



COLORADO
Department of Health Care
Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

November 7, 2017

The Honorable Kent Lambert, Chair
Joint Budget Committee
200 East 14th Avenue, Third Floor
Denver, CO 80203

Dear Senator Lambert:

Enclosed please find a legislative report to the Joint Budget Committee from the Department of Health Care Policy and Financing on Inpatient Substance Use Disorder (SUD) Treatment.

Pursuant to section 25.5-4-214, C.R.S., on or before November 1, 2017, the Department of Health Care Policy and Financing (the Department) shall prepare a written report with assistance from the Department of Human Services' Office of Behavioral Health concerning the feasibility of providing residential and inpatient substance use disorder treatment as part of the Medicaid program. In addition, the report must also include an analysis of providing residential and inpatient substance use disorder treatment as a state-funded benefit rather than through the Medicaid program.

The Department contracted with Colorado Health Institute to conduct the research, interview stakeholders and, in collaboration with the Department's budget team, provide a financial model of the potential costs of an added residential and inpatient SUD benefit. The Department considered a number of factors as specified in the legislation to inform the final report, including the prevalence of opioid addiction and other substance use disorders in Colorado, evidence-based practices for the treatment of substance use disorders, the current publicly-funded Colorado system for SUD treatment, any gaps in services currently available through state or federal funding and the federal authorizations necessary to include an enhanced SUD benefit.

The report identifies steps that may be necessary to implement a residential and inpatient SUD benefit, including a review of the current regulatory landscape, enhanced training requirements under Health First Colorado for the current SUD workforce, potential changes to state law and potential federal authority required. In addition to the final recommendations, the financial impacts to other systems are also considered, as well as any potential for long-term cost containment.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Zach Lynkiewicz, at Zach.Lynkiewicz@state.co.us or 720-854-9882.



Sincerely,



Susan E. Birch, MBA, BSN, RN
Executive Director

SEB/lr

Enclosure(s): HCPF 2017 Inpatient Substance Use Disorder Treatment Report

Cc: Representative Millie Hammer, Vice-chair, Joint Budget Committee
Representative Bob Rankin, Joint Budget Committee
Representative Dave Young, Joint Budget Committee
Senator Kevin Lundberg, Joint Budget Committee
Senator Dominick Moreno, Joint Budget Committee
Carolyn Kampman, Joint Budget Committee Analyst
Bettina Schneider, Budget Analyst, Office of State Planning and Budgeting
Legislative Council Library
State Library
John Bartholomew, Finance Office Director, HCPF
Gretchen Hammer, Health Programs Office Director & Community Living Office Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Chris Underwood, Health Information Office Director, HCPF
Dr. Judy Zerzan, Client and Clinical Care Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Zach Lynkiewicz, Legislative Liaison, HCPF





COLORADO
Department of Health Care
Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

November 7, 2017

The Honorable Jim Smallwood, Chair
Health and Human Services Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Senator Smallwood:

Enclosed please find a legislative report to the Senate Health and Human Services Committee from the Department of Health Care Policy and Financing on Inpatient Substance Use Disorder (SUD) Treatment.

Pursuant to section 25.5-4-214, C.R.S., on or before November 1, 2017, the Department of Health Care Policy and Financing (the Department) shall prepare a written report with assistance from the Department of Human Services' Office of Behavioral Health concerning the feasibility of providing residential and inpatient substance use disorder treatment as part of the Medicaid program. In addition, the report must also include an analysis of providing residential and inpatient substance use disorder treatment as a state-funded benefit rather than through the Medicaid program.

The Department contracted with Colorado Health Institute to conduct the research, interview stakeholders and, in collaboration with the Department's budget team, provide a financial model of the potential costs of an added residential and inpatient SUD benefit. The Department considered a number of factors as specified in the legislation to inform the final report, including the prevalence of opioid addiction and other substance use disorders in Colorado, evidence-based practices for the treatment of substance use disorders, the current publicly-funded Colorado system for SUD treatment, any gaps in services currently available through state or federal funding and the federal authorizations necessary to include an enhanced SUD benefit.

The report identifies steps that may be necessary to implement a residential and inpatient SUD benefit, including a review of the current regulatory landscape, enhanced training requirements under Health First Colorado for the current SUD workforce, potential changes to state law and potential federal authority required. In addition to the final recommendations, the financial impacts to other systems are also considered, as well as any potential for long-term cost containment.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Zach Lynkiewicz, at Zach.Lynkiewicz@state.co.us or 720-854-9882.



Sincerely,



Susan E. Birch, MBA, BSN, RN
Executive Director

SEB/lr

Enclosure(s): HCPF 2017 Inpatient Substance Use Disorder Treatment Report

Cc: Senator Beth Martinez Humenik, Vice-Chair, Health and Human Services Committee
Senator Irene Aguilar, Health and Human Services Committee
Senator Larry Crowder, Health and Human Services Committee
Senator John Kefalas, Health and Human Services Committee
Legislative Council Library
State Library
John Bartholomew, Finance Office Director, HCPF
Gretchen Hammer, Health Programs Office Director & Community Living Office Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Chris Underwood, Health Information Office Director, HCPF
Dr. Judy Zerzan, Client and Clinical Care Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Zach Lynkiewicz, Legislative Liaison, HCPF





COLORADO
Department of Health Care
Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

November 7, 2017

The Honorable Jonathan Singer, Chair
Public Health Care and Human Services Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Representative Singer:

Enclosed please find a legislative report to the House Public Health Care and Human Services Committee from the Department of Health Care Policy and Financing on Inpatient Substance Use Disorder (SUD) Treatment.

Pursuant to section 25.5-4-214, C.R.S., on or before November 1, 2017, the Department of Health Care Policy and Financing (the Department) shall prepare a written report with assistance from the Department of Human Services' Office of Behavioral Health concerning the feasibility of providing residential and inpatient substance use disorder treatment as part of the Medicaid program. In addition, the report must also include an analysis of providing residential and inpatient substance use disorder treatment as a state-funded benefit rather than through the Medicaid program.

The Department contracted with Colorado Health Institute to conduct the research, interview stakeholders and, in collaboration with the Department's budget team, provide a financial model of the potential costs of an added residential and inpatient SUD benefit. The Department considered a number of factors as specified in the legislation to inform the final report, including the prevalence of opioid addiction and other substance use disorders in Colorado, evidence-based practices for the treatment of substance use disorders, the current publicly-funded Colorado system for SUD treatment, any gaps in services currently available through state or federal funding and the federal authorizations necessary to include an enhanced SUD benefit.

The report identifies steps that may be necessary to implement a residential and inpatient SUD benefit, including a review of the current regulatory landscape, enhanced training requirements under Health First Colorado for the current SUD workforce, potential changes to state law and potential federal authority required. In addition to the final recommendations, the financial impacts to other systems are also considered, as well as any potential for long-term cost containment.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Zach Lynkiewicz, at Zach.Lynkiewicz@state.co.us or 720-854-9882.



Sincerely,



Susan E. Birch, MBA, BSN, RN
Executive Director

SEB/lr

Enclosure(s): HCPF 2017 Inpatient Substance Use Disorder Treatment Report

Cc: Representative Jessie Danielson, Vice-Chair, Public Health Care and Human Services Committee
Representative Marc Catlin, Public Health Care and Human Services Committee
Representative Justin Everett, Public Health Care and Human Services Committee
Representative Joann Ginal, Public Health Care and Human Services Committee
Representative Edie Hooton, Public Health Care and Human Services Committee
Representative Lois Landgraf, Public Health Care and Human Services Committee
Representative Kimmi Lewis, Public Health Care and Human Services Committee
Representative Larry Liston, Public Health Care and Human Services Committee
Representative Dafna Michaelson Jenet, Public Health Care and Human Services Committee
Representative Dan Pabon, Public Health Care and Human Services Committee
Representative Brittany Pettersen, Public Health Care and Human Services Committee
Representative Kim Ransom, Public Health Care and Human Services Committee
Legislative Council Library
State Library
John Bartholomew, Finance Office Director, HCPF
Gretchen Hammer, Health Programs Office Director & Community Living Office Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Chris Underwood, Health Information Office Director, HCPF
Dr. Judy Zerzan, Client and Clinical Care Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Zach Lynkiewicz, Legislative Liaison, HCPF





COLORADO
Department of Health Care
Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

November 7, 2017

The Honorable Joann Ginal, Chair
Health, Insurance, and Environment Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Representative Ginal:

Enclosed please find a legislative report to the House Health, Insurance, and Environment Committee from the Department of Health Care Policy and Financing on Inpatient Substance Use Disorder (SUD) Treatment.

Pursuant to section 25.5-4-214, C.R.S., on or before November 1, 2017, the Department of Health Care Policy and Financing (the Department) shall prepare a written report with assistance from the Department of Human Services' Office of Behavioral Health concerning the feasibility of providing residential and inpatient substance use disorder treatment as part of the Medicaid program. In addition, the report must also include an analysis of providing residential and inpatient substance use disorder treatment as a state-funded benefit rather than through the Medicaid program.

The Department contracted with Colorado Health Institute to conduct the research, interview stakeholders and, in collaboration with the Department's budget team, provide a financial model of the potential costs of an added residential and inpatient SUD benefit. The Department considered a number of factors as specified in the legislation to inform the final report, including the prevalence of opioid addiction and other substance use disorders in Colorado, evidence-based practices for the treatment of substance use disorders, the current publicly-funded Colorado system for SUD treatment, any gaps in services currently available through state or federal funding and the federal authorizations necessary to include an enhanced SUD benefit.

The report identifies steps that may be necessary to implement a residential and inpatient SUD benefit, including a review of the current regulatory landscape, enhanced training requirements under Health First Colorado for the current SUD workforce, potential changes to state law and potential federal authority required. In addition to the final recommendations, the financial impacts to other systems are also considered, as well as any potential for long-term cost containment.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Zach Lynkiewicz, at Zach.Lynkiewicz@state.co.us or 720-854-9882.



Sincerely,



Susan E. Birch, MBA, BSN, RN
Executive Director

SEB/lr

Enclosure(s): HCPF 2017 Inpatient Substance Use Disorder Treatment Report

Cc: Representative Daneya Esgar, Vice Chair, Health, Insurance and Environment Committee
Representative Susan Beckman, Health, Insurance and Environment Committee
Representative Janet Buckner, Health, Insurance and Environment Committee
Representative Phil Covarrubias, Health, Insurance and Environment Committee
Representative Steve Humphrey, Health, Insurance and Environment Committee
Representative Dominique Jackson, Health, Insurance and Environment Committee
Representative Chris Kennedy, Health, Insurance and Environment Committee
Representative Lois Landgraf, Health, Insurance and Environment Committee
Representative Susan Lontine, Health, Insurance and Environment Committee
Representative Kim Ransom, Health, Insurance and Environment Committee
Legislative Council Library
State Library
John Bartholomew, Finance Office Director, HCPF
Gretchen Hammer, Health Programs Office Director & Community Living Office Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Chris Underwood, Health Information Office Director, HCPF
Dr. Judy Zerzan, Client and Clinical Care Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Zach Lynkiewicz, Legislative Liaison, HCPF





COLORADO
Department of Health Care
Policy & Financing

Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203

November 7, 2017

The Honorable Brittany Pettersen, Chair
Opioid and Other Substance Use Disorders Interim Study Committee
200 E. Colfax Avenue
Denver, CO 80203

Dear Representative Pettersen:

Enclosed please find a legislative report to the Opioid and Other Substance Use Disorders Interim Study Committee from the Department of Health Care Policy and Financing on Inpatient Substance Use Disorder (SUD) Treatment.

Pursuant to section 25.5-4-214, C.R.S., on or before November 1, 2017, the Department of Health Care Policy and Financing (the Department) shall prepare a written report with assistance from the Department of Human Services' Office of Behavioral Health concerning the feasibility of providing residential and inpatient substance use disorder treatment as part of the Medicaid program. In addition, the report must also include an analysis of providing residential and inpatient substance use disorder treatment as a state-funded benefit rather than through the Medicaid program.

The Department contracted with Colorado Health Institute to conduct the research, interview stakeholders and, in collaboration with the Department's budget team, provide a financial model of the potential costs of an added residential and inpatient SUD benefit. The Department considered a number of factors as specified in the legislation to inform the final report, including the prevalence of opioid addiction and other substance use disorders in Colorado, evidence-based practices for the treatment of substance use disorders, the current publicly-funded Colorado system for SUD treatment, any gaps in services currently available through state or federal funding and the federal authorizations necessary to include an enhanced SUD benefit.

The report identifies steps that may be necessary to implement a residential and inpatient SUD benefit, including a review of the current regulatory landscape, enhanced training requirements under Health First Colorado for the current SUD workforce, potential changes to state law and potential federal authority required. In addition to the final recommendations, the financial impacts to other systems are also considered, as well as any potential for long-term cost containment.

If you require further information or have additional questions, please contact the Department's Legislative Liaison, Zach Lynkiewicz, at Zach.Lynkiewicz@state.co.us or 720-854-9882.



Sincerely,



Susan E. Birch, MBA, BSN, RN
Executive Director

SEB/lr

Enclosure(s): HCPF 2017 Inpatient Substance Use Disorder Treatment Report

Cc: Senator Kent Lambert, Vice Chair, Opioid and Other Substance Use Disorders Interim Study Committee
Senator Irene Aguilar, Opioid and Other Substance Use Disorders Interim Study Committee
Senator Cheri Jahn, Opioid and Other Substance Use Disorders Interim Study Committee
Senator Kevin Priola, Opioid and Other Substance Use Disorders Interim Study Committee
Senator Jack Tate, Opioid and Other Substance Use Disorders Interim Study Committee
Representative Perry Buck, Opioid and Other Substance Use Disorders Interim Study Committee
Representative Chris Kennedy, Opioid and Other Substance Use Disorders Interim Study Committee
Representative Clarice Navarro, Opioid and Other Substance Use Disorders Interim Study Committee
Representative Jonathan Singer, Opioid and Other Substance Use Disorders Interim Study Committee
Legislative Council Library
State Library
John Bartholomew, Finance Office Director, HCPF
Gretchen Hammer, Health Programs Office Director & Community Living Office Director, HCPF
Tom Massey, Policy, Communications, and Administration Office Director, HCPF
Chris Underwood, Health Information Office Director, HCPF
Dr. Judy Zerzan, Client and Clinical Care Office Director, HCPF
Rachel Reiter, External Relations Division Director, HCPF
Zach Lynkiewicz, Legislative Liaison, HCPF



Exploring Options for Residential and Inpatient Treatment of Substance Use Disorder in Health First Colorado

A Report to the General Assembly
in Response to House Bill 17-1351

NOVEMBER 2017



COLORADO HEALTH INSTITUTE

Informing Policy. Advancing Health.

Acknowledgements

The Colorado Health Institute would like to thank all stakeholders who participated in developing of this report:

- Advocates for Recovery
- Center for Dependency, Addiction and Rehabilitation
- Colorado Behavioral Healthcare Council
- Colorado Consortium for Prescription Drug Abuse Prevention
- Colorado Hospital Association
- Colorado Providers Association
- Colorado Society of Addiction Medicine
- Denver CARES Detoxification and Drug and Alcohol Rehabilitation
- Foothills Behavioral Health
- Signal Behavioral Health Network
- Virginia Department of Medical Assistance Services
- West Pines Behavioral Health

We would also like to thank staff from the Department of Health Care Policy and Financing and Department of Human Services for their input and guidance.

CHI members who contributed to this report:

- Teresa Manocchio, lead researcher
- Brian Clark
- Chrissy Esposito
- Cliff Foster
- Deborah Goeken
- Joe Hanel
- Emily Johnson
- Emily Morian-Lozano
- Adrian Nava
- Ian Pelto
- Sara Schmitt
- Jackie Zubrzycki

Exploring Options for Residential and Inpatient Treatment of Substance Use Disorder in Health First Colorado

A Report to the General Assembly
in Response to House Bill 17-1351

Exploring Options for Residential and Inpatient Treatment of Substance Use Disorder in Health First Colorado

A Report to the General Assembly
in Response to House Bill 17-1351

Contents

Executive Summary **6**

Introduction **8**

The Problem in Colorado **8**

Assessing Current Capacity **12**

The Evidence for Effective Treatment **17**

Understanding the Regulatory Landscape **22**

Costs and Benefits: A Financial Model **24**

Steps to Implementation **27**

Conclusion **30**

Appendices **31**

Appendix A. House Bill 17-1351 Final Signed Act **32**

Appendix B. Comparison of Residential and Inpatient SUD Treatment **40**

Appendix C. Training Requirements for Certified Addiction Counselors (CACs) and Licensed Addictions Counselors (LACs) **41**

Appendix D. ASAM Criteria for Inpatient and Residential SUD Treatment **42**

Appendix E. Details on Other States with Existing 1115 Waivers That Include Residential or Inpatient SUD Treatment **43**

Appendix F. Methodology **44**

Appendix G. Centers for Medicare & Medicaid Services: New Service Delivery Opportunities for Individuals with a Substance Use Disorder **50**

Appendix H. Mental Health and Substance Use Services Maps **66**

Endnotes **71**

Twenty Questions

HB17-1351 directed the Department of Health Care Policy and Financing to answer 20 specific questions about the possibility of a residential and inpatient substance use treatment benefit in Health First Colorado. Here are the questions, listed under the sections of this report in which they are addressed.

The Problem in Colorado

- What is the prevalence of substance use disorders (SUDs) in Colorado?

Assessing Current Capacity

- Can facilities currently providing residential and inpatient SUD treatment provide those services under the Medicaid program?
- What changes to training requirements for certified addiction counselors are necessary to implement effective SUD treatment and meet federal requirements for Medicaid providers?

The Evidence for Effective Treatment

- What are the evidence-based best practices for the treatment of substance use disorders?
- What is residential and inpatient substance use disorder treatment?
- What state costs for Medicaid and other public assistance programs may be avoided if residential and inpatient substance use disorder treatment is included under Medicaid?
- How many county law enforcement contacts occur with people using drugs or alcohol and how many people enter county jails with SUD?
- How does access to inpatient and residential substance use disorder treatment impact recidivism and law enforcement resources?

Understanding the Regulatory Landscape

- What are the eligibility criteria for publicly funded residential and inpatient SUD treatment?
- What residential and inpatient SUD treatment not currently included in Colorado's Medicaid program could be provided by the state as an optional benefit or through a federal waiver?

- What federal authorization is necessary to include residential and inpatient SUD treatment as a benefit under Colorado's Medicaid program?
- What is known about other states providing residential and inpatient SUD treatment as part of their Medicaid program and what are the experiences related to implementation, cost, savings and efficacy?

Costs and Benefits: A Financial Model

- Compare the treatment and administrative costs of providing inpatient and residential services using Medicaid dollars or state funding.
- What is the estimate of state costs associated with residential and inpatient substance use disorder treatment as part of the Medicaid program?
- What is the estimate of the number of Medicaid clients who may be eligible for the benefit if it were included as part of the Medicaid program?
- How many emergency room visits or hospital stays by Medicaid clients are related to substance use disorders?
- What is the most effective use of state and federal funding in administering all substance use disorder programs and treatment options in Colorado?

Steps to Implementation

- What is the expected time frame for implementing an inpatient and residential SUD treatment benefit under the Medicaid program? What about other planning or implementation considerations?
- How can coordination be improved among state agencies in administering all SUD program and treatment options in Colorado?
- What changes to state law are necessary to implement the residential and inpatient SUD treatment benefit as part of the Medicaid program?

Executive Summary

Increased attention to substance use disorder (SUD) has led to interest at both the federal and state government levels in expanding the range of treatment services available through Medicaid.

SUD is a chronic, relapsing condition that requires professional, evidence-based treatment to sustain recovery, and more is being learned about SUD and its treatment options every year. Only about 10 percent of people nationally with SUD receive any type of treatment. Of those receiving treatment, fewer still are receiving quality, evidence-based care.

Experts interviewed for this report agree that Health First Colorado has a gap in the range of covered SUD services. Less intensive treatments, such as outpatient therapy, are covered, as is inpatient detoxification for patients with the most acute medical problems. But residential and other inpatient treatment programs are not covered because of a federal prohibition on the use of matching funds for services in certain settings.

Residential treatment provides a safe and stable 24-hour environment for patients who do not need acute medical support but do need the structure of this type of environment, including treatment for any co-occurring mental health and general health needs. Inpatient treatment is more medically intensive and includes 24-hour nurse monitoring to stabilize people in acute withdrawal.

Federal guidance issued in 2015 points the way for states to obtain waivers to offer residential and inpatient treatment for SUD and receive federal matching funds for these services. Colorado's General Assembly passed House Bill 17-1351 directing the Department of Health Care Policy and Financing (Department) to study this option. The Department contracted with the Colorado Health Institute to help examine the issue.

This report fulfills HB 17-1351's charge to the Department. It examines the problem of SUD in Colorado; the state's capacity to address the problem through residential and inpatient SUD treatment services under Health First Colorado; the evidence behind treatment programs; a look at the current regulatory landscape; estimated costs and benefits of adding the services; and potential

steps to implementing a waiver to cover residential and inpatient services if the legislature chooses to authorize these services.

It concludes there is a gap in the continuum of care for Health First Colorado enrollees age 21 or older with SUD and lays out numerous considerations for adding residential and inpatient services for SUD to the program.

- **The Problem:** An estimated half a million Coloradans are dependent on alcohol or have used illicit drugs, and about 142,000 of them are enrolled in Health First Colorado. Alcohol remains the most abused substance in Colorado, but a surge of overdose deaths by people who use opioids has focused attention on SUD. Data also show that Medicaid enrollees have slightly higher rates of SUD than non-Medicaid enrollees.
- **Capacity:** Colorado likely lacks sufficient capacity to handle increased demands for residential and inpatient treatment through Health First Colorado, particularly residential treatment. Based on the key informant interviews and the state of Virginia's experiences implementing a residential and inpatient benefit in Medicaid, reimbursement from Medicaid and higher reimbursement rates could increase the number of available beds. Colorado's addictions professionals who may be providing services in residential and inpatient settings also would need to meet the criteria to enroll as Health First Colorado providers, potentially requiring additional training, graduate-level education and licensure for those who currently have only a bachelor's degree and certification.



- **Evidence:** Multiple studies show the benefits of SUD treatment on individual lives, government spending and recidivism rates in the justice system. Studies have found that residential treatment for SUD, just one of a continuum of treatment options, has either no effect or an improved effect on drug and alcohol use, employment, medical/social problems and other outcomes, as compared with other types of treatment. Key informants said a gap in currently covered services for Medicaid enrollees limits providers' abilities to provide the full continuum of needed treatment. Treating SUD requires a personal and individualized approach, and not every person struggling with SUD requires a residential level of care.
- **Regulatory Landscape:** All Medicaid enrollees meeting medical necessity criteria would be eligible for publicly funded residential or inpatient SUD treatment if a residential or inpatient benefit were added to Medicaid. In order to draw down matching federal funds for an added residential or additional inpatient SUD treatment to Health First Colorado's benefits, the Department would need to seek a Section 1115 waiver from the federal government.
- **Costs and Benefits:** CHI built a financial model to project additional costs and savings if residential and inpatient treatment benefits were offered by Health First Colorado.
- **Steps to Implementation:** Successful pursuit of a waiver, including implementation of the benefit, is likely to require at least two years, with multiple steps and analyses to perform.

After conducting research of the evidence, interviewing stakeholders and experts across the state, and creating a predictive model of the costs and benefits, this analysis finds that Colorado could potentially benefit from an adult SUD residential and inpatient treatment benefit in Health First Colorado.

CHI estimates that a benefit potentially could be implemented as soon as July 1, 2020. State costs could grow an estimated \$34 million in the first year to serve approximately 17,000 Medicaid enrollees and up to \$43 million by year five to serve 20,800 people. We estimate this could result in 7,600 fewer ED visits and 1,700 fewer hospitalizations in the first year following the benefit implementation.

The estimate includes a series of assumptions that are detailed in Appendix F. Any changes to the assumptions could lead to significantly different cost estimates. Research suggests there may be savings to employers and the criminal justice system (see page 21), but we are unable to quantify them with the available data.

Introduction

Recent federal guidance for Medicaid allows states to offer a residential and inpatient treatment benefit for adults with SUD. This type of treatment currently is not covered by Health First Colorado, and offering it could fill a gap in the continuum of services that help Coloradans recover from SUD.

The General Assembly is interested in exploring how this benefit would work in Colorado. Governor John Hickenlooper signed House Bill 17-1351 into law on June 2, 2017. The law directs the Colorado Department of Health Care Policy and Financing (the Department) to examine the feasibility of adding residential and inpatient treatment options to Health First Colorado, the state's Medicaid program.

The Department contracted with the Colorado Health Institute (CHI) to examine the issue and answer specific questions posed in HB17-1351. CHI constructed a financial model to help estimate the costs and benefits of offering a residential and inpatient treatment benefit for SUD.

The model concludes that offering this benefit could increase spending by Health First Colorado over a 10-year time frame. A more detailed actuarial analysis may point to additional savings that could help offset the costs and support a cost-neutral estimate, as required by the federal waiver that would be needed to add residential and additional inpatient treatment for SUD to Health First Colorado.

However, financial projections are just one consideration. The federal waiver comes with many of its own considerations for both the Department and the General Assembly, such as specific program criteria, evaluation criteria and quality measures. Additionally, CHI's analysis and key informant interviews highlight deficits in the current workforce and facility capacity, all of which will take time to address.

CHI used published research, data analysis and interviews with a wide range of stakeholders to produce this report and its considerations. CHI conducted 10 interviews of state experts, including providers (health care, mental health and substance use), consumer advocates, insurers and state agency staff.

CHI also spoke with staff in Virginia about their experiences securing and implementing an 1115 Medicaid waiver to offer residential and inpatient SUD treatment services. For the purposes of this analysis, CHI focused on Virginia as the closest approximation of Colorado's landscape, but there are four additional states with approved waivers that should also be consulted if the legislature chooses to move forward with this benefit. There are also seven other states with pending waivers that could have insights to offer as well.

A full list of the participating stakeholders is included in the acknowledgements section on page 2.

Data was acquired from the Department and the Office of Behavioral Health (OBH) at the Colorado Department of Human Services (CDHS) where available. Published literature was extracted from a wide variety of journals and respected scientific agencies and bolstered by state and national survey data, including the Colorado Health Access Survey and the National Survey on Drug Use and Health.

The Problem in Colorado

Alcohol and drug dependency have been persistent challenges for Colorado residents.

Approximately 7.5 percent of Coloradans age 12 and older in 2014-15 abused or were dependent on alcohol in the previous year, according to the National Survey on Drug Use and Health (NSDUH).

