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Substance Use Disorder 1115 Waiver

Overview of Fiscal Portions of the New Program

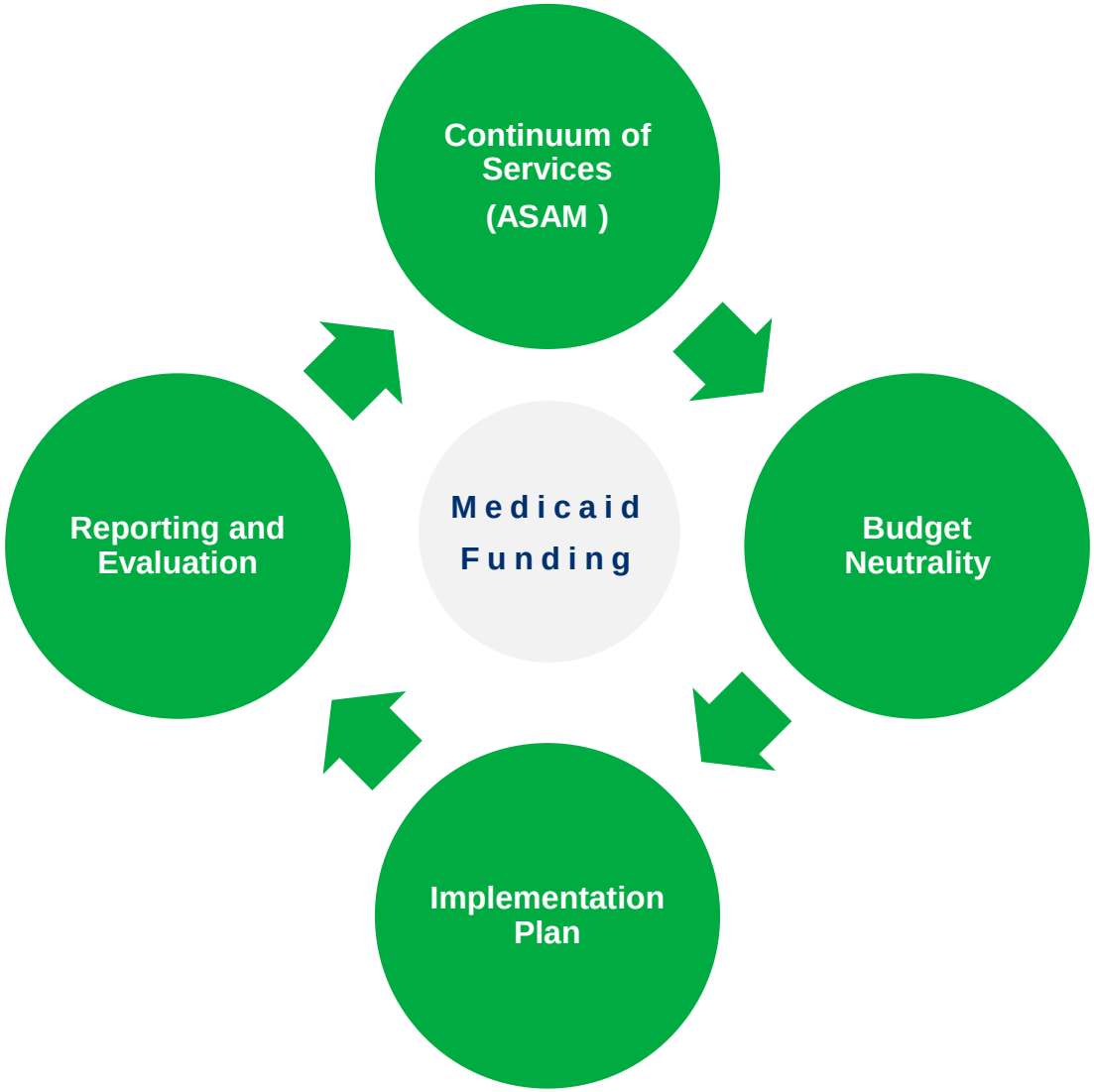
State of Connecticut

September 11, 2020

Goals for Today
SUD 1115 Waiver Opportunity – Fiscal Aspects

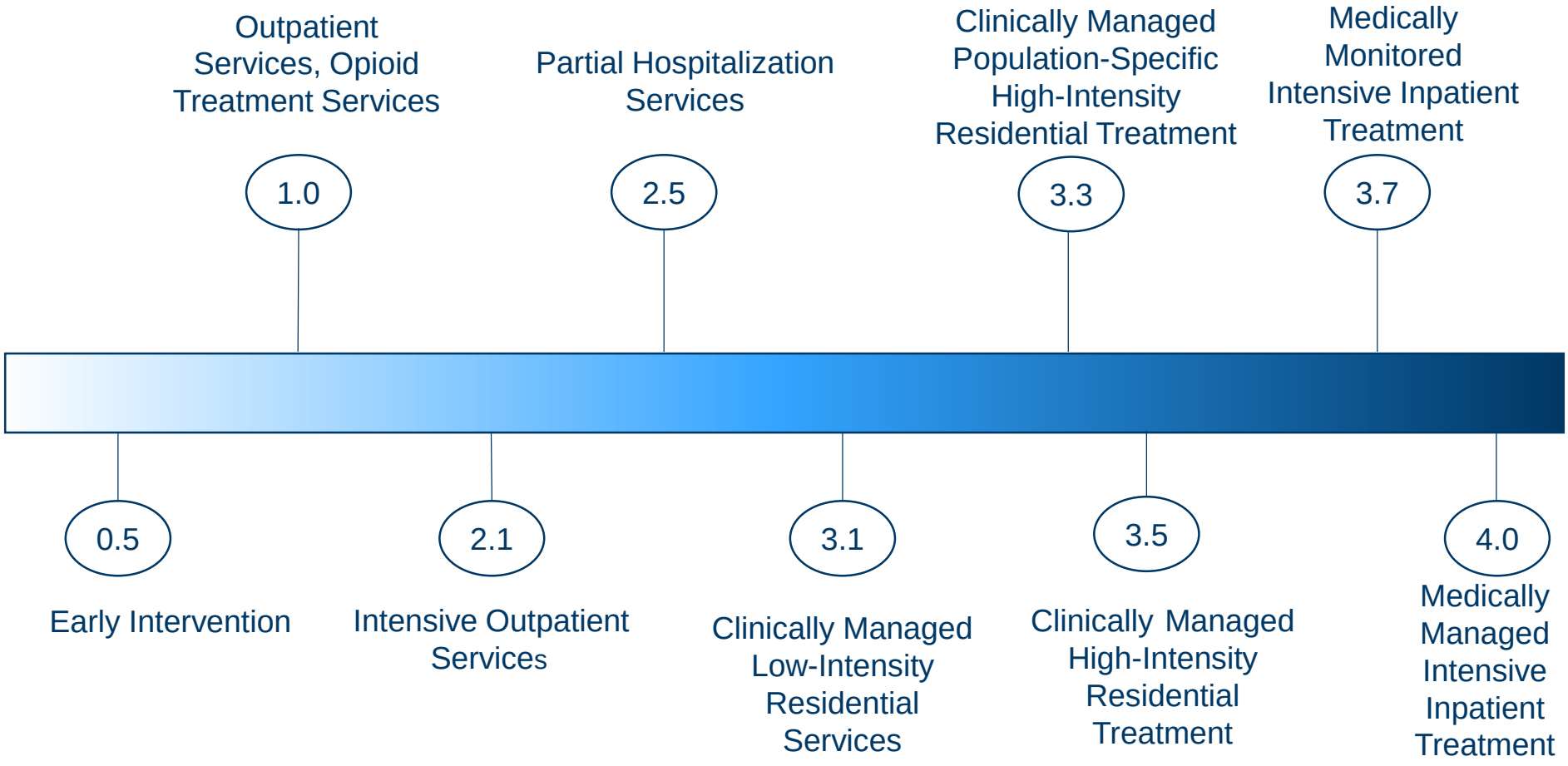
- High Level SUD Waiver Requirements
- Federal IMD Policy and Expectations
- Differences in Fiscal Aspects of SUD Medicaid Program
    - Rate Setting for Provider Fees
    - State Budget Fiscal Impact Illustrative Calculation Approach
    - SUD Budget Neutrality Modeling
- Next Steps

