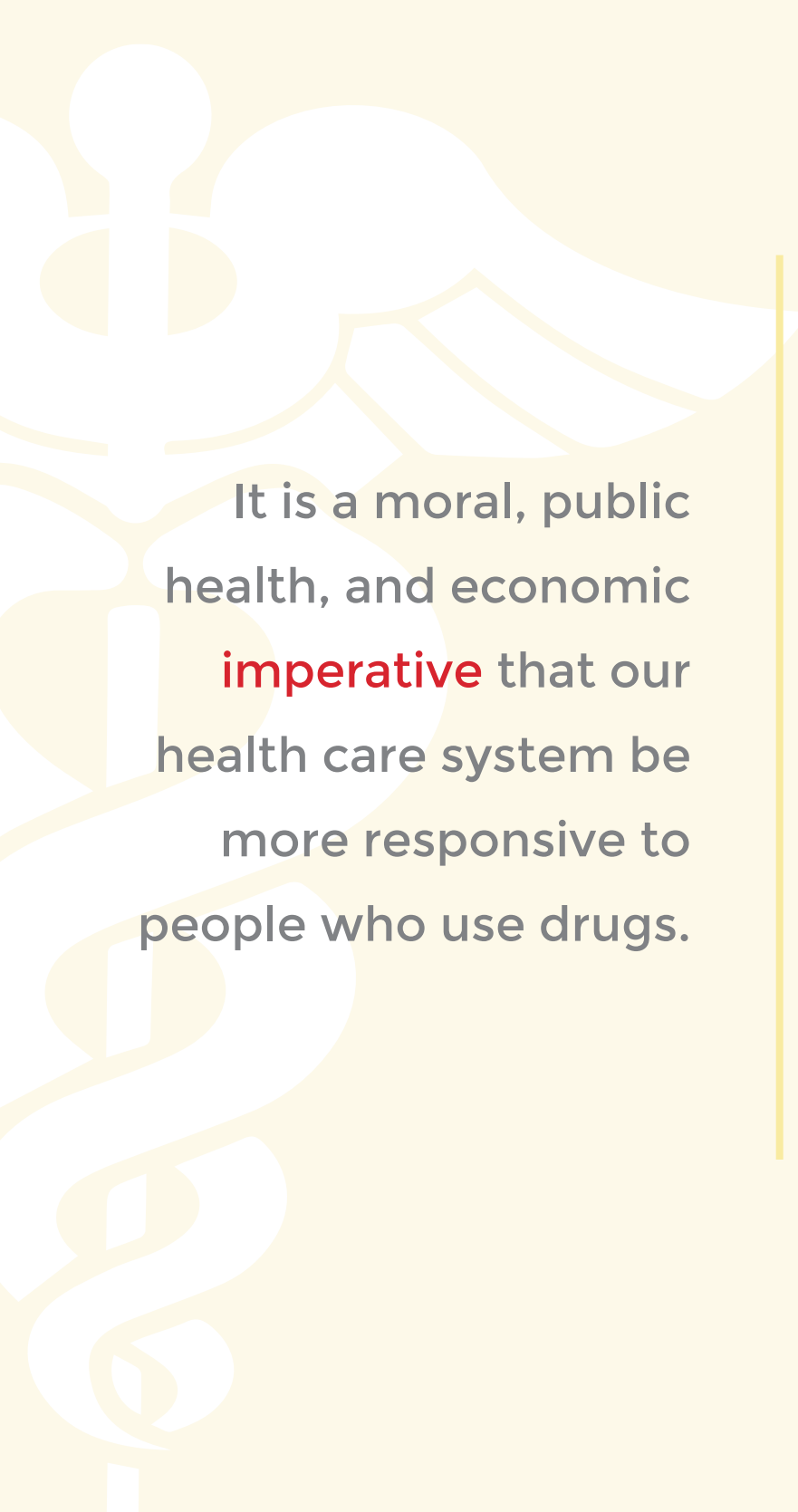




MODERNIZING PUBLIC HEALTH
TO MEET THE NEEDS OF PEOPLE WHO USE DRUGS

Affordable Care Act Opportunities



It is a moral, public health, and economic **imperative** that our health care system be more responsive to people who use drugs.

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Introduction

THE PUBLIC HEALTH CRISIS

It is a public health, economic, and moral imperative that our health care system be more responsive to people who use drugs. Fragmented services, insufficient coverage and financing for behavioral health and harm reduction services, and stigma related to drug use create significant barriers to vital prevention and health care services for people who use drugs. This broken system has contributed to alarming increases in rates of infectious disease and overdose-related deaths. Rates of HIV infection and viral hepatitis are substantially higher among persons who use drugs than among persons who do not.¹ Opioid use in particular in the United States is at epidemic proportions. The federal government has recognized this crisis and developed strategies that marshal resources across federal agencies, including through the *Action Plan for the Prevention, Care & Treatment of Viral Hepatitis (2014-2016)*² and the *2014 National Drug Control Strategy*.³ Most recently, the Office of National Drug Control Policy announced a *High Intensity Drug Trafficking Areas Program*,⁴ which supports public health and public safety partnerships across 15 states. Federal efforts that emphasize a multi-sector approach to the public health crisis of drug use, in turn, support state efforts to engage public health, health care systems and payers, law enforcement and community-based organizations in innovative state and local programs and activities. This crisis — coupled with limited federal and state resources for drug user health programs and services — has made leveraging the Affordable Care Act (ACA) and partnerships with broader health systems and payers even more critical.

Public Health Crisis for People Who Use Drugs

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47,500 people in the U.S. were diagnosed with HIV in 2010, with **8%** acquiring HIV as a result of injection drug use.

In 2013, there were an estimated **30,000** cases of acute HCV in the U.S., with a growing number of those cases among young people who inject drugs

Drug overdose is the number one cause of injury-related death in the US.

Between 2002 and 2013, the rate of heroin-related overdose deaths nearly **quadrupled**, with 8,200 deaths in 2013

¹ *Surveillance for Viral Hepatitis — United States, 2011*, Centers for Disease Control and Prevention (2015), available at <http://www.cdc.gov/hepatitis/statistics/2011surveillance/commentary.htm>; Belani, H., et al., *Integrated Prevention Services for HIV Infection, Viral Hepatitis, Sexually Transmitted Diseases, and Tuberculosis for Persons Who Use Drugs: Summary Guidance from CDC and the U.S. Department of Health and Human Services*, Morbidity and Mortality Weekly Report (MMWR), Centers for Disease Control and Prevention, 61(RR05): 1-40 (2012), available at: <http://1.usa.gov/10SZvC0>

² *Action Plan for the Prevention, Care, & Treatment of Viral Hepatitis 2014-2016*, Department of Health & Human Services (2014), available at: <https://www.aids.gov/pdf/viral-hepatitis-action-plan.pdf>

³ *2014 National Drug Control Strategy*, Office of National Drug Control Policy, available at: <https://www.whitehouse.gov/ondcp/national-drug-control-strategy>

⁴ *High Intensity Drug Trafficking Areas Programs*, Office of National Drug Control Policy (2015), available at: <https://www.whitehouse.gov/ondcp/high-intensity-drug-trafficking-areas-program>









The National Alliance of State & Territorial AIDS Directors (NASTAD) and the health department members it represents have long been concerned about the role of substance use in the transmission of HIV and hepatitis, health outcomes for people living with HIV and hepatitis with substance use disorders, and the need to address the structural and policy barriers to effectively address the needs of this population.⁵ Health departments play an essential role in assuring that drug user health services are included in ACA implementation and broader health care systems and covered by new payers, including through collaboration with state agencies that oversee Medicaid and insurance as well as community-based organizations and stakeholders.

