



State Approaches to Developing the Residential Treatment Continuum for Substance Use Disorders

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Executive Summary

Objective

This brief is intended to support state Medicaid agencies (SMAs) in their efforts to incorporate substance use disorder (SUD) residential treatment providers into Medicaid provider networks. The authors used a case-study approach and conducted interviews in five states that are early leaders in modernizing their SUD treatment systems: California, Maryland, Massachusetts, Michigan, and Virginia. Each state's experience provides valuable insights on planning and implementing similar reforms through section 1115 SUD demonstration projects and other Medicaid authorities. This brief identifies key decision points that other states are likely to encounter as they expand coverage for residential SUD treatment services, offers strategic recommendations based on the experiences of these five leading states, highlights best practices, and identifies additional factors for SMAs to consider when implementing section 1115 SUD demonstration projects or other SUD program reforms.

The recommendations in this brief can support states in developing effective, evidence-based approaches that address opioid addiction and that appropriately leverage the recent 2017 1115 SUD demonstration authority, which provides flexibility to SMAs to include residential SUD services provided in an Institution for Mental Disease (IMD).¹ The brief may also assist with the implementation of the SUPPORT Act, which allows states to cover services in IMD for 30 days each year for Medicaid beneficiaries through a state plan option.

Why Residential Treatment Providers?

State Medicaid programs are increasingly expanding and strengthening their SUD service systems. This energy began several years ago, accelerating as the scale and impact of the national opioid epidemic have intensified. Today, Medicaid covers nearly four in ten non-elderly adults with an opioid use disorder (OUD)² and finances about one-fifth of all addiction treatment.³ Federal health care reform law and policy changes have further propelled states to review and modify their Medicaid benefits and policies for individuals with SUDs. Studies show that residential SUD treatment services produce cost offsets, reducing hospital emergency department, inpatient, mental health, and public costs.⁴ A recent

¹ Centers for Medicare & Medicaid Services, U.S. Department of Health & Human Services (2017). Strategies to address the opioid epidemic. State Medicaid Director Letter #17-003. <https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf>

² Zur, J. & Tolbert, J. (2018). The opioid epidemic and Medicaid's role in facilitating access to treatment [Issue Brief]. Kaiser Family Foundation. <https://www.kff.org/medicaid/issue-brief/the-opioid-epidemic-and-medicaids-role-in-facilitating-access-to-treatment/>.

³ Substance Abuse and Mental Health Administration (2014). Projections of national expenditures for treatment of mental and substance use disorders, 2010–2020. <https://store.samhsa.gov/system/files/sma14-4883.pdf>

⁴ Substance Abuse and Mental Health Administration (1999). Koenig, L., Denmead, G., Nguyen, R., Harrison, M., Harwood, H. The costs and benefits of substance abuse treatment: findings from the National Treatment Improvement Evaluation.; Ettner S., Huang D., Evans E., Ash D., Hardy M., Jourabchi M., Hser Y. (2006). Benefit-cost in the California treatment outcome project: does substance abuse treatment "pay for itself"? *Health Services*

meta-evaluation of research reviews and individual studies found a moderate level of evidence for residential treatment for SUD, noting the field would benefit from systematic, methodologically rigorous studies.⁵

States are turning to the 1115 SUD demonstration to expand access to treatment by offering the full continuum of outpatient, residential, and recovery services to Medicaid beneficiaries with SUDs. With the expanded coverage of residential treatment services, SMAs face the prospect of adding new benefits and enrolling new providers with which they have little familiarity, as the longstanding statutory exclusion of IMDs prohibited most residential SUD facilities from being part of state Medicaid provider networks. In many states, residential SUD treatment providers that are IMDs may lack experience with newer quality standards for SUD care, and with Medicaid and managed care billing and documentation requirements. Bringing quality IMD services into networks will require adequate time and resources.

Decision Points

The following brief offers recommendations to SMAs at important decision points in four areas as they decide, plan and implement strategies for including SUD residential providers in their network. The four areas are service coverage, quality of care, determining the appropriate level of care and reimbursement. As they plan and implement SUD service expansions, other states can leverage the successful approaches, early findings, and lessons learned in the five early adopter states. Many of the interviewed states followed similar trajectories for some decision points, such as ensuring robust coverage and networks for evidence-based outpatient services, and closely assessing residential providers' success in delivering care consistent with clinical treatment guidelines. For other decision points, the approaches reflect state-specific needs and circumstances, such as focusing on developing one sublevel of residential treatment in particular, or adhering to state regulations governing rate development. Table 1 provides an overview of the decision points and recommendations to address these decisions. Table 4 (located in the Appendix) highlights best practices and examples implemented by the interviewed states to respond to the decision points in their 1115 SUD demonstration efforts.

Table 1. Decision Points for 1115 SUD States.

Area	Decision Point	Recommendation
	How can states produce the necessary data to support decision-making for service coverage and provider network development planning related to sublevels of residential treatment?	Collaborate with the Single State Agency for Substance Abuse (SSA) and other payers to develop a provider network inventory by level of care and to establish a baseline for coverage and network expansions.

Research, 41(1): 192-213.; Koenig, L., Siegel J., Harwood H., Gilani J., Chen Y., Leahy P., Stephens R. (2005). Economic benefits of substance abuse treatment: findings from Cuyahoga County, Ohio. *Journal of Substance Abuse Treatment*, 28(2): S41-S50.; French, M., Saleme H., Carney M. (2002). Using the DATCAP and AS/ to estimate the costs and benefits of residential addiction treatment in the State of Washington. *Social Science & Medicine*, 55(12): 2267-2282.; Koenig, L., Harwood H., Sullivan, K., Sen, N. (2000). The Economic Benefits of Increased Treatment Duration and Intensity in Residential and Outpatient Substance Abuse Treatment Settings. *Journal of Psychopathology and Behavioral Assessment*, 22(4), 399-417.

⁵ Reif, S., Preethy, G., Braude, L., Dougherty, R., Daniels, A., Ghose, S., Delphin-Rittoman, R. Residential treatment for individuals with substance use disorder: assessing the evidence. *Psychiatric Services*, 65, 301-312

Area	Decision Point	Recommendation
Coverage	Which sublevels of residential treatment will states cover through the 1115 SUD option, and when?	Designate intensive residential treatment as the top priority — and stagger implementation of other sublevels.
	Which levels of care within the SUD continuum of care should be enhanced to support beneficiaries transitioning from residential treatment?	To the extent feasible, strengthen the full continuum to ensure a balance of outpatient and residential services.
Quality of Care	How will states select, develop, or modify program standards to set residential treatment provider qualifications?	Determine whether provider program standards comport with industry standards — and seek alignment.
	How will states promulgate program standards for residential SUD treatment providers?	Consider using procurement and contracting, versus statutory or regulatory vehicles, to supplement state policy levers
	How will states implement program standards for residential SUD treatment providers, both initially and on an ongoing basis?	Establish a clear process to review compliance with program standards — prioritizing on-site reviews.
	How will states assure the provision of evidence-based practices (EBPs), including MAT?	States will need to develop protocols requiring that providers assertively arrange for patients to have access to MAT — and that they deliver additional EBPs as well.
	How will states support residential treatment providers to successfully participate in Medicaid?	Pay attention to new providers' ability to participate in the Medicaid program — and make sufficient investments in to help providers with network development.
Determining the Appropriate Level of Care	Which assessment instrument should be required for assessing level of care?	Choose one or more SUD-specific, multidimensional assessment tools based on clinical treatment guidelines.
	How can states ensure that providers are using the assessment instrument to produce appropriate level of care determinations?	Implement front- and back-end processes that offer training and provide feedback to providers regarding their use of the instrument and treatment recommendations.
	How can states ensure that their independent review process results in consistent decisions regarding level of care recommendations?	Closely support providers to develop appropriate treatment recommendations — and require Medicaid managed care partners to maintain expertise with the designated assessment instrument(s).

Area	Decision Point	Recommendation
Reimbursement	How should states develop Medicaid reimbursement rates for residential SUD services?	While a variety of rate-setting approaches can be used, consider cost modeling as an effective and efficient method to set residential SUD treatment rates.
	Which services should states include or exclude in residential payment rates?	Bundled residential rates should be inclusive of core treatment services used by nearly all beneficiaries — consider reimbursing MAT services separately.
	How can states account for costs not allowable for federal financial participation, such as room and board costs?	Use cost modeling to develop room and board rates — and braid funding streams.

Background

Over the past six years, many SMAs have boosted their efforts to improve beneficiaries’ access to a continuum of services related to SUDs. This shift is jointly driven by the public health crisis posed by the opioid epidemic and by statutory and regulatory changes made during and after the enactment of the Affordable Care Act (ACA). Some of these federal policy changes established SUD treatment as a critical part of the health care delivery system; other changes responded directly to the growing opioid addiction crisis. Beginning in 2010, various federal changes provided the stimulus for states to enhance their coverage for SUD for Medicaid beneficiaries. For instance:

- The ACA required Medicaid Alternative Benefit Plans (ABPs) to cover essential health benefits, including mental health and SUD treatment services.⁶ This benefit package applies to people who are eligible through Medicaid expansion, and states may extend these benefits to other Medicaid-covered populations.
- The Centers for Medicare and Medicaid Services (CMS) promulgated regulations that applied the Mental Health Parity and Addiction Equity Act (MHPAEA) to the Medicaid program, requiring parity for beneficiaries enrolled in managed care and covered under ABPs.⁷

⁶ The Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18001.
<https://www.gpo.gov/fdsys/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf>

⁷ The Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans. Federal Register vol. 81, no. 61 (March 30, 2016).
<https://www.govinfo.gov/content/pkg/FR-2016-03-30/pdf/2016-06876.pdf>

- In 2015, CMS established [a new opportunity for states under Section 1115 demonstration authority](#).⁸ States that received approval for an 1115 SUD demonstration could establish a continuum of care based on evidence about what is most effective in addressing SUDs. Under this authority, CMS indicated for the first time that it would finance services provided in an IMD as part of a continuum of care.⁹ In November 2017, with a stated goal of increasing state flexibility, CMS replaced [the 1115 SUD guidance with a revised approach](#) that permits a phased state implementation approach based on goals, milestones, and an implementation plan, while enhancing states' monitoring requirements.¹⁰
- Through changes in managed care rules, in 2016 CMS relaxed its prohibition against payment for services delivered in IMDs that provide inpatient hospital services or crisis stabilization services for individuals with behavioral health conditions.¹¹
- Congress passed the SUPPORT Act in 2018, introducing a Medicaid state plan benefit option to cover SUD treatment services in IMDs for 30 days in a year, and requiring states to cover all forms of medication-assisted treatment (MAT) unless a state receives a waiver due to provider shortages.¹²

These statutes, regulations, and additional guidance were well-timed for states responding to the dynamic changes in the opioid epidemic since passage of the ACA. Between 1999 and 2011, the use of oxycodone (a prescription opioid pain reliever) increased by nearly 500 percent, the rate of individuals seeking treatment for addiction to prescription opioids increased by 900 percent, and the rate of overdose deaths associated with prescription opioids nearly quadrupled.¹³ When the rate of overdose deaths associated with prescription opioids began to stabilize in 2011, overdose deaths involving heroin

⁸ Centers for Medicare & Medicaid Services, U.S. Department of Health & Human Services (2015). New service delivery opportunities for individuals with a substance use disorder. State Medicaid Director Letter #15-003. <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf>. Three authors of this brief (John O'Brien, Vikki Wachino, and Tyler Sadwith) were involved in the development of the 2015 guidance at CMS.

