

# 2019 Treatment Stakeholder Input

## Opioid & Other Substance Use Disorders Study Committee

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*Stakeholders from healthcare, local government, public health, criminal justice, professional associations, and private citizens had the opportunity to submit feedback via paper or electronic form. 232 individuals or agencies submitted 241 stakeholder input forms. In total, 374 policy recommendations were received as each submission could include more than one policy recommendation.*

*Results are compiled and summarized below related to Treatment. Please see the binder folder or electronic file of all submissions.*

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### Substance Use Disorder Payment & Coverage

- Develop and promote health plan network adequacy standards ensuring insured patients with substance use disorders have adequate access to a multi-modal approach to care and treatment on demand
- Enforce parity and equity within the behavioral health system. Mental health reimbursement rates are higher than substance use disorder (SUD) reimbursement rates. Allow facilities to charge for both mental health and substance use at the same rate in the same facility
- Require state agencies to develop an adequate rate setting methodology for substance use disorders. Require robust stakeholder engagement along with provider input to determine appropriate rates for billing Medicaid and Block Grant dollars for substance use disorders. Recent annual 1% aggregate adjustments have not been sufficient
- Require all insurance carriers to use the American Society of Addiction Medicine (ASAM) placement criteria
  - Three other states (Connecticut, Rhode Island and Illinois) require carriers to use ASAM standard and the Colorado Department of Health Care Policy and Financing (HCPF) will require Regional Accountable Entities (RAEs) to use the ASAM criteria when substance use disorder residential benefit begins)
- Require insurance companies to justify denial of substance use disorder treatment services
- Assign reviews of the appeal process for insurance denial to a state agency versus the insurance company
- Require private insurance to pay for psychiatry, inpatient, and residential SUD treatment for all substances
- Require residential substance use providers to treat mental health and substance use concurrently
- Increase reimbursement rates for providers who treat opioid use disorder in addition to continued training
- Reimburse providers for time with patients in listening, joint decision-making and patient empowerment
- Integrate mental health and substance use co-occurring services into the state incentive measures

### Medicaid

- Fold all healthcare treatment services into Regional Accountable Entity (RAE) system
  - Remove existing carve-outs for behavioral health and substance use
- Create financial incentives for providers to accept Medicaid and reduce bureaucratic barriers to billing
- Address access to treatment during lapses in Medicaid
- Increase outpatient reimbursement rates and stabilize that system prior to expanding SUD residential benefits
- Lift the Colorado Department of Healthcare Policy and Financing (HCPF) gag that prevents Medicaid beneficiaries from enrolling into Direct Primary Care
- Triple Medicaid reimbursements for the treatment of opioid use disorders

- Encourage HCPF to adjudicate physicians dispensing prescriptions
- Lift the 25 mile rule in place for "rural" exceptions to dispensing medications to address urban needs

## SB16-202

- Update the Community Needs Assessment requirement related to SB16-202 funding by requiring the needs assessment to be conducted bi-annually and involve community engagement in funding decisions
  - Through SB16-202, Managed Service Organizations (MSOs) were required to complete a community needs assessment before Feb. 2017 and *may* periodically update the plan; change 202 to require completing an assessment at least bi-annually by a third-party organization
    - Require meaningful input and engagement of local communities with increased transparency for funding decisions (e.g., county commissioners, mayors, law enforcement, public health)
- Restructure current Managed Service Organization (MSO) funding system
  - Allocate funding directly to the agencies that are providing services for treatment within communities
  - Change regional-based funding structure to eliminate inconsistencies across the state and reduce layers of bureaucracy
  - Restrict individuals who manage agencies receiving state or federal funding from serving on any board that is making funding decisions (i.e. broaden current Colorado Conflict of Interest Statute to board members of organizations soliciting state or federal funding)
  - Require rebidding on MSO contracts on regular basis to encourage competitive delivery of quality services to clients (similar to renewal of Regional Accountable Entity (RAE) contracts every 5 years)

## Substance Abuse Prevention and Treatment Block Grant (SABG)

- Reverse the State's decision to restrict Block Grant funds to indigent only
  - Review the decision to limit Federal Block Grant (SABG) funds to indigent only and align with Federal Block Grant's purpose via (42 U.S.C. 300e 21, et seq.) to "provide funds to states ... to supplement services covered by Medicaid, Medicare and private insurance." Expand the Colorado Block Grant to be more flexible to pay for substance use treatment and services for individuals that do not qualify as 'indigent' only
- Require transparent reports of established measures to indicate the proper use of resources provided to agencies who are funded to provide services through therapy, medication, education, etc.