DEFINING DRUG USER HEALTH

Before assessing ACA-related opportunities to improve prevention and care for people who use drugs, we first sought to define the scope of services that encompass “drug user health.” At the heart of this service set is an underlying harm reduction philosophy that emphasizes “meeting people where they are.” Providing services and support that address the structural and social barriers that may underlie use of drugs instead of a “treatment only” approach is what engages individuals to seek and return for services from compassionate and competent providers. The philosophy can be summed up in one sentence found on buttons and stickers at harm reduction organizations across the country: “Be nice to drug users.” The types of services that make up drug user health are expansive and run along

⁵ *Minimizing Harm, Maximizing Health*; Policy Statement, NASTAD (2015), available at: <https://www.nastad.org/sites/default/files/MHMH-Drug-User-Health-Toolkit-FINAL.pdf>.

DRUG USER HEALTH SERVICES CONTINUUM

SERVICE ENTRY POINT/GATEKEEPER	SERVICES TO PREVENT INFECTIOUS DISEASES	ADDICTION AND OVERDOSE TREATMENT: OUTPATIENT	ADDICTION TREATMENT: INPATIENT
<ul style="list-style-type: none"> Insurance application and enrollment assistance Navigation and linkage of social, housing, and supportive services Navigation and linkage to clinical care 	<ul style="list-style-type: none"> HIV testing HCV testing Syringe and paraphernalia exchange Education on safe injecting practices 	<ul style="list-style-type: none"> MAT Naloxone Outpatient individual and group counseling 	<ul style="list-style-type: none"> Hospital stay Inpatient mental health or SUD treatment
 PROVIDER TYPES Navigator, Certified Application Counselor, case manager, community health worker, peer navigator	 PROVIDER TYPES Case manager, nurse, community health worker, peer navigator	 PROVIDER TYPES Pharmacist, physician, social worker, case manager, peer navigator	 PROVIDER TYPES Physician, psychiatrist
 PRIMARY SETTING Community	 PRIMARY SETTING Community	 PRIMARY SETTING Community and Clinical	 PRIMARY SETTING Clinical

a continuum of community-based services that are often less intensive and occur in community settings to clinical services that include more intensive inpatient and outpatient substance use and behavioral health services primarily provided in clinical settings.

This paper focuses on ACA-related coverage opportunities for the community-based services at the beginning of the continuum and is not intended to address clinical addiction and behavioral health services (though there are many opportunities to expand access to those critical services through the ACA as well). Because of the importance of community-based services and providers in the provision of culturally competent services for people who use drugs and because these types of services are not traditionally covered by public and private payers, this paper highlights the innovative models that integrate these services and providers into broader health systems.

DRUG USER HEALTH SERVICES AND ACA OPPORTUNITIES

Through a significant expansion of Medicaid and private insurance coverage, coupled with *new coverage requirements*⁶ for prevention, mental health, and behavioral health services, the ACA provides unprecedented opportunities for a coordinated, health system-wide approach to drug user health for people living with and at risk for HIV and/or HCV. This changing health care landscape comes at a time when many states have faced decreases in HIV prevention funding, making the need to take advantage of new funding streams and opportunities that support HIV and HCV prevention and care efforts — including harm reduction and drug user health services for people who inject drugs — through the ACA

The harm-reduction philosophy can be summed up in one sentence: “Be nice to drug users.”

essential to the sustainability and relevance of these services. Though the examples included below highlight innovative approaches that can be implemented in Medicaid and non-Medicaid expansion states alike, the reality is that in states that have not yet expanded Medicaid, a significant portion of non-disabled, low-income adults are simply left out of ACA reforms. Until every state expands Medicaid, the ability of statewide systems of prevention and care to respond to the public health crisis of the opioid epidemic will be limited.

RESEARCH METHODS

This paper was supported by a generous grant from the Elton John AIDS Foundation. The paper highlights best practices from eight states — California, Colorado, Hawaii, New Mexico, New York, North Carolina, Rhode Island and Washington — chosen to reflect diversity in Medicaid expansion uptake, political landscape and geography. Research for this paper included analysis of state legal/regulatory schemes, Medicaid benefits, and payment and delivery reform structures and opportunities. The research team also conducted phone interviews with representatives from the state health department HIV, viral hepatitis, and drug user health programs, community-based harm reduction organizations, hospital community health programs, and Medicaid managed care plan representatives.

⁶ *Health Reform Issue Brief: Essential Health Benefits (EHB)*, NASTAD (2013), available at: <https://www.nastad.org/sites/default/files/HCA-Brief-ACA-EHB-May-2013.pdf>

Policy Themes

As millions of Americans continue to gain access to public and private insurance through the ACA, the health system must also adapt and innovate to provide quality, cost-effective care. These efforts have meant increased attention to prevention, including ensuring that the health system is responsive to social determinants of health. As state and local policymakers confront a growing opioid epidemic, increasingly, reforms are addressing the needs of people who use drugs. State Medicaid programs, public health programs, and safety net hospital systems have been at the forefront of creative payment and delivery reforms that have included community-based drug user health services in new ways. Pushing broader health systems to be accountable for meeting the prevention and health care needs of people who use drugs has been challenging, and public health government and community stakeholders have had to address political opposition to drug user health services, a legal and regulatory environment that continues to criminalize syringe access and stigmatize people who use drugs, and a health care system that historically has not been inclusive of harm reduction and other community-based services. Successful strategies have depended on building broad coalitions, identifying Medicaid champions, and helping to educate providers and insurers alike on the benefits of inclusion of drug user health services into coverage options.

The policy themes below highlight some of the innovative ways that states are incorporating community-based drug user health services into health systems and payers, particularly through Medicaid. Successful strategies have leveraged statewide efforts to reform payment and delivery systems — through expansion of Medicaid managed care, integration of physical and behavioral health, and implementation of Medicaid State Plan Amendments or waivers that allow states to cover new services. Please refer to the Appendix for a reference guide to the various policy mechanisms discussed in this paper.

The following are key themes and innovative best practices identified in intensive state research in eight states.

As millions of Americans become insured through the ACA, the health care system must adapt to provide quality care.

1 *It is critical to build coalitions, engage broad stakeholders, and participate in new decision-making tables and forums*

To move broader health systems to take ownership of and responsibility for drug user health in new ways, public health and community stakeholders have forged partnerships and relationships with Medicaid programs, health care financing stakeholders, and hospitals. States are implementing a range of large-scale payment and delivery reforms, and finding the appropriate decision-making tables that shape the types of services and providers included and the health outcomes that will be prioritized are critical to ensure drug user health perspectives and voices are included in the process.

HEALTH FRAMEWORK

SPOTLIGHT California



As the most populous state in the United States, California's public health and health care bureaucracy and infrastructure are complex. Responsibility for drug user health falls across multiple agencies and requires a great deal of communication and coordination. At the state Department of Public Health, the state's Viral Hepatitis Prevention Coordinator works closely with the Injection Drug User Specialist in the Office of AIDS. Both of these public health department officials, in turn, work closely with a Psychiatric and Substance Use Disorder Pharmacist at the Department of Health Care Services (DHCS), the agency that oversees the state's Medicaid program, Medi-Cal, along with the state's alcohol and drug programs. Working together, they work within a **drug user health framework**⁷ that helps to guide the state's work. The framework outlines a culturally competent approach to drug user health that ensures drug users are empowered to protect their health and receive quality care. It includes a list of services and policies that are important for drug user health, including overdose prevention, access to safe injection equipment, access to medication assisted therapies such as methadone and buprenorphine, HIV and HCV testing, utilization of drug users as peers, and provider training. The framework was developed in close collaboration with community-based organizations serving IDUs, including syringe exchange programs.

Health department staff participate in a state-level, inter-agency overdose work group, which identifies policy and program approaches to preventing overdoses and overdose deaths. As members of the work group, the Viral Hepatitis Prevention Coordinator and Injection Drug User Specialist contributed substantive changes to draft Medical Board of California pain management guidelines by suggesting an added emphasis on co-prescription of naloxone with along with opioid prescriptions. Co-prescription programs encourage prescribers to offer patients a prescription of naloxone for home use at the same time patients receive a prescription for an opioid, especially for patients at high risk for accidental overdose. In addition to participation in the work group on naloxone co-prescription, health department staff participate in a work group promoting awareness of a new law, **Assembly Bill 1535**⁸ (Chapter 326, Statutes of 2014), which established a state-wide protocol allowing pharmacists to dispense naloxone to the friends and family members of people who might be at risk for an overdose. Health department staff also collaborate with pharmacists to promote a new law allowing for statewide sale of an unlimited number of syringes without a prescription.

