PRISM Virtual Learning Session #2: Maternal Mental Health Systems Change & IMD Exclusion Waivers

Tuesday, September 17, 2019
PRISM Learning Community: Cohort 1

CNMI

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CNMI
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<tr>
<th>Time</th>
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| 2:00pm| **Welcome and Introductions**                                                               | • Welcome remarks  
• Review session objectives and agenda                                                            |
| 2:05pm| **Maternal Mental Health Systems Change**                                                   | • Joy Burkhard, MBA, Founder and Executive Director, 2020 Mom                                     |
| 2:20pm| **Overview of IMD Exclusions Waiver**                                                       | • Deb Fournier, Senior Director of Clinical to Community Connections, ASTHO                      |
| 2:35pm| **Optimizing Access to Care for Pregnant and Parenting Women with Substance Use Disorders** | • Ashley Harrell, LCSW, Senior Program Advisor, Division of Behavioral Health, Virginia Department of Medical Assistance Services |
| 2:50pm| **Q & A**                                                                                     |                                                                                                |
| 3:00pm| **Closing Remarks & Adjourn**                                                               |                                                                                                |
Objectives

• Describe how maternal mental health and substance use disorder (MH/SUD) systems changes can lead to increases in diagnosis and treatment rates.

• Identify ways to utilize the lifting of the Medicaid Institutions for Mental Disease (IMD) exclusion to improve treatment of mental health and substance use disorders.

• Delineate the process by which Virginia leveraged a Medicaid waiver to improve access to care and treatment for mental health and substance use disorders.
Please note:

The content, findings, and conclusions shared in this presentation are those of the speakers and do not necessarily reflect the official positions of or endorsements by ASTHO, AMCHP, or the PRISM project funder (HRSA).
Joy Burkhard, MBA

- Founder and Executive Director, 2020 Mom
- Regulatory Affairs Manager, Cigna
Who is 2020 Mom?

Formed in 2011 at the suggestion of the California legislature in 2010 as CMMHC
Now as 2020 Mom Working Nationally and Supporting State Policy Change

Mission:
To close gaps in Maternal Mental Health Care.
We believe if families, employers and society are paying for health care benefits, the health care system should detect and treat MMH disorders.
Women in their childbearing years account for the largest group of Americans with Depression.

Postpartum depression is the most common complication of childbirth.

There are more new cases of mothers suffering from Maternal Depression each year than women diagnosed with breast cancer.

New onset of maternal depression occurs almost as frequently in pregnancy as in the postpartum period.

American Academy of Pediatrics has noted that Maternal Depression is the most under diagnosed obstetric complication in America.

Despite the Prevalence Maternal Depression goes largely undiagnosed and untreated.
American Academy of Pediatrics (AAP)
- Recommends screening in Bright Futures and Mental Health Task Force (2010)

American College of Obstetrics and Gynecology (ACOG)
- Recommends screening at least once for depression & anxiety 2017
- Redesigning Postpartum Care (‘4th Trimester’) 2019

US Preventive Services Task Force
- Included Pregnant/postpartum women in recommendation to screen (2009) 2017
- Recommends Screening and Treatment for Prevention of Maternal Depression 2018

Agency for Health Research & Quality
Reported in 2019 only 35% of adults were screened for depression (2015 data).
Federal Legislation & Funding

-Bringing Postpartum Depression Out of the Shadows Act (HR 3235/S 2311) “The MMH Act”
Funded grants to states for innovative solutions, like psychiatry access
Passed in Nov. 2017 as part of
H.R. 34, the 21st Century Cures Act

HRSA Awarded Grants to 7 States
FL, KS, LA, MT, NC, RI, VT
AZ, CA, FL, IL, PA, UT
Legislation in 2018

MA, MD, CA
Ran state commissions in 2016/2018

CO, ME, MN, NJ, NY, OR, TX*, VA, WA, WV
Has addressed MMH screening/awareness in the past

IL, TX
Infanticide law: passed in IL, attempted in TX

NY City
A jurisdiction that has addressed screening/awareness MMH in 2016/2017

CA, IL, MI, MN, TX, UT, VA
State declarations of May as Maternal Mental Health Month

*Reimbursement to pediatricians for children w/ Medicaid or CHIP
States that passed Legislation in 2018

UT and MI
Duplicating Prior state Awareness Resolutions

MD SB 600/ HB 775
Requires Department of Health to Develop Continuing Ed for Providers, Expand the state’s Pediatric Consultation Psychiatric Line to include MMH, Create materials and list information on the website.

