MEDICAID PAYMENT POLICY AND CARE COORDINATION WORKGROUP

Meeting 6

June 16, 2021

Agenda

- Welcome
- Review of Behavioral Health Feedback from Workgroup
- Overview of Embedded Care Coordination Model
- Project BRAVO
- Building a low-threshold, high-retention approach to addiction care in Virginia
- The Carilion Emergency Department Bridge to Treatment Program
- Continue EDCC Discussions from Meeting 5
- Wrap Up and Adjourn

Review of Behavioral Health Feedback

Feedback from workgroup members largely requested more information from subject matter experts on behavioral health to expand the discussion in this area.

- ✓ Discuss an embedded care coordination model for behavioral health, including roles for hospitals/ CSBs, information from subject matter experts.
- ✓ Consider care management services in regional, multi-disciplinary team to meet the needs of members with high ED utilization and behavioral health diagnoses.
- ✓ Discuss how to build/support/expand access to community based services for behavioral health to potentially reduce avoidable or unnecessary ED utilization in non-emergent cases.

One Anthem

Virginia Medicaid Market Embedded Care Coordination Program

Victoria McCown, LCSW
Behavioral Health Program Manager

Embedded Care Coordination

General Overview

In partnership with a large volume (2,900+ members) outpatient behavioral health provider group, Anthem Care Coordinators work onsite alongside their doctors, therapists and nurses to offer support though an integrated model ensuring behavioral health, physical health and social determinant of health needs of our members are identified and met in timely manner.

Why Embedded Care Coordination?

Member Access

- Ability to reach and engage members (previously unsuccessful via traditional telephonic methods)

Exchange of Information

- Member level gaps in care and claims data shared with provider
- Identification of high needs/high cost members
- Use of data to drive interventions

Integrated Whole Person Care

- Nurses on staff within a BH practice
- Partnering with a BH provider and placing care coordinators onsite where members are regularly attending appointments creates opportunity for member engagement around significant and previously unaddressed PH and social determinant of health needs.

Initial Data Review

Utilization Pre ECC
Top 100 Members Compared to All Other Members

CATEGORY	TOP 100 MEMBERS	ALL OTHER MEMBERS (2,8oo+)
Inpatient Behavioral Health Admits/K	753	133
Inpatient Behavioral Health Days/K	6,628	865
Inpatient Physical Health Admits/K	1,150	114
Inpatient Physical Health Days/K	6,816	565
Outpatient ER Visits/K	5,833	1,574

Role of the Care Coordinator

- Provide education on available physical and behavioral health benefits
- Work with members to encourage and aid in navigating preventative care
- Assist with selecting and registering a PCP
- Provide referrals to in network behavioral health and/or physical health specialist providers
- Assist with obtaining durable medical equipment, disposable supplies and in home monitoring devices
- Assist with medication pre-authorizations so that members receive their medications in a timely manner
- Schedule transportation and/or help with resolving transportation Issues
- Visit members that are hospitalized prior to discharge serving as a bridge support ensuring a solid transition between levels of care

Role of the Provider Nurse/Program Liaison

- Work alongside Anthem Care Coordinator to identify and address whole person needs
- Educate members regarding BH and PH diagnoses
- Provide in house lab work
- Diabetic screenings
- Monitor blood pressure
- Weight checks
- Drug screens

Outcomes

- Initial focus was on top 100 spend members but given the impact noted early on, the program soon expanded to include any identified member being seen at the practice.
- The ability to reach high needs members that we were previously unable to engage via traditional telephonic case management methods has proven valuable with the greatest impact noted in physical health.

- **1-Year Cost of Care Savings = 971.4k**

- 26% decrease in Inpatient Physical Health Admits (Top 100)
- 17% decrease in Inpatient Physical Health Admits (Total Membership)
- 59% decrease in Physical Health 30 Day Readmission Rates (Top 100)
- 54% decrease in Physical Health 30 Day Readmission Rates (Total Membership)
- 33% decrease in ER visits (Top 100)

One Anthem

Member Success Story

Mary, a 60 year old CCC+, BH Vulnerable Subpopulation member had been outreached over a long period of time by her Anthem Care Coordinator without success. However, soon after the Embedded Care Coordination program going live Mary's Care Coordinator was able to connect with her face to face during one of her appointments. She quickly established a relationship and learned that in addition to her mental illness Mary was diabetic and living in terrible conditions. She was non-adherent with medications, and was not seeking adequate treatment for her diabetes, frequently ending up in the hospital with sepsis and having toes amputated. Mary's Care Coordinator in collaboration with the provider's staff worked to link her with Crisis Stabilization services and then Mental Health Skill Building. She is now in more stable housing, has become adherent with her medications, has been linked with an endocrinologist, obtained diabetic shoes, and began attending a Psychosocial Rehab Program 5 days a week.

One Anthem

WE BELIEVE IN OUR VISION:

To be America's valued health partner.

WE WORK WITH ONE PURPOSE:

Together, we are transforming health care with trusted and caring solutions.

WE LIVE OUR VALUES:

Accountable

Caring

Easy to do business with

Innovative

Trustworthy

PROJECT BRAVO:

BEHAVIORAL HEALTH REDESIGN FOR ACCESS, VALUE AND OUTCOMES

Alyssa Ward, Ph.D.

Behavioral Health Clinical Director

Department of Medical Assistance Services

Medicaid Payment Policy and Care Coordination workgroup

PROJECT BRAVO

VIRGINIA'S MEDICAID PROGRAM DMAS INNOVATION • QUALITY • VALUE

Behavioral Health Redesign for Access, Value and Outcomes

Vision

Implement fully-integrated behavioral health services that provide a full continuum of care to Medicaid members. This comprehensive system will focus on access to services that are:

High Quality

Quality care from quality providers in community settings such as home, schools and primary care

Evidence-Based

Proven practices that are preventive and offered in the least restrictive environment