In that same time period, 2.9 percent abused or were dependent on illicit drugs, defined as cocaine (including crack), marijuana, heroin, hallucinogens, inhalants and prescription drugs used non-medically.¹

Colorado's rates of drug and alcohol abuse and dependence are slightly higher than the national average. While the 2014-15 rates of use in Colorado were slightly lower than in previous years, the change was not statistically significant. But some substances have seen increases in use over time: Rates of heroin dependence, for instance, increased dramatically in Colorado between 2003 and 2014.

These rates reflect a substantial number of Coloradans abusing alcohol or using illicit drugs — half a million people. In 2013 and 2014, some 128,000 Coloradans 12 and older had used illicit drugs in the year before they were surveyed, according to the

NSDUH, and some 329,000 reported abusing or being dependent on alcohol.²

Data from the Department shows that approximately 142,000 Medicaid enrollees, or about 11 percent of all enrollees in FY 2015-16, had a SUD diagnosis as either a primary or secondary diagnosis.³

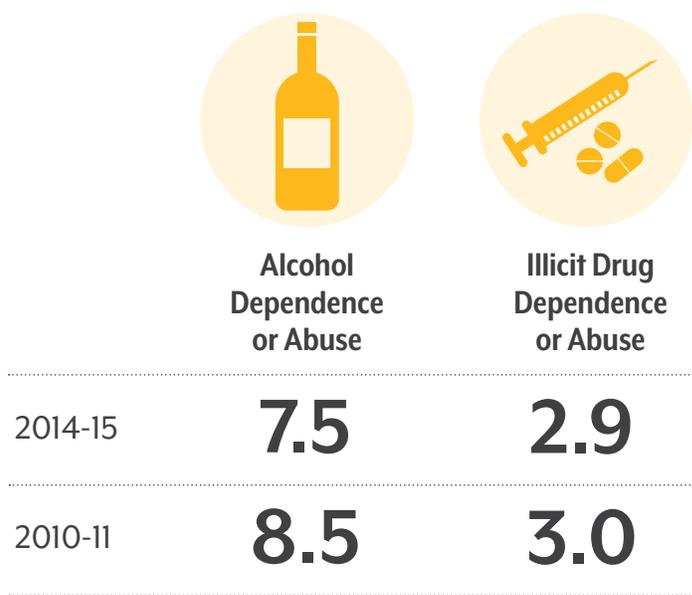
Meanwhile, deaths due to drug overdoses have increased in the state: In 2016, a record 912 Coloradans died of a drug overdose, according to the Colorado Department of Public Health and Environment. The rate of overdoses has increased over time: In 2000, there were 7.8 deaths per 100,000 residents, and in 2016, 16.1 Coloradans per 100,000 residents died due to a drug overdose.

All in all, a total of 11,464 Colorado residents died due to a drug overdose between 2000 and 2016.⁴ In almost every year, the rate of drug overdoses in Colorado was higher than the national average.

In 2015, about 23 percent of Coloradans were enrolled in Medicaid. In that same year, 259 Coloradans died of a prescription drug overdose, and 87 of those overdoses were Medicaid enrollees, or about 34 percent of prescription drug overdose deaths. Additionally, Medicaid enrollees accounted for 29 percent of all drug overdose deaths in 2015.⁵

But those who died due to an overdose are just a fraction of the thousands who report substance abuse or dependence and who might benefit from residential or inpatient treatment for alcohol or drug use. National data indicate that the opioid epidemic in particular disproportionately impacts Medicaid enrollees. Enrollees have higher rates of opioid use disorder than the commercially insured, but they also

Table 1. Percentage of Coloradans 12 or Older Reporting Alcohol and Drug Dependency in the Previous Year



Source: National Survey on Drug Use and Health

have higher treatment rates than the commercially insured.⁶

While opioid addiction and deaths due to overdoses have attracted well-deserved public attention, the most common substance use challenge in Colorado is alcohol. Across all age groups in Colorado, NSDUH data show that more Coloradans report abuse or dependence on alcohol than all other substances, including marijuana.

Table 2. Past Year Abuse or Dependence on Pain Relievers and Heroin

Annual Average Numbers, Ages 12 and Older. Rates per 1,000

	2003-2006		2007-2010		2011-2014	
	Number	Rate	Number	Rate	Number	Rate
Pain Relievers	30,000	7.9	18,000	4.5	19,000	4.5
Heroin	1,000	0.2	2,000	0.6	4,000	1.0
All Opioids	31,000	8.1	19,000	4.8	22,000	5.0

* Pain relievers + heroin will not sum to all opioids because individuals may report multiple drugs. Source: National Survey on Drug Use and Health

Geography

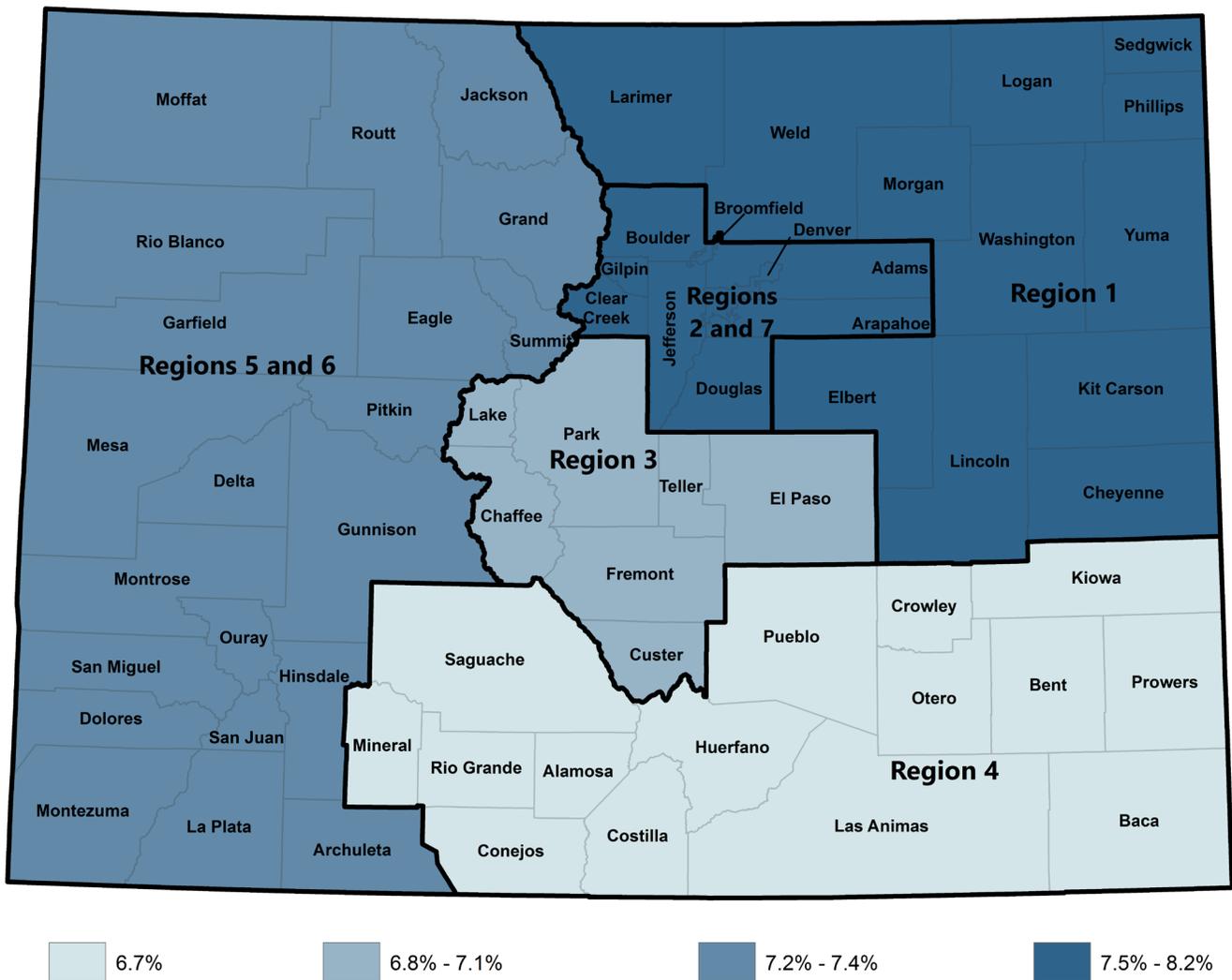
Counties in northeast Colorado, metro Denver and northern Front Range have the highest rates of alcohol and drug dependence as compared with the rest of Colorado, according to NSDUH regional estimates.

The highest rates of alcohol dependence or abuse in Colorado are regions 2 and 7 – metro Denver and surrounding counties – with a rate of 8.2 percent. The

northeast corner of the state is the second highest at 8.0 percent. The southeast corner, region 4, comes in at the lowest, with 6.7 percent (See Map 1).⁷

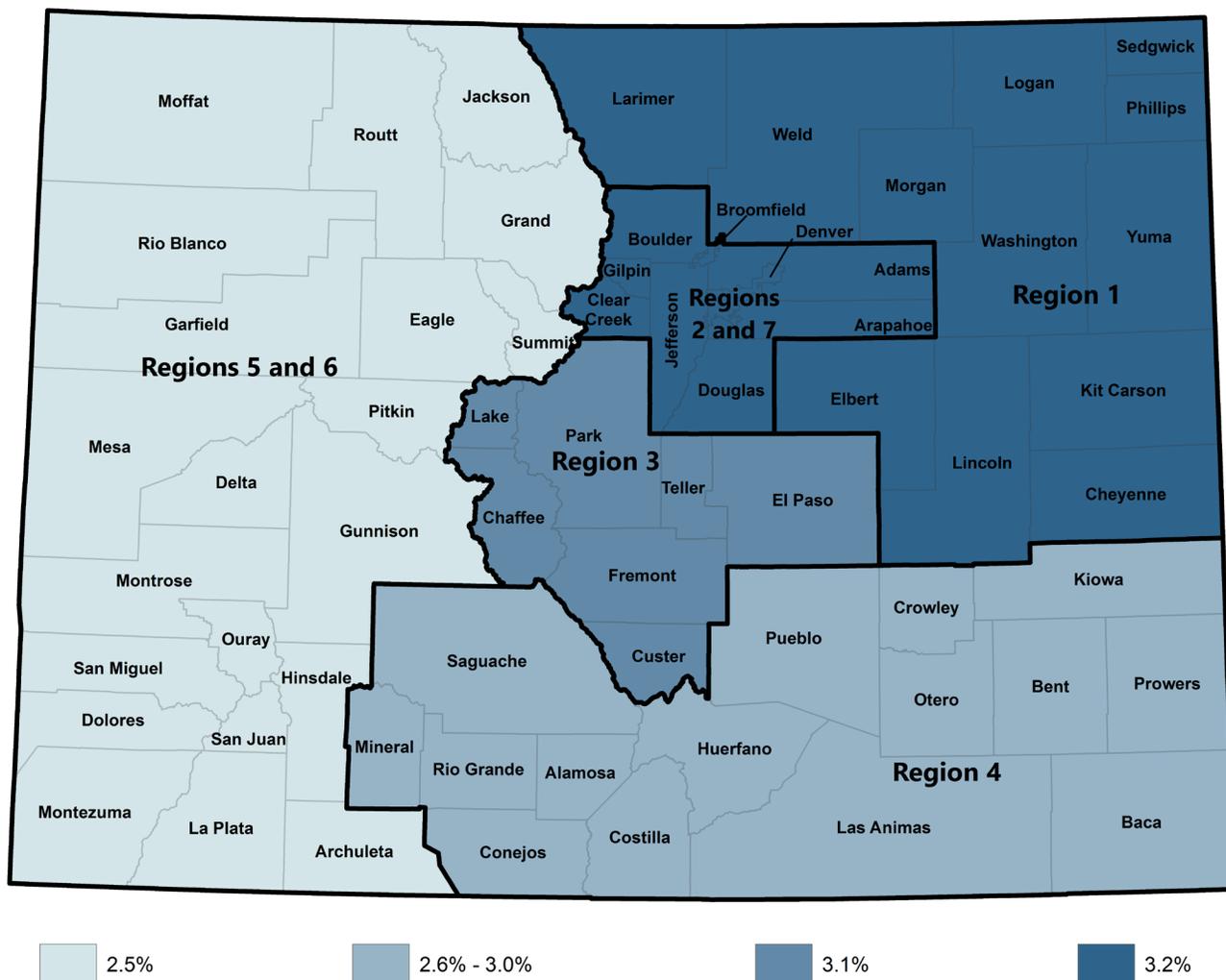
The northeast corner and the metro Denver region have the highest rates of reported illicit drug dependence or abuse, at 3.2 percent. The western regions 5 and 6 have the lowest, at 2.5 percent. (See Map 2.) Illicit drugs are defined as cocaine (including crack), heroin, hallucinogens, inhalants and non-medical use of prescription opioids.⁸

Map 1. Alcohol Dependence or Abuse in the Past Year Among Individuals Age 12 or Older, by Substate Region (2012-2014)



Source: National Survey on Drug Use and Health

Map 2. Illicit Drug Dependence or Abuse in the Past Year Among People Age 12 or Older, by Substate Region (2012-2014)



Source: National Survey on Drug Use and Health

Coloradans in Need of Treatment

Colorado has unmet needs for SUD treatment.

More than 67,000 Coloradans needed some type of treatment for drug or alcohol use but didn't receive it, according to the 2017 Colorado Health Access Survey (CHAS). The survey question covered only people who said they need SUD treatment. Many more Coloradans need treatment but do not know it or are not ready to seek it. From 2010-14, approximately 10.9 percent of Coloradans who needed treatment for alcohol abuse or dependence received it, and 15.7 percent who needed treatment for illicit drug use received it.⁹

In Colorado, Health First Colorado enrollees are twice as likely to report needing treatment for drug or alcohol use but not getting it – about 2.9 percent of enrollees compared with 1.2 percent of people who are commercially insured.

Using September 2017 caseload data from the Department, that means an estimated 39,000 Medicaid members say they did not receive needed SUD treatment.

More than half (54.1 percent) of survey respondents – covering both Health First Colorado enrollees and non-enrollees – who said they weren't getting needed treatment said it was because of the cost. Nearly as

many, 52.8 percent, said they didn't think their health insurance would cover it. More than four of 10 (43.9 percent) said they were worried about someone finding out.

Two of 10 (20.5 percent) reported having a hard time getting an appointment, according to the CHAS.¹⁰

This survey question allows a peek at the unmet need for SUD treatment in Colorado. The next section addresses the ability of Colorado providers to meet the need for residential and inpatient treatment specifically.

Assessing Current Capacity

CHI estimates that Colorado's substance use treatment facilities could serve up to 5,256 people with a 15-day inpatient stay and 15,525 people with a 30-day residential stay.

Current capacity is inadequate to serve the number of Colorado Medicaid enrollees who CHI estimates would seek residential or inpatient treatment, particularly residential treatment. In addition, 28 counties lack treatment facilities. Additional supports such as transportation may be needed for enrollees in those counties who could require a residential level of care but do not live near a qualified provider.

Several key informants interviewed for this report expressed concerns that Colorado facilities may have limited capacity to meet future needs if reimbursement for these services is deemed inadequate.

Colorado's current addictions workforce comprises individuals with either a high school diploma or bachelor's degree and a level I, II or III certification. A focus is needed on continuing education opportunities in addictions for master's-educated and licensed mental health clinicians to ensure that comprehensive assessment and treatment interventions are available to people with SUD and co-occurring mental health concerns.

Colorado's addictions professionals who may be providing services in residential and inpatient settings also would need to meet the criteria to enroll as Medicaid providers, potentially requiring additional training, graduate-level education and licensure for those who currently have only a bachelor's degree and certification.

Residential and Inpatient Treatment Options for SUD in Colorado

Residential and inpatient treatment for SUD aim to meet the distinct needs of individual patients and specific clinical guidelines. Residential and inpatient treatment programs have specific staffing levels, services and outcomes, according to the American Society of Addiction Medicine (ASAM).

Residential Treatment

Residential treatment provides a safe and stable 24-hour environment for patients who don't need acute medical support. Staff are available for SUD treatment, mental health treatment and general health needs. Residential treatment also includes long-term (15 days or more) rehabilitation services. It is typically lengthier than inpatient treatment and is provided in non-hospital settings¹¹ such as freestanding residential facilities licensed by OBH, the state agency that oversees substance use services. The managed service organizations (MSOs), which OBH contracts with to provide SUD services, work with some licensed facilities to reimburse for residential services for low-income Coloradans.

Treatment in a residential setting must include a wide range of evidence-based services to be effective. Patients typically stay 28 days, although some programs are shorter or longer.¹² The 28-day duration is not based on scientific evidence, but rather appears to reflect estimates of how long it takes people to stabilize and how much treatment insurance will typically cover.¹³ These services are not currently covered for adult enrollees by Health First Colorado due to a federal prohibition on drawing down matching funds for services in residential settings.

Inpatient Treatment

Inpatient treatment for SUD, often characterized as more medically intensive than residential treatment, includes 24-hour nurse monitoring.¹⁴ In Colorado, this type of treatment is delivered in hospitals for people who require acute medical support while withdrawing from a substance. Withdrawal is often accompanied by depression, body tremors, vomiting and insomnia, to name a few. Such symptoms typically require medical and nursing care to stabilize the patient physically and mentally.¹⁵

American Society of Addiction Medicine (ASAM) level 4.0, or medically managed intensive inpatient services, is covered by Health First Colorado when medically necessary. Health First Colorado is not authorized to cover ASAM level 3.7, or medically monitored intensive inpatient services (for a person with severe symptoms that require inpatient monitoring but not the full range of an acute care hospital).

Withdrawal Management

In addition to the two types of treatment described above, ASAM has criteria for three levels of withdrawal management (WM) care that can be delivered in either a residential or inpatient setting (3.2-WM, 3.7-WM and 4.0-WM). The best care for someone in withdrawal may range from a moderate level (24-hour support without the need for on-site medical personnel) to severe (medically unstable withdrawal that requires 24-hour nursing care and daily physician consultation).

The U.S. Department of Health and Human Services describes a suggested progression for rehabilitation for people with severe SUD. The progression begins with an initial withdrawal period in an inpatient treatment setting, as needed, followed by one-to-three months of residential treatment.¹⁶ Appendix B compares staffing, services and intended outcomes of both residential and inpatient treatment options.

Table 3. Number of Beds for Substance Use Treatment, 2015

Residential		Inpatient	
Number of Facilities	Range of Beds Reported	Number of Facilities	Range of Beds Reported
15	0 to 12	5	0 to 10
9	13 to 18	3	16 to 21
13	19 to 28	2	22 to 34
6	29 to 47	1	35+
6	48+	Min to Max Range	127 to 216
Min to Max Range	826 to 1,276		

Source: N-SSATS, 2015

Capacity – Number of Beds

Colorado has between 826 and 1,276 residential beds dedicated to substance use treatment, according to the National Survey of Substance Abuse Treatment Services (N-SSATS). (See Table 3.) Between 127 and 216 beds are designated for inpatient treatment of substance use, the survey found. (See Table 3.)¹⁷

The survey included 562 Colorado facilities in 2015. By the time the survey was issued in March 2017, 83 facilities (15 percent) had closed or no longer provided substance use treatment or detoxification services. Of the remaining 479 eligible facilities, 418 responded to the survey.

While the national survey is the most reliable and accurate data source for this information, it has limitations. It's possible there are actually fewer available beds to accommodate a new Medicaid benefit. Not all facilities included in the survey are eligible to participate in Health First Colorado. Participating facilities may limit the number of beds available to Medicaid enrollees.

At the same time, it's also possible that facilities may have expanded the number of beds available since the last survey was conducted. The lower end of the range also assumes that all facilities in the 0-to-10 bed range and 0-to-12 bed range have zero dedicated beds, and there is no way to identify whether that is zero or more than zero beds. Additionally, there is no

Table 4. Beds for Substance Use Treatment in Number of Days, 2015

Residential Beds			
	Beds	Days	Maximum Number of People Served*
Min	826	301,490	10,050
Max	1,276	465,740	15,525

Inpatient Beds			
	Beds	Days	Maximum Number of People Served**
Min	127	46,355	3,090
Max	216	78,840	5,256

* 30 day average length of stay ** 15 day average length of stay
Source: N-SSATS, 2015

way to know through the survey exactly how many beds are included in the 35+ and 48+ categories.¹⁸

Capacity – Number of Days

An estimated 10,050 to 15,525 people could receive residential treatment annually, assuming an average residential treatment stay of 30 days. (See Table 4).

Between 3,090 and 5,256 people could receive inpatient treatment annually, assuming an average inpatient stay of 15 days. (See Table 4.)

These estimates are based on no vacancy rates, meaning the beds are never empty. The estimates could shift significantly with vacancies or shifts in the average length of stay. Not every person struggling with SUD will require this level of care, including detox services. Careful third-party assessment that adheres to ASAM criteria would help ensure that those who truly needed and could benefit from these services would receive them if added to Health First Colorado.

Given these data, it is likely that current facility capacity would be unable to meet the estimated demand for beds that a new residential benefit would create. However, it is likely that existing inpatient capacity would be able to absorb the small number of additional enrollees estimated to take advantage of a new inpatient benefit, as those who require

medically managed inpatient services are already receiving them — either in a bed designated for substance use or in a general hospital.

Geography

Colorado has regional differences in the number of treatment facilities. Most are concentrated along the Front Range and population centers. Large parts of the state do not have any.

Even if the number of current beds were sufficient to accommodate the number of clients who might need these services, their availability is not widespread enough to serve people in rural parts of the state (see Map 3).

Twenty-eight counties do not have OBH-licensed residential and inpatient SUD treatment facilities, community mental health centers, opioid treatment programs, medication-assisted treatment providers or Special Connections providers. These counties include areas of the San Luis Valley, southeast Colorado and northern Colorado.

Below are a number of considerations in expanding treatment capacity and enhancing training so providers can be as effective as possible if residential and inpatient treatment options are authorized by the legislature.

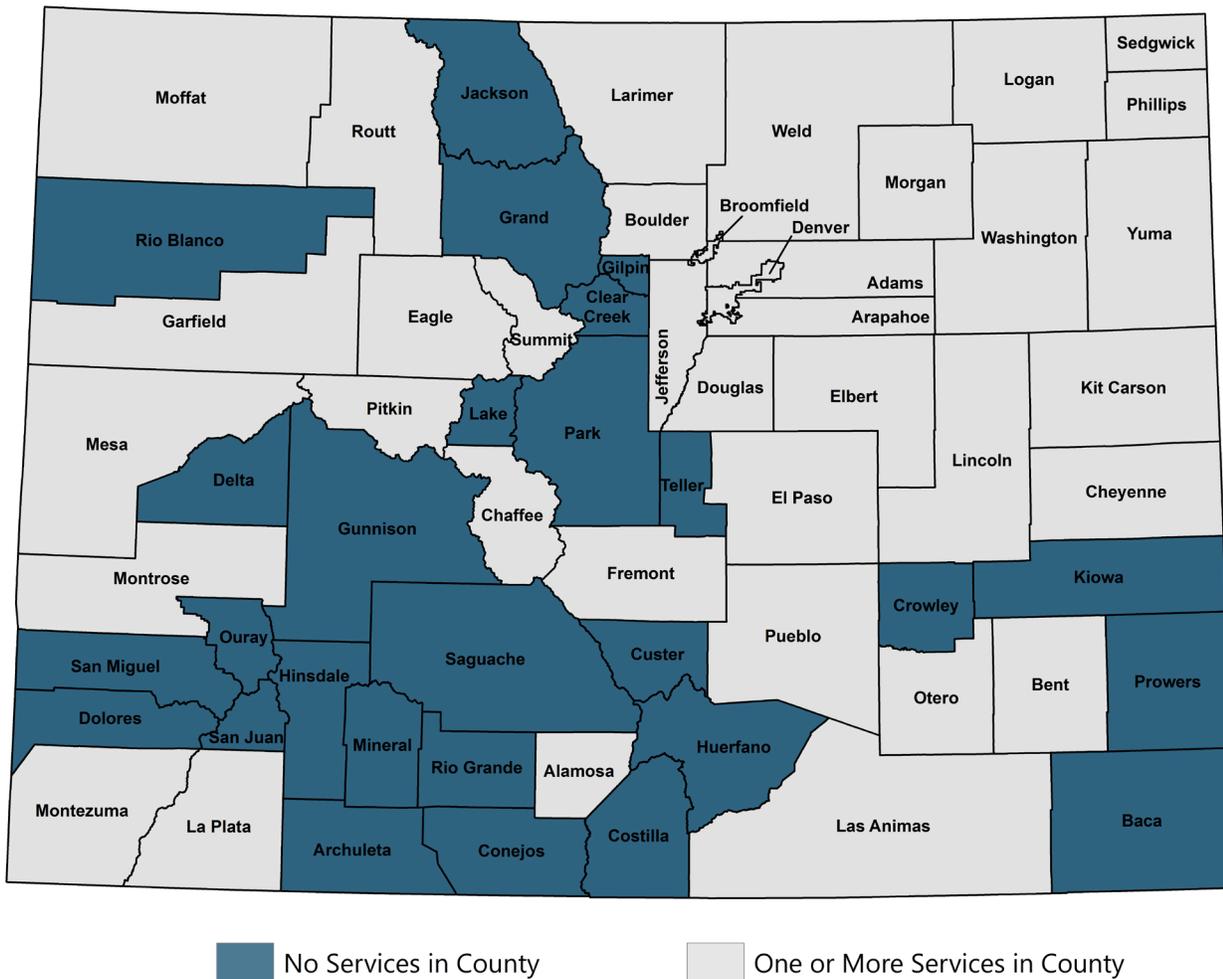
Provider and Facility Considerations

- If the legislature authorizes the Department to seek approval for and implement a residential or inpatient SUD benefit, this would become a new medical benefit, and not all current substance use providers are qualified to enroll in Medicaid. The Department and OBH should continue to work together on outreach to and enrollment of eligible OBH facilities into Medicaid. The Department and the new Regional Accountable Entities (RAEs) would need to contract with and reimburse only for residential or inpatient services that are delivered in

Special Connections

The Special Connections program provides case management, counseling and health education to pregnant Health First Colorado enrollees with substance use problems.

Map 3. Mental Health and Substance Use Services Combined



Source: Office of Behavioral Health

qualified OBH-licensed facilities that also meet the conditions of participation in Medicaid.

- Robust provider outreach and training may need dedicated funding as well and could take time to enact. The Department can consider requiring facilities that are not Health First Colorado providers to complete trainings or otherwise demonstrate that they are able to meet the ASAM criteria and Medicaid conditions of participation, and in so doing, offer these services (see breakout box on page 16 for example).
- Another consideration involves current Medicaid providers that treat enrollees with acute medical

conditions and SUD in an inpatient hospitalization setting under fee-for-service reimbursement. Many of these providers also have residential programs and will need to be contracted with the RAEs to serve Health First Colorado enrollees for the residential and inpatient detox side.

