Qualitative Needs Assessment of State Infrastructure and Provider Capacity to Deliver Substance Use Disorder Treatment and Recovery Support Services to Illinois Medicaid Members

AUTHORS AND AFFILIATION

Authors *(alpha order)*
Angie Bailey, MPH, M.S.Ed, CHES, *Southern Illinois Healthcare*
Danielle Begeske, BS, CHES, *Southern Illinois Healthcare*
Natasha Dolgin, MD, PhD, *Cook County Health*
Christie Edwards, MPH, *Cook County Health*
Juleigh Nowinski Konchak, MD, MPH, *Cook County Health*
Jacqueline Korpics, MD, MPH, *Cook County Health*
Fanta Saidou, MPH, CHES, *Southern Illinois Healthcare*

Affiliation
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Abbreviations and Acronyms

BH - Behavioral Health
CCH - Cook County Health
CMS - Centers for Medicare and Medicaid Services
COVID-19 - Coronavirus-19
DEA - Drug Enforcement Agency
DMH - Illinois Department of Human Services: Division of Mental Health
ED - Emergency Department
FQHC - Federally Qualified Health Centers
HFS - Illinois Department of Health and Family Services
IL - Illinois
MCO - Managed Care Organization
OUD - Opioid Use Disorder
PCP - Primary Care Provider
SAMHSA - Substance Abuse and Mental Health Services Administration
SIH - Southern Illinois Healthcare
SUD - Substance Use Disorder
SUPR - Illinois Department of Human Services: Division of Substance Use Prevention and Recovery
X-Waiver - DEA waiver for prescribing buprenorphine, also known as xDEA or XDEA

Glossary

Behavioral Health: Behavioral health is a general term used to refer to both mental health and substance use (Substance Abuse and Mental Health Services Administration (SAMHSA) 2016).

Care Coordination: Care coordination applies to activities that have the purpose of coordinating and managing the care and services furnished to each consumer as required by the Protecting Access to Medicare Act of 2014 (including both behavioral and physical health care), regardless of whether the care and services are provided directly, through referral, or other affiliation with care providers and facilities (Substance Abuse and Mental Health Services Administration (SAMHSA) 2016).

Case Management: A coordinated approach to the delivery of health and medical treatment, substance use disorder treatment, behavioral health treatment, and social services, linking patients with appropriate services to address specific needs and achieve stated goals. In general, case management assists patients with other disorders and conditions that require multiple services over extended periods of time and who face difficulty in gaining access to those services (Illinois General Assembly: Legislative Reference Bureau 2019).

Criminal Justice System: Consists of law enforcement agencies, courts and accompanying prosecution and defense lawyers, and agencies for detaining and supervising offenders. The total correctional population is the population of persons incarcerated, either in a prison or a jail, and persons supervised in the community, either through problem solving courts or on probation or parole (American Society of Addiction Medicine 2019).

Harm Reduction: A treatment and prevention approach that encompasses individual and public health needs, aiming to decrease the health and socioeconomic costs and consequences of substance use and addiction-related problems, especially medical complications and transmission of infectious diseases, without necessarily requiring abstinence. A range of treatment and recovery support activities may be included in a harm reduction strategy (American Society of Addiction Medicine 2019).

Initiation (Office and Home): The phase of opioid use disorder treatment during which medication dosage levels are commenced and adjusted until a patient attains stabilization. Buprenorphine initiation may take place in an office-based setting or home (or other community)- based setting. By regulation, methadone initiation must take place in an Opioid Treatment Program or acute care setting (under limited circumstances). Initiation is sometimes referred to as Induction. While the meaning is the same in this context, the American Society of Addiction Medicine notes this language does not align with the terminology used for other medical conditions and can make the process sound more difficult and complex than it is (American Society of Addiction Medicine 2019).

Limited English Proficiency: Includes individuals who do not speak English as their primary language or who have a limited ability to read, write, speak, or understand English and who may be eligible to receive language assistance with respect to the particular service, benefit, or encounter (Substance Abuse and Mental Health Services Administration (SAMHSA) 2016).

Maintenance Medications: Pharmacotherapy on a consistent schedule for persons with opioid or alcohol use disorder, consistent with a chronic condition model (American Society of Addiction Medicine 2019).

Managed Care Organization (MCO): A health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contractual arrangements between state Medicaid agencies and managed care organizations (Centers for Medicare and Medicaid Services 2017).

Medications for Opioid Use Disorder (MOUD); *Also known as Medications for Addiction Treatment or Medication-Assisted Treatment (MAT) and Medication-Assisted Recovery (MAR)*:
FDA-approved medications to treat substance use disorders, is inclusive of methadone,

buprenorphine, and naltrexone (Substance Abuse and Mental Health Services Administration (SAMHSA) 2020).

Opioid: A current term for any psychoactive chemical that resembles morphine in pharmacological effects, including opiates and synthetic/semisynthetic agents that exert their effects by binding to highly selective receptors in the brain where morphine and endogenous opioids affect their actions (American Society of Addiction Medicine 2019).

Patient: Within this document, the term “patient” refers to persons with substance use disorders for whom health care services, including behavioral health services, are provided; also known as clients and consumers (Substance Abuse and Mental Health Services Administration (SAMHSA) 2016).

Prevention: Interactive process of individuals, families, schools, religious organizations, communities and regional, state and national organizations whose goals are to reduce the prevalence of substance use disorders, prevent the use of illegal drugs and the misuse of legal drugs by persons of all ages, prevent the use of alcohol by minors, build the capacities of individuals and systems, and promote healthy environments, lifestyles, and behaviors (Illinois General Assembly: Legislative Reference Bureau 2019).

Psychosocial Interventions: Non-pharmacological interventions that may include structured, professionally administered interventions (e.g., cognitive behavior therapy or insight-oriented psychotherapy) or nonprofessional interventions (e.g., self-help groups and non-pharmacological interventions from traditional healers) (American Society of Addiction Medicine 2019).

Recovery: Recovery is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.This definition does not describe recovery as an end state, but rather as a process. Complete symptom remission is neither a prerequisite of recovery nor a necessary outcome of the process. Recovery can have many pathways that may include professional clinical treatment; use of medications; support from families and in schools; faith-based approaches; peer support; and other approaches. There are four major dimensions that support a life in recovery: **Health**: Learning to overcome, manage, or more successfully live with symptoms and making healthy choices that support one’s physical and emotional wellbeing; **Home**: A stable and safe place to live; **Purpose**: Meaningful daily activities, such as a job, school, volunteer work, or creative endeavors; increased ability to lead a self-directed life; and meaningful engagement in society; and **Community**: Relationships and social networks that provide support, friendship, love, and hope (Substance Abuse and Mental Health Services Administration (SAMHSA) 2016).

Recovery Support: Services designed to support individual recovery from a substance use disorder that may be delivered pre-treatment, during treatment, or post-treatment. These services may

be delivered in a wide variety of settings for the purpose of supporting the individual in meeting his or her recovery support goals (Illinois General Assembly: Legislative Reference Bureau 2019).

Substance Use Disorder: Substance use disorder is marked by a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues to use alcohol, nicotine, and/or other drugs despite significant related problems (DSM-5). Formerly referred to as substance dependence and substance abuse (DSM-4) (American Society of Addiction Medicine 2019).

SUPR Licensed Treatment Programs: Organizations with a contract to provide substance use disorder prevention, intervention, and treatment services as authorized by the Illinois Department of Human Services, Division of Substance Use Prevention and Recovery (SUPR). Full compliance with and a thorough understanding of Department rules and procedures are expected of all funded organizations (Illinois Department of Human Services, Division of Substance Use Prevention and Recovery 2020).

Stakeholder: Stakeholders are individuals and organizations that have an interest in or are affected by an evaluation and/or its results. Stakeholders provide a reality check on the appropriateness and feasibility of evaluation questions, offer insight on and suggest methods to access the target populations, provide ongoing feedback and recommendations, and help make evaluation results actionable (Centers for Disease Control and Prevention 2012). *For this project, participation was open to any and all Illinois residents, and broad solicitation for participation occurred through the Illinois Department of Healthcare and Family Services (HFS), Cook County Health (CCH), Southern Illinois Healthcare (SIH), and the Illinois Opioid Crisis Response Advisory Council. Stakeholders participated, representing regions spanning across the state, including the northernmost areas of Illinois, cook county, central Illinois, metro east, and the lower 16 counties of southern Illinois.*

Trauma-Informed: A trauma-informed approach to care “realizes the widespread impact of trauma and understands potential paths for recovery; recognizes the signs and symptoms of trauma in clients, families, staff, and others involved in the system; and responds by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively resist re-traumatization.” The six key principles of a trauma-informed approach include: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice and choice; and cultural, historical and gender issues (Substance Abuse and Mental Health Services Administration (SAMHSA) 2014).

Treatment for Opioid Use Disorder: A service or set of services that may include medication, behavioral interventions, and other supportive services designed to enable an individual to reduce or eliminate drug use, address associated physical or behavioral health problems, and restore one’s maximum functional ability (National Academies of Sciences, Engineering, and Medicine 2019).

Withdrawal Management Services: Services designed to manage intoxication or withdrawal episodes (previously referred to as detoxification), interrupt the momentum of habitual, compulsive substance use and begin the initial engagement in medically appropriate substance use disorder treatment. Withdrawal management allows patients to safely withdraw from substances in a controlled medically-structured environment (Illinois General Assembly: Legislative Reference Bureau 2019). According to the American Society of Addiction Medicine, withdrawal management alone can be the first step but is not a treatment for opioid use disorder and should only be considered as a part of a comprehensive and longitudinal plan of care (American Society of Addiction Medicine 2019).

X-Waiver: SAMHSA handles the application process for practitioners who want to prescribe buprenorphine for opioid addiction treatment. A DEA Controlled Substances Registration is required to apply. In addition, typically, unless a physician holds the appropriate board certifications, an 8-hour training course is required to qualify for the waiver. Once a physician has either taken the required training or received the appropriate board certification, they may apply for a waiver to begin treating 30 patients with buprenorphine. Certain practitioners may immediately begin treating up to 100 patients if they hold certain board certifications, or if they provide medications for the treatment of opioid use disorder in a qualified practice setting. For nurse practitioners (NPs), physician assistants (PAs), certified nurse specialists (CNSs), certified registered nurse anesthetists (CRNAs), and certified nurse midwives (CNMs) to be eligible to apply for a buprenorphine waiver, they must complete 24 hours of training (American Society of Addiction Medicine 2020). *The x-waiver is commonly referred to as xDEA, XDEA, X waiver, DEA-X waiver, X-number, or DATA-waived, among others.*

EXECUTIVE SUMMARY

Background: The opioid epidemic has shattered the lives of Illinoisians, families and communities across the state, claiming the lives of over 11,000 Illinoisians from 2008 and 2017, and fatality rates continue to climb.

Purpose: Comprehensive needs assessment for the advancement of state-wide opioid use disorder treatment infrastructure for Illinois Medicaid beneficiaries.

Methods: Qualitative analysis of community and expert input from over 260 stakeholders and organizations.

Results: Key Recommendation Themes

1. Substance Use Disorder Treatment & Recovery		
A. Access to Care	B. Reimbursement & Administrative Hurdles	C. Integrated Longitudinal Care
· X-waiver training · Workforce education and training · Medications for Opioid Use Disorder · Emergency department resources · Community-based care · Residential treatment and recovery homes · Geographic distribution · Telehealth solutions · Stigma reduction and cultural competency · Outcome metrics for success	· Adequate reimbursement · Timely reimbursement · Ease administrative burden · Patients with co-occurring mental illness · Systems alignment with DMH · Reimburse supportive services · Payment for long-term recovery care · Promising Models	· Transitions of care and warm handoffs · Referral systems · Chronic Disease Model · Comprehensive care · Provider collaboration · Behavioral health and addiction Services integration · Increase supportive services

2. Harm Reduction & Health Promotion	
A. Overdose Prevention and Safe Use	B. Upstream Interventions
· Naloxone training and distribution · Needle exchange programs and overdose prevention sites · Physician education on harm reduction · Health screening · Community outreach and anti-stigma efforts	· Youth-focused SUD education and prevention · Behavioral health resources for families · Trauma-informed care training · Illinois Prescription Monitoring Program · Coverage of alternative and non-opioid therapies for pain

3. Social Determinants of Health	
A. Health Equity	B. Socioeconomic Barriers
· Root causes of SUD · Racial disparities · Health inequities · Diversify workforce · Culturally-sensitive and linguistically appropriate services	· Transportation · Housing · Employment · Childcare · Education

4. Special Populations		
A. Dual Diagnoses	B. Justice-Involved	C. Other Special Populations
· Integrate mental health and SUD treatment · Trauma-informed care	· Access to care while incarcerated · Pre-release Medicaid enrollment · Release-to-community transitions · Reduce barriers to employment · Diversion and deflection programs	· Populations with housing instability · Pregnant women/women with children · Youth

CMS: Centers for Medicare & Medicaid Services. DMH: Division of Mental Health. SUD: Substance Use Disorder.

INTRODUCTION

Background

Drug overdoses have become the leading cause of death nationwide for people under the age of 50. Opioids were involved in 80% of drug overdose fatalities in Illinois in 2018, higher than the nationwide average of 70%, and the state ranks 28th in the US for opioid-related overdoses (National Institute on Drug Abuse 2020). The opioid epidemic claimed over 11,000 lives between 2008 and 2017 and accounted for more than twice as many fatalities as for car accidents in 2019 (Illinois Department of Public Health 2020) (Illinois Department of Public Health 2017). Opioid-related overdose fatalities increased by 82% between 2013 and 2016; during that same period of time, overdose deaths due to synthetic opioids increased tenfold (Illinois Department of Public Health 2020). Emergency department visits for opioid overdoses also increased by 22% between 2018 and 2019 (Illinois Department of Public Health 2020).

Key tools in the treatment of substance use disorder include medications, behavioral interventions, and wraparound supportive services such as housing resources and other socioeconomic interventions. Despite the toll that the opioid epidemic has taken on Illinoisans, families, communities, and institutions, there is a significant shortage of resources available to meet the extraordinarily high demand for substance use disorder (SUD) care in the state. For example, Illinois ranks 30th in the country in mental health workforce availability with 844 people per mental health worker, compared to the national median of 752 (Medicaid and CHIP Payment and Access Commission 2018).

The American Society of Addiction Medicine supports the efficacy of using medications for Opioid Use Disorder (OUD) independent of the availability of psychosocial interventions (American Society of Addiction Medicine 2019). However, while there are several FDA-approved medications for treating substance use disorders on the market, providers must obtain special training and licensure to be able to prescribe one of the most convenient and effective medications, buprenorphine, further limiting the availability of much-needed SUD treatment in the state.

Understanding the state's capacity to meet the pressing needs around SUD care and prevention is imperative for designing, improving, and implementing high-impact systems and interventions that are tailored to the unique SUD landscape in Illinois.

Demonstration Project to Increase Substance Use Provider Capacity

On October 24, 2018, the **S**ubstance **U**se Disorder **P**revention that **P**romotes **O**pioid **R**ecovery and **T**reatment for Patients and Communities (SUPPORT) Act became federal law. Under section 1003 of the SUPPORT Act, the Centers for Medicare & Medicaid Services (CMS), along with Substance Abuse and Mental Health Services Administration (SAMHSA) and the Agency for Healthcare Research and Quality (AHRQ), is conducting a 54-month demonstration project titled,

“Demonstration Project to Increase Substance Use Provider Capacity.” Fifteen state Medicaid authorities, including the Illinois Department of Healthcare and Family Services (HFS), received 18-month planning grants ($50 million total) to conduct comprehensive needs assessments of state infrastructure and provider capacity, among additional activities, to deliver substance use disorder (SUD) treatment and recovery support services to state Medicaid members.

The Illinois Department of Healthcare and Family Services partnered with Cook County Health (CCH) and Southern Illinois Healthcare (SIH) to conduct Illinois’ needs assessment of substance use disorder treatment for Medicaid beneficiaries through hosting regional community forums and interviews, and collecting written letters from the general public and key stakeholders throughout the state. By understanding what is working well, the gaps and challenges in the care continuum, and promising practices already underway, HFS will be well positioned to develop a plan to ensure that Medicaid beneficiaries with substance use disorder have access to high quality, comprehensive, evidence-based, and patient-centered care.

Cook County Health

Since the founding of the original Cook County Hospital in 1834, the mission of Cook County Health (CCH) has been to deliver integrated health services with dignity and respect regardless of a patient's ability to pay. Cook County Health is committed to fostering partnerships with other health providers and communities to enhance the health of the public, and to advocating for the policies which promote and protect the physical, mental, and social well-being of the people of Cook County. Cook County Health comprises two hospitals, two emergency departments, and a network of over a dozen health centers throughout Cook County, with over 1 million outpatient visits and 140,000 ED visits annually.

With 45% of CCH patients uninsured, CCH provides 50% of all charity care in Cook County. CCH includes Cook County Department of Public Health, the state and nationally certified health department for the majority of suburban Cook County. Cermak Health Services is a part of CCH, which provides healthcare for individuals incarcerated at Cook County Department of Corrections and Cook County Juvenile Temporary Detention Center. In addition, CCH includes County Care, the IL Medicaid managed care organization that serves one in three Cook County residents enrolled in Medicaid.

Southern Illinois Healthcare

Southern Illinois Healthcare (SIH), founded in 1946, is a not-for-profit integrated health care system serving all individuals regardless of their ability to pay. SIH employs over 3,700 people and comprises more than 30 facilities, including three hospitals, numerous physician offices, walk-in rural clinics, with over 400,000 outpatient visits and 74,000 ED visits annually. SIH is a major provider of health care for the 16 county Southern Illinois region and “is dedicated to improving the health and well-being of all people in the communities we serve.” SIH collaborates with partners through the

Healthy Southern Illinois Delta Network to transform Southern Illinois into a region that supports and enhances healthy living through creating infrastructure that leads to policy, system and environmental changes, with an emphasis on prevention and treatment.

METHODS

The Illinois Department of Healthcare and Family Services (HFS), Cook County Health (CCH), and Southern Illinois Healthcare (SIH) partnered to collect data through a variety of methods. Community forums were organized in collaboration with stakeholders throughout Illinois to collect primary data, scheduled for Spring 2020. Due to COVID-19, the majority of these forums were cancelled and replaced with 60 minute virtual interviews scheduled March through June 2020. In addition, stakeholders had the option to write letters. Both the interviews and letters used the same template of questions (Appendix A).

A request for community and expert input was issued to stakeholders and their contacts throughout Illinois through HFS, CCH, and SIH distribution lists, as well as the Illinois Opioid Crisis Response Advisory Council Listserv. Input was received from over 260 individuals and organizations. We hosted 16 forums and community listening sessions, conducted 14 interviews, and received a total of 41 letters (Appendix B).

All qualitative data was reviewed by at least six independent reviewers (three from CCH and three from SIH). The reviewers evaluated the data to find major themes, subthemes, and recommendations. This report details the summary of findings.

In September of 2020, a summary of the report's findings was presented to the Illinois Opioid Crisis Response Advisory Council. Their input was requested, along with a request to consider the report as a resource in the development of the revised State Opioid Action Plan (SOAP).

RESULTS

1. Substance Use Disorder Treatment & Recovery

Stakeholders noted both recent advancements in Illinois as well as continued barriers to SUD care for Medicaid beneficiaries. Stakeholders discussed many potential opportunities to overcome these barriers to care, emphasizing changes made during the COVID-19 pandemic including reimbursement and regulations for telehealth. Stakeholders discussed barriers and opportunities related to access to care, reimbursement, transitions in care, and evidence-based care. Stakeholders emphasized the need to improve reimbursement of long-term and recovery care in order to address SUD as a chronic disease. Stakeholders emphasized the need for comprehensive care that addresses root causes of SUD, such as behavioral health concerns and social determinants of

health. Various alternative care and reimbursement models were cited by stakeholders as models to consider adapting (see Special Box 1, pg. 20, for inclusive list of models).

A. Access to Care

Stakeholders reported that all healthcare delivery settings -- including hospitals, emergency departments (ED), primary care offices, and community health centers -- should be competent at initiating, continuing and/or linking patients to medications for OUD, psychosocial interventions, and recovery support services. Yet there are severe shortages of providers and support staff who are trained and able to care for patients diagnosed with SUD, such as addiction specialists, primary care providers (PCP), psychiatrists, ED physicians, social workers, and other specialists and support staff. This is especially the case in rural communities and communities with large populations of persons with limited English proficiency. While stakeholders note increased hospital and physician awareness for substance use disorder, they described not enough training around screening and referral to SUD services. There is a pressing need for more training to improve use of best practices for areas such as pharmaceutical options and dosing, treatment goals, caring for patients who return to use, trauma-informed care, cultural competency, and addressing stigma/bias.

1. Medications for Opioid Use Disorder Treatment

Provider Challenges

Key challenges in addressing SUD provider shortages include limited SUD training, regulatory training requirements for buprenorphine prescribing, reimbursement for services, and administrative hurdles. In addition to shortages of x-waivered providers that can prescribe buprenorphine, x-waivered prescribers have strict patient limits, and stakeholders identified reimbursement issues for new or complex patients that may require additional time. The x-waiver training requirement for prescribing medications for OUD is universally felt to be a major and unnecessary administrative hurdle, limiting patients' access to care. Despite severe provider shortages, providers report turning patients away because of x-waiver patient limitations. Though stakeholders report improvements in the number of x-waivered ED and primary hospital providers, there is limited availability of medications for OUD when patients are admitted to the hospital, in the ED, or as a bridge to outpatient care. This often results in patients leaving against medical advice when coming into the hospital for medical issues, such as injection drug use-related infections.

Expanding Access to Best Practices

Stakeholders overwhelmingly supported medications for OUD, particularly buprenorphine, citing the robust evidence showing its effectiveness for achieving long-term recovery over models that do not offer or allow medications. However, stakeholders report significant variability in the types of treatment offered at various SUD treatment programs across both inpatient and outpatient settings throughout Illinois. Many programs do not offer any kind of opioid agonist therapy, some offer only buprenorphine, some only offer methadone.

> "I have witnessed, countless times throughout the years, of patient harm that stems from practices, policies and frank stigmatization based on the idea that a lower dose or a shorter time spent on buprenorphine is somehow what is best. The opposite is actually true. The clinical research on MAT with buprenorphine shows that the longer and more adequate the dose of buprenorphine, the better the outcome for addiction treatment."
>
> *-Provider at Shawnee Health Service*
> *(Federally Qualified Health Center located in southern Illinois)*

Furthermore, many SUD treatment programs and housing options in the state rigidly decline patients that are being treated with medications for OUD (e.g. buprenorphine), and those who are not fully abstinent (e.g. occasional return to use). Per multiple stakeholders, abstinence-only models can be damaging to provider-patient relationships, and damaging to patients' potential to achieve recovery because they may be discharged from treatment. Furthermore, such policies reduce the already limited number of treatment options available in the state for SUD patients. Input suggested reconsidering outcome metrics for success, such as assessing social and occupational functioning rather than time abstained from substance use.

2. SUPR Licensed Treatment Programs & Other Psychosocial Interventions

Residential treatment and recovery homes were identified as key treatment and support resources for patients with severe opioid use disorder. Placement in intensive SUD treatment programs and recovery homes is challenging in the state of Illinois. There is a shortage of availability and geographic distribution. Many programs or "beds" within programs are reserved for patients with private insurance, further limiting access to existing programs.

> "Waitlists…..when it takes too long to get in, they give up."
>
> *-Patient at a community forum hosted by Touchette Regional Hospital*
> *(located in Illinois Metro East)*

There is a shortage of recovery coaches and trained/certified peer support specialists. Stakeholders note that there are few peer-support and community groups outside of the city of Chicago. These services are not covered by Medicaid and thus patients have limited options. Beyond the clinic, stakeholders described the effectiveness of having recovery coaches and addiction specialists in the ED, which serve as a key touch point for connecting patients with outpatient SUD treatment upon discharge. After leaving the ED, clinic, or withdrawal management program, there are not enough recovery homes, stable housing options, or shelters for patients to call home. Inhibitory restrictions, such as requiring sobriety for 30 days, refusing patients that are taking buprenorphine, or not allowing persons with children need to be reconsidered.

> "Substance use/addiction is a chronic condition that is best treated with bio-psycho-social factors in mind. According to SAMHSA, recovery-oriented care and recovery support systems help people with mental and substance use disorders manage their conditions successfully. One of the biggest gaps in Illinois's Medicaid system is the lack of recovery support services for individuals with substance use disorders. The peer recovery coaches are critical in outreach and engagement; they know the community, know the resources, and are able to communicate effectively, and are able to draw upon their own experiences with SUD and recovery. We recommend Illinois incorporate recovery support services and allow for peer support professionals to bill Medicaid for those services."
>
> *-Community Behavioral Healthcare Association of Illinois (not-for-profit professional organization in Illinois)*

3. Telehealth

Stakeholders discussed the importance of "meeting patients where they're at," both physically and metaphorically. Policy changes amidst COVID-19 that allowed for initiation and continuation of medications for OUD and psychosocial interventions via telehealth were celebrated for their innovative solution to limited access to care. Telehealth relieved transportation, employment, and childcare demands for many patients which are major barriers to connecting patients with SUD care. This is especially true for patients of lower socioeconomic status and for those in rural communities. The importance of caring for vulnerable patients beyond the clinic, in the community, and with meeting patients' non-clinical needs such as access to housing and other resources, were strongly emphasized as integral to recovery outcomes, and as an area for improvement.

4. Stigma

Stigma within the community, in health care, and in the criminal justice system are discussed as significant barriers to patients reaching out for help, accessing resources, and staying engaged with treatment (medications for OUD and/or psychosocial interventions). Communities are reportedly resistant to having treatment centers and recovery homes in their community, and don't always foster a supportive environment for those with SUD. Stakeholders report implicit and explicit provider biases in how patients with SUD are seen and treated. Stakeholders report that patients with SUDs are often labeled "addicts," "drug-seeking," and generally treated differently, with punitive actions when return to use occurs. This leads to avoidance behaviors due to fear of being judged, seen as weak, or being refused care. Importantly, stakeholders discussed at length the extent to which discrimination and racism compound baseline biases surrounding SUD for minorities, leading to even worse access to and quality of care.

"[They] do not seek treatment because they don't want to be labeled in their community as "not strong," "crazy," or "weak."

-K.A.M. Alliance
(behavioral health clinic located in Chicago)

Access to Care: Recommendations

Workforce

- Educate and incentivize providers to undergo x-waiver training and provide medications for OUD treatment
- Education and training
    - Increase availability of current best practices reference materials
    - Incorporate a robust Addiction Medicine curriculum into medical training
    - Be able to complete certification to Rx buprenorphine upon graduation
    - Increase education around interplay of SUD and behavioral health
    - Expand trauma-informed care trainings
    - Offer stipends for SUD-related trainings
- Create incentives for recruitment and retention of diverse SUD workforce
- Incentivize schedule flexibility facilitating immediate, weekend and evening access
- Recruit more persons with lived experience into the treatment/recovery process
- Promote collaboration amongst SUD providers and experts

Outpatient clinics and community-based SUD care

- Improve geographic distribution
- Increase the availability of medications for OUD treatment in primary care, pain clinics, and other outpatient clinical settings
- Incentivize providers to care for SUD patients
- Allow community-based services like mobile clinics
- Increase funding for support groups and peer recovery

Hospitals

- Provide resources for EDs and inpatient medicine teams to integrate screening, initiation of medications for OUD, and links to long-term care for SUD
- Incentivize availability of recovery coaches, social workers, and addiction specialists in EDs and hospital settings

Residential treatment and recovery homes

- Increase availability and geographic reach of residential treatment programs

- Increase and streamline Medicaid coverage for residential treatment
- Increase availability of recovery homes
- Medicaid coverage and reimbursement for recovery homes
- Allow funding for the development of sober living facilities
- Decrease requirements for admission to treatment programs
- Require facilities to accept patients that are engaged in medications for OUD
- Discourage termination based on positive urine toxicology or return-to-use

Best Practices
- Prioritize longitudinal care over episodic or stabilization-focused care
- Reconsider outcome metrics for success
    - Assess social and occupational functioning rather than time abstained from substance use
    - Discourage over-reliance on urine drug screens
    - Education around return-to-use and continuation of care
    - Discourage termination based on positive urine toxicology or return-to-use

Telehealth
- Continue telehealth services and other new practices beyond the COVID-19 pandemic
- Continue to allow buprenorphine initiation and assessment via telehealth
- Increase patient access to telehealth resources and technology (e.g. toll-free phone numbers, wifi access)

Stigma
- Improve education of physicians and other healthcare workers about OUD and medications for OUD
- Expand cultural competency training including in schools, medical education, law enforcement, legal system, and communities
- Decrease use of stigmatizing language such as “dirty” or “clean”

B. Reimbursement & Administrative Hurdles

> “Care planning is being driven by cost and coverage, not by patient need which, in the long run, is probably even less cost effective.”
>
> *-Mercyhealth*
> *(regional health care system, location in northern Illinois)*

Many stakeholders report difficulties with patient coverage and reimbursement for providers. The processes for applying for Medicaid, both for enrolling as a Medicaid-approved provider, as well

as for applying for Medicaid insurance coverage as a patient, are time-consuming and burdensome. Following enrollment, providers experience significant delays in receiving reimbursement.

> *"*...trying to implement policies and procedures that fit BH into a primary care setting is challenging, again because most of our training and even licensure requirements do not fit this setting. For example, even SUPR's documentation guidelines for substance use patients is written assuming a very traditional, linear track for a patient. We are required to document a thorough assessment, treatment plans every 60 days, a continuing recovery plan and discharge summary when the patient stops attending treatment. Trying to implement these requirements in a primary care setting is doable and valuable, but very challenging. Patients are often referred to behavioral health in precontemplation or contemplation about a certain problem that is affecting their health. Many times they are still using."
>
> *-Licensed Clinical Social Worker at Shawnee Health Service (Federally Qualified Health Center located in southern Illinois)*

1. Provider Reimbursement Rates

Stakeholders shared that the typical Medicaid reimbursement for prescribing provider visits does not adequately cover the cost of the provider, and is a significant barrier for offering medications for OUD. Some stakeholders suggested that reimbursement comparable to FQHC rates would be more appropriate and sufficient.

Several providers of SUD care noted not being able to bill for the additional support services needed to stabilize and monitor someone who starts medications for OUD such as case management. Providers also found the involvement of Managed Care Organizations in determining medical necessity and prior authorization requirements unnecessarily cumbersome and an additional disincentive to prescribe, especially given low reimbursement rates.

Fear of not getting reimbursed in a timely manner inhibits providing appropriate treatment at times. Stakeholders reported administrative rules that bundle providing buprenorphine with providing methadone for SUPR licensed programs, despite significant differences in storage, prescribing, and dispensing for these two medications, make prescribing buprenorphine not financially feasible for many.

> "Most substance use treatment providers on the West Side of Chicago, which is ground zero for overdose deaths in Illinois, do not provide immediate Medication Assisted Treatment (MAT) using Suboxone"
>
> *-Thresholds*
> *(Chicago-based dual diagnosis recovery services organization)*

2. Systems for Patients with Comorbid Conditions

There is a high prevalence of co-occurring mental illness among patients with substance use disorder (SUD). Stakeholders reported that although the standard of care for SUD patients includes mental health services, state funding streams for mental health and substance use disorder services are separate, thus often requiring parallel and redundant processes for reimbursement, creating an extraordinary administrative burden for providers.

> "The complexities of integration of mental health & substance use treatment all begins at the top. With the numerous differences in administrative rules & regulations between mental health & substance use, clinical integration becomes difficult to implement while needing to dedicate specialized administrative resources to ensure our department follows each state program's unique set of rules/regulations around billing, record keeping, and auditing/licensing."
>
> *-DuPage County Health Department*
> *(located in northern Illinois)*

Reimbursement & Administrative Hurdles: Recommendations
Reimbursement rates - Increase reimbursement rates for SUD care across various care settings - Incentivize equitable, patient-centered, open door care, and harm reduction approaches - Allow providers to dictate medical necessity determinations - Reimburse for long-term services - Increase payment for long-term recovery care over episodic or stabilization-focused care - Reimburse longer primary care visits to allow for complete complex care and psychosocial assessments - Discontinue limits for inpatient treatment   - 14-21 days is insufficient, private insurance typically allows 90 days for treatment

- Allow coverage for services prior to official diagnosis of SUD
- Reimburse for supportive services as discussed below (e.g. recovery coaches and other peer support services within primary care, emergency departments, inpatient, and SUPR licensed treatment programs)

Administrative burden

- Improve timing of reimbursement
    - Consider reimbursement at set time frames
- Simplify reimbursement processes
- Integrate SUPR and DMH in regards to administrative processes, policies, services/rates, referral systems
- Remove prior-authorization and re-authorization requirements
- Increase Medicaid staffing to provide assistance in reimbursement
- Provide funding for provider administrative staff related to reimbursement, such as coders and billers
- Decrease MCO paperwork
- Allow fast-tracking of Medicaid applications for vulnerable populations as discussed below

Care Models (see Special Box 1, pg. 20, for inclusive list of models)

- Incentivize team-based provider models
- Shift toward value-based care and diagnostic group models over fee-for-service
    - Reconsider MCO restrictions

SPECIAL BOX 1: PROMISING MODELS STAKEHOLDERS RECOMMEND ILLINOIS CONSIDER

- Promising State Examples
  - Illinois
    - Recovery-Oriented System of Care (ROSC) Model
    - Division of Mental Health Models
    - Mental Health Crisis Model
  - Massachusetts
    - Medicaid Accountable Care Organization (ACO)/Behavioral Health Partnership
  - Maryland
    - Baltimore Buprenorphine Initiative
  - Missouri
    - State Targeted Response and State Opioid Response
  - Certified Peer Specialist (CPS) Initiative
    - Medication First Model
  - Minnesota
    - Milwaukee Housing First Funding Model
    - Model for Post-Hospital Coordination
  - Virginia
    - Addiction and Recovery Treatment Services (ARTS)
  - Washington State
    - Pay-for-Performance
- Payment Models
  - Bundled Payment Model
  - Shared Risk Model
  - FQHC Encounter-Based Payment
  - Actuarial Sound Method
  - Per Member Per Month Payment Model
  - Case-Rate Model
  - Patient Centered Payment Model
  - Value-Based Payment
- Behavioral and Mental Health
  - Illinois Division of Mental Health Models
  - Illinois Mental Health Crisis Model
  - Medicaid Rule 140/Model for Mental Health
  - CCBHC Certified Community Behavioral Health Clinics (CCBHC)
  - Community Support Team (CST)
- Care Delivery Models
  - Hub and Spoke Model
  - Screening, Brief Intervention, Referral, Treatment (SBIRT) Model
  - Addiction Recovery Medical Home Alternative Payment Model (ARMH-APM)
  - Chronic Disease Models (e.g. diabetes, chronic heart failure, chronic obstructive pulmonary disease)

C. Integrated Longitudinal Care

> "It is imperative that the future of SUD care go beyond stabilization to a biopsychosocial sustained model of recovery management comparable to the management standards and protocols for physical chronic disease management."
>
> *-Alliance for Addiction Payment Reform*
> *(national multi-sector healthcare alliance)*

Stakeholders emphasized the importance of viewing Substance Use Disorder (SUD) as a complex chronic disease, and using a coordinated team-based approach with a focus on long-term comprehensive care and wellness. Linking patients to care, initiating patient treatment, and transitioning care between providers were highlighted as key challenges in establishing successful SUD care pathways.

1. Entry Points and Transitions of Care

Transitions between discharge from the ED or hospital, from incarceration, or between providers to community-based care were widely cited challenges for treatment initiation, continuity of care, and patient recovery. Stakeholders advocated for the creation of “bridge clinics” and behavioral health stabilization and triage centers, which can facilitate post-discharge linkage to care in the community by providing intake assessments, continuation of medications for OUD, and connecting patients with ongoing care, ideally allowing for walk-in visits.

Communication between providers across transitions of care is too often lacking. Stakeholders praised state initiatives around improving warm handoffs as effective and would like to see their expansion. Employing support staff that can facilitate these patient transitions, such as care coordinators, social workers, case managers, and recovery coaches in hospitals, jails, and clinics was also emphasized.

> “It is imperative that acute care hospitals/Emergency Departments have personnel who can assess and motivate patients at the bedside. If a patient is not met with empathy, support, and information about treatment options during hospitalization, it is unlikely for a patient to get the follow up care they need.”
>
> *-Amita Alexian Brothers Health Hospital*
> *(behavioral health hospital located in northern Illinois)*

Referral Systems

Many respondents indicated that the referral process for linking patients to SUD treatment is poor. The referral process is dependent on a patchwork system for finding referrals and is noted by stakeholders to be less efficacious than in the mental health system for the state of Illinois. Stakeholders cited the IL state SUD "Helpline" (The Illinois Helpline for Opioids and Other Substances) website (helplineIL.org) as useful for finding providers and what kind of services they offer, but incomplete.

Enforcement officials, probation officers, and other professionals in the criminal justice system are often potential points of intervention for SUD patients. However, due to stigma and a lack of competency training around substance use disorder, resources and referral processes, these interventions too-often result in adverse consequences.

2. Treatment Initiation

Stakeholders advocated for shifting the current emphasis on detox and withdrawal management in a medically-monitored inpatient setting to community-based outpatient medication treatment for OUD. The role financial incentives play in the common practice of rapid tapering patients versus utilization of medications for OUD and community stabilization was specifically addressed, stating that lack of reimbursement and outdated policies are what prevents many from offering the preferred type of treatment to patients.

> "Financial incentives [that] encourage risky [medical] and clinically-monitored withdrawal management, with methadone management of severe withdrawal symptoms followed by rapid taper, which is associated with a higher risk of return to use and overdose. MAT initiation followed by community stabilization and maintenance is preferred but there is no reimbursement mechanism to support providing this service and incentivizing hospitals to revise their practices."
>
> *-Health Policy Lead at Heartland Alliance*
> *(Chicago-based anti-poverty comprehensive service organization)*
>
> "I am convinced after nine (9) years of providing buprenorphine therapy that lack of understanding effective MAT principals and persistent prejudice against the treatment altogether are the greatest barriers to quality treatment access when it even exists."
>
> *-Provider at Shawnee Health Service*
> *(Federally Qualified Health Center located in southern Illinois)*

3. SUD as a Complex Chronic Disease

Many stakeholders discussed the importance of treating SUD as a chronic disease; warranting long-term, complex care approaches similar to other chronic diseases, such as diabetes and heart disease rather than episodic care. Stakeholders suggested redefining goals of care in SUD such that functional status is prioritized over the duration of the patient maintaining abstinence. Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF) are examples of chronic diseases that have balanced treatment goals and outcome metrics that take into account overall functional status rather than quantitative frequency of "flares."

Care Coordination

Communication between collaborating providers across different settings is a cornerstone of team-based approaches in healthcare, but is cited as a major challenge and is not incentivized. Care coordination across providers and services is a fundamental necessity in any complex care model, but SUD presents an even higher level of need in this domain due to SUD patients' circumstances beyond the clinic and social complexity. Care for this population should address root causes of SUD, including behavioral health and social determinants of health. Recovery coaches, case managers, and administrative staff are key to patient retention. Loss-to-follow-up is a major challenge, as it is difficult to contact patients who are often in transient living situations.

4. Access to Resources Beyond the Clinical Setting

Case managers, social workers, and care coordinators serve key roles throughout treatment by supporting patients and connecting them with needed wraparound resources beyond the clinical setting, such as health insurance, housing, financial, and legal support. Stakeholders identified addressing patients' needs beyond the clinic, education on resources available, and, very importantly, providing direct counseling to patients amidst severe behavioral health service shortages as fundamental to successful SUD treatment.

> "A patient who had a series of admission to hospitals, intensive residential and intensive outpatient care will find it hard, even with the support of case managers/recovery coaches, to navigate through the system to find affordable housing, applying for Medicaid, retaining Medicaid, obtaining job skills, finding jobs, working through the legal system, obtaining stable housing, obtaining funding for basic amenities because all these require involvement with various departments of the government."
>
> *-South Suburban Council on Alcoholism and Substance Abuse (regional substance use and behavioral health treatment and recovery center)*

Integrated Longitudinal Care: Recommendations
Improve referral systems and care initiation - Improve the completeness and referral functionality of the Illinois Helpline for Opioids and Other Substances - Educate providers on availability of referral resources - Invest in “bridge clinics” - Prioritize community-based stabilization - Improve the ability to provide and incentivize warm handoffs Support integrated longitudinal care - Encourage team-based approaches, including provider collaboration and information sharing - Manage SUD using chronic disease models - Promote comprehensive care and wellness Support patients through all phases of recovery including periods of return-to-use - Discourage discontinuing medications for OUD after a temporary return to use - Discourage discontinuing access to recovery housing after a return to use - Encourage harm reduction approaches over abstinence-only goals - Increase funding and reimburse recovery coaches and peer support services Integrate behavioral health and addiction services - Improve coverage of behavioral health - Explore reimbursement alignment between the IL Division of Mental Health and the IL Division of Substance Use Prevention and Recovery - Reimburse longer initial visits to allow for a complete psychosocial assessment - Increase access to and number of trained behavioral health and addiction providers Address social determinants of health and root causes - Increase care coordination, case management, and social work services - Reimburse supportive services

2. Harm Reduction & Health Promotion

> “Make sure people stay alive to get help.”
>
> *-Patient at a community forum hosted by Kendall County Health Department (located in the greater Chicagoland area)*

Harm reduction services are a way to “meet patients where they are at” according to multiple respondents. The stakeholders felt the state has been supportive of harm reduction initiatives, but that there is not enough provider training around harm reduction, linkage/referral to programs, and integration with primary care. Community drug take-back days, medication disposal sites, and the Illinois Helpline (833-2FINDHELP) were identified as important resources to maintain. Multiple stakeholders voiced the importance of outreach to the community in order to provide prevention, education, access to care, and anti-stigma efforts.

> “Invest in low-barrier, subsidized housing programs that embrace housing first and harm reduction models. These programs must not require strict abstinence and should recognize relapse as a part of recovery.”
>
> *-IL Harm Reduction and Recovery Coalition*
> *(state-wide multi-organization coalition)*

A. Overdose Prevention and Safe Use

Stakeholders noted that deaths from opioid overdose continue to be a major public health issue, and one of the most common preventable causes of mortality in the state of Illinois. Fentanyl is almost ubiquitously present in street opioids, yet providers are having difficulty with being able to test for fentanyl. Naloxone is an effective intervention that is cost-effective and decreases mortality. Stakeholders emphasized their appreciation of the effort by the state to expand the availability of this life-saving medication. Safe injection sites, or “overdose prevention centers” have been shown effective in overdose prevention in other jurisdictions, but there are no sanctioned sites in Illinois at this time. Needle exchange services in the state have been effective, but are reportedly rare outside of Chicago. Stakeholders also cite the importance of screening for hepatitis B and C and HIV among persons who inject drugs.

> “Continue to provide Naloxone funding, training, distribution. Continue to provide and expand overdose prevention education. Look at other options for overdose prevention. There are other states or countries that are much more progressive in this area.”
>
> *-Bridgeway Inc*
> *(regional community-based health and human services organization)*

B. Upstream Interventions

Stakeholders discussed the importance of SUD prevention by investing in youth services and providing early outreach and education of children and their parents regarding SUD prevention. Because SUDs have been associated with childhood trauma and behavioral health, stakeholders discussed the importance of trauma-informed care, trauma-informed schools, social emotional learning, and addressing behavioral health in youth. Stakeholders also discussed the importance of programs that focus on prevention of childhood trauma, such as home visiting programs.

Stakeholders also highlighted the value and importance of education around safe opioid and prescribing practices through utilization of the ILPMP, as well as considering non-opioid treatment of chronic pain as an upstream intervention.

Harm Reduction and Health Promotion: Recommendations

Overdose Prevention and Safe Use

- Invest in harm reduction approaches
- Advocate for legalization and funding of overdose prevention sites
- Distribution of supplies for safe use such as needle exchange programs
- Provide accessible Fentanyl testing, other drug adulterant testing
- Increase physician education on harm reduction
- Encourage harm reduction approaches in all social service settings, such as housing, homeless shelters, and workforce development
- Provide overdose training and Naloxone for schools
- Improve the availability and distribution of naloxone
    - Distribute naloxone at no cost in the ED, upon hospital discharge, in Federally Qualified Health Centers, pharmacies, homeless shelters, and in schools
    - Distribute to and educate first responders, community-based organizations, and families/friends of those with SUD
    - Educate providers around prescribing of Naloxone when prescribing opioids

Health promotion

- Promote HIV and hepatitis screening

Community Outreach

- Reimburse for outreach, awareness, promotion, community interventions and trainings, and anti-stigma efforts

Upstream Interventions

- Invest in youth-focused SUD education and prevention
- Increase behavioral health resources for youth and adults
- Training in trauma-informed care

- Encourage opioid-prescribing providers to utilize Illinois Prescription Monitoring Program
- Increase coverage of alternative and non-opioid therapies for pain

3. Social Determinants of Health

Illinois Medicaid should advocate for federal policy changes to improve the care of Illinois beneficiaries across the state. Stakeholders stated the need for racial and health equity; emphasizing the need for policies to decriminalize substance use disorder (SUD), address root causes of substance use such as social determinants of health inequalities, and disinvestment in communities. Stakeholders noted that minorities are disproportionately subject to penalization by the criminal justice system, and stakeholders say there is little minority representation in government to help advocate for this population.

A. Health Equity

> "Rates of both fatal and nonfatal overdoses have continued to balloon in these [Black and Latinx] communities… Illinois must prioritize supporting its Black and Latinx residents and provide them the care they need to address SUD and other health challenges."
>
> *-IL Harm Reduction and Recovery Coalition (state-wide multi-organization coalition)*

The opioid epidemic has adversely affected minorities to a greater extent compared with white, English-speaking U.S. citizens. Stakeholders discussed overdose rates as one of the most pressing issues plaguing racial/ethnic minorities, citing, for example, overdose-related fatality rates that are nearly double for black versus white Chicagoans. Access to treatment was discussed as a major driver for disparities in recovery. One stakeholder notes that white patients are 35 times more likely to seek and receive buprenorphine. A major contributor discussed is the significant shortage of bilingual and racially/ethnically diverse SUD providers, staff, and community support. Baseline inequities in poverty and access to education means this population is less likely to have jobs that offer paid time off, sick days, or FMLA (Family and Medical Leave Act of 1993) coverage, further compounding challenges in accessing limited treatment options.

B. Socioeconomic Barriers

In addition to housing stability, recovery is strongly correlated with economic stability. Stakeholders frequently discussed the importance of connecting patients with job training and jobs, life skills training, financial, and legal services. Some discuss that such resources may exist, yet patients are not being connected with them routinely. Some organizations work with employers and

assist patients with the process of employment applications. Many patients need support with transportation and childcare so that they are logistically able to attend appointments, life skills/job training, interviews for employment, etc. In addition to cost barriers, it is difficult for patients to obtain driver's licenses and other forms of identification. Telehealth has been an important resource for minimizing transportation and childcare challenges; however, patients with limited digital literacy need assistance with digital training. Food security and accessing Women, Infants, and Children (WIC) benefits are an area of need as well.

> "Illinoisans seeking recovery from SUD/OUD rely on socioeconomic supports just as much as they rely on treatment and recovery services themselves."
>
> *-IL Harm Reduction and Recovery Coalition (state-wide multi-organization coalition)*

Social Determinants of Health: Recommendations

Health Equity

- Address root causes of substance use, such as the social and structural determinants of health
- Improve access and quality of care for minorities and patients with limited English proficiency
- Analyze barriers to care for Black and Latinx communities and revise service delivery as needed
    - Track funding and investments, by community and racial makeup
    - Address explicit and implicit bias in healthcare
    - Strive towards equitable access to medications for OUD
- Provide access to culturally, racially, and linguistically diverse health care providers
    - Actively work to diversify the workforce
    - Incentivize bilingual providers to enter field of SUD care
    - Require cultural competency training of all healthcare professionals
    - Promote culturally relevant support services
- Reimburse increased care coordination and case management

Socioeconomic Barriers

- Address root causes of SUD, such as the social determinants of health and behavioral health needs
    - Support a housing-first model
    - Fund transportation services
        - Increase access to Medicaid-funded transportation
        - Collaborate with transportation agencies, especially outside of Chicago

- Improve availability of community-based treatment centers to reduce the barrier of transportation
- Increase job training and life skills programs
- Increase minimum wage
- Improve family-based care/support
  - Increase availability of childcare available during treatment (including onsite)
  - Reimburse for family/group therapy

4. Special Populations

Within the spectrum of Substance Use Disorder, there are several vulnerable and unique subpopulations that stakeholders felt warrant special consideration. Respondents most commonly described challenges with meeting the needs of the justice-involved and of those with dual-diagnoses (SUD and mental illnesses). Other populations discussed included postpartum women, women with children, and DCFS-referred persons.

A. Dual Diagnoses: Addiction and Mental Illness

Comorbid mental illness, including schizophrenia and bipolar disorder, is common in the SUD patient population, but access to comprehensive behavioral health services is often lacking in SUD care. There is a severe shortage of mental health services available. Patients with these diagnoses are often refused by various SUD treatment programs; and therefore, securing residential placement is difficult. The availability of co-occurring programming is rare, and tailoring programming to the unique needs of this population is challenging. There is also a lack of training on trauma-informed care for providers. Additionally, the lack of integration or alignment between the Illinois Division of Mental Health and the Illinois Division of Substance Use Prevention and Recovery systems creates administrative burden on both patients and providers.

> “In the clinical world, “integration” of substance use and mental health treatment has been at the forefront of our treatment models. If reimbursement models for substance use treatment in Illinois mirrored how it looks for mental health clients, administrative integration would be realized, allowing for time & resources to be shifted to direct service.”
>
> *-DuPage County Health Department (located in northern Illinois)*

B. Justice-Involved

Challenges for the justice-involved population were often described in terms of access to care while incarcerated, transitions from incarceration to the general community, and in terms of the lasting impact that criminalization has on patients' livelihoods, family and support systems, and subsequently, prospects of recovery.

A minority of jails and prisons offer medications for OUD to incarcerated patients, and many that do only offer naltrexone. If a patient with OUD has been followed by an outpatient provider prior to arrest, their care is most often discontinued upon incarceration. While some progressive jail systems (e.g. Cook County) are able to start or continue patients on all forms of medications for OUD while incarcerated, most jail and prison systems across the state do not have the same capabilities.

Transitioning into the community after incarceration poses several challenges. Patients with SUD are at extremely high risk of overdose-related mortality within the first few weeks of release. Another significant challenge is the gap in Medicaid/insurance coverage upon release due to ineligibility while incarcerated, as well as the lack of a universal system for connecting patients with SUD providers and/or resources in the community upon release.

After release, a criminal record makes getting employment and secure housing, keystones of successful recovery, extraordinarily difficult. Furthermore, without connection to SUD resources after release, formerly incarcerated individuals are at higher risk of re-offending. Probation and parole officers are not adequately trained/educated in SUD, especially with respect to available resources in the community. Drug courts and diversion programs are discussed as effective in decreasing criminal justice consequences of SUD, and stakeholders advocate for further measures to combat the stigma that a criminal record carries with it, such as reducing offense classification and eliminating need for disclosure on employment applications.

> "Disparities in arrests and incarceration are seen for both drug possession law violations as well as low-level sales. Those selling small amounts of drugs to support their own drug use may go to jail for decades. This unequal enforcement ignores the universality of drug dependency, as well as the universal appeal of drugs themselves. Mass criminalization of people of color for drug use/possession/sales, specifically Black people is as discriminatory and profound as Jim Crow laws. This contributes to the breakdown of family systems on all levels (jobs, education, health). People involved in the criminal legal system should have access to the full range of treatment service options available in the

community. Clients should determine the course of treatment with their credentialed provider and without influence from the criminal legal system."

-Center for Housing and Health
(Chicago-based housing cooperative)

C. Other Special Populations

There were several other unique patient populations that were frequently discussed as vulnerable and warranting special consideration. Minorities, those with limited English proficiency, immigrant and refugee populations, as well as rural populations were often discussed, particularly in the context of access to care. Additional populations of concern included pregnant women, parents with young children, and families with Department of Children and Family Services (DCFS) involvement. Patients with physical or intellectual disabilities, including traumatic brain injury (TBI), and those with chronic pain syndromes, were also discussed as higher risk for both developing SUD and underutilizing SUD resources. Similar to some of the issues henceforth described for incarcerated populations, other institutional settings of concern were nursing homes or intermediate care facilities, and patients admitted to hospitals for medical reasons (e.g. injection drug use-related infections). Youth and children are a unique population affected directly or indirectly by SUD, and there are not enough school-based education programs or Medicaid-covered child therapy resources. LGBQT populations were also cited as a population of concern.

Special Populations: Recommendations

Improve access and quality of care for special populations

- Fast track Medicaid applications from vulnerable populations
- Reimburse for longer appointment times, increased care coordination and case management, and supportive services needs
- Encourage cultural competency training for the care of patients with physical and cognitive disabilities

Dual-diagnosis

- Implement comprehensive behavioral health models that integrate mental health and SUD treatment
- Expand trauma-informed care training

Justice-Involved

- Require all forms of medications for OUD be universally available in jails and prisons and be covered by Medicaid
- Invest in diversion and deflection programs to minimize justice involvement

    - Encourage collaboration among providers and law enforcement
    - Encourage medical and legal systems to work together
- Allow pre-release Medicaid enrollment for justice-involved populations and coverage of undocumented persons (especially those who are pregnant)
- Improve release to community transitions for justice-involved populations
- Reduce barriers to employment for those with a history of SUD and a criminal record
    - Incentivize hiring of those with a history of SUD and a criminal record
- Decriminalize SUD
    - Deprioritize drug possession arrests
    - Reduce offense classification and penalties
- Consider moving funding from law enforcement to social services
- Incentivize employment of those with SUD and a criminal record
- Stop criminal record disclosure requirements, especially if offense was during active SUD

Other Special Populations
- Populations with housing instability
    - Facilitate access to Medicaid
    - Increase street outreach and engagement
    - Fund targeted care coordination and case management
    - Increase housing options
- Pregnant Women/Women with Children
    - Expand home visiting program availability and usage for pregnant women with SUD
    - Work with DCFS
    - Improve childcare options during treatment
- Youth
    - Encourage Assertive Community Treatment and/or Community Support Team model for youths with co-occurring substance use and mental health disorders

CONCLUSION

The opioid epidemic has taken an extraordinary toll on Illinoisians, families, communities, and institutions, and there is a need for additional resources and coordination to meet the high demand for substance use disorder (SUD) care. This report summarized major themes derived from key Illinois SUD care stakeholder perspectives on the current state of, and future directions for, addressing the opioid epidemic through advancing SUD care capacity for Medicaid beneficiaries in the state of Illinois.

Illinois strengths included:

- Recent policy changes allowing telehealth services for initiation and continuation of medications for Opioid Use Disorder (OUD) treatment
- Medicaid coverage of medications for OUD
- Effective Division of Mental Health (DMH) care models within the state which establish precedent and existing infrastructure that can pave the way for SUD treatment redesign
- Illinois Helpline for Opioids and Other Substances
- Illinois Prescription Monitoring Program

Major challenges where stakeholders would like to see improvement include:

- Insufficient and slow reimbursement from all state funding streams, at all levels of provider, including support staff
- Shortages of SUD medication treatment providers, behavioral health professionals, and other key SUD supportive services
- Inequitable geographic distribution of resources
- Transitions of care and warm handoffs
- Fragmentation of care, particularly between mental health and SUD treatment
- Criminalization of SUD and limited access to SUD care, including medications for OUD, in jails/prisons
- Health inequities and racial disparities
- Challenges working with Medicaid MCOs
- Limited harm reduction and health promotion initiatives
- X-waiver prerequisite for buprenorphine prescribers

The majority of policy recommendations were at the state level. Stakeholders advocated for Medicaid to design better payment models that can also be used as levers for improving quality of care in terms of transitions and long-term care planning, in addition to improving the amount of reimbursement for services. Stakeholders advocated for more inclusion of SUD clinicians/providers in policy-making and expressed tremendous gratitude to CMS and the state of Illinois for conducting a needs assessment to solicit input from those working on the front lines of the opioid epidemic.

