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SCHOOL OF PUBLIC HEALTH AND TROPICAL MEDICINE
Department of Health Policy and Management

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

February 2018 through mid-2020

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Executive Summary

We conducted a review of results from the overall Demonstration Evaluation, implementation and progress reports, and we conducted key informant interviews with staff from the Louisiana Department of Health (LDH) who are involved in implementing the SUD 1115 Demonstration. We conducted our analysis by Demonstration milestones and included an assessment of the likelihood that the Demonstration would achieve its milestones based on progress to date.

Our results indicate substantial increases in Medicaid beneficiaries receiving Medication Assisted Treatment (MAT), even with little change to the number of providers overall or per capita. Other results have not shown substantial impact, but we conclude that this is because of the short time period post intervention, particularly around care coordination.

We also examined budget neutrality requirements and conclude that the excess expenditures over projected expenditures is the result of under estimating enrollment and participation by the Medicaid Expansion population.

Our recommendations are:

- CMS and LDH should agree on appropriate and useful measures with which to monitor progress. LDH and CMS have recently finalized the Monitoring Protocol metrics, and it will take time and substantial effort to apply and use these metrics to determine the overall impact of the Demonstration.

- Flexibility in implementation and reporting from hurricane-affected regions will give a more accurate picture of the success of the Demonstration. LDH and CMS should agree on any adjustments resulting from the weather-related disruptions, particularly in southwest Louisiana.

- Finally, we recommend that the model for budget neutrality be re-examined in light of the actual Medicaid Expansion enrollment and participation in the Demonstration, and the likelihood that this population will continue to increase because of the Covid-19 pandemic.

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/report/national-survey-substance-abuse-treatment-facilities-n-ssats-2016-data-substance-abuse).

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
- Case or care management
- Medication
- Recovery support services
- Peer supports

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 Center 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 Demonstration 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

[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)

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 evaluated progress toward these milestones and their potential impact on the demonstration goals below.

Methods

Qualitative Methods

A desk review of the SUD 1115 Demonstration implementation plan and quarterly and annual reports was conducted to document the activities that have taken place under each implementation milestone. Next, key informant interviews were conducted with staff from the Louisiana Department of Health (LDH) who are involved in implementing the SUD 1115 Demonstration. Key informants were selected based on their subject matter expertise. Interviews took place in October 2020 and a total of seven individuals were interviewed. The interviews covered detailed descriptions of the activities that have been carried out, reasons why planned activities may not have been carried out, plans for activities going forward, barriers to success, and benefits of participation in the Demonstration. Interviews were recorded, transcribed, and analyzed according to the implementation milestones. Findings were triangulated among key informants; cases in which key informants' perspectives differed are noted. Key informants' identities were kept confidential so that they could feel comfortable speaking freely.

Quantitative Methods

Results from the overall evaluation of the SUD 1115 Demonstration were reviewed and incorporated in the mid-point assessment to assess progress made toward milestones. Data were available through October 2019. The evaluation metrics were revised to align with the final approved Monitoring Protocol metrics during the fourth quarter of 2020. This was done because the original evaluation metrics were developed before the final Monitoring Protocol was approved. Details on the specific methods used in the overall evaluation are included in the approved Evaluation Plan. In summary they consist of descriptive analyses of trends and Interrupted Times Series (ITS) analyses where feasible.

Results

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

The first action item under Milestone 1 was to **update the State Plan and provider manual** to reflect the current services array and requirements. LDH determined that an update to the State Plan was not needed. The provider manual was updated in April 2018. According to one key informant, updates to the manual undergo a public comment period before approval. Once approved, the manual is posted to LDH's website. LDH communicates changes to the MCO's by email providing an overview of the updates and tracked changes version of the manual. MCO's are subsequently responsible for communicating them to their provider networks. LDH does not track the degree to which this communication with the providers occurs.

The implementation plan listed **Medicaid coverage of methadone** as a proposed future state. In 2018, LDH requested that methadone as a treatment for SUD be covered by Louisiana Medicaid. The Governor approved the request, and methadone became a covered service beginning on January 20, 2020. Key informants reported support for this coverage from the legislature, and that appropriations have been made to cover this service. The change was publicized through a Health Plan Advisory that was released on January 14, 2020. A key informant expressed that Medicaid coverage of methadone had significantly expanded access to care, as the service had historically been mostly cash-based. *"It has really opened the door to the under and uninsured populations that otherwise would never be able to receive this level of care because it's cash-based. And now we're able to get our population, our target population, some services that they well-deserved. So absolutely we've created a system that has increased access to care."* Another key informant estimated that since Methadone coverage was instituted, an additional one hundred people had accessed methadone each month across the state.

