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IAP | Medicaid Innovation Accelerator Program

Medicaid Innovation Accelerator Program (IAP)

Substance Use Disorders (SUD) High-Intensity Learning Collaborative

HILC Meeting 4: SUD Benefits and the SUD Care Continuum

Logistics for the Webinar

- Please mute your line and do not put the line on hold
- Use the chat box on your screen to ask a question or leave comment
  - Note: chat box will not be seen if you are in "full screen" mode
- To participate in a polling question, exit out of "full screen" mode
- Moderated Q&A will be held periodically throughout the webinar
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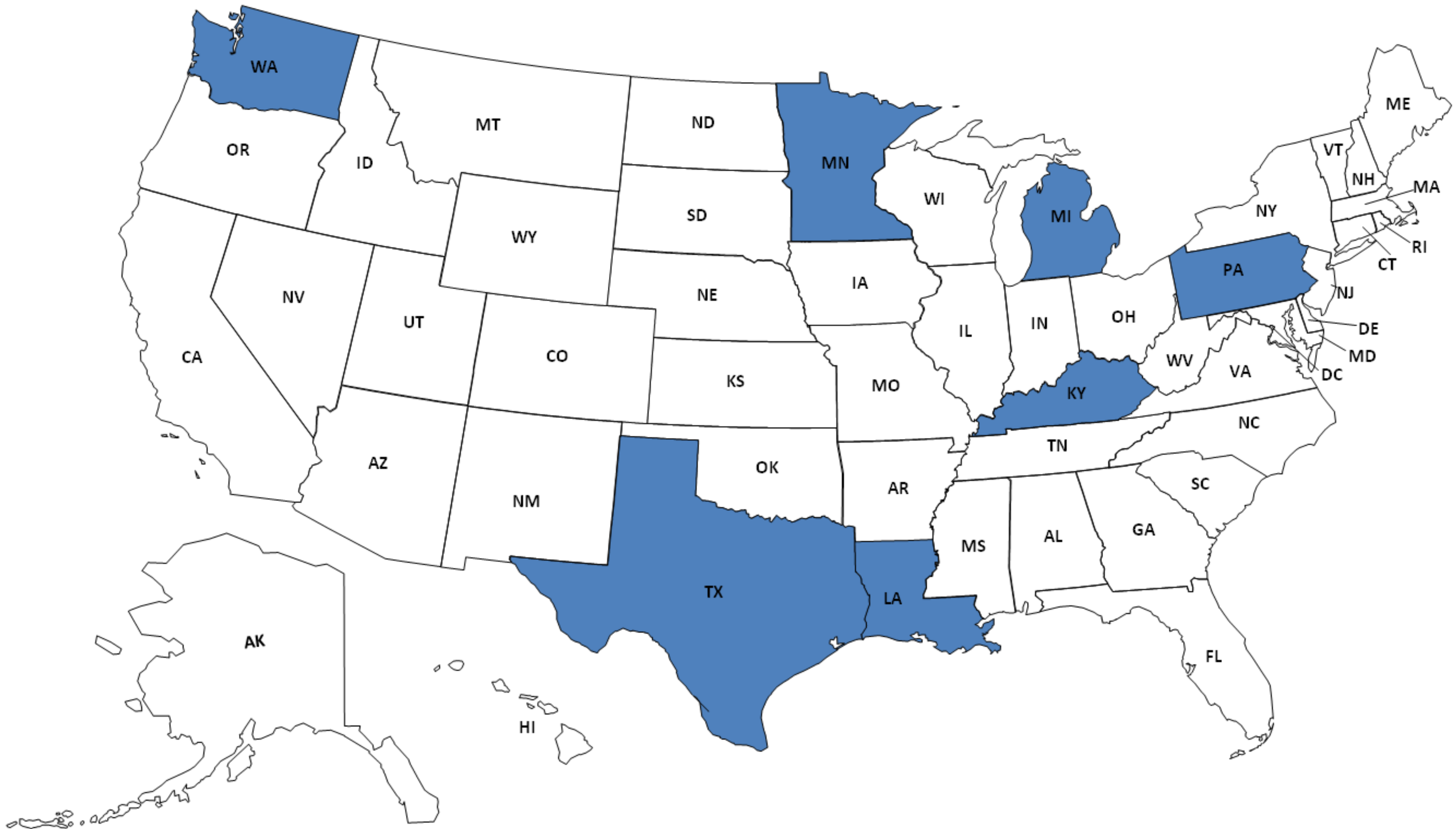
HILC State Roll Call



Agenda

- Introduction
- Treating the Chronic Disease of Addiction
  - Questions and Discussion
- California SUD Delivery System and Care Continuum
  - Questions and Discussion
- Recovery Oriented and Peer Support Services
  - Questions/Discussion
- Wrap Up and Next Steps

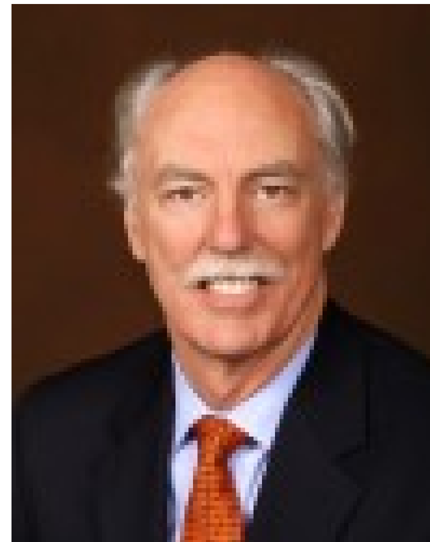
Purpose and learning objectives

- Gain an understanding of the core components of a chronic disease, continuous care, recovery oriented SUD treatment system grounded in science, research, and proven practice.
- Learn how this model is being developed in one state's Medicaid system.
- Create opportunities for discussion about the implications of this model for:
  - the design of Medicaid benefit packages; and
  - the development/ expansion of provider networks.

