Budgeting for Results

Department of Human Services
Division of Substance Use Prevention and Recovery

Illinois Methadone Maintenance Program Report

Table of Contents

Introduction

The statute that created Budgeting for Results (BFR) states that in Illinois, "budgets submitted and appropriations made must adhere to a method of budgeting where priorities are justified each year according to merit" (ILCS 20/50-25). The BFR Commission, established by the same statute, has worked since 2011 to create and implement a structure for data-driven program assessment useful to decision makers. The BFR framework utilizes the Results First benefit-cost model and the State Program Assessment Rating Tool (SPART) to produce comprehensive assessments of state funded programs.[i]

The Pew-MacArthur Results First Initiative developed a benefit-cost analysis model based on methods from the Washington State Institute for Public Policy (WSIPP). BFR has adapted this model to correspond to our State's specificities. The Budgeting for Results model is utilized to analyze programs within multiple policy domains, including adult crime, juvenile justice, substance use disorders, K-12 and higher education, general prevention, health, and workforce development.

The State Program Assessment Rating Tool (SPART) combines both quantitative (benefit-cost results) and qualitative components in a comprehensive report. It is based on the federal Program Assessment Rating Tool (PART) developed by the President's Office of Management and Budget and has been modified for Illinois use.[ii] The SPART provides a universal rating classification to allow policy makers and the public to more easily compare programs and their performance across results areas.

Methods

BFR begins each assessment by examining an Illinois program's design and assessing its implementation. Each program is then matched with an existing rigorously studied program or policy in the Results First model. BFR completes a comprehensive review of related program literature to inform the matching process.

Each rigorously studied program has an effect size determined by existing national research that summarizes the extent to which a program impacts a desired outcome. The effect size is useful in understanding the impact of a program run with fidelity to established core principles and best practices.

The Budgeting for Results benefit-cost model uses the effect size combined with the state's unique population and resource characteristics to project the optimal return on investment (OROI) that can be realized by taxpayers, stakeholders, and others in society when program goals are achieved.

The SPART contains summary program information, historical and current budgetary information, the statutory authority for the program, and the program's performance goals and measures. The SPART tool consists of weighted questions which tally to give a program a numerical score of 1-100. Numerical scores are converted into qualitative assessments of program performance, including effective, moderately effective, marginal and not effective.

Section 1

Program Overview

Report Summary

The major takeaways from this analysis can be found in Table 2 below along with the program's comprehensive SPART score.

Table 2: Report Summary

Illinois Department of Human Services, Division of Substance Use Treatment, Prevention and Recovery	Illinois Methadone Maintenance Treatment Program[iii]
Optimal Benefits	$14,105
Real Cost (Net) per participant	$5,200
Benefits – Costs (Net Present Value)	$8,905
Benefits/Costs (OROI)	$2.71
Chance Benefits Will Exceed Costs	94%
SPART Score	Moderately Effective, 74

The optimal return on investment calculated by BFR on the IDHS/SUPR methadone maintenance treatment program determined that for every one dollar spent by IDHS/SUPR, $2.71 of future benefits from reduced crime, reduced death, reduced opioid use disorder by program participants, Illinois taxpayers and crime victims.

Program Overview – Illinois Methadone Maintenance Program

About Opioid Use Disorder

Opioid use disorder (OUD) is a chronic, treatable illness that requires continuing care for effective treatment. Treatment for OUD relieves symptoms, stabilizes the patient, and helps establish and maintain recovery. Because there is no "one size fits all" approach to OUD treatment, care is patient-centric and individualized to best meet the needs of each patient. Many people with OUD benefit from methadone maintenance treatment for varying lengths of time, including lifelong treatment, and some patients benefit from different levels of care at different points in their recovery, such as outpatient counseling, intensive outpatient treatment, inpatient treatment, or long-term therapeutic communities. Patients with OUD have access to mental health services, medical care, addiction counseling, recovery coaching, medication management, and recovery support services.[iv]

Core Components

Methadone maintenance treatment (MMT) constitutes a component part of a larger complex of evidence-based treatment services for opioid use disorder (OUD) known as medication assisted recovery (MAR). Opioid use disorder is a chronic medical condition caused by the repeated use of opioids, including prescription drugs such as oxycodone and hydrocodone, and illicit substances such as heroin or fentanyl. The Illinois Department of Public Health (IDPH) defines MAR as the use of medications, alongside counseling and behavioral therapies, to treat opioid use disorder.

Methadone maintenance treatment, as a part of MAR, is a "whole-patient" approach that combines the use of medications, counseling and behavioral therapies with wraparound mental and social support services. This process leads to the best outcomes, according to the most recent research, by normalizing the patient's brain chemistry, blocking the euphoric effects of opioids, and relieving the physical cravings and other symptoms associated with opioid use disorder.

Recovery from opioid use disorder is a voluntary, self-directed, ongoing process where patients access formal and informal resources; manage their care and their addiction; and rebuild their lives, relationships, and health to lead full meaningful lives. In addition to dispensing medication, successful recovery requires the use of support services which may include follow-up phone calls, face-to-face meetings, emails, peer-to-peer services, procedures that address patients' mental health problems, and ongoing recovery management that support patients' recovery within their own environment.[v]

The following paragraphs detail the core components of the Methadone Maintenance Treatment program.

Clinical Assessment

Each patient receives a full clinical biopsychosocial assessment by a licensed or certified clinician to determine their individualized treatment program. Through this assessment, the physician determines the medication treatment schedule and dosage for the patient along with concomitant residential or outpatient treatment services, including individual or group counseling and access to long-term therapeutic communities. The full-scale assessment constitutes an integral part of methadone maintenance treatment.

Toxicology, Testing, and Screening for Drug Use

The initial assessment also includes toxicology testing as part of the admissions process. These admissions samples are tested, at a minimum, for opioids, methadone, buprenorphine, amphetamines, cocaine, marijuana, and benzodiazepines. Additional testing is based on the individual patient's needs and localized drug use patterns and trends. All maintenance patients receive a minimum of eight toxicology tests per year for the purposes monitoring and progress evaluation for long-term recovery. [vi]

Case Management

Each patient's recovery is monitored by a case manager or counselor, and case managers make modifications to the patient's treatment program based on that patient's individualized needs. Modifications to participation in individual or group counseling, therapy, and access to take-home dosages of medication are made through a collaborative process that includes the patient, his or her case manager, and the licensed clinician.

