Financing and Increasing Access to SUD Treatment: Current Landscape

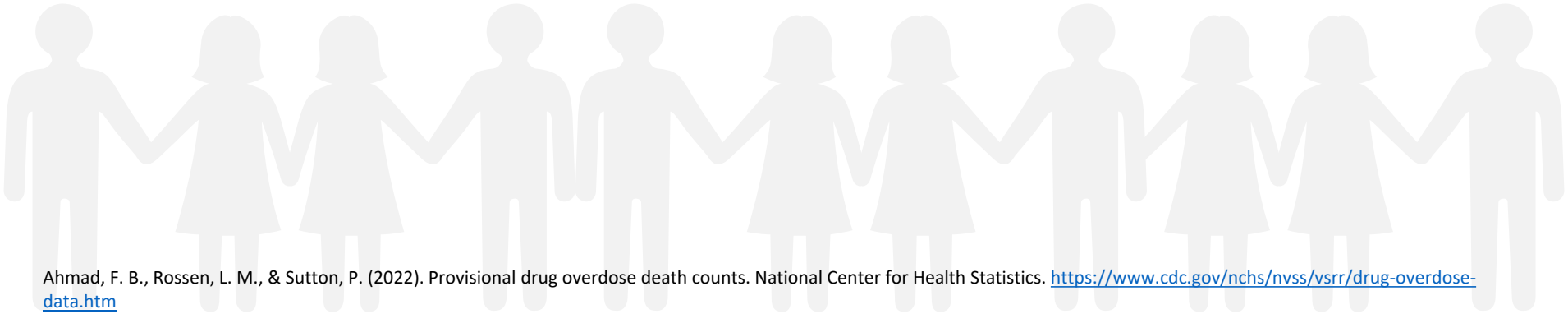
A Conversation with the National Conference of State Legislatures' Opioid Policy Fellows

June 5, 2022

MORE THAN

107,000

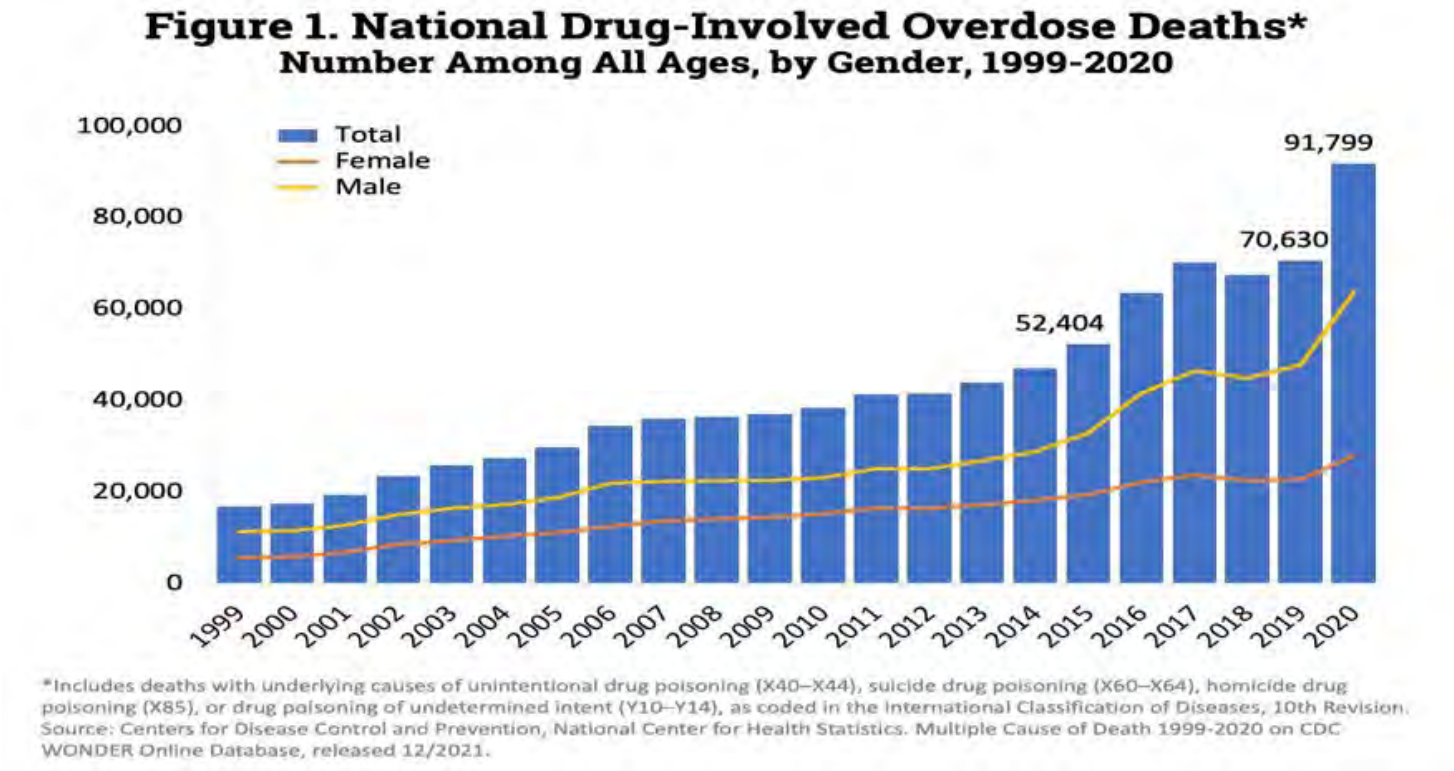
PEOPLE DIED OF AN OVERDOSE
in the 12-month period ending, December 2021



