Maryland
DEPARTMENT OF HEALTH

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

July 19, 2021

The Honorable Guy Guzzone
Chair
Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Maggie McIntosh
Chair
House Appropriations Operations
121 House Office Bldg.
Annapolis, MD 21401-1991

Re: 2020 Joint Chairmen's Report (p. 104-105) – Report on Substance Use Disorder (SUD) Treatment Limitations in the Medicaid Program

Dear Chair Guzzone and Chair McIntosh:

In keeping with the requirements of the 2020 Joint Chairmen's Report (p. 104-105), enclosed is the Maryland Department of Health's report on Substance Use Disorder (SUD) Treatment Limitations in the Medicaid Program.

If you have questions or need more information, please contact Heather Shek, Director, Office of Governmental Affairs at 410-767-5282 or heather.shek@maryland.gov.

Sincerely,

Dennis R. Schrader
Secretary

cc: Aliya Jones, M.D., MBA, Deputy Secretary, Behavioral Health
Steven R. Schuh, Deputy Secretary, Health Care Financing and Medicaid
Heather Shek, Director, Office of Governmental Affairs
Sarah Albert, Department of Legislative Services, 5 copies

2020 Joint Chairmen's Report
Report on Substance Use Disorder (SUD) Treatment Limitations in the Medicaid Program

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I. Executive Summary

This report addresses the 2020 Joint Chairmen's Report, pages 104–105, request on residential substance use disorder (SUD). This report will detail findings on the efficacy and effectiveness of residential SUD treatment, clinical best practices in residential SUD treatment, the frequency and length of such treatment, opportunities to seek waiver authority for the expansion of Medicaid coverage for residential SUD treatment to include participants with a mental health diagnosis, and timelines for seeking adjustments or revisions to the Medicaid reimbursement policies and protocols.

II. Background

The 2020 Joint Chairmen's Report requested that the Maryland Department of Health (MDH) submit a report on residential SUD treatment and the alignment of Medicaid reimbursement methodologies and protocols for residential SUD treatment with clinical best practices and medical findings.

The Behavioral Health Administration (BHA) defines "residential SUD treatment" as professionally directed evaluation, observation, medical monitoring, and addiction treatment in a single facility or campus setting in which the individual resides.[1]

In December 2016, the Centers for Medicare and Medicaid Services (CMS) approved MDH's application to amend its Section 1115 Demonstration Waiver[2] to enable the Maryland Medical Assistance (MA) program to receive Federal Financial Participation (FFP) for clinical SUD treatment and withdrawal management services provided to Medicaid-eligible adults who meet Medical Necessity Criteria (MNC) and reside in a non-public Institute for Mental Diseases (IMD).[3]However, Medicaid coverage is limited to two nonconsecutive 30-day residential SUD treatment stays without a break in treatment within a rolling calendar year.[4] Individuals who require a length of stay beyond current Medicaid coverage limits may remain in residential SUD treatment for a longer term stay if they continue to meet the Medical Necessity Criteria (MNC) for a residential SUD level of care. Such services are reimbursed by BHA using State General Funds (SGF). BHA also uses SGFs to cover the room and board costs for all service recipients and the full cost of residential SUD treatment, clinical services and room and board, for uninsured service recipients who meet financial eligibility criteria for behavioral health treatment services to be subsidized by the State. Authorization and reimbursement of residential

[1] COMAR 10.63.01.02B(74) Proposed Regulations Draft, p.2 retrieved from https://bha.health.maryland.gov/Documents/Chapter%2001%20Requirements%20for%20All%20Licensed%20Programs.pdf

[2] Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve demonstration projects that waive certain provisions of the Medicaid law to give states additional flexibility to design and improve their programs.

[3] An Institution for Mental Disease (IMD) is defined as a hospital, nursing facility, or other institution of more than 16 beds that is primarily designed to provide diagnosis, treatment, or care of persons with mental diseases, which includes SUDs. A residential SUD treatment facility with more than 16 beds would be considered an IMD.

[4] Maryland Department of Health HealthChoice Section 1115 Demonstration Waiver, as amended and approved on April 16, 2020, retrieved from https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/md/md-healthchoice-ca.pdf.

SUD treatment services are predicated on an individual meeting MNC for a residential SUD level of care based on the American Society of Addiction Medicine (ASAM) placement criteria. An episode of treatment qualifies as a single 30-day stay, even if an individual receives services at multiple, different ASAM levels of care. Residential SUD treatment was historically grant-funded and transitioned to Fee-for-Service (FFS) reimbursement through the Department's Administrative Services Organization (ASO) on July 1, 2017, for ASAM Levels 3.7-WM, 3.7, 3.5, and 3.3; and on January 1, 2019, for ASAM Level 3.1.

