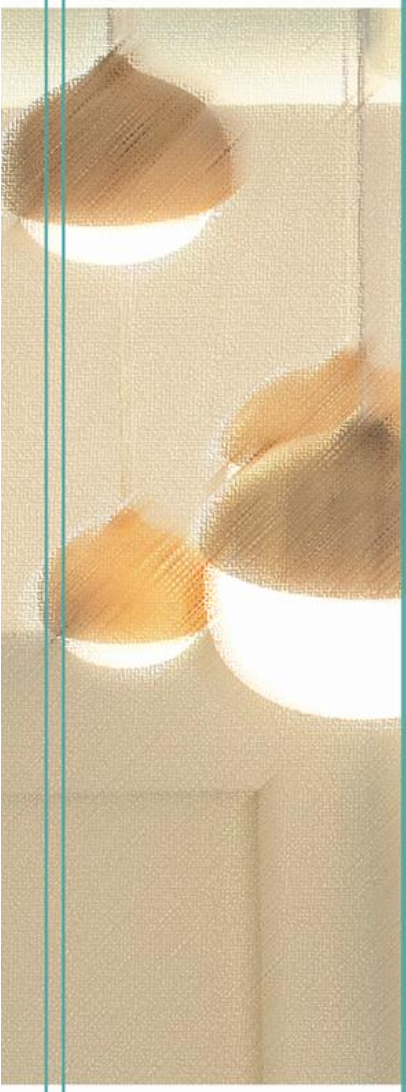

MID-POINT ASSESSMENT OF NORTH CAROLINA'S SUBSTANCE USE DISORDER 1115 WAIVER

UNC | THE CECIL G. SHEPS CENTER FOR HEALTH SERVICES RESEARCH

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Table 1. List of Abbreviations.

ASAM	American Society for Addiction Medicine
BH I/DD	Behavioral Health and Intellectual/Developmental Disabilities
CDC	Centers for Disease Control and Prevention
CFAC	Consumer and Family Advisory Committee
CMS	Centers for Medicare and Medicare Services
COVID-19	Coronavirus disease 2019
CPT	Current Procedural Terminology
CSRS	Controlled Substance Reporting System
DHB	Division of Health Benefits
DHSR	Division of Health Services Regulation
DMH or DMH/DD/SAS	Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
DSOHF	Division of State Health Facilities
DY	Demonstration Year
IMD	Institute for Mental Disease
IOPH	Intensive Outpatient and Partial Hospitalization Services
LCAS	Licensed Clinical Addiction Specialist
LME/MCO	Local Management Entity/Managed Care Organization
MAT	Medication Assisted Therapy (older term for MOUD that is preserved in metric names)
MMIS	Medicaid Management Information Services
MOUD	Medications for opioid use disorder
MPA	Mid-Point Assessment
NC	North Carolina
NCDHHS	North Carolina Department of Health and Human Services
NP	Nurse Practitioner
OBOT	Office-based opioid treatment
OTP	Opioid treatment program
OUD	Opioid use disorder
PA	Physician Assistant
PDMP	Prescription Drug Monitoring Program
PHP	Prepaid Health Plans
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SMI	Serious Mental Illness
SPA	State Plan Amendment
SUD	Substance Use Disorder

Executive Summary

This document represents a Mid-Point Assessment of the North Carolina Medicaid 1115 Substance Use Disorder (SUD) Waiver. As required by the Centers for Medicare and Medicaid Services (CMS), the components of the SUD Waiver are organized around 6 "Milestones," briefly described as (1) Access, (2) Placement Criteria, (3) Provider Qualifications, (4) Capacity, (5) Prescribing and Overdose, and (6) Care Coordination. Multiple sources of information were considered for this Assessment, including monitoring metrics, implementation plan action items, North Carolina Department of Health and Human Services (NCDHHS) web pages, and qualitative interviews with key stakeholders. We factored in the context of the time period examined, which was unprecedented for North Carolina and the nation, with the COVID-19 pandemic and public health emergency (PHE) occurring during most of the implementation period, as well as other large components of North Carolina's Medicaid transformation, such as the movement of most Medicaid beneficiaries into capitated managed care Standard Plans on July 1, 2021.

Based on this information, we determined that NC is at Low risk of not meeting Milestones 2 (Use of Evidence-Based SUD-Specific Patient Placement Criteria) and 5 (Implementation of Comprehensive Strategies to Address Prescription Drug Abuse and Opioid Use Disorders). The State has made significant progress on the metrics associated with these Milestones. In addition, we believe the State is at Low/Medium risk for not meeting Milestone 4 (Sufficient Provider Capacity at Critical Levels of Care, including for Medication-Assisted Treatment for Opioid Use Disorder). We explain the reasoning behind these levels and the supporting metrics in the full document.

NC is at High risk for not meeting Milestone 1 (Access to Critical Levels of Care for SUD). Few of the implementation plan actions have been completed, and there has been progress in fewer than half of the monitoring metrics. Interviews revealed that policy development is the foundation of subsequent progress in SUD care improvement, so the state of Milestone 1 is concerning for the timely implementation of the remainder of the SUD waiver components. However, there are significant mediating factors, including the COVID-19 crisis and the implementation of Standard Plans. Flexibilities put in place during COVID-19 have improved patient care, for which NCDHHS should be commended.

The remaining Milestones 3 (Use of Nationally Recognized SUD-Specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities) and 6 (Improved Care Coordination and Transitions Between Levels of Care) were assessed at Medium risk. Ensuring access to evidence-based care has been complicated by many factors, including provider turnover exacerbated by the COVID-19 crisis, limited funding to start up new facility-based services, and lack of requirements around providing medications for opioid use disorder (MOUD) at residential treatment facilities.

Recommendations for progress are provided and include: provide greater web content for providers and beneficiaries on the SUD components of the waiver; determine barriers for metrics not meeting targets and identify incentives that could address these barriers; continue COVID-19 flexibilities; use monitoring metrics to mount an adaptive response to immediate needs; triangulate code lists and service definitions going forward; prioritize minimum MAT access requirements for residential treatment facilities; streamline the licensure process for facility-based treatment; support inpatient service capacity through direct financial support and/or improved allocation of beds; consider expanding Medicaid in NC to cover those who don't have access to SUD services; and identify and reward higher levels of beneficiary engagement in care.

Chapter 1: Introduction

This document represents the independent Mid-Point Assessment of the North Carolina Medicaid Substance Use Disorder 1115 Waiver. Below, we briefly describe the history of the waiver components related to substance use disorder (SUD) and their implementation in North Carolina and provide an independent assessment of the implementation activities to date.

History of North Carolina Medicaid's SUD 1115 Demonstration

North Carolina's 1115 Waiver entitled "North Carolina Medicaid Reform Demonstration" was approved by the Centers for Medicare & Medicaid Services (CMS) on October 24, 2018. The waiver contains both substantial changes to the substance use disorder benefits and treatment system in North Carolina, as well as components, such as a transformation from fee-for-service to capitation through Standard and Tailored Plans, and the implementation of the Healthy Opportunities Pilots, which redirect Medicaid funds to provide non-traditional services that directly address social determinants of health. This document will focus on the waiver components related to the transformation of the substance use disorders (SUD) benefits and treatment system, which began on January 1, 2019 and are currently set to expire on October 31, 2023.

Intervening Factors

There are several major events that occurred since the approval of the SUD Implementation Plan in 2019 that have substantially affected the implementation timeline. These include the COVID-19 public health emergency, which began in March 2020, just one year into the implementation of the SUD components of the waiver; the implementation of Standard managed care plans on July 1, 2021 as part of the overall waiver; planning for Tailored Plans, the comprehensive capitated plans customized for people with behavioral health conditions, which will be implemented in December 2022; and the dissolution of Cardinal Innovations, one of the Local Management Entity / Managed Care Organizations (LME/MCOs) that held a contract for carved-out capitated behavioral health services in 2020-2021. (LME/MCO is a term used by North Carolina to refer to regional entities that manage behavioral health care for state- and Medicaid-funded individuals, respectively.) The counties that were served by the Cardinal LME/MCO were distributed among other LME/MCOs, causing a relatively sudden increase in service areas. The impact of these events on Medicaid beneficiaries and the dedicated employees at North Carolina Department of Health and Human Services (NCDHHS) and the LME/MCOs who run these programs cannot be overstated. COVID-19 had a particularly strong impact on substance use that disproportionately affected the SUD provider community. The Centers for Disease Control and Prevention (CDC) reports that the drug overdose death rate that had been increasing prior to the COVID-19 PHE further escalated during this time[1]. We are mindful of this context as we describe the changes in metrics and timelines throughout this report.

Goals of the Demonstration

We begin by reviewing the stated goal of the SUD components of the 1115 Medicaid waiver. This goal is to strengthen the SUD delivery system by:

[1] Centers for Disease Control and Prevention, "Overdose Deaths Accelerating During COVID-19" https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html. Published December 2020, Accessed April 22, 2022.

- Expanding SUD benefits to the full American Society of Addiction Medicine (ASAM) continuum of care
- Obtaining a waiver of the Institution for Mental Disease (IMD) exclusion that prohibits federal financial participation for care for non-elderly adult Medicaid beneficiaries aged 21-64 receiving SUD care in an IMD
- Modernizing licensure standards
- Increasing provider capacity
- Strengthening care coordination and care management
- Improving the prescription drug monitoring program (PDMP), referred to as the Controlled Substances Reporting System (CSRS) in North Carolina

In brief, the reform efforts center around six milestones established by the Centers for Medicare and Medicaid Services (CMS):

- Milestone 1: Access to Critical Levels of Care for SUD ("Access")
- Milestone 2: Use of Evidence-Based SUD-Specific Patient Placement Criteria ("Placement Criteria")
- Milestone 3: Use of Nationally Recognized SUD-Specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities ("Provider Qualifications")
- Milestone 4: Sufficient Provider Capacity at Critical Levels of Care, including for Medication-Assisted Treatment for Opioid Use Disorder (OUD) ("Capacity")
- Milestone 5: Implementation of Comprehensive Strategies to Address Prescription Drug Abuse and Opioid Use Disorders ("Prescribing and Overdose")
- Milestone 6: Improved Care Coordination and Transitions Between Levels of Care ("Coordination")

Role of the Independent Evaluator

The Cecil G. Sheps Center for Health Services Research at UNC-Chapel Hill is serving as the Independent Evaluator for the 1115 and SUD waiver evaluations. Sheps Center faculty and staff have decades of experience in policy evaluation, including mixed methods evaluations with claims data analysis, survey data fielding and analysis, and qualitative interview and focus group analysis. The multidisciplinary team has expertise on a number of dimensions important to this project, including behavioral health, CMS processes and procedures, federal waivers, financial and economic analyses, administrative data analytics, organizational behavior, quality of care metrics, data visualization, implementation science, social determinants of health, and safety net providers.

Relationship to the Status Update and Mitigation Plan

The Division of Health Benefits recently contracted with Manatt Health to evaluate the status of the SUD Waiver implementation and develop a mitigation plan. This assessment was carried out contemporaneously with the Mid-Point Assessment (MPA), though the two assessments were largely performed independently. Manatt contractors participated in some of the key stakeholder interviews with state representatives. In addition, they provided the MPA team with drafts of their Status Update and Mitigation Plan, which contained extensive information on the status of the implementation plan action items.

Information that is contained in this document and not the Status Update and Mitigation Plan includes:

- An analysis of monitoring metrics that assesses progress since the beginning of the SUD Waiver
- Synthesis of interviews with LME/MCOs and SUD treatment providers
- Focus groups with Medicaid beneficiaries receiving SUD services

Further, the Sheps Center evaluation team independently assessed the risk of not meeting each milestone, although we were provided Manatt's assessment of this risk. The Sheps Center's risk assessment follows the CMS guidance, described further below, in terms of basing risk levels (low, medium, and high) on the proportion of critical metrics for each milestone that are moving in the target direction, while Manatt's assessment is based on the completion of key implementation dates. Thus, the two reports are complementary.

Chapter 2: Assessment Methodology

We used several methods and sources to evaluate North Carolina's progress towards achieving the implementation milestones (Table 2). The monitoring metrics form the main quantitative assessment of progress to date and have been prepared by the Sheps Center for the quarterly reports to CMS since the beginning of the evaluation contract. We used these data to assess impacts of any policy changes taken to date, identify gaps in North Carolina's SUD service delivery system, and to assist in the development of recommendations. We interpret changes in the metrics since the waiver baseline period, described below, in the context of the intervening factors, and account for this in our analyses when possible.

Table 2. Sources and types of data used in this report.

Type of Data	Description	Data Source
Critical monitoring metrics	A subset of monitoring metrics identified by CMS that must be in the MPA.	Analysis of Medicaid administrative data provided to the Sheps Center by NCDHHS
Other monitoring metrics	Non-critical metrics that are included in the approved monitoring protocol.	Analysis of Medicaid administrative data provided to the Sheps Center by NCDHHS
Global review of information on NCDHHS web pages	A review for availability of content related to SUD waiver components on NCDHHS (DHB and DMH web sites)	https://medicaid.ncdhhs.gov https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-abuse-services
Stakeholder perspectives	Results from rapid qualitative analysis of key stakeholder interviews.	The MPA team interviewed: ♦ Representatives from NCDHHS ♦ Representatives from the LME/MCOs ♦ Providers of SUD treatment services ♦ Medicaid beneficiaries with SUD
Implementation Plan action items	A list of all action items intended to be completed by the waiver mid-point (taken to be January 1, 2022 for the purposes of this assessment).	The list of action items was extracted from the CMS-approved Implementation Plan. The status of each item was extracted from the Manatt Report and consulting with DHB representatives.

Monitoring Metrics

Data Sources

The primary data source for the monitoring metrics is the Sheps Center's calculations from Medicaid claims, encounter, membership, and provider participation data. These data are provided to the Sheps

Center by NCDHHS on a monthly basis. A description of all Critical Monitoring Metrics is provided in Attachment 3.

The Sheps Center began reporting SUD metrics after the start of the demonstration due to delays in the procurement process, so initial monitoring reports were reported to CMS by NCDHHS. In some cases, prior reports were resubmitted by the Sheps Center because of feedback received from CMS. In all cases, the most recent metrics reported to CMS for each period and metric were used.

Analytic Methods

We calculated changes in metrics from baseline for both the required Critical Monitoring Metrics and selected additional metrics.

As per CMS guidance,[2] we report the unadjusted absolute and relative change from baseline for all metrics. The central methodology recommended by CMS does not incorporate a denominator such as all Medicaid beneficiaries at risk for SUD. Therefore, the metrics reported are generally to be interpreted as the distinct number of beneficiaries receiving a service or diagnosis. We occasionally provide additional context on these metrics, for example by comparing the growth of the number of individuals with a SUD with the growth of the Medicaid population during the same time period, but this context does not factor into our assignment of risk.

The absolute change is reported as:

Absolute Change = Value at mid-point - Value at baseline

The relative percent change is reported as:

Percent Change = (Value at mid-point - Value at baseline) / Value at baseline

For metrics reported annually according to the demonstration year (CMS metrics), the **baseline period** is November 1, 2018 to October 31, 2019 (DY1). For metrics reported by calendar year, we use 2018 as the baseline period. For metrics reported quarterly, the baseline period is November 1, 2018 to January 31, 2019 (DY1Q1). Because CMS agreed to a timeline for the Mid-Point Assessment that is slightly longer than the mid-point of the study, we used the latest reported estimates that were available at this writing as the mid-point for this analysis, which include data from November 1, 2020 through October 31, 2021 (DY3) for demonstration year metrics, 2020 for calendar year metrics, and monthly and quarterly data from August to October 2021.

For selected metrics, we include figures demonstrating longitudinal trends since October 2015 from the SUD Data Dashboard the Sheps Center creates monthly for the Demonstration Evaluation. These figures help to provide greater context about trends in the metrics than just providing information from the two required time points at baseline and mid-point.

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[2] Centers for Medicare & Medicaid Services (CMS). *Medicaid Section 1115 Substance Use Disorder (SUD) and Serious Mental Illness and Serious Emotional Disturbance (SMI/SEC) Demonstrations Mid-Point Assessment Technical Assistance.* https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/1115-sud-smised-mid-point-assessment-ta.pdf. Published October 2021. Accessed February 6, 2022.

In the second analysis, we report the unadjusted change by subpopulations of interest, which includes age groups, pregnant beneficiaries, criminally involved beneficiaries, or Medicaid/Medicare dual eligible beneficiaries, depending on the metric.

