CT 1115 SUD Demonstration Discussion

BHPOC Adult Quality, Access, and Policy Subcommittee Presentation

July 9, 2024

Discussion Questions

1) **Pre-demonstration Substance Use Disorder Residential Patients Served vs. Post-demonstration of the 1115 Waiver Patients Served (3.7/3.7E, 3.5, 3.5 PPW, 3.1)**

2) **Impact of SUD Residential Bed Reduction of 100 Beds**

   A. **Is there an industry standard on # of SUD residential beds needed to meet Connecticut's needs?**

   B. **Are we tracking how many patients seeking SUD residential are not able to access care?**

   C. **How is the reduction of 100 beds impacting geographic availability of SUD residential services? Are there regions where access to SUD residential beds is of concern?**

   D. **Are we seeing an increase of patients accessing lower levels of care due to access issues with SUD residential services?**

Background and Purpose of Waiver

- As part of the U.S. Department of Health and Human Services' effort to combat the ongoing opioid crisis, the Centers for Medicare & Medicaid Services (CMS) created an opportunity under the authority of section 1115(a) of the Social Security Act for states to demonstrate and test flexibilities to improve the substance use disorder (SUD) service system for beneficiaries.
- The purpose of this waiver is to allow coverage of residential and inpatient SUD services under HUSKY Health that have previously been excluded due to longstanding federal policies.
- Connecticut received CMS approval of the waiver on April 14, 2022, with a Demonstration approval period through March 2027.

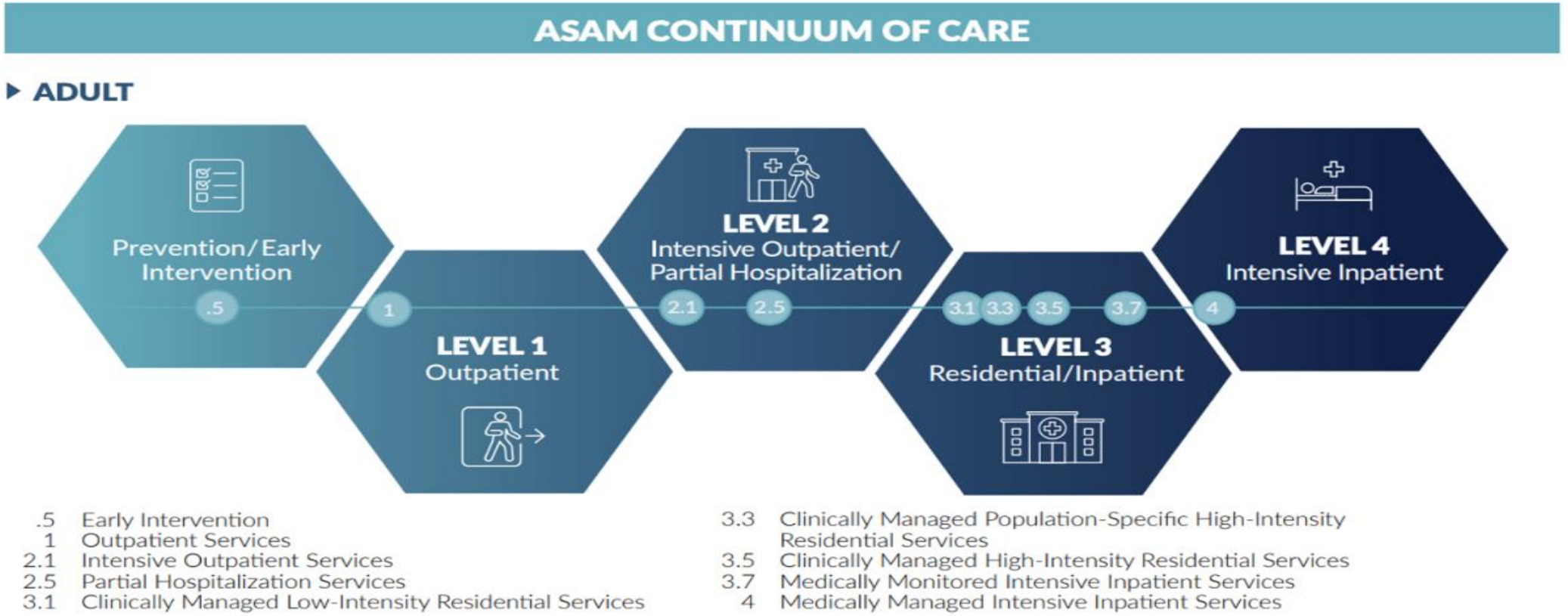
CT 1115 SUD Demonstration Goals

Increased rates of identification, initiation and engagement in treatment for OUD and other SUDs
Increased adherence to and retention in treatment for OUD and other SUDs;
Reductions in overdose deaths, particularly those due to opioids
Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;.
Fewer readmissions to the same or higher level of care where readmissions is preventable or medically inappropriate for OUD and other SUDs
Improved access to care for physical health conditions among beneficiaries with OUD or other SUDs

CT 1115 SUD Demonstration Milestones

Access to critical levels of care for OUD and other SUDs
Widespread use of evidence-based, SUD-specific patient placement criteria
Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications
Sufficient provider capacity at each level of care, including medication assisted treatment (MAT);
Implementation of comprehensive treatment and prevention strategies to address opioid misuse and OUD
Improved care coordination and transitions between levels of care.

ASAM Levels of Care



Mee-Lee, D, Shulman, GD, Fishman, MJ, Gastfriend DR, Miller MM, eds. The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, 3rd ed. Carson City, NV: The Change Companies; 2013

Connecticut SUD Residential Bed Distribution
May 1, 2022

ASAM Level of Care	Number of Beds	Percentage of Overall Beds
3.1	76	6.51%
3.3	50	4.28%
3.5	495	42.42%
3.5 PPW	54	4.63%
3.7	218	18.68%
3.7 Withdrawal Management	172	14.74%
Connecticut Valley Hospital	102	8.74%
Totals	1167	100%

Connecticut SUD Residential Bed Distribution
July 1, 2024

ASAM Level of Care	Number of Beds	Percentage of Overall Beds
3.1	73	6.84%
3.3	24	2.25%
3.5	433	40.58%
3.5 PPW	48	4.50%
3.7	212	19.87%
3.7 Withdrawal Management	155	14.53%
Connecticut Valley Hospital	122	11.43%
Totals	1067	100%

Question: Pre-demonstration Substance Use Disorder Residential Patients Served vs. Post-demonstration of the 1115 Waiver Patients Served (3.7/3.7E, 3.5, 3.5 PPW, 3.1)

- The 1115 SUD Demonstration Waiver expands Medicaid reimbursement to residential SUD treatment providers by waiving the IMD Exclusion.