The following Tables 1–3 display utilization of SUD residential services and transitions through the ASAM levels of care from July 1, 2017, through December 31, 2019. Table 1 shows the utilization of each ASAM level of care by number of individuals, total number of days, the average length of stay, and days paid out of state funds due to lack of MA eligibility or stays beyond the 30 day limit. ASAM Level 3.5 saw the highest utilization by total number of days, while ASAM Level 3.7WM saw the greatest number of individuals and least amount of days due to individuals transitioning to lower intensity ASAM levels of care.

Table 1. SUD Residential Services by ASAM Level of Care, July 1, 2017–December 31, 2019[5]

Metric	SUD ASAM LEVEL OF CARE				
	Level 3.1	**Level 3.3**	**Level 3.5**	**Level 3.7**	**Level 3.7WM**
Number of Individuals	1,481	3,940	6,809	13,745	12,005
Total Number of Days	104,025	194,357	277,451	265,017	89,404
Days paid out of state funds because of the two episode 30-day limit rule but have MA eligibility	74,272 (71%)	99,818 (51%)	122,630 (44%)	26,110 (10%)	8,742 (10%)
Days paid out of state funds because of lack of MA eligibility	1,826 (2%)	11,084 (6%)	18,740 (7%)	14,323 (5%)	6,020 (7%)
Number of Discharges	1,824	4,723	8,281	17,936	15,969
Average Length of Stay (in days)	57.0	41.2	33.5	14.8	5.6

Table 2 presents combined admits to each ASAM level of care and shows the average as well as the range of number of admits per individual. The number of admits is unique and counted only once for each episode even if an individual transitioned to another level of care. The number of discharges is reported for each level of care, and counted under each level of care. While 22,418 unique individuals were served, the number of admits at 34,427 demonstrates how individuals move through ASAM levels of care.

[5] Based on Beacon Paid Claims Data through January 2, 2020.

Table 2. Number of Admits from July 1, 2017 through December 31, 2019

Number of Admits	34,427
Distinct Number of Individuals Served Across Levels of Care	22,418
Average Number of Admits per Individual	1–5
Range of Number of Admits per Individuals	1–13

Lastly, Table 3 displays the movement of individuals from either higher or lower levels of care based on their MNC and is reported by procedure code[6] for each ASAM level of care. Table 3 also shows the number of individuals that moved through multiple levels of care and represents the continuum of residential SUD treatment.

Table 3. Levels of Care Change from July 1, 2017 through December 31, 2019[7]

Lower level of care to Higher level of care		**Higher level of care to Lower level of care**	
By 1 Level		**By 1 Level**	
Level Change	**# of Individuals**	**Level Change**	**# of Individuals**
W7310 to W7330	47	W7330 to W7310	342
W7330 to W7350	292	W7350 to W7330	418
W7350 to W7370	435	W7370 to W7350	2,626
W7370 to W7375	2,027	W7375 to W7370	8,314
Total	**2,727**	**Total**	**9,990**
Multiple Levels		**Multiple Levels**	
Level Change	**# of Individuals**	**Level Change**	**# of Individuals**
W7310 to W7350	60	W7350 to W7310	414
W7310 to W7370	44	W7370 to W7310	377
W7310 to W7375	55	W7370 to W7330	1,063
W7330 to W7370	224	W7375 to W7310	33
W7330 to W7375	406	W7375 to W7330	360
W7350 to W7375	716	W7375 to W7350	617
Total	**1,428**	**Total**	**2,757**

[6] Note: ASAM Level 3.1 is W7310, 3.3 is W7330, 3.5 is W7350, 3.7 is W7370, and 3.7WM is W7375.
[7] Based on Beacon paid claims data through January 2, 2020.

The stated goals of the Medicaid Section 1115 Demonstration Waiver for residential SUD treatment include, among other things, facilitating access to evidence-based treatment; promoting holistic, person-centered care planning; addressing social determinants of health and barriers to treatment engagement; and improving individual and health system outcomes.[8] To that end, CMS has advocated focus on the full continuum of community-based SUD treatment services, not merely residential SUD treatment, and on SUD provider practice and program standards.[9] ASAM criteria are the only comprehensive, nationally recognized set of empirically supported clinical practice standards available for SUD treatment consistent with the goals of the Section 1115 Demonstration Waiver.[10] These standards can be used, at treatment inception, to determine the type and level of care an individual seeking SUD treatment may need and, over the course of the individual's treatment, to inform clinical decisions for continuing stay, transfer to a lower level of care, and discharge from treatment. In the ASAM taxonomy, placement decisions are guided by a strengths-based, multidimensional assessment that takes into account individual needs, obstacles and liabilities as well as individual strengths, assets and supports. The ASAM criteria serve as a clinical decision support tool to facilitate clinician-informed treatment decision-making in selecting the most clinically appropriate level of care across a continuum of SUD levels of care.[11] These standards can also be used at a system level to design Medicaid and state benefit coverage plans, to identify gaps in services, and to establish requirements for provider network participation.[12]

III. Alignment of Residential SUD Treatment with Clinical Best Practices

Maryland's Section 1115 Demonstration Waiver for residential SUD treatment encompasses the ASAM levels of care service definitions and placement criteria. Additionally, the Department's ASO has adopted MNC criteria that are fully aligned with ASAM criteria for the continuum of SUD treatment services.