Stakeholder Input

Data Sources

We identified key stakeholders as employees of North Carolina state agencies within NCDHHS, LME/MCO representatives, NC providers of SUD services whose caseloads include at least some Medicaid beneficiaries, and Medicaid beneficiaries receiving SUD services. We reached out to state agencies and LME/MCOs directly via phone and email and utilized professional networks to gain additional referrals. For providers and Medicaid beneficiaries, we used a variety of recruitment methods, including consulting with providers known to the study team, snowball sampling, searching the provider directories provided on LME/MCO websites, and distributing recruitment materials through professional email lists. Our goal for the provider sample was to identify individuals representing various roles, types of organizations, and geographic areas within the state.

We developed interview guides for this report by adapting the interview guides used by the qualitative team of the Sheps Center's overall 1115 waiver evaluation. Draft guides were reviewed and edited by the entire study team and, in the case of the provider interview guide, piloted with a SUD expert at UNC-Chapel Hill.

NCDHHS. We aimed to recruit at least one representative from each division of interest within NCDHHS to obtain diverse perspectives: the Division of Health Benefits (DHB), the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), the Department of State-Operated Health Facilities (DSOHF), and the Controlled Substance Reporting System (CSRS). We were able to interview a total of 10 state representatives across 4 agencies: three representatives from DHB, three representatives from DMH/DD/SAS, two representatives from CSRS, and two from DSOHF. Because an important component of the evaluation focuses on the SUD-specific health information technology system, we attempted to interview the health information technology lead, but were unable to do so because of a personnel change that occurred prior to the completion of the MPA.

LME/MCOs. We aimed to recruit at least one participant from each of the 6 extant LME/MCOs (Vaya, Eastpointe, Sandhills, Partners, Trillium, and Alliance) and the one LME/MCO that dissolved after the initiation of the SUD waiver (Cardinal). Ultimately, we were able to interview 11 LME/MCO representatives across five LME/MCOs: one representative from Vaya, three representatives from Eastpointe, two from Partners, three from Trillium, and two representatives from Alliance. We were not able to recruit study participants from Sandhills or Cardinal Health.

SUD Providers. We interviewed 13 SUD providers across geographic regions (Mountains, Coastal Plain, and Piedmont), professional training (psychiatrist, primary care providers, Licensed Clinical Addiction Counselors (LCASs), social workers, and advanced practice providers [nurse practitioners (NPs) and physician assistants (PAs)], and practice type (inpatient, outpatient, and opioid treatment programs (OTPs)).

Medicaid beneficiaries receiving SUD services. In order to include the beneficiary voice, we conducted two focus groups, which included a total of 13 participants, and one individual interview with Medicaid

beneficiaries with self-reported SUD. Beneficiaries were recruited by a) requesting that interviewed providers and others share flyers with their clients who may be eligible, b) direct outreach to providers at local SUD/SMI treatment organizations, and c) outreach to peer support providers and associated organizations.

Analytic Methods

The overarching analysis method for the stakeholder interviews was Rapid Qualitative Analysis, as described by Alison B. Hamilton and others.[3] Briefly, we defined *a priori* domains for each stakeholder type based on the interview guides. Two members of the study team then summarized each interview according to these domains, which are shown in Table 3. The domain-related summaries were copied into a matrix with one interview per row and one domain per column. For state agencies and LME/MCOs, these matrices are presented; we also created a summary memo that described the key points from each interview. For the provider and beneficiary interviews, further summaries were derived, both overall and by certain characteristics. Finally, for all four stakeholder types, we mapped insights from the interviews onto the six Milestones. These insights were divided into whether they indicated "Successes" or "Challenges" related to each Milestone.

In the results, if a particular topic did not arise in the interviews or participants did not provide an answer to a planned question, we report "Not discussed." If a general topic was discussed but stakeholders responses could not be classified as either successes or challenges, we report "None mentioned." If we deemed ahead of time that a topic was not relevant to that stakeholder, we report "NA," for "not applicable.

Table 3. Analysis domains for stakeholder interview summaries.

State Agencies	LME/MCOs	SUD Providers	Medicaid SUD Service Beneficiaries
♦ Overall Implementation Status ♦ COVID-19 Effects ♦ Provider and Beneficiary Awareness ♦ Milestones: Successes ♦ Milestones: Challenges ♦ Milestones: Priorities ♦ Tailored Plans	♦ Overall Implementation Status ♦ Interaction with State Agencies ♦ Engagement with Providers ♦ Raising Patient Awareness ♦ COVID-19 Effects ♦ Waiver Components: Successes and Challenges ♦ Waiver Components: Strategies and Priorities ♦ Planning for Tailored Plans	♦ Overall Perception of SUD Change ♦ Preparation for Change ♦ Engagement with State/LME/MCOs ♦ Uptake of New Services ♦ Tailored Plans ♦ Effects of COVID-19	♦ Accessing SUD Services ♦ Required Adjustments ♦ Experience with Insurance Plan ♦ Experience with State

[3] Hamilton AB. Qualitative Methods in Rapid Turn-Around Health Services Research. *Health services research & development cyberseminar*. Published online 2013:42. https://www.hsrd.research.va.gov/for_researchers/cyber_seminars/archives/780-notes.pdf

Implementation Plan Action Items

Data Sources

The list of action items and intended completion dates was obtained from the CMS-approved Implementation Protocol.[4] The status of each action item was determined by reviewing the revised draft of the Manatt Report (received 3/19/2022), which determined the status of each item based on interviews with NCDHHS staff and review of documents. Changes in status of actions since the receipt of the Manatt Report are not captured.

Analytic Methods

We report the status of each action item as follows:

- Complete: the action item is complete; no work remains to be done
- In Progress: work on this action item has begun, but is not complete
- Open: work has yet to begin on achieving this action item.[5]

If an action item was intended to be completed by January 1, 2022, we included this item in the denominator; if it was intended to be completed after the demonstration midpoint, it is not included in our calculations for this assessment.

We calculated the number of action items intended to be completed by the midpoint, then calculated the number and percentage of complete action items. In the text, we also report the number of in-progress and open action items, and the number of action items intended to be completed after the midpoint assessment.

Risk Assessment Methodology

We assessed the level of risk for non-completion of a milestone by following CMS's technical assistance document. In its guidance for Mid-Point Assessments[6], CMS requires that risk categories are assessed based on the proportion of metrics that demonstrate progress toward the program goals as shown in Table 4. However, we deviate somewhat from these categories when (a) relative percent changes were modest; (b) there were significant external factors that may have contributed to directional effects (such as the COVID-19 PHE on metrics tracking the overdose death rate); (c) progress towards the implementation plan action items are substantially different from the picture given by metric changes alone; and (d) if we received information from key stakeholders that modify the information in the metrics. We provide additional context based these factors for each Milestone.

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[4] NCDHHS Division of Health Benefits. *Substance Use Disorder Implementation Plan Protocol*. March 8, 2019. Available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/Medicaid-Reform/nc-medicaid-reform-demo-sud-imp-plan-prtcl-20190425.pdf

[5] In the Manatt report, these items are reported as "to be completed." We have adjusted the terminology for consistency with the CMS Mid-Point Assessment Technical Assistance document.

[6] Centers for Medicare & Medicaid Services (CMS). *Medicaid Section 1115 Substance Use Disorder (SUD) and Serious Mental Illness and Serious Emotional Disturbance (SMI/SEC) Demonstrations Mid-Point Assessment Technical Assistance.* https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/1115-sud-smised-mid-point-assessment-ta.pdf. Published October 2021. Accessed February 6, 2022.

Table 4. Methodology for Assignment of Risk for Not Meeting Milestones.

	Risk of not Meeting Milestone		
Data Source	Low	Medium	High
Critical Monitoring Metrics	More than 75% of critical metrics are trending in the expected direction	Between 25 and 75% of critical metrics are trending in the expected direction	Less than 25% of critical metrics are trending in the expected direction
Implementation Plan Action Items	More than 75% of action items were completed by January 1, 2022	Between 25 and 75% of action items were completed by January 1, 2022	Less than 25% of action items were completed by January 1, 2022
Stakeholder Feedback	Few stakeholders identified risks; risks easily addressed	Several stakeholders identified risks; risks may cause challenges in meeting Milestone	Many/all stakeholders identified significant risks that are likely to cause challenges in meeting Milestone

Source: Table adapted from MPA Technical Assistance Version 1.0, Table 2 (p. 10).

Limitations

While we use a comprehensive set of data, our approach is not without its limitations. While the evaluation team has decades of experience working with administrative data from Medicaid programs, the encounter data from the Standard Plans that were launched in July 2021 has become usable to the evaluation team within the last two months and a comprehensive set of quality reporting has not been completed as of this writing. While the qualitative data provides nuance and context to the quantitative findings, the perspectives represented do not represent all stakeholders.

Chapter 3: Results

In this chapter, we report the results of our analysis of critical monitoring metrics, Implementation Plan action items, and stakeholder feedback. In Chapter 4, we summarize our assessment of risk and provide recommendations to the state to consider during the remainder of the SUD waiver demonstration.

Although not linked to a Milestone, we begin by reporting metrics counting the number of Medicaid beneficiaries with administrative diagnoses of SUD at baseline and midpoint (Table 5). This is a denominator of potential SUD treatment service users that underlies many of the subsequent metrics, so tracking its change over this time period is critical to understanding the subsequent trends.

Assessment of Need and Qualification for SUD Treatment Services

Table 5. Metric 3: Medicaid beneficiaries with SUD diagnoses.

Metric #	Metric name	Monitoring metric rate or count[a,b]				State's demonstration target	Directionality at mid-point	Progress (Yes/No)
		At baseline	At midpoint	Absolute change	Percent change			
3	Medicaid beneficiaries with SUD diagnoses (monthly)	67,838	79,043	11,205	16.5%	Increase[c]	Increase	Yes

[a]Baseline periods are November 1, 2018 to October 31, 2019 (DY1) for CMS-constructed demonstration year metrics; calendar year 2018 for established metrics; and November 1, 2018 to January 31, 2019 (DY1Q1) for quarterly metrics.
[b]Midpoint periods are October 31, 2021 (DY3) for CMS- constructed demonstration year metrics; calendar year 2020 for established metrics, and August - October 31, 2021 for quarterly metrics.
[c]The short-run target for metric 3 is an increase although the long-run target is a decrease. We list the short-run target here.

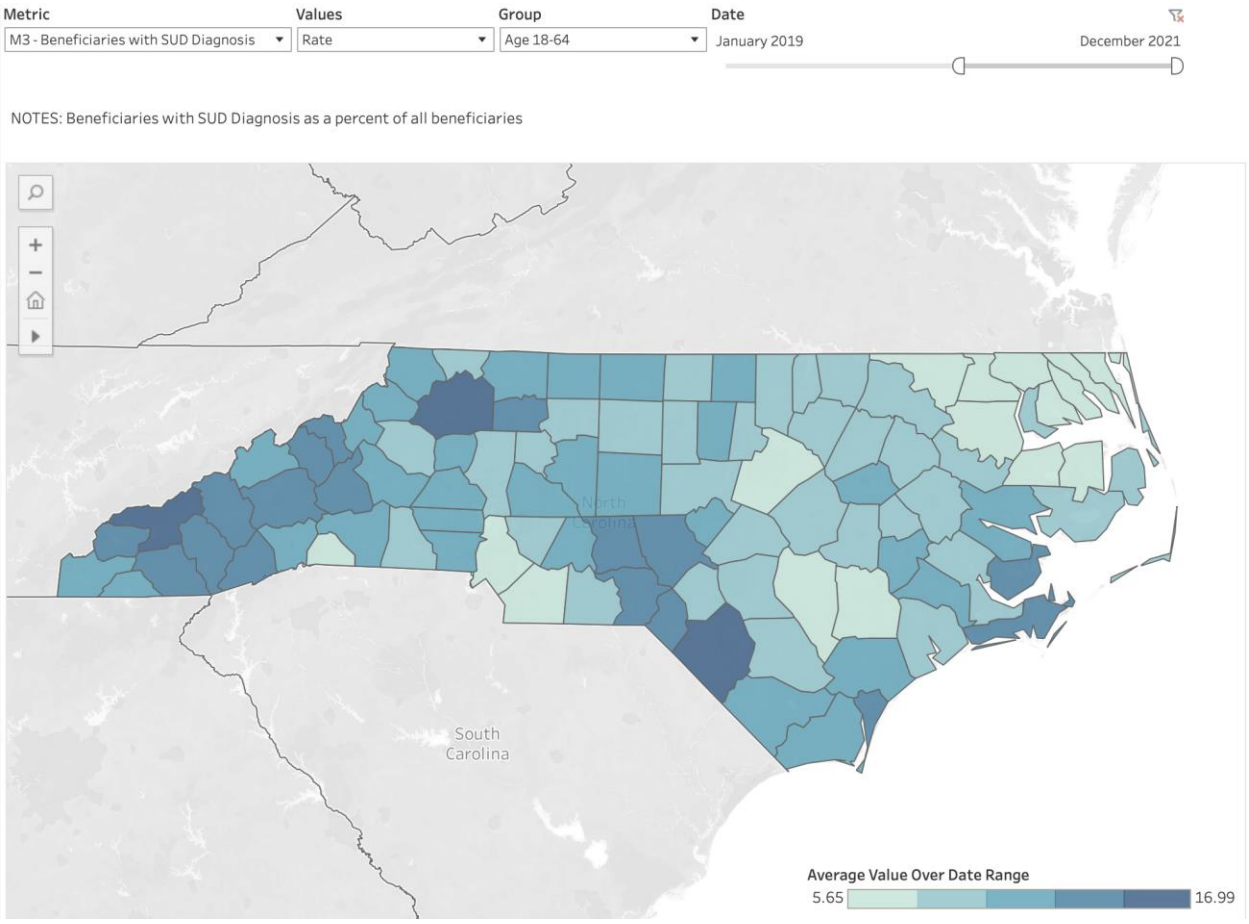
The number of Medicaid beneficiaries with a SUD diagnosis as measured monthly increased by over 11,000 individuals, a 16.5% increase. This indicates progress in the intended direction, in that a larger absolute number of NC residents are identified with SUD through Medicaid-funded services. This is concordant with the goal of the demonstration to expand access to SUD services. The long-run target is a decrease, which reflects the intention to have a greater emphasis on prevention of SUD.

Assessing the change in overall Medicaid enrollment during the waiver period helps to contextualize these changes. In particular, there is evidence that, while the absolute number of Medicaid beneficiaries receiving SUD services has increased, the *proportion* of Medicaid beneficiaries receiving these services has decreased. During the public health emergency, the discontinuation of eligibility redetermination and disenrollment from Medicaid resulted in a greater total number of Medicaid beneficiaries remaining enrolled in Medicaid. We estimate that the total number of Medicaid beneficiaries during August–October 2021 is 22.1% higher than the number of Medicaid beneficiaries in November 2018 – January 2019. Thus, the *proportion* of Medicaid beneficiaries who have a SUD diagnosis has declined as a percent of the

Medicaid population. Even limiting this estimate to non-elderly adult Medicaid beneficiaries, we calculate a 33.7% increase in Medicaid enrollment during this time period, further showing evidence of a decline in the relative *proportion* of beneficiaries with an administrative diagnosis of SUD. However, without additional analysis of the composition of this population, we conclude that Metric 3 trending in the direction of the intended short-run target is promising.

We also map out the county-level rates of non-elderly adult beneficiaries with SUD as a proportion of the Medicaid population in Figure 1 below. There is substantial variation in this rate throughout the state, with a higher proportion of beneficiaries diagnosed with SUD in the western and southern parts of the state.

Figure 1: Non-elderly adult beneficiaries with SUD as a proportion of the Medicaid population from January 2019 – December 2021.



Milestone 1: Access to critical levels of care for SUD

Critical Monitoring Metrics

The set of metrics relevant to Milestone 1 examine the use of different types of services for SUD treatment or prevention (Table 6).

Table 6. Critical monitoring metrics for Milestone 1.

