A Statewide SUD Redesign:

The Missouri CSTAR Program Case Study

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Outcomes for this session:

1. Understand the historical context and evolution of the CSTAR program in Missouri.
2. Analyze the impact of the ASAM Criteria and the new payment model on the delivery of SUD services.
3. Evaluate the collaborative efforts of state leaders and treatment providers in the SUD redesign process.

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Transform a System from the Outside In²

The Power of Partnerships

- Missouri Department of Mental Health, Division of Behavioral Health
- Missouri Department of Social Services, MO HealthNet Division
- Missouri Behavioral Health Council

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The History

Missouri's SUD System

- CSTAR- Comprehensive Substance Treatment and Rehabilitation
- 3 levels + "detox"
  - Outpatient
  - Intensive Outpatient
  - Residential
  - Social Setting "Detox"
  - Medically Monitored "Detox"

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The History

Missouri's SUD System

- Developed in state regulation in the 1990s
- Few program updates since then
- MOUD/MAUD requirement (2010ish)
- Peer Suppor requirement (2019)
- Little data output

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Who Provides Services?

Providers contract with DMH

- Meet state certification requirements
- Bill directly to DMH for Medicaid, GR, and federal grants (SOR)

Contract Types

- General Adult
- Women and Children
- Adolescent
- Opioid Treatment Program

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Traditional Rates

SUD service rates have historically been lower than other Medicaid rates paid in the state.

1

2

Billed in 15-minute increments.

3

Incentivizies services with lower level, low-cost staff and disincentivized high level, high-cost staff.

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How and Why

The CSTAR Transformation Workgroup began in September 2019 consisting of DMH, MBHC, and provider leadership.

VISION:

Moderize the SUD model of care to be a medically-focused, evidenced-based, outcomes-driven program.

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Implement ASAM

Use the ASAM Criteria in all SUD programs

ASAM Provides:

- The “gold” standard of care
- Objective decision making
- Mulit-demonsional assessment
- Continuum of care
- Improved outcomes
- Standardized training

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Payment Reform

Impact

Small, rural providers were more negatively impacted by the federal public health emergency.

Re-examine payment levels for financially vulnerable rural and safety net providers. To the extent that other initiatives are undertaken that could reduce revenue to hospitals generally, the state could consider re-examining the effects of the initiatives on financially vulnerable rural and safety net providers in particular to determine whether adjustments in payment levels, value-based payment structures, or other changes are necessary to mitigate the potential for erosion of access to care.[1]

Close the Gap

Current fee-for-service rates do not cover costs.

Improve physician and behavioral health reimbursement. For physicians, not only has the methodology for establishing rates (e.g., as a percentage of Medicare) not been updated, but once set, the rates do not change. As a result, physician reimbursement is low. It is likely that increasing reimbursement could help reduce provider shortage. Likewise, there is a shortage of behavioral health providers. The state could consider integrating this initiative in an overall VBP program.[1]

Missouri Department of Social Services, Rapid Response Review- Assessment of Missouri Medicaid Program, February 11, 2019

Payment Reform

ASAM Team-Based Rates

- Based on services and staffing requirements for intensive outpatient and residential levels of care.
- Rate setting work completed with Mercer.
- Actuarily sound rates.
- CCBHC SUD programs will continue to bill their PPS rate.

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Quality Improvement

To Qualify for ASAM Rates:

- National accreditation
- Report outcomes data
- Incorporate EBPs:
  - Trauma-Informed Care
  - Co-Occurring Capable
  - Peer Specialists
  - MOUD/MAUD
  - Tobacco Treatment Specialist
  - Zero Suicide
- Implement ASAM throughout

Rate Development

Rate Restructuring

Model

DMH and MBHC engaged Mercer in January 2021 to begin restructuring CSTAR service rates.

Rates were modeled using methodologies Mercer suggested. National and state data was applied.

Design

Rates aligned with the ASAM levels. ASAM level 1 services have been condensed and rates were developed based on the most current national and state data. All other ASAM levels (2.1-3.7) are team-based rates and were developed according to required services and staffing for those levels of care.

