IDUHA Injection Drug Users Health Alliance

NEW YORK STATE MEDICAID COVERAGE FOR HARM REDUCTION SERVICES

A WHITE PAPER: POSITIONS AND POLICY STATEMENTS OF THE INJECTION DRUG USERS HEALTH ALLIANCE (IDUHA)

October 2013

This white paper provides the position of IDUHA with regard to pending state proposals for Medicaid coverage of harm reduction services. In stating the positions of IDUHA, this white paper contemplates how harm reduction services should fit into the larger Medicaid reimbursement landscape, addresses gaps in existing coverage proposals and discusses the potential synergies between harm reduction services and New York State's goals in achieving better health outcomes and reduced costs for Medicaid beneficiaries.

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ACKNOWLEDGEMENTS

This paper was developed primarily by Daniel Raymond (Harm Reduction Coalition), Matt Curtis (VOCAL New York), and Jamie Favaro (IDUHA), with important technical assistance, advice, and writing contributions from Brett Friedman and Jonathan Zucker of the law firm Ropes & Gray LLP, which supported the project *pro bono* through an agreement with VOCAL New York. Through a series of meetings and other opportunities for feedback, staff from other IDUHA member organizations contributed to the content of the white paper, including AIDS Center of Queens County, After Hours Project, BOOM!Health, Community Health Action of Staten Island, Family Services Network, FROST'D at Harlem United, Housing Works, Lower East Side Harm Reduction Center, NY Harm Reduction Educators, Positive Health Project, St. Ann's Corner of Harm Reduction, Streetwork / Safe Horizon, and the Washington Heights CORNER Project. In particular we wish to acknowledge the contributions of Charles King, Bart Majoor, Hector Quinones, Jeremy Saunders, and Joshua Sippen for comments on the final draft of the paper and/or assistance in formulating the project.

EXECUTIVE SUMMARY

As part of its efforts to reduce state Medicaid costs, the New York Medicaid Redesign Team ("MRT") recommended the addition of harm reduction services as a Medicaid covered service. This recommendation constitutes a major shift in the manner of funding for harm reduction services, and recognizes the fact that the provision of harm reduction services is an effective method of treatment that has the potential to produce significant cost savings. Since the MRT made its recommendations in 2011, the Injection Drug Users Health Alliance ("IDUHA"), a coalition of sixteen harm reduction providers across the five boroughs of New York City, has been working with the New York State Department of Health ("DOH") and the AIDS Institute ("AI") to develop the manner in which Medicaid reimbursement for the provision of harm reduction services will operate. In order to implement these changes, DOH and AI have developed a draft State Plan Amendment ("SPA") to submit to the Centers for Medicare and Medicaid Services ("CMS") for approval. Based on the experience of its constituent organizations in the harm reduction field, this white paper provides IDUHA's comments and policy positions regarding the content of the draft SPA and subsequent state guidance or regulation, and describes how these recommendations are consistent with the general direction of Medicaid reform in New York State.

INTRODUCTION

This white paper has been developed by the members the IDUHA. IDUHA's constituent organizations include:

- After Hours Project
- AIDS Center of Queens County
- BOOM!Health
- Community Health Action of Staten Island
- Family Services Network
- FROST'D at Harlem United
- Harm Reduction Coalition
- Housing Works
- Lower East Side Harm Reduction Center
- New York Harm Reduction Educators
- The Peer Network of New York
- Positive Health Project
- Praxis Housing Initiatives
- St. Ann's Corner of Harm Reduction
- Streetwork / Safe Horizon
- VOCAL New York
- Washington Heights CORNER Project

IDUHA's constituent organizations include the largest harm reduction organizations in New York State and work tirelessly to promote and implement strategies that prevent the spread of diseases such as HIV/AIDS and Hepatitis C ("HCV"), prevent death by overdose and disease, support healthy behaviors, address drug dependence and facilitate participants into medical care, mental health care and drug treatment.

The objective of the white paper is for IDUHA, and its constituent organizations, to present our collective thoughts, opinions and policy positions regarding the current proposals for Medicaid coverage of harm reduction services by New York State. As DOH and AI continue to work to refine the current proposal for Medicaid coverage of harm reduction services and present the resulting SPA to CMS for approval, IDUHA has worked, with the help of outside counsel from Ropes & Gray LLP, to solicit the feedback of its constituent organizations and to help understand the mechanics and impact of Medicaid coverage on the provision of our important, mission-based services. The resulting white paper analyzes the critical elements of the state coverage proposals to date so that the ultimate reimbursement methodology presented by DOH, ratified by CMS, and further elaborated in state guidance or regulation appropriately accounts for the unique aspects and challenges of the harm reduction provider community.

The following white paper is organized in four-parts:

- **Section I** discusses the philosophical underpinnings of harm reduction and specific concerns of the provider community with regard to the extension of the Medicaid coverage framework to harm reduction programs and services;
- **Section II** provides background on, and describes the status of, the existing proposals for Medicaid coverage of harm reduction;
- **Section III** provides specific comments and policy positions with regard to the content of the draft SPA distributed by AI to the harm reduction provider community and focuses on anticipated program, billing and documentation requirements; and
- **Section IV** describes how consideration of IDUHA's policy positions are consistent with and enhance other recent Medicaid reform proposals in New York State, including Health Homes and mandated managed care enrollment.

I. THE PHILOSOPHY AND FEATURES OF HARM REDUCTION

Harm reduction's unique approach, as compared to traditional abstinence-based drug treatment approaches, is an essential component of its effectiveness. In order to maintain this efficacy, the SPA and coverage proposals should incorporate and reflect the clinical approach and treatment philosophy that are unique to harm reduction. A brief overview of this philosophy is provided below.

A. Harm Reduction as a Drug Treatment Philosophy

Harm reduction differs from abstinence-based drug treatment philosophies in a number of key ways that makes it uniquely suited to engage and treat high-risk drug users. Recent research and regulatory efforts have recognized that preventing emergency care episodes and disease transmission leads to healthier results and cost savings.[1] Harm reduction embraces these goals by advocating for a holistic approach to care that focuses on providing participant driven care in a low pressure and comfortable atmosphere. This approach has been proven to achieve positive health results and cost savings.

Harm reduction providers have been particularly successful at engaging a difficult to reach population of drug users by embracing the core tenets of its treatment philosophy, which include the "Three A's":

1. **Anonymity** – Participants should have an expectation of anonymity where possible (i.e. for services not requiring individual identification, such as receiving a prescription for medication) and until such time that they choose to disclose personal information;
2. **Access to Services** – Harm reduction providers ensure that participants have easy and open access to services. Among other methods, this access is accomplished through extensive street outreach, community-based treatment locations and flexible operating hours; and
3. **Attitude of Staff** – Harm reduction staff provide services in a respectful, non-judgmental and participant-centered manner.

A large percentage of injection drug users choose not to utilize the services available to them because they are afraid of possible repercussions, such as being reported to legal authorities or being committed to a mandated drug treatment program. By allowing participants to remain anonymous until they are comfortable disclosing their identity, harm reduction providers are able to foster trust between providers and participants, which in turn facilitates these participants to access other needed health care services. Similarly, actively engaging participants in the community through this "low-threshold" approach enables harm reduction providers to engage drug users who are either incapable or unwilling to access traditional facility-based or outpatient drug treatment programs.

The overall treatment goal of harm reduction is achieving self-reliance and optimal autonomy.[2] Once a participant is actively engaged, harm reduction providers establish flexible individual goals to ensure participants remain engaged. Participants are not forced to achieve a result they themselves have not prioritized. Even in the event a specific individual goal is not achieved, a participant is permitted to continue utilizing self-selected services that remain consistent with the overall treatment goal. IDUHA believes that if a participant stays actively

[1] MRT Proposal; *See, e.g.,* David Vlahov & Benjamin Junge, *The Role of Needle Exchange Programs in HIV Prevention*, 113 PUBLIC HEALTH REPORTS 75 (1998); *See infra* at Section II.B.
[2] Bart Majoor & Joyce Rivera, *SACHR: An Example of an Integrated, Harm Reduction Drug Treatment Program*, 25 J. Substance Abuse 257 (2003).

engaged, at a minimum, they receive services that lead to healthier results, and a support structure is in place if and when an individual is ready to attempt more.

The ability of harm reduction providers to reach participants and foster trust is buttressed by the individuals working in our programs. Harm reduction providers have identified the value of having former and current participants (who have trained in harm reduction principles and services) to serve as "peer supports." These peer supports furnish selected harm reduction services to prospective and current participants and often return to their community to spread healthier and safer practices. The use of peers is particularly effective at engaging potential participants by building on shared experiences and monitoring participant engagement within a program. As a result, harm reduction providers demonstrate ability to improve health alongside other key outcomes in functional domains.