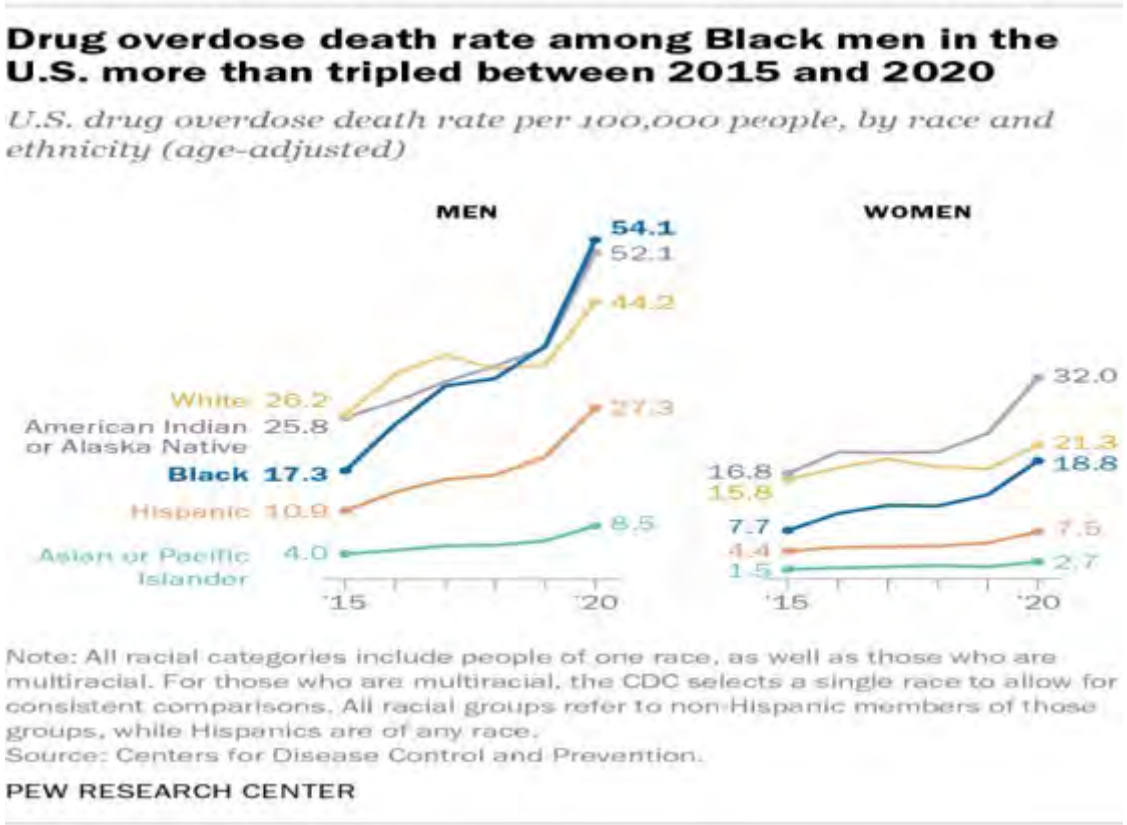
Ahmad, F. B., Rossen, L. M., & Sutton, P. (2022). Provisional drug overdose death counts. National Center for Health Statistics. https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