The effectiveness of each patient's treatment plan is evaluated at regular intervals (quarterly) and the plan's effectiveness is based on the patient's progress toward the identified recovery goal. The patient's progress through treatment determines his or her progression though each stage of the treatment plan; while some patients may stay on one stage for a considerable period, others may progress more rapidly through the stages of treatment and recovery. Research indicates that the best recovery outcomes are directly related to the duration of retention in maintenance treatment. Patients may remain in treatment for as long as clinically appropriate, medically necessary, and acceptable to the patient; maintaining a patient on maintenance treatment is beneficial to both the patient and the public health.[vii]

Medication Distribution

After receiving a full clinical assessment, a patient may be prescribed medication for OUD on a short-term or long-term basis. The best results occur when a patient receives medication for as long as the medication continues to provide a benefit. This is known as "maintenance treatment." Maintenance treatment minimizes cravings and withdrawal symptoms and gives patients the time and ability to make the necessary life changes associated with long-term recovery. Medication for OUD is integrated with outpatient or residential treatment services, as determined by the individualized clinical assessment and treatment program. Medication is available to patients across all settings and at all levels of care as a tool for recovery.

The OTP program physician is the only practitioner authorized to order and change a patient's dosage of methadone and the physician makes his or her decision based on the patient's individualized assessment and treatment program and the physician's decision is informed by clinical judgement. Regulations stipulate that the initial, day-one dose of methadone should not exceed 30 mg unless the physician documents his or her carefully thought out justification for exceeding that dosage amount. The total amount of methadone administered on day one must not exceed 40 mg. This is because methadone has a long half-life that accumulates in the body with repeated dosing; the full effect of a single dose may not be appreciated for several days. The total dose and interval between doses are adjusted for each patient's individual heath particularities.[viii]

Take-home medication constitutes an important therapeutic tool that lends itself to the individualized characteristics of each patient's individualized treatment plan. A patient must meet time-in-treatment requirements to be considered for take-home medication, and the primary clinician in tandem with the medical director conducts a holistic assessment of the patient's ability to responsibly handle the unsupervised use of take-home medication and if the therapeutic benefit outweighs the risks the medical director may make a final decision to approve or rescind any patient's use of take-home medication.[ix]

Treatment Services

Based on each individual patient's clinical assessment and recovery needs, he or she receives either residential or outpatient treatment services. Within a residential treatment placement setting, clients are continually assessed and receive treatment based on their current needs. The primary goal of residential treatment is to provide a client with a structured environment that interrupts his or her usage pattern and optimizes a positive treatment outcome. Residential treatment settings are professionally staffed therapeutic communities that provide clinical programming and support 24-hours a day to develop clients' recovery skills. These therapeutic communities allow for the emergence of a social network that provides support for the client in recovery.

Outpatient treatment services include the use of highly structured and focused treatment sessions in either group or individual settings where patients are educated on the intricacies of addiction and recovery. These sessions address the patient's personal addictive history and use patterns and provide the patient with concrete strategies to interrupt patterns of drug use and addiction. Employment, family, legal, and mental health concerns are also addressed in a holistic manner. Patients attend a minimum number of hours of counseling per week and are provided with periodic drug screenings to track and maintain recovery progress.

Medically Supervised Withdrawal

Over the course of the treatment program, patients may want to stop methadone maintenance treatment by gradually tapering doses of the medication. The physician may initiate medically supervised withdrawal at the request of the patient. During medically supervised withdrawal, the physician reduces dosages of medication at a rate in accordance with sound clinical judgement and close observation of the patient. Because of the risk of fatal overdose and relapse, patients undergoing medically supervised withdrawal continue to receive psychosocial and recovery support services and are monitored during and after the dose taper. Successful outcomes are based on factors such as the length of treatment, abstinence from illicit drugs, financial and social stability and motivation to discontinue medication.[x]

Target Population

This program aims to assist Illinoisans affected with OUD to achieve and maintain a state of recovery. Individuals whose financial or personal circumstance pose a barrier to treatment are eligible to have their Methadone Maintenance Treatment (MMT) paid by the State's Illinois Methadone Maintenance Treatment program.

Figures 1-3 document demographic information collected by Illinois Department of Public Health (IDPH) and graphed for a presentation for the Opioid Advisory Council.[xi] The charts describe the demographics

of individuals with opioid use disorder and illustrate a disparity among the population where the majority are male, 50-69, and/or black.

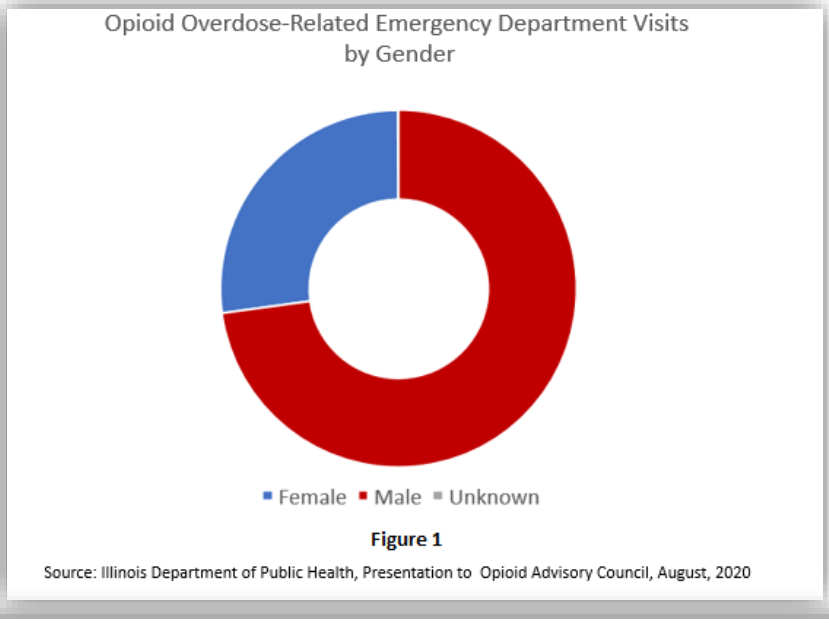


Figure 1

Source: Illinois Department of Public Health, Presentation to Opioid Advisory Council, August, 2020