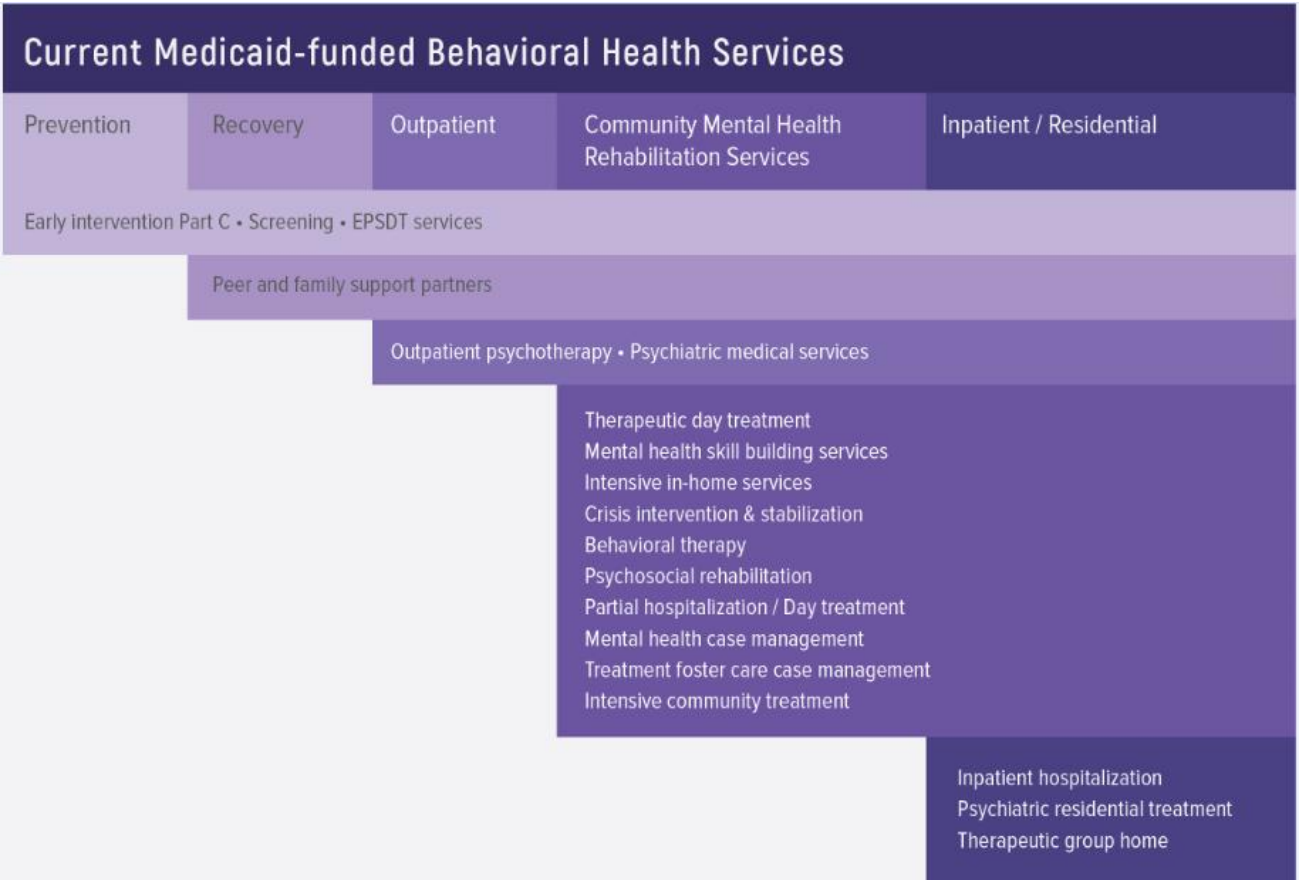
Trauma-Informed

Better outcomes from best-practice services that acknowledge and address the impact of trauma for individuals

Cost-Effective

Encourages use of services and delivery mechanism that have been shown to reduce cost of care for system

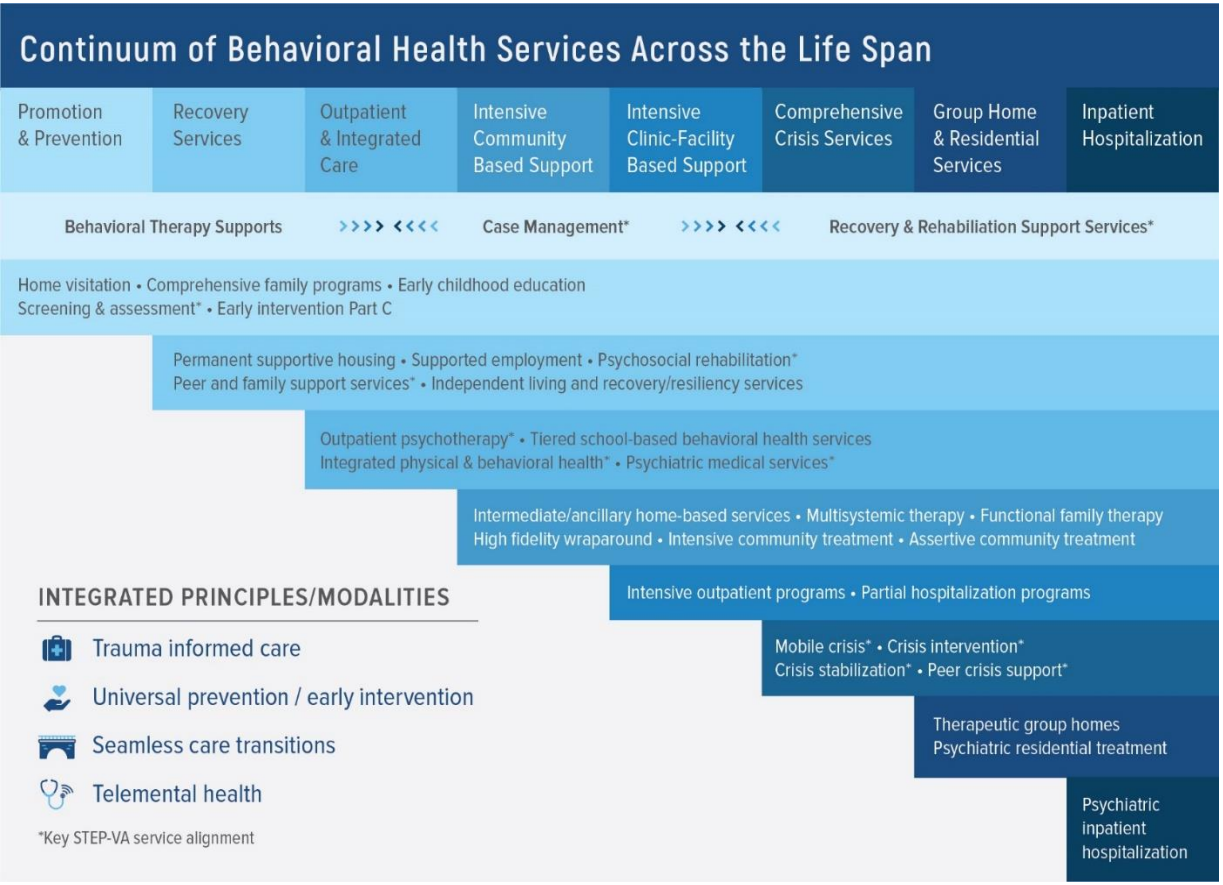
Current Continuum



-Lack of evidence-based services
-Reliance on intensive services for acute problems
- Service definition and rate structures do not support best practice

The North Star
Behavioral Health Services Enhancement

PROJECT BRAVO



This represents the long term vision for the development of a robust continuum

VIRGINIA'S MEDICAID PROGRAM DMAS INNOVATION • QUALITY • VALUE

BRAVO Brings Alignment Across Initiatives

BRAVO Leverages Medicaid Dollars to Support Several Secretariat Priorities

Enhancement & Family First Prevention Services Act

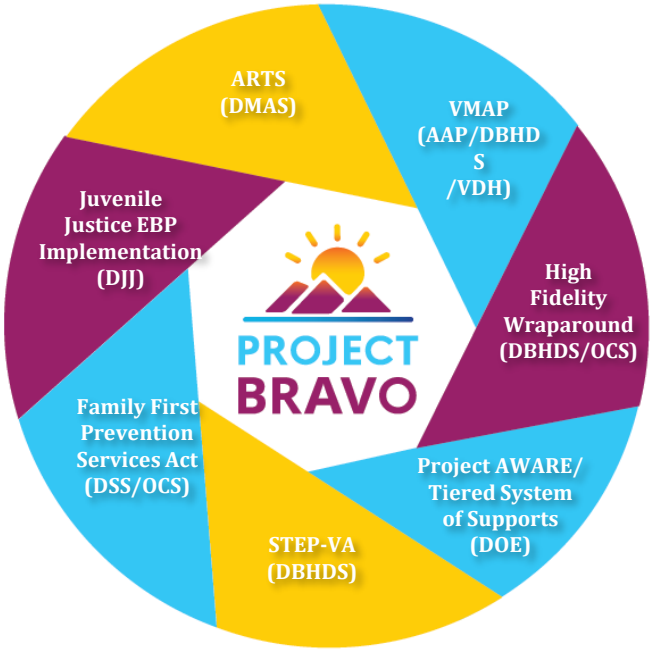
Focused on workforce development, evidence-based programs, prevention-focused investment, improving outcomes, and trauma informed principles