Residential and Inpatient Treatment Staffing Requirements and Considerations

SUD is a chronic, relapsing disease, much like any other chronic medical condition. However, most medical professionals are not trained to recognize or treat it. According to the National Center on

Addiction and Substance Abuse, medical schools have historically devoted little or no time to teaching addiction medicine to their students.

As a result, most medical professionals who should be providing SUD treatment are not doing so, and most who are providing SUD treatment are “not medical professionals and are not equipped with the knowledge, skills or credentials necessary to provide the full range of evidence-based services to address addiction effectively.”¹⁹

Colorado has historically taken a broader view on the appropriate level of training for addictions professionals and does not require either a medical degree or a graduate-level degree except for Licensed Addiction Counselors (LACs) (See Appendix C). CACs receive training specific to addictions but are not required to receive instruction that is comparable to master’s level training required of mental health practitioners.

A mental health practitioner in Colorado must have a graduate-level clinical degree and a license to provide diagnostic and treatment services reimbursable by private insurance and Health First Colorado. In addition to licensed psychologists (doctorate-level education), licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists and LACs (master’s-level education) are eligible for enrollment in Health First Colorado.

A Certified Addiction Counselor I (CAC I) is not eligible to independently practice and CAC IIs and CAC IIIs are not eligible for enrollment in Health First Colorado unless they also have a clinical graduate degree and a mental health or addictions license.

SUD and mental health issues frequently present as co-occurring conditions requiring training in both disciplines to effectively treat the individual struggling with SUD. Colorado’s addiction training program requires CACs II and III receive one course (14 hours) on trauma-informed care for diverse populations. Given the prevalence of trauma underlying or co-occurring with SUD (see next section: The Evidence for Effective Treatment), in-depth training on trauma assessment, with a particular emphasis on the relationship between trauma and SUD, is recommended for current and future CACs of all levels to ensure adequate preparation for effectively treating SUD.

To meet ASAM criteria for staffing and service

Lessons from Virginia

- The Commonwealth of Virginia noticed shortly after implementing its residential SUD treatment benefit that enrollees with court-ordered treatment were staying in residential services longer than was recommended. Virginia discovered that because the court ordered the enrollee into residential treatment, the provider could not discharge them to a lower level of care without enrollees violating the terms of their parole. Outreach to the judicial system is now ongoing so that courts order enrollees into assessment and placement as determined by an addiction professional. Colorado could avoid a similar issue by engaging the criminal justice system in its initial stages and on an ongoing basis to mitigate these types of unforeseen circumstances.



- The Virginia Department of Medical Assistance Services (DMAS) began provider outreach and training seven months before the benefit was implemented, and its work continues today, several months after implementation. DMAS collaborated with the Department of Behavioral Health and Developmental Services, which contracted with Train for Change. This is a program that offers courses in assessments, case management and quality assurance skill-building for clinicians. It also offers sessions for non-clinical managers and sessions to train coaches who will provide ongoing continuity to assure Virginia providers are trained in and using the ASAM criteria. DMAS also contracted with a vendor to perform site visits and certify if its residential treatment services providers met the criteria for each residential or inpatient ASAM level for credentialing with Virginia’s Medicaid health plans and its behavioral health services administrator. This allowed for consistency across health plans and the administrator in credentialing providers at the same ASAM levels for residential services.

requirements in residential facilities, there must be appropriately credentialed clinical staff, such as licensed addictions counselors, licensed professional counselors and licensed social workers to perform assessment and treatment services for people with SUD. Physician support in-person or on-call is required. Allied health professionals, including counselors and group-living workers, provide residential oversight. In Colorado, these allied health professionals would include CACs I, II and III.

To comply with federal provider screening and enrollment regulations, the Department promulgated rules that stipulate the following:

- Health First Colorado providers who deliver services to enrollees as part of a managed care entity's provider network must be screened and enroll with the Department.
- All physicians or other professionals must be enrolled in order for claims to be submitted and reimbursed by the Department. This includes anyone who orders, prescribes, or refers services for Health First Colorado enrollees, whether as part of fee-for-service or as part of a managed care entity's provider network under either the state plan, the Children's Health Insurance Program or a waiver.
- As a condition of reimbursement, any claim submitted that was ordered, referred, or prescribed for a Medicaid client must contain the National Provider Identifier (NPI) of the ordering, referring or prescribing physician or other professional.

Community mental health centers (CMHCs) are an approved provider type in the Health First Colorado state plan and therefore serve as the rendering provider on claims for services performed under the CMHC by behavioral health practitioners who lack the credentials necessary to enroll in Medicaid.²⁰

Medicaid services provided in all other group provider settings, such as substance use disorder clinics, and potentially residential SUD facilities, by practitioners not enrolled in Medicaid must be supervised by and billed under a Medicaid enrolled practitioner who is documented as overseeing the member's course of treatment.

If the legislature and the federal government authorize a residential benefit under Health First Colorado, careful consideration of workforce requirements and eligibility to participate in Medicaid should be part of the design process.

The Evidence for Effective Treatment

Risk Factors

"Substance use disorders are not inevitable," according to former Surgeon General Vivek Murthy's 2016 Report on Alcohol, Drugs and Health.²¹

Prevention plays a key role in reducing SUD prevalence rates and overdose deaths. While there is no single factor that predicts whether a person will develop SUD, several factors can heighten the risk.

Adverse childhood experiences (ACEs) can put someone at risk for SUD later in life. ACEs are events such as physical abuse, substance abuse, mental illness and neglect during the first 18 years of life.²² ACE scores, based on a scale of zero to 10, are used to assess cumulative childhood stress. Traumatic experiences as a child or teenager result in higher ACE scores.

Research finds that higher ACE scores correspond with a greater risk of smoking, illicit drug use, alcohol abuse and other unhealthy behaviors. They are also correlated with the risk of heavy drinking, alcoholism and marrying an alcoholic.²³ And those with the highest scores — five or more ACEs — are more likely to report SUD or other illicit drug use problems.²⁴

Treatment for people with SUD is highly individualized and personal. Not everyone will benefit from the same type of treatment, and certain treatments show different levels of effectiveness with different substances. The Surgeon General's report indicates that a range of personal considerations should be factored into a person's treatment plan, including history of trauma, co-occurring mental and physical health conditions, age and gender, among others. Understanding each individual's circumstances can help a professional tailor treatment options and ultimately achieve better outcomes.²⁵

Next, we will delve into a summary of evidence-based treatment approaches for SUD, including the evidence related to residential treatment.

Treatment Approaches, Settings and Outcomes: A Summary of the Evidence

Helping a person with SUD sustain recovery is a lifelong process that requires close collaboration with his or her multidisciplinary care team.²⁶ Data show

that while effective treatment options exist for SUD, only about one in 10 people who need SUD treatment receive it — meaning more than 20 million people nationally do not receive needed SUD treatment. A 2012 study found that of those who are receiving treatment, “few receive anything that approximates evidence-based care.”²⁷

Evidence-based treatment options for people with SUD depend on several factors, including the type of substance, the stability of their home life, what their health insurance will cover and the presence of mental health issues or other medical concerns.

For people in acute withdrawal, either a freestanding detoxification center or an acute care general hospital may be required to medically manage the symptoms before they are able to transition to a residential or outpatient treatment option. People with less severe symptoms can be treated in an outpatient setting with regular follow-up.

It typically takes a year or more of treatment to recover from SUD. For example, a person might begin in a medically managed withdrawal program, defined here as inpatient treatment, then move into residential treatment, followed by an intensive outpatient program and finally a traditional outpatient program. The person may cycle between levels of care as the severity of the SUD improves or worsens.²⁸

Evidence shows that some people may require inpatient, residential and outpatient treatment multiple times. Like most chronic conditions, any person struggling with SUD is at risk of relapsing. Relapse is not a treatment failure. Rather, it is part of the challenge of managing SUD — much like any other chronic condition.

The effectiveness of the treatment is an important variable in the determination of whether a residential or inpatient SUD benefit should be added. A summary of the effectiveness of several treatment approaches is below. There is wide variation in the level of effectiveness across approaches, which may be influenced by the population receiving the treatment and the professionals delivering it. Not all approaches will be effective for every patient or for every substance.

- **Cognitive-behavioral therapy:** A counseling technique that includes exploring consequences of drug use, self-monitoring for cravings, and

strategies to cope with cravings and other risks. This technique may be delivered in residential and outpatient settings, and the monitoring and craving recognition skills learned can continue to be employed by people after treatment has concluded. The evidence shows that these interventions are found to be quite effective but are further enhanced when combined with other behavioral or pharmacological components if available.²⁹ For example, one systematic review of several controlled trials found that participants in cognitive-behavioral therapy treatment (CBT) groups had better outcomes among several measures related to alcohol and drug use, manic-depressive symptoms and adherence to CBT sessions than non-CBT participants.³⁰

- **Community reinforcement plus incentives:** A 24-week outpatient program that uses social, vocational and financial incentives to encourage people to avoid drugs or alcohol. Individuals attend weekly counseling sessions and submit urine samples. Rewards for clean samples can include benefits such as retail vouchers. The evidence points to improved psychosocial functioning and abstinence among individuals who receive the community reinforcement plus vouchers compared with those who did not receive the vouchers.³¹ For example, one study of 40 cocaine-dependent adults showed that 75 percent of patients in a group that received vouchers completed 24 weeks of treatment, as opposed to 40 percent in the group without vouchers.³²
- **Motivational enhancement therapy:** A counseling technique geared toward rapid, self-motivated change. The counselor uses motivational interviewing techniques to strengthen the patient’s ability to handle high-risk situations and sustain recovery. It is often used with other behavioral interventions. The evidence shows more favorable outcomes for people dependent upon alcohol or marijuana when combined with cognitive-behavioral therapy but mixed results for people who use heroin, cocaine and nicotine. According to the National Institute of Drug Abuse (NIDA), “in general, MET seems to be more effective for engaging drug abusers in treatment than for producing changes in drug use.”³³
- **Pharmacotherapy:** Medications approved by the Food and Drug Administration and typically coupled with behavioral therapies or supports

Medications Used in SUD Treatment

Opioids:

Methadone, buprenorphine, naltrexone

Alcohol:

Acamprosate, disulfiram, topiramate, oral naltrexone

Tobacco:

Bupropion, varenicline, nicotine-replacement (patch, gum, spray, lozenge)

can be used for tobacco, alcohol and opioid use disorders. (See breakout box above.) This approach, called medication-assisted treatment (MAT), includes counseling as well as medical care, drug screening, social or family services, employment help and more. The evidence shows that MAT produces better outcomes than just behavioral treatments and that withholding medication for opioid use disorder in particular leads to increased risk of relapse and overdose.³⁴ For example, one study of heroin-related overdose deaths found that increasing the availability of MAT was associated with an estimated 50 percent decrease in fatal overdoses.³⁵

- **Peer support networks:** Peer support programs such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) have been in existence for decades. They focus on specific pathways to recovery rather than offering a variety of recovery and support options. Learning from peers is a central element of these programs. The Department of Health and Human Services defines these programs as recovery support services rather than medical treatments. Most research has been conducted on AA, and finds that participation promotes recovery, strengthens social networks, increases coping mechanisms and enhances psychological well-being. One study showed that cognitive-behavioral therapy combined with 12-step facilitation increased AA involvement and abstinence over a follow-up period, as opposed to cognitive-behavioral therapy alone.³⁶ There is less research on NA, but early evidence shows similar results.³⁷

Evidence for Residential Treatment

The behavioral and pharmacological therapies detailed above can be delivered in residential or outpatient treatment settings. Residential treatment is typically used for people with SUD or SUD and co-occurring mental health issues that need more structured care. Treatment occurs in non-hospital settings and provides a safe housing and recovery environment.

A systematic review of the evidence basis for residential treatment found that there are significant methodological challenges with many existing studies but that it can be effective for certain types of patients. The authors of the review concluded that there is a moderate level of evidence of effectiveness, meaning there was either an improvement or no difference in outcomes depending on the study. They also tentatively conclude that much of the literature suggests residential treatment is as or more effective as other modalities, but more research with rigorous methods is required.³⁸

Below is a summary of select studies reviewed and the effectiveness described in each study:

- **Treatment Outcomes of an Integrated Residential Programme for Patients with Schizophrenia and Substance Use Disorder (2011):** This study examined integrated treatment for patients with schizophrenia and co-occurring SUD in a residential setting compared with treatment as usual. The patients in the integrated residential setting showed considerable reductions in alcohol and illicit drug use, improved psychiatric symptoms and reported a higher quality of life. The study authors conclude that an integrated residential approach is superior to standard treatment for this patient group.³⁹
- **Client Matching: A Severity-Treatment Intensity Paradigm (2008):** This study provided empirical evidence for matching patients to treatment using the “least treatment intensity required.” The study defined the levels as 1) matched: appropriate for and received residential treatment, 2) overtreated: appropriate for outpatient but served in a residential setting and 3) undertreated: appropriate for residential and served in an outpatient setting. The results showed that undertreated clients showed less improvement compared with both matched and overtreated clients.⁴⁰

• **Treatment Setting and Baseline Substance Use Severity Interact to Predict Patients’ Outcomes (2007):** This is a study of mostly male patients enrolled in Veterans Affairs treatment programs, with follow-up an average of 6.7 months later. The authors examined whether patients with more severe SUD at intake respond better to more structured treatment (inpatient or residential) and whether patients with less severe SUD have similar outcomes regardless of their treatment setting. The study found that baseline severity predicted follow-up severity, with no main effect from the setting. The study does note interaction effects including more severe patients had better alcohol and drug outcomes following inpatient or residential treatment than following outpatient treatment.⁴¹

The authors examined whether patients with more severe SUD at intake respond better to more structured treatment (inpatient or residential) and whether patients with less severe SUD have similar outcomes regardless of their treatment setting. The study found that baseline severity predicted follow-up severity, with no main effect from the setting. The study does note interaction effects including more severe patients had better alcohol and drug outcomes following inpatient or residential treatment than following outpatient treatment.⁴¹

ASAM Levels of Care

The ASAM levels of care define the types of services needed to treat SUD. Health First Colorado currently covers levels 0.5 – 2.5 and 4.0 (with a medical diagnosis) for adult enrollees.

Residential levels 3.1, 3.3 and 3.5 are only authorized for children and young adults up to age 20 in Health First Colorado due to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) regulations. Inpatient level 3.7 is the only inpatient level not currently authorized for Health First Colorado adult enrollees.

Appendix D details the criteria for both residential and inpatient treatment options. These begin at ASAM Level 3.1 and continue through level 4.0 and can be found in more detail on page 42.⁴²

Cost-Effectiveness of Substance Use Disorder Treatment Options

SUDs cost the United States \$600 billion annually in health care, criminal justice and lost productivity. For example, the use of illicit drugs cost \$11 billion in health care spending in 2007 and \$193 billion overall. About three quarters of the costs associated with alcohol use were due to binge drinking alone. Studies have measured the impact of treating SUDs on medical expenses, productivity and recidivism, but few have calculated cost savings specifically related to residential or inpatient treatment.

The Surgeon General’s 2016 report on Alcohol, Drugs,

and Health finds that treating people with SUD has the potential for positive net economic benefits.⁴³ Below are summaries of several studies that assessed the cost-effectiveness of treatment for SUDs:

- A report from Washington state reveals lower medical costs, hospital expenses and reduced likelihood of arrests for Supplemental Security Income (SSI) clients who received alcohol or drug abuse (AOD) treatment. The report outlines two factors in AOD treatment that were associated with lower medical costs: completing treatment or remaining in treatment for longer periods of time. For those who entered treatment, average monthly medical costs were \$459 in the pre-treatment period (18-month average). Upon entering treatment, their average monthly costs rose to \$615 for an average of 27 months, compared with the untreated group who had average monthly costs of \$1,013 for 25 months after their need for treatment was identified.⁴⁴
- A study of Washington state’s expansion of AOD treatment in Medicaid – specifically residential and inpatient treatment – found an increase in treatment coincided with “significant” reductions in rates of growth in medical and nursing facility costs. The study estimates a 2:1 return on investment in medical and nursing facility costs saved per dollar invested in treatment over the four-year study period from 2006 to 2009. The study documents a \$51.8 million investment and \$107.4 million in savings to medical costs.⁴⁵
- A cost-effectiveness assessment of inpatient, residential, outpatient detox/methadone, and outpatient drug-free treatment models found that each technique is cost-effective. It also found that while the most cost-effective method to treat SUDs is in outpatient drug-free settings, the highest rates for abstinence at the five-year mark were through inpatient and residential treatment. Average cost for every abstinent case for residential treatment was \$14,900, while the average cost for an outpatient, drug-free abstinent case was \$6,300. The study used data from a survey of 3,047 clients in a random sample of 99 drug treatment facilities in the United States.⁴⁶

Substance Use Disorder and County Law Enforcement Contacts

There is no centralized source of county jail data in Colorado. However, reports on different state and county programs found high rates of alcohol and drug use and mental illness among Colorado's prison population. The state prison system reported up to 72 percent of inmates had a SUD in 2014, and a statewide jail program showed nearly half of inmates who were screened had some type of SUD.

Colorado's Correctional System and SUD

The Jail Based Behavioral Health Services (JBBS) program under OBH supports jails in 46 counties across Colorado in screening, assessing and treating inmates with SUDs as well as those with co-occurring mental health conditions. Of those who were screened for SUD through this program in FY 2016-17, 89.8 percent had an SUD.⁴⁷

While there is minimal data about rates of SUD among county jail populations, a 2014 study by the Behavioral Health Task Force of the League of Women Voters of Colorado found high rates of alcohol and drug use and mental illness among the state's prison population. More than 35 percent of prisoners had a mental health diagnosis, and 72 percent had severe substance use problems. Twenty-seven percent of the population had a dual mental health and a SUD diagnosis.⁴⁸

Residential Treatment and Recidivism

Literature on the relationship between residential treatment for SUD and recidivism is limited. Studies on residential treatment focus on special populations such as adolescents or pregnant women. However, there is ample literature on the elevated risk of overdose immediately following release from incarceration, with drug overdose cited as the leading cause of death among former inmates in one study.⁴⁹ Another study showed that former prisoners have a 10-fold increased risk for overdose than the rest of the population.⁵⁰

Studies of how residential treatment more broadly impacts prisoners suggest that treatment can reduce the risk of an overdose following release, as well as potentially reduce recidivism rates and criminal behavior.

Below is a summary of select studies.

- **Outcome Evaluation of the Crossroads to Freedom House and Peer I Therapeutic Communities (2004):** Researchers concluded that long-term intensive treatment that continued from prison to the community produced a greater reduction in recidivism compared with treatment confined to one of those locations, either prison or the community, and with prisoners who didn't complete the treatment.
- This Colorado study of 778 people evaluated the effectiveness of the Residential Substance Abuse Treatment (RSAT) for state prisoners in two programs — a prison-based program that included a minimum of 180 days of residential treatment and a community program that offered outpatient services. People who completed both programs stayed out of jail an average of 549 days, compared with a control group that averaged just 352 days before returning to jail.⁵¹
- **The Safety and Effectiveness of Diverting Felony Drug Offenders to Residential Treatment as Measured by Recidivism (2000):** Researchers studied a Brooklyn, New York, residential program for “nonviolent, drug-addicted offenders who were prison bound.” They found that four percent of participants were rearrested during treatment compared with 13 percent of nonparticipants.⁵² Twenty-three percent were rearrested three years after the residential treatment period compared with about 46 percent of those who did not complete treatment. Researchers concluded that successful completion of the program was “much more effective in reducing recidivism than completion of traditional sentences.”
- **Recidivism Following Mandated Residential Substance Abuse Treatment for Felony Probationers (2006):** A study of “drug-addicted probationers in a large metropolitan area” found that individuals who did not complete the residential treatment program were more likely to be rearrested for a serious felony within two years of leaving the program than those who graduated or probationers who were not treated.⁵³ Very few graduates were rearrested during the second year after completing treatment compared with those who dropped out of the program or who didn't receive treatment.

Understanding the Regulatory Landscape

All Medicaid enrollees meeting medical necessity criteria would be eligible for publicly funded residential or inpatient SUD treatment if a residential or inpatient benefit were added to Medicaid. This analysis assumes no changes to eligibility for Health First Colorado would be required to implement a residential or inpatient treatment benefit for SUD.

Health First Colorado's Current SUD Services

Health First Colorado covers outpatient SUD services for its enrollees, which include individual or group counseling, case management and drug screening and monitoring.

Inpatient hospitalization is covered by Health First Colorado for enrollees with acute medical needs, such as seizures or kidney disease. The inpatient hospitalization benefit must meet the criteria for ASAM Level 4.0, or “medically managed intensive inpatient services” and is considered a medical benefit. This hospitalization is paid for under Health First Colorado’s fee-for-service medical program.

Children under 21 receive all medically necessary services under EPSDT regulations.

Clinical Criteria

Most people with SUD do not require residential or inpatient treatment. Appropriate screening is necessary to determine the best option for each person, and screening should consider the severity of the condition, co-occurring mental health conditions, underlying trauma and available treatment options and resources.

ASAM is widely viewed by experts as setting the industry standard for SUD treatment. If Health First Colorado is authorized to pursue a waiver to use federal money for inpatient or residential treatment, the Centers for Medicare & Medicaid Services (CMS) states that ASAM criteria should be used in developing a residential or inpatient treatment benefit and that a full continuum of care should be available to all enrollees.

CMS guidance also states that providers should meet the ASAM criteria for provider qualifications. Additionally, enrollee assessment for residential SUD

What is an IMD?

A facility meets the definition of an IMD if:

- It has more than 16 beds;
- Is licensed as a psychiatric facility;
- Is maintained primarily for the care of people with mental diseases;
- Has more than 50 percent of its patients admitted based on a mental disease diagnosis.

services must be carried out by an independent third party that uses the ASAM Patient Placement Criteria. In Colorado, the RAEs could serve as this third party.

Under ASAM criteria for placement into residential treatment, an enrollee must not be experiencing withdrawal, and the independent assessor must determine that the enrollee’s symptoms can be safely managed in a non-acute setting. In addition, the criteria consider whether candidates for residential treatment have safe or stable home environments to support recovery or whether they have severe mental, cognitive or behavioral problems that require 24-hour residential settings.

ASAM criteria recommends inpatient treatment for patients with severe or unstable SUD symptoms that can be complicated by additional medical issues such as kidney disease or diabetes. Inpatient treatment is for people who require access to a wide range of medical interventions that can only be delivered in a 24-hour medically managed setting.⁵⁴

Institutions for Mental Diseases Exclusion

Since Medicaid was enacted in 1965, there has been a statutory prohibition on using federal Medicaid dollars for care provided in mental health and SUD residential facilities, otherwise known as institutions for mental diseases (IMD; see box above for definition).

The prohibition on using matching federal funds for residential treatment offered at IMDs does not apply to Health First Colorado enrollees under age 21. That’s because EPSDT provides comprehensive health care services that are medically necessary to these enrollees. These services include all medically necessary SUD treatment, regardless of setting.

This would not change if the benefit were added for people age 21 and older.

Substance use disorder is defined by the Diagnostic and Statistical Manual of Mental Disorders as a class of mental disorder. Thus, facilities providing inpatient or residential SUD treatment also fall under the IMD exclusion.⁵⁵ As a result, Medicaid enrollees across the country can experience trouble accessing substance use treatment delivered in a residential or certain inpatient setting. In Colorado, OBH and the MSOs provide funding for Health First Colorado enrollees who struggle with SUD and require and receive this level of care but do not meet the ASAM 4.0 level of care.

The IMD exclusion can limit access to a full continuum of care for people with SUD, and it may prevent full integration of physical and behavioral health within Medicaid programs by limiting treatment options for enrollees. The state could cover residential treatment in Health First Colorado, but would have to use only state dollars to pay for it. However, the CMS issued guidance in July 2015 on how state Medicaid programs can now seek a waiver of the IMD exclusion to provide residential treatment and receive matching federal funds.⁵⁶ If this path is pursued, the benefit would likely become an entitlement for the duration of the demonstration period and any subsequent extensions of the waiver.⁵⁷

Recent Federal Guidance

Since 1999, overdose deaths from all drugs more than tripled in the U.S., to over 52,000 in 2015.⁵⁸ In recognition of obstacles resulting from the IMD exclusion and rising substance use disorder rates, CMS proposed guidance in July 2015 to help states pursue a Section 1115 waiver with a focus on developing a full continuum of care for Medicaid enrollees with SUD needs. The aim is “to enable states that are pursuing significant delivery system transformation efforts in the area of SUD to better identify Health First Colorado enrollees with SUD, increase access to care for these people, increase provider capacity, deliver effective treatments for SUD, and use quality metrics to evaluate the success of these interventions.”⁵⁹

Section 1115 of the Social Security Act allows for pilot or demonstration projects that promote Medicaid objectives while allowing additional flexibility in designing programs. This can include expanding eligibility to people who might not traditionally fall

under Medicaid, providing services not typically covered, or using innovative delivery systems to improve care or reduce costs.⁶⁰ Because the IMD exclusion is a federal statutory prohibition, a waiver must be obtained by any state that wants to use federal Medicaid dollars to support residential or inpatient substance use services.

Recent Policy Developments

The 1115 waiver option is the only current path for Colorado to truly offer a full continuum of care for SUDs in its Health First Colorado program and be eligible for a federal financial match. However, there is additional activity related to the IMD exclusion that may yet gain traction and should be monitored.

A draft report from the President’s Commission on Combatting Drug Addiction and the Opioid Crisis, released in July 2017, includes a recommendation to grant waivers to any state that applies in order to rapidly eliminate barriers resulting from the IMD exclusion. The report recognizes that a statutory change is still required but also suggests that an emergency declaration by the president would empower HHS to grant waivers to every state that requests one.⁶¹ On August 10, 2017, the president declared a state of emergency for the opioid epidemic. However, no formal action has been taken as of October 24, 2017, and it is not clear whether or when that provision to grant waivers could apply.

In the most recent of many bills that address this issue, Representative Bill Foster of Illinois is sponsoring H.R. 2687, which includes statutory language undoing the prohibition of federal dollars for substance use services in an IMD starting in January 2019. It was introduced in the House on May 25, 2017, but no further action has been taken as of October 24, 2017.⁶²

It is possible these or other developments could supersede the need for a 1115 waiver. The state can also continue funding residential treatment under OBH using block grant, cash fund or General Fund dollars, and can expand access by adding more state funding. This could prove to be the more flexible and faster path forward, due to less stringent provider and education requirements as well as the estimated timeline for pursuing and receiving approval for the waiver. However, the 1115 waiver is the only current legal path forward to expanding

Medicaid coverage and drawing down matching federal funds for SUD treatment in an IMD.