Overdose Deaths

- **2021: More than 107,000**



Drug Overdose Death by Race and Ethnicity



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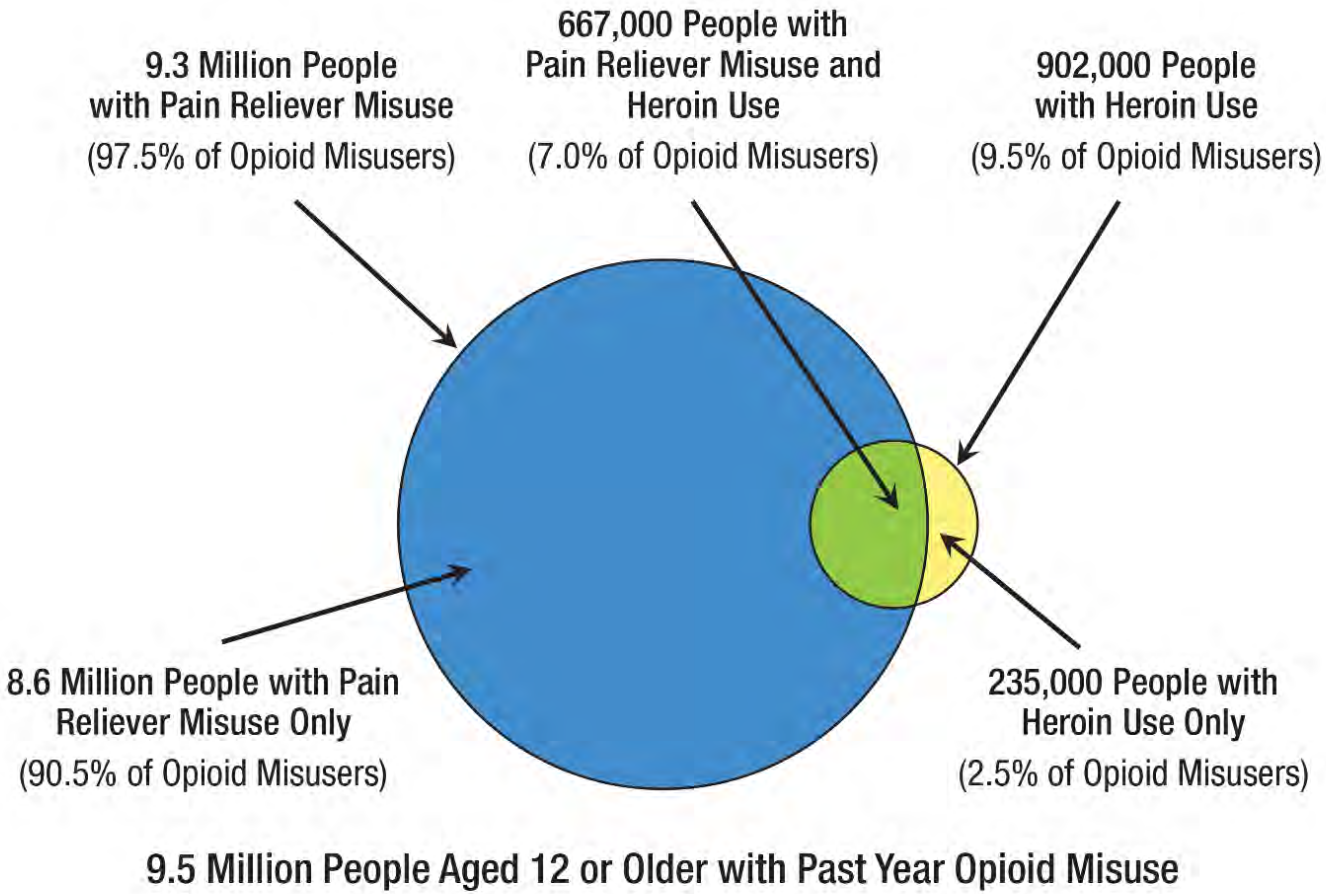
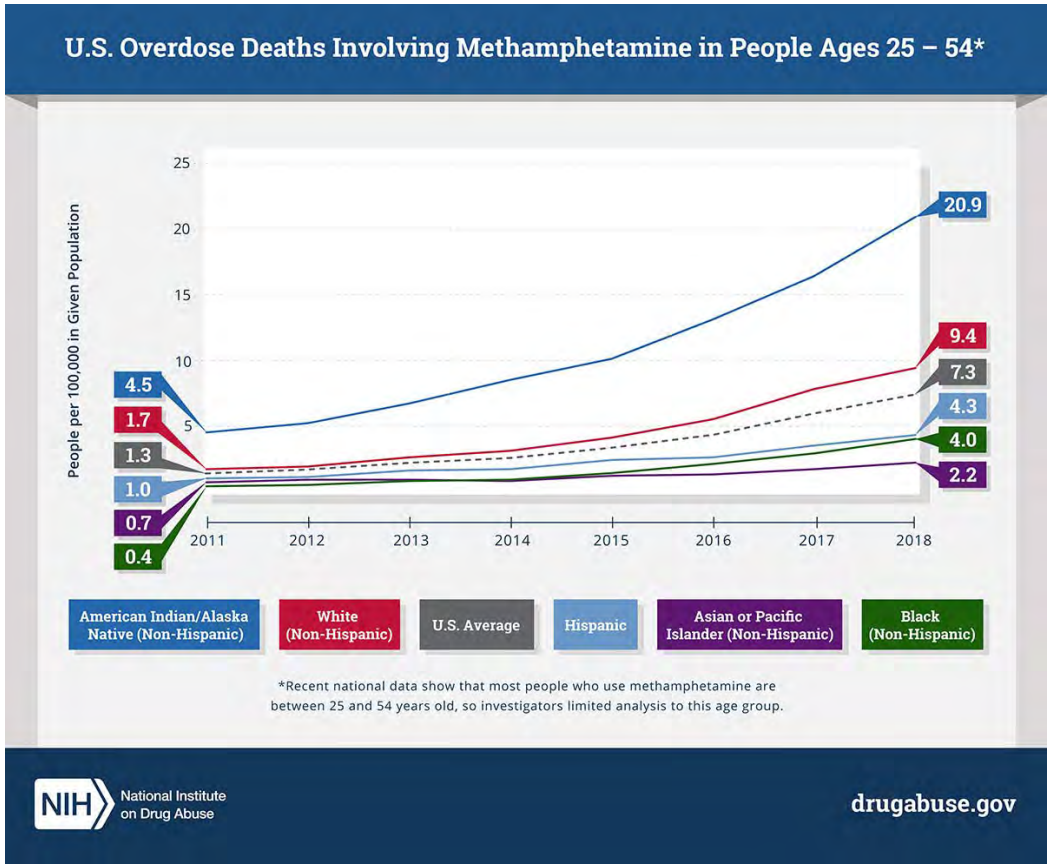
Past Year Opioid Misuse: Among People Aged 12 or Older; 2020

