Substance Use Disorder Treatment Policy Recommendations for the State of Indiana

Final Report — September 2018

Submitted to Governor Eric J. Holcomb and Jim McClelland, the Executive Director of Drug Prevention, Treatment, and Enforcement

The Pew Charitable Trusts

Executive Summary

The Pew Charitable Trusts (Pew) is an independent, nonpartisan research and policy organization dedicated to serving the public. Our substance use prevention and treatment initiative works with states to expand access to evidence-based treatment, such as medication-assisted treatment (MAT), for substance use disorders (SUDs).

Pew provides technical assistance to states that request Pew's expertise and support with a formal invitation. Pew's partnership with states is intended to assist in their efforts to achieve a treatment system that provides quality SUD treatment that is disease-focused, addresses stigma, and supports improved disease management and patient outcomes.

In response to the state's technical assistance invitation, Pew assesses the state's treatment system against a set of comprehensive treatment principles. This evaluation is based on:

- Interviews with key stakeholder groups. Overall, Pew consulted more than 100 individuals and organizations including representatives from state and local government agencies, elected and appointed officials, health care provider associations, clinicians, and patient advocates.
- Consultation with national experts and review of evidence-based strategies in both peer-reviewed publications and the gray literature (e.g., reports, briefings, case studies, and presentations).
- Focus groups with persons currently misusing opioids or in recovery, professionals who care for people with SUD, and family members of people with an SUD.
- Review of public data sets.

Pew provided an initial set of three policy recommendations to the Executive Director of Drug Prevention, Treatment, and Enforcement in October 2017;[*] an additional six recommendations are presented here. By implementing these recommendations in a timely manner, Pew believes that Indiana can improve access to effective treatment for people with SUD, helping to address a pressing public health crisis.

The six recommendations span three broad categories: 1) Treatment system transformation, 2) Substance use disorder workforce, and 3) Underserved populations.

[*] The recommendations included: 1) The Indiana Professional Licensing Agency (PLA) should study licensure standards for addictions counselors (i.e., substance use disorder counselors) and provide recommendations to the Governor on licensure for addictions counselors that maintain the highest standards for professional competence while eliminating unnecessary barriers for entry into the field; 2) Amend the statutory limit on OTPs to reflect opioid use disorder treatment needs in the state as determined by the Indiana Family and Social Services Administration (FSSA), which will use a standards-driven process to determine the optimal number of OTPs needed throughout the state; and, 3) Use a phased approach to mandate prescriber registration with the state's prescription drug monitoring program—Indiana Scheduled Prescription Electronic Collection and Tracking Program (INSPECT)—and prescriber use of INSPECT prior to issuing an initial prescription for an opioid or benzodiazepine and every 90 days as long as treatment continues.

Treatment System Transformation

Recommendation 1: The Governor should direct the Family and Social Services Administration (FSSA), in collaboration with the Executive Director of Drug Prevention, Treatment, and Enforcement, to develop a comprehensive, regulatory approach for office-based opioid treatment (OBOT) that considers quality improvement efforts, increasing number of providers, and diversion minimization with expert input and emerging evidence from other states.

Recommendation 2: The Governor should require annual reporting from the Family and Social Services Administration (FSSA) to describe the progress made in establishing new opioid treatment programs (OTPs) and increasing patient access to evidence-based care.

Recommendation 3: The Indiana legislature, in collaboration with the Family and Social Services Administration (FSSA), should revise the legal definition of recovery housing to prevent the exclusion of persons taking Food and Drug Administration (FDA)-approved medications for the treatment of substance use disorders (SUDs).

Substance Use Disorder Workforce

Recommendation 4: Indiana Medicaid, in collaboration with the Indiana Professional Licensing Agency (IPLA) should access its reimbursement rates for counseling services for substance use disorder (SUD) treatment in community-based settings and increase them as appropriate to improve access to these services

Underserved Populations

Recommendation 5: Building on programs initiated in Indiana's prisons, the Governor should task the Indiana Criminal Justice Institute (CJI) with assessing medication-assisted treatment (MAT) availability within county jails and develop a pilot program to expand availability of all Food and Drug Administration (FDA)-approved medications for opioid use disorder (OUD) in at least one county jail.

Recommendation 6: The Governor should task Indiana Medicaid, in collaboration with the Indiana Criminal Justice Institute (CJI) with establishing a pilot program for jails to test innovative ways to ensure Medicaid-eligible inmates reentering the community have Medicaid benefits unsuspended upon release, are aware of their Medicaid benefits, and are connected to health care in the community.

Introduction

Indiana policymakers have taken steps to promote access to effective treatment for individuals with OUD. In 2017, Governor Holcomb named combatting the opioid crisis as one of five pillars in his policy agenda. Recently, the state authorized the addition of nine more OTPs, raising the total programs authorized to operate in the state to 27, and ensuring that all Indiana residents are within one hour's drive of an OTP.[1] Indiana Medicaid also began covering methadone, one of three drugs approved by the FDA to treat OUD.[2] Groups in the state — including Indiana's Chamber of Commerce, Indiana University, the Richard M. Fairbanks Foundation, the Management Performance Hub, and the Bowen Center for Health Workforce Research and Policy — have forged partnerships to address issues such as workforce, data accessibility, and stigma reduction. Pew's recommendations build off the progress these groups have made.

In July 2017, Governor Holcomb and Jim McClelland, the Executive Director for Drug Prevention, Treatment, and Enforcement, invited Pew to provide technical assistance on expanding access to evidence-based treatment for SUD. Pew's technical assistance included a treatment system needs assessment based on stakeholder engagement, a review of public data, and a qualitative analysis through a series of focus groups and in-depth interviews. The needs assessment and qualitative research informed policy recommendations in this report.

Scope of the Opioid Crisis in Indiana

The opioid epidemic continues to affect Indiana families. Visits to emergency departments due to suspected opioid overdose increased 35 percent between July 2016 and September 2017 in Indiana according to the Centers for Disease Control and Prevention (CDC).[3] Additionally, from 2015 to 2016 drug overdose deaths increased 23.1 percent, to 1,526 people.[4] Indiana's opioid prescribing rate is higher than the national average (83.9 and 66.5 prescriptions per 100 people, respectively, in 2016).[5]

Despite the scale of the epidemic, Indiana lacks sufficient providers to deliver MAT and address the state's treatment needs. MAT—the use of FDA-approved medications for the treatment of OUD in combination with behavioral therapy—is the most effective way to treat OUD. People who receive MAT are less likely to die of overdose, use illicit opioids, and contract infectious diseases such as HIV and hepatitis C.[6]

One example of Indiana's treatment gap is the shortage of providers who can prescribe buprenorphine, another of the three medications approved by the FDA to treat OUD. Buprenorphine can be prescribed on a weekly or monthly basis for at-home use.[7,8] A 2015 study reported significant gaps between need and buprenorphine treatment.[9] This study, using data from 2012, reported that Indiana had a maximum potential buprenorphine treatment capacity rate of 2.8 patients per 1,000 people; neighboring states Kentucky (5.8 patients per 1,000 people), Michigan (5.3 patients per 1,000 people), and Ohio (4 patients per 1,000 people) all had higher rates. As another example, a 2016 Indiana licensure survey found that half (46 of 92) of Indiana counties have no full-time addiction counselor; 30 of the 46 counties (65.2 percent) are in rural areas.[10]

Stakeholder Engagement

Since July 2017, Pew has met with over 100 stakeholders across Indiana. These discussions strengthened understanding of state data, highlighted key barriers to evidence-based treatment, and helped focus recommendations toward areas of highest need for reform in Indiana. Broadly, these stakeholders included state agency leaders and program administrators, state legislators, county agency directors and staff, provider professional societies, individual providers across the continuum of care and across practitioner types, associations representing various care settings, individuals and organizations in the recovery community, and public and private insurers, among others.