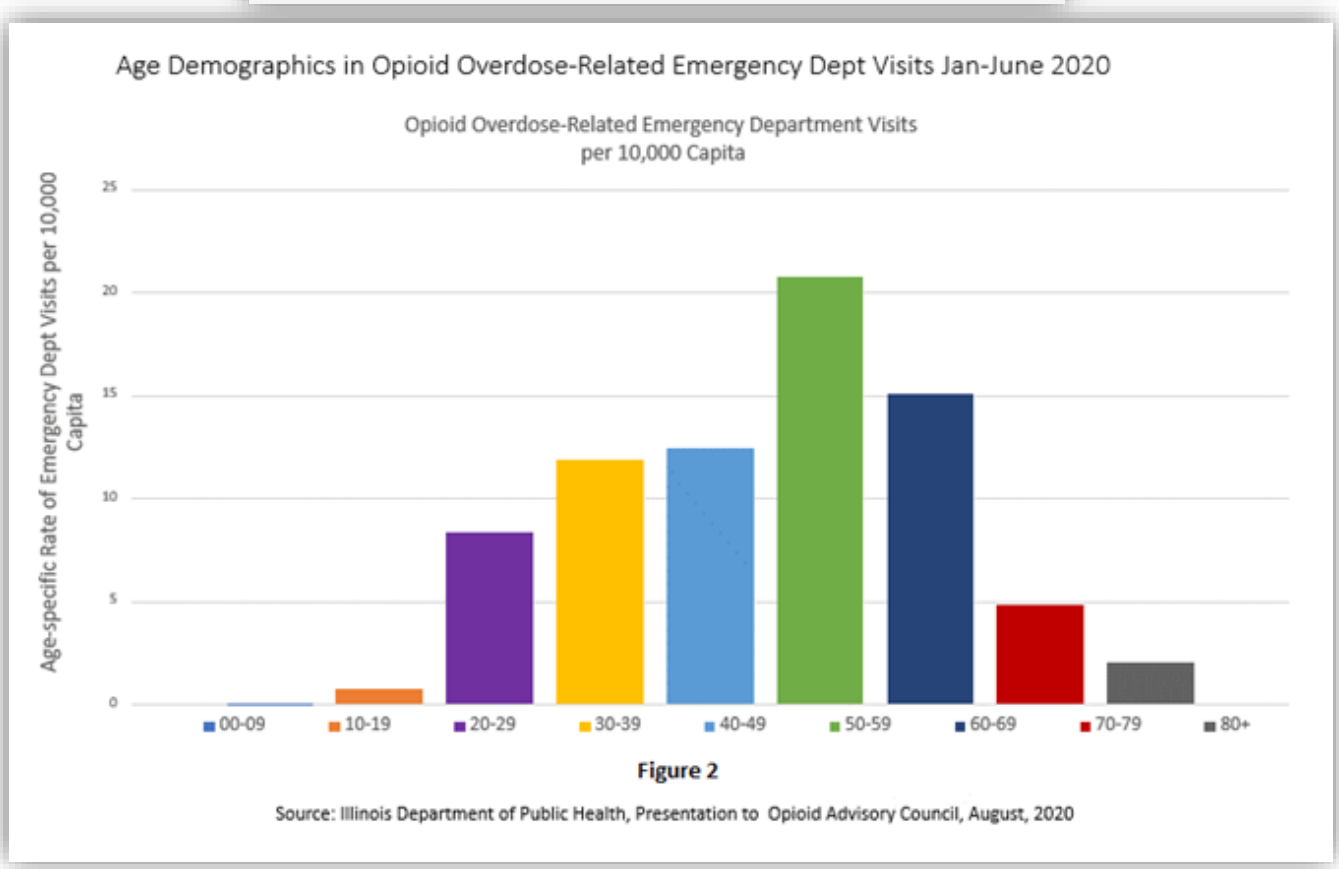


Figure 2

Source: Illinois Department of Public Health, Presentation to Opioid Advisory Council, August, 2020

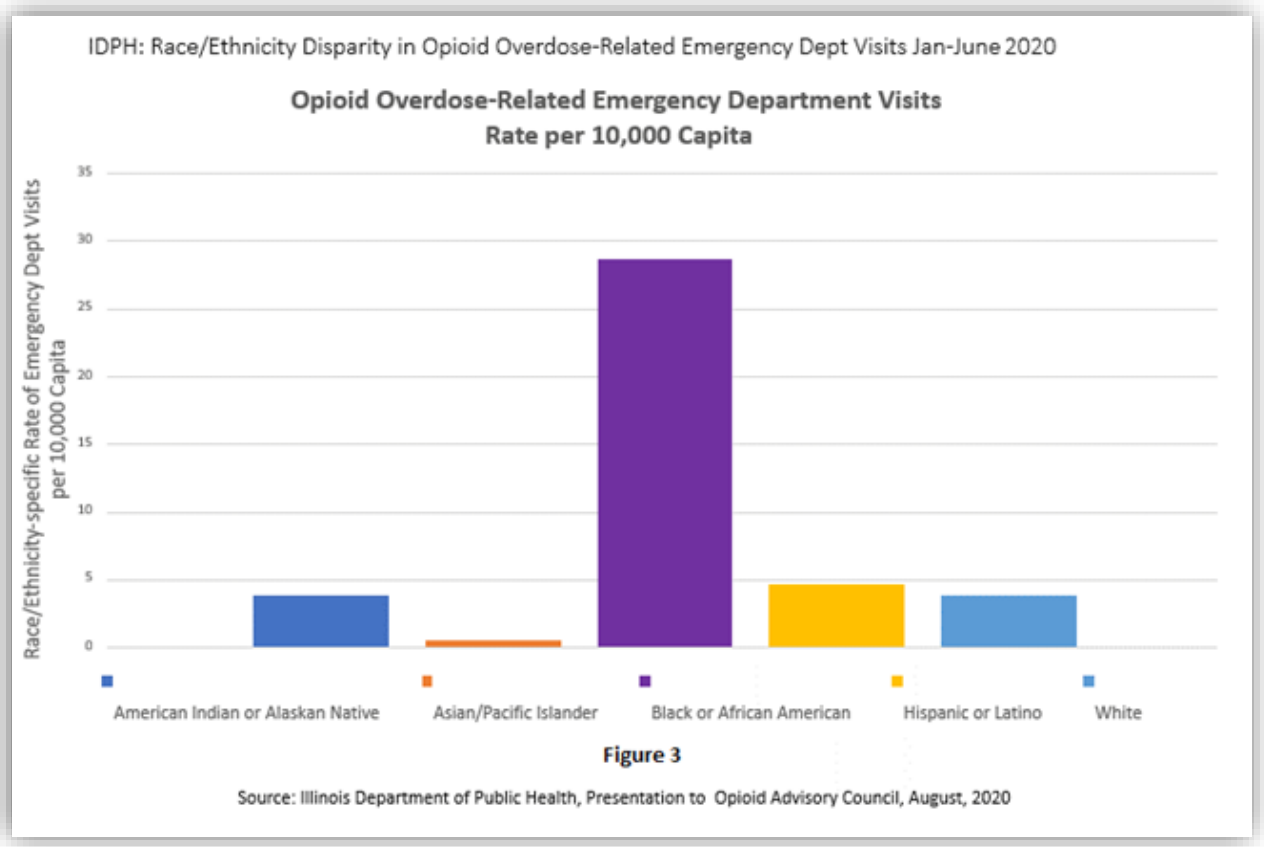


Figure 3

Source: Illinois Department of Public Health, Presentation to Opioid Advisory Council, August, 2020