The health department has also been involved in several Medicaid stakeholder opportunities with DHCS as the state's Medi-Cal program develops a number of coverage and payment and delivery reforms that could

⁷ Addressing HCV through a Drug User Health Framework, California Department of Public Health, available at: <http://bit.ly/1FLBTNP>

⁸ Assembly Bill No. 1535 Pharmacists: naloxone hydrochloride, California Legislative Information (2014), available at: <http://bit.ly/1wog7X5>

impact behavioral health and substance use disorder services. In particular, health department staff have leveraged a *DHCS Stakeholder Engagement Initiative*⁹, which provides a formal process for stakeholders to provide input on a *number of subjects*¹⁰ on an ongoing basis. Opportunities include:

1. Participation in subject specific workgroups, committees and panels

By participating in various DHCS stakeholder work groups regarding substance use disorder delivery system reform, health homes for people with chronic conditions, supportive housing, and the 1115 waiver, health department staff had the opportunity to provide input on the behavioral health services component of the state's 1115 waiver; identify strategies to promote supportive housing for people experiencing chronic homelessness and repeat hospitalizations; and explore opportunities to better integrate community health workers serving IDU populations into health home models.

2. Comment submission during public comment periods

Health department staff found that persistently submitting comments during public comment periods led to invitations to participate in relevant work groups which, in turn, provided an opportunity to inform the development of programs and initiatives at the state level.

3. Relationship building

Through participation in stakeholder groups, health department staff are able to build relationships across programs and agencies to strengthen internal collaboration, which is particularly important for those subjects for which there may not be a single coordinating body, for example on drug user health-related services and initiatives.

⁹Stakeholder Engagement Initiative, California Department of Health Care Services (2015), available at: <http://www.dhcs.ca.gov/provgovpart/Pages/StakeholderEngagement.aspx>

¹⁰Stakeholder Engagement by Subject, California Department of Health Care Services (2015), available at: <http://www.dhcs.ca.gov/provgovpart/Pages/Stakeholder-Directory.aspx>

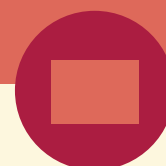
2 *Insurance navigation and enrollment assistance from trusted community providers is crucial to connecting hard-to-reach and vulnerable populations to new ACA coverage*

People who use drugs may avoid traditional health care providers because of stigma and law enforcement concerns, making community providers and syringe services programs an essential link between this population and access to health care and health insurance. The ACA provides unprecedented expansion of access to public and private insurance; however, without targeted outreach and navigation efforts, there is no guarantee that the people who are eligible for and serve to benefit the most from access to insurance, will enroll. Engaging harm reduction providers — including syringe services providers and community-based organizations that serve a large population of people who use drugs — in ACA outreach and enrollment activities is an effective strategy to ensure that this population is able to access insurance and regular medical care. Indeed, states with a robust and longstanding network of syringe services programs and providers have a built-in mechanism to launch insurance enrollment and education activities targeting people who use drugs.

The ACA creates streamlined, consumer-friendly processes that allow applicants to apply for multiple coverage options (e.g., Medicaid and federal subsidies to purchase private insurance) at the same time. To help consumers understand their new options and to apply for and enroll in appropriate coverage, the ACA includes a number of consumer assistance programs and resources. Many HIV/AIDS state health department programs and community-based providers have either become or developed successful partnerships with a number of ACA assister entities – including Patient Navigators and Certified Application Counselors. These early experiences with ACA enrollment efforts provide important lessons learned for successful partnerships and an opportunity to expand existing work to drug user health programs and organizations (see *NASTAD's Issue Brief on ACA Outreach, Eligibility, and Enrollment*¹¹).

ENROLLMENT EFFORTS

SPOTLIGHT | Colorado



Colorado has embraced the ACA's coverage expansion, opting both to expand Medicaid and to operate a state-based Marketplace, *Connect for Health Colorado*.¹² Nearly 182,000 Colorado residents who couldn't previously qualify for Medicaid can now do so due to the state's expanded Medicaid program. In addition, in July 2015, Connect for Health Colorado released an *enrollment update for 2015 with data through the end of June*,¹³ placing enrollment numbers at 138,502. Sixty percent of individuals in QHPs purchased through the Marketplace were eligible for premium subsidies. Colorado had a very successful inaugural enrollment period, where the state's uninsured rate dropped from 17% before the 2014 ACA open enrollment period to 11% after open enrollment, according to *Gallup*.¹⁴

To ensure that enrollment efforts included people who use drugs, the Colorado Department of Public Health and Environment engaged the Harm Reduction Action Center (HRAC), a community-based syringe services and harm reduction provider. Staff at HRAC have worked to educate clients about what insurance coverage means and how to enroll. The advantage of having enrollment done at centers such as HRAC instead of centralized state-run application centers is that community-based organizations already have an existing relationship with clients. When people come in for other services such as needle exchange or HIV testing they can be asked if they want to sign up for QHPs or Medicaid. Colorado Medicaid supports these enrollment efforts and sends Medicaid enrollment workers to HRAC every week to directly enroll clients. Embedding Medicaid enrollment staff at community-based organizations takes pressure off of overburdened staff, freeing them up to focus on the harm reduction and other drug user health services needs of clients. Another benefit of signing up at HRAC is that individuals who enroll can receive mail at the agency. Medicaid cards can be immediately sent to clients at the organization's address, and HRAC is able to make copies of cards as well. This is particularly important for the homeless, for whom lack of a stable address is often a significant barrier to enrolling in public programs. The mobilization of Colorado's syringe services provider network to ensure ACA outreach and enrollment efforts included people who use drugs is testament to the importance of a legal and regulatory scheme that supports clean syringe access and the other drug user health services these types of organizations provide.

¹¹ *Health Reform Issue Brief: Outreach, Eligibility, and Enrollment*, NASTAD (2013), available at: <https://www.nastad.org/sites/default/files/HCA-Outreach-Brief-July-2013.pdf>

¹² *Connect for Health Colorado* (2015), available at: <http://connectforhealthco.com/>

¹³ *Marketplace Dashboard (Ending June 2015)*, Connect for Health Colorado (2015), available at: <http://bit.ly/1Lb8tT7>

¹⁴ *Witters, Dan, Arkansas, Kentucky Report Sharpest Drops in Uninsured Rate*, Gallup (2014), available at: <http://bit.ly/1r9ej0k>

3 Public health programs and community-based organizations have an important education role to play to ensure increased access to naloxone

Naloxone (also known as Narcan) is an opioid antagonist used to reverse the effects of an opioid (e.g., heroin or morphine) overdose. Naloxone is available both as an injection and an intranasal spray and has been an increasingly important tool in community efforts to reduce overdose deaths (see [Harm Reduction Coalition Resources on Naloxone](#)¹⁶). To increase access to naloxone to the people who need it most, state and local efforts have focused on changing laws and policies to expand prescribing rights for naloxone and increase availability through pharmacies, community-based organizations, and law enforcement officers. The ACA has the potential to expand access to naloxone by expanding access to a financing mechanism – through Medicaid and QHPs – for the increasingly expensive medication (see table below). The majority of state Medicaid formularies include naloxone and the ACA Essential Health Benefits requirements reinforced this trend through inclusion of “opioid antagonists” as one of the classes of drugs for which QHPs and Medicaid expansion benefits must demonstrate adequate coverage (see [NASTAD Health Reform Issue Brief: Essential Health Benefits](#)¹⁷).

Despite widespread availability of naloxone on formularies, prescribing limitations and provider and pharmacy unwillingness to prescribe or stock naloxone have created significant barriers to widespread access. The state examples below have marshaled public health expertise to assist in pharmacy and provider training and education to ensure that naloxone is easily accessible.

