

National Dissemination Webinar 2020

Leveraging Managed Care: Examples of State Strategies to Enhance Medication-Assisted Treatment and Peer Support Services

August 25, 2020 3:00-4:30pm EST

KRISTIN SCHRADER: Hello, and welcome to today's Medicaid Innovation Accelerator Program webinar, "Leveraging Managed Care for Substance Use Disorders: Examples of Strategies to Enhance Medication-Assisted Treatment and Peer Support Services." For today's webinar, all participants are on muted lines. To submit a question during the webinar, please use the chat box on the Webex platform. Be sure to expand the chat panel on your screen or click on the ellipsis icon if you do not see the box. There will be Q & A segments during the webinar, during which today's presenters will respond to your submitted questions. Additionally, the slides, recording, and transcript from this webinar will be available on Medicaid.gov within a few weeks of the webinar. At this time, I would like to introduce Katherine Vedete, Senior Advisor for the Medicaid Innovation Accelerator Program at CMS.

KATHERINE VEDETE: As a Senior Advisor to the Medicaid IAP, I'd like to welcome everyone to today's webinar. IAP has provided technical assistance to Medicaid agencies on substance use disorder-related delivery system reforms for over five years now. As part of that work, Medicaid agencies often have questions about how to work with their managed care organizations (MCOs) on such reforms. We're excited to have presenters from New Mexico and Tennessee on today's webinar to share their experiences, and we encourage everyone on the line to ask them questions as you consider similar reforms.

(next slide) Gina Eckart will be facilitating today's webinar. Gina is a licensed mental health counselor with over 20 years of experience in the public behavioral health field. As a contractor with Health Management Associates (HMA), Gina has served as a coach and subject matter expert for a few of the IAP technical assistance opportunities for Medicaid agencies. Until December 2011, Gina served as Commissioner for the Indiana Division of Mental Health and Addiction, with responsibility for policy and funding of the publicly funded mental health and addiction system of care across the state. During that time, she worked closely with the Indiana Office of Medicaid Policy and Planning to improve efficiency and oversight of Medicaid-funded behavioral health services. Prior to joining the state of Indiana, Gina served in various clinical and leadership roles at Midtown Community Mental Health Center, also in Indiana. At HMA, Gina has assisted clients with strategic planning and evaluation of both substance use disorder (SUD) and mental health programs.

GINA ECKART: (next slide) We will be sharing a lot of great information with you today. We're going to start with an overview of our agenda. In a moment we will review the purpose of our webinar along with the associated learning objectives. Then, before turning things over to our state speakers, I will provide you with a brief background and overview focused on two elements within the continuum of SUD services, specifically medication-assisted treatment (MAT) and peer support services, and states' use of managed care arrangements in administering these and other SUD benefits.

Next our speakers from New Mexico and then Tennessee will share their experiences. Following each state's presentation, we will provide attendees the opportunity to ask questions of our presenters. As

indicated at the start of the webinar, feel free to send questions through chat box throughout the presentation and we will field these questions to our speakers at the end of each presentation.

Finally we will end the webinar with an overview of key takeaways for attendees.

(next slide) So, purpose and learning objectives for today's webinar. We will be focusing on state Medicaid agencies' use of managed care arrangements to expand access to services, specifically to evidence-based practices, MAT and peer support. Today's webinar will include information on how two states have partnered with their Medicaid managed care plans to include or enhance access to these services within their provider networks. Finally, building and expanding capacity for services can sometimes pose challenges, especially with notable workforce shortages facing states today. Therefore, we will also explore the obstacles these states have faced in expanding these services, and how they leverage managed care arrangements to overcome these challenges.

(next slide) If you're joining us today, you may be among the many states pursuing expansions of your substance use disorder systems of care. These service expansions have been driven more recently by the opioid epidemic and further supported by federal funding as well as CMS initiatives such as the SUD 1115 waiver demonstration opportunity. As of August 20th, 28 states have approved SUD 1115 demonstrations, and seven states currently have waivers pending approval. States are leveraging these waivers to ensure access to a robust set of services aligned with the American Society of Addiction Medicine (ASAM) levels of care.

As states add to their service array covered under their Medicaid program, they are seeking to ensure covered services are evidence-based and therefore likely to result in positive outcomes. The SUPPORT Act furthered these two goals of increased service access or expansion and use of evidence-based services by requiring Medicaid coverage for all FDA-approved medications for treatment of opioid use disorder. Medication-assisted treatment, or MAT, refers to the use of medication, along with recovery support services such as counseling, for treatment of an SUD.

MAT is a service that can be utilized across ASAM levels of care including both outpatient and residential programs. The evidence for MAT is strong for both methadone and buprenorphine. In the studies cited here, which are more recent, methadone has been found to be effective in reducing all causes of mortality, opioid-related mortality and the risk of acquiring HIV. Buprenorphine has been found to be effective in decreasing mortality.

Despite the evidence, use of medications to treat SUD has been stifled by stigma and misconceptions about its role in bringing about recovery. However, as states look to solutions for the rising rates of overdose and OUD, the necessity has been even greater to educate providers on this effective intervention and support expanded utilization.

(next slide) In addition to MAT, peer supports is another evidence-based practice with increasing use across the country. According to a 2019 MACPAC report, 38 states cover some form of peer support for Medicaid beneficiaries with an SUD. Peer supports are typically delivered by a person with lived experience in treatment and recovery. These services may be provided on an individual or group basis as defined by the state. Nearly one in every eight adults enrolled in Medicaid has a SUD, and a significant barrier to treatment is the shortage of SUD professionals in every state.

State Medicaid agencies are increasingly leveraging a nonlicensed workforce including counselors, peers and other qualified staff to meet the growing need for SUD treatment and recovery services by their Medicaid-enrolled population.

In 2007, CMS issued a letter to state Medicaid directors authorizing them to offer peer support services as part of a comprehensive mental health and substance use service delivery system under Medicaid. States may choose to deliver peer support services through several Medicaid funding authorities including the state plan authority, which includes the Medicaid rehabilitative services state plan option, the section 1915i state plan option, and the health home state plan option.