Opioid Use Disorder in Illinois

Illinois finds itself amid a public health and safety crisis caused by the opioid epidemic and characterized by an alarming rate of opioid overdose deaths. Opioid use disorder is a chronic disease and opioid overdoses have claimed the lives of too many Illinoisans, but recovery is possible. In 2018, for the first time in five years, Illinois saw a slight decrease in opioid related deaths. However, this progress in treatment was complicated by the onset of the COVID-19 pandemic. In the first three quarters of 2020, the number of fatal opioid overdoses increased by 36% as compared to the same period the previous year. Illinois also saw the annual number of opioid overdose-related emergency department visits increased 16.8% and emergency medical service encounters increased 20.9% in 2020 compared to 2019. Growing social and racial disparities exist in the opioid crisis and minority communities have been disproportionately impacted by the crisis. Certain communities have disproportionately suffered the harms of enforcement of drug laws and their residents face greater difficulties accessing opioid use disorder treatment. [xii]

The Illinois Department of Human Services Division of Substance Use Prevention & Recovery (IDHS/SUPR) has been firmly committed to addressing this troubling epidemic through evidence-based policies and programs like prevention, education, and treatment. One method of assisting Illinois residents battling opioid use disorder is through the Methadone Maintenance Treatment program.

Access to Treatment

In June 2020, analyses showed that Illinois has 39 counties that are "MAR deserts," or counties that lack access to medication assisted recovery services. Approximately 629,053 Illinoisans do not have access to MAR anywhere in their county.

IDHS/SUPR's Access to Medication Assisted Recovery (A-MAR) project seeks to remedy this lack of access by broadening services in MAR deserts. The A-MAR project utilizes an evidence-based hub and spoke model that connects regional opioid treatment centers with primary care practices to provide clients with treatment and other recovery support services.[xiii] Methadone Maintenance Treatment does have a limitation where methadone can only be administered through an opioid treatment center (the hubs) and cannot be received by primary care providers (the spokes). IDHS is working on expanding access to medicated assisted recovery through "spokes" using other medication and providers.

To increase access to MAR, the Medication Assisted Recovery Committee of the Illinois Opioid Crisis Response Advisory Council recommends making the telehealth policies established during the COVID-19 pandemic permanent; telehealth can reach people with OUD in rural and MAR desert areas of the state by reducing transportation barriers and allowing clients to receive treatment in the privacy of their own homes.[xiv]

Program Funding

Since September 2016, the IDHS/SUPR has been awarded over $110 million across four federal grants to address the opioid crisis from the Substance Abuse and Mental Health Services Administration (SAMHSA), a branch of the U.S. Department of Health and Human Services (HHS).[xv] Methadone maintenance treatment is one core program supported by these federal grants. Methadone maintenance treatment also receives funding from the state of Illinois' general revenue fund, and patients receiving methadone maintenance treatment either pay privately or bill their treatment costs to the state Medicaid program or IDHS/SUPR.

Table 1 below shows the appropriations and expenditures for IDHS/SUPR which are used as a last resort to pay for methadone treatment for patients that do not have Medicaid and are unable to pay privately. This fiscal information was obtained through IDHS/SUPR.

Table 1: Illinois Methadone Maintenance Treatment Program Appropriations and Expenditures by Fiscal Year

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Appropriated	$20,380,007	$20,033,358	$11,520,280	$9,149,729	$10,764,250
Expended	$18,779,098	$10,952,584	$6,876,009	$7,404,756	Not Yet Available

Section 2

Benefit-Cost Results

Benefit-Cost Results – Illinois Methadone Maintenance Treatment Program

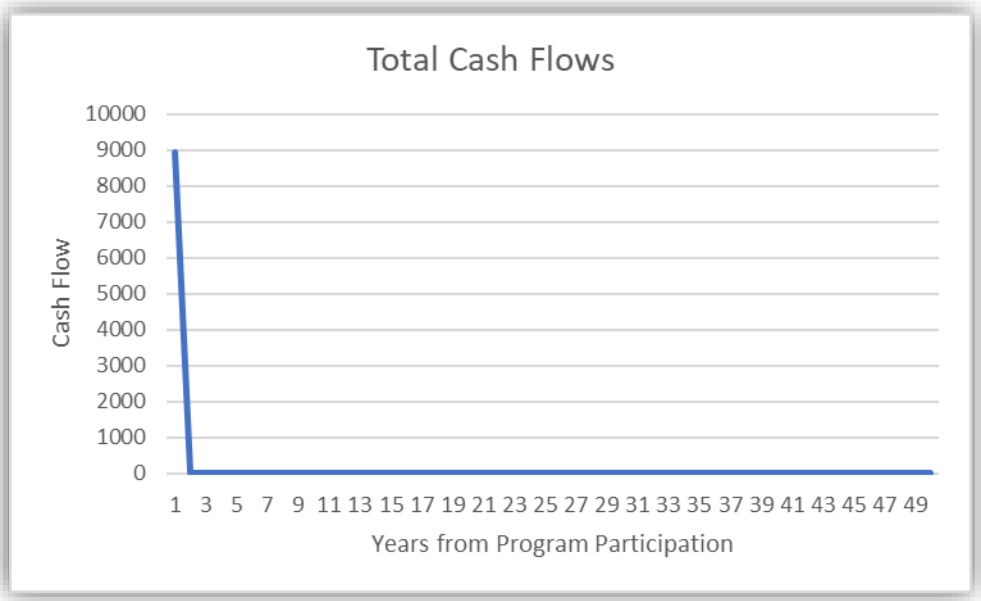
The benefit-cost model is based on a meta-analysis methodology where outcomes are quantified by calculating effect sizes that are derived from the results of credible research on the topic of Methadone Maintenance Treatment.

