

RUTGERS

# Center for State Health Policy

*A Unit of the Institute for Health, Health Care Policy and Aging Research*

## The NJ FamilyCare Section 1115 Opioid and Substance Use Disorder Demonstration Program: Midpoint Assessment

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# Table of Contents

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Acknowledgments .....	i
Executive Summary .....	ii
Background .....	2
Methodology .....	6
<i>Data Sources</i> .....	6
<i>Analytic Methods</i> .....	9
<i>Assessment of Overall Risk of Not Meeting Milestones</i> .....	10
Milestone 1: Access to Critical Levels of Care for OUD and Other SUDs .....	11
<i>Performance on Monitoring Metrics</i> .....	11
<i>Key Informant Comments</i> .....	14
<i>Overall Risk Assessment</i> .....	20
Milestone 2: Use of Evidence-Based, SUD-Specific Patient Placement Criteria .....	21
<i>Performance on Monitoring Metrics</i> .....	21
<i>Key Informant Comments</i> .....	23
<i>Overall Risk Assessment</i> .....	27
Milestone 3: Residential and ASAM requirements .....	28
<i>Performance on Monitoring Metrics</i> .....	28
<i>Key Informant Comments</i> .....	28
<i>Overall Risk Assessment</i> .....	33
Milestone 4: Sufficient Provider Capacity at Each Level of Care .....	34
<i>Performance on Monitoring Metrics</i> .....	34
<i>Key Informant Comments</i> .....	35
<i>Overall Risk Assessment</i> .....	40
Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD .....	41
<i>Performance on Monitoring Metrics</i> .....	41
<i>Key Informant Comments</i> .....	43
<i>Overall Risk Assessment</i> .....	47
Milestone 6: Improved Care Coordination and Transitions between Levels of Care .....	48
<i>Performance on Monitoring Metrics</i> .....	48

<i>Key Informant Comments</i> .....	52
<i>Overall Risk Assessment</i> .....	55
Key Informant Overall Recommendations .....	56
Discussion .....	57
<i>Limitations</i> .....	59
References .....	61
Appendix.....	63

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# **The NJ FamilyCare Section 1115 Opioid and Substance Use Disorder (O-SUD) Demonstration Program: Midpoint Assessment**

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## **Executive Summary**

Under the NJ FamilyCare 1115 Demonstration Waiver, the New Jersey Division of Medical Assistance and Health Services (DMAHS) is participating in a comprehensive initiative for addressing the opioid use disorder / substance use disorder (OUD/SUD) crisis, over the period 10/31/2017-6/30/2022. The NJ FamilyCare OUD/SUD program aims to bring a full continuum of evidence-based care to beneficiaries with OUD/SUD in an effort to improve accessibility, treatment quality, and health outcomes for this population through the completion of six demonstration milestones.

As part of the demonstration, the Center for Medicare & Medicaid Services requires New Jersey to conduct an independent midpoint assessment to examine implementation progress, identify factors and risks affecting milestone completion, and provide recommendations for state actions. The Rutgers Center for State Health Policy conducted the independent assessment based on the data available between years two and three of New Jersey's Section 1115 OUD/SUD Demonstration Program. This assessment utilized a mixed-methods, complementary design, consisting of examination of trends in demonstration monitoring metrics, review of the State's Action Items for implementation of the Program, and interviews with 27 individuals representing different stakeholder groups.

During the first three years of O-SUD Program, the State made significant progress toward advancing OUD/SUD services for NJ Medicaid beneficiaries. At the midpoint, the State was on target to meet its goals for the demonstration monitoring metrics (i.e., Critical Metrics) and Action Items. For three out of the six milestones, the state had completed all of its Action Items that were due by the midpoint. Stakeholders reported numerous external and internal factors that facilitated the implementation process, though there were barriers as well. Taken together, the risk assessment at midpoint for the NJ O-SUD Program is low-medium for not meeting demonstration milestones.





# The New Jersey Medicaid Section 1115 Opioid and Substance Use Disorder Demonstration Program: Midpoint Assessment

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## Background

Under the NJ FamilyCare 1115 Comprehensive Demonstration, the New Jersey Division of Medical Assistance and Health Services (DMAHS) is participating in an initiative for addressing the opioid use disorder / substance use disorder (OUD/SUD) crisis over the period 10/31/2017-6/30/2022. The NJ FamilyCare OUD/SUD program brings a full continuum of evidence-based care to beneficiaries with OUD/SUD in an effort to improve accessibility, treatment quality, and health outcomes for this population.

The Implementation Plan for New Jersey's OUD/SUD program was approved by the Centers for Medicare and Medicaid Services (CMS) on May 17, 2018 (NJDHS-DMAHS 2018). In this plan, the State details the overall goals of the OUD/SUD program. They are:

1. Increase the rates of identification, initiation and engagement in treatment for OUD and other SUDs;
2. Increase adherence to, and retention in, treatment for OUD and other SUDs;
3. Reduce overdose deaths, particularly those due to opioids;
4. Reduce utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment, where the utilization is preventable or medically inappropriate;
5. Reduce preventable, or potentially preventable, readmission to the same or higher level of care for OUD and other SUD; and
6. Improve access to care for physical health conditions among beneficiaries with OUD or other SUDs.

In pursuit of these goals, CMS prescribed milestones for the implementation of New Jersey's OUD/SUD program (CMS 2017a; 2017b). These milestones require the State to:

1. Establish new benefits for access to critical levels of care for OUD/SUD;
2. Establish requirements for evidence-based, SUD-specific patient placement criteria to govern providers' assessments of beneficiaries and guide utilization management;
3. Establish residential treatment provider qualifications using evidence-based, SUD program standards and require that residential treatment providers offer access to

Medication Assisted Treatment (MAT), and ensure provider compliance with standards of care;

4. Assess provider capacity at each level of care (including MAT for OUD) and develop a plan for addressing any identified gaps;
5. Implement comprehensive treatment and prevention strategies to address opioid abuse and OUD via prescribing guidelines, access to Naloxone, and an SUD Health Information Technology (IT) Plan for prescription drug monitoring;
6. Develop and implement policies to improve transitions between levels of care and improve care coordination between residential/inpatient facilities and community supports.

The timeframes laid out in the Waiver Special Terms and Conditions require completion of Milestones 1-5 within 24 months of the demonstration approval on October 31, 2017. Milestone 6 can be carried out over the course of the five-year demonstration period.

To allow for the flexibility and innovation needed to craft a successful OUD/SUD program, the Waiver also gives the State authority to make key service delivery changes. Due to an existing federal policy, prior to the demonstration, only Medicaid members ages 18-20 and 65 or older were covered for both detox-rehabilitative services and short-term residential treatment (STR) in an Institution for Mental Disease (IMD). Any hospital, nursing facility, or other institution of more than 16 beds caring for individuals where the majority of residents have a diagnosis of mental disease qualifies as an IMD, thus severely limiting the bed capacity in the state available for treatment of Medicaid beneficiaries with OUD/SUD aged 21-64. These individuals had to self-pay or access state funding for treatment, which entailed waiting for a bed in one of only four facilities statewide. The result was delayed treatment admission for withdrawal management services that are vital to the continuum of care. After Waiver approval on October 31, 2017, gaps in the care continuum, like the IMD exclusion, could be closed. Specifically, the State was granted waiver authority to make these service delivery changes (NJ DHS-DMAHS 2018):

- Remove the exclusion prohibiting withdrawal management or residential treatment services delivered in an IMD;
- Add long-term residential treatment, including treatment in an IMD, as a new level of care in the OUD/SUD service continuum;
- Add peer recovery support specialist and case management programs to the benefit package for individuals with OUD/SUD;
- Move to a managed care delivery system with integrated physical and behavioral health services, with gubernatorial approval, over the course of the 5-year demonstration under an amendment to the waiver.

These service delivery changes complement additional activities and policies enacted by the State under this initiative. These other activities are described in detail in the State's Implementation Plan. Briefly, the State had to:

- Operationalize the use of American Society for Addiction Medicine (ASAM) criteria\* and the LOCI-3 assessment tool for SUD treatment;
- Operationalize and align the utilization management by managed care organizations and the Interim Managing Entity (IME)<sup>†</sup> to ensure the appropriate level of care;
- Ensure NJ residential treatment facility (RTF) regulations and provider contracts with MCOs (managed care organizations) meet ASAM criteria for services types, hours of care, and staff credentials and establish a review process to ensure provider compliance;
- Ensure access to MAT on-site and after RTF discharge;
- Conduct a statewide capacity report and maintain provider capacity data profiles for all levels of care with a plan to address any insufficiency;
- Implement strategies under the Health IT plan to connect SUD providers to EHRs and the Prescription Drug Monitoring Program;
- Utilize and expand training and use of Naloxone to reverse overdoses; and
- Implement an Opioid Overdose Recovery program to those who have received Narcan reversal.

Taken together, these changes under the demonstration are intended to enable New Jersey to achieve the programmatic milestones and goals described above. Specifically, lifting the IMD exclusion (delivery change 1) increases access to critical levels of care for OUD/SUD for beneficiaries aged 21-64 who will have access to hundreds of additional withdrawal management and detox beds in NJ. The addition of long-term residential (LTR) treatment (delivery change 2), peer recovery support, and case management (delivery change 3) are also new benefits expanding the continuum of care as per the first milestone.<sup>‡</sup> LTR treatment and peer recovery services are available to beneficiaries of all ages with OUD/SUD, and the case management benefit will be available for adults ages 18 and older.<sup>§</sup> The movement towards integrated physical and behavioral health under a managed care model (delivery change 4) supports the sixth milestone of improving transitions and care coordination in OUD/SUD treatment and affects beneficiaries of all ages with OUD/SUD.<sup>\*\*</sup> Finally, all of the additional activities in the State’s Implementation Plan enumerated above are also intended to benefit beneficiaries with OUD/SUD of all ages.

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\* The ASAM criteria describes substance use disorder treatment as a continuum marked by 5 broad levels of care: 0.5 – Early intervention; 1 – Outpatient services; 2 – Intensive outpatient or partial hospitalization services; 3 – Residential or inpatient services; 4 – Medical managed intensive inpatient services.

<sup>†</sup> The IME is an organization providing a coordinated point of entry for those seeking SUD treatment.

<sup>‡</sup> Some special populations (Managed Long Term Services and Supports [MLTSS], Division of Developmentally Disabled [DDD], and Fully Integrated Dual Eligible Special Needs Plans [FIDE SNP]) who were already receiving integrated physical and behavioral health could receive case management from their MCO and therefore, this would not be a new benefit for them.

<sup>§</sup> Children with behavioral health needs already receive case management services.

<sup>\*\*</sup> The MLTSS, DDD, and FIDE-SNP populations were already receiving integrated physical and behavioral health services under managed care, but most SUD services were carved out at the time this initiative began.

**Midpoint Assessment.** The Rutgers Center for State Health Policy was engaged as an independent assessor to conduct a midpoint assessment on years two and three of New Jersey’s Medicaid Section 1115 OUD/SUD Demonstration Program (“O-SUD program”). CMS set guidelines for this assessment, including the specification of demonstration monitoring metrics to include (State Demonstrations Group, Center for Medicaid and CHIP Services, and Centers for Medicare & Medicaid Services 2021). The midpoint assessment has two objectives:

**Objective 1.** To describe progress toward meeting the opioid/substance use disorder program implementation milestones and estimate whether the milestones will be achieved during the demonstration period.

**Objective 2.** To identify factors that may have potentially affected achievement of milestones and recommendations for refining the implementation protocol and mitigating risks of not meeting the milestones.

To achieve these objectives, we conducted quantitative and qualitative assessments of the O-SUD program implementation progress during its first three years, **comparing the baseline period (January 1, 2017 – December 31, 2017 or October 1, 2017 – September 30, 2018, depending on the specific metrics) to one year of data post-baseline.** Collectively, interview participants were thus asked to reflect upon program activities and factors affecting implementation from January 1, 2017 through September 30, 2019.

In this report, we include a summary of demonstration monitoring metrics data (i.e., Critical Metrics) as evidence of the State’s progress towards its six demonstration milestones. We also include a summary of findings from our assessment of other available information including the State’s progress towards completing Action Items identified in the implementation plan. The Critical Metrics and Action Items have directional goals and target completion dates, respectively, which serve as markers for our assessment. Where possible, we include feedback from key stakeholders to describe factors that influenced the early years of the demonstration.

Furthermore, while the assessment focuses on the first three years of the demonstration (2017 to 2019), we provide an early assessment of how the Coronavirus (COVID-19) public health emergency may have affected the demonstration implementation, including changes in service delivery or utilization. Accounting for COVID-19 may help anticipate barriers to monitoring and implementing the demonstration program. Findings were used to assess the risk of not achieving each milestone and, if needed, make recommendations for the State to achieve progress toward that milestone.

## Methodology

To conduct the midpoint assessment, we used a mixed-methods, complementarity design, which is the sequential analysis and interpretation of quantitative data followed by the review of qualitative data to understand a phenomenon more completely (Palinkas et al. 2011). The project team at the Rutgers Center for State Health Policy also consulted with a subject matter expert in OUD/SUD policy who is unaffiliated with the State of New Jersey and the Center for State Health Policy. This expert provided independent interpretation of the study findings and their implications regarding the State’s implementation progress and, further, recommendations on course correction strategies if adjustments are required to the implementation plan to achieve demonstration objectives.

### Data Sources

The data sources included: Critical Metrics, implementation plan Action Items, and key informant interviews. The Critical Metrics and Action Items were used to address objective 1 of the assessment, and the interviews were used to shed light on objective 1 and address objective 2.

**Critical Metrics and Action Items.** The State provided demonstration monitoring information in the forms of Critical Metrics and implementation Action Items; these monitoring metrics were set by CMS. The Critical Metrics analyzed are listed in Table 1 and correspond with implementation Milestones 1, 2, 4, 5, and 6. CMS did not set metrics for Milestone 3. Critical Metric data are from the baseline period (January 1, 2017 – December 31, 2017 or October 1, 2017 – September 30, 2018 depending on the specific metrics) to the midpoint period (one year of data post-baseline). Appendix A gives details on the baseline and implementation periods for each Critical Metric. We only included Action Items with a target completion date through September 30, 2019, the end of the midpoint period; omitting Action Items due beyond this date.

**Table 1: Critical Metrics for Assessing Progress for the SUD Midpoint Assessment**

Metric #	SUD Monitoring Metric Name
Milestone 1. Access to critical levels of care for OUD and other SUDs.	
6	Any SUD Treatment
7	Early Intervention
8	Outpatient Services
9	Intensive Outpatient and Partial Hospitalization Services
10	Residential and Inpatient Services
11	Withdrawal Management
12	Medication-Assisted Treatment
22	Continuity of Pharmacotherapy for Opioid Use Disorder

Metric #	SUD Monitoring Metric Name
Milestone 2. Use of evidence-based, SUD-specific patient placement criteria.	
5	Medicaid Beneficiaries Treated in an IMD for SUD
36	Average Length of Stay in IMDs
Milestone 4. Sufficient provider capacity at each level of care.	
13	Provider Availability
14	Provider Availability – MAT
Milestone 5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD.	
18	Use of Opioids at High Dosage in Persons Without Cancer (NQF #2940)
21	Concurrent Use of Opioids and Benzodiazepines (NQF #3175)
23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries
27	Overdose Death Rate
Milestone 6. Improved care coordination and transitions between levels of care.	
15	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF #0004)
17(1)	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (NQF #2605)
17(2)	Follow-up after Emergency Department Visit for Mental Illness (NQF #2605)
25	Readmissions Among Beneficiaries with SUD

Notes. There are no Critical Metrics identified for Milestone 3 (Use of nationally recognized, evidence-based O-SUD program standards to set residential treatment provider qualifications). IMD = institution for mental disease; MAT = medically assisted treatment; NQF = National Quality Forum; OUD = opioid use disorder; SUD = substance use disorder. Source: CMS Guidance Document.