High Level SUD Waiver Requirements



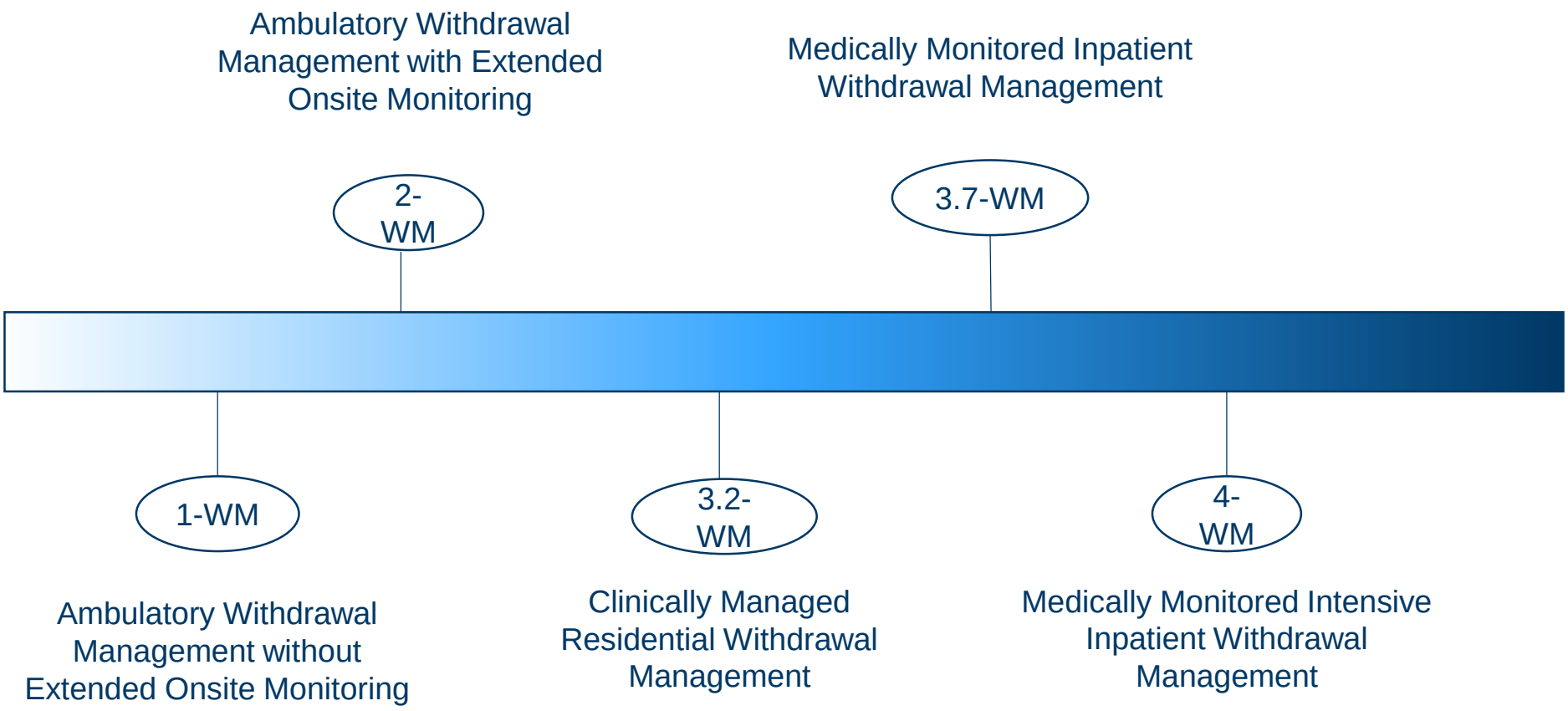
Continuum of Services Through New Medicaid State Plan Amendment