The implementation plan also states that **Medicaid coverage of ASAM Level 1-WM** was under consideration. ASAM Level 1-WM is "Ambulatory Withdrawal Management without Extended On-site Monitoring (Outpatient Withdrawal Management)" and is appropriate for patients experiencing mild withdrawal.[3] A key informant explained that Medicaid coverage of this level of care is not required by the Demonstration, and that, to their knowledge, there are no plans to pursue legislative approval of its coverage. The key informant reported that ASAM Level 1-WM is one of the ASAM levels that Louisiana Medicaid does not cover, and, in their view, it is not needed for a complete continuum of care.

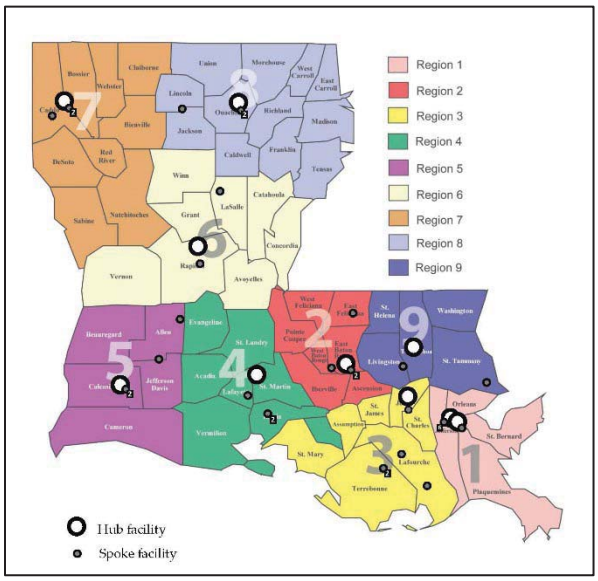
LDH has implemented the **Hub and Spoke model** to ensure that patients receive the appropriate level of care throughout the state. The Hub and Spoke is a nationally recognized model that SAMHSA developed. Under this model, the ten licensed opioid treatment programs in Louisiana (one per Local Governing Entity region) are considered "hubs." These facilities are the only providers licensed to administer all three FDA approved medications, including methadone, and therefore treat the most severe cases of SUD. In addition to MAT, these facilities provide an array of services such as counseling, drug screening, and crisis interventions. "Spokes" are office-based opioid treatment providers. These are typically physician offices, Federally Qualified Health Facilities, and behavioral health providers, and treat people with moderate to severe OUD with buprenorphine or Suboxone. Each spoke is linked to a hub within 25 miles. Hubs and spokes communicate and refer patients to one another under the principle that patients can present at any facility and will be assessed and sent to the appropriate level of care. Additionally, LDH has facilitated referral agreements

[3] http://www.aetna.com/healthcare-professionals/documents-forms/asam-criteria.pdf

between emergency departments and licensed opioid treatment programs so that patients can be sent directly from the hospital to an SUD treatment facility and is working to expand these arrangements to more emergency departments throughout the state.

Figure 1 maps the locations of the ten hubs and thirty-three spokes that are accepting patients as of December 2020. Currently, each hub has between two and five associated spokes. Thirty-nine percent (25/64) of the parishes in Louisiana contain at least one spoke facility.

Figure 1. Hub and spoke facilities (December 2020).



Base map source: https://ldh.la.gov/index.cfm/page/2

Marketing campaigns are carried out to publicize the services that are available within the networks to providers who can refer to the network and to patients who might access it directly. A key informant described the system as *"entities that collaborate and work together to make sure that people are receiving services at the right place at the right time, at the right level of care."* Another informant echoed the success of the Hub and Spoke model, estimating that there are currently approximately 5,000 people throughout Louisiana that are admitted to those ten clinics.

Evaluation metrics to assess access to care include the share of beneficiaries with an OUD/SUD treated in an IMD, the average length of stay for beneficiaries with an OUD/SUD treated in an IMD, share of beneficiaries who used early intervention services, outpatient services for SUD, intensive outpatient and/or partial hospitalization services, residential and/or inpatient services, or withdrawal management services, respectively.

