Medicaid Reform for Addressing SUD – Carve Through Approach DRAFT

[INTRO SLIDE]

Thank you for the opportunity to share some thoughts on Medicaid Reimbursement for Substance Use Disorder services. Also, thank you for your service and sacrifice for this great Commonwealth. As you see on the slide, our team provides services across the nation to help build recovery ecosystems.

[FLETCHER GROUP SLIDE]

Background

[SLIDE OF DESPAIR]

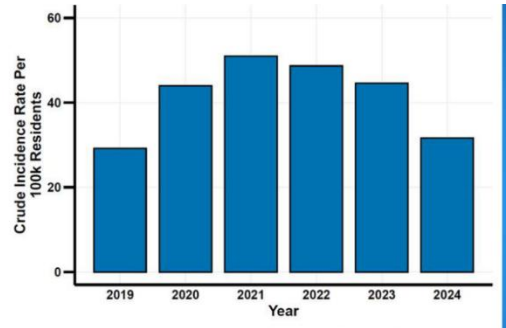
Addiction is a disease of despair, unlike any other chronic disease. For many it destroys connection to family, community—to purpose and meaning, all hijacked by an unrelenting urge.

[SLIDE SHOWING BROKEN FAMILIES, ETC.]

It drives homelessness, broken families, and crime, destroys careers and traumatizes loved ones. It is also a disease replete with comorbidities, some for whom self-treatment led to substance use in the first place. No other disease has this far-reaching impact.

[SUCCESSES SLIDE]

The Commonwealth has made great strides, and we laud you for that. Over the last few years, overdose deaths are down by over 30%. Your efforts of harm reduction and more, have bent this epidemic's deadly curve downward. So, whatever we do, let's not pull back on what created that success.



	2019	2020	2021	2022	2023	2024
N	1307	1983	2298	2196	2018	1434
Rate per 100k	29.2	44.0	51.0	48.7	44.6	31.7
YoY % Rate Change	--	50.7%	15.9%	-4.5%	-8.4%	-28.9%

But let's look deeper into our data to see what remains to be done. The overdose deaths still exceed those of a decade ago and the non-fatal overdoses have not decreased accordingly.

[REMAINING CHALLENGE SLIDE]

In 2024 there were 12,207 nonfatal drug overdose emergency room visits, a 12.8% decrease over 2023. However, there has been an increase among Hispanic and children under the age of 14. The difference between fatal vs non-fatal shows about an 18% gap between deaths and non-fatal overdoses over the last year.

What does that imply? We are saving more lives than we are transforming. That means we have an opportunity to make a more impactful difference.

Also, this data does not include Alcohol Use Disorder. SAMHSA data indicates that 20% of Kentuckians 18 and over have engaged in binge drinking in the past month. And less than six percent of individuals with an SUD receive treatment.

[COST OF SUD CARE SLIDE]

Researchers evaluating Kentucky Medicaid beneficiaries with an opioid use disorder identified over 25,000 Medicaid recipients receiving SUD treatment services. We analyzed Medicaid claims (in another state) data for those with SUD and found that the average medical claims were approximately 8 times greater than for those without an SUD diagnosis. The annual cost with SUD is $24,508; but without SUD it is $3,325 (N=5,135).

Thus, you have an opportunity to make a significant difference, initiate a change that will not only save lives, but transform them while saving money in the long run. I encourage you to be bold and willing to take reasonable risks. The industry has a great deal of data on what works, but we still have not devised a system that incorporates or coordinates effective modalities in a full continuum of care model.

SUD Services: A Holistic Model—Carve Through

Because of the complexities of SUD, we propose a "Carve Through" approach that reflects a Recovery Ecosystem, which blends the resources of clinical services, the social recovery model, and community assets of housing, transportation, employment, and social connections to meet individuals in their readiness to embrace recovery.

So, let me suggest some ideas. Ideas that come from our work across the nation.

Here are a few principles to guide this effort:

[SHOW NATURAL COURSE OF DISEASE SLIDE].

1. Understand the natural course of the disease. We don't address that adequately in our treatment schemata. For example, reuse is a natural part of this disease. Those with SUD have an average of 5 attempts before successful recovery. Also, judgement is impaired. It takes 9-12 months to heal the brain. As shown on the slide, only a fraction of wellbeing is driven by clinical efforts for chronic disease. 75% of affected individuals will eventually recover, we just need to speed the process to provide them with more years to build their lives.

[SHOW THE HRSN SLIDE]

2. A 30-to-60-day residential length of stay is inadequate for healing and long-term recovery. The brain needs to heal, requiring engagement in treatment for at least six months, considered a minimum length of stay for long-term recovery to be successful.