B. The Proven Benefits of Harm Reduction

Harm reduction, once considered a novel approach to the promotion of wellness and cost reduction, is now solidly embraced by numerous U.S. cities and countries around the world. Both domestic and international research supports findings of reduction of transmission of HIV/AIDS and HCV, significant healthcare cost savings, fatal overdose prevention and even reduction of long-term intravenous drug abuse through the institution of harm reduction programs. The Journal of the American Medical Association credits syringe exchange programs with helping lower HIV incidence in the United States by 80% among people who inject drugs.[3] Recent research analyzing a series of studies involving intervention targeting injection drug using populations also reveals progress in preventing the transmission of HCV.[4]

Through reduced emergency care and transmittance of long-term diseases, harm reduction programs have also demonstrated reduced costs of care in a number of international studies. The Australian Centre in HIV Epidemiology and Clinical Research estimates that the $27 million per year invested in Australian needle and syringe exchange programs from 2000 to 2009 resulted in a net cost-savings of $1.28 billion due to prevention of both HCV and HIV.[5] Similar studies analyzing Vancouver's harm reduction and supervised injection facility estimate a societal savings of over $6 million in prevention of HIV infections and overdose deaths each year in the city of Vancouver alone.[6]

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[3] H. Hall et al., *Estimation of HIV Incidence in the United States*, 300 J. AM. MED. ASS'N 500 (August 2008).

[4] Success rates for reduction HCV transmission have still lagged behind those for HIV/AIDS, and studies consistently suggest that additional sterilization and educational measures could improve these figures. Nat MJ Wright & Charlotte NE Tompkins, *A Review of the Evidence for the Effectiveness of Primary Prevention Interventions for Hepatitis C Among Injecting Drug Users*, 3 HARM REDUCTION J. 27 (September 2006).

[5] National Centre in HIV Epidemiology and Clinical Research, *Return on Investment 2: Evaluating the Cost-Effectiveness of Needle and Syringe Programs in Australia 2009*, AUSTRALIAN GOVERNMENT DEPARTMENT OF HEALTH AND AGEING (2009).

[6] Andersen, M.A.& Boyd, N., *A Cost-benefit and Cost-Effectiveness Analysis of Vancouver's Supervised Injection Facility*, INT'L J. OF DRUG POL'Y, (2009).

Although access to sterile equipment likely accounts for a portion of these health and cost improvements, the other work of harm reduction programs likely also accounts for significant additional cost savings through the prevention of downstream emergency care costs. Studies reflect that chronic drug users, including those who are also injection drug users, consume significantly more inpatient and emergency care than non-drug users, and less outpatient (primary care) services relative to non-drug users.[7] Of injection drug users, preventable injection-related complications such as soft-tissue infections account for a large portion of emergency room use.[8] A series of studies analyzing consecutive admissions of injection drug users to emergency care facilities for late stage treatment of these preventable ailments suggest that preventative harm reduction care, including skin-cleaning techniques, are best equipped to reduce preventable episodes and acute care costs.[9]

Opioid Overdose Prevention Training and outreach as an element of harm reduction has also produced encouraging statistics of reduced deaths by overdose. In 2005, heroin overdose was the leading cause of death of injection drug users, exceeding all other causes including AIDS, HCV or homicide.[10] A recent study compared fatal opioid overdose rates in 19 Massachusetts communities that instituted opioid education and naloxone distribution programs against overdose rates prior to implementation of the programs.[11] Both high and low implementation rates of the programs within these communities, compared to no implementation, reflected overall reduced rates of opioid-related deaths.[12]

Despite concerns from critics in the past over potentially enabling or prolonging drug abuse by focusing on reducing harm instead of abstinence, recent research reflects strong evidence of long-term cessation of injection drug use through harm reduction programs. A recent case study of Vancouver injection drug users found that over a period of 1996-2010, injection drug use among users actually *decreased* progressively, consistent with expansion of harm reduction services in the region.[13] The established health, humanitarian, cost and societal gains of similar harm reduction programs recommends harm reduction as an effective public health policy.

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[7] French, MT, et al., *Chronic Illicit Drug Use, Health Services Utilization and the Cost of Medical Care*, 50 SO. SCI. MED. 1703 (2000).
[8] T. Kerr, et al., *High Rates of Primary Care and Emergency Department Use Among Injection Drug Users in Vancouver*, 27 J. OF PUB. HEALTH 62-66 (2005).
[9] M.D. Stein & M. Sobota, *Injecting Drug Users: Hospital Care and Charges*, 64 DRUG ALCOHOL DEPEND. 117-20 (2001); National Centre in HIV Epidemiology and Clinical Research , *supra* note 6.
[10] Karen H. Seal, et al., *Naloxone Distribution and Cardiopulmonary Resuscitation Training for Injection Drug Users to Prevent Heroin Overdose Death: a Pilot Intervention Study*, 82 J. OF URBAN HEALTH 303 (2005).
[11] Alexander Y. Walley, et al, *Opioid Overdose Rates and Implementation of Overdose Education and Nasal Naloxone Distribution in Massachusetts: Interrupted Time Series Analysis*, 346 BRITISH MED. J. (2013).
[12] *Id*.
[13] Werb, D., et al., *Patterns of Injection Drug Use Cessation During an Expansion of Syringe Exchange Services in a Canadian Setting*, DRUG AND ALCOHOL DEPEND. (2013).

Embracing what makes harm reduction unique has the potential to result in the realization of cost savings and improved health outcomes in New York State.

C. Core Principles of Harm Reduction as a Medicaid Covered Service

In order to preserve harm reduction's efficacy, Medicaid coverage needs to function in a manner that maintains the unique philosophy, culture and treatment goals of harm reduction. As such, Medicaid coverage must be structured in a manner that enables harm reduction providers the ability to continue to provide these important services, including recognition of the following principles:

- Coverage must recognize that the process of intake and comprehensive needs assessment is the culmination of community/street outreach and other initial services provided on an anonymous basis, which cannot be tied to a specific Medicaid recipient;
- Treatment may occur in a variety of community-based settings and through a variety of methods, including peer outreach, which must be reflected in the authorized service offerings of harm reduction;
- Treatment goals are participant-driven such that harm reduction providers must be given flexibility in establishing treatment objectives and adjusting service offerings on an encounter-by-encounter basis to track the participant's needs and as the participant's desires change; and
- As many harm reduction providers are small community-based organizations with limited budgets, Medicaid coverage must minimize the administrative burdens associated with documentation, billing and aggregate data reporting.

II. STATUS OF MEDICAID COVERAGE FOR HARM REDUCTION SERVICES

On April 22, 2013, AI distributed a draft SPA to members of the harm reduction community for review and comment, including members of IDUHA. IDUHA acknowledges and appreciates that the SPA represents the culmination of many months of effort both within DOH as well as in the provider community to help educate members of state government about the unique aspects of harm reduction and how it differs from traditional drug treatment and education. This state-driven process began in 2011 as part of the work of the Health Disparities Workgroup of the MRT, which, as part of its mandate to work cooperatively to reform the Medicaid coverage system and reduce costs and spending in the Medicaid program, recommended in its final report issued in October 2011 that the MRT should take the following steps to promote and address health care needs for persons with chemical dependency:

- Clarify regulations to allow any medical provider to prescribe syringes to an injection drug user for prevention of disease transmission;
- Allow harm reduction therapy as an appropriate and reimbursable treatment modality in facilities licensed by the New York Office for Alcohol and Substance Abuse Services ("OASAS"); and

- Authorize AI-licensed syringe exchange programs (community-based organizations) to be reimbursed by Medicaid for harm reduction and syringe exchange services provided to Medicaid eligible individuals.[14]

The rationale for this last recommendation reflects existing literature on syringe exchange and harm reduction; syringe exchange and other harm reduction strategies serve to reduce costs and improve health outcomes through preventing the incidence of transmittable diseases endemic to injection drug users, such as HIV/AIDS and HCV.[15] This recommendation by the MRT constitutes a significant shift in the way that harm reduction providers and harm reduction services have been funded by the state. As the MRT report notes, state support was previously confined to grant funding. The report recommended that, in addition to retaining the current funding mechanisms, the state should "complement" these existing structures by creating channels for Medicaid reimbursement of harm reduction services.[16]

More than just improving health outcomes, the MRT recognized that extending Medicaid reimbursement to harm reduction would help link this modality of substance abuse services and drug treatment into the larger system of care. The result of this linkage would be the ability to encourage individuals to more easily access other related health care services already reimbursed by Medicaid, including mental health and medical services. Accordingly, the MRT reflected several key features about harm reduction services that make such services an indispensable aspect of the Medicaid program. These aspects include:

- The ability to provide effective outreach to high risk beneficiary populations and introduce them to the larger health care system;
- The ability to monitor and coordinate care for high acuity populations with multiple mental health, physical and behavioral diagnoses; and
- The ability to improve health outcomes by reducing the incidence of dangerous behavior.[17]

This white paper builds on this foundational rationale of the MRT to explain and elaborate on the best ways to provide such coverage without compromising the critical aspects of the harm reduction philosophy that made it the basis of this MRT recommendation and state reform efforts.

