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
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• Moderated Q&A will be held periodically throughout the webinar
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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.
• **Thomas McClellan, PhD**  
  Chairman of the Board and co-founder of the Treatment Research Institute
Presenter (2 of 6)

- Jack Kemp, MS
  TRI Consultant
• 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
• Marlies Perez, MA
Division Chief, Substance Use Disorder Compliance Division, CA Department of Health Care Services
• Neil Campbell, MS
  Executive Director, Georgia Council on Substance Abuse
Substance Use Among US Adults (1 of 3)

- Very Serious Use
  - In Treatment ~ 2,300,000
  - Addiction ~ 23,000,000

- Little Use
  - Harmful Use - 40,000,000

- No Use
  - Little or No Use
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)

Very Serious Use

$40 bn Per yr

$80 bn Per yr

Little or No Use
Insurance Only for “Addiction”

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

**Diabetes**
- Pre-Diabetes
- Clinically Managed Diabetes
- Personally Managed Diabetes

**What is Needed?**
- Screening those at risk
- Motivational education
- Behavioral Interventions
- Electronic Monitoring

**SUD**
- Harmful Use
- Clinically Managed SUD
- Personally Managed SUD

- Behavioral Interventions
- Medications
- Family/Peer Support
- Close Monitoring

- Electronic Monitoring
- Social/Environment Services
- Family/Peer Supports
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

<table>
<thead>
<tr>
<th>Goals</th>
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<tbody>
<tr>
<td>1. Establish/Maintain reductions in substance use</td>
<td>4. Engage Patient/Family/Support network into Stage 3 care</td>
</tr>
<tr>
<td>2. Improve general health and social function</td>
<td></td>
</tr>
<tr>
<td>3. Educate patient/Family to understand, monitor and manage substance use problem</td>
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</tbody>
</table>

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

**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

<table>
<thead>
<tr>
<th>Outcomes &amp; Indicators</th>
<th>Best Case</th>
<th>Or</th>
<th>But Not</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Elimination or significant reduction of use as indicated by urine drug screens during monitoring</td>
<td>• Patient acknowledges “relapse”</td>
<td>• Serious relapse or overdose incident</td>
</tr>
<tr>
<td></td>
<td>• Active engagement in stage 3 care</td>
<td>• Patient agrees to more intensive monitoring and/or</td>
<td>• Hospital, ER or Residential Treatment Required</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Patient agrees to intensify care</td>
<td></td>
</tr>
</tbody>
</table>
Substance Use Among US Adults (3 of 3)

Benefit for “Substance Use Disorders”

- Prevention
- Early Intervention
- Treatment
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

<table>
<thead>
<tr>
<th>DMC Services</th>
<th>SPA 13-038 (Non-Waiver)</th>
<th>Opt-in Waiver</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient/Intensive Outpatient</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>NTP (including buprenorphine, naloxone, disulfiram)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Residential</td>
<td></td>
<td>X (one level)</td>
</tr>
<tr>
<td>Withdrawal Management</td>
<td></td>
<td>X (one level)</td>
</tr>
<tr>
<td>Recovery Services</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Case Management</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Physician Consultation</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Additional MAT</td>
<td></td>
<td>X (optional)</td>
</tr>
</tbody>
</table>
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 opioid treatment
• Provide counties with technical assistance to implement any new services
## Additional Medication Assisted Treatment (cont’d)

<table>
<thead>
<tr>
<th>Medication</th>
<th>TAR* Required</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methadone</td>
<td>No</td>
<td>Only in NTP/OTP</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>Yes, unless provided in an NTP/OTP</td>
<td>Pharmacy Benefit, NTP/OTP</td>
</tr>
<tr>
<td>Naltrexone tablets</td>
<td>No</td>
<td>Pharmacy Benefit, DMC Benefit</td>
</tr>
<tr>
<td>Naltrexone long-acting injection</td>
<td>Yes</td>
<td>Pharmacy Benefit, Physician Administered Drug</td>
</tr>
<tr>
<td>Disulfiram</td>
<td>No</td>
<td>Pharmacy Benefit, NTP/OTP</td>
</tr>
<tr>
<td>Acamprosate</td>
<td>Yes</td>
<td>Pharmacy Benefit</td>
</tr>
<tr>
<td>Naloxone</td>
<td>No</td>
<td>Pharmacy Benefit; NTP/OTP</td>
</tr>
</tbody>
</table>
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)
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...
“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

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 Chinman Ph.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 DBHDD/Office of 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
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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neil@gasubstanceabuse.org
Questions on presentations so far? (2 of 2)
Final Observations/Discussion
Up Next

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

After you exit the webinar an evaluation will appear in a pop-up window on your screen. Please help us to continually improve your experience.

We greatly appreciate your participation!