ASAM Levels of Care:[13]

Level 0.5 Early Intervention

- Level .05 early intervention services target individuals who are at risk of developing a substance-related disorder or for whom there is insufficient clinical information to document a diagnosable SUD. These services—such as motivational interventions, Screening, Brief Intervention, and Referral to Treatment (SBIRT), and Driving While Intoxicated/Driving Under the Influence (DWI/DUI) education—seek to identify substance-related risk factors to help individuals recognize the potentially harmful consequences of high-risk behaviors.

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[8] Centers for Medicare and Medicaid Services, retrieved from About Section 1115 Demonstrations.

[9] Centers for Medicare and Medicaid Services, Overview of Substance Use Disorder (SUD) Clinical Care Guidelines: A Resource for States Developing SUD Delivery System Reforms, April 2017.

[10] Mee-Lee, D. (Ed.). The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, October, 2013.

[11] *Ibid*.

[12] Centers for Medicare and Medicaid Services, Overview of Substance Use Disorder (SUD) Clinical Care Guidelines. April 2017.

[13] Mee-Lee, D. (Ed.). The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, October, 2013.

Level 1.0 Outpatient (OP) SUD Treatment

- Level 1.0 outpatient SUD treatment services provide less than 9 hours of outpatient SUD treatment weekly for adults with an SUD diagnosis and less than 6 hours of outpatient SUD treatment weekly for adolescents with an SUD diagnosis; such services may also be used as a step-down from a more intensive level of care. Level 1.0 outpatient SUD treatment may include individual, family, or group counseling as well as withdrawal management and opioid treatment services,[14] such as Medication-Assisted Treatment (MAT).

Level 2.1 Intensive Outpatient (IOP) SUD Treatment

- Level 2.1 intensive outpatient programs are required to provide a minimum of 9 hours and a maximum of 19 hours of structured SUD programming weekly for adults with an SUD diagnosis and a minimum of 6 hours and a maximum of 19 hours of structured SUD programming weekly for adolescents with an SUD diagnosis; such services may also be used as a step-down from a more intensive level of care. Level 2.1 outpatient SUD treatment may include individual, family, or group counseling as well as withdrawal management and opioid treatment services, such as MAT. IOP treatment services are designed to meet the treatment needs of individuals with complex SUDs and co-occurring conditions, but who do not require 24-hour care.

Level 2.5 SUD Partial Hospitalization

- Level 2.5 partial hospitalization programs are required to provide 20 or more hours weekly of clinically intensive SUD programming services weekly for an individual with an SUD diagnosis who requires daily monitoring and management in a structured outpatient setting; such services may also be used as a step-down from a more intensive level of care. Level 2.5 outpatient SUD treatment may include individual, family, or group counseling, psychoeducation and recovery support services, as well as withdrawal management and opioid treatment services, such as MAT. Partial Hospitalization Program services are designed to meet the treatment needs of individuals with complex SUDs and co-occurring conditions, but who do not require 24-hour care.

Level 3.1 Clinically Managed Low Intensity Residential SUD Treatment

- Level 3.1 residential SUD treatment programs are required to provide at least five hours weekly of clinically managed,[15] low-intensity services to an individual with an SUD diagnosis who requires 24-hour staff oversight in a large or small halfway house;[16] such services may also be used as a step-down from a more intensive level of care. Level 1.0 outpatient SUD treatment services, including individual, family, or group counseling as well as withdrawal management and opioid treatment services, such as MAT, may be provided in conjunction with the Level 3.1 residential SUD treatment service. The

[14] BHA requires the accreditation-based license to specifically authorize withdrawal management and opioid treatment services in addition to the program type (COMAR 10.63.03).

[15] Clinically managed residential SUD treatment services are directed by nonmedical addiction specialists and are applicable to Level 3.1, 3.3, and 3.5 residential SUD treatment. Clinically-managed services are appropriate for individuals whose primary problems involve emotional, behavioral, cognitive, readiness to change, relapse, or recovery environment concerns. Intoxication, withdrawal, and biomedical concerns, if present, must be safely manageable in a clinically managed service.

[16] Halfway houses must comply with Health-General Article, §§8–406 and 10–518, Annotated Code of Maryland.

Level 3.1 service is directed toward supporting individuals to prevent relapse, apply recovery skills, and reintegrate into the community.

Level 3.3 Clinically Managed Population Specific, High Intensity Residential SUD Treatment

- Level 3.3 residential SUD treatment programs are required to provide a minimum of 20 hours and a maximum of 35 hours weekly of clinically managed, population-specific , high intensity treatment services for individuals with an SUD diagnosis and a co-occurring disorder who require 24-hour professional staff oversight in a therapeutic residential facility. This service is designed for individuals with a SUD diagnosis who do not need skilled nursing care, but may have physical or mental disabilities resulting from a prolonged substance-related disorder or a history of multiple admissions to substance related disorder programs. Individuals in Level 3.3 residential SUD treatment have been assessed to require a controlled environment with supportive counseling. All individual, family, or group treatment services must be provided on-site and are inclusive of mental health treatment. Withdrawal management and opioid treatment services, such as MAT, may be provided if the program's license specifically authorizes the service.