**Key Informant Interviews.** We conducted semi-structured interviews to obtain stakeholder feedback on internal and external factors influencing the O-SUD program’s progress toward meeting its milestones. The interview guide embedded select quantitative Critical Metric data trends, implementation Action Items, and questions that explored the program’s implementation process (i.e., concepts of planning, engaging, executing, and reflecting/evaluating (Damschroder et al. 2009)).

During the interview, participants were first read a description of each milestone and then shown select Critical Metric data trends and Action Items corresponding with the milestone. For example, Milestone 1 is “Access to critical levels of care for OUD and other SUDs.” Using Zoom’s screenshare feature, the interviewer showed participants graph(s) corresponding with Critical Metric data trends, such as “Utilization of Withdrawal Management services,” and asked participants to describe facilitators and barriers to meeting the Critical Metric’s goal. Participants were also asked to describe how they believed COVID-19 may affect the program’s progress to

meeting goals. The interviewer then showed participants a table with the status of Action Item(s) associated with the milestone, such as “Implement Withdrawal Management service by July 2018.” Participants were asked to describe facilitators and barriers to meeting the target completion date. See Appendix B for the interview guide.

To recruit participants, we used purposive sampling with a snowballing strategy (Marshall 1996), as described below. We identified and recruited different stakeholders who could share insights on the progress of the program across four stakeholder groups: provider organization, consumer advocacy group, managed care organization (including Interim Managing Entity [IME]), and state (e.g., the NJ Division of Medical Assistance and Health Services [DMAHS] and the NJ Department of Mental Health & Addiction Services [DMHAS]). We targeted 20 stakeholders, as the literature indicates thematic saturation is typically reached in qualitative research with 9-17 interview participants (Hennink and Kaiser 2021).

Recruitment was informed by a list of relevant stakeholders from DMHAS corresponding with the four stakeholder groups. We emailed an invitation to an initial selection of stakeholders (i.e., purposive sampling), and during interviews, we asked participants to recommend additional stakeholders (i.e., snowball sampling). We sent email invitations to a total of 43 stakeholders and recruited 27 individuals (63% participation rate), who represented 20 organizations. Fifteen individuals were non-responsive, and three declined for reasons including: recommended another stakeholder within their organization and recommended another organization. The distribution of participants is summarized in Table 3.

**Table 3: Interview Participants**

Stakeholder Group	Target # of Participants (N=20)	Total # of Participants (n=27)	Total # of Participating Organizations (n=20)
Provider organization	8	9	8
Consumer advocacy group	4	9	5
Managed care organization (MCO), including Interim Managing Entity (IME)	5	5	5
State	3	4	2

Interviews were conducted from August to September 2021 virtually using Zoom. Each interview employed two trained interviewers, with one serving as lead and the other taking notes and asking clarifying questions. Interviews were conducted with 1-3 participants at a time, lasted 60-90 minutes, were confidential, and audio-recorded with consent.



## **Analytic Methods**

We used a mixed methods analysis to integrate the quantitative and qualitative data. By triangulating (Kimchi, Polivka, and Stevenson 1991) multiple data sources, we are able to robustly ascertain progress of the program at the midpoint and any risks of not meeting goals.

**Critical Metrics and Action Items.** For objective 1 of the assessment, we calculated changes in monitoring metrics between demonstration baseline (January 1, 2017 – December 31, 2017 or October 1, 2017 – September 30, 2018 depending on the specific metrics) and midpoint (one year post-baseline). For Critical Metrics, we applied a formula from the *CMS Mid-Point Assessment Technical Assistance* document (State Demonstrations Group, Center for Medicaid and CHIP Services, and Centers for Medicare & Medicaid Services 2021):

$$\text{Percent Change} = \frac{\text{Value of Critical Metric at midpoint} - \text{Value of Critical Metric at baseline}}{\text{Value of Critical Metric at baseline}}$$

The percent change of each Critical Metric was compared to the State’s directional goal (i.e., positive, negative, or no change) to determine whether it was on target or not on target to meeting goals. The percent change can reflect a monthly or yearly average depending on the measurement period of each Critical Metric; details are given in Appendix A.

The state also set target dates to complete each Action Item. We assessed the completion of Action Items based on whether the State achieved completion by the target date. The completion status of each Action Item at the midpoint (one year post-baseline, defined as September 30, 2019) using the following formula:

$$\text{Months Since Target Date} = \text{Completion Date} - \text{Target Date}$$

If the “Months Since Target” was zero, the Action Item was noted as being completed on target. If the “Months Since Target” was less than zero, the Item was completed on target but ahead of schedule. If the “Months Since Target” was more than zero, the Item was not completed on target, as it was behind schedule. Items still in-progress were indicated as such.

Results of Critical Metrics and Action Items were shared with the NJ DMAHS for input on which to use in the key informant interviews. Generally, there was greater interest in data trends that were not on target, as well as Metrics and Action Items associated with services that were scheduled to be implemented by the midpoint. After taking into account input from DMAHS, we identified Critical Metric and Action Item results to share with stakeholders; some results were shared only with selected stakeholder groups.

**Key Informant Interviews.** For objective 2, we used rapid qualitative analysis techniques (Beebe 2001), which start with team members debriefing following each interview and populating a structured template that corresponded with central topics of the interview guide. During this debriefing process, team members assessed data saturation, finding no new major themes after interviewing the twentieth participant (Marshall 1996); any variation was often unique to a stakeholder’s specific role or organization. Next, data were aggregated into a matrix to compare preliminary themes across participants. The lead researcher identified the key themes, seeking clarification or discussion from team members as needed. The full project team then reviewed all resulting themes of facilitators and barriers of each milestone and recommendations.

**Assessment of Overall Risk of Not Meeting Milestones**

Finally, we used criteria from Table 4 to assess risk for not meeting milestones as low, medium, or high based on the share of Critical Metrics that show change in the direction of their goals, the percentage of Action Items completed, and stakeholder feedback.

**Table 4: Considerations for Assessing Risk of Not Meeting Milestones**

Risk level	Considerations for assessing risk
Low	<ul style="list-style-type: none"> <li>• <b>Monitoring metrics.</b> State is moving in the expected direction relative to its annual goals and overall demonstration targets for all or nearly all (75% or more) of the associated monitoring metrics</li> <li>• <b>Implementation plan action items.</b> State fully completed most/all (75% or more) associated action items as scheduled</li> <li>• <b>Stakeholder feedback.</b> No stakeholders identified risks related to meeting milestone</li> </ul>
Medium	<ul style="list-style-type: none"> <li>• <b>Monitoring metrics.</b> State is moving in the expected direction relative to its annual goals and overall demonstration targets for most (25-75%) of the associated monitoring metrics</li> <li>• <b>Implementation plan action items.</b> State fully completed some (25-75%) of the associated action items as scheduled</li> <li>• <b>Stakeholder feedback.</b> Few stakeholders identified risks related to meeting milestone</li> </ul>
High	<ul style="list-style-type: none"> <li>• <b>Monitoring metrics.</b> State is moving in the expected direction relative to its annual goals and overall demonstration targets for few (25% or less) of the associated monitoring metrics</li> <li>• <b>Implementation plan action items.</b> State fully completed few or none (25% or less) associated action items as scheduled</li> <li>• <b>Stakeholder feedback.</b> Many stakeholders identified risks related to meeting milestone</li> </ul>

Source: CMS Guidance Document

## Milestone 1: Access to Critical Levels of Care for OUD and Other SUDs

The first milestone is to improve access to critical levels of care for OUD and SUD. The effectiveness of the type of treatment or level of care varies depending on the individual beneficiary; therefore, it is important to offer a range of services at varying levels of intensity across a continuum of care. There were already many services available to Medicaid beneficiaries before the O-SUD program started in 2017, some of which included: coverage of outpatient, intensive outpatient, partial care / partial hospitalization, short term residential, non-hospital based withdrawal management, ambulatory withdrawal management services, medication assisted treatment, and medically supervised withdrawal management services. The O-SUD program added long-term residential services to the SUD continuum. Further, short term residential and non-hospital based withdrawal management services in an Institution for Mental Disease (IMD)\* could begin for Medicaid beneficiaries ages 21-64 upon approval. The state also created a Medicaid benefit of peer support and case management services for beneficiaries with an SUD diagnosis.

### ***Performance on Monitoring Metrics***

***Critical Metrics.*** Milestone 1 Critical Metrics are summarized in Table 5 and visualized in Figures 1-3. Seven out of eight Critical Metrics were on target at the midpoint. Between the baseline and midpoint periods, the largest percent change was in *early intervention* (80% increase), increasing from an average of 0.42 persons per month to 0.75 persons per month (less than 10 individuals received early intervention each year). The next largest percent change was *residential and inpatient services* (70% increase), increasing from an average of 1,066 persons per month to 1,814 persons per month. One Critical Metric was not on target at the midpoint – *intensive outpatient and partial hospitalization services* (4% decrease), dropping from 3,727 persons per month to 3,570 persons per month.

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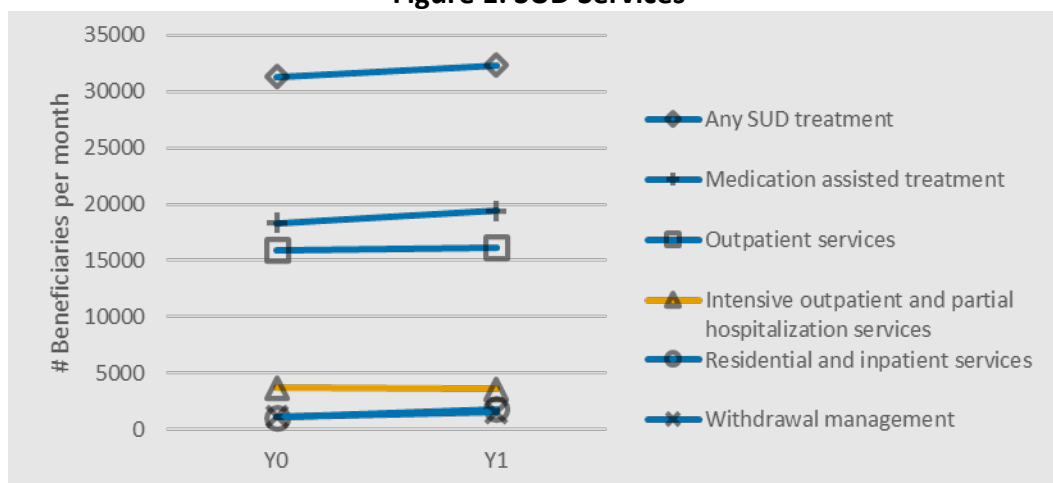
\* Any hospital, nursing facility, or other institution of more than 16 beds caring for individuals where the majority (over 50%) have a diagnosis of mental disease qualifies as an Institution for Mental Disease (IMD).

**Table 5: Milestone 1 Critical Metrics**

Metric #	Critical Metric	Unit	Baseline	Midpoint	Target	% Change	Shown in Interview
6	Any SUD treatment	(# persons/mth)	31,291	32,335	↑	3%	✓
7	Early intervention	(# persons/mth)	0.42	0.75	↑	80%	
8	Outpatient services	(# persons/mth)	15,938	16,147	↑	1%	
9	Intensive outpatient and partial hospitalization services	(# persons/mth)	3,727	3,570	↔	-4%	
10	Residential and inpatient services	(# persons/mth)	1,066	1,814	↑	70%	✓
11	Withdrawal management	(# persons/mth)	1,132	1,535	↑	36%	✓
12	Medication assisted treatment	(# persons/mth)	18,349	19,381	↑	6%	
22	Continuous OUD pharmacotherapy for 180+ days	(% persons/2 yrs)	20.2	26.2	↑	30%	

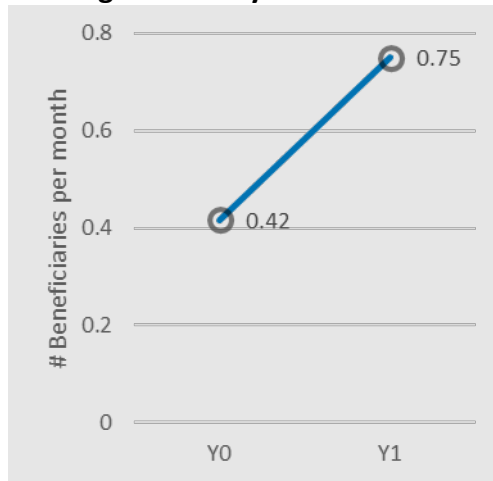
Notes. Baseline corresponds with January 1, 2017 – December 31, 2017 or October 1, 2017 – September 30, 2018 depending on the specific metric. Midpoint is one year post-baseline period. Blue = on target; Orange = not on target; OUD = opioid use disorder; SUD = substance use disorder.

**Figure 1: SUD Services**



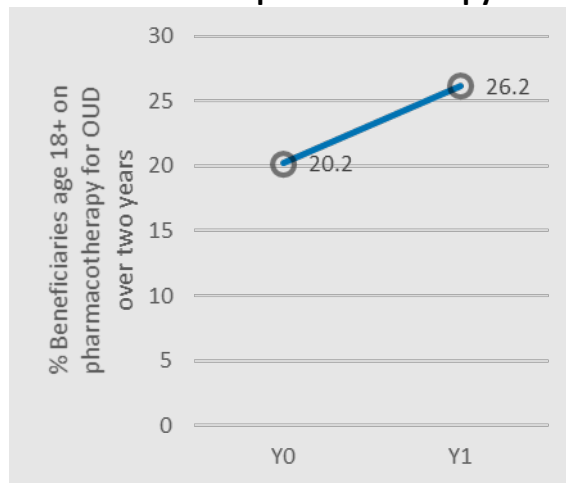
Notes. Y0 = Baseline period (January 1, 2017 – December 31, 2017 or October 1, 2017 – September 30, 2018 depending on the specific metric); Y1 = Midpoint period (one year post-baseline period); Blue = on target; Orange = not on target; SUD = substance use disorder.

**Figure 2: Early intervention**



Notes. Y0 = Baseline period (January 1, 2017 – December 31, 2017 or October 1, 2017 – September 30, 2018 depending on the specific metric); Y1 = Midpoint period (one year post-baseline period); Blue = on target.

**Figure 3: Continuous OUD pharmacotherapy for 180+ days**



Notes. Y0 = Baseline period; Y1 = Midpoint period; Blue = on target; OUD = opioid use disorder.

**Action Items.** Milestone 1 Action Items are summarized in Table 6. Twelve out of thirteen Action Items were completed by the target date. Four of those Action Items were completed ahead of schedule, including: long-term residential (LTR) regulation review (6 months early); submission of the LTR state plan amendment (SPA) to CMS (1 month early); convening the Professional Advisory Committee (PAC) for the peer recovery specialist service (9 months early); and submitting the peer recovery specialist SPA to CMS (1 month early). One Action Item was not on target – drafting regulations for the peer recovery specialist service, which had a target date of July 2019. As of the midpoint, this Item had a status of, “Currently in draft (NJAC 10:66) for next regulation update cycle.”

**Table 6: Milestone 1 Action Items**

Action Items	Target Date	Completion Date	Months	Shown in Interview
			Since Target	
<i>Withdrawal management and short-term rehab</i>				
Review ASAM placement criteria	Jul 2018	Jul 2018	0	
Review current SPA for any needed updates	Jul 2018	Jul 2018	0	
Stakeholder meetings Dec 2017 thru Feb 2018	Feb 2018	Feb 2018	0	
Service Implementation	Jul 2018	Jul 2018	0	
<i>Long-term residential</i>				
Regulation review	Oct 2018	Apr 2018	-6	✓
Submit SPA to CMS	Oct 2018	Sep 2018	-1	✓
Utilization management criteria with IME and DMHAS	Oct 2018	Oct 2018	0	
Service Implementation	Oct 2018	Oct 2018	0	✓
<i>Peer recovery specialist</i>				
Meet with providers and stakeholders (PAC) subcommittee	Sep 2019	Dec 2018	-9	
Fiscal rate setting	Jul 2019	Jul 2019	0	
Submit SPA to CMS	Jul 2019	Jun 2019	-1	
Implement Service	Jul 2019	Jul 2019	0	
Draft Regulations	Jul 2019	In-progress		

Notes. Blue = on target; Orange = not on target. SPA completion date = Date of SPA announcement posted for public comment. SPA typically submitted to CMS 30 days following public comment. ASAM = American Society of Addiction Medicine; CMS = Centers for Medicaid & Medicare Services; IME = Interim Managing Entity; PAC = Professional Advisory Council; SPA = State Plan Amendment.