Presenter (1 of 6)

- **Thomas McClellan, PhD**

  Chairman of the Board and co-founder of the Treatment Research Institute



Presenter (2 of 6)

- **Jack Kemp, MS**

  TRI Consultant

Presenter (3 of 6)

- **Toby Douglas, MPH, MPP**

  Former Director, California Department of Health Care Services

Presenter (4 of 6)

- **Karen Baylor, PhD**

  Deputy Director of Mental Health and Substance Use Disorders, CA Department of Health Care Services

Presenter (5 of 6)

- **Marlies Perez, MA**

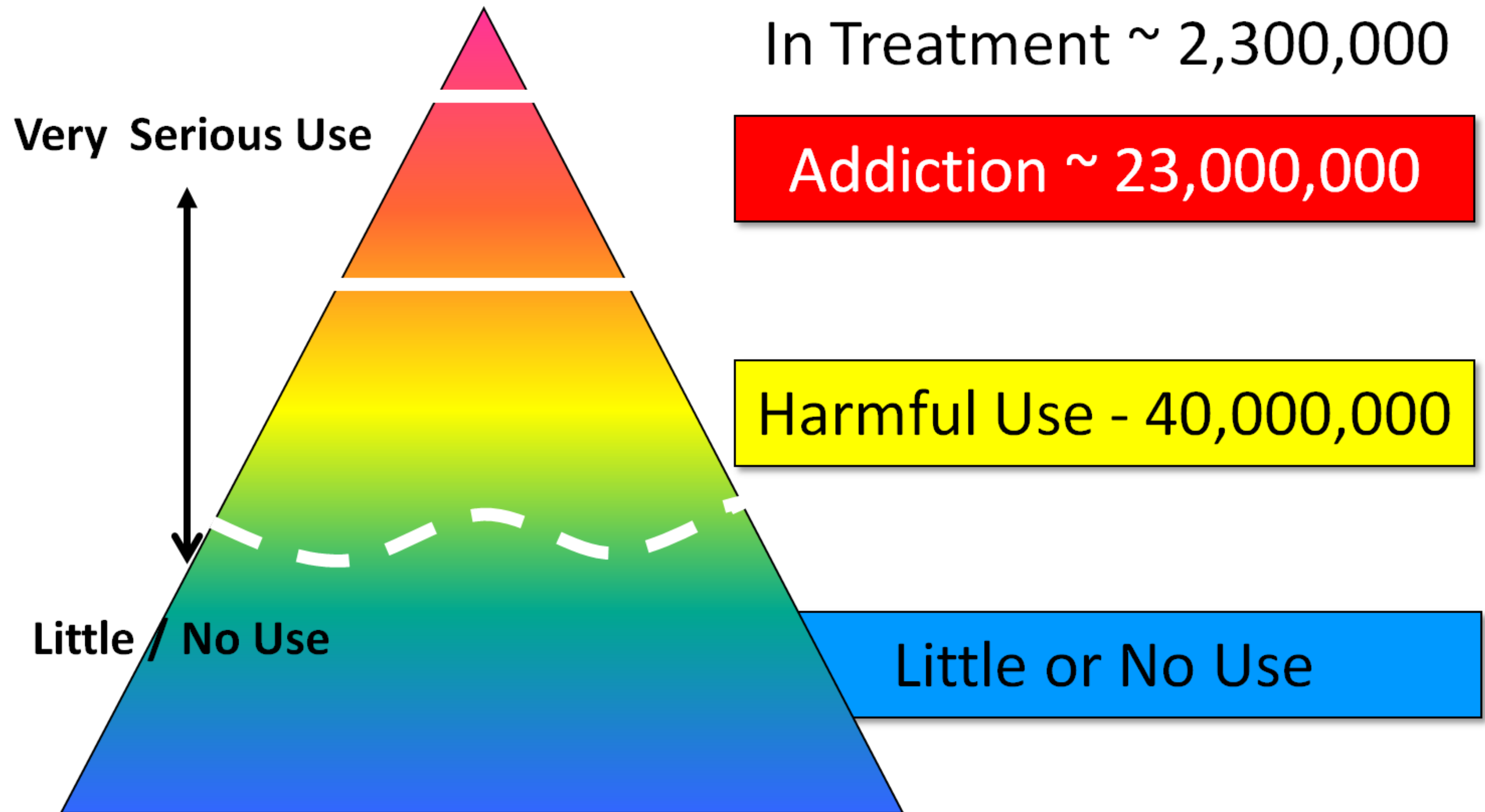
  Division Chief, Substance Use Disorder Compliance Division, CA Department of Health Care Services

Presenter (6 of 6)