To include peer supports in the state Medicaid plan, peers must be supervised by a mental health professional defined by the state, must coordinate peer support with an individualized recovery plan that includes measurable goals, and must complete training and certification as defined by each state. Peer supports can also be added under section 1915b or 1915c waivers as well as serious mental illness (SMI) or SUD 1115 demonstration waivers. Under these authorities, state Medicaid agencies determine the service delivery system, medical necessity criteria and the scope of these services.

Of the approved SUD 1115 demonstrations I mentioned earlier, eight states have incorporated one or more recovery support services such as peer supports. Peer support workers engage in a wide variety of activities including advocating for people in recovery, leading recovery groups, and mentoring and setting goals. Peers also provide outreach, assisting with initiation and engagement of beneficiaries who may be in the precontemplative or contemplative stages of change.

With these benefits in mind, it is not surprising that the evidence for peer-based supports demonstrates that peer supports are associated with improvements in SUD treatment and recovery outcomes, including hospital readmission rates, primary care visit rates, housing stability and recidivism. And people utilizing peer supports are more likely to complete OUD treatment.

(next slide) So as states expand service offerings, they're also continuing to carve in behavioral health services into MCO contracts. This can include peer supports and MAT. According to the Kaiser Annual Survey of State Medicaid Authorities, as of July 1, 2019, among the 40 states with comprehensive risk-based MCOs, 33 states reported that 75% or more of their Medicaid beneficiaries were enrolled in MCOs. Just as use of managed care arrangements have grown, the most common benefit enhancements reported during the last survey were for mental health and SUD services. It then comes as no surprise that partnerships between Medicaid agencies and their contracted managing entities can assist in achieving the state's program goals. This includes areas such as evidence-based practice expansion, addressing geographic access concerns, and ongoing monitoring of the quality of services and outcomes for beneficiaries.

Managed care plans have experience working directly with providers in supporting provider networks through training and technical assistance, as well as use of alternative payment strategies to incentivize practice change or enhancement. Today we are highlighting New Mexico and Tennessee as examples of Medicaid programs working with managed care entities in a concerted effort to support, build or expand provider networks specifically for MAT and peer support services.

We've got a poll question: *Is your state currently building capacity to offer any of the following services: methadone, buprenorphine, naltrexone, and peer supports?* You should be able to choose more than one if your state is building capacity for several of these.

The majority of our attendees today who participated in the poll were split between building capacity for the delivery of buprenorphine and peer supports. But we also have several attendees with states that are also expanding methadone and naltrexone. Almost equally split across the four options today. Given the interest with both MAT and peer supports, you will enjoy the speakers we have today. We've got great examples for both.

(next slide) Now our speakers from New Mexico. Dr. Neal Bowen became a psychologist later in life after working to defend human life in war zones, among other occupations. Witnessing a project in Sri Lanka created by a Dutch psychologist—training village health workers to provide mental health first aid – inspired him to obtain training in psychology.

After initial work in Milan, he obtained degrees, including a PhD in Counseling Psychology, from the University of Texas at Austin. While there he was awarded the Harrington Fellowship for his work with refugees, culminating in the creation of The Sunrise Center, a mental health agency for refugees and asylum seekers.

He joined the faculty of Central Washington University where he conducted research in multicultural competencies prior to responding to the allure of New Mexico and the challenge of building a mental health department within Hidalgo Medical Services (HMS), in an underserved and economically challenged rural area. He was named the Behavioral Health Provider of the Year for 2011 by the New Mexico Primary Care Association. He left HMS in November 2019 when he was appointed by Governor Lujan Grisham to serve as Director of the Behavioral Health Services Division in the Human Services Department.

Joining Dr. Bowen in presenting for New Mexico is Liz Lacouture. She has 30 years of experience working in the New Mexico behavioral health system, with 23 years of that in managed care. She joined Presbyterian Health Plan, a subsidiary of Presbyterian Healthcare Services in Albuquerque, New Mexico, in 2012 as the executive director of behavioral health. Presbyterian Healthcare Services is a locally owned, not-for-profit healthcare system that was founded in New Mexico in 1908, and the health plan provides healthcare coverage for more than 611,000 members – commercial, Medicare and managed Medicaid – in the state. Ms. Lacouture oversees all health plan policy and operational areas that support specialty behavioral health services, programs and providers. She was also a key contributor to the development of the health plan’s care coordination model, which was designed to support the plan’s managed Medicaid program, Centennial Care.

DR. NEAL BOWEN: The featured provider is an exemplary type MCO provider who collaborates quite well with the State of New Mexico and all of the steps that we undertake.

(next slide) I just want to give the basic foundation about the state structure. As mentioned, I am the Director of the Behavioral Services Division, which is embedded within the Human Services Department, together with the Medicaid division here in New Mexico. We also have a structure established in 2005 of a behavioral health collaborative, which is a collaboration of many departments, basically all the executive departments which manage any behavioral health moneys. We do that to try to align the payments that we provide and therefore the services that we provide to the citizens of New Mexico.

Medicaid is by far the largest provider of behavioral health services in the state of New Mexico and one strength of this particular administration is good collaboration. For example, all the expansions have access to telehealth services. We were able to provide those through Medicaid, through the non-Medicaid services, and with the collaboration of the Office of the Insurance Commissioner to private insurance as well. I think that makes all of the initial intake much stronger.

Embedded within the Behavioral Services Division is the Office of Peer Recovery and Engagement, which is the office responsible for providing training for people with lived experiences, either substance use or serious mental illness, and the basic training that is required of them to become peer support specialists. It also manages testing for that and renewal of their certification, and provides ongoing training for certain certifications that we have for specialized peer supports, which I’ll take a little bit more about later.

I also want to emphasize that we have a very good relationship with protocol, which is the national service for crisis lines in New Mexico. It's called the New Mexico Crisis and Access Line, which has for at least ten years been providing an excellent service to the citizens of New Mexico, both responding to their crisis and connecting them to care in their local community as appropriate as a result of that.

Several years ago they also established a peer support warm line so that people suffering from substance use or serious mental illness can call or text peers and have that kind of direct support rather than something aimed at crisis. Many of my own patients, when I was a provider in the southwest corner of New Mexico, took great advantage of that warm line staffed by peers. So that expanded the employment opportunities for our peer support services as well.

