
New England
NARR
NATIONAL ALLIANCE FOR
RECOVERY RESIDENCES
NARR Affiliates

ASAM Criteria: What are the Funding Opportunities for Recovery Residences?

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Fletcher Group

Objectives for Today

- Identify opportunity for RR for operational funding based on ASAM criteria
- Learn the definition and components of value-based care (VBC) models
- Discuss the relationship between value, quality outcomes, and cost in VBC models
- Understand how recovery residences can qualify as a value-based care (VBC) model
- Explore how we can align clinical and social approaches in care to support service engagement

The Fletcher Group Approach: Recovery Center of Excellence

- **Community Catalyst.** We engage individuals, organizations, and communities through a “boots on the ground” personal approach**.**
- **Drive best practice and innovation.** Develop, implement, evaluate, and disseminate best recovery practices.
- **Training and technical assistance.** Provide training, consultation and technical assistance to program managers, RCOs, RHs on issues relevant to quality care and implementation of best practices for substance use disorders.
- **Research and evaluation.** Conduct original research to inform and improve recovery programs and services.

By the Numbers: 2023 Impact

35

Active States

48 since 2019

1,169

Partners/Clients

4,158 since 2019

3,665

TA Encounters

11,037 since 2019

382

Trainings

2,032 participants

5

Peer-Reviewed

Publications (12 total)

11

Research Projects

11 more ongoing

11

Rural Houses Built

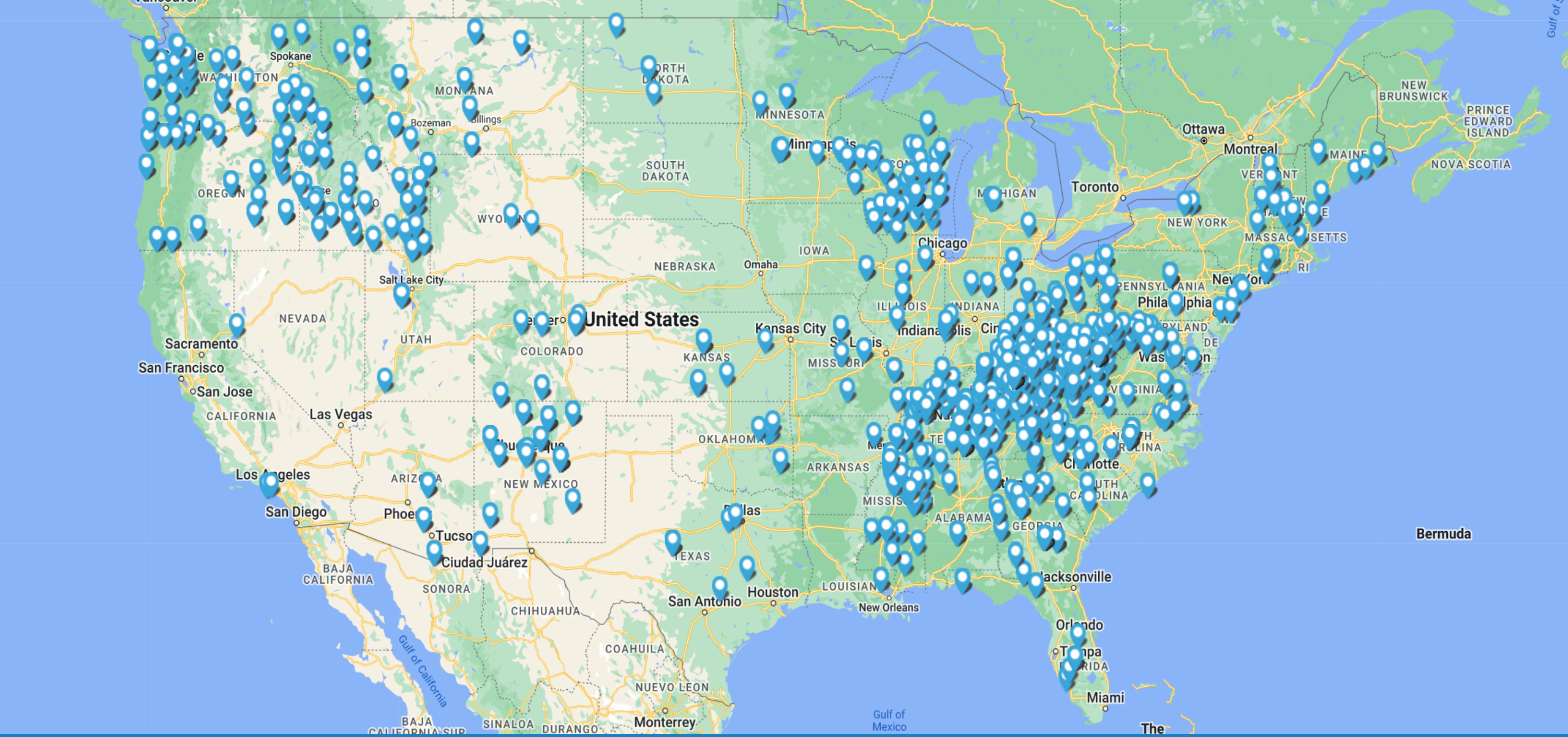
62

Housing Projects

128

New Beds

Serving 256 annually



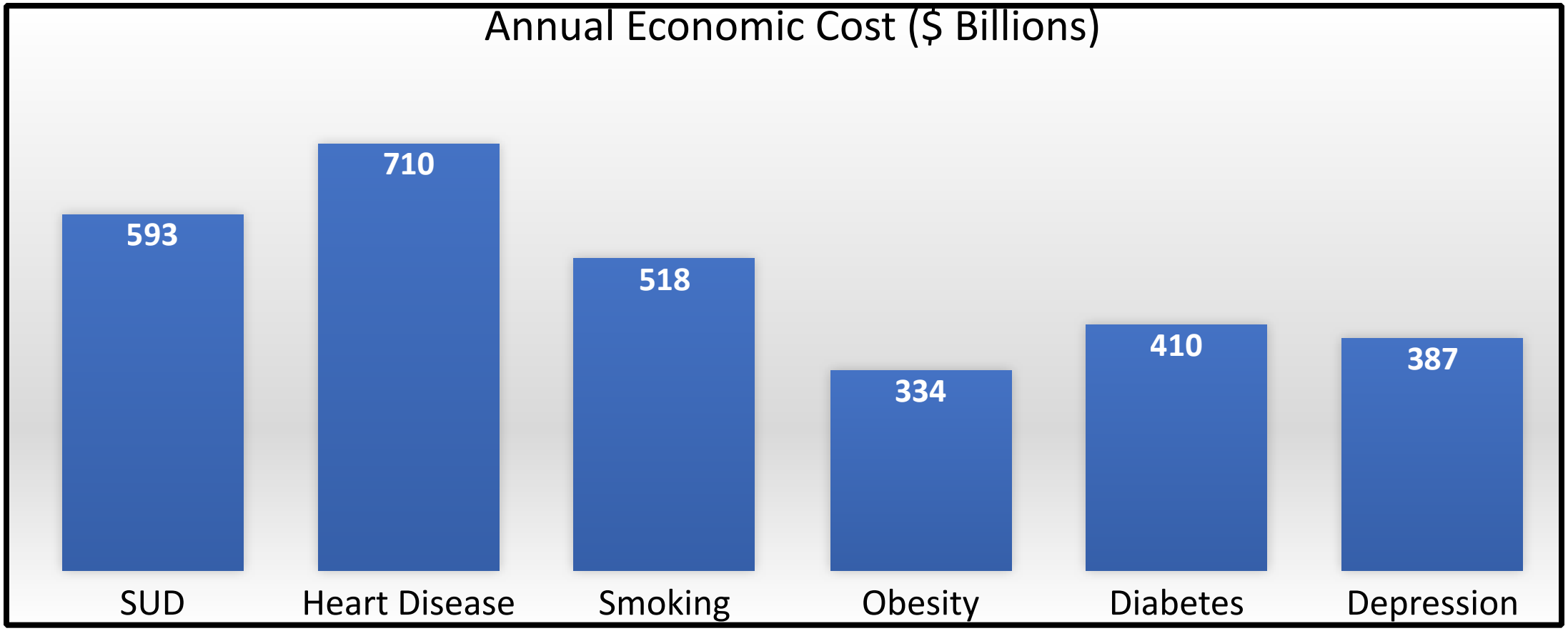
Serving rural clients in 48 states to date

