Options to Support Substance Use Navigators in Emergency Departments

by

David Maxwell-Jolly

Meredith Wurden

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Executive Summary

The opioid crisis remains a substantial public health concern that will likely be accelerated by the economic insecurity and social isolation heralded by the spread of COVID-19. Emergency departments (EDs) are on the front lines of both of these public health crises. The goal of the CA Bridge Program is to make it possible for people who use drugs to get treatment for their substance use disorder (SUD) at any hospital emergency department in the state. CA Bridge helps hospitals set up medication for addiction treatment (MAT) programs, a critical component of which is a substance use navigator (SUN). As trained peer support, SUNs have been successful in helping to establish treatment initiation and in providing navigation to ongoing outpatient treatment services after patients leave the hospital. Current statewide grant support for CA Bridge SUNs is time limited. Through interviews with key stakeholders and additional research, this report explores potential models for ongoing financing of SUN services and the barriers to establishing and sustaining these funding sources in the future.

Ninety-one percent of individuals who present for care at California’s EDs with SUD have some form of health coverage, and this offers an opportunity to finance SUN services in the long run. However, the wide variety of coverage arrangements means that there is no single approach that will apply in all cases. This paper identifies different pathways for financial support for SUNs.

- **Drug Medi-Cal Reimbursement**: EDs could enroll with their counties and register with the state to become Drug Medi-Cal providers in counties operating Organized Delivery Systems and claim reimbursement for SUN services.

- **Managed Care Claiming for Screening, Brief Intervention, and Referral to Treatment (SBIRT)**: EDs could submit claims for SBIRT reimbursement for Medi-Cal enrollees where their managed care plans cover those services.

- **Managed Care Value-Based Payment**: A Medi-Cal managed care plan could develop a program of incentive payments for hospitals or physician groups who establish SUNs in hospitals in the plan’s service area or achieve quality measures related to outcomes for patients with SUD.

- **Managed Care Case Management**: Managed care plans with responsibility for managing the care of their enrollees and, in particular, those with delegated care management responsibilities for clients served by the Drug Medi-Cal system could support SUN services in EDs.

- **County Behavioral Health Departments**: These agencies can provide SUN services in EDs either by directly placing staff in EDs or by subsidizing the hiring of SUNs by the hospital or ED staffing group.

- **Clinics and CBOs**: These providers could place SUNs in hospitals to ensure effective initiation of care, and their services could be reimbursed through the Drug Medi-Cal program if the clinic were an enrolled provider.

Finally, there are opportunities to shape state policy to more strongly support reimbursement of SUN services by these actions:

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- Advocate for extension of Medi-Cal reimbursement for SBIRT to the ED setting.
- Advocate for the reimbursement of all aspects of navigator services, not just SBIRT, both in the ED and other appropriate settings.
- Work with the Department of Managed Health Care to communicate the requirement that SBIRT is covered as an essential health benefit.
- Support the change proposed by the Department of Health Care Services (DHCS) under the current waiver extension and California Advancing and Innovating Medi-Cal (CalAIM) to permit billing for services, particularly assessment and initiation of MAT prior to establishing a confirmed diagnosis on record with the DMC-ODS program.
- Support other proposed changes in the waiver extension, CalAIM, and waiver renewal that could enhance MAT availability.
- Advocate that DHCS change the performance measures for DMC-ODS to include consideration of clients who are initially screened in hospital EDs.
- Explore the value of adding the HEDIS measure on follow up from an emergency room visit for substance use disorder to the DHCS Managed Care Accountability Set.
Introduction

CA Bridge
The opioid crisis remains a substantial public health concern that will likely be accelerated by the economic insecurity and social isolation heralded by the spread of COVID-19. Emergency departments (EDs) are on the front lines of both of these public health crises. The goal of the CA Bridge Program is to make it possible for people who use drugs to get treatment for their substance use disorder (SUD) at any hospital emergency department in the state. The landmark 2015 randomized clinical trial demonstrated the effectiveness of ED-initiated buprenorphine in improving opioid use disorder (OUD) treatment outcomes and retention in adults and sparked interest among a small number of EDs across the nation. CA Bridge, administered by the Public Health Institute, is taking this model to scale, helping hospitals set up medication for addiction treatment (MAT) programs with the goal of making it standard of care.

CA Bridge began initially through a series of pilots funded by the California Health Care Foundation. In 2018, the program was able to scale up with over $18 million in time-limited federal grants supporting 52 hospitals in 35 counties throughout the state. Subsequently, the California Budget Act of 2019 appropriated $20 million in state funding for the Department of Health Care Services (DHCS) to support Substance Use Navigators in EDs, funding which was reappropriated in the 2020 budget act to make the funds available during the 2020-2021 fiscal year. In February 2020, DHCS issued a request for applications for general acute care hospitals to apply for these funds under the name Behavioral Health Pilot Project. Over 200 hospitals will receive one-time awards of $50,000-$100,000 in the fall of 2020.

Substance Use Navigators
A critical component of advancing MAT in the CA Bridge model is the use of a substance use navigator (SUN). SUNs are trained peers, sometimes certified drug and alcohol counselors, who identify people in the ED with possible substance use, support MAT initiation, providing navigation services to ongoing outpatient treatment, and engage in community outreach to raise awareness of MAT services at the hospital. SUNs help facilitate referral to the appropriate level of care outside the hospital at a time when patients are at higher risk for opioid overdoses. Research has found an increase in treatment engagement when ED-initiated MAT is combined with coordinated follow-up.

