HEALTH WEALTH CAREER

ADDING EVEN MORE SUBSTANCE TO MANAGED CARE

OPTIMIZING MEDICAID TO RESPOND TO SUBSTANCE USE DISORDERS

NATIONAL ACADEMY FOR STATE HEALTH POLICY
30TH ANNUAL STATE HEALTH POLICY CONFERENCE
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David Kelley, MD
Chief Medical Officer
Commonwealth of Pennsylvania, Department of Human Services,
Office of Medical Assistance Programs

Pat Lincourt, LCSW
Director, Division of Practice Innovation and Care Management
New York State Office of Alcoholism and Substance Abuse Services

Laura Nelson, MD
Principal
Mercer Government Human Services Consulting

OUTLINE AND FORMAT

FRAMING THE ISSUE

SHIFTING TO A MANAGED CARE SYSTEM

VALUE-BASED PURCHASING IN A MANAGED CARE ENVIRONMENT

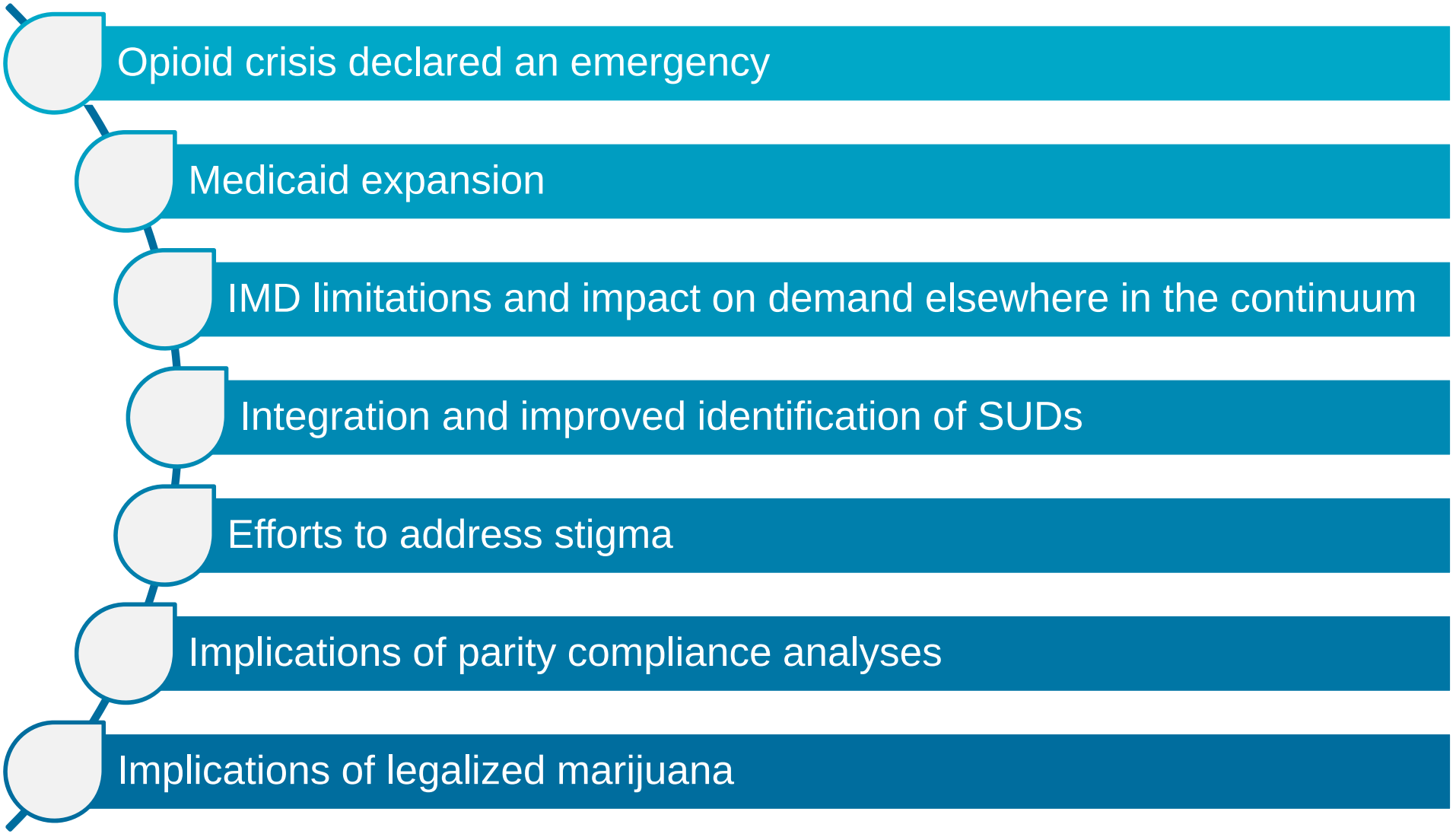
SHARING LESSONS LEARNED AND INNOVATIONS

COSTS OF SUBSTANCE ABUSE

	HEALTH CARE	OVERALL	YEAR ESTIMATE BASED ON
TOBACCO	$168 billion	$300 billion	2010
ALCOHOL	$27 billion	$249 billion	2010
ILLICIT DRUGS	$11 billion	$193 billion	2007