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[14] Medicaid Redesign Team, Health Disparities Workgroup: Final Recommendations (Oct. 20, 2011), *available at* http://www.health.ny.gov/health_care/medicaid/redesign/docs/health_disparities_report.pdf [hereinafter MRT Report].

[15] National Centre in HIV Epidemiology and Clinical Research, *Return on Investment 2: Evaluating the Cost-Effectiveness of Needle and Syringe Programs in Australia 2009*, AUSTRALIAN GOVERNMENT DEPARTMENT OF HEALTH AND AGEING (2009); Andersen, M.A.& Boyd, N., *A Cost-benefit and Cost-Effectiveness Analysis of Vancouver's Supervised Injection Facility*, INT'L J. OF DRUG POL'Y, (2009).

[16] MRT Report.

[17] *Id*.

III. POLICY STATEMENTS ON THE DRAFT STATE PLAN AMENDMENT

A. Definition of Covered Services

The harm reduction services reimbursable through Medicaid under the draft SPA are: (1) intake and comprehensive risk assessment; (2) counseling; (3) client (participant) navigation; (4) referrals; (5) support groups; (6) wellness services; (7) peer training; (8) opioid overdose prevention training; (9) monitoring and follow-up; (10) crisis intervention; (11) reassessment; (12) case closure; (13) client advocacy and interagency coordination activities; and (14) supervisory oversight/case-specific supervision ("Covered Services"). While the list of Covered Services provides an extensive and well-crafted array of services offered by harm reduction providers within a program site, the list misses four crucial components of harm reductions services.

1. The Covered Services should reflect the importance of outreach and community-based service delivery.

Central to the harm reduction service philosophy and approach are street outreach and other approaches to furnish services in a community-based setting. As previously stated, a unique component of harm reduction is its focus and effectiveness at connecting with, and continuing to engage, an otherwise difficult to reach population of high risk drug users. While the Covered Services include the programs and services that will be furnished once a participant has agreed to become "enrolled" in a program, the definition does not recognize that harm reduction providers achieve enrollment through often extensive street outreach efforts. It is through this street outreach that harm reduction providers identify and educate potential participants on service offerings; develop trust between the potential participant and the program staff; and ultimately enable the potential participant to seek other harm reduction services. Individualized Care Coordination ("ICC") (as discussed below in Section III.B.2.iv) provides a precedent for Medicaid reimbursement for activities conducted prior to enrollment. ICC reimbursement provides an enhanced rate for "Start-Up Services" whereby a provider is able to bill for a single month that includes "payment for services that cannot be billed until the child is enrolled" in the ICC program. ICC, like harm reduction, recognizes that there is a tremendous amount of outreach and groundwork necessary to start offering Covered Services to a difficult to engage participant population.[18]

Moreover, once enrolled in a program, state guidance and/or regulations should better memorialize that Covered Services, such as counseling, wellness activities, training and interventions, are often furnished within a community-based setting that may be outside the four walls of the program facility. The flexible, community-centered nature of harm reduction service delivery ensures that harm reduction providers furnish the most meaningful services possible and meet their participants in environments in which they are comfortable and

[18] *See Home and Community Based Services (HCBS) Waiver Guidance Document Section 600.2: Billing for Individualized Care Coordination (ICC),* DIVISION OF CHILD AND FAMILIES, OFFICE OF MENTAL HEALTH.

familiar. Many of these services are already provided in the community through DOH-licensed syringe exchange programs, and Medicaid coverage should continue to provide this flexibility to harm reduction providers.

It is IDUHA's position that:

- *Street Outreach, either as a standalone service or as a derivative service of intake and comprehensive risk assessment, should be specifically included as a Covered Service;*
- *Harm reduction providers should be able to bill for all documented outreach for individuals that are Medicaid eligible at intake, but enroll post-intake; and*
- *Harm reduction providers should be able to bill for all Covered Services furnished in a community-based setting.*

2. The Covered Services do not provide adequate clarity around the type of case management functions performed by harm reduction providers.

The Covered Services envision that harm reduction providers will serve in a hybrid care coordination role for participants, as evidenced by permitting reimbursement for conducting a comprehensive risk assessment, referrals, monitoring, re-assessment and case closure. Notwithstanding the reimbursement for these Covered Services, the SPA does not address how these care coordination functions may overlap and duplicate care coordinating functions performed by Health Homes or Medicaid Managed Care Organizations ("MCOs") (once these individuals are enrolled within Medicaid), other than indicating that harm reduction providers should "include the participant's Heath Home, Medicaid Managed Care Provider" or other case manager, where appropriate. Moreover, as part of the State's emphasis on care management for all, the vast majority of Medicaid beneficiaries will soon be part of an MCO, Behavioral Health Organization ("BHO"), Health Assessment and Recovery Plan ("HARP") and/or Health Home that will be ultimately responsible for case management.

In order to allow harm reduction providers to continue to provide care coordination, additional guidance and/or regulations on the Covered Services must better clarify whether reimbursement for certain Covered Services will supplement or supplant case management services furnished by other entities; and whether harm reduction providers may act as approved downstream contractors for Health Homes and managed care entities for care management services. The SPA specifically states that harm reduction providers may not be reimbursed for case management activities that are already provided by Medicaid.

It is IDUHA's position that:

- *Harm reduction providers can both complement and supplement care coordination functions, either as part of a Health Home subcontractor relationship, a delegated management services vendor of an MCO or through a more informal information sharing role;*
- *Additional guidance should expressly permit harm reduction providers to furnish care coordination under contract with other care management entities (for a portion of the PMPM or other approved reimbursement methodology) and those which are separately reimbursable as complementary services; and*
- *Further guidance should expressly indicate those Covered Services that are separately reimbursable as complementary services to other care management services.*

3. The SPA generally and Covered Services specifically do not provide guidelines around when syringe exchange services are capable of being reimbursed by Medicaid.

IDUHA appreciates the SPA's efforts to provide clarity around when certain syringe exchange activities would qualify as a component of a Covered Service, but seeks additional guidance to avoid implicating the federal ban on funding. The SPA explains that syringe exchange may be reimbursable when it is an ancillary component of a Covered Service, such as Opioid Overdose and Prevention Training. The ban on federal funding of syringe exchange programs was originally enacted in 1988, and although it was lifted briefly in 2009, the ban was reinstated in 2011.[19] The purported reasoning behind the ban is that syringe exchange programs promote drug use, despite countless studies that show the opposite is in fact true.[20]

While syringe exchange is not eligible for federal reimbursement as a result of the ban, the Covered Services contemplate reimbursement for services that might include the provision of clean syringes. In light of the federal ban, IDUHA strongly supports the SPA's attempt at integrating syringe exchange within Covered Services; however, IDUHA seeks a refinement to the list of Covered Services for which syringe exchange is an allowable component.

In addition, given that syringe exchange is not a separately reimbursable Covered Service, IDUHA believes it is vital that harm reduction providers not be required to disclose when a syringe is distributed to a specific individual as a component of a Covered Service. The protection provided by anonymity allows participants to receive clean syringes without having to fear the possibility of repercussions or revealing whether that participant is an active injection drug user. While IDUHA recognizes that in many situations the preservation of anonymity may be inconsistent with Medicaid reimbursement principles, individual

[19] Azmat Khan, *Despite Show of Support, Federal Funding Ban on Needle Exchange Unlikely to be Lifted Anytime Soon*, PBS (August 7, 2012).
[20] *See* Section I.B.

documentation of each syringe distributed would unduly compromise this core tenet of the harm reduction philosophy. IDUHA, therefore, recommends that syringe exchange distribution is only required to be reported in the aggregate based on the total number of syringes distributed per month, rather than on an individual participant basis.

It is IDUHA's position that all Covered Services should include a syringe exchange component if dictated by a participant's plan of care. Specifically, IDUHA envisions syringe exchange being a critical component to the following Covered Services: Intake and Comprehensive Risk Assessment; Counseling; Wellness Activities; Opioid Overdose Prevention Counseling; Monitoring and follow-up; Crisis Intervention; and Street Outreach (when authorized as an additional Covered Service) (see Section III.A.1). In addition, syringe distribution should be reported in the aggregate, without any required disclosure of distribution information to individual participants. To the extent that federal dollars cannot currently be spent on syringe exchange, the state should consider using state-only Medicaid dollars to reimburse for the costs of this service component.

4. The scope of the Wellness Covered Service does not accurately reflect the range of palliative services performed by harm reduction providers.

The inclusion of Wellness as a Covered Service appropriately recognizes the fact that harm reduction providers often perform an array of palliative services for their participants. As the draft standards for harm reduction billable services (the "Standards") states, the Wellness services cover "basic need[s] that must be addressed to enable clients to engage in other services." While IDUHA appreciates the SPA's recognition of the efforts of harm reduction providers in this regard, the SPA appears to provide strict limits as to the type of wellness activities that are reimbursable.[21] In practice, harm reduction providers perform numerous additional necessary services for their participants, including but not limited to providing a place to take a shower, the ability to wash their clothes, and a safe place to rest. In order to allow harm reduction providers to continue to perform these services, IDUHA requests that the scope of Wellness be expanded through guidance and/or regulation in order to account for these specific activities.

