STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Dennis R. Schrader, Secretary

January 20, 2017

The Honorable Edward J. Kasemeyer
Chair
Senate Budget and Taxation Committee
3 West Miller Senate Office Building
Annapolis, MD 21401-1991

The Honorable Maggie McIntosh
Chair
House Appropriations Committee
121 House Office Building
Annapolis, MD 21401-1991

RE: 2016 Joint Chairmen's Report (Page 72) – Alternatives to Residential Treatment for Commitments under Section 8 - 507 of the Health - General Article

Dear Chair Kasemeyer and Chair McIntosh:

Pursuant to page 72 of the 2016 Joint Chairmen's Report, the Department of Health and Mental Hygiene (DHMH) respectfully submits this report on alternatives to residential treatment for commitments under Section 8 - 507 of the Health - General Article. Specifically, the report outlines the appropriateness of utilizing recovery support housing in conjunction with outpatient services to meet the needs of those individuals committed to the Department under this procedure.

As requested by the Department of Legislative Services, this report has been shared with the Judiciary prior to submission. The Judiciary submitted their commentary to the Senate Budget and Taxation Committee and the House Appropriations Committee for this JCR last month.

Thank you for your consideration of this information. If you have any questions regarding this report, please contact Webster Ye, Director of Governmental Affairs, at (410) 767-6480 or at webster.ye@maryland.gov.

Sincerely,

Dennis R. Schrader
Secretary

Enclosure

cc: Barbara J. Bazron, Ph.D.
The Honorable Mary Ellen Barbera
Webster Ye
Jordan More, DLS

Maryland Department of Health and Mental Hygiene
Behavioral Health Administration

Alternatives to Residential Treatment under Section 8-507 of the Health – General Article
2016 Joint Chairmen's Report (Page 72)

Introduction

The 2016 Joint Chairmen's Report adopted by the Maryland General Assembly during the 2016 legislative session, requires the Department of Health and Mental Hygiene (Department) to report on alternatives to residential treatment for commitments under § 8-507 of the Health - General Article. This includes the appropriateness of utilizing recovery support housing in conjunction with outpatient services to meet the needs of those individuals committed to the Department under this procedure.

Background

Before issuing a court order to commit an individual to the Department for treatment under § 8-507 of the Health - General Article, an evaluation must first occur under §§ 8-505 or 8-506. These evaluations are conducted through local health departments to determine what level of care within the American Society of Addiction Medicine's (ASAM) criteria is medically necessary for each individual. During this evaluation, all levels of treatment are considered, including alternatives to residential placement in instances in which residential treatment is not medically appropriate.

When an evaluation is ordered under §§ 8-505 or 8-506, an appropriate level of care is recommended, based on the ASAM criteria. On motion of the defendant, a court may subsequently order treatment at the level of care indicated in the §§ 8-505 or 8-506 evaluation. The Department is unable to place a patient in a lower level of care if the evaluation indicates a residential placement is required. There is generally no flexibility for the Department to consider an alternative treatment option once the evaluation and court order have been issued.

If a residential placement is determined to be medically necessary through the evaluation, individuals are referred to one of the Department's three contracted § 8-507 treatment providers: Gaudenzia, Inc., New Horizons Health Services, and Jude House, Inc., which serve different regions of the state.

It should be noted, however, that not everyone who is evaluated as needing residential placement is subsequently ordered into an § 8-507 residential placement. For example, a defendant must accept the recommendation for the level of care and then file a motion for the court to issue the order under § 8-507 before a court can grant the motion for treatment. In addition, if any

outstanding warrants or detainers are identified during the clearance process following a court order being issued, this would preclude or delay the order from being implemented.

Annual Census and Funding

In fiscal year 2016, the Department was appropriated approximately $6 million in funding, which supported 360 individuals in § 8-507 treatment placements. This is based upon an average daily census of 120 individuals with an average length of stay of four months. While the Department places individuals as court orders are issued, there are many factors that determine the annual census. These include:

- Annual budget
- Daily rate of services, which varies by provider
- Percentage of cases referred to each provider
- Average length of stay

In fiscal year 2017, the Department was awarded an additional $3 million in funding, bringing the total funding level to approximately $8,953,588 (50% increase over FY16). The Department anticipates placing 540 individuals during the current fiscal year, based upon a daily census of approximately 180 patients and admitting approximately 45 patients per month. In addition, there is supplemental grant funding for services in Baltimore City. These residential substance use disorder services are similar to § 8-507 services and have historically been included in the Department's § 8-507 data collection. In FY16, $1,117,307 was spent to serve 163 individuals. A reconciliation of the supplemental grant funds with the § 8-507 program will occur on July 1, 2017 when the Department finalizes the transfer of grant funding for substance use disorder residential services to fee-for-service.

Alternatives to Health - General Article § 8-507

As previously mentioned, the Department must place an individual in a § 8-507 residential treatment placement upon court order if it is determined to be medically necessary and indicated by the §§ 8-505 or 8-506 evaluation. If residential treatment by a traditional § 8-507 residential provider was not indicated in the evaluation, then the Department or its designee may refer the individual to other providers who provide care at the level of care recommended in the evaluation. Any considerations of alternative placements would be based on medical necessity using ASAM criteria.