Enhancement & Juvenile Justice Transformation

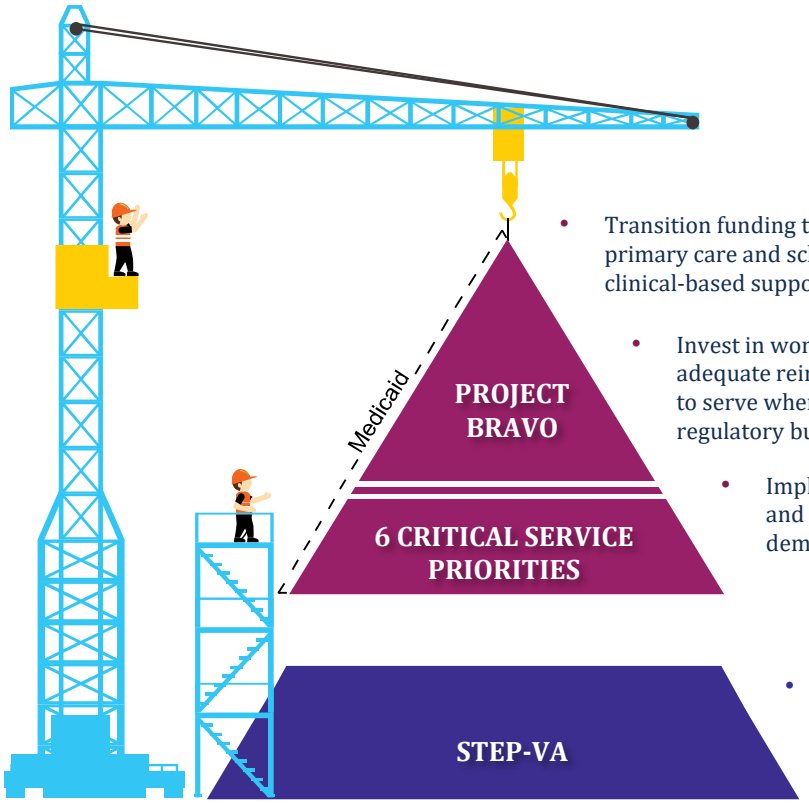
Supports sustainability of these services for the provider community, particularly in rural settings who have struggled with maintaining caseloads and business models when dependent on DJJ or CSA

Enhancement & Governor's Children's Cabinet on Trauma Informed Care

BH Enhancement continuum is built on trauma-informed principles of prevention and early intervention to address adverse childhood experiences



BRAVO Enhancements & STEP-VA



- Transition funding to outpatient services, integrated services in primary care and schools, and intensive community-based and clinical-based supports
- Invest in workforce development including provision of adequate reimbursement to recruit and incentive providers to serve where most needed. Streamline licensure and reduce regulatory burdens that impede workforce development
- Implementation of high quality, high intensity and evidence-based SIX services that demonstrate high impact and value
- STEP-VA services improve access, increase quality, build consistency and strengthen accountability across Virginia's public behavioral health system (CSBs)

BRAVO Enhancements:
Current Priorities Explained

PROJECT BRAVO

What are our top priorities at this time?

Implementation of ***SIX*** high quality, high intensity and evidence-based services that have demonstrated impact and value to patients

Services that currently exist and are licensed in Virginia ***BUT* are not covered by Medicaid *or the service is not adequately funded through Medicaid***

- Partial Hospitalization Program (PHP)
- Assertive Community Treatment (ACT)
- Multi-Systemic Therapy (MST)
- Intensive Outpatient Program (IOP)
- Comprehensive Crisis Services (Mobile Crisis, Intervention, Community-Based, Residential, 23Hr Observation)
- Functional Family Therapy (FFT)

Why Enhancement of BH for Virginia?

- ✓ Provides alternatives to state psychiatric admissions and offers step-down resources not currently available in the continuum of care, which will assist with the psychiatric bed crisis
- ✓ Demonstrated cost-efficiency and value in other states

Enhancement of Behavioral Health Services

Special Session 2020 and GA Session 2021

PROJECT BRAVO

	Fiscal Year 21-22		
	Initial Budget Projection	Reduction Due to Change in Implementation Dates (Pandemic Delay)	Final Budget Allocation
General Fund	$10,273,553	-$10,062,988	$210,565
Non-General Funds	$14,070,322	-$38,332	$14,031,990
TOTAL FUNDS	$24,343,875	-$10,024,656	$14,242,555

Implementation *July 2021*
Assertive Community Treatment
Partial Hospitalization
Intensive Outpatient Programs

Implementation *December 2021*
Multi-Systemic Therapy
Functional Family Therapy
Comprehensive Crisis Services (23 hour beds, Residential Crisis, Community Stabilization, Mobile Crisis Intervention)

High Level Implementation Progress:
PHP-IOP-ACT (Phase 1)

PROJECT BRAVO

In Progress

- MCO Readiness Reviews
- "Bonus" Guidance Documents
- Establish Structure for Learning Collaborative Groups
- Regulation Development

Near Complete

- Service Authorization Postings
- Dashboard Finalization
- Accreditation & Medicare Certification Guidance
- State Plan Approval

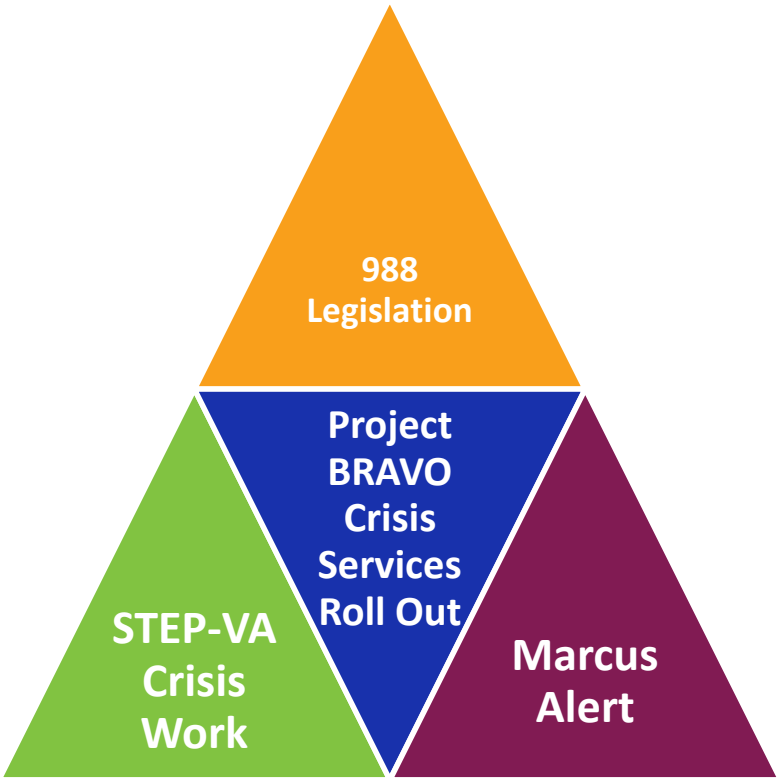
Completed

- Rate Setting
- Provider Bulletins on Codes and Rates
- Policy Development
- Stakeholder Engagement
- Provider Manual Trainings
- Accreditation Orientations
- System Changes
- Manual Postings

Project BRAVO Next Steps

Continued Close Collaboration with DBHDS

- Phase 2 BRAVO 12/1/21:
  - Crisis Services Implementation
  - Multisystem Therapy
  - Functional Family Therapy
- DMAS does not hold any authority to enhance any additional services at this time*



** Exception is Behavioral Therapy and 2021 budget language mandates implementation of new ABA Codes*

Thank you for your partnership, support and participation.

Additional Questions?

