

Identifying Existing Health Resources for Participants in Diversion Programs

**A RESOURCE GUIDE
FOR STAKEHOLDERS**

**Milken Institute School
of Public Health**

THE GEORGE WASHINGTON UNIVERSITY

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Prologue: Three Possible Participants in Diversion Programs

Ellie

Ellie is 24 years old and struggling with a substance use disorder (SUD). After repeated attempts to get Ellie into treatment, each following discoveries of cocaine in Ellie's room or personal belongings, her parents asked her to leave their home when she turned 18. Her SUD and lack of a college degree continue to complicate Ellie's ability to find and maintain both steady employment and safe housing. After a number of months of living on the street, Ellie discovered she was pregnant. She has decided to have the baby and wants to stop using drugs, but doesn't know how to get help.

Jake

After two tours in Afghanistan, Jake returned home struggling with post-traumatic stress disorder (PTSD). Although his wife and family suspected that he may have PTSD, they were not sure how to help. Jake began to drink to ease his anxiety. For a while, he was able to hide his drinking from his family, but eventually his alcohol abuse became so severe that Jake couldn't work, and his wife feared for their child's safety. His wife took their child and moved in with family in another city. Unable to maintain employment and disconnected

from friends and family, Jake eventually found himself living on the streets. One night at a shelter, Jake met another homeless veteran who introduced him to heroin. Jake has struggled with his heroin addiction since then.

Leah

After bouncing between several negligent foster care homes, Leah decided that she would be better off on her own. She managed to find her way to a new city, but without friends or contacts, she didn't know where to look for shelter or how to find a way to support herself. One night as she was sleeping at a bus stop, an older man introduced himself and offered food and a place to stay. Hungry and cold, Leah felt grateful for his kindness. However, in the months that followed, the man introduced Leah to meth and other drugs, and forced her into prostitution. Within nine months, Leah discovered she was HIV positive.

I. Introduction

According to the U.S. Department of Justice, an estimated one-half of all incarcerated persons meet the criteria for drug abuse or dependence.^{1,2} While many of these individuals have been convicted of drug-related offenses, some have participated in any number of other illegal activities, often under the influence of drugs at the time of their crime, or committing the offense to get money to buy drugs.³

Despite some efforts by the state and federal criminal justice systems to address SUD among incarcerated individuals, few inmates with SUD have meaningful treatment options. According to the National Center on Addiction and Substance Abuse, of the 1.5 million prison and jail inmates with substance use disorder in 2006, only 11.2% had received any type of professional treatment while incarcerated.⁴ When substance use treatment does occur within prison and jail settings, it is often coercive and punitive, reflecting the environment and philosophy of many correctional facilities; studies show that inmates have low levels

1. Karberg JC, James DJ. Substance Dependence, Abuse, and Treatment of Jail Inmates, 2002. Washington, DC: Office of Justice Programs, Bureau of Justice Statistics; 2005. Dept of Justice publication NCJ 209588.

2. Mumola CJ, Karberg JC. Drug Use and Dependence, State and Federal Prisoners, 2004. Washington, DC: Office of Justice Programs, Bureau of Justice Statistics; 2006. Dept of Justice publication NCJ 213530.

3. Chandler RK, Fletcher BW & Volkow ND. Treating Drug Abuse and Addiction in the Criminal Justice System: Improving Public Health and Safety. *JAMA*. 2009 Jan 14; 301(2): 183–190.

4. National Center on Addiction and Substance Abuse at Columbia University. Behind Bars II: Substance Use and America's Prison Population. 2010. Available at: <http://www.casacolumbia.org/addiction-research/reports/substance-abuse-prison-system-2010>.

of motivation to participate in these treatment programs.⁵ Furthermore, incarcerated individuals are often able to obtain illicit drugs, exacerbating their illness and making recovery more difficult.⁶ Inadequate access to SUD services and support systems while incarcerated means that offenders are more likely to relapse into drug use resulting in criminal behavior when released, jeopardizing individual and public health and safety and further taxing criminal justice system resources.

Addressing SUD before entry into the criminal justice system is an opportunity to decrease drug use, reduce associated criminal behavior, and improve public health. “Diversion programs” can reduce the costs associated with the arrest and incarceration of individuals with SUD by replacing incarceration with meaningful treatment and social support options. “Pre-booking” diversion programs steer individuals to treatment and support services before they would have been charged with a crime. These types of programs can provide individuals with the treatment they may need to confront and manage their SUD and allow individuals to avoid the stigma and social and economic impact of a criminal record. In addition, such programs save taxpayers the cost of potential incarceration. Estimates by the National Institute on Drug Abuse suggest that for every dollar invested in SUD treatment programs, there is a return on investment between \$4 and \$7 due to reduced crime and related criminal justice costs,⁷ with even further savings to the healthcare system.

The purpose of this resource guide is to facilitate a stronger understanding among stakeholders, such as law enforcement agencies, of health resources that may be available to participants in diversion programs. The guide begins with background information about pre-booking diversion programs, including profiles of existing programs. It continues with a compilation of the types of health services that participants in diversion programs may need and the providers who can offer them, first outlining services specific to the treatment of substance use disorder, and then discussing community providers that can offer a full range of physical and behavioral health services. It then provides information about several health insurance options, including Medicaid, the Children’s Health Insurance Program, Medicare, and private subsidized coverage. Finally, the resource guide includes a brief overview of existing support services beyond the healthcare system, including housing, cash assistance, and food stamps. Each section contains specific information on how to identify resources and providers by location.

5. Burdon WM, De Lore J & Prendergast ML. Developing and Implementing a Positive Behavioral Reinforcement Intervention in Prison-Based Drug Treatment: Project BRITE. *J Psychoactive Drugs*. 2011 Sep; Suppl 7: 40–50.

6. Simpler AH, Langhinrichsen-Rohling J. Substance use in prison: how much occurs and is it associated with psychopathology? *Addict Res Theory*. 2005;13(5):503–511.

7. National Institute on Drug Abuse. Principles of Drug Addiction Treatment, Third Edition. 2008. Available at: https://www.drugabuse.gov/sites/default/files/podat_1.pdf.

This resource guide is not a comprehensive manual describing how to implement a diversion program. Nor does it focus on resources to directly fund the administration of a diversion program, though we provide links to information on possible resources in the Appendix. Rather, this document focuses on existing payers, providers and programs that can offer healthcare services and support often needed by individuals with SUD in diversion programs. Our intention is that this resource guide will serve as a starting point for law enforcement, corrections and other stakeholders who want to better understand the landscape of potential health resources, federal programs and insurance options that can make diversion programs successful and sustainable.

II. Background

“Diversion programs” are an important alternative to incarceration because they aspire to address SUD as a public health issue. A successful diversion program begins early in the criminal process by redirecting individuals with SUD from the criminal justice system and into comprehensive treatment programs and community support services where recovery is more likely.

A variety of diversion programs already exist in jurisdictions across the country. Models that divert individuals before trial include Crisis Intervention Team Programs at the law enforcement level (over 2700 programs nationally), and other pretrial diversion programs (approximately 300 nationally).^{8, 9} A recent report by the Center for Health and Justice at Treatment Alternatives for Safe Communities (TASC) describes a range of diversion models and offers detailed information on program design, stakeholders, key communities, challenges and successes of implementation and, where available, evidence of cost savings and effectiveness.¹⁰ TASC found that most diversion programs have a focus on individuals with substance use and/or mental health issues, and that most are limited in scope to first-time and/or low-level offenders. In addition, TASC noted that many jurisdictions are

8. National Alliance on Mental Illness. Crisis intervention teams pamphlet. Available at: <https://www2.nami.org/Template.cfm?Section=CIT&Template=/ContentManagement/ContentDisplay.cfm&ContentID=147603>.

9. Mahoney B, Beaudin BD, Carver JA, Ryan DB, Hoffman RB. Pretrial services programs; responsibilities and potential. Washington, DC: Office of Justice Programs, Bureau of Justice Statistics; 2001. Dept of Justice publication NCJ 181939.

10. The Center for Health and Justice at TASC. No Entry: A National Survey of Criminal Justice Diversion Programs and Initiatives. Chicago: Author. 2013.

looking to various diversion program models as a means of addressing the record number of individuals overloading criminal justice systems.

Diversion programs can be categorized into pre-booking and post-booking:

PRE-BOOKING DIVERSION	POST-BOOKING DIVERSION
<p>Refers individuals with low-level or first time offenses, often including behavioral health issues, into social support, community education and/or treatment services.</p> <p>Diversion can occur at the time of arrest but before booking. Alternatively, an officer can refer a person they know to be at risk into a diversion program voluntarily (sometimes called a “social contact referral”).</p>	<p>Diverts individuals to community programs and treatment at some point in the process after they are booked. Diversion can occur:</p> <ul style="list-style-type: none"> • at the time the individual is booked; • before the formal filing of charges; • at the time of release from pretrial detention, with the condition of participation in the diversion program; • prior to disposition; or • at disposition or sentencing.

While the resources highlighted in this resource guide may be useful to all diversion programs, this resource guide will focus on pre-booking diversion programs because these programs begin the diversion process at point of law enforcement contact, substantially reducing (and in some cases preventing) contact with the criminal justice system.

Two pioneering pre-booking diversion programs, the original LEAD program in Seattle and LEAD-Santa Fe, offer useful examples of pre-booking diversion programs.

LEAD Seattle

The Law Enforcement Assisted Diversion (LEAD) program was established in Seattle in 2011 as a means of allowing law enforcement officers to direct individuals engaged in low level drug and/or prostitution activities to health and social services, rather than to jail and prosecution. LEAD represents a unique collaboration of law enforcement, public officials and community-based organizations committed to implementing a new approach to addressing drug and prostitution activity in the Seattle area. LEAD Seattle links people to SUD services, but recognizes that participants have a broad range of medical and social needs. As such, the program focuses on overall health rather than abstinence.

When an eligible individual is arrested for a drug or prostitution offense, a trained police officer has the discretion to refer the arrestee to a designated LEAD case worker instead of making a criminal arrest (prior violent offenses may make an individual ineligible

for diversion). The LEAD case worker conducts an initial intake assessment of the individual either at the police station or a safe location nearby and connects the person with resources to address immediate needs, such as food or treatment for injuries. During a second, more detailed follow-up assessment, which must take place within 30 days of the initial intake, case workers connect LEAD participants with services that meet additional needs, including referral to drug treatment, housing, education, job placement, transportation, child care and other services. LEAD contracts with Evergreen Treatment Services, an established provider of addiction treatment, to address participants' substance use disorder with a harm reduction approach, which seeks to employ public health strategies to reduce the harmful effects associated with drug use rather than focusing on abstinence.¹¹ In addition, case managers have access to local and foundation funding to provide financial support for participants' basic needs, including motel stays, food and clothing.

A criminal offense is not a prerequisite for program participation. Law enforcement can make a "social contact" referral to the LEAD program, recruiting participants outside of a criminal incident. Here, if an officer believes an individual in the community could benefit from services offered in the diversion program, then the officer may link that person to LEAD case workers.

Participants may continue with the program even if they do not maintain complete abstinence from drug use. Allowing this leeway among program participants recognizes the long and difficult process of recovery, and that in fact, relapse is a symptom of SUD. If a LEAD participant does not complete their LEAD assessment within 30 days, he or she may be processed through the justice system 'as usual'; however, once the assessment is complete there are no further obligations placed on the individual to participate in SUD treatment or any other program.

One objective of the LEAD program is to reduce criminal recidivism, and on this metric, the program has shown success. An initial evaluation of the program by the University of Washington found that LEAD participants were 60% less likely than non-participants to be arrested during the 6 months subsequent to their entry into the program.¹² LEAD conducted an evaluation entitled "The Criminal Justice and Legal System Utilization and Associated Costs Report," which measured the effectiveness of the LEAD program in reducing publicly funded legal and criminal justice service utilization and associated costs prior and subsequent to evaluation entry. The evaluation found statistically significant reductions

11. What is Harm Reduction? Harm Reduction International. Available at: <http://www.ihra.net/what-is-harm-reduction>.

12. Collins SE, Lonczak HS & Clifasefi SL. LEAD Program Evaluation: Recidivism Report. University of Washington. March 2015. Available at: http://static1.1.sqspcdn.com/static/f/1185392/26121870/142851375150/LEAD_EVALUATION_4-7-15.pdf?token=i6MueygLYMkp3tDCr7DlGCUoBSs%3D.

in the yearly criminal justice and legal system utilization and associated costs among LEAD participants as compared to those who did not participate in the program.¹³ LEAD aims to improve psychosocial, housing and quality-of-life outcomes for participants; evaluations of these outcomes are ongoing.

