Federal Medicaid for Residential DOSA and Intensive Inpatient Treatment Funding

2021 Findings and Recommendations

As required by ESSB 5092

Scott Russell, Deputy Director of Health Services
scott.russell@doc.wa.gov

Dawn Williams, Program Director of Substance Abuse Recovery Unit
dawn.williams@doc.wa.gov

This is the report to the Legislature as directed by ESSB 5092 and contains information on Medicaid as match for Intensive Inpatient Treatment and Residential DOSA Treatment in the community.

600-SR002 (01/2022)

Table of Contents

Federal Medicaid for Residential DOSA and Intensive Inpatient Treatment Funding

2021 Report to the Legislature

Executive Summary

The Washington State Department of Corrections (DOC) and the Health Care Authority (HCA) work together to explore ways to utilize federal Medicaid funds as a match to fund residential substance use disorder treatment- based as alternative beds under RCW 9.94A.664 under the offender drug sentencing alternative program and residential substance use disorder treatment beds that serve individuals on community custody.

As part of the work Department of Corrections and Health Care Authority held several meetings to discuss the possibilities and challenges of using federal dollars to provide treatment for DOC Involved individuals. This report provides background information, current Washington state treatment capacity and areas of risk, Medicaid reimbursable services analysis and recommendations respectively.

Part of the process includes the recommendation findings at the end of the report. Given the complexities around Medicaid funding and residential DOSA and intensive inpatient care, the top five recommendations include:

1. Continue a more thorough analysis of the impact of Medicaid reimbursement practices and substance use disorder treatment across the Department of Corrections, including the addition of the opioid use disorder treatment program (MOUD).
2. The state may benefit from a longer-term planning process that would assess current and anticipated gaps in services. Allowing multiple agencies to come together in a coordinated way across the state.
    a. Engage multiple stakeholders to assess and plan for the future of Washington's SUD and behavioral health systems.
        i. Ensure connection with the substance use disorder certification advisory committee through Department of Health to keep notified of licensure and practice changes.
        ii. Participation on the Behavioral health Advisory Council of HCA to ensure creation of joint advisory processes and grant application opportunities are realized for additional funding.
    b. Bring more stakeholder viewpoints into the Washington's larger Medicaid Transformation project (MTP) to further understand community barriers to recovery.
3. Establish consistent payer and provider interpretation of criteria for residential SUD treatment services.
    a. The state may benefit from developing further guidelines on their application and having a consensus among providers as well as managed care organizations. This would include appropriate length of stay within residential settings.

b. This develops additional data for consistency of an individual's process to receiving care and cost of care. As well as highlighting different approaches that individualize care to each patient. Ultimately leading to a more evidence-based process when reviewing the benefit and risk to communities and the individuals we serve.

4. Consider the value of expanding the Foundational Community Supports (FCS) program
    a. Recent SUD related contracting for FCS – part of Washington's larger Medicaid Transformation Project (MTP) – could be a mechanism for providing recovery supports such as stable housing, supported employment, opportunities, transportation and peer services.
5. Explore opportunities to provide additional treatment services through telehealth.
    a. Due to the CDC social distancing guidelines and closure of agency doors, we currently have not determined the lost bed capacity across Washington State. Finding alternative methods to provide successful treatment to residents is imperative.

Background

Residential DOSA

In 1995, the Washington State Legislature enacted RCW 9.94A.664 and created the Drug Offender Sentencing Alternative (DOSA) for drug-involved felony offenders facing a prison sentence. Subsequently in 2005, the Legislature amended the law to create the Residential DOSA as an alternative to prison for offenders with substance abuse problems. This newly created alternative afforded individuals the ability to receive treatment while in the community and avoid prison altogether. Under the statute, individuals are required to enter and complete treatment for up to 6 months. Treatment is currently reimbursed by the DOC and Medicaid.

Prior to being sentenced to a Residential DOSA, offenders may be ordered by the court to undergo a comprehensive screening and examination report that is then provided to the court at the time of sentencing. Courts have widely adopted this alternative and created therapeutic DOSA courts whereby individuals meet with the presiding judge weekly, bi-weekly and/or monthly while in and then once discharged from treatment. Residential DOSA treatment in the community is currently delivered by one contracted vendor using the evidenced based Therapeutic Communities model.

An individual is referred for a Residential DOSA examination by the court of jurisdiction. The court officers send the court order for assessment and examination to the Department of Corrections Substance Abuse Recovery Unit (SARU). The SARU sends a referral to contractors that are then required to provide an assessment and examination report to the court within 10 days. Over 95 percent of these assessments and examinations are conducted in the jurisdiction's jail facilities and the remaining 5 percent occur in the community. The concluded examination report provided to the court has the contract provider's first available bed date along with the transportation information.