Other States

Four states — California, Maryland, Massachusetts and Virginia — have launched residential or inpatient treatment options for SUDs under a Section 1115 waiver. A fifth state, West Virginia, was just approved on October 6, 2017. Seven additional states have pending waiver applications with the Centers for Medicare & Medicaid Services.

Under Section 1115 guidance, the waiver must be budget neutral to the federal government over the span of the demonstration period and any subsequent extensions. This means that actual service expenditures plus any new expenditures authorized under the waiver cannot be greater than projected “without waiver” expenditures. Other states are predicting budget neutrality by off-setting medical services or by including this expanded SUD treatment option as part of broader payment or delivery-system reform efforts that could help drive down costs over the life of the waiver.

California, the first state with an approved waiver, began its treatment program in July 2016. The three other states started providing services at various times in 2017. None of these four states has yet released a report on costs, savings or efficacy. Appendix E highlights key features of the four states

that have a waiver, including services covered, ASAM criteria covered and the waiver approval period. West Virginia was approved after this report was drafted and thus is not included.

The seven states with pending applications to implement residential or inpatient treatment are: Arizona, Illinois, Indiana, Kentucky, Michigan, Wisconsin and Utah.⁶³

Costs and Benefits: A Financial Model

CHI built a computer model to project the costs and benefits of offering a residential and inpatient treatment benefit in Health First Colorado.

The model concludes that expanding access to residential or inpatient SUD treatment would likely result in additional state costs — \$34 million in the first year the benefit is offered, or about 0.6 percent of the state’s share of Health First Colorado spending. Additional state costs will be an estimated \$33 million in the second year the benefit is offered, as savings from avoided costs begin to accrue.

CHI’s model includes several assumptions, including rate increases in residential and inpatient treatment costs, avoided costs, caseload growth and administrative expenses. Many of these assumptions are difficult to estimate, particularly the rate at which

Figure 1. Cost of Residential and Inpatient Treatment (Millions)

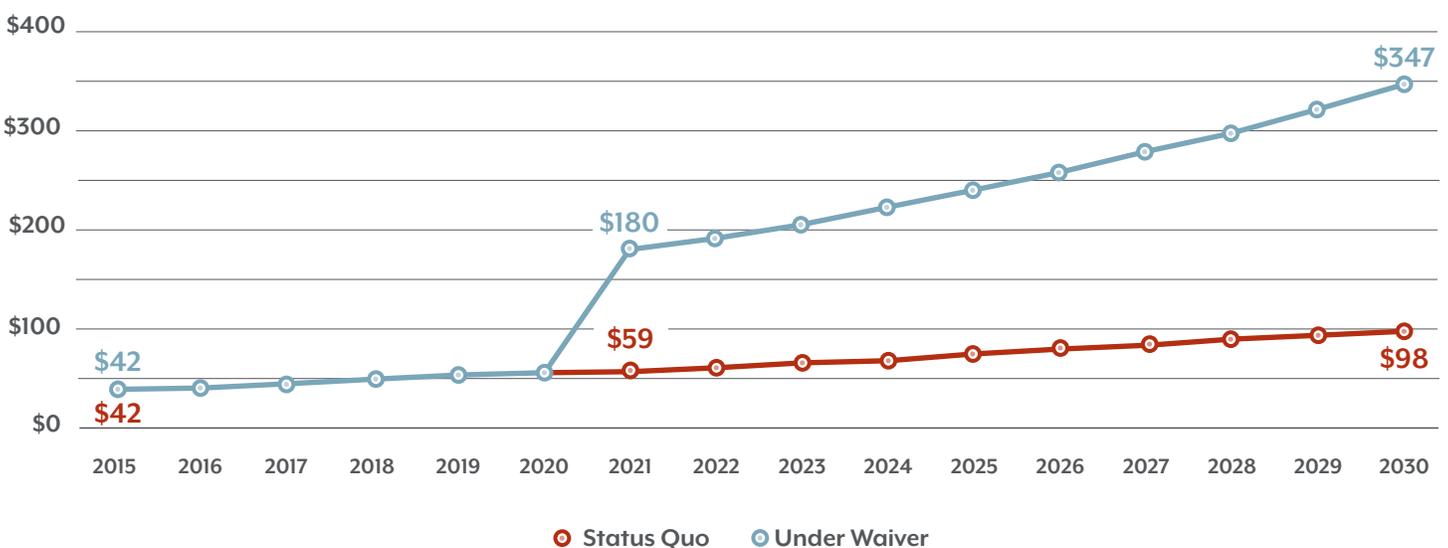
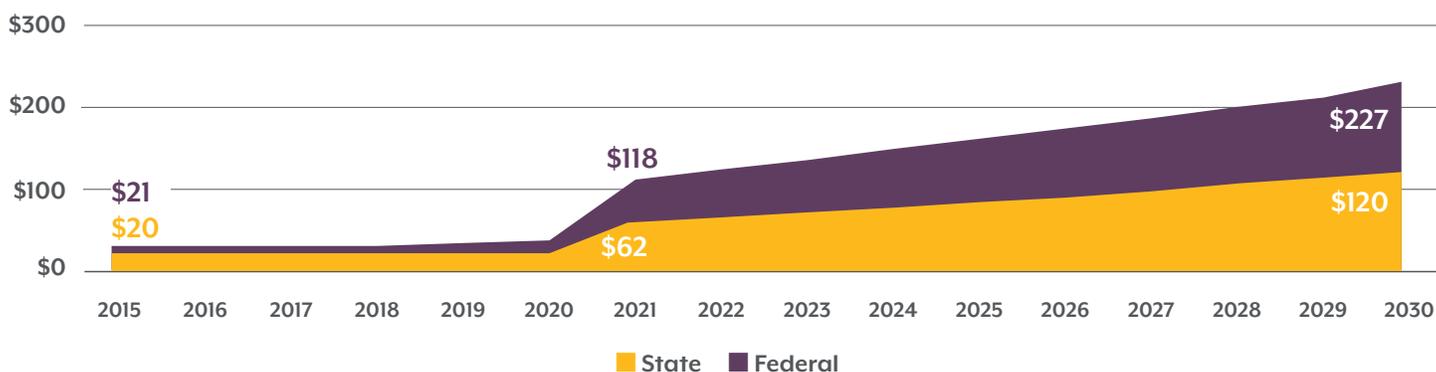


Figure 2. Cost of Residential and Inpatient Treatment with Benefit, Federal and State Dollars (Millions)

enrollees will require this level of care and utilize it (take-up rate) under a new benefit.

This model provides early insights on the potential costs and benefits of adding residential and inpatient SUD treatment for all Health First Colorado enrollees. Privacy restrictions under 42 CFR Part 2 meant that claims-level data were not available for analysis, and thus, this model potentially contains less detail than could be available under a more detailed actuarial analysis. Additionally, CHI was unable to use data from states with existing waivers as they are still very early on in their respective programs and have not released cost or utilization data.

Any changes to these assumptions, including costs, prevalence and take-up rates, would produce different results. Please see Appendix F for more detail on the development of these estimates.

New Costs

Providing residential and inpatient SUD treatment benefits for all Health First Colorado enrollees will cost \$180 million in FY 2020-21 (Figure 1). This is \$121 million more than the expected \$59 million that Colorado would spend to provide these services to enrollees who are already eligible to receive them in Health First Colorado (those under age 21 and pregnant women) or who get these services through OBH. This estimate assumes that 17,000 enrollees over age 21 with SUD would use residential or inpatient treatment. On the inpatient side, only ASAM level 3.7 is not currently authorized. ASAM level 4.0 inpatient treatment services are already authorized.

Of the additional estimated \$121 million in costs, \$34 million would be paid for by the state and \$87

million by the federal government in the first year of the benefit, bringing total state spending to \$62 million and federal spending to \$118 million (Figure 2). Additional costs to the state would increase to \$37 million in FY 2021-22, the second year of the benefit, and \$72 million by FY 2029-30.

CHI projects the new residential treatment benefit to account for a majority of the additional costs. New inpatient treatment (ASAM level 3.7) is projected to cost an additional \$163,000 in FY 2020-21, as many enrollees already receive these services under medical-necessity criteria.

In addition to new treatment costs, there will be a slight increase in administrative expenses associated with the waiver and new benefit.

CHI estimates \$254,000 for a contractor or term-limited FTE to facilitate the waiver application in FY 2018-19. An additional \$110,000 is estimated for the cost of a contractor to assist with an initial actuarial analysis during the implementation plan phase in FY 2019-20. A five-year contractor evaluation of the program from FY 2019-20 through FY 2023-24 is estimated to cost \$266,000.

Additionally, 1.5 new full-time equivalent employees responsible for program management and administration will begin in FY 2019-20. These costs will be incurred annually, and are expected to be \$129,000 in FY 2020-21.

It is also possible that adding a new residential or inpatient benefit may have an impact on take-up rates for SUD services as well, but we are unable to quantify that impact at this time. A more detailed actuarial analysis could potentially help quantify it.

Figure 3. Cost of Related Health Care Associated with SUD (Millions)

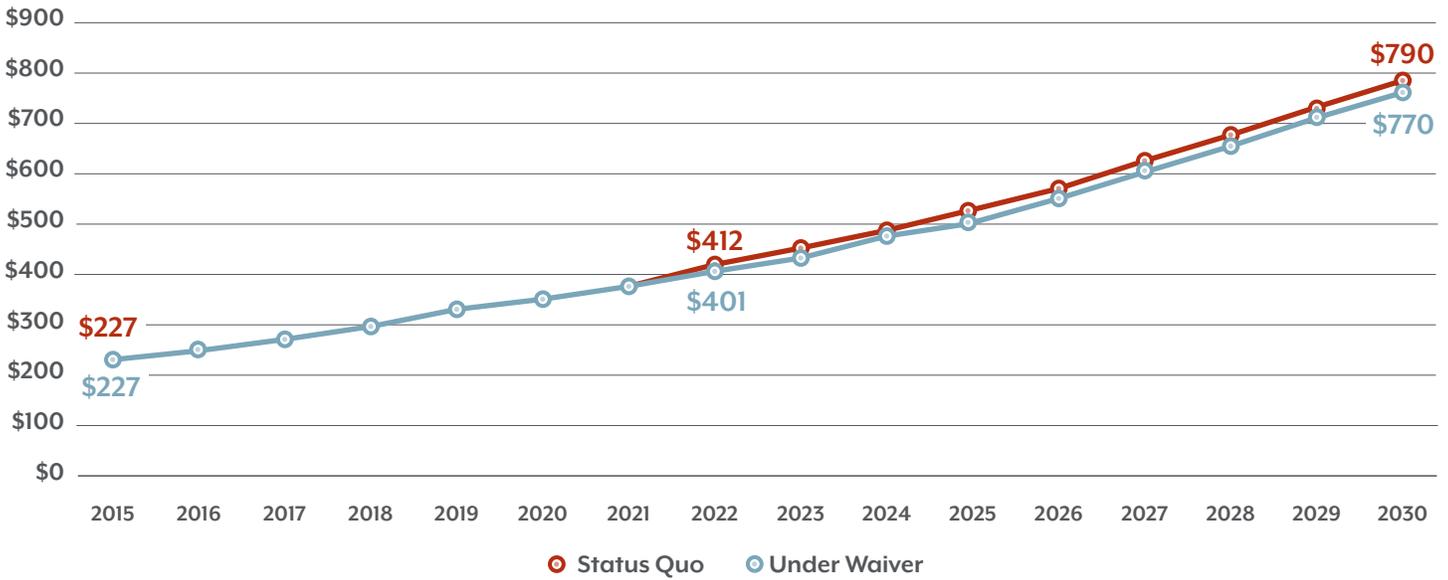
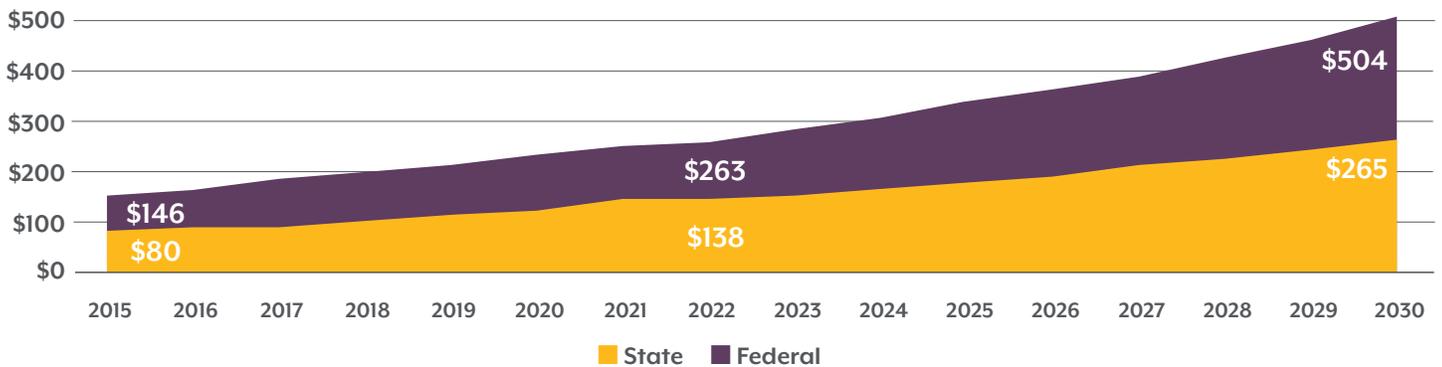


Figure 4. Cost of Related Health Care Associated with SUD with Benefit, Federal and State Dollars (Millions)



Savings

Literature shows that appropriate treatment for SUD can produce cost savings in other areas of health services. Cost savings have been found in a number of services, including the reduction of ED use, reduced hospitalizations, and reduction in the cost of other services such as physician visits and chronic disease management.

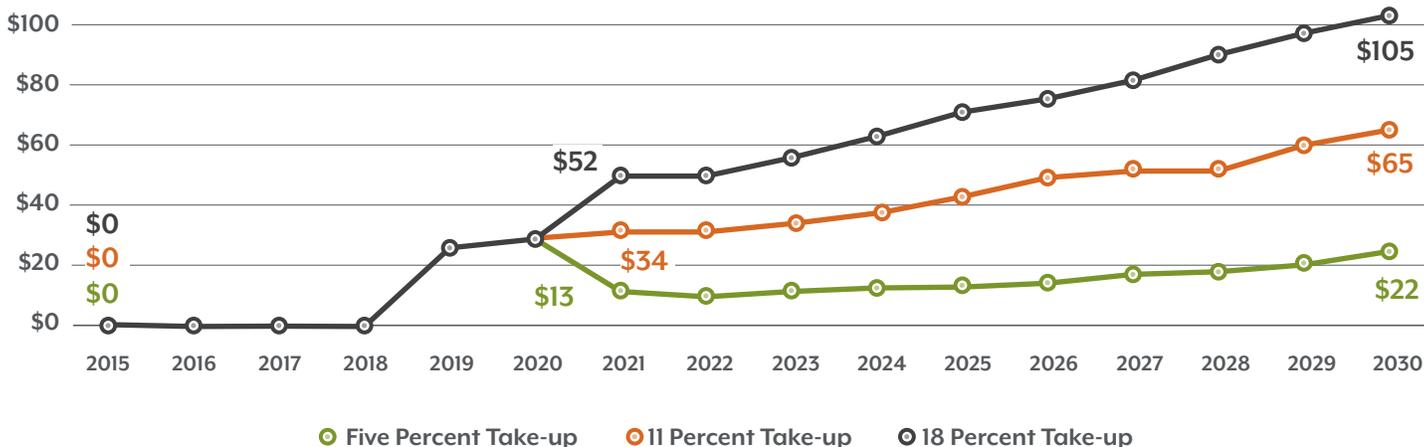
These savings were identified in peer-reviewed cost studies of substance use disorder treatment in Ohio and California published in *Health Services Research* and the *Journal of Substance Abuse Treatment*.

CHI estimates that the addition of an inpatient and residential substance use benefit would reduce spending on health care services among those who would use the benefit by \$11 million in FY 2021-22, the second year of the program.

CHI conservatively modeled no savings in the first year of the benefit, as it may take a while for new treatments to have an impact on other medical services.

With a benefit, these services could total an estimated \$401 million in FY 2021-22, \$11 million less than the \$412 million in projected spending based on the status quo (Figure 3). These savings come from approximately

Figure 5. Additional State Expenditures with Benefit (Millions)



7,600 fewer ED visits, 1,700 fewer hospitalizations and other savings related to health services.

Of the estimated \$11 million in savings, \$4 million would accrue to the state and \$7 million to the federal government. This could increase to \$7 million in state savings and \$13 million in federal savings during FY 2029-30.

Estimate of Net Cost and Savings

In the first year of the benefit, the state would only incur the additional \$34 million in costs for providing new residential and inpatient SUD treatment and not see any savings. In the second year, FY 2021-22, combining the estimated \$37 million additional state expenditures for treatments with the \$4 million in savings would mean that the state could spend an additional \$33 million. This equates to approximately \$1,859 in additional state funds per treated Health First Colorado enrollee.

Sensitivity Analyses

This analysis assumes that 11 percent of Health First Colorado enrollees age 21 and older with an SUD diagnosis would use residential or inpatient treatment services. However, this take-up rate is an important assumption with considerable impact on the total cost and savings estimated. At this time, there is no data from other states with which we can make a comparison.

Additionally, if the supply of providers does not

expand as quickly as demand, not everyone who needs residential treatment will receive it. Because of this uncertainty, CHI conducted a sensitivity analysis by creating estimates using both lower and higher take-up rates of 5 and 18 percent, respectively.

No scenario indicates net savings to the state under the waiver. But the additional cost is smaller when fewer enrollees are assumed to use these services (See Figure 5).

Under a take-up rate of 5 percent, CHI estimates an additional cost of \$13 million in state funds in FY 2020-21 to cover 7,000 enrollees. At an 18 percent take-up rate, the state could anticipate as much as \$53 million in additional costs to cover 27,000 people.

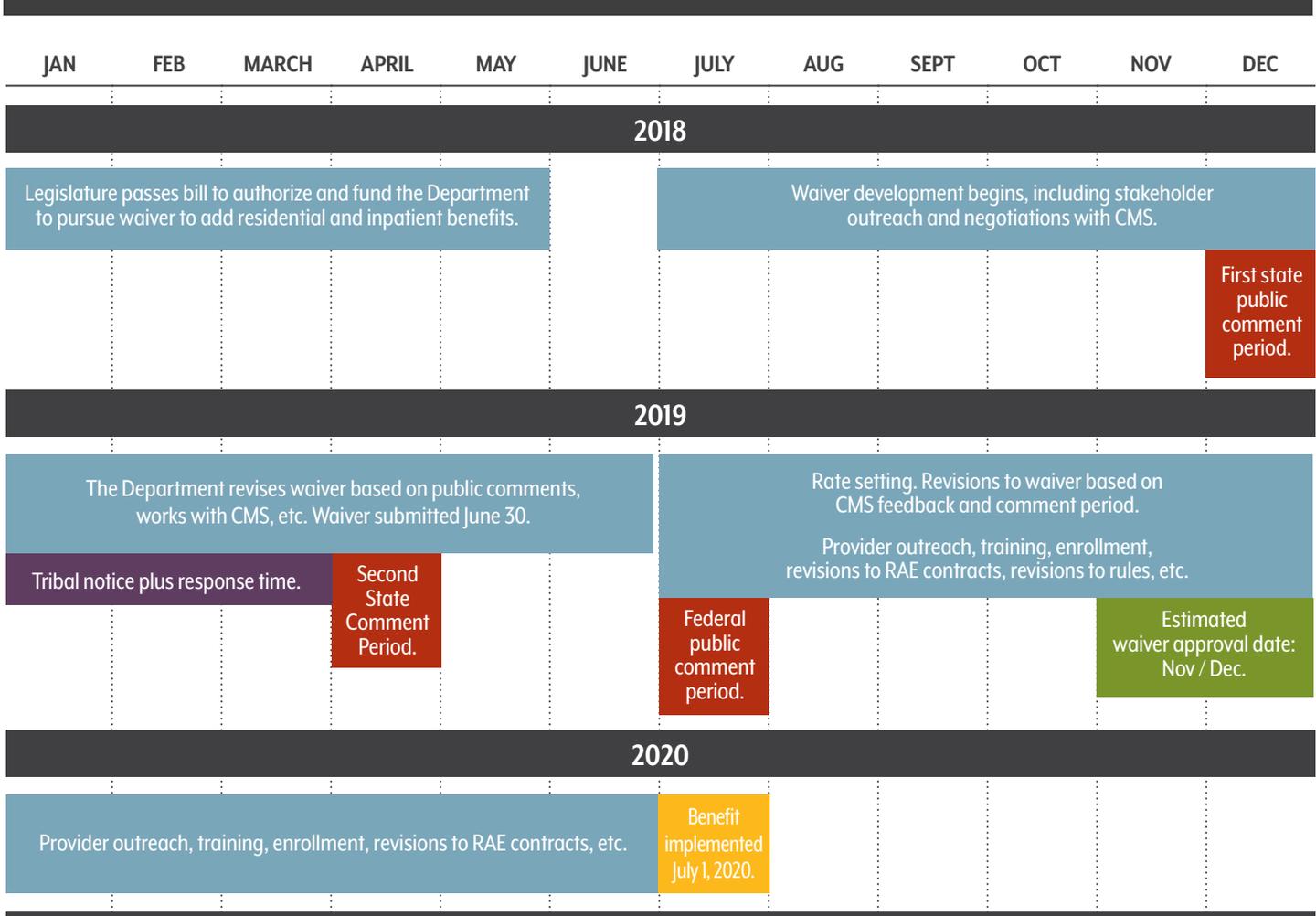
Steps to Implementation

This section outlines various considerations and steps for timing, administrative needs, waiver development, and benefit design to offer an inpatient and residential treatment benefit in Health First Colorado.

Timeline

It would take, at minimum, two years for the Department, in coordination with OBH, to seek the necessary authorizations and to develop a residential and inpatient treatment benefit. Approximately one year will be required to develop and receive approval of the 1115 waiver. Another year will be needed to implement the benefit.

An 1115 demonstration waiver is a lengthy and

Table 5. Estimated Timeline for a 1115 Waiver Approval and Implementation


complicated undertaking that requires extensive stakeholder engagement, several public comment periods and considerable negotiations with CMS regarding benefit design, evaluation design, stakeholder input and budget neutrality, among other considerations.

A potential timeline of the required steps for Colorado is outlined in Table 5.

During the waiver development process, the state will be required to:

- Develop a comprehensive, evidence-based benefit package;
- Establish a process to assess level-of-care and length-of-stay recommendations;
- Develop a plan to recruit, train and enroll a network of OBH-licensed providers in the ASAM levels of care;

- Establish a process to ensure seamless transitions and information sharing between levels and settings of care;
- Create or enhance program integrity protocols to safeguard against fraudulent billing;
- Create a utilization review process; and
- Establish a process to collect and report specific SUD quality measures and ensure that Medicaid enrollees are receiving evidence-based care.⁶⁴

Upon approval of the waiver, the state will need approximately 12 months to implement the benefit. If the General Assembly gives approval and allocates resources for the Department to seek the waiver during the 2018 legislative session, for example, the earliest a benefit could be implemented would be July 2020.

In CHI's model, estimated savings from this benefit do not begin until July 2021.

Administrative Needs

The Department will require additional resources to develop a waiver and implement a new, evidence-based benefit of this magnitude. Assuming legislative authority is granted in 2018, temporary resources of approximately \$254,000 should be allocated in the FY 2018-19 budget for the duration of the waiver development process to write, submit and oversee the waiver through approval. This could be either a term-limited full-time equivalent employee or general professional services, plus funding for travel and other stakeholder outreach expenses.

Approximately \$127,000 for permanent FTE would need to be allocated for FY 2019-20 for the implementation and ongoing management of the waiver. This work would oversee the day-to-day operations under the waiver as well as the numerous requirements from CMS, including utilization review, provider outreach, and cost and quality reporting requirements.

CMS requires a plan for evaluating the waiver. An estimated \$266,000 would need to be allocated from FY 2019-20 through FY 2023-24 for an independent contractor to design an evaluation and evaluate the waiver for costs, savings and other program outcomes. This estimate is based on the Department's review of contractor costs for similar state projects. Intermediate and conclusive results should be submitted to the Department, CMS and the General Assembly. If the benefit is effective July 1, 2020, then the final report would be due in 2025.

If the legislature authorizes the Department to pursue new residential (ASAM level 3.1, 3.3 or 3.5) or inpatient (ASAM level 3.7) benefits, they should be administered under the new Regional Accountable Entities (RAE) model in the Accountable Care Collaborative (ACC). Both should be included in the capitation for behavioral health services to keep funding streamlined and coordinated within the SUD delivery system. However, the inpatient hospitalization treatment benefit (for ASAM level of care 4.0) should remain on the medical fee-for-service (FFS) side of the Department's financing structure due to the medical nature of these services.

1115 Waiver Development and Benefit Design

Many CMS requirements will need to be addressed through the waiver development and benefit design process. Meanwhile, key informants raised several additional considerations.

First, a comprehensive, evidence-based treatment program is needed. This includes a full continuum of care available to each enrollee with SUD, from outpatient counseling to inpatient detox services, depending on the enrollee's needs. The 1115 waiver authority would allow the Department to cover the residential and inpatient services that are not currently covered and receive matching federal funds for these services.

However, key informants expressed concern that there has not been enough take-up of existing outpatient SUD benefits. Based on that feedback, along with requirements from CMS, the benefit design process needs to include expanding and coordinating outpatient SUD services with any newly covered inpatient or residential services. This could result in additional costs. CHI's model did not account for the potential increase in use of other SUD services based on limited available data.

Senate Bill 16-202 directed the Department of Human Services (DHS) to study the effectiveness of intensive residential treatment for SUD that is delivered through the MSOs to determine whether the benefit should also be added to the Medicaid program. That evaluation is due by February 1, 2019.

This report includes estimated costs, savings and number of enrollees who might use these benefits but it does not include an actuarial analysis of a new rate with these benefits. A detailed actuarial analysis would need to be conducted as part of the benefit development process to determine the reimbursement rates for residential or inpatient treatment. An additional \$110,000 is estimated for the cost of a contractor to assist with an initial actuarial analysis during the implementation plan phase in FY 2019-20, if the legislature authorizes the Department to move forward with this benefit. This estimate is based on the Department's costs for other rate-setting projects. Key informants believe there is significant pent-up demand for this benefit and providers will need sufficient reimbursement to expand capacity and infrastructure to accommodate this new benefit.