All of these measures were relatively stable during the period of review, with the exception of the share of beneficiaries receiving treatment using intensive outpatient services, which decreased over the period of 2017 – 2019, averaging 0.43% in 2017 and 0.29% in 2019. The share of beneficiaries who used early intervention services varied substantially over the period, ranging from 0.01% to 0.16%, and averaging 0.06% over 2017 and 0.13% in 2019, indicating that there may be a gradual increase.

The number of providers dispensing Buprenorphine or Methadone per 100,000 state residents has increased over the period of 2017 – 2019, averaging 81 in 2017 and 104 in 2019. We conducted an ITS analysis of the number of providers dispensing Buprenorphine or Methadone per 100,000 state residents to evaluate whether the overall change is significant. The ITS results indicate that while the slope has decreased the change has not been significant.

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

Under Milestone 2, the **Behavioral Health Provider Manual was updated** to clarify that ASAM criteria and levels of care shall be used to substantiate patient placement in the appropriate ASAM level of care for each provider's assessment tool. This was completed in November 2018.[4]

LDH also aimed to perform ongoing **review of policies and procedures** to ensure the MCOs include the use of evidence-based practices and SUD-specific criteria will occur to determine if any additional education or changes are warranted, relative to utilization management. Specifically, LDH reported to be including screening and assessments of SUD services in the existing audit tool elements document for record review, to collect additional data on providers to ensure that interventions are appropriate. Currently, the State's contracts with MCO's require them to have policies and procedures that align with State requirements for utilization management such as medical necessity criteria and authorization requests. LDH monitors this through MCO reports submitted to the State. LDH also tracks utilization data such as length of stay and retention in treatment, stratified by region. To supplement routine data, LDH has developed a reporting template by which MCO's submit additional utilization data.

We examined Emergency Department (ED) visits, inpatient stays, and readmissions among beneficiaries with SUD both descriptively and using an ITS approach. All three of these metrics have remained essentially stable over the evaluation period.

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

Under the Demonstration, residential providers are required to offer MAT onsite or to have a process by which their patients can receive MAT offsite. **The Provider Manual was updated** to reflect this requirement in November 2018. **MCO contracts were reviewed** and it was determined that no changes were needed relative to the requirement. MCO's are responsible for **monitoring whether patients who need MAT are receiving it**. MCO's conduct provider monitoring reviews during which they audit patient medical charts to determine whether, when clinically appropriate, SUD residential providers educated patients on the proven effectiveness, benefits, and risk of MAT. They also audit whether the providers provided onsite MAT or referred the audited patients to MAT offsite when clinically appropriate and documented the patients' responses.

In addition to enforcing the requirement through contracts and regulations, LDH focused on **educating abstinence-only providers about the benefits of MAT** to promote a cultural shift toward the use of MAT as a complementary service. A key informant stated that the strategy had been to provide education on MAT incrementally to give providers a chance to

[4] See Milestone 1 results for details on how changes to manuals are made and communicated.

acclimate to the idea. They explained, *"we introduced the idea to them by participating in large conferences and talking about the evidence behind the use of MAT.…We just gave them nuggets along the way as we prepped and prepared them for what was upcoming."*
We examined the share of Medicaid beneficiaries with OUD/SUD that were treated using MAT over the evaluation period. The share of beneficiaries treated using MAT has increased over the period of 2017 – 2019, averaging 28.6% in 2017 and 33.4% in 2019. Further, we conducted an ITS analysis of the share of Medicaid beneficiaries treated using MAT to evaluate whether the overall change is significant. The ITS results indicate that the slope has significantly increased post intervention, which indicates a significant increase in the share of beneficiaries receiving MAT.

