The Evolution and Future of Public Substance Use Disorder Prevention and Treatment Services in California

Major Features of Health Reform and Realignment That Impact the Financing and Delivery of Publicly-Funded Substance Use Disorder Prevention and Treatment

Background and Context

Substance Use Disorders (SUD) constitute substantial health problems, and they also cause or contribute to other serious health conditions or complicate treatment for other conditions. Along with mental illnesses, substance use disorders drive many of the costs and caseloads in child welfare & criminal justice systems, hospitals, ERs and other health care systems.

In California, the public system of care for the prevention and treatment of SUD is overseen by a single state agency, the State Department of Health Care Services, but is administered by counties, which either provide services directly or (in most cases) contract with private providers for services.

Background and Context (cont.)

Historically, public treatment of SUD has been predominantly provided in separate specialty services programs, some of which are based on social-model recovery (i.e. 12-step), and others which offer medication-assisted treatment (i.e. methadone maintenance).

Sources of funding for public SUD services include:

- Federal Substance Abuse Prevention & Treatment Block Grant.
- FFP for Drug Medi-Cal
- 2011 Realignment Funding (formerly SGF) for:
  - Drug Medi-Cal Match
  - Perinatal Services
  - Drug Court Treatment Programs
- Funding from Criminal Justice System (i.e. PSN, AB 109)

Background and Context (cont.)

The Current Landscape:

- Treatment of SUD has largely evolved outside of the mainstream healthcare system, and has been predominantly provided in separate specialty services programs, only some of which offer medication-assisted treatment.

- Because substance abuse as a disease has been viewed with suspicion and disapproval, funding streams that have been developed for other systems have not been developed for SUD services.

- Until this year, the Drug Medi-Cal system has had limited benefits that do not allow practitioners to provide best practices, and has not covered evidence-based interventions adequately to address needs of patients with SUD. Moreover, reimbursement rates for some services are (and remain) so low that it is often difficult to find providers.

Background and Context (cont.)

- Some SUD treatment facilities lack the administrative and infrastructure support necessary to meet the requirements of mainstream health care financing and management. Some providers are not integrated with other health service systems, and make limited use of information technology, even for administrative, claims, and/or billing purposes.
- Many SUD treatment programs do not have an integrated clinical information system that provides treatment staff with access to electronic patient records.
- SUD treatment is typically provided by staff members who are state-certified, but not professionally-licensed.
- About 40% of nonprofit facilities do not accept either private insurance or Medicaid, and about half do not have any contracts with managed care plans.

Background : Drug Medi-Cal

The Drug Medi-Cal program must comply with Section 1902 of the Social Security Act, which specifies the basic federal Medicaid requirements. With few exceptions, and absent a federal waiver, the following rules must hold for the Drug Medi-Cal program administration:

- **Comparability of Services**
  - Services to be comparable for eligible individuals – equal in amount, scope, duration for all beneficiaries in a covered group; services to categorically needy cannot be less in amount, scope, duration than those provided to medically needy groups.
- **Statewideness**:
  - Benefits offered to any individual must be available throughout the state.
- **Choice of Providers (Any Willing Provider)**:
  - An individual may obtain Drug Medi-Cal services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services (i.e. D/MC-certified).

Drug Medi-Cal Reform

Current (Base) Benefits:

- Narcotic Treatment Program (NTP) – Outpatient treatment primarily utilizing methadone.
- Outpatient treatment utilizing the narcotic antagonist Naltrexone.
- Outpatient Drug Free – Mostly group counseling and some limited individual counseling.
- Day Care Rehabilitative – Intensive outpatient treatment, including group and individual counseling, eligibility for which is limited to pregnant and postpartum women and, as an EPSDT benefit, to children under 21.
- Perinatal Residential – Residential treatment provided to pregnant and postpartum women in facilities of 16 beds or less, not including beds occupied by children. (Room & board must be paid for by revenue other than D/MC.)

Drug Medi-Cal Reform (cont.)