**Key Informant Comments**

Overall, stakeholders agreed that the O-SUD program has increased access to critical levels of care for OUD and SUD by the midpoint – driven by newly covered services, such as long-term residential services. More work is needed, however, to meet growing demand and to combat long-standing stigma and knowledge gaps regarding OUD/SUD services. COVID-19 likely caused

a dip in access to services, but stakeholders expect demand to rebound and likely increase. Existing concerns regarding insufficient bed capacity may be exacerbated by the pandemic. In this section, we describe the facilitators and barriers to meeting implementation goals for Milestone 1, as well as stakeholders' reflections on the impact of COVID-19 on access to OUD/SUD care.

**Facilitator: Expanded coverage of services due to the Medicaid 1115 demonstration and removal of IMD exclusion**

The Medicaid 1115 demonstration added long-term residential services to the SUD continuum. It also expanded IMD services to include inpatient and withdrawal management. Stakeholders overwhelmingly reported that the expansion of coverage was critical to increasing access to OUD/SUD services and *“changing how we get people treatment.”* (Advocacy representative)

*“The biggest win of the 1115 waiver was the Medicaid individuals can now receive residential treatment.”* (Provider representative)

*“The IMD exclusion was huge... At one time, these Chapter 51 funds\* were all we had. Funds would run out. This was tremendous for us, for inpatients, to have another [funding] source.”* (Provider representative)

Stakeholders remarked that, since LTR service implementation was due October 2018, the midpoint data may not fully capture the impact of LTR coverage expansion, which they expect to be greater in subsequent years. Coverage expansion also resulted in increased availability of services. Participants from the MCOs shared they have found it easier to connect their beneficiaries to the services needed.

*“Previously, the availability of treatment slots was 1 out of 6 would get in. Now that’s improved.”* (MCO/IME representative)

*“Medicaid managed care is perceived as ‘real insurance’ now.”* (MCO/IME representative)

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\* Chapter 51 funds refer to the “Alcohol Education, Rehabilitation and Enforcement Fund” (AEREF). The AEREF is a non-lapsing, revolving trust fund into which \$11 million are deposited annually from a tax on the sale of alcoholic beverages. In order to participate in this county program, each county must develop a plan to deliver comprehensive addiction services across the full continuum of care, including prevention, early intervention, treatment and recovery support, based on a county-sponsored, community-based needs assessment and planning process.

**Facilitator: Increased awareness of OUD/SUD services through efforts by the State, provider organizations, and MCOs**

In order to increase access to OUD/SUD care, stakeholders believed that we need to reduce stigma to OUD/SUD treatment. One way to reduce stigma is to increase public and provider awareness of OUD/SUD services and treatment, as summarized:

*“We have no shortage of prescribers, but prescribers are reluctant to do so because of their comfort level and reluctance to service the population in their practices. There’s a problem at the provider level and societal norms. Additional support and training resources could help mitigate this.”* (MCO/IME representative)

Consumer advocacy group and provider organization stakeholders noted the impact of the State’s OUD/SUD campaigns as a positive start to increasing public and provider awareness.

*“There was increased media campaigns by the State and increased knowledge among providers, which led to increased awareness of SUD services.”* (Provider representative)

Such campaigns sparked these organizations to educate beneficiaries on OUD/SUD services. MCOs, for example, employed staff to directly educate their Medicaid beneficiaries on what services were available and covered.

**Facilitator: Existing infrastructure and processes from previous regulations and LTR programs**

New Jersey had existing OUD/SUD regulations in place as well as LTR programs for private insurers, which provided groundwork to build a program for NJ Medicaid beneficiaries. Stakeholders from the State, in particular, noted that the existing infrastructure helped facilitate completion of many of the Action Items ahead of schedule.

*“The state already had regulations for long-term rehab because it was covered outside of Medicaid, and it could use existing regulations and put it into the Medicaid format.”* (State representative)

*“New Jersey regulations were already developed in accordance with the ASAM criteria, so we were ahead of the game. Reviewing the regulation was not as cumbersome because of that.”* (State representative)

A few MCO stakeholders shared that, prior to the O-SUD program, their providers were already required to use the ASAM criteria for their fee-for-service population. Therefore, they already



had processes in place to expand ASAM training to additional providers and education to their Medicaid members.

**Barrier: Insufficient bed capacity**

While stakeholders commended that the O-SUD program has increased the number of LTR beds, there are still not enough beds to meet the needs of patients, which hinders smooth transitions of care. Provider organizations reported first-hand barriers to locating beds for their patients.

*“There are still lots of people waiting for beds. There’s a perception that there’s no guarantee you can get into a residential treatment center... It would be interesting to compare how wait times for beds have changed too.”* (Provider representative)

Consumer advocacy group and MCO stakeholders have faced similar barriers locating beds, sharing particular examples of shortages for specific client populations, including youths, women, and methadone users.

*“It’s still difficult to get into long-term residential programs. A number of them have closed down, especially on the youth side.”* (Advocacy representative)

*“It’s challenging for our members to access care, especially women. Methadone managed patients also face barriers because residential requires them to be off of methadone first.”* (MCO/IME representative)

Participants from a couple different stakeholder groups noted that some LTR beds are allocated to the criminal justice system, as described:

*“Many of these programs are taken by the courts. It’s not for non-court program patients to get access. Court programs, like drug courts, are in every county. Treatment is a big factor there, where 50-70% of patients have chaotic [substance] use.”* (Advocacy representative)

Therefore, it may be important to consider how beds are allocated while examining bed capacity.

**Barrier: Increasing OUD/SUD rates**

While stakeholders were generally optimistic about seeing increased OUD/SUD service utilization by the midpoint, they noted these trends may be driven by increased rates of OUD/SUD.

*“Increased access to services is a good trend. But is this about access or increased demand? It’s hard to say if this is progress.”* (Provider representative)

One stakeholder’s comment supports the importance of examining disaggregated service data, when possible:

*“I’d actually rather see the trend of any SUD service go up, while inpatient and residential services go down.”* (MCO/IME representative)

Around the country, the use of fentanyl, a synthetic opioid that is 50 to 100 times more potent than morphine, has increased overdose deaths in recent years. Some stakeholders expressed concern regarding how fentanyl may affect volume and types of services needed to treat beneficiaries.

*“Fentanyl has changed things. It’s hard to keep people in treatment now because of fentanyl.”* (Advocacy representative)

#### **COVID-19 Impact: Reduced OUD/SUD services due to pandemic safety protocols and fear**

Looking beyond the midpoint, stakeholders reflected on how access to OUD/SUD treatment has been impacted by the COVID-19 pandemic and the implications for meeting Milestone 1 goals. With NJ being one of the initial pandemic epicenters, all stakeholders noted a huge reduction in OUD/SUD services – for both inpatient and outpatient services – particularly in spring 2020. Facilities had to adopt COVID-19 safety protocols or temporarily close, which reduced access to care across all levels of care.

*“COVID caused a bump, especially in March to May 2020. Facilities were forced to come up with their own COVID guidelines. Some had to close off admittance due to outbreaks. Some had to cut their roster to allow for more social distancing.”* (Advocacy representative)

*“During COVID, it was impossible to get people into shelters. There are also more inpatient residential facilities located in the northern part of the state, fewer in the southern. Transporting people to North Jersey was a challenge heightened by COVID-19.”* (Provider representative)

With lower censuses, stakeholders were also concerned about long-term financial sustainability of facilities that provide OUD/SUD services. However, most stakeholders were cautiously

optimistic that provider organizations and clients will be able to maintain care by leveraging tools such as telehealth.

*“COVID had an impact on the trends, but I think we are still on track to meeting the goals... Now that telehealth is available, services like outpatient services are back on track.”* (State representative)

As facilities re-open for in-person care, there remains concerns about how to safely provide treatment and recovery services, especially if the service relies on peer or group support.

*“How do you safely bring in a person who is COVID+ into a group setting?”* (MCO/IME representative)

### **COVID-19 Impact: Telehealth helped maintain some OUD/SUD services**

Telehealth was used by some facilities to maintain OUD/SUD services through the pandemic. Stakeholders were generally optimistic about the ability of telehealth to expand access to care.

*“I hope that innovations like telehealth continue to help. Telehealth doesn’t require an in-person appointment. We can do an assessment and start the client on meds immediately.”* (Provider representative)

However, as referenced by the provider stakeholder above, telehealth cannot be used by all and may not be appropriate for all.

*“Telehealth is a godsend. There has been almost 100% compliance with treatment. Initially there were issues with logistics, like instructions, [cell phone] minutes, hardware. Now, 80% [of our patients] prefer remote. Some percentage of that does require in-person. Twenty percent are too high risk or cannot be addressed through telehealth. Medicaid should step it up to make sure it [telehealth] works equitably.”* (Provider representative)

*“Telehealth was well-received by consumers with the technical ability to use it, but not everyone has phones. We do advocacy work to try to help people get smart phones, but consumers have restrictive phone plans. They’d have to use personal minutes [to use telehealth].”* (Advocacy representative)

### **COVID-19 Impact: Increased demand for OUD/SUD services**

Finally, stakeholders speculated that COVID-19 will lead to increased demand for OUD/SUD services.

*“Now, there should be a huge spike in people asking for services. Historically, six months after a disaster, there is a spike. We’ll also see more Medicaid benefits requests due to job loss.”* (Advocacy representative)

*“When COVID hit, opioid addicts tried to ride out their withdrawals with alcohol.”* (Provider representative)

It remains unclear the short- and long-term impact of COVID-19 on access to services until more data are available.

### **Overall Risk Assessment**

#### **Milestone 1: Access to Critical Levels of Care for OUD and Other SUDs**

##### **Summary of considerations:**

- Critical Metrics: 7 out of 8 on target (88%)
- Action Items: 12 out of 13 on target (92%)
- Stakeholder feedback: Many facilitators

**Risk assessment for Milestone 1: Low**

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

Milestone 2 is widespread use of the national SUD guidelines for treatment placement, called the ASAM Criteria. Currently, NJ providers assess treatment needs based on SUD-specific, multi-dimensional ASAM assessment tools that reflect evidence-based clinical guidelines. Through the O-SUD program, the Interim Managing Entity (IME) makes initial and continued stay determinations (e.g., in an Institution for Mental Disease [IMD]) based on review of the patient’s DSM 5 diagnosis, the ASAM LOCI-3 assessment tool, and supporting documentation submitted by the provider. By using national SUD guidelines for treatment placement, metrics such as average length of stay can inform whether placement for short-term residential stays are based on ASAM guidelines. This Utilization Management approach ensures that beneficiaries have access to SUD services at the appropriate level of care and that those services are appropriate for the diagnosis and treatment needs of the individual.

### Performance on Monitoring Metrics

**Critical Metrics.** Milestone 2 Critical Metrics are summarized in Table 7 and visualized in Figures 4-5. One out of two Critical Metrics were on target at the midpoint. Between the baseline and midpoint periods, the *number of patients treated in an Institution for Mental Disease (IMD) for SUD* increased by 405%, from an average of 1,638 persons per year to 8,272 persons per year. The directionality of this change was consistent with the State’s target. The Critical Metric that was not on target at the midpoint was *average length of stay in IMDs* (74% increase), increasing from 10.2 days per year to 17.8 days per year.

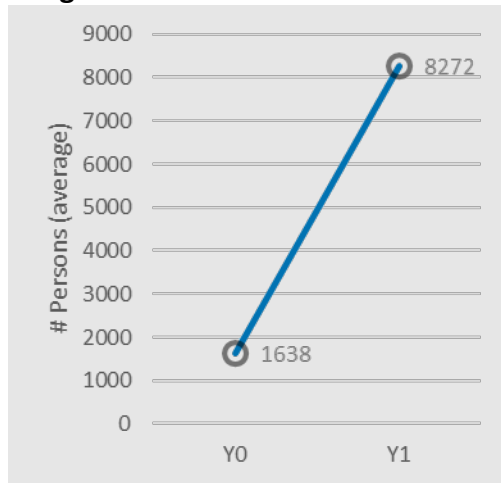
**Action Items.** Milestone 2 Action Items are summarized in Table 8. Five out of six Action Items were completed by the target date. One Action Item was not on target – ASAM training for providers, which was completed 2 months after the target date.

**Table 7: Milestone 2 Critical Metrics**

Metric #	Critical Metric	Unit	Baseline	Midpoint	Target	% Change	Shown in Interview
5	Treated in IMDs for SUD	(# persons/yr)	1,638	8,272	↑	405%	✓
36	Average length of stay in IMDs	(# days/yr)	10.2	17.8	↓	74%	✓

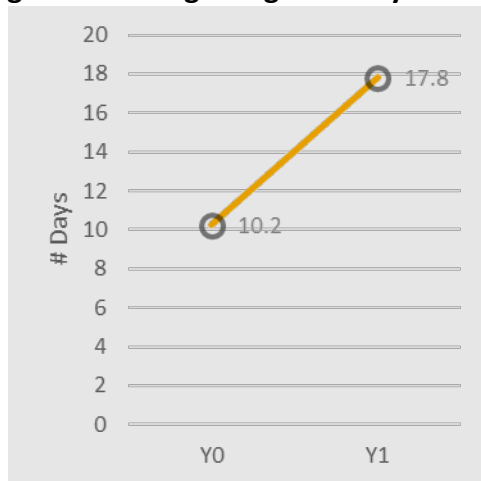
Notes. Baseline corresponds with January 1, 2017 – December 31, 2017 or October 1, 2017 – September 30, 2018 depending on the specific metric. Midpoint is one year post-baseline period. Blue = on target; Orange = not on target; IMD = Institution for Mental Disease; SUD = substance use disorder.

**Figure 4: Treated in IMDs for SUD**



Notes. Y0 = Baseline period (January 1, 2017 – December 31, 2017 or October 1, 2017 – September 30, 2018 depending on the specific metric); Y1 = Midpoint period (one year post-baseline period); Blue = on target; IMD = Institution for Mental Disease; SUD = substance use disorder.

**Figure 5: Average length of stay in IMDs**



Notes. Y0 = Baseline period (January 1, 2017 – December 31, 2017 or October 1, 2017 – September 30, 2018 depending on the specific metric); Y1 = Midpoint period (one year post-baseline period); Orange = not on target; IMD = Institution for Mental Disease.

**Table 8: Milestone 2 Action Items**

Action Items	Target Date	Completion Date	Months Since Target	Shown in Interview
<i>ASAM patient placement criteria</i>				
ASAM trainings for providers	May 2018	Jul 2018	2	✓
Standardize LOCI-3 assessment tool for FFS and MCO	Jul 2018	Jul 2018	0	
Add to MCO contracts	Jul 2018	Jul 2018	0	
Provider and Stakeholder meetings	Feb 2018	Feb 2018	0	
<i>Utilization management approaches</i>				
Implement ASAM criteria with LTR providers	Oct 2018	Oct 2018	0	
Provider and Stakeholder meetings	Feb 2018	Feb 2018	0	

Notes. Blue = on target; Orange = not on target. ASAM = American Society of Addiction Medicine; FFS = Fee-for-Service; LOCI-3 = Level of Care Index-3-Adult; LTR = Long Term Residential; MCO = Managed Care Organization.

### **Key Informant Comments**

The Medicaid 1115 demonstration, particularly expanded coverage of OUD/SUD services, helped move evidence-based practices like the ASAM patient placement criteria into real world practice. Those who used the State-provided ASAM provider trainings reported positive experiences. Building on ASAM principles, many stakeholders discussed ways to better measure successful patient placement, noting that *average length of stay in IMDs* varies by individual patient need and can be difficult to interpret. In this section, we describe the facilitators and barriers to meeting implementation goals for Milestone 2, as well as stakeholders’ reflections on the impact of COVID-19 on evidence-based approaches to patient placement.