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LIZ LACOUTURE: I'd like to talk a little bit about some of the key features of our current managed Medicaid program, Centennial Care. New Mexico has had a managed Medicaid program in the state of New Mexico since 1997, and we transitioned to an 1115 demonstration waiver, which went live, the beginning of 2014. Prior to 2014, New Mexico had really split populations. So we had four different managed care organizations managing a traditional physical health benefit. We had two who were managing long-term services and supports, members in those categories of eligibility. Then we had yet another MCO who was administering behavioral health benefits across all of those populations.

What the 1115 demonstration waiver did was really allow us to bring all those populations and services together so they were all going to be coordinated by a smaller number of MCOs and really allow for more holistic care and support of all those Medicaid members.

In addition to that major change, I want to focus on two of the key features where peer support was really critical within the model. Although New Mexico had certified peer specialists within the state and we have for many years, until 2014, we did not have a covered service that was in the service array and the benefit structure. Most peer support functions most recently within peer-run wellness centers receive funding in a variety of different ways but outside of the managed care Medicaid system. Then of course we're providing some various roles within state policy and within training within communities.

In the 1115 waiver, we added recovery and family support services. Recovery support services and peer support services were designed really to target adults with severe mental illness and SUD. The family support service was initially designed to support the families of children with severe emotional disturbance. While respite isn't specific to peer support, it was also another critical add that we identified as desperately needed and historically funded in different ways, but brought it under managed care coverage.

The other thing we did that many people consider to be the cornerstone of Centennial Care was include a really robust care coordination model. Initially the care coordination was primarily done and still largely done by the MCOs and not providers. It's not a covered benefit. It's really considered to be part of the overall managed care function, but it is working very closely with members and providers to really support all their needs and help them achieve their healthcare outcomes.

Although it wasn't mandated that MCOs include peer support within their care coordination models, when Presbyterian was responding to the initial proposal to bid on this contract, and we looked at some of the populations and some of the criteria that the state had established for people who would benefit from care coordination, what we saw on that list were people who are in traditionally very difficult-to-engage populations. So for example, it included people with SUD who were not currently engaged in treatment or maybe not very consistently engaged and not successful in treatment at this time.

There were also homeless populations and some others with SUD and mental illness that we knew if we didn't have peer support within our workforce, we would have limited success in really engaging those folks in their healthcare. So within our model we actually built in a department within our care coordination. We built the department that we call the Recovery and Resilience Department. It's led by a director and includes our peer support work, but it also includes trainers.

Using peer support within a very traditional medical model is not intuitive. A lot of healthcare professionals don't really know how to use peer support within their environment. So we knew that it was going to take some time to really evolve the role of peer support within our model, and we wanted to build it in from the very beginning and begin to start to shift our culture within the health plan.

(next slide) On this slide are just some service definitions. These appear within the state's behavioral health policy manual. It's primarily geared toward services delivered by providers, but it really applies in principle to what we're doing within care coordination within the MCOs. The peer support specialists who serve on our care coordination team and who work within our provider community are really there to be part of an interdisciplinary team to bring not just direct interaction with members and bring value to members and patients who are in care, but to really also serve a consultative role within those interdisciplinary teams. I think they bring perspectives that often are lacking when you just bring together people with a lot of letters behind their name.

(next slide) Within the first few years of Centennial Care, before we went through the waiver renewal, we identified some things that were working really well within the peer support structure. I want to talk primarily about what happened within care coordination. When we started using peers in our care coordination model, initially we started with training. We did a lot of mental health first aid training and just generally recovery and resilience training with all of our care coordination staff, which today number in the hundreds. We also train our customer service staff.

We then started to include our Director of Recovery and Resilience in complex case rounds. So when we identified members we were having particular challenges with in engaging, we would pull together a multidisciplinary group that included physical health, behavioral health, long-term services experts, and we also started including our Recovery and Resilience director. What we really learned quickly was that the team we're really benefitting, from this perspective—some of you may have heard the term used with difficult members or patients, that they're noncompliant, they're resistant to treatment because they're not doing what we tell them they should be doing.

The perspective that peer support brought was really getting people to start thinking about what are those barriers that that member is experiencing that's preventing them from engaging in their healthcare. In many cases, it's their social determinants. We found a very high prevalence within that membership of housing and food insecurity. When you're not able to feed your family, you're not able to keep a roof over your head, you don't really care about engaging in treatment or following the recommendations of a doctor or nurse or a social worker who's telling you what you should be doing better.

So having that perspective really started to shift people's thinking a bit and got them farther away from that medical model mentality and really starting to think about how do we do this better and how do we support this member to get their needs met.

One of the very early initiatives we took on in Centennial Care were our high emergency department utilization members. We started pulling lists of I think the top 100 people using the emergency room, particularly in a nonemergency way, and started to staff some of those cases. Initially, we used care coordinators to try to outreach to those members and try to figure out what was going on. As we started to really look at these members and their histories, what we found is that there was a very high prevalence

of SUD within this population, and in many cases it was not being treated or the member was just not consistently engaged in any type of care through a provider in the community.

Some of their emergency department (ED) utilization was in a pattern of drug utilization or related to SUD, and in some cases it was simply how they accessed their healthcare. So when we tried to do outreach through care coordination staff—licensed clinicians, nurses, we were very unsuccessful in engaging this population. They wouldn't call us back. If they did talk to us initially they were refusing care coordination. They really didn't want to participate in that process and they just wanted to continue to do things the way that they were doing.

So in the course of discussing some of these cases in our complex case round setting, our Recovery and Resiliency director really started to shift the conversation to using peers to try to outreach to some of these members to see if that worked differently and better. And lo and behold, it did. We would send our peer supports out. We would identify these members. In the very early stages of Centennial Care we didn't really have real-time notification capabilities for ED visits. We actually have that now and in some cases can even catch these members while they're still in the ED. In other cases it took a little more investigative work to try to track some of them down. Many of them, as I mentioned, had housing insecurities. We have a lot of homeless members in this bucket.

So our peer support started establishing time with some of our local opioid treatment providers, our homeless shelters and healthcare services. We were able to start finding these folks and beginning to have conversations with them about what their needs were, what they wanted to accomplish with their healthcare and how they could support them through it. They even went so far as to offer to go with them to a primary care appointment. Primary care is not always very comfortable for people with severe mental illness and SUD. So that was one possibility.

