



**U.S. Department of Health and Human Services**  
**Office of the Assistant Secretary for Planning and Evaluation**  
**Office of Behavioral Health, Disability, and Aging Policy**

# **STATE RESIDENTIAL TREATMENT FOR BEHAVIORAL HEALTH CONDITIONS: REGULATION AND POLICY**

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## **Office of the Assistant Secretary for Planning and Evaluation**

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## ACRONYMS

The following acronyms are mentioned in this report and/or appendices A and C. Appendix B has an extensive acronym list that is not included here.

ASAM	Americans Society of Addiction Medicine
ASO	Administrative Service Organization
ASPE	HHS Office of the Assistant Secretary for Planning and Evaluation
AUD	Alcohol Use Disorder
CHIP	Children’s Health Insurance Program
CMS	HHS Centers for Medicare & Medicaid Services
COA	Council on Accreditation
CON	Certificate of Need
DSH	Disproportionate Share Hospital
HHS	U.S. Department of Health and Human Services
IDU	Injection Drug Use
IMD	Institution for Mental Disease
IRTS	Intensive Residential Treatment Services
LOCUS	Level of Care Utilization System
M/SUD	Mental and Substance Use Disorders
MACPAC	Medicaid and CHIP Payment and Access Commission
MAT	Medication-Assisted Treatment
MCE	Managed Care Entity
N-MHSS	National Mental Health Services Survey
N-SSATS	National Survey of Substance Abuse Treatment Services
NASADAD	National Association of State Alcohol and Drug Abuse Directors
OUD	Opioid Use Disorder
QA/QI	Quality Assurance/Quality Improvement
PPW	Pregnant and Parenting Women
R/S	Restraint/Seclusion
SAMHSA	HHS Substance Abuse and Mental Health Services Administration

SMI	Serious Mental Illness
SUD	Substance Use Disorder
SUPPORT	Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for patients and communities act
TJC	The Joint Commission
WM	Withdrawal Management

# EXECUTIVE SUMMARY

## Background

Residential treatment facilities are a key component of states' behavioral health systems. They form part of the spectrum of treatment for both mental and substance use disorders (M/SUDs). Residential treatment involves providing health services or treatment in a 24-hour-a-day, 7-day-a-week structured living environment for individuals who need support for their mental health or substance use recovery before living on their own, but where inpatient treatment is not needed. Care is provided for limited periods of time and has the goal of preparing people to move into the community at lower levels of care.<sup>1</sup>

Recently, more attention has been paid to these intermediate levels of care for persons with M/SUD. The Centers for Medicare & Medicaid Services (CMS) has expanded efforts to ensure a broader continuum of care for both M/SUD, including demonstration opportunities for state Medicaid programs to receive federal matching funds for an expanded range of services that include residential treatment. On July 27, 2015, and November 1, 2017, CMS announced opportunities for states to design new substance use disorder (SUD) service delivery systems using the Section 1115 demonstration authority under Medicaid.<sup>2,3</sup> Among other things, these opportunities enabled approved states to expand reimbursement for residential SUD treatment. More recently, on November 13, 2018, CMS announced similar opportunities regarding service delivery systems for adults with a serious mental illness (SMI). Improving quality is a key component of those demonstrations.<sup>4</sup>

Residential M/SUD treatment settings are governed almost exclusively by state statutes and regulations, rather than by federal laws. This Compendium's purpose is to inform behavioral health treatment policy by providing detailed information about each state's approach to regulating and funding services in residential M/SUD treatment settings. The Compendium describes regulatory provisions and Medicaid policy for residential treatment in all 50 states and the District of Columbia (hereafter states) and contains links to detailed summaries of state licensure<sup>5</sup> and oversight standards and, separately, state Medicaid requirements. The supporting research examined residential treatment from a legal perspective, focusing foremost on state statutes and regulations, supplemented by other documents and input from states.

In reading this Compendium, however, it is critical to remember that states may use other levers of oversight in addition to regulations, such as contracts with facilities receiving state funds, contracts between the state and Medicaid managed care entities (MCEs) or individual providers, and contracts between MCEs and individual providers. State licensure manuals and state Medicaid policies also are used to define provider responsibilities. Additionally, all state Medicaid programs require appropriate licensure of providers, hence, incorporating by that mandate all relevant requirements for obtaining and maintaining licensure.

## Methodology

As a precursor to the collection and synthesis of data drawn primarily from state law, we conducted an environmental scan<sup>4</sup> and interviewed experts in the field. We then examined relevant statutes and regulations governing behavioral health treatment and licensing or certification for the 51 states, as well as examining state Medicaid requirements regarding residential treatment. The domains examined for both licensure and Medicaid relate to standards: (1) regarding processes of oversight such as regulation and licensure; and (2) related to facility operation that are conditions of operation and licensure.

The primary focus of this Compendium is residential M/SUD treatment for adults ages 21-64 years. For this Compendium, we define *residential treatment* as clinical treatment services for M/SUD provided in a 24-hour living environment, including withdrawal management residential facilities. This Compendium excludes residential settings that predominantly serve people with intellectual and other developmental disabilities or settings that are forensic, correctional, or inpatient.

## Research Findings

**Processes of oversight.** From state to state, regulations and Medicaid policy vary dramatically in how states define residential treatment settings. The largest category of mental health residential facilities among states comprises those that are crisis focused. In the realm of SUD residential treatment, the categories identified in the American Society of Addiction Medicine (ASAM) criteria as Level 3 residential and withdrawal management facilities form a substantial portion of state facility types. Other states focus on, for example, the duration of stay or the condition treated. Regulatory processes sometimes vary between states by funding type (e.g., publicly-funded, Medicaid-enrolled, private facilities). In addition, many states have multiple agencies or subagencies overseeing and/or licensing treatment facilities, including separate entities regulating mental disorder versus SUD treatment, separate entities overseeing Medicaid-enrolled facilities, and layers of regulation that may include a state behavioral health agency, a state public health department, and a state Medicaid agency. Mental health residential treatment is less likely than SUD residential treatment to be regulated, although determining which facilities in the states are unregulated is difficult. Doing so requires a thorough understanding of which types of facilities are regulated. From that, one can conclude that certain facility types are or may be unregulated, if they exist in the state.

The licensure process can be quite complex and entail many requirements. Accreditation by an independent body is somewhat unlikely to be required; it is more likely that a state will confer “deemed status” on facilities that are accredited, absolving them of certain licensure requirements. Often the requirement being excused relates to some portion of licensure



inspections, most often at renewal. Viewing inspections as an indicator of the state's ability to monitor facilities over time, whether as part of licensure, renewal, or for cause, we closely examined the extent to which states have some provision for inspection, whether through licensure and related standards or as part of Medicaid enrollment. We found such requirements for 47 and 50 states, for mental disorder and SUD treatment, respectively.

**Standards for facility operations.** This study examined many aspects of facility operation that may be addressed via regulation. We found that some, such as wait time requirements for placement, are often not included in regulations but may be found in contracts or on agency websites. Other operational considerations are frequently addressed in a regulatory context. Some primary findings are summarized below.

**Placement** in the appropriate setting and level of care is important to ensure that patients receive the care they need. We examined whether there were specific state criteria for placement and/or assessment, to ascertain whether placement in a given residential facility type is suitable for the individual seeking treatment. Specific placement criteria for residential treatment facilities are the norm, derived from a combination of licensure-related and Medicaid requirements; 42 and 50 states were found to include such requirements for mental disorder and SUD residential treatment, respectively. As might be expected, required use of the ASAM Patient Placement Criteria was nearly exclusively limited to residential SUD treatment. A total of 45 states specifically use the ASAM criteria for placement in SUD treatment; many of those 45 states have Section 1115 Institution for Mental Diseases (IMD) demonstrations. Many states also have, in addition to standards of placement, criteria for continued stay and/or discharge.

States are more likely to include **treatment planning and discharge planning** requirements in licensure and related standards than they are to include them as Medicaid requirements. Documentation examined revealed that treatment planning requirements were included for 46 and 50 states, respectively, for mental disorder and SUD residential treatment. Nearly as many states included discharge planning requirements: 40 and 49 states for mental disorder and SUD treatment, respectively. These high numbers indicate the importance placed on appropriately planning treatment and the provision for ongoing treatment and support after discharge, preferably beginning early in the treatment process.

Even though discharge planning requirements are common, state standards for the actual provision of **aftercare services** by a residential facility as a bridge to subsequent care or **follow-up after discharge** from a residential facility are rare. Six and 13 states include such requirements for mental disorder and SUD residential treatment, respectively, primarily in licensure or other non-Medicaid standards and most frequently requiring follow-up rather than aftercare.

Ensuring the provision of evidence-based or best practice treatment is crucial to maintaining high-quality residential services for M/SUDs. In addition to assessments related to placement, treatment planning, and coordination of care, **treatment services** in the form of psychosocial

and medication treatment are key components of residential treatment. Although states vary in the extent to which they elaborate, in the SUD treatment realm, the ASAM Level 3 standards increasingly are adopted to guide state treatment requirements, driven in part by approved Section 1115 Medicaid demonstrations. These standards set criteria for different levels of residential and withdrawal management treatment. Two discrete indicators of service requirements that were examined as part of this study were requirements for use of: (1) evidence-based practices generally; and (2) medication-assisted treatment<sup>6</sup> (MAT) specifically, in residential treatment. Regarding the first, we found that SUD residential treatment facilities are most likely to have requirements for evidence-based practices, with 43 out of 51 states including some form of requirement, most commonly MAT. In contrast, only 16 states, in total, incorporated requirements specific to evidence-based practices for residential mental health treatment. Regarding MAT, requirements were more commonly specific to SUD treatment facilities, with a total of 39 states having SUD licensure-related and/or Medicaid-related requirements in place in regulations or other documents specific to residential treatment. A significant portion of the Medicaid requirements reflect the existence of Section 1115 demonstrations.

**Staffing** standards may include requirements regarding hiring, credentialing, training, documentation of employment requirements or practices, and staffing levels, among other things. As one indicator of state involvement in staffing standard-setting, we looked at staffing levels. Adequate staffing levels are needed to ensure quality treatment and safety in 24-hour mental disorder and SUD treatment settings. Among requirements for mental health residential treatment, 30 states had general requirements for “adequate” or “sufficient” staffing and 27 had specific ratio requirements. For SUD residential treatment, 41 states had general requirements and 34 had specific ratio requirements. Most such requirements sprang from licensure and other non-Medicaid standards.

The scope and nature of **quality assurance/quality improvement** requirements applicable to residential M/SUD treatment vary considerably, but some form of explicit requirement imposed on facilities is common (e.g., written quality improvement plan, use of data for quality improvement purposes). This is truer for SUD than for mental disorder treatment and generally originates in licensure and related oversight standards rather than in state Medicaid requirements. We identified 38 and 48 states that impose some such requirement for residential mental disorder and SUD treatment facilities, respectively.

We looked at two discrete aspects of **service recipient rights**, related to: (1) the right to voice grievances, taken as an indicator of the ability of service recipients to enforce their rights in general; and (2) rights related to restraint and seclusion, because restraint and seclusion affect safety and dignity. The first--the right to voice grievances--is most commonly mandated, with 37 and 42 states having such requirements for mental disorder or SUD treatment, respectively, as part of licensure standards. In contrast, rights regarding restraint or seclusion were found for mental disorder or SUD treatment in 42 and 37 states, respectively.

**Governance** standards are elaborate in some states and nonexistent in others. They may be integrated into licensure requirements, for example, as part of what facilities must demonstrate in their application. They also may be a more general part of state regulations governing operating requirements. They may be as simple as requiring information at licensure and the development and maintenance of policies and procedures, or they may include detailed requirements regarding different areas of facility internal structure and oversight. Some form of governance requirements were located in licensure standards in 36 states regarding mental disorder residential treatment and in 41 states regarding SUD residential treatment.

States identify a range of *special populations* to whom they wish to target services. This is truer of SUD treatment than of mental disorder treatment and often stems from block grant requirements. The two most common populations identified, particularly for SUD residential treatment, are those with co-occurring M/SUDs and pregnant and parenting women or parents of dependent children. Regarding the latter, many states have specific requirements for residential facilities in which pregnant women, parenting women, and/or families with dependent children may receive treatment, including educational, health, and safety requirements for children. Regarding standards applicable to treating those with co-occurring M/SUDs, although additional requirements may exist in contracts or policy documents, in the documentation reviewed, we found nearly twice as many states with licensure-related requirements for treatment of co-occurring M/SUD disorders stemming from the SUD side of state policy (29 states) compared with mental disorder residential treatment (15 states). Many of the former reflect requirements based in Section 1115 demonstrations but states have, apart from that, often sought to ensure that SUD-focused treatment facilities address mental disorders as well.

**Other key findings.** This research also produced at least four overarching additional findings.

1. State Medicaid programs all incorporate some requirement for appropriate licensure within the state, for facilities providing residential treatment. This allows state Medicaid regulations to be less exacting in many cases, because they rely on already existing standards.
2. Section 1115 demonstrations, as well as the ASAM criteria, have been critical to strengthening regulation of residential SUD treatment. The state structure and oversight of residential mental disorder treatment has not kept pace.
3. We did not include all residential settings in this study. For example, small group homes and recovery housing, where clinical treatment is not integrated into the residence, were excluded. Such facilities may or may not be regulated or licensed. They may be providing very valuable benefits to their residents or services of unknown quality.
4. States have diverse ways of overseeing M/SUD treatment. Some rely heavily on published statutes and regulations. This results in clearly established, transparent requirements that

lay out the legal basis for oversight, licensure, and/or Medicaid enrollment. It also may result in requirements being established that can be difficult to change when flexibility or adaptation is needed. Comparable to promulgated regulations are state Medicaid demonstration or state plan documents that have been approved by CMS, which are binding and have the benefit of transparency and certainty, provided rapid change is not required. Some states rely more heavily on contractual requirements, also binding but often less transparent. States also use agency licensing or standards manuals and, for Medicaid, provider manuals or other policy documents. Theoretically, these may be less binding on providers unless, as is often the case, they are incorporated by reference into state statutes, regulations, or provider agreements. This approach has the benefit of requiring only that the manual or other document be amended and published to alter requirements when doing so may be time sensitive. However, hurdles can exist that impede public access to such documents.

## Conclusions

Regulation and oversight of residential treatment is a patchwork, and identification of unregulated facilities is an imprecise exercise. Regulation of SUD treatment is more pronounced and somewhat more consistent across states than is regulation of mental disorder treatment, although both have room for improvement. This difference is often driven by the fact that many of the SUD treatment requirements are a result of Medicaid demonstration/waiver requirements that also appear to be seeping into SUD licensure and other non-Medicaid oversight standards. The inclusion of requirements as part of Medicaid demonstrations, such as requirements regarding provision of MAT in residential treatment, even if only directly applicable to certain facilities or certain populations, means that it is more likely that other facilities and individuals in the state will experience spillover as MAT becomes more widely available. This suggests that, if more states obtain approval for Section 1115 demonstrations that affect reimbursement of mental disorder treatment in IMDs in accordance with the November 2018 State Medicaid Directors Letter,<sup>4</sup> it is possible that similar strides could take place for mental disorder residential treatment. Additionally, the Section 1115 demonstrations are laboratories for innovation that may spread best practices to other states. Consideration of how to create more such laboratories for the treatment of SMI is an important next step.

## SECTION 1. INTRODUCTION

Residential treatment facilities are a key component of states' behavioral health systems. They form part of the spectrum of treatment for both mental and substance use disorders (M/SUDs). Residential treatment involves providing health services or treatment in a 24-hour, 7-day a week structured living environment for individuals who need support for their mental health or substance use recovery before living on their own, but where inpatient treatment is not needed. Care is provided for limited periods of time and has the goal of preparing people to move into the community and into lower levels of care.<sup>1</sup>

The Substance Abuse and Mental Health Services Administration's (SAMHSA's) National Mental Health Services Survey (N-MHSS) for 2017 reported that the United States had 856 organizations providing residential mental health treatment for adults. Eighty percent of adult residential treatment facilities offered psychotropic medications, 65% offered group psychotherapy, 60% offered individual psychotherapy, and 58% offered cognitive behavioral therapy.<sup>7</sup> More than 80% of these facilities provided only mental health services, whereas 19% also provided substance use services. Most facilities were nonprofit and accepted Medicaid payments.<sup>8</sup>

The SAMHSA National Survey of Substance Abuse Treatment Services (N-SSATS) survey for 2017 found that approximately 3,125 organizations were providing residential substance use disorder (SUD) treatment in the United States.<sup>9</sup> Among all residential substance use facilities, about 23% of these facilities had fewer than 13 residential beds, 59% of facilities had more than 18 residential beds, and 18% had 48 or more residential beds.<sup>10</sup> Most residential SUD treatment facilities were nonprofit. About half accepted Medicaid and more than 60% accepted private insurance.<sup>9</sup>

Recently, increased attention has been paid to these intermediate levels of care for persons with M/SUD. The Centers for Medicare & Medicaid Services (CMS) has expanded efforts to ensure a broader continuum of care for both M/SUD, including demonstration opportunities for state Medicaid programs to receive federal matching funds for an expanded range of services that include residential treatment. On July 27, 2015, and November 1, 2017, CMS announced opportunities for states to design new SUD service delivery systems using the Section 1115 demonstration authority under Medicaid.<sup>2,3</sup> Among other things, these enabled approved states to expand reimbursement for residential SUD treatment. More recently, on November 13, 2018, CMS announced similar opportunities regarding service delivery systems for adults with a serious mental illness (SMI).