Substance Use Disorder – National Epidemic

- 111,380 predicted fatal drug overdoses (Sept 2022 – 2023) (CDC, 2024)
- Substance use disorder (SUD) presents multifaceted challenges (Stone et al., 2012; Ogden et al., 2022)
  - Combination of risk factors contributing to development
- Recovery from SUD challenging – average of 5 attempts before resolution (Kelly et al., 2019)
- 80% of health outcomes are impacted by non-clinical social drivers of health (Elevance Health, 2023)

RCOE
THE FLETCHER GROUP
RURAL CENTER OF EXCELLENCE

The Cost of Illness



https://recoverycentersofamerica.com/resource/economic-cost-of-substance-abuse-disorder-in-united-states-2019/#:~:text=The%20current%20estimated%20economic%20cost,than%20the%20combined%20GDP%20of
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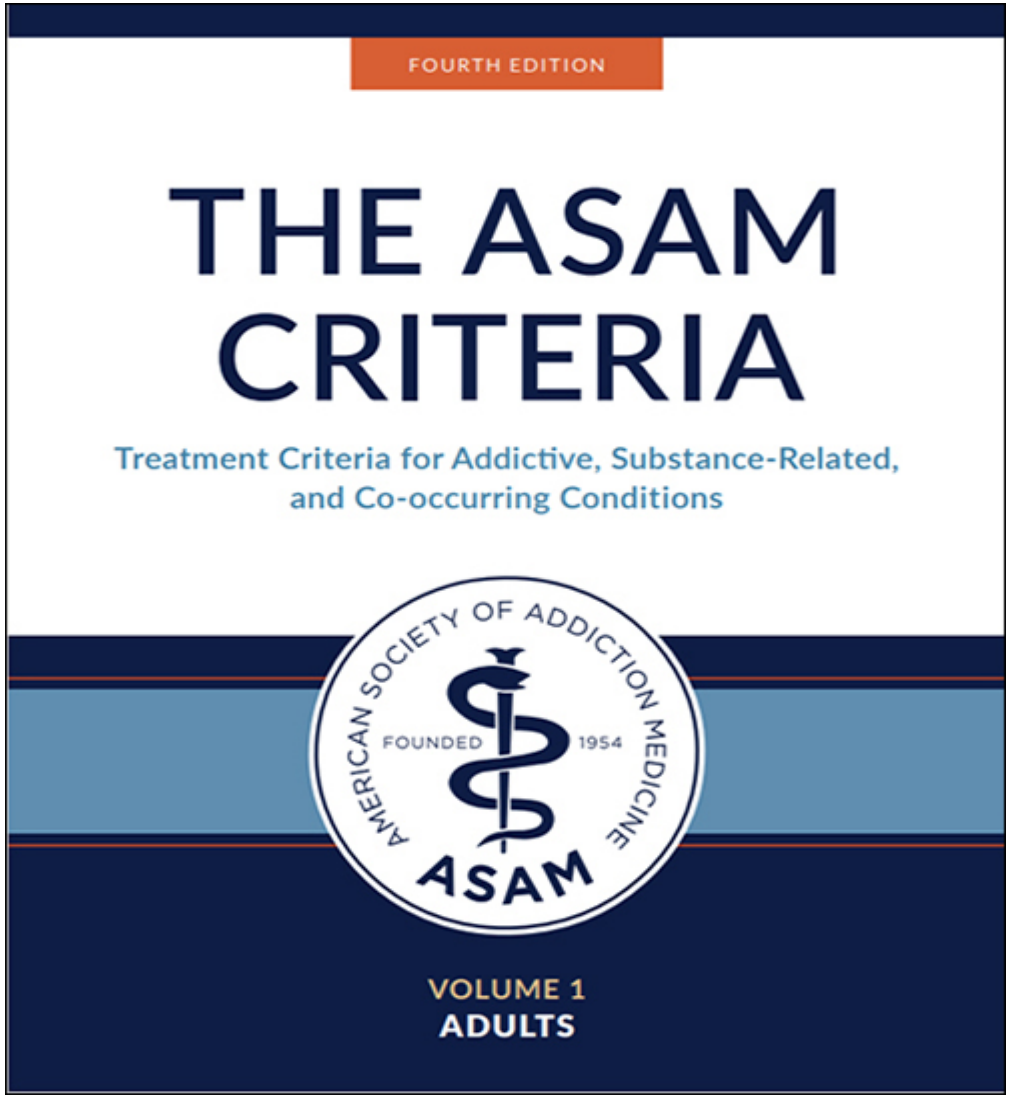


The ASAM Criteria 4th Edition
Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions Fourth Edition

ASAM Criteria serves as an Industry Standard in determining the level of care for a person with a substance use disorder. Defines both assessment criteria and service levels based on severity/acuity.

ASAM 4th Edition Assessment Criteria

Dimension 1: Intoxication, Withdrawal, and Addiction Medications

- Intoxication and Associated Risks
- Withdrawal and Associated Risks
- Addiction Medication Needs

Dimension 2: Biomedical Conditions

- Physical Health Concerns
- Pregnancy-Related Concerns
- Sleep Problems

Dimension 3: Psychiatric and Cognitive Conditions

- Active Psychiatric Symptoms
- Persistent Disability
- Cognitive Functioning
- Trauma-Related Needs
- Psychiatric and Cognitive History

Dimension 4: Substance Use-Related Risks

- Likelihood of Engaging in Risky Substance Use[1]
- Likelihood of Engaging in Risky SUD-Related Behaviors[2]

Dimension 5: Recovery Environment Interactions

- Ability to Function Effectively in Current Environment
- Safety in Current Environment
- Support in Current Environment
- Cultural Perceptions of Substance Use and Addiction

Dimension 6: Person-Centered Considerations

- Barriers to Care
- Patient Preferences
- Need for Motivational Enhancement

ASAM 4th Edition Guidance in Considering Recovery Housing Referrals

Access to medications

- Ensure recovery residence does not discourage use of medications supporting individual's recovery