LEAD Santa Fe

LEAD Santa Fe was modeled on LEAD Seattle but focuses on a harm reduction model for opioid abuse exclusively. LEAD identifies low-level opioid (pills and heroin) drug offenders for whom probable cause exists for an arrest and redirects them from jail and prosecution by immediately providing linkages to treatment and social supports including harm reduction and intensive case management.

LEAD Santa Fe participants are often heavy users of opioids and need comprehensive wrap-around services in addition to SUD services. While many clients will need drug counseling or rehab, the LEAD Santa Fe intervention program does not insist on total sobriety. Instead, the program focuses on addressing a holistic range of client needs, which may be as complex as securing stable housing or employment, or may be as simple as helping a client obtain a cell phone or basic transportation. For example, many of the program participants are mothers with young children. In these cases, access to supportive childcare arrangements—that reduce caregiver stress and enable clients to seek employment—may be the key factor in breaking the cycle of addiction and arrest.

As with Seattle, an arresting officer has discretion as to whether to divert an individual into the LEAD program. Officers use checklists to determine whether an individual matches the criteria for LEAD services. Law enforcement can also make social referrals if they are aware of an individual's opioid abuse. Social referrals often allow for a less coercive model of diversion.

When a diversion takes place, police contact LEAD within an hour of coming into contact with an individual who meets the criteria to become a LEAD client. Within 72 hours, clients are assigned a LEAD case manager who completes an intake assessment questionnaire and then engages clients in a motivational interview to identify needs and pinpoint which clinical, social and community-based services may be most appropriate to meet those

13. Collins SE, Lonczak HS & Clifasefi SL. LEAD Program Evaluation: Criminal Justice and Legal System Utilization and Associated Costs Report. University of Washington. June 2015. Available at: <http://static1.1.sqspcdn.com/static/f/1185392/26401889/1437170937787/June+2015+LEAD-Program-Evaluation-Criminal-Justice-and-Legal-System-Utilization-and-Associated-Costs.pdf?token=iR5odwLtV7bc%2BMXBz2u%2BjsgtYsY%3D>.

needs. After this client assessment, case managers design an individualized action plan. In addition, peer support specialists work to enroll clients in Medicaid or another insurance program if they are eligible.

III. Healthcare Services and Providers

There are numerous healthcare resources available to help participants in diversion programs. This section provides a description of the types of healthcare services available for people with SUD and provides information about how to find them. It first describes services and providers that are specific to SUD, and then discusses other categories of safety-net providers that can offer a broad range of physical and mental health services that help support recovery.

Depending on the scope and goals of a diversion program, it may be beneficial for diversion programs to establish a close relationship with existing providers of SUD services and other types of safety-net providers. The end of this section has information on how to identify providers in your area.

It is important to note that some providers of the services listed below may offer care to uninsured individuals, while other providers may require insurance or other payment. Section IV of this report discusses health insurance coverage options for participants

SYRINGE EXCHANGE PROGRAMS

Syringe exchange programs (SEPs) supply sterile needles and collect used needles from people who inject drugs (PWID) in an effort to reduce HIV and other blood borne disease transmission. Research has shown that PWID will use sterile syringes if they are freely available, and distributing sterile syringes through SEPs does not increase drug use. Furthermore, SEPs have been successful in linking PWID to health and social services such as primary medical care and HIV/AIDS education.





The North American Syringe Exchange Network (NASEN) is a non-profit organization, operating nationally, providing support for SEPs. NASEN's support includes technical and financial assistance to SEPs, efforts to expand the network of individuals and organizations interested in SEPs, and the dissemination of information about SEPs. NASEN offers several programs including grants, start-up kits, and loans, to aid in the establishment of new SEPs and the continuation of existing SEPs.

For more information about NASEN programs see: https://nasen.org/about/#nase_n_programs.

To locate a syringe exchange program in your area see: https://nase_n.org/directory/

in diversion programs. Health insurance and specifically Medicaid coverage of SUD services is highly variable between states. As a result, the availability and funding of services is dependent on the region in which an individual resides.

A. SUD Treatment Services

SUD treatment plans are highly individualized and often incorporate several types of addiction services. The most effective treatment plan will be tailored to the needs of the individual and take into consideration the individual's community. Examples of categories of substance use treatment include, but are not limited to, those outlined in the table below:

Type of SUD Service	Description
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	SBIRT is a practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. A healthcare professional first screens a patient for substance use behaviors using standardized screening tools. If indicated, this is followed by a brief intervention in which the provider counsels the patient about risky behaviors and provides feedback and advice. The patient will then be referred to treatment based on individual needs if the brief intervention is not adequate. ¹⁴

14. Substance Abuse and Mental Health Services Administration/HRSA Center for Integrated Health Solutions. SBIRT: Screening, Brief Intervention, and Referral to Treatment, Opportunities for Implementation and Points for Consideration. 2012. Available at: http://www.integration.samhsa.gov/SBIRT_Issue_Brief.pdf.

Type of SUD Service	Description
Detoxification	Detoxification is a medically supervised process by which an individual who is physiologically dependent upon a substance is safely withdrawn from the addicting substance. While it is often considered the first step of treatment, detoxification alone does not address the psychological, social and behavioral problems associated with addiction. As such, detoxification is often followed by a formal assessment and referral to a drug treatment program. ¹⁵
Medication Assisted Treatment (MAT)	Medication-Assisted Treatment is a form of pharmacotherapy that treats SUD through the use of a pharmacologic intervention within a comprehensive SUD treatment plan, usually including individual or group counseling. MAT has been effective in the treatment of opioid dependence and may be used with methadone, naltrexone and/or buprenorphine. MAT can also effectively treat alcohol dependence using naltrexone, disulfiram, and/or acamprosate calcium. ¹⁶
Inpatient Treatment	Inpatient substance use disorder treatment may include medically supervised detoxification services during which the patient is under 24 hour a day medical supervision. ¹⁷ The patient typically has access to a broad range of medical professionals, including physicians, physician's assistants, behavioral therapists and occupational therapists. Patients may also be admitted to a psychiatric unit, which offers substance use disorder treatment and treatment of comorbid substance abuse and psychiatric illnesses. ¹⁸ Inpatient treatment is hospital-specific; therefore, the services offered may vary greatly.
Residential Treatment Programs	Short-Term Residential Short-term residential programs, typically lasting from 3–6 months, provide round-the-clock intensive care, typically using a 12-step approach. ¹⁹ Upon completion of a short-term residential stay, individuals are encouraged to engage in programs tailored to their individual needs to decrease the chance of relapse. This can include outpatient treatment programs, cognitive behavioral therapy, counseling and Narcotics Anonymous meetings.

15. National Institute on Drug Abuse. Principles of Drug Addiction Treatment, Third Edition. 2008. Available at: https://www.drugabuse.gov/sites/default/files/podat_1.pdf.

16. Substance Abuse and Mental Health Services Administration. Medication-assisted treatment (MAT). Available at: <http://www.samhsa.gov/medication-assisted-treatment>. 2014.

17. Substance Abuse and Mental Health Services Administration. Treatment for Substance Use Disorders. Available at: <http://www.samhsa.gov/treatment/substance-use-disorders>.

18. Johns Hopkins Medicine. Treatment Settings. Available at: http://www.hopkinsmedicine.org/substance_abuse_center/treatment/settings.html#opioid_treat.

19. National Institute on Drug Abuse. Principles of Drug Addiction Treatment, Third Edition. 2008. Available at: https://www.drugabuse.gov/sites/default/files/podat_1.pdf.

Type of SUD Service	Description
Residential Treatment Programs <i>(continued)</i>	<p>Long-Term Residential</p> <p>Long-term residential treatment provides 24-hour care similar to that of a short-term residential program, but in a nonhospital setting and for a longer period of time. An example of this treatment is a therapeutic community, with planned lengths of stay between 6 and 12 months. The therapeutic community approach sees the residential community as a whole—its staff and clients, and its daily activities—as the active components of treatment. In therapeutic communities, treatment focuses on developing a resident’s sense of personal accountability for their actions, helping residents to: (i) overcome damaging beliefs or destructive behavioral patterns; and (ii) adopt more constructive social interactions. Many therapeutic communities offer comprehensive services to aid in an individual’s transition from the program, such as employment training.²⁰</p>
Outpatient Treatment Programs	<p>Outpatient treatment programs vary in the types and intensity of services offered, but most programs are more cost effective than residential programs and more suited to individuals with jobs and family responsibilities.</p> <p>Partial Hospitalization</p> <p>Partial hospitalization programs are non-residential treatment programs that may or may not be hospital based. These programs offer clinical diagnostic and treatment services which are as intense as a residential program, but on less than a 24-hour basis. Programs generally take place during the day with emergency services available outside of program hours. Partial hospitalization programs offer varying services that can include therapy, nursing, psychiatric/medical evaluation, medication management and counseling.²¹</p> <p>Intensive Outpatient Treatment Program (IOT)</p> <p>Intensive outpatient treatment is a structured, short-term outpatient program employing individual, group and family therapy at least three times per week. IOT programs use a variety of approaches to treatment, including the 12-step approach, cognitive-behavioral therapy, motivational incentive approaches and therapeutic community models (<i>see descriptions of these types of approaches elsewhere in this chart</i>).²²</p>

20. National Institute on Drug Abuse, National Institutes of Health. Principles of Drug Addiction Treatment: A Research-Based Guide Available at: <http://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/drug-addiction-treatment-in-united-states/types-treatment-programs>.

21. Centers for Medicare & Medicaid Services. Mental health care (partial hospitalization). Available at: <http://www.medicare.gov/coverage/partial-hospitalization-mental-health-care.html>.

22. Center for Substance Abuse Treatment. Chapter 8. Intensive outpatient treatment approaches. In: Center for Substance Abuse Treatment, ed. Substance abuse: Clinical issues in intensive outpatient treatment. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2006. Available at: <http://www.ncbi.nlm.nih.gov/books/NBK64102/>.

Type of SUD Service	Description
Counseling	<p>Counseling aims to help individuals change unhealthy behaviors, and to develop the coping strategies and tools needed to abstain from or manage drug use.²³ Counseling is provided by trained clinicians such as psychologists, psychiatrists, social workers and counselors. Counseling varies in duration, typically from a few months to years, and can take a number of forms depending on the type of therapy being used, the goals of the treatment and the needs of the individual.</p> <p>Individuals with SUD may benefit from individual, group and/or family counseling. Group counseling takes advantage of social reinforcement and provides a community of support. Family counseling aims to engage family members in helping the individual make necessary changes to overcome addiction. Family counseling can be especially important in the case of adolescents.</p>
Cognitive Behavioral Therapy (CBT)	<p>Cognitive-Behavioral Therapy (CBT) is based on the theory that learning processes play a critical role in the development of a substance use disorder. Individuals learn to seek their own solutions to problems by applying different skills learned in CBT. These skills include exploring the positive and negative consequences of continued drug use, increasing the ability to recognize cravings and identify risky situations, developing strategies for coping with cravings, and avoiding negative situations.²⁴ A computer-based CBT system has also been developed to help reduce drug use following SUD treatment.²⁵</p>
Housing First	<p>Housing First is a program that aims to provide people experiencing homelessness with permanent and sustainable housing as quickly as possible. The program also provides services individuals may need for overall health and wellness. The program does not require an individual to be in a treatment program for SUD or to remain abstinent.</p>
Sober Living	<p>Sober living environments typically provide a home to those transitioning from an intensive residential SUD treatment program to independent living. These facilities are meant to serve as a supportive drug-free environment for those who have not established a stable living situation or for those who are not ready to return home to an unstructured environment.</p>

23. Substance Abuse and Mental Health Services Administration. Behavioral Health Treatment and Services. Available at: <http://www.samhsa.gov/treatment>.

24. National Alliance on Mental Illness. Treatments and Services: Cognitive-Behavioral Therapy. Available at: http://www2.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/About_Treatments_and_Supports/Cognitive_Behavioral_Therapy1.htm.