- **Neil Campbell, MS**

  Executive Director, Georgia Council on Substance Abuse

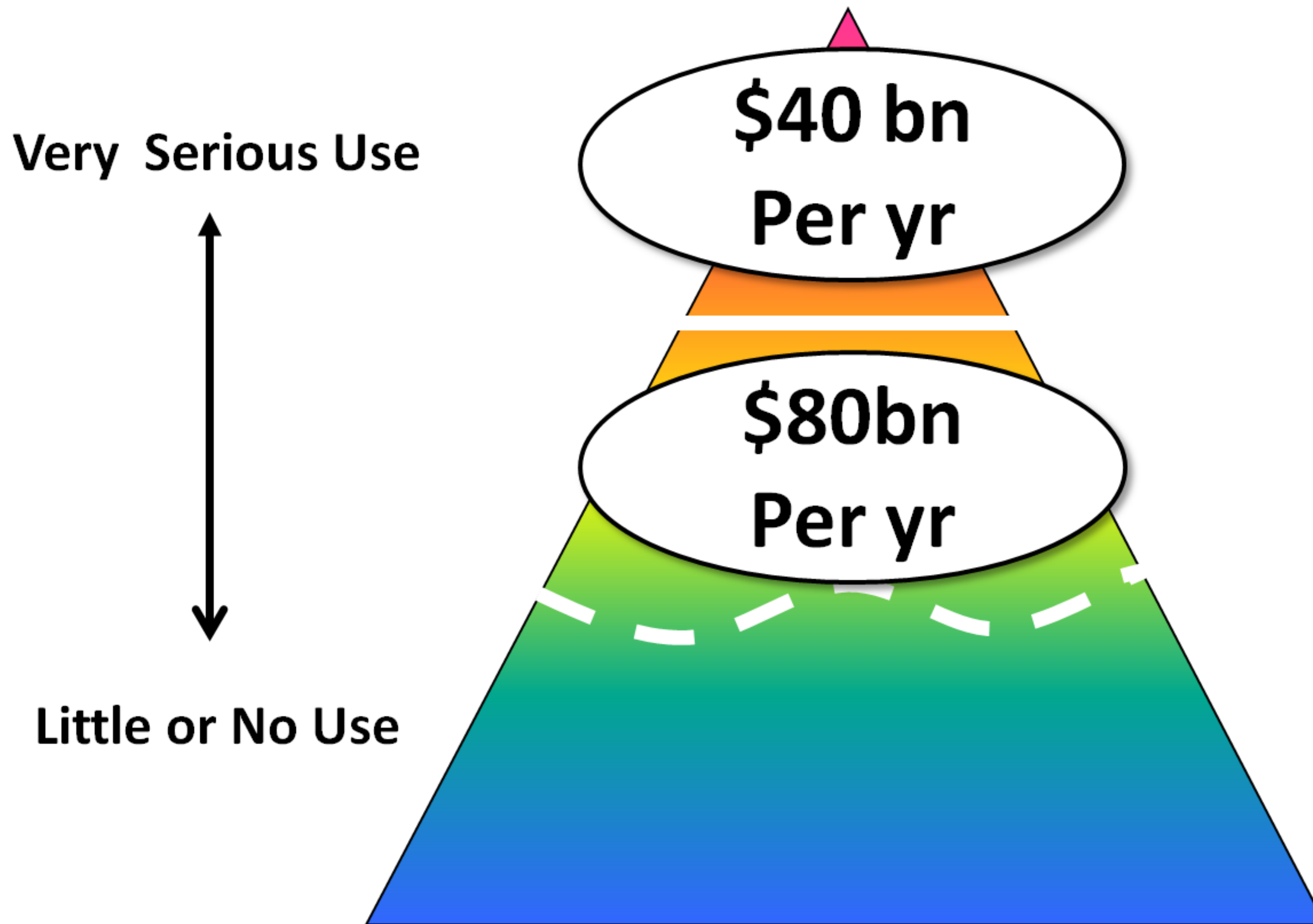
Substance Use Among US Adults (1 of 3)