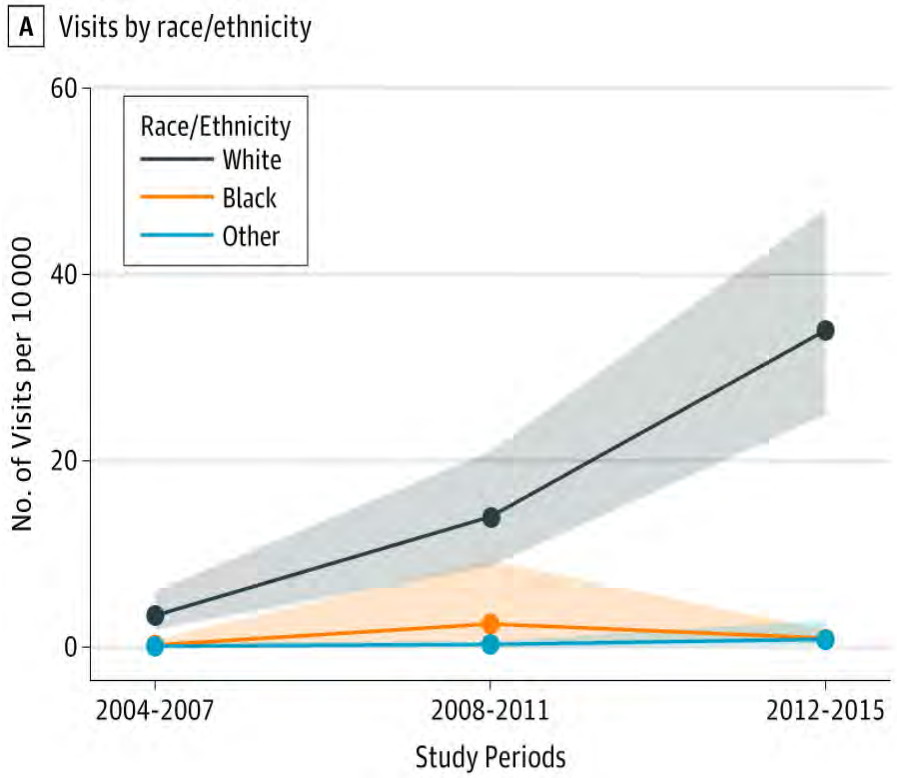
- NSDUH (2020)

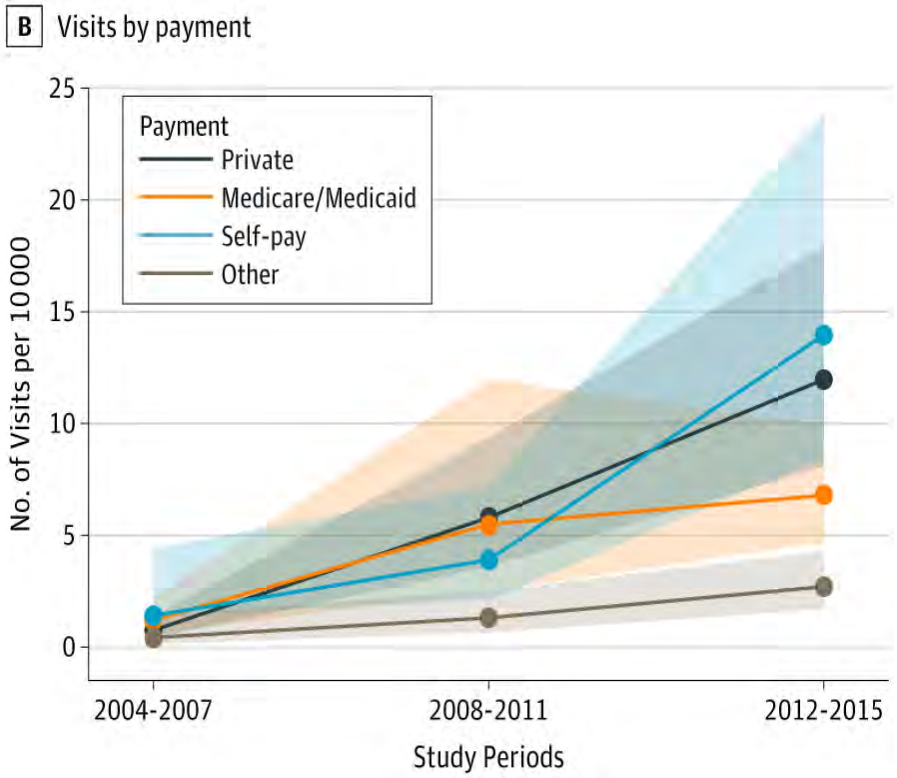


“Not Just Opioids”



Inequities in MOUD Access





- Black patients were **70% less likely** to receive a prescription for buprenorphine at their visit when controlling for payment method, sex and age
- This study demonstrates that buprenorphine treatment is concentrated among white persons and those with private insurance or use self-pay.