Metric #	Metric name	Monitoring metric rate or count[a,b]				State's demonstration target	Directionality at mid-point	Progress (Yes/No)
		At baseline	At midpoint	Absolute change	Percent change			
7	Early Intervention	231	3	-228	-98.7%	Increase	Decrease	No
8	Outpatient Services	16,795	16,993	198	1.2%	Increase	Increase	Yes
9	Intensive Outpatient and Partial Hospitalization Services	1,333	1,187	-146	-10.9%	Increase	Decrease	No
10	Residential and Inpatient Services	351	222	-129	-36.7%	Increase	Decrease	No
11	Withdrawal Management	128	129	1	0.8%	Increase	Increase	Yes
12	Medication-Assisted Treatment	12,025	15,163	3138	26.1%	Increase	Increase	Yes
22	Continuity of Pharmacotherapy for Opioid Use Disorder	24.64%	22.88%	-1.76% points	-7.2%	Increase	Decrease	No

[a]Baseline periods are November 1, 2018 to October 31, 2019 (DY1) for CMS-constructed demonstration year metrics; calendar year 2018 for established metrics; and November 1, 2018 to January 31, 2019 (DY1Q1) for quarterly metrics.
[b]Midpoint periods are October 31, 2021 (DY3) for CMS-constructed demonstration year metrics; calendar year 2020 for established metrics, and August - October 31, 2021 for quarterly metrics.

Early Intervention: The number of beneficiaries receiving early intervention services dropped substantially by the end of calendar year 2019. At mid-point, we only observe 3 individuals receiving services in the last quarter, a 99% decrease. The CPT codes used by NC are contained within the value set for Metric 7 (99408 and 99409), so this change is not the result of codes used. Beginning in February 2021, NC increased the number of provider types that can bill for early intervention, or Screening, Brief Intervention and Referral to Treatment (SBIRT) codes. To date, that increase has not shown up in the administrative data sources. Upon review of code usage longitudinally, we determined that a relatively small number of providers were

offering SBIRT and a bubble of use occurred in early 2019 and returned to prior levels by 2020 (see Appendix Figure 1).

Outpatient Services: There has been a modest 1.2% increase in the number of beneficiaries who have received outpatient SUD services. Because the size of the population with SUD diagnoses increased by 16.5% over this time period, this is a relative decrease in the proportion of Medicaid beneficiaries with an SUD diagnosis who have received outpatient services for SUD. There was a drop in outpatient service users during the initial months of the PHE, then an increase until March of 2021, prior to Standard Plan implementation, at which point the number of users declined (see Appendix Figure 2).

Intensive Outpatient and Partial Hospitalization Services: There has been a 10.9% percent decrease in the number of beneficiaries who have received IOPH services. This may be a coding issue because the state uses a different set of codes to code intensive outpatient and partial hospitalization services from those provided in the CMS value set. Future analyses will examine the trends in the codes used by NC for these services.

Residential and Inpatient Services: There has been a large 36.7% relative decrease in the number of Medicaid beneficiaries with SUD receiving these services over the first half of the waiver demonstration. The number of individuals has remained close to 325 each month since waiver implementation, with a substantial decline beginning in August 2019, well before the PHE. A longer time series on this variable (Appendix Figure 3) demonstrates that the level of use of residential and inpatient services returned to the normal level of use by June 2020 but has declined since the July 2021 implementation of Standard Plans.

Withdrawal management: The number of Medicaid beneficiaries receiving these services has remained constant throughout the waiver period.

Medication Assisted Treatment (or what is more commonly now referred to as Medications for OUD): We observe over a 26% relative increase in the use of MOUD. This is a greater increase than the number of beneficiaries with SUD diagnoses, indicating that a greater proportion of beneficiaries with SUD are receiving medication treatment.

Continuity of Pharmacotherapy for Opioid Use Disorder: The rate of individuals receiving MOUD who have been retained for 180 days has declined by 1.8 percentage points, or a 7.2% relative decrease since study baseline. This is a calendar year metric that was last reported in 2020, so does not reflect any changes that may have occurred in 2021, such as the increase in access to MOUD noted above.

Implementation Plan Action Items

The list of implementation plan action items for Milestone 1 is the largest out of all the milestones and is included in Table 7.

Table 7. Implementation plan action items for Milestone 1.

ASAM Level of Care	Action Item Description	Date to be Completed*	Current Status
Level 0.5 (Early Intervention)	Implement MMIS modifications	Apr-20	Complete
Level of Care 1 (Outpatient Services)	Amend current Medicaid clinical coverage policies 8-A Diagnostic Assessment and 8-C to reflect ASAM Criteria	Apr-20	In progress
	Submit SPA for 8A Diagnostic Assessment	Apr-20	Open
Level of Care 2.1 (Intensive Outpatient Services)	Amend current Medicaid clinical coverage policy 8-A to reflect 2013 ASAM Criteria, add parameters for adolescents, require the presence of a full-time licensed professional, and permit the service to be reimbursed in an IMD	Oct-20	In progress
	Update MMIS to permit this service to be reimbursed for individuals residing in an IMD	Apr-19	Open
	Develop a licensure rule waiver process	Oct-20	Open
	Revise licensure rule	*Oct-22*	*Open*
	Revise LME/MCO contracts	Oct-20	Open
Level of Care 2.5 (Partial Hospitalization Services)	Amend current Medicaid clinical coverage policy 8-A to align with ASAM criteria, require the presence of full-time licensed professional, and permit this service to reimbursed in an IMD	Oct-20	In progress
	Update MMIS to permit this service to be reimbursed for individuals residing in an IMD	Apr-19	Open
	Develop a licensure rule waiver process	Oct-20	Open
	Revise licensure rule	*Oct-22*	*Open*

ASAM Level of Care	Action Item Description	Date to be Completed*	Current Status
	Revise LME/MCO contracts	Oct-20	Open
Level of Care 3.1 (Clinically Managed Low-Intensity Residential Treatment Services)	Develop a Medicaid clinical coverage policy	Oct-20	In progress
	Create a licensure rule waiver process	Oct-20	Open
	Create licensure rule	*Oct-22*	*Open*
	Implement MMIS modifications	Oct-20	Open
	Submit SPA	Oct-20	Open
Level of Care 3.3 (Clinically Managed Population-Specific High-Intensity Residential Programs)	Develop a Medicaid clinical coverage policy	Oct-20	In progress
	Create a licensure rule waiver process	Oct-20	Open
	Create licensure rule	*Oct-22*	*Open*
	Implement MMIS modifications	Oct-20	Open
	Submit SPA	Oct-20	Open
Level of Care 3.5 (Clinically Managed High-Intensity Residential Services)	Amend current Medicaid clinical coverage policy 8-A to reflect 2013 ASAM criteria, add adolescents as a population eligible to receive service, include IMDs as eligible service providers, and extend coverage for treatment services provided in a therapeutic community	Oct-20	In progress
	Implement MMIS modifications to permit this service to be reimbursed in an IMD	Apr-19	Open
	Develop a licensure rule waiver process	Oct-20	Open
	Revise existing licensure rules and create new licensure rules	*Oct-22*	*Open*
	Revise LME/MCO contracts	Oct-20	Open
	Submit SPA	Oct-20	Open
Level of Care 3.7 (Medically Monitored Intensive Inpatient Services)	Amend current Medicaid clinical coverage policy 8-A to reflect ASAM criteria, add adolescents as a population eligible to receive service, and include IMDs as eligible service providers	Oct-20	In progress

ASAM Level of Care	Action Item Description	Date to be Completed*	Current Status
	Implement MMIS modifications to permit this service to be reimbursed in an IMD	Apr-19	Open
	Develop a licensure rule waiver process	Oct-20	Open
	Revise and create licensure rules	*Oct-22*	*Open*
	Revise LME/MCO contracts	Oct-20	Open
	Submit SPA	Oct-20	Open
Level of Care 4 (Medically Managed Intensive Inpatient Services)	Amend current Medicaid clinical coverage policy 8-B to reflect ASAM criteria and include IMDs as eligible service providers for SUD treatment	Jul-20	In progress
	Implement MMIS modifications to permit this service to be reimbursed in an IMD	Apr-19	Open
	Revise LME/MCO contracts	Jul-20	Open
Level of Care OTP (Opioid Treatment Programs)	Amend current Medicaid clinical coverage policy 8-A to reflect ASAM criteria, permit service to be reimbursed in an IMD, and create integrated service model	Apr-20	In progress
	Implement MMIS modifications to permit this service to be reimbursed in an IMD	Apr-19	Open
	Develop a licensure rule waiver process	Apr-20	Open
	Revise licensure rule	*Oct-22*	*Open*
	Submit SPA	Apr-20	Open
	Revise LME/MCO contracts	Apr-20	Open
Level of Care 1-WM (Ambulatory Withdrawal Management Without Extended On-Site Monitoring)	Develop new Medicaid clinical coverage policy to align with ASAM criteria	Jul-20	In progress
	Develop a licensure rule waiver process	Jul-20	Open
	Revise licensure rules	*Oct-22*	*Open*
	Submit SPA	Jul-20	Open
	Revise LME/MCO contracts	Jul-20	Open

ASAM Level of Care	Action Item Description	Date to be Completed*	Current Status
Level of Care 2-WM (Ambulatory Withdrawal Management With Extended On-Site Monitoring)	Develop a Medicaid clinical coverage policy	Jul-20	In progress
	Develop a licensure rule waiver process	Jul-20	Open
	Create licensure rule	*Oct-22*	*Open*
	Implement MMIS modifications	Jul-20	Open
	Submit SPA	Jul-20	Open
	Revise LME/MCO contracts	Jul-20	Open
Level of Care 3.2-WM (Clinically Managed Residential Withdrawal)	Develop a Medicaid clinical coverage policy	Jul-20	In progress
	Develop a licensure rule waiver process	Jul-20	Open
	Revise licensure rule	*Oct-22*	*Open*
	Implement MMIS modifications	Jul-20	Open
	Submit SPA	Jul-20	In progress
	Revise LME/MCO contracts	Jul-20	Open
Level of Care 3.7-WM (Medically Monitored Inpatient Withdrawal Management)	Amend current Medicaid clinical coverage policy 8-A to reflect ASAM criteria and include IMDs as eligible service providers	Jul-20	In progress
	Implement MMIS modifications to permit this service to be reimbursed in an IMD	Apr-19	Unknown^
	Develop a licensure rule waiver process	Jul-20	Open
	Revise licensure rule	*Oct-22*	*Open*
	Submit SPA	Jul-20	In progress
	Revise LME/MCO contracts	Jul-20	Open
Level of Care: Medically Supervised or Alcohol and Drug Abuse Treatment Center (ADATC) Detoxification Crisis Stabilization	Amend current Medicaid clinical coverage policy 8-B to reflect ASAM criteria	Jul-20	Open
	Implement MMIS modifications to permit this service to be reimbursed in an IMD	Apr-19	Open
Level of Care: 4-WM (Medically Managed Intensive Inpatient Withdrawal)	Amend current Medicaid clinical coverage policy 8-B to reflect ASAM criteria and include IMDs as eligible service providers	Jul-20	In progress

ASAM Level of Care	Action Item Description	Date to be Completed*	Current Status
	Implement MMIS modifications to permit this service to be reimbursed in an IMD	Apr-19	Open
	Revise LME/MCO contracts	Jul-20	Open

*The intended completion dates are as reported in the CMS-approved Implementation Plan. *Action items with intended completion dates set after the MPA window of analysis are italicized.*

^In the draft of the Manatt Report received by our team on 3/19/2022, this was marked as "for discussion," the term Manatt used to denote unknown status.

As of this writing, of the 72 Milestone 1 implementation action items, 61 were intended to be completed by Jan 1, 2022. Of these 61, 1 has been completed, 17 are currently in progress, and 42 items are open. The status of one item is unknown. A total of 11 items (all related to the creation and revision of licensure rules) have an intended completion date of October 2022; although we do not formally include them in our mid-point assessment of risk, their chance of timely completion is low, given that many of the preceding items remain open.

Stakeholder Input

Stakeholder input relevant to Milestone 1 is displayed in Table 8. We summarize major themes of the interviews and focus groups below. Although the implementation of Tailored Plans is relevant to all Milestones, we include stakeholder feedback on Tailored Plans here. In addition, we discuss Medicaid expansion under this Milestone, which was a theme raised by several stakeholders. In most of the discussion, we include input from all stakeholders; however, two themes unique to beneficiaries were the benefits they have experienced from Medicaid enrollment and the difficulties they have personally experienced in accessing Medicaid treatment.

Table 8: Stakeholder input relevant to Milestone 1.

Milestone 1		
Stakeholder	**Successes**	**Challenges**
State agencies		
DHB	♦ Milestone 1 has been the main focus so far. "Policy foundation has to happen first"	♦ Tailored Plan launch pushed to December 1, 2022, largely due to Cardinal's exit. ♦ Policies' go-live planned for July 1, 2022 (later than planned)
DMH	♦ Some policies already implemented (ASAM 0.5, ending IMD exclusion).	♦ Movement of policies slowed by implementation of Standard Plans. ♦ Policy implementation has been challenging since "people don't want to change". Policies have not changed significantly since around 2006. ♦ Rate-setting has been the biggest challenge, especially for new services.
DSOHF	♦ IMD waiver has allowed for SUD treatment in ADATCs.	♦ Difficulty keeping up with changes to ASAM continuum.

CSRS	NA	NA
LME/MCOs	♦ Good ASAM continuum available currently. ♦ COVID-related flexibilities (telehealth, verbal consent, take-home for methadone) have improved access to care and reduced administrative burden.	♦ Waiting for new policies to be updated on July 1, 2022. ♦ Preparing for Tailored Plans has been extremely time-intensive.
SUD providers	♦ Telehealth has been critical during COVID-19, and many providers hope the policies and reimbursements will not be changed back. Take-home methadone has also been helpful.	♦ Some feel that communication from state/LMEs has been lacking with providers, and one interviewee mentions communication has been lacking for patients (mailings not reaching them or too complex to understand). ♦ ASAM continuum is disjointed – on paper, looks nice, but people only do a piece of it. Service definitions are also often very strict, with large impacts on billing for small deviations from protocol (e.g. 240 minutes/day for SACOT). ♦ Some suggest that utilization review by the PHPs is not supporting the continuum of care. One provider mentions almost all MAT dosing has been denied coverage. Another states that changes to formularies and prior authorizations have led to delays in accessing medications. ♦ Providers are mixed on whether they will be Tailored Plan providers, with one stating that they don't have the resources for the required care management.
Medicaid SUD service beneficiaries	♦ Access to SUD care is good overall and has subjectively improved during the waiver period. ♦ Recent improvements include more flexible take-home MOUD during COVID-19.	♦ Difficulties include finding providers who accept Medicaid and travel distance to those who accept Medicaid. ♦ Providers less available in rural areas. ♦ In some cases, services are not available for those who are not currently intoxicated or positive on drug screens, so beneficiaries have felt the need to use drugs to get care.

Access to Services (Beneficiaries)

In focus groups, beneficiaries reported that Medicaid offers access to a variety of services that would not be accessible without coverage. One beneficiary said:

> *"Just having access to treatment and having those barriers be addressed has been a big help, because most of us who struggle with substance abuse are not extremely wealthy and can't really, if it wasn't for Medicaid, we wouldn't be able to afford to get treatment."*

Similarly, one declared:

> *"I would say without Medicaid I would not be doing well with my substance abuse help or my mental health, or even having my back surgeries that I've had to have…"*

Another reported that Medicaid allowed her to get both SUD treatment and prenatal care while incarcerated:

> *"I was able to get great prenatal care, I was able to get substance abuse treatment while incarcerated. Yeah. So, it was really, really, really helpful for me."*

Several beneficiaries reported good, timely access to Medicaid SUD services:

> *"I got into the SAIOP group really quick, and it was more geared to moms and stuff, but it's been really helpful with my recovery. I'm only five months clean. So I think without them getting to me so quickly, I would've ended up using again."*

However, this experience was not universal as others reported difficulty in finding practices that accept Medicaid patients. One beneficiary reported, *"A lot of places don't accept Medicaid."* Similarly, some beneficiaries reported that access to SUD services has improved during the waiver period—*"I have seen that it's more available these days"*—whereas others reported access has become a problem:

> *"I had a provider, two providers that stopped accepting Medicaid, so I had to find somebody different. So yeah…And my understanding was that they didn't want to...And it was the LME, they had issues with the local management of care. They didn't want to jump through the hoops to accept my insurance."*

Overall, beneficiaries reported being very appreciative of the Medicaid program; however, accessing services was challenging for some participants.

Coverage Policies (State Agencies and LME/MCOs)

The importance of coverage policies was emphasized by the state and the LME/MCOs. First, DHB reported that developing the policies relevant to Milestone 1 has been their main focus so far, emphasizing that "the policy foundation has to happen first." Representatives from DHB and DMH reported that multiple events have slowed the development and implementation of policies, including COVID-19, the dissolution of Cardinal Innovations, and the launch of Standard Plans. The policies that have been implemented already include the 0.5 ASAM level (SBIRT) and ending the IMD exclusion. The tentative date for implementation of the remainder of the policies regarding ASAM levels is July 1, 2022. The state agencies recognized that stakeholder feedback is essential but reported that the many steps involved in policy development has slowed their launch.