Qualitative Research

With funding support from the Open Society Foundations, Pew contracted with the Prime Group to conduct qualitative research on the lived experiences of persons with OUD to explore motivators and barriers to seeking and receiving treatment for OUD. Prime Group conducted in-depth interviews, focus groups, and QualBoards® (online focus groups) as part of this qualitative data collection that helped inform the recommendations provided in this report. Data collection, using a convenience sample, included:

- In-depth interviews with national SUD leaders and persons currently misusing opioids or in recovery;
- In-person and online focus groups in Indiana with:
    - Persons currently misusing opioids,
    - Persons in treatment or recovery;
- In-person focus groups in Indiana with:
    - Health care and other professionals who engage with individuals with OUD, and
    - Family, friends, and/or caregivers of persons with OUD.

Additional information is discussed in the Findings section and quotes from these interviews are included in relevant recommendations.

It is important to highlight that the results of the qualitative data collection are anecdotal and directional, but not generalizable. The methods used in recruiting participants qualify as convenience sampling, relying upon networks, referrals, and databases of potential participants rather than pure probability sampling in which every member of the targeted population has an equal chance of being invited to participate. Accordingly, the findings are not necessarily reflective of the experiences of all people with OUD. Nevertheless, the findings from this qualitative research highlight the challenges that persons with lived experience of OUD face in seeking and accessing treatment.

Key Qualitative Research Findings

The research findings included themes across all data collection methods. Participants delineated two major categories of barriers – barriers to seeking treatment and barriers to accessing treatment.

Barriers to Seeking Treatment

- **Mental Health:** Most of the participants currently misusing opioids or in recovery had a history of mental health, emotional abuse, or trauma prior to their misuse of opioids. Many participants said they feared dealing with the challenges of their mental illness — depression, anxiety, bipolar disorder, post-traumatic stress disorder — without opioids. Many participants reported they used opioids to self-treat their emotional pain.
- **Self-Blame and Internalized Stigma:** When asked, "What prevented you from seeking treatment earlier (or at all)?", the most common answer was "Myself." There was a significant disconnect between most of the participants in the health care and other professionals focus groups who considered these individuals to be experiencing OUD, and the individuals themselves who thought they were weak or lacked willpower.
- **Stigma of OUD:** Nearly all the participants believed there was stigma attached to opioid misuse and OUD that served as a barrier to seeking treatment. This belief was prevalent among the public, employers, those in law enforcement and criminal justice, and even some providers of OUD treatment.
- **Stigma of MAT:** While some individuals participated in and benefitted from MAT programs, many others held very negative views of MAT. Many people said that persons in a MAT program were still "addicted" or "dependent" and not "sober" or "clean." Many participants considered MAT a "substitution" of one drug for another, and there was a suggestion among some that those choosing "sobriety" or "abstinence" were superior to those who "need" MAT. Some people believed that MAT inevitably leads to lifelong and ever-increasing dependence upon methadone or buprenorphine.
- **Fear of Detox and Withdrawal:** Those who experienced detox/withdrawal or watched others go through withdrawal without medication were very reluctant to enter any treatment program that did not offer medication assistance as part of the detox program. Interestingly, many of these same individuals rejected medications for long-term treatment as "substituting one drug for another."
- **Loss of Social Network:** Most participants said they felt they could not succeed in treatment if they maintained contact with their opioid-centered social network. But for many of them, it was the only network they had left. The challenge of disrupted social networks was very frequently cited as a reason to not seek treatment and, in some instances, was a cause of relapse/setbacks.

Barriers to Accessing Treatment

Once an individual with OUD overcomes barriers to seeking treatment, participants reported several additional barriers in accessing an appropriate treatment program.

- **Lack of Accurate, Evidence-Based Treatment Information:** While many participants said they had little problem getting useful and accurate information about treatment options — either online, from friends and family, or from treatment programs in their area — others reported that finding the right program or a convenient program was difficult. This seemed particularly true for individuals in remote or rural areas where there were fewer programs available.
- **Insufficient Treatment Capacity:** Some participants cited the inability to be admitted in outpatient and residential treatment programs. Some participants hypothesized that the

few open treatment slots led some treatment programs to expel a patient for a single offense. Individuals in more rural and remote areas also mentioned a lack of residential or outpatient programs near them, particularly the unavailability of MAT programs or clinicians who can prescribe buprenorphine.

- **Cost of Treatment and Lack of Coverage:** For many individuals, the cost of treatment was a significant roadblock. Many participants could not begin treatment when ready because of affordability issues. For others, the cost of treatment was not a major barrier even though some of them were unemployed when they began treatment. Other participants did not even attempt to access treatment because they believed it would be very expensive and had no means to pay. Many participants talked about television and other advertising for 28-day residential treatment programs and seemed much more aware of these programs than outpatient programs. The 28-day residential program was considered by many participants to be the gold standard, and most of them assumed such programs were very expensive and therefore out of their financial reach.
- **Lack of Transportation:** One of the most common barriers centered around transportation to MAT programs and the need to travel to a methadone clinic daily or to travel long distances to a buprenorphine-waivered clinician. Most urban participants said they had little difficulty getting to and from their outpatient treatment. However, those in more rural areas had more difficulty accessing outpatient treatment.
- **Pregnancy:** Becoming pregnant can be a catalyst for seeking treatment; however, the barriers to seeking treatment for pregnant women are especially steep. Some women reported hiding their pregnancy to receive treatment or avoiding treatment altogether out of fear of losing their baby or other children. Health care and other professionals, and expert in-depth interview participants, were sensitive to these challenges and generally viewed the involvement of child protective services as negative.
- **Incarceration:** Many of the participants reported having been incarcerated for reasons related to their opioid use. Only a few participants reported being able to move toward recovery because of incarceration. There was general agreement that illegal opioids were readily available in prison (but not in jails). Participants reported that most local jails did not provide MAT but that some state prisons did. There was consensus among those with OUD and the health care and other professionals that incarceration does little to nothing to address the opioid crisis.
- **Challenges with Medicaid Coverage:** Participants reported their interpretations of Medicaid coverage which may not reflect Medicaid policy. Participants reported that the Healthy Indiana Plan (HIP) provides coverage for only a few days of treatment, which is seldom sufficient, and that they had difficulty finding treatment centers that would accept HIP. Medical providers reported that reimbursement for treatment services can be slow. Those with criminal justice system involvement reported that Medicaid coverage is terminated quickly upon incarceration and reapplying for Medicaid can be an arduous process.