## Continuum of Care

- Combine and align statutory language in state statutes 27-81 and 27-82 to eliminate the separation of alcohol and other substances. Remove or modernize stigmatizing language, align civil commitment processes, end jail as a placement option for emergency civil commitment, expand secure transport options to divert from criminal justice involvement or transfer to withdrawal management or treatment settings
  - Ensure statutes 27-81 and 27-82 are connected with the M-1 process
- Establish a coordinated network of community-based services and supports that is person-centered (i.e. Recovery-Oriented Systems of Care):
  - Ensure treatment system is available 24/7 and designed to address multiple treatment episodes
    - Treatment services should be provided swiftly when people are at a decision making point
  - Create comprehensive continuum of care, including the following ancillary services:
    - Housing
      - Target individuals completing outpatient services
      - Expand residential treatment for people who are homeless and need treatment
      - Expand supportive housing in rural and frontier Colorado

- Partner with licensed behavioral health treatment agencies to add recovery beds to existing programs
- Childcare
  - Create a study of alternative payment structures for sustainably funding childcare or children's services alongside a parent or caregiver's treatment
- Employment
- Transportation for rural and frontier counties. Even though Medicaid covers transportation to medical appointments, there is sometimes only one provider to cover a large geographic area

## Access to Treatment

- Increase evidence-based withdrawal management, treatment, and recovery capacity
  - Encourage development of more medically monitored and managed withdrawal management, inpatient, residential treatment, and long-term recovery residences
    - Increase knowledge of requirements and sustainability of funding for operating a new facility
  - Assure that a person with a substance use disorder has access to a psychiatric assessment
  - Increase funding for more withdrawal managements to be incorporated within crisis stabilization units and improve quality of integrated services
- Review policy recommendations focusing on methamphetamine, benzodiazepine, and alcohol use issues
  - Open up funding to treatment beyond opioids, and trust local communities and jurisdictions to address the primary substance problems in their own area
    - Counties that are affected more by methamphetamines need specific funding to tailor response
- Continue to fund expansion of treatment capacity in rural and frontier areas (building off HB1287 and SB202 funding streams)
  - Address disparities in access to care based on income and geographic location (particularly in eastern CO and western slope and for court-mandated treatment)
- Create intensive outpatient treatment programs that serve individuals for at least 3-4 months and are tailored to meet the specific brain chemistry needs of individuals with a methamphetamine use disorder
  - Tailor treatment programming (materials, handouts, program structure) to address significant cognitive impairment that long-term methamphetamine use can cause
- Review state-based options for funding treatment options (such as Temporary Assistance for Needy Families (TANF), Marijuana Tax, and Human Services funds)
- Expand eligibility criteria for admissions to treatment and services:
  - Allow individuals to access services regardless of intoxication level
  - Allow individuals with sexual offense charges to participate in treatment
- Enforce mental health and substance use parity in domestic violence organizations
- Expand opioid funding to include domestic violence/crisis and victim services agencies

## Improved Quality of Treatment

- Establish a report card system for substance use treatment services (similar to consumer-oriented systems like the Centers for Medicare & Medicaid Services (CMS) Hospital Compare program)
  - Ensure that all services follow state-of-the-art standards of care, as supported by Substance Abuse & Mental Health Services Administration (SAMHSA), American Society of Addiction Medicine (ASAM) etc.
  - Implement a comprehensive, standardized substance use disorder assessment, using ASAM Criteria to assist with proper treatment placement at all levels
    - Provide statewide training on this instrument to assure fidelity and inter-rater reliability
- Continue funding for education to prescribers and teams in primary care and other ambulatory care settings in the form of expert peer-to-peer consultants, learn and action networks, and practice team trainings