ACKNOWLEDGMENTS

We would like to express gratitude to Centers for Medicare and Medicaid Services (CMS) and the Illinois Department of Healthcare and Family Services (HFS) for the opportunity and support to conduct this needs assessment. We sincerely thank all stakeholders who submitted letters, participated in listening sessions and interviews, and attended community forums; the SIU School of Medicine Center for Rural Health and Social Service Development for hosting listening sessions in central and southern IL; Lawndale Christian Health Center, Westside Heroin Opioid Task Force, and Kendall County Health Department for hosting listening sessions in northern IL, and the Illinois Opioid Crisis Response Advisory Council, for their support and feedback. Finally, we thank our internal institutional colleagues and external subject matter experts who served as reviewers and provided valuable feedback on the final draft of this report.

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APPENDICES

APPENDIX A- COMMUNITY CORRESPONDENCE

I. INVITATION LETTER

ILLINOIS DEPARTMENT OF Healthcare and Family Services

JB Pritzker, Governor
Theresa Eagleson, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: (217) 782-1200
TTY: (800) 526-5812

January 22, 2020

To Illinois partners, stakeholders, and residents:

Illinois' Department of Healthcare and Family Services (HFS) is launching a stakeholder engagement initiative to better understand and address gaps in substance use disorder (SUD) treatment across Illinois, with the ultimate goal of improving access to care for Medicaid beneficiaries with substance use disorders. This work is funded by the U.S. Centers for Medicare and Medicaid Services (CMS) through the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act.

To launch this effort, HFS is partnering with Cook County Health (CCH) and Southern Illinois Health (SIH) to host regional listening sessions with the general public and key stakeholders throughout Illinois. By understanding what is working well, what are the gaps in the care continuum, and what are promising practices already underway, we can together develop and implement a plan to ensure that Medicaid beneficiaries with substance use disorders have access to high quality, comprehensive, evidence-based, and patient-centered care.

To make these listening sessions as informative and effective as possible, I am asking that you and your organizations partner with CCH and SIH on this effort. Please reach out to any of the project leads, listed below, with questions, comments, or suggestions:

Mary Fleming, M.S.
HFS SUPPORT Project Director
mary.fleming@illinois.gov
312-793-3505

Juleigh Nowinski-Konchack, MD MPH
Cook County Health SUPPORT Project Lead
jkonchak@cookcountyhhs.org
312-864-0637

Angie Bailey, MPH, M.S.Ed, CHES
Southern Illinois Healthcare SUPPORT Project Lead
angie.bailey@sih.net
618-457-5200, ext 67834

Your voice and partnership in this process is essential, and I thank you for prioritizing this important task at hand.

With appreciation,

Doug Elwell, Medicaid Director

II. INTERVIEW TEMPLATE

Community Input: Improving Substance Use Disorder (SUD) Care in Illinois Medicaid

Through a grant from the Centers for Medicare and Medicaid Services (CMS), Illinois is seeking community input on how to improve substance use disorder care for Medicaid beneficiaries. To complement feedback received at community forums held across Illinois, we also welcome written comments.

We have provided some questions below to help guide your responses. Answering all the questions is **not expected or required.** Please limit written comments to no more than 3 pages.

In your responses, please be concise and do not include extensive background information for well-accepted concepts. Please do provide examples, references, or data for newer concepts. Be sure to include a contact name, title, email, and organization, if applicable.
Thank you for providing us with your valuable input!

Treatment Initiation, Retention & Recovery

- What is working well in Illinois?
- What are the biggest challenges/ barriers to accessing and initiating evidence-based treatment?
  (E.g. provider access/capacity, medications, staff recruitment, behavioral health capacity)
- What are the biggest challenges/ barriers to retention?
  (E.g. support staff capacity)
- What are the biggest challenges/ barriers to recovery?
  (E.g. case management and referral processes/handoffs especially to mental health services, employment, social support)
- What are gaps in the continuum of care spanning from early intervention and outpatient services to medically monitored intensive inpatients services and medically managed intensive inpatient services?
  (E.g. linkage to a higher level of care, transition from crisis care settings to community-based settings)
- What are the barriers to providing behavioral health care, including SUD treatment, integrated in a primary care setting?
- What opportunities should Illinois Medicaid pursue to improve treatment initiation, retention, and recovery?

Supportive Services

- What are the essential supportive services and what is their capacity in Illinois for those with SUD?
  (E.g. housing, mental health services, family supports, life skills, job training, education, recovery support)
- What is working well in Illinois?
- What are the biggest challenges/barriers?
  (E.g. homelessness and lack of available housing, unemployment)
- What should Illinois Medicaid do to foster access to supportive services?

Harm Reduction & Health Promotion

- What is the role of harm reduction and health promotion in treatment of SUD?
  (E.g. Naloxone distribution, syringe services, overdose prevention/safe consumption sites, hepatitis testing and treatment)
- How might Illinois Medicaid more fully support overdose prevention and harm reduction for Medicaid beneficiaries?
- What more can we do in terms of early intervention?

Payment Issues

- How has the current reimbursement model affected treatment?
  (E.g. fee for service, lack of Medicaid for those incarcerated, MAT coverage)
- How might alternative models of payment for care help facilitate improved access to care for Medicaid beneficiaries? *(please provide data and references for innovative solutions whenever possible, including contact information for further discussion)*

Special Populations

- Do you have any specific concerns regarding special populations?
  (E.g. justice-involved population, post-partum women, women with children, DCFS-referred persons, individuals with co-occurring serious mental illness (schizophrenia, bipolar disorder)

Policy & Societal Barriers

- How does racism and discrimination affect those with SUD and their recovery?
  (E.g. Disparities in outcomes, Disparities in justice-involvement (e.g. incarceration, probation)
- How does bias and stigma affect those with SUD and their recovery?
- What are promising proposals for Medicaid to consider that would require a policy change at the Federal level?

APPENDIX B- COMMUNITY INPUT

I. FORUMS

Jackson County Healthy Communities Coalition- Behavioral Health Action Team

June 9, 2020
Note taking by: Fanta Saidou, Angie Bailey & Eric Wiedenman

TREATMENT INITIATION, RETENTION & RECOVERY

What is working well in Illinois?

- IL Prescription Monitoring Program (PMP)- working well and taking on new meaning. Watching Opioid prescribing and seeing that information. Providers have to check it before a prescription.

What are the biggest challenges/barriers to accessing and initiating evidence-based treatment?

- Transportation to any and all appointments.
- Medicaid reimbursement rates are low and very slow. A lot of people don't see patients due to the reimbursement issues and slow rates. Hesitations to take Medicaid clients due to reimbursement issues (slow rates to reimburse for service). History of reimbursement issues perhaps dissuading younger professionals from seeing Medicaid clients.
- Working with SUD presents a degree of risk. Could be a medical emergency if acute withdraws present…. need to get them in to a medical center fast. Limited impatient beds around here. Availability and affordability are barriers.
- Access, capacity, limited providers that accept Medicaid.

What are the biggest challenges/barriers to retention?

- Staff burnout because of high risk for relapse. Staff possible discouragement when relapse happens. Staff fatigue. Large caseloads.
- Documentation requirements for Medicaid are extreme. Having to balance case load with paperwork is challenging.

What are the biggest challenges/barriers to recovery?

- Provider shortages. Case management becomes really challenging. Limit places people can go. They may have been there and don't want to go back to the same places. They would prefer a different provider…but nowhere different to go.
- The treatment doesn't end even when the treatment is over (patient is sober). Ongoing work through other professionals. Sober but other ongoing stuff can keep going throughout their lifetime.
- Safe recovery houses. Get people into environments where they are not using and can feel safe. Respite from the normal life. Need more recovery houses.

What are gaps in the continuum of care spanning from early intervention and outpatient services to medically monitored intensive inpatients services and medically managed intensive inpatient services?

- We don't really catch people until it starts to dominate their lives. One of the areas we fail the most is after impatient treatment round; they go back to their same dose and can overdose. We should work to detect earlier and follow people a little bit after the impatient treatment.

- Lack of good early intervention service.
- Lack of quality options beyond initial care (maintenance of SUD).

What are the barriers to providing behavioral health care, including SUD treatment, integrated in a primary care setting?

- Not a lot of time in a primary care visit to deliver that kind of care. Lack of time for PCP to address in a substantive way.
- Looking at the things that need to be done and putting that back on lower skills personnel. Allowing other professionals to complete test, allowing PCP more time for other issues (SUD). Having more mental health and behavioral health staff integrated into the primary care system.
- Screening test done but very quick. Training the providers better across the board- the screening tools are being used fast as if the person is expected to respond "no". Train how the question is asked, take time to ask….

What opportunities should Illinois Medicaid pursue to improve treatment initiation, retention, and recovery?

- Could there be an opportunity to have CMS reimburse for a lump of patients at a time so that providers aren't being pushed away from taking the patients? (Lump sum every quarter, 6 months, a year)
- Anything to incentivize providers to take on Medicaid SUD clients would be beneficial.

<u>SUPPORTIVE SERVICES</u>

What are the essential supportive services and what is their capacity in Illinois for those with SUD?

- No comments.

What is working well in Illinois?

- No comments.

What are the biggest challenges/barriers?

- Frequency of visits. Patient may or may not be ready. Be able to compensate for that.
- Internal motivation. So many people are considering change but are conflicted internally to take that necessary step. Systemic stuff in place need to be there quickly for the clients as soon as they are ready.
- Recovery support specialists.
- Lack of support groups in the area.
    - Lack of availability.
    - Can't get to them – too far away.
- Transportation
- Peer recovery specialists

What should Illinois Medicaid do to foster access to supportive services?

- If we can fund transportation.
- Funding Peer recovery specialists. Missouri is doing it well – using this model.

HARM REDUCTION & HEALTH PROMOTION

What is the role of harm reduction and health promotion in treatment of SUD?

- Health promotion and health education plays a large role in harm reduction.
- Lots of work being done in Southern Illinois through health departments, local hospitals.
- Social Norming messaging
- Designated Driver Program – free nonalcoholic drinks
- Needle Exchanges
- Medication – drug take back days, drop off sites
- Need more people to be aware of the helpline. Early intervention. If someone has an episode, call the helpline, the helpline can get them the information they need
- Naloxone – give out

How might Illinois Medicaid more fully support overdose prevention and harm reduction for Medicaid beneficiaries?

- No comments.

What more can we do in terms of early intervention?

- No comments.

PAYMENT ISSUES

How has the current reimbursement model affected treatment?

How might alternative models of payment for care help facilitate improved access to care for Medicaid beneficiaries?

- Serving certain number of patients…provide a flat fee.

SPECIAL POPULATIONS

Do you have any specific concerns regarding special populations?

- Students transitioning from student health insurance after graduation. No longer able to access university services, difficult to be paired with community services.

POLICY & SOCIETAL BARRIERS

How does racism and discrimination affect those with SUD and their recovery?

- Minority groups and discrimination in Health Care, structural racism…somethings are just built into the system for minority populations.…advancing health equity.
- Frequent flyers…maintaining the speed of helping them regardless of their relapse counts.

How does bias and stigma affect those with SUD and their recovery?

- Bias in diagnosis of various populations that can end up harming people. The way we diagnose, availability of services.

- The way we view SUD broadly. The forgotten truth that not all individuals pick up to abuse. We are making strides to eliminate that…but more work needs to be done.
- Movement from coast to coast to try to get prescribing and x-waivers eliminated….. ??

What are promising proposals for Medicaid to consider that would require a policy change at the Federal level?

- Reimbursement issues should better be addressed.
- Invest in the types of treatments that already work…. are they readily available?
- Making access to the current effective treatments (readily available). Complex, can't approach at one angle. Systemic way of intervention should be used more.

Any additional comments or feedback about other ways to improve SUD care and treatment for Medicaid enrollees.

- No additional comments were made.

Centerstone

June 15, 2020
Note taking by: Fanta Saidou and Angie Bailey

TREATMENT INITIATION, RETENTION & RECOVERY

What is working well in Illinois?

- Big grant
- More grant funding available for SUD treatment
- More collaborations with community.
- More community meetings to be able to attend to discuss barriers and how to eliminate them.

What are the biggest challenges/barriers to accessing and initiating evidence-based treatment?

- Hard to attract people with skills to do the tasks. Want to attract good candidates for jobs/hard to hire higher quality.
- Reimbursement for services is so low. Payment system/reimbursement.
- Engagement efforts
- Huge administrative burden. If without license, you can't.
- We can't provide community services (outside of our building. Huge barrier to access). Can't provide video services outside of building.
- Having a mobile clinic would be amazing – with reimbursement.
- Community piece is really big.

What are the biggest challenges/barriers to retention?

- Transportation barrier in Southern Illinois. Transportation is very difficult.
- Money and additional training. With reimbursement rate, it's hard to train people the trainings they need.
- Referrals in the system of care – limited number of higher levels of care. The quicker we can get people into the next level, the better.
- Barriers to higher level care. Lack of care/referrals.
- More resources available/referrals.
- Need more warm handoff referrals.
- More facilities open to take Medicaid.

What are the biggest challenges/barriers to recovery?

- Referral process/ hand off
- If we are able to provide more community-based services, we would do better. If you can go to them.
- Need more community-based services.
- Allow providers to go out into the community – would help with engagement.
- When people leave treatment, limited funding available for sober living. Models to be re-looked and adapted. People can actually have a chance at rebuilding their lives. Burned bridges. Revolving treatment/revolving door.
- Need more sober living facilities in Illinois create recovery supportive housing (allows to change, people, places, and things).

What are gaps in the continuum of care spanning from early intervention and outpatient services to medically monitored intensive inpatients services and medically managed intensive inpatient services?

- If someone does need residential treatment, it's so hard to find the transportation. 4-5 hours to Chicago or something. Using a bus…. they need your help when they get there. You do not want them on a bus alone since they are in a vulnerable place.
- Support when they get out.
- Lack of options (availability, waitlist).
- Prevention- we have a substance use prevention grant/program but not big enough to serve all school.
- Where can people go…. "People face revolving door….."
- Evidence based curriculums are being utilized. I wish there is more funding for that.
- Medically managed program…when they get out…. they go back to their reality and revolving doors
- Start education early. Kids need to understand that coping is not just about alcohol or drugs. Need coping strategies early not just alcohol and drugs. Teach people that it is an issue. Learn alternative coping strategies.
- If in the community more, we can be going to these homes and working with the families more.
- Heartbreaking calls - family member is talking about a loved one who is clearly going down the wrong path, they may not be ready for treatment, and the family member wants us to do something. Helping those family members as well. That's maybe a part of the process of going out in the community and providing education and support.

What are the barriers to providing behavioral health care, including SUD treatment, integrated in a primary care setting?

- Bifurcated funding system, mental health, medical, SUD treatment…how do you treat someone holistically? It's a huge burden. Does not break down the barriers for the client. Funding streams do not allow holistic care.
- It is hard for the client when there are so many loopholes…. many different appointments, very cumbersome for appointment.
- If we can have funding to pay for primary care physicians or mid-level providers to conduct assessments for the clients, that would help.
- Not a lot of people that does MAT. Having video and having mid-level providers to do some of the work. We shouldn't have to always ask for exceptions. Rules should be re-looked at/ need to be modernized.
- SUDs an issue have to add additional counselors due to funding.
- If someone builds a relationship with someone, then you are adding more people in….
- It's difficult to tell them that they need to make various types of appointments. They already have challenges of their own…. their body and mind….when we ask them to take on making appointments, we lose a lot of them.

What opportunities should Illinois Medicaid pursue to improve treatment initiation, retention, and recovery?

- A better, easier continuum of care
- More acceptance of MAT. Makes a big difference. Stigma attached to it. Reduced stigma.
- System of Care Grant – SUD treatment could model this.

- System of care – family/resource developer for those w/SUDs. More funding for peers.

SUPPORTIVE SERVICES

What are the essential supportive services and what is their capacity in Illinois for those with SUD?

- Too little. You cannot get treatment when you need it. You cannot find housing appropriate to go back into after treatment.
- Capacity is too little.
- Difficult
- Not enough/many barriers.
- We have to help people meet their basic needs. Live, eat…The rest of it comes after that. We aren't even meeting their basic needs (SDOH).
- The grant that we have for the MAT clinic in Marion
- COVID situation has allowed us to do stuff on video.
- Transportation supportive services needed.

What is working well in Illinois?

- Grant MAT, allow peers
- Video visits peer

What are the biggest challenges/barriers?

- No comments.

What should Illinois Medicaid do to foster access to supportive services?

- Funding for SUD – they need to change it…they should look at states that do it well and emulate them. State of Texas (near San Antonio – Brexner??)
- Funding stream.
- Work with judicial system and law enforcement, community
- Will pay for somewhere Jail vs. SUD treatment

HARM REDUCTION & HEALTH PROMOTION

What is the role of harm reduction and health promotion in treatment of SUD?

- We don't really talk about it very much. Except maybe with Methadone.
- Don't really see it being implemented well in Illinois.
- We had a guy that was working with Hepatitis and educating them once a week. Not sure if they defunded or what happened. There was no needle exchange. Education and overall wellness and things associated with that. We don't do it. I don't understand why. I think it would be beneficial. FQHCs was funding that.
- There is such a big focus on abstinence. We have to have a whole range of options. We really need a system that has more than abstinence to it.
- How do you keep healthy? Need a continuum of abstinence vs. harm reduction/MAT.
- Education with stigma around it. Educate the community and providers re: importance.

- Need more education & overall wellness.

How might Illinois Medicaid more fully support overdose prevention and harm reduction for Medicaid beneficiaries?

- Try to do something innovative.
- Increase access. Reduce barrier of not only having service but also travel distance.
- Make it easier for individuals when they are ready. Have a seamless way to help.
- Training.
- Learning Collaborative.
- Paying for items.
- Hawaii – detox at home with support via video.
- Supportive warm hand off when you cannot help them where you are. Make it easy for the client.
- Increase access to overdose prevention or harm reduction. Reduce barriers of distance/location.

What more can we do in terms of early intervention?

- Early intervention and prevention in schools. Make screening for SUD the norm in primary care.
- Integrating the system. Make PCP do screen. Make screen not so stigmatized.
- Early intervention to prevention or treatment?
- Developing other coping mechanisms. Educating how the media affects them in encouraging use. This is critical.
- Curriculum they use – educate young people on how the media seduces them.
- The State is doing well- young people can seek treatment without parent knowledge. This is a positive thing. Some kids might have parent who use and they themselves want treatment.
- Need increasing drug courts- work with providers.
- Have behavioral health in schools. Libertyville IL – SEL education in elementary school.
- Social and Emotional Educator position – helpful to have.
- School district reached out that wants to hire one of their counselors to do that position. It's important to have one in every school.

<u>PAYMENT ISSUES</u>

How has the current reimbursement model affected treatment?

- Can't keep staff in those roles. You can't pay them – they want to make more money.
- MAT to those incarcerated prior to exiting.
- More access to the transitional type housing. (120 days)
- Recovery - Permanent Supportive Housing
- Some states and places do well. Lack of Medicaid for those in jail/prison – lack of meds (have not had meds while there).
- Have to apply for a medical card for them…. can take time to set it all up.

How might alternative models of payment for care help facilitate improved access to care for Medicaid beneficiaries?

- Washington State has this pay for performance model (BH issues).
- More comparable mental health reimbursement rates.
- Various other States are doing a great job.

SPECIAL POPULATIONS

Do you have any specific concerns regarding special populations?

- Incarcerated individuals.
- Agree with all the e.g. listed.
- Concerns with all of the population.

POLICY & SOCIETAL BARRIERS

How does racism and discrimination affect those with SUD and their recovery?

- Most of our clients receiving these services are white. Majority of people of color are receiving community-based services.
- Black population are not coming in, not reflective of population.
- We need to explore this as an organization. I think it's a system wide issue. We should explore.
- Not reaching them (AA and other people of color)

How does bias and stigma affect those with SUD and their recovery?

- Tempted to hid relapse.
- Hide issue. Struggling with relapse.
- Not seeing many in Hispanic population. Not English speaking. Not legal.
- Cultural, financial, fear if they are not a legal resident here, not speaking English,
- LGBTQI – train staff about cultural acceptance. State need to change their forms. State forms don't have anything for mixed race.

What are promising proposals for Medicaid to consider that would require a policy change at the Federal level?

- Remarkable adaptation to Methadone due to COVID.
- Methadone with video visits – important.
- Telehealth video for SUD in rural areas. Adding video-based services for SUD is a must
- Rural communities should look at…...?
- Community based part will make more impact. Add community based efforts, go out and look for people.
- Clients with Medicare + Medicaid – LPCP billing – difficult to get people into care.
- Have lots of money for Opioid. Not other substances.
- FQHCs can only pay SWs.
- "SW are like unicorns, hard to find"

Any additional comments or feedback about other ways to improve SUD care and treatment for Medicaid enrollees.

- No additional comments.

DREAM - Franklin/Williamson County Substance Misuse Coalition

June 23, 2020
Note taking by: Fanta Saidou and Angie Bailey

TREATMENT INITIATION, RETENTION & RECOVERY

What is working well in Illinois?

- No comments.

What are the biggest challenges/barriers to accessing and initiating evidence-based treatment?

- MCOs are picking and choosing what medications they will allow for detox and which ones they won't pay for. Even in the residential portion - some are given 14 and 21 days. Limit to 14 – 21 days. This is just the beginning of them getting any type of knowledge.
- Difficulty with more MCOs than others.
- Transportation - coordination doesn't match up to appropriate appointment times. Hot or cold on buses. Getting individuals to treatment, and is not convenient.
- Waitlists. "I'm on the list at several places…but nobody has called me. I hear that one quite a bit". Lack of facilities and places for people to go.

What are the biggest challenges/barriers to retention?

- No comments.

What are the biggest challenges/barriers to recovery?

- Not enough in the community to do. Such as art. No funding or programs for art.
- Lack of job opportunities.
- Hard to get into housing. Lack of housing opportunities.
- When they get into detox, they are in for 3-4 days, and then they are right back to using and, on the streets, again. Not enough beds and places to go for more care.
- Summertime has brought out the drugs and more people using.

What are gaps in the continuum of care spanning from early intervention and outpatient services to medically monitored intensive inpatients services and medically managed intensive inpatient services?

- The lack of facilities throughout So IL from beginning to end…all the way through that process.
- I don't see the DARE program anymore…. we need more things like that. We need to get something going that educates in schools.
- More education and prevention in So IL and in schools.
- After school programming. That is the most vulnerable time. When not in school and not around adults, they have more free time on their hands.

What are the barriers to providing behavioral health care, including SUD treatment, integrated in a primary care setting?

- No comments.

What opportunities should Illinois Medicaid pursue to improve treatment initiation, retention, and recovery?

- Get more involved with other programs. More community collaborations.

- It would be nice to going back to treating the person…….
- “Do away with the time limits in regards how long they will pay for treatment.”
- Barriers of the MCO paperwork.
- Transportation

SUPPORTIVE SERVICES

What are the essential supportive services and what is their capacity in Illinois for those with SUD?

- Transportation barriers continue.
- Housing
- Not enough job opportunities
- More structured and safer/sober houses for people coming out of rehab. Both men and women.
- Transitional living options.
- Job training options.
- Life coach type programs.
- Provide services while incarcerated.

What is working well in Illinois?

- No comments.

What are the biggest challenges/barriers?

- More transitional Housing
- Life type coach programs
- County jails have no programs at all. This is also a prime time to reach out to these individuals.
- No programs for those getting out of jail.
- “Lack of programs, lack of availability with openings in the programs that are available. Lack of assistance working through barriers.”
- Lack of consistency of care between the systems (providers). Educational component, MH, medical capability, what they have access to.
- MAT services in jails – SHS.
- People detoxing in jails.

What should Illinois Medicaid do to foster access to supportive services?

HARM REDUCTION & HEALTH PROMOTION

What is the role of harm reduction and health promotion in treatment of SUD?

- Support medication drop off Locations. Various locations available. (12 locations)
- Promote more. Need in all counties. Educate more.
- Need to continue drop – off locations and to promote more.
- Need more physicians to promote medication drop offs more.
- Another needle exchange. Community action place – harm reduction – lower 18 counties – STD testing/needle. Exchange etc.
- Working w/ETHIC.
- Mobile syringe service by delivery (SIU SOM)
- Naloxone Trainings. Homeless shelter, how are we reaching them?

How might Illinois Medicaid more fully support overdoes prevention and harm reduction for Medicaid beneficiaries?

- No comments.

What more can we do in terms of early intervention?

- No comments.

PAYMENT ISSUES

How has the current reimbursement model affected treatment?

- Reimbursement rates are several months behind on payments.
- MCOs that are not paying in appropriate manner…."let us know of any specific ones that are not…so we can see what we can do about it"

How might alternative models of payment for care help facilitate improved access to care for Medicaid beneficiaries?

- No comments.

SPECIAL POPULATIONS

Do you have any specific concerns regarding special populations?

- Incarcerated individuals (MAT, detox)
- Special concerns

POLICY & SOCIETAL BARRIERS

How does racism and discrimination affect those with SUD and their recovery?

- No comments.

How does bias and stigma affect those with SUD and their recovery?

- Stigma behind even having an addiction is a problem, especially for those with jobs who are functioning.
- Some are able to handle what needed to be handled.
- Some hide it very well seeing physician – hiding from others.
- Vicious cycle

What are promising proposals for Medicaid to consider that would require a policy change at the Federal level?

- No comments.

Any additional comments or feedback about other ways to improve SUD care and treatment for Medicaid enrollees.

Fulton County ROSC Council

Listening Session

Coordinated By: Josh Crist, SIU Medicine
Contact Person: Josh Crist
Phone Number: 504-296-8253
Email Address: jcrist56@siumed.edu
Date Held:6/19/2020
Time Held: 1:00-1:50PM
Total Number in Attendance: 12

Participants in this discussion are members of the Fulton County ROSC Council, representing Fulton, McDonough, Peoria, and Tazewell Counties. Members of this group hold roles in behavioral health services, Overdose Education Naloxone Distribution, Regional Office of Education, church leadership, and higher education. Very few participants completed the demographic survey, despite multiple requests; you can find the short list in the spreadsheet entitled “19June2020 Fulton Co. ROSC” in the All Listening Session Roster file.

Barriers

- Transportation is a significant barrier, even though there is some Medicaid coverage for transport
- Sometimes the intake threshold is a barrier – if a person is not intoxicated when they present, then they are not acute enough to gain access to inpatient services
- People in SUD treatment reach fatigue of the “Medicaid hoop-jumping” □ too many “hoops” □ in need of streamlining

  Improving Access
- Telehealth – although services are expanding, access to technologies remain a limiting factor for some
- Telehealth – rapid coronavirus adaptation has demonstrated feasibility of telehealth for SUD services
- Suggestion that, between improving transportation systems vs. high speed internet systems, high speed system improvement will render greater gains
- For detoxed people being released from jail, Medicaid status is “detoxed” and therefore not eligible for residential services, yet they still need the in-patient support
    - Lower threshold of Medicaid coverage for residential treatment

Fulton County Social Service Committee

Listening Session

Coordinated By: Josh Crist, SIU Medicine

Phone Number: 504-296-8253

Email Address: jcrist56@siumed.edu

Date Held:6/24/2020

Time Held: 12:00-1:00PM

Total Number in Attendance: 18

Participants in this discussion are members of the Fulton County Social Service Committee. Members of this group hold roles in the county health department, behavioral health services, medicine, the Regional Office of Education, church leadership, higher education, and others. Many of the participants completed the demographic survey; you can find the list in the spreadsheet entitled "24June2020 Fulton SSC" in the All Listening Session Roster file.

Barriers

- No available Medicaid-eligible beds when inpatient crisis needs arise
- No inpatient beds in Macomb; few beds available, in Canton
- Transition housing is lacking
- Transportation remains a challenge
- An awareness/acknowledgement of the extent of the problem remains deficient – some community members are reluctant to accept that there is a problem; "not in my backyard"

Improving Access

- Medicaid does not cover sustained, sufficient time for recovery. Brain science evidence suggests that healing often takes much longer than the window of Medicaid coverage. This is a chronic condition that calls for sustained Medicaid support for the patient.
- Expand the scope of services/supports reimbursed, so that agencies are better suited to provide the sustained community-based stabilization supports that a person in recovery most likely needs. This includes reimbursing for the administrative burden on the agencies and the personnel hours involved.

Illinois Coalition for Educating At-Risk Youth

Listening Session

Coordinated By: Josh Crist, SIU Medicine

Phone Number: 504-296-8253

Email Address: jcrist56@siumed.edu

Date Held: 6/18/2020

Time Held: 10:00-10:20AM

Total Number in Attendance: 24

Participants in this discussion represented the education community. The group, Illinois Coalition for Educating At-Risk Youth, is comprised of teachers, school administrators, school social workers/psychologists, and Regional Office of Education administrators, and other staff, representing schools and districts from across Illinois. Very few participants completed the demographic survey, despite multiple requests; you can find the short list in the spreadsheet entitled “18June2020 ICEARY Board Mtgt” in the All Listening Session Roster file.

Barriers

- Desire (appetite) of student or parent to initiate treatment/seek help
- Lack of an available Medicaid-eligible bed at the precise moment when a person needs detox/inpatient treatment
- Scope and spectrum of services available – many rural localities do not offer all levels/types of treatment and recovery support services.
- The character and types of factors vary widely between urban and rural localities.
- Transportation remains a challenge

Improving Access

- Because of the disparity between population-dense (urban, metro) and population-sparse (rural) availability of services, a new model is needed. A member made a simple suggestion, “we should bring services to the people, rather than people to the services.” Implicit in this comment is the pervasive transportation issue faced by rural dwellers.
- Telehealth eligibility and coverage for Medicaid expanded in May – keep this coverage and expand it
- A more sensitive, person-centered philosophy should guide progress measurement – recovery is not linear, it’s cyclic and relapse doesn’t necessarily constitute a failure

Kendall County Health Department Forum

3/9/19, Yorkville IL (at Kendall Cty HD)
Note taker: Juleigh Nowinski Konchak
Facilitator: Christie Edwards
Attendance: 10, including Kendall County health department director Dr. Amaal Tokars

Intro- Amaal; no need to disclose anything not want to; purpose- HFS – what is working, what are hardships for receiving and providing services.

Amaal re: Kendall health department. Person-based services, and population-based services, policy-based services. Lots of individual services- energy assistance, BH services, nutrition, lead, family case management. A health and human services organization. Primarily serves kendall (125,000 individuals)- smallest metropolitan health department in IL; staff of 50

JNK- who I am, the role CCH is playing in helping the state collect information re: what is working/not working. 18 month planning, HFS hopes to apply for implementation funding

Christie- introduce self, will facilitate questions. Introduce written input option during session.

Main question- how we can improve SUD/OUD care for Medicaid beneficiaries in IL.

Explain how treatment was first initiated:

- had been using for a while, faced legal consequences.
- losing her kids as a reason to enter treatment
- hard to find places that would accept public aid for insurance.
- first time, was on medicaid. Actually had less hoops to jump through with medicaid than has now when has private insurance. Now needs a referral from primary care. In past with medicaid, just had to get on the waiting list and then got in.
    - Went to gateway lake villa, only paid $5/day
- thought would go to florida on a vacation for SUD care. Went to haymarket – staff was amazing.
- waiting list for access to inpatient is very hard.
    - First time, waited 2 weeks with state insurance.
    - With private insurance, 10 day wait
    - 3-4 day wait with Medicaid
    - Waiting period- discouraged him at times. Sitting there waiting, using
- Residential programs have limited beds for public and private. This can be a barrier.
- was hard to enter rehab- had a 3yo, was in process of moving. Was really hard for her husband
- A design where aftercare and recovery are available on the same campus as residential would be really helpful. Some folks want the stepdown available. “30 days and out is not sufficient for some.”
- Some providers not accepting Medicaid at all is a problem. Residential treatment
- Drug court was taking care of residential for her. For others, getting turned away from (gateway and haymarket)- b/c insurance would only pay for a certain amount of days.
    - Two women commented they wouldn’t have navigated it on their own; they had heard nightmare stories, none of it ended up being true. Had heard from a step brother about horror stories

- Counselor perspective- trying to help someone on a Friday that is local on Medicaid is hard. Haymarket has helped a lot and there is a relationship there that has been great
- Tx provider- she went and watched how people were spoken to, what security interacted with. Then she got to ask all the questions. They do outpatient, but needed access to inpatient. Wanted to be able to get people right in. If don't know the places they are telling about, that's a problem. Seeing this was really important. Had to as a service provider see herself what was out there.
    - Work with the patient to see how can get them there. Haymarket will pick them up from train if needed.

Retention;

- Programs with kids- the haymarket program for kids to stay is great. Not everyone has family members who can take care of their kids. Need access to family-based programs.

Recovery:

- Only 28 or 30 days and then going out. "a lot of it falls on the person themselves" - if been in a lifestyle for years, its not enough. Going right back into the damage "you caused", not yet ready. Heard about 90 days in the past.
- Funded-ness of recovery is similar to how we treat mourning. In 30 days, you are supposed to be ready. If this is a lifestyle you have struggled with……residential needs to be longer for some. And recovery services need to be in the community and available. The recovery process and after-care services.
- The Sangamon house- she really liked the staff sending the message, that "they had been just like me, in my shoes"
    - They are working constantly to help get people into the services they need. They are really passionate about what they are doing
- Had good access to after care services b/c of drug court.
- The weekly requirements gave her accountability. She went to treatment in the middle of drug court career. Got immediate access to a counselor, had meetings had to attend. "wasn't just thrown out into the world."
- Sometimes when use drugs, use with loved ones. Couldn't find any place that would take her and her husband both. And they wanted to enter treatment together.
- Drug court- set up with outpatient, meetings. Had to be in school or hold employment. (No comments from anyone about accessing services outside of drug court.)

Supportive services:

Challenges:

- Home environment
    - Hard to come when the people you are living with are not getting better
- Transportation
- Socioeconomic duress and challenges for individuals
- Affordable housing
- Getting employment, especially if have a record
    - Also getting something worthy. Can get a fast food job but can't move up b/c then need a background check to enter management. Some have theft in background.
    - Violent charges, domestic violence charges- people don't want to hire you
- No one is aware of services to help with the employment challenges

- There is a local workforce opportunities, one stop shop. There is one in Kankakee and one in Aurora. They do what they can to try and match those looking for employment and those looking to employ. Sometimes there is consideration of CJ records. "maybe this needs to be better advertised"
- She went up for management at a local fast food chain. Both her and other applicant had a record, but his was just drugs and hers was drugs and domestic violence. He was picked. It used to be just felons, now they are picking and choosing.
- Transportation- most of us didn't have a license b/c of legal issues. How are we going to get to outpatient if we don't have a ride
- There is Kendall area transit, but need to schedule this a week in advance. Priority is given to
    - There is no mass transit. Train stops at Kane county.
    - It is an appointment based, kind of like a cab except need to call a week in advance. Helpful to some, but doesn't replace mass transit. Do have to pay, but reasonable. $3/ride in the county. $5 out of county. The health department gives coupons.
        - Ie- if get a call and have an interview the next day, this is not an option
            - This makes it frustrating
    - For woman in drug court, feels would have been in big trouble if grandma couldn't take her
    - Can cancel at last minute if an appt comes up that trumps their need

What are the essential supportive services? What is the capacity?

- Mental health needs
    - The individual counseling helped her. There isn't much focus on the mental health in SUD tx. Felt like for her it was put in back burner. She too wasn't focusing on it.
    - He was in a co-occurring unit in residential treatment recently. 35 days. But barely started to scratch the surface on those things.
        - Feels drug court is good at addressing both.
- Drug court is an option. There are choices. "we chose drug court" (over prison…)
- Seeing the psychiatrist here at health department is really helpful. Plus the individual and group counseling. Counseling weekly, psychiatry every 3 months
- It is critical from a structural perspective that mental health services be available at the same time as SUD services. Having services embedded in the location the patient chooses
- - the health department does treatment services in the jail- mental health and addiction treatment. Also energy assistance, WIC – these are other ways to touch individuals in the community who need other resources but may not be the center focus for them right now
- CJ representative- getting services running in the jail was great, but is just the tip of the iceberg. It is once getting out, the continued partnership to continue to get the treatment that they need. Transportation, family, this all ties together. In the jail it is a one stop shop. Once outside, it's the partnership that is needed and that can break down. Travel, employment, health services.
    - Some of the feedback received from individuals who received tx in jail- it was a start for them.
    - We don't control how long people are there; the judiciary does that. But we can start it, help set them up with who to call when get out. Without this it becomes cyclical
- Re: readiness for tx- we have individuals that call and are looking for a place to go. Really important to help them all the way through, not just give them a number to call. We need to do a lot of the legwork. "its better for us to hit the brick walls (than the patient)"
    - Sometimes individuals are not ready for tx but a loved one hopes they would be. They (treatment provider) welcome in the loved one so everyone can help each other. Need to

help people move along readiness to change. And as soon as they are ready, need to help them immediately and help them prepare.

- Getting birth certificate, driver's license- they have not run into this but could help with it. Patient commented she heard more about it in Chicago.
- Accessing insurance coverage- we (health department) take everyone in including those without insurance. When individuals don't have insurance, they work to try and help them set it up.
- Other needs?
    - Financial classes. She wracked up some debt, intimidating to think about where to get out of it.
    - She is still paying off debt from her first arrest
    - They have a 2
    - opportunity program in jail that offers job placement. It's a guy who served 17 years in federal penitentiary. He knew what it was like to not be able to get gas or power in his name, get a bank account, driver's license. He developed a program to help get inmates through that. But on the outside, not many places to go to help with this in Kendall. Health and human services tries to help, but so many cogs in the wheel that aren't there.
    - The community college- sheriff partnered with them for inmates in the jail, but that's not where we want it. We want it in the community. We don't see these opportunities. Not sure if there are private funding or grant opportunities to do anything on this or even a contract. Its not enough to say there are websites, an actual contact who can steer you in the right direction or take the journey with you would make it much easier.
    - Counselor- when trying to help people navigate HFS, usually can't get through on a phone call. If problems with insurance or link card, often have to take a day off of work to solve an issue.
    - They are not accessible in a meaningful way. ("I can't believe it took us this long to say this part. This is so important.")
        - "they are inaccessible….by design"
        - There used to be a local office to set up link etc, but it has been shut down. Now traveling somewhere (Kane) and sitting there for 5 hours.
    - Had a friend who got kicked off link and insurance due to having a cash pay job.

Housing

- Lots of places around here will not rent to you if you have a felony.
- 2+ years long waiting list for low income housing in Plano. But you can't put in an application if have a background. Have to have a family member who will do this for you, and many of us have burned bridges with our family. Even if have one family member, it's a burden to ask that person to do so much
- Affordable housing is so limited in the county. You fill out an application, and the list is SO long….and they aren't picking someone with 8 felonies. Not sure how to correct this.
- Purchased a home with her BF, she didn't add her name until she was going for expungement.

Health promotion and harm reduction:

- Medication assistance , is it available- yes, it is.
    - Vivitrol is readily available.
    - Methadone not readily available in Kendall. Thinks is available in kane county.

    - Buprenorphine is available from the health department and from other providers. (NOTE: this was said in the meeting but then clarified after that buprenorphine is NOT offered by the health department)
- Harm reduction role- “making sure people stay alive long enough to get the help they need”
- Preventing recidivism, helping you become a contributing member of society
- Meeting people where they are as navigating through the treatment process
    - “I wouldn’t be alive if I didn’t get picked up and put in jail”
        - Was on drug court, broke a bunch of rules, misbehaved
    - Had a friend pass away b/c didn’t have $ for methadone
    - Drug court falls in this bucket
    - Family systems environment.
    - Not having any qualification for coming into treatment. No eligibility requirements- an enormous piece of harm reduction.
    - Also an approach to treatment that recognizes the individuals ability to see, name, state where they are. This has to be a center piece.
        - Gave an example of someone checking in on someone, bringing them daily to a methadone clinic, until can get them on an airplane. From a show on viceland. “very cool to see”- I wish this would be available to everyone when they are in between, when they’ve made the decision (to go to tx) but have a wait
    - In prison, would call it the halfway house. For drug addiction, he doesn’t see that there. He doesn’t see nonprofits to help. Ie- help with transportation.
    - Assertive care coordination - if have someone having a hard time in the community, the are able to go and be there with them. With them, engage them, assist with the process. Work to get them the services,
        - Looking to establish a relationship, so if its not today its another time.
        - A lot of this comes from law enforcement, but also from concerned individuals I the community.
    - He has heard examples of being able to go into a detox until can get into treatment- linden oaks? Other option is mercy for psych
    - There probably are more services available, but don’t know about it.
    - Needed to change they way she thought- CBT was available at the health department and was really helpful to her. “this is one of the most important things took from health department”
        - Change the way you think, changes the way you live”
    - Comes from a family with “both parents are addicts”- knew nothing else but this.
        - Now, life is boring, but its so peaceful
        - 28 days wasn’t enough. I had done IOP many times. And counseling. It wasn’t til was “forced to do residential that I got the message”
    - Kendall is committed that anyone who is coming out of residential or jail can get an appt in 24 business hours. Very hard to do this. Also responsive to any emergent issues. But outside of that, there is not enough staff so there are waitlists. People are waiting. 3-4 weeks.
    - Medications:
        - We are not a med pickup. They get therapy or psychiatric if need it. This is part of our design.
        - No wait for naltrexone- “people get it at the right time”- feels often people wait to get into treatment- get their appts scheduled. “they don’t come here for medication, they come for treatment”- they get it if it’s necessary.

- Thinks there is methadone widely available for Medicaid. One patient commented had 2 day wait.
- No wait for buprenorphine. Same as naltrexone. (per counselor)

Anything for early intervention?

- Its an ongoing cycle. Going to depend on the person. Often kids see the lifestyle with their parents.
- Maybe counseling for children of addicts
    - One patient feels that would have benefited her more during her youth than anything else. In her situation, mom wasn't involved or engaged. Grandma would bail her out of jail. Feels someone talking to her mom about how to better parent would have also been helpful. Dad was homeless, felt police would go and check on her. Wishes mom had been forced to do youth education classes with her.
- Some mandated parental classes
- Another example of mom who was a great mom but she was just "lost" as a kid
- Maybe a juvenile mental health or drug court program- instead of ankle monitor or being thrown into juvy would have been helpful.
    - Would say mandated for juvenile.
- As a youth, if her mom didn't feel like driving her, it wasn't happening..and she was going back to court for a violation, back to JJDC?
- The parent needs the education. Wishes had the chance to have a conversation with mom in a controlled environment with a counselor. Used this as a tool with granddaughter- educating the grandma in a clinic appt seems to be helpful. So maybe having done that as a kid would have been helpful.
- Time between onset of symptoms and diagnosis- lots of self-medicating before received a diagnosis. Didn't know why wanted to alter,but knew that she did.
    - Similar feeling. If something had been caught t at younger age, might have helped
    - Had a misdiagnosis for 12 years. Wasn't until saw psychiatrist through drug court. For her it was the opposite- had been on 30+ antipsychotics by time 17 years old. Too much all the time. She was in an out of mental hospitals at age 10. She just wanted to help herself sit still. Wasn't craving the drug.
- Thinks most of the suicides in the county are individuals who never received MH tx. Not the kinds of diagnoses the state would recognize. Not schizophrenia, schiozoeffective, bipolar, or depression. But for many people anxiety is debilitating and leads to doorstep of depression,
    - The definition of mental health for state programs is limiting. So here (at health department), no restriction. No eligibility criteria. With an eligibility criteria, can't have early intervention. But of course not everyone knows this. But no need for a formal diagnosis . most of the young people are coming here for anxiety. Want to engage them at that time, before or instead of developing another major diagnosis,
    - If someone is feeling depression, they should be able to get help. And if they need medication, they should be able to get that.

Payment issues:

- Lots of issues, loophole, that make it hard for treatment providers to survive

If people can't get a call back to understand what their insurance status is in the first place, insurance coverage is sort of a moot point. Shouldn't need to give up their day and sit all day. "it is not run professionally" (talking about Medicaid office)

-if someone is dropped (from Medicaid coverage) and has to restart, need to go sit there at 8am. Now nearest office is 20 miles away in Aurora.

Not return calls, not give appts,

- Received a letter that had ana ppt for reinstatement- got the letter 2 weeks after the appointment

- One woman googled and found a back-office person who was willing to help get the message to the right person. Felt really had to be assertive to get through.
- "it's a cultural problem with the organization"

(I asked if anyone has called the hotline and their experience)
No one has used the state hotline- told "not to bother"

-told it is a dead end, all smoke and mirrors, not access anything
- counselor hasn't used it b/c feels it will just lead to dead ends.

-she called it a few times. Feels it was ran well at first by haymarket , but now feels it is like calling a phone book. In past, could call and they would work you into treatment. Now its helpful but not what it used to be; now you get a phone number. Now ran by a different organization who doesn't have the expertise.

Great staff at treatment programs (haymarket) but not enough of them.

Special populations
-socioeconomic duress is what creates barriers.
-wage job workers- hard to make a choice to go to inpatient if going to lose job. "no FMLA for those kinds of jobs"

Policy and social barriers:
-If can't have continuous access to insurer, hard to sustain all kinds of health treatment.
-family systems matter- hard to sustain tx if in same environment.

The only thing that worked for me was that we just purchased a new house and was not going to be going back to the old place. In past, had to go back home so could be near oldest child who was in custody of the grandma. She needed to be near her to make sure she was safe. This caused her to go "right back to the lion's den"

Leaving Gateway, counselors are helpful to find a halfway house. But if placed in Joliet, Aurora, Addison, that's not feasible with a drug court program here in Kendall. That's going to be a challenge, or for single mother that can't bring her children. There are some out there but not enough. And dad might have the children too. "There's nowhere I know of that will let a man take his kids". What if mom's not around? these services aren't offered at all.

If someone goes into treatment and has an apt, they often lose their apt b/c can't afford to pay for it.

She had several times had thoughts "maybe I should go and get some help" but then thought went away immediately b/c "who is going to watch (my daughter)?" mom unreliable, grandma not there.

The metra stops before Kendall, that's a problem. If got metra, also get pace automatically. Then that's access to more jobs that don't rely on having a car. This would give so much more opportunity for jobs and living situations. There is discussion of metra in Oswego. Hope to see this but not sure when. Has been talk for a while.

How are community stakeholders involved?

- Do a lot of public outreach to help spread the message of the services provided. Large groups
    - County wide interagency council that meets monthly in Yorkville. Sit down with a group of human services providers who span the whole county. Helps minimize redundancies, and help ID any gaps.
    - Work closely with law enforcement. Really committed to community policing, drug and mental health court, DV prevention/response team.
    - Involvement with schools, senior center. Helping spread the word on what is available.
    - Training partners on BH issues
    - Involved with the MH summit of IL; the N IL PH Consortium; Community Behavioral health association

Cook County Jail

- The detox unit is amazing. No other jail has the medical unit to detox like that, or the MH services. Very helpful that has methadone and bup available. The surrounding counties don't have that. "I know its not the jail's fault"
    - Kane county has started it
    - Kendall doesn't have the space for it. But that's why brought in the health dpt to help.
        - Only 12 hours of medical a day; whereas cook has 24 hours
        - In cook, vitals are checked, get meds/imodium etc.
- DuPage county- was in withdrawal from benzo and was held in holding for 8 days. Had a phone wheeled to her door. "this was horrific, barbaric". "I can't begin to express how that makes someone feel" when finally got into gen population, was menstruating and didn't' get offered anything. She begged her uncle who posted $3,000 to get her out. "that's a lot of $ for people who don't have it."
    - "you listen to people scream for 24 hours/day
    - She wasn't going through withdrawal but was forced to stay there.

Thinks emergency rooms could be better prepared to help people right away when they show up for help. When people show up in ED its out of desperation. Having clear direction and options for people from there.

Cultural competence, cultural equity- counselor- we put a lot of this into our training and hiring to make sure our staff is competent. Would like to think people feel this when they come in the door.

"its nice to know people care enough to ask our opinion"

Side conversation at end with health department re: medications: they are not offering buprenorphine, but feel it is available in the community, perhaps with Mathers. Vivitrol is their "clinical choice" and they have great success with it.

Facilitator notes: Christie R. Edwards
Kendall County Health Department Focus Group
– 3/9/19, Yorkville IL (at Kendall Cty HD)

<u>Treatment Barriers, Initiation, Retention & Recovery</u>

- Legal

- Family
- Places that take public aid
- State insurance vs private
- # of beds set aside for private insurance
- transportation/distance
- Aftercare/recovery on same campus
- Don't take Medicaid (residential treatment agencies)
- Family based-treatment
- Helpful staff (able to relate to patient needs)

Health Promotion

- Making sure people stay alive to get help (patient comment)
- Reduce recidivism
- Meeting people were they are
- Drug court
- "In-between" help

Supportive Services

- Drug court - outpatient aftercare
- Treatment in the jail

Supportive Services (Challenges)

- Home (triggers for patients)
- Transportation - no license
- SEC
- Housing (not always available to patients who need treatment)
- Employment/Backgrounds not clean due to drugs
- Financial classes/debt
- Grant funding for educational resources
- Renting is a challenge for those with a drug background

Mental Health Services

- Not a lot of focus for those with SUD
- Individual/group therapy with access to Psych

Special Populations

- SEC duress

Policy & Societal Barrier

- Continuous access to the insurer
- Police training on behavioral health

Southern Illinois Online Community Forum

June 23, 2020
Note taking by: Kitty Juul & Angie Bailey

TREATMENT INITIATION, RETENTION & RECOVERY

What is working well in Illinois?

-

What are the biggest challenges/barriers to accessing and initiating evidence-based treatment?

- Being able to get the service when they have the availability to get it.
- Sometimes it's distance or sometimes it has to do with having an office that has an appointment.
- We have seen an increase in the number of providers over the past couple of years….but caseloads are full or that person may not be able to get to the appointments that are available.
- Treatment limits….patient come to me….I can't take them in…because I don't have enough slots. Then there is going to be a barrier. Coordinating the care can take days.
- Expansion for peer recovery support.

- Patients on MAT sometimes don't really fit into the typical 12 step groups or the neutral health groups….might be helpful to have formal treatment centers that have access to group therapy programs and such that's open to that would be helpful I think.

What are the biggest challenges/barriers to retention?

-

What are the biggest challenges/barriers to recovery?

-

What are gaps in the continuum of care spanning from early intervention and outpatient services to medically monitored intensive inpatients services and medically managed intensive inpatient services?

-

What are the barriers to providing behavioral health care, including SUD treatment, integrated in a primary care setting?

-

What opportunities should Illinois Medicaid pursue to improve treatment initiation, retention, and recovery?

-

SUPPORTIVE SERVICES

What are the essential supportive services and what is their capacity in Illinois for those with SUD?

-

What is working well in Illinois?

-

What are the biggest challenges/barriers?

-

What should Illinois Medicaid do to foster access to supportive services?

-

HARM REDUCTION & HEALTH PROMOTION

What is the role of harm reduction and health promotion in treatment of SUD?

-

How might Illinois Medicaid more fully support overdose prevention and harm reduction for Medicaid beneficiaries?

-

What more can we do in terms of early intervention?

-

PAYMENT ISSUES

How has the current reimbursement model affected treatment?

-

How might alternative models of payment for care help facilitate improved access to care for Medicaid beneficiaries?

-

SPECIAL POPULATIONS

Do you have any specific concerns regarding special populations?

-

POLICY & SOCIETAL BARRIERS

How does racism and discrimination affect those with SUD and their recovery?

-

How does bias and stigma affect those with SUD and their recovery?

-

What are promising proposals for Medicaid to consider that would require a policy change at the Federal level?

-

Any additional comments or feedback about other ways to improve SUD care and treatment for Medicaid enrollees.

PANELISTS

- Angie Bailey – SIH
- Kitty Juul – SIU School of Medicine
- Sherrie Harlow – SIH
- Mona Miller – Centerstone
- Bill McCreery
- Dr. Aaronn Newcomb – SHS
- A'nna Jurich – Gateway

ATTENDEES: 22 total

CHALLENGES

Sherrie

- High demand on limited resources – SIH BG SW tries to set up appointments for Medicaid patients – wait listed.
- Barriers with patient follow through
- Lack of treatment providers, need more providers.

Bill

- Creating issues with pain as 5th vital sign – was mass-produced.
- IL PMP
- Works for IL Helpline (833- 2FINDHELP)

A'nna Jurich

- Outpatient services have gone virtually (Gateway)
- Transportation (to various appointments, managing setting up transportation)
- Limited phone or Wi-Fi – reach out to patients
- Choosing money for transportation vs. food/shelter
- Medicaid expansion
- MC – does not take into effect many of the issues, limits time that can be taken for residential care, limited house, needs nutrition
- Need to connect
- Utilize "alumni program" to help.

Mona Miller – MAT Grant Coordinator

- Methadone – August 2019 (6 days a week)
- Barrier- transportation. Door to door transportation across county lines.
- MAT providers concerned re: liability, stigma
- Lack of providers
- Struggle to get people in/available beds/providers
- Must strike while iron is hot to get them help.
- Services more immediate
- Increased access to providers
- Wide variances in prescribing of medications for MAT (buprenorphine)
- Training for providers.

Dr. Newcomb

- Issue:
- Heavy regulation of MAT
- Limits on providers
- Stigma re:
- No one wants to do MAT due to so many regulations
- Layers + layers of stigma – addiction and treatment
- Hear from providers, patients, etc.
- Weaning patients off, not enough BH treatment
- Transportation.

Comments:

- Getting service when it is needed. Caseloads are full, open appointments today.
- Treatment limits for PCP for MAT.

Alisha Foster – FC Center

- When I think of comprehensive SU care or treatment or just intervention is an expansion for peer recovery supports. Meet the needs of those in our communities when they need help.
- Peer recovery coaches/specialists
- Be able to be reimbursed for the peer recovery service.
- More access to group therapy.
- Ideas you have?
- To improve access to care: Reduce so many steps/intake processes to receive services. We need to look at: what are we asking them to do before they can even step foot into services – through the actual agency? I know there is a lot of community support. Sometimes it can be hard to get people to buy into those community supports if it doesn't align with their ideology.

Leigh Poore – EHD

- Improve access to care: Peer support. "Meet them where they are at".
- Suboxone – out patient.

Mike Tyson - Founder of a Recovering Community Organization.

- Peer recovery support
- Transportation
- How can we form services? What can we do to help you guys and to help people be successful after they complete MAT programs?
    - A lot of the agencies and providers have Monday – Friday set model of hours. We know people have "revelations" outside those hours. Having support services around the clock would be helpful. To be able to begin MAT as they leave the ER with a linkage to someone that has an opening. After hours needs need addressed.

What can we do to help people after/during treatment?

- Help people around the clock "after hours" services, nights & weekends.
- MAT as people leave the ER and link to counseling.

IL Medicaid

- Needs to look at length of care, stays – individualized to program, not using a table with regards to length of stay. What is realistic for that specific individual?
- Some individuals are more successful with longer-term programs. Should be individualized based on what the participant needs and what the team thinks can help the person be more successful.

Medicaid Parityrady ??

NIDA article - has anyone read this?

- 1 /20 people with non-fatal overdoses die within the year of an overdose. Many within days of being released from the ER. We seem to be missing something there. Some kind of transition.
    - I feel like this is where our gap is. In our ERs. Allow someone to come talk to them rather than tell them to call Egyptian Health.
- Need to increase treatment/ connection to care from ED's.

What items are essential?

- Treatment needs to be immediate.
- Get help ASAP
- Formal program for ER's to all when there is an issue.

Work in local ER's – attitudes of staff.

- EDs doing more to train more – it is a disease.
- Continue to reduce stigma, education.

What were your biggest obstacles to initiating care/staying in care?

- No comments.

Medicaid Reimbursement:

- Gateway takes Medicaid clients State often cuts funds for treatment, creates a barrier for providers. The cuts hurt several entities.
- I don't think we can work in this field, especially this area that we are in; it's hard to not work with Medicaid clients. We want to help those clients with the resources they have.

MAT DATA Waivers:

Bill

- Recently found this topic of a movement to try to get rid of DATA waiver. Less than 7% of providers in the country, that are MAT approved.
- There is so much that licensed providers can do, why something special to treat MAT?
- Mass General hospital is really pushing this treat it like anyway (Dr. Sarah Wakeman)
- If we had more providers treating it like a disease, we can see better results and outcomes. We can get more families back together and more people back into the workforce.
- We can approach and attach this epidemic with both hands.

Touchette Regional Hospital

June 23, 2020
(Note taking by: Fanta Saidou & Angie Bailey)

TREATMENT INITIATION, RETENTION & RECOVERY

What is working well in Illinois?

- The system is sort of broken. I am sorry to say. I don't think we have a lot going on.
- So many barriers and obstacles that we have right now. MCOs that provide coverage – hard to get them to approve for SUD treatment is difficult. Getting push back.
- Dual diagnoses patients….we are given the days they need for detox…..

