Ohio SUD 1115 Waiver Demonstration

Mid-Point Assessment

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OHIO COLLEGES OF MEDICINE
GOVERNMENT RESOURCE CENTER

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Acronyms

Acronyms	
ASAM	American Society of Addiction Medicine
AUD	Alcohol Use Disorder
BH	Behavioral Health
CMS	Centers for Medicare & Medicaid Services
GRC	Government Resource Center
IMD	Institutions for Mental Disease
IOP	Intensive Outpatient
LOC	Level of Care
MAT	Medication Assisted Treatment
MCP	Managed Care Plan
MITS	Medicaid Information Technology System
MPRE	Medicaid Pre-Release Enrollment
ODM	Ohio Department of Medicaid
OhioMHAS	Ohio Department of Mental Health and Addiction Services
OUD	Opiate Use Disorder
PDMP	Prescription Drug Monitoring
PHP	Partial Hospitalization
SOR	State Opioid Response
SUD	Substance Use Disorder
Tx	Treatment

Executive Summary

Background

On September 24, 2019, the Centers for Medicare and Medicaid Services approved the *Ohio Medicaid 1115 Demonstration Proposal for Substance Use Disorder Treatment.* The Waiver Demonstration supports a comprehensive continuum of care for individuals enrolled in Medicaid with a substance use disorder (SUD) diagnosis, including opioid use disorder (OUD), and expands Ohio's efforts to improve access to high-quality, evidence-based SUD services based on clinical guidelines set by the American Society of Addiction Medicine (ASAM). The demonstration period goes through September 2024.

Ohio experienced a significant increase in opioid deaths from 2012 through 2020,[1] and nationally, Medicaid enrollees have higher rates of opioid use disorder (OUD) than privately insured individuals.[2] In response to the opioid epidemic, Ohio has implemented a number of interventions to monitor and limit overprescribing of opioids, expand access to the overdose reversal drug Naloxone, and improve access to the full continuum of SUD treatment services for Medicaid-enrolled individuals. As Medicaid caseloads expanded during the PHE from 2.65 million in December 2019 to 3.19 million in December 2021, there was also an increase in the number of Medicaid beneficiaries with an SUD primary or secondary diagnosis from 404,235 in 2019 to 436,346 in 2021.[3]

Ohio identified six overarching goals for the Waiver Demonstration period:

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[1] 2020+Unintentional+Drug+Overdose+Annual+Report.pdf (ohio.gov)

[2] https://www.macpac.gov/wp-content/uploads/2017/06/Medicaid-and-the-Opioid-Epidemic.pdf

[3] 12-Caseload.pdf (ohio.gov), Caseload_SFY22_DEC.pdf (ohio.gov) Accessed September 21, 2022. For change over time in Medicaid beneficiaries with an SUD diagnosis, see state-provided counts in Table 25-Table 30 and Metrics 3 and 4 in Table 17 for monthly and annual SUD diagnosis counts.

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

CMS has set forth the following milestones to measure progress towards the Waiver Demonstration targets:

CMS Milestones to measure progress toward the waiver demonstration Targets	
Milestone 1	Access to critical levels of care (LOCs) and other SUDs
Milestone 2	Use of evidence-based, SUD specific patient placement criteria (ASAM)
Milestone 3	Use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities
Milestone 4	Sufficient provider capacity at critical LOCs including for medication assisted treatment (MAT) for OUD
Milestone 5	Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD
Milestone 6	Improved care coordination and transitions between LOCs

Ohio's Waiver Demonstration is administered by the Ohio Department of Medicaid (ODM) with support from a variety of stakeholders, including the Ohio Department of Mental Health and Addiction Services (OhioMHAS), the Ohio Board of Pharmacy, Managed Care Plans (MCPs), the SUD 1115 Stakeholder Advisory Committee, and other state agencies. The Advisory Committee is a statewide group of behavioral health (BH) and SUD treatment providers and recovery advocates convened by ODM to advise state agencies on the implementation of the SUD 1115 Waiver.

The Ohio Colleges of Medicine Government Resource Center (GRC) was selected to administer the SUD 1115 Waiver Demonstration Evaluation, Mid-Point Assessment, and Monitoring for the 5-year demonstration period of 2019 through 2024. GRC conducted an independent mid-point assessment to examine the progress of meeting the Waiver Demonstration milestones, and performance metrics, looking at activities and data from October 2019 through March 2022. This mid-point assessment identifies factors that contributed to Waiver Demonstration progress, as well as gaps, and identifies possible solutions the state can implement to support progress.

COVID-19 Public Health Emergency

The COVID-19 Public Health Emergency (PHE) impacted multiple aspects of the provision of SUD treatment services across Ohio, as well as SUD 1115 Waiver implementation. Nationally, the pandemic brought on an increase in demand for mental health services, substance use, and overdose.[4] Ohio treatment providers and state agency representatives we interviewed described similar trends within the state, and Ohio's overdose death rate in Q2 of 2020 returned to levels as high as the previous peak of 10.87 per 100,000 in Q1 of 2017.[5] Stakeholders described COVID-19's disruption to normal services and supports, including impacts on both

[4] https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm
https://www.apa.org/monitor/2021/03/substance-use-pandemic
https://www.apa.org/news/press/releases/2020/11/anxiety-depression-treatment
[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8919935
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8047728/

access and workforce, and the shift in resources required by the PHE slowed some Waiver Demonstration activities, such as implementation of new OhioMHAS provider certification standards and the launch of on-site reviews for residential treatment providers, by several months. Conversely, early approval of telemedicine for behavioral health and SUD treatment services helped to maintain access to services for many Medicaid enrollees. The mid-point assessment discusses the potential impacts of the PHE on data collection, waiver activities, and outcomes.

Approach

The primary data source used to determine state progress toward milestones is a subset of critical metrics from the SUD 1115 waiver Monitoring Metrics. This is supplemented by findings from qualitative interviews and focus groups with key stakeholders, a survey with providers, a review of the state's progress toward its implementation plan, and an evaluation of the state's provider availability assessment data. We also cite preliminary findings from the Interim Evaluation analysis where relevant.

In assessing the state's overall risk of not meeting milestones we primarily focus our assessment of milestone risk on the performance of critical monitoring metrics, per CMS guidance, but also weigh findings from the other identified data sources in order to give a full picture of progress toward milestones.

Summary of Findings

Overall, Ohio has made significant progress towards meeting the six Waiver Demonstration milestones. Action items for milestones 2, 4, and 6 have been completed (no action items for Milestone 1 were identified). The remaining work to complete action items for milestones 3 involves completing residential provider on-site reviews and providing education and technical assistance to abstinence-only residential treatment providers, both of which commenced in fall 2022. Milestone 5 action items focus on upgrades to the state's prescription drug monitoring program, Ohio Automated Rx Reporting System (OARRS), enhancements in the use of prescribing data, and enforcement of the state's prescribing guidelines. Milestone 5 action items are not due to be completed until September 30, 2024.

Ohio is also meeting 16 of the 28 critical monitoring metrics associated with milestones, as well as two additional critical metrics identified by CMS.

Accomplishments

Ohio's Waiver Demonstration achievements demonstrate the state's comprehensive approach to improving access to appropriate treatment services and outcomes for Medicaid beneficiaries experiencing SUD:

- Implemented the SUD 1115 Stakeholder Advisory Committee, a diverse group of treatment professionals and recovery advocates to advise state agencies on Waiver Demonstration implementation.
- Developed and implemented a standardized behavioral health prior authorization form to streamline access to care and ensure adherence to ASAM LOC standards.
- Developed and distributed an optional SUD Residential Notification of Admission Form to aid residential treatment providers and MCPs in coordination of transitions between LOCs and prevent readmissions.
- Procured Next Generation MCP contracts that establish requirements for adherence to ASAM standards, county-level treatment access standards by ASAM LOC, and other safeguards to ensure access to appropriate care.
- Launch of OhioRISE (Resilience through Integrated Systems and Excellence), an intensive behavioral health managed care and care coordination program for children with complex needs.
- Updated OhioMHAS rule 5122-29-09 to strengthen Ohio's requirements to ensure that residential treatment and withdrawal management services are delivered in accordance with ASAM LOCs 3, 3-WM, and associated sub levels.

- Initiated residential treatment on-site reviews intended to assess compliance with rule 5122-29-09 and provide technical assistance to help providers meet requirements.
- Distributed provider relief funds in 2020 and 2022 to support behavioral health and SUD provider operations during the COVID-19 PHE.
- Provided funding opportunity to expand Health Information Exchange access for 80 behavioral health providers.

Recommendations

While the state has made substantial progress towards meeting Waiver Demonstration milestones, further action is needed. Based on data and findings from the midpoint assessment, including stakeholder input, we believe the following actions may improve the potential for the state to meet its goals:

- Implement quality improvement and/or workforce development initiatives that aim to increase delivery of early intervention services in healthcare settings with enhanced focus on non-OUD SUDs.
- Re-evaluate and update monitoring metric #11 target to reflect state's desired change in withdrawal management services.
- Update Waiver Demonstration implementation plan to include action items to ensure equitable access to SUD treatment services for Medicaid beneficiaries.
- Develop educational materials and conduct MCP and provider education regarding the application of ASAM criteria and the tools commonly used to assess patient need for SUD treatment.
- Conduct quality assurance reviews of MCP and provider use of the Substance Use Disorder Services Prior Authorization Request form to

assess use of ASAM criteria for assessment of patient need and service approval.

- ☐ Continue to develop educational and technical assistance resources for residential SUD treatment providers based on findings from on-site reviews.
- ☐ Engage abstinence-only residential treatment providers in dialogue and provide educational resources about the benefits of MAT accessibility.
- ☐ Continue with plans to use improved rendering provider data from the Provider Network Management module to perform provider availability assessments in the future.
- ☐ Monitor increases in SUD diagnosis, particularly in pockets of lower provider capacity and in special populations and develop targeted strategies to increase access to appropriate LOCs.
- ☐ Continue to work with The State of Ohio Board of Pharmacy to incorporate planned OARRS updates.
- ☐ Work with SUD Advisory Committee and state agency partners to re-evaluate implementation action items and identify additional strategies that minimize administrative burdens and restrictive treatment rules (at both the provider and payer levels) that delay start of and improve retention in SUD treatment.
- ☐ Develop and disseminate provider and consumer education resources to clarify the rules, responsibilities, and service delivery requirements at each LOC.
- ☐ Make Notification of Admission form and/or process mandatory to ensure transition planning between LOCs.
- ☐ Work with state agency partners, MCPs, and providers to improve care coordination for pregnant women with an SUD diagnosis.

- ☐ Work with state agency partners, MCPs, and providers to improve care coordination to facilitate initiation and engagement in treatment for individuals with Alcohol Use Disorder.
- ☐ Continue plans, through the Next Generation MCP contracts, to assess social determinants of health and housing stability as part of transitions between levels of care.

Ohio SUD 1115 Waiver Demonstration: Mid-Point Assessment

A. General Background Information

The following Ohio Section 1115 Substance Use Disorder (SUD) Waiver Demonstration Mid-Point Assessment will examine the progress toward meeting the goals, milestones, and performance metric targets related to Ohio's demonstration, which was approved by CMS on September 24th, 2019. The mid-point assessment identifies factors that contributed to progress, as well as those that contributed to gaps, from October 2019 through March 2022, and identifies potential implementation or other solutions the state can influence to support improvement.

The Problem of Substance Use Disorder

National opioid overdose deaths have substantially risen over the past decade.[6] Ohio experienced an increase in opioid deaths from 1,914 in 2012 to 5,017 in 2020.[7] This is of particular concern for the Medicaid population because nationally, Medicaid enrollees have higher rates of OUD than privately insured individuals.[8] In response, Ohio has been actively participating in a multi-agency workgroup which tracks and details drug use and movement. In addition, the State of Ohio passed a bill limiting the number of opioids that can be dispensed to a patient, and the Ohio Department of Medicaid implemented a rule limiting claims for opioid prescriptions.[9] As Medicaid caseloads expanded during the PHE[10] from 2.65 million

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[6] https://www.cdc.gov/opioids/data/analysis-resources.html#anchor_trends_in_deaths_rates

[7] https://odh.ohio.gov/know-our-programs/violence-injury-prevention-program/drug-overdose/

[8] https://www.macpac.gov/wp-content/uploads/2017/06/Medicaid-and-the-Opioid-Epidemic.pdf

[9] https://oig.hhs.gov/oas/reports/region5/51900036_Factsheet.pdf

[10] The expansion of Medicaid caseloads was largely driven by the pause in redeterminations required by the Families First Coronavirus Response Act (FFCRA).

in December 2019 to 3.19 million in December 2021, there was also an increase in the number of Medicaid beneficiaries with an SUD primary or secondary diagnosis from 404, 235 in 2019 to 436,346 in 2021.[11] This indicates an increased need for SUD treatment among Medicaid enrollees in Ohio.

ODM's Update of Behavioral Health Service Coverage

Ohio started updating Medicaid behavioral health (BH) coverage in 2012 with the elevation of BH funding at the state level. From August 2014 – December 2017, the Ohio Department of Medicaid continued improvements to their coverage in partnership with the Ohio Department of Mental Health and Addiction Services (OhioMHAS). This culminated in the implementation of Behavioral Health (BH) Redesign, which included a comprehensive Medicaid benefits package of services provided by mental health and SUD providers on January 1, 2018.

The new BH Redesign benefit package introduced new evidence-based practices, such as Assertive Community Treatment (ACT) for adults, and promising practices, such as Intensive Home-Based Treatment (IHBT) for children with MH conditions, while also updating the SUD outpatient and residential treatment benefit to align with the American Society of Addiction Medicine (ASAM) levels of care (LOCs). ASAM was introduced with the intention of increasing utilization of community-based and non-hospital residential programs to assure that inpatient hospitalizations are mainly used for situations in which there is a need for safety, stabilization, or acute detoxification (ASAM LOC 4).[12]

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[11] 12-Caseload.pdf (ohio.gov), Caseload_SFY22_DEC.pdf (ohio.gov) Accessed September 21, 2022. For change over time in Medicaid beneficiaries with an SUD diagnosis, see state-provided counts in Table 25-Table 30 and Metrics 3 and 4 in Table 17 for monthly and annual SUD diagnosis counts.

[12] Medicaid SUD 1115 Proposal: https://bh.medicaid.ohio.gov/Portals/0/About/CMS%20Approved%20Waiver%20Application%20and%20Implementation%20Plan%20092419.pdf?ver=2019-09-25-060624-387

Community BH services were carved into managed care on July 1, 2018, making MCPs responsible for the provision of all health care, including BH services. This integration into capitated care targeted the goal of implementing improved models of care which focus on allowing individuals to receive treatment in the community and home outside of institutions, increasing outpatient MH rehabilitation services, initiating SUD services aligned with ASAM criteria, and reducing the burden of covered services on hospitals and large institutions (IMDs).

Role of the SUD 1115 Waiver

In an effort to further expand Ohio's support for Medicaid-enrolled individuals with opioid use disorder (OUD) or other substance use disorders (SUDs), the Centers for Medicare and Medicaid Services (CMS) approved Ohio's "Section 1115 Demonstration Waiver Proposal for Substance Use Disorder Treatment" (Waiver Demonstration) on September 24th, 2019. The demonstration gives Ohio Medicaid the authority to cover high quality, clinically appropriate treatment to beneficiaries with an SUD diagnosis during short-term stays in residential and inpatient treatment settings, including stays in Institutions for Mental Disease (IMDs). This demonstration also supports Ohio's efforts in implementing improved models of care which focus on allowing individuals to receive treatment in the community and home outside of institutions, increasing outpatient behavioral health rehabilitation services, initiating SUD services aligned with ASAM criteria, and increasing the utilization of treatment services in community settings.

During the demonstration period, the state seeks to achieve the following goals:

- Increased rates of identification, initiation, and engagement in treatment for SUD;
- Increased adherence to and retention in treatment;
- Reductions in overdose deaths, particularly those due to opioids;
- Reduced utilization of emergency departments and inpatient hospital settings for treatment where the utilization is preventable or medically

inappropriate through improved access to other continuum of care services;

- ☐ Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and
- ☐ Improved access to care for physical health conditions among beneficiaries with SUD.

During the demonstration period, Ohio has the following milestones to measure progress towards the demonstration goals:

- ☐ Access to critical levels of care (LOCs) for OUD and other SUDs
- ☐ Use of evidence-based, SUD specific patient placement criteria (ASAM)
- ☐ Use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities
- ☐ Sufficient provider capacity at critical LOCs including for medication assisted treatment (MAT) for OUD
- ☐ Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD
- ☐ Improved care coordination and transitions between LOCs

Achievements in Waiver Implementation

In December 2019, the Ohio Department of Medicaid (ODM) convened the SUD 1115 Stakeholder Advisory Committee, a diverse group of treatment providers and recovery advocates from across Ohio who meet regularly to advise state agencies on the implementation of the SUD 1115 Waiver.

In July of 2021, the Ohio Department of Medicaid (ODM) implemented a standardized behavioral health treatment prior authorization form in order to streamline access to care and minimize disputes between providers and managed

care plans. ODM established a utilization management workgroup, who worked collectively to develop a standardized prior authorization form that covers both residential treatment and partial hospitalization. The form uses a checkbox format that aligns directly to the ASAM requirements at each level of care. This puts providers and managed care plans on the same page and allows providers to adequately summarize each case without having to submit lots of additional documentation.

Similarly, in August of 2022, ODM released a new SUD Residential Notification of Admission Form, which is an optional, standardized form and process for SUD residential providers to notify the MCP of patient admission. The point of the form is to encourage coordination of care and prevent readmissions.

In July 2022, the Ohio Department of Medicaid completed a 3-year managed care procurement process and awarded new managed care contracts to 7 payor organizations. This next generation of MCPs and contracts go into effect February 1, 2023, providing Ohio the opportunity to make several innovative improvements in the coverage of SUD treatment services for beneficiaries. For example, agreements will require ODM review and approval of all changes to clinical or coverage policies. In addition, MCPs will be required to cover the next level of care available if the recommended LOC is not reasonably available in the patient's geographic area.

In July 2022, ODM implemented OhioRISE (Resilience through Integrated Systems and Excellence), an intensive behavioral health managed care and care coordination program for children and youth with complex BH care needs, including SUD, who may have multisystem needs and/or be at risk of or currently experiencing out-of-home placement. As part of the care coordination benefit, family members, such as parents or guardians with SUD care needs, can be referred for necessary services.

A new Ohio Department of Mental Health and Addiction Services (OhioMHAS) rule relating to SUD providers will be going into effect on July 1, 2023. A major component of this rule is the requirement for residential treatment facilities to provide access to MAT, either on-site or through partnerships that allow residential patients to have access to MAT. ODM has contracted with Health Management

Associates to conduct statewide on-site reviews for all SUD residential providers that are participating in Medicaid. These visits will assess provider alignment with new standards and identify gaps in meeting the new rule requirements. Recommendations and technical assistance will be available to the providers based on their assessments. In addition, this will provide ODM with an opportunity to assess their provider network with respect to the application of ASAM and inform ODM of facilities that have the characteristics of IMDs.

Mid-Point Assessment

The Ohio Colleges of Medicine Government Resource Center (GRC) was selected to administer the SUD 1115 Waiver Demonstration Evaluation, Mid-Point Assessment, and Monitoring for the 5-year demonstration period of 2019 through 2024. GRC conducted an independent mid-point assessment to examine the progress of meeting the Waiver Demonstration goals, milestones, and performance metrics looking at activities and data from October 2019 through March 2022.

This mid-point assessment identifies factors that contributed to Waiver Demonstration progress as well as gaps, through March 2022 and identifies possible solutions the state can influence to support progress. GRC, as an independent evaluator, worked with ODM while following CMS guidance to develop a mid-point assessment that engaged key stakeholders in all aspects of the project.

This document is presented in five primary sections: (A) Introduction, (B) Methodology, (C) Assessment Findings, (D) Assessment of Overall Risk of not Achieving Milestones and Recommendations, and (E) Next Steps.

B. Methodology

Data Sources

The primary data source used to determine state progress toward milestones is a subset of critical metrics from the SUD 1115 waiver Monitoring Metrics. This is supplemented by findings from qualitative interviews and focus groups with key

stakeholders, a survey with providers, a review of the state's progress toward its implementation plan, and an evaluation of the state's provider availability assessment data. We also cite preliminary findings from the Interim Evaluation analysis where relevant.

Monitoring Metrics

The primary data source for the official Monitoring Metrics is Ohio Medicaid administrative billing data, consisting of claims, beneficiary eligibility, and provider enrollment records. Claims include final adjudicated fee-for-service and encounter records for inpatient, outpatient, professional medical, and pharmacy services. Diagnoses are also included for inpatient, outpatient, and professional medical services. Eligibility records include beneficiary coverage dates, type of coverage (dual or non-dual), and demographic information. Supplementary data related to pre-release program enrollment are used to determine criminal justice involvement. Medicaid provider enrollment records are linked to Ohio Prescription Drug Monitoring Program (PDMP) provider registrations to determine PDMP-EHR integration and active utilization by Medicaid-enrolled providers. We use the subset of 19 critical metrics identified by CMS, plus two additional recommended metrics (Metric #3 and Metric #4), to evaluate progress toward demonstration targets.

Stakeholder feedback

The midpoint team used two targeted qualitative data collection efforts to gather feedback from key stakeholders - interviews with key informants and focus groups with individuals with lived experience. Additionally, we fielded a non-probability survey of SUD treatment providers to collect experiences from a broad range of providers.

Key informant interviews

Twenty-three semi-structured interviews of 37 key informants were conducted between October and December 2020, with 5 follow-up interviews. Key informants included representatives from state agencies (7 interviews of 14 people), SUD treatment providers (7 interviews of 7 people), treatment and recovery advocates (4

interviews of 5 people), and representatives from managed care organizations (5 interviews of 11 people, including 7 BH/medical/clinical directors and 4 administrative directors/staff). Participants were selected from among the SUD 1115 Waiver Stakeholder Advisory Committee members, state policy makers, and managed care plans. Participants from state agencies were selected to gather the perspectives from key actors in state agencies responsible for policy development and implementation. Providers and treatment/recovery advocates were selected to ensure representation by geography, populations served, and services provided. Each of Ohio's five managed care plans were included. Characteristics of the key informants who participated in interviews are summarized below. Interviews were conducted over Zoom and were recorded with participant permission.[13] They were then professionally transcribed for qualitative analysis. Each interview lasted approximately one hour, and topics covered the implementation of the 1115 waiver, including access to care along the continuum, MAT, and the impact of the COVID-19 pandemic. Interview guides were tailored to the participants' role in SUD treatment to capture the unique experiences and perspectives of the diverse stakeholders we engaged. The key informant interview guides can be found in Appendices A3-A6.

Key Informant Interview Participants

- ☐ State agencies (7 interviews)
    - State mental health agency (4)
    - State Medicaid (3)
- ☐ Treatment providers (6 interviews)
    - Southwest Ohio provider for women (1)
    - Northeast Ohio providers (2)
    - Northern Ohio adolescent provider (1)
    - Central Ohio MAT provider (1)

[13] One interview with a state agency was not recorded due to agency policy. Instead, verbatim notes were taken during the interviews.

    - Statewide professional association for treatment providers (1)
- ☐ Treatment & Recovery advocates (4 interviews)
    - Statewide recovery housing representative (1)
    - Statewide SUD recovery advocate (1)
    - Statewide SUD treatment advocacy organization (2)
- ☐ Managed Care Plans (5 interviews)
    - Buckeye (1)
    - CareSource (1)
    - Molina (1)
    - Paramount (1)
    - United Health Care (1)

Focus groups with individuals with lived experience

Ten focus groups were conducted with individuals actively receiving SUD treatment. Focus groups included between 2 and 11 participants with a total of 79 participants and included treatment providers offering the full range of ASAM LOCs and recovery housing. Focus group participants were engaged in outpatient, intensive outpatient, and residential treatment programs. Table 1 below provides characteristics about each focus group. Focus groups were conducted over Zoom between May and July 2021. Participants were recruited with the assistance of treatment and recovery housing providers. Some treatment providers were SUD 1115 Advisory Committee members and others were recommended by state and Advisory Committee partners as attempts were made to reach diverse populations and regions of the state.[14] All participants were actively enrolled in Medicaid at the time of their focus group. Topics discussed included barriers and facilitators to entering or staying in treatment, MAT, court-involvement in treatment, and the

[14] Attempts to recruit participants from Northwest Ohio through multiple treatment and recovery housing providers were unsuccessful due to scheduling conflicts and limited interest in participation.

impact of COVID-19 on treatment services. Focus groups lasted one hour, and each participant received a $75 Amazon gift card for their participation. The focus group interview guide is available in Appendix B.

Table 1: Focus Group Participants

Care Provided to Participants by Participating Facility	*Treatment Demographic*	*Geographic Region of Facility*	*Number of Participants in Focus Group*
Residential treatment	Pregnant women and mothers with young children	Southeast Ohio	11
Residential treatment	Adult men and women	Southeast Ohio	11
Residential treatment	Pregnant women and mothers with young children	Southeast Ohio	5
Recovery housing	Women	Southwest Ohio	10
Outpatient treatment	Adult men and women	Southwest Ohio	6
Residential and IOP treatment	Adult men and women	Northeast Ohio	10
IOP treatment	Adult men and women	Northeast Ohio	2
Opioid Treatment Program and IOP treatment (combined group for two facilities)	Adult men and women	Central Ohio	6
Residential, IOP, and recovery housing	Adult men and women	Central and Southwest Ohio	10
Residential, IOP, and recovery housing	Adult men and women	Central and Southwest Ohio	8

Provider Survey

In addition to qualitative data collection, the midpoint team designed and fielded a non-probability sample web survey of SUD treatment providers to gather a broader range of perspectives and experiences than what could be collected through interviews with providers. The instrument was developed following qualitative analysis of the key informant interview data and leveraged findings from interviews to determine key topics. Topics included organizational demographics, such as services provided and populations treated, access to care, MAT, care coordination,

impacts of COVID, and impacts of the SUD 1115 Waiver. Questions were predominantly close-ended[15] and modeled after validated survey questions where possible. The instrument was cognitively reviewed by ODM and OhioMHAS staff as well as treatment providers that participated in key informant interviews. The survey was fielded in October 2021 using Qualtrics and used a non-probability sampling method to recruit respondents. The Ohio Department of Medicaid distributed recruitment letters to all SUD treatment providers through their Medicaid Information Technology System (MITS) online portal. Additionally, members of the SUD Stakeholder Advisory Committee shared the survey link with their contacts. 94 completed surveys were collected. The survey instrument and recruitment letter can be found in Appendix C1 & C2. About two-thirds (67.44%) of respondents categorized their substance abuse treatment facility as a community mental health SUD center, and another one-quarter (23.26%) worked at non-hospital residential facilities (free-standing residential centers). 86 of 94 respondents accepted Medicaid (91.5%), so we limit findings to the Medicaid providers.

Provider Availability Assessment Data

A provider availability assessment was conducted by the state per its Milestone 4 requirements. The data for the assessment comes from the Ohio Department of Medicaid's Electronic Data Warehouse (EDW) Health and Human Services Public Policy (HHSPP) library, which houses Medicaid claims, eligibility data, and provider information for critical levels of care. The data was gathered and analyzed by the Ohio Department of Medicaid's Analytics team, which created tables and visualizations to summarize provider availability state-wide for every year between 2018 and 2021, as well as change over time between 2018 and 2021 at the county level. This assessment analysis was presented at the 1115 Waiver SUD Stakeholder

[15] Multiple question types were used, including 25 multiple choice (22 select-all-that-apply and 3 select-one-response), 7 yes/no, 7 Likert scale, 5 matrix-style, and 3 open-ended questions.

Advisory Committee meeting on August 16, 2022, and figures and tables were received by the GRC on September 11, 2022**.**

Interim Evaluation Report Data

The Interim Evaluation analyses use Medicaid administrative data (claims/encounters, eligibility, and provider information) to construct a variety of measures to track progress for waiver milestones. We use findings for measure H1A1 (quarterly SUD provider availability ratio) to triangulate some of the reported stakeholder experiences about geographic variation in provider capacity between 2019 and 2020, discussed in Milestone 4.

Analytic Methods

Monitoring Metrics

Monitoring metrics were calculated as described in the official 1115 SUD Technical Specifications (referred to as "technical specifications" from here forward) applicable to the reporting period, including deviations documented within the state's approved Monitoring Protocol. The baseline reporting period used Version 3 specifications, and the mid-point period used Version 4 specifications.

Measurement periods, baseline reporting, and midpoint reporting periods vary depending on the metric type specified in the technical specifications and the state's demonstration start date. CMS-constructed metrics are either monthly or annual (tied to demonstration year) and established quality metrics are annual (tied to calendar year). CMS monthly metrics use the first month in which the demonstration started as the baseline reporting period (October 2019) and 18 months into the demonstration period as the midpoint reporting period (March 2022). CMS annual metrics use the first demonstration year (October 2019 – September 2020) as the baseline reporting period and the second demonstration year (October 2020 – September 2021) as the midpoint reporting period. Annual established quality metrics use the calendar year in which the demonstration started as the baseline reporting period (2019) and the following calendar year as the midpoint reporting period (2020). Metric #22 is calculated over a two-year time

period and therefore uses the calendar year before and during the demonstration start as the baseline reporting period (2018-2019) and the calendar year during the following the demonstration start as the midpoint reporting period (2019-2020).

While Ohio's baseline reporting period for CMS monthly metrics is October 2019, changes in performance for these metrics were assessed starting in December 2019. This is because the midpoint evaluation team opted to use three-month moving averages for monthly metrics to smooth inter-month variation and minimize the likelihood that the progress assessment would be influenced by the individual months chosen for baseline and midpoint reporting periods. Therefore, the baseline period for evaluation for monthly metrics is three months after the start of the demonstration (e.g. December 2019), as this is the first available period with three months of data for use in the moving averages calculation.

In order to assess progress along performance metrics, we calculate the absolute and percent change between the baseline and midpoint reporting periods for each metric using the formulas specified in the Mid-Point Assessment Technical Assistance document (Version 1.0). We use metric values for the entire demonstration population ("all Medicaid") for this assessment; analyses of subpopulation trends are discussed when available but do not contribute to assessments of progress for individual metrics. For metrics using proportions, we use a two-sided hypothesis test to test for a statistical difference between the baseline and midpoint proportions. We use a 95% confidence level (α=0.05) for these tests and indicate significant differences with *** and non-significant differences with †. For count metrics, we evaluate progress based on the value of the percent change between baseline and midpoint and therefore do not indicate any statistical difference.

We then classify metrics as either meeting or not meeting the state's demonstration target. For this classification, we take into consideration the direction of the change between baseline and midpoint, the statistical significance of the change (if

available), typical variation between measurement periods over time,[16] any known problems with metric construction, and any additional context about the implication of the observed change for waiver goals. We use the following rules to classify each metric:

- ☐ **Meeting**
  - Change between baseline and midpoint is in the direction of the state's demonstration target (and if available, is a statistically significant change)
- ☐ **Not meeting – monitor**
  - Change between baseline and midpoint is not in the direction of the state's demonstration but there are known problems with metric construction, or the implication of the observed change does not necessarily indicate risk for waiver goals
- ☐ **Not meeting – low risk**
  - Change between baseline and midpoint is not in the direction of the state's demonstration target but this change is not statistically significant
  - Change between baseline and midpoint is in the direction of the state's demonstration target but this change is not statistically significant
- ☐ **Not meeting – medium risk**
  - Moderate change between baseline and midpoint which is not in the direction of the state's demonstration target (and if available, is a statistically significant change); here we consider typical variation between measurement periods as well
- ☐ **Not meeting – high risk**

[16] For example, monthly metrics tend to exhibit more variation between measurement periods than annual metrics, so a change of 10% in the former might not be as substantively meaningful as the same percent change in the latter.

- Substantial change between baseline and midpoint which is not in the direction of the state's demonstration target (and if available, is a statistically significant change); here we consider typical variation between measurement periods as well

Although it is not a core part of Ohio's mid-point assessment, we also present monitoring metric data for trends over time for subpopulations where available, including youth, older adults, pregnant individuals, individuals with criminal justice system involvement, and individuals with an OUD diagnosis. We opt to include monitoring metric data for subpopulations to give a full picture of the variation in experience of and access to SUD treatment by different demographic groups in the state. Subpopulation data was collected by the Monitoring team according to technical specifications (version 3.0 and 4.0), so not all critical metrics have subpopulation trend data available. Definitions for each subpopulation can be found in Table 2 below.

Table 2: Subpopulation Definitions

All Medicaid (Demonstration)	All full-benefit beneficiaries who were enrolled in the month (duration is metric specific)
OUD	Opioid use disorder diagnosis recorded in the month
Youth	Under age 18 as of the first day of the month
Older Adult	Age 65 and over as of first day of month
Pregnant	Women of reproductive age with a claim in MACBIS pregnancy value sets in the month or two months prior
Criminal justice involvement	MPRE (Medicaid Pre-Release Enrollment) program enrollment (defined by intended release date) occurring in the month or 12 months prior

Stakeholder feedback

Interviews & focus groups

Once professionally transcribed, all qualitative data from key informant interviews and focus groups were uploaded to ATLAS.ti for content analysis using a multiple

coding approach in which passages of text could be categorized with one or more relevant code. For each data collection effort, we used a multi-stage approach to qualitative coding. First, the project team generated a coding frame through a combination of deductive and inductive methods. We leveraged the subject matter and policy expertise of our 6-member coding team, which included a PhD social epidemiologist and a PhD urban sociologist, to identify prominent themes embedded in the extant literature on substance use disorder and SUD treatment. Next, two team members independently coded each transcript, with coders allowed to add codes to the frame as they reviewed the transcripts. The team met weekly for informal intercoder comparisons and discussions, followed by additional coding and refinement of the coding frame. This iterative process continued until all 34 transcripts were coded.

For the analysis of key informant interview data, the team developed more than 149 codes grouped into 27 overarching themes, including Best Practices, Medication Assisted Treatment, ASAM levels of care, Care Coordination, Quality of Care, COVID-19, Structural Factors, Cultural Competency, Stigma, Criminal Justice System, Geographic Differences, Technology, 12-Step Programs, Waiver Design & Implementation, Rules & Regulations, Data and Data Tracking, Market Factors, Collaboration, and Community. For the analysis of focus group data, we developed more than 173 codes grouped into 31 overarching themes. Many of these overlapped with the themes identified for analysis of key informant interviews, with the addition of themes such as Barriers to Accessing, Entering, or Staying in Treatment, Triggers to Leaving Treatment, Factors Facilitating Entering or Staying in Treatment, Experiences with Treatment Providers, Environmental Factors, Insurance, Family, Behavioral Health, Physical Well-Being, Peer Supports/Recovery, and the Addiction Cycle.

Once all transcripts were coded, the files were merged, codes were deduplicated, and areas of inconsistency were flagged. The analytics leads then met to discuss overlaps and divergences in coding and resolved any outstanding discrepancies. Finally, the team reviewed code densities, co-occurrences, and relationships between topics, and generated reports in ATLAS.ti to assess patterns emerging in the data.

Provider Survey

Provider survey data was exported from Qualtrics for analysis in R. Responses were de-duplicated using respondent IP addresses and surveys with high item non-response (greater than 50%) were removed. No survey weighting was applied due to the sampling approach (convenience), and sample proportions were calculated for close-ended questions for the subset of respondents who identified themselves as Medicaid providers. Open-ended "other" response options were reviewed and recoded to close-ended responses as appropriate. Completely open-ended responses, of which there were three, were analyzed inductively for prominent themes and results are presented in summary form when discussing relevant findings.

Provider Availability Assessment Data

Provider availability data gathered by the state through its assessment of the availability of Medicaid providers at critical levels of care is used to describe change over time in provider capacity and the adequacy of capacity to provide SUD treatment services. This data is presented and discussed under Milestone 4. The midpoint assessment team reviewed the tables and maps provided by the state to make our assessment, in addition to calculating statistical difference between yearly provider-beneficiary rates to determine significant change between 2018 and 2021. We assess state-wide capacity to deliver services by considering capacity relative to need through an examination of provider counts at each level of care and counts of beneficiaries with an SUD diagnosis by year. We also assess change over time at both the state and county level by examining the net change in provider counts between 2018 and 2021.

Interim Evaluation Report Data

The Interim Evaluation data was analyzed and maps were produced by the GRC SUD 1115 Evaluation team. The quarterly SUD provider availability ratio (Evaluation measure H1A1) was calculated using Medicaid administrative data for Quarter 1 of 2019 and Quarter 4 of 2020 by dividing the number of SUD rendering and prescribing providers at all levels of care by the number of beneficiaries with an

SUD diagnosis and multiplying by 1,000. Beneficiaries with a SUD diagnosis were defined as any individual with a claim for MAT, a primary SUD diagnosis, a claim from provider type 95, or a claim with an ASAM level of care and any SUD diagnosis (primary or secondary). Maps were produced using ArcGIS Pro and data was classified manually to aid in the ease of interpretation.

Methods for assessing overall risk of not meeting milestones

In assessing the state's overall risk of not meeting milestones, we follow the guidance of the Version 1.0 Mid-Point Assessment Technical Assistance in Table 2 of Section B.3, which provides the following considerations for assessing risk of not achieving each demonstration milestone:

Table 3: Technical Assistance Guidance on Assessing Overall Risk of Not Achieving Demonstration Milestones

Overall risk of not meeting milestone				
Data Source	*Considerations*	*Low*	*Medium*	*High*
Critical metrics	For each metric associated with the milestone, is the state moving in the direction of the state's annual goal and overall demonstration target?	All or nearly all (e.g., more than 75%) of the critical metrics trending in the expected direction	Some (e.g., 25-75%) of the critical metrics and other monitoring metrics trending in the expected direction	Few (e.g., less than 25% of the critical metrics and other monitoring metrics trending in the expected direction)
Implementation plan action items	Has the state completed each action item associated with the milestone as scheduled to date?	All or nearly all (e.g., more than 75%) of the action items completed	Some (e.g., 25-75%) of the action items completed	Few (e.g., less than 25% of the action items completed)
Stakeholder feedback	Did key stakeholders identify risks related to meeting the milestone?	Few stakeholders identified risks; risks can be easily addressed within the planned timeframe	Multiple stakeholders identified risks that may cause challenges meeting milestone	Stakeholders identified significant risks that may cause challenges meeting milestone
Provider availability assessment data	Does the state have or expect to have adequate provider availability at critical levels of care?	Availability is adequate	Availability is not yet adequate but is moving in expected direction	Availability is not yet adequate and not moving in expected direction

We primarily focus our assessment of milestone risk on the performance of critical monitoring metrics, per the guidance in the Technical Assistance (page 10), but also weigh findings from the other three data sources in order to give a full picture of progress toward milestones. For the critical metrics and for implementation action items, we use the suggested thresholds (75% or greater, 25-75%, less than 25%) in Table 3 for the proportion of metrics trending in the expected direction or the proportion of completed action items for each milestone to assess risk. For stakeholder feedback, we consider the number of stakeholders identifying risks, as well as breadth or prevalence of the issues identified, and the difficulty of addressing these challenges. For provider availability assessment data, we review state-level capacity (defined as the provider-to-beneficiary-with-an-SUD-diagnosis ratio) for the most recently available data (2021), trends over time in this capacity (2018-2021), sub-state geographic variation in provider availability for the most recent year (2021), as well as county-level provider counts over time (2018-2021).

Limitations

Monitoring Metrics

The primary limitation of the monitoring metric data for evaluation of state progress pertains to defining an IMD. In Ohio, Institutional/hospital-based IMDs are identified using state-specific Provider Type 02 (Psychiatric Hospital) with state-specific Provider Specialty 018 (IMD). As part of the 1115 Demonstration, the Ohio Department of Medicaid is collaborating with Ohio Mental Health and Addiction Services to develop a method to identify bed counts at residential IMDs in Ohio. This method is still in development, and therefore residential IMDs are currently identified using all residential treatment facilities (Step 1 of Metric #5, including approved state-specific deviations) as a proxy. Once the bed count method is finalized by the state, Ohio will report Metric #5 according to the full monitoring specifications.

As a result, we expect that Metric #5 (Medicaid beneficiaries treated in an IMD for SUD) is overestimating the number of individuals receiving treatment at residential IMDs. Many of the facilities that are currently being counted in this metric (which currently includes all residential treatment facilities, not just residential IMDs) will

not qualify as IMDs once the bed census is complete. Additionally, Metric #36 (average length of stay in IMDs) may not be accurately reflecting the length of stay in an IMD, as the measure is currently capturing the average length of all residential treatment stays rather than a subset of those in IMDs.

Stakeholder Feedback

Key informant interview and focus group participants were not randomly sampled from their target populations and, therefore, the qualitative findings discussed in this report are not generalizable to the broader population. Rather, they are indicative of the specific experiences and views of the participants, which may or may not be shared by the general population. For example, for key informant interviews, SUD treatment providers and recovery advocates were recruited from the SUD Stakeholder Advisory Committee, limiting feedback collected to potentially better-informed individuals who were closely engaged with waiver planning and implementation activities. While these providers may have more intimate knowledge of the state's waiver progress than other providers around the state, their experiences of SUD treatment in Ohio may not be the average experience. For focus groups, we attempted to recruit diverse participants from treatment centers around the state, but the final sample lacked representation from northeast Ohio and for some subpopulations, such as LGBTQ+, immigrant, returning citizen, non-English speaking, and Hispanic populations. Additionally, focus group recruitment strategies failed to engage individuals who left treatment early or had not yet started treatment, so the narratives we gathered are to some extent those of the "success stories." Therefore, there may be additional barriers to entering or staying in treatment or challenges faced by individuals needing treatment which are not reported in our summaries of the lived experiences of individuals with SUD. However, despite the fundamental limits to the generalizability of our stakeholder feedback, we report these stories due to the inherent importance of each person's experience and we attempt to triangulate any claims made with other sources of data. The geographic coverage across the state of both treatment providers interviewed and individuals in treatment in focus groups, as well as the breadth of roles of key informants interviewed, have provided us with a variety of unique

perspectives and experiences to help shed light on what it is like to receive substance use disorder treatment in Ohio.

Similar to the qualitative data collection for the midpoint assessment, the primary limitation of the SUD treatment provider survey is that findings are not generalizable to the broader population due to the use of a non-probability convenience sample. Despite this limitation, the findings from the provider survey give insight into services provided and challenges faced by nearly 100 service providers across Ohio. This data helped us to contextualize the monitoring metric and qualitative findings as well as helps to identify areas of limited information where future investment of state resources into a probability sample survey of providers might be worthwhile.

C. Assessment Findings

Progress Towards Demonstration Milestones

Ohio's progress towards meeting each of the demonstration milestones is described separately by milestone in this section. After a general discussion about the impact of the COVID-19 Public Health Emergency (PHE), each milestone is organized by Metrics Reporting and Implementation Plan Action Items. The Provider Availability Assessment is discussed under Milestone 4. Discussion of additional metrics, 3 and 4, follows Milestone 6 and a discussion of stakeholder input concludes this section.

COVID-19 Impact on Waiver Implementation

The COVID-19 PHE has impacted some facets of the SUD 1115 Waiver implementation. The shift in resources required by the PHE slowed some activities by several months. Examples include implementation of new OhioMHAS provider certification standards and the launch of on-site reviews for residential treatment providers. Conversely, early approval of telemedicine for behavioral health and SUD treatment services has increased access to services for many Medicaid enrollees.

The disruptive effect of COVID-19 on access to care is visible in the monthly trends of many of the critical metrics discussed throughout the report. There were substantial drops in the number of beneficiaries who received treatment for early intervention services, IOP/PHP, residential and inpatient treatment, withdrawal management, and ED utilization for SUD in March, April, and May of 2020. There are additional cyclical drops in many of these metrics (e.g., residential and inpatient treatment, ED utilization for SUD) during COVID-19 case spikes, primarily in the winters of 2020 and 2021. While we have less granular data available for assessing the effect of the pandemic on many of the annual metrics, all of the midpoint reporting periods included some portion of time when COVID-19 was impacting the health system in Ohio. Undoubtedly this influenced the state's progress between baseline and midpoint on many metrics, although the magnitude and duration of the effect is indeterminable at this time.

One area of service delivery in Ohio that was not substantially impacted by the PHE was SUD non-acute/non-emergent services. Despite the ongoing COVID-19 pandemic, there was little change in overall service provision for these services due to the rapid expansion of telehealth, which was able to replace in-person services that had suddenly become unsafe. See the section entitled "Provider Availability Via Telehealth" for further data and discussion of the impact of telehealth on SUD service provision in Ohio.

Milestone 1: Access to Critical LOC for OUD and Other SUDs

Milestone 1 aims to ensure access to critical levels of care for Opioid Use Disorder (OUD) and other substance use disorders (SUD). Critical levels of care include early intervention, outpatient treatment, intensive outpatient treatment, partial hospitalization, MAT (including medication and behavioral health counseling and other services), intensive LOCs in inpatient and residential treatment settings, and medically-supervised withdrawal management. Ohio covered all critical LOCs identified in Milestone 1, including MAT, before applying for the waiver.