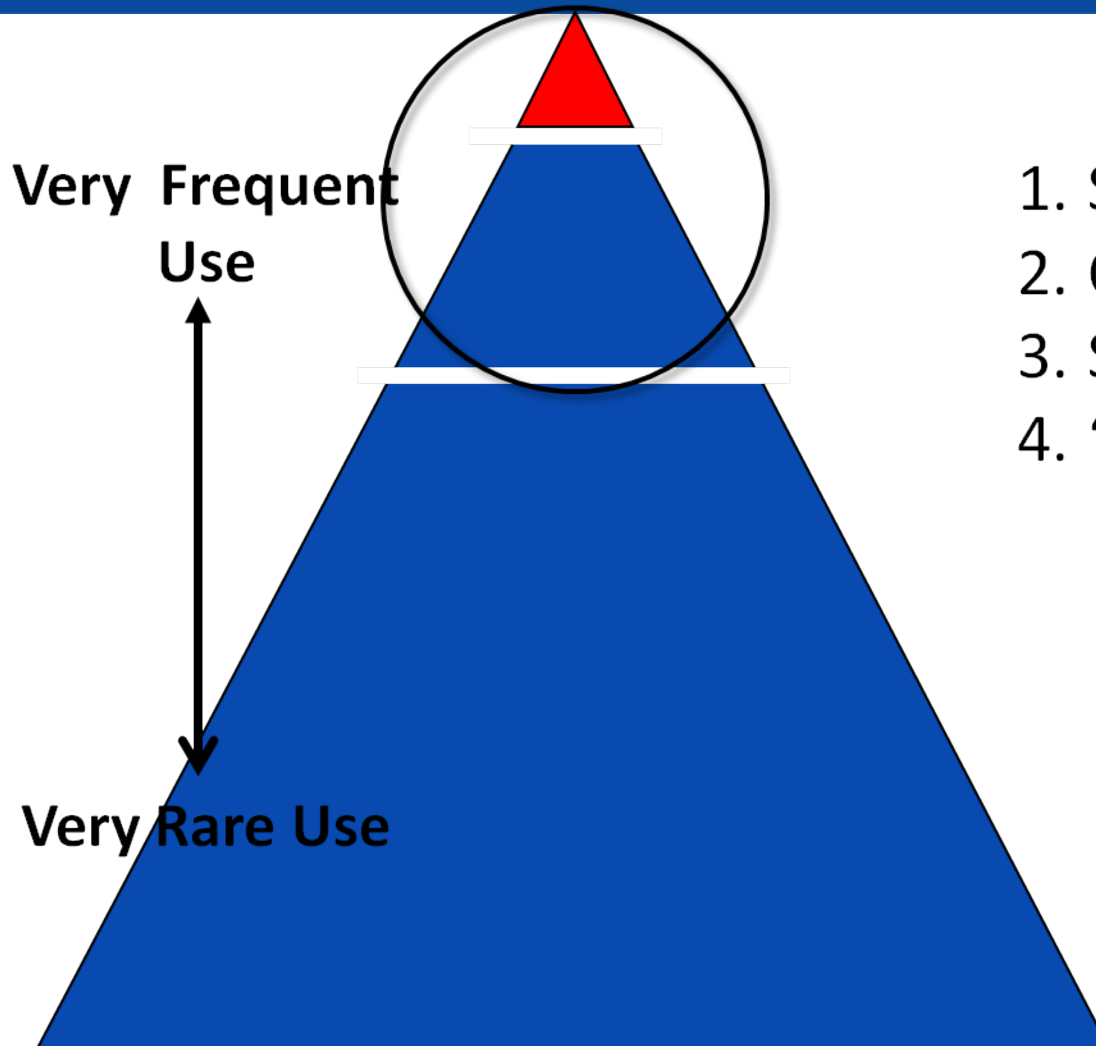
Substance Use Impact on Healthcare

- Alcohol and drug use **below addiction** lead to:
  - Misdiagnoses
  - Poor adherence to prescribed care
  - Interference with prescribed medications
  - More physician time
  - Unnecessary medical testing
  - Poor outcomes
  - Increased costs
  - **Particularly in chronic illnesses**

Substance Use Among US Adults (2 of 3)



Insurance Only for "Addiction"



1. Specialty Care Only
2. Only Most Serious
3. Segregated Finance
4. "Programs" Only

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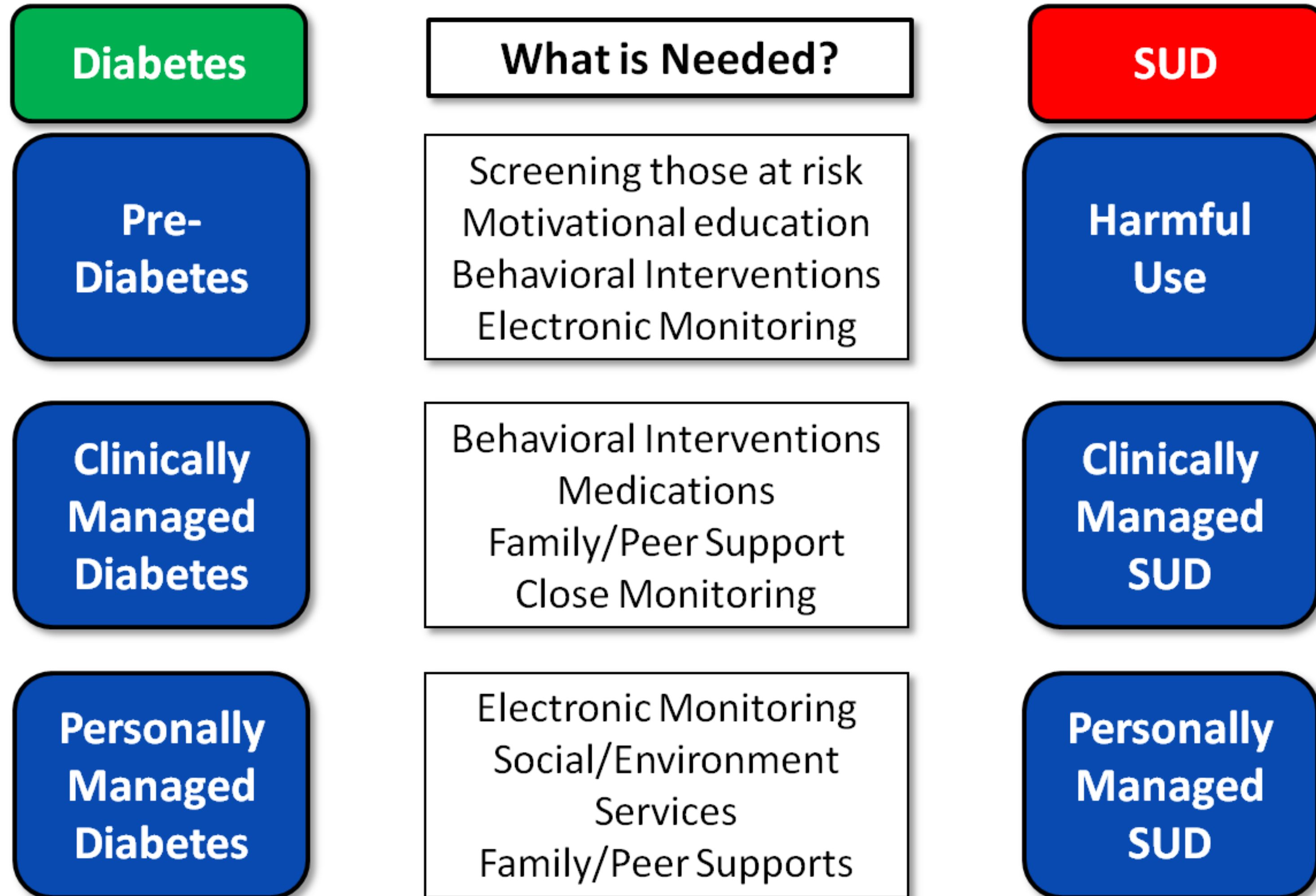
Compared to What?