On-site staffing and governance model

- Peers vs. clinical staffing, peer roles in person-centered support

On-site supports and services

- Mutual support (spiritual, secular or religious) Employment training

Culture and community

- Group and community dynamics, rules for living in community

ASAM's conceptual framework for recovery supports including housing

Recovery Capital

- Underlying concept that supports integrating RSS in ASAM Criteria
- Clinical services and recovery support work in tandem to build recovery capital

Definition: Total resources available to a person to help them find and maintain their recovery, including the person's skills, abilities, and knowledge; resources to fulfill their basic needs and social and community support

Social Model Recovery Support

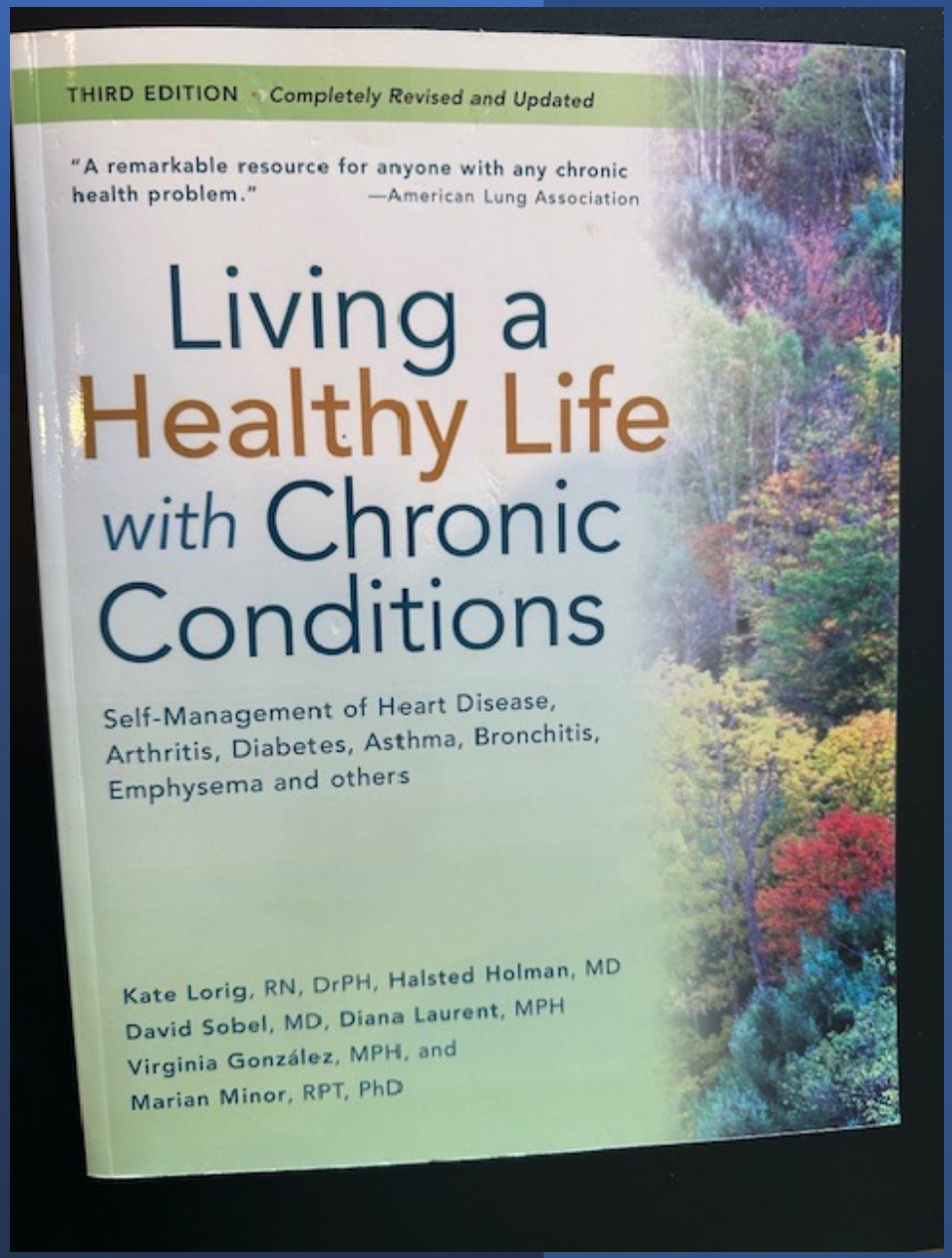
- 4th Edition notes that many recovery residences utilize a social model to guide their programs and structure, creating a therapeutic milieu in a community that reinforces skills and attitudes needed for sustained recovery

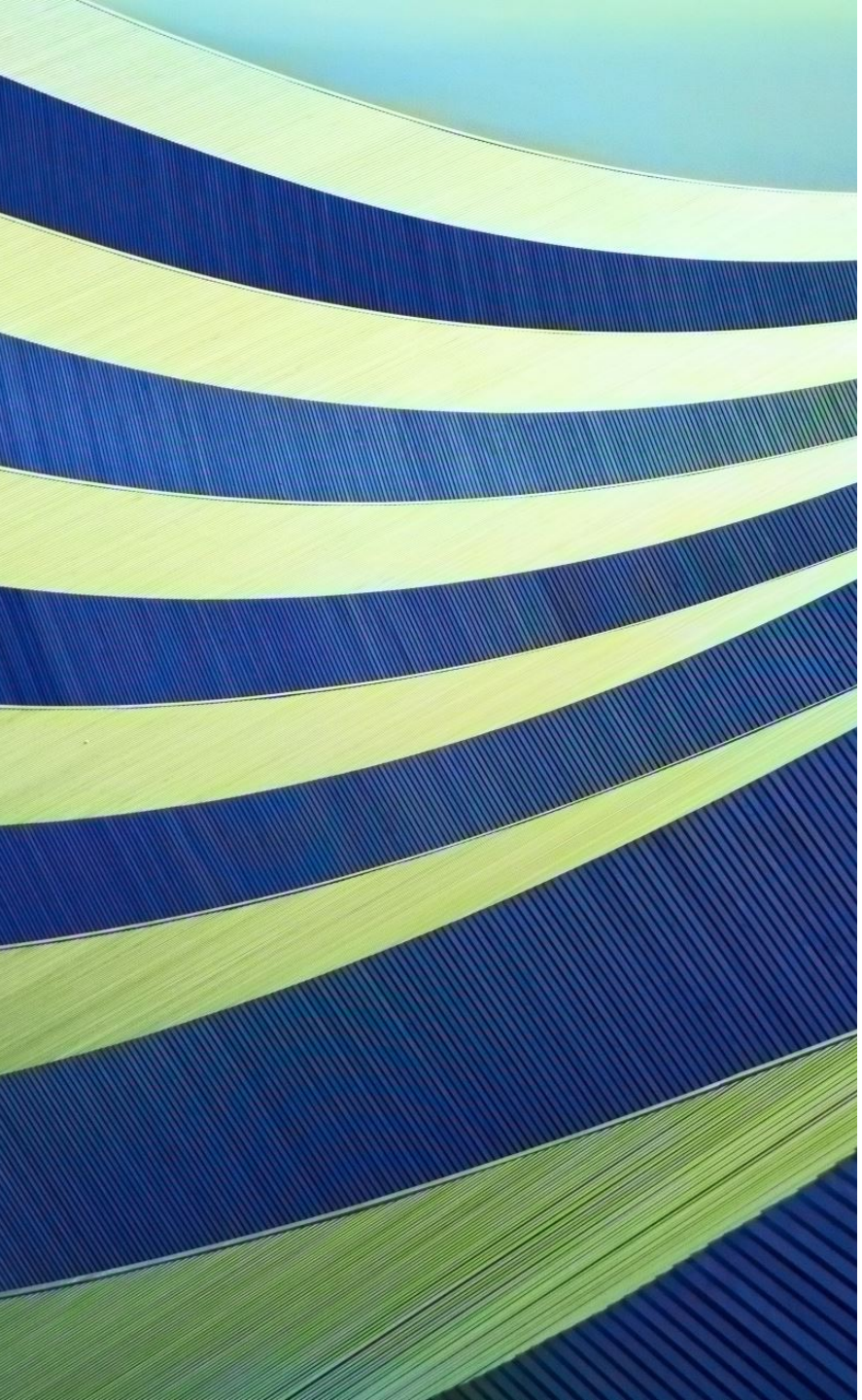
Addiction as a Chronic Illness

The 4th Edition recognizes addiction as a chronic illness and encourages treatment providers to adopt the Chronic Care Model in order to:

