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Heartland Alliance Policy Recommendations to the Department of Healthcare and Family Services and the Medicaid Advisory Committee OUD Withdrawal Management Subcommittee

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Heartland Alliance is committed to advancing effective policy and practice reforms to improve the Illinois response to the opioid epidemic. We recognize the significant steps taken thus far by the state to reduce overdose deaths and promote recovery, but also appreciate the call for recommendations to further improve our treatment system. As a Federally Qualified Health Center, Substance Use Prevention and Recovery (SUPR)-licensed provider, and provider of harm reduction interventions, Heartland Alliance has a unique vantage point. We welcome the opportunity to comment and share our recommendations to address withdrawal management services in Illinois.

Traditional Withdrawal Management Is Often Ineffective, Expensive, and Dangerous

Medically and clinically-monitored withdrawal management services (ASAM Level 4.0 and 3.7) are well-established interventions for substance use disorder (SUD), including opioid use disorder (OUD). In the case of OUD withdrawal management, the traditional approach has been to use quickly tapering doses of methadone or other opioid agonist medication to reduce severe withdrawal symptoms while weening the individual off of opioids entirely. Once the individual has eliminated opioids entirely from their system, they could then move onto a lower level of care in the community or in an inpatient program. Unfortunately, this intervention is rarely clinically-indicated and can set the individual up for relapse and even fatal overdose.

The safer and more effective intervention is induction of agonist medication assisted treatment (MAT) such as methadone or buprenorphine with no intention of tapering for the foreseeable future. Withdrawal from opioids is not required to start such a treatment. Indeed, it can be a complicating factor. Full withdrawal from opioids through traditional withdrawal management is nonetheless common due to financial incentives and a system that was not built to support low-barrier and immediate MAT induction. Traditional withdrawal management does not have good outcomes, as evidenced by the Department's concerns about readmission and is costly based on the data shared with the OUD Withdrawal Management MAC Subcommittee. It can also be dangerous. An individual who receives withdrawal management services and is not provided with appropriate connections in the community or ongoing MAT is at a high risk for relapse and overdose. It is time for Illinois to redesign its OUD treatment system to avoid unnecessary withdrawal management interventions.

A Better Way: A Medication-First Approach to OUD Treatment

There is broad scientific consensus that agonist MAT is an effective intervention to prevent overdose and increase the likelihood of achieving recovery. This is true in combination with behavioral therapy but also true with just medication itself. Indeed, the consensus is that MAT should be the standard of care regardless of treating setting, interest in behavioral counseling, or compliance with other elements

of a treatment plan.[1] Illinois removed many barriers to MAT in the Heroin Crisis Act but has not done enough to promote the integration of MAT into OUD treatment programs and other treating settings like hospitals. This is evident in the continued frequent use of traditional withdrawal management.

Illinois can look to other states for guidance on how to better promote and integrate MAT. For example, Missouri has established an innovative medication-first approach to treating OUD.[2] This approach is a philosophical reorientation that is derived in part from the housing-first approach to ending chronic homelessness. Under a medication-first treatment system, participants receive pharmacotherapy through MAT agonist induction as quickly as possible, prior to any lengthy assessments. Maintenance MAT is ongoing without any arbitrary tapering and without requiring participation in psychosocial services. Participants could request OUD treatment without MAT if they choose, but the professional standard of care is agonist MAT. It will require specific policy changes to expand the availability and use of MAT but pursuing such policies is the best way to prevent inappropriate withdrawal management interventions.

Policy Recommendations

Establish a Medicaid benefit to cover the full range of MAT related services

All forms of MAT are covered by Illinois Medicaid, but the support services associated with successful medication administration are not reimbursable for SUPR licensed facilities. This has led to uneven adoption of buprenorphine as a front-line treatment option at SUPR facilities, as well as in most hospital emergency rooms. It is more common to receive buprenorphine from a Federally Qualified Health Center or private doctor. These clinics and providers are important components of the continuum of OUD treatment, but buprenorphine treatment must be more easily provided at hospitals and SUPR licensed facilities considering that many individuals seeking treatment will go to these providers first or while in crisis.

To promote MAT using buprenorphine (or in some case naltrexone), we recommend that Illinois create a new Medicaid benefit specifically to reimburse providers for the entire course of MAT treatment. This would include assessment, treatment plan development, induction of the medication, medication monitoring and training, medical visits to support stabilization, individual and group support, maintenance support, and ultimately discontinuation if it is desired by the participant themselves and clinically indicated. Examples of these type of benefit were evaluated and described by the Center for Medicare and Medicaid Services (CMS) Medicaid Innovation Accelerator Program and several state models are provided.[3]

We would recommend paying particular attention to the Baltimore Buprenorphine Initiative.[4] This program and the Medicaid benefits that support it allows for MAT induction and stabilization at specialty treatment settings followed by referral to primary care for maintenance. A key element includes reimbursement for medication administration, monitoring, and training which are not currently reimbursable at SUPR-licensed facilities. It also provides for different reimbursement rates for each phase of MAT intervention and is specifically designed for that model of treatment rather than traditional individual and group treatment.[5] The establishment of a Medicaid benefit along these lines

will provide an evidence-based alternative to traditional withdrawal management and other less effective OUD treatment interventions.