Improving access to needed treatment and quality care are key components of the Section 1115 demonstrations.<sup>4</sup> For SUD treatment generally, this has been shaped by the demonstration requirements that treatment follow aspects of the American Society of Addiction Medicine (ASAM) treatment criteria, and the ASAM criteria have increasingly made

their way into state Medicaid and non-Medicaid requirements as a result. The ASAM criteria were developed to improve assessment, treatment and recovery services, and to match patients to the appropriate level of treatment. For adult residential treatment, this includes the following levels:

- Level 3.1. Clinically Managed Low-Intensity Residential Services.
- Level 3.3. Clinically Managed Population-Specific High-Intensity Residential Services (formerly Medium-Intensity).
- Level 3.5. Clinically Managed High-Intensity Residential Services.
- Level 3.7. Medically Monitored High-Intensity Inpatient Services (which, in many states, are offered in residential settings).
- Level 3.2-WM. Clinically Managed Residential Withdrawal Management.
- Level 3.7-WM. Medically Monitored Inpatient Withdrawal Management (in many states, offered in residential settings).

A similar system of levels of care and placement criteria exists for mental health treatment in the Level of Care Utilization System (LOCUS):

- Level 5. Medically Monitored Residential Services.
- Level 6. Medically Managed Residential Services.<sup>11</sup>

According to expert interviews, states are increasingly requiring the LOCUS for placement purposes in their contracts with providers or managed care entities (MCEs).

Control and oversight of residential behavioral health treatment settings, including with regard to placement, quality, treatment services, and other matters, however, are fundamentally governed by state laws and regulations, and these vary by state. Indeed, some states may have multiple sets of oversight, licensure, or certification requirements, and some licensure standards also may require accreditation or provide for optional accreditation. Thus, accreditation by an independent accrediting body such as the Joint Commission (TJC), the Commission on Accreditation for Rehabilitative Facilities, or the Council on Accreditation (COA) can provide yet another layer of oversight and inspection, beyond that carried out by the states. This Compendium describes regulatory provisions and Medicaid policy for residential treatment in all 50 states and the District of Columbia (hereafter states). Appendix B contains links to detailed summaries of state licensure and oversight requirements and state Medicaid requirements, including Section 1115 demonstration requirements.

The primary focus of this Compendium is residential M/SUD treatment for adults ages 21-64 years. As more fully explained under Methodology, this Compendium does not include residential settings that predominantly serve people with intellectual and other developmental disabilities or settings that are forensic or correctional. It also does not include residential placements that are not required to include some form of clinical psychosocial treatment for mental disorders or SUDs, although withdrawal management facilities are included. States use

many terms for residential treatment settings. This Compendium uses the term *residential treatment* as a generic label that encompasses all state licensure categories; the state summaries use each state's specific licensure or certification term(s).

The Compendium's purpose is to inform residential behavioral health treatment policy by providing detailed information about each state's approach to regulating and funding services in residential behavioral health treatment settings. In reading this Compendium, however, it is critical to remember that states may use other levers of oversight in addition to regulations, such as contracts with facilities receiving state funds, contracts between the state and Medicaid MCEs or individual providers, or contracts between MCEs and individual providers. State licensure manuals and state Medicaid policies also are used to define provider responsibilities. Additionally, all state Medicaid programs require appropriate licensure of providers, incorporating by that mandate all relevant requirements for obtaining and maintaining licensure.

## Methodology

As a precursor to the collection and synthesis of data drawn primarily from state law, we conducted an environmental scan and interviewed experts in the field. Relevant articles and other source documents were reviewed, synthesized, and summarized in the environmental scan, which is published separately.<sup>12</sup> In addition, we identified and interviewed a number of subject matter experts who are recognized in the acknowledgments section of this Compendium.

On the basis of findings from the environmental scan<sup>12</sup> and interviews with experts, we developed a template that provided the coding structure for data collected throughout the project. Relevant statutes and regulations governing behavioral health treatment and licensing or certification from 51 jurisdictions were reviewed and abstracted into the data collection template. We prepared detailed state summaries of: (1) licensure standards; and (2) Medicaid requirements by synthesizing the abstracted information (see Appendix B).

Several parameters were placed around the scope of data collection to ensure consistency:

- *Residential treatment* was defined as clinical treatment services provided in a 24-hour living environment, including withdrawal management treatment.
- Only residential treatment facilities for adults were included; thus, treatment specific to children or adolescents was excluded.
- We excluded facilities that are associated with the criminal justice system or that are in inpatient settings.
- Medicaid-specific requirements are included separately for each state.

The state summaries that resulted from data collection regarding licensure were shared with the individual states for validation. On the basis of input from the states, the summaries were revised as necessary. In some instances, state personnel provided additional sources of information beyond the statutes and regulations and, to the extent that it was pertinent to the study, we included that information. Among other things, this included information in certification or licensure manuals and written input from state staff. All publicly available documents on which we relied are referenced in the state summaries.

In the summaries of state Medicaid requirements, we primarily relied on state Medicaid regulations and Section 1115 demonstration documents. Where necessary, these were supplemented with additional sources. The relative absence of certain requirements in state Medicaid regulations, however, does not mean that Medicaid programs do not have service requirements in provider agreements with Medicaid or MCEs, provider manuals, or elsewhere. Similarly, some states may passively rely on the presence of licensure requirements to ensure that service standards are in place.

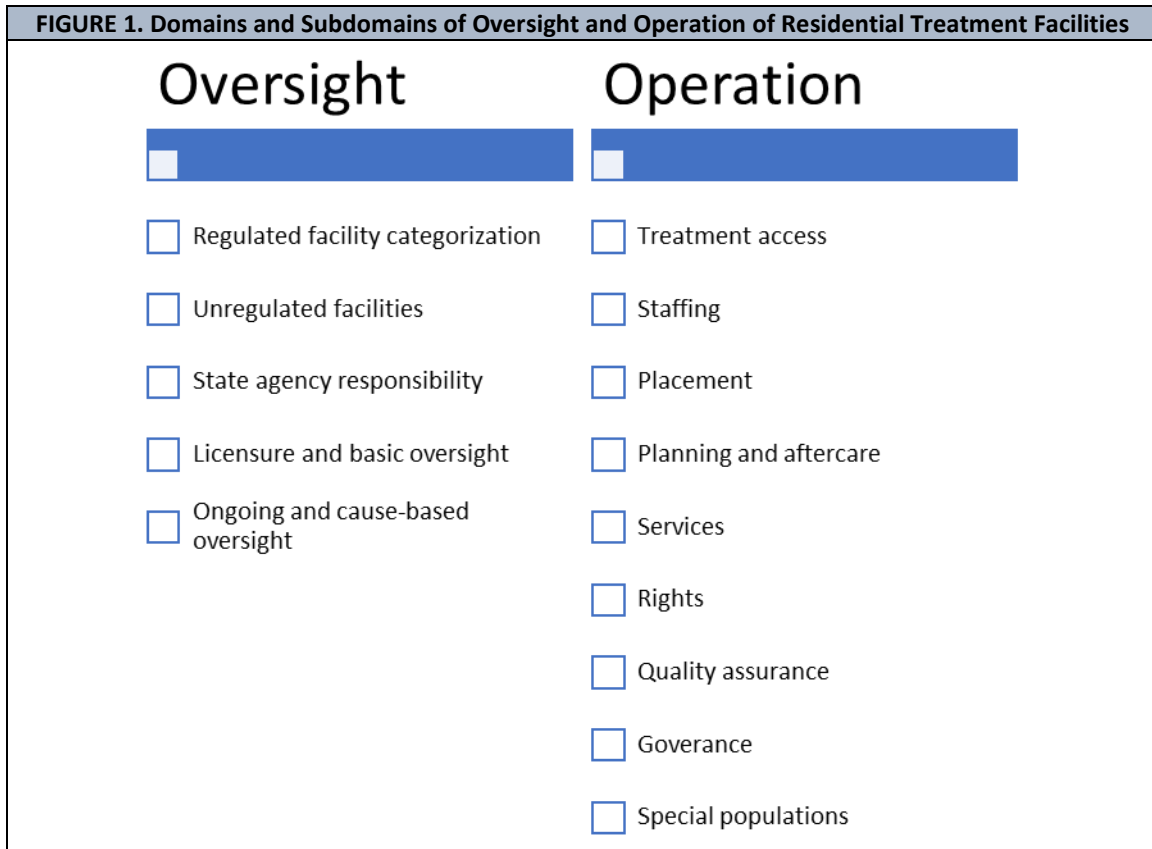
Throughout the study, we used a legal mapping framework. This approach provides structured steps to follow in reviewing and compiling information from legal documents. In addition, we coordinated with other federal efforts on this topic and leveraged efficiencies available through ongoing parallel efforts, such as those being led by the Medicaid and CHIP Payment and Access Commission (MACPAC).<sup>13</sup> By integrating input from leaders in this field throughout the course of the project, as well as applying a rigorous legal mapping framework for abstraction and synthesis, we generated accurate information to disseminate widely and inform next steps in addressing capacity for M/SUD treatment across the continuum of care (see Appendix C for more detailed description of the methods for this Compendium).

**Conceptual framework.** This study examines residential treatment from a legal perspective, focusing foremost on state statutes and regulations. The domains examined relate to regulatory standards: (1) regarding processes of oversight such as regulation and licensure;<sup>14</sup> and (2) related to facility operation that are conditions of operation and licensure. Figure 1 identifies those domains and subdomains, all of which are described and discussed more fully in Section 2 of this Compendium. Complementing this, Section 3 uses some but not all of the same domains and subdomains in the context of state Medicaid requirements.

**Study limitations.** One limitation is that a full understanding of a state's oversight of residential treatment facilities requires examination of more than the state statutes and regulations, which provide only a partial picture of how oversight works in reality. Those statutes and regulations are, however, the legally enforceable mechanisms that govern facilities, and they are publicly available to all stakeholders. Additional information, however, could be gleaned from provider or MCE contracts, additional policy documents, or from an understanding of how regulations are enforced, or not, in practice. Another limitation is that the summaries reflect state law at a single point in time. Statutes and regulations are amended on an ongoing basis. This means that, at the point of publication of this Compendium, some statutes and regulations will have been amended, repealed, or replaced, rendering some portion of the summaries no longer



accurate.<sup>15</sup> Last, because data collection requires deliberate selection of some characteristics over others and some components of regulatory oversight (such as building, fire, and zoning requirements) were not included, the scope of these summaries cannot be considered exhaustive.



## Organization of the Report

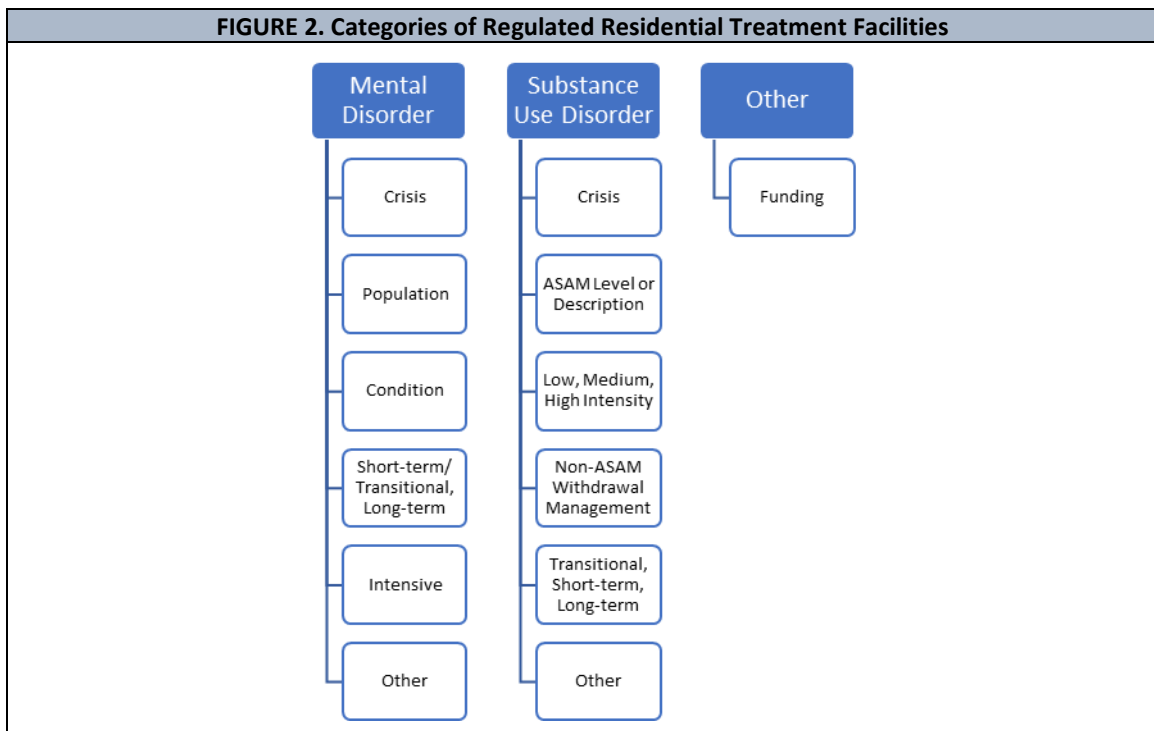
Section 2 provides an overview of state regulatory provisions covering the two broad domains and 14 subdomains introduced in the study framework, including primary implications of those findings. Section 3 contains an overview of state Medicaid funding for services furnished in these settings and related policies, including primary implications of those findings. Section 4 discusses the key trends identified in this Compendium, including discussion of the ways in which state licensing regulations and Medicaid requirements often complement each other. Appendix A includes detailed tables showing results in each subdomain by state, and Appendix B contains links to each of the individual state licensing and Medicaid summaries. Appendix C contains a more complete methodology than that in Section 1 of this Compendium.

## SECTION 2. OVERVIEW OF NONMEDICAID RESIDENTIAL TREATMENT REGULATIONS

The two primary domains examined relate to: (1) regulatory standards regarding processes of oversight such as regulation and licensure; and (2) regulatory standards regarding facility operation that are conditions of operation and licensure. Each domain and subdomain (hereinafter domains) is addressed in turn below. We provide an explanation for why each domain is important to the regulation and oversight of residential treatment, what each domain encompasses, and a discussion of major findings.

### Domains Regarding Processes of Oversight

Domains regarding processes of oversight include categorization of regulated facilities, identification of unregulated facilities, state agency responsibility for oversight, processes of licensure and basic oversight, and processes of ongoing oversight.



**Categorization of regulated facilities.** State regulations identify residential treatment facilities in many ways. Those identified in the regulations, therefore, had to be categorized in order to understand and describe the scope of what is regulated in a given state. We began with a distinction between mental disorder and SUD treatment facilities, given the historic bifurcation of the two systems,<sup>16</sup> and with an understanding that some states would distinguish facilities on

the basis of their sources of funding. Further categorization was not possible until after data collection, and this post hoc categorization was primarily intended to identify major categories of residential treatment as often viewed by the states. Figure 2 depicts the categories ultimately used.

We discuss separately below the categorization for regulated mental disorder and SUD residential treatment, as well as categorization by funding source. It is apparent that the landscape of regulated residential treatment in the states is as diverse as the states themselves. There are many differences among states, as further discussed below.

- ***Mental disorder residential treatment.*** The largest group of mental disorder residential facility types were those labeled as some form of specialized crisis facility. At least 32 states have such facilities serving individuals with mental disorders, some of which also serve clients with SUDs.<sup>17</sup> Detail by state is included in Table A1 and in the relevant state summaries (Appendix B). In addition to the states that regulate crisis facilities as such, some simply incorporate crisis services into other types of residential facilities. A much smaller number of states regulate facilities within the other identified categories. Nine states included facilities labeled as either short-term or transitional. The time period covered by this label varies considerably (e.g., 90 days or less for short-term facilities in Florida vs. 12 months for transitional facilities in California).<sup>18,19</sup> Six states expressly label mental health facilities as long-term and, again, what is considered long-term varies by state (e.g., 60 days or greater average length of stay in Florida vs. 18 months maximum in California).<sup>20,21</sup> Three states label or define certain facilities as intensive. An example of an intensive mental disorder residential treatment facility is the Minnesota Intensive Residential Treatment Services (IRTS).<sup>22</sup> In addition to states with facilities specific to women, which are addressed in the section of this Compendium regarding special populations, at least three states have facilities focused on specific populations. One example is Virginia, which has separate regulations specific to acute gero-psychiatric residential services.<sup>23</sup> A similarly small number of states identify residential facilities for individuals with specific conditions, in particular, three for eating disorders.<sup>24</sup> Finally, at least 31 states identify residential mental disorder treatment with nonspecific labels that do not fit our categories (e.g., Mental Health Centers, Residential Treatment Programs, Specialized Treatment Facilities). In addition, four states that do not identify any regulated residential mental disorder treatment facility types that fall within the definition used in this study.
- ***Substance use disorder residential treatment.*** States also take many approaches to labeling, defining, and categorizing residential SUD treatment facilities. As with mental disorder facilities, crisis facilities often are so labeled (13 states), although it is clear that withdrawal management and other facilities also handle individuals presenting with high acuity. As noted above, some states have crisis facilities that are not strictly limited to mental disorder versus SUD treatment. Additionally, 35 states have SUD treatment labels that defy categorization (e.g., Specialized Treatment Facilities).<sup>25</sup> Facilities also were categorized as follows (see Table A2 for more detail by state):

1. States that expressly identify by label or definition the ASAM level applicable to a specific facility type, which we include if they were identified as being residential. These are Levels 3.1 (16 states), 3.2-WM (13 states), 3.3 (ten states), 3.5 (15 states), 3.7 (ten states), and 3.7-WM (12 states).
  2. States may identify facilities as low, medium, or high-intensity, with or without parroting the ASAM label or level number. In some instances,<sup>26</sup> a state may reference ASAM with regard to these facilities, but not expressly link by level. In those instances, for purposes of the Appendix, we did not attempt to draw that connection. Rather, we relied on the state's designation as low, medium, or high. Whether identified using a precise ASAM label (e.g., Clinically Managed Low-Intensity Residential Services) or another label of low, medium, or high, 16, nine, and 16 states, respectively, fell into these categories. In some instances, states identify Level 3.3 with medium-intensity services for adults,<sup>27</sup> although that is inconsistent with the current ASAM criteria and reflects the older criteria.<sup>28</sup> In those instances, we counted the state as providing Level 3.3 services (because that is how they are identified by the state) and medium-intensity services.
  3. Fourteen, 15, and five states identify detoxification/withdrawal management facilities as Clinically Managed, Medically Monitored, or Medically Managed, respectively, in accordance with ASAM criteria. Ten states identify some withdrawal management facilities as social detoxification. In some cases, social detoxification is expressly linked to ASAM Level 3.2-WM or to Clinically Managed Detoxification,<sup>29</sup> in which case we included it in both categories. Some states may use the term *medical detoxification* or *medically supervised detoxification*, without clear indication whether it is medically monitored or medically managed. In those instances, we included it with other unspecified withdrawal management as Detoxification/Withdrawal management.<sup>30</sup> A total of 23 states have facilities that we have placed into the general Detoxification/Withdrawal management category.
  4. *Transitional, short-term, and long-term* are labels that states sometimes use to identify facilities and, when that is the case, we counted the categories accordingly, with 11 states using the label transitional, five states the label short-term, and six states the label long-term.
- **Funding criteria.** In many states, regulations and/or licensing requirements vary on the basis of a facility's sources of funding. Differential regulation and/or licensure based on funding relates to whether a facility receives public funds (including block grant funds, state financing, and/or Medicaid). In Table 1, we identify the number of states that indicate requirements applicable to both Medicaid and other public funds in their

regulations and licensure requirements. Separate requirements related only to Medicaid are discussed in our review of Medicaid regulations (see Section 3).

