Nebraska Medicaid
Section 1115 Substance Use Disorder (SUD) Demonstration Waiver

Renewal Application Draft

May 1, 2023

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Introduction

The Nebraska Department of Health and Human Services (DHHS), Division of Medicaid and Long-Term Care (MLTC) is requesting a five (5) year renewal of the NE 1115 Substance Use Disorder (SUD) Demonstration Waiver Program. The current 1115 SUD Demonstration is approved for July 1, 2019, through June 30, 2024, and this renewal application is requesting to renew the demonstration waiver for an additional five (5) year period, July 1, 2024, to June 30, 2029.

Nebraska's Substance Use Disorder (SUD) Demonstration Waiver provides Nebraska Medicaid expenditure authority to cover SUD treatment services provided in facilities that meet the definition of an Institution for Mental Diseases (IMDs). The expenditure authority under this 1115 waiver allows Nebraska Medicaid to better ensure members are receiving effective SUD treatment in the most appropriate setting. Coverage of residential services allows Medicaid enrollees to receive the appropriate level of care, reducing emergency department visits and increasing referrals for outpatient community-based services upon discharge.

This renewal application requests authority for the State of Nebraska to continue to operate the 1115 SUD Demonstration Waiver as approved without changes.

1 – Overview of the Nebraska Medicaid Delivery System

The Nebraska Medicaid Program provides health coverage to approximately 370,000[1] members with between 18 and 19 percent of Nebraska residents enrolled in the program in any given month[2]. At the time of initial application for the Section 1115 SUD Demonstration, Nebraska Medicaid had approximately 240,000 enrolled. Primary drivers of the increase in program enrollment include the expansion of health coverage to adults 19 to 64 years of age with income up to 138% of the federal poverty level (FPL) on October 1, 2020, and the impact of the federal COVID public health emergency continuous enrollment requirement.

Over 99 percent of Medicaid members are served through the state's managed care delivery system. The populations remaining in the fee-for-service (FFS) delivery system include individuals in the following categories:

- Aliens who are eligible for Medicaid for an emergency condition only;
- Beneficiaries who have excess income or who are required to pay a premium, except those who are continuously eligible due to a share of cost obligation to a nursing facility or for HCBS Waiver services;
- Beneficiaries who have received a disenrollment or waiver of enrollment;
- Participants in the Program for All-Inclusive Care for the Elderly; and
- Beneficiaries with Medicare coverage where Medicaid only pays co-insurance and deductibles.

[1] Based on enrollment data run for total managed care enrollment in June 2022 during DY3Q4. Data run in October 2022 to account for claims lag and retroactive Medicaid enrollment.
[2] Calculation based on current Nebraska Medicaid enrollment and the population of Nebraska from the 2020 Decennial Census: https://www.census.gov/programs-surveys/decennial-census/about/rdo.html

While Medicaid beneficiaries receiving long-term services and supports (LTSS) receive their physical health, behavioral health, and pharmacy services through their managed care plan, their LTSS benefits continue to be delivered through the legacy FFS system.

1.1 – Medicaid Managed Care Program

Established January 1, 2017, Nebraska's Managed Care Program, Heritage Health, provides comprehensive physical health, behavioral health, and pharmacy services to Nebraska Medicaid beneficiaries. SUD treatment services are delivered almost exclusively through Heritage Health.

At the time of the submission of this renewal request the Heritage Health program consists of three (3) managed care plans: United HealthCare, Nebraska Total Care, and Healthy Blue Nebraska. MLTC recently completed a new procurement for the Heritage Health program for contracts that will go into effect January 1, 2024. Healthy Blue Nebraska will be replaced by Molina Healthcare, with United Healthcare and Nebraska Total Care continuing as contracted Heritage Health plans. Table 1 indicates the individuals currently enrolled in with Heritage Health plans.

Table 1: Nebraska Heritage Health Plan Enrollment

Heritage Health Plan	Health Plan Enrollment (June 2022, DY3Q4)
UnitedHealthcare Community Plan	126,996
Nebraska Total Care	126,761
Healthy Blue Nebraska	116,573
Total	370,330

1.2 - Eligibility

Medicaid eligibility requirements will not differ from the approved Medicaid state plan.

1.3 – SUD Continuum of Care

Nebraska Medicaid provides a broad range of community-based and residential SUD services. This service offering reflects MLTC's strategy of investing in community-based treatment while ensuring access to a full continuum of SUD services. Under the waiver program, the service continuum has been expanded with the addition of state plan coverage for Opioid Treatment Program (OTP) and Medically Monitored Inpatient Withdrawal (MMIW).

Table 2 illustrates the American Society of Addiction Medicine (ASAM) Levels of Care currently addressed Medicaid SUD treatment services. Services that are impacted by the expenditure authority allowed under this demonstration waiver include a reference to 1115(a) authority and the services implemented as a part of this waiver notated with the associated authority and implementation date. The state is in active development of the state's Medical Service Definitions (MSDs) and the descriptions for ASAM have been updated with these changes through the state's overarching SUD

and behavioral health regulations update.

Table 2: Nebraska Medicaid SUD Services by ASAM Level of Care

ASAM Level of Care	ASAM Service Title	ASAM Brief Definition	Medicaid Service Authority[4]
1.0	Outpatient Services	Less than nine hours of service/week (adults); less than six hours/week (adolescents) for recovery or motivational enhancement therapies/strategies.	1915(b)
2.1	Intensive Outpatient Services	Nine or more hours of service/week (adults); six or more hours/week (adolescents) to treat multidimensional instability.	1915(b)
2.5	Partial Hospitalization Services	20 or more hours of service/week for multidimensional instability not requiring 24-hour care	1915(b)
3.1	Clinically Managed Low-Intensity Residential Services	24-hour structure with available trained personnel; at least five hours of clinical service/week and prepare for outpatient treatment.	1915(b) and 1115(a)
3.2-WM	Clinically Managed Residential Withdrawal Management	Moderate withdrawal but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.	1915(b)
3.3	Clinically Managed Population-Specific High-Intensity Residential Services	24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community and prepare for outpatient treatment.	1915(b) and 1115(a)
3.5	Clinically Managed High-Intensity Residential Services	24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full milieu or therapeutic community.	1915(b) and 1115(a)

ASAM Level of Care	ASAM Service Title	ASAM Brief Definition	Medicaid Service Authority[4]
3.7-WM	Medically Monitored Inpatient Withdrawal (MMIW)	Medically Monitored Inpatient Withdrawal Management (ASAM Level 3.7-WM) is a non-hospital intervention delivered by medical, nursing, mental health and substance use clinicians, which provide 24-hour medically monitored evaluation under physician-approved policies and procedures or clinical protocols.	State Plan Amendment Approved 11/3/2020
Opioid Treatment Program (OTP)	Must meet ASAM criteria for care placement	Opioid Treatment Programs (OTPs) provide medication-assisted treatment (MAT) for people diagnosed with an opioid use disorder (OUD). OTPs must be certified by SAMHSA and accredited by an independent, SAMHSA-approved accrediting body.	State Plan Amendment Approved 11/3/2020
Other	Peer Support	Certified Peer Support services are provided by individuals who have lived experience with mental health or substance use disorders (SUD).	State Plan

1.4 – Cost Sharing

Cost sharing requirements under the demonstration will not differ from the approved Medicaid state plan.