It is IDUHA's position that the scope of the Wellness Covered Service should be expanded to accurately reflect the breadth of palliative services performed by harm reduction providers.

B. Medicaid Coverage Requirements

Two broad categories of requirements typically govern the eligibility of services for coverage by Medicaid: (1) Program requirements that establish the operational standards

[21] The three services included in the SPA are wellness plan development and implementation, the provision of meals and auricular acupuncture/acupressure.

necessary in order to become an authorized provider, such as credentialing, staffing requirements and facility/physical plan requirements, but do not affect reimbursement for individual services; and (2) billing requirements that establish the procedures and steps that must be followed in order for Medicaid to pay for covered services. This dual framework is often cited in regulations and administrative guidance setting forth the requirements imposed on Medicaid-eligible services.[22] This white paper addresses each in turn, and provides IDUHA's recommendations on how each should be structured for harm reduction.

1. Program Requirements

a. Licensure and Credentialing

Central to expanding Medicaid coverage is the prevention of fraud or abuse of the newly reimbursable services. Strong licensing and credentialing standards can help mitigate the incentives for, and prevent, such abuse by centrally controlling—through the state, Medicaid MCO or delegated contractor, such as an Independent Practice Association ("IPA")—who can participate and the terms of such participation. MCOs, for example, may have incentives to enroll otherwise ineligible individuals in programs in order to increase the capitated payment they receive from the State. Likewise, providers may have incentives to enroll beneficiaries and bill for delivery of services otherwise unnecessary, or potentially not delivered in the capacity anticipated by Medicaid. This problem may be exacerbated if the provider begins attracting these individuals and referring them back to MCOs, resulting in a reciprocal relationship.

IDUHA advocates for strong credentialing and licensure requirements to limit entry to harm reduction networks to those providers committed to the harm reduction philosophy and treatment principles.

The pitfalls of imposing weak licensure and credentialing requirements have recently played out in the news. As first reported in an April 22, 2013 news article in the *New York Times*, Medicaid coverage for Adult Social Day Care services provides a helpful case study for potential abuses absent sufficient licensing and credentialing controls in the Managed Care Medicaid system.[23] According to reports in the *New York Times* and other media outlets, several Adult Social Day Care centers lured able-bodied seniors (who are otherwise ineligible for Medicaid long-term care coverage) on their premises with prohibited bribes such as free takeout food, casino visits and cash in exchange for attending the center and enrolling for services with a state-approved Managed Long-Term Care Plan. These seniors would then depart the center without having received Medicaid services, but the centers still received

[22] See the *Home and Community Based Services (HCBS) Waiver Guidance Document Section 600.2: Selecting an Individualized Care Coordination Agency,* DIVISION OF CHILD AND FAMILIES, OFFICE OF MENTAL HEALTH, which prescribes separate program and billing requirements for ICCs.

[23] Nina Bernstein, *State Suspends Enrollment in Adult Care Plan Amid Fraud Concerns*, N.Y. TIMES, April 25, 2013, *available at* http://www.nytimes.com/2013/04/26/nyregion/new-york-suspends-enrollment-in-long-term-care-plan.html?_r=2&.

funds for services from the MCOs, and in turn the MCOs received capitated payments from the State. In response to initial investigations of these alleged abuses, state officials have suspended enrollment in some of the largest MCOs suspected of abuse, pending investigations.

Reimbursement for Adult Social Day Care services, unlike other services eligible for reimbursement through Medicaid and Medicaid MCOs, creates a unique opportunity for abuse of the system. This opportunity was in part a function of the facilities providing services on their own premises without any requirements for formal licensure from the State and with only minimal operational standards.[24] MCOs are ultimately responsible for dictating operational and billing standards, which are set forth in the contracts between payer and provider. In contrast, other managed care services, such as providers who furnish care in the home or deliver specific products and medical services, are required to obtain licenses and/or credentialing of its workers from DOH or the State Education Department ("SED"). Provision of more concrete services or oversight by DOH has worked to curb abuse in other reimbursable programs and services.

Harm reduction providers offer many services with detailed medical or recordkeeping requirements, such as monitoring and counseling activities, which are less prone to abuse because of the rigor and substance of recordkeeping. Some Covered Services, such as trainings and outreach at centers may be more susceptible to fraud by unscrupulous providers because DOH and MCOs may compensate providers on the basis of attendance records only, creating the possibility of luring ineligible recipients or delivering abbreviated services. However, IDUHA believes that there are a number of ways in which coverage for harm reduction services can mitigate this risk through specific licensure and credentialing requirements.

It is IDUHA's position that:

- *While the draft SPA does not contemplate any specific licensure, harm reduction community-based organizations should obtain a waiver from AI to conduct a comprehensive harm reduction program, including syringe exchange, which builds on an existing approval process and infrastructure;*
- *In order to be approved, organizations must meet threshold experience and staffing requirements established by AI and explained further in this white paper; and*
- *DOH and AI should encourage and support existing harm reduction providers in establishing a voluntary delegated services organization, such as an IPA, that can ensure that participating providers meet harm reduction's philosophical goals.*

These requirements, if contained in state guidance and/or regulations and facilitated by an IPA, will provide the more concrete oversight by DOH that has been shown to reduce abuse, and should serve as minimum requirements for any contracts with MCOs.

[24] Older Americans, Community Services, and Expanded In-Home Services for the Elderly Programs: Social Adult Day Care Programs, 9 N.Y.C.R.R. §6654.20.

b. Staffing Requirements

Staffing requirements typically specify the roster of staff members by qualification that a licensed program must employ or engage by contract. The SPA and the Standards appropriately do not require a specific mix of staffing for harm reduction providers. In fact, services are permitted to be provided by a variety of non-clinical staff members, including counselors, community health workers, health educators, prevention specialists, volunteers and peers. Certain Covered Services (e.g. Opioid Training) do contemplate the involvement of clinical staff, including trained opioid overdose prevention staff, credentialed alcohol and substance abuse counselors ("CASACs"), physicians, nurse practitioners and physician assistants. Such overall flexibility is necessary for harm reduction, as numerous non-licensed educators and peer supports are used to supplement the services provided by the clinical staff.

It is IDUHA's position that the following Covered Services may be furnished by non-licensed, trained peers under the supervision of a licensed program staff: Counseling; Client Navigation; Wellness Activities; Monitoring and follow-up; Crisis Intervention; and Client Advocacy and Interagency Coordination. Other services should require the direct involvement of clinical staff.

In all instances, Covered Services should be provided with proper supervisory oversight. The SPA requires harm reduction providers to implement quality assurance programs to ensure that documented activities are appropriately supervised. A harm reduction care plan must be developed for each participant, and a supervisor must be assigned who is responsible for reviewing the original care plan, and for reassessing the care plan every 180 days. In addition, the entire staff must meet at least once quarterly to discuss specific participant cases. Discussions between supervisors or care plan managers must be case specific, and details of the discussions must be documented in the care plan.

c. Staff Licensure Requirements

The SPA does not specify the licensure requirements for specific staff positions, although it does reference SED categories and titles. To ensure harm reduction staff performing specific types of Covered Services have adequate training, the training and licensure requirements for positions such as counselors, community health workers and health educators need to be clearly enunciated. For example, the SPA or the Standards do not indicate whether Licensed Clinical Social Workers ("LCSWs") or Licensed Master Social Workers ("LMSWs") are specifically required to fill roles and furnish services, or whether these roles may be filled by qualified peer supports. To ensure that all staff members of harm reduction providers have a base line understanding of the harm reduction philosophy, including peer workers, IDUHA recommends the development of a mandatory "Harm Reduction Service Provision" training course that must be provided to all staff members furnishing reimbursable services.

Individual service delivery for the Covered Services should be furnished by a trained/experienced individual, even if unlicensed, who has developed trust and a working relationship with the participant.

d. Special Confidentiality Considerations

As currently drafted, the SPA does not address directly the importance of confidentiality to the harm reduction treatment philosophy. Many harm reduction participants have participated, or currently participate, in illegal activities related to their substance use. In order to conduct successful outreach and maintain trust for ongoing services, harm reduction providers must be able to assure participants that any information disclosed during the harm reduction process will remain confidential, and there will be no repercussions for disclosed activities. As such, the SPA should contemplate that harm reduction providers have no obligation to report to law enforcement, and furthermore must maintain confidentiality in accordance with HIPAA (and its implementing regulations) as well as 42 C.F.R. Part 2. In addition to not being required to report on individual syringe distribution, as described above, harm reduction providers must be given discretion, subject to reasonable state oversight, regarding the inclusion of past drug abuse, involvement in illegal activities and other confidential information in any required documentation. Specifically, any state guidelines and/or regulations should not dictate that this type of clinical information be a mandated component of any clinical recordkeeping requirements.

e. Facility Requirements

The SPA also does not address directly what requirements, if any, a harm reduction facility must meet. As reflected to some extent in the draft SPA and in this white paper's recitation of the harm reduction philosophy, community-based service delivery is essential to the success of harm reduction, both in engaging a difficult to reach participant population and ensuring compliance with treatment objectives. Any state guidelines and/or regulations should reflect this.