Setting payment rates for existing and new services is one step in the chain of policy development, and both DHB and DMH report that setting rates has been very difficult. This is true especially for services that are new to North Carolina or services that are usually paid for through state funds. As DMH reports:

> *"…Usually the claims and billing history is how you kind of help build the rate, but we've got three or four levels of care that we've never had in North Carolina before, or we've only had on the state side where there was limited billing, because we have much more limited funding. And so, you know, it*

takes a little bit more to try and figure out a rate, and an appropriate rate that, you know, is going to keep a program viable and…totally support an evidence-based program."

Several of the LME/MCOs report that they are waiting for new coverage policies to be implemented on July 1, 2022, and are not able to advance before they see the new service definitions. This presents a potential risk for delay for coverage launch even after the new coverage policies are approved.

Overall, LME/MCOs, providers, and beneficiaries do not report many effects of policies specific to the SUD waiver itself. This is consistent with the fact that most of the new clinical coverage policies (e.g., around the new ASAM continuum services) have not been implemented. However, several LME/MCOs and providers mentioned that ending the IMD exclusion has been a positive step forward for accessing inpatient SUD treatment. Finally, two LME/MCOs reported that they feel that the networks for currently implemented coverage policies are sufficient, and the main concerns are around the policies to be newly implemented.

COVID-19 (All Stakeholders)

The impact of the COVID-19 pandemic on the SUD waiver implementation has been overall negative, with one LME/MCO stating "*it's impacted everything*" and another saying that it has been the "*biggest barrier right now*." State agencies also report that much time and attention had to be paid to maximizing the flexibility of current policies, rather than implementing new policies. That being said, the stakeholders contributed to a rapid and successful response to the COVID-19 public health emergency. In particular, the policy flexibilities that have been a focus of DHB over the past two years have expanded the care available during COVID-19.

Stakeholders reported overwhelming support for these flexibilities, with one provider stating that the *"flexibilities that have been offered throughout COVID as a result have been really successful for our clients."* The most helpful flexibilities mentioned were relaxed regulations around telehealth and take-home MOUD and increased reimbursements for telehealth services.

Telehealth

Providers reported that the transition to telehealth was initially difficult, but then it became a natural and sustainable part of the practice. One provider reported:

"[telehealth has] been great for us, we can reach so many more people, people we would never ever reach before, people who live more rurally or in areas where there's absolutely no MOUD, where there're counties where there's no MOUD, or people that will take folks that are unstable. So we really feel like we've been able to reach a lot more people."

This provider reported that they were *"never going to go back to in-person entirely,"* and that they were *"probably always going to stay majority virtual."* Specific benefits for providers around telehealth included reduced no-show rates and greater patient retention overall. However, one provider noted a decrease in engagement with virtual group treatment, which may have translated less well to the virtual setting than individual treatment.

Some providers also mentioned difficulties reaching clients who did not have video capability, data plans, or wireless internet. One organization had received a telehealth-related grant prior to COVID-19, which supported them in providing devices to clients and expanding their Wi-Fi service to include the parking lot, while not every organization had the resources to provide this kind of support.

One beneficiary discussed ambivalence around telehealth, which made treatment more convenient but less personal for them:

> *"Yeah, I don't know. It's tough…now it's more convenient, and I don't have to worry about getting sick…It's [of] course less personal, but I get back to my other life…"*

Several providers expressed concern that telehealth would be less sustainable if reimbursement policies returned to pre-COVID-19 levels. This feedback was largely obtained prior to North Carolina's announcement through a Special Bulletin on March 2, 2022, that telehealth policies will be made permanent[7].

Take-home MOUD

Beneficiaries receiving MOUD reported unanimous support for the new flexibilities during COVID-19. Specifically, instead of going to an OTP every day, they were able to bring more doses of medication home. This was much more convenient, with one beneficiary stating *"it sure helps me only going once a month now opposed to four days a week."* Another provider specifically referenced new flexibility around screening for THC:

> *"We have folks who have been in treatment and stable in their recovery for eight or ten years who have never been eligible for take-homes, but under the COVID exemptions they were, because we didn't have to penalize for THC usage."*

Several providers appreciated the more flexible take-home policies as well, with one saying *"It worked well and people liked it. People felt much more respected."*

Medicaid Expansion (LME/MCOs and Providers)

Many of the LME/MCOs and providers strongly advocated for Medicaid expansion, arguing that the lack of expansion interfered with the implementation of the SUD Waiver. The MPA team did not specifically ask about Medicaid expansion in our interviews, but 3 out of 5 LME/MCOs and 4 out of 11 providers independently recommended it, with several more providers referencing difficulty in providing services to uninsured patients. One LME/MCO representative stated that *"North Carolina not expanding Medicaid is a barrier to implementation."* Another LME/MCO representative remarked that funding new services in the presence of non-expansion can be an issue because clients who are uninsured may want to access these services but funding may not be available through Medicaid or elsewhere. This generates uncertainty about whether the LME/MCOs can cover the cost of new services.

Many providers reported that high percentages of their caseload were uninsured (often between 40% and 60%). There were differences in the services available to those with insurance and those without, especially on the full continuum of behavioral, mental, and primary care. In a representative quote, a provider stated:

> *"Our patients are pretty high need and like I said, 30% Medicaid, but about 60% uninsured. So when people have Medicaid, it's like a huge relief because I can get them primary care really easily, I can*

[7] SPECIAL BULLETIN COVID-19 #234: UPDATE to Permanent Changes Made for PHE Flexibilities and Plan for Sunsetting of Temporary Policies - March 4, 2022. https://medicaid.ncdhhs.gov/media/10972/download?attachment Accessed April 22, 2022.

get them aftercare and they don't have to pay for it, which is great. And all the places we refer to are happy to take people with Medicaid."

Another provider said that providing services to people not able to enroll in Medicaid is one of their *"ongoing challenges,"* and it is difficult to find "*what is available for them."*

Some of the specific services within the SUD treatment continuum unavailable to the uninsured include office-based opioid treatment (OBOT):

"…Medicaid expansion is so important, because then you get a consistent program across the board that you can, in that case, pay for an OBOT when you couldn't do that, except unless they had Medicaid."

Ultimately, several providers felt that the lack of Medicaid expansion meant that there was a limit on the potential benefits of Medicaid transformation. One provider stated:

"We are not serving our community. We are not serving our people who need it most. And, in particular, people with substance use disorders need it more than any other group."

Another saw the lack of expansion as a "rate-limiting step":

"I think until we actually tap into those folks having the full breadth of services that Medicaid can provide, I think we will continue to see, I think, similar numbers of overdoses and even deaths, because I think we're not reaching a critical part of the population."

In conclusion, there appears to be strong support for Medicaid expansion among LME/MCOs and behavioral health providers. The question of expansion was not raised in interviews with state agencies or beneficiaries.

Standard Plan Implementation (State Agencies, LME/MCOs, and Providers)

As mentioned previously, the state is pursuing the Medicaid SUD 1115 Waiver at the same time as the overall Medicaid 1115 Waiver. A central goal of the Transformation under the overall 1115 Waiver is the shift to managed care for nearly all beneficiaries. The Standard Plans offered by 5 Prepaid Health Plans (PHPs) were launched in July 2021, after delays related to the NC legislature budget impasse and COVID-19. Most Medicaid beneficiaries with SUD are eligible for Tailored Plans, so they theoretically should have not been heavily impacted by Standard Plan launch. However, DHB is responsible both for managing Standard Plans and the SUD waiver, and several stakeholders reported that the implementation of Standard Plans in July 2021 slowed development of policies around the ASAM continuum. The LME/MCO representatives mentioned Standard Plan development in relation to preparing for Tailored Plans, which we discuss more in the next section.

Interviews with providers revealed that Standard Plan implementation has had widespread impacts. The most salient themes were concerns about how well-informed beneficiaries are about plan details, burdens of explaining plan details falling on providers, and how beneficiaries may or may not be assigned to the correct plans.

Lack of Information and Burden on Providers

Many providers endorsed that beneficiaries often were unclear on the details of Standard Plans and that these details were not sufficiently communicated to them, leaving the providers to do so. Regarding the Standard Plan implementation, one provider stated *"That was hell….that was awful,"* and expressed concern that they also would be responsible for explaining Tailored Plans to beneficiaries. Several providers perceived that sending postal mail was the main strategy of state agencies for disseminating information, but that many of their clients change addresses frequently and had not received the mailings. One provider stated that:

> *"A lot [of clients] just don't know. And sending out mail when we have people that have 40 addresses in three years is not effective. We still have people that came in and said they didn't know about Medicaid transformation."*

This lack of information has led to service denials for beneficiaries with SUD: *"patients across the board ... had so little information in choosing those plans that they didn't know,"* which has led to their services not being covered at OTPs.

Providers then try to inform beneficiaries about the service options available, but this is made difficult by the fact that most people seeking SUD treatment are not in an optimal state for retaining information – that information is better provided when people are not in crisis.

In addition, providers themselves had very little knowledge about the components of the SUD waiver and were often unaware of the changes that had either been implemented, such as the IMD waiver, or were forthcoming. Our review of NCDHHS web pages also revealed very little information on the SUD components of the waiver on DMH's web pages outside of the forthcoming transition to Tailored Plans. We could not locate any documents advising SUD treatment providers or beneficiaries of how changes from the IMD waiver and new benefits related to the ASAM levels of care could affect treatment options.

Correct Plan Assignment

Several providers expressed concerns that beneficiaries were not being enrolled in the correct plan type, as well as uncertainty about how this process was decided. One provider mentioned that those seeking SUD services for the first time may have been switched to Standard Plans and then were not able to access the recommended SUD services. This same provider found that the PHPs allowed clients to access MOUD but not SAIOP until they switched back to Medicaid Direct. Overall, this process has complicated access.

Another provider stated that *"the transition was kind of difficult on our patients"* and led to interruptions in provider and pharmacy access. In an extreme case, one provider at an OTP has not been able to contract with PHPs, which has led to almost all of their MOUD services being denied reimbursement by Medicaid. This has led to a decrease in their Medicaid population from 60% down to 40% as a proportion of the caseload.

Similarly, one LME/MCO expressed that it was unclear to them how beneficiaries with SUD would be assigned to a Standard Plan or Tailored Plan based on the severity of their SUD diagnosis, and how they might transition between Standard Plans and Tailored Plans if the severity changed.

Tailored Plans (State agencies, LME/MCOs, and Providers)

The launch of Tailored Plans was pushed to December 1, 2022, and DHB reports that the primary cause of this was the dissolution of the LME/MCO Cardinal Innovations. The counties served by Cardinal were picked up by other LME/MCOs, and the process "took a lot of focus." DHB representatives reported some concern with the development of Tailored Plans, particularly because the LME/MCOs have historically focused on only mental and behavioral health. They state, *"fully integrated health plans from just behavioral health plans is very different."* This was echoed by some of the LME/MCO representatives, with one describing a very steep learning curve. DMH representatives believe that the push to December 2022 will work out well, giving DMH and other agencies some additional cushion if unexpected delays occur.

The LME/MCO representatives report spending large amounts of time and effort preparing for the launch of Tailored Plans in December 2022, though most report being confident that they will be prepared for the launch. One LME/MCO representative stated that the push to December 2022 has not changed the urgency of their preparation, and another described that the size of their agency has doubled in preparation for the launch.

Several LME/MCO representatives reported that much of their effort has been on the technological details of the transition, including interoperability of systems. Although the state has been helpful in this regard, it is still difficult for the LME/MCOs to *"know what they don't know"* about providing physical health and the data analytics required.

Some of the LME/MCO representatives did raise concerns about the communication given by the state, though they report that the conversations have been helpful overall. One LME/MCO representative felt that the state has offered *"changing guidance, changing timelines, changing expectations,"* and that has made it difficult to prepare. Another LME/MCO representative stated that the guidance from the state has seemingly encouraged partnering with Standard Plans but has not offered regulation or guidance on how to do this. The same organization also reported that the state has presented PHPs as paradigms of physical health plans; however, PHPs have more financial resources than LME/MCOs, so the LME/MCOs are not necessarily able to follow their example.

Most providers reported some level of preparation for Tailored Plans, although some denied any awareness of them. The majority of efforts are directed toward discussions with their LME/MCO partners and educating staff at the practices. Providers generally expect that a large proportion of their clients will be enrolled in Tailored Plans, though one provider stated they do not plan to contract with Tailored Plans at all. Providers also report difficult decisions around becoming a Tailored Plan provider and/or providing their own care management services.

Milestone 1 Risk Assessment

In summary, three of the seven metrics for Milestone 1 have demonstrated progress in terms of moving in the target direction, while four of the seven metrics are moving in the opposite direction. In addition, the magnitude of the direction is much larger for those metrics not demonstrating progress. Stakeholder input suggests that COVID-19 impacts, such as capacity limitations in inpatient facilities, could have influenced the direction of some of these metrics. Access to MOUD is a notable exception in that the state has made substantial progress on this metric.

Out of 61 Implementation Plan action items intended to be completed by January 1, 2022, only 1 has been completed, with 17 in progress and 42 open items. This is suggestive of higher risk of not meeting Milestone 1 than indicated in the monitoring metrics.

Stakeholder feedback from beneficiaries indicates several positive developments during the SUD Waiver implementation period, including flexibilities related to COVID-19, as well as a general perception that SUD care is more available than previously. In terms of policy implementation, state agencies plan to implement coverage policies by July 1, 2022, much later than previously intended, and LME/MCOs report that they are unable to begin developing networks for new services before they see the service definitions. In addition, both state agencies and LME/MCOs report concerns about the launch of Tailored Plans, given the complexity involved in the transition of organizations with an exclusive behavioral health focus to providing comprehensive medical and behavioral health care. Stakeholder feedback is suggestive of higher risk of not meeting Milestone 1 than indicated in the monitoring metrics.

> **In summary, because few of the critical metrics associated with Milestone 1 are moving in the expected direction, most Implementation Plan Action items are open, and stakeholders express significant concerns, we believe the state is at High risk for not meeting demonstration milestones.**

Milestone 2: Use of Evidence-Based SUD-Specific Patient Placement Criteria

Critical Monitoring Metrics

Table 9. Critical monitoring metrics for Milestone 2.

Metric #	Metric name	Monitoring metric rate or count[a,b]				State's demonstration target	Directionality at mid-point	Progress (Yes/No)
		At baseline	At mid-point	Absolute change	Percent change			
5	Medicaid Beneficiaries Treated in an IMD for SUD	638	718	80	12.5%	Increase	Increase	Yes
36	Average Length of Stay in IMDs	8.70	9.17	0.41	4.7%	Decrease	Increase	No

[a]Baseline periods are November 1, 2018 to October 31, 2019 (DY1) for CMS-constructed demonstration year metrics; calendar year 2018 for established metrics; and November 1, 2018 to January 31, 2019 (DY1Q1) for quarterly metrics.
[b]Midpoint periods are October 31, 2021 (DY3) for CMS-constructed demonstration year metrics; calendar year 2020 for established metrics, and August - October 31, 2021 for quarterly metrics.

Summary

Milestone 2 is associated with two metrics (Table 9). The number of Medicaid beneficiaries treated in an IMD for SUD according to the technical specifications provided by CMS has increased from 638 to 718, which increases this metric in the target direction. We note that the technical specifications substantially limit the number of persons in an IMD to a small subset of the revenue codes used in an IMD, thus substantially reducing the numbers. Separately, our team estimates that over 7000 non-elderly adults age 21-64 have received Medicaid-funded stays in an IMD since the start of the SUD waiver. The average length of stay has shown a small increase of less than half of a day, though we believe the length of stay has not changed appreciably. In addition, CMS's guidance for this metric indicates that "if the state's ALOS in IMDs is known to be less than 30 days prior to the demonstration… CMS understands that the state may observe and report an increase in the ALOS as the state expands coverage for care in IMDs during the demonstration."

Implementation Plan Action Items

There were 10 implementation plan action items related to Milestone 2 (Table 10). Of these, 3 were completed prior to implementation plan approval, 3 were completed after approval, 3 are in progress, and 1 is open. The outstanding items relate to clinical coverage policies – specifically, that a determination of the ASAM level must be part of the diagnostic assessment and that SUD providers must receive and document their training on the ASAM criteria. In addition, the department has yet to update LME/MCO contracts.

Table 10: Implementation plan action items for Milestone 2.