Metrics Reporting

TABLE 4: MILESTONE 1 MONTHLY PERFORMANCE METRICS

#	Milestone 1 Monthly Performance Metrics	Description	3-Month Moving Average at Baseline (Dec 19)	3-Month Moving Average at Mid-Point (Mar 22)	Absolute Change	% Change	State's Demonstration Target	Status at Mid-Point
7	Early Intervention	Number of beneficiaries who used early intervention services (includes screening and SBIRT services) during the measurement period	143	73	-70	-48.95	Increase	NOT MEETING—HIGH RISK
8	Outpatient Services	Number of beneficiaries who used outpatient services for SUD during the measurement period	79,601	97,369	17,768	22.32	Increase	MEETING
9	Intensive Outpatient and Partial Hospitalization Services	Number of beneficiaries who used intensive outpatient and/or partial hospitalization services for SUD during the measurement period	9,240	11,087	1,847	19.99	Increase	MEETING
10	Residential and Inpatient Services	Number of beneficiaries who use residential and/or inpatient services for SUD during the measurement period	4,369	4,577	208	4.76	Increase	MEETING
11	Withdrawal Management	Number of beneficiaries who use withdrawal management services during the measurement period	3,566	4,608	1,042	29.22	Consistent	NOT MEETING-MONITOR
12	Medication-Assisted Treatment	Number of beneficiaries who have a claim for MAT for SUD during the measurement period	45,197	56,961	11,764	26.03	Increase	MEETING

TABLE 5: MILESTONE 1 YEARLY PERFORMANCE METRICS

#	Milestone 1 Yearly Performance Metrics	Description	At Baseline (2018-2019)	At Mid-Point (2019-2020)	Absolute Change	% Change	State's Demonstration Target	Status at Mid-Point
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	52.84	55.62	2.79	5.28***	Increase	MEETING

*Notes: *** = significant at α=0.05, † = not significant at α=0.05*

Of the seven monitoring metrics aligned with Milestone 1, Ohio is meeting the demonstration target for five metrics. Between baseline and the midpoint, there was a substantial (about 20-25%) increase in the provision of outpatient services (ASAM 1), intensive outpatient and partial hospitalization services (ASAM 2.1, 2.5), and medication-assisted treatment. There was a more modest (4.76%) increase in residential and inpatient services (ASAM 3) and in the continuity of pharmacotherapy for OUD (5.1%). The change between baseline and midpoint for Metric 22 was a statistically significant increase. We note that Metric 10 exhibits substantial periodicity, likely attributable to the effect of COVID-19 case spikes in March 2020, winter 2020, and winter 2021, and the midpoint period for evaluation happens to be at a relative low point in the temporal cycle. This means that counts of beneficiaries receiving residential and inpatient services would be expected to increase in the spring and summer of 2022, which would increase the magnitude of the positive change in this metric since baseline. Trend plots for Metrics 8, 9, 10, and 12 can be found in the Appendix in Figure 7, Figure 9, Figure 11, and Figure 15, respectively.

Ohio is not meeting the demonstration target for Metric 7 (early intervention services) and is classified as “high risk” (trend plot can be found in the Appendix in Figure 6). Between the baseline and the midpoint, there was a large decrease (-48.95%) in the provision of early intervention services, while the demonstration target was an increase. The magnitude of this decrease relative to the average quarter-to-quarter variation (-11.05%) merited a classification of “high risk” for this metric. Figure 6 indicates that there was a large drop-off in early intervention services at the onset of the COVID-19 pandemic in March and April 2020, but following a modest recovery in the second half of 2020, there has continued to be a decline in these services for the “all Medicaid” group. For the OUD subpopulation (which is the only subpopulation with sufficient observations to report findings) there was a comparable drop corresponding to the onset of the pandemic, but early intervention services have been largely consistent following that initial decrease. This seems to indicate that early intervention services for beneficiaries without an OUD diagnosis are the source of decline since the end of 2020 for the “all Medicaid” group. Further investigation from the SUD monitoring team has shown that there was a significant decrease in early intervention services prior to

the onset of the pandemic: starting in November 2019, there was a drop in the number of providers billing for one key Early Intervention code (G0397, longer SBIRT). It is worth noting that the specifications for Metric 7 excludes any early intervention service that is delivered on the same day as an outpatient service, which is likely resulting in an undercounting of early intervention services in Ohio (although this would not be expected to impact the trend over time).

Ohio is also not meeting the demonstration target for Metric 11 (withdrawal management services) and is classified as "monitor" (trend plot can be found in the Appendix in Figure 13). For Metric 11, there was a substantial (29.22%) increase in the provision of withdrawal management services, while the demonstration target for this metric was consistency. We classify this metric as "monitor" because it is not inherently clear that an increase in withdrawal management services between the baseline and midpoint is cause for concern, despite this outcome not aligning with the state's original target. Further explanation is needed for the state's target of "consistency" for withdrawal management to understand the full implications of an increase in this metric. We also note that while the number of beneficiaries receiving withdrawal management has increased in the demonstration population, the OUD subpopulation, and among older adults, there was little change for pregnant women, youth, or the MPRE subpopulation (Figure 14).

While "all Medicaid" trends between baseline and midpoint are meeting targets for Metrics 8, 9, 10, and 12, there are certain subpopulations in Ohio that are experiencing very different care provision. Figure 8, Figure 10, Figure 12, and Figure 16 in the Appendix show subpopulation trends over time for these metrics. We discuss each subpopulation below.

- A particularly concerning finding is that there has been a decline in the number of pregnant women receiving care for outpatient services (M8), IOP/PHP services (M9), residential and inpatient services (M10), and MAT (M12). Stakeholder feedback on barriers to care for pregnant women are further discussed in the stakeholder input sections of Milestones 1 and 4.
- There has also been a decline in the number of individuals with criminal justice involvement (MPRE) receiving care for outpatient services (M8),

residential and inpatient services (M10), and MAT (M12), with little change in provision of IOP/PHP services (M9) for this subpopulation. However, there has been a decline in enrollment in the MPRE program over the last two years, so the trends exhibited for these metrics are consistent with a shrinking subpopulation and may not indicate any meaningful reduction in access to care.

- For youth, there has been little change between baseline and midpoint for outpatient services (M8) and MAT (M12), with a decline in provision for IOP/PHP services (M9) and residential and inpatient services (M10).

- For older adults, there has been a strong upward trend in treatment that matches the trends for the entire Medicaid population for outpatient (M8), IOP/PHP (M9), and residential and inpatient (M10), with a more modest increase in MAT (M12).

- For the subpopulation with an OUD diagnosis (see Figure 7, Figure 9, Figure 11, and Figure 15), trends match the broader Medicaid population, although increases between baseline and midpoint tend to be less substantial, except for MAT services (M12), for which the change in treatment for the OUD subpopulation very closely mirrors treatment for the broader demonstration population.

Overall, the trends in metrics associated with Milestone 1 indicate a substantial increase in the number of beneficiaries receiving treatment for SUD between baseline and midpoint. There has been an expansion in care for much of ASAM levels 1-3, and for MAT, in addition to an increase in the use of continuous pharmacotherapy treatment for adults with OUD. The increase in withdrawal management services may also be indicative of a positive expansion of treatment, although further explanation from the state is required. These trends are consistent for the Medicaid population overall, as well as for older adults and among those with an OUD diagnosis. However, the areas of most concern for Milestone 1 are the substantial decline in the number of beneficiaries receiving early intervention services (M7), a decline in treatment along multiple critical levels

of care for pregnant women, and little change in treatment over time for youth beneficiaries.

Monitoring metrics associated with Milestone 1 (access to critical levels of care) indicate that Ohio is on track to reach demonstration period targets. It is important to note, however, that six of the seven metrics associated with this milestone are counts of beneficiaries receiving services rather than measures of true *access*, which would measure the proportion of beneficiaries needing care who were able to receive that care. Medicaid caseloads expanded during the PHE from 2.65 million in December 2019 to 2.97 million in December 2020 and 3.19 million in December 2021, and there was an increase of 32,111 in the number of Medicaid beneficiaries with a primary or SUD diagnosis between 2019 and 2021.[17] Therefore, the increase in beneficiaries receiving each level of care described in Metrics 8-12 between December 2019 and March 2022 may be a result of increased Medicaid enrollment and more beneficiaries with an SUD diagnosis who were seeking treatment, rather than reflecting improved access to care. While increases in the numbers of people receiving SUD treatment at most levels of care is a positive change in Ohio, Metrics 8-12 alone likely do not provide a full picture of access to treatment. In fact, the stakeholder feedback we gathered described barriers to care that persist for some Ohio Medicaid enrollees needing SUD treatment (see: Stakeholder Input).

Implementation Plan Action Items

Ohio was meeting CMS Milestone 1 specifications prior to application and implementation of the Waiver Demonstration. As a result of BH redesign, Ohio Medicaid covered all ASAM critical levels of care, including outpatient and intensive outpatient services, MAT, intensive LOC in residential and inpatient settings, and medically supervised withdrawal management. Accordingly, no action items were identified for Milestone 1. However, efforts may be required at the state level to

[17] 12-Caseload.pdf (ohio.gov), Caseload_SFY22_DEC.pdf (ohio.gov) Accessed September 21, 2022. For change over time in Medicaid beneficiaries with an SUD diagnosis, see state-provided counts in Table 25-Table 30 and Metrics 3 and 4 in Table 17 for monthly and annual SUD diagnosis counts.

ensure that Medicaid recipients have equitable access to appropriate LOCs across the state. Stakeholder feedback described existing structural, procedural, and individual factors that impact access to care and Ohio's progress in meeting Milestone 1.

Milestone 2: Use of Evidence-based, SUD-specific Patient Placement Criteria

Milestone 2 assures that evidence-based, SUD-specific patient placement criteria are used to assess and deliver individualized care. SUD treatment providers and Medicaid MCPs must adhere to ASAM criteria when assessing treatment needs and implementing treatment plans. MCPs are responsible for implementing utilization management policies that ensure individuals have access to the appropriate ASAM LOC and receive appropriate care for their diagnosis and LOC, and an independent process for reviewing placement in residential treatment settings. Prior to applying for the Waiver Demonstration, Ohio required all SUD treatment providers to assess and provide services using ASAM criteria. Ohio's comprehensive approach includes strategies to review existing utilization management policies and practices and develop new, standardized, utilization management policies and procedures.

Metrics Reporting

TABLE 6: MILESTONE 2 YEARLY PERFORMANCE METRICS

#	Milestone 2 Yearly Performance Metrics	Description	At Baseline (Oct 2019-Sep 2020)	At Mid-Point (Oct 2020 – Sep 2021)	Absolute Change	% Change	State's Demonstration Target	Status at Mid-Point
5	Medicaid Beneficiaries Treated in an IMD for SUD	Number of beneficiaries with a claim for inpatient/residential treatment for SUD in an IMD during the measurement period	28,010	30,323	2,313	8.26	Decrease	NOT MEETING-MONITOR
36	Average Length of Stay in IMDs	The average length of stay for beneficiaries discharged from IMD inpatient/residential treatment for SUD	15.59	14.84	-0.75	-4.81	Consistent	NOT MEETING-MONITOR

Yearly Metrics 5 and 36 are the two critical metrics associated with Milestone 2. The state's demonstration targets were a decrease in the number of beneficiaries treated in an IMD for SUD (M5) and no change in the average length of stay in IMDs (M36). Ohio is not meeting targets for either of these metrics – between baseline and midpoint there was a modest increase (8.26%) in beneficiaries treated in an IMD and a small decrease (-4.81%) in the average length of stay in an IMD. Despite the state not meeting targets for these two metrics, we classify each as "monitor" rather than at-risk because of known measurement issues discussed in the

Limitations section. While Ohio identifies institutional/hospital-based IMDs using state-specific Provider Type 02 (Psychiatric Hospital) and state-specific Provider Specialty 018 (IMD), the state is currently developing a method to identify bed counts at residential IMDs in Ohio. In the meantime, Metrics 5 and 36 both use all residential treatment facilities as a proxy for residential IMDs. Therefore, we caution against using these findings to assess change in treatment for SUD in all IMDs for two reasons. First, these metrics likely do not accurately reflect patient counts and stay lengths due to the discrepancy between the proxy measure for residential IMDs and the true outcome. For example, we expect that Metric 5 is overestimating the number of individuals receiving treatment at residential IMDs, as many residential treatment facilities will not qualify as IMDs once criteria are finalized. Relatedly, Metric 36 may not be capturing the average length of stay for beneficiaries in an IMD because the current data does not identify residential IMD stays directly. Second, the change between baseline and midpoint for these metrics may not reflect true trends in treatment in an IMD. Since Metric 5 is using all residential treatment facilities as a proxy for residential IMDs, the increase between baseline and midpoint may simply be reflecting the expansion in overall residential and inpatient services discussed in the context of monthly Metric 10 (see Table 4) and may not actually indicate a true increase in the number of beneficiaries with a claim for inpatient/residential treatment for SUD in an IMD in particular. This is similarly the case for Metric 36, which is indicating an overall decrease in the length of all residential treatment stays, but which might not be representative of IMD stays specifically. Once the state has completed its process of defining residential IMDs, further examination into these metrics will be necessary.

Implementation Plan Action Items

Ohio identified five action items, detailed in Table 7, related to the use of evidence-based, SUD-specific placement criteria for Medicaid beneficiaries in need of SUD treatment services. All five action items have been completed.

Ohio completed the utilization management review and data analysis as part of the waiver requirements and stakeholder concerns. Data was collected and analyzed from each of the MCPs, including quantitative review of claim approvals, denials, appeals, average length of stay, etc., as well as qualitative review of MCP policies and procedures. Data reviewed encompassed the first 15 months of MCP oversight of SUD residential treatment (07/01/2018 – 10/31/2019). Analysis included ASAM levels of care 3.1-3.7 and ASAM level 4. Results of the review were shared during the June 26, 2020 SUD 1115 Stakeholder Advisory Committee meeting.

In partnership with the SUD 1115 Stakeholder Advisory Committee Utilization Management Targeted Workgroup, Ohio developed the *Substance Use Disorder Services Prior Authorization Request*, a standard form to be used by all MCP, Fee for Service, and MyCare plans and treatment providers for all SUD residential and partial hospitalization services. The form was implemented on July 1, 2021. Extensive guidance was provided to MCPs and providers via the Ohio Department of Medicaid website[18] and other communications.

[18] Ohio Department of Health Prior Authorizations webpage: https://medicaid.ohio.gov/resources-for-providers/billing/prior-authorization-requirements/prior-authorization-requirements

Table 7: Milestone 2 Action Items		
Action Item Description	Date to be completed	Current Status (completed, open, suspended)
Review plan policies for utilization review and prior authorization for compliance.	09/24/2021	Completed
Review plan delivery for program compliance (e.g. treatment plan, provider qualifications, etc.)	09/24/2021	Completed
Collect, review, and analyze utilization management information for CY2018	09/24/2021	Completed
Based upon review and analysis, develop changes to the utilization management approach that reflect analysis and ensure compliance with ASAM and MHPAE	09/24/2021	Completed
Develop necessary guidance to plans and providers regarding the new UM process	09/24/2021	Completed

As adherence to Milestone 2 is strengthened, each of these domains will continue to improve to further data tracking and healing outcomes, among levels, agencies, providers and clients, across the SUD 1115 waiver's continuum of care.

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

Milestone 3 aims to ensure implementation of residential treatment provider qualifications that meet ASAM's SUD-specific program standards regarding services provided, staff credentials, and hours of clinical care, as well as a state process for reviewing compliance with these standards. The milestone includes a requirement

that residential treatment facilities either offer MAT on-site or facilitate off-site access. Ohio's strategies for ensuring compliance with ASAM standards among residential treatment providers include implementing updated provider requirement rules for OhioMHAS certified treatment providers, requiring MCPs to adhere to ASAM standards, facilitating a cultural shift from abstinence-only treatment to acceptance of MAT, and completing comprehensive SUD residential treatment provider on-site reviews to assess ASAM compliance and provide technical assistance.

Metrics Reporting

There are no critical monitoring metrics associated with Milestone 3.

Implementation Plan Action Items

Ohio identified 8 action items, detailed in Table 8, related to implementation of ASAM standards for treatment services and staff credentials, facilitation of MAT in residential treatment and on-site compliance reviews. Six of those action items have been completed and two are still open.

The OhioMHAS residential and withdrawal management of SUD services rule (OAC 5122-29-09) was submitted to Ohio's Common Sense Initiative Office (CSIO) for review on September 20, 2021. The proposed changes were open for public comment until October 8, 2021, and will go into effect on July 1, 2023. While this action item was planned for completion by September 24, 2021, shifting resources resulting from the COVID PHE delayed rule development and submission. The updated rule, developed with SUD Advisory Committee Prover Standards Targeted Workgroup input, strengthens Ohio's requirements for residential and withdrawal management substance use disorder services to ensure that residential treatment services are delivered in accordance with ASAM LOCs 3, 3-WM, and associated sub levels.

On July 1, 2020, Ohio's MCP provider agreement was amended to include the use of ASAM criteria in approvals of inpatient SUD treatment admissions. Additionally, Ohio's managed care plan agreements, which go into effect on February 1, 2023,

require MCPs to comply with ASAM criteria for residential treatment requirements, as well as state processes for credentialling SUD residential providers.

On January 3, 2022, Ohio released a Request for Proposals to select the statewide vendor to perform SUD residential treatment on-site reviews. Health Management Associates were selected as the vendor and the on-site review process commenced in late summer 2022. The site visits are intended to assess residential treatment provider compliance with pending OhioMHAS rule 5122-29-09 requirements, which go into effect July 1, 2023, and provide technical assistance to help providers meet the requirements. The site visits are expected to continue through spring of 2023, with a final report due to ODM in the summer of 2023. Vendor selection and site visit action items, which were expected to have been completed by September 24, 2021, were delayed due to the COVID-19 PHE. Resource shifts required to address the PHE and safety considerations related to on-site visits contributed to the delay.

While a cultural shift toward acceptance of MAT among SUD treatment providers is well underway, no formalized education or engagement strategies have been implemented with abstinence-only treatment providers. While access to MAT in Ohio continues to improve (see MM12), key informant interview and focus group discussions revealed there are still many providers in Ohio who adhere to abstinence-based treatment ideologies. It is unknown how many providers continue to deliver abstinence-only treatment services, but on-site SUD residential treatment reviews will provide the state with a clearer picture of the prevalence of abstinence-only residential care in Ohio.

Table 8: Milestone 3 Action Items		
Action Item Description	Date to be completed	Current Status (completed, open, suspended)
Update the State requirements to reflect residential requirements for the types of services, hours of clinical care and credentials of staff for each ASAM residential LOC.	09/24/2021	Completed
Require the plans to comply with updated ASAM residential requirements.	09/24/2021	Completed
Implement a standardized State on-site review process of residential provider qualifications against State requirements for ASAM including the types of services, hours of clinical care and credentials of staff for each ASAM residential LOC	09/24/2021	Open
Implement a single statewide vendor to survey Ohio SUD residential providers to assure they meet certain standards and manage provider enrollment on an on-going basis.	09/24/2021	Completed
Require the plans to comply with state processes for credentialling SUD residential providers.	09/24/2021	Completed
Educate abstinence-based residential providers on benefits of MAT accessibility and begin cultural shift toward acceptance of MAT as a complementary treatment.	09/24/2021	Open
Require SUD treatment providers to offer access and to facilitate patient access to MAT while in residential settings	09/24/2021	Completed
Require the FFS delivery system and the plans to monitor access to MAT in residential settings including access to MAT counseling	09/24/2021	Completed

Ohio has implemented sweeping changes to SUD residential treatment policies and practices through strengthened provider requirement rules, updated MCP agreements, and the implementation of SUD residential treatment on-site reviews and technical assistance. Lingering stigma associated with MAT and adherence to abstinence-only treatment among some SUD providers pose barriers to implementing MAT in residential treatment and efforts to educate providers and treatments are still needed.

Milestone 4: Sufficient Provider Capacity at Critical LOC including for MAT for OUD

Milestone 4 requires the state to complete an assessment of provider availability at each LOC listed in Milestone 1. The assessment must determine the availability of treatment for individuals enrolled in Medicaid in each LOC, including the availability of MAT and medically supervised withdrawal management, throughout the state. The assessment is intended to identify gaps in availability of services at each critical LOC. Prior to the incorporation of community BH services into MCP contracts in 2018, Ohio completed readiness reviews of MCPs to ensure provider panel standards were being met. Ohio's strategies to meet Milestone 4 include comprehensive provider availability assessment and implementation of policies that address gaps in services across the state.

Metrics Reporting

TABLE 9: MILESTONE 4 YEARLY PERFORMANCE METRICS

#	Milestone 4 Yearly Performance Metrics	Description	At Baseline (Oct 2019-Sep 2020)	At Mid-Point (Oct 2020 - Sep 2021)	Absolute Change	% Change	State's Demonstration Target	Status at Mid-Point
13	Provider Availability	The number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period	89,023	96,149	7,126	8.00	Increase	MEETING
14	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	2,141	4,594	2,453	114.57	Increase	MEETING

The two critical metrics associated with Milestone 4 are provider availability (M13) and provider availability for MAT (M14), both of which are yearly metrics. Ohio is meeting the demonstration target (increase) for both of these metrics. Between baseline and midpoint, there was a small increase (8.0%) in the number of providers who were enrolled in Medicaid and qualified to deliver SUD services during the measurement period (M13). There was a much larger increase (114.57%) in the expansion of provider availability for MAT, with the number of qualified Medicaid providers who met standards to provide buprenorphine or methadone more than doubling between demonstration year 1 and demonstration year 2. The trends in these metrics indicate good progress at the state-level for access to SUD care, and medication-assisted treatment in particular. The state's provider availability assessment data collection effort along with feedback from stakeholders indicate sub-state geographic variation in availability, which we discuss in-depth in the next few sections

Implementation Plan Action Items

Ohio identified five action items, shown in Table 10, related to sufficient provider capacity at all LOCs, including MAT for OUD. These action items focused on assessing provider capacity and creating access standards for each of the LOCs. Each of the five action items have been completed.

Ohio completed an access assessment baseline (state fiscal year 2019) of SUD treatment providers, including MAT for OUD, in September 2020. A follow-up assessment was completed in August 2022. These assessments are discussed in detail under the *Provider Availability Assessment* section of this report.

Ohio's Next Generation MCP contracts, including the OhioRISE contract, require MCPs to ensure member access to all Medicaid-covered BH services and maintain provider appointment access standards, as well as time and distance standards, by ASAM LOC. MCPs are additionally required to maintain provider panel access standards in compliance with federal standards set forth in 42 CFR 438.206. MCPs that do not meet access standards are required to pay for the next higher LOC for individuals seeking SUD treatment services. MCPs must maintain provider directories that include indication of whether each provider is accepting new

members and submit quarterly reports to ODM that demonstrate provider panel adequacy.

In addition to the completing the identified action items, Ohio distributed Coronavirus Aid, Relief and Economic Security (CARES) Act funds[19] in 2020 and American Rescue Plan (ARPA) Supplemental Block Grant funds in 2022[20] to support behavioral health and SUD treatment provider operations.

Table 10: Milestone 4 Action Items

Action Item Description	Date to be completed	Current Status (completed, open, suspended)
Create a comprehensive access assessment baseline of all SUD providers and all SUD LOC, including MAT capacity	09/24/2020	Completed
ODM will create access standards for SUD LOC	09/24/2020	Completed
Require MCPs to update their SUD network development and management plan to specifically focus on SUD provider capacity by LOC, including MAT	03/24/2021	Completed
Add an indicator for providers accepting new patients to the plan quarterly network adequacy reports	09/24/2021	Completed
Require the plans to adopt access requirements for all ASAM LOC	09/24/2020	Completed

[19] https://mha.ohio.gov/about-us/media-center/news/pr12-23-2020

[20] https://mha.ohio.gov/about-us/media-center/news/nearly-15-million-of-arpa-block-grant-funding-will-help-strengthen-behavioral-healthcare-services-01262022

Provider Availability Assessment Data

As a part of Milestone 4 requirements, Ohio Department of Medicaid conducted a provider availability assessment to help determine whether the state has adequate provider capacity at critical levels of care. Tables and maps for each level of care were shared with the midpoint assessment team. This data was also presented by the Ohio Department of Medicaid to the SUD 1115 Stakeholder Advisory Committee during its August 16, 2022 meeting as a part of its provider availability assessment for the state of Ohio.

The data provided by the state, however, has limited use in evaluating provider availability, or in assessing whether the state has sufficient provider capacity at each level of care, due to several limitations. First, nearly all of the provider data shared by the state uses *billing* provider information; the only exception to this is for MAT for OUD providers, for which the state provided *prescribing* provider data in addition to billing provider data. While counts and geolocations of billing providers gives an approximate view of provider capacity, it does not provide a full picture of the number and locations of providers who are providing services to patients. This is because billing providers vary in their number of associated rendering providers, the latter being more indicative of the number of available providers who can give care to patients. Additionally, the geolocation of a rendering provider may be substantially different from the location of its associated billing provider. The state has shared with the GRC Midpoint Assessment team that billing provider information was used for the state provider availability assessment despite these substantial limitations because Medicaid rendering provider information is unreliable due to incomplete information about provider type. Data collected through Ohio Medicaid's new Provider Network Management (PNM) module, which launched October 1, 2022, is expected to greatly improve the quality of rendering provider data. The PNM is a component of Ohio's Medicaid systems modernization efforts that will collect data, such as location and specialty, directly from providers. The state will be able to perform future provider availability assessments with precise rendering provider data.

Second, beyond the issue of unreliable rendering provider information and the substantial limitations in drawing conclusions about provider capacity from billing provider data, we are also limited in our ability to determine "sufficient capacity" without county-level provider-to-SUD-beneficiary ratios. While the state provided state-wide billing provider-to-SUD-beneficiary ratios, the substantial geographic variation in SUD prevalence indicates that sub-state assessments which account for variation in treatment need are imperative. Mapping county-level provider counts or change over time in those counts is not adequate to determine whether there is sufficient supply of treatment providers for the number of Medicaid beneficiaries needing that care. Rendering provider data collected through the PNM is expected to allow the state to calculate county-level rendering-provider-to-SUD-beneficiary-ratios to determine sub-state provider availability relative to need. This will, in turn, allow the state to more accurately set state-wide and county-level access standards to address any regional gaps in capacity.

Finally, in addition to higher quality and more geographically disaggregated data accounting for SUD treatment demand, we require state guidance on SUD treatment access standards. For example, while we have calculated the state-wide MAT for OUD prescribing provider to SUD beneficiary ratio (discussed in detail in the next section), this proportion is somewhat unhelpful without a standard against which to evaluate it. Both state-wide and county-level (the latter potentially taking into consideration population density) access standards for SUD treatment provider ratios are required for any complete assessment of state capacity.

Therefore, we feel that we do not currently have sufficient data to make a complete and accurate assessment of provider availability as requested by CMS. Below, we review findings from an analysis of MAT for OUD *prescribing* providers, for which the state believes there is good quality provider information. We also offer a limited discussion of the billing provider data shared with us in an effort to give an approximate, but incomplete, view of provider capacity in Ohio. We direct the reader to Appendix F for a more thorough discussion of the billing provider data tables and maps provided by the state. We conclude that it is of the utmost importance that the state continues efforts to gather higher quality data for identifying rendering providers. The counts and geolocation of rendering providers,

in addition to the counts and geolocations of Medicaid beneficiaries with SUD diagnoses, are arguably the most essential, and certainly the most proximate, inputs needed to measuring SUD treatment capacity in Ohio.

For the analysis of change over time in state-level provider to SUD beneficiary ratios discussed in the next two sections, we use hypothesis testing at $\alpha=0.05$ to determine statistically significant changes between 2018 and 2021. Statistically significant changes are indicated in tables with *** and insignificant changes are indicated with †.

Medication-Assisted Treatment for OUD (Prescribing Providers)

The state provided both prescribing and billing counts for MAT OUD providers. We discuss trends and capacity in prescribing providers here and review MAT OUD billing provider data in the Appendix.

Table 11 shows that the rate of Medicaid MAT OUD prescribing providers per 1,000 Medicaid members with a primary or secondary SUD diagnosis has increased since 2018. We find that there is a significant increase at the 0.05 level between the 2018 and 2021 rates. The largest increase in the rate occurred between 2018 and 2019, and while there was a slight decline between 2020 and 2021 due to an expansion of the number of Medicaid members with an OUD diagnosis, the rate in 2021 is substantially higher than it was in 2018. Between 2018 and 2021 there was a net addition of nearly 1,000 Medicaid MAT for OUD providers. The 2021 rate of providers to patients equates to 1 Medicaid MAT OUD prescribing provider for every 33 Medicaid members with an OUD diagnosis.

Figure 1 shows that Ohio's two most populated counties, Cuyahoga County and Franklin County, had an enormous net increase in their number of MAT OUD prescribing providers between 2018 and 2021: 252 providers added in Cuyahoga and 288 additional in Franklin County. Other counties that experienced sizable increases (although nothing on the scale of Cuyahoga and Franklin counties) in their number of MAT OUD prescribing providers were Hamilton County (64), Summit County (48), Green County (36), and Butler County (28). Counties that experienced the largest contractions in net MAT OUD prescribing providers were

generally in the east and southeast of the state, including Gallia (-12), Jefferson (-9), Belmont (-9), and Coshocton (-8).

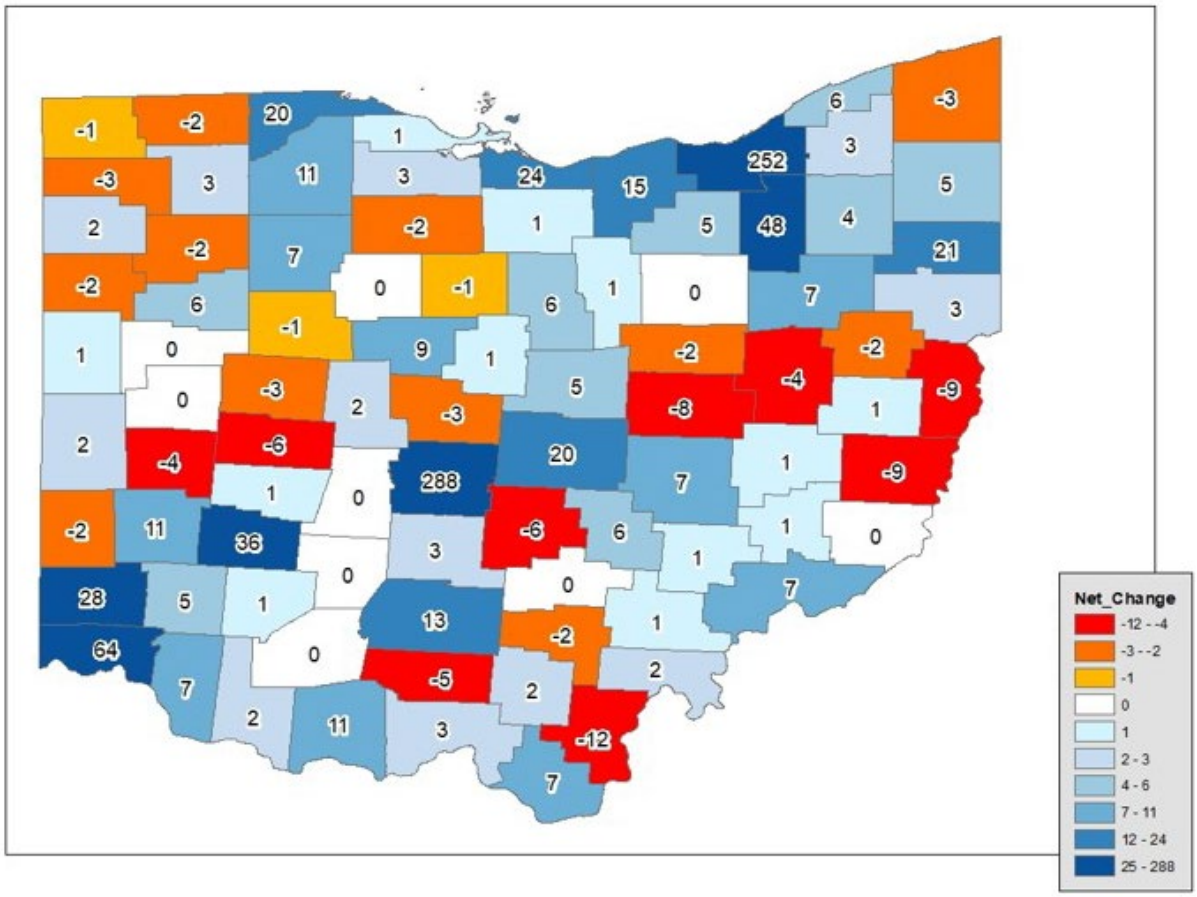
In conclusion, Ohio has expanded its MAT for OUD prescribing provider capacity, with a statistically significant increase in the prescribing provider to beneficiary ratio from 25.3 in 2018 to 30.4 in 2021. About half of this expansion occurred in two counties - Cuyahoga and Franklin counties.

Table 11: Statewide Counts for Medicaid MAT OUD Prescribing Providers (2018-2021)

Year	Medicaid Provider count	Medicaid members with OUD primary or secondary diagnosis	Medicaid Providers per 1,000 patients with OUD diagnosis
2018	4155	164,141	25.3
2019	4771	162,099	29.4
2020	5116	162,679	31.4
2021	5147	169,195	30.4***

*Notes: *** = significant difference from 2018 at α=0.05, † = not significant difference from 2018 at α=0.05*
Source: Ohio Department of Medicaid's Electronic Data Warehouse HHSPP, August 2022; Received from Ohio Department of Medicaid September 2022

Figure 1: Change in Medicaid MAT OUD Prescribing Provider Counts (2018 to 2021)



Source: Ohio Department of Medicaid's Electronic Data Warehouse HHSPP, August 2022; Received from Ohio Department of Medicaid September 2022

Summary of Findings from Analysis of Billing Provider Data

Between 2018 and 2021 there was no statistically significant change in billing provider ratios for most of the critical levels of care in Ohio: early intervention, IOP/PHP, withdrawal management, residential treatment, inpatient treatment, or MAT for OUD at the billing provider level (see Table 25, Table 27, Table 28, Table 29, Table 30, and Table 31 in Appendix). However, during this time period there was a statistically significant decrease in the outpatient billing provider ratio, from 13.2 in 2018 to 11.1 in 2021 (see Table 26 in Appendix). There has been a continuous decline in the number of outpatient billing providers since 2018.

There has been some clear geographic clustering in the expansion and contraction of all SUD billing providers in Ohio since 2018 (see Figure 41 in Appendix). Northeast counties have been particularly impacted by the overall decline in billing providers at all levels of care, with nearly all counties in the region experiencing a net loss of billing providers. This region also specifically lost many outpatient billing providers (see Figure 35 in Appendix) and some IOP/PHP billing providers during this period (see Figure 36 in Appendix), but did have a modest expansion in the number of MAT OUD billing providers (see Figure 40 in Appendix).

When it comes to treatment capacity at all levels of care in 2021, it is clear that billing providers are concentrated in the state's population centers (see Figure 44 in Appendix). This is undoubtedly due to higher absolute need for treatment in these areas, despite having lower relative need (i.e., lower rates of SUD diagnosis). Counties in southern Ohio have some of the highest rates of SUD diagnosis in the state, but the billing provider availability assessment maps show that there are limited numbers of billing providers operating in these areas. However, without county-level billing provider ratio data (i.e., data that takes into consideration the volume of need for treatment through county-level counts of SUD diagnosis), it is difficult to assess the adequacy of the billing provider capacity in these southern counties. Considering the aforementioned discussion of the limitations of billing provider data, our recommendation would be for the state to focus efforts on collecting and analyzing higher quality county-level rendering provider-to-SUD-beneficiary ratio data.

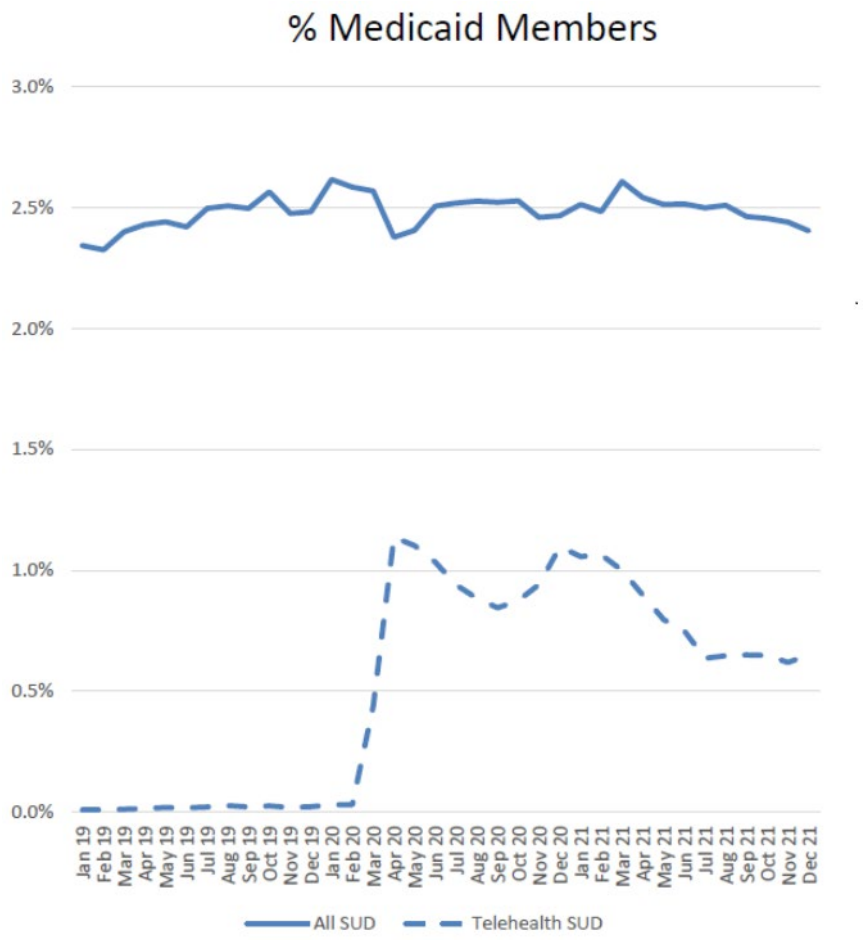
Provider Availability Via Telehealth Services

When the public health emergency began in full-effect in March 2020, SUD treatment providers were suddenly faced with substantial obstacles to providing services to patients in-person (see the section on COVID-19's Impact on Waiver Implementation for more discussion). In response, Ohio rapidly began to offer many SUD services via telehealth. Figure 2 below shows patient counts for the number of Medicaid members (as a percentage of total Medicaid members) using non-acute/non-emergent SUD services, as well as these patient counts for SUD

services provided via telehealth.[21] From January 2019 to December 2021, about 2.5% of all Medicaid members were receiving non-acute/non-emergent SUD services, with between 0.5 and 1% receiving these services via telehealth starting in March 2020. This means that between 20-40% of non-acute/non-emergent SUD services were being provided by telehealth between March 2020 and December 2021.

[21] SUD non-acute/non-emergent services were defined as claims that met any of the following criteria: SUD primary diagnosis, SUD procedure code, PT 95 billing provider, place of service code 55 or 58, SUD revenue center code. Outpatient and professional claims were used to identify SUD claims. ED claims were excluded and inpatient claims were not included.

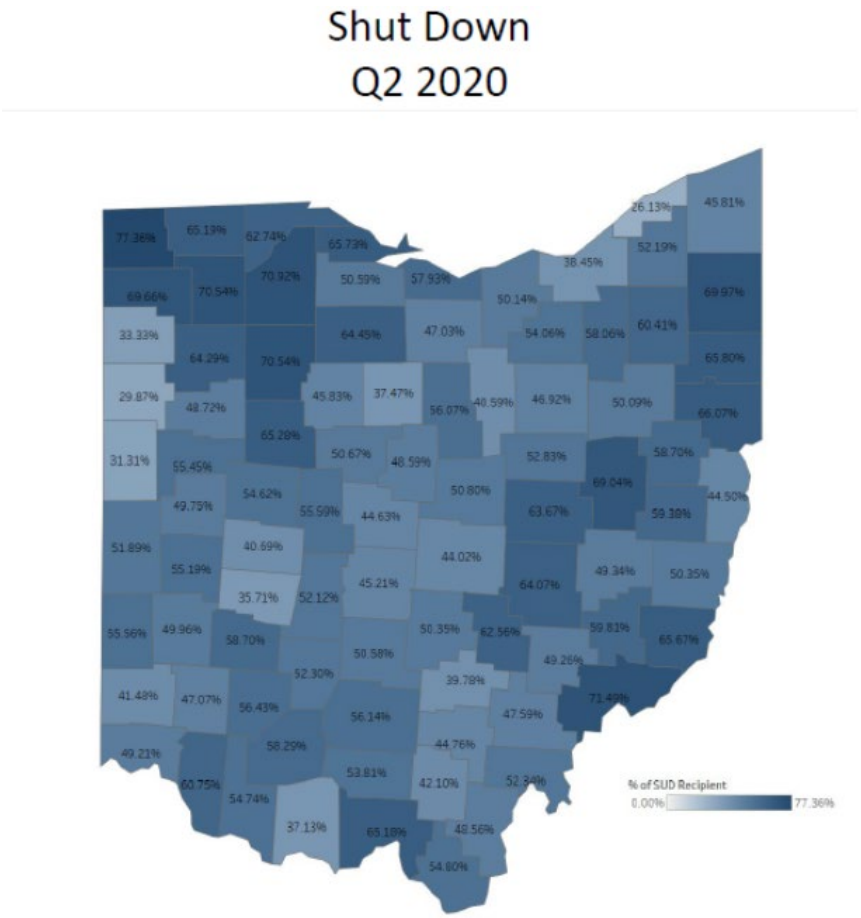
Figure 2: Medicaid members using non-acute/non-emergent SUD services (patient counts as a percentage of total Medicaid members) with telehealth split



Source: Ohio Department of Medicaid's Electronic Data Warehouse HHSPP, April 2022; Received from Ohio Department of Medicaid September 2022

Figure 3 below shows the percentage of Medicaid patients using telehealth for non-acute/non-emergent SUD services in Q2 of 2020 by county level. During this quarter, telehealth SUD services consisted of between 21 and 77% of non-acute/non-emergent SUD services being provided in Ohio counties, with 80 counties have 40% or more of these services provided via telehealth. These rates were substantial expansions as compared to Q4 of 2019 - maps for the percentage of Medicaid patients using telehealth for non-acute/non-emergent SUD services prior to the PHE (Q4 of 2019) and in Q4 of 2021 are in the Appendix (Figure 45 and Figure 46).

Figure 3: Percentage of Medicaid patients using telehealth for non-acute/non-emergent SUD services during the PHE, Q2 2020



Source: Ohio Department of Medicaid's Electronic Data Warehouse HHSPP, April 2022; Received from Ohio Department of Medicaid September 2022

In response to the public health emergency in March 2020, Ohio Medicaid implemented a rapid expansion of telehealth for SUD non-acute/non-emergent services. This innovative strategy to mitigate the decline in in-person services undoubtedly assisted Ohio in maintaining access to many services for patients with

SUD during the pandemic shutdown.[22] The long-term implications of a shift toward telehealth (which has been partially scaled back as of Q4 2021, see Figure 46 in Appendix) for SUD treatment access and quality are somewhat unclear. On the one hand, the use of telehealth presents an opportunity to reach more geographically remote patients and potentially minimize regional gaps in access to SUD services. On the other hand, as discussed in stakeholder feedback reviewed in the COVID-19 Impact on Waiver Implementation section, telehealth services face obstacles of a digital divide (either because of limited access to technology or digital illiteracy), and the reality that for some patients, telehealth services are no substitute for in-person treatment and support. Further examination of the impact of telehealth SUD services on treatment outcomes is needed to fully understand the (likely important) role that telehealth could play in not just maintaining but eventually increasing SUD provider availability in Ohio.

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

Milestone 5 focuses on a comprehensive approach to treatment and prevention strategies to address opioid abuse and OUD for individuals in Medicaid. Prior to Ohio's Waiver Demonstration application, comprehensive opioid prescribing guidelines that addressed emergency department prescribing, treatment of chronic, non-terminal pain, management of acute pain in non-emergency settings, and safety and screening for misuse which set a 50 MED threshold for reevaluating misuse were in place. Other initiatives implemented prior to the Waiver

[22] As discussed in the section titled *COVID-19 Impact on Waiver Implementation*, there were substantial drops in the number of beneficiaries who received treatment for early intervention services, IOP/PHP, residential and inpatient treatment, withdrawal management, and ED utilization for SUD in March, April, and May of 2020 (Metrics 7,9,10,11, and 23). These metric trends indicate that while non-acute/non-emergent SUD services did not experience a decline during the PHE, telehealth delivery was not able to services as a substitute for all types of SUD services.

Demonstration included closure of “pill mills”, prohibition of physicians’ ability to “phone in” Schedule II drugs, changes in MCP policies and practices related to problematic polypharmacy and case management services, inclusion of non-medication pain management services in Medicaid benefits, creation of a statewide drug prevention program for youth and families, and more. Additionally, Ohio made great strides in expanding access to Naloxone for overdose reversal, including covering Naloxone administered by pharmacists without a prescription. Ohio’s comprehensive approach strategies to meet Milestone 5 include improving the use of EHR and long-term opioid prescribing data, as well as incorporation of an enforcement plan to minimize the risk associated with overprescribing.