It is IDUHA's position that:

- *All Covered Services, including counseling, wellness activities, peer training and crisis intervention, should be exempt from any requirements that they be furnished at the program site; and*
- *Other than standard building safety requirements (e.g., fire codes), any facility requirements imposed on the physical site of the harm reduction program should be minimal and not more than required to protect confidentiality of participant encounters and participant information.*

2. Billing Requirements and Method of Reimbursement

The draft SPA is notably silent regarding the specific methodology by which harm reduction services will be reimbursed by the state or MCOs. Moreover, the Standards that accompany the SPA do not specify whether the intensity of the service offerings will result in different levels of reimbursement for the Covered Services. Furthermore, the Standards do not make distinctions between whether certain standards, including duration and documentation, are programmatic standards, in that they affect licensure and eligibility for reimbursement, or are billing standards in that they affect reimbursement or subsequent recoupment regarding claims for covered services.

IDUHA and other members of the harm reduction community anticipate, based on discussions with AI and DOH, that the Covered Services will be reimbursed similar to freestanding diagnostic and treatment centers licensed under Article 28 of the Public Health Law and use Ambulatory Patient Groups ("APGs") to receive rate-based reimbursement on a per-encounter basis. While IDUHA supports this payment methodology, we also wish to recommend an alternative payment structure for future consideration, which could be implemented as part of a demonstration project following the approval of Medicaid funding for harm reduction services.

IDUHA believes that a per-encounter reimbursement methodology based on APGs, whereby a program must submit a separate claim for each Covered Service furnished to a harm reduction participant, may not adequately account for the programmatic and operational practicalities of harm reduction services as well as key aspects of the nature of harm reduction service delivery. Furthermore, IDUHA is concerned that a per-encounter, APG-based reimbursement methodology may also impose burdensome administrative requirements on providers to develop billing infrastructure and systems similar to that of much larger and experienced Medicaid providers. This administrative burden would decrease available resources to put towards service delivery.

Set forth below is an alternative reimbursement methodology, based on established Medicaid reimbursement principles, which IDUHA believes may be better aligned with the nature of harm reduction services. In proposing this alternative reimbursement methodology, IDUHA surveyed the ways that Medicaid reimburses other types of providers for certain service modalities furnished to high-need Medicaid recipients. IDUHA believes that this approach could more appropriately balance the programmatic needs of harm reduction programs against the need to ensure adequate clinical documentation is completed to prevent fraud, waste and abuse. This reimbursement methodology would apply to claims submitted by harm reduction providers to both DOH and MCOs. IDUHA requests the opportunity to participate in a demonstration project in order to introduce this reimbursement methodology and establish its efficacy as applied to harm reduction services.

a. Proposed Demonstration Project: Monthly Base Rate

i. Description of Methodology

As opposed to a traditional, encounter-based reimbursement methodology, whereby harm reduction providers must submit a claim to DOH or an MCO within 90 days (or another time period as determined by an MCO contract) following the provision of any one of the Covered Services contained in the draft SPA, IDUHA would seek reimbursement based on a monthly case payment basis. Under this methodology, harm reduction providers would receive a monthly base rate in exchange for furnishing a minimum number of units of Covered Services in that month to enrolled participants. The number of units of Covered Services furnished to a participant would correspond to a contact or encounter with a participant and be accumulated during the course of each month during which the participant participates in the harm reduction program. The number of units would in turn determine whether the base rate can be billed by a provider for an enrolled participant during the month.

The monthly base rate would be tied to several factors, including the documented acuity and needs of the participant; the number of medically necessary Covered Services ("service frequency") during the month based on a participant's comprehensive risk assessment; and the duration of Covered Services furnished. Based on these factors, if a harm reduction provider satisfies the minimum service frequency requirement for the billing month by delivering Covered Services that both meet the durational requirements and are consistent with the participant's comprehensive risk assessment and care plan, it will be entitled to the monthly base rate for that participant. For purposes of this reimbursement methodology, a qualifying unit or encounter would constitute satisfying the standards for any one of the Covered Services. For example, a qualifying unit might involve the participant's attendance at a weekly support group that lasts two hours; a participant arriving at the harm reduction program and engaging in a wellness activity in connection with a meal or acupressure session for 30 minutes; or a harm reduction staff member engaging in a text message conversation with the participant for purposes of monitoring and follow-up services.

Under this proposed methodology, a harm reduction provider is responsible for assessing and reassessing each participant to determine the required service frequency and determining whether Covered Services qualify as an eligible unit of service for billing purposes. Given the participant-driven and flexible nature of harm reduction programs, a participant's needs and resulting service frequency very often change over time, which dictate the number of service units that would be required for the monthly case based payment.

ii. Safeguards and Curbs on Under- and Over-Utilization

In addition to the proposed documentation requirements described below, this reimbursement methodology builds in several features that are designed to curb any potential for under- or over-utilization. This monthly base rate reimbursement methodology would be subject to a maximum number of units in a given month, over which harm reduction providers

are still able to provide services, but for which the monthly case rate would not provide reimbursement. This cap aligns the monthly rate with the previously established needs of the participant, as set forth in the care plan. Accordingly, a provider is dis-incentivized from furnishing Covered Services that are not needed by the participant, as they would be in a traditional individual encounter-based reimbursement methodology. Moreover, if a participant is constantly exceeding his or her pre-determined service units in a given month, then the harm reduction provider could use this service utilization pattern as part of a reassessment process and care plan adjustment.

Imposing a minimum threshold, or a floor, on the number of units of Covered Services that are required to be furnished in a month also helps curb under-utilization. If a provider fails to achieve the minimum number of service units in a given month, then the provider is at risk for not being able to bill at all for that participant. The possibility of nonpayment also serves to prevent the provider from inappropriately raising the service frequency in order to increase the base rate. If the target service frequency is set too high, the provider risks failing to complete the minimum number of Covered Services in a given month, which would result in no reimbursement. This floor thus encourages providers to ensure that enrolled participants are adequately engaged month-to-month, which builds on the strengths of harm reduction to engage harm to reach participants and foster trust such that these participants continue to seek services. IDUHA proposes that any established billing standards that subscribe to this reimbursement methodology would impose reasonable limits on how many units of Covered Services could be offered to a participant in the same calendar day or program visit.

While IDUHA believes that many of the Covered Services are synergistic and are expected to be offered during a single encounter, placing a reasonable limit will further encourage long-term participant engagement and reflects that multiple Covered Services offered in the same day may have diminishing efficacy.

iii. Applicability to the Harm Reduction Philosophy

As reflected above, this monthly base rate methodology aligns well with the treatment goals and philosophy of harm reduction and appropriately reflects the underlying policy objectives for extending Medicaid reimbursement to harm reduction programs. In particular, IDUHA notes the following features of this reimbursement methodology that are ideal for harm reduction:

- ***In many ways, harm reduction is a hybrid method of service delivery that combines features of case management and traditional clinic-base services.*** By establishing a monthly base rate that is tied to documented and medically necessary encounters, accounted for by service units, this methodology borrows elements from, and appropriately balances features of, case management reimbursement (e.g., monthly billing following enrollment) and clinic-based reimbursement (e.g., documented service encounters).