With more time, there will also be additional information that can be gained from the experiences of other states that have implemented a similar benefit. They are all currently limited in either the duration or statewide scope of their benefits but should be consulted in the future if the legislature authorizes the Department to pursue adding

residential and inpatient treatment. As discussed on page 15, if a robust provider education and outreach campaign needs to be pursued, there would need to be additional dedicated funds for OBH for that purpose.

CMS guidance regarding 1115 waivers to address the IMD prohibition indicates that the length of stay for residential treatment should average 30 days. Some enrollees will require shorter stays and others will require longer stays. There is precedent for approval of up to two, 90-day stays in a calendar year (California) as well as shorter stays of two, 30-day stays in a year (Virginia). If the benefit is authorized under Health First Colorado, it should, at a minimum, cover two, 30-day stays in a year with the option for longer stays for those who need it and require re-authorization no more than monthly.

The assessment for SUD services, level-of-care and length-of-stay recommendations must be performed by a third party that can appropriately use the ASAM criteria in making enrollee placement decisions, per guidance from CMS. This means that the provider rendering services cannot also perform the assessment and recommend services. The Department could contract with the RAEs to be that third-party assessor. This would accomplish two goals: meeting the requirements of the waiver and maintaining a streamlined admissions process.

The following change to Colorado Revised Statutes (C.R.S.) is needed to consider adding residential and inpatient treatment options for SUD under the Medicaid program:

- C.R.S. 25.5-5.411 needs a new section to authorize the Department to pursue a 1115 waiver to add residential and inpatient treatment options to the community mental health services program.

There may be additional statute changes required in the future, pending the outcome of the waiver development process. For example, definitions may need to be added or changed.

Changes to benefit design and provider requirements would likely happen through rule-making, rather than statutory changes, and would reflect specific decisions or recommendations resulting from the waiver development process.

Conclusion

Colorado has a demonstrated need for substance use treatment among its Medicaid population, with Medicaid members twice as likely as non-Medicaid members to say they did not get needed treatment. Health First Colorado enrollees made up 23 percent of the population but 34 percent of prescription drug overdose deaths and 29 percent of all drug overdose deaths in 2015. There is a documented gap in coverage for certain services among adult Medicaid enrollees.

Increasing treatment options for those struggling with substance use aligns with efforts by the Department to integrate physical and behavioral health care with the goal of achieving better health outcomes. Colorado could also see cost savings from fewer emergency department visits and hospitalizations. It is likely that expanding treatment options could also lead to fewer incarcerations.

Colorado could leverage federal matching Medicaid dollars to offer these benefits. There is potential to free up federal block grant funds that OBH currently uses for residential treatment. These funds could be used for other purposes, such as preventive efforts or SUD treatment for non-Medicaid enrollees.

Colorado could expect to see an increased number of Medicaid enrollees who regain the ability to support their families and contribute to their communities, benefits that are not quantifiable.

The Colorado Health Institute, after conducting research of the evidence, interviewing stakeholders and experts across the state, and creating a predictive model of the costs and benefits, finds that Colorado could possibly benefit from implementing an adult substance use disorder residential and inpatient treatment benefit in its Medicaid program. Stakeholders across Colorado support this expanded benefit, and have indicated a willingness to work with the Department and OBH to develop the waiver.

Appendices

Appendix A.

House Bill 17-1351

Final Signed Act

An Act

HOUSE BILL 17-1351

BY REPRESENTATIVE(S) Pettersen and Rankin, Becker K., Coleman, Danielson, Esgar, Exum, Ginal, Hamner, Herod, Jackson, Kennedy, Lontine, Michaelson Jenet, Mitsch Bush, Rosenthal, Salazar, Singer, Valdez, Winter, Young, Duran, Buckner, Hansen, Lee, Weissman; also SENATOR(S) Crowder and Jahn, Aguilar, Fenberg, Kagan, Kerr, Merrifield, Todd, Williams A.

CONCERNING UTILIZING INFORMATION TO IMPROVE TREATMENT FOR SUBSTANCE USE DISORDERS UNDER THE MEDICAID PROGRAM, AND, IN CONNECTION THEREWITH, MAKING AN APPROPRIATION.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Legislative declaration. (1) The general assembly hereby finds and declares that:

(a) According to the 2015 national survey on drug use and health, an estimated twenty-two million Americans have a drug or alcohol use disorder that needs treatment, yet only one in ten receive it;

(b) Because loss of income is a symptom of substance use disorders, an inability to pay is among the biggest barriers to receiving treatment;

(c) Colorado faces a prescription drug and heroin use problem, with drug overdose deaths in Colorado increasing by sixty-eight percent between 2002 and 2014;

(d) Opioid painkillers cause nearly seventeen thousand overdose deaths nationwide and three hundred such deaths in Colorado annually;

(e) In 2015, nearly thirty percent of total overdose deaths in Colorado were medicaid clients;

(f) According to the national institute on drug abuse, every dollar invested in the treatment of substance use disorders yields a return of up to seven dollars in reduced drug-related crime and criminal justice costs, and, when health care savings are included, more than a twelve-dollar return on investment; and

(g) States have an option as part of the medicaid program to cover residential and inpatient substance use disorder treatment.

(2) Therefore, the general assembly declares that the department of health care policy and financing and the department of human services should prepare and submit a report to the general assembly concerning treatment options for substance use disorders under the medicaid program.

SECTION 2. In Colorado Revised Statutes, add 25.5-4-214 as follows:

25.5-4-214. Feasibility study - residential and inpatient substance use disorder treatment - repeal. (1) ON OR BEFORE NOVEMBER 1, 2017, THE STATE DEPARTMENT SHALL PREPARE A WRITTEN REPORT WITH ASSISTANCE FROM THE DEPARTMENT OF HUMAN SERVICES' OFFICE OF BEHAVIORAL HEALTH CONCERNING THE FEASIBILITY OF PROVIDING RESIDENTIAL AND INPATIENT SUBSTANCE USE DISORDER TREATMENT AS PART OF THE MEDICAID PROGRAM. IN ADDITION, THE REPORT MUST ALSO INCLUDE AN ANALYSIS OF PROVIDING RESIDENTIAL AND INPATIENT SUBSTANCE USE DISORDER TREATMENT AS A STATE-FUNDED BENEFIT RATHER THAN THROUGH THE MEDICAID PROGRAM. THE STATE DEPARTMENT SHALL SUBMIT THE REPORT TO THE JOINT BUDGET COMMITTEE, THE PUBLIC HEALTH CARE AND HUMAN SERVICES COMMITTEE OF THE HOUSE OF REPRESENTATIVES, THE HEALTH AND HUMAN SERVICES

COMMITTEE OF THE SENATE, OR ANY SUCCESSOR COMMITTEES, AND TO ANY LEGISLATIVE STUDY COMMITTEE ADDRESSING SUBSTANCE USE DISORDER TREATMENT THAT MEETS DURING THE 2017 LEGISLATIVE INTERIM. THE STATE DEPARTMENT SHALL PREPARE A COMPREHENSIVE REPORT, INCLUDING WITHIN THE REPORT INFORMATION PROVIDED BY THE DEPARTMENT OF HUMAN SERVICES, AS WELL AS ANY OTHER SOURCES OF INFORMATION AS DETERMINED BY THE STATE DEPARTMENT.

(2) THE STATE DEPARTMENT SHALL CONSIDER AND REPORT ON THE FOLLOWING:

(a) THE PREVALENCE OF OPIOID ADDICTION AND OTHER SUBSTANCE USE DISORDERS IN COLORADO, INCLUDING DEMOGRAPHIC AND GEOGRAPHIC INFORMATION;

(b) EVIDENCE-BASED BEST PRACTICES FOR THE TREATMENT OF SUBSTANCE USE DISORDERS;

(c) A DESCRIPTION OF RESIDENTIAL AND INPATIENT SUBSTANCE USE DISORDER TREATMENT AND A COMPARISON OF THE TREATMENT COSTS AND ADMINISTRATIVE COSTS OF PROVIDING THE SERVICE UTILIZING MEDICAID DOLLARS OR WITH STATE FUNDING;

(d) THE ELIGIBILITY CRITERIA FOR PUBLICLY FUNDED RESIDENTIAL AND INPATIENT SUBSTANCE USE DISORDER TREATMENT;

(e) RESIDENTIAL AND INPATIENT SUBSTANCE USE DISORDER TREATMENT THAT IS NOT CURRENTLY INCLUDED IN COLORADO'S STATE MEDICAID PLAN BUT THAT MAY BE PROVIDED BY THE STATE AS AN OPTIONAL BENEFIT OR THROUGH A FEDERAL WAIVER;

(f) ANY FEDERAL AUTHORIZATION NECESSARY TO INCLUDE RESIDENTIAL AND INPATIENT SUBSTANCE USE DISORDER TREATMENT AS A BENEFIT UNDER THE MEDICAID PROGRAM OR WAIVER OF FEDERAL RULES THAT WOULD ALLOW FOR EXPANSION OF RESIDENTIAL AND INPATIENT TREATMENT;

(g) AN ESTIMATE OF THE NUMBER OF MEDICAID CLIENTS WHO MAY BE ELIGIBLE FOR THE BENEFIT IF THE BENEFIT WERE INCLUDED AS PART OF THE MEDICAID PROGRAM;

(h) WHETHER FACILITIES CURRENTLY PROVIDING RESIDENTIAL AND INPATIENT SUBSTANCE USE DISORDER TREATMENT IN COLORADO WOULD BE ABLE TO PROVIDE THOSE SERVICES UNDER THE MEDICAID PROGRAM;

(i) AN ESTIMATE OF STATE COSTS ASSOCIATED WITH PROVIDING RESIDENTIAL AND INPATIENT SUBSTANCE USE DISORDER TREATMENT AS PART OF THE MEDICAID PROGRAM;

(j) PUBLISHED RESEARCH RELATING TO OTHER STATE COSTS INCURRED FOR THE MEDICAID PROGRAM AND OTHER PUBLIC ASSISTANCE PROGRAM EXPENSES THAT MAY BE AVOIDED IF RESIDENTIAL AND INPATIENT SUBSTANCE USE DISORDER TREATMENT IS INCLUDED AS PART OF THE MEDICAID PROGRAM;

(k) IF KNOWN, OTHER STATES PROVIDING RESIDENTIAL AND INPATIENT SUBSTANCE USE DISORDER TREATMENT AS PART OF THE MEDICAID PROGRAM AND THE EXPERIENCES OF THOSE STATES RELATING TO IMPLEMENTATION, COST, SAVINGS, AND EFFICACY OF RESIDENTIAL AND INPATIENT TREATMENT;

(l) IF KNOWN, THE NUMBER AND COST OF EMERGENCY ROOM VISITS OR HOSPITAL STAYS BY MEDICAID CLIENTS IN COLORADO RELATING TO SUBSTANCE USE DISORDERS;

(m) IF KNOWN, THE NUMBER OF COUNTY LAW ENFORCEMENT CONTACTS RELATED TO PERSONS USING DRUGS OR ALCOHOL AND THE PERCENTAGE OF PERSONS ENTERING COUNTY JAILS WHO HAVE SUBSTANCE USE DISORDERS; AND

(n) IF KNOWN, STATE AND NATIONAL RESEARCH ON HOW ACCESS TO RESIDENTIAL AND INPATIENT SUBSTANCE USE DISORDER TREATMENT IMPACTS RECIDIVISM AND LAW ENFORCEMENT RESOURCES.

(3) AS PART OF THE REPORT, THE STATE DEPARTMENT AND THE DEPARTMENT OF HUMAN SERVICES SHALL INCLUDE RECOMMENDATIONS TO THE GENERAL ASSEMBLY CONCERNING:

(a) THE TIME FRAME FOR IMPLEMENTATION OF RESIDENTIAL AND INPATIENT SUBSTANCE USE DISORDER TREATMENT AS A BENEFIT UNDER THE MEDICAID PROGRAM, AS WELL AS ANY OTHER BENEFIT PLANNING OR

IMPLEMENTATION CONSIDERATIONS;

(b) EFFECTIVE USE OF STATE AND FEDERAL FUNDING AND THE IMPROVEMENT OF COORDINATION AMONG STATE AGENCIES IN ADMINISTERING ALL SUBSTANCE USE DISORDER PROGRAMS AND TREATMENT OPTIONS IN COLORADO;

(c) CHANGES TO STATE LAW NECESSARY TO IMPLEMENT THE RESIDENTIAL AND INPATIENT SUBSTANCE USE DISORDER TREATMENT BENEFIT AS PART OF THE MEDICAID PROGRAM; AND

(d) CHANGES, IF ANY, TO TRAINING REQUIREMENTS FOR CERTIFIED ADDICTION COUNSELORS NECESSARY TO IMPLEMENT EFFECTIVE SUBSTANCE USE DISORDER TREATMENT AND TO MEET FEDERAL REQUIREMENTS FOR MEDICAID PROVIDERS.

(4) IN PREPARING THE REPORT, THE STATE DEPARTMENT AND THE DEPARTMENT OF HUMAN SERVICES MAY USE NATIONAL DATA FROM RECOGNIZED SOURCES IF STATE-LEVEL DATA IS UNAVAILABLE AND MAY SOLICIT INFORMATION AND RESEARCH FROM STATE AGENCIES AND OTHER ORGANIZATIONS REGARDING THE SOCIAL AND FINANCIAL IMPACTS OF SUBSTANCE USE DISORDERS IN COLORADO AND EFFECTIVE OPTIONS FOR TREATMENT.

(5) THIS SECTION IS REPEALED, EFFECTIVE JULY 1, 2019.

SECTION 3. In Colorado Revised Statutes, 39-28.8-501, add (4)(e) as follows:

39-28.8-501. Marijuana tax cash fund - creation - distribution - legislative declaration. (4) The state treasurer shall make the following transfers from the fund to the general fund:

(e) ON JUNE 30, 2018, THIRTY-SEVEN THOUSAND FIVE HUNDRED DOLLARS FOR THE PURPOSE SPECIFIED IN SECTION 25.5-4-214.

SECTION 4. Appropriation. (1) For the 2017-18 state fiscal year, \$37,500 is appropriated to the department of health care policy and financing. This appropriation is from the general fund. To implement this act, the department may use this appropriation for general professional

services and special projects.

(2) For the 2017-18 state fiscal year, the general assembly anticipates that the department of health care policy and financing will receive \$37,500 in federal funds for general professional services and special projects to implement this act. The appropriation in subsection (1) of this section is based on the assumption that the department will receive this amount of federal funds, which is included for informational purposes only.

SECTION 5. Safety clause. The general assembly hereby finds,

determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.



Crisanta Duran
SPEAKER OF THE HOUSE
OF REPRESENTATIVES



Kevin J. Grantham
PRESIDENT OF
THE SENATE



Marilyn Eddins
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

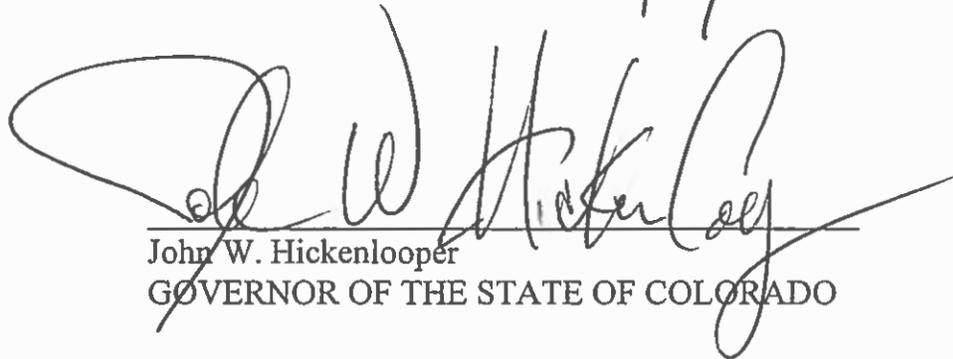


Effie Ameen
SECRETARY OF
THE SENATE

APPROVED

10:14 am

8/2/17



John W. Hickenlooper
GOVERNOR OF THE STATE OF COLORADO

Appendix B. Comparison of Residential and Inpatient SUD Treatment

	Residential	Inpatient
Duration	Programs, on average, range from 28 days to 90 days	Usually less than 15 days
Staff Needs	24-hour staffing for mental health, SUD and general health needs	24-hour nursing and medical supervision
Services	Like inpatient services, residential services offer assessments of physical and mental health needs as well as therapy and counseling and skill-based learning for outpatient settings.	Inpatient care includes an assessment of past and current substance use; health history and physical conditions; exploration of mental health needs; and acute care hospital or psychiatric hospital services as needed.
Location (in Colorado)	Freestanding residential facility	Acute care hospital
Intended Outcome	A longer-term approach designed to offer in-depth counseling and support services to help patients transition to outpatient settings and return home.	Medical stabilization of a patient, typically after a detox process

Appendix C. Training Requirements for Certified Addiction Counselors (CACs) and Licensed Addiction Counselors (LACs)

CACs and Licensed Addiction Counselors (LACs) must complete a certain number of hours in a range of trainings and hold specific degrees to be certified as CAC Level I, CAC Level II, CAC Level III, and LACs.^{65, 66}

Certification	CAC I	CAC II	CAC III	LAC	Clinical Supervision
Educational Requirement	High School Diploma/GED	High School Diploma/GED	Bachelor's Degree in Behavioral Health Sciences	Master's Degree or higher in Behavioral Health Sciences	
Skills Courses and Professional Hours Required	<ul style="list-style-type: none"> • Addiction Counseling Skills • Client Record Management • Principles of Addiction • Professional Ethics I • Culturally Informed Treatment • Infectious Diseases • Pharmacology 1,000 hours of clinically supervised work. 3 hours of clinical supervision per month for full-time work.	CAC I training plus: <ul style="list-style-type: none"> • Professional Ethics II • Motivational Interviewing • Cognitive Behavioral Therapy • Group Counseling Skills • Pharmacology II • Clinical Assessment & Treatment Planning • Co-occurring disorders • Trauma-Informed Care for Diverse Populations Additional 2,000 hours of clinically supervised work (total of 3,000 hours). 3 hours of clinical supervision per month, for full-time work. National examination	CAC II certification plus: <ul style="list-style-type: none"> • Clinical Supervision I • Advanced Motivational Interviewing • Clinical Supervision II • Professional Practice Additional 2,000 hours of clinically supervised work experience (total of 5,000). 2 hours of clinical supervision per month for full-time work. National examination	<ul style="list-style-type: none"> • Hold an active certificate for CAC III or meet all the requirements for a CAC III 	<ul style="list-style-type: none"> • CAC III • LAC

Appendix D. ASAM Criteria for Inpatient and Residential SUD Treatment ⁶⁷

* Dimension 1: acute intoxication or withdrawal. Dimension 2: medical condition or complication. Dimension 3: emotional, behavioral or cognitive complication.

Level of Care	Title	Inpatient/Residential	Staffing and Care	Current Covered Benefit under Health First Colorado?
3.1	Clinically Managed Low-Intensity Residential	Residential	24-hour structure with trained personnel; at least five hours of clinical service/week	No
3.3	Clinically Managed Population-Specific High-Intensity Residential	Residential	24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments.	No
3.5	Clinically Managed High-Intensity Residential	Residential	24-hour care with trained counselors to stabilize and prepare for outpatient treatment.	No
3.7	Medically Monitored Intensive Inpatient	Inpatient	24-hour nursing care with physician availability for significant problems in Dimensions 1, 2 or 3.* Sixteen hour/day counselor ability.	No
4.0	Medically Managed Intensive Inpatient	Inpatient	24-hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2 or 3. Counseling available to engage patient in treatment.	Yes <i>Note: This is medical detox coverage for people with severe and acute medical needs that may result from SUD.</i>

Sources: American Society of Addiction Medicine, Department of Health Care Policy and Financing.

Appendix E. Details on Other States with Existing 1115 Waivers that Include Residential or Inpatient SUD Treatment

	California	Maryland	Massachusetts	Virginia
Benefit(s)/Service(s) Covered Through the Waiver	Services for otherwise eligible people who are short-term residents in IMDs, including case management	Full continuum of care for SUD under ASAM criteria	High-intensity residential services, clinically managed low-intensity residential services, recovery support coach and navigator services	Full continuum of SUD treatment, including short-term residential and inpatient, case management, care coordination and peer supports
ASAM Level of Care Covered Through the Waiver	All participating counties are required to offer one level of ASAM residential treatment. ASAM levels 3.1, 3.3 and 3.5 are required within three years.	All ASAM levels covered in the following time frame: By July 2017: ASAM 3.3, 3.5, 3.7 and 3.7-WM. By January 2019: 3.1 Other ASAM criteria covered by the state plan	ASAM 3.1, 3.3	All ASAM levels 0.5 through 4; state plan already covers ASAM 1.0 (OTP, OBOT) for all Medicaid enrollees
Eligible Population(s)	All adults with full Medicaid benefits Only a handful of counties have executed contracts.	Ages 21-64 with full Medicaid benefits Full benefit Medicaid-Medicare enrollees will be eligible no later than January 2020.	All enrollees with full Medicaid benefits	All Medicaid-eligible enrollees
Residential Length of Stay Offered	Up to two, 90-day residential treatment stays in a year	Up to two, 30-day residential treatment stays in a year	Up to two, 30-day residential treatment stays in a year	Up to two, 30-day residential treatment stays in a year
Effective Date of Waiver	December 30, 2015; first implementation phase began in July 2016.	July 1, 2017; waiver retroactively approved starting January 1, 2017	November 4, 2016; service provision began July 2017.	December 15, 2016; started delivering services in April 2017
Period in Which Waiver is in Effect	December 30, 2015 – December 31, 2020	January 1, 2017 – December 31, 2021	July 1, 2017 – June 30, 2022	January 12, 2015 – December 31, 2019

Appendix F. Methodology

CHI developed a model to estimate the potential costs and savings of adding inpatient and residential substance use treatment as a covered benefit for adult Health First Colorado enrollees. The model is based on data from the Department of Health Care Policy and Financing (the Department), the Office of Behavioral Health (OBH) and the Bureau of Labor Statistics, combined with findings from peer-reviewed literature. CHI estimated the administrative costs associated with developing and implementing a new waiver. The analysis also accounts for the different federal matching rates available in Medicaid and OBH for these services and provides sensitivity analyses based on a range of projected utilization.

The analysis was limited by privacy restrictions, which reduced the amount of detailed data available. CHI recommends that future analysis by the Department seek to take advantage of more detailed data on claims and populations to be served, among other data.

Step One. Costs

Providing a new benefit to Health First Colorado enrollees means new costs. CHI estimated these costs in three categories — additional cost of new inpatient substance use treatment (ASAM level 3.7); additional cost of new residential substance use treatment; and administrative costs that will be incurred as a result of the waiver application and benefit administration.

The first step in estimating the incremental cost of additional services is to estimate how much would be spent without the benefit. Health First Colorado already covers many of these services for some Medicaid enrollees. The expected cost of these services with no changes to the program are referred to as “status quo.”

CHI then estimated how much would be spent on inpatient and residential substance use treatment if a benefit were added for all eligible enrollees.

Inpatient Substance Use Treatment

Status Quo

The Department provided CHI with the inpatient SUD treatment cost per utilizer for three age groups: under 21, 21 to 64, and 65 and older. These costs were provided for fiscal year (FY) 2014-15, FY 2015-16 and FY 2016-17. However, due to changes in systems and

diagnosis codes used, the costs fluctuated greatly across years. After discussing these variations with Department staff, CHI used only FY 2014-15 data in this analysis, as these estimates most closely aligned with literature around SUD treatment cost.

The Department also provided the number of inpatient SUD treatment utilizers by age group for FY 2014-15. Multiplying the cost per utilizer with the number of utilizers provided the annual expenditure on inpatient SUD treatments for FY 2014-15.

Both per capita costs and caseload were then increased in order to project spending to FY 2029-30.

The Department’s payment to the BHOs for behavioral health services is negotiated annually as part of larger capitated payments. CHI assumed that every year, inpatient treatment costs would grow at 2.25 percent, the midpoint of the estimated range of 2 and 2.5 percent provided by HCPF.

Depending on the year, CHI used different growth rates for the Health First Colorado inpatient utilizer caseload in order to account for smaller increases in the years further out from the Affordable Care Act’s 2014 expansion. Different growth estimates also were used for different age groups.

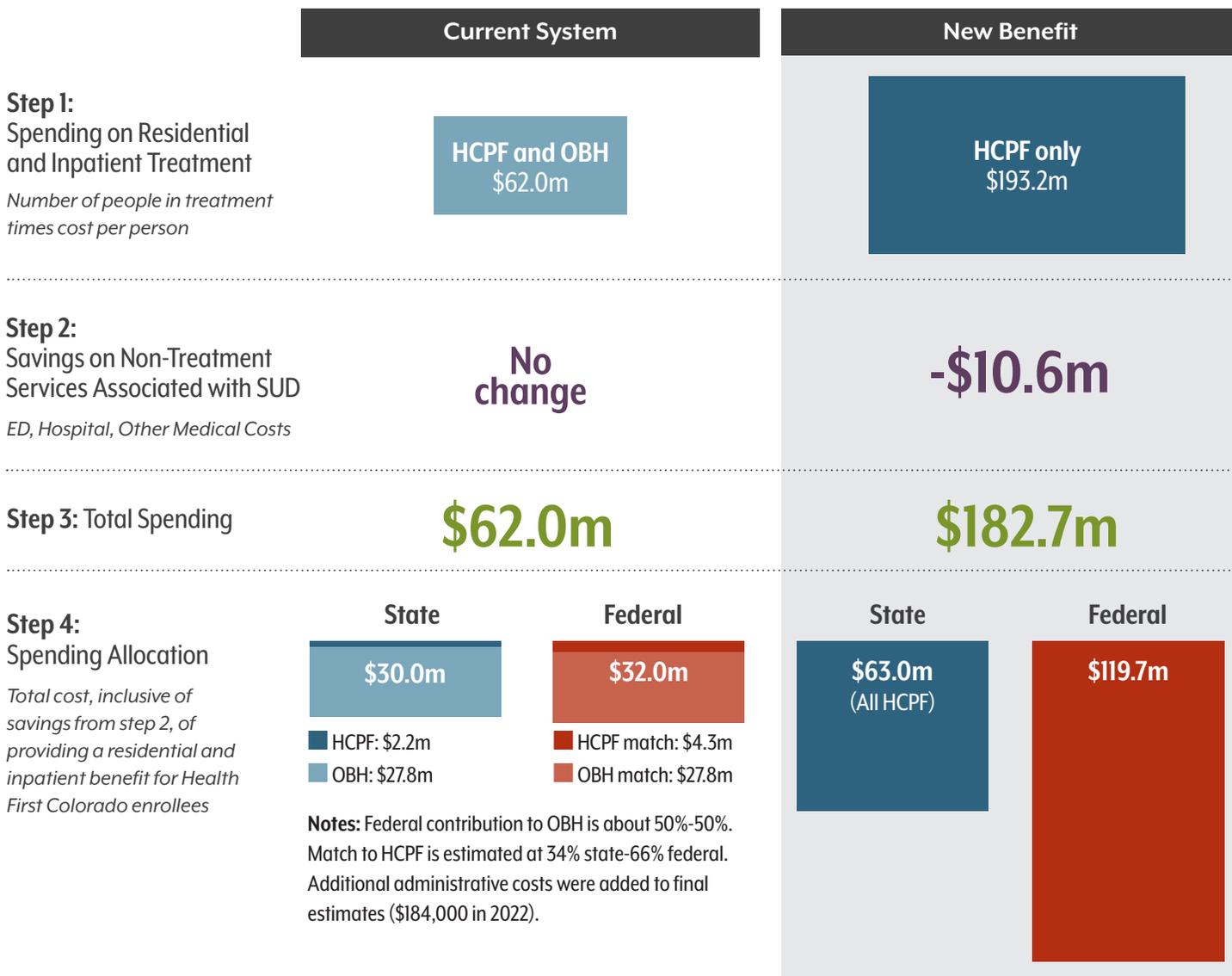
Growth in fiscal years 2015-16, 2016-17 and 2017-18 was based on Department projections in its most recent budget request.⁶⁸ From FY 2018-19 onward, the FY 2017-18 growth rate was used.