TABLE 1. Number of States Regulated and Licensed by Funding Source		
Requirements	Mental Health	Substance Use
Regulated based on funding source	18	22
Licensure based on funding source	16	17
<b>NOTES:</b> Detailed in Table A3 and Table A4. This table does not include information about requirements applicable only to Medicaid		

One example of a state with multiple approaches to regulation is Ohio. Licensure by the Ohio Department of Mental Health and Addiction Services is required for all residential mental health facilities.<sup>31</sup> Separate certification by the Department also is required if the facility provides services that are funded by: (a) the Ohio Medicaid program for community mental health or community addiction services; (b) a board of alcohol, drug addiction, and mental health services; or (c) federal or department block grant funding for certified services. In addition, other Ohio facilities may voluntarily request certification.<sup>32</sup>

It is important to note that regulations and licensure are not the only mechanisms that a state has to oversee publicly-funded facilities. Of the states counted in Table 1, the regulations based on funding often coexist with other regulations for a larger group of residential facilities. For the subset of facilities receiving block grant funds from the state, oversight also or alternatively may occur pursuant to contractual provisions.

**Identification of unregulated facilities.** After categorizing types of facilities that are regulated, we undertook to determine which facilities in the states are unregulated. This is important in order to understand areas where state oversight and regulation are not currently present. Doing so requires a thorough understanding of what is regulated. From that, one can conclude that certain facility types are unregulated. Beyond that, unless there is a clear understanding of the types of facilities that actually exist in a state, it is impossible to say that a given state contains specific types of unregulated facilities. However, states may use other levers of oversight such as legally binding contracts for facilities receiving state funds.

Our survey of the states found that residential mental disorder treatment facilities are less likely to be regulated and/or licensed than are residential SUD treatment facilities. Table A5 in the Appendix identifies states by whether they have regulation and/or licensure of every type of mental disorder or SUD residential treatment that is within the scope of this study. We estimated that 23 states have fully regulated all residential mental disorder treatment in their jurisdiction and that 39 states have fully regulated all residential SUD treatment. Of those states included in Table A5 as not fully regulating the range of residential treatment in the state, it is important to note that most, in fact, do regulate a segment of residential treatment. The following are some examples of situations in which states are classified as having unregulated or potentially unregulated facilities:

- A state may have no licensure regulations regarding mental disorder residential facilities.<sup>33</sup>
- A state may regulate or license only facilities receiving public funding, although, in some instances, private facilities may seek licensure voluntarily.<sup>34</sup>
- A state may regulate a limited range of facility types, and it is impossible to determine whether there actually are any such unidentified, unregulated facilities. An example is a state where regulated residential mental disorder treatment consists of two facility types that can also provide SUD treatment, Acute Crisis Units, and Therapeutic Communities.<sup>35</sup> In this instance, it is possible that those two types of facilities encompass every type of residential mental disorder treatment in the state, or they may not.
- A state may have agency staff who indicate that certain types of facilities exist but are unregulated. An example is a state in which agency staff indicated that residential mental health facilities of less than five beds are not regulated.<sup>36</sup>

**State agency responsibility.** The state agency responsibility for M/SUD oversight varies widely between states, with variability according to agency focus (either mental disorder treatment, SUD treatment, or both) as well as according to how the state assigns responsibility for regulation and licensure across different agencies. Table A6 in the Appendix captures the current state of separate versus combined agency oversight. States are increasingly integrating all functions into a single agency (40 states), although many still use distinct subagencies for oversight of different types of residential treatment. Other states still administer the functions of regulation and licensure across multiple agencies according to the unique structures of the M/SUD treatment systems and public health tradition in the state. Among the latter were 12 states with agencies specifically regulating residential mental disorder treatment and 15 states doing so for residential SUD treatment. A few states had some variation on this approach to regulation. Georgia, for example has one agency regulating both with additional regulation by another agency for SUD. Kentucky, New Jersey, and Vermont have both combined and separate agencies with regulatory responsibility. We refer the reader to the state summaries (Appendix B) for further details regarding individual states.

**Processes of licensure and basic oversight.** The licensure process can be quite complex and entail many requirements. This may include requirements imposed through multiple processes. Thus, the licensure process may entail, for a single facility, multiple applications or processes with one or more agencies. This may apply, for instance, if a facility must be separately licensed to operate and certified to obtain public funding. In the first two rows of Table 2, we identify when this complication exists. One example is Colorado, where the Department of Human Services, Office of Behavioral Health requires designation for mental health facilities that receive public funds or that initiate an involuntary hold on a person with mental illness. This includes, among other facilities, Acute Treatment Units, which also must be *licensed* by the Colorado Department of Public Health and Environment.<sup>37</sup>

TABLE 2. Number of States Using Different Approaches to Licensure and Other Oversight				
Requirements	Mental Health	Partially <sup>a</sup> for Mental Health	Substance Use	Partially <sup>a</sup> for Substance Use
One licensure/certification (L/C)	38	0	41	1
Multiple L/C	7	0	8	1
Duration identified	45	n/a	50	n/a
Inspection at L/C	41	2	42	6
Accreditation required	7	2	3	9
Deemed status	14	7	23	8
CON required	10	7	4	11
<b>NOTE:</b> Detailed in Table A7 and Table A8.				
a. <i>Partially</i> indicates that the characteristic or requirement is applicable to some but not all facility types in the state.				

The remainder of Table 2 indicates the extent to which licensure processes offer potential for state assessment and/or oversight of facility operations and quality. To that end, we focused on four components. These include: (1) the duration of licensure, because that may affect how often facilities are examined by the state; (2) whether an inspection or survey is required at licensure; (3) whether states require accreditation by an outside entity and, if not, whether accreditation serves to offset some portion of the requirements for licensure; and (4) whether a certificate of need (CON) is required.<sup>38</sup> Requirements for a CON typically are found in state law and historically have been used to ensure that operation of a proposed new facility meets the needs of the community.

The duration of licensure for residential treatment varies but is specified in more than four-fifths of states (Table 2). In many states, a renewal application must be submitted annually; in a few others, the duration may be as long as 3 years.<sup>39</sup> Some states provide a time range during which expiration may occur. For example, Kansas regulations state that the duration is “a term to be stated upon the license, which shall not exceed two years, unless revoked earlier for cause.”<sup>40</sup> More detail regarding the duration of licensure by state is included in Table A7 and Table A8.

Most states require an inspection or survey to be completed as part of licensure (Table 2), although some regulations appear to include agency discretion (e.g., for SUD residential treatment licensure in Texas, “If an on-site inspection is necessary, the Commission will conduct the inspection within 45 days of receiving a materially complete application packet”).<sup>41</sup> In total, 43 and 48 states clearly require licensure inspection for mental disorder and SUD residential treatment, respectively, either fully or partially for all such facilities.

In addition to licensure, accreditation by an independent accrediting body such as TJC, the Commission on Accreditation for Rehabilitative Facilities, or the COA may be required. An actual regulatory requirement is relatively uncommon for residential treatment facilities, with 9 (mental health) and 12 (SUD) states requiring for either some or all residential facilities. Such requirements, however, may be imposed by contract, as is true in New Hampshire.<sup>42</sup> One example of a state where accreditation is required by regulation is Nebraska, where locked

mental health facilities or facilities that use mechanical or chemical restraints or seclusion must be accredited.<sup>43</sup> It is more common that regulations convey “deemed status” on facilities that achieve accreditation, allowing accreditation to supplant aspects of licensure (21 [mental health] and 31 [SUD] states). For example, in Missouri, accreditation by an approved body confers deemed status, allowing an applicant for certification to submit a different application and forego a survey, other than to clarify aspects of the accreditation.<sup>44</sup> As another example, in Utah, the licensing agency may rely on the accreditation documentation to assist in determining if licensure is appropriate.<sup>45</sup> When accreditation replaces part of the licensing process, it often takes the place of inspections, although states nearly always reserve the right to conduct inspections for cause.<sup>46</sup>

Some states also may require a CON before a facility may be built or opened, although this is only approximately one-quarter of states for some or all facility types. This does vary by facility type, as, for example, in Florida, where a CON is required for Crisis Stabilization Units and Short-Term Residential Treatment Programs.<sup>47</sup> Alternatively, states may require a demonstration of need so as to obtain licensure, apart from any formal state CON requirements that may exist.<sup>48</sup>

**Ongoing oversight.** Ongoing facility oversight by state regulators, licensing bodies, or their surrogates takes different forms, providing additional opportunities for state agencies to assess facility compliance and quality. In Table 3, we identify the number of states that require: (1) regular ongoing inspections; and (2) cause-based inspections. License renewal, which typically happens at regular intervals, provides an opportunity for review of a renewal application, document review, and for renewal site inspections. Approximately four-fifths of states clearly provide for renewal inspections. States often explicitly also provide for cause-based inspections or other investigations, which may be prompted by various events, and for unannounced inspections. Among the states, approximately four-fifths have regulatory requirements mentioning such inspections. Within these requirements for routine ongoing or cause-based inspections, there are occasional nuances. One example is Texas, where the Health and Human Services Commission “may conduct a scheduled or unannounced inspection,” but where it is not clearly specified in the regulation that routine inspections will regularly be required for licensure or renewal.<sup>49</sup>

Requirements	Mental Health	Partially <sup>a</sup> for Mental Health	Substance Use	Partially <sup>a</sup> for Substance Use
Ongoing inspections	42	2	43	4
Caused-based inspections	40	1	44	1

**NOTE:** Detailed in Table A9.  
a. *Partially* indicates that the characteristic or requirement is applicable to some but not all facility types in the state.

State laws also generally provide for required plans of correction and action pursuant to those plans; actions against the license such as limitation, suspension, or revocation; and/or penalties (see Appendix B for details by state).<sup>50</sup> In addition, states may rely on contractual provisions for entities receiving public funding through block grants, Medicaid, or other avenues to activate



oversight at times other than upon renewal. Thus, even if provisions were not located in the licensing regulations regarding ongoing or cause-based inspections, it is very possible that such requirements exist in other formats.

## Domains Regarding Facility Operations

Domains regarding facility operations include standards regarding access to treatment, staffing, placement, treatment and discharge planning and aftercare, treatment services provided (including medication-assisted treatment [MAT]), service recipient rights, quality assurance or improvement, governance, and requirements related to special populations.

**Access to treatment.** Access to the full continuum of behavioral health treatment is a persistent problem and multiple barriers to accessing care may exist. Regarding access to residential treatment, this study examines whether states impose requirements regarding wait time to access treatment. This was selected as a discrete measure of whether access is explicitly addressed in the regulations. About a third of the states have wait times or requirements regarding wait time facility policies present in the regulations (15 [mental health] and 17 [SUD], partially or fully) (see Table 4). Where such requirements exist in the regulations, they may appear as a general mandate<sup>51</sup> or as applicable to certain facility types only (e.g., South Carolina crisis stabilization units or Idaho withdrawal management).<sup>52,53</sup> A different approach is taken by Missouri; its regulations include what are called “Essential Principles” that are intended to guide the facility. Among the Essential Principles is “Easy and Timely Access to Services,” in which the Department of Mental Health suggests (but does not require) that some potential performance indicators for mental health services generally might include: (1) same-day access to services; or (2) reduced wait time to set a first or subsequent appointment(s).<sup>54</sup> There also are instances in which wait time requirements are applied through nonregulatory means. For instance, staff from both Arizona and Tennessee indicated that they have online portals to manage wait times. Although these are not included as regulatory requirements, they do exist and are addressed in the respective state summaries (Appendix B). Several states have wait time requirements specific to priority populations, which is discussed further under Special Populations. We also discuss, under Treatment Services, regulatory requirements that access not be denied because a person is receiving or has received MAT or, in the case of mental health facilities, has an SUD.

Requirements	Mental Health	Partially <sup>a</sup> for Mental Health	Substance Use	Partially <sup>a</sup> for Substance Use
Wait times	9	6	8	9
<b>NOTE:</b> Detailed in Table A10.				
a. <i>Partially</i> indicates that the characteristic or requirement is applicable to some but not all facility types in the state.				

**Staffing standards.** Qualified staff at all levels are important to the provision of quality care in residential treatment. Many states include explicit staffing requirements in regulations,<sup>55,56</sup>

whereas other states may rely more heavily on incorporation by reference, such as of ASAM staffing standards for SUD residential treatment, which Iowa staff indicate are applicable,<sup>57</sup> or, perhaps, on requirements placed in policy documents or contracts. For this study, staffing was examined from two perspectives: (1) regulatory requirements related to required staffing, credential or experience requirements, and required levels for staffing; and (2) regulatory requirements regarding staff training.

The focus for the first was on quantifiable standards, such as whether there are any requirements related to facility administrators, medical directors, other medical staff, clinical staff, or direct care staff, and the extent to which staffing ratios or other criteria for staffing levels exist (Table 5). States may approach this as simply, for instance, requiring that there be an administrator, or, instead, may specify acceptable age, educational credentials, and/or experience. Mental health residential facility regulations are somewhat less likely than SUD regulations to have administrator requirements. States are much less likely to require that facilities have a medical director and are even less likely to require that to be a physician.<sup>58</sup> Within the realm of residential SUD treatment, requirements for a medical director or even medical staff were most common in residential detoxification or withdrawal management facilities as opposed to other types of residential treatment.<sup>59</sup> Requirements related to clinical staff refer to licensed mental disorder or SUD treatment providers such as psychologists, social workers, or drug and alcohol dependence counselors. Among the states requiring that substance abuse counseling generally be provided by licensed drug and alcohol dependence counselors are a few that expressly except from that requirement otherwise licensed professionals such as physicians or psychologists.<sup>60</sup> *Direct care staff*, as that term is used in this Compendium, means nonlicensed staff, or peer staff who may be certified, who are charged with day-to-day contact with residents. In all instances, SUD regulations are more likely to specify such staffing requirements.

TABLE 5. Number of States by Staffing Standards for Licensure				
Requirements	Mental Health	Partially <sup>a</sup> for Mental Health	Substance Use	Partially <sup>a</sup> for Substance Use
Standards				
Administrator	32	5	34	6
Medical Director	7	4	7	12
Medical staff	23	9	20	24
Clinical staff	3	2	37	10
Direct care staff	30	4	31	6
Staffing levels				
Ratios	18	9	17	17
Adequate	26	4	31	10
<b>NOTE:</b> Detailed in Tables A10-A12.				
a. <i>Partially</i> indicates that the characteristic or requirement is applicable to some but not all facility types in the state.				

We also examined the extent to which states incorporate staffing ratios or requirements for policies regarding ratios into regulations and/or require that there be “sufficient” or “adequate” staffing. In some instances, a state may use both approaches, often depending on facility type.<sup>61,62</sup> When ratios are prescribed, it typically is for certain types of personnel and not

others (e.g., nursing staff, clinical staff, direct care staff). Again, this is somewhat more likely to be seen in SUD regulations than in those governing mental health residential facilities. It also is likely that states without explicit ratios in regulations do include them in other policy documents or contracts.