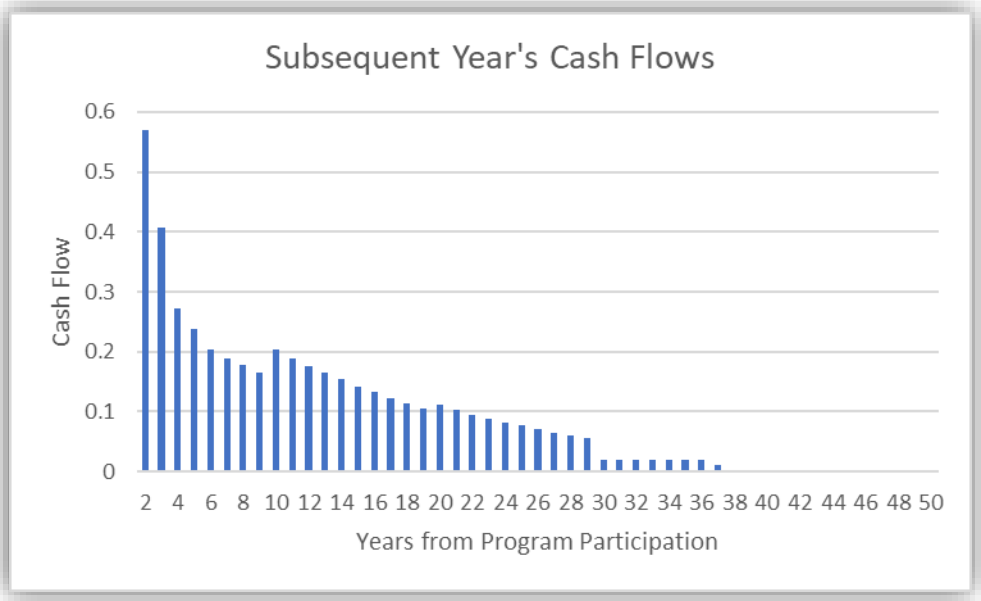
The annual costs and benefits for the IDHS/SUPR methadone maintenance treatment program can be seen below in *Figure 1*. Expenses for the program include an initial assessment upon entry to the program, reoccurring toxicology tests, case management, the dispensing of methadone, and individual/group counseling. Each participant receives a unique mixture of services tailored to their needs. For example, an individual recovering from a prescription drug addiction may require a different set of services compared to somebody recovering from a heroin addiction. Another factor in treatment costs is the duration in which the participant has been receiving MMT. Those just starting in MMT require more support and wraparound services. MMT is provided by SUPR licensed SUD providers within the State. Most of the patients receiving methadone maintenance treatment provide payment through Medicaid or through a private payer. Individuals whose services are paid by SUPR meet the following criteria:

- Income eligibility requirements are set by each provider to reflect what is appropriate for their area. For example, if the area has a higher standard of living, a higher income threshold may be set.
- The primary goal for SUPR paid services is that the inability to pay is not the reason an individual does not receive needed treatment.
- SUPR is the payer of last resort. Therefore, the individual does not have Medicaid or Private Insurance.
- An Individual may receive SUPR paid services if the services they are receiving are not eligible for Medicaid Payment. However, if the service is denied because it was not a medical necessity, SUPR cannot be charged for the service.
- SUPR considers personal circumstances of each client. For example, SUPR may justify paying for adolescent services if the youth is not comfortable talking to a guardian about treatment needs. An individual in a domestic abuse situation that does not want their spouse aware and/or involved in the treatment services may justify SUPR payment.

The average annual cost for each program participant is estimated to be $5,195. With the average total benefits around $14,113, the net present value for each participant engaging in the program is about $8,918. The return on investment per dollar spent is $2.72 with a 94% probability that the net present value will be positive for each participant. All the benefits are realized within the first year of the program and no additional benefits are seen upon exiting.

Figure 4





As indicated in *Figure 1,* the benefits are accrued immediately upon entering the program. *Figure 2* shows the benefits by recipient. The majority of the benefits are seen in an "Indirect" category which encapsulates the value of a statistical life (VSL). In other words, by entering the methadone maintenance treatment program, the risk of the individual dying due to their addiction decreases which then increases the VSL. Additional indirect benefits accrue to society as well. When tax revenue is spent on one program, it has an opportunity cost of revenue that cannot be spent on other beneficial programs and services like public

safety or economic development. Money that is taxed is also not available for private consumption and investment. The indirect benefits of making effective, economically efficient investments to reduce opioid use disorder are quantified within the BFR model using the deadweight cost of taxation. This inefficiency creates both a benefit and a cost in this model – the initial spending on the program generates a cost. Savings for Illinois due to reduced opioid use disorder decreases the deadweight cost of inefficient government taxation and spending. The deadweight cost of initial program spending is subtracted from indirect benefits in the first year. Other major areas of benefits that have been monetized are the reduction of healthcare costs and increased earnings.

Examples of these benefits can be seen throughout research conducted on this program. For instance, one study observed the rehabilitation of Swedish heroin addicts. Of 174 participants, 75% discontinued their drug abuse behavior and began working; 71% of the those that once engaged in prostitution started a regular job. The control group of this study, the individuals that did not receive methadone as a maintenance treatment, saw a death rate at least 73 times higher than the treatment group.[xvi]

The IDHS/SUPR methadone maintenance treatment program's benefits to Illinois are based mostly on decreased substance use disorder for program participants, avoided state medical costs and avoided private costs incurred as a result of fewer crime victims. The private victimization costs include lost property, medical bills, wage loss, and the pain and suffering experienced by crime victims.

Better outcomes for participant employment as opposed to alternative available treatments lead to increased tax revenue for the state and a decreased need for taxpayer services.

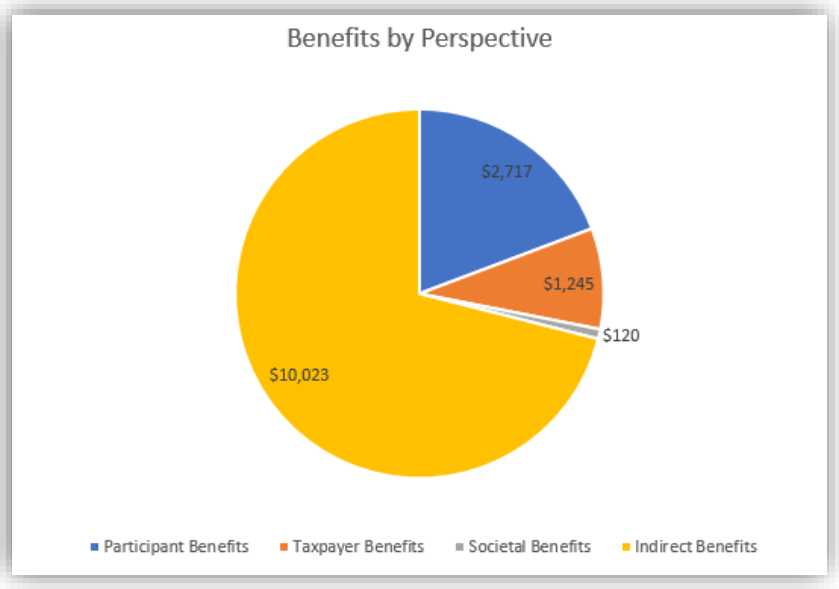


Figure 5 - This program is modeled with a one-year duration and most of the benefits are from avoided healthcare use and death during the year of treatment. A small amount of benefit is realized for subsequent years after the initial program entry due to increased earning and crime.

All program benefits are predictive, and there is uncertainty when forecasting future outcomes. To help account for the uncertainty, BFR runs each benefit-cost analysis 10,000 times with random variations in the costs and benefits. The optimal program benefits exceeded the program costs in 94 percent of the simulations.