⁹ An Institution for Mental Disease is defined by the Centers for Medicare & Medicaid Services as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases. <https://www.govinfo.gov/content/pkg/CFR-2007-title42-vol4/pdf/CFR-2007-title42-vol4-sec435-1010.pdf>

¹⁰ Centers for Medicare & Medicaid Services, U.S. Department of Health & Human Services (2017). Strategies to address the opioid epidemic. State Medicaid Director Letter #17-003. <https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf>. One author of this brief (Tyler Sadwith) was involved in the development of the 2017 guidance at CMS.

¹¹ Centers for Medicare & Medicaid Services, U.S. Department of Health & Human Services (2016). Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP delivered in managed care, and revisions related to third party liability (Final Rule). *Federal Register*, 81(88), 27498–27901 (May 1, 2016).

¹² The SUPPORT for Patients and Communities Act of 2018. <https://www.congress.gov/115/bills/hr6/BILLS-115hr6enr.pdf>.

¹³ Kolodny, A., Courtwright, D., Hwang, C., Kreiner, P., Eadie, J., Clark, T., & Alexander, G. (2015). The prescription opioid and heroin crisis: A public health approach to an epidemic of addiction. *Annual Review of Public Health*, 36, 559–574.

began to rise rapidly, and since 2013 overdose deaths involving illicitly manufactured fentanyl, a synthetic opioid, have skyrocketed.¹⁴ SMAs are particularly concerned about the rise in opioid use, since Medicaid covers nearly 40 percent of adults with an OUD.¹⁵ Beneficiaries with opioid addiction and other SUDs often have complex health profiles with significant physical and behavioral health issues that coexist with addiction, driving relatively high medical, SUD, mental health, and pharmacy utilization, including expensive curative therapies for hepatitis C.¹⁶ For this reason, addressing SUD can advance efforts to address chronic and disabling conditions. It can also help address the fiscal impact of the opioid epidemic on state Medicaid spending, which is considerable. In many states, the state Medicaid director is tapped to help lead statewide efforts (in partnership with the state’s SUD agency and public health agency) to address the crisis.

The opioid crisis prompted states to take advantage of the new opportunities created for Medicaid beneficiaries with SUDs. The 1115 SUD policies encouraged states to fill the gaps in their treatment continuum for beneficiaries with SUDs. The longstanding statutory IMD exclusion did not allow reimbursement for treatment services or for any other Medicaid-covered service provided to a beneficiary residing in an IMD, such as case management services for the purpose of discharge and transition planning. The new ability to seek reimbursement for residential services was therefore a significant driver in states’ decisions to seek an 1115 SUD demonstration, as states could seek reimbursement for both treatment and case management services for individuals in IMDs who were completing treatment and discharged to outpatient services. Significantly, both the 2015 and 2017 guidance documents provide a clear path for states to develop quality clinical and program standards. The guidance took the “guess work” out of determining what constitutes good practice with respect to residential services.

While states were excited about these opportunities, federal and state policymakers had some concerns about the new flexibility offered through the 1115 authority and the managed care regulations. The statutory exclusion of IMDs had long prohibited most SUD residential facilities from being part of state Medicaid provider networks. In most cases, SMAs had little familiarity with these providers and did not know which standards, qualifications, and review processes could ensure the quality of their services. In some states, IMD services had been funded through managed care plans despite the statutory prohibition, further underscoring the variation in designing and managing the benefit.¹⁷ Most IMDs were funded through state and federal grants, and some providers were not paid on a unit basis (e.g. daily rates). In some states, SUD residential providers did not have to meet specific standards that would

¹⁴ Centers for Disease Control and Prevention (2018). Understanding the epidemic. Retrieved on February 26, 2019 from: <https://www.cdc.gov/drugoverdose/epidemic/index.html>

¹⁵ Zur, J. & Tolbert, J. (2018). The opioid epidemic and Medicaid’s role in facilitating access to treatment [Issue Brief]. Kaiser Family Foundation. <https://www.kff.org/medicaid/issue-brief/the-opioid-epidemic-and-medicaids-role-in-facilitating-access-to-treatment/>.

¹⁶ Young, K. & Zur, J. (2017). Medicaid and the opioid epidemic: Enrollment, spending, and the implications of proposed policy changes [Issue Brief]. Kaiser Family Foundation. <https://www.kff.org/medicaid/issue-brief/medicaid-and-the-opioid-epidemic-enrollment-spending-and-the-implications-of-proposed-policy-changes/>

¹⁷ Centers for Medicare & Medicaid Services, U.S. Department of Health & Human Services (2016). Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP delivered in managed care, and revisions related to third party liability (Final Rule). *Federal Register*, 81(88), p. 27560. (May 6, 2016)

comport with national industry standards. As we show in this brief, such operational issues pose significant challenges to SMAs and SUD residential providers.

CMS' 2015 guidance established specific requirements for provider standards and set 13 programmatic expectations. Reflecting the growing urgency of responding to the opioid epidemic, the 2017 guidance prioritized speed of implementation. It replaced the specific 2015 policies with a phased implementation guided by milestones. This approach permits faster state action, but also creates greater risk that states might adopt less robust approaches in areas like establishing quality standards and provider qualifications, potentially undermining the effectiveness of these groundbreaking new policies in addressing the opioid epidemic. For instance, starting implementation before providers are fully trained and vetted, for example, may impact quality of care. In addition, the 1115 demonstrations have sometimes been described or perceived as authorizing all types of care in IMDs. However, not all residential programs or services offer high quality, evidence-based treatment services. For instance, residential program settings with large congregate sleeping facilities and little privacy or attention to developing a treatment milieu may not be poised to deliver care consistent with treatment criteria, and may not be ideal candidates for Medicaid provider network enrollment and credentialing. In addition, while long-term stays in residential treatment programs (for example, 180 days or more) may be clinically appropriate for certain subpopulations (such as pregnant women), states run the risk of using Medicaid to finance long-term residential stays in cases where continued treatment in lower levels of care may be more appropriate based on a person's clinical needs. For such individuals, longer-than necessary residential treatment utilization would not be clinically beneficial and would be an inefficient use of resources.¹⁸

The potential negative consequences of a rushed or broad-brush approach to the use and Medicaid financing of IMD services include providing ineffective SUD treatment at a time when evidence-based care is badly needed. In addition to putting the most effective forms of addiction treatment at risk, such an approach might create incentives toward institutional rather than community-based care, countering major progress made over the course of decades to reduce reliance on institutional care for low-income individuals with mental health, addiction, and disabling conditions.¹⁹

Purpose

In this brief, we examine the experiences of state leaders in their early efforts to build an SUD continuum of care under 1115 SUD demonstrations, focusing on their implementation of the new authority to fund short-term residential treatment through Medicaid. We conducted interviews in five states and reviewed implementation documents from California, Maryland, Virginia, and Massachusetts, the first four states to receive approval from CMS for section 1115 SUD demonstrations. We also focus on Michigan, which over the course of several years has significantly advanced its implementation efforts with respect to residential services provided in IMDs, although its SUD 1115 application is still

¹⁸ Magura, S., Staines, G., Kosanke, N., Rosenblum, A., DeLuca, A., & Bali, P. (2003). et al. Predictive validity of the ASAM Patient Placement Criteria for naturalistically matched vs. mismatched alcoholism patients. *American Journal of Addiction*, 12(5), 386–397.

¹⁹ Musumeci, MaryBeth and Henry Claypool. *Olmstead's Role in Community Integration for People with Disabilities under Medicaid: 15 Years After the Supreme Court's Olmstead Decision*. Kaiser Family Foundation, June 2014. <https://www.kff.org/report-section/olmsteads-role-in-community-integration-for-people-with-disabilities-under-medicaid-issue-brief/>.

awaiting CMS approval. The lessons learned in these states can inform a series of policy and program decisions that other SMAs will confront in developing and implementing their 1115 SUD demonstrations. These decisions revolve around four questions:

- Which SUD services and providers should be included in the state’s SUD reform efforts — both within and in addition to residential treatment?
- How can states promote high quality care in IMDs and ensure the use of evidence-based practices (EBPs)?
- Which assessment protocols and processes can secure level of care recommendations that best meet the treatment and support needs of Medicaid beneficiaries with SUDs?
- What reimbursement strategies should be considered to purchase services provided in IMDs?

For each of these areas we set forth key decision points, recommended strategies, best practices employed by the five interviewed states, and additional factors that states should consider as they design or redesign their 1115 SUD demonstrations.

Overview of States

Participating states used the 1115 SUD demonstration to ensure that a comprehensive SUD benefit was available to Medicaid beneficiaries; to apply a consistent set of SUD-specific quality standards and measures; to leverage political and administrative momentum to deploy strategies to better address the burgeoning opioid crisis; and to integrate SUD and physical health care. The goals set forth in these states’ 1115 SUD demonstrations were to expand access, improve health outcomes, and reduce costs through payment reform strategies. As discussed throughout this brief, the interviewed states differed in their implementation approaches, though all states worked with a managed care or administrative partner, including prepaid inpatient health plans (PIHPs), administrative service organizations (ASOs), and managed care organizations (MCOs). Most of these partners have specific responsibilities set forth in their state’s 1115 SUD demonstration and relevant contracts.

Table 2. Overview of 1115 SUD Demonstration Projects in Interviewed States.