- ***Harm reduction differs from traditional substance abuse and behavioral health treatment programs by encouraging long-term relationships.*** This methodology encourages harm reduction providers to maintain a long-term relationship with participants and to ensure that these participants remain actively engaged in their treatment through monitoring and follow-up by the provider.
- ***Harm reduction services are participant-driven.*** This methodology provides flexibility so that the participant can dictate, between the minimum threshold and maximum cap, how many Covered Services he or she needs in a given month and provides flexibility to account for monthly changes in utilization patterns. Moreover, harm reduction providers are given flexibility to adjust covered services on a monthly basis based on participant needs.
- ***There is a wide range of Covered Services***. The Covered Services differ substantially in intensity, duration and staff demands. By permitting monthly billing based on aggregated service units, a harm reduction provider can balance the mix of Covered Services and ensures that each type of Covered Services is provided in the context of larger treatment.
- ***Harm reduction providers do not have experience in traditional fee-for-service reimbursement methodologies***. Monthly base rate reimbursement eases the administrative burdens associated with encounter-based billing in that each encounter will not result in a claim submission to a payor. Moreover, monthly billing permits providers to establish a process through which review of a participant's case for accuracy and against billing standards at month's end occurs before billing.

iv. Use of Monthly Base Rate Methodology in Other Medicaid Covered Services

This type methodology is not without precedent. There is an array of Medicaid-approved services and treatment modalities, specifically with regard to behavioral health and long-term support services, that use a monthly base rate reimbursement methodology similar to what IDUHA believes is best suited for harm reduction services. A brief recitation of three selected examples of services and treatment modalities include:

- **Comprehensive Personalized Recovery Oriented Services ("PROS")**. PROS is a comprehensive recovery oriented program established by the New York State Office of Mental Health ("OMH") for individuals with severe and persistent mental illness. The goals of PROS are to integrate treatment, support and rehabilitation in a manner that facilitates the individual's attainment of goals, which may include improved functioning, reduced inpatient utilization, reduced emergency services, increased employment and securing housing. PROS, like harm reduction, treats a high-need population and permits for the participant and provider to develop shared, but flexible goals towards recovery. In addition, PROS has a strong community rehabilitation and support component and recognizes that participant engagement can save costs by reducing more expensive,

higher acuity services. Like the methodology described above, PROS is billed monthly based on the frequency of service units furnished to participants in a given month.[25]

- **Individualized Care Coordination**. ICC is an OMH-regulated home and community based waiver service whereby providers under contract with OMH offer care coordination services to children and adolescents with serious emotional disturbance. The goal of ICC is to prevent long-term institutionalization through the development of an individualized care approach, which may include many services that are similar to the Covered Services found in the draft SPA. Again, ICC involves a hard to engage population, with a larger program goal of reducing more serious and expensive diagnoses and treatment options. ICC, like harm reduction, recognizes that fostering a long-term relationship is vital to achieving the program goals, which was accomplished through a monthly-base rate methodology calculated through the number of face-to-face encounters.[26]
- **Supported Employment Program ("SEMP")**. SEMP services are offered to intellectually and developmentally disabled individuals who often receive services through providers licensed by the New York State Office for People with Developmental Disabilities ("OPWDD"). SEMP services assist individuals in finding and maintaining employment that is meaningful to them and requires providers of SEMP services to provide a minimum number of face-to-face contacts to ensure that the enrolled participant is achieving employment objectives. Like the reimbursement methodology described above, once the provider documents that it has provided the minimum number of encounters through a monthly progress note and related document, it is entitled to bill for the services.[27]

b. Supporting Documentation

IDUHA and the harm reduction community recognize that completion and maintenance of supporting documentation is necessary to both track a participant's progress in meeting goals and objectives as well as to substantiate that billable services have been furnished. The Standards that accompanied the draft SPA provide guidance as to the documentation that must be completed in the course of furnishing such services. The documentation requirements are specific, but provide some flexibility as to what might be most appropriate for the particular service delivered. For example, harm reduction providers are required to complete documentation of counseling sessions, which may be in the form of the service log, summary or case note in the participant's chart. For support groups, documentation is required to include the names of participants, a summary of the topics covered and highlights of the discussion, but the Standards do not indicate the exact form and format of such documentation.

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[25] 14 N.Y.C.R.R. § 512; *Personalized Recovery Oriented Services (PROS) Finance Handbook*, OFFICE OF MENTAL HEALTH, http://www.omh.ny.gov/omhweb/pros/finance.

[26] 14 N.Y.C.R.R. § 6002. ICC services also provide an enhanced rate for "Start-Up Services," which as discussed in Section III.A.1 can serve as a model for reimbursement of street outreach.

[27] *ADM #2007-01, Supported Employment Service Delivery and Documentation Requirements*, OPWDD (Nov. 15, 2007), http://www.opwdd.ny.gov/node/984.

While IDUHA supports these documentation standards as a best practice and programmatic requirement to govern eligibility to participate in the program under the original encounter-based payment methodology, these standards should not also represent the billing requirements for the demonstration project. As discussed above, the unique nature of harm reduction services are better addressed through a monthly base rate methodology, which has been used for other Medicaid covered services that reimburses providers for treating a high-need participant population with multiple encounters in a given month. Imposing rigorous documentation standards for each encounter to support billing the monthly base rate may impose an unreasonable burden on program staff to document and assess progress of a participant in each instance, even when a participant's ability to meet his or her established goals and objectives is far from linear. Moreover, a participant may utilize program services extensively in the course of a month, which would result in "documentation fatigue" and jeopardize the integrity of a participant's case record.

In lieu of service-specific documentation requirements to support billing under the demonstration project, harm reduction providers would determine, on a programmatic basis, what types of documentation in the case record will reflect the participant's partaking in specific Covered Services in compliance with the broad parameters contained in the Standards.[28] To support billing the monthly case rate, the Standards would be limited to requiring providers to document when the participant received Covered Services and an overall monthly assessment of the participant's progress towards his or her stated objectives in the care plan. Similar to the other Medicaid covered services that use a monthly base rate,[29] the required documentation for billing under the demonstration project could include:

- **Plan of Care**. IDUHA recognizes that the plan of care constitutes the core documentation that establishes a participant's need for harm reduction and the participant's goals and objectives associated with the receipt of service. Maintaining an updated plan of care should be required both as a programmatic standard and as a billing one.

[28] IDUHA anticipates that harm reduction providers will maintain a case record with documentation that supports the provision of Covered Services, even if such documentation is not a pre-requisite to billing. This documentation will include notes from outreach activities once a participant is enrolled in services; the participant's plan of care (and any amendments thereto based reassessments); documentation supporting the intake and comprehensive risk assessment upon which the plan of care is based; participant case notes for counseling sessions and support groups; releases, consent forms and authorizations; results of screenings and tests; service and training logs; and other documentation to reflect the provision of Covered Services. Notwithstanding the anticipated retention of this documentation, failure to maintain such documentation should not affect the provider's ability to bill for a monthly base rate nor subject any past reimbursement to recoupment if such documentation of Covered Services is not maintained.

[29] For example, the documentation requirements for the PROS program include: an Individualized Recovery Plan (Plan of Care); a Record of Service, which includes information such as the type of service provided, the date and the duration for service provided to a participant (Service Log); and a progress note, which must be completed a least once per calendar month (Monthly Note). *See* PROS Documentation – An Overview, New York State Office of Mental Health, Bureau of Program Coordination & Support, Rehabilitation Services Unit (June 2009), *available at* http://www.omh.ny.gov/omhweb/pros/overview.html#a.

- **Service Log**. The Standards reflect that most Covered Services will be documented through a service or training log. These logs would constitute simple documents that reflect the participant's receipt of services on a particular day, the duration of such services and how such Covered Services related to a participant's goals and objectives in the plan of care. Although harm reduction providers would likely maintain other documentation associated with the delivery of certain Covered Services (e.g., counseling sessions, support groups), the maintenance of such documentation would not be dispositive to the provider's ability to submit a claim for the monthly base rate. Rather, the harm reduction provider would look to the service log to determine whether the participant received a sufficient number of necessary Covered Services in order to bill for that month.[30]
- **Monthly Note**. As a capstone to billing the monthly base rate, the Standards should mandate that harm reduction providers complete a monthly progress note that summarizes the services received, how such services related to pre-established goals and objectives and whether, based on the participant's progress, there should be changes to the participant's goals and objectives during the next re-assessment.

Collectively, these three types of documentation would appropriately balance the need to memorialize the participant's receipt of Covered Services during a month against the unique, participant-driven nature of the harm reduction treatment philosophies and the realities of caring for this high need population.

IV. INTEGRATION OF HARM REDUCTION INTO THE MEDICAID REFORM LANDSCAPE

Approval of the SPA without due consideration of how coverage for harm reduction services will align with existing Medicaid reform activities with regard to care management is necessarily incomplete. The harm reduction treatment philosophy and harm reduction services are consistent and entirely supportive of care management principles in several key respects:

- Providers identify Medicaid-eligible individuals through outreach efforts and help link those individuals with needed health, housing and support services;
- Providers utilize accepted case management techniques to ensure that participants are receiving needed services, whether education, counseling, health services or other support and follow-up, where appropriate; and
- Providers report data and other information on a routine basis in an effort to monitor health outcomes and track progress.

Notwithstanding this synergy, as the state advocates for stronger care management by Health Homes, Medicaid MCOs, BHOs, HIV Special Needs Plans ("SNPs") and HARPs, the SPA needs to account for the relationship between harm reduction and the transition from the fee-for-service reimbursement. In light of this changing reimbursement landscape, consideration of

[30] Future billing standards should permit harm reduction providers to retain such other documentation in lieu of the less onerous service log, if the provider elects to retain such alternative documentation for billing purposes.

this relationship between harm reduction and care management is essential to the longevity of achieving a meaningful reimbursement methodology for harm reduction services.

A. Combining Harm Reduction with Other Medicaid Proposals Focusing on Care Management for All

The MRT's recommendations did not provide a specific mechanism for Medicaid coverage of harm reduction services, but did state that coverage should build on current grant funding.[31] Early discussions on the appearance of Medicaid coverage for harm reduction services focused on fee-for-service models that would reimburse providers in a similar fashion to traditional substance abuse and behavioral health providers. Moreover, other than referencing Health Homes and stating the goal to prevent "duplication or disruption of efforts" with regard to a participant's other providers, the SPA is silent as to how coverage for harm reduction will complement with other reform efforts, which include Health Home assignment and Medicaid MCO enrollment, to enhance care coordination and reduce costs.