- Establish and encourage long term remission
- Provide recovery management checkups
- Include planned visits for remission monitoring in treatment plan
- Support rapid re-engagement into care when needed, acknowledging relapse can be part of the disease process

The Stanford Chronic Care model is an educational approach in which peers provide leadership in a group setting to facilitate knowledge and skills for coping with and managing a chronic health condition.





Recovery oriented chronic disease curriculums

- Wellbriety (White Bison Coyhis Publishing – Wellbriety)
- Recovery Dynamics (Kelly Foundation)
- Successful Life Skills (SMART Recovery)
- COR-12 MAT (Hazelden)
- Matrix Model Collection (Hazelden)
- Celebrate Recovery (www.celebraterecovery.com/resources/cr-tools/dna)

Funding opportunities for recovery housing programs

Center For Medicare Medicaid Services

The CMS Innovation Center

Developing and testing health care payment and service delivery models to improve patient care, lower costs, and align payment systems to promote patient-centered practices

Alternative Payment Methods and Value-based Care

The Centers for Medicare & Medicaid Services Innovation Center (CMMI) develops and tests new healthcare payment and service delivery models to:

Improve patient care.

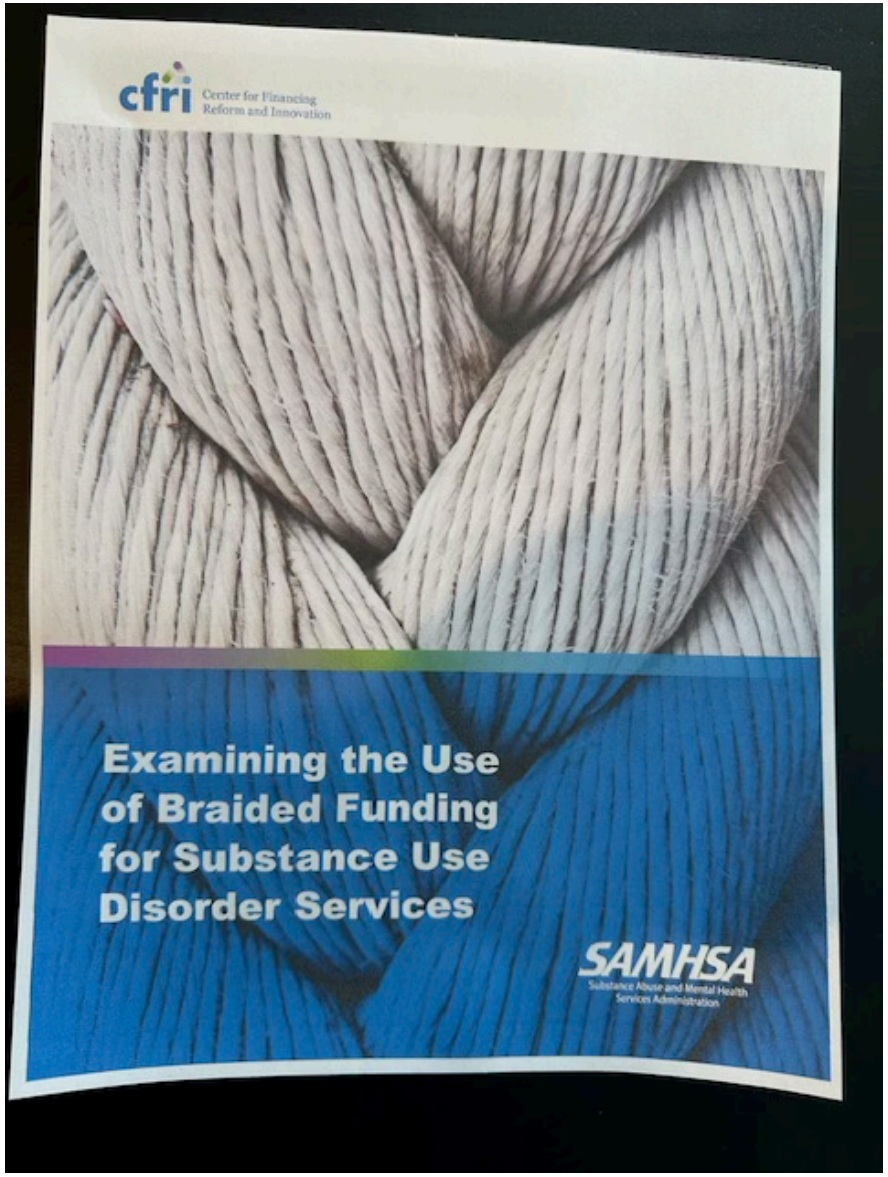
Lower costs.

Align payment systems to promote patient-centered practices.

CMMI has promoted APMs and VBP as a strategy to improve care and lower costs

APMs may include a variety of payment options including bundled rates incorporating several services

Bundled services might include medication, substance use counseling, group therapy, intake activities, periodic assessments, and toxicology testing



This SAMHSA 2024 report outlines defines braided funding models which use one or more sources of funding in a coordinated fashion to support a single individual or program. Examples demonstrate use of braded funding in recovery programs.

Bringing Innovation to SUD Interventions

APM/VBP offers an opportunity to establish a financial model to provide stability and sustainability to RH programs

APMs

- **Performance-based payments** (Service standards are defined—access, intensity of services—inpatient/outpatient, payments made based on achieving performance matrix)
- **Case Rates** (An episode of care is defined, and a fee is paid to cover that episode of care)
- **Bundled Rates** (A group of services are incorporated into the payment)
- **Global Payments** (A total annual amount paid to the provider)
- **Per Patient Per Month** (Limited Risk—a set rate is paid for each person in the panel, stop-loss limits are defined)
- **Risk-based payments** (Cover all health care costs for an enrolled population; per member per month fee)
- **Prospective Payments** A Prospective Payment System (PPS) is a method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount.)