FL Families First Act of 2018 (SB 138/ HR 937)
Requires Department of Health to provide awareness materials on its toll-free family line, website, and through providers. Requires birth hospitals to screen.

CA AB 3032 Hospital MMH, AB 2193 OB Screening & Insurer Support
Requires Hospitals to train staff & educate patients // Requires providers screen & Insurers Support
States that successfully addressed policy in 2019

**UT**

Increased Funding for Early Childhood to Address MMH

**VA HR 2613**

Adds education about maternal anxiety to the list of topics hospitals and midwives must address with patients

**Pending: CA AB 845**

Encourages the state medical board to create training for MDs

**To be reintroduced in CA in 2020: AB 2193**

Telepsychiatry Consultation for Moms & Children for Obs/PCPs/Pediatricians

**Continued legislative attempts in PA.**
Health care insurance policies must provide for screening, referral and treatment performed by an obstetrician, gynecologist, or pediatrician. Consistent with the ACA, Screening must be billed at no cost share to the patient (as preventive care).

If the billed by the pediatrician, under a separate policy that the infant is covered under, insurer can “coordinate benefits.” It is not the intent that services be billed/provided under both the Ob/Mom’s policy AND the Pediatrician/Baby’s policy.
How?
Task Force, Blue Ribbon Commission or Legislative, Commission

Task Force or Blue Ribbon Commission:
Statewide, Standing or Temporary Group of Multiple Stakeholders

Goal: Issue a White Paper and/or State Strategic Plan
Emphasis Stakeholder Buy-in + on Root Cause Identification

Root Causes
are underlying factors
that create problems
and allow these
problems to persist often
after attempts to
address the challenge.
States that ran Task Forces or Commissions in 2016/2017
CA Task Force: ACR to call for formation of a multi-stakeholder body to study & recommend
California’s Recommended Endgame

100% Screening by 2025
80% by 2021

Emphasizes and Measures via Ob/Gyns, but Recommends a “No Wrong Door” policy
California’s Work Products

Provider Core Competencies
*Identifies the skills and knowledge various providers should have who interact with women in the perinatal period*

A Continuum of Care
*Summarizes the 4 critical timeframes for providers to address MMH disorders*

Screening: Score “Cut Offs” and Timing Recommendations
*Developed by PSI at the urging of the task force to identify score cut-off for PHQ-9 and EPDS & Timing of Screens by PCP, Ob/Gyn and Pediatrician*

A “Menu” of Treatment Options
*Adapted from the MCPAP for Moms Toolkit to Include Full Range of Tx Options by Severity*

Detailed Recommendations for All Stakeholders
*Everyone can and must do something*
Other States Leading Change w/o Leg.

Iowa:
Listening Visits in Home Visiting Settings
https://idph.iowa.gov/family-health/maternal-health

Colorado:
Public Awareness Campaign
https://www.colorado.gov/pacific/cdphe/prd-public-awareness-campaign
Public-Private Partnerships
http://coloradomaternalmentalhealth.org/

Others?
Resources from 2020 Mom

- CA Task Force White Paper on Maternal Mental Health
- Community ACTION Toolkit for MCH Coalitions
- E-news
- Blog Posts
Thank you!
1. Home Base for MMH, Referral Pathways, Capacity & Support

(Recommendations 1-5)