Scope of the Report

OUD is a complex, relapsing brain disease caused by the recurrent use of opioids, including prescription opioids, heroin, or other synthetic opioids like fentanyl. Evidence-based treatment is one component of addressing the opioid crisis, but prevention, harm reduction, and recovery support services are also important and often complementary. In this report, Pew has focused on expanding access to treatment that is timely, comprehensive, evidence-based, and sustainable. Although there are some recommendations that touch on aspects of recovery support services, they are in the context of improving treatment initiation and retention. The exclusion of interventions from other domains does not reflect a lack of importance, but rather Pew's expertise on and the need for access to evidence-based treatment to curb the opioid crisis and prepare the treatment system for future treatment needs.

This report is focused on policy recommendations to expand access to treatment for people with OUD, which is only one form of SUD. A conclusive body of research has demonstrated that MAT is the most effective way to treat OUD. Based on the strength of the evidence of effectiveness and clear lack of availability of MAT, Pew is focusing its efforts on policy changes that could expand access to all three FDA-approved medications and behavioral health counseling. Although the recommendations are focused on OUD, many of the policy recommendations in this report are aimed improving the state's ability to respond to any future drug use epidemics with effective, evidence-based treatment.

Stigma toward individuals with SUD is also an important issue that is not directly addressed in this report. Many of the recommendations in this report could affect stigma by improving the integration of SUD treatment with physical and mental health care; however, stigma is not the direct target of any single recommendation.

Goals of a high-functioning treatment system

The American Society of Addiction Medicine (ASAM),[11] the U.S. Surgeon General's Report on Alcohol, Drugs, and Health,[12] and the National Academies of Sciences, Engineering, and Medicine[13] support a SUD treatment system that ensures patients have access to evidence-based treatment that is matched with disease severity. Policy options intended to increase access to SUD treatment should include data-informed practices, as well as some emerging and innovative models, that can be described by the following characteristics:

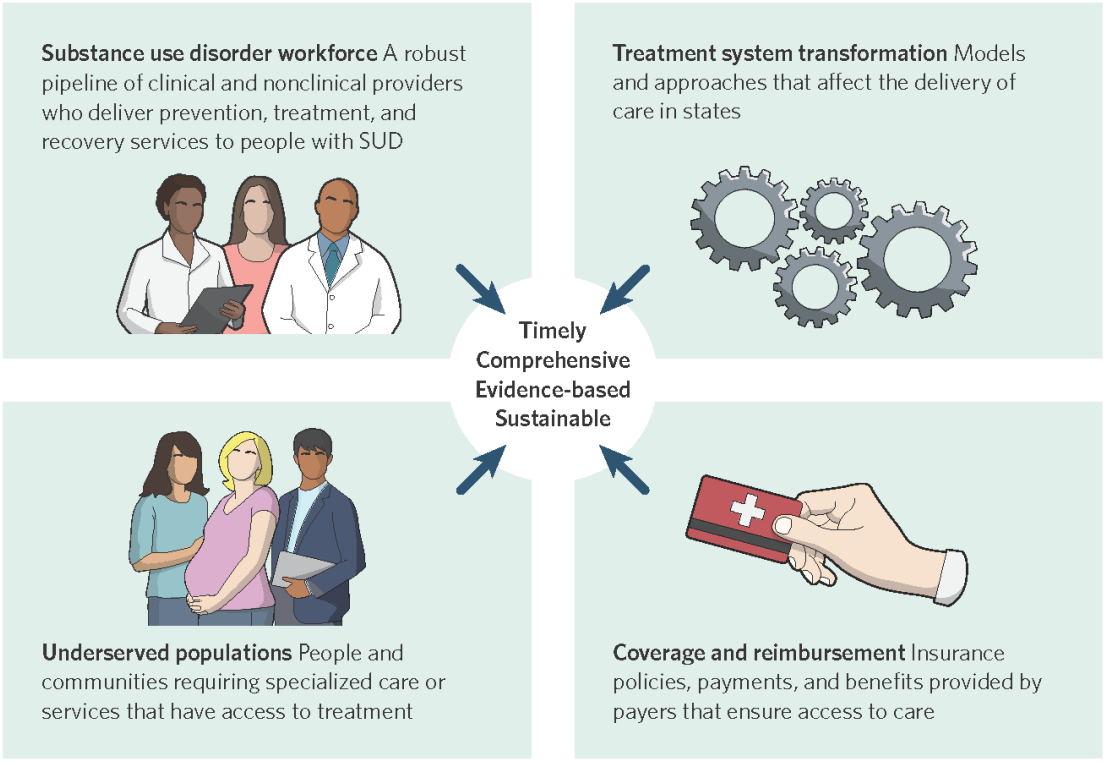
- **Timely:** A timely system ensures that capacity exists to meet treatment demands through the availability of facilities, providers, and services. It ensures that all services and levels of care recommended by the ASAM guidelines[14] are geographically distributed across the state according to need. To the extent possible, timely systems include access to on-demand treatment, or at a minimum, timing of treatment that is consistent with disease severity.
- **Comprehensive:** A comprehensive treatment system provides coverage of the full spectrum of treatment services — including screening, diagnosis, withdrawal management,

maintenance, and recovery — by public (such as Medicaid) and private insurers. This system addresses population-specific needs, such as care for juvenile, pregnant, and justice-involved populations, and coordinates care for SUDs, mental health, and physical health.

- **Evidence-based:** An evidence-based system includes coverage and utilization of all FDA-approved medications for the treatment of SUD and behavioral health services recommended in evidence-based guidelines, as well as the screening and treatment of co-occurring mental health disorders and infectious disease complications. The state infrastructure, including surveillance systems, will be optimized to document the scope of SUDs, monitor progress, and guide evidence-based interventions.
- **Sustainable:** A sustainable system uses funding efficiently, optimizes federal funding resources, and collaborates with community-based partners to augment treatment services. It retains relevance by adapting to emerging substances of misuse and effectively managing the disease burden in the state.

Comprehensive Treatment System Framework

An effective and comprehensive treatment system requires several foundational elements to ensure access to high quality and evidence-based care, including substance use disorder workforce, treatment system transformation, coverage and reimbursement, and underserved populations. Pew's focus on these areas are based upon engagement with state stakeholders and extensive discussions with federal, state, and academic experts. This framework provides a lens to monitor and guide Indiana's progress towards building a robust treatment system that can meet the need for SUD care across the state.



Proposed Recommendations

Treatment System Transformation

Recommendation 1: The Governor should direct the Family and Social Services Administration (FSSA), in collaboration with the Executive Director of Drug Prevention, Treatment, and Enforcement, to implement a comprehensive regulatory approach to office-based opioid treatment (OBOT) that considers quality improvement efforts, increasing number of providers, and diversion minimization with expert input and emerging evidence from other states.