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Rate Overview

Rate Assumptions Logs

Cost components considered in the rate modeling process. Shows the values assumed to develop the rate ranges.

Wage Exhibit

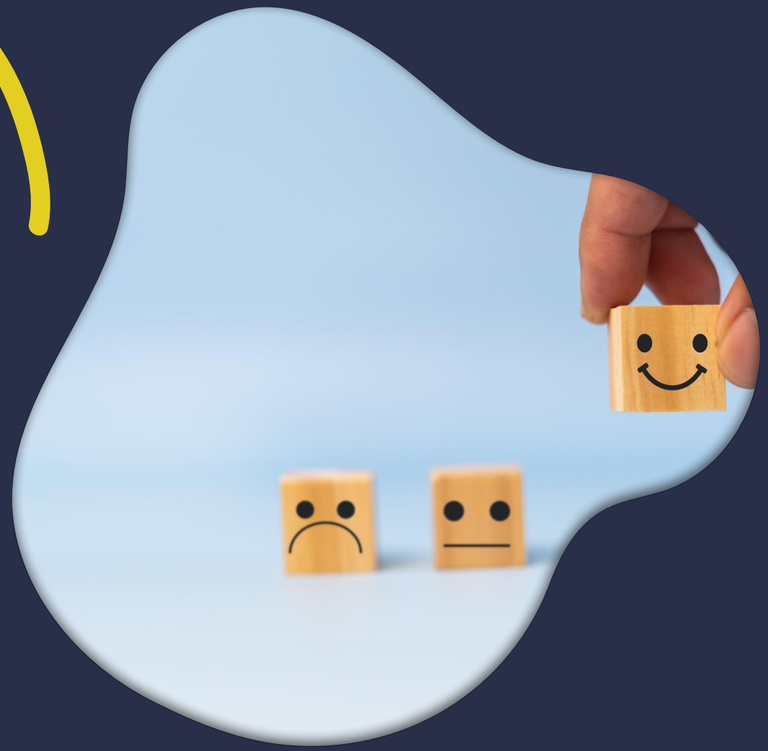
Job position and wage ranges for each type of direct care worker. BLS data was used in addition to MO survey data.

Staffing Exhibit

FTE staffing assumptions and staffing patterns used to develop the rates.

Rate Ranges

Developed using the 50th and 75th percentiles of BLS wage data.



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Missouri Rate Factors

Labor markets & staffing shortages of qualified staff.

Increased costs associated with the public health emergency.

Accounting for new quality improvement requirements.

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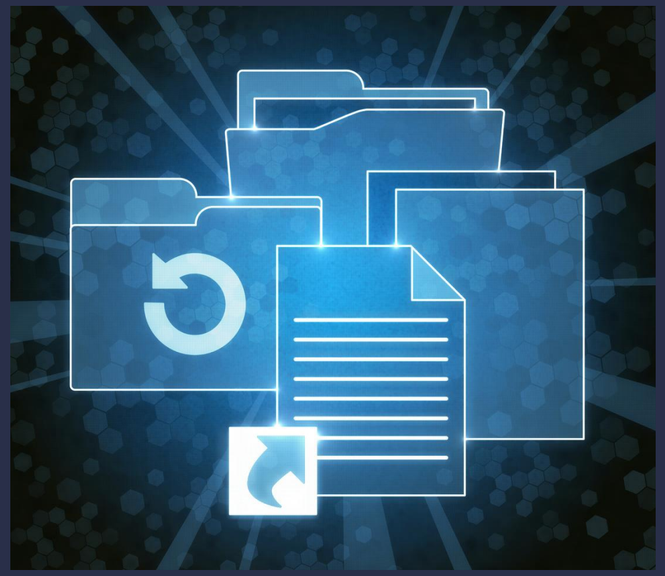
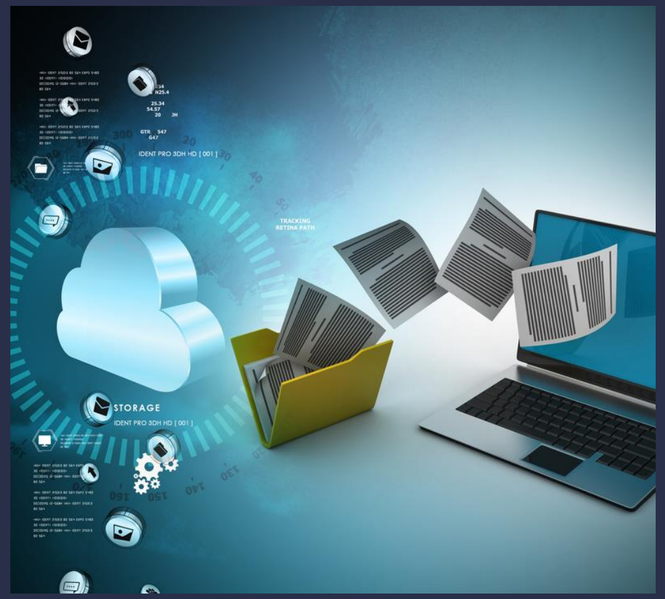
Future work