Institutes for Mental Disease

An Institute for Mental Disease (IMD) is defined as a facility with more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases and chemical dependency disorders.

The Institutions for Mental Diseases (IMD) exclusion limits the number of beds a treatment facility may operate in order to receive reimbursement from Medicaid to less than 16. Furthermore, it excludes states from receiving federal matching dollars for services provided by IMDs for individuals between 21 and 64 years old. Receiving federal financial participation for services provided to individuals residing in IMDs would allow providers to admit more patients into residential treatment for substance use disorders (SUD).

The effects of the IMD exclusion are significant. The IMD exclusion incentivizes hospitalization in a general acute care hospital rather than in an SUD residential treatment program. These hospitalizations typically only treat the medical effects of individuals' illnesses while neglecting the illnesses themselves and the long-term consequences of SUDs. The National Council on Alcoholism and Drug Dependence-Maryland noted that the IMD exclusion results in individuals seeking treatment in lower levels of care than what is clinically recommended.

Although the IMD exclusion is one of the few instances where Medicaid is not permitted to provide payment for medically necessary services, this was not always the case. The Centers for Medicare and Medicaid Services (CMS) had approved IMD exclusion waivers in the past. For instance, Maryland's first IMD exclusion waiver was granted in 1997 and allowed adults between 21 and 64 with acute episodes of mental illness to receive Medicaid-covered treatment in IMDs, rather than general acute care hospitals. However, beginning in FY 2006, CMS phased out the use of IMDs, resulting in Maryland receiving 50% of the expected Federal Financial Participation for FY 2007 and 0% for FY 2008.

Maryland was also one of the states selected for the Medicaid Emergency Psychiatric Demonstration, a pilot program established under Section 2707 of the Affordable Care Act that made Medicaid funds available to non-public psychiatric hospitals for emergency inpatient psychiatric care provided to Medicaid enrollees aged 21 to 64 for an initial three-year period. The demonstration tested the extent to which reimbursing these hospitals for inpatient services needed to stabilize a psychiatric emergency medical condition, which is generally prohibited

under Medicaid statute, improved access to and quality of care for beneficiaries and reduced overall Medicaid costs and utilization.

On July 27, 2015, Maryland submitted an amendment to its HealthChoice §1115 demonstration waiver to allow for coverage of residential treatment for both SUD and mental health diagnoses. That amendment was denied by CMS. The State modified its proposal to only focus on SUD coverage for these and other services, in accordance with the State Medicaid Director letter #15-003[1]. Maryland is continuing to work with CMS on this amendment. Currently, Maryland is in the process of renewing its HealthChoice § 1115 demonstration waiver[2]. As part of its renewal application submitted on June 30, 2016, Maryland is seeking an amendment that would allow for Medicaid payments for services in IMDs. This would (1) target private IMDs treating individuals with SUD treatment needs, and (2) allow adults aged 21 to 64 to continue to receive services in IMDs, rather than in general acute care hospitals. The Department received approval for the waiver amendment request at the end of December so it is now able to move forward with the proposed changes.

More specifically, Maryland has applied for expenditure authority for otherwise-covered services provided to Medicaid-eligible individuals aged 21 to 64 who are enrolled in a Medicaid MCO and reside in a non-public IMD for American Society of Addiction Medicine (ASAM) Residential levels 3.1, 3.3, 3.5, 3.7, and 3.7WM. Effective July 1, 2017, Maryland proposes to provide reimbursement for up to two 30-day stays annually for ASAM levels 3.3, 3.5, 3.7, and 3.7WM. Maryland intends to phase in coverage of ASAM level 3.1 beginning on January 1, 2019.

The Department received approval from CMS regarding its waiver renewal application on December 27, 2016.

Outpatient Treatment Services

Individuals who do not meet ASAM level of care for residential treatment services and meet medical necessity criteria for Public Behavioral Health Services (PBHS) may also be treated in an outpatient setting, combined with a recovery environment that is supportive, provided the individual has the skills to cope. Outpatient treatment options may include: Level 1 Opioid

[1] https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf
[2] https://mmcp.dhmh.maryland.gov/Pages/1115-HealthChoice-Waiver-Renewal.aspx

Maintenance Therapy (OMT), Level 1 Outpatient Services, Level 2 Withdrawal Management, Level 2.1 Intensive Outpatient Treatment Services, and Level 2.5 Partial Hospitalization Services.

Level 1 OMT individuals receive pharmacological interventions, including but not limited to methadone.
Level 1 Outpatient Services provides less than nine (9) hours of services weekly. Services are tailored based on the individual's clinical severity.
Level 2 Withdrawal Management (WM) provides ambulatory withdrawal management with extensive on-site monitoring.
Level 2.1 Intensive Outpatient Treatment Services provides nine (9) or more hours of services weekly.
Level 2.5 Partial Hospitalization Services, provides nine (9) or more hours of day treatment services weekly.

