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Coverage of Room and Board Costs during Residential Substance Use Disorder Treatment (Health Services -- Medical Assistance)

[LFB 2021-23 Budget Summary: Page 264, #15]

CURRENT LAW

The Medical Assistance (MA) program currently provides coverage for residential treatment for substance abuse when medically necessary, as determined by the acuity of the patient's substance use disorder and the stability and supports available to them outside of a residential facility. Facilities that provide residential treatment must be licensed by the Department of Health Services (DHS) as either a transitional residential treatment service or a medically-monitored treatment service. A transitional residential treatment service is defined as a clinically-supervised, peer-supported, therapeutic environment with clinical involvement providing substance abuse treatment in the form of counseling for three to 11 hours per week. A medically-monitored treatment service is defined as a 24-hour service providing observation, monitoring, and treatment by a multidisciplinary team under supervision of a physician, with a minimum of 12 hours of counseling provided per week.

MA provides residential substance use disorder (SUD) treatment under two separate circumstances. Some MA beneficiaries have been able to access residential treatment since May 1, 2017, as part of the comprehensive community services (CCS) benefit. CCS gives counties the option to offer a variety of psychosocial rehabilitation and support services as MA benefits. Beginning February 1, 2021, a new benefit expanded the range of eligible providers and covered MA recipients who are not enrolled in a county CCS program. Specifically, this new benefit takes advantage of a federal waiver that allows substance abuse services to be provided as an MA benefit for non-elderly adults in an institution for mental disease (IMD), in addition to previously-eligible facilities. IMDs are larger facilities, with over 16 beds; federal law otherwise restricts Medicaid coverage to facilities with 16 beds or fewer.

Federal law excludes residential room and board costs from eligibility for federal matching funds, except in the case of inpatient hospital care. Consequently, under current policy, MA provides coverage only for the treatment costs of residential SUD care. MA patients must pay their own room and board costs, unless a county program or charitable organization provides funding.

DISCUSSION POINTS

1. Assembly Bill 68 and Senate Bill 111 would provide $3,274,600 GPR annually to fund coverage of room and board costs for MA enrollees receiving residential SUD treatment (Alternative 1). DHS has not yet established a reimbursement policy, but indicates that it would likely include a maximum daily rate and take into consideration the MA member's ability to contribute to the room and board costs. Because federal Medicaid funds cannot be used for residential facility room and board costs, this MA benefit, unlike most MA costs, would be funded entirely with GPR.

2. Patients require residential SUD treatment when they have severe or complex substance use disorders, often with co-occurring conditions such as psychiatric disorders or unstable housing. The department indicates that these patients are at high risk of immediate relapse, continued use, harm to themselves or others, and in some cases death, unless they receive residential SUD treatment. Patients experiencing physiological withdrawal symptoms or other acute medical conditions require monitored detoxification treatment in an inpatient hospital setting before they can be safely discharged to a residential SUD treatment facility.

3. Residential SUD treatment provides individual, family, and group counseling and therapy, medication management, nursing services, case management, peer support, and recovery coaching, for a total of at least twenty hours per week for high-intensity patients and six hours per week for low-intensity or transitional patients. Approximately 85% of recent MA admissions have been for high-intensity patients. In addition to direct treatment services, the safe and stable living environment gives patients the opportunity to stabilize and develop recovery skills. High-intensity patients typically require two to six weeks of care, while low intensity patients typically receive four to thirteen weeks of care before they can be discharged. Discharge decisions are based on clinical evaluation of a patient and their particular circumstances, and MA coverage policy allows members to receive care as long as is medically necessary.

4. The administration estimates that, with the newly-expanded coverage of residential SUD treatment and the proposed coverage of room and board, MA could provide residential treatment for approximately of 240 patients at a time across the state. Based on an average stay of four weeks, this bed capacity could provide treatment for approximately 3,000 MA members per year.

