Connecticut 1115 SUD Post-award Forum

The Connecticut SUD 1115 Demonstration Post-award Forum was held on October 21, 2022. Sixty-nine individuals attended.

Attendees self-report statistics:

- An individual eligible for Medicaid — one attendee
- Five attendees were interested parties
- 32 attendees were Medicaid enrolled providers
- 16 attendees were State agency staff

Attendee rating of the current Connecticut substance use disorder (SUD) treatment system:

- Excellent — four attendees
- Good — 27 attendees
- Fair — 31 attendees
- Poor — two attendees
- Of those who rated the system “excellent” — two were providers and two were State agency staff
- Of those who rated the system “poor” — one was a provider and one was a State agency staff

Attendee reported ability to access the current Connecticut SUD treatment system:

- I do not know how to access SUD services — two attendees
- I know how to access SUD services — 52 attendees
- Of those who said they did not know how to access treatment — one was a State agency staff and one was an interested party (our interpreter).

For the question “Connecticut Medicaid covers the following substance use disorder treatment services, check all that apply:

A. Outpatient Services

B. Outpatient services with withdrawal management (detoxification) services

C. Medication for addiction treatment (e.g., buprenorphine, methadone, and naltrexone)

D. Intensive outpatient and partial hospital treatment

E. Residential treatment

F. Residential treatment for withdrawal management (detoxification)”

- Of those who selected less than six, there was variation in what people knew for Medicaid covered SUD services — some included residential in their response, some did not.
- 36 people selected all six (the full continuum)
- Seven people selected five
- Six people selected four
- Three people selected three
- Two people selected one – both selected “residential” for this answer, both respondents were State agency staff

Feedback:

1. Process:
    a. This has been an amazingly inclusive process with lots of back and forth. We are appreciative of this. We hope that we are able to continue this process in future design processes.
    b. We wish that the intensive outpatient rate development was as inclusive as the residential rate development.
    c. Everyone has been focused on person-centered and recovery-oriented care. The opportunity to work with the State, Advanced Behavioral Health, and Beacon has been excellent. Everyone is collegial and recovery-oriented. It is much appreciated.
    d. The providers want to give credit to the State agencies on the collaboration and believe we have reached a better outcome because of it. This process should be a model of how changes to the Behavioral Health system should embark on changes. The work that happens next, we encourage continued collaboration. Inflation and workforce have affected the providers’ ability to implement the American Society of Addiction Medicine (ASAM) but the implementation is so far working well. Outpatient, intensive outpatient, and partial hospitalization need to have the same level of collaboration to get a good outcome.
    e. The State agency partners expressed appreciation for the openness and collaboration of the process. The Judicial Branch of the Court Support Services Division acknowledged that there has been lots of consideration for the judicial and corrections population. A few of the State agencies participated in a regional justice opioid initiative conference and there we heard that hiring qualified licensed staff is a concern in other states as well. We should recognize workforce issues wherever we can and work together to resolve these.

2. Workforce:
    a. We underestimated how difficult it has been to hire licensed clinical staff, especially for residential staff. We are concerned with the geographical difficulties. It is hard to hire staff in both outpatient and residential settings. The lack of licensed staff will impact the ability to meet the standards, and could impact future audits. The lack of staff has increased pressure on program managers. We ask that State Partners be aware of this.
    b. It has been extremely difficult to hire licensed clinical staff, especially for residential and outpatient settings. There is a concern about how this will impact the ability to meet the standards and future audits. This also places additional burden on the managers of the programs. There are currently vacancies for counselor positions and drug courts that require licensed staff.
    c. Providers have tried numerous recruitment strategies (e.g., sign on bonuses, benefit package revisions, and partnerships with Universities). The struggle with hiring issues are compounding other issues. Vacant counselor positions place pressure on pre-licensure individuals as well as managers and directors.
    d. Workforce recruitment remains a significant challenge because providers are facing incredible competition. It is challenging to meet guidelines and compliance with the workforce issues.
3. Length of Stay:
    a. Please keep an eye on length of stay impact to make sure there's not an inadvertent impact to members and so that quality does not increase.
4. Training:
    a. Training requirements should not duplicate existing training to ensure that there is no duplication of what is already required of staff.
5. Authorization:
    a. Please continue to revisit the authorization process to see if once implementation has passed that processes could be streamlined to further reduce those burdens.
    b. Residential authorizations have been a challenge, but are improving. Concurrent authorizations are the most challenging. Having the same expectations as commercial insurers may be more difficult in Medicaid and make access more difficult.
6. Flex beds:
    a. We recommend allowing providers to flex the level of care that a bed can be certified for. Flexing the beds would allow members to remain in care where they are.
    b. Allowing for flex beds as the length of stay tightens up will keep an individual in treatment for longer periods.
7. Housing:
    a. There is a need to continue building up housing options including sober living and other step-down housing.

8. Diversity, Equity, and Inclusion (DEI):
    a. We encourage the State to combine the SUD waiver efforts with other DEI initiatives to ensure that providers are increasing diversity among licensed staff and leadership. Please loop together the Behavioral Health Partnership Oversight Council DEI subcommittee efforts. Heather Gates will bring that suggestion back to DEI as a participant in that committee.
9. Implementation timelines and flexibility:
    a. Providers recommended continued flexibility from the Department of Social Services (DSS) and the Centers of Medicare & Medicaid Services (CMS) in this program — somewhat concerned that the two year period may not be enough time to meet the goals of the ASAM criteria. A two year implementation timeline may not be long enough to adequately implement ASAM. Providers wanted a commitment from DSS and CMS to hold providers harmless during this period of time should they be audited at a future date. Providers stated that there may need to be continued flexibility from DSS and CMS after that time. The State noted that CMS and DSS require provider compliance with Medicaid requirements and that there is no grace period for Medicaid provider audits. For audits — DSS does not have the authority to waive all quality assurance components; however, the State may be able to have flexibility for some component parts.
10. Licensed Alcohol and Drug Counselors (LADCs):
    a. Will LADCs be covered?
    Response: Yes, they are independent licensed practitioners who we recognize as being able to perform the clinical services within their scope of practice. LADCs are an instrumental part of the new delivery system.