Report to
The Vermont Legislature

Residential Substance Abuse Treatment: Impact of Concurrent Utilization Review

In Accordance with Act 179 (2014), Section E.300.2,
An Act Relating to Making Appropriations
For the Support of Government

Submitted to:	**House Committees on Appropriations and on Human Services** **Senate Committees on Appropriations and on Health and Welfare**
Submitted by:	**Barbara Cimaglio, Deputy Commissioner, Department of Health**
Prepared by:	**Ann Van Donsel**
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Department of Health

108 Cherry Street, PO Box 70
Burlington, VT 05402
802.863.7341
healthvermont.gov

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VERMONT

AGENCY OF HUMAN SERVICES
Department of Health

Residential Substance Abuse Treatment:
Impact of Concurrent Utilization Review
Act 179 (2014), Section E.300.2
December 11, 2014

Executive Summary

The Secretary of the Agency of Human Services in consultation with the Vermont Department of Health, the Department of Vermont Health Access, the Department of Finance and Management, and the Joint Fiscal Office submit this report pursuant to Act 179 (2014), Section E.300.2, As called for in Act 179, this report describes the impact of the concurrent utilization process on residential substance abuse treatment and responds to specific questions posed in the Act. Concurrent utilization review is a process by which the residential treatment providers and the Vermont Department of Health Division of Alcohol and Drug Abuse Programs staff use clinical criteria to review treatment progress and discharge plans to determine if a patient continues to meet the need for ongoing residential care.

The current Medicaid requirement of concurrent utilization review after 15 days of residential treatment for adult patients is more lenient than review and prior approval requirements by third party payers. It has largely improved care, and has resulted in more people accessing residential care in Vermont. Data regarding requests for approval of additional days show that the vast majority of supported requests are approved.

Increasing the number of days prior to concurrent utilization review will not significantly impact the total cost of the program, and instead is likely to result in fewer people being able to access residential care. Vermont's system of state-funded residential substance treatment facilities has a fixed capacity based on the number of beds available at each site so increasing the length of stay decreases the number of people who can be served.

Residential Substance Abuse Treatment:
Impact of Concurrent Utilization Review

December 11, 2014

Introduction

The Secretary of the Agency of Human Services has been asked to describe the impact of the concurrent utilization process on residential substance abuse treatment and to respond to the following specific questions outlined in Act 179 (2014), Section E.300.2.(a):

> The Agency of Human Services in consultation with the Department of Vermont Health Access, the Department of Health, the Department of Finance and Management, and the Joint Fiscal Office shall review the fiscal impact of increasing the number of preapproved residential substance treatment day from the current 15 days for adult Medicaid recipients. The review shall consider the following:
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> 1. The American Society for Addiction Medicine Patient Placements Criteria;
> 2. Third-party payers processes for determination of length of stay;
> 3. The process for extending the number of days of residential treatment beyond 15; and
> 4. The relationship between the number of days in residence and patient outcomes.

This report was written in consultation with the Vermont Department of Health's Division of Alcohol and Drug Abuse Programs (ADAP), the Department of Vermont Health Access, the Department of Finance and Management, and the Joint Fiscal Office. Concurrent utilization review is a process by which the residential providers review treatment progress and discharge plans with ADAP clinical staff to determine if, based on clinical criteria, the patient continues to meet criteria for residential treatment.

The Vermont system of residential substance abuse care has grown significantly over the years. The state paid for 85% of the residential bed days[1] of service provided in Vermont at a FY14 cost of $8,879,992 for 2958 state-funded patients. More Vermont Department of Health Division of Alcohol and Drug Abuse Programs (ADAP) funding was spent on residential care than any other type of treatment in the ADAP system of care.

In order to address wait lists, better align access to state-funded residential treatment services to those of third party insurers and develop consistency throughout the system of care, ADAP began a concurrent utilization review process in 2013. The length of stay in residential programs is not limited for uninsured and Medicaid eligible adults. Instead, to extend care past 15 days for adults and 30 days for adolescents, providers may request a concurrent utilization review. The review and approval process to extend care may be repeated as many times as necessary to provide medically necessary care to the patient. This process, effective July 1, 2013, is described in detail on the ADAP website.[2]

Background

The American Society for Addictions Medicine (ASAM)[3] criteria are a set of comprehensive guidelines for placement, continued stay, and transfer or discharge of patients with addiction and co-occurring mental health conditions. Vermont, along with a majority of other U.S. states, requires that all state funded treatment providers follow ASAM criteria when providing clinical care. Vermont has required the use of ASAM criteria for more than eight years. It is important that patients receive an appropriate level of care and move from one level of care to another as needed, similar to protocols for medical procedures.