- Ob/Gyns to Serve as Home Base
- Provider “No Wrong Door” for Screening
- Boards to Credential/Test Therapists & Repro-Psychiatrists
- Provider-to-Provider Consult (MCPAP for Moms like strategy)
- Insurers to Develop Case Management Programs
2: Need to Integrate MH-Medical Systems  
(Recommendation 6)

- Integrated BH-Medical Insurance (companies: policies/networks)

3: Need for Measurement of Screening Rates  
(Recommendation 7)

- NCQA HEDIS measure via insurers (OB medical records)  
  Starting with “Process” Measure (screening)  
  - Later possibly with “Outcomes” Measure (improved screening score)
4: All Women Need More MMH Education & Support
(Recommendations 8-11)

- Community based solutions & resources via Community Coalitions
  - Low Income with basic needs
- Churches and Community orgs to recognize programs and refer
- All women with family-friendly policies
- Public Awareness Campaign
5: Detailed Recommendations for All Stakeholders, ex:
(Recommendation 12)

- Trade Association/Board Testing
- Hospitals: Tx Programs, Mindful of PTSD, 2020 Mom Recs
- Insurers & Regulators: Designations for specialists + Network
- State Agencies:
  ex: DHCS Memo on Screening

Specified Deliverable Dates & Implementation to be Overseen by a “Steering Committee”
Deborah H. Fournier, JD

• Senior Director, Clinical to Community Connections, ASTHO
Medicaid’s IMD Exclusion

Deborah H. Fournier, JD

PRISM Learning Community
September 17, 2019
A 54 year-old, jointly-funded (federal and state) health insurance program

For low-income people in these GENERAL CATEGORIES >>

Usually in the top three state budget line items
Figure 4

Medicaid plays a key role for selected populations.

Percent with Medicaid Coverage

- **Families**
  - Nonelderly Below 100% FPL: 55%
  - Nonelderly Between 100% and 199% FPL: 40%
  - All Children: 38%
  - Children Below 100% FPL: 76%
  - Parents: 17%
  - Births (Pregnant Women): 49%

- **Elderly and People with Disabilities**
  - Medicare Beneficiaries: 20%
  - Nonelderly Adults with a Disability: 45%
  - Nonelderly Adults with HIV in Regular Care: 42%
  - Nursing Home Residents: 62%

**NOTE:** FPL-- Federal Poverty Level. The U.S. Census Bureau’s poverty threshold for a family with two adults and one child was $19,318 in 2016.

WHAT IS AN IMD AND WHAT IS THE IMD EXCLUSION

IMD = Institution for Mental Diseases

• Federal law prohibits Medicaid from making payments to states “with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases”

• IMDS are defined in statute as any “hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.”
The First Bursts in the Dam: Medicaid Managed Care Rule & DSH Payments

- States can receive FFP for capitated payments made to health plans on behalf of enrollees who receive psychiatric or SUD inpatient or crisis residential services in an IMD for up to 15 days a month “in lieu of” those services covered under the Medicaid state benefit package.

- Disproportionate Share Hospital Payments (pronounced DISH). State Medicaid programs are required to make DSH payments to hospitals serving a high proportion of Medicaid beneficiaries and other low income patients. States can make DSH payments for uncompensated care costs at IMDS so long as payments do not exceed the amount of DSH funds paid to IMDs in FY 1995 or 33 percent of the State’s FY 1995 DSH allotment for all hospitals.
Regulatory Mechanisms: Waivers

States seek flexibility outside of federal regulations

- States seek to target specific services to particular groups.
- States test innovation to promote state policies.
Waivers

1115

• Allows state to use funds in ways not otherwise allowed to experiment, pilot or demonstration projects likely to assist in promoting the objectives of the Medicaid program.
CMS’ evolution on IMD in subregulatory guidance

• July 2015: Guidance issued confirming that CMS would allow federal Medicaid match for short-term inpatient treatment for individuals with SUD and that the stay would be limited to 15 days.

• These were contingent on the states covering community based services together with institutional services that supplement but not supplant community-based services.
CMS’ evolution on IMD in subregulatory guidance

• November 2017: Additional guidance released suggesting the time limit was more flexible and outlines the parameters for states to obtain a Section 1115 waiver to pay for short-term residential SUD treatment in IMDs, contingent on addressing certain criteria.