	California	Maryland	Massachusetts	Michigan	Virginia
Program Name	Drug Medi-Cal Organized Delivery System	HealthChoice	MassHealth	Pathway to Integration	Addiction and Recovery Treatment Services
Waiver Approval Date	August 2015	June 2017	November 2016	Pending	December 2016
Managed Care Approach	County-based PIHPs (non-risk)	Statewide ASO	Statewide PIHP and MCOs (risk-based)	County-based PIHPs (non-risk)	Statewide managed care (risk-based)
Delivery System	Integrated and carve-out approach	Carve-out approach	Integrated and carve-out approach	Carve-out approach	Integrated MCOs

Service Coverage

The American Society of Addiction Medicine (ASAM) has developed criteria that offer a useful taxonomy for describing levels of care for addiction treatment. The ASAM Criteria® describe treatment as a

continuum marked by diverse levels of care, such as outpatient and residential.²⁰ Payers, patients, and the public can use The ASAM Criteria’s level of care framework as a common reference point for describing the intensity of treatment services offered by specialty SUD providers, identifying where these services fall along the continuum of care, and matching individual patient’s needs to the appropriate level of care (see Table 3 below).

Table 3. The ASAM Criteria Levels of Care

LEVEL 0.5	EARLY INTERVENTION
LEVEL 1	OUTPATIENT SERVICES
LEVEL 2	INTENSIVE OUTPATIENT SERVICES/PARTIAL HOSPITALIZATION SERVICES
	2.1 Intensive Outpatient Services
	2.5 Partial Hospitalization Services
LEVEL 3	RESIDENTIAL/INPATIENT SERVICES
	3.1 Clinically Managed Low-Intensity Residential Services
	3.3 Clinically Managed Population-Specific High-Intensity Residential Services
	3.5 Clinically Managed High-Intensity Residential Services
	3.7 Medically Monitored High-Intensity Inpatient Services
LEVEL 4	MEDICALLY MANAGED INTENSIVE INPATIENT SERVICES

Under The ASAM Criteria level of care framework, sublevels differentiate intensity of services within each level of care. As conveyed in Table 2 above, the ASAM Criteria describes several sublevels for residential treatment services (Level 3), including 3.1 (less intensive treatment programs), 3.3 (specialized treatment programming for patients with cognitive or other conditions), 3.5 (highly intensive treatment programs), and 3.7 (intensive treatment programs with the capacity to medically monitor, as opposed to clinically manage, patients with biomedical or other conditions).²¹

The federal policy guidance released by CMS in 2017 requires states to meet six milestones over the course of their 1115 SUD demonstration. The first milestone requires states to provide access to critical levels of care, specified in the guidance as including coverage for outpatient services, intensive outpatient services, intensive levels of care in residential and inpatient settings, and medically supervised withdrawal management. The guidance also requires states to include MAT in residential settings, and to ensure sufficient MAT capacity across all levels of care. The guidance allows states up to 24 months to meet this first milestone after demonstration approval. Accordingly, states must make decisions regarding which levels of care to cover under an 1115 SUD demonstration and by when, including which sublevels of intensive residential and inpatient treatment.

²⁰ Mee-Lee D., ed. (2013) The ASAM Criteria: Treatment criteria for addictive, substance-related, and co-occurring conditions. Chevy Chase, MD: American Society of Addiction Medicine.

²¹ American Society of Addiction Medicine (2015). What are the ASAM levels of care? www.asamcontinuum.org/knowledgebase/what-are-the-asam-levels-of-care/

Coverage for Residential Care: Cross-walking to The ASAM Criteria

State Medicaid agencies may have to undertake several steps prior to launching their residential benefit. Initially, states will need to “size” the potential network. Some large states may have hundreds of SUD residential provider that could potentially participate in their network. States will therefore need to obtain basic data regarding the potential residential treatment provider network to support decisions regarding which sublevels to cover and when to launch service delivery within the 24-month timeframe allotted for this 1115 SUD milestone. At a minimum this will include both determining whether these residential programs comport with The ASAM Criteria and mapping the location of these programs to identify potential access issues.

Historically, many of the state’s residential treatment providers have been reimbursed by other state agencies, such as the SSA. The SSAs may or may not use The ASAM Criteria definitions to describe which levels of care are offered by SUD residential providers. Therefore, it will be necessary to compare The ASAM Criteria residential level of care framework to the current residential provider system to determine which sublevels are predominant across the state. For states that currently cover residential SUD treatment in Medicaid (covering these services in facilities with fewer than 17 beds), a useful exercise is to overlay The ASAM Criteria residential level of care framework onto the existing Medicaid SUD residential benefit to see which levels are currently covered.

Cross-walking the residential treatment provider network to the sublevels of care described in The ASAM Criteria will generate critical information for network adequacy assessment and planning efforts to support an 1115 SUD demonstration. For example, determining which sublevels of intensive residential treatment (e.g. sublevels 3.3, 3.5, and 3.7) are available in distinct geographic areas, demographic groups, and health plan networks will enable state officials to identify potential gaps in the network and prioritize some sublevels for immediate coverage and implementation, while focusing on other sublevels for further provider recognizance and development.

Decision Point: How can states produce the necessary data to support decision-making for service coverage and provider network development planning related to sublevels of residential treatment?

Recommendation: Collaborate with the SSA and other payers to develop a provider network inventory by level of care and establish a baseline for coverage and network expansions.

Best Practices

Starting with a blank slate, California developed an efficient process for producing a provisional inventory of residential providers with delineation by sublevel of care.²² California, through its SSA and licensing authority, collaborated with the chief editor of The ASAM Criteria on the creation of a questionnaire used to provisionally designate sublevels of residential treatment offered by providers. All residential providers in the state seeking to participate in the 1115 SUD demonstration must complete

²² See “The American Society of Addiction Medicine Designation” on the website of the California Department of Health Care Services: <https://www.dhcs.ca.gov/provgovpart/Pages/ASAM-Designation.aspx>

the questionnaire. The state uses responses to develop and update an inventory of residential providers categorized by sublevel of care. The county-based PIHPs managing the 1115 SUD benefit use the state's inventory to inform provider networking and planning efforts.

Virginia used data analytics and data visualization tools to produce maps of SUD treatment provider networks by level of care displayed geographically.²³ Geomapping the available provider network by level of care (and comparing that data to geomaps of beneficiaries' need for SUD treatment) can drive network adequacy and access planning strategies, supporting decisions to target sublevels of care and regions for expansion prior to implementation.

Additional Considerations

The SSA can be an excellent source of information regarding the current residential treatment provider network. While some states may have an SUD residential benefit in their Medicaid programs (covering these services in facilities with fewer than 17 beds), many SUD residential providers are not currently Medicaid providers. These providers are often under contract to their SSA or to other state or local agencies. SMAs can leverage the experience and expertise of their SSA counterparts to strengthen their understanding of the potential residential provider network.

Health plans may have valuable information regarding the pool of in-state SUD treatment providers above and beyond the data maintained by SMAs and SSAs. MCOs that offer commercial products may have credentialed SUD residential provider networks for plans. These networks may include specialty SUD treatment providers that do not currently accept grant funding from the SSA but that may be candidates for participating in Medicaid. These insurance-based addiction treatment providers are an additional set of providers to consider for incorporation into network assessment and strategy planning activities.

Coverage for Residential Care: Staging Implementation

As noted above, states may have a large number of residential providers that could potentially join the Medicaid provider network. Assessing the various sublevels of residential treatment for potential coverage entails considering the readiness of these providers to deliver services consistent with industry standards and determining whether they have the operational capacity to become Medicaid providers (billing and reporting data for outcomes). Subsets of residential providers offering more clinically intensive levels of care may be poised to successfully participate in Medicaid and implement a new residential treatment benefit immediately, whereas other subsets of providers offering less clinically intensive programming may benefit from targeted technical assistance prior to service delivery and claims submission.

Decision Point: Which sublevels of residential treatment will states cover through the 1115 SUD option, and when?

²³ Neuhausen, K. & Boynton, M. (2017). Assessing SUD provider and service capacity (webinar). Centers for Medicare and Medicaid Services, Medicaid Innovation Accelerator Program. <https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/reducing-substance-use-disorders/provider-capacity-webinar.pdf>

Recommendation: Designate intensive residential treatment as the top priority — and stagger implementation of other sublevels.

Best Practices

A best practice in introducing Medicaid coverage for residential treatment is sequencing the implementation of specific sublevels of residential treatment over time, in order to ensure provider readiness for service delivery and adherence to Medicaid program requirements. Focusing on implementing one intensive sublevel initially, such as level 3.5, will allow states to develop the network as a cohort and to streamline common issues pertaining to sublevel-specific criteria that may arise during MCO credentialing, site reviews, or other preliminary steps prior to delivering services and submitting claims under the waiver.

For example, Maryland staggered implementation of each level of residential care, initially focusing efforts on levels 3.3 through 3.7, and including level 3.1 later. This provided the state with a low-risk, high-yield opportunity for a successful initial phase of implementation. Providers that already participate in a commercial payer’s insurance or network may be adept at meeting specific service and billing requirements. Starting coverage and implementation efforts with providers most capable of meeting Medicaid and MCO requirements may provide states with a frictionless experience of managing the benefit and provider network, and may offer a glide path to ultimately cover programs that offer less clinically intensive services (such as level 3.1) and are possibly less familiar with insurance-based funding.

Other states (California and Massachusetts) focused on developing specific residential sublevels of care. This choice was motivated by their existing benefit for specific sublevels, as these states already covered some of the higher levels of care (e.g. level 3.7) and were using their opportunity under the 1115 demonstration to fill in the gaps of the residential continuum for their Medicaid beneficiaries.

Additional Considerations

One strategy for determining which residential sublevels to cover, and when, would be to use the exploratory phase, public notice period, and/or stakeholder engagement process to get a better sense of the readiness of residential treatment providers to participate in the Medicaid network. States can use the public notice process to gather recognition on which sublevels are poised for immediate successful implementation and which ones would benefit from provider technical assistance efforts prior to participation in Medicaid. Conducting due diligence on provider readiness will support the design process for staging residential treatment benefit implementation and service delivery by sublevel of care.

Improving Access to Other Parts of the Continuum

Residential services are just one component of the continuum of SUD treatment and recovery services. Without better access to community-based services and supports, individuals will continue to seek treatment in residential settings or, more likely, emergency departments. The CMS guidance requires states both to provide access to intensive residential and inpatient SUD services, and to cover outpatient and intensive outpatient services, with a particular focus on increasing access to MAT. Although much attention has been focused on states’ interest in including residential services offered in an IMD through these 1115 SUD demonstrations, CMS’ interest is broader than residential treatment. A key goal for the

demonstrations is to expand the full continuum of services in order to “progressively improve outcomes for Medicaid beneficiaries with addictions.”²⁴ Outcomes can only be improved with treatment and recovery supports provided through connected networks that create strong and effective relationships among residential and outpatient providers, which in turn requires that a state have adequate numbers of both.