ASAM 4th Edition

Work has began this spring to plan implementation of the ASAM 4th edition.



Statewide Data Collection

The statewide TEDS data collection system continues to improve.

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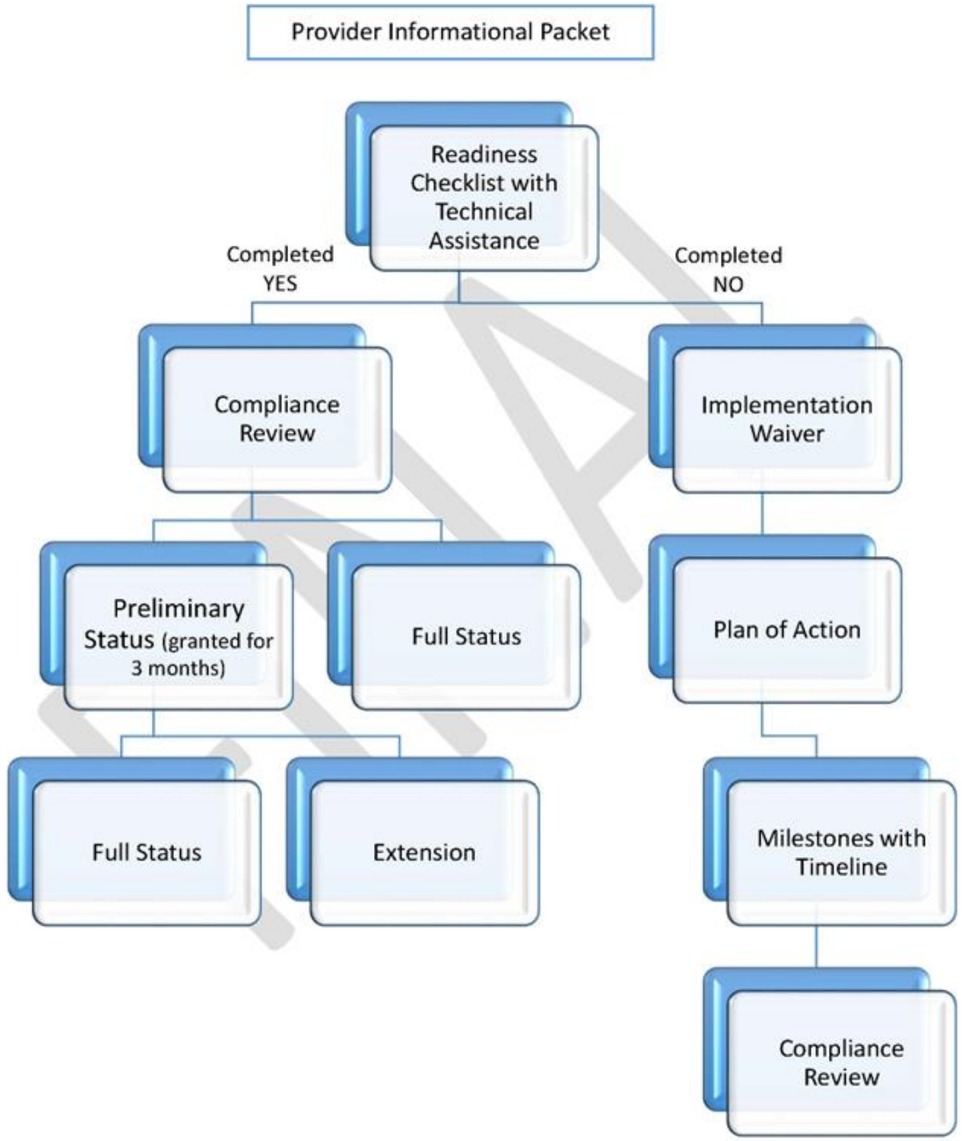
Transformation Implementation