Milestone 4: Sufficient provider capacity at each level of care, including MAT

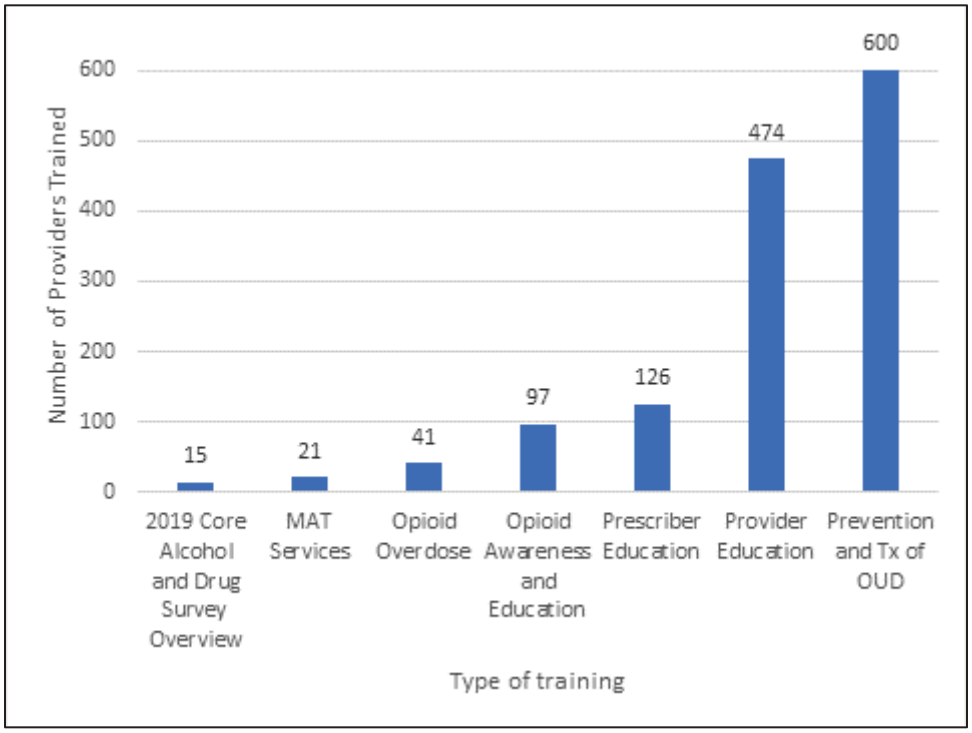
LDH took three initial steps toward achieving Milestone 4. In March 2019, LDH added an **indicator of whether providers accept new patients** to the Specialized Behavior Health (SBH) quarterly network adequacy reports and **assessed MAT capacity based** on MCO data or independent review. LDH also required MCOs to **update their Specialized Behavioral Health network development and management plan** to specifically focus on SUD provider capacity, including MAT; this was completed in July 2020. A key informant explained that, as a component of the Demonstration, the network adequacy report has been revised to include an indicator to allow MCOs to identify MAT providers. Additionally, geographic mapping has been expanded to monitor access to MAT.

LDH has implemented several strategies to **encourage providers to become credentialed to prescribe buprenorphine**. Originally, LDH provided their own training. Now, they refer providers to SAMHSA's free online training program. LDH, in partnership with Tulane University and Project ECHO, is also improving provider capacity through a **virtual peer education program** offered to providers who wish to become MAT certified. Tulane's faculty, the majority of whom are addiction medicine specialists, serve as instructors. Instructors discuss real cases to assist others in learning to treat patients with SUD and mental, physical, and behavioral comorbidities. Participants can also access on-demand, individual assistance in beginning to offer MAT services in their practices. A key informant explained that participants are mostly behavioral health providers whose patients include those who would benefit from MAT. A smaller percentage are providers who are exclusively targeting patients with SUD.

In total, LDH has administered seven different MAT training packages across 32 sessions for SUD providers, from 2018 through 2020 (Figure 2). A total of 1,374 providers received training.[5] Tulane University Project ECHO administered Provider Training for 474 of those providers. Trainings on prevention and treatment of OUD and general provider education were the most well-attended.

[5] Individual providers could have taken multiple trainings, so the number of distinct providers trained may be lower.

Figure 2. Louisiana Department of Health-sponsored provider trainings by type and number of participants.



Another activity listed in the implementation plan was the initiation of a centralized **provider enrollment and credentialing system**. LDH is in the process of developing a short-term portal to enroll and screen or revalidate providers with tentative implementation in March 2021; however, LDH is working with CMS to achieve compliance with requirements for provider management as a result of termination of the CVO contract in April 2020.

LDH is currently considering whether, where, and at what levels additional providers are needed.

An analysis shows that the number of providers in the state has remained relatively stable from 2017 to 2019. Specifically, the number of providers increased from an average of 7,347 in 2017 to an average of 8,266 in 2019 (through October). We conducted an ITS analysis of the number of providers in the state to evaluate whether the overall change is significant. The ITS results indicate that the slope has not changed significantly indicating that there has not been a significant change in the overall trend in the number of providers delivering OUD/SUD services to this point. If the trend continues to increase at the current rate, however, the overall number of providers will continue to increase.