For example, in the medical world, a knee replacement patient would consult with his or her primary care physician, be referred for surgery and step down to physical therapy.

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[1] The residential providers for the purpose of this report are: Maple Leaf Farm, Serenity House, and Valley Vista as these are the only providers for whom the concurrent utilization review process is used. There are two other residential treatment providers from which ADAP purchases a small amount of services: Act One, a 2-3 day program in Burlington, and Phoenix House in Dublin, NH, a long term residential treatment program.
[2] http://healthvermont.gov/adap/grantees/documents/ResidentialConcurrentUtilizationReviewProcedure.pdf
[3] http://www.asam.org/publications/the-asam-criteria

For substance abuse treatment, a patient would ideally receive an assessment and referral from an outpatient facility, be referred for residential care and step down for follow up outpatient and recovery services.

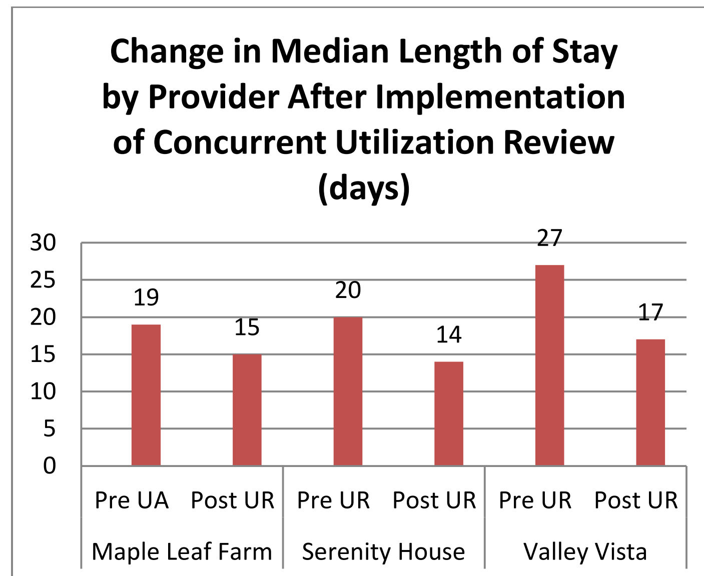
Third party payers also use clinical criteria in determining appropriate levels of care. In addition to the concurrent utilization review process, private payers require a prior authorization approval for care prior to, or within the first 24 hours, of care. As a payer, the State does not currently require prior authorizations.

PrimariLink, part of Brattleboro Retreat, is the behavioral health Managed Care Organization (MCO) for MVP. In order for a provider to receive reimbursement, MVP requires that the provider receive authorization prior to beginning treatment. When that is not possible, authorization must be received within 24 hours of the patient presenting for services. Determining length of stay is based on clinical criteria and medical necessity. Concurrent utilization review is required at a frequency designated by the insurer as it relates to the presenting symptoms. Reviews may be required as frequently as daily to allow the individual to remain in treatment. Brattleboro Retreat is also the behavioral health MCO for Blue Cross Blue Shield (BCBS). BCBS policies are generally consistent with MVP policy; the primary difference between them is that MVP uses ASAM criteria while BCBS has its own criteria which are similar to ASAM.

Organization	Prior Authorization Requirement	Concurrent Utilization Review Requirement
Medicaid	None	15 days for adults/30 days for adolescents, subsequent reviews may be necessary
Uninsured	None	15 days for adults/30 days for adolescents, subsequent reviews may be necessary
BCBS	Within 24 hours of admission.	Determined by admission symptoms and BCBS protocols. May be as frequently as daily.
MVP	Prefers authorization prior to admission. Will accept within 24 hours of admission.	Determined by admission symptoms and MVP protocols. May be as frequently as daily.

The current state utilization review requirements place less of a burden on providers than those of third party payers.

After the implementation of concurrent utilization review[4], the median length of stay for state-funded patients decreased from 20 days to 15 due to shorter stays at all three residential facilities; it decreased ten days at Valley Vista, six days at Serenity House, and four days at Maple Leaf Farm. During the same period, the median length of stay for third party insurers decreased from 13 to 12 days.