Reimburse MAT induction and monitoring at similar levels to traditional withdrawal management

The financial incentives to provide traditional withdrawal management services make the transition towards more effective and clinically indicated interventions difficult to achieve. Medically monitored withdrawal management pays a higher rate than other forms of treatment, such as MAT induction, and it discourages the development of better approaches. To address these financial headwinds, the state should provide similar reimbursement for several days of medically monitored MAT induction. This will provide financial incentives for hospitals to build out a buprenorphine practice, incorporate it into their emergency room practices, and move away from the historic approach to withdrawal management.

This could be achieved either by creating a new benefit along the lines of the MAT benefit described above, or by redefining withdrawal management to make clear that methadone and buprenorphine induction and monitoring without any tapering off is allowable under withdrawal management and reimbursable at the same rates. If the state went the latter route, then it should publish a provider notice and accompanying training for existing withdrawal management providers to understand the range of interventions eligible under that benefit.

Create a timeline for withdrawal management providers to transition away from reliance on traditional approaches

The state should direct withdrawal management providers to transition away from the historic approach of providing limited doses of opioid agonist medication to taper off of opioids entirely. This may be the preferred approach of a subset of individuals in need, but it should not be the default approach. Instead, the state should establish a medication-first policy. Providers must be given some time to make this transition but the new Medicaid benefits recommended here should allow most to successfully reorient their services. After the timeline set by the state elapses, new medical necessity requirements should be put in place to ensure full withdrawal from opioids only occurs when asked for by the individual themselves or in the event of some other clinical need.

Require effective discharge planning for all withdrawal management providers

Formal discharging planning policies and documentation should be required of all withdrawal management providers. These required policies must include connections to treatment in the community, pharmacological interventions to prevent overdose, distribution of overdose prevention medication such as naloxone, and plans for follow up with the individual post discharge. This should be a requirement for licensure and/or payment.

Establish a Medicaid benefit to support warm handoff and other community transition services

Illinois Medicaid does not currently have a defined benefit to support warm handoffs or other effective discharge plans at withdrawal management providers. Federal opioid dollars currently support several warm handoff pilot programs, but the state needs a more systemic way of financing these services. One promising approach could be to create a peer recovery support benefit and use peers to provide the warm handoff services needed for an individual leaving a higher level of care. Another could be to use

Integrated Health Home (IHH) funds to better support these care transitions, although a drawback to this approach is that IHH services will not be available to all Medicaid beneficiaries.

Invest in monitoring and evaluation

Illinois needs more frequent monitoring and evaluation of the effectiveness of its interventions. The Department should track the frequency of withdrawal management services, any readmissions, and the recovery rate (or overdose rate) of those who receive these services. The Department can then compare the success of those services to any reforms and system changes they implement. Investment in accurate evaluation is the only way to determine the effectiveness of any reforms.

Conclusion

Only by following the evidence and investing in the interventions shown to be most effective can Illinois truly halt and reverse the opioid epidemic. This will require state resources and a commitment to transforming our existing OUD treatment system. With the proper commitment, however, we can save lives, reduce state costs, and help many more individuals struggling with opioid dependence to achieve recovery.

Heartland Alliance is eager to further discuss these recommendations. Please contact Dan Rabbitt at drabbitt@heartlandalliance.org or (443) 401-6142 for more information.

Endnotes

[1]National Academies of Sciences, Engineering, and Medicine. 2019. *Medications for opioid use disorder saves lives.* Washington, DC. The National Academies Press. Available at https://doi.org/10.17226/25310

[2] State of Missouri Department of Mental Health. Medication First Model for the Treatment of Opioid Use Disorder. Available at https://static1.squarespace.com/static/594939ba197aea24a334ef60/t/5b9a6a6740ec9a28d6531057/1536846442834/Medication+First+Model_1+pager+%282%29.pdf

[3] Center for Medicare and Medicaid Services (CMS). Innovation Accelerator Program MAT Overview. Available at: https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/reducing-substance-use-disorders/mat-overview.pdf

[4] CMS. Innovation Accelerator Program. MAT Clinical Pathway Model Three. Available at: https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/reducing-substance-use-disorders/mat-clinical-pathway-model-3.pdf

[5] CMS. Innovation Accelerator Program. MAT Rate Design Tool Model Three. Available at: https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/reducing-substance-use-disorders/mat-rate-design-tool-3.xlsx