For the second aspect of staffing, we looked at orientation and ongoing training requirements, as well as two selected potential foci of training, specifically staff training regarding trauma-informed care and regarding suicide assessment and/or prevention (or crisis intervention). Table 6 provides basic information on training standards that are incorporated into state regulations. Training requirements vary greatly. Some are specific as to orientation versus ongoing training, whereas others are not explicit about the timing for training. Some state regulations go into great detail about mandatory or optional training required of staff generally, in contrast to others that focus on training for specific staff types. Some, such as regulations governing personnel in residential mental health facilities in Iowa, vary the training requirements by level of care, for example, placing greater emphasis on training for staff at Intermediate Care Facilities for Persons with Mental Illness<sup>63</sup> than at Residential Care Facilities with a Three to Five-Bed Specialized License.<sup>64</sup>

States have many different areas on which they may elect to focus staff training. Training subjects range from first aid to dual diagnosis to restraint and seclusion (R/S), with many other topics emphasized by different states. More than four-fifths of states use regulations as a way to impose training requirements. The training requirements are highlighted in Table 6; training regarding trauma-informed care and regarding suicide assessment and/or prevention, are just two out of many possible subjects of regulation-mandated training. They were selected, however, because trauma-informed care is generally regarded as a best practice in both mental disorder and SUD treatment and because training related to suicide was selected as an indicator of focus on safety. More states require use of trauma-informed care, sometimes in conjunction with other requirements that staff be “qualified” to perform their job responsibilities, than do states that explicitly require staff training in trauma-informed treatment. One example of the former is Mississippi, which requires that all services be designed to provide trauma-informed care but does not include a specific regulatory requirement related to training in such care.<sup>65</sup> Similarly, although crisis services may be a fundamental part of the treatment spectrum in many states or suicide assessment explicitly must be conducted, not all state regulations are explicit in requiring more general suicide assessment and prevention training for staff. An example is Missouri, which requires suicide screening as part of admission assessment, “competent staff” to identify risks and behaviors that can lead to a crisis and the use of “effective strategies to prevent or intervene,” the development of crisis prevention plans where at-risk behavior including suicide is identified, and “ready access to crisis assistance and intervention ... provided by qualified staff,” but does not include an explicit requirement for suicide prevention and assessment training.<sup>66</sup> We include in Table 6 only those states that are explicit about requiring trauma or suicide-related (or crisis-related) training in regulations.

TABLE 6. Number of States by Training Requirements for Licensure				
Requirements	Mental Health	Partially <sup>a</sup> for Mental Health	Substance Use	Partially <sup>a</sup> for Substance Use
Orientation and/or ongoing training	31	10	36	11
Trauma-informed care training	4	0	5	1
Suicide assessment/prevention training	6	2	4	3
<b>NOTE:</b> Detailed in Table A13.				
a. <i>Partially</i> indicates that the characteristic or requirement is applicable to some but not all facility types in the state.				

Staffing in residential care is one of the few domains that was explicitly addressed in earlier research. Our scan found much lower rates of required training than was found in data from two short reports by the SAMHSA. SAMHSA examined this subject for mental disorder and SUD specialty treatment, using 2010 N-MHSS and 2013 N-SSATS data.<sup>67</sup> Those analyses examined three markers of quality assurance practices related to facility workforce. Practices varied considerably by state and by type of organization (e.g., private for-profit, private nonprofit, state government entities, Veterans Health Administration). Table 7, however, shows the results for the three measures in residential treatment settings for mental health and SUD respectively.

TABLE 7. Residential Treatment Facilities Using Workforce Quality Assurance Practices as Standard Operating Procedure, Mental Health 2010, SUD 2013		
Quality Assurance Practices	Mental Health Treatment (%) <sup>a</sup>	SUD Treatment (%) <sup>a</sup>
Continuing education requirement for professional staff	87.7	97.9
Regularly scheduled case review with supervisor	94.6	97.7
Regularly scheduled case review by appointed quality review committee	69.2	77.8
<b>SOURCE:</b> Sherman LJ, Lynch SE, Greeno CG, Hoeffel EM. <i>Behavioral Health Workforce: Quality Assurance Practices in Mental Health Treatment Facilities</i> . The CBHSQ Report. Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration; 2017.		

These measures reflect the data available from the surveys, which are voluntarily reported, but generally indicate that large numbers of the residential facilities surveyed followed these practices. These are not comparable to the data collected as part of this study, which relate to requirements found in state statutes and regulations and include neither facility-required training nor requirements imposed by nonregulatory sources. Nonetheless, even state statutes and regulations frequently include training requirements. These studies, however, highlight the widespread use of two practices that should be a basic part of treatment delivery, in particular, continuing education and regular case review with a supervisor, and a third less commonly used practice of case review by a quality review committee.

**Placement standards.** Placement in the appropriate setting and level of care is important to ensure that patients receive the care they need. For example, research shows that receiving SUD treatment in the appropriate type and intensity of care can positively affect treatment participation and retention, reduce use of more intensive services, and result in better outcomes than is true for those placed in a lower or, in some instances, a higher level of care than is recommended<sup>68</sup> by the ASAM Patient Placement Criteria.

To determine whether state placement oversight exists, we examined whether there were specific criteria for placement and/or assessment, including whether regulations delegated this function by way of facility policy and procedure requirements. Within the realm of SUD treatment, we looked at regulatory requirements related to use of the ASAM Patient Placement Criteria. Also included in the state summaries (Appendix B) are requirements regarding continued placement and discharge criteria.

Placement standards within state licensing regulations generally fall into four categories, more than one of which may be present in any given state:

1. Specific statements in the law about the population intended to be served by a given facility type.<sup>69</sup>
2. Requirements that facilities have policies or procedures setting forth requirements for and/or approaches to admission and determining if placement is appropriate.<sup>70</sup>
3. Specific requirements for how appropriate placement is determined and, sometimes, by whom, such as in New Hampshire residential SUD treatment facilities where, among other things, requirements include “a screening and assessment interview conducted or supervised by a licensed counselor to determine ... that the client meets the requirements for treatment of a substance use disorder; and ... a determination of the appropriate ASAM level of care needed.”<sup>71</sup> This also may be determined by role rather than by credential, such as in Idaho where the Department of Health and Welfare determines whether an individual is eligible for Crisis Intervention Services.<sup>72</sup>
4. Criteria or requirements for policies for continuing stay or discharge, such as Montana standards for chemical dependency facilities that require use of the ASAM Patient Placement Criteria to establish level of care for, in addition to placement, continued stay, discharge criteria, and ongoing assessment of the client.<sup>73</sup>

If any regulatory specificity is provided about population served or how to ascertain appropriateness, the analysis considers that specific placement criteria do exist. We identified these criteria for 33 (mental disorder) and 45 (SUD) states partially or fully (Table 8). We also treat regulations as requiring a screening or assessment for placement if it is clear that a placement assessment is required, for some or all facility types, either before admission (23 states and 31 states, respectively, for mental disorder and SUD residential treatment) or within 24 hours of admission (33 and 48 states, respectively for mental disorder and SUD residential

treatment). In some instances, early assessments are required, but regulations do not clearly indicate that it is part of placement determination; in those instances, we treat that as an “other” nonplacement assessment if required within 24 hours. Many states have additional requirements for ongoing assessments later in the early course of treatment, which we do not include in this study. For example, the Minnesota variance for IRTS requires that the LOCUS be used for assessment of suitability for the setting, to be conducted within 10 days of admission.<sup>74</sup>

If regulations require use of the ASAM Patient Placement Criteria for SUD treatment level of care determination, or if state staff so indicated, we specifically included that. Thirty-six states were identified as relying on the ASAM criteria for placement in SUD residential treatment. This excludes other states that may require it as part of Medicaid regulations, through policy documents, or by contract. In contrast, although an assessment may be required, it is uncommon for state regulations to indicate a specific tool for admission to residential mental disorder treatment. Among the rare instances in which a regulation approached doing so was in Utah, where service providers who contract with the Division of Substance Abuse and Mental Health and County Local Authority programs are subject to regulations that require levels of care to be “based on the ASAM or equivalent Mental Health criteria.”<sup>75</sup>

TABLE 8. Number of States Regulating Placement Criteria				
Requirements	Mental Health	Partially <sup>a</sup> for Mental Health	Substance Use	Partially <sup>a</sup> for Substance Use
Criteria for placement				
Specified in regulations	26	7	38	7
Facility policy required	17	1	30	3
Placement assessment	31	2	44	4
ASAM for placement	1	1	23	13
Timing of assessment				
Before admission for placement	18	5	23	8
Within 24 hours for placement	5	1	5	7
Within 24 hours nonplacement assessment	9	3	9	8
<b>NOTE:</b> Detailed in Table A14 and Table A15.				
a. <i>Partially</i> indicates that the characteristic or requirement is applicable to some but not all facility types in the state.				

**Treatment and discharge planning and aftercare requirements.** Treatment planning and regular review of treatment plans are critical to ensure that appropriate treatment is in place, delivered, and adjusted when required. In addition, discharge or aftercare planning is important to determine whether the treatment plan and delivery are pointed in the intended direction, working toward objectives of recovery and ongoing treatment outside of the residential setting. In addition to examining these requirements, we also analyzed whether states had in place provisions related to residential delivery of aftercare or follow-up, in the interest of continuity of care and avoiding loss to treatment.

Most state regulatory structures include a requirement for treatment or service planning; we located 44 and 48 states with such regulatory requirements applied to mental disorder and SUD residential treatment, respectively, either partially or fully (Table 9). It is more common that states fail to include such a requirement in very short-term services such as Vermont’s residential and withdrawal management SUD treatment if a person is present fewer than 6 days.<sup>76</sup> It also is common to see requirements for time to completion and timing of review, although we identified them more frequently in regulations pertinent to SUD residential treatment than mental health. These requirements are generally specific but, in some instances, may be requirements that must only be established in policies or procedures by the facility or, for timing of review, as required in the individual’s treatment plan.

Discharge planning often is required (by more than 60% of states and more so for residential SUD treatment), sometimes as early as upon admission, such as for Illinois’ Crisis Stabilization Units.<sup>77</sup> Discharge planning also is often referred to as aftercare planning. In a very few instances, however, aftercare actually may encompass provision for contact with the client after discharge, such as following residential SUD treatment,<sup>78</sup> or, less commonly, a clear option for ongoing aftercare by a residential SUD treatment facility.<sup>79</sup>

TABLE 9. Number of States with Requirements Regarding Treatment or Discharge Planning or Aftercare Services				
Requirements	Mental Health	Partially <sup>a</sup> for Mental Health	Substance Use	Partially <sup>a</sup> for Substance Use
Treatment plan required	42	2	43	5
Timeframe to complete	26	8	30	10
Timeframe to review	30	5	28	14
Discharge plan required	32	5	42	4
At admission or shortly thereafter	13	7	13	8
Aftercare services/follow-up required	2	3	6	5
<b>NOTE:</b> Detailed in Table A16 and Table A17.				
a. <i>Partially</i> indicates that the characteristic or requirement is applicable to some but not all facility types in the state.				

**Treatment services.** Ensuring the provision of evidence-based or best practice treatment is crucial to maintaining high-quality residential services for M/SUDs. Given the range of types and levels of treatment, we focused on whether therapeutic services were required by the regulations, if amount was specified, and whether states included requirements regarding evidence-based or best practice treatment. One specific evidence-based practice, examined within the realm of service delivery, was medication treatment as part of MAT specific to residential settings,<sup>80</sup> discussed in greater detail below.

Because we excluded residential facilities that do not provide clinical treatment (excepting some withdrawal management facilities), most residential treatment facility regulations did include at least some reference to services to be provided, including clinical services (Table 10). Whenever regulations mandated some form of clinical treatment, even if only referencing “treatment,” “counseling,” “psychological,” or “therapeutic” services or, in the case of

withdrawal management, nursing services, we considered that the state had service requirements specific to clinical service types. When regulations specify the number of hours of clinical treatment, that is indicated separately because it is less commonly included in regulations and more likely to be in a policy or contractual document. In all instances, these requirements were most commonly found in regulations applicable to residential SUD treatment than to residential mental disorder treatment.

To determine whether evidence-based or best-practice requirements were in place, we included states where “evidence-based” practices or “best practice” were required by the regulations. For example, the Colorado Office of Behavioral Health regulations require that a “best practice” comprehensive assessment be used for both M/SUD residential treatment at placement<sup>81</sup> and that “evidence-based” practices be used in crisis stabilization units.<sup>82</sup> We also included states where trauma-informed care,<sup>83</sup> motivational interviewing,<sup>84</sup> or MAT<sup>85</sup> is explicitly required to be used or, in the case of the last, available, although these requirements may vary by facility type within states. We identified such regulatory requirements for 11 (mental health) and 26 (SUD) states, partially or fully. We recognize that there are other evidence-based treatments, but we selected these as representative approaches that are most likely to be reflected in regulatory language.

Requirements	Mental Health	Partially <sup>a</sup> for Mental Health	Substance Use	Partially <sup>a</sup> for Substance Use
Any service requirements	45	1	51	0
Specific to clinical service types	33	6	41	6
Specific to clinical service hours	5	5	9	17
Evidence-based	9	2	11	15
<b>NOTE:</b> Detailed in Table A18.				
a. <i>Partially</i> indicates that the characteristic or requirement is applicable to some but not all facility types in the state.				

Given the importance of MAT as an evidence-based treatment for opioid use disorder (OUD) and alcohol use disorder (AUD), additional attention was paid to the incorporation of requirements for MAT into regulations specific to residential treatment. Medications for OUD include methadone, buprenorphine, and naltrexone and for AUD include naltrexone, acamprosate, and disulfiram.<sup>86</sup>

Table 11 identifies the states that have explicit requirements for residential treatment related to receipt of MAT services. Only about a third of the states require it for SUD residential treatment, and only a fraction for mental health facilities. State regulations may expressly allow or require MAT to be offered or access to it provided (18 states for SUD, fully or partially), may prevent providers from denying access to SUD treatment because a person is receiving MAT (eight states for SUD, fully or partially), or may establish a right to receive or be offered MAT (ten states for SUD, fully or partially). One approach is to allow a residential provider to offer MAT if it is suitably licensed.<sup>87,88</sup> Some states explicitly require MAT in residential detoxification



or withdrawal management facilities,<sup>89</sup> and some require the provision of medication in such facilities but are not specific about it being MAT (e.g., “medication should be available to manage withdrawal/intoxication from all classes of abusable drugs”).<sup>90</sup> States also may require that residential or other SUD providers not discriminate against<sup>91</sup> or deny services to<sup>92</sup> an individual because he or she is receiving MAT. In Utah, all service providers contracting with the Division of Substance Abuse and Mental Health and all County Local Authority programs must provide written information to every treatment participant regarding rights to MAT<sup>93</sup> and, in community-based treatment programs, all individuals with AUD and/or OUD must be educated and screened for the potential use of MAT.<sup>94</sup>

TABLE 11. Number of States with Regulations Regarding MAT Specific to Residential Treatment				
Requirements	Mental Health	Partially <sup>a</sup> for Mental Health	Substance Use	Partially <sup>a</sup> for Substance Use
Requirements for MAT services	1	1	6	12
MAT and access to SUD treatment	1	1	5	3
Rights to MAT in residential treatment	2	0	6	5
<b>NOTE:</b> Detailed in Table A19.				
a. <i>Partially</i> indicates that the characteristic or requirement is applicable to some but not all facility types in the state.				

**Service recipient rights.** Statutes and regulations governing service recipient or patient rights evolved out of a history of maltreatment in some institutions. The range of rights is broad and varies across states. For that reason, in addition to identifying if rights of any sort were memorialized by law, we selected two discrete aspects of service recipient rights for quantification. These related to: (1) the right to voice grievances, taken as an indicator of the ability of service recipients to enforce their rights in general; and (2) rights related to restraint and seclusion, because restraint and seclusion affect both safety and dignity. We examine above the express right to receive MAT in residential treatment.

Service recipient rights may include the right to informed consent, privacy, communication, to be treated with dignity, to be treated in the least restrictive appropriate setting, and to be free from abuse, neglect, or exploitation, among many other frequently enumerated rights for individuals in the M/SUD treatment system. In Table 12, we indicate whether any such rights were located that were applicable to residential treatment within the states. Laws regarding service recipient rights were identified in 42 and 45 states, for mental disorder and SUD residential treatment.

The right to voice grievances is commonly found in state statutes and regulations and is indicative of the ability of service recipients to enforce their rights. We located such rights in 37 and 42 states, for mental disorder and SUD residential treatment, respectively, fully or partially. As an example, the state of New Hampshire relies on a statutory “Patients’ Bill of Rights,”<sup>95</sup> which includes requirements that patients be “encouraged and assisted throughout the patient’s stay to exercise the patient’s rights as a patient and citizen. The patient may voice grievances and recommend changes in policies and services to facility staff or outside

representatives free from restraint, interference, coercion, discrimination, or reprisal.” States also may expand on statutory rights by regulation, for example, establishing procedures for submitting complaints or grievances and having them addressed and, occasionally, requiring that information on grievances be reported to the state.<sup>96</sup> Regulations requiring that grievances be reported to the state are not the norm, and some states do not, by regulation, require the reporting of grievances in residential SUD treatment but rather ensure service recipients of the general right to “contact the Department,”<sup>97</sup> placing the onus, at least in the regulations, on the recipient rather than on the provider.

Recipient rights related to restraint or seclusion reflect the fact that these behavior management techniques have repercussions both for safety and dignity. States take different approaches in their statutes and regulations regarding restraint and seclusion. These include: (1) no mention of these behavior management techniques in regulations; (2) prohibitions and/or restrictions on one or all of seclusion or physical, mechanical or chemical restraints; or (3) applying different requirements to different categories of facilities. One example of the latter two approaches is Indiana, which prohibits chemical restraints and allows physical restraint or seclusion only in Sub-acute Stabilization Facilities.<sup>98</sup> Regulatory requirements that restraint or seclusion be reported to the state are relatively uncommon, although they do appear, as for instance in Kansas regulations governing residential mental disorder treatment that require that it be reported if it “results in serious injury to the consumer.”<sup>99</sup> As shown in Table 12, 42 (mental disorder) and 37 (SUD) states have some formalized rights regarding restraint or seclusion. It is completely prohibited in one state’s mental health regulations and partially prohibited in another 18 states. It is completely prohibited in five state’s SUD regulations and partially prohibited in 13 states. The majority of states that permit some form of restraint or seclusion have regulations regarding how they may occur.

TABLE 12. Number of States with Regulations Regarding Service Recipient Rights				
Requirements	Mental Health	Partially <sup>a</sup> for Mental Health	Substance Use	Partially <sup>a</sup> for Substance Use
Recipient Rights	42	0	45	0
Complaints/Grievances	34	3	39	3
Complaints reported to state	2	6	4	7
Rights re Restraint/Seclusion	39	3	34	3
Restraint/Seclusion Prohibited	1	18	5	13
Restraint/Seclusion Regulated	24	16	17	12
Restraint/Seclusion reported to state	5	3	2	1

**NOTE:** Detailed in Table A20 and Table A21.  
a. *Partially* indicates that the characteristic or requirement is applicable to some but not all facility types in the state.