IDUHA shares the goals of the MRT in advocating for strong care coordination among harm reduction participants and believes that direct fee-for-service reimbursement does not account for what makes Medicaid coverage for harm reduction services a unique opportunity for reform and achieving substantial cost savings. Specifically, any expansion of reimbursement to harm reduction needs to consider how coverage of these services will fit into the larger structural goals of DOH to have all Medicaid enrollees served in care management by April 2016,[32] as well as the federal ban on funding for syringe exchange programs last imposed by Congress in December 2011. To this end, IDUHA considers how state coverage for harm reduction services will align with Health Homes, mandated enrollment in Medicaid MCOs and BHOs. Set forth below is a description of how harm reduction services may be integrated within these larger changes to Medicaid.

IDUHA's members are committed to contributing their knowledge and expertise to Health Homes, BHOs and Medicaid MCOs, both through outreach and service coordination, but remain in a position in which they are unable to fully make such participation feasible from an economic and operational standpoint because of the lack of funding for service support.

B. Harm Reduction Providers and Health Homes

The development and implementation of Health Homes in New York State represents a fundamental shift in how Medicaid beneficiaries with high-cost and complex chronic conditions receive services and must be considered in light of any Medicaid coverage proposals for harm

[31] Current grant funding streams must remain in place to supplement any Medicaid reimbursement and to ensure that syringe exchange, a critical component of harm reduction services, continue to be supported in light of the federal ban of funding.

[32] *Care Management for All*, NEW YORK STATE DEPARTMENT OF HEALTH, http://www.health.ny.gov/health_care/medicaid/redesign/docs/care_manage_for_all.pdf.

reduction services. IDUHA supports the goals of Health Homes, which are to improve health outcomes and avoid duplication of services through assignment of a primary "care manager" and the promotion of extensive communication and data exchange between and among the array of providers from whom an individual receives services.[33] Health Homes are phasing out the traditional case management functions historically performed by Medicaid providers on an unreimbursed de facto basis or through previously reimbursed care coordination services, such as Targeted Case Management ("TCM").[34] IDUHA's members have provided extensive care coordination, both on an unreimbursed basis and on a reimbursable basis through TCM programs, and have worked with Phase I Health Homes to support the transition of our participants with chronic and high-cost diagnoses, such as HIV, HCV, substance abuse, mental health conditions and/or other co-morbidities, to Health Homes.

Some New York harm reduction providers are either participating in Health Homes or have been approached to participate in Health Homes . That said, without access to state resources to support acquisition and integration of health information technology infrastructure, any participation by harm reduction providers in Health Homes will be incomplete. Harm reduction is a natural fit within the Health Home structure, as the vast majority of harm reduction participants meet the Health Home requirements based on anticipated diagnoses. In addition, harm reduction providers already offer many of the key services required to be provided by Health Homes, including: care management; care coordination and health promotion; transitional care; individual and family support; and referral to community and social support services. There are a number of different roles within the Health Home structure that harm reduction providers can participate.

1. Network Provider

Harm reduction providers may join a Health Home network as a provider. As part of the network, providers would be eligible to deliver harm reduction services to Health Home beneficiaries when recommended by the care manager in exchange for agreeing to data reporting requirements and meeting other standards prescribed by the Health Home "hub." However, currently there is no structure in place that allows for a provider to bill for services furnished pursuant to a referral from a Health Home, unless proposals for Medicaid coverage of harm reduction come to fruition. In order for this relationship with Health Homes to function, harm reduction must either be directly reimbursable by Medicaid, or added as a service required to be covered by MCOs as part of a bundle of health services offered to plan enrollees. Accordingly, providing Medicaid coverage for harm reduction services will encourage harm reduction providers, including members of IDUHA, to serve as key linkages and provide support to Health Home enrollees. In many ways, the success of Health Homes for the State's

[33] *Medicaid Health Homes*, NEW YORK STATE DEPARTMENT OF HEALTH, http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/.
[34] *Targeted Case Management (TCM) to Health Homes (HHs) Information*, OFFICE OF MENTAL HEALTH, http://www.omh.ny.gov/omhweb/adults/health_homes/.

population of injection drug users is tied to the expansion of Medicaid coverage for harm reduction services.

2. Downstream Case Management

A second way that Medicaid-authorized harm reduction providers can participate in Health Homes is as a downstream care coordination entity. Under existing rules and guidance, Health Homes may offer a portion of their per member per month payment ("PMPM") received from the State for care coordination services performed by downstream care management entities.[35] As the State formalizes the Medicaid-eligibility of harm reduction providers, the State and providers should explore jointly whether harm reduction providers, especially those who have operated TCM programs, are able to serve as a downstream case management provider for a Health Home. Moreover, as elements of the Covered Services specifically contemplate roles that either supplement or complement the care management furnished by Health Homes, the State should encourage Health Homes to leverage harm reduction providers to serve in a downstream care management capacity.

3. Outreach

Outreach is another Health Home function at which harm reduction providers excel. As harm reduction providers already have built a strong outreach network with ties in many at-risk communities, Health Homes that partner with harm reduction providers for outreach will be able to reach a greater percentage of their assigned beneficiaries. However, while Health Homes are eligible to receive 80% of a participant's PMPM for up to three months of outreach, they are currently unable to reimburse harm reduction providers with part of that PMPM payment if the harm reduction provider identifies an eligible Health Home beneficiary or if the harm reduction provider works with the Health Home to locate and engage a pre-assigned member.

In order to take advantage of harm reduction providers' experience and effectiveness in this field, Health Homes must be granted express permission, and be encouraged, to subcontract and share a portion of the PMPM for outreach activities to this population. Alternatively, street outreach could be separately designated as a Health Home service, and harm reduction providers could receive a capitated payment in exchange for conducting outreach for a Health Home. This expansion of the use of a Health Home's PMPM is important given early challenges in engaging assigned beneficiary populations.

Given the continued challenges with Health Home enrollment, particularly for assignees with high needs and high costs, new mechanisms and strategies to support outreach and enrollment should be pursued. Harm reduction and other providers with access through a Health Home network to the Health Home Tracking System (HHTS) portal should be

[35] *Health Homes Provider Manual: Billing Policy and Guidance*, NEW YORK STATE DEPARTMENT OF HEALTH (May 20, 2013), http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/hh_prov_manual.pdf.

incentivized to identify and enroll eligible members who have been assigned but not found nor enrolled through outreach efforts through a payment. This model could be further supplemented to reward high quality outreach, enrollment and linkage through providing a supplementary performance payment when those members are successfully retained and engage in health services within six months of enrollment. This structure would facilitate greater enrollment and participation in Health Homes by establishing a "finders fee"/bonus payment model for harm reduction providers with existing contacts and relationships with assigned but unenrolled members.

An additional strategy to supplement Health Home outreach would entail a competitive grant program to support organizations with strong outreach components, such as harm reduction providers, to conduct active and intensive outreach and Health Home enrollment efforts, with a focus on high cost/high need members such as those with histories of homelessness and incarceration. Such a program could follow the Assertive Community Treatment (ACT) model, reflecting the intensity of outreach efforts required to enroll and retain these members. A grant program would enable harm reduction providers with existing outreach efforts to expand their capacity to deliver high-quality, intensive case-finding and enrollment for a critical subpopulation of members.

4. Special PMPM for Harm Reduction Enrollees

Regardless of the structure of the relationship between harm reduction and Health Homes, the PMPM paid by the State for harm reduction participants in Health Homes needs to be adequate in order to compensate both entities for the services provided. Harm reduction participants typically have multiple key diagnoses, including substance abuse, HIV/AIDS, HCV or the potential to contract these chronic diseases. While this is partly reflected in the acuity score basis for PMPM rates, the acuity score alone does not distinguish between level of intensity required for populations served by harm reduction providers with a substantial propensity for other social determinants of health, particularly histories of homelessness and incarceration. These latter factors are reflected in greater marginalization from the health care system, weaker social supports, and poorer functional status, all requiring distinct strategies and substantive efforts to meet their care management needs. The care management of these individuals is therefore more complex yet also more important, as while greater attention is required to ensure the necessary care is delivered, the potential for costs savings is also magnified. The creation of a special PMPM for the population of harm reduction participants, with a high rate in recognition of key diagnoses, will ensure that providers are adequately compensated for their efforts, and also incentivize Health Homes to enroll these individuals who could generate vast cost savings.

C. Harm Reduction Services as a Medicaid Managed Care Covered Benefit

In recognition of DOH's established goal to have virtually all Medicaid enrollees served in care management by April 2016, any reimbursement proposals for harm reduction services also need to consider the future relationship between harm reduction and Medicaid MCOs.