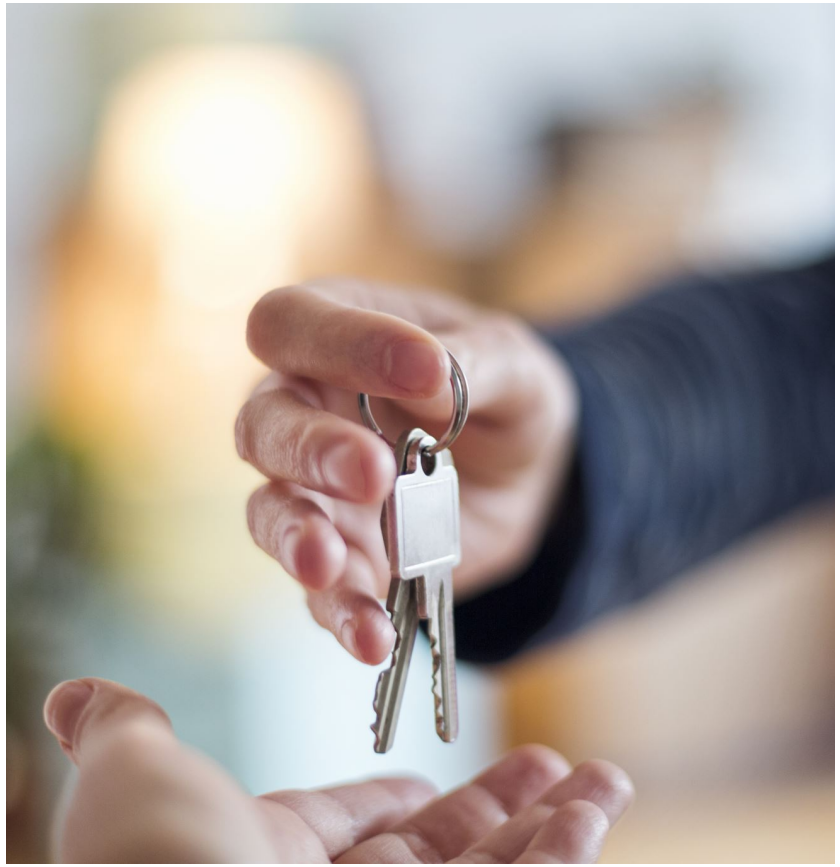
Alternative Payment Methodologies (APM) and Value Based Care (VBC)

- Funding of health care services is most frequently based on “volume”
- Current models seek to pay for “value”
- Defining value has been a challenge
  - Is value reduced use of high-cost medical services, inpatient, emergency department?
  - Is value preventing the development of health conditions?
  - Is it increasing longevity?
  - Is it increased satisfaction of the health services an individual receives?
  - Is it an increase in a person’s perception of health and well-being?

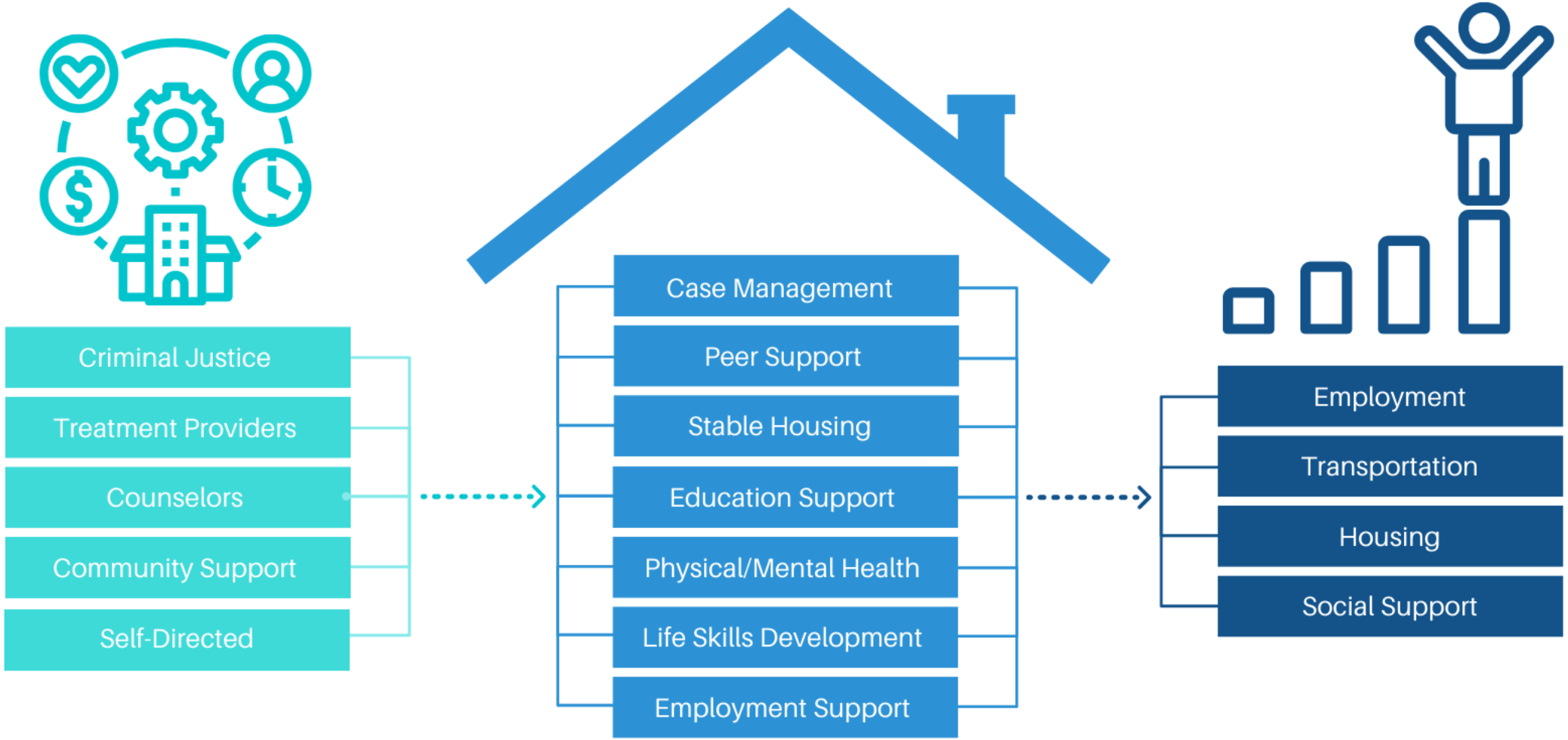
How does recovery housing fit as a value-based care (VBC) model?

How Does Recovery Housing Create Value?

- Prioritizes patient outcomes by providing a **supportive and structured environment** that promotes long-term recovery.
- Provides residents with a **community of peers** who share similar experiences and can **offer support and guidance.**
- Addresses a **KEY** *health related social needs* including, housing, employment, social connections, and removing barriers to care to enable an individual to focus on their recovery.