Lagisetty 2019

Biden-Harris Administration Approach to Substance Use

- Increase funding for public health and supply reduction
- Removing barriers to treatment
  - supports eliminating outdated rules that place unnecessary administrative burdens on providers, discouraging them from prescribing effective treatments for addiction.
  - will propose making permanent the emergency provisions implemented during the COVID-19 pandemic concerning MOUD authorizations.
  - expand MOUD throughout Federal incarcerated settings
- Reducing harm and saving lives
  - Greater access to noloxalone
- Stopping the trafficking of illicit drugs

https://www.whitehouse.gov/briefing-room/statements-releases/2022/03/01/fact-sheet-addressing-addiction-and-the-overdose-epidemic/

Notable grant funding

- State Opioid Response Grants- **$1,439,500,000**
- Strategic Prevention Framework for Prescription Drugs (SPF Rx)-**$3,000,000**
- Medication-Assisted Treatment – Prescription Drug and Opioid Addiction (MAT- PDOA)-**$22,575,000**
- Harm Reduction Grant Program (Harm Reduction)-**$29,250,000**
- Certified Community Behavioral Health Clinic Expansion Grants- **$149,000,000 (2021)**

Current Legislation

Mainstreaming Addiction Treatment (MAT) Act (S. 445/H.R. 1384)

Medication Access and Training Expansion (MATE) Act (S.2235/H.R. 2067)

Medicaid Reentry Act (S. 285/H.R. 955)

Excellence in Recovery Housing Act (H.R.2376)

National Trends: Medicaid

- HCP-LAN goals include having **half of Medicaid** and commercial plan payments and all of Medicare payments be **value-based by 2025**.
- Growth and expansion of managed care: In 2019, **37 states had the majority of their population enrolled in managed care**, compared to 2010 when only 25 states had the majority of their population enrolled in managed care.
- In 2019, $299 billion—**over half of the total Medicaid spending** — was for managed care capitation and premium assistance payments.
- Approximately **93% of Medicaid managed care organization (MCO) plans reported using VBP** or alternative payment models (APMs) during 2019. About 79% of the plans reported that their state contracts required them to implement VBP contracting with provider organizations.

https://openminds.com/market-intelligence/executive-briefings/medicaid-health-plans-vbr-pick-up-steam/

National Trends: Medicaid

- Medicaid health plans are changing how they reimburse provider organizations for services.
  - **28 state Medicaid plans** require their health plan contractors to reimburse provider organizations using APMs.
  - The Institute for Medicaid Innovation reported that **all Medicaid MCOs covering more than 250,000 consumers** reported using VBPs or APMs; about 80% of MCOs with up to 250,000 consumers also used VBPs and APMs.
- The most common payment strategies:
  - Payment incentives based on access to care (about 64%)
  - Incentives for availability of same-day or after-hours appointments (43%)
  - Enhanced payment rates for hard-to-recruit provider types (29%)
  - Other strategies (29%) including the integration of behavioral health care into primary care

https://openminds.com/market-intelligence/executive-briefings/medicaid-health-plans-vbr-pick-up-steam/

COVID Implications for VBP

- Organizations engaged in alternative payment generally **reported having more financial protection against FFS downturns during the pandemic**, since their payments were less affected by declines in service volume.
- VBP model flexibility **allowed practices to pivot quickly to develop and sustain effective care models** during the public health emergency, regardless of whether the services or activities are reimbursed (or not) under a fee-for-service system.
- Organizations engaged in VBP reported having developed a wide range of capabilities which were critical for effective COVID-19 responses, such as:
  - Dedicated staff and workflows to support care coordination and information sharing across providers and settings
  - Robust data infrastructures enabling population health management
  - Established telehealth platforms capable of handling quick shifts to virtual care delivery and management.

https://healthpolicy.duke.edu/sites/default/files/2020-07/best_practices_brief_final.pdf

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The Case for Value-Based Payment for Substance Use Disorder Treatment and Recovery Services

- The COVID-19 pandemic has exacerbated the challenges of the substance use crisis and revealed longstanding gaps in access to quality care.
  - Drug overdose deaths rose by over 30 percent between 2020 and 2021.
  - Data has indicated that behavioral health needs have increased during the pandemic while utilization of services has not risen enough to meet these additional demands.
- Value-based payment as a tool to incentivize high-quality, coordinated care that can support continued disease management.
  - Individuals with SUD often have complex psychosocial needs that may require varying levels of treatment and other supports.
- Comprehensive or “team-based” care delivery models can support coordination across these services; facilitate improved delivery of evidence-based practices and connect individuals to the appropriate level of care through the recovery process.

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Funding Gaps

- Recovery Housing
- Recovery Supports
- Social Determinants of Health
- Harm Reduction/Outreach Services

The Certified Community Behavioral Health Clinic (CCBHC) Model

June 5, 2022

A CCBHC is a specially-designated clinic that receives flexible funding to expand the scope of **mental health and substance use services** available in the community to ensure health equity and high-quality care for underserved populations.