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Treatment System Transformation

Background

Across the country, the treatment system falls short in meeting the needs of people with SUDs. Roughly 2 in 10 people with an SUD receive any treatment,[15] the quality of treatment varies significantly, and many programs do not even offer MAT, the gold standard of care.[16] When people with SUD seek treatment, they often face barriers related to access, including lack of health care coverage and not being able to afford the cost of treatment (26.9 percent) and not knowing where to go for treatment (19.1 percent).[17] The lack of integration of treatment for physical and mental health conditions is another limitation of the U.S. treatment system. More than 8 million adults have co-occurring mental illness and SUD, but only 6.9 percent of this population receive treatment for both conditions.[18] Access to affordable care that is integrated across primary, acute, and behavioral health settings is critical to meet the complex needs of patients with SUD.

Recommendations

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Problem

The number of providers eligible to prescribe buprenorphine, one of three FDA-approved medications used to treat OUD, is lower in Indiana than surrounding states. In addition, stakeholder interviews revealed concerns about the quality of treatment available when delivering buprenorphine in office-based settings. The state would benefit from a comprehensive approach that examines financial incentives and the state's regulatory structure with the goal of enhancing access to treatment in this setting.

Background

Any comprehensive strategy to increase access to MAT must ensure that people with OUD have access to all three FDA-approved medications to treat OUD: methadone, buprenorphine and naltrexone. The right medication for any one person may depend on a variety of factors; treatment plans for OUD are patient-specific, created with input from the patient, the prescriber, and other members of the health care team.

Unlike methadone, buprenorphine can be prescribed by providers working in office-based settings. These providers are subject to federal requirements, including a full day or more of training that is needed to obtain the waiver needed to prescribe buprenorphine; many states also impose additional restrictions on buprenorphine providers. In general, OBOT refers to treatment provided outside of opioid treatment programs — where methadone can be administered — and commonly involves prescribing buprenorphine.

Buprenorphine is a partial opioid agonist that may be prescribed on a weekly or monthly basis for at-home use.[19,20] Many stakeholders interviewed during Pew's system assessment expressed concerns about the quality of OBOT treatment, including whether counseling was provided with medications and whether buprenorphine was being diverted to people for whom it had not been prescribed.[21] A 2016 National Forensic Laboratory Information System analysis found buprenorphine was the ninth most common drug, and fourth most common prescription opioid, among drugs secured in law enforcement operations.[22] However, other studies have shown that much of the diversion is linked to the deficiency in treatment options.[23] Illicit buprenorphine is often used to manage symptoms by those unable to access treatment;[24] most illicit buprenorphine users are interested in initiating treatment.[25]

The lack of treatment options for people with OUD has been well-documented. Indiana has only 8.2 buprenorphine-waivered prescribers per 100,000-person population in comparison to its neighboring states, which average over 20 buprenorphine prescribers per 100,000-person population.[26] Almost half of counties nationwide do not have a physician with a waiver to provide buprenorphine. The problem is even worse in rural areas where 60 percent of counties lack a buprenorphine prescriber.[27] Concerns about diversion are a barrier to prescriber uptake. A survey of rural physicians found that worries about diversion, time constraints, and lack of access to mental health supports were the top barriers to incorporating buprenorphine into their practice.[28]

Given concerns about diversion and the overall quality of care delivered to people with OUD, many states have created regulatory structures for OBOT. Any regulatory approach must balance: 1) minimizing diversion, 2) improving quality, and 3) ensuring that access to care is not impeded by deterring providers from being willing to prescribe buprenorphine. ASAM has outlined recommendations for states considering regulations. For example, states should rely on medical boards and health departments to oversee regulations. Additionally, regulations should not include non-evidence-based treatment standards, such as tapering schedules (the gradual discontinuation of a therapeutic drug over time).[29]

To address this issue, Indiana lawmakers in 2016 passed two laws, Senate Enrolled Act 297[30] and Senate Enrolled Act 214,[31] which required the FSSA's Division of Mental Health and Addiction (DMHA) to develop best practice guidelines for OBOT. These guidelines, which provide a standard of care, were informed by existing research, such as the Substance Abuse and Mental Health Services Administration's (SAMHSA) buprenorphine clinical guidelines,[32] which detail the pharmacology of buprenorphine and the screening and assessment protocols necessary when determining the appropriateness for buprenorphine treatment. DMHA's guidelines provide important direction on treatment components such as diagnosing OUD, using medications appropriately, delivering counseling, training providers, and treating pregnant women.
However, these guidelines have not been translated into regulatory policy.

In creating any regulations, Indiana officials could draw from the experience of other states in developing an approach tailored to the state. Evidence regarding the effectiveness of OBOT regulations at reaching the three goals described earlier is still emerging. States that have taken regulatory action include Tennessee, West Virginia, and Ohio. Common themes across these

regulations included medical regulatory board oversight; exemptions for providers with specific caseloads; definitions for providers, facilities and services associated with buprenorphine prescribing; and standardized reporting structures to monitor quality of care. Examples by state include:

Medical Regulatory Board Oversight:

- Ohio: OBOTs are regulated by the State Medical Board of Ohio and State of Ohio Board of Pharmacy. The state medical board issued proposed regulations for physicians[33] and physician assistants[34] that establish standards and procedures for treatment within OBOTs.
- Tennessee: OBOTs are regulated by the Department of Mental Health and Substance Abuse Services (TDMHSAS).[35]
- West Virginia: OBOTs are regulated by the Office of Health Facility Licensure and Certification within the Department of Health and Human Resources and must designate a medical director responsible for overseeing the program.[36]

Provider Exemptions:

- Ohio: Facilities treating 30 or fewer patients are exempt from obtaining a terminal distributor of dangerous drugs license.[37,38]
- Tennessee: Facilities (stand-alone clinics, individual prescribers) treating fewer than 150 patients, or less than 50 percent of their patient base, with buprenorphine are exempt from obtaining a license through the TDMHSAS.[39]
- West Virginia: Practitioners treating 30 or fewer patients may be exempted from licensure through an application to the Office of Health Facility Licensure and Certification.[40]

Another consideration is how a state may encourage providers to offer quality care consistent with ASAM[41] and SAMHSA buprenorphine clinical guidelines.[42] Virginia Medicaid demonstrated an increase in OUD treatment with the Department of Medical Assistance Services' Addiction and Recovery Treatment Services (ARTS) program in 2017. Through ARTS, the state implemented a comprehensive package of changes designed to deliver the full continuum of care for OUD treatment, which included an OBOT component. [43] To promote provider participation, the agency made reimbursement rates for addiction treatment services more competitive with statewide commercial payers. To direct state funds to cost-effective, evidence-based treatment, ARTS initiated a preferred OBOT model of care, which gave qualifying providers an enhanced rate that included care coordination payments and a simplified prior authorization process. Within nine months, the state went from 38 to 76 OBOT treatment locations and experienced a 51 percent increase in Medicaid members treated for OUD. During the first five months of the program, the number of Medicaid beneficiaries receiving buprenorphine increased by 25 percent.[44]

Massachusetts implemented an OBOT model in 2007 that allowed physicians to treat a larger patient base with clinical support from a Nurse Care Manager (NCM) who completed a training program.[45] In the Massachusetts NCM Model, NCMs are responsible for conducting an initial screening of patients, including documentation of substance use, treatment history, and medical and psychiatric history. After the physician confirms the patient's diagnosis and appropriateness of

buprenorphine treatment, the patient schedules an appointment with the NCM for medication induction.