What are the biggest challenges/barriers to accessing and initiating evidence-based treatment?

- When it comes to discharge, people want more solid ground resources to help them continue to carry on. The next level of care for residential treatment is missing.
- Some program that helps people reintegrate into the community when they have a SUD. They go back to the same environment…then we see them again with the same or similar problems.
- The continuum of care is a huge barrier.
- Having funding for that continuum of care is lacking.
- Not a lot of resources available that we need. We just don't have the resources we need.
- Outpatient programs- they have to make a lot of the initiatives themselves, so they give up. Put too/so much on the patient – delay in treatment.
- Waitlists…..when it takes too long to get in, they give up.
- MCOs – they often provide some really good case management services for MH but not that same level of commitment to SUD. We don't get the same wraparound of care that we see when it's MH related.
- MCOs- if SUD, not the same services, greater stigma against those needing substance misuse services.
- SUD- issues/treatment put back on patient.
- SUD- may not have as much family support due to stigma.
- SUD it's really put back on the person….you need to call this number…you need to show up on this day….
- The family support is another factor. The family may not be supportive. Maybe the patient doesn't want their family involved.
- Lack of recovery homes

What are the biggest challenges/barriers to retention?

- We have staff to provide the services.
- Turnover rate in staff in low.
- Staff is committed to appropriately serve the patients we have here.

What are the biggest challenges/barriers to recovery?

- Lack of recovery homes
- Stigma
- Medically monitored impatient services…..we did have a program….had to cease it. MCOs…would not pay for that impatient service. They felt that everything needed to be done outpatient. We could not afford to keep it open even though we need it in our community.
- MCOs are not giving us good information as to what they would require in order to provide impatient.
- Biggest obstacles is the people that the State has contracted with don't give good information to people.
- Medically stabilization unit programs
- MCO's would not pay for services had not been reimbursed by Medicare.
- No good answers for what "they" MCO's will pay for.
- MCOs not following same rules and guidelines as regular Medicaid.
- When they discharge patients, people driving 125 miles to suboxone providers.
- Distance is a barrier.
- Wraparound services are needed.

What are gaps in the continuum of care spanning from early intervention and outpatient services to medically monitored intensive inpatients services and medically managed intensive inpatient services?

- Impatient services, so many have to be treated on a BH unit, where actually another unit may be best for them.
- There are few medically monitored places in our area that may be best appropriate. Need more of these for detox in So IL.

What are the barriers to providing behavioral health care, including SUD treatment, integrated in a primary care setting?

- A lot of PCP are not comfortable with these types of services. PCPs don't see as their specialty.
- We do not have good communication between the PCP and the other teams that address the BH concerns.
- Make sure we have easy access to whatever medication that the patients have on the outside.
- Struggling with resources of where to send people.

What opportunities should Illinois Medicaid pursue to improve treatment initiation, retention, and recovery?

- No comment.

<u>SUPPORTIVE SERVICES</u>

What are the essential supportive services and what is their capacity in Illinois for those with SUD?

- Very few services to give to patients that are homeless.
- Lack of shelter, follow up, repeatedly come in with SUD or MH issues, nowhere to send them, the changes of follow up is very poor.
- Send them to a STL shelter. Chances of follow up are minimal. Same people who have been repeatedly homeless. “they are on a merry-go-round they can’t get off of. There really isn’t anywhere to send them”
- Need more help for homeless population.
- Housing, life skills,
- Need to have the motivation to engage in that…
- If we can have somewhere they can stay and get the treatment they need while learning life skills…job trainings, coaching,
- A more comprehensive support system will most certainly help with the recovery. We need a complete package – have somewhere they can go get treatment, get therapy, training, job training more comprehensive services.
  What is working well in Illinois?
- No comment.

What are the biggest challenges/barriers?

- No comment.

What should Illinois Medicaid do to foster access to supportive services?

- No comment.

<u>HARM REDUCTION & HEALTH PROMOTION</u>

What is the role of harm reduction and health promotion in treatment of SUD?

- Providing Naloxone when our patients are discharge may be a good idea. It can save lives.
- Family members to assist to those who may need it.
- Hepatitis testing and treatment. Need to promote.

How might Illinois Medicaid more fully support overdoes prevention and harm reduction for Medicaid beneficiaries?

What more can we do in terms of early intervention?

- State need to be more involved in the schools especially elementary schools.
- “Prevention is the best early intervention” – need to prevent in grade schools.
- IHA program – ALTO program. Emergency departments.
- They are long standing in many families, so any early intervention to break the cycle helps.
- Do what we can do to prevent the addiction from happening in the first place.

- Providers prescribing more often than they should. Database should be often checked before prescribing. IL PMP – good resource.
- "People don't intend to become an addict"
- More education.

PAYMENT ISSUES

How has the current reimbursement model affected treatment?

- MCOs….are roadblocks. They do everything they can to not pay for the full treatment really needed.
- They should be mandated to pay for the needed treatment.
- Incarcerated…..they send them out with no coverage nor support. No case management when released.
- MCO's inconsistent when covering or not. Especially opiates if you detox them if you cant document severe medical crisis (nausea, vomit).
- Documentation for MCOs Illinois medication (utilization review).
- Problem has gotten out of control. Overwhelming the system.
- Think of housing, jobs, jobs skills.
- Create these supports to prevent hospitalization.

How might alternative models of payment for care help facilitate improved access to care for Medicaid beneficiaries?

- No comment.

SPECIAL POPULATIONS

Do you have any specific concerns regarding special populations?

- Women in 2nd trimester of pregnancy.
- Postpartum women – depression.
- Those with children- work with DCFS
- At least 50% of patients they see would have a co-occurring serious mental illness.
- Need to treat the whole person-housing, healthcare, medication, getting to doctor, need a case manager.
- Medical stabilization.
- Need medical and legal system to work better together.
- Incarcerated
- Special Needs (treat the whole person)

POLICY & SOCIETAL BARRIERS

How does racism and discrimination affect those with SUD and their recovery?

- Centerville - Poorest zip code. Underserved community.

- Need more community and family resources.

How does bias and stigma affect those with SUD and their recovery?

What are promising proposals for Medicaid to consider that would require a policy change at the Federal level?

- No comment.

Any additional comments or feedback about other ways to improve SUD care and treatment for Medicaid enrollees.

- No comment.

Logan County Collective

Coordinated By: Josh Crist, SIU Medicine

Phone Number: 504-296-8253

Email Address: jcrist56@siumed.edu

Date Held:6/18/2020

Time Held: 8:30-9:45AM

Total Number in Attendance: 20

Participants in this discussion represented a range of stakeholders in the SUD/OUD prevention, treatment and recovery space, including people in recovery with lived experience, recovery community organizations and ROSC group leaders/members, substance use prevention coalition leaders/members, MAT prescribers and other behavioral health service providers, and other community members. A technical anomaly complicated confirming the attendees from the registrant list. You will find the registrant list attached.

Barriers

- The inpatient community care process needs to be streamlined, in terms of fewer places for a struggling SUD person to slip through the cracks. A suggestion was discussed and affirmed by several participants that a peer recovery coach would make initial contact and serve as a liaison for the patient transitioning from inpatient to community, ensuring linkage
- Readiness for treatment. The readiness window can be fleeting
- Transportation remains a challenge

Improving Access

- Best success rates were patients that were actively engaged in counselling, increase the numbers of facilities, the geographic scope, and the eligibility for behavioral health services/counselling.
- Specifically, include behavioral health services at FQHCs
- Reimburse for outreach and administrative services performed by staff of MAT/BH clinic. These critical roles are often a significant burden on the service provider workload and finances, and are necessary for an impactful agency
- Include peer recovery coaching as a reimbursable service
- Doc-only appointments, those lacking supplemental services, fail to treat the whole person. This is, in part, why there is a distrust for MAT among some members of substance-using and recovery communities.
- The relative newness of many MAT programs includes gaps (policy and regulatory) for ensuring that MAT prescriptions come with a compliment of counselling and recovery support services (which are Medicaid reimbursed)
- Participants see increased and successful usage of telehealth services for counseling. The COVID exceptions for reimbursement should remain in place. This is an especially valuable workaround for transportation-limited people/regions
- Participants were enthusiastic about increasing funding channels and supports for expansion of recovery-oriented communities and recovery-oriented systems of care
- Illinois CMS/DHFS could create a program that identifies, codifies, and publicizes those entities who are exemplars of person-centric wrap-around service provision

Harm Reduction

- Prescribers discussed how MAT diversion, though it defies drug contracts and has the potential to jeopardize prescribers' licensure, really does function as harm reduction in the communities. This works both ways: patients that divert portions of their buprenorphine MAT regimen for illegal sale are indirectly contributing to the total harm reduction in the community, and those who are seeking buprenorphine/Suboxone through illegal routes often do so in an effort to reduce the amount of other, stronger opioids they use.
- Close link between harm reduction and manifestations of stigma – needle exchange stigma education
- School staff individuals are not comfortable with being designated to dispatch Naloxone, despite the fact that the staff is aware of the potential that a student might overdose at school
- Overdose education training for staff

SIU-Hosted Listening Session: Multiple Counties

Counties: Lawrence, Richland, Coles, Douglas, Shelby, Effingham, Cumberland, Wayne, Hamilton, Piatt, Dewitt, Jefferson

Coordinated by: Liesl Wingert
Contact person: Liesl Wingert
Phone: 618-967-0151
Email address: lwingert68@siumed.edu
Date held: 6.25.2020
Time held: 12:00pm-1:30pm
Total number in attendance: 8
Names/titles of participants:

- Liesl Wingert – Rural Health Project Coordinator, SIU School of Medicine Center for Rural Health and Social Service Development
- Michael Tyson – Executive Director, Take Action Today
- Amy Marley – Administrator, Lawrence County Health Department
- Andrea McDowell – Director of Human Resources/Marketing, Lawrence County Health Department
- Jenna Hays – Director of Community Outreach, Hour House Prevention and Treatment Services
- Jeanne Johnson – Director of Clinical Services, Jasper County Health Department Behavioral Health Services
- Tony Kirkman – Executive Director, Piatt County Mental Health Center
- Lukus Atkins – House Manager, Addiction Solutions Sober Living Home

A total of 8 participants representing 28 counties in the southeastern region of Illinois (Dewitt, Piatt, Moultrie, Douglas, Edgar, Coles, Shelby, Christian, Cumberland, Clark, Crawford, Jasper, Effingham, Fayette, Bond, Clinton, Marion, Clay, Richland, Lawrence, Washington, Jefferson, Franklin, Hamilton, Wayne, Hamilton, Edwards, White, Wabash) participated in this Listening Session. Participants represented the following positions in the communities that they served:

- Social services
- Sober living facility
- Public Health
- SUD treatment provider
- Academic
- Coalition member
- Consumer who has used substance misuse services
- Community member

Discussion Results

Treatment Initiation, Retention & Recovery:

- For outpatient treatment, there is no limit on the length of time a patient can receive services (unlike inpatient treatment).

- Difficult to find availability for inpatient treatment, typically a 30-90 day wait list as there are not enough beds available.
- Due to COVID19, there are now increased screening requirements for services
- Those clients who require repeated stays for inpatient services are put at the bottom of the waiting list AND are seemingly not as quickly admitted – possibly due to stigma of "repeat offender" mentality.
- There is a very limited array of living options after inpatient treatment (half-way houses, sober living facilities/homes) in the southeastern Illinois area. Most patients "go back" to their communities and fall into the same practices that they had prior to treatment, thus causing them to fall back into the same misguided friendships and living situations. Those who living near the Indiana border are not able to access these types of healing and healthy living situations due to the unwillingness of Indiana facilities to accept Illinois Medicaid/MCO payment sources.
- Typical limit of 14-21 day inpatient treatment is NOT LONG ENOUGH. There is no option for extension by Illinois Medicaid/MCO. They are discharged WAY TOO SOON. (In comparison, private insurance will typically allow a 90 day treatment stay).
- Illinois Medicaid/MCO are not paying the treatment organizations in a timely manner – treatment organizations are having to fight Medicaid/MCO for costs going back over 2 years. Organizations have had to create entire departments that work to get payment from Medicaid/MCO's.
- Patients need to have access to recovery services immediately – need to be linked to appropriate and TIMELY care immediately with no gap in time.
- There is a lack of providers for MAT in rural counties. Many counties only have 1-2 providers and they do not have time to provide MAT services also. It is difficult to convince medical providers to provide MAT services due to the time intensity of these services.
- Many providers do not understand MAT and how it works, or may still feel that it carries a stigma to treat those patients for SUD.
- Many providers do not understand SUD, thus are driven by misinformation and outdated belief systems.
- There is an extreme lack of behavioral health treatment providers in rural areas.
- Health departments cannot bill for services at the same rate as a hospital can, thus they cannot offer a competitive compensation package which makes it very difficult to retain behavioral health providers and SUD providers. In addition, if there is a state prison in the area, the pay will also be considerably higher which makes it difficult to hire and retain these same providers.
- Inpatient treatment barrier is a CAPACITY issue, whereas outpatient treatment barrier is an ACCESS issue.

Supportive Services:

- Someone with a felony conviction on their record has no recourse that allows them to find adequate life sustaining employment with a good, stable employer. Employers are unwilling to hire a convicted felon, and there is a lack of supportive services to assist with finding appropriate employment after treatment or incarceration (or both).
- Illinois is severely lacking in case management services that might assist with supportive services for a recovering SUD patient OR a convicted felon who is in successful recovery.

Harm Reduction & Health Promotion:

- There are limited community options for the take-back of unused/unwanted medications – a community has to implement this type of service on their own. Medicaid/MCO do not financially assist with such an activity.
- Needle Exchange programs are seen as "condoning" the illegal drug activity, as well as possibly encouraging it. There are no Needle Exchange programs in southeastern Illinois.
- Patients are in medical treatment for Hepatitis A or HIV due to not having access to clean needles (and treatment is considerably more expensive than providing a clean needle).
- The recovery community itself often does not want to offer a Needle Exchange program, feeling that it is more harmful than good.
- There is not a good understanding of the use of Narcan/Naloxone, nor how to access it or whether it is paid for by Illinois Medicaid/MCO's. There has been no education on this from the State of Illinois Medicaid/MCO's.

Payment Issues:

- There is a severe and devastating backlog for reimbursements, causing multiple layers of financial hardship on those organizations who provide for Illinois Medicaid/MCO patients.
- It is always a battle for an organization to get paid for providing treatment, as well as keep a patient for longer length of treatment.
- MCO's are completely unwilling to work with a treatment organization and do not give any details as to why they will not pay for an appropriate amount of time for inpatient treatment.
- Those who are incarcerated often have decreased or no options for treatment, as their Medicaid/MCO is dropped after 29 days of incarceration. They have to start all over again after they are released, thus delaying any treatment that they need.
- Currently, MAT providers are struggling to figure out how much reimbursement they will actually receive from IL Medicaid/MCO's – nothing is "clear".

Special Populations:

- Folks who have a felony on their record are unable to find life-sustaining work, as employers will not hire them. This makes recovery and renewal very difficult for that person, and adds to the recidivism rate due to these folks not having the tools needed to succeed.
- Those who are incarcerated will lose their Medicaid/MCO coverage after 29 days of incarceration. Once they are released, they have to apply for the program from the beginning steps which delays needed treatment and medications even longer.
- Folks who live in rural areas have a HUGE lack of resources – SUD therapies, MAT services, wider variety of jobs, etc….
- Migrant workers are unique to rural areas in the eastern region, and many are reluctant to utilize any area services other than those for basic living. These same workers also may encounter racial biases as well as language barriers for any help that is available to them.

Policy & Societal Barriers:

- There needs to be specific requirements by the federal government regarding the provision and use of both state and federal Medicaid/MCO funding that would provide for all SUD clients who utilize Medicaid/MCO's in APPROPRIATE and REALISTIC ways. By having these requirements come from the federal government, the state of IL would be required to offer these services and expend the funding more appropriately (example: provision of appropriate funding for longer and comprehensive length of stays in inpatient SUD treatment centers **OR** a certain percentage of funding applied to the development of more sober living facilities **OR** the requirement of a simple Medicaid program that does not allow

for the use of MCO's **OR** specific requirements for inpatient stays that also require a transfer to a sober living facility for several months post-discharge to assist the client with appropriate and safe acclimation into society).

- There needs to be higher reimbursements for ALL services in organizations in rural areas that are on an equal par with hospital reimbursement for the same or similar services.
- There needs to be better reimbursement for administrative costs to provide SUD services.
- Eliminate all MCO's – they do not function well and are harmful to their clients. One united Medicaid system that is equal to all participants in the state of IL is a better choice overall. MCO's are NOT WORKING.

SIH Medical Executive Committee

Coordinated By: Angie Bailey

Contact Person: Jill Bruce – Medical Executive Committee Meeting

Phone Number: 618.457.5200 ext. 65799

Email Address: jill.bruce@sih.net

Date Held: 3.2.2020

Total Number in Attendance: 45

Total numbers from attendee cards:

- Community member: _____
- Consumer who utilizes substance misuse services: _____
- Family member of someone who utilizes or is in need of substance misuse services: _____
- MAT provider: 1
- Physician: 27
- Midlevel provider: _____
- Medical Office Staff/Practice Manager: 6
- Nurse: 7
- SUD treatment provider; _____
- Social service agency staff:_____
- Public health: _____
- Coalition member: _____
- Law enforcement: _____
- Other:
  - Hospital Admin : 6
  - Pharmacist: 1

Major themes/concerns (please provide a summary of comments in these areas):

Barriers to SUD Treatment/Services for Medicaid Members:

Issues related to Medicaid reimbursement:

- Difficulty with prior authorizations and acceptance of Medicaid

Barriers for DATA waived providers:

- Narcan: Narcan availability needs to be increased for Medicaid patients.

Training/Technical assistance needs:

Staffing needs:

- Lack of substance misuse counselors. Very few providers in area accept Medicaid.

Referrals:

- There is a lack of providers for behavioral health providers; both inpatient and outpatient.
- Providers do not accept Medicaid.

Care coordination:

- Length of stay: years ago, Gateway accepted adolescents and Medicaid allowed 3 months of treatment, then it was reduced to only one month. Not sure what the length is not, but a longer length of stay is needed for those in treatment.

Other:

- In general in Southern Illinois there is a lack of those providing home health services that accept Medicaid. It is difficult placing Medicaid patient. Prior authorizations needed are a barrier.

*Attach transcript of all comments/notes/forms completed.

Comments from Attendee Check-In Cards:

- Refusal of Medicaid MCO to adequately cover psychological services
- Lack of trained professionals in Southern Illinois
- Patients: Lack of family support
- Free availability (low cost) of drugs
- Long wait time for specialty outpatient referral
- Limited/no pediatric inpatient facility for S.U.D. (3+ hours away)
- Limited adult inpatient facility for S.U.D.

SIH Medical Group Operations

Coordinated By: Angie Bailey

Contact Person: Tami Fagerland, Operational Excellence Project Manager

Phone Number: 618.457.5200 ext. 67165

Email Address: tami.fagerland@sih.net

Date Held: 3.3.2020

Total Number in Attendance: 7

Total numbers from attendee cards:

- Community member: 2
- Consumer who utilizes substance misuse services: _____
- Family member of someone who utilizes or is in need of substance misuse services: _____
- MAT provider: _____
- Physician: 1
- Midlevel provider: 1
- Medical Office Staff/Practice Manager: 7
- Nurse: 1
- SUD treatment provider; _____
- Social service agency staff:_____
- Public health: _____
- Coalition member: _____
- Law enforcement: _____
- Other

Major themes/concerns (please provide a summary of comments in these areas):

Barriers to SUD Treatment/Services for Medicaid Members:

Issues related to Medicaid reimbursement:

Barriers for DATA waived providers:

Training/Technical assistance needs:

Staffing needs:

Referrals:

Care coordination:

Other:

*Attach transcript of all comments/notes/forms completed.

Comments from Attendee Check-In Cards:

- The availability of short term and long term treatment facilities with ability to subsidize care for low income consumers
- Lack of providers willing to treat this population
- Lack of behavioral health providers
- Public awareness for family resources
- I believe there is a need for more MAT providers

- Issues with patients keeping appointments sometimes related to transportation, work schedules or other family issues

Youth Quality of Life Task Force

Coordinated By: Josh Crist, SIU Medicine

Phone Number: 504-296-8253

Email Address: jcrist56@siumed.edu

Date Held:6/12/2020

Time Held: 8:30-9:30AM

Total Number in Attendance: 1

Total numbers from attendee cards:

Educator/Education Administrator

- The participant is an educator and was recruited from the McDonough Co. Youth Quality of Life Task Force.

Barriers

- Students lack education on the severity of the problem and the risks surrounding substance misuse, young people feel immune to the risks of SUD.
- Parents use/are addicted which normalizes the behavior from the vantage of the child (student).
- Deficient substance use prevention interventions when a child is removed from his/her home because of documented cases of neglect, child is particularly vulnerable to initiating substance use

How to improve access

- Increased substance use prevention counselling for students, on site (at the schools)
- Increased substance use prevention training for teaching staff
- Training to equip staff in recovery support philosophies and practices

Harm Reduction

- School staff individuals are not comfortable with being designated to dispatch Naloxone, despite the fact that the staff is aware of the potential that a student might overdose at school
- Overdose education training for staff

Structural/Policy

- Mental health literacy training to reduce stigma
- Kids living in poverty have a greater need for education around bias and stigma

West Side Opioid Heroin Task Force

March 6, 2020
Note taking by: Chen Wang and Christie Edwards

Participants in listening session: 6 LHC patients. Also present at listening session were 2 medical providers Dr. Huggett and Dr. Preyss, pastor Brooks, representative Ford. Questions facilitated by LHC
BH provider Brittany Bruckner. Listening session lasted about 1 hour 15 - 30minutes.
Estimated attendance: 50+
Key stakeholders in attendance: Dr. Bruni, Danielle Kirby.

Agencies in attendance
West Side of Chicago is leading in overdose
Night Ministry
Above and Beyond
CPD
Chicago Housing Authority
Voice Newspaper
Pioneer House
HRDI
Peace therapies
CDPH
Gateway
Drexel counseling services
Thresholds
Cook County Health
UCan
YOS Health
Emergent Bio Solutions
Access Community Health
Salvation Army
West Care Foundation
New Age Services
Family Guidance
Breakthrough
Emmanuel Health
Norweigan American Hospital

What has been most helpful to you in terms of receiving services for substance use?

- LHC patient on vivitrol: personalized care, to be able to get care at a clinic for several years (like LHC) outreach from the doctor to where the person rather than waiting for patients to come to you, “meeting someone where they’re at”. E.g. this patient met Dr. Huggett when he was at a shelter. lhc also provides mental health otherwise hard to be in recovery.
- LHC patient x3 years suboxone: feels not judged at lhc, access to his pcp -- his pcp Dr. Preyss always sees him even when he doesn’t have an appointment.
- need different treatment options available. Patient at LHC x4 years: He had been to other treatment centers and had been on methadone but was still using while on methadone. He

heard about suboxone being available at LHC, and has been here for 4 years.

- LHC patient x3 years: provider went to shelter outreach that's how pt knew about lhc, access to lhc provider ->s/p 3d detox, wanted to go to 28d treatment on weekend couldn't get 28 d program bc he had methadone in his system from 3d detox.
- Vivitrol
- Assistance with mental health symptoms have been helpful at Lawndale Health Christian Center
- Suboxone - it's important to not be judged and to be looked at like a person not a drug addict
- The patients are not the problem, the drugs are the problem.
- Patient said methadone gets him high. He appreciates that doctors care for him more than he cares about himself.
- Doctors don't turn you away and they treat you like a human being. Started the detox program which was beneficial to helping him get sober. When he had methadone in his system a treatment center wouldn't take him.
- Has a direct line to the doctor even on the weekends. Being able to trust the doctor with anything.

What are the gaps in care for women in treatment? 1 of the 6 patients was a woman, and she responded to this question:

- women have different concerns from men ->concerned about dcfs/custody of kids. In her experience there are fewer women's shelters, fewer women's recovery home available [don'tknow if this is objectively true?]
- Detox programs, Recovery homes and treatment facilities IMPORTANT ISSUE
- Need both treatment and recovery homes – they have different roles. Need residential treatment that is longer than 28 days.
- ? 4 months limit for recovery home? But it takes longer for recovery. Would like to see longer ability to stay in recovery home.
- One patient had the experience where the free recovery home is full and he didn't have $ to pay for one. --> more recovery homes for people who can't pay
- For detox program you have to have drugs in your system. [I'm not sure if I got this right]
- Recovery home wouldn't let him in bc he had both suboxone and methadone on his utox b/c he was coming from only 2 days in detox at hospital, so he was denied entry to a recovery home.

- Perceived unfairness that someone coming from the prison system can get a stay in a recovery home paid for, and this patient wasn't able to even after he had completed treatment. Restrictions recovery homes have on taking residents with comorbidities are a barrier:
- One patient takes psych meds for schizophrenia and "hearing voices": "Since I've been on psych meds I've been functioning in society, got a degree. But if I tell a recovery home I'm on psych meds they won't let me in, unless you have insurance or you can pay for it, then they will take you." [perceived that recovery homes have different entry criteria depending on your source of payment. I don't know that this is actually true, but this was how this patient felt.]
- Recovery is a long process, and need to have continued support and services: IMPORTANT ISSUE
- "It's like we're starting over. We're in preschool. We're starting from scratch and need help in every aspect. There's no way I can get my life back in 28 days (in a treatment program) or 6 months (in recovery home). It's gonna take at least 18 months to 2 years to learn how to do a lot of things over again."
- "I can't get ID w/o birth certificate. You can't get a birth certificate w/o $20." so can't start to get

your life back together. The only way to get $20 is to sell drugs
- Would like to see recovery home with job training services, voucher to pay for id or birth certificate, how to apply for jobs, help look for housing.
- Background checks – janitorial certificate but haven't found a job. Why can't I get a job? I have a college degree. It's bc of my background [alluding to criminal history and drug use].

- On suboxone program - women deal more with the drug usage because they have to deal with DCFS and lose their kids.
- Fear or what other people think is common.
- There are more shelters for women than men.
- Need more shelters for women with children.
- More recovery home options for men instead of women.
- Syblocate program tends to forget sometimes so this med works better

Could you share about a time you used Narcan or use it on someone else?

- Use of Narcan should be more widespread even than what it is today: "I'm here bc someone gave me narcan."
- Narcan should be available as easily as free condoms: "Like you can get free condoms, syringes.
- It should be given just as freely." more kits given, more classes teaching pp how to use it.
- "Somebody needs to go up and down the streets". There are ppl who don't know where to get it or ppl feel ashamed to ask so you need [so you have to go to the streets to distribute it.]
- One patient gave narcan to himself.
- Another patient's experience: he was using together with a friend. "When I turned around, I saw he was laying on his back on the ground. I was really scared we grew up together." Then gave narcan to a friend he was using with.
- Need for Good Samaritan laws: But when he first saw his friend passed out he got scared bc if his friend didn't wake up, then he thought, "I'm at a murder scene. [implies he's now part of a murder investigation, suspect.] IMPORTANT ISSUE
- One patient: Hadn't heard of narcan until he OD'd and woke up in the ambulance and EMT told him they gave him narcan.

What services would have helped you as a mom in recovery?

- Childcare while you're in treatment. She didn't have these services, and sometimes when childcare was available it felt like the childcare wasn't safe.
- People are very scared of dcfs.
- It's easy to lose your child if you don't do the mandated treatment. She felt the mandated treatment was helpful, so people should do it even if it wasn't mandated.

What challenges?

- Not knowing what your future actually holds. More supportive services that will continue.
- "supportive services going with you to the next level. You don't have any game plan in place. That's when you end up falling through the cracks. We need to be assisted from one level to the next. Need support network in place."
- How many people know someone where their criminal charge should be responded to with an offer for help, rather than criminalization? --> implying there should be alternatives to incarceration.

- All the panelists raised their hands

Other themes

- A lot of people want help but are scared to come forward, need community outreach to the streets.
- Importance of being treated with respect, dignity: “We're already sensitive about what we’re going through”

What prompted your decision to go into high level care? What worked and what were the barriers?

- The patient bought into the program after learning a lot about himself. He went to Haymarket and didn’t get medicare.
- Anxiety flared up
- Hard to find a place in recovery being black, gay and a drug addict
- Let’s differentiate between treatment center and recovery home
- Insurance only pays for a short term though more time is needed to get your life together.
- Patients needs longer terms at recovery homes.

How difficult is it to find a recovery home that fits your needs?

- Patients need longer than 28 days. There are some good ones, and free ones but it’s hard if you get turned away which will send you back into the streets to use. Didn’t have the money to pay for treatment so after 18 months.
- The state of Illinois will pay for someone from the penitentiary to recover for 90 days/6 months but won’t help for drug users to go into a recovery home.
- For patients who are trying to save their life why is it so hard? This is what makes people give up. They need places where they can be safe and recover.
- For patients who take psych meds at the recovery home they will turn patients around immediately unless you have money or good insurance. If you don’t have either you are just left to fend for yourself.
- More people need to be educated on how to use Norcan. Overdosing can happen at any point.
- It’s important for the patient to know how to administer it and others.

How can the local churches get involved? Is there training for training for local churches in administering Narcan?

- Some patients have learned how to administer but it’s important to provide training to prevent death

What social services do you wish had been available to you during your usage?

- Childcare would have been great since there were trust issues not knowing who to trust to leave her children with
- A lot of women who are drug abusers are afraid of DCFS even though there are services out there who can help but fear of leaving their kids may prevent them for getting the help they may need
- If moms test positive, is it easy to lose your children?
- If you have kids and have drugs in your system you can lose your children.
- There are barriers to getting an ID. You can’t get an ID without a birth certificate and you can’t

get a birth certificate without $20. Where do you get the money from? 28 days is not enough time to get your life together.

Are there recovery homes that can help patients for 2 years?

- Recovery homes are needed with onsite job training who can assist with obtaining copies of the birth certificates, getting a state ID, housing and more places are needed for the winter.
- Cease Fire type organizations are needed to talk to drug users on the street
- A lot of places will not hire you if you can't pass a background check to get a job. You'd have to go back to the block to get money to get a copy of your rap sheet, but may find yourself using again.
- There are no violent crimes in the patient's background but he still can't get a job

Western Illinois ROSC Council

Coordinated By: Josh Crist, SIU Medicine

Contact Person: _Josh Crist

Phone Number: 504-296-8253

Email Address: jcrist56@siumed.edu

Date Held:6/18/2020

Time Held: 1:00-1:45PM

Total Number in Attendance: 12

Participants in this discussion are members of the Western Illinois ROSC Council, representing Henderson, Warren, Knox, and Henry Counties. Members of this group hold roles in behavioral health services, the Regional Office of Education, church leadership, and higher education. Very few participants completed the demographic survey, despite multiple requests; you can find the short list in the spreadsheet entitled “18June2020 WIRC” in the All Listening Session Roster file.

Barriers

- Medicaid beneficiaries in need of critical inpatient care often find out there are no available Medicaid-eligible beds
- Stigma as a barrier should be differentiated between SUD stigma and MH stigma
- Medicaid rates are not competitive, and do not entice greater provider participation
- Protracted reimbursement timelines are a deterrent to greater provider participation

Improving Access

- Increase the number of Medicaid-eligible inpatient SUD beds
- Increase residential services in smaller, more rural localities
- Build a reimbursement structure for peer recovery coach supportive services
- Decriminalize for users (as opposed to distributing or trafficking)
- Fund program improvement for increased cultural competency and inclusivity for LGBTQ+ persons
- Expand telehealth service eligibility – or at least continue with the eligibility expansions made during the pandemic

II. INTERVIEWS

Carle Foundation Hospital

Name: James Besante, MD
Role: Addiction Medicine Physician
Location/County: Champaign, IL
Services Offered: Outpatient, addiction treatment, MAT IOP individual counseling also works on an inpatient addiction consult service

TREATMENT INITIATION, RETENTION & RECOVERY

What is working well in Illinois?

- Moved to IL in October 2019 and thus far leadership from the state seems to be working; specifically the opioid action plan and the various elements within

What are the biggest challenges/ barriers to accessing and initiating evidence-based treatment?

- Stigma, buy in from providers (hospitals/clinics),
- Cost of medication is expensive without Medicaid

What are the biggest challenges/ barriers to retention?

- Issues outside of medicine; social support; housing; employment

What are the biggest challenges/ barriers to recovery?

- Recovery is more longitudinal; takes place over many years as addiction is a chronic disease; don't know how to help patients recover over a long period of time
- Transition from hospital to recovery house/primary care provider is a challenge
- Every time there is a transition of care there is a bit difficulty because of all of the moving pieces (some facilities have more resource than others, etc)

What are the barriers to providing behavioral health care, including SUD treatment, integrated in a primary care setting?

- Shortage of BH in this country at baseline
- Need to acknowledge we are working in a system that is broken; fails patients with SUDs; patient needs tend to be higher and more complex
- More BH providers need to be recruited across the board; should expand their ability to provide treatment via training, access to grant funds, etc.

What opportunities should Illinois Medicaid pursue to improve treatment initiation, retention, and recovery?

- The best way to get healthcare in America is through money
- Tying reimbursement providing SUD treatment in new and expanded ways would be a huge step forward and that may look like Medicaid patients admitted to a hospital must be given access to SUD treatment for the hospital admission to be covered. If there admitting diagnosis is related to their SUD
- Readmissions to the hospital for issues related to patients SUD should also be considered; Contingency management – monetary reimbursement for meeting certain goals related to SUD treatment – incentives work for patients; specifically monetary – shows patients what they are doing is valuable; people early in recovery, financial stability is a big issue. Patients get excited about seeing change in their financial health.

SUPPORTIVE SERVICES

What are the essential supportive services and what is their capacity in Illinois for those with SUD?

- He's new to IL so he's a little limited with his knowledge but will share his experience – there is a shortage of quality housing options who are in recovery; this has been recognized at a state level; Joined Medication Assisted Recovery Vision Committee – to help and find and improve housing across the state; low quality exists now; many options do not provide or support MAR (similar to MAT, but you are giving Rx to patients transitioning to housing) assisted recovery; state leadership from the top down is what will help to create improvement
- Housing is number 1 and 2; job training and work

What should Illinois Medicaid do to foster access to supportive services?

- He favors more of a carrot instead of a stick; there should be incentives for housing options that offer MAT; recovery living/sober homes; how do you incentive this?

HARM REDUCTION & HEALTH PROMOTION

What is the role of harm reduction and health promotion in treatment of SUD?

- It's fundamental; in Champaign there is excellent public health department that provides every aspect of harm reduction he can think of
- Hepatitis testing and treatment – there is too little of in central IL
- Length of "sober time" to access treatment isn't clear for patients with Hepatitis C; gets push back due to patients only being sober for a certain amount of time; where is this information from IL Medicaid

What more can we do in terms of early intervention?

- Primary care screening and treatment for SUDs; needs to be much stronger
- Primary care and urgent care/EDs should be required to screen for SUD and provide access to some sort of treatment (even if it's just a referral to treatment)

PAYMENT ISSUES

How has the current reimbursement model affected treatment?

- Managed care Medicaid – it provides a level of complexity for all levels of services for Medicaid beneficiaries; ex: Hepatitis patients – requires a different processes and higher authorizations for this particular population of patients
- "Medicaid should be Medicaid should be Medicaid" - patients with Medicaid get access to different private insurance; adds billing complexity; small addiction providers and clinics where that administrative burden is forced unnecessarily and disruptive to the care that is provided
- MCOs (Managed Care Organizations) do not increase access, nor reduce spending or realize savings for Medicaid patients

SPECIAL POPULATIONS

Do you have any specific concerns regarding special populations?

- Transgender individuals – they have highest rates of SUDs or mental health issues of any population; they benefit from specific care and resources that are tailored to meet their specific

circumstances in recovery; very few resources available to them in IL - residential treatment programs (offering personal rooms)

POLICY & SOCIETAL BARRIERS

How does racism and discrimination affect those with SUD and their recovery?

- All forms of trauma make recovery difficult for patients – racism and structural racism make it hard for his patients of color to achieve recovery; takes place in many ways (providers in clinics, at an institutional level – not prioritizing their issues; failure of medical education to provide training to minority populations; address historical gaps in training; prison industrial complex – individuals do not receive adequate treatment while incarcerated.

How does bias and stigma affect those with SUD and their recovery?

- It is one of the single greatest barriers to his patients; patients afraid of how their loved ones may think of them; patient can't continue recovery because of job (suboxone); family didn't want patient in house because of suboxone; recovery house not letting patient back into recovery house because patient was prescribed suboxone so patient declined to get refill.
- Stigma definitely effects patients access to care

What are promising proposals for Medicaid to consider that would require a policy change at the Federal level?

- Telemedicine will become fundamental to addiction treatment moving forward; it is not clear the steps the federal government will take and maintain. Ex: The Ryan Haight Act – changed overnight because of COVID to allow bup prescribing using telemedicine which was tremendous for a lot of addiction providers. Will this change continue? What other steps will the government take for telemedicine and the provision of MAT.

Cook County Health - Recovery Coaches

Role: Recovery Coaches
Location/County: Cook County

TREATMENT INITIATION, RETENTION & RECOVERY

What is working well in Illinois?

- Not able to really answer; MAT for opioid users seems to be working, however placing patients in inpatient treatment has been a challenge due to COVID; there are a lot of resources available for MAT; expanded Medicaid to allow more people to be eligible;

What are the biggest challenges/ barriers to accessing and initiating evidence-based treatment?

- Not a lot of residential program as in the past; having the resources to be able to implement best practice; little training for medical staff on how to identify SUD in patients for treatment; Medical providers do not have a lot of training on linking patients after the hospital setting; A good discharge plan is necessary.

What are the biggest challenges/ barriers to retention?

- Inability to contact patients; updating them in the system when phone; different forms of communication;

What are gaps in the continuum of care spanning from early intervention and outpatient services to medically monitored intensive inpatients services and medically managed intensive inpatient services?

- Level of services in between (residential setting etc); patients aren't physically well enough for residential treatment (childcare issues) but need high level of structure and support, improves over time, a lot of barriers for patients on bup to gain access to residential homes.

What are the barriers to providing behavioral health care, including SUD treatment, integrated in a primary care setting?

- Space can be an issue; staff support; various factors; limited resources; no social worker; No access to psych; it takes a long time to get a psych appointment because of the limited amount of staff.

What opportunities should Illinois Medicaid pursue to improve treatment initiation, retention, and recovery?

- Longer term (more than 30 days); short term is not working; funding and sustainability in recovery coaches in Medicaid reimbursement; relying on grant funding – another model would be great.

SUPPORT SERVICES

What are the essential supportive services and what is their capacity in Illinois for those with SUD?

- Housing (we need more of it, but need more diversity in terms of options – ex: housing first model), mental health, access to shelters; food; job training; healthcare; community support

What is working well in Illinois?

- Having recovery coaches in the clinic; or readily available; nurses/docs know they are available as a resource

What are the biggest challenges/barriers?

- Getting patients to their appointments

What should Illinois Medicaid do to foster access to supportive services?

- Incorporate everything suggested; the ER waiver training is helpful but it is not enough; not sure if Medicaid is the right avenue to request more training/education around reimbursement schedules

HARM REDUCTION & HEALTH PROMOTION

What is the role of harm reduction and health promotion in treatment of SUD?

- If education can be provided for patients, less harm can be done; give patient the route to choose their form of treatment can lead to recovery on their terms.

How might Illinois Medicaid more fully support overdose prevention and harm reduction for Medicaid beneficiaries?

- Narcan treatment, educational resources about harm reduction and overdose prevention; if more primary care providers integrated in overall patient care

What more can we do in terms of early intervention?

- Intervention begins early in grade school and high school; more education for students in the school system; grants that fund early intervention not sure if Medicaid funds any of this work; there is room for education around patients who are on pain meds specifically opioid based (what are the warning signs, preventing misuse) if Medicaid could reimburse around this type of model.

PAYMENT ISSUES

How has the current reimbursement model affected treatment?

- It takes too long to pay; the person waiting on the funding puts them in a bind or can't get the resources they need to provide education and treatment for those who need the services; less providers that accept Medicaid which creates limited choices where they can go.

How might alternative models of payment for care help facilitate improved access to care for Medicaid beneficiaries?

- 5 year voucher – if they wanted to go to inpatient treatment; voucher would be nice to have to prevent waiting; use for 3 or 5 year timeframe for SUD treatment; patient wouldn't have to worry about funds as it would included in the voucher;

SPECIAL POPULATIONS

Do you have any specific concerns regarding special populations?

- Patients who are single and male don't have a lot of options to access treatment/care - especially if they don't have dependent children;
- People who suffer from co-occurring mental health or health issues need total wrap around services

- Spanish speaking individuals or patients who do not speak English as there are limited resources

POLICY & SOCIETAL BARRIERS

How does racism and discrimination affect those with SUD and their recovery?

- There is a stigma behind patients who have addiction especially in Spanish speaking or AA; AA are less likely to be treated for pain meds as there may be a stigma they are looking for drugs;

How does bias and stigma affect those with SUD and their recovery?

- When patients come into the clinic or hospital they get treated differently, it stops them from reaching out for help – they go back to doing what they did
- Lack of education in the clinics so the bias is there; it might be helpful to provide SUD services as a regular patient care so there is no bias.
- Patients will be less likely to return if there is any bias; if they are not being treated with empathy they may discontinue care and go back to using because of the stigma

What are promising proposals for Medicaid to consider that would require a policy change at the Federal level?

- Change in leadership (US president)
- Restructure income guidelines/pay scale for patients; stop looking at need for Medicaid at it only being a minority/poor person's benefit
- Universal healthcare system

Delnor

Name: Steve Holtsford, MD
Role: Delnor ER Physician; Medical Director for Lighthouse Recovery (St. Charles); Bright Heart Health
Location/County: Kane County
Services Offered: SUD services including MAT with buprenorphine or suboxone; outpatient facility

TREATMENT INITIATION, RETENTION & RECOVERY

What is working well in Illinois?

- Medicaid's coverage of medications – very helpful (Buprenorphine; Vivitrol)

What are the biggest challenges/ barriers to accessing and initiating evidence-based treatment?

- Not enough people doing this work in Opioid use disorder; takes a waiver to write for buprenorphine; not enough people get the waiver training; if receive training don't get enough patients to use the training
- Hope is that some of this can be done via telemedicine – opportunity to bring services to this specific population
- Bright Heart takes ALL Medicaid plans – Joint Commission approved; counseling for telemedicine they need to have licensing to do this but working on it; ONLY does telehealth appointments; active in 21 states
- Medication management and treatment done telemedicine – research is proving beneficial; not having to deal with transportation issues; privacy of your own home: no childcare issues

What are the biggest challenges/ barriers to retention?

- At Lighthouse: have a lower barrier into treatment; if you miss appointments or have urine that shows use; they aren't punitive; gives patients ownership over treatment; rigid treatment plan can make it difficult for patients in recovery.

What are the biggest challenges/ barriers to recovery?

- Not addressing the issues that got the person using drugs in the first place

What are gaps in the continuum of care spanning from early intervention and outpatient services to medically monitored intensive inpatients services and medically managed intensive inpatient services?

- From ER perspective: difficult to get patient residential treatment who has Medicaid; most SUD is an outpatient problem; some patients require residential treatment; long waiting lists; needs to be an increase in available beds for Medicaid patients; if you have great insurance – beds become available.

What are the barriers to providing behavioral health care, including SUD treatment, integrated in a primary care setting?

- Not sure why primary care doesn't do a better job embracing patients with SUD; not too familiar with primary care setting but seems like IM and family practice are not doing this line of work and nor interested.

What opportunities should Illinois Medicaid pursue to improve treatment initiation, retention, and recovery?

- A lot of this is around payment for services; if you get reimbursed more for this type of work, you would offer these services; waiting lists are very long
- Residential care, group therapy, Psych counseling – these areas need to improve; especially for patients with Medicaid

SUPPORT SERVICES

What are the essential supportive services and what is their capacity in Illinois for those with SUD?

- Counseling, Case Management (job training, housing, roles of recovery homes/halfway houses)

What are the biggest challenges/barriers?

- Not enough people doing this work for Medicaid patients; probably deals with reimbursement

What should Illinois Medicaid do to foster access to supportive services?

- FQHCs are a good avenue and do good work; working through FQHCs; evaluate how FQHCs are doing the work of SUD + Case Management around SUD this might be provide useful information.

HARM REDUCTION & HEALTH PROMOTION

What is the role of harm reduction and health promotion in treatment of SUD?

- It's very important!
- Every dollar spent in this area is a lot saved on the backend; many of the issues are completely preventable; expansion of these services would be helpful in reducing costs

How might Illinois Medicaid more fully support overdose prevention and harm reduction for Medicaid beneficiaries?

- If Medicaid could fund needle exchanges this would help; perhaps at certain FQHC's doing outreach; for most people harm reduction services (ie. Needle exchange program) is the entry point for treatment (same for the ER); this becomes a point of stability for the patient in the community; important to support these organizations with funding; money well spent by Medicaid

What more can we do in terms of early intervention?

- Education, job training, mental health, economics – we gotta do better!
- Prevention of substance use disorder - tackling all social determinants of health
- Work on psycho-social causes of human misery; if you can do this you can address the causes of substance use disorder.

PAYMENT ISSUES

How has the current reimbursement model affected treatment?

- If Medicaid reimbursed more for MAT treatment, counseling or inpatient care, more of these services would be available
- At Lighthouse, they have a billing consultant who has been trying to work with Medicaid and is not getting anywhere
- Proportion of patients on Medicaid at Lighthouse at 50%; they don't take Medicaid so they offer a sliding scale; Bright Heart does take Medicaid so about 90% of patients are on Medicaid

SPECIAL POPULATIONS

Do you have any specific concerns regarding special populations?

- Yes. I spend a morning a week at the Kane County Jail. They are treating patients with SUD at the jail; should be universally available; has a protocol similar to ER once they enter the jail; every county jail in the state should have MAT available for patients with SUD; violence in the jail has decreased because of this treatment program
- Medicaid should pay for this

POLICY & SOCIETAL BARRIERS

How does racism and discrimination affect those with SUD and their recovery?

- It is a tragic legacy of this country where minorities do not have access to quality care; this needs to be addressed; people with SUD are stigmatized enough and then coupled with racism it's a double whammy; these services need to be available to everyone whenever they need it; this is the key; a real policy needs to be developed and implemented
- Telemedicine helps with this; as long as you have a smart phone and internet connection you can avoid some of these issues; at least overt racism; telemedicine seems to be an equalizer
- Recovery pod is 70% minority in the jail system; 15%-16% of the Kane county population is black

How does bias and stigma affect those with SUD and their recovery?

- The shifting of the stigma is getting better (especially in the ER), but it's happening slowly; pendulum is moving; people are beginning to understand that SUD is a brain problem and not a problem with character; will take a lot of work as much as in the area of racism; re-evaluate your thoughts related to people and their use of drugs

What are promising proposals for Medicaid to consider that would require a policy change at the Federal level?

- Getting rid of x waiver that requires people to do the 8 hours of training for the Buprenorphine; it's a hurdle that doesn't make sense; in order to write you have to have a special DEA license; in order to get the license you have to do 8 hours of training.

Family Guidance Center

Name: Ron Vlasaty
Role: Chief Operation Officer
Location/County: Cook
Services Offered: MAT provider, outpatient substance use, mental health substance use and residential substance use
Patients: 5500 patients in system; annually 15,000

TREATMENT INITIATION, RETENTION & RECOVERY

What is working well in Illinois?

- Working well on providing access to care throughout the state; not available throughout the state but working on it

What are the biggest challenges/ barriers to accessing and initiating evidence-based treatment?

- Immediate access to care; not just geographic dependent but reimbursement dependent; recent activities related to civil unrest and COVID-19

What are the biggest challenges/ barriers to retention?

- Having providers implement a strong recovery support system – traditional treatment methods (case management, etc) not as effective, now patients have more complex problems and are not being addressed through counseling; transportation; education; vocation, etc. All about recovery support.

What are gaps in the continuum of care spanning from early intervention and outpatient services to medically monitored intensive inpatients services and medically managed intensive inpatient services?

- There used to be a huge gap in warm hand-off services; state is working on filling these gaps;

What are the barriers to providing behavioral health care, including SUD treatment, integrated in a primary care setting?

- Reimbursement is a barrier; educating medical practitioners on SUD (how to identify it and what to do if they require treatment)

What opportunities should Illinois Medicaid pursue to improve treatment initiation, retention, and recovery?

- Reimbursement initiatives (rewarding providers for immediate access to care/retention/recovery support services to patients – helping them stay out of jail or the hospital.

SUPPORTIVE SERVICES

What are the essential supportive services and what is their capacity in Illinois for those with SUD?

- Recovery support services (non-reimbursable service in IL), housing (for SUD individuals in recovery home settings) - capacity needs to be expanded and better care coordination

What is working well in Illinois?

- Recognition of the important of recovery support services and housing needs. Now a reimbursement model needs to be created for this.

What are the biggest challenges/barriers?

- Lack of recovery support services, housing and lack of reimbursement

What should Illinois Medicaid do to foster access to supportive services?

- Medicaid has to recognize supportive services and recovery home services should be a reimbursable category

HARM REDUCTION & HEALTH PROMOTION

What is the role of harm reduction and health promotion in treatment of SUD?

- To promote healthy lifestyles; to offer tools to provide safe use of illegal drugs (naloxone, needles, needle exchange, etc.)

How might Illinois Medicaid more fully support overdose prevention and harm reduction for Medicaid beneficiaries?

- Reimbursement for naloxone; needle exchange

What more can we do in terms of early intervention?

- Continued expansion of education of SUD services in the schools

PAYMENT ISSUES

How has the current reimbursement model affected treatment?

- Unfortunately, the treatment system is currently based off of a fee for service reimbursement and should be the other way around.

How might alternative models of payment for care help facilitate improved access to care for Medicaid beneficiaries?

- Alternative models would include incentives, shared risk models, and bundled rate models
- 80% of patients on Medicaid

SPECIAL POPULATIONS

Do you have any specific concerns regarding special populations?

- FGC puts a lot of focus on incarcerated patients; current patients can access services during incarceration; can continue services upon release
- Ensure women who are pregnant or moms who have SUD are prescribed appropriate med while pregnant and postpartum

POLICY & SOCIETAL BARRIERS

How does racism and discrimination affect those with SUD and their recovery?

- Geographical access to services; appropriate services provided in disadvantaged communities; Lack of education and employment impacts SUD and individuals in recovery

How does bias and stigma affect those with SUD and their recovery?

- Starts at the provider level; lots of communities that stigmatize SUD and recovery which translates to difficulty community-based orgs have getting approval from community to offer services to those in need.
- Communities are aware of drug use but would prefer for treatment services to be located outside of their communities.

What are promising proposals for Medicaid to consider that would require a policy change at the Federal level?

- Full implementation of Telemedicine
- Consideration of different reimbursement models

Henry's Recovery House

Name: Henry McGee; Henry D Mcghee Jr
Role: Founder and CEO; Founder/ Executive Director, respectively
Location/County: Cook County (4 locations) Woodlawn, Englewood 2 locations in Grand Crossing
Location/County Served: Cook
Services offered: Recovery services for patients with SUD, homeless, transitioning housing; level 1 & level 2 provider. Recovery Home, Level 1/2 Treatment, Transitional Housing For Ex Offenders

TREATMENT INITIATION, RETENTION & RECOVERY

What is working well in Illinois?

- An individual has to see that they are in need of treatment and recovery; once a person gets into treatment relapse can be a part of the recovery process; treatment then begins once they realize they need to try harder

What are the biggest challenges/ barriers to accessing and initiating evidence-based treatment?

- Having ample services in the correct geographical areas; the services aren't always in the areas where people use drugs; access and making sure the services offered are in the areas and ARE easily accessible to those who require the services.

What are the biggest challenges/ barriers to retention and recovery?

- Making sure patients stay away from triggers, or drug infested neighborhood people places and things.

What are gaps in the continuum of care spanning from early intervention and outpatient services to medically monitored intensive inpatients services and medically managed intensive inpatient services?

- Recovery homes play a huge ROLE in care in the continuum of care; people are still having to go back to the environment which triggered their drug addiction; job training/job placement; keeping patients in a like-minded environment (Recovery homes) where they are supported and can stay sober.

What are the barriers to providing behavioral health care, including SUD treatment, integrated in a primary care setting?

- Can't speak to this; HMO or other managed healthcare services don't offer a enough time for patients to recover; patients will go to the ER sometimes for access shelter.

What opportunities should Illinois Medicaid pursue to improve treatment initiation, retention, and recovery?

- Illinois is now certifying program much quicker; providers had to provide services for 2 years prior before requesting funding; opportunities include to remove barriers causing patients to not receive the care they require in SUD and to invest in recovery homes.

SUPPORTIVE SERVICES

What are the essential supportive services and what is their capacity in Illinois for those with SUD?

- Linkage agreements, agreements for job training, education, and organizations who can help;

What is working well in Illinois?

- There are programs similar to Henry's Sober Living House that are offering services to patients to help people to recover with wrap around services; includes recovery home and job training services as well; These programs are available in Illinois

What are the biggest challenges/barriers?

- Access to job training and advertising so people know where to go who have SUD; there is a lot of information available to people; training individuals for a job but THEY don't have a job at the completion of training.

What should Illinois Medicaid do to foster access to supportive services?

- Illinois could fund services and make sure these organizations are in the best locations for patients to access; help companies realize it's to their benefit to offer wrap around services.

HARM REDUCTION & HEALTH PROMOTION

What is the role of harm reduction and health promotion in treatment of SUD?

- Prevention, education and offering services (i.e like clean needles, Narcan?)

How might Illinois Medicaid more fully support overdose prevention and harm reduction for Medicaid beneficiaries?

- IL Medicaid can provide funding; it saves them money on the back-end by preventing patients from accessing emergency room services

What more can we do in terms of early intervention?

- Get into the schools and talk real to the kids; start educating them early.

PAYMENT ISSUES

How has the current reimbursement model affected treatment?

- Can't speak to this; just received an agreement with Medicaid Provider

SPECIAL POPULATIONS

Do you have any specific concerns regarding special populations?

- We have served the LGBT community; WE need to know how patients WANT to be identified as far as gender is concerned.

POLICY & SOCIETAL BARRIERS

How does racism and discrimination affect those with SUD and their recovery?

- Minorities aren't always taken seriously for their addictions; individuals get blown off and can't access services; discriminated individuals will not always have access to quality healthcare; blacks can't assimilate which can create gaps in recovery because of limited access.

How does bias and stigma affect those with SUD and their recovery?

- Sometimes stigma can play a role in a person's ability to recovery based on how many times they relapse; PROVIDERS SHOULD continue to offer assistance to those who need the help regardless of how many times they come IN CONTACT

Would like contacts to the following for Medicaid agreements: Illinicare, Cook County Health and Meridian Health if possible

K.A.M. Alliance

Name: Angela Ratcliffe
Role: Chief Executive Officer, Administrators, Founder, also Certified Drug & Alcohol Counselor
Location/County: Beverly in Chicago – 95th & Bell St.
Services Offered: Drug & Alcohol Counseling, mental health counseling, psychiatry/medication, family/couple/individual therapy, no MAT but [Nurse Practitioner] given training and primary care doctor on call, licensed for DUI evaluation and risk education. Established around 2006.
Patients: about 2500, about 1500 active
Medicaid Patients Seen: Medicaid 80%

TREATMENT INITIATION, RETENTION & RECOVERY

What is working well in Illinois?

- "I don't see a strong effort to incorporate [Medicaid] patients."
- Services available but... no one getting linked up or referred seamlessly
- KAM for example would like to see more referrals for substance use, but they tend to really only get mental health/psychiatry referrals and THEN find out about substance use.
-

What are the biggest challenges/ barriers to accessing and initiating evidence-based treatment?

What are the biggest challenges/ barriers to retention?

- Patients losing insurance benefits

What are the biggest challenges/ barriers to recovery?

- People are not getting linked up to services/referred.
- Referrals aren't happening so KAM is being underutilized for substance use services
- She thinks this is because certain organizations are well known and others are not
- there are problems with getting a license (SUPR).
- E.g. they started May 2019, did not get it until Jan 2020
- Medicaid can be tricky for people to obtain
- Patients need more education on benefit eligibility

What are gaps in the continuum of care spanning from early intervention and outpatient services to medically monitored intensive inpatients services and medically managed intensive inpatient services?

What are the barriers to providing behavioral health care, including SUD treatment, integrated in a primary care setting?