Level 3.5 Clinically Managed High Intensity Residential SUD Treatment

- Level 3.5 residential SUD treatment programs are required to provide at least 36 hours weekly of clinically managed, high-intensity SUD treatment and ancillary services for individuals with an SUD diagnosis who are in some imminent danger and have social and psychological conditions which cannot be safely treated outside of a highly structured residential environment with a 24-hour on-site multidisciplinary treatment team. All individual, family, or group treatment services must be provided on-site and are inclusive of mental health treatment. Withdrawal management and opioid treatment services, such as MAT, may be provided if the program's license specifically authorizes the service. Level 3.5 services rely on the therapeutic milieu and treatment community as an agent of change.

Level 3.7 Medically Monitored High Intensity Residential SUD Treatment

- Level 3.7 medically monitored,[17] high intensity residential SUD treatment programs are required to provide a minimum of 36 hours of medically monitored, high intensity treatment to individuals with a SUD diagnosis who have subacute biomedical and emotional, behavioral, or cognitive problems that are so severe that they require 24-hour nursing care with physician availability. All individual, family, or group treatment services must be provided on-site and are inclusive of mental health treatment.

3.7 WM Medically Monitored High Intensity Withdrawal Services

- Withdrawal management and opioid treatment services, such as MAT, may be provided if the program's license specifically authorizes the service. Individuals engaged in this level of care are experiencing severe withdrawal symptoms and require medication or have a recent history of withdrawal management at a less intensive level of care, marked

[17] Medically monitored residential SUD treatment services are provided by a multidisciplinary treatment team and is applicable to Level 3.7. Medical monitoring is provided through direct patient contact, review of records, team meetings, 24-hour coverage by a physician, 24-hour nursing and a quality assurance program.

by past and current inability to complete withdrawal management and enter into continuing addiction treatment. The individual needs 24-hour nursing care with physician oversight as necessary, and is unable to safely complete withdrawal management without 24-hour medical and nursing monitoring.

IV. Efficacy and Effectiveness of Residential SUD Treatment

Residential SUD treatment is a setting in which both SUD treatment and ancillary services occur rather than a separate and discrete model of SUD treatment.[18] In general, residential SUD treatment consists of a constellation of services and interventions delivered to an individual with a diagnosed SUD residing in a licensed residential SUD treatment facility. However, while the intensity of treatment is generally defined by the required number of hours of service, service definitions for residential SUD treatment and the core treatment components which comprise residential SUD treatment at each level of care have varied considerably from program to program, jurisdiction to jurisdiction, and state to state.

As programs, states, and managed care organizations increasingly adopt ASAM criteria as a standard for determining levels of care, service definitions are becoming more standardized. But even with greater standardization, the precise constellation of services and clinical interventions to be delivered in the residential SUD treatment setting is often left to program discretion and the clinical judgment of practitioners. Thus, research into the efficacy and effectiveness of residential SUD treatment has been complicated by factors such as the absence of a coherent service model, the lack of a standardized service definition, and the lack of specificity in the treatment modalities and interventions to be delivered. In addition, some of the research studies that have been conducted have been beset with methodological flaws, such as non-equivalent samples and selection bias due to high rates of attrition.[19] Notwithstanding the confounds cited above, a synthesis of the available research literature suggests that there is moderate evidence for the effectiveness of residential SUD treatment, with some mixed results .[20,21]

Despite the general consensus that residential SUD treatment confers modest benefits for substance use and mental health outcomes for certain service recipients, the active ingredients and mechanisms of change underlying this service modality remain unclear.[22,23] Although certain health services researchers have called for further specification of the core treatment components and interventions inherent in residential SUD treatment, others have argued that the defining feature of residential SUD treatment is its focus on the micro-community of residents as a catalyst for behavioral change. Thus, in their view, equal, if not more important, than the actual

[18] Relf, S., George, P., Braude, L., Dougherty, R., Daniels, A., Shoma-Gose, S., and Delphin-Rittman, M. Residential Treatment for Individuals with Substance Use Disorders: Assessing the Evidence. Psychiatric Services, 65(3), pp. 301–312, 2014.
[19] *Ibid.*
[20] *Ibid*.
[21] De Andrade, D..Elphinston, R., Quinn, C., Allan, J., and Hides, L. The Effectiveness of residential treatment services for individuals with substance use disorders: A systematic review. Drug and Alcohol Dependence, 201(2019), pp. 227–235, 2019.
[22] *Ibid*.
[23] Relf, S. et al. Residential Treatment for Individuals with Substance Use Disorders: Assessing the Evidence. Psychiatric Services, 65(3), pp. 301–312, 2014.