3. SUD-specific examples for CCBHC criteria:

- [illegible] services can be delivered in other [illegible] hospitals, [illegible] resource [illegible] with [illegible] these [illegible] to [illegible] share [illegible] impacts in [illegible] care [illegible] disorders in children and adolescents

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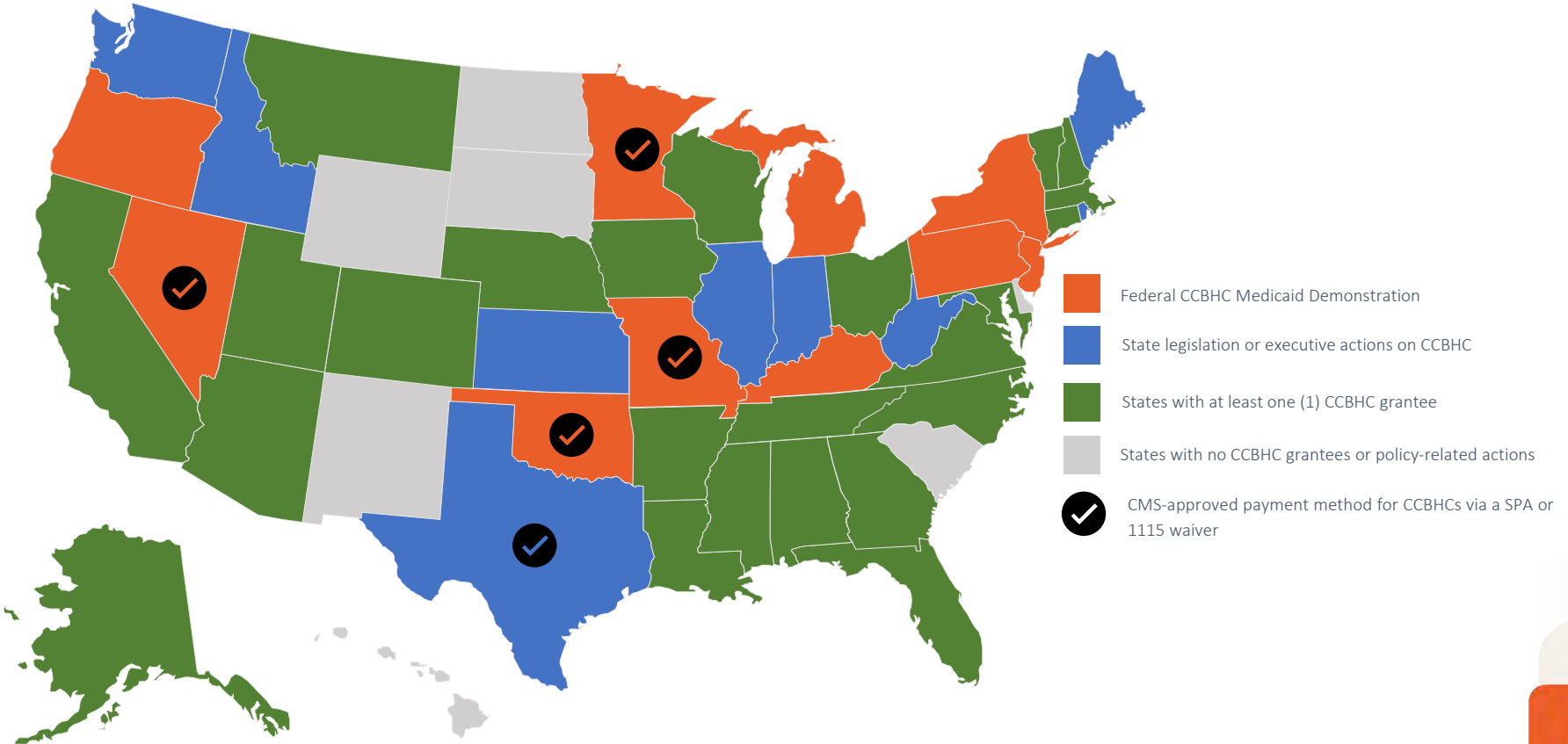
CCBHCs Across the Country



Note: Delaware, Hawaii, South Carolina, North Dakota, and Wyoming are part of a national CCBHC learning Collaborative and have confirmed that more than one clinic within their states have applied for the CCBHC grant. A current list of CCBHCs by state can be found here.