2 – NE 1115 SUD Demonstration Waiver Program

In accordance with the SUD Implementation Plan, the state submitted State Plan Amendments (SPAs) to add Medicaid coverage for Opioid Treatment Programs (OTPs) and Medically Monitored Inpatient Withdrawal (MMIW). These amendments were submitted during the first part of 2020 and approval was received by the state on November 3, 2020, with service dates retroactive to January 1, 2020.

2.1 – Medication-Assisted Treatment (MAT)

The addition of Medication-Assisted Treatment (MAT) into the Nebraska State Plan allows for the provision of or access to MAT drugs to treat substance use disorders (SUDs). As of October 1, 2020[3], residential treatment facilities, including Institutions for Mental Diseases (IMDs), must offer MAT on-site

[3] Nebraska Medicaid SPA 21-0006 MAT ABP Basic (August 24, 2021): https://dhhsemployees/sites/MLTC/RegulatoryCompliance/StatePlanAmendments/NE%2021-0006%20MAT%20Basic%20ABP/NE-21-0006%20MAT%20ABP%20SPA%20Approval.pdf

or facilitate access to MAT off-site. The allowance of MAT was implemented under the Section 1115 SUD Demonstration as a SPA.

To fulfill the SUD Demonstration's milestones and improve the continuum of care for SUDs, the state has updated each SUD Medical Service Definition (MSDs) to include the following language, "Facilitate access to MAT as medically necessary." The language, found under "Service Expectations," ensures that providers will provide or facilitate access to the continuum of care as appropriate at all levels of care. These requirements will be included in regulation as well as MCO contract updates.

MSDs were updated as part of an extensive service definition and regulation modernization project that included the DHHS Divisions of Medicaid and Long-Term Care, Behavioral Health, and provider and member stakeholders. These definitions MSDs were published on 3/31/2023 and can be found on the Nebraska Medicaid Behavioral Health Service Definitions website.

2.2 – OTP and MMIW

The implementation of Medicaid coverage for OTPs and MMIW has enhanced the SUD treatment continuum by adding additional treatment options in both community-based and residential settings. Within six (6) months of implementation, Medicaid received enrollment applications for the additional service types from all the certified OTPs and MMIW providers in Nebraska.

The visuals below depict the impact the service authorities have had on the ability for Nebraska Medicaid beneficiaries to receive the medically appropriate care needed for their specific circumstance. Figure 1 shows that as of the end of DY4Q1, over 5,000 individuals on average have received any SUD treatment by Medicaid providers, increasing from 1,527, with nearly an average of 1,000 individuals per quarter were positively impacted through the ability to receive treatment in an OTP, going up from 294 individuals on average at the beginning of the demonstration. In addition, as shown in Figure 2, utilization of withdrawal management increased to over 160 individuals on average per quarter.

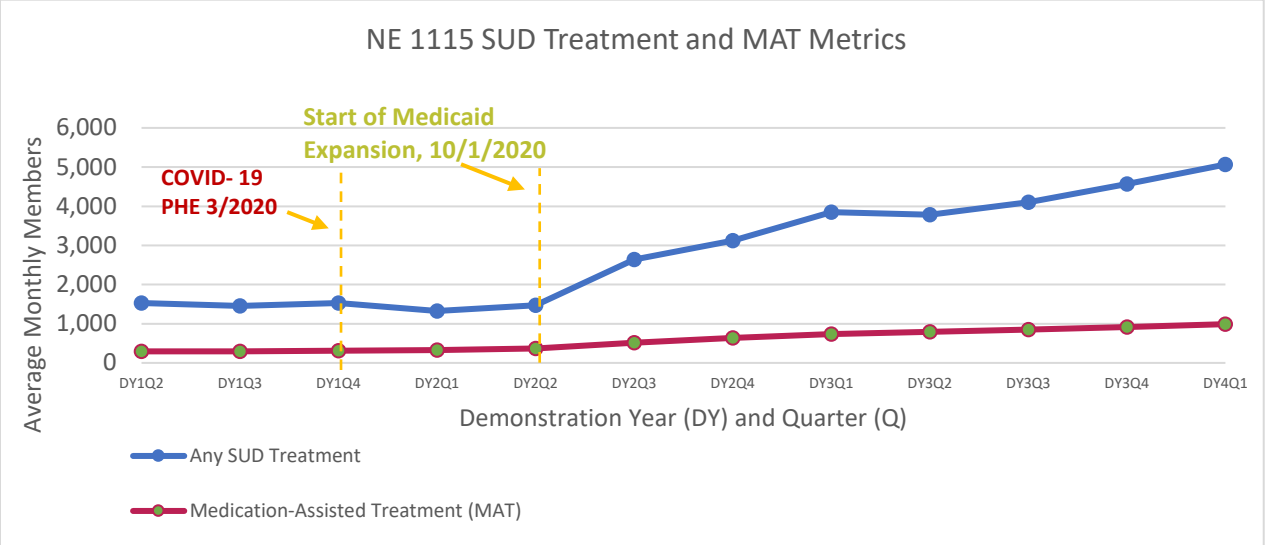

Figure 1 NE 1115 SUD Monitoring Measure Results for Any SUD Treatment and Medication-Assisted Treatment (MAT) by Average Members Per Quarter, 7/1/19 - 9/30/22.

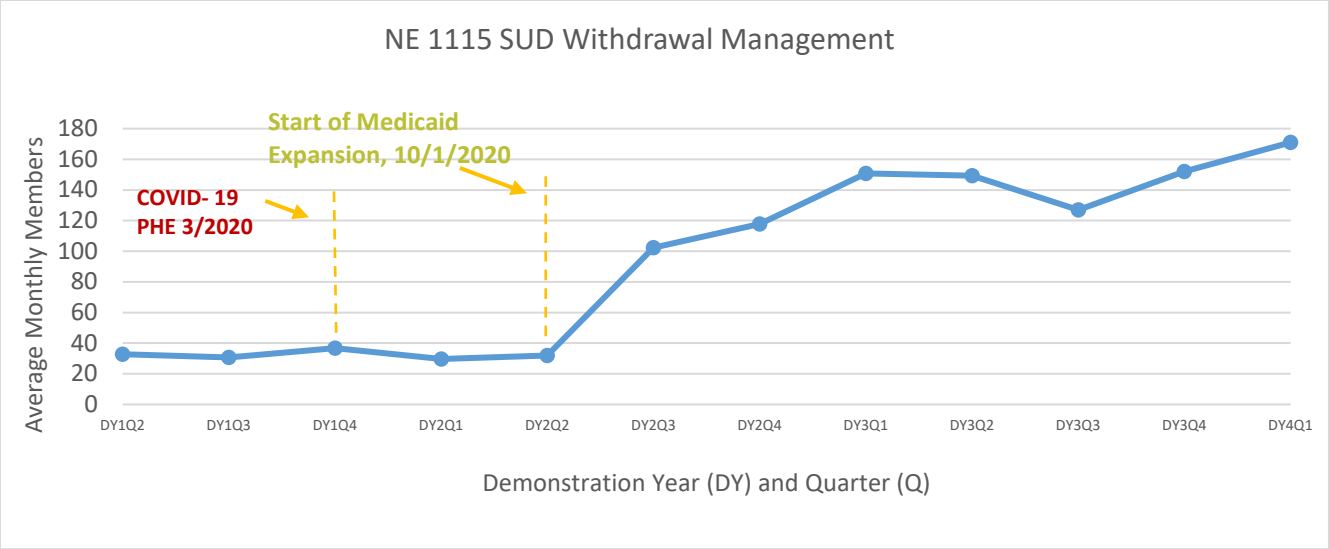

Figure 2 NE 1115 SUD Monitoring Measure Results for Withdrawal Management by Average Members Per Quarter, 7/1/19 - 9/30/22.