SUD treatment services and interventions themselves, is the use of the residential community as a resocialization agent to instill prosocial behavior, reestablish daily routines, and reinforce adaptive coping mechanisms.[24,25] This approach to residential SUD treatment is referred to as "therapeutic communities" or the "therapeutic community model" and is derived from social learning and rehabilitation theories.[26,27]

In therapeutic communities, individuals with SUD diagnoses are sequestered from their home communities and assimilated into an abstinence-based culture which is solidified by participation in communal activities, such as meal preparation, household chore assignment, community meetings, and group peer and mutual support sessions. Residents earn privileges for program compliance and achievement of milestones and incur sanctions for violation of program rules. Abstinence-based norms are supported and strengthened through random toxicology screenings and substance use surveillance. In addition, prosocial behavior is modeled by residents with sustained abstinence from substances and by staff who are often individuals in long-term recovery. Participants who uphold program standards gain increasing levels of responsibility and status over time, culminating in preparation for their re-entry into employment, education, and community living. Historically, proponents of the therapeutic communities approach have viewed MAT as incompatible with the program's abstinence-based tenets; however, contemporary adaptations have emerged which embed established evidence-based practices (EBPs), such as MAT, cognitive behavioral therapy (CBT), and motivational interviewing (MI), into the traditional therapeutic communities approach.[28,29] Unfortunately, residential SUD treatment programs have been slow to adopt these contemporary adaptations, and not all provide access to EBPs.[30,31]

The evidence for the effectiveness of the therapeutic communities approach to residential SUD treatment is modest, similar to that for residential SUD treatment in general, although there is some evidence that, for specialized populations, such as those with significant psychiatric comorbidities, criminal justice involvement, homelessness, or treatment resistant histories, the therapeutic communities model may be superior, particularly for social outcomes,[32] to other

[24] National Institute on Drug Abuse. Research Reports:Therapeutic Communities. National Institute of Health, July 2015.
[25] Kast, K., Manella, G., and Avery, J. Community as Treatment: The Therapeutic Community Model in the Era of the Opioid Crisis. Journal of Addictive Behaviors, Therapy, and Rehabilitation, 8(2), 2019.
[26] *Ibid.*
[27] National Institute on Drug Abuse. Research Reports:Therapeutic Communities. National Institute of Health, July 2015.
[28] *Ibid.*
[29] Kast, K. et al. Community as Treatment: The Therapeutic Community Model in the Era of the Opioid Crisis. Journal of Addictive Behaviors, Therapy, and Rehabilitation, 8(2), 2019.
[30] National Institute on Drug Abuse. Research Reports:Therapeutic Communities. National Institute of Health, July 2015.
[31] Olsen, Y, and Sharfstein, S. The Opioid Epidemic: What Everyone Needs to Know, 2019.
[32] De Andrade et al. The Effectiveness of residential treatment services for individuals with substance use disorders: A systematic review. Drug and Alcohol Dependence, 201(2019), pp. 227–235, 2019.

forms of residential SUD treatment.[33,34] Therapeutic communities may be the preferred treatment for individuals for whom MAT is inadvisable due to underlying medical conditions.[35]

The empirical support for this approach, however, is largely from non-experimental and quasi-experimental research designs which make attributions of effectiveness more tenuous. Certain individuals with SUDs may benefit from insulation from their high-risk communities for an extended period of time to permit focused attention on their treatment and recovery goals which otherwise would not occur in the absence of the therapeutic community; however, for others, this isolation prevents them from learning to cope with the real-life stressors and risk factors they are likely to confront when they return to their home communities.[36] Since strategies learned in the therapeutic community setting do not necessarily generalize to the real-world setting, a clinically sound aftercare plan with linkages to continuing treatment is critical to consolidate treatment gains and prevent relapse and, in practice, this is not always a consideration prior to discharge.[37]

As the residential SUD treatment approach evolves over time to incorporate more forms of evidence-based treatment, it will become increasingly more difficult to ascertain the extent to which the residential SUD treatment modality independently contributes to positive outcomes for individuals with SUDs. More rigorous, methodologically sound research is needed to determine which residential SUD treatment components and interventions are most effective, under what circumstances, and for which types of individuals with SUDs.[38,39]

V. Clinical Best Practices in Residential Treatment

In recognition that residential SUD treatment is primarily a locus for treatment rather than a set of manualized treatment interventions, it stands to reason that by embedding evidence-treatment services and interventions within the residential SUD treatment environment, SUD treatment outcomes are likely to improve. It may be that residential SUD treatment, when combined with EBPs, has a synergistic impact on treatment outcomes.