We conducted an additional analysis of the number of providers delivering OUD/SUD services per 1,000 Medicaid beneficiaries with OUD/SUD in the state that shows this number has slightly decreased from 2017 to 2019. Specifically, the number of providers decreased from an average of 463 in 2017 to an average of 429 in 2019. An ITS analysis of the number of providers delivering OUD/SUD services per 1,000 Medicaid beneficiaries with OUD/SUD in the state shows that the slope has not changed significantly, indicating no change in the trend in the number of providers per beneficiary to this point.

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

The implementation plan states that LDH will coordinate with stakeholders on **establishing required reporting for Naloxone administration**. Louisiana has had a standing order for Naloxone in place since 2016. LDH purchases and distributed Naloxone kits through a grant-funded program that also enabled the institution of a tracking system. Recipients use the tracking system to report where and to whom the kits are administered. The tracking system is limited to kits that LDH distributes. There is no State-level tracking system for Naloxone kits that are distributed through the private sector, nor is data collected on Naloxone administration.

The implementation plan also states that LDH will coordinate with the Board of Pharmacy to create Medicaid access to **monitor prescribing practices of opioids under the Prescription Monitoring Program** (PMP). However, there is a law prohibiting Medicaid access to the PMP. Rather than attempt to change the law, LDH is exploring sources of administrative data that could be used to track Naloxone administration.

In order to increase the utilization of SUD treatment, LDH has engaged in various types of outreach to providers and the public. Tactics include booths and presentations at conferences, radio and news interviews, and fliers. For a more targeted approach, there are peer support specialists embedded in programs who do outreach to people with SUD. Additionally, LDH provides support to local health departments for their own outreach efforts.

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

To improve care coordination and transitions between levels of care LDH aimed to continue to monitor MCO compliance with existing contract requirements in an effort to assure beneficiary needs are met relative to linkage with community-based services.

The implementation plan also stated that OBH had revised the existing **provider quality monitoring** to include specific to SUD providers to monitor areas such as but not limited to adherence to clinical practice guidelines, treatment planning components, and coordination of care. A sample of providers is monitored on a quarterly basis by the MCO's.

Key informants reported that quality monitoring, which requires staff to be physically present in provider offices, had been suspended in March 2020 due to COVID-19 and an active hurricane season. LDH plans to resume quality monitoring in January 2021; monitoring will be prospective and data from the months that were missed will not be reported retrospectively.

Evaluation metrics under this milestone include the initiation of follow-up after discharge from the emergency department or hospital for Alcohol and Other Drug Abuse or Dependence (AOD), follow-up after discharge from the emergency department for AOD, and initiation and engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD). We

analyzed both follow-up after discharge measures at 7-days and at 30-days post discharge. We analyzed eight separate rates for the engagement measure at both 14 and 34 days of the initiation visit. The following diagnosis cohorts were analyzed 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

We conducted descriptive and ITS analyses on these metrics. The ITS results for these analyses are provided in the Appendix. Overall, at this point in the demonstration, there is little to no significant movement among these metrics. It is important to recognize, however, that the post-period for these metrics is short. ITS estimates depend on average pre and post trends, so it is probably too early to detect any significant changes in these metrics.

Early impacts of the SUD 1115 Demonstration

Our evaluation quantitative results indicate that there has been little movement on evaluation and monitoring metrics to this point. One notable exception is the share of beneficiaries receiving MAT, which has substantially increased. This is particularly encouraging given that the number of providers and providers per capita have remained stable over the period. This indicates that the Demonstration has been effective at educating providers on the benefits of MAT and encouraging providers to initiate MAT. The relative lack of movement on other metrics, particularly around care coordination, appear to be the result of too short a time period post intervention.

Key informants stressed that in Louisiana, only minor changes had been necessitated by the Demonstration and that most providers were unaware that anything had changed. Informants felt that the state had "hit the ground running" on the Demonstration. Although it may be too early to assess the full impact of the Demonstration, informants stressed that the increased attention to Louisiana's SUD care system, particularly in the area of access to care, was a benefit of participating in the Demonstration.