25. National Institute on Drug Abuse. Cognitive Behavioral Therapy. Available at: <http://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral>.

Type of SUD Service	Description
Naloxone	<p>Naloxone, also known by the brand name Narcan, is a drug that can be used to reverse the effects of opioid overdose. Naloxone can be administered in an emergency room. Increasingly, first responders, including law enforcement officers, are also being trained to administer naloxone. In addition, people at risk of opioid overdose can be prescribed “take-home” naloxone.</p> <p>Diversion program participants at risk of opioid overdose should be provided with naloxone along with the appropriate SUD treatment services listed above.</p> <p><i>See the search box at http://stopoverdose.org/faq.htm to identify naloxone distribution programs in your region.</i></p>

The federal Substance Abuse and Mental Health Services Administration, or SAMHSA, funds a broad range of substance use disorder treatment providers, mostly through block grants to states.

- *SAMHSA has a user-friendly website that allows you to search for substance use treatment clinics and facilities by location at <https://findtreatment.samhsa.gov/>. In the “Find Facility” box at the upper right, click the box for “Substance Use.” A drop-down menu will appear that permits searches by primary focus of provider; type of care; service setting; payment types accepted; sliding scale information; language services; target population(s); age groups and gender(s) accepted; and whether the provider offers methadone or buprenorphine treatment for opioid addiction.*
- You can also call SAMHSA’s Treatment Referral line at 1-800-662-HELP

In addition, every state has a “Single State Agency”—often called the Substance Abuse and Mental Health Program Office or Division of Behavioral Health—that coordinates substance use services statewide. These state agencies often provide funding to SUD providers across the state and may be a good source of information about providers in your area.

- *A directory of every state’s agency, with contact information, is available at <http://www.samhsa.gov/sites/default/files/ssadirectory.pdf>*

B. Safety Net Providers and Services for Special Populations

Leaders of diversion programs should also establish relationships with providers that offer a range of physical and mental health services, beyond those focused on substance use disorder. “Safety net providers”, including public hospitals, community health centers and rural clinics, generally offer patients access to services regardless of their ability to pay. A substantial proportion of their patients are uninsured or Medicaid beneficiaries.²⁶

This section outlines key categories of safety net providers that offer important health services for individuals in diversion programs.

1) Safety-Net Providers

Public & Nonprofit Hospitals

Public hospitals and nonprofit health systems provide significant levels of care to low-income, uninsured and vulnerable populations. Some safety-net hospitals are publicly owned and operated by local or state governments, and some are nonprofit, privately-owned entities. All are committed to providing access to healthcare for people with limited or no access due to their financial circumstances, insurance status or health

26. Kaiser Commission on Medicaid and the Uninsured. Uncompensated Care for Uninsured in 2013: A Detailed Examination. 2014. Available at: <https://kaiserfamilyfoundation.files.wordpress.com/2014/05/8596-uncompensated-care-for-the-uninsured-in-2013.pdf>.

CASE STUDY: VERMONT

The Care Alliance for Opioid Addiction is a statewide partnership of clinicians and treatment centers in Vermont. The Care Alliance has established a “hub and spoke” model of collaborating with community based SUD providers to create a coordinated, systematic response to opioid use in the state. Methadone clinics serve as the “hub”; these are specialty treatment centers responsible for coordinating the care of individuals who struggle with opioid use, offering comprehensive assessments, providing methadone treatment and supports and coordinating referral to ongoing care. Primary care doctors and other wraparound services serve as the “spokes,” and monitor adherence to treatment, coordinate access to recovery supports and provide counseling, contingency management and case management services. In Vermont, law enforcement taps into this coordinated hub and spoke system to divert would-be offenders into SUD treatment.

See more information at:
<http://healthvermont.gov/adap/treatment/documents/CareAllianceOpioidAddiction.pdf>;
<http://healthvermont.gov/adap/documents/HUBSPOKEBriefingDocV122112.pdf>.

condition. Nationwide, approximately 20% of hospitals are government owned, and 60% are nonprofit.²⁷

Medicare and Medicaid fund a large portion of the care provided at safety-net hospitals, but these hospitals also rely on funding from patients with commercial insurance and self-pay patients (uninsured individuals who pay what they can for their care).²⁸ In addition, public hospitals receive significant funding from local, state and/or federal governments.²⁹ With the passage of the Affordable Care Act (ACA), public and nonprofit hospitals stand to play an even larger role as safety net providers over the next decade. The expansion of insurance coverage among low-income populations will provide a new source of revenue for these hospitals, especially for treating the formerly uninsured.

To maintain their tax exempt status, nonprofit hospitals have an obligation to provide a “community benefit” to their surrounding community. As required by the ACA, nonprofit hospitals often meet their community benefit requirement by undertaking special initiatives to improve health in the communities they serve; such initiatives are identified through a comprehensive community health needs assessment which identifies and prioritizes community needs. (See Section V for more details).

Many public and nonprofit hospitals offer programs for SUD treatment. Some of these programs, like the Division of Substance Abuse and Addiction Medicine at San Francisco General Hospital, treat SUD broadly, offering programs like Opiate and Stimulant Outpatient Treatment Programs (OTOP/STOP) and Methadone Vans.³⁰ Other safety-net hospitals treat substance use disorder among specific populations like pregnant women.³¹ In general, public and nonprofit hospitals can offer important SUD treatment services to populations who would otherwise not have access to important healthcare services. In addition, public and nonprofit hospitals can offer these and other patients a broad range of physical and mental health services.

- Contact hospitals in your region to determine what services they may be able to provide to participants in a diversion program.

27. American Hospital Association. Facts on US Hospitals. 2014. Available at: <http://www.aha.org/research/rc/stat-studies/fast-facts.shtml>.

28. America's Essential Hospitals. Frequently Asked Questions. Available at: <http://essentialhospitals.org/about-americas-essential-hospitals/frequently-asked-questions/>.

29. Kaiser Commission on Medicaid and the Uninsured. Uncompensated Care for Uninsured in 2013: A Detailed Examination. May 2014. Available at: <https://kaiserfamilyfoundation.files.wordpress.com/2014/05/8596-uncompensated-care-for-the-uninsured-in-2013.pdf>.

30. University of California, San Francisco Department of Psychiatry. Division of substance abuse and addiction medicine. Available at: <http://psych.ucsf.edu/sfgh/saam>.

31. Andrulis D, Hopkins S. Public hospitals and substance abuse services for pregnant women and mothers: Implications for managed-care programs and medicaid. *J Urban Health*. 2001;78(1): 181–198.

Federally-Qualified Health Centers

In many communities, clinics called “Federally-Qualified Health Centers” (FQHCs) are the key primary care providers for low-income populations. FQHCs must provide comprehensive primary care services to all people who come for care, regardless of ability to pay, offering services either at no cost or on a sliding scale. In return, FQHCs receive Section 330 federal grant funds designated in the Public Health Service Act, as well as enhanced Medicaid and Medicare reimbursement.³² In addition, FQHCs bill insurance, including Medicaid; Medicaid payments represent 40% of FQHC funding.³³

There are about 1,300 FQHCs³⁴ nationally with 9,000 service delivery sites, serving patients in every state.³⁵ FQHCs have seen a significant increase in patients served in recent years, rising from 19.5 million in 2010 to an estimated 24 million in 2014.³⁶

Usually longstanding safety-net providers, FQHCs are often adept at serving marginalized populations and linking patients to key support services in the community. Many FQHCs offer a broad range of services in addition to offering primary care, including other physical, mental and dental health services. FQHCs also offer support services, like medical transportation and language services. As of 2013, approximately 1 in 5 FQHCs was also offering substance use treatment services.³⁷

In 2014, the federal government made two sets of grants to FQHCs to enhance their mental health and substance use disorder services. Grants were made to a total of 443 FQHCs across the country to hire new behavioral health providers, expand services and work to integrate behavioral healthcare with primary care.

32. Health Resources and Services Administration. The affordable care act and health centers. 2013. Available at: <http://bphc.hrsa.gov/about/healthcenterfactsheet.pdf>.

33. Shin P, Sharac J, Barber Z, Rosenbaum SJ, Paradise J. Community health centers: A 2013 profile and prospects as ACA implementation proceeds. Washington, DC: The Henry J. Kaiser Family Foundation. 2015. Available at: <http://kff.org/medicaid/issue-brief/community-health-centers-a-2013-profile-and-prospects-as-aca-implementation-proceeds/>.

34. This figure includes approximately 100 “FQHC look-alikes,” which meet federal requirements for the definition of an FQHC, but do not receive Section 330 funds.

35. Health Resources and Services Administration. The affordable care act and health centers. 2013. Available at: <http://bphc.hrsa.gov/about/healthcenterfactsheet.pdf>.

36. *Ibid*

37. Shin P, Sharac J, Barber Z, Rosenbaum SJ, Paradise J. Community health centers: A 2013 profile and prospects as ACA implementation proceeds. Washington, DC: The Henry J. Kaiser Family Foundation. 2015. Available at: <http://kff.org/medicaid/issue-brief/community-health-centers-a-2013-profile-and-prospects-as-aca-implementation-proceeds/>.

- Lists of FQHCs that received these specific funds, sorted by state, are available at <http://www.hrsa.gov/about/news/2014tables/behavioralhealthintegration/index.html> and <http://www.hrsa.gov/about/news/2014tables/behavioralhealth/index.html>.³⁸

Almost 60% of FQHCs are designated as patient centered medical homes (PCMHs).³⁹ PCMHs are a type of provider that emphasizes care coordination and communication to improve quality.⁴⁰ Their approach is encapsulated in principles established by four medical specialty societies in 2007; the principles prioritize personal relationships, team delivery of care for the whole person, coordination across specialties and care settings, quality and safety improvement, and open access.⁴¹ As such, clinics designated as PCMHs—and many without the specific designation—strive to provide quality care and promote coordinated primary and preventive services.

Some FQHCs exclusively or primarily serve certain populations. For example:

- **Healthcare for the Homeless** is a program that provides federal funds to FQHCs serving people experiencing homelessness.⁴²
- **Public Housing Primary Care Centers** are FQHCs situated on or near public housing and offer health services to residents. Public Housing Primary Care Centers aim to increase access to comprehensive care by providing accessible services in conjunction with health promotion and prevention activities.⁴³
- **Rural Health Clinics** were created to address the inadequate supply of physicians in rural areas and to increase the use of other healthcare providers such as nurse practitioners and physician assistants. These clinics are a type of FQHC that receive special reimbursement from Medicaid and Medicare to provide access to primary care services in rural areas.⁴⁴

38. Health Resources and Services Administration. HRSA awards \$51.3 million in affordable care act funding to support mental health and substance abuse treatment. Health Resources and Services Administration News Room. November 6 2014. Available at: <http://www.hrsa.gov/about/news/pressreleases/141106behavioralhealth.html>.

39. Health Resources and Services Administration. What is a health center? Available at: <http://bphc.hrsa.gov/about/what-is-a-health-center/index.html>.

40. *Ibid.*

41. Hasselt M, McCall N, Keyes V, Wensky SG, Smith KW. Total Cost of Care Lower among Medicare Fee-for-Service Beneficiaries Receiving Care from Patient-Centered Medical Homes. Health services research. 2015; 50(1), 253–272.

42. National Health Care for the Homeless Council. Fact sheet; health care for the homeless. 2010. Available at: <http://www.nhchc.org/wp-content/uploads/2011/09/HCHFactSheetMay2011.pdf>.

43. National Association of Community Health Centers. Healthcare for residents of public housing. Available at: <https://www.nachc.com/public-housing-residents.cfm>.

44. Health Resources and Services Administration. What are rural health clinics (RHCs)? Available at: <http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/ruralclinics.html>.