Please contact EnhancedBH@dmas.Virginia.gov

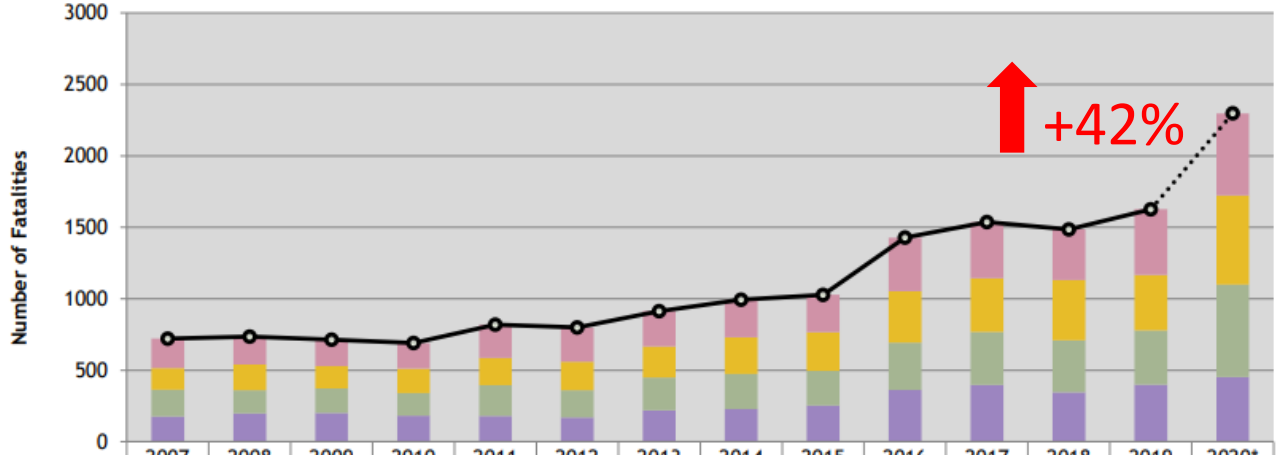
BUILDING A LOW-THRESHOLD, HIGH-RETENTION APPROACH TO ADDICTION CARE IN VIRGINIA

John Morgan, MD
Ashley Harrell, LCSW
Department of Medical Assistance Services

Bad Synergy: Dual Opioid & COVID-19 Epidemics

Fatal Drug Overdose Trends – updated numbers as of **April 2021**

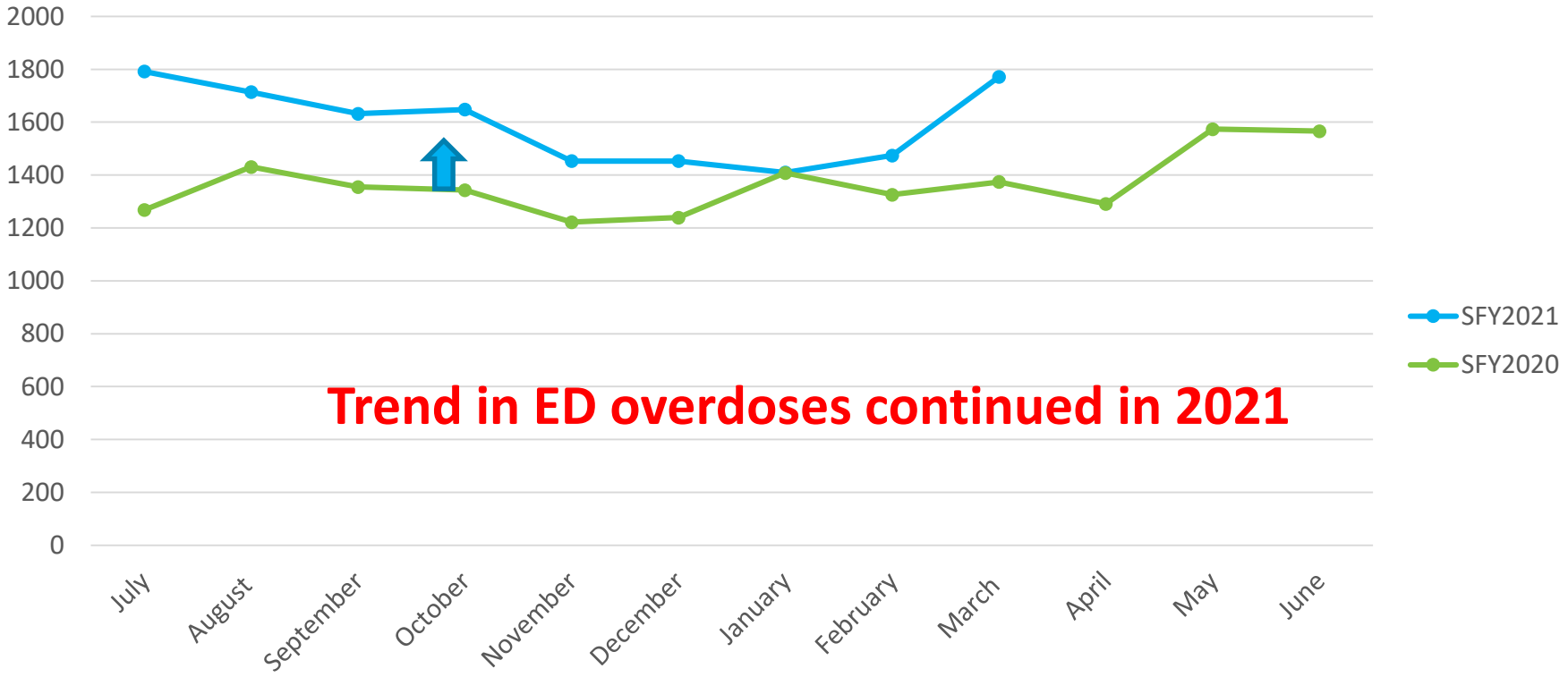
Total Number of Fatal Drug Overdoses by Quarter and Year of Death, 2007-2020*



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020*
Q4	205	195	183	179	232	240	248	263	262	375	393	354	459	574
Q3	152	180	157	170	191	199	217	257	270	359	376	423	389	623
Q2	188	162	172	159	215	190	230	246	243	332	371	363	380	647
Q1	176	198	201	182	181	170	219	228	253	362	397	346	399	453
Total Fatalities	721	735	713	690	819	799	914	994	1028	1428	1537	1486	1627	2297

https://www.vdh.virginia.gov/medical-examiner/forensic-epidemiology/

Touchpoint Trends: ED Overdoses

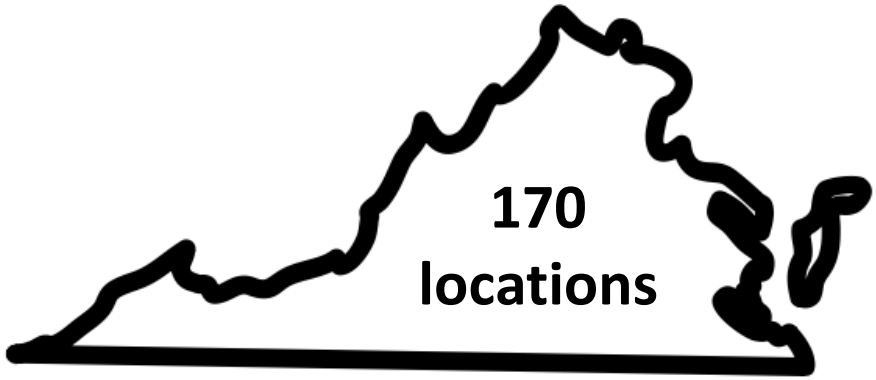


https://www.vdh.virginia.gov/surveillance-and-investigation/syndromic-surveillance/drug-overdose-surveillance/