Section 3

State Program Assessment Rating Tool

State Program Assessment Rating Tool (SPART)

Methadone Maintenance Treatment Program

444 – Department of Human Services

This report was compiled by the Budgeting for Results Unit of the Governor's Office of Management and Budget with the support of the Department of Human Services (DHS). The SPART is an assessment of the performance of state agency programs. Points are awarded for each element of the program including: Program Design and Benefit-Cost and Performance Management/Measurement. This combined with benefit-cost analysis through Results First establishes an overall rating of the program's effectiveness, which can be found on the final page of this report.

Part 1: General Information

Is this program mandated by law? Yes __ No __X[xvii]
Identify the origin of the law: State __ Federal ___ Other ___
Statutory Cite: The Substance Use Disorder Act (20 ILCS 301)
Program Continuum Classification: Recovery

Evaluability

Provide a brief narrative statement on factors that impact the evaluability of this program.

In Illinois, performance measures are not set at the treatment component level. MAR interventions do not clearly isolate performance outcomes at the treatment component level. Because SUPRs is not able to quantify data specific to Methadone Maintenance Treatment program, this report cannot provide conclusive evidence that the effects produced in national research are recreated in Illinois through this program. This report cannot conclude the degree to which Illinois implemented the Methadone Maintenance Treatment program in fidelity to the evidence-based best practices.

Key Performance Measure	FY 2017	FY 2018	FY 2019	FY 2020	Reported in IPRS Y/N
N/A					

Part 2: Program Design and Benefit-Cost **Total Points Available: 55**

Total Points Awarded: 55

Question	Points Available	Evidence Level	Points Awarded
2.1 What is the program evidence level? - Evidence Based 25pts - Theory Informed 15 pts - Unknown Effect 0 pts - Negative Effect -5 pts Describe the evidence base reviewed.	25	Evidence Based	25

Explanation:

The Illinois Department of Public Health Division of Substance Use Prevention and Recovery (IDHS/SUPR) endorses methadone maintenance treatment as an evidence-based approach for the treatment of opioid use disorder. The American Society of Addiction Medicine (ASAM) maintains in its national practice guidelines that the use of assistive medications like methadone in combination with behavioral services sustains recovery better than just medication or behavioral services on their own. [xviii]

A large body of clinical literature documents the effectiveness of methadone maintenance treatment in decreasing opioid-related overdose deaths, illicit opioid use, criminal activity, and the transmission of infectious diseases like HIV and Hepatitis C, while increasing patients' social functioning and their retention in OUD treatment.[xix]

	Question	Points Available	Yes/Partial/No	Points Awarded
	2.2 To what extent is the program implemented and run with fidelity to the program design? Describe the core components of the program as designed and as implemented in Illinois.	25	Yes	25

Explanation:
Opioid Treatment Providers (OTP) are all licensed by SUPR, certified by the federal government, and registered with the DEA. The licensing process is initiated at the State level by verifying that the provider meets the standards set in the Illinois Administration Code, Rules 2060 and 2090.[xx] The federal level certification is reviewed and granted by SAMSHA whom outlines their requirements as a part of the Federal Guidelines for Opioid Treatment Programs.[xxi] These organizations set the standards for MMT and conduct audits of the programs.

At minimum, every three years SUPR conducts an audit on these providers to review their policies, procedures, personnel, and patient files to verify that they are meeting the minimum standards of Administrative Rules 2060 and 2090.

	Question	Points Available	Yes/Partial/No	Points Awarded
	2.3 To the extent that the program did not receive full points in question 2.2, has the program been adapted responsibly according to competing best practices in the field, or have modifications been made due to under-resourcing or for other reasons?	(15)	N/A	N/A

Explanation:
Not Applicable.

	Question	Points Available	Yes/Partial/No	Points Awarded
	2.4 If the program achieved full credit in question 2.2, can we expect the Optimal Return on Investment (OROI) for this program to be equal to or greater than $1 for each $1 spent?	5	Yes	5

Explanation:
See section 2 **–** Benefit Cost Analysis.

Part 3: Performance Management/Measurement **Total Points Available: 45**

Total Points Awarded: 19

Question	Points Available	Yes/Partial/No	Points Awarded
3.1 Does the program regularly collect timely and credible performance measures? Partial points may be awarded for an existing but not yet implemented plan for a performance measure regime.	10	No	5

Explanation:

According to federal guidelines (42 CFR 8.12(c)), an OTP must maintain current quality assurance and quality control plans that include, among other things, annual reviews of program policies and procedures and ongoing assessment of patient outcomes. The Center for Substance Abuse Treatment and the Substance Abuse and Mental Health Services Administration (SAMHSA) recommends OTPs measure outcomes continuously to improve treatment quality. Administrators and staff are encouraged to implement program evaluation processes to improve treatment based on evidence and data.[xxii]

While the OTP is required to maintain outcome records, IDHS/SUPR does not currently request or review this information from the providers in order to conduct performance measurements. SUPR staffing and technological are factors in limiting their oversite. Technology is limited to collecting and reporting provider claim information. Existing operational structures do not support key functions including auditing, monitoring, and evaluation of the program, providers, and participants.

Another factor that hinders IDHS/SUPR's ability to collect regular and timely information on program participants is the longevity of the program. Methadone maintenance treatment does not have a specific admit and discharge date as seen in other substance use disorder recovery programs such as inpatient treatment. The program is designed to occur over years or even for the remainder of the participant's life. The current infrastructure of data collection in their DARTs system is defined by the status of a set suite of outcomes at the time of admittance and after discharge. In order to navigate this difficulty, the Budgeting for Results team recommends, at minimum, understanding the number of people receiving SUPR-assisted methadone maintenance treatment. In addition, a survey of quality-of-life indicators such as education status, housing situation, employment, social connectivity, etc., should be administered upon entry to the program and every year thereafter.

	Question	Points Available	Yes/Partial/No	Points Awarded
	3.2 Do the performance measures focus on outcomes?	5	No	3

Explanation:
Performance measures are not collected for this program.

However, as a requirement of the Federal Block Grant, SUPR is required to submit performance measures for the umbrella of Substance Use Disorder treatment programs they offer. This information appears in a summarized format that aggregates all SUD treatment programs. Outcome information is reported through this report including employment status, school enrollment, housing situation, criminal activity, alcohol use abstinence, drug use abstinence, and participation in recovery programs. For this reason, we are assigning partial credit for this question.

	Question	Points Available	Yes/Partial/No	Points Awarded
	3.3 Do the performance measures include data on program implementation and fidelity to core principles?	5	No	0

Explanation:
Desired outcomes are documented for each individual by OPTs according to the SUPR Contractual Policy Manual and are available for SUPR to review upon request. However, SUPR is currently only receiving and reviewing claim information submitted by the provider. The division is limited by claim software capabilities which make it very difficult to analyze raw data to identify any measurements on program implementation and fidelity to core principles.