The state continues to screen enrollment requests and anticipates increased enrollment by providers in the coming demonstration years as new facilities and clinics are implemented to meet the need for providing services for SUD at the appropriate levels of care.

3 – Renewal Request

The state is requesting a five-year renewal of the Section 1115 Substance Use Disorder Demonstration Waiver Program for the period of July 1, 2024, through June 30, 2029.

The 1115 SUD Demonstration Waiver currently authorizes the state to provide expenditures for services in settings not otherwise covered for substance use disorder (SUD) treatment to eligible individuals within residential treatment programs in facilities that meet the definition of an institution for mental disease (IMD). This 1115 renewal application seeks to extend the expenditure authority to continue to operate as approved without changes.

4 – Goals, Objectives, and Evaluation

The SUD program demonstration describes six goals established by Nebraska DHHS for the program:

1. Increased rates of identification, initiation, and engagement in treatment for SUD
2. Increased adherence to and retention in treatment
3. Reductions in overdose deaths, particularly those due to opioids
4. 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
5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate
6. Improved access to care for physical health conditions among beneficiaries with SUD

4.1 – Demonstration Goals and Hypotheses

The objective of the SUD program is to improve the state's ability to provide a full continuum of care for people experiencing SUD by improving access to evidence-based SUD treatment, and by improving the quality of available SUD treatment. By doing so, the State seeks to maintain or reduce the cost of care for beneficiaries with SUD. As such, the evaluation questions are:

1. Did the demonstration increase access to health care for beneficiaries with SUD?
2. Did the demonstration improve the quality of SUD treatment?
3. Did the demonstration maintain or reduce total cost of care?

Table *3* highlights the demonstration goals and connects them to the evaluation questions with the respective hypotheses and data sources. The Independent Evaluator (IE) will analyze varying components of the demonstration and determine the effectiveness and successes to determine overall implementation progress.

Table 3: Evaluation Hypotheses and Measures

Demonstration Goal	Evaluation Question	Hypothesis	Data Source
Improve Access to Health Care for Beneficiaries with SUD	Did the demonstration improve access to health care for beneficiaries with SUD?	The demonstration will increase access to evidence-based SUD treatment, reflected in increased utilization.	Claims; provider enrollment database; MCO reporting; N-SSATS; NSDUH
		The demonstration will increase access to evidence-based SUD treatment, reflected in increased capacity.	
		The demonstration will increase access to care for physical health conditions among beneficiaries with SUD	
Improve Quality of Care for Beneficiaries with SUD	Did the demonstration improve the quality of SUD treatment?	The demonstration will Improve rates of identification, initiation, and engagement, in treatment for SUD	Claims; National Center for Health Statistics
		The demonstration will improve rates of adherence to and retention in treatment for SUD	

Demonstration Goal	Evaluation Question	Hypothesis	Data Source
		The demonstration will reduce ED use for SUD	
		The demonstration will reduce readmissions for SUD	
		The demonstration will reduce overdose deaths, particularly those due to opioids	
Maintain or reduce costs	Did the demonstration maintain or reduce total cost of care?	The demonstration will reduce inpatient hospitalization and ED use for SUD	Claims
		The demonstration will reduce inpatient hospitalization and ED use for beneficiaries with SUD	

4.2 – Interim Evaluation Report Executive Summary

At the time of the Interim Evaluation Report, the state has completed key milestones per CMS acknowledgement and confirmation by the state's independent evaluator, Health Services Advisory Group, Inc. (HSAG), even as these implementation activities were delayed due to the COVID-19 PHE as priorities shifted to address urgent healthcare needs associated with the PHE. These implementation milestones, as noted below, have been completed as of this renewal request.

The executive summary, below, is preliminary at the time of this draft and may not be reflective in the final version of this renewal application.

Executive Summary

The Nebraska Department of Health and Human Services (DHHS) Section 1115 Substance Use Disorder (SUD) Demonstration Waiver (the Waiver) application was approved by the Centers for Medicare & Medicaid Services (CMS) on June 28, 2019, effective July 1, 2019, through June 30, 2024.[4] The Waiver allows DHHS to provide high-quality, clinically appropriate treatment to Medicaid enrollees 19 to 64 years of age primarily diagnosed with opioid use disorder (OUD) and/or other SUDs at Institutions for Mental Disease (IMDs). In addition to providing the appropriate level of care, the coverage of IMD stays reduces emergency department (ED) visits and increases referrals for outpatient (OP) and community-

[4] Centers for Medicare & Medicaid Services. CMS Initial Approval. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ne/ne-substance-use-disorder/ne-sud-demo-initial-appvl-20190628.pdf. Accessed on: Mar. 1, 2023.

based services upon discharge. Additionally, the Waiver enables the State to implement models focused on increasing home-and-community-based support for beneficiaries and improve access to evidence-based SUD services based on the American Society of Addiction Medicine (ASAM) criteria. The Waiver was designed to support three aims:

Aim One: Improve access to health care for beneficiaries with an SUD.

Aim Two: Improve quality of care for beneficiaries with an SUD.

Aim Three: Maintain or reduce costs.

Pursuant to the Special Terms and Conditions (STCs) of the Waiver, DHHS contracted with Health Services Advisory Group, Inc. (HSAG), as the independent evaluator to conduct a comprehensive evaluation of the Waiver. The purpose of the evaluation is to provide CMS and DHHS with an independent evaluation that ensures compliance with the requirements of Section 1115 Demonstration Waivers; assist in State and federal decision-making about the efficacy of the Waiver; and enable DHHS to further develop clinically appropriate, fiscally responsible, and effective Medicaid Section 1115 Demonstration Waivers. This is the Interim Evaluation Report for the Waiver. This report evaluates the first three years of the Waiver, July 1, 2019, through June 30, 2022. Following the conclusion of the Waiver in 2024, a Summative Evaluation Report will report an analysis of the full five-year demonstration period.

Conclusions

Aim One

Evaluation of this question was complicated by the coronavirus disease 2019 (COVID-19) public health emergency (PHE) and Medicaid expansion, two events that coincided with the initial implementation period of the Waiver, and close enough in time to the full implementation to preclude disentangling the effects of all events. The COVID-19 PHE impacted healthcare utilization as social distancing guidelines, mandated shut-downs, and stay-at-home orders were in effect. Medicaid expansion made it possible for people under the age of 65 who earn up to 138 percent of the federal poverty level (FPL) to receive Medicaid health insurance coverage. Expansion confounds assessment of the Waiver impact as increases in utilization could be a result of the large influx of members needing SUD services.

Successes and challenges associated with Aim One include the following.

Successes

Several measures indicated support for hypotheses that the Waiver would increase access to evidence-based SUD treatment reflected in increased utilization (Hypothesis 1) and increased capacity (Hypothesis 2):

- An increased percentage of beneficiaries with an SUD who received any SUD treatment service
- Improved rates of residential service utilization for an SUD
- An increased percentage of beneficiaries with an SUD who had a medication-assisted treatment (MAT) claim for an SUD
- An increasing number of Medicaid providers delivering SUD services

Following initial implementation of the Waiver that extended coverage to IMD stays of any duration, there were potential improvements in the average number of IMD stays for an SUD and average number of days of IMD treatment for an SUD among beneficiaries with an SUD. Additionally, the average length of stay (ALOS) of IMD stays for an SUD also stabilized around the statewide goal of 30 days. The number of beds available in IMD facilities providing SUD services also trended upward. However, due to the lack of pre-implementation data or a viable comparison group, these improvements cannot be attributed directly to the Waiver.