3. Harm reduction is essential but alone does not transform lives for the more severe and costly cases of SUD, approximated 17-20% of the patients with SUD.

[RKY OUTCOMES SLIDE]

4. Social Recovery and Peer support are effective and less costly especially when combined with clinical support. The data from quality evidence-based Recovery Housing shows unmatched effectiveness. And yet we don't reimburse this treatment.

5. Certified Evidence-based Recovery Housing can provide nearly 6 months of care for what it costs for 30 days of clinical inpatient and with better outcomes.

Outcomes Recovery Kentucky 2024

Consistent findings reported over 12-years of annual evaluations conducted by Center for Drug and Alcohol Research at UK.

Outcome Measure	Baseline—At Intake	Follow-up—at 12 months	Relative Change
Illegal Drug Use	89%	11%	-88%
Opioid Use	44%	3%	-93%
Alcohol Use	40%	05%	-88%
Homelessness	32%	4%	-88%
Rearrest	65%	7%	-89%
Anxiety	67%	26%	-61%
Depression	62%	16%	-74%
Suicidal ideation	28%	4%	-86%
Employment	50%	85%	70%

6. Current reimbursement models have perverse incentives. We pay for encounters and we get them; plenty of them. We pay for the lowest level of care which often needs escalating to be effective. The current system invites fraud, and we are getting what we pay for.

[PERVERSE INCENTIVE SLIDE]

7. There is an inherent conflict of interest in providers charting a care plan that will create revenue for them.

8. There is no shared saving or risk to drive value.

9. We have siloed care that impairs meeting the health-related social needs of patients.

10. There are few metrics that measure wellness, resiliency, and recovery capital metrics of efficacy beyond process.

11. There is no proactive effort to engage patients, this is the biggest gap in care. Only a small percentage of individuals with SUD access care.

12. There is no formal collaboration between most providers and criminal justice and yet that is a big cost driver, in both human and fiscal capital related to SUD. Recidivism is still high.

[CJ SLIDE]

Data, you must have data, timely metrics to measure success, allocate resources and manage your program. The legislature is not expected to monitor real-time data, but you should have good data to develop policy, and you don't have that.

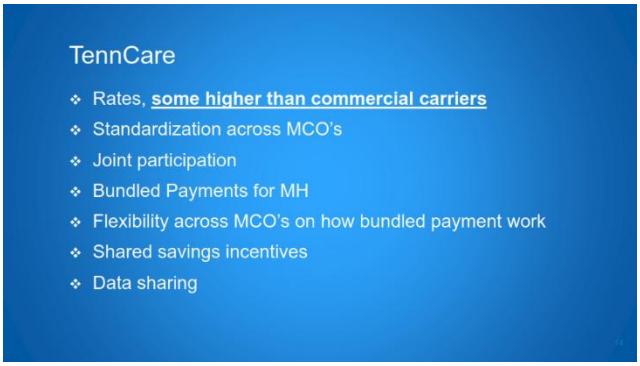
For this presentation, I could not get some data needed to do a more comprehensive look, but we do have some data from DMS which shows that Kentucky spent over $ 1 billion on SUD including Behavioral Health. 4,458 individuals received residential services per month and over 35,000 received MAT.

Thus, what am I suggesting. I don't have a silver bullet, no one does. But my team has some suggestions that come from work around the nation.

[OTHER STATE INTITIATIVES]

A full 'at-risk' model is ideal, but very difficult, especially with relatively small numbers with SUD, whereas shared savings and partial risk models are realistic.

First, we recommend a program that is administered at the MCO level with standard metrics. Data sharing across providers and MCOs with DMS and the legislature in compliance with HIPAA and 42 CFR Part 2. In our conversation with Dr. Victor Wu, CMO of TennCare, standardization is crucial to compare outcomes across MCOs.



[TENNCARE SLIDE]

Secondly, set aside a percentage of expected expenditure based on the usage over the last several years, adjusted for medical inflation to contract with an independent Recovery Coordinator. The set aside for the coordinator may be 8-12% depending on the acuity and cost expectations. These entities will be independent and not a service provider to avoid conflict of interest. Their interest will be driving value.

[COORDINATION SLIDE]

The Recovery Coordinators should be capable of completing these functions:

- Biopsychosocial Assessments & Peer support needs assessment to establish level and type of care
- Patient Advocacy
- Establishing Provider Networks with:. Clinical providers including Telemedicine, and Recovery Houses.
- Establishing relationship with;
    - Criminal Justice including Alternative Sentencing Workers,
    - QRT, EMS, EDs,
    - Barrier Relief and other similar supportive resources,
    - Workforce Development Entities,
    - Foster Care,
    - Childcare resources,
    - Workforce Development Entities and Kentucky Adult Education and other educational resources for job training.