Hospitals report that having a SUN helps the ED run more smoothly by having a dedicated person to work with patients with SUD who are often frequent users of the ED. SUNs have the potential to generate improved patient outcomes and hospital cost savings through more effective treatment in the

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4 A federal Substance Abuse and Mental Health Services Act (SAMHSA) grant administered through the California Department of Health Care Services (DHCS) originally provided $14.5 million in funding. DHCS subsequently awarded an additional $4 million.
5 Risk is higher after discharge from a hospital ED; see SAMHSA Opioid Overdose Prevention TOOLKIT, Opioid Use Disorder Fact, p. 1.
ED, reduced ED wait times, fewer inpatient hospital stays, and reduced hospital readmissions. Other parts of the health care and social service systems also benefit when people are engaged in treatment. Effective engagement decreases health care costs (e.g., decreased admissions for abscesses or other infections) and decreases law enforcement costs (decrease re-arrests and jail time). SUNs have been credited with reducing stigma and changing hospital culture so that SUD is treated like any other life-threatening medical condition.

The Sustainability Challenge
Current financing for SUNs through state and federal grants is time limited. Out of the initial 52 hospitals funded by CA Bridge, 19 report that they will be able to maintain the SUN position after termination of the grant funding. Additional revenue, incentives, or partnerships would enable more hospitals to fund this position permanently. This report explores potential models to support the position of the SUN with funding sources that can be sustained after the end of the existing grants. Interviews were conducted with individuals in a range of settings that have a stake in the delivery of effective services to people with substance use disorder—hospitals, ED staffing groups, managed care plans, and counties—to identify options for ongoing financing of SUN services.

Background
Coverage for Substance Use Services
Since the implementation of the Affordable Care Act, coverage for substance use services has been a mandatory component of public coverage programs (Medicare and Medi-Cal). Medi-Cal has a separate system for organizing the delivery of substance use services, known as Drug Medi-Cal (DMC). It provides basic substance use treatment services, including intensive outpatient treatment, naltrexone treatment, narcotic treatment program, outpatient drug free treatment, and residential substance use disorder services. Thirty counties, covering more than 90 percent of the state’s population, have chosen to expand their DMC benefit to offer a continuum of managed substance use services through a waiver program known as the Drug Medi-Cal – Organized Delivery System (DMC-ODS). DMC-ODS services include case management, narcotic treatment program, counseling, expanded medication assisted treatment (MAT), and residential treatment. (Appendix A compares benefits under DMC and DMC-ODS and identifies the specific services and codes reimbursed under DMC-ODS.)

In October 2019, the state proposed several significant Medi-Cal reforms, known as California Advancing and innovating Medi-Cal (CalAIM), that would impact coverage for substance use services authorized under the Medi-Cal 2020 Waiver mentioned above. Due to the COVID 19 pandemic, CalAIM has been delayed. However, the state is preparing a formal request to extend the existing waiver that included a substantial reform of the DMC-ODS. In October 2019, the state proposed several significant Medi-Cal reforms, known as California Advancing and innovating Medi-Cal (CalAIM), that would impact coverage for substance use services authorized under the Medi-Cal 2020 Waiver mentioned above. Due to the COVID 19 pandemic, CalAIM has been delayed. However, the state is preparing a formal request to extend the existing waiver that included a substantial reform of the DMC-ODS. (Appendix B includes additional detail on the waiver extension and CalAIM proposals.)

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7 Based on discussions with Dr. Aimee Moulin regarding data collected at UC Davis.
8 See http://www.californiamat.org/matproject/mat-toolkits/
Private insurers in California are required to include coverage of substance use services in plans that must conform to the state-defined “essential health benefits.” This requirement applies to plans sold individually and for small businesses as well as to most large employer insurance plans. However, private coverage may vary regarding the specific elements of service that are covered.

Hospital Characteristics
How hospitals approach supporting the cost of a SUN in the emergency department will depend on hospital characteristics such as whether they are a private or public facility or part of an academic institution, how the ED is staffed, what the patient insurance mix is.

Ownership
In 2017, California had 367 general acute care hospitals with a variety of ownership and governance models. The largest ownership model constituting 65 percent of beds is the private nonprofit sector. These hospitals operate as charities with community benefit obligations. Many of these hospitals have consolidated their ownership and governance under larger nonprofit organizations. Hospitals in the next largest category, constituting 18 percent of licensed beds, are publicly owned and operated according to three models: 1) county hospitals where the county owns and operates the hospital itself or as a county-controlled enterprise; 2) University of California hospitals owned and operated by the University of California and operated as teaching hospitals for their respective medical schools; and 3) district hospitals, established as independent public entities that originally received a share of property tax revenues and are operated by a local board of directors. Finally, privately owned hospitals that are operated as profit-making enterprises account for about 17 percent of licensed beds.