Metrics Reporting

TABLE 12: MILESTONE 5 MONTHLY PERFORMANCE METRICS

#	Milestone 5 Monthly Performance Metrics	Description	3-Month Moving Average at Baseline (Dec 19)	3-Month Moving Average at Mid-Point (Mar 22)	Absolute Change	% Change	State's Demonstration Target	Status at Mid-Point
23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	Number of ED visits for SUD (any diagnosis) per 1,000 beneficiaries	5.88	4.68	-1.2	-20.41***	Decrease	MEETING

*Note: *** = significant at α=0.05, † = not significant at α=0.05*

TABLE 13: MILESTONE 5 YEARLY PERFORMANCE METRICS

#	Milestone 5 Yearly Performance Metrics	Description	At Baseline (2019)	At Mid-Point (2020)	Absolute Change	% Change	State's Demonstration Target	Status at Mid-Point
18	Use of Opioids at High Dosage in Persons Without Cancer	Percentage of beneficiaries aged 18 or 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	3.57	3.39	-0.18	-5.04†	Decrease	NOT MEETING—LOW RISK
21	Concurrent Use of Opioids and Benzodiazepines	Percentage of beneficiaries aged 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	17.14	15.48	-1.66	-9.68***	Decrease	MEETING
	Metric	Description	At Baseline (Oct 2019-Sep 2020)	At Mid-Point (Oct 2020 - Sep 2021)	Absolute Change	% Change	State's Demonstration Target	Status at Mid-Point
27	Overdose death rate	Rate of overdose deaths (all causes) during the measurement period among Medicaid beneficiaries living in a geographic area covered by the demonstration (per 1,000 beneficiaries)	0.954	1.06	0.11	11.11***	Decrease	NOT MEETING-HIGH RISK

*Note: *** = significant at α=0.05, † = not significant at α=0.05*

There is one monthly and three yearly metrics associated with Milestone 5, and Ohio is meeting the state's demonstration target for two of the four metrics. Ohio's target for emergency department utilization for SUD (Metric 23) was a decrease, and between the baseline and midpoint there was a substantial (-20.41%) and statistically significant drop in the number of ED visits for SUD (any diagnosis) per 1,000 beneficiaries (see Figure 17 in the Appendix). Ohio's target for use of opioids at high dosage in persons without cancer (Metric 18) was a decrease, and while there was a modest decline (-5.04%) between baseline (2019) and midpoint (2020), this change was not statistically significant. Therefore, we classify Metric 18 as "not meeting – low risk" because hypothesis testing indicates that there was no significant change in this metric at midpoint. Ohio's target for concurrent use of opioids and benzodiazepines (Metric 21) was also a decrease, and there was a statistically significant decline (-9.68%) in the percentage of adult beneficiaries with concurrent use of prescription opioids and benzodiazepines between the baseline and midpoint.

Metric 21 indicates a reduction in the overuse of prescription opioids. The interpretation of the substantial drop in ED visits for SUD (Metric 23) is more difficult to discern. It may be that the overall trend does indicate a shift toward more appropriate levels of care for treatment of SUD. However, we caution that this metric has substantial periodicity and therefore the magnitude of the change between baseline and midpoint is highly dependent upon the selection of these two evaluation points. For example, Figure 17 shows that the midpoint (March 2022) is at a relative low point in the cycle and therefore ED utilization would be expected to increase in the following months. Depending on the size of the increase in the spring and summer of 2022, this could even change the direction of overall trend. However, the average rate for March 2022 is noticeably lower than rates from March 2021 and March 2020, so it is unclear whether the cyclical increase would bring ED utilization rates as high as they've been at previous peaks.

The periodicity in this metric may be driven by the dynamics of the COVID-19 pandemic: the rate of ED utilization for SUD exhibited a cyclical trend that corresponded with COVID-19 spikes at the beginning of the pandemic and in the winters of 2020 and 2021 (Delta wave). It is possible that Ohioans were avoiding

emergency departments and hospitals and staying home rather than seeking care. Therefore, a longer time horizon is required to determine whether the downward trend in this metric is truly reflecting a long-term reduction in the rate of ED utilization for SUD.

When examining subpopulation trends for Metric 23, the rate of ED utilization for SUD among the OUD subpopulation exhibited a decline similar to the "all Medicaid" group (Figure 18 in Appendix). However, during this period there was no change in the already very low rate of ED utilization for SUD for youth, and there was an increase in the rate for older adults (Figure 19). The latter finding indicates that while ED utilization for SUD is trending in the right direction for the general Medicaid population, the state should further examine the use of emergency department services for older adults with SUD. Version 4.0 of the Monitoring Metrics Technical Specifications do not list pregnant or criminal justice system-involved beneficiaries as subpopulations for reporting in Ohio for Metric 23.

For Metric 27, Ohio's demonstration target was a decrease in the overdose death rate, but between baseline (October 2019-September 2020) and midpoint (October 2020-September 2021) there was a statistically significant 11.11% increase in the all-cause rate of overdose deaths among Medicaid beneficiaries (per 1,000 beneficiaries). We classify this metric as "high risk" because of the size of this change relative to average inter-year changes, as well as the severity of the implications of an increase in this metric. Ohio's 11 percentage point increase in overdose deaths between demonstration year 1 and 2 (Metric 27) seems to contradict much of the progress made along other critical metrics, such as an expansion in the number of beneficiaries receiving treatment (Metrics 8-10, 12, 22) and provider availability (Metrics 13, 14), along with a reduction in the harmful use of prescription opioids (Metric 21). This disconnect may be indicative of the challenge of keeping pace with a changing addiction landscape as abuse of non-prescription synthetic narcotics rises in Ohio: the CDC estimated that while there was not a significant change in prescription opioid-related overdose deaths between 2019 and 2020 in Ohio, there was a 31.8% increase in synthetic opioid-

related overdose deaths during this same period.[23] This changing drug use landscape was highlighted in interviews with multiple treatment providers and state officials.

Implementation Plan Action Items

Ohio identified four action items related to implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD. The action items, listed in Table 14, are due to be completed by the end of the Waiver Demonstration period and are currently open. A number of updates are planned for the state's PDMP, Ohio Automated Rx Reporting System (OARRS), including flags for individuals participating in drug court programs and non-fatal overdose. State partners continue to collaborate on comprehensive communication and policy approaches to the prevention of opioid misuse and OUD.

An additional strategy employed by the state focused on supporting behavioral and physical health integration through care coordination and data exchange through increased use of Ohio's Health Information Exchanges (HIE) among inpatient and residential treatment providers. Approximately 80 behavioral health providers were awarded funds to expand their HIE connectivity.

[23] https://www.cdc.gov/drugoverdose/deaths/synthetic/index.html

Table 14: Milestone 5 Action Items		
Action Item Description	Date to be completed	Current Status (completed, open, suspended)
Continue to onboard new EHR and pharmacy dispensing system vendors.	09/30/2024	Open
Explore the possibility of analysis to correlate long-term opioid use directly to clinician prescribing patterns in conjunction with the ODM (Action item for the Board of Pharmacy).	09/30/2024	Open
Implement enhanced information in the OARRS including: OARRS flags for individuals who are participating in one of Ohio's drug court programs; non-fatal overdose, and naltrexone identification to identify individuals treated for SUD.	09/30/2024	Open
Implement an enforcement plan to minimize the risk of inappropriate overprescribing consistent with prescribing guidelines.	09/30/2024	Open

Ohio implemented a variety of comprehensive strategies to combat OUD prior to applying for the Waiver Demonstration. These included extensive prescribing guidelines, expanded access to Naloxone, and extensive use of the state's PDMP, OARRS, to monitor and address overprescribing of opioids. Ohio's progress in fighting the opioid epidemic has been the result of collaboration across state agencies, including health policy, law enforcement, and clinical authorities. Continued coordinated efforts to address opioid misuse and OUD prevention strategies will strengthen efforts to complete Milestone 5 objectives.

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

Milestone 6 focuses on interventions for coordinating the care of individuals with SUD as they transition between LOCs. Prior to Waiver Demonstration implementation, multiple interventions were in place to coordinate the care of individuals with SUD, including targeted case management, facility discharge requirements, care coordination in MCP contracts, and a proposed BH Care Coordination Program. Approval of Ohio's Waiver Demonstration has allowed Ohio the opportunity to re-evaluate care coordination and move towards more tailored care coordination models that meet the needs of populations with highest risk. Ohio's strategies to meet Milestone 6 include data and analysis review to identify the needs of individuals with SUD and development and implementation of care coordination models to meet those needs.

Metrics Reporting

TABLE 15: MILESTONE 6 YEARLY PERFORMANCE METRICS

#	Milestone 6 Yearly Performance Metrics	Description	3-Month Moving Average at Baseline (Dec 19)	3-Month Moving Average at Mid-Point (Mar 22)	Absolute Change	% Change	State's Demonstration Target	Status at Mid-Point
15.1	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation, alcohol)	Percentage of beneficiaries aged 18 and older with a new episode of alcohol abuse or dependence who initiated treatment through an AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis	44.19	44.64	0.450	1.02†	Increase	NOT MEETING—LOW RISK
15.2	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation, opioid)	Percentage of beneficiaries aged 18 and older with a new episode of opioid abuse or dependence who initiated treatment through an AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis	57.89	60.67	2.78	4.80***	Increase	MEETING
15.3	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation, other)	Percentage of beneficiaries aged 18 and older with a new episode of other drug abuse or dependence who initiated treatment through an AOD	43.89	44.85	0.96	2.19***	Increase	MEETING

		admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis						
15.4	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation, total)	Percentage of beneficiaries aged 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment through an AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis	46.12	46.95	0.83	1.80***	Increase	MEETING
15.5	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement, alcohol)	Percentage of beneficiaries aged 18 and older with a new episode of alcohol abuse or dependence who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit	14.40	14.72	0.32	2.22†	Increase	NOT MEETING—LOW RISK
15.6	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement, opioid)	Percentage of beneficiaries aged 18 and older with a new episode of opioid abuse or dependence who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit	37.07	39.48	2.41	6.51***	Increase	MEETING
15.7	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement, other)	Percentage of beneficiaries aged 18 and older with a new episode of other drug abuse or dependence who initiated treatment and who were	14.19	14.91	0.72	5.06***	Increase	MEETING

		engaged in ongoing AOD treatment within 34 days of the initiation visit						
15.8	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Engagement, total)	Percentage of beneficiaries aged 18 and older with a new episode of alcohol or other drug (AOD) abuse or dependence who initiated treatment and who were engaged in ongoing AOD treatment within 34 days of the initiation visit	18.50	18.9	0.40	2.15***	Increase	MEETING
17(1)	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (7 Day)	Percentage of ED visits for beneficiaries aged 18 and older with a principal diagnosis of AOD abuse or dependence who had a follow-up visit for AOD abuse or dependence within 7 days	18.59	18.11	-0.48	-2.58***	Increase	NOT MEETING—MEDIUM RISK
17(1)	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (30 Day)	Percentage of ED visits for beneficiaries aged 18 and older with a principal diagnosis of AOD abuse or dependence who had a follow-up visit for AOD abuse or dependence within 30 days	28.51	28.01	-0.50	-1.75†	Increase	NOT MEETING—LOW RISK
17(2)	Follow-up after Emergency Department Visit for Mental Illness (7 Day)	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 within 7 days	41.07	41.41	0.34	0.83†	Increase	NOT MEETING—LOW RISK
17(2)	Follow-up after Emergency Department Visit for Mental Illness (30 Day)	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	55.72	56.76	1.04	1.87***	Increase	MEETING

		follow-up visit for mental illness within 30 days						
	Metric	Description	At Baseline (Oct 2019-Sept 2020)	At Mid-Point (Oct 2020 – Sept 2021)	Absolute Change	% Change	State's Demonstration Target	Status at Mid-Point
25	Readmissions Among Beneficiaries with SUD	The rate of all-cause readmissions during the measurement period among beneficiaries with SUD	0.198	0.201	0.003	1.52†	Decrease	NOT MEETING—LOW RISK

*Note: *** = significant at α=0.05, † = not significant at α=0.05*

There are 13 metrics associated with Milestone 6 and Ohio is meeting targets for 7 of the 13. Metrics 15.1-15.4 address initiation of alcohol and other drug dependence treatment, and Ohio is meeting its demonstration target (increase) for Metrics 15.2-15.4, with statistically significant increases of 4.80% for Metric 15.2, 2.19% for Metric 15.3, and 1.80% for Metric 15.4 between the baseline and midpoint. While Ohio had a 1.02% increase for Metric 15.1 – initiation of treatment for alcohol use - this was not a statistically significant change. Therefore, we classify Metric 15.1 as "low risk" due to the lack of significant change between baseline and midpoint. Metrics 15.5-15.8 address engagement of alcohol and other drug dependence treatment, and for this set of metrics Ohio is meeting its demonstration target (increase) for Metrics 15.6-15.8, with statistically significant increases of 6.51% for Metric 15.6, 5.06% for Metric 15.7, and 2.15% for Metric 15.8 between baseline and midpoint. Ohio had a 2.22% increase for Metric 15.5 – engagement of treatment for alcohol use – but this was not a statistically significant change. Therefore, we classify Metric 15.5 as "low risk" due to the lack of significant change between baseline and midpoint. From this set of 8 metrics, it appears that Ohio needs to focus efforts on increasing the initiation and engagement of treatment for individuals with alcohol use. Between baseline and midpoint, the state has increased its rates in the initiation and engagement of treatment for individuals using opioids and other substances.

There are four metrics associated with emergency department follow-ups for AOD abuse/dependence and mental illness, with each metric measured at 7 days following a visit and 30 days following a visit. Ohio is meeting the demonstration target (increase) for one of the four metrics – between baseline and midpoint there was a statistically significant increase of 1.87% in the percentage of 30-day follow-ups for a mental illness visit to the emergency department (Metric 17(2), 30). However, the state is not meeting the target for the 7-day version of Metric 17(2) or either the 7-day or 30-day versions of Metric 17(1). [24] While there was a 0.83% increase in 7-day follow-ups for a mental illness visit to the emergency department (Metric 17(2), 7), this was not a statistically significant change. Therefore, we classify Metric 17(2), 7 as "low risk" due to the lack of significant change between baseline and midpoint. For the 7-day version of Metric 17(1), there was a statistically significant -2.58% decrease in 7-day follow-ups for an AOD abuse/dependence visit.

[24] We note that there is some misalignment between Ohio's billing practices and national metric standards for Metric 17(1). While the list of follow-up services considered numerator compliant is expansive (such as most critical ASAM services, individual and group psychotherapy, and Evaluation/Management codes such as telehealth-based services), there is a set of services excluded from the metric. This includes any service with a non-primary SUD diagnosis, services for MAT/MOUD, and a few specific services such as Peer Recovery Support (H0038) and ASAM level 3.1 low-intensity residential treatment (H2034). The exclusion of these services from the metric leads us to expect that that as currently constructed, Ohio's Metric 17(1) is underestimating follow-up care. However, we do not expect that this difference in billing practices is impacting the trend over time, as a test of including the excluded value sets did not change the overall trend between baseline and midpoint.

Since this is a significant change in the opposite direction of the demonstration target, we classify Metric 17(1), 7 as "medium risk." For the 30-day version of Metric 17(30) there was a -1.75% decrease in 30-day follow-ups for an AOD abuse/dependence visit. However, this was not a statistically significant change. Therefore, we classify Metric 17(1), 30 as "low risk" due to the lack of a significant change between baseline and midpoint.

Finally, Ohio is not meeting the demonstration target for yearly Metric 25, which is readmissions among beneficiaries with SUD. While the state's target was a decrease in readmissions, there was a 1.52% increase in the rate of all-cause readmissions among beneficiaries with SUD between demonstration year 1 and demonstration year 2. However, this was not a statistically significant increase, so we classify Metric 25 as "low risk" due to the lack of a significant change between baseline and midpoint.[25] We expect that that the COVID-19 public health emergency impacted this metric. First, follow-up outpatient care was somewhat limited during the PHE, so if an individual with an AOD diagnosis had complications or a relapse, they may have ended up back in the hospital rather than receiving outpatient care. Second, due to the PHE hospitals had limited capacity and therefore patients may have been discharged sooner than would be ideal, therefore resulting in an increase in the number of AOD patients ending up back in the hospital. There was a large spike in COVID-19 case counts in Ohio in the winter of 2020, which is included in the midpoint evaluation period (October 2020-September 2021), and plausibly impacted both hospital and outpatient care in the aforementioned ways.

Overall, while Ohio is making good progress on the initiation and engagement of treatment for opiate and other substance use, as well as in the 30-day follow-up care for mental illness, there is more to be done in initiation and engagement of treatment for alcohol use, follow-up care for AOD, and in mitigating readmissions for beneficiaries with an SUD diagnosis

Implementation Plan Action Items

Ohio identified three action items related to improving care coordination and transitions between levels of care. Each of the three action items have been completed.

The Waiver Demonstration provided Ohio the opportunity to re-evaluate care coordination strategies and develop care coordination models tailored to meet the

[25] We also note that while Metric 25 data is processed with a 4-month lag (e.g. September 2021 data is processed in January 2022), inpatient claims often take many months to come in, and therefore may not all be captured in this metric. Additionally, because the metric uses paid claims only, and a lot of hospital claims do not get settled for 6+ months, this means that readmission rates may be updated as these claims are adjudicated. These two data processing realities would impact both the baseline and midpoint periods, but if there were any inconsistencies in billing patterns across years, this could affect the temporal trend.

needs of special populations, specifically for individuals with SUD. Ohio's Waiver Demonstration activities have included data review and analysis related to individuals enrolled in Medicaid with an SUD diagnosis, and service utilization. ODM and OhioMHAS have worked closely with MCPs and providers to identify BH and SUD care coordination needs and to develop care coordination models specific to populations identified to have the highest need. Ohio's updated care coordination models will aim to move away from "one size fits all" models and recognize that different target populations require different types of care coordination. Considerations for new models include using multiple attributes related to BH and SUD populations, data-driven attribution methodologies that can be replicated and updated regularly, multiple tiers of care coordination and re-evaluation of existing services with care coordination components, provider criteria that align with the care coordination needs of special populations, and other benefit considerations

OhioRISE (Resilience through Integrated Systems and Excellence) is the specialized managed care program for youth enrolled in Medicaid with complex behavioral health and multisystem needs. A primary component of OhioRISE is comprehensive, community-driven, care coordination across healthcare, BH, SUD, education, families, and other local entities to ensure individual care needs are met. Each youth involved with OhioRISE, and their family, is connected with a Care Management Entity (CME) to serve as the family's primary point of contact for coordinating behavioral health and family support services, including SUD services. OhioRISE launched on July 1, 2022. Ohio has also identified individuals with SUD and co-occurring/chronic conditions and individuals with mental illness and co-occurring/chronic conditions as potential target populations for new care coordination models.

Ohio's ongoing work with the SUD Advisory Committee Utilization Management Targeted Workgroup addresses the care coordination needs among individuals with SUD. To smooth transitions along the continuum of care, the group developed the *Substance Use Disorder Residential Treatment Notification of Admission* form. Released on August 12, 2022, the optional, standardized form can be used by residential treatment providers to notify a patient's Managed Care Entity (MCE) upon the patient's admission. The form and process is intended to facilitate communication between providers and MCEs and allow for early discharge planning and improved care coordination after discharge.

Table 16: Milestone 6 Action Items		
Action Item Description	Date to be completed	Current Status (completed, open, suspended)
Review data and conduct analysis of individuals with SUD.	09/24/2021	Completed
Based upon data analysis, develop care coordination model(s) specific to identified populations.	09/24/2021	Completed
Implement care coordination for identified populations	09/24/2021	Completed

Care coordination is a critical component of SUD recovery for many individuals in treatment. Ohio's continued efforts to reform BH and SUD care coordination aims to enhance individualized approaches and improve behavioral and physical health outcomes for people seeking SUD treatment.

Additional Metrics

In addition to the critical monitoring metrics that align with the SUD waiver milestones, Version 1.0 of the Mid-Point Assessment Technical Assistance document specifies that Metrics 3 and 4 should be considered in the overall assessment of the state's progress. Table 17 below shows the monthly and yearly versions of metrics tracking SUD diagnoses among Medicaid beneficiaries. For both Metric 3 and 4, Ohio is meeting the demonstration target (increase). For the monthly metric, there was a substantial increase (22.57%) between the baseline and midpoint in the number of beneficiaries who received MAT or SUD-related treatment with an SUD diagnosis during the measurement period. Figure 20 in the Appendix shows the monthly trend for Metric 3. The annual metric had a much more modest increase (5.96%) between the baseline and midpoint.

TABLE 17: ADDITIONAL PERFORMANCE METRICS (M3 & M4)

#	Monthly Performance Metric	Description	3-Month Moving Average at Baseline (Dec 19)	3-Month Moving Average at Mid-Point (Mar 22)	Absolute Change	% Change	State's Demonstration Target	Status at Mid-Point
3	Medicaid Beneficiaries with SUD Diagnosis (Monthly)	Number of beneficiaries who received MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period and/or in the 11 months before the measurement period	243,994	299,069	55,075	22.57	Increase	MEETING
	Yearly Performance Metric	Description	At Baseline (Oct 2019-Sep 2020)	At Mid-Point (Oct 2020 – Sep 2021)	Absolute Change	% Change	State's Demonstration Target	Status at Mid-Point
4	Medicaid Beneficiaries with SUD Diagnosis (Annual)	Number of beneficiaries who received MAT or a SUD-related treatment service with an associated SUD diagnosis during the measurement period and/or in the 12 months before the measurement period	379,313	401,914	22,601	5.96	Increase	MEETING

While the “all Medicaid” trend for the monthly metric (M3) exhibited a substantial increase between baseline and midpoint, there is some variation in trending for different subpopulations. Figure 21 in the Appendix shows trends for subpopulations for Metric 3. There was a very modest increase in SUD diagnoses among beneficiaries with OUD, and little change over time in the number of beneficiaries with a SUD diagnosis for youth and pregnant women. There was a substantial increase in the number of older adults who had a SUD diagnosis between the baseline and midpoint, which may be a significant driver of the upward trend for the “all Medicaid” group. Finally, there was a modest decline in the number of MPRE beneficiaries with an SUD diagnosis during the demonstration.

Stakeholder Input

Stakeholders provided valuable input regarding the state of SUD treatment access and care delivery in Ohio. Key informant interviews with state agency representatives, treatment providers, MCP representatives, and recovery advocates, focus groups with individuals with lived experience, and provider surveys provided a better understanding of waiver activities and progress, as well as the obstacles experienced by those delivering and receiving care across the state. The following discussion of stakeholder input represents common themes across data collection activities and may not reflect the opinions and experiences of the broader population. The findings and quotes included are indicative of the specific experiences, understandings, and views of the participants, which may not be shared by the general population or reflect Ohio Department of Medicaid’s policies or waiver implementation. Finally, it should be noted that stakeholder input presented for one milestone may hold implications for, or be closely related to, other Waiver Demonstration milestones. We have organized stakeholder input content to closely align with the critical monitoring metrics associated with each milestone.

COVID-19

Discussions with stakeholders have illustrated some of the ways the impacts of COVID have manifested and continue to serve as a challenge in the state. The primary ways discussed among stakeholders included increased demand for services, disruption in normal services and supports, including impacts on both access and workforce, and experiences with telehealth services to attempt to meet these demands.

Increase in demand for services

Both key informants and those interviewed as part of focus groups discussed how the global COVID-19 pandemic led to an increased demand for behavioral health services. One key informant likened the trauma many were feeling to that of other natural disasters:

> *"There is…an increased demand for behavioral health services…this will be no different than what folks might have experienced…through Katrina or Sandy, or you know, those other types of big traumatic events."*

Disruption of normal services

Reduced access

The pandemic's impact has also led to increases in substance use as many struggle to find ways of coping. Several key stakeholders made note of the ongoing nature of the opioid epidemic within the state. The pandemic added the complicating factor of many individuals in need not being able to access services, either out of concern for their health (and being exposed to the virus while trying to seek services), or because services have become more limited through the course of the pandemic. More than 60% of providers surveyed "strongly agreed" or "agreed" that the COVID-19 pandemic reduced the number of patients their organization has been able to treat at one time, although less than half (45%) felt that the pandemic had impacted their organization's ability to treat patients at their diagnosed level of care (Figure 23 in Appendix). In an open-ended response, one provider expressed the difficulty of protecting patients during the pandemic:

"Again, COVID-19 created challenges assuring the patients' safety while requiring in-person drug screen visits."

In an interview, one recovery advocate discussed how stay-at-home orders during the early months of the pandemic particularly impacted those who were not in active addiction:

"It was people who had maybe been longer term recovery who no longer had access to the services…30, 40 year plus people in recovery starting to relapse because they didn't have access to those services any longer."

These concerns and complications extended beyond support group meetings, as other stakeholders mentioned the impact the pandemic has had on simply being in line on a daily basis to receive MAT or how it has created a logjam for those seeking to enter residential treatment. Entering into treatment has been especially trying for mothers with childcare concerns, as some residential treatment facilities will not allow children over a certain age, allow more than one child, or allow any children at all. Even among those able to get into residential treatment, the pandemic meant that while they were able to work on addressing their SUD, access to integral outside supports, such as family and group meetings, were no longer permitted.

Workforce Impact

The COVID-19 pandemic has put a strain not only on those seeking care, but those tasked with providing it as well. As one provider reported, there are a lot of factors that can drain staff and make it difficult to remain motivated and focused. The pandemic exacerbates this issue by removing opportunities for those providers to "refill the tank":

"We're just burning people out and it's in an area in which we already had a workforce shortage".

This, coupled with issues in recruitment and retention, as well as shortages resulting from mandatory quarantining after contact with a COVID positive individual, means that it is difficult to maintain a workforce that can address the

needs of those seeking services. A majority (57%) of providers we surveyed "strongly agreed" that the COVID-19 pandemic had reduced their staffing capacity.

Use of telehealth services

One means of addressing some of the issues discussed above (e.g. an inability to meet in person for support groups or for meetings with providers) that has been explored is the use of telehealth services. 95% of providers we surveyed reported that their organization utilized telehealth or virtual treatment modalities following the outbreak of the COVID-19 pandemic in March 2020. Telehealth was predominantly used for individual therapy, evaluations, and group therapy (Figure 22 in Appendix).

These services have been met with mixed reviews from both providers and those in treatment. Some seeking treatment found that telehealth services meant that they had greater flexibility to maintain a more regular work schedule when they were able to call in rather than having to physically attend sessions:

> *"It [treatment] was easier because it was over the phone, and if I was working…I could still accommodate phone calls, but now they're going into person, and the job I have it switches hours every two weeks."*

The benefits of this flexibility were observed on the provider side as well, with several noting a large drop in the rate of "no-shows", with one provider mentioning a drop of "about 35%". While the rise of telehealth for some can be viewed as a "silver lining" in the pandemic, there were others who did note concerns about it. The "digital divide" prevented some from easily accessing telehealth services, either because they did not have access to the technology or their own digital literacy meant it was more difficult for them to access. For others, telehealth was simply not seen as a substitution for actual in-person meetings and supports.

Milestone 1: Access to Critical LOC for OUD and Other SUDs

State agency representatives, Managed Care Plan (MCP) representatives, treatment providers, recovery advocates, and individuals with lived experience- shared their perspectives regarding factors associated with access to and retention in critical levels of care. Their insights and experiences provide a broader view of access to care in Ohio and highlight some of the factors that may impact Ohio's ability to meet metrics associated with Milestone 1 in coming years. We group these challenges into three categories: those pertaining to (1) delivery of care; (2) provider availability; and (3) individual-level factors. We also discuss factors that were reported to facilitate treatment access and retention.

Delivery of Care

Disagreements over appropriate level of care

One barrier to accessing the appropriate level of care, as discussed by stakeholders, is that treatment providers and MCPs don't always agree on what is the appropriate level of care for a patient. For example, we heard from both sides about disagreements around the length of stay in residential or inpatient treatment, A MCP gave another example of a disagreement about medically-supervised detox:

> *"There's not that same kind of ability to have a cohesive message on what the appropriate levels of care are. As a result, what we tried to do is say to the providers, and through peer-to-peer discussions, through meetings with different providers, that [detox] is not medically necessary. This is not advisable, in fact, and if you do feel the need to have a longer withdrawal process or something, 3.7 is available to you as an option without prior authorization. Their response is, 'we're not going to do 3.7; it doesn't reimburse us well enough.' And so we're then in a position of being the bad guy because we're saying, "this is not medically necessary..."*

Court-ordered treatment

Additionally, while many individuals in treatment credited court involvement as facilitating treatment access, some treatment providers and MCPs cited courts as creating barriers to care. Among providers surveyed who reported that structural factors were a barrier to their patients' access to care, the most common structural barrier reported was court-involvement (Figure 25 in Appendix). In an interview with a provider, court-ordered participation in naltrexone programs was specifically mentioned as a barrier because it limited treatment options for individuals who might have better outcomes with another type of care or medication. The provider told us:

> *"There is an enormous structural problem with our … courts. You have all kinds of specialty dockets that have drug court, for example, and many of them mandate Vivitrol only. I find it interesting that a judge would want to mandate certain kinds of treatment – you wouldn't see that in cancer care or in some other neurological issue, traumatic brain injuries, for example, but they do it in addiction, all the time."*

Provider Availability

Workforce shortages

Treatment providers pointed to the behavioral health workforce shortage as an obstacle to providing critical levels of care. In our survey of treatment providers, more than half indicated that insufficient staffing and workforce shortages created a barrier to their patients' access to care (Figure 24 in Appendix). Reimbursement rates and COVID-19 have contributed to the shortage at all levels of care, which is particularly acute in some regions of the state. One provider described shortages for outpatient care:

> *"…our OTPs and our office-based opiate treatment providers are, … we try to avoid the clustering, but … it's hard to get folks to locate to some of the rural communities."*

"Where we are in the state of Ohio, geographically speaking, we have a lot of challenges to recruit workforce. It's very difficult for us to compete with, in terms of our treatment agencies, the types of … money that people can make in [the] Columbus area or even Toledo."

In follow-up interviews, state agency representatives and treatment providers discussed Ohio's proposed plan to combat the BH workforce shortage. The plan includes investments to support students entering the BH field, such as tuition assistance and licensing support, as well as incentives for experienced professionals to either return to BH practice or stay in practice, such as retention bonuses and license renewal support.

Limited provider availability in rural areas

Geography was frequently discussed as posing a barrier to accessing critical levels of care, particularly for rural and Appalachian Ohioans. Some individuals living in rural areas of the state seek treatment in urban centers, but described the difficulties that regional differences pose:

"Those that come from more of a rural area, often find they don't adjust well to what they consider the city, [when they] com[e] to [this treatment center]. It's a harder adjustment for them when they come from a rural area, often."

Waitlists for care

Another commonly cited barrier to accessing care was waitlists for treatment:

"…especially now with … the fentanyl, I mean, it's serious. … It's so super serious. So, … waitlists are definitely an issue because … you can't just … tell your addiction, you know, hey, disease, … just hold on a little bit, we got to wait this list out[;] …it just doesn't work that way."

While many individuals in treatment described struggling as they waited anywhere from hours to weeks for a bed at a treatment center, this experience almost certainly varies by geographic location, as other individuals in urban centers reported short wait times for care. While waitlists were cited as a barrier to care by

about one-in-four surveyed treatment providers (Figure 24 in Appendix), other barriers were reported to be more common, such as patients' employment, staffing challenges, insufficient childcare, and lack of transportation.

Non-opiate addiction limits treatment options

Stakeholders also reported that the focus of federal and state dollars on building OUD treatment capacity to combat the opioid crisis has had the unintended consequence of creating obstacles for individuals seeking treatment for alcohol use disorder and other SUDs. For example, a treatment provider described the impact of SOR funding and difficulty finding treatment for AUD:

> *"Well there's pretty good access [for] people who have an opiate addiction[. F]inding treatment for folks, for example, who have a serious alcohol addiction[,] needing any kind of help [for] withdrawal from alcohol, … having alcoholism; it's harder to find some of those kinds of treatments, because we have built our system up so much … [with] SOR dollars, state opioid response dollars, it's sometimes folks who have other types of addiction, [who] have a little more trouble finding treatment."*

Limited recovery housing

Some key informants indicated that quality recovery and other sober housing resources are scarce in certain communities due to local funding limitations and local ordinances that prohibit more than two or three unrelated adults living together. Treatment providers, recovery advocates, and individuals with lived experience emphasized the critical role recovery housing plays in both short- and long-term recovery for individuals engaged in outpatient, intensive outpatient, and partial hospitalization programs. While Medicaid does not cover housing costs, stakeholders consistently identified a lack of quality recovery housing as a leading barrier to SUD treatment and long-term recovery:

> *"The place I lived in was drug infested, and I choose not to go back there. [The recovery house] helped me see I can't go back [to that home] because this would all be useless for me. So it was my environment, being around my environment, you know what I'm saying? That's the biggest barrier for me: my environment."*

"Every community doesn't have [an] adequate amount of recovery housing, so we can't really say that we have the full continuum of care represented, when … one of our rural communities only has a house for single women. So women with children, or women that are currently pregnant don't actually have access to recovery housing. So then the full continuum of care is actually not represented."

Individual-Level Factors

Work limitations

Individuals in treatment also described their job as a barrier. Among surveyed treatment providers, more than half indicated that patient's work hours conflicting with treatment availability poses a barrier to care (Figure 24 in Appendix). One individual in treatment expressed that they didn't get treatment because they were trying to maintain employment:

"I was in an active addiction, there was a lot of times when I needed treatment, but I didn't go because I had a job. I always ended up losing the job anyway because I didn't go get help."

Transportation barriers

Even when treatment services are available in the area, lack of transportation can hinder access to care, and stringent insurance requirements can limit the ability to use subsidized transportation:

".. [T]hey'll say, we have a bed for you at two o'clock[.] [W]ell if you don't have a car, and you don't have transportation, you can't get there at two o'clock[.] [A]nd then your insurance requires like 24 to 40 -- well usually a 48-hour notice [--] to transport you, so they won't hold the bed for you for your insurance to bring you in [after] 48 hours, so you lose the bed. So, if you don't have a way there, you don't get a bed and you really want it. [T]hat's a cycle that I kept getting caught in."

In fact, lack of or insufficient transportation was the most cited (83.72%) barrier to care mentioned by surveyed providers, and more than one-in-three providers

indicated that the treatment facility's distance from the patient's home also created barriers to care (Figure 24 in Appendix).

Insurance restrictions

Insurance restrictions were another type of barrier:

> *"I had one experience where … my insurance cut off, … I had to wait for it to come back on, so therefore, I couldn't go to treatment because of my insurance."*

Many respondents in our treatment provider survey confirmed this issue: 50% of providers reported that healthcare coverage fluctuations were a barrier to care for their patients (Figure 24 in Appendix).

Challenges for adolescents

Stakeholders reported that there are fewer adolescent treatment providers across the state than adult providers and it can be especially challenging for adolescents seeking residential treatment or MAT services. For example, treatment providers reported that a large adolescent treatment facility closed in 2020 while other providers were at capacity. One provider told us:

> *"There's not a lot of prescribers in the state of Ohio who're going to prescribe to adolescents or … induct… into a MAT model."*

These observations are supported by trends in Metrics 10 and 12: between baseline and midpoint there was a decrease in the number of youth beneficiaries receiving residential or inpatient services (Figure 12) and little change in medication-assisted treatment, but also an exceedingly small number of youth beneficiaries receiving MAT (Figure 16). While there has been a decline in treatment for youth in IOP and PHP services (Figure 10), the decrease between baseline and midpoint is much more moderate than for youth care at ASAM Level 3, indicating that the latter is an area of particular concern. Funding for adolescent treatment also introduces obstacles for providers:

> *"Well, now that's a problem because that county has different protocols for helping to fund or pay for that young person. So in the state of Ohio, at least for adolescents, we*

gotta lower some of these artificial barriers, if we want people to get help. It's a kid who's in multi systems, juvenile court, behavioral health, kicked out of school. And we're dickering about who's going to pay for part of the treatment. It's a huge barrier for adolescents."

Challenges for pregnant people and mothers

Stakeholders indicated that accessing critical LOCs for SUD and OUD can be particularly complicated for pregnant people and mothers with young children. For example, many MAT prescribers are hesitant to treat pregnant people, which limits available options to this demographic group. One provider highlighted this as an issue:

"…one of the… typical challenges that we have is really finding enough providers, [specifically] MAT providers, … who are willing to treat pregnant addicted women. So you know that's something we've had to continue to work on[:]… trying to ensure access to MAT for those women. And then … oftentimes they have other children in the home. So then you've got a child care … need, which is difficult."

This concern is supported by the aforementioned decline over time in the number of pregnant women receiving MAT in Ohio between December 2019 and March 2022 (Metric 12, see Figure 16 in Appendix). Additionally, mothers seeking residential treatment or other critical levels of care often have to choose between delaying treatment until they find a provider that offers childcare or residential beds for children, and placing their children in foster care or family care while they seek treatment:

"…there's not very many treatment facilities that accept women with children. So… we have to wait for others to complete before we could come and … sometimes there wasn't enough space for our number of children."

Facilitators to treatment access and retention

Peer support and court/CPS involvement

Individuals in care often cited personal and family hardships related to active addiction as the motivation to seek treatment. However, they also credited peer support services, court and child protective services (CPS), case management, and telehealth as facilitating access to and maintaining critical levels of care. For example, one individual in treatment described the critical role that peer support has played in their recovery journey:

"…I overdosed last June and when I got released from the hospital…I kind of got hooked up with [a peer supporter,] and then I was still using. …[My peer supporter] has been on my journey with me the entire time since I overdosed, … still to this day. [I]f it wasn't for him being so consistent, I mean, he called me every day[,] sometimes multiple times a day to check on me to get me into treatment[.] [W]hen I got indicted, he was there[;] he was my emergency contact in rehab[.] [I]f it wasn't for him, I probably … wouldn't be here today."

Another individual in treatment described the way that a court-mandate gave them the necessary push to get into treatment:

"Honestly, I was rolling pretty hard last year and ended up getting in a car accident and court got involved. First time ever put on probation and if I hadn't been on probation, I would have never probably gone into treatment. I felt like I was too set in my ways [-] there's no way treatment would help me and there's no way I was going to stop. But I was sincerely glad that I actually went through the 90-day treatment because I was proven wrong [about] all the reasons that I didn't think that treatment would help me. So I'm very grateful now, but yeah, probation saved my life."

The decision to enter treatment was also motivated by CPS requirements:

"Treatment at first to me was just something to appease CSB, so that I could get my daughter back, and also something that the courts smiled upon, so that I wouldn't end up in jail. And beyond that opportunity, it was like a restart button on my life because …

I knew where I was going to end up [--] jails, institutions and death [--] and this is a lot better than any of those.

Milestone 2: Use of Evidence-based, SUD-specific Patient Placement Criteria

Milestone 2 is focused on improving the "fit" of the continuum of care for any prospective client seeking treatment into the level and quality of care that maximizes their likelihood for SUD treatment success. While some stakeholders questioned the appropriateness of using ASAM criteria to assess LOCs, most providers and MCPs discussed support for the criteria. As one person in recovery stated:

"I got tired. And I knew there was some way. Word of mouth is how I heard about treatment…I was tired of living the way I was living. So I went to [MCP name]. They hooked me up with a number and I got in touch with [treatment provider name]. They didn't leave me out there. Once I got in touch with [treatment provider name], like immediately, they brought me in for an assessment. I went through the medical part of it, and now I'm here. They didn't turn me away. I mean, I immediately got help and was able to change my life."

Milestone 2 is a critical inflection point to help realize this type of client outcome and contribute to the potential for their treatment success and long-term healing.

How ASAM is used

According to the State Health and Values Strategies (Bailit Health 2019:2), the ASAM Criteria "includes five broad levels of care (Levels 0.5–4) with specific services and provider requirements to meet client needs at each level." Together, the levels of care make up the SUD care continuum which is based on resources including direct medical management structure, safety and security, and the intensity of treatment services provided. The best client outcomes are the goal, and service provision within a specific level of care is designed to promote their achievement in the most

effective and least intensive setting. As one managed care plan (MCP) respondent stated, to contribute to the achievement of Milestone 2, they:

"...review trends related to the ASAM levels of care, in particular in relation to 4.0 and 3.7 and PHP and IOP admission rates and reviews. This includes not just reviewing the data, but also reviewing any regulatory or state-level policy changes that may be impacting this. Any operational issues that we may have about claims payment [or] adjudication, [we want] to know, delays and turnaround times for us. But the intent is really to identify what the trends are [in] as close to real time as we can get, to then...address those gaps."

To help improve the evidence base for the continuum of care, ASAM implementation is being refined through dialogue between key state agencies and providers to improve its client-centered measurement. As a state government official noted:

"We established ASAM as the [state unit's] coverage framework for SUD services and now we're kind of taking that to a more detailed level and working with providers to say, 'Okay, now which pieces or components of ASAM do we need to incorporate into state rules and regulations?' So that's one of the things we will be doing that I think will help. And then also at the patient or at the individual level, we're working on changes to our utilization management process."

A community learning collaborative approach is being used to further ASAM familiarity, utility, and improved placement criteria and treatment outcomes. An MCP staff member noted:

"We have provided ASAM training to our staff in conjunction with [state agency] and [training firm], the actual trainers that are hired from ASAM... We are hoping that accrediting bodies are going to provide that structured training for providers and facilities, but as of yet, I haven't seen any action as far as actually moving towards that. Internally, we have hosted ASAM training for our providers."

Among treatment providers that we surveyed, nearly 97% reported that their organization assessed patients' treatment needs according to ASAM standards. Nearly half (45.35%) of survey providers reported that it was "sometimes" necessary

for their organization to treat a patient at a level of care that does not match their diagnosed level of care (Figure 27 in Appendix). However, only about 7% of respondents indicated that they did this "frequently" or "all the time." The majority (52.33%) of providers surveyed reported that when their organization has a patient whose treatment needs do not match up with the ASAM levels of care that their center is able to provide, they take two actions. First, they will treat the patient at the level of the care provided by their organization that is closest to the patient's diagnosed level of care. Then they will also refer the patient to another provider who can treat them at their diagnosed level of care (Figure 26 in Appendix). Another four-in-ten providers indicated that they would simply refer the patient to another provider who can treat them at their diagnosed level of care.

Continuum of Care

Because a strong continuum of care nurtures a strong quality of care, improving the efficiencies of prior authorization timing and completion strengthens the care continuum at multiple levels, particularly with client-centered assessment of LOC. As one person in recovery noted:

> *"I was in a domestic violence situation, as well as struggling with addiction. So, I called the 211-help network, they were able to place me. I went to the hospital and got picked up. They arranged for a domestic violence shelter to pick me up. While I was at that shelter, the health network continued to work with me and got me placed into [residential treatment] and their MAT program."*

As an MCP client-recovery advocate noted:

> *"So, if MAT outpatient is working, that's fantastic. If that's working, it's keeping people sober, it's reducing relapse rates, it's reducing overdoses and their retaining engagement into treatment and not dropping out. But what we also don't have is outcome data."*

As adherence to Milestone 2 is strengthened, each of these domains will continue to improve to further data tracking and healing outcomes, among levels, agencies, providers and clients, across the SUD 1115 waiver's continuum of care.

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

Managed care plans and state agency representatives described ongoing efforts to fund ASAM training for providers, and sponsoring programs to ensure that providers are all properly licensed and certified. However, there was not significant discussion of training for residential treatment providers in particular. Stakeholder input relevant to milestone 3 goals was predominantly focused on the implementation of the requirement that residential treatment facilities offer MAT on-site or facilitate access off-site.

Obstacles to providing MAT in residential treatment: capacity, infrastructure & resources

Across the board, key informants highlighted the infrastructure and resources required to provide MAT in residential treatment. Many expressed concern about the same workforce shortages plaguing SUD treatment more generally, with a state agency representative lamenting this reality:

> *"The workforce doesn't exist to have prescribers in every residential program and in every part of Ohio."*

Additionally, treatment providers described the ramp up costs involved in starting a MAT program, including needing access to labs, and a significant increase in staff hires, such as prescribers and nurses. Without sufficient prescribing staff, providers expressed that MAT would not be a viable treatment option in their facilities.

Obstacles to providing MAT in residential treatment: rules and regulations

Treatment providers and managed care plans highlighted rules and regulations about the provision of MAT as an obstacle to its use in residential treatment facilities. Due to strict rules about storing controlled substances, including needing a distributors' license, many residential treatment providers are not able to keep drugs such as buprenorphine on their premises. Instead, they need to transport

patients to off-site locations to receive their medication. However, multiple treatment providers expressed how this transportation poses logistical issues, especially for patients on methadone who receive daily treatments. It also poses significant financial barriers to residential treatment providers, who are only being reimbursed for medication costs, and not the time or resources involved in transportation.

Resistance to MAT in residential treatment persists

State agency representatives and managed care plans acknowledged that philosophical objections to medication assisted treatment are posing challenges to provision of MAT in residential facilities. This resistance has implications for an individual's treatment plan more generally, as it can present limitations to care. One managed care plan described how many inpatient settings were not aware that their residential referral wasn't allowing continuation medications. Another managed care plan described being forced to advise the detoxification of a patient, against their better judgement, in order to be able to find that patient a spot in a residential treatment facility as they moved through the care continuum:

"…we're told by these inpatient facilities, 'why are you detoxifying when we know that they are [at] at higher risk for relapse, or for relapse and overdose[?]'… well, because the residential treatment facility that we have access to does not allow MAT."