What opportunities should Illinois Medicaid pursue to improve treatment initiation, retention, and recovery?

- They should make it easier for people to get Medicaid via the application.
- Some people not savvy with computer and have to go to the office, but then there are long waits.

- Shows as pending for a long time after the application.
- Many come to KAM and can't be treated because they do not have Medicaid yet even though they applied a long time ago.
- They end up seeing a lot of people for free, but they need to be funded.
- Reimbursement has been an issue but improved recently with KAM. It is still sometimes delayed.
- KAM needed to hire a third party biller to deal with Medicaid reimbursement.
- Payment improved during COVID in terms of reimbursement – in terms of speed of getting paid.

SUPPORTIVE SERVICES

What are the essential supportive services and what is their capacity in Illinois for those with SUD?

- Harm reduction

What is working well in Illinois?

- Programs for harm reduction work well/better e.g. needle exchange.
- Approval for reimbursement of more qualified/certified professionals

What are the biggest challenges/barriers?

- The referral process is not good, and getting linked up is hard.
- There is not enough information about where to go especially if no insurance company to use as the referring entity.

What should Illinois Medicaid do to foster access to supportive services?

- There needs to be a better referral process.
- Need something like large database but even if we had that many people probably would not know where to look for it
- Unsure how to fix this but maybe let providers know that they can find the large database through Illinois.

HARM REDUCTION & HEALTH PROMOTION

What is the role of harm reduction and health promotion in treatment of SUD?

How might Illinois Medicaid more fully support overdose prevention and harm reduction for Medicaid beneficiaries?

- They need to be funded!
- They are limited due to lack of funding—we need more financial support

What more can we do in terms of early intervention?

- Need more youth programs
- Need to teach parents how to connect with youth programs and services

PAYMENT ISSUES

How has the current reimbursement model affected treatment?

- Reimbursements to individual provider are "ridiculously low and insulting" ▪ It has been hard for them to attract a substance use counselor.
- KAM is paying more in hourly rate for a counselor than Medicaid will reimburse for service... "sometimes 17 dollars for a counseling session"
- Can't bill for lab/drug testing

How might alternative models of payment for care help facilitate improved access to care for Medicaid beneficiaries?

- Need to raise set fees for service

SPECIAL POPULATIONS

Do you have any specific concerns regarding special populations?

- Very large DCFS population and foster families at KAM/women with children
- A lot don't have Medicaid still
- Foster kids gets approved immediately but why not for other special populations?
- Special populations need a fast track for the Medicaid application (similar to foster children)
- Need more supportive services for women, also women who have been recently incarcerated
- Is there a way to bill for more services upon discharged from jail/prison? Because more services are needed for this population
- KAM gets referrals from Safer Foundation who tries to link with Medicaid benefits and then they are still pending.
- Special populations need better access to services.
- Special populations need more services so more services should be funded – equitable reimbursement?

POLICY & SOCIETAL BARRIERS

How does racism and discrimination affect those with SUD and their recovery?

- AA and Latinx are disproportionately affected by SUD due to many things.
    - ▪ Health problems
    - ▪ Poverty
- As an AA women, Angela feels like it is the norm to be the victim of poor services. ▪ "Nothing has changed over time—hoping things may be different now."

How does bias and stigma affect those with SUD and their recovery?

- Stigma plays a huge role
- E.g. African American women with mental health do not seek treatment because they don't want to be labeled in their community as "not strong," "crazy," or "weak."
- Angela thinks this is due to culturally conditioning to believe African
- Americans and other minorities are already seen as bad "so why would we admit to having something bad"
- Angela thinks African Americans are "more resilient because they were forced to be."

- On the other hand, there is large white population in KAM. It seems to be a status symbol that they are seeking help.

What are promising proposals for Medicaid to consider that would require a policy change at the Federal level?

- Police brutality needs to be a crime.
- More supportive services are needed before things become a problem.
- Need more funded support before crimes/in jail for SUD.
- It “took a pandemic to finally approve telehealth.”
- Telehealth has been invaluable to KAM—NEEDS TO STAY AFTER PANDEMIC
- Before did not boost telehealth because not paid for and then also hard to connect with video but now they allow calling and that can get paid for. This should not stop.
- Some Medicaid services contracted with are only allowed a certain amount of business per year
- “People making laws are not clinical – this does not make sense.”
- We need to meet people where they are and not just give them 12 visits per year for mental health.
- Prior approval for more visit from MCOs
- They have been told they need to slow down on visits or otherwise need prior authorization. This should not be necessary.
- We need to rely on clinical decision making
- “If you highlight anything, highlight issue with prior authorizations. When a clinician is stating that a person needs something – they shouldn’t have to deal with a limit and paperwork/prior authorization.”
- The state does not want to pay for certain brands of medication.
- “Fear of not getting reimbursed gets in the way of trying to give good care.”
- KAM has actually paid cash before to wait for prior authorization
- Need better channels to point in direction of providers who provide SUD.
- For example, KAM is here and not enough people know about them (for SUD services)

Perfectly Flawed

Luke Tomsha
June 26, 2020
Note taking by: Fanta Saidou & Angie Bailey

TREATMENT INITIATION, RETENTION & RECOVERY

What is working well in Illinois?

What are the biggest challenges/barriers to accessing and initiating evidence-based treatment?

- When people reach out for help, they don't get it.
- Waitlist
- Lack of care.
- ER - they get a short waiver…..
- Stigma
- "I just took care of you yesterday…."
- Had to go to multiple ER's to get help.
- Lack of training
- Lack of prioritization in the hospital system.
- The way they are treated when they go in….it really takes away their hope.
- Hard to build trust.
- Local decision makers
- Clean, addict, sober….we put a gold standard. If you don't reach that gold standard, you are being judged.

What are the biggest challenges/barriers to retention?

What are the biggest challenges/barriers to recovery?

What are gaps in the continuum of care spanning from early intervention and outpatient services to medically monitored intensive inpatients services and medically managed intensive inpatient services?

- Hard to get people to services
- Waitlist
- Hard to get them into services
- Having a peer navigator that understands the services in the area. We are an open door. But we are too small.
- Overdose prevention coordinator is in Peoria. Too far away. How can other organizations collaborate with the smaller organizations….
- Help with reinforcement from other agencies….to get grants and funding…..

What are the barriers to providing behavioral health care, including SUD treatment, integrated in a primary care setting?

What opportunities should Illinois Medicaid pursue to improve treatment initiation, retention, and recovery?

- If someone comes for care….they don't have insurance and the waitlist…..
- When someone comes to my door, for help, it's nice to be able to give them help.
- What can we do to facilitate those that need help to pay for rehab or their needed services?

SUPPORTIVE SERVICES

What are the essential supportive services and what is their capacity in Illinois for those with SUD?

- Need to understand the services that exist in the area. It's hard for me to understand what exists sometimes.
- Having peer navigators that will assist in the process… "here's what exists…. let me help you". Need navigators to help through the system.
- Paperwork after paperwork.
- Proof of all documents. Birth certificate $50.
- Paperwork for patients.
  What is working well in Illinois?

What are the biggest challenges/barriers?

What should Illinois Medicaid do to foster access to supportive services?

- Tri-county opportunity council – serve 8 county area. Life skills and training.
- Help people complete paperwork. So much stress/have some to help them along "mother figure".
- People that care for them and can help.
- Criminalized too much
- 2 systems (law enforcement SW or mediators w/ lead w/ passion.
- Have more trauma involved services.
- Incentive to engage with peer recovery coaches.
- Fund wellness related activities, gym memberships
- Social connection
- Cover wellness
- Gym – new environment, open door to new life.

HARM REDUCTION & HEALTH PROMOTION

What is the role of harm reduction and health promotion in treatment of SUD?

- Harm reduction is an open door. Trust is important. 5 minute conversation.
- It takes years to build trust. We are going to meet you where you are at.

- We have to stop creating barriers.
- Hard to get out of situations if you don't have family support.
- Get in a hole/hard to get out.
- More easily support groups help those.
- Referrals from agencies.
- Address the underlying reasons people are using drugs.
- Most adults experimented.
- Just say no.

How might Illinois Medicaid more fully support overdoes prevention and harm reduction for Medicaid beneficiaries?

What more can we do in terms of early intervention?

- A way for Medicaid to support us. We just operate on our own.
- Making it more where the supportive groups and agencies can easily be promoted to help individuals as needed.
- Addressing the underlying reasons people are choosing to use.
- Changing the messaging.
- Fentanyl – "Safety first" – BOOK

PAYMENT ISSUES

How has the current reimbursement model affected treatment?

- We are not a billing agency.
- The waitlists make it hard to get people in. I think it is because of the lack of fast reimbursements.
- Waitlists- for those accepting IL Medicaid due to lack of reimbursement.

How might alternative models of payment for care help facilitate improved access to care for Medicaid beneficiaries?

SPECIAL POPULATIONS

Do you have any specific concerns regarding special populations?

- Law enforcement involved.
- Stigmatized by all – many stigmatized

POLICY & SOCIETAL BARRIERS

How does racism and discrimination affect those with SUD and their recovery?

- Black individuals
- Systemic racism is huge.

- In rural area, black 35x
- Stigma for coming for help
- Systemic racism in law enforcement.
  How does bias and stigma affect those with SUD and their recovery?
- They feel shame….
- Don't come/out for help.
- Eliminate mandates for waiver/MAT prescribing.
- Not knowledgeable re:federal.

What are promising proposals for Medicaid to consider that would require a policy change at the Federal level?

- Eliminating the mandates…..getting a waiver….

Any additional comments or feedback about other ways to improve SUD care and treatment for Medicaid enrollees?

- People need hope, non-judgement;
- Overwhelming; understanding the drastic change take time, not getting drug tested and kicked out of treatment; stigma in hospital settings, police, tough love;
- General public needs education and realization that drug use is human behavior;
- hard to build trust;
- need local decision makers leading w compassion,
- harm reduction, education around that;
- education in schools to teachers to combat stigma; abstinence isn't the only option; we put too much emphasis in words like clean, addict and sober;
- focus on safety first high school and college.
- Parents must accept that kids are curious and may try things.
- Put it into perspective of why people chose alcohol; talk about aces."

Safer Foundation

Name: Sherie Arriazola
Role: Associate VP of Behavioral Health
Location/County: Cook County
Location/County Served: Cook County + Rock Island County + collar counties
Services Offered: Outpatient and intensive outpatient SUD treatment; provided within the framework of reentry services with an overall focus on economic development/employment. Service array includes education, GED classes, occupational training, benefit assistance, financial counseling, behavioral health treatment, subsidized housing via CHA (Focus Apartments), correctional services via adult transitional services, job placement and retention.
Number of Clients Served/Proportion on Medicaid: Target population people with arrest and conviction records

TREATMENT INITIATION, RETENTION & RECOVERY

What is working well in Illinois?

- The fact that they allow all forms of MAT to be covered under Medicaid is great (vivitrol, suboxone, etc.); the Opioid helpline and website is helpful to locate providers to see who is offering what services.

What are the biggest challenges/ barriers to accessing and initiating evidence-based treatment?

- People who don't have coverage; it takes time for applications to be approved for those who need it; gap in coverage for those coming out of prison; has to wait until Medicaid is approved
- Lack of coverage for certain services with people diagnosed with SUD; can only bill for assessments and individual counseling. Screening and referral, crisis intervention, case management are not covered under Medicaid, even though these types of services are covered in Medicaid for people who have mental health disorders. The cost of medications to treat alcohol and opiate use disorders is covered, but there is no code for substance use treatment providers to cover medication administration and monitoring, like there is in mental health.
- How can small mom and pop providers get infrastructure put in place to provide quality services?
- Lack of funding/infrastructure to cover all that is required to operate in Medicaid and managed care, e.g. billing staff; EHR; system/quality people; front desk staff.
- Part-time physician or APN needed, but many social service organizations do not have the funding; these are vital pieces

What are the biggest challenges/ barriers to retention?

- Inability to address all of the underlying needs that are often the drivers of use, e.g. housing, employment, community-based issues around violence, lack of resources.

- Lack of flexibility with approach towards treatment, some clients admitted to IOP need to work and we try to be flexible with our hours, but don't have enough staff to hold a variety of hours for IOP.
- A lot of work is in the pre-treatment phase, which is not covered in Medicaid. Our ability to do case management is limited. We only are paid to do individual and group sessions, but clients need more than this approach.
- Minimum treatment hours need to be flexible enough to support people's efforts to become gainfully employed.
- Insurance – once people start working, their benefits in Medicaid are cut off. We accept a sliding fee scale, but we don't charge as much as we need to to cover costs or clients wouldn't be able to afford it.

What are the biggest challenges/ barriers to recovery?

- Treatment services will look different depending on population; treatment needs to look at other issues patients may be dealing with (housing, transportation, lack of income, neighborhood, etc.) Treatment cannot be as effective if these services are not offered.
- 1115 waiver for employment and housing pilot was approved in May of 2018 but has not been implemented.
- Housing – a lot of recovery homes will not take patients if you have not used for 30 days; already need to be sober before arriving; difficult for those who may have slipped up and used and now have to wait to get a slot.
- Recovery homes that do not take women and children who cannot get in because of their children.
- There is a stigma between MAT treatment in the Latino and AA community; the use of peers who have had MAT treatment is important; peer support is not covered under Medicaid; Kentucky adopted all of these services to their state plan as a standard and billable service; why can't Illinois?[1]

What are gaps in the continuum of care spanning from early intervention and outpatient services to medically monitored intensive inpatients services and medically managed intensive inpatient services?

- See written input regarding screen and crisis intervention not being covered
- Some people need services right away before getting an official diagnosis. When crisis presents, work is done prior to the assessment; you still have done work to stabilize them or initiate a relationship with them but those services are not covered; in mental health these services are covered without a diagnosis for up to 30 days, whereas in SUD you need a diagnosis first—no exceptions.
- Mobile crisis is not billable to Medicaid
- We offer case management but do not get paid for it

[1] https://chfs.ky.gov/agencies/dms/member/Pages/SubstanceAbuse.aspx

- How to do MAT without a billing code? Most places are linked with hospital are able to bill for MAT, but it is challenging for the smaller organizations who do not have the ability to bill through a hospital or physician.

What opportunities should Illinois Medicaid pursue to improve treatment initiation, retention, and recovery?

- Adding services to state plan to cover other services for SUD providers; implementing the two pilots (supportive housing and supported employment) mentioned above; need to look at housing and employment and work with other state agencies to see how the gap can be closed
- Grants/state funding that is specific to certain populations including populations on the west and south sides of Chicago.
- Meet people where they are; current treatment is rigid – very limited flexibility towards approach, frequency;
- For people coming out of jail or prison, there is no pre-release treatment initiation; New York applied for the provision to allow services to be covered 30 days prior to release. Illinois applied, but these provisions were not approved. There is work at the federal level to remove or modify the "inmate exclusion" under Medicaid-related law.
- Medicaid pre-enrollment release is an issue; if they could receive coverage before release this would be helpful. Benefits are supposed to be suspended upon incarceration and reactivated upon release. In past two months, we have worked with over 200 clients coming out of IDOC and not one of them had active benefits upon release. They were either uninsured or their benefits were still "restricted" or "suspended."

<u>SUPPORTIVE SERVICES</u>

What are the essential supportive services and what is their capacity in Illinois for those with SUD?

- Housing – a lot of recovery home require patients to be sober for 30 days
- Lack of funding for providers to open recovery homes + to add new line of service. Most funding is going to providers that are already licensed as recovery homes.
- Employment services – not many providers offers this alongside treatment, but it is critical for low-income populations in recovery.
- Mental health – especially those coming out of prison; there is a waitlist to get an assessment appointment from provider; shortage of mental health providers.
- Family support – if there was a code for family counseling would make things easier for providers
- Digital literacy – clients who have been in prison for so many years are having challenges getting up to speed with technology; webinar; telehealth; a lot of technology component to access treatment these days; job applications are now online; difficult for those who do not have a cell, computer or who don't know how to use it.

HARM REDUCTION & HEALTH PROMOTION

What is the role of harm reduction and health promotion in treatment of SUD?

- Some people are not ready to engage in treatment; if they are not ready for this stage we need to figure out how to educate them until they are; you want to give patients something; leads to crisis intervention work needing to be billable

How might Illinois Medicaid more fully support overdose prevention and harm reduction for Medicaid beneficiaries?

- Need to cover prevention work in Medicaid; whatever you want to call it – crisis intervention, early intervention, stabilization, etc.
- Clients coming from prison – requested Narcan, but cannot get it for those getting released. 40x's more likely to die from overdose from other people; they haven't used in several years so whatever amounts they may have used before incarceration may kill them; high risk population but no resources in Medicaid exist to get to those for patients prior to release.[2]

PAYMENT ISSUES

How might alternative models of payment for care help facilitate improved access to care for Medicaid beneficiaries? (Please provide data and references for innovative solutions whenever possible, including contact information for further discussion)

- One of the problems that affects care is the fee-for-service model. It doesn't cover all of the things that go into helping someone; needs to be a bundled payment for treatment providers to help them with all of the things required to help; providers could do more if they had more billable codes.
- Need a bundled payment for treatment providers, similar to encounter fees for FQHCs.[3] These codes would pay for all the work that goes into an initial visit and services provided by a multidisciplinary team. It would be designed to reflect the cost for all the services associated with a comprehensive visit, even if not all the services occur on the same day. These should be based at the community-based provider level in order to expand the reach to hard-to-reach populations that don't innately engage in primary care, but that might first get assistance first with things like housing or employment. Payment models should be adjusted to meet the population where they are at.
- Safer Foundations is operating at a loss most of the time – constantly providing more than what is reimbursable. FQHC's/Hospitals – often in meetings, we hear representatives from these institutions say that such is such is not covered, so they cannot do x, y, and z. they cannot provide services, without a code(s). Reference legislation to create a collaborate care model, which opened up a new billing codes to provide behavioral health care within their practices.[4] But with smaller community-based organizations, they are expected to provide

[2] https://sph.unc.edu/sph-news/former-inmates-at-high-risk-for-opioid-overdose-following-prison-release/
[3] https://www.cms.gov/medicare/medicare-fee-for-service-payment/fqhcpps/downloads/fqhc-pps-specific-payment-codes.pdf
[4] https://legiscan.com/IL/bill/SB2085/2019

services for free even if they aren't getting paid. The need for support is not met with the same response from government decision makers that it is for larger medical providers/health systems.

SPECIAL POPULATIONS

Do you have any specific concerns regarding special populations?

- Justice-involved population has a lot of needs; many prisoners who need treatment don't get it while incarcerated (16%), not enough treatment happening pre-release; lack of coverage before release; depends on what parole officer patients get; some don't come to the work with a social worker lens or some are not as knowledgeable about resources as others.
- Clients are on electronic monitoring and cannot go to an appointment if they are on house arrest; Services have to address the reality of this population; more education needs to be offered to providers in justice system and able to accommodate processes to better accommodate this population.
- Some clients do not have family support which needs to be considered; some providers will only look at the use of drugs/alcohol and not the myriad of issues that drive the use.
  Policy & Societal Barriers

How does racism and discrimination affect those with SUD and their recovery?

- There is a blanket level of assumption when it comes to education level with clients; Ex: telehealth but you don't break down sitting down with a client on how to access telehealth or whether or not they have an email or know how to get an email from their phone and how to send or receive an email; no effort to address the needs they have; turning a blind eye to the other issues. Some clients have never used a cell phone. They've been locked up for 20 plus years.
- With the millions of dollars that came through the federal government, the initial providers were awarded in 2017/2018 were re-funded with additional dollars that came through in subsequent years. Did not see many opportunities for new providers to apply to draw down on these critical resources over the span of the 3-4 years. When new funding opportunities were announced, they were largely for existing MAT or recovery home providers, versus for providers that wanted to expand to offer these new service types. We could have expanded our capacity with such funding, but we are limited; trying to seek dollars to cover current costs rather than to innovate, which is what is needed especially for our population.
- Other issues patient population may deal with that no one wants to help with; Ex: client was referred to detox but couldn't because client had to go to work
- Clients are more likely to be arrested/incarcerated for previous SUD in the Latino/AA population; Opioid conversation until 2019-2020 was centered largely around the opioid epidemic from a white patient's lens – e.g. pain pills and doctor's offices, versus the opioid epidemic as it exists within black and brown communities; not a lot of minority representation to help advocate for this patient population.
- When you ask the AA community about the opioid epidemic, they say we don't have an opioid problem—we have a heroin problem and its not just heroin.

How does bias and stigma affect those with SUD and their recovery?

- SUDs are looked at as having bad behavior; it isn't looked at on the same level of other diseases; people are using to prevent the sick feeling from detox to cope with mental health issues stemming from trauma past and present;
- Continuing to educate providers, correctional officers and other people assisting in the treatment of these patients
- Breaking down stigma by saying 65% of population suffer from SUD (amongst cj pop); the same way mental health is mainstream; the more it is normalized, the less it will be stigmatized.
- State's effort to promote MAT needs to recognize medications are necessarily a cultural thing; acknowledge this isn't something all people will do

What are promising proposals for Medicaid to consider that would require a policy change at the Federal level?

- Coverage of Medicaid before pre-release with 1115 waiver or statutory change with the inmate exclusion provision in the Social Security Act.
- Increase Medicaid coverage of Substance Use Services; Meaning inclusion of these services in the state plan and not on a pilot/limited basis. Other states[5] cover way more services than Illinois, e.g.
    - Screening (not a full blown assessment, but a quick screen for immediate needs) - Evaluates the presence of mental health, substance use or co-occurring disorder to establish the need for an in-depth assessment.
    - Crisis intervention - Offers immediate, short-term face-to-face in-office help to those experiencing event-triggered emotional, mental, physical and behavioral distress or problems. Should be offered up to 30 days prior to needing a diagnosis as with mental health crisis intervention.
- Mobile crisis - Full-time response team to safely transition a beneficiary in crisis to the most appropriate services including short-term face-to-face outside a provider facility.
- Peer Support - Services provide social and emotional support by qualified adults and youth in recovery or family members of persons substance use or co-occurring disorder.
- Targeted Case management - Services to assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. Should be offered up to 30 days prior to needing a diagnosis as with mental health targeted case management.
- Family/Couple Outpatient Therapy - Scheduled visits between a therapist, beneficiary and the beneficiary's family or household member to address issues in an effort to improve interpersonal relationships in the home.
- MAT - Bundled payment for substance use treatment providers and medical practices to offer Medication Assisted Treatment (MAT) to cover patient education, prescribing, medication

[5] https://chfs.ky.gov/agencies/dms/member/Pages/SubstanceAbuse.aspx

administration, monitoring, and maintenance. Lack of adequate payment affects availability of services.

Sinissipi Centers

Names: Patrick Phalen, CEO; Stacie Hemp; Rebecca Johanning
Location/County: Northwest IL, 5 full time office sites, 2 recovery homes, 4 residential settings, 2 safe passage counselors for justice-involved centers—grant funded, only short term funded
Location/County Served:
Services Offered: Prevention, intervention, DCFS programs, substance abuse treatments, Vivitrol. They partner with a local health dept (Whiteside county)/FQHC for MAT (Suboxone).
Number of Clients Served/Proportion on Medicaid: 5500 individuals per year; 88%

TREATMENT INITIATION, RETENTION & RECOVERY

What is working well in Illinois?

- The ease of restrictions such as telehealth during COVID as been a huge help. This needs to be extended past COVID.
- This helps supplement office-based services and helps people access/retain/recover.
- They have been able to have conversations with SUPR to see what can be done and how they can fund it.

What are the biggest challenges/ barriers to accessing and initiating evidence-based treatment?

What are the biggest challenges/ barriers to retention?

What are the biggest challenges/ barriers to recovery?

- Services are mandated to be provided within their 4 walls but they need to do community-based work. They need to be able to go into the community, go out into homes, but they feel like they are stuck. They need to actively engage people in treatment.
- Access to inpatient treatment is an issue where they are. For them, the nearest place is 40 miles away in Chicago.
- Continuity of care is lost.
- Even though they set up treatment upon discharge, communication is often poor. A care coordinator is needed to follow through all steps and transitions.
- They would love to have one where they are but infrastructure costs are prohibitive, and they can't do what Chicago can do.
- Lack of meeting availability e.g. AA
- Reimbursement is low

What are gaps in the continuum of care spanning from early intervention and outpatient services to medically monitored intensive inpatients services and medically managed intensive inpatient services?

- Even though they set up treatment upon discharge, communication is often poor. A care coordinator is needed to follow through all steps and transitions.

- They need a stepdown structure between recovery homes and outpatient services, but this is not funded. “There seems to be a level of care that is missing.” More funding is needed for ALL stages.
- They have had to be creative in the way they run recovery homes to make them sustainable, and they work with SUPR to do this—otherwise can’t break even and support their work.
- Not sustainable based on per diem rate
- A lot of staff have to wear several hats due to cost of operating

What are the barriers to providing behavioral health care, including SUD treatment, integrated in a primary care setting?

- They have worked with primary care providers/hospitals (one in the same with them) to set up detox given their reimbursement issues. Hospitals do the detox and they do the treatment.
- There have been a lot of issues with regulatory requirements. “They need flexibility to do things as they need to do it.”
- They have care coordinators on site to connect people with Medicaid/care.
- “PCPs have been responsive but do not always understand addiction very well.”
- Needs PCPs who are more educated in addiction medicine
- They need to understand where the person is/what long term recovery is/what it looks like
- Sometimes clients are treated poorly due to stigma

What opportunities should Illinois Medicaid pursue to improve treatment initiation, retention, and recovery?

- Improve reimbursement as many are limited by this.
- AST/CST provide model for SUD—would love to put this together for people with addiction
- Need to institutionalize more diversion programs
- Has been successful so far, but many counties do not have the resources for this

<u>SUPPORTIVE SERVICES</u>

What are the essential supportive services and what is their capacity in Illinois for those with SUD?

What is working well in Illinois?

What are the biggest challenges/barriers?

- Employment can be difficult.
- People limited in who will hire them.
- Older people sometimes need new training in order to be hired.
- Need more education and incentives for employers to hire people with a history of SUD/criminal record.
- Hard for someone in recovery to find a job on their own, e.g. don’t have a license, transportation to interview/to job

- They don't always have the ability to provide this in a rural setting
- Often jobs are very far away
- Housing can be difficult.
- They are able to provide mental healthcare.
- Fortunately they have an involved community working on these supportive services.
- they work with local employers to get people hired

What should Illinois Medicaid do to foster access to supportive services?

- Improve reimbursement!
- Reduce constraints, especially the need to provide services within their 4 walls.
- Need a recovery support person to follow through all stages and transitions.
- Help people get their driver's license back after recovery – currently too many rules
- Need to support axillary services better
- Need to reimburse for case management

HARM REDUCTION & HEALTH PROMOTION

What is the role of harm reduction and health promotion in treatment of SUD?

- They try to practice harm reduction model.
- E.g. Conversations with clients about what is less harmful e.g. marijuana over IV heroin (stigma in smoking marijuana though)
- All health depts have needle exchanges in their rural area
- Narcan is readily available here – "for a while it seemed like all the money was thrown into this when more money could be given to other strategies."
- They do not have safe injection sites, not usually available in rural areas

How might Illinois Medicaid more fully support overdose prevention and harm reduction for Medicaid beneficiaries?

- It seems kind of hard to see how Medicaid can support this because so many things are not traditional Medicaid ability, seems like it may need to come from other funding sources.

What more can we do in terms of early intervention?

PAYMENT ISSUES

How has the current reimbursement model affected treatment?

- Reimbursement is low and limits services.

How might alternative models of payment for care help facilitate improved access to care for Medicaid beneficiaries?

- CST MODEL on mental health side would be a nice marriage from having a primary care physician

- Allows more community based
- Reimbursed as a group
- Look at Medicaid rule 140/model for mental health
- Per member per month model is a possible option
- Can taper funding down to encourage movement through levels from high intensity
- Should marry SUPR and DMH in regards to policies, services/rates

SPECIAL POPULATIONS

Do you have any specific concerns regarding special populations?

- Justice-involved have a lot of barriers
- They "have progressive system that gives Vivitrol."
- Inmates reoffend due to lack of access to treatment.
- Dual diagnosis with serious mental illness is common.
- However there are different funding streams with different rules for mental health and addiction.
- Try to make this seamless for their clients whether mental health funding or SUPR – BUT this results in challenges with assessment/documentation
- Need to unify rules and regulations
- Should marry SUPR and DMH in regards to policies, services/rates

POLICY & SOCIETAL BARRIERS

How does racism and discrimination affect those with SUD and their recovery?

- "It is interesting for us because we live in a homogeneous area without much diversity."
- However, they do have a sizable Latino population and engaging in services is challenging for them because there are only 1-2 Spanish speaking providers in the agency.

How does bias and stigma affect those with SUD and their recovery?

- The someone is treated by the hospital/PCP is different. They are often thought of as a bad person if they said they are in longterm recovery or if they have a history of criminal activity while struggling with addiction.
- Stigma has been very challenging to deal with. Neighbors were concerned about having their organization in their community even though known that their community had high drug use. Seems to be concerned about attracting "drug addicts" but not realizing those "drug addicts" were already in their community and were their neighbors. People seem to associate those with addiction with rapists and murderers.

What are promising proposals for Medicaid to consider that would require a policy change at the Federal level?

- Stop the requirement to disclose felony charges especially if the crime was during active addiction.
- Need to incentivize employers to give people a second chance

- Need more education in communities
- Need more education of PCPs/hospitals
- Need Narcan in drug court and employers
- Some judges seem set in their ways and not open-minded about having drug court or having employers carry Narcan
- Need to incentivize Spanish-speaking people to go into the field, e.g. loan forgiveness, paying more

OTHER:

- “Tax dollars for the cannabis is frustrating because those dollars will be so specific that they won’t be useful.”
- So specific that it is not helping them do what they need to do which is just to fund what they are already doing--to much administrative burden
- Administrative burden in general is a problem
- “We want to help people without all the barriers and red tape....We need flexibility of funding and rules.”
- “A lot of people are out there that just want to help but feel like they can’t.”

Skokie Department of Public Health

Name: Beth Lindley
Role: Director of Human Services Division
Location/County: Cook/Skokie Township
Services Offered: None by HD except for information and referral
Patients: N/A

TREATMENT INITIATION, RETENTION & RECOVERY

What is working well in Illinois?

- There are service resources available for youth and adults at the outpatient and inpatient level.

What are the biggest challenges/ barriers to accessing and initiating evidence-based treatment?

- Funding, coordination of care, not great entry points for people
- In Skokie, many different languages spoken, and programs available usually have white clinicians who don't speak other languages. They struggle with inclusion in their very diverse community.

What are the biggest challenges/ barriers to retention?

- For staff/organizations, they are not paid well so people sometimes go into entry level for their supervision/education but then move on to other opportunities.
- Case loads are heavy and people are spread thin.

What are gaps in the continuum of care spanning from early intervention and outpatient services to medically monitored intensive inpatients services and medically managed intensive inpatient services?

- Follow up services are difficult and coordination of care is poor.
- E.g. in Minnesota seemed more coordinated from hospitalizations to community level.
- Employment/hierarchy of needs not met in the beginning—cycle and social determinants of health need to be addressed.
- Schools have supports, but school social worker positions reduced and she is unsure why.
- Often the police is the intervention point for people/kids with mental health problems which is a problem.
- Then law enforcement issue and treatment is a forcible issue.
- We support self-determination, but the barrier is that there are major limitations in terms of how to bring people in to get treatment.

What are the barriers to providing behavioral health care, including SUD treatment, integrated in a primary care setting?

- Having the appropriate staff available in primary care settings to make sure assessments done and follow up interventions done
- Usually RNs can only do very quick assessment and physicians are stacked, so there is not opportunity in the current structure to get at these issues. People need to be seen quickly so there is no time for a psychosocial, multidisciplinary assessment. This seems to be the case in every medical setting.

What opportunities should Illinois Medicaid pursue to improve treatment initiation, retention, and recovery?

- Need to improve reimbursement for assessment in the primary care setting
- "Reimbursement in general has been difficult."
- "The managed care model in Illinois seems to make sense but has created a lot of confusion about where people can go and not enough staffing to help guide people through... Medicaid itself needs more staffing."

SUPPORTIVE SERVICES

What are the essential supportive services and what is their capacity in Illinois for those with SUD?

- Community based supports mostly but right now we are geared more towards hospital settings with inpatient services.
- Beth would love more group support for people.
- There is a good 12 step network in Chicago, but in the suburbs people find that the Chicago-based programs are better and there is not much available in the suburbs.

What is working well in Illinois?

- Skokie is making an effort for organizations to be in connection with each other.
- However, "we more share with each other rather than work together and collaborate. We need to bring our resources together and be more collaborative and collective."
- E.g. like the IL ACEs Response Collaborative

What are the biggest challenges/barriers?

- Absence of funding and support
- E.g. Community Development Block Grant funds – tiny 15% service cap allocated to 20 different non-profits and exclude others – amount allocated is super small.
- Affordable housing always barrier as well as meaningful employment opportunities
- Rent continues to rise in Skokie.

What should Illinois Medicaid do to foster access to supportive services?

- Bolster and improve their own service system
- Develop increased reimbursement models for service providers

HARM REDUCTION & HEALTH PROMOTION

What is the role of harm reduction and health promotion in treatment of SUD?

- Acknowledge where people are and do not create rigid models of care that exclude someone where they are on their stages of change. You need to meet people where they are at and provide harm reduction services.

How might Illinois Medicaid more fully support overdose prevention and harm reduction for Medicaid beneficiaries?

- Beth worked with services unit from Chicago with mobile unit that did outreach and assessment—if more services like that were funded that would be helpful.
- Motive needs to be bring people in for services not to make the community look better.
- Less rigid guidelines and rules are needed.
- Need to work to end homelessness.
- Beth was excited about model in Milwaukee where managed care programs helped fund housing first models for homeless/vulnerable populations.
- Cost-effective model that reduces ER visits and hospitalizations

What more can we do in terms of early intervention?

- Talk with youth especially in high school and learn more from them. Kids need to learn from each other with guidance.
- Engage families and children at younger ages re SUD and mental health.

PAYMENT ISSUES

How has the current reimbursement model affected treatment?

- Reimbursement is poor
- Managed care model has affected care
- E.g. People prefer to stay in Skokie but with MCO plans end up in Chicago rather than close place like NorthShore
- Disruption in care happens when people don't receive paperwork or a phone call and their case is terminated. Sometimes they do not realize this until they go to the doctor.

How might alternative models of payment for care help facilitate improved access to care for Medicaid beneficiaries?

- Beth was excited about model in Milwaukee where managed care programs helped fund housing first models for homeless/vulnerable populations.

SPECIAL POPULATIONS

Do you have any specific concerns regarding special populations?

- Overall accessibility of the system is a challenge
- The pandemic has been an interesting circumstance that created barriers for people

- We should improve the use of technology, be more efficient
- Transportation is an issue to get care, waiting for hours to have someone work with them on their case

POLICY & SOCIETAL BARRIERS

How does racism and discrimination affect those with SUD and their recovery?

- Disproportionate numbers of black and brown people deal with barriers to getting service and care and getting treatment.
- Systems predominately have white providers--not enough treatment represented by people who look like them and can give a lived experience

How does bias and stigma affect those with SUD and their recovery?

- No one will ever be free of this but we can support each other—we would be better advised if we had a more diverse workforce.

What are promising proposals for Medicaid to consider that would require a policy change at the Federal level?

- When the ACA rolled out, the federal government provided additional supports and services and this seemed to really make a difference, expanded coverage also a big deal. Thinking about the poverty line and how it has been set there for a long time and has not changed to reflect the current state of things. You can't survive on $1000 per month and people need to figure it out just to have a normal life. The federal government needs to think about that, change how we look at poverty. We should look at eligibility and resources, housing, employment, training, and supports.

So7 Healthy Communities Coalition

June 8, 2020
Note taking by: Fanta Saidou, Angie Bailey, & Kitty Juul

TREATMENT INITIATION, RETENTION & RECOVERY

What is working well in Illinois?

- The changes to the PMP. Over the last 6 months, it has been more user-friendly. You can check TN, MO, and KY PMPs.
- Telehealth is working well. Many people are enjoying them better than in-person appointments. It is going well for seniors especially. Convenience – not having to wait in waiting rooms for hours and transportation is not needed. Patients can easily be at home on their phone.
- In the recent months, there have been success with some patients on Subutex.
- Tablets availability for senior centers to have medical appointments from their car – new thing that will be offered.

What are the biggest challenges/barriers to accessing and initiating evidence-based treatment?

- Lack of substance abuse counseling, limited mental health professionals
- Limited BH, telehealth psych – 1 per week
- Transportation Issues
    - Access to consistent transportation.
    - Transportation companies recently stopped taking people to methadone clinics and when running, timing of pickups and drop offs are inconsistent.
- Lack of providers
    - No providers or they have their waivers but are not willing to prescribe.
    - Providers are unwilling to take referrals and only want to serve their existing clientele.
- Waitlist to get into services.
    - Waiting can cause people to change their mind.
- Many of the local ERs still provide patients with whatever is asked for, so for providers trying to help people get off opioids, that makes it difficult. Patients are shopping around.
- One system is using a one chart EMR system, and staff is still learning how to send messages to warn other prescribers about someone with OUD/comment on patient charts of what not to prescribe. It's hard if they go to a different system. Patients keep searching and they can easily find what they want. "It's hard to do the right thing, when so many other places are not."
- Lack of warm handoff. Create a better process from ED to provider.
- Lack of being able to "get through to" managed care providers and the approval process is an issue. Approval process is a little difficult with the manage care site.
- Telehealth is a good solution to the transportation issues, but it uses up cellphone minutes. Sometimes you are dealing with people without a cell phone to begin with.

What are the biggest challenges/barriers to retention?

- Lack of childcare
- Lack of consistent transportation
- Juggling home life
- Having an underlying medical condition which requires the medication that patient is addicted to. Get the medical condition cleared up and also deal with the addiction side of it. COVID added more issues on top of everything.
- Education is needed for pregnant women who are receiving MAT; some think they need to go off it. It is completely safe to continue SUD treatment. Education is needed about the consequences of lack therefore continuing treatment while pregnant.
- Women's health related help is limited in the So7 area.
- Stigma attached to MAT services; belief that it's changing one drug for another. Family members believe that there is a different route to go, so they drop out. Stigma impacts people staying in it. Support system that the patient has makes a difference. Support systems are not seeing MAT as beneficial.

What are the biggest challenges/barriers to recovery?

- The environment that patients in MAT live in. Some believe that if they change their environment, they could be successful. But, if you don't have the means to pick up and move, it's difficult. Huge barrier.
- Need to set up appointments for patients instead of giving them numbers to call. Hand offs/referrals – when you actually call and set it up for them, they are more prone to go. Them having to make the calls can feel very overwhelming in their state.
- Warm handoffs needed.

What are gaps in the continuum of care spanning from early intervention and outpatient services to medically monitored intensive inpatients services and medically managed intensive inpatient services?

- If people need a higher level of care, sometimes they refuse to go. Do you continue to work with them or lose them all together? When they decide to go, getting them into the higher level of care takes a long time. Once someone says they're ready to go to treatment, they need to go right away. If they wait, they may be lost.

What are the barriers to providing behavioral health care, including SUD treatment, integrated in a primary care setting?

- Staff education. Some staff still have an "old school" way of viewing behavioral health and looking at things. They patients are often labeled, and not treated like other patients. Stigma among staff. More trainings and education for staff is needed.
- Primary care providers have had to do more mental health than they are trained to do. This is due to lack of resources. Southern Illinois does not have the resources that larger cities have. No extra level of expertise to rely upon. Lack of resources across the care continuum.

- Difficulty recruiting LCPCs and LCSWs with the necessary credentials because they are expensive. Hard to recruit the professional staff needed.
- Video services is new to SHS for behavioral health as a result of COVID. This service may prove to be beneficial going forward.

What opportunities should Illinois Medicaid pursue to improve treatment initiation, retention, and recovery?

- Cover social work services.
- Cover transportation costs.
- Have a reliable busing system.
- I would, as a physician, be willing to obtain a waiver, but there is a lack of time to do that and see current patients.
- More trained MAT providers.
- Lack of incentives – to incentivize people to give waivers for MAT services. Lack of abundance of MAT providers. Incentivize MAT training/services.
- Need providers who can focus on managing the unstable patients while other providers manage the medications. Two tiers of providers needed – stable individuals and unstable individuals.
- MAT helps with opioids, and we have a lot of people with meth addiction. There are a lot of places where they can receive treatment for more than one substance. People have poly SUDs. High level of care is hard to find that can continue the MAT treatments. Not a lot of places they can go to continue treatment when various substances are involved.

<u>SUPPORTIVE SERVICES</u>

What are the essential supportive services and what is their capacity in Illinois for those with SUD?

- Peer recovery support services are very essential. When utilized, they help with recovery. Cover by Medicaid.
- Patients with felonies on their record that can't find work. Puts them back in the light of using, selling, or both. If they could get back to meaningful employment, it could help with mental health and substance use.

What is working well in Illinois?

- No comments.

What are the biggest challenges/barriers?

- No comments.

What should Illinois Medicaid do to foster access to supportive services?

- No comments.

HARM REDUCTION & HEALTH PROMOTION

What is the role of harm reduction and health promotion in treatment of SUD?

- Internet access put in for those that need it to do telehealth appointments.
- Make things more convenient.
- Needle exchange program in Southern Illinois.

How might Illinois Medicaid more fully support overdoes prevention and harm reduction for Medicaid beneficiaries?

- An example comes from addressing mental health in rural Native American communities: tablets are placed in fire stations and police stations, making it more convenient for telehealth appointments. Open 24 hours.
- Promote more needle exchange programs (Scott Fletcher)

PAYMENT ISSUES

How has the current reimbursement model affected treatment?

- No comments.

How might alternative models of payment for care help facilitate improved access to care for Medicaid beneficiaries?

- No comments.

SPECIAL POPULATIONS

Do you have any specific concerns regarding special populations?

- Teens and substance use – truth and consequences.
- Pregnant women.
- Felons.

POLICY & SOCIETAL BARRIERS

How does racism and discrimination affect those with SUD and their recovery?

- Limited access to care in general across the board…. things not racially related…. just a matter of where we are as a State.
- Limited access to resources. So much given to Chicago that south of Springfield doesn't matter. Lack of resources in rural areas.
- The reason large amounts of money from the federal government has given to this issue is because of the suburban whites. Those other drugs of people from low SES need fed funds.

How does bias and stigma affect those with SUD and their recovery?

- With opioids, people say, “it’s not their fault”. It can be blamed on the provider. The same messaging should be applied to everyone addicted to drugs.

What are promising proposals for Medicaid to consider that would require a policy change at the Federal level?

- No comments.

Any additional comments or feedback about other ways to improve SUD care and treatment for Medicaid enrollees.

- No comments.

Trilogy Inc.

Name: Courtney Emery and Crystal Hreska
Role: Outpatient Services/Recovery Services Program Manager
Location/County: Cook County (city)
Services Offered: Community mental health center; mental health services; intensive community based mental health services; group therapy; residential program; 40% of clients have co-occuring SUD; primary clinic and Psych. 2nd largest community mental health facility
Patients: 1400-1500 seen annually

TREATMENT INITIATION, RETENTION & RECOVERY

What is working well in Illinois?

- Expansion around harm reduction; ability to access naloxone more easily
- Open door policy which makes it easy for people to gain access to care quickly

What are the biggest challenges/ barriers to accessing and initiating evidence-based treatment?

- Trilogy serves clients with Medicaid insurance; for people who need residential treatment there are very few Medicaid beds available; most people need treatment right away
- IOP (intensive outpatient program) hard to find something that has the capacity to assist the clients immediately; when you don't have access to a bed you lose momentum
- Concerns about the quality of IOP's available for people with Medicaid; in addition to them not being harm reduction focused
- For clarification: IOPs that serve people with Medicaid are generally not of high quality and not trauma informed in addition to not being harm reduction oriented

What are the biggest challenges/ barriers to retention?

- Wrap around services; housing, employment, financial needs become barriers
- Housing is an important part of harm reduction; challenge when there are so few subsidies available; very few rentals available
- Integrated trauma care is a barrier as it isn't always available due to limited resources; most SUD clients receive trauma care if they involved in therapy; Trilogy is very trauma informed based so staff is educated around this

What are the biggest challenges/ barriers to recovery?

- Housing, employment, financial needs, the stigma around care, the provider's training – how to engage someone who has a substance use issue

What are gaps in the continuum of care spanning from early intervention and outpatient services to medically monitored intensive inpatients services and medically managed intensive inpatient services?

- Clear to see lots of gaps between IOPs and residential programs
- MAT is offered at Trilogy but there is a lack of providers overall available to the Medicaid population
- Preauthorization on medications – there is a delay in paperwork being sent, communication between provider and insurance company where patient is then suffering because they are without meds; providers are reluctant to become prescriber because of this "red tape"

What are the barriers to providing behavioral health care, including SUD treatment, integrated in a primary care setting?

- Communication and seamless exchange of information

What opportunities should Illinois Medicaid pursue to improve treatment initiation, retention, and recovery?

- Recruitment (of people), train (faculty/staff) and retain (there is a lot of turn over)
- Access to more funds to assist with payment of staff

SUPPORTIVE SERVICES

What are the essential supportive services and what is their capacity in Illinois for those with SUD?

- Trilogy has several wrap around services and legal services but capacity, funding and resources is an issues as well as how much is available.

What are the biggest challenges/barriers?

Resources and lack of trauma informed lens which is the root of SUD

- Incarcerated patients having access to engage in services can become a barrier

What should Illinois Medicaid do to foster access to supportive services?

- Funding

HARM REDUCTION & HEALTH PROMOTION

What is the role of harm reduction and health promotion in treatment of SUD?

- MAT drugs, naloxone distribution, clean and safe equipment, meeting a client where they are
- The overall harm reduction orientation keeps clients in treatment who otherwise might discontinue or drop out of treatment

How might Illinois Medicaid more fully support overdose prevention and harm reduction for Medicaid beneficiaries?

- Having fentanyl testing has been difficult, legality issues access fentanyl testing strips
- CRA has vans; some more support around these services would be helpful
- ER should start patients on MAT drugs and linking patients from ER to recovery

- Patients cannot obtain drugs if they come through ER; longer term care after they leave would be best
- A person who detoxes will relapse and the risk of overdose is higher if they don't have access to long term care
- Opioid users using benzo and trying to find a detox for benzos is hard with patients on Medicaid

What more can we do in terms of early intervention?

- Education around SUD and providing warning signs on how this looks; teachers and people providing care should know
- Schools are not trauma informed care; kids need to learn about self-regulation
- Finding therapy for your child who may have Medicaid is difficult; there is always a waitlist

PAYMENT ISSUES

How has the current reimbursement model affected treatment?

- Trilogy stated documentation requirements are time and labor intensive; brings the issue of money and more resources needed to help patients; even with developing expertise in helping to treat patients with extreme needs; very complex
- Fee for service offers more freedom; but shines the light on the business aspect because funds are not always available for specific services; not as supported as Medicaid system as it should be
- 95% Medicaid; small sliding fee scale for commercial insurance to diversify; Trilogy exists to serve people who have Medicaid
- Providers commonly develop expertise in working with complex presentations and then depart community mental health due to pay

SPECIAL POPULATIONS

Do you have any specific concerns regarding special populations?

- Lack of resources for formally incarcerated individuals which creates a cycle that perpetuates repeating
- Trilogy offers services to formally incarcerated; very common to serve this populatioN

POLICY & SOCIETAL BARRIERS

How does racism and discrimination affect those with SUD and their recovery?

- Racism and discrimination affects those with SUD immensely
- Many patients they have witnessed are overwhelmingly been traumatized by racism, homeless, history of incarceration, intergenerational trauma

How does bias and stigma affect those with SUD and their recovery?

- Some of this is internalized by the distrust with providers and treatment centers due to how they have been treated; more education/training is an opportunity around this area
- Very individual focused; evidence-based practices; trauma-based care – Trilogy could benefit from adding additional training

What are promising proposals for Medicaid to consider that would require a policy change at the Federal level?

- Trilogy doesn't receive any federal funding; grants + Medicaid fee for service

Winnebago Department of Public Health

Name: Dr. Sandra Martell, RN, DNP
Role: Public Health Administrator
Location/County: Winnebago
Services Offered: The Health Dept is funded for rescue services

TREATMENT INITIATION, RETENTION & RECOVERY

What is working well in Illinois?

- There is a commitment from the prescriber side to check the prescription monitoring program before prescribing opioids
- Looking at prescriber standards/guidelines to reduce OUD
- Coverage of MAT

What are the biggest challenges/ barriers to accessing and initiating evidence-based treatment? What are the biggest challenges/ barriers to retention?

- Few access points/limited access
- Limited providers providing MAT
- Providers reluctant to go into the treatment arena/MAT
- Access is poor for counseling and supportive services
- Stigma and bias with SUD decreases quality of care
- Need to see SUD as a chronic disease e.g. similar to diabetes

What are gaps in the continuum of care spanning from early intervention and outpatient services to medically monitored intensive inpatients services and medically managed intensive inpatient services?

- Gaps at every step, not coordinated
- Need to do more in terms of early intervention and prevention
- E.g. seeing rise in opioid use in youth in YRBS and need to improve prevention education

What are the barriers to providing behavioral health care, including SUD treatment, integrated in a primary care setting?

- Often referral to other providers instead of managed within primary care
- Short visits with primary care providers
- Not providing holistic mental + physical healthcare
- Providers reluctant to provide MAT

What opportunities should Illinois Medicaid pursue to improve treatment initiation, retention, and recovery?

- Integration of medical records to make things seamless for providers
- Expand capacity of primary care providers

- Increase reimbursement for amount of time providers can spend, need more than 15 minutes
- Promote holistic care: integrate mental health and physical health – SUD needs to be part of regular care and reimbursed accordingly
- Improved mental health access, especially for youth
- Keep telemedicine as this has been helpful during COVID
- Reimbursement rates for providers need to be competitive
- Incentives for providers to provide MAT
- Equitable reimbursement

SUPPORTIVE SERVICES

What are the essential supportive services and what is their capacity in Illinois for those with SUD?

- Transportation
- Access to culturally competent, linguistically appropriate providers
- Employment
- Money
- Care coordination
- Support groups – AA/NA, need peer base

What is working well in Illinois? What are the biggest challenges/barriers?

- Need supportive employment and schools that are trauma-informed rather than punitive
- Need better reimbursement

What should Illinois Medicaid do to foster access to supportive services?

- Cover peer support/support groups as they are a method of treatment
- More reimbursement for supportive services in general
- More reimbursement for care coordination

Harm Reduction & Health Promotion

- What is the role of harm reduction and health promotion in treatment of SUD?
- Safe syringe programs are important
- Winnebago is looking at this as another tool in OUD toolkit
- Narcan training
- STI prevention/treatment
- “What can I do to help you to move along the path?” - working with those with SUD rather than against
- Helps to establish a relationship with those with SUD

How might Illinois Medicaid more fully support overdose prevention and harm reduction for Medicaid beneficiaries?

- For every opioid prescription, there should be an auto-prescription for Narcan

- Need more “alternative” services covered such as PT/OT, acupuncture, massage therapy

What more can we do in terms of early intervention?

- Outreach
- Need more and improved prevention education early on in schools
- Early mental health access for children (currently limited)
- Need counselors in schools
- Trauma-informed schools
- Schools that are not punitive but rather address and traumas/issues at home
- Improve coverage of diseases associated with substance use such as chronic pain and mental health
- Coverage for PT/OT, acupuncture, massage therapy
- More mental health coverage and access (especially for youth)
- Destigmatize SUD, personal shame

PAYMENT ISSUES

How has the current reimbursement model affected treatment?

- Insurance limitations, limit to how many visits covered, have to choose between different needs for healthcare
- Providers limit Medicaid individuals they treat
- Low reimbursement
- Medicaid now covers MAT but hard to find a provider to do it

How might alternative models of payment for care help facilitate improved access to care for Medicaid beneficiaries?

- Need a solid commitment to make reimbursement competitive
- Incentivize more people into MAT
- Need prompt payment - pay within 30 days
- Payment cycle has impact on institutional bottom line
- Decrease need for prior authorization

SPECIAL POPULATIONS

Do you have any specific concerns regarding special populations?

- Justice-involved
- Need deflection and diversion
- Those with chronic pain
- More time consuming and need more than 15 min visit with providers
- Those with mental health comorbidities
- Need more mental health access
- Minorities

- Immigrant and refugee
- Bilingual, bicultural
- Hard to find bilingual providers
- Pregnant women

POLICY & SOCIETAL BARRIERS

How does racism and discrimination affect those with SUD and their recovery?

- Need more culturally competent care in order to impact health
- “Double whammy” - e.g. stigma against SUD PLUS provider bias from race PLUS possibly a pregnant women

How does bias and stigma affect those with SUD and their recovery?

- There is a built-in view of having a character flaw if you have SUD and this needs to change to recognizing it as a chronic disease
- Especially true for justice-involved
- Affects the receipt of good care/the way they are treated by providers
- Prevents those with SUD from seeking care when needed

What are promising proposals for Medicaid to consider that would require a policy change at the Federal level?

- Invest in primary prevention – SDOH model
- People in a better initial state do better
- Need more support for those who are marginalized not less (equity)
- Treat early to prevent severe chronic disease
- Equitable healthcare system for all
- Funding needs to support the care that is needed for each population
- Partner with the population to make them healthy
- Look at system to see where there are areas for improvement
- Be thoughtful about MCOs
- Commit to providing competitive reimbursement

Working Sobriety Chicago

Name: Dr. Jeffrey Roth
Role: Medical Director
Location/County: Cook County
Location/County Served: Cook County and collars, entire state (works virtually)
Services Offered: Individual, couples, family, and group psychotherapy, pharmacotherapy, medication assisted recovery (suboxone)
Number of Clients Served/Proportion on Medicaid: ~150 total clients, because Medicaid reimbursement is so low/barriers, let go of working with Medicaid population
Has worked in high Medicaid populations in the past for the first 10-15 years of practice
7 staff total (2 psychiatrist, 2 SW, psychologist, addiction counselor, PA)

TREATMENT INITIATION, RETENTION & RECOVERY

What is working well in Illinois?

- There is a well-developed system of mutual support meetings – AA, NA, ALANON which are low cost, high effectiveness for addiction related disorders.

What are the biggest challenges/ barriers to accessing and initiating evidence-based treatment?

- 1-The way we measure success and attempt evidence-based treatment is “primitive” and we need better ways to assess outcomes.
- We measure how long alcoholics abstain from alcohol, when it would be better to measure occupational/professional functioning and relational functioning, improvement or worsening.
- Some people still drink but are heavily involved in recovery and function well – it is a chronic disease.
- 2-We treat mental health services and addiction services as separate entities when they should be coordinated and integrated.
- 3-We do not have adequate system of training health professionals and addiction professionals. We need to train them in treatment together and mutual support.
- 4-Mental health treats people as individuals rather than social systems. Dr. Roth is one of the only psychiatrists in Illinois who does group therapy.
- Dr. Roth sees group psychotherapy as most effective as well as cost-effective.
- Peer led
- Groups can be family/friends, people in recovery together
- How people interact can fuel the addition
- Need group structure of social support/mutual support – can coordinate social support and treatment together

What are the biggest challenges/ barriers to retention?

- Our system punishes addicts for having the disease.

- We should assume substance use may occur again as addiction is a chronic disease, but we do not.
- We want people to feel open about talking about their use and not feel punished for it.
- We throw people out of treatment when they still use even though that is expected in a chronic, progressive, relapsing disease.

What are the biggest challenges/ barriers to recovery?

- The person's own denial
- When a person exposes their denial, "We welcome them and celebrate their sharing."
- Motivational interviewing is key – not a treatment but it is the "path to engaging" and finding out what the client would like help with
- E.g. helps people discover how their drinking is worsening their depression and the depression is then feeding the alcoholism
- People being told their addiction is a moral problem rather than a disease.
- Clinicians need to be more aware of the system of support that exists in the community.

What are gaps in the continuum of care spanning from early intervention and outpatient services to medically monitored intensive inpatients services and medically managed intensive inpatient services?

- What are the barriers to providing behavioral health care, including SUD treatment, integrated in a primary care setting?
- Treatment for mental illness and addiction needs to be integrated and done together, but it is not.
- Primary care providers are not always well trained which could sabotage the treatment.

What opportunities should Illinois Medicaid pursue to improve treatment initiation, retention, and recovery?

