North Carolina
Substance Use Disorder Waiver

Agenda

- 1115 Waiver Overview
- Continuum of Care
- Placement Criteria
- Provider Qualifications
- Provider Access
- Controlled Substance Reporting System
- Opioid Prescribing
- STOP Act

1115 Substance Use Waiver

Initiative from the Centers for Medicare and Medicaid Services in November of 2017
Intended to combat the opioid crisis
Requirements:

- Full continuum of care
- Quality measurement
- Coordination across systems and levels of care
- Benefit management strategy

Other states approved:

- California
- Massachusetts
- Virginia
- Maryland
- West Virginia
- Utah
- Indiana

Levels of Care

- 0.5 – Early Intervention
- 1 – Outpatient Services
- 2.1 – Intensive Outpatient Services
- 2.5 – Partial Hospitalization Services
- 3.1 – Clinically Managed Low Intensity Residential Services
- 3.3 – Clinically Managed Population Specific High Intensity Residential Services

Levels of Care Continued

- 3.5 – Clinically Managed High-Intensity Residential Services
- 3.7 – Medically Monitored Intensive Inpatient Services
- 4 – Medically Managed Intensive Inpatient
- OTP – Opioid Treatment Program
- 1-WM – Ambulatory Withdrawal Management without Extended On-Site Monitoring
- 2-WM – Ambulatory Withdrawal Management with Extended On-Site Monitoring

Levels of Care Continued

- 3.2-WM – Clinically Managed Residential Withdrawal Treatment
- 3.7-WM – Medically Monitored Inpatient Withdrawal Management
- 4-WM – Medically Managed Intensive Inpatient Withdrawal Management

Evidence Based Patient Placement Criteria

- All providers of SUD services and all providers of CCA and DA would be required to document American Society of Addiction Management (ASAM) Criteria training.
- Medicaid or their vendors will monitor the PIHPs for compliance with use of ASAM Criteria.
- Medicaid will continue to support beneficiaries remaining connected to SUD treatment and supports.

Length of Stay

- Retention in treatment is the factor most consistently associated with positive client outcomes.
- The appropriate length of a treatment varies based on the needs of the individual.
- National Institute of Drug Addiction (NIDA) states:

  "Participation in residential or outpatient treatment for less than 90 days is of limited effectiveness and treatment lasting significantly longer is recommended for maintaining positive outcomes. For methadone maintenance, 12 months is considered a minimum, and some individuals with opioid use disorders continue to benefit from methadone maintenance for many years."

Provider Qualifications

- Revise and update ASAM Level 2.1 and 2.5 (.4400 and .4500 rules).
- Develop a new rule for ASAM Level 3.1 to replace the .5600E rule.
- Develop a new rule for ASAM Level 3.3.
- Develop a new rule for ASAM Level 3.5 for adults or adolescents in addition to .4100 for individuals with children.
- Revise the Therapeutic Community rule (10A NCAC 27G .4300) for ASAM Level 3.5.

Provider Qualifications Continued

- Revise the .3400 rule to be consistent with the expectations of ASAM Level 3.7. This will need to include adult and adolescent regulations.
- Revise .3600 rule for ASAM Opioid Treatment Program (OTP) Level of Care.
- Revise .3300 Outpatient Detox rule for ASAM Level 1-WM. Consider including 2-WM in this rule (Ambulatory withdrawal management with and without extended on-site monitoring).
- Revise .3200 Social Setting Detox rule for ASAM Level 3.2-WM.
- Revise .3100 Non-Hospital medical detox rule for ASAM Level 3.7-WM.
- Develop plan for DHSR MHLC to conduct annual surveys of all MH licensed ASAM level services.