CSTAR Transformation Review



Implementation

Readiness Checklist (next slide):

- Assists agencies with gauging readiness for implementation of the ASAM requirements.

Transformation Review:

- DMH will review with agencies their checklist and provide a waiver for agencies not ready to implement.

CSTAR Transformation Readiness Checklist

Does your agency have a CSTAR Transformation readiness team?

- [ ] Billing, Quality, Finance, and Clinical staff
- [ ] CEO/COO support

National Accreditation

- [ ] Scheduled
- [ ] Accreditation Survey completed- action required
- [ ] Accreditation Survey completed- report pending
- [ ] Obtained

EHR/CIMOR System Changes Complete

- [ ] Ability to report CSTAR measurements

ASAM Training

- [ ] ASAM Foundations Course
- [ ] ASAM Skill Building Course

Agency ASAM Levels of Care have been determined

- [ ] Staffing plan for each level
- [ ] QA/QI plan for utilization management

Zero Suicide Institute

- [ ] Attended ZSI
- [ ] ZS Implementation Plan
- [ ] Participating in ZS Learning Collaborative

Trauma Informed Care

- [ ] Completed Trauma Informed Care Assessment
- [ ] Participating in Trauma Informed Care Learning Collaborative
- [ ] Employ staff who specialize in the treatment of trauma

ency is Co-Occurring Capable according to ASAM

- [ ] P&P
- [ ] Training for program staff
- [ ] Assessment/treatment plan
- [ ] Program content
- [ ] Discharge Planning

Submit ongoing training plans

ASAM dimensions and risk ratings are incorporated into your assessment and treatme plan

Tobacco Treatment Specialist on staff

Readiness

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Support & Technical Assistance

Trauma-Informed Assessments & Learning Collaborative

- MBHC contracts with Resilience Builders for trauma-informed assessments with each CSTAR provider.
- MBHC hosts a quarterly TIC Learning Collaborative.

ASAM Office Hours

- DMH hosted weekly “Office Hours” open to all providers to join and ask questions related to transformation.

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Support & Technical Assistance

Zero-Suicide Academy

- DMH and MBHC offer an annual Zero-Suicide Academy from the Zero-Suicide Institute.
- MBHC hosts a quarterly Zero-Suicide Learning Collaborative.

Tobacco Treatment Specialist Training

- DMH hosts an annual TTS training in the spring and CSTAR providers are invited to attend.

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1

CMS State Plan Amendment

2

State Regulations

3

Medicaid Manuals

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1115 CMS waiver

Missouri applied to CMS for an 1115 SUD Waiver

- Worked with HMA and Mercer
- Waive the IMD rule
- Increase residential SUD treatment capacity

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ASAM Requirement
Setting
Applicable to: All Levels of Care
Applicable to: 3.1, 3.2 WM, 3.3, 3.5, 3.7, and 3.7 WM
Support Systems
Applicable to: all WM Levels of Care (1 WM, 2 WM, 2 WM EM, 3.2 WM, and 3.7 WM) unless specified
Applicable to: 1, 1 OTP, 2.1, and 2.5 unless specified
Applicable to: 3.7
Staff
Applicable to: 1 WM, 2 WM, and 2 WM EM
Applicable to: 1 and 1 OTP unless specified
Applicable to: 2.1 and 2.5