• This criteria is meant to encourage development of a comprehensive approach to treating SUDs. Among other things, criteria address coverage of certain outpatient and residential services, provider requirements, and evaluation and reporting milestones.

• In November 2018, more guidance was issued indicating that states would be allowed to obtain Section 1115 waivers of the federal IMD payment exclusion for services for individuals with serious mental health conditions.
IMD 1115 Waivers – As of August, 2019

24 states with approved waivers of IMD payment exclusion for SUD treatment:

AK, CA, IL, IN, KS, KY, LA, MD, MI, MN, NC, NE, NH, NJ, NM, PA, RI, UT, VA, VT, WA, WI, WV

• 5 states with 1115 applications for IMD payment approval pending:
  AZ, DC, DE, OH, TN,

• 1 state with approved 1115 for IMD payment exclusion for Mental Health treatment is VT; DC has a pending waiver
Support Act

Partially eliminates the IMD payment exclusion from FYs 2019–23. Specifically, states can cover, with Medicaid funds, IMD services to people with at least one substance use disorder for up to 30 days over a 12-month period (federal funding is not extended for treatment of mental illness).

The law provides states with this option only if they agree to offer the full continuum of care that someone with a substance use disorder might require, including outpatient services and support making the transition back into the community.

Section 1012 of the SUPPORT Act also created a limited exception to the IMD exclusion for certain women who are eligible for Medicaid on the basis of pregnancy. Specifically, it prohibits states from denying federal financial participation (FFP) for non-IMD services delivered to pregnant women (and up to 60 days postpartum) that are patients of an IMD for the treatment of a SUD. States are expected to be in compliance by October 1, 2020, relative to certain state legislative time frames.
Thank you!

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Ashley Harrell, LCSW

• Senior Program Advisor, Division of Developmental Disabilities and Behavioral Health, Virginia
Virginia Department of Medical Assistance Services
Addiction and Recovery Treatment Services (ARTS) Benefit

Optimizing Access to Care for Pregnant and Parenting Women with Substance Use Disorders

Ashley Harrell, LCSW
Senior Program Advisor
Virginia Department of Medical Assistance Services
## Addiction and Recovery Treatment Services (ARTS) Benefit

### Changes to DMAS’ Substance Use Disorder (SUD) Services for Medicaid and FAMIS Members approved by General Assembly in Spring 2016

1. Expand short-term SUD inpatient detox to all Medicaid /FAMIS members
2. Expand short-term SUD residential treatment to all Medicaid members
3. Increase reimbursement for existing Medicaid/FAMIS SUD treatment services
4. Add Peer Support services for individuals with SUD and/or mental health conditions
5. Require SUD Care Coordinators at DMAS contracted Managed Care Plans
6. Organize Provider Education, Training, and Recruitment Activities
SUD Services Transformation

1115 SUD Demonstration Waiver

• Allows Virginia to draw down federal matching funds for IMDs – SUD residential treatment facilities > 16 beds
• Resulted in significant increase in number and size of SUD residential treatment facilities
  ▪ Residential and inpatient SUD services are short-term – defined as statewide average of 30 days
• Requires Virginia to implement national American Society of Addiction Medicine (ASAM) to create evidence-based continuum of addiction treatment including robust community-based services
• Requires robust independent waiver evaluation – partnering with Virginia Commonwealth University
• Virginia has non-residential SUD services in the Medicaid State Plan
Note:
Within the five broad levels of care (0.5, 1, 2, 3, 4), decimal numbers are used to further express gradations of intensity of services. The decimals listed here represent benchmarks along a continuum, meaning patients can move up or down in terms of intensity without necessarily being placed in a new benchmark level of care.
Addiction and Recovery Treatment Services
Transforming the Delivery System of Medicaid SUD Services