U.S. Pharmacopeia (USP) Guidelines Version 5.0*

(USP Guidelines are used to determine compliance with the ACA Essential Health Benefits pharmacy benefit requirement; QHPs and Medicaid expansion benefits must have same number of drugs per category/class as the [state’s benchmark plan](#)¹⁵)

Category	Class
ANTI-ADDICTION/ SUBSTANCE ABUSE TREATMENT AGENTS	Alcohol deterrents/ anti-craving
ANTI-ADDICTION/ SUBSTANCE ABUSE TREATMENT AGENTS	Opioid Reversal Agents This class includes Naloxone (brand names include Narcan, Narcon, Narcotan), Naltrexone, Vivitrex
ANTI-ADDICTION/ SUBSTANCE ABUSE TREATMENT AGENTS	Smoking cessation agents

**Note: version 5.0 of the USP Guidelines, which are the guidelines that govern current EHB and Medicaid expansion benefits requirements, do not include medication assisted therapy; version 6.0 does include these therapies.*

¹⁵ Information on Essential Health Benefits (EHB) Benchmark Plans, Centers for Medicare & Medicaid Services (2015), available at: <https://www.cms.gov/ccio/resources/data-resources/ehb.html>

¹⁶ Understanding Naloxone, Harm Reduction Coalition (2015), available at: <http://harmreduction.org/issues/overdose-prevention/overview/overdose-basics/understanding-naloxone/>

¹⁷ supra note 6.

Naloxone Distribution Financing¹⁸

Service	Financing Mechanism
Provider training & education	Public health funding
Community training & education	Public health funding
Patient education upon distribution (educational handout)	<p>Medicaid may cover the provider’s time in training and educating patients (varies by state; limitations apply, e.g. will only cover education done by pharmacists)</p> <p>Medicaid covers Screening, Brief Intervention & Referral to Treatment (SBIRT), to counsel clients on how to recognize overdose and how to administer naloxone (varies by state; limitations apply, e.g., only certain provider types may bill for this service)</p>
Medication <ul style="list-style-type: none"> Naloxone (can be injected intramuscularly, intranasally, or with an auto-injector) 	Included in most formularies and in the EHB drug count classification system; however, take-home naloxone is not covered by Medicaid or insurance in every state (only covered for direct administration in medical settings)
Devices <ul style="list-style-type: none"> Atomizer Auto-injector 	Currently, this atomizer does not have a national drug code (NDC), an identifier that state Medicaid and insurance regulations require for reimbursement (though some states allow reimbursement following an exceptions process). The auto-injector does have a NDC identifier and is covered by many Medicaid programs and insurance plans.

HARM REDUCTION

SPOTLIGHT | New Mexico

New Mexico’s statewide **Harm Reduction Program (HRP)**¹⁹ was created in 1998 and is part of the Department of Health’s Infectious Disease Bureau. The HRP focuses on preventing the spread of hepatitis C, HIV, and other blood-borne pathogens by providing syringe exchange and related harm reduction services. These services are provided by community-based organizations and regional New Mexico Department of Health Public Health Offices. These organizations also provide overdose prevention training for opiate users as well as training for personnel that prescribe naloxone, a set of services and expertise that are now in demand for New Mexico’s Medicaid managed care plans as naloxone access through Medicaid has expanded.

In June 2014, New Mexico’s Medicaid program — called Centennial Care — announced that the four Medicaid Managed Care Organizations (MCOs) in the state as well as the fee-for-service system would cover “naloxone rescue kits,” which include medication, naloxone syringes (both for intramuscular or intranasal use) as well as the nasal atomizer. The coverage of naloxone by Medicaid has eased what was becoming a significant financial burden on public health funding, as costs for the drug have more than doubled in the last year.

Expanded Medicaid coverage has been coupled with a push to expand the types of providers able to prescribe and distribute naloxone. Recently, the New Mexico Board of Pharmacy added a regulation to the New Mexico Administrative Code adding pharmacists to the list of providers in the state who can prescribe

¹⁸ *Instructions for Healthcare Professionals: Prescribing Naloxone, Prescribe to Prevent*, (2015), available at: http://www.wsha.org/files/257/prescribetoprevent_naloxone_instructions1_2.pdf

¹⁹ *Harm Reduction Program*, New Mexico Department of Health (2015), available at: <http://nmhealth.org/about/phd/idb/hrp/>

naloxone rescue kits after undergoing appropriate training. All pharmacists registered and practicing within New Mexico may prescribe naloxone under a protocol developed by the New Mexico Board of Pharmacy (*Pharmacists Prescriptive Authority of Naloxone Rescue Kit Protocol*²⁰), after successfully completing an approved course of training in naloxone and opioid overdose drug therapy. Training has been provided by the New Mexico Pharmacists Association and by Project ECHO of the University of New Mexico's School of Medicine, through the New Mexico Public Health Division. These last two entities have worked together in previous years on trainings and certification programs for the distribution of naloxone and certification to provide harm reduction services, making them well suited to work with the state to expand training to include pharmacists. The New Mexico Medical Board recently circulated information to all licensed providers in the state, encouraging them to write naloxone prescriptions for their patients on high dose pain medications or who are otherwise at risk of opioid overdose.

Pharmacists who fill naloxone recovery kit prescriptions for Centennial Care-enrolled patients can file claims and be reimbursed for dispensing the kits. What is less common is that Medicaid will also pay for the patient education that pharmacists must provide when prescribing a kit. Effective April 1, 2014, participating pharmacies can submit claims to all four managed care organizations (Presbyterian, Molina, Blue Cross and Blue Shield, and United Health Care). The ability to bill for patient education may be a reason pharmacy willingness to prescribe naloxone has been higher in New Mexico than in other states. The cost of the education is incorporated into a bundled rate, which covers the drug and the education component. Bundling these services together was intended to allow New Mexico to overcome the barrier described above posed by covering the atomizer. Instead of being included directly in the bundled rate, additional revenue in the bundled rate would have allowed purchase of the atomizer at no or low cost. Unfortunately, because the bundled reimbursement rate is so low, pharmacists still have to charge for the atomizer.

In addition, while billing for the education associated with naloxone distribution has helped pharmacies to expand access to the drug, community-based organizations and public health offices are not able to bill Medicaid for the education component and may only bill for the actual distribution of the kit. Those community-based organizations who are contracted with the HRP to provide overdose and naloxone administration education can invoice the HRP for the education component.

²⁰ *Pharmacist Prescriptive Authority of Naloxone Rescue Kit Protocol*, New Mexico Regulation & Licensing Department (2015), available at: <http://bit.ly/1iAJcgh>

NALOXONE AVAILABILITY

SPOTLIGHT | California



There are similar efforts in California aimed at expanding availability of naloxone through pharmacies. Naloxone has been included on the Medi-Cal formulary in both its intramuscular and intranasal forms since **March 2014**.²¹ Reimbursement for the nasal atomizer remains a challenge in the absence of a National Drug Code (NDC) identifier and need for an approved **Treatment Authorization Request (TAR)**.²² A new state law, **AB1535**,²³ established a state-wide protocol to furnish naloxone directly without a prescription from a physician. California is in the process of implementing this law, and health department staff, the Board of Pharmacy, the Medical Board, and related provider organizations are collaborating to ensure that the public, providers, and pharmacists are aware of and educated about the law and are able to provide access to take-home naloxone. The California State Board of Pharmacy, with joint approval by the Medical Board of California, worked to develop a set of **protocols**²⁴ to implement

²¹ *Improving access to naloxone in California*, Department of Health Care Services, March 11, 2014, available at: http://files.medi-cal.ca.gov/pubdoco/BULLETINS/docs/Letter_22470.1.pdf

²² *Treatment Authorization Request (TAR)*, California Department of Health Care Services, available at: <http://www.dhcs.ca.gov/provgovpart/Pages/TAR.aspx>

²³ *supra* note 8.