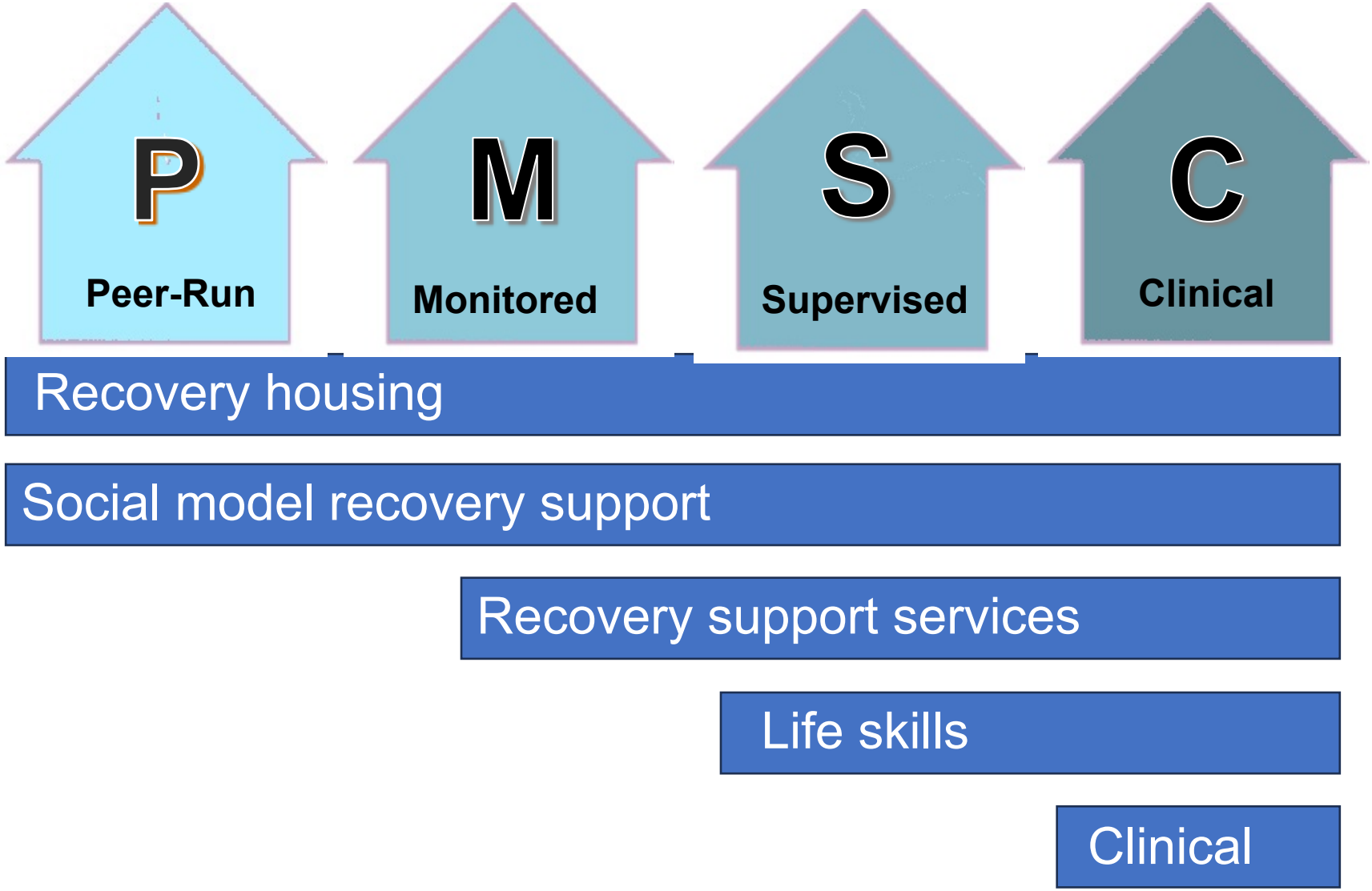


How A Recovery Ecosystem Creates Recovery Capital



ASAM & NARR: Four Types of Recovery Housing

Graphic provided by Paul H. Earley, M.D., DFASAM and Beth Fisher Sanders LCSW, LCAS, MAC, CCS



Current State
RH Operational Funding

Resident Fees

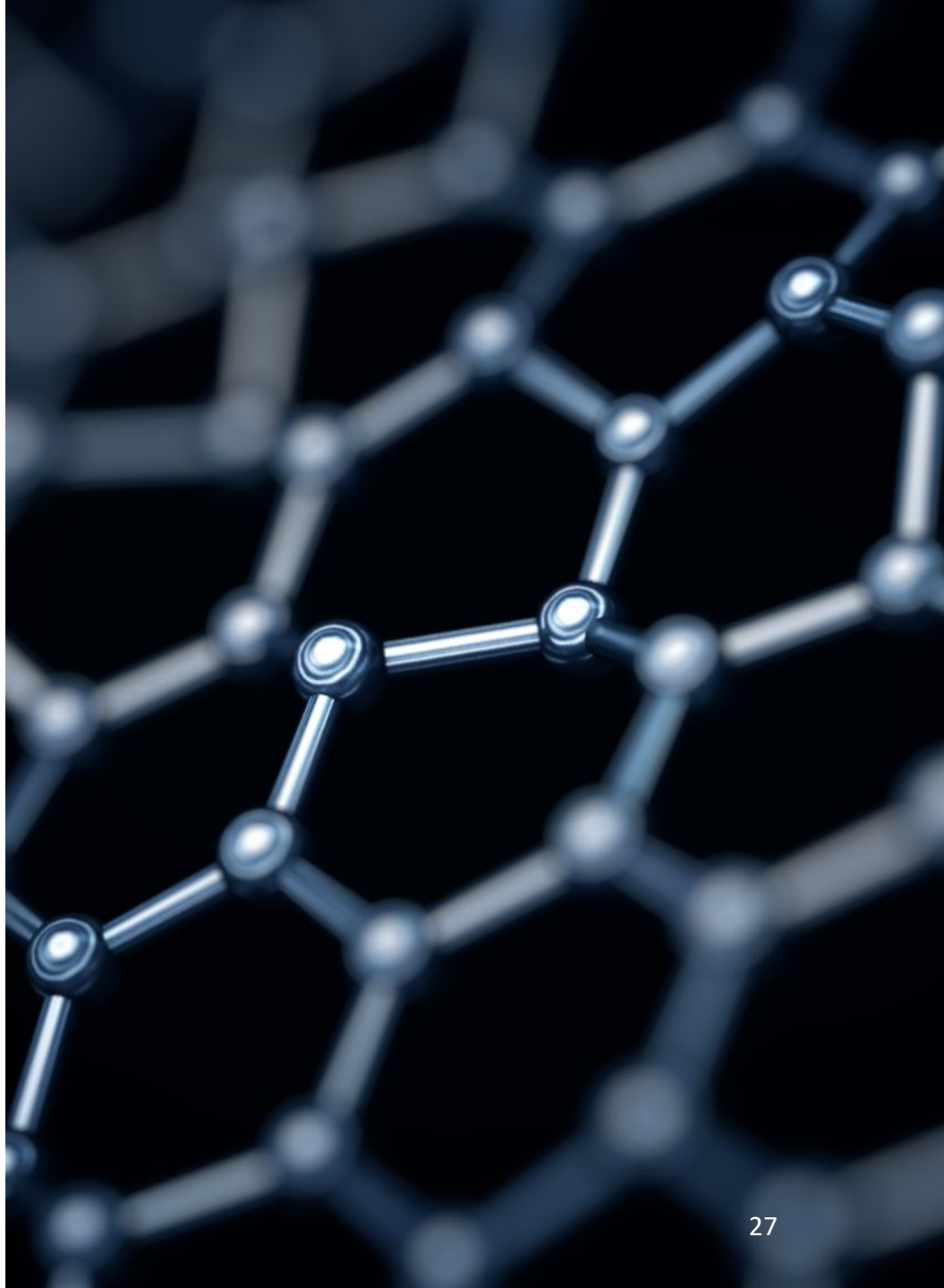
Donations

Financial Assistant Programs

- Section 8 Housing Vouchers
- SNAP

Contracts

- Corrections
- CDBG Block Grants—Service Funds
- State Block Grants (services)
- **Medicaid**



Future Funding Streams through Medicaid and Commercial Insurers

To be paid as a “medical service” it is important to understand the language, the process and the procedures.