Effective April 1, 2017 - All ARTS services are covered by managed care plans

ARTS offers a fully integrated physical and behavioral health continuum of care
### Critical Elements of Successful Transformation

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<tr>
<th>Category</th>
<th>Description</th>
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<tr>
<td>Political Will</td>
<td>• High-level support from Governor’s Executive Leadership Team on Opioids &amp; Addiction</td>
</tr>
<tr>
<td>Stakeholder Engagement</td>
<td>• MCOs, state agencies, and providers</td>
</tr>
<tr>
<td>Shared Agenda</td>
<td>• Clear goals around access, quality, utilization, and mortality</td>
</tr>
<tr>
<td>Data</td>
<td>• Independent evaluation and regular quality meetings</td>
</tr>
<tr>
<td>Medicaid Support</td>
<td>• Increased reimbursement and technical assistance on billing</td>
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</tbody>
</table>
Key Partnerships

- **Virginia Department of Health**
  - Trained over 850 providers in Addiction Disease Management
  - Project ECHO ARTS Preferred OBOT Learning Collaborative
  - Project ECHO buprenorphine waiver training

- **Department of Behavioral Health and Developmental Services**
  - Trained over 400 providers in ASAM criteria
  - Trained over 1,000 Peer Recovery Support Specialists

- **Department of Health Professions**
  - Boards of Medicine, Nursing, and Dentistry implemented opioid prescribing regulations based on CDC Opioid Prescribing Guideline

- **Department of Corrections**
  - Offering Project ECHO buprenorphine waiver training to DOC staff
  - Collaborating on MAT Summit for DOC clinicians and staff

- **Medicaid Managed Care Organizations**
  - Network capacity
  - Care Coordination
1st Quarter 2019 Fatal Drug Overdose Report

Evolving Strategy to Address the Addiction Epidemic

- Reduce Risk of Addiction and Overdose
- Reduce Stigma
- Increase Access to MAT
- Priority Populations
Priority Populations

- Pregnant Women
- Justice-Involved
- Acute Care
Ongoing Efforts to Achieve Goal

Medicaid’s Role in Improving Access to Care

- **Removal of PA for up to 24 mg/day of Suboxone film** for in-network buprenorphine waivered practitioners
- **Removal of the automatic lock-in** for members receiving a buprenorphine product
- Allow and encourage **same-day billing of medical and behavioral health services**
- **Require access to MAT** along the addiction continuum
- **Encourage MAT during and after release** from institutional settings including hospitals, EDs, jails, and inpatient rehabilitation
Ongoing Efforts to Achieve Goal

Medicaid’s Role in Improving Access to Care for Women

- DMAS supports integration of reproductive health services including contraception and pregnancy/postpartum support with addiction treatment.

- DMAS and the Medicaid MCOs cover all family planning services and devices including long acting reversible contraception (LARC) without a prior authorization.

- Medicaid MCOs have High-Risk Maternity Programs that support members with substance use or misuse.

- Medicaid Expansion: As of September 2019, automatic enrollment into Medicaid in the postpartum period when no longer eligible for Medicaid as a pregnant woman.
Ongoing Efforts to Achieve Goal

Best practice: Integration of reproductive health services including contraception with addiction treatment.

- DMAS supports **screening for more than pregnancy** with urine pregnancy test
  - Screen for Pregnancy Planning
- One Key Question:
  - *Would You Like to Become Pregnant in the Next Year?*
- Referral for family planning services
- **Integrated service delivery** with LARCs and other contraceptive methods
- Always be attentive to **patient autonomy and support individual reproductive rights**
<table>
<thead>
<tr>
<th>Code</th>
<th>Service</th>
<th>Who Can Bill?</th>
<th>Unit</th>
<th>Rate/Unit</th>
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</thead>
<tbody>
<tr>
<td>H0014</td>
<td>Medication Assisted Treatment (MAT) induction</td>
<td>Buprenorphine Waivered Practitioner</td>
<td>Per encounter</td>
<td>$140</td>
</tr>
<tr>
<td>H0004</td>
<td>Opioid Treatment – individual and family therapy</td>
<td>Credentialed Addiction Treatment Professional</td>
<td>1 unit = 15 min</td>
<td>$24</td>
</tr>
<tr>
<td>H0005</td>
<td>Opioid Treatment – group therapy</td>
<td>Credentialed Addiction Treatment Professional</td>
<td>1 unit = 15 min (per patient)</td>
<td>$7.25</td>
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<tr>
<td>G9012</td>
<td>Substance Use Care Coordination</td>
<td>Buprenorphine Waivered Practitioner or Credentialed Addiction Treatment Professional</td>
<td>1 unit = 1 month</td>
<td>$243</td>
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More Pregnant Women Received Treatment for all Substance Use Disorders and Opioid Use Disorders