Several survey measures using data from the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Survey on Drug Use and Health (NSDUH), and the National Survey of Substance Abuse Treatment Services (N-SSATS) also showed promise as rates trended in a desired direction. The treatment gap for beneficiaries with an illicit drug or substance use disorder is decreasing in Nebraska, although only pre-implementation data were available. There were slight improvements in the number of facilities providing any type of MAT per 100,000 adult Nebraskans. While the rate of facilities with opioid treatment programs (OTPs) per 100,000 adults in Nebraska remains lower than the national average, all Nebraska OTPs are being offered in OP facilities, and all OTPs are providing medication-assisted opioid therapy. However, no statistical testing was conducted as data for these measures were only available prior to the full implementation of the MAT/OTP component of the Waiver. As additional data points become available, HSAG will continue its assessment of these measures for the Summative Evaluation Report.

Challenges

There were some notable challenges to achieving Aim One:

- Reduced percentages of beneficiaries who use withdrawal management services following the full implementation of the Waiver and **medically monitored inpatient withdrawal (MMIW) management** service category.
- Lower rates of beneficiaries with an SUD who had an ambulatory or preventive care visit
- Zero residential (non-hospital) facilities offering OTPs

Evidence of decreasing percentages of beneficiaries who use withdrawal management services following full Waiver implementation in which coverage for MMIW became available may be indicative of a substitution effect; it is possible that the current measure does not capture treatment codes for the new services and that members are switching from existing withdrawal management services to more clinically appropriate MMIW services. Alternatively, challenges that providers noted in providing these services (ASAM Level 3.7) may have temporarily impacted the provision of existing withdrawal management services.

The hypothesis that the Waiver will increase access to care for physical health conditions among beneficiaries with an SUD was not supported by increased utilization of ambulatory and preventive care; however, lower rates of preventive and primary care may be largely influenced by COVID-19 PHE impacts during 2020 and 2021.

The number of OP facilities offering detoxification per 100,000 adults in Nebraska and the number of facilities offering opioid-specific detoxification per 100,000 adults in Nebraska continues to fall below the national averages.

Aim Two

Successes

Through activities related to promoting evidence-based assessment and referral, standardizing assessment and placement criteria for patients, establishing qualifications for residential providers, and

assuring compliance with treatment standards, the Waiver is hypothesized to improve the appropriateness and continuity of care for SUD beneficiaries. Several measures support the hypotheses:

Increased rates of adherence to and retention in treatment for an SUD

Reduction in the average number of ED visits for an SUD among beneficiaries with an SUD

Challenges

Key challenges were also present:

- An increasing trend in the rate of overall overdose deaths and opioid-specific overdose deaths in Nebraska from 2017 to 2020
- Increased rates of 30-day readmission for an SUD
- Decline in the percentage of beneficiaries initiating treatment within 14 days of a new SUD diagnosis

The increased rate of overdose deaths was exacerbated by the COVID-19 PHE, as was seen across the country during this time.[5] Compared to national rates, Nebraska experienced a greater increase in overdose deaths between 2019 and 2020; this may be explained by studies that show a disproportionate impact of the pandemic on drug use patterns among people living in rural areas.[6]

Although initiation of treatment for an SUD declined during this period, results on engagement in SUD treatment were mixed. The percentage of beneficiaries who initiated treatment and who had two or more additional services for an SUD within 34 days of the initiation visit improved during the initial implementation period, before worsening during the full implementation period.

Aim Three

Aim Three focuses on cost maintenance as an intended outcome of treating patients in the most appropriate settings and asks whether the Waiver maintained or reduced total cost of care. It is hypothesized that the increased cost of SUD treatment as a result of higher utilization (increase in claims for treatment, longer IMD stays, etc.) will be balanced out by reduced acute care utilization. Thus, the Waiver is hypothesized to reduce inpatient (IP) hospitalization and ED use specifically for an SUD (Hypothesis 1) as well as overall hospital admissions and ED visits for beneficiaries with an SUD (Hypothesis 2) and ultimately result in maintained or reduced total cost of SUD-related care (Hypothesis 3) and overall total cost of care (Hypothesis 4).

Successes

There was strong evidence of a decrease in inpatient (IP) hospitalizations following implementation of the Waiver, as evidenced by:

- Reductions in the average number of IP hospitalizations and average number of days of IP hospitalization among all beneficiaries ages 19–64, for an SUD specifically.

[5] Centers for Disease Control and Prevention. Overdose Deaths Accelerating During COVID-19. Available at: https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html. Accessed on: Mar. 7, 2023.

[6] Walters SM, Bolinski RS, Almirol E, et al (2022). "Structural and community changes during COVID-19 and their effects on overdose precursors among rural people who use drugs: a mixed-methods analysis," *Addiction Science & Clinical Practice* 17(24); Available at: https://ascpjournal.biomedcentral.com/articles/10.1186/s13722-022-00303-8. Accessed on: Mar. 17, 2023.

- Reductions in the average number, average number of days and ALOS of IP hospitalization for any cause among beneficiaries with an SUD diagnosis.

Challenges

Several measures demonstrated mixed results and neither supports nor fails to support the associated hypotheses. The ALOS of IP hospitalization for an SUD did not demonstrate any statistically significant results but was trending in the desired direction. The average number of ED visits for any cause among beneficiaries with an SUD diagnosis demonstrated a relative decrease in the trend upon initial implementation and a relative increase in the trend upon full implementation. Therefore, this measure neither supported nor failed to support the hypothesis that the Waiver would reduce IP hospitalization and ED use or beneficiaries with an SUD.

In general, the results of the analysis on cost for SUD treatment neither supported nor failed to support the hypothesis that the Waiver would reduce or maintain total cost of SUD-related care (Hypothesis 3). A decrease in the average SUD-IMD cost at the start of each implementation period suggests trending of SUD-IMD costs in the desired direction, but the change in monthly trend during both implementation periods was not statistically significant. Although there was a decreasing trend for other SUD costs, these costs increased significantly upon initial implementation, and non-SUD costs also followed a similar pattern of mixed results.

Similarly, analysis of the total cost of care and costs stratified by category of service also neither supported nor failed to support the hypothesis that the Waiver would reduce or maintain total cost of care overall (Hypothesis 4). There are some indications of improvements. ED and IP costs demonstrated continued cost reductions through the Waiver period; in particular, statistically significant decreasing monthly trends during the initial implementation period compared to projected costs had the baseline period continued suggest support for Hypothesis 4. Pharmacy and professional costs also demonstrated evidence of an increase following full implementation of the MAT/OTP component of the Waiver.

Overall Results

The findings demonstrate that beneficiaries increased utilization of SUD treatment services, particularly residential services, and MAT throughout the Waiver period. This increase may reflect the Waiver's emphasis on expanding residential providers' treatment methods and increasing the number of practitioners trained on MAT. Analysis of the number of Medicaid providers delivering SUD services showed an approximately 21 percent increase from the baseline years to 2022 and may reflect provider capacity building efforts.

The number of IMD stays and number of days of IMD treatment increased between the start of the initial implementation period and the start of the full implementation period in alignment with the Waiver's goals. There were also improvements in meeting the statewide target for ALOS in an IMD of 30 days; six out of the last eight months of the Waiver period were below 30 days and two months were only slightly above 30 days, indicating that the ALOS stabilized around the statewide goal of 30 days at the time of evaluation.