PRESCRIPTION OPIOIDS	$26 billion	$78.5 billion	2013

NIDA. (2017, April 24). Trends & Statistics.
Retrieved from https://www.drugabuse.gov/related-topics/trends-statistics on 2017, August 28

INCREASED DEMAND FOR TREATMENT



RESPONDING TO DEMAND

21ST CENTURY CURES ACT

THE COMPREHENSIVE ADDICTION AND RECOVERY ACT (CARA)

MEDICAID INNOVATION ACCELERATOR PROGRAM (IAP)

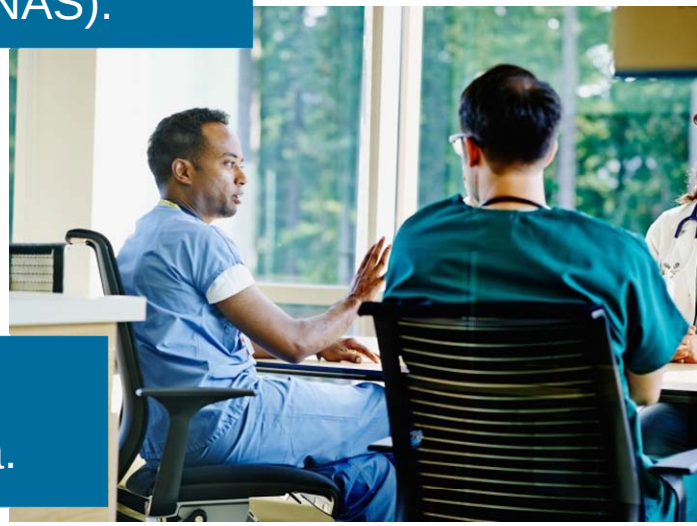
- Better identify individuals with a SUD,
- Expand coverage for effective SUD treatment,
- Enhance SUD care delivered to beneficiaries,
- Review the availability and quality of medication-assisted treatment (MAT) service delivery, and
- Develop payment mechanisms for SUD services that incentivize better outcomes

KENTUCKY

Increasing the use of evidence-based practices to treat opioid addiction and enhancing provider capacity for treatment.

LOUISIANA

Increasing early identification and referral to treatment of mothers at-risk for SUD and infants at risk for neonatal abstinence syndrome (NAS).