Challenges in implementing the SUD 1115 Demonstration

Informants listed three main challenges in implementing the Demonstration. The first was obtaining the data needed to monitor the program, particularly buprenorphine waivered physicians. The second challenge was in having appropriate and useful measures with which to monitor progress, both within Louisiana and in comparison with other states. Lastly, the 2020 hurricane season was extremely active and had especially devastating impacts in the western region of the state. This caused interruptions in data collection (due to facility closures) and in care (due to both facility closures and patient displacement).

Apart from interruptions in quality monitoring, informants did not list COVID-19 as a challenge in implementing the Demonstration to date. However, informants did anticipate a disruption in the SUD care system as overdose rates rise and clinic operations are impacted by COVID-related restrictions.

Progress toward implementing secondary drivers

Figure 3 displays the driver diagram for the SUD 1115 Demonstration. It illustrates the relationships between secondary drivers (activities), primary drivers (outcomes), and the purpose of the Demonstration, which is to "maintain critical access to OUD/SUD services and continue delivery system improvements to provide more coordinated and comprehensive treatment for Medicaid beneficiaries." Table 1 provides an overview of Louisiana's progress on each secondary driver. All the secondary drivers have been implemented except for extended coverage to ASAM Level 1-WM, which is not being pursued.

Figure 3. Driver diagram.

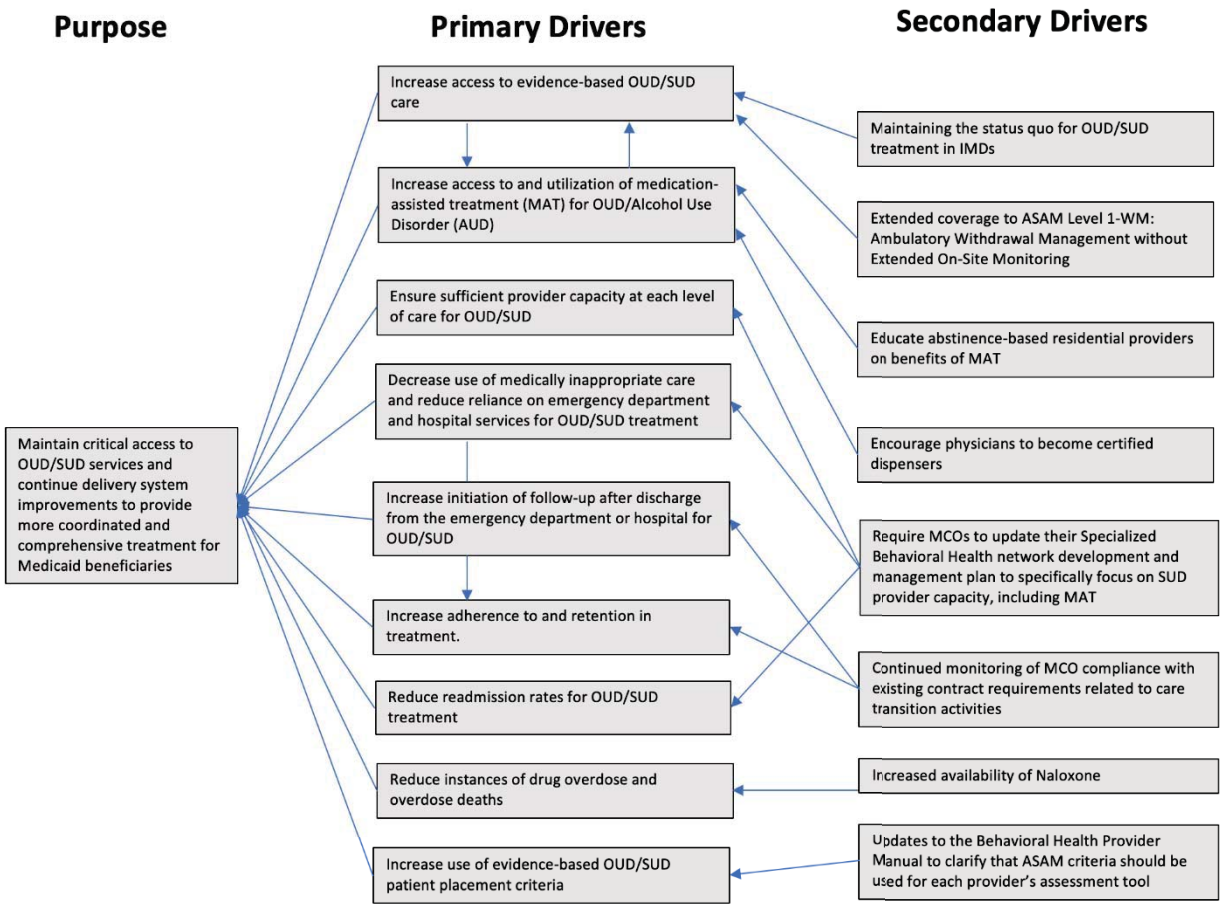


Table 1. Progress toward implementation of secondary drivers at midpoint.