A few treatment providers and recovery advocates speculated that some of this resistance to MAT in residential treatment may be due to a desire to provide a MAT-free environment to individuals who feel that the presence of MAT poses a threat to their recovery, such as those who used Suboxone as their drug of choice.

Potential evasion of MAT requirements for residential treatment facilities

Finally, there were a few key informants who expressed concerns about the potential ineffectiveness of the waiver if residential treatment providers can find

loopholes that would allow them to avoid providing MAT. One of the managed care plans highlighted the frequency of delays in offering MAT to patients, as well as other provider justifications for not providing MAT in residential treatment:

> *"…I think it's very easy for a provider to say, 'well, we don't think that they're clinically ready for that discussion,' because again, if somebody is getting authorized for 30 days of residential, as an example, and you're saying 'well at day 29 we have that conversation with him about MAT. So that's in compliance with your recommendations,' or they could say 'well you know the patient is refusing that as a treatment option.' "*

Milestone 4: Sufficient Provider Capacity at Critical LOC including for MAT for OUD

At the state level, SUD provider capacity at critical levels of care was largely described by stakeholders as adequate. This aligns with findings for critical monitoring metrics 13 and 14, which exhibited an increase in provider availability between demonstration years 1 and 2. However, four major outstanding issues of concern with regard to provider capacity are discussed below, in addition to 2 particular concerns about care provision for specific drug dependencies and subpopulations. Geographic variation in provider capacity was a central piece of feedback we received from stakeholders and supporting data from the SUD 1115 Evaluation team analysis for 2019 and 2020 is discussed.

Geographic variation in provider capacity

Across the state, there is geographic variation in SUD provider capacity. The disparity seems to fall largely along a rural-urban divide, with key informant state agency representatives describing known discrepancies between SUD prevalence and provider availability, and individuals in treatment reporting issues accessing care in rural areas. In a state interview, one key informant admitted that "there's not a large enough population to support the practice of some of the medicine that needs to be practiced in all parts of Ohio." In some cases, this results in treatment

at a different level of care than what is diagnosed. A managed care plan described a particular case in a rural part of southeastern Ohio:

"...the provider offered partial hospitalization... [as] the highest level of care... and when they contacted us about the authorization, it was suggested that the member really would have benefited from an SUD residential level of care, but the closest residential facility was maybe two hours away. [...] The member didn't want to have to be two hours away from their home."

In other cases, focus group participants reported having to wait many months to receive treatment:

"We only have one residential treatment in our town and it's usually 150-200 people who are on a waiting list to get in there and it only holds 16 people. So that could take up to a year, year and a half to even get in..."

Others living close to the West Virginia border described needing to travel to the state's urban centers, such as Columbus and Cincinnati, to get access to care. However, many focus group participants who were residing in urban areas of the state described access to care ranging from walk-in availability, to a few days or weeks wait for treatment, and generally viewed this provider capacity as sufficient to meet their needs. Telehealth was suggested by some key informants as a potential method for expanding provider availability, especially as a means to combat geographic disparities in capacity.

The narratives emerging from stakeholder feedback about geographic variation in provider capacity and specifically differential access in urban and rural areas of the state are generally supported by preliminary analyses from the SUD 1115 Evaluation team for 2019 and 2020 data. Figure 4 and Figure 5 below show SUD rendering and prescribing providers at all levels of care per 1,000 beneficiaries with an SUD diagnosis at the county level. Figure 4 shows data for the last quarter of 2020 - about 1 year into the demonstration and just following our first round of key informant interviews - and Figure 5 shows the percent change between the first quarter of 2019 (about 6 months prior to the demonstration start) and the last quarter of 2020. Figure 4 shows that in the final quarter of 2020, the state's

population centers in Cuyahoga and Franklin counties had some of the highest provider to SUD beneficiary ratios (200-300 providers per 1,000 SUD beneficiaries), along with Wood, Defiance, Mercer, Warren, and Ross counties. Athens county and Geauga county had the highest provider to SUD beneficiary ratios during this quarter (300-400 providers per 1,000 SUD beneficiaries) in the state. Figure 4 indicates that while some of Ohio's rural counties in the south and southeast of the state had provider to SUD beneficiary ratios of 150+ in 2020, many others had lower availability ratios (e.g. 50-100 providers to SUD beneficiaries), such as in Adams, Highland, Jackson, Hocking, Pickaway, Mengs, and Vinton counties. This matches the experiences described by managed care plans, state agency representatives, and individuals in treatment in these areas of the state.

However, Figure 5 does show that between the first quarter of 2019 and the end of 2020 there was an expansion of providers per SUD beneficiaries in many of the southern counties in the state, even if this change was modest (5-15% change), which indicates a positive direction for provider capacity in light of concerns expressed in stakeholder feedback in 2020. There was, however, a substantial reduction in provider to SUD beneficiary ratios in many western counties (-25 to -40%) between 2019 and 2020, so this is another region of the state where access to care may be of concern in coming years. Unfortunately, stakeholder feedback from treatment providers and individuals in treatment in the west and northwestern parts of the state was very limited, so we highlight these trends in provider availability from the Evaluation team's analysis as areas to monitor.

Figure 4: Geographic variation in provider availability (SUD 1115 Evaluation)

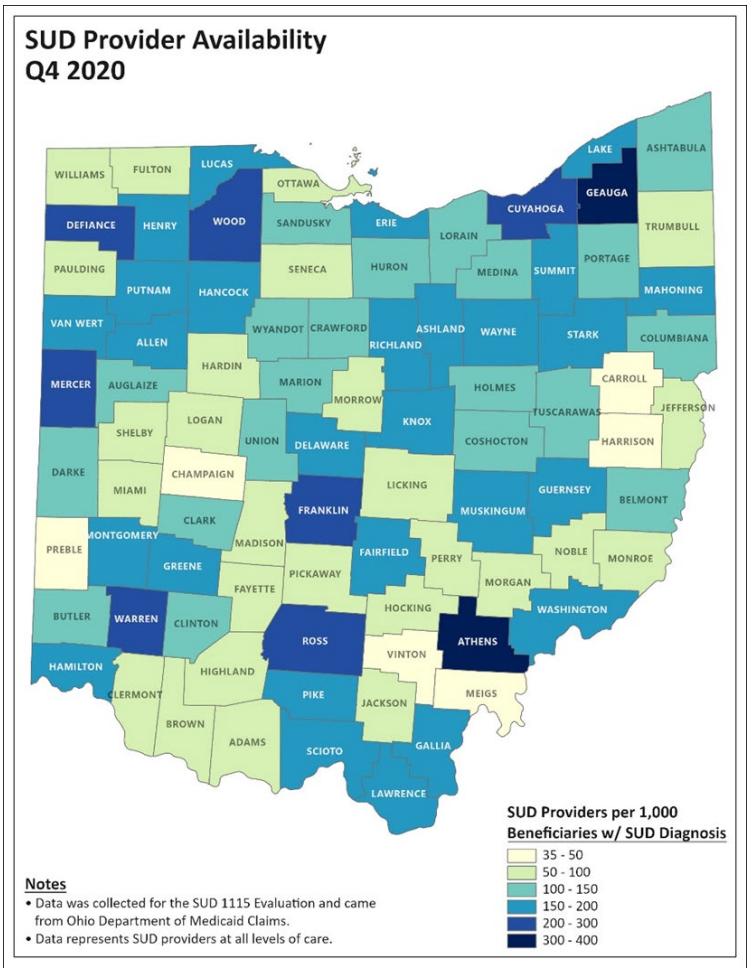
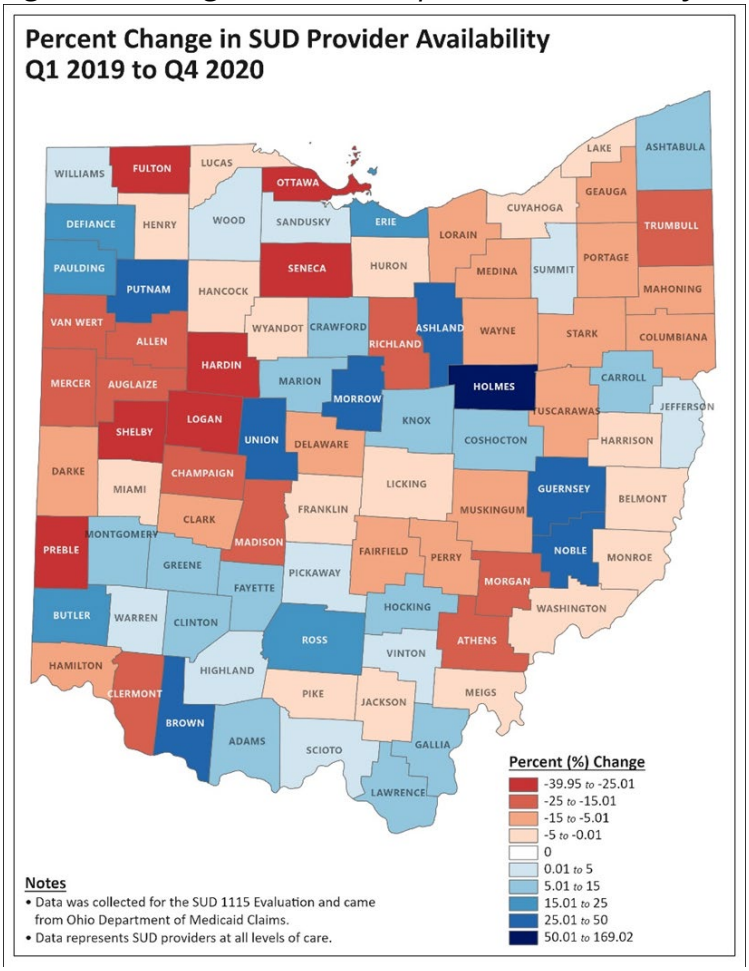


Figure 5: Change over time in provider availability (SUD 1115 Evaluation)



In key informant interviews, state agency representatives, managed care plans, and treatment providers all attributed geographic disparities in provider capacity to market forces and the reality that providers have to sustain a business model. Some stakeholders tied this to small population centers where there wasn't sufficient demand for all levels of care. Decisions to provide certain services are also tied to reimbursement rates - one managed care plan reported a provider saying that they didn't offer ASAM level 3.7 care because it didn't reimburse well. These market forces also influence the level of care of received treatment. A managed care plan described this incentive:

> *"...everybody's in business. It's important to stay in business. And so there's a tendency to want to provide a service when somebody walks in the door."*

Differential access to all forms of MAT

In addition to differential access across the state to SUD treatment at all critical levels of care, provision of MAT varies by geography, and not all types of MAT are equally provided. This was again attributed to market forces, with stakeholders explaining that providers can only establish MAT services if it is economically viable in their area. However, this geographic variation in MAT capacity was also attributed to persistent cultural and philosophical objections to the use of medication assisted treatment. This stigma from providers was often discussed as being rooted in abstinence-only and 12-step philosophies, and is most prominent in Northeast Ohio, including the Cleveland-Akron area.

Both focus group participants and key informants described how agonist MAT, and particularly methadone, is more stigmatized than antagonist MAT, such as naltrexone. This stigma may feed into limited provider availability, with individuals in recovery and state agency representatives describing difficulty accessing methadone in some parts of the state. This is supported by the findings of our provider survey: while 80% of respondents provided some type of MAT and more than 70% offered naltrexone, naloxone, MAT for AUD, or buprenorphine, only 20% provided methadone (Table 24 in Appendix).

Stigma around MAT can also result in forced tapering in some treatment facilities; an individual in recovery described the rigidity of some of these policies at an abstinence-only treatment center:

> *"...some of the requirements are like set in stone. There's no give and take, like here they want you to wean down off of your MATs, in order to stay. They want, there's no exception. Like you have to or you can't stay, in order to compete, you have to be off of it."*

While it is unclear exactly how widespread the issue of forced tapering is in Ohio (for example, just under 5% of surveyed providers indicated that their facility required patients to taper from MAT upon admission or does not accept patients using MAT – see Figure 28 in Appendix), many individuals in recovery described fears and anxieties around being weaned off of medications that they felt "kept

them alive." Receiving MAT also presents some barriers to treatment at other levels of care - two individuals in recovery described the ways that methadone was limiting their ability to find treatment centers that would accept them as they transitioned from residential treatment to lower levels of care.

Despite some stakeholders' concerns about variable access to MAT around the state and limited access to methadone in more rural areas, at the state-level provider availability for MAT has clearly expanded in recent years (Metric 14). As aforementioned from our provider survey, we found that the vast majority of providers offered access to MAT in some form. The location of these services did vary by medication type (Figure 29 and Figure 30 in Appendix): providers were much more likely to provide naltrexone, naloxone, buprenorphine, and MAT for AUD on-site (62-68% of providers did so) than methadone (just 10% provided on-site, 10% off-site). Based on our survey data, when patients received MAT that originated from or was prescribed by another entity (Figure 28 in Appendix), they tended to obtain their prescriptions from a prescribing entity with which a facility has no formal relationship (53.49%), as opposed to a prescribing entity in the facility's network (37.21%) or a prescribing entity with which the facility has a business, contractual, or formal referral relationship (30.23%)

Chronic workforce & staffing shortages

When discussing SUD provider capacity, key informants repeatedly highlighted concern about chronic workforce and staffing shortages. One managed care plan explicitly raised a concern about SUD providers having enough staff to be able to meet the ASAM requirements for medical oversight, citing the general lack of practitioners in the behavioral health system in Ohio. One treatment provider told us:

"You can't build a program if you don't have the workforce to sustain it."

Workforce obstacles to SUD provision are compounded by geographic disparities in resources. State agency representatives and treatment providers described difficulty recruiting qualified providers in rural areas, explaining that they must

compete with treatment centers in urban centers that can afford to pay higher salaries. Other treatment providers expressed that while the cost of hiring staff was going up, the reimbursement rates from Medicaid were not increasing to match these rising costs.

Staffing issues were frequently cited as a particular concern around MAT provision, with providers describing struggling to hire enough clinical staff to administer the MAT, or simply not being able to afford to hire MAT prescribers.

Limited resources for recovery housing results in lack of care at lowest ASAM levels

Although Medicaid-funded provision of care was generally described as adequate at the state level, state agency representatives, treatment providers, recovery advocates, and managed care plans universally expressed concerns around limited provision of care at some of the lowest levels of the ASAM continuum. Most specifically, reliance on private funds and local levies for recovery housing has, in effect, truncated the continuum of care for many individuals with SUD – "it's not a full continuum when you look at it from the peer support perspective" (state interviews). Geographic disparities again emerge with regard to provider capacity for recovery housing, since counties with higher unemployment and poverty rates (such as those in Appalachia) that cannot afford to levy taxes to fund these non-clinical and social support aspects of SUD treatment, are therefore unable to provide services. These limited resources were lamented as a gap in the broader approach to SUD treatment in Ohio, with one recovery advocate describing how the insufficient provision of recovery housing has implications for long term recovery:

> *"…people who receive treatment at a residential treatment facility and then […] don't have access to a safe place to live, they might return to a place where they're surrounded by people, places, and things that more support a lifestyle of addiction versus support a lifestyle of recovery."*

Limited SUD provision for non-opiate drug dependencies & pregnant women

Finally, two specific provider capacity issues repeatedly emerged in stakeholder interviews. First, both individuals in recovery and key informants described a lack of availability of treatment for AUD and other non-opiate drug dependencies. This was frequently discussed in the context of federal funding being tied to OUD treatment. One focus group participant reported being turned down from three treatment centers because they were abusing crack cocaine, not opiates. Second, managed care plans and treatment providers described obstacles to finding care for pregnant addicted women, and even more so for medication assisted treatment for this subpopulation. This difficulty was confirmed in focus group interviews, where multiple participants described only being able to find a single treatment center that would accept them while pregnant. These individual experiences are supported by monitoring metric findings discussed under Milestone 1: There has been a decline in the number of pregnant women receiving treatment at many levels of care (outpatient services, IOP/PHP services, residential and inpatient services), as well as the number of pregnant women receiving MAT, between December 2019 and March 2022.

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

State agency representatives, MCPs, and treatment providers discussed a variety of data and communication barriers that prevent a comprehensive approach to prevention and treatment of OUD among Medicaid beneficiaries.

Data, data tracking, and other barriers

One barrier identified by stakeholders is miscommunication/misunderstanding about the rules regarding care coordination among providers, specifically the belief that care coordination is only possible when a provider has seen the patient within the past 30 days. Further, extensive intake assessments (e.g., psychosocial surveys

and ASAM) on the first couple of visits delays the onset of appropriate SUD treatment and care and negatively impacts patient experience. It was also noted by our key informants that the acceptability of MAT may have a regional variance, with Cincinnati-Dayton having greater adoption than Cleveland-Akron and Appalachia areas. Further, the Appalachian regions have prioritized abstinence only recovery-based programs in response to the negative impacts of "pill mills" and Suboxone misuse. From a case management perspective, it takes 30 days for notification that a member is in treatment facility, and this conflicts with the HEDIS measures that require follow-up between 7-14 days to ensure the member receives the appropriate level of care. This is important because there is a small window of opportunity to ensure patients are at the correct level of care before the residential stay was wasted. Claims data, which is sparse, of poor quality, and has inherent time lags, creates gaps in understanding whether standards at each level of care are being met, especially since this data is for billed services only. Since the board of pharmacy initiated the prescription drug monitoring program, advanced data analytics are possible which allows insight into prescribing practices of individual clinicians. This has resulted in partnerships with the emergency departments to assess diagnosis and utilization data in real time and compare it with historical records. More monitoring of and data collection from MAT providers, as well as ensuring that the outcomes meet expectations in outpatient treatment, are warranted to ensure adherence to best practices and reduce relapse and overdose rates and providing educational and support interventions if necessary. With full sobriety as the goal, retention in MAT and addressing comorbidities with mental health and other substances is key:

"…And then our planning and how we're addressing overdoses and overdose deaths has changed drastically too. We have a team that monitors data points with the Department of Health weekly, and overdose anomaly reports, and does outreach to those communities to see what is happening in real time. And then we call the board, and providers, and health departments, and coroners, and prevention coalitions--anyone they want to include—and we're talking about overdose and suicidality, and even the overlap between those two things. [S]o [we're doing] a lot more."

"So retention into treatment, relapse rate, overdose rate, ED utilization, inpatient hospitalization. You know, like, are you able to impact those things in your treatment of this member[?] [V]ersus asking them if they were satisfied with the services that they received. So [for] the provider community as a whole, I've never gotten any type of outcome[s] [information]… that is truly data-driven type information."

Individuals in treatment cited the many rules and restrictions associated with inpatient, residential, and intensive outpatient as barriers to staying in treatment, leading to relapse and the risk of overdose. One focus group participant recounted an incident in which a stomach virus affected several individuals in a residential treatment facility but "insurance" (MCP) requirements regarding the number of treatment hours required daily forced them to participate in groups to avoid being kicked out of treatment, rather than allowing them to rest. Other individuals in treatment described visitation restrictions resulting from COVID-19 as a primary reason for either failure to enter or remain in treatment. Restrictive, inflexible treatment hours prohibit people in certain treatment programs from maintaining employment and often present childcare challenges for parents with young children.

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

Stakeholders generally agreed that care coordination is an important component of SUD recovery. Stakeholders identified numerous benefits of care coordination and discussed barriers to adequate care coordination services, such as workforce challenges, geographic barriers, and administrative burden.

Importance of establishing care coordination

Both providers and MCPs discussed the multifaceted concerns which manifest among those seeking treatment for SUD. Management of both SUDs as well as co-morbidities is important for avoiding additional health concerns for individuals and reducing overall costs. Efforts to coordinate have been undertaken by both groups. As one key informant from an MCO discussed:

"We're really just working to identify, s the resource experts, what services and supports would help the member meet and attain those goals. Like a hub and spoke model, working with all of those identified service providers to unify them so that they're working in tandem. And so we're really coordinating that across the multiple systems: the behavioral health, physical health, specialty providers, the community, the natural supports. [It's] almost like a wraparound model, working to make sure that everyone is working in sync and not duplicating services and efforts, and then removing any barriers to getting those services"

Providers also generally agreed that early engagement with individuals in treatment and working to link them with these other services they may need was key to helping improve their outcomes. One provider discussed moving ahead of Behavioral Health Care Coordination (BHCC) and hiring a care coordinator to address a perceived gap in patient care coordination. State agency stakeholders also mentioned that there needs to be continued investment and efforts to build capacity within the "addiction workforce":

"Care coordination is kind of the backbone of what we do. So I think what we have done in our community, [the] team-based care models, is really what we need to do. We just need to figure out how to make it much more accessible and make sure we have the workforce that can do it and that is trained, and that has the capacity and payment structures to actually do what they're being asked to do."

Among surveyed treatment providers, care coordination services were widespread. At least three-in-four providers facilitated or coordinated community services, support groups, and housing or shelter support for patients, and more than half provided behavioral health services, social services, physical health services, or another level of care for SUD treatment (Figure 31 in Appendix). When it came to transitional services, nearly all provided discharge planning services (95.18%) and aftercare or continuing care for patients (80.72%), and the majority provided outcome follow-up after discharge or take-home naloxone provision and training on overdose management (Figure 32 in Appendix). Care coordinators for the providers in the sample included certified chemical dependency counselors

(80.23%), social workers (77.91%), clinicians (75.58%), and other staff (63.95%) (Figure 33 in Appendix).

Individuals in treatment also discussed the value they placed on being able to address issues beyond their addiction in order to maintain recovery and a healthy lifestyle. A person in treatment compared these two types of facilities: one that took this type of holistic approach, and another that did not.

"...this place gave you medical health and mental health. They gave you physical health. They help you [in] all sorts of ways. The other place did not help you like that. The [first place] went way beyond, they helped you more...they just love you and care for you genuine. Other places don't do that, they just don't."

Despite there being general agreement among stakeholders on the importance of coordination, there wasn't always agreement on roles and the involvement of care managers. Some MCPs felt they had a good working relationship with providers and that they were able to serve as a way to facilitate discussion and innovation between providers:

"they are really open to sharing ways that they are doing their own coordination of care there and letting us be part of that and then coming to us, even for, you know, help when they are struggling, they open to asking how, you know, their fellow providers are managing things..."

Some disagreement was also noted in terms of ultimately who decides what an appropriate level of care is. Others have also mentioned feeling that the inclusion of a number of care managers can be detrimental, paralyzing efforts to coordinate care and ultimately may even frustrate those in treatment:

"What is ridiculous and a waste of time, effort, and energy is when people are care-managed to death "

Geographic disparities in services and telehealth

There was discussion among several stakeholders about geographic disparities in access to services needed by those in SUD treatment. They may be able to find a residential treatment center, but there were not necessarily services for the treatment of mental health nearby. Telehealth has been one way in which some of these providers have attempted to fill in the gap. As one discussed:

"Many of the conditions that we see with substance use or even severe mental illness, they're chronic conditions. They need a whole plan of management and ongoing care and connection with a care provider who can really meet [their] needs. I think the uneven access to care…we have parts of the state [that] … have a lot more resources than others, so how do we continue to think about that? I think we still want to use technology. What we've learned from telehealth and tele-resources has been very valuable, and I think some communities have really benefitted a lot, but then that speaks to the infrastructure and how do we make that more available to all our communities."

Timing/length of stay

Concerns were also raised about being able to access and remain at the level of care needed while in residential treatment where there may be overlapping/competing concerns, such as physical or mental health needs. Many have expressed concern about the challenges of managing these. One provider discussed the possibilities of trying to have some of these other needs met while in a residential treatment setting:

"Having worked the field a long time, there's a lot of overlap between what we might see as mental health needs…along the substance use…there's a very high rate of comorbid mental health conditions…I would be all for using, you know, residential facilities to try to address both of those needs as best we can"

Workforce considerations

Another concern regarding care coordination is its perceived reliance on highly motivated individuals to make sure coordination of patient care for other needs was being met. If those integrated individuals who had established connections between organizations and providers left, then the system no longer functions and care coordination falls apart for many patients. There aren't illusions that care coordination would always lead to seamless working relationships with other providers, but it would "be the glue that, for many of our patients, they just don't have" in keeping the many pieces of their health and wellness together. Some groups are still working internally trying to integrate the definitions for levels of care, making sure that each level there is appropriate staffing, and how to make sure other pieces are in place for transitions between those levels of care.

Rules and regulations as barriers

While all stakeholders acknowledged the need for rules and regulations, and the positive impact they have with regards to safety and consistency across organizations, there were some concerns about perceived barriers that some of these rules may put into place when trying to coordinate care. One rule in particular which was called out was 42 CFR Part 2 to protect patient records created by federally assisted programs for the treatment of substance use disorders (SUD).

> *"If you're a treatment provider. How do you coordinate care when you're not even allowed to acknowledge someone being in care without, you know, pretty specific and identified authorizations and ways to disclose that"*

This provider did go on to discuss how changes had made it easier to coordinate care internally for organizations but can still be burdensome when trying to discuss a patient with another care organization. Others mentioned how other regulations made it difficult for residential treatment facilities to provide basic care (including use of OTC medications) and instead made the process more time intensive and complicated for patients. Ways that SUD care coordination has been modeled also differed administratively to how care coordination was modeled for mental health according to one stakeholder. As such, there was a difference in the degree of

approaches and individual engagement that can be utilized for those with SUD compared to those under Mental Health CPS. There were also concerns raised by some of the stakeholders interviewed that some providers are still adhering to rules about when to close a case which had been eliminated for several years. Despite this, the adherence to this "legacy rule" meant that care coordination was hindered for some patients. Other outdated regulations which hinder care, such as the notion that an extensive assessment and ASAM level of care needs to be done before treatment can be rendered (rather than brief assessments which do not require multiple visits), were discussed.

D. Assessment of Overall Risk of not Achieving Milestones and Recommendations

In this section, we summarize the progress made towards each milestone at the mid-point of Ohio's Waiver Demonstration, assess the risk of not meeting each milestone, and make recommendations for Ohio as it continues to improve SUD treatment access and quality and strive to reduce overdoses across the state.

Milestone 1: Access to Critical Levels of Care for SUD Treatment

Ohio was meeting CMS specifications for coverage of all critical LOCs prior to the Waiver Demonstration. Ohio covers outpatient services, intensive outpatient services, MAT (medications and counseling), intensive LOCs in residential and inpatient settings, and medically supervised withdrawal management. MCPs are contractually obligated to demonstrate network adequacy for services and to contract outside of identified regions if services are not adequate. Stakeholder feedback identified considerable barriers to access and indicated disparity in access to critical LOCs for some subpopulations in Ohio. While Ohio covers all critical LOCs, work is still needed to ensure equitable access for all individuals needing SUD treatment.

Table 18: Summary of Mid-Point Assessment of Risk of Not Meeting Milestone 1			
Percentage of Fully Completed Action Items (# completed/total)	*Percentage of Monitoring Metric Goals Met (#metrics/total)*	*Key Themes from Stakeholder Feedback*	*Risk Level*
N/A	71.4% (5/7)	- Court-ordered treatment often limits access to MAT - Access to care threatened by workforce shortages, geographic disparities, waitlists, substance-specific treatment limitations, and social determinants - Limited access to treatment for adolescents, pregnant women, and parents with young children - Treatment access enhanced by peer supports and supportive community services	MEDIUM

Independent Assessor Recommendations for Ohio

1. *Implement quality improvement and/or workforce development initiatives that aim to increase delivery of early intervention services in healthcare settings with enhanced focus on non-OUD SUDs*
2. *Re-evaluate and update monitoring metric #11 target to reflect state's desired change in withdrawal management services.*
3. *Update Waiver Demonstration implementation plan to include action items to ensure equitable access to SUD treatment services for Medicaid beneficiaries.*

Ohio Medicaid's Response:

- *The Ohio Department of Medicaid will continue to work with our state partners and the SUD 1115 Stakeholder Advisory Committee to develop strategies to increase utilization of early intervention services.*
- *ODM agrees with GRC's assessment of Metric 11 and we will discuss changing the target for Metric 11 to "increase" rather than "consistent" as is currently identified as a demonstration target for the Waiver.*
- *Lastly, ODM will continue to engage with our providers and other stakeholders to explore strategies to ensure equitable access to care among at risk subpopulations.*

Milestone 2: Use of Evidence-based, SUD-specific Patient Placement Criteria

Prior to the Waiver Demonstration, Ohio required providers to use ASAM criteria to assess patient treatment needs. Ohio has made significant progress in reviewing and analyzing utilization management policies and practices, standardizing prior approval processes across providers and MCPS, and providing guidance regarding the new process. While Ohio is not meeting the critical monitoring metrics for Milestone 2, this is likely due to measurement issues discussed in the *Limitations* section of this report. Ohio is currently developing a methodology to more accurately identify residential IMDs, rather than using all residential treatment facilities as a proxy. Stakeholder feedback regarding Milestone 2 generally indicated agreement that Ohio is achieving milestone specifications.

Table 19: Summary of Mid-Point Assessment of Risk of Not Meeting Milestone 2			
Percentage of Fully Completed Action Items (# completed/total)	Percentage of Monitoring Metric Goals Met (#metrics/total)	Key Themes from Stakeholder Feedback	Risk Level
100% (5/5)	0% (0/2) NOTE: See discussion of measurement limitations	- Perceived misapplication of ASAM criteria via inaccurate or inconsistent use of ASAM in assessment of individual needs by providers and/or MCPs - ASAM implementation being refined through dialogue between key state agencies and stakeholders - ASAM training is needed for providers across the state - Some disconnect exists between assessed LOC and received LOC due to availability of appropriate services - ASAM criteria being used by majority of providers	LOW

Independent Assessor Recommendations for Ohio

4. *Develop educational materials and conduct MCP and provider education regarding the application ASAM criteria and the tools commonly used to assess patient need for SUD treatment.*
5. *Conduct quality assurance reviews of MCP and provider use of the* Substance Use Disorder Services Prior Authorization Request *form to assess use of ASAM criteria for assessment of patient need and service approval.*

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

OhioMHAS provider certification rules (OAC rule 5122-29-09) in place prior to the Waiver Demonstration required residential, withdrawal management, and inpatient SUD treatment services to be provided in accordance with ASAM LOC 3 and associated sublevels. Throughout Waiver Demonstration implementation, the state has worked with key stakeholders to refine and update provider qualifications, including requiring residential SUD treatment providers to facilitate patient access to MAT while in residential settings. MCPs are also contractually obligated to adhere to ASAM criteria for residential SUD treatment services. Ohio has contracted with Health Management Associates to conduct residential SUD treatment provider on-site reviews to assess compliance with the new certification criteria and provide technical assistance to providers not yet meeting requirements. It should be noted that Ohio's planned Milestone 3 activities were delayed by the COVID-19 PHE, but most activities were either completed or initiated by the mid-point.

Table 20: Summary of Mid-Point Assessment of Risk of Not Meeting Milestone 3			
Percentage of Fully Completed Action Items (# completed/total)	Percentage of Monitoring Metric Goals Met (#metrics/total)	Key Themes from Stakeholder Feedback	Risk Level
75% (6/8)	N/A	- Strict rules and regulations related to storing controlled substances present obstacles to providing MAT on-site - Transportation and other structural barriers may limit options for facilitating access to MAT off-site for residential patients - MAT-related stigma and abstinence-only ideology may interfere with access to MAT in residential treatment settings - Loopholes may allow MAT-resistant providers to limit access to MAT	LOW
Independent Assessor Recommendations for Ohio			
6. *Continue to develop educational and technical assistance resources for residential SUD treatment providers based on findings from on-site reviews.* 7. *Engage abstinence-only residential treatment providers in dialogue and provide educational resources about the benefits of MAT accessibility.*			

Milestone 4: Sufficient Provider Capacity at Critical LOC Including for MAT for OUD

Critical monitoring metrics indicate an expansion in state-wide provider availability between baseline and midpoint. Ohio also completed baseline and follow-up provider capacity assessments over the course of the Waiver Demonstration. However, our provider availability assessment findings are limited and incomplete due to a lack of pertinent data. We are able to conclude that between 2018 and 2021 there was a statistically significant increase in the MAT for OUD prescribing provider-to-beneficiary ratio, although about half of the expansion in these providers came in the state's two most populated counties. There was little state-wide change in billing provider-to-beneficiary ratios for most of the critical LOCs between 2018 and 2021, with the exception of a statistically significant decrease in the outpatient billing provider ratio. However, conclusions about Ohio's provider capacity from the billing provider information are potentially inaccurate and are reviewed only as an approximation of capacity at different levels of care.

The state's new Provider Network Management (PNM) module is expected to considerably improve the quality and completeness of rendering provider data, such as location and specialty. Data collected through the PNM will allow the state to continue work toward improving rendering provider measurement (activities of this sort are planned and discussed further under Milestone 4) in order to evaluate counts and geolocations of the providers who are providing services to individuals with SUD. Additionally, it is critical that county-level provider-to-SUD-beneficiary ratio data is gathered in order to determine whether low provider counts in certain areas of the state are resulting in treatment shortages or if this simply reflects lower absolute need. For example, there is clear concentration of MAT for OUD prescribing providers and SUD all levels of care billing providers in the state's population centers, but the maps and data shared with the midpoint assessor were not sufficient to determine whether this supply is adequate or in the areas of the state where it is most needed, such as in southern Ohio.

Table 21: Summary of Mid-Point Assessment of Risk of Not Meeting Milestone 4			
Percentage of Fully Completed Action Items (# completed/total)	Percentage of Monitoring Metric Goals Met (#metrics/total)	Key Themes from Stakeholder Feedback	Risk Level
100% (5/5)	100% (2/2)	- Geographic differences in provider availability create disparities along the urban-rural divide - Market forces of supply and demand impact providers' ability to serve more rural areas of the state - Even in areas of adequate provider capacity, access may be limited for some subpopulations and in areas of concentrated stigma around MAT	LOW
Independent Assessor Recommendations for Ohio			
8. *Continue with plans to use improved rendering provider data from the Provider Network Management module to perform provider availability assessments in the future.* 9. *Monitor increases in SUD diagnosis, particularly in pockets of lower provider capacity and in special populations and develop targeted strategies to increase access to appropriate LOCs.*			

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

Prior to Ohio's Waiver Demonstration application, the state had implemented significant policy changes in the areas of prescribing guidelines, PDMP requirements, expanded access to Naloxone, closure of "pill mills", and medication therapy management to combat the opioid epidemic. Ohio's planned Milestone 5 action items have been impacted by resource strains resulting from the COVID-19 PHE and are not due to be completed until the end of the demonstration period. Similarly, Ohio's performance across critical monitoring metrics associated with Milestone 5 may have been impacted by COVID-19's strain on health systems. While the mitigating circumstances of Ohio's pre-Waiver Demonstration accomplishments

and the PHE's impact on allocation of state and health systems resources may have lowered our assessment of risk to Medium, the significant increase in overdose deaths warrants a High risk level. It should be noted that recommendations made in each milestone section of this assessment will contribute to Ohio's overall success in addressing the opioid epidemic.

Table 22: Summary of Mid-Point Assessment of Risk of Not Meeting Milestone 5			
Percentage of Fully Completed Action Items (# completed/total)	Percentage of Monitoring Metric Goals Met (#metrics/total)	Key Themes from Stakeholder Feedback	Risk Level
0% (0/4)	50% (2/4)	- Administrative burdens associated with provision of SUD assessment and treatment contribute to treatment delays - Abstinence-only treatment programs and recovery housing increase risk of relapse and overdose - Overall, state efforts related to prescribing guidelines and expanded use of OARRS have significantly reduced over-prescribing - Inflexible treatment rules and restrictions associated with insurance requirements or provider rules present barriers to treatment engagement and retention, leading to risk of relapse and overdose	HIGH

Independent Assessor Recommendations for Ohio

10. *Continue to work with The State of Ohio Board of Pharmacy to incorporate planned OARRS updates.*
11. *Work with SUD Advisory Committee and state agency partners to re-evaluate implementation action items and identify additional strategies that minimize administrative burdens and restrictive treatment rules (at both the provider and payer levels) that delay start of and improve retention in SUD treatment.*
12. *Develop and disseminate provider and consumer education resources to clarify the rules, responsibilities, and service delivery requirements at each LOC.*

Ohio Medicaid's Response:

- *ODM will continue to work with the Ohio Board of Pharmacy to monitor EHR onboarding and planned OARRS activities and system updates.*
- *ODM will continue to monitor the use of opioids at high dosages in persons without cancer (Metric 18).*
- *ODM will also continue to work with our providers and stakeholders to identify strategies to combat increased opioid utilization and deaths from illicit drug use (Metric 27).*
- *ODM will engage with our sister state agencies and the SUD 1115 Stakeholder Advisory Committee to continue to discuss the issues raised concerning delays in treatment due to administrative burdens and the impact on initiating and sustaining treatment and explore strategies to address these.*

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

Ohio had multiple care coordination interventions in place for Medicaid beneficiaries with SUD prior to the Waiver Demonstration. Approval of Ohio's Waiver Demonstration has allowed the state to re-evaluate care coordination and move towards more tailored care coordination models that meet the needs of populations with highest risk. While Ohio is only meeting slightly more than half of the critical monitoring metrics (53.8% = medium risk), the state has made significant progress completing identified action items (100% = low risk). In addition to launching a care coordination model specifically designed to meet the needs of youth with complex behavioral health needs, Ohio created a notification of admission form and process to ease transitions between LOCs. Additionally, stakeholder feedback regarding care coordination services was generally positive with some concerns regarding workforce challenges and structural barriers to care coordination.

Table 23: Summary of Mid-Point Assessment of Risk of Not Meeting Milestone 6			
Percentage of Fully Completed Action Items (# completed/total)	Percentage of Monitoring Metric Goals Met (#metrics/total)	Key Themes from Stakeholder Feedback	Risk Level
100% (3/3)	53.8% (7/13)	- Care coordination occurs across the majority of SUD treatment services - Provider and beneficiary experiences with care coordination are generally positive - Workforce shortages and other structural barriers may limit access to care coordination	LOW

Independent Assessor Recommendations for Ohio

13. *Make Notification of Admission form and/or process mandatory to ensure transition planning between LOCs.*
14. *Work with state agency partners, MCPs, and providers to develop and implement a care coordination model for pregnant women with an SUD diagnosis.*
15. *Work with state agency partners, MCPs, and providers to develop and implement a care coordination model to facilitate initiation and engagement in treatment for individuals with Alcohol Use Disorder.*
16. *Continue plans, through the Next Generation MCP contracts, to assess social determinants of health and housing stability as part of transitions between levels of care.*

Risk Summary

Overall, Ohio has made significant progress towards meeting Waiver Demonstration milestones. Despite delays resulting from the COVID-19 Public Health Emergency (PHE), Ohio has completed over 75 percent of the action items identified in the approved Waiver Demonstration implementation plan and is meeting half of critical monitoring metrics. Ohio had many of CMS's waiver-related specifications in place prior to Waiver Demonstration approval, including coverage of all ASAM critical LOCs. At the Waiver Demonstration midpoint, Ohio is at low risk of not meeting four milestones, medium risk of not meeting one milestone, and high risk for not meeting one milestone. Recommendations based on stakeholder feedback, CMS specifications, and current state activities have been included to assist Ohio in supporting a comprehensive continuum of care and reducing overdose among individuals enrolled in Medicaid.

E. Next Steps

The mid-point assessment reveals substantial progress towards meeting Ohio's SUD 1115 Waiver Demonstration milestones and targets. The Ohio Department of Medicaid has actively engaged stakeholders and sister agencies in identifying, developing, and implementing policies and practices to ensure access to appropriate SUD treatment and improve SUD outcomes for Medicaid beneficiaries. Action items for milestones 2, 4, and 6 have been completed (no action items for milestone 1 were identified). The remaining work to complete action items for milestone 3 involves completing residential provider on-site reviews and providing education and technical assistance to abstinence-only residential treatment providers, both of which commenced in fall 2022.

Ohio is at medium risk of not meeting Milestone 1. While Ohio Medicaid covered all critical LOCs prior to the Waiver Demonstration, the critical monitoring metric for *Early Intervention* (7) is not being met. Rather than increasing, the number of beneficiaries who used early intervention services during the measurement period decreased by nearly 49%. Additionally, stakeholders identified considerable barriers

to access and indicated disparity in access to critical LOCs for some subpopulations in Ohio

Ohio is at high risk of not meeting Milestone 5. Milestone 5 action items focus on upgrades to the state's prescription drug monitoring program, Ohio Automated Rx Reporting System (OARRS), enhancements in the use of prescribing data, and enforcement of the state's prescribing guidelines. Milestone 5 action items are not due to be completed until September 30, 2024. Ohio is not meeting two critical monitoring metrics associated with Milestone 5, *Use of Opioids at High Dosage in Persons Without Cancer* (18) and *Overdose Death Rate* (27). There was an 11.11% increase in the all-cause rate of overdose deaths among Medicaid beneficiaries (per 1,000 beneficiaries) during the measurement period.

Ohio is committed to working with sister agencies, stakeholders, and CMS to complete remaining action items and identify additional implementation strategies to ensure the state meets Waiver Demonstration milestones and identified targets. As a result of the mid-point assessment findings, the state proposes the following next steps to ensure Waiver Demonstration success:

- ODM will share mid-point assessment findings and recommendations with the SUD 1115 Advisory Committee and state partners
- ODM will continue to work with state partners and the SUD 1115 Advisory Committee to develop strategies to address areas where the state is at risk for not meeting Waiver Demonstration milestones, including increasing utilization of early intervention services, ensuring equitable access for high risk subpopulations, and addressing administrative burdens that impact entry into and retention in treatment.
- ODM will continue to work with Ohio Board of Pharmacy to monitor EHR onboarding and planned OARRS activities and system updates.
- ODM will continue to monitor the use of opioids at high dosages in persons without cancer (Metric 18).

- ODM will also continue to work with our providers and stakeholders to identify strategies to combat increased opioid utilization and deaths from illicit drug use (Metric 27)
- ODM will discuss changing the target for Metric 11 to “increase” rather than “consistent” as is currently identified as a demonstration target for the Waiver.
- ODM will continue to work with CMS to address deficiencies in Waiver Demonstration performance.

Appendices

Appendix A1: Key Informant Interviews Email Introduction

E-mail Introduction draft:

Hello _____,

The Ohio Colleges of Medicine Government Resource Center (GRC) has been selected by the Ohio Department of Medicaid (ODM) to conduct components of the SUD 1115 Waiver Demonstration, including evaluation, metric monitoring, and the mid-point assessment. The mid-point assessment includes key informant interviews designed to gain a better understanding of the challenges and successes associated with implementation. You have been identified as a key informant due to your area of expertise.

Our discussion will focus on three key components of the Substance Use Disorder (SUD) 1115 Waiver which reflect the key goals and objectives for the waiver demonstration:

1. Access to care along the continuum

2. Access to Medication Assisted Treatments (MAT)

3. Impact of COVID-19 on the Waiver

Your participation is completely voluntary. In the next week I will be contacting you to schedule a one- hour interview to gather your perspective regarding waiver implementation. In the next week I will be contacting you to schedule a one hour interview to gather your perspective regarding waiver implementation. If you have questions about the interview process or believe someone else in your organization should be interviewed, please let me know.

We look forward to hearing your insights regarding the SUD 1115 Waiver.

Appendix A2: Key Informant Interviews Consent Language

Key Informant Interviews Consent Language

Hello, my name is _____ and today I am joined by _____. We are part of the GRC research team from the Substance Use Disorder (SUD) 1115 Waiver Demonstration Study. Thank you for speaking with us today. Before beginning, we thought it would be helpful to review the goals and process of this interview as well as answer any questions you have.

Part of SUD 1115 Waiver mid-point assessment involves interviews with key stakeholders, like you, who have been involved in the planning and/or implementation of the waiver. The goals of these interviews are:

(1) To understand the factors that may hinder or facilitate implementation of the SUD 1115 Waiver, such as access to appropriate levels of care, national program standards and staff credentials, and care coordination;
(2) To gain insight into how organizations, including state agencies, treatment providers, advocacy groups, and managed care organizations are addressing access to Medication-Assisted Treatment (MAT)
(3) To understand how COVID-19 has impacted waiver implementation.

We understand it may be difficult to differentiate the impact of changes due to COVID vs. the waiver. We ask that you try to think about changes brought about by COVID and those implemented under the waiver demonstration separately, although we recognize differentiating the two may not be always be possible. We will discuss these issues throughout our conversation today.

Your participation in today's interview will help us gain valuable insight into the factors contributing to the success of the waiver implementation as well as the challenges. Our discussion will last about one hour. Your participation is voluntary. You do not have to answer any questions you do not want to answer. Know that we will keep everything you say confidential. Our discussion today will be recorded via the Zoom video conferencing application, which will also produce a verbatim

transcript of our conversation. We will also be taking notes during our discussion. Please feel free to share your ideas, even if you feel like they are different from others in your field. There is no right or wrong answer. Remember that everything that is said during our discussion today is confidential and specifics of what is said will not be repeated. The information you share will only be presented in summary form. If at any time you wish to discontinue participation, we can end our discussion.

Do you have any questions for us before we begin? Do we have your permission to begin the interview?