To find FQHCs in your area, including public housing primary care centers, see:

- <http://findahealthcenter.hrsa.gov/http://bphc.hrsa.gov/programopportunities/lookalike/index.html>

To find health centers focusing on the homeless in your area, see:

- <http://bphc.hrsa.gov/uds/datacenter.aspx?q=d&year=2013>

To find rural health clinics, contact the CMS Regional Office Rural Health Coordinator in your area:

- <http://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/Downloads/CMSRuralHealthCoordinators.pdf>

TITLE X FAMILY PLANNING

CENTERS receive federal funds to provide high quality and cost-effective family planning and related preventive health services for low-income women and men. The family planning services are offered on a sliding scale. Family planning centers offer contraceptive methods, pregnancy testing, breast and cervical cancer screening, screening and treatment for sexually transmitted infections (STIs), HIV testing, counseling and patient education and referrals. Title X providers may or may not also provide other health services. To find Title X family planning centers, see the “Family Planning Locator” at the bottom right of the page at: <http://www.hhs.gov/opa/title-x-family-planning/>

2) Services for Special Populations

Veterans Health Administration

The Veterans Health Administration (VA), administered by the federal government through the Department of Veterans Affairs, provides hospital and outpatient healthcare services to veterans “to promote, preserve, or restore” health.⁴⁵ While members of the armed forces have lower rates of illicit drug use than civilians, they have higher rates of prescription drug misuse, with 11% of service members reporting misuse in 2006.⁴⁶ In light of these figures, diversion programs may want to establish relationships with the VA and other providers that offer services geared toward veterans.

45. U.S. Department of Veterans Affairs. Medical benefits package. 2015. Available at: http://www.va.gov/HEALTHBENEFITS/access/medical_benefits_package.asp.

46. National Institute of Drug Abuse. DrugFacts: Substance abuse in the military. 2013. Available at: <http://www.drugabuse.gov/publications/drugfacts/substance-abuse-in-military>.

The VHA offers treatment for substance use disorders, including:⁴⁷

- first-time screening for alcohol or tobacco use
- intensive outpatient treatment including counseling
- residential care
- medically managed detoxification
- continuing care and relapse prevention
- marriage and family counseling
- self-help groups
- drug substitution therapies and newer medicines to reduce craving.⁴⁸

When indicated, the VA offers medication-assisted treatment for alcohol dependence, nicotine addiction and opioid addiction, including methadone programs as well as buprenorphine/naloxone and naltrexone treatments.⁴⁹ In addition, the VA runs an Opioid Overdose Education and Naloxone Distribution (OEND) program that trains veterans to respond to and reverse an opioid overdose.⁵⁰

Staff at the LEAD program in Seattle (described in detail on p. 12) found that many of the individuals eligible for enrollment into their diversion program were veterans. Despite the presence of a VA hospital in the city, there was a very low level of utilization of VA services, with many of the veterans not even aware of the hospital's existence. Many needed assistance accessing a VA facility and utilizing the agency's services.

Veterans returning to civilian life may be dealing with a host of mental health challenges, including the 18.5% of service members returning from Iraq or Afghanistan who suffer from Post-Traumatic Stress Disorder (PTSD), and the 19.5% with traumatic brain injuries sustained during deployment.⁵¹ The VA offers benefits for mental healthcare, including specialized PTSD services.

While some veterans may be eligible for more healthcare services than others based on their eligibility status, all veterans

47. U.S. Department of Veterans Affairs. Mental health care. 2015. Available at: http://www.va.gov/healthbenefits/access/mental_health_care.asp.

48. U.S. Department of Veterans Affairs. Treatment programs for substance use problems. 2015. Available at: <http://www.mentalhealth.va.gov/res-vatreatmentprograms.asp>.

49. *Ibid.*

50. U.S. Department of Veterans Affairs. Substance use. 2015. <http://www.mentalhealth.va.gov/substanceabuse.asp>.

51. Substance Abuse and Mental Health Services Administration. Veterans and military families. 2014. Available at: <http://www.samhsa.gov/veterans-military-families>.

have access to the VA's comprehensive medical benefits package. This includes prevention services like immunization, screening and behavioral health services to reduce risk factors for disease, emergency care and specialty care.⁵²

- *To find a VA SUD treatment provider, see:* www.va.gov/directory/guide/SUD_flsh.asp. VA facilities that are not specific SUD treatment providers may still offer SUD services in their mental health clinics. To locate all VA hospitals and clinics, see: http://www.va.gov/directory/guide/division_flsh.asp?dnum=1.
- In addition to their medical facilities, the VA runs a network of Veterans' Centers that assist veterans and their families with readjustment to civilian life. Services provided include substance use assessment and referral services.⁵³ *A map of Vet Centers by state is available at* http://www.va.gov/directory/guide/vetcenter_flsh.asp.

Ryan White Services for People Living with HIV

People with substance use disorder are at elevated risk of HIV. Use of a range of substances can increase risky behavior, including unprotected sex and transactional sex. In addition, shared equipment for injection drug use is a direct exposure route for HIV, with an estimated 7% (3,096) of the estimated annual 47,352 diagnoses of HIV infection in the United States attributed to injection drug use.⁵⁴ People who inject drugs make up less than 3% of the U.S. population, but approximately 22% of people living with HIV.⁵⁵

In light of these statistics, a diversion program should consider establishing a relationship with a Ryan White HIV/AIDS program provider.

The Ryan White Comprehensive AIDS Resources Emergency Act (CARE) was enacted in 1990 to provide care and support to individuals affected by HIV/AIDS.⁵⁶ The Ryan White program is the largest federal program designed specifically for individuals with HIV/AIDS in the United States and the third largest source of federal funding for HIV care behind

52. U.S. Department of Veterans Affairs. Health promotion and disease prevention. 2015. http://www.va.gov/healthbenefits/access/health_promotion.asp.

53. U.S. Department of Veterans Affairs. Vet Center Program. 2015. http://www.vetcenter.va.gov/Vet_Center_Services.asp.

54. National Center for HIV/AIDS, Viral Hepatitis, Sexual Transmitted Diseases and Tuberculosis Prevention. HIV and injection drug use. 2015. <http://www.cdc.gov/hiv/risk/behavior/idu.html>.

55. Lansky A, Finlayson T, Johnson C, Holtzman D, Wejnert C, Mitsch A, et al. (2014) Estimating the Number of Persons Who Inject Drugs in the United States by Meta-Analysis to Calculate National Rates of HIV and Hepatitis C Virus Infections. PLoS ONE. 9(5): e97596. doi:10.1371/journal.pone.0097596.

56. The Henry J. Kaiser Family Foundation. Fact sheet: The Ryan White program. 2013;7582-07. Available at: <http://kff.org/hiv/aids/fact-sheet/the-ryan-white-program/>.

Medicare and Medicaid.⁵⁷ The program serves as a “payer of last resort,” covering services and drugs for people with no health insurance coverage or limited coverage.⁵⁸

The range of services offered by Ryan White providers includes:

- HIV testing;
- primary care;
- specialty medical care;
- prescription drugs to treat HIV and co-occurring conditions;
- mental health services;
- substance use treatment;
- medical case management;
- food;
- medical transportation; and
- support services for women and children.

In addition, some states and cities use Ryan White funding to help pay insurance premiums and cost sharing related to healthcare services for people living with HIV.

- *A directory of Ryan White-funded providers is available at <https://locator.aids.gov/>. It permits searches for Ryan White HIV care, as well as SUD providers and facilities that offer specific services for people living with HIV.*
- In addition to finding specific providers, it may be helpful to contact the state and/or city agencies that administer Ryan White program funding for your area to discuss eligibility and the range of services available. *Maps with links to contact information are available at <https://careacttarget.org/grants-map/1433> (states) and <https://careacttarget.org/grants-map/1432> (certain highly affected urban areas).*

Indian Health Service

The Indian Health Service (IHS) is the principal federal health care provider and health advocate for American Indians and Alaska Natives. IHS provides comprehensive health care to individuals who are members of 566 federally recognized Tribes across the U.S.⁵⁹

57. Crowley JS, Kates J. Updating the Ryan White program for a new key era: Key issues & questions for the future. 2013;8431.

58. *Ibid.*

59. Indian Health Service. Agency overview. Available at: <http://www.ihs.gov/aboutihs/overview/>.

IHS is not a health insurance provider, but rather a health care delivery system consisting of federal hospitals and clinics that exclusively treat American Indians and Alaska Natives.⁶⁰

Alcoholism and substance use disorder are serious health concerns for the American Indian and Alaska Native community. IHS has sought to address alcoholism and SUD via policy recommendations since at least 1969 when it released the report on the IHS Task Force on Alcoholism.⁶¹ This policy focus over the past half century has resulted in a series of programs and practices that contend with SUD among the American Indian and Alaska Native community through a multi-pronged approach.

IHS offers a variety of treatments for SUD including:

- detoxification (both medical and non-medical);
- residential treatment;
- outpatient care;
- group and halfway housing; and
- drop-in centers that can provide referrals to a variety of other SUD treatment options.⁶²

IHS has also implemented several initiatives to address various types of substance use disorder and those affected by it. The Alcohol and Substance Abuse Program (ASAP) works to reduce the incidence and prevalence of alcohol and substance abuse in the American Indian and Alaska Native community.⁶³ To achieve this goal, ASAP has implemented programs with emergency and inpatient and outpatient treatment within tribal communities, as well as rehabilitation services in rural and urban settings. In addition, IHS offers “The Women and Children Program,” a residential, intensive treatment program that places women struggling with SUD with their dependent children in therapeutic environments. Within these therapeutic environments, program participants receive individual and group counseling, substance abuse education, and classes to develop decision-making and parenting skills all designed to build and develop participants’ ability to cope with problems of alcoholism and substance abuse.⁶⁴

60. Indian Health Service. For Patients. Available at: <http://www.ihs.gov/forpatients/>.

61. Indian Health Service. Chapter 18—Alcohol/Substance abuse. Indian health manual. Rockville MD: U.S. Department of Health and Human Services: 3-18.10J.

62. *Ibid.*

63. Indian Health Service. Alcohol and substance abuse program. Available at: <http://www.ihs.gov/asap/>.

64. Indian Health Service. Chapter 18—Alcohol/Substance abuse. Indian health manual. Rockville MD: U.S. Department of Health and Human Services: 3-18.10J.

- *The policies, standards and procedures used to determine if an individual is eligible to receive care through the Indian Health Service can be found at http://www.ihs.gov/IHM/index.cfm?module=dsp_ihm_pc_p2c1#2-1.2/.*
- *Information on IHS providers by region is available at <http://www.ihs.gov/findhealthcare/>.*

Innovative Projects

In addition to federally- and state-funded SUD initiatives, there may be a number of innovative projects and programs that are relevant to SUD and SUD-related care and services in your state. They may be facilitated through public-private partnerships, universities and other academic institutions, or other community-based organizations. In addition to federally funded initiatives, leaders of diversion programs should search for state specific and privately funded initiatives to help support their clients. For example:

Project ECHO, New Mexico, Nationwide

Hepatitis C is highly prevalent among injection drug users: within 5 years of beginning to inject drugs, 70–80% of people are infected with hepatitis B, and 50–80% with hepatitis C. Project ECHO (Extension for Community Healthcare Outcomes) is a collaborative effort to promote improved care for patients with Hepatitis C and other complex conditions in their communities. Project ECHO works to increase access to specialty treatment in rural and other underserved areas by using telemedicine to connect specialists at academic medical centers with front-line clinicians managing patients with hepatitis C, chronic pain, and/or behavioral health disorders. Project ECHO is supported by grants from foundations and multiple federal agencies.

University of Pittsburgh Medical Center, Pittsburgh, PA

Women with SUD need specialized and non-punitive health and support services when they are pregnant. In August 2014, in collaboration with the Allegheny County Office of Behavioral Health and four local managed care organizations, the Magee-Women’s Hospital of University of Pittsburgh Medical Center launched the Pregnancy Recovery Center, an innovative comprehensive program that provides concurrent treatment for opioid dependence and prenatal care and delivery.

The Pregnancy Recovery Center offers Medication Assisted Therapy treatment on an outpatient basis to pregnant women struggling with opioid dependence. This treatment is integrated with their obstetric services, including prenatal care. Women undergoing treatment also receive behavioral health counseling and clinic visits with social workers and midwives.

IV. Health Insurance Resources

Diversion programs often refer clients to a variety of providers who offer services that can be reimbursed through health insurance. While public and private health insurers are unlikely to offer coverage for support services that are not typically considered medical assistance (such as job placement or housing services), many services important to SUD treatment may be covered benefits. This section of the guide provides information about several health insurance options—including Medicaid and the Children’s Health Insurance Program (CHIP), Medicare, and private, subsidized coverage—that may cover, and pay for, SUD services.