Enhanced Benefits:

- Inpatient detoxification; hospitalization for medical management of withdrawal symptoms, including room and board, physician services, drugs, dependency recovery services, education and counseling;
- Outpatient chemical dependency care, including day treatment programs, intensive outpatient treatment programs, individual and group chemical dependency counseling, medical treatment for withdrawal symptoms, methadone maintenance treatment for pregnant members during pregnancy and for 2 months after delivery at a licensed treatment center; and
- Transitional residential recovery services, including chemical dependency treatment in a nonmedical transitional residential recovery setting that provides counseling and support services in a structured environment.

Drug Medi-Cal Reform (cont.)

- **Currently Eligible (eligible under current rules)**: All who are currently eligible for Medi-Cal, even if not currently enrolled.

- **Newly Eligible (eligible under new rules)**:
  (1) Single, childless adults with incomes below 138% FPL.
  (2) Families with children whose income and/or assets make them currently ineligible for Medi-Cal, but whose income falls below 138% FPL.

Drug Medi-Cal Reform (cont.)

Summary of Provisions:

- The state's benchmark plan benefits (Kaiser Small Group) will become the ***enhanced*** benefits for the Medicaid population, and will be added to the State Plan for Drug Medi-Cal beginning January 1, 2014.
- These enhanced benefits will ***supplement, not replace*** the current Drug Medi-Cal benefits.
- These benefits, like the current DMC benefits, will be available statewide. There is no county opt-in.
- The enhanced benefits will be an entitlement for ***all*** Drug Medi-Cal eligible, not just for the newly-eligible (the expansion population).

Drug Medi-Cal Reform (cont.)

- Drug Medi-Cal will remain a carve-out, with services and benefits administered by County Alcohol and Other Drug programs.
- For the ***enhanced*** benefits, the state will pay the non-federal share of cost for all DMC populations.
- For the ***current*** benefits, the counties will continue to pay the non-federal share of cost for current beneficiaries.

Drug Medi-Cal Reform

Federal, State, and County Drug Medi-Cal funding in 2014-2016						
	Current Drug Medi-Cal Benefits			Enhanced Drug Medi-Cal Benefits		
Share-of-Cost	Feds	State	County	Feds	State	County
Current Eligibles	50%	0%	50%	50%	50%	0%
New Eligibles	100%	0%	0%	100%	0%	0%

Recent Mental Health/Substance Use Disorder Policy Milestones

- 2008: Federal Mental Health Parity (The Paul Wellstone/Pete Domenici Mental Health Parity and Addiction Equity Act) Passes
- 2009: The Federal Affordable Care Act Passes
- 2010: CA Receives Federal Approve for its 1115: A "Bridge to Health Reform" Demonstration Waiver
- 2011: Realignment 2011/Public Safety Realignment

Health Reform Provisions

- Section 1302(b) of the Affordable Care Act lists the 10 Essential Health Benefits required to be covered by every health plan, to include: "(E) Mental health and substance use disorder services, including behavioral health treatment."
- The Affordable Care Act extends mental health and SUD coverage at parity for the Medicaid benchmark and benchmark-equivalent plans that states must provide to the expanded Medicaid population.
- These plans are based on the Federal Employee Health Benefits program, the state employees' health plan, the health maintenance organization with the largest non-Medicaid enrollment in the state, or a plan approved by the Secretary of Health & Human Services.

Federal Mental Health & Addiction Parity

- MH & SU services must be provided at parity with general healthcare services, including in these areas:
  - **Coverage restrictions (copayments, deductibles, etc.)**
  - **Lifetime limits/costs**
  - **Treatment limits (number of visits/days covered)**
- Parity applies to:
  - **Large Employers**
  - **Medicaid Managed Care Plans**
  - **Health Insurance Exchanges for Individual and Small Group Policies**

Health Reform Provisions (cont.)

The Affordable Care Act contains other provisions that will affect the financing, design and delivery of public SUD treatment services:

- Generally these provisions are designed to increase service delivery through various types of integrated systems, often based on more comprehensive primary care.
- The goal is to promote a whole-person approach to care, including the integration of SUD and MH services with general medical care, as provided, for example, in medical or health homes.
- Enhanced federal matching funds in Medicaid will support the establishment of health homes.
- The ACA provides funding to increase the number and capacity of FQHCs by providing an additional $11 billion in dedicated funds to the health centers program.

Health Reform Provisions (cont.)

Health reform is also expected to greatly expand the number of insured people with substance use disorders.

- An estimated 20 – 30 million more Americans will be covered in 2014 under the ACA. Over 30% of these (10 million people) will have a mental health or substance use disorder.
- One estimate predicts that this expansion will double the number of nonelderly childless adults with MH & SU disorders in Medicaid, because this population is more concentrated among the low-income insured.
- The largest proportional increase in the newly-insured population may be for those with substance use disorders. An estimated 147,000 to 195,000 of the new Medi-Cal enrollees will need substance use disorder services.

Trends & Developments in Medi-Cal

Potential Impacts on Drug Medi-Cal:

- Ramping up to serve the Medi-Cal expansion population will place additional responsibility on organizations providing SUD treatment to expand capacity.
- SUD programs will be more involved in their clients' health care.
- The health care system will experience demands for care from a caseload with which it has had little experience.
- There will be a resurgence of offender treatment as D/MC coverage becomes available to childless adults.

CHALLENGES

- **Treatment Capacity:**

  Given their intimate knowledge of local populations, the counties are uniquely qualified to develop new systems of substance use disorder services. The enhanced SUD benefit option is an opportunity for counties to develop capacity to deliver crucial services to some of their most vulnerable populations.

- **IMD Exclusion**

- **Workforce**

CHALLENGES (cont.)

Connecting health care in jails to health care in the community

- Jails have become *de facto* behavioral health providers in many communities, a role for which they are not adequately equipped.
- 60% – 80% of arrestees tested positive for at least one drug in their system, and few reported having received outpatient drug or alcohol treatment in the prior year—less than 10%.

CHALLENGES (cont.)

- 96% of jail detainees and inmates return *directly* to the community from jail, along with their often untreated health conditions.
- Few people in jail or prison today are enrolled in Medi-Cal because – as non-elderly, childless adults – they have not been eligible. That will change beginning in 2014.
- Currently, an estimated 90% of detainees have no health insurance upon release from jail.

CHALLENGES (cont.)

- About 2/3 of the jail-involved population will be eligible for Medi-Cal under the expansion, creating access to health care for many individuals for the first time.
- Counties can fully realize the potential benefits of the ACA by choosing to provide the enhanced SUD benefit, by enrolling the jail-involved population in Medi-Cal and Covered California plans, and by engaging the justice-involved population in treatment.

Impacts of the ACA on the Public SUD Treatment System

Requirements for Expanded SUD Coverage:

Along with the expansion of Medicaid eligibility, the ACA will greatly increase public support of SUD treatment services. These and other changes will have a significant impact on the types and relative importance of funding sources, the numbers and types of SUD treatment providers, the workforce, and the kinds of services offered.

Sources of Funding:

- Under health reform, Medicaid's share of total public funding for SUD treatment will increase, while the share from SGF spending will probably continue to decline.

- The other major source of non-Medicaid funding, the federal Substance Abuse Prevention & Treatment (SAPT) Block Grant, is also likely to decline in relative importance.

Impacts on the Public SUD Treatment System (cont.)

These funding changes will have three major consequences:

1) Overall public spending for SUD treatment should greatly expand as a result of increased Medicaid enrollment and new benefit and parity requirements.

2) Expansion of Medicaid coverage will increase the proportion of federal spending for SUD treatment services in comparison to other funding sources.

3) The model in which public SUD treatment services are now organized and delivered will be fundamentally transformed. Rather than these services being administered by a single state authority that funds designated providers through a system of grants and contracts supporting a specified number of treatment slots, Medicaid will increasingly displace this model with a medical model payment system more characteristic of health plan managed care.

Impacts on the Public SUD Treatment System (cont.)

Changes in SUD Treatment Services:

Changes now underway, driven largely by the increase in Medicaid funding of SUD services at parity, reflect the following features of national health care reform:

- Near-universal coverage
- Systems of payment and administration more characteristic of medical-model health plans
- Integrated models of care coordinated mainly through primary care settings
- Expanded use of health information technology

Impacts on the Public SUD Treatment System (cont.)

Other changes that will come with the implementation of health care reform:

- More integrated, person-centered systems of care will change the character of some existing SUD treatment programs, and expand the participation of non-specialty providers, such as Medicaid health homes and FQHCs, into the SUD service system.
- New funding mechanisms will increase opportunities for larger, better-operated programs to expand through the acquisition of smaller, independent providers.
- The medicalization of public SUD treatment will result in greater participation and direction from physicians, psychologists, nurse practitioners, and other health professionals. Physician-directed treatment is a general requirement for most Medicaid outpatient services, and some SUD treatment services currently provided by peer counselors may not qualify for Medicaid or private health insurance reimbursement.

Impacts on the Public SUD Treatment System (cont.)

- Payment systems for SUD providers will need to be based on equitable reimbursement for services consistent with a medical model framework for levels of care, such as the patient placement criteria offered by the American Society of Addiction Medicine.

- The increased reliance on Medicaid as a funder of public SUD treatment systems may further challenge the role of residential programs, since Medicaid excludes medical assistance for people in institutions for mental diseases, and Medicaid funding does not extend to the room and board costs of residential facilities. Maintaining residential programs at existing levels will require continuing support from SGF and Block Grant funding at a time when both sources of funding are being increasingly reduced.

Implications for Counties

- Your county may have as much as a 50% increase in Medi-Cal enrollees in 2014.

- How well will your county and its network providers be able to address the whole health needs of...
  - The 5% of the population who use 50% of the resources, half of whom have a mental health or substance use disorder?
  - The 20% of the population who use 80% of the resources, 30%-40% of whom have a mental health or substance use disorder?

Opportunities for Behavioral Health Under 2011 Realignment

- Opportunities to maximize available FFP under the new Medicaid expansion, using Realignment 2011 funds (including enrolling AB 109 parolees)
- Opportunities to improve care for those with co-occurring MH/SU disorders
- Opportunities to improve public safety and reduce recidivism
- Opportunity to work with all health/human services departments to identify cost-effective ways to serve the same clients
- Opportunities (over the long term) to ensure growth for behavioral health services, rather than protect against State General Fund cuts

Opportunities for a Good and Modern MH & SUD Services Continuum

The federal Substance Abuse/Mental Health Services Administration believes that a good system of care for MH and SUD is achievable under health care reform, and is a step to developing an "ideal" service system.

The integration of primary care, mental health and addiction services is an integral part of the vision. It is also bi-directional:

- MH/SUD in primary care settings
- Primary care in MH/SUD settings

A Good and Modern Services Continuum (cont.)

The vision for the system is grounded in a public health model that addresses:

- System and service coordination.
- Health promotion and prevention.
- Screening and brief intervention.
- Treatment, recovery, and resiliency supports to promote optimal health.

Principles of a good and modern system of care:

- Prevention and treating mental and substance use disorders is integral to overall health.
- Services must address current health disparities.
- Person-centered care is the framework of shared decision-making in which the individual is the center of the health care system.

A Good and Modern Services Continuum (cont.)

A wide continuum of evidence-based services should be available based on a range of acuity, disability, and engagement levels. The benefit continuum should include:

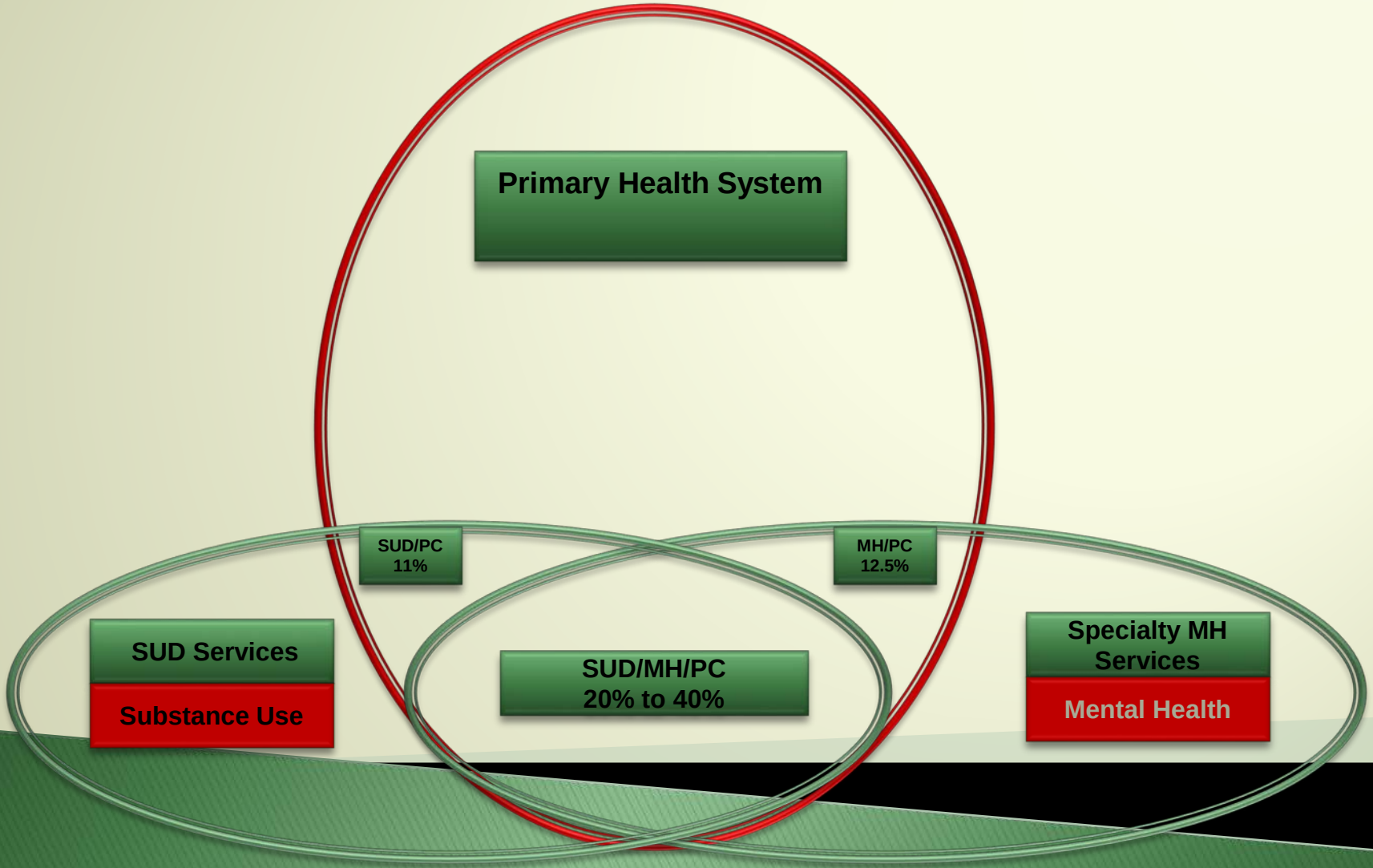
- ✓ Health homes
- ✓ Prevention and wellness services, and chronic disease management
- ✓ Assessment and patient placement criteria
- ✓ Residential and inpatient services
- ✓ Outpatient and acute intensive services
- ✓ Medication-assisted treatment
- ✓ Maternal, newborn, and pediatric services
- ✓ Rehabilitative services
- ✓ Community supports and recovery services

The Importance of Integrated Care

"Almost all the new service models unleashed by the Accountable Care Act – from Medicaid Health Homes to Accountable Care Organizations to patient-centered Medical Homes – cannot succeed without integrating behavioral and general medical care. The theme of "integration" is popping up everywhere. Yet the mainstream is not prepared. They need our help."

– Michael F. Hogan, PhD, Commissioner
New York State Office of Mental Health

Behavioral Health Integration

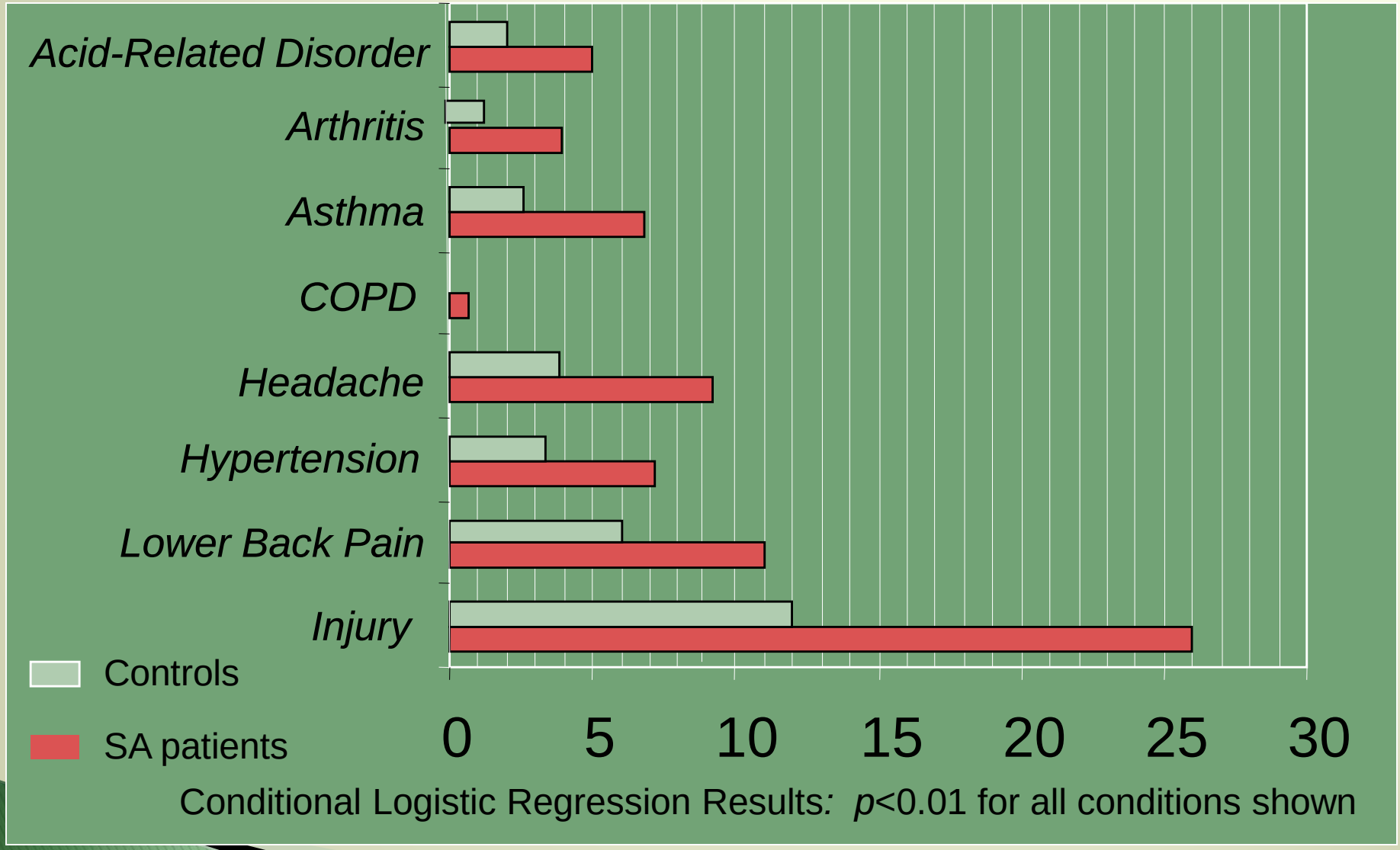


Bending the Cost Curve

The Kaiser Substance Use Study:

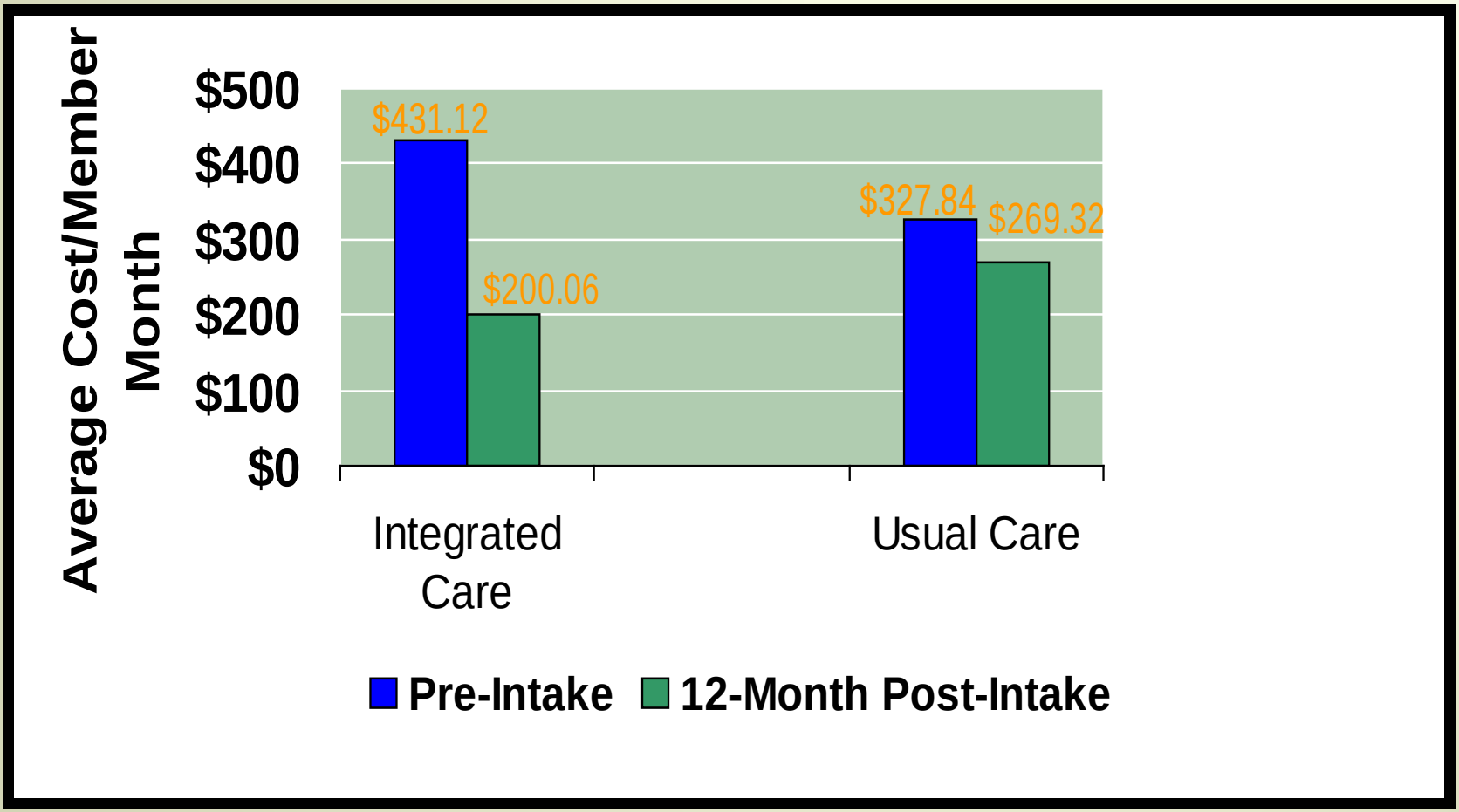
- Context of a health plan
  - Employers are primary purchasers.
- Alcohol and drug problems as primary problems and as risk factors for other health conditions.
- Treatment can be effective.
- Not treating them causes lack of improvement in other health conditions (and problems in work productivity).
- Not treating them causes more ER and inpatient utilization.
- Not treating them causes health problems and cost for family members

Prevalence in Substance Abuse Patients Vs. Matched Controls



Mertens et al. (2003). *Archives of Internal Medicine* 163: 2511-2517.

Medical Costs after Treatment for Integrated Medical Care for Those with Substance Abuse–Related Medical Conditions



Parthasarathy S, Mertens J, Moore C, Weisner C. Utilization and cost impact of integrating substance abuse treatment and primary care. *Med Care.* Mar 2003;41(3):357-367.

SUD Workforce Needs

- Especially important now with ACA implementation, the SUD workforce needs to increase knowledge/skills/practices, including:
  - Evidence Based Practices
    - MAT, MI, SBIRT
  - Integration with mental health
  - Prescription drug abuse problem
  - Harm reduction approaches
  - Addiction and pain
  - Addiction as a chronic disease
  - Use of data to modify services

ACA – 2014

- The substance use disorder treatment field will be held to the same standards and requirements as the primary health field.
- Therefore, the substance use disorder treatment profession needs to be ready to document and codify its services and service delivery systems.

ACA-Integrating Care

(from the UCLA/ATTC Workforce Report)

- Increased recognition of issues related to non-communicable diseases (including co-occurring MH/SA disorders)
- Increased use of disease management for chronic health disorders
- Development of evidence based practices for SUD to be implemented in primary care: SBI, medication assisted treatment, brief treatments.

A Workforce with a Diverse Set of Knowledge and Skills

- In primary care settings, people delivering behavioral health services (including SUD) will need a very diverse set of knowledge and skills.
- Knowledge and skills needed:
  - Preparation in SUD
  - Preparation in MH disorders
  - Preparation in common health conditions
  - Preparation to have work driven by data
  - Preparation to work in integrated environments
- Different environmental cultures, workflow
- Team skills

Enhanced Skill Set Required Post-ACA

- Evidenced based practices in SUD
- Address all behavior change issues
- Harm reduction mentality
- Interpersonal skills:
  - Communication (Motivational Interviewing)
  - Conflict resolution
  - Teamwork (with MD as boss)
- Quality Improvement Skills
  - Use of data to drive change
  - Technology competence

Training the California Workforce

Content areas important to begin to build the California Behavioral Health workforce:

- *Providing Behavioral Health Care in a Primary Care Setting: Culture, Needs and Interdisciplinary Collaboration*
- *Screening Brief Intervention and Referral for Substance Use, Mental Health and Medical Diseases*
- *Understanding Chronic Medical Diseases, Basic Physiology, Terminology and Treatment Strategies*
- *Understanding Common Mental Health Disorders—Identification and Intervention*
- *Medical Interventions for Substance Use, Physiology of Drugs of Abuse and Medication Assisted Treatment*
- *Care Management of Clients in a Multi-Service Setting*

Where is Health Care Headed?

- More of a system, less of a cottage industry
- More integration of care
- More focus on primary care:
  - Patient-centered medical homes
  - Federally Qualified Health Centers
- More accountability (pay for outcomes)
- Bundled payments (Accountable Care Organizations)
- Electronic health records, health information exchanges
- Under Realignment, counties will have more responsibility for managing and funding public sector MH & SUD treatment.

About CADPAAC

The County Alcohol and Drug Program Administrators' Association of California (CADPAAC) is a non-profit association comprised of the designated county alcohol and drug program administrators representing the 58 counties within California. CADPAAC is dedicated to the reduction of individual and community problems related to the use of alcohol and other drugs.

For further information, or questions regarding this presentation, contact:

Thomas Renfree
Executive Director, CADPAAC
tom@slgs.org