**Quality assurance or improvement.** It is important to understand a wide range of aspects related to quality. For example, are there standards for high-quality safe treatment in place and is compliance with those standards monitored and enforced? To some extent, all the domains identified in this Compendium ultimately feed into quality. For purposes of examining quality assurance or improvement, specifically, we collected information on regulatory requirements for quality assurance or improvement plans, including whether some form of

measurement was required to be integrated into those plans and whether either the plan or the results of implementation must be provided to the state.

Table 13 identifies the number of states with quality assurance/quality improvement (QA/QI) requirements within their regulations (37 [mental disorder] and 48 [SUD], partially or fully). Some states have explicit and very detailed requirements, such as Colorado, which requires that all facilities designated or licensed by the Office of Behavioral Health, or that contract with Office of Behavioral Health, have a program that monitors, evaluates, and initiates quality improvement activities. Among other things, this includes requirements for a written plan, quality measures of performance, documentation of quality improvement findings incorporated into clinical and organizational planning, and an annual evaluation that results in an update to the quality improvement plan as necessary. Colorado requires that the annual findings and report be available for review.<sup>100</sup> A few jurisdictions explicitly require data or plan submission (one [mental disorder] and 15 [SUD] partially or fully). For example, Minnesota requires that specific data related to residential mental disorder treatment facilities be submitted to the state and other data to the pertinent county.<sup>101</sup> In two states, facilities must undertake an assessment of need for residential SUD treatment.<sup>102</sup> Other states, such as Idaho, do not require quality assurance or performance improvement by regulation but do so, instead, under terms of contracts with entities receiving public funding.<sup>103</sup> All of these requirements are more abundant in the regulations governing residential SUD treatment than in the mental health regulations, including requirements for measurement as part of the plan.

TABLE 13. Number of States with QA/QI Regulations				
Requirements	Mental Health	Partially <sup>a</sup> for Mental Health	Substance Use	Partially <sup>a</sup> for Substance Use
QA/QI requirement	34	3	46	2
Written plan/policy	27	3	38	2
Needs assessment	0	0	2	0
Measurement	19	7	26	7
Provide to state	0	1	5	10
<b>NOTE:</b> Detailed in Table A22.				
a. <i>Partially</i> indicates that the characteristic or requirement is applicable to some but not all facility types in the state.				

**Governance standards.** Facility governance concerns who is accountable for facility performance and safety and how they are tasked with responsibility. This study examined the extent to which states have some form of governance requirements in place. Many state licensing or oversight regulations include a requirement that facilities have a governing body or other entity responsible for facility governance or oversight. These requirements may be quite detailed in terms of matters the governing body must address.<sup>104</sup> Table 14 identifies the number of states in which requirements for governing bodies were located, with more than half of all states having regulations requiring this for mental disorder and SUD residential treatment. Although not included in this table, it is even more likely that state regulations will include requirements related to policies and procedures that effectively govern how the facility is operated. Those policies can touch on any or all aspects of factors explored in this

Compendium (e.g., personnel, admission and discharge requirements, patient rights, quality assurance).

TABLE 14. Number of States with Governing Body Regulations				
Requirements	Mental Health	Partially <sup>a</sup> for Mental Health	Substance Use	Partially <sup>a</sup> for Substance Use
Governing body requirements	30	6	38	3
<b>NOTE:</b> Detailed in Table A23.				
a. <i>Partially</i> indicates that the characteristic or requirement is applicable to some but not all facility types in the state.				

**Special populations.** States often focus on specific vulnerable populations to ensure that adequate services are available for them. To some extent, this reflects requirements for states to receive block grant funding, such as those for the SAMHSA Substance Abuse Block Grants regarding pregnant women and injection drug users.<sup>105</sup> Within the state summaries (Appendix B), we compile the different populations targeted, focusing in Table 15 on dual diagnosis, pregnant, and parenting women, and injection drug users, with a varied category of “other.”

It is unusual for residential mental health facilities to be subject to regulations regarding provision of services to specific populations (Table 15). When there are such requirements, they tend to apply to facilities receiving public funds<sup>106</sup> and/or relate to individuals with a co-occurring SUD.<sup>107</sup> Regulatory requirements related to special populations most frequently apply to SUD treatment facilities. For such facilities, requirements related to individuals with dual diagnosis (29 states, partially or fully) or pregnant and parenting women (27 states, partially or fully) tend to be most frequently specified in the regulations. Some regulations also include requirements related to injection drug users (13 states, partially or fully). Specific requirements related to pregnant women or injection drug users in SUD treatment are generally attributable to federal block grant requirements and may exist in some states in regulations not examined as part of this licensure survey or may be in separate policy or contract documents, as is the case in Idaho, Texas, Vermont, and other states. In addition to the most frequently prioritized populations, other categories also appear in state regulations. A few salient examples, out of more than 20 special populations, include individuals with cognitive impairment due to substance use or co-occurring conditions,<sup>108</sup> those who have experienced traumatic events,<sup>109</sup> and individuals with a history of criminal justice involvement.<sup>110</sup>

TABLE 15. Number of States with Regulations Regarding Special Populations				
Requirements	Mental Health	Partially <sup>a</sup> for Mental Health	Substance Use	Partially <sup>a</sup> for Substance Use
Dual diagnosis	9	6	27	2
Pregnant and parenting women	1	0	25	2
Injection drug users	0	0	11	2
Other	9	3	19	4
<b>NOTE:</b> Detailed in Table A24.				
a. <i>Partially</i> indicates that the characteristic or requirement is applicable to some but not all facility types in the state.				

## **SECTION 3. OVERVIEW OF STATE MEDICAID REQUIREMENTS FOR RESIDENTIAL TREATMENT**

Medicaid is the largest payer of behavioral health services in the United States.<sup>111</sup> As such, regulation and oversight of Medicaid-enrolled providers by state Medicaid programs can have an outsized influence on the structure and quality of behavioral health treatment. Especially since CMS expanded the possibilities of Medicaid reimbursement for residential behavioral health treatment with the Section 1115 demonstrations, Section 1115 demonstration requirements have been seeping into the Medicaid regulations as well as into other state laws and regulations, including those pertaining to licensure. Hence, there is both an overlay of Medicaid with licensure requirements and influence by the Medicaid requirements on a broader range of programs. In addition, state Medicaid programs require that providers be licensed or certified in accordance with applicable laws in order to be enrolled in Medicaid. This has the effect of incorporating state licensure requirements into the Medicaid requirements, bolstering what Medicaid can expect of its providers.

As with the overview of non-Medicaid residential treatment regulations, as part of our review of Medicaid requirements we examined two domains, specifically: (1) standards regarding processes of oversight; and (2) standards regarding facility operation that are conditions of Medicaid enrollment and participation. Each domain and many of the subdomains addressed in Section 2 (hereinafter *domains*) is addressed in turn below, with explanation for why each domain is important to the regulation and oversight of Medicaid providers of residential treatment, what each domain encompasses, and a discussion of major findings. First, however, we examine the sources of state Medicaid authority to reimburse residential treatment.

In researching state Medicaid requirements, we primarily relied on state Medicaid regulations and Section 1115 demonstration documents, supplementing as necessary with additional sources. The relative absence of certain requirements in state Medicaid regulations, however, does not mean that Medicaid programs do not have service requirements in provider agreements with Medicaid or MCEs, provider manuals, or elsewhere. Similarly, some states may more passively rely on the presence of licensure requirements to ensure that service standards are in place.

### **Sources of State Medicaid Authority to Reimburse Residential Treatment**

Historically, M/SUD treatment was not reimbursed as robustly as other medical care. Treatment relied heavily on public funding such as state and more local funding, as well as SAMHSA block grants. Requirements for reimbursement of M/SUD treatment were improved by the federal Mental Health Parity and Addiction Equity Act of 2008 and the 2010 Patient Protection and Affordable Care Act.<sup>112</sup> Insurance coverage for residential treatment, however, continued to be more restricted than was the case for community-based care.

Within Medicaid, these coverage restrictions stem from the Institution for Mental Disease (IMD) exclusion from reimbursement, which prevents the use of federal matching dollars for treatment in settings with more than 16 beds that primarily provide services to individuals with mental disorders, including SUDs.<sup>113</sup> This exclusion presently applies to Medicaid beneficiaries from ages 21-64 years and pertains to both residential and specialty M/SUD inpatient settings.<sup>114</sup> To expand access to care for Medicaid beneficiaries, states are now able to avoid the IMD exclusion and use Medicaid funds to pay for care in IMDs through: (1) use of Section 1115 demonstration waivers whereby states may apply to use federal funds for services in an IMD; (2) managed care rules allowing Medicaid managed care plans to pay for treatment in an IMD “in lieu of” more expensive state plan services (e.g., care in an acute general hospital setting) for no more than 15 days in a calendar month and no more than 30 days over 2 months; and (3) use of disproportionate share hospital (DSH) payments for uncompensated care costs. Very recently, state plan options under the Substance Use Disorder Prevention That Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act were authorized to enable use of Medicaid funds to cover SUD treatment in an IMD for up to 30 days in a year; this option also codifies allowance of Medicaid managed care payment in an IMD for up to 15 days in a given month.<sup>115,116</sup>

This history has resulted in a patchwork of sources of state Medicaid authority to reimburse residential treatment, both in and outside IMDs, and considerable disparity between states regarding what is covered and how clear it is that residential treatment is, in any fashion, reimbursed. Some states have historically reimbursed some form of residential treatment not in an IMD (i.e., 16 or fewer beds) pursuant to their state plan,<sup>117</sup> and some reimburse not residential treatment per se but rehabilitation or other services provided in residential settings as well as in other locations.<sup>118</sup> Wyoming, for example, allows certain services to be reimbursed in residential settings, but they are treated as agency-based rather than community-based services and the setting is treated as an extension of the agency office. Thus, the services of individual or family therapy or collateral contacts are billed as agency services and regulated as they would be if the services were offered in an outpatient clinic or other setting, with the apparent result that the residential treatment facility itself is not enrolled in Medicaid.<sup>119,120</sup> Some states have relied on DSH payments and/or, with changes in managed care rules, the “in lieu of” provision to cover some services provided in IMDs.<sup>115</sup> Increasingly, however, states are seeking Section 1115 demonstration approval from CMS to reimburse M/SUD treatment in IMDs, generally of shorter-term stays.<sup>121</sup>

For purposes of this Compendium, some states have no evidence of residential treatment in their Medicaid regulations or elsewhere but may allow reimbursement based on the general standards of their Medicaid program such as the “in lieu of” provision. Others have more or less detailed regulations or policy documents that address residential requirements. Finally, some have detailed Section 1115 demonstration implementation plans approved by CMS, the contents of which may or may not be reflected in regulations and/or other policy documents. Table A21 and Table A22 in the Appendix identify sources of state Medicaid authority to reimburse residential M/SUD treatment in an IMD. This Compendium and the accompanying

summaries do not go into detail regarding sources of authority for treatment in nonIMDs but do include identified state requirements related thereto.

Only five states appear to have no mechanism for avoiding the IMD exclusion and covering at least some care in IMD settings. Additionally, the Medicaid reimbursement for IMD services is much more likely in a SUD than in a mental health facility. Table 16 summarizes the number of states relying on Section 1115 demonstrations, “in lieu of” reimbursement, and DSH payments for Medicaid reimbursement of M/SUD treatment in an IMD, as well as the number with no evidence of any reimbursement in an IMD. More than four times as many states have approved Section 1115 demonstrations that allow reimbursement of treatment for SUD than for mental disorder in an IMD residential setting. As of early 2020, more than half of all states had approved Section 1115 waivers for SUD. The information on Section 1115 demonstrations is current as of early January 2020; however, several states have pending applications and others, doubtless, will also apply. These numbers are subject to relatively rapid change. In addition, and not included in Table 16, states such as Alaska and Oregon have Section 1115 waivers that address mental disorder residential treatment but not in an IMD.

An even larger number of states relied on the “in lieu of” provision and/or DSH payments for reimbursement of some services in an IMD. As identified in Table A21 and Table A22, many states have relied on both and some on only one of these two approaches. The information about state reliance on “in lieu of” and DSH payments derives from a November 2019 synthesis by the Kaiser Family Foundation<sup>121</sup> that does not distinguish between payments for mental disorder versus SUD treatment or between payments for IMDs that are residential versus specialty inpatient.

Finally, the last column of Table 16 identifies that there are five states for which we found no evidence of reliance on any of the three approaches to reimbursing for treatment in any type of IMD for any M/SUD coverage. Notably, one of these five states (Idaho) presently has a pending Section 1115 application to allow coverage of residential treatment in an IMD for both mental disorder and SUD treatment.

<b>TABLE 16. Sources of State Medicaid Authority to Reimburse Behavioral Health Treatment in IMDs, Number of States</b>				
<b>Source of Authority</b>	<b>Mental Health</b>	<b>Substance Use</b>	<b>Mental Health and/or Substance Use</b>	<b>No Evidence of Any IMD Coverage</b>
1115 demonstration (IMD residential)	4	28		
“In lieu of” (residential and/or inpatient IMD) <sup>a</sup>			33	
DSH (residential and/or inpatient IMD) <sup>a</sup>			32	
No evidence of any IMD coverage				5
<b>NOTE:</b> Detailed in Table A25 and Table A26.				
a. Musumeci M, Chidambaram P, Orgera K. <i>State Options for Medicaid Coverage of Inpatient Behavioral Health Services</i> . Kaiser Family Foundation; November 2019. <a href="http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services">http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services</a> .				

## Domains Regarding Processes of Oversight

Domains regarding processes of oversight include categorization of enrollable facilities and processes of Medicaid enrollment and basic oversight.

**Categorization of Medicaid facilities.** As was true for licensure requirements, Medicaid enrollment requirements for residential mental health treatment are less common and less elaborate than is true for residential SUD treatment in most states. Table A23 and Table A24 include the state-by-state categorization of mental disorder and SUD residential treatment, respectively, within state Medicaid programs.

Table 17 identifies the number of states with different categorizations of residential mental disorder treatment, separated into whether the enrollment is specific to IMDs or nonIMDs. It is very common for these mental health facilities to bear unique labels that prevent categorization beyond “other.” The largest number, however, are crisis facilities, some of which are specific to mental disorders and some of which also appear in the SUD table (Table 18). A total of 18 states provide evidence of Medicaid coverage for residential crisis treatment for mental disorders, four in IMDs, 15 in nonIMDs, including Massachusetts, which appears in both categories. All of these are, by definition or de facto, intended to be short-term. Among the four states where mental health services are reimbursable in a crisis facility that is an IMD, all require a statewide average length of stay of 30 days, but the District of Columbia waiver also explicitly limits the Medicaid coverage to no more than 60 days.<sup>122</sup> Only Texas identifies a nonIMD short-term mental disorder residential treatment facility for coverage that is not a crisis facility, although the state also covers nonIMD crisis facilities. The covered noncrisis facilities in Texas are categorized here as short-term/transitional, and they provide short-term day programs for acute needs in a residential facility with fewer than 17 beds.<sup>123</sup>

TABLE 17. Number of States With Different Categories of Residential Mental Disorder Treatment Facilities That Can Enroll in Medicaid			
IMD Status	Crisis	Short-Term/ Transitional	Other
IMD	4	0	0
NonIMD	15	1	16
Overlap	1	0	0

**NOTES:** Detailed in Table A27.  
Massachusetts Section 1115 waiver includes crisis units as diversionary facilities for both IMDs and nonIMDs and only for the population enrolled in managed care. Massachusetts crisis facilities are included in both rows.

Table 18 identifies the number of states with different categorizations of residential SUD treatment, separated into whether the enrollment is specific to IMDs or nonIMDs. To simplify, we relied on categories of crisis, clearly identified ASAM levels, short-term facilities, and other nonwithdrawal management and withdrawal management (WM) facilities, with overlap



between categories. The large number of states with identified ASAM Level 3 or residential levels of care reflect the use of Section 1115 waivers. In addition, the IMDs that fall under either of the “other” categories reflect Section 1115 waivers where the precise levels are not identified in the waiver documents reviewed.

TABLE 18. Number of States with Different Categories of Residential SUD Treatment Facilities That Can Enroll in Medicaid										
IMD Status	Crisis	ASAM Level 3.1	ASAM Level 3.3	ASAM Level 3.5	ASAM Level 3.7	Short-Term	Other NonWM	ASAM Level 3.2-WM	ASAM Level 3.7-WM	Other WM
IMD	1	21	17	21	18	25	5	15	16	5
NonIMD	7	8	5	7	5	5	11	3	4	6
Overlap	1	5	4	5	2	4	4	3	3	3

**NOTE:** Detailed in Table A28.

**Processes of enrollment and basic oversight.** In this section, we look at some basic indicators of oversight that may be incorporated into state Medicaid enrollment processes. Even if we were unable to determine that any residential treatment is reimbursed by a given state Medicaid program, we gathered this information to ensure that the reader is aware of the presence or absence of these processes, in the event reimbursement of residential treatment is available. Specifically, we looked at whether state licensure is required to obtain enrollment, whether duration of Medicaid is identified, whether inspection is required at enrollment or otherwise by the Medicaid agency, and whether accreditation is required for enrollment.

One of the most critical findings is that all states require that providers that wish to enroll in Medicaid be licensed or certified in accordance with applicable laws. Most states have fairly broad requirements, but some are more specific, requiring licensure for enrollment if licensure is required to provide those services in their state.<sup>124</sup> In theory, this leaves an opening for enrollment of provider types for which there are no licensure requirements. The general requirement of licensure or certification, however, has the very important effect of incorporating by reference all of the state licensure requirements into the Medicaid requirements, broadening state Medicaid requirements beyond what is apparent in the remainder of this section of the Compendium that focuses on explicit Medicaid requirements.