- Medicaid should support and encourage a group/team approach.
- This would actually be helpful because it would mean less individual appointments.
- This is especially helpful for when people do not show up. Then the provider's time is not wasted during this scheduled time.
- Group relations training is a method to experientially to help people learn about organizations and social systems.
- Medicaid should support training on the group approach.
- Dr. Roth does trainings on this method. He has tried to share more widely but did not get traction.

Key Points for This Section per Dr. Roth:

- Don't put obstacles in front of people
- Don't try to force them into treatment
- Need to do treatment in groups, not individually. It is effective, cost-effective, and reduces stigma of being on medication.

    - Intake group oriented together, not bureaucratic process of intake with a ton of forms
- Make a telehealth/calling group available if transportation is an issue (Doing this a lot during COVID)
- Don't waste time on people who are not ready – treat those who want treatment
    - Readiness is just showing up
    - If family members try to schedule an appointment for an individual, they are encouraged to come for a family visit.
- Need to set up system so clients can come and go when they are ready – Open system.
    - If they leave, they can come back via the next group intake session
    - No boundaries, people can come and go as they please
- Need to have attached relationship with client so that people will follow up
- A protocol to set up medications so enough is given to come back

SUPPORTIVE SERVICES

What are the essential supportive services and what is their capacity in Illinois for those with SUD?

- Mutual/peer support programs, e.g. 12 step

What is working well in Illinois?

- 12 step programs exist

What are the biggest challenges/barriers?

- Mutual/peer support programs are "the most underutilized resource in Illinois"
- There are a lot of volunteers who could provide this and "no one seems to know this."

What should Illinois Medicaid do to foster access to supportive services?

- Medicaid needs to invest in city mental health centers that coordinate mental health and addiction services.

HARM REDUCTION & HEALTH PROMOTION

What is the role of harm reduction and health promotion in treatment of SUD?

- Abstinence-based and harm-reduction-based is not a good divide.
- E.g. Big Book of AA – take the alcoholic in acute withdrawal in a meeting and give them a shot of whiskey so they are not in withdrawal anymore
- There are treatment centers who offer a more militant stance who think people need to "learn from withdrawal"
- You cannot harm the relationship between the addict and the one who is supposed to support them. You need to have that relationship.
- Do not give just enough medication to avoid death.
- Support being compassionate, relationships with providers, and don't kill the system of caring.

- Don't withhold but also don't just offer medications when social support/engagement is needed

How might Illinois Medicaid more fully support overdose prevention and harm reduction for Medicaid beneficiaries?

- You need to build in structure of social support and engagement.

What more can we do in terms of early intervention?

- Early Intervention is essential. Addiction begins as a family disease. Families need to be worked with and not just given Narcan. It is like giving the addict suboxone without any social services/therapy.

PAYMENT ISSUES

How has the current reimbursement model affected treatment?

How might alternative models of payment for care help facilitate improved access to care for Medicaid beneficiaries?

- Medicaid should reimburse for group psychotherapy and should perhaps incentivize group therapy over individual therapy.
- If the patient shows up, they should be treated. Money should not be a factor.

SPECIAL POPULATIONS

Do you have any specific concerns regarding special populations?

- "The treatment of the black population is atrocious and tragic."
- Top down hierarchy has not addressed the special needs of black people having been a chronically oppressed population. The new Chicago Mayor should hopefully bring some attention to this.
- On the South Side there is a great recovery program of recovering alcoholics who are majority black – Evans Ave Club. You should be able to be inspired by people who look like you. Community members who recovered can become role models for other community members.
- Fortunately AA has meetings in Spanish and Polish and specific meetings for LBGT community. However, not everyone knows about this.
- "Anyone with addiction has co-occurring mental illness – depression, anxiety, ADHD."
- Growing up in a dysfunctional family who did not pay attention to you can lead to ADHD. We do not solve the problem when we give medication instead of the attention and support people need.

POLICY & SOCIETAL BARRIERS

How does racism and discrimination affect those with SUD and their recovery?

- Referencing the recent tragedies – you can be a non-intoxicated African American man and be killed; if you have mental illness as an African American you can be killed; if you are intoxicated as an African American, you are at a serious risk of being killed.
- The same problems in minorities are 10x or more the risk than for a white person with the same issues

How does bias and stigma affect those with SUD and their recovery?

What are promising proposals for Medicaid to consider that would require a policy change at the Federal level?

- We need more reimbursement for Medicaid.
- Licensing restraints should be relaxed. If you have an IL license, you should be able to treat people in other states.
- We need to promote working together/collaboration amongst national experts. We need to not be in silos.
- Dr. Roth would like to train in group treatment for Medicaid providers (like he does in China).

III. LETTERS

Access Living of Metropolitan Chicago

Improving Substance Use Disorder (SUD) Care in Illinois Medicaid For Persons with Disabilities

Established in 1980, Access Living is the federally designated Center for Independent Living for metropolitan Chicago. We are a cross disability rights and services organization providing individualized, peer-based independent living, legal and advocacy services to ensure that Chicagoans with disabilities live fully-engaged and self-directed lives in their homes and communities. With a staff and board made up of a majority of people with disabilities, we are a part of the Illinois Network of Centers for Independent Living, which consists of 22 Centers for Independent Living serving people with disabilities in Illinois. Over the years since our founding, we have assisted thousands of Chicagoans living with a wide array of conditions, both acute and chronic, to live successfully and safely in the community. As such, we view substance abuse disorder as an essential issue which must be addressed in order to ensure people with disabilities have equitable access to quality healthcare and community life. In addition to signing on in support of the Illinois Harm Reduction and Recovery Coalition letter that was also submitted in response to this call for comments, we offer here more detailed comments about the specific needs of people with disabilities with SUD.

The interconnections between disability and substance use disorder (SUD) are multifaceted and complex. Treatment for SUD requires medical care and rehabilitation. SUD itself constitutes a disability and addicts in recovery in some contexts are protected under the American with Disabilities Act. In addition, SUD can co-occur with, exacerbate and/or produce other disabling conditions such as physical, cognitive, sensory, and mental health disabilities. Despite the complex and compounding implications of substance abuse for people with disabilities, there is a dearth of data about their status.

However, the data that does exist suggests that people with disabilities experience a disproportionate rate of SUD. The United States Department of Health and Human Services Office on Disability reports that over 4.7 million individuals in the United States have both a disability and SUD. This represents 9% of the over 54 million people with disabilities in the US. The risk of SUD also varies depending on the type of disability. People with physical disabilities reportedly experience substance use disorders at two to four times the rate of the general population. Prevalence rates approach or exceed 50 percent for individuals experiencing traumatic brain injury (TBI), spinal cord injury (SCI), and/or mental illness compared to ten percent of the general population. These disparities are exacerbated based on race, class and gender.

There are several factors that contribute to the high rates of SUD among people with disabilities. In the case of opioid abuse, people with disabilities tend to be prescribed medication more frequently and in larger quantities than nondisabled people. In addition, people with disabilities often depend on others to monitor and manage their medical care and medication distribution. Care givers may mismanage the meds given to people with disabilities and provide them greater doses than prescribed in order to control them. People with disabilities may also lack the assistance they need to take

medication correctly, and then mismanage their meds because of lack of support or understanding. Co-occuring conditions like depression, anxiety, unhealed trauma, and chronic pain are also prevalent conditions among this population which can lead to substance dependency in order to cope.

We feel compelled to point out that there are people who live with chronic illness who have made compelling arguments that the effort to address the opioid crisis should not result in barring access to medications needed for living one's daily life. Access Living's national umbrella organization, the National Council on Independent Living, has a Chronic Pain/Opioids Task Force that has established clear principles in this area, as well as produced multiple sets of public comments at this link. We would strongly advise that this viewpoint not be ignored, while at the same time recognizing that for many other people, SUD is, and has been, life threatening.

Despite experiencing high rates of SUD, people with disabilities have less access to treatment than nondisabled people. Treatment programs and centers are often inaccessible and lack the cultural competency needed in order to communicate with and serve people with disabilities in ways that do not reinforce stereotypes and negative attitudes. Common social beliefs that people with disabilities are pitiful, that their lives are less worthy of living and more are some of the very social stressors which have led many to self-medicate. Hence it is vitally important that these beliefs are not reinforced in substance rehabilitation programs and services. In addition, many people do not know that they have disabilities, are afraid to talk about their disabilities because of stigma, or do not know how to ask for accommodations.

We recommend that:

- All treatment programs should be evaluated for their compliance with the ADA and should provide information on the accommodations available in their program on their websites and information materials.
- SUD programs should assess each consumer's individual needs and abilities and provide accommodations and resources accordingly.
- Treatment providers should let all consumers know about the accessibility options available to them, whether they ask for them or not.
- Some disabilities may make it difficult for consumers to comply with a SUD treatment or program. Programs should keep this in mind and receive training on how to provide services to all kinds of people with disabilities.
- Reasonable accommodations may require the altering of standard formats and communication styles.
- Because people with disabilities are more likely to be low income, economic support to help bridge their financial gap should be provided through Medicaid to help them afford to participate in substance abuse treatment and prevention programs.
- Funding for educating people with disabilities on substance about prevention and treatment must also be provided.
- SUD programs should educate people with disabilities on the signs of addiction and on how to seek help if they believe they may be becoming addicted. It may help prevent overdose and other exacerbating outcomes of addiction if the problem is identified early on.
- Steps must be taken to ensure that people with disabilities who are in chronic pain and rely on opioid medication to function daily without suffering are able to

maintain adequate access to relief, while still having access to information on how to prevent and treat addiction to opioids should that become a problem.
- Finally, the above must be implemented in a way that accounts for disability as it intersects with race, ethnicity, class, gender, sexuality and other areas of marginalization in order to eliminate disparate outcomes based on identity and remain culturally competent, nondiscriminatory and inclusive.

We are confident that if these steps are taken, the disparate impact that SUD has on people with disabilities will be significantly reduced.

For more information or discussion about disability and SUD, please contact Dr. Angel Miles, Healthcare/Home and Community Based Services Policy Analyst for Access Living, at amiles@accessliving.org.

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The Alliance for Addiction Payment Reform

(The Alliance) is grateful for the opportunity to provide input regarding how to improve substance use disorder (SUD) treatment and recovery services for Illinois (IL) Medicaid beneficiaries in response to the state's Section 1003 of the SUPPORT Act award. As a national multi-sector health care alliance focused on improving SUD services through the implementation of value-based alternative payment models, The Alliance is uniquely positioned to provide strategic feedback on how to enhance the delivery of SUD services through leveraging sustainable outcome-driven funding mechanisms.

TREATMENT INITIATION, RETENTION & RECOVERY

What are the biggest challenges/ barriers to retention?

- One of the biggest challenges to retention is developing a treatment and recovery plan that is specific to individual patient needs, goals, and circumstances. The Alliance recommends a two-prong approach to address this challenge: 1. Conduct whole-person assessments within 24-48 hours of referral and 2.Ensure that the care recovery team fully utilizes the outcome of the assessment to construct a recovery and treatment plan and proactively engage each patient in the clinical services recommended.
- The lack of diverse cultural representation exacerbates the challenges to treatment retention as it perpetuates biases and stigma which prevent many people of color from accessing and completing treatment eventually leading to poor health outcomes. In 2014, only 2 percent of psychiatrists, 2 percent of psychologists and 4 percent of social workers in the United States are African American.
- The Alliance recommends comprehensive review of treatment centers policies and staffing arrangements to encourage a more diverse and inclusive workforce. This includes implicit bias trainings, greater promotion of people of color in leadership roles, and efforts to expose diverse individuals in a healthcare career path at a younger age.

What are the biggest challenges/ barriers to recovery? (E.g. case management and referral processes/handoffs especially to mental health services, employment, social support)

- Historically addiction treatment services have been developed and delivered primarily in acute care settings that have limited ability to align and integrate economic structures related to the chronic nature of the condition and achieve long-term patient-centered outcomes. The fragmented and disjointed nature of most SUD and opioid use disorder (OUD) treatment and recovery services has created challenges and barriers for patients to manage what is a primary chronic disease. While nearly all health systems have dedicated strategies and departments in place for population health and the management of other prevalent chronic illnesses like heart disease or diabetes (many of which were developed in response to aid providers in transitioning to value-based payment arrangements), very few have similar resources and processes in place for SUDs. The Alliance recommends that Illinois begin the work of incentivizing the

implementation of integrated models of care for SUD and OUD services that leverages longitudinal treatment and recovery support services based chronic disease management principles shown effective in physical health.

What are the barriers to providing behavioral health care, including SUD treatment, integrated in a primary care setting?

- One of the greatest impediments to sustained recovery for patients is that various specialty SUD programs and treatment settings operate in isolation from mainstream health care with limitations in referrals and/or requisite information sharing with other key parties. It is imperative that the future of SUD care go beyond stabilization to a biopsychosocial sustained model of recovery management comparable to the management standards and protocols for physical chronic disease management.
- The Alliance recommends that providers work together through shared accountability and shared risk arrangements or establish common ownership by a single entity who may be better positioned to facilitate the desired integration. This includes shared access to health information, shared long-term treatment and recovery goals for the patient, shared quality and process measurements, and shared performance and outcome-based payment.

What are gaps in the continuum of care spanning from early intervention and outpatient services to
medically monitored intensive inpatients services and medically managed intensive inpatient
services? (E.g. linkage to a higher level of care, transition from crisis care settings to community-based settings)

- The two primary gaps The Alliance finds most frequent in the system exist in care coordination and the provision of peer recovery supports. Currently the workforce is not saturated with peer recovery coaches because it is a novel field. However, because of the substantial need for and nature of these paraprofessionals, the role is arguably easier to scale and can yield the greatest returns.
- The Alliance believes that a care coordinator and peer recovery coach should be viewed as inextricably linked partners who serve different, but related, functions in supporting the patients experience. While the recovery coach is working directly with the patient on objectives and supports, the care coordinator should be ensuring that appropriate care is being administered at all points in the care continuum.

PAYMENT ISSUES

How has the current reimbursement model affected treatment? (E.g. fee for service, lack of Medicaid for those incarcerated, MAT coverage)

- In most fee-for-service payment models for addiction, providers and payers are unable to control or directly influence all facets of a person's recovery journey, including the various manifestations of recovery disruptions.
- The Alliance views the disintegration of economic resources as chiefly responsible for the fragmentation of addiction treatment and recovery services. Even with increased reimbursement and coverage through Medicaid expansion efforts and other grant-driven capacity expansion programs, the nearly 90

percent addiction treatment gap persists. In recent years, government and commercial payers have increasingly introduced payment demonstrations designed to promote improved integration of disparate parts of the delivery system to foster improved collaboration and efficiency.

- An alternative payment model aligned with stakeholder objectives will create conditions and engagement protocols that materially improve the patient's likelihood of long- term recovery, generating savings for the system and benefiting participants.
- The Alliance recommends that Illinois begins implementing payment model demonstration programs, inclusive of risk-bearing components, within its Medicaid program specifically focused on the provision of addiction health services.

How might alternative models of payment for care help facilitate improved access to care for
Medicaid beneficiaries?

- The economic impact of the COVID-19 pandemic is expected to bring an estimated 75 million individuals into a newly unemployed status, thus increasing the need for a Medicaid program with resilient provider partners. Among these newly unemployed, more than one-third are expected to have a behavioral health need (including substance use); 21% of this need is anticipated to be a new behavioral health need.
- Emerging data trends suggest that providers involved in alternative payment arrangements are better suited to maintain consistent access to services for patients than those solely in fee-for-service arrangements given their access to capital stemming from bundled payments or shared savings Arrangements.
- In the view of major insurers, health systems, subject matter experts, and other diverse stakeholders as part of The Alliance for Addiction Payment Reform, there are five critical domains required to manage addiction as the persistent chronic disease that it is over a five year – not a 28-day – period:
- 1. Develop care recovery teams. Such teams are led by a care coordinator, and augmented by a peer recovery coach, a primary care physician, addiction specialists, counselors, pharmacists, and other specialists.
- 2. Form integrated and coordinated community-based treatment and recovery networks. These systems must be able to accompany the patient through the entire continuum of recovery.
- 3. Create a treatment and recovery plan that encompasses not just physical and psychological health needs, but housing, employment, family, medications, and other social determinants of health and well-being.
- 4. Establish a means to manage disruptions in the recovery journey, intervening when there is a reoccurrence of symptoms, and flexibly adjusting the treatment and recovery plan.
- 5. Design a multi-year economic model that rewards the system's performance, while acknowledging that like any chronic condition, addiction too must not be treated as an acute episode akin to responses for infectious diseases. In effect, payers must begin to incentivize recovery, not relapse.
- The Addiction Recovery Medical Home – Alternative Payment Model (ARMH-APM) is designed to promote improved integration of treatment and recovery resources with corresponding financial incentives that inure to the

stakeholders' benefit when the patient is on a sustained path to recovery.
- Thank you for taking the time to review our feedback. Should you have any questions or wish to further the discussion, please contact greg@thirdhorizonstrategies.com.

Sincerely,
The Alliance for Addiction Payment Reform Conveners, Members, and Advisors

children's home & aid
AHLQUIST CENTER for
Policy | Practice | Innovation

June 29, 2020

Community Input: Improving Substance Use Disorder Care in Illinois Medicaid

For more than 135 years, Children's Home & Aid has paved the way by establishing best practices and shaping laws in child welfare, early childhood and juvenile justice. As a leading social service agency, Children's Home & Aid serves nearly 30,000 children and families in need each year in 60 of Illinois' 102 counties. While Children's Home & Aid is not a substance use provider, our programs often serve clients who may struggle with substance abuse issues. Our programs are a crucial community support for clients who are receiving substance use treatment and we thank you for the opportunity to provide feedback.

Treatment Initiation, Retention, Recovery

The following are identified barriers that exist for individuals with a substance use disorder when accessing and receiving treatment:

- Access to child care for parents receiving both outpatient and inpatient treatment is a barrier to recovery. Parents need to spend time in their treatment but if they can't afford child care or don't have child care that is open during their outpatient treatment hours, they struggle to access and complete treatment. Additionally, while there are inpatient treatment centers that allow children, oftentimes there are restrictions on the number of children and on the children's age. HFS should look at increasing the number of inpatient centers that serve families and outpatient treatment that provides child care options.
- Transportation to and from treatment is a barrier, especially for rural areas where providers are limited. HFS should look at incentivizing programs to provide transportation for clients to/from their treatment centers or consider programs that provide at-home drug treatment.
- Capacity limitations on the number of beds saved for Medicaid clients and the subsequent waitlists to receive treatment are a barrier for clients, especially in rural areas (like Southern Illinois) where options are already limited. HFS should work with providers to increase the number of beds reserved for Medicaid clients and develop sustainable strategies to reduce their waitlists.

With providers and clients facing the impacts of an unprecedented economic downturn amid a pandemic, HFS should look at how to increase support to community resources that provide wrap-around services for individuals with substance use disorders. Community supports and resources for individuals with substance use disorders are already lacking and the pandemic will only continue to devastate these areas. **Mental health services should also be prioritized as a needed service for individuals in treatment.** Moving forward, HFS should have structures in place to support providers as they re-open or function at capacity after the pandemic to ensure that their clients are receiving the care and treatment they need. Staff members providing substance use treatment should continue to be trained on the importance of building strong working relationships with other human service providers and the role of those services in enhancing the success of their clients.

Supportive Services

Programs for Families Involved in Child Welfare System

In 2018, the Council for a Strong America released their report, *Stopping the Opioid Crisis Begins at Home*, stating that opioid addiction has contributed to the number of children in foster care in the U.S. The report found that 34% of children in the child welfare system had parental substance abuse as a contributing reason for removal (Baizer et al, 2018). Families with substance use issues that are also involved in the child welfare system face unique challenges when it comes to treatment and recovery. Therefore, it is crucial to maximize community supports that are available to this population. This may include programs like the Intact Family Recovery Programs that provide a substance use case manager to co-case manage with child welfare workers throughout their treatment and are an additional support for families. These programs, based on a pilot by Lutheran Social Services of Illinois, were developed through a federal demonstration grant beginning in Northern Illinois, with Children's Home and Aid as one of the providers, and recently expanded to Eastern Illinois. Furthermore, utilizing home visiting programs throughout treatment and recovery can provide crucial supports for families via home-based counseling from trained experts.

Early Childhood Home Visiting Services

Home visiting programs have been proven to prevent negative childhood experiences such as abuse and neglect and can decrease the risk of substance use later in life (Baizer, 2018). Medicaid substance use providers should utilize an efficient referral process and build strong working relationships with home visiting programs in their areas to utilize this crucial support more.

Infants who are exposed to substance use while in utero are at higher risk to experience issues related to physical and mental health. Exposed infants often require unique care throughout their infancy due to withdrawal symptoms, gastrointestinal issues, difficulty feeding, etc. These infants/children and their caregivers should have access to services and trainings regarding the long-term impacts of exposure in utero. The Governor recently announced his five-year plan to provide home visiting services to all children in Illinois which starts with children most at-risk, including children involved in the child welfare system. This emphasis provides an opportunity for substance use providers and home visiting programs to establish strong relationships to make these services available to pregnant and parenting adults of very young children with substance use disorders.

Special Populations

Stigmas regarding substance abuse impact special populations such as pregnant mothers, families involved with the child welfare system, and individuals seeking treatment in smaller rural areas. The stigma surrounding substance use impacts their ability to access and be successful in their treatment process and recovery. Educational training about addiction should be available for support systems like family members, friends, DCFS caseworkers, etc.

Youth Involved in the Juvenile Justice System

Individualized treatment plans are important for special populations to be successful in their treatment and recovery. This is especially true for youth who are involved in the juvenile justice system. They face stigma and bias based on their criminal charges when entering treatment and this impacts the type of care they receive in treatment. Some youth have been forced to leave their treatment centers because this stigma created an unwelcome environment or staff weren't appropriately using de-escalation tactics for their behaviors. Staff should be appropriately trained in trauma informed care including how to recognize trauma triggers and how to de-escalate someone who is experiencing fight-flight-freeze. Individualized treatment plans can provide youth with varying treatment modes that include both group work and one-on-one care with their substance use counselors.

Policy & Societal Barriers

We know that implicit bias is a contributor to racial and ethnic inequities in the health care system. Training counselors and staff to be culturally competent isn't enough when successful recovery is a life or death situation for many of the clients served in substance use treatment. It is crucial for staff (at all levels) involved in substance use treatment to be appropriately trained in anti-racist practices to ensure

that their clients are receiving the care and treatment they deserve. It is also important for HFS to review contracts with providers to determine if policies are contributing to inequities for the clients their providers serve.

Thank you again for the opportunity to provide feedback. Should you have further questions regarding these comments, please contact Ali Schoon, Early Childhood and Child Welfare Policy Associate at aschoon@childrenshomeandaid.org.

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Amita Alexian Brothers Behavioral Health Hospital

Amita Alexian Brothers Behavioral Health Hospital does not receive funding from SUPR or Illinois Medicaid for primary SUD treatment at any level of care.

Please see my answers to the recent questionnaire that was sent on behalf of Illinois Medicaid.Thank you and Best Regards

Sarah Briley

What is working well in Illinois?

- In my opinion, the Chicagoland SUD treatment market has many providers that are top notch. Outside of metro Chicago market, the options are very limited. There are a limited number of programs that have the ability to access care is limited significantly when clients do not have a commercial insurance benefit that covers higher levels of care. This creates a system in which patients need to utilize the ED to treat acute detox/withdrawal in many situations when they would not otherwise be able to access care. Also, Medicare benefits limit a patient's options for Residential care. Patients who have means have many options open to them that patient's without commercial insurance do not.

What are the biggest challenges/ barriers to accessing and initiating evidence-based treatment?

- Access to care is limited largely by the ability to find and secure treatment that will be covered by Illinois Medicaid. Our facility is unable to treat patients for inpatient detox, php/iop programs, and residential care who have Medicaid.

What are the biggest challenges/ barriers to retention?

- Securing stable living environments that are affordable and allow a person to access community resources. We find our options are very limited, as they are very few sober living programs that have IOP/PHP treatment programs nearby. As a result, patients are forced to use the ED to get care when they relapse.

What are the biggest challenges/ barriers to recovery?

- Recovery coaches at the bedside can be the difference between a patient choosing to access continued care or not. It is imperative that acute care hospitals/Emergency Departments have personnel who can assess and motivate patients at the bedside. If a patient is not met with empathy, support, and information about treatment options during hospitalization, it is unlikely for a patient to get the follow up care they need.

What are gaps in the continuum of care spanning from early intervention and outpatient
services to medically monitored intensive inpatients services and medically managed intensive?

- There is still a lack medical providers who prescribe FDA approved relapse prevention medications.

What are the barriers to providing behavioral health care, including SUD treatment, integrated in a primary care setting?

- Most providers in a primary care setting have limited training and understanding of addiction as a chronic disease state. It would be wonderful if more providers across the state would be trained to prescribe relapse prevention medications such as suboxone.

What opportunities should Illinois Medicaid pursue to improve treatment initiation, retention, and recovery?

- Improve reimbursement

SUPPORTIVE SERVICES

What are the essential supportive services and what is their capacity in Illinois for those with SUD?

- Affordable housing, job training, mental health therapy and support, access to transportation and community resources

What is working well in Illinois?

- There are some really wonderful programs that offer housing, but they have limited capacity. The need is larger than what is available.

What is the biggest barrier?

- Limited housing options available, especially for women

What should Illinois Medicaid do to foster access to supportive services?

- Develop more partnerships with health systems to educate patients on treatment options

HARM REDUCTION & HEALTH PROMOTION

What is the role of harm reduction and health promotion in treatment of SUD?

- Access to MAT treatment, naloxone/Overdose education for community agencies

How might Illinois Medicaid more fully support overdose prevention and harm reduction for Medicaid beneficiaries?

- Provide additional training and support for primary care providers to incent them attain competency in MAT.

Treatment Initiation, Retention and Recovery:

What is working well in Illinois?

- Access to outpatient substance use services in our local area is good.
- With no substance use residential/inpatient/detox in our service areas, our partnerships and relationships with those higher levels of care is positive. We continue to work on establishing collaborations with these high level providers in order to make referrals and recommendations when clients are in need for that level of service.
- Our referral networks to ancillary services is broad and we have opportunities to connect clients to different types of necessary services.
- Illinois recently established grants to develop Recovery Oriented Systems of Care throughout the state. This is a start to help communities work toward education, understanding and decrease in stigma related to SUD needs and treatment.
- Bridgeway is a long-standing community agency that has provided SUD treatment for many years through grant funding from the state. It is organizations like ours that have worked diligently to provide on-going services to those in need, especially in more rural areas.

What are the biggest challenges/barriers to accessing and initiating evidence-based treatment? • The cost of many evidence-based treatment programs is high, especially for community-based providers. There is also possible on-going costs with EBT as well as re-training staff due to turnover of staff.

- In regards to Medication Assisted Treatment, we are limited on the number of MAT participants due to the many needs of psychiatry time, where psychiatry time is not appropriately funded but very expensive to have.

What are the biggest challenges/barriers to retention?

- Clients: transportation, flexibility of scheduling, client frequently change employment and housing, lack of family involvement in treatment services
- Staff: rural locations, rate of pay, ability/ease of SUD required certifications

What are the biggest challenges/barriers to recovery?

- Recovery support services (peer support) is non-existent, transportation, housing, legal involvement is substantial with probation/parole NOT being trained in or do not follow/understand the necessary variables for successful recovery – often focus solely on positive drug tests then violate probation, extreme difficulties in engaging families in the treatment process, stigma, lack of sustainable employment and difficulties attaining employment due to backgrounds, etc.

What are the gaps in continuum of care spanning from early intervention and outpatient services to medically-monitored intensive inpatient services and medically managed intensive inpatient services? • There are no levels of care higher than II for 50 miles from us as the outpatient provider and in our local, rural service areas.

- It is extremely difficult to access detox beds from so far away.
- There is always a waiting list for residential or inpatient beds, which are located at a distance. • There is always a waiting list for higher levels of care.

- Methadone treatment does not exist in our area and is over 50 miles away. We would love to provide it but are not supported in the opportunity to do so.
- Insurance for SUD treatment is not always inclusive of the appropriate services needed.

What are the barriers to providing behavioral health care, including SUD treatment, integrated in a primary care setting?

- SUPR would require an exception for off-site care.
- There is currently a lack of interest from primary care in our local areas and we would need the funding to be able to develop it in-house.
- In our local service areas, the issue is also that primary care providers or even those with both are very "territorial" and do not want other providers offering the same coordination of services.

What opportunities should Illinois Medicaid pursue to improve treatment initiation, retention and recovery?

- Allow reimbursement for recovery support services, including peer support services. • Make transportation for treatment services widely available.
- Allow for telehealth services and reimbursement when appropriate.
- Make reimbursement for services equitable.

Supportive Services:

What are the essential supportive services and what is their capacity in Illinois for those with SUD? • All types of SUD housing opportunities are lacking or non-existent in our area and often, SUD clients with criminal backgrounds are restricted from many housing opportunities. • Same issues above in regards to employment and education opportunities. • Recovery support services are lacking due to not being reimbursable.

What is working well in Illinois?

- As mentioned in the first section, the state grants to establish the Recovery Oriented Systems of Care (ROSC) but this is not enough. SUD treatment/services need to be seen as a priority and funded/reimbursed appropriately. Only when it is seen as a priority will it begin to address the stigma related to it.

What are the biggest challenges/barriers?

- As mentioned previously, transportation, housing, employment, peer recovery support and stigma are the biggest challenges/barriers.

What should Illinois Medicaid do to foster access to supportive services?

- Reimburse for support services appropriately.
- Provide widespread transportation opportunities.
- Work hand in hand with other entities to remove barriers for housing and employment.

Harm Reduction and Health Promotion:

What is the role of harm reduction and health promotion in treatment of SUD?

- Currently, there is a SUPR Prevention program in the schools that is grant funded by the state. The funding is only for very specific curriculum and not enough to cover the prevention/promotion need.

- We currently have Naloxone distribution.
- There are no other programs acceptable in the state of IL. In our local service area, we do not have the "opioid issue" that other places or more urban locations are experiencing.

How might Illinois Medicaid more fully support overdose prevention and harm reduction for Medicaid beneficiaries?

- Continue to provide Naloxone funding, training, distribution.
- Continue to provide and expand overdose prevention education.
- Look at other options for overdose prevention. There are other states or countries that are much more progressive in this area.

What more can we do in terms of early intervention?

- Again, those indicated above.
- Begin to really work closely with physicians to get onboard regarding this issue and their role as well as how they can support the local SUD providers.
- Bridgeway was a pilot program for the National Council for Behavioral Health and Lady Gaga's Born This Way Foundation's *tMHFA – teen Mental Health First Aid* training in two local high school 10th grade classes during 2019-20. This is a great early intervention tool for high school students.

Payment Issues:

How has the current reimbursement model affected treatment?

- The current reimbursement model is not equitable to the services provided.

How might alternative models of payment for care help facilitate improved access to care for Medicaid beneficiaries?

- There are very limited alternative models of payment for care to even access.

Special Populations:

Do you have any specific concerns regarding special populations?

- No answer at this time.

Policy and Societal Barriers:

How does racism and discrimination affect those with SUD and their recovery?

- It is another level of stigma that fully surrounds SUD, treatment and recovery.

How does bias and stigma affect those with SUD and their recovery?

- Bias and stigma regarding SUD is HUGE in our local service areas. We definitely have a very long way to go to break down these barriers. Bridgeway has been training Mental Health First Aid in our area for many years and works with all organizations to reduce stigma. We have been the recipient of the ROSC grant, which is also helping.

What are promising proposals for Medicaid to consider that would require a policy change at the Federal level?

- For co-occurring disorders, we need to improve services overall and ensure a specific funding stream instead of separating the two.
- We need to work on pulling more Federal funding to the state level.
- As a long-standing SUD treatment service provider and advocate, we have repeatedly seen the

state of IL distribute federal funding through grant processes that are absolutely too restrictive and cater only to urban areas with already existing systems and services instead of working to assist rural areas in building up what we have and establishing what we need to best serve this population.

Stacy L. Brown, LCPC LMHC
Vice President of Behavioral Health Services
Bridgeway Inc
2323 Windish Drive
Galesburg, IL 61401
www.bway.org
www.bridgewaybusiness.com
Office: (309) 344-4265
Cell: (309) 221-2112
stacyb@bway.org

Center for Housing and Health

Comments Regarding: Improving Substance Use Disorder (SUD) Care in Illinois Medicaid

The Center for Housing & Health (CHH), a supporting organization of AIDS Foundation Chicago (AFC), is currently funded by a Substance Use Prevention and Recovery (SUPR) grant to administer a program named Connection to Recovery or C2R.

C2R offers resources to people who have experienced homelessness and are now living in supportive housing and have self-identified as having a Substance Use Disorder (SUD). C2R is a voluntary program that offers clients formal treatment navigation, overdose prevention education (including distribution of naloxone) as well as in-home substance use counseling. It is via our experience within this program that we provide our feedback.

NOTE: In referencing "treatment" - we are referring to all forms of SUD treatment: inpatient, outpatient and Opioid Treatment Programs (OTP).

In our experience, treatment must be available on demand. It needs to be affordable and accessible. Treatment must address the needs of the whole person and be integrated with other health and social services. There is a mismatch between the current treatment system that operates in acute "episodes of care," and the long-term support that most people need for lasting recovery.

Illinois' existing treatment options –like a 28-day stay in rehab – are almost entirely time limited. There remains significant unmet need for long-term support services. Medications for Opioid Use Disorder or MOUD should be made available and easily accessible to all who are interested. Too often, punitive and program-centered approaches supersede the client-centered approach that is necessary for successful outcomes.

TREATMENT INITIATION, RETENTION & RECOVERY

The following are the biggest challenges/barriers to accessing and initiating evidence-based treatment:

- Opioid Agonist Therapy (OAT) is the gold standard for treating OUD yet only 20% of OUD diagnosed patients use these medications. This statistic is reflective of the lack of access and information for these life-saving medications for opioid use disorder. Access to methadone is easier due to the number of OTP's in Chicago however, this is in stark contrast to access to Buprenorphine.

- The lack of access to Buprenorphine or Suboxone is created by the limited number of providers who are eligible to dispense this medication. Physicians (including Nurse Practitioners and Physicians Assistants) are required to receive a waiver in order to prescribe buprenorphine. Once the X waiver (via an 8+ hour

training) is attained, there are limits to how many prescribed patients a physician can see within the waiver's first year – thus making access and availability of Buprenorphine difficult. This is particularly apparent with POC who are 35x less likely to be prescribed this medication in comparison to white people.

- Most inpatient treatment facilities don't offer OAT, creating death traps for patients/clients once they leave a structured environment and are at their highest risk for overdose due to decreased tolerance.

- For the small number of treatment providers that will accept a patient who uses OAT, the barriers for entry are problematic – as an example, requiring a patient to bring their own supply of OAT in a locked box in 2-week increments.

- Many Medicaid/state funded inpatient treatment centers in Illinois do not offer methadone. Established methadone patients have limited treatment options due to these restrictions. Some inpatient programs do NOT offer any form of OAT and some only offer Buprenorphine.

- Treatment options for Medicaid funded inpatient beds are very limited because of reimbursement rates. In the experience of CHH's C2R program, it is often difficult to get return phone calls from treatment providers. The window of time in which a client desires to go to treatment and an inpatient bed is confirmed as available is critical to successful outcomes.

Recommendations:

- Continue and sustain changes in response to COVID-19
    - Opioid Treatment Program (OTP): The ability of methadone users to have additional take home doses as a result of distancing precautions taken in response to the COVID-19 pandemic has allowed clients to have increased autonomy over managing their medication and eliminating transportation (i.e., compliance) barriers. Client-centered versus program-centered procedures such as this need to be considered as an ongoing practice beyond the scope of the current pandemic.
    - For buprenorphine users, inductions and assessments are available via telehealth. This eliminates transportation requirements which serves as a barrier for many people who use drugs (PWUD). Recommendation to continue this option beyond the pandemic and institute as standard protocol.

- All Illinois SUD treatment providers offer and educate clients on the evidence-based efficacy of OAT and other MOUD's as well as medications available to support Alcohol Use Disorder.

- Eliminate the Data 2000 waiver for prescribers.

The following are the biggest challenges/barriers to recovery:

- The current system often discharges a client after treatment without any pre-arranged connection to services. This practice leaves a client vulnerable to continued drug use due to a lack of a pre-established support system of care. For example: a client who is discharged from inpatient treatment and given the phone number to contact an OTP on their own. The connection to the OTP needed to be established PRIOR to discharge with preferred provider input from client and an appointment and contact name provided.

Recommendations:

- Enhance and expand the continuum of care/wraparound services, referrals and follow-up for aftercare including:
    - Supportive living arrangements (halfway house; temporary sober living housing)
    - Availability of sober leisure activities
    - Connection to peers in recovery.
    - Employment services.
    - Mental health counseling and support.
    - Funding in-home counseling, community-based counseling
    - Track long-term outcomes (minimum 1-year follow-up program)

The following are the barriers to providing behavioral health care, including SUD treatment, integrated in a primary care setting:

- The culture or belief system that one cannot address mental health issues until the substance use is under control. This is problematic when considering that the vast majority of PWUD also present with chronic mental health conditions related to trauma, anxiety, depression and isolation.

- PCP's can prescribe narcotics but cannot prescribe OAT out of their office.

- Physicians use stigmatizing language ("addict"); physicians uneducated about OAT or stigmatize OAT ("substituting one drug for another."). Physicians assume PWUD are drug seeking.

- Funding streams for mental health and substance use are separate – bringing these together would help providers more successfully integrate patient care.

- Decrease in punitive-perceived surveillance tactics or Urine Drug Screens (positive results may equal mandatory treatment, a dosage decrease and/or loss of take-home doses). These tactics mirror criminal justice practices (messaging: if you're "good" you get a take-home dose. If you're "bad" you are punished). Decrease stigmatizing language such as "dirty" or "clean."
    - Example: a client of an OTP recently reported that after providing a UDS, she was asked by her counselor, "this is going to be clean, right?" This is a punitive approach that is unnecessary and furthers feelings of stigmatization.

HARM REDUCTION & HEALTH PROMOTION

Recommendations:

- Harm Reduction must be instituted as public health practice and a standard of care across all platforms. Most inpatient programs continue to push 12-step based recovery which is rooted in the abstinence model as the only measure of success.
- Mandate harm reduction for all treatment providers and develop a system to hold providers accountable to implementing harm reduction practices.
- All patients leaving inpatient treatment should be given naloxone upon discharge.
- Naloxone should be free and available upon request at all pharmacies across Illinois.

POLICY & SOCIETAL BARRIERS

- Disparities in arrests and incarceration are seen for both drug possession law violations as well as low-level sales. Those selling small amounts of drugs to support their own drug use may go to jail for decades. This unequal enforcement ignores the universality of drug dependency, as well as the universal appeal of drugs themselves.
- Mass criminalization of people of color for drug use/possession/sales, specifically Black people is as discriminatory and profound as Jim Crow Laws. This contributes to the breakdown of family systems on all levels (jobs, education, health). People involved in the criminal legal system should have access to the full range of treatment service options available in the community. Clients should determine the course of treatment with their credentialed provider and without influence from the criminal legal system.

Thank you for your consideration of these comments and recommendations. We appreciate the opportunity to provide feedback.

Sincerely,

Peter Toepfer
Executive Director
Center for Housing and Health
ptoepfer@housingforhealth.org
(312) 334-0919

MIDWESTERN UNIVERSITY
CHICAGO COLLEGE OF PHARMACY
555 31st Street
Downers Grove, IL 60515
Phone: 630/969-4400
www.midwestern.edu

June 29, 2020

Dear Centers for Medicare and Medicaid Services (CMS):

As a clinical pharmacist on the Substance Use Intervention Team at Rush University Medical Center and an Associate Professor at Midwestern University College of Pharmacy, I am unaware of any reasons to prohibit pharmacists from providing care to individuals with SUD. Tens of thousands of pharmacists practice in hospitals, clinics, and community pharmacies in Illinois and can greatly expand the capacity for SUD treatment as doctorate level practitioners trained specifically on the therapeutic and safe use of medications.

Thus I would advocate to allow pharmacists to care for this population by explicitly enabling them to:
- screen for SUD in ambulatory care clinics/community pharmacies
- administer prescribed long-acting injectable medications for opioid use disorder and alcohol use disorder
- include monitoring and dose adjustment of FDA-approved medications including buprenorphine/controlled substances as part of physician-pharmacist collaborative practice agreements
- be included as a reimbursable healthcare provider for services to care for patients with SUD

When given specific authorities and compensation of services, pharmacists have successfully improved the number of immunizations and demonstrated improved outcomes in diabetes, hypertension and chronic disease state management (Victor 2018, Martin 2018, Tannenbaum 2014, Hanlon 1996). Pharmacy training has made progress in adopting SUD into the curriculum as a result of expanded naloxone access laws across all 50 states. If legislation and policies were in place to tap into this profession as an available resource, many more individuals with SUD would have broader and improved access to care.

I appreciate your consideration of my reply o the Illinois Department of Healthcare and Family Services (HFS) seeking input regarding how to improve SUD care for Medicaid beneficiaries through Sec. 1003 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act. It would be my pleasure to be available for any additional questions.

Respectfully,

Tran H. Tran, PharmD, BCPS

Associate Professor, Midwestern University, Chicago College of Pharmacy, Department of Pharmacy Practice
Alumni Hall Room 353
555 31st Street • Downers Grove, IL 60515
campus office: 630-515-6463
campus fax: 630-515-6958
ttran@midwestern.edu

Substance Use Intervention Team (SUIT) Clinical Pharmacist
RUSH University Medical Center
1611 W Harrison St, room 106B
Chicago, IL 60612
office: 312-563-0838
Tran_H_Tran@rush.edu

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Community Behavioral Healthcare
Association of Illinois

Community
Behavioral
Healthcare
Association

Marvin Lindsey, MSW, CADC
Chief Executive Officer
3085 Stevenson Drive, Suite 203
Springfield, Illinois 62703
Phone: 217/585-1600
Fax: 217/585-1601
www.cbha.net

Recommendations Community Forum: BH Committee on Addressing SUD Treatment Gaps

The Community Behavioral Healthcare Association of Illinois (CBHA) welcomes the opportunity to provide input on how to improve substance use disorder care for Medicaid beneficiaries. CBHA's members provide both substance use and mental health services to individuals with substance use disorders and eligible for Medicaid. Close to 60% (50 members), provide substance use services with 60-80% of their substance use revenues generated by Medicaid. Currently, those Medicaid services are residential, outpatient, diagnostic services and detoxification.

The experts agree that substance use disorders are complex, biological, psychological and social conditions that are progressive and chronic in nature and negatively impact individuals, families, communities, and society.

CBHA believes that the current Illinois Medicaid substance use services are inadequate in addressing a chronic condition as defined above.

CBHA would like to offer the below recommendations to address the current treatment gaps in the Medicaid substance use system. We believe our recommendations will help to modernize and improve our current system.

Expanding warm hand off interventions such as the Hub and Spoke model

- The Hub and Spoke Model has proven to be successful and it offers a systemic way to provide treatment and supportive services that are needed for many of those individuals seeking substance use services. The Medicaid program should find a way to incentive providers that participate in Hub and Spoke type models.

Implementing Recovery Support Services and Recovery Coaching

- Substance use/addiction is a chronic condition that is best treated with bio-psycho-social factors in mind. According to SAMHSA, recovery-oriented care and recovery support systems help people with mental and substance use disorders manage their conditions successfully. One of the biggest gaps in Illinois's Medicaid system is the lack of recovery support services for individuals with substance use disorders. The peer recovery coaches are critical in outreach and engagement; they know the community, know the resources, and are able to communicate effectively, and are able to draw upon their own experiences with SUD and recovery. We recommend Illinois incorporate

recovery support services and allow for peer support professionals to bill Medicaid for those services.

Allow substance use treatment to be provided beyond the 4 walls of an organization

- The current Illinois substance use Administrative Rule 2060 only allows for treatment services to be provided within the four walls of an organization. We recommend that the Illinois Medicaid Program allow for treatment services to be allowed in the community by licensed substance use organizations. We also recommend that Illinois Medicaid allow for a type of Assertive Community Treatment and/or Community Support Team model for youths with co-occurring substance use and mental health disorders.

Implement the use of telehealth for SUD

- The chronic nature of substance use disorders calls for methods for clinicians to stay connected with patients over extended periods of time. Telehealth can increase access to addiction treatment services by removing the barriers of geography and stigma. Despite having great potential for assisting recovery and treating patients with substance use disorders, telehealth is underutilized in substance use treatment centers. In order to fill this gap, we recommend that Illinois Medicaid Program add telehealth services as a treatment and support options for those seeking substance use services. Telehealth services to consider are:
    - Telephone-based support
    - Videoconferencing
    - Texting
    - Mobile apps
    - Web-based treatment supports

The SUD Workforce Shortage

- The SUD workforce shortage creates gaps in services. CBHA recommends that Illinois Medicaid work with other state departments to create incentives for recruitment and retention of SUD workforce through loan repayment programs and other targeted efforts. The efforts should also include a focus on incentivizing workforce diversity.

Collaboration between providers and law enforcement

- CBHA recommend that Illinois Medicaid work with other state agencies to build on existing efforts to strengthen collaboration between providers and law enforcement to divert individuals with substance use disorders from the criminal justice system into treatment.

Review substance use treatment Medicaid rates

- CBHA strongly recommends that the Illinois Medicaid Department use an actuarial sound method to review the substance use outpatient treatment service rates. The method should factor in provider's total cost of providing care. The current rates have been historically low compared to other states the size of Illinois and have not kept pace with the cost of living over the last two decades.

Medicaid case management

- CBHA believes that the state of Illinois is leaving millions of dollars on the table by using grant dollars to cover the cost of substance use case management. We recommend that

Illinois Medicaid add substance use case management services to the Medicaid program service array similar to what is offered in the state's mental health Medicaid program.

Promote Culturally Relevant Treatment and Supports

- CBHA recommends that the state take a leading role in promoting treatment and supports that are culturally specific to different populations and geographical areas. The state should invest in up to date cultural relevant trainings that focus on treatment and supports. Because state SUD treatment programs that invest in cultural competence are more likely to invest in ancillary services such as employment counseling, spiritual strength, and physical health, it is also critical for Medicaid reimbursement policies and program management, and services delivery to respond to the multiple service needs that compromise the recovery of different populations.

Value Based Payment Models

- We recommend that the state explore value-based payment models for Medicaid substance use treatment. The state must take an active role in helping to prepare the substance use treatment community for what seems to be an imminent change in how providers will be paid. Currently providers in a fee-for-service world don't necessarily have the flexibility to meet the needs of their patients in different ways. Value-based payment models allow for the flexibility SUD patients and providers need to treat the disorders as chronic conditions, which require long-term, personalized treatment plans. Most SUD substance are currently not prepared to enter into a VBP arrangement but the state must help to transition those providers who are able and willing.

Primary Care Screening for Substance Use Disorders

- CBHA recommends that the state Medicaid department require all primary care physicians who contract with Medicaid to provide annual substance use disorder screenings to all adults Medicaid patients. A comprehensive approach that includes prevention, early intervention, treatment, and recovery support is needed to fully address the broad spectrum of substance use problems and disorders. Primary care should be included in that continuum as it offers a unique opportunity to intervene early and provide access to treatment through early and periodic screening for SUDs with referral to treatment.

(CRCC) Community Resource and Counseling Center

Lynn O'Dell, MSEd, LCPC
Clinical Supervisor
CRCC
P.O. Box 162
1510 W. Ottawa Rd.
Paxton, IL 60957
Tel: 217.379.4302 Ext. 137
Fax: 217.817.0379
lynn@4crcc.org

Treatment Initiation, Retention & Recovery

- What is working well in Illinois? Integrated care between mental health and substance use disorder at our agency; telehealth has been positive during COVID-19; strong relationships with probation and parole in our area.

- What are the biggest challenges/ barriers to accessing and initiating evidence-based treatment? *(E.g. provider access/capacity, medications, staff recruitment, behavioral health capacity)* Not every client has access to the technology needed for telehealth. Referral and linkage to more intensive services and other resources limited. We experience difficulty with maintaining staff overall due to ability to compete with more urban areas for salaries.

- What are the biggest challenges/ barriers to retention? *(E.g. support staff capacity)* Salaries and money for training. It would be beneficial if documentation for SUD services was in line with mental health requirements, i.e. IMCANS. Clients who have dual diagnosis would also only complete one assessment rather than having to schedule one for each program.

- What are the biggest challenges/ barriers to recovery? *(E.g. case management and referral processes/handoffs especially to mental health services, employment, social support)* We struggle with referrals to more intensive care. We either can't find appropriate services or there are extensive waiting lists. Limited programs for adolescents. Limited AA/NA meetings. Transportation is a huge barrier.

- What are gaps in the continuum of care spanning from early intervention and outpatient services to medically monitored intensive inpatients services and medically managed intensive inpatient services?*(E.g. linkage to a higher level of care, transition from crisis care settings to community-based settings)* We can make referrals but can't get placements. Early intervention provided by another provider in schools with no collaboration/consultation or referrals to our agency for services.

- What are the barriers to providing behavioral health care, including SUD treatment, integrated in a primary care setting? We provide behavioral health care and SUD treatment but are not

integrated with primary care. Within the past year, local medical provider has had a few physicians trained in and now offering MAT. Unclear if only self-referrals.

- What opportunities should Illinois Medicaid pursue to improve treatment initiation, retention, and recovery? Increase SUD rates to be more in line with mental health. Provide opportunities for free or low cost training, especially for small providers. Assistance with up to date training materials and access to DVDs, etc. that are more attainable.

Supportive Services

- What are the essential supportive services and what is their capacity in Illinois for those with SUD? *(E.g. housing, mental health services, family supports, life skills, job training, education, recovery support)* Ford County has limited access to housing, job training and education. There is no supportive housing, supervised housing, domestic violence or homeless shelters. Neighboring counties may have these resources, but limit participation to those who live in that county. Even then, some of those resources have closed.

- What is working well in Illinois? WOIA has a variety of programs

- What are the biggest challenges/barriers?
  (E.g. homelessness and lack of available housing, unemployment)
  More access to addiction specialists and/or psychiatrist with experience in SUD. We also provide Sex Offender Treatment. For these clients, it is extremely difficult to find SUD treatment at residential level.

- What should Illinois Medicaid do to foster access to supportive services?
  Streamline funding/payment for services.

Harm Reduction & Health Promotion

- What is the role of harm reduction and health promotion in treatment of SUD?
  (E.g. Naloxone distribution, syringe services, overdose prevention/safe consumption sites, hepatitis testing and treatment) We screen all clients for opioid use, as well as provide information on how to address overdose and administer Naloxone. Several staff have completed training on administration through our local health department and have Naloxone on hand in their office. We provide education on STDs, TB and other communicable diseases. Our local public health department provides testing. Planned Parenthood from neighboring county has presented to our group on prophylactic medication for AIDS, STD prevention and access to birth control and related services.

- How might Illinois Medicaid more fully support overdose prevention and harm reduction for Medicaid beneficiaries? Allow billing for community interventions and training.

- What more can we do in terms of early intervention? Summer programming is lacking in our county for children and adolescents. It is felt this provides opportunity for prevention, social interaction, and improving peer and community relationships.

Payment Issues

- How has the current reimbursement model affected treatment?
  (E.g. fee for service, lack of Medicaid for those incarcerated, MAT coverage)
  Fee for service limits programming. We can't afford to offer additional opportunities for groups just for women/men, trauma and SUD, healthy living as we don't have enough clients engaged to support these issues even if they are needed. It prevents us from doing open or drop-in type support groups as IMCANS must be completed. Unable to bill community support or case management for SUD clients funded by Medicaid.

- How might alternative models of payment for care help facilitate improved access to care for Medicaid beneficiaries? *(please provide data and references for innovative solutions whenever possible, including contact information for further discussion)* Value-based could potentially help if supportive and/or non-traditional services demonstrated increase in outcomes for our limited population.

Special Populations

- Do you have any specific concerns regarding special populations?
  (E.g. justice-involved population, post-partum women, women with children, DCFS-referred persons, individuals with co-occurring serious mental illness (schizophrenia, bipolar disorder)
  DCFS has not traditionally paid for SUD services. We do not have formal services in other languages without translator line. Supports for child care during group times would be beneficial for women with children.

Policy & Societal Barriers

- How does racism and discrimination affect those with SUD and their recovery?
  (E.g. Disparities in outcomes, Disparities in justice-involvement (e.g. incarceration, probation)
  Our services are provided in a primarily White county. This is a concern as we gain more diverse clients from neighboring counties, stemming from service shortages. Cultural competence of natural supports/community organizations needs to be strengthened; as well as understanding of other races, ethnicities and immigrant experiences. Clients express that they are "known" in small towns and feel targeted. Participating in small therapy groups whose racial make-up is primarily White can also inhibit participation. White group members may have limited understanding of minorities' life experiences, historical trauma and fears. Feelings of being unsafe or unable to trust other members could also negatively impact progress.

- How does bias and stigma affect those with SUD and their recovery? Clients continue to hear from their families, community, and supports that they are weak or lack motivation. Negative

belief systems continue to erode progress. Client biases regarding support groups that are spiritually based decrease options.

- What are promising proposals for Medicaid to consider that would require a policy change at the Federal level? Open Medicare billing to LCPCs. Rate changes, decriminalization. Federal support for payment to task forces, mental health/SUD crisis response by specially trained teams, immediate response to treatment. Improvement in coordination of care of inpatient/outpatient SUD treatment providers.

Cook County Health - Inpatient Team

The biggest barriers that I've seen Medicaid patients with SUD experience are:

- homelessness: without a home basis it is very difficult for patients to keep up with Methadone dosing.
- Transportation cannot be arranged for on-going treatment without a pick-up and drop-off location.
- Patients with hx of IVDU cannot access care in a SNF and often leave the hospital AMA without adequate treatment with I.V. antibiotics or wound care. This increases the likelihood of repeated readmissions to the hospital without any on-going substance use treatment.
- Patient's not already in treatment for OUD before admission are often denied admission to SNF's even without hx of IVDU.
- The Boulevard does not allow readmission for 18 months after completing their program.
- When the in-patient treatment facilities are open, patient's with co-occurring mental health disorders are declined admission because the of the mental health dx
- Spanish speaking clients have limited options for in-patient treatment.

Kayla Morgan, LCSW, MJ

Cook County Health- Debra Carey, Interim CEO

COOK COUNTY HEALTH

June 29, 2020

Theresa Eagleson, Director
Illinois Department of Healthcare and Family Services
201 S. Grand Avenue, East
Springfield, IL 62763

Re: Substance Use Disorder Comments

Dear Director Eagleson,

Thank you for the opportunity to provide comments towards improving Substance Use Disorder (SUD) care for Medicaid beneficiaries. Illinois has a unique opportunity to lead SUD efforts, specifically when it comes to maximizing opportunities within our state Medicaid program to promote evidence-based care, ensure health equity, and address the social needs of persons living with SUD.

Cook County Health (CCH) has a more than 180 year history of providing care to all regardless of income, immigration status, or ability to pay. CCH serves the region's most vulnerable residents through our network of hospitals, community health centers, correctional health at the Cook County Jail and Juvenile Temporary Detention Center, CORE Center, Cook County Department of Public Health, and the CountyCare Medicaid managed care plan. As a result, CCH has experienced the challenges of the opioid crisis firsthand and offers the following written recommendations, in addition to those that have been provided through the structured interview process, for your consideration in improvement of SUD care in Illinois' Medicaid program.

Treatment Initiation, Retention and Recovery

Medicaid serves as a critical program for many individuals with SUD and ensuring that evidence-based practices are used and promoted among providers is crucial to supporting those in treatment and recovery.

- In partnership with other state agencies (Departments of Human Services, Public Health, Insurance, and Financial and Professional Regulation), implement an education and training program for health care, housing, and service providers who work with persons

with SUD so that they can better understand evidence-based practices and how to decrease stigma associated with SUD care.

- Ensure that a broad range of services that support patients with SUD are available, including, but not limited to case management, peer recovery supports, crisis intervention, and medication administration and monitoring.
- Review reimbursements and payment models in fee-for-service and managed care to ensure that financial structures *encourage* providers to use the most current and accepted evidence-based treatment (e.g. Medications for Addiction Treatment or MAT) and *discourage* them from using non-evidence based or even harmful approaches (e.g. "traditional" withdrawal management or detox through rapid tapering and without a confirmed discharge plan for long-term follow up care).