Recovery Housing

The outpatient services mentioned may be combined with Recovery Housing; however, Recovery Housing cannot be mandated. Recovery (residences) Housing sites are independently owned by private landlords. They have their own set of admission policies just as any other private landlord. They can decide who to accept or not accept in their homes. The State cannot order a private landlord to accept someone into their home. With 8-507, the Department has contracts with specific providers. These providers are delivering clinical treatment in a residential setting. The State could possibly reach out to providers to develop specialized recovery housing for forensically involved individuals. This will require a Request for Proposal process and funding.

Recovery Housing is alcohol and illicit-drug free housing for individuals with substance use disorders or co-occurring mental health and substance use disorders. Typically, this type of housing does not include clinical treatment services on-site. However, many residents access clinical treatment and/or recovery support services while residing in recovery housing. The levels of Recovery Housing consist of:
Level 1: (democratically peer run) residences offer supportive housing in a community-based peer environment that includes drug screening, house meetings, and encourages involvement in self-help groups. Oversight of residents is peer-based within the home; residents are self-monitoring and accountable to each other.

Level 2: (monitored) residences are characterized by a community-based environment supervised by a senior resident or house manager who monitors operations and residents, and enforces structure that is implemented in the form of house rules or standards. Residents may be engaged in outpatient treatment services and other recovery support services within the community. Level 3: (supervised service provider) residence is characterized by a high degree of daily structure. Clinical treatment and case management services are delivered on- site by licensed/credentialed staff with emphasis on life skill development and resident involvement in recovery sustaining activities.

Recovery Housing is funded through Recovery Support Services grants to the Local Health Department and Local Addiction Authorities, Maryland RecoveryNet (MDRN), or self-pay. In FY 2016, $1,209,702 in Recovery Support Services grants were used locally to fund Recovery Housing. Through MDRN, a full array of recovery support services are provided to fill gaps in services and assist an individual in recovery. In FY 2016, 4,356 individuals received services through MDRN. Services consisted of transportation, vital records, medical and dental until benefits are obtained, Half-way and Recovery Housing, assistance with personal needs, gap services, peer services, and care coordination. Services were reimbursed through the ASO at $3,071,303 in FY 2016.

The eligibility criteria for Recovery Housing providers to be reimbursed with state funding are: (1) the individual must be Medicaid eligible or uninsured; (2) have a substance use disorder or co-occurring substance use disorder and mental illness; and (3) be a Maryland resident. The Recovery Housing provider may not exclude an individual receiving Medication Assisted Treatment. The Recovery Housing provider may also establish additional criteria for participation in the housing, i.e. have a certain length of time in recovery, exclusion based on criminal history, etc.

<u>Recovery Housing Providers</u>

In November 2013, the Behavioral Health Administration (BHA) entered into a three year agreement ($305,000) with the Maryland Recovery Organization Connecting Communities (M-ROCC) to establish the Maryland State Association of Recovery Residences (M-SARR), a member of the National Alliance of Recovery Residences. Based on national standards, M-SARR established a BHA approved application process for establishing recovery residences and

criteria for membership, conducting inspections and re-inspections, and monitoring recovery residences using national standards[3]. As of
September 9, 2016, M-SARR had certified 136 residences (Table 1).

Table 1. M-SARR Membership

Affiliated Housing Providers	69
Recovery Residences	136
Bed Capacity	1271

The totals reflect recovery residences that are state and non-state funded as of 9/9/16.

These recovery support services are available for those who are court-involved and are transitioning from an § 8-507 placement under the Maryland Recovery Net Program (MDRN). MDRN pays for gap services such as transportation, medication, peer support, care coordination, medical/dental as well as Half-way and Recovery Housing. The program's budget was increased from $2.1 million to $3.1 million in FY 2017. Cost containment strategies have been put in place in FY 2018 to remain within budget.

As a result of Chapter 711, Acts of 2016 (House Bill 1411), the Department is now required to approve a credentialing entity to develop and administer a certification process for recovery residences. With the M-SARR contract ending in December 2016, BHA issued a letter of interest in September 2016 to the 24 local behavioral health authorities who manage substance use disorder services in each local jurisdiction. Based on interest, BHA will be selecting one local authority to serve as a statewide credentialing entity or three local authorities to serve regions of the state. It is anticipated that the new credentialing entity/entities will begin during the second quarter of Fiscal Year 2017.

[3] Membership application, code of ethics, standards, etc. can be found on M-SARR's Membership Webpage: http://www.m-rocc.org/msarr/become-member

Conclusion

While the Department is committed to providing the least restrictive setting for individuals in need of substance use treatment services, it is also committed to identifying medically appropriate placements that follow the levels of care under the American Society of Addiction Medicine's (ASAM) criteria. Therefore, the Department is required to place an individual under a § 8-507 court order according to the results of an evaluation under §§ 8-505 or 8-506 of the Health - General Article. As is current practice, the Department will continue to consider and place in the least restrictive alternative setting whenever the evaluation does not require a residential treatment placement, including outpatient treatment combined with recovery housing or other supportive housing.