- Mercer is calculating the number of Medicaid recipients served pre/post implementation. We do not have that data yet.

- The following data is the total number of individuals served at DMHAS contracted programs based on DMHAS provided data. Please note:

    - DMHAS does not contract with all the residential programs participating in the 1115 SUD Demonstration.

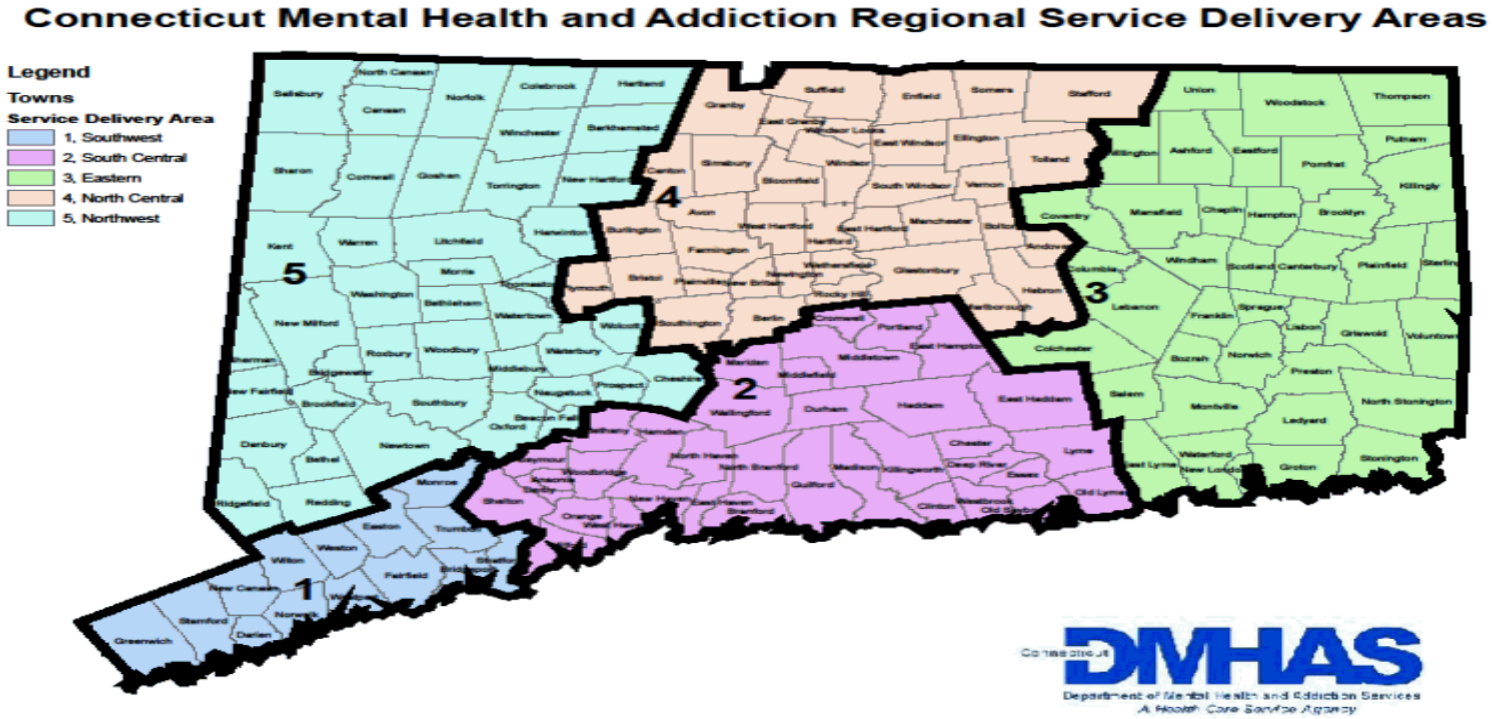
    - In some instances, the number of individuals served in the years prior to the Demo launch only reflects the number of DMHAS funded beds vs. DPH licensed or those beds funded by other state agencies.

Unduplicated Client Counts for SUD Residential Rehabilitation (State-Operated and State-Funded)	
FY2019	9927
FY2020	9192
FY2021	7835
FY2022	8066
FY2023	8807

Points of Consideration:

- Overall numbers were impacted by the COVID-19 Pandemic and resulting Public Health Emergency from FY2020-FY2023
- The 1115 SUD Demonstration was launched in April 2022.
- While bed capacity at Non-DMHAS contracted facilities is not included in this data, it provides a general overview of the residential SUD system. Inclusion of those sites would increase these numbers.
- FY2024 and FY 2025 will provide more clarity based on claims data at all participating sites.

Question: How is the reduction of 100 beds impacting geographic availability of SUD residential services? Are there regions where access to SUD residential beds is of concern?



Connecticut SUD Residential Bed Distribution
Regional Variations by Level of Care
ASAM Level 3.1 Clinically Managed Low-Intensity Residential Services

Region	Bed Capacity May 1, 2022	% of Statewide Bed Capacity May 1,2022	Bed Capacity July 1, 2024	% of Statewide Bed Capacity July 1, 2024
1 Southwest	6	7.89%	6	8.22%
2 South Central	0	0%	0	0%
3 Eastern	34	44.74%	34	46.58%
4 North Central	22	28.95%	20	27.40%
5 Northwest	14	18.42%	13	17.81%

Connecticut SUD Residential Bed Distribution
Regional Variations by Level of Care
ASAM Level 3.5- Clinically Managed High-Intensity Residential

Region	Bed Capacity May 1, 2022	% of Statewide Bed Capacity May 1,2022	Bed Capacity July 1, 2024	% of Statewide Bed Capacity July 1, 2024
1 Southwest	67	13.54%	64	14.78%
2 South Central	178	35.96%	144	33.26%
3 Eastern	134	27.07%	111	25.64%
4 North Central	25	5.05%	25	5.77%
5 Northwest	91	18.38%	89	20.55%

Connecticut SUD Residential Bed Distribution
Regional Variations by Level of Care
ASAM Level 3.7- Medically-Monitored Intensive Inpatient

Region	Bed Capacity May 1, 2022	% of Statewide Bed Capacity May 1,2022	Bed Capacity July 1, 2024	% of Statewide Bed Capacity July 1, 2024
1 Southwest	48	17.20%	46	15.70%
2 South Central	82	29.39%	102	34.81%
3 Eastern	16	5.73%	16	5.46%
4 North Central	73	26.16%	69	23.55%
5 Northwest	60	21.51%	60	20.48%