Category	Action item description	Date to be completed	Current status
Enrollee Assessments	Revise clinical coverage policies to require that (1) an ASAM determination is part of the diagnostic assessment and CCA and (2) licensed providers providing SUD services or assessments document their training with respect to the ASAM criteria	Apr-20	In progress
	Contractually require Standard Plans to comply with the provisions related to behavioral health assessments included in Medicaid clinical coverage policies 8-A and 8-C	Completed before implementation plan approval	Completed
	Contractually require Tailored Plans to comply with the provisions related to behavioral health assessments included in Medicaid clinical coverage policies 8-A and 8-C:	Jul-21	Completed

Person-Centered Plan	Contractually require Standard Plans to comply with the provisions related to person-centered planning included in Medicaid clinical coverage policies 8-A and 8-C	Completed before implementation plan approval	Completed
	Contractually require Tailored Plans to comply with the provisions related to person-centered planning included in Medicaid clinical coverage policies 8-A and 8-C	Jul-21	Completed
Utilization Management	Revise clinical coverage policies to require that (1) an ASAM determination is part of the diagnostic assessment and CCA and (2) licensed providers providing SUD services or assessments document their training with respect to the ASAM criteria	Apr-20	In progress
	Submit SPAs as needed to reflect updated utilization management requirements	Oct-20	In progress
	Update LME/MCO contracts, as necessary	Oct-20	Open
	Require Standard Plans to follow clinical coverage policies 8-A and 8-C	Completed before implementation plan approval	Completed
	Require Tailored Plans to follow clinical coverage policies 8-A and 8-C	Jul-21	Completed

Stakeholder Input

A summary of stakeholder input relevant to Milestone 2 is displayed in Table 11. Most of the stakeholder input was related to the ASAM continuum trainings, with the state reporting a significant number of providers trained, though the turnout was not as high as hoped. Some of the LME/MCO representatives reported that the fee associated with the training was a barrier. Most of the providers had an overall positive perception of the trainings.

Several Medicaid beneficiaries reported a troubling pattern related to proper placement with negative drug screens. Specifically, they report that when seeking treatment after not using for a number of days, and their urine drug screen is negative, they have been told that they cannot access treatment without a positive screen. In one beneficiary's words:

> *"I've had that happen where I hadn't used in a couple days, so I would've had a negative result. So, I've had it before where I had to use just to get help."*

It is possible that this represents a pattern in locations where there is a very limited selection of services available (e.g., with mostly detox facilities available). Regardless, it is concerning that multiple beneficiaries reported being turned away from treatment due to a negative drug screen. As they reported, this may lead some individuals with SUD to use drugs in an effort to qualify for treatment.

Table 11: Stakeholder input relevant to Milestone 2.

Milestone 2		
Stakeholder	**Successes**	**Challenges**
State agencies		
DHB	♦ ASAM trainings: have had around 600 providers trained	♦ Training turnout has not been as high as hoped
DMH	♦ Did "massive" training around the ASAM criteria.	None mentioned.
DSOHF	Not discussed	Not discussed
CSRS	NA	NA
LME/MCOs	♦ The ASAM training was well implemented and helpful.	♦ The fee associated with the ASAM training was a barrier, especially during COVID-19 revenue struggles.
SUD providers	♦ Most providers interviewed have been through ASAM training and had an overall positive perception.	♦ Some mention that the ASAM trainings are too general or too long for their staff to benefit. ♦ Some providers mentioned that they did not perceive a need for the trainings, given their level of in-house knowledge.
Medicaid SUD service beneficiaries	None mentioned.	♦ Some beneficiaries report not being able to access services unless they have a positive drug screen, which acted as an inducement to use.

Milestone 2 Risk Assessment

The state has made progress on one out of two (50%) of critical metrics relevant to Milestone 2. The state has completed six out of ten (60%) of Implementation Plan action items relevant to Milestone 2. There was relatively little stakeholder feedback relevant to Milestone 2. There are some concerns about fewer providers being trained in the ASAM criteria than hoped, but this concern is relatively minor given the substantial number of providers trained.

> **While only one of the two metrics has achieved progress in the target direction, the other metric is relatively flat, more than half of the action items are complete, and no concerns were raised by stakeholders, so we believe the state is at Low risk for not meeting Milestone 2.**

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

Critical Monitoring Metrics

No critical monitoring metrics are reported for Milestone 3.

Implementation Plan Action Items

There were four implementation plan action items relevant to Milestone 3 (Table 12). Of these 4, 3 were intended to be completed by January 1, 2022. Of the 3, 2 are open and 1 is in progress.

Table 12. Implementation plan action items for Milestone 3.

Category	Action item description	Date to be completed	Current status
Provider Licensure	Develop a licensure rule waiver process to incorporate ASAM criteria	Oct-20	Open
	Revise existing licensure rules to align provider qualifications with 2013 ASAM criteria	Oct-22	Open
Monitoring of SUD Treatment Providers	Revise DHSR Mental Health Licensure and Certification Section's annual survey process to provide the ability to assess compliance with 2013 ASAM standards	Oct-20	Open
Requirement That Residential Treatment Providers Offer MAT On-Site or Facilitate Access to Off-Site Providers	Develop requirement for residential treatment providers to be able to refer patients to MAT within a minimum number of miles or minutes	Oct-20	In progress

Stakeholder Input

Stakeholder input relevant to Milestone 3 is displayed in Table 13. LME/MCO representatives reported concern about the prolonged licensure process for facility-based services. On the other hand, a SUD provider reported concerns that even some licensed programs offering higher-level care do not offer evidence-based treatment like MOUD.

One provider (an OTP) reported that their practice was audited by their LME/MCO, which led to changes in their staffing practices; specifically, they dropped one certified alcohol and drug counselor and added one more licensed clinical addiction specialist. They also received constructive criticism about their care coordination practices during the audit. Overall, they applauded their experience in this audit despite the criticism, stating they hope it changes perceptions of OTPs.

Table 13. Stakeholder input relevant to Milestone 3.

Milestone 3		
Stakeholder	**Successes**	**Challenges**
State agencies		
DHB	Not discussed	Not discussed
DMH	♦ Working with partners at DHSR to get licensure rules in place	None mentioned.
DSOHF	Not discussed	Not discussed
CSRS	NA	NA
LME/MCOs	♦ State's presentations have been helpful for understanding licensing requirements.	♦ The licensure process for residential facilities is very prolonged (18 months). During this period, the provider has to pay staff and capital costs. Changes to licensing may further complicate startup.
SUD providers	♦ Overall, providers did not have strong opinions about changes to provider qualifications. ♦ One provider reported they had changed staffing to have one fewer LCAS and one more LCSW in response to the new standards, and felt it was a positive change.	♦ One participant mentioned many programs offering higher-level care still do not offer evidence-based treatment - for example, not offering medication for alcohol or opioid use disorder treatment.
Medicaid SUD service beneficiaries	Not discussed	Not discussed

Milestone 3 Risk Assessment

There are no metrics to inform this Milestone and stakeholder input was limited, so the only data available is the number of implementation actions completed.

> **Given that none of the required Implementation Plan action items have been completed, but at least some are in progress, we determine that the state is at Medium risk of not achieving Milestone 3.**

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

Critical Monitoring Metrics

Both metrics on provider availability have demonstrated progress (

Table 14). While further progress is likely necessary due to the continued shortages of providers available to meet the needs of the growing SUD and OUD demands, both metrics are moving in the right direction.

Table 14. Critical monitoring metrics for Milestone 4.

Metric #	Metric name	Monitoring metric rate or count[a,b]				State's demonstration target	Directionality at mid-point	Progress (Yes/No)
		At baseline	At mid-point	Absolute change	Percent change			
13	Provider Availability	5,871	6,181	310	5.3%	Increase	Increase	Yes
14	Provider Availability – MAT	1,110	1,511	401	36.1%	Increase	Increase	Yes

[a]Baseline periods are November 1, 2018 to October 31, 2019 (DY1) for CMS-constructed demonstration year metrics; calendar year 2018 for established metrics; and November 1, 2018 to January 31, 2019 (DY1Q1) for quarterly metrics.
[b]Midpoint periods are October 31, 2021 (DY3) for CMS-constructed demonstration year metrics; calendar year 2020 for established metrics, and August - October 31, 2021 for quarterly metrics.

Implementation Plan Action Items

There are three implementation plan action items relevant to Milestone 4, all planned to be completed before January 1, 2022 (Table 15). Of these, 2 remain open and 1 is in progress.

Table 15: Implementation plan action items for Milestone 4.

Category	Action item description	Date to be completed	Current status
Sufficient provider capacity at critical levels of care	Conduct an assessment of all Medicaid-enrolled providers, to include the identification of providers that are accepting new patients at the critical levels of care	Oct-19	Open
	Work to build Medicaid provider networks for new Medicaid levels of care	Oct-20	In progress
	Develop BH I/DD Tailored Plan network adequacy standards for SUD treatment services, taking into account results of provider assessment	Oct-19	Open

Stakeholder Input

Themes from the stakeholder interviews relevant to Milestone 4 are displayed in Table 16. Overall, major themes included perceived poor access to residential services, some limitations in outpatient service capacity and medication access, positive experiences with the state's support of MOUD, and positive effects of expanded telehealth on capacity.

Low Residential Service Capacity

Multiple stakeholders expressed concerns with the available capacity of residential services. Staffing residential programs as well as OTPs is a major concern that has been exacerbated by COVID-19. Several stakeholders report high turnover at OTPs, specifically, as well as trouble hiring at residential treatment programs.

DHB representatives expressed concern for LME/MCOs establishing capacity for new and residential services, which is corroborated by the LME/MCOs themselves. A concern for many of the LME/MCOs is a lack of startup funds for these capital-intensive facility-based services. They find that the providers they contract with are unable to afford the startup costs needed to finance these programs.

Providers also report difficulty referring Medicaid beneficiaries to inpatient treatment. For example, one provider recognized that the state is trying to make changes but reported that it has not helped the situation so far: *"There's always a waiting list, and so it's easier to just send them to the ER."*

Another provider reports severe difficulties finding inpatient beds for their clients. They reported that for each client they have to call inpatient treatment programs every day for up to 2 weeks, and then frequently the program does not accept Medicaid. This organization has resorted to sending clients out of state for inpatient treatment, but this is not paid for by Medicaid.

Another provider reports that a key barrier to expanding inpatient treatment options is that most hospitals across the state do not offer evidence-based addiction services, and most do not even offer MOUD. This provider also states that many inpatient programs that do exist still do not offer medications for OUD or alcohol use disorder.

Medicaid beneficiaries also perceive that inpatient services are less available than outpatient services, and that this has been exacerbated by COVID-19. This is even more acute of a problem in rural areas, where most facilities have long waiting lists, and other options are several counties away. One beneficiary reported that:

> *"What usually takes a week to get into a detox, it was taking double or three times that amount of time just because of space and that stuff. Or going on lockdown. I remember places being on lockdown because there was an outbreak of COVID or something."*

A major step forward, however, is the ending of the IMD waiver exclusion, which allows for Medicaid payment for SUD treatment in IMDs. DSOHF also reports expanding services at several of the ADATCs, which is improving the continuity of care.

Community-based services

Several state agencies and providers also endorsed perceived shortages of outpatient care. DSOHF representatives stated that discharging their patients to outpatient services can be difficult, due to outpatient provider shortages.

Like inpatient services, beneficiaries also report more difficulty accessing care in rural regions. One beneficiary stated:

"I know that North Carolina has a lot of treatment places. I think that there's so many in a particular area that some areas have nothing and it's like three or four pop up in one place, and then there's this place over here that people might not have the resources to get out here and they go without."

Overall, however, Medicaid beneficiaries reported greater perceived access to outpatient services than prior to the waiver.

Capacity for MOUD

Several providers positively describe the state's support for MOUD and innovative delivery approaches. However, some feel that there are still shortages specifically in providers that offer OBOT. An advanced practice provider (APP) reported that the policies written by the state and LME/MCOs are largely targeted to physicians. This provider recommends that Medicaid and the LME/MCOs reimburse other providers for MOUD services in addition to physicians. Also, this provider reported frustration with regulations around advertising MOUD services; specifically, they felt that they do not get sufficient referrals from the LME/MCO. One provider from the eastern part of the state reported that some of her clients still are not aware that Medicaid covers MOUD, so they will purchase it off the street.

Generally, however, providers report optimism about the ability of the SUD waiver to improve access to MOUD. Similarly, the LME/MCO representatives report that the state has been very supportive of MOUD expansions and innovative delivery methods, like mobile MOUD services. One LME/MCO is in the process of developing 6 mobile MOUD clinics, which are fairly new to the state.

Telehealth

As discussed more in Milestone 1, many providers endorse that telehealth and other COVID-19 flexibilities have improved provider capacity and access to care, and hope that these flexibilities continue.

Table 16. Stakeholder input relevant to Milestone 4.

Milestone 4		
Stakeholder	**Successes**	**Challenges**
State agencies		
DHB	None mentioned.	♦ Staffing has been a challenge at OTPs due to turnover. ♦ Concern about LME/MCOs establishing capacity, especially for services new to NC and residential services.
DMH	Not discussed	Not discussed
DSOHF	♦ Expanded services at several of the ADATCs, like a full outpatient program and a peer support outpatient program.	♦ Community outpatient provider shortages exacerbated by COVID-19. ♦ Budgetary concerns led to contracting with SME to improve business model.
CSRS	NA	NA

LME/MCOs	♦ State has been very supportive of MAT expansions and innovative service delivery methods (mobile clinics, etc.)	♦ Facility-based treatment is overall more challenging, due to lack of startup funds. ♦ COVID-19 has reduced residential staffing. ♦ Funding is an issue, especially for new services since most people with SUD are uninsured and may want or need to access new services also. State funds are important for this.
SUD providers	♦ Several providers are planning to expand existing services or add new services due to the waiver. ♦ Telehealth increases provider capacity and improves access to care. Recommend continuing COVID-19 flexibilities.	♦ Participants identified a lack of inpatient SUD beds, especially for those with Medicaid, with staff having to call daily for days or weeks to get a bed. ♦ Others identified a lack of outpatient care and OBOT. ♦ Many hospitals in the state do not offer addiction treatment, or even MAT.
Medicaid SUD service beneficiaries	♦ Most beneficiaries report better access to outpatient treatment overall.	♦ COVID-19 has negatively impacted access to inpatient ♦ Accessing any type of SUD service in rural areas is still very difficult

Milestone 4 Risk Assessment

In summary, both of the metrics for Milestone 4 have demonstrated progress in terms of moving in the target direction. Out of three Implementation Plan action items, none have been completed. In particular, the required assessment of SUD provider availability has not been completed, which is a critical step for determining the state of access to SUD care in NC. However, our concerns about the lack of a comprehensive assessment are moderated by the positive trends seen in the critical monitoring metrics for this milestone. Stakeholder feedback reveals significant concerns about current and future capacity, especially regarding inpatient services and services in rural areas. In the absence of a completed comprehensive provider availability assessment, it is difficult to compare these subjective assessments with objective data. However, the concerns appear substantial.

> **In summary, all of the critical metrics associated with Milestone 4 are moving in the target direction, but all action items remain open and stakeholders express significant concerns. We determine that the state is at Low/Medium risk for not meeting Milestone 4.**

Milestone 5: Implementation of Comprehensive Strategies to Address Prescription Drug Abuse and Opioid Use Disorders

Critical Monitoring Metrics

The estimates for critical monitoring metrics relevant to Milestone 5 are shown in

Table 17, and are summarized narratively below.

Use of Opioids at High Dosage in Persons Without Cancer tracks the "Percentage of beneficiaries age 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more." This measure has decreased from its value at the start of the waiver.

Concurrent Use of Opioids and Benzodiazepines has shown a marked decrease since the start of the SUD waiver.

Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries has shown a modest increase since SUD waiver implementation. This measure could have been affected by the implementation of Standard Plans on July 1, 2021.

Overdose Death Rate in North Carolina, as in most states, has shown a marked increase during the COVID-19 pandemic. The national increase from April 2020 to April 2021 was 28.5%,[8] consistent with NC's overdose death rate increase since waiver implementation.

Table 17. Critical monitoring metrics for Milestone 5.