Diabetes

Medicaid Benefit in Diabetes

- Physician Visits- 100%
- Clinic Visits- 100%
- Home Health Visits- 100%
- Glucose Tests, Monitors, Supplies- 100%
- Insulin and 4 Other Meds- 100%
- HgA1c, eye, foot exams- 100%
- Smoking cessation- 100%
- Personal Care Visits- 100%
- Language Interpreter- Negotiated

Spectrum of Illness and Care Continuum: Diabetes Compared to SUD



Clinically Managed Care Setting for SUD

- Traditional Settings/Programs
  - Detox/Stabilization
  - Residential
  - Partial Hospitalization
  - IOP/Outpatient
- Setting placement/transition determined by:
  - Severity, duration, complexity of illness
  - Availability of social supports

Stage 2- Clinical Management: Goals and Methods

Goals

1. Establish/Maintain reductions in substance use
2. Improve general health and social function
3. Educate patient/Family to understand, monitor and manage substance use problem
4. Engage Patient/Family/Support network into Stage 3 care

Methods

1. Individual, Family and Group Behavioral therapies
2. Rational Medication Regimen
   a. Anti-craving medications (maintenance?)
   b. Appropriate meds for psychiatric and physical illness
3. Electronic and personal monitoring –
   a. Weekly for 1 month – Bi-Weekly for 3 months
   b. Monthly for six months

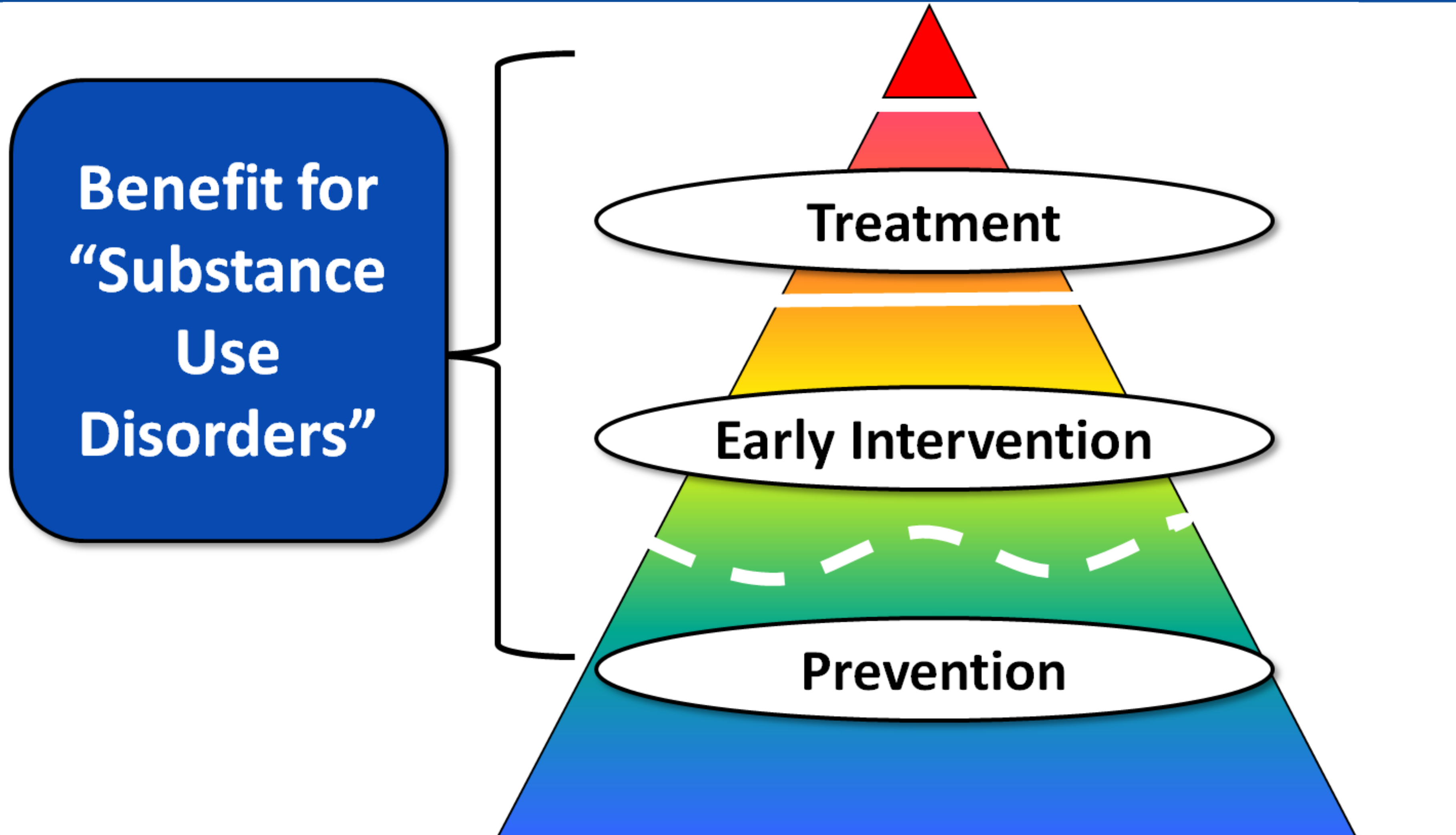
NOTE: Stage 2 can be done in Primary, Specialty OPT or Specialty Residential Settings
Greater severity/complexity/chronicity increases:

- Need for frequent monitoring and medication
- Need for specialty care, and
- Need for protective setting

Stage 2- Clinical Management: Outcomes & Indicators

Outcomes & Indicators		
	Best Case	• Elimination or significant reduction of use as indicated by urine drug screens during monitoring • Active engagement in stage 3 care
	Or	• Patient acknowledges “relapse” • Patient agrees to more intensive monitoring and/or • Patient agrees to intensify care
	But Not	• Serious relapse or overdose incident • Hospital, ER or Residential Treatment Required

Substance Use Among US Adults (3 of 3)



Points

- Substance Use Disorders will be treated/ managed like other chronic illnesses
- Three stages of Chronic Care- Identification, Clinical Management, Self-Management
- Each stage prepares the patient for a less intensive stage- ultimately patient self-management
  - Monitoring key to prevent regression
- Within Clinical Management Stage- the setting of care determined by patient severity and progress

Questions on presentations so far?

Outline

- Understand the background/context of the SUD services in CA and the changes under the ACA that led to need for a SUDS organized delivery system
- Review the goals and outcomes of an 1115 SUDS Organized Delivery system
- Present the continuum of services under the Waiver and the waiver flexibilities
- Recap the Lessons learned

Drug Medi-Cal Benefits Prior to ACA

- Modalities
  - Outpatient Drug Free (ODF) - all populations
  - Narcotic Treatment Programs (NTP) - all populations
  - Residential (perinatal only in non-IMDs)
  - Intensive Outpatient Therapy (IOT) - perinatal only
- NTP 34 percent of beneficiaries served
- ODF 58 percent of beneficiaries served

Bridge to Reform 1115 Waiver

- Early Implementer of the Medicaid Coverage Expansion through Counties in 2011-- Low Income Health Program (LIHP)
- Conducted a SUD Needs Assessment
  - Uncovered gaps
  - High prevalence/need
- Knowledge Gained from Low Income Health Programs
  - Need for Continuum
  - Physical and Behavioral Health Integration

Program Integrity Issues

- Uncovered widespread fraud in the Drug Medi-Cal program, in particular Outpatient Drug Free services in 2013
  - Inability to hold providers accountable for quality of care
  - Over utilization of services
  - Fraudulent billing practices
  - Misuse of SUD treatment dollars while the overall population is in need of services

Physical Health/Behavioral Health Integration

- Merging of community mental health and substance use disorder services into the Department of Health Care services in 2012/13 and 2013/14
- Implementation of Screening Brief Intervention and Referral Treatment in Managed Care (SBIRT)
- Expansion of Mild to Moderate mental health services in Managed care

ACA Expansion

- Increased Eligible Beneficiaries (expanded population of childless adults)
  - Needs assessment found most of the incidence of SUDs in the expansion population
- CA chose to expand modalities
  - Intensive Outpatient Treatment
  - Residential

Drug Medi-Cal Organized Delivery System Waiver Goals

- The goal is to improve Substance Use Disorder (SUD) services for California beneficiaries
- Authority to select quality providers
- Provide Access to Level of Care based on ASAM model
- Consumer-focused; use evidence based practices to improve program quality outcomes
- Support coordination and integration across systems
- Managed care delivery system with counties assuring access, care coordination, and quality reporting as PIHPs

Drug Medi-Cal Organized Delivery System Waiver Goals (cont'd)

- Reduce emergency rooms and hospital inpatient visits
- Ensure access to SUD services
- Increase program oversight and integrity
- Provide more intensive services for the criminal justice population
- Provide availability of all SUD services
- Place client in the least restrictive level of care

Drug Medi-Cal Organized Delivery System Waiver

DMC Services	SPA 13-038 (Non-Waiver	Opt-in Waiver
Outpatient/Intensive Outpatient	X	X
NTP (including buprenorphine, naloxone, disulfiram)	X	X
Residential		X (one level)
Withdrawal Management		X (one level)
Recovery Services		X
Case Management		X
Physician Consultation		X
Additional MAT		X (optional)

Early Intervention Services

- SBIRT (screening, brief intervention and referral to treatment) American Society of Addiction Medicine (ASAM) Level 0.5
- Provided by non-DMC providers to beneficiaries at risk of SUD (through FFS system)
- Referrals by managed care providers or plans to DMC-ODS will be governed by the Memorandum of Understanding

Outpatient

- ASAM Level 1
- Individual and group counseling up to 9 hours a week for adults
- Determined by a Medical Director or Licensed Practitioner of the Healing Arts (LPHA)
- Services can be provided in-person, by telephone or by telehealth (except group)
- Addition of family therapy

Intensive Outpatient

- ASAM Level 2.1
- Minimum of nine hours with a maximum of 19 hours a week for adults
- Determined by a Medical Director or LPHA
- Services can be provided in-person, by telephone or by telehealth (except group)
- Addition of family therapy

Partial Hospitalization

- ASAM Level 2.5
- 20 or more hours of clinically intensive programming per week
- Providing this level of service is optional for participating counties

Residential (1 of 3)