Connecticut SUD Residential Bed Distribution
Regional Variations by Level of Care
ASAM Level 3.7 WM- Medically Monitored Inpatient Withdrawal Management

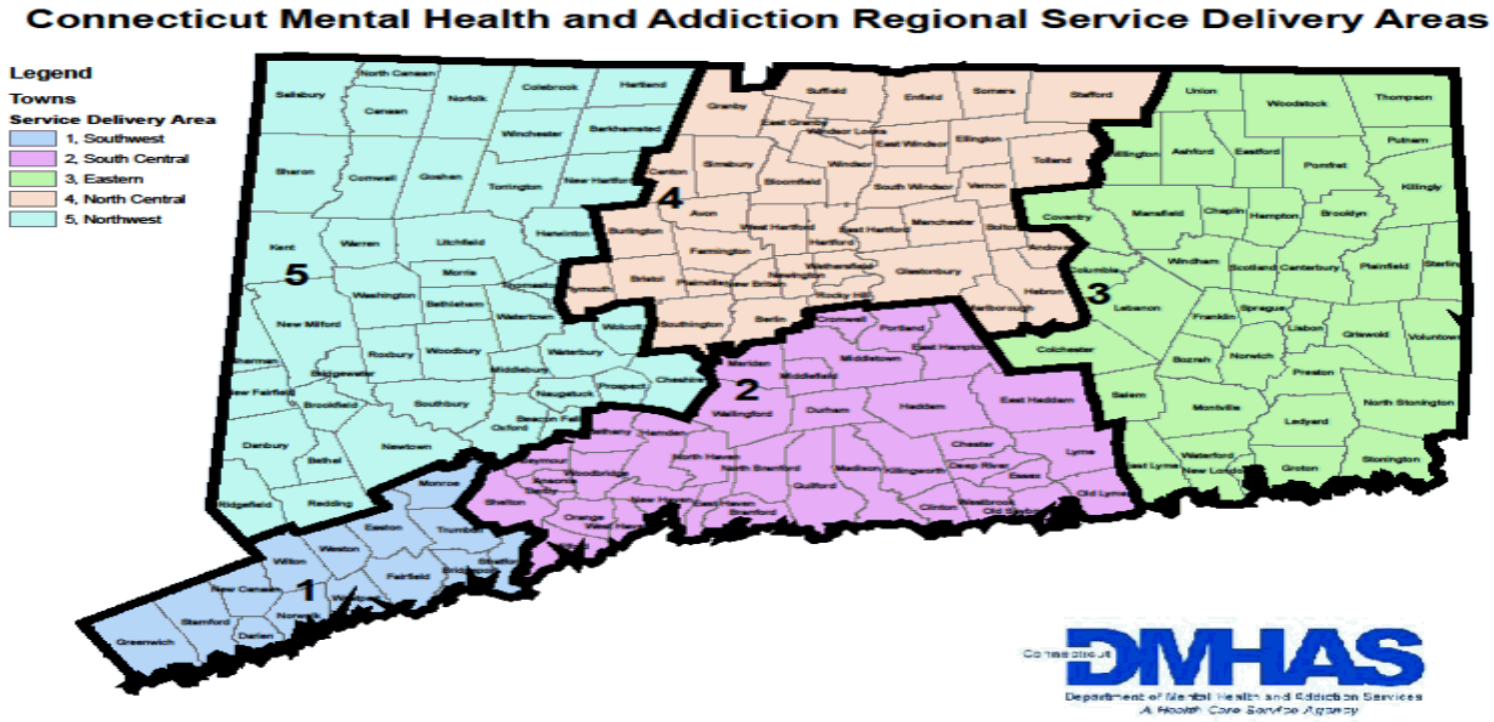
Region	Bed Capacity May 1, 2022	% of Statewide Bed Capacity May 1,2022	Bed Capacity July 1, 2024	% of Statewide Bed Capacity July 1, 2024
1 Southwest	27	12.68%	24	12.24%
2 South Central	66	30.99%	63	32.14%
3 Eastern	50	23.47%	50	25.51%
4 North Central	56	26.29%	45	22.96%
5 Northwest	14	6.57%	14	7.14%

Points for Consideration

- **3.1 Programs**- These programs have the lowest bed capacity particularly in Regions 1 and 2. This level of care is focused on community reengagement and developing recovery support systems.
- **3.5 Programs**- Regions 1 and 4 have much lower bed capacities compared to other areas of the state (14.78% and 5.77%)
- **3.7R Programs**- Relatively equally distributed statewide except for Region 3 (Eastern Connecticut).
- **3.7 WM Programs**- Western Connecticut accounts for 7.14% of withdrawal management beds.
- While there is co-ed programming throughout the state, gender specific female beds are limited

Gender Specific Female Beds	
3.1	15.06% Beds (n=11)
3.5	1.6% (n=7)
3.7R	5.46% (n=16)

Question: Is there an industry standard on the number of SUD residential beds needed to meet Connecticut's needs?