Requirements related to the duration of facility enrollment and the time between enrollment and reenrollment or revalidation are often less than precise in state Medicaid regulations. Such requirements were not located for all states and, for some, reenrollment may be required “from time to time”<sup>125</sup> or based on results of an audit (e.g., Vermont, every 1-3 years).<sup>126</sup> It is important to note, however, that this requirement, as well as others such as inspections by the Medicaid agency or accreditation requirements imposed by the Medicaid agency, may be reflected in other documents rather than in regulations. Locations for requirements related to enrollment also might include provider agreements with Medicaid or MCEs, provider manuals, or enrollment guidance on state websites. Similarly, some states may rely on licensure requirements to ensure that inspections occur or, in some cases, that accreditation is required.

TABLE 19. Number of States with Different Processes of Medicaid Enrollment Fully or Partially Present		
Requirements	Mental Health	Substance Use
State licensure/certification required	51	51
Enrollment duration specified	13	15
Inspections by Medicaid agency required	11	10
Accreditation required	3	4
<b>NOTE:</b> Detailed in Table A29.		

## Domains Regarding Facility Operations

Domains regarding facility operations include standards regarding staffing, placement, treatment and discharge planning, care coordination and aftercare requirements, treatment services provided (including MAT), quality assurance or improvement, and requirements related to special populations.

**Staffing standards.** Qualified staff at all levels are important to the provision of quality care in residential treatment. In our examination of state Medicaid requirements, we examined, first, requirements regarding staffing (Table 20) and, second, regarding staff training (Table 21).

The focus of the first was on quantifiable standards, such as whether there are any requirements related to facility administrators, medical directors, other medical staff, clinical staff, or direct care staff. States may approach this as simply as requiring that there be an administrator, or, instead, may specify educational credentials and/or experience. We also examined the extent to which states incorporate staffing ratios and/or require that there be “sufficient” or “adequate” staffing. Finally, in order to provide an overall sense of whether the Medicaid standards reviewed included any staffing requirements, Table 20 also provides that information. As may be seen in Table 20, specific staffing requirements as part of state Medicaid regulations are relatively uncommon but more frequently found, for some or all Medicaid-enrolled facilities, regarding SUD than mental disorder residential treatment.

As noted before, however, all state Medicaid programs require appropriate licensure or certification of enrolled providers (both facilities and individual providers), and it appears that most rely on the licensure requirements for explicit staffing standards related to specific facility types. Similarly, many state Medicaid programs no doubt rely on M/SUD provider manuals or on contracts between the Medicaid agency or its MCEs and providers. In addition, states with Section 1115 waivers are required to implement certain activities related to staffing, with waiver documents usually including requirements that the state “establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding credentials of staff for residential treatment settings.”<sup>127</sup> As an example, Michigan has implemented requirements in its provider manual<sup>128</sup> and requires by contract that its Medicaid

health plans “conduct ongoing validation and revalidation of provider credentials.”<sup>127</sup> More significantly, both those waivers and separate requirements put in place by states lead to incorporation of the ASAM standards as expectations for facilities providing SUD residential treatment. The ASAM standards vary in the degree to which they specify staffing type, but the Level 3.7-WM standards in particular are fairly detailed regarding medical personnel.<sup>28</sup>

<b>TABLE 20. Number of States with Medicaid Requirements for Staffing in Residential Facilities</b>		
<b>Requirements</b>	<b>Mental Health<sup>a</sup></b>	<b>Substance Use<sup>a</sup></b>
Standards		
Administrator	4	5
Medical director	1	3
Medical staff	8	16
Clinical staff	8	15
Direct care staff	5	8
Staffing levels		
Include ratios	3	3
Require adequate staffing	5	4
Any staffing requirements	24	35
<b>NOTE:</b> Detailed in Table A30.		
a. The characteristic or requirement is either fully or partially applicable to all facility types in the state. If partially applicable, it is required of some but not all facility types.		

For the second aspect of staffing, we looked at: (1) orientation and ongoing training requirements; (2) two selected potential foci of training, specifically staff training regarding trauma-informed care and regarding suicide assessment and/or prevention (or crisis training); and (3) whether any Medicaid requirements existed regarding staff training. Very few states include requirements regarding staff training in Medicaid regulations for some or all Medicaid-enrolled facilities (Table 21), although it is possible that more exists in the form of contracts with providers. With regard to our two exemplar training topics, trauma-informed care and suicide assessment/prevention or crisis training, only one state Medicaid program required training related to either in the documents examined or pursuant to state staff report. Nebraska Medicaid requires, for psychiatric residential rehabilitation, that all staff be educated or trained in trauma-informed care,<sup>118</sup> and Maryland Medicaid requires, for all Level 3 SUD treatment facilities, that there be staff trained in crisis intervention or management.<sup>129</sup>

<b>TABLE 21. Number of States with Medicaid Requirements for Staff Training in Residential Facilities</b>		
<b>Requirements</b>	<b>Mental Health<sup>a</sup></b>	<b>Substance Use<sup>a</sup></b>
Orientation and/or ongoing training	1	2
Trauma-informed care training	1	0
Suicide assessment/prevention or crisis training	0	1
Any training requirements	4	6
<b>NOTE:</b> Detailed in Table A31.		
a. The characteristic or requirement is either fully or partially applicable to all facility types in the state. If partially applicable, it is required of some but not all facility types.		

**Placement standards.** Placement in the appropriate setting and level of care is important to ensure that patients receive the care they need and that Medicaid funds are not expended for either unnecessary or inadequate care. To determine whether state Medicaid agency placement oversight exists, we examined whether there were specific criteria for placement and/or assessment, for some or all Medicaid-enrolled facilities, including whether regulations delegated this by way of facility policy and procedure requirements. Within the realm of SUD treatment, we looked at Medicaid requirements related to use of the ASAM Patient Placement Criteria. We exclude from the numbers shown in Table 22 basic requirements for prior authorization, which act as a filter for payers such as Medicaid. Many of the detailed state summaries, however, mention requirements for prior authorization as well as requirements for continued stay and discharge criteria.

As Table 22 indicates, specific placement criteria were identified in Medicaid requirements in slightly less than half and nearly four-fifths of the states for mental disorder and SUD residential treatment respectively. Somewhat fewer of each included language clearly providing information regarding the process of placement assessment or screening. The larger number for SUD treatment reflects, in large part, adoption of the ASAM placement criteria, identified as necessary in 31 of 51 jurisdictions, many through standard Section 1115 IMD waiver requirements as well as waiver implementation plans. Nearly universal language for the approved demonstrations specifies that the state must establish a requirement that providers and sometimes MCEs “assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the ASAM Criteria or other comparable assessment and placement tools that reflect evidence-based clinical treatment guidelines.” The state also is required to establish “a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings.”<sup>130</sup> Unlike state licensing requirements, state Medicaid programs do not typically have a practice of requiring facilities to adopt policies and procedures to address placement. Rather, it is likely that states rely on the fact that licensure requirements often take that approach. It also is possible that Medicaid programs have these and other requirements in provider agreements with Medicaid or MCEs or in provider manuals.

Of separate interest are the requirements that are found for residential mental disorder treatment. Most requirements involve descriptions of whom different types of residential treatment are designed to serve. Some specify that assessments occur to ensure that placement is correct. There are, however, at least three states with somewhat specific requirements related to identified tools for placement. All three have different approaches to these requirements. The District of Columbia has an approved Section 1115 waiver permitting Medicaid coverage for both mental disorder and SUD residential treatment. The approval required adoption of “an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association (e.g., LOCUS or CASII) to determine appropriate level of care and length of stay,” and the District has opted to use the “Level of Care Utilization System (LOCUS) level of care assessment tool to ensure that services to adults are individualized, clinically appropriate, and least restrictive. The LOCUS assists in determining

the appropriate level of care and treatment interventions are based on individualized clinical assessments. LOCUS evaluations must be used at intake, during treatment plan development, when a consumer is in crisis, and when a level of care change is needed.”<sup>122</sup> In contrast, Nevada has adopted the LOCUS as part of the state Medicaid Services Manual,<sup>131</sup> which is incorporated by reference into the administrative rules, and Maine agency staff indicated during validation that the LOCUS is required by the state Medicaid program.<sup>132</sup>

<b>Requirements</b>	<b>Mental Health<sup>a</sup></b>	<b>Substance Use<sup>a</sup></b>
Specific placement criteria identified	22	38
Placement assessment/screening	14	33
ASAM for placement	0	31
Policies or procedures	0	0

**NOTE:** Detailed in Table A32.  
a. The characteristic or requirement is either fully or partially applicable to all facility types in the state. If partially applicable, it is required of some but not all facility types.

**Treatment and discharge planning, care coordination, and aftercare requirements.** Solid treatment and discharge planning are critical to ensuring appropriate treatment that is focused on recovery and next steps as well as on immediate needs. Care coordination and aftercare relate to planning for the present and the future.

Approximately one-third to one-half of state Medicaid programs have explicit requirements for treatment planning, for some or all Medicaid-enrolled facilities (Table 23). Fewer incorporate requirements for discharge planning, and very few Medicaid programs are explicit that discharge planning should begin at or near admission (mental health: three; substance use: five). Few Medicaid programs incorporate express requirements for follow-up with discharged clients or the continued provision of aftercare by the residential facility. Those that do include Vermont, which requires follow-up with both the patient and receiving provider within 72 hours after discharge from mental disorder residential treatment;<sup>126</sup> New Hampshire, which requires “active outreach” to clients following discharge;<sup>133</sup> and New Mexico, which requires follow-up after discharge from crisis stabilization services.<sup>134</sup>

The relative paucity of some of these standards in state Medicaid regulations does not mean that the programs do not have such requirements, because they may be in provider agreements with Medicaid or MCEs or in provider manuals. Similarly, some states may rely on the presence of licensure requirements to ensure that treatment and discharge planning requirements, in particular, apply to facilities. Additionally, those programs that incorporate the ASAM standards also effectively incorporate the ASAM principle that an individualized assessment-based treatment plan should be developed.<sup>28</sup>

As states seek to integrate all aspects of physical and M/SUD care, care coordination has received greater emphasis. Care coordination requirements were located in more than one-third of state Medicaid mental health requirements and nearly four-fifths of state Medicaid SUD requirements. The number of states with SUD treatment care coordination requirements

reflects, in part, the nearly universal requirement in Section 1115 waivers allowing reimbursement of SUD treatment in IMDs that “beneficiaries will have improved care coordination” and requiring the state to ensure the establishment and implementation of policies to ensure residential facilities “link beneficiaries with community-based services and supports, including tribal services and supports, following stays in these facilities within 24 months of SUD program demonstration approval.”<sup>135</sup> States use different approaches to meet this mandate. Washington State, for instance, relies heavily on its MCEs and as part of waiver implementation is implementing a requirement that “MCOs [managed care organizations], residential treatment providers, and outpatient providers work to develop policies and practices that enhance care coordination, including transitions between levels of care following residential treatment stays.”<sup>135</sup> Oklahoma, which does not have a Section 1115 waiver, has in place a program of Behavioral Health Case Management available to individuals transitioning from nonIMD institutions to the community. “Individuals are considered to be transitioning to the community during the last thirty (30) consecutive days of a covered institutional stay. This time is to distinguish case management services that are not within the scope of the institution’s discharge planning activities from case management required for transitioning individuals with complex, chronic, medical needs to the community. Transition services provided while the individual is in the institution are to be claimed as delivered on the day of discharge from the institution.”<sup>136</sup>

TABLE 23. Number of States with Medicaid Requirements for Treatment and Discharge Planning, Care Coordination, and Aftercare in Residential Treatment		
Requirements	Mental Health <sup>a</sup>	Substance Use <sup>a</sup>
Treatment plan required	18	26
Discharge plan required	8	17
Discharge plan early	3	5
Care coordination	20	37
Aftercare/follow-up	1	2
<b>NOTE:</b> Detailed in Table A33.		
a. The characteristic or requirement is either fully or partially applicable to all facility types in the state. If partially applicable, it is required of some but not all facility types.		

**Treatment services.** Ensuring the use of evidence-based or best practice treatment is crucial to providing high-quality M/SUD residential services. Given the range of types and levels of treatment, we focused on whether therapeutic services were required by the regulations, if amount was specified, and whether states included requirements regarding evidence-based or best practice treatment. One specific evidence-based practice, examined within the realm of service delivery, was medication treatment as part of MAT specific to residential settings, which is discussed in greater detail below.

All Medicaid programs require medical necessity for services in order to obtain reimbursement. More detailed Medicaid service requirements for some or all Medicaid-enrolled facilities, however, are found most often regarding residential SUD treatment in contrast to residential mental disorder treatment (Table 24). The increasing adoption by states of the ASAM standards, whether as part of a Section 1115 waiver mandate to establish “residential

treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other comparable, nationally recognized, SUD-specific program standards regarding in particular the types of services, [and] hours of clinical care, ... for residential treatment settings,”<sup>137</sup> or otherwise, contributes to this distinction. Some states, however, have taken additional steps. Ohio, for example, provides that “individuals in residential treatment may receive medically necessary services from practitioners who are not affiliated with the residential treatment program. Examples include, but are not limited to, psychiatry, MAT, or other medical treatment that is outside the scope of the residential level of care as defined by ASAM. Medicaid reimburses providers of these services outside the per diem rate paid to residential treatment programs.”<sup>138</sup>

As also may be seen in Table 24, only five states were found to have explicit regulatory or waiver-based Medicaid requirement regarding use of evidence-based practices for mental disorder residential treatment. Michigan and Nevada, for instance, require that evidence-based practices be used for both mental disorder and SUD residential treatment.<sup>128,131</sup> In contrast, 31 states require use of evidence-based practices in some aspects of Medicaid-reimbursed residential SUD treatment, many by requiring access to MAT (see also Table 25), but some are specific about other evidence-based practices. For example, the Maryland Medicaid regulations require participating adult residential treatment facilities to demonstrate competence in the ability to deliver a minimum of three evidence-based practice services.<sup>139</sup>

<b>TABLE 24. Number of States with Medicaid Requirements for Services in Residential Facilities</b>		
<b>Requirements</b>	<b>Mental Health<sup>a</sup></b>	<b>Substance Use<sup>a</sup></b>
Any service requirements	20	38
Specific to clinical service types	17	38
Specific to clinical service hours	2	28
Evidence-based	5	31
<b>NOTE:</b> Detailed in Table A34.		
a. The characteristic or requirement is either fully or partially applicable to all facility types in the state. If partially applicable, it is required of some but not all facility types.		

Review of state Medicaid requirements revealed that 31 of 51 jurisdictions explicitly call for the provision of MAT in residential SUD treatment settings or that access to an outside provider be a component of treatment in the residential facility, for some or all Medicaid-enrolled facilities (Table 25). Most Section 1115 waivers permitting reimbursement of SUD treatment provided in residential IMD facilities include requirements that the state: (1) undertake “an assessment of the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT”; and (2) establish a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site.”<sup>126</sup> States implement this along different timeframes, but Vermont, for example, already required that MAT be offered in all residential programs.<sup>126</sup> Two states with Section 1115 waivers that permit residential treatment in an IMD, Maryland and Massachusetts, reimburse MAT, but their waiver documents do not incorporate it into residential settings.<sup>140,141</sup>



TABLE 25. Number of States with Medicaid Requirements for MAT in Residential Facilities		
Requirements	Mental Health <sup>a</sup>	Substance Use <sup>a</sup>
MAT required	0	31
<b>NOTE:</b> Detailed in Table A35.		
a. The characteristic or requirement is either fully or partially applicable to all facility types in the state. If partially applicable, it is required of some but not all facility types.		

**Quality assurance or improvement.** Explicit requirements for quality assurance or improvement programs imposed directly on facilities were relatively rare in the Medicaid regulations or in Section 1115 waiver documents, for some or all Medicaid-enrolled facilities (mental health: nine; substance use: ten) (Table 26). Requirements for measurement or data submission (beyond claims or encounters data) (mental health: two, substance use: five) were even less common. This, however, does not mean that Medicaid programs may not have such requirements because they may appear in provider agreements with Medicaid or MCEs, in provider manuals, or on state websites. Similarly, some states may rely on the presence of licensure requirements to ensure that quality assurance or improvement requirements apply to facilities.

It also is important to note that state contracts with MCEs impose QA/QI requirements on the MCE, which MCEs may or may not translate into requirements imposed on their network providers. Additionally, Section 1115 demonstrations nearly always include requirements designed to ensure quality of services that apply to the state itself as manager of the demonstration. In the Section 1115 waivers that allow reimbursement for SUD services in an IMD, there is a nearly uniform requirement similar to that found in the North Carolina approval that the state must establish “a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings within 12-24 months of SUD program demonstration approval.”<sup>142</sup> States then address implementation in different ways in their individual SUD implementation plans, for example, by assuring CMS that licensing requirements do or will reflect ASAM criteria or by promising expanded facility monitoring.<sup>142</sup> Requirements such as these related to licensing requirements reflecting ASAM criteria or monitoring, however, are not the same as requiring that residential facilities themselves develop and undertake an explicit QA/QI program.

TABLE 26. Number of States with Medicaid Requirements for QA/QI		
Requirements	Mental Health <sup>a</sup>	Substance Use <sup>a</sup>
QA/QI required	9	10
Measurement/data	2	5
<b>NOTE:</b> Detailed in Table A36.		
a. The characteristic or requirement is either fully or partially applicable to all facility types in the state. If partially applicable, it is required of some but not all facility types.		