According to the California Health Care Foundation, most general acute care hospitals in California (80 percent) have emergency care of some kind. The basic level of care is available in 70 percent of the hospitals which maintain a staff of emergency physicians on site 24 hours a day. Another eight percent are standby levels of care where emergency staff are on call. Only two percent are comprehensive emergency rooms with emergency personnel as well as specialists available.

| Table 1: Ownership of Hospitals Receiving CA Bridge Grants |
|----------------|-----------------|----------------|
| Ownership Category | Number of Hospitals | Average Number of Licensed Beds |
| County            | 11               | 403             |
| University of California | 4           | 653             |
| District          | 7                | 187             |
| Private Non-Profit| 29               | 338             |
| Private for Profit| 1                | 461             |
| **Total**        | **52**         | **358**        |

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11 Based on communications with the California Department of Managed Health Care, July 22, 2020.
13 California Emergency Departments: Use Grows as Coverage Expands, California Health Care Foundation, August 2018
14 Analysis of data from Office of Statewide Health Planning and Development 2018 CY Hospital Annual Selected File
Table 1 shows the ownership distribution of the 52 hospitals that received federal funding and successfully implemented the CA Bridge model in 2018-2020. The diversity of hospital types and sizes indicates that the CA Bridge model can be successful in a wide range of settings and that the financial solutions for sustaining this model must span a diverse set of hospitals.

**Staffing**

Because of the rules governing the relationship between a hospital and its physician staff, these different operating models vary in how they staff their EDs. With the exception of county, critical access, and UC hospitals, hospitals are not permitted to hire ED physicians. As a result of these rules, these hospitals cannot themselves claim for professional services provided in their EDs. The hospital’s cost for ED services is reimbursed through the room charge which is not increased when a SUN is part of the hospital’s ED staff. Professional services in the ED are usually provided through a contracted professional staffing group that can claim reimbursement for services provided in the ED.

The exception is county, critical access, and UC hospitals that can directly hire the physician staff in their EDs and claim separately for their professional services.

**Insurance Status of ED Patients**

Most individuals coming to the ED have some type of health coverage to help pay for the services they receive. Among all Californians, 55 percent have private insurance through an employer plan or an individual health plan. About a quarter have Medi-Cal coverage, 11 percent have Medicare, and the remaining 7 percent are uninsured. Figure 1 shows as of 2017 the overall insurance coverage pattern among Californians.

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**Figure 1. Source of Health Coverage for California Residents and ED Patients, 2017**

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15 “Health Insurance Coverage of the Total Population,” The Henry J. Kaiser Family Foundation, 2018. Here dually eligible, those with both Medicare and Medi-Cal, are shown only in the Medi-Cal category; and “California Emergency Departments: Use Grows as Coverage Expands,” California Health Care Foundation, August 2018. Payer source for ED visits comes from the California State Emergency Department Databases (SEDD), Healthcare Cost and Utilization Project (HCUP), Agency for Healthcare Research and Quality.
The distribution of health coverage sources for those visiting the state’s EDs is significantly different from the coverage sources of the overall population. A larger share of ED patients rely on Medi-Cal and Medicare. The incidence of health problems in these coverage categories is higher than in the privately insured population which is more likely to be young and employed. An even larger share of individuals visiting EDs with opioid use have Medi-Cal coverage (49 percent in 2017).

It is also important to note that the distribution of coverage varies significantly around the state. For example, the share of Medi-Cal coverage for those arriving at EDs averages about 34 percent in the Bay Area counties, while it is 56 percent in the San Joaquin Valley. There is also great variation in the payer mix across hospitals, even within the same region.

**Sustainability Strategies**

Because of the wide variation in how managed care and SUD care is organized by county, and the variation in hospital ownership and staffing arrangements, there is no single, one-size-fits-all sustainability strategy for SUNs. Based on our interviews and exploration of current policies, we have identified the following six strategies as those with the greatest potential for piloting in different counties and hospitals.

- Drug Medi-Cal Reimbursement
- Managed Care Claiming for SBIRT
- Managed Care Value-Based Payments
- Managed Care Case Management
- County Behavioral Health Departments
- Clinic and Community Based Organizations

**Drug Medi-Cal Reimbursement**

Drug Medi-Cal reimburses services for patients with SUD diagnoses, as well as assessment services prior to diagnosis. However, the program limits reimbursement only to those providers who contract with the county and are certified by the state as a DMC provider. The 30 counties that have established DMC-ODS offer a wider array of services than the traditional Drug Medi-Cal program. An ED could be reimbursed for assessment and treatment services if the ED were a contracted Drug Medi-Cal provider. Most of the initial contact with a client in an ED would likely be assessment and initiation of treatment and not continuing case management, but arranging for referral to continue services or for any additional supports that the individual might need could potentially qualify as case management services. SUN services would be reimbursable as long as the SUN is a certified substance use counselor.

In summary, EDs with significant volumes of substance use clients who are Medi-Cal eligible could enroll as Drug Medi-Cal providers and receive reimbursement from the county as a contracted provider. Claimable services could include the initial assessment, initial treatment once diagnosed, and additional referral to ongoing care and additional case management services provided by the SUNs in the ED or afterward.
Managed Care Claiming for SBIRT
The services provided by SUNs are not a uniquely defined service in any of the public or private coverage sources. However, one service category that encompasses much of the activities of the SUN is known as Screening, Brief Intervention, and Referral to Treatment (SBIRT). SBIRT is a service that seeks to identify individuals with alcohol or substance use disorder conditions and refer them for treatment. Emergency department SBIRT programs have been found to improve outcomes and to be cost-effective approaches to SUD management by reducing SUD related utilization and costs. Research has also found that, when combined with the type of support provided by SUNs, SBIRT can reduce ED recidivism as well as potentially decrease ED resource utilization, crowding, and length of stay. Table 2 outlines SBIRT services and billing codes by payer type.