ASAM Levels of Care (LOC) for Treatment



Continuum of Services Through New Medicaid State Plan Amendment

ASAM LOCs for Withdrawal Management



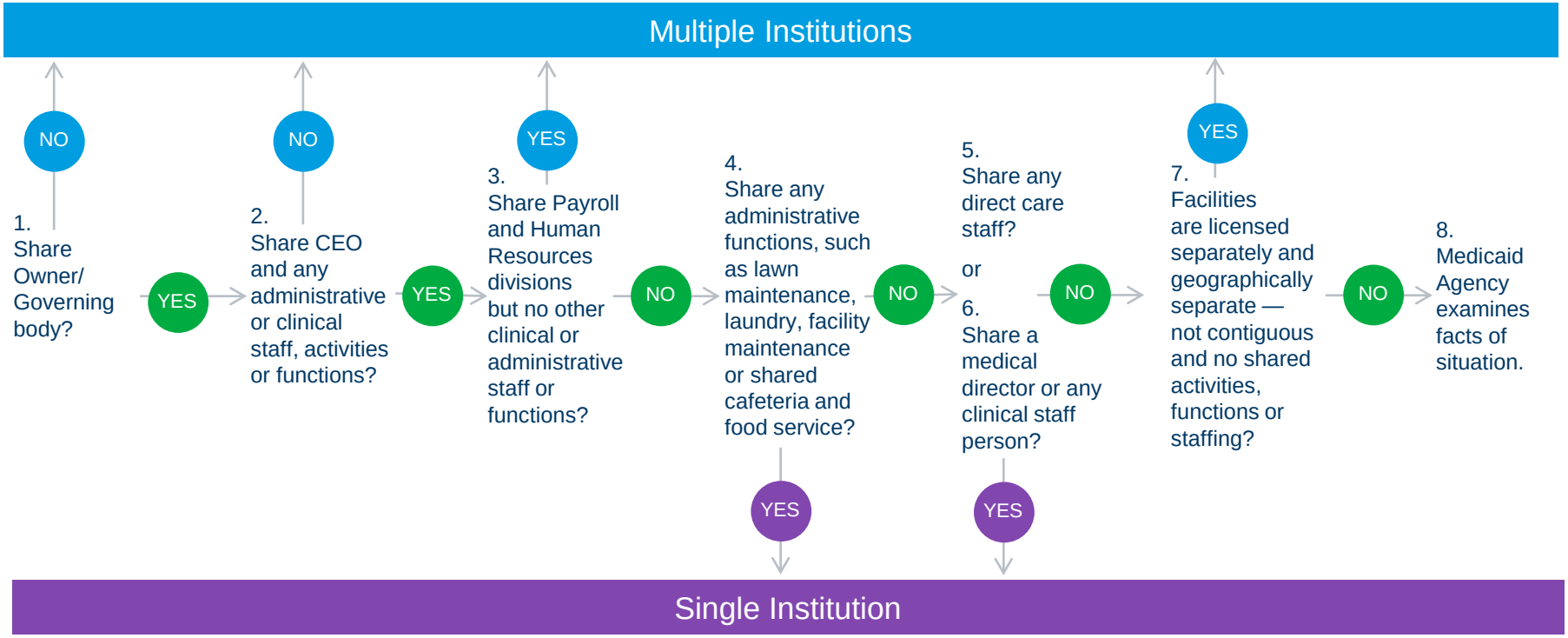
Federal IMD Policy and Expectations

1. Medicaid prohibits reimbursement for any Medicaid services provided resident of an IMD under the age of 65 with some specific exceptions (i.e., children in PRTFs/hospitals and pregnant women).

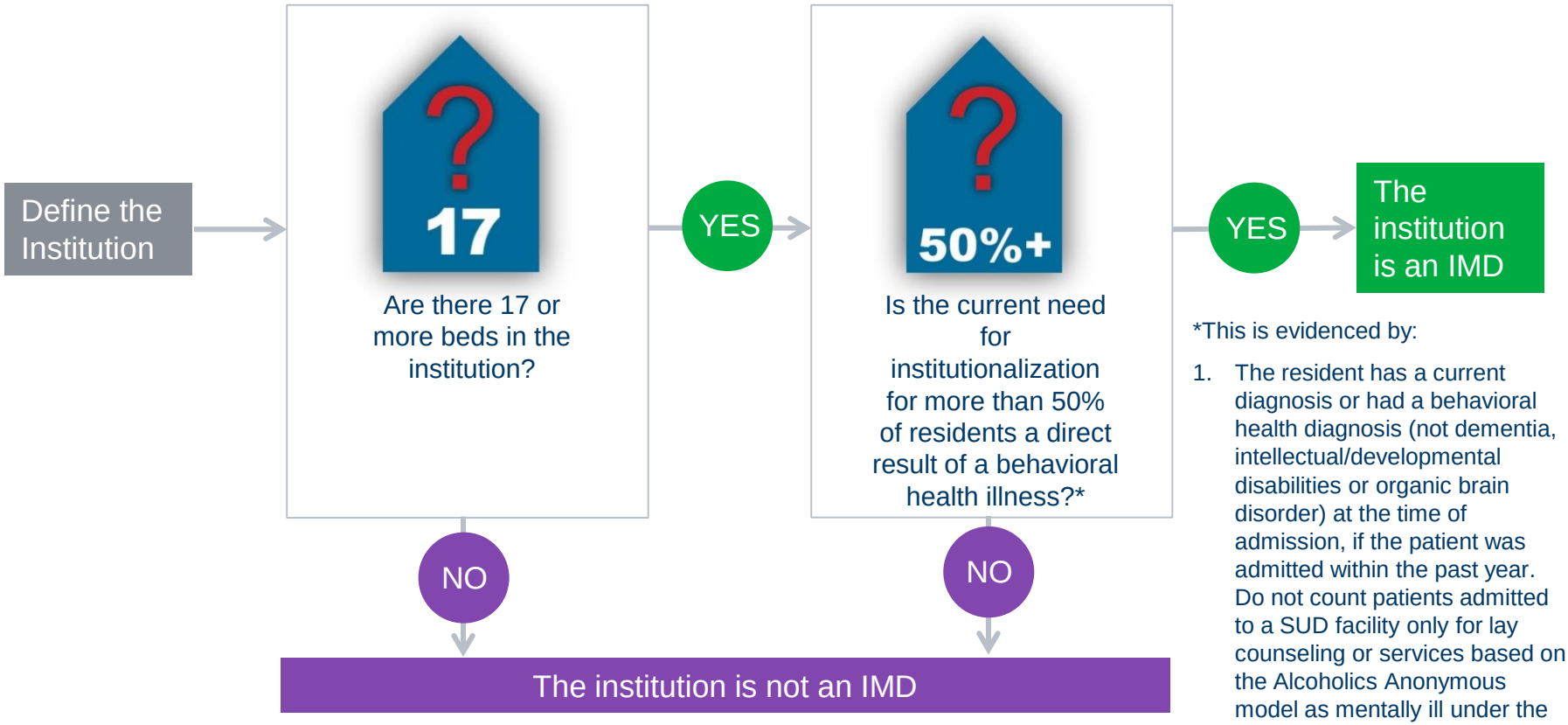
2. CMS historically allowed reimbursement for IMDs under 1115 demonstrations using cost not otherwise match-able (CNOM) authority or through managed care in-lieu of services for state utilizing managed care delivery systems.

3. CMS published a state plan option for stays of no more than 15 days annually with strict maintenance of effort requirements.

Principles for Determining if Multiple Facilities are a Single Institution



Determining if a Residential Facility is an IMD



*This is evidenced by:

1. The resident has a current diagnosis or had a behavioral health diagnosis (not dementia, intellectual/developmental disabilities or organic brain disorder) at the time of admission, if the patient was admitted within the past year. Do not count patients admitted to a SUD facility only for lay counseling or services based on the Alcoholics Anonymous model as mentally ill under the 50% guideline.
2. A large proportion of the residents are receiving psychopharmacological drugs.