Supportive Services

Stable, safe, and affordable housing continues to be a significant barrier for individuals with SUD. CCH believes that housing is health and that a "housing first" approach that prioritizes the provision of permanent supportive housing and that values flexibility, individualized supports, client choice, and autonomy[1] must be used to meet the needs of persons with SUD.

We applaud HFS for including tenancy and pre-tenancy support services in its Section 1115 Medicaid waiver focused on behavioral health transformation, and look forward to learning from this pilot. We also encourage pursuit of the following:

- Expand tenancy and pre-tenancy support services as part of the standard Medicaid package and for beneficiaries statewide.
- In partnership with the Illinois Department of Human Services, require state-funded recovery housing programs to accept individuals engage in Medications for Addiction Treatment (MAT), including agonist treatment for opioid use disorder.
- Explore flexibility in the Medicaid program, including leveraging Medicaid managed care relationships, to cover the cost of recovery housing for persons with SUD.

Special Populations

Justice-involved individuals with SUD are especially vulnerable to overdose within a few weeks of release from jail or prison. Ensuring that Medicaid-eligible individuals are enrolled in Medicaid and connected with care coordination services immediately upon discharge/release from jail or prison can help ensure continuity of care and prevent fatal overdoses or other negative outcomes.

- Given CCH's role as a provider of correctional health and significant experience with the justice-involved, auto-enroll those with a history or risk of SUD and who are leaving Cook County Jail or an Illinois Department of Corrections facility and returning to Cook County into CCH's CountyCare Medicaid managed care plan.

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[1] Per the National Alliance to End Homelessness

- Explore opportunities for Medicaid to start coverage, specifically but not limited to care coordination, 30 days prior to release from prison.

Harm Reduction and Health Promotion

The overwhelming majority of those with SUD and who are in recovery do not achieve success on the first attempt. It is important to ensure that Medicaid recognizes this and supports a harm-reduction approach in treatment and coverage of services.

- Remove operational barriers to maximize providers' ability to directly distribute naloxone to at-risk individuals (instead of requiring individuals to go to a pharmacy to obtain naloxone); allow these providers to be reimbursed by Medicaid.
    - Leverage the expertise of community health workers, peer recovery counselors, and similar groups to directly distribute naloxone and to provide overdose prevention education.
- Coordinate with other state agencies (e.g. Human Services and Public Health) to incorporate harm reduction principles into programs and services promoted and funded by the state.

Again, thank you for the opportunity to provide comment. We look forward to continued partnerships with Medicaid and other state-supported efforts.

Sincerely,

Debra D. Carey

Debra D. Carey
Interim CEO
Cook County Health

TREATMENT INITIATION, RETENTION & RECOVERY

What is working well in Illinois?

- Services continue on during the pandemic. SUPR has been responsive to eliminate some barriers that are in the Rule. Hopefully some of the changes - i.e. allowing for individuals sessions to be telephonic– become permanent**.**

What are the biggest challenges/ barriers to accessing and initiating evidence-based treatment?(*E.g. provider access/capacity, medications, staff recruitment, behavioral health capacity)*

- Many evidence based treatments are highly outdated, especially for co-occurring disorders. I.E. Seeking safety hasn't been updated in years. It's not hard to access them, but they're also expensive and require us as staff to make a lot of copies due to not being able to provide individual workbooks.

What are the biggest challenges/ barriers to retention? *(E.g. support staff capacity)*

- Support staff is a big one. There's not a lot of availability for outreach and out of office case management for my staff. We're busy with in person treatment in the building but having a person to borderline mimic SASS for SUDs or do community outreach would be a big help.

What are the biggest challenges/ barriers to recovery?*(E.g. case management and referral processes/handoffs especially to mental health services, employment, social support)*

- Referral processes for inpatient treatment and Vivitrol are really difficult. The wait times are insane and quite frankly, any time a client mentions they have a psychotic disorder or has hospitalizations in their past for psych, they get denied due to the inpatient program 'not being able to medically handle that'. Limited transportation, finances, homelessness also make it difficult to maintain sobriety.

What are gaps in the continuum of care spanning from early intervention and outpatient services to medically monitored intensive inpatients services and medically managed intensive inpatient services?*(E.g. linkage to a higher level of care, transition from crisis care settings to community-based settings)*

- See above answer about inpatient.

What are the barriers to providing behavioral health care, including SUD treatment, integrated in a primary care setting?

- Not a lot of providers specialize in SUD so therefore they just continue to refer clients out instead of addressing the SUD in house as well with other BH staff. This is why we struggle to obtain Vivitrol or suboxone in BH settings and wind up referring clients to other places which makes them less likely to follow through.

What opportunities should Illinois Medicaid pursue to improve treatment initiation, retention, and recovery?

- Make case management billable as FFS not just grant based. Improve payments for services to hire and retain quality staff; unfortunately agency services follow the money, the more avenues to bill via FFS (not grants because every agency doesn't get grants), the more support will be offered to individuals

SUPPORTIVE SERVICES

What are the essential supportive services and what is their capacity in Illinois for those with SUD? ***(E.g. housing, mental health services, family supports, life skills, job training, education, recovery support)***

- All of their examples… housing, MAT, family supports, job training, GED education, recovery support, transportation.

What is working well in Illinois?

What are the biggest challenges/barriers?***(E.g. homelessness and lack of available housing, unemployment)***

- Homelessness, lack of inpatient beds, unemployment/SSDI/SSI rates, limited access to MATs; archaic medical necessity guidelines for detox (opioid use disorders)

What should Illinois Medicaid do to foster access to supportive services?

- Increase funding , target grants towards providers who are innovating and finding creative solutions to make things work

HARM REDUCTION & HEALTH PROMOTION

What is the role of harm reduction and health promotion in treatment of SUD? ***(E.g. Naloxone distribution, syringe services, overdose prevention/safe consumption sites, hepatitis testing and treatment)***

- It is so important. We need better access to MAT services, Narcan, and especially safe injection sites .. as there truly aren't any within 50 mins from us.

How might Illinois Medicaid more fully support overdose prevention and harm reduction for Medicaid beneficiaries?

- Better access to MAT and injections sites/education

What more can we do in terms of early intervention?

- See above. Allow for case management – linkage, support services to people at risk not just high need

PAYMENT ISSUES

How has the current reimbursement model affected treatment? ***(E.g. fee for service, lack of Medicaid for those incarcerated, MAT coverage)***

- We would like to bill for case management services and MAT (not methadone) through Medicaid but there is no vehicle for that.

How might alternative models of payment for care help facilitate improved access to care for Medicaid beneficiaries? ***(please provide data and references for***

innovative solutions whenever possible, including contact information for further discussion)

SPECIAL POPULATIONS

Do you have any specific concerns regarding special populations?*(E.g. justice-involved population, postpartum women, women with children, DCFS-referred persons, individuals with co-occurring serious mental illness (schizophrenia, bipolar disorder)*

- There are essentially ZERO resources for sex offenders with SUDs/MI that are low income in the state of IL .

POLICY AND SOCIETAL BARRIERS

How does racism and discrimination affect those with SUD and their recovery? *(E.g. Disparities in outcomes, Disparities in justice-involvement (e.g. incarceration, probation)*

- Far more minorities in the justice system, which makes them less likely to succeed.

How does bias and stigma affect those with SUD and their recovery?

- It completely shuts the clients down. Even staff at times and providers can judge them based off of their race, SES, and MI status. It harms everyone.

What are promising proposals for Medicaid to consider that would require a policy change at the Federal level?

Dekalb Behavioral Health Foundation, Inc.

Northwestern Medicine Ben Gordon Center

To Whom It May Concern:

Kim Volk, Director of Behavioral Health Services, Marissa Kirch, MSW, LCSW, CADC, Manager of Addiction Treatment Services and Discovery House (a recovery home for women) and Lori Nelson, MA, LCPC, CSADC, Behavioral Health Services Compliance Officer, have provided the responses to your survey on how to improve substance use disorder care for Medicaid beneficiaries.

Thank you for soliciting this input on behalf of our clients. Should you have any questions, please feel free to contact us at Northwestern Medicine Ben Gordon Center at (815) 756-4875.

What is working well in Illinois?

- The Public Health Emergency expansion of telehealth has increased attendance and engagement. The inclusion of peer recovery, gambling services and Medication Assisted Therapy (MAT) has enhanced services. The inclusion of trainings for reimbursement has increased staff engagement and retention and has increased the quality of services provided.

What are the biggest challenges/ barriers to accessing and initiating evidence-based treatment?

(E.g. provider access/capacity, medications, staff recruitment, behavioral health capacity)

- Staff recruitment, staff turnover, safety issues facing employees
- Capacity based on staffing
- Difficulty recruiting psychiatrists with expertise in addictions and their philosophies regarding treating clients with SUD, particularly MAT
- Difficulty finding psychiatrists with expertise in treating pregnant women with addiction
- Lack of funding available in order to obtain evidence-based curriculum

What are the biggest challenges/ barriers to retention?

- Pay is not comparable to other degrees, certified and licensed providers in the field. Reimbursement does not cover the expense of psychiatric services (psychiatrists, nurses, etc.) nor the support staff necessary.

What are the biggest challenges/ barriers to recovery? *(E.g. case management and referral processes/handoffs especially to mental health services, employment, social support)*

- We are a Community Mental Health Center, so behavioral health and employment services are integrated into our care. The inability to provide expanded services in the community and at none certified sites. Minimal access to transportation and childcare services impact client engagement. Difficulty finding clients placement in higher level of care also impacts recovery. It is difficult to maintain IOP and group programming for adolescents.

What are gaps in the continuum of care spanning from early intervention and outpatient services to medically monitored intensive inpatients services and medically managed intensive inpatient services? *(E.g. linkage to a higher level of care, transition from crisis care settings to community-based settings)*

- There is insufficient access and capacity at higher levels of care (detox, PHP, residential and inpatient) for adolescents and adults.

What are the barriers to providing behavioral health care, including SUD treatment, integrated in a primary care setting?

- We are part of a large medical system, Northwestern Memorial HealthCare, and our clients also have access to the Federally Qualified Health Care (FQHC) provider in our area.
- We also need clarity and access to be able to provide SUD treatment at off-site locations under our main TIN.

What opportunities should Illinois Medicaid pursue to improve treatment initiation, retention, and recovery?

- Increased funding through adequate Medicaid rates and routine increases, as well as expanded contract funding. Continue funding for telehealth services post the Public Health Emergency.

SUPPORTIVE SERVICES

What are the essential supportive services and what is their capacity in Illinois for those with SUD? *(E.g. housing, mental health services, family supports, life skills, job training, education, recovery support)*

- Housing, mental health services/medication assisted treatment, family supports, life skills, job training, education, recovery support, legal supports through Drug and Mental Health Courts. Increased funding for case management and community support services are indicated to manage the needed services.

What is working well in Illinois?

- Drug and Mental Health courts, Individual Placement Service grants, telehealth services, and peer support.

What are the biggest challenges/barriers?

Clients with limited English proficiency, or intellectual capacity, legal issues, unemployment, lack of access to transportation, lack of access to childcare, and difficulty with hiring and turnover.

What should Illinois Medicaid do to foster access to supportive services?

- Expand payment for case management and community support activities similar to the mental health rules, expand reimbursement for non-certified sites without the need for waivers.

HARM REDUCTION & HEALTH PROMOTION

What is the role of harm reduction and health promotion in treatment of SUD? ***(E.g. Naloxone distribution, syringe services, overdose prevention/safe consumption sites, hepatitis testing and treatment)***

- Essential for the safety of our clients and increases client engagement and retention.

How might Illinois Medicaid more fully support overdose prevention and harm reduction for Medicaid beneficiaries?

- Continuation of the HIV, STD and Naloxone programs.

What more can we do in terms of early intervention?

- Encourage partnerships with schools.

PAYMENT ISSUES

How has the current reimbursement model affected treatment? ***(E.g. fee for service, lack of Medicaid for those incarcerated, MAT coverage)***

- It has suppressed services with inadequate funding supports for MAT and support services, as well as prevented funding for the incarcerated that require adequate linkage and medical care, as well as treatment.

How might alternative models of payment for care help facilitate improved access to care for Medicaid beneficiaries? ***(please provide data and references for innovative solutions whenever possible, including contact information for further discussion)***

- Additional contract funds that run out early in the fiscal year.

SPECIAL POPULATIONS

Do you have any specific concerns regarding special populations? ***(E.g. justice-involved population, postpartum women, women with children, DCFS-referred persons, individuals with co-occurring serious mental illness (schizophrenia, bipolar disorder)***

- It is difficult to engage justice involved clients. It is also difficult to tailor programming to meet the needs of clients with serious mental illness and/or lower cognitive abilities. There is also resistance to MAT and the philosophy of MAT for individuals with addiction. It can be difficult to engage women with children as well due to lack of available and affordable childcare.

POLICY & SOCIETAL BARRIERS

How does racism and discrimination affect those with SUD and their recovery? ***(E.g. Disparities in outcomes, Disparities in justice-involvement (e.g. incarceration, probation*****)**

- Reluctance to engage in services and support groups and services, including Drug and Mental Health Court. Disparities in legal consequences and opportunities for treatment.

How does bias and stigma affect those with SUD and their recovery?

- It affects access and engagement. It also affects the availability of various treatment modalities such as MAT.

What are promising proposals for Medicaid to consider that would require a policy change at the Federal level?

- The continued expansion of telehealth as a viable option for treatment provision
- Adequate fee for service reimbursement at the levels of FQHCs and routine increases in rates
- Inclusion in all health proposals, as consistently, addictions and mental health are not considered at all or included at a minimal level

Community Input: Improving Substance Use Disorder (SUD) Care in Illinois Medicaid

Comments provided by:
Jeff Lata
Assistant Director of Adult Outpatient Services
DuPage County Health Department
630-221-7546
jlata@dupagehealth.org

Treatment Initiation, Retention & Recovery

- What are the biggest challenges/ barriers to recovery?
  (E.g. case management and referral processes/handoffs especially to mental health services, employment, social support)

  The complexities of integration of mental health & substance use treatment all begins at the top. With the numerous differences in administrative rules & regulations between mental health & substance use, clinical integration becomes difficult to implement while needing to dedicate specialized administrative resources to ensure our department follows each state program's unique set of rules/regulations around billing, record keeping, and auditing/licensing.

Supportive Services

- What are the essential supportive services and what is their capacity in Illinois for those with SUD?
  (E.g. housing, mental health services, family supports, life skills, job training, education, recovery support)

  Mental health services and housing are critical for sustaining someone through the recovery process. Housing is a critical issue, with little capacity of affordable housing in our communities.

Harm Reduction & Health Promotion

- What is the role of harm reduction and health promotion in treatment of SUD?
  (E.g. Naloxone distribution, syringe services, overdose prevention/safe consumption sites, hepatitis testing and treatment)

  Naloxone distribution is a very important step in the harm reduction approach. We have found it to be an important addition to our approach with engaging family & natural supports, ensuring affordable access to this important life-saving medication.

Payment Issues

- How has the current reimbursement model affected treatment?
  (E.g. fee for service, lack of Medicaid for those incarcerated, MAT coverage)

SUPR reimbursement model

The current reimbursement model has resulted in needing to allocate resources away from direct service to administrative overhead. In our field, we constantly talk about the importance of treating both mental health & substance use together at the same time. Yet, the reimbursement models for mental health & substance use are handled on parallel pathways.

For HFS Medicaid and Medicaid MCO mental health clients, treatment reimbursement is handled by the single payer. However, for substance use clients, the source of reimbursement is based on which treatment activity is provided. If providing group therapy, our billing system needs to process through HFS Medicaid or the MCO. If providing some type of case management, the provider has to have a contract with the state, and set up a separate billing pathway within our medical record system to be reimbursed through the state's DARTS system. Billing through the DARTS system often requires hours of additional staff time.

Billing/accounting, IT, and contracting/credentialing have considerable additional work to ensure that activities are billed out to either the MCO or SUPR contract. The DARTS system creates additional burden, as EMR's need to be structured to communicate with a system unique only to Substance Use providers. Coding, billing process, rules for which activities can be billed/etc. all become barriers to shifting resources to where it's needed most: direct service.

In the clinical world, "integration" of substance use and mental health treatment has been at the forefront of our treatment models. If reimbursement models for substance use treatment in Illinois mirrored how it looks for mental health clients, administrative integration would be realized, allowing for time & resources to be shifted to direct service.

Reimbursement rates

In addition to the differences in billing processes, the rates of reimbursement for outpatient substance use treatment are lower than those for outpatient mental health treatment. On average, a counselor providing individual substance use counseling to a client with Medicaid MCO coverage will be reimbursed 15% less than if they were counseling someone with a primary mental health disorder. This is not the case with private insurance, where the billing rates would be equal. The DSM-5 is our sole diagnostic manual for behavioral health disorders, and reimbursement should not look different based on primary diagnosis.

Specialty populations

Lack of Medicaid coverage for incarcerated individuals becomes a barrier to providing treatment, especially to those pending release. Continuity of treatment (or, initiating treatment while incarcerated) is an important step to decrease recidivism as well as to decrease risk of overdose upon release from jail/prison. At a minimum, enabling Medicaid eligibility ahead of release would remove many barriers to re-entry in terms of setting up treatment following release.

Special Populations

- Do you have any specific concerns regarding special populations?
  (E.g. justice-involved population, post-partum women, women with children, DCFS-referred persons, individuals with co-occurring serious mental illness (schizophrenia, bipolar disorder)

Co-occurring disorders

See answers above re: reimbursement models for substance use treatment. In our agency, we see a high percentage of co-occurring disorders, and strive to provide treatment for both disorders at the same time. Aligning the substance use and mental health reimbursement models would be truly support clinical models our treatment programs are striving to provide.

Justice-involved population

Those suffering from substance use and mental health disorders continue to be over-represented in our criminal justice system. Continuing to build capacity in our treatment system to deflect away from our jails and prisons should remain high priority.

Esperanza Health Centers

Barriers

Consult line and shadowing opportunities

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Phone: 618-683-2461 Fax: 618-683-2066 golconda@fccinconline.org	Phone: 618-658-3079 Fax: 618-658-2759 bhdiv@fccinconline.org	Phone: 618-658-2611 (TTY) Fax: 618-658-2501 bhdiv@fccinconline.org	Phone: 618-734-2665 Fax: 618-734-1999 bhdiv@fccinconline.org	Phone: 618-287-7010 Fax: 618-287-7016 bhdiv@fccinconline.org

Family Counseling Center, Inc. Input: Improving Substance Use Disorder (SUD) Care in Illinois Medicaid

Family Counseling Center, Inc. appreciates the opportunity to share our experiences and concerns regarding the substance use care in Illinois Medicaid. For the most part with the SUPR contract, Illinois Medicaid and private insurance reimbursement, residents of Illinois who are living with, or at-risk of, a substance use disorder can access some, if not all, levels of substance use treatment.

With Family Counseling Center, Inc.'s service area primarily in HRSA-designated rural counties and limited reimbursement from payment sources for higher salaries, there is a challenge in recruiting and retaining substance use/behavioral health providers and staff to implement evidence- based treatment within the service area. There is high turnover within the behavioral health field that results in displaced clients and disruption in continuity of care. Within the unique substance use population, it is vital to intervene during opportune times (i.e. ER visits, police deflection, primary care referrals) however with limited workforce to provide immediate response, it becomes a significant barrier to the client whom may not follow through with treatment. In order to transition from treatment into long-term recovery, it will greatly benefit clients in having consistent treatment providers and recovery supports that have developed long-term therapeutic and recovery relationships.

It is essential to improve staff capacity through improved compensation. However, even with new minimum wage increases, there is concern if Medicaid's reimbursement rates will not adequately increase in order to compensate for higher wages; or many outpatient behavioral health agencies, such as Family Counseling Center, Inc., will need to limit the number of substance use treatment providers on staff. This can bring challenges in providing adequate support to clients (i.e. obtaining and maintaining an independent life in addition to social support) while they are in recovery as the focus will be treatment. An additional recovery support challenge is the limited recovery support Medicaid reimbursement for peer recovery coaches working solely in the substance use program. With non-clinical reimbursement limited to case management within the confines of recovery support for recovery coaches, there are limited non-clinical community support substance use service codes for clients solely opened to the substance use program.

Additional funding needs should include Medicaid reimbursement for substance use engagement, outreach, and crisis intervention. Most behavioral health agencies rely on the SUPR funding contract to compensate the above mentioned services without a client being opened to services. However, the compensation is minimal when taking into account the provider's salary and agency costs to respond. Modeling Illinois' mental health crisis intervention, it would provide a greater incentive and ability to be compensated for responding to an individual during a substance-use related destabilizing situation. By responding during these critical points, crisis intervention can prevent further damage due to an individual's harmful and risky substance use as well as increase engagement for the individual to pursue treatment. At this time, Medicaid crisis intervention can only be billed for adults experiencing a psychiatric crisis (harm to self, others, and/or property) while youth must be experiencing a psychiatric crisis, mental health crisis, and other destabilizing factors. It is suggested to expand the criteria for billing Medicaid for adult crisis situations to include destabilizing factors that takes into account substance use-related situations.

Nevertheless, given our service area resource disparities, it is difficult to assist clients in obtaining housing due to potential felony charges that limit access to public housing. Partners within our service area that have unique public service programs struggle with getting these services to qualified individuals due to limited staffing as well. The essential support services are services that will build an individual's recovery capital as outlined within Illinois' Recovery-Oriented System

of Care (ROSC) model. These should include, but not limited to, access to substance use treatment and recovery support, housing, job training, employment, independent life skills, parenting skills, peer recovery support, and improving the family support. All in all, an individual needs to be able to live and function within the community to sustain long-term recovery. Throughout the Southern 7 counties, transportation is one of the most significant barriers for an individual to live independently. Although Medicaid will reimburse medical related transportation needs, there does not appear to be reimbursement for community support and case management needs such as employment and job training. Also, it would benefit agencies and the community to learn how to become a Medicaid contracted transportation provider in order to expand transportation options within our rural area.

Furthermore, in regards to harm reduction and health promotion, it appears that only Illinois State Opioid Response (SOR) grantees are given the full resources to provide harm reduction trainings and naloxone distribution. However, behavioral health agencies are encouraged to get their Drug Overdose Prevention Program certification even thought there is no attached funding or reimbursement for providing these services. The most that our agency can do is provide case management services by linking the individual to harm reduction services. However, those in need of harm reduction may not be opened to services yet which limit what our community providers can deliver even while utilizing the SUPR contract. Thankfully, the local public health departments are a great resource for testing and treating infectious diseases. Overall, early intervention is critical whether it is providing education, engaging in harm reduction, building engagement, or reducing negative impact on community and families.

Lastly, as our agency is in the early stages of collaborating with local hospitals and clinics to implement the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model as best practice, there are concerns for reimbursement within Federally Qualified Health Center (FQHCs). Potential limitations for integration within the primary care setting are as followed:

- Medicaid and other insurers' limitations on payments for same-day billing for both a physical health and a behavioral health service visit.
- Lack of reimbursement for collaborative care and case management related to behavioral health services.
- Absence of reimbursement for services provided by non-physicians, alternative practitioners, and contract practitioners and providers.
- Medicaid and other insurers' disallowance of reimbursement when primary care practitioners submit bills that list only a behavioral health diagnosis and corresponding treatment.
- Inadequate reimbursement rates in both rural and urban settings.
- Lack of reimbursement incentives for screening and providing preventive behavioral health services in primary care.
- All in all, it is difficult to convince primary care providers to provide screenings and brief interventions for behavioral health needs when there is no, or limited, reimbursement attached. Instead, there is just more work put on the heavily relied on hospitals and providers in the resource-ridden rural areas.

Finally, it is apparent and encouraging that Illinois is looking for opportunities to improve access to care for those with SUDs. Although there are opportunities to provide greater detail, Family Counseling Center, Inc. hopes that our recent experiences and barriers will paint a picture of what a community-based non-profit behavioral health agency has to do in order to provide adequate, best practice care to those in need of substance use treatment services.

Prepared by Alisha Foster, LCSW
Hardin County Opioid Response Program Coordinator
Hardin County Office
147 North Market Street
Elizabethtown, IL 62931
618-658-2611 (Home Office)
618-841-3901 (Cell phone)
afoster@fccinconline.org

Gateway Foundation

Gateway Foundation Responses – Respectfully Submitted by Dr. Teresa Garate, Vice President

Treatment Initiation, Retention & Recovery	**Response**
What is working well in Illinois?	The SUPR global grant allows us to provide recovery home supports following active treatment – this results in clients without sober living stable housing to continue with treatment while they are able to access long-term housing. The recent digital recovery program is giving us an opportunity to test innovative ways to engagement for long-term recovery statewide – it is also allowing us to create a virtual recovery community. The quality of the services provided at every level of treatment for Medicaid eligible individuals far exceeds what the rates cover – in other words the state is getting much more that what they are paying for and that is definitely a benefit to the people served.
What are the biggest challenges/ barriers to accessing and initiating evidence-based treatment? *(E.g. provider access/capacity, medications, staff recruitment, behavioral health capacity)*	Setting up transportation is extremely difficult for clients; they do not always know how to navigate the system and they require significant support from our staff to do so – for the clients already engaged in treatment staff is able to help but they still get frustrated; There are many more individuals who can't even set up initial transportation to make it to the facility for initial intake assessments and determination of treatment so they tend to give up. Providing MAT is very challenging – we are not able to get it approved; It is much easier for clients with commercial insurance to have MAT covered. Physicians don't want to accept Medicaid because of the low reimbursement rates so it is difficult to get people enrolled in MAT – if a client is in residential and transitioning to OP we are able to prescribe and dispense first dose of Vivitrol but continuing MAT in OP is challenging with other prescriptions is very challenging. For people who access OP as their first level of treatment it is almost impossible to find a physician to prescribe and treat as a result of the rates. OP rates have not been reviewed for over a decade – they are extremely low – for example a commercial insurance may reimburse $300 for a 3-hour OP session but Medicaid only reimburses between $70 and $80; basically providers get $.25 on the dollar. For Medicaid there is no option for partial hospitalization with boarding option – this become critical when and MCO states they aren't going to approve residential services after a certain period of time but the person still needs intensive support. For clients with commercial insurance a payor may stop covering residential but will still cover PHP and the client is able to use other resources to pay for the room and board, this isn't even an option for our Medicaid clients and so they have to go straight into OP which may not be sufficient for their treatment needs.
What are the biggest challenges/ barriers to retention? *(E.g. support staff capacity)*	Utilization review and shorter lengths of stays authorized by the Managed Care Organizations (MCOs) are often not in line with treatment plans are a major barrier to retention. If clients cannot remain in residential programs to address their SUD completely and they have to step down to IOP or OP they may not stay engaged in treatment and decided to end treatment prematurely.
What are the biggest challenges/ barriers to recovery? *(E.g. case management and referral processes/handoffs especially to mental health services, employment, social support)*	In many areas of the state there is little to no recovery home support options; Clients complete residential treatment and if they don't have stable sober living options they return unsafe living environments and are more likely to relapse. Clients who are frequent flyers in hospitals do not have appropriate support at discharge – According to Health Affairs, Emergency Room departments are ill-

	equipped to meet the needs of patients with substance use disorder and patient end up returning; Some health systems, such as UI Health and the Trinity Health system, have started to invest in transitional housing options so that patients have somewhere safe to go upon discharge from the hospital; For clients with mental illness there are permanent supportive housing options with the use of rental vouchers for affordable housing – clients with SUD only do not have this option to access long term permanent supportive housing; in relation to employment, the supported employment model of IPS is highly effective for people with MI, but this model has not been implemented for people with SUD; Recently there was a study conducted by Smart PolicyWorks with a grant from the Pritzker Foundation to conduct a road map initiative using local Chicago and County data to show the biggest needs of the population of patients who use hospitals as housing – the findings are not at all surprising in that often the population that benefits from the community based supports are those with SMI (severe mental illness) but the larger portion of these patients do not meet the criteria for sever mental illness and are left out of accessing the available supports.
What are gaps in the continuum of care spanning from early intervention and outpatient services to medically monitored intensive inpatients services and medically managed intensive inpatient services? *(E.g. linkage to a higher level of care, transition from crisis care settings to community-based settings)*	For rural and suburban areas a significant gap is the lack of transitional recovery home supports; There aren't enough physical spaces to provide 30-60-90 recovery home supports following active treatment; There are little opportunities to people living in more rural areas to access on-going outpatient services and telehealth was not an option until the COVID19 public health emergency was a reality.
What are the barriers to providing behavioral health care, including SUD treatment, integrated in a primary care setting?	Primary care settings do not have sufficient staff/providers specializing in mental health and SUD treatment; primary providers are reluctant to get certified as MAT prescribers in general but especially for the Medicaid population because of the very low rate; the FQHCs that do provide primary care are starting to also provide MAT but they are not able to provide all the available prescriptions
What opportunities should Illinois Medicaid pursue to improve treatment initiation, retention, and recovery?	Continue expanding digital options where providers can offer virtual services in rural areas; continue expanding digital recovery support so that we can offer virtual recovery coaches to support long-term recovery and reduce incidence or relapse; Invest into regional recovery homes to provide transitional short term housing following discharge; allow for billing for care coordination to be to provide additional social supports upon active treatment completion.

Supportive Services

Question	**Response**
What are the essential supportive services and what is their capacity in Illinois for those with SUD? *(E.g. housing, mental health services, family supports, life skills, job training, education, recovery support)*	Housing as described above is a challenge to long term recovery; having two systems of care and services for people with SUD vs those with Mental Illness is also a challenge. There are best-practices such as Assertive Community Treatment (ACT) which are used and covered for people with Mental Illness but there aren't similar interventions approved for people with SUD only or with SUD as a primary. Another best practice that has demonstrated excellent outcomes with people with MH is the IPS model for employment. This model could be adapted to be used with clients with SUD and funded through Medicaid.
What is working well in Illinois?	Approving clients in Medicaid managed care has improved Average Length of Stay (ALOS) has improved but continues to require much effort from the providers to continue advocating for length of stay approval.
What are the biggest challenges/barriers? *(E.g. homelessness and lack of available housing, unemployment)*	Hospitals should not be used for housing – the state is over-beaded and with an increased focus on prevention and population health, housing is critical. For clients with MI there are opportunities to rental vouchers for permanent

	supportive housing and PSH services. For people with SUD there is no such programming and opportunity.
What should Illinois Medicaid do to foster access to supportive services?	Help providers build a care coordination workforce to provide billable care coordination support that is integrated with primary care and social supports; Allow provider to cover housing costs as part of Medicaid billable services – currently the SUPR Global grant allows us to cover these non-billable services but more and more of the GRF appropriation gets transferred from DHS to HFS each year to cover MCO expenses and this reduces the amount of resources available to cover this type of support; If clients are un-insured or dropped from Medicaid MCO, we are able to use SUPR grant dollars to services adding additional approved services e.g. employment coaches and housing would provide for better wrap around services. Examine how under-utilized hospitals can be re-purposed to become treatment centers with housing and wraparound services that clients can access upon residential treatment completion.
Harm Reduction & Health Promotion - Question	**Response**
What is the role of harm reduction and health promotion in treatment of SUD? *(E.g. Naloxone distribution, syringe services, overdose prevention/safe consumption sites, hepatitis testing and treatment)*	As an advocate for people with SUD we believe in harm reduction and health promotion as a means of saving lives and getting people into treatment. We support the use of safe/consumption sites but understand there are many issues related to the use of these across the state. Recent study shared during the WestSide Heroin Taskforce, which we are members of indicated much fear and confusion about how these sites are used effectively in other part of the world. As we move forward in improving services for our Medicaid covered residents.
How might Illinois Medicaid more fully support overdose prevention and harm reduction for Medicaid beneficiaries?	For clients with Mental Illness/Mental Health needs the use of community based ACT teams is a common practice and while that is not a harm reduction intervention per se, having an opportunity to have a similar approach for people with SUD would help get people more engaged and perhaps open to harm reduction types of engagements/activities.
What more can we do in terms of early intervention?	As recreational cannabis became a reality in Illinois there is an opportunity to conduct aggressive education and outreach on the dangers of cannabis use disorder – while we should respect personal choice, we should remember that alcohol is also a legal substance and Alcohol Use Disorder (AUD) is the most common SUD we treat. Note that at Gateway we see over 10,000 people annually in IL and of those, 30% have a primary diagnosis of cannabis use disorder (CUD), 6% have it as a secondary diagnosis, and last year 1300 calls we received to the call center were for CUD from individuals experiencing barriers to accessing treatment.
Payment Issues - Question	**Response**
How has the current reimbursement model affected treatment? *(E.g. fee for service, lack of Medicaid for those incarcerated, MAT coverage)*	We outlined some of the challenges above, however it is worth re-iterating that the Medicaid reimbursement rates of outpatient are a significant barrier to expanding this level of treatment. When we consider the need to increase medication assisted treatment, we have to acknowledge that prescribers a reluctant to see people on Medicaid because of the extremely low rates. As a result we see for profit OTPs, like Symetria for example only providing services to people with commercial insurance and leaving out a large portion of people who could benefit from the services of an OTP along with outpatient and/or 1:1 counseling.
Special Populations - Question	**Response**
Do you have any specific concerns regarding special populations? *(E.g. justice-involved population, post-partum women, women with children, DCFS-referred persons, individuals with co-occurring serious mental illness (schizophrenia, bipolar disorder)*	The DCFS referral system is extremely challenging – the amount of paperwork, lack of communication from DCFS has resulted in us not accepting those referrals in some of our locations; payments from DCFS were lacking for DCFS young adults or adult women with children. Similarly we experience the same type of challenges serving clients from IDOC.

Gateway Foundation Responses – Respectfully Submitted by Dr. Teresa Garate, Vice President

Policy & Social Barriers - Question	**Response**
How does bias and stigma affect those with SUD and their recovery?	The stigma related to mental health and substance use disorder is a significant barrier to accessing treatment. Since the passage of the Mental Health Parity and Addiction Equity Act (MHPAEA) there has been progress made towards improving party and equity for equal insurance coverage for SUD treatment. However, the stigma continues and it is even stronger toward SUD. While there seems to be some realization that a mental illness/mental health condition is a disease of the brain, the greater understanding of addiction and SUD as a disease continues to be a struggle. This stigma poses a challenge for people to seek treatment and for families to understand how to best support their loved ones.
What are promising proposals for Medicaid to consider that would require a policy change at the Federal level?	Working in partnership with federal advocates, e.g. the Kennedy Forum will help continue moving parity forward and blocking violations of parity for both commercially insured as well as Medicaid covered individuals.

HEARTLAND ALLIANCE

Improving Substance Use Disorder (SUD) Care in Illinois: Community Input from Heartland Alliance

The opioid overdose epidemic has ravaged communities across Illinois. The lives of our neighbors have been cut short far too often and we have made little progress in spite of our best efforts. The emergence of the COVID-19 pandemic and its accompanying economic distress only adds to the headwinds we face. Early indicators point to dramatic increases in overdose deaths, disproportionately impacting communities of color.

The challenges we face are significant but in fact we have all the tools and information we need to reverse these trends and save lives. Medication assisted treatment (MAT) is an exceptionally effective treatment for opioid use disorder (OUD) and community driven peer supports can both prevent overdose and support recovery. Illinois must act with urgency to invest in these services and eliminate the systemic hurdles that prevent these effective treatments from reaching all who need them.

Barriers to Treatment, Retention, and Recovery

MAT is considered the gold standard for OUD treatment but federal and state government have imposed numerous restrictions that limit and stigmatize their use. The federal regulation of methadone clinics and buprenorphine prescribing are unique in all of medicine – more strict than other prescription opioids that are far more dangerous. Indeed, Illinois Medicaid only covered buprenorphine for a lifetime limit of 12 months, leading many providers to refrain from ever prescribing it due to fear of being forced to cease treatment against clinical guidelines and increase overdose risk. This limitation was lifted in 2015 with the passage of the Heroin Crisis Act. MAT is now covered without utilization controls in both Medicaid and private insurance. This policy change was transformative but the previous restrictions have left a legacy of unfamiliarity and discomfort with MAT.

Regulatory barriers have compounded this historic underutilization of MAT. Traditional SUD treatment facilities licensed by the Division of Substance Use Prevention and Recovery (SUPR) are organized around American Society for Addiction Medicine (ASAM) criteria that categorize services based on the level and amount of either outpatient or residential treatment services. Medicaid payment is based on SUPR licensing and meeting the ASAM requirements. Illinois Medicaid does not incorporate buprenorphine or naltrexone-based MAT into its SUD treatment reimbursement structure and instead only reimburses for a 15 minute visit by the prescribing doctor, plus the cost of the medication.

This poor integration of buprenorphine and naltrexone-based MAT into the SUD treatment regulatory and reimbursement structure discourages their use. Medicaid reimbursement levels for a 15 minute prescribing provider visit is not nearly enough to cover the cost of hiring a prescriber at the organization. Federally Qualified Health Centers (FQHCs) can fill this gap because they receive a much higher rate for a provider visit but they should not be the only organizations able to provide this service. SUD programs also cannot bill for the additional supports needed to stabilize and monitor someone who starts MAT – they either meet the requirements of the ASAM level of care or not. There is no way to bill for extra services beyond those requirements.

Financial incentives also encourage risky medically and clinically-monitored withdrawal management. Traditionally, OUD withdrawal management uses methadone to address severe withdrawal symptoms while quickly tapering the patient off of opioids entirely over three days. This intervention results in a

higher risk of relapse and overdose but many hospitals still provide the service. Readmission for withdrawal management is common and the state has voiced concerns over its cost. MAT induction followed by community stabilization and maintenance is preferred but there is no reimbursement mechanism to support providing this service and incentivizing hospitals to revise their practices.

These structural and financial factors have impeded widespread use of MAT and the reality is that most people struggling with OUD do not receive MAT even though it is the most effective treatment. These barriers are multiplied when considering Black, Latinx, and low-income communities struggling with OUD.[1] Indeed, one study found that Black patients received buprenorphine from their primary care provider **35 times less often** than white patients.[2] This inequity is outrageous and must be addressed head on. We are still learning about the various causes of this inequity in buprenorphine treatment but partnering with trusted members of the community, employing persons of color as staff, and tailoring outreach and engagement strategies to specific communities of color appear key to addressing racial inequities in OUD treatment.[3] As a start, the state should target investments in communities of color and make intentional revisions to service delivery.

Promising State Examples

Missouri: One solution for Illinoisans generally and for communities of color is the medication-first approach pioneered by Missouri. The state used its State Targeted Response and State Opioid Response dollars to fund this new model of care where those struggling with OUD received timely buprenorphine or methadone without lengthy assessments or time limits. Patients were encouraged to participate in psychosocial services but this was not a condition of receiving medications. They could also choose to engage in treatment without medications but providers recommended MAT as the gold standard. In the event of poor compliance or a positive drug test, medications would continue with more intense support.[4,5] This paradigm shift has had excellent outcomes with increased access to MAT, improved treatment retention, and lower costs for the state.[6]

Maryland: Another example to look towards is the Baltimore Buprenorphine Initiative pursued in Maryland. This initiative provided free training to providers to become waivered to prescribe buprenorphine and created episodic payment rates for each phase of buprenorphine treatment. Induction and stabilization occurred at a specialty SUD provider and then patients were transferred to a primary care provider (PCP) for ongoing maintenance. Induction, stabilization, PCP transfer, maintenance, and discontinuation if requested each had their own bundled rate that supported all aspects of that phase of service.[7] The rate was set high enough to allow for hiring of all needed support staff in addition to the prescribing provider. This effort has helped over 3,000 patients with retention rates in the community of over 90%.[8]

Virginia: The most comprehensive state example comes from the Virginia Medicaid Addiction and Recovery Treatment Services (ARTS) program. This waiver demonstration established a comprehensive array of SUD services that included all forms of MAT, SUD case management, and peer recovery supports. The plan also provided incentives for providers to become able to prescribe MAT and increases in reimbursement rates of up to 400% in order to properly expand the number of community providers.[9] This combination of increased services, significantly increased rates, and an emphasis on buprenorphine led to impressive results including decreased ER usage, new community providers, increased community treatment, and particularly increased treatment for Black residents and persons with disabilities.[10] They recently received an extension to continue through 2024.[11]

Illinois Medicaid Payment and Policy Recommendations

Illinois must improve its SUD system of care by expanding access to evidence-based services, particularly for Black and Latinx residents. MAT and community peer recovery supports are among the

most promising interventions. The state should build off of the successful state initiatives outlined here and leverage federal Medicaid and SUPPORT Act funds to bring these services to the scale needed to reverse the rise in fatal overdose.

Heartland Alliance recommends the following Medicaid payment and policy changes:

- **Provide higher rates for SUD services across the board and for MAT in particular**

  Illinois Medicaid rates are too low to incentivize increased access to treatment and recovery services. The experience of Virginia shows that significant rate increases will result in new providers and capacity to scale up the treatment services necessary to meet the need that has resulted from the opioid crisis. Illinois should consider increasing rates enough to compare with private insurance rates in order to expand access for low-income Illinoisans.

  In particular, Illinois should focus on incentivizing MAT induction through significantly increased rates. Hospitals and SUPR licensed facilities need to have the financial incentive to initiate MAT induction and maintenance rather than provide fast-tapering withdrawal management. Rates for MAT induction and monitoring need to be comparable or higher than the rates for medically-monitored withdrawal management. Effective referral and transition supports to a community MAT provider should be required for the new higher MAT induction reimbursement rate.

- **Create a comprehensive buprenorphine or naltrexone-based MAT Medicaid benefit**

  The Illinois Medicaid program provides a bundled payment for methadone treatment but does not offer a similar reimbursement structure for buprenorphine or naltrexone. Proper induction and support for a patient requires far more than a 15 minute provider visit. Patient assessments, urinalysis, treatment planning, and other supports typically provided by social workers or addiction counselors are not currently reimbursable. Furthermore, reimbursement for the provider time is insufficient to support integrating medical providers into traditional OUD care.

  The state should use the clinical pathways and rate development guide based on the Baltimore Buprenorphine Initiative and promoted by the CMS Innovation Accelerator Program to create a financially viable reimbursement structure that would allow SUPR licensed facilities, hospitals, primary care providers, and FQHCs to establish MAT practices.[12] The bundled rate should incorporate all necessary services and staff time for each phase of MAT induction such as initiation, stabilization, community referral, and maintenance. The rate should be high enough to incentivize new providers and SUPR licensed organizations to participate.

- **Establish peer recovery supports and SUD case management as Medicaid benefits**

  Medicaid reimbursement for peer recovery supports and SUD case management can fund the support staff necessary for comprehensive SUD care and can fund community health workers that go out into the community to prevent overdose and engage with those struggling with SUD. This service could be of particular value in addressing the inequity in buprenorphine access and rates of fatal overdose experienced by Black and Latinx communities.

Thank you for the opportunity to provide feedback. Please reach out to Heartland Alliance health policy lead Dan Rabbitt with any questions at drabbitt@heartlandalliance.org or 443-401-6142.

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Human Support Services

April 6, 2020

RE: Improving Substance Use Disorder (SUD) Care in Illinois Medicaid

Human Support Services (HSS) has re-initiated SUD services in a rural community and faced challenges to start up a smaller SUD program. Through the support of SUPR, our courts and law enforcement agencies HSS has been able to re-establish and show the need for these services in our community. The biggest challenges/barriers HSS has faced include provider access and capacity as a smaller provider. HSS fee for service and grant funding has helped to start these services, however with one primary staff the impact is substantial when trying to schedule new clients and completing the requirements of treatment due to availability. HSS is working toward providing medication assisted recovery, however a barrier is provider access and capacity to be able to extend these level of services.

One of the biggest barriers to recovery HSS faces is connected to having a single primary staff providing all primary SUD services. This can limit case management services, warm handoffs from other providers or jail, peer recovery support services, and handoffs to employment and social supports. Due to limitations of provider availability HSS SUD staff are not always available to help with linkage to a higher level of care or with transitions from a higher level of care to community-based services. HSS is able to only have single primary staff at this time as that is all funding has allowed for. Currently, SUD programs at HSS operate at a loss and that loss is covered by HSS as the belief is that SUD services are invaluable to our community members.

Illinois Medicaid should continue to improve treatment linkage within behavioral health care to provide treatment for individuals with co-occurring disorders as well with linkage to medication assisted recovery for best treatment practices. SUD case managers could assist with linkage and community resources to provide care in the community when able to reduce the need for a higher level of treatment.

HSS has continued to grow the SUD program for outpatient services with plans to provide medication assisted recovery. The capacity in Illinois for these essential supportive services such as housing, mental health services, family support, vocational/educational/life skills and recovery support continue to be limited for clients seen at HSS in Monroe County. Through mental health programs for supportive housing there continues to be waiting lists for resources. HSS is able to provide SUD services such as intensive outpatient therapy groups, the need continues to be for case management, community based services and more individual services. By creating a wraparound set of services for individuals with SUD in Monroe County would have an increased support system and be more likely to support those in recovery.

HSS provides Naloxone distribution in connection with Egyptian Health Department who covers Monroe County for Narcan training and distribution. HSS and Egyptian Health Department have partnered to provide trainings over the past year to help distribute and train community members, HSS staff and stakeholders in education and administration of Narcan to help prevent a possible overdose in the

988 N Illinois Route 3 | P.O. Box 146 | Waterloo, Illinois 62298-0146

www.hss1.org

community. HSS utilizes all staff to help support and train on overdose prevention through school connections and counselors providing in school services. HSS was involved in a fall training for students in Monroe county speaking about suicide and suicide prevention including overdose prevention.

Fee for service has significantly affected HSS due to provider access and retention of fully licensed professional staff for those individuals whom are not eligible for Medicaid. HSS provides services and linkage to those incarcerated for crisis services whom are no longer eligible for Medicaid. Delays to begin MAT services due to funding and provider access/capacity.

HSS has helped partner and create a Criminal Justice Behavior Health (CJBH) task force to identify and work on solutions to the specific problems related to both behavioral health and substance use disorders in Monroe county to link individuals to treatment when possible to help avoid incarceration or to defer incarceration through the courts. The justice-involved population, DCFS-referred persons, and individuals with co-occurring serious mental illness are at higher risk of substance use disorders or developing a SUD and are some of the individuals the CJBH task force tries to identify to help with warm handoffs to help with engagement in treatment.

Through continued community partners HSS has worked to promote access and treatment for SUD services in Monroe County and this has not come without stigma which continues to affect those with SUD and their recovery. A community partner has helped to support a local support group for individuals with a loved one struggling with a SUD. The stigma surrounding SUD continues to restrict the level of services and engagement for both individuals with SUD and loved ones seen by the small numbers of individuals engaged in services and supports. The majority of services for SUD treatment continue to be provided for individuals involved with the criminal justice department or DCFS mandated interventions.

Sincerely,

Adam Woehlke MA, LCPC
Clinical Director
Human Support Services

988 N Illinois Route 3 | P.O. Box 146 | Waterloo, Illinois 62298-0146
www.hss1.org

Lakshmi Emory, MD, MPH
CMO, IlliniCare Health, an Aetna/CVS company
1333 Burr Ridge Pkwy, Burr Ridge, IL 60527
Ext: 8046589
Cell: (630) 538-1744
Pronouns: she/her/hers

Executive Assistant – Joanne Jonnson
Direct: (630) 203-9160
Joanne.T .Johnson@IlliniCare.com

TREATMENT INITIATION, RETENTION & RECOVERY

What is working well in Illinois?

- Counselors and individuals working with SUD have a lot of skills in the area and they exhibit expertise when working with our members.

What are the biggest challenges/ barriers to accessing and initiating evidence-based treatment?*(E.g. provider access/capacity, medications, staff recruitment, behavioral health capacity)*

- Behavioral Health access to services especially for members in need of treatment urgently and barriers to communication among providers once the individual engages in treatment

What are the biggest challenges/ barriers to retention? *(E.g. support staff capacity)*

- Services to promote continuity of care such as housing and sober living
- Confidentiality rules (42 CFR Part B) lead to lack of communication among MCO, PCP and treating provider(s)
- Lack of psychiatric resources specifically in terms addiction psychia**try**

What are the biggest challenges/ barriers to recovery? (*E.g. case management and referral processes/handoffs especially to mental health services, employment, social support)*

- Lack of training in co-occurring disorders for MH and SUD providers
- Lack of MAT providers in rural regions
- Lack of job and basic skills training as part of SUD treatment
- More training opportunities for Harm Reduction and alternative modes of treatme**nt**

What are gaps in the continuum of care spanning from early intervention and outpatient services to medically monitored intensive inpatients services and medically managed intensive inpatient services? *(E.g. linkage to a higher level of care, transition from crisis care settings to community-based settings)*

- Expansion of covered services including PHP, experiential therapy, DBT, and peer services
- Statewide ADT system, access to IM-CAT and IM+CANS systems

What are the barriers to providing behavioral health care, including SUD treatment, integrated in a primary care setting?

- Lack of partnerships between PCPs and SUD professional
- Limits to confidentiality related to the understanding of 42CFR Part B Consent
- Statewide ADT system, access to IM-CAT and IM+CANS systems

What opportunities should Illinois Medicaid pursue to improve treatment initiation, retention, and recovery?

- Services to promote continuity of care such as housing and sober living
- Confidentiality rules (42 CFR part B) lead to lack of communication among MCO, PCP and treating provider
- Lack of psychiatric resources specifically in terms addiction psychiatry
- Members fearing losing disability benefits by staying in sober housing
- Statewide ADT system including access to IM-CAT and IM+CANS

SUPPORTIVE SERVICES

What are the essential supportive services and what is their capacity in Illinois for those with SUD? *(E.g. housing, mental health services, family supports, life skills, job training, education, recovery support)*

- Housing- There is not access to housing resources and long wait to find housing. This is also a complicated system.
- Peer Support, Job training and educational opportunities are not covered benefits
- Lack of capacity for SUD Residential treatment providers specializing in co-occurring disorders.

What is working well in Illinois?

- The expansion of SUD providers to cover more rural regions
- SUD providers are part of the member's community, and because they know their communities, they can provide resources to support the individual

What are the biggest challenges/barriers?

- There is not access to housing resources and long wait to find housing. This is also a complicated system.
- Peer Support, job training, and educational opportunities are not covered benefits
- Lack of capacity for SUD Residential treatment providers specializing in co-occurring disorders.
- Lack of understanding of available community resources

What should Illinois Medicaid do to foster access to supportive services?

- Revisiting understanding of 42 CFR Part B to foster greater communication among treating providers
- ED and IP providers to track referrals given to members after a crisis episode or detox

HARM REDUCTION & HEALTH PROMOTION

What is the role of harm reduction and health promotion in treatment of SUD? ***(E.g. Naloxone distribution, syringe services, overdose prevention/safe consumption sites, hepatitis testing and treatment)***

- Providing an alternative treatment and support to members to make independent choices about their journey through recovery
- Fidelity to providing supportive services for individuals utilizing MAT services
- Enhanced the number of screenings completed for SUD in the primary health care setting

How might Illinois Medicaid more fully support overdose prevention and harm reduction for Medicaid beneficiaries?

- Expansion of training for MAT education and certification
- Expansion of supportive services including group meetings for individuals with SUD
- Housing Services that support Harm Reduction
- Partner with pharmacies to educate on Naloxone for families with individuals living with SUD

What more can we do in terms of early intervention?

- Create more programs that support family engagement
- More Education on SUD and more supportive services at school
- More campaigns and education to de-stigmatize SUD

Illinois Association for Behavioral Health

937 South Second Street · Springfield, IL 62704
217.528.7335 · 217.528.7340 fax
www.ilabh.org

IABH Programs:

July 1, 2020

Healthcare and Family Services
CMS SUPPORT Act Grant for Community Input
Attn: Christie Edwards
Cook County Health

Via email: credwards@cookcountyhhs.org

Comments: Improving Substance Use Disorder Care in Illinois Medicaid

The Illinois Association for Behavioral Health (IABH) was established in 1967 and is a statewide organization representing more than 70 addiction and mental illness prevention, treatment, and recovery agencies with over 240 sites, affiliated organizations, corporations and over 8000 individual members serving the behavioral health field. IABH's mission is to advocate for sound public policies in the behavioral health field, on behalf of the clinicians, consumers, family members, individuals in recovery and youth who need services. IABH educates the general public about addiction and mental health; sharing the message that addiction can be prevented, mental health wellness opportunities exist; there are effective treatment strategies for those struggling with addiction and mental illness; and recovery is possible for everyone.

In the past several years, IABH has successfully fought for policies that expand access and remove unnecessary barriers to substance use disorder treatment including:

- Removal of Prior Authorizations, quantitative/non-quantitative treatment limitations, and negative medical necessity determinations restricting access to all FDA approved medications for the treatment of Alcohol and Opioid Use Disorders.
- Removal of Prior Authorizations for admission to treatment services for inpatient and outpatient treatment of substance use disorders or conditions at American Society of Addiction Medicine levels of treatment 2.1 (Intensive Outpatient), 2.5 (Partial Hospitalization), 3.5 (Clinically Managed High-Intensity Residential), and 3.7 (Medically Monitored Intensive Inpatient) and OMT (Opioid Maintenance Therapy) services.

IABH supports the removal of unnecessary barriers to treatment such as continuing stay reviews and medical necessity determinations. These utilization management processes are intended to shorten an individual's length of stay rather than ensuring an individual is on the right path to recovery. IABH recommends that HFS explore models of reimbursement that begin to transition the system away from payment based on a unit of service to a value-based payment model.

Tele-behavioral Health Services
The Association advocates for the permanent adoption of telehealth services with the necessary flexibility so that clients can receive mental health and substance use disorder (SUD) treatment without the need for travel or close proximity in the post-COVID-19 environment.

Prior to the COVID-19 pandemic, telehealth for mental health and SUDs was essentially non-existent. Especially for SUPR-licensed treatment providers who were not a qualifying entity permitted to serve their patients via telehealth. With the accommodation afforded under the COVID-19 pandemic state of emergency, not only were SUPR-licensed providers able to deliver SUD services via telehealth but it was a covered service by Medicaid and Medicaid Managed Care.

Investments will need to be made to ensure that telehealth can be accessed and delivered in rural areas. Many of the areas that currently can be referred to as treatment deserts will need infrastructure improvements to ensure that patients who do not have access to travel will have access through technology platforms. With the availability/access to a mobile device, a patient can receive telehealth services without being in a designated site location. Thus, it should be acceptable that an individual's home/place of residence is considered an acceptable site location to receive telehealth services.

At a minimum, SUD treatment services should be permitted to be delivered via telehealth. IABH believes that telehealth should be available and reimbursed for initial screening and assessment, level 1 outpatient and level 2 intensive outpatient individual and group counseling services, case management and all recovery support service.

Increasing Access to Medication Assisted Treatment (MAT) for Opioid Use Disorder (OUD)
SUPR-licensed treatment providers need to have the ability to prescribe MAT such as buprenorphine or suboxone. Currently in Illinois, SUPR licenses Opioid Treatment Programs (OTP), which are Federal approved clinics that provide Methadone as an adjunct to treatment through a controlled dispensary procedure. Buprenorphine may be prescribed by a physician, physician assistant or nurse practitioner whose license allows them to prescribe medications, and who has obtained a waiver through SAMHSA and the Drug Enforcement Administration (DEA). Both dispensing of Methadone and prescribing of buprenorphine are Medicaid reimbursable services. However, in Illinois there is not a mechanism currently under Medicaid which permits a SUPR-licensed treatment provider to be reimbursed for the delivery of MAT services. If a Medicaid eligible individual who was seeking treatment at a SUPR-licensed provider wished to be put on buprenorphine for OUD, a provider would need to refer that individual out to a medical provider to be prescribed buprenorphine. If SUPR-licensed providers with the necessary qualified staff were able to prescribe and be reimbursed for the MAT, it would increase a individual's chance of engagement and increased retention in treatment.

Certified Community Behavioral Health Clinics (CCBHC)
IABH is a leading proponent for Illinois to adopt the CCBHC model of care beginning with a pilot demonstration. The CCBHC model has significant potential to impact many of the gaps that exist between behavioral health and physical health, including the Illinois Opioid Crisis, Medication-Assisted Treatment (MAT) deserts, Mobile Crisis Response, Crisis Stabilization, and Recovery Support.

The Excellence in Mental Health Act demonstration established a federal definition and criteria for Certified Community Behavioral Health Clinics (CCBHCs), which provide a comprehensive range of addiction and mental health services to vulnerable individuals. In return, CCBHCs receive a Medicaid reimbursement rate based on their anticipated costs of expanding services to meet the needs of these complex populations.[1]

CCBHCs are required by statute to provide a comprehensive range of addiction and mental health services, including: 24/7/365 mobile crisis team services; immediate screening and risk assessment; easy access to care; tailored care for active duty military and veterans; expanded care coordination; and commitment to peers and family.[2]

The CCBHC model has allowed organizations to expand their workforce by bringing on new staff, increase the patient caseloads, decrease both wait times, increase access to new addiction treatment services or expansion of medication-assisted treatment, and significantly increase integration of mental health, addiction, and primary care.