<table>
<thead>
<tr>
<th>Payer</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid option</td>
<td>H0049</td>
<td>Alcohol and/or drug screening</td>
</tr>
<tr>
<td></td>
<td>H0050</td>
<td>Alcohol and/or drug screening, brief intervention, per 15 minutes</td>
</tr>
<tr>
<td>Medicare</td>
<td>G0396</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes</td>
</tr>
<tr>
<td></td>
<td>G0397</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes</td>
</tr>
<tr>
<td>Commercial Insurance</td>
<td>CPT 99408</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; 15 to 30 minutes</td>
</tr>
<tr>
<td></td>
<td>CPT 99409</td>
<td>Alcohol and/or substance abuse structured screening and brief intervention services; greater than 30 minutes</td>
</tr>
</tbody>
</table>


Medi-Cal offers coverage for these kinds of screening services provided by licensed professionals, but historically they were limited to screening performed in primary care settings for the purpose of identifying those suspected of alcohol misuse. Recent legislation -- SB 78 (Stats. 2019, Ch. 38, Sec. 46)

18 Medi-Cal covers Alcohol Misuse Screening and Counseling (AMSC) which was formerly known as SBIRT. Department of Health Care Services. All Plan Letter 17-016. Alcohol Misuse: Screening and Behavioral Counseling Interventions in Primary Care. Available at: https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-016.pdf
19 See Item 133, California Medi-Cal 2020 Demonstration, 11-W-00193/9, Special Terms and Conditions as amended Nov 19, 2019, Term #133, page 103.
-- expanded this to include screening for opioid and other illicit drug use in the primary care setting effective July 1, 2020. While not a required covered benefit in the ED setting, Medi-Cal health plans can elect to cover SBIRT in EDs.

Medicare also covers SBIRT. Under both Medi-Cal and Medicare, the service must be claimed by a licensed health professional, so that while it may be possible for the SUN to perform a portion of this service working under the supervision of a licensed provider, it would require a licensed provider to validate the results. 20

Private insurance may or may not cover SBIRT services. Most insurance coverage is required to include coverage for the essential health benefits identified by the state’s selected benchmark plan. This requirement applies to individual health coverage and small group employer coverage. However, not all large employer groups are required to offer the list of essential health benefits. California’s definition of essential health benefits includes substance use services, but it is not known whether all plans include SBIRT-type services in their set of covered benefits.

In June 2020, the United States Preventative Services Task Force (USPSTF) updated recommendations to include screening for unhealthy drug use for adults 18 years and older. 21 Medi-Cal covers USPSTF recommended preventative services and provisions are included in the Medi-Cal managed care contract to enforce this requirement. Private health plans are also required to cover recommended preventative services under the federal Affordable Care Act without any cost sharing. 22 As a result, the new USPSTF recommendations may open doors for more reimbursement for SBIRT. For Medi-Cal beneficiaries, it is currently only required in primary care settings, however, while not required by the state, Medi-Cal managed care plans can choose to voluntarily reimburse this service in an ED. This is a promising area for exploration in a local pilot.

Managed Care Value-Based Payment
Hospitals and the staffing groups in their EDs often have contractual relationships with managed care plans, both public and private. These contracts establish the rates of payment agreed to for services to patients enrolled in the plan. At times, these contracts, rather than paying on a fee-for-service basis, establish payment on a capitated basis where the provider bears a share of the financial risk. Because plans are graded on their performance in delivering care to their membership, with specific measures related to the delivery of care for those with substance use disorder, plans have an interest in structuring financial relationships with providers to encourage them to help the plan improve the quality of care provided to its members. (See Appendix C for the list of substance use related measures currently being used. 23)

20 SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT (SBIRT) SERVICES, Medicare Learning Network, ICN MLN904084, March 2020.
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/drug-use-illicit-screening#fullrecommendationstart
22 Kaiser Family Foundation. Preventive Services Covered by Private Health Plans under the Affordable Care Act. August 4, 2015. Available here: 
23 DHCS has added two measures related to substance use as of 2020 but does not use the HEDIS measure regarding follow up from ED visits for substance use as part of its core measures to evaluate its plans’ performance.
Managed care plans, both commercial and Medi-Cal, could create value-based payment arrangements to support the availability of SUNs in EDs, which might be of particular interest in hospitals where a large share of ED patients are enrolled in the plan. For example, where the health plan has a capitated payment arrangement with either the hospital or the ER staffing group, the payments could be increased to provide for part or all the costs of a SUN. Health plans costs could be offset by the savings that would result from decreased repeated ED visits or, if the SUN serves admitted patients, decreased readmissions. These savings could also be measured and incorporated into a shared savings payment arrangement (between the health plan and provider) to help finance SUN services. Partnership HealthPlan, for example, includes payment incentives for MAT initiation and community referral as part of their large hospital quality improvement program.