5. Indicative of the prevalence of severe SUD in the state, approximately 5,000 MA members received inpatient hospital detoxification treatment in 2019. Alcohol abuse and dependence accounted for approximately half of these patients, opioid abuse and dependence for one quarter, and other substance use disorders for the remaining quarter. Approximately 25% of patients were readmitted into an inpatient hospital for detoxification treatment for a second time within the calendar year, and approximately 10% required detoxification treatment three or more times in the year. DHS indicates that improved access to residential SUD treatment, especially after a patient has already received inpatient detoxification treatment, could improve patients' recovery and decrease the likelihood of relapse and the need for inpatient detoxification.

6. A systematic research review supported by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and published by *Psychiatric Services* in March, 2014, finds evidence that residential SUD treatment can reduce alcohol and drug relapse, reduce crime rates, reduce suicide rates, improve quality of life, and improve social and community functioning. However, results varied between treatment populations, specific interventions, and study methodologies. A study published in the *Journal of Addictive Diseases* in October, 2008, found that, among patients recommended for residential treatment, those who received it were 1.7 times as likely to remain sober after one year compared to those who received lower levels of treatment.

7. In a 2020 report produced with grant funding from the U.S. Department of Justice, the National Alliance on Mental Illness finds that, "without an effective mental health system, communities have relied on the criminal justice system to provide mental health care and as a result, every year over 2 million people with mental illness are booked into America's jails and prisons." In 2019-20, the Wisconsin Department of Corrections contracted for 176 beds in residential SUD treatment facilities across the state to provide SUD treatment for probationers, parolees, offenders on extended supervision, or intensive sanctions inmates, at an annual cost of $6.2 million GPR and $0.8 million PR.

8. DHS reports that many residential treatment providers are reluctant to accept MA patients given the current lack of a consistent source of funding for room and board. Providers have expressed that doing so would be unsustainable financially.

9. The facilities that accept MA patients frequently have waitlists, typically around two weeks in length. County officials indicate that this delay poses a significant barrier for some patients; severe substance used disorders often prevent patients from remaining ready and committed to receiving care for the duration of the waiting period.

10. Currently, counties are the most common source of room and board funding for MA patients to receive residential SUD treatment. Many counties provide some funding for this purpose, supported by local tax levy or grant funding, but they typically do not guarantee funding to all MA patients who meet the MA conditions of eligibility for residential SUD treatment. Instead, most counties place a variety of additional restrictions and conditions on which patients may receive county funding, and may implement waiting lists.

11. When county funding for room and board is unavailable, few MA members with substance use disorders have the resources to pay these costs themselves. This does happen in occasional cases, however, most often with financial support from family and friends.

12. As well as removing a financial barrier, counties indicate that state funding for room and board would streamline patients' access to residential SUD treatment; currently, people rely on county human services departments for placement, but the availability of state room and board reimbursement would allow patients to seek care directly, opening more avenues to connect patients with treatment providers and removing administrative barriers. This would build on the recent benefit expansion's potential for broadening access.

13. Research published in *Psychiatric Services* in May, 2019, reports that "the high

prevalence of homelessness among individuals with a substance use disorder, frequent and repeated use of emergency department services, extended boarding in emergency rooms, and frequent readmission to the hospital all indicate unmet need for residential services." The researchers identify insufficient access among Medicaid members in particular.

14. The variety of ways that states and local government could chose to fund residential SUD treatment limits the ability to make direct comparisons of Wisconsin policy to other states. For instance, a state may not provide funding for room and board costs directly, but may nevertheless support this cost indirectly, through general aid to local government human services agencies. Based on available data for neighboring states, however, Iowa and Michigan do not provide direct state funding for room and board costs of treatment but Minnesota does.

15. Providing MA coverage for room and board costs could impact the MA budget in three distinct ways: the room and board reimbursement itself would represent a new GPR cost, the improvement in access would likely lead to increased utilization and hence increased GPR and FED reimbursement costs, and the increase in residential SUD treatment would likely reduce the need for certain other services, such as emergency room care and inpatient detoxification treatment, reducing GPR and FED reimbursement costs.