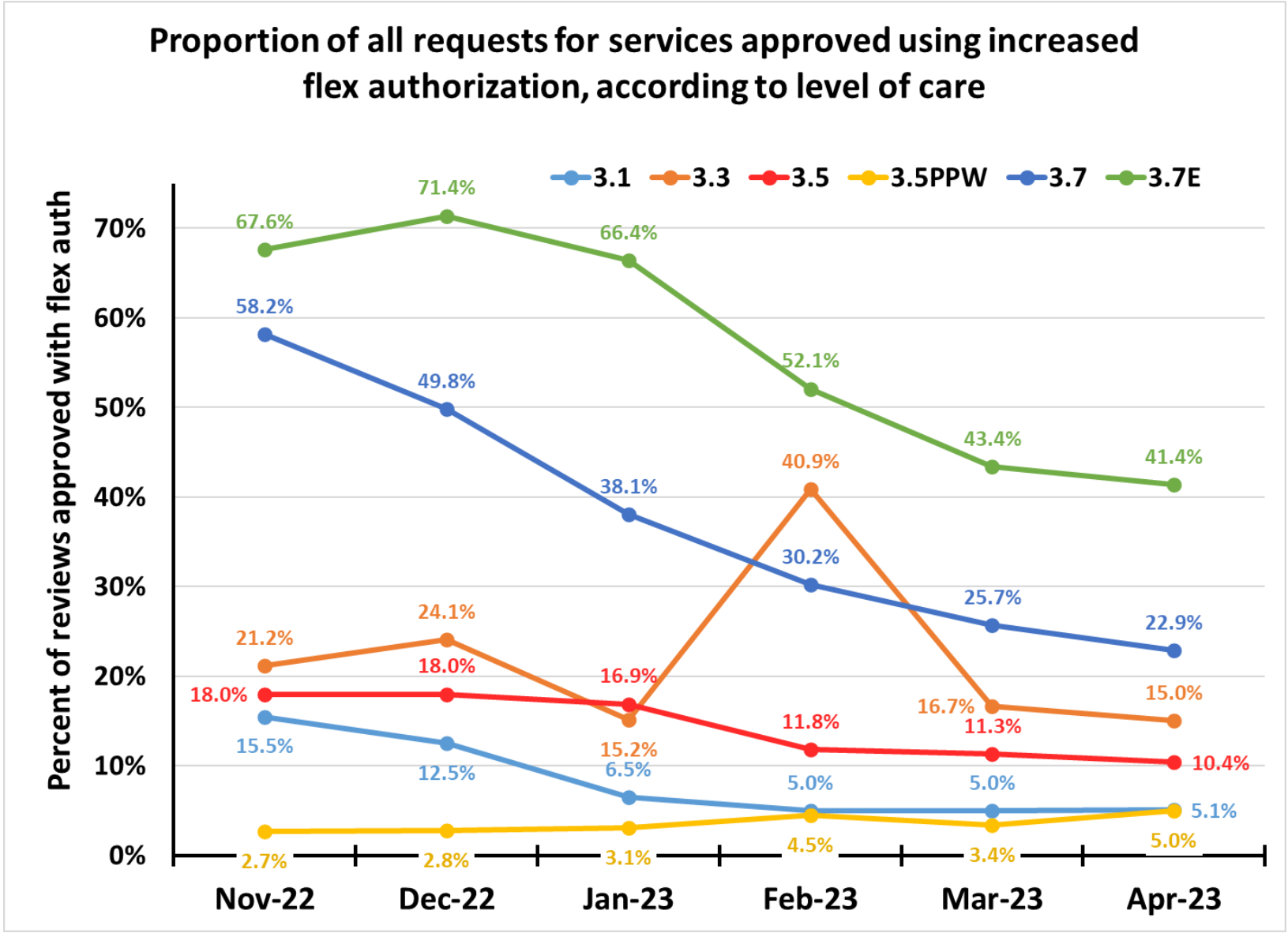


Defining Network Adequacy

- Network adequacy is often defined as having enough providers within a health plan network to ensure reasonable and timely access to care. At a minimum, health plans must include a sufficient number of providers who deliver mental health and SUD services (collectively referred to in this report as behavioral health services) to support access to those services. Beyond a minimum number of providers, adequate networks must have an appropriate geographic distribution of providers who have the capacity to deliver a wide range of services that align with enrollees' needs[1]
- Determining the number of beds needed by level of care is an ongoing process for the Demonstration.
  - This process is aided by an increased understanding of the ASAM Criteria and implementation across the SUD continuum (next slide)
  - Geoanalysis has been utilized for the state's outpatient system

[1]Bradley, K., Wishon, A., Donnelly, A., & Lechner, A. (2021). NETWORK ADEQUACY FOR BEHAVIORAL HEALTH: Existing Standards and Considerations for Designing Standards: Prepared for Office of Behavioral Health, Disability, and Aging Policy Office of the Assistant Secretary for Planning and Evaluation U.S. Department of Health and Human Services, Mathematica

Increased appropriate ASAM level of care (LOC) utilization, reflected by decreased need for flex authorizations during earlier implementation of the 1115 Waiver.



Connecticut BHP Supporting Health and Recovery

Administered by carelon Behavioral Health

Points for Consideration

- Ongoing ASAM training and support within the utilization review process resulted in appropriate placements by level of care occurring.
- This allows us to see issues of access more clearly. We will continue to utilize this information to establish appropriate time and distance (geographic access) standards and Provider-to-enrollee ratios (by level of care and region)[1].
- We will need to continue to customize our geoaccess standards to account for Connecticut's geographic size and our goals for equitable access to these services.

[1] Concepts drawn from-Bradley, K., Wishon, A., Donnelly, A., & Lechner, A. (2021). NETWORK ADEQUACY FOR BEHAVIORAL HEALTH: Existing Standards and Considerations for Designing Standards: Prepared for Office of Behavioral Health, Disability, and Aging Policy Office of the Assistant Secretary for Planning and Evaluation U.S. Department of Health and Human Services, Mathematica

Question: Are we tracking how many patients seeking SUD residential are unable to access care?

Access to Care from Inpatient Psychiatric

Currently, Carelon BH CT tracks the volume of discharges from an IPF of members awaiting SUD residential services. For these members, Carelon BH CT documents overall wait time and the percent of their inpatient stay waiting for SUD residential treatment. Operationalization of designating awaiting ASAM SUD residential services began in Q2 2023.

	Discharges	ALOS	Avg. Wait LOS	% Days Waiting
Resi Rehab 3.5	27	20.6	7.3	35.5%
Resi Rehab 3.1	20	20.6	9.9	48.2%
Resi Rehab 3.3	12	18.3	7.0	38.2%

Connecticut BHP Supporting Health and Recovery

Administered by carelon Behavioral Health

Discharges from Providers between 7/1/2023 and 12/31/2023
Tables are not inclusive of all awaiting placement reasons and highlight specific LOC the purpose of the presentation