²⁴ *Protocol for Pharmacists Furnishing Naloxone Hydrochloride (1746.3)*, Board of Pharmacy — Department of Consumer Affairs California (2014), available at: <http://bit.ly/1Ve9Mxu>

the new state law. Over the course of one year, the Board of Pharmacy convened a number of public meetings to develop the protocols.²⁴ A Psychiatric and Substance Use Disorder Pharmacist and champion with the California Department of Health Care Services provided expert technical assistance to the California Pharmacists Association during the drafting of the bill and was lead in providing recommendations on this process, in consultation with key injection drug use staff at the California Department of Public Health (see the discussion above about state-level collaboration). Once both boards approved the protocols, the Board of Pharmacy initiated a rulemaking process and **adopted**²⁵ the protocols as an emergency regulation. In addition to the Board of Pharmacy and the Medical Board of California, AB 1535 specifically encourages the California Pharmacists Association and the California Society of Addiction Medicine to participate in the process. Additionally, the San Francisco Department of Public Health developed a **naloxone fact sheet**,²⁶ targeting patients and caregivers, illustrating proper use of naloxone and underscoring opioid safety for use in pharmacies.

Work is ongoing to ensure that pharmacists and physicians are aware of the new law. For example, the California Pharmacists Association, accredited by the Accreditation Council for Pharmacy Education (ACPE), offered an hour of Continuing Pharmacy Education (CPE) to pharmacists who participated in a **March Webinar**²⁷ on furnishing take-home naloxone. Even with this important law change, implementation challenges have been significant, particularly with regard to supply acquisition and third-party reimbursement.

²⁵ *Request for Review and Approval by the Medical Board of California Protocols to Permit Pharmacists to Provide: 1. Self-Administered Hormonal Contraception, 2. Nicotine Replacement Products, and 3. Naloxone Hydrochloride*, California State Board of Pharmacy, January 14, 2015, available at: http://www.mbc.ca.gov/About_Us/Meetings/2015/Materials/materials_20150129_brd-26.pdf

²⁶ *Naloxone Fact Sheet*, San Francisco Department of Public Health—California State Board of Pharmacy (2015), available at: http://www.pharmacy.ca.gov/publications/naloxone_fact_sheet.pdf

²⁷ *Opioid Safety with Naloxone: A Life-Saving Tool for California Pharmacists*, California Pharmacists Association (2015), available at: <https://www.cpha.com/Naloxone>

COMMUNITY EFFORTS

SPOTLIGHT | North Carolina



Community-based harm reduction and drug user health organizations in North Carolina have developed broad coalitions to advance a public health approach to the opioid epidemic.

Leveraging the ACA has been challenging because North Carolina has not yet expanded Medicaid, leaving many of the lowest income residents of the state without access to insurance. Despite this significant challenge, community-based organizations in the state have leveraged Medicaid where possible and built strong community systems and infrastructure to address the needs of the large number of people who use drugs who are uninsured.

Central to this approach are efforts to expand access to harm reduction services and naloxone. North Carolina Harm Reduction Coalition (NCHRC), a community-based harm reduction organization, successfully advocated for SB20 the “911 Good Samaritan/Naloxone Access Law” that went into effect in April 2013 and SB154, the “Clarifying the Good Samaritan Law,” that went into effect June 2015. These laws allow naloxone distribution under a standing order model, enabling a prescribing physician to authorize specified and trained pharmacists and community health care workers to dispense the medication. Under these laws, a practitioner’s standing order may be used to provide naloxone to an individual at risk for an overdose, their friends and family, or another person associated with the individual, also known as third-party access. For instance, NCHRC has a standing order in place under the authority of its Medical Director, and relies on a network of three staff, eight consultants, and more than 100 volunteers to distribute naloxone kits across the state. NCHRC has also focused its outreach to drug users, people on methadone and buprenorphine, people residing in jails and prisons who are about to be released, people residing in drug treatment, and mental and behavioral health providers. These outreach activities include training providers on naloxone and naloxone distribution and

encouraging providers to dispense naloxone to people leaving the facilities. In August 2015, the North Carolina Department of Public Health issued a [toolkit](#)²⁸ for local health departments to assist them in adapting standing orders to distribute naloxone.

In addition to the community-based approach of NCHRC, Project Lazarus has adopted an approach that relies heavily on the state's Medicaid managed care network. Project Lazarus is a non-profit organization that provides technical assistance to community groups and clinicians to prevent drug overdoses and meet the needs of those living with chronic pain. Project Lazarus was established in 2008 in Wilkes County, North Carolina in response to the extremely high rate of drug overdose deaths, which was four times the state's average. Unlike NCHRC's model, which uses private funding and complements, rather than integrates into, Medicaid and clinical systems, Project Lazarus has implemented a medical model for its services.

In 2012 Project Lazarus received a Robert Wood Johnson Community Health Leader grant, which it has used to provide services for people in recovery. Project Lazarus relies on a peer-based model for this work, utilizing Peer Guides who receive 60 hours of certification training and provide a range of services, including life skills coaching, housing and clothing assistance, family reunification support, and other services designed to support former drug users entering recovery. These services are Medicaid reimbursable, [under 1915 waiver authority for home and community based services](#),²⁹ and Project Lazarus is currently seeking to become a certified Medicaid provider so that it may reimburse for these peer services.

As part of its work to prevent overdose through safe opiate prescribing, Project Lazarus also works to expand access to naloxone and to train and educate patients, providers, and the public on its use. Project Lazarus provides kits that include education materials, the naloxone atomizer (used for the intranasal formulation), and the auto-injector. These efforts have included developing innovative financing relationships with Medicaid MCOs in the state.

In 2013 [Community Care of North Carolina \(CCNC\)](#),³⁰ a Medicaid MCO, secured a [\\$2.6 million grant](#)³¹ from the Kate B. Reynolds Charitable Trust and matching funds from the North Carolina Office of Rural Health and Community Care to partner with and expand Project Lazarus. While not a formal Medicaid coverage mechanism for the services Project Lazarus provides, this grant-funding model from a Medicaid managed care plan (often funded through the plan's administrative budget or charitable arm, so somewhat more limited than the other Medicaid-covered services the plan provides) is a creative way to cover community-based services delivered by non-Medicaid community providers. The care management system in North Carolina is accomplished through 14 non-profit networks, integrated into the health departments in each of their counties. Under CCNC, and based on the success of the pilot Project Lazarus initiative in Wilkes County, [community coalitions](#)³² have been established across the state. In addition to establishing community-based coalitions, Project Lazarus at CCNC is also focused on influencing the clinical component of chronic pain management by developing tailored toolkits to guide decision-making and to support providers in safe opioid prescribing. According to Project Lazarus, preliminary evaluation from the University of North Carolina Injury Resource Center shows that communities that have adapted the Project Lazarus model have seen an 18-26% reduction in overdose related emergency room admissions.

The success of the Project Lazarus model has made it attractive to new ACA-related demonstration projects. The Mountain Area Health Center, for instance, was a recipient of a recent Center for Medicare and Medicaid Innovation (CMMI) Health Care Innovation Award aimed at increasing training for providers to reduce unintentional drug overdose. Mountain Area Health Center partnered with Project Lazarus, allowing statewide expansion of the model.

²⁸Adopting Naloxone Standing Orders — Toolkit for North Carolina Local Health Departments, N.C. Department of Health and Human Services (2015) available at:<http://bit.ly/1iAKLul>

²⁹Letter to State Medicaid Director SMDL #07-011, Center for Medicare & Medicaid Services, August 15, 2007, available at: <http://1.usa.gov/1VpJIE4>

³⁰The Community Care Story, Community Care of North Carolina (2015), available at: <https://www.communitycarenc.org/about-us/>

³¹Craver, Richard, \$2.6 million to fund health care initiative Project Lazarus, Winston-Salem Journal, April 19, 2013, available at: <http://bit.ly/1MYNqfd>

³²Project Lazarus: A Community-wide Response to Managing Chronic Pain, CCNC, available at: <http://bit.ly/1NzGCVj>

4 *The ACA's emphasis on holistic care and care coordination in Medicaid provides an opportunity for inclusion of a range of harm reduction and drug user health services that address social determinants*

People who use drugs often have myriad social services, housing, and health care needs that take precedence over substance use treatment. At its core, the harm reduction philosophy is one of “meeting people where they are” and providing non-judgmental and often peer-based support and services that promote health and reduce harm for people who use drugs. This harm reduction philosophy and set of supportive services complements ACA payment and delivery reform models that emphasize care coordination for people with chronic and complex conditions. Medicaid models that emphasize health homes and integration of physical and behavioral health may be strengthened by inclusion of community-based services that meet people who use drugs where they are and link them to the services they need to engage in the health care system. The examples below have successfully integrated harm reduction services into these new models.