The other thing they might do is make sure that that member knows how to get in touch with the New Mexico crisis and access line, and maybe even call with me so that when they really need it they know what to expect and they know what it's going to sound like and feel like when they call.

And within a very short period of time, we actually saw our engagement rate go up with that population to about 70%, which was enormous. Because in addition to being on our high ED utilization list, they were also people we had identified as difficult to engage. In New Mexico, we actually have a category within care coordination reporting where we identify a member who we believe meets criteria for care coordination, either through a health risk assessment and needs assessment or through claims utilization data that suggests that they're hitting some criteria, but we're not able to successfully engage them either. They refuse to participate or even if they initially agree they sometimes drop out and aren't actively engaged.

There was a significant overlap between what we call the full-time equivalent (FTE) population and the high ED utilization population. But even within the FTE population, we continued to identify mechanisms to leverage peer support to really target those folks that we felt would benefit most. Because care support is just really the only way where some of these populations, we can really successfully engage them. Especially if they're still in that precontemplative state and are not quite ready for any kind of change, they're really not going to respond well to healthcare discussions in that setting.

Part of our peer support interventions with these members is to do a social determinants screen. So really to understand what their needs are, what's not happening, what's not getting met. It's further complicated by the fact that for those of you who have seen New Mexico on the map, we're very large geographically. We have a lot of rural and frontier communities. While we have quite a bit of access to

services in two or three of our larger communities relatively speaking to our rural and frontier communities, it really can vary by community what resources are available.

So it's important that we have peer support who are really familiar with those resources in those different communities and can assist members to access the services that they need. We have peer supports who are basically locally based. The majority of our care coordination staff are all community-based and they're spread throughout the state of New Mexico so they really are familiar with the resources available in their community, and to make sure that those members get access.

We did find that particularly with housing the need was greater than what we had available to support them, so it was an area where we had to continue to work collaboratively with our state partners and our providers to try to come up with some new and better solutions in these areas where we weren't able to fully meet people's housing needs. So even outside of those covered Medicaid benefits, we have a history in New Mexico of working very closely together across systems, across departments within communities to try to solve these common problems within our communities.

(next slide) I'm going to start us off on what didn't work. Initially when we started looking at the new covered service, recovery support and family support services, we found that providers really weren't delivering them. We identified that fairly early on. We started asking questions. We started talking to our providers about it to try to understand what the barriers were.

We found that when we initially set the service definition—I can't really speak to how we came about it. We've had two or three changes in leadership since the time the waiver and contract were originally developed back then. But when they created the service definitions for recovery support they made it such that it was only going to be delivered by a fairly narrow group of providers. They also made it so it was a stepdown service. So basically the patient has to have completed other services and is ready for the stepdown peer support service as their primary service.

It was really just too narrow and wasn't, one, going to have sufficient demand, or sufficient numbers for it to really be a viable service that providers could deliver. They really gave that feedback. They couldn't even afford to hire an FTE based on the revenue they might generate based on how the service was currently defined. So we began to work closely with the state and with the other MCOs and providers to try to work through the challenges to try to come up with something that was really going to fit better within the overall service array.

We also had workforce capacity issues. I mentioned before that we did have certified peer specialists in the state before Centennial Care, but because there weren't a lot of opportunities for them to be employed, many of them were losing their certification because they weren't maintaining their continuing education requirements and some other requirements. So there were a lot of folks that had previously been certified but would have to go through a recertification process. And our certification process frankly at that time was not terribly efficient. It was not easy for people to, one, go through because of the time required and the travel required, which the state supported but it's still difficult for people to participate in that. And it wasn't quite scalable at that time given where we really wanted to go in building the workforce capacity.

So we had some work to do in terms of getting people trained and certified in such a way that they could begin to work in the workforce. I'd like to hand it over to Neal to finish off the slide for us. Neal, at the time this was all actually happening, was on the provider side so I thought he might also be able to offer some of that perspective.

DR. NEAL BOWEN: (next slide) Yes, I was a provider and eligible for having peers, though we didn't actually hire peers until 2018 when the restrictions were loosened somewhat, and when we opened a specific SUD facility we were at a federally qualified health center (FQHC), which provided MAT, among other things. In the six months after we hired our very first peer, we realized we had successfully assisted more patients to go to a higher level of care, inpatient or residential care, and then successfully transition them back to ongoing care in their home communities in that six months with the assistance of a peer than we had in the ten years prior to their arrival.

So obviously we were sold very quickly on the value of having peers on the staff and some of their very specific skills in helping enhance motivation for change and to walk with people through some very difficult transitions in their life. So we extended it quickly, and we also had a very robust care coordination project, two different projects that we hired peers for. And we saw the difference between SUD peers and mental health peers, people who had lived experience with serious mental illness and substance use. We realized they didn't necessarily understand the other folks they might be helping so the mental health peers may not have a great understanding of SUD unless they've been through it themselves and vice-versa.

I'll just underline how important the clinical supervision provided to peers was in helping smooth out those differences and helping to maximize the availability of them. Now as the DBHSD director, I'll just mention that I came with that perspective and also with the idea that expanding not just the number of peers who are certified in the state of New Mexico but the geographic distribution of them. As with most behavioral health professionals, the urban areas of New Mexico—Albuquerque, Las Cruces and Santa Fe—were well-represented with the number of certified peers, but the rural and frontier areas, the rest of the state, not so much. So we worked really hard to expand access to that training and the certification process into our rural and frontier areas. Because, as Liz alluded to, the knowledge of those local resources and limitations is really critical to the effective implementation of their role.

We expanded the number of things that they can do. In New Mexico we have something called CCSS, Comprehensive Community Support Services. It's similar to care coordination but not exactly the same thing in that it's more designed to teach people skills than enhance their independence. But we added an improved reimbursement rate for certified peers if they also got the CCSS training. I just wanted to underline that. I'll move on quickly.

