Issue Brief: Oregon's SUD IMD Waiver | October 2024

Oregon SUD IMD waiver mid-point assessment shows advances, lingering barriers to progress

Early implementation results of the 2021 waiver were mixed: progress in reimbursement and telehealth prescribing, but persistent shortcomings in residential beds, staffing, and access to withdrawal management medications

Increasing fentanyl use during the early waiver period made for more complex treatment demands

In April 2021, Oregon became one of 37 states to obtain a Medicaid Section 1115 waiver to help maintain and expand access to treatment for adults with substance use disorder (SUD). The waiver permits federal matching funds for short-term residential treatment in Institutions for Mental Disease (IMDs). It requires progress in such areas as provider capacity, treatment standards and care coordination.

Waiver implementation occurred amid sweeping changes affecting SUD treatment delivery: Oregon's Medicaid program was 10 years into a major restructuring, prioritizing behavioral health integration, care coordination, and social supports; the state was rolling out broader initiatives to bolster response to a widely acknowledged behavioral health crisis, and the arrival of fentanyl in Oregon and the COVID-19 Public Health Emergency (PHE) dramatically shifted the landscape.

The state and providers completed almost all actions in the CMS Implementation Plan by the midpoint and made at least minor progress on just over half of the critical metrics (see list, page 2). Yet efforts were consistently foiled by the inadequacy of the state's toolbox — from a shortage of beds, providers and staff to persistent barriers to providing proven medication-assisted treatment.

KEY POINTS

- **State reimbursement rate increases** improved hiring and retention and hence the array of treatment services.
- **Access to withdrawal medication** remained inadequate due to costly, arduous rules for storing and dispensing; lack of trained providers; and lingering stigma and liability fears around providing medications despite FDA approval and Medicaid coverage.
- **The severity and complexity of fentanyl and of polysubstance use** required more intensive care and longer stays, stymied by length of stay limitations.
- **Lack of detox and residential beds** created months-long wait lists, especially for youth.
- **Staff shortages** spanned all levels of care and certification. Among causes: Higher pay for remote work siphoned the ranks of in-person caregivers.

OHSU

Medicaid reform

Rethinking the IMD Exclusion alone isn't enough. States need medication access, more treatment beds and providers.

About the evaluation

The Oregon Health Authority (OHA) contracted with the OHSU Center for Health Systems Effectiveness to complete the mid-point assessment (2021–2022) of the state's Substance Use Disorder Medicaid Section 1115 Waiver Demonstration Project. The Center used the following data sources:

- Critical metrics: Medicaid claims provided by OHA
- Implementation plan action items: Point-in-time updates of OHA tracking
- Feedback from relevant organizations: Presentations to behavioral health groups on the conduct of the evaluation
- Qualitative findings: Interviews with IMD, SUD program and CCO staff

The report presents assessment findings, cataloging completion of planned implementation actions and assessing changes in milestone metrics between baseline (2021) and mid-point (2022).

The assessment also reports feedback from SUD residential treatment providers and coordinated care organizations (CCOs) about the progress of the SUD treatment system and the risks of not meeting the waiver milestones. The findings inform Oregon's continued implementation efforts and highlight how SUD waivers may affect treatment systems in other states.

Institution for Mental Disease (IMD)

A hospital or facility of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases. **Medicaid does not cover substance use or mental health care in such facilities, except in states with a Section 1115 waiver.** The rule, called the IMD Exclusion, shifts payment for such care to states and counties.

Medication Treatment for Opioid Use Disorder (OUD)

The Food & Drug Administration approved methadone for opioid use disorder in 1972, followed by naltrexone in 1984, and buprenorphine in 2002.

Methadone and **buprenorphine** inhibit opioid withdrawal symptoms. **Naltrexone** blocks the euphoric effect of opioids. (Naloxone, known as Narcan, can reverse an overdose.)

A federal law sponsored by former U.S. Rep. Greg Walden, R-Hood River, in 2018 requires states to cover the medications. However, lingering stigma around addiction extends to the medicines; regulations around storage and dispensing limit purveyors, and a shortage of trained providers further impedes access.

CMS Milestones for SUD waivers

1. Access to Critical Levels of Care for Opioid Use Disorder and other Substance Use Disorders
2. Use of Evidence-based, SUD-specific Patient Placement Criteria
3. Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities
4. Sufficient Provider Capacity at Critical Levels of Care including for Medication Access Treatment for OUD
5. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD
6. Improved Care Coordination and Transitions between Levels of Care

Voices from the front lines of SUD treatment delivery

Some of the report's most valuable insights came from the participants interviewed about their work within Oregon's treatment systems.