Caseloads by program were assigned to age groups as follows.

Health First Colorado Program	Assumed Age Group
MAGI Eligible Children	<21
SB 11-008 Eligible Children	<21
Foster Care	<21
Disabled Adults 60 to 64 (OAP-B)	21-64
Disabled Individuals to 59 (AND/AB)	21-64
Disabled Buy-In	21-64
MAGI Parents / Caretakers to 68% FPL	21-64
MAGI Parents / Caretakers 69% to 133% FPL	21-64
Breast & Cervical Cancer Program	21-64
MAGI Pregnant Adults	21-64
SB 11-250 Eligible Pregnant Adults	21-64
Adults 65 and Older (OAP-A)	65+
Partial Dual Eligibles	65+
Non-Citizen Emergency Services	NA

CHI's Methodology for Estimating Costs and Benefits of a Residential/Inpatient Benefit

A proposed residential and inpatient treatment benefit for substance use disorder through Health First Colorado would shuffle costs and benefits among the Department of Health Care Policy and Financing (HCPF), the Office of Behavioral Health (OBH) and the federal government. This model shows how it would work in Fiscal Year 2021-22.



By applying these growth rates, CHI arrived at estimates of the total cost of inpatient SUD treatments that will be incurred by Health First Colorado enrollees through FY 2029-30 under the status quo.

With New Benefit

While most inpatient treatment is already covered under Health First Colorado, some care currently covered by OBH would move under Health First Colorado. OBH provided data to CHI on inpatient

treatment encounters by Health First Colorado enrollment status and age group. CHI used the ratio of SUD treatment clients to treatment encounters as reported in the OBH annual report to estimate the number of Health First Colorado-enrolled clients receiving treatment.⁶⁹

To project increased use of inpatient treatment, CHI assumed that all Health First Colorado enrollees currently receiving inpatient services through OBH would get those services through Health First Colorado. Only 0.01 percent of all Health

First Colorado enrollees with a SUD diagnosis get inpatient services through OBH.

The increased number of utilizers of Health First Colorado inpatient services was multiplied by the cost per utilizer, by age group, to arrive at the total additional cost of providing inpatient SUD treatment. When added to the status quo cost of inpatient SUD treatment, CHI estimated a new higher total cost for inpatient SUD treatment.

Residential Treatment

Status Quo

As with inpatient treatment, the first step in estimating the incremental cost of additional services is to determine how much would be spent without the benefit. Health First Colorado currently covers residential treatment for SUD for a limited number of clients — those under age 21 or pregnant women.

Again, the Department provided CHI with the FY 2014-15 residential SUD treatment cost per utilizer for the three age groups, as well as the number of utilizers per age group. (Because enrollees over age 65 do not qualify by age and are unlikely to qualify by pregnancy status, the number of residential SUD treatment utilizers for this age group was zero.)

Multiplying the cost per utilizer with the number of utilizers provides the annual expenditure on residential SUD treatments for FY 2014-15.

Both per capita costs and caseload were then increased in order to project spending to FY 2029-30, using the same method described under inpatient treatment. By applying these growth rates, CHI arrived at estimates of the total cost of residential SUD treatments that will be incurred by Health First Colorado enrollees through FY 2029-30 under the status quo.

With New Benefit

The next step is estimating how much would be spent on residential SUD treatment were the Health First Colorado benefit added for enrollees age 21 and older. An important part of this is estimating how many Medicaid enrollees who currently have a SUD diagnosis would qualify for — and use — residential treatment.

The number of Health First Colorado enrollees age 21

and older that would use residential SUD treatment is an important assumption with considerable impact on the total cost and savings estimated by the model. There is a general lack of literature-based evidence on take-up rates. While other states have implemented this new benefit, they did so too recently to have data on take-up rates that can be applied to this model — though these state experiences may be able to inform estimates in the future. Therefore, CHI included a sensitivity analysis by creating estimates using take-up rates of both 5 and 18 percent. The median value between these two take-up rates (11 percent) is used through the analysis as a point estimate.

The Department provided the number of people under age 21 currently receiving residential treatment for SUD. OBH provided the number of Health First Colorado enrollees under age 21 getting residential treatment through its program. By adding these clients together, CHI found that 614 Health First Colorado enrollees under age 21 in the state receive residential treatment in a year — about five percent of all Health First Colorado enrollees under age 21 with a SUD diagnosis.

To choose the lowest point in its range of estimates, CHI assumed that the use of residential treatment among Health First Colorado enrollees with a SUD diagnosis is the same for clients under age 21 as it is would be for those age 21 or older when the benefit is available to both groups. This would mean that 5 percent of Health First Colorado enrollees age 21 or older with a SUD diagnosis would receive residential treatment under the benefit.

However, the increased acuity of SUD in adults means this is likely a very low estimate. Indeed, data from OBH show that 22,000 Medicaid enrollees age 21 or older are getting residential SUD treatment at its facilities — 18 percent of all enrollees reported by HCPF to have a SUD diagnosis. (Health First Colorado generally does not pay for these services provided by OBH. A combination of state funding and a federal block grant is used.)

However, CHI found discrepancies in the way clients are counted that led us to believe an 18 percent take-up rate was likely a high estimate. Therefore, this value was used as the upper, rather than midpoint, estimate.

Take-up rates were applied to the number of Health First Colorado enrollees with a SUD diagnosis to

arrive at the estimated number of enrollees age 21 or older who would use these services. This was multiplied by the residential treatment cost per utilizer provided by the Department, by age group. (Because there is no existing cost per utilizer for enrollees age 65 or older, the cost for the 21- to 64-year-old age group was used instead.)

This provided the additional cost of residential services under the new benefit. When added to the status quo cost of residential SUD treatment, a new higher total cost for residential SUD treatment is estimated.

Administration

Status Quo

There are no additional administrative costs under the status quo.

With New Benefit

CHI assumed additional costs would be incurred to establish and administer a waiver and new benefit.

First, the cost of a waiver application and evaluation was based on spending costs allocated for another waiver in FY 2017-18.⁷⁰ CHI assumed that half of this cost went to the waiver application and the other half to waiver evaluation.

Second, the cost of waiver management and administration was assumed to require 1.5 full-time equivalent Department employees. The cost of an employee's salary and ancillary expenses such as office space and benefits was estimated to be \$82,054 per year in FY 2019-20, according to the template from the Governor's Office of State Planning and Budgeting.

Finally, because the new benefit would be administered as part of the capitated behavioral health program, actuarial analyses would have to be conducted in order to determine appropriate payment. The cost of these analyses was based on a Department estimate of actuarial costs when adding the outpatient SUD benefit in FY 2014-15.⁷¹

Costs for all administrative expenses were inflated to the appropriate year based on the 10-year compound annual growth rate for the overall consumer price index, U.S. city average.⁷²

Step Two. Savings

While providing a new benefit to Health First Colorado enrollees will cost the program money, there is also the potential for savings via reduced use of other, often expensive, services among enrollees with SUD. CHI estimated savings in three health care categories — emergency department visits, hospitalizations, and other medical care not related to SUD treatment — as well as savings from services no longer being paid for by OBH.

ED Visits

Status Quo

As with costs, the first step in estimating savings from a new benefit is determining how much would be spent without the benefit.

The Department provided CHI with the per capita cost of ED visits associated with a SUD diagnosis code by age group in FY 2014-15. It also provided the Health First Colorado caseload by age group for the same time period. Multiplying the per capita cost by caseload provided the annual expenditure on ED visits associated with a SUD diagnosis code for FY 2014-15.

In order to project spending to FY 2029-30, per capita costs were grown at a 10-year compound annual growth rate for medical care inflation, U.S. city average. Using the method described in the cost section above, caseload was also increased in order to project spending to FY 2029-30. By applying these growth rates, CHI arrived at estimates of the total cost of ED visits associated with SUD diagnosis codes that will be incurred by Health First Colorado enrollees through FY 2029-30 under the status quo.

With New Benefit

The next step is estimating how much would be spent on ED visits with the benefit.

As discussed in the cost section above, CHI assumed that 11 percent of Health First Colorado enrollees with a SUD diagnosis would receive inpatient or residential treatment under the new benefit. (As with cost, sensitivity analyses provided estimates at 5 and 18 percent as well.)

Literature shows that when Health First Colorado enrollees receive treatment for SUD, the cost of their

non-treatment medical services is lower. One study found that patients receiving residential treatment for SUD had ED visit costs that were just 37 percent of the cost for those who did not receive treatment.⁷³

(The study used to arrive at this cost reduction is not limited to residential or inpatient SUD treatment, but includes other outpatient treatments for SUD. However, another analysis⁷⁴ shows long-term drug abstinence rates do not vary by the type of treatment provided, given that the treatment is matched to the patient's needs.)

Multiplying the 37 percent reduced per capita cost by the 11 percent caseload estimate provides an expected cost savings from reduced ED use. These costs begin to accrue in the second year of benefit implementation, FY 2021-22. When subtracted from the status quo cost of ED use, a new lower total cost for ED visits associated with a SUD diagnosis under the benefit is estimated.

Under the 11 percent take-up rate, this means an overall cost reduction of 7 percent in ED visits associated with a SUD diagnosis.

This estimate assumes the effect size identified in national studies will be similar in Colorado. However, if recent state efforts to reduce ED utilization have resulted in lower costs for SUD-related ED visits already, then the cost reduction may be smaller.

Hospitalizations

Status Quo

The cost of hospitalizations associated with a SUD diagnosis code under the status quo were estimated in the same manner as ED visits.

With New Benefit

The cost of hospitalizations associated with a SUD diagnosis code under the benefit were estimated in the same manner as ED visits. The only difference was the factor by which these services were expected to cost less for Medicaid enrollees who receive treatment. The same study used for ED cost reduction showed that hospitalization costs were 53 percent of what they would otherwise be without treatment. Under an 11 percent uptake, this means an overall cost reduction of 5 percent in hospitalizations associated with a SUD diagnosis.

Other Services

Status Quo

The cost of other medical services (excluding SUD treatments) associated with a SUD diagnosis code under the status quo were estimated in the same manner as ED visits.

With New Benefit

The cost of other medical services (excluding SUD treatments) associated with a SUD diagnosis code under the status quo were estimated in a similar manner as ED visits and hospitalizations. Again, the only difference was the factor by which these services were expected to cost less for Health First Colorado enrollees who receive treatment. Another study found that physician services costs for people who receive treatment are 85 percent of what they would otherwise be.⁷⁵ This means an overall cost reduction of 2 percent in other services associated with a SUD diagnosis.

Residential and Inpatient Care Through OBH

Status Quo

To estimate spending on residential and inpatient treatment under the status quo, CHI used the number of encounters provided by OBH, adjusted to account for unique clients as described in the cost section above. CHI calculated the average treatment cost per client by dividing FY 2015-16 total SUD service costs by the number of SUD treatment clients.⁷⁶ However, the total SUD service cost includes the cost of less expensive services such as detox treatment. To account for this, the cost per treatment per client was adjusted according to the relative per client cost of residential treatment and detox estimated in the literature.⁷⁷

Multiplying average cost of residential or inpatient treatment per client by the number of Health First Colorado enrollees receiving inpatient or residential care from OBH provided the expected cost of treatments provided by OBH under the status quo. This exercise was repeated for the 5, 11 and 18 percent take-up rates described above.

Per capita cost growth for OBH services was assumed to keep pace with medical inflation.⁷⁸ Caseload growth was assumed to be consistent with OBH Medicaid enrollee caseload growth from FY 2014-15 to FY 2015-16. Using these growth rates, CHI projected status quo costs to FY 2029-30.

With New Benefit

Under the benefit, all OBH residential and inpatient treatment for Medicaid eligible enrollees was assumed to move under Health First Colorado, meaning there would no longer be any cost for those enrollees under OBH.

Step Three. Cost and Savings Allocation

After estimating total costs and savings for FY 2014-15 through FY 2029-30, the next step was to allocate total amounts to the state and federal government.

Status Quo

Under the status quo, all Health First Colorado costs (those for non-treatment services such as ED visits as well as the expected inpatient and residential treatment costs) are shared by the state and federal government using the federal Medicaid assistance percentage (FMAP). The FMAP for most Health First Colorado enrollees is 50 percent — i.e., the federal government pays for half of these costs. However, Medicaid enrollees covered by the Affordable Care Act expansion are matched at a higher rate — 100 percent through 2016, decreasing to 90 percent by 2020. CHI calculated an annual weighted average FMAP of approximately 65 percent, meaning the state covers 65 percent of the cost. Weights were based on Medicaid expansion and non-expansion enrollment projections from the Department and accounted for the higher SUD prevalence rates likely to be found among expansion enrollees.^{79,80} While the costs of enrollees under age 21 do not change between the status quo waiver scenarios, these costs were included in total spending cited. Therefore, this weighted average includes Health First Colorado enrollees of all ages.

The average annual FMAP was calculated to be between 65 and 67 percent. A sensitivity analysis that changes this to 70 percent estimates state additional costs to be \$25 million, rather than \$33 million, in FY 2021-22. Lowering the FMAP to 60 percent puts additional state costs at \$43 million.

CHI assumed the costs for OBH services under the status quo were shared equally by the state and federal government. This assumption is based on the federal and state funding splits for SUD treatment programs reported by OBH.⁸¹

Total state and federal costs were calculated by

summing their respective Health First Colorado and OBH costs.

With New Benefit

Under the new benefit, the adjusted costs of Health First Colorado services would be shared by the state and federal government using the same weighted FMAP between 65 and 67 percent.

Under the benefit, all OBH residential and inpatient treatment for Medicaid eligible enrollees was assumed to move under Health First Colorado, meaning there would no longer be any cost for those enrollees under OBH.

Step Four. Timeline

After developing cost and savings estimates for FY 2014-15 through FY 2029-30, CHI developed a timeline to determine when these costs and savings would be incurred.

CHI assumed that the legislative authorization to apply for the waiver would happen during the state legislative session in FY 2017-18. During FY 2017-18, costs under the status quo and the waiver scenarios remain the same.

In the event of legislative approval, CHI assumed that the waiver application and submission would occur in FY 2018-19. During this time, additional state expenditures would be limited to the administrative costs associated with the waiver application.

In the event of waiver approval, CHI assumed that the development of a benefit implementation plan would occur in FY 2019-20. During this time, additional state expenditures would be limited to the administrative costs associated with waiver management and administration and actuarial analyses conducted to determine the appropriate capitation amount.

The new benefit would begin in FY 2020-21. From this point on, the state would incur the costs of inpatient and residential SUD treatment. The state would also incur the annual administrative costs related to waiver management and administration.

Beginning in FY 2021-22, the state would realize the savings associated with reduced SUD.

CHI assumed the waiver evaluation would take place from FY 2019-20 through FY 2023-24. That cost is added to the state cost for these years and left out of costs thereafter.

Appendix G.

**Centers for Medicare & Medicaid Services
New Service Delivery Opportunities
for Individuals with a Substance
Use Disorder**

SMD # 15-003

July 27, 2015

**Re: New Service Delivery Opportunities for
Individuals with a Substance Use Disorder**

Dear State Medicaid Director:

The purpose of this letter is to inform states of opportunities to design service delivery systems for individuals with substance use disorder (SUD), including a new opportunity for demonstration projects approved under section 1115 of the Social Security Act (Act) to ensure that a continuum of care is available to individuals with SUD. There are numerous federal authorities offering states the flexibility to implement system reforms that improve care, enhance treatment and offer recovery supports for SUD. Many states have made significant progress in achieving better outcomes for individuals with SUD through traditional Medicaid authorities. In addition, the Centers for Medicare & Medicaid Services (CMS) recently introduced the Medicaid Innovation Accelerator Program (IAP) for SUD to support participating states in improving their SUD delivery system. However, a few states may also want to consider proposing a section 1115 demonstration project in this context to undertake or complement broader SUD delivery system transformation efforts.

Section 1115 demonstration projects allow states to test innovative policy and delivery approaches that promote the objectives of the Medicaid program. States may receive federal financial participation (FFP) for costs not otherwise matchable, such as services delivered to targeted populations, in limited geographic areas, or in settings that are not otherwise covered under the Medicaid program. CMS recognizes the statutory payment exclusions for services provided to individuals who reside in specific settings may challenge states' abilities to offer a full continuum of care and effectively treat individuals with SUDs.¹ CMS supports state efforts to reform systems of care for individuals with SUD, such as by enhancing the availability of short-term acute care and recovery supports for individuals with SUD, improving care delivery, integrating behavioral and physical care, increasing provider capacity and raising quality standards. As stated, CMS is offering a new opportunity for Medicaid demonstration projects authorized under section 1115 to test Medicaid coverage of a full SUD treatment service array in the context of overall SUD service delivery system transformation, provided participating states meet specific requirements outlined below. This letter details the new demonstration opportunity, outlines our expectations of a transformed SUD service delivery system and explains how to submit an application for such a demonstration project.

¹ Cf. paragraph (B) following section 1905(a)(29) of the Act.

Background

Medicaid is playing an increasingly important role as a payer for services provided to individuals with SUD in the United States. An estimated 12 percent of adult Medicaid beneficiaries ages 18-64 have an SUD.² In addition, an estimated 15 percent of uninsured individuals who could be newly eligible for Medicaid coverage in the New Adult Group have an SUD.³ CMS is committed to helping states effectively serve these individuals and introduce benefit, practice and payment reforms through the technical assistance and coverage initiatives described below.

States have compelling reasons to provide Medicaid coverage for the identification and treatment of SUD, many of which are given urgency by the national opioid epidemic. Untreated substance use disorders are associated with increased risks for a variety of mental and physical conditions that are costly. In 2009, health insurance payers spent \$24 billion to treat SUD, of which Medicaid accounted for 21 percent of expenditures.⁴ Two of the top ten reasons for Medicaid 30-day hospital readmissions are SUD-related.⁵ Individuals with SUD and co-morbid medical conditions account for high Medicaid costs, such that \$3.3 billion was expended in one year on behalf of 575,000 beneficiaries with SUD as a secondary diagnosis.⁶ Beyond health care risk, the economic costs associated with SUD are significant. States and the federal government spend billions every year on the collateral impact associated with SUD, including criminal justice, public assistance and lost productivity costs.⁷ Alarming, the rate of fatal drug overdose in the U.S. has quadrupled between 1999 and 2010.⁸ Drug overdose has become the leading cause of injury death, causing more deaths than traffic crashes.⁹ Other problems also relate to opioid prescribing including opioid exposed pregnancies, drugged driving, and increases in Hepatitis C and in some circumstances HIV from prescription opioid injection.

As states expand Medicaid coverage to millions of new beneficiaries that may have been previously uninsured, states are also expanding access to behavioral health services including

² Substance Abuse and Mental Health Services Administration. Behavioral Health Treatment Needs Assessment Toolkit for States [online]. 2013. Retrieved from: <http://store.samhsa.gov/shin/content/SMA13-4757/SMA13-4757.pdf>, p.10.

³ Busch, S, et al (2013). Characteristics of Adults with Substance Use Disorders Expected to be Eligible for Medicaid under the ACA. *Psychiatry Services*, 64(6).

⁴ Substance Abuse and Mental Health Services Administration. National Expenditures for Mental Health Services and Substance Abuse Treatment, 1986–2009. HHS Publication No. SMA-13-4740. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

⁵ Hines, A, et al. *Conditions With the Largest Number of Adult Hospital Readmissions by Payer, 2011*. Healthcare Cost and Utilization Project. Statistical Brief #172. Agency for Healthcare and Quality, 2014.

⁶ Bouchery, E, et al (2012). Medicaid Substance Abuse Treatment Spending: Findings Report. Retrieved from: <http://aspe.hhs.gov/daltcp/reports/2012/msaspend.shtml>.

⁷ Heroin addiction costs the US \$20 billion annually in crime, preventable medical costs and lost productivity. See University of Maryland, Baltimore County. *An Evaluation of Whether Medical Savings are Associated with Expanding Opioid Maintenance Therapy for Heroin Addiction in Baltimore City*. Center for Health Program Development and Management, 2007.

⁸ *Results from the 2010 National Survey on Drug Use and Health: Detailed Tables*. Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, September 2011, <http://www.samhsa.gov/data/nsduh/2k10NSDUH/tabs/LOTsect7pe.htm#TopOfPage>.

⁹ Centers for Disease Control and Prevention. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. 2014. Retrieved from: <http://www.cdc.gov/injury/wisqars/fatal.html>.

covering these services in Alternative Benefit Plans as required by the Affordable Care Act. CMS has received a number of requests from states and stakeholders interested in enhancing care for individuals with SUD. Many requests center on short-term acute treatment services, including detoxification, intensive outpatient programs, and residential treatment services. However, there are other important service modalities and approaches vital to effectively treating SUD that we encourage states to provide, including screening and intervention services in a broad range of settings, integration with primary care, medication assisted treatment and recovery supports services such as peer recovery supports and recovery coaches. Providing these services will help achieve better health outcomes among individuals with SUD, helping them to lead healthier and longer lives.

Many states have already achieved notable success in improved care and lower costs for SUD services through benefit, practice and payment reform. For instance:

- Massachusetts found that monthly Medicaid expenditures were significantly less for beneficiaries receiving SUD treatment compared to diagnosed but untreated beneficiaries. Treatment included ambulatory detoxification and medication-assisted treatment services.¹⁰
- Washington found that Screening, Brief Intervention and Referral to Treatment (SBIRT) services significantly reduced healthcare costs among Medicaid beneficiaries, resulting in savings of \$250 per member per month associated with inpatient hospitalization from emergency department admissions.¹¹
- In addition, Washington tackled SUD and emergency department (ED) usage by adopting seven best practices. As a result, ED visits decreased by 9.9 percent; the number of people with frequent ED use dropped by 10.7 percent; and the number of visits resulting in narcotic prescription dropped by 24 percent. The state attributed savings of about \$34 million.¹²
- For individuals in managed care with alcohol dependence, total healthcare costs were 30 percent less for individuals receiving medication-assisted treatment than for individuals not receiving medication-assisted treatment.¹³
- Medical costs for Medicaid patients in California decreased by one-third over three years following engagement in medication-assisted treatment. This includes reduced

¹⁰ Clark, R.E., et al (2011). The Evidence Doesn't Justify Steps by State Medicaid Programs to Restrict Opioid Addiction Treatment with Buprenorphine. *Health Affairs*, 30(9), 1425-1433.

¹¹ Estee, S et al. *Medicaid Cost Outcomes*. Department of Social and Health Services, Research and Data Analysis Division. Olympia, Washington, 2006.

¹² Washington State Health Care Authority, Report to the Legislature: Emergency Department Utilization: Update on Assumed Savings from Best Practices Implementation, March 20, 2014. Retrieved from: http://www.hca.wa.gov/documents_legislative/EmergencyDeptUtilization.pdf.

¹³ Baser, O., Chalk, M. Rawson, R. et al. (2001) Alcohol treatment dependence: comprehensive healthcare costs, utilization outcomes, and pharmacotherapy persistence. *The American Journal of Managed Care*, 178(8), S222-234.

expenditures in all types of health care settings, including hospitals, emergency departments and outpatient clinics.¹⁴

CMS supports states' important efforts to improve care for individuals with SUD. Over the past several years, CMS has provided states with information and technical assistance to enhance coverage for behavioral health conditions. In July 2014, CMS released a joint Informational Bulletin in partnership with the Centers for Disease Control and Prevention, the National Institute of Health and the Substance Abuse and Mental Health Services Administration (SAMHSA) describing best practices, state-based initiatives and useful resources to help ensure proper delivery of medication assisted treatment (MAT) for SUD.¹⁵ In January 2015, CMS released a joint Informational Bulletin in partnership with SAMHSA promoting behavioral health coverage opportunities for youth with SUD.¹⁶

While progress has been made, states report challenges in achieving better care for the SUD population. States cite a lack of data analytics to accurately identify prevalence and need in the Medicaid population, too few endorsed metrics for quality measurement, a lack of resources to collect and evaluate data, variation in provider qualifications, difficulties in integrating primary and substance use disorder care, and federal payment prohibitions as barriers to providing a comprehensive benefit package and delivery system.

To address these challenges, CMS recently launched the Medicaid Innovation Accelerator Program. The Innovation Accelerator Program supports state efforts to accelerate Medicaid innovations by offering technical assistance and expert resources to states engaged in Medicaid system redesign efforts. Based on our work with states and stakeholders, CMS identified SUD as the first area of focus for the Innovation Accelerator Program. As part of a strategy to improve the care and health outcomes and reduce costs for individuals with a SUD, CMS has begun engaging states to leverage IAP resources to introduce system reforms that better identify individuals with a SUD, expand coverage for effective SUD treatment, and enhance SUD practices to effectively treat beneficiaries.

Participation in the Innovation Accelerator Program is not a requirement for introducing SUD system reforms through the Medicaid authorities discussed in this letter. However, states participating in the Innovation Accelerator Program may request and receive technical assistance to identify and address the transformational activities set forth in this letter. For more information regarding Innovation Accelerator Program opportunities for substance use disorder, please visit <http://medicaid.gov/state-resource-center/innovation-accelerator-program/reducing-substance-use-disorders/reducing-substance-use-disorders.html>. Interested states should email MedicaidIAP@cms.hhs.gov. We encourage states to leverage the Innovation Accelerator Program's supports in areas where they currently do not meet the expectations for a transformed system as described below.