ASAM Monitoring

Policy and Procedure Attestation Tool

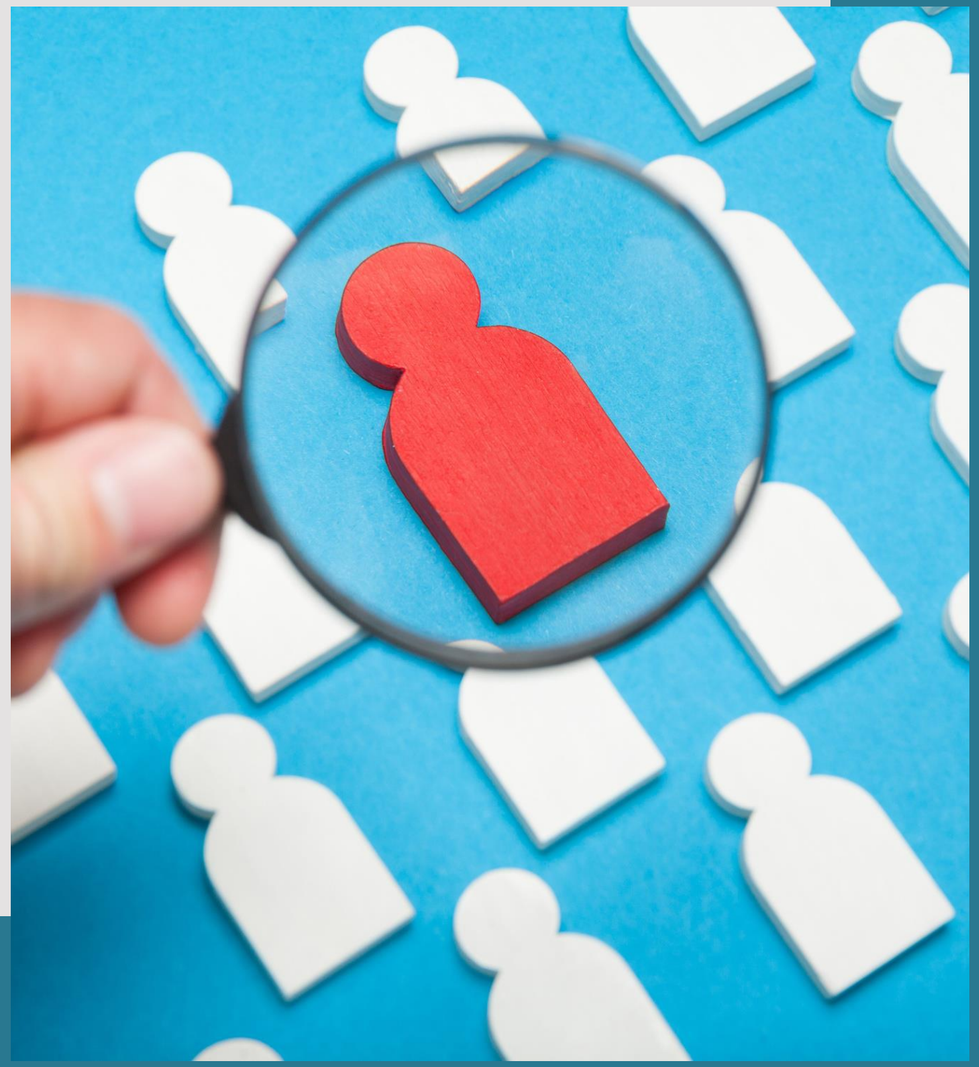
- Across programming and per level of care
- Tool for providers to expand programming

ASAM Monitoring

Quality and Compliance Monitoring Tool

- Across programming and per level of care
- Disallowances based on expected elements within individual medical record
- 2-month longitudinal approach to view LOC changes that may be occurring as individuals needs change

on 2: Admission/Treatment Consents			Medical Record #1	
allowable Code Crosswalk	Numbering	Question	Evidence the requirement was met?	Justification for score
	2.1	Program materials provided at the time of admission do not refer to a fixed program length of stay as a requirement for successful treatment completion(but instead on the individual's process toward meeting treatment goals)		
	2.2	**Applicable to all Ambulatory Levels of Care Only (1.0, 1WM, 2WM, 2WM EM, OTP, 2.1, 2.5)** The program has written materials for individuals on how to access emergency services by telephone 24 hours a day, 7 days a week.		
	2.3	**Applicable to Residential Levels of Care Only (3.1, 3.3, 3.5, and 3.7)** The organization implements procedures for handling of items brought into the program. Program materials describe what can and cannot come into the program.		
	2.4	**Applicable to Residential Levels of Care Only (3.1, 3.3, 3.5, and 3.7)** Individuals are either provided or have access to treatment or programming calendars that identify treatment opportunities they can participate in while in that level of care.		