May require someone on staff to be an interpreter.

Aligning medical and social models of care - Considerations when Contracting with Medicaid

STAFFING

PROGRAM SERVICE DEFINITION

POLICIES AND PROCEDURES

BILLING

OUTCOMES

Staffing

- A medical model based on ASAM criteria requires staff who are licensed and credentialled to be eligible for payment of services
- Licensed staff may include:
  - Psychiatrists/Medical Director
  - Nurse
  - Psychologist
  - Social Worker (MSW)
  - Licensed Drug and Alcohol Counselor (CAC)

- In contrast the social recovery model brings opportunity for collaboration with a health provider with staffing that supports addressing health related social needs by trained professionals
- Staff may include:
  - House Manager
  - Program Coordinator
  - Recovery Coach
  - Peer Support Specialist

Policies and Procedures

It is expected that a recovery residence will have a range of policies and procedures addressing expectations for staff and residents

- Non-discrimination
- Staff background checks and other personnel policies and procedures
- Admissions
- Grievance
- Drug Screening Protocol
- Return to use
- Documentation and file management
- Program requirements

See for example: NARR_Standard_V.3.0_release_11-2018.pdf (narronline.org)

Documentation

Each resident to have an individual record that meets 42 CFR, Part 2, Final rule

No other resident identifying information is allowed in another resident's record

Records are generally required to include:

- A unique identifier—name, id#
- Date of Birth
- Preferred name and preferred pronoun
- Race or ethnicity
- Address or “homeless”
- Emergency Contact
- Release of Information
- [eCFR :: 42 CFR Part 2 -- Confidentiality of Substance Use Disorder Patient Records (federalregister.gov)]

Documentation

A **medical model** will have additional documentation requirements

- Intake and admission (may include a physical exam)
- Resident Assessment and Diagnosis
- Treatment Plan (Recovery Plan)
- “Progress notes” (Participation in RH activities—attendance and involvement)
- Justification for ongoing services (response to treatment)
- Laboratory test orders and results
- Counseling notes
- Discharge Plan
- Discharge Summary

Review State requirements regarding the retention of medical records, often minimum retention is 7 to 10 years after the last date of service

Program Components

Specialty Outpatient or Intensive Outpatient Services (Medical Model)

- Intake assessment and treatment Planning
- Medical supervised withdrawal from drugs/ alcohol
- Individual and Group Counseling
- Patient Education
- Family Therapy
- Medication Services
- Case management
- Physician Consultation
- Crisis Intervention
- Discharge Planning

Social Recovery Model (Community-Based or Recovery Housing)

- Assessing recovery capital for recovery support plan
- Socially supervised withdrawal
- Peer led activities and supports
- Education on chronic condition management
- Training and education
- Life Skills and employment readiness
- Housing, transportation and employment support
- Mutual-aid groups
- Linkage and coordination to services

Outcomes—National Committee for Quality Assurance

The 2021 Adult Core Set of quality indicators for Medicaid includes five SUD measures as well as three SUD core measures for SUD Health Homes.*

1. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
2. Use of Opioids at High Dosage in Persons with Cancer
3. Concurrent Use of Opioids and Benzodiazepines
4. Use of Pharmacotherapy for Opioid Use Disorder
5. Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence

*Overview of Substance Use Disorder Measures in the 2021 Adult and Health Home Core Sets (medicaid.gov) Accessed August 18, 2021

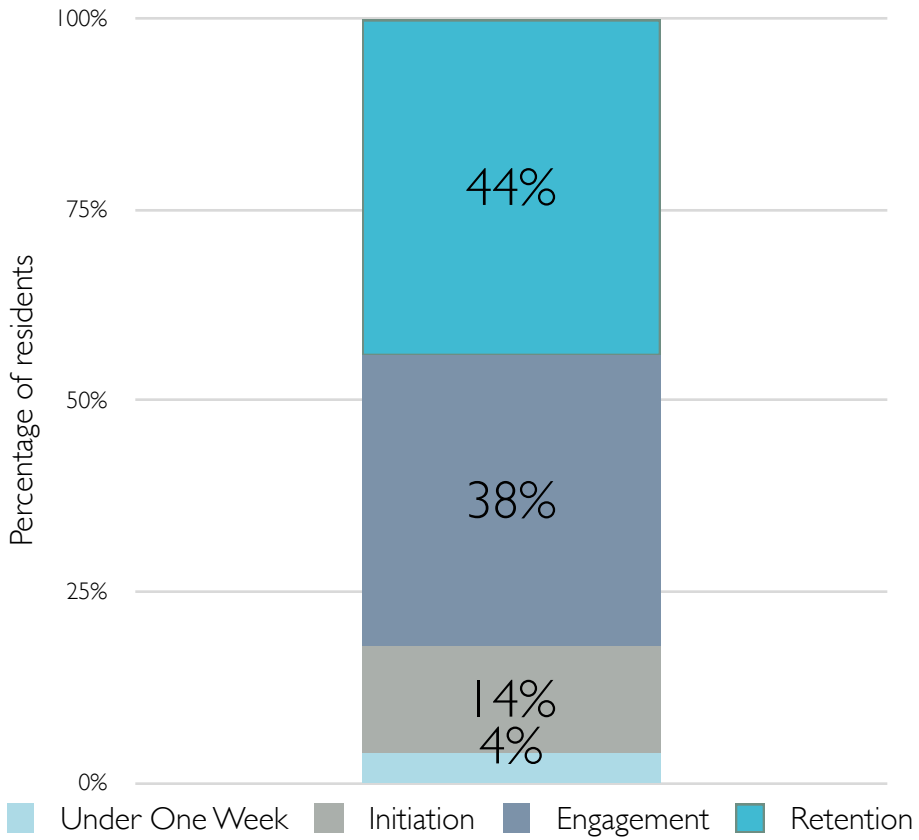
HEDIS Measures

- Initiation and Engagement
  - Percentage of individuals with a new episode of AOD who received treatment within 14 days of diagnosis
  - Engagement of AOD treatment is defined as engaged in ongoing AOD treatment within 34 days of initiation of visit
    - Individual received at least on engagement medicaton treatment event or at least two engagement visits

- Modified for RH (FGI recommended)
  - Initiation—enters the RH for at least 7 days (7 to 29 days)
  - Engagement—maintains residence for at least 30 days (30 to 179 days)
  - Retention—maintains recovery services for at least 180 days (180+ days)

Initiation and Engagement Recovery House Compared to HEDIS

Length of Stay Among Rea of Hope Recovery Housing Residents, 2005 – 2022, West Virginia (N=566)



In sum, **82%** of residents entering Rea of Hope between 2005 - 2022 met criteria for engagement in the home.

Adults and adolescents (>13) with a new episode of alcohol or drug dependence, 2021, Nationwide, NCQA

Care Continuity Level	Percent %
Initiation	33.1 – 44.2%*
Engagement	4.5 – 13.9%

In 2021, between 4.5% (Medicare PPO) and **13.9%** (Medicaid HMO) of adults and adolescents (>13) nationwide met criteria for engagement with medical treatment.