MICHIGAN

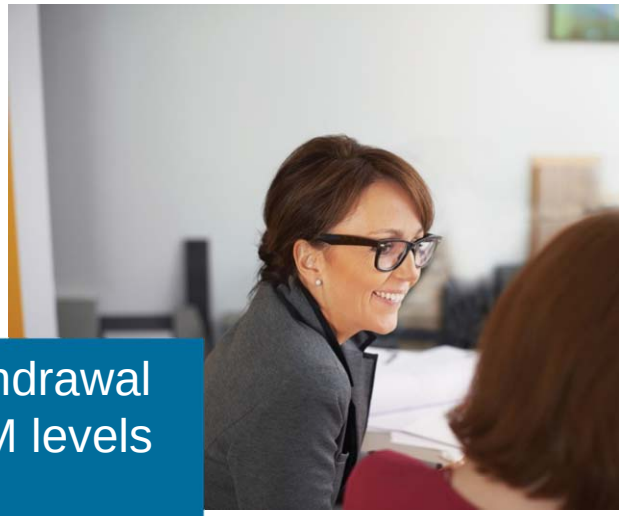
Expanding treatment capacity and access to a full continuum of SUD services based on ASAM Criteria.

PENNSYLVANIA

Increasing the provision of naloxone to reduce the risk of opioid-related overdoses/deaths and improving the initiation and engagement in treatment.

TEXAS

Increasing utilization of SUD services for adult Medicaid beneficiaries by 100%.



WASHINGTON

Improving continuity of care, especially after discharge from withdrawal management settings and ensuring access to appropriate ASAM levels of care.

RESPONDING TO DEMAND (CONTINUED)