The evaluation showed a significant decrease in both the level and trend of ED visits for an SUD at the time of full implementation, suggesting evidence of the Waiver's impact on reducing ED utilization among beneficiaries with an SUD. As the full implementation of the Waiver effected increased availability of OTPs and more facilities providing MAT statewide, this decline may be representative of a

shift away from reliance on EDs for SUD treatment. Decreasing ED costs during the initial implementation period lends additional support for reduced ED utilization by beneficiaries with an SUD.

The Waiver was also associated with improvements in IP stays for an SUD and IP stays for any cause. The average number of stays, average number of days and ALOS for an SUD specific and any-cause IP stays declined during the study period. Furthermore, examination of IP costs demonstrated a continued reduction in costs throughout the Waiver period.

Finally, pharmacy costs were increasing during the baseline period but began to decrease during the initial implementation period. Upon full implementation of the MAT/OTP services, pharmacy costs increased again as would be expected with wider accessibility of MAT treatment.

Lessons Learned and Recommendations

While the Waiver shows promise across several dimensions of care and improvements, there are some lessons learned and recommendations related to the provision of new services stemming from key informant interviews.

Issue: Some providers noted difficulties in providing ASAM Level 3.7 MMIW management services.

Recommendation: The State should continue working with managed care organizations (MCOs) and providers to streamline or expedite the credentialling process. The State could also reiterate to providers that there are no changes to the provision or billing of existing services to reduce any confusion or uncertainty providers may have regarding billing State plan services.

Issue: Some providers felt uncomfortable prescribing methadone treatment.

Recommendation: The State and/or MCOs could assist providers in prescribing methadone treatment, including providing clinical guidelines and recommendations. MCOs could facilitate collaboration among providers and existing methadone treatment facilities to address providers' concerns about lack of experience providing methadone treatment.

4.3 – COVID-19 Public Health Emergency (PHE)

Due to the coronavirus disease (COVID-19) public health emergency (PHE), Nebraska's SUD demonstration experienced delays implementing some of the action items outlined in the implementation plan and STCs. Based on these actions and the ongoing efforts to meet the milestones, the delays caused by the COVID-19 PHE have not prevented the state from continuing significant progress toward meeting the milestones.

5 – Monitoring, Reporting and Quality

In accordance with STC 18b, the state received approval of the Monitoring Protocol on November 16, 2020. Since approval, the state has submitted both annual and quarterly monitoring reports inclusive of the CMS required measures and state-specific measures for Health IT. The state continues to monitor the impact of the SUD demonstration.

5.1 – Institutions for Mental Disease (IMD) Stays For Individuals Aged 21 to 64 Years Old

The expenditure authority under this 1115 demonstration waiver allows Nebraska Medicaid to better ensure members are receiving effective SUD treatment in the most appropriate setting. Figure 3 reviews the total IMD stays, stays over 15 days, and stays under 15 days. Of these, stays over 15 days account for 68 percent of the total stays reported by the MCOs. The state has observed the percentage of all stays that exceed 15 days stabilizing around 68 to 70 percent, indicating the need Nebraska Medicaid beneficiaries have for these services. To date, without the waiver authority, Nebraska would be unable to reimburse for over 2,200 stays since the beginning of the demonstration, July 1, 2019 through September 30, 2022.

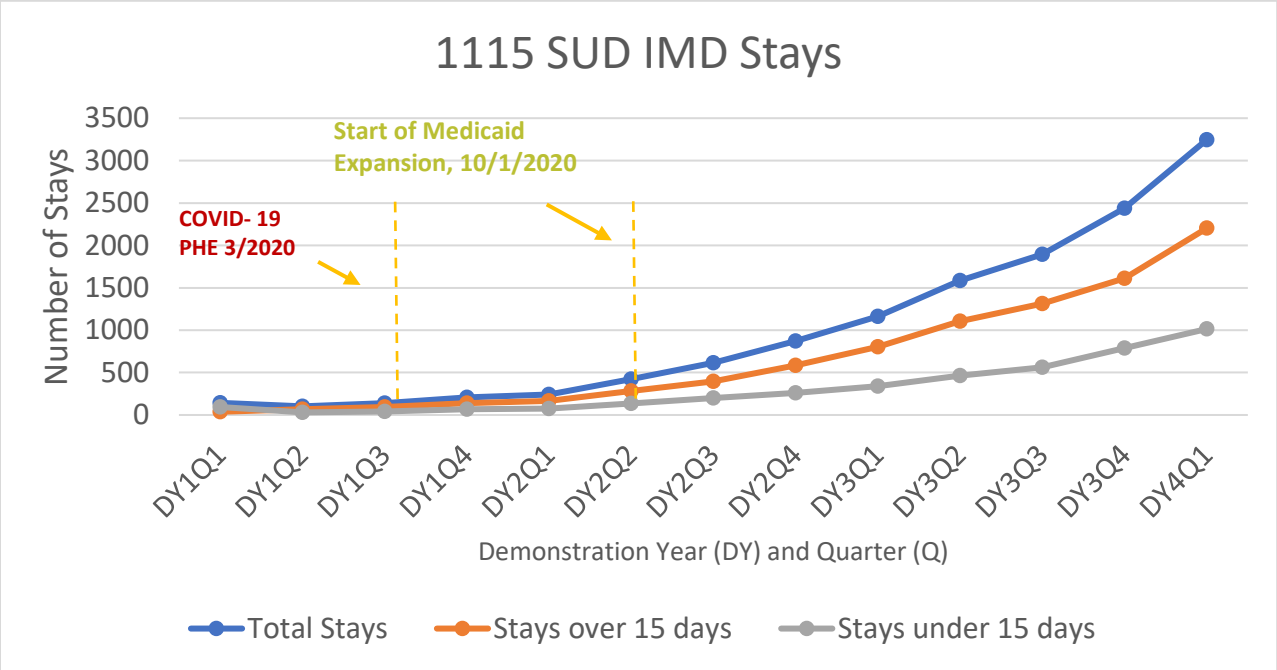

Figure 3: 1115 SUD IMD Stays claims data since the beginning of the demonstration, July 1, 2019, through September 30, 2022. Stays over 15 days account for 68% of total IMD Stays for individuals aged 21 to 64 years old.

5.2 Monitoring Metrics

Over the course of the demonstration, the state has monitored the progress of SUD related metrics as determined by the state's Monitoring Protocol. The state determined the reporting of the CMS specific measures and an additional three (3) state-specific measures for Health IT. Below are reviews of the telehealth-specific measure and a look at follow-up after ED visit, metric 17-1.

The state chose to monitor telehealth for SUD as part of the state defined health IT metrics (metric Q3) at the start of the demonstration. Figure 4, below, uses the quarter over quarter results of that metric to highlight the increase in utilization of SUD telehealth. The start of the demonstration saw low utilization of telehealth for SUD, with the first two reporting periods having only 15 and 11 average visits per month. However, starting in DY1Q3, the impacts of the COVID-19 PHE drove a significant increase to 906

average monthly telehealth visits in DY1Q4. Since DY3Q2, the average monthly telehealth visits have mostly stabilized at a higher level than before the initial COVID-19 PHE driven increase. As mentioned in subsection 4.2 – Interim Evaluation Report, the state received confirmation from the State Demonstrations Group on December 16, 2021 verifying the completion of Milestone 4.