#### **Facilitator: Expanded coverage helped organizations adopt evidence-based patient placement**

Stakeholders recounted that expanded coverage under the Medicaid 1115 demonstration facilitated the adoption of evidence-based SUD patient placement. One provider noted that the large increase in patients treated in an IMD for SUD, *“is an indication that the State got it right with the 1115 waiver.”* (Provider representative) Expanded coverage led to new services opening, such as long-term residential treatment. Stakeholders surmised that the increase in the average length of stay resulted from such services being used.

*“The increase in length of stay is not surprising because of the new service that opened up – long-term residential treatment wasn’t open in year 0 [baseline period].”* (State representative)

Expanded coverage also led to provider organizations learning to bill for OUD/SUD services.

*“Counselors started filling out the paperwork appropriately. Counselors were completing the ASAM criteria and submitting them.” (Advocacy representative)*

**Facilitator: State-provided ASAM training helped increase awareness of SUD guidelines**

The State-provided ASAM trainings began two months behind schedule. The delay was due to scheduling, as State organizers wanted to have the author of the ASAM criteria Dr. David Mee-Lee at the training to enhance quality and attendance.

*“It was three, 2-day trainings with 120 providers at each, held throughout the state so that it was accessible to people from North, Central, and South Jersey... There was more interest and applications than we anticipated for the training.” (State representative)*

Provider organizations that participated reported positive experiences with the widespread dissemination and content of the free trainings.

*“The trainings were well-publicized – in emails, from trade associations. They were well-attended and high quality.” (Provider representative)*

Despite the rigorous dissemination campaign, however, some stakeholders from provider and MCO organizations reported that they did not know about the State-provided ASAM trainings. These stakeholders shared that a large volume of their providers were already trained in ASAM prior to the demonstration, so it is possible they did not make note of the State-provided ASAM trainings, as it was not needed at their organizations when offered.

*“The two month delay did not have a negative impact on us since most of our staff previously had trainings. Trainings should be directed to new providers.” (Provider representative)*

**Barrier: The ASAM criteria may not account for the complex needs of all patients**

Stakeholders were generally in favor of the ASAM criteria and evidence-based approaches to patient placement, but many remarked that the ASAM criteria may not account for the complex needs of all patients.

*“The ASAM criteria is evidence-based and fluid, but it has become very structured that it doesn’t capture harm reduction or motivational interviewing.” (Provider representative)*



*“There’s no cookie cutter number that’s appropriate for every member. It doesn’t matter when they go to treatment, as long as they get to treatment. We have to be ready to give the members the tools they need when they leave.”* (MCO/IME representative)

**Barrier: Length of stay is not an indicator of successful patient treatment**

All stakeholders noted that length of stay varies by patient need. From baseline to midpoint, the length of stay increased, which did not surprise stakeholders, given that LTR care was a new service added as part of the O-SUD program – a service which focuses on inpatient care. One stakeholder noted that, while length of stay increased, an average of 17.8 days per year still falls within the State’s goals.

*“Long-term residential treatment is increasing the length of stay, but it’s still below the desired average length of stay, which is less than 30 days.”* (State representative)

Another stakeholder noted the midpoint data trends may not reflect the effects of ASAM trainings, which aim to educate providers on tailoring the care to individual patient needs.

*“ASAM trainings were in 2018 or 2019. Hopefully the 2019 numbers will have better [length of stay] outcomes. We focused on length of stay in IMDs in the trainings. It was a concern of ours. When we converted to the IME from our previous system – the previous system was all providers who submitted requests for 2 week stays. That was not [in line with] ASAM... With ASAM, every individual has their own needs.”* (State representative)

Many stakeholders remarked that length of stay is not an indicator of successful patient treatment and deliberated on how to benchmark it. Some argued that we should not set a directional goal for length of stay. They elaborated that reducing length of stay can reduce costs but does not necessarily improve care for patients.

*“Length of stay is a terrible goal. The guidelines were set by individuals, payers, who don’t understand... The goal should be to extend length of stay and establish the patient more firmly with a treatment and recovery plan. Overdose rates actually increase because tolerance levels drop due to withdrawal. Fentanyl has changed the landscape too.”* (Advocacy representative)

*“For providers, a long length of stay means better success for patients. We need to keep our arms around them as long as possible. For payers, however, a long length of stay is more costly.”* (Provider representative)

Length of stay can be difficult to reduce, as it can be affected by external factors, such as provider scheduling or lack of step-down services for patient transfer.

*“Some units have doctors who only show up one to two times a week, so consumers would have to wait for them and had a longer length of stay.”* (Provider representative)

*“There a shortage of stepdown services to move people from higher to lower levels of care. It’s important – the therapeutic relationship and continuity of care. Some people may need less treatment intensity, but it’s important to keep relationships they’ve built to prevent relapse.”* (Provider representative)

Length of stay data may also be difficult to interpret. As mentioned earlier, stakeholders believe the length of stay increased between baseline and midpoint because LTR care was added to the SUD continuum. To better understand the distribution of various OUD/SUD services to length of stay, stakeholders recommended disaggregating the data by type of service and patient population.

*“Long-term detox might be skewing the data. You may also have a sicker population. You should also look at co-occurring diagnoses and those with a secondary diagnosis of SUD.”* (MCO/IME representative)

### **COVID-19 Impact: Admissions in IMDs likely decreased while need for care increased**

Stakeholders did not have enough data to confirm but speculated that IMD admissions decreased due to COVID-19 safety protocols and fear of the virus. However, they suspected that the need for OUD/SUD services has increased, as psycho-social factors affected by COVID-19 (e.g., job loss and social isolation) may have led to increased OUD/SUD.

*“Treatment numbers probably went down due to COVID precautions. But overdose deaths, alcohol and all substances [used] are increased due to emotions, loss of job, and unstable housing.”* (Provider representative)

*“In March of 2020, there was a mass exodus of parents collecting their children [from residential treatment programs].”* (Provider representative)

For patients admitted into IMDs, COVID-19 safety protocols likely increased the length of stay.

*“COVID decreased the number of people served and increases the length of stay due to quarantine or exposure.”* (Provider representative)

Provider organization stakeholders reported concerns about the financial sustainability of residential programs due to these impacts on IMD admissions. State stakeholders clarified that reimbursements were recently increased to help mitigate those concerns.

*“Admissions probably went down with COVID for residential programs, according to providers. They were looking for financial help. They couldn’t run at capacity. We did give them a rate increase, which helped.”* (State representative)

While IMDs push forward with providing care amidst a pandemic, they have adopted telehealth to help sustain some of their services; however, the future role of telehealth in IMDs and OUD/SUD treatment remains uncertain.

*“IMDs have transitioned to telehealth for most outpatient services. But I’m not sure whether members prefer telehealth or in-person... I am eager to get peer-to-peer services back in place though, which generally works better in-person.”* (MCO/IME representative)

## **Overall Risk Assessment**

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

#### **Summary of considerations:**

- Critical Metrics: 1 out of 2 on target (50%)
- Action Items: 5 out of 6 on target (83%)
- Stakeholder feedback: Mixed

**Risk assessment for Milestone 2: Medium**

## Milestone 3: Residential and ASAM requirements

Milestone 3 is the use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications. SUD and ASAM services are outlined in provider licensing regulations that include provider licensing inspections occurring every two years. NJ has offered voluntary quality reviews to SUD providers to ensure compliance and utilize opportunities for targeted assistance, and ongoing Medicaid audits occur on a quarterly basis. As part of the O-SUD program, the State will look at other credentialing and certification options. Before the program, residential treatment facilities were not required to provide Medication-Assisted Treatment (MAT) service. As part of the program, the State is working to remove the barriers and provide needed supports for this service to be included in residential treatment when clinically necessary.

### Performance on Monitoring Metrics

**Critical Metrics.** This milestone does not have Critical Metrics.

**Action Items.** Milestone 2 Action Items are summarized in Table 9. All six Action Items were completed by the target date.

**Table 9: Milestone 3 Action Items**

Action Items	Target Date	Completion Date	Months Since Target	Shown in Interview
<i>Residential Provider Qualifications</i>				
Crosswalk NJAC 10:161A regulations with ASAM	Mar 2018	Mar 2018	0	
Provider and MCO contracts	Jul 2018	Jul 2018	0	✓
<i>Implement Compliance/Review Process</i>				
Review of DOH (office of CN&L) process for audits	Mar 2018	Mar 2018	0	
Develop Medicaid Audit Process with MACC offices	Jul 2018	Jul 2018	0	
<i>Residential MAT requirement</i>				
Develop Inter-agency workgroup	Jan 2018	Jan 2018	0	
Develop list of barriers and make any changes to policy	Jul 2018	Jul 2018	0	

Notes. Blue = on target. ASAM = American Society of Addiction Medicine; CN&L = Certificate of Need and Licensing; DOH = Department of Health; MACC = Medical Assistance Customer Center; MAT = medication-assisted treatment; MCO = Managed Care Organization; NJAC = New Jersey Administrative Code.

### Key Informant Comments

Stakeholders reported mixed experiences in meeting the residential and ASAM requirements for residential treatment services. Provider and MCO contracts, once executed, were easy to renew; however, initial contracting was challenging and cumbersome for some provider organizations.

MAT has had a slow start, and reception to MAT has been variable. Stakeholders acknowledged that there is value in standardizing SUD and MAT regulations, and there has been promising progress. However, regulations have also made it difficult for providers and facilities to obtain licenses and certifications. In this section, we describe the facilitators and barriers to meeting implementation goals for Milestone 3, as well as stakeholders' reflections on the impact of COVID-19 on the use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications.

### **Facilitator: Provider-MCO contracts help ensure standards are met for residential provider qualifications**

Contracts are now in place between many provider organizations and the five NJ MCOs, which help ensure that standards are met for residential provider qualifications and that beneficiaries can find providers. The MCO stakeholders, who are well-versed in executing provider contracts, reported generally positive experiences getting provider-MCO contracts in place.

*"It's been collaborative and an iterative process. I've been very pleased."* (MCO/IME representative)

*"Initially, MCOs were recruiting providers. This has tapered off, and now providers are reaching out to contract with MCOs. Southern NJ counties are generally lean on [SUD] services."* (MCO/IME representative)

Some provider organization stakeholders similarly reported that contracts were straightforward. A few, however, reported initial difficulties setting up and enforcing contracts.

*"The provider-MCO contracts were cumbersome and challenging... The State also does not enforce its own contracts and requirements."* (Provider representative)

The State noted that difficulties may have stemmed from providers being less familiar with the contracting process, which led to confusion about elements related to contracting, such as how to bill MCOs for services and how to use MCOs to connect patients to other services.

*"The provider enrollment process takes time, especially if there are inaccuracies in the initial application. MCOs have 90 days to process it. But if the provider doesn't submit everything to MCO standards, that can delay enrollment. A provider also needs to apply to each MCO separately... So with 5 MCOs and 1 fee-for-service, that's up to 6 applications."* (State representative)

*“It was challenging training providers on MCOs. They need to understand which individuals were contracted through MCOs and how that process worked... Now, after some time, providers have gotten used to it, but in the beginning, it was difficult.”* (State representative)

These difficulties have attenuated with time, and contract renewals have been relatively easy.

**Facilitator: Support and expertise are available if needed**

On the topics of SUD licensing and MAT certification, some stakeholders reported that their organizations took advantage of local support and expertise to help navigate the O-SUD program. Stakeholders referenced the Northern and Southern Centers of Excellence and Project ECHO programming as examples of helpful resources.

*“It’s great having the Centers of Excellence and coaching.”* (Provider representative)

*“Education was disseminated through Project ECHO programs, like alternative buprenorphine dosing strategies.”* (Provider representative)

**Barrier: The reception to MAT has been highly variable, with a slow start**

Generally, stakeholders were favorable toward adding MAT services to the SUD continuum, acknowledging that it is helpful to offer more options to recovering patients.

*“Adding MAT services is a key part in assisting our members with remaining sober. MAT providers give members another option. It’s a great treatment option while maintaining sobriety and getting their life back in place.”* (MCO/IME representative)

However, they noted that the reception to MAT has been variable across the State and had a slow implementation start. This was observed by participants in all four stakeholder groups.

*“It’s been a slow start. Residential treatment providers offer vivitrol but not methadone or suboxone. It’s slowly changing and moving in the right direction.”* (Provider representative)

*“It’s not going well. Providers are only using suboxone as a detox and not allowing [consumers] to stay on it during treatment... Six to eight programs are still abstinence-based, which is not effective.”* (Advocacy representative)

*“We’ve been underwhelmed by [MAT] treatment quality based on member experiences... The program design theoretically meets standards but not necessarily so in practice. There’s still a gap between Medicaid and privately-insured members.”* (MCO/IME representative)

*“It’s slow moving, but it’s in progress. We lifted the prior authorization requirement for MAT and worked on incentive payments for residential treatment.”* (State representative)

There has been steady progress and “*meaningful shifts*” (Provider representative), but MAT services are not consistently available yet across NJ.

### **Barrier: State regulations has made it difficult to obtain licenses**

Updating NJ’s regulations for OUD/SUD services was a concerted effort by multiple regulating bodies and included workgroups.

*“It was a big move to align standards. Licensing at DOH [Department of Health], lots of lawyers, lots of providers, and associations made recommendations... We had meetings to oversee the goal to make licensing easier.”* (State representative)

While state regulations help standardize the quality of care for patients, many stakeholders found that the state regulations – specifically for licensing and certification – also hindered their abilities to provide OUD/SUD care. The initial response to new regulations was negative, with stakeholders reporting administrative challenges obtaining an SUD facility license, MAT certification, and integrated facility license.

*“Licensing in New Jersey is long and confusing.... Those who want to open a new facility can’t due to these barriers.”* (Advocacy representative)

*“New Jersey state officials are focused on regulations. They’ve actually added barriers to get MAT... There are too many [site] visits that take up time, and the Office of Licensing makes special rules for the use of MAT, claiming it’s done for patient safety.”* (Provider representative)

*“There are still lots of barriers to full integration... The State is just starting to realize that we need to align co-occurring diagnoses with levels of care. There’s cost savings realized when that happens.”* (Provider representative)

Stakeholders also noted that licensing barriers led to difficulties finding and maintaining staff.

*“Standards, though welcomed, made it harder for people with lived experience to work in this field. I’m still concerned that program standards are too rigid, making it difficult, especially now, to hire staff... Workforce is a big problem.”* (Advocacy representative)

*“Having back-up personnel who have ASAM qualifications is difficult and unrealistic.”* (Advocacy representative)

### **Barrier: Reimbursements and incentives for MAT are inadequate**

One barrier to widespread adoption of MAT was inadequate reimbursement and incentives.

*“From a clinical standpoint, the availability of MAT is positive, but there’s a significant cost... Reimbursement rates are not adequate.”* (Advocacy representative)

*“Residential programs have been slow to adopt evidence-based practices like MAT because of a lack of incentives for those facilities to adopt it.”* (MCO/IME representative)

A provider organization stakeholder posited that MAT underutilization may be connected to insufficient reimbursement for integrated care in general.

*“One of the current problems is that Medicaid behavioral health is carved-out of managed care.”* (Provider representative)

### **COVID-19 Impact: Reduced availability of SUD workforce**

Stakeholders reported that COVID-19 had indirect impact on this milestone, as COVID-19 reduced the availability of an already limited SUD workforce. Stakeholders observed that providers and staff who were licensed and certified for SUD and/or MAT left the field or moved to private practice, no longer available to treat Medicaid beneficiaries.

*“The workforce went into private practice, taking care of their own patient panel due to COVID.”* (Advocacy representative)



## ***Overall Risk Assessment***

### **Milestone 3: Residential and ASAM requirements**

#### **Summary of considerations:**

- Critical Metrics: None Available
- Action Items: 6 out of 6 on target (100%)
- Stakeholder feedback: Many barriers

**Risk assessment for Milestone 3:** Medium

## Milestone 4: Sufficient Provider Capacity at Each Level of Care

Milestone 4 is to ensure sufficient provider capacity at each level of care. NJ used data from the Department of Health’s licensing unit to complete a provider capacity study. The study identified individual providers that are licensed to provide SUD services in NJ, including ones that were not involved in NJ FamilyCare. This capacity study assisted the State in identifying gaps in service availability and identified state strategies to engaging new providers to meet the gaps in service.