MEDICAID EXPANSION

SPOTLIGHT | Hawaii



Hawaii has expanded access to Medicaid through the ACA and has embraced a number of initiatives to improve care coordination for Medicaid beneficiaries with chronic conditions, including mental health and substance use disorders. Ohana Health Plan (a Medicaid MCO in Hawaii), for instance, was awarded a statewide contract to provide behavioral health services to Medicaid-eligible adults who have serious mental illnesses. All Medicaid beneficiaries have access to standard behavioral health services, and those with a serious mental illness have access to **specialized behavioral health services**³⁴ (including case management and care coordination). Ohana provides these services through their **Community Care Services (CCS)**³⁵ program. If a person is eligible for these services, Ohana links the individual to a case manager (through a community agency that has a contract with Ohana) and the agency is compensated for providing these services.

The Hawaii Department of Health STD/AIDS Prevention Branch funds the statewide syringe services program through the community-based Community Health Outreach Work to Prevent AIDS Project (**CHOW Project**)³⁶, a statewide, not-for profit organization and coordinating agency for the statewide syringe exchange program. In addition to syringe services, the CHOW Project provides a range of peer support, hepatitis care coordination, drug treatment linkage, and overdose prevention services. Because a large number of CHOW Project clients are living with a mental illness and eligible for Ohana’s behavioral health services, referral and linkage to these services is integrated into CHOW Project’s program. Ohana’s interest in contracting with community-based agencies for provision of behavioral health services (rather than requiring provision of services by clinical providers) has created opportunities for Hawaii’s strong network of syringe services programs. CHOW Project’s service mix and relationship with the population combined with the high proportion of CHOW Project clients who have a mental illness, makes CHOW Project an excellent partner for Ohana’s behavioral health community services, and CHOW Project has begun conversations with Ohana to become a provider — not only for housing outreach, but the host of care coordination services.

³³Health Care Innovation Awards: North Carolina, Center for Medicare and Medicaid Innovation, available at: <http://1.usa.gov/1RgaLaE>

³⁴Community Forum: Integration and Expansion of Behavioral Health Services for Medicaid Beneficiaries, Department of Health and Department of Human Services (2013), available at: <http://human-services.hawaii.gov/mqd/files/2012/12/AMHD-CCS-presentation-July-29-2013-final.pdf>

³⁵Community Care Services, Ohana Health Plan (2015), available at: <https://www.ohanaccs.com/>

³⁶The Chow Project (2015), available at: <http://www.chowproject.org/>



Section 2703 of the ACA allows states to amend their Medicaid State Plans to establish health homes to coordinate care for Medicaid recipients with chronic conditions. Health home providers are charged with integrating and coordinating all primary, acute, behavioral health, and long term services and supports to treat the “whole-person.” States choose which chronic conditions to prioritize for health, home services, and several states have included mental health and substance use disorders and HIV/AIDS.

MEDICAID HEALTH HOME SERVICES

Comprehensive care management: includes screenings to assess health needs, health literacy, and to develop care plans.

Care coordination: ensures access to all needed services, such as behavioral health services and preventive services.

Health promotion: includes educating patients about the importance of immunizations and screenings, healthy eating and healthy lifestyle.

Comprehensive transitional care/follow-up: for example, support for from inpatient services to other settings.

Individual and family support: includes educating and empowering patients and families to be part of the health team and to make decisions about treatment options.

Referral to community and social support services: includes communication with, and referrals to, other support services such as day care for individuals with disabilities.

Rhode Island was *one of the first states to implement a Medicaid Health Home*³⁷ and one of three states (along with Maryland and Vermont) for individuals with opioid dependency. In Rhode Island, the target population are participants in the state’s Opioid Treatment Program, which is run through the Rhode Island Department of Behavioral Healthcare, Development Disabilities, and Hospitals. The program offers care coordination services to Medicaid enrollees with a substance use disorder, and provides patients with resources to navigate an often-fragmented service delivery system. The target population for Rhode Island’s Medicaid health home program is opioid dependent Medicaid recipients who are receiving or meet the criteria for Medication Assisted Therapy (MAT).

Medicaid beneficiaries are assigned a health home with the ability to opt-out. Health Home participants receiving MAT for opioid dependence are identified through providers or community partner referrals (including the judicial system). Physicians, other health providers, managed care organizations, treatment centers, and criminal justice system professionals have been made aware of the integrated MAT system and referral process through

a variety of means, including websites, emails, community meetings, and provider agreements. All eligible patients currently enrolled in Opioid Treatment Programs are provided a letter explaining health home services and given the opportunity to meet with Health Home team representatives to discuss their options.

Designated providers for these particular health homes must be licensed by the state as a Behavioral Healthcare Organization. In Rhode Island, there is a diverse network of Federally Qualified Community Health Centers (FQHCs) and substance use agencies, which are eligible. Currently, there are five providers with 12 statewide locations. Each health home team is made up of: a supervising physician, a registered nurse, a health home team coordinator, a case manager/hospital liaison, and a pharmacist. There are also three shared positions across health home sites: administrator level coordinator, HIT coordinator, and health home training coordinator. Rhode Island uses a weekly bundled payment with the rate based on whether the member is enrolled in fee-for-service or managed care. The rate is \$87.52 for fee-for-service members and \$52.52 for managed care members.

³⁷ Moses, Kathy & Klebonis, Julie, Designing Medicaid Health Homes for Individuals with Opioid Dependency: Considerations for States, Centers for Medicare & Medicaid Services (2015), available at: <http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/downloads/health-homes-for-opioid-dependency.pdf>

While the health home's emphasis on care coordination creates new opportunities for coverage of linkage and supportive services through Medicaid, a significant challenge is that there are no requirements that Health Homes include community (non-Medicaid) providers in their models, meaning that even if there is a referral process to community-based harm reduction and syringe services programs, there is no mechanism to pay the community-based organization for these services outside of a contractual relationship with the Medicaid provider. Health home programs that have stronger engagement requirements for community-based providers and services may be better able to reach and meet the various needs of people who use drugs.

HEALTH SYSTEM INTEGRATION

SPOTLIGHT | Washington



Washington has embraced Medicaid expansion, implemented its own state-based Marketplace, and has taken steps to implement state-wide payment and delivery reforms that seek to better coordinate care across payers, improve health care quality, and reduce costs. The Health Care Authority, which oversees six contracted health plans within the Medicaid program (Apple Health) is currently preparing to transition Apple Health toward full health systems integration of medical, mental health and substance use treatment services. Prior to this integration — and as is the case in many states — substance use disorder services, mental health services, and physical/medical health services were funded and delivered through different systems. **Optum**,³⁸ the entity that manages the behavioral health benefit for United Health Group, one of the contracted health plans, is responsible for development of the process for integration for United, as well as oversight of the program, once complete. Integration will occur in two phases, the first of which will prioritize integration of mental health and substance use treatment services while the second phase will integrate the behavioral health services with primary physical health services.

As it embarks on this endeavor, Optum is currently working with stakeholders — including syringe services programs — to better understand the populations utilizing and/or in need of Medicaid behavioral and mental health services across the state. Many of these patients are being treated for co-morbid conditions; some may present for substance use treatment but also have an underlying mental health condition that has not been identified. The discussions assist Optum in developing its network, integrating services, and identifying new partnerships that will help Optum continue to provide quality care as it expands the services it oversees.

Conversations with **Point Defiance AIDS Project**³⁹ (PDAP), a syringe services and harm reduction program in Tacoma, Washington, for instance, have helped Optum identify both the needs of potential enrollees as well as the community expertise that may already exist for this population. As PDAP expands its clinical relationships and makes program changes to better emphasize reimbursable services like care coordination and **Screening, Brief Intervention and Referral to Treatment (SBIRT)**⁴⁰, it is in good position to better integrate into the state's Medicaid behavioral health system (either by itself through new payment models being developed or through partnership and pass-through billing with a clinical provider).