Managed Care Case Management
The capitated payment structure for managed care plans provides a financial incentive to engage in care management of members with high utilization to help reduce overall costs. Additionally, the CalAIM reforms proposed in the Medi-Cal program would require plans to establish more formal care management structures focused on improving care for the highest users among their membership. This will likely include some number of members with substance use disorder who may present at the ED for care. Including individuals as part of the plan’s managed care team who have the training and skills of a SUN might be an effective way to engage high users with substance use disorders to moderate their service use and receive better outcomes when undergoing treatment. In this approach, the managed care plan can make these specialized team members available to serve at one or more of the plan’s contracted hospitals, being available either in-person or through a remote connection, to address the needs of their members visiting the EDs of those hospitals. The SUN could serve as the case manager for these individuals.

In cases where a county has established a Drug Medi-Cal-Organized Delivery System, that system has the responsibility to manage the substance use treatment care of its clients. The county could potentially delegate the DMC-ODS care management responsibility to the client’s Medi-Cal managed care plan so that the plan would oversee all aspects of that member’s care. Shifting this responsibility to the plan would reinforce the need for SUN services that could be available to hospitals in the plan’s service area to provide service to clients who initiate treatment in EDs. One example of this arrangement is Partnership HealthPlan that is administering the DMC-ODS benefit on behalf of seven northern California counties. (Additional state approvals may be required depending on the structure of delegation.) Reforms proposed in CalAIM may also help facilitate similar arrangements.

County Behavioral Health Departments
Counties could support SUNs placed at the hospital or ED staffing group through direct grants and other programs operated by the county outside of the Drug Medi-Cal Program. Table 3 outlines the major potential sources of county related funds that could support SUNs. Hospitals or ED staffing groups would need to work directly with their counties to be included in budget decisions and program development to access these potential funding sources.

25 Effective July 1, 2020 Partnership HealthPlan assumed DMC-ODS administration in seven California counties: Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou and Solano.
### Table 3. Potential Sources of County Behavioral Health Funds for SUNs

<table>
<thead>
<tr>
<th>Source</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>County</td>
<td>Counties use their own local general fund, special funds, and Realignment revenue to finance substance use treatment services, and when provided to Medi-Cal beneficiaries, they can be matched with federal funds.</td>
</tr>
<tr>
<td>General Fund, Realignment Revenue, other special revenue funds</td>
<td>Passed in 2004 as Proposition 63, the MHSA provides about $2 billion annually primarily to counties to support a variety of mental health programs and services. Clients served include those with co-occurring mental health and substance use disorders. Some of these funds are used to match federal dollars for Medi-Cal eligible individuals and services. For individuals with co-occurring disorders, a county could choose to support SUN services or support navigators trained to assist clients in the ED with either diagnosis. The funds could come out of the MHSA’s direct service allocations or could be approved on a pilot basis as part of a county’s innovation grants.</td>
</tr>
</tbody>
</table>
| Mental Health Service Act (MHSA)

26 While MHSA funds are designated as support for mental health programs, nearly 1 in 4 persons nationally with serious mental illness have a substance use disorder as well. See Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health, September 2015


| Federal                                         | This is the federal share of substance use treatment services covered by Medi-Cal, with the federal share ranging from 50 to 90 percent depending on the nature of the service and the eligibility category of the client. These funds are accessed by counties sending eligible service expenditure information to DHCS. |
| Medicaid matching funds                         | SABG is the largest statewide substance use grant received by counties and targets specific populations and services including primary prevention services, intravenous drug users, and pregnant women with dependent children. California receives about $255 million annually from the SABG. With the expansion of the Drug Medi-Cal program and other services, pressure on the SABG funds is not as great as it traditionally has been. |
| Substance Abuse Prevention and Treatment Block Grant (SABG) | Instead of a hospital or ED staffing group employing a SUN, a county could also hire SUNs directly and place them in EDs in the county. The funding sources identified in Table 3 above are those that could potentially support the direct employment of SUNs. A county program that employed a SUN deployed physically or remotely to an ED could potentially increase available funds if it could claim higher federal matching funds through the Drug Medi-Cal claiming system for the services provided. This ability to claim is not clearly understood by counties and needs clarification. DHCS is considering clarifying the policy on claiming prior to the diagnoses in the context of the upcoming waiver renewal. |
| Riverside County                                | Riverside County is an example of a county behavioral health department that has hired and placed SUNs at the Riverside University Health System Medical Center in Valley. (See Appendix D for a more complete description of this approach.) These two positions are supported out of the general administrative budget of the substance use treatment program, the same budget that supports the county substance use hotline. |

26 While MHSA funds are designated as support for mental health programs, nearly 1 in 4 persons nationally with serious mental illness have a substance use disorder as well. See Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health, September 2015


Clinics and Community-Based Organizations
Clinics or CBOs that provide treatment for substance use could also employ SUNs to be made available to hospital EDs. Clinics that are Federally Qualified Health Clinics would not be able to submit separate claims for the services of a SUN under the Medi-Cal program if these services were part of a visit that was being reimbursed through the Prospective Payment System. However, additional revenue could be obtained through reimbursement for these services through Drug Medi-Cal if the clinic were a contractor with the county and that client has a recognized substance use disorder diagnosis. (As discussed above this constraint is being reconsidered.) In addition, there is also potential reimbursement through DMC-ODS for services provided in the ED through “field-based services.”