During this most recent legislative session, under HB 4970, IABH championed the CCBHC model unique to Illinois providers, consumers, and the current Medicaid system. IABH's bill creates the Illinois Certified Community Behavioral Health Clinics Act. It requires the Department of Healthcare and Family Services and the Department of Human Services to jointly develop a pilot program based upon the certified community behavioral health clinic criteria and the prospective payment system methodology issued by the federal Substance Abuse and Mental Health Services Administration and the Centers for Medicare and Medicaid Services as created under the federal Protecting Access to Medicare Act of 2014. The bill requires the Departments to seek federal financial assistance for the pilot program and CCBHC technical assistance and support through all potential federal sources, including, but not limited to, the federal Delivery System Reform Incentive Payment program. The bill would create a prospective payment system (PPS) for reimbursement and include quality incentives.

IABH believes that CCBHCs are the model of addiction and mental health treatment for the future. The integration of physical and behavioral health; transformation of reimbursement from fee-for-service to PPS and outcomes; and demonstrated improvement in quality are all reasons to pursue the CCBHC model. We encourage HFS to support HB 4970, and to look for other ways in which the SUD treatment system may be modified and improved.

IABH seeks to continue its longstanding relationship with the Department and improve SUD treatment for the Medicaid – and other – populations. Working together we can improve quality, obtain better outcomes, reduce inefficient and disruptive utilization review processes, and increase productive residents in recovery in the State. Please contact me so that we may continue this dialogue and provide meaningful input on the course the Department seeks to pursue.

Sincerely,

Gerald (Jud) E. DeLoss
CEO

1. Data Highlights: Certified Community Behavioral Health Clinics (August 2019).
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   Retrieved from https://www.nationalcouncildocs.net/wp-content/uploads/2020/03/2020-CCBHC-Impact-Report.pdf)
3. Bridging the Addiction Treatment Gap: Certified Community Behavioral Health Clinics. (2019, August 29)
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Improving Substance Use Disorder (SUD) Care in Illinois Medicaid

Community Input from the Illinois Harm Reduction and Recovery Coalition

Illinois has a critical opportunity to reimagine its approach to substance use disorders (SUD). Leaders at the state and national levels have devoted tremendous attention and resources to combating the opioid epidemic and yet opioid overdoses and other deaths of despair related to substance use have continued to climb. Progress has been made in building system that can prevent overdose and mitigate the harms of opioid use disorder (OUD) and SUD but communities throughout Illinois still bear too heavy a burden of lost livelihoods and preventable deaths. Early reports show that after several years of modest progress, the state experienced an increase in opioid overdose death in 2019 and there is evidence of a dramatic increase in overdose deaths thus far in 2020. We must change how we confront these challenges.

Of particular concern is the inequitable impact of overdose deaths on Black and Latinx communities. Rates of both fatal and nonfatal overdoses have continued to balloon in these communities while rates have declined among whites. This reality layered on top of the disproportionate impact that the coronavirus pandemic has had on Black and Latinx communities has been a perfect storm of health inequity. Illinois must prioritize supporting its Black and Latinx residents and provide them the care they need to address SUD and other health challenges.

The grant provided through the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act to conduct a statewide SUD needs assessment comes at a crucial moment. Illinois can reduce overdose deaths and build healthier communities through a robust reform effort and this grant can catalyze that effort. The state must do more to promote evidence-based treatment such as opioid agonist treatment (OAT), address racial and geographic disparities, use Medicaid to provide comprehensive recovery services, champion harm reduction efforts, and reduce barriers to care for those who are justice involved or living with a disability. If Illinois acts with urgency, we can build a system capable of addressing one of our community's worst public health crises.

Racial Equity within the SUD/OUD Treatment System

Illinois suffers from dramatic racial inequities in SUD/OUD care in spite of its well-intended efforts. The most dramatic examples are in fatal and nonfatal overdose rates but the inequity extends to access to OAT, bias treatment by providers, over-policing, and justice involvement. One study showed whites are **35 times** more likely to seek and receive buprenorphine (an effective OAT treatment).[1] The state must commit to investigating and addressing these inequities and should consider the following:

- Track state SUD/OUD investments based on the race of program participants and/or the racial makeup of the community. Make this data public and make funding decisions to address inequity.
- Determine if there are any cultural or attitudinal barriers within Black and Latinx communities to accessing traditional treatment or harm reduction services and revise service provision as needed.
- Invest in community health workers who are members of the communities served. They can provide health education, overdose prevention, and recovery and other supports. Use Medicaid to fund these services.
- Address the disparity in buprenorphine access through low-barrier induction and targeted investments in Black and Latinx communities.
- Recognize the disproportionate enforcement of drug prohibition. Deprioritize drug possession arrests and reduce drug possession charges to misdemeanor at the most.
- Recognize and address racial inequities in poverty and wealth.

Treatment Initiation, Retention & Recovery

The state has taken significant strides in improving the SUD/OUD treatment system. The removal of prior authorization and utilization management policies for medication assisted treatment (MAT) under Medicaid along with investments in evidence-based programs like hospital warm handoff programs are important achievements of the last few years. Illinoisans still face considerable barriers, however, to accessing evidence-based treatment and achieving recovery. In particular, the state must do more to promote MAT and a *medication-first* approach to OUD treatment and recovery. Please consider the following:

- Create a bundled MAT induction and maintenance Medicaid benefit for buprenorphine and naltrexone similar to the Medicaid benefit that supports methadone treatment. Conduct an assessment of all related costs and ensure the bundled rate is high enough to incentivize primary care providers and SUPR licensed providers to dramatically ramp up MAT services.
- Provide capacity grants and incentives to primary care providers and SUPR licensed providers to start or expand methadone and other MAT practices.
- Implement *medication-first* policies throughout the treatment system along the lines of the Missouri approach to OUD.[2,3]
- Invest in the ability to track MAT through primary care providers and SUPR licenses providers in one unified system. Provide this data in real-time for use in referrals provided through the Illinois Opioid HelpLine. Use this data to make investment decisions to promote MAT.
- Maintain the COVID pandemic related policies expanding telehealth, allowing OAT induction through telehealth, and allowing larger quantities of OAT medications to be taken home.
- Explore the feasibility a targeted OUD Section 2703 Health Home program.
- Expand the peer recovery supports pilot included in the Illinois Behavioral Health Transformation Section 1115 Medicaid Waiver to become a regular benefit under the State Plan.
- Establish SUD case management as a reimbursable benefit under the Illinois Medicaid State Plan, with services allowable up to 30 days prior to a diagnosis as currently exists with mental health.
- Create behavioral health stabilization and triage centers across the state.
- Expand hospital OUD/SUD screening, referral, and treatment. Build upon the successful hospital warm handoff program and provide Medicaid funding to support this expansion.
- Use incentivizes to help hospitals transition away from traditional medically-monitored withdrawal management programs. Managed withdrawal from opioid use is not treatment and increases the risk of fatal overdose. Hospitals instead should implement OAT induction and referral programs.
- Require state-funded recovery housing programs to accept individuals using OAT in their recovery.

Supportive Services

Illinoisans seeking recovery from SUD/OUD rely on socioeconomic supports just as much as they rely on treatment and recovery services themselves. A lack of supportive services also contributes to the racial inequities plaguing Illinois. The state can do much more to provide supportive services:

- Invest in low-barrier, subsidized housing programs that embrace housing first and harm reduction models. These programs must not require strict abstinence and should recognize relapse as a part of recovery.
- Establish Medicaid benefits to provide services in supportive housing along the lines of the Assistance in Community Integration Services included in the Illinois Behavioral Health Transformation Section 1115 Medicaid Waiver. Establish this benefit statewide.
- Use Medicaid to provide supported employment and food delivery services.

Harm Reduction & Health Promotion

Harm reduction must play a central role in addressing SUD/OUD. Individuals struggling with SUD/OUD face serious challenges and may not be ready to pursue recovery. Most people have many starts and stops prior to overcoming SUD/OUD. We must act to prevent overdose and reduce the other related harms of substance use regardless of whether someone is working towards abstaining from drugs. The state has become more supportive of these initiatives but too many parts of the state are still skeptical of their benefit and propriety. The state must act to promote harm reduction and should consider the following:

- Flood communities with naloxone and target naloxone distribution to high-impact groups like people who use drugs, harm reduction outreach workers, and first responders.
- Distribute naloxone in hospital emergency rooms and enact policy changes to allow hospitals to seek insurance reimbursement for directly distributed naloxone.
- Use community health workers and peer specialists to directly distribute naloxone and to provide overdose prevention education.
- Promote syringe service programs and encourage community-based organizations to register through IDPH. Communicate with law enforcement to ensure legally registered programs and their participants are not harassed by local police.
- Support other harm reduction strategies such as fentanyl testing, other drug adulterant testing, and the distribution of safe smoking and snorting supplies.
- Incorporate harm reduction principles into all social service programs such as the homeless shelter system and the workforce development sector. Eliminate punitive approaches to substance use.

Justice-Involved Populations

The state's reliance on the criminal justice system to address SUD/OUD has led far too many Illinoisans to become justice involved. Justice involvement creates barriers to employment, housing, and social support that frustrates effective SUD/OUD treatment. Individuals in these circumstances require special attention. The state must implement these policy and system changes to ensure better outcomes:

- Invest in existing diversion and deflection programs to promote treatment and minimize justice involvement.
- Provide training and resources to criminal justice stakeholders (judges, prosecutors, public defenders) on available diversion and deflection programs and sentencing options.
- Allow OAT in criminal justice settings such as jails and prisons. Individuals should be able to initiate and maintain medically prescribed treatments like OAT even when incarcerated. OAT should be maintained at release through connection to a community provider.
- Distribute naloxone to incarcerated individuals with a history of SUD/OUD at release.
- Invest in reentry services that complete Medicaid applications and provide specific community connections to individuals with a history of SUD/OUD who are reentering after incarceration. Explore opportunities to support 30-day pre-release services through Medicaid.

Thank you for the opportunity to provide feedback. Endorsing organizations are listed on the following page.

Endorsing Organizations:

Above and Beyond
Access Living
AIDS Foundation Chicago
Buddy's Purpose
Chicago Recovery Alliance
Chicago Urban League
Family Guidance Centers, Inc.
Health & Medicine Policy Research Group
Heartland Alliance
Illinois Collaboration on Youth (ICOY)
Illinois Harm Reduction and Recovery Coalition
League of Women Voters
Legal Council for Health Justice
Live4Lali
Perfectly Flawed Foundation
Prevention Partnership, Inc.
Safer Foundation
Sisters In Sobriety Transformed Anointed & Healed (SISTAH)
The Kennedy Forum Illinois
The Porchlight Collective
Thresholds
Treatment Alternatives for Safe Communities (TASC)
West Side Heroin/Opioid Task Force

Endnotes:

[1] Lagisetty PA, Ross R, Bohnert A, Clay M, Maust DT. Buprenorphine Treatment Divide by Race/Ethnicity and Payment. *JAMA Psychiatry*. Published online 8 May 2019. https://jamanetwork.com/journals/jamapsychiatry/articleabstract/2732871.
[2] Burgess D. Medication-First Approach to Treating Opioid Use Disorder. *KC Medicine*. https://kcmedicine.org/medication-first-approach-to-treating-opioid-use-disorder/.
[3] Missouri Hospital Association. Opioid Use Disorder: A Medication First Model. Opioid Webinar Series. https://www.mhanet.com/mhaimages/webinars/Opioid_Webinar_Part_2.pdf.

Illinois Health and Hospital Association

TREATMENT INITIATION, RETENTION & RECOVERY

What is working well in Illinois?

- Individualized care coordinators designated to higher risk populations who have a history of Re-hospitalization. These teams have been delegated due to their own extensive knowledge and understanding of dual diagnosis. Individualized care teams have been given resources/funds to further explore positive ways of keeping those at risk further incentives to remain in compliance with positive aftercare treatment; which further enables individuals to gain autonomy and confidence in maintaining a healthy lifestyle.

What are the biggest challenges/ barriers to accessing and initiating evidence-based treatment? (E.g. provider access/capacity, medications, staff recruitment, behavioral health capacity)

- Limited number of beds allocated to DASA funded beds in residential substance abuse/dual diagnosis treatment centers.
- Staff education/training of advanced best practices and understanding of dual diagnosis treatment
- Prior authorization/coverage
    - Delays in obtaining medications due to insurance coverage concerns. (primary versus secondary party coverage for pharmacy coverage)
    - Lack of coverage due to medication requiring failed attempts at utilizing plan covered medications
- Plan education to clients
    - Designated pharmacy coverage (ie. Walgreens versus CVS)
    - Language barrier
    - Utilization of electronic/paperless documentation for those not well versed in technology.

What are the biggest challenges/ barriers to retention? (E.g. support staff capacity)

- Staff satisfaction
    - Salary
    - Benefits
    - Training
    - Supervision
- Personal Recovery history/countertransference
- Compassion Fatigue

What are the biggest challenges/ barriers to recovery? (E.g. case management and referral processes/handoffs especially to mental health services, employment, social support)

- Lack of available resources
- Discharge placement options and availability
    - Extremely limited resources for those without funding/financial stability
    - Location of sober living homes/residence

        - Requirements of financial standing at start of treatment
        - Requirements of obtaining employment/work within recovery facility

- Physical/Mental capacity
- Family/Social Support system distrust/dysfunctional relationships due to substance abuse behaviors (ie. stealing, lying, manipulating, intoxication, cheating, etc.)
    - Lack of education/stigma for mental health and substance abuse/addiction
- Care - coordinator personal knowledge and experience with discharge planning (ie. training)
- Legal Records for those struggling with addiction/mental health can provide complicated restrictions for location/availability to work.
- Co-occurring physical disabilities/health issues
    - Complication for work programs
    - Medication restrictions in recovery facilities

What are gaps in the continuum of care spanning from early intervention and outpatient services to medically monitored intensive inpatients services and medically managed intensive inpatient services? (E.g. linkage to a higher level of care, transition from crisis care settings to community-based settings)

- Transportation
- Communication barriers
    - Language
    - Technology
    - Phone access (financial strain)
- Difficulty in finding residential substance abuse treatments that understand and accept individuals with dual diagnosis
    - Lack of knowledge in treatment for mental health and substance abuse
    - Fear of psychosis/self harming behaviors due to admission criteria
    - Medication restrictions (certain psychotropic medications not allowed within specific treatment centers/sober living environments)

What are the barriers to providing behavioral health care, including SUD treatment, integrated in a primary care setting?

What opportunities should Illinois Medicaid pursue to improve treatment initiation, retention, and recovery?

- Covered length of stay
- Longer coverage for residential treatment
- Bed Space Capacity
- Staff training
    - Substance Abuse disorder education
    - Harm reduction models
    - De-escalation training
    - Mental Health disorder education
    - Compassion fatigue training
    - Trauma informed care training

SUPPORTIVE SERVICES

What are the essential supportive services and what is their capacity in Illinois for those with SUD? (E.g. housing, mental health services, family supports, life skills, job training, education, recovery support)

- Residential services
- Nursing home care facilities with specialization in SUD treatment/therapy
- Recovery Homes (most require funding)
- Family Support Groups/education- al-anon/ NAMI
- Work Programs
    - Job skill training
- Mental health
    - IOP
    - Psychiatry
    - Individual Therapy
        - Trauma, Substance abuse counseling, CBT, DBT, Humanistic, etc.)
    - Family/Couples Therapy
- CD IOP
- Care Coordinator Sponsorship
- Community Care Teams
- Provider communication between inpatient/outpatient/PCP etc. history and treatment.

What is working well in Illinois?

- Medical Homes
- All inclusive services : PCC Wellness, VA facilities
    - Clinics which provide one location for multiple services
        - Psychiatry
        - Therapy/Counseling
        - Support Group meetings
        - Primary Care Physician
        - Optometry
        - Dentistry
        - Gynecology

What are the biggest challenges/barriers? (E.g. homelessness and lack of available housing, unemployment)

- Severe amount of homelessness with in dual diagnosis population
- Stigma and misunderstanding of treatment for dual diagnosis population
- Available housing
    - Location of current limited housing
- Available work programs
    - Provide sustainable wages for independence
- Lack of community knowledge/awareness to need for support and guidance for those struggling with dual diagnosis

What should Illinois Medicaid do to foster access to supportive services?

- Provide funding for first month's rent requirement

- Provide payment plans for housing/recovery home treatment
- Educate care coordinators on available resources for clients seeking assistance in housing/treatment
- Provide integrated care teams to support individual with in the community maintain outpatient appointments and support network meetings

HARM REDUCTION & HEALTH PROMOTION

What is the role of harm reduction and health promotion in treatment of SUD? (E.g. Naloxone distribution, syringe services, overdose prevention/safe consumption sites, hepatitis testing and treatment)

- Advanced practices acknowledge a change in positive outcomes from harm reduction models with those in high risk heroin/alcohol abuse
    - Suboxone maintenance
    - Methadone maintenance
    - Naltrexone/Vivitrol
    - Antibus
    - Designated Driver Programs
    - Syringe/needle exchange sites
        - Eliminate/reduce blood borne viruses spread through sharing of needle drug use

How might Illinois Medicaid more fully support overdose prevention and harm reduction for Medicaid beneficiaries?

- School education and training
- Availability to Narcan
- Family/Social support groups - training and destigmatizing of mental health/addiction
- Community outreach and engagement (education/training offered to public)
- Social Media - Support the awareness/understanding to the cycle of addiction/disease model

What more can we do in terms of early intervention?

- Destigmatize residential substance abuse treatment
- Destigmatize mental health (dual diagnosis)
- NAMI - personal recovery specialist interventions
- School education/target location interventions

PAYMENT ISSUES

How has the current reimbursement model affected treatment? (E.g. fee for service, lack of Medicaid for those incarcerated, MAT coverage)

- Negatively impacted those that receive managed care coverage due to certain clinicians/physicians not being paid the same amount as other insurance providers
    - Causing residential treatment/clinicians' to restrict the amount of individuals seen with managed care coverage or eliminate all managed care coverage acceptance.

    - Resulting in an overflow of clients seeking clinicians who do provide services to manage care insurances
        - creating burn out
        - longer schedule appointment dates
        - Possible fall out with noncompliance to medication regimen.
        - Shorter appointment length times for each client to be seen by clinicians (reducing quality of care provided)

How might alternative models of payment for care help facilitate improved access to care for Medicaid beneficiaries? (please provide data and references for innovative solutions whenever possible, including contact information for further discussion)

- Create level service coverage for all providers/insurance providers to ensure client care is equivalent to non-managed insurance.

SPECIAL POPULATIONS

Do you have any specific concerns regarding special populations? (E.g. justice-involved population, postpartum women, women with children, DCFS-referred persons, individuals with co-occurring serious mental illness (schizophrenia, bipolar disorder)

- Co-occurring mental illness and substance abuse disorder population/Drug Court-Mental Health Court population
    - Access to residential substance abuse treatment
    - Access to Stable/structured living environment
        - Recovery Homes
        - Nursing Home
        - Work Programs
- Pregnant women access to:
    - inpatient psychiatric treatment
    - Residential substance abuse treatment
    - Outpatient substance abuse treatment (MAT)
    - Work/job training

POLICY & SOCIETAL BARRIERS

How does racism and discrimination affect those with SUD and their recovery? (E.g. Disparities in outcomes, Disparities in justice-involvement (e.g. incarceration, probation)

- Lower socioeconomic status
    - Increased number of police/legal involvement
        - Resulting Fines
        - Institutionalization
    - Increased exposure to violence/trauma and substances
        - Resulting in mental health symptoms/disorders
        - Resulting in self medication substance abuse
        - Resulting in unhealthy relationship/bonding
            - Domestic violence trauma/charges
    - Delay in treatment

    - Limited access
    - Transportation issues
    - Communication issues (phone access)

How does bias and stigma affect those with SUD and their recovery?

- Care providers are unable to appropriately assess individuals once stabilized from acute care facilities
- Stigma of mental health decreases clinicians aptitude in accepting clients needing specialized support/treatment

What are promising proposals for Medicaid to consider that would require a policy change at the Federal level?

- Creating a plan that offers coverage for coordination of care for people suffering from chronic pain and SUD's

Illinois Health and Hospital Association- Michael Wahl M.D., Medical Director

Illinois Health and Hospital Association

June 29, 2020

Christie Edwards
Cook County Health
credwards@cookcountyhhs.org

Dear Ms. Edwards,

On behalf of our more than 200 member hospitals and nearly 40 health systems, the Illinois Health and Hospital Association (IHA) thanks you for this opportunity to provide input to improve substance use disorder (SUD) care for Medicaid beneficiaries.

We continue to hear from providers that there are limited options for Medicaid patients to access outpatient/community therapy, citing low reimbursement rates and significant levels of required paperwork as reasons for so few service providers. Increasing reimbursement would be an important step to increase access and accelerate delivery of medication assisted treatment (MAT) and opioid use disorder (OUD) treatment in the community.

There also needs to be better relationships between hospitals and OUD-SUD providers to speed the referral process and time to be seen in the clinic (e.g. same day or next day). Another step is to increase the number of ED physicians who have obtained a data-2000 waiver.

One of the gaps in the continuum of care is the ability for patients to obtain Naloxone kits. Hospitals are not reimbursed for providing Naloxone kits to patients with opioid use disorder (OUD) discharged from the emergency department (ED). It is estimated that prescription filling is only an estimated 15%, meaning 85% of patients discharged from hospitals with a prescription do not obtain the rescue drug. We believe that the best way to standardize delivery of naloxone to those at risk across the hospital community is to establish a central source that can supply kits to hospitals to give to patients with OUD.

The lack of ability to share information among providers inhibits treatment. The CARES Act recently amended 42 CFR Part 2 to allow revocable, one-time permissions to share SUD records, which will be helpful in overcoming this barrier.

Thank you for the opportunity to provide input. If you have any questions regarding these comments, please reach out to me at 312-906-6176 or mwahl@team-iha.org.

Sincerely,

Dr. Michael Wahl
Medical Director

cc:
Theresa Eagleson
Director
Illinois Department of Healthcare and Family Services
Theresa.Eagleson@Illinois.gov

Illinois Helpline for Opioids and Other Substances

Attn: Christie Edwards

Request for comment: Improving Substance Use Disorder (SUD) Care in Illinois Medicaid

The following comments for improving substance use disorder care for individuals and families covered by Illinois Medicaid are submitted by the Illinois Helpline for Opioids and Other Substances (Illinois Helpline), a project of Health Resources in Action.

The Illinois Helpline is the statewide, public resource for finding substance use treatment and recovery services in Illinois. The Helpline refers to hundreds of treatment and recovery providers across Illinois and does not operate any treatment programs. Helpline services are always free and confidential, with the goal to guide individuals to the treatment, recovery, and harm reduction options that are best for them.

Ninety-one percent of Helpline consumers are current or potential Medicaid recipients. From December 2017 through June 23rd, 2020, the Helpline has served 28,834 callers from across Illinois. Our Screening & Information Specialists (SIS) ask about insurance status to ensure the caller can access and afford the appropriate service. Of the contacts with the Helpline, 17,201 calls resulted in referrals to substance use treatment and support services; of those callers seeking services, 24% reported a Medicaid MCO as their primary insurance, 10% reported they were insured by Medicaid, 57% reported they were uninsured. This means that 91% of Helpline consumers are current or potential Medicaid recipients.

Medicaid can reconsider how they educate and communicate coverage plans to enrollees. Many Helpline consumers experience uncertainty in relation to their health care coverage, which can impede their timely access to SUD treatment. Of all individuals calling for themselves (individuals with active SUD or in recovery) reporting Medicaid or a Medicaid MCO as their insurance, 31% were unsure of their plan type. Consumers' confusion about their health care coverage, as well as under- or uninsured status has resulted in a high number of Helpline referrals to state-funded treatment facilities and referrals to providers who do not accept a caller's insurance. This can over-burden state-funded programs, which may result in longer wait times for all people seeking treatment. Referrals to programs that do not accept the consumer's insurance are frustrating and confusing, jeopardizing consumers' ability and readiness to access treatment. To reduce these issues, Medicaid could reconsider how they educate and communicate about coverage with recipients. Additionally, sharing information with the Helpline on Medicaid MCO coverage and contracted-providers could further reduce coverage-related frustration for many Helpline consumers.

Medicaid can decrease stigma associated with MAT and increase access to MAT services. The most common referrals provided to Helpline callers who are uninsured or have Medicaid are SUD Residential Services (38%), Withdrawal Management (36%), and Impaired Driver Interventions (18%). For uninsured or Medicaid MCO-covered Helpline callers reporting opioids as their primary substance of concern,

11% were provided referrals to buprenorphine / Suboxone treatment services and 16% were provided referrals to methadone treatment. The Helpline encourages all SIS to refer callers to Medication for Addiction Treatment (MAT) when relevant. However, the percent of MAT referrals remains low relative to referrals to withdrawal management for opioid use (54%). While access to MAT services has increased for some Illinoisans, there are still access issues and stigma against this treatment. Systems like Medicaid have the power to influence change in this space by: encouraging access to MAT when
necessity for inpatient treatment is not indicated, supporting and requiring Medicaid-contracted providers to serve clients on MAT, and implementing services to increase access to MAT (such as regulations around availability of dosing times, reducing barriers to initiate MAT, or providing transportation to appointments).

Underserviced areas of the state, with a high Medicaid recipient population, also suffer from lack of options for treatment. Below is a table demonstrating the average number of referrals given to consumers from each region of the state based on treatment type.

For people without insurance or who have Medicaid, these are the average number of treatment program referrals per call by type of treatment requested.

Avg. number of referrals per call Treatment	Region 1	Region 2	Region 3	Region 4	Region 5	All
All	10	10	8.4	8.0	7.7	10
SUD Residential and Withdrawal management	10.7	11.6	8.6	7.7	8.9	9.9
SUD Residential	11.4	11.8	8.8	7.4	8.0	10.1
MAT services	11.8	10.0	8.0	10.6	4.3	9.6

Demonstrated by this data, residents of IDHS Region 5 (Southern Illinois) may have fewer options for accessing much-needed MAT services. This was anecdotally confirmed by providers in Southern Illinois, several of whom indicated Illinois residents were traveling to border states to access MAT privately because there were not enough public clinics in their area.

Medicaid can promote understanding about transportation offerings. Often, transportation and distance to services covered by a caller's insurance is a reported barrier. While Medicaid funds rides to medical appointments, usage and knowledge of this service throughout the state is variable. The Helpline does not collect data on provider knowledge of these systems, but in our role increasing treatment access across Illinois, Helpline staff have discussed Medicaid transportation with providers. Some providers have many patients who use Medicaid-funded transportation to access their services, while some did not know that this was available. Increasing understanding and access to these services is critical for consumers to reliably access treatment services, particularly MAT services which require frequent visits.

Medicaid can improve reimbursement rates and payment structures for supportive services to improve retention in treatment and recovery. Continued efforts to improve reimbursement rates for inpatient treatment, extended care and supportive sober housing, recovery coaching, and medication assisted treatment are

essential in improving retention rates. The transitional periods into and between treatments and recovery support services can be tenuous for many individuals. The ability for individuals with Medicaid to have access to additional supportive services can increase the likelihood they enter and maintain substance use treatment.

Medicaid can improve access to mental health services for people with SUD. Developing a Medicaid system that supports individuals with SUD to readily access mental health services is a critical need. Among callers with Medicaid, 19% indicated they had a dual diagnosis (co-morbid mental health disorder and SUD). Among callers who are uninsured, 6% of referral calls were for people with dual diagnosis. The estimated prevalence of dual diagnosis in the United States is 50%; much greater than
what is being reported from Helpline callers. Comparing the Helpline data to the overall prevalence of dual diagnosis suggests that callers with SUD may not have previously been assessed or treated for mental health conditions. Focusing benefits and reimbursement structures to support reintroduction/introduction to primary care and mental health providers while accessing substance use treatment could support retention in treatment.

Example: In Massachusetts, Medicaid recently transitioned to an ACO model based on primary care providers and hospital networks, with an integrated plan for substance use treatment and mental health. Massachusetts Behavioral Health Partnership works with members across ACOs, providing case management support and creating a state-wide network of options for patients. This model reduces the barrier to care and ensures an option for case management for those seeking behavioral health services.

Thank you for the opportunity to comment on the process, provide data and perspective from the Helpline. If there is any clarification needed or additional data requests, please contact Jennifer Toth, Director, Substance Use Services at jtoth@hria.org and Chelsea McCarron, Illinois Helpline Project Manager at cmccarron@hria.org.

Illinois Public Health Institute (IPHI)

Date: June 29, 2020
To: State of Illinois

Contact: Laurie Call, Director of the Center for Community Capacity Development, IPHI,
Laurie.Call@iphionline.org

Illinois Public Health Institute (IPHI) submits this input based on recommendations that come out of our experience working with hospital and outpatient providers in the Hospital Opioid Treatment and Response Learning Collaborative in Chicago/Cook County and learnings from community-based efforts through the Illinois Harm Reduction and Recovery Coalition.

The full evaluation report and recommendations from the Hospital Opioid Treatment and Response Learning Collaborative is online at https://allhealthequity.org/wp-content/uploads/2020/03/Hospital-Opioid-Treatment-and-Response-Learning-Collaborative-Final-Report.pdf

We applaud the State of Illinois for seeking input from communities across the state to improve our state's care for people experiencing substance use disorders (SUD). This is a critical time to reimagine the state's approach to SUDs, and we appreciate the state's leadership to engage a diverse set of stakeholders and community members across the state.

Despite work to build systems to prevent overdose and mitigate the harms of opioid use disorder (OUD) and SUD in Illinois, early reports show that after several years of modest progress, there was an increase in opioid overdose deaths in Illinois in 2019 and initial analysis indicates a substantial increase in overdose deaths thus far in 2020. And, of particular concern, the inequitable impact of overdose deaths on black and Latinx communities has persisted even in years when rates declined among white Illinoisans. The COVID-A9 pandemic has magnified inequitable health outcomes and disease burden among Black and Latinx communities, emphasizing that Illinois must prioritize supporting black and Latinx residents and providing the care and resources needed to address SUD and other health challenges.

The statewide SUD needs assessment (supported by the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act) provides an opportunity for the State to work with stakeholders statewide to address racial and geographic disparities, promote evidence-based treatment, use Medicaid to increase access to comprehensive recovery services, champion harm reduction efforts, and reduce barriers to care for those who experience structural barriers such as justice involvement, immigration status, or living with a disability.

Recommendations from the *Hospital Opioid Treatment and Response Learning Collaborative*

In 2019, IPHI worked with the Alliance for Health Equity (a collaborative of 30+ hospitals along with health departments and community partners) to launch the Hospital Opioid Treatment and Response Learning Collaborative in Cook County. The first phase of the learning collaborative included nine hospitals, with participation from doctors, pharmacists, nurses, and social workers. Over the course of the learning collaborative work, we have identified the following recommendations for improving treatment and care for OUD. More details are available in the learning collaborative's 2019 evaluation at https://allhealthequity.org/wp-content/uploads/2020/03/Hospital-Opioid-Treatment-and-Response-Learning-Collaborative-Final-Report.pdf

- Identify financially sustainable mechanisms to support naloxone distribution across diverse settings in communities. For distribution from hospital settings, some specific ideas include:
    - A government central purchasing with a grant program for safety net or other high-need providers. New York City has taken this approach, utilizing public funds to purchase the medication.
    - Enact policy changes to allow hospitals to seek insurance reimbursement for directly distributed naloxone. Alternative billing systems could also include use of J codes or a voucher program similar to what was created to allow hospitals to give sexual assault postexposure prophylaxis kits.
- Work with regulatory bodies and other stakeholders to increase clarity around rules and regulations specific to dispensing naloxone from emergency department and inpatient settings. Some potential opportunities include:
    - Illinois Administrative Code Section 1330.530: Onsite Institutional Pharmacy Services, subsections (b)(1-3), (c)(3), (e)(4) could be updated to also include "overdose antidote" or other specific mention of naloxone.
    - Illinois Pharmacy Practice Act could review and provide guidance to hospitals on allowable ways to store, label, and keep records for medications being dispensed.
- Provide expert training and technical assistance to interested hospitals while simultaneously providing financial support to hospitals to buy out staff time to offset the cost of training clinicians.
- Work with Illinois Medicaid to restructure reimbursement to provide incentives for screening for OUD and SUD, initiating and providing MOUD treatment in the hospital setting, and warm handoffs and linking to ongoing care.
- Work with Illinois Medicaid and SUPR to increase opportunities for peer support specialists and recovery coaches, as these roles are increasingly being used in emergency department and hospital settings. in particular, there are opportunities to work toward more Medicaid reimbursement and cross-training of different peer workforce roles across the health system. One specific approach would be to Expand the peer recovery supports pilot included in the Illinois Behavioral Health Transformation Section 1115 Medicaid Waiver to become a regular benefit under the State Plan.
- Support the creation of "bridge clinics" and behavioral health stabilization and triage centers that would allow for follow-up from hospital and community settings. The goal of these clinics would be to provide an intake assessment,

continue MOUD, and work with the individual to determine where they could go for ongoing care—ideally allowing for walk-in visits so people could come at any time of day and be seen.

- Housing instability has continually come up as an exacerbating factor that relates to increasing risk for individuals who use opioids, challenges related to hospital discharge, and linkage to ongoing services. Some recovery homes continue to prohibit individuals who use medications for opioid use disorder from receiving recovery home services. Similarly, there is a need for more “housing first” programs that provide housing to individuals who are actively using substances or are using medication as part of their recovery. Recent experiences during the COVID-19 pandemic have continued to reinforce the importance of robust residential treatment and permanent supportive housing, and housing programs coming online under COVID-19 recovery should accept people using MOUD.
- Incorporate harm reduction principles into social service programs such as the homeless shelter system and the workforce development sector, and eliminate punitive approaches to substance use. Permanent supportive housing and supportive services should include:
    - Low-barrier subsidized housing programs that embrace housing first and harm reduction models. These programs must not require strict abstinence and should recognize relapse as a part of recovery.
    - Establish Medicaid benefits to provide services in supportive housing along the lines of the Assistance in Community Integration Services included in the Illinois Behavioral Health Transformation Section 1115 Medicaid Waiver. Establish this benefit statewide.
    - Use Medicaid to provide supported employment and food delivery services.
- Maintain the COVID pandemic related policies expanding telehealth, allowing MOUD induction through telehealth, and allowing larger quantities of MOUD medications to be taken home. Explore the feasibility a targeted OUD Section 2703 Health Home program.

Racial Equity within the SUD/OUD Treatment System

Illinois suffers from dramatic racial inequities in SUD/OUD care in spite of its well-intended efforts. The most dramatic examples are in fatal and nonfatal overdose rates but the inequity extends to access to MOUD, bias in treatment by providers, over-policing, and justice involvement. The State should continue its commitment to investigating and addressing these inequities and should consider the following:

- Track state SUD/OUD investments based on the race of program participants and/or the racial makeup of the community. Make this data public and make funding decisions to address inequity.
- Work with black and Latinx communities to identify any cultural or attitudinal barriers for accessing traditional treatment or harm reduction services and revise service provision as needed.
- Invest in community health workers and peer support specialists and recovery coaches who are members of the communities served. They can provide health education, overdose prevention, and recovery and other supports. Use Medicaid to fund these services.
- Address the disparity in buprenorphine access through low-barrier induction and targeted investments in Black and Latinx communities.

- Recognize the racial inequities in criminal justice and disproportionate enforcement of drug prohibition. Deprioritize drug possession arrests and reduce drug possession charges to misdemeanor at the most. Invest in existing diversion and deflection programs to promote treatment and minimize justice involvement. Provide training and resources to criminal justice stakeholders (judges, prosecutors, public defenders) on available diversion and deflection programs and sentencing options. Invest in reentry services that complete Medicaid applications and provide specific community connections to individuals with a history of SUD/OUD who are reentering after incarceration. Explore opportunities to support 30-day pre-release services through Medicaid.

Illinois Public Health Institute and our hospital partners in the Alliance for Health Equity and Hospital Opioid Treatment and Response Learning Collaborative look forward to continuing engagement with the State and other stakeholders to work together to improve care for SUD. Thank you for the opportunity to provide input, and please contact Laurie Call at Laurie.Call@iphionline.org for any follow-up questions or engagement opportunities.

Jackson Park Hospital

Danielle Webb LCSW CADC
Director of Therapeutic Services
Jackson Park Hospital
Chicago, IL
7739477640
June 28,2020

Treatment Initiation, Retention, & Recovery:

In my 20 years work experience, I am pleased that Illinois started to recognize the need to reform substance abuse treatment and healthcare systems. There has been more awareness around educating primary care doctors about substance abuse and mental illness. State funding programs such as SBIRT (screen, brief, intervention, referral to treatment) have helped us reach individuals that may have never stepped up to ask for treatment on their own(solely because they were unaware of what their insurance would cover). Individuals have access to individual behavioral health services, psychiatric appointments, transportation, and informed care with their doctors. More people are able to attend group with their peers.

The challenges I see happening is that most if not ALL funding is going towards opiate addiction. Substance abuse has been a long- standing issue that plagues all communities. The funding resources get allocated towards opioid addicts, and then you have a whole group of others that get left. There are little to very few options for people to get help that use cocaine, methamphetamines, marijuana, etc. As well know, most people don't just use "primary drug of choice". There are usually a secondary and third drug as well. The state guidelines are too loosely based and just appear to focus on that individuals use of opioids. Physicians are only required to take a quick course on substance abuse, no formal courses or any long -term education like they do for all other requirements to become a doctor. Those in the medical field have little to no education about Substance abuse and psychiatric problems because that is not their specialty. When in fact it is just as important as learning about the human anatomy and all other treatment. This is when the problem begins. Individuals come into a healthcare setting seeking help for whatever may be plaguing them. Stress, anxiety, drugs, finances etc. Treatment takes a team of individuals to help. Healthcare facilities need to be fully staff and knowledgeable about how to help.

There are gaps in the referral process and poor hand offs to other professionals. People often times get turned away from same day treatment because of the referral process with Medicaid. They are asking for help but have to go get a referral from their PCP in order to begin an overly booked program that they may or may not qualify for. Having to wait for a referral or leaving, would make anyone discouraged.

The idea of integrated healthcare system seems to be the best idea. We are in need of funding for more substance abuse professionals, behavioral health therapist, training and more education for all involved.

Policy and Societal Barriers

I propose to move this up to my 2nd point because I feel like this is the place to have this discussion. Systematic racism and discrimination are the biggest reasons why people are not being helped or that their recovery is being affected. African Americans that go in to see their doctors about pain are more likely to be assumed to be “drug or narcotic seeking” if the reveal they ever had an addiction. Healthcare treatment is not equal across the board. Race plays a big part in whether they will receive a proper referral over their Caucasian counterpart. There is a huge stigma related to drug use. Drug use by a minority is considered criminal and mental illness if a White American is seeking help. Outcome barriers are also affected by housing issues, lack of resources or interpreters, poor workforce development, etc. The problems are much bigger than the substance itself. In order to rectify this, we must change a much bigger system at the Federal level. These managed care programs do not seem to be working and should be dismantled. They are picking a choosing who THEY want to get services. Meanwhile, people of color are the ones suffering.

Once upon time Illinois had access to life skills programs, recovery support, housing, and mental health programs that flourished. Our government did not see them as “cost efficient “or working. People need to these programs to survive. There is little to nowhere to refer people. People with co-occurring illness are aimlessly wondering the streets. These programs provided the necessity of survival. Illinois can benefit from more programs to help minorities, justice involved individuals, those with mental illness and DCFS involved. Though we have some programs, they are few and understaffed. Psychologist Abraham Maslow theory of *The Hierarchy of Needs,* proposed that before psychological needs are met, we must have a sense of safety, community and belonging, and sense of esteem. I too agree with this theory. It is basic human right to all have equal access to these things. It is our right to give them these things if they do not have them.

In conclusion, I am pleased with prevention plans for harm reduction, but more needs to be done. The naloxone distribution, syringe services, and overdose prevention programs are great ideas. I think in the end that our professionals will play a big part in early intervention. There should be more access for facilities participate in social support meetings. Medical professionals must be properly educated in order to distribute opioid agonist medication. This will lead to empathy and decreasing criminalization of people that need help. We need to break down system barriers that are discriminatory and be more proactive in helping people get access to the basic necessities in life. Though substance abuse if the main topic of discussion, I always feel that it has such deeper roots than just the drug or alcohol itself. If we get to that root I feel as though we will see a difference in reduction rates.

Mercyhealth

Treatment Initiation, Retention & Recovery

What is working well in Illinois? If you have private insurance, services are readily available. Rosecrance has expanded adolescent treatment options.

What are the biggest challenges/ barriers to accessing and initiating evidence-based treatment? *(E.g. provider access/capacity, medications, staff recruitment, behavioral health capacity)*
If your primarily insurance is Medicaid, there is a waiting list for services. Patients have a hard time meeting the daily call requirement at Rosecrance. Others are allowed to call for them but if they do not have a support system, they will fall through the cracks. There are problems accessing detox services. There are a limited number of beds and trying to discharge a patient from our ED departments to the detox unit. Other providers, such as Gateway, speak about open access but it is difficult to secure placement from the ED. Many agencies report available services for substance abuse treatment but when you attempt to access these services, they are unavailable. I have had patients come to the ED stating they are suicidal when they are unable to access detox or inpatient treatment. They think that if they say they are suicidal, they will be admitted and detoxed while on the psychiatric unit. Patients do not want to go to Chicago for treatment and staff is unable to access Chicago based services after hours if a patient would agree. **Patients are at least able to gain access to waiting lists at places such as Gateway and Rosecrance and we are able to make referrals and send packets while they are on the unit. Patients are then responsible for the follow up and continuing to make those calls to remain on the waiting lists. Occasionally, a patient does go directly from inpatient to the substance abuse facility, but that is when they start the process of finding placement right away and are very diligent about finding placement.**
Patients that have primary straight Medicare have the biggest issue finding treatment. Medicare as a primary is not covered at most facilities. Patients with Medicaid and no insurance have a better chance of receiving treatment than a patient with straight Medicare. Yes, patients with Medicare have very few options, similar to the patients we service with straight IPA having limited access to inpatient behavioral health treatment options. Many patients with straight IPA are unable to receive treatment from dual-diagnosis hospitals because these facilities only take managed Medicaid plans. For instance we mostly refer dual-diagnosis patients to Riveredge, CBH, and Lake Behavioral, none of which accept straight Illinois Medicaid.

What are the biggest challenges/ barriers to retention? *(E.g. support staff capacity)* unable to answer this question

What are the biggest challenges/ barriers to recovery? *(E.g. case management and referral processes/handoffs especially to mental health services, employment, social support)* it appears that our patients do not engage in follow up services as outline on their discharge plan. Some have reported changes in case managers and inability to engage in the counseling process with their new case manager. **I agree, they do not follow up upon discharge. A lot of patients do not attend initial follow up appointments, which causes them to never gain access to initial follow up mental health and substance abuse treatment. They in turn quickly run out of medication and then the cycle begins again. They also do not follow up with AA/NA recommendations, other support groups in the community, miss appointments with case managers, and return to toxic**

environments and relationships. Additionally hospital stays are not going to remedy the systemic barriers patients face which may have driven them to substance use in the first place.

- What are gaps in the continuum of care spanning from early intervention and outpatient services to medically monitored intensive inpatients services and medically managed intensive inpatient services? *(E.g. linkage to a higher level of care, transition from crisis care settings to community-based settings)* difficulty if finding immediate placement from the ED setting. **Also, in finding placement prior to a patient discharging from the inpatient setting.**

- What are the barriers to providing behavioral health care, including SUD treatment, integrated in a primary care setting? inadequate treatment or compliance in the community, creating an emergency situation. **We often find that when referring our behavioral health care patients to their primary care doctors for follow up, their physicians feel uncomfortable prescribing psychiatric medications and more importantly, doing follow up long acting injections. Thankfully, Crusader Clinic in the Rockford and surrounding areas does provide behavioral health services as well.**

- What opportunities should Illinois Medicaid pursue to improve treatment initiation, retention, and recovery? **Primary case managers assigned to each patient to coordinate services. Patients do have these assigned through managed Medicaid and it does seem to help when the patient utilizes the services. However, sometimes the patient does not understand the role of this person and the service is under-utilized for a variety of reasons. If this case manager or coordinator can manage all services from medical, mental health, and substance abuse services, the patient could benefit more.**

Supportive Services

- What are the essential supportive services and what is their capacity in Illinois for those with SUD? *(E.g. housing, mental health services, family supports, life skills, job training, education, recovery support)* all of the ones listed below. There is a lack of coordination of care.

- What is working well in Illinois? unable to answer **Many patients that have managed Medicaid do have access to care coordinators that can assist them with accessing resources within the community. They have more access to transportation services, phones, etc.**

- What are the biggest challenges/barriers? *(E.g. homelessness and lack of available housing, unemployment)* patients need to have a primary case manager that coordinates care across all providers. Staffings with all providers would be beneficial. **Definitely housing resources that can assist patients with behavioral health needs. There need to be more supportive housing options with staff available to help with behavioral health needs in the community. I agree with the previously mentioned options. Having a primary case manager would allow for a better coordination of care across the area's agencies as we often times see a lack of coordination between all agencies leading to interrupted services for our patients. Housing resources have been difficult to obtain for many of our patients and we have seen several of our more complex patients thrive (or at least stabilize for extended periods of time, lessening the need for recurrent hospitalizations) when matched with supportive housing options.**

🍫 What should Illinois Medicaid do to foster access to supportive services? payment for coordination of care meetings and appointments.

Harm Reduction & Health Promotion

🍫 What is the role of harm reduction and health promotion in treatment of SUD? *(E.g. Naloxone distribution, syringe services, overdose prevention/safe consumption sites, hepatitis testing and treatment)* many patients or their family members have access to Naloxone.

🍫 How might Illinois Medicaid more fully support overdose prevention and harm reduction for Medicaid beneficiaries? Unknown **More Narcan training for staff and agencies, wet/damp housing options.**

🍫 What more can we do in terms of early intervention? arrange and pay for an immediate outpatient appointment for patients that are identified with a substance abuse problem in the outpatient or inpatient setting. Evening and weekend appointments by service providers are needed. **Definitely the evening and weekend appointments, childcare options on site.**

Payment Issues

🍫 How has the current reimbursement model affected treatment? *(E.g. fee for service, lack of Medicaid for those incarcerated, MAT coverage)* limited access to services when Medicaid is the primary insurance. **Limited coverage for inpatient stays for both mental health and substance abuse. Ability to get patients open to services to enable them to be able to even begin to access services. Outpatient fee for service reduces the amount of time that can be provided to each patient because you are focused on each visit, appointment, etc. We've seen lack of coverage for both Medicaid and managed Medicaid funded patients. Care planning is being driven by cost and coverage, not by patient need which, in the long run, is probably even less cost effective.**

🍫 How might alternative models of payment for care help facilitate improved access to care for Medicaid beneficiaries? *(please provide data and references for innovative solutions whenever possible, including contact information for further discussion)* **Prior to *fee for service, services focused more on the needs of the patient and the time was able to be spent with patients with the greatest need, not in blocks of time as required.***

Special Populations

🍫 Do you have any specific concerns regarding special populations? *(E.g. justice-involved population, post-partum women, women with children, DCFS-referred persons, individuals with co-occurring serious mental illness (schizophrenia, bipolar disorder)* **All special populations have their own specific needs. We need programs that can specifically address the needs of each individual and centralized case management services. Agreed. Having specialized programming for each specific population is key rather than having blanket protocols and treatment plans. Individualized services understanding the complexities of each population's needs are essential to success.**

Policy & Societal Barriers

🍫 How does racism and discrimination affect those with SUD and their recovery? *(E.g. Disparities in outcomes, Disparities in justice-involvement (e.g. incarceration, probation)* **Individuals of color are at a higher risk for behavioral health issues than other demographics due to social and**

economic factors. Additionally people of color are disproportionately represented in high poverty areas. Their socioeconomic status is often stigmatized and taken into consideration and labeled as a personal failure rather than a mental health issue, even in healthcare settings.

🎬 How does bias and stigma affect those with SUD and their recovery? **Many patients cannot and do not receive appropriate treatment and often are not treated appropriately due to their mental health and substance abuse issues. Social stigma and their own self-perceived stigma prevent individuals from receiving help on a daily basis.**

🎬 What are promising proposals for Medicaid to consider that would require a policy change at the Federal level? **Unknown**

Norwegian Hospital

TREATMENT INITIATION, RETENTION & RECOVERY

What are the biggest challenges/ barriers to retention?

- Lack of follow up due to loss of contact. Patients have no email or stable phones.

What are the biggest challenges/ barriers to recovery?
Lack of centers equipped to handle dual diagnoses.

What are gaps in the continuum of care spanning from early intervention and outpatient services to medically monitored intensive inpatients services and medically managed intensive
inpatient services?

- Lack of available beds. Patients sometimes have to wait weeks for a bed to open up but have nowhere to go in the meantime which makes relapse a real possibility forcing them to restart the recovery process.

What are the barriers to providing behavioral health care, including SUD treatment, integrated in a primary care setting?

- The required minimum 60 day between detox admittance proves to be a hurdle for patients who have been in a detox facility and relapse. The required wait time of 60 days makes it hard for them to stay sober and follow through.

What opportunities should Illinois Medicaid pursue to improve treatment initiation, retention, and recovery?

- Remove the minimum of 60 days between detox admittance
- Allow for the doctor or counselor to assess if a patient needs detox services, not a set scale
- Allow for the extension of days a patient may need for detox from three days to seven days
- Allow benefits to cover or help cover supportive housing once discharged

SUPPORTIVE SERVICES

What are the essential supportive services and what is their capacity in Illinois for those with SUD?

- More service for supportive housing is needed. Patients who are discharged from a detox facility or an inpatient treatment facility need a place to stay while they are continuing their recovery journey. Without supportive housing, patients fall through the cracks and lost.

What should Illinois Medicaid do to foster access to supportive services?

- Having a ready list of housing options for patients and walking them through the process would be most helpful in addition to providing funds to help pay some or all of the expenses associated.

HARM REDUCTION & HEALTH PROMOTION

What is the role of harm reduction and health promotion in treatment of SUD?

- To reduce overdoses and subsequent death. To help provide human decency and improve living conditions of those with SUD leading to better public health and safety.

How might Illinois Medicaid more fully support overdose prevention and harm reduction for Medicaid beneficiaries?

- Allow for more access to drug counseling early on and for one on one therapy sessions as well group therapies.

SPECIAL POPULATIONS

Do you have any specific concerns regarding special populations?

- Patients with dual diagnosis of SUD and severe mental illness. Finding the correct placement for such patients is not easy as many places do not accept patients with these diagnoses or who are on certain medications.

POLICY & SOCIETAL BARRIERS

How does bias and stigma affect those with SUD and their recovery?

- The unfortunate bias and stigma that surrounds SUD and the recovery process affects greatly those who are affected by SUD. Families and even medical professionals with inherent biases will ultimately impede the recovery process of those with SUD. Many believe substance abuse is a moral failing and a choice made by the individual instead of treating it as a medical problem.

OUNCE OF PREVENTION FUND
33 West Monroe Street
Suite 1200
Chicago, IL 60603
P. 312.922.3863
F. 312.346.2981

theOunce.org

Illinois Department of Healthcare and Family Services
Division of Medical Programs
201 South Grand Avenue East
Springfield, IL 62794

Re: Illinois Department of Healthcare and Family Services' request for community input regarding how to improve substance use disorder care for Medicaid beneficiaries.

To whom it may concern:

The Ounce of Prevention Fund ("The Ounce") appreciates the opportunity to provide comments to the Illinois Department of Healthcare and Family Services (DHFS) on how to improve substance use disorder (SUD) care for Medicaid beneficiaries. For over 35 years, The Ounce has been committed to giving children in poverty the best chance for success in school and in life by advocating for and providing the highest quality care and education for children from birth to age five. This work includes attention to the comprehensive development of young children, including health and nutrition, mental health and family engagement. Thousands of pregnant and parenting individuals, infants, toddlers and preschoolers are reached each year across the state through our programs, training, evaluation and advocacy efforts.

We commend the Department's desire to improve SUD services for Medicaid beneficiaries and congratulate DHFS for being selected by the Centers for Medicare & Medicaid Services (CMS) to receive one of fifteen state planning grants under section 1003 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act. We fully support the goals of this planning grant to assess the SUD treatment needs of the state, improve training and TA for Medicaid providers, and improve reimbursement for and expansion of the treatment capacity of Medicaid providers. In service of these goals, we appreciate the Department's focus on collecting information specific to racial disparities and discrimination in the provision of SUD services, as well as the specific needs of special populations, including people living in rural areas, pregnant persons, parents with young children, families with Department of Children

the Ounce

OUNCE OF PREVENTION FUND
33 West Monroe Street
Suite 1200
Chicago, IL 60603
P. 312.922.3863
F. 312.346.2981

theOunce.org

- Increase the number of SUD treatment providers across the state who are trained to care specifically for pregnant individuals with substance use disorder in a culturally responsive manner.
- Extend state-funded Medicaid coverage to 12 months postpartum for pregnant persons who are undocumented.
- Encourage SUD treatment providers to refer pregnant patients to home visiting programs that provide a range of supports to pregnant individuals and children that can help them continue treatment and avoid DCFS involvement.
- Consider the role that home visitors can play in harm reduction, including what would be needed to prepare them to carry and administer naloxone.

DHFS should reexamine service delivery models to make them more responsive to the unique dynamics of family life and invest in the appropriate supports that those with children need to access and participate in recovery services. To better respond to the needs of families, we recommend the following strategies:

- Explore options for providing both outpatient and residential SUD services for parents with young children that do not require separation of parents from their children.
- Provide treatment models that incorporate the entire family and evidence-based family support treatment models, such as multidimensional family therapy.
- Develop a best practice protocol for family-specific Medication-Assisted Recovery (MAR) and ensure implementation across the state.

Racial discrimination in SUD services presents further obstacles to accessing certain aspects of treatment, particularly for Medicaid beneficiaries who are Black. Patients with SUD report being denied MAR due to prior involvement in the criminal justice system – which Black patients are disproportionately

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33 West Monroe Street
Suite 1200
Chicago, IL 60603
P. 312.922.3863
F. 312.346.2981

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more likely to experience than Whites patients[1]. Indeed, studies have found that Black patients with Opioid Use Disorder are less likely than White patients to have access specifically to safer and less burdensome forms of medication such as buprenorphine.[2]

In order to combat systemic racism in SUD services for Medicaid beneficiaries, we recommend that DHFS support Medicaid providers across the state with understanding and meeting the Substance Abuse and Mental Health Services Administration requirements to obtain a buprenorphine waiver, including by providing the resources providers need to be able to access required training. DHFS should consider encouraging OB/GYN and other prenatal healthcare providers to equitably screen patients for SUD and to seek qualifications for prescribing buprenorphine. The Ounce also encourages DHFS to develop and implement strategies that advance equity, reduce implicit bias, and promote access to culturally, racially, and linguistically diverse health providers for Medicaid beneficiaries.

Thank you for consideration of the above comments. For any additional information, please contact Ireta Gasner, Vice President, Illinois Policy, Ounce of Prevention Fund, 33 W. Monroe Street, Suite 1200, Chicago, Illinois 60603. IGasner@ounceofprevention.org

Sincerely,

Ireta Gasner
Vice President, Illinois Policy
Ounce of Prevention Fund

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[1] The Sentencing Project: *Report of the Sentencing Project to the United Nations Special Rapporteur on Contemporary Forms of Racism, Racial Discrimination, Xenophobia, and Related Intolerance* (March, 2018). Available at: https://www.sentencingproject.org/publications/un-report-on-racial-disparities/

[2] Substance Abuse and Mental Health Services Administration: *The Opioid Crisis and the Black/African American Population: An Urgent Issue*. Publication No. PEP20-05-02-001. Office of Behavioral Health Equity. Substance Abuse and Mental Health Services Administration, 2020.