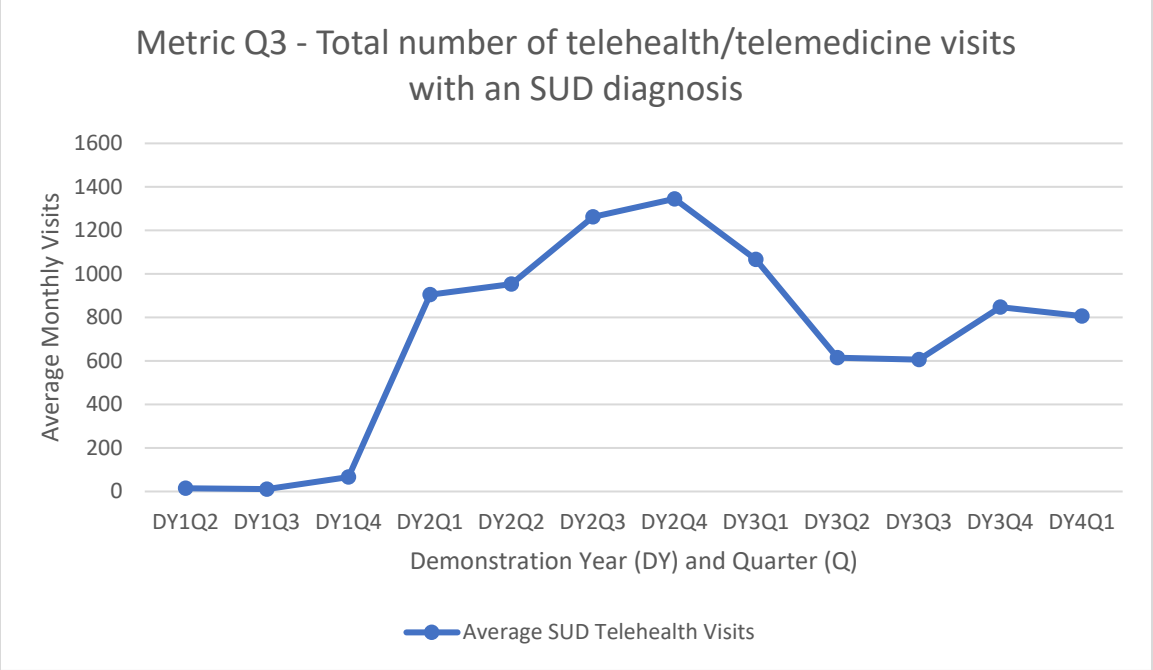

Figure 4: Q3 - Total number of telehealth/telemedicine visits with an SUD diagnosis. Figure shows the percentage changes, quarter over quarter, indicating increased utilization since the beginning of the demonstration.

The state would like to highlight several metrics to speak to the ED utilization portion of Goal #4 "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." Below are metrics #17-1 Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD) and #23 Emergency Department Utilization for SUD per 1000 Medicaid beneficiaries as Figure 5 and Figure 6 respectively.

Figure 5 and Figure 6 look at the trends for ED utilization during the demonstration thus far.

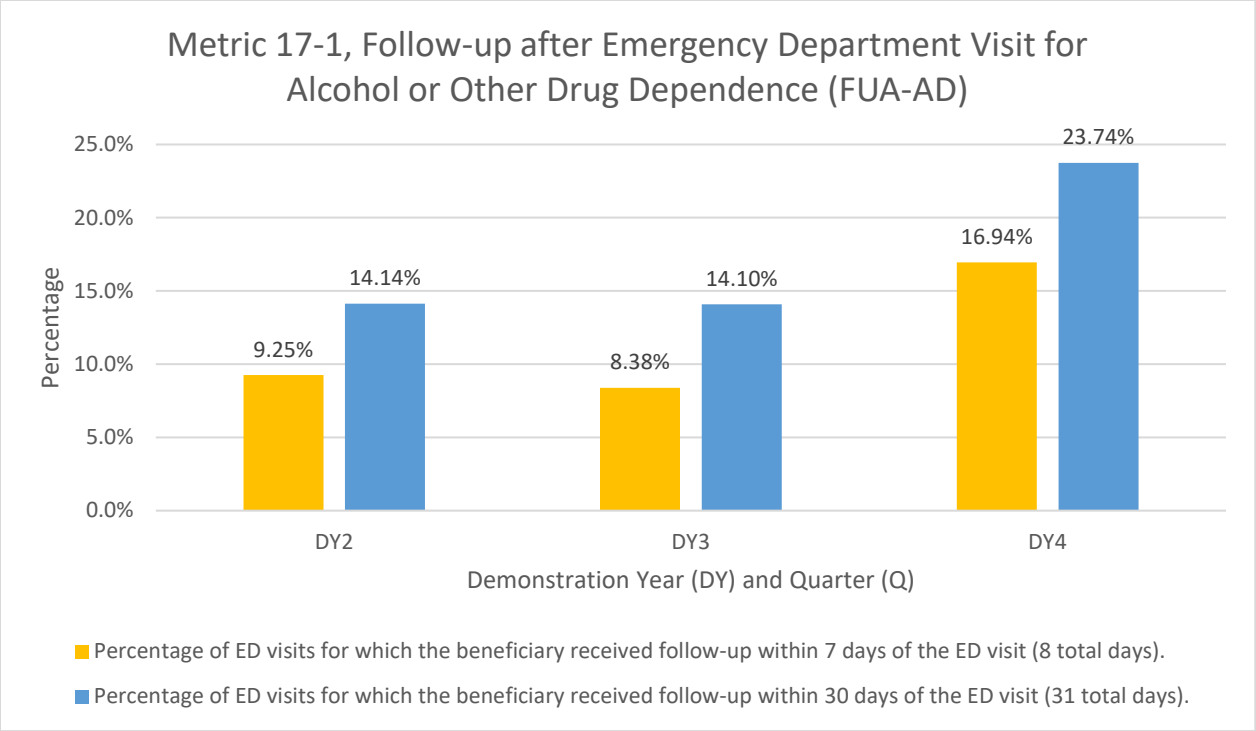

Figure 5: NE 1115 Monitoring Protocol Metric 17-1 Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (FUA-AD) results from Demonstration Year (DY) 2 to DY4. Measure calculated on an annual basis.

Figure 5 highlights the progression of follow-up adherence after an Emergency Department (ED) visit for alcohol or other drug dependence within 7 and 30 days from the ED visit. As indicated in the chart, in DY2 the state saw adherence at 9.25 percent and 14.14 percent for follow ups within 7 and 30 days, respectively. During the most recent demonstration year, DY4, the state reported adherence at 16.94 percent and 23.74 percent, indicating an increased adherence by Medicaid beneficiaries utilizing the recommendations for the continuum of care post-ED visit. Of note, the total beneficiaries in the demonstration denominator increased by 149.6% percent from DY2 to DY4. The state presumes the Adult Expansion and COVID-19 PHE factoring into the increases in demonstration population for the measure; however, the measure still demonstrates progress in completing follow up visits during the demonstration period.

