

WORKGROUP ON SUT-CST
MINUTES OF MEETING ON FEBRUARY 18, 2021 - FINAL

PRESENT VIA WEBEX:

Kristine Herman, HFS
Eric Foster, HFS
Stephanie Frank, SUPR
Lisa Betz, DMH
Daniel Rabbitt, Heartland Alliance
Ed Stellon, Heartland Alliance
Grace Hong Duffin, Kenneth Young
Lisa Hendrickson, Kenneth Young
Heather O'Donnell, Thresholds
Tim Devitt, Thresholds
Joseph Kreul, Rosecrance
Andrea Quigley, Centerstone
Orville Mercer, Chestnut
Patrick Phelan, Sinnissippi
Stephen Brown, UIC Health & Hospital System
Jeffrey Collord, Haymarket Center
Gerald (Jud) E. DeLoss, Illinois Association for Behavioral Health
Jim Noe, Rosecrance
Randy Well, IABH
Katrina Flesvig, Kenneth Young

First on the agenda was to debrief from the presentation by Pathways to Housing, Philadelphia PA at the January Workgroup meeting. The following were some takeaways from that presentation:

- It would be useful to get more information about their financing, billing, rates and productivity standards
- They refer their clients out for SUD treatment; we are trying to focus on SUD patients
- Advantage of model is bundled rate with flexibility built in; outreach is covered in very liberal terms
- This model may not be relevant to the IL Medicaid Program; Pathways is dealing with one Medicaid MCO managed by Philadelphia and housing vouchers controlled by city
- PA mentioned that DC and VT are doing this with multiple MCOs; could be another resource
- Real challenges for SUD users are in retaining housing
- Some of the things these clients need are not Medicaid billable services
- Super-utilizers all have multiple chronic conditions + homelessness

The Workgroup then had a presentation on some key differences in mental health and substance use treatment models from Kenyatta Cathey, VP of Clinical Services, Haymarket. After describing the services at Haymarket, Kenyatta stated that treatment providers need to treat 3 conditions: SUD, MH, medical conditions; if they're not treated simultaneously, there will be a relapse. Opiotes are a huge concern, but alcohol is #1 SUD.

Kenyatta then described differences between Rule 2060 for SUD treatment providers and Rule 132 for MH providers. Under Rule 2060:

- For off-site services, providers have to have permission; there are regulations around where and how to provide those services
- If not connected to a level of care: called community intervention (\$47/hour)
- If connected to a level of care: called case management (\$50/hour)
- At these rates, it is difficult to provide team approach
- ASAM guides the services and patient placements necessary to move to recovery based on severity and need
- Although 80% of clients have co-occurring SUD and MH, it is not necessary to have licensed person working with the SUD client; provider is a certified alcohol/drug counselor
- Telehealth is available, but large number of clients don't have telephones or data packages

Rule 2060 does not preclude treatment providers from providing services in community settings; for Haymarket, 60% of services are outside a facility

- Recovery coaching services provide the type of services in a CST but it is one person, not a team
- Relationship building is key and occurs while in treatment
- Recovery coaching is for 12-18 months in duration

The desired end is managing all 3 conditions: identify MH crisis quickly by linking to psychiatrist, to medications, and/or bring back to residential care. All providers have crisis stabilization programs.

Community Intervention is supported with a grant, not Medicaid, and recovery coaching is not under Medicaid. Outreach is not funded through the Medicaid program either. There is no coherent approach to engagement.

The question was discussed: are we focused on people with the most acute needs and connecting them to services in the community? If so, it would require a major revision to the current rule on offsite "exception". There are significant cost savings to getting people into treatment: The super-utilizers are in the highest quintile of Medicaid costs.

Members summarized various systemic barriers:

- Lack of cross-sectional conversations (SUPR, DMH, HFS) to recognize prevalence of co-occurring conditions
- Conflicts between Rules 2060 and 132; pigeonholing rules into a Medicaid-covered model
- Siloed funding rather than blended funding streams
- Lack of transitions of care
- Identifying the need for team support v individual support
- Systemwide evolution on what is recovery-based v abstinence-based
- Making permanent the new COVID flexibility in licensure provisions in Rules 2060 and 132
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Eric Foster, HFS, described the status of the Medicaid 1115 Waiver related to SUD services, including peer recovery support and case management

Stephanie Frank, SUPR summed up: "Treatment is a journey to recovery".

For the next Workgroup meeting in March, Stephen Brown, UI Health & Hospital System, was asked to present to the Workgroup, focusing on these questions:

- What does success look like?
- How do we operationalize that?
- How do we measure that?