As states introduce coverage for residential SUD treatment to Medicaid, effective system design approaches will include coverage and provider network planning efforts for lower levels of care as well, such as outpatient, intensive outpatient, and MAT services. When individuals move through the treatment continuum, they may need to “step up” or “step down” to different levels of care depending on their clinical needs. Without the ability to transition to less or more intensive levels of care throughout treatment in response to changing clinical needs and treatment goals, individuals with SUDs face higher risk of relapse and worse behavioral and physical health outcomes, including increased inpatient hospital utilization.²⁵

Decision Point: Which levels of care within the SUD continuum of care should be enhanced to support beneficiaries transitioning from residential treatment?

Recommendation: To the extent feasible, strengthen the full continuum. Without coverage and networks for evidence-based outpatient services, IMDs will be costly and ineffective.

Best Practices

While the addition of SUD residential facilities was critical to offer the full continuum of SUD services, states also chose to increase access to community-based treatment and recovery services as part of their overall 1115 SUD demonstrations. There was an indication in every interviewed state that EBPs such as MAT are sorely needed, and each state undertook efforts to increase the availability of these services while enhancing its SUD residential provider networks. Two states, California and Virginia, provide examples of efforts to expand access to MAT in outpatient settings:

- In Virginia, during the first five months of Addiction and Recovery Treatment Services (ARTS) implementation the number of SUD providers offering outpatient services increased by 139 percent, opioid treatment services by 383 percent, and intensive outpatient services by 177 percent. New provider types (16 partial hospitalization providers and 88 office-based opioid treatment providers) also joined the ARTS network.

²⁴ Centers for Medicare & Medicaid Services, U.S. Department of Health & Human Services (2017). Strategies to address the opioid epidemic. State Medicaid Director Letter #17-003. <https://www.medicare.gov/federal-policy-guidance/downloads/smd17003.pdf>

²⁵ Garnick, D., Lee, M., Horgan, C., Acevedo, A., & the Washington Circle Public Sector Workgroup (2009). Adapting Washington Circle performance measures for public sector substance abuse treatment systems. *Journal of Substance Abuse Treatment*, 36(3), 265–277. Magura, S., Staines, G., Kosanke, N., Rosenblum, A., DeLuca, A., & Bali, P. (2003). et al. Predictive validity of the ASAM Patient Placement Criteria for naturalistically matched vs. mismatched alcoholism patients. *American Journal of Addiction*, 12(5), 386–397.

- Virginia also increased the number of beneficiaries served in its ARTS program (across all levels of care) from 12,089 during the year prior to ARTS implementation to 20,436 as of August 2018.
- California increased the number of buprenorphine waived prescribers from 2,400 in 2015 prior to full implementation of the state’s SUD demonstration to 4,300 prescribers in 2017.²⁶
- California increased the number of Medi-Cal beneficiaries receiving buprenorphine from 9,200 in 2015 to 16,400 in 2017.

The other interviewed states took varied approaches to developing a continuum of SUD treatment services. Their choices were highly dependent on the extent of previous investments by each state’s Medicaid agency in outpatient, intensive outpatient and recovery services. As targeted MAT initiatives had already been launched in several states, they focused their 1115 SUD efforts on implementing residential services. For instance, since 2007 Massachusetts’ Collaborative Care Model has focused on expanding access to MAT through its network of community health centers. Maryland already had in place the Baltimore Buprenorphine Initiative, which recruited physicians to obtain a waiver to prescribe buprenorphine.

Additional Considerations

Some states are using the statutory intent of Section 1115 authority to test the effectiveness of coverage for recovery and peer support services as well, adding recovery coaches and peer providers as Medicaid provider types in their SUD demonstration designs. In addition to serving as a source for ongoing recovery support following a treatment episode, peer providers can also help beneficiaries identified with OUD become aware of covered treatment benefits, enter into treatment, stay in treatment, and transition successfully between levels of care. Health systems are embedding peers at critical touchpoints, such as emergency departments, syringe exchange programs, and withdrawal management centers, where they can interact with individuals with SUDs and facilitate direct referrals to treatment. Some initiatives that have embedded recovery coaches in emergency departments have shown some significant reductions in subsequent emergency department visits by overdose.²⁷

²⁶ “Waivered prescribers” are legally allowed to prescribe buprenorphine for opioid dependence treatment in accordance with the Drug Addiction Treatment Act of 2000. See “Buprenorphine Waiver Management” at <https://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management>).

²⁷ Joyce, T. & Bailey, B. (2016) Supporting recovery in acute care and emergency settings (webinar). SAMHSA “Recovery to Practice” initiative. https://www.samhsa.gov/sites/default/files/programs_campaigns/recovery_to_practice/supporting-recovery-in-acute-care-emergency-settings.pdf

Quality of Care

Research has shown that SUD treatment is effective, with relapse rates comparable to or lower than those for other chronic conditions such as diabetes and hypertension.²⁸ However, the effectiveness and quality of treatment can vary widely by provider. Last year, the Substance Abuse and Mental Health Services Administration (SAMHSA) published a fact sheet for individuals seeking behavioral health services listing five signs of quality treatment: accreditation, MAT, evidence-based practices, the inclusion of family members, and supports.²⁹ State Medicaid agencies are poised to ensure that these and other elements of quality treatment are available to beneficiaries. States leveraging the 1115 SUD demonstration to cover residential services have an opportunity to ensure that participating providers offer treatment that comports with clinical guidelines.

As context, the original 1115 SUD guidance issued by CMS in 2015 required states to use established standards of care in designing their SUD benefit packages and to incorporate industry-standard benchmarks for covered services and provider qualifications. Specifically, the 2015 guidance required states to assess and demonstrate that residential providers comprehensively meet and deliver services consistent with The ASAM Criteria prior to participation in the demonstration.

The current 1115 SUD guidance, issued in 2017, emphasizes that improving the quality of treatment and ensuring Medicaid beneficiaries' access to high-quality, evidence-based treatment services is a central goal of the policy.³⁰ In the updated guidance, states must establish residential treatment provider qualifications that meet nationally recognized, SUD-specific, evidence-based program standards, but no specific standards are designated. The guidance specifies that the program standards must include the types of services offered, hours of clinical care, and credentials of staff for residential treatment settings.

Developing Program Standards

As states expand their Medicaid benefits packages and provider networks to include residential SUD treatment services and providers, it is imperative that they set clear requirements for provider qualifications based on relevant programmatic standards. The purpose of establishing SUD-specific program standards for residential providers is to ensure that beneficiaries are able to receive high-quality care from IMDs, a subset of providers historically excluded from Medicaid. As noted above, CMS guidance requires states to use nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities.

To date, only ASAM has promulgated a set of standards specifically for SUD treatment services. While several accrediting bodies' standards for rehabilitative providers can be applied to SUD residential treatment providers, they may lack detail in clinical and service criteria for treating patients with SUDs

²⁸ National Institute on Drug Abuse (2018, January 17). Principles of drug addiction treatment: A research-based guide (third edition). Retrieved from <https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition> on February 27, 2019.

²⁹ Substance Abuse and Mental Health Services Administration (2018). Finding quality treatment for substance use disorders (fact sheet). <https://store.samhsa.gov/product/Finding-Quality-Treatment-for-Substance-Use-Disorders/PEP18-TREATMENT-LOC>

³⁰ Centers for Medicare & Medicaid Services, U.S. Department of Health & Human Services (2017). Strategies to address the opioid epidemic. State Medicaid Director Letter #17-003. <https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf>

specifically. For instance, The ASAM Criteria sets forth the setting for the provision of services, the types of providers that should render the services (e.g. physician or licensed professional), and the types of therapies that may be offered (e.g. cognitive, behavioral, and other therapies administered on an individual or group basis). The ASAM Criteria standards also include a recommended schedule of services and recommended staffing patterns for residential SUD treatment.

Decision Point: How will states select, develop, or modify program standards to set residential treatment provider qualifications?

Recommendation: Determine whether current provider program standards comport with industry standards — and seek alignment.

Best Practices

All the states we interviewed had adopted The ASAM Criteria specifications as benchmark requirements for SUD residential services, though adoption strategies varied. As part of the 1115 demonstration application and review process, states compared their existing residential SUD treatment standards with The ASAM Criteria specifications and performed an analysis to identify differences. States took different approaches to revising their standards to address some or all of the gaps. Massachusetts conducted a very thorough review of its existing standards compared with The ASAM Criteria program standards. Massachusetts used four sources of documentation to crosswalk standards: state licensing requirements, regulations, provider procurement documents (e.g. request for proposals), and the SSA's Standards of Care manual. Officials developed a comprehensive crosswalk that included key components of The ASAM Criteria program standards (e.g. settings, provider types, and specific services) and that also considered distinguishing features set forth in the ASAM standards such as admission criteria, admission process, and purpose of treatment. It is a value-added exercise to identify and include all potential sources of provider-facing guidance (such as licensure standards, regulations, contracting, and manuals) when performing a comparison assessment to identify relevant gaps between The ASAM Criteria and state policy in its totality.

Other states (California, Virginia and Michigan) promulgated new standards that included key ASAM Criteria components (staffing and provider type, physician coverage, schedule and type of clinical activities, services, and support systems). Maryland had already addressed most of The ASAM Criteria requirements, and focused primarily on staffing requirements.

Additional Considerations

Consistent with the 1115 SUD guidance issued by CMS in 2017, states should consider aligning their residential SUD treatment provider qualifications with the most critical elements described in The ASAM Criteria, for example, the types of services, schedule of services, and staffing patterns recommended for residential SUD treatment. Prioritizing these core standards could mitigate concerns raised by ASAM about maladaptation or regimentation associated with incorporating the full set of ASAM-developed provider criteria into state administrative documentation.

Promulgating Program Standards

As described above, the provider and service criteria outlined in industry guidelines can be used as a basis for designing Medicaid SUD program standards to promote quality of addiction care and protect the integrity of the Medicaid provider network. The CMS guidance specifies that states should implement these standards through avenues such as licensure standards, policy manuals, managed care contracts, or other program guidance. States can use these and other vehicles to disseminate specific expectations of providers that are delivering SUD residential services.

Decision Point: How will states promulgate program standards for residential SUD treatment providers?

Recommendation: Consider using procurement and contracting versus statutory or regulatory vehicles to supplement state policy levers.