Providers comment on challenges

Increasing severity of illness

The severity of illness and complexity of treatment increased with the heightened prevalence of fentanyl, straining the treatment delivery system. People in treatment for fentanyl require more time in withdrawal management and residential treatment to be safely discharged and have a chance at a successful recovery.

I think people up until now have really been treating [fentanyl detox] like a heroin detox or pain pills. And it's not like that. It's harder, and it's longer.

Fragmented policymaking and communication

Some perceived that Oregon either did not have a strategic plan to improve SUD prevention and treatment or was not following its plan. Shifting goals after gubernatorial and state agency leadership changes impeded the focused, cohesive execution of policies. Participants praised the hard work and dedication of OHA staff to improve treatment, yet disorganization, staff instability, misinformation, and siloed communication within OHA caused confusion and a lack of trust between OHA and providers.

Nobody on the state level is on the same page.

OHA had either not solicited or had ignored provider input about how to improve service delivery.

We have (solutions); we know how to work better with our partners… For us, our patients are dying. They're dying because they can't stay longer. They're dying because they can't get the medication they need.

Insufficient residential bed capacity

Oregon is severely deficient in residential treatment bed capacity. Most of the SUD programs reviewed operated at a deficit, tenuously relying on funding streams outside of Medicaid dollars to remain operational.

The (recent) rate increases have been very helpful, but they're only just finally barely getting us to where we can just maybe make it work.

Providers universally described residential care as unique for giving SUD clients time and space to focus on recovery, skill building, and commitment to sobriety without outside distractions and stressors. An appropriate length of stay is equally critical, especially for fentanyl users.

Authorizations for 30 days or less are ***"barely enough time to just get your head on your shoulders and get through the detox process. There's not a lot of time to really learn the skills you need to maintain sobriety in that."***

Challenging hiring and retention environment

Despite state and community efforts to address staffing shortages, participants noted shortages spanning all levels of care and staff types. Expanded options and higher pay for remote work made in-person behavioral health and residential treatment work less appealing for many people, leading to stiff competition in hiring.

I've never seen it be this hard to hire people in the 28 years that I've been in the field, particularly people who hold certifications. And we've had to significantly increase pay, which then has offset the increase in the code reimbursements that we've gotten.

A positive impact of the COVID-19 Public Health Emergency

The expansion of telehealth infrastructure and Medicaid reimbursement during COVID-19 provided an unexpected, ongoing benefit, facilitating continuity of care during the pandemic and increased access to care, including medication-assisted treatment, afterward, especially in rural areas.

Aspirations vs. reality

Requiring cutting-edge and standardized care is a shared goal, yet burdensome amid basic delivery system inadequacies.

Progress Toward Milestones

Following are highlights of the progress and barriers reported at each milestone. For the full list, please see the report.

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

Four metrics (Early Intervention, Intensive Outpatient and Partial Hospitalization, Residential and Inpatient Services, and Withdrawal Management) improved. Three metrics (Outpatient Services, Medication-Assisted Treatment, and Continuity of Pharmacotherapy for OUD) did not. Changes were small to moderate.

Milestone 1: Progress

- OHA increase in daily residential payments helped hiring, retention, and range of services.
- Ability to bill for time spent with individuals before treatment and for community integration service helped program viability.

Milestone 1: Barriers

- Insufficient access to withdrawal management and residential treatment.
- Lack of detox and residential beds: waitlists of one to two months for many programs and up to nine months for youth.
- Waiver's failure to address co-occurring mental health and substance use disorders and challenges finding experienced, qualified clinicians to treat them.
- Overwhelming administrative burden and insufficient technical assistance. Example: The cost of creating the infrastructure for storing and dispensing medications made it difficult to provide medication in-house, and red tape around raising dosage amounts created barriers to access and treatment persistence.

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

Medicaid Beneficiaries Treated in an IMD for SUD improved but by less than 2%. The average length of stay in IMDs decreased slightly from 17.3 days to 16.6 days.

Milestone 2: Progress

Participants generally supported the idea of uniformity across organizations in order to provide quality care. Requiring a shift to "ASAM-like" criteria was deemed a positive step towards easing the burden.

Milestone 2: Barriers

- Integration, use of ASAM time-intensive
  - Still difficult with ASAM-like requirements to make changes to existing assessments. Integrating the criteria in an electronic health record could be problematic, time-consuming.
  - On top of low wages, staff shortages, and provider burnout, participants called the labor required to achieve uniform patient assessments statewide "salt in a wound."