Residential DOSA clients are released from jails to immediately transport to the provider for up to 6 months of treatment per RCW 9.94A.664. If a bed is not immediately available, the individual may be held in confinement up to 30 days. The contractor provides transportation directly from the jail as

ordered by the court, to one of the contractor's three treatment facility locations (two of which are in Spokane, Washington and one in Chehalis, Washington). Individuals on DOC community supervision similarly benefit from transportation to treatment from strategic locations across the state including their community supervision service office, prisons, and jails where they are serving time for violations.

The contracts were awarded based upon a competitive process to ensure streamlined transportation to treatment, admission process and the minimization of barriers when accessing care. The contracts also require weekly reporting to the courts and community service officers regarding progress including individuals that abscond from treatment into the community.

Once the individual completes the program, the individual is then transported back to their jurisdiction by the treating agency. If an individual leaves the treating agency without medical advice, the provider is required to notify the DOC Warrants Desk within 24 hours 7 days per week.

Residential Treatment for Individuals on Supervision

The Department of Corrections similarly contracts with the Residential DOSA provider to also provide residential treatment to individuals supervised by the DOC. The contractor delivers the above noted Therapeutic Communities model of treatment to community supervised individuals.

In response to the legislative changes regarding the behavioral integrated health model implemented in 2016, DOC SARU no longer provides outpatient services to individuals on community supervision in DOC field office or community justice center.

Other Considerations

In 2020, the Department of Corrections requested additional funding for residential care in the community to eliminate the wait lists for DOSA individuals and individuals on supervision to ensure the judiciary's continued use of the alternative, decrease community supervision violations and decrease the likelihood of recidivism. The legislature fully funded this request.

The Department of Corrections is improving capacity for the release of individuals into the community from prison confinement under the Graduated Release (GRE) programs. The DOC SARU is currently working with the Reentry Division to identify individuals who are eligible for GRE and in need of residential treatment but have not had time to enter treatment prior to eligibility for GRE.

Current Washington State Treatment Capacity and Areas of Risk

In 2018, Washington State obtained an amendment to its Section 1115 Waiver, allowing the state to obtain federal financial participation for services provided to Medicaid recipients receiving short-term residential treatment for substance use disorder (SUD). Federal funding was contingent upon the state's progress toward a set of milestones and metrics for care delivery.

1. Access to critical levels of care for OUD and other SUDs ("Access").
2. Widespread use of evidence-based, SUD-specific patient placement criteria ("Assessment").
3. Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications ("Provider Qualifications, MOUD").

4. Sufficient provider capacity at each level of care, including MOUD ("Capacity").
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD ("Prescribing, Overdose Prevention").
6. Improved care coordination and transitions between levels of care ("Care Coordination")

Washington State was also required to conduct an independent mid-point assessment ("MPA") to examine the progress in these areas, identify factors and risks affecting their achievement, and provide recommendations for state actions to support improvement.

The Center for Health System's Effectiveness summarized their findings in a report dated December 11, 2020.[1] The report noted an overall movement in the desired direction and suggested significant progress in expanding access and provider capacity (there is currently a shortage of SUD residential beds in Washington State), increasing treatment availability and improving care coordination. Despite the noted progress, interviews with stakeholders revealed implementation challenges as the state transitioned to Integrated Managed Care, in which Managed Care Organizations are responsible for providing both psychical and behavioral health benefits to Medicaid Enrollees. Some of the challenges were delays in payment impacting provider financial stability and the disagreement between payers and providers about the role of residential care in SUD treatment.

Medicaid Reimbursable Services

Using Medicaid match for individuals on community supervision and in need of residential treatment is possible by building the following process:

Individuals enrolled in treatment receive coverage using the following steps:

- Individual is enrolled in Medicaid
- Provider verifies contract with the MCO in which the individual is enrolled
- If MCO denies treatment per medical necessity, provider can pursue appeal process
- While appeal process is pursued, client is retained in treatment
- If appeal is upheld, provider works with DOC for continued stay
- DOC adjust rates to reflect MCO rates
- MCO's contract reflects provider requirement to allow court access during treatment stay for DOSA review court dates
- MCO's contract reflects provider requirement to provide transportation to and from treatment with pick up points across 39 counties to include jails and prison facilities with regularly scheduled pick up times
- Ensure bed capacity across Washington State can accommodate this added influx of population
- MCO's contractually require providers to serve registered sex offenders
- MCO's contractually require providers to allow DOC specialists (graduated reentry and community parenting alternative) face to face access to patients while they are in treatment several times per week.

[1] https://www.hca.wa.gov/assets/program/mtp-initiative-4-assessment-report.pdf.

The average length of stay in treatment for Residential DOSA is 90 days and for Prison DOSA serving community supervision time is 45 days. The average length of stay for non-DOSA individuals on supervision not on DOSA is 45 days. RCW 9.94A.664 requires individuals to remain in treatment for up to 6 months as set by the court. The treatment provider is required to send a report to the court within 30 days of arrival to residential substance use disorder treatment. However, MCOs are required to reimburse treatment in accordance with medical necessity and the use of ASAM criteria to determine length of stay which many times does not align with required court ordered requirements. The discrepancy can leave a sizable gap in payment between what is a Medicaid-allowable expense and what would need to be covered with General Fund State dollars.