ASAM Monitoring

Staffing Allocations

- Per level of care, per site
- Reviewed to confirm minimum requirements are met and maintained

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A Provider's Perspective

Planning and Implementation

Real Implementation Planning

Agency Implementation Team Formed

- Broad Membership

Hire New Staff

- Determine new capacity

Training

- ASAM Foundations/Skill Building
- Internal agency training

Develop New Policy & Procedure

EMR Overhaul

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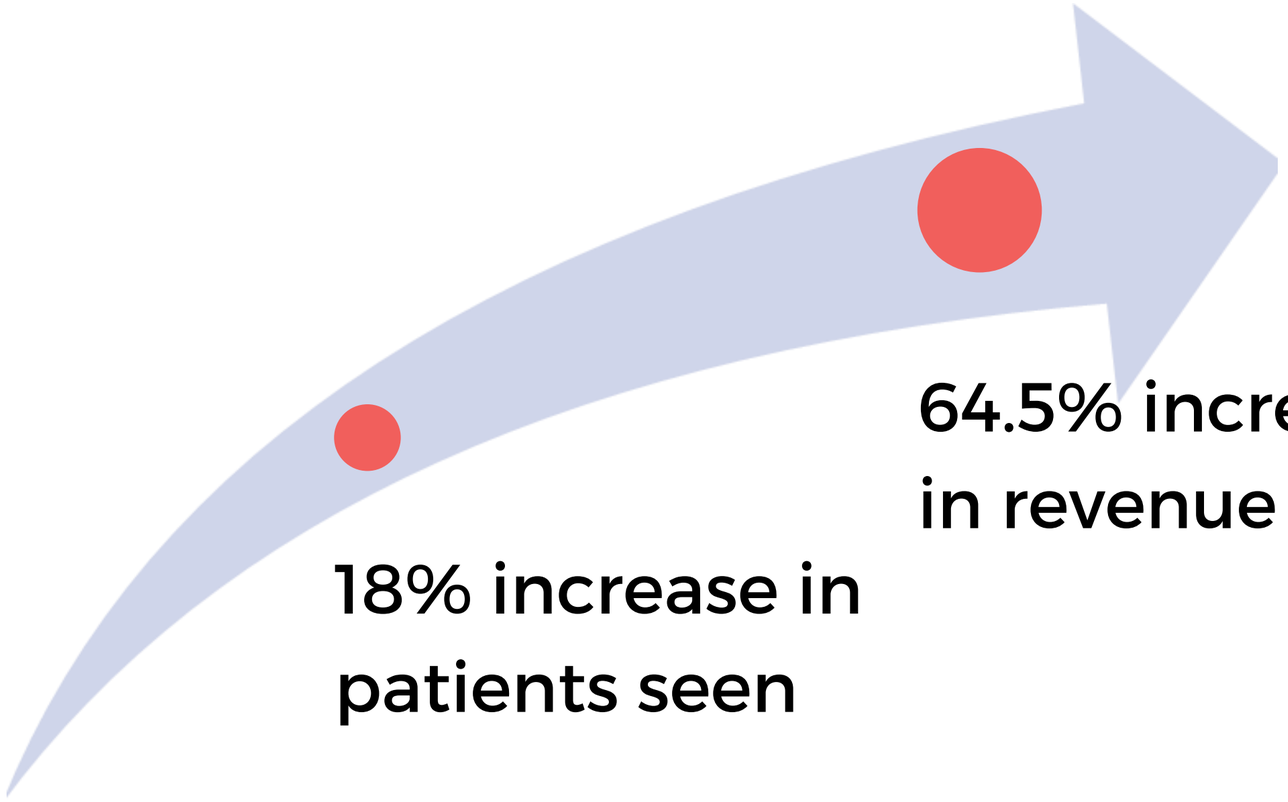
Impact on Access & Revenue