¹⁴ Walter, L. et al (2006). *Medicaid Chemical Dependency Patients in a Commercial Health Plan*, Robert Wood Johnson Foundation, Princeton, New Jersey, 2006.

¹⁵ <http://www.medicaid.gov/federal-policy-guidance/downloads/cib-07-11-2014.pdf>

¹⁶ <http://medicaid.gov/federal-policy-guidance/downloads/cib-01-26-2015.pdf>

Goals for the Section 1115 Demonstration Initiative

To complement the work to date, CMS is proposing an opportunity to allow states embarking on broad and deep system transformations in the area of SUD to pursue 1115 demonstrations to improve the care and outcomes for individuals with SUD. This new initiative would be available to states that are developing comprehensive strategies to ensure a full continuum of services, focusing greater attention to integration efforts with primary care and mental health treatment, and working to deliver services that are considered promising practices or have fidelity to evidence-based models consistent with industry standards. In addition, we seek to support states that are interested in developing new payment mechanisms and performance quality initiatives. As states take the necessary steps to design and implement major transformations to systems of care for individuals with SUD, this section 1115 demonstration initiative can support these efforts by addressing some of the barriers to providing effective care to individuals. Below, CMS sets forth the goals and expectations pursuant to this new section 1115 demonstration opportunity.

The aim of this initiative is to enable states that are pursuing significant delivery system transformation efforts in the area of SUD to better identify individuals with an SUD in the Medicaid population, increase access to care for these individuals, increase provider capacity, to deliver effective treatments for SUD, and use quality metrics to evaluate the success of these interventions. The specific goals of the initiative are to:

- Promote strategies to identify individuals with substance use issues or disorders.
- Enhance clinical practices and promote clinical guidelines and decision-making tools for serving youth and adults with SUD.
- Build aftercare and recovery support services, such as recovery coaching.
- Coordinate SUD treatment with primary care and long-term care.
- Coordinate with other sources of local, state and federal funds for an efficient use of resources consistent with program objectives.
- Encourage increased use of quality and outcome measures to inform benefit design and payment models.
- Identify strategies to address prescription and illicit opioid addiction, consistent with national efforts to curb this epidemic.

Reforms

CMS expects that states interested in pursuing a section 1115 demonstration in this area will promote both systemic and practice reforms in their efforts to develop a continuum of care that effectively treats the physical, behavioral and mental dimensions of SUD. Examples of systemic changes include:

- Promoting a definition of substance use disorders as a primary, chronic disease requiring long-term treatment to achieve recovery with relapse potential.
- Aligning Medicaid benefit packages, provider requirements, reimbursement, utilization review processes, medical necessity criteria, and quality indicators with Medicare and commercial plans.

- Introducing a comprehensive continuum of care based on industry standard patient placement criteria, including withdrawal management, short-term residential treatment, intensive outpatient treatment, medication assisted treatment and aftercare supports for long-term recovery such as transportation, employment, housing, and community and peer support services.
- Adding coverage of evidence-based and promising practices shown to effectively treat youth and adults for SUD that are not available through traditional Medicaid 1905(a) authority.
- Partnering with drug courts and juvenile justice systems to ensure referrals to SUD treatment are medically appropriate and effectively managed.
- Proposing payment models to support the goals of this project, such as shared savings, and managed care.¹⁷
- Collecting and reporting data to internal and external evaluators, including CMS, to assess the impact of the proposed changes.

Examples of practice changes include:

- Enhancing strategies for primary care and specialty practitioners to better identify and treat individuals with SUD in primary care through Screening, Brief Intervention and Referral to Treatment (SBIRT).
- Developing effective care coordination models to link individuals identified with SUD to appropriate providers.
- Improving efforts to enhance coordination models between SUD providers, primary care-including FQHC's, corrections systems, schools and long-term services and supports.
- Enhancing provider competencies to deliver SUD services with fidelity to industry standard models, such as the American Society for Addiction Medicine (ASAM) Criteria.
- Ensuring accreditation for residential and other SUD providers.
- Improving care transitions when individuals receive a course of treatment with various levels of care from different providers.
- Developing networks to provide long-term recovery services and supports to individuals with SUD following acute treatment regimens.
- Enhancing provider, plan, county and state capacity to secure, maintain, and utilize 42 CFR Part 2 compliant consent to disclose and/or re-disclose records on substance abuse treatment for the purposes of care coordination, population health management, research and evaluation.
- Increasing provider adoption of Office of the National Coordinator-certified health information technology products, allowing for interoperable health information exchange.

Introducing a comprehensive continuum of care will require states to ensure access to inpatient and short-term residential levels of care to provide SUD treatment and support recovery. CMS

¹⁷ <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-005.pdf>

recognizes that in some instances these levels of care are offered in facilities defined as institutions for mental diseases (IMD) at 42 CFR 435.1010. While services provided to individuals residing in IMDs are excluded as medical assistance under a state plan, states can request authority for federal financial participation (FFP) for these expenditures if their proposal for a section 1115 demonstration project meets the programmatic expectations described below.

Expectations for a Transformed System

In addition to the standard requirements for an 1115 demonstration, states submitting proposals through this initiative must meet and will be subject to program requirements specific to SUD that will be incorporated into the Standard Terms and Conditions (STCs) of the waiver. These SUD-specific program requirements will reflect the following expectations, which we believe are hallmarks of a transformed system of care for individuals with SUD. The expectations to be incorporated into a state's state plan, Alternative Benefit Plan (ABP), 1915 waivers, or 1115 demonstration proposal and resulting STCs include:

Comprehensive Evidence-based Benefit Design

States will be asked to develop a substance use disorder benefit that guarantees a full continuum of evidence-based best practices designed to address the immediate and long-term physical, mental and SUD care needs of the individual. This includes better use of evidence based practices in the SUD field, including SBIRT, withdrawal management, MAT, care coordination, and long-term recovery supports and services. This can include short-term institutional services, including short-term inpatient and short-term residential SUD services for individuals in IMDs which supplement and coordinate with, but do not supplant, community-based services and supports.

Appropriate Standards of Care

States will be asked to use established standards of care in their design of the SUD benefit package, incorporating industry-standard benchmarks for defining medical necessity criteria, covered services and provider qualifications. For example, the ASAM Criteria is a nationally accepted set of treatment criteria for SUD care. States should use the ASAM Criteria as they develop a residential or inpatient SUD service continuum, and are encouraged to adopt the ASAM Criteria for other treatment modalities and levels of care as well.

In order to receive approval for a section 1115 demonstration under this opportunity, states must implement a process to assess and demonstrate that residential providers meet ASAM Criteria prior to participating in the Medicaid program under the demonstration and rendering services to beneficiaries. In addition, the assessment for all SUD services, level of care and length of stay recommendations must be performed by an independent third party that has the necessary competencies to use ASAM Patient Placement Criteria. Specifically, an entity other than the rendering provider will use the ASAM Criteria to perform a multidimensional assessment of beneficiaries, place beneficiaries at appropriate levels of care, and make recommendations for length of service.

States seeking to transform their SUD systems are encouraged to develop additional strategies adopted by health systems to ensure quality and consistent practices. One of the paths toward

this goal may be accreditation of their providers. Currently, some SUD providers are accredited by national organizations (e.g. the Joint Commission and the Commission on Accreditation of Rehabilitation Facilities).

Strong Network Development Plan

States will be asked to develop a network development and resource plan to ensure there is a sufficient network of knowledgeable providers in each of the levels of care recognized by ASAM and recovery support services. In addition, the state should have the resources to ensure that providers have the ability to deliver services consistent with the ASAM Criteria and provide evidence based SUD practices. The network should be sufficiently robust so that access can be assured in the event that some providers stop participating in Medicaid, are suspended or terminated.

Care Coordination Design

Coordination of care design is integral to SUD delivery reform. This entails developing processes to ensure seamless transitions and information sharing between levels and settings of care (withdrawal management, short-term inpatient, short-term residential, partial hospitalization, outpatient, post-discharge, recovery services and supports), as well as a collaboration between types of health care (primary, mental health , pharmacological, and long-term supports and services). CMS encourages states to test how to best achieve care transitions across the care continuum, including aftercare and recovery support services CMS encourages states to support electronic health information exchange, including the use of ONC-certified health IT products, to improve care coordination consistent with federal health privacy (HIPAA) and confidentiality (42 CFR Part 2) requirements.

Integration of Physical Health and SUD

State should have a clear approach for coordinating physical health and behavioral health services which could include the use of:

- Section 2703 health homes
- Integrated care models
- Accountable care organizations
- Primary care medical homes

States must specify a timeframe for integrating physical and behavioral health care for the population of individuals with SUD or a subpopulation, including committing to an approach within twelve months after 1115 SUD demonstration approval, producing a concept design within eighteen months after demonstration approval, and implementing within two years after demonstration approval.

Program Integrity Safeguards

As states strengthen their SUD benefit package, expand their Medicaid eligibility criteria and receive enhanced FMAP levels for expansion populations, the Medicaid program faces greater levels of risk of fraud and abuse. To be effective stewards of taxpayers' dollars, CMS and states must ensure there are rigorous program integrity protocols in place to safeguard against fraudulent billing. At a minimum, this should include conducting risk-based screening of all newly enrolling providers, as well as revalidating existing providers (including ordering and

referring practitioners) pursuant to provider screening rules at 42 CFR Part 455 Subpart E and accompanying guidance, ensuring SUD providers have entered into Medicaid provider agreements pursuant to 42 CFR 431.107, and ensuring that there is a process the state has put into place to address billing and other compliance issues.

Benefit Management

The provision of more clinically intensive services (including short-term inpatient and short-term residential treatment) must be managed with regular utilization review processes to ensure that these services are medically necessary. For example, these can include prior authorization, targeted post-payment claims review and billing system edits to deny claims beyond a time span, among others. States are encouraged to use capitated and managed fee-for-service approaches for their benefit management strategy. States that propose to introduce financial or treatment limitations must demonstrate compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA).

Community Integration

In January 2014, CMS issued regulations regarding our Home and Community Based Services programs.¹⁸ Those regulations set forth requirements regarding person-centered planning and the characteristics of home and community based settings. States should include how they will incorporate these requirements in their service planning and service delivery efforts, including adherence to the settings requirements, where applicable.

Strategies to Address Prescription Drug Abuse

The Centers for Disease Control and Prevention has classified prescription drug abuse as an epidemic. In 2011 the Administration published its Prescription Drug Abuse Prevention Plan, which outlined four pillars, education, monitoring, safe storage and disposal, and enforcement.¹⁹ These were geared towards preventing non-medical prescription drug use and the consequences of the opioid epidemic and augmented the interagency efforts outlined in the National Drug Control Strategy concerning supply and demand reduction and consequence prevention. While there has been a marked decrease in the use of some illegal drugs like cocaine, data from the National Survey on Drug Use and Health show that nearly one-third of people aged 12 and over whom used drugs for the first time in 2009 began by using a prescription drug non-medically.²⁰ From 1999 to 2013, the rate for drug poisoning deaths involving opioid analgesics nearly quadrupled.²¹

¹⁸ Centers for Medicaid and CHIP Services. *Final Rule – CMS 2249-F – 1915(i) State Plan Home and Community-Based Services, 5-Year Period for Waivers, Provider Payment Reassignment, Setting Requirements for Community First Choice, and CMS 2296-F 1915(c) Home and Community-Based Services Waivers*. [2014]. Retrieved from: <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-10-14.pdf>.

¹⁹ Office of National Drug Control Policy. *Epidemic: Responding to America's Prescription Drug Abuse Crisis*. [2011]. Retrieved from: https://www.whitehouse.gov/sites/default/files/ondcp/issues-content/prescription-drugs/rx_abuse_plan.pdf.

²⁰ National Survey on Drug Use and Health. Retrieved From: <http://www.samhsa.gov/data/population-data-nsduh>

²¹ Centers for Disease Control and Prevention. *QuickStats: Rates of Deaths from Drug Poisoning and Drug Poisoning Involving Opioid Analgesics — United States, 1999–2013*. MMWR Weekly. Retrieved from: <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6401a10.htm>.

There are a variety of strategies that states and payers have put into place to address prescription drug abuse. These include issuing prescribing guidelines, introducing claims edits for equivalent opioid and concomitant benzodiazepine prescriptions, utilizing Prescription Drug Monitoring Programs (PDMPs), and supporting Electronic Prescribing of Controlled Substances (EPCS). CMS encourages states to promote and improve the use of PDMPs and to encourage adoption of EPCS. We are requesting that states develop and implement proven strategies to address prescription drug abuse at the state, plan, patient, pharmacy and provider level.

Strategies to Address Opioid Use Disorder

The abuse of and addiction to opioids is a serious and challenging public health problem. While the rate for drug-poisoning death involving opioid analgesics has leveled in the most recent years, the rate for deaths involving heroin nearly tripled between 2010 and 2013.²²

On March 26, 2015, the U.S. Department of Health and Human Services announced a targeted initiative to decrease opioid overdoses, decrease overall overdose mortality, and decrease the prevalence of opioid use disorder. The Secretary's initiative targets three priority areas to combat opioid abuse:

- Opioid prescribing practices to reduce opioid use disorders and overdose
- Expanded use and distribution of naloxone
- Expansion of MAT to reduce opioid use disorders and overdose.

These three interventions align with the goal of this 1115 demonstration opportunity and reflect the expectations of a transformed system of care for individuals with SUD outlined in this letter. As described above, states should develop and issue opioid prescribing guidelines in concert with other interventions to address prescription drug abuse. States should expand the coverage of and access to naloxone in Medicaid, and should work in partnership with relevant social services and law enforcement agencies to design and deploy naloxone distribution strategies. States should also consider developing a robust benefit package and enhance clinical practices for MAT and other services to treat opioid addiction.

Services for Adolescents and Youth with an SUD

States will ensure that benefits are covered, services are available and access is timely for the youth and adolescent population with SUD. Pursuant to the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, states are required to provide all 1905(a) coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions for Medicaid beneficiaries under the age of 21. Please visit <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-01-26-2015.pdf> for more information on Medicaid coverage for behavioral health services for youth with SUD.

²² Centers for Disease Control and Prevention. *Drug-poisoning Deaths Involving Heroin: United States, 2000-2013*. National Center for Health Statistics Data Brief #190 [2015]. Retrieved from: <http://www.cdc.gov/nchs/data/databriefs/db190.pdf>.

Reporting of Quality Measures

A critical component of evaluating the efforts that states undertake to transform care for individuals with SUD will rely on a state's ability to track quality measures. States will be required to report certain current quality measures as part of this demonstration project.

Specifically, states will be required to report the relevant quality measures from the Medicaid Adult and Children's Core Sets for individuals with SUD, including the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF #0004).²³ States submitting proposals under this opportunity will also be required to report the SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and the SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge (NQF #1664) measures. States are encouraged to use the Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence (NQF #2605) measure in their evaluation design. States are also encouraged to include the Pharmacy Quality Alliance opioid performance measures in their design for evaluating efforts to reduce prescription opioid drug abuse.²⁴

CMS is interested in evaluating the effectiveness of the services delivered through this demonstration initiative in terms of health outcomes, health care costs and service utilization. To that end, we ask that states to assess the impact of providing SUD services on:

- Readmission rates to the same level of care or higher;
- Emergency department utilization; and
- Inpatient hospital utilization.

Proposals should also include a framework to evaluate successful care transitions to outpatient care, including hand-offs between levels of care within the SUD care continuum as well as linkages with primary care upon discharge. For example, states may consider adapting and modifying the Timely Transmission of Transition Record (NQF #0648) or Transition Record With Specified Elements Received by Discharged Patients (NQF #0647) measures for appropriate application to SUD services.

States may also propose other quality or process measures they currently use or may be asked to use measures that become available for this population. The data collected and reported by states participating in this demonstrative initiative will contribute to setting an initial baseline and establishing a national benchmark for these vital behavioral health services.

Collaboration With Single State Agency for Substance Abuse

Achieving the goals of this system transformation initiative will take the combined efforts of stakeholders across the health care system. The state Medicaid agency will need to apply for changes to the approved state plan or for demonstration projects to implement this initiative. In doing so, state Medicaid agencies should coordinate with the state's substance use disorder

²³ These measures can be found at <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-adult-core-set.pdf> and <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/2015-child-core-set.pdf>.

²⁴ These measures can be found at http://pqaalliance.org/images/uploads/files/Memo_NewMeasures_Opioids_Final.pdf.

authority on the concept design for the system transformation. These authorities can provide valuable data sets, such as block grant encounter information, which may inform the concept design and may be integral to data analytics and evaluation strategies. As a condition for approval of any demonstration authority to implement this initiative, state Medicaid agencies are required to collaborate and coordinate funding with the state substance use disorder authority in their efforts to transform their SUD system. State Medicaid agencies should also work and partner with relevant local, state and federal social services agencies to ensure the overall welfare of beneficiaries is provided for so they are positioned to respond to treatment successfully.

Medicaid Authorities Including Section 1115 Demonstrations

Many traditional (non-demonstration) Medicaid authorities provide states the flexibilities necessary to implement desired coverage and delivery reforms. These include options for coverage under section 1905(a) of the Act and Alternative Benefit Plan authorities under section 1937 of the Act, health home programs with enhanced federal matching for the first 8 quarters under section 1945 of the Act, managed care options under sections 1915(b) and 1932 of the Act, and coverage of home and community-based services under sections 1915(c), (i) and (k) of the Act. States seeking to transform their SUD systems may consider these other authorities in lieu of or in addition to 1115 demonstration projects. Please visit <http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/pathways-2-9-15.pdf> for more information on pursuing SUD system transformation efforts through these and other pathways.

Section 1115 demonstrations may be designed to provide more effective treatment of SUD by extending coverage for services in inpatient and/or residential settings that are within the definition of IMDs at 42 CFR 435.1010. To the extent that a demonstration initiative is consistent with the expectations for a transformed SUD treatment system, CMS would specifically allow FFP for costs not otherwise matchable to provide coverage for services furnished to individuals residing in IMDs for short-term acute SUD treatment. Short-term acute SUD treatment may occur in inpatient settings and/or residential settings.

Inpatient services are described by the ASAM Criteria as occurring in Level 4.0 settings, which are medically managed services. Inpatient services are provided, monitored and observed by licensed physician and nursing staff when the acute biomedical, emotional, behavioral and cognitive problems are so severe that they require inpatient treatment or primary medical and nursing care. For short-term inpatient treatment for individuals with SUD in settings that meet the definition of an IMD, stays have been proposed to be limited to fifteen (15) days.

Residential services are provided in in ASAM Level 3.1, 3.3, 3.5 and 3.7 settings, which are clinically managed and medically monitored services typically provided in freestanding, appropriately licensed facilities or residential treatment facilities without acute medical care capacity. For short-term residential SUD treatment in settings that meet the definition of an IMD, stays will be limited to an average length of stay of thirty (30) days.

CMS remains committed to the underlying rationale of ensuring integrated and community-based care provided in right settings, so such inpatient and residential care should supplement

and coordinate with community-based care and be clinically appropriate. CMS encourages states continue to maintain its current funding commitment and levels to a continuum of community services consistent with SAMHSA's maintenance of effort requirements for its Substance Abuse Prevention and Treatment Block Grant, regardless of increased federal contributions. This SUD initiative should not reduce or divert state spending on mental and substance use disorder service as a result of available federal funding for services in IMDs.

In addition to promoting the objectives of the Medicaid program and improving care for low-income individuals, section 1115 demonstrations must be budget neutral. This means that the proposed demonstration cannot cost the federal government more than it would absent the demonstration. CMS will work closely with states in their efforts to determine the feasibility of their budget neutrality model while they are developing their conceptual demonstration project design.

Submission Process for Section 1115 Demonstration Projects

States should follow the usual process for submitting 1115 demonstration projects proposals. CMS requests that the proposal address each of the expectations set forth in this guidance. Generally, states must provide at least the information listed below:

- A demonstration program description, and goals and objectives that will be implemented under the demonstration project.
- The description of the proposed health care delivery system and benefit coverage.
- An estimate of the expected increase or decrease in annual aggregate expenditures by population group impacted by the demonstration. If available, include historic data for these populations.
- An estimate of historic coverage and enrollment data (as appropriate), and estimated projections expected over the term of the demonstration, for each category of beneficiary whose health care coverage is impacted by the demonstration.
- Other demonstration program features that require flexibilities within the Medicaid and CHIP programs.
- The types of waivers and expenditure authorities that the State believes to be necessary to authorize the demonstration.
- The research hypothesis or hypotheses that are related to the demonstration's proposed changes, goals, and objectives, a plan for testing the hypotheses in the context of an evaluation, and, if a quantitative evaluation design is feasible, the identification of appropriate evaluation indicators.

Section 1115 demonstration applications may be submitted electronically to 1115DemoRequests@cms.hhs.gov or by mail to:

Eliot Fishman
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850

Public Input

The Affordable Care Act required the Secretary to set forth transparency and public notice procedures for experimental, pilot, and demonstration projects approved under section 1115 of the Social Security Act that increase the public availability of information about Medicaid and CHIP demonstration applications and approved demonstration projects and promote public input as states develop and the federal government reviews these demonstrations. CMS issued a final regulation on February 27, 2012, outlining the new regulatory requirements for initial section 1115 demonstration applications and extension requests, public notice procedures, and reporting and evaluation requirements. The rule can be found at <http://www.gpo.gov/fdsys/pkg/FR-2012-02-27/pdf/2012-4354.pdf>.

The high rates of alcohol and substance use disorder, mental health disorders, suicide and behavior-related chronic diseases in American Indian and Alaska Native (AI/AN) communities are well documented. AI/ANs are significantly more likely to report past-year alcohol and substance use disorders than any other race.²⁵ As required by the transparency regulations cited above, states with Indian tribes and Indian health providers must consult with the tribes and solicit advice from the Indian health providers to assure access to these services is available and meets the unique and cultural needs of AI/AN individuals. In addition, states must solicit advice from the Indian health providers in the state as required by 1902(a)(73) of the Social Security Act. We encourage states to work collaboratively with the Indian health providers in the state to assure inclusion of providers that have the expertise to address the unique cultural needs of AI/AN.

We hope this information will be helpful. Questions regarding this guidance may be directed to Mr. John O'Brien, Senior Policy Advisor, Disabled and Elderly Health Program Group (John.O'Brien3@cms.hhs.gov), or Mr. Eliot Fishman, Director, State Demonstrations Group (Eliot.Fishman@cms.hhs.gov). We look forward to continuing our work together.

Sincerely

/s/

Vikki Wachino
Director

cc:

National Association of Medicaid Directors

National Academy for State Health Policy

²⁵ Indian Health Service. *Behavioral Health*. [2015]. Retrieved from: http://www.ihs.gov/newsroom/includes/themes/newihstheme/display_objects/documents/factsheets/BehavioralHealth.pdf.

National Governors Association

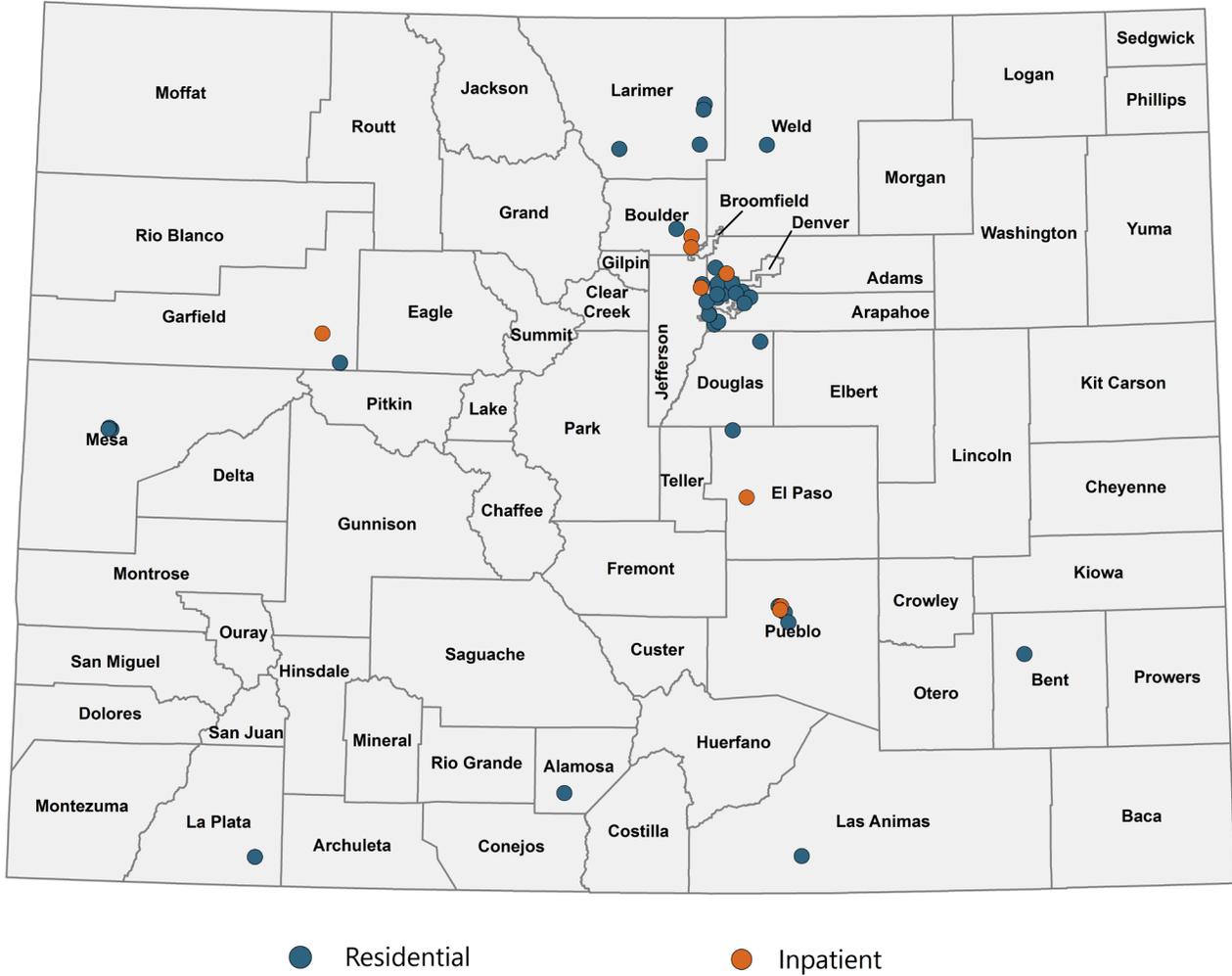
American Public Human Services Association