Some individuals eligible for a diversion program may already have insurance, such as through public insurance programs (including Medicaid and Medicare), or private insurance offered through their employer. Others may have gained insurance through the new state Health Insurance Marketplaces established by the Affordable Care Act (ACA), or through efforts to expand Medicaid in their state. These insurance expansions are explained in greater detail below. In many cases, people may be eligible for programs, but not enrolled.

At the end of this section is a description of what the remaining uninsured population is expected to look like after full implementation of the ACA, with a discussion of the barriers that persons with SUD may have in obtaining public or private health insurance.

A. Medicaid

Medicaid is the largest health insurance program in the U.S., covering over 72 million low-income Americans.⁶⁵ Medicaid can be an important source of health insurance coverage for individuals with SUD, as an estimated 11.3% of adults and 6% of adolescents enrolled in Medicaid have a substance use disorder.^{66, 67} As described below, depending on what type of Medicaid coverage an individual is eligible for, SUD services may or may not be covered benefits. Diversion programs that serve predominantly Medicaid-eligible populations should become aware of the differences in SUD coverage for various populations covered by Medicaid in their state.

Eligibility

Medicaid is an entitlement program, meaning that *any* person who meets his or her state's Medicaid eligibility criteria has a right to Medicaid coverage in that state. Traditionally, Medicaid has provided coverage to a core group of low-income individuals, including pregnant women, children, parents, elderly individuals, and individuals with disabilities, with income below specified minimum thresholds, such as 100% or 133% of the federal poverty level (FPL) (\$11,700 and \$15,654 per year, respectively for a single person in 2015). States have broad flexibility to extend coverage to people in these core groups above the federal minimum threshold. For this reason, eligibility looks different in every state.

Historically, Medicaid excluded most non-elderly, childless adults from coverage. The ACA gives states the option to expand their Medicaid programs to reach *all* people under age 65 with income at or below 138% of the federal poverty level; this amount would be \$16,243 per year for a household of one person in 2015.

Each state can decide whether to adopt the Medicaid expansion. As of September 2015, 20 states have *not* adopted the ACA's Medicaid expansion (see Figure 1).⁶⁸ Low-income adults eligible for diversion programs in these states are likely to remain uninsured, unless they qualify for one of the other Medicaid eligibility categories (pregnant, disabled etc.) or meet eligibility requirements through a waiver granted by the Centers for Medicare and Medicaid Services.

65. MACPAC. Medicaid 101. Available at: <https://www.macpac.gov/medicaid-101/>.

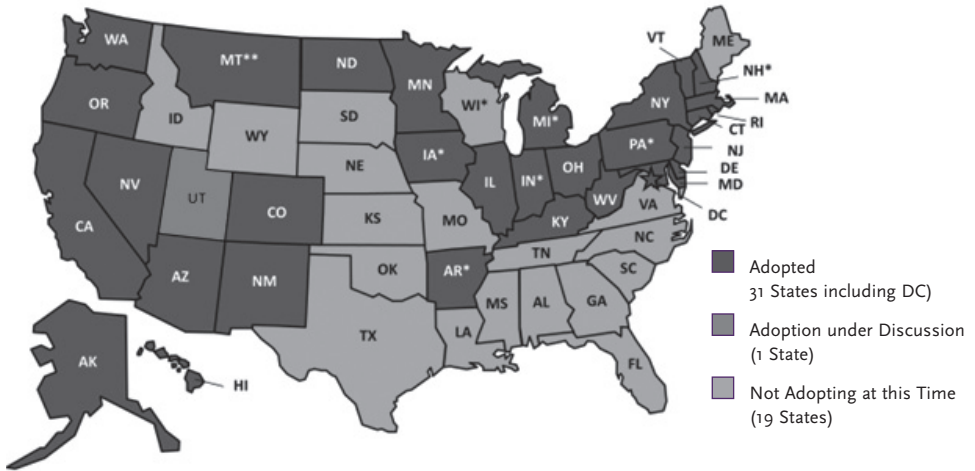
66. Busch SH, Meara E, Huskamp HA, Barry CL. Characteristics of Adults With Substance Use Disorders Expected to Be Eligible for Medicaid Under the ACA. *Psychiatr Serv.* 2013 Jun 1; 64(6): 520–526.

67. Centers for Medicare and Medicaid Services. Reducing Substance Use Disorders. 2014. Available at: <http://www.medicaid.gov/state-resource-center/innovation-accelerator-program/reducing-substance-use-disorders/reducing-substance-use-disorders.html>.

68. Henry J. Kaiser Family Foundation. Current Status of State Medicaid Decisions. June 22, 2015. Available at: <http://kff.org/health-reform/slide/current-status-of-the-medicaid-expansion-decision/>.

FIGURE 1:

Current Status of State Medicaid Expansion Decisions; Source: Henry J. Kaiser Family Foundation



Notes: Current status for each state is based on KCMU tracking and analysis of state executive activity. ** MT has passed the expansion; it requires federal waiver approval. * AR, IA, IN, MI, PA and NH have approved Section 115 waivers. Coverage under the PA waiver went into effect 1/1/15, but it is transitioning coverage to a state plan amendment. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.

Source: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated September 1, 2015. <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>



Enrollment

Eligible people can enroll in Medicaid at any point in the year, allowing individuals in diversion programs to quickly gain health insurance coverage when needed.

Medicaid Benefit Coverage

Coverage for SUD services may vary depending on whether an individual qualifies for Medicaid by meeting the eligibility criteria for one of the traditional core coverage groups (low-income children, pregnant women etc.), or qualifying based on the Medicaid expansion supported by the ACA. SUD coverage can also vary under different Medicaid managed care organizations and in states that have been granted a waiver from CMS. This section provides additional information about SUD benefits within these different Medicaid arrangements.

1) SUD Benefits in the Traditional Medicaid Program

In terms of covered benefits for the “traditional” Medicaid population (those categories of individuals eligible for Medicaid prior to the ACA), some Medicaid benefits are mandatory and others are optional. The following chart outlines many of the categories of mandatory and optional benefits:

Mandatory Benefits Include:	Optional Benefits Include:
<ul style="list-style-type: none"> • Physicians’ services • Hospital services (inpatient and outpatient) • Laboratory and x-ray services • Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) (a comprehensive range of preventive and treatment programs for beneficiaries under the age of 21) • Federally-qualified health center (FQHC) and rural health clinic (RHC) services • Family planning services and supplies • Transportation services⁶⁹ 	<ul style="list-style-type: none"> • Prescription drugs • Clinic services • Care furnished by other licensed practitioners such as podiatry services • Rehabilitation and other therapies • Case management • Home and community-based services (including under waivers) • Inpatient psychiatric services for individuals under age 21 • Personal care services⁷⁰

Only certain SUD services fall into mandatory Medicaid coverage categories, such as inpatient and outpatient hospital services. Many of the “optional” Medicaid benefits listed above are important for comprehensive, community-based SUD treatment. For example, state Medicaid programs can use the unique flexibilities in the rehabilitation optional benefit to offer services to beneficiaries in non-clinical, community settings by a broader range of professionals than is typically allowable under the “mandatory” benefit categories.⁷¹ In addition, case management services help individuals gain access to needed medical, social, educational, and other services. Prescription drugs are also important for persons with SUD, and though an optional benefit, are covered to some extent in all 50 states.

69. Centers for Medicare & Medicaid Services. Benefits. 2015. <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/medicaid-benefits.html>.

70. *Ibid.*

71. The Henry J. Kaiser Family Foundation. Medicaid’s Rehabilitation Services Option: Overview and Current Policy Issues. 2007. Available at: <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7682.pdf>.

Because of the broad flexibility to choose among optional benefits, covered benefits look different in every state. For example, as of 2014, Michigan’s Medicaid program covered a range of SUD services including detoxification, residential placement, care coordination, health assessments, outpatient therapy, methadone and other medication-assisted treatment, and recovery support services.^{72,73} New Jersey Medicaid covered SUD services including opioid treatment, methadone, naloxone, acute medical detoxification, and some outpatient services.⁷⁴

2) SUD Benefit Coverage for the Medicaid Expansion Population

In states that have expanded Medicaid under ACA provisions, newly eligible populations *must* receive a package of “essential health benefits” that include substance use disorder treatment.⁷⁵ The law sets a floor of covered benefits for SUD in the Medicaid expansion population that goes far beyond what is required for the “traditional” Medicaid population.

With the expansion of Medicaid to single and childless adults, Medicaid for the first time will also cover a significant number of individuals released from jail or prison, many of whom have SUD and could become eligible for a diversion program. One study estimates that 20 to 30% of new Medicaid beneficiaries in 2014 are likely to be individuals reentering the community from incarceration.⁷⁶

Medicaid Managed Care

Nationwide, the majority of Medicaid beneficiaries are enrolled in Medicaid managed care organizations, or MCOs.⁷⁷ MCOs contract with the state Medicaid program to deliver required benefits and services. An MCO must cover the same benefits as the state’s underlying Medicaid or Medicaid expansion program, but may also cover additional health and coordination services that could help participants in a diversion program.

72. Horton et al. research for OSF, 2014.

73. Horton et al. research for OSF, 2014.

74. Horton et al. research for OSF, 2014.

75. Medicaid and Children’s Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment; Final Rule, 78 Fed. Reg 42160. July 15, 2013. Available at: <http://www.gpo.gov/fdsys/pkg/FR-2013-07-15/pdf/2013-16271.pdf>.

76. Regenstein, M. Jail Populations: Characteristics and Coverage. 2013. Rockville: SAMHSA-HRSA Center for Integrated Health Solutions. Available at: http://www.integration.samhsa.gov/about-us/Presentation_061813_final.pdf.

77. Kaiser Commission on Medicaid and the Uninsured. Medicaid Managed Care: Key Data, Trends, and Issues. 2012. Available at: <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8046-02.pdf>.

Medicaid Waivers

States may choose to request a waiver of certain statutory requirements from CMS, the federal agency that administers the Medicaid program. Medicaid waivers offer states additional flexibility to test new approaches to delivering services,⁷⁸ to expand Medicaid eligibility, or to provide services not normally covered under Medicaid.⁷⁹ Section 1115 waivers provide states with flexibility to administer demonstration or pilot initiatives, upon receiving approval from the Secretary of Health and Human Services. Sections 1915(a) and (b) provide waivers allowing states to experiment with managed care and home and community-based services. On July 27, 2015, CMS released a policy guidance document encouraging states to apply for Section 1115 waivers to broaden their SUD delivery systems.⁸⁰

States may apply for waivers to fund SUD treatment under Medicaid. For instance, Connecticut's Acquired Brain Injury program (ABI) offers a number of services, including SUD treatment, for adults with brain injuries under a Medicaid waiver.⁸¹ In New York, the state's Delivery System Reform Incentive Payment (DSRIP) Program (which provides states with significant funding to change how they provide care to Medicaid beneficiaries), also established under a Medicaid waiver, integrates primary and behavioral health services by reducing the licensure burden for healthcare providers offering both primary and behavioral healthcare.⁸²

- *A full list of Medicaid waivers, including those that cover substance use programs for specific populations, is available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/waivers_faceted.html*
- Because Medicaid coverage and eligibility varies significantly by state, each state's Medicaid office is the best source of information for how the program can help par-

78. Centers for Medicare & Medicaid Services. Waivers. 2015. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>.

79. Centers for Medicare & Medicaid Services. Section 1115 demonstrations. 2015. Available at: <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/section-1115-demonstrations.html>.

80. Centers for Medicare and Medicaid Services. New Service Delivery Opportunities for Individuals with a Substance Use Disorder. July 27, 2012. Available at: <http://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf>

81. Centers for Medicare & Medicaid Services. CT waiver factsheet. 2015. Available at: <http://www.medicaid.gov/Medicaid-CHIP>.

[Program-Information/By-State/Waiver-Descript-Factsheet/CT-Waiver-Factsheet.html#CT0302](http://www.medicaid.gov/Medicaid-CHIP).

