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Substance Use Disorder (SUD) Inpatient and Residential Treatment Waiver Development

Stakeholder Engagement Meeting Summary
May 28, 2019

Meeting slides are available on the Department of Health Care Policy and Financing (HCPF) website.

Meeting Goals

- Understand the process and timeline for developing the Substance Use Disorder (SUD) 1115 waiver application.
- Inform key implementation milestones (Milestones 1, 2, 4) for the waiver application.
- Identify activities and topics for June stakeholder meetings.

SUD Waiver Timeline and Application Overview – Presentation by Kim McConnell, PhD, ACC SUD Administrator

- Brief overview of the waiver development timeline, components of the demonstration, evaluation and monitoring, and six milestones.
- Question regarding if there will be a benefit to offer partial hospitalization, prior to intensive outpatient programs (IOPs).
    - HCPF is still considering what options will constitute the continuum of care.
- Question about how much thought has been given to care coordination.
    - House Bill 1287 mandates a new system for coordinating care. HCPF will be working with Regional Accountable Entities (RAEs) and Managed Service Organizations (MSOs) to further care coordination and will engage stakeholders for their feedback.
    - Plans with the RAEs still being developed, their role in ensuring care continuity will be important.
- HCPF noted that waiver will apply/be available for all Medicaid enrollees with no age limitations or restrictions.

Group Discussion: Milestone 2 – Assessment and Placement Criteria

Responses to question about current assessment and placement practices:

- American Society of Addiction Medicine Level of Care Designations criteria (ASAM criteria) can be subject to interpretation. This issue, combined with a public perception that residential rehabilitation services are the "best" substance use disorder treatment, may cause a collision in the decision-making process.
- ASAM criteria are being used well, however, Colorado needs to ensure that facilities' licensures truly align with criteria.
- As a state, Colorado has a good foundation for these milestones.

- Milestone 2 Discussion Question: How consistent with ASAM are current patient placement decision-making processes?
  - RAEs are only looking at IOP or outpatient treatment and not opportunities for social detox, from a utilization management perspective.
  - Using ASAM criteria and standards for utilization management is easy, but education will be needed on the provider side.
  - HCPF believes there may be a lot of variation in criteria currently being used.
  - Providers perform good biopsychosocial assessments, but do not do as good of a job with the risk ratings and mapping.
  - Not all facilities are using risk rating; providers who use admission criteria would need to do a "new" crosswalk from their criteria to the risk ratings.

Unedited comments and questions submitted by participants regarding ASAM criteria and care coordination.

- With the addition of waivered medication-assisted treatment physicians (buprenorphine and naltrexone in particular), how are the physicians being monitored to ensure that level of care is being provided?
- All providers, especially at higher levels of care, should be able to treat co-occurring substance use and mental health. This should be the standard of care in both mental health and substance use systems.
- Licensed for the right level of care – facilities say they are one level but they aren't; ensuring licensing criteria; can they provide the services they are licensed for?
- Residential programs need to be accurately licensed at the correct level (3.1-3.7) in order to determine accurate reimbursement.
- OBH has large role in setting standards for care; many of those details/coordination fell through the cracks during SUD benefit expansion in 2014. How do we implement lessons learned from that process?
- The MSOs always believe they are doing ASAM assessment criteria well and need to be open to evaluating their own process and abilities, particularly are they consistent?
- Concern about meeting criteria – who will be doing assessment and how it will be made
- On network adequacy: level of "CAC" professionals has remained flat, while Colorado's population has soared; how do we address workforce and volume problems on Western Slope / frontier Colorado?
- What type of documentation / data collection will be required to demonstrate medical necessity for authorization of payment? How extensive is the authorization for payment if consumer is coming from a different RAE?
- How to address SUD staffing issues in order to provide care? (not enough staffing and ongoing training issues)
- ASAM criteria and UM: I feel strongly that UM processes and criteria must be standardized across RAEs. Variability across RAEs is burdensome for providers and leads to different outcomes in different parts of the state.
- Care coordination requires that the provider doing the assessment has the authority/ability to connect the patient to the right treatment. Currently, a facility that

assesses the patient may be denied by the RAE and no placement may be provided/identified. How will that change under the waiver?

Milestone 2 Discussion Question: What would it take to make current practices more consistent with ASAM criteria?

- Providers need better education on risk criteria in order to move in that direction.
- Perhaps a pre-screening process would help to catch a patient sooner in order to ensure level of care is appropriate; assessments are often performed assuming patients are already admitted to the right level of care. However, it was noted that adding a pre-screen as another assessment may create another hurdle; many providers already have a sense of what level of care patients need.
- Need to take capacity into account for appropriate level of care. How can we provide supports while patients are on waitlists? There is an opportunity to address these issues with the waiver.
- Having appropriate staffing will determine the level of care that a facility can bring in; may be an added complexity to ensuring patient is placed appropriately.
- Question about whether a substance use disorder has to be the primary diagnosis, because mental health is often the primary diagnosis when patients seek services at community mental health centers.
    - HCPF has not determined, though the intention is not to exclude patients.
    - Physical health diagnoses must also be considered as part of eligibility.
- Providers will have to be informed and engaged as the RAEs assume utilization management. Providers have years of lessons learned from behavioral health organizations (BHOs) that need to be integrated into new systems. With BHOs there was a question of who was covering services; RAEs are managing both, so there shouldn't be issues.
- We also want to make sure patients aren't wanting to jump plans if perceive that placement criteria are subjective.