Metric #	Metric name	Monitoring metric rate or count[a,b]				State's demonstration target	Directionality at mid-point	Progress (Yes/No)
		At baseline	At mid-point	Absolute change	Percent change			
18	Use of Opioids at High Dosage in Persons Without Cancer (NQF #2940)	6.46%	6.25%	-0.21% points	-3.2%	Decrease	Decrease	Yes
21	Concurrent Use of Opioids and Benzodiazepines (NQF #3175)	19.51%	13.53%	-5.98% points	-30.7%	Decrease	Decrease	Yes

[8] CDC, National Center for Health Statistics, Office of Communication. *Drug Overdose Deaths in the U.S. Top 100,000 Annually.* https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm. Published November 2021. Accessed March 31, 2022.

23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	1.50	1.51	0.008	0.55%	Decrease	Increase	No
27	Overdose Death Rate	0.27	0.35	0.08	29.6%	Decrease	Increase	No

[a]Baseline periods are November 1, 2018 to October 31, 2019 (DY1) for CMS-constructed demonstration year metrics; calendar year 2018 for established metrics; and November 1, 2018 to January 31, 2019 (DY1Q1) for quarterly metrics.
[b]Midpoint periods are October 31, 2021 (DY3) for CMS-constructed demonstration year metrics; calendar year 2020 for established metrics, and August - October 31, 2021 for quarterly metrics.

Implementation Plan Action Items

There is only one implementation plan action item relevant to Milestone 5, and it has been completed (Table 18).

Table 18: Implementation plan action items for Milestone 5.

Category	Action item description	Date to be completed	Current status
Prescription Drug Abuse and OUD	Continue Implementation of the STOP Act provisions on an ongoing basis	Oct-20	Completed

Stakeholder Input

Themes from stakeholder interviews are displayed in Table 19.

The Controlled Substance Use Reporting System (CSRS) has made improvements to its prescription drug monitoring program (PDMP) database, and there is a consensus among providers that the changes to the PDMP have been positive. However, these changes were not directly related to the SUD waiver.

The LME/MCOs also report new, innovative services and collaborations to improve access to naloxone and reduce the risk of fatal overdose. Examples include collaborations with North Carolina Harm Reduction Coalition and increased efforts in distributing naloxone.

A number of beneficiaries reported that the pharmacy lock-in program occasionally makes it difficult for them to obtain MOUD. One beneficiary mentioned one case in which their locked-in pharmacy was out of MOUD, and they were not able to transfer their prescription to another pharmacy. A provider had similar concerns and advocated for the removal of combination buprenorphine and naloxone from the pharmacy lock-in program due to their perception of care disruption related to this program. Several other providers reported additional problems with the pharmacy lock-in program around the time of the transition to Standard Plans.

Table 19. Stakeholder input relevant to Milestone 5.

Milestone 5		
Stakeholder	**Successes**	**Challenges**
State agencies		
DHB	Not discussed	Not discussed
DMH	Not discussed	Not discussed
DSOHF	NA	NA
CSRS	♦ Use and functionality of PDMP have increased, continue to work on new reports and flags.	♦ CSRS cannot identify who in the PDMP is prescribing to Medicaid beneficiaries. ♦ 1115 waiver did not "have a huge impact" on CSRS work since they were already working toward similar goals
LME/MCOs	♦ State has been very supportive of MAT expansions ♦ Preparing for Tailored Plan has included opioid misuse treatment and prevention planning (addresses use of PDMP/CSRS). ♦ Pursuing collaborations with other local organizations (e.g. NCHRC) to promote "never use alone" and to raise awareness of access to naloxone.	None mentioned.
SUD providers	♦ There is a consensus that improvements to the PDMP have been very successful, being easier to use, more information-rich, and better integrated into EHR.	♦ One provider mentions that methadone is not shown in the PDMP. Has led to some OTP patients being prescribed benzodiazepines, etc., at outside clinics. ♦ Concern that pharmacy lock-in of combination buprenorphine-naloxone negatively affects MOUD access
Medicaid SUD service beneficiaries	None mentioned.	♦ Pharmacy lock-in can interrupt continuity of medication treatment.

Milestone 5 Risk Assessment

In summary, half of the four metrics for Milestone 5 have demonstrated progress in terms of moving in the target direction, and one that has not demonstrated progress (metric 23) is essentially unchanged. Furthermore, increases in the overdose death rate reflect national trends during the COVID-19 public health emergency. The state has completed all implementation plan action items relevant to Milestone 5. Stakeholders report that the functionality and utility of the PDMP has vastly improved and commend the state for its encouragement of innovative methods for overdose prevention. There are some concerns about the pharmacy lock-in program, but these do not significantly impact the risk of completion.

> **In summary, given progress on two out of four monitoring metrics, underlying national trends in overdose deaths, and substantial progress as reflected by action items and stakeholder input, the state is at Low risk of not meeting Milestone 5.**

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

Critical Monitoring Metrics

The critical monitoring metrics relevant to Milestone 6 are described in

Table 20, and are summarized narratively below.

Initiation of Alcohol and Other Drug Dependence Treatment: There has been an appreciable increase in the initiation of treatment services since waiver implementation.

Engagement of Alcohol and Other Drug Dependence Treatment: While more people are initiating in services, fewer have engaged in services, defined as those who initiated and engaged in on-going treatment within 34 days.

Follow-up after Emergency Department visit for SUD at 7 and 30 days: 7-day follow-up rates declined while 30 days rates increased since waiver implementation.

Follow-up after Emergency Department visit for mental health at 7 and 30 days: Rates of follow up at both time periods have increased since waiver implementation.

Readmissions Among Beneficiaries with SUD: This metric has decreased by 4.1% since baseline.

Table 20. Critical monitoring metrics for Milestone 6.

Metric #	Metric name	Monitoring metric rate or count[a,b]				State's demonstration target	Directionality at mid-point	Progress (Yes/No)
		At baseline	At mid-point	Absolute change	Percent change			
15	Initiation of Alcohol and Other Drug Dependence Treatment (NQF #0004)	38.29%	41.13%	2.83% points	7.40%	Increase	Increase	Yes
15	Engagement of Alcohol and Other Drug Dependence Treatment (NQF #0004)	18.71%	15.52%	-3.19% points	-17.07%	Increase	Decrease	No
17.1	Follow-up at 7 days after Emergency Department Visit for Alcohol or Other Drug Dependence (NQF #2605)	13.87%	13.61%	-0.26% points	-1.91%	Increase	Decrease	No
17.1	Follow-up at 30 days after Emergency Department Visit for Alcohol or Other Drug Dependence (NQF #2605)	24.02%	24.29%	0.27% points	1.14%	Increase	Increase	Yes

17.2	Follow-up at 7 days after Emergency Department Visit for Mental Illness (NQF #2605)	24.27%	24.74%	0.47% points	1.92%	Increase	Increase	Yes
17.2	Follow-up at 30 days after Emergency Department Visit for Mental Illness (NQF #2605)	44.05%	45.47%	1.42% points	3.22%	Increase	Increase	Yes
25	Readmissions Among Beneficiaries with SUD	23.41%	22.46%	-0.95% points	-4.06%	Decrease	Decrease	Yes

[a]Baseline periods are November 1, 2018 to October 31, 2019 (DY1) for CMS-constructed demonstration year metrics; calendar year 2018 for established metrics; and November 1, 2018 to January 31, 2019 (DY1Q1) for quarterly metrics.
[b]Midpoint periods are October 31, 2021 (DY3) for CMS-constructed demonstration year metrics; calendar year 2020 for established metrics, and August - October 31, 2021 for quarterly metrics.

Implementation Plan Action Items

There are three implementation plan action items relevant to Milestone 6 (Table 21). Of these, 2 are completed and 1 is in progress. The item remaining to be completed is authorizing the creation of behavioral health homes through a SPA.

Table 21: Implementation plan action items for Milestone 6.

Category	Action item description	Date to be completed	Current status
Care management and transitions	Incorporate care management provisions into standard plan contracts	Nov-19	Completed
	Incorporate care management provisions into BH I/DD Tailored Plan contracts	Jul-21	Completed
	Submit a health home SPA to authorize the creation of behavioral health homes	Mar-20	In progress

Stakeholder Input

A summary of the stakeholder input relevant to Milestone 6 is shown in Table 22. Stakeholders generally agreed that care coordination could be improved, with one provider reporting it is "not there yet." One LME/MCO also feels that there are "cliffs" between levels of the ASAM continuum, which can make care disjointed. One provider felt that there is not a designated actor that can *"pick a person up and kind of track them through the different levels of care."*

Several stakeholders report that a co-location model has been useful for care coordination, including at the ADATCs and elsewhere. DSOHF reports that care coordination has been a central motivation in their launch of new outpatient services at the ADATCs. Other innovative models for care coordination and continuity of care include efforts such as a one LME/MCO's "Welcome Program" with tokens of appreciation. This organization found that such programs improved appointment attendance. Another organization recommended greater use of the NCCARE360 platform for enhanced care management.

Other providers report much deliberation on care management and Tailored Plans, with one reporting that they have decided to not be a Tailored Plan provider due to the amount of care coordination required, and one reporting they wish there was more funding available. One provider reported that uncertainty about upheavals related to politics and state decisions makes them hesitant to face the large upfront cost that care management requires.

For their part, beneficiaries report some difficulty with care continuity, especially during life transitions such as transitioning out of the justice system. Several Medicaid beneficiaries in a high-intensity treatment program expressed their desire for more transitional (step-down) care:

> *"Because we do focus our time on our treatment and even when we can work, your opportunities are kind of slim and you're looking back at trying to reestablish transportation, move to another safe environment that you can maintain the structure and consistency you picked up here, and that's like, I think transitional programs would be really good for folks."*

Overall, stakeholders are optimistic that the SUD waiver will improve care coordination and will allow for the flexibility that stakeholders need to improve it. Regarding more continuous services, one LME/MCO representative said *"I think that's going to be feasible; I think the waiver allows for some flexibility with that."*

Table 22: Stakeholder information relevant to Milestone 6.

Milestone 6		
Stakeholder	**Successes**	**Challenges**
State agencies		
DHB	♦ There have started to be more conversations with addiction professionals around care coordination	♦ Given the focus on transitions of care in Tailored Plans, the launch was pushed after Cardinal's dissolution.
DMH	Not discussed	Not discussed
DSOHF	♦ Establishing outpatient services at several of the ADATCs has improved care coordination, including outpatient peer support programs.	None mentioned.
CSRS	NA	NA
LME/MCOs	♦ Some LMEs report innovative programs, like improving continuity of care for people exiting the judicial system and a welcome program with food/"token of appreciation" that improved appointment attendance.	♦ Perception that ASAM criteria have "cliffs" between them, which can make care disjointed. ♦ Wish more funding was available for care coordination and patient tracking.

	♦ Perception that waiver will allow for flexibility to support continuum of care	
SUD providers	♦ Several providers operate in an co-location model, where several behavioral and physical health services are offered at the same site – has been successful.	♦ Hard decisions around practices doing their own care management, given the large up-front investment. ♦ Several providers feel that care coordination is "not there yet", with one saying that there's nobody to track individuals through the different levels of care.
Medicaid SUD service beneficiaries	None mentioned.	♦ There is a need for more transitional programs after high-level care. ♦ Continuity of care can be difficult when exiting the justice system.

Milestone 6 Risk Assessment

In summary, five of the seven metrics for Milestone 6 have demonstrated progress in terms of moving in the target direction, while two of the seven metrics are moving in the opposite direction. One of these two, 7-day follow-up after ED visits for SUD, has a very small decrease. Two of the three implementation action items are complete, with only submitting a health home SPA in progress. Overall, stakeholders did not have concerns about care coordination that impact the risk of achieving Milestone 6, though providers report some concerns about care coordination overall.

> **Because most but not all of the critical metrics associated with Milestone 6 are moving in the expected direction, we believe the state is at Medium/Low risk for not meeting Milestone 6.**

Chapter 4: Summary and Recommendations

Summary

Table 23 summarizes the percent of action items complete and the proportion of monitoring targets met for each Milestone. In summary, North Carolina is at Low risk for not meeting two of the six milestones: Placement Criteria (Milestone 2) and Prescribing and Overdose (Milestone 5). The state is at Low/Medium risk of not meeting Milestone 4 (Capacity). The assessment of Milestone 4 depends on the relative importance of changes in the metrics (number of providers providing SUD and MOUD services to Medicaid beneficiaries from claims data) and completion of the implementation activities specified in the Implementation Plan and STCs. Required network adequacy assessments and provider outreach have not yet been completed. The Milestone 4 metrics are advancing in the intended direction (implying Low risk of not meeting the milestone), while the implementation activities have not been completed (implying Medium risk).

The State is at Medium risk for not completing Milestone 3, Qualifications, based solely on implementation activities and is also at Medium risk on Milestone 6 on Coordination of Care. Finally, the state is at High risk for not completing Milestone 1 on Access to Critical Levels of Care for SUD based on a lack of progress in achieving targets for a number of metrics reflecting service use and most implementation activities not being completed.

Table 23. Assessed risk of not achieving milestones.

Milestone	Proportion of monitoring metric goals met (# metrics / total)	Percentage of fully completed action items (# completed / total)	Key themes from stakeholder feedback	Risk level
1. Access	**43% (3/7)**	2% (1/61)	♦ Milestone 1 has been a main focus of DHHS agencies. ♦ Several factors contributed to delays, including COVID-19, Standard Plan launch, the exit of one LME/MCO, and preparing for Tailored Plans. ♦ Providers and LME/MCOs report waiting for finalized policies for new services before beginning to establish networks and care standards. ♦ Multiple stakeholders express concerns about preparedness for Tailored Plans. ♦ Beneficiaries report good access to SUD care overall and improved access to care as a result of COVID-19 flexibilities.	High
2. Placement Criteria	**50% (1/2)**	60% (6/10)	♦ NCDHHS agencies have made significant efforts around training providers in ASAM criteria, with over 600 trained. Turnout has not been as high as hoped, which may be	Low

			partially attributable to the small fee for training.	
3. Qualifications	--	0% (0/4)	♦ The state's presentations have clarified licensure requirements. ♦ LME/MCOs have concerns about the licensure process for residential facilities, which is long and costly. ♦ Some programs in NC still do not offer medication to treat opioid or alcohol use disorder.	Medium
4. Capacity	**100% (2/2)**	0% (0/4)	♦ Staffing inpatient facilities and ensuring sufficient outpatient provider supply is a persistent concern for both state agencies and LMEs. Providers perceived shortages of inpatient beds, outpatient care, and OBOT. ♦ LMEs report that developing capacity for facility-based treatment is overall more challenging, especially with lack of startup funds. ♦ Funding services is an issue, given that most people with SUD in NC are uninsured. State funds are critical for this, and the ongoing lack of Medicaid expansion threatens funding streams for new services.	Low/ Medium
5. Prescribing and Overdose	**50% (2/4)**	100% (1/1)	♦ There is a broad consensus that improvements to the PDMP have been very successful.	Low
6. Coordination	**71% (5/7)**	66% (2/3)	♦ Both providers and state agencies report co-locating services has improved care coordination. ♦ Several providers report needing to make hard decisions about care management going forward, especially with the coming launch of Tailored Plans.	Medium

Recommendations

We have focused our recommendations on the four Milestones (1, 3, 4, and 6) with the highest levels of risk for not achieving benchmarks.

Milestone 1: Access

1. ***Create more user-friendly content for providers and beneficiaries related to the changes in treatment availability, benefit expansions, and payment rates on NCDHHS and in particular DMH's website*.** Many providers attended the ASAM trainings and rated them positively but frequenly did not understand the changes in the benefit package for their patients with SUD. This is even more likely to be needed by primary care providers, who may have less occasion to refer their Medicaid beneficiaries for SUD treatment.
2. ***Determine available providers and barriers to entry* t**o each of the service types represented as critical metrics for Milestone 1 and ***identify incentives that could address these barriers*** in order to create an adequate supply of providers to meet State targets.
3. ***Continue COVID-19 flexibilities for the foreseeable future*.** Providers report that telehealth, take-home methadone, and other policy flexibilities have improved access to care and their ability to care for patients. Given the continuation of the COVID-19 pandemic, continuing these flexibilities will help to maintain these successes. This recommendation is generally consistent with the State's March 2022 policy announcement of a continuation of many of the PHE flexibilities. However, there is a possibility that telehealth and care delivery methods with less oversight may not fully meet people's needs, as well as a possibility that long-term telehealth may lead to weaker attachments to the SUD care system. Therefore, we also recommend that, going forward, NCDHHS develop SUD-specific monitoring metrics of telehealth use and the use of other flexibilities to ensure that these services are consistent with quality standards. CMS points to other COVID-19 related flexibilities in their COVID-19 State Implications document.
4. ***Use the metrics to mount an adaptive response.*** In addition to the Manatt Report's suggestion to increase accountability and ownership of the waiver changes, we believe the owner state agency should carefully use the measures reported each quarter as part of a rapid assessment to react to areas without change.
5. ***Triangulate code lists and service definitions going forward.*** As new services and service definitions are added, the state and independent evaluator should triangulate with existing code lists and technical specifications to ensure that service use is captured in on-going SUD monitoring reports.