Appendix A3: Key Informant Interview Guide: Guiding Questions for State Agency Leadership

Guiding Questions for ODM and OHMAS Leadership

1. We are trying to understand how SUD 1115 Waiver Demonstration implementation is going in Ohio right now, and we value your expertise and contributions. Can you tell us about your role in implementation of the SUD 1115 Waiver, and what you hope to achieve?
2. When the waiver implementation plan was being developed, what did you hope would be the most significant benefits?
    - ☐ For payers?
    - ☐ For providers?
    - ☐ For individuals seeking treatment?

Access to care along the continuum

The SUD 1115 Waiver aims to reduce overdose and overdose death through a series of policy and practice changes that improve access to high-quality treatment at all ASAM levels of care. We would like to spend some talking about the changes that you have seen or anticipate in access to care.

3. Within your organization, what changes have been or are being made to ensure access to or placement in the appropriate levels of care?
    - ☐ Policy/rule changes?
    - ☐ Data analysis/use of data?
    - ☐ Access standards for each level of care?
4. What, if any, changes has your organization made or planned to make to assure compliance with nationally recognized program standards and provider qualifications?
5. How will utilization management change within your organization under the waiver?

6. How do structural factors such as racism, sexism, classism, heteronormativity, and other "isms" impact access to SUD treatment?
7. What other factors lead to disparities in access to care right now?
    - ☐ Substance (certain substances increase access to Tx?)
    - ☐ Geography
    - ☐ Disability
    - ☐ Other
8. How do you think waiver implementation will impact non-clinical care services, such as peer-support, 12-step programs, and other mutual aid services?

Medication Assisted Treatment

Under the waiver, residential treatment programs will be required to offer MAT or facilitate access to MAT. We are interested in your thoughts regarding the potential impacts of this new requirement.

9. How will access to MAT in residential treatment settings change as a result of the waiver?
10. What challenges and benefits do you anticipate for residential treatment providers and patients?

Impact of COVID-19 on SUD treatment

COVID-19 has had a significant impact on access to and delivery of healthcare in Ohio and across the nation. We are interested in better understanding the impact of COVID-19 on delivery of SUD treatment in the state.

11. How has COVID impacted SUD treatment in Ohio?
    - ☐ For instance, changes in demand for services or changes in the levels of care needed?
    - ☐ Access to care or a greater impact on certain levels of care? MAT?
12. How has COVID impacted waiver planning and implementation?
    - ☐ Application of program standards?
    - ☐ Timeline changes?

- ☐ Have you seen unexpected consequences, both beneficial and challenging?

Wrap Up

13. What are your primary concerns about the future of SUD 1115 waiver implementation within and outside the context of COVID-19?
14. What other important issues should we be considering or specific questions we should consider asking other key informants?
    - ☐ State leadership?
    - ☐ MCPs?
    - ☐ Residential or Community Treatment Providers?
    - ☐ Medicaid beneficiaries?

Appendix A4: Key Informant Interview Guide: Guiding Questions for Residential and Community Treatment Providers

Guiding Questions for SUD Advisory Committee Members – Residential and Community Treatment Providers

1. We are trying to understand how SUD 1115 Waiver Demonstration implementation is going in Ohio right now, and we value your expertise and contributions. Can you tell us about your role in implementation of the SUD 1115 Waiver, and what you hope to achieve?

Access to care along the continuum

The SUD 1115 Waiver aims to reduce overdose and overdose death through a series of policy and practice changes that improve access to high-quality treatment at all ASAM levels of care. We would like to spend some talking about the changes that you have seen or anticipate in access to care.

2. How does your organization contribute to assessing individual treatment needs and assuring access to the appropriate levels of care?
3. What, if any, changes has your organization made or planned to make in assessing the level of care an individual should be receiving?
    - ☐ How are/will those changes ensure individuals are placed in the appropriate level of care?
    - ☐ What, if any, challenges are providers and beneficiaries facing, or anticipating, as they implement these changes?
    - ☐ What, in any, improvements are providers and beneficiaries seeing or anticipating?
4. How do structural factors such as racism, sexism, classism, heteronormativity, and other "isms" impact access to SUD treatment?
    - ☐ Can you talk about a specific client experience that highlights access inequity?

- ☐ How might another client experience access (African American woman, Latin mom, transgendered person, etc.) to care?

5. What other factors lead to disparities in access to care right now?
    - ☐ Substance (certain substances increase access to Tx?)
    - ☐ Geography
    - ☐ Disability
    - ☐ Other
6. What is your organization's experience with coordination of care and how has it changed over time?
    - ☐ What among those changes have been most beneficial?
    - ☐ Have any of those changes been less helpful, perhaps even harmful?
    - ☐ How might the 1115 Waiver and its beneficial resources be most useful in improving care coordination?
    - ☐ What are the challenges associated with coordinating transition across levels of care?
    - ☐ How are physical healthcare needs and behavioral healthcare needs being coordinated differently?
7. How can coordination of care, starting at the point of entry into treatment, improve an individual's long-term recovery outcomes?
    - ☐ Reduce overdose?
    - ☐ Can you tell us about a specific example of a care coordination success?
8. How do you think waiver implementation will impact non-clinical care services, such as peer-support, 12-step programs, and other mutual aid services?

Medication Assisted Treatment

Under the waiver, residential treatment programs will be required to offer MAT or facilitate access to MAT. We are interested in your thoughts regarding the potential impacts of this new requirement.

9. What role does your organization play in delivery of or access to MAT?
    - ☐ How might your organizational role change with the 1115 SUD Waiver?

10. What are the challenges, if any, for providers who will be required to offer MAT under the Waiver?
    - ☐ What are the potential risks?
11. What benefits do you anticipate with the new requirement?

Impact of COVID-19 on SUD treatment

COVID-19 has had a significant impact on access to and delivery of healthcare in Ohio and across the nation. We are interested in better understanding the impact of COVID-19 on delivery of SUD treatment in the state.

1. In what ways has COVID impacted individuals experiencing SUD, including those in treatment or recovery, differently than other individuals?
    - ☐ Differences by treatment setting, i.e. residential vs. community, etc.?
    - ☐ How does this intersect with the disparities we discussed earlier?
2. How has COVID impacted SUD treatment in Ohio?
    - ☐ For instance, changes in demand for services or changes in the levels of care needed?
    - ☐ Access to care or a greater impact on certain levels of care?
    - ☐ Treatment/facility capacity (for residential)
    - ☐ MAT?
3. How has COVID impacted staffing within your organization/treatment community?
    - ☐ Staffing levels?
    - ☐ Morale

Wrap Up

4. What else would you like us to know about the state of SUD treatment services in Ohio right now?
5. Prior to COVID-19, we were planning to convene focus groups of individuals who had received treatment services in the prior six months to gather their perspectives about treatment services in their communities. Now, the risks associated with bringing groups of people together make focus groups an unlikely option for us. How would you recommend we reach out to this

population to gain their insights and a better understanding of their experiences?

- ☐ What should we be asking them?

Appendix A5: Key Informant Interview Guide: Guiding Questions for Treatment and Recovery Advocates

Guiding Questions for SUD Advisory Committee Members – Treatment and Recovery Advocates

1. We are trying to understand how SUD 1115 Waiver Demonstration implementation is going in Ohio right now, and we value your expertise and contributions. Can you tell us about your role in implementation of the SUD 1115 Waiver, and what you hope to achieve?

Access to care along the continuum

The SUD 1115 Waiver aims to reduce overdose and overdose death through a series of policy and practice changes that improve access to high-quality treatment at all ASAM levels of care. We would like to spend some talking about the changes that you have seen or anticipate in access to care.

2. What challenges are treatment providers and beneficiaries experiencing around access to the appropriate level of care?
    - ☐ Provider capacity
    - ☐ Social determinants of health (housing, employment, education, transportation, etc.)
3. What, if any, improvements have you seen in access to the appropriate level of care?
4. What changes have you seen/do you anticipate in access to appropriate levels of care or in ensuring individuals are placed in the appropriate level of care?
5. How do structural factors such as racism, sexism, classism, heteronormativity, and other "isms" impact access to SUD treatment?
    - ☐ Can you talk about a specific client experience that highlights access inequity?

- ☐ How might another client experience access (African American woman, Latin mom, transgendered person, etc.) to care?

6. What other factors lead to disparities in access to care right now?
    - ☐ Substance (certain substances increase access to Tx?)
    - ☐ Geography
    - ☐ Disability
    - ☐ Other
7. Are you seeing changes in coordination of care as individuals transition from one type of treatment (level of care) to another?
    - ☐ How might the 1115 Waiver and its beneficial resources be most useful in improving care coordination?
    - ☐ How are physical healthcare needs being coordinated?
8. What, if any, benefits have you seen with regard to changes in coordination of care?
9. How do you think waiver implementation will impact non-clinical care services, such as peer-support, 12-step programs, and other mutual aid services?

Medication Assisted Treatment

Under the waiver, residential treatment programs will be required to offer MAT or facilitate access to MAT. We are interested in your thoughts regarding the potential impacts of this new requirement.

10. What role does your organization play in delivery of or access to MAT?
    - ☐ How do you anticipate your organizational role changing with the 1115 SUD Waiver?
11. What are the challenges, if any, for providers who will be required to offer MAT under the Waiver?
    - ☐ Risks?
12. What benefits do you anticipate with the new requirement?

Impact of COVID-19 on SUD treatment

COVID-19 has had a significant impact on access to and delivery of healthcare in Ohio and across the nation. We are interested in better understanding the impact of COVID-19 on delivery of SUD treatment in the state.

13. In what ways has COVID impacted individuals experiencing SUD, including those in treatment or recovery, differently than other individuals?
    - ☐ Differences by treatment setting, i.e. residential vs. community, etc.?
    - ☐ How does this intersect with the disparities we discussed earlier?
14. How has COVID impacted SUD treatment in Ohio?
    - ☐ For instance, changes in demand for services or changes in the levels of care needed?
    - ☐ Access to care or a greater impact on certain levels of care?
    - ☐ Treatment/facility capacity (for residential)
    - ☐ MAT?
15. How has COVID impacted staffing within your local treatment community?
    - ☐ Staffing levels?
    - ☐ Morale

Wrap Up

16. What else would you like us to know about the state of SUD treatment services in Ohio right now?
17. Prior to COVID-19, we were planning to convene focus groups of individuals who had received treatment services in the prior six months to gather their perspectives about treatment services in their communities. Now, the risks associated with bringing groups of people together make focus groups an unlikely option for us. How would you recommend we reach out to this population to gain their insights and a better understanding of their experiences?
    - ☐ What should we be asking them?

Appendix A6: Key Informant Interview Guide: Guiding Questions for Managed Care Plans

Guiding Questions for Managed Care Plans

1. We are trying to understand how SUD 1115 Waiver Demonstration implementation is going in Ohio right now, and we value your expertise and contributions. Can you tell us about your role in implementation of the SUD 1115 Waiver, and what you hope to achieve?

Access to care along the continuum

The SUD 1115 Waiver aims to reduce overdose and overdose death through a series of policy and practice changes that improve access to high-quality treatment at all ASAM levels of care. We would like to spend some talking about the changes that you have seen or anticipate in access to care.

2. Within your organization, what changes have been or are being made to ensure access to or placement in the appropriate levels of care?
    - ☐ Policy/rule changes?
    - ☐ Data analysis/use of data?
    - ☐ Access standards for each level of care?
3. What, if any, changes has your organization made or planned to make to assure compliance with nationally recognized program standards and provider qualifications?
4. How will utilization management change within your organization under the waiver?
5. How do structural factors such as racism, sexism, classism, heteronormativity, and other "isms" impact access to SUD treatment?
    - ☐ Can you talk about a specific client experience that highlights access inequity?
    - ☐ How might another client experience access (African American woman, Latin mom, transgendered person, etc.) to care?

6. What other factors lead to disparities in access to care right now?
    - ☐ Substance (certain substances increase access to Tx?)
    - ☐ Geography
    - ☐ Disability
    - ☐ Other
7. What is your organization's role in coordination of care and how has it evolved over time?
    - ☐ What future changes do you anticipate?
    - ☐ What are the challenges associated with coordinating transition across levels of care?
    - ☐ How are physical healthcare needs and behavioral healthcare needs being coordinated differently?
8. What, if any, benefits have you seen with regard to changes in coordination of care?

Medication Assisted Treatment

Under the waiver, residential treatment programs will be required to offer MAT or facilitate access to MAT. We are interested in your thoughts regarding the potential impacts of this new requirement.

9. How will access to MAT in residential treatment settings change as a result of the waiver?
10. What challenges and benefits do you anticipate for residential treatment providers and patients?

Impact of COVID-19 on SUD treatment

COVID-19 has had a significant impact on access to and delivery of healthcare in Ohio and across the nation. We are interested in better understanding the impact of COVID-19 on delivery of SUD treatment in the state.

11. How has COVID impacted SUD treatment in Ohio?
    - ☐ For instance, changes in demand for services or changes in the levels of care needed?

- ☐ Access to care or a greater impact on certain levels of care?
- ☐ MAT?

12. How has COVID impacted application of program standards?
    - ☐ Have you seen unexpected consequences, both beneficial and challenging?
    - ☐

Wrap Up

13. What are your primary concerns about the future of SUD 1115 waiver implementation within and outside the context of COVID-19?
14. What else would you like us to know about the state of SUD treatment services in Ohio right now?

Appendix B: Focus Group Interview Guide for Focus Groups with Individuals with Lived Experience

SUD 1115 Waiver Focus Group Questions

Informed consent:

Hello, my name is _____ and today I am joined by _____. We are part of a research team working on behalf of the Ohio Department of Medicaid to better understand the issues faced by those seeking drug and alcohol treatment. Thank you for speaking with us today. Before beginning, we thought it would be helpful to review the goals and process of this focus group as well as answer any questions you have.

We are part of a project looking at access to drug and alcohol treatment across the state. To better understand the issues faced by people trying to get into treatment, we are facilitating focus groups with people who are enrolled in Medicaid and have been in some type of substance use treatment and/or recovery services in the past 6 months. Our hope is that your stories can help improve access to care and recovery outcomes for other Ohioans enrolled in Medicaid. We hope that you will feel free to discuss your experience or the experiences of others close to you.

[Skip this section if all participants are in the same room] During our conversation today, we ask that you mute your microphone when you are not speaking. You can do this by clicking the microphone picture at the bottom of your screen or pressing *6 on your phone. We also ask that you change your Zoom display name to your first name. To change your Zoom name click on the “Participants” button at the top or bottom of the **Zoom** window. Next, hover **your** mouse over **your name** in the “Participants” list on the right side of the **Zoom** window. Click on “More” then click “Rename” and type in your first name. If you on a phone or unable to change your display name, please say your first name before speaking.

Our discussion will last about an hour and a half. Your participation is voluntary. You do not have to answer any questions you do not want to answer. Our discussion today will be recorded via the Zoom video conferencing application, which will also produce a word-for-word transcript of our conversation*. [this portion only for participants in the same room*] Before speaking, please say your first name so the recording is correct. Everything said today is confidential. The information you share will only be presented in summary form, and none of your personal information will be shared with anyone. If at any time you wish to discontinue participation, we can end our discussion. We appreciate there are many pathways to recovery and we want to understand your experiences and observations on what helps and what may get in the way of recovery. We also appreciate that each person and each community is different, and our goal is to gather information about a variety of experiences. Again, what you share here is confidential and will not be attributed to any one person. Do you have any questions for us before we begin? Do we have your permission to begin recording?

1. To begin today, it would be helpful for us to understand what "treatment" means to you.
2. From your experience, how do people in your community typically get into treatment?
    - ☐ Recognizing there are many paths to recovery, what helped you find treatment services that met your needs? What helped you most in accessing those services? Were the services you needed different from what you thought you wanted?
    - ☐ What factors influence a person's decision to seek treatment?
    - ☐ Do you have an example of a person or community resource that has been successful in helping people seek treatment or get into treatment?
    - ☐ When people are focusing on the internal drivers (i.e. being ready, reaching bottom, being tired of the lifestyle): Was there a person or

organization that helped you get from that point where you were ready for treatment to actually walking through the door?

3. What are the biggest barriers to treatment?
    - ☐ What problems in your community make it difficult to access treatment?
        - Wait list
        - Insurance
        - Types of treatment available in your community
        - Medication Assisted Treatment
        - Telehealth
    - ☐ How easy or difficult is it to find a treatment program that offers medication for treatment, such as methadone, buprenorphine, or suboxone?
    - ☐ How might court involvement create barriers to treatment in your community?
        - Do you feel that others' experiences with the court system match your own?
    - ☐ How has COVID-19 impacted access to treatment? Did you participate in telehealth services and how was that experience for you?
    - ☐ *Are there other personal issues, such as child care or work schedules, that can limit access to care for some people?*
        - *Housing*
        - *Physical healthcare needs*
    - ☐ *What role does stigma play in getting a person into treatment?*
4. What makes people want to leave treatment?
    - ☐ Are there triggers in treatment or in the community that influence people's decisions about staying in treatment?
    - ☐ How do people in treatment experience stigma? Does that influence decisions about seeking or staying in care?
5. What keeps people in treatment?

- ☐ Are there specific supportive services that make staying in treatment easier?
    - Housing
    - Access to healthy food
    - Healthcare access
    - Supported employment/vocational training
    - Childcare

6. How does the recovery community support treatment services?
    - ☐ What has your experience been with peer recovery services?
    - ☐ Have you accessed recovery operated services (RCO), recovery communities, or recovery-oriented support services?
    - ☐ If you were interested in recovery housing options, were they available or difficult to find?
7. If you had to pick one word/short phrase to describe your strength in recovery, what would it be?

☐ Thank you all again for your time today and for sharing your experiences. We are truly grateful to you for sharing your stories. If you have any further questions, thoughts, or information you want to share with us after we end our conversation today, we welcome you to reach out via our project email account SUDwaiver@osumc.edu. You will get an email within the next few days with your digital gift card information. Thank you again, and we wish you all the best on your continued journey.

☐

Appendix C1: SUD Treatment Provider Survey Invitation

MITS BITS **STAKEHOLDER INFORMATION RELEASE**

SUD Waiver Evaluation Provider Survey Open, 10/1/21 – 10/22/21

October 1, 2021

SUD Waiver Evaluation Provider Survey Opens

As part of the evaluation of Ohio's Substance Use Disorder (SUD) 1115 Demonstration Waiver, the Ohio Colleges of Medicine Government Resource Center (GRC) has developed a survey of substance use disorder (SUD) treatment providers. The goal of the anonymous survey is to gather the perspectives of treatment providers related to the SUD 1115 Demonstration Waiver. Survey questions include topics such as:

- Access to treatment,
- Medication assisted treatment (MAT) and
- Coordination of care.

Results from this survey will provide the Ohio Department of Medicaid with valuable information about treatment delivery across Ohio as well as identify the successes and challenges experienced by SUD treatment providers and their clients.

GRC requests that the survey be completed by agency clinical directors in SUD treatment settings, including community-based treatment centers, intensive outpatient, office-based opioid treatment programs (OBOT), opioid treatment programs (OTP), residential treatment facilities, etc. The survey is estimated to take about ten minutes to complete. The survey opens today, October 1, 2021 and will remain open until October 22, 2021.

Please click the following link to complete the survey:
https://osu.az1.qualtrics.com/jfe/form/SV_5hy0FV5Y0MRwtdI

The Ohio Colleges of Medicine Government Resource Center (GRC) is the independent evaluation body selected by the Ohio Department of Medicaid to conduct a research evaluation of Ohio's SUD 1115 Waiver. More information about GRC can be found here: Ohio Colleges of Medicine Government Resource Center (osu.edu)

More information about Ohio's SUD 1115 waiver can be found here:
https://bh.medicaid.ohio.gov/SUD-1115

Questions about Ohio's SUD 1115 Demonstration Waiver or the SUD provider survey can be sent here: MCD_SUD1115@Medicaid.ohio.gov

MITS BITS Stakeholder Information Release
To view previous MITS Bits, click HERE

Appendix C2: SUD Treatment Provider Survey

SUD 1115 Mid-Point Provider Survey

Introduction

The following survey, administered on behalf of the Ohio Department of Medicaid, examines the perspectives and experiences of Ohio's substance use disorder (SUD) treatment providers. This anonymous survey takes about 10 minutes to complete and should be completed by a clinical director or their designee at the facility level. "Facility" refers to a physical location where services are delivered. Multiple facilities within an organization may deliver different levels of treatment services and the survey should be completed for each separate facility in the organization. Once you start the survey, your progress will be saved so that if you need to take a break, you can start where you left off when you return to the survey (on the same device). The survey will remain open until October 22, 2021. On behalf of the Ohio Department of Medicaid, thank you for taking time to complete this brief, confidential survey. Questions regarding the survey can be sent to: MCD_SUD1115@medicaid.ohio.gov.

Services

The following set of questions gather information about your treatment facility and the range of services provided.

Q1 Which of the following describes the setting or location of your substance abuse treatment facility: Select all that apply.

- ☐ Hospital (General, VA, psychiatric or other specialized) (1)
- ☐ Non-hospital residential facility (free-standing residential) (2)
- ☐ Community Mental Health/SUD center (for example, OhioMHAS certified Community Mental Health Provider, or Federally Qualified Health Center or Rural Health Center that also provides SUD/behavioral health services) (3)

- ☐ FQHC/RHC (4)
- ☐ Federally-certified Opioid Treatment Program (OTP) (5)
- ☐ Office-based Opioid Treatment Provider (6)
- ☐ Halfway house or transition housing (7)
- ☐ Jail, prison, or other organization that provides treatment exclusively for incarcerated persons or juvenile detainees (8)
- ☐ Solo or group practice (one or more independent practitioner or counselor) (9)
- ☐ Other (Please specify; e.g., school, outpatient, other) (10)

Q2 Do you offer behavioral health treatment to patients with substance use disorder?

- ☐ No (1)
- ☐ Yes (2)

Q3 Do you offer behavioral health treatment to patients with NO substance use disorder?

- ☐ No (1)
- ☐ Yes (2)

Q4 Does your facility provide treatment services for the following substances? Select all that apply.

- ☐ Alcohol (1)
- ☐ Opiates (heroin, prescription opioids, fentanyl) (2)

- ☐ Cannabis/cannabinoids (including synthetic) (3)
- ☐ Cocaine/crack cocaine (4)
- ☐ Benzodiazepines (5)
- ☐ Other (Please specify) (6)

Q5 For each of the following Recovery Support Services, please select whether your facility currently provides this service:	Yes (1)	No (2)	Unsure or N/A (3)
Mentoring/peer support (1)	1.	2.	3.
Self-help groups (for example, AA, NA, SMART Recovery, other 12 step programs) (2)	4.	5.	6.
Assistance in locating housing for patients (3)	7.	8.	9.
Assistance with obtaining social services (for example, Medicaid, WIC, SSI, SSDI) (4)	10.	11.	12.
Recovery coaching (5)	13.	14.	15.

Q6 Which categories of individuals listed below are served by your facility? Select all that apply.

- ☐ Women (1)
- ☐ Men (2)
- ☐ Adolescents (3)
- ☐ Non-binary/gender non-conforming (4)

Q7 Some facilities tailor their programs or groups to certain patient categories. For which patient categories does your facility offer a substance use treatment program/group specifically tailored for patients in that category? If this facility treats patients in any of these categories but does not have a specifically tailored

program or group for them, do not mark the box for that category. Select all that apply.

- ☐ Adolescents (1)
- ☐ Young adults (2)
- ☐ Adult women (3)
- ☐ Pregnant/postpartum women (4)
- ☐ Adult men (5)
- ☐ Seniors/older adults (6)
- ☐ Lesbian, gay, bisexual, transgender, queer/questioning, (LGBTQ+) patients (7)
- ☐ Veterans (8)
- ☐ Other specific programs/groups (Please specify) (9)
- ☐ No specific programs/groups are offered (10)

Q8 Which of the following types of patient payments or insurance are accepted by your facility for substance use treatment? Select all that apply.

- ☐ No payment accepted (free treatment for all patients) (1)
- ☐ Cash/self-payment (2)
- ☐ Medicare (3)
- ☐ Medicaid/Medicaid Managed Care (4)
- ☐ Federal military insurance (e.g., TRICARE) (5)
- ☐ Private health insurance (6)

- ©/Tribal/Urban (ITU) funds (7)
- County ADAMHS Board funding (8)
- Other (Please specify) (9)

Q9 Which of the following Medicaid/Managed Care Plans are accepted by your facility for substance use treatment? Select all that apply.

- Fee for Service (1)
- Buckeye Health Plan Managed Care Plan (2)
- CareSource Managed Care Plan (3)
- Molina Healthcare Managed Care Plan (4)
- Paramount Advantage Managed Care Plan (5)
- United Healthcare Community Plan Managed Care Plan (6)

Q10 Does your organization operate transitional housing, a halfway house, or a sober home for substance use disorder patients? Select all that apply.

- Yes, at this location (1)
- Yes, at another location (2)
- No (3)

Q11 Which of the following statements BEST describes this facility's smoking/tobacco policy for patients?

- ☐ Not permitted to smoke or use tobacco products anywhere outside or within any building (1)
- ☐ Permitted in designated area(s) (2)

Q12 Does your facility offer smoking/tobacco cessation counseling or education?

- ☐ Yes (1)
- ☐ No (2)

Q13 Which of the following statements BEST describes this facility's caffeine policy for patients?

- ☐ Not permitted to consume caffeinated products in the facility (1)
- ☐ Limited use of caffeine allowed (2)
- ☐ No caffeine restrictions (3)

Access to Care

The following questions address access to care along the continuum, as well as some of the barriers that impact access to care.

Q14 The American Society of Addiction Medicine (ASAM) Levels of Care (LOC) are national placement criteria used to match the intensity of treatment services to identified patient needs. They provide a standard set of terms for describing the continuum of recovery-oriented addiction services. For more information on ASAM please go to https://www.asam.org/

Does your organization assess patient treatment needs according to ASAM standards?

- ☐ Yes (1)
- ☐ No (2)

Display this question if Q14=No

Q15 What criteria does your organization use to assess patient treatment needs?

Q16 Which ASAM levels of care does your organization offer? Select all that apply.

- ☐ Level 0.5 Early intervention (1)
- ☐ Level 1 Outpatient services (2)
- ☐ Level 1 Opioid treatment services (3)
- ☐ Level 2 Ambulatory withdrawal management with extended onsite monitoring (5)
- ☐ Level 2.1 Intensive outpatient (6)
- ☐ Level 2.5 Partial hospitalization (7)
- ☐ Level 3.1 Clinically managed low-intensity residential treatment (8)
- ☐ Level 3.2 Clinically managed residential withdrawal management (9)
- ☐ Level 3.3 Clinically managed population-specific high intensity residential treatment (10)
- ☐ Level 3.5 Clinically managed high intensity (adults) residential treatment and medium intensity (adolescents) (11)

- ☐ Level 3.7 Medically monitored intensive inpatient treatment (adults)/medically monitored high intensity inpatient treatment services (adolescents) (12)
- ☐ Level 3.7 Medically monitored inpatient withdrawal management (13)
- ☐ Level 4 Medically managed intensive inpatient treatment/withdrawal management (14)

Q17 What does your organization do if you have a patient whose treatment needs do not match up with the ASAM levels of care that your center is able to provide?

1. Refer patients to another provider who can treat them at their diagnosed level of care (1)
2. Treat patients at the level of care provided by our organization that is closest to their diagnosed level of care (2)
3. Treat patients at the level of care provided by your organization that is closest to their diagnosed level of care, and additionally refer patients to another provider who can treat them at their diagnosed level of care (3)
4. Other (Please specify) (4) _____

Q18 How often is it necessary for your organization to treat a patient at a level of care that does not match their diagnosed level of care?

- ☐ All the time (1)
- ☐ Frequently (2)
- ☐ Sometimes (3)
- ☐ Rarely (4)

- ☐ Never (5)

Q19 In your experience, which of the following are barriers to your patients' access to care? Select all that apply.

- ☐ Lack of or insufficient transportation (1)
- ☐ Distance of treatment facility from patient's home (2)
- ☐ Lack of or insufficient childcare (3)
- ☐ Patient's work hours conflict with treatment availability (4)
- ☐ Healthcare coverage fluctuations (5)
- ☐ Insufficient staffing/workforce shortage among SUD treatment providers (6)
- ☐ Structural factors (such as race, ethnicity, gender, gender identity, socioeconomic status, court-involvement) (7)
- ☐ Waitlist for treatment (8)
- ☐ Cost of care (9)
- ☐ Other (please specify) (10) _____

Display this question if Q19= "Structural factors":

Q20 In your experience, which of the following structural factors are barriers to your patients' access to care? Select all that apply.

- ☐ Race (1)
- ☐ Ethnicity (2)
- ☐ Gender (7)

- ☐ Gender identity (3)
- ☐ Socioeconomic status (4)
- ☐ Court-involvement (5)
- ☐ Other (Please specify) (6) _____

Q21 Which of the following services does your facility currently provide for patients with minor children? Select all that apply.

- ☐ Childcare for patients' children (1)
- ☐ Residential beds for patients' children (2)
- ☐ Referrals to childcare providers (3)
- ☐ Child visitation for patients in residential treatment (4)
- ☐ Other (Please specify) (5) _____
- ☐ No services provided for patients' children (6)

Q22 Please select the operating hours during which your facility's patients can access care/treatment:

	8am-5pm (1)	After hours (but not overnight) (2)	Overnight (3)
Monday – Friday (1)	☐	☐	☐
Saturday (2)	☐	☐	☐
Sunday (3)	☐	☐	☐

Q23 Which of the following types of appointments does your organization offer? Select all that apply.

- ☐ Same-day (1)
- ☐ Telephone appointments (2)
- ☐ 24-hour crisis response (3)
- ☐ Individual video conference appointments (4)
- ☐ In-person group therapy/group appointments (5)
- ☐ Group video conference appointments (6)
- ☐ Other (Please specify) (7) _____

Q24 In what languages do staff provide substance use treatment in your facility? Select all that apply. *Do not count languages provided only by on-call interpreters.*

- ☐ English (1)
- ☐ American Sign Language (ASL) (4)
- ☐ Spanish (5)
- ☐ American Indian or Alaskan Native Languages (e.g. Hopi, Lakota, Navajo, Ojibwa, Yupik) (6)
- ☐ Chinese Languages (e.g. Mandarin, Cantonese) (7)
- ☐ Arabic (8)
- ☐ Somali (9)
- ☐ Other (Please specify) (10) _____

MAT

The following questions address medication assisted treatment (MAT) services in your facility.

Q25 For each of the following, please select whether your organization currently provides this service (a) on-site, (b) off-site (for example, through a business, contractual, or formal referral relationship), or (c) not at all:	On Site (1)	Off-Site (2)	Not Provided (3)
Medically supervised withdrawal management (detoxification) (1)	☐	☐	☐
Opioid agonist maintenance treatment: methadone (2)	☐	☐	☐
Opioid agonist maintenance treatment: buprenorphine (3)	☐	☐	☐
Opioid receptor antagonist: naltrexone (4)	☐	☐	☐
Opioid receptor antagonist: naloxone (5)	☐	☐	☐
Medication for alcohol use disorder (naltrexone, acamprosate, and/or disulfiram) (6)	☐	☐	☐
Overdose management services (7)	☐	☐	☐
Methadone or buprenorphine for pain management (12)	☐	☐	☐
Nicotine replacement (9)	☐	☐	☐
Non-nicotine smoking/tobacco cessation medications (for example bupropion, varenicline) (13)	☐	☐	☐
Medications for other behavioral health disorders (for example antidepressants, antipsychotics) (14)	☐	☐	☐

Q26 For those patients using MAT, but whose medications originate from or are prescribed by another entity, from where do patients obtain their prescriptions? Select all that apply.

- ☐ A prescribing entity in our network (1)
- ☐ A prescribing entity with which our facility has a business, contractual, or formal referral relationship (5)
- ☐ A prescribing entity with which our facility has no formal relationship (6)
- ☐ Facility requires patients to taper from MAT upon admission or does not accept patients using MAT (7)

Coordination of Care

The following questions address coordination of care, meaning deliberate activities conducted for the purpose of organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care.

Q27 Where does your facility get referrals from? Select all that apply.

- ☐ Other treatment facilities (1)
- ☐ Criminal justice system (10)
- ☐ Self-referred/voluntary (11)
- ☐ Patient's family or friends (12)
- ☐ Patient's employer (14)
- ☐ Heath care or mental health providers (15)
- ☐ Social service agencies (16)

- ☐ Other (Please specify) (17) _____

Q28 Beyond substance use disorder treatment, does your organization offer other physical healthcare services (for example primary healthcare) via: (Select all that apply)

- ☐ Referrals to other providers (1)
- ☐ Contracts/partnerships with other providers (6)
- ☐ Within facility treatment (7)
- ☐ Joint program or venture (8)
- ☐ Our organization does not offer any health services other than substance use disorder treatment (9)

Q29 At your organization, who provides coordination services for patients who require health services beyond substance use disorder treatment? Select all that apply.

- ☐ Clinicians (for example physicians, advanced practice nurses) (1)
- ☐ Social workers (7)
- ☐ Certified chemical dependency counselor (8)
- ☐ Other staff (9)
- ☐ Coordination of services provided via business, contractual, or formal referral partnership (10)
- ☐ Coordination of services not provided by this facility (11)

Q30 To what degree are you satisfied with your organization's ability to coordinate (or efficacy in coordinating) health services for patients who require care beyond substance use disorder treatment?

- ☐ Very satisfied (16)
- ☐ Somewhat satisfied (17)
- ☐ Neither satisfied nor dissatisfied (18)
- ☐ Somewhat dissatisfied (19)
- ☐ Very dissatisfied (20)

Q31 When a patient has concluded their treatment in your organization's care, to which of the following services do you routinely facilitate or coordinate their transition (this may also be referred to as a "warm handoff")? Select all that apply.

- ☐ Community services (1)
- ☐ Employment/income generation support (10)
- ☐ Educational/vocational training (11)
- ☐ Housing/shelter support (12)
- ☐ Social services (13)
- ☐ Physical health services (14)
- ☐ Behavioral health services (15)
- ☐ Support groups (16)
- ☐ Another level of care for substance use disorder treatment services (17)

Q32 For each of the following Transitional Services, please select whether your facility currently provides this service:

	Yes (1)	No (2)	Unsure (3)
Discharge planning (1)	☐	☐	☐
Aftercare/continuing care (5)	☐	☐	☐
Take-home-naloxone provision and training on overdose management (6)	☐	☐	☐
Outcome follow-up after discharge (7)	☐	☐	☐

Q33 Is there anything else you would like to share regarding your organization's experience with care coordination (for example, obstacles, successes, aids)?

Impact of COVID-19

The following questions address the impact of COVID-19 on SUD treatment services provided by your facility.

Q34 Following the outbreak of the Covid-19 pandemic in March 2020, did your organization utilize telehealth/virtual treatment modalities?

- ☐ Yes (1)
- ☐ No (2)

Q35 For which of the following services did your organization use telehealth to treat patients? Select all that apply.

- ☐ Evaluations (1)
- ☐ Individual therapy (6)
- ☐ Group therapy (7)
- ☐ MAT (8)
- ☐ Others (Please specify) (9) _____

For questions 36 through 40, please indicate how strongly you agree or disagree with each statement.

Q36 The Covid-19 pandemic reduced the number of patients our organization has been able to treat at one time.

- ☐ Strongly agree (9)
- ☐ Agree (10)
- ☐ Neither agree nor disagree (11)
- ☐ Disagree (12)
- ☐ Strongly disagree (13)

Q37 The Covid-19 pandemic reduced our staffing capacity.

- ☐ Strongly agree (9)
- ☐ Agree (10)
- ☐ Neither agree nor disagree (11)

- Disagree (12)
- Strongly disagree (13)

Q38 The Covid-19 pandemic reduced our organization's ability to accept new patients.

- Strongly agree (9)
- Agree (10)
- Neither agree nor disagree (11)
- Disagree (12)
- Strongly disagree (13)

Q39 The Covid-19 pandemic increased the number of treatment requests our organization received.

- Strongly agree (9)
- Agree (10)
- Neither agree nor disagree (11)
- Disagree (12)
- Strongly disagree (13)

Q40 The Covid-19 pandemic impacted our organization's ability to treat patients at their diagnosed level of care (e.g. due to pressure to limit inpatient treatment).

- Strongly agree (9)

- ☐ Agree (10)
- ☐ Neither agree nor disagree (11)
- ☐ Disagree (12)
- ☐ Strongly disagree (13)

Impact of SUD 1115

The following questions address the impact of the SUD 1115 Waiver Demonstration on your facility. Information about the waiver can be found here: https://bh.medicaid.ohio.gov/SUD-1115.

Q41 Has your organization made, or does it plan to make, programmatic changes in anticipation of the SUD 1115 waiver (for example, adding MAT on-site or establishing contracts for physical health care services)?

- ☐ Yes (1)
- ☐ No (2)
- ☐ Unsure (3)

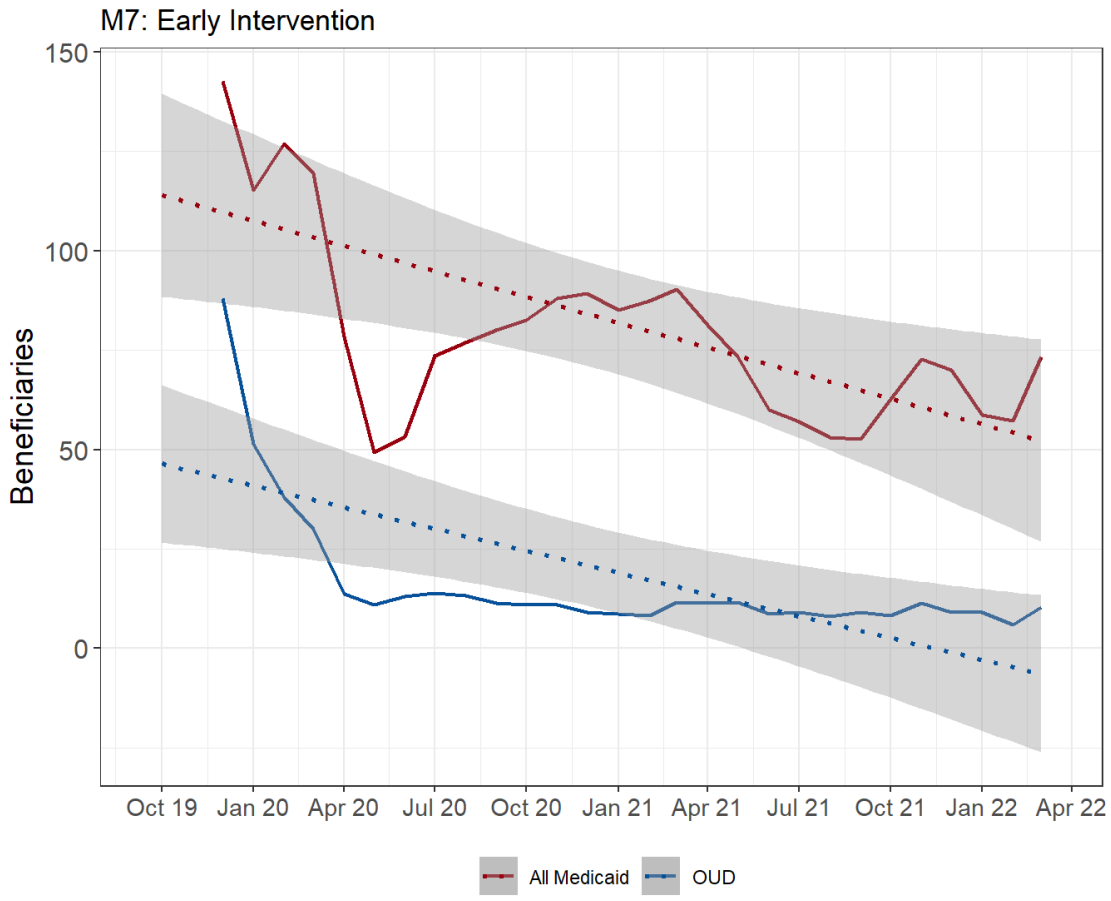
Q42 For each of the following, please select whether your organization (a) plans to change, (b) has already changed, or (c) has no plans to change as a result of the SUD 1115 Waiver.	Plan to Change (1)	Already Changed (2)	No Change Planned (3)
Accept patients on MAT/allow continuation of MAT in care (1)	☐	☐	☐
Prescribe/administer MAT on-site (16)	☐	☐	☐
Provide access to MAT off-site (through contract or business agreement (17)	☐	☐	☐
Provide primary health care or other medical services on-site (18)	☐	☐	☐
Provide access to medical care off-site (through contract or business agreement) (19)	☐	☐	☐
Provide care coordination services (20)	☐	☐	☐
Expand services to add ASAM levels of care (21)	☐	☐	☐
Reduce services to reduce ASAM levels of care (22)	☐	☐	☐
Expand residential treatment capacity (beds) (23)	☐	☐	☐
Reduce residential treatment capacity (beds) (24)	☐	☐	☐
Add other office or treatment locations to serve more patients (25)	☐	☐	☐

Add behavioral health services (26)	☐	☐	☐
Expand referral practices or agreements to improve access to care or care coordination (27)	☐	☐	☐
Expand hours of operation (28)	☐	☐	☐
Add staff (29)	☐	☐	☐

Q43 Is there anything else you would like to share regarding how the SUD 1115 Waiver will impact your organization? (For example, barriers or aids to implementing Waiver-related changes). **[Open-ended]**

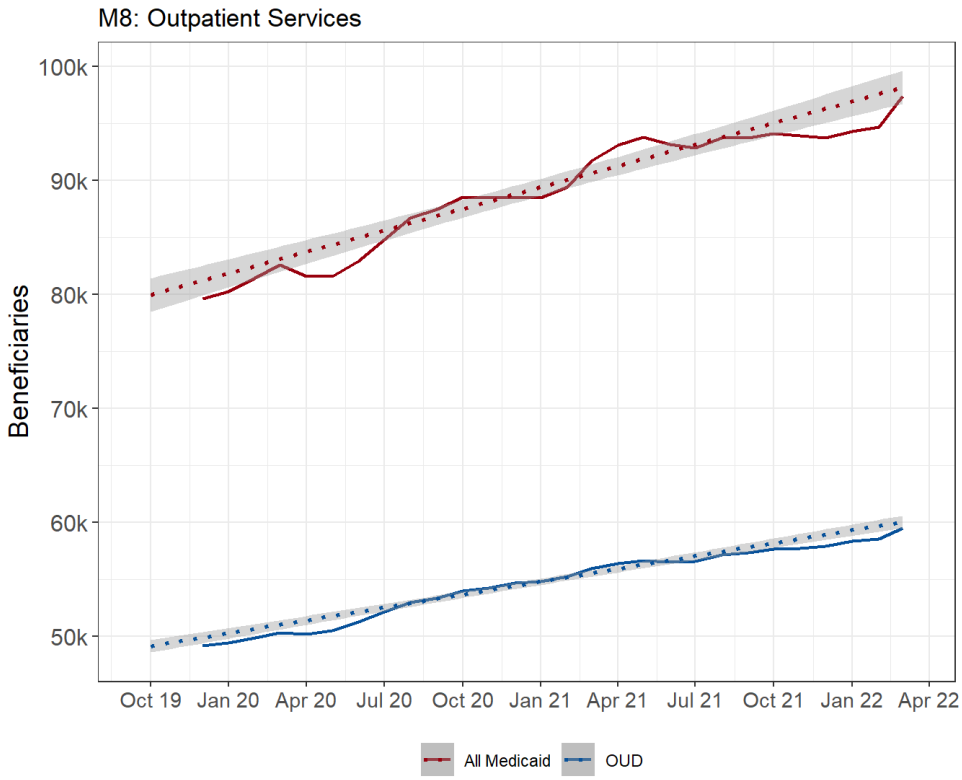
Appendix D: Monitoring Metric Graphics

Figure 6: Early Intervention (M7)



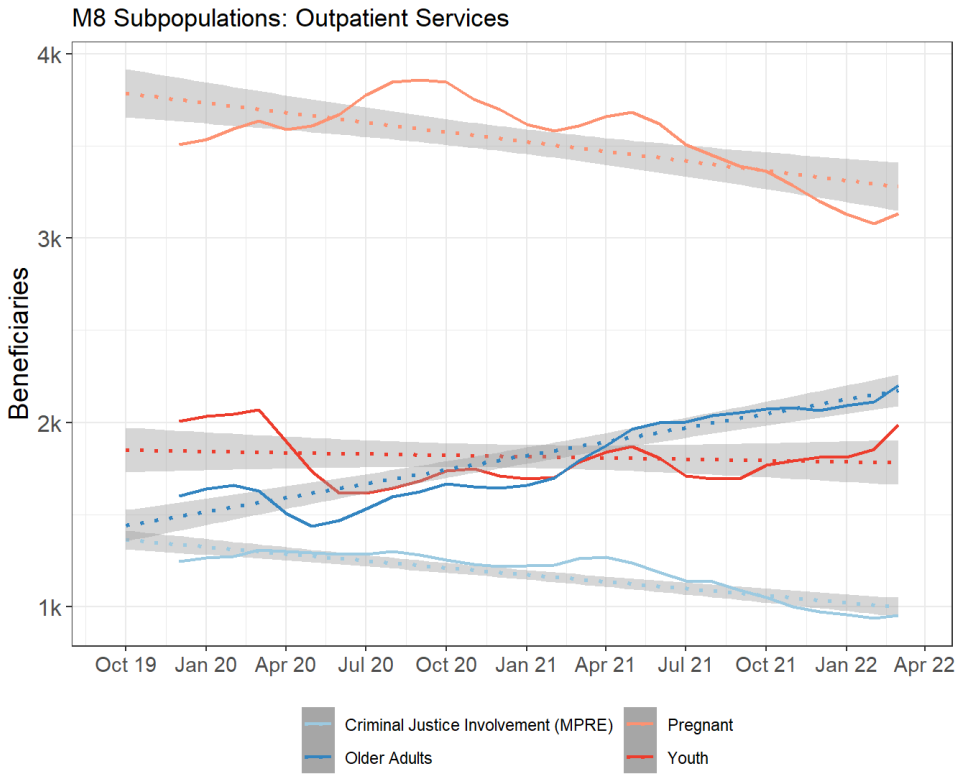
Solid line represents 3-month moving average and dotted line represents linear best fit with 95% CI.