The clearest and strongest evidence for the effectiveness of residential SUD treatment is for integrated treatment approaches for individuals with co-occurring mental health and substance

[33] Kast, K. et al. Community as Treatment: The Therapeutic Community Model in the Era of the Opioid Crisis. Journal of Addictive Behaviors, Therapy, and Rehabilitation, 8(2), 2019.
[34] National Institute on Drug Abuse. Research Reports:Therapeutic Communities. National Institute of Health, July 2015.
[35] Kast, K. et al. Community as Treatment: The Therapeutic Community Model in the Era of the Opioid Crisis. Journal of Addictive Behaviors, Therapy, and Rehabilitation, 8(2), 2019.
[36] Olsen, Y, and Sharfstein, S. The Opioid Epidemic: What Everyone Needs to Know, 2019.
[37] *Ibid.*
[38] Relf, S. et al. Residential Treatment for Individuals with Substance Use Disorders: Assessing the Evidence. Psychiatric Services, 65(3), pp. 301–312, 2014.
[39] De Andrade et al. The Effectiveness of residential treatment services for individuals with substance use disorders: A systematic review. Drug and Alcohol Dependence, 201(2019), pp. 227–235, 2019.

use disorders.[40] When implemented with fidelity,[41] integrated residential treatment approaches have yielded clinically significant improvements in mental health and substance use outcomes for individuals with co-occurring disorders.[42] Integrated co-occurring disorders treatment (ITCOD) is a Substance Abuse and Mental Health Services Administration (SAMHSA) recognized EBP;[43] however, implementation of ITCOD in routine practice settings with fidelity to the practice is not likely to occur in the absence of committed change agents, organizational and leadership supports, and focused attention to clinical skills training with clinical supervision to provide feedback and to reinforce skill acquisition.[44,45] Nonetheless, with organizational and clinician supports to address implementation barriers, combined with ongoing fidelity monitoring to provide quality assurance, integrated treatment within residential SUD treatment settings can be implemented effectively with fidelity.[46]

Despite the well-established effectiveness of integrated treatment, studies have shown that few residential SUD treatment programs have the capacity to provide co-occurring capable[47] or co-occurring enhanced[48] services.[49] In fact, nationally, only 12% of adults with a co-occurring serious mental illness and SUD received both mental health and specialty SUD treatment.[50] This is due in part to the complexity of achieving both system-level integration and service integration. Empirically supported tools exist for assessing provider co-occurring capability and co-occurring enhanced services.[51] BHA provides funding to the University of Maryland Baltimore Evidence Based Practice Center (EBPC) and Systems Evaluation Center (SEC) to

[40] Substance Abuse and Mental Health Services Administration. Substance Use Disorder Treatment for People With Co-Occurring Disorders. Treatment Improvement Protocol (TIP) Series, No. 42. SAMHSA Publication No. PEP20-02-01-004. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020.
[41] Fidelity is the degree to which an intervention is delivered as designed. EBPs can only be expected to yield the expected outcomes when they are implemented with fidelity.
[42] McKee, S., Harris, G., and Cormier, C. Implementing Residential Integrated Treatment for Co-occurring Disorders. Journal of Dual Disorders, 9(3), pp. 249–259, 2013.
[43] Substance Abuse and Mental Health Services Administration. Integrated Treatment for Co-Occurring Disorders: The Evidence. DHHS Pub. No. SMA-08-4366, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2009.
[44] Torrey, W., Tepper, M., and Greenhold, J. Implementing integrated services for adults with co-occurring substance use disorders and psychiatric illnesses: A research review. Journal of Dual Diagnosis, 7, pp. 150–161, 2011.
[45] Kikkert M, Goudriaan A, De Waal M, Peen J, Dekker J. Effectiveness of Integrated Dual Diagnosis Treatment (IDDT) in severe mental illness outpatients with a co-occurring substance use disorder. Journal of Substance Abuse Treatment, v. 95, pp. 35–42, 2018.
[46] McKee, S.et al. Implementing Residential Integrated Treatment for Co-occurring Disorders. Journal of Dual Disorders, 9(3), pp. 249–259, 2013.
[47] Co-occurring capable services address co occurring mental and substance-related disorders in their policy, workforce development, and clinical practice (assessment, treatment planning, treatment, and discharge planning).
[48] Co-occurring enhanced services are SUD programs with enhanced resources that specifically and preferentially serve individuals with more severe psychiatric disabilities, or specialized mental health programs that focus on individuals with severe mental health conditions and active SUDs.
[49] Kast, K. et al. Community as Treatment: The Therapeutic Community Model in the Era of the Opioid Crisis. Journal of Addictive Behaviors, Therapy, and Rehabilitation, 8(2), 2019.
[50] Substance Abuse and Mental Health Services Administration, National Survey of Substance Abuse Treatment Services (N-SSATS): 2017. Data on Substance Abuse Treatment Facilities. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018.
[51] Minkoff, K. and Cline, C. Co-Occurring Capability Progress Checklist: ZiaPartners, 2018.

conduct a Co-Occurring Capability Assessment Project. The Co-Occurring Disorders (COD) Consultant/Trainer at the EBPC has been working with a variety of providers in the Maryland Public Behavioral Health System (PBHS) to enhance behavioral health Co-Occurring Capability (COC). The SEC is collecting data on each of these providers using the Co-Occurring Capability Progress Checklist.[52] The EBPC then uses the data to guide its work with individual sites as well as across the PBHS. In addition, the EBPC is facilitating the administration of the COMPASS-EZ, a more comprehensive assessment of co-occurring capability, for programs who voluntarily agree to participate in the assessment.