Cost Considerations

The HCA requires MCO's to ensure providers utilize ASAM criteria to authorize payment for services and the contract providers are required to provide services that are medically necessary. Providers continue to struggle with the application of ASAM criteria and some perform better than others. The current system of delivery for DOSA and DOC involved individual's residential treatment is a predictable process and the hundreds if not thousands of county, state and community personnel as well as supervised individuals and families benefit from a streamlined process for referral, intake, reporting, transportation and continuing care coordination. The DOC is utilizing this predictable model to establish a process for individuals releasing early from prison who don't have time to receive residential SUD treatment the opportunity to receive care in the community.

The DOC will continue to analyze the enaction of the transfer of state treatment fund for residential care for DOC involved individuals. The initial analysis shows this to be cost prohibitive as well as detrimental to the wellbeing of justice involved DOC individuals. It is important to note the following impacts to individuals under the jurisdiction of DOC, DOC employees, employee resources, operational costs to include salaries, benefits, private consultation space in the community if enacted. Please see the analysis of project costs below. Included in the projections are Substance Use Disorder Care Coordinator positions that would be strategically located in DOC field offices, community justice centers, and prisons to assist with this mandate in transitioning DOSA, individuals on community supervision, those releasing from prison and individuals identified for graduated reentry (GRE) and in need of residential treatment and care coordination.

Bed Type	2019 Average Monthly Bed Count	Current Daily Rate	Monthly Cost	Annual Cost	Adjusted Rate (Medicaid Rate)	Medicaid Rate Monthly 25%	Medicaid Rate Annual Cost 25%	Additional Cost to DOC	Current Allocation
Residential	$155.31	$116.00	540,479	$6,485,746	$217.00	$758,301	$9,099,613	$2,613,867	$4,741,608.00
Co-Occurring	$20.44	$165.00	$101,178	$1,214,136	$251.00	$115,435	$1,385,219	$171,083	$3,277,729.00
Residential DOSA	$178.07	$103.00	$550,236	$6,602,836	$217.00	$869,427	$10,433,121	$3,830,286	$8,209,707.00
Co-Occurring DOSA	$27.28	$165.00	$135,036	$1,620,432	$251.00	$154,064	$1,848,766	$228,334	$750,641.00
Total All Types	$381.10		$1,326,929	$15,923,149		$1,897,227	$22,766,719	**$6,843,569**	$16,979,685

Current allocation is reflective of projected bed needs when not in COVID times.

Positions Needed	Salary	Benefits	Total
Recovery Advocate (14)	$970,536.00	$336,949.00	$1,307,485.00
Recovery Advocate Supervisor (3)	$253,368.00	$80,315.00	$333,683.00
		Total	$1,641,168.00

Recommendations

5. Continue a more thorough analysis of the impact of Medicaid reimbursement practices and substance use disorder treatment across the Department of Corrections, including the addition of the opioid use disorder treatment program (MOUD).
6. Develop a robust plan whereby individuals released on Electronic Home Monitoring are able to be considered for residential treatment care by a current contract provider.
    a. This process would include the cost falling under a different kind of funding as the federal financial options do not apply as well as potential updates to the recent law.[2]
7. The state may benefit from a longer-term planning process that would assess current and anticipated gaps in services. Allowing multiple agencies to come together in a coordinated way across the state.
    a. Engage multiple stakeholders to assess and plan for the future of Washington's SUD and behavioral health systems.
        i. Ensure connection with the substance use disorder certification advisory committee through Department of Health to keep notified of licensure and practice changes.
        ii. Participation on the Behavioral health Advisory Council of HCA to ensure creation of joint advisory processes and grant application opportunities are realized for additional funding.
    b. Bring more stakeholder viewpoints into the Washington's larger Medicaid Transformation project (MTP) to further understand community barriers to recovery.
8. Establish consistent payer and provider interpretation of criteria for residential SUD treatment services.
    a. The state may benefit from developing further guidelines on their application and having a consensus among providers as well as managed care organizations. This would include appropriate length of stay within residential settings.
    b. This develops additional data for consistency of an individual's process to receiving care and cost of care. As well as highlighting different approaches that individualize care to each patient. Ultimately leading to a more evidence-based process when reviewing the benefit and risk to communities and the individuals we serve.
9. Consider the value of expanding the Foundational Community Supports (FCS) program
    a. Recent SUD related contracting for FCS – part of Washington's larger Medicaid Transformation Project (MTP) – could be a mechanism for providing recovery supports such as stable housing, supported employment, opportunities, transportation and peer services.

[2] https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bills/Session%20Laws/Senate/5121-S.SL.pdf?q=20211022141230

6. Explore opportunities to provide additional treatment services through telehealth.
    a. Due to the CDC social distancing guidelines and closure of agency doors, we currently have not determined the lost bed capacity across Washington State. Finding alternative methods to provide successful treatment to residents is imperative.