Access to Care from 3.7 Withdrawal Management

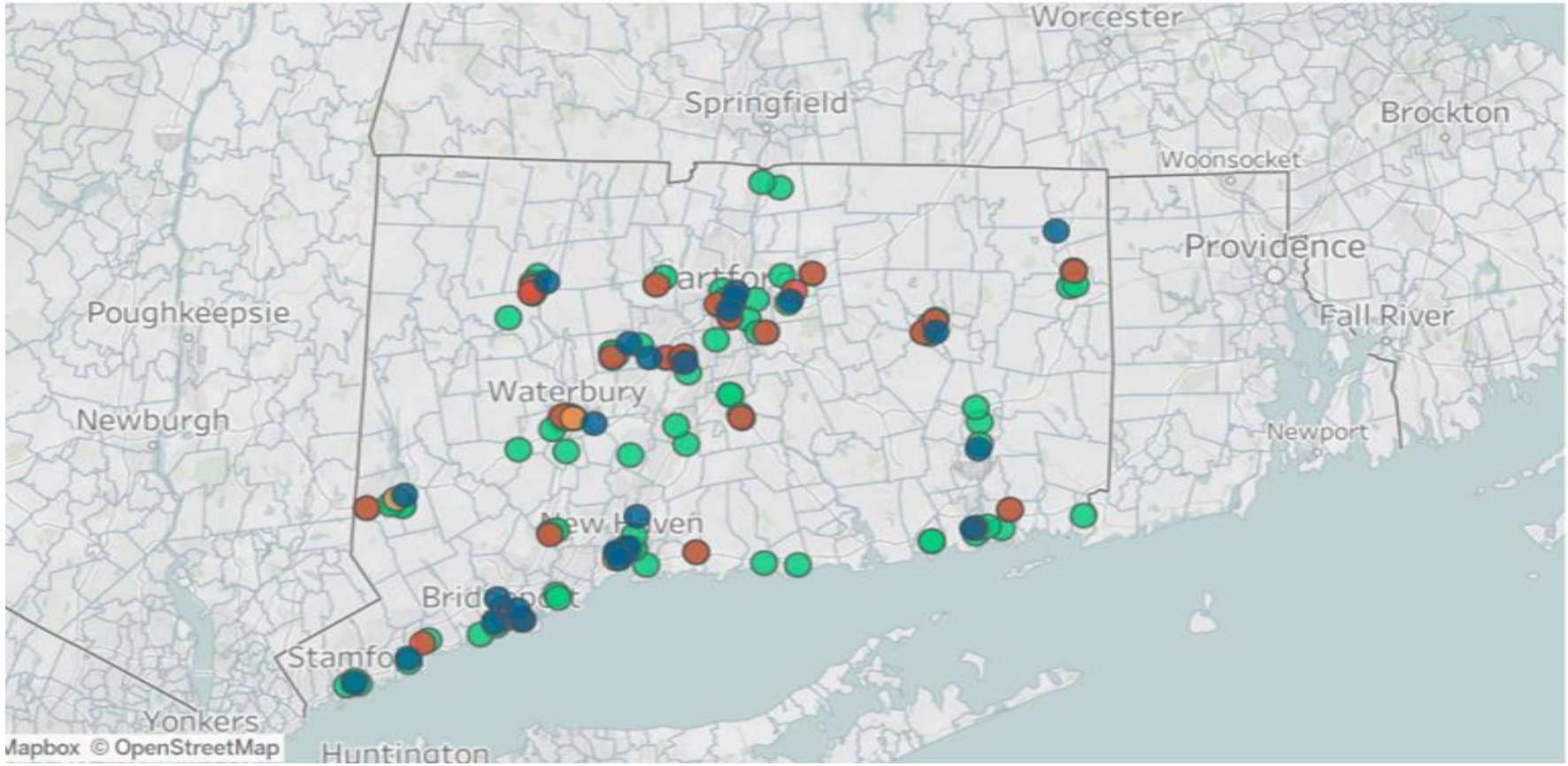
	Discharges	ALOS	Avg. Wait LOS	% Days Waiting
Resi Rehab 3.7	44	7.1	2.1	29.1%
Resi Rehab 3.5	27	7.4	1.9	25.4%
3.7 E	2	9.0	2.5	27.8%
Resi Rehab 3.3	1	10.0	5.0	50.0%
Resi Rehab 3.1	1	11.0	6.0	54.5%

Discharges from Providers between 7/1/2023 and 12/31/2023
Tables are not inclusive of all awaiting placement reasons and highlight specific LOC the purpose of the presentation

Points for Consideration

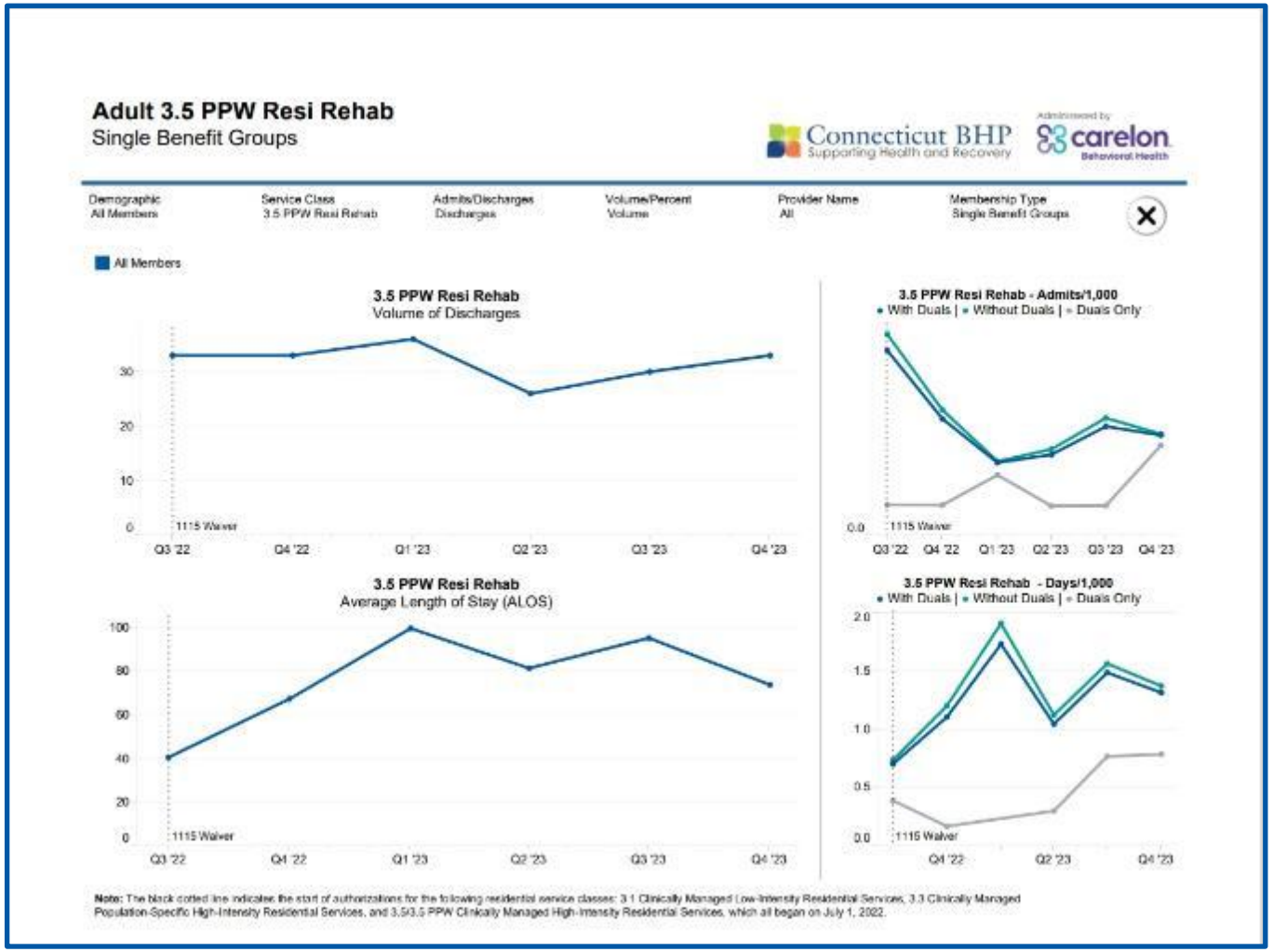
- People access residential substance use treatment through a variety of pathways e.g. hospitals, lower levels of SUD treatment, withdrawal management programs, criminal justice system etc. The previous slides outline inpatient hospitals and withdrawal management programs. We'd like to focus on improving those transitions and developing systems to better track the outcomes of community-based referrals.
- Part of what we would like the accomplish is to create (where needed) and streamline reporting on wait times, referral denials and referral pathways by level of care and region. Adoption of the ASAM Criteria and accurate assessment/placements within all levels of care were the first steps in the process.
- Connecticut Addiction Services (ctaddictionservices.com)
- Access Line- For 24/7 access to substance use treatment, including withdrawal management and transportation, call the Access Line at 1-800-563-4086.