Secondary Driver	Status
Maintaining the status quo for OUD/SUD treatment in IMDs	No action needed
Extended coverage to ASAM Level 1-WM	Not done, no plans to pursue
Educate abstinence based residential providers on benefits of MAT	• Education through conference presentations on evidence for MAT • Quantitative results show substantial progress
Encourage physicians to become certified dispensers	• Supported through virtual peer education program • Unable to calculate, but MAT results combined with provider supply indicate progress
Require MCO's to update their Specialized Behavioral Health network development and management plan	Completed
Continued monitoring of MCO compliance with existing contract requirements related to care transition activities	Ongoing
Increased availability of Naloxone	• Standing order in place since 2016 • LDH using grant funding to purchase and distribute Naloxone kits
Updates to the Behavioral Health Provider Manual to clarify that ASAM criteria should be used for each provider's assessment tool	Completed

Budget Neutrality

We are also asked to provide a status update of budget neutrality requirements. The Demonstration has consistently shown higher numbers than projected from the beginning of the Demonstration period. A review of the budget neutrality calculations shows that this excess is driven almost entirely by a greater number of actual member months than projected member months, which is most likely a result of under estimating Medicaid Expansion enrollment and participation in the Demonstration (the budget neutrality projections limited LDH to using only the first six months of Expansion experience). The actual excess calculated by LDH has remained relatively stable, which also indicates the difference in member month actuals and projections is the cause.

We also note that LDH has recently begun to use the CMS approved budget neutrality workbook (beginning in the second quarter of Demonstration Year 3). Results do not appear to differ substantially. Lastly, we expect the number of Expansion enrollees to increase because of COVID-19 and the resulting decision by the Medicaid program to put a hold on eligibility review, coupled with job losses across the state.

Discussion and Recommendations

Overall, our assessment is that LDH has made substantial progress toward achievement of its milestones, despite a number of challenges during the Demonstration so far. Where there appears to be a lack of progress, we do not see any major concerns over the ability to achieve targets over the course of the Demonstration that requires substantial changes in approach. Rather, we conclude that in these areas the interventions have not had sufficient time to determine their impact and any adjustments at this point would only confuse and complicate our ability to determine impact over the entire course of the Demonstration. If the Demonstration does not achieve its goals, in our view it will likely be a failure of theory or program design rather than implementation. However, we do have several recommendations for the remaining Demonstration period that we believe will enhance the ability of the Demonstration to achieve its goals.

CMS and LDH should agree on appropriate and useful measures with which to monitor progress. Many program staff do not know whether the Demonstration is having an impact, in part due to a lack of consensus on measures. LDH and CMS have recently finalized the Monitoring Protocol metrics, and the Tulane Evaluation team has worked with LDH to align these measures with the Evaluation metrics. This has just recently been completed and it will take time and substantial effort to apply and use these metrics to determine the overall impact of the Demonstration.

Flexibility in implementation and reporting from hurricane-affected regions will give a more accurate picture of the success of the Demonstration. LDH and CMS should agree on any adjustments resulting from the weather-related disruptions, particularly in southwest Louisiana.

Finally, we recommend that the model for budget neutrality be re-examined in light of the actual Medicaid Expansion enrollment and participation in the Demonstration, and the likelihood that this population will continue to increase because of the Covid-19 pandemic.