<table>
<thead>
<tr>
<th></th>
<th>ARTS Phase 1 (Jan 2017-Jun 2017)</th>
<th>ARTS Phase 2 (Jan 2018-Jun 2018)</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members with SUD receiving treatment</td>
<td>3494 (34%)</td>
<td>4476 (39%)</td>
<td><strong>↑28%</strong></td>
</tr>
<tr>
<td>Members with OUD receiving treatment</td>
<td>6650 (59%)</td>
<td>8723 (76%)</td>
<td><strong>↑31%</strong></td>
</tr>
</tbody>
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Prevalence of SUD among Women with 6 Months of Continuous Full Medicaid Coverage Prior to Delivery

Statewide (2017-2018)
10% SUD
3% OUD
1% AUD
6% other SUD
SUD Treatment Rates among Women with 6 Months of Continuous Full Medicaid Coverage Prior to Delivery

Statewide (2017-2018)
- **36%** SUD
- **70%** OUD
- **30%** AUD
- **17%** other SUD
More time in Medicaid = more likely to be diagnosed and treated

Prevalence and treatment by length of time continuously enrolled in Medicaid

- SUD Dx
- SUD Tx
- OUD Dx
- OUD Tx

- <1 month
- 1-6 months
- 6-12 months
- 12+ months
Increases in Addiction Providers Due to ARTS

Over 445 new Addiction Treatment Provider Sites in Medicaid as of September 2019

<table>
<thead>
<tr>
<th>Addiction Provider Type</th>
<th># of Providers before ARTS</th>
<th># of Providers after ARTS</th>
<th>% Increase in Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Detox (ASAM 4.0)</td>
<td>Unknown</td>
<td>103</td>
<td>NEW</td>
</tr>
<tr>
<td>Residential Treatment (ASAM 3.1, 3.3, 3.5, 3.7)</td>
<td>4</td>
<td>88</td>
<td>↑ 2075%</td>
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<tr>
<td>Partial Hospitalization Program (ASAM 2.5)</td>
<td>0</td>
<td>22</td>
<td>NEW</td>
</tr>
<tr>
<td>Intensive Outpatient Program (ASAM 2.1)</td>
<td>49</td>
<td>137</td>
<td>↑180%</td>
</tr>
<tr>
<td>Opioid Treatment Program</td>
<td>6</td>
<td>38</td>
<td>↑533%</td>
</tr>
<tr>
<td>Preferred Office-Based Opioid Treatment Provider</td>
<td>0</td>
<td>121</td>
<td>NEW</td>
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</table>
ARTS Resources Available on the DMAS ARTS Website

Visit the DMAS ARTS website to locate providers with Google Maps: http://www.dmas.virginia.gov/#/arts

New! Indicator if ARTS providers treat pregnant women
DMAS ARTS website:
http://www.dmas.virginia.gov/#/arts

Please email questions regarding the ARTS program to sud@dmas.virginia.gov
REMINDER

Please send us your technical assistance requests!

ASTHO and AMCHP are happy to help answer questions, find resources, and facilitate connections.
Your Input Matters

• Please help ASTHO and AMCHP evaluate the PRISM Learning Community: Virtual Learning Session #2 by visiting http://bit.ly/prismvls2 on your device now.

• Thank you!