Figure 7: Outpatient services (M8)



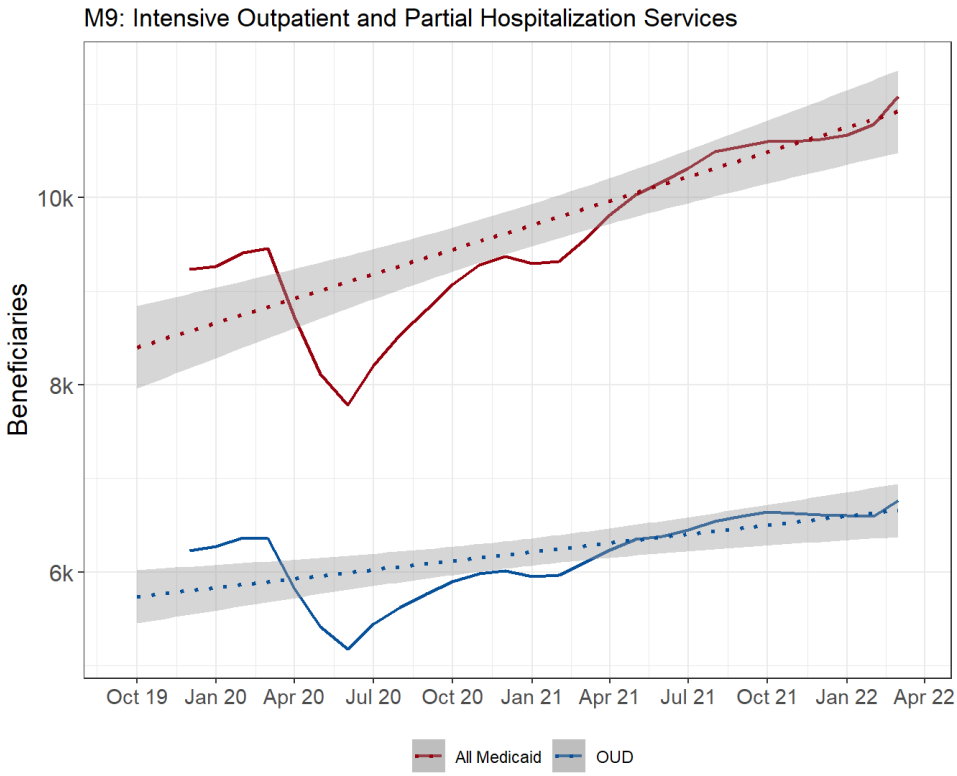
Solid line represents 3-month moving average and dotted line represents linear best fit with 95% CI.

Figure 8: Outpatient services, subpopulations (M8)



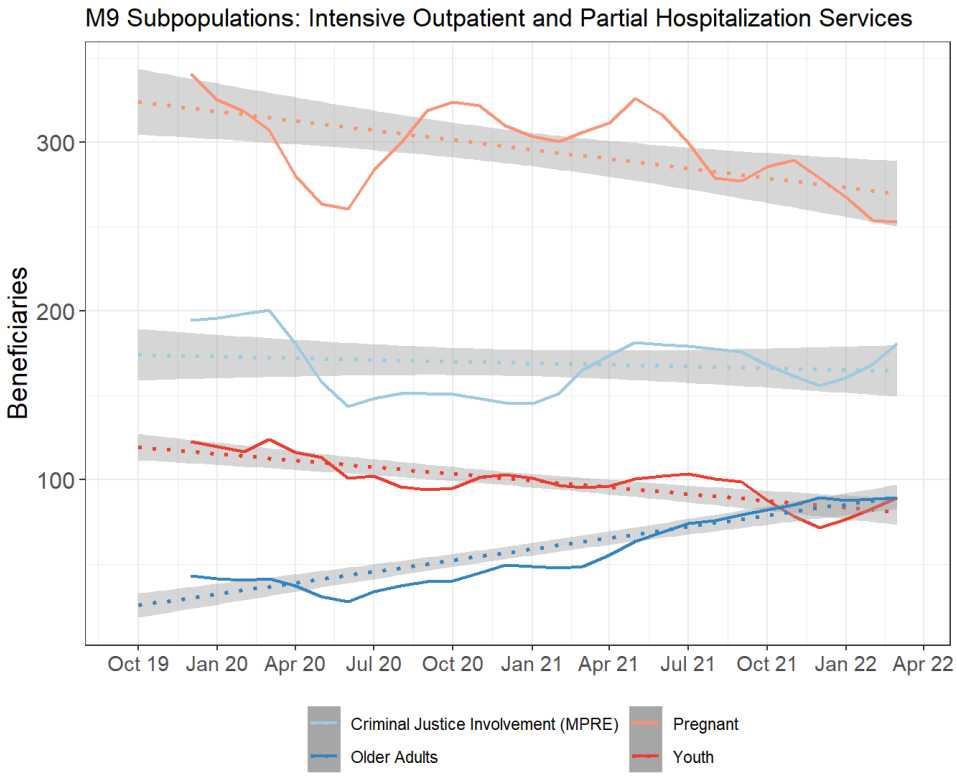
Solid line represents 3-month moving average and dotted line represents linear best fit with 95% CI.

Figure 9: IOP/PHP services (M9)



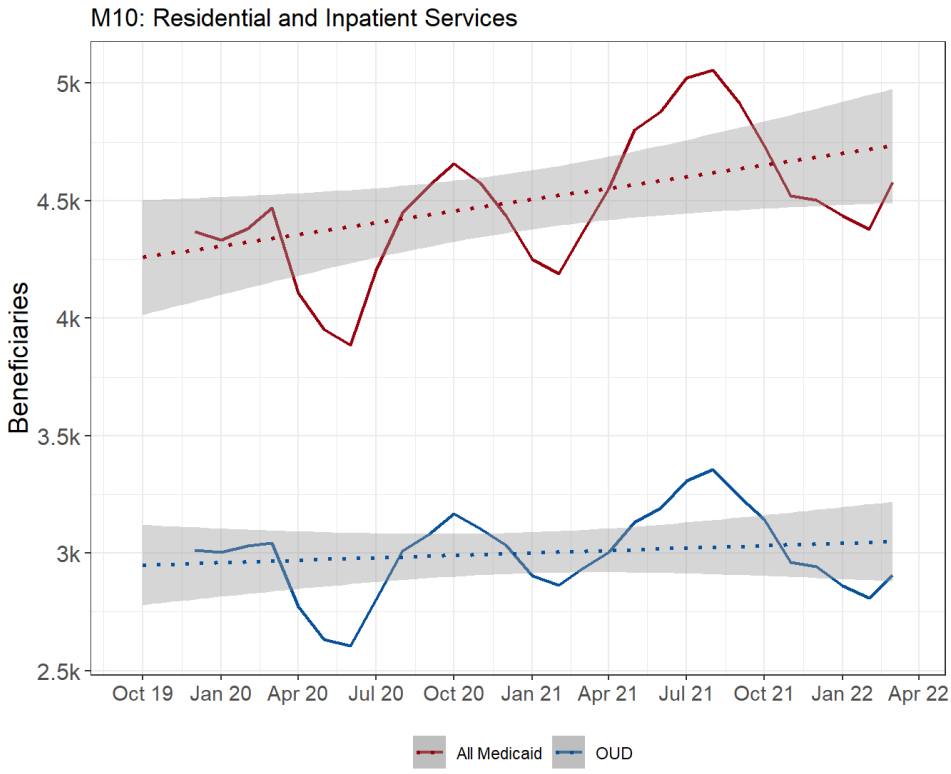
Solid line represents 3-month moving average and dotted line represents linear best fit with 95% CI.

Figure 10: IOP/PHP services, subpopulations (M9)



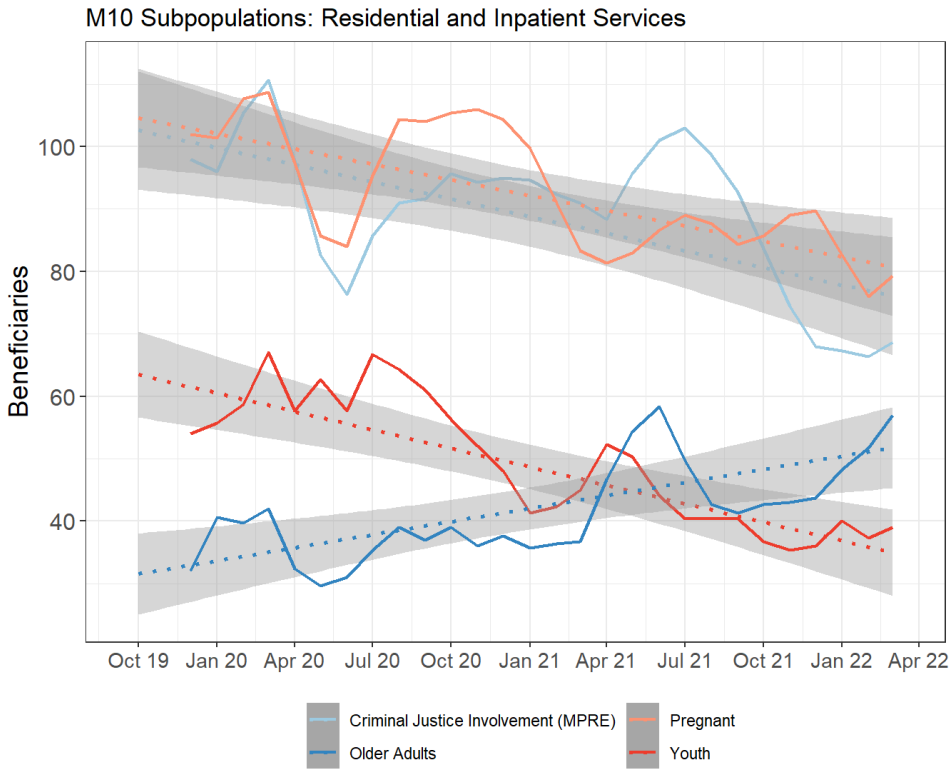
Solid line represents 3-month moving average and dotted line represents linear best fit with 95% CI.

Figure 11: Residential and Inpatient services (M10)



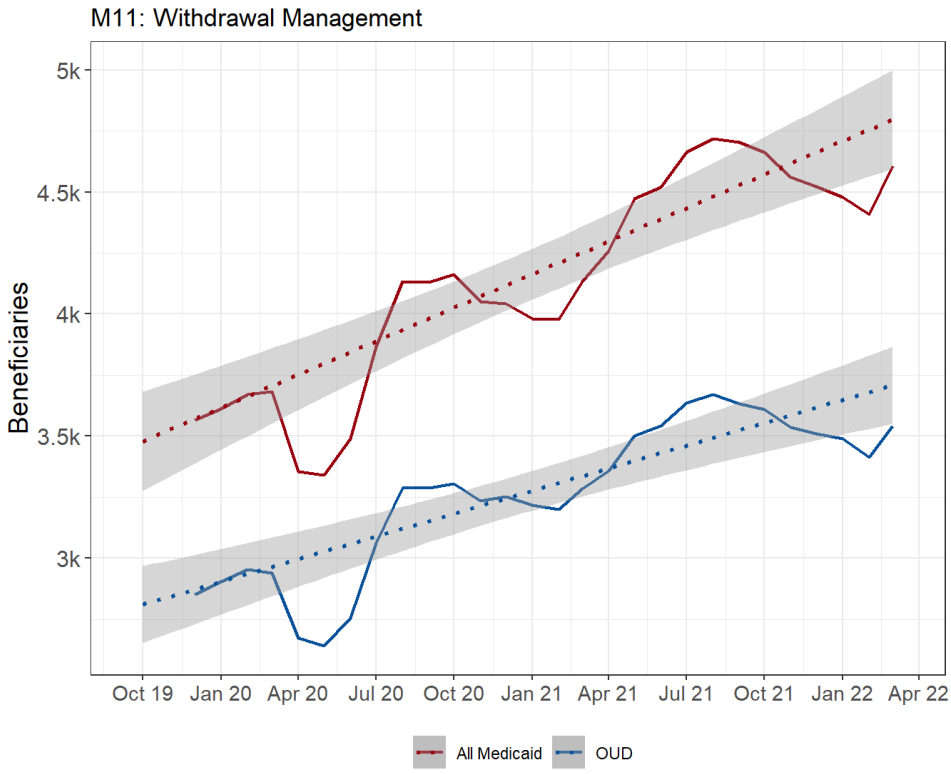
Solid line represents 3-month moving average and dotted line represents linear best fit with 95% CI.

Figure 12: Residential and Inpatient services, subpopulations (M10)



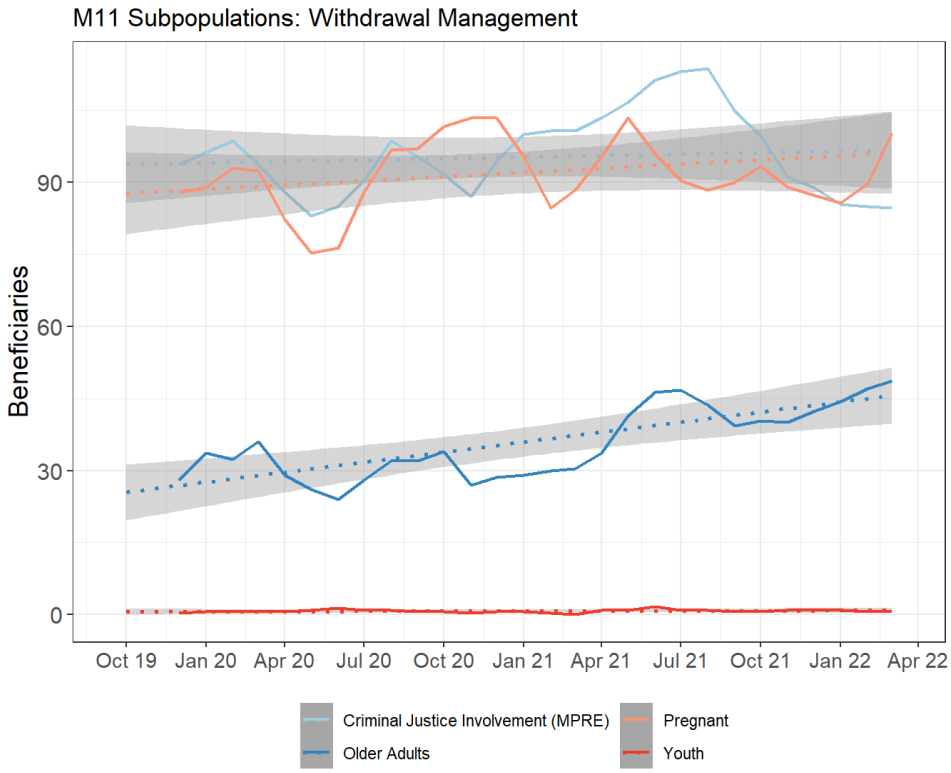
Solid line represents 3-month moving average and dotted line represents linear best fit with 95% CI.

Figure 13: Withdrawal Management services (M11)



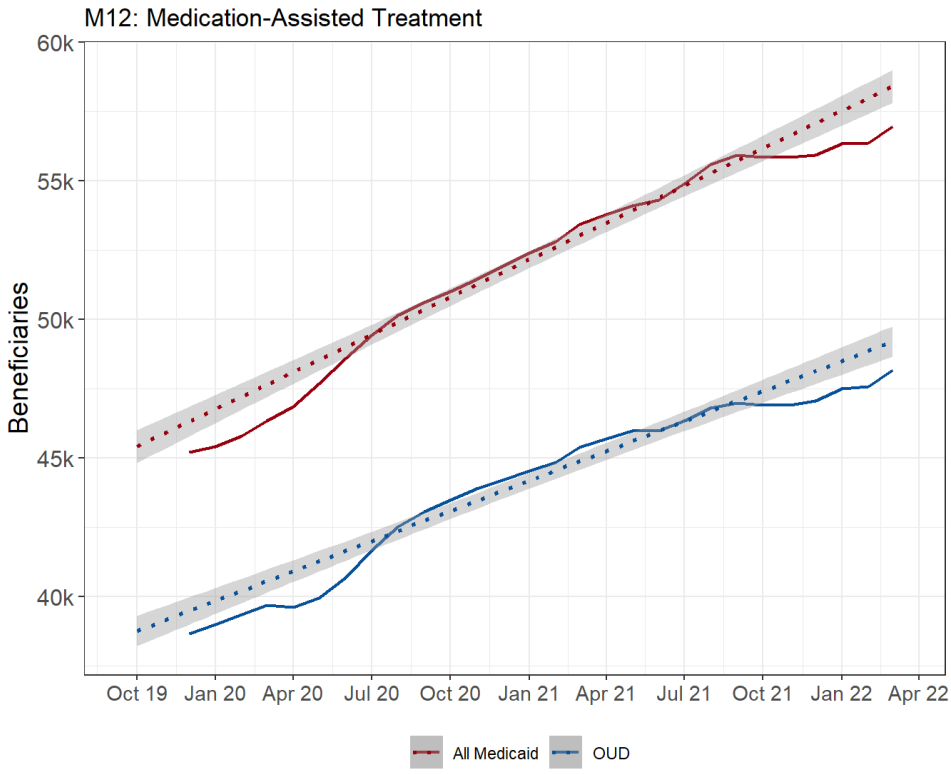
Solid line represents 3-month moving average and dotted line represents linear best fit with 95% CI.

Figure 14: Withdrawal Management services, subpopulations (M11)



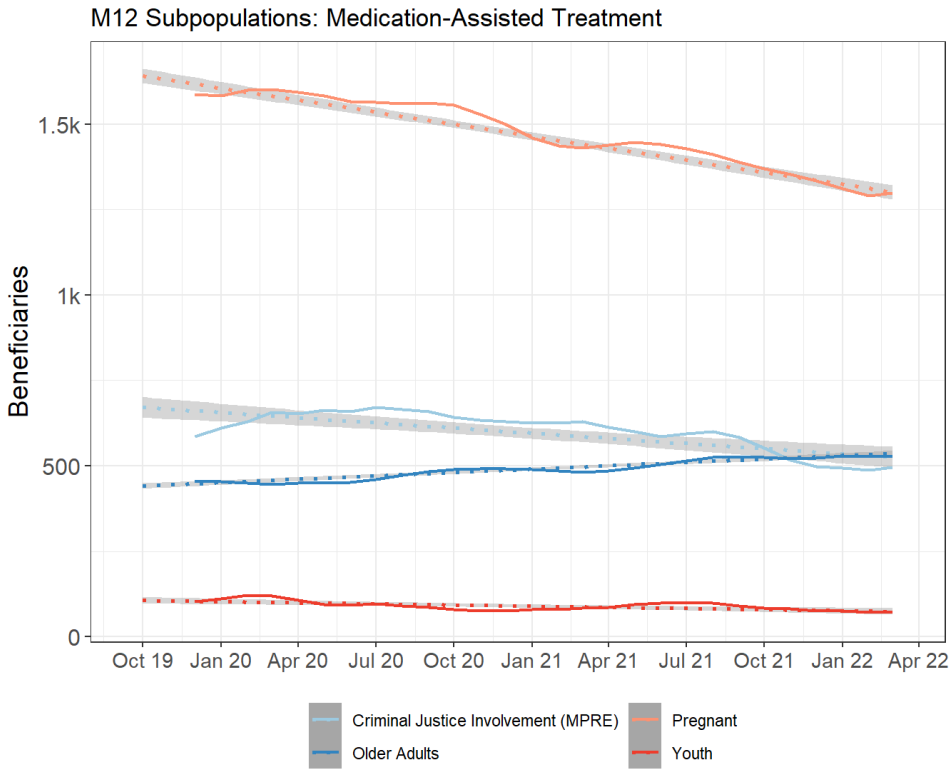
Solid line represents 3-month moving average and dotted line represents linear best fit with 95% CI.

Figure 15: Medication-Assisted Treatment (M12)



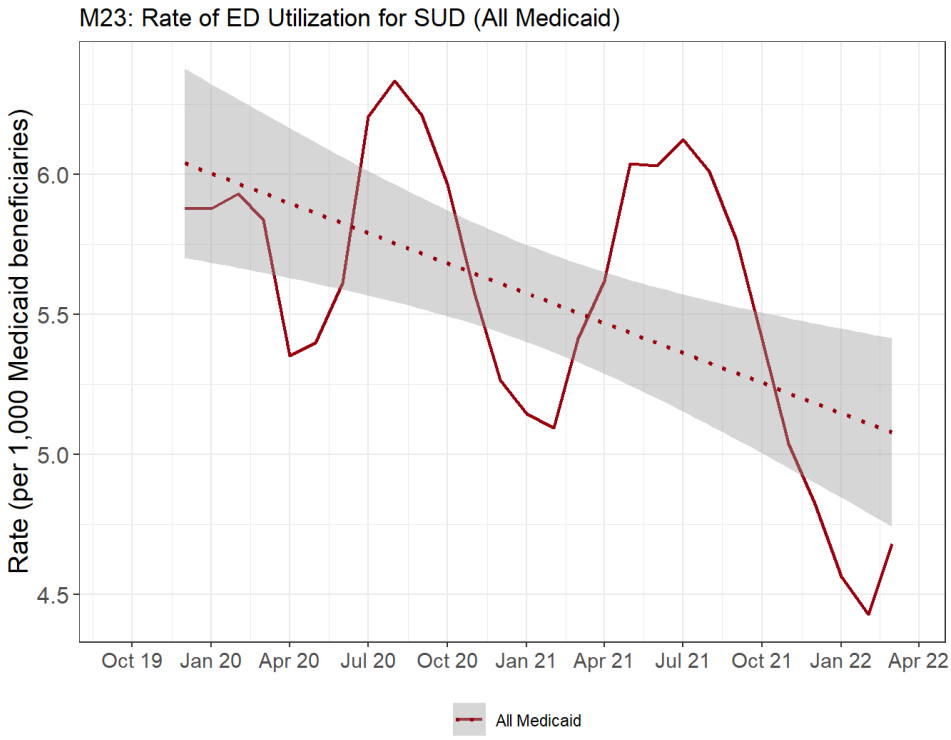
Solid line represents 3-month moving average and dotted line represents linear best fit with 95% CI.

Figure 16: Medication-Assisted Treatment, subpopulations (M12)



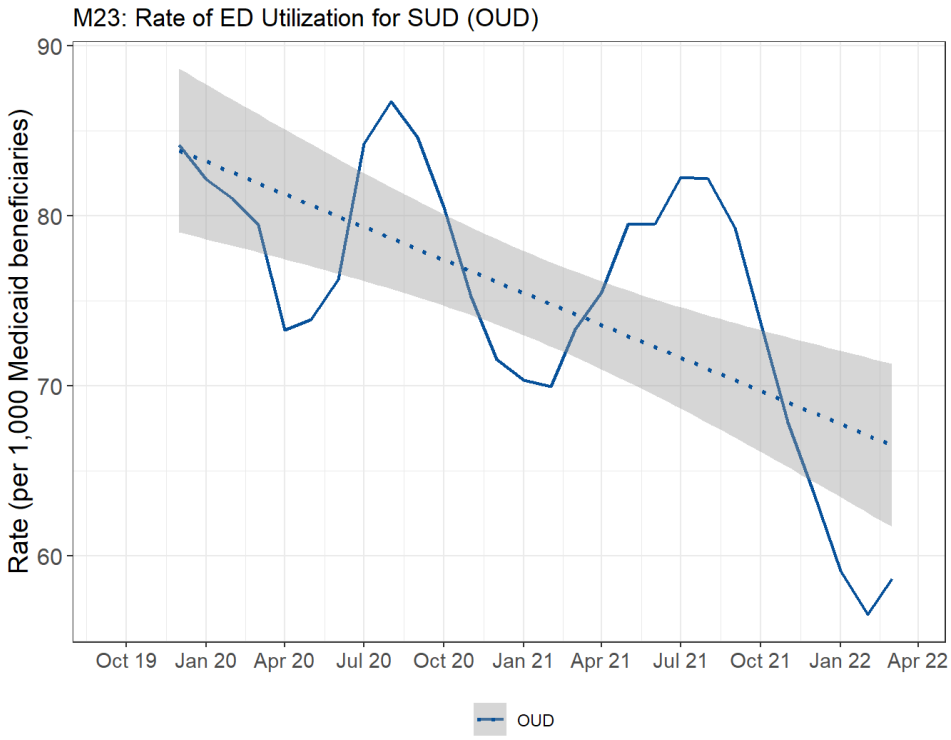
Solid line represents 3-month moving average and dotted line represents linear best fit with 95% CI.

Figure 17: Rate of ED Utilization for SUD (M23)



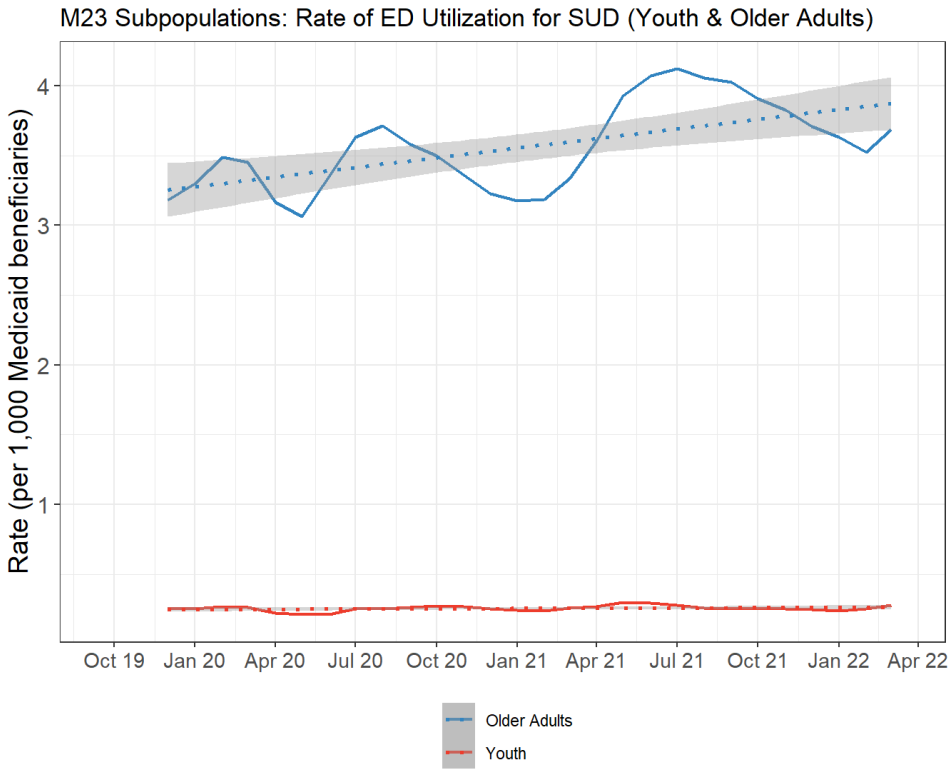
Solid line represents 3-month moving average and dotted line represents linear best fit with 95% CI.

Figure 18: Rate of ED Utilization for SUD, OUD diagnosis (M23)



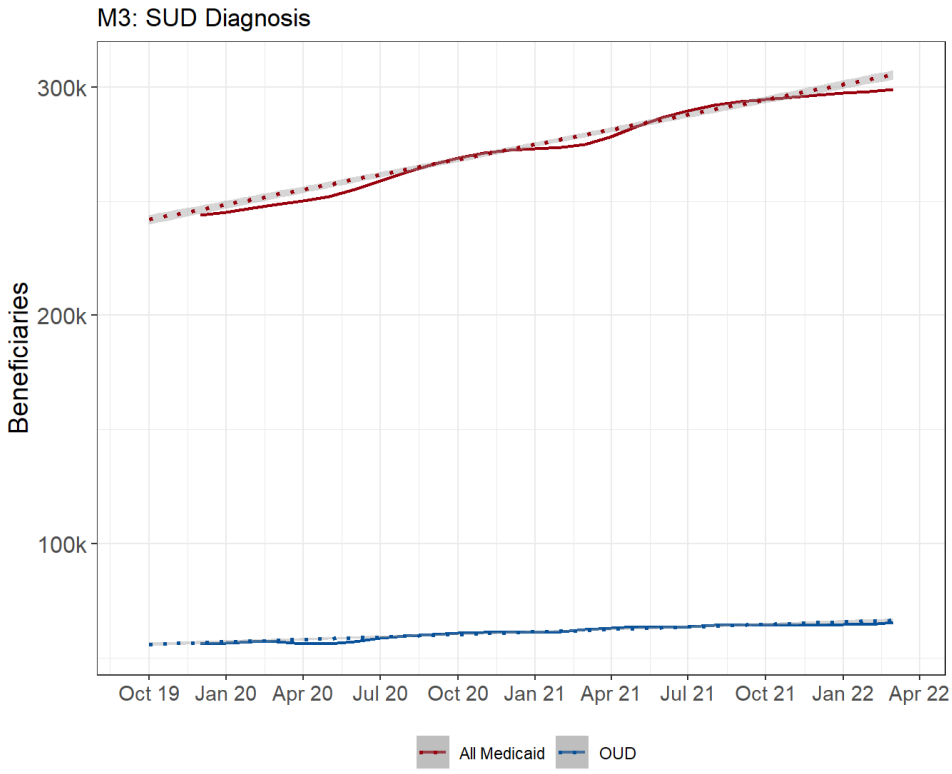
Solid line represents 3-month moving average and dotted line represents linear best fit with 95% CI.

Figure 19: Rate of ED Utilization for SUD, subpopulations (M23)



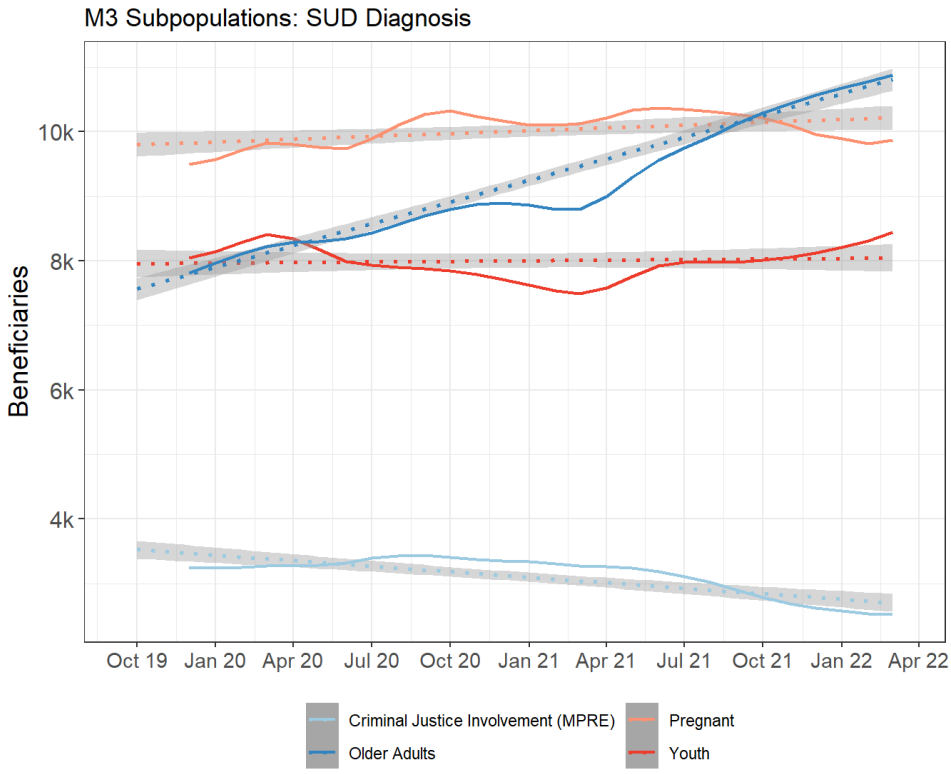
Solid line represents 3-month moving average and dotted line represents linear best fit with 95% CI.

Figure 20: SUD diagnosis (M3)



Solid line represents 3-month moving average and dotted line represents linear best fit with 95% CI.

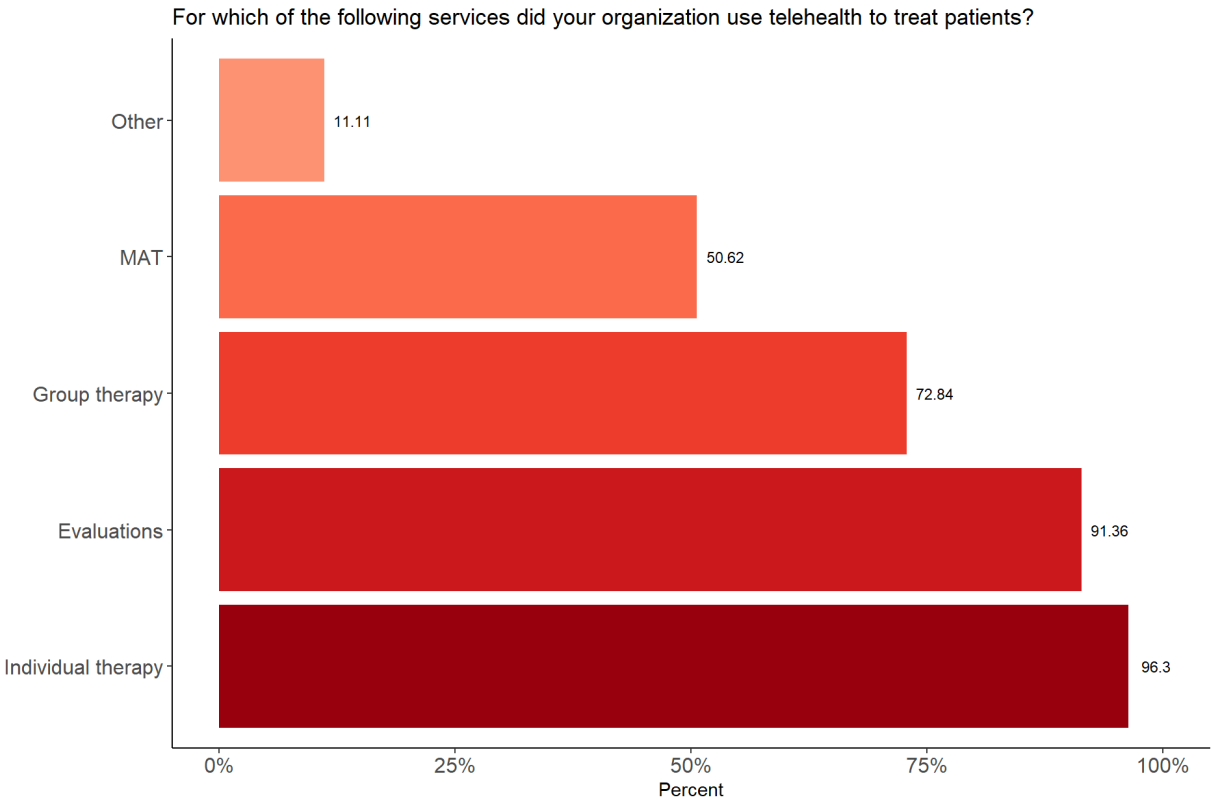
Figure 21: SUD diagnosis, subpopulations (M3)



Solid line represents 3-month moving average and dotted line represents linear best fit with 95% CI.

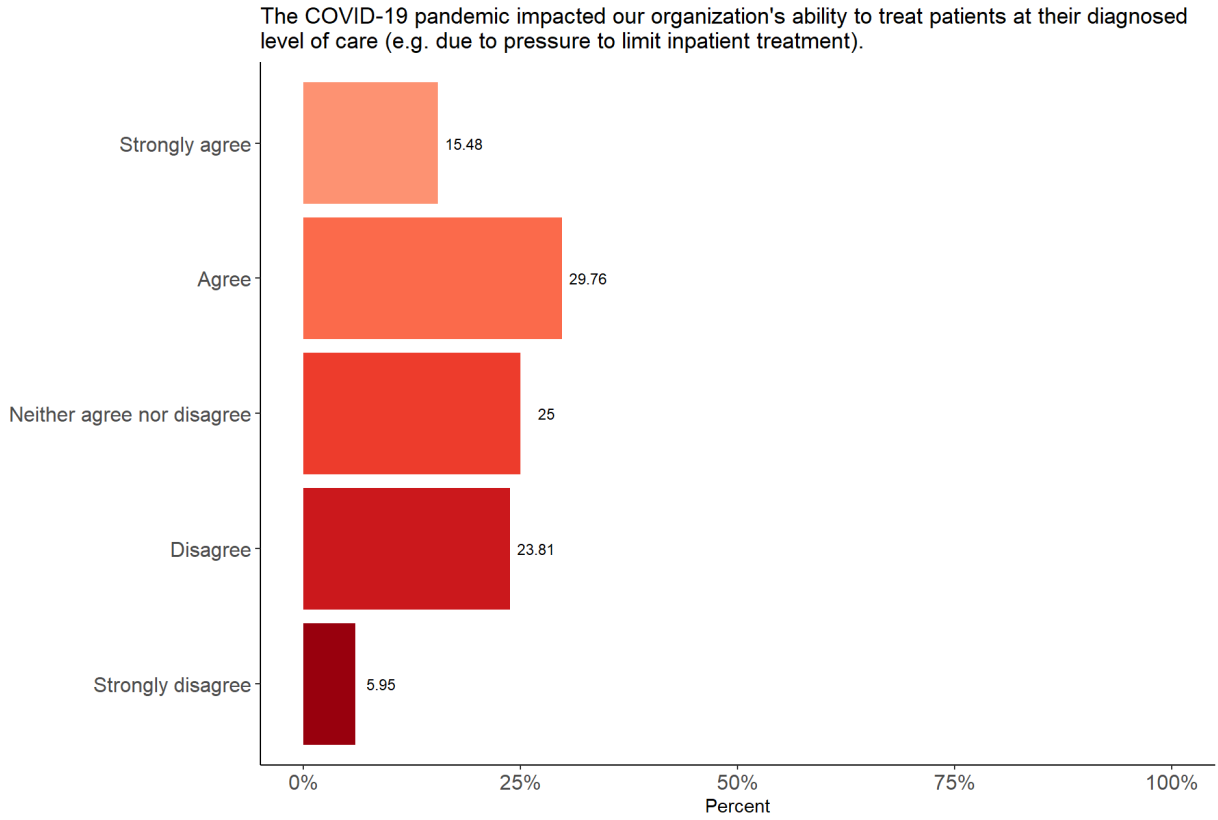
Appendix E: SUD Provider Survey Graphics

Figure 22: Telehealth services used



Source: 2021 Ohio SUD 1115 Midpoint Provider Survey
Note: These proportions are among those who utilized telehealth/virtual treatment modalities following the outbreak of the Covid-19 pandemic in March 2020

Figure 23: Ability to treat at diagnosed level of care



Source: 2021 Ohio SUD 1115 Midpoint Provider Survey
Note: Survey used non-probability sampling and therefore findings are not generalizable to the target population.

Figure 24: Barriers to Accessing Care

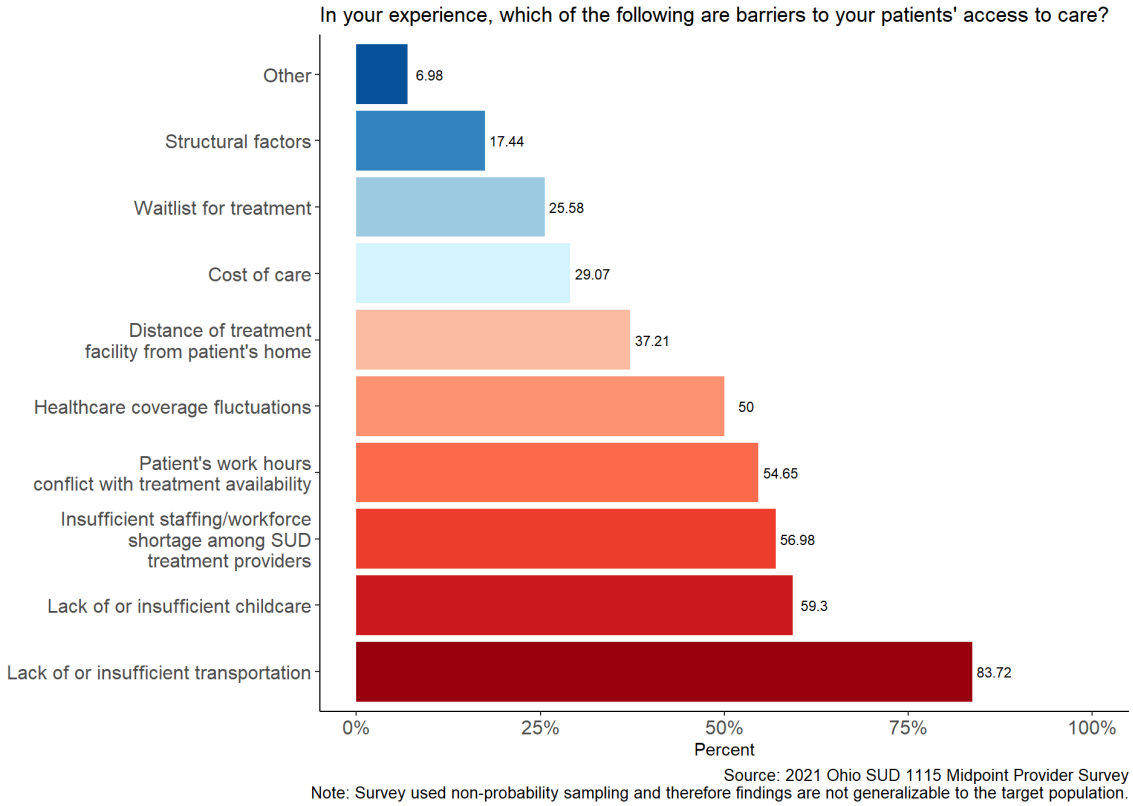
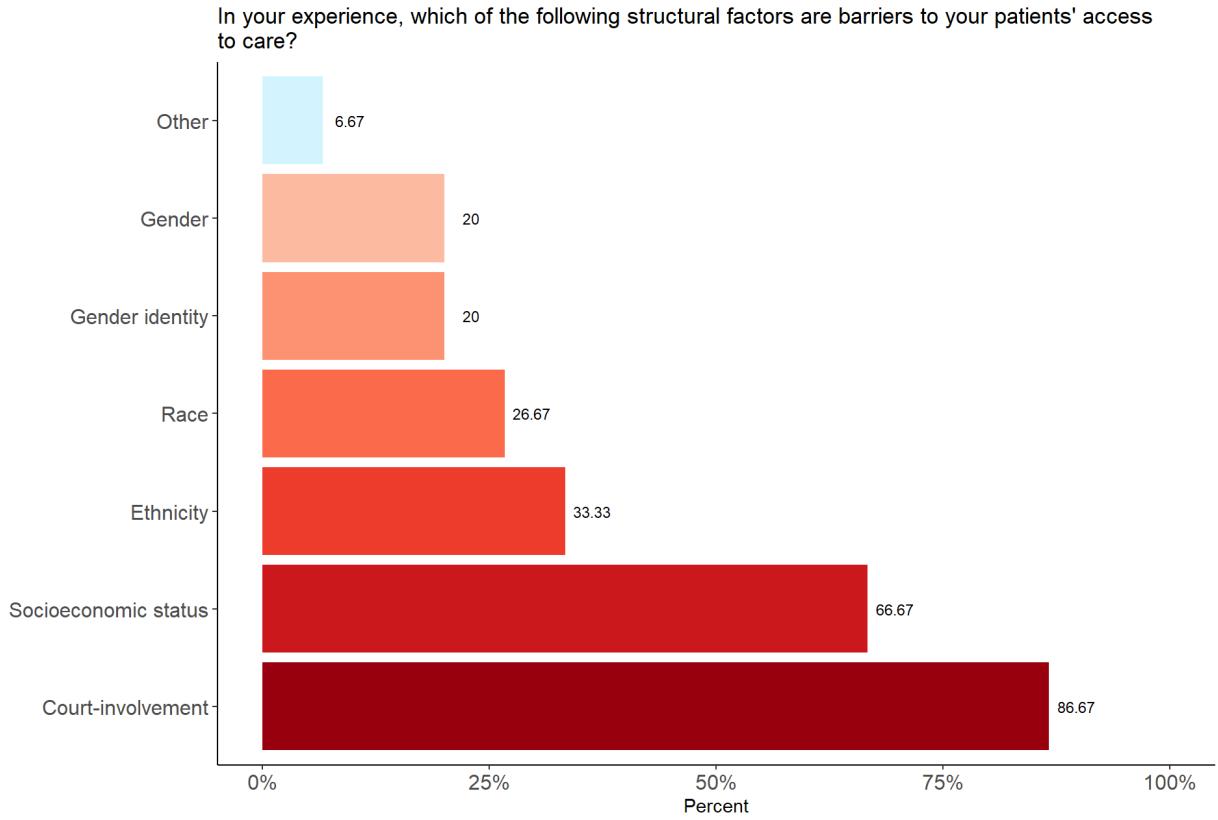
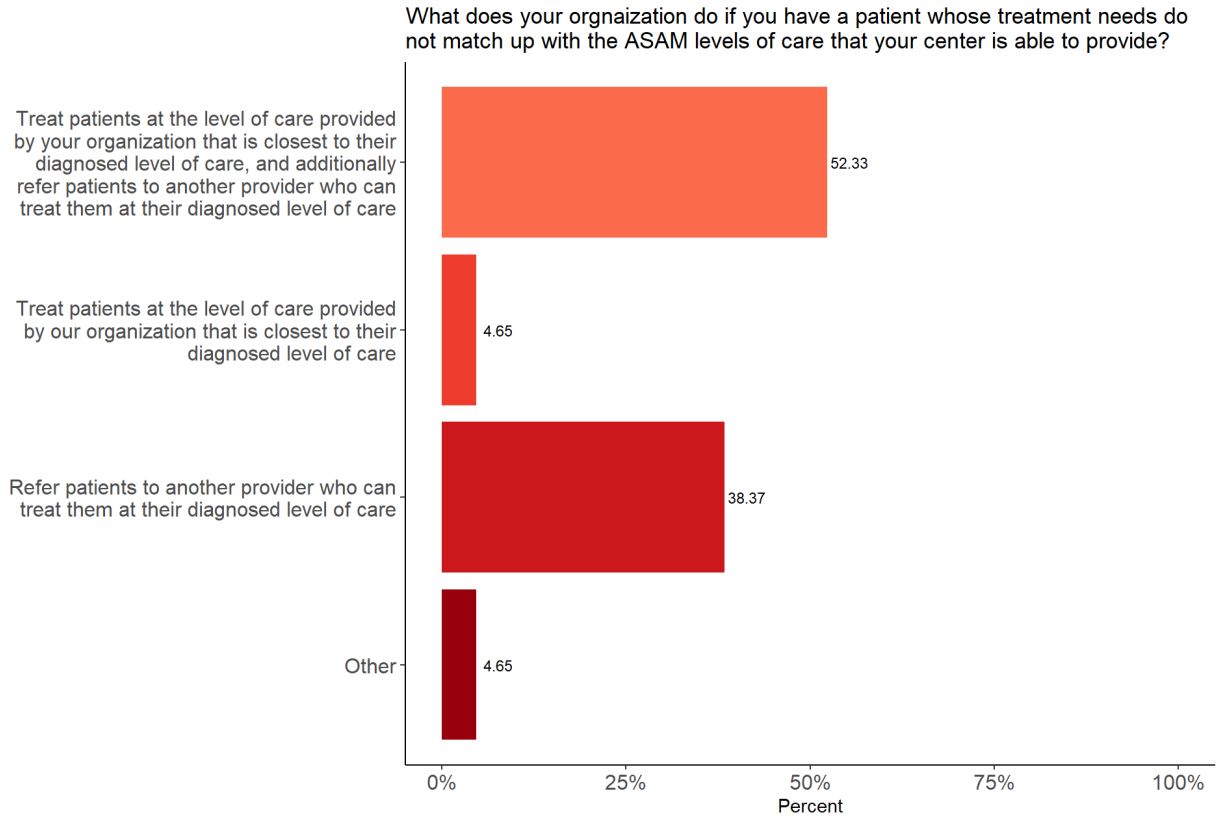


Figure 25: Structural Barriers to Care



Source: 2021 Ohio SUD 1115 Midpoint Provider Survey
Note: Survey used non-probability sampling and therefore findings are not generalizable to the target population.