Rate Setting for Provider Fees

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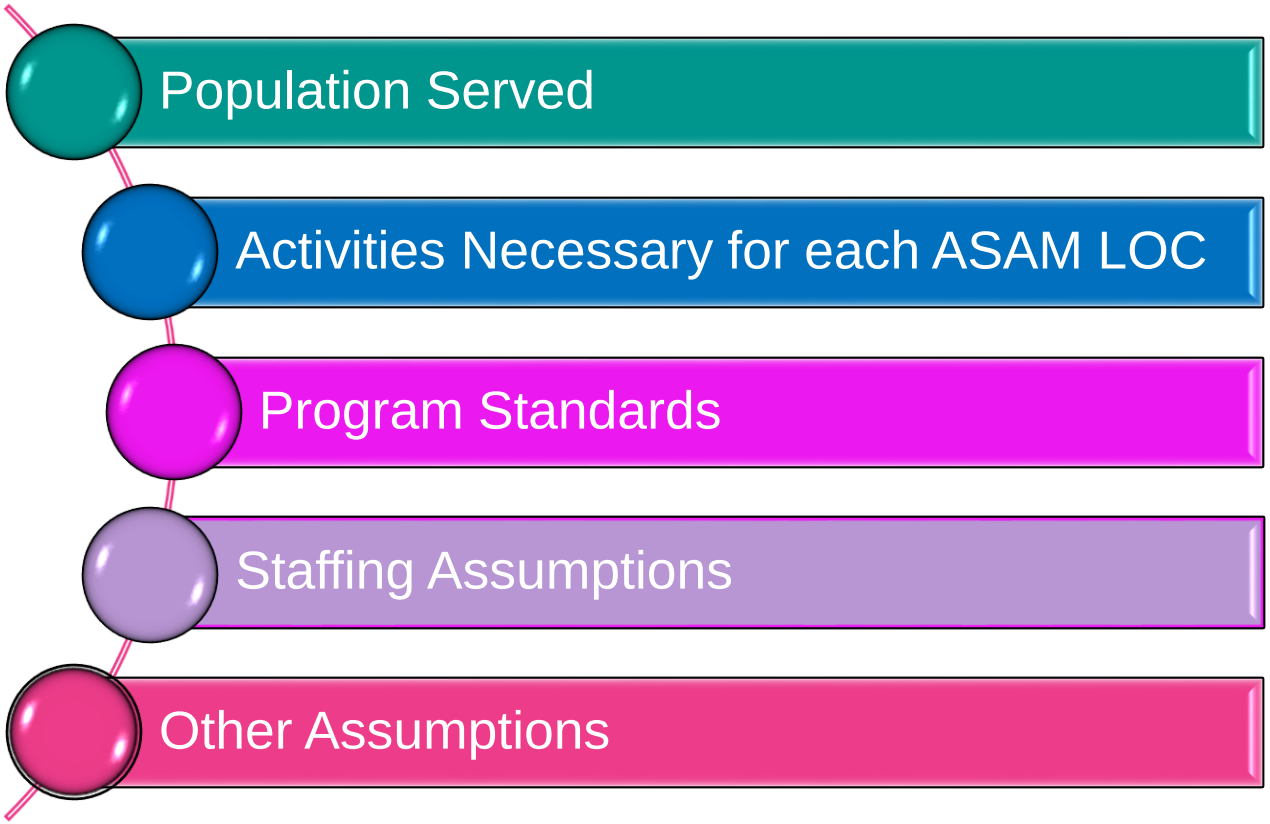
Rate Setting for Provider Fees



One Potential Definition of a Service
ASAM 3.5: Clinically Managed High-Intensity

The following is from another State and is utilized as an example only:

- ASAM 3.5 Clinically Managed High-Intensity Residential programs are required in this example State to offer 24-hour treatment staff.
  - The State requires at least 30 hours per week of a combination of clinical and recovery-focused services specifically focused on individuals who have significant social and psychological problems.
  - At least 10 of the 30 hours are to include individual, group, and/or family counseling.
- Programs rely on the treatment community as a therapeutic agent. The treatment aims to stabilize a person who is in imminent danger if not in a 24-hour treatment setting. The treatment promotes abstinence from substance use and antisocial behavior to effect a global change in participants' lifestyles, attitudes, and values. Individuals typically have multiple deficits, which may include substance-related disorders, criminal activity, psychological problems, impaired functioning, and disaffiliation from mainstream values.

Population Served: Placement Criteria
ASAM 3.5: Clinically Managed High-Intensity

The following is from another State and is utilized as an example only:

- **Acute intoxication and/or withdrawal potential**: None, or withdrawal symptoms can be safely managed at this level.
- **Biomedical conditions and complications:** None or stable and participant can self-administer any prescribed medication, or if condition is severe enough to distract from treatment and recovery participant can receive medical monitoring within the program or through another provider.
- **Emotional, behavioral, or cognitive conditions and complications:** Demonstrates repeated inability to control impulses, or a personality disorder requires structure to shape behavior. Other functional deficits require a 24-hour setting to teach coping skills. A co-occurring disorder enhanced setting is required for seriously and persistently mentally ill patients.
- **Readiness to change:** Has marked difficulty with or opposition to treatment with dangerous consequences. If there is high severity in this dimension but not in other dimensions, the individual; therefore, needs ASAM Level 1 placement with inclusion of motivational enhancement therapy (MET). MET is a therapeutic intervention and a component part of the program.
- **Relapse, continued use, or continued problem potential:** Participant is unable to recognize relapse triggers and has no recognition of the skills needed to prevent continued use, with limited ability to initiate or sustain ongoing recovery and sobriety in a less structured environment.
- **Recovery environment:** Participant lives in an environment with moderately high risk of abuse or in a culture highly invested in substance use. Participant lacks skills to cope with challenges to recovery outside of a highly structured 24-hour setting.

Activities Necessary for Each ASAM LOC

ASAM 3.5

The following is from another State and is utilized as an example only:

- *A urine drug screen and a tub*erculosis test are required within 72 hours of admission and as directed by the treatment plan, and are considered covered under the rates paid to the provider.
- Nursing assessment within 24 hours of admission reviewed by a physician to determine need for eligibility and appropriateness (proper patient placement) for admission and referral.
- For individuals new to the program, a comprehensive bio-psychosocial assessment completed within 48 hours of admission, which substantiates appropriate patient placement. Assessment must be reviewed and signed by a qualified professional. This typically occurs with a diagnostic assessment to confirm the SUD diagnosis and determine the appropriate LOC and a comprehensive bio-psychosocial assessment to inform the treatment plan and on-going care.
- A physical examination performed within a reasonable time, as determined by the client's medical condition.
- Individualized, interdisciplinary treatment/treatment plan, consistent with state licensing regulations, which includes problem formulation and articulation of short-term, measurable treatment goals and activities designed to achieve those goals. This plan should be developed within 72 hours and in collaboration with the individual.
- The treatment/treatment plan is reviewed in collaboration with the individual every 30 days and documented accordingly.
- Discharge/transfer planning begins at admission.
- Referral and assistance as needed for the beneficiary to gain access to other needed Medicaid SUD or mental health services.