Currently, many harm reduction participants are eligible for participation in SNPs, HARPs or may otherwise qualify for enrollment in Medicaid MCOs, such as partial capitation long term care plans or mental health and substance abuse SNPs. Ensuring coverage for the full complement of harm reduction services through the SPA will be effective only if SNPs, HARPs and physical health Medicaid MCOs support harm reduction treatment principles as legitimate services, establish rates that are adequate to reimburse the costs of providing covered services, impose reasonable reporting requirements and credential harm reduction providers in accordance with accepted principles and in a non-discriminatory fashion. Moreover, the care management functions performed by these MCOs should align with the treatment approaches approved by the state, such that harm reduction providers are not excluded on a de facto basis through unreasonable prior authorization requirements, claims denials or retrospective recoupment and utilization review. IDUHA recommends that the following steps be taken in order to ensure that the full complement of harm reduction services will remain available under MCOs.

1. Protections to Guarantee Successful Expansion of Harm Reduction Services as a Managed Care benefit

Under managed care arrangements, MCOs receive capitated funds from the State for each enrollee in their program at a rate determined by the Medicaid network. Rates of reimbursement to service providers, as well as qualifications of these providers as conditions of joining the MCO network, however, are primarily dictated by the contractual provisions of the MCOs. Accordingly, the administrative and contractual complexities of adding harm reduction providers to MCO networks, combined with the potential that MCOs may not embrace harm reduction as a covered service, creates a potential incentive that MCOs will affirmatively exclude harm reduction agencies from their provider networks, fail to refer qualifying enrollees to harm reduction providers or create administrative barriers prohibitive to reimbursement of harm reduction services.

Regardless of whether harm reduction services become eligible for Medicaid reimbursement on a direct fee-for-service basis through the State or through an MCO's provider network, IDUHA strongly encourages the State to implement reasonable safeguards to ensure that harm reduction providers are able to participate fully in both reimbursement models. To accomplish full participation of harm reduction providers in MCO provider networks, it is IDUHA's position that the State should intervene on a temporary basis (for at least one year) in the MCO contracting process and adopt reasonable safeguards to protect against the risk of affirmative or effective exclusion of harm reduction providers and services. These safeguards include:

- **State-Mandated Inclusion**. DOH should mandate that all MCOs that enroll members who are identified injection drug users or are at risk of being injection drug users, including HIV SNPs and HARPS, to include any willing provider offering harm reduction services within its provider network. This mandated inclusion will ensure that enrollees have an option to select harm reduction services over abstinence-based drug treatment

programs.**Universal Credentialing**. DOH should require MCOs to adopt the same licensure and credentialing requirements imposed by AI and as discussed in this white paper. Accordingly, if a harm reduction provider meets AI-established criteria for being able to bill Medicaid on a fee-for-service basis, an MCO should not be able to impose any additional credentialing requirements that would serve to exclude otherwise eligible harm reduction providers from participation in the MCO's network.

- **Billing Requirements and Rate Structure**. Given that many harm reduction providers have never before engaged in provider agreement negotiations with MCOs, DOH should require MCOs to offer the same rates that are first promulgated by DOH for Medicaid fee-for-service beneficiaries for two years. Similarly, in the event that the monthly base rate billing methodology demonstrations is successful, MCOs should be encouraged to adopt this methodology under commercial contracts.
- **Reasonable Limitations on Prior Authorization and Retrospective Review**. Once an MCO's member has been enrolled in a harm reduction course of treatment, as evidenced by creation of a plan of care, the MCO should be restricted from imposing prior authorization requirements or undertaking recoupments for any Covered Services that are deemed consistent with the enrollee's plan of care. This requirement will not absolve harm reduction providers from complying with MCO requirements on amending plans of care to expand Covered Services offered to a member nor will it preclude MCOs from reviewing plans of care and service offerings to ensure that they are medically necessary. However, at least during the initial roll-out of harm reduction as a managed care benefit, the Covered Services furnished consistent with a plan of care must be deemed presumptively valid to ensure that harm reduction providers are not handicapped in their ability to identify and furnish medically necessary care through MCO-imposed administrative hurdles, such as prior authorization and post-hoc retrospective reviews. Initial intake and comprehensive assessment should be deemed presumptively valid and excluded from prior authorization requirements. Appropriate assessment instruments that identify need for harm reduction services will be important for MCOs and HARPs to guide utilization.

2. Formation of an IPA

To complement these initial State-imposed safeguards on the expansion of harm reduction services as an MCO-covered benefit, harm reduction providers must also collaborate to prevent erosion of these safeguards following their sunset. The approved corporate vehicle for such collaboration comes in the form of an IPA. IPAs are special purpose entities that are able to contract collectively on behalf of multiple providers as well as bear downstream risk through sub-capitated arrangements or other risk-based arrangements, such as quality of care withholds.[36] Additionally, IPAs are able to perform delegated management functions under contract with MCOs, which may include quality assurance, utilization review, provider

[36] *Provider Contract Guidelines for MCOs and IPAs*, NEW YORK STATE DEPARTMENT OF HEALTH (March 39, 2011), http://www.health.ny.gov/health_care/managed_care/hmoipa/guidelines.htm.

credentialing and claims processing.[37] IDUHA believes that voluntary collaboration among providers through an IPA will help participating harm reduction providers both improve the quality of their services and prepare for the expansion of managed care coverage into the harm reduction provider community.

Collaboration through an IPA may come in the form of clinical integration, financial integration, or both. Clinical integration refers to providers developing systems and processes through which providers collaborate on furnishing clinical services to participants based on common clinical practice protocols as well as undertaking other efforts to ensure that all providers furnish services at a uniform level of care.[38] Financial integration means that providers share the financial burden and bear risk associated with caring for a group of managed care enrollees.[39] Achieving meaningful financial and/or clinical integration is essential to leveraging the core purposes of an IPA and facilitating effective collaboration among participating harm reduction providers in addressing the seen and unforeseen issues associated with MCO coverage of harm reduction services.

D. Harm Reduction Providers and Behavioral Health Organizations

BHOs will also need to figure prominently in any state proposals for Medicaid coverage of harm reduction. Although Phase I BHOs do not bear risk, they perform additional notification and information gathering functions specific to individuals with serious mental illness or substance use disorders.[40] Formalizing Medicaid coverage for harm reduction will help providers facilitate cross-systems linkage for individuals who are required to be tracked by BHOs and who utilize harm reduction services. As BHOs enter Phase II and begin to bear risk in conjunction with other managed entities, care management and performance measures conducted by these entities will need to align with harm reduction coverage principles. Otherwise, BHOs may limit access to harm reduction services that were previously available on a fee-for-service basis.

Medicaid funding proposals need to address specifically the role of harm reduction as part of a larger care coordination process and reimburse providers accordingly.

CONCLUSION

Despite all of its benefits, integrating harm reduction services into existing benefit programs presents difficult issues and challenges for harm reduction providers. Ensuring that existing harm reduction providers are prepared for the changing reimbursement landscape and

[37] *Id*.
[38] Gary J. McRay, *Clinical Integration as an Alternative to the Messenger Model*, Foster Swift Health Care Law Report (2008).
[39] *Id*.
[40] *Behavioral Health Organizations Implementation*, OFFICE OF MENTAL HEALTH http://www.omh.ny.gov/omhweb/bho/

working with DOH, AI and other state regulators in developing coverage proposals consistent with established harm reduction proposals is essential. Although this white paper attempts to identify in a comprehensive fashion those issues associated with the expansion of Medicaid coverage to harm reduction (as well as present some solutions), there are likely to be other challenges that are either unforeseen or unexpected. IDUHA looks forward to working with the provider community, the State and MCOs in ensuring that injection drug users and other populations that benefit from harm reduction are cared for appropriately and efficiently to achieve shared goals of improved health outcomes and lower costs.

GLOSSARY OF ACRONYMS

- AI – AIDS Institute
- APGs – Ambulatory Patient Groups
- BHOs – behavioral health organizations
- CASACs – Credentialed alcohol and substance abuse counselors
- CMS – Centers for Medicare & Medicaid Services
- DOH – Department of Health
- HARPs - Health and Recovery Plans
- HCV – hepatitis c
- ICC – Individualized Care Coordination
- IDUHA – Injection Drug Users Health Alliance
- IPA – Independent practice association
- LCSWs – Licensed Clinical Social Workers
- LMSWs – Licensed Master Social Workers
- MCOs – Medicaid Managed Care Organizations
- MRT – Medicaid Redesign Team
- OASAS – New York Office for Alcohol and Substance Abuse Services
- OMH – New York State Office of Mental Health
- OPWDD – New York State Office for People with Developmental Disabilities
- PMPM – per member per month
- PROS – Comprehensive Personalized Recovery Oriented Services
- SED – State Education Department
- SEMP – Supported Employment Program
- SNPs – HIV Special Needs Plans
- SPA – State Plan Amendment
- TCM – Targeted Case Management