Best Practices

To communicate the clinical details of treatment expectations, we recommend that states use contractual and policy manuals rather than statutory and regulatory changes. Over time, treatment standards evolve as the field has better research and information for treating addiction. Therefore, states may prefer to forgo (when possible) lengthy legislative and rulemaking processes for establishing regulations pertaining to treatment criteria. It may make more sense to use a regulatory approach for the *processes* that states will use to apply these standards to provider agencies (discussed below in the “Operationalizing Program Standards” decision point). Massachusetts used provider procurement documents to set forth The ASAM Criteria standards, and complemented this addition with revisions to its MassHealth Provider Manual. Massachusetts also included these service specifications in its managed behavioral health care organization provider contracts.

Other states took different approaches to promulgate the new SUD residential treatment requirements. Some states (e.g. California) used interagency agreements to incorporate ASAM elements into provider applications. Others (e.g. Michigan) used policy guidance or letters to providers regarding ASAM specifications. Maryland created a Medicaid payment regulation that included ASAM staffing requirements.

Additional Considerations

In 2018, the nonprofit organization Shatterproof announced a plan to develop a provider rating system to give patients, payers, and stakeholders standardized information about the services and quality of care available at addiction treatment providers. The Shatterproof Provider Rating System seeks to adapt existing health care rating systems (such as those developed by the Leapfrog Group and available through the CMS Hospital and Nursing Home Compare Program) for the SUD field, with the goal of increasing transparency, accountability, quality evaluation, and quality improvement opportunities among treatment providers. If and when the Shatterproof Provider Rating System is finalized and becomes broadly available, states and payers could incorporate the ratings into contracting or provider requirement criteria — for example, by establishing a minimum score for credentialing or eligibility for incentive payments. These efforts will be critical for payers; notably, none of the states interviewed are using performance measures to evaluate the quality of services in IMDs or the efforts of their MCOs to improve these providers’ practice.

Operationalizing Program Standards

Under the current 1115 SUD guidance, states must have a process in place for reviewing residential treatment providers and assuring their compliance with program standards (and other requirements).³¹ In the interest of effectuating residential service delivery to coincide with or succeed the approval of an 1115 SUD demonstration, states may develop and conduct an “initial determination” process to assess whether residential providers are able to deliver care consistent with programmatic requirements. This process is conducted in lieu of rulemaking or licensure, which generally takes more time than an initial determination approach. The relative speed of the initial determination process enables states to implement the demonstration and begin drawing down the federal match for residential treatment services. There are various processes states can use to conduct these initial determinations, including on-site reviews, desk audits, and provider attestation of compliance with The ASAM Criteria standards.

Decision Point: How will states implement program standards for residential SUD treatment providers, both initially and on an ongoing basis?

Recommendation: Establish a clear process to review compliance with program standards — prioritizing on-site reviews.

Best Practices

Best practices include conducting on-site reviews at the beginning of the network development process. While desk audits and self-attestations submitted by providers as part of an initial determination process can be efficient, on-site reviews within a brief time after provider enrollment will reduce the risk of noncompliant services and the subsequent need to make changes downstream to ensure quality of care or patient safety, or to take compliance action such as withholding or reducing future provider reimbursement.

Of the states interviewed, Virginia performed an initial on-site review to determine if providers comported with The ASAM Criteria program standards. The state incorporated The ASAM Criteria requirements into a survey instrument and used a contractor familiar with ASAM to determine whether residential providers met the standards. This contractor was able to complete these on-site reviews and offer recommendations to the state within six months. The six-month timeframe could work for many states seeking an 1115 SUD demonstration since the milestone for implementing a process to review residential providers against program standards is within 24 months after the 1115 demonstration is approved.

Other states that used more expeditious review processes are performing on-site reviews within the first year of a provider’s enrollment in the Medicaid program and will leverage state licensing bodies for ongoing monitoring. For example, California and Maryland will use licensure staff to conduct site visits to review and confirm providers’ adherence to specified ASAM requirements.

³¹ Centers for Medicare & Medicaid Services, U.S. Department of Health & Human Services (2017). Strategies to address the opioid epidemic. State Medicaid Director Letter #17-003. <https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf>

Additional Considerations

In October 2018, ASAM announced a partnership with the accreditor CARF International to pilot a level of care certification program for addiction treatment programs. The ASAM Level of Care certification program will provide an independent, comprehensive assessment of treatment providers' ability to deliver care consistent with specific levels of care described in The ASAM Criteria. ASAM and CARF anticipate piloting the certification in the first half of 2019, and launching in the third quarter, focusing initially on residential treatment levels of care. ASAM plans to expand the program to include the other levels of care. When the ASAM-CARF certification program is finalized and becomes broadly available, it represents a promising option for states to require providers to receive and maintain certification. This certification process will parallel accreditation and credentialing processes (e.g. The Joint Commission) that exist for other health and behavioral health providers. Accreditation and credentialing are often prerequisite for other providers as a condition of network participation in Medicaid and commercial markets. Similar to other accreditation options, there will be a charge for the level of care certification.

Evidence-Based Practices and Medication-Assisted Treatment

Historically, little attention has been paid to the availability of EBPs (including MAT) in SUD residential treatment. Since residential services typically represent a large proportion of a public purchaser's spending, especially under SAMHSA's federal block grant, the use of EBPs has the potential to maximize the federal government's return on investment by advancing quality care. States, other payers, and the treatment community as a whole are increasingly recognizing the importance of patients' access to EBPs in order to improve care and outcomes. States should include in SUD program standards a modest list of optional EBPs with a strong research base for treating SUDs (e.g. motivational interviewing and cognitive behavioral therapy) in order to facilitate improved outcomes.

Some EBPs, however, will not be optional: under the current 1115 SUD guidance issued in 2017, states must require residential providers to offer MAT or facilitate access to MAT off-site (the 2015 guidance did not explicitly contain this requirement). MAT has been established by research and clinical science as the best standard of care for treating OUD.³² States implementing SUD 1115 demonstrations will therefore need to develop protocols that require providers to assertively arrange for patients to have access to MAT — either on-site or through formal affiliations with MAT providers. States can allow providers to create the specific method they will use to make MAT available, but all patients must be offered medication as a treatment option.

Decision point: How will states assure the provision of evidence-based practices, including medication-assisted treatment?

Recommendation: Develop protocols requiring that providers assertively arrange for patients to have access to medication-assisted treatment — and that they deliver additional evidence-based practices as well.

³² U.S. Department of Health and Human Services (HHS), Office of the Surgeon General (2018). Facing addiction in America: The Surgeon General's spotlight on opioids. Washington, D.C.: HHS.

Best Practices

The five states we interviewed all require the provision of MAT to Medicaid beneficiaries in residential settings, but Virginia developed the most detailed policies. Specifically, Virginia requires residential treatment organizations to ensure access to MAT for anyone admitted, through one of three methods:

- Employing prescribing practitioners
- Contracting with prescribing practitioners
- Making MAT available on-site

Each residential provider in Virginia Medicaid must submit to the state for approval its method for providing or arranging for MAT. Providers are required to include this information on the service authorization request for residential treatment services. For any method chosen, Virginia's residential treatment programs participating in the 1115 demonstration must provide their staff/practitioner rosters (Drug Enforcement Administration X numbers) and detail the prescribers' hours of on-site availability. Residential treatment centers must also detail how they will ensure that patients with OUD have a smooth transition and continued access to MAT after discharge. Other states may want to consider Virginia's approach as a best practice because these methods can be operationalized by providers and can be tracked during state reviews of providers to ensure they are meeting the 1115 requirements.

In addition to MAT, states are requiring residential providers to deliver other EBPs as part of the course of treatment. California requires providers to deliver at least two EBPs from a list of five; Maryland requires providers to deliver at least three from a list of eleven. Examples of these EBPs include motivational interviewing, cognitive behavioral therapy, youth-specific interventions, and trauma informed treatment.

Additional Considerations

As with many ASAM-aligned program and service requirements, residential treatment providers may benefit from education, training, and technical assistance regarding options, strategies, and best practices to facilitate access to MAT or deliver MAT on-site. Providers may especially benefit from technical assistance related to applicable federal regulations pertaining to MAT prescribing, dispensing, and administration at treatment facilities, such as using the appropriate DEA registration number (e.g. the waived prescriber number versus the institution's number, if applicable), and adhering to relevant physical security control and storage requirements. California has developed several resources to offer guidance regarding some applicable rules for providing MAT in residential treatment facilities.³³

³³ California Department of Health Care Services (2019) Incidental Medical Services: Frequently asked questions. https://www.dhcs.ca.gov/provgovpart/Documents/IMS_FAQs-January_2019.pdf

California Department of Health Care Services (2018). MHSUDS Information Notice No.: 18-031. https://www.dhcs.ca.gov/formsandpubs/Documents/MHSUDS_Information_Note_18-031_Incidental_Medical_Services%20FINAL%207.20.18.pdf

California Department of Health Care Services. What are the benefits of offering MAT at residential treatment facilities? https://www.dhcs.ca.gov/provgovpart/Documents/MAT_Toolkit_Part_Two.pdf.

Provider Network Development, Training, and Technical Assistance

Many residential providers now enrolled in Medicaid networks as a result of the 1115 SUD demonstrations have never been subject to ASAM standards, are not aligned with a particular ASAM residential level of care, and/or have not incorporated the clinical programming that may be required by the SMA. Such providers may have typically operated apart from the outpatient treatment system as well. Residential SUD treatment providers may also be inexperienced with Medicaid and MCO billing and documentation requirements, and may therefore require training and support in this area.

States should be cognizant of the up-front investments that they will need to make to train providers and help providers gain competencies in delivering services consistent with Medicaid program standards and requirements. In addition, many of these providers will be transitioning to Medicaid financing from being paid primarily through state or local contracts, and may have limited cash reserves. Denials of payments due to billing problems, administrative errors, or a poor audit may have adverse consequences for these providers until competencies improve. These consequences could potentially compromise beneficiary access to services.

Decision Point: How will states support residential treatment providers to successfully participate in Medicaid?

Recommendation: Pay attention to new providers' ability to participate in the Medicaid program — and invest in helping providers meet network requirements.

Best Practices

States described undertaking significant efforts to train providers on The ASAM Criteria standards, including level-of-care determinations, service requirements, and staffing levels. Training during implementation was significant. Ongoing training was also necessary to reinforce requirements and to support providers as they gained experience with operation of the services.