Staffing Overview
ASAM 3.5

The following is from another State and is utilized as an example only:

- Level 3.5 residential settings include an array of licensed practitioners, unlicensed counselors, as well as certified recovery coaches and credentialed behavioral health technicians operating within their scope of practice to provide services appropriate to the bio-psychosocial needs of individuals being admitted to the program. These facilities must have medical personnel including physicians or physician extenders knowledgeable about addiction treatment, appropriately credentialed licensed mental health professionals, and allied health professional staff. The number and disciplines of team members are appropriate to the range and severity of the individual's problems.
- One FTE during clinic hours dedicated to performing referral arrangements for all individuals served by the facility. This FTE may be a licensed practitioner, unlicensed counselor, or certified peer.

Specific Staffing Assumptions

Example ASAM 3.5

The following is from another State and is utilized as an example only:

Staff Title	Staffing Goal
Medical Director/ Psychiatric Medical Staff	• A designated medical director certified in addiction medicine or an addiction psychiatrist available on call at all times. • A psychiatrist or psychiatric NP is on site at least five hours/week for every 16 residents.
Medical Staff (Physician, NPs, and PAs)	• A primary care/physical health physician (or physician extender) is on site at least 2.5 hours/week for every 16 residents.
Nurse (RN)	• An RN on-site per 16 residents during the day shift.
Clinical SUD Staff	• One licensed practitioner or unlicensed counselor with direct supervision per 16 residents is on site during days and evenings and on call 24/7 when not on site.
Certified Peer/Tech	• One behavioral health technician and/or Certified Peer per 16 residents is on site and awake at all time.
Care Coordinator (SW)	• One FTE during clinic hours dedicated to performing referral arrangements and discharge planning for all individuals served by the facility. • Caseload size is based on needs of individuals, but should not exceed 35 active individuals for each licensed practitioner and unlicensed counselor (for this standard, active is defined as being treated at least every 90 days).

Fee setting Methodology Staffing Assumptions
ASAM 3.5 Varies Based on Facility Size

The following is from another State and is utilized as an example only:

Staffing per 15 beds/168 hours per week	FTE: Day	Evening	Overnight
Medical Director/Psychiatric Medical Staff	0.13	0.00	0.00
Medical Staff (Physician, NPs, PAs)	0.06	0.00	0.00
Nurse (RN)	1.00	0.00	0.00
Clinical SUD Staff	1.00	1.00	0.00
Certified Peer/Tech	1.00	1.00	1.00
Care Coordinator (SW)	0.50	0.00	0.00
Total Staffing (per 15 beds / 168 Hours week)	**3.69**	**2.00**	**1.00**

Staffing per 43 beds/168 hours per week	FTE: Day	Evening	Overnight
Team Staffing (per 43 beds/168 Hours week)	**6.88**	**4.00**	**2.00**

Note: Weekend staffing should also be estimated

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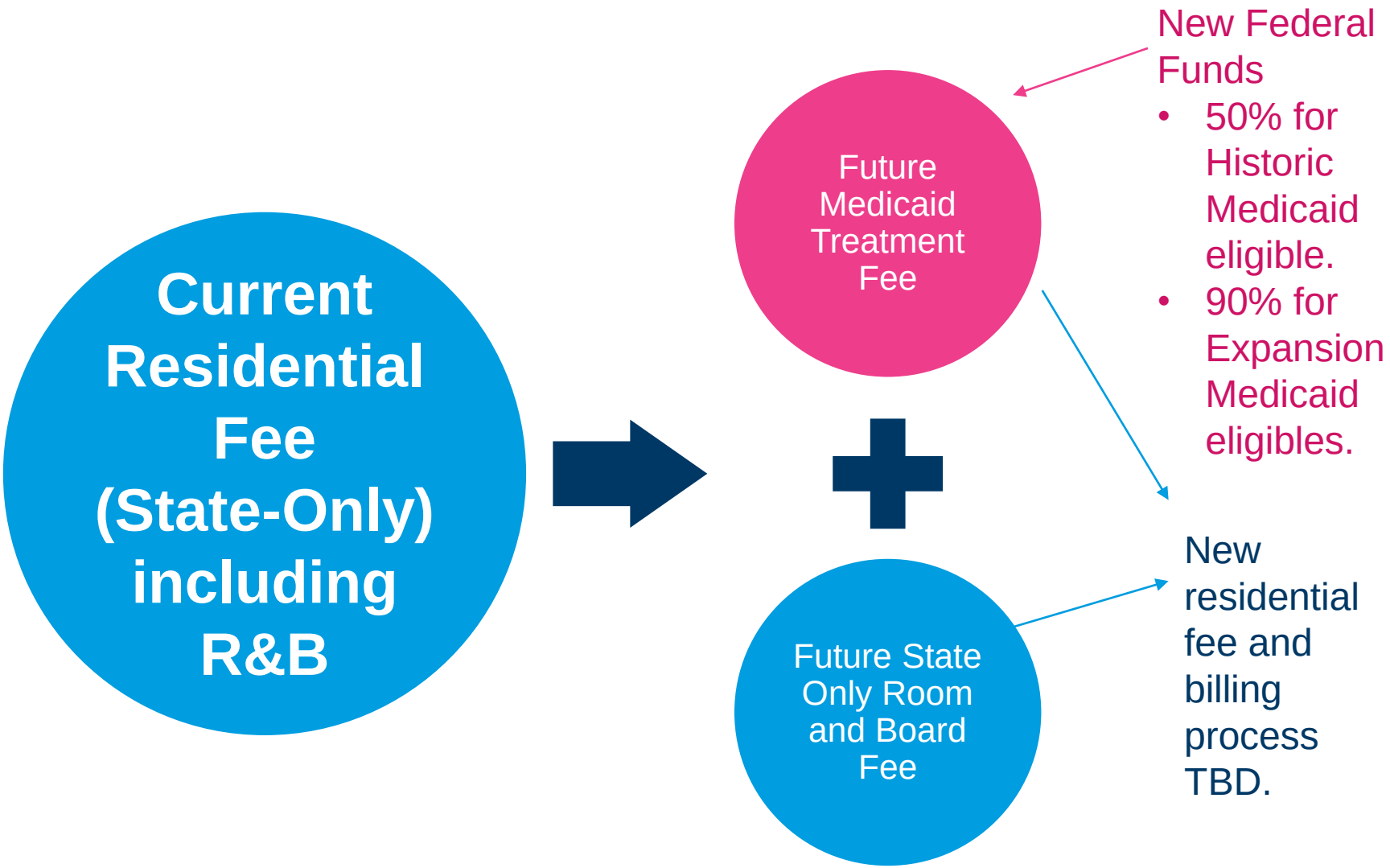
Other Aspects of Fee Setting

- Wages Based on Bureau of Labor Statistics Data Specific to Connecticut.
- Employee Related Expenses (ERE).
  - Health Insurance Premium.
  - FUTA/SUTA Annual Cost.
  - Percent Worker's Comp.
  - FICA Percentage.
  - Other (Retirement, LTD/STD, etc.).
- Accreditation Expenses.
- Training Expenses.
- Total Provider Overhead (Administration, Supplies, Facility).
- Size of Facility.
- Occupancy Rate.