Milestone 3: Qualifications

1. ***Prioritize minimum MOUD access requirements for residential treatment facilities.*** Given the large increase in opioid overdoses observed in NC and around the country, ensuring that Medicaid beneficiaries have access to life-saving treatment is of utmost importance. Although the number of providers offering MOUD has increased, providers report a perception that many of the facilities at higher ASAM levels do not offer or refer to MOUD, which is inconsistent with modern treatment

guidelines, especially given the High risk for overdose after discharge from residential facilities.[9] Ensuring access to MOUD and OBOT should be a priority.

2. ***Streamline the licensure process for facility-based treatment*.** Although licensure and oversight are critical, as mentioned in the previous point, the length of the licensure process for new residential facilities may be prohibitive. Because efforts are being made to expand access, shortening and/or simplifying the licensure process for residential facilities may facilitate this aim. NCDHHS should strive to maintain quality and qualification standards while reducing the risk and effort required in facility start-up and licensing.

Milestone 4: Capacity

1. ***Support inpatient service capacity*.** The state agencies and LME/MCOs concur that capacity for higher-intensity services is a concern, and one provider reported immense difficulty in referring patients to inpatient beds. Several LME/MCOs mention that starting up new facilities is expensive and risky, and there are no startup funds available. We make the following recommendations:
    a. ***As possible, the state should provide or facilitate financial support for introduction of new facility-based services*.** If sufficient funds are not available directly through the State, agencies should work facilitate grant applications and other funding procurement efforts.
    b. ***Work to support awareness and allocation efforts of higher-level services*.** If financial support of startup of new services is not available, enhanced efforts to raise awareness and allocate beds to those in most need may increase the effective access to the services that are available. Cross-region and cross-LME/MCO collaboration may facilitate this process.
2. ***Expand Medicaid to childless adults.*** Many providers report that most of the SUD patients they see are uninsured, and that improvements to the Medicaid program will not improve outcomes among this population. Furthermore, failing to expand Medicaid is a barrier to implementation of new services, because if those who are currently uninsured obtained Medicaid coverage, these new services would be nearly fully subsidized by the federal government. As it stands, uninsured clients access SUD services that are financed through state funds. The services themselves do not have the associated network of social services and supports that Medicaid has, and the funds themselves are limited. Without Medicaid expansion, there may be a ceiling on the improvements in SUD mortality and morbidity that are possible through the 1115 SUD Waiver alone.

Milestone 6: Coordination

1. ***Identify and reward higher levels of beneficiary engagement in care.*** One of the largest declines in the Coordination metrics was the 17% relative decline in engagement in SUD treatment after initiation. This is a critical metric, since literature shows repeatedly that greater retention in SUD treatment is associated with better outcomes. Achieving greater engagement can be a complex task, but an HIT infrastructure could provide early warnings to providers whose patients have not followed up with treatment through prescription fills or missed appointments that would allow for early opportunities for intervention. Incorporating engagement rates into Tailored Plan contracts or with LME/MCOs could also provide a mechanism for innovation that may improve retention rates.

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[9] See, for example, Morgan JR, Wang J, Barocas JA, et al. Opioid overdose and inpatient care for substance use disorder care in Massachusetts. *Journal of Substance Abuse Treatment*. 2020;112:42-48. doi:10.1016/j.jsat.2020.01.017

Conclusions

In summary, we determined that North Carolina Medicaid is at the following risk levels:

- High risk of not achieving demonstration Milestone 1
- Medium risk of not achieving Milestones 3 and 6
- Medium/Low risk of not achieving Milestone 4
- Low risk of not achieving Milestones 2 and 5

We have provided recommendations for mitigating the risk of not achieving these Milestones. The state of North Carolina should determine next steps based on input from CMS, their own Mitigation Plan, and this report.

Attachment 1: Independent Assessor Description

The Team conducting this Mid-Point Assessment consisted of faculty and staff from the UNC Sheps Center Medicaid Evaluation team and graduate students at UNC-Chapel Hill:

- Kathleen Thomas, PhD
- Chris Shea, PhD
- Marisa Elena Domino, PhD
- Jamie Jackson
- Caleb Easterly, MD/PhD student
- Phillip Hughes, PhD student

In addition, several members of the Sheps Center Evaluation team reviewed and provided critical feedback on this report. We are grateful for their assistance.

The Sheps Center Mid-Point Assessment team worked with the Division of Health Benefits at North Carolina's Department of Health and Human Services in the following ways. We discussed the format and content of the MPA prior to its initiation, but once a design was agreed upon, we conducted the work and developed recommendations independently. Staff from Manatt participated in the interviews with NCDHHS staff in order to reduce the burden on staff from having separate interviews related to the MPA and the Mitigation Plan. Several staff at NCDHHS and from Manatt reviewed the first draft of this report and provided critical feedback for consideration but did not influence the risk assessments or recommendations. We are grateful for their thoughtful and sensitive feedback.

Conflict of Interest Statement

Organization: University of North Carolina at Chapel Hill, Cecil B. Sheps Center for Health Services Research
Activity/Title: NC 1115 Medicaid Waiver: Mid-Point Assessment

All faculty and staff involved in conducting the mid-point assessment have been reviewed for conflict of interests and a status of "No conflict" has been determined and confirmed based on their responses.

Marisa Domino, PhD, principal investigator

Signature 4/22/2022 Date

Kathleen Thomas, PhD, MPH, co-investigator

Signature 4/22/2022 Date

Chris Shea, PhD, co-investigator

Signature 4/22/2022 Date

Jamie Jackson, BS, project manager

Signature 4/22/2022 Date

Attachment 2: Data Collection Tools

NCDHHS Interview Guide

Opening Questions

1. Overall, how would you describe the status of the implementation of the Medicaid Transformation SUD components?
2. Some elements of the SUD transformation have been in effect for several months. Has implementation of these elements gone as expected?
3. How aware are SUD providers of the elements of SUD transformation?
4. How aware of these changes are patients using SUD services?

Milestones

5. Which milestones have been most challenging so far?
6. Could you describe the specific strategies being used to overcome these challenges?
7. Are certain milestones being prioritized by your agency?
8. Have additional changes to the SUD delivery or benefits system been identified that were not included in the original implementation plan?
    a. If so, what are these changes? How do these changes relate to the milestones in the original plan?
    b. If not, do you anticipate any additional changes? If so, what might these be?
9. Do you anticipate any other changes to demonstration activities that we haven't discussed so far?

Planning for Tailored Plans

10. The implementation of Tailored Plans was pushed to July 1, 2022. How would you describe the status of preparation for implementation of the Tailored Plans?
11. What are the most challenging aspects of preparing for implementation of the Tailored Plans?

LME/MCO Interview Guide

Opening Questions

1. Can you tell us a little about your agency and briefly describe the level of interaction and support that your agency receives from the State agencies, such as the DMH and DHB?
2. Overall, how would you describe the status of the implementation of the SUD components of Medicaid Transformation?
3. Some elements of the transformation related to SUD have been in effect for several years, since early 2019. Has implementation of these elements gone as expected?
4. How has your agency engaged differently with SUD providers because of the new features of the SUD elements of Medicaid transformation?
5. What is your agency doing to help raise awareness among patients of the changes of SUD services?
6. How has COVID-19 affected the status of the implementation of these components?

Waiver Components

7. Which components of the waiver have been most successful so far?
8. Which components of the waiver have been the most challenging so far?
9. Could you describe the specific strategies being used to overcome these challenges?
10. Are certain components being prioritized by your agency?
11. Have additional changes to the SUD delivery or benefits system been identified that were not included in the original transformation plan?
    c. If so, what are these changes? How do these changes relate to the components in the original plan?
    d. If not, do you anticipate any additional changes? If so, what might these be?
12. Do you anticipate any other changes to demonstration activities that we haven't discussed so far?

Planning for Tailored Plans

13. The implementation of Tailored Plans was pushed to December 1, 2022. How would you describe the status of preparation for implementation of the Tailored Plans?
    a. Can you describe what types of activities you are undertaking in reaching out to primary care providers?
    b. Can you describe how you are working with the State agencies on Tailored Plan implementation.
14. What are the most challenging aspects of preparing for implementation of the Tailored Plans?

Closing Questions

1. Are there topics or issues that you think it's important to ask in our next round of provider and beneficiary interviews?
2. Is there anything else you'd like to provide feedback on that we haven't touched on?

Provider Interview Guide

For context, we'd like to learn a little about you:

1. What is your title, role, and responsibilities at your organization?
2. How long have you been in this role?
3. Approximately what percentage of your patients are Medicaid beneficiaries? What percentage of your Medicaid beneficiaries have substance use disorders?
4. What are the names of the practices/clinics that you work in? Are they part of a larger health system?
5. Which counties does your practice serve?
6. Do you or any providers in your practice have a DATA 2000 waiver for buprenorphine prescribing?

Questions

7. What does Medicaid transformation of SUD care mean to you?
8. Here are the expanded services (slide). What are your general impressions of each of these expanded services?

9. How have you been preparing for changes to the SUD care delivery system from Medicaid Transformation?
10. How have you engaged with the state and your local LME/MCO around changes to the SUD delivery system?
    a. For example, have you and your staff attended the state-sponsored ASAM levels-of-care trainings?
        i. How accessible were they?
        ii. What was your opinion of those trainings?
    b. How closely do you work with your local LME/MCO(s) surrounding the care of your Medicaid patients with behavioral health disorders?
11. Is your practice going to offer any new service options being implemented by Medicaid?
    c. What effects do you think these new Medicaid SUD services will have on process, quality of care, and outcomes for patients with SUD?
    d. Will it make it easier for Medicaid patients to get MAT or MOUD?
12. How are you preparing for the implementation of the Tailored Plans?
13. The COVID-19 pandemic brought about a lot of changes. Can you tell us how the COVID-19 pandemic impacted your practice or preparation for Medicaid SUD services expansion?
    e. [prompt] Positive changes as a result of COVID-19?

Closing

1. If you could make any recommendations to the state around Medicaid Transformation, what would they be?
2. Is there anything else about the Medicaid program that you would like to share? Anything else we should know that we haven't asked about?

Focus Group Guide

1. Thinking about your experience with substance use disorder services paid for by Medicaid over the last few years (since spring of 2019), what has gone well for you?
    a. Provide a slide that shows all of the SUD services we are discussing (In-patient/residential, PHP, etc.).
2. Have you experienced any problems with receiving Medicaid-funded substance use services?
3. Have you noticed any changes in the availability of substance use disorder services through the Medicaid program over the last few years?
    a. For example, changes to getting an appointment in a timely manner.
4. Have you had to do anything differently to get the Medicaid-funded substance use disorder services you need?
    a. For example, have you had to change providers in the last year?
5. Has the COVID-19 pandemic changed your ability to receive Medicaid substance use disorder services? Made it easier or harder?
6. Is there anything else you would like to share with us about Medicaid substance use disorder changes over the last few years?

Attachment 3: Description of All Critical Monitoring Metrics

Details for each metric are reported based on the CMS-approved SUD monitoring metric protocol (approved 10/30/2019 and available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/Medicaid-Reform/nc-medicaid-reform-demo-cms-appvl-sud-monitoring-metrics-10302019.xlsx). The assignment of metrics to Milestones in the table below is based on the 1115 SUD MPA Technical Assistance document, Version 1.0.

Attachment 3 Table: Description of All Critical Monitoring Metrics

Number	Name	Description	Data Source	Measurement Period
Milestone 1: Access to Critical Levels of Care for SUD ("Access")				
7	Early Intervention	Number of beneficiaries who used early intervention services (such as procedure codes associated with SBIRT) during the measurement period	Claims and encounters	Month
8	Outpatient Services	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	Claims and encounters	Month
9	Intensive Outpatient and Partial Hospitalization Services	Number of unique 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	Claims and encounters	Month
10	Residential and Inpatient Services	Number of beneficiaries who use residential and/or inpatient services for SUD during the measurement period	Claims and encounters	Month
11	Withdrawal Management	Number of beneficiaries who use withdrawal management services (such as outpatient, inpatient, or residential) during the measurement period	Claims and encounters	Month
12	Medication Assisted Treatment (MAT)	Number of beneficiaries who have a claim for MAT for SUD during the measurement period	Claims and encounters	Month
22	Continuity of Pharmacotherapy for Opioid Use Disorder [USC; NQF #3175]	Percentage of adults 18 years of age and older with pharmacotherapy for OUD who have at least 180 days of continuous treatment	Claims and encounters	Calendar Year

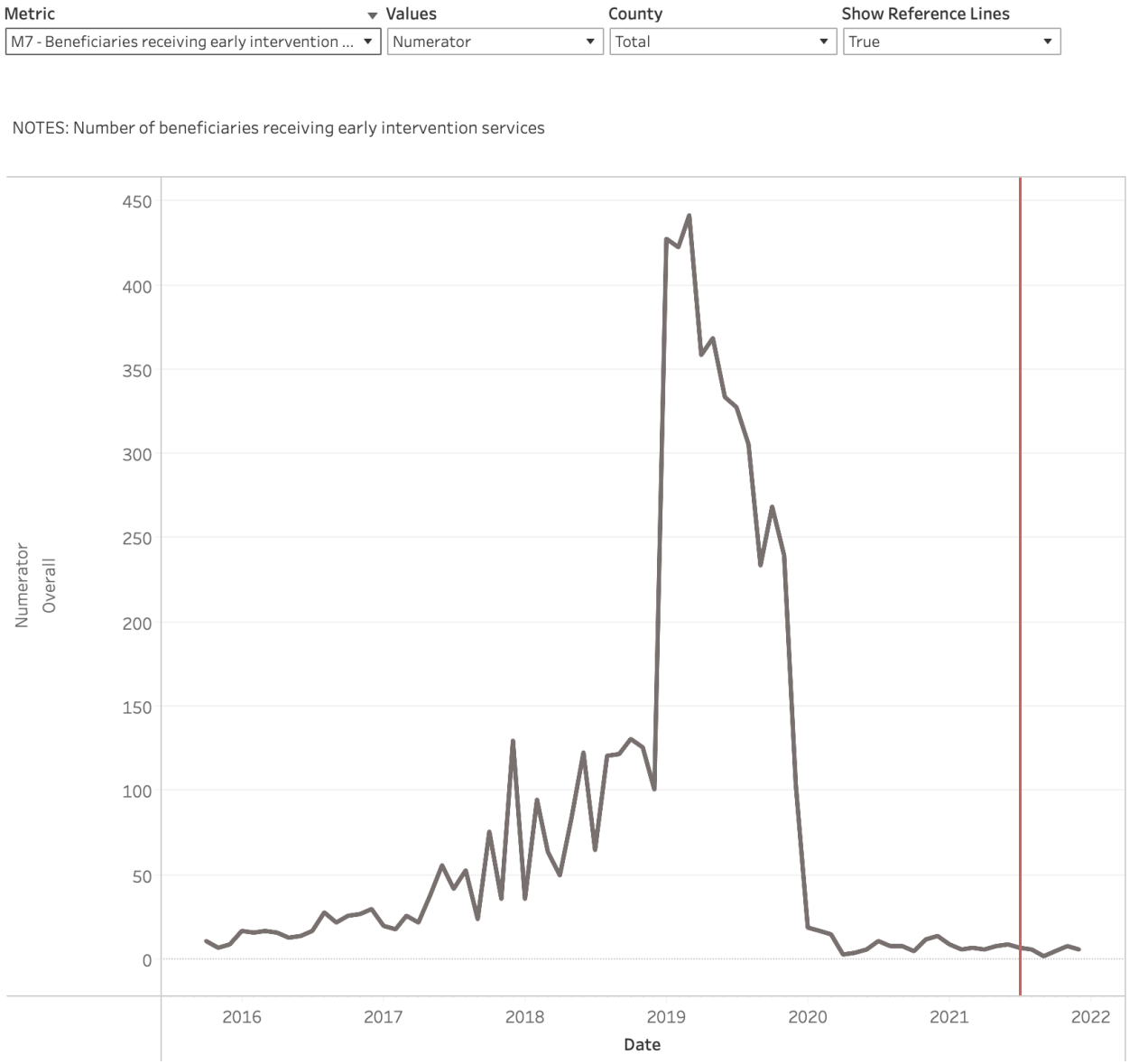
Number	Name	Description	Data Source	Measurement Period
Milestone 2: Use of Evidence-Based SUD-Specific Patient Placement Criteria ("Placement Criteria")				
5	Medicaid Beneficiaries Treated in an IMD for SUD	Number of beneficiaries with a claim for residential treatment for SUD in an IMD during the reporting year	Claims and encounters	Demonstration Year
36	Average Length of Stay in IMDs	The average length of stay for beneficiaries discharged from IMD inpatient/residential treatment for SUD.	Claims and encounters, and state-specific IMD data	Demonstration Year
Milestone 3: Use of Nationally Recognized SUD-Specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities ("Provider Qualifications")				
N/A	No critical metrics defined for Milestone 3			
Milestone 4: Sufficient Provider Capacity at Critical Levels of Care, including for Medication-Assisted Treatment for Opioid Use Disorder (OUD) ("Capacity")				
13	SUD Provider Availability	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period	Provider enrollment database; Claims and encounters	Demonstration Year
14	SUD Provider Availability – MAT	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	Provider enrollment database; Claims and encounters	Demonstration Year
Milestone 5: Implementation of Comprehensive Strategies to Address Prescription Drug Abuse and Opioid Use Disorders ("Prescribing and Overdose")				
18	Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD) [PQA, NQF #2940; Medicaid Adult Core Set]	Percentage of beneficiaries age 18 and older who received prescriptions for opioids with an average daily dosage greater than or equal to 90 morphine milligram equivalents (MME) over a period of 90 days or more. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice are excluded.	Claims and encounters	Calendar Year