### Performance on Monitoring Metrics

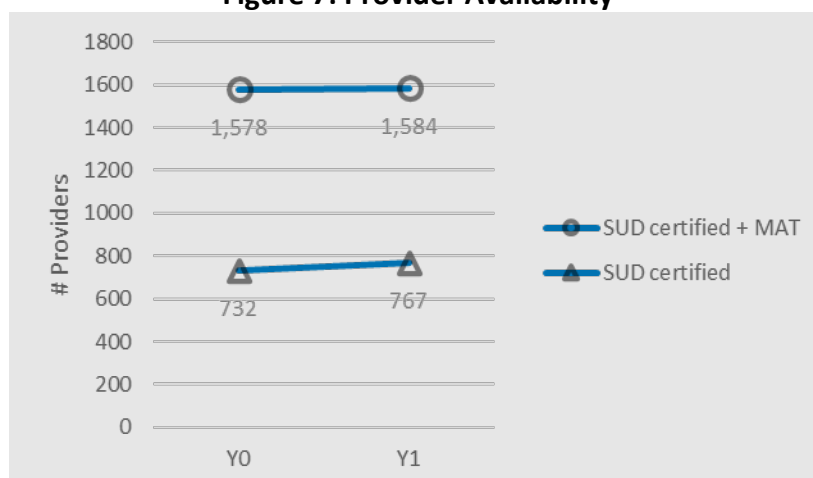
**Critical Metrics.** Milestone 4 Critical Metrics are summarized in Table 10 and visualized in Figure 7. Both Critical Metrics were on target at the midpoint. Between the baseline and midpoint periods, the numbers of *SUD certified providers* and *SUD certified with MAT providers* increased by 5% and 0.4%, respectively. This was an increase of 35 individual providers who are SUD certified and 6 providers who are SUD certified with MAT.

**Table 10: Milestone 4 Critical Metrics**

Metric #	Critical Metric	Unit	Baseline	Midpoint	Target	% Change	Shown in Interview
13	SUD certified	(# providers/yr)	732	767	↑	5%	✓
14	SUD certified + MAT	(# providers/yr)	1,578	1,584	↑	0%	✓

Notes. Baseline corresponds with January 1, 2017 – December 31, 2017 or October 1, 2017 – September 30, 2018 depending on the specific metric. Midpoint is one year post-baseline period. Blue = on target; MAT = medication-assisted treatment; SUD = substance use disorder.

**Figure 7: Provider Availability**



Notes. Y0 = Baseline period (January 1, 2017 – December 31, 2017 or October 1, 2017 – September 30, 2018 depending on the specific metric); Y1 = Midpoint period (one year post-baseline period); Blue = on target; MAT = medication-assisted treatment; SUD = substance use disorder.

**Action Items.** Milestone 4 Action Items are summarized in Table 11. All three Action Items were completed by the target date.

**Table 11: Milestone 4 Action Items**

<b>Action Items</b>	<b>Target Date</b>	<b>Completion Date</b>	<b>Months Since Target</b>	<b>Shown in Interview</b>
<i>Assessment of provider capacity</i>				
Evaluate bed capacities for Residential	Apr 2018	Apr 2018	0	✓
Evaluate provider availability for outpatient	Jul 2018	Jul 2018	0	✓
Submit comprehensive statewide study to CMS	Oct 2018	Oct 2018	0	

Notes. Blue = on target; CMS = Centers for Medicare & Medicaid Services.

**Key Informant Comments**

Stakeholders were not surprised by the small increase in SUD and SUD + MAT providers between the baseline and midpoint periods, citing that it takes time for providers and facilities to obtain licensure and complete necessary trainings. Furthermore, key program initiatives like the Centers of Excellence were implemented in 2018. Stakeholders expect greater changes to SUD workforce supply in subsequent years, though COVID-19 may have slowed workforce growth. The Interim Managing Entity (IME) has maintained a bed and provider registry to support this milestone. While a promising resource, stakeholders have experienced administrative burden and data inaccuracies related to the registries. In this section, we describe the facilitators and barriers to meeting implementation goals for Milestone 4, as well as stakeholders’ reflections on the impact of COVID-19 on ensuring sufficient provider capacity at each level of care.

**Facilitator: Medicaid coverage of SUD services helped attract additional providers**

The Medicaid 1115 demonstration helped expand coverage to additional OUD/SUD services, which attracted additional SUD providers to NJ.

*“As we added more services [to be covered by Medicaid], provider availability went up.”*  
(State representative)

*“Once services became in-network with MCOs, MCOs have been reaching out to providers. It was carved-in to MCOs.”* (MCO/IME representative)

**Facilitator: Program initiatives are expected to increase SUD provider workforce**

Stakeholders noted that there has been *“long-term stigmatization of providers working in treatment centers and with SUD”* (Provider representative), and the O-SUD program and its key

initiatives, such as the Centers of Excellence, have helped reduce stigma through increased awareness and education.

*“The Centers of Excellence started running in 2018, so there should be more updates with MAT after that. And in 2019, there was a push to activate the OBAT [office-based addiction treatment] model.”* (Provider representative)

Reduced stigma and increased education can encourage providers to obtain SUD licensure and MAT certification.

*“We’ll see an increase [in SUD providers] in the next few years of data. Delays in licensing played a significant role, and the number of applications poised for MAT is higher. We’re getting better at it because there’s a better understanding of what MAT is. The crux of the issue is induction and learning what can you do and who can you bill.”* (Provider representative)

**Facilitator: The bed and provider registry is a promising resource to help place beneficiaries**

As part of the O-SUD program, the IME created a registry to track available beds and providers across the State. All stakeholders recognized that the registry is a promising resource, and a few reported positive experiences working with the IME to place patients.

*“The IME is trying to manage capacity, and they’re doing a great job. They collaborate with us, they listen to us. They’re a good source on capacity.”* (Provider representative)

MCO stakeholders noted that the IME serves as a complement to their in-house resources.

*“When it comes to the IME, to my knowledge, I believe that everything in their accounts is accurate with what the providers are giving them... I will say that if we have a member who’s in care management, we try and do the legwork for the member and provide them with providers in that area first. If needed, we give the IME contact to them as a backup.”* (MCO/IME representative)

**Barrier: There is an uneven distribution of SUD providers across state**

Despite the expectation for a steadily growing SUD workforce, stakeholders reported that the distribution of SUD providers is uneven across the State, which makes it difficult for some beneficiaries to access services.

*“I think it’s unbalanced. There are areas with not enough capacity and areas with too much capacity.” (Provider representative)*

*“There are clusters of waived docs and then barren spots. Everything’s in Central Jersey, the Northeast, a little bit around Camden, and Atlantic City maybe a little bit. But really, there’s not a lot in-between... Ocean County has tremendous programs in the Northern part – it’s a very big county. But we struggle with Southern Ocean County... I know Medicaid pays for transportation, but it’s a bus an hour each way.” (Provider representative)*

Stakeholders from the State recognized this barrier and have strategies in place to monitor provider and bed availability with resources through the IME.

*“We monitor the waitlist through the IME to see if people need service or if they’re not able to get it. We try to keep track of that.” (State representative)*

**Barrier: Medicaid reimbursement for SUD services remains inadequate**

While the State has worked extensively to increase provider rates, many stakeholders still perceived Medicaid reimbursement for SUD services as being inadequate. Stakeholders acknowledged, however, that low reimbursement is a national issue.

*“There’s a scarcity of Medicaid providers, and unfortunately, the payment does not match the effort. Medicaid reimbursement for SUD and mental health is a national problem.” (Advocacy representative)*

A few stakeholders raised concerns that lower rates can make it challenging for smaller, non-profit facilities to retain their SUD workforce.

*“Medicaid providers are more likely to be in large systems with more robust services, so they’re more likely to offer SUD and MAT services.” (MCO/IME representative)*

*“For-profit programs are looking for high-end, cash-paying clients. We’re concerned that for-profit motives may lead to understaffing in our facilities.” (Provider representative)*

**Barrier: The initial implementation of the bed and provider registry created administrative burdens and inaccuracies**

As mentioned earlier, the bed and provider registry is a promising resource; however, most stakeholders found that the initial implementation resulted in high administrative burden for

provider organizations. Provider organizations were required to manually report, on a daily basis, the number of available beds and providers to the IME. Several stakeholders reporting staffing issues related to this task.

*“For the system, we have to actively contribute to it. I had to hire additional staff to do the IME and bed stuff.”* (Provider representative)

*“Providers are not often compliant in reporting data in a timely fashion. And I think some of that is related to staffing.”* (MCO/IME representative)

A few noted that the burden has decreased with time, as IME has made improvements to enable streamlined, automated reporting.

*“In the original monitoring system by the IME, I’m pretty sure providers had to send info to two separate systems – the IME and NJSAMS [New Jersey Substance Abuse Monitoring System] – and be responsible for keeping that updated. The new system is a major improvement. It’s not additional work and is part of the existing workflow.”*  
(Provider representative)

*“It has evolved from separate reporting steps to automatic tracking with admission and discharge of clients.”* (State representative)

Stakeholders also reported many experiences in which the bed and provider registry were inaccurate, particularly in the beginning. They posited that this was due to manual reporting and facility-level requirements that cannot be captured by the IME’s database.

*“I’ve had issues with the IME giving me the wrong information on bed availability. Another problem is that consumers can only be referred to one program at a time, and if there is actually no bed open, we have to repeat this all over again.”* (Advocacy representative)

*“Each [facility] has its own screening, so even if there’s a bed open, my patient won’t necessarily get in.”* (Provider representative)

Thus, stakeholders reported contacting facilities directly instead to determine bed and provider availability, which often required building and maintaining relationships with local facilities.

*“My experience with the IME is that the number of beds wasn’t correct. We ended up calling providers directly for availability, especially for members with higher levels of need and ready for detox today.” (MCO/IME representative)*

*“Facilities seem to be holding certain beds for people who show up at their door. Then the IME doesn’t have an accurate bed count, and it makes it harder for them to effectively manage. So there’s a perception among providers that the IME is not actually real-time.” (Provider representative)*

### **COVID-19 Impact: Telehealth waivers enabled SUD providers to expand their reach**

The telehealth waivers, which relaxed originating site requirements among other things, allowed SUD providers to expand their reach, mitigating some of barriers caused by uneven provider distribution.

*“COVID increased the amount of providers due to telehealth and relaxed regulations... Providers can now extend beyond county lines driven by COVID changes because they can see patients from their homes.” (Provider representative)*

### **COVID-19 Impact: The pandemic may have slowed the growth of the SUD workforce**

A common theme across all sectors of healthcare is workforce burnout and early retirement. The stakeholders raised concerns that, even if *“hundreds are entering the workforce, more are leaving”* (Advocacy representative), which may mean that SUD workforce growth has slowed.

*“The seeds were planted long before COVID. We have an aging physician workforce and an aging nursing workforce. I think what COVID did was accelerate the pace of people leaving the field, whether for retirement a bit earlier than anticipated or just leaving the field out of a pure exhaustion. I think the State may find it very difficult to meet its goals in this area as we’re having trouble with overall healthcare workforce.” (Advocacy representative)*

Relatedly, it is possible the pandemic also slowed processes for licensing and certification.

*“There are a number of waivers in place to expedite credentialing, but at the same time, lots of state offices have closed, causing processes to slow.” (MCO/IME representative)*

## ***Overall Risk Assessment***

### **Milestone 4: Sufficient Provider Capacity at Each Level of Care**

#### **Summary of considerations:**

- Critical Metrics: 2 out of 2 on target (100%)
- Action Items: 3 out of 3 on target (100%)
- Stakeholder feedback: Mixed

**Risk assessment for Milestone 4:** Medium



## Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

Milestone 5 is the implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD. NJ has taken significant efforts to address the opioid addiction crisis, including providing education to prescribers, putting in place best practices for opioid prescribers, having pharmacy programs lock certain Medicaid consumers into one pharmacy, and state-wide distribution and education on Naloxone use. Prior to the O-SUD program, payers, including Medicaid, did not have access to the NJ Prescription Monitoring Program (NJMPMP) before making prescription coverage decisions. There is pending state legislation to ensure access to NJMPMP by all payers. There also was no connectivity between the NJMPMP and the NJ Health Information Network. This milestone includes establishing connectivity between the two systems. These are some of the strategies that the State has or will put into place as part of the O-SUD program to continue to address prescription drug abuse and OUD, which aim to result in a reduction in opioid abuse and an increase in appropriate levels of care for individuals with SUD.

### Performance on Monitoring Metrics

**Critical Metrics.** Milestone 5 Critical Metrics are summarized in Table 12 and visualized in Figures 8-10. Two out of three Critical Metrics were on target at the midpoint. Between the baseline and midpoint periods, the percent of *persons with concurrent use of opioids and benzodiazepines* decreased by 6%, from an average of 24.2% of persons per year to 22.7% of persons per year. The directionality of this change was consistent with the State’s target. The number of *emergency department visits for SUD* also decreased by 7%, from an average of 4.7 visits per 1,000 persons per month to 4.4. The Critical Metric change for *use of opioids at high dosage* could not be calculated due to a metric specification change from 120 morphine milligram equivalents (MME) for 90+ consecutive days in CY17 to 90 MME between first opioid fill and the last day of last opioid fill in CY18 and 19.

**Table 12: Milestone 5 Critical Metrics**

Metric #	Critical Metric	Unit	Baseline	Midpoint	Target	% Change	Shown in Interview
18	Use of opioids at high dosage*	(% persons/yr)	7.1	13.4	↓	See note	✓
21	Concurrent use of opioids and benzodiazepines	(% persons/yr)	24.2	22.7	↓	-6%	
23	ED visits for SUD	(# visits /1000 persons-mth)	4.7	4.4	↓	-7%	✓

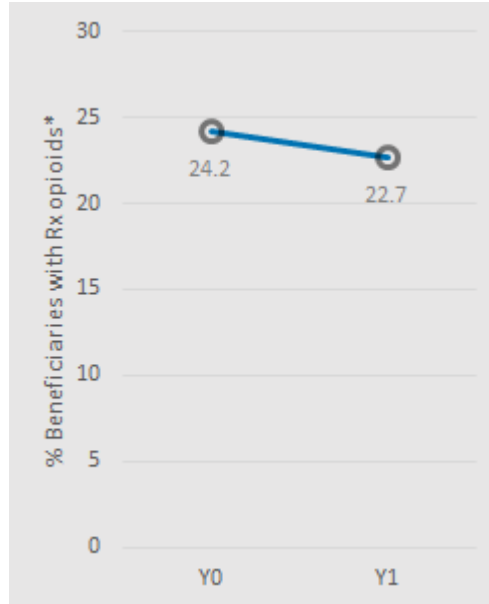
Notes. \* Metric #18 had a metric specifications change between the two time periods, see in-text description. Baseline corresponds with January 1, 2017 – December 31, 2017 or October 1, 2017 – September 30, 2018 depending on the specific metric. Midpoint is one year post-baseline period. Blue = on target; Orange = not on target; ED = emergency department; SUD = substance use disorder.

**Figure 8: Use of opioids at high dosage\***



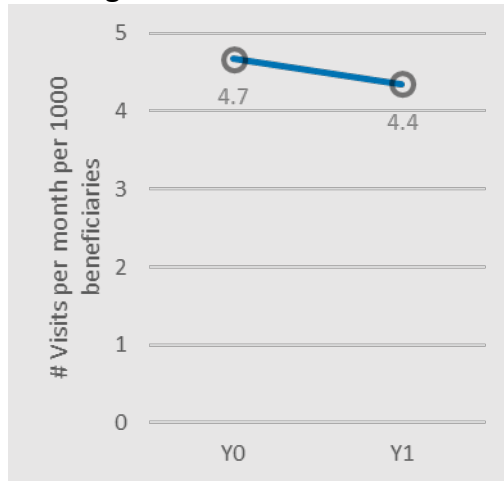
Notes. \* Metric #18 had a metric specifications change between the two time periods that could potentially explain the large change in magnitude, see in-text description. Y0 = Baseline period (January 1, 2017 – December 31, 2017 or October 1, 2017 – September 30, 2018 depending on the specific metric); Y1 = Midpoint period (one year post-baseline period); Rx = prescription.