VA's Preferred Office-Based Opioid Treatment (OBOT) Programs

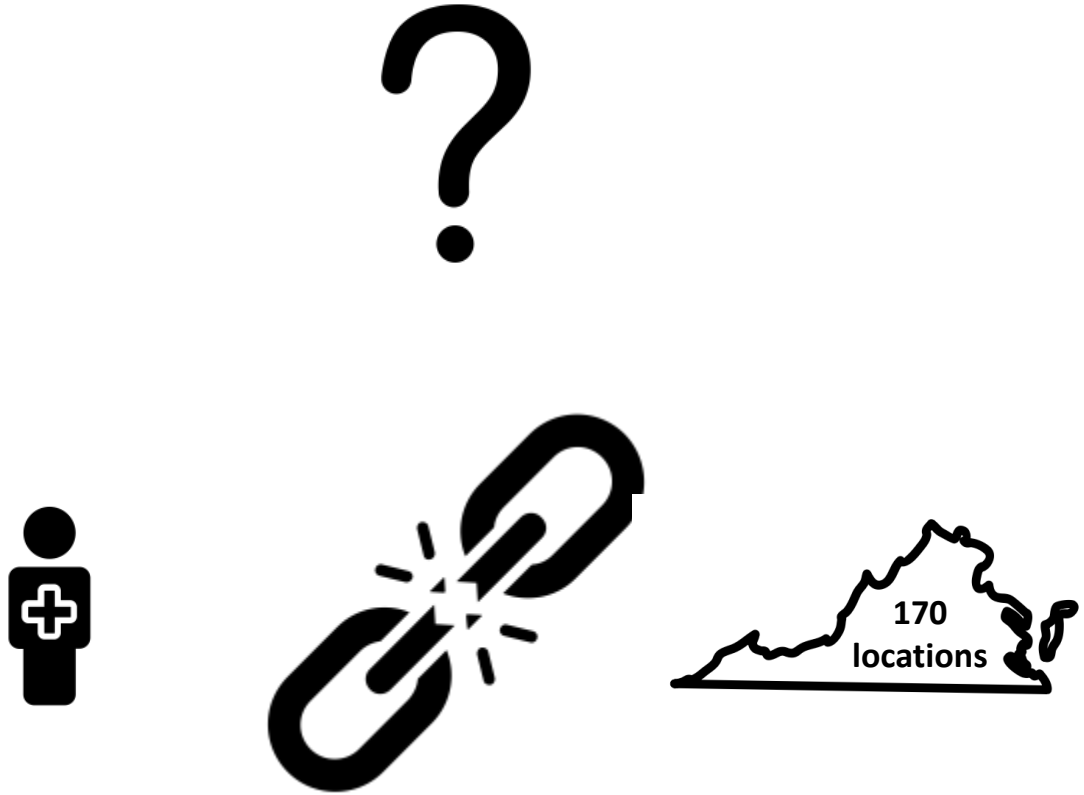
Leveraging the Evidence-Based model for OUD

- **Setting:** Primary care clinics, outpatient health system clinics, psychiatry clinics, Federally-Qualified Health Centers (FQHC), Community Services Boards (CSB), Health Departments, and physician offices
- **Support Systems:** Access to emergency medical and psychiatric care and connections for referrals to higher levels of care
- **Staff Requirements (minimal):**
  - Licensed buprenorphine-waivered practitioner
  - Co-located Licensed Behavioral Health Professional



Rates of MOUD use were higher during episodes of treatment at Preferred OBOT (81 percent), compared to other outpatient providers (56 percent)

WHAT NOW?



Touchpoints: What are they?

Opportunities to predict and prevent opioid overdose

- **37%** of fatal overdoses experience one of **4** critical touchpoints:
  - **opioid detoxification, nonfatal opioid overdose, injection-related infection, and release from incarceration**.

- Recent non-fatal overdoses are **independently associated** with subsequent overdose mortality
- These patients **should be engaged with evidence-based interventions**: Medications for Opioid Use Disorder (MOUD)

https://www.sciencedirect.com/science/article/abs/pii/S0376871619302960

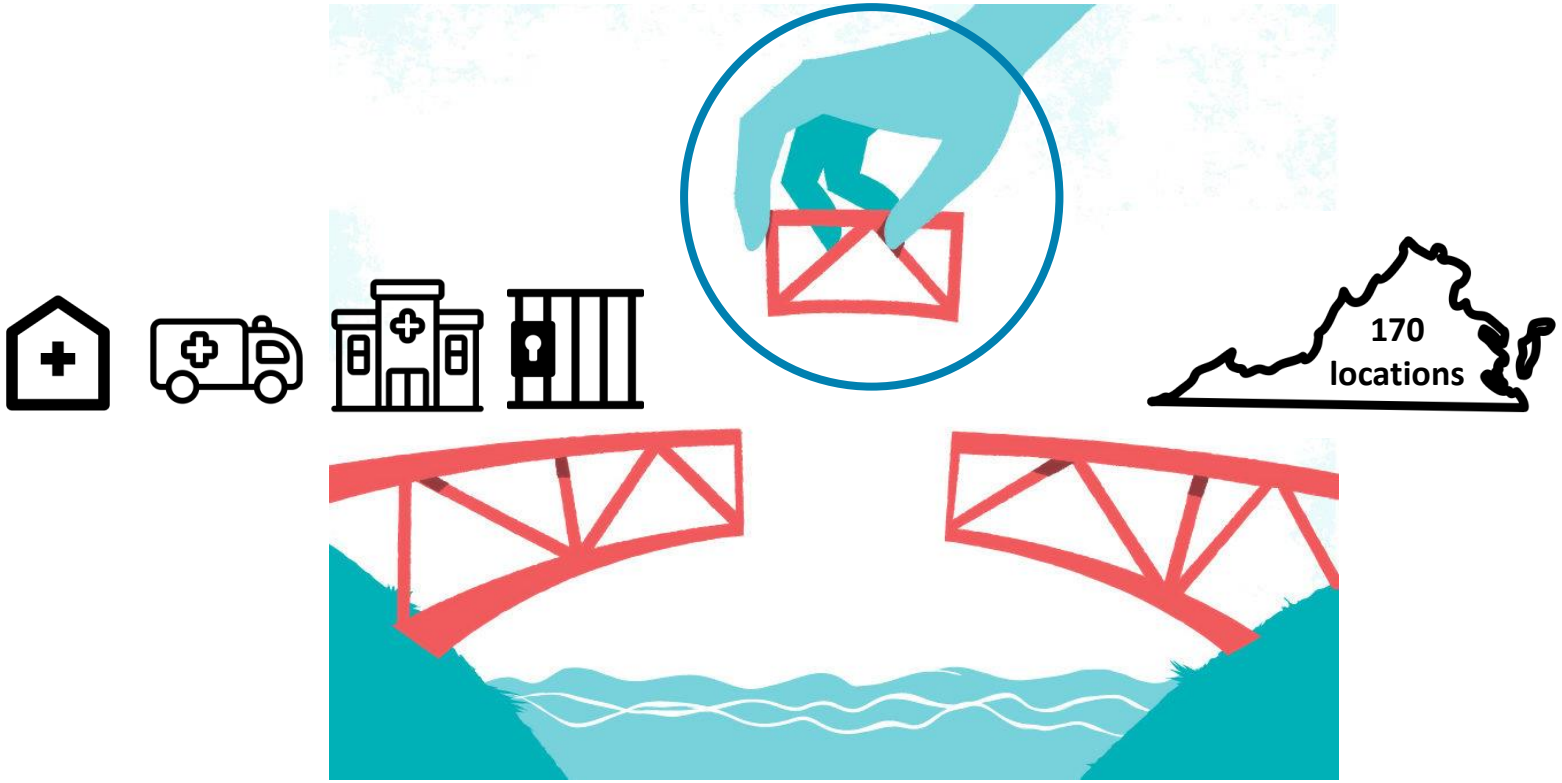
Touchpoints: Initiate Quickly

Initiating Treatment Immediately

- Randomized Control Trial (RCT): OUD ED Patients - Likelihood of entering outpatient treatment:
  - ***Buprenorphine Initiation***: 74%
  - Brief Intervention & Referral: 47%
  - Referral Alone: 53%
- Leveraging Preferred OBOTs can facilitate:
  - Rapid *Initiation* of MOUD
  - Long-term *continuation* of MOUD

Sources: D'Onofrio G et al. Emergency Department-Initiated Buprenorphine for Opioid Dependence with Continuation in Primary Care: Outcomes During and After Intervention. JGIM 2017. Liebschutz JM et al. Buprenorphine Treatment for Hospitalized, Opioid-Dependent Patients: A Randomized Clinical Trial. JAMA IM 2014. Caudarella A, Dong H, Milloy MJ, Kerr T, Wood E, Hayashi K. Non-fatal overdose as a risk factor for subsequent fatal overdose among people who inject drugs. Drug Alcohol Depend. 2016;162:51-55. doi:10.1016/j.drugalcdep.2016.02.024

Case for a “Bridge” Clinic



Versatility of Bridge Model

Awareness: Need For “Bridge” Clinics

ED BRIDGE
Emergency Buprenorphine Treatment

HOW-TO GUIDE FAQ OPPORTUNITIES
STORIES RESOURCES REFERENCES CONNECT

The ED-BRIDGE Buprenorphine Guide provides a practical framework for the use of buprenorphine as an effective short-term treatment for pain and opioid withdrawal, and a bridge to long-term treatment of opioid use disorder.