Medicaid Treatment vs Room and Board

- Medicaid will only reimburse for the treatment portion of the non-hospital SUD residential facility. Room and board for non-hospital residential facilities must be reimbursed through other sources.
- Room and board is only paid by Medicaid in the following circumstances:
  - The facility is a Psychiatric Residential Treatment Facility for under age 21.
  - The facility is a hospital (either general hospital or psychiatric hospital) and the individual is receiving an inpatient level of care (e.g., ASAM 4.0 Treatment or Acute Withdrawal).

ASAM 3.5 Provider Fees



State Fiscal Impact Illustrative Calculation Approach

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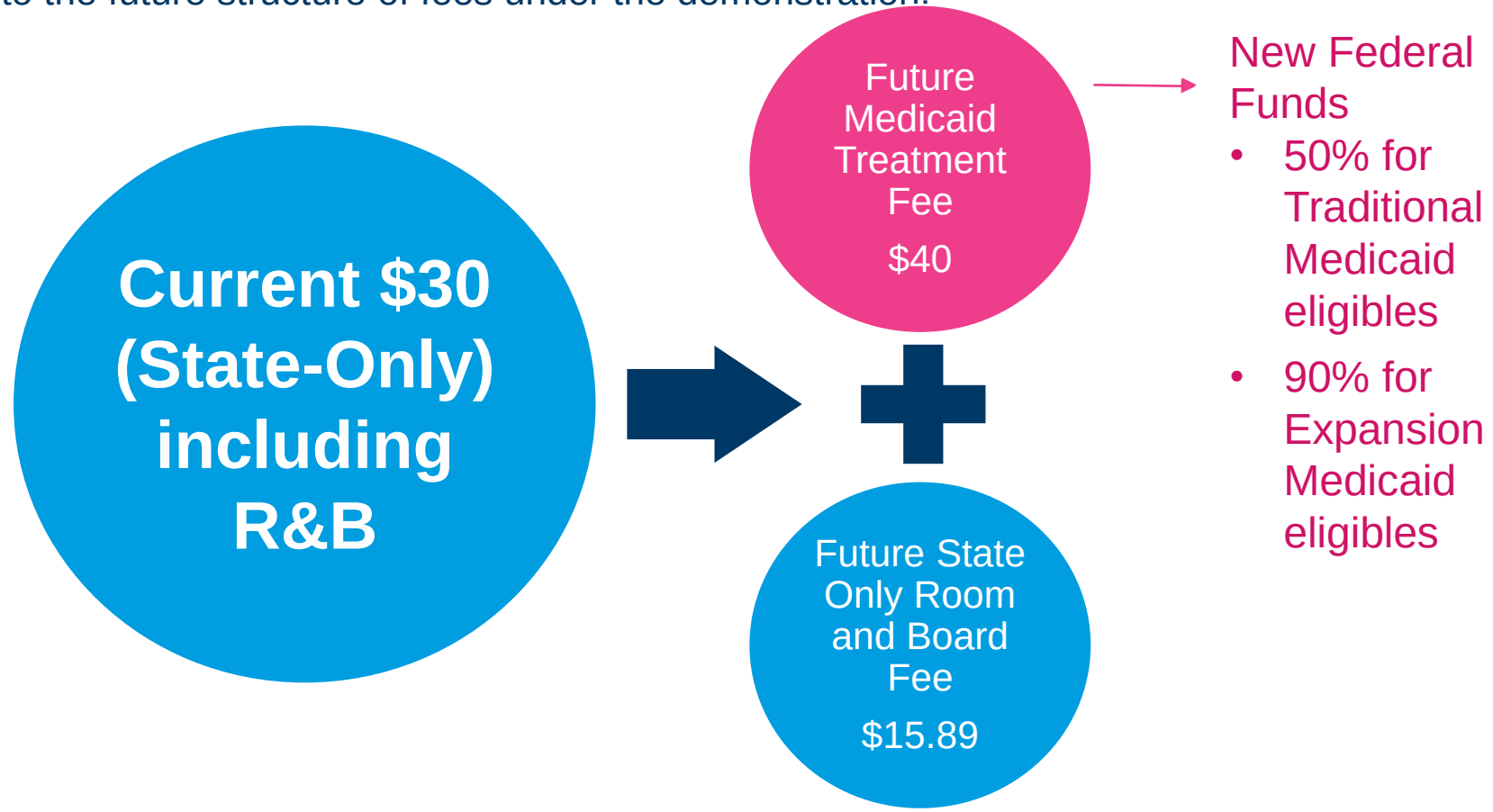
Fiscal Impact Analysis
Strawman

Strawman results are dependent on final fees yet to be established. Fiscal impacts **will vary** based on final provider fees. Totals may differ due to rounding.