The change in length of stay is not because ADAP is limiting care. The state's concurrent utilization review process is based on medical necessity and allows for consideration of extenuating circumstances. The 15 day requirement for concurrent utilization review is based on typical residential lengths of stay of 13 days for third party payers which already use prior authorization and concurrent utilization review processes at these three facilities.

Two additional days were added because Medicaid patients often have more complex clinical needs than the insured population. During the concurrent review process, ADAP provides a high level of oversight and assistance in case management and discharge planning.

[4] Implement dates for concurrent utilization review are as follows: Valley Vista: 5/1/13, Maple Leaf Farm and Serenity House: 7/1/2013

The concurrent utilization process assures that patients are receiving the care that best meets their needs. Since the implementation of concurrent utilization review, there have been 1,376 requests for treatment extensions; a total of 29 (2%) were denied any additional days. Of the total requests, 75% were approved for the full number of days requested by the providers. Providers appealed ADAP's decision on two occasions, both of which were resolved without proceeding to a tertiary review.

Providers give the following reasons for needing to extend care:

Reason for Requested Extension	Percent of Requests
Psychiatric Medication Stabilization	29%
Other	16%
Complicated Treatment Plan	15%
Housing Problems	10%
Medication Assisted Treatment Induction	8%
Psychiatric Evaluation Has Not Yet Occurred	7%
Complicated Withdrawal	5%
No Discharge Plan Developed	5%
No step-down capacity available	4%
Medical complication	1%

Third party insurers account for 15% of the total bed days provided at these three providers; 85% of days are state-funded. In addition to the prior authorization and concurrent utilization requirements, BCBS and MVP require medical review within 24 hours.

Impact of concurrent utilization review on patient outcomes

The measures below were identified as indicators of the impact of the concurrent utilization review process.

These measures were compared for periods before and after concurrent utilization was implemented[5]. The pre-concurrent utilization review dates are admissions between 7/1/12-4/30/13 and post review dates are 7/1/13-4/30/14.

[5] Concurrent utilization review began 5/1/13 for Valley Vista and 7/1/13 for Maple Leaf Farm and Serenity House.

- **Planned discharges:** The percent of patients discharged because he or she completed treatment or transferred to another treatment facility, a measure that indicates that the facility has provided the care appropriate for that individual, increased from 67% to 71%.

- **Access to residential treatment:** The total number of people receiving care increased 21%, from 1168 to 1410.

- **Frequency of use:** At discharge, the percentage of patients showing decreases in frequency of use improved from 87% to 92% for all providers combined.

- **Patients stepping down to outpatient care within 30 days of residential discharge:** Addiction is a chronic disease which means that it is a long-lasting condition that can be controlled but not cured. Residential care is just one step toward alleviating cravings and improving quality of life; best practice is that after discharge from residential treatment, patients step down to an outpatient level of care and later to recovery services Patients may step down to outpatient care within the Preferred Provider system or at mental health agencies, private practitioner mental health clinicians, and medical facilities, such as physicians who prescribe buprenorphine ("spokes") to treat opioid addiction. Service providers who are not Preferred Providers are not funded by ADAP so step down data are not available for those stepping down for care at those providers.

- In the ADAP funded Preferred Provider system, patients step down to outpatient treatment providers and, for those needing medication assisted treatment (MAT), opioid treatment hubs are followed by peer and recovery support services.

After the implementation of concurrent utilization review, the percentage of patients stepping down for outpatient or hub care in the Preferred Provider system increased from 24% to 27% at Valley Vista and from 15% to 21% at Serenity House. It decreased from 25% to 22% at Maple Leaf Farm.

In FY14, Maple Leaf began providing interim "spoke" services to some patients after completing residential treatment to allow the patient to begin treating opioid addiction with buprenorphine while he or she waits for a permanent "spoke" physician to become

available in the patient's community. This level of care is not within the Preferred Provider system so is not included in the step down calculations. When these patients, reported by Maple Leaf, are included in the calculation, the rate of step down care increased from 25% to 31% at Maple Leaf Farm.

- **Patient functioning at discharge:** The facility-reported improvement in overall patient functioning increased at Maple Leaf (from 78% to 85%) and Serenity House (from 79% to 83%) after the implementation of concurrent utilization review. Valley Vista showed a decrease from 57% to 41%. This decrease does not appear to be related to the length of stay imposed by the concurrent utilization process. At Valley Vista, functioning was higher after implementation for lengths of stay under 20 days. For stays longer than 20 days, the longer an individual stayed, the less likely he was to show improvement at discharge.