1115 SUD Waivers

Moving SUD Into Managed Care

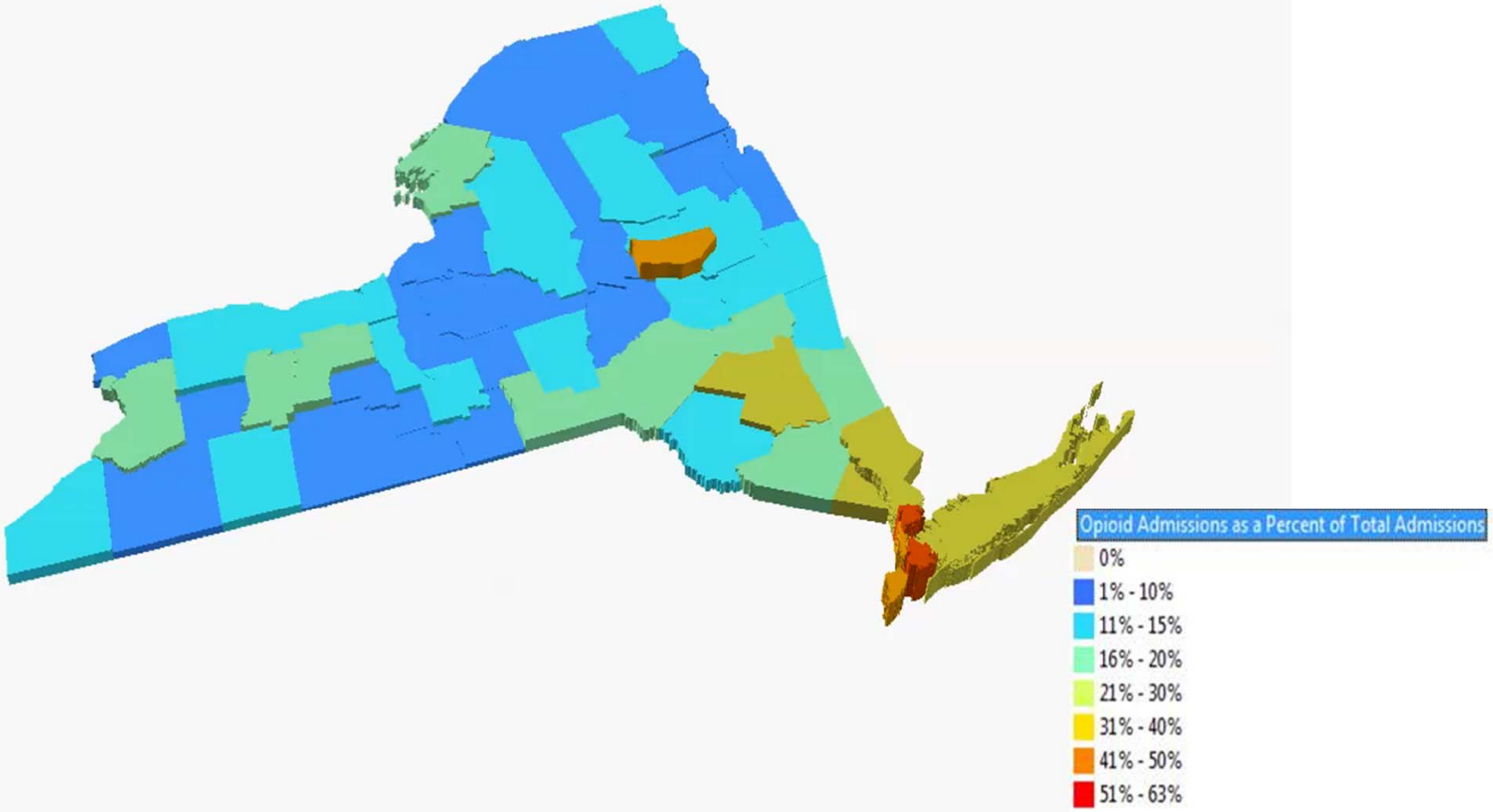
Optimizing Managed Care

What is OASAS?

New York State Office of Alcoholism and Substance Abuse Services (OASAS):

- Oversees approximately **1,600** treatment, prevention, recovery, and housing programs.
- Treats more than **230,000** New Yorkers on an annual basis, with an average daily enrollment of nearly **100,000**.
- Delivered direct prevention services to **336,000** youth during the 2015-2016 School Year.
- Operates **12** Inpatient Addiction Treatment Centers.
- Manages **2,810** Permanent Supportive Housing (PSH) apartment units.