Despite an opioid crisis, most ERs don’t offer addiction treatment. California is changing that.

This is what it looks like when we stop treating addiction as a moral failure.

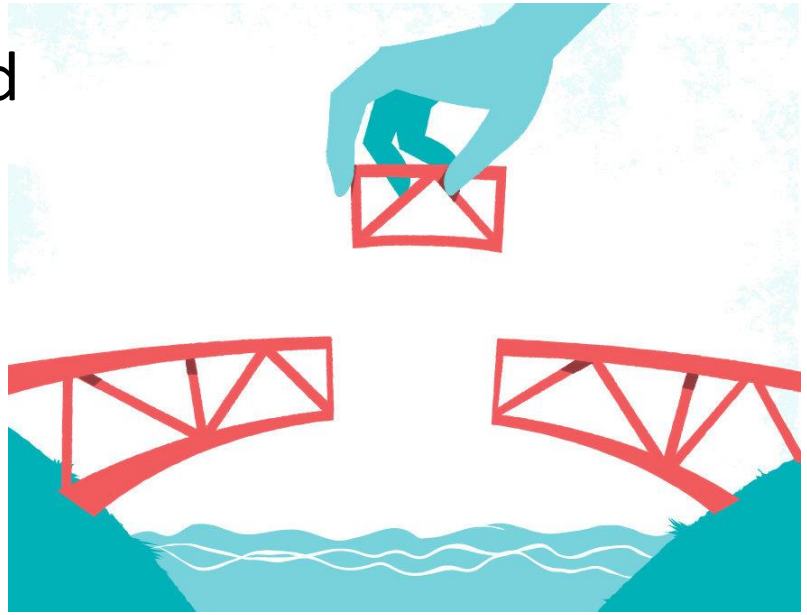
By German Lopez | @germanrlopez | german.lopez@vox.com | Updated Jan 8, 2019, 11:25am EST

Now Mandated To Offer Meds For Opioid Addiction In The ER, Mass. Hospitals Get 'How-To' Guidelines

January 07, 2019 By Martha Bebinger

Role of Bridge Clinics

- Rapid Access to Evidence-Based Initiation
- Easy Access to Long-term Maintenance
- Peer Assistance & Warm Hand-offs/Coordination



SUPPORT Act Grant: FINANCING the BRIDGE

2 “Virtual Bridges” Under Construction

- **VCU Emergency Department Virtual Bridge Clinic**
  - Design and implement an opioid withdrawal treatment protocol
  - Create a Virtual Bridge Clinic to help transition individuals who present to the VCU ED with an overdose emergency to the VCU MOTIVATE clinic for community-based addiction and recovery treatment services.

- **Carilion Clinic – Virtual Expansion of Bridge Clinic**
  - Enhance Carilion's Existing ED Bridge Capacity
  - Develop a curriculum for EDs interested in building their own ED Bridge to Care program, and lead a group Learning Collaborative with up to four hospitals

THE CARILION EMERGENCY DEPARTMENT BRIDGE TO TREATMENT PROGRAM

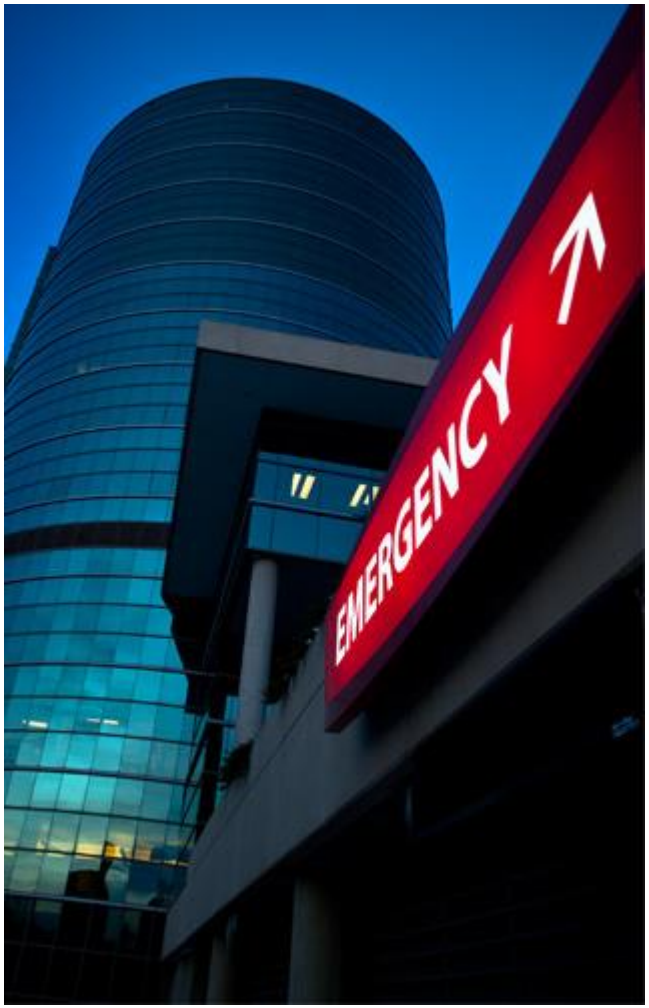
John H. Burton, MD

Cheri Hartman, PhD

The Carilion ED Bridge to Treatment Program

John H. Burton, MD
Chair, Department of Emergency Medicine
Cheri W. Hartman, Ph.D.
Office-based Opioid Treatment Program Manager
Carilion Clinic

MAT in the ED: why or why not?

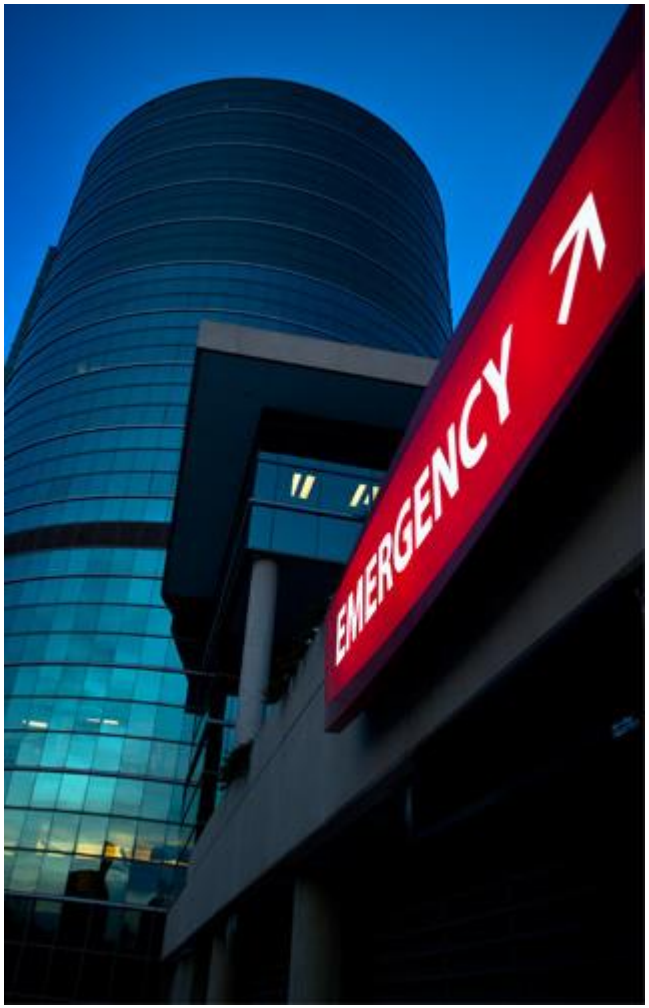


- "That's not what we do":
  Emergency physicians have historically refused to engage in addiction treatment

- "Seems kinda complicated"
  New Knowledge, no outpatient partner

- "Open the flood gates"
  EDs are already busy, no financial gain, dependent pts/frequent flyers, not fun…

MAT in the ED: why or why not?