The NCM model has shown promising outcomes. Between 2007-2014, the number of patients accessing buprenorphine increased from 327 to 3,000[46] and the number of physicians prescribing buprenorphine in participating community health centers rose from 24 to 114 within 3 years of implementation.[47] By demonstrating compliance with standards such as patient treatment counts and an increased number of OBOT providers, the program received state grant funding for seven years.[48]

Proposed Solution

The Governor should charge the FSSA and the Executive Director of Drug Prevention, Treatment, and Enforcement with developing a comprehensive approach to OBOTs in Indiana that minimizes diversion, increases quality, and does not deter patient access. This approach should be informed by national best practices of evidence-based care, such as those from SAMHSA and ASAM, and draw on preexisting regulatory efforts underway from the DMHA. FSSA and the Executive Director should consult with the DMHA, Indiana State Department of Health, Indiana Medicaid, Indiana ASAM, Professional Licensing Agency, members of law enforcement, and any additional groups or stakeholders deemed appropriate.

This comprehensive approach should consider:

- Quality improvement efforts
    - The appropriate public health agency or agencies to implement and oversee any regulatory approach;
    - Services offered directly or through referral as part of quality care (e.g., medications, counseling, etc.);
    - Quality metrics to ensure the delivery of evidence-based care required through a reporting mechanism to the appropriate state oversight agency; and
    - Specialized treatment for pregnant women (i.e. co-management with an obstetrician and other specialists).
- Increasing number of providers
    - Exemptions for prescribers treating low numbers of patients;
    - Financial and administrative incentives to encourage quality care;
    - Collaborative relationships between office-based providers and OTPs; and
    - Elimination of any regulatory barriers that limit access to evidence-based care such as requirements that a patient have OUD for a certain period before receiving care.
- Diversion minimization
    - Regulatory requirements such as licensing;
    - Diversion control measures (e.g., drug testing, prescription drug monitoring program queries, etc.); and
    - Appropriate licensed and credentialed healthcare providers overseeing treatment.

FSSA and the Executive Director of Drug Prevention, Treatment, and Enforcement should outline the necessary authorities, resources, and regulations needed to advance the plan, and report to the Governor no later than December 1, 2018 to inform the 2019 legislative session.

Recommendation 2: The Governor should require annual reporting from the Family and Social Services Administration (FSSA) to describe the progress made in establishing new opioid treatment programs (OTPs) and increasing patient access to evidence-based care.

Problem

The number of OTPs in the state is insufficient to meet the needs of Indiana residents with OUD, and there is currently no timeline to establish the new OTPs permitted under Public Health Law 195.

Background

OTPs are state- and federally-regulated facilities that provide medication, counseling and other services for individuals with OUD.[49] An OTP is the only facility where patients can receive methadone for the treatment of OUD.[50] Although patients can receive buprenorphine and naltrexone in other settings, methadone is a critical part of any state's treatment system.

OTPs have demonstrated effectiveness in Indiana. In 2016, 78.9 percent of patients receiving treatment at an OTP reported reduced use of prescription opiates, 85.1 percent reported reduced use of illegal non-prescription opiates, and 70.9 percent reported improved family relationships.[51]

In 2014, only 14 state-regulated OTPs existed.[52] Recognizing the need to expand access to methadone and OTPs, Indiana engaged in an OTP expansion process over the course of several years. In 2015, Senate Act 464 enabled the establishment of five new centers by June 2018.[53] Locations of the five OTPs were strategically chosen to reduce the time it takes individuals to access daily treatment, and target counties with high numbers of naloxone use.[54,55] Three years later, four of these five OTPs have opened, providing 18 facilities for Indiana residents to obtain treatment. Despite these increases, Indiana currently ranks 42nd in OTPs per capita, with 2.7 facilities per 1,000,000 residents,[56] and the state has a moratorium on the establishment of new OTPs without legislative authorization.[57]

Qualitative information gathered through focus groups, collected prior to the most recent expansion, also confirmed barriers to treatment access. Many participants — especially those in rural areas — expressed a sense of urgency relating to treatment access, with a need for more locally based MAT programs. A focus group participant reported the challenge of not having an OTP in her area:

> *We live in a city of 300,000 people and there's only one methadone clinic. That's ridiculous. - Currently Misusing Opioids, Ft. Wayne, Female*

In 2018, the Indiana General Assembly passed House Bill 1007, enabling the FSSA to establish nine additional OTPs. When these OTPs begin serving people with OUD, nearly every person in the state should be within an hour's drive to treatment.[58] However, no formal timeline exists to facilitate this expansion and ensure a swift rollout for these facilities.

Expansion of OTPs is particularly important given that the state took another important step forward by implementing Medicaid coverage of methadone in 2017, increasing the number of patients with access to that medication.[59] Indiana is now one of 37 states that provides coverage of methadone.[60]

To ensure that people with OUD are able to obtain care, the state needs to ensure that these OTPs are placed in high-need areas and open in a timely manner.

Proposed Solution

The Governor should issue an Executive Order to amend Indiana Code (12-23-18-8) to require new annual reporting by FSSA to describe the progress made in establishing new OTPs and the adequacy of the state's OTP system. DMHA should include this in its annual report to the legislature beginning in June 30, 2019.

The Indiana legislature recognized the value of collecting data on the progress of opening new OTPs by requiring a progress report as part of Senate Act 464, which authorized the establishment of five new OTPs. Many measures in this report would be valuable to collect as part of DMHA's annual report on key metrics of the state's OTP system. This additional information would assist the Commission and policymakers in identifying whether additional steps need to be taken to increase patient access to OTPs.

Starting with the 2019 report, FSSA should use the following minimum information to describe the progress of the OTP expansion in annual reports:

- The number of OTPs that opened in the previous year;
- The impact that the new facilities had on patient access to OTPs (e.g., reduced distance to OTPs, decreased overdose incidents reported by emergency medical providers, etc.);
- The number of individuals served in OTPs;
- The number of OTPs accepting Medicaid patients;
- The number of Medicaid patients treated in OTPs;
- Treatment outcomes for individuals receiving services in OTPs;
- The adequacy of the existing OTP treatment system in meeting the needs of residents with an opioid use disorder; and
- Efforts to engage with state and local officials to educate communities about the evidence-based treatment delivered by OTPs and expand these facilities. This includes an aggregate description of outreach to:
    - Local law enforcement officials;
    - Local coordinating councils;
    - Organizations representing;
        - OTPs;
        - The medical community;
    - Local health departments;
    - Community-based mental health and addiction service providers;
    - City and county government representatives;
    - School administrators; and

- Other interested parties as determined by the state.

This report will complement the work of the state's Management Performance Hub (MPH), which aided in identifying placement for the five OTPs and will assist in the data-driven selection of future OTPs.

Recommendation 3: The Indiana legislature, in collaboration with the Family and Social Services Administration, should revise the legal definition of recovery housing to prevent the exclusion of persons taking Food and Drug Administration (FDA)-approved medications for the treatment of substance use disorders (SUDs).