**Special populations.** State Medicaid requirements regarding residential M/SUD treatment pertinent to special populations are rare, for some or all Medicaid-enrolled facilities and, when



seen, generally relate to treatment of co-occurring M/SUD conditions or treatment of pregnant women (Table 27). In the miscellaneous category of “other” special populations, regulations found included references to a number of disparate groups, such as those with co-occurring mental and physical health conditions<sup>126</sup> or “adults with I/DD and severe psychiatric or behavioral symptoms following a crisis event and/or psychiatric inpatient stay and/or transitioning out of the criminal justice system or a long-term (2 or more years) institutional placement (including residential psychiatric treatment facility).”<sup>143</sup>

More commonly, state Medicaid programs or other state agencies that have adopted the ASAM criteria for SUD treatment are essentially incorporating the ASAM standards for those with co-occurring mental disorders.<sup>28</sup> Similarly, it is increasingly common to find states that are subject to explicit requirements in Section 1115 waivers regarding, in particular, treatment of co-occurring disorders. Nearly all Section 1115 approved waivers that permit Medicaid reimbursement of SUD treatment in IMDs require that the waiver be used to improve “care for co-morbid physical and mental health conditions.”<sup>134</sup> The implementation of this is reflected in different ways. For example, in its submitted SUD implementation plan, New Mexico plans to include ASAM levels “3.2, 3.3, and 3.5 in adult accredited residential settings for individuals with SUD and co-occurring conditions.”<sup>134</sup>

<b>Requirements</b>	<b>Mental Health<sup>a</sup></b>	<b>Substance Use<sup>a</sup></b>
Co-occurring M/SUDs	6	29
Pregnant/parenting women	2	8
Other	4	2

**NOTE:** Detailed in Table A37.

a. The characteristic or requirement is either fully or partially applicable to all facility types in the state. If partially applicable, it is required of some but not all facility types.

## SECTION 4. DISCUSSION AND SYNTHESIS

The primary purpose of this Compendium and its accompanying state summaries is to develop a better understanding of the landscape of state regulation and oversight of M/SUD residential treatment. One of the first tasks was to decide what constituted M/SUD residential treatment. Doing so made it clear that, aside from the Level 3 facility standards found in the ASAM criteria, there are no consistent and common definitions. To define and bound the scope of this research, we took the approaches, discussed in our methodology, of requiring clinical treatment in the residential settings and of excluding certain categories of facilities. Even after using this approach, this study makes evident that there are many labels for residential treatment in the United States, as well as residential settings that are not included in this research. Despite this limitation, the study framework, with primary domains of oversight and operations, allowed us to look at the landscape of incorporated facilities methodically.

### Oversight

**Bifurcated and trifurcated systems.** As is true of other forms of M/SUD treatment, and despite ongoing efforts to integrate care in the United States, mental disorder and SUD treatment in residential settings often remains bifurcated, in terms of: (1) who is being treated in different facilities; (2) who is overseeing many of those facilities; and (3) how extensive the range of comparative oversight is for the two broad categories of M/SUD residential treatment. The addition of separate Medicaid agencies further divides oversight and regulation.

- Distinctions commonly remain as to whether a given type of facility is intended to treat mental disorders versus SUDs. This most often hinges on whether facilities are distinctly created for one or the other, in contrast to being, for instance, crisis facilities designed to treat both.<sup>144</sup> Refinements exist, such as permitting treatment for SUD in a mental health residential facility if a person's primary diagnosis falls into the mental disorder category. In addition to crisis facilities designed for both, however, this distinction is increasingly breaking down in the realm of SUD treatment, in which it is widely acknowledged that many individuals with SUD also have a mental disorder and that they must be treated concurrently. This need for concurrent treatment is recognized in an increasing number of states that specifically call by statute or regulation for treatment of co-occurring conditions<sup>145</sup> and in the ASAM criteria,<sup>28</sup> which are increasingly adopted by states to structure and define their SUD treatment. Many states, however, have not taken such steps and, ones that do, tend to approach it from the SUD side of behavioral health.
- This phenomenon relates to the often bifurcated nature of state oversight, with separate agencies or, at least, separate subagencies still common regarding licensure and/or other oversight. States are increasingly opting to combine all behavioral health

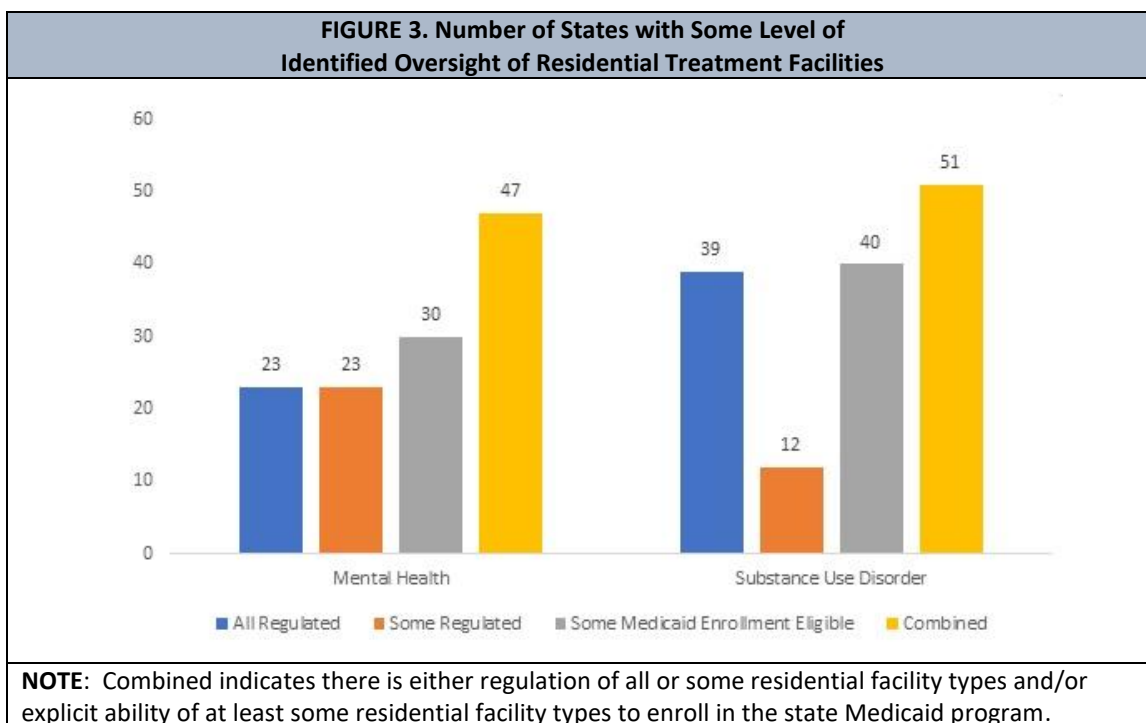
into one agency. Even when this combination occurs, however, internal silos may remain that still must be breached in order to fully coordinate oversight of all behavioral health in a given state.

- As was evident from the findings in the separate sections of this Compendium dealing with state: (1) licensure and related standards; and (2) Medicaid regulation of M/SUD residential treatment, there is considerable disparity in the extent to which states regulate mental disorder versus SUD residential treatment. SUD residential treatment presently has far greater structure and oversight in many states. The likely reasons for this are three-fold.
  1. The opioid epidemic has forced state legislatures and agencies in recent years to give particular attention to expanding and overseeing SUD treatment. This is partly reflected in state regulations and policies.
  2. In recent years, parity legislation and Medicaid expansion have combined with the opioid epidemic to increase avenues for reimbursement of treatment for SUD more rapidly than parity and Medicaid expansion alone might have, leading to greater attention to facilitating access to and reimbursement of SUD treatment compared with mental health treatment. Thus, we see burgeoning opportunities and new avenues for financing SUD treatment, including within IMDs. SAMHSA's *Projections of National Expenditures for Treatment of Mental and Substance Use Disorders, 2010-2020*<sup>146</sup> predicted increased spending for SUD relative to mental disorder treatment. In addition, supplemental government spending, such as that resulting from the SUPPORT Act and funds provided through the SAMHSA State Targeted Response and State Opioid Response grants, resulted in substantial funding available to address the opioid epidemic.
  3. The increased funding that came with changes regarding IMDs has also brought changes in requirements accompanying the funding. We also see an even larger patchwork of oversight and opportunity. The incorporation of ASAM placement, treatment, staffing, and other requirements has influenced far more than treatment in IMDs. As states may increasingly seek Section 1115 waivers for treatment in IMDs of individuals with SMI as well as SUD, comparable attention to regulation and oversight of mental disorder residential treatment may follow suit.

**Unregulated facilities.** Our examination of state regulations and statutes, state Medicaid requirements, and, to a limited extent, policy documents, indicates that there are intermittent gaps or potential gaps in regulation and licensure of residential treatment facilities. Figure 3 presents an overall picture of the extent to which oversight generally does or does not exist in the states on the basis of the data sources used for this study. For residential mental disorder and SUD treatment facilities, we provide counts, based on the documentation examined for this study, of: (1) the number of states in which all residential treatment facilities are regulated and/or licensed; (2) the number of states where some are regulated and/or licensed; (3) the

number with evidence of ability to enroll in Medicaid; and (4) the total number that meet at least one of those criteria.

From these data, we see that all states but four have some form of oversight of residential mental disorder treatment and all 51 states do so for residential SUD treatment, either through state licensure and oversight standards, applicable state Medicaid requirements, or both. Additional detail is available in the detailed tables at Appendix A, but the four states with no apparent regulatory oversight specific to residential mental disorder treatment facilities are Idaho, New Jersey, North Dakota, and South Dakota. It is important to realize, however, that these states may oversee and mandate standards via contracts with providers. Additionally, as is true for New Jersey, states may have an array of regulated mental health residential facilities (e.g., residential health care facilities, supervised residences for adults with mental illness) that do not require treatment as a component of services.

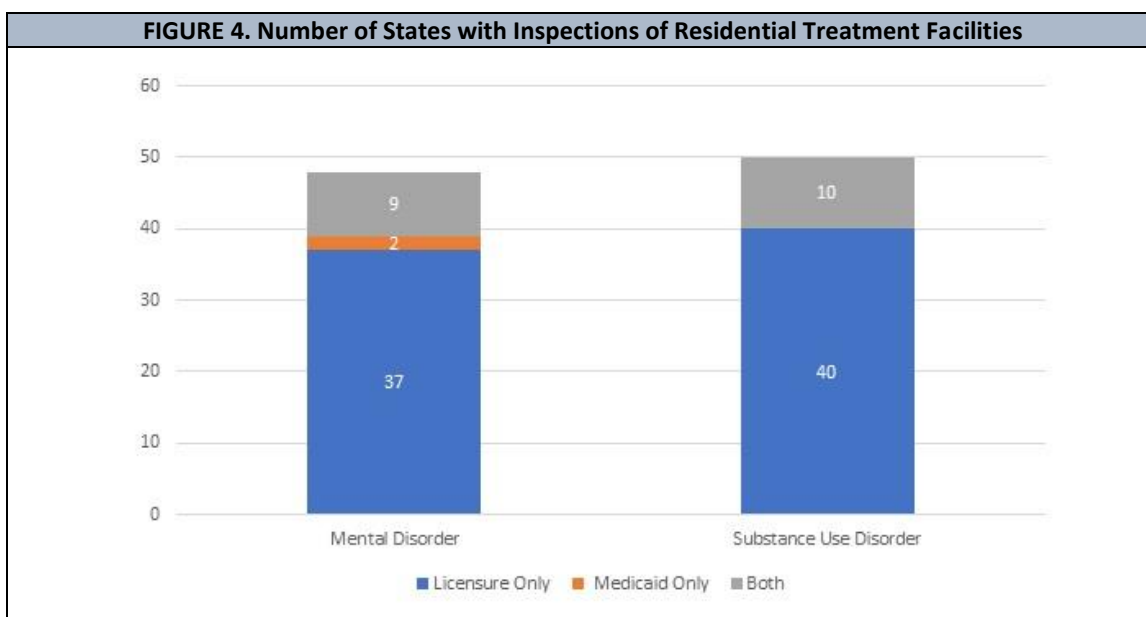


**Processes of regulation, oversight, and licensure.** Facilities in some states may be subject to multiple sets of state oversight, licensure, or certification and, on occasion, state licensure standards also may require accreditation or provide “deemed status” for optional accreditation. Accreditation by an independent accrediting body such as TJC, the Commission on Accreditation for Rehabilitative Facilities, or the COA can provide yet another layer of oversight and inspection, beyond that carried out by the states. When accreditation takes the place of oversight, however, it is imperative--and many states are clear on this point--that the accreditation standards must cover and address the state standards that will not be a focus of oversight by the state. States typically retain authority, even in the event of deemed status, to

conduct cause-based investigations and inspections. Indeed, provision for state inspection is an important indicator of opportunities for concerted oversight.

Analysis of inspection requirements found that most states have some provision for inspections of some or all M/SUD residential treatment facilities. On the basis of the information in state summaries, we looked at whether there were any inspection requirements associated with licensure, at any point and for any reason, and at whether there were any inspection requirements associated with Medicaid enrollment, at any point and for any reason.

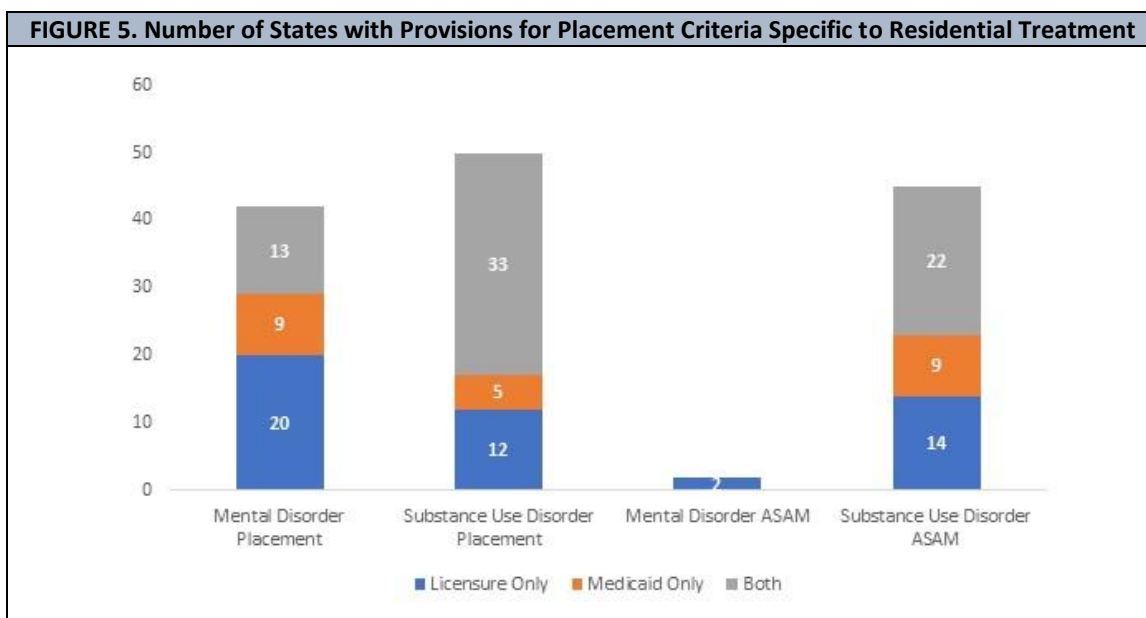
As shown in Figure 4, out of 51 jurisdictions, 48 had provisions for inspection at licensure, post-licensure, or some point in Medicaid enrollment for mental disorder residential treatment and 50 had provisions for inspections of SUD residential treatment. Most of the four states without any apparent provision for inspection for mental health facilities, did not have any identified regulated mental health residential facilities.



**Intersection of licensure and Medicaid in the imposition of standards.** All states require that providers that wish to enroll in Medicaid be licensed or certified in accordance with applicable laws, assuming applicable laws exist in the state. This requirement pertains equally to facility providers, such as residential treatment programs, and to individual providers. This requirement has the very important effect of incorporating by reference all state licensure requirements into the Medicaid requirements, broadening state Medicaid requirements beyond what is explicit in Medicaid regulations, waivers, or other documents. Because Medicaid is the largest payer for behavioral health services in the United States, these requirements have broad effect on a large population. Especially for SUD treatment, the spate of new state regulatory requirements and of approved Medicaid waivers, the latter of which can influence state regulatory requirements, there may be a synergistic effect.