Question: Are we seeing an increase of patients accessing lower levels of care due to access issues with SUD residential services?

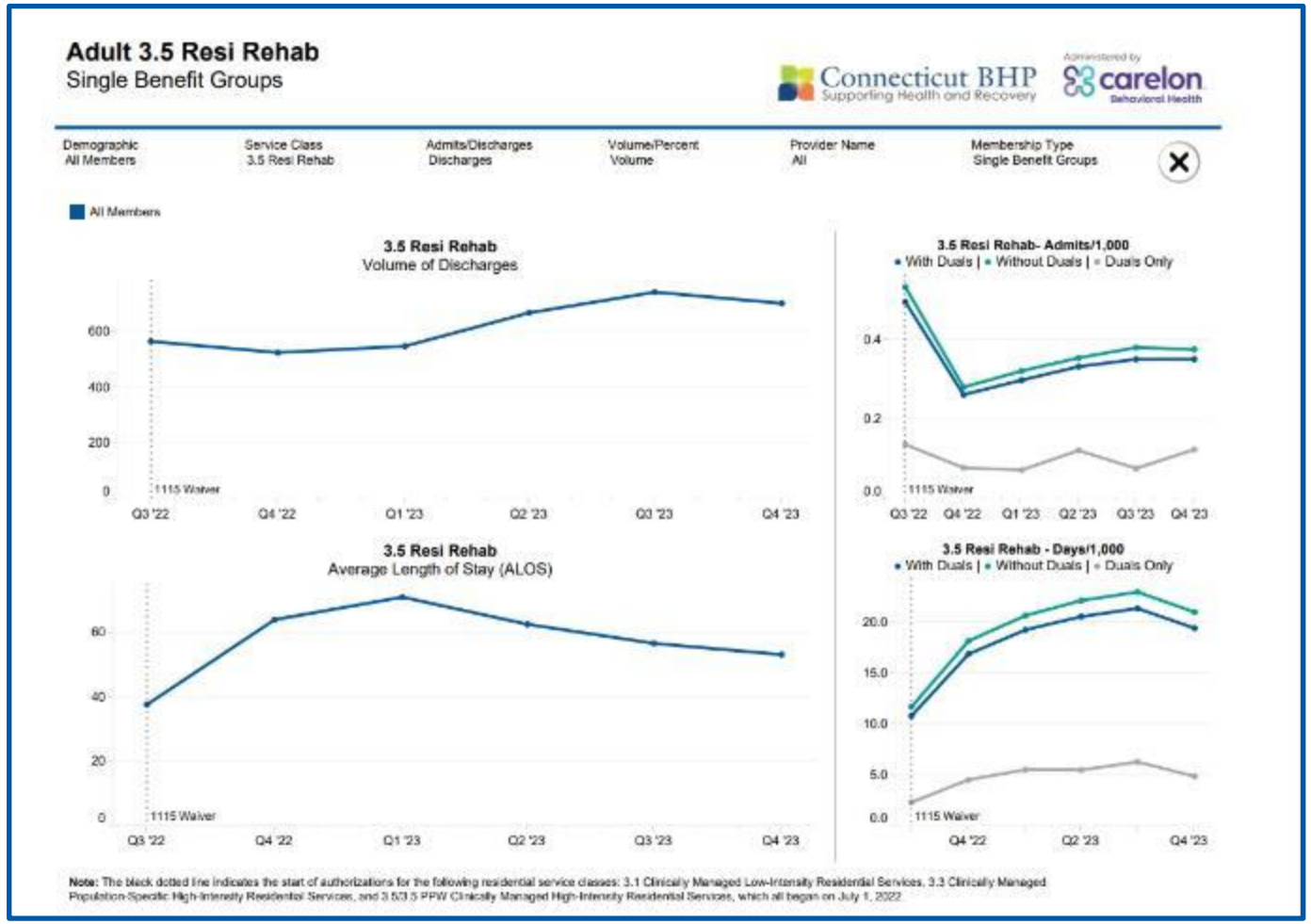


ASAM 3.5 PPW Residential Services (single benefit group)