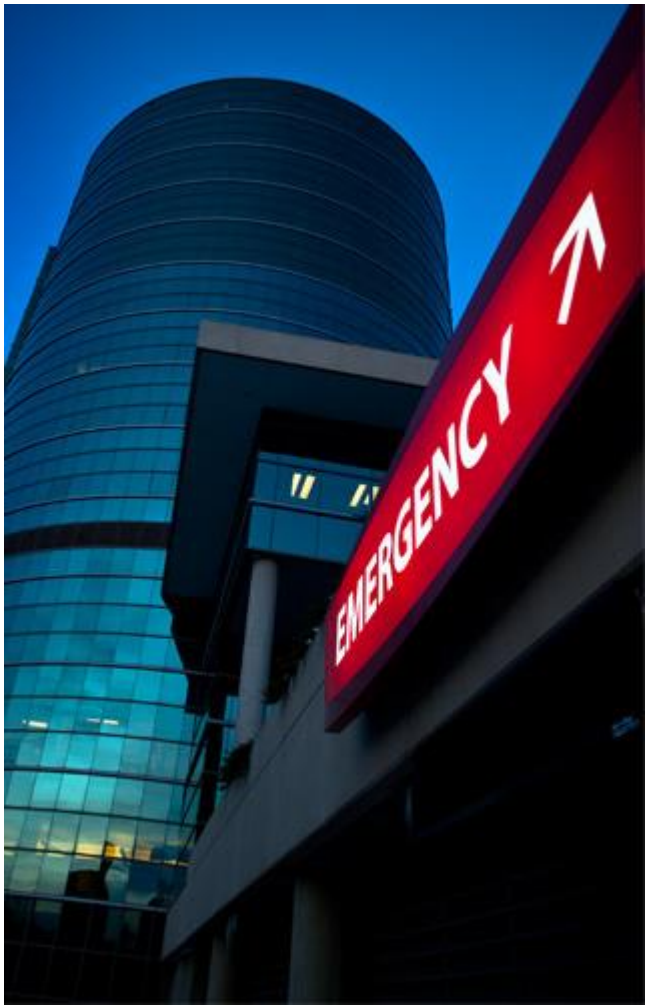


"That's not what we do":

Emergency physicians have historically refused to engage in addiction treatment

- The numbers and need is staggering….
- Wait times to intake: weeks/months
- Time-dependent therapy
- Window of opportunity

MAT in the ED: why or why not?



"Seems kinda complicated"

New Knowledge, no outpatient partner

- Outpatient partner: OBOT
- Pts "fired" from their OBOT
- Know your OBOT philosophies/tactics

MAT in the ED: Who Prescribes?

- **<u>X Waiver Training</u>**: SAMHSA Notice of Intent (NOI) submitted to apply for waiver. To treat 30 patients at a time **no waiver training required**; NOI with medical license number and current DEA number sufficient to get waiver from SAMHSA now. To prescribe for > 30 patients requires completion of approved 8 hours training.

<u>Emergency Physician(s) Models</u>

- One/Few on call for Rx
- Entire Group EM physicians

<u>Dedicated PA or NP</u>

- PA/NP same process with SAMHSA, >30 patients requires 24 hours training

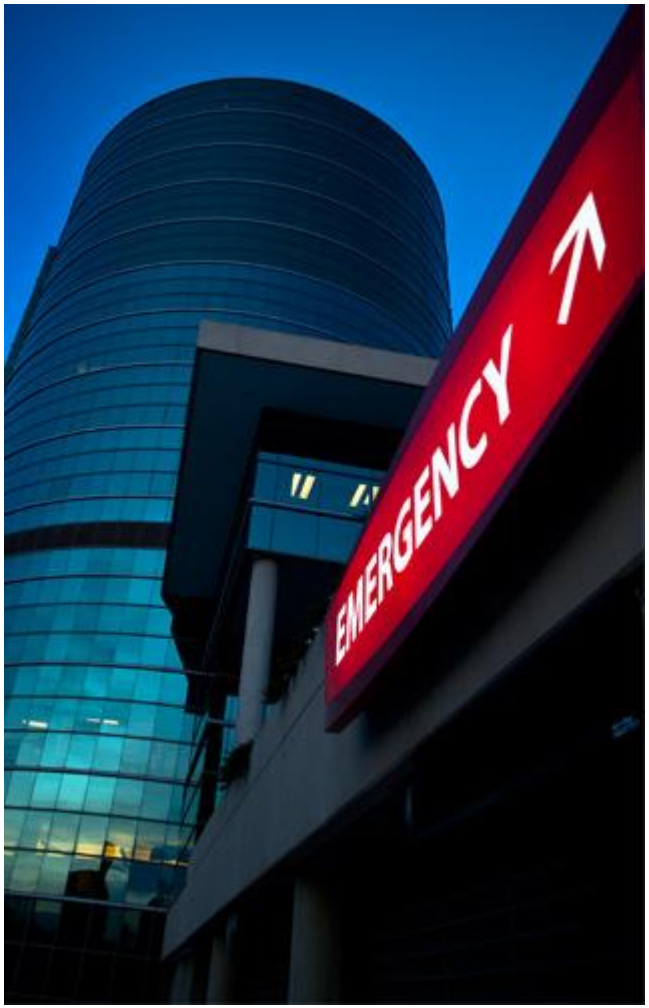
More Issues: ED Work-up

- Baseline Urine Drug Screen: don't wait for results…
- **COWS** Score in chart: mild/moderate withdrawal, if not in withdrawal, consider home induction
- Labs: Urine Pregnancy, LFTs, Hepatitis B/C – all ideal but not essential
- Peer Counselor consult
- Social Work/Case Management: Rx, follow up

More on what to do…

- Peer Counselor “Bridge”
- Diagnosis/Impression: Opioid Use Disorder (OUD)
- Checking the PMP
- Prescribing Narcan
- Discharge Handout

MAT in the ED: why or why not?



"Open the flood gates"

EDs are busy, no financial gain, dependent pts/freq flyers, not fun

- One year prior to ED MAT compared to One year After MAT: ***40% reduction in utilization***
- Reputation of program has grown
- 2-3 pts per shift
- Pts are grateful, simple, easy and quick (usually): Reduce mental health "pivots" to SI
- We've not seen frequent flyers

Carilion's ED Bridge Program Results

- 82% of pts seen in ED "crossed the bridge" to be seen within a week at OBOT (office-based opioid treatment) in Year 1;
- 78% of pts seen in ED "crossed the bridge" seen within 8 days on average in Year 2; average length of script in Year 2 = 8 days;
- 90% of those who crossed the bridge were still in treatment at 30-days in Year 1; 82% still in treatment at 30 days in Year 2.
- Factors associated with OBOT appearance:

  - Suboxone treatment in ED

  - ED COWS > 11

  - Peer Counselor involvement/direct linkage from the ED doubled the chances of successful transition from ED into ambulatory care in the OBOT.

Training Guide with Portable Tools

- Thanks to a contract with VA's DMAS and quality improvement study support from the VA Dept of Health, a training guide is being developed by the Carilion ED Bridge Team led by Dr. Cheri Hartman for use by interested health care systems throughout Virginia.
- Modules with online training tools will be included (some already created, others newly developed) on:

  (1) embedding peer recovery specialists in the ED,

  (2) protocols for initiating buprenorphine in the ED to treat withdrawal,

  (3) protocol for post-overdose interventions in the ED,

  (4) workflow recommendations for achieving the warm handoff supported by a medical bridge (a prescription),

  (5) tips for creating rapid access to treatment supported by triage expertise using the ASAM six dimensions to identify best treatment level of services matching patients' individual needs and strengths,

  (6) overview of office-based opioid treatment preferred model for enhancing retention in treatment and patient outcomes.

Thank you!

Revolutionizing the System of Addiction Care

- How might we ensure that every Virginian presenting to the ED in crisis is **able to be connected to evidence-based and life-saving care**?
- How to leverage the **new Health and Human Services flexibilities** for obtaining the DEA-X without the training requirements to treat up to **30 patients**? Opportunities for recommendations to the General Assembly to consider?