NEW YORK STATE | Office of Alcoholism and Substance Abuse Services

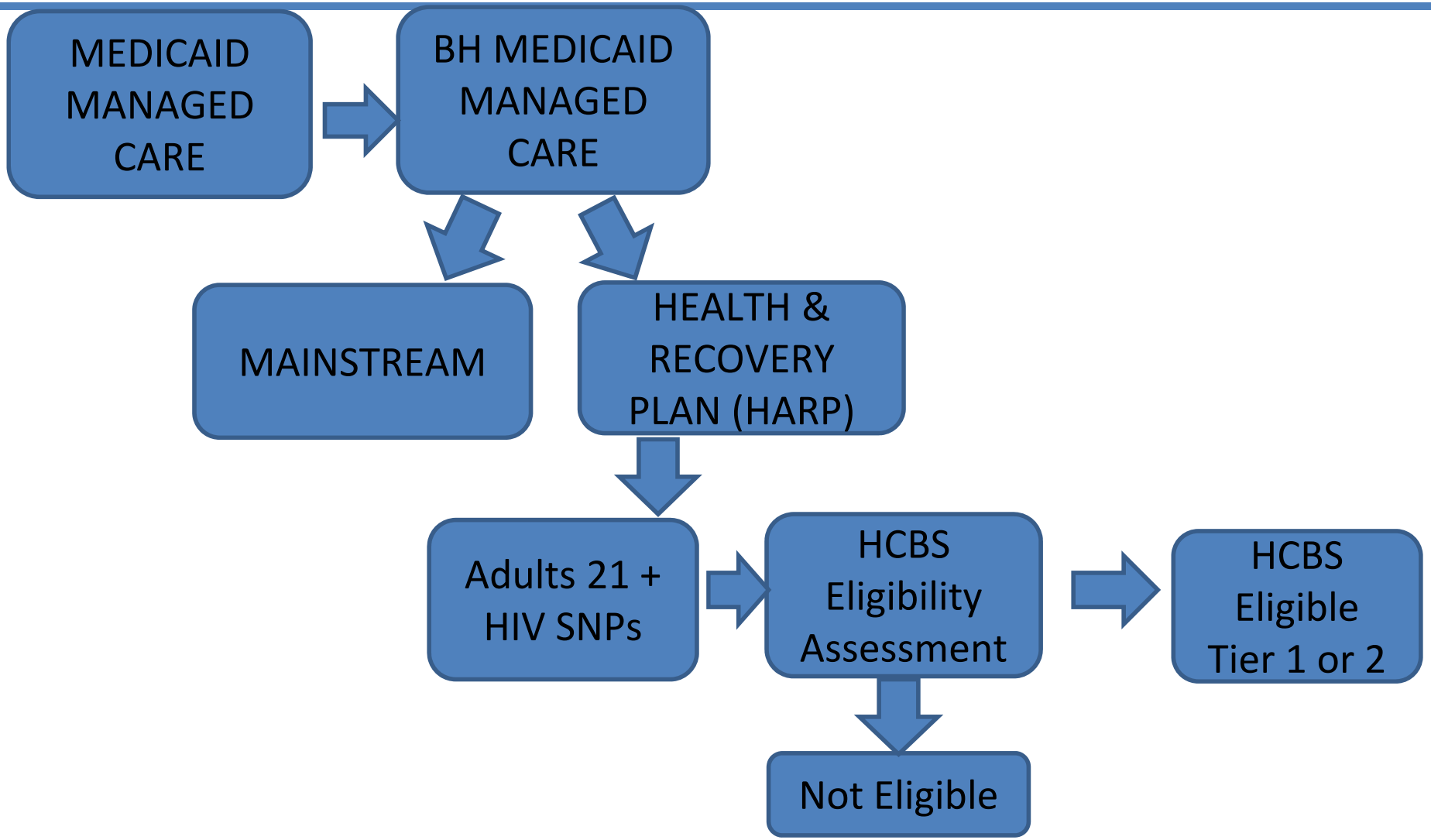


NEW YORK STATE | Office of Alcoholism and Substance Abuse Services

Behavioral Health Managed Care Design

https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/index.htm

- Behavioral Health will be managed by:
  - Managed Care Organizations (MCO) meeting rigorous standards (with and without partnership with Health Organization (BHO) – 21 total plans in NYS
    - All Plans MUST qualify to manage newly carved in behavioral health services and populations
    - Plans can meet State standards internally or contract with a BHO to meet State standards
  - HARPs for adults with significant behavioral health needs
    - MCOs may choose to apply to operate a HARP product with expanded benefits
    - HIV SNPs will include HARP benefits for eligible members


MEDICAID MANAGED CARE
BH MEDICAID MANAGED CARE
MAINSTREAM
HEALTH & RECOVERY PLAN (HARP)
Adults 21 + HIV SNPs
HCBS Eligibility Assessment
HCBS Eligible Tier 1 or 2
Not Eligible

OASAS 1115 Changes

- Transition to Rehab (services in community) – the glue for integration and linkage

- Residential Re-design (three elements of care within residential setting)
  - Medicaid Managed Care purchases clinical services

Behavioral Health Home and Community Based Services (BH HCBS)

Find Housing. Live Independently.

- Psychosocial Rehabilitation
- Community Psychiatric Support and Treatment
- Habilitation
- Non-Medical Transportation for needed community services

Return to School. Find a Job.

- Education Support Services
- Pre-Vocational Services
- Transitional Employment
- Intensive Supported Employment
- Ongoing Supported Employment

Manage Stress. Prevent Crises.

- Short-Term Crisis Respite
- Intensive Crisis Respite

Get Help from People who Have Been There and Other Significant Supporters

- Peer Support Services
- Family Support and Training

Discussion

For states that have moved SUD services into managed care, what were some of your biggest challenges and lessons learned?

What advice would you have for states considering moving SUD into managed care?