The volume of discharges decreased in Q2 2023 and steadily increased thereafter



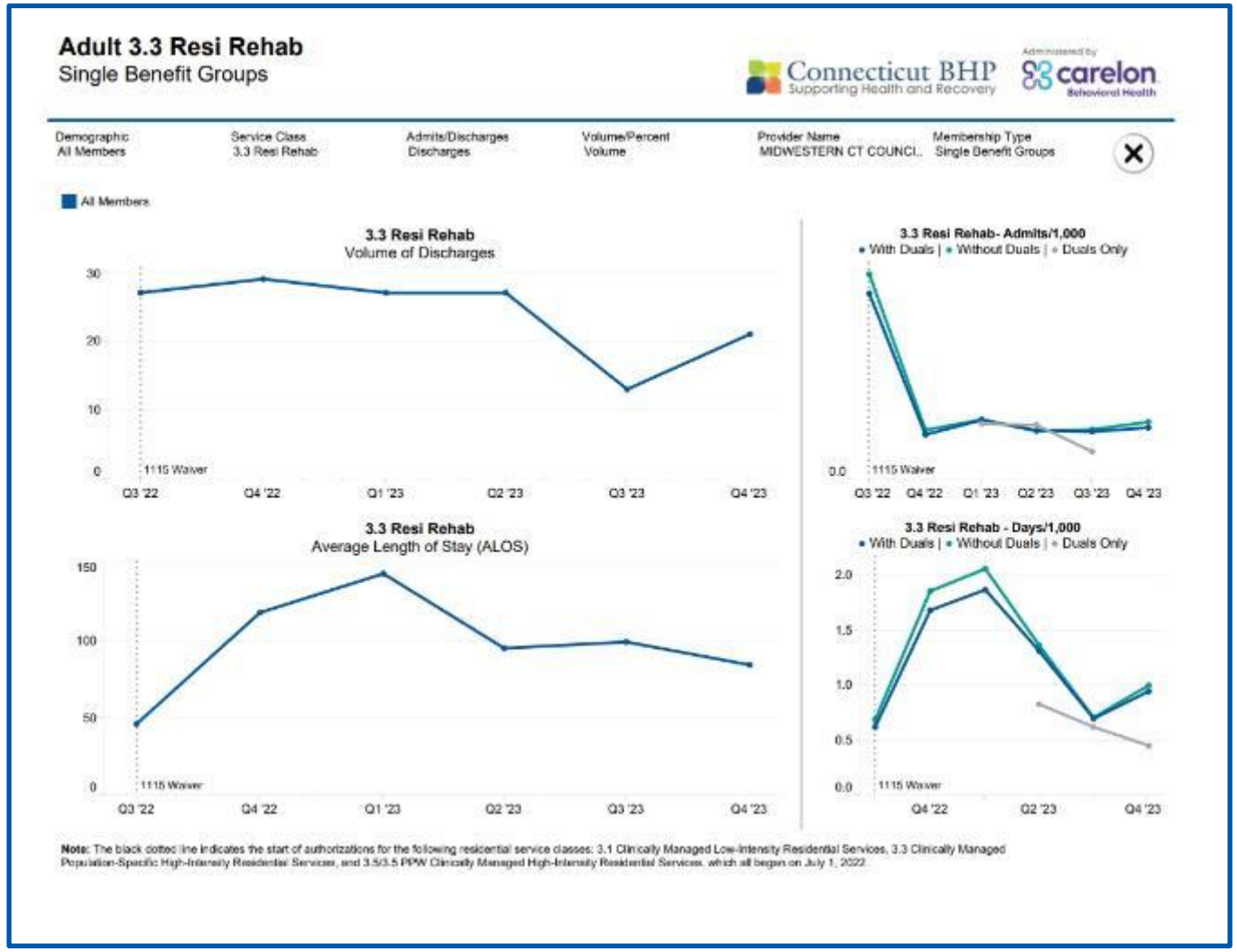
ASAM 3.5 Residential Services (single benefit group)



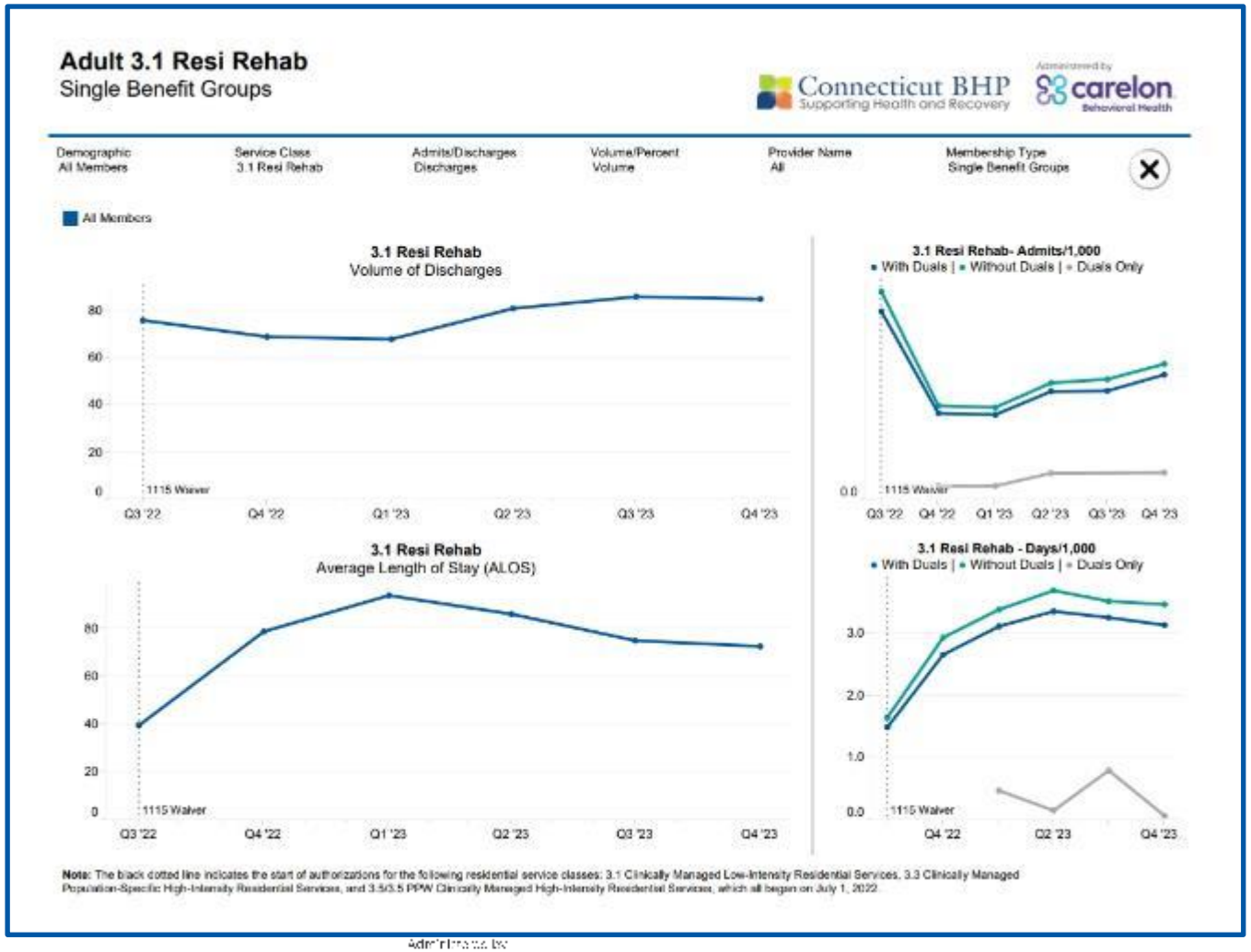
The volume of discharges steadily increased during Q1 and Q3 2023 before a slight decline in Q4 2023

ASAM 3.3 Residential Services (single benefit group)