Like hospitals, clinics that contract with managed care plans could also be the beneficiaries of managed care incentive programs that are targeted towards behavioral health integration and reducing the health consequences of opioid use. This could be through managed care pay for performance programs or other supplemental programs such as the behavioral health integration program funded by Proposition 56 as described earlier. For example, one health plan indicated that they established a grant program to support SUNs in local federally qualified health centers.²⁹

Actions to Advance State Policy
There are several steps that can be taken to modify state policy regarding reimbursement of SUN services in the ED.

State Policy on Reimbursement
- **Extend Medi-Cal reimbursement for SBIRT to the ED setting.**
  Current policy limits reimbursement to primary care settings which excludes screens done in EDs. Extending reimbursement to the ED would provide a revenue stream for one of the key functions of the SUN when performed under the supervision of a licensed health professional.

- **Advocate for the reimbursement of all aspects of navigator services, not just SBIRT, both in the ED and other appropriate settings.**
  Recognition of SUN services as a comprehensive package would facilitate claiming. These services increase the effectiveness of MAT initiated in the ED and reduce the risks of repeated ED visits.

- **Work with the Department of Managed Health Care to communicate the requirement that SBIRT is covered as an essential health benefit.**
  Health plans required to cover essential health benefits should include in their offerings screening and referral for substance use. Health plans should accept claims for their enrollees whose benefits are governed by this rule.

²⁹ Interview with CalOptima staff.
1115 Waiver Extension, CalAIM, and Waiver Renewal

- Support the change proposed by the Department of Health Care Services (DHCS) under the current waiver extension and California Advancing and Innovating Medi-Cal (CalAIM) to permit billing for services, particularly assessment and initiation of MAT prior to establishing a confirmed diagnosis on record with the DMC-ODS program. This change is important to increase access to services and will facilitate the initiation of services for those service locations that seek to contract with the county.

- Support other proposed changes in the waiver extension, CalAIM, and waiver renewal that could enhance MAT availability. The waiver extension request currently includes a proposal to require counties to mandate that all DMC-ODS providers, at all levels of care, demonstrate that they either directly offer, or have effective referral mechanisms to, MAT and to add coverage for naltrexone in the Narcotic Treatment Program setting. This will help to ensure that individuals initiating MAT in EDs will be able to locate community providers for follow-up.

Substance Use Quality and Performance Measures

- Advocate that DHCS change the performance measures for DMC-ODS to include consideration of clients who are initially screened in hospital EDs. Currently, ODS plans are required to report on the effectiveness of follow up when clients are first enrolled in care. However, this measure now excludes individuals referred for care in the ODS from hospital EDs. Including these individuals would provide a more complete picture of the effectiveness of ED follow up care and increase the value of the services provided by the SUN for increasing follow up rates for this population of patients.

- Explore the value of adding the HEDIS measure on follow up from an emergency room visit for substance use disorder to the DHCS Managed Care Accountability Set. The DHCS Managed Care Accountability Set used to assess the quality of care provided by those plans. The percentage of patients who receive follow up SUD care after an emergency room visit is a current HEDIS measure but is not included in the subset of measures that DHCS requires plans to report. Including this measure will elevate its importance to plans and create strong incentives to support SUNs who can support improved outcomes on this important measure.
About the Authors

David Maxwell-Jolly has held a variety of executive state government positions including Chief Deputy Executive Director at Covered California, Undersecretary and Deputy Secretary at the Health and Human Services Agency, and Director of the Department of Health Care Services. Through his firm, DMJ Advisors LLC, he provides policy analysis of issues related to health and human services and information technology management.

Meredith Wurden, MPH, MPP, of Wurden Consulting, provides health policy and strategy services with a focus on public health care programs and financing. She has held several health related positions including Director of Policy and Fiscal Strategy for Partnership HealthPlan and Assistant Deputy Director of Health Care Financing at the California Department of Health Care Services.
Appendix A – Drug Medi-Cal Program

Medi-Cal has a separate system for organizing the delivery of substance use services, known as Drug Medi-Cal (DMC). Thirty counties have chosen to expand their state plan DMC benefit to offer a continuum of managed substance use services through a waiver program known as the Drug Medi-Cal – Organized Delivery System (DMC-ODS). Table B-1 compares benefits under the two models, and Table B-2 identifies the specific services and codes reimbursed under Drug Medi-Cal -ODS.

<table>
<thead>
<tr>
<th>Table B-1. Drug Medi-Cal Program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
</tr>
<tr>
<td>Medi-Cal specialty substance use service benefit provided by counties. These benefits are “carved-out” of Medi-Cal managed care services and provided by counties.</td>
</tr>
</tbody>
</table>

**General Requirements**
- All counties must provide basic set of services
- Entity offering services must be DMC certified by the state and contracted with the county
- Beneficiaries must be Medi-Cal eligible and be diagnosed with a SUD
- Voluntary for counties to expand
- Entity offering services must be DMC certified by the state and contracted with the county
- Beneficiaries must be Medi-Cal eligible and diagnosed with a SUD

**Services Covered**

- Benefits specified in State Medicaid Plan:
  - Outpatient treatment and intensive outpatient treatment
  - Residential services for perinatal women
  - Naltrexone treatment
  - Narcotic treatment (methadone only)
  - Detoxification in a hospital

- State Plan listed services plus:
  - Case management, including assessments
  - Expanded residential treatment (not limited to perinatal and multiple levels provided; includes federal funds for facilities with more than 16 beds)
  - Expanded narcotic treatment including buprenorphine
  - Withdrawal management
  - Physician consultation
  - Recovery services
  - Additional MAT (optional)
  - Partial hospitalization (optional)

Note: outpatient and intensive outpatient services also include assessment.