(next slide) One of the things we learned very quickly when COVID impacted New Mexico was we needed to set up specific shelters for some people impacted by COVID, either because they were COVID -positive or awaiting the results of testing or other reasons. And that isolation in itself was a risk factor for decompensation for the people in those kinds of non-congregant shelters. So we very quickly developed a project where we connected certified peer support specialists who had been trained to work with people in those shelters to the shelters by telehealth through iPads we deployed or telephonically. Again we saw very quickly much better compliance with the conditions of the shelter, much better completion of the time they were designed to be in the shelter, and more importantly even, a much better rate of transition from the shelter to ongoing care for SUD and mental health disorders for responding to the social determinants that put someone in that situation.

Because of that experience we also deployed them, together with the behavioral health providers in general, to provide telehealth services into our long-term care facilities where many of our elder residents were decompensating from the isolation as well. We've got a number of different expansions of the role of peers in New Mexico. I'll name one. Just today, the Medical Advisory Team to the Governor, we agreed that we would start deploying peers in our senior service centers, especially in delivering food to our

elders in rural and frontier populations, in order to provide the first connection possibly to behavioral health services when that was indicated.

Mindful of time, I'll stop here and be open to questions. Thank you.

GINA ECKART: Thank you, Dr. Bowen and Liz. Interesting to see how you guys have evolved peer services over time built on lessons learned, and really expanded and gotten uptake in the use of it with both health plans and providers as well. We have one question for you guys related to your social determinants of health (SDOH) assessment. *Is the SDOH assessment similar to the health assessment to address social needs? If so, is the SDOH and assessment results integrated in the care plan for Medicaid beneficiaries with SUD?*

LIZ LACOUTURE: We have a brief at SDOH assessment that is ad hoc to our comprehensive needs assessment but also integrated within it, so it can be done either way. So someone who's just getting peer support intervention, they're just going to be doing that SDOH assessment if one hasn't already been completed or it's maybe not current, but it is ultimately integrated into the member's care plan for the health plan. And to the degree possible, it's coordinated and communicated with the member's provider if they have one.

GINA ECKART: Our next speaker is from the great state of Tennessee. Mary Shelton is the Director of Behavioral Health Operations at the Division of TennCare, Tennessee's state Medicaid agency. She oversees the mental health and substance abuse Medicaid benefits, behavioral health and primary care integration efforts and the design and implementation of new behavioral health programs including Value-Based Programs. She also directs the operations of the Tennessee Health Link program, the health home care coordination model which serves 75,000 TennCare members with SPMI across the state. Mary has worked for the State of Tennessee for 24 years including 12 years at the Department of Mental Health and Substance Abuse Services.

MARY SHELTON: (next slide) Thank you to CMS for this opportunity to share Tennessee's MAT strategy.

(next slide) TennCare is Tennessee's state Medicaid program covering the entire state. We are 100% managed care. We have 1.4 million enrollees and we have operated under an 1115 waiver since 1994. We cover 20% of the state's population, 50% of the state's children. TennCare is fully integrated, which includes coverage of behavioral health, long-term services and supports, and children, including children in state custody.

(next slide) There is mandatory enrollment for all Medicaid-eligible Tennesseans into a managed care organization. We have three statewide MCOs: Amerigroup, United Healthcare, and BlueCare Tennessee. TennCare uses managed care to provide high-quality cost-effective care. Our experience has shown that managed care allows for better coordinated, more efficient and higher quality care. It also reduces avoidable emergency room visits and hospital stays.

(next slide) As we started to build TennCare's MAT program, we identified a few challenges in building out a MAT network. Providers had concerns about contracting for this service which were related to the stigma around providing MAT, such as prescribing buprenorphine. While this is evidence-based, they might receive questions from folks in the community and they didn't want to be labeled as the dosing clinic. Then also drawing in an individual who might abuse the service through diverting buprenorphine. Also administrative burdens from TennCare's perspective. They needed a dedicated provider infrastructure and business practice changes that would allow for those providers who attest to our program description to be in the MAT network.

(next slide) We knew that building a dedicated MAT network was needed. It was evidence-based, and we wanted to ensure that our members with opioid use disorder had access to high-quality care. This was our path to build a high-quality SUD and OUD treatment network. First, we established a MAT program description and quality standards, through defining program standards for MAT providers, leading the MCO collaboration to develop supports for the MAT providers, and identifying quality metrics for reporting.

Second, build access and capacity across the spectrum. We developed a program description for existing SUD providers to ensure quality opioid treatment, supporting the MCO to develop a statewide program network adequacy focused on MCO contracting with high-quality providers. Then we also implemented a Project ECHO program to scale education and training for MAT primary care physician providers.

Third, increasing coordination of care in clinical integration. Here increased coordination between inpatient and intensive outpatient residential facility and MAT providers and supporting helping the integration between MAT provider networks and the PCP and pain management team.

Up next, for the future, we aren't here yet but hopefully in the next year or so we'll identify opportunities for value-based intervention and then integrating health outcomes and quality metrics into the value-based care model.

(next slide) TennCare's opioid strategy has three prongs: primary, secondary and tertiary prevention. The next three slides introduce our approaches, then I will share additional guidance and data for each prong.

First, primary prevention. Our aim here is to eliminate opioid exposure and prevent progression to chronic opioid use for nonchronic and first-time users of opioids. The work here was mainly administrative. We implemented a rule in January of 2018 placing dosage and day coverage allowances on opioid prescriptions for naïve and acute users. We increased prior authorization requirements for all opioid refills and continued support of nonpharmacological pain management and clinical services such as physical therapy.

(next slide) Secondary prevention: The aim here is early detection and intervention to reduce impact of opioid use for women of childbearing age and increasing provider education. To work towards this, we partnered with the Tennessee Department of Health to better integrate the controlled substance monitoring database, or CSMD, and then TennCare's MCOs developed strategies to proactively engage women of childbearing age who are using opioids, based on data and clinical risk. The MCOs have performed outreach to thousands of women of childbearing over the past year, and this is an ongoing effort by all MCOs.

(next slide) Tertiary prevention: The aim here is to support active recovery for our members who have a chronic dependency or addiction. Our work here is: through increased outreach to chronic opioid users to refer them to treatment and to prevent overdoses; support actively building MCO networks of MAT providers to broaden access to high-quality treatment for OUD and SUD; and align chronic opioid users' morphine milligram equivalent dosage allowances with the Centers for Disease Control and Prevention chronic pain guidelines.