The volume of discharges decreased in Q3 2023, with an increase in Q4 2023



ASAM 3.1 Residential Services (single benefit group)

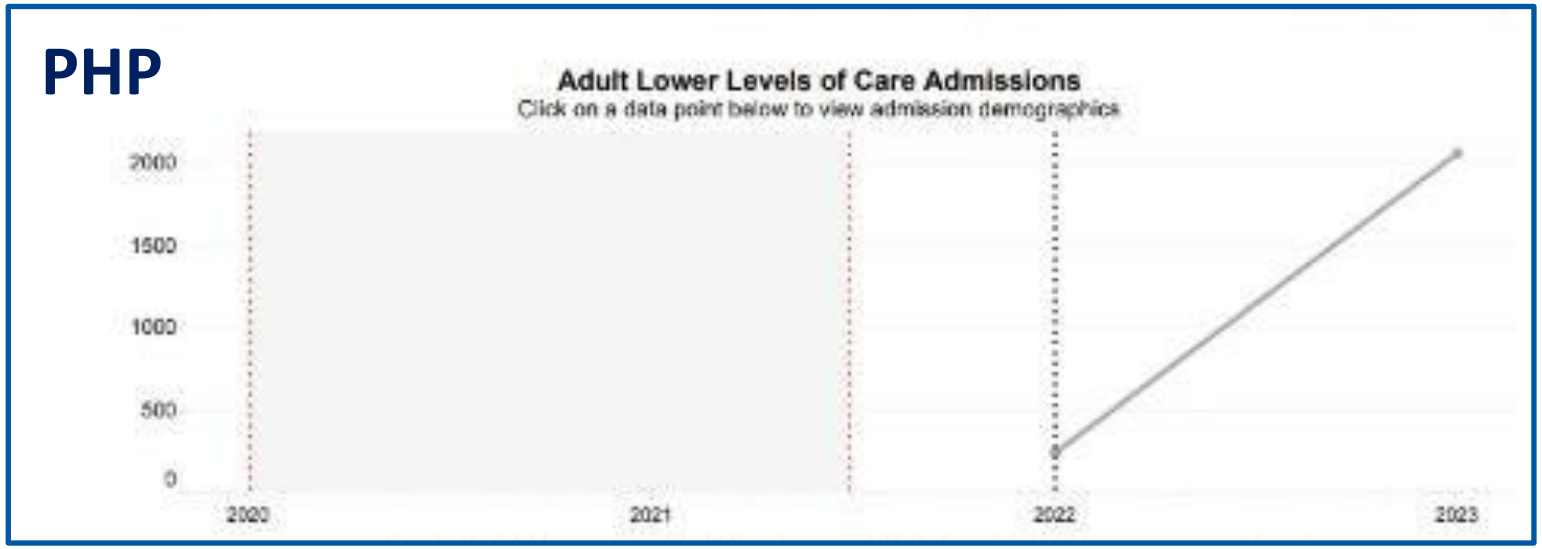


The volume of discharges increased in Q1 2023 and remained steady throughout 2023

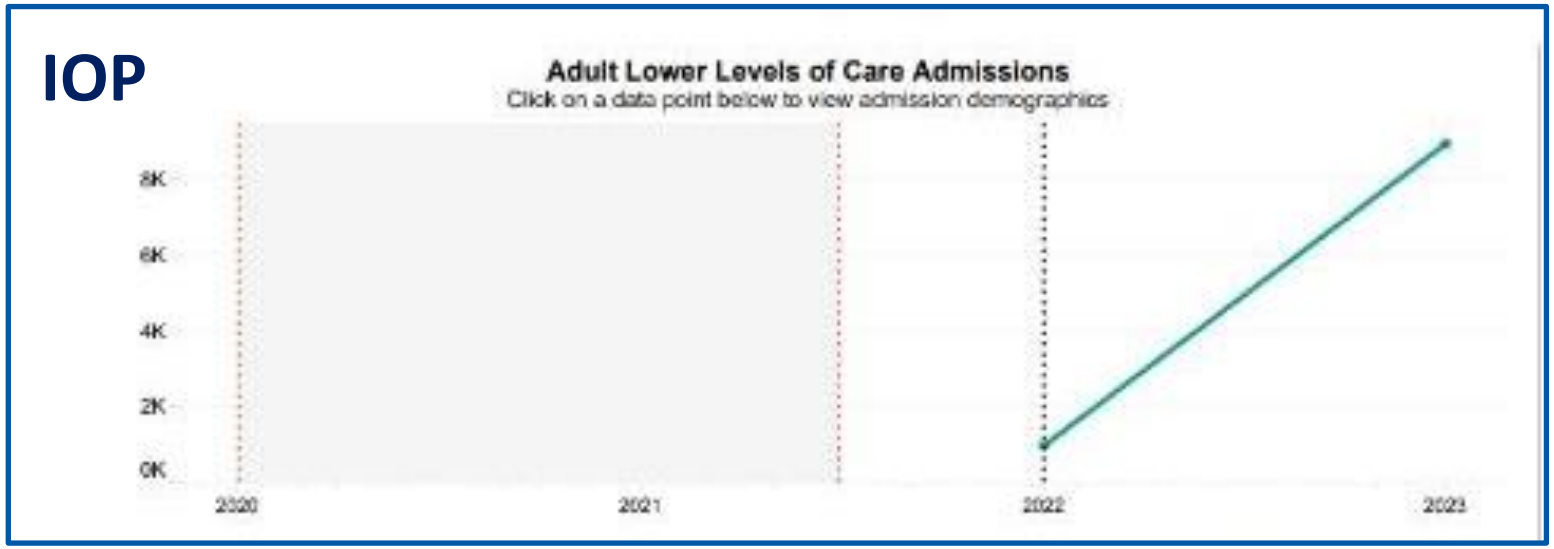
Adult Lower Levels of Care- Partial Hospitalization (PHP) and Intensive Outpatient (IOP) SUD

- **Authorizations for SUD LLOC did not begin until November 15, 2022**

PHP



IOP

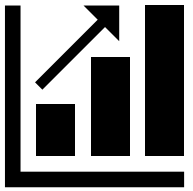


Connecticut BHP
Supporting Health and Recovery

Administered by
carelon
Behavioral Health

Preliminary Review of Trends for SUD Treatment Utilization

- There has been a reduction in Average Length of Stay (ALOS) for all residential rehab levels of care (LOC)
- For most residential LOC, the volume of discharges began to increase by Q4 ‘23
- Authorizations for SUD LLOC did not begin until November 15, 2022
- There was increase in appropriate ASAM level of care utilization, reflected by decreased use of flex auths



Questions?