Problem

SUD patients on MAT experience exclusion or discrimination in Indiana's recovery housing infrastructure.

Background

Recovery houses are residential environments that provide individuals in recovery from SUD with alcohol and drug-free cohabitation spaces. They often include peer support and other services such as individual and group therapy, employment opportunities, and assistance with social, personal, and living skills.[61]

These types of living environments can play a positive role in helping individuals achieve long-term recovery. Patients in recovery homes have reduced substance use, lower incarceration rates, and increased employment compared to those not in recovery homes.[62,63] Recovery houses have been shown to be cost-effective, with cost savings between $17,830 and $29,000 per person; these savings factor in the cost of substance use, illegal activity, and incarceration that might occur without the support that recovery housing offers.[64] Another analysis found patients who had stayed in recovery homes for longer than six months had better employment and substance use outcomes than those who did not enter recovery homes.[65]

Patients with SUD report housing as a top concern during their recovery, and may need to stay in recovery housing as part of their treatment.[66] Unfortunately, many of these residences prohibit or actively discourage the use of MAT.

Indiana Senate Bill 402 (2017) requires that certified recovery residences adhere to ethical standards set by the National Alliance for Recovery Residences to ensure quality, safety, and accountability.[67] Additionally, Sec. 158.2 of the bill defines a recovery residence as an abstinence-based living environment that promotes recovery from alcohol and other drugs. For individuals who are in treatment for OUD, an abstinence-based living environment allows medications (i.e., methadone, buprenorphine, and naltrexone) if there is a "goal of opioid abstinence or the minimum clinically necessary medication dose."[68]

According to conversations with stakeholders, this qualifier has led some recovery residences that receive state funding to pressure those individuals on MAT to cease taking medications prematurely in the pursuit of opioid abstinence, and has contributed to exclusion of and discrimination against

individuals taking medications as part of their OUD treatment. This bias against the use of MAT is consistent with what was said by some focus group participants, who felt that MAT was a "substitution" of one drug for another.

Proposed Solution

The legislature should promptly clarify the definition of "recovery residence" under Sec. 158.2 of Senate Bill 402 (2017). As currently written, the definition of "recovery residence" may allow for the exclusion of or discrimination against individuals on MAT. In order to ensure that all individuals on MAT can access recovery housing, the definition of recovery residence should be amended to include clear, affirmative language that allows the use of MAT. FSSA may consider drawing language from New Jersey's Senate Bill 2964 (2017), which prohibits residential housing from denying admission to individuals receiving MAT, or from Ohio, which amended House Bill 483 (2016) to specify that patients are permitted to take their prescribed medication while residing in these facilities.[69,70]

Substance Use Disorder Workforce

Background

An effective treatment system must ensure enough providers are available to meet the need for services across the state. A number of initiatives — including the Governors Health Workforce Council, Indiana University Grand Challenges, and advocacy groups across the state — have allocated resources to support research and implement programs to enhance the quantity and quality of Indiana's SUD workforce. Efforts by state agencies, legislators, health care experts and industry leaders across the public and private sectors will be needed to coordinate efforts and develop a long-term strategy to ensure that Indiana has an accessible, well-trained, and flexible health workforce.

Recommendation 4: Indiana Medicaid, in collaboration with Indiana Professional Licensing Agency (PLA) should assess its reimbursement rates for counseling services for substance use disorder (SUD) in community-based settings and increase them as appropriate to improve access to these services.

Problem

Indiana does not have enough counselors to treat people with SUD in community-based settings.

Background

Substance use disorder counselors and other mental health professionals (e.g., marriage and family therapists, social workers, mental health counselors, psychologists, psychiatrists, and psychiatric advanced practice nurses) provide behavioral therapy services — a key component of MAT.[71] Specifically, counselors with experience in SUD provide particular therapies (e.g. motivational interviewing, cognitive behavioral therapy, and contingency management) that are designed to change or manage behaviors related to substance use.[72] Addiction counselors can work in a range of locations: OTPs, community mental health centers (CMHCs), and various private inpatient and outpatient settings.

Shortages of counselors exist in many parts of the country. For example, 55 percent of U.S. counties do not have a practicing behavioral health worker and 77 percent of counties reported unmet behavioral health needs.[73] The Bureau of Labor Statistics (BLS) predicts a 23 percent increase in demand for these providers between 2016 and 2026.[74]

Indiana faces an even greater shortfall of counselors. Advocates for Human Potential, a non-profit that seeks to improve health and human services systems, developed a Provider Availability Index that quantifies the number of providers available per 1,000 individuals in need of mental health and substance use disorder treatment. Nationally, the Provider Availability Index for SUDs estimates that there are 32 behavioral health specialists available for every 1,000 people with SUD.[75] Indiana falls into the lowest quartile of states, with just 18.3 behavioral health specialists for every 1,000 people with SUD.[76] Additionally, a 2016 survey of Indiana CMHCs revealed that half of addiction counselor positions are unfilled at these facilities.[77]

Despite the severe treatment gap in Indiana, the number of licensed addiction counselors (i.e., licensed clinical addiction counselors, licensed addiction counselors, and associate level counselors)[78] has decreased since 2010. According to IPLA, Indiana had 1,899 licensed addiction counselors in December 2013. By May 2018, the number of counselors had decreased to 1,512. Currently, half (46 of 92) of Indiana counties have no full-time addiction counselor; 30 of the 46 counties (65.2 percent) are in rural areas.[79]

During our conversations, Indiana stakeholders stated their belief that low provider reimbursement has contributed to the decrease in licensed addiction counselors working in Indiana. Studies in the early 2000s found that a high turnover rate for these counselors was linked to poor compensation and counselor "burnout."[80,81]

Medicaid is an important source of coverage for people with OUD. Nationwide, Medicaid covered 4 in 10 nonelderly adults with OUD in 2016[82] and over 50 percent of patients at CMHCs.[83] As of May 2018, Indiana has enrolled 435,397 individuals in the Healthy Indiana Plan (Indiana's Medicaid plan designed for people aged of 19 to 64 with family incomes less than approximately 138 percent of the federal poverty level).[84,85] The state estimates that 81,000 Healthy Indiana Plan members have SUD, but that only 28 percent of people with a formal diagnosis received any care.[86]

Other states have taken steps to grow their provider workforce by increasing reimbursement and amending Medicaid reimbursement policy. For example, all licensed alcohol and drug abuse counselors in Vermont can participate as Medicaid providers regardless of whether the counselor works for a state-licensed provider adhering to ASAM standards.[87] Kentucky amended its licensure laws in 2014, allowing addiction counselors greater options for what facilities they can work in, as well as allowing them to be reimbursed by Medicaid for a subset of their OUD services.[88]

In 2017, Maine's Department of Health and Human Services — in a partnership with external health consultants — conducted a comprehensive rate review for their Medicaid policy that included an analysis of BLS wage data, benefit packages, and benchmarks from other states.[89] As a result of the review, Maine raised Medicaid reimbursement rates for addiction counselors by 20 percent.[90]

Virginia's ARTS program enhanced the Medicaid benefit as a part of an 1115 waiver that included several reforms, one of which quadrupled reimbursement rates for counselors. Reimbursement rates for other community-based services increased by 50 to 400 percent to bring Medicaid rates in line with commercial payers.[91] The number of counselors and social workers treating patients with OUD increased by 56 percent, and the number of Medicaid members on buprenorphine who received other associated services such as counseling, intensive outpatient, and residential treatment increased by 25 percent from the previous year.[92]

Proposed Solution

The FSSA should assess the Medicaid reimbursement rates for mental health professionals to determine whether changes are needed to increase access to counseling.