In Maryland, the ASO performed on-site reviews as needed, and additional support for individual programs was provided by the Behavioral Health Administration through local behavioral health authorities. Maryland also developed a residential quality review meeting as another access point for providers to engage with the state. Through other processes, Maryland worked with its provider network and ASO to provide information and direction regarding authorizations and billing practices. Virginia used significant resources for trainings and certifications to help residential providers meet The ASAM Criteria standards.

Additional Considerations

States should plan to invest resources in provider education and training as part of their SUD 1115 implementation efforts. This may require a combination of staff and contractors to develop and coordinate network development activities. States with comprehensive managed care programs can delegate some of these functions to their MCOs to mitigate bandwidth challenges for state staff. Medicaid managed care partners are a valuable resource for states during implementation of SUD residential services. Activities that states can require of managed care partners to expedite network development include on-site reviews of residential programs relative to newly developed state

standards. These partners can also provide technical assistance to providers to meet standards and resolve billing problems.

States might also consider allowing providers transitioning from regular contract payments to fee-for-service to operate in both worlds — with the original state/local payer continuing to make contract payments for a limited time while the providers “shadow bill” Medicaid. The shadow billing process will allow providers to project the change in cash flow timelines they will experience after they transition to fee-for-service.

Determining the Appropriate Level of Care

As with any medical benefit, CMS and other payers expect that SUD services provided to a beneficiary must be medically necessary. Often this determination is made through a comprehensive assessment that is the foundation for a treatment plan. This assessment recommends the appropriate level of care, specifies the services needed by the beneficiary, and lays out a timeframe for the recommended course of treatment. Importantly, the comprehensive assessment assures that the patient is served in the right treatment setting, and avoids inappropriate assignment to residential care. It is incumbent on the state to ensure that assessment instruments are valid and reliable and that the state have the necessary processes in place to ensure that providers are knowledgeable about the instrument and its application. States can accomplish this by offering technical assistance to providers and can be reinforced by SMAs and managed care partners during the utilization management or review process.

Choosing the Assessment Instrument

CMS guidance requires providers to assess treatment needs based on SUD-specific, multi-dimensional assessment tools. The guidance references ASAM’s Patient Placement Criteria (PPC), or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines. There are a variety of nationally recognized assessment tools for states to consider. In addition to the ASAM PPC, the University of Washington has developed a list of evidence-based screening and assessment tools for adolescents and adults.³⁴

Decision Point: Which assessment instrument should be required for assessing level of care?

Recommendation: Choose one or more SUD-specific, multidimensional assessment tools based on clinical treatment guidelines.

Best Practices

A key consideration in choosing an assessment instrument is whether the instrument directly connects the results of the assessment to a recommendation for a specific level of care. The ASAM PPC and the Global Appraisal of Individual Needs Initial (GAIN-I) are examples of tools that result in a clear level-of-care recommendation. Maryland, Virginia, and California required their providers to use ASAM PPC. Michigan is using the GAIN-I rather than the PPC. Both instruments offer a comprehensive biopsychosocial assessment designed to support clinical diagnosis, level-of-care placement recommendations, and treatment planning.

³⁴ <http://lib.adai.washington.edu/dbtw-wpd/exec/dbtwpub.dll>

As indicated above, some states or providers chose an approach that uses a computer-based interactive assessment instrument that relies on algorithms to generate level-of-care treatment recommendations. The ASAM CONTINUUM³⁵ (used by some providers in California) and GAIN-I (used by Michigan) provide real-time feedback to clinicians and their supervisors regarding incomplete assessment data and other information that can guide technical assistance to improve the assessment process, performance monitoring, program planning, and economic analysis. Use of these instruments has been shown to improve the clinical assessment process and can improve the likelihood of authorizations and reimbursement.³⁶

Additional Considerations

SMA that choose an assessment instrument without a built-in algorithm for recommending a level of care should develop their own algorithm or decision process that will take the results of the assessment and generate a level-of-care recommendation. This will require states to have the necessary resources and competencies to create such algorithms. Inaccurately matching an individual's treatment need may be a risk factor for treatment non-completion. In these instances, states may want to work with their universities, managed care partners, and network providers to develop crosswalks to ensure that treatment decisions resulting from these assessments result in consistent level-of-care recommendations.

For states that are using The ASAM Criteria there are additional considerations. Recently, ASAM has raised concerns with states and other stakeholders regarding the improper use of The ASAM Criteria. Specifically, recent growth in use of the ASAM Criteria (often pursuant to regulatory requirements) has sparked concerns from patients, families, providers and payers about whether The ASAM Criteria standards are being implemented with fidelity. ASAM has stated that providers may not be using The ASAM Criteria as intended, weakening the validity and reliability of the resulting treatment recommendations. ASAM has noted that improper use of The ASAM Criteria may run afoul of its intellectual property interests, and is modifying its copyright and permissions processes to help avoid any confusion among patients, families, providers, or payers.

Ensuring the Appropriate Use of the Assessment Instrument

Regardless of the assessment instrument selected, states unanimously stated that providers need initial and ongoing training in the use of the instrument and resulting treatment recommendations. For some SUD residential programs, it has been a seismic shift to go from relying on a home-grown instrument to working with a new instrument in use by the industry. Each interviewed state emphasized that significant state resources were needed to help with this change — with several having underestimated the initial and ongoing training needs of their provider networks.

Decision Point: How can states ensure that providers are using the assessment instrument to produce appropriate level-of-care determinations?

Recommendation: Implement front-end and back-end processes that offer training and provide feedback to providers regarding their use of the instrument and treatment recommendations.

³⁵ For more information, see <https://www.asamcontinuum.org/products/>

³⁶ For more information, see <https://www.asamcontinuum.org/products/>

Best Practices

Most states developed both front- and back-end processes for training providers in the appropriate use of the assessment instrument so as to generate appropriate treatment recommendations. For instance, Maryland engaged the programs from the launch of its demonstration and continued for months with "Residential Joint Operations Team" calls, which were initially scheduled weekly and then bi-weekly. These calls provide extensive support to providers on policy and billing questions related to the state and ASO. California, Virginia, and Massachusetts developed similar technical assistance processes for their provider networks regarding clinical and operational issues.

Additional Considerations

States made significant investments in training providers to use the assessment tools and develop appropriate treatment recommendations. Interviewees repeatedly stressed that states should plan ahead for initial and ongoing workforce trainings regarding any assessment instrument. Initial trainings, while helpful, were not sufficient to ensure that appropriate treatment recommendations were made. States and providers that used data-driven instruments such as ASAM CONTINUUM and GAIN-I were less likely to need significant review of providers' level-of-care recommendations since those instruments generated consistent and appropriate level-of-care recommendations.

Developing Utilization Management Approaches

The 1115 SUD guidance issued by CMS requires states to implement a utilization management approach for SUD residential treatment services. This approach must ensure that beneficiaries have access to SUD services at the appropriate level of care, that the interventions are appropriate for the diagnosis and level of care, and that there is an independent process for reviewing placement in residential treatment settings. Many SUD residential providers have had little experience with utilization management processes (e.g. prior authorization or continued stay review). Implementing new clinical and administrative processes without technical assistance may result in service and payment interruptions that could have adverse impacts on both beneficiaries and providers.

Decision Point: How can states ensure that their independent review process results in consistent decisions regarding level-of-care recommendations?

Recommendation: Closely support providers to develop appropriate treatment recommendations — and require Medicaid managed care partners to maintain expertise with the designated assessment instrument(s).

Best Practices

States used various managed care delivery systems for their utilization management efforts including MCOs, PIHPS, and ASOs. The utilization management processes include oversight and technical assistance for service providers in their assessment efforts to ensure that beneficiaries have access to SUD services at the right level of care and that interventions are appropriate for the diagnosis and recommended level of care. While these processes are helpful in ensuring appropriate placements, states also created supplemental strategies to ensure that managed care partners and the provider

network worked collaboratively on the rollout of their utilization management processes for SUD residential services.

For instance, in addition to the “Residential Joint Operations Team” calls described above, Maryland instituted a residential quality review meeting as another access point for providers to engage with state staff. Virginia and California developed similar processes with their MCOs and PIHPs to engage and provide technical assistance to providers regarding level-of-care determinations and utilization management processes. States found these processes to be very helpful in proactively identifying issues that would result in services being inappropriately denied, therefore reducing the likelihood of individuals not receiving the appropriate treatment.

Additional Considerations

States are asking their managed care partners to review the appropriateness of admissions to SUD residential programs. This review process can be designed specifically to support and assist providers in understanding medical necessity requirements, and can create “teachable moments” for the program staff making recommendations for admissions. The caveat is that the MCO staff will need to be knowledgeable regarding The ASAM Criteria program standards and clinical criteria, while the state must be clear about its expectations for reviewing residential providers against the standards. Although managed care resources and expertise can be valuable for the tasks associated with developing SUD residential services, states should consider retaining policy and oversight responsibility to ensure alignment with legal and regulatory requirements in state Medicaid programs (e.g. compliance with Medicaid MHPAEA regulations).

The 2015 guidance from CMS emphasized that treatment provided in an SUD residential program should be short-term, and the 2017 guidance establishes a statewide average length of stay of 30 days as a performance goal for approved demonstrations. States may be interested in promoting short-term stays (30 days or less) through appropriate utilization management policies. Creating restrictive policies regarding length of stay and other treatment limitations is cautioned. For instance, allowing only two 30-day admissions within a specific time period (e.g. twelve months) doesn’t acknowledge the likelihood of relapse or the possibility that individuals may need several levels of residential treatment to complete an episode of care.

For benefit management purposes, some managed health plans may already be using medical and utilization review tools that are proprietary products. States covering SUD benefits in a managed care environment can require their MCOs to demonstrate how their utilization management systems, techniques, and decision criteria comport with the level of care and patient placement recommendations generated by the SUD-specific, evidence-based assessment tools that the state has designated for providers’ use.

Reimbursement

States will need to establish residential SUD treatment payment rates that comply with CMS requirements, are sufficient to ensure access, and — where appropriate — align with any historical non-Medicaid payment methods or service delivery systems in order to avoid excessive provider network disruption. Determining an appropriate rate helps ensure access (especially pertinent when it comes to SUD, where access has been lacking), keeps expenditures cost-efficient, and incentivizes the delivery of

care and treatment services that meet program standards. Rates should reflect current costs, particularly for required personnel, to support access to services.