Figure 26: When treatment needs don't match available care



Source: 2021 Ohio SUD 1115 Midpoint Provider Survey
Note: Survey used non-probability sampling and therefore findings are not generalizable to the target population.

Figure 27: Treating patients at LOC that don't match their diagnosed LOC

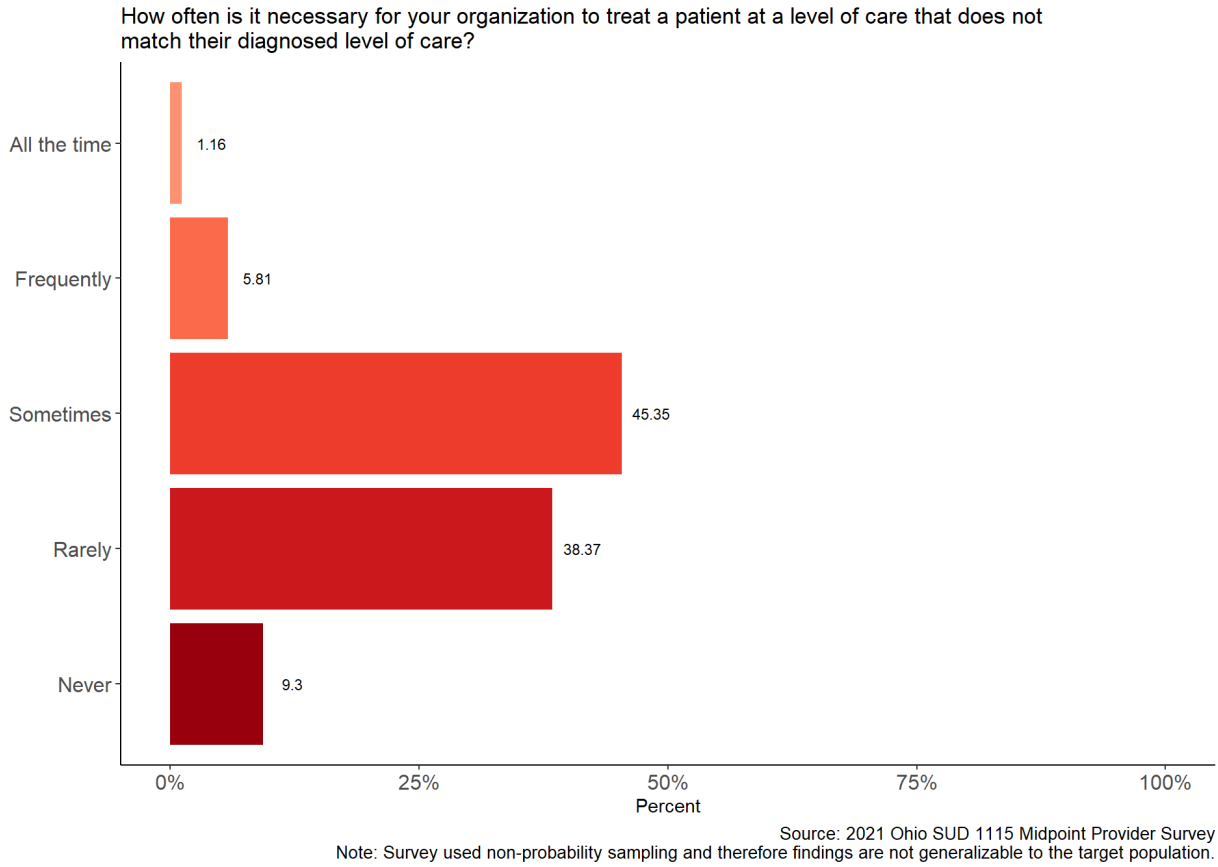


Table 24: MAT services

MAT Type	Percent of Providers with MAT	Number of Providers with MAT
MAT – any	80.85%	76
Naltrexone	74.47%	70
Naloxone	74.47%	70
MAT for AUD	74.47%	70
Buprenorphine	71.28%	67
Methadone	20.21%	19
No MAT	10.64%	10

Source: 2021 Ohio SUD 1115 Midpoint Provider Survey; Note: Survey used non-probability sampling and therefore findings are not generalizable to the target population

Figure 28: Where do patients obtain their MAT prescriptions?

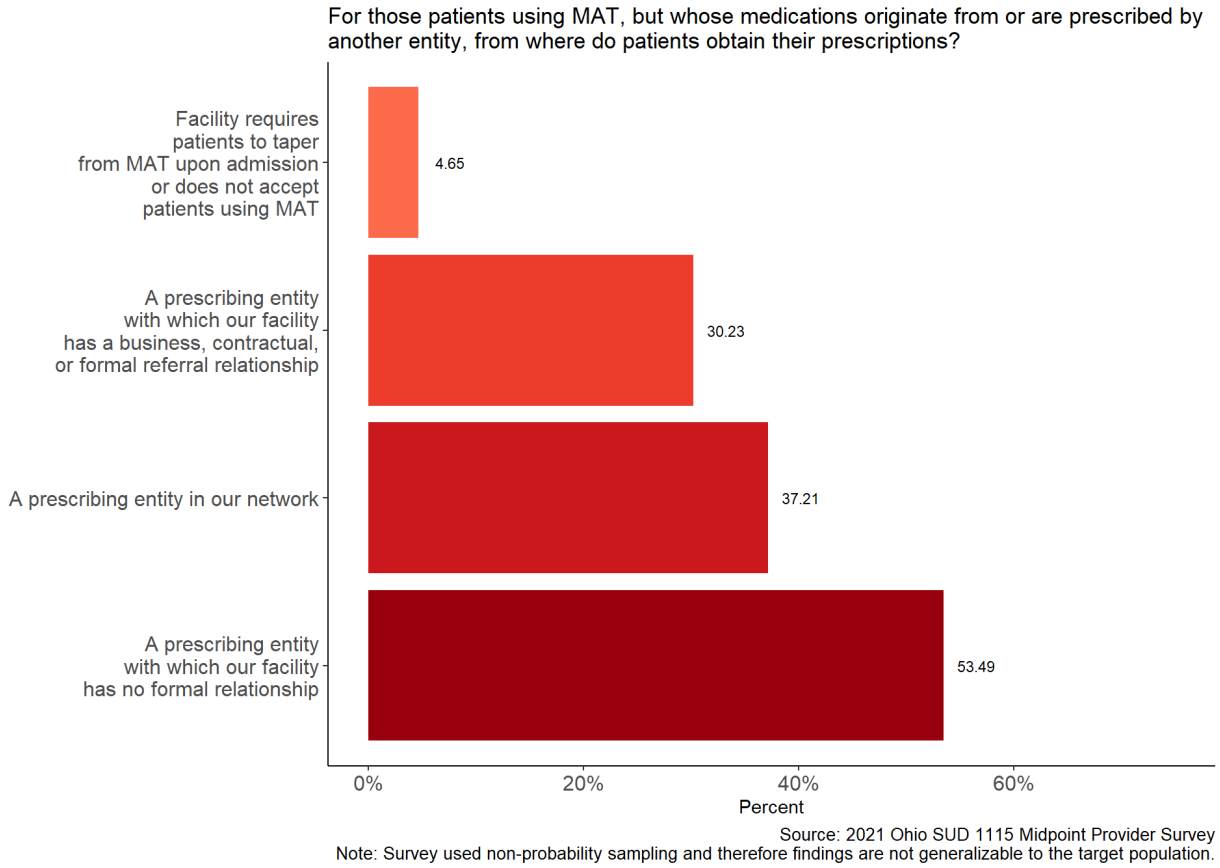


Figure 29: Location of MAT services provided (1)

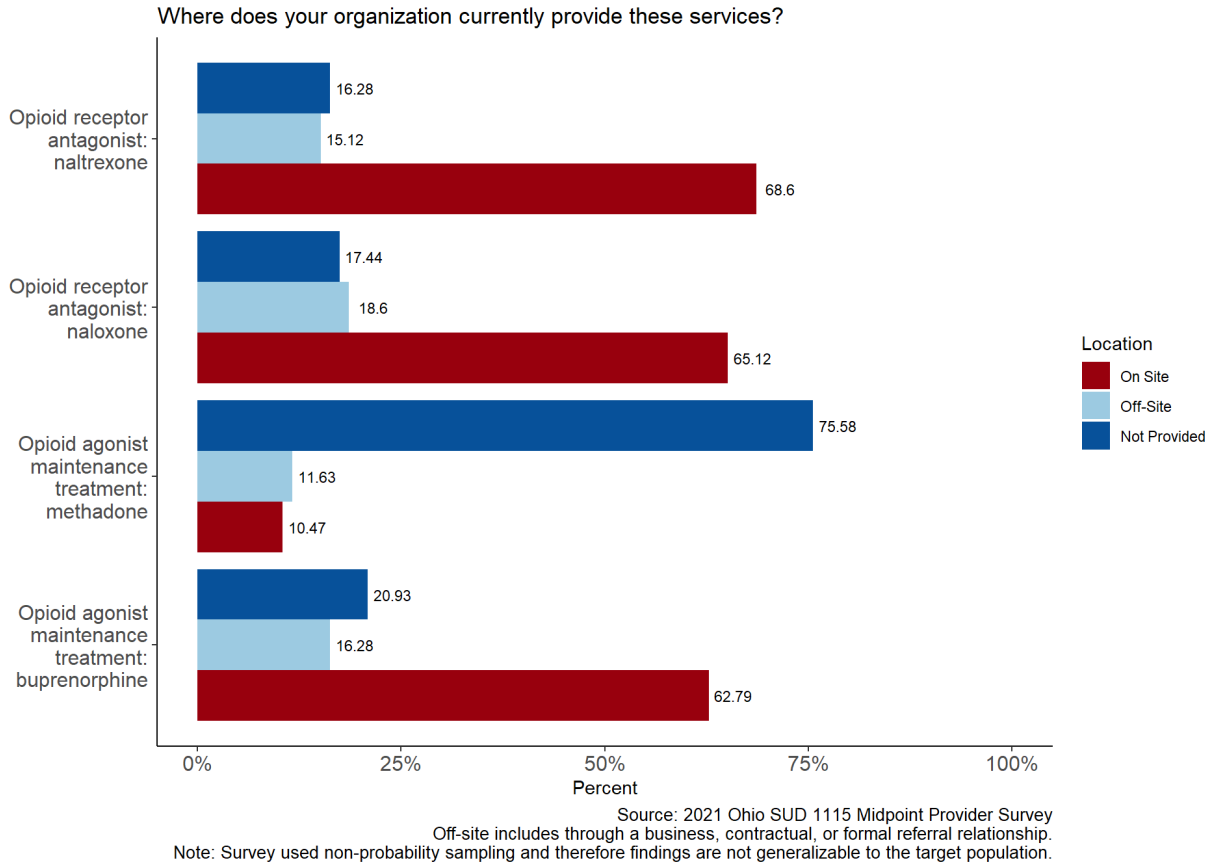


Figure 30: Location of MAT services provided (2)

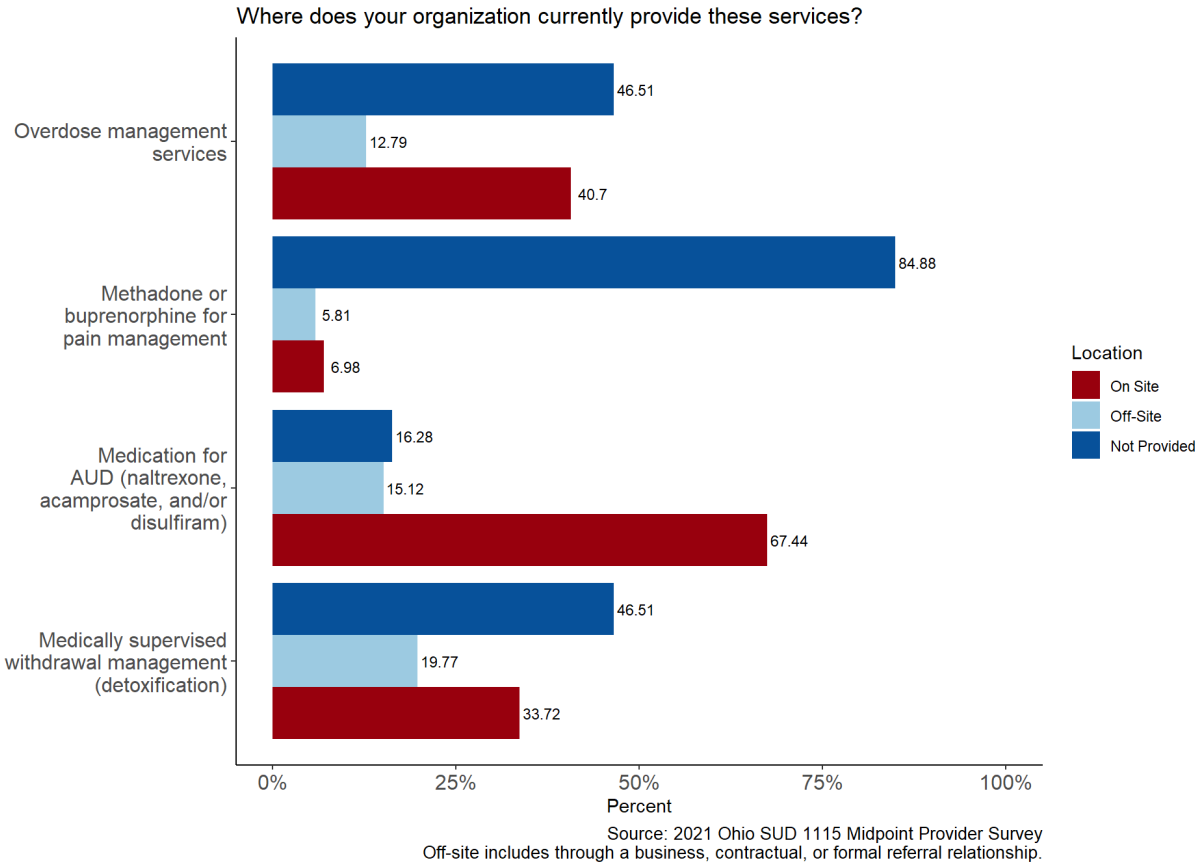
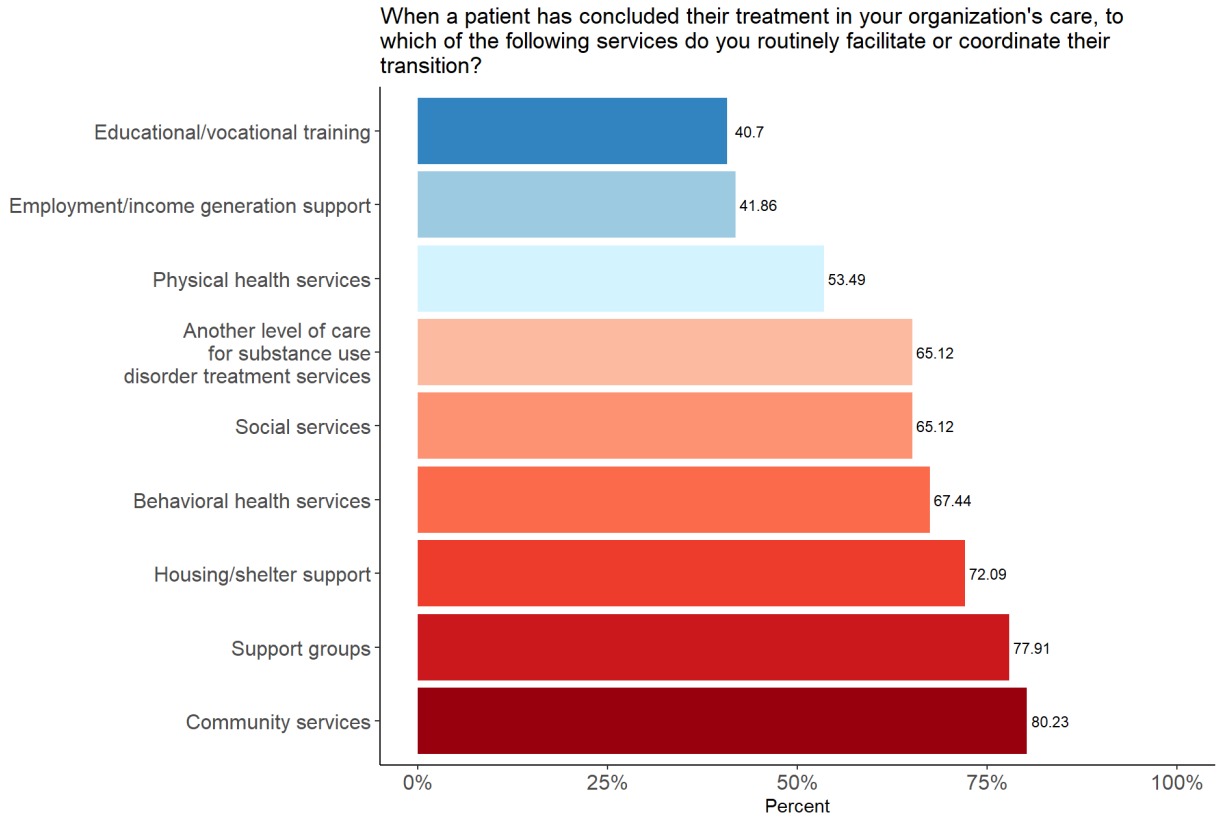
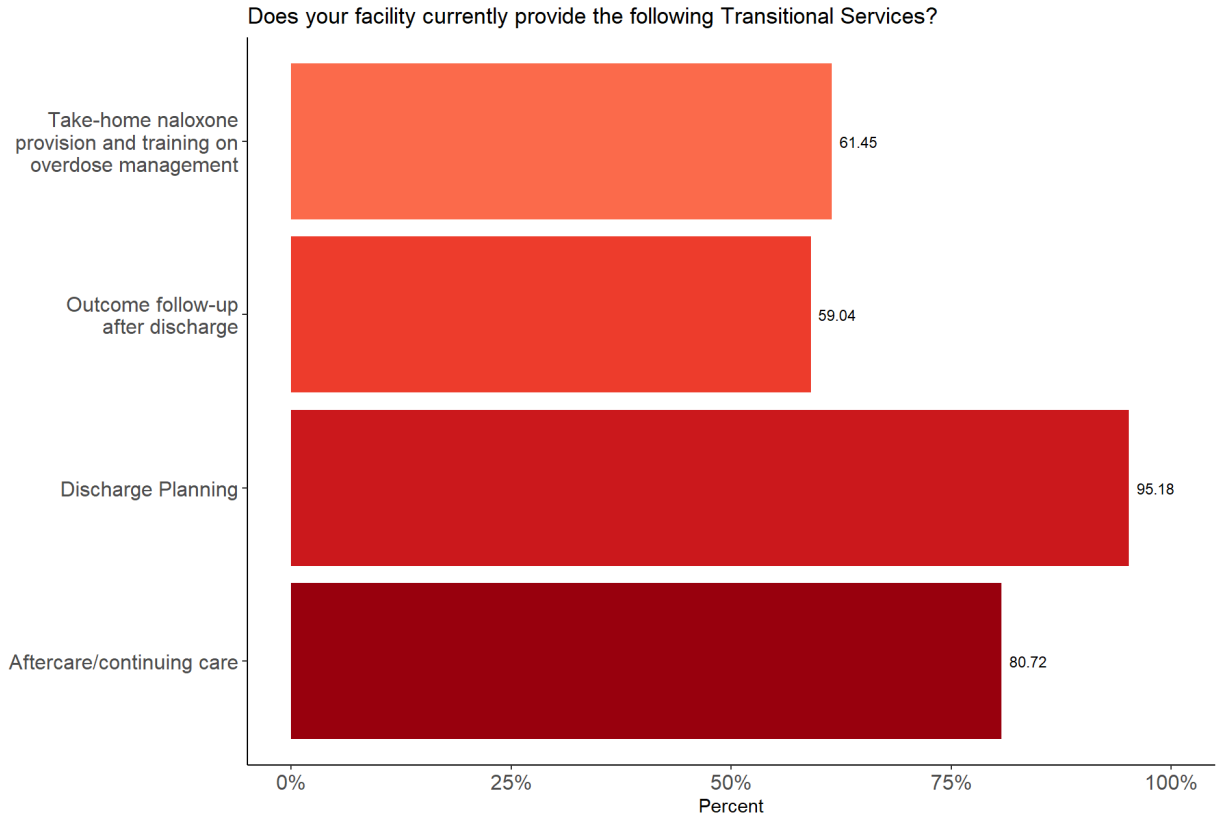


Figure 31: Services coordinated



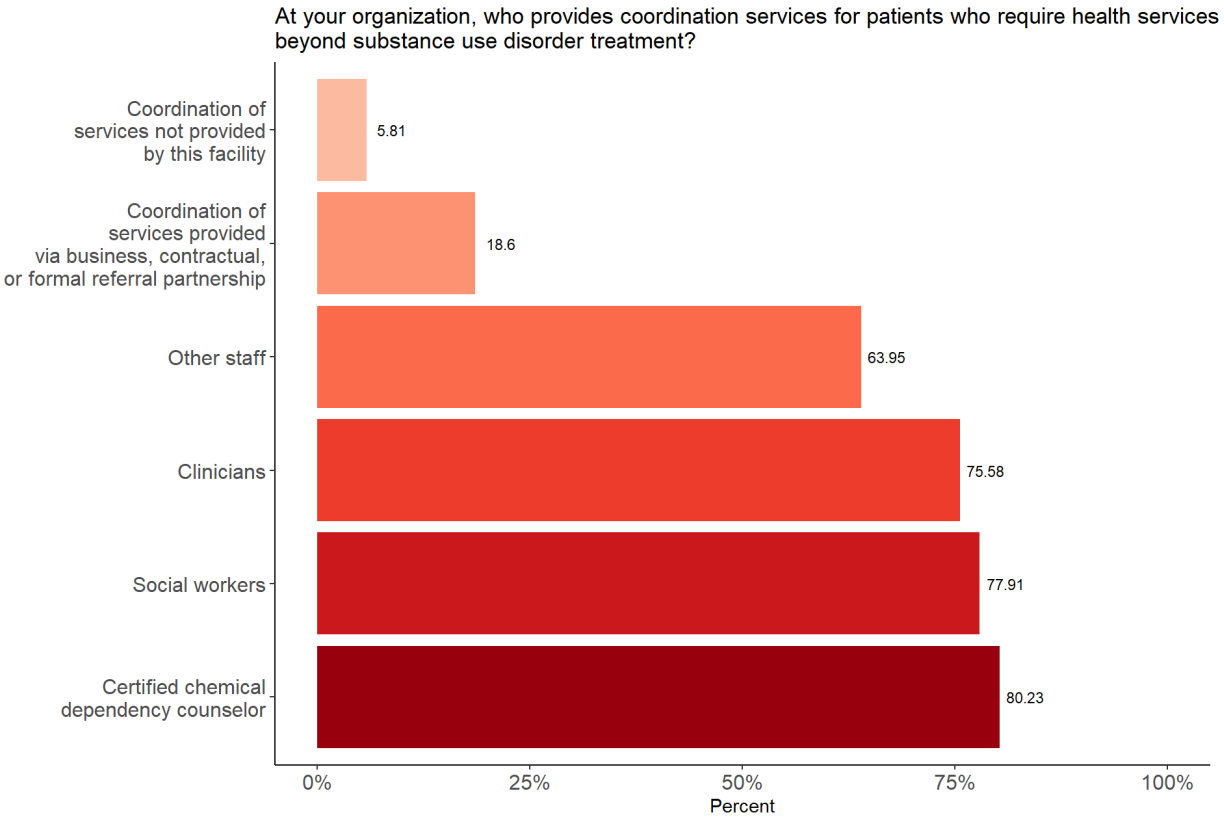
Source: 2021 Ohio SUD 1115 Midpoint Provider Survey
Note: Survey used non-probability sampling and therefore findings are not generalizable to the target population.

Figure 32: Transitional services



Source: 2021 Ohio SUD 1115 Midpoint Provider Survey
Note: Survey used non-probability sampling and therefore findings are not generalizable to the target population.

Figure 33: Care coordination services provided



Source: 2021 Ohio SUD 1115 Midpoint Provider Survey
Note: Survey used non-probability sampling and therefore findings are not generalizable to the target population.

Appendix F: Provider Availability Assessment Data

In this section, billing provider data for all critical levels of care (early intervention, outpatient, IOP/PHP, residential, and inpatient treatment) are reviewed, in addition to provider availability for withdrawal management services, MAT for OUD, and an aggregated all levels of care measure. GRC did not receive billing provider availability data for MAT for SUD. Additionally, while state-level billing provider-to-beneficiary (with an SUD diagnosis) ratio information was shared for each level of care, we were only provided with maps indicating county-level billing provider ratio information for the all levels of care measure (see Figure 41-Figure 43). Therefore, we primarily discuss capacity for each level of care at the state-level. The state did provide county-level maps with change over time in billing provider counts at each level of care, which we discuss to provide context about geographic variation across the state in billing provider availability.

For evaluating change over time in state-level provider to SUD beneficiary ratios, we use hypothesis testing at $\alpha=0.05$ to determine statistically significant changes between 2018 and 2021. Statistically significant changes are indicated in tables with *** and insignificant changes are indicated with †.

ASAM Level 0.5: Early Intervention

To determine provider capacity at ASAM Level 0.5, the state defined early intervention providers as those who provide screening and SBIRT services (some of which overlap with outpatient value sets), including G0396, H0049, H0050, 99408, and 99409.

Table 25 shows that the rate of Medicaid SUD Early Intervention billing providers per 1,000 Medicaid members with a primary or secondary SUD diagnosis has increased since 2018, but there is no statistically significant difference at the 0.05 level between the 2021 and 2018 rates. There was an expansion of Medicaid billing providers at this level of care between 2018 and 2019 which increased the billing provider-patient rate for two years but following a sizable increase in the number of

Medicaid members with an SUD primary or secondary diagnosis in 2021, this rate has declined. The 2021 rate of billing providers to patients equates to 1 Medicaid Early Intervention billing provider for every 3,185 Medicaid members with a SUD diagnosis.

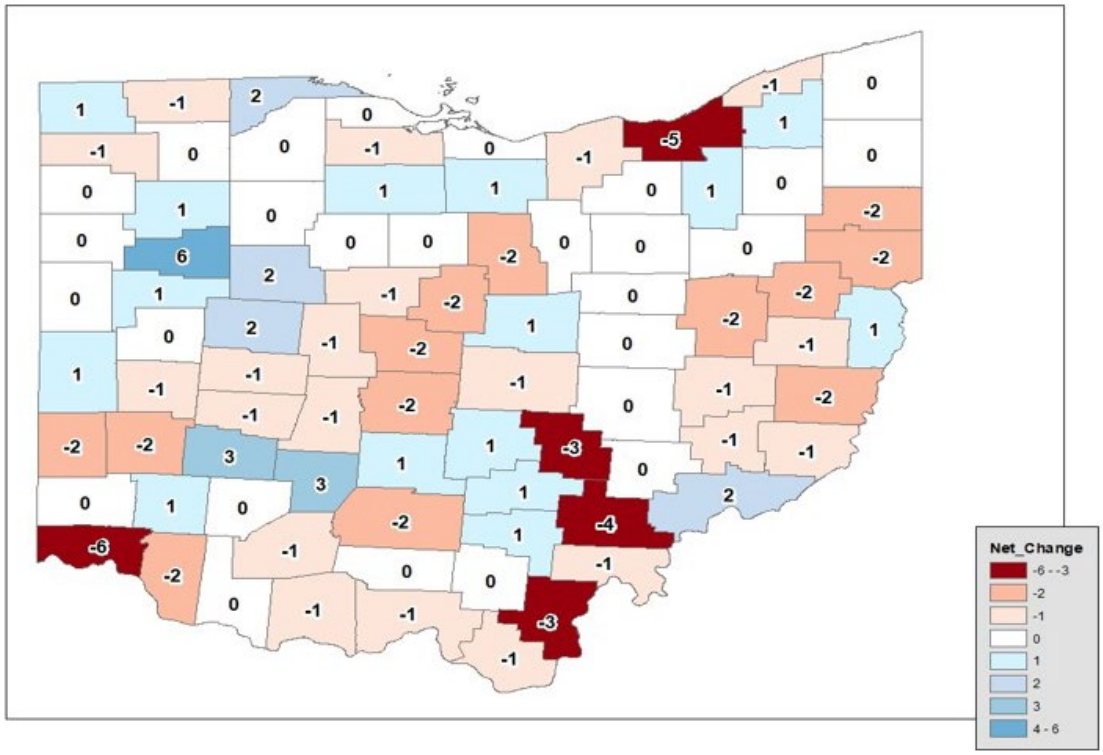
Figure 34 shows that between 2018 and 2021 there were generally small net changes in the number of Early Intervention billing providers in each county. Allen County expanded its Early Intervention billing provider capacity by 6 providers, while Hamilton County contracted by 6 billing providers and Cuyahoga County contracted by 5 billing providers during this time period.

Table 25: Statewide Counts for Medicaid SUD Early Intervention Billing Providers (2018-2021)

Year	Medicaid billing provider count	Medicaid members with SUD primary or secondary diagnosis	Medicaid billing providers per 1,000 patients with SUD diagnosis
2018	117	410,519	0.285
2019	136	404,235	0.336
2020	136	410,051	0.332
2021	137	436,346	0.314†

*Notes: *** = significant difference from 2018 at α=0.05, † = not significant difference from 2018 at α=0.05*
Source: Ohio Department of Medicaid's Electronic Data Warehouse HHSPP, August 2022; Received from Ohio Department of Medicaid September 2022

Figure 34: Change in Medicaid SUD Early Intervention Billing Provider Counts (2018 to 2021)



Source: Ohio Department of Medicaid's Electronic Data Warehouse HHSPP, August 2022; Received from Ohio Department of Medicaid September 2022

ASAM Level 1: Outpatient

To determine provider capacity at ASAM Level 1, the state defined outpatient providers as those who provided outpatient services that are not Residential Treatment or IOP/PH, including services billed by provider type 95.

Table 26 shows that the rate of Medicaid SUD Outpatient billing providers per 1,000 Medicaid members with a primary or secondary SUD diagnosis has continued to decrease since 2018, with a statistically significant drop in rates between 2018 and 2021. The largest shift occurred between 2019 and 2020 when there was a 6.6% decrease in the number of Medicaid billing providers at this level of care. The 2021

rate of billing providers to patients equates to 1 Medicaid Outpatient billing provider for every 90 Medicaid members with a SUD diagnosis.

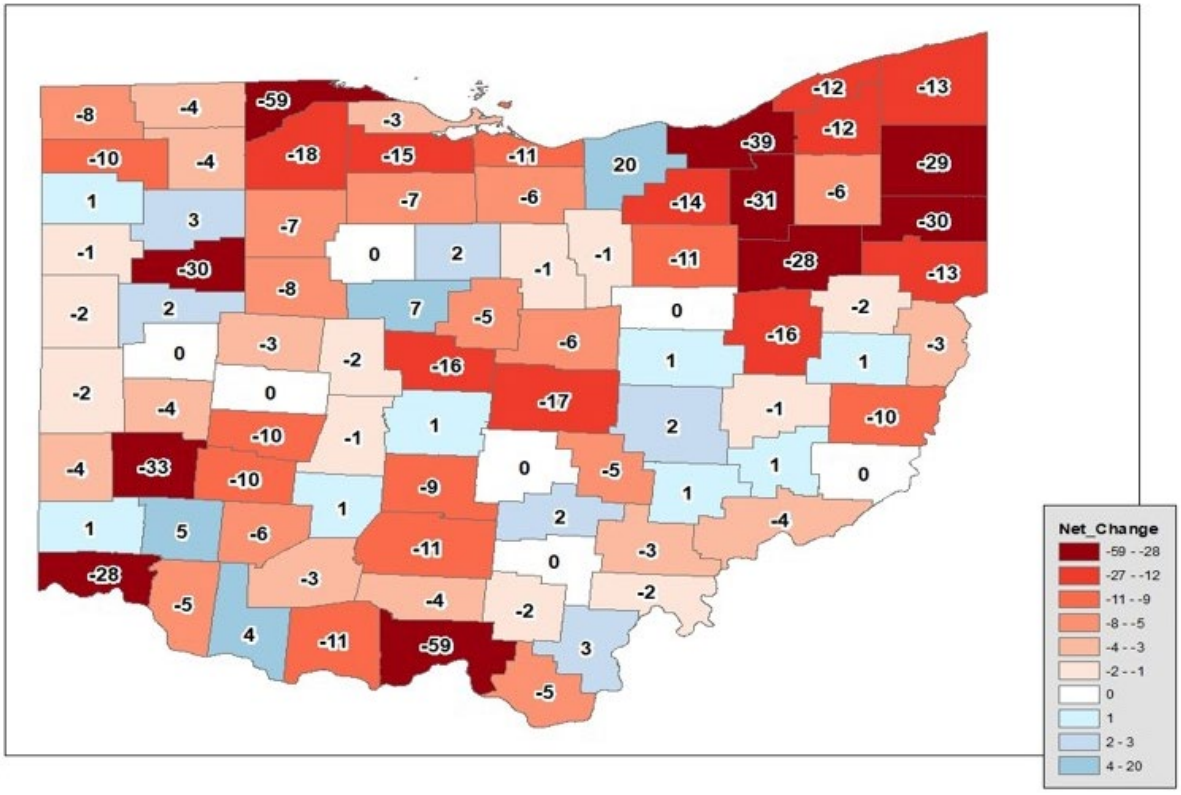
Figure 35 shows geographic clustering of the reduction of the number of Outpatient billing providers between 2018 and 2021 in Northeast Ohio counties. There was not a substantial contraction in the number of Outpatient billing providers in the counties along Ohio's southeastern border. Some of the largest absolute declines in the number of Medicaid Outpatient billing providers occurred in Lucas County (-59), Scioto County (-59), and Cuyahoga County (-39). While expansion of Outpatient providers was generally pretty modest (e.g. less than 7 new billing providers in a county) during this time period, Lorain county stands out as having a net 20 new billing providers serving patients in 2021.

Table 26: Statewide Counts for Medicaid SUD Outpatient Billing Providers (2018-2021)

Year	Medicaid billing provider count	Medicaid members with SUD primary or secondary diagnosis	Medicaid billing providers per 1,000 patients with SUD diagnosis
2018	5435	410,519	13.2
2019	5240	404,235	13.0
2020	4893	410,051	11.9
2021	4853	436,346	11.1***

*Notes: *** = significant difference from 2018 at α=0.05, † = not significant difference from 2018 at α=0.05*
Source: Ohio Department of Medicaid's Electronic Data Warehouse HHSPP, August 2022; Received from Ohio Department of Medicaid September 2022

Figure 35: Change in Medicaid SUD Outpatient Billing Provider Counts (2018 to 2021)



Source: Ohio Department of Medicaid's Electronic Data Warehouse HHSPP, August 2022; Received from Ohio Department of Medicaid September 2022

ASAM Level 2.1 & 2.5: Intensive Outpatient (IOP) and Partial Hospitalization (PHP)

To determine provider capacity at ASAM Levels 2.1 & 2.5, the state defined IOP and PH providers as those providing intensive outpatient and partial hospitalization services billed with HCPCs H0015.

Table 27 shows that the rate of Medicaid SUD IOP & PHP billing providers per 1,000 Medicaid members with a primary or secondary SUD diagnosis has decreased slightly since 2018, but that there is no statistically significant difference at the 0.05 level between the 2018 and 2021 rates. Between 2018 and 2019 there were nearly 40 new IOP/PHP Medicaid billing providers, but the count of billing providers dropped by 16.9% in 2020 down to 412 in total. This billing provider count has seemingly begun to recover in 2021 but is not yet at 2018 levels. The 2021 rate of billing providers to patients equates to 1 Medicaid IOP/PHP billing provider for every 1,000 Medicaid members with a SUD diagnosis.

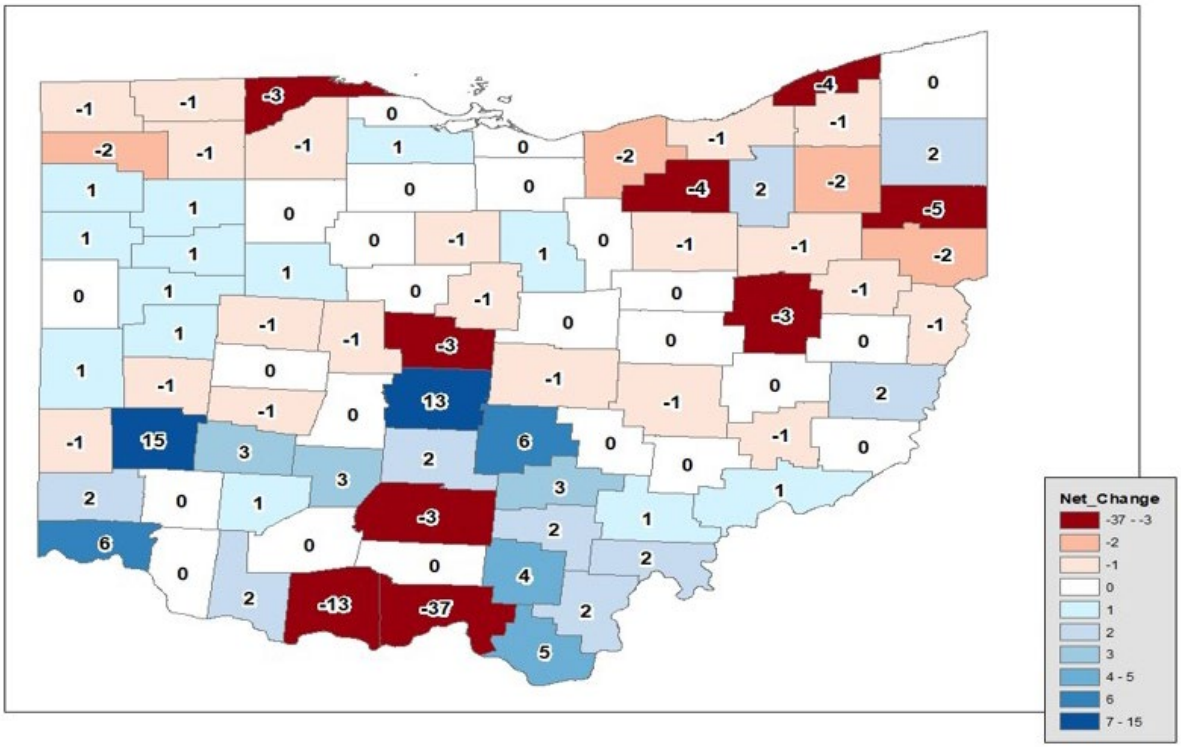
Figure 36 shows a small expansion in the number of IOP/PHP billing providers in southern and eastern Ohio between 2018 and 2021, with the exception of a few counties in southern Ohio where there were substantial decreases, including a net loss of 37 billing providers in Scioto county and a net loss of 13 billing providers in Adams county. There was a net increase of 15 billing providers in Montgomery county, 13 in Franklin county, 6 in Fairfield county and 6 in Hamilton county during this time period. There was a modest contraction of IOP/PHP billing providers in four northeast Ohio counties.

Table 27: Statewide Counts for Medicaid SUD IOP & PHP Billing Providers (2018-2021)

Year	Medicaid billing provider count	Medicaid members with SUD primary or secondary diagnosis	Medicaid billing providers per 1,000 patients with SUD diagnosis
2018	457	410,519	1.1
2019	496	404,235	1.2
2020	412	410,051	1.0
2021	440	436,346	1.0†

*Notes: *** = significant difference from 2018 at α=0.05, † = not significant difference from 2018 at α=0.05*
Source: Ohio Department of Medicaid's Electronic Data Warehouse HHSPP, August 2022; Received from Ohio Department of Medicaid September 2022

Figure 36: Change in Medicaid SUD IOP/PHP Billing Provider Counts (2018 to 2021)



Source: Ohio Department of Medicaid's Electronic Data Warehouse HHSPP, August 2022; Received from Ohio Department of Medicaid September 2022

Withdrawal Management

To determine provider capacity for Withdrawal Management, the state included withdrawal management and detoxification services (acute and sub-acute). Detoxification spans were collapsed for gaps of less than 1 day for inpatient claims and fewer than 3 days for professional and outpatient claims.

Table 28 shows that the rate of Medicaid SUD Withdrawal Management billing providers per 1,000 Medicaid members with a primary or secondary SUD diagnosis has slightly decreased since 2018, but there is no statistically significant difference in rates between 2018 and 2021. There has been some variation in the rate of billing providers from year to year: Between 2018 and 2019 the rate decreased, reflecting a drop in the number of billing providers, but recovered in 2020 with the

addition of 8 net new withdrawal management billing providers. There has been no change between 2020 and 2021 in the number of billing providers, but there has been an increase in the number of Medicaid members with an SUD primary or secondary diagnosis, which has resulted in a decrease in the provider rate between 2020 and 2021. The 2021 rate of billing providers to patients equates to 1 Medicaid Withdrawal Management billing provider for every 7,143 Medicaid members with a SUD diagnosis.