## Medication Assisted Treatment (MAT)

- Require withdrawal management services funded by the state to provide a stay of sufficient length to establish the required length of abstinence prior to Medication Assisted Treatment (MAT) induction
- Mandate Medicaid coverage of Sublocade, the injectable, monthly formulation of buprenorphine, as a carve-out in Federally Qualified Health Centers (FQHCs)
  - Fund a pilot project for Sublocade in a Federally Qualified Health Center
- Revisit arbitrary Opioid Medication Assisted Treatment (OMAT) rules regarding a 50:1 patient to therapist ratio
- Incentivize development of more opioid treatment providers (OTPs) with methadone in rural areas to decrease current day-long travel times
- Address Medicaid regulations to allow pharmacists to inject Vivitrol for Medicaid insurees who have a physician's order (address barriers to the payment mechanism)
- Encourage increase of number of emergency departments inducting patients on buprenorphine
- Require all state-funded substance use disorder treatment centers to offer MAT for all levels of treatment
- Prohibit blanket policies which forbid the utilization of MAT in any setting (treatment, correctional, withdrawal management, problem solving courts, etc.)
- Mandate availability of methadone, buprenorphine, and naltrexone in every county of the state based on the estimated number of individuals with an opioid use disorder residing there
- Prohibit physicians from prescribing a narcotic for patients in methadone treatment
- Require a psychotherapy counselling component for all clients receiving medication assisted treatment

## Treatment Options for Youth

- Increase the number of psychiatrists focused on youth and adolescent populations with substance use disorders
- Create financial incentives and reduce barriers for healthcare providers to treat substance use in youth
- Address shortages of providers accepting private insurance
- Mandate parental involvement and education in the judicial process of adolescent substance abuse offenders
- Require substance use assessment and referral to treatment specifically for youth
- Encourage hospitals to establish a protocol for referral to treatment for adolescent substance use
- Encourage collaboration between all hospital and acute care facilities to aid in placement and treatment

## Workforce Development

- Ensure staff salary increases for community substance use disorder providers in alignment with state staff agencies such as Department of Housing and staff providing direct care in state-operated facilities
- Expand recent increase in funding for behavioral health and mental health staff salaries in past legislative session to include increase in salary for substance use disorder providers
- Provide funding incentives for hospitals to offer addiction medicine consultation for hospitalized patients
- Create an incentive program specifically for eastern Colorado to recruit credentialed providers
- Change existing licensing and credentialing process:
  - Address Department of Regulatory Agency (DORA) delays in approval of licensure applications
  - Increase frequency of DORA subcommittee meeting to review applications to reduce delays
  - Amend the Office of Behavioral Health Rule 21.210.1.B., where substance use disorder providers must employ 50% or more of its staff registered as a Certified Addiction Counselor (CAC) II, III, or LAC
  - Enhance rigor of CAC credentialing to ensure evidence-based, medical model training
- Provide waivers of CAC III requirements for rural substance abuse and treatment providers
- Require substance use training for all crisis workers and case management providers
- Require mandatory training for clinicians in Trauma-Informed Therapy and Intergenerational Trauma

- Increase availability of Driving Under the Influence (DUI) facilitator trainings

## Federal

- Eliminate waiver requirement for prescribing buprenorphine
- Reduce federal regulations on opioid treatment providers (OTPs)
- Allow advance practice nurses to prescribe methadone and conduct physicals
- Require Medicare coverage for medication assisted treatments
- Examine federal versus state restrictions on prescribing and dispensing of MAT medications and Medicaid reimbursement (e.g., Medicaid should reimburse for pharmacist-administered Vivitrol)
- Allow treatment facilities with appropriate medical oversight to store and return Vivitrol free of charge if unused
- Ease regulations on CFR Part 2 to allow sharing of treatment-related information with other providers
- Improve coordination of funding at the federal level