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

No metrics. All action items were completed.

Milestone 3: Progress

Participants viewed enforcement of standard provider qualifications as critical to ensuring quality care and, equally importantly, to the public perception of a competent system. Most felt that the pre-waiver status of residential treatment facilities in Oregon would assist the state in meeting Milestone 3.

Milestone 3: Barriers

- Licensing each level of care was burdensome. Providers saw the need for licensing residential and higher levels of care separately. For lower levels, regular

state audits and certification seemed sufficient.

- Medication-assisted treatment (MAT) providers were in short supply, impeding hiring in-house MAT providers and contracting with external providers.
- Policies reflected a lack of understanding of care delivery and provider operations on the ground, contributing to untenable requirements, such as the requirement to initiate MAT within 72 hours of diagnosing a patient with OUD when providers could not obtain the medication that quickly.

Milestone 4: Sufficient Provider Capacity at Critical Levels of Care Including for MAT for OUD

The number of SUD providers enrolled in Medicaid increased by 11.1% from baseline. The number of MAT providers enrolled in Medicaid increased by 10.6%.

Milestone 4: Progress

- Expanding MAT access quickly is critical to combat the rise in fentanyl use. Provider and client access to services varied widely.
- Providers are more open to using SUD medication as stigma and the perception of provider risk have lessened. Some organizations had prioritized expanding MAT; telehealth was an important catalyst for expanding the prescriber base.
- Changes to federal laws, such as the X Waiver, and Behavioral Health Resource Network funding helped with MAT access.

Milestone 4: Barriers

- Hiring and retaining staff were barriers to MAT access. While some participants had drastically expanded MAT services, most said that the shortage of providers had created a critical lack of access.
- Although the stigma around SUD medication had lessened, some endured. Some programs still predicated treatment on abstinence, and some prescribers still perceived authorizing medication as a liability.

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

All three metrics moved in the desired direction. Improvements were substantial for two measures, Use of Opioids at High Dosage in Persons Without Cancer and ED Utilization for SUD.

Milestone 5: Progress

- Most participants shared at least one example of progress. They acknowledged state successes in supporting access to an array of services, specifically peer support workers, medication prescriptions, and culturally relevant services.
- Some participants noted the ability to supply more Naloxone to clients than possible in the past; two indicated that the waiver had improved the ability to obtain Naloxone and reduced the administrative burden of providing it to clients.

Milestone 5: Barriers

- Prevention efforts were minimal, despite being vital to decreasing SUD.
- Restrictions on coverage for Naloxone persisted. Despite observed gains in Naloxone access and distribution, medication remained expensive, and organizations could not bill for the Naloxone distributed at their facilities. Requiring clients to go to a pharmacy to fill a Naloxone prescription was a barrier.
- Fentanyl and polysubstance use were on the rise, making treatment and recovery longer and more difficult for many clients.

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

Measures for initiation and engagement in SUD treatment mostly showed improvements, but measures for ED follow-up care and readmissions got worse.

Milestone 6: Progress

- Some participants incorporated more integrative services and enlisted partners to increase access to services, noting more collaboration between organizations and community engagement during the waiver period.
- Organizations emphasized the value of the additional reimbursement to fund operations and free up money to be used elsewhere, such as hiring more staff, returning to full capacity post-COVID, providing better support for client transitions, and helping cover uninsured clients.

Milestone 6: Barriers

- Care coordination required time outside of care delivery that participants did not have.
- Large caseloads, understaffing, and lack of clinician training made coordination across facilities challenging.
- Interoperability between different electronic health records systems was limited.

There were additional limitations around billing for peer providers, such as being unable to bill for drop-in hours, that did not always align with best practices.

Recommendations

The following are the most critical recommendations. For a more detailed list, please see the report.

- **Standardize requirements** across the coordinated-care organizations.
- **Continue outreach** to providers for technical assistance.
- **Continue efforts** to increase OUD medication treatment, including:
  - Outreach to providers to reduce stigma.
  - Incentives to recruit new providers as substance use medication prescribers, especially for buprenorphine and other non-methadone options.
  - Support OUD medication treatment in opioid treatment programs, including ways to collaborate with providers on wraparound services and care coordination.
  - Continue to allow the use of telehealth for OUD medication treatment, especially in rural areas where transportation is a major barrier to access.

CENTER FOR HEALTH SYSTEMS EFFECTIVENESS

This Issue Brief was produced by CHSE in its role as independent external evaluator for the Oregon Health Authority's Section 1115 SUD IMD waiver.

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