PEER Services

Improving Substance-Use Disorder (SUD) Care in Illinois

Thank you for this opportunity to provide our feedback and input on improving SUD care in Illinois. We are very pleased that Medicaid has supported methadone treatment in Illinois since 2017, adding a primary tool for harm reduction. But in our decades of service in this field we have encountered many factors that limit our ability to engage with and retain clients. With respect to Medicaid, specifically, we have identified three key areas for improvement:

1. **Low reimbursement rates leave no margin for investment in infrastructure to strengthen our institutional capacity.**
2. **Lack of Medicaid coverage for case management severely limits our ability to address social determinants that are the biggest barriers for client engagement and retention. 3. Gaps in linkage to care miss key opportunities for outreach and client engagement.**

Details for each improvement area are outlined below.

1. **The low reimbursement rates we are paid leave no margin.**
    - o State Medicaid provides no infrastructure for investment.
    - o For example, we are unable to prepare for another shutdown in the fall if/when we face a second wave of COVID.
        - ▪ We need to provide our staff with cell phones for work.
        - ▪ Our clients do not have tablets and other means to access COVID-modified care through ongoing telehealth counseling.
        - ▪ Without the resources to invest in these preventive measures, our ability to provide services will crash yet again.
    - o We are very grateful to Medicaid for supporting methadone, which is a primary harm reduction tool, but we would also love to expand our services to be a primary provider for buprenorphine and vivitrol as well. Unfortunately, that is impossible within the Medicaid reimbursement model.
        - ▪ We would have to cover the costs of expansion including staff, medical director time, and medications during the 3–6 months it will likely take to build the program to a sustainable level, marketing, etc. — that is just impossible for us to do.
        - ▪ We could only do that within a payment model that provides up-front investments in necessary supportive care.
    - o Outreach is a critically important missing link.
        - ▪ There are no strong mechanisms in place to help people get from a point of crisis into treatment or recovery other than interactions with law enforcement. ▪ There are a lot of people out there who need treatment but are not getting to us. We need frontloaded funding to support outreach positions. Traditional reimbursement structures will not work for that kind of support.
        - ➢ If we could employ someone to work in outreach, they could also work with our current clients to address social needs before they become a bigger problem.

➢ For example, we have a client who has zero social connections. She is now experiencing COVID symptoms and has literally no one to bring her her medication. If we had an outreach worker, we would have already been on top of that rather than having to scramble to cobble together a solution at the last minute.

2. Medicaid does not cover in-depth case management, which is essential to solving problems related to social determinants of health that are the biggest impediments to clients' progress. o All the work we do to coordinate care for our clients and help them with very high social determinants and needs around those is not covered by Medicaid.

- o Social determinants associated with high needs include:
  - ▪ Housing
  - ▪ Employment
  - ▪ Food access
  - ▪ COVID care
  - ▪ Access to benefits
- o Problems arising in social determinants are the most significant barriers to client engagement and retention.
- o It would be great if nurses could bill their time spent on health promotion/education, at both individual and group levels, as well as care coordination – working with hospitals, medical practitioners, jails, coordinating with other care providers and educating them about methadone.
- o While Medicaid may not be able to invest directly in housing, job training, recovery support services, etc. — more coordination and alignment between state agencies can help to bolster these supports.
- o These are factors that affect people's willingness to participate, competing with the spectrum of other things that are happening in their lives.
- o We acknowledge that the 1115 waiver supports demonstration projects for SUD case management in the Illinois Medicaid program – with a five-year timeline to prove net savings. Our clients simply do not have time to wait five years before we can even begin to move on these efforts.

3. Gaps in linkage to care between primary care, emergency rooms, hospitals, and SUD treatment agencies have not improved through Medicaid.

- o There is no organized system to manage transitions into SUD treatment for people leaving jails or hospitals and prevent them from cycling back through those institutions – but it is absolutely in the interests of the health plan to help people progress.
- o Dedicated case management support, with 1:20 caseload ratios, is needed to encourage progress. Giving patients a phone number in the ER, or even putting them on the phone with a treatment center while in the ER, is not enough to establish a relationship that can lead to motivation to change or address the social determinant needs that get in the way of making lifesaving changes.

- Ideally, we would hire someone with lived experience to meet people in the ER. They could meet people at a very different place than a licensed counselor would. This would also help people who are already in recovery by providing them with meaningful employment.
- Additionally, inadequate pain management is taking people back to the ER a lot. Doctors continue to prescribe opioids for pain management to people who struggle with SUD.

Broader policy changes are needed as well, to the extent that Medicaid can support or advocate for those. For example, substance use is only a criminal justice problem because having drugs on your person is a crime, but it does not have to be. Similarly, if a city's funding was shifted from police to social workers, what role could Medicaid play in supporting that? While these factors may not explicitly fall under the purview of Medicaid, meaningful engagement with other agencies and stakeholders around these issues could really help to move things forward. Thank you again for this opportunity to share our perspective based on our experience.

CONTACT

Maureen McDonnell, Executive Director
PEER Services
906 Davis Street
Evanston, IL 60201
mmcdonnell@peerservices.org

SUPPORT ACT PLANNING GRANT

Recommendations

June 29, 2020

Safer Foundation is one of the largest nonprofit social impact organizations focusing on human capital development for people with arrest and conviction records. At Safer, we focus on helping our clients secure and maintain employment because we understand that employment offers the best chance at successful reentry and recovery. We also understand the hierarchy of needs our clients face upon reentry, many of which have to do with basic needs of housing, physical health and behavioral health care. Medicaid is one of the most important benefits our clients have to address these needs upon release while looking for economic opportunity and working towards self-sufficiency. Our largest population of clients reside in areas on the west and south sides of Chicago in communities that are disproportionally impacted by poverty, unemployment, opioid overdose, behavioral health hospitalizations, and violence[1,2,3,4,5,6,7]. Approaches towards substance use treatment in these communities have to be holistic to address the myriad of issues/needs faced by this population. With this perspective we offer the following recommendations for investment in Medicaid as it relates to the needs of individuals who have substance use disorders.

1. **Implement the 1115 Waiver Supported Employment and Assistance in Community Integration (Housing) Pilots** that were approved by the feds in May 2018 (and expires June 30, 2023), but has yet to be implemented. Housing and Employment are social determinants of health that have yet to be systemically addressed in Illinois behavioral health system or health system. The inability to be stably housed or earn an income to pay the bills and provide for one's self or his family directly affect his/her ability to engage in substance use services or any other care.

2. **Increase Medicaid coverage of Substance Use Services**; Meaning inclusion of these services in the state plan and not on a pilot/limited basis. Other states, such as Kentucky, cover more services in the continuum than Illinois.[8]
    - **Screening** (not a full-blown assessment, but a brief screen/triaging tool) - Evaluates the presence of mental health, substance use or co-occurring disorder to establish the need for an in-depth assessment.
    - **Crisis intervention** - Offers immediate, short-term face-to-face in-office help to those experiencing event-triggered emotional, mental, physical and behavioral distress or problems, for up to 30 days prior to diagnosis.
    - **Mobile crisis** - Full-time response team to safely transition a beneficiary in crisis to the most appropriate services including short-term face-to-face outside a provider facility.
    - **Peer Support** - Services provide social and emotional support by qualified adults and youth in recovery or family members of persons with mental health, substance use or co-occurring disorder.
    - **Targeted Case management** - Services to assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other

community services, for up to 30 days prior to diagnosis as is offered in mental health.
    - **Family/Couple Outpatient Therapy** - Scheduled visits between a therapist, beneficiary and the beneficiary's family or household member to address issues in an effort to improve interpersonal relationships in the home.
    - **MAT** - Bundled payment for substance use treatment providers and medical practices to offer Medication Assisted Treatment (MAT) to cover prescribing, medication administration, monitoring, and maintenance. Lack of adequate payment affects availability of services.
    - **Create a bundled payment for treatment providers, similar to encounter fees for FQHCs.**[9] These codes would pay for all the work that goes into an initial visit and services provided by a multi-disciplinary team. It would be designed to reflect the cost for all the services associated with a comprehensive visit, even if not all the services occur on the same day.

3. **Issue Capacity Grants for Substance Use Treatment Providers** – Fund costs related to infrastructure; i.e. costs not covered by grants and Medicaid but that are necessary to serve the population. Areas that require attention include:
    - Back office support
        - Invest in infrastructure for non-traditional social service providers to operate in Medicaid and managed care. Many of these providers have the reach into what others define as "hard-to-reach" populations, but have existed outside of the Medicaid model and require assistance and the right infrastructure to operate in this space.
            - Funding for: (Billing staff, Electronic Health Record setup, EHR Systems personnel, technical assistance on how to set up new lines of service, e.g. MAT, recovery homes, dual-diagnosis, managed care, etc.)
    - Invest in social service provider capacity to offer MAT
        - The primarycare-behavioral health integration conversation has been largely focused on integrating behavioral health into primary care, but little investment has been made to integrate primary care into behavioral health. Reaching hard-to-reach populations requires outside the box thinking and for many of the individuals involved in the justice system, the doctor's office is not something that they have a history of engaging in outside of care provided inside a correctional institution.[10] But this population will engage in programs for help with housing or employment. Approaches to engage this population should meet the population where they are and build on engagement strategies from there. That means bringing treatment to non-traditional settings, such as settings where they are going to seek help for basic needs support.
            - Funding for: Hiring of full or part-time physicians or nurses on-site and technical assistance in regards to offering MAT; how to staff, structure, and drawn down reimbursement.

For more information, contact: Sherie Arriazola, AVP, Behavioral Health, sherie.arriazola@saferfoundation.org, 773-887-2422

[1] Chicago Department of Public Health. (2016). Healthy Chicago 2.0: Partnering to improve health equity. Retrieved from https://www.chicago.gov/content/dam/city/depts/cdph/CDPH/Healthy%20Chicago/HC2.0Upd4152016.pdf
[2] Tamara Rushovich, Allison Arwady, Elizabeth Salisbury-Afshar, Ponni Arunkumar, Mark Kiely, Steven Aks, Nikhil Prachand. (2018). Annual Opioid Surveillance Report – Chicago 2017. Retrieved from https://www.chicago.gov/content/dam/city/depts/cdph/CDPH/Healthy%20Chicago/ChicagoOpioidReport2018.pdf
[3] Population Estimates Source: Chicago Metropolitan Agency for Planning (CMAP) Community Data Snapshots, updated in June 2016 with new information from the U.S. Census Bureau's 2010-14 American Community Survey, available at:http://www.cmap.illinois.gov/data/metropulse/communit y-snapshots
[4] Violent Crime rate per 1000 people, past month. Source: The Chicago Tribune, Crime and Chicagoland, Violent crime data for the Chicago area is updated weekly from the crime dataset on the City of Chicago's data portal.
[5] Violent crimes: assault, battery, homicide, robbery, sexual assault. Violent crime reported (in past 30 days) per thousand people in each Chicago community area since June 20, 2016, 11:55 p.m. These tables are updated weekly and reflect a 7 to 14-day lag period. Available at: http://crime.chicagotribune.c om/.
[6] Violent crime Reports past year, Source: Chicago Police Department Crime Summary, past 365 days (as of July 6, 2016), available at: http://gis.chicagopolice.org/websit e/clearMap_crime_sums/viewer.htm?SUMTYPE=COMM&SUMCATA=VIOL&SUMTIME=365
[7] Ibid. Chicago Department of Public Health, 2016.
[8] https://chfs.ky.gov/agencies/dms/member/Pages/SubstanceAbuse.aspx
[9] https://www.cms.gov/medicare/medicare-fee-for-service-payment/fqhcpps/downloads/fqhc-pps-specific-payment-codes.pdf
[10] Regenstein, M., and Christie-Maples, J. (2012). Medicaid Coverage for individuals in jail pending disposition: Opportunities for improved health and health care at lower costs. Washington, DC: Department of Public Health Policy, School of Public Health and Health Service, George WashingtonUniversity. Retrieved from http://sphhs.gwu.edu/departments/healthpolicy/publications/DHP percent20Reportpercent20Regenstein percent2010 percent20reasons percent20November percent206.pdf

Shawnee Health Service- Aaron Newcomb, D.O. to HFS

Shawnee Health Service
A Non Profit Organization Serving Southern Illinois Since 1972
An Equal Opportunity Employer and Provider

109 California Street
P.O. Box 577
Cornerville, IL 62916-0577
Phone (618) 519-9200
Fax (618) 965-4836

Illinois Department of Health and Family Services (HFS)
2200 Churchill Rd
Springfield, IL 62702

June 21st, 2020

Re: Improving Substance Use Disorder Care for Medicaid Beneficiaries.

Dear Sir or Madam,
I have been employed by Shawnee Health Service and Development Corporation (SHS), a federally qualified health center (FQHC) since 2008 and I currently serve as the Substance Use Disorder (SUD) Medical Director for SHS. I hold primary board certification in Family Medicine and subspecialty board certification in the field of Addiction Medicine. I have been personally providing frontline treatment of the opioid crisis since 2011 treating patients with buprenorphine therapy. My experience and expertise lay solidly in the treatment of opiate use disorder (OUD). Buprenorphine for office-based opiate treatment (OBOT) is the specific area that I would like to address during this listening session.

In short, I would like to address the widespread problems I see regarding fundamental misunderstandings of effective buprenorphine therapy and how these misconceptions cause barriers to treatment and result in real patient harm.

As far as buprenorphine dosing and treatment length, it is imperative to understand that the goal of medication-assisted treatment (MAT) is to achieve and sustain recovery. It is not to use the lowest dose or shortest duration possible. These are often misunderstood concepts. Tragically, it is all too often misunderstood and acted upon by insurance providers, Medicaid and Medicare, pharmacists, many types of healthcare professionals and even uninformed providers of addiction treatment. I have witnessed, countless times throughout the years, of patient harm that stems from practices, policies and frank stigmatization based on the idea that a lower dose or a shorter time spent on buprenorphine is somehow what is best. The opposite is actually true. The clinical research on MAT with buprenorphine shows that the longer and more adequate the dose of buprenorphine, the better the outcome for addiction treatment.

For instance, higher dose buprenorphine therapy defined as 16-32mg has been shown to result in statistically better treatment outcomes then doses below 16mg.[1] Although methadone shows the strongest benefits for treatment outcomes, buprenorphine at doses of 16mg or higher is similarly effective.[2]

In contrast, many in the medical field, including a significant number of MAT providers and even some medical directors of addiction treatment centers, continue to operate under the false notion that 16mg of buprenorphine is the highest effective dose for MAT. This fallacy is not based on clinically significant research but is rather based on published studies of PET scan results after buprenorphine

[1] Fareed A, Vayalapalli S, Casarella J, Drexler K. Effect of Buprenorphine Dose on Treatment Outcome. *J Addict Dis*. 2012;31(1):8-18. doi: 10.1080/10550887.2011.642758.
[2] Wakeman S. Diagnosis and Treatment of Opioid Use Disorder in 2020. *JAMA*. 2020;323(2):2082-2083. doi:10.1001/jama.2020.4104. Hereinafter referred to as the "2020 JAMA Article".

administration on the brains of a small hand full of subjects in 2000 and 2003.[3][4] Modern medicine unequivocally designates clinically and statistically significant research-based outcomes as normative and it would be quite the opposite to hold in vivo research results above evidence-based medicine.

In a similar vein, buprenorphine treatment length is often restricted by MAT providers and various addiction treatment programs in this area. I have assumed care of countless patients over the years that were forced off medication prematurely and were experiencing the clinical harms associated with the lack of access to buprenorphine treatment. Some patients have reported to me that they were informed that they were, "Just acting like an addict" when requesting continued buprenorphine treatment during a forced taper. Many of these patients who were disregarded by other providers are finding long-term remission of their opiate use disorder with indefinite buprenorphine therapy in our program.

The Substance Abuse and Mental Health Services Administration (SAMHSA) addresses this problem directly in the TIP 63 document. The Treatment Improvement Protocol states, "[f]orcing a patient to taper off of medication for nonmedical reasons or because of ongoing substance misuse is generally inappropriate."[5] It further states, "[d]o not require discontinuation of pharmacotherapy because of incomplete treatment response. Doing so is not a rational therapeutic response to the predicted course of a chronic condition"[6] and similarly, "[p]roviding short-term medical treatment for OUD is the same as treating a heart attack without managing the underlying coronary disease."[7]

So how long should the patient be treated with buprenorphine therapy? According to SAMSHA, "[t]he TIP expert panel recommends offering maintenance therapy with medication, not short-term medically supervised withdrawal. The TIP expert panel also supports maintaining patients on OUD medication for years, decades, and even a lifetime if patients are benefiting."[8] TIP 63 notes, "[l]ong-term treatment outcomes up to 8 years after buprenorphine treatment entry show lower illicit opioid use among those with more time on medication. Patients should take buprenorphine as long as they benefit from it and wish to continue."[9]

This treatment approach for the duration of buprenorphine therapy is the exception rather than the norm for southern Illinois region. The lack of adherence to effective dose and duration of buprenorphine therapy is not unique to our region. For instance, the 2020 JAMA Article mentions explicitly that, "[e]ven when available, pharmacotherapy [medication assisted treatment] is often unreasonably restricted through low dosages and limited duration."[10]

Another problem that I frequently witness is that buprenorphine treatment access is discontinued based on arbitrary behavioral health mandates in different treatment programs even when MAT has proven effective to stabilize a patient with OUD into remission. I have had many patients during treatment entry into the

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[3] Zubieta J, Greenwald M, Lombardi U, *et al.* Buprenorphine-induced Changes in Mu-Opioid Receptor Availability in Male Heroin-Dependent Volunteers: A Preliminary Study. *Neuropsychopharmacology*. 2000;23(3):326–334. doi:10.1016/S0893-133X(00)00110-X.

[4] Greenwald, M, Johanson, C, Moody, D, *et al.* Effects of Buprenorphine Maintenance Dose on Mu-Opioid Receptor Availability, Plasma Concentrations, and Antagonist Blockade in Heroin-Dependent Volunteers. *Neuropsychopharmacology*. 2003;28(11):2000–9. doi:10.1038/sj.npp.1300251.

[5] SAMHSA. Treatment Improvement Protocol TIP 63: Medications for Opioid Use Disorder. https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-006_508.pdf at 3-92. Updated 2020. Accessed June 16, 2020. Hereinafter referred to as SAMSHA TIP 63.

[6] *Id*.

[7] *Id*. at 4-6.

[8] *Id*. at 3-11.

[9] *Id*. at 3-70.

[10] 2020 JAMA Article at 3.

SHS program, describe how they have had their buprenorphine treatment either threatened, reduced or stopped altogether based on mandatory behavioral health thresholds that were not met. That is truly a disgrace. Behavioral health services can be extremely valuable and important for successful treatment, but MAT without counseling has been demonstrated as equally effective.[11] There is absolutely no evidence that behavioral health is necessary to achieve clinically important outcomes with buprenorphine therapy.

The 2020 JAMA Article specifically states, "[a]lthough psychosocial treatments should be available to individuals treated with medication, randomized clinical trials examining adjunctive cognitive behavioral therapy, contingency management (giving tangible rewards to reinforce positive behaviors), and individual addiction counseling have not shown benefit compared with medical management alone with methadone or buprenorphine in opioid use outcomes."[12]

Even SAMSHA specifically addresses this issue as follows, "[c]linical trials have shown no differences in outcomes for buprenorphine with medical management between participants who get adjunctive counseling and those who don't (i.e., prescriber-provided guidance focused specifically on use of the medication)."[13] Similarly, in Exhibit 4.2 entitled "Recommending Versus Requiring Counseling" the TIP expert panel affirms that "counseling and ancillary services greatly benefit many patients. However, such counseling and ancillary services should target patients' needs and shouldn't be arbitrarily required as a condition for receiving OUD medication (although they are required by regulations in OTPs), especially when the benefits of medication outweigh the risks of not receiving counseling."[14]

That all being said, I must say that I have personally witnessed exceptional results from patients engaging in behavioral health services for recovery, quality of life and many important clinical outcomes while engaged in MAT. I think this aspect of treatment plays a vital role in many OUD cases. Patients in our program are encouraged and we readily link to behavioral health services throughout the treatment process.

I am not sure how to solve these problems, but I am convinced that educational awareness is needed and that stigma of MAT must be addressed. I am convinced after nine (9) years of providing buprenorphine therapy that lack of understanding effective MAT principals and persistent prejudice against the treatment altogether are the greatest barriers to quality treatment access when it even exists.

I must make mention, however, of the elephant in the room. In addition to the lack of quality MAT available, the vast majority of patients suffering from OUD have no access whatsoever to the most effective treatment option for their illness. The regulations on MAT leave a paucity of access to needed treatment. As it stands now, the overwhelming majority of patients don't get the most effective treatment they need when they are suffering from OUD, and when they do it is often substandard as I have already described. Because of the patient limit for MAT, I have personally had the heartbreaking experience of having patients establish care with me as their primary care doctor simply to beg me to provide buprenorphine therapy when I am not legally able to do so because of the patient limits. I have made the choice to always follow the law even though I know that when these patients leave without buprenorphine treatment, the Narcan order is just a Band-Aid. They are basically just as close to the next overdose as they were before seeing an addiction doctor. They leave and their life remains in shambles.

In years past when the DATA waiver patient limit was at one-hundred (100), I had to live with seeing some patients in the obituaries because there was not an open slot at the moment of need. I currently have a patient limit of two hundred and seventy-five (275) and I have two hundred and seventy-one (271) patients

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[11] SAMSHA TIP 63 at 4-7.
[12] 2020 JAMA Article at 3.
[13] SAMSHA TIP 63 at 4-7.
[14] *Id.* at 4-5.

on my active list. I don't want to have to turn patients away because of arbitrary patient limits. It is not what I consider an ethical practice of medicine.

The path forward is limited by federal regulations that must be addressed if we are to effectively remove the barriers that exist to accessing the highest quality of treatment for patients that suffer from OUD. In the meantime, we must address the lack of quality and the stigma that permeates the limited MAT that is available to patients with OUD. These patients have an illness and they deserve at least the respect and dignity of having access to effective treatment.

Sincerely,

Aaron Newcomb, D.O.
Family & Addiction Medicine
Shawnee Health Services
400 S. Lewis Lane
Carbondale, IL 62901
(618) 519-9200

Shawnee Health Service- Aaron Newcomb, D.O

From: Aaron Newcomb, DO <anewcomb@shsdc.org>
Sent: Saturday, April 25, 2020 4:06 PM
To: Angie Bailey <Angie.Bailey@sih.net>; Katharine Juul <kjuul31@siumed.edu>; Sarah O Dell <Sarah.ODell@sih.net>; Sherrie Harlow <Sherrie.Harlow@sih.net>; Bill <bmccreery57@gmail.com>; kunthank@egyptian.org; Jurich, Anna <agjurich@gatewayfoundation.org>; Mona Miller <Mona.Miller@centerstone.org>
Subject: [EXTERNAL] Re: Substance Misuse Listening Session/Community Forum - Carterville 5-630 pm (room holds 80 people)

Hello there,

This is an excellent synopsis of opiate dependency and the current state of treatment from JAMA which I have copied the link below. I think it speaks to many of the barriers that exist ubiquitously for treatment of opiate use disorder. Much of my experience since 2011 for barriers to MAT in this area is unreasonable restricted access to medication-assisted treatment when it does exist.

One example is with mandated levels of behavioral health engagement in order to access medications even when these patients have been previously compliant for a long period of time in a MAT program and have proven stable recovery on MAT. The JAMA article speaks to this problem specifically, "Although psychosocial treatments should be available to individuals treated with medication, randomized clinical trials examining adjunctive cognitive behavioral therapy, contingency management (giving tangible rewards to reinforce positive behaviors), and individual addiction counseling have not shown benefit compared with medical management alone with methadone or buprenorphine in opioid use outcomes.", and "All patients should be offered pharmacotherapy for OUD. Adjunctive psychosocial treatments may be helpful, but are not required."

Furthermore there has been and still persists the practice of using low dosages or limited duration of MAT which is 'unreasonable' per the JAMA article and is associated with worse outcomes as is also highlighted in the article. For instance, the article states, "Of the 3 medications, methadone is associated with the strongest benefit for retention in addiction treatment and reduced opioid use compared with nonpharmacologic treatment.[2] At

doses of 16 mg or higher, buprenorphine is similarly effective." and "Even when available, pharmacotherapy is often unreasonably restricted through low dosages and limited duration".

There has been and continues to be problems with various pharmacies and covering entities like insurance companies that erect unnecessary barriers to medication access and perpetuate attitudes of judgement and stigma towards myself and my patients in Southern Illinois. These problems have not gone away despite Illinois having enacted the parity law.

I am encouraged by the work of Centerstone with the OTP and with Gateway's evolution into MAT services and the other FQHCs that have made strides in developing programs. I am hopeful that SIH being the major healthcare provider in the area can someday actualize MAT treatment services which is the most effective treatment available for opiate dependency. I am also hopeful that some of the problems I sited above can be addressed by various programs so that patients can receive the best quality care with MAT. My personal list of active patients hovers around 265 for the past number of months which leaves 10 open spots so I cannot be the one that patients continue to find to provide them effective long-term MAT when other treatment providers under treat by dosage, wean off prematurely or worse, cut patients off abruptly because of arbitrary program rules and not due to safety issues.

Thank you for your consideration. Sorry it took me a while to provide this response after the forum was canceled but the JAMA article came to me yesterday and really speaks to me and I felt affirmed about the problems that I have been experiencing over the years. I hope it is helpful. I also hope everyone is safe and finding ways to stay sane during these most difficult times.

Sincerely,

Aaron Newcomb, DO
Family and Addiction Medicine
400 South Lewis Lane
Carbondale IL 62901
(618) 519-9200

https://jamanetwork.com/journals/jama/fullarticle/2765301?guestAccessKey=2ca446b5-62ec-4ef3-864d-63ad3ca96b89&utm_source=silverchair&utm_medium=email&utm_campaign=article_alert-jama&utm_content=olf&utm_term=042420

Shawnee Health Service- Stacy Agosto, AM, LCSW, CADC

Shawnee Health Service
A Non-Profit Organization Serving Southern Illinois Since 1972
An Equal Opportunity Employer and Provider

109 California Street
P.O. Box 577
Carterville, IL 62918-0577
Phone (618) 519-9200
Fax (618) 985-6860

Illinois Department of Health and Family Services (HFS)
2200 Churchill Rd
Springfield, IL 62702
June 21st, 2020

Re: Improving Substance Use Disorder Care for Medicaid Beneficiaries

To whom it may concern:

Thank you for allowing me this opportunity to provide comments on improving behavioral health and substance use disorder care. I am the Clinical Director of Behavioral Health at Shawnee Health Service, an FQHC serving southern Illinois. Before that, I worked as a therapist and manager of a mental health and substance use disorder (SUD) team at Howard Brown Health, an FQHC in Chicago. I am a licensed clinical social worker and certified alcohol and drug counselor. I have organized my comments based on topic.

What is working in Illinois?

Southern Illinois is strengthening its partnerships across agencies and organizations that provide SUD care. There has been success in getting patients from the point of identifying a need for services in our primary care setting (Shawnee Health), for example, and being able to link them quickly to a higher level of care (Centerstone, Gateway). We have more options for treatment, including trauma-focused treatment for women, through expanded service lines at partnering organizations. There is much more awareness of the impact of SUDs on patients and communities than there was before.

What are the barriers of providing behavioral health in a primary care setting?

One of the biggest barriers of providing behavioral health care in an integrated, primary care setting is simply that BH practitioners are not trained to do it. Traditional PhD and masters level graduate programs in social work, counseling and psychology are set up to train therapists who work in traditional settings that resemble private practice. The implicit idea is that the patient willingly attends therapy, with an issue they have already identified and want to work on. Said patient often has infinite number of weeks to work on their problem. This is not the world of behavioral health in primary care.

Students are not well-trained in brief, health-focused intervention in a medical setting. I myself have had to "undo" some of the training I received in order to fit this model. I have worked in two FQHCs in Illinois, one in Chicago and now in Southern Illinois. The same issues have arisen at both in terms of training staff and transitioning their mentality from long-term work with clients on deep psychological issues to shorter-term, more focused brief intervention. This burdens the organization to completely retrain the BH practitioner when they arrive at the agency – to learn how to work in a medical setting,

Shawnee Health Service
A Non-Profit Organization Serving Southern Illinois Since 1972
An Equal Opportunity Employer and Provider

109 California Street
P.O. Box 577
Carterville, IL 62918-0577
Phone (618) 519-9200
Fax (618) 985-6860

how to think about the relationship between physical and behavioral health, to learn the nuances of most common physical diagnoses and medications patients might be on.

Additionally, trying to implement policies and procedures that fit BH into a primary care setting is challenging, again because most of our training and even licensure requirements do not fit this setting. For example, even SUPR's documentation guidelines for substance use patients is written assuming a very traditional, linear track for a patient. We are required to document a thorough assessment, treatment plans every 60 days, a continuing recovery plan and discharge summary when the patient stops attending treatment. Trying to implement these requirements in a primary care setting is doable and valuable, but very challenging. Patients are often referred to behavioral health in precontemplation or contemplation about a certain problem that is affecting their health. Many times they are still using.

As a result, the BH then has to "sell" the patient on completing the lengthy SUPR SUD assessment – when patients aren't even ready to say they have a problem that needs assessing. Patients can drop off for weeks or months before they may be ready or able to come in for another appointment. This is especially true in a rural setting. As a result, we are already out of compliance with our treatment plan timelines, and perhaps need to initiate discharge summaries. The patient then returns, wants to re-engage or is required to re-engage by their primary care provider. At this point we may have already "discharged" them due to requirements, only to have to decide whether or not to re-initiate the whole process all over again. This administrative burden stymies us and makes it difficult to "meet the person where they are."

It would improve primary care for all if more training for mental health practitioners in Illinois were tailored for a medical setting and patient health issues. It would also help for licensing bodies to take the primary care setting into consideration when developing requirements.

Bias/stigma

Those of us who have worked in SUD often take on the burden of convincing other providers that these patients deserve compassion, respect, evidence-based treatment and the *right to choose their options.* It continues to be the case that certain providers impose arbitrary or outdated guidelines on patients, which seem to be based more on the provider's own moral code or fears than any evidence-based medicine. I would rather see providers stay out of the field of SUD completely, than begin to treat these patients in order to "fix" them, forcing them into treatment that patients are not ready, willing or able to complete. For example, one of our referral partners recently had a change in medical personnel. One of their buprenorphine prescribers left the organization and the new one had vastly different "rules" around how they would prescribe compared to the first prescriber. I'm told patients were being given different dosages, different prescribing timelines, different and new behavioral health requirements. As a result, these patients wanted to "jump ship" and switch to prescribers outside the organization. I believe many organizations grapple with this – working to standardize care for those on MAT using the newest evidence-based medicine instead of treating based on morals or emotion.

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A Non-Profit Organization Serving Southern Illinois Since 1972
An Equal Opportunity Employer and Provider

109 California Street
P.O. Box 577
Carterville, IL 62918-0577
Phone (618) 519-9200
Fax (618) 985-6860

Thank you again for allowing the opportunity to provide comments. Please feel free to get in touch with me with further questions.

Stacy Agosto, AM, LCSW, CADC
Clinical Director Behavioral Health
Shawnee Health Service

The South Suburban Council on Alcoholism and Substance Abuse

03/27/2020

Written response submitted by: Ramaswamy Srinivasan, President & CEO, The South Suburban Council on Alcoholism and Substance Abuse, 1909 Cheqer Square, East Hazel Crest, Illinois 60429 (Cook County), Work Phone: 708-647-3305, Email Address: rsrinivasan@sscouncil.org

Response submitted to: Christie Edwards, Cook County Health, credwards@cookcountyhhs.org

TREATMENT INITIATION, RETENTION & RECOVERY

Working Well: 1) Drug Courts, 2) Identification of proper level of care, co-occurring disorders and recovery support needs using [American Society of Addiction Medicine], 3) Availability of Medicaid through Affordable Care Act for uninsured/underinsured, and 4) Increased awareness by primary care hospitals and primary care physicians for addiction related disorders

Challenges/Barriers

> **Access and Initiating:** 1) Laws that prevent online access and initiation, 2) Affordability to offer more evening and weekend services, 3) Transportation and 4) Education and Early Intervention Retention
>
> **Retention:** 1) Lack of competent staffing in the field, 2) Lack of Transportation, 3) Lack of technology based solutions and the laws preventing them, and 4) Shortage of Addictionologists and Psychiatrists.
>
> **Recovery:** 1) Shortage of Post-treatment support and 2) Conflict in prioritizing treatment, finding/retaining jobs and available clean living support system

Gaps in continuum of care: 1) Living arrangement and the need to support themselves rather than focusing on treatment during critical transition from residential to outpatient

Barriers to integration: 1) Transportation, 2) Availability of PCP Appointments, 3) Lack of annual physical exam to identify key physical health issues for early prevention, and 4) No Continuity of Care Document for all providers in the Patient's Care Team

Opportunities: 1) Remove barriers to using technology based solutions to support new developing trends, 2) Shift medical necessity determination to providers as opposed to Managed Care Organizations, 3) Remove prior authorization and re-authorization requirements, 4) Allow for APNs to perform more functions due to shortage of Psychiatrists, and 5) Provide viable living arrangement that allow patients to prioritize treatment

SUPPORTIVE SERVICES

What are the essential supportive services and what is their capacity in Illinois for those with SUD? *(E.g. housing, mental health services, family supports, life skills, job training, education, recovery support)*

Essential supportive services: 1) Clean living environment, 2) Life skills and job training, 3) Education, 4) Availability of recovery coaches 24/7, 5) Legal services, and 6) co-occurring disorder services

Working Well: Funding support provided by SUPR, IL for case management and community intervention services (not utilizing Medicaid Dollars)
Barriers/Challenges: 1) Homelessness, 2) Lack of available housing, 3) Difficulty to prioritize treatment over affordable housing and acquiring basic amenities when discharged from intensive Residential services or while in Intensive Outpatient services, 4) Medicaid not supporting case management and intervention services, and 5) Lack of trained/certified peer support specialists and recovery coaches

Actions to Foster access to supportive services: 1) Carve out dollars for supportive services or provide additional grant options to State; 2) Create agreements at State/Federal department levels to provide a one-stop access for patients. A patient who had a series of admission to hospitals, intensive residential and intensive outpatient care will find it hard, even with the support of case managers/recovery coaches, to navigate through the system to find affordable housing, applying for Medicaid, retaining Medicaid, obtaining job skills, finding jobs, working through the legal system, obtaining stable housing, obtaining funding for basic amenities because all these require involvement with various departments of the government. In addition, the patient (and the provider) needs approval from various managed care entities and departments for the holistic service model where primary care services, Mental Health services, substance use services, dental services and other physical services are governed by different rules and different points of contact. There are further complications if the patient is a youth as it involves further scrutiny of insurance availability through parents/guardians.

HARM REDUCTION & HEALTH PROMOTION

Role of harm reduction and health promotion: SUD providers currently are not in a position to play a key role in harm reduction and health promotion as the responsibilities are widely distributed. There is a lack of coherent relationships among various key stakeholders. SUD providers by far have the most relationship with patients identified with SUD. The key is to bring all the key stakeholders together and utilize the power of knowledge and patient relationship developed by SUD providers to play a major role in coordinating with various stakeholders.
Support overdose prevention and harm reduction: It will be helpful to offer funding and training for SUD community providers so they are integral part of education, intervention and service delivery to prevent overdose and in harm reduction. In addition, SUD community providers need to be properly included in the structure as to the prevention of overdose and harm reduction to utilize the personal relationships created by case managers/recovery coaches of community providers.
Early Intervention: 1) Education, training and prevention needs to be the priority; 2) Public Health departments of each county should be properly funded to govern a model wherein all SUD community providers, first responders, public safety officers, school personnel are educated and trained to function and coordinate appropriately during emergency situations and also on educating the community. SUD community providers can play a major role in education and intervention as many providers have the in-built structure to promote awareness for various SUD related issues; 3) Mobile Crisis can play a key role in harm reduction. However, this is very hard to setup and the funding is not easy to come by. Speaking for the areas The Council operates (South Suburbs of Cook County), there isn't a Mobile Crisis team, although The Council will be very interested in developing and maintaining one, if a startup funding is offered.

PAYMENT ISSUES

Treatment affected by current reimbursement model: 1) Only Methadone is considered for MAT payments via SUD funds and all other MAT billing has to be billed to Primary Care Contracts, which is not available or affordable to be created for SUD community providers, 2) Prior authorization requirements, re-authorization requirements, 3) Dispute with discharge dates due to placement issues, 4) Need to receive authorization from multiple entities for one episode of care, 5) Uncovered services, 6) Conflict in establishing Medical Necessity, 7) Conflict with second opinions on medical necessity establishment, 8) Different rules and procedures among Managed Care Organizations, and 9) No recovery support payment post discharge

Alternative payment models: Two models The Council would propose are Case Rate model and Patient-centered payment model, which allows the treatment provider to customize the services offered for a specific patient, as opposed to being dictated by a payer (one rate for all patients within the same level of care). Within the levels of care defined by [American Society of Addiction Medicine], a particular patient's needs are different depending on where the patient is at in the Stage of Change, ancillary service needs (e.g. domestic violence, mild or moderate risk mental health needs, high risk mental health needs). For Residential providers, a daily rate for a particular level of care forces the providers to offer similar kinds of services to all of its patients in the same level of care, even though the services are supposed to be driven by Individualized Treatment Plan. While Value Based Payment model addresses the outcome aspect of the treatment, it does not address what happens to the client during each level of care and the SUD providers have less control over the primary care treatment of the patient. A combination of overall umbrella VBP along with Case Rate of payment at individual stage of care could be an optimal model. This would also allow a patient to participate in how the allocated money is spent on his or her treatment. The proposed Integrated Health Home model in Illinois addresses the care coordination spectrum across holistic care for SUD patients, but fails to address the building blocks of that holistic care at the treatment provider level for Residential, Outpatient and Recovery Support services. Please refer to this link and contact me if you have questions.
(https://www.openminds.com/market-intelligence/executive-briefings/options-alternative-payment-models-behavioral-health/)

SPECIAL POPULATIONS

Concerns about special population: 1) Special populations are generally forced to a similar set of services as general population because the payment structures established are at a level of care such as [American Society of Addiction Medicine] levels 3.5, 3.2. It utilizes economies of scale to establish a treatment model and is controlled by how many days a patient is staying in treatment, how many groups a patient is attending or how many individual sessions a patient is receiving. It fails to recognize that it is not the number of sessions or days that impact the quality of the treatment. However, how the needs of a patient are identified and how a program can have staff with vastly different specializations to support the various needs of the patient, identified through assessment. E.g. [American Society of Addiction Medicine] Level 3.5 has further classifications for co-occurring complex, enhanced and enabled. It further classifies during the individualized treatment plan process to identify the various needs of the patient. Yet, the payment structure is established at 3.5 level and the providers are expected to use economies of scale in staffing to address all the needs of the patient using various components of level 3.5; 2) Youth programs are costly due to various special needs of the youth. The services are distributed as schools are meant to handle the majority of the load. Yet, schools are not properly funded to offer these services. There is a lack of coordination

between schools and treatment providers due to various barriers in funding and lack of guidance from policy makers as to how to utilize the vast knowledge of community based providers and the inherent relationship the school counselors have with the students. 3) There is a lack of services offered to women with children. The services are costly, yet the available rates and service models are geared towards a universal service model offered to all types of patients.

POLICY & SOCIAL BARRIERS

Current policies that could affect services offered to minorities: In Fiscal Year 2019, of all the patients seen by The Council, over 65% of the patients provided their race information that are classified as minority. The primary, secondary or tertiary drug usage information provided indicated that nearly 30% of the total patients seen by The Council have used a drug that is considered opioid and that percentage has been consistent over the last three years. The Council advocates for new funding made available for opioid use disorders as there is a clear need. However, the majority of substance use disorders are related to non-opioid substances, and the funding of treatment for opioids should not be done at the cost of reduced funding for substance use disorder treatment overall. The Council advocates for new overall funding of substance use disorder treatment in addition to the necessary focus on additional funding to address the opioid crisis.

Proposals for Medicaid to consider at Federal level: 1) Under current policy, non-Methadone drugs offered under Medication Addiction Treatment (MAT) are not allowed under SUD budget and the providers have to bill Primary Care budget line for non-Methadone MAT services, which is almost always never billed due to complexity and the nature of operations of many SUD providers; 2) Parity in Psychiatric payment rates for SUD providers; 3) SUD is often included in the conversation of Behavioral Health. Yet, many of the policies are geared towards organizations that operate primarily for Mental Health disorders. E.g. CCBHC; 4) A treatment provider cannot offer case management for patients post discharge unless the treatment provider places the patient in their own recovery home or halfway house, which is not funded by Medicaid. This creates a void for SUD patients who do not have stable housing post discharge from outpatient counseling who need sustained recovery support.

TASC | Administrative Offices • 700 S. Clinton St. • Chicago, IL 60607
312.787.0208 • 312.787.9663 fax • www.tasc.org

June 29, 2020

Christie Edwards
Cook County Health
Submitted via: credwards@cookcountyhhs.org

RE: Improvements in substance use disorder (SUD) care for Medicaid beneficiaries

Dear Ms. Edwards:

We appreciate the opportunity to provide input on improvements in substance use disorder (SUD) care for people enrolled in Medicaid. While local, state, and federal efforts to tackle the opioid crisis in recent years have made progress in supporting recovery, reducing harm, and reducing overdoses, overdoses and racial disparities in overdoses are surging in Illinois. COVID-19 has dramatically increased the need for services and required sudden and massive transformations in care delivery. The statewide SUD needs assessment funded through Illinois' SUPPORT Act grant comes at an absolutely critical moment, providing a timely opportunity to make life-saving improvements to the State's continuum of SUD and harm reduction care.

TASC connects people involved in the criminal legal system to substance use treatment and services in the community. Through our statewide alternative-to-prison services, our work with people involved with courts and probation departments across the state, and our services that support community reentry following release from incarceration, TASC provides combinations of clinical assessment, linkage to appropriate community-based substance use treatment services, and specialized case management. We help people with involvement in the system—a burden disproportionately borne by Black Illinoisans, families, and communities—get the care they need, succeed in achieving their goals, and prevent future involvement in these systems.

We offer the following recommendations for improvements in SUD care and harm reduction services for Medicaid beneficiaries involved in or at risk for involvement in Illinois criminal legal systems:

1) **Establish SUD case management as a reimbursable benefit under the State Plan.** Individuals with SUD who are involved in the criminal legal system often need specialized case management to help achieve stability, maintain treatment engagement, and remain in compliance with system-imposed conditions. These services are distinct from those offered by an SUD treatment provider to manage their own clients' cases; instead, they address the broad spectrum of needs that may be felt by an individual receiving SUD services, such as medical and/or mental health care, application for and receipt of health, food, and childcare benefits, as well as assistance with housing, transportation, and employment. Currently, the SUD case management benefit is temporarily reimbursable for criminal justice clients under the Illinois Behavioral Health Transformation 1115 waiver, but it should be made permanent. Moving forward, both the specialized case management such as that offered by TASC, as well as the traditional treatment-based case management, should be covered for those with and without justice system referrals.

2) **Support deflection and diversion programs that expand access to SUD treatment and services and minimize justice system involvement.** State law authorizes an array of law enforcement deflection options, as well as pre-trial diversion programs and sentencing options, all of which are supplemented by discretionary programs developed and implemented by law enforcement, prosecutors, and judges across the State. However, use of these options are far from maximized. Investments should focus on supporting outreach, education, training, and

technical assistance to community organizations, SUD service providers, and system stakeholders (police, prosecutors, public defenders, judges) on the many mutual benefits of such approaches, program models, adjudication and sentencing options, best practices, and resources.

3) **Decriminalize or reduce offense classification and penalties for drug possession and purchasing-related offenses.** The criminalization of SUD symptoms and the people exhibiting them contributes to preventable arrests, criminal records, jail and prison incarceration, and life-long collateral consequences that impede the pursuit of health, wellness, and stability for individuals, families, and communities. Reducing offense classification and penalties for drug possession and low-level purchasing offenses—or decriminalizing them altogether—would allow a shift away from criminalization toward a public health-oriented approach that is better able to meet the wide-ranging needs of people involved in the system and decrease their contact with it.

4) **Increase access to SUD medications in jails and prisons.** Individuals with SUDs who are incarcerated may need SUD medications or withdrawal management (when indicated or desired) very quickly after intake and ongoing, and there can be grave health outcomes when these are not made available. Forced withdrawal and denial of SUD medications may contribute to overdose deaths upon release. Due to a variety of persistent barriers, few institutions offer these SUD medications despite a solid base of evidence in support of them, recent legal rulings requiring access to them, and guidance, standards, and recommendations of a multiplicity of authoritative entities recognizing their value and/or endorsing their voluntary use, including the World Health Organization; the National Governor's Association; the National Sheriff's Association; the National Commission on Correctional Health Care; the National Academy of Sciences, Engineering, and Medicine; the U.S. Substance Abuse and Mental Health Services Administration; and the American Society of Addiction Medicine, to name a few. Some institutions offer limited access to these medications, and some are interested in instituting or increasing access. The State should promote education and technical assistance to sheriffs and jail administrators, as well as to partnering community-based treatment and service providers, and invest in development and implementation support for strategies to cease the denial of life-saving SUD medications and treatments to individuals in jail and prison.

5) **Maintain and build on the COVID-19 policies that expanded coverage for service delivery via telehealth.** Illinois' COVID-19 Executive Order 7 on telehealth defines telehealth services to include substance use disorder treatment and related services, and permits telehealth services to be provided without regard to a client's location. It allows telehealth services to be delivered via popular electronic platforms, in alignment with federal guidance temporarily waiving enforcement for use of non-HIPAA-compliant telehealth technologies. The EO also requires commercial health plans to cover telehealth services and services provided by non-authorized providers. It prohibits prior authorizations, utilization review, and special treatment limits on services provided via telehealth. In the Medicaid system, patients are allowed to participate in reimbursable telehealth services from home, and parity in reimbursement rates is required. In the DHS/SUPR system, blanket exceptions were made for licensed/funded SUPR SUD treatment and intervention services. Restrictions related to recommended hours of service per level of care were lifted; coverage was authorized for all clinical services; the origination requirement mandating that a session originate in a prearranged secured location was lifted; use of home computers, mobile devices, or land line phones was allowed; assessments for placement into treatment services via telehealth means were allowed; and treatment plan development and continued stay review timeframe requirements were lifted.

State laws, rules, and contracts supporting the delivery of SUD and other services via telehealth should be modernized to carry forward and build on the changes that have proven feasible and essential during the pandemic. Telehealth should be considered as a means of service delivery rather than a service unto itself, and specific credentials required for delivery of services via

telehealth should be eliminated. It should not be required for clients who don't want it nor denied until in-person services are tried first. Case management for SUD should be included as an expressly authorized service to be delivered via telehealth. Clinical necessity may be a more appropriate standard of care instead of medical necessity, which is not the appropriate standard for all behavioral health services. Infrastructure investments should be made to support delivery and receipt of SUD services via telehealth. Client needs and challenges should be addressed through meaningful access to sufficient data, via free Wi-Fi or otherwise, and devices that can be used for telehealth from locations that are convenient for clients.

6) **Ensure Medicaid coverage upon release from incarceration in prison.** Coverage to support reentry case management and treatment services during the days and weeks immediately following release is critical to ensure life-saving SUD care throughout this vulnerable time, when the risk of overdose death is tremendously increased.

   a. *Encourage federal coverage of eligible incarcerated individuals 30 days prior to their release.* While Illinois' application for this coverage in the current 1115 waiver (Illinois Behavior Health Transformation) was denied, the State should support federal legislation that would permit federal matching Medicaid dollars spent on services delivered to eligible individuals during the 30 days prior to their release.

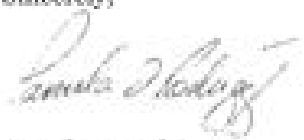
   b. *Implement current law requiring IDOC to provide insurance application assistance prior to release.* Existing State law requires IDOC to offer insurance enrollment assistance to individuals in Illinois prisons prior to their release, but it has not yet been broadly implemented.

7) **Provide naloxone and training to people being released from prison and jail, and to their families and friends.** Because the risk of overdose death during the days and weeks immediately following release from jail or prison is tremendously increased, all individuals with OUD leaving Illinois' jails and prisons, and their friends and family, should be supplied with naloxone at no cost, and education and training on its use should be offered.

8) **Eliminate co-pays for SUD medications—including the opioid reversal medication naloxone.** While co-pays are relatively modest in the Medicaid system, they remain a barrier to accessing SUD medications for our clients. As Illinois communities continue to observe a surge in opioid overdoses, it is especially crucial for naloxone in any of its forms (injection, nasal spray) to be freely available, at any pharmacy, and with no co-pay.

Thank you for your consideration. Please feel free to contact me at (312) 573-8372 or prodriguez@tasc.org.

Sincerely,



Pamela F. Rodriguez
President & CEO

THRESHOLDS

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June 29, 2020

Comments: Improving Substance Use Disorder Care in Illinois Medicaid

Thresholds is encouraged by the Department's request for input on ways to strengthen the state's substance use disorder treatment system. As a provider of care to people living with serious mental illnesses and substance use disorders for over 60 years, we hope you will take our recommendations outlined below into consideration.

As the opioid epidemic continues to rage, Illinois must adopt treatment and support approaches that ***embrace the concepts that recovery and treatment begin before a person is ready for an abstinence-only approach, and that services can and should be provided in the community, rather than being solely facility-based.*** While the models of residential and clinic-based outpatient treatment make sense for individuals ready for those levels of engagement, facility-based approaches leave out an enormous swath of people struggling through addiction, many of whom are living in poverty and/or homelessness, and are people of color.

It is also important to highlight that care coordination, which will be delivered through Integrated Health Homes and will be community-based, is not the same as substance use treatment and care delivered out in the community. Both are extremely important to reaching individuals most impacted by the social determinants of health, and both are necessary and compliment each other.

The current treatment system is not designed to reach out to individuals who are harder to support because of their existing drug/alcohol use, support them in ways that meet them where they are in their process of recovery nor facilitate the development of a trusted, therapeutic relationship prior to abstinence and more intensive in-clinic treatment.

In Chicago, the communities most affected by opioid overdoses are Austin, West Garfield Park and Humboldt Park, which are largely African American and Latino communities with high poverty rates.[1] ***Black Chicagoans are continuing to die from overdoses at nearly twice the rate of white Chicagoans.***[2] However, there is a major lack of treatment and support services that enable recovery in these communities, particularly services that:

- Support safe use,
- Enable community-based engagement and treatment prior to abstinence, and
- Build on-ramps into more traditional forms of clinic-based care when people are ready.

Our existing approaches and level of investment simply do not come close to addressing the drug epidemic in poor communities of color and do not take into account the often chaotic lives of people living in poverty with an addiction. ***Illinois must be innovative in its approaches to addressing the opioid epidemic if the state is to stem the death rate, particularly in Black communities being ravaged by overdose-related deaths.***

II. Illinois Should Develop Overdose Prevention Sites to Save Lives.

A comprehensive overdose prevention effort must be funded to address the catastrophic death rates of opioid overdose in Illinois. ***The literature demonstrates that Overdose Prevention Sites (OPSs) can save lives and help people take steps to make positive changes.***

Overdose Prevent Sites should include the following to protect the lives of people continuing to use, and to offer a pathway into recovery support services when the person is ready:

- ***Testing of drugs*** to ensure the person knows the content and potency of what they are intending to use before they use, and to prevent the use of deadly, tainted supply.
- ***Presence of compassionate staff*** standing ready to help with safe use and to administer naloxone to reverse an opioid overdose.
- ***Trauma-informed, safe space***, where people who use can access safe, hygienic supplies, and be offered engagement and practical assistance by trained clinicians and people with lived experience who will provide them a full array of resources and hopeful connection.

OPSs need to be part of the full continuum of care, and provide a pathway to building what we know to be foundationally necessary for initiating and sustaining recovery from addiction: increased access to healthcare, affordable housing, purposeful pursuits such as employment, and increased contact with people who support recovery and positive change.

III. Street Outreach to Engage Individuals Struggling with Homelessness and Addiction Must be Included in the Continuum of Substance Use Disorder Care.

Nearly three-quarters (73.5 percent) of Chicago's unsheltered population is Black and African American, many of whom struggle with addiction.[3] ***Street and mobile outreach is crucial for engaging this population*** with severe substance use disorders who are living on the streets and unable to navigate the complexities inherent in our system of care.

The Medicaid fee-for-service model disincentivizes caring for this homeless population because they often don't have the resources for securing state identification, housing, employment/income, Medicaid, and comprehensive health care. This makes care delivery within the traditional fee-for-service model extremely difficult.

The Department must think beyond care coordination for this population and incorporate outreach and engagement into substance use disorder care models themselves. Keeping a person engaged in substance use treatment and supporting them through recovery who is living on the streets is far more than care coordination.

IV. The Administrative Rules for Medication Assisted Treatment using Suboxone, Which Does Not Need to be Stored and Dispensed Onsite, Should Be Decoupled from Methadone, Which Does Require Onsite Storage and Dispensing.

Most substance use treatment providers on the West Side of Chicago, which is ground zero for overdose deaths in Illinois, do not provide immediate Medication Assisted Treatment (MAT) using Suboxone because the administrative rules for Suboxone MAT are

bundled with Methadone MAT, which is administered very differently, and because it is not financially feasible.

Under current administrative rules, Suboxone-only MAT providers must have protocols and operations in place for storing, prescribing, and dispensing Methadone. A person only needs a prescription for Suboxone from a licensed prescriber. Suboxone does not need to be stored or dispensed onsite, whereas Methadone does. ***For these reasons, it is unnecessarily costly for Suboxone-only MAT providers to provide this treatment. The administrative rules for Suboxone MAT should be decoupled from Methadone MAT to enable providers to prescribe Suboxone as an essential Opioid Use Disorder treatment.***

This could save thousands of lives, particularly in Black and Brown communities that have been hit the hardest by the opioid epidemic.

V. Reimburse Suboxone MAT at an Episode Rate to Incentivize Providers to Deliver to this Treatment, and Expanding Access to MAT.

Non-FQHC licensed substance use treatment facilities must be financially incentivized by the Department to provide MAT.

Suboxone MAT reimbursement does not cover the cost of the physician, causing providers to lose money to deliver this treatment. For example, a physician who is not a psychiatrist and not working for a OUD program, has to prescribe Suboxone at the medication monitoring rate – $65/hour. This is the same rate billed for individual counseling by a CADC, which requires only a GED or high school diploma, some college level course, and a 6-month internship. ***The $65 hourly rate is simply financially insufficient for employing physicians or APNs, and greatly contributes to people from marginalized communities, specifically communities of color, having limited access to this essential treatment for Opioid Use Disorders. This is why many providers don't offer this treatment, and why access is therefore limited.***

To enable providers to cover the cost of physicians and APNs delivering Suboxone MAT, ***we strongly urge the Department to allow an episode rate for all Suboxone MAT at least equal to the episode rate paid to Federal Qualified Health Centers for this service.***

Thank you again for the opportunity to provide input as the Department considers how to strengthen substance use disorder care in Illinois.

Sincerely,

Heather O'Donnell
Senior Vice President, Public Policy & Advocacy

[1] Chicago Department of Public Health, Healthy Chicago, *2018 Chicago Opioid Overdose Data Brief*, December 2019.
[2] Chicago Department of Public Health, Healthy Chicago, *2018 Chicago Opioid Overdose Data Brief*, December 2019.
[3] City of Chicago, *2018 Homeless Point-In-Time County & Survey Report*.

Union Health

Jim Turner, DO [mailto:JTURNER@uhhg.org]

Subject: Re: Community Forums on Medicaid and Substance Use Disorder in southern Illinois have been cancelled - Please submit written feedback by Monday, April 6th.

Busy Times. My main recommendation would be incorporate a robust Addiction Medicine curriculum into nursing, PA, and NP school as well state wide Family Medicine Residencies. All eligible should complete certification to Rx suboxone upon graduation. It would be their decision if they want to incorporate into their practice. Studies are clear that Addiction Disease is the most expensive disease in the US, will see it daily in one way or another. Education is the key.

Best. Dr Jim Turner

Anonymous Citizen

03.9.2020 **Memo**

Comments:

I have been a visitor to a few local SUD centers many, many times. And I am deeply discouraged by the lack of support/requirement for the patients to get outside on beautiful days and get some fresh air and sunshine and Vitamin D!! I'm certain there are a few exceptions, but many of the facilities have outside garden areas that simply aren't utilized on a daily basis. This seems to be to be a basic health need that is not being met by doctors and nursing staff. This is not only becoming a barrier to SUD recovery, but numerous studies show that sunshine also combats depression, anxiety and numerous accompanying illnesses to SUD.

As a tax-paying truly concerned citizen I would like to see this change made please.

Thank you.