Recent studies have examined broader health, well-being, and social outcomes, which suggests that a more holistic approach to residential SUD treatment may help address the social determinants of health,[53] by lowering risk factors, reducing health disparities to treatment access, increasing motivation to change, and promoting treatment retention. In addition, to the extent that residential SUD treatment is seen more as a continuum of care than a discrete service, the focus on aftercare and continuing care becomes more salient. Care coordination interventions which originate in residential SUD treatment facilities and continue post-discharge to assist the individual in accessing community resources, navigating the behavioral and somatic health systems of care, and coordinating services across providers and service delivery systems are critical to long-term treatment engagement and retention.[54,55,56,57]
Continuation of care following discharge from residential SUD treatment significantly increases the likelihood of substance use recovery[58]

The use of ASAM criteria to match individual characteristics to treatment environment, intervention and service has shown predictive validity in ensuring that individuals are matched to the most clinically appropriate level of care at the most appropriate time. Individuals who are matched to the least restrictive SUD treatment level of care based on the application of ASAM criteria are more likely to experience positive treatment outcomes than individuals who are either overmatched or undermatched to a SUD treatment level of care.[59]

Some residential SUD treatment programs subscribe to a strict abstinence only philosophy and are not supportive of the use of MAT for SUDs. In Maryland, residential SUD treatment programs cannot refuse an individual based on participation in MAT. Although MAT is an

[52] Minkoff, K. and Cline, C. COMPASS-EZ 2.0 (second edition). COMPASS-EZ 2.0 (second edition): ZiaPartners, 2016.
[53]De Andrade et al. The Effectiveness of residential treatment services for individuals with substance use disorders: A systematic review. Drug and Alcohol Dependence, 201(2019), pp. 227–235, 2019.
[54]Substance Abuse and Mental Health Services Administration. Substance Use Disorder Treatment for People With Co-Occurring Disorders. Treatment Improvement Protocol (TIP) Series, No. 42. SAMHSA Publication No. PEP20-02-01-004. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020.
[55] *Ibid*.
[56] McKay, J. Continuing Care Research: What We've Learned and Where We're Going. Journal of Substance Abuse Treatment.36(2)m 131–145, 2009.
[57] Relf, S. et al. Residential Treatment for Individuals with Substance Use Disorders: Assessing the Evidence. Psychiatric Services, 65(3), pp. 301–312, 2014.
[58] De Andrade et al. The Effectiveness of residential treatment services for individuals with substance use disorders: A systematic review. Drug and Alcohol Dependence, 201(2019), pp. 227–235, 2019.
[59]Mee-Lee, D. (Ed.). The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, October, 2013.

evidence-based and cost-effective intervention for OUD, medications are not always available in substance use residential treatment programs.[60] The 2017 National Survey of Substance Abuse Treatment Services (N-SSATS) indicates that most residential treatment programs nationally do not offer the three Food and Drug Administration (FDA) approved medications to treat opioid use disorder (OUD): methadone, buprenorphine, and naltrexone are all evidence-based treatments for OUD.[61] In Maryland, SUD programs that offer MAT, offer at least one of the three FDA approved medications. However, these programs do not necessarily offer all three of the FDA approved medications. For those on methadone, residential SUD treatment programs work with Opioid Treatment Programs (OTPs) to facilitate access to opioid medications. BHA regulations require that OTPs transport opioid medications dispensed to an individual be transported to residential SUD treatment facilities.[62] Additionally, under federal law, behavioral health care providers may not discriminate against an individual on MAT, if the individual otherwise meets eligibility requirements for the program.[63]

Other evidence-based practices (EBPs) delivered in residential SUD treatment may include motivational interviewing and cognitive behavioral therapy; however, not all residential SUD programs provide evidence-based services. For example, in 2013, only two states required use of EBPs in SUD residential SUD treatment.[64] A challenge for states and residential SUD treatment programs that do deliver EBPs in residential settings, is that there is no systematic, cost-effective mechanism to assess fidelity of EBP implementation to ensure that the essential ingredients of the service intervention are implemented as intended.

In 2016, as part of the approval from CMS for the Section 1115 Demonstration Waiver for adults, MDH agreed to require demonstrated competency in and deliver a minimum of three evidence-based practices (EBPs). Maryland Medicaid requires that applicants for enrollment in Medicaid as a PT54-Residential SUD Adult Treatment provider attest that a minimum of three of the following EBPS are offered by the program: Acceptance and Commitment Therapy (ACT); Cognitive Behavioral Therapy (CBT); MAT; Motivational Enhancement Therapy (MET); Motivational Interviewing (MI) Psychoeducation; Psychotherapy; Relapse Prevention (RP); Solution-Focused Group Therapy (SFGT); Supportive Expressive Psychotherapy (SE); and Trauma Informed Treatment.