In addition, and similar to the North Carolina Medicaid managed care grant model described above, Optum operates a Community Reinvestment Fund, which allows it to allocate funds for community giving initiatives. For instance, the Community Reinvestment Fund has allowed Optum to provide grants to 24 community-based programs that provide services not covered by Medicaid. This is another partnership route for community-based harm reduction organizations.⁴¹

³⁸Optum, UnitedHealth Group (2015), available at: <http://www.unitedhealthgroup.com/businesses/optum.aspx>

³⁹North American Syringe Exchange Network; Point Defiance AIDS Project (2015), available at: <https://nasen.org/>

5 *Hospitals are key partners in addressing the opioid epidemic and increasing access to substance use and drug user health services*

Hospitals have both a financial and community stake in responding to the public health and health care crisis resulting from drug use. Failure to provide community-based harm reduction and drug user health services that meet people who use drugs where they are and help link them to a range of social and health care services results in unnecessary hospitalizations and increased use of emergency rooms. According to the [U.S. Department of Justice National Drug Intelligence Center](#)⁴², estimated annual health care costs related to drug use are \$11 billion. In addition, an estimated two million emergency department visits in 2009 were related to drug misuse or abuse.

Charity care and community benefit programming has been a requirement for the non-profit hospital federal tax exemption since the 1950s.⁴³ In return for a significant tax exemption — researchers estimate that in 2011 the total value of which was \$24.6 billion — non-profit hospitals are required to provide a range of activities to address health care needs of populations who have no other access to care and to improve community health.⁴⁴ While the ACA does not significantly shift how non-profit hospitals are required to meet their community benefit requirements, it does include new community benefit reporting requirements (through [IRS Schedule H](#)⁴⁵ Attachment to Form 990) and requirements to work in partnership with community stakeholders to conduct comprehensive Community Health Needs Assessments every three years. These assessments, in turn, inform how community benefit programs are structured. As access to insurance has expanded through the ACA, there may be opportunities to shift some charity care funding to community health funding, including programs and services that meet the needs of people who use drugs.

Hospitals — particularly safety net hospitals that serve a greater number of uninsured, low-income, and vulnerable populations — have become an essential partner in ramping up services and programs for people who use drugs, through community-based grant programs as well as new Medicaid payment and delivery models.

⁴⁰Substance Use, SAMSHA-HRSA Center for Integrated Health Solutions (2015), available at: <http://www.integration.samhsa.gov/clinical-practice/substance-use>

⁴¹FACT SHEET: Community Giving Programs of Medicaid-Focused Health Plans, Association for Community Affiliated Plans (2009), available at: <http://communityplans.net/Portals/0/ACAP%20Docs/Foundations%20Report.pdf>

⁴²National Drug Threat Assessment, U.S. Department of Justice — National Drug Intelligence Center (2011), available at: <http://www.justice.gov/archive/ndic/pubs44/44849/44849p.pdf>

⁴³Folkemer, Donna, et al., Hospital Community Benefits after the ACA: The Emerging Federal Framework, The Hilltop Institute (2011), available at: <http://www.hilltopinstitute.org/publications/HospitalCommunityBenefitsAfterTheACA-HCBPIssueBrief-January2011.pdf>

⁴⁴Rosenbaum, Sara, et al., The Value Of The Nonprofit Hospital Tax Exemption Was \$24.6 Billion In 2011, Health Affairs (June 2015).

⁴⁵Internal Revenue Service, Schedule H (Form 990), available at: <http://www.irs.gov/pub/irs-pdf/f990sh.pdf>



POPULATION-WIDE PROJECTS

NEW YORK'S PREVENTION AGENDA

Promote Mental Health and Prevent Substance Abuse (MHSA)

- Promote mental, emotional and behavioral (MEB) well-being in communities
- Prevent substance abuse and other mental emotional behavioral disorders
- Strengthen mental health and substance abuse infrastructure across systems

Prevent Chronic Diseases

- Promote tobacco use cessation, especially among low SES populations and those with poor mental health
- Increase access to high quality chronic disease preventative care and management in both clinical and community settings (note: this project targets chronic diseases that are not included in domain 3, such as cancer)

Prevent HIV and STDs

- Decrease HIV morbidity
- Increase early access to, and retention in, HIV care
- Decrease STD morbidity

Because of the populations served by safety net non-profit hospitals and because of the financial stake hospitals have in reducing unnecessary hospitalizations and emergency department visits, they have become a key component of several Medicaid payment and delivery reform models. The Delivery System Reform Incentive Payment (DSRIP)⁴⁶ model, for instance, is part of broader section 1115 Medicaid waivers and have been used to give states the flexibility to incentivize safety net hospitals to work with a range of providers, community-based organizations, and public health entities in a region on a number of identified goals and projects. A key theme in many of these programs — and a prominent part of New York's model — has been an emphasis on population health.⁴⁷

New York's DSRIP program is part of an \$8 billion 1115 waiver approved in April of 2014. The program relies on a number of "Performing Provider Systems" made up of hospitals and other community providers in a geographic area. Upon formation, each Performing Provider System selects from a [list of state approved projects](#)⁴⁸ with associated goals and metrics. New York's program includes a specific emphasis on "population-wide" projects focusing on prevention, and includes several HIV and substance use and treatment integration projects, each of which offer opportunities for collaboration between community-based organizations and hospitals. The HIV projects, for instance, include specific peer initiatives that utilize peers to find and link people into care and navigate the system.

While the opportunity exists for inclusion of community-based harm reduction providers — and while there is good reason to include them in projects aimed at reducing HIV transmission and reducing harms associated with substance use — logistical and implementation hurdles to meaningful inclusion of these types of non-traditional Medicaid providers have been challenging. Small, non-clinical, community-based organizations that cater to niche populations and have little interaction with clinical providers may have difficulty adapting to and engaging with this model unless the state and Performing Provider Systems do a better job of facilitating their inclusion. One community-based organization, for instance, is working with a large safety net hospital on two specific projects — one focused on co-occurring illnesses and connecting individuals to care and the other on primary care HIV and STD prevention and treatment retention efforts. This organization is concerned that as a non-Medicaid and largely non-clinical provider, the only way to negotiate payment is through grant funding, which may not cover the costs of providing intensive services to a high-need population.

Despite these challenges, public health and community stakeholders agree that forging relationships between hospitals and harm reduction and drug user health services organizations through DSRIP and other payment and delivery reforms is essential to developing cohesive systems of prevention and care that address the complex needs of people who use drugs.

⁴⁶Guyer, Jocelyn, et al., Key Themes From Delivery System Reform Incentive Payment (DSRIP), Kaiser Family Foundation (2015), available at: <http://bit.ly/1EtVXNa>

⁴⁷Schafer, Peter and Calvo, Michele, The Integration of Harm Reduction and Healthcare: Implications and Lessons for Healthcare Reform, New York Academy of Medicine (2015), available at: http://www.nyam.org/news/docs/pdf/Harm_Reduction-Report.pdf

⁴⁸New York State Delivery System Reform Incentive Payment Project Toolkit (2015) available at: http://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrp_project_toolkit.pdf

Recommendations for Action

The examples above demonstrate successful policy changes that have leveraged ACA and related health systems reforms to expand access to community-based drug user health services. The states chosen represented a diverse cross-section of political climates, legal/regulatory environment for syringe access, and Medicaid expansion, but despite this diversity, there are several common themes and lessons learned that health departments can use to expand access to these services in their states.