16. The additional cost resulting from the reimbursement itself is the most straight-forward component to estimate, although it could vary depending on the final reimbursement amount and the total utilization of residential SUD treatment. The administration estimates that reimbursement would be $50 per day, approximately equal to the current rate paid by Minnesota's MA program and the room and board costs paid by the Department of Corrections for placement of state inmates in county jails. The administration also estimates that, on average, 240 MA members will be receiving residential SUD treatment on any given day, for a total annual cost of $4.3 million GPR. This estimate of daily MA utilization corresponds to 23% of the state's total treatment bed capacity.

17. The administration's funding estimate assumes that the gross cost of room and board payments would be offset by savings in other MA services. In 2019, MA paid $3,700 on average for inpatient detoxification treatment, on an all-funds basis. As noted above, approximately 25% of patients were readmitted for inpatient detoxification treatment two or more times within the year, a population that likely has an unmet need for residential SUD treatment. Members of this group received detoxification treatment an average of two additional times in the year, for an additional cost of $7,400 after their first treatment. These amounts do not include other costs associated with substance abuse disorder, such as hospital emergency room visits, although the Department does not have a way to reliably track those costs. By comparison, residential SUD treatment is expected to cost approximately $6,000 to $6,500, excluding room and board. Consequently, a case where residential treatment prevents readmissions for detoxification treatment would result in a modest net reduction in MA benefits expenditures.

18. Several other factors influence the overall fiscal effect of increasing access to residential SUD treatment, with various degrees of uncertainty, including what percentage of members receiving residential treatment would otherwise have required detoxification treatment or other MA services, how many additional readmissions could be prevented beyond the first year analyzed here, and to what degree the need for other services, such as emergency room care, could be prevented. The

funding provided in AB 68/SB 111 is based on the Department's assumptions regarding offsetting savings, accounting for about 25% of the gross room and board costs.

19. In counties that currently provide some room and board funding, county officials report one motivation for doing so is to prevent the need for admissions into residential assisted living facilities, the state mental health institutes, or other intensive care. Counties are generally responsible for the costs for such treatment, or at least the non-federal share of certain MA-funded services, meaning that improved access to residential SUD treatment for MA beneficiaries could have a positive fiscal impact on counties as well. Counties would also likely reduce expenditures of county funds for room and board costs. County officials indicate that these savings would likely be reinvested in behavioral health services to meet a rising need for crisis services, to continue to provide treatment to uninsured residents, and to improve preventative interventions.

20. Since the Department has not yet established policies for reimbursement of room and board costs, it is reasonable to assume that reimbursement for these costs, if approved, would not begin for some period of time after the passage of the budget. Assuming that the implementation process takes approximately six months, the funding could be adjusted accordingly, to provide $1,637,300 GPR in 2021-22 and $3,274,600 GPR in 2022-23 (Alternative 2).

21. The Committee may determine that room and board costs should continue to be a county responsibility (Alternative 3). In this case, counties would continue to determine the amount of funding allocated for this purpose, weighing the costs and benefits alongside other county priorities.

ALTERNATIVES

1. Provide $3,274,600 GPR annually to provide coverage for room and board costs of MA enrollees receiving residential treatment for substance use disorders and include room and board for residential substance use disorder treatment as a covered service under MA, with coverage estimated to begin effective July 1, 2021

ALT 1	Change to Base
GPR	$6,549,200

2. Provide $1,637,300 GPR in 2021-22 and $3,274,600 GPR in 2022-23 to provide coverage for room and board costs of MA enrollees receiving residential treatment for substance use disorders and include room and board for residential substance use disorder treatment as a covered service under MA, with coverage estimated to begin effective January 1, 2022.

ALT 1	Change to Base
GPR	$4,911,900

3. Take no action.

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