*Range reflects differences from low to high end based on payer type.

RH Recovery Outcomes

Establish and collect data using standardized measures

➢Engagement rates—continue in RH for 30 or more days

➢Recovery measures

- Brief Assessment of Recovery Capital
- CDC Health-Related Quality of Life Scale
- PHQ-4
- AUDIT-C
- Screen of Drug Use
- Housing (type of housing)
- Criminal Justice (arrests and incarceration)
- Employment (part/full-time, salary)

➢Service Utilization

- Emergency Department Visits
- Inpatient Admissions
- Routine medical care

Outcomes - Recovery Kentucky 2024

Outcome Measure	Baseline—At Intake	Follow-up—at 12 months	Relative Change
Illegal Drug Use	89%	11%	-88%
Opioid Use	44%	3%	-93%
Alcohol Use	40%	05%	-88%
Homelessness	32%	4%	-88%
Rearrest	65%	7%	-89%
Anxiety	67%	26%	-61%
Depression	62%	16%	-74%
Suicidal ideation	28%	4%	-86%
Employment	50%	85%	70%

Cole, J., Logan, T., White, A. & Scrivner, A. (2024). Findings from the Recovery Center Outcome Study 2024 Report. Lexington, KY: University of Kentucky, Center on Drug and Alcohol Research

Billing

- The American Medical Association own the “CPT” codes
- The Center for Medicare and Medicaid (CMS) define codes to be used for Medicare billing that are also adopted by payers for Medicaid and Commercial insurance building from CPT codes CMS defines HCPCS codes (Healthcare Common Procedure Coding System)
- A complex system—most medical groups have staff with expertise in coding and billing
  - In 2019 there were 10,294 CPT codes (Current Procedure Terminology)
- To further complicate Medicaid billing states may submit waivers to cover additional services and Managed Care Organizations may cover services or setting that are *in lieu** of service or settings covered under the State Plan.

* 42 CFR § 438.3 - Standard contract requirements. | CFR | US Law | LII / Legal Information Institute (cornell.edu) (Accessed January 5, 2021).

Billing Continued

Sample CPT Codes		
CPT Code	**Description**	**Per Unit Sample Fee Rates (15 min unit)**
H0038	**Peer Support Service**	**$8.61**
H0040	**Group Peer Support Services**	**$3.56**
H0025	**Behavioral Health Prevention Education**	**$17.11**
H2027	**Psychoeducational Services**	**$11.09**
T1014 (HCPCS)	**Case Management**	**$15.75**

Model and Service Matrix	
ASAM Supervised (NARR Level III)	**ASAM Monitored (NARR Level II)**
Level of Care: ASAM Level 3.3/3.1	**Level of Care: ASAM Level 2/2.5**
Length of Stay **Phase 1: 4-12 weeks** **Phase 2: 12-36 weeks** **Intensity: 10 hours per week**	**Length of Stay** **6-24 months** **Intensity: 5 hours per week**
Services • **Standardized Recovery Supports Curriculum (SMART Recovery, Recovery Dynamics, Celebrate Recovery, White Bison)** • **Peer mentor** • **Group Peer Support** • **Employment and Training Supports** • **Life Skills (Soft Skills)** • **Optional (Mindfulness, Medication, Contingency Management)** • **Health Home 6 Core Services**	**Services** • **Standardized Recovery Supports Curriculum (SMART Recovery, Recovery Dynamics, Celebrate Recovery, White Bison)** • **Employment Support** • **Housing case management** • **Peer Mentor**

Services and Bundled Payment Model

- Length of stay—6 to 24 months
- Service Intensity—5 to 10 hours per week
- Service Bundle—5 to 10 services

- Basic Intensity—5 to 9 hours of service per week, 5 services in bundle
- Enhanced Intensity—10 to 15 hours service per week, 8 to 10 services in bundle

- Service Rate
- Basic--$54 per day
- Enhanced--$60 per day

THE COST

A BUNDLED RATE

Cost Comparison

Recovery Housing		Intensive Outpatient	Residential Treatment Center
210 Days @ $54 per day	210 days @ $60 per day	90 days @ $125 per day	60 days @ $225 per day
$11,340	$12,600	$11,250	$13,500

Sample APM Recovery Programs

- **California's Recovery Bridge Housing** program combines a subsidy for recovery residences with concurrent treatment in outpatient services, intensive outpatient treatment, opioid treatment, or outpatient withdrawal management.
- **Michigan,** Prepaid Health Plans option to pay for recovery housing.
- **Washington** also certifying RH as Foundations of Community Support Providers. Eligible of fee-for-service payment ($27 per 15-minute unit; 4 units = $108)
- **Arizona, Nevada, Oregon, Utah, and West Virginia pursuing** 1115 waivers to pay for housing and other health related social needs
- **North Dakota SUD voucher** promotes access to Recovery Housing for Medicaid eligible individuals and can cover individuals for up to 200% of FPL
- **Kentucky** is conducting a pilot project that creates a bunded weekly rate of $237 for Level M (2) and $308 for Level S (3) up to 90 days.

*Recovery Bridget Housing Narrative. http://publichealth.lacounty.gov/sapc/HealthCare/StartODS/030217/RBHnarrative022717.pdf#:~:text=from%20the%20California%20Department%20of%20Health%20Care%20Services,outpatient%20%28IOP%29%2C%20Opioid%20Treatment%20Program%20%28OTP%29%2C%20or%20outpatient

#42 CFR § 438.3 - Standard contract requirements. | CFR | US Law | LII / Legal Information Institute (cornell.edu) (Accessed January 5, 2021).

Federal Initiatives

This year CMS issued a notice of funding opportunity "Community Health Access and Rural Health Transformation Model." The initiative seeks to "catalyze modernization of rural health delivery systems by offering technical support, operational flexibilities, and an APM specifically designed for rural communities#

Center for Medicare Medicaid—"*Value in Opioid Use Disorder Treatment (ViT)"*

Federal Legislation "*Turn the Tide Act"* is a comprehensive bill that addresses funding issues supporting programs and services addressing SUD. May provide an opportunity to promote funding for RH.

#42 CFR § 438.3 - Standard contract requirements. | CFR | US Law | LII / Legal Information Institute (cornell.edu) (Accessed January 5, 2021).

Action steps

- **Present a VBP Pilot with Recovery Housing based on providing reimbursement for Evidenced-based treatment provided within RR.**
- **Establish agreements with certified homes/programs**
- **Define elements of a recovery plan**
- **Define required data collection of Outcomes for VBP**
- **Establish a bundled per diem rate to avoid the high administrative cost of encounter based care and billing**
- **Utilize third party administrators to ensure certification, program fidelity (evidence-based) and participation validation for reimbursement**

Summary

- Recovery housing has engagement and outcome rates that meet or exceed the current standard of practice and delivers person-centered care
- Despite its social and economic value, RH programs and services have not been a widely covered benefit in current funding models or payor contracting
- APM offer promise in supporting long-term recovery-based programs to help individuals recover from SUD and secure housing and employment
- To engage in a financial model for RH, providers, payors, and people will need to align on a service and payment model that gives flexibility and aligns with person centered approaches and outcomes
- Some states are already moving towards this model – **let's catalyze!**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THANK YOU

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