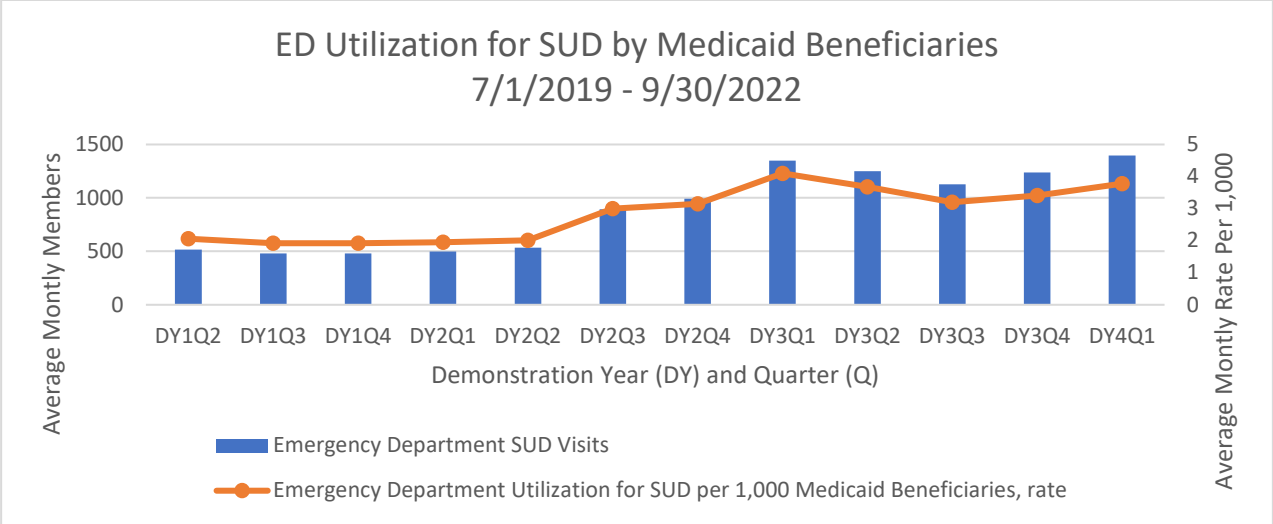

Figure 6: Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries, average members per month and per 1,000 beneficiaries.

Figure 6 highlights the impact of Medicaid expansion on the SUD ED visits during the demonstration. An immediate impact in SUD ED utilization is seen the very first quarter of Medicaid expansion in DY2Q3 which then rises over the next two quarters compared to the prior utilization experience. However please note that even though the overall SUD ED visits have increased, the rate per 1,000 has improved for comparable quarters, such as DY3Q2 compared to DY3Q4. While it is still too early to say with complete confidence, the information is pointing toward the SUD ED rates stabilizing and even improving since the implementation of the demonstration.

5.3 – Data Quality

Nebraska MLTC is required to conduct an annual external quality review (EQR) of the services provided by contracted Medicaid managed care entities (MCEs). The state contracts with the EQRO Health Services Advisory Group, Inc. (HSAG) to assess and report the impact of its Medicaid managed care program, Heritage Health, and each of the participating MCEs on the accessibility, timeliness, and quality of services.

HSAG completes all EQR activities identified as mandatory by 42 CFR 438.358 annually. The final aggregate 2022 Technical Report is found on MLTC's Heritage Health Resources public website and it includes the results of the following activities:

- Validation of performance improvement projects (PIPs)
- Validation of performance measures – HEDIS methodology
- Validation of performance measures – Dental PAHP
- Assessment of compliance with Medicaid and CHIP managed care regulations
- Validation of network adequacy

This report is intended to help the Heritage Health Program to:

- Identify areas for quality improvement
- Ensure alignment among an MCE's Quality Assessment and Performance Improvement (QAPI) requirements, the state's quality strategy, and the annual EQR activities
- Purchase high-value care
- Achieve a higher performance health care delivery system for Medicaid and CHIP beneficiaries
- Improve states' ability to oversee and mange MCEs they contract with for services
- Help MCEs improve their performance with respect to quality, timeliness, and accessibility to care

While the Technical Report includes results which could be impacted by the NE 1115 SUD Demonstration waiver, such as the validation of PIPs and performance measures which are related to SUD services and an assessment of the adequacy of the MCE Behavioral Health provider network, it does not include an assessment specific to this waiver.

6 – Budget Neutrality

The following includes historical enrollment and expenditure totals from the first three years of the initial demonstration period and projected totals for the extension period. Each year listed in the table below represents twelve months of data collected in the months January through December. Expenditures reported represent the capitation payments paid to the MCOs for those receiving qualifying SUD services in IMDs. The state's actuarial partner provided the projections methodology and analysis for the renewal period.

6.1 – Budget Neutrality Waiver Summary

Table 4 reviews the initial waiver period expenditures for the total waiver population and the prospective renewal period expenditures and waiver population totals, with and without the expansion population.

Table 4: Total Eligible Waiver Population with Respective Total Expenditures

SUD 1115 Waiver Summary

		Total			Non-Expansion			Expansion		
DY	SFY	Member Months	PMPM	Dollars	Member Months	PMPM	Dollars	Member Months	PMPM	Dollars
DY1[1]	SFY20	562	$781.19	$439,029	562	$781.19	$439,029	-	$-	$-
DY2[1]	SFY21	1,778	$872.97	$1,552,147	688	$826.97	$568,957	1,090	$902.01	$983,190
DY3[1]	SFY22	3,521	$915.86	$3,224,734	1,035	$896.43	$927,803	2,486	$923.95	$2,296,930
DY4[2]	SFY23	3,591	$1,072.09	$3,850,328	1,056	$971.83	$1,025,961	2,536	$1,113.83	$2,824,366
DY5[2]	SFY24	3,663	$1,117.08	$4,092,136	1,077	$1,007.17	$1,084,530	2,586	$1,162.84	$3,007,606
DY6[3]	SFY25	3,735	$1,062.49	$3,968,405	1,097	$1,026.88	$1,126,487	2,638	$1,077.30	$2,841,917
DY7[3]	SFY26	3,810	$1,106.81	$4,216,930	1,119	$1,063.77	$1,190,362	2,691	$1,124.70	$3,026,568
DY8[3]	SFY27	3,886	$1,153.00	$4,480,547	1,141	$1,102.01	$1,257,396	2,745	$1,174.19	$3,223,152
DY9[3]	SFY28	3,964	$1,201.48	$4,762,676	1,164	$1,142.87	$1,330,296	2,800	$1,225.85	$3,432,380
DY10[3]	SFY29	4,043	$1,252.02	$5,061,916	1,187	$1,185.20	$1,406,836	2,856	$1,279.79	$3,655,080

Note: 1. DY1 through DY3 reflect actual SUD IMD member months and capitation payments made to the MCOs; capitation payments are based on the capitation rates (HH and Dental) effective for the month of IMD stay. Historical figures, notably DY3, may change with additional paid runout since SUD IMD member months are based on SUD IMD stay utilization data. 2. DY4 and DY5 reflect projected member months based on the actual SFY22 member months and PMPMs from the initial 1115 Waiver Budget Neutrality submission. Projected member months may change in final version, as a result of review of SFY22 and emerging SFY23 SUD IMD utilization with additional claims runout. 3. DY6 through DY10 reflect the draft 1115 Waiver renewal member months and PMPMs.

6.2 – Budget Neutrality Projections Narrative

CBIZ Optumas (Optumas) worked in conjunction with the state to update the SUD 1115 budget neutrality template for the 5-year renewal waiver period outlined in Table 5.

The remainder of this document describes the assumptions used in the accompanying SUD 1115 budget neutrality template called "NE SUD 1115 Waiver Model – DY6-DY10."