Association of State and Territorial Health Officials

Council of State Governments

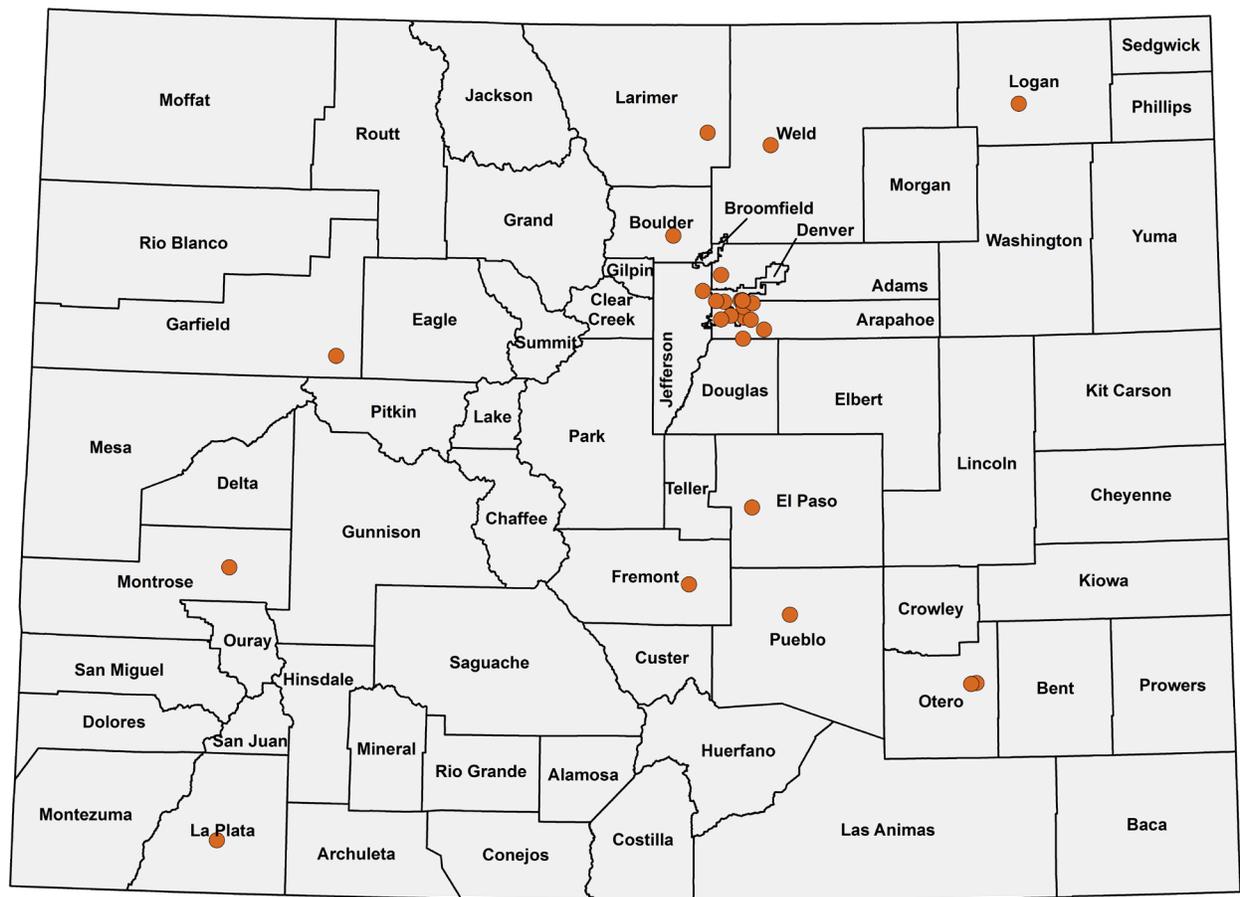
Appendix H. Mental Health and Substance Use Services Maps

OBH-Licensed Residential and Inpatient Treatment Facilities



Source: Office of Behavioral Health

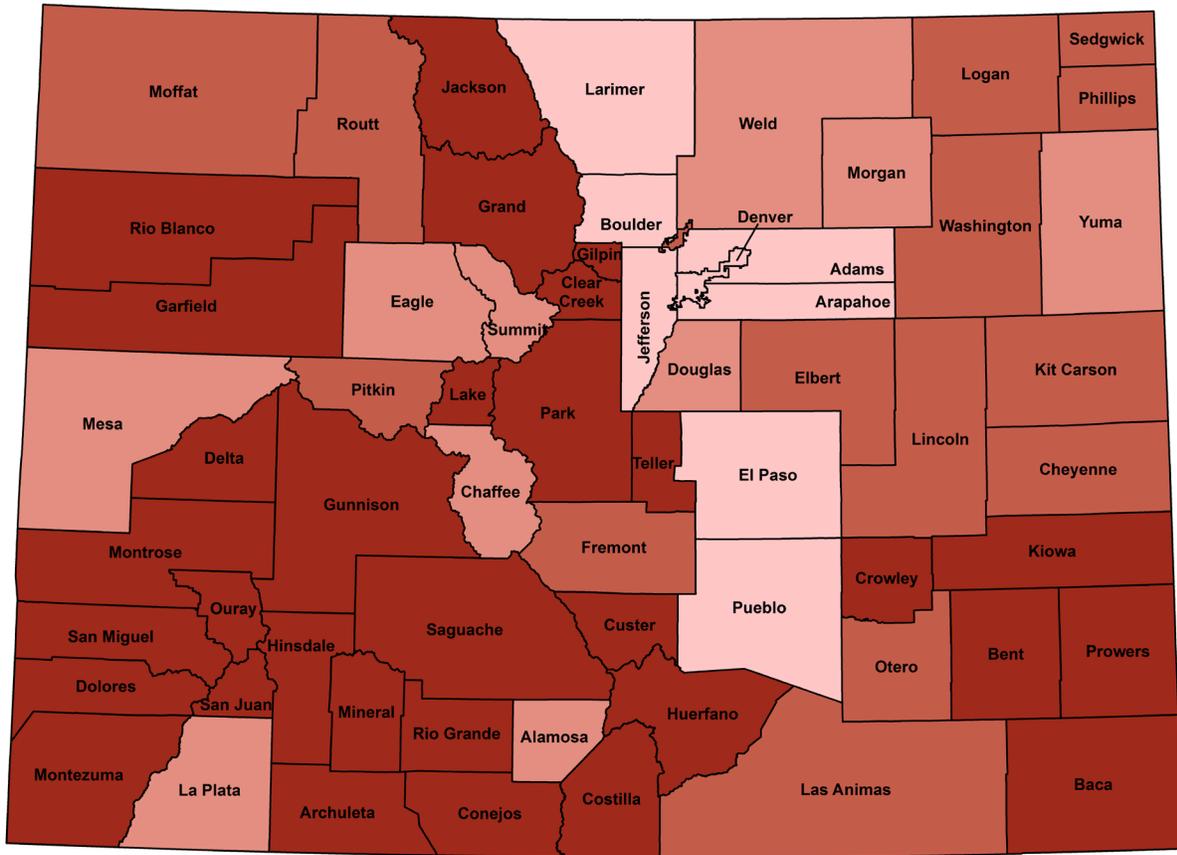
Community Mental Health Centers



● Community Mental Health Centers

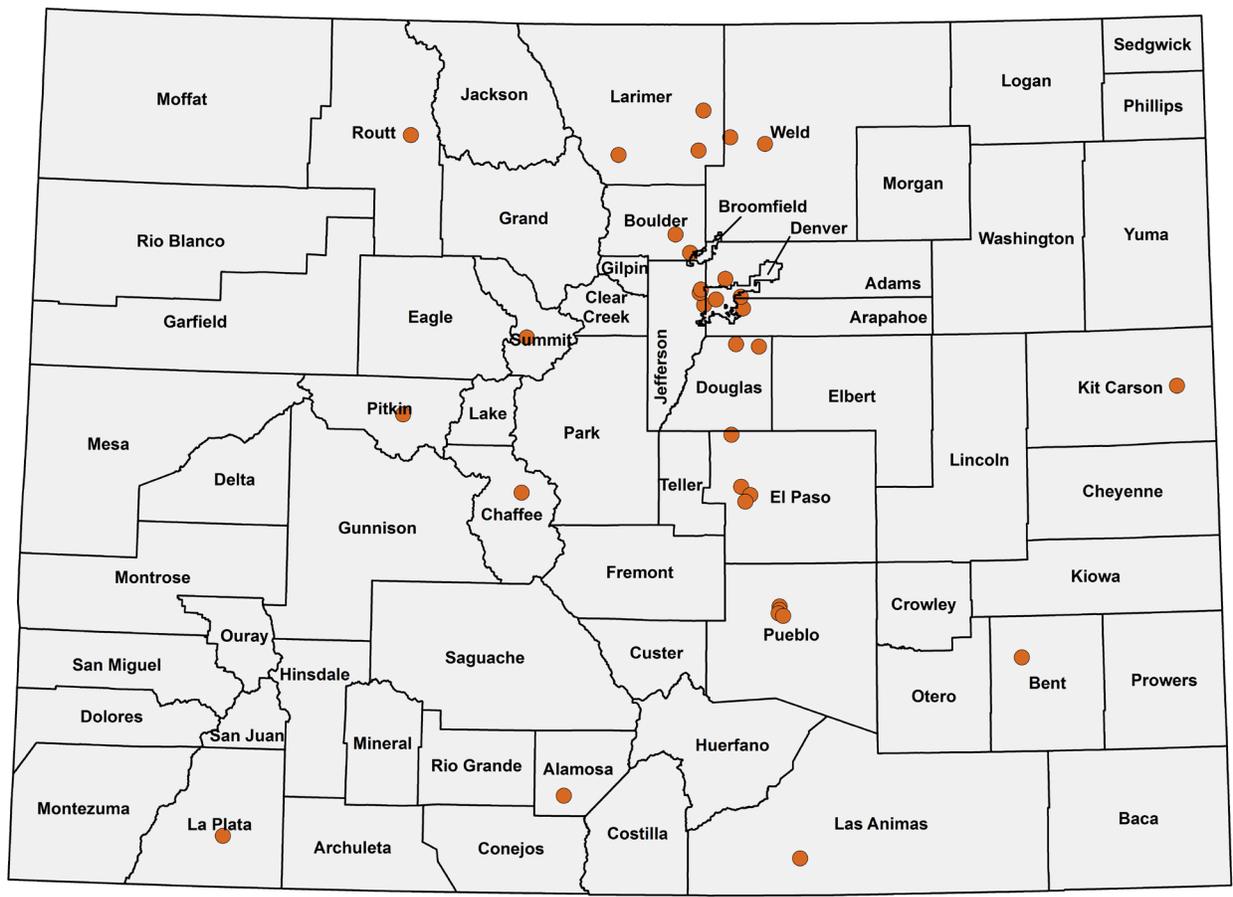
Source: Colorado Department of Public Health and Environment

Number of Opioid Treatment Programs and Medication-Assisted Treatment Providers



Source: Substance Abuse and Mental Health Services Administration

OBH-Licensed Detox Locations



● Detox Locations

Source: Office of Behavioral Health

Special Connections Providers



● Special Connections Providers

Source: Colorado Department of Health Care Policy and Financing

Endnotes

- ¹ Substance Abuse and Mental Health Services Administration. (2015). "Behavioral Health Barometer: Colorado." <https://store.samhsa.gov/shin/content//SMA16-BARO-2015/SMA16-BARO-2015-CO.pdf>.
- ² Substance Abuse and Mental Health Services Administration. (2015). "Behavioral Health Barometer: Colorado." <https://store.samhsa.gov/shin/content//SMA16-BARO-2015/SMA16-BARO-2015-CO.pdf>.
- ³ Department of Health Care Policy and Financing. (2017). Data Request.
- ⁴ Colorado Department of Public Health and Environment. (2016). "Health Watch No. 100: Examining Opioid and Heroin-Related Drug Overdose in Colorado." www.chd.dphe.state.co.us/Resources/pubs/Colorado-Opioid-and-Heroin-Overdose.pdf.
- ⁵ Department of Health Care Policy and Financing. (2017). "Opioid Use in Colorado: Medicaid Addresses Addiction." <https://www.colorado.gov/pacific/sites/default/files/Opioid%20Use%20in%20Colorado%20-%20March%202017.pdf>.
- ⁶ Medicaid and CHIP Payment and Access Commission. (2017). "Report to Congress on Medicaid and CHIP: Medicaid and the Opioid Epidemic." <https://www.macpac.gov/wp-content/uploads/2017/06/Medicaid-and-the-Opioid-Epidemic.pdf>.
- ⁷ "Substance Abuse and Mental Health Services Administration. (2015). National Survey on Drug Use and Health: 2012-2014."
- ⁸ SAMHSA. "National Survey on Drug Use and Health: 2012-2014."
- ⁹ Substance Abuse and Mental Health Services Administration. (2015). "Behavioral Health Barometer: Colorado." <https://store.samhsa.gov/shin/content//SMA16-BARO-2015/SMA16-BARO-2015-CO.pdf>.
- ¹⁰ Colorado Health Institute. (2017). "Colorado's New Normal: Findings from the 2017 Colorado Health Access Survey." <https://www.coloradohealthinstitute.org/research/colorado-health-access-survey>.
- ¹¹ American Society of Addiction Medicine. (2013). "Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions." Third Edition.
- ¹² Reif, S., et al. (2014). "Residential Treatment for Individuals with Substance Use Disorders: Assessing the Evidence." *Psychiatric Services*. Vol. 65, No. 3.
- ¹³ Allen, Ben. (2016). "How We Got Here: Treating Addiction in 28 Days." National Public Radio. <http://www.npr.org/sections/health-shots/2016/10/01/495031077/how-we-got-here-treating-addiction-in-28-days>.
- ¹⁴ Office of the Surgeon General. (2016). Facing Addiction: The Surgeon General's Report on Alcohol, Drugs, and Health. U.S. Department of Health and Human Services. <https://addiction.surgeongeneral.gov/surgeon-generals-report.pdf>.
- ¹⁵ National Institutes of Health. (1980). "Drug Withdrawal Symptoms: A Literature Review." *Western Journal of Medicine* 133(5): 383-391.
- ¹⁶ Office of the Surgeon General. (2016). Facing Addiction.
- ¹⁷ SAMHSA. (2015). National Survey of Substance Abuse Treatment Services (N-SSATS): Public Use File.
- ¹⁸ SAMHSA. (2017). National Survey of Substance Abuse Treatment Services (N-SSATS): Data on Substance Abuse Treatment Facilities. BHSIS Series S-88, HHS Publication No. (SMA) 17-5031. Rockville, MD: 2017. https://www.samhsa.gov/data/sites/default/files/2016_NSSATS.pdf.
- ¹⁹ "Addiction Medicine: Closing the Gap Between Science and Practice." (2012). The National Center on Addiction and Substance Abuse at Columbia University. <https://www.centeronaddiction.org/addiction-research/reports/addiction-medicine-closing-gap-between-science-and-practice>.
- ²⁰ 42 CFR 438.602(b)(1).
- ²¹ Office of the Surgeon General. (2016). Facing Addiction.
- ²² Centers for Disease Control and Prevention. (2016). Adverse Childhood Experiences (ACE) Study. <https://www.cdc.gov/violenceprevention/acesstudy/about.html>.
- ²³ Dube, SR. et al. (2002). "Adverse Childhood Experiences and Personal Alcohol Abuse as an Adult." *Addictive Behaviors*.
- ²⁴ Dube, SR. et al. (2003). "Childhood Abuse, Neglect, and Household Dysfunction and the Risk of Illicit Drug Use: The Adverse Childhood Experiences Study." *Pediatrics*. Volume 111, Issue 3.
- ²⁵ Office of the Surgeon General. (2016). Facing Addiction.
- ²⁶ Office of the Surgeon General. (2016). Facing Addiction.
- ²⁷ The National Center on Addiction and Substance Abuse at Columbia University. (2012). "Addiction Medicine: Closing the Gap Between Science and Practice." <https://www.centeronaddiction.org/addiction-research/reports/addiction-medicine-closing-gap-between-science-and-practice>.
- ²⁸ Office of the Surgeon General. (2016). Facing Addiction.
- ²⁹ McHugh, RK, Hearon, BA and Otto, MW. (2010). "Cognitive-Behavioral Therapy for Substance Use Disorders." *Psychiatric Clinics of North America*.
- ³⁰ Gregory, VL. (2011). "Cognitive Behavioral Therapy for Comorbid Bipolar and Substance Use Disorders: A Systematic

Review of Controlled Trials.” *Journal of Mental Health and Substance Use*. 4(4).

³¹ Secades-Villa, R, et al. (2011). “Community Reinforcement Approach Plus Vouchers Among Cocaine-Dependent Outpatients: Twelve Month Outcomes.” *Psychology of Addictive Behaviors*.

³² Higgins, ST et al. (1994). “Incentives Improve Outcome in Outpatient Behavioral Treatment of Cocaine Dependence.” *Archives of General Psychiatry*. 51(7):568-76.

³³ National Institute on Drug Abuse. (2012). *Motivational Enhancement Therapy (Alcohol, Marijuana, Nicotine). “Principles of Drug Addiction Treatment: A Research-Based Guide.”* Third Edition.

³⁴ Office of the Surgeon General. (2016). *Facing Addiction*.

³⁵ Schwartz, RP, et al. (2013). “Opioid Agonist Treatments and Heroin Overdose Deaths in Baltimore, Maryland, 1995-2009.” *American Journal of Public Health*. v. 103(5).

³⁶ Walitzer, KS, et al. (2009). “Facilitating Involvement in Alcoholics Anonymous During Outpatient Treatment: A Randomized Control Trial.” *Addiction*. 102.

³⁷ Office of the Surgeon General. (2016). *Facing Addiction*.

³⁸ Reif, S, et al. (2014). “Residential Treatment for Individuals with Substance Use Disorders: Assessing the Evidence.” *Psychiatric Services*. Vol. 65, No. 3.

³⁹ Morrens, M. et al. (2011). “Treatment Outcomes of an Integrated Residential Programme for Patients with Schizophrenia and Substance Use Disorder.” *European Addiction Research*.

⁴⁰ De Leon, G. et al. (2008). “Client Matching: A Severity-Treatment Intensity Paradigm.” *Journal of Addictive Diseases*.

⁴¹ Tiet, Q. et al. (2007). “Treatment Setting and Baseline Substance Use Severity Interact to Predict Patients’ Outcomes.” *Addiction*.

⁴² American Society of Addiction Medicine. (2013). “Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions.” Third Edition.

⁴³ Office of the Surgeon General. (2016). *Facing Addiction*.

⁴⁴ Estee, S. and Nordlund, D. (2003). “Washington State Supplemental Security Income (SSI) Cost Offset Pilot Project.” Washington State Department of Social and Health Services. <https://www.dshs.wa.gov/sesa/rda/research-reports/washington-state-supplemental-security-income-ssi-cost-offset-pilot-project-0>.

⁴⁵ Mancuso D, Felver BE. (2010). “Bending the Health Care Cost Curve by Expanding Alcohol/Drug Treatment.” Washington State Department of Social and Health Services. <https://>

www.dshs.wa.gov/sites/default/files/SESA/rda/documents/research-4-81.pdf.

⁴⁶ Mojtabai, R. and Graff Zivin, J. (2003). “Effectiveness and Cost-effectiveness of Four Treatment Modalities for Substance Disorders: A Propensity Score Analysis.” *Health Services Research*, 38(1p1): 233-259.

⁴⁷ Shah, J. (2017). “Jail Based Behavioral Health Services. Office of Behavioral Health Testimony to the County Courthouse and County Jail Funding and Overcrowding Solutions Interim Study Committee.”

⁴⁸ Behavioral Health Task Force. (2014). “Final Report: An Overview of Colorado’s Behavioral Health System.” <http://lvvcolorado.org/docs/behavioral-health-task-force-may-2014.pdf>.

⁴⁹ Binswanger, I.A. et al. (2007). “Release from Prison – A High Risk of Death for Former Inmates.” *New England Journal of Medicine*. 356;2.

⁵⁰ Binswanger, I.A. et al. (2013). “Mortality After Prison Release: Opioid Overdose and Other Causes of Death, Risk Factors, and Time Trends from 1999 to 2009.” *Annals of Internal Medicine*. 159(9).

⁵¹ Klebe, K.J., and O’Keefe, M. (2004). “Outcome Evaluation of the Crossroads to Freedom House and Peer I Therapeutic Communities.” *NCJRS*.

⁵² Dynia, P., and Sung, H. E. (2000). “The Safety and Effectiveness of Diverting Felony Drug Offenders to Residential Treatment as Measured by Recidivism.” *Criminal Justice Policy Review*, 11(4):299-311.

⁵³ Hiller, M.L. et al. (2006). “Recidivism Following Mandated Residential Substance Abuse Treatment for Felony Probationers.” *The Prison Journal*. 86(2):230-241.

⁵⁴ American Society of Addiction Medicine. (2013).

⁵⁵ Legal Action Center. (2014). “The Medicaid IMD Exclusion: Overview and Opportunities for Reform.” https://lac.org/wp-content/uploads/2014/07/IMD_exclusion_fact_sheet.pdf.

⁵⁶ Wachino, V. (2015). “State Medicaid Director Letter: New Service Delivery Opportunities for Individuals with a Substance Use Disorder.” Centers for Medicare & Medicaid Services. <https://www.medicare.gov/federal-policy-guidance/downloads/SMDI5003.pdf>.

⁵⁷ Distinct categories of Medicaid enrollees receive a higher match rate from the federal government. For example, the Medicaid expansion population receives a 95 percent match from CMS now and it will decrease to 90 percent by 2020. <https://www.coloradohealthinstitute.org/research/medicaid-expansion-colorado>. The 50 percent match rate is the minimum rate for Colorado and is used as the baseline for this analysis.

⁵⁸ National Center for Health Statistics. (2017). “Data Brief 273 Tables: Drug Overdose Deaths in the United States, 1999-2015.” Centers for Disease Control and Prevention. <https://www.cdc.gov>

- gov/nchs/data/databriefs/db273_table.pdf.
- ⁵⁹ Wachino, V. (2015).
- ⁶⁰ Centers for Medicare & Medicaid Services. "Section 1115 Demonstrations." <https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html>.
- ⁶¹ Commission on Combatting Drug Addiction and the Opioid Crisis. (2017). Interim Draft Report. <https://www.whitehouse.gov/sites/whitehouse.gov/files/ondcp/commission-interim-report.pdf>.
- ⁶² H.R. 2687: "Medicaid Coverage for Addiction Recovery Expansion Act." (2017). <https://www.congress.gov/bill/115th-congress/house-bill/2687/text?r=8>.
- ⁶³ Kaiser Family Foundation. (2017). "Section 1115 Medicaid Demonstration Waivers: A Look at the Current Landscape of Approved and Pending Waivers." <http://www.kff.org/medicaid/issue-brief/section-1115-medicaid-demonstration-waivers-a-look-at-the-current-landscape-of-approved-and-pending-waivers/>.
- ⁶⁴ Wachino, V. (2015).
- ⁶⁵ Code of Colorado Regulations. (2016). "Statement of Basis and Purpose, Fiscal Impact/Regulatory Analysis and Specific Statutory Authority."
- ⁶⁶ Prior to 2012, the Bachelor's degree requirement was not in place. CACs III who were already certified did not undergo further certification to meet the post-2012 requirement.
- ⁶⁷ American Society of Addiction Medicine. (2013).
- ⁶⁸ Colorado Department of Health Care Policy and Financing. (2017). "Funding Request for the FY 2017-18 Budget Cycle. Exhibit B – Medicaid Caseload." https://www.colorado.gov/pacific/sites/default/files/S-1A%2C%20BA-1%20MSP_Exhibit%20B.pdf.
- ⁶⁹ Colorado Department of Human Services. (2016). "The Cost and Effectiveness of Substance Use Disorder Programs" (C.R.S. 27-80-110) Fiscal Year 2015-2016.
- ⁷⁰ Colorado Department of Health Care Policy and Financing. (2017). "Funding Request for the FY 2017-18 Budget Cycle. Schedule 13." <https://www.colorado.gov/pacific/sites/default/files/HCPF%2C%20FY18%2C%20R-07%20Oversight%20of%20State%20Resources.pdf>.
- ⁷¹ Colorado Department of Health Care Policy and Financing. (2012). "Funding Request for the FY 2013-14 Budget Cycle. Schedule 13." https://www.colorado.gov/pacific/sites/default/files/FY%202013%2014%20R-7%20Substance%20Use%20Disorder%20Benefit_0.PDF.
- ⁷² Bureau of Labor Statistics. (2016). Consumer Price Index – All Urban Consumers, U.S. city average. <https://data.bls.gov/cgi-bin/surveymost?cu>. (Compound annual growth rate calculated for September 2007-September 2016.)
- ⁷³ Ettner, S.L., Huang, D., et al. (2006). "Benefit-Cost in the California Treatment Outcome Project: Does Substance Abuse Treatment 'Pay for Itself?'" Health Services Research. 41(1). Pages 192-213, Table 2. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1681530/>
- ⁷⁴ Mojtabai, R. and Graff Zivin, J. (2003). "Effectiveness and Cost-effectiveness of Four Treatment Modalities for Substance Disorders: A Propensity Score Analysis." Health Services Research. 38:1, Part I. Page 246, Table 1.
- ⁷⁵ Gerson, L.W., et al. (2001). "Medical Care Use by Treated and Untreated Substance Abusing Medicaid Patients." Journal of Substance Abuse Treatment. 20, 115-120. Page 116, Table 1.
- ⁷⁶ Colorado Department of Human Services. (2016).
- ⁷⁷ Mojtabai, R. and Graff Zivin, J. (2003). Page 245, Table 1.
- ⁷⁸ Bureau of Labor Statistics. (2016). Consumer Price Index Medical Care Component – All Urban Consumers, U.S. city average. <https://data.bls.gov/cgi-bin/surveymost?cu>. (Compound annual growth rate calculated for September 2007-September 2016.)
- ⁷⁹ Colorado Department of Health Care Policy and Financing. "Funding Request for the FY 2013-14 Budget Cycle. Funding Request for the FY 2017-18 Budget Cycle." Medical Services Premiums Exhibit B – Medicaid Caseload.
- ⁸⁰ Busch, S., et al. (2013). "Characteristics of Adults with Substance Use Disorders Expected to be Eligible for Medicaid Under the ACA." Psychiatry Services. 64(6).
- ⁸¹ Colorado Department of Human Services. (2016). Page 6, Figure 3. (Medicaid was excluded from calculation of fund splits.)



COLORADO HEALTH INSTITUTE

The Colorado Health Institute is a trusted source of independent and objective health information, data and analysis for the state's health care leaders. The Colorado Health Institute is funded by the Caring for Colorado Foundation, Rose Community Foundation, The Colorado Trust and the Colorado Health Foundation.

303 E. 17th Ave., Suite 930, Denver, CO 80203 • 303.831.4200
coloradohealthinstitute.org

OUR FUNDERS