(next slide) Back to primary prevention. These new benefit limits came into effect July of 2018. So for first-time or nonchronic opioid users, TennCare would cover opioid prescriptions for up to 15 days in a 180-day period with a maximum dosage of 60 morphine milligram equivalents (MMEs) per day. So for the first day in a 180-day period, the member could get five days at 60 MME with no prior authorization needed. Then after that first fill, they were allowed a 10-day maximum fill, again at 60 MME, but then aprior authorization was required. There were exceptions to the benefit limits on opioid prescriptions such

as those with sickle cell, severe burn victims, severe cancer pain, hospice care members, and those members in a nursing facility or an intermediate Care Facilities for individuals with Intellectual disability (ICF/ID). Also included were increased prior authorization requirements for the opioid refills and increased access to nonpharmacological pain management and clinical services, such as physical therapy.

(next slide) We are pleased to share the before and after views of TennCare's prescription patterns for the acute opioid use. Ninety-four percent (94%) of all first-time and acute opioid users are now receiving six days or less of opioids after the new limits were implemented. Here you can see the days before on the left-hand side and then the day's supply after the TennCare benefit limit.

(next slide) This graph shows the number of opioid pills dispensed in the TennCare program since 2015. As you can see, TennCare has cut the number of opioid pills dispensed on more than a third since 2015. You can see the arrow pointing to where the TennCare opioid benefit limit began between 2017 and 2018, and then definitely the drastic reduction.

(next slide) Secondary prevention: This focused on all chronic and acute opioid users of women of childbearing age. Women who might be pregnant or known to be pregnant and taken opioids, and women with a prior diagnosis of a neonatal abstinence syndrome (NAS) baby delivery. Additionally for outreach, all MCOs are tracking the number of contacts made with women at risk, as well as the intensity of the outreach performed. For example, high-intensity outreach involved an in-person visit compared to low-intensity outreach, which can be an email or a news flash with general information.

The goal of the outreach is to connect women at risk with the appropriate resources. TennCare and the MCOs developed a risk stratification algorithm to proactively identify women of childbearing age who were using opioids based on clinical risk, and an integrated controlled substance monitoring database with the medical claims and pharmacy claims to identify potential opioid misuse or OUD clinical risk for member engagement.

The MCOs use multiple engagement strategies to outreach to women based upon potential risk of opioid-related health issues. Reports include flags from the CSMD data for opiates, benzodiazepines and buprenorphine, and include women paying out of pocket for prescriptions not identified through TennCare paid claims.

(next slide) This graph shows the live NAS births within the TennCare program since 2008. As you can see, there is a downward turn starting in 2017, and we definitely celebrate that with all of our partners throughout Tennessee—the primary care providers, the OB's, the Tennessee Department of Health, Tennessee Department of Mental Health, and we so hope that this trend continues.

(next slide) This graph shows the total acute and chronic opioid users within the TennCare program. The blue represents the acute users and the gray represents the chronic users. Overall the number of TennCare new acute opioid users has declined by 52% since 2015. The largest decrease occurred following the implementation of the new TennCare opioid benefit limit.

(next slide) Tertiary prevention: TennCare's MCOs, Amerigroup, BlueCare Tennessee and United Healthcare, have further identified ways to increase access to comprehensive MAT for our members with SUD and OUD. This through the development of a MAT provider network. Behavioral health counseling and therapy is a necessary component of a MAT treatment that providers in the network must have means to provide. By participating in the network, providers will receive enhanced resources and support from the MCOs. TennCare in collaboration with our MCOs developed program descriptions for both buprenorphine MAT and naltrexone MAT.

TennCare partnered with the MCOs to develop guidelines for contracting with high-quality MAT providers and then TennCare hosted two introductory webinars for providers and practices about MAT and how to start the contracting process.

(next slide) This map shows those providers who are contracted with at least one MCO for our high-quality, specialized MAT provider network, which launched on January 1, 2019. There are currently 180 newly contracted MAT providers across the state, and that number is continuing to increase.

(next slide) So there are two principle strategies when implementing a new program at TennCare. First, multiple collaborative meetings between TennCare and all three MCOs. I can't stress enough the power of collaboration. Over the past 12 years of working here at TennCare, I've been asked multiple times how we have launched several statewide programs and then kept them running, meeting with the providers, the MCOs and our sister state agency, the Department of Mental Health and Substance Abuse Services, has been key to designing successful programs and having a smoother launch. It's not always a smooth launch—there will always be issues, but when you have had folks at the table already throughout the design, it's so much easier to get buy-in if and when you have to make programmatic changes throughout an implementation.

Second, our contractor risk agreement. This is the contract between TennCare and our contracted MCOs. We rely on this contract between us and our MCOs. Here we include requirements for GO access, implementation time frames, reporting requirements including time frames, and staffing requirements. Our contract deliverables are submitted through a web-based platform, which tracks the submissions and allows for future actions such as approving the reports, asking for corrections to the reports or adding additional information requesting a corrective action plan from the MCO and, if warranted, assessing liquidated damages.

The contractor risk agreement (CRA) is the foundation for the TennCare program and when there is any question about what is required of the MCOs, we all go back to this source document.

(next slide) I will highlight a few of the requirements for the MAT program, which are found in the contractor risk agreement. We included these outreach requirements to help with coaching and education for the providers and to assure the provider is rendering the service as contracted and as required by the MAT program description. Like in other states, we already had a few bad actors within our state, and we wanted to ensure that the providers in our MAT network remained high-quality.

So as you can see here, for the first two calendar years of participation within the TennCare MAT network, the contractors in that MCO will provide at a minimum three examples with each contracted MAT provider, an in-person check-in, an in-person audit meeting, and virtual education session. Then one in-person check-in at the national provider identifier (NPI) level with each contracted MAT provider per calendar year.

(next slide) Here you can see contractors and again the MCOs must have the appropriate representative present to discuss the following with the provider in person: billing or processing questions; programmatic and clinical education needs; quality metrics; and program description and opportunities for additional supports. I think the key language here is making sure that the MCO has the appropriate person, because as you can see, this is quite a broad spectrum of topics.

(next slide) Then contractors must conduct at a minimum of one virtual education session for the MAT providers per year to provide additional training, education and necessary general updates to the MAT network requirements. Then the MCOs should share the topics with TennCare at least 90 days in advance for appraisal.