1 *Support a strong legal, regulatory, and syringe access foundation*

Perhaps the most significant finding of this paper is the important role that state and federal laws play in the ability of state public health programs to leverage health systems and payers to improve drug user health. States that have implemented legal and regulatory reforms that allow access to clean syringes and naloxone are in the best position to collaborate with broader health systems, including state Medicaid and Medicaid managed care plans. Robust networks of syringe services programs with deep connections with people who use drugs have been critical in efforts to enroll this population in newly available Medicaid and Marketplace coverage, engage them in preventive services, care, and treatment, and keep them retained in care and out of the emergency department. The public health impact of these types of services and providers is testament to the need to end both state prohibitions on syringe access as well as the congressional ban prohibiting the use of federal funds for syringe exchange. In addition, a legal and regulatory environment that allows expanded prescribing authority for naloxone (including standing orders and third-party prescriptions) helps to leverage the expertise and community reach of pharmacists, community-based organizations, and family members and friends to prevent overdose deaths.

2 *Use new federal payment and delivery reform initiatives to find and influence state policy decision-making tables and make the case for inclusion of community-based services*

As described in the Appendix, there are a number of Medicaid payment and delivery reforms, demonstration projects, state plan amendments, and accompanying federal guidance that allow and encourage state Medicaid programs to provide community-based drug user health services. These

There are several common themes and lessons learned that health departments can use.

materials may assist health department staff in both identifying new opportunities and approaching Medicaid program officials about inclusion of the services that will have the biggest impact on drug user health. Without drug user health stakeholders making the case for inclusion of peer and community-based services, models may prioritize clinical providers and existing Medicaid providers over innovative financing mechanisms for community-based providers.

3 *Mobilize harm reduction organizations and syringe services programs to participate in ACA outreach and enrollment activities*

A critical lesson learned from early ACA enrollment efforts has been the importance of community messengers in ensuring that vulnerable populations know about the new coverage options, understand the benefits of insurance coverage, and are able to apply for and enroll in coverage. Just as HIV-focused community-based organizations, programs, and case managers were instrumental in reaching out to people living with HIV to enroll in expanded Medicaid and Marketplace coverage, community-based harm reduction organizations and syringe services programs are incredible messengers supporting insurance coverage for people who use drugs.

4 *Work with community-based providers to develop relationships with Medicaid MCOs to expand access to naloxone and to support care coordination activities*

The vast majority of Medicaid beneficiaries are covered through Medicaid MCOs instead of traditional fee-for-service arrangements. Community-based organizations should inventory their service mix and assess the value they could bring to a managed care plan, including reducing emergency room visits and engaging and retaining a notoriously hard-to-reach population in preventive services, care, and treatment. Even if community-based organizations are not clinical providers and are not eligible Medicaid providers in their state, there may be opportunities to leverage a MCO's grant-based community giving program or to partner with clinical providers for provision of community-based services. At the state level, there may be opportunities for health department staff to participate in Medicaid managed care uniform contract discussions (the uniform contract is the contract every state Medicaid program has with Medicaid MCOs that governs the types of services the plan must provide, the settings and provider types associated with certain services, and access protection for particular populations).

5 *Approach safety net non-profit hospitals that serve a large proportion of people who use drugs*

Hospitals may be strong allies in efforts to address the needs of people who use drugs. Through community benefit programs, other community health initiatives focused on substance use disorders, and statewide 1115 waivers that implement DSRIP, hospitals are increasingly becoming public health partners in fighting the opioid epidemic. Health departments should assess the community health programs at large hospitals that may serve populations disproportionately impacted by HIV, HCV, and overdose, including community benefit programs and other opportunities to support community-based drug user health services.

Appendix

MODELS FOR COVERAGE OF COMMUNITY-BASED DRUG USER HEALTH SERVICES

PAYMENT AND DELIVERY MODEL	APPROVAL PROCESS	FINANCING MECHANISM	FEDERAL GUIDANCE/ RESOURCES
Medicaid Health Home	State Plan Amendment, submitted to Centers for Medicare and Medicaid Services (CMS)	Varies by state – primarily per member per month amount to health home provider	CMS Medicaid Health Home Resource Page ⁴⁹
Insurance Enrollment and Navigations Services	Application for Navigator/ assister grant or Certified Application Counselor designation (to HHS if federally facilitated Marketplace state and to state Marketplace if state-based Marketplace state)	Grant funded	Find funded Navigators and CACs in your area through the Healthcare.gov Find Local Help Resource ⁵⁰ Access Healthcare.gov Enrollment Training and Resources ⁵¹
Mental Health/ Substance Use Disorder Peer and Community-based Services	State Plan Amendment; 1915(i) Home and Community-Based Services; 1115 waivers States have a great deal of flexibility to cover community-based services and providers through State Plan Amendments. However, there may be instances when states may want to consider a section 1115 waiver, which allows HHS to waive certain federal provisions so that states are able to test innovative policy and delivery approaches areas.	Fee-for-service or per member per month	CMS State Medicaid Director Letter on Medicaid Coverage of Peer Support Services ⁵² and CMS Clarifying Guidance on Coverage of Peer Support Services ⁵³ CMS State Medicaid Director Letter on New Service Delivery Opportunities for Individuals with a Substance Use Disorder ⁵⁴ CMS Guidance on Medicaid Preventive Services Rule Change ⁵⁵ (allowing preventive services to be delivered when recommended by physician or licensed provider instead of delivered by physician or licensed provider)

PAYMENT AND DELIVERY MODEL	APPROVAL PROCESS	FINANCING MECHANISM	FEDERAL GUIDANCE/ RESOURCES
<i>Delivery System Reform Incentive Plan (DSRIP)</i>	1115 waiver	Per member per month; grant funding	Medicaid and CHIP Access Commission, Using Medicaid Supplemental Payments to Drive Delivery System Reform ⁵⁶
<i>Screening, Brief Intervention and Referral to Treatment (SBIRT)</i>	State Plan Amendment	Fee-for-service or per member per month	SAMHSA-HRSA Center for Integrated Health Solutions, SBIRT: Opportunities for Implementation and Points for Consideration ⁵⁷
<i>Insurance Plan Community Foundations</i>	Plan discretion	Grant funded	Check with Medicaid managed care plans in your area to see what types of programs they fund
<i>Non-profit Hospital Community Benefit</i>	Requirement for state and federal non-profit tax exemption; reporting process through IRS tax form 990	Grant funded	IRS, New Requirements for 501(c)(3) Hospitals under the ACA ⁵⁸

⁴⁹Health Homes, Centers for Medicare and Medicaid Services (CMS), available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html>

⁵⁰Find Local Help, Healthcare.gov, available at: <https://localhelp.healthcare.gov/>

⁵¹Training for Navigators, Agents, Brokers, and Other Assistants, Healthcare.gov, available at: <https://marketplace.cms.gov/technical-assistance-resources/training-materials/training.html>

⁵²State Medicaid Director Letter 07-011, Centers for Medicare and Medicaid Services (CMS) (2007), available at: <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd081507a.pdf>

⁵³Clarifying Guidance on Peer Support Services Policy, Centers for Medicare and Medicaid Services (CMS) (2013), available at: <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/clarifying-guidance-support-policy.pdf>

⁵⁴State Medicaid Director Letter 15-003 Re: New Service Delivery Opportunities for Individuals with a Substance Use Disorder, Centers for Medicare and Medicaid Services (CMS) (2015), available at: <http://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf>

⁵⁵Medicaid Preventive Services: Regulatory Change, Centers for Medicare and Medicaid Services (CMS) (April 2014), available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Preventive-Webinar-Presentation-4-9-14.pdf>

⁵⁶Using Medicaid Supplemental Payments to Drive Delivery System Reform, Medicaid and CHIP Access and Payment Commission (June 2015), available at: <https://www.macpac.gov/wp-content/uploads/2015/06/Using-Medicaid-Supplemental-Payments-to-Drive-Delivery-System-Reform.pdf>

⁵⁷SBIRT: Screening, Brief Intervention, and Referral to Treatment Opportunities for Implementation and Points for Consideration, SAMHSA-HRSA Center for Integrated Health Solutions, available at: http://www.integration.samhsa.gov/sbirt_issue_brief.pdf

⁵⁸New Requirements for 501(c)(3) Hospitals Under the Affordable Care Act, Internal Revenue Service, available at: [http://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501\(c\)\(3\)-Hospitals-Under-the-Affordable-Care-Act](http://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501(c)(3)-Hospitals-Under-the-Affordable-Care-Act)

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