**Figure 9: Concurrent use of opioids and benzodiazepines**



Notes. Y0 = Baseline period (January 1, 2017 – December 31, 2017 or October 1, 2017 – September 30, 2018 depending on the specific metric); Y1 = Midpoint period (one year post-baseline period); Blue = on target; Rx = prescription.

**Figure 10: ED visits for SUD**



Notes. Y0 = Baseline period (January 1, 2017 – December 31, 2017 or October 1, 2017 – September 30, 2018 depending on the specific metric); Y1 = Midpoint period (one year post-baseline period); Blue = on target; ED = emergency department; SUD = substance use disorder.

**Action Items.** Milestone 5 Action Items are summarized in Table 13. All four Action Items were completed by the target date. The Service Plan Amendment for the opioid overdose recovery program (OORP) and peer services was completed one month ahead of schedule.

**Table 13: Milestone 5 Action Items**

Action Items	Target Date	Completion Date	Months Since Target	Shown in Interview
<i>Opioid overdose recovery program (OORP) and peer services</i>				
Statewide survey of Peer agencies	Jul 2018	Jul 2018	0	
Fiscal rate setting	Jul 2019	Jul 2019	0	
State Plan Amendment	Jul 2019	Jun 2019	-1	✓
Service Implementation	Jul 2019	Jul 2019	0	✓

Notes. Blue = on target. Service Plan Amendment (SPA) completion date = Date of SPA announcement posted for public comment. SPA typically submitted to CMS 30 days following public comment.

**Key Informant Comments**

Stakeholders expect a drop in the use of opioids at high dosage. They were not surprised by the overall decrease in ED visits for SUD and expect COVID-19 to cause first a steeper drop in ED visits followed by an uptick. Many components of the O-SUD program helped reduce opioid prescriptions and ED visits, including: increased education about SUD treatment, increased use of MAT, prescriber access to the NJPMP, more options for alternate treatment, and availability of OORP and peer recovery specialists. While the peer recovery support service has been well-

received, some stakeholders recommend standardization. In this section, we describe the facilitators and barriers to meeting implementation goals for Milestone 5, as well as stakeholders' reflections on the impact of COVID-19 on implementing comprehensive treatment and prevention strategies to address opioid abuse and OUD.

**Facilitator: Education from COEs and MCOs may have helped reduce opioid use and ED visits**

Stakeholders had difficulties interpreting the data on use of opioids at high dosage due to the metric specification change between the two years. Some referenced internal data and others referenced state reports were showed decreased opioid prescribing in NJ. Stakeholders attributed the decrease in opioid prescribing and the reduced ED visits to effective education from the Centers of Excellence (COE) and MCOs.

*"I think setting up the COEs was a great idea. I also think that it's people like Erin Zerbo [COE Director] and Cooper that really made a difference. They've walked the walk. They started doing the education."* (Provider representative)

*"The MCOs have programs in place... to educate prescribers on high doses of opioid prescriptions, which I think is resulting in decreased prescriptions of opioids."* (Advocacy representative)

**Facilitator: MAT services may have helped reduce opioid use and ED visits**

Perhaps as a result of increased education about SUD treatment, stakeholder also reported seeing acceptance and use of MAT services, which they attributed to reduced opioid use and ED visits. Stakeholder cited examples of the use of Naloxone, buprenorphine, and suboxone.

*"The drop in ED visits can be explained by an increased use and access to Naloxone."* (MCO/IME representative)

*"Bridge clinics – Cooper has one, which has x-waivered all their physicians so that they can prescribe buprenorphine. They're set up with an outpatient clinic, where patients can filter in."* (Provider representative)

*"Lots of pain management doctors are using suboxone."* (Provider representative)

The State stakeholders also acknowledged the use of MAT in the corrections system, which has a large volume of beneficiaries with OUD/SUD.

*“The Department of Corrections and county jails did a lot of work. They provided MAT to people while in jail, and then connected them with providers when they leave. This reduced unnecessary utilization of EDs.” (State representative)*

**Facilitator: The NJPMP has potential to support monitoring of opioid prescriptions**

While payers do not have access to the NJPMP yet, prescribers are able to look up the prescription history of their patients. Stakeholders believed that the NJPMP is a potential asset in monitoring opioid prescriptions across the State.

*“Prescription monitoring with HIN [the Health Information Network] is helpful because we’re getting better data. The interoperability of HIN is moving in the right direction. We’re still nascent in maximizing HIN opportunities though before we can get more robust, real-time data.” (Provider representative)*

**Facilitator: Alternate options for treatment, OORP, and peer recovery specialists may have helped reduce ED visits**

The O-SUD program has expanded services available and covered for SUD care, and stakeholders highlighted that there are several alternate options to the ED.

*“There are a lot of alternate options for clients now to get assistance with their SUD, like recovery centers or going straight to treatment programs. They don’t have to go to the ED.” (Advocacy representative)*

In addition, stakeholders reported very positive experiences with the OORP and peer recovery support services, which serve as support systems to divert beneficiaries from the ED into alternate services. The peer recovery support services became a Medicaid covered benefit on July 1, 2019.

*“These are great programs because they’re a valuable component, particularly for the Medicaid population. Wrap around services are important.” (MCO/IME representative)*

*“I couldn’t be happier with OORP... They’re saving lives are doing a great job.” (Provider representative)*

*“Peer services is the best thing to have happened, and we’re able to bill for them now.” (Provider representative)*

**Barrier: Peers are not standardized**

While the peer recovery support service has been well-received by most stakeholders, some shared concerns that the program is not standardized – resulting in a wide range of quality and inconsistent experiences for beneficiaries.

*“There’s no verifiable way to see if a peer is sober and remains sober and how much time they’ve remained in recovery... There’s also struggles with professionalism, struggles that some of our peers have relapsed with patients.”* (Provider representative)

A few stakeholders noted that peers are not always be effective at producing the desired outcome, which is to connect beneficiaries to appropriate treatment.

*“I am a fan of both programs [OORP and peer recovery support services], and I think that they do an amazing job of engaging people for the moment that they have them. But it doesn't always translate into people being in treatment. Fact of the matter is, the numbers are abysmal when it comes to the actual folks who go to treatment as a result, or it's the revolving door kind of thing.”* (Provider representative)

*“I like the idea behind these programs... But they’re good at making initial contact, less successful at connecting people to treatment. I’d hate to see them stop though because there’s potential that may not have been realized.”* (Advocacy representative)

Stakeholders recommended more stringent supervision of peers to help standardize the service and reach O-SUD program goals.

*“The value of peers is tremendous because of their lived experience, but at the same time, they need to be properly supervised because they’re working with a very vulnerable population.”* (Provider representative)

**COVID-19 Impact: Peers certifications were delayed**

As the State continues to refine its peer recovery support program, stakeholders noted that there may be some delay in building the peer workforce, as the pandemic reportedly delayed peers in obtaining their certifications.

*“Peers were definitely affected by COVID... They couldn't get the hours they needed for the certification because of COVID, so we had a major problem with not having enough peers out there. So we extended it a couple times to try and get more.”* (State representative)

### **COVID-19 Impact: ED visits dropped initially but will uptick**

Finally, stakeholders noted that ED visits likely dropped significantly at the height of the pandemic, when EDs were limiting capacity. However, stakeholders pointed out that social factors may have led to increased OUD/SUD during the pandemic. Furthermore, many SUD treatment centers were closed, which may lead to an uptick in ED visits.

*“There was a lack of services during the pandemic, so I assume perhaps ED visits have increased actually because people couldn’t go anywhere else.”* (Provider representative)

*“These numbers are going to continue [to increase] for some time. Remember that, included in this is you’ve got all of these home and household issues, you’ve got job market issues, and all of these issues that folks are facing are starting to compound. The only good news in all of this is that if kids had remained in a classroom, they would have had more access [to opioids and substances].”* (Advocacy representative)

## **Overall Risk Assessment**

### **Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD**

#### **Summary of considerations:**

- Critical Metrics: 2 out of 3 on target (67%)
- Action Items: 4 out of 4 on target (100%)
- Stakeholder feedback: Many facilitators

**Risk assessment Milestone 5:** Medium

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

Milestone 6 is improved care coordination and transitions between levels of care. Before the program, within the Medicaid State Plan, there was no case management or peer recovery support service available to individuals with an SUD in any level of care.\* Case management and peer support services aim to increase the rate of alcohol or drug treatment initiation and importantly, sustained engagement in treatment. The program provides coverage of these services by grants and Federal Block Grant dollars within the state-funded services until the establishment of the benefit for Medicaid beneficiaries with SUD. The peer recovery support service became a Medicaid covered benefit on July 1, 2019.

### Performance on Monitoring Metrics

**Critical Metrics.** Milestone 6 Critical Metrics are summarized in Table 14 and visualized in Figures 11-15. Ten out of thirteen Critical Metrics were on target at the midpoint. Between the baseline and midpoint periods, the greatest increases were for *alcohol or drug treatment engagement*, particularly other alcohol (99% increase) and other substances (115% increase). The directionalities of these changes were consistent with the State’s targets. The three Critical Metrics that were not on target were related to *follow-up care post emergency department (ED) visit for mental illness* (1% decrease for follow-up within 7 days; 1% decrease for follow-up within 30 days) and *readmissions among beneficiaries with SUD* (5% increase).

**Table 14: Milestone 6 Critical Metrics**

Metric #	Critical Metric	Unit	Baseline	Midpoint	Target	% Change	Shown in Interview
15	<i>AOD treatment initiation</i>						
15	Alcohol	(% persons/yr)	36.6	39.4	↑	8%	
15	Opioid	(% persons/yr)	58.6	61.7	↑	5%	
15	Other	(% persons/yr)	42.1	44.8	↑	7%	
15	Any	(% persons/yr)	41.1	44.7	↑	9%	✓
15	<i>AOD treatment engagement</i>						
15	Alcohol	(% persons/yr)	5.8	11.6	↑	99%	
15	Opioid	(% persons/yr)	17.1	25.2	↑	47%	
15	Other	(% persons/yr)	6.8	14.7	↑	115%	
15	Any	(% persons/yr)	9.4	16.2	↑	73%	✓
17	<i>Follow-up care post ED visit for alcohol or opioid use disorder</i>						

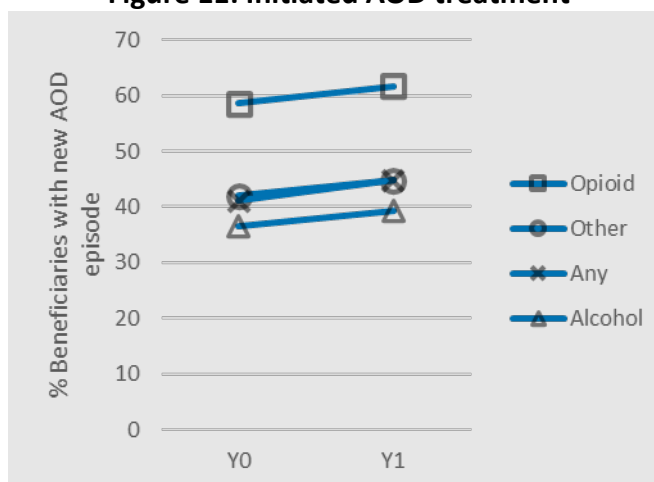
\* Case management was a service provided by MCOs to special populations (MLTSS, DDD, and FIDE-SNP) with integrated physical and behavioral healthcare and youth with behavioral health needs served by the Children’s System of Care could also receive case management.



Metric #	Critical Metric	Unit	Baseline	Midpoint	Target	% Change	Shown in Interview
17	Within 7 days	(% ED visits/yr)	12.4	14.9	↑	20%	✓
17	Within 30 days	(% ED visits/yr)	16.7	20.7	↑	24%	
17	<i>Follow-up care post ED visit for mental illness</i>						
17	Within 7 days	(% ED visits/yr)	61.9	61.3	↑	-1%	✓
17	Within 30 days	(% ED visits/yr)	70.5	70.1	↑	-1%	
25	Readmissions among beneficiaries with SUD	(% persons/yr)	17.7	18.6	↓	5%	

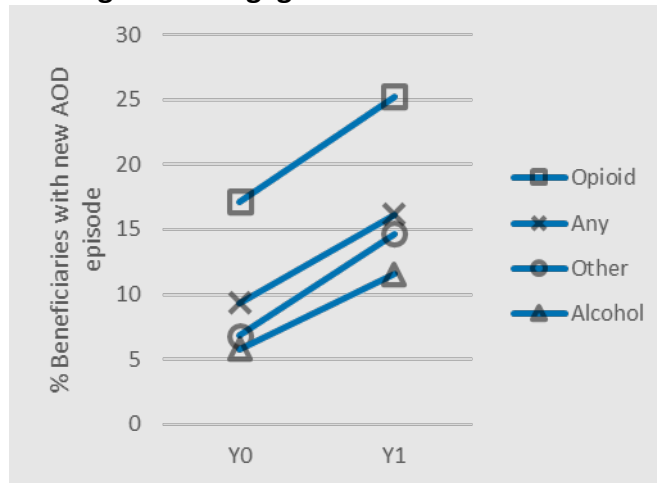
Notes. Baseline corresponds with January 1, 2017 – December 31, 2017 or October 1, 2017 – September 30, 2018 depending on the specific metric. Midpoint is one year post-baseline period. Blue = on target; Orange = not on target; AOD = alcohol or drug; ED = emergency department; SUD = substance use disorder.

**Figure 11: Initiated AOD treatment**



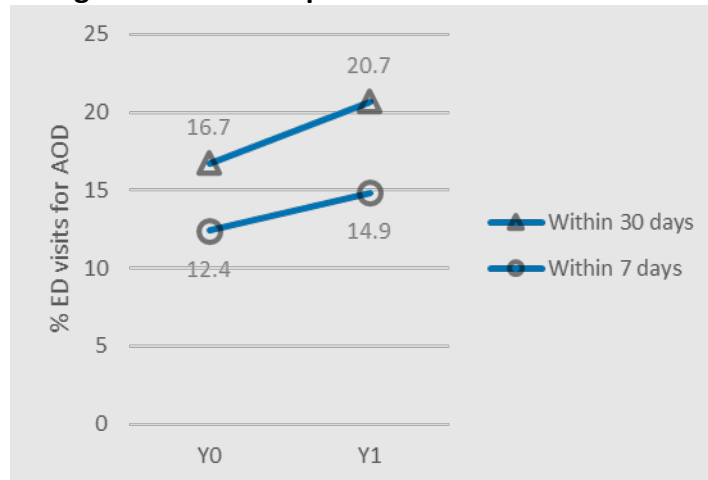
Notes. Y0 = Baseline period (January 1, 2017 – December 31, 2017 or October 1, 2017 – September 30, 2018 depending on the specific metric); Y1 = Midpoint period (one year post-baseline period); Blue = on target; AOD = alcohol or drug.

**Figure 12: Engaged with AOD treatment**



Notes. Y0 = Baseline period (January 1, 2017 – December 31, 2017 or October 1, 2017 – September 30, 2018 depending on the specific metric); Y1 = Midpoint period (one year post-baseline period); Blue = on target; AOD = alcohol or drug.

**Figure 13: Follow-up care after ED visit for AOD**



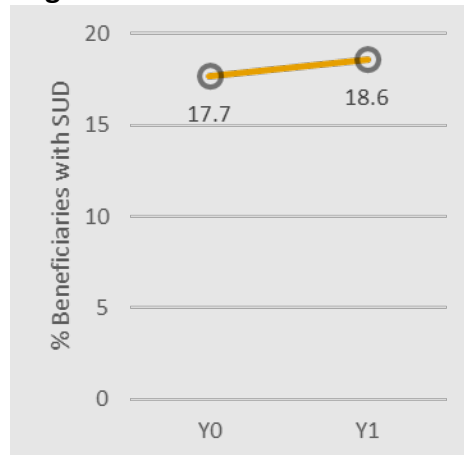
Notes. Y0 = Baseline period (January 1, 2017 – December 31, 2017 or October 1, 2017 – September 30, 2018 depending on the specific metric); Y1 = Midpoint period (one year post-baseline period); Blue = on target; AOD = alcohol or drug; ED = emergency department.