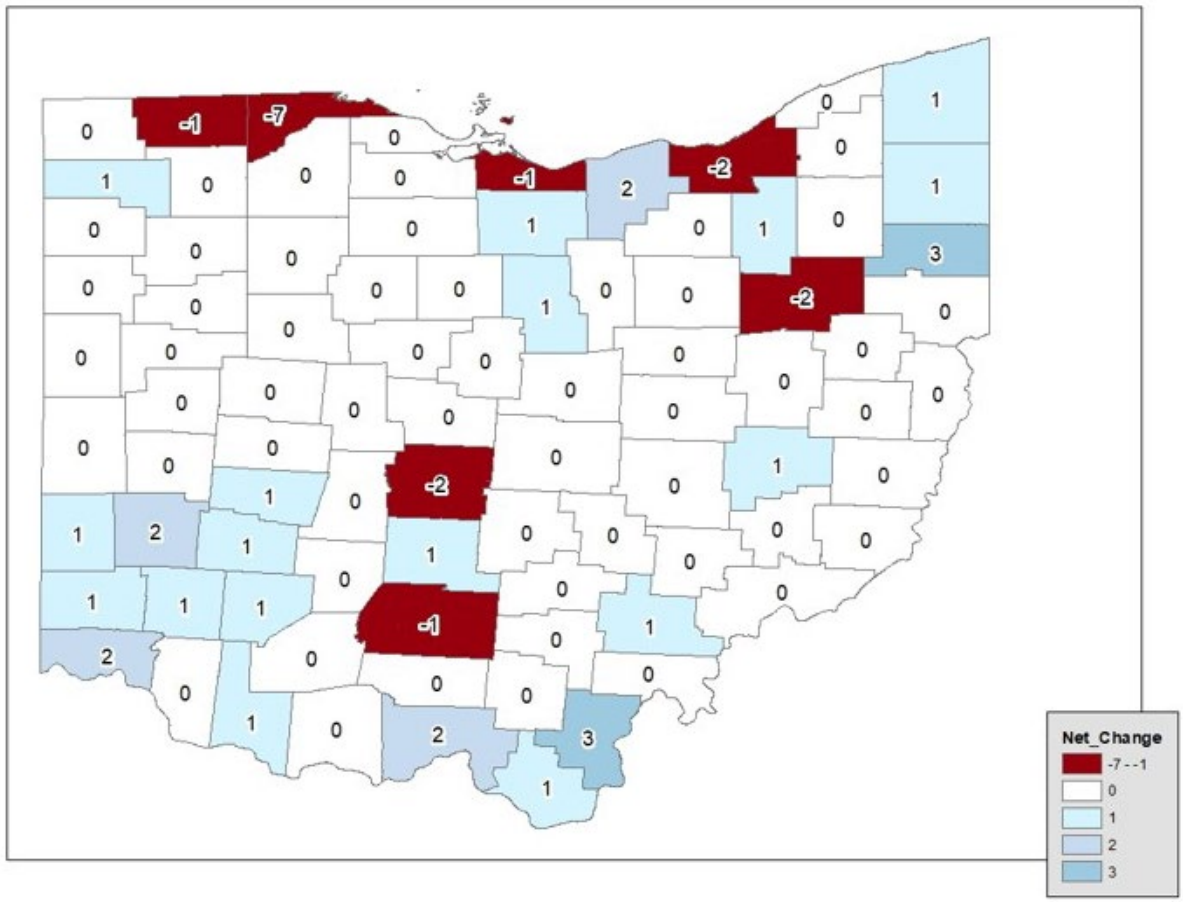
Figure 37 shows that there was no net change in Withdrawal Management billing providers for at least half of Ohio's counties between 2018 and 2021, and small increases in the number of billing providers in the counties along Ohio's southern and southwestern border. There were 7 counties that exhibited contractions in their net count of Withdrawal Management providers, with the largest decrease in Lucas County (-7).

Table 28: Statewide Counts for Medicaid SUD Withdrawal Management Billing Providers (2018-2021)

Year	Medicaid billing provider count	Medicaid members with SUD primary or secondary diagnosis	Medicaid billing providers per 1,000 patients with SUD diagnosis
2018	59	410,519	0.144
2019	53	404,235	0.131
2020	61	410,051	0.149
2021	61	436,346	0.140†

*Notes: *** = significant difference from 2018 at α=0.05, † = not significant difference from 2018 at α=0.05*
Source: Ohio Department of Medicaid's Electronic Data Warehouse HHSPP, August 2022; Received from Ohio Department of Medicaid September 2022

Figure 37: Change in Medicaid SUD Withdrawal Management Billing Provider Counts (2018 to 2021)



Source: Ohio Department of Medicaid's Electronic Data Warehouse HHSPP, August 2022; Received from Ohio Department of Medicaid September 2022

ASAM Level 3: Residential Treatment

To determine provider capacity for Residential Treatment, the state included residential and inpatient SUD services (Ohio ASAM 3.1, 3.3, 3.5, 37). Residential treatment spans were collapsed for gaps of 2 days or fewer, and inpatient stays for gaps of no more than 1 day.

Table 29 shows that the rate of Medicaid SUD Residential Treatment billing providers per 1,000 Medicaid members with a primary or secondary SUD diagnosis

has slightly increased since 2018, but there is no statistically significant difference at the 0.05 level between the 2018 and 2021 rates. There were 13 net new billing providers added between 2018 and 2020 which increased the rate, but an increase in the number of Medicaid members with a SUD diagnosis in 2021 decreased the billing provider rate to a level comparable with 2018. The 2021 rate of billing providers to patients equates to 1 Medicaid Residential Treatment billing provider for every 3,610 Medicaid members with a SUD diagnosis.

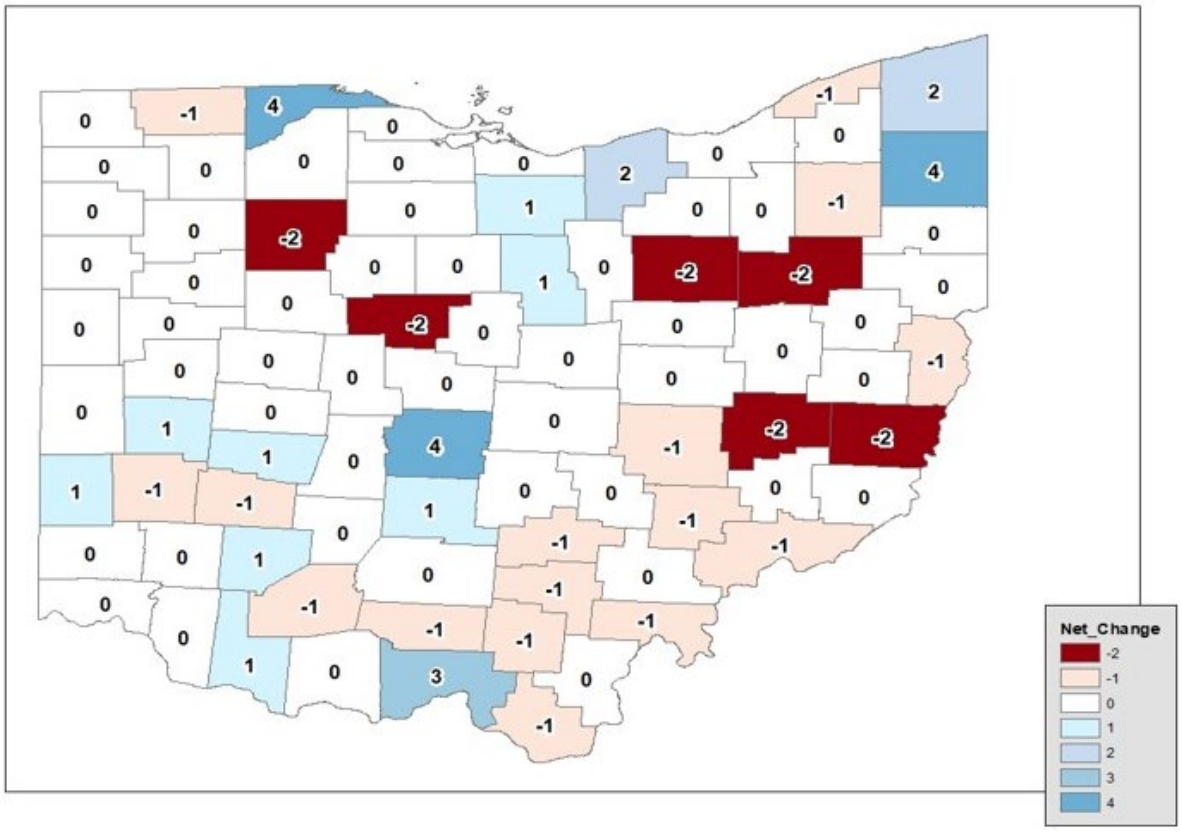
Figure 38 shows that most counties in the state had little to no change in their net Residential Treatment billing providers between 2018 and 2021. There were 6 counties that had a net loss of 2 billing providers each, but 3 counties added 4 net billing providers each (Lucas, Trumbull, and Franklin counties), Scioto County added 3 net billing providers, and Ashtabula and Lorain counties each added 2 net billing providers. There are few clear geographic patterns to the change in residential treatment billing providers in this time period.

Table 29: Statewide Counts for Medicaid SUD Residential Treatment Billing Providers (2018-2021)

Year	Medicaid billing provider count	Medicaid members with SUD primary or secondary diagnosis	Medicaid billing providers per 1,000 patients with SUD diagnosis
2018	112	410,519	0.273
2019	122	404,235	0.302
2020	125	410,051	0.305
2021	121	436,346	0.277†

*Notes: *** = significant difference from 2018 at α=0.05, † = not significant difference from 2018 at α=0.05*
Source: Ohio Department of Medicaid's Electronic Data Warehouse HHSPP, August 2022; Received from Ohio Department of Medicaid September 2022

Figure 38: Change in Medicaid SUD Residential Treatment Billing Provider Counts (2018 to 2021)



Source: Ohio Department of Medicaid's Electronic Data Warehouse HHSPP, August 2022; Received from Ohio Department of Medicaid September 2022

ASAM Level 3: Inpatient Treatment

To determine provider capacity for Inpatient Treatment, the state included inpatient claims with a primary SUD diagnosis (Ohio ASAM 4).

Table 30 shows that the rate of Medicaid SUD Inpatient Treatment billing providers per 1,000 Medicaid members with a primary or secondary SUD diagnosis has decreased since 2018, but there is no statistically significant difference between the 2018 and 2021 rates. Between 2018 and 2020 this billing provider rate was trending downward due to a decrease in the number of Medicaid providers and little change in the number of members with a SUD diagnosis. Between 2020 and 2021 there

was some recovery in the billing provider rate with the net addition of 25 Inpatient providers. The 2021 rate of billing providers to patients equates to 1 Medicaid Inpatient billing provider for every 1,647 Medicaid members with a SUD diagnosis.

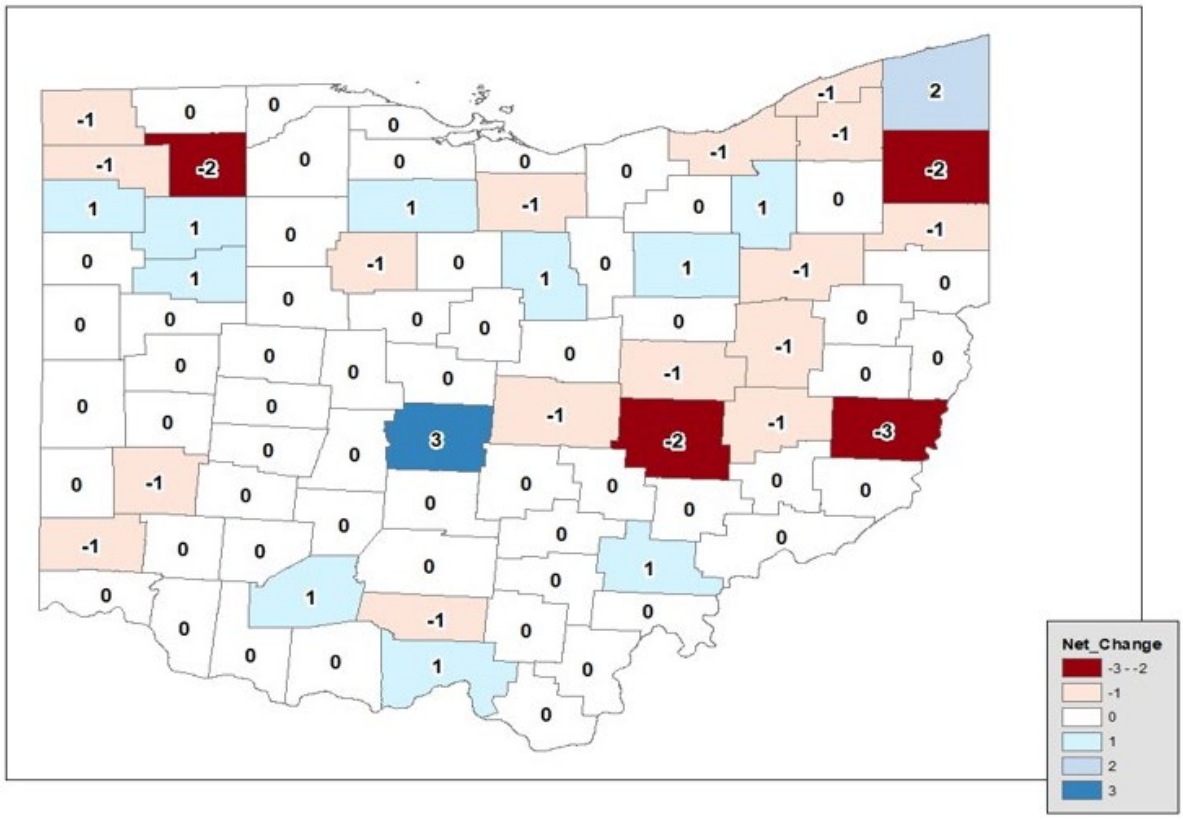
Figure 39 shows that for about half of Ohio's counties there was no net change in inpatient billing provider counts between 2018 and 2021. Franklin county stands out as adding 3 net providers, while Henry County, Trumbull County, and Muskingum County each lost 2 billing providers, and Belmont County lost 3 billing providers. Similarly to the change over time in residential treatment billing provider capacity, there are few geographic patterns in net changes other than more overall change in Ohio's northeast counties relative to other regions.

Table 30: Statewide Counts for Medicaid SUD Inpatient Billing Providers (2018-2021)

Year	Medicaid billing provider count	Medicaid members with SUD primary or secondary diagnosis	Medicaid billing providers per 1,000 patients with SUD diagnosis
2018	258	410,519	0.628
2019	241	404,235	0.596
2020	240	410,051	0.585
2021	265	436,346	0.607†

*Notes: *** = significant difference from 2018 at α=0.05, † = not significant difference from 2018 at α=0.05*
Source: Ohio Department of Medicaid's Electronic Data Warehouse HHSPP, August 2022; Received from Ohio Department of Medicaid September 2022

Figure 39: Change in Medicaid SUD Inpatient Billing Provider Counts (2018 to 2021)



Source: Ohio Department of Medicaid's Electronic Data Warehouse HHSPP, August 2022; Received from Ohio Department of Medicaid September 2022

Medication-Assisted Treatment for OUD (Billing Providers)

Table 31 shows that the rate of Medicaid MAT OUD billing providers per 1,000 Medicaid members with a primary or secondary SUD diagnosis has increased since 2018, but there is no significant difference at the 0.05 level between the 2018 and 2021 rates. There has been a consistent increase in the number of MAT OUD billing providers since 2018, with a net increase of 215 billing providers during this period. The 2021 rate of billing providers to patients equates to 1 Medicaid MAT OUD billing provider for every 64 Medicaid members with an OUD diagnosis.

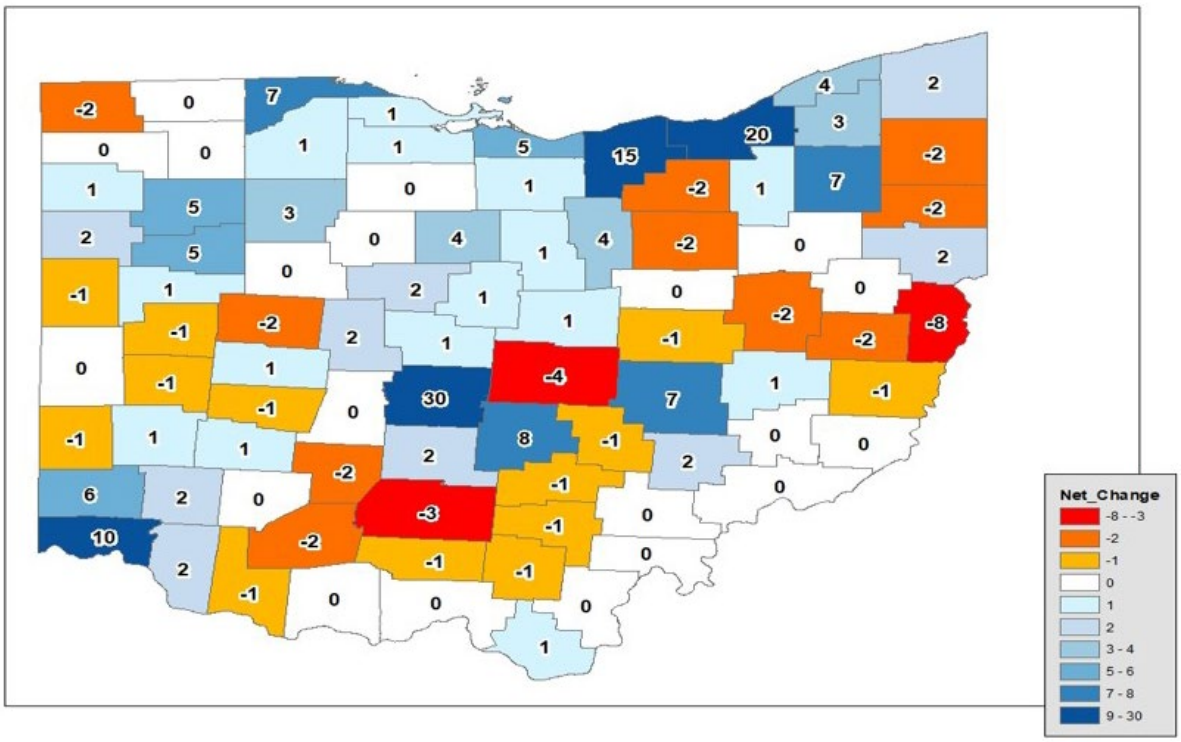
Table 31: Statewide Counts for Medicaid MAT OUD Billing Providers (2018-2021)

Year	Medicaid billing provider count	Medicaid members with OUD primary or secondary diagnosis	Medicaid billing providers per 1,000 patients with OUD diagnosis
2018	2441	164,141	14.9
2019	2553	162,099	15.7
2020	2574	162,679	15.8
2021	2656	169,195	15.7†

*Notes: *** = significant difference from 2018 at α=0.05, † = not significant difference from 2018 at α=0.05*
Source: Ohio Department of Medicaid's Electronic Data Warehouse HHSPP, August 2022; Received from Ohio Department of Medicaid September 2022

Figure 40 shows that Franklin, Cuyahoga, Lorain, and Hamilton counties experienced the largest net increases in MAT OUT billing providers between 2018 and 2021. Throughout the rest of the state there were relatively small net changes in provider counts, although Jefferson County stands out as having a net decrease of 8 billing providers during this period. North and northwest Ohio generally saw a modest expansion in the number of MAT OUD billing providers.

Figure 40: Change in Medicaid MAT OUD Billing Provider Counts (2018 to 2021)



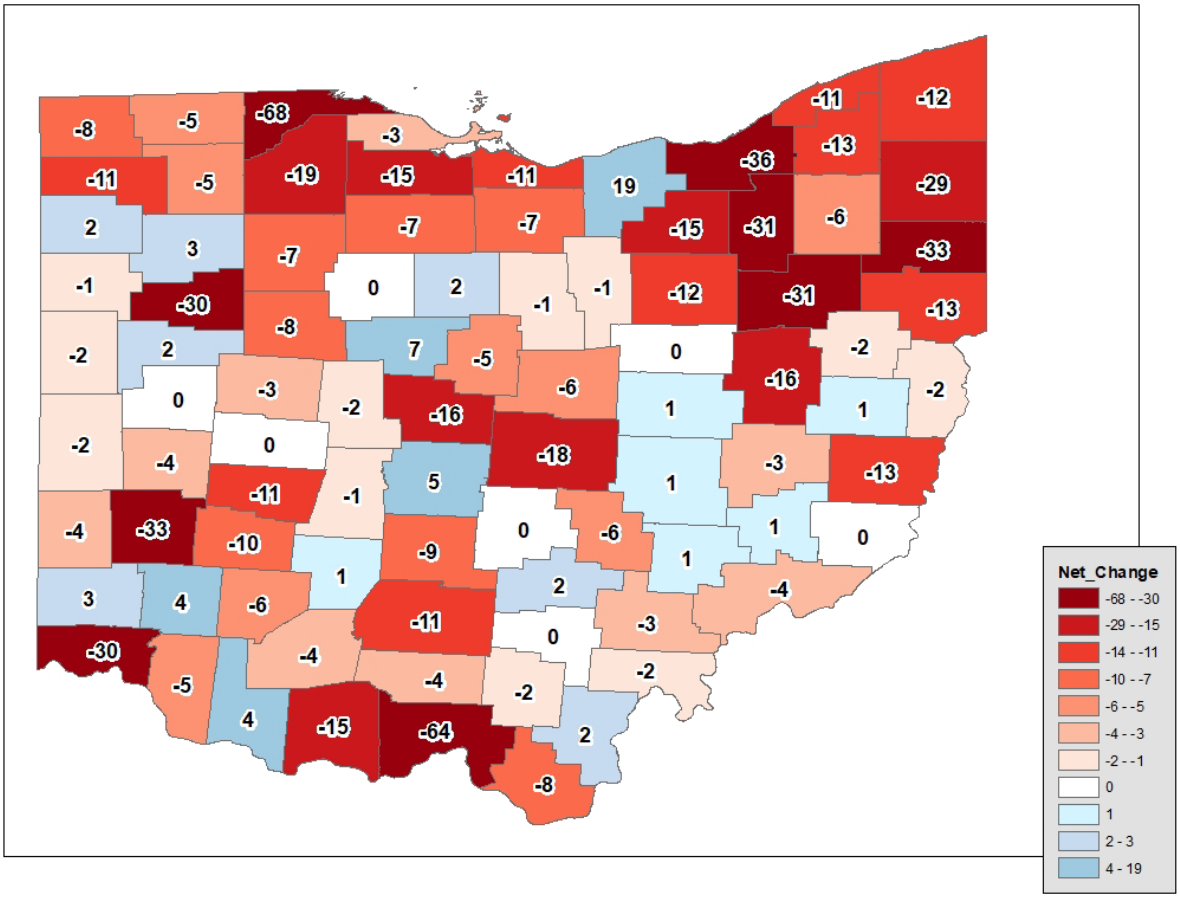
Source: Ohio Department of Medicaid's Electronic Data Warehouse HHSPP, August 2022; Received from Ohio Department of Medicaid September 2022

SUD Providers for All Levels of Care

Figure 41 shows that there was a substantial decline in total SUD billing providers for all levels of care in Ohio between 2018 and 2021. We do not have yearly billing provider counts to be able to assess whether this decline in the number of billing providers has resulted in a statistically significant decrease in billing provider-to-beneficiary rates for all levels of care. Northeast Ohio was particularly affected by this decline, with nearly all counties in the region experiencing a net loss of billing providers at all levels of care. Many counties in southwest Ohio as well as northwest Ohio also experienced net losses. Counties with some of the largest net losses include Lucas County (-68), Scioto County (-64), Cuyahoga County (-36), Montgomery County (-33), and Mahoning County (-33). One county – Lorain County – stands out as having a net increase of 19 SUD all levels of care billing providers

between 2018 and 2021. Counties along the western border, in central Ohio, and along the southeastern border of the state generally had the smallest net changes in billing provider counts during this period.

Figure 41: Change in Medicaid SUD All Levels of Care Billing Provider Counts (2018 to 2021)

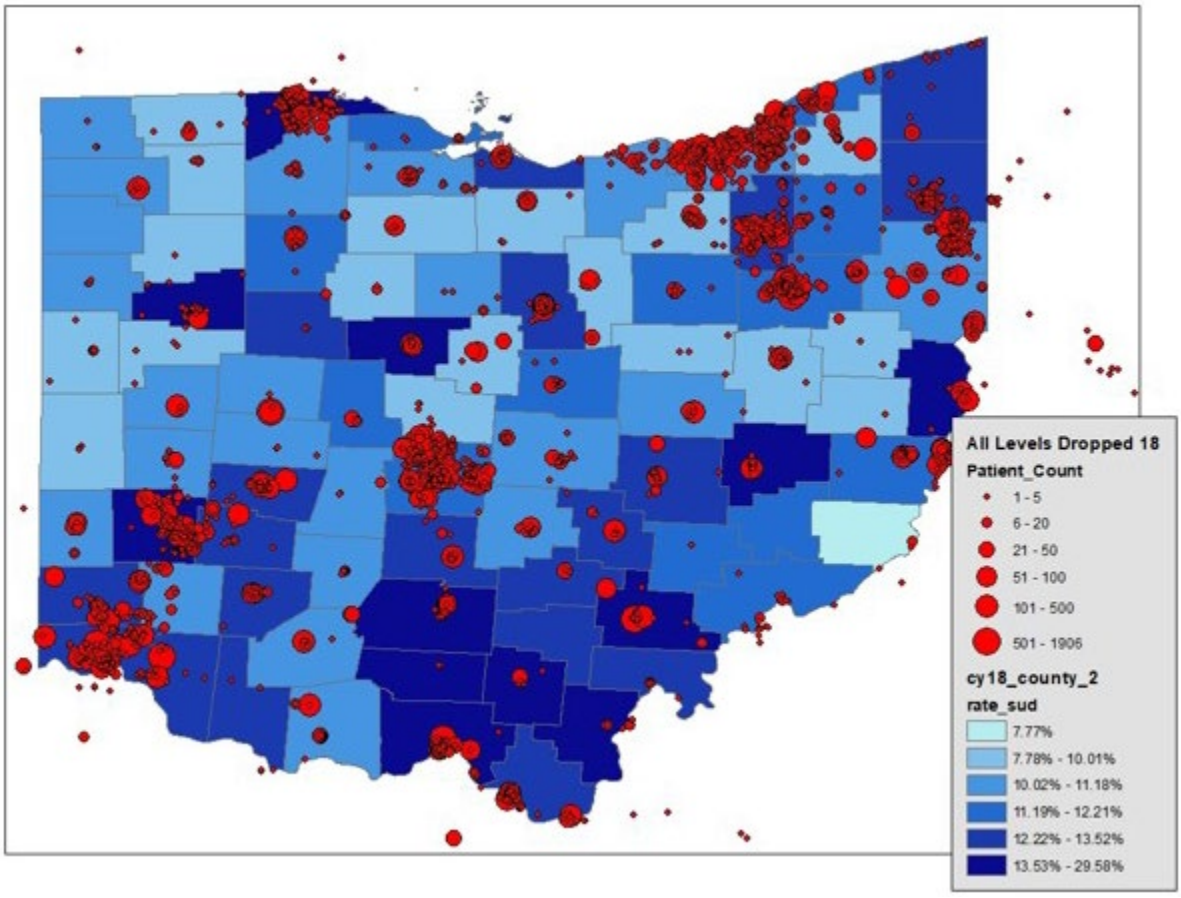


Source: Ohio Department of Medicaid's Electronic Data Warehouse HHSPP, August 2022; Received from Ohio Department of Medicaid September 2022

Figure 42 and Figure 43 show change over time (2018 to 2021) in counts of providers billing for SUD all levels of care, overlayed on county-level percent of Medicaid members with an SUD primary or secondary diagnosis (presumably in 2021). Each circle represents a billing provider, and the size of the circle indicates

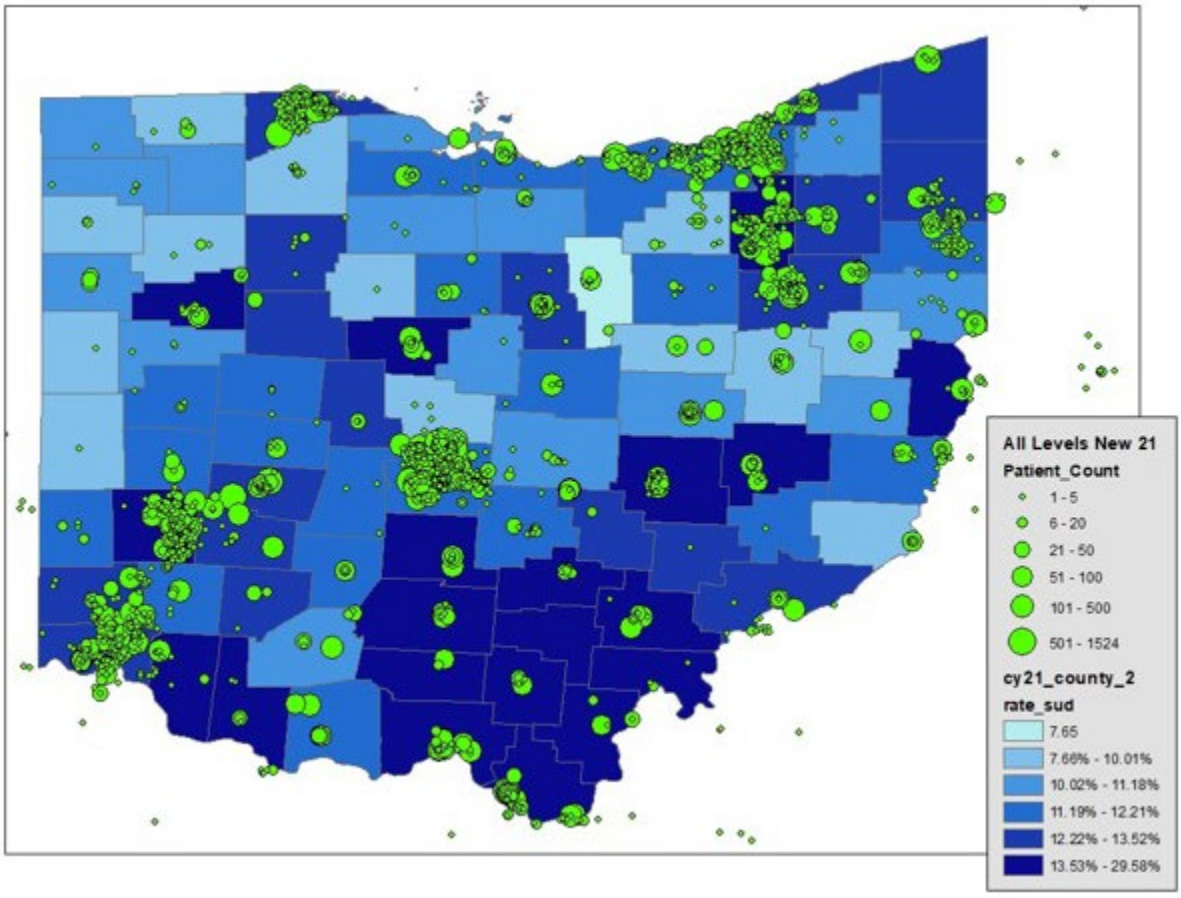
the count of patients each billing provider served. Figure 42 shows providers who were dropped between 2018 and 2021 and Figure 43 shows new providers who were added between 2018 and 2021. A precise replacement rate is difficult to assess from these maps due to overlapping provider circles. Generally, it appears that a lot of the change in billing providers occurred in the three largest population centers of the state (Cuyahoga County, Franklin County, and Hamilton County), in addition to change in other counties in northeast Ohio and in Lucas County. There seems to have been replacement of providers who were no longer billing in a certain area in 2021 with new providers in that same area. Its noteworthy that a lot of the change in all levels of care billing provider counts between 2018 and 2021 was not occurring in counties with the highest rates of SUD diagnoses, with the exception of Lucas county, Montgomery county, and somewhat in Scioto county.

Figure 42: SUD All Levels of Care Providers Billing in 2018 and Not Billing in 2021, Overlayed on County-Level Percent of Medicaid Members with SUD Primary/Secondary Diagnosis



Source: Ohio Department of Medicaid's Electronic Data Warehouse HHSPP, August 2022; Received from Ohio Department of Medicaid September 2022

Figure 43: SUD All Levels of Care Providers Billing in 2021 and Not Billing in 2018, Overlayed on County-Level Percent of Medicaid Members with SUD Primary/Secondary Diagnosis

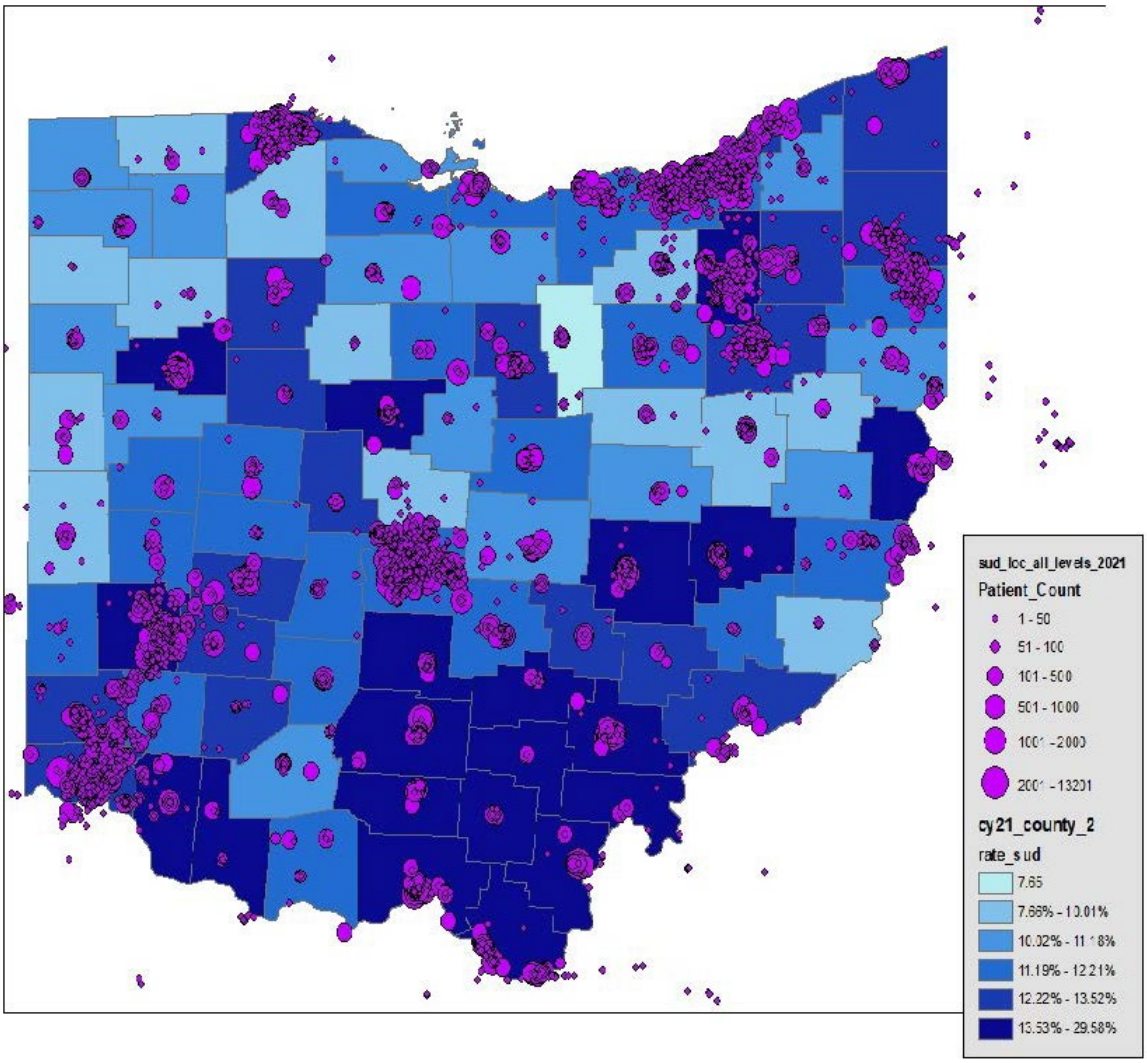


Source: Ohio Department of Medicaid's Electronic Data Warehouse HHSPP, August 2022; Received from Ohio Department of Medicaid September 2022

Figure 44 shows SUD providers for all levels of care in 2021 overlayed on county-level percent of Medicaid members with an SUD primary or secondary diagnosis. Similarly to Figure 42 and Figure 43, each circle represents a billing provider and the size of the circle indicates the count of patients each provider served. This map shows that while certain counties with high percentages of Medicaid members with SUD primary/secondary diagnoses have clusters of SUD billing providers at all levels of care (e.g. Montgomery county and Summit county), there are many more counties in southern Ohio with high SUD rates but limited numbers of billing providers. This map does not account for the billing provider to beneficiary rate, so

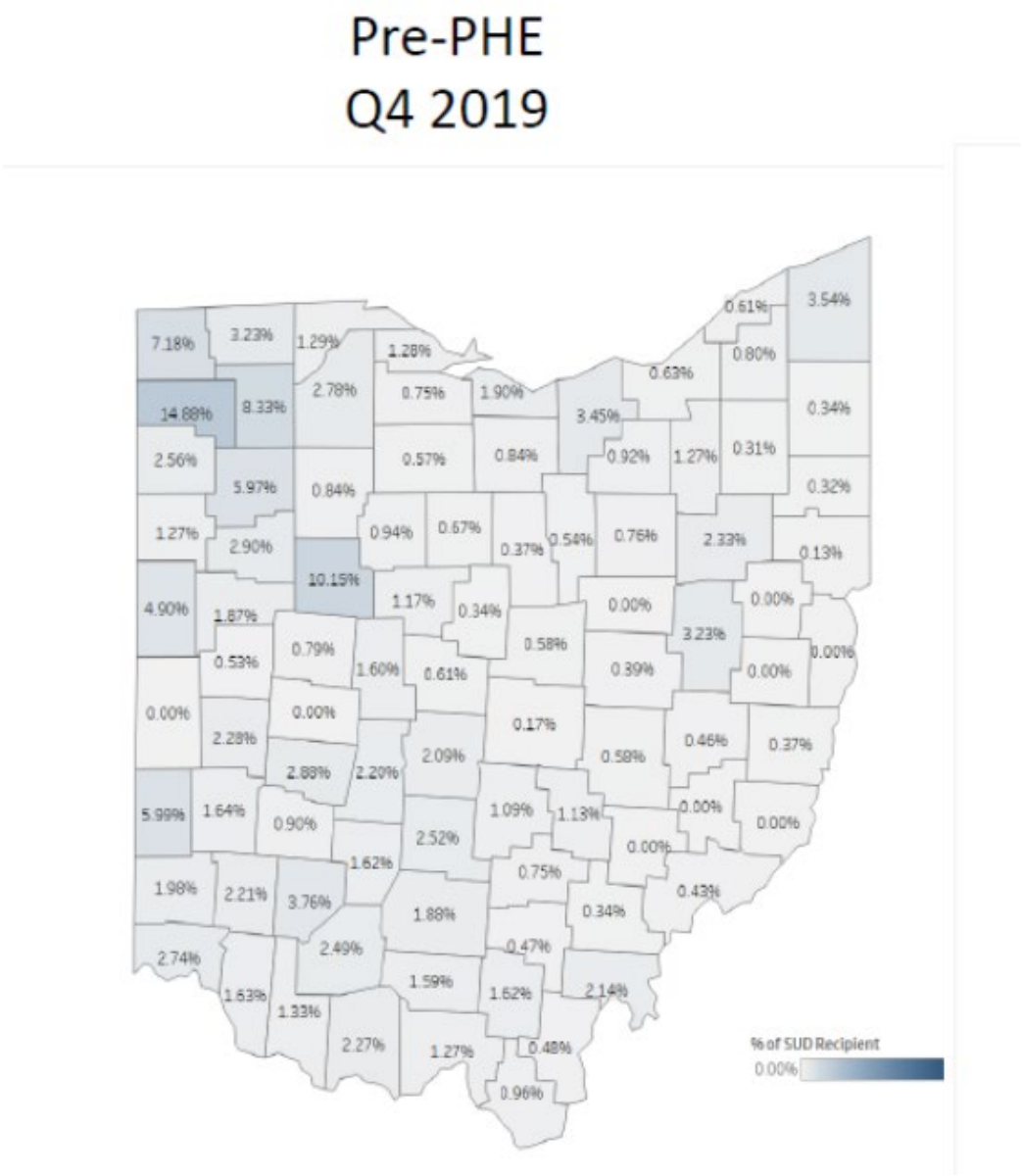
it may be the case that with a smaller population and fewer absolute numbers of Medicaid beneficiaries needing SUD treatment (even if the proportion of the population needing treatment is high), southern Ohio counties do not require as many SUD providers as other, more populous counties such as Franklin or Cuyahoga. With the provided map, it is difficult to assess whether this is the case. From this map we are also unable to determine how the visible clustering of providers within counties impacts access to care in rural states such as those in south and southeast Ohio, where residents' homes are often distributed throughout the state. County-level provider-to -beneficiary-with-an-SUD-diagnosis rates would allow for a more comprehensive assessment of adequate SUD provider capacity throughout Ohio.

Figure 44: SUD Billing Providers for All Levels of Care (2021), Overlayed on County-Level Percent of Medicaid Members with SUD Primary/Secondary Diagnosis



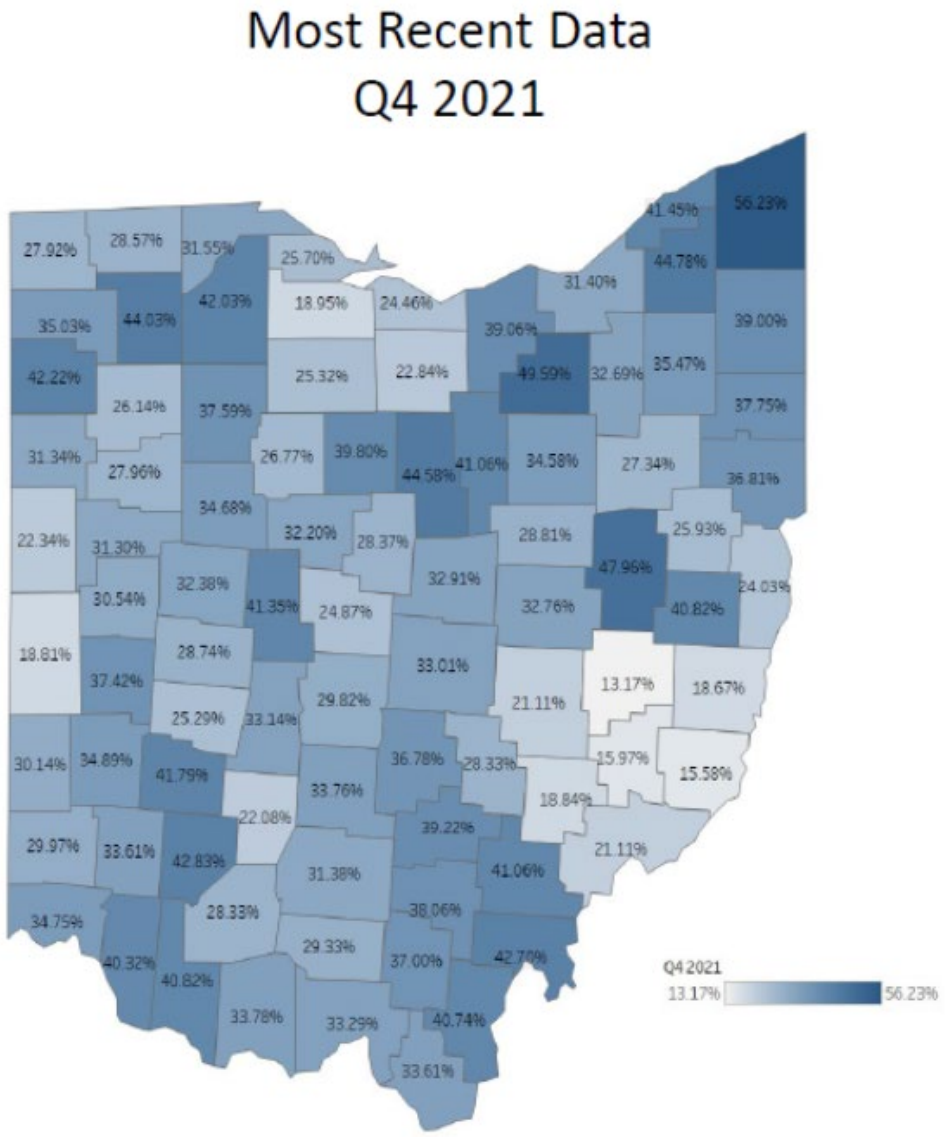
Source: Ohio Department of Medicaid's Electronic Data Warehouse HHSPP, August 2022; Received from Ohio Department of Medicaid September 2022

Figure 45: Percentage of Medicaid patients using telehealth for non-acute/non-emergent SUD services during the PHE, Q4 2019



Source: Ohio Department of Medicaid's Electronic Data Warehouse HHSPP, April 2022; Received from Ohio Department of Medicaid September 2022

Figure 46: Percentage of Medicaid patients using telehealth for non-acute/non-emergent SUD services during the PHE, Q4 2021



Source: Ohio Department of Medicaid's Electronic Data Warehouse HHSPP, April 2022; Received from Ohio Department of Medicaid September 2022