Group Discussion: Milestone 1/4 - Ensuring Network Adequacy

Participants responded to a poll question: Which service has the most limited network of providers today? (slide 28). Follow-up discussion about why services are limited and what it would take to improve adequacy.

- There were no votes for outpatient services.

- There was one vote for intensive outpatient programs.
    - These programs are a critical level of care to ensure patients are not over-or under-treated. Additionally, IOP supports stepping down from residential or inpatient settings and can prevent backlog.
    - Programs need evening and weekend hours to accommodate patients.
    - We need to consider how we can build programs that meet intent of ASAM and meet needs of rural issues.

  - Perception that patients need to go to rehab (not IOP) to get substance use disorder treatment.
  - Challenge to engage patients in levels of services offered; the ASAM criteria may state one level of care, but the facility may be engaging them in another. Participant highlighted patients engaged in criminal justice system may be court-ordered to a level of care that does not align with ASAM placement criteria.
    - HCPF is forming partnerships with criminal justice entities to work on this.
    - Participant noted that probation officers are trying to make treatment recommendations and are likely not using an assessment tool.
    - When asked what treatment area HCPF thought has the lowest network adequacy, the HCPF team commented that IOP may not be adequate in rural areas. HCPF is less concerned about outpatient services but discussion about limited availability in rural areas, specifically the Western Slope.

- Four votes for medication assisted treatment.
  - MAT overlays all other levels of care.
  - Strategies are needed to support MAT providers' caseloads.
  - Encouraging to see MAT as a milestone with this demonstration.

- 15 votes for intensive levels of residential and inpatient care (levels 3.7 and 4).
  - There are a lack of facilities – some patients are on waitlists for several months.
  - Staffing required for certain levels of care impacts capacity.
  - Programs need flexibility to step patients down to IOP or partial hospitalization.
  - Brick and mortar challenges with creating sites outside metro area.
  - Need to bolster mom/baby care while mom is in inpatient setting.
  - Shortage in these types of treatment services for adolescents.

- Seven votes for medically supervised withdrawal management

Unedited comments and questions submitted by participants regarding network adequacy:

- When providing vivitrol, need five-day detox. Will these five days be paid for / reimbursable before starting on vivitrol?
- The MSOs always believe they are doing ASAM assessment criteria well and need to be open to evaluating their own process and abilities, particularly are they consistent?
- The waiver question of network adequacy does not get at the issue of workforce shortage. That is going to be one of the biggest barriers to the success of the benefit.
- In the interest of cost neutrality, I think that an assessment of the adequacy of OP treatment is essential. We have observed that frequency of visits is often not great enough to be therapeutic.
- What is in place now to determine which programs work best – i.e. use best practices, outcomes data?
- Concern about definition of facilitating MAT.

- How will individuals get connected to service; currently if they are denied, there isn't a direct connection to other levels of care that may be more appropriate – how could this be done differently

Additional unedited feedback provided by participants via evaluation forms and comment cards:

Issues related to an SUD diagnosis
- SUD as primary diagnosis can be a barrier to sharing data.
- Diagnostic overshadowing has been an issue in the past and could be again if the member is required to have an SUD diagnosis to qualify for the SUD waiver.

Co-occurring diagnoses
- Make sure that co-occurring diagnoses are dealt with in this new program – both I/DD and medical.

RAEs
- What is HCPF going to do to ensure those nationally held RAEs are following the CO process and not just their national office process and deny services? Mental health providers have been providing a full continuum of care with the BHOs. RAEs are not functioning as effectively as the BHOs. How will they begin to manage SUD – having no (or little) experience there?
- Curious about RAE overlap with 1287 (care navigation) and 222 (BH safety net / high intensity); utilization management confusion, overlap with 1269 rulemaking
- Concern about process/timeline for RAE/provider contract renegotiation (capacity, staffing), i.e., not enough time from agreeing on rates to building out appreciate capacity.

Medication Assisted Treatment
- What evidence-based treatment other than MAT?
- MAT providers for adolescents.
- I would be curious to learn more about MAT being offered at each contact; what all does this include? Anyone with opiate / alcohol use disorder?

General questions and information
- Will DRGs be used for reimbursement?
- Will services be bundled? Right now social detox is not.
- What codes will be allowed? (from Coding Committee perspective / coding manual)
- Providers need training on ASAM and understanding of ASAM
- Will providers have ability and understanding to do transitions of care vs. 28-30 days needed?
- Sobriety vs. controlled use

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Upcoming SUD Stakeholder Engagement Activities

- There are three June meetings scheduled.
    - Wednesday, June 19 from 3:30-5:30pm in Colorado Springs.
    - Thursday, June 20 from 8:00-10:00am in Greeley
    - Thursday, June 20 from 3:30-5:30 via Zoom
- All three meetings will have the same agenda, content, and goals: report on the progress and outcomes of the May discussion and review waiver application highlights.
- Formal public comment processes will begin mid-late summer when the waiver application is final.