82. New York Department of Health. Attachment A: DSRIP project 3.a.i licensure thresholds. 2015. Available at: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/regulatory_waivers/licensure_thresholds.htm.

ticipants in a diversion program. A full directory of state Medicaid offices is available at: <http://medicaiddirectors.org/about/state-directors>

- CMS publishes state profiles of the current status of MCOs in each state. These resources can be found at: <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/managed-care-site.html>

B. Children’s Health Insurance Program (CHIP)

The Children’s Health Insurance Program, or CHIP, builds on Medicaid to provide insurance coverage to uninsured, low-income pregnant women, parents, children and adolescents under the age of 19 whose household income is low, but above Medicaid income eligibility thresholds. Approximately eight million children were enrolled in CHIP in 2014.⁸³ Understanding the differences between Medicaid and CHIP coverage in your state is important, especially if your diversion program serves juveniles.

Unlike the Medicaid program to which certain individuals are entitled if they meet designated criteria, no individual entitlement to coverage exists for CHIP programs. Similarly, funding is not open-ended.⁸⁴ Each state administers its own CHIP program within federal rules and receives federal matching funds for program spending.⁸⁵

CHIP gives states flexibility to create their programs: (1) as an expansion of Medicaid; (2) as a program entirely separate from Medicaid; or (3) as a combination of both approaches. As of January 1, 2015, 8 states

OTHER STATE & LOCAL INSURANCE PROGRAMS: Some states and localities run special public health insurance programs to cover people who are not eligible for Medicaid and/or CHIP. For example, Washington DC’s Healthcare Alliance Plan is open to all adults up to 200% of the federal poverty level (approximately \$23,500 for an individual). Your state’s Medicaid office should have information regarding whether such additional health insurance resources are available in your area. More information regarding Washington DC’s Healthcare Alliance Plan can be found at <http://dhcf.dc.gov/service/health-care-alliance>

83. MACPAC. State Children’s Health Insurance Program (CHIP) Fact Sheet. 2015. Available at: <https://www.macpac.gov/publication/state-childrens-health-insurance-program-chip-fact-sheet/>.

84. MACPAC. Key CHIP design features. 2015. Available at: <https://www.macpac.gov/subtopic/key-design-features/>.

85. *Ibid.*

and 5 territories ran CHIP as a Medicaid expansion, 2 states operated separate CHIP programs, and 41 states operated a combination program.⁸⁶

Covered benefits in CHIP differ substantially from state to state. Like Medicaid, CHIP provides coverage for a broad range of medical services, and coverage can include a range of services for people with SUD. In states that run CHIP as an extension of the Medicaid program, CHIP covers the same services as Medicaid (as described above) including the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. Where CHIP is administered as a standalone program, states receive more flexibility around benefit design, and are not required to offer the set of mandatory Medicaid services. Given the variability, diversion programs should connect with CHIP programs in their state to determine coverage for SUD treatment.

- *State Medicaid offices will be able to provide information about CHIP eligibility and coverage of SUD and other services. A full directory of state Medicaid offices is available at <http://medicaiddirectors.org/about/state-directors>*

C. Medicare

Some diversion program participants may be eligible for, or enrolled in, Medicare. Medicare is the federal health insurance program for people who are 65 or older, people with certain disabilities⁸⁷ or people with End-Stage Renal Disease.⁸⁸ Medicare is divided into 4 different parts, Parts A, B, C, and D:⁸⁹

- **Medicare Part A** provides hospital insurance consisting of inpatient hospital stays, care in a skilled nursing facility, hospice care and some home health care.
- **Medicare Part B** provides medical insurance consisting of physician services, outpatient care, medical supplies and preventive services.
- Some Medicare beneficiaries choose to enroll in Medicare Part C, also referred to as the **Medicare Advantage Program**. Medicare Part C includes private health plans that contract with Medicare to provide Part A and Part B benefits and sometimes Part

86. *Ibid.*

87. A person, who is under 65 and disabled, is eligible for Part A and Part B after receiving disability benefits from Social Security or certain disability benefits from the Railroad Retirement Board for 24 months.

88. Centers for Medicare & Medicaid Services. What is Medicare? Available at: <http://www.medicare.gov/sign-up-change-plans/decide-how-to-get-medicare/whats-medicare/what-is-medicare.html>.

89. *Ibid.*

D benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans and Medicare Medical Savings Accounts.

- **Medicare Part D**, which is optional, provides prescription drug coverage.⁹⁰

Medicare will help pay for treatment of SUD by a Medicare-participating provider or facility in both inpatient and outpatient settings if the services are medically necessary and the provider creates a plan of treatment. Medicare pays for medically reasonable and necessary SBIRT services provided in physicians' offices or outpatient hospitals.⁹¹ Medicare Part A will cover hospitalization for SUD treatment, including inpatient mental healthcare in a general hospital. Medicare Part B covers outpatient SUD treatment services from a clinic or hospital outpatient department. For beneficiaries enrolled in Part D, coverage of medically necessary drugs to treat SUD varies; methadone for outpatient SUD treatment may not be covered.⁹²

Medicare generally will cover 80% of the cost of covered services. The beneficiary is responsible for payment of the remaining 20%. While some choose to pay out of pocket, some beneficiaries enroll in Supplement Insurance policies, also known as Medigap. These plans can help pay copayments, coinsurance, and deductibles.⁹³

- *Information about Medicare eligibility and enrollment can be found at* <https://www.medicare.gov/people-like-me/new-to-medicare/getting-started-with-medicare.html>.

Dual Eligibles. About 9 million people in the US are “dual eligible,” covered by *both* Medicare and Medicaid.⁹⁴ These individuals are entitled to Medicare, but are also eligible for some level of assistance from their state Medicaid program. Medicare is the primary source of coverage for dual eligibles, with Medicaid filling in the gaps in Medicare's benefit package, such as by helping to pay for Medicare's premiums and cost-sharing or by providing benefits not offered under Medicare, such as long-term care. *Information about dual eligibles can be found at:* <http://www.medicare.gov/affordablecareact/provisions/dual-eligibles.html>

90. *Ibid.*

91. Centers for Medicare & Medicaid Services. Screening, Brief Intervention, and Referral to Treatment (SBIRT) Services. Washington, DC: Department of Health and Human Services; 2014. Dept of HHS publication.ICN 904084. Available at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/SBIRT_Factsheet_ICN904084.pdf.

92. Medicare Interactive. Medicare coverage of treatment for alcoholism and drug abuse. Available at: http://www.medicareinteractive.org/page2.php?topic=counselor&page=script&script_id=925.

93. Centers for Medicare & Medicaid Services. What's Medicare Supplement Insurance (Medigap)? Available at: <http://www.medicare.gov/supplement-other-insurance/medigap/whats-medigap.html>

94. The Henry J. Kaiser Family Foundation. Dual Eligible. Available at: <http://kff.org/tag/dual-eligible/>.

D. Private Health Insurance: Subsidized Coverage through State Exchanges

In the past, coverage of SUD by private insurance plans was often very limited. With the passage of the Affordable Care Act, individuals and small businesses in every state can now directly purchase private, commercial health insurance policies through state-level marketplaces, known as “Exchanges” (or by state-specific names). All of these plans are required to cover a set of ten “essential health benefits” (EHBs) to be considered “Qualified Health Plans”:

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.⁹⁵

Qualified Health Plans that provide health insurance in the new marketplace must cover mental health and SUD services “at parity” with other conditions (see textbox for further discussion of parity requirements). In addition, qualified health plans may not reject applicants, or charge them higher premiums because of pre-existing health conditions such as substance use disorder. They also may not place annual or lifetime dollar caps on coverage.⁹⁶

Open enrollment for plans selling insurance through the new marketplaces runs for several months in the late fall and winter; for 2016 plans, open enrollment will be from November 1, 2015 to January 31, 2016. However, individuals may be eligible to sign up for health insurance through an exchange plan outside of the open enrollment period if they

95. Centers for Medicare & Medicaid Services. Essential health benefits. Available at: <https://www.healthcare.gov/glossary/essential-health-benefits/>.

96. *Ibid.*

qualify for “special enrollment” because of a life event like marriage, the birth or adoption of a dependent child, moving residencies, or loss of other healthcare coverage.⁹⁷ Other “exceptional circumstances” might also qualify someone for special enrollment.⁹⁸

Low- and middle-income people are eligible for federal subsidies that can substantially reduce the cost of monthly insurance premiums. These subsidies are available for people whose income and household size puts them between 100% and 400% of the federal poverty level (an income of \$11,670–\$46,680 per year for a single person household in 2015).⁹⁹ People with incomes between 100% and 250% of the federal poverty level (\$11,670–\$29,175 per year) are also eligible for subsidies to reduce their out-of-pocket expenses when they receive medical services.¹⁰⁰ [Note that people with incomes below these levels may be eligible for Medicaid, particularly in states that have enacted a Medicaid expansion; see Section on Medicaid, above, for more details].

Every state has “Navigators” and other assisters who provide guidance and enrollment help for applicants. A diversion program should establish relationships with an appropriate Navigators in the region to provide program-level and individual advice regarding Exchange coverage.

- *How to connect to the private insurance exchange in your state:* Contact the entity that runs your state’s Exchange to determine how the population served by your diversion program could best access coverage. In some states, the Exchange is administered by the federal government, and in other states, it is administered by the state govern-

MENTAL HEALTH & SUD PARITY:

Health plans for people with mental illness or SUD, if they included behavioral health benefits at all, have historically been more expensive, with limited benefits and significant administrative hurdles to obtaining care. Today, federal law requires private insurers that cover mental health and substance use disorder services to cover them “at parity” with other medical and surgical services. In general, financial requirements, like copayments for office visits, and treatment limitations, like visit limits, cannot be any more restrictive for mental health and substance use disorder than they are for other conditions. The law applies to most employer health plans; both large and small group, as well as to individual health plans, and to Medicaid managed care organizations. Parity laws help reduce discrimination in health insurance benefits for persons with SUD.

97. Centers for Medicare & Medicaid Services. Getting 2015 coverage with a special enrollment period. <https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period>.

98. *Ibid.*

99. Centers for Medicare & Medicaid Services. Incomes that qualify for lower costs: Accessible chart. Available at: <https://www.healthcare.gov/qualifying-for-lower-costs-508/>.

100. *Ibid.*

ment. The website www.healthcare.gov provides information for contacting exchange authorities in every state.

- *Information about finding a Navigator or Assister to help choose a health insurance plan can be found at www.localhelp.healthcare.gov.*
- *Community Catalyst has developed a guide to ACA outreach and enrollment for people with substance use disorders, available at: <http://www.communitycatalyst.org/resources/publications/document/Enrolling-People-with-Substance-Use-Disorders-1.pdf?tr=y&auid=16151180>.*

E. Uninsured

Despite new insurance options and the requirement that most Americans maintain health insurance, many individuals with SUD are likely to remain uninsured. In Massachusetts, for example, although 97% of residents were enrolled in public or private health insurance in 2012, 25% of individuals with SUD remained uninsured.¹⁰¹ Persons with SUD may experience several barriers to enrollment, including lack of information or misinformation about eligibility, infrequent encounters with the healthcare system, difficulty in obtaining documentation needed to complete the application process, stigma in seeking treatment, and social factors such as homelessness.¹⁰²

In addition, some individuals who are eligible for diversion programs may not be eligible for any form of insurance. In states that have not expanded Medicaid, most low-income childless adults will not qualify for Medicaid and may have difficulty affording other insurance. Also, undocumented immigrants are generally not eligible for Medicaid and cannot purchase insurance through state Health Insurance Marketplaces.

Free or low-cost SUD services may be available for uninsured individuals from grant-supported providers and programs.

- *For information about SUD services in your state that may be available regardless of a person's insurance status see <https://findtreatment.samhsa.gov/>.*

101. Capoccia VA, Grazier KL, Toal C, Ford II, JH, Gustafson DH, Massachusetts's Experience Suggests Coverage Alone Is Insufficient To Increase Addiction Disorders Treatment. *Health Affairs*. 2012; 31(5): 1000–1008.

102. Community Catalyst. ACA Enrollment: Reaching People with Substance Use Disorders. October 2014. Available at: <http://www.communitycatalyst.org/resources/publications/document/Enrolling-People-with-Substance-Use-Disorders.pdf>.

- In addition, many of the safety net providers described in section III(B) will serve uninsured people at little or no cost.

Many states offer Consumer Assistance Programs which provide help with any questions or issues related to health insurance and health resources.