- Residential needed in the continuum of care
- Restricted due to the Institute for Mental Disease (IMD) exclusion
- Ninety percent of California’s residential bed capacity is considered an IMD
- Clients in IMD’s restricted from all Medi-Cal services
- Without the DMC-ODS Waiver Pilot, California cannot provide residential services

Residential (2 of 3)

- Levels of Residential Based on ASAM (Levels 3.1, 3.3, 3.5)
- One level required initially for DMC-ODS
- **No bed capacity limit**
- Short term length of stay

Residential (3 of 3)

- Medical necessity can authorize a one-time extension of up to 30 days on an annual basis
- Perinatal clients may receive a longer length of stay based on medical necessity
- CDRH and Acute Free Standing Psych paid through the FFS system

Withdrawal Management

- (Levels 1, 2, 3.2, 3.7 and 4 in ASAM)
- Determined by a Medical Director or LPHA
- Monitored during detoxification
- IMD expenditure approval for Chemical Dependency Recovery Hospitals and Free Standing Psychiatric Hospitals (paid through FFS system)

Opioid (Narcotic) Treatment Program

- ASAM OTP Level 1
- Required service in all opt-in counties
- Adding buprenorphine, disulfiram and naloxone in NTP settings
- Minimum fifty minutes of counseling sessions up to 200 minutes per calendar month or more with medical necessity

Additional Medication Assisted Treatment

- The goal of the DMC-ODS for Medication Assisted Treatment (MAT) is to open up options for patients to receive MAT by requiring MAT services as part of the waiver
- Educate counties on the various options pertaining to MAT
- Amend regulations to include office based opiod treatment
- Provide counties with technical assistance to implement any new services

Additional Medication Assisted Treatment (cont'd)

Medication	TAR* Required	Availability
Methadone	No	Only in NTP/OTP
Buprenorphine	Yes, unless provided in an NTP/OTP	Pharmacy Benefit, NTP/OTP
Naltrexone tablets	No	Pharmacy Benefit, DMC Benefit
Naltrexone long-acting injection	Yes	Pharmacy Benefit, Physician Administered Drug
Disulfiram	No	Pharmacy Benefit, NTP/OTP
Acamprosate	Yes	Pharmacy Benefit
Naloxone	No	Pharmacy Benefit; NTP/OTP

Recovery Services

- May access recovery services after completing the course of treatment, if triggered, if relapsed or as a preventative measure to prevent relapse
- Provided face-to-face, by telephone, or by telehealth with the beneficiary and may be provided anywhere in the community

Case Management

- Counties will coordinate case management services
- Services can be provided in various locations
- Coordinate with Mental and Physical Health
- Provided face-to-face, by telephone, or by telehealth

Physician Consultation Services

- Physician consultation services with addiction medicine physicians, addiction psychiatrists or clinical pharmacists
- Designed to assist DMC physicians with treatment plans for DMC-ODS beneficiaries
- Medication selection, dosing, side effect management, adherence, drug-to-drug interactions, or level of care considerations

Federal Waiver Flexibilities

- Selective contracting of providers to ensure high quality, accountable care
- Expanded workforce to include LPHAs
- Added Recovery Services
- Short term residential treatment
- Counties held to all federal 42 CFR 438 requirements (quality assurance, beneficiary protections, access)
- External Quality Review requirements must be phased in within 12 months of having an approved implementation plan

General Waiver Provisions

- Amendment to Bridge to Reform and folded into Medi-Cal 2020 1115 Waiver
- Pilot for 5.5 years
- Counties administered managed care model with a choice to opt-in
- 53 of 58 counties expressed an interest

Physical Health Integration

- MOUs with Managed Care Plans
  - Care coordination
  - Medication management
  - Coordinated treatment plans
- Future integration
  - Payment incentives across physical and behavioral health
  - Health Plans reward SUDS providers for reduction in inpatient and ED
  - 2703 Health Homes

Substance Abuse Prevention and Treatment (SAPT) Block Grant Integration

- Repurposing SAPT Block Grant Funds
  - Room and Board for Residential
  - Recovery Residences
  - Optional Services in the DMC-ODS
- Continuing to work with SAMHSA

DMC-ODS Waiver Implementation

- Regional Implementation

  Phase I – Bay Area (May-August 2015)

  Phase II – Southern California

  Phase III – Central Valley

  Phase IV – Northern California

  Phase V – Tribal Delivery System

Lessons Learned

- Leadership and Subject Matter Expertise
- Robust Stakeholder Engagement Process, Provider support
- Engage Tribal Delivery System at Onset
- Build the evaluation throughout the design
- Collaboration with CMS and SAMHSA

Questions on presentations so far? (1 of 1)

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What's Right in Georgia Since 1999? Peer-Based Recovery Support

- Certified Peer Specialists!
- Over **1250 MH** peers trained
- Medicaid Billable

- 2010 - Certified Addiction Recovery Empowerment Specialists (CARES) or *Addiction Peer Specialists* (292 trained)
- 2013 - CHPRA trained *Parent Peer Specialists*
- 2015 - *Youth Peer Specialists* will be trained

Where Peers Work…

- The voice of lived recovery experience has branched out into ACT, Mobile Crisis, Wellness and Respite Centers, Supported Employment, Supported Housing, new employee orientation, public speaking/awareness (Respect Institute, Recovery Messaging from F&V), HIV/EIS services, adolescent residential programs, more…

Cobb/Douglas Community Service Board Clinical Director, HIV/EIS

- “They (peer specialists) are able to engage the people we serve on a whole different level.”
- “They talk about what helped them and they walk beside their peers as they travel on their recovery journeys.”
- “We couldn’t do what we do without them.”