(next slide) So simply, the TennCare contractor risk agreement allows for accountability, expectations, so setting the expectations for the MCOs and for those expectations that need to be passed down to the contracted providers, and then requires the MCOs to have the staff to fulfill those established duties. We have heard from MCOs in the past that building such requirements in the contract service agreement really assists the local plan to justify any staffing needs or resources to their corporate headquarters.

(next slide) Translation into methadone: TennCare was not covering methadone for OUD but to comply with the SUPPORT Act, TennCare added this as a covered benefit, and it went live on June 1st of this year. As we all know, the opioid treatment providers are heavily regulated, and TennCare just added some limited guidance and developed a program description to define the billing methodology and set the reimbursement rate for the program for at least the first two years of operation.

(next slide) I'm going to highlight two of the main additions to TennCare's current opioid treatment program (OTP) operation, and this is for counseling and care coordination. So we added these components to the methadone program description. So first for counseling, we're requiring a master's degree in a mental health discipline. The person either needs to be independently licensed to provide the counseling services or be under the direct supervision of a licensed mental health provider.

(next slide) Then continuing on with the counseling sessions requirement, for the individual counseling sessions, this must be performed by a mental health counseling professional with at least a master's degree, but the group counseling session can provide it under the supervision of the professional with at least a master's degree.

(next slide) Then care coordination, as we all know, an important component to an MAT program. Here we are requiring that each contracted OTP employ, contract or partner with a care coordination resource. This is to help maintain contact with the member, provide information or support for social services, organize and facilitate communication between two or more participants involved in the care, such as the OTP, the primary care provider (PCP), specialty services or mental health services.

(next slide) Then care coordination continues, along with the employee, contractor or partner with the care coordination resource, and this is to continue to communicate timely with other providers who are treating the member, coordinate communication, verification and reduction in illicit substances prescribed by licensed providers, and, where appropriate, improve management of medical conditions in the individual's present plan.

(next slide) Looking back on the design and implementation of TennCare's buprenorphine and methadone MAT programs, these are activities which help us stand up these high-quality programs. Seek input from providers who are already following best practices and have shown positive outcomes. Prior to covid, we regularly visited providers across the state. We would sit down with them, get a tour of their facility, ask questions, and learn what was working in their program. They all have tried different business designs and clinical designs, and we wanted to know what was working right for our members.

Second, coordinate efforts and partner with sister state agencies for developing statewide initiatives. Even though here at TennCare we don't have a contractual relationship with our Department of Mental Health or our Department of Children's Services, we partner closely, talking frequently, asking questions, making sure that our initiatives are aligned. Also collaborating with contracted MCOs. The utilization management (UM) and business staff at the MCOs have so much information on the members they serve and they're always a great resource for ideas and input on program design and implementation.

Then also ensure that the contract language reflects the needs of the program. We amend our contractor risk agreement twice a year, which helps us keep our language up to date. Thank you.

GINA ECKART: Thank you so much. A wealth of information, and an excellent example where a state has really partnered with its health plans to build that provider network, but it also sounds like through multiple initiatives you're really raising the bar of expectations on those providers, especially as it relates to care coordination. So excellent information.

We did get a question in the chat for you. *Did the success rate for the TennCare SUD program increase or decrease post-covid-19?* I think they may be referring to some of the data you were sharing.

MARY SHELTON: As far as the data that I shared, we don't have any updated. We're still waiting on some claims data to come through to process that. But I did talk to a couple of SUD providers during COVID and they were seeing fewer folks presenting for detox and fewer folks presenting for rehab. But I have a feeling those numbers are starting to increase. But no, I don't have an update on the data.

GINA ECKART: Related to the data, is there a way you're formally sharing that or using that data with the health plans? Do they get dashboards related to the opioid prescriptions and some of the information you were sharing earlier in some kind of formal structure?

MARY SHELTON: Yes. We send them feeds from our pharmacy program. So within TennCare, pharmacy is a carve-out. We have a pharmacy benefits manager, but we send daily feeds to the MCOs for their members so that they can see their pharmacy usage.

GINA ECKART: Another question specific to your MAT outreach required of the MCOs. One of the things you mentioned you're doing in the various outreach activities was audits. Are they doing formal chart audits when they're visiting the MAT providers and if so, are there tools that are plan-made or created or is the state working with MCOs for a standard way for them to go in and do those visits?

MARY SHELTON: TennCare, along with the MCOs, develop an audit tool, so all three MCOs use the same audit tool for the provider. So yes, they're using the tool when they go into the practice, and it's not just for the chart, it's also for the practice itself. Wanting to do a tour of the practice, meeting with staff. But yes, there is information in the audit tool related to the chart, but then also how is the practice showing and demonstrating that they're following the MAT program description.

GINA ECKART: Then do they share the audit findings back with you guys and/or your licensure agencies? Or is that all kept internal between the provider and the health plan?

MARY SHELTON: They share it back with TennCare, so we're able to see how each practice is performing. We're able to see how practices are performing within the MCOs or within certain regions. We haven't got to this point yet definitely since we have just implemented the program, but if any of the MCOs put a provider on a corrective action plan or if they're looking at possibly terming a provider because they're not meeting the standards for the program, then they would share that with us as well.

GINA ECKART: Another question regarding the requirement of counselors to be licensed mental health professionals. *Have you had issues with finding enough licensed professionals to fill this requirement? In my state, it is difficult to find enough professionals to fill this role in the mental health plans. How are these professionals paid? Is it solely through Medicaid?*

MARY SHELTON: We work with our opioid treatment providers and we've actually given them a year to ramp up and hire enough master's level clinicians to serve the Medicaid members. So here in Tennessee, OTP methadone treatment has been cash pay for quite a while. We're now covering methadone treatment for Medicaid members, but we heard this from them, and we also talked with a few other states and heard that they allow six months for a year to allow the providers to hire master's level clinicians. So we are giving them a year to fully staff, and the professionals are paid, at least for those who

are seeing TennCare members, it is rolled into the case rate that is reimbursed by the TennCare MCO. Exactly how the business practice of the OTP, that would be up to each OTP, but the case rate does contemplate counseling by master's level clinicians.