**Figure 14: Follow-up care after ED visit for mental illness**



Notes. Y0 = Baseline period (January 1, 2017 – December 31, 2017 or October 1, 2017 – September 30, 2018 depending on the specific metric); Y1 = Midpoint period (one year post-baseline period); Orange = not on target; ED = emergency department.

**Figure 15: All-cause readmissions**



Notes. Y0 = Baseline period (January 1, 2017 – December 31, 2017 or October 1, 2017 – September 30, 2018 depending on the specific metric); Y1 = Midpoint period (one year post-baseline period); Orange = not on target.

**Action Items.** Milestone 6 Action Items are summarized in Table 15. Four out of five Action Items were completed by the target date. One of those Action Items were completed ahead of schedule: convening the Professional Advisory Committee (PAC) for the peer recovery specialist service (1 month early). One Action Item was not on target – drafting regulations for the peer recovery specialist service, which had a target date of July 2019. As of the midpoint, this Item had a status of, “Currently in draft (NJAC 10:66) for next regulation update cycle.”

**Table 15: Milestone 6 Action Items**

Action Items	Target Date	Completion Date	Months Since Target	Shown in Interview
<i>Peer recovery specialist</i>				
Meet with providers and stakeholders (PAC) subcommittee	Jul 2019	2017-present		✓
Fiscal rate setting	Jul 2019	Jul 2019	0	
Submit SPA to CMS	Jul 2019	Jun 2019	-1	✓
Implement Service	Jul 2019	Jul 2019	0	✓
Draft Regulations	Jul 2019	In-progress		

Notes. Blue = on target; Orange = not on target. SPA completion date = Date of SPA announcement posted for public comment. SPA typically submitted to CMS 30 days following public comment. CMS = Centers for Medicaid & Medicare Services; PAC = Professional Advisory Council; SPA = State Plan Amendment.

**Key Informant Comments**

Many components of the O-SUD program have enhanced care coordination and transitions of care across NJ. The opioid overdose recovery program (OORP), the peer recovery support services, the IME, and MAT services are believed to have contributed to improvements in treatment initiation, treatment engagement, and follow-up after ED visits. PAC committee meetings allow this type of work to keep advancing. There is still work to be done to improve mental health treatment, however, with stakeholders recommending more focus on patients with co-occurring diagnoses. The COVID-19 pandemic is expected to have increased need for OUD/SUD services, in part due to the inability of peers to work as effectively via telehealth compared to in-person. In this section, we describe the facilitators and barriers to meeting implementation goals for Milestone 6, as well as stakeholders’ reflections on the impact of COVID-19 on improved care coordination and transitions between levels of care.

**Facilitator: OORP, peer recovery support services, and the IME have helped link consumers to treatment**

Stakeholders believed that O-SUD program components helped link consumers to treatment. OORP was expanded as part of the program, alongside the peer recovery support services, which became a Medicaid covered service. Both were cited as contributing to improvements in treatment initiation, treatment engagement, and follow-up after ED visits.

*“These positive trends are a result of the OORP program and expansion of peer services. The OORP program was already here before but expanded statewide in 2017.” (Provider representative)*

*“Peers reassure members of the value of treatment programs, and they remind members of their own self-efficacy.” (MCO/IME representative)*

*“Peers was something that started early. We read about it, and there was evidence from DMHAS programs that this is what was wanted and effective. We met with stakeholders in the PAC, and there was a lot of interest.” (State representative)*

Stakeholders also acknowledged the role of the IME in care coordination and care management.

*“The IME also calls consumers to keep them engaged, and they call providers for consumers who are in detox.” (MCO/IME representative)*

#### **Facilitator: MAT services may help reduce ED visits**

Some stakeholders reviewed the ED visit trends and suggested that MAT services were helping to mitigate ED visits and increase treatment in specialized facilities.

*“Doctors have lots of power in turning the tide... What’s happening now is helping with [treatment] engagement. For example, an overdose individual who goes to the ED is administered Narcan. That agitation causes them to leave ED before getting connected to an appropriate treatment program. Now, buprenorphine is given to reduce agitation. We need doctors to come on board to administer MAT while the patient is in ED.” (Provider representative)*

#### **Facilitator: PAC subcommittee meetings were a valuable forum**

As part of this milestone, the State convened PAC committee meetings, with one subcommittee focused on the peer recovery support service. Not all stakeholders were a part of this subcommittee, but generally, they reported that PAC meetings were a valuable forum for identifying barriers and solutions, with opportunity for input from both frontline staff and leadership.

*“The PAC meetings have a subcommittee for peers. There were initially lots of glitches in billing and the enrolling system, which the subcommittee worked on to help improve.” (State representative)*

#### **Barrier: Investment in mental health access has been less than SUD access**

What remains a challenge in NJ is that we need more investment in mental health, according to stakeholders. The O-SUD program by design focuses first on expanding SUD access. The program

and stakeholders recognize the need to address the co-occurring role of mental illness in SUD treatment.

*“The co-occurring gap remains a significant issue. Kids and people are waiting in the psychiatric ED for days or even weeks waiting to go to the hospital.” (MCO/IME representative)*

While the State is working toward increasing mental health access, at the midpoint, stakeholders reported areas for improvement, such as providing specialized mental health training for OORP and peers.

*“The downward trend for mental illness follow-up might be due to lack of training in mental illness for peers.” (Provider representative)*

*“Recovery coaches are not mental health people. Rather, they’re trained in substance use.” (Provider representative)*

#### **COVID-19 Impact: Peer recovery specialists were not as effective via telehealth**

Stakeholders expressed concerns that COVID-19 has increased the need for OUD/SUD services, which may then increase the need for support systems, such as peer recovery specialists. Stakeholders noted that some peers transitioned to telehealth, but they believed peers were not as effective via telehealth as compared to in-person.

*“Peers are face-to-face. It just doesn’t work as well with telehealth because they need to motivate them. Peers were definitely affected by COVID.” (State representative)*

*“Human connection is essential in recovery from SUD. Outcomes improved initially but declined. I think people also just got tired of video conferencing.” (Provider representative)*

## ***Overall Risk Assessment***

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

#### **Summary of considerations:**

- Critical Metrics: 10 out of 13 on target (77%)
- Action Items: 4 out of 5 on target (80%)
- Stakeholder feedback: Many facilitators

**Risk assessment for Milestone 6:** Low

## Key Informant Overall Recommendations

Considering the six demonstration milestones, stakeholders provided the following overall recommendations that they believed may help the O-SUD program meet its goals, while mitigating risks identified in the early years of the demonstration. These recommendations aim to help the State of NJ improve OUD/SUD care for its Medicaid beneficiaries.

1. Increase reimbursements and incentives for Medicaid SUD services, including a carve-in of behavioral health services in MCOs, which would help attract and retain an SUD workforce.
2. Add halfway houses to the SUD continuum and coverage to ensure better care transitions for recovering patients.
3. Increase bed capacity for residential programs, particularly in geographic areas with identified insufficient supply.
4. Allow for more flexibility of the billing system, licensing, and referrals to align with the complex needs of the vulnerable patient population.
5. Breakdown the average length of stay measures to better understand needs of specific patient populations in different settings.
6. Streamline provider enrollment to enhance MCO and provider collaborations.
7. Streamline the integrated licensure process to reduce barriers to providing integrated treatment.
8. Expand the peer recovery support services program by standardizing program requirements, connecting peers more to the community, and reviewing education requirements that may prohibit potentially qualified individuals from serving as a peer.
9. Continue to offer provider education to increase awareness and reduce stigma of OUD/SUD services.



## Discussion

During the first three years of O-SUD Program, the State made significant progress toward advancing OUD/SUD services for NJ Medicaid beneficiaries. At the midpoint, the State was on target to achieve targets for the majority of the demonstration monitoring metrics (i.e., Critical Metrics) and Action Items. All Action Items that were due by the midpoint were completed for Milestones 3, 4, and 5. Stakeholders reported numerous external and internal factors that facilitated the implementation process, though there were barriers as well. Taken together, the risk assessment at midpoint for the NJ O-SUD Program is low-medium for not meeting demonstration milestones.

There is a lot to be learned from the progress of each milestone to ensure that all milestones are met by the end of the demonstration period. Considerations of stakeholder recommendations may help mitigate identified risks and address potential upcoming challenges due to the COVID-19 public health emergency – to ensure access to high-quality care for NJ beneficiaries. Table 16 summarizes the midpoint risk assessments for each milestone. The assessment draws upon criteria from CMS (see Table 4), and details on the considerations for each milestone are in the corresponding chapter. At the midpoint, Milestones 1, 5, and 6 were at low risk, and Milestones 2, 3, and 4 were at medium risk.

**Table 16: Overall Risk Assessment at Midpoint**

Milestone	Critic Metrics On Target	Action Items On Target	Stakeholder Feedback	Risk Assessment
1. Access to Critical Levels of Care for OUD and Other SUDs	7 out of 8 (88%)	12 out of 13 (92%)	Many facilitators	Low
2. Use of Evidence-Based, SUD-Specific Patient Placement Criteria	1 out of 2 (50%)	5 out of 6 (83%)	Mixed	Medium
3. Residential and ASAM requirements	Not applicable	6 out of 6 (100%)	Many barriers	Medium
4. Sufficient Provider Capacity at Each Level of Care	2 out of 2 (100%)	3 out of 3 (100%)	Mixed	Medium
5. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD	2 out of 3 (67%)	4 out of 4 (100%)	Many facilitators	Low
6. Improved Care Coordination and Transitions between Levels of Care	10 out of 13 (77%)	4 out of 5 (80%)	Many facilitators	Low
Overall	22 out of 28 (79%)	34 out of 37 (92%)	Mixed	Low-Medium

Efforts were particularly successful in Milestone 1 “Access to critical levels of care for OUD/SUD services,” Milestone 5 “Implementation of Comprehensive Treatment and Prevention

Strategies to Address Opioid Abuse and OUD,” and Milestone 6 “Improved care coordination and transitions between levels of care.” These three milestones were facilitated by the Program’s multi-faceted components, including expanded Medicaid coverage to the SUD continuum, improved education of providers on SUD (including the ASAM criteria and MAT services), establishment of the Centers of Excellence, and expansion of support structures (including OORP, peer recovery support services, and the Interim Managing Entity). Some changes, such as the 4% reduction in intensive outpatient and partial hospitalization services may also be explained by substitution of services, in which individuals who would have previously been admitted to ASAM 2 level care are now able to use residential services.

The COVID-19 pandemic may have hindered some of these components due to reduction in facility capacity and staffing, but the groundwork laid holds promise in the ability of the program to adapt. Opioid prescriptions overall and within NJ Medicaid began to decline even before the State passed a 2017 law restricting prescriptions (Agrawal et al. 2019b). In 2018, NJ providers wrote 38.9 opioid prescriptions for every 100 persons, compared to the average U.S. rate of 51.4 prescriptions. This is the lowest rate in the State since data became available in 2006 (U.S. Centers for Disease Control and Prevention 2019; NIDA 2020). The NJ Attorney General’s monitoring shows that overall opioid prescription numbers have continued to decrease (NJ OAG 2021). With regard to treatment, an Urban Institute analysis showed growth in the percentage of substance use treatment facilities in NJ offering OUD pharmacotherapy from 49% in 2018 to 56% in 2019 (Clemans-Cope, Winisky, and Epstein 2020), and an analysis of medication-assisted treatment and naloxone in NJ Medicaid found increases in outpatient prescriptions from 2015 to 2018 (Agrawal et al. 2019a).

Three milestones were rated at medium-risk. The assessment score for Milestone 2, “Use of Evidence-Based, SUD-Specific Patient Placement Criteria,” was driven mostly by the *Average Length of Stay in IMDs* Critical Metric. This Metric trended in the opposite direction as the State’s goal; however, stakeholder feedback revealed some concern about the appropriateness of this Metric for assessing appropriateness of patient placement. The average length of stay is a complicated measure that does not account for variation in individual patient needs. Furthermore, stakeholders wished to see differences in the average length of stay by setting. Stakeholders also highlighted that, as residential treatment services were added to the SUD continuum of coverage, it was not surprising that the average length of stay increased, as more complex patients were entering the residential treatment settings.

The assessment score for Milestone 3, “Residential and ASAM requirements,” was driven mostly by stakeholder feedback. While the monitoring metrics and implementation Action Items were on track to meeting goals, progress for this milestone may be hindered by administrative barriers to obtaining licenses and certifications and establishing MCO-provider contracts. Stakeholders who reported these barriers acknowledged that careful implementation of licensure, certifications, and contracts are necessary to establishing high standards of OUD/SUD

care; however, these measures make it more challenging for interested and qualified parties to provide services that are in demand. Licensing barriers were documented in a comprehensive report in 2016 (Jacobi, Ragone, and Greenwood 2016). The NJ Department of Health has also published a guide to help clarify licensing requirements by facility type; this guide was created at the request of the stakeholder group on licensing integration (NJ DOH n.d.).

Finally, the medium-risk assessment for Milestone 4, “Sufficient Provider Capacity at Each Level of Care,” was driven by stakeholder reports of administrative complications related to the bed and provider registry – one of the key Action Items to understanding provider capacity. While stakeholders noted that this registry holds exceptional promise, at the midpoint, they noted several areas for improvement. The daily, manual reporting was a heavy burden upon provider organizations. Furthermore, many stakeholders did not use the registry, having experienced that the data are not reliable, in part due to the complexities of SUD facility requirements. Stakeholders noted recent improvements; however, it remains to be seen whether the registry serves as a useful resource beyond the midpoint.

Some of the potential barriers identified at this midpoint could be resolved over the longer term. For instance, the uneven distribution of providers across the state was being addressed by the shift towards telehealth, a trend that we expect to continue. Providers may adapt over time to the reporting burdens relating to registries. Some of the benefits may also become apparent over the longer term. For instance, as stakeholders noted, the midpoint trends may not yet reflect the beneficial effects of ASAM training on consumers.

### ***Limitations***

Our assessment has some limitations. First, the monitoring metrics used were State-reported, aggregated, quantitative data. While external factors, such as geographic region and treatment setting are known to contribute to O-SUD program implementations (e.g., Grunditz et al. 2020), these stratifications of the monitoring metrics were out of the scope of NJ’s Monitoring Protocol and not available for this assessment. Second, Metric #18 which is part of Milestone 5 had a significant metric specification change between the baseline and midpoint time periods. This resulted in the two data points being difficult to compare and potentially conflated the progress of this milestone. Future monitoring metrics should aim to keep specifications as consistent as possible. Third, while the qualitative interviews were confidential, due to the nature of the topic, it is possible that participants may have felt inclined to report more favorable experiences. We took steps to minimize bias by using a semi-structured interview guide and interviewers who had no prior relationship to the project. Alternative approaches that would ensure anonymity, such as a survey, may have resulted in different or additional insights. Finally, while stakeholders were asked to comment on the impact of COVID-19 on meeting program goals, many comments were speculative (i.e., there is limited data to confirm) and limited to the stakeholder’s scope and changing safety protocols.