Does This Work?

Two randomized controlled trials and one quasi-experimental study were of sufficient quality to rate the level of evidence as moderate. Primary outcomes included:

- Improved relationships with providers and social supports
- Reduced rates of relapse
- Increased satisfaction with the overall treatment experience
- Increased treatment retention

From: Peer Recovery Support for Individuals With Substance Use Disorders: Assessing the Evidence Sharon Reif, Ph.D.; Lisa Braude, Ph.D.D. ;Russell Lyman, Ph.D. ;Richard H. Dougherty, Ph.D.; Allen S. Daniels, Ed.D. Sushmita Shoma Ghose, Ph.D. Onaje Salim, Ed.D., L.P.C.; Miriam E. Delphin-Rittmon, Ph.D.

Does This Work? (cont'd)

Across the service types, improvements have been shown in the following outcomes:

- Reduced inpatient service use
- Improved relationship with providers
- Better engagement with care
- Higher levels of empowerment
- Higher levels of patient activation
- Higher levels of hopefulness for recovery

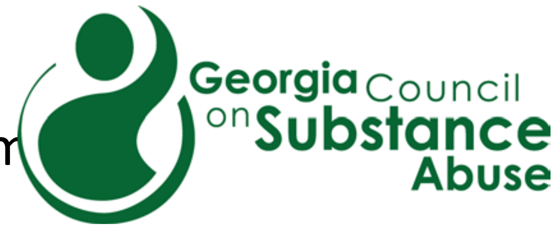
From: Peer Support Services for Individuals With Serious Mental Illnesses: **Assessing the Evidence**

Matthew ChinmanPh.D.; Preethy George, Ph.D.; Richard H. Dougherty, Ph.D. ;Allen S. Daniels, Ed.D.; Sushmita Shoma Ghose, Ph.D.; Anita Swift, M.S.W.;

Miriam E. Delphin-Rittmon, Ph.D.

Certified Addiction Recovery Empowerment Specialists (CARES) (1 of 3)

- Beginnings:
  - Focus Groups around the state
  - Meetings with key stakeholders
  - Partnering with MH
  - Workforce development initiative from Addictive Diseases



Certified Addiction Recovery Empowerment Specialists (CARES) (2 of 3)

- Funded by Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) since 2010
- We have trained 292 CARES who work in a variety of behavioral health and healthcare settings
- Co-Founded by Neil Campbell, Georgia Council on Substance Abuse; George Braucht, LPC and an Advisory Council with **over 380 years** in recovery!

Certified Addiction Recovery Empowerment Specialists (CARES) (3 of 3)

- Core competencies:
  - Recovery Advocacy
    - Self
    - Peers
    - Recovery-Oriented System
  - Recovery Check-Ins
    - Assess Recovery Capital
    - Engagement
  - Recovery Groups
    - Partners for Change Outcome Management System (P-COMS)
    - Motivational Interviewing

CARES Academy is just the beginning…

- Minimum of 55 Trained Peers/Year
- "Fidelity" Activities
- Continuing Education
- Stay connected…..

Creating a Recovery-Oriented System of Care in Georgia

How our Peers See Themselves

CPS-AD Service Definition

- Recovery Bill of Rights philosophy must be actively incorporated into all services & activities
  - View each individual as the driver of his/her recovery process
  - Promote the value of self-help, peer support, and personal empowerment to foster recovery
  - Promote information about the science of addiction, recovery
  - Promote peer-to-peer training of individual skills, community resources, group and individual advocacy and the concept of "giving back"
  - Actively seek ongoing input into program and service content so as to meet each individual's needs and goals and fosters the recovery process.

CPS-AD Service Definition (cont'd)

- Promote the concepts of employment and education to foster self-determination and career advancement
- Support each individual to embrace SAMHSA's Recovery Principles and to utilize community resources and education regarding health, wellness and support from peers to replace the need for clinical treatment services
- Support each individual to fully participate in communities of their choosing in the environment most supportive of their recovery and that promotes housing of his/her choice and to build and support recovery connections and supports within his/her own community.

Language Matters!

- From→ Addictive Diseases Peer Support Individual, Medicaid service definition:
  - This service provides interventions (in an agency or community-based setting) which promote recovery, self-advocacy, relationship enhancement, self awareness and values, and self-directed care.
  - Individuals served are introduced to the reality that there are many different pathways to recovery and each individual determines his or her own way.

Language Matters (cont'd)

- From→ Addictive Diseases Peer Support Individual, Medicaid service definition, cont'd:
  - Supports are recovery-oriented and occur when individuals share the goal of long-term recovery.
  - Each participant identifies his/her own individual goals for recovery.
  - Interventions must promote self-directed recovery by honoring the many pathways to recovery, by tapping into each participant's strengths and by helping each to recognize his/her "recovery capital", the reality that each individual has internal and external resources that they can draw upon to keep them well.

Sustainable Funding

- For Peer Whole Health and Wellness Coaches at Cobb-Douglas Site
  - CMS approved Georgia as first state to have Medicaid-billable whole health and wellness peers
  - Services provided by peer support whole health and wellness coaches certified in WHAM training began sustainable billing and provided medical support by nurses

THANK YOU!

Neil Campbell, Executive Director

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Questions on presentations so far? (2 of 2)

Final Observations/Discussion

Up Next

- HILC Meeting #5: Care Transitions (July 15th)

Evaluations

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We greatly appreciate your participation!