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How States Establish the CCBHC Model in Medicaid

Two Paths for CCBHC…

Establishing CCBHC at the State Level

- CCBHC Medicaid Demonstration
- 1115 waiver or State Plan Amendment

Establishing CCBHC at the Clinic or Community Level

- $4 SAMHSA grant for 4-year person
- Certification by your state through Medicaid (State owns the certification of CCBHCs, not SAMHSA or CMS)

Medicaid Waiver (e.g., 1115)	State Plan Amendment	CCBHC Demonstration
Enables states to experiment with delivery system reforms	Enables states to permanently amend Medicaid plans to include CCBHC as a provider type, with scope of services, criteria and requirements, etc.	Enables states to experiment with delivery system reforms
Requires budget neutrality	Does not require budget neutrality	Does not require budget neutrality and provides an enhanced FMAP for states
Must be renewed every 5 years	With CMS approval, can continue PPS	For only 10 states till Sept. 30, 2023
State must be sure to specify inclusion of selected CCBHC services (some may not otherwise be included in the plan)	Cannot waive "state-wideness," may have to certify additional CCBHCs (future CCBHCs may be phased in)	State may limit the number of clinics selected to receive the PPS rate
With CMS approval, offers opportunity to continue or establish PPS		State must be sure to follow all CCBHC criteria with ability to build onto them

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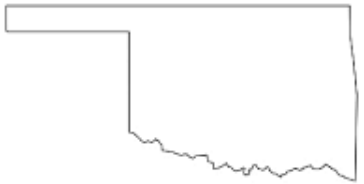
CCBHCs' State Impact Over Time

New York

- All-cause readmission dropped **55%** after year 1
- BH inpatient an overall inpatient services show a **27% and 20% decrease in monthly costs** respectively
- BH ED and overall ED services show a **26% and 30% decrease in monthly cost** respectively
- **24% increase** in BH services for children and youth
- **85% satisfaction rating** from clients with cooccurring SUD and SMI



Oklahoma

- **Nearly 1,000 new jobs to health care with an economic impact of $35 million dollars** and an overall reduction in unemployment.
- Inpatient hospitalizations among adult clients at any Oklahoma psychiatric hospital fell **reduced by of 93.1%.**
- From 2016-2021, the decreases in inpatient hospitalizations produced a **$62 million dollars cost savings.**
- Nearly a **700% increase in medication-assisted treatment** (MAT) services through the CCBHC model

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CCBHCs' State Impact Over Time

Missouri

- Hospitalizations **dropped 20%** after 3 years, ED visits **dropped 36%**
- Access to BH services **increased 23% in 3 years,** with a 123% increase in medication-assisted treatment (MAT)
- **In 1 year, 20% decrease** in cholesterol; **1.48-point Hgb A1c decrease**
- Justice involvement with BH populations **decreased 55%** in 1 year
- **$15.5M per year in savings** (14% decrease in yearly spend) equated to approx. $484 saved per person served.
- $3M decrease in Medicaid for children's poverty and a $1.8M decrease in older youth foster care, a **56% and 47% decrease in yearly costs** respectively

Texas

- The CCBHC model in Texas is projected to save **$10 billion by 2030**
  - Harris County (Houston) found every $1 invested had a $5.54 return.
  - Travis County (Austin) identified about $1.64 million in cost avoidance
- In 2 years, there were **no wait lists** at any CCBHC clinic
- **40% of clients** treated for cooccurring SUD and SMI needs, compared to 25% of other clinics

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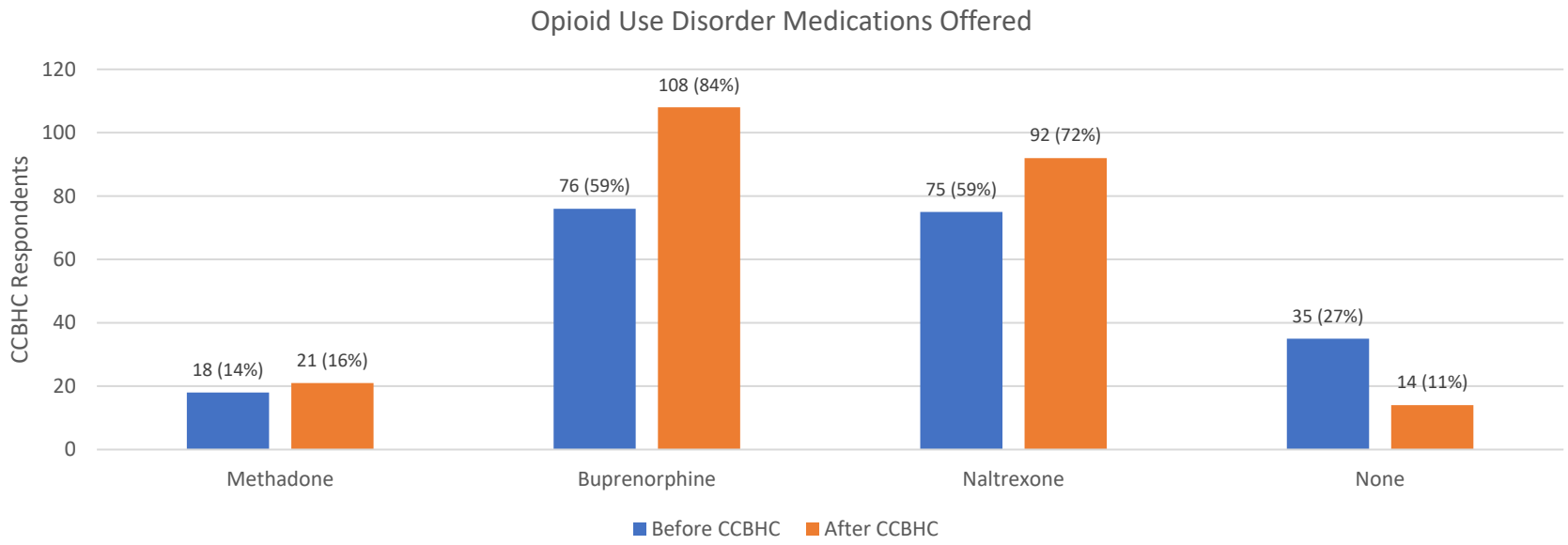
CCBHC's are Increasing Access to MAT

- 89% of CCBHCs offer one or more forms of MAT
  - Compared to 56% of substance use clinics nationwide.
  - An estimated **37,000 clients** are engaged in MAT at a CCBHC nationwide.
- 60% of clinics added MAT for the first time as a result of becoming a CCBHC.



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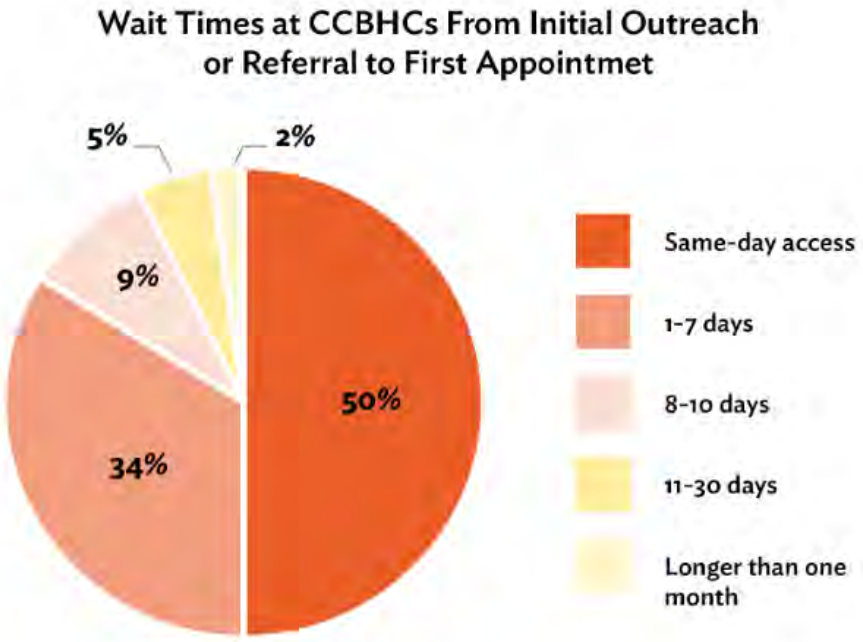
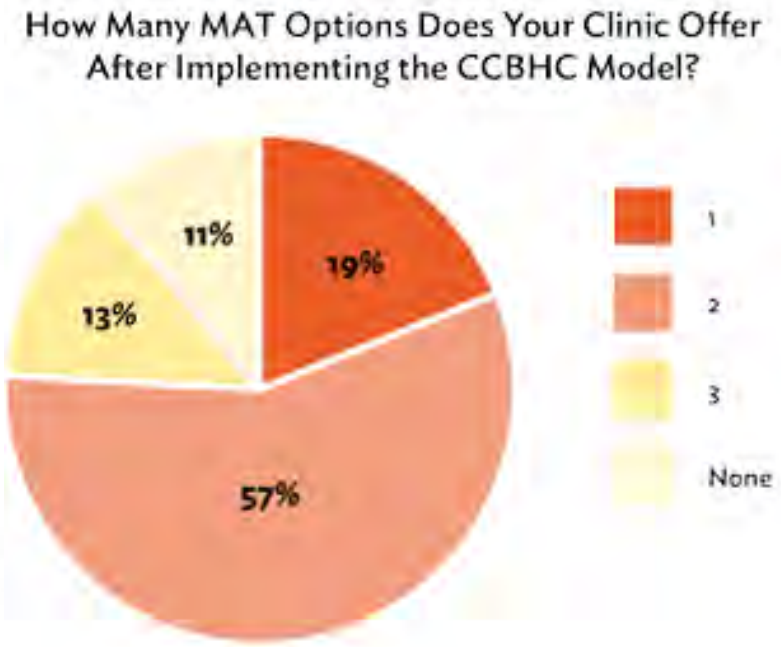
Timely access to SUD care

- 60% of surveyed CCBHCs added MAT services for the first time as a result of becoming a CCBHC
- 31% of surveyed CCBHCs were able to offer more forms of MAT after converting to a CCBHC
- 55% of surveyed CCBHCs saw an increase in the number of clients engaged in MAT after CCBHC implementation





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Enhanced Medicaid Match for Mobile Crisis, 988 components

- 85% Medicaid match available for qualifying mobile crisis services and activities for mental health AND substance use crisis needs
  - Available for first 12 fiscal quarters the program is in effect during the period April 1, 2022 through March 31, 2027
- "Mobile crisis intervention services should be integrated with the national suicide prevention and mental health crisis hotline, state funding of core crisis care elements, **and community-level efforts to implement CCBHC crisis management services.**"
- States should be aware of requirements around qualifying activities and claiming the enhanced match

https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf

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Thank You!

Questions and Comments

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