Table 5: Five-Year Demonstration Years

Current Approved Waiver - Demonstration Year (DY)				
DY1	**DY2**	**DY3**	**DY4**	**DY5**
7/1/2019 - 6/30/2020	7/1/2020 - 6/30/2021	7/1/2021 - 6/30/2022	7/1/2022 - 6/30/2023	7/1/2023 - 6/30/2024

Waiver Renewal - Demonstration Year (DY)				
DY6	**DY7**	**DY8**	**DY9**	**DY10**
7/1/2024 - 6/30/2025	7/1/2025 - 6/30/2026	7/1/2026 - 6/30/2027	7/1/2027 - 6/30/2028	7/1/2028 - 6/30/2029

Medicaid Eligibility Group (MEG)

The MEG structure is unchanged from the current approved 1115 SUD IMD waiver for the non-expansion populations. These MEGs include ABD, Dual and FAM. The current approved demonstration includes two separate MEGs for the adult expansion population, originally intended to recognize the differentiation of medically frail vs non-Medically frail beneficiaries. This renewal consolidates these two separate MEGs into a single MEG consistent with DHHS's alignment of benefit packages for the adult expansion population. In this waiver renewal, DHHS is including one Expansion (EXP) MEG. Table 6 illustrates MEGs in the current demonstration and the renewal MEGs.

Table 6: Medicaid Eligibility Group (MEG) Structure

Originally Approved Waiver MEG	**Renewal Waiver MEG**
ABD	ABD
Dual	Dual
FAM	FAM
EXP – Non-Medically Frail	EXP
EXP – Medically Frail	

Historical Data Assumption

Optumas utilized actual SUD IMD utilizers and their corresponding Heritage Health and Dental capitation rates for the historical data in the SUD 1115 budget neutrality template. Optumas reviewed multiple calendar and state fiscal years of data and determined that July 1, 2021 – June 30, 2022 (SFY22) was the most recent complete historical period. As a result, this period was selected as the base data projection point for the SUD 1115 budget neutrality template.

Projected IMD Member Months/Caseloads

As stated above, SFY22 enrollment (limited to SUD IMD utilizers) is the initial base point for the number of projected SUD IMD Member Months/Caseloads. SFY22 includes members continuously enrolled due to the Maintenance of Effort (MOE) requirements in effect during the COVID-19 Public Health Emergency (PHE), within the broad Medicaid program. As a result, there may be certain SUD IMD utilizers who will ultimately be disenrolled due to the unwinding of this provision. Since the base period represents beneficiaries who utilized a SUD IMD, the impact of the unwinding of the MOE is not expected to have an impact. Thus, SFY22 is deemed reasonable for the starting base enrollment. The projected caseload growth is assumed 2% annually for each MEG, which is consistent with the growth assumed in the current approved 1115 SUD IMD waiver. Table 7 shows the Projected IMD Member Months/Caseloads by DY. This information can be found in the "IMD Caseloads" tab in the SUD 1115 budget neutrality template.

Table 7: Projected IMD Member Months/Caseloads

		Waiver Renewal - Demonstration Year (DY)				
MEG	**SF22 Actual MMs**	**DY6**	**DY7**	**DY8**	**DY9**	**DY10**
ABD	250	265	270	275	281	287
Dual	235	249	254	259	264	269
FAM	549	583	595	607	619	631
EXP	2,486	2,638	2,691	2,745	2,800	2,856

Historical PMPM Adjustments

While SFY22 capitation rates were determined to be the most recent complete historical period, there are programmatic and fee schedule changes that are necessary to account for before projecting to the new waiver period. The capitated rates used in the historical base data were adjusted for benefit and fee schedule changes implemented by DHHS. Below is a description of each item that was included in the "Historical PMPM Adjustment" tab in the SUD 1115 budget neutrality template. Table 8 illustrates the impact of these adjustments on the SFY22 historical PMPMs, each impacting the proportion of the historical data associated with the Heritage Health capitation rates.

- Provider Rate Increase of 17% effective July 1, 2022 for Behavioral Health providers.
- The SFY22 Q1 time period has been adjusted to reflect the Expansion Benefit Changes effective October 1, 2021, which allowed member who previously were covered under the "Basic" benefit package to be eligible for vision services, over-the-counter drugs, and dental services.
- A new benefit for Continuous Glucose Monitoring (CGM) was effective January 1, 2023 and therefore not reflected in the historical SFY22 PMPMs.
- Removal of an explicit negative adjustment to the SFY22 capitation rates related to the estimated acuity changes due to the continuous enrollment provision of the Public Health Emergency (PHE).

Table 8: Historical PMPM Adjustments

MEG	SFY22 Unadjusted	SFY22 Adjusted	Percent Change
ABD	$2,044.05	$2,074.13	1.5%
Dual	$311.66	$326.65	4.8%
FAM	$625.18	$653.52	4.5%
EXP	$923.95	$946.75	2.5%

Projected Without Waiver PMPMs

The SFY22 Adjusted PMPMs were projected to DY6 through DY10 (shown in Table 9Table 8) using the trend factors included reflected in the current approved 1115 SUD IMD waiver, shown in Table 10. There are 36 trend months between the historical SFY22 period and DY6 of the waiver renewal.

Table 9: Projected Without Waiver PMPMs

		Waiver Renewal – Demonstration Year (DY)				
MEG	**SFY22 Adjusted**	**DY6**	**DY7**	**DY8**	**DY9**	**DY10**
ABD	$2,074.13	$2,306.29	$2,389.32	$2,475.34	$2,564.45	$2,656.77
Dual	$326.65	$363.22	$376.30	$389.85	$403.88	$418.42
FAM	$653.52	$728.78	$755.74	$783.70	$812.70	$842.77
EXP	$946.75	$1,077.30	$1,124.70	$1,174.19	$1,225.85	$1,279.79

Table 10: Trend Rates

MEG	Current Approved Waiver Annual Trend Rates
ABD	3.60%
Dual	3.60%
FAM	3.70%
EXP	4.40%

Budget Neutrality Summary

The Without and With Waiver are equivalent and treated as "Hypothetical" consistent with the current demonstration. The budget neutrality expenditure estimates for SUD 1115 Waiver Renewal are summarized in Table 11 below:

Table 11: Budget Neutrality Expenditure Estimates

	Waiver Renewal - Demonstration Year (DY)					
MEG	**DY6**	**DY7**	**DY8**	**DY9**	**DY10**	**Total DY6-DY10**
ABD	$611,167	$645,116	$680,719	$720,610	$762,493	**$3,420,105**
Dual	$90,442	$95,580	$100,971	$106,624	$112,555	**$506,172**
FAM	$424,879	$449,665	$475,706	$503,061	$531,788	**$2,385,099**
EXP	$2,841,917	$3,026,568	$3,223,152	$3,432,380	$3,655,080	**$16,179,097**
Total	**$3,968,405**	**$4,216,930**	**$4,480,547**	**$4,762,676**	**$5,061,916**	**$22,490,474**

The complete Budget Neutrality workbook is included as Appendix 3.

7 – Compliance with Public Notice and Tribal Consultation

7.1 – Annual Public Forums

Pursuant to 42 CFR 431.420(c), the state held a public forum on Wednesday December 14th, from 2pm to 3pm CST and plans for future public forums in subsequent demonstration years.

7.2 – Public Notice

Public Notice – May 2023

7.3 – Tribal Consultation:

Appendix 1 – Interim Evaluation Report

Appendix 2 – Health Information Technology (HIT) Plan

Appendix 3 – Budget Neutrality Workbook

Appendix 4 – Public Notice (including Tribal Public Notice)