Appendix

Table A1: Interrupted Time Series Estimates of Goal 3.1

	Goal 3.1			
	7-day ED Follow-up	30-day ED Follow-up	7-day Hospital Follow-up	30-day Hospital Follow-up
Time	0.010*** (0.000)	0.010*** (0.001)	0.001*** (0.000)	0.001*** (0.000)
Implement	0.082*** (0.025)	0.164*** (0.010)	0.115*** (0.016)	0.155*** (0.009)
Time x Implement	-0.003*** (0.001)	-0.006*** (0.001)	-0.004*** (0.001)	-0.006*** (0.000)
Baseline Mean	0.545	0.628	0.688	0.795
R^2	0.923	0.916	0.387	0.397
Observations	34	34	34	34

Notes: Coefficient definitions are as follows: *Time* represents the pre-intervention estimate of the slope of the linear trend in the outcome variable; *Implement* is an indicator for level changes in outcomes coinciding with the intervention period; *Time x Implement* represents 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. *$p<0.10$, **$p<0.05$, ***$p<0.01$

Table A2: Slope Estimates of Goal 3.1

	Goal 3.1			
	7-day ED Follow-up	30-day ED Follow-up	7-day Hospital Follow-up	30-day Hospital Follow-up
Pre-Implementation	0.010*** (0.000)	0.010*** (0.001)	0.001*** (0.000)	0.001*** (0.000)
Post-Implementation	0.007*** (0.001)	0.005*** (0.000)	-0.003*** (0.000)	-0.005*** (0.000)
Baseline Mean	0.545	0.628	0.688	0.795
R^2	0.923	0.916	0.387	0.397
Observations	34	34	34	34

Notes: Definitions are as follows: *Pre-Implementation* represents the pre-intervention estimate of the slope of the linear trend in the outcome variable; *Post-Implementation* represents the post-intervention slope of the linear trend. 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. *$p<0.10$, **$p<0.05$, ***$p<0.01$

Table A3: Interrupted Time Series Estimates of Goal 3.2

	Goal 3.2							
	Alcohol Initiation	Alcohol Engagement	OUD Initiation	OUD Engagement	Other Drug Initiation	Other Drug Engagement	Total AOD Initiation	Total AOD Engagement
Time	0.002*** (0.000)	-0.000 (0.000)	0.001*** (0.000)	-0.000* (0.000)	0.002*** (0.000)	0.000 (0.000)	0.002*** (0.000)	0.000** (0.000)
Implement	0.240*** (0.024)	-0.004 (0.041)	0.212*** (0.052)	0.030 (0.039)	0.008 (0.054)	-0.025 (0.044)	0.219*** (0.040)	0.037** (0.015)
Time x Implement	-0.008*** (0.001)	-0.000 (0.001)	-0.007*** (0.002)	-0.001 (0.001)	-0.000 (0.002)	0.001 (0.001)	-0.007*** (0.001)	-0.001** (0.000)
Baseline Mean	0.659	0.041	0.813	0.027	0.671	0.042	0.772	0.063
R^2	0.509	0.129	0.407	0.164	0.638	0.025	0.653	0.158
Observations	34	34	34	34	34	34	34	34

Notes: Coefficient definitions are as follows: *Time* represents the pre-intervention estimate of the slope of the linear trend in the outcome variable; *Implement* is an indicator for level changes in outcomes coinciding with the intervention period; *Time x Implement* represents 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. *$p<0.10$, **$p<0.05$, ***$p<0.01$

Table A4: Slope Estimates of Goal 3.2

	Goal 3.2							
	Alcohol Initiation	Alcohol Engagement	OUD Initiation	OUD Engagement	Other Drug Initiation	Other Drug Engagement	Total AOD Initiation	Total AOD Engagement
Pre-Implementation	0.002*** (0.000)	-0.000 (0.000)	0.001*** (0.000)	-0.000* (0.000)	0.002*** (0.000)	0.000 (0.000)	0.002*** (0.000)	0.000** (0.000)
Post-Implementation	-0.006*** (0.001)	-0.000 (0.001)	-0.006*** (0.002)	-0.001 (0.001)	0.002 (0.002)	0.001 (0.001)	-0.005*** (0.001)	-0.001** (0.000)
Baseline Mean	0.659	0.041	0.813	0.027	0.671	0.042	0.772	0.063
R^2	0.509	0.129	0.407	0.164	0.638	0.025	0.653	0.158
Observations	34	34	34	34	34	34	34	34

Notes: Definitions are as follows: *Pre-Implementation* represents the pre-intervention estimate of the slope of the linear trend in the outcome variable; *Post-Implementation* represents the post-intervention slope of the linear trend. 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. *$p<0.10$, **$p<0.05$, ***$p<0.01$