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<table>
<thead>
<tr>
<th>Name of Service</th>
<th>Service Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Withdrawal Management 3.2</td>
<td>H0012</td>
</tr>
<tr>
<td>Ambulatory Withdrawal Management 2</td>
<td>H0014</td>
</tr>
<tr>
<td>Ambulatory Withdrawal Management 1</td>
<td>H0014</td>
</tr>
<tr>
<td>Residential</td>
<td>H0019</td>
</tr>
<tr>
<td>Partial Hospital</td>
<td>S0201</td>
</tr>
<tr>
<td>Intensive Outpatient</td>
<td>H0015</td>
</tr>
<tr>
<td>Individual Counseling</td>
<td>H0004</td>
</tr>
<tr>
<td>Group Counseling</td>
<td>H0005</td>
</tr>
<tr>
<td>Individual Counseling NTP</td>
<td>H0004</td>
</tr>
<tr>
<td>Group Counseling NTP</td>
<td>H0005</td>
</tr>
<tr>
<td>Recovery Services-Individual</td>
<td>H0004</td>
</tr>
<tr>
<td>Recovery Services-Group</td>
<td>H0005</td>
</tr>
<tr>
<td>Recovery Services-Case Management</td>
<td>H0006</td>
</tr>
<tr>
<td>Recovery Services-Support</td>
<td>T1012</td>
</tr>
<tr>
<td>Methadone Dosing</td>
<td>H0020</td>
</tr>
<tr>
<td>MAT-Dosing, NTP and Non-NTP</td>
<td>S5000/S5001</td>
</tr>
<tr>
<td>MAT – Non-NTP</td>
<td>H2010</td>
</tr>
<tr>
<td>Case Management</td>
<td>H0006</td>
</tr>
<tr>
<td>Physician Consultation</td>
<td>G9008</td>
</tr>
</tbody>
</table>

Appendix B – Medi-Cal Reform Proposals Under Consideration

California Advancing and Innovating Medi-Cal (CalAIM)
In October 2019, the state released a sweeping transformation initiative known as California Advancing and Innovating Medi-Cal (CalAIM) that would significantly impact the current Medi-Cal program. The proposal was introduced to describe the state’s intentions once the current 1115 waiver expires at the end of this year. Enhancing the Medi-Cal managed care system as well as modernizing county behavioral health systems are key features of the proposal that could help improve the conditions for supporting the cost of SUNs by reducing barriers to current reimbursement and coverage.

The progress of the CalAIM proposal has been delayed due to the diversion of resources to tackle COVID-19. The breadth of the proposal that can be undertaken is also uncertain due to the change in the state’s financial future. While the window for formal input has passed, the extended planning process may offer additional opportunities for stakeholder input as priorities are reconsidered and the ultimate form of the proposal takes shape.

Selected key CalAIM proposals that would further potential funding opportunities described above are outlined below.

Managed Care Changes
- Requires health plans to implement a population health plan and approach to care that would include greater specificity than currently required regarding levels of case management.
- Establishes an enhanced care management benefit for beneficiaries who are at the highest risk and who need long-term coordination for multiple chronic conditions.

Drug Medi-Cal - Organized Delivery System Changes
- Eliminate requirements to have a mental health or SUD diagnosis to receive program treatment services. This significantly opens the possibility of reimbursing services provided in the ED to individuals with no prior known experience with the substance use treatment system.
- Clarifying the coverage provisions to require that all substance use disorder managed care providers demonstrate that they either directly offer, or have referral mechanisms to, medication assisted treatment.
- Integration of specialty mental health and DMC-ODS systems into a comprehensive program authorized under one federal waiver authority agreement. DHCS aims to design a cohesive plan to address beneficiaries’ substance use disorder treatment needs across the continuum of care, ensure that all Medi-Cal beneficiaries receive coordinated services, and promote long-term recovery. This proposed change provides the greatest opportunity to ensure substance use treatment advances the strategies promoted by the CA Bridge program and may allow for additional flexibilities to directly support SUN services.

Establish “Full Integration” Plans
- DHCS proposes to test the effectiveness of full integration of physical health, behavioral health, and oral health under one entity contracted with DHCS. This simplified arrangement from the

perspective of the recipient could provide for a more streamlined pathway to support SUNs in EDs by allowing for more flexibility in reimbursement. The details of these pilot projects have not yet been developed.