- *For more information about Consumer Assistance Programs see <https://www.cms.gov/ccio/resources/consumer-assistance-grants/>.*

V. New Opportunities in Care Delivery

The healthcare delivery system is changing rapidly. New federal law has created opportunities for providers, states and other stakeholders to establish innovative healthcare payment and delivery models which, in turn, can give people with SUD more comprehensive and better coordinated care. Some, or all, of the models discussed below may be available for collaboration with diversion programs, though the presence of each type of model varies by state.

A. Medicaid Health Homes

Medicaid Health Homes are a delivery model that could provide coordinated medical and social support services for participants in diversion programs. Medicaid Health Homes provide a comprehensive set of primary and acute physical health services, behavioral health care, and long-term community-based services and supports.

Definition. The Affordable Care Act establishes a “[s]tate option to provide Health Homes for enrollees with chronic conditions.” The federal government pays an enhanced match rate for two years to states for Health Home coordination services. States then have flexibility in how to pay providers, with most using a per-member/per-month payment system. As of May 2015, 19 states have received CMS approval for the implementation of one or

CASE STUDY: NEW YORK CITY

The New York City Police Department is working with the Metropolitan Transit Association to link homeless individuals in the subway system to care and support services instead of arresting them for low-level offenses. As part of their program, they are working with Medicaid Health Homes in the city that coordinate physical and mental health services for people with SUD.

more Medicaid Health Homes.¹⁰³ The goal of a Medicaid Health Home, in general, is to provide coordinated care to Medicaid beneficiaries who have two or more chronic conditions, have one chronic condition and are at risk of developing a second, or have serious and persistent mental illness.¹⁰⁴

Notably, the definition of chronic conditions in this law includes substance use disorders. Several states, including Alabama, Iowa, Maine, Missouri, and Washington, use this federal definition of “chronic conditions”

to include individuals with SUD as eligible for their state Medicaid Health Home programs.¹⁰⁵ Medicaid Health Homes in several additional states including Maryland, Rhode Island, and Vermont specifically focus on individuals with opioid dependency.¹⁰⁶ Overall, Medicaid Health Homes, in states where they are available, can be an important source of treatment and care coordination for individuals with SUD, especially when compared to the alternative of incarceration.

Services. In addition to medical care, Medicaid Health Homes must provide patients with six core coordination services: comprehensive care management, care coordination and health promotion, comprehensive transitional care/follow-up, individual and family support, referral to community and social support services, and use of health information technology to link services.¹⁰⁷ These services underlie the “whole person” treatment philosophy of Health Homes. This philosophy encourages communication and collaboration between primary and behavioral healthcare providers and makes Medicaid Health Homes particularly well suited to provide care for individuals with SUD, many of whom have both

103. Centers for Medicare & Medicaid Services. Approved Health Home State Plan Amendments. <http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/approved-health-home-state-plan-amendments.html>.

104. Centers for Medicare & Medicaid Services. Health Homes. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html>.

105. *Ibid.*

106. Paradise J, Nardone M. Medicaid Health Homes: A Profile of Newer Programs. 2014. Available at: <http://kff.org/report-section/medicaid-health-homes-a-profile-of-newer-programs-issue-brief/>.

107. Centers for Medicare & Medicaid Services. Guide to Medicaid Health Home Design and Implementation. Available at: <http://www.medicaid.gov/state-resource-center/medicaid-state-technical-assistance/health-homes-technical-assistance/guide-to-health-homes-design-and-implementation.html>.

physiological and behavioral challenges that healthcare providers must address concurrently to provide effective care.

Providers. Several different types of entities may serve as Health Home providers. The first are “designated providers” and include, but are not limited to, physicians, clinical practices or clinical group practices, rural health clinics, community health centers, community mental health centers, and home health agencies.¹⁰⁸ A “team of health professionals” may also serve as Medicaid Health Home providers and can include physicians, nurse care coordinators, nutritionists, social workers and behavioral health professionals. The team may be freestanding, but may also operate out of a hospital or even virtually. Finally, interdisciplinary groups of medical specialists, nurses, pharmacists, nutritionists, dietitians, social workers, behavioral health providers (including mental health providers, and substance use disorder prevention and treatment providers), doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physicians’ assistants may serve as “health teams” and qualify as Medicaid Health Homes providers.¹⁰⁹

Substance Use Disorder Treatment

Despite the wide variety of providers, practices and state laws governing Medicaid Health Homes in the United States, the foundation on which Medicaid Health Homes are built is consistent with the intent of substance use diversion programs: addressing the medical needs of individuals with substance use disorder in a comprehensive manner to achieve maximum individual health. Medicaid Health Homes can be a valuable resource for diversion programs.

B. Community Benefit

Nonprofit hospitals have an obligation to provide a benefit to their surrounding communities as a condition of maintaining their tax-exempt status. The ACA created a new requirement that nonprofit hospitals “demonstrate community benefit by conducting a community health needs assessment (CHNA) and adopting an implementation strategy to meet the

108. Centers for Medicare & Medicaid Services. Health Homes. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html>.

109. *Ibid.*

identified community health needs.¹¹⁰ Where hospitals have identified SUD treatment as a community health need, diversion programs may be able to link their uninsured and underinsured clients to the special community-based initiatives implemented by hospital systems to address SUD.

Under the law, nonprofit hospitals are required to complete a formal and public CHNA once every three years and report annually on ways that the hospital is contributing financial and/or other resources to address the problems the assessment identifies.¹¹¹ CHNAs and other reports provide insight into how each nonprofit hospital is meeting its community benefit obligation and may provide collaborative starting points for community-based SUD and diversion programs.

- Hospitals often post their CHNA and additional reports on their websites.
- In addition, most hospitals designate a specific individual responsible for their CHNA, and this person can provide information related to a hospital's community benefit.

CASE STUDY: ST. VINCENT HOSPITAL

St. Vincent Hospital, a nonprofit hospital in Santa Fe, New Mexico, conducted a countywide assessment focusing on gaps in health for the elderly, children and the poor. The hospital produced a profile of community needs that was used by the Santa Fe LEAD program (see p. 14 for full profile) to make decisions about priorities. As part of their program, they are working with Medicaid Health Homes in the city that coordinate physical and mental health services for people with SUD.

Some hospitals have initiated creative programs to address SUD within their surrounding communities. For example, in Boston Medical Center's Mental Health Diversion Initiative, the hospital's Department of Psychiatry collaborates with law enforcement, courts, the state Department of Health, and the County District Attorney's office to divert people with co-occurring mental health and substance use disorders into treatment instead of incarceration.¹¹² Further upstream, advocates for community-based substance use and diversion programs may also have the opportunity to engage during the community health needs assessment process, shaping the

contents of the report so that the hospital identifies substance use as an issue on which it would like to focus further resources.

110. U.S. National Library of Medicine. Community Benefit/Community Health Needs Assessment. 2015. https://www.nlm.nih.gov/hsrinfo/community_benefit.html.

111. *Ibid.*

112. Boston Medical Center. About BMC. 2014. Available at: <http://www.bmc.org/about/commitment-to-community.htm>.

- *For more information regarding community benefit see <http://www.communitycatalyst.org/resources/publications>.*
- *For more tools regarding engagement in the community health needs assessment process see <http://www.communitycatalyst.org/resources/tools>.*

C. Medicaid Innovation Accelerator Program

In July 2014, the Centers for Medicare and Medicaid Services launched the Medicaid Innovation Accelerator Program (IAP). The goal of the program is to improve healthcare for Medicaid beneficiaries by aiding the states in implementing new payment models and service delivery reforms. With nearly 12% of adults and 6% of adolescents in Medicaid experiencing a substance use disorder, CMS designated SUD as a priority of IAP.¹¹³ States must submit a letter of interest and be selected by CMS to participate in the program. Once selected, IAP will provide technical assistance to the states, beginning in August 2015, in developing and implementing innovative delivery system reforms that address SUD.¹¹⁴ The support includes:

- *Payment and healthcare delivery models:* Identify successful service delivery models, benefit strategies, and payment methodologies to promote improved care and better coordination between SUD and healthcare systems.
- *Data analytics:* Support states in using data to better understand the needs of the Medicaid populations that have SUD or are at risk of developing SUD.
- *Quality measurement:* Collect and test metrics that support states in more accurately measuring improvements in health outcomes for individuals with SUD.
- *Rapid-cycle learning:* Assist states in understanding how to integrate elements of rapid-cycle learning as part of their SUD-related projects.
- *State to state learning:* Share lessons and interventions used by other states.

¹¹³. Centers for Medicare & Medicaid Services. Medicaid innovation accelerator program (IAP). Available at: <http://www.medicaid.gov/state-resource-center/innovation-accelerator-program/innovation-accelerator-program.html>.

¹¹⁴. Medicaid Innovation Accelerator Program. IAP Program Support to State Medicaid Agencies Medicare-Medicaid Data Integration. 2015. Available at: <http://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/mmdi-expression-interest-06232015.pdf>

States can get involved in IAP SUD work in three ways: (1) The High Intensity Learning Collaborative (HILC), (2) Targeted Learning Opportunities (TLO), or (3) National Dissemination.

- HILC is a year-long technical assistance initiative that supports states in the development of necessary policy and infrastructure changes to improve the care and outcomes for individuals with SUD.
- TLO is a web-based learning series designed to support states in developing strategies for improving their SUD systems.
- National Dissemination provides stakeholders with access to materials and resources developed for the HILC and TLO.¹¹⁵
- *For more information and up to date news about IAP see:* <http://www.medicaid.gov/State-Resource-Center/Innovation-Accelerator-Program/innovation-accelerator-program.html>.

D. State Innovation Models

A new potential partner for diversion programs may be State Innovation Model (SIM) initiatives. Under this effort, the Centers for Medicare and Medicaid Services (CMS) Innovation Center provides federal funding and technical support for the development and testing of state-led, multi-payer healthcare payment and service delivery models. The purpose of this initiative is to determine the potential of new models to improve care and lower costs for Medicare, Medicaid and CHIP.¹¹⁶

Many states with SIM grants have designed and are testing models that link primary care and behavioral health services. One such model, the Comprehensive Primary Care Initiative, is undergoing testing in Arkansas, Colorado, New Jersey and Oregon, as well as parts of New York, Ohio, Kentucky and Oklahoma.¹¹⁷ The goal of this initiative is to redesign practices so they can provide patients with accessible and continuous care, as well as

115. Centers for Medicare & Medicaid Services. Medicaid innovation accelerator program (IAP). Available at: <http://www.medicaid.gov/state-resource-center/innovation-accelerator-program/innovation-accelerator-program.html>

116. Centers for Medicare & Medicaid Services. State Innovation Models Initiative: General Information. Available at: <http://innovation.cms.gov/initiatives/state-innovations/>.

117. Centers for Medicare & Medicaid Services. Comprehensive Primary Care Initiative: Seven Regions. Available at: <http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/Seven-Regions.html>.

effective coordination of care across the “medical neighborhood.”¹¹⁸ Like in Medicaid Health Homes, the coordination of care across medical neighborhoods in this State Innovation Model and others like it provides an environment conducive to treating individuals with SUD. As such, State Innovation Model initiatives could play an important role in developing and facilitating diversion programs.

- *To determine if your state has a state innovation model initiative underway, see <http://innovation.cms.gov/initiatives/map/index.html#model>*

118. Centers for Medicare & Medicaid Services. Comprehensive Primary Care Initiative. Available at: <http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/>

VI. Other Support Services

People with substance use disorder often face a host of other social and financial challenges. This section outlines key federally-funded support services that already exist in many communities. The list is by no means exhaustive. In addition to investigating these resources, diversion programs should contact their state and local social services agencies to identify other supports that may be helpful for people in their programs.

A. Temporary Assistance for Needy Families (TANF)

The Temporary Assistance for Needy Families (TANF) program provides temporary financial assistance for pregnant women and families with at least one dependent child. States have flexibility in how they use their TANF funds, but commonly provide non-medical financial assistance for low-income families to help purchase child care, job training, utilities, work assistance and transportation.¹¹⁹

While a state retains broad discretion when determining what benefits it will provide and additional requirements for TANF eligibility, general program requirements include the following:

1. The applicant must either be pregnant or responsible for a child under 19 years of age.
2. The applicant must be a U.S. national, citizen, legal alien or permanent resident.

¹¹⁹. Center on Budget and Policy Priorities. Policy Basics: An Introduction to TANF. 2015. Available at: <http://www.cbpp.org/research/policy-basics-an-introduction-to-tanf?fa=view&id=936>.