The Governor should direct FSSA to assess Medicaid reimbursement rates for addiction counseling in Indiana by comparing these rates to the rates paid by other states' Medicaid programs and private

payers in Indiana. Assessment of reimbursement rates may lead to a recommendation that rates be increased. This action may provide incentives for counselors to work in community-based settings, where there are currently fewer IPLA-licensed clinical addiction counselors and more patients who are enrolled in Medicaid than in private practice settings. With more providers in community-based settings, the capacity of these state-funded centers to provide the counseling component of MAT would increase. Improved rates in Medicaid may also increase the number of total licensed clinical addiction counselors in the state in other settings.

FSSA should deliver a report on their reimbursement assessment with recommendations to the legislature and Governor by June 30, 2019.

Underserved Populations

Background

Some populations in Indiana face specific barriers in accessing evidence-based treatment, and one group stood out from stakeholder conversations with patients and providers across the state. Justice-involved individuals are largely unable to access any MAT while incarcerated, regardless of whether they were maintained on medications upon entry into jail. This disruption in access to effective treatment puts individuals reentering the community at a high risk for relapse, overdose, or death. In fact, a study from Washington state found that within one week of release from prison, overdose deaths are responsible for more than twice as many deaths as any other cause.[93]

Recommendation 5: Building on programs initiated in Indiana's prisons, the Governor should task the Indiana Criminal Justice Institute (CJI) with assessing medication-assisted treatment (MAT) availability within county jails and develop a pilot program to expand availability of all Food and Drug Administration (FDA)-approved medications for opioid use disorder (OUD) in at least one county jail.

Problem

Provision of medications used to treat OUD in jails is at the discretion of local sheriffs, which often limits the availability of treatment for this vulnerable population.

Background

The criminal justice system provides an opportunity to connect patients with SUD to needed treatment in a stable and controlled space. However, availability of MAT is inadequate in these settings. According to the most recently available national data, although 55 percent of jail inmates met criteria for SUD, fewer than 7 percent of those individuals received treatment while incarcerated.[94]

ASAM and the American Correctional Association recommend that all inmates with OUD who are undergoing treatment prior to incarceration should be evaluated for consideration to continue treatment in jail or prison.[95] Other organizations such as the Legal Action Center suggest that the justice system, including jails, should offer MAT as a treatment option when clinically appropriate.[96]

Access to MAT in criminal justice settings is associated with reduced recidivism rates, decreased overdose rates, and improved health outcomes.[97] For example:

- In 2016, inmates of the Rhode Island Department of Corrections (RIDOC), a unified prison and jail system, launched a treatment program that provided all FDA-approved medications for those screened for OUD. Within six months of implementation, there was a 61 percent decrease in post-incarceration deaths, accounting for much of the state's overall 12 percent reduction in overdose deaths.[98] A 2018 study showed that methadone and buprenorphine were used more often than naltrexone for treatment within the correctional facility.[99]

- A study in Maryland prisons found that individuals who received buprenorphine while incarcerated were more likely to continue treatment upon release than those who received counseling only.[100]

While the majority of studies conducted on the efficacy of MAT in criminal justice settings have focused on prisons, jails also provide an important opportunity for inmates to initiate treatment. For example, beginning in October 2015, inmates in Middlesex County, Massachusetts, jails enrolled in the Medication Assisted Treatment and Directed Opioid Recovery program were offered extended release naltrexone. As of April 2018, among those who have completed the program, 82 percent have not recidivated and 98.5 percent of participants, regardless of program completion, have not experienced a fatal overdose post release.[101] In Rikers Island Correctional Facility in New York, all three medications approved for MAT are provided and treatment staff work with inmates to select the medication of their choice.[102] The majority of inmates receive methadone, some choose buprenorphine, and few receive naltrexone.

Programs that cover all three medications help ensure that treatment meets individual needs. The right medication for any one person may depend on a variety of factors, including mechanism of action and treatment delivery settings.

Naltrexone is available in all Indiana state prisons and efforts are underway to further expand access. For example, in Spring 2017, the Indiana Department of Correction (IDOC) Addiction Recovery Services Division implemented Recovery While Incarcerated, a program that expands the availability of oral naltrexone to individuals with OUD and refers inmates to community-based care for continued MAT upon release.[103,104]

Availability of MAT in Indiana county jails, however, is at the discretion of local sheriffs. According to stakeholders, in instances where MAT is offered, only naltrexone is made available. For example, Madison County offers injectable naltrexone through a pilot program for select inmates, and Boone and Porter counties have also begun similar programs that offer naltrexone exclusively.[105,106,107] Through the pilot program, which is funded through the Opioid State Targeted Response grants, these county jails provide medication to inmates 90 days before their release. In Madison County, over 80 percent (23 of 28 inmates) of inmates successfully maintained their treatment on naltrexone following discharge.[108] Additionally, a new initiative of the Indianapolis-Marion County Community Justice Campus Assessment and Intervention Center will focus exclusively on serving individuals with SUD and mental health needs. The goal of Center is to divert people with SUD and mental health needs out of traditional jail settings and place them in a specialized unit where they can receive treatment.[109]

In 2014, Indiana passed House Enrolled Act 1006, which established a partnership between the Justice Reinvestment Advisory Council (JRAC) and CJI. These two entities are charged with developing an annual report that includes recommendations on improvements to the criminal justice system, informed by annual jail inspection reports submitted by the 92 facilities in Indiana. Annual jail inspection reports provide data on the services delivered, inmate capacity, and resources needed within each jail.[110] Based on the recommendations, IDOC may award grants for county jails to provide evidence-based mental health and addiction treatment services.[111]

House Enrolled Act 1006 also requires jails to report data relevant to the availability and effectiveness of mental health and addiction programs for justice-involved individuals, but metrics are not specified. For instance, although nearly three-quarters of jails report providing substance use treatment, no information about which medications are offered and to which populations it is available.[112] A comprehensive understanding of treatment need and availability, including information on availability of MAT availability and prevalence of SUD in jails, could potentially allow IDOC to better direct funding allocation across county jails.

Proposed Solution

To better inform JRAC and CJI's recommendations to the IDOC, the Governor should task county jails with collecting the following data, relevant to the availability and effectiveness of mental health and addiction programs:

- Prevalence of SUD;
- Facilities for inpatient detoxification, including the number of rooms available;
- Availability of FDA-approved medications for the treatment of OUD, including which medications are available, which populations have access to medications (e.g., pregnant women and individuals who arrive into the correctional system who are undergoing MAT), and the number of individuals receiving each medication per month;
- Number of addiction counselors on staff;
- Referral mechanisms to community-based treatment; and
- Additional measures as determined by CJI and JRAC.