Medi-Cal 2020 1115 Waiver Extension
The Medi-Cal 2020 1115 waiver, which provides the authority for the DMC-ODS program, expires on December 31, 2020. As described above, the state intended to advance CalAIM to provide new federal waivers to further proposed changes in light of the expiring waiver. Due to the COVID-19 public health emergency, CalAIM has been delayed. In the interim the state is drafting a 12-month extension proposal of the existing Medi-Cal 2020 waiver with a limited number of requested technical changes that had been included in the CalAIM proposal including. The relevant changes include:

- Clarify that reimbursement is available for SUD assessment and appropriate treatment even before a definitive diagnosis is determined.
- Expand access to MAT by requiring counties to mandate that all DMC-ODS providers, at all levels of care demonstrate that they either directly offer or have effective referral mechanisms to MAT.
Appendix C – Substance Use Treatment Quality Measures

Health plans are evaluated based on a common set of performance measures known as the Healthcare Effectiveness Data and Information Set (HEDIS) which include specific substance use and other related measures. HEDIS measures allow for comparisons across health plans to judge performance on which quality assessments and other activities, such as incentive programs, are based. For example, the National Committee for Quality Assurance accreditation for health plans—one marker of quality for a health plan—uses HEDIS measures to review health plans’ relative performance. Although not required by the state, about 14 out of 25 managed Medi-Cal plans are NCQA accredited.\(^34\) The Centers for Medicare and Medicaid Services (CMS) uses HEDIS as well as measures developed by other organizations to evaluate Medicare and Medicaid program performance as well. Poor performance on these measures is indicators of poor quality in health care that could have negative consequences on health care costs and patient outcomes. For example, lack of follow-up after an ED visit could result in continued substance use, additional use of ED or other intensive health care resources, as well as additional morbidity and mortality. The SUD specific measures are highlighted in Table A-1 below. The use of these measures is optional for states. The table indicates the measures that California has required plans to report.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Payer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HEDIS Performance Measures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) – 7-day rate</td>
<td>Assesses emergency department visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence, who had a follow up visit for AOD.</td>
<td>Medicaid, Medicare and Commercial; not in Medi-Cal Managed Care Accountability Set</td>
</tr>
<tr>
<td>Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)</td>
<td>Assesses adults and adolescents 13 years of age and older with a new episode of alcohol or other drug dependence who initiated treatment within 14 days of the diagnosis and had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.</td>
<td>Medicaid, Medicare and Commercial; not in Medi-Cal Managed Care Accountability Set</td>
</tr>
<tr>
<td>Use of Opioids at High Dosage (OHD)</td>
<td>Proportion of members 18 years and older who received prescription opioids at a high dosage for ≥15 days during the measurement year.</td>
<td>Medicaid and Commercial; not in Medi-Cal Managed Care Accountability Set</td>
</tr>
<tr>
<td>Use of Opioids from Multiple Providers—Multiple Prescribers and Multiple Pharmacies (UOP)</td>
<td>Assesses potentially high-risk opioid analgesic prescribing practices: The proportion of members 18 years and older, receiving prescription opioids for ≥15 days during the measurement year from multiple providers.</td>
<td>Medicaid and Commercial; not in Medi-Cal Managed Care Accountability Set</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pharmacy Quality Alliance Performance Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)</strong></td>
</tr>
<tr>
<td><strong>Concurrent Use of Opioids and Benzodiazepines (COB-AD)</strong></td>
</tr>
</tbody>
</table>

**SOURCES:**
- [https://www.pqaalliance.org/opioid-core-measure-set](https://www.pqaalliance.org/opioid-core-measure-set)
Appendix D - Riverside County’s ED Integrated Navigation Team

Riverside University Health System – Behavioral Health’s (RUHS-BH) Regional Emergency Assessment at Community Hospitals (REACH) Program uses clinical and peer support positions working in the ED as well as in the inpatient side of the hospital to assist patients in getting the treatment they need and to connect with the appropriate community resources when they leave the hospital. The program supports the ED at the Riverside University Medical Center to serve individuals with behavioral health needs with a specific focus on substance use disorders, homelessness and domestic violence. Specifically, the county supports an integrated SUD navigation team that consists of two county counselors who can complete Drug Medi-Cal - Organized Delivery System (DMC-ODS) required American Society of Addiction Medicine (ASAM) screening. Other services include engagement, risk assessment, short term follow-up to ensure linkage and engagement with services, and determination of lower level of care and need for community-based services. These individuals are connected to the county referral hotline known as SU CARES – Substance Use Community Access, Referral, Evaluation and Support. ED based services are available from 2 pm to midnight. The positions are funded by the county as general administration costs because of the recognized value they provide to the system and community.

Billing for services provided by these positions depends on the individual being served. None of the screening, coordination, and related hotline services are currently billable under the DMC-ODS if the individual does not already have a SUD diagnosis and open treatment episode. However, this would change if the state’s waiver extension and CalAIM proposal to relax this requirement described in Appendix B is implemented. Based on conversation with Riverside, if the individual is a Medi-Cal beneficiary and has a SU diagnosis known to the county, services are billable through the field-based services mechanism under the DMC-ODS. case management benefit. Field-based services are allowable for outpatient services when there is a demonstrated and documented need for services outside of a DMC-certified site but should not be used in-lieu of DMC certification. There must be a contractual link between the FBS site and the DMC-certified entity billing for the service. Thus, the clinic and County Care Coordination Team would support ongoing treatment bills for the ED based services.

RUHS-BH has worked with the local Medi-Cal managed care plans to further support these program services through the state’s Behavioral Health Integration Incentive Project.

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35 The behavioral health department is part of a larger health care system that includes the 439 bed county hospital, public health, behavioral health and 13 FQHCs.