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# Appendix

## Appendix A: Baseline Period and Implementation Period of Critical Metrics

Monitoring Protocol Metric #	Metric	Metric Definition	Measurement Period	Baseline	Implementation
<b>Milestone 1. Access to critical levels of care for OUD and other SUDs</b>					
6	Any SUD Treatment	Number of beneficiaries enrolled in the measurement period receiving any SUD treatment service, facility claim, or pharmacy claim during the measurement period	Month	Oct 2017 – Sep 2018	Oct 2018 – Sep 2019
7	Early Intervention	Number of beneficiaries who used early intervention services (such as procedure codes associated with SBIRT) during the measurement period	Month	Oct 2017 – Sep 2018	Oct 2018 – Sep 2019
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	Month	Oct 2017 – Sep 2018	Oct 2018 – Sep 2019
9	Intensive Outpatient and Partial Hospitalization Services	Number of beneficiaries who used intensive outpatient and/or partial hospitalization services for SUD (such as specialized outpatient SUD therapy or other clinical services) during the measurement period	Month	Oct 2017 – Sep 2018	Oct 2018 – Sep 2019
10	Residential and Inpatient Services	Number of beneficiaries who use residential and/or inpatient services for SUD during the measurement period blank	Month	Oct 2017 – Sep 2018	Oct 2018 – Sep 2019
11	Withdrawal Management	Number of beneficiaries who use withdrawal management services (such as outpatient, inpatient, or residential) during the measurement period	Month	Oct 2017 – Sep 2018	Oct 2018 – Sep 2019
12	Medication Assisted Treatment	Number of beneficiaries who have a claim for MAT for SUD during the measurement period blank	Month	Oct 2017 – Sep 2018	Oct 2018 – Sep 2019
22	Continuity of Pharmacotherapy for Opioid Use Disorder	Percentage of adults 18 years of age and older with pharmacotherapy for OUD who have at least 180 days of continuous treatment	Year	Jan 2016 – Dec 2017	Jan 2017 – Dec 2018
<b>Milestone 2. Use of evidence-based, SUD-specific patient placement criteria</b>					
5	Medicaid Beneficiaries Treated in an IMD for SUD	Number of beneficiaries with a claim for residential or inpatient treatment for SUD in IMDs during the measurement period	Year	Oct 2017 – Sep 2018	Oct 2018 – Sep 2019
36	Average Length of Stay in IMDs	The average length of stay for beneficiaries discharged from IMD inpatient/residential treatment for SUD	Year	Oct 2017 – Sep 2018	Oct 2018 – Sep 2019
<b>Milestone 4. Sufficient provider capacity at each level of care</b>					
13	SUD Provider Availability	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period	Year	Oct 2017 – Sep 2018	Oct 2018 – Sep 2019

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	Year	Oct 2017 – Sep 2018	Oct 2018 – Sep 2019
<b>Milestone 5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD</b>					
18	Use of Opioids at High Dosage in Persons Without Cancer	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.	Year	Jan 2017 – Dec 2017	Jan 2018 – Dec 2018
21	Concurrent Use of Opioids and Benzodiazepines	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	Year	Jan 2017 – Dec 2017	Jan 2018 – Dec 2018
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	Month	Oct 2017 – Sep 2018	Oct 2018 – Sep 2019
27	Overdose Deaths (rate) <sup>2</sup>	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).	Year	Jan 2017 – Dec 2017	Jan 2018 – Dec 2018
<b>Milestone 6. Improved care coordination and transitions between levels of care</b>					
15	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Percentage of beneficiaries age 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who received the following: <ul style="list-style-type: none"> <li>• Initiation of AOD Treatment—percentage of beneficiaries who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis</li> <li>• Engagement of AOD Treatment—percentage of beneficiaries who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit</li> </ul>	Year	Jan 2017 – Dec 2017	Jan 2018 – Dec 2018
17(1)	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence	Percentage of ED visits for beneficiaries age 18 and older with a principal diagnosis of AOD abuse or dependence who had a follow-up visit for AOD abuse or dependence. Two rates are reported: <ul style="list-style-type: none"> <li>• Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days)</li> <li>• Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)</li> </ul>	Year	Jan 2017 – Dec 2017	Jan 2018 – Dec 2018
17(2)	Follow-up after Emergency Department Visit for Mental Illness	Percentage of ED visits for beneficiaries age 18 and older with a principal diagnosis of mental illness or intentional self-harm and who had a follow-up visit for mental illness. Two rates are reported: <ul style="list-style-type: none"> <li>• Percentage of ED visits for mental illness for which the beneficiary received follow-up within 30 days of the ED visit (31 total days)</li> </ul>	Year	Jan 2017 – Dec 2017	Jan 2018 – Dec 2018



		<ul style="list-style-type: none"> <li>Percentage of ED visits for mental illness for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)</li> </ul>			
25	Readmissions Among Beneficiaries with SUD	The rate of all-cause readmissions during the measurement period among beneficiaries with SUD	Year	Oct 2017 – Sep 2018	Oct 2018 – Sep 2019

## Appendix B: Interview Guide

### OUD/SUD Midpoint Assessment: Interview Guide

Note. Highlighted in gray indicates the stakeholder groups that will be asked each question.

#### **Introduction**

Hi. My name is... This is [Interviewer 2 name]. Thank you for agreeing to do this interview.

#### **Purpose of the Interview**

We are speaking with you today because you were identified as a key stakeholder in the State’s Opioid and Substance Use Disorder program, “the OUD/SUD program.” The OUD/SUD program is a 5-year, Medicaid 1115 demonstration project that started in 2017. The overarching goal of the program was to help Medicaid (NJ FamilyCare) beneficiaries with opioid or substance use disorder get connected to high quality, evidence-based treatment. A key part of the program was ensuring that patient treatment placement adheres to national guidelines by the American Society of Addiction Medicine, referred to as the “ASAM Criteria.”

*The ASAM Criteria describes SUD treatment as a continuum marked by 5 broad levels of care:*

*0.5 – Early intervention*

*1 – Outpatient services*

*2 – Intensive outpatient or partial hospitalization services*

*3 – Residential or inpatient services*

*4 – Medical managed intensive inpatient services*

We are going to refer to the ASAM Criteria and this continuum throughout the interview. We are now about 3 years into the program. We are interested your experiences with the OUD/SUD program thus far as a [say role: provider, patient, administrator] and any recommendations you have to make the program better.

We recognize that COVID-19 has impacted this program. For this interview, the data we will show you will be from before COVID-19. We will ask you to think back to 2017, which was when the program started, to early 2020, right before the pandemic began. We will give you a chance to comment on the impact of COVID-19 on the program.

I would like to get your perspective on the program’s progress toward meeting its goals for its Medicaid beneficiaries. The State set six key milestones that it wanted to meet. I am going to describe each of the milestones, and then ask for your help to understand how things are going.

#### **Question Bank**

##### **Interviewee Introduction**

1. First, tell me a little bit about yourself and your specific role in the OUD/SUD program. [Provider Consumer MCO State]

##### **Milestones**

*Note: There are 6 Milestones:*

- *Access to Critical Levels of Care for OUD and other SUDs*
- *Widespread use of evidence-based, SUD-specific patient placement criteria*
- *Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications*
- *Sufficient provider capacity at each level of care*
- *Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD*
- *Improved care coordination and transitions between levels of care*

For each milestone, briefly describe (see Table for descriptions to be read during interview), show data results, and ask the following questions:

2. What are 1-2 factors that you think explain this trend?  
Probe: *What are some facilitators that are helping this program meet the milestone? What are some barriers?*
3. Thinking about factors related to COVID, as well as factors not related to COVID, do you think the program is on track to meeting its goal for this Metric?  
Probe: *Tell me some reasons related to COVID. Tell me some reasons not related to COVID.*
4. One of the Action Items associated with this trend is [insert Action Item]. This Action Item was [completed / not completed] on schedule. What do you think that means for the program’s progress?

**Summary**

That concludes the series of questions about the specific milestones. Now I want to give you a chance to comment on the program as a whole.

5. Thinking about the core components of the program and how it was rolled out, what are 1-2 recommendations you would make to ensure the State meets its goals of improving OUD/SUD treatment for Medicaid beneficiaries across New Jersey? [Provider Consumer MCO State]  
Probe: *What components of the program worked well? What should be changed?*

You have shared great information with us. [Interviewer 2 name], what clarifying questions do you have?

**Close**

6. Before we close, is there anything we missed about the OUD/SUD program implementation? [Provider Consumer MCO State]
7. Lastly, is there anyone you recommend that we talk to who would speak to the implementation of the OUD/SUD program? [Provider Consumer MCO State]

Thank you for taking the time to talk to us. We learned so much about how the OUD/SUD program is going. If you have additional comments or questions, please don’t hesitate to contact us. <End recording>

**Table.** Description of milestones to be read by interviewer.

Milestone	Description	Applicable Questions
MILESTONE #1: Access to critical levels of care for OUD and other SUDs	<p>The first milestone is to improve access to critical levels of care for opioid and substance use disorders. It is important to offer a range of services at varying levels of intensity across a continuum of care, since the type of treatment or level of care needed may be more or less effective depending on the individual Medicaid beneficiary.</p> <p>There were already many services available to Medicaid beneficiaries before the O-SUD program started in 2017.</p> <p>The services available prior included: Coverage of outpatient, intensive outpatient, partial care, short term residential, and non-hospital based withdrawal management, ambulatory withdrawal management services,</p>	<p>What are 1-2 factors that you think explain this trend? [State Consumer Provider MCO/IME] Probe: <i>What are some facilitators that are helping this program meet the milestone? What are some barriers?</i></p> <p>Thinking about factors related to COVID, as well as factors not related to COVID, do you think the program is on track to meeting its goal for this Metric? [State Consumer Provider MCO/IME] Probe: <i>Tell me some reasons related to COVID. Tell me some reasons not related to COVID.</i></p> <p>One of the Action Items associated with this trend is [insert Action Item]. This Action Item was [completed / not</p>

	<p>medication assisted treatment, and medically supervised withdrawal management services.</p> <p>The O-SUD program added long term residential services to the SUD continuum. Further, short term residential and non-hospital based withdrawal management services in an Institution for Mental Disease (IMD) could begin for Medicaid beneficiaries age 21-64 upon approval. The state also created a Medicaid benefit of peer support and case management services for beneficiaries with an SUD diagnosis.</p>	<p>completed] on schedule. What do you think that means for the program's progress? [State Consumer Provider MCO/IME]</p>
<p>MILESTONE #2: Widespread use of evidence-based, SUD-specific patient placement criteria</p>	<p>Like I mentioned earlier, a key milestone of this program is widespread use of the national SUD guidelines for treatment placement, called the ASAM Criteria. Currently, NJ providers assess treatment needs based on SUD-specific, multi-dimensional ASAM assessment tools that reflect evidence-based clinical guidelines.</p> <p>Through the program, the Interim Managing Entity makes initial and continued stay determinations based on review of the patient's DSM 5 diagnosis, the ASAM LOCI-3 assessment tool, and supporting documentation submitted by the provider. This Utilization Management approach ensures that beneficiaries have access to SUD services at the appropriate level of care and that those services are appropriate for the diagnosis and treatment needs of the individual.</p>	<p>What are 1-2 factors that you think explain this trend? [State Consumer Provider MCO/IME]</p> <p>Probe: <i>What are some facilitators that are helping this program meet the milestone? What are some barriers?</i></p> <p>Thinking about factors related to COVID, as well as factors not related to COVID, do you think the program is on track to meeting its goal for this Metric? [State Consumer Provider MCO/IME]</p> <p>Probe: <i>Tell me some reasons related to COVID. Tell me some reasons not related to COVID.</i></p> <p>One of the Action Items associated with this trend is [insert Action Item]. This Action Item was [completed / not completed] on schedule. What do you think that means for the program's progress? [State Provider MCO/IME]</p>
<p>MILESTONE #3: Use of Nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications</p>	<p>Milestone 3 is about the use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications.</p> <p>SUD and ASAM services are outlined in provider licensing regulations that include provider licensing inspections that occur every two years.</p> <p>NJ has offered voluntary quality reviews to SUD providers to ensure compliance and utilize opportunities for targeted assistance, and ongoing Medicaid audits occur on a quarterly basis.</p>	<p>One of the Action Items associated with this trend is [insert Action Item]. This Action Item was [completed / not completed] on schedule. What do you think that means for the program's progress? [State Provider MCO/IME]</p>

	<p>As part of the O-SUD program, the State will look at other credentialing and certification options. Before the program, residential treatment facilities were NOT required to provide a Medically Assisted Treatment, or MAT, service. As part of the program, the State is working to remove the barriers and provide needed supports for this service to be included in residential treatment when clinically necessary.</p> <p>We do not have data on this milestone to show you, but we would like to hear your thoughts in general about how it is going.</p>	
<p>MILESTONE #4: Sufficient provider capacity at each level of care</p>	<p>Milestone 4 is about ensuring sufficient provider capacity at each level of care.</p> <p>New Jersey used data from the Department of Health’s licensing unit to complete a provider capacity study. The study identified providers that are licensed to provide SUD services in NJ, including ones that were not involved in NJ FamilyCare. This capacity study assisted the State in identifying gaps in service availability and identified state strategies to engaging new providers to meet the gaps in service.</p>	<p>What are 1-2 factors that you think explain this trend? [State Consumer Provider MCO/IME]</p> <p>Probe: <i>What are some facilitators that are helping this program meet the milestone? What are some barriers?</i></p> <p>Thinking about factors related to COVID, as well as factors not related to COVID, do you think the program is on track to meeting its goal for this Metric? [State Consumer Provider MCO/IME]</p> <p>Probe: <i>Tell me some reasons related to COVID. Tell me some reasons not related to COVID.</i></p> <p>One of the Action Items associated with this trend is [insert Action Item]. This Action Item was [completed / not completed] on schedule. What do you think that means for the program’s progress? [State Consumer Provider MCO/IME]</p>
<p>MILESTONE #5: Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD</p>	<p>Milestone 5 is the implementation of comprehensive treatment and prevention strategies to address opioid abuse and opioid use disorder.</p> <p>New Jersey has taken significant efforts to address the opioid addiction crisis, including providing education to prescribers, putting in place best practices for opioid prescribers, having pharmacy programs lock certain Medicaid consumers into one pharmacy, and state-wide distribution and education on the use of Naloxone.</p>	<p>What are 1-2 factors that you think explain this trend? [State Consumer Provider MCO/IME]</p> <p>Probe: <i>What are some facilitators that are helping this program meet the milestone? What are some barriers?</i></p> <p>Thinking about factors related to COVID, as well as factors not related to COVID, do you think the program is on track to meeting its goal for this Metric? [State Consumer Provider MCO/IME]</p> <p>Probe: <i>Tell me some reasons related to COVID. Tell me some reasons not related</i></p>

	<p>Prior to the O-SUD program, payers, including Medicaid, did not have access to the New Jersey Prescription Monitoring Program (NJPMP) prior to making prescription coverage decisions. There is currently pending state legislation to assure access to NJPMP by all payers. There also was no connectivity between the NJPMP and the NJ Health Information Network. This milestone includes establishing connectivity between these two systems. These are some of the strategies that the State has or will put into place as part of the O-SUD program to continue to address prescription drug abuse and OUD.</p>	<p>to COVID.</p> <p>One of the Action Items associated with this trend is [insert Action Item]. This Action Item was [completed / not completed] on schedule. What do you think that means for the program's progress? [State Consumer Provider MCO/IME]</p>
<p>MILESTONE #6: Improved care coordination and transitions between levels of care</p>	<p>Milestone 6 is improved care coordination and transitions between levels of care.</p> <p>Before the program, within the Medicaid State Plan, there was no case management or peer recovery support service available to individuals with an SUD in any level of care. The program provides coverage of these services by grants and Federal Block Grant dollars within the state-funded services until the establishment of the benefit for Medicaid beneficiaries with SUD. The peer recovery support service became a Medicaid covered benefit on July 1, 2019.</p>	<p>What are 1-2 factors that you think explain this trend? [State Consumer Provider MCO/IME]</p> <p>Probe: <i>What are some facilitators that are helping this program meet the milestone? What are some barriers?</i></p> <p>Thinking about factors related to COVID, as well as factors not related to COVID, do you think the program is on track to meeting its goal for this Metric? [State Consumer Provider MCO/IME]</p> <p>Probe: <i>Tell me some reasons related to COVID. Tell me some reasons not related to COVID.</i></p> <p>One of the Action Items associated with this trend is [insert Action Item]. This Action Item was [completed / not completed] on schedule. What do you think that means for the program's progress? [State Provider]</p>



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