These measures should be incorporated into the facilities' annual jail inspection reports delivered to JRAC and CJI by December 2019. CJI and JRAC's annual report should include detailed data on the availability of and need for treatment in each of the 92 facilities, and a recommendation on what facilities may best be positioned to participate in a pilot that offers inmates all three FDA-approved medications.

Based on the findings, the Governor should direct DMHA to develop a plan with IDOC and/or identified county leaders to pilot the availability of all three medications in at least one jail. The state should seek federal funding for this pilot. The Bureau of Justice Assistance previously awarded more than $10.8 million to assist 162 state, tribal, and local government agencies to improve evidence-based SUD treatment programs for inmates through their Residential Substance Abuse Treatment for State Prisoners Program. If necessary, the legislature should enact legislation to authorize and fund this pilot.

Recommendation 6: The Governor should task Indiana Medicaid, in collaboration with the Indiana Criminal Justice Institute (CJI) with establishing a pilot program for jails to test innovative ways to ensure that Medicaid-eligible inmates re-entering the community have Medicaid benefits unsuspended upon release, are aware of their Medicaid benefits, and are connected to health care in the community.

Problem

Persons with OUD reentering the community from jail are at increased risk for overdose and death,

due in part to a lack of connection to OUD treatment in the community and lack of health insurance to cover the cost of treatment.

Background

The prevalence of SUD in incarcerated populations is high nationwide.[113] In Indiana, more than half of persons (53 percent) who are incarcerated are diagnosed with a SUD.[114] Among those who recidivate, 75 percent have a SUD.[115]

The period of time immediately after someone with an SUD is discharged from incarceration is a particularly dangerous time for overdose.[116] All inmates are presumably abstinent from illicit opioids during their incarceration. As a result, someone reentering the community has a reduced physiologic tolerance for opioids. If he or she takes an opioid at the same dose taken previously, he or she is at much higher risk for overdose and death. Accordingly, individuals with SUD reentering the community from incarceration should be connected to community-based care upon release and without delay. Continuity of care contributes to reduced drug use, decreased risk of overdose, and improved outcomes such as reduced criminal activity and incarceration for individuals with SUDs.[117]

Prison and jail inmates are ineligible for Medicaid while incarcerated. In Indiana, those enrolled in Medicaid when entering jail or prison have their benefits suspended during incarceration for up to 24 months. Benefits are discontinued after 24 months of continuous incarceration. [118]

Indiana has taken a two-step process to facilitate reestablishing Medicaid benefits for prison inmates reentering the community. First, IDOC provides Medicaid with a weekly report of all inmates being released from prison. Upon receipt, Medicaid unsuspends benefits. However, in some cases, persons reentering the community may not be informed of their benefits and cannot afford to pay into HIP's Personal Wellness and Responsibility (POWER) health savings account — a requirement to maintain Medicaid benefits.

Second, Indiana assigns all Medicaid-eligible prisoners returning to the community to one Medicaid Managed Care Entity (MCE) — CareSource Indiana. CareSource, using a model implemented in Ohio,[119] seeks to engage with inmates prior to release learn about their health needs and coordinate their care in the community. The CareSource Transition Program in Ohio started in July 2016 and has served over 2,000 people in the first year, with 85 percent receiving their first CareSource contact while incarcerated.[120] Currently, these two programs — the automatic unsuspension of Medicaid benefits and the CareSource MCE assignment — exist only for individuals leaving prison. There are no similar statewide care coordination efforts for persons returning from jail.

Indiana's Public Health Law 185[121] requires the county sheriff or a designee to assist inmates in applying for Medicaid. However, sheriffs often lack the resources to help persons reentering the community[122] to unsuspend their Medicaid benefits. Currently, all persons returning to the community from jail are required to call FSSA, Division of Family Resources (DFR) to unsuspend benefits. In some cases, health navigators — professionals who provide guidance to patients as they move through the health care system — call DFR on behalf of the person reentering the community to unsuspend benefits. For those without the help of a health navigator, reinstating health insurance

may be confusing, burdensome, and low priority. Furthermore, upon reinstatement of benefits, it can take up to 10 days for beneficiaries to receive their health insurance card.

Given the challenges persons reentering the community from jail face to establish benefits and connect to care, the Marion County jails are piloting three activities to streamline Medicaid enrollment and improve care coordination:

1. Using grant funds, the Marion County jails will soon fund two health navigators to help inmates apply for Recovery Works benefits,[123] a program to provide support services to eligible persons with felony convictions, and to ensure that Medicaid benefits are unsuspended upon release.
2. The Marion County jails recently began sending a daily spreadsheet of releasees to Midtown Community Mental Health (Midtown). Midtown calls DFR to unsuspend benefits for their recently released patients, informs the patient's MCE of their release, and connects the releasees to a Midtown medical provider.
3. The Marion County jails will soon inform the MCEs Anthem and CareSource of releasees. The MCEs will assist their beneficiaries in unsuspending benefits. The Anthem partnership was scheduled to begin June 11, 2018. The start date of the CareSource partnership is yet to be scheduled.

For Medicaid to automatically unsuspend benefits for persons reentering the community from jail, there must be a systematic procedure like the IDOC/Medicaid partnership so unsuspension is not overly burdensome for Medicaid. However, it is unclear what interventions are most appropriate for Indiana's 92 jails in 91 counties.

Proposed Solution

To promote continuity of care among persons reentering the community from jail, Indiana should promptly allocate state funds to launch a pilot program for jails. The pilot program should ensure that Medicaid-eligible inmates reentering the community have their Medicaid benefits unsuspended upon release or are enrolled in Medicaid if they were not previously, are aware of their Medicaid benefits, and are connected to health care upon release. The Executive Director should work with the Indiana Sheriff's Association, CJI, and other stakeholders to aid in the development of the request for proposals.

These pilot programs should emphasize care coordination and transitions of care.[124] Delays in accessing treatment can lead to negative outcomes, including overdose, death, relapse, or recidivism.[125]

The pilot programs could include the following types of activities:

- Telenavigation services from a remote health navigator, to assist the inmate with Medicaid eligibility paperwork, unsuspending benefits, and care coordination;
- Partnership with a MCE to provide care coordination services in-person or remotely prior to release to ensure seamless connection to care in the community;
- Partnership with a MCE so the MCE contacts Medicaid to unsuspend benefits for beneficiaries upon release;

- Partnership with Medicaid to develop an automated process to inform Medicaid of upcoming releases and an agreement for Medicaid to unsuspend benefits for persons re-entering the community;
- Sustainable ways to pay outstanding and at least one month of current POWER account fees for persons reentering the community from jail; and/or
- Partnership with relevant Indiana state agencies or other organizations to develop a model of sustainable funding for health navigators to support the county jail in completing inmate Medicaid eligibility paperwork, unsuspending benefits, and care coordination.

The pilot programs should have the potential for scalability; ultimately, all 92 jails should be able to adopt best practices resulting from the pilot programs.

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