- Overseeing: 1. Level of care coordination, 2. Care Plan development, maintenance, and compliance, 3. Metrics collection and management, 4. Patient advocacy, 5. Education and self-management
- Coordinating with Primary Care and Specialist as referred by Primary Care for co-morbidities.

[COORDINATING FUNCTIONS SLIDE]

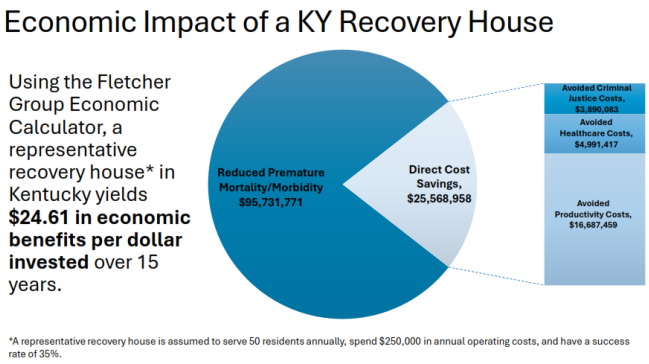
The metrics for patient success might include self-sufficiency, stable housing, meaningful employment, family reunification, healthcare utilization, and justice involvement.

The Recovery Coordinator will be responsible for referral to providers based on the assessments for both the type and level of care. The assessor's team members should be trained in all modalities of treatment and recovery. The providers may be paid by FFS or by a bundled/PMPM rate as negotiated by the Recovery Coordinator and/or MCO, similar to what TennCare does.

[RH ROI SLIDE]

Recovery Housing will be reimbursed on a per diem or weekly basis. Participating Recovery Houses must provide a care plan that is based on the 10 domains of recovery capital and evidence-based programs, e.g. AA or SMART Recovery. They must also be capable of reporting the value-based metrics.

As you can see on the slide, the ROI for Recovery Housing is significant.



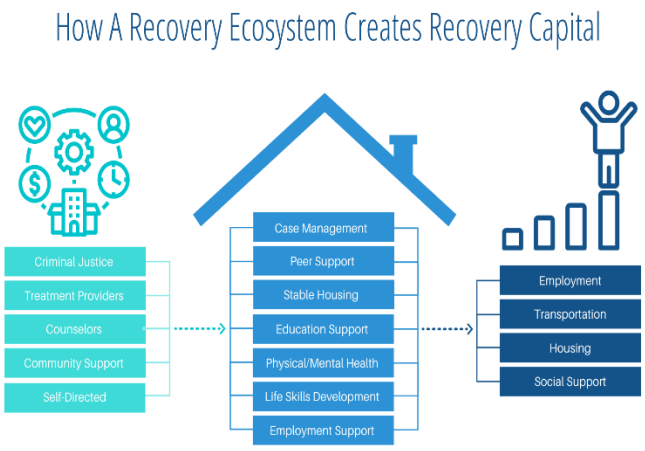
Shared Savings

Some portion of the actuarial cost basis, for example 20% may be withheld for the network, including both the Recovery Coordinator and the providers utilizing bundled payments. The withhold will establish the basis for shared savings and risk. Saving will then be shared across the providers based on participation in the patient's recovery and meeting the established goals. Providers or Recovery Coordinators that are willing to take risks can be provided with a higher upside for shared savings.

Reimbursement and Leveraging other Resources

TennCare has increased their reimbursements rates, some above commercial. This reduces the temptation to provide excess services while also encouraging more provider participation. This would also help pay for the increased work of data collection and collaboration efforts.

How do would we pay for higher reimbursements given the federal cuts and budget challenges? By Carving Through SUD, other funds may be leveraged including Opioid Abatement Funds. Additionally, with the coordination provided by the Recovery Coordinators other funds, such as SUD, Federal Transportation funds, Childcare grants and resources, Workforce Investment Opportunity Act funds for workforce training and employment support may be leveraged to provide the full continuum of care.



The funds used to support this will help establish a sustainable model that provides the full continuum of care essential for building recovery capital that rebuilds lives.

[RECOVERY CAPITAL SLIDE]

We have talked about tearing down silos for years. Building on your success here lies an opportunity to expand your work and provide a continuum of care that will change lives, rebuild families, create stronger communities and make safer streets.

I want to ask our CEO, Dave Johnson, to make a few comments and then we will be glad to take questions.