3. The applicant must have low or very low income.
4. The applicant must be under-employed (working for very low wages), unemployed or about to become unemployed.¹²⁰

States also require that recipients are engaged in “work activities,” which can range from unsubsidized employment and job searching to subsidized private-or-public sector employment and education directly related to employment.¹²¹

- *Contact information for every state TANF agency is available at <http://www.acf.hhs.gov/programs/ofa/help>.*

B. Housing

The federal Department of Housing and Urban Development, or HUD, is the primary federal funder of housing programs. As part of its mission, HUD provides extensive services for homeless individuals and families, serving more than 1 million people.¹²² Services include housing vouchers, public housing and assistance in transitions to permanent housing.

An individual or family may qualify as homeless for HUD housing programs if they are:

- homeless
- at imminent risk of homelessness; or
- fleeing or attempting to flee domestic violence.¹²³

Local Public Housing Agencies, or PHAs, can provide information about available public housing programs, including information on waitlists and solutions for short-term housing.

A map with contact information by state for all PHAs is available at http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/pha/contacts

For people who are homeless or at risk of homelessness, a SAMHSA program called Projects for Assistance in Transition from Homelessness (PATH) may be able to provide important support services (though it is not a housing program itself). PATH is a federal

120. U.S. Department of Health and Human Services. Temporary Assistance for Needy Families. Available at: <http://www.benefits.gov/benefits/benefit-details/613>.

121. *Ibid.*

122. U.S. Department of Housing and Urban Development. Homelessness Assistance. Available at: http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/homeless.

123. *Ibid.*

grant program that supports nearly 600 local organizations that provide services to people with mental illness, including people with co-occurring substance use disorders, who are experiencing homelessness or are at risk of becoming homeless.¹²⁴ Local PATH service providers can focus on a specific area or on multiple areas, including outreach; screening and diagnostic treatment services; community mental health services; care management services; and referrals for housing, employment and primary care.¹²⁵

- *To find a PATH provider in your area, see <http://pathprogram.samhsa.gov/Path/List-Providers.aspx>*

C. Childcare

The need for safe and affordable childcare can be an important factor in an individual's ability to access jobs, medical care or other services. The federal government provides support for childcare for low-income parents who are working or who are in education or training programs through the Child Care and Development Block Grant (CCDBG). The program serves over 1.4 million children per month, and emphasizes improving access to child care for homeless children.¹²⁶ Each state and territory sets its own eligibility requirements for subsidized childcare; see <http://www.urban.org/policy-centers/income-and-benefits-policy-center/projects/ccdf-policies-database> for information by state.

- *To learn more about CCDBG and other possible resources for childcare for diversion program participants with children, find contact information for your state child care office here: <http://www.acf.hhs.gov/programs/occ/resource/ccdf-grantee-state-and-territory-contacts>*

D. WIC

The Special Supplemental Nutrition Assistance Program for Women, Infants and Children (WIC) serves low-income pregnant, postpartum and breastfeeding women, infants and children up to age five who are at nutritional risk. WIC provides nutritious foods, informa-

124. Projects for Assistance in Transition from Homelessness. About PATH. Available at: <http://path-program.samhsa.gov/super/path/about.aspx>.

125. *Ibid.*

126. Office of Child Care. Characteristics of Families Served by Child Care and Development Fund (CCDF) Based on Preliminary FY 2013 Data. 2014. Available at: <http://www.acf.hhs.gov/programs/occ/resource/characteristics-of-families-served-by-child-care-and-development-fund-ccdf>.

tion on healthy eating and health care, welfare and social services screenings and referrals.¹²⁷ Services are provided in a variety of locations, including county health departments, hospitals, community centers and schools.

The *Substance Use Prevention: Screening, Education, and Referral Resource Guide for Local WIC Agencies* guides local WIC agency staff in deciding how to integrate alcohol and substance use information and referrals into their agencies' nutrition activities and other healthcare and social services referrals.¹²⁸ Referral services allow for the development of relationships between WIC agencies and treatment facilities, which fosters better continuity of care. Many states also require WIC staff to attend an annual training on substance use disorder.

- *State WIC agency contact information is available at <http://www.fns.usda.gov/wic/wic-contacts>.*

E. Supplemental Nutrition Assistance Program (SNAP)

The Supplemental Nutrition Assistance Program, also known as SNAP but informally known as the food stamp program, is a federal nutrition program overseen by the U.S. Department of Agriculture. SNAP enrollees receive monthly benefits through a debit-like card that can be used to purchase food at grocery stores, convenience stores, and some farmers' markets and co-op food programs. There are limits on eligibility based on duration of benefits; for example, nondisabled adults without dependent children can only receive SNAP benefits for 3 months within a 36-month period.¹²⁹

- *Information on SNAP eligibility is available at <http://www.fns.usda.gov/snap/eligibility>.*
- *To apply for SNAP benefits or for further information about SNAP, see <http://www.fns.usda.gov/snap/apply> or contact a local SNAP office at <http://www.fns.usda.gov/snap/snap-application-and-local-office-locators>.*

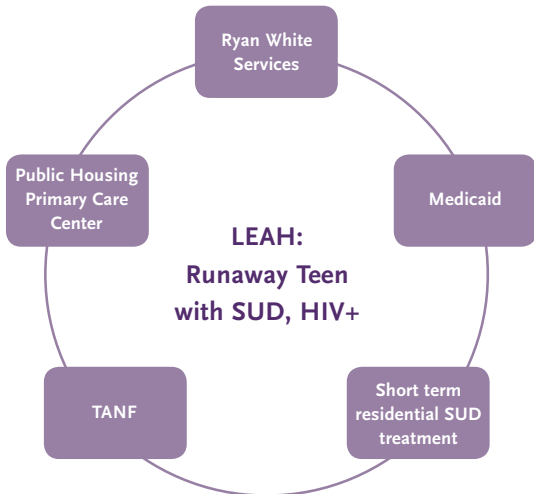
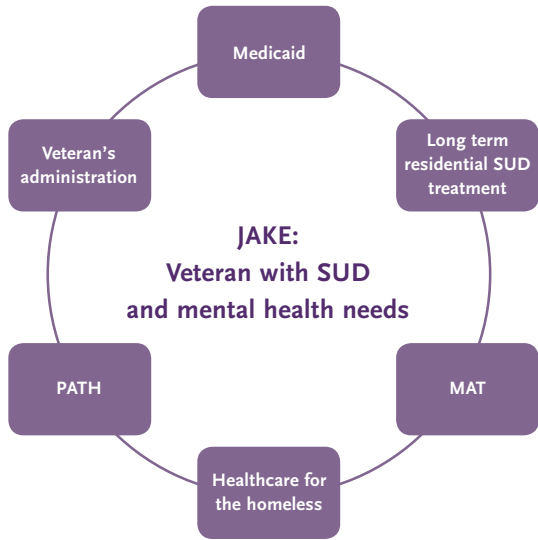
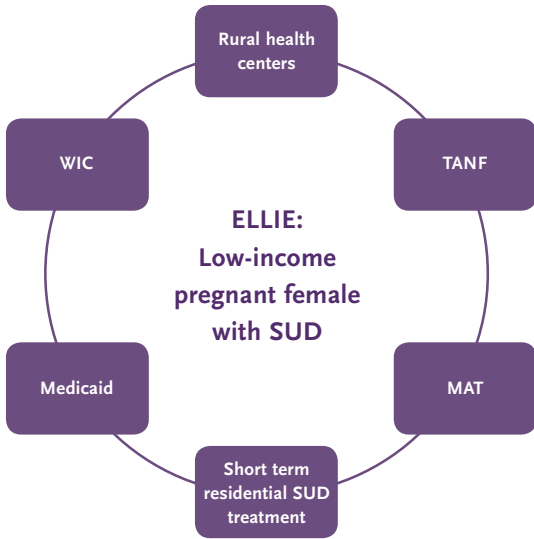
127. U.S. Department of Agriculture Food and Nutrition Service. Women, Infants, and Children (WIC). 2015. Available at: <http://www.fns.usda.gov/wic/women-infants-and-children-wic>.

128. U.S. Department of Agriculture Food and Nutrition Service. Substance Use Prevention: Screening, Education, and Referral Resource Guide for Local WIC Agencies. 2013. Dept of Agriculture publication FNS-276 revised. Available at: <http://www.nal.usda.gov/wicworks/Topics/ResourceManual.pdf>.

129. Silbermann L. Supplemental Nutrition Assistance Program – Able-Bodied Adults without Dependents (ABAWD) Questions and Answers – June 2015. Washington, DC: United States Department of Agriculture. 2015. Available at: <http://www.fns.usda.gov/sites/default/files/snap/ABAWD-Questions-and-Answers-June%202015.pdf>.

VII. Three Possible Diversion Program Participants and the Connections Diversion Programs Can Make for Them

The stories of individuals introduced at the beginning of this resource guide illustrate how existing providers and programs can offer services, coverage and support for diversion program participants. As discussed in the background, pre-booking diversion programs use case managers to assess each participant, identify short- and medium-term needs, and pinpoint which clinical, social and community-based services may be most appropriate to meet those needs. The following diagrams show the range of existing health and support services that our hypothetical diversion program participants, described in the Prologue, could be connected to by a pre-booking diversion program.



VIII. Looking Ahead

On March 26, 2015, U.S. Health and Human Services Secretary Sylvia M. Burwell announced an initiative to reduce prescription opioid and heroin related overdose, death and dependence. The Secretary's initiative consists of three priority areas:

1. Providing training and educational resources to assist health professionals in making informed prescribing decisions and to address the over-prescribing of opioids
2. Increasing use of naloxone
3. Expanding the use of Medication-Assisted Treatment (MAT)

The Secretary's initiative also seeks to build on current HHS strategies to address the opioid epidemic and expands those with the greatest potential for impact.¹³⁰ In support of this initiative, the Health Resources and Services Administration (HRSA) is contributing \$100 million to 300 Community Health Centers for the expansion of substance use disorder services, and SAMHSA is contributing \$11 million to 11 states for the expansion of medication assisted treatment services. Furthermore, CMS will release guidance to help states more effectively administer substance use disorder services.¹³¹ As additional information is

130. U.S. Department of Health and Human Services. HHS takes strong steps to address opioid-drug related overdose, death and dependence. HHS News. March 26 2015. Available at: <http://www.hhs.gov/news/press/2015pres/03/20150326a.html>.

131. Jim Macrae. HHS Launches Multi-pronged Effort to Combat Opioid Abuse. July 27, 2015. Available at: <http://www.hhs.gov/blog/2015/07/27/hhs-launches-multi-pronged-effort-combat-opioid-abuse.html>.

released about this new initiative, diversion programs should look for possible new resources and opportunities to build on this effort.

This initiative comes at a time when there has been a growing understanding among lawmakers that substance use disorder should be treated as a public health challenge rather than a criminal justice issue. The Affordable Care Act both reflected and supported this change by recognizing substance use treatment as part of the “essential health benefits” necessary for all Americans accessing healthcare through the Medicaid expansion or purchasing health insurance through state Exchanges. In addition, the law prohibits discrimination in coverage for persons with SUD by ensuring that persons in need of SUD treatment can receive those services at parity with other medical and surgical benefits. CMS has proposed and is expected to finalize a rule to apply certain parity provisions to much of Medicaid and CHIP,¹³² which will reduce barriers to treatment for millions of beneficiaries.

These efforts to expand SUD benefit coverage and strengthen parity requirements represent a monumental step forward in ensuring broad access to SUD services for Americans. Importantly, these changes come at a time when the healthcare system is increasingly looking for ways to better integrate community-based services into clinical care through innovative models of healthcare service delivery—such as Health Homes and state innovation models—that seek to deliver care to patients holistically and to bridge connections between clinical and community providers.

These changes mean that now, even more than in the recent past, diversion programs do not have to “go it alone.” There are unprecedented opportunities for diversion programs to help participants find SUD treatment services, along with comprehensive health coverage. Creating relationships with health system providers and stakeholders now can position diversion programs and law enforcement as key players in reducing the individual and societal costs of the cycle of addiction and arrest.

132. Centers for Medicare & Medicaid Services. Medicaid Fact Sheet: Mental Health Parity Proposed Rule for Medicaid and CHIP. 2015. Available at: <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/medicaid-fact-sheet-parity.pdf>.