Provider Access

Availability	Accessibility	Accommodation	Acceptability	Realized Access
Provider Capacity	Timely Access to care	Cultural competencies & Operating Hours	Customer Service	Appropriate Service Use
Number of providers accepting new Medicaid enrollees	Percentage of consumers living within 30 minutes/30 miles for urban and 45 minutes/45 miles for rural areas. Percentage of consumers able to be seen within maximum wait time for emergent, urgent and routine care.	Availability & delivery of services in a cultural competent manner regardless of cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity	Consumer Perception of Care Surveys Number of appeals, grievances and complaints.	Critical Performance Indicators: Follow-up After Care Readmissions Initiation & Engagement Physical Health Care Visits

Controlled Substance Reporting System (CSRS)

- DMH/DD/SAS is connecting to others states PDMP using PMPi.
- Working to develop an interface between the NC CSRS and the NC HIE.
- Currently providing advance reporting to the NC Medical Board and NC Board of Pharmacy for them to investigate patients prescribing behaviors in relation to specific identify thresholds.
- As part of the current development of the advance analytics DHHS is developing a sophisticated process to improve identity resolution for not only patients but also prescribers and dispenser data contained in the CSRS.

CSRS Continued

- DHHS is working to develop an integration of the NC CSRS query system into the prescribers' and dispensers' workflow. At the same time, DHHS is engaging major hospital systems in order to develop clear directives and processes that will allow prescribers to query the NC CSRS before prescribing opioids.

CSRS Continued

- DMH/DD/SAS is working to be able to provide visual analytics to support clinician review of the patients' history of controlled substance prescriptions.
- We began work to develop advance analytics utilizing not only PDMP data but other data sources available to the state.
- DMH/DD/SAS is actively starting the appropriate coordination in order to share data with Medicaid in order to minimize the risk of inappropriate opioid overprescribing and to ensure that Medicaid does not inappropriately pay for opioids.

Opioid Prescribing

- Updated Medicaid policy based on the CDC Guideline for Prescribing Opioids for Chronic Pain to reduce the oversupply of prescription opioids available for diversion and misuse.
  - These updates began on May 1, 2017, when the refill threshold for all opioids and benzodiazepines prescriptions was increased from 75% to 85%.
  - **Effective August 27, 2017, prior approval will be required for opioid analgesic doses for NC Medicaid and NC Health Choice (NCHC) beneficiaries which:**
    - Exceed 120 mg of morphine equivalents (MME) per day;
    - Are greater than a 14-day supply of any opioid; or
    - Are non-preferred opioid products on the NC Medicaid Preferred Drug List (PDL).
- The prescribing provider may submit prior authorization requests to NCTracks through the NCTracks portal or by fax.
  - New opioid analgesic prior authorization forms and revised clinical coverage criteria are available on the NCTracks Prior Approval Medications webpage.
  - **Beneficiaries with diagnosis of pain secondary to cancer will continue to be exempt from prior authorization requirements.**

STOP Act Provisions (Full name: Strengthen Opioid Misuse Prevention (STOP) Act of 2017) SL 2017-74:

- Reduce doctor shopping and improve care with required check of state prescription database.
- Reduce unused, misused, and diverted pills with 5-day limit on initial prescriptions for acute pain.
- Reduce fraud through e-prescribing.
- Reduce diversion of veterinary drugs.

STOP Act Continued

- Tighter supervision.
- Stronger oversight.
- Better data use.
- More secure funding.
- Universal registration and reporting.
- Near-time reporting to detect and stop doctor-shopping.
- Detect fraud, misuse and diversion. Better data.
- Improve health and save money by investing in local treatment and recovery services.
- Reverse overdoses and save lives.

Care Management

- Enrollees should be closely connected to providers with whom they have frequent interaction and trusting relationships, and care management services should be provided at these sites to the maximum extent possible.
- Care management services for these populations should be more intensive and should occur. Due to intensity of the service, low care manager to enrollee ratios are necessary.
- Care managers must have specialized expertise, including training in managing physical and BH, I/DD co-morbidities, and specialized clinical supervision to support the coordination of care between physical and BH or I/DD care.
- The model should provide:
  - Monitoring service utilization and response to treatment;
  - Providing care coordination across settings;
  - Educating individuals on how to self-manage their health conditions;
  - Providing and following up on referrals; and
  - Providing linkages to community resources