18% increase in patients seen

64.5% increase in revenue

When comparing the first 6 months

Growth expected to level off after the first 12 months

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Impact on Patient Care

- Increased engagement and services
- Offering patients choice
- Reduce readmissions
- Provided smoother transitions between levels

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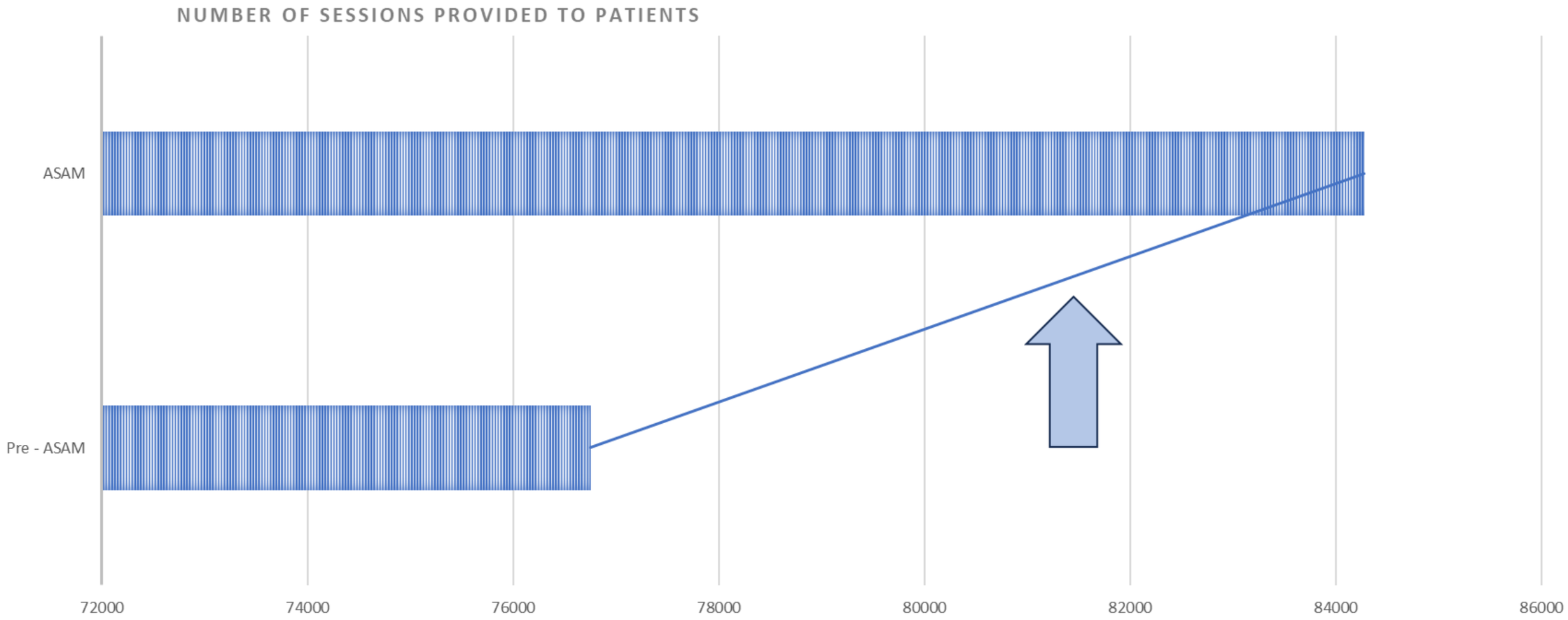
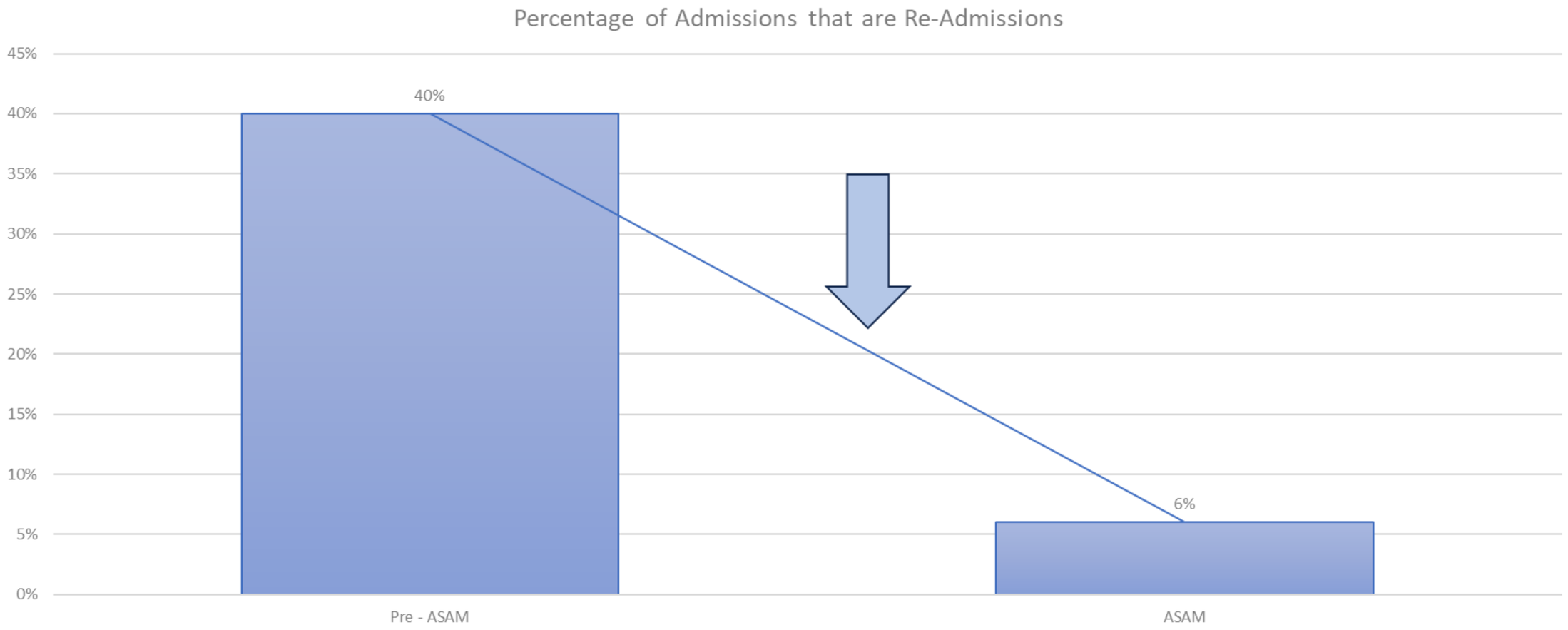
Increase in Sessions - Engagement



Reduced Re-Admissions



What are People Saying?

"Prior to ASAM, our patients had a steady diet of back-to-back groups. It was a frenetic pace that I would not want to subject myself to on my best day."

Then ASAM Happened!!!

What are People saying?

"In withdrawal management we are able to **provide many more services like peer support** and case management."

"From a diagnostic perspective **I feel much more equipped using the 6 dimensions**. It allow us to get a much better snapshot in time in order to make clinical decisions in the best interest of the patient."

"Treatment is no longer focused on the singular issue of substance use, **ASAM allows for a much more comprehensive look at the patient**."

What are People Saying?

"It has become **a very individual approach** that takes into consideration the complexities and nuances of the disease of substance use disorder along with the **unique needs of each individual patient**."

"Since the program has been implemented, **we have seen fewer behavioral issues**, fewer patient write-ups, fewer discharges for noncompliance, fewer overall issues."

"It has been transformative for our program and transformative for the patient experience as they are allowed to experience treatment in a whole new, more holistic way. In short, **the ASAM model allows our patients time to breathe**. To collect their thoughts. To process. To relax. To practice self-care. To rest. To recover!"

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Thank You So Much

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