Thank you for your partnership, support and participation.

Additional Questions?

Please contact
EnhancedBH@dmas.virginia.gov
SUD@dmas.virginia.gov
SUPPORTGrant@dmas.virginia.gov

Additional Discussion of EDCC Optimization (Cont'd)

Policy Option 2c—Align Definitions

The group provided verbal and written feedback on policy options; the most common comment for this option was support for how the Collective Medical/ EDCC platform categorizes utilization.

Policy Option Discussed in Meeting 4	High Level Feedback from the Group
Align Measurement Efforts: DMAS could work with VHI and VHHA to craft a uniform definition of ED "super-utilizer" to align performance measurement efforts for Medicaid members across the state.	• Group sentiment was to align with Collective Medical/ EDCC platform. • Some referenced the alert for a person who has 5+ ED visits in 12 months (which is not the Collective Medical/ EDCC definition)

Review of Definitions from Collective Medical/ EDCC

- ✓ The EDCC platform does “flag” patients with 5+ visits to the ED within in 12 months.
- ✓ The EDCC platform defines “Super-Utilization” as 50-99 ED visits in 12 months.

Collective Utilization Category	Visit Count in 12 Months
Rising Risk	10 - 14
	15 - 19
High Utilization	20 - 29
	30 - 49
Super Utilization	50 - 74
	75 - 99
Extreme Utilization	100 +

Workgroup Discussion of Aligning Definitions

- ✓ Should the workgroup adopt the Collective Medical / EDCC definitions for the utilization categories for the report and policy options?
  - **Rising Risk**: 10-19
  - **High Utilization**: 20-49
  - **Super Utilization**: 50-99
  - **Extreme Utilization**: 100+

Policy Option 2a—Increase Downstream Provider Use of EDCC

The group provided verbal and written feedback on policy options; the feedback on this option was mixed on whether or not action is needed.

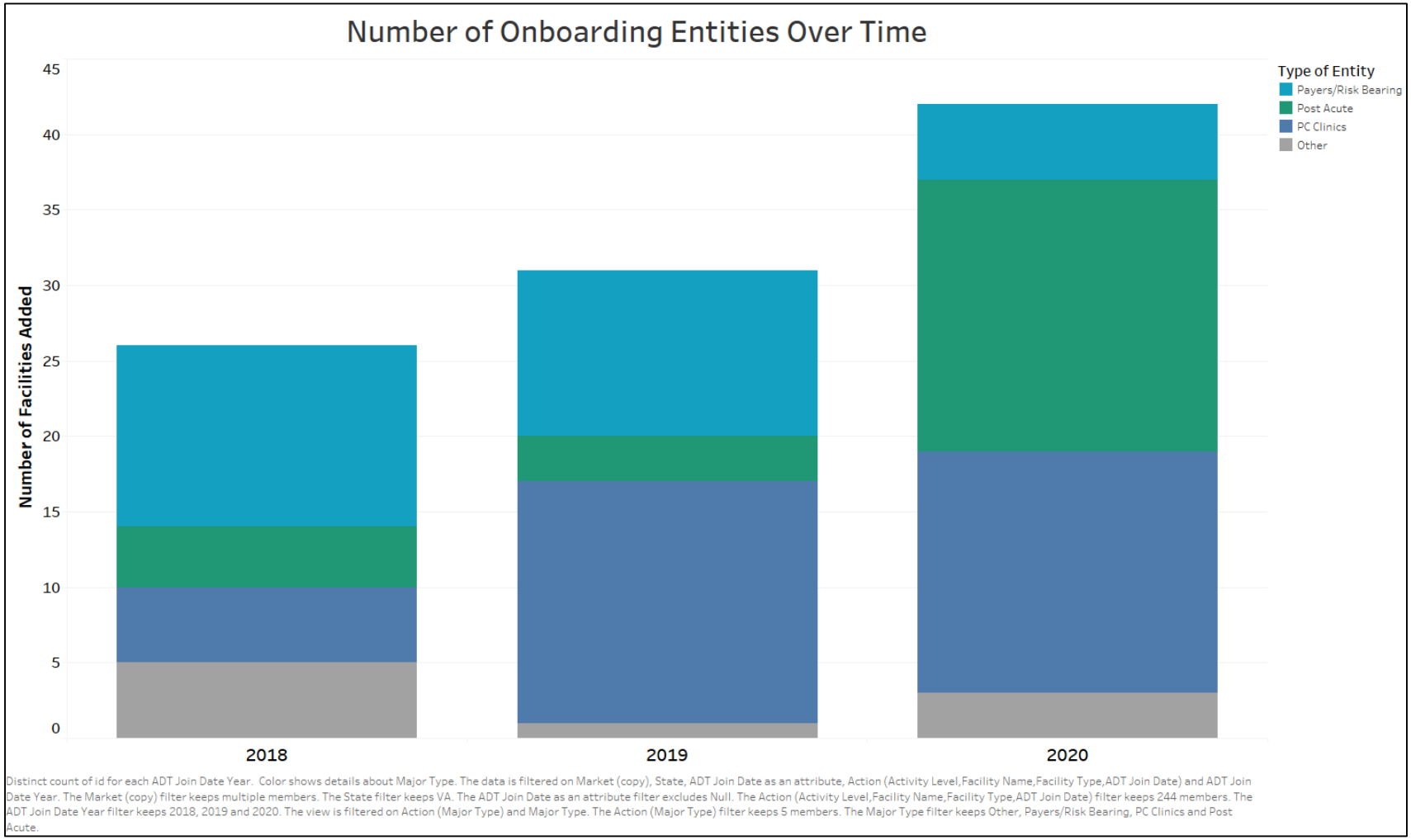
Policy Option Discussed in Meeting 4

Increase Downstream Provider Use of EDCC: The General Assembly could provide VHI with direction and funding to address barriers to on-boarding downstream, non-acute providers to the EDCC. This charge should also support creating a functionality that notifies downstream providers when their patients had an ED visit and relevant information from the visit. Such efforts could include, but are not limited to, allowing additional customization of the amount and type of data a provider is able to receive, streamlining legal and administrative requirements to accessing such data, and the flexibility necessary to undertake additional efforts to appropriately expand EDCC access to providers with a member care business case for such access.

High Level Feedback from the Group

- General support, consensus that it would be a positive outcome to have more downstream providers engaged with EDCC.
- Differing views on whether adoption/expansion would occur with time or there needs to be policy to spur and/or expedite.

EDCC Onboarding Update (VHI)



Distinct count of id for each ADT Join Date Year. Color shows details about Major Type. The data is filtered on Market (copy), State, ADT Join Date as an attribute, Action (Activity Level,Facility Name,Facility Type,ADT Join Date) and ADT Join Date Year. The Market (copy) filter keeps multiple members. The State filter keeps VA. The ADT Join Date as an attribute filter excludes Null. The Action (Activity Level,Facility Name,Facility Type,ADT Join Date) filter keeps 244 members. The ADT Join Date Year filter keeps 2018, 2019 and 2020. The view is filtered on Action (Major Type) and Major Type. The Action (Major Type) filter keeps 5 members. The Major Type filter keeps Other, Payers/Risk Bearing, PC Clinics and Post Acute.

Growth of Downstream Network: Currently in IT Implementation (VHI)

Workgroup Discussion of Increasing Downstream Provider Use of EDCC

- ✓ Should the workgroup continue to consider this policy option to increase use of the EDCC among downstream providers?
- ✓ If yes, how might the workgroup make the policy option more specific? For example,
  - Prioritize certain downstream providers with most ability to impact future ED utilization,
  - Define an improvement target and reasonable timeframe,
  - Identify how to support this policy, like funding for VHI, provider contracts, etc.

Next Meeting and Timelines

- ✓ **Meeting 7: July 9, 2021,** 3:00 – 5:00 p.m.
  - Final discussion on policy options by workgroup members
  - Updated report will be provided in advance of this meeting
- ✓ **August:** Incorporate final input & complete drafting
- ✓ **September & October:** Department & Administration Review
- ✓ **November 1, 2021:** Report Due to the General Assembly