Number	Name	Description	Data Source	Measurement Period
21	Concurrent Use of Opioids and Benzodiazepines (COB-AD) [PQA, NQF #3389; Medicaid Adult Core Set]	Percentage of beneficiaries age 18 and older with concurrent use of prescription opioids and benzodiazepines. Beneficiaries with a cancer diagnosis, sickle cell disease diagnosis, or in hospice are excluded.	Claims and encounters	Calendar Year
23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	Total number of ED visits for SUD per 1,000 beneficiaries in the measurement period	Claims and encounters	Month
27	Overdose Deaths (rate)	Rate of overdose deaths during the measurement period among adult Medicaid beneficiaries living in a geographic area covered by the demonstration. The state is encouraged to report the cause of overdose death as specifically as possible (for example, prescription vs. illicit opioid).	State data on cause of death	Demonstration Year
Milestone 6: Improved Care Coordination and Transitions Between Levels of Care ("Coordination")				
15	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET) [NCQA; NQF #0004; Medicaid Adult Core Set]	1. Initiation of AOD Treatment—percentage of beneficiaries who initiated treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or MAT within 14 days of the diagnosis.	Claims and encounters	Calendar Year
15	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET) [NCQA; NQF #0004; Medicaid Adult Core Set]	2. Engagement of AOD Treatment—percentage of beneficiaries who initiated treatment and who had two or more additional AOD services or MAT within 34 days of the initiation visit	Claims and encounters	Calendar Year

Number	Name	Description	Data Source	Measurement Period
17(1)	Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence [NCQA; NQF #2605; Medicaid Adult Core Set]	Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days).	Claims and encounters	Calendar Year
17(2)	Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence [NCQA; NQF #2605; Medicaid Adult Core Set]	Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days).	Claims and encounters	Calendar Year
25	Readmissions Among Beneficiaries with SUD	The rate of all-cause readmissions during the measurement period among beneficiaries with SUD.	Claims and encounters	Demonstration Year

Appendix Figure 1

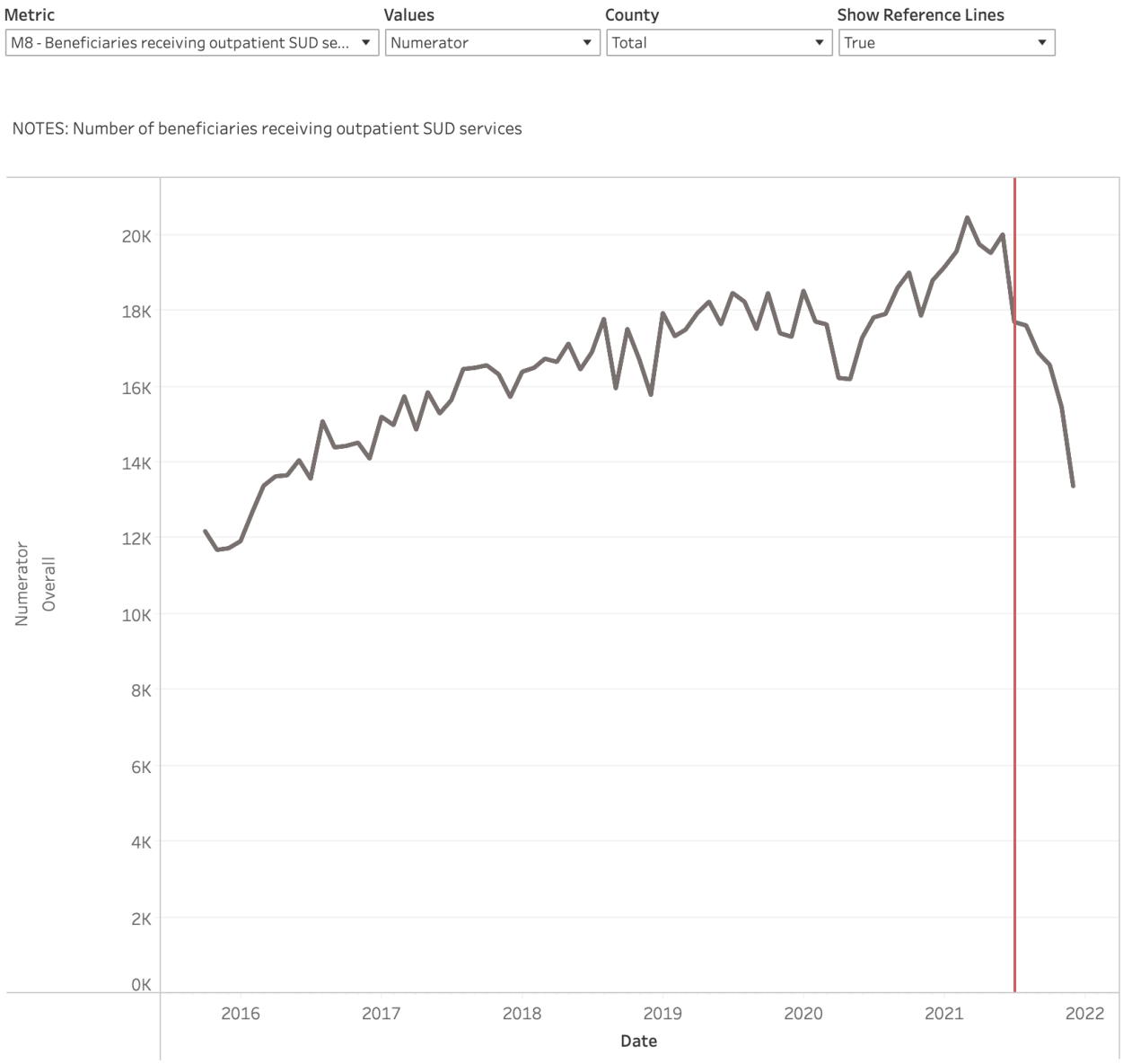
Appendix Figure 1: Trends in users of early intervention services (metric 7) by month*



* Vertical red line identifies the implementation of Standard Plans and the incorporation of encounters from Standard Plans for metrics

Appendix Figure 2

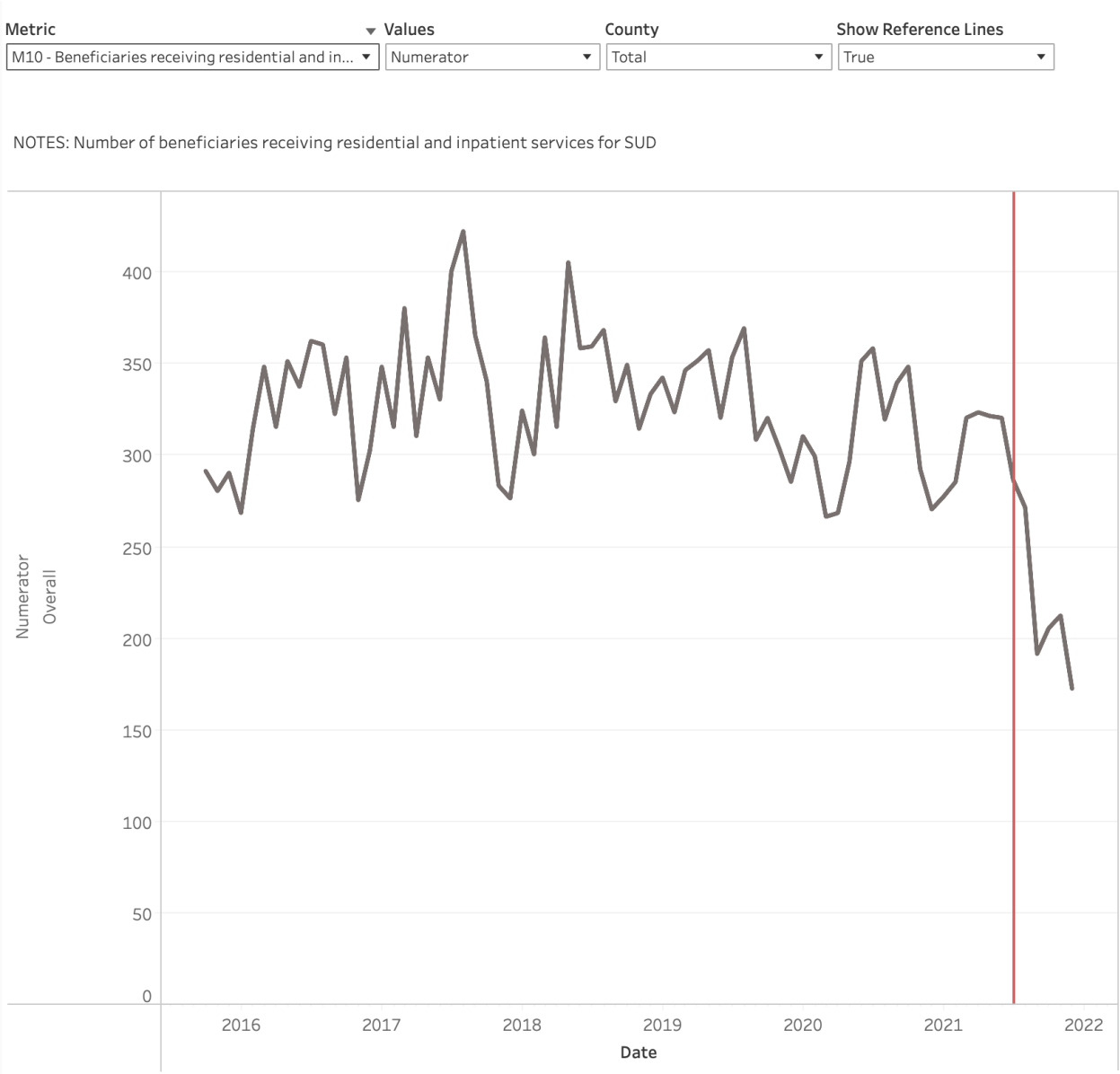
Appendix Figure 2: Trends in users of outpatient SUD services (metric 8) by month*



* Vertical red line identifies the implementation of Standard Plans and the incorporation of encounters from Standard Plans for metrics

Appendix Figure 3

Appendix Figure 3: Trends in users of residential and inpatient SUD services (metric 10) by month*



* Vertical red line identifies the implementation of Standard Plans and the incorporation of encounters from Standard Plans for metrics

North Carolina 1115 SUD Waiver: Mitigation Plan

Recommendations and Mitigation Plan

The Mid-point Assessment offers the opportunity for the Department to update its Implementation Plan to meet CMS requirements. The following recommendations are designed to expedite implementation, minimize the risk of subsequent delays, and ensure ongoing transparency.

Departmental responses to the Recommendations and Mitigation Plan are included in *blue* below.

Recommendation 1: Integrate the Implementation Plan into Existing Project Oversight Processes.

To date, a small group of motivated individuals across DHB and DMH have completed the majority of the actions planned in the waiver. They have deep subject matter expertise and should continue to do much of the substantive work on the implementation plan. However, their work should be integrated into existing Department processes designed to provide transparency and support project management.

- **Executive Sponsor.** To date, the Implementation Plan has not had an executive sponsor. Given the significant financial investment that CMS has made in NCDHHS by granting expenditure authority for care delivered to individuals in IMDs, we recommend that the Department identify an executive owner responsible for project oversight.

  In response to this recommendation, the Department has assigned Sandy Terrell, Chief Clinical Officer, NC Medicaid as executive sponsor.

- **Project Management**. The Implementation Plan requires close coordination across DHB, DMH/DD/SAS, DHSR, and other Divisions. Outstanding "actions needed" have numerous dependencies and interrelated tasks. To ensure prompt completion of the final phase of the Implementation Plan, we recommend developing a robust project plan and project management function across all areas of the Implementation Plan, which will allow Department SMEs currently supporting project management to focus on substantive issues.

  The Department can use existing project management vendors, such as Accenture, to develop and manage an ongoing project plan.

  The updated project plan should calculate new anticipated completion dates for all "actions needed" not yet completed, including creating a new timeline for clinical coverage policy implementation and implementation of tasks for other milestones.

  In response to this recommendation, the Department has arranged for Accenture to monitor project management, develop a project plan, and calculate new anticipated completion dates.

  Integration with other Departmental Projects. The Project Plan should integrate dependencies for

Tailored Plan launch and Foster Care Plan launch, including potential interruptions in PAG availability, limits in Departmental resources, and limits in provider resources.[1]

In response to this recommendation, the Department has arranged for Accenture to integrate dependencies related to other Departmental priorities into the project plan. The Department plans to share updated projected completion dates for Implementation Plan action items with CMS in an upcoming quarterly monitoring submission.

Recommendation 2: Prioritize Completion of Waiver Requirements Specified in the SMD

The requirements for states to claim FFP for individuals residing in IMDs with a SUD diagnosis are laid out in SMD #17-003 "Strategies to Address the Opioid Epidemic." While NCDHHS plans to complete all "actions needed" that it committed to in the Implementation Plan, the State's Project Plan should prioritize completion of "actions needed" that align with requirements in the SMD over those that North Carolina proposed that are above in beyond those required by CMS.

In particular:

- **Milestone 4.** SMD 17-003 specifically requires "completion of assessment of the availability of providers enrolled in Medicaid and accepting new patients in the critical levels of care throughout the state (or at least in participating regions of the state) including those that offer MAT." While LME/MCOs have assessed the availability of enrolled providers accepting new patients, they could reassess with an additional focus on MAT availability, which was discussed in more limited detail in the earlier assessment. This assessment can be completed independent of clinical coverage policies being finalized. Potentially, the assessment could be completed by the EQRO as part of their larger review of network adequacy.

In response to this recommendation, the Department is engaging in conversations with the EQRO, Health Services Advisory Group, around having them conduct the provider assessment. The Department is also considering ways in which the PIHP Quarterly Contract Monitoring / Intradepartmental Monitoring Team (IMT), an internal workgroup that meets regularly with LME/MCOs, can contribute to monitoring of provider availability.

Recommendation 3. Proactively Communicate with CMS about the Status of the Implementation Plan.

Concurrently with sharing the mid-point assessment, NCDHHS should communicate with CMS about the current status of the Implementation Plan and activities underway to come into compliance with CMS

[1] Based on the Department's experience during Standard Plan launch, there may be delays with PAG availability and general Departmental prioritization during the months close to Tailored Plan and Foster Care plan launch. This will be of particular concern given that the requirements of the Implementation Plan will have a significant impact on Tailored Plan enrollees.

requirements. North Carolina has reported implementation progress as required in CMS documentation templates, but CMS may not be actively tracking North Carolina's compliance with previously agreed-

upon deadlines. As referenced in "Current Status" above, the template for the quarterly monitoring reports asks the State to report changes in implementation compared to the demonstration design but does not provide a cohesive way to report delays or deadlines that have passed.

CMS has encouraged states to share information about delays related to COVID-19 in their monitoring reports and evaluations. Some states have taken this opportunity to report delays related to other challenges as well.

In response to this recommendation, the Department will provide concrete updates on the status and timing of activities related to the mitigation plan in forthcoming quarterly SUD monitoring submissions.