- **Readmissions for residential treatment:** The percentage of people with more than one admission for residential treatment in the measurement period went from 13% to 15%. During the same period, for payers other than the state, the percentage of people with more than one admission went from 9% to 10%. Addiction is a chronic relapsing condition and a portion of the treatment population will always cycle through the system. When a patient relapses, a readmission to residential treatment is a more appropriate and lower cost alternative to an inpatient detoxification level of care. Longer residential stays are not necessarily better for most people and Vermont's readmission rates are on par with other states.

Overall, the majority of measures show positive change as the result of the concurrent utilization policy. It has improved the discharge planning process by focusing on patient post-discharge needs earlier in the treatment process.

Impact on Cost due to Changing the Concurrent Utilization Review Process

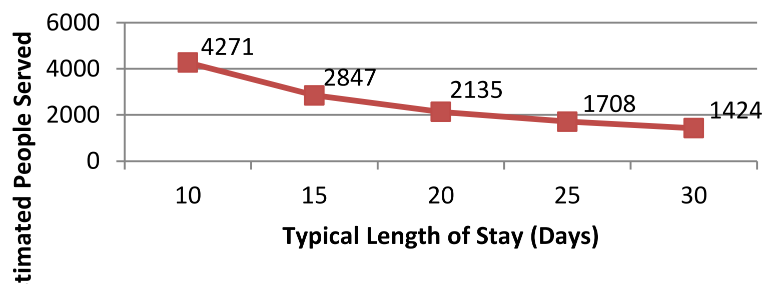
Each residential facility has a maximum capacity based on the number of beds available. The number of beds available to treat adults is 41 at Maple Leaf, 24 at Serenity, and 65 at Valley Vista. The state currently pays for 85% of the bed days provided at these residential facilities.

Each facility has fixed costs that do not change based on census. In order to remain financially viable, programs must maximize filled beds. Shorter stays require programs to spend more time on admissions processes and discharge planning as a portion of the total care. While providers have always had the administrative burden of prior authorization and concurrent utilization review for private payers, the concurrent review requirement for state-funded stays has increased this burden because the vast majority of people receiving residential treatment are state funded.

Because there are a fixed number of beds and there is demand for care, increasing the concurrent utilization requirement will not have an impact on the total cost of the program. Instead it would result in fewer people receiving care.

Using the total available adult bed days of 42,705 per year, which assumes that 90% of beds will be filled at any one time to allow for bed turnover, the change in the number of people who can access care in a year based on the length of stay is shown below.

Estimated Total Number of People Who Can Receive Residential Care Based on Typical Length of Stay (Assume 90% Census)



In other words, the longer the stay, the fewer people who can be treated. The change in cost related to changing the number of days before concurrent utilization review is needed is negligible as long as there is no change in the per diem rate. There is potential risk: when there is no waiting list, shorter stays increase the possibility that facilities would have empty beds, thereby decreasing facility revenue.

Recommendations and Opportunities

Expenditures for residential care exceeded any other type of ADAP-funded treatment in state fiscal year 2014. Optimizing the use of this level of care is essential for maintaining a continuum of care and matching patients with the most appropriate care. To accomplish this, ADAP and DVHA have the following recommendations:

1. The current requirements for concurrent utilization review process should be maintained. The implementation of concurrent utilization review appear to have resulted in positive trends in discharge planning, access to residential treatment, frequency of use, and patient functioning at discharge. Additional recommendations below attempt to address the identified trends in readmissions to treatment.

2. It is best practice for patients to receive additional substance abuse treatment and support after discharge from residential care. ADAP and the residential treatment providers must explore methods to improve linkages between levels of care as well as methodology to better monitor and report on these linkages.

3. In conjunction with the residential providers, modifications in the current system of residential care should be explored to better match services to patients. The portion of state-funded patients readmitted to residential treatment, 13%-15% of patients, indicates that the short term residential care currently provided may not be adequate for some of those accessing care. Patients with multiple admissions may be better served through, for instance, longer term residential care, partial hospitalization services, or sober housing with wraparound support services.

4. ADAP should continue its work with DVHA on how best to implement McKesson's InterQual ®[6] tool, an evidence-based clinical decision support criteria tool used by insurers and providers, into its utilization review process.

[6] http://www.mckesson.com/payers/decision-management/interqual-evidence-based-clinical-content/