CD Integration Work Group

RECOMMENDATIONS TO THE TASK FORCE
July 18, 2014

1. Each Behavioral Health Organization should *provide rapid access to the following billable services* along a continuum of care for chemically dependent clients:

Each BHO will need to arrange for access to the full range of services but does not necessarily need to have all types of facilities within their geographic coverage area. This is similar to the network requirement for RSNs – the need to arrange for all medically necessary services does not mean all types of services will need to exist in the geographic coverage area. This is an important distinction for the actuary process because it means that every BHO will need to have included in its rates the types of services (i.e. acute detox and sub-acute detox) , even if some of those services are not located within their geographic area.

- *Outreach/engagement:* proactively seeking out individuals in need of CD treatment, encouraging them to seek treatment, and helping to connect them to care (e.g. at needle exchanges, homeless encampments, etc.)
- *Pre-treatment/interim services:* help and support for individuals who are waiting to get into treatment (e.g. waiting for detox, waiting between detox and residential). This could include having a case manager call every day to check in or having a client come in once or twice per week until they can get into treatment
- *Withdrawal management*: (formerly known as "detox") inpatient, outpatient/ambulatory, acute, sub-acute, and medication assisted
- *Outpatient treatment*: abstinence only, medication assisted, and co-occurring
- *Intensive outpatient treatment (IOP):* abstinence only, medication assisted, and co-occurring
- *Residential treatment:* short and long term, including care for specialty populations such as pregnant and parenting women (PPW) and ethnic minority communities, medication assisted, and co-occurring
- *Integrated crisis response services:* integrated mental health/chemical dependency outreach and detention services for individuals in crisis
- *Case management/care transitions (care coordinators/navigators):* for patients in all levels of care, including discharge planning from hospitals and jails, in order to safely transition and not "drop off" in between levels or types of care
- *Peer services:* peer support specialists are central to the recovery model and should be utilized along the entire continuum of care
- *Recovery supports:* including support with access to housing (ATR likely going away), transportation, job training (supported employment), and childcare

It is imperative that this continuum of services is not condensed or diminished as a result of the transition to BHOs. It is because of the broad range of services (e.g. medication assisted options, programs for individuals involved in the criminal justice system, pregnant and parenting women programs) that our clients have the positive outcomes that they do today.

2. Any RSN who has not yet contacted the CD agencies in their area should initiate meetings with them immediately

3. The actuarial studies need to be reviewed as the RSN's was by the community to provide feedback.

- Actuarial rates need to be realistic
- Concern over the timeline with the final rates and requirements
- Make sure the recommendations take into account the actual cost of doing business, not the current rates. Outside of the recent detox rate increase, the rate structure for CD services has not had any significant changes in the past 7 years. While the cost of providing services continues to grow.
- Our community providers have done an amazing job signing people up for Medicaid. This has been a disincentive to them as Medicaid rates are lower than state funded low income rates. The shift to Medicaid as the payee for clients caused a drop in revenue for a number of programs.

4. Data management

- The State needs to look at creating an integrated database to take the best elements of Target and the mental health database so that agencies that provide both CD and MH services won't have to do dual entry
- Date should be kept locally such that each BHO can customize the data to meet their community needs and just provide the state with the information that they request
- Need for an integrated accounting/billing system

Additional issues that were discussed

- Therapeutic courts and how they fit into financing model
- The State should play a more active role in the fight against the IMD exclusion so that our residential facilities that are larger than 16 beds can bill Medicaid
- Improved access to mental health services in residential chemical dependency treatment
- Issue of not being able to bill Medicaid for people with abuse (mild addiction) and not just the clinical diagnosis of dependency
- Common performance outcome measures
    - Do the agreed upon outcomes accurately represent CD specific issues?
        - E.g. in CD treatment, you want to move people quickly through treatment to enter lifelong recovery. So the goal is to have them stop coming to treatment, whereas in MH, you often have lifelong clients and so the retention rates may be higher
    - Need to make distinctions clear when examining outcomes: E.g. court ordered programs have higher retention rates than voluntary programs so they look better in that outcome measure
    - Could mandate incremental improvements in performance in certain categories
- BHOs need to be given flexibility to set up performance incentive systems
- There are provider meetings for inpatient facilities, but not for outpatient providers, so outpatient providers feel left out of the feedback/engagement loop
- Primary care integration: Need for training of physicians (primary care, psychiatrists, etc.) on safe prescribing to individuals with a history of addiction
- Work force development continues to be a major need: Agencies are having a difficult to finding and retaining a qualified workforce due to the low pay, because of low reimbursement rates. There is additional need for increased cross-training across MH and CD, but not everyone needs to be dually licensed
- Importance of peer support specialists throughout the continuum of care, but especially for outreach/engagement work
- Where is the line between healthcare and social services? E.g. in residential programs clients receive parenting classes, housing assistance, child care, etc. It is far more complex than medical services
- DMHPs need tools to appropriately place CD clients who are at risk of harm to self or others (e.g. secure detox facilities)
- Now that we've presented the "what" (continuum of care), at our next meeting, this group will discuss the "how"—how these services should be financed, contracted, etc.