## Operations

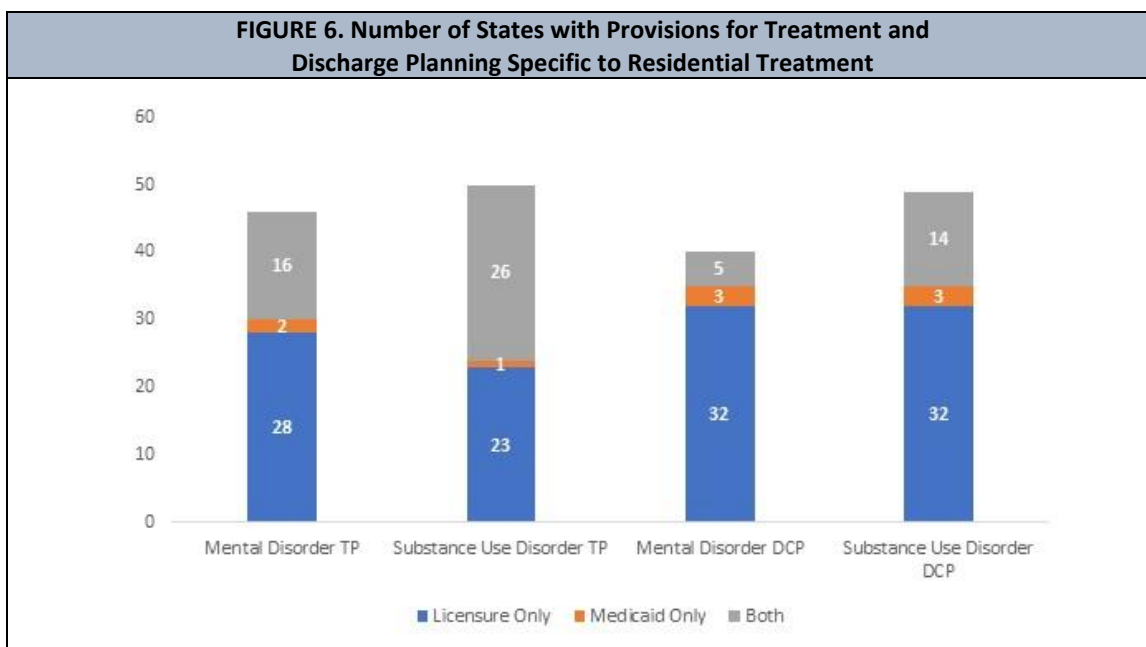
**Access and placement.** Access to and placement in treatment are related. Access to residential treatment is most often addressed in regulations as functions of nondiscrimination and of physical access. This study examined access in the context of wait times and, although states occasionally address wait times in regulations, it is more commonly a feature of other policy documents, state website portals, or contractual requirements. The latter can include requirements imposed on Medicaid MCEs regarding network adequacy. Additionally, within the context of residential treatment where time is often of the essence and placements are scarce, formal measured wait times may be less meaningful than for outpatient treatment in the community. Especially if Medicaid does not reimburse for residential M/SUD treatment, what is most likely to happen may be settling for a second-best level of care, whether inpatient, intensive outpatient, or other outpatient treatment. This relates, therefore, to appropriate placement because absent access, placement may not be ideal.



Specific placement criteria for residential treatment facilities are the norm, derived from a combination of licensure-related and Medicaid requirements; 42 and 50 states were found to include such requirements for mental disorder and SUD residential treatment, respectively (Figure 5). As might be expected, required use of the ASAM Patient Placement Criteria were nearly exclusively limited to residential SUD treatment. A total of 45 states specifically use the ASAM criteria for placement in SUD treatment, and many of those states include those with Section 1115 IMD demonstrations. Two states, Indiana and Utah, also require that it be used in mental disorder residential treatment when appropriate.<sup>75,147</sup> Many states also have, in addition to standards of placement, criteria for continued stay and/or discharge. These appear both in licensure-related standards and in Medicaid requirements. We did not see any single set of placement criteria predominant through the mental health residential requirements. The

best-known placement approach, the LOCUS, was mentioned no more than once or twice in the regulatory review. We are aware, however, from our interviews with experts that more states are using it and requiring its use via contract and other mechanisms. It is possible that its use will increase as more states receive approval of Section 1115 demonstrations related to the provision of services to individuals with SMI.

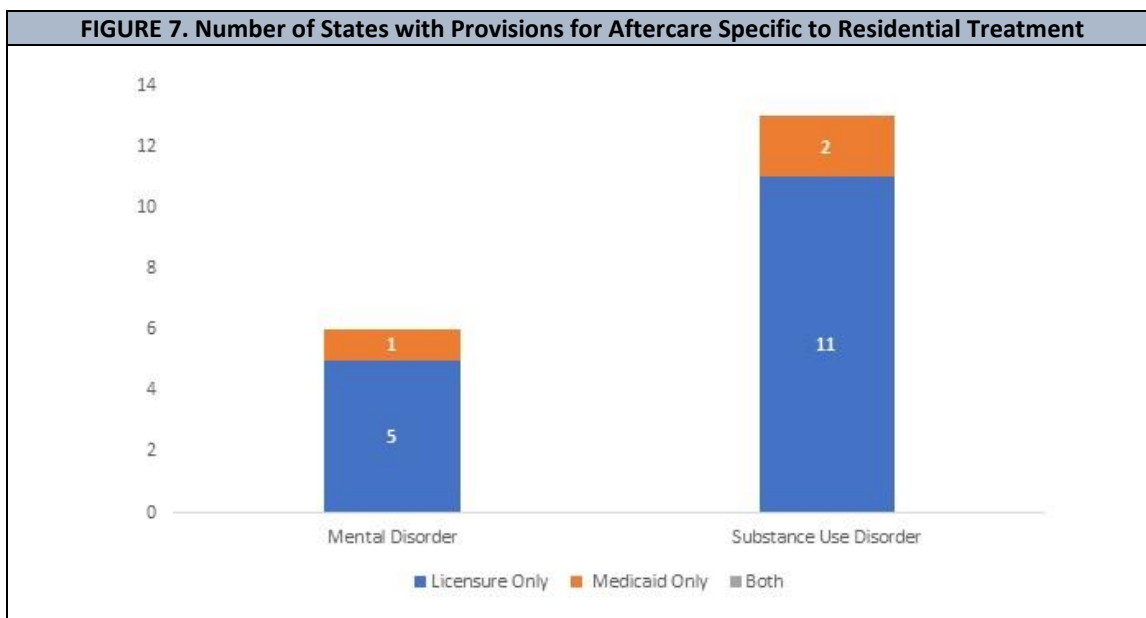
**Treatment and discharge planning.** States are more likely to include treatment planning and discharge planning requirements in licensure and other non-Medicaid standards than they are as Medicaid requirements, although a number do that as well (Figure 6). Documentation examined revealed that treatment planning requirements were included for 46 and 50 states, respectively, for mental disorder and SUD residential treatment. Somewhat fewer included discharge planning requirements, 40 and 49 states for mental disorder and SUD residential treatment, respectively. These high levels indicate a concern that treatment be appropriately planned and that provision for ongoing treatment and support after discharge should be an essential component of services, preferably beginning early in the treatment process.



**Requirements related to aftercare services or follow-up.** State standards for, if not requirements for the provision of, aftercare services or follow-up after discharge from a residential facility are rare, particularly on the Medicaid side in regulations and waivers. As a reminder, in discussing aftercare services and follow-up requirements, we are not discussing discharge planning and referrals but, rather, practices in which the residential facility discharging the individual continues some ongoing service or follows up on the status of the individual post-discharge. When such provisions exist, they are designed to either: (1) provide a bridge for services until the person is established in a new setting; or (2) allow the discharging facility to know whether referred post-discharge services are being accessed and if they are successful. As Figure 7 displays, six and 13 states include such requirements for mental

disorder and SUD residential treatment, respectively, primarily in licensure or other non-Medicaid standards. Interestingly, there is no overlap between licensure and Medicaid requirements, and only one state includes aftercare or follow-up provisions for both sides of M/SUD residential treatment--that is follow-up after crisis services.<sup>148</sup>

The three state Medicaid programs in which such requirements were located all focused on required follow-up after discharge from mental disorder residential treatment (Vermont),<sup>126</sup> from SUD residential treatment (New Hampshire),<sup>133</sup> or from SUD crisis stabilization services (New Mexico).<sup>134</sup> Similarly, requirements in ten states, including for mental disorder residential treatment--Illinois, Iowa, Kansas, Oklahoma, and Washington, and for SUD residential treatment--Iowa, Massachusetts, Ohio, Oklahoma, Oregon, and Wisconsin--involved follow-up and not ongoing treatment by the residential facility.<sup>149</sup> In contrast, Wyoming requires, for detoxification facilities, provision for referral, escort, and transportation to other treatment services, as necessary, to ensure that continuity of care is provided.<sup>150</sup> Michigan,<sup>151</sup> Pennsylvania,<sup>152</sup> and South Carolina<sup>153</sup> apparently envision both follow-up and potential provision of aftercare services by at least some of their licensed SUD residential treatment facilities. Hopefully, these relatively few standards related to ensuring follow-up and the provision of aftercare as a bridge service indicate a trend that will evolve further. As we seek to improve retention in treatment, ensuring follow-on care after residential placement is important.

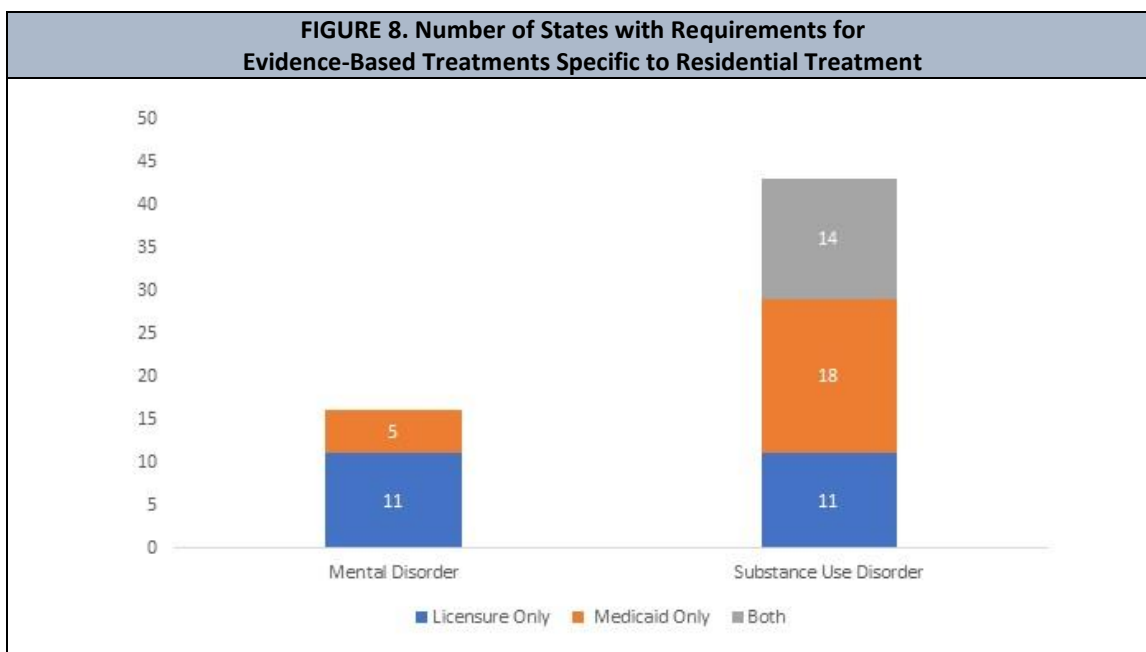


**Standards for treatment services.** In addition to assessments related to placement, treatment planning, and coordination of care, treatment services in the form of psychosocial and medication treatment are key components of residential treatment. The states vary in the extent to which they elaborate, some being very specific and others less so. In the SUD treatment realm, however, Level 3 standards increasingly are being adopted, with different degrees of fidelity and specificity, from the ASAM criteria, driven in part by Section 1115



Medicaid demonstration requirements. Two discrete indicators of states wading into the prescribing of services are the extent to which: (1) evidence-based practices; and (2) MAT are overtly required regarding residential treatment.

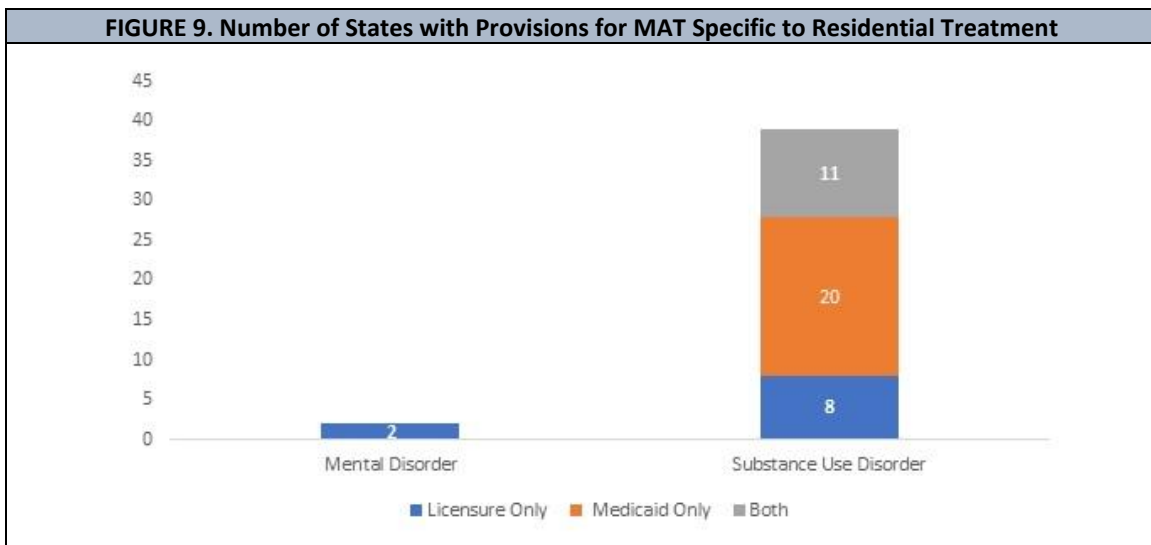
- Evidence-based care can be difficult to define. For this study, we looked at whether states had explicit requirements for “evidence-based” practices or “best practices.” We also included states where either trauma-informed care, motivational interviewing, or MAT is explicitly required to be used or, in the case of the latter, available, although these requirements may vary by facility type within states. We recognize that there are other evidence-based practices, but these are the ones that are most likely to be clearly included as requirements. SUD residential treatment facilities are most likely to have requirements for evidence-based practices, with 43 out of 51 states including some form of requirement (Figure 8), most commonly MAT. In contrast, only 16 states, in total, incorporated requirements specific to evidence-based practices for residential mental disorder treatment. This difference between mental disorder and SUD treatment might seem unwarranted, but many of the requirements related to MAT are waiver-driven Medicaid requirements that also appear to be seeping into SUD licensure and other non-Medicaid oversight standards. This suggests that wider use of Section 1115 waivers for mental health services might have similar effect.



- Figure 9 displays the number of states that have any requirements in place specific to residential treatment regarding access to MAT. As would be expected, they are much more commonly specific to SUD treatment facilities, with a total of 39 states having SUD licensure-related and/or Medicaid-related requirements in place. These numbers, however, may include some states that address MAT only for a subset of regulated residential facilities (e.g., publicly-funded), and, likewise, Medicaid requirements apply

only to Medicaid-enrolled providers and, in some cases, perhaps only to IMDs or nonIMDs. However, a significant portion of the Medicaid requirements reflect the existence of Section 1115 waivers, the number of which presumably will continue to increase. Additionally, the inclusion of requirements related to MAT in residential treatment, even if only directly applicable to certain facilities or certain populations depending on funding or other factors, means that it is more likely that other facilities and individuals in the state will experience spillover as MAT becomes more widely available. Additionally, the Section 1115 demonstrations are laboratories for innovation that may spread best practices to other states.

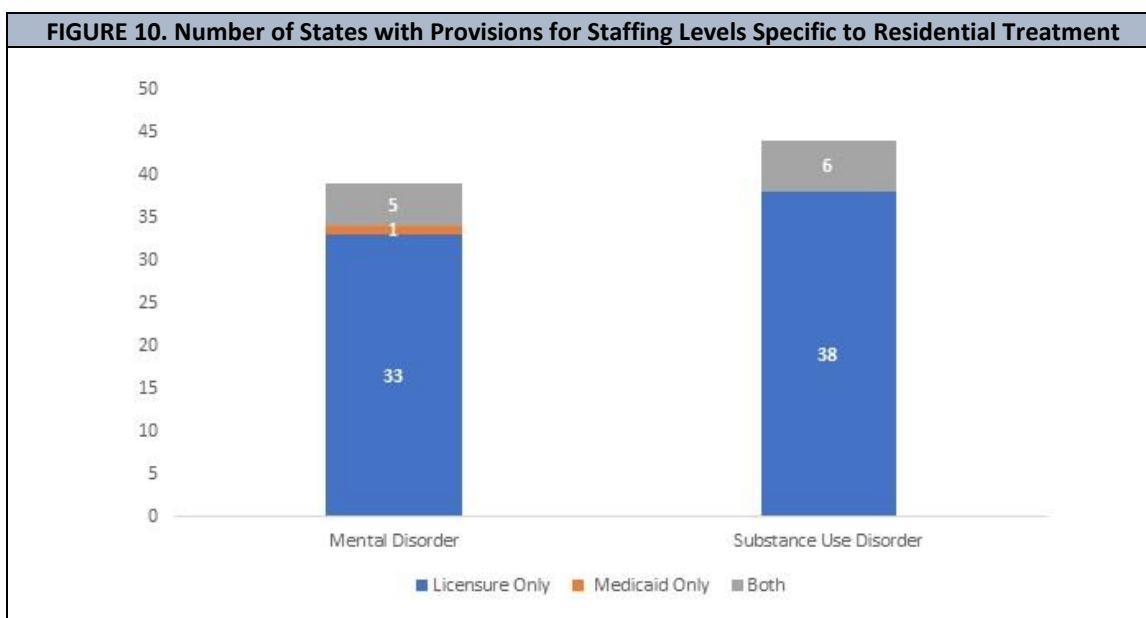
Of separate interest, however, are the two states, Maryland and Utah, that also have licensure or other oversight requirements regarding MAT that apply equally to residential mental disorder and SUD treatment facilities. In Maryland, no Behavioral Health Authority-licensed community-based M/SUD programs may exclude or discriminate against an individual on the basis of the individual receiving opioid treatment services.<sup>91</sup> In Utah, all service providers contracting with the Division of Substance Abuse and Mental Health and all County Local Authority programs must provide written information to every treatment participant regarding rights to MAT<sup>93</sup> and, in community-based treatment programs, all individuals with AUDs and/or OUDs must be educated and screened for the potential use of MAT.<sup>94</sup> Although neither of these requirements go so far as to require access to MAT in a residential mental disorder treatment setting, they do pave the way for better care integration and access to MAT for all individuals needing residential care regardless of primary diagnosis.