GINA ECKART: Very helpful. Going back to your contract risk agreements, your contracts with your MCO, you've touched on this a little bit, but were there any components specifically within the contract related to the MAT provider requirements that you felt were particularly helpful in having that accountability you sought and really getting the outcomes in terms of building the network that you guys are achieving?

MARY SHELTON: With the program description, each provider has to attest to the program description. We aligned it with standards from the Substance Abuse and Mental Health Services Administration (SAMHSA), from our own Department of Mental Health and with ASAM. So for those providers who are already providing a quality service it wasn't much of a lift for them. But for those providers that unfortunately may have just been writing scripts for buprenorphine, they either were not even considered to be part of the network or didn't ask to be part of the network. But I believe that attesting to the program description really put some teeth into the program description and what TennCare and its MCOs were expecting.

GINA ECKART: Along the same lines, you differentiated some of the requirements the health plans are assisting with for OTPs as well as settings where buprenorphine is being prescribed that are not in OTP. One of the questions is: *Do you anticipate having similar requirements of your OBOT providers in particular as you have with the OTPs?* So if an office-based opioid treatment program is prescribing buprenorphine but also providing counseling, that they also are using master's-prepared clinicians, they are also being audited or having some of the outreach you talked about with OTPs.

MARY SHELTON: Yes, absolutely. Of course I just highlighted some of the components of the methadone program description. The buprenorphine program description was developed first, and we actually modeled the methadone program description off of the buprenorphine, so yes, the buprenorphine requires a master's degree for counseling. It requires care coordination and connection with peer support services. Yes to all of that.

GINA ECKART: It shows how great a job you're doing, the interest in the program.

MARY SHELTON: The program descriptions are listed on our website so if you google TennCare, there's a tile on the landing page that says TennCare's Opioid Strategy, and that takes you to a page and there are links to the buprenorphine program description and the methadone program description.

GINA ECKART: You just mentioned care coordination. There was a question about the requirement. *Who typically is providing that care coordination for those using MAT or receiving MAT from an OTP? Is it the MCO or do you have care coordination providers in the state? Other treatment providers?*

MARY SHELTON: The information I've presented here from the program description, that is referring to a provider-based care coordination. It says employee, contractor or partner. That's definitely provider-based, so if they want to do care coordination within the OTP they may do that. If they want to partner with a community mental health center and have the care coordination rendered through the community mental health center they may do that. Or they may contract with a care coordination entity, a provider care coordination entity, and they may provide the care coordination.

But we do not say they have to be at a certain licensure level or educational level. That we have not spelled out. But yes, our MCOs do provide case management and care coordination. It's through a stratification.

But if a provider identifies a member with multiple medical conditions or needs help seeking services, then that provider may contact one of the MCOs for help with care coordination.

GINA ECKART: We've got a question for New Mexico on their presentation related to peer support services. The question is: *What strategies did the state or MCOs utilize to build the peer support workforce and initially encourage providers to hire these individuals and incorporate them in the treatment team?*

You guys had mentioned challenges dealing with those in terms of lifting certification barriers, but wondering if there were other incentives or strategies you used to build that workforce in New Mexico.

DR. NEAL BOWMAN: One of the strategies we used was collaborating with the peer community broadly to increase the awareness of the opportunity among people in recovery. Then for the providers we've developed and provided them both a learning community about working with peers, especially for the clinical supervision of peers, which is a critical element in success there. Then the expansion of the service definition was definitely a critical aspect in allowing more people to access them.

The increased rate of reimbursement for peers who get the additional certification also helped expand it.

GINA ECKART: Another question you touched on, Dr. Bowman: *Are there lessons learned regarding the occupational supports, such as supervision for the peer workforce?* You mentioned the importance of supervision. How does that work in New Mexico and did the MCOs have any kind of role in that process?

DR. NEAL BOWMAN: One of the real critical things we learned very early on is that you want your clinical supervisors to understand peers, their lived experience, their expectations. So it helps a great deal to have clinical supervisors who are attuned to the specific life experiences of peers and treat them not as if they were master's level or doctorate level therapists but as the people they are. That's proved really critical providing that support. The National Council for Behavioral Health provides excellent resources for training clinical supervisors to be good clinical supervisors for peers.

One additional thing that we just completed this week, a second specific training for peers, is training in workforce readiness. That includes understanding the difference between advocacy and participation, and understanding the difference between being in a 12-step provider and being in a provider environment. But also we developed clothing drives to provide peers who often are coming from disadvantaged circumstances economically into the workforce. We provided lots of very practical support and assistance to them in being workforce ready, and that has also helped improve the outcomes. Liz, do you want to say something about the MCO role?

LIZ COUTURA: Sure. I don't know that the MCOs really had a role in the overall statewide strategy so much as just initially being employees of many peers in the beginning of Centennial Care. From our own experience, what we realized early on is that we had to be really thoughtful about where we put the peers within the organization. We thought it would be a good idea to have some peers that were part of our customer service unit, and while they had some support from our director of Recovery and Resilience who had extensive experience working with peer support workforce, they were in an environment that was just not a good fit for most peers that are in the workforce. So we had to quickly shift that thinking and ensure that they were in an organizational structure that provided them with the kind of personal support that they needed to help them maintain their own recovery goals and give them the flexibility that they needed.

The other piece of that is we really limit the peers' caseloads within the MCO and we use them heavily for consultation. So we're educating care coordinators who are working with these peers at better

supporting, and we're using them to also provide consultation to a community health worker workforce which we also employ and has a little bit more capacity.

GINA ECKART: Great examples for folks. The slides will be posted and available. In addition to the slides today, Mary has included some Tennessee contract language slides you'll see at the end of the deck once it's posted. [reminds of evaluation form at end of webinar] Today we had some excellent speakers who really drove home the fact that managed care plans can be important partners for Medicaid programs and gave us really specific examples today of how you can leverage our health plans or your managing entities to work directly with providers not only to build capacity but also support service delivery. I think there was a lot of attention to the quality of services being delivered in these two states and ways to make sure that the providers are supported and that the services are evolving.

Again we'll have managed care contract language to share with you in the slides. But I also think our speakers today gave us awesome ideas about how we can incorporate some of those expectations on the plans that translate down to our providers. Thank everybody for joining today.

[end of recording]