Developing a reimbursement methodology for SUD residential services is complex. There are several aspects of the reimbursement process that are unique to these services (e.g. minimal state Medicaid experience with these providers, exclusion of room and board, and unbundled versus bundled payments for treatment services). States that have historically been reimbursing some types of residential SUD services using federal Substance Abuse Prevention and Treatment Block Grants (SAPTBG) funds or state and other local funding may draw on this experience in their initial rate-setting process. However, rates also need to comply with overarching CMS rate-setting requirements for efficiency, economy, and quality of care, and with actuarial soundness and rate development standard requirements for managed care — while also being sufficient to support access across the SUD service continuum.

Rate-Setting Methodology

Because SUD residential services have historically not been covered by Medicaid, there is no historical Medicaid expenditure data or methodology to work with in calculating the rate; in most cases, the rates must be newly developed. Within the context of states seeking approval for and implementing 1115 SUD demonstrations, the policy guidance issued by CMS is agnostic to rate development methodologies (with the exception of clarifying that room and board payments are allowable only for certain inpatient facilities, as described below in the “Room and Board” section.)

Decision Point: How should states develop Medicaid reimbursement rates for residential SUD services?

Recommendation: While a variety of rate-setting approaches can be used, consider cost modeling as an effective and efficient method to set residential SUD treatment rates.

Best Practices

Identifying a “best practice” for rate-setting strategies for SUD residential care is challenging given state Medicaid agencies’ limited experience in purchasing this service. However, it is generally a best practice to create an efficient rate through a cost modeling approach. Cost modeling that includes average local costs for staffing (salaries, benefits, and overhead rates), occupancy, and other cost factors (using actual or benchmark data) may be the most effective rate development methodology for ensuring network adequacy and access to services by level of care. Cost modeling also allows states to adjust historical rates — for example to align with new service, clinical activity, staffing, or other programmatic requirements — and to establish overhead or profit limitations for cost effectiveness. Cost modeling to set rates is distinguished from cost-based reimbursement, which uses cost reports to collect providers’ actual costs and calculates rates based on those costs, along with processes to periodically update cost-based rates by provider. In contrast, cost modeling simplifies data collection, and high cost providers are not rewarded for inefficiencies. In this model, salary and other cost data can be estimated with salary surveys and other benchmark data, and rates are not specific to each provider. Regional rates can be used to account for high cost areas within a state, where salaries and property costs are substantially higher than in other areas.

None of the interviewed states initially used a cost modeling approach for setting rates. The processes they used to develop and manage Medicaid rates for SUD residential services varied, but generally

aligned with existing Medicaid structures for behavioral health services and with historical non-Medicaid funding for SUD residential services. Several states reported using historical non-Medicaid rates as the basis for their Medicaid rates. While this solution may be expeditious, it presents certain issues, including the possible absence of a determination of actuarial soundness for past rate-setting methodology or results, lack of alignment with specific staffing and service requirements, and imprecise relationship to current costs. Specific methodologies used by the interviewed states to develop rates for the treatment component of SUD residential services include:

- *Cost-based methodology.* Cost-based rates are determined at one point in time, but may be reviewed and adjusted periodically based on updated cost reports submitted by each provider. Cost-based rates are typically specific to each provider. States that used the cost-based rate approach indicated that significant staff resources were needed at both the state and provider levels to develop tools, collect cost data, and review results. Ongoing processes to update cost data and to reconcile actual costs to interim rates were also a resource concern. In California and Virginia, a process existed or was developed to capture provider costs of services and capacity in order to calculate a rate for the defined level of care. Some states (e.g. Virginia) have regulatory or other restrictions that do not permit adjustment once a rate has been established.
- *Using historical rates.* Several states (e.g. California, Maryland, and Massachusetts) used their historical rates for residential SUD services (funded through federal block grant or state general revenue funds) as a basis for their initial rates. Historical rates were then adjusted to account for differences in the new service requirements, such as increased staffing and credentials to comply with ASAM levels of residential care.
- *Using other payers' rates.* Some states (e.g. Maryland) obtained rates from other states for similar services, compared the other states' rates against historical rates paid for services in their state, and adjusted for differences in salaries and local costs of living using publicly available indices.
- *Negotiated rates.* Several states (e.g. Virginia and Michigan) allowed their managed care partners to establish rates and to negotiate these rates with providers, subject to state review and approval. MCOs are contractually required to provide adequate access to services, and typically draw on other states' rates for similar services, commercial rates, or historical non-Medicaid rates for SUD residential services to establish their negotiated rates.

Rates were provider-specific in Michigan and Virginia; regional in California; and statewide by level of care in Maryland and Massachusetts.

Additional Considerations

States report slow adoption of alternative payment models (APMs) and value-based purchasing (VBP) due to the absence of historical data and outcome measures needed to establish thresholds or performance targets. In addition, residential SUD providers often have limited information system capacity to support electronic health records and other tools needed to manage APMs/VBP. Over time, states may move to establishing APMs.³⁷ A gradual shift toward VBP, sensitive to provider readiness, could incentivize better care and outcomes for patients entering and leaving residential treatment.

³⁷ Schulman, M., O'Brien, J., Pierre-Wright, M., & Thomas-Henkel, C. (2018) Exploring value-based payment to encourage substance use disorder treatment in primary care. Boston, MA: Technical Assistance Collaborative. http://www.tacinc.org/media/59564/vbp-for-sud_final_june-2018.pdf

Un/Bundling Residential Payment Rates

Residential rates are typically established using a per diem unit that includes an identified set of activities that nearly all clients receive as a part of the residential service array. Bundled residential rates should be inclusive of “core” treatment services: assessment, treatment planning and updates, individual/group counseling, therapies, psychoeducation, case management or care coordination with payers or other providers, and other clinical treatment activities. In addition, residential rates should reflect the clinical and staffing capacities required to provide withdrawal management services to patients whose conditions require medical monitoring. The 2017 CMS guidance specifies that under SUD demonstrations, medically supervised withdrawal management must be covered; residential treatment programs can be an appropriate setting for this service, and their payment rates should reflect the requisite costs.

Decision Point: Which services should states include or exclude in residential payment rates?

Recommendation: Bundled residential rates should be inclusive of core treatment services used by nearly all beneficiaries. Consider reimbursing medication-assisted treatment services separately.

Best Practices

As a part of rate-setting, each state interviewed determined which specific services were included in the residential treatment rate, such as individual or group counseling and transportation to other provider locations for frequently used services. California and Massachusetts included almost all SUD services in their residential rates. The decision to include specific services in the per diem rate often depends upon whether the services are available to nearly all clients at consistent quantities — and, for states that used non-Medicaid rates as a foundation for Medicaid residential rates (Maryland, Massachusetts, and Michigan), also on whether those historical non-Medicaid rates included group counseling or other treatment services. Maryland allows a MAT provider and a residential treatment center to bill simultaneously, although the residential provider cannot bill for MAT in addition to its facility rate for these individuals. California allows residential providers to bill separately for MAT which may incentivize MAT service provision. Distinct payment for MAT services is preferable regardless of whether it is delivered by the residential provider or a different provider because separate payment encourages provision of the services for those individuals who need it, and improves claims data available to analyze utilization of MAT.

The most common services excluded from states’ residential rates were laboratory, transportation, pharmacy, and professional services for MAT because these services may be structured through other Medicaid contracts (e.g. transportation, pharmacy, lab) or used at varying levels based on a beneficiary’s needs or preferences.

Additional Considerations

Rates based on residential level of care (e.g. 3.1 versus 3.5) are easier to administer than provider-specific rates, particularly if a cost model is used to establish SUD residential rates. Provider-specific rates are more common when rates are established using provider cost reports, but may encourage variations in costs that do not align with service standards (e.g. ASAM). Any increased costs associated with “enhancements” offered by specific providers, such as shorter lengths of stay, reduced recidivism

or diminished emergency department usage, should be incorporated into an APM, not into a provider-specific base rate.

Room and Board

Federal regulations do not allow Medicaid reimbursement for room and board except in certain institutions such as nursing homes, intermediate care facilities for persons with intellectual disabilities, hospitals, and for respite care furnished in a state-approved facility. For Medicaid purposes, “room” means hotel- or shelter-type expenses, including all property-related costs such as rental or purchase of real estate and furnishings, maintenance, utilities, related administrative services, and taxes. “Board” means three meals a day or any other full nutritional regimen.³⁸ The 1115 SUD guidance issued in 2017 confirms that federal matching funds authorized under the demonstration opportunity are limited to Medicaid-coverable services, and that room and board payments are allowable only for facilities that qualify as inpatient facilities under Section 1905(a) of the Social Security Act.

Therefore, non-Medicaid funding must be available to support the room and board portion of SUD residential services. Cost modeling is an effective methodology for establishing room and board rates, yielding a distinct rate excluded from Medicaid that could be reimbursed through SAPTBG or local funding.

Decision Point: How can states account for costs not allowable for federal financial participation, such as room and board costs?

Recommendation: Use cost modeling to develop room and board rates — and braid funding streams.

Best Practices

As with establishing rates for treatment services, there is no single best practice for setting the room and board rate, nor one recommended approach for identifying which funding source to use for these services. In most instances, the reimbursement methodologies used by the interviewed states for room and board and residential treatment services were similar to those for residential treatment: either cost-based or adapted from other services or states. Among the interviewed states, federal SAPTBG and state or local funding were the most common sources for room and board reimbursement.

Additional Considerations

As SMAs and MCOs enter into contracts with residential treatment providers to purchase Medicaid-covered services, state agencies (including SSAs) should review existing provider contracts and pursue modifications where necessary to ensure that treatment services are not being purchased in duplicate. Whereas previously SSAs may have been underwriting clinical treatment activity in addition to room and board, provider contracts should now reflect discrete funding streams for Medicaid-coverable services and non-Medicaid costs.

³⁸ See 42 CFR § 441.360 - Limits on federal financial participation.
<https://www.law.cornell.edu/cfr/text/42/441.360>

In addition, the federal match for residential treatment services now covered under Medicaid may result in additional block grant or general revenue monies previously allocated for SUD treatment. After covering the state share for Medicaid-covered services and room and board costs of residential treatment providers, states may repurpose existing grant or state funding allocations to address critical gaps in the continuum of care or provider capacity. For example, the influx of federal financial participation for IMDs may enable states to begin purchasing recovery support services or opioid treatment programs in Medicaid for the first time if those services were not previously covered. Alternatively, states with robust benefit packages may reinvest the surplus in residential levels of care to further develop capacity.