Question	Points Available	Yes/Partial/No	Points Awarded
3.4 Are independent and thorough evaluations of the program conducted on a regular basis or as needed to support program improvements and evaluate effectiveness?	5	Yes	3

Explanation:
Performance evaluations specific to how OTP providers administered the MMT program are not conducted by SUPR's instruction in Illinois. However, on-going clinical research is conducted on Methadone Maintenance Treatment and Opioid Use Disorder. SAMSHA updates their guidelines based on findings and communicates those with the OTP providers.

Question	Points Available	Yes/Partial/No	Points Awarded
3.5 Does the agency use performance information (including that collected from program partners) to adjust program priorities or allocate resources?	5	No	3

Explanation:
The methadone maintenance treatment program is a subset of IDHS/SUPR's overall initiative of Access to Medication Assisted Treatment (A-MAR). This program seeks to expand services where there are Medication Assisted Recovery (MAR) "deserts." These deserts are defined as counties without providers that offer MAR services. MAR services include methadone, buprenorphine, and naltrexone.

Methadone has a limitation where only SUD clinics can administer the drug. In contrast, Buprenorphine can be prescribed by a primary care provider (PCP) which allows for a much more flexibility in the expansion of the MAR network of providers offering this type of opioid recovery option. Understanding the limits of methadone, IDHS/SUPR has implemented a "hub" and "spoke" model of MAR OTP providers where IDHS/SUPR is working to expand services to those counties that have been flagged as deserts.

For the above, partial points are awarded. The Budgeting for Results Unit recognizes the importance of the overall program goals of the A-MAR program. However, the Unit is interested in seeing more specific applications of adjusting program priorities or resource allocations specific to the methadone maintenance treatment program.

Question	Points Available	Yes/Partial/No	Points Awarded
3.6 Does the agency use performance information to adapt program implementation or take other appropriate management actions?	5	Yes	0

Explanation:
Desired outcomes are documented for each individual by OPTs according to the SUPR Contractual Policy Manual and are available for SUPR to review upon request. However, SUPR's program analysis capacity is limited to claim information submitted by the provider. Technical limitations within the claim software restrict SUPRs ability to analyze the raw data to identify potential issues or opportunities for modifications or alternate action.

Question	Points Available	Yes/Partial/No	Points Awarded
3.7 Are key performance measures for this program reported in the Illinois Performance Reporting System? Partial points may be awarded if key performance measures are not reported in IPRS but are made available to the public through other means.	10	Partial	5

Explanation:
IDHS/SUPR's A-MAR program has released annual progress reports since 2019. The performance measures indicated in the report are acceptable as outcomes for the entire A-MAR program whose scope is larger than the methadone maintenance treatment program.

Similarly, IDHS/SUPR provides performance metrics in IPRS, but the performance measures are not specific to the outcomes of the Substance Use Prevention and Recovery (SUPR) division of IDHS.

The Budgeting for Results unit recommends a more detailed reporting of performance measurements due to the differences in the role SUPR has in recovery/treatment depending on the medication provided. In the case of Methadone Maintenance, SUPR acts as a payer of last resort and provides reimbursement for low income, uninsured individuals. In contrast, SUPR licenses providers to prescribe buprenorphine. A distinction between these two methods of providing MAR should be made in reporting measures.

Concluding Comments

The Methadone Maintenance Treatment program as detailed in the national model is a highly efficient and effective program evidenced through a large body of clinical research literature. In Illinois, OPT's deliver this program under the umbrella of A-MAR. Under contract terms, SUPR has authority to monitor, audit, and evaluate this program. This program assessment recognizes an opportunity to improve performance evaluation of MMT outcomes to strengthen data and inform decision-making to best target these funds to effectively serve this high-risk population.

IDHS/SUPR is required to collect and submit data for programs funded in part by the Federal Block Grant. With MMT being one part of the suite of programs using those grant dollars, the Budgeting for Results Unit understands that the outcomes of this program are captured within existing reporting under the large "umbrella" program, Accessing to Medication Assisted Recovery (A-MAR). The desired goals, performance measurements, and outcomes of A-MAR are clearly stated, however, it is not possible to extract performance information, detailed monitoring and auditing efforts specific to Methadone Maintenance Treatment program.

Furthermore, SUPR is unable to extract program information to quantify outcomes and make informed decisions for the improvement of the program. The division desires to improve program oversight and needs to expanded capacity to be able to more adequately monitor, audit, and evaluate the efficacy of this program.

Final Program Score and Rating o

Final Score	Program Rating
Moderately Effective	74

SPART Ratings
Programs that are <u>PERFORMING</u> have ratings of Effective, Moderately Effective, or Adequate.

- <u>Effective.</u> This is the highest rating a program can achieve. Programs rated Effective set ambitious goals, achieve results, are well-managed and improve efficiency. Score 75-100
- <u>Moderately Effective.</u> In general, a program rated Moderately Effective has set ambitious goals and is well-managed. Moderately Effective programs likely need to improve their efficiency or address other problems in the programs' design or management in order to achieve better results. Score 50-74
- <u>Marginal.</u> This rating describes a program that needs to set more ambitious goals, achieve better results, improve accountability or strengthen its management practices. Score 25-49

Programs categorized as NOT PERFORMING have ratings of Ineffective or Results Not Demonstrated.

- Ineffective. Programs receiving this rating are not using your tax dollars effectively. Ineffective programs have been unable to achieve results due to a lack of clarity regarding the program's purpose or goals, poor management, or some other significant weakness. Score 0-24
- Results Not Demonstrated. A rating of Results Not Demonstrated (RND) indicates that a program has not been able to develop acceptable performance goals or collect data to determine whether it is performing.

Section 4

Supplemental Materials

Supplemental Materials

Please see www.Budget.Illinois.gov for additional information

Glossary

Best Practices: Policies or activities that have been identified through evidence-based policymaking to be most effective in achieving positive outcomes.

Evidence-Based: Systematic use of multiple, rigorous studies and evaluations which demonstrate the efficacy of the program's theory of change and theory of action.

Illinois Performance Reporting System (IPRS): The state's web-based database for collecting program performance data. The IPRS database allows agencies to report programmatic level data to the Governor's Office of Management and Budget on a regular basis.

Optimal Return on Investment (OROI): A dollar amount that expresses the present value of program benefits net of program costs that can be expected if a program is implemented with fidelity to core principles or best practices.

Outcome Measures: Outcomes describe the intended result of carrying out a program or activity. They define an event or condition that is external to the program or activity and that is of direct importance to the intended beneficiaries and/or the general public. For example, one outcome measure of a program aimed to prevent the acquisition and transmission of HIV infection is the number (reduction) of new HIV infections in the state.

Output Measures: Outputs describe the level of activity that will be provided over a period of time, including a description of the characteristics (e.g., timeliness) established as standards for the activity. Outputs refer to the internal activities of a program (i.e., the products and services delivered). For example, an output could be the percentage of warnings that occur more than 20 minutes before a tornado forms.

Randomized Controlled Trial (RCT): A study that randomly assigns participants into one or more treatment groups and a control group. This is the most rigorous type of study, because the random assignment allows researchers to isolate the effects of treatment from other participant characteristics that may be correlated with receiving treatment in the absence of random assignment. However, RCTs are not feasible or ethical in every research setting.

Results First Clearinghouse Database: One-stop online resource providing policymakers with an easy way to find information on the effectiveness of various interventions as rated by eight nation research clearinghouses which conduct systematic research reviews to identify which policies and interventions work.

Target: A quantifiable metric established by program managers or the funding entity established as a minimum threshold of performance (outcome or output) the program should attain within a specified timeframe. Program results are evaluated against the program target.

Theory Informed: A program where a lesser amount of evidence and/or rigor exists to validate the efficacy of the program's theory of change and theory of action than an evidence-based program.

Theory of Change: The central processes or drives by which a change comes about for individuals, groups and communities

Theory of Action: How programs or other interventions are constructed to activate theories of change.

Endnotes

[i] See Pew Research Center – Results First Initiative. Available at: https://www.pewtrusts.org/en/projects/results-first-initiative.

[ii] See Office of Management and Budget – Assessing Program Performance. Available at: https://georgewbush-whitehouse.archives.gov/omb/performance/index.html.

[iii] The optimal benefits are the benefits the program can expect to achieve if run with fidelity to best practices or core principles. Benefits per participant are projected annually for program participation. The per participant real costs of the program are the sum of its direct and indirect costs, minus the cost of treatment as usual. The benefits and the costs are discounted to present value. The benefit/cost ratio is the optimal return on investment (OROI) Illinois can expect from implementing the program with fidelity.

[iv] Substance Abuse and Mental Health Services Administration (SAMHSA). 2020. "Medications for Opioid Use Disorder: For Healthcare and Addiction Professionals, Policymakers, Patients, and Families." Available at: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-006_508.pdf.

[v] Substance Abuse and Mental Health Services Administration. 2015. *Federal Guidelines for Opioid Treatment Programs*. HHS Publication No. (SMA) PEP15-FEDGUIDEOTP. Rockville, MD: Substance Abuse and Mental Health Services Administration. Available at: Federal Guidelines for Opioid Treatment Programs (samhsa.gov). Center for Substance Abuse Treatment. 2005. *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs.* Treatment Improvement Protocol (TIP) Series 43. HHS Publication No. (SMA) 12-4214. Rockville, MD: Substance Abuse and Mental Health Services Administration. Available at: Bookshelf_NBK64164.pdf (nih.gov).

[vi] Center for Substance Abuse Treatment. 2005. *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs.* Treatment Improvement Protocol (TIP) Series 43. HHS Publication No. (SMA) 12-4214. Rockville, MD: Substance Abuse and Mental Health Services Administration. Available at: Bookshelf_NBK64164.pdf (nih.gov).

[vii] *Ibid.*

[viii] *Ibid.*

[ix] *Ibid.*

[x] *Ibid.*

[xi] Maria Bruni and Ron Vlasaty. December 17, 2020. *Strategy to Increase Follow-Up after Emergency Department Visit and Hospitalization for Opioid Use Disorder*. A presentation given to the Illinois Opioid Crisis Response Advisory Council. Available upon request.

[xii] Illinois Department of Human Services. 2018. "The Opioid Crisis in Illinois: Data and the State's Response." Available at: https://www.dhs.state.il.us/OneNetLibrary/27896/documents/The_Opioid_Crisis_in_Illinois.pdf. Case, Anne and Angus Deaton. 2020. *Deaths of Despair and the Future of Capitalism*. Princeton, New Jersey: Princeton University Press.

[xiii] Illinois Department of Human Services. October 2020. *State of Illinois Opioid Action Plan Implementation Report.* Available at: https://www.dhs.state.il.us/OneNetLibrary/27896/documents/SOAP_Implementation_Report_October_2020.pdf.

[xiv] Illinois Opioid Crisis Response Advisory Council Committee. October 2020. "Recommendations for the 2020 State Opioid Action Plan (SOAP)." Available at: https://www.dhs.state.il.us/OneNetLibrary/27896/documents/Council_Committees_2020_SOAP_Recommendations.pdf.

[xv] Illinois Department of Human Services. 2018. "The Opioid Crisis in Illinois: Data and the State's Response." Available at: https://www.dhs.state.il.us/OneNetLibrary/27896/documents/The_Opioid_Crisis_in_Illinois.pdf.

[xvi] Leif Gronbladh and Lars Gunne. September 1989. "Methadone-Assisted Rehabilitation of Swedish Heroin Addicts." *Drug and Alcohol Dependence* 24(1), pp. 31-7.

[xvii] The Substance Use Disorder Act (20 ILCS 301) requires DHS to fund a "comprehensive" range of SUD services including recovery support, but MAR is not specified.

[xviii] Illinois Department of Human Services Division of Substance Use Prevention and Recovery (IDHS/SUPR). March 5, 2020. "Guideline: Medication Assisted Recovery (MAR)." Available at: https://www.dhs.state.il.us/OneNetLibrary/27896/documents/2020SmartAlerts/IDHS_SUPR_MAR_Guideline.pdf.

[xix] Pew Charitable Trusts. December 17, 2020. "Medications for Opioid Use Disorder Improve Patient Outcomes." Available at: Medications for Opioid Use Disorder Improve Patient Outcomes | The Pew Charitable Trusts (pewtrusts.org).

[xx] See Illinois Department of Human Services - SUPR Licensing and Certification Forms. Available at: IDHS: SUPR Licensing and Certification Forms (state.il.us).

[xxi] Substance Abuse and Mental Health Services Administration. 2015. *Federal Guidelines for Opioid Treatment Programs*. HHS Publication No. (SMA) PEP15-FEDGUIDEOTP. Rockville, MD: Substance Abuse and Mental Health Services Administration. Available at: Federal Guidelines for Opioid Treatment Programs (samhsa.gov).

[xxii] Center for Substance Abuse Treatment. 2005. *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs.* Treatment Improvement Protocol (TIP) Series 43. HHS Publication No. (SMA) 12-4214. Rockville, MD: Substance Abuse and Mental Health Services Administration. Available at: Bookshelf_NBK64164.pdf (nih.gov).