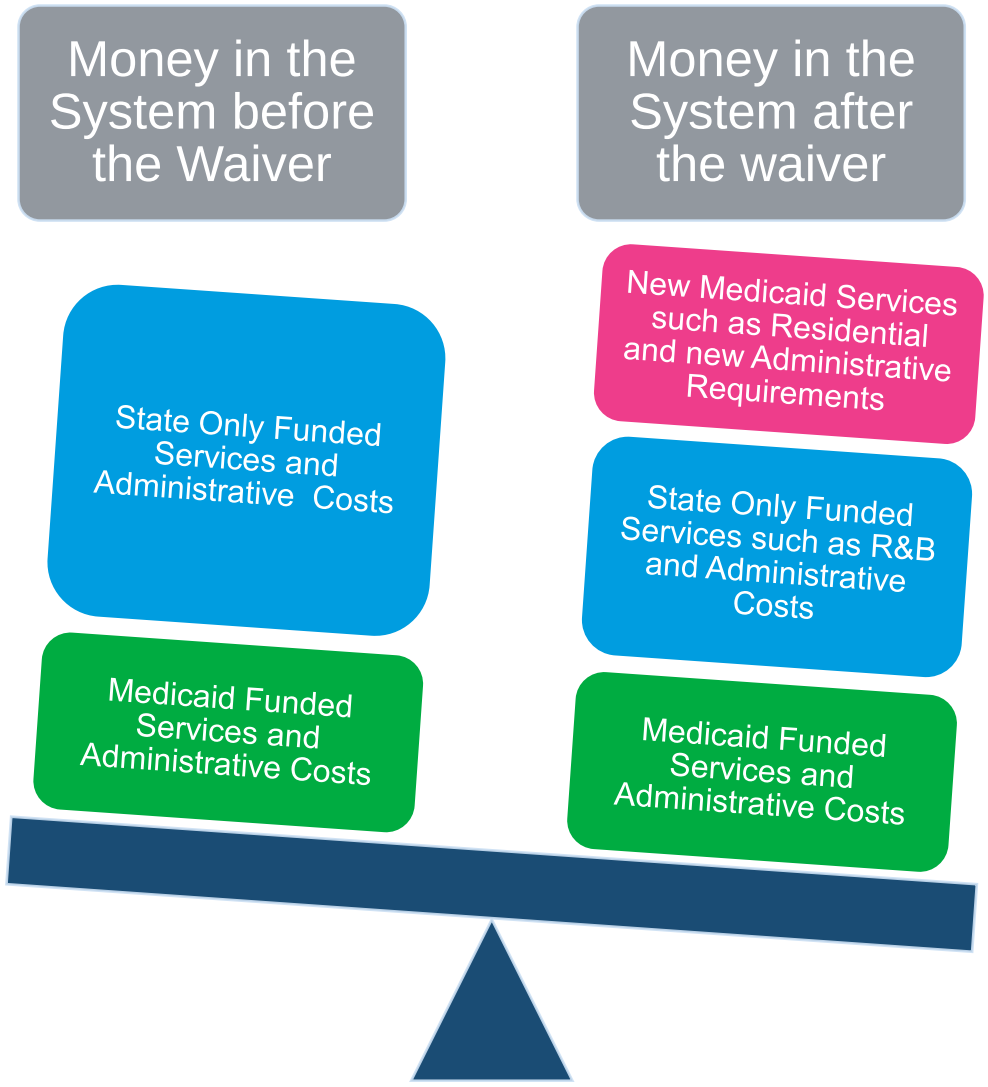
ASAM 3.5 Provider Fees

Strawman: Current vs Future Fees

An example for illustration purposes only and represents the potential comparison of current fees for services provided to Medicaid eligible individuals for SUD treatment to the future structure of fees under the demonstration.



Fiscal Impact of New Authority for SUD Services



New federal funds to match existing state funds but also new administrative requirements

Current Financing of ASAM 3.5

An example for illustration purposes only and represents the potential utilization and cost of services.

X 120 days = $3,600

Fiscal Impact Analysis- Calculating Residential Costs
Strawman — Current Financing of all Residential

An example for illustration purposes only and represents the potential utilization and cost.

Services	Current Fee (State-Only) including R&B	Utilization (Days)	Total Costs
ASAM 3.1	$ 10.00	100	$ 1,000
ASAM 3.3	$ 20.00	35	$ 700
ASAM 3.5	$ 30.00	120	$ 3,600
ASAM 3.7	$ 40.00	55	$ 2,200
ASAM 3.7-WM	$ 50.00	50	$ 2,500
Total		**360**	**$ 10,000**

Fiscal Impact Analysis

Strawman — Current Funding Sources

- Includes state-only benefits as well as Medicaid funded benefits
- The following is an example for illustration purposes only and represents the potential **current** funding for services provided to Medicaid eligible individuals for SUD treatment.

Services	Medicaid Federal Funds 50% (Traditional)	Medicaid Federal Funds 90% (Expansion)	Total Federal Funds	Total State Share	Total Funding
Residential Services	*$ - -*	*$ - -*	*$ - -*	*$ 10,000*	*$ 10,000*
Other SUD Services	*$ 250*	*$ 450*	*$ 700*	*$ 300*	*$ 1,000*
Total Service Costs	**$ 250**	**$ 450**	**$ 700**	**$ 10,300**	**$ 11,000**

Future Financing of ASAM 3.5

An example for illustration purposes only and represents the potential utilization and cost of services.

New Federal Funds

- 50% for Traditional Medicaid eligibles
- 90% for Expansion Medicaid eligibles

x120 days = $6,707

Fiscal Impact Analysis – Projecting Residential Costs
Strawman — Post SUD Waiver Financing

The following is an example for illustration purposes only and represents the *potential* funding for services provided to Medicaid eligible individuals for SUD treatment.

Services	Treatment Component (Medicaid)	R&B Component (State only)	Utilization (Days)	Total Costs
ASAM 3.1	$ 20.00	$ 15.89	100	$ 3,589
ASAM 3.3	$ 30.00	$ 15.89	35	$ 1,606
ASAM 3.5	$ 40.00	$ 15.89	120	$ 6,707
ASAM 3.7	$ 50.00	$ 15.89	55	$ 3,624
ASAM 3.7-WM	$ 60.00	$ 15.89	50	$ 3,794
Total			**360**	**$ 19,320**

Fiscal Impact Analysis

Strawman — Post SUD Waiver Sources of Funding

The following is an example for illustration purposes only and represents **waiver** funding for services provided to Medicaid eligible individuals for SUD treatment.

Services	Medicaid Federal Funds 50% (Traditional)	Medicaid Federal Funds 90% (Expansion)	Total Federal Share	Total State Share	Total Funding
Residential Services	*$ 3,400*	*$ 6,120*	*$ 9,520*	*$ 9,800*	*$ 19,320*
Other SUD Services	*$ 250*	*$ 450*	*$ 700*	*$ 300*	*$ 1,000*
Total Service Costs	**$ 3,650**	**$ 6,570**	**$ 10,220**	**$ 10,100**	**$ 20,320**

State Administrative Requirements are not yet included

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Fiscal Impact Analysis

Strawman – Additional State Administrative Costs

- The waiver requires reporting and an evaluation, which is eligible for Federal Financial Participation (FFP), but will require 50% State matching funds. Provider administrative costs should be covered in the fees paid to providers.
- Additional annual administrative costs might include:
  - 1115 Demonstration Project Management.
  - Evaluation Reports.
  - Quarterly Data Collection.
  - ASAM Certification of Provider.
  - Utilization Review (already on-going state cost using existing ASO costs).

Carrying the example forward, the sources of federal funds for new administration costs might look like:

Services	Medicaid Federal Funds 50%	Total Federal Share	Total State Share	Total Funding
SUD Administration before Waiver	$ 50	$ 50	$ 50	$ 100
Administration Costs After Waiver	$ 250	$ 250	$ 250	$ 500

Overall Fiscal Impact of the Waiver

Strawman – Overall Funding in the System Increases

Carrying the example forward and including historic and new administrative costs, the sources of federal funds for the overall waiver might look like:

Services	Total Federal Share	Total State Share	Total Funding
TOTAL Costs – Before Waiver	$ 750	$ 10,350	$ 11,100
Total Costs – After the waiver	$ 10,470	$ 10,350	$ 20,820

This example assumes no growth in member months or utilization. Realistically, there will be growth.