Conclusion

The rich experiences of the interviewed “pace car” states provide valuable lessons both for revisions to existing demonstrations and for new 1115 SUD demonstrations. The 1115 SUD policies offer a substantial opportunity for states to advance access to effective and needed SUD treatment. Rapidly growing state interest in pursuing these 1115 opportunities attests to the value that states see in them as a tool for addressing opioid addiction, and to the urgency state officials feel to put effective measures in place to address the epidemic. The recommendations made in this report are developed to help foster state approaches that are effective and evidence-based in addressing opioid addiction; that appropriately leverage the recent flexibility that the federal government has offered to authorize Medicaid funding for residential SUD services; and that achieve appropriate quality, patient safety, intensity and setting. They also can help advance sound investment of state and federal resources.

The recommendations offered here may help inform state implementation of some of the new Medicaid policies established in the SUPPORT Act passed by Congress in October 2018, as our interviews with states were taking place. For example, the SUPPORT Act establishes a new five-year option for states to use federal Medicaid funding for services provided to nonelderly adults in IMDs for up to 30 days in a year, subject to a maintenance of effort requirement. States must have processes in place to ensure that individuals are provided evidence based clinical screening before receiving services, as well as processes to determine level of care, length of stay, and appropriate care settings. The SUPPORT Act also requires coverage of all FDA-approved drugs for MAT for five years in states that do not receive an exemption on the grounds of a provider shortage, and authorizes grants to states to increase SUD provider capacity.

A key takeaway from the experience of the five interviewed states that designed and executed strategies in response to the decision points highlighted in this brief is the considerable level of effort they found necessary to effectively plan and implement an 1115 SUD demonstration. Generally, the recommendations set forth in this brief for each decision point may be adapted to meet the evolving needs of states and to address state-specific circumstances. Nevertheless, the singular theme emerging from these five states (and other states that are implementing SUD demonstrations) is that states will need adequate time and resources needed to integrate SUD residential providers (and other SUD providers) into the Medicaid provider network.

Staff in state Medicaid agencies and SUD providers are in most cases developing their working relationships for the first time, and need time to understand each other’s worlds. A solid understanding of how SUD providers operate in each state will be critical to determine the time and resources necessary to develop and launch that state’s network. Crucially, state Medicaid agencies also need to

develop an understanding of the addiction treatment industry — especially the program standards, medical necessity criteria, and quality measures that exist for these services, and how to strengthen those standards where needed to ensure effective, high quality treatment. A meta-recommendation of this brief applicable to each decision point is to resist underestimating the amount of groundwork and preparation required to design, plan, and successfully implement the program reforms supported by an 1115 SUD demonstration. The common thread underlying the experience of the interviewed “pace car” states is that committing sufficient operational and administrative investments to thorough review, planning, and ongoing implementation is the linchpin to successful service delivery transformation and opioid response efforts ushered in through the 1115 SUD opportunity.

Appendix

Table 4 encapsulates the decision points, recommendations, best practices, and state examples of the 1115 SUD implementation efforts described in this brief.

Table 4. Key Takeaways from Interviewed 1115 SUD States.

Area	Decision Point	Recommendation	Best Practices	State Examples
Coverage	How can states produce the necessary data to support decision-making for service coverage and provider network development planning related to sublevels of residential treatment?	Collaborate with the Single State Agency for Substance Abuse (SSA) and other payers to develop a provider network inventory by level of care and to establish a baseline for coverage and network expansions.	<ul style="list-style-type: none"> • Work with your SSA to see if it has information by provider by sublevel • Crosswalk the Medicaid and SSA residential provider network with The American Society of Addiction Medicine Criteria sublevels to identify coverage and network gaps. 	California developed a provisional inventory of residential providers with delineation by sublevel of care. Virginia used geomapping to analyze level of care and treatment needs.
	Which sublevels of residential treatment will states cover through the 1115 SUD option, and when?	Designate intensive residential treatment as the top priority — and stagger implementation of other sublevels.	<ul style="list-style-type: none"> • Cover clinically intensive sublevels of care initially, such as 3.5 and 3.7. These providers may already be participating in insurance or meeting specific service and billing requirements of commercial payers. • Stagger implementation for each level of residential care, allowing enough time to become knowledgeable about the overall provider network 	Maryland initially focused on higher levels of care (3.3 through 3.7) and included level 3.1 providers later in the demonstration.
	Which levels of care within the SUD continuum of care should be enhanced to support beneficiaries transitioning from residential treatment?	To the extent feasible, strengthen the full continuum to ensure a balance of outpatient and residential services.	<ul style="list-style-type: none"> • Focus network development on other levels of care necessary for transitioning and diverting individuals from residential care. • Strengthen efforts to increase medication-assisted treatment (MAT) availability in outpatient settings 	Virginia and California used their 1115 waivers to increase access to community-based treatment and recovery services focusing on enhanced access to MAT. Both states experienced significant increases in the number of MAT prescribers and beneficiaries receiving MAT.

Area	Decision Point	Recommendation	Best Practices	State Examples
Quality of Care	How will states select, develop, or modify program standards to set residential treatment provider qualifications?	Determine whether provider program standards comport with industry standards — and seek alignment.	<ul style="list-style-type: none"> • Develop a crosswalk that compares existing standards against ASAM standards, and identify gaps • At a minimum, revise your standards to address all key programmatic ASAM standards (staffing and type, physician coverage, schedule and type of clinical activities, services, and support systems) 	California, Michigan and Virginia issued new standards to address all gaps found during the crosswalk of their standards and the ASAM standards.
	How will states promulgate program standards for residential SUD treatment providers?	Consider using procurement and contracting, versus statutory or regulatory vehicles, to supplement state policy levers	<ul style="list-style-type: none"> • Use contractual and policy manuals rather than statutory and regulatory changes since treatment standards change over time; regulatory standards may be more appropriate for process requirements 	Massachusetts used changes in provider contracts and provider manuals, rather than statutory and regulatory changes, to communicate treatment expectations.
	How will states implement program standards for residential SUD treatment providers, both initially and on an ongoing basis?	Establish a clear process to review compliance with program standards — prioritizing on-site reviews.	<ul style="list-style-type: none"> • At the beginning of the network development process, conduct on-site reviews rather than desk audits and provider self-attestations. • On-site reviews before or shortly after provider enrollment will reduce the risk of noncompliant services and the subsequent need to make network changes 	Virginia conducted on-site reviews at the beginning of the network development process.
	How will states assure the provision of evidence-based practices (EBPs), including MAT?	States will need to develop protocols requiring that providers assertively arrange for patients to have access to MAT — and that they deliver additional EBPs as well.	<ul style="list-style-type: none"> • Establish clear protocols for residential providers to operationalize requirements regarding access to MAT • Require providers to offer EBPs from a pre-defined list from the state 	<p>Virginia requires residential providers to ensure access to MAT for anyone admitted to their facilities through three well defined methods.</p> <p>California and Maryland require providers to deliver at least 2-3 EBPs from a pre-defined list, respectively.</p>

Area	Decision Point	Recommendation	Best Practices	State Examples
Quality of Care	How will states support residential treatment providers to successfully participate in Medicaid?	Pay attention to new providers' ability to participate in the Medicaid program — and make sufficient investments in to help providers with network development.	<ul style="list-style-type: none"> Identify initial provider clinical and operational technical assistance needs early in the network development process. Develop opportunities for ongoing learning and provider feedback on implementation issues. 	Maryland provided ongoing training and learning communities to reinforce requirements and to support providers as they gained experience with operation of the services.
Determining the Appropriate Level of Care	Which assessment instrument should be required for assessing level of care?	Choose one or more SUD-specific, multidimensional assessment tools based on clinical treatment guidelines.	<ul style="list-style-type: none"> Choose a standard comprehensive biopsychosocial assessment that adequately crosswalks assessment results to a specific level of care. Encourage providers to use a computer-based interactive assessment to generate level-of-care treatment recommendations 	California and Michigan providers used ASAM CONTINUUM, GAIN-I to make consistent level of care determinations and provide real-time feedback to assessing clinicians.
	How can states ensure that providers are using the assessment instrument to produce appropriate level of care determinations?	Implement front- and back-end processes that offer training and provide feedback to providers regarding their use of the instrument and treatment recommendations.	<ul style="list-style-type: none"> Invest significantly in ongoing training for instrument assessment. Implementation of computer-based assessments decreases the need for ongoing training. 	Maryland engaged the programs from the launch of its demonstration and continued for months with "Residential Joint Operations Team" calls. These calls provide extensive support to providers on policy and billing questions related to the state and administrative service organization (ASO)
	How can states ensure that their independent review process results in consistent decisions regarding level of care recommendations?	Closely support providers to develop appropriate treatment recommendations — and require Medicaid managed care partners to maintain expertise with the designated assessment instrument(s).	<ul style="list-style-type: none"> Use managed care delivery systems to provide not only oversight but also technical assistance for providers in their assessment efforts. Establish clear expectations for managed care organization (MCO) review of providers. Require MCOs to demonstrate how existing UM systems comport with provider assessment tools. with Medicaid parity requirements. 	Maryland instituted a residential quality review meeting as another access point for providers to engage with state and ASO staff regarding level of care review by the ASO.

Area	Decision Point	Recommendation	Best Practices	State Examples
Determining the Appropriate Level of Care			<ul style="list-style-type: none"> • Develop strategies to ensure that managed care partners and provider networks work together to rollout utilization management (UM) processes. • Review MCO utilization management protocols to ensure they comport with Medicaid parity requirements. 	
Reimbursement	How should states develop Medicaid reimbursement rates for residential SUD services?	While a variety of rate-setting approaches can be used, consider cost modeling as an effective and efficient method to set residential SUD treatment rates.	<ul style="list-style-type: none"> • Set rates using cost-modeling, including local staffing, occupancy, and other cost factors. This allows states to adjust historical rates and establish overhead/profit limitations. • Statewide rates by level of care are easier to administer than provider-specific rates. 	N/A
	Which services should states include or exclude in residential payment rates?	Bundled residential rates should be inclusive of core treatment services used by nearly all beneficiaries — consider reimbursing MAT services separately.	<ul style="list-style-type: none"> • Bundled residential rates should include core treatment services. • Rates should reflect the cost of medically supervised withdrawal management. • Reimburse for MAT separately; not all levels of care offer MAT directly, and an add-on payment may incentivize MAT service provision. 	California allows for providers to bill for MAT in addition to their residential rates for core services.
	How can states account for costs not allowable for federal financial participation, such as room and board costs?	Use cost modeling to develop room and board rates — and braided funding streams.	<ul style="list-style-type: none"> • Review existing provider contracts with SSAs to make sure treatment services aren't being purchased in duplicate • Repurpose any surplus block grant or general revenue monies to build the care continuum and provider capacity. 	N/A