Outline

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- Overview of Pennsylvania Medicaid
  - Statewide mandatory managed care for non-dual eligible population- HealthChoices (HC)
  - Carve out model- 5 behavioral health (BH) MCOs, 9 physical health (PH) MCOs
  - Expansion state- over 700,000 adults now have access to healthcare
- OUD treatment provided within managed care networks across all ASAM Levels of Care (LOC)
- Harm reduction
- Health System Redesign
  - Centers of Excellence, AHRQ grant, Integrated Care Program, TiPS consultative program
- Quality metrics to assess OUD treatment

Treatment Provided within Managed Care

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- Medication Assisted Treatment (MAT)
  - Methadone (OTP)- paid by BH MCOs, 70 clinical sites serving about 24,000 unique individuals in 2016
  - Buprenorphine (OBOT)- paid by both BH and PH MCOs, over 750 waivered prescribers treating more than 28,000 in 2016
  - Naltrexone injectable- paid by both BH and PH MCOs, treating over 8,600 in 2016; some MCOs no longer doing PA on naltrexone
- Abstinence based treatments at all ASAM LOCs

Special Populations

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- Pregnant women
  - Standard of care is MAT with Buprenorphine or Methadone
  - PH and BH MCOs required to pay for inpatient methadone induction or outpatient buprenorphine induction
  - PH MCOs required to establish SUD care management programs at top 20 health systems that provide obstetrical care
  - PH MCOs required to pay for LARC especially during the post-partum hospital stay
- Neonatal Abstinence Syndrome (NAS)
  - Rising number of NAS cases per year
    - More pregnant women diagnosed with OUD
    - More pregnant women treated with buprenorphine and methadone
  - NICU average LOS trending downward
  - Looking at long-term medical and early intervention costs
  - Lack of standardized treatment protocols and reporting

Harm Reduction

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- Naloxone-
  - MCOs must cover with no prior authorization (PA) if preferred product used, co-pay exempt
  - No requirement of OUD diagnosis
  - Utilization continues to climb, Medicaid MCOs recognize Physician General's standing prescription
- CDC guideline based opioid prior authorization-
  - Implemented by MCOs in 9/17 through 12/17
  - Pediatric and Adults- short acting and long acting opiates
- MCOs required to submit comprehensive opioid plan to include:
  - Prior authorization of opioids to reduce supply
  - Care management working closely with pharmacy benefit managers
  - Comprehensive pain management program development
  - Claims-based risk model for predicting overdose events
  - Expanding coverage/networks of alternative treatments such as chiropractic, acupuncture
  - Measure quality
  - Establish payment reform models

OUD Centers of Excellence

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- DHS implemented 45 OUD Centers of Excellence (COEs) in 2016-17
- COEs were selected by DHS through an application process with input from stakeholders
- 26 COEs licensed drug and alcohol providers that provide counselling, methadone, buprenorphine, or naltrexone assisted treatment (OTPs)
- 19 COEs providing buprenorphine and naltrexone treatment through the HealthChoices physical health network of providers (OBOTs)
- Each COE expected to see 300 new patients over 12 months

OUD Centers of Excellence

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- Each COE awarded funding of $500,000 to:
  - Deploy a community-based care management team of licensed and unlicensed professionals
  - Track and report aggregate outcomes
  - Meet defined referral standards for drug and alcohol as well as mental health counseling
  - Report on standard quality outcomes
  - Participate in a learning network

Quality Metrics

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- Network adequacy across all LOCs
- Initiation and Engagement of SUD treatment (HEDIS®)
- Follow-up treatment after ED visit for SUD (HEDIS®)
- Length of time to initiate treatment from first OUD diagnosis
- Pharmacy (HEDIS®2018)- opioid high dose, multiple providers
- Duration of treatment (MAT and abstinence)
- Detox patients that continue in D&A treatment
- Recovery assessment questionnaire
- Individuals referred for mental health and pain management services
- OBOT- percent patients receiving monthly urine drug screening, PDMP check, not on concomitant benzo/opioid/muscle relaxant
- Other

Conclusions

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- OUD is a chronic disease that requires ongoing treatment
- Providing continuum of care coverage is important to achieving recovery
- Ongoing duration of treatment essential to recovery
- Health system personnel and payment redesign necessary to improve initiation and ongoing engagement in treatment
- Managed care can provide:
  - Care management support
  - Prior Authorization of opioids to reduce supply
  - Coordinate supportive services
  - Establish payment reform models
  - Measure quality

Discussion

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- States are increasingly shifting to value based purchasing arrangements. What experience do you have with VBP for providers of SUD services? What might be reasonable VBP initiatives that focus on SUDs?