Fiscal Impact Analysis
Strawman Comparison

Potential impact of SUD waiver replacing state-only funding for with some Medicaid funding.

- Potentially lower total state service funding with freed up state funds that could support more enrollees, more services, or a rate increase.
- Greater administrative costs.
- Greater federal spending.
- Greater total service spending.
- New services not offered in the current state.

In addition, the State must agree to:

- Administrative roles.
- Sources of state funding.
- Reserving funding for remaining uninsured individuals and for room and board expenditures for Medicaid individuals.
- Maintenance of Effort to maintain current state funding levels for SUD treatment.

SUD Budget Neutrality Modeling

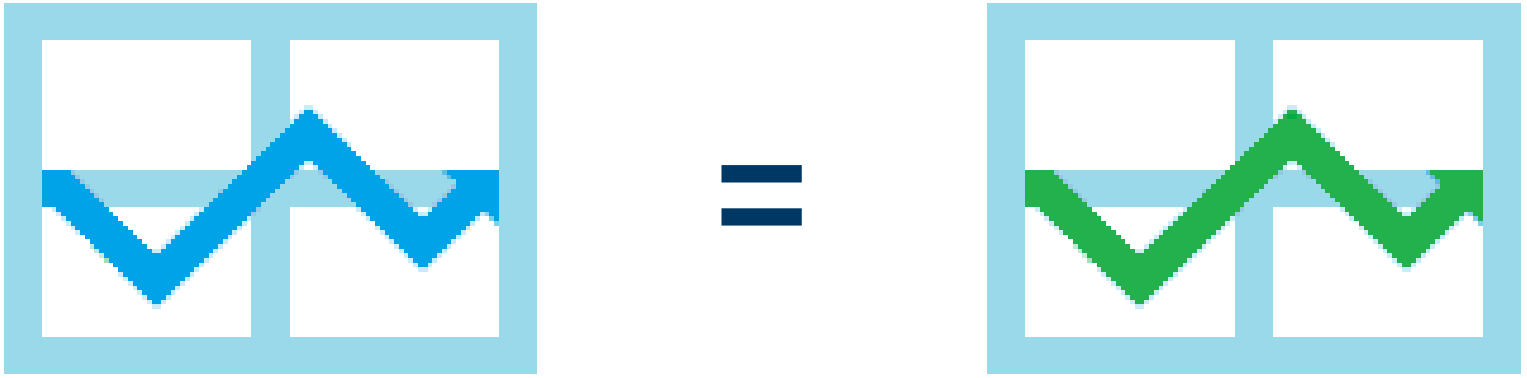
Federal Perspective

- Federal Rule: Spending under the program cannot exceed expected Medicaid spending absent the demonstration.

Without Waiver (WOW) **>** **With Waiver**

Federal Perspective: Hypothetical Costs

- Under a SUD 1115, CMS allows states to treat costs for residents of an IMD as if those costs were allowable under Medicaid (called Hypothetical Costs).



Without Waiver

With Waiver

What is Subject to Budget Neutrality?

Actual Medicaid service costs for the resident of an SUD IMD during the stay.

Medicaid Eligibility Groups (MEGs)

- Waiver projections and eventual reporting will be itemized by MEG.
- MEGs should reflect expected differences in population acuity.
- MEGs can play a key role in mitigating the impact of adverse case mix or other factors that could affect budget neutrality.

TANF-related Adults

TANF-related Children

SSI-related Adults

SSI-related Children

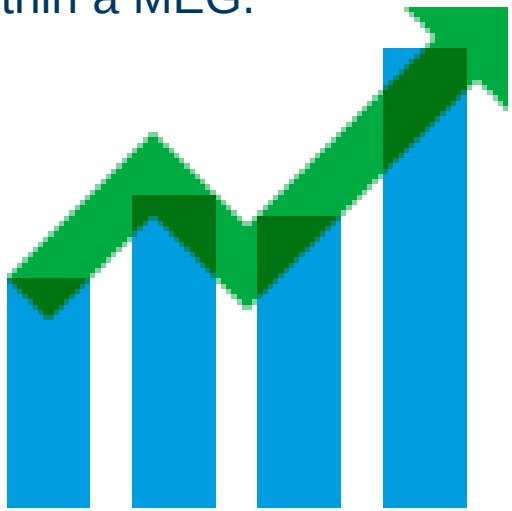
Five Years of Historic Costs

- Per member per month (per capita) cost calculation using a CMS template based on five years of historical cost data.
- Historic costs should reflect past State expenditures for IMD recipients. Illustrative example below (totals may differ due to rounding).

Medicaid Eligibility Group	Base Year 1	Base Year 2	Base Year 3	Base Year 4	Base Year 5	Demo Year 1
Adult IMD Cost PMPM	$ 1,100	$ 1,117	$ 1,133	$ 1,150	$ 1,167	$ 1,185
Adult User Months	9.00	9.27	9.55	9.83	10.13	10.43
Child IMD Cost PMPM	$ 1,100	$ 1,150	$ 1,201	$ 1,255	$ 1,312	$ 1,371
Child User Months	1.00	1.42	2.02	2.87	4.08	5.80
Total Cost	**$ 11,000**	**$ 11,984**	**$ 13,248**	**$ 14,918**	**$ 17,182**	**$ 20,320**

Federally Allowed Trend Rates

- Trend by the lesser of historic trend by MEG or President's budget.
- Final agreed trend rate should accommodate future PMPM expense growth over the five-year demonstration period.
- Typically, budget neutrality models have per capita limits, so no risk for enrollment growth within a MEG.



Without Waiver Limit

- Without Waiver = With Waiver (hypothetical).
- Here 1.5% cost trend was assumed for adults and 4.5% was assumed for children. Illustrative example below (totals may differ due to rounding).

Medicaid Eligibility Group	Demo Year 1	Demo Year 2	Demo Year 3	Demo Year 4	Demo Year 5
Adult IMD Cost PMPM	$ 1,185	$ 1,203	$ 1,221	$ 1,239	$ 1,258
Adult User Months	10.43	10.75	11.07	11.40	11.74
Child IMD Cost PMPM	$ 1,371	$ 1,432	$ 1,497	$ 1,564	$ 1,635
Child User Months	5.80	6.96	8.36	10.03	12.04
Total Cost	**$ 20,320**	**$ 22,903**	**$ 26,025**	**$ 29,817**	**$ 34,444**

Next Steps: Finalize SUD Waiver Development

UNDER CONSTRUCTION…

SUD Continuum Defined (e.g., ASAM)

Benefit Design

Historic Costs and PMPM Modeling

Program Standards

Benefit and Funding Mapping

Member Month Projections