VI. Frequency and Length of Treatment

Research on the length and frequency of residential SUD treatment by level of care is mixed, with some studies suggesting that significant and durable treatment benefits can derive from

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[60] Olsen, Y, and Sharfstein, S. The Opioid Epidemic: What Everyone Needs to Know, 2019.

[61] Substance Abuse and Mental Health Services Administration, National Survey of Substance Abuse Treatment Services (N-SSATS): 2017. Data on Substance Abuse Treatment Facilities. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2018.

[62] COMAR 10.63.03.19D.

[63] Attorneys at the Legal Action Center authored, Know Your Rights: Rights for Individuals on Medication Assisted Treatment. HHS Publication No. (SMA) 09–4449. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2009.

[64] National Association of State Alcohol and Drug Abuse Directors (NASADAD). State Regulations on Substance Use Disorder Programs and Counselors: An Overview. December, 2012, retrieved from http://nasadad.org/wp-content/uploads/2010/12/State_Regulation_of_SUD_Programs_and_Counselors-7-26-13.pdf.

residential treatment stays as short as 30 days; whereas other research suggests that 90-day stays may result in significant treatment benefit.[65] Engagement, retention in, and continuity of treatment is far more important than the duration of residential treatment in predicting long-term recovery.[66] Residential treatment has evolved over time from a stand alone point in time service to a service with graduated levels of care embedded within a full continuum of SUD treatment and recovery support services. This is in large part a reflection of shifting conceptualization of SUD treatment from an episodic, acute care model to a chronic, disease management model that recognizes the chronic, remitting nature of the disorder.

In the acute care model, a durable treatment outcome is expected at the conclusion of a treatment episode; whereas, in the chronic disease management model, outcomes are collected longitudinally throughout the service progression and a durable treatment outcome is not expected in the absence of ongoing treatment. Thus, more longitudinal research is needed to determine the role of residential treatment in the SUD continuum of care and the factors that lead to improved treatment outcomes. Since the population of individuals who receive residential SUD treatment is heterogeneous, a robust investigation of individual level factors that may contribute to successful treatment outcomes is needed to determine which individuals are most likely to benefit from residential SUD treatment. In the absence of further research, the determination of the frequency and intensity of treatment should be an individualized decision informed by a comprehensive, multidimensional assessment and the application of ASAM criteria.

VII. Opportunities to Seek Waivers for Treatment Expansion and Timeline

Maryland Medicaid is currently evaluating opportunities to expand coverage of IMD services to include residential mental health services in light of new guidance issued by CMS. Previously on July 27, 2015, Maryland submitted an amendment to the existing Section 1115 waiver to allow for coverage of residential treatment for both SUD and mental health diagnoses. That amendment was denied by CMS. Maryland Medicaid subsequently sought and was granted a waiver amendment, as part of the 2016 HealthChoice Section 1115 renewal application, to cover SUD services delivered in IMDs for adults aged 21 to 64. Since July 1, 2017, Medicaid has reimbursed up to two nonconsecutive 30-day stays of IMD services according to the following implementation schedule:

- Effective July 1, 2017: Coverage of ASAM levels 3.7WM, 3.7, 3.5, and 3.3;
- Effective January 1, 2019: Coverage of ASAM level 3.1; and
- Effective January 1, 2020: Coverage for dual eligibles

Additionally, Medicaid sought and was granted another waiver amendment in order to provide coverage for inpatient services for individuals with a primary SUD diagnosis and a secondary mental health diagnosis for up to 15 days per month at ASAM level 4.0, beginning on July 1, 2019.

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[65] De Andrade, D., Elphinston, R., Quinn, C., Allan, J., and Hides, L. The effectiveness of residential treatment services for individuals with substance use disorders: A systematic review. Drug and Alcohol Dependence, 201(2019), pp. 227–235, 2019.
[66] *Ibid*.

More recently, in November 2018, CMS lifted the IMD exclusion for Medicaid payment for inpatient mental health treatment and announced opportunities for states to apply for demonstrations to cover residential mental health services in IMD settings.[67] The District of Columbia became the first Medicaid program to be approved under this new guidance, and other states are pursuing similar expansions.

IX. Conclusion

The Maryland Department of Health has taken great strides to facilitate access to the full continuum of care for SUD services by applying for various waivers to draw down federal funding, thus freeing up state funds to provide coverage for the uninsured and underinsured population. Using EBPs, ASAM placement criteria, and person-centered care planning while aligning Medicaid reimbursement for services has enabled Maryland to improve health outcomes and remove barriers for those seeking treatment for SUD.

[67] State Medicaid Director Letter, SMD # 18--011 RE: Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance, available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf.