclusion: One (1) of the 6 IET performance indicators and 1 of the 2 FUA performance indicators demonstrated that the plan achieved improvement. The plan should address the feedback provided with the aim to achieve the targeted rates for all performance indicators.

Aetna

Overall Credibility of Results: The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution due to the intervention and ITM issues identified, as well as the correction needed to the Indicator 2 calculation.

Conclusion: Three (3) of the 6 IET performance indicators demonstrate that the plan achieved improvement; however, the newly added FUA indicators did not. The plan should address the feedback provided with the aim to achieve the targeted rates for all performance indicators.

Healthy Blue

Overall Credibility of Results: The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution due to the ITM issues identified, as well as the correction needed to Indicator 5.

Conclusion: Both of the newly added FUA performance indicators demonstrated improvement; however, the IET performance indicators did not. The plan should address the feedback provided with the aim to achieve the targeted rates for all performance indicators.

LHCC

Overall Credibility of Results: The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution due to the ITM issues identified.

Conclusion: Four (4) of the 6 IET performance indicators demonstrated improvement; however, the 2 newly added FUA indicators did not. The plan should address the feedback provided with the aim to achieve the targeted rates for all performance indicators.

UHC

Overall Credibility of Results: There were no validation findings that indicate that the credibility of the PIP results is at risk.

Conclusion: Each of the 6 IET performance indicators demonstrated improvement; however, the 2 newly added FUA performance indicators did not. The plan should address the feedback provided with the aim to achieve the targeted rates for all performance indicators.

Summary of Findings
For all MCOs, it was found that the credibility of the PIP results was not at risk. However, for all MCOs with the exception of UHC, it was found that the results need to be interpreted with some caution due to issues calculating performance indicators and/or intervention tracking measures.

PIP: Improve Screening for Chronic Hepatitis C Virus (HCV) and Pharmaceutical Treatment Initiation

ACLA
Overall Credibility of Results: The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution due to the OPH [Office of Public Health] denominator data discrepancy issues identified.

Conclusion: Three (3) of the 4 screening performance indicators and each of the 3 treatment indicators demonstrate that the plan achieved improvement. The plan should address the feedback provided with the aim to achieve the targeted rates for all performance indicators.

Aetna
Overall Credibility of Results: The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution due to the intervention and ITM issues noted, including the inappropriate modification made to the OPH listing.

Conclusion: Each of the 7 performance indicators demonstrated that the plan achieved improvement. The plan should address the feedback provided with the aim to achieve the targeted rates for all performance indicators.

Healthy Blue
Overall Credibility of Results: The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution due to the ITM issues identified.

Conclusion: Each of the 3 treatment performance indicators demonstrated improvement; however, the screening performance indicators did not. The plan should address the feedback provided with the aim to achieve the targeted rates for all performance indicators.

LHCC
Overall Credibility of Results: The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution due to ITM issues.

Conclusion: One (1) of the 4 screening performance indicators and 1 of the 3 treatment performance indicators demonstrated improvement. The plan should address the feedback provided with the aim to achieve the targeted rates for all performance indicators.

UHC
Overall Credibility of Results: The validation findings generally indicate that the credibility of the PIP results is not at risk. Results must be interpreted with some caution due to the ITM and performance indicator issues identified.

Conclusion: One (1) of the 4 screening performance indicators and each of the 3 treatment performance indicators demonstrated improvement. The plan should address the feedback provided with the aim to achieve the targeted rates for all performance indicators.

Summary of Findings
For all MCOs, it was found that the credibility of the PIP results was not at risk. However, for all MCOs, it was found that the results need to be interpreted with some caution due to issues with data collection and/or measure calculation.

III. Performance Measures: HEDIS 2020 (Measurement Year 2019)

MCO-reported performance measures were validated as per HEDIS 2020 Compliance Audit specifications developed by the National Committee for Quality Assurance (NCQA). The results of each MCO's HEDIS 2020 Compliance Audit are summarized in its Final Audit Report (FAR).

HEDIS Effectiveness of Care Measures

HEDIS Effectiveness of Care measures evaluate how well an MCO provides preventive screenings and care for members with acute and chronic illnesses. **Table 1** displays performance rates of all five MCOs in Louisiana and the Healthy Louisiana 2020 statewide averages for select HEDIS Effectiveness of Care measures for HEDIS 2020. For each measure, the rates above the statewide average are highlighted green and the rates below the statewide average are highlighted red.

Table 1: HEDIS Effectiveness of Care Measures: MCOs and Healthy Louisiana 2020 Statewide Average

Measure	ACLA	Aetna	Healthy Blue	LHCC	UHC	Healthy Louisiana HEDIS 2020 Average
Adult BMI Assessment	87.04%	85.40%	84.18%	69.10%	91.97%	82.90%
Antidepressant Medication Management - Acute Phase	50.14%	59.00%	48.24%	45.53%	49.26%	48.98%
Antidepressant Medication Management - Continuation Phase	33.83%	44.53%	33.72%	29.96%	32.54%	33.25%
Asthma Medication Ratio (5-64 Years)	57.48%	60.02%	59.16%	69.48%	65.45%	64.50%
Breast Cancer Screening in Women	61.65%	59.93%	58.59%	60.37%	54.57%	58.13%
Cervical Cancer Screening	59.61%	53.04%	55.23%	59.85%	56.93%	57.49%
Childhood Immunization Status – Combination 3	68.37%	73.24%	70.07%	68.13%	71.78%	69.99%
Chlamydia Screening in Women (16-24 Years)	67.83%	64.06%	67.16%	68.21%	65.18%	66.88%
Comprehensive Diabetes Care - HbA1c Testing	88.08%	87.83%	85.64%	85.40%	86.13%	86.28%
Controlling High Blood Pressure	51.58%	50.36%	47.93%	41.61%	57.42%	49.98%
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	53.26%	43.43%	49.33%	40.78%	46.24%	45.42%
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	70.25%	61.64%	65.12%	56.10%	59.55%	60.24%
Medication Management for People With Asthma Total - Medication Compliance 75% (5-64 Years)	33.87%	43.02%	38.67%	27.88%	31.09%	32.06%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile	77.64%	65.45%	65.69%	57.42%	80.54%	68.57%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition	68.06%	56.45%	54.01%	46.23%	67.15%	56.89%

Measure	ACLA	Aetna	Healthy Blue	LHCC	UHC	Healthy Louisiana HEDIS 2020 Average
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity	63.14%	47.69%	45.74%	35.28%	59.61%	48.23%

Green: rate above statewide average. red: rate below statewide average.

ACLA is the best performing MCO with 14 of 16 measures above the statewide average. LHC is the worst performing MCO with 4 of 16 measures above the statewide average and 12 of 16 measures below the statewide average. Both Aetna and UHC have 9 of 16 measures above the statewide average, and Healthy Blue has 8 of 16 measures above the statewide average.

HEDIS Access to/Availability of Care Measures

The HEDIS Access to/Availability of Care measures examine the percentages of Medicaid children/adolescents, child-bearing women, and adults who receive PCP/preventive care services, ambulatory care (adults only), or receive timely prenatal and postpartum services. **Table 2** displays all five MCOs' rates for select HEDIS Access to/Availability of Care measure rates for HEDIS 2020 and Healthy Louisiana 2020 statewide averages. For each measure, the rates above the statewide average are highlighted green and the rates below the statewide average are highlighted red.

Table 2: HEDIS Access to/Availability of Care Measures

Measure	ACLA	Aetna	Healthy Blue	LHCC	UHC	Healthy Louisiana HEDIS 2020 Average
Children and Adolescents' Access to PCPs						
12–24 Months	96.60%	95.52%	96.41%	96.93%	96.24%	96.51%
25 Months–6 Years	89.40%	85.89%	89.33%	89.76%	87.77%	88.84%
7–11 Years	91.73%	85.57%	91.03%	91.66%	91.15%	91.27%
12–19 Years	90.71%	84.42%	90.57%	90.74%	90.21%	90.38%
Adults' Access to Preventive/Ambulatory Services						
20–44 Years	74.73%	69.39%	76.28%	76.79%	77.99%	76.19%
45–64 Years	84.12%	80.83%	84.18%	84.76%	85.91%	84.49%
65+ Years	77.69%	79.06%	78.19%	75.14%	85.57%	84.71%
Access to Other Services						
Prenatal Care	87.59%	83.45%	87.59%	82.24%	88.32%	85.85%
Postpartum Care	76.64%	76.40%	75.43%	71.53%	78.59%	75.38%

Green: rate above statewide average; red: rate below statewide average.

ACLA and LHCC are the two best performing MCOs with 6 of 9 measures above and 3 below the statewide average. Aetna is the worst performing MCO with only 1 of 9 measures above the statewide average. UHC and Healthy Blue both have 5 of 9 measures above the statewide average.

HEDIS Use of Services Measures

This section of the report details utilization of MCOs' services by examining selected HEDIS Use of Services rates. **Table 3** displays all five MCO rates for select HEDIS Use of Services measure rates for HEDIS 2020, and Healthy Louisiana 2020 statewide averages. For each measure, the rates above the statewide average are highlighted green and the rates below the statewide average are highlighted red.

Table 3: HEDIS Use of Services Measures

Measure	ACLA	Aetna	Healthy Blue	LHCC	UHC	Healthy Louisiana HEDIS 2020 Average
Adolescent Well-Care Visit	62.53%	45.50%	62.04%	55.37%	61.80%	58.97%
Ambulatory Care Emergency Department Visits/1,000 Member Months[1]	81.06	81.28	80.65	70.60	71.37	74.57
Ambulatory Care Outpatient Visits/1,000 Member Months	409.04	599.47	432.95	398.70	446.35	433.98
Well-Child Visits in the First 15 Months of Life 6+ Visits	68.09%	66.91%	65.94%	62.77%	64.48%	64.72%
Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life	73.98%	63.75%	70.56%	72.75%	72.02%	71.86%

Green: rate above statewide average; red: rate below statewide average.

UHC is the best performing MCO with 4 of 5 measures above the statewide average. ACLA has 3 of 5 measures above the statewide average. Aetna, Healthy Blue, and LHCC each have 2 of 5 measures above the statewide average and 3 of 5 measures below the statewide average.

Member Satisfaction: Adult and Child CAHPS 5.0H

In 2020, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) 5.0H survey of adult Medicaid members and child Medicaid with chronic care conditions (CCCs) was conducted by an NCQA-certified survey vendor. For purposes of reporting the Child Medicaid with CCC survey results, the results are divided into two groups: general population and CCC population. The general population consists of all child members who were randomly selected for the CAHPS 5.0H Child survey during sampling. The CCC population consists of all children (either from the CAHPS 5.0H Child survey sample or the CCC Supplemental Sample) who are identified as having a chronic condition, as defined by the member's responses to the CCC survey-based screening tool.

Table 4, **Table 5,** and **Table 6** show each MCO's CAHPS 2020 rates for adult, child, and child CCC population. For each measure, the best performance is highlighted green and the worst performance is highlighted red.

Table 4: Adult CAHPS 5.0H–2020

Measure	ACLA	Aetna	Healthy Blue	LHCC	UHC
Getting Needed Care	81.37%	79.25%	N/A	81.32%	86.81%
Getting Care Quickly	78.53%	80.37%	N/A	N/A	83.92%
How Well Doctors Communicate	91.58%	94.31%	97.49%	87.25%	92.64%
Customer Service	90.98%	N/A	N/A	N/A	N/A
Coordination of Care	N/A	N/A	N/A	N/A	N/A
Rating of All Health Care	77.35%	73.26%	85.37%	71.74%	78.19%
Rating of Personal Doctor	83.33%	83.05%	87.60%	74.26%	84.73%
Rating of Specialist	87.13%	N/A	N/A	N/A	N/A
Rating of Health Plan	78.30%	74.39%	85.98%	77.14%	85.90%

Green: best performance; red: worst performance; N/A: Sample size less than 100.

Due to small sample sizes, we can only compare rates for six of the nine measures. Healthy Blue is the best performing MCO with the highest percentage for 4 of the 6 measures. LHCC is the worst performing MCO with the lowest percentage for 3 of 6 measures and highest percentage for 0 of 6 measures. UHC has the highest percentage for 2 of 6 measures. Aetna has and the lowest percentage for 2 of 6 measures and ACLA has the lowest percentage for 1 of 6 measures.

Table 5: Child CAHPS 5.0H General Population

Measure	ACLA	Aetna	Healthy Blue	LHCC	UHC
Getting Needed Care	86.71%	N/A	86.90%	N/A	86.57%
Getting Care Quickly	91.25%	N/A	94.05%	N/A	95.03%
How Well Doctors Communicate	94.17%	94.55%	95.71%	98.41%	94.89%
Customer Service	N/A	N/A	N/A	N/A	N/A
Coordination of Care	N/A	N/A	N/A	N/A	N/A
Rating of All Health Care	90.21%	88.00%	86.18%	89.83%	93.14%
Rating of Personal Doctor	92.79%	89.13%	93.29%	91.24%	93.39%
Rating of Specialist	N/A	N/A	N/A	N/A	N/A
Rating of Health Plan	89.09%	84.24%	88.59%	86.45%	87.59%

Green: best performance; red: worst performance; N/A: Sample size less than 100.

Due to small sample sizes, we can only compare rates for six of the nine measures. UHC is the best performing MCO with the highest percentage for 3 of 6 measures and the lowest percentage for one measure. Aetna is the worst performing MCO with the lowest percentage for 2 of 6 measures and highest percentage for 0 of 6 measures. ACLA has the lowest percentage for 2 of 6 measures and the highest percentage for 1 of 6 measures. LHCC has the highest percentage for 1 of 6 measures. Healthy Blue has the lowest percentage for 1 of 6 measures and the highest percentage for 1 of 6 measures.

Table 6: Child CAHPS 5.0H CCC Population

Measure	ACLA	Aetna	Healthy Blue	LHCC	UHC
Getting Needed Care	88.88%	87.06%	86.01%	N/A	91.80%
Getting Care Quickly	92.06%	94.93%	95.33%	N/A	96.98%
How Well Doctors Communicate	95.62%	96.25%	93.54%	N/A	97.31%
Customer Service	N/A	N/A	N/A	N/A	N/A
Coordination of Care	N/A	N/A	N/A	N/A	77.37%
Rating of All Health Care	93.03%	86.27%	83.20%	N/A	90.30%
Rating of Personal Doctor	94.17%	92.12%	89.78%	90.18%	92.25%
Rating of Specialist	N/A	N/A	N/A	N/A	90.00%
Rating of Health Plan	87.97%	88.00%	82.99%	85.59%	88.52%

Green: best performance; red: worst performance; N/A: Sample size less than 100.

Due to small sample sizes, we can only compare rates for six of the nine measures. UHC is the best performing MCO with the highest percentage for 4 of 6 measures. Healthy Blue is the worst performing MCO with the lowest percentage for 5 of 6 measures. ACLA has the highest percentage for 2 of 6 measures and the lowest percentage for 1 of 6 measures. Aetna has neither lowest nor highest percentage for all 6 measures. LHCC has neither lowest nor highest percentage for all 6 with most of the measures having a sample size less than 100.

IV. Compliance

IPRO conducted the 2020 Compliance Audit on behalf of the LDH. Full compliance audits occur every 3 years, with partial audits occurring within the intervening years. The 2020 annual compliance audit was a partial review of each MCO's compliance with contractual requirements during the period of April 1, 2019, through March 31, 2020.

For this audit, compliance determinations of "full," "substantial," "minimal," "non-compliance," and "not applicable" were used for each element under review.

Please note this ATR represents a partial review. **Table 7** excludes full items from the prior review. Total compliance for each tool (including full items from prior year) will be higher for domains scoring less than 100%. Additionally, some items were new requirements for this review and might have an impact on overall percentages.

Table 7: MCO Performance by Review Domain

Review Domain	CFR 438 Crosswalk	Aetna	ACLA	Healthy Blue	LHCC	UHC	MCO Average
Reporting	438.242 Health information systems	0%	100%	N/A	N/A	100%	67%
Core Benefits and Services	438.208 Coordination and continuity of care	83%	83%	100%	88%	54%	82%
Utilization Management	438.210 Coverage and authorization of services 438.236 Practice guidelines	100%	N/A	N/A	75%	100%	92%
Quality Management	438.224 Confidentiality 438.330 Quality assessment and performance improvement program	100%	100%	100%	100%	N/A	100%
Member Grievances and Appeals	438.210 Coverage and authorization of services	100%	N/A	100%	75%	N/A	92%
Fraud, Waste and Abuse	438.206 Availability of services 438.207 Assurances of adequate capacity and services 438.208 Coordination and continuity of care 438.210 Coverage and authorization of services 438.214 Provider selection	N/A	N/A	100%	N/A	100%	100%
Marketing/Member Education	No crosswalk	40%	100%	100%	100%	100%	88%
Provider Network	438.206 Availability of services 438.207 Assurances of adequate capacity and services 438.208 Coordination and continuity of care 438.210 Coverage and authorization of services 438.214 Provider selection 438.230 Subcontractural relationships and delegation 438.224 Confidentiality	31%	48%	47%	23%	44%	39%

Review Domain	CFR 438 Crosswalk	Aetna	ACLA	Healthy Blue	LHCC	UHC	MCO Average
Eligibility, Enrollment and Disenrollment	No crosswalk	0%	N/A	100%	N/A	100%	67%
Total		**43%**	**61%**	**87%**	**58%**	**61%**	**62%**

Green: review domains with 100% compliance; N/A counts as 100% compliance as the requirement domain received 100% compliance in the prior compliance review; red: review domains with less than 100% compliance.

Healthy Blue was compliant in all 9 domains with the exception of provider network; note that N/A indicates the MCO received 100% compliance in the prior compliance and therefore did not have any requirements to review in the RY 2020 compliance review. ACLA and UHC had 100% compliance with the exception of provider network, and core benefits and services domains. LHCC was not fully compliant in 4 of 9 domains: core benefits and services, utilization management, member grievances and appeals, and provider network. Aetna was the least compliant MCO with less than 100% compliance in 5 domains: reporting, core benefits and services, marketing/member education, provider network, and eligibility, enrollment and disenrollment.

Section 1115 Substance Use Disorder (SUD) Demonstration:
Guide for Developing Implementation Plan Protocols

Attachment A – Template for SUD Health Information Technology (IT) Plan

Section I.

As a component of Milestone 5, Implementation of Strategies to Increase Utilization and Improve Functionality of Prescription Drug Monitoring Programs (PDMP), in the SMD #17-003, states with approved Section 1115 SUD demonstrations are generally required to submit an SUD Health IT Plan as described in the STCs for these demonstrations within 90 days of demonstration approval.

The SUD Health IT Plan will be a section within the state's SUD Implementation Plan Protocol and, as such, the state may not claim FFP for services provided in IMDs until this Plan has been approved by CMS.

In completing this plan, the following resources are available to the state:

a. Health IT.Gov in "Section 4: Opioid Epidemic and Health IT."[1]
b. CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" and, specifically, the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.[2]

As the state develops its SUD Health IT Plan, it may also request technical assistance to conduct an assessment and develop its plan to ensure it has the specific health IT infrastructure with regards to the state's PDMP plan and, more generally, to meet the goals of the demonstration. Contacts for technical assistance can be found in the guidance documents.

In the event that the state believes it has already made sufficient progress with regards to the health IT programmatic goals described in the STCs (i.e. PDMP functionalities, PDMP query capabilities, supporting prescribing clinicians with using and checking the PDMPs, and master patient index and identity management), it must provide an assurance to that effect via the assessment and plan below (see Table 1, "Current State").

[1] Available at https://www.healthit.gov/playbook/opioid-epidemic-and-health-it.
[2] Available at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html.

SUD Demonstration Milestone 5.0, Specification 3: Implementation of Strategies to Increase Utilization and Improve Functionality of PDMP

The specific milestones to be achieved by developing and implementing an SUD Health IT Plan include:

- Enhancing the health IT functionality to support PDMP interoperability; and
- Enhancing and/or supporting clinicians in their usage of the state's PDMP.

The state should provide CMS with an analysis of the current status of its health IT infrastructure/"ecosystem" to assess its readiness to support PDMP interoperability. Once completed, the analysis will serve as the basis for the health IT functionalities to be addressed over the course of the demonstration—or the assurance described above.

The SUD Health IT Plan should detail the current and planned future state for each functionality/capability/support—and specific actions and a timeline to be completed over the course of the demonstration—to address needed enhancements. In addition to completing the summary table below, the state may provide additional information for each Health IT/PDMP milestone criteria to further describe its plan.

Table 1. State Health IT / PDMP Assessment & Plan

Milestone Criteria	Current State	Future State	Summary of Actions Needed
5. Implementation of comprehensive treatment and prevention strategies to address Opioid Abuse and OUD, that is: *--Enhance the state's health IT functionality to*	*Provide an overview of current PDMP capabilities, health IT functionalities to support the PDMP, and supports to enhance clinicians' use of the state's health IT functionality to achieve the goals of the PDMP.*	*Provide an overview of plans for enhancing the state's PDMP, related enhancements to its health IT functionalities, and related enhancements to support clinicians' use of the health IT functionality to achieve the goals of the PDMP.*	*Specify a list of action items needed to be completed to meet the HIT/PDMP milestones identified in the first column. Include persons or entities responsible for completion of each action item. Include*

support its PDMP; and *--Enhance and/or support clinicians in their usage of the state's PDMP.*			*timeframe for completion of each action item*
Prescription Drug Monitoring Program (PDMP) Functionalities			
Enhanced interstate data sharing in order to better track patient specific prescription data	The Louisiana Prescription Drug Monitoring Program (PDMP) is part of the PMP Interconnect (PMPi), in conjunction with Appriss Health and the National Association of Board of Pharmacy that enables the secure sharing of PMP data across states and systems. InterConnect includes a 'smart hub' routing methodology and rules engine to enforce interstate sharing permissions. Through participation with the PMP Interconnect and the National Association of Boards of Pharmacy, Louisiana achieved connection with the United States Military Health System and 31 states/territory/district, including Alabama, Alaska, Arizona, Arkansas, Connecticut, Delaware, D.C., Florida, Georgia, Idaho, Iowa, Kansas, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Montana, Nevada, New Mexico, North Carolina, North Dakota, Oklahoma, Pennsylvania, Puerto Rico, South Carolina, South Dakota, Tennessee, Texas, Virginia and West Virginia.[1]	Louisiana's PDMP will continue to engage and participate with the PMP Interconnect in conjunction with Appriss Health and the National Association of Boards of Pharmacy. The PMP InterConnect system is actively engaged with interstate data sharing among most states via PMP Interconnect and Louisiana currently plans to continue to take part, along with the advances in its future state. The Louisiana Board of Pharmacy has awarded a new five-year contract in January 2019 to Appriss.	The Louisiana Board of Pharmacy will explore options to award another contract after the current five-year contract ends in 2024.

[1] Louisiana Board of Pharmacy. (2020). Prescription Monitoring Program Annual Report http://www.pharmacy.la.gov/assets/docs/PMP/PMP_AnnRpt_2020_Pkg.pdf

Current and Future PDMP Query Capabilities			
Facilitate the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e. the state's master patient index (MPI) strategy with regard to PDMP query)	Current state law does not permit a direct interface with the PDMP to match Medicaid patients receiving opioid prescriptions with patients listed in the PDMP. Medicaid is continuing to pursue modernization of its supporting technology infrastructure in modular component projects. LDH has completed the transition of eligibility and enrollment services into the new MES modular approach, known as Louisiana Medicaid Eligibility Determination System (LaMEDS). In addition, the Office of Technology Services (OTS) has implemented and owns the Enterprise Architecture (EA) technology that provides the capability to share data between MES modules, external State systems, and other systems used for Louisiana Medicaid Program and LaCHIP operations. The next planned modules will implement at state-wide Health Information Exchange, address Member Management, Third Party Liability and implement Electronic Visit Verification for Home and Community Based Services. Future expansion plans reflect a claim and MCO encounter solution, a data warehouse and analytics tool, as well as improving care management and provider management.	The state explored ways to build an interfacing function between its MMIS Management & Warehousing module during its system modernization and the Board of Pharmacy's PDMP to identify patients receiving opioid prescriptions on an ongoing basis; however, any data sharing requires legislative action changing current law to include the PDMP in the enterprise architecture build-out under the Office of Technology Services (OTS) for the state. The state was unsuccessful with gaining the necessary support to move this legislation forward. The state's current plan is to pursue alternative data tracking internal to Medicaid.	Explore internal data resources needed for tracking.

Use of PDMP – Supporting Clinicians with Changing Office Workflows / Business Processes			
Develop enhanced provider workflow / business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance to address the issues which follow	On January 1, 2019, the LA Board of Pharmacy partnered with the Louisiana Dept. of Health's Office of Public Health, Bureau of Community Preparedness (LDH-OPH-BCP) and Appriss Health to provide a statewide PMP integration option to all healthcare providers in Louisiana utilizing a service called PMP Gateway®. Gateway offers healthcare providers an option to integrate PMP data within the provider's electronic health record (EHR) or pharmacy information system to provide a streamlined clinical workflow for providers. The integration eliminates the need for providers to log in separately to the PMP web portal; instead, the EHR automatically initiates a patient query and returns the patient's PMP information directly within the provider's EHR or pharmacy information system. Included as part of the integration, users now have access to an advanced analytics and patient support tool called NarxCare®. In addition to the existing Louisiana PMP functionality, NarxCare aggregates and analyzes prescription information from pharmacies and presents visual interactive information, as well as advanced analytic insights, machine learning risk scores and more to help prescribers and pharmacists provide better patient safety and outcomes for every patient. NarxCare also provides tools and resources that support patients' needs and assists a healthcare provider to connect their patient to treatment when appropriate.	LDH will continue its partnership with the Statewide Integration Project to promote streamlined access of PMP data for Louisiana providers.	No action required.

Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions provided through the PDMP—prior to the issuance of an opioid prescription	The Board of Pharmacy has created a mechanism for automatic enrollment in its PDMP for prescribers to facilitate easier access. Additionally, the PDMP law was amended in 2013 to allow prescribers and pharmacists to enable delegates to search the PDMP on their behalf in order to streamline the process of collecting the necessary information to review before prescribing.	LDH will continue to work with its partners to educate and assist with supports if identified to meet this goal, however, has no identifiable actions at this time.	No action required.
Master Patient Index / Identity Management			
Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery.	The master patient index, or Master Data Management (MDM), is a component of the Enterprise Architecture. The foundation was created with the Medicaid Eligibility and Enrollment modernization project, however it will need to be expanded as future MMIS modules are on boarded. Currently it houses a minimum set of data elements for Medicaid applicants/enrollees.	The Decision Support System module (previously known as Data Warehouse) is starting procurement activities in 2021, with planned contract execution by July 2023, if State funding is approved and a vendor is selected timely. With the implementation of that module, the data architecture required to enhance the MDM for expanded use will be in place. In future, LDH will continue to expand the use of the MDM data attributes for each modernization module as it executes. When the Pharmacy Management module implements the MDM will be expanded in support of SUD care delivery.	The procurement process for the DSS system will likely be pursued in two increments - platform and analytics separately. The combined procurement is currently estimated to complete in approximately three years, with implementation taking an additional three years, depending on the selected solution. RFP for Pharmacy Management module, further expanding MDM. Timeline: 24+ months

Overall Objective for Enhancing PDMP Functionality & Interoperability			
Leverage the above functionalities / capabilities / supports (in concert with any other state health IT, TA or workflow effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing—and to ensure that Medicaid does not inappropriately pay for opioids	In accordance with CDC guidelines, Louisiana Medicaid has implemented maximum quantity and dosage limits for opioid prescriptions for intractable, non-cancer pain according to the following criteria and timeline: Jan. 10, 2017 — Fee for Service (FFS) Patients: **Acute & Chronic Pain** — Medicaid opioid 15-day quantity limits March 22, 2017 — Managed Care Organization Patients: **Acute Pain** — Implement 15-day quantity limit for opioid-naïve recipients May 2017 — FFS and Managed Care Organization Patients: **Acute & Chronic Pain** — Alert to notify providers of upcoming Morphine Equivalent Dosing (MED) limit of 120 mg per day for all opioid prescriptions July 10, 2017 — FFS and Managed Care Organization Patients: **Acute Pain** — 7-day quantity limit for opioid-naïve recipients or Morphine Equivalent Dosing (MED) limit of 120 mg per day, whichever is less July 10, 2017 — FFS and Managed Care Organization Patients: **Chronic Pain** — Morphine Equivalent Dosing (MED) limit of 120 mg per day for all opioid prescriptions Sept. 12, 2017 — FFS and Managed Care Organization Patients: **Chronic Pain** — Morphine Equivalent Dosing (MED) limit of 90 mg per day for all opioid prescriptions and consolidated Opioid Worksheet to 3 pages These limits have already shown a marked reduction in opioid prescriptions reimbursed by Medicaid.	In the future, LDH will explore alternative data tracking mechanisms internal to Medicaid to support its payment integrity functions.	Over the five-year demonstration period, LDH will continue to assess the activities/initiatives listed above to further enhance PDMP functionality and interoperability.

The State has a sufficient health IT infrastructure at every appropriate level including state Medicaid and pharmacy systems, contracted managed care organizations, and provider electronic health records in order to achieve the goals of the demonstration. The State Medicaid Health IT Plan (SMHP) will serve to support HIEs, Admit, Discharge and Transfer (ADT) feeds, infrastructure, and innovation to connect data, providers, and systems with the SUD Health IT plan. These functionalities are scheduled to implement over the next 18-24 months to support the SUD Health IT Plan.

The State will ensure that appropriate revisions are made during the next managed care procurement to incorporate the requirement to use health IT standards referenced in 45 CFR 170 Subpart B and the Interoperability Standards Advisory (ISA) as set forth by the Office of the National Coordinator for Health IT (ONC). To that end, Louisiana currently has statutory authority and the corresponding health IT infrastructure to support electronic prescribing, which is currently operable statewide. Additionally, as per La. RS 40:978, prescribers have the obligation check the PDMP before initial prescribing of an opioid and every 90 days thereafter that the treatment continues. Prescribers are granted the ability to obtain a patient's medication history from the PDMP housed with the Board of Pharmacy through an automatic enrollment process and the state's largest provider also links it through its EHR.

Louisiana has developed admit, discharge, transfer (ADT) feeds with emergency departments. Document exchange and sharing of care plans using Clinical Document Architecture (CDA) is accomplished through our state HIEs. The State is also currently tracking the opioid naïve prescriptions dispensed through our Medicaid claims/encounters and is able to provide corresponding metrics. The Louisiana Department of Health has created an internal opioid steering committee which will review metrics from other states for possible adoption within Louisiana for tracking. Current PDMP reporting includes, but is not limited to, the data sets in Tables 1 through 3 below. These and other metrics listed below will be used for ongoing quality monitoring and clinical outcomes.

Program Data and Metrics

The State plans to continue quarterly reporting on the following metrics included below and in tables #5-8. The following metrics are included in the state's Monitoring Protocol:

- Percentage of eligible physicians with active access privileges to the PMP – Target - Maintain
- Number of Emergency Departments providing admit, discharge, transfer (ADT) information to the state – Target - Maintain
- Number of incarcerated individuals who are Medicaid eligible that are enrolled with a MCO prior to release – Target - Maintain
- Number of inquiries to the AWARxE™ system made by physicians with active access privileges – Target - Increase

The first table presents information about the use of the PMP by the authorized users for the different categories of prescribers, including the number of prescribers authorized to obtain PMP access privileges, the number with active access privileges and the number of queries to the PMP database by those prescribers.

The second and third tables present information related to the numbers of controlled substance prescriptions dispensed in the state for benzodiazepines and opioids.

The fourth table presents information concerning the number of eligible prescription transactions reported to the PMP.

Tables five through eight represent data related to the four metrics included in the state's Monitoring Protocol the state will continue to monitor and report to CMS on a quarterly basis.

Table 1

User Statistics by Provider Type

PMP User Statistics as of 06/30/2021				
PMP Role Title - Healthcare Provider	Number of Providers Eligible for PMP Access (as of 06/30/2021)	Number of Providers with PMP Active Access Privileges (as of 06/30/2021)	Number of PMP Requests by Providers through AWARxE™ During 2021Q2	Number of PMP Requests by Providers through GATEWAY™ During 2021Q2
Physician (MD, DO)	13,591	8,968	476,975	3,834,480
Nurse Practitioner (APRN)	4,231	3,347	186,997	401,264
Dentist (DDS)	2,288	1,521	5,486	823
Physician Assistant (PA)	1,119	862	32,177	45,991
Optometrist (OD)	371	157	2	0
Podiatrist (DPM)	171	111	1,384	0
Medical Psychologist (MP)	96	90	9,562	4,579
Medical Intern/Resident	1,831	1,313	12,873	2,314
Prescriber's Delegate	NA	3,210	202,478	0
Pharmacist (PST)	9,315	4,753	949,910	1,818,539
Pharmacist's Delegate	NA	1,438	95,682	0
Totals	33,013	25,770	1,973,526	6,107,990

Table 2

Utilization of Benzodiazepines Used in the Treatment of Anxiety

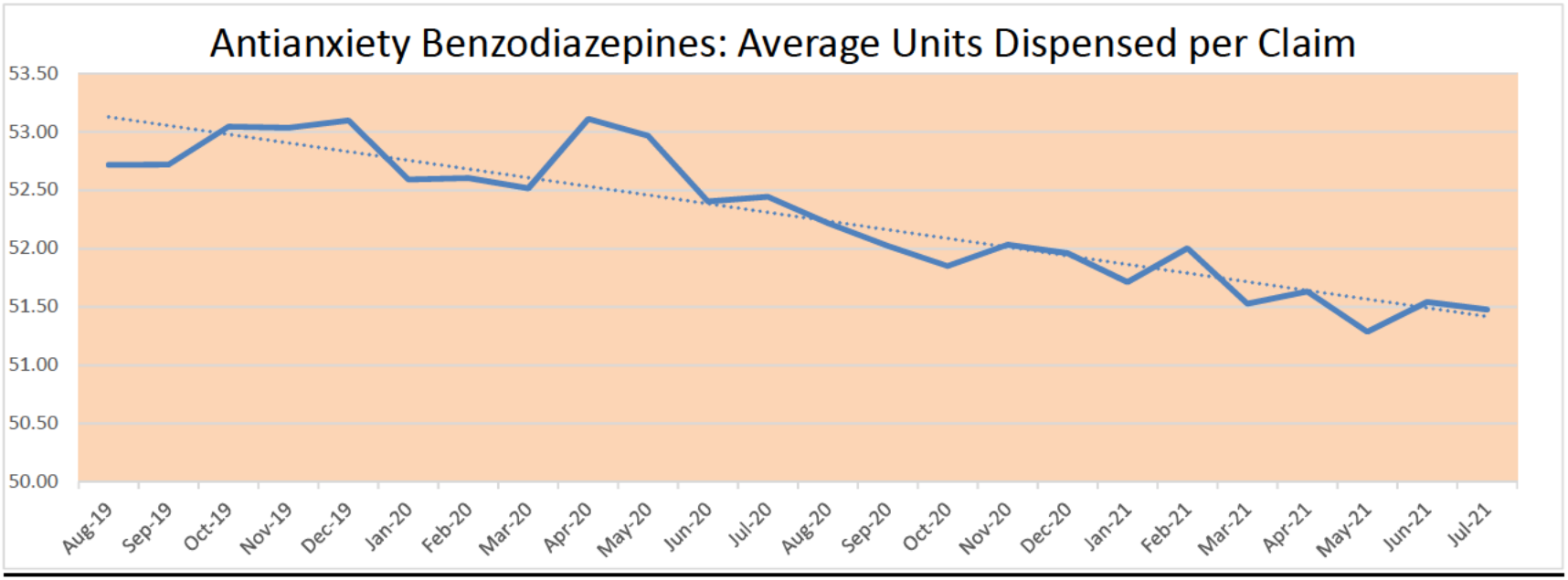


Table 3

Utilization of Solid Oral Dosage Forms of Short-Acting Opioids in Opioid Naïve Recipients

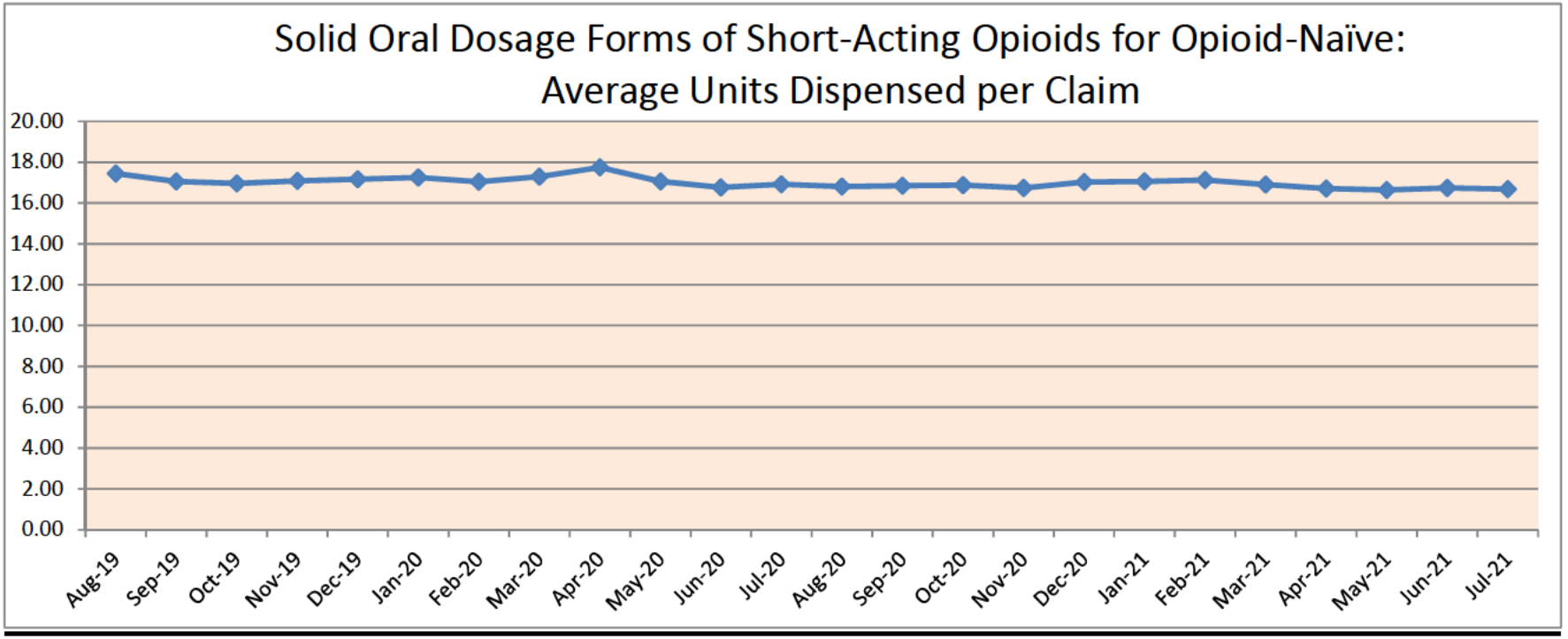


Table 4

Number of Eligible Prescription Transactions Reported to the PMP

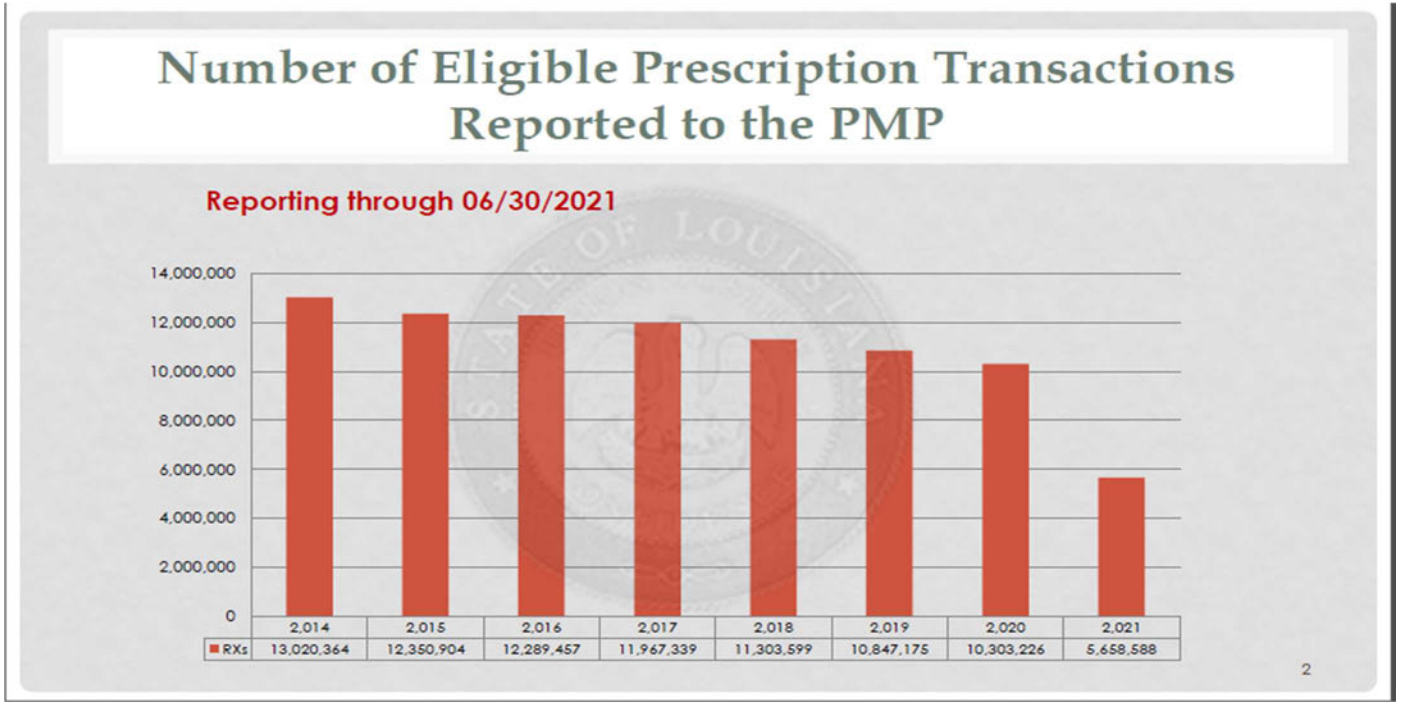


Table 5

Percentage of Eligible Physicians With Active Access Privileges to the PMP

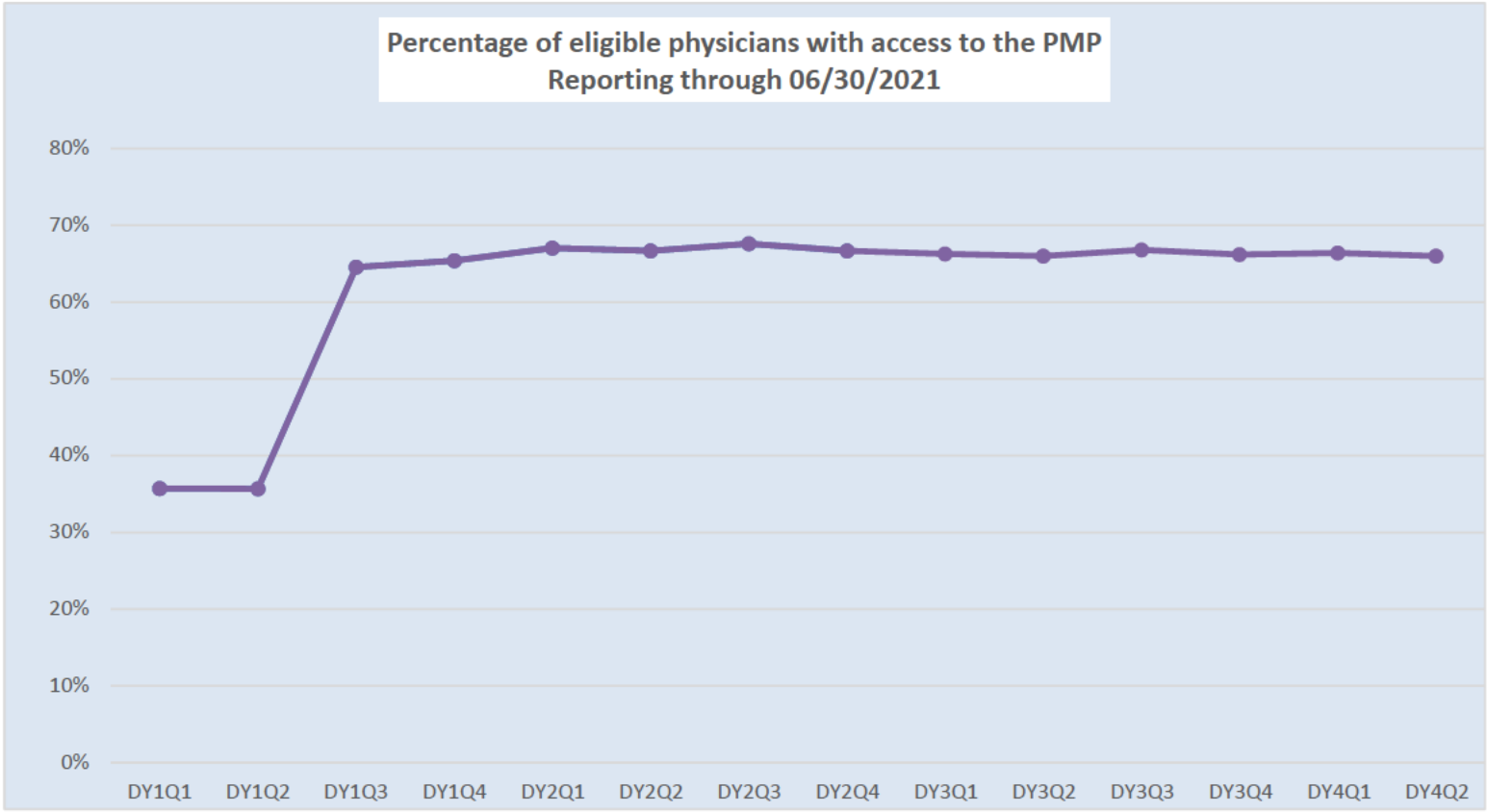


Table 6

Number of Emergency Departments Providing ADT Information to the State

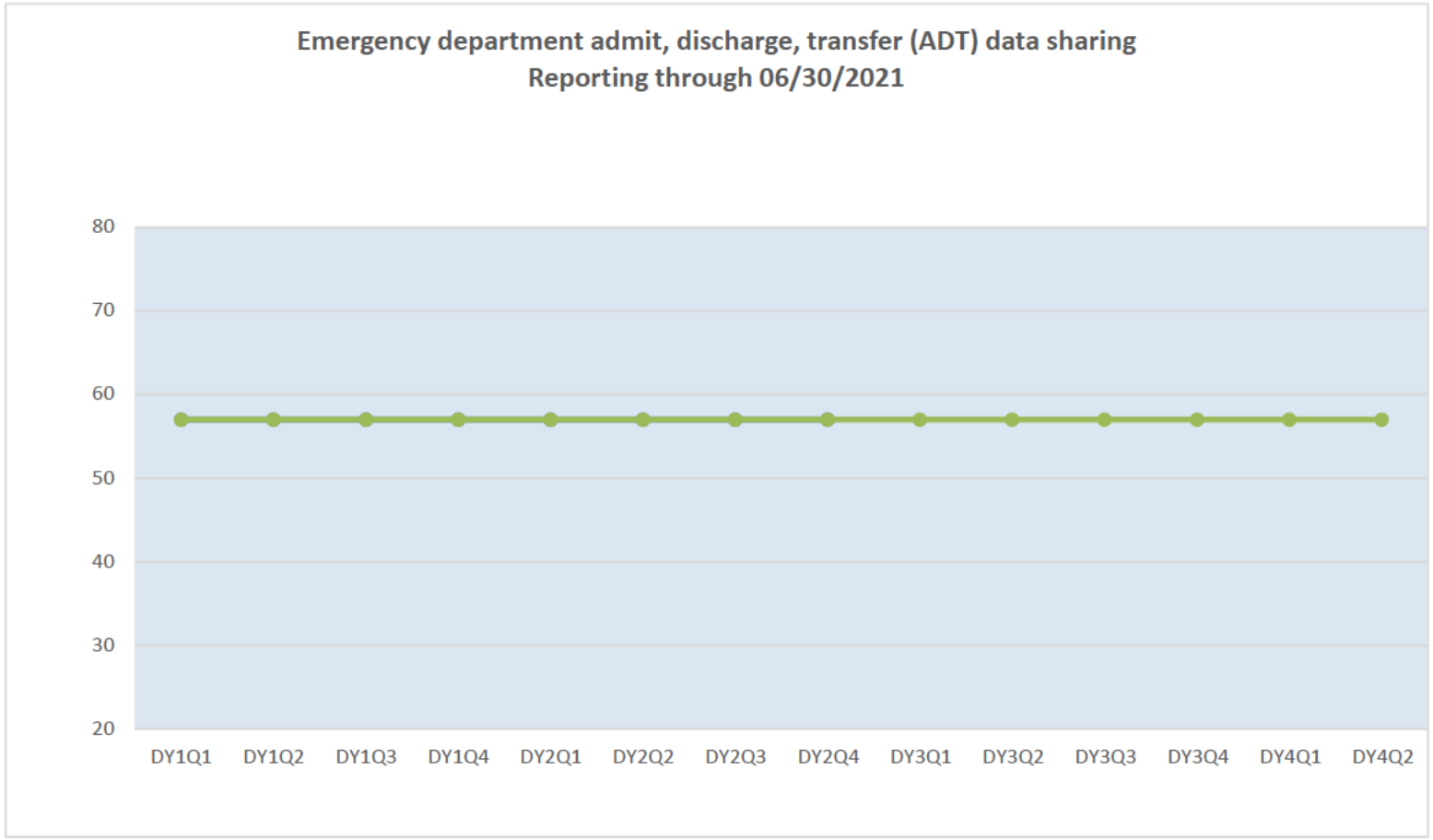


Table 7

Number of Incarcerated Individuals Who are Medicaid Eligible That are Enrolled With a MCO Prior to Release

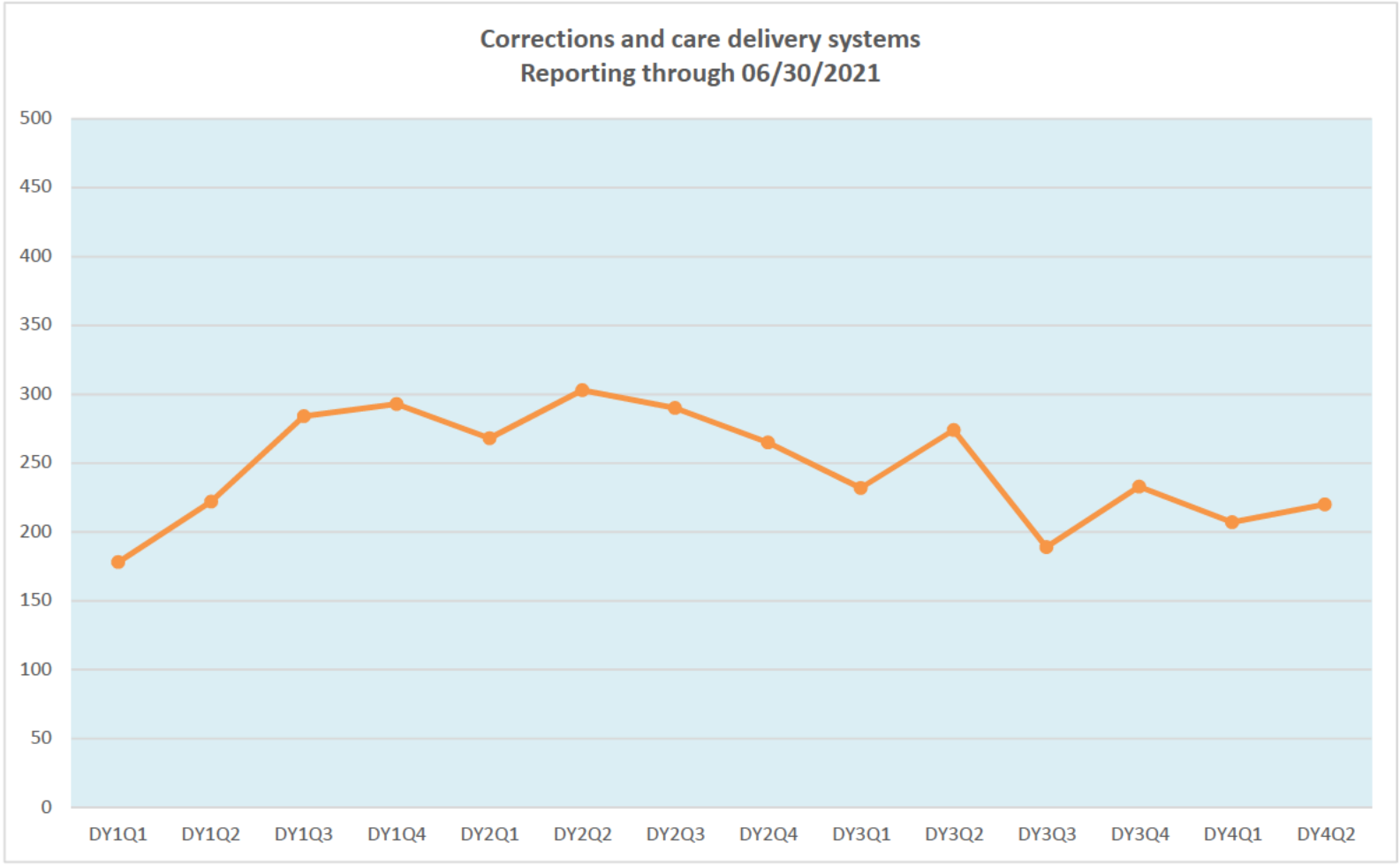
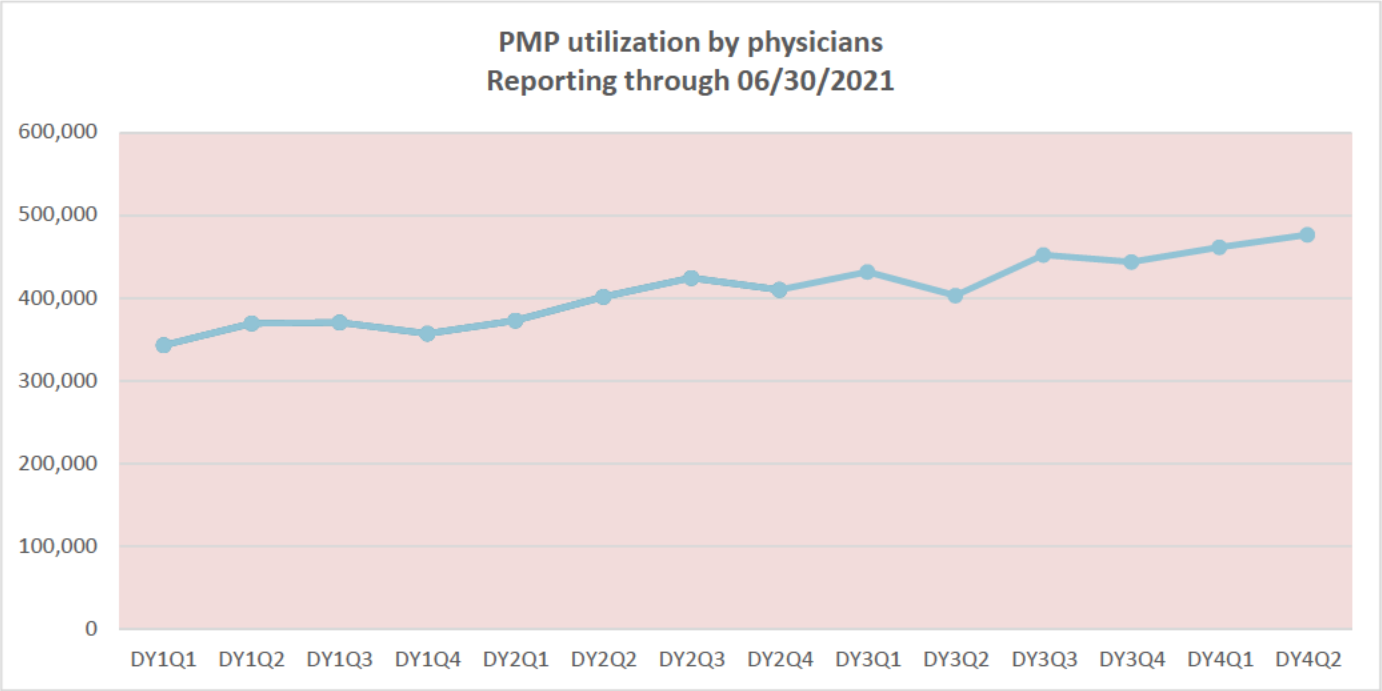


Table 8

Number of Inquiries to the AWARxE™ System Made by Physicians With Active Access Privileges



A. Section II – Implementation Administration

Please provide the contact information for the state's point of contact for the SUD Health IT Plan.

Name and Title: Brian Bennett, Section Chief, Louisiana Medicaid
Telephone Number: 225-342-9846
Email Address: Brian.Bennett@LA.GOV

Attachment A. Section III – Relevant Documents

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

PUBLIC NOTICE

Louisiana Department of Health
Bureau of Health Services Financing
and
Office of Behavioral Health

Healthy Louisiana Substance Use Disorder 1115 Demonstration Waiver

The Louisiana Department of Health (LDH), Bureau of Health Services Financing (BHSF) and the Office of Behavioral Health (OBH) currently provide critical access to opioid use disorder (OUD) and other substance use disorder (SUD) services, and continue delivery system improvements for these services to provide more coordinated and comprehensive OUD/SUD treatment for Medicaid beneficiaries through the Healthy Louisiana Substance Use Disorder 1115 Demonstration Waiver program.

LDH hereby gives public notice of its intent to seek approval from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) for a renewal of its application for the Healthy Louisiana Substance Use Disorder 1115 Demonstration Waiver program.

Interested persons may attend one of two public hearings the Louisiana Department of Health is conducting in order to present the Healthy Louisiana Substance Use Disorder 1115 Demonstration Waiver Renewal Application and take comments and questions from members of the public. Due to COVID-19 and physical distancing recommendations, the public hearings will be

held via internet and telephone only on the following dates and times:

Monday, November 1, 2021, 9:00 a.m. to 10:30 a.m.; and

Tuesday, November 16, 2021, 3:00 p.m. to 4:30 p.m.

Please visit www.ldh.la.gov/SUD1115 for links and telephone numbers necessary to access the hearings.

Dr. Courtney N. Phillips

Secretary

PUBLIC NOTICE

Louisiana Department of Health
Bureau of Health Services Financing
and
Office of Behavioral Health

Healthy Louisiana Substance Use Disorder 1115 Demonstration Waiver

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LDH hereby gives public notice of its intent to seek approval from the U.S. Department of Health and Human Services,

Centers for Medicare and Medicaid Services (CMS) for a renewal of its application for the Healthy Louisiana Substance Use Disorder 1115 Demonstration Waiver program.

In compliance with CMS requirements, LDH is posting the Healthy Louisiana Substance Use Disorder 1115 Demonstration Waiver renewal application for public comment from October 29, 2021 through November 28, 2021. CMS regulations require LDH to actively engage the public and give program participants, advocates, providers and other community stakeholders the chance to provide input regarding changes made to current waiver applications prior to submission of final versions to CMS.

The Healthy Louisiana Substance Use Disorder 1115 Demonstration Waiver renewal application is posted to the OBH website and may be accessed at the following address: www.ldh.la.gov/SUD1115. To request a hard copy, email Missy Graves at Missy.Graves@La.Gov or call (225)342-2540. Implementation of the provisions of this waiver renewal application is contingent upon CMS approval.

Interested persons may submit written comments via electronic mail to Keith Durham at Keith.Durham@La.Gov. Written comments may also be mailed to the Louisiana Department of Health, Attn: Keith Durham, P.O. Box 91030 (Bin #24), Baton Rouge, LA 70821. Mr. Durham is responsible for responding to inquiries regarding this proposed renewal. The deadline for

submitting written comments is at 4:30 p.m. on November 28, 2021.

Dr. Courtney N. Phillips

Secretary

State of Louisiana

Louisiana Department of Health
Bureau of Health Services Financing

Tribal Notice

VIA ELECTRONIC MAIL ONLY

October 15, 2021

Karen Matthews,
Health and Human Services Director
Chitimacha Health Clinic
P.O. Box 640
Charenton, LA 70523

Angela Martin
Chitimacha Tribe of Louisiana
P. O. Box 640
Charenton, LA 70523

Mildred Darden, Clinic Office Supervisor
Chitimacha Tribe of Louisiana
P. O. Box 640
Charenton, LA 70523

Marshall Pierite, Chairman
Tunica-Biloxi Tribe of Louisiana
P. O. Box 1589
Marksville, LA 71351-1589

Chief Beverly Cheryl Smith
Kellye Smith, Health Director
The Jena Band of Choctaw Indians
P. O. Box 14
Jena, LA 71342

David Sickey, Chairman
Paula Manuel, Health Director
Coushatta Tribe of Louisiana
P. O. Box 818
Elton, LA 70532

Cameron Chase, Health Director
Tunica-Biloxi Tribe of Louisiana
P. O. Box 1589
Marksville, LA 71351-1589

Dear Louisiana Tribal Contact:

RE: Notification of Healthy Louisiana Substance Use Disorder 1115 Demonstration Waiver - Renewal Application

The Louisiana Department of Health, Bureau of Health Services Financing and the Office of Behavioral Health, through collaborative efforts, currently provide critical access to opioid use disorder (OUD) and other substance use disorder (SUD) services, and continue delivery system improvements for these services to provide more coordinated and comprehensive OUD/SUD treatment for Medicaid beneficiaries through the Healthy Louisiana SUD 1115 Demonstration Waiver program.

In compliance with the provisions of the American Recovery and Reinvestment Act (ARRA) of 2009, the Louisiana Department of Health is taking the opportunity to notify you of our intent to submit a waiver renewal application to the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) to renew the provisions governing the Healthy Louisiana SUD 1115 Demonstration Waiver program.

Implementation of the provisions of this waiver renewal application is contingent upon CMS approval.

Please provide any comments you may have by **November 14, 2021,** to Karen Barnes via email at Karen.Barnes@la.gov or by postal mail to:

Louisiana Department of Health
Bureau of Health Services Financing
Medicaid Policy and Compliance
P.O. Box 91030
Baton Rouge, LA 70821-9030

Should you have additional questions about Medicaid policy, Ms. Barnes will be glad to assist you. You may contact her via email at the email address above or via telephone at (225) 342-3881.

Thank you for your continued support of the tribal consultation process.

Sincerely,

Karen H. Barnes for
Patrick Gillies
Medicaid Executive Director

PG/KHB/KS

c: Brian Bennett
Babette Bordelon
Missy Graves
Robyn McDermott
Nancy Grano

PUBLIC NOTICE

Louisiana Department of Health
Bureau of Health Services Financing
and
Office of Behavioral Health

Healthy Louisiana Substance Use Disorder 1115 Demonstration Waiver

The Louisiana Department of Health (LDH), Bureau of Health Services Financing (BHSF) and the Office of Behavioral Health (OBH) currently provide critical access to opioid use disorder (OUD) and other substance use disorder (SUD) services, and continue delivery system improvements for these services to provide more coordinated and comprehensive OUD/SUD treatment for Medicaid beneficiaries through the Healthy Louisiana Substance Use Disorder 1115 Demonstration Waiver program.

LDH hereby gives public notice of its intent to seek approval from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) for a renewal of its application for the Healthy Louisiana Substance Use Disorder 1115 Demonstration Waiver program. A copy of the full public notice and application may be viewed at www.ldh.la.gov/SUD1115. To request a hard copy, email Missy Graves at Missy.Graves@La.Gov or call (225)342-2540. Comments may be submitted via electronic mail to Keith Durham at Keith.Durham@La.Gov. Written comments may also be mailed to the Louisiana Department of Health, Attn: Keith Durham, P.O. Box

91030 (Bin #24), Baton Rouge, LA 70821. Mr. Durham is responsible for responding to inquiries regarding this proposed renewal. The deadline for submitting written comments is at 11:59 p.m. on May 6, 2022.

A public hearing will be held to present the Healthy Louisiana Substance Use Disorder 1115 Demonstration Waiver Renewal Application and take comments and questions from members of the public. Due to COVID-19 and physical distancing recommendations, the public hearing will be held via internet and telephone only on Monday, April 11, 2022, 2:00 p.m. to 3:00 p.m. Please visit www.ldh.la.gov/SUD1115 for the link and telephone number necessary to access the hearings.

Dr. Courtney N. Phillips

Secretary

LOUISIANA DEPARTMENT OF HEALTH SECTION 1115 HEALTHY LOUISIANA SUBSTANCE USE DISORDER EXTENSION APPLICATION

Public Notice - Updated
April 5, 2022

The Louisiana Department of Health (LDH) is providing a revised public notice of its intent to submit to the Centers for Medicare and Medicaid Services (CMS) an extension application for the Healthy Louisiana Substance Use Disorder (SUD) section 1115 demonstration. The application requests a five-year renewal of the demonstration for the period of January 1, 2023 through December 31, 2027. This application seeks approval to continue to operate the demonstration as approved with no changes.

This notice revises a prior notice issued on October 29, 2021. The revisions to this public notice include additional detail related to the demonstration's goals, objectives, hypotheses, health care delivery system, eligibility and cost sharing requirements, expenditure authority, and enrollment and expenditure data.

Demonstration Overview

In response to the growing concern over rates of opioid use disorders (OUDs) and SUDs in general, LDH applied for an 1115 Demonstration Waiver in 2017 to allow continuation of treatment for OUD/SUD in institutions for mental diseases (IMDs) regardless of length of stay. Approval was received to begin the Healthy Louisiana SUD 1115 demonstration waiver effective February 1, 2018. The demonstration allows LDH to receive federal financial participation (FFP) for SUD treatment and withdrawal services provided to beneficiaries residing in IMDs with stays longer than 15 days. Medicaid eligible beneficiaries may receive SUD treatment and withdrawal services through a contracted Medicaid managed care organization (MCO). This demonstration makes no changes to Louisiana Medicaid's State Plan benefits and imposes no cost sharing requirements for beneficiaries.

Goals, Objectives, and Hypotheses

The overall goal of this demonstration is for Louisiana to maintain critical access to OUD and other SUD services and continue delivery system improvements for these services to provide more coordinated and comprehensive OUD/SUD treatment for Medicaid beneficiaries. During the demonstration period, Louisiana seeks to achieve the following:

- Increase enrollee access to and utilization of appropriate OUD/SUD treatment services based on the American Society of Addiction Medicine (ASAM) criteria;
- Decreased use of medically inappropriate and avoidable high-cost emergency department and hospital services by enrollees with OUD/SUD;
- Increased initiation of follow-up after discharge from emergency department for alcohol or other drug dependence; and
- Reduced readmission rates for OUD/SUD treatment.

The following goals and hypotheses are proposed for the extension period and are unchanged from the initial demonstration approval:

Table 1: LA Healthy LA 1115 SUD Goals and Hypotheses

Goal	Hypothesis	Example Measure	Data Source
Increase access to evidence-based OUD/SUD care	The demonstration will increase the share of beneficiaries who are treated for OUD/SUD in ways that are consistent with evidence-based care	Share of beneficiaries with an OUD/SUD treated in an IMD	Louisiana Medicaid Claims Data
Increase access to and utilization of medication-assisted treatment (MAT) for OUD/Alcohol Use Disorder (AUD)	The demonstration will increase the use of MAT	Share of those with an OUD/AUD diagnosis who are treated using MAT	Louisiana Medicaid Claims Data; Key informant interviews
Ensure efficient provider capacity at each level of care for OUD/SUD	The demonstration will improve provider capacity	Total number of SUD providers	Louisiana Medicaid Claims Data
Decrease use of medically inappropriate care and reduce reliance on emergency department and hospital services for OUD/SUD treatment	The demonstration will reduce visits to the emergency department and the use of hospital services for the treatment of OUD/SUD	Emergency department visits for OUD/SUD	Louisiana Medicaid Claims Data
Reduce readmission rates for OUD/SUD treatment	The demonstration will reduce hospital readmission rates for OUD/SUD	Readmissions for OUD/SUD	Louisiana Medicaid Claims Data
Increase use of evidence-based OUD/SUD patient placement criteria	The demonstration will increase the use of evidence-based OUD/SUD patient placement criteria	Appropriate placement for OUD/SUD treatment	MCO Monitoring Reports
Increase initiation of follow-up after discharge from the emergency department or hospital for OUD/SUD	The demonstration will increase initiation of follow-up after discharge from the emergency department or hospital for OUD/SUD	Follow-up after discharge from the ED for OUD/SUD	Louisiana Medicaid Claims Data
Increase adherence to and retention in treatment	The demonstration will increase adherence to and retention in treatment	Share of those with an OUD/SUD diagnosis who receive follow-up treatment within 35-60 and 61-90 days after initial episode of care	Louisiana Medicaid Claims Data
Reduce instances of drug overdose and overdose deaths	The demonstration will decrease the rate of drug overdose and the number of drug deaths	Number of non-fatal drug overdoses	Louisiana Medicaid Claims Data and Louisiana Office of Public Health Vital Records

Enrollment and Expenditure Projections

The following table includes historical enrollment and expenditure totals from the first three years of the initial demonstration period and projected totals for the extension period. No changes are projected in enrollment for the extension period and expenditures are trended based on historical experience.

Table 2: LA Healthy LA 1115 SUD Historical and Projected Enrollment and Expenditures

	Number of Persons Eligible	Total Expenditures
Initial Waiver Period		
2018	2,008	$12,744,753
2019	1,942	$14,291,000
2020	1,944	$16,109,357
Extension Waiver Period (projected)		
2023	1,944	$24,030,297
2024	1,944	$27,457,029
2025	1,944	$31,372,362
2026	1,944	$35,846,062
2027	1,944	$40,957,694

Note: 2021 actual enrollment and expenditure data not finalized and 2022 data not available

Waiver and Expenditure Authorities

Louisiana requests to extend the following expenditure authority authorized under the initial demonstration:

Residential Treatment for Individuals with SUD. Expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are short-term residents in facilities that meet the definition of an IMD.

Demonstration Application and Public Comment

LDH will be accepting public comment on the Healthy Louisiana SUD 1115 Demonstration application from April 6, 2022 through May 6, 2022. The application is available on LDH's website for public review at the following web address: www.ldh.la.gov/SUD1115. To request a hard copy of the application for review, email Missy Graves at Missy.Graves@la.gov or call (225) 342-2540. Interested persons may submit written comments via electronic mail to Keith Durham at Keith.Durham@la.gov. Written comments may also be mailed to:

Louisiana Department of Health
Attn: Keith Durham
P.O. Box 91030 (Bin #24)
Baton Rouge, LA 70821.

The deadline for submitting written comments is at 11:59 p.m. on May 6, 2022.

Public Hearing

LDH will conduct a public hearing to present the Healthy Louisiana SUD 1115 Demonstration application to the public and receive comments. This hearing will be held via web conference and by telephone. The information for the hearing is included below. Any comments received during the public hearing will be recorded and incorporated into the final demonstration application, along with LDH's response.

April 11, 2022
2:00 p.m. to 3:00 p.m. CST
https://us06web.zoom.us/j/85693465774
USA 602 333 0032
Conference code: 1935026