- When thinking of your state Medicaid program and its approach to preventing and/or treating SUDs, what are you most proud of? What innovative approaches or programs have you developed and what outcomes have you achieved?

COE Care Management Team

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- Care management team helps individuals with OUD navigate the health care system by:
  - Facilitating initiation into OUD treatment from emergency departments & primary care physicians
  - Helping individuals transition from inpatient levels of care to ongoing engagement in outpatient treatment
  - Facilitating transition of individuals with OUD leaving state & county corrections systems to ongoing treatment within the community
  - Collaborating with local primary care providers to educate about screening, referral, and treatment for OUD
  - Working with telemedicine psychiatry providers in rural areas to increase the referral for appropriate treatment of mental health conditions
  - Motivating & encouraging individuals with OUD to stay engaged in both physical health and behavioral health treatments
  - Facilitating recovery by helping individuals find stable housing and employment, and reestablishing family/community relationships

AHRQ MAT Grant

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- Department of Human Services (DHS) received nearly $3 million federal grant over 3 years from AHRQ.
- Objective: to double the number of primary care physicians (75 providers at 25 practice sites) delivering high-quality medication-assisted treatment (MAT) in **rural Pennsylvania**.
- The grant funds will be used to:
  - Educate and train primary care providers to deliver high-quality Opioid Use Disorder (OUD) treatment
  - Focus on the details of implementation within primary care
  - Facilitate coordination among the broader health system and community-based resources
  - Provide access to clinical specialists
  - Link participating practices with hubs who can guide them towards a sustainable MAT program

Integrated Care Program (ICP)

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- New value-based purchasing program for 2016
- Focus on integrated care for those living with Serious Persistent Mental Illness (SPMI) and Substance Use Disorder (SUD)
- Requires specific BH-PH MCO collaboration
- Incentive program for the MCOs to earn up to $20 million dollars based on:
  - Three process activities
    - Member stratification to focus care management
    - Minimum of 500 joint BH-PH integrated care plans
    - Hospital notification of 90% inpatient stays within 1 business day
  - Five performance measures

Integrated Care Program (ICP)

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1. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - **20%***
    - Initiation rate-10%
    - Engagement rate- 10%
2. Adherence to Antipsychotic Mediations for Individuals with Schizophrenia- **20%** *
3. Combined BH-PH Inpatient 30 Day Readmission Rate for Individuals with Serious Persistent Mental Illness (SPMI)-**20**%**
4. Emergency Department Utilization for Individuals with Serious Persistent Mental Illness- **20**%**
5. Combined BH-PH Inpatient Admission Utilization for Individuals with Serious Persistent Mental Illness (PSMI)-**20**%**

* HEDIS® measure **Pa Performance measure developed by IPRO

(TiPS)

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- Telephonic Psychiatric Consultation Service Program (TiPS)
  - TiPS is designed to increase the availability of peer-to-peer child psychiatry consultation teams to primary care providers (PCPs), medical specialists, and other prescribers of psychotropic medications for children.
  - The program provides real time resources to the PCPs and other providers who desire immediate consultative advice for children with behavioral health concerns (including substance use disorder), covered by Medical Assistance, up to age 21.
- The TiPS teams are comprised of child psychiatrists, licensed therapists, care coordinators, and administrative support. TiPS LN22e services include:
  - Telephone and face-to-face consultation
  - Care coordination
  - Training and education
- Three teams cover entire state
- http://www.dhs.pa.gov/provider/mentalhealth/telepsychcConsultServProgrTiPS/

Slide 30

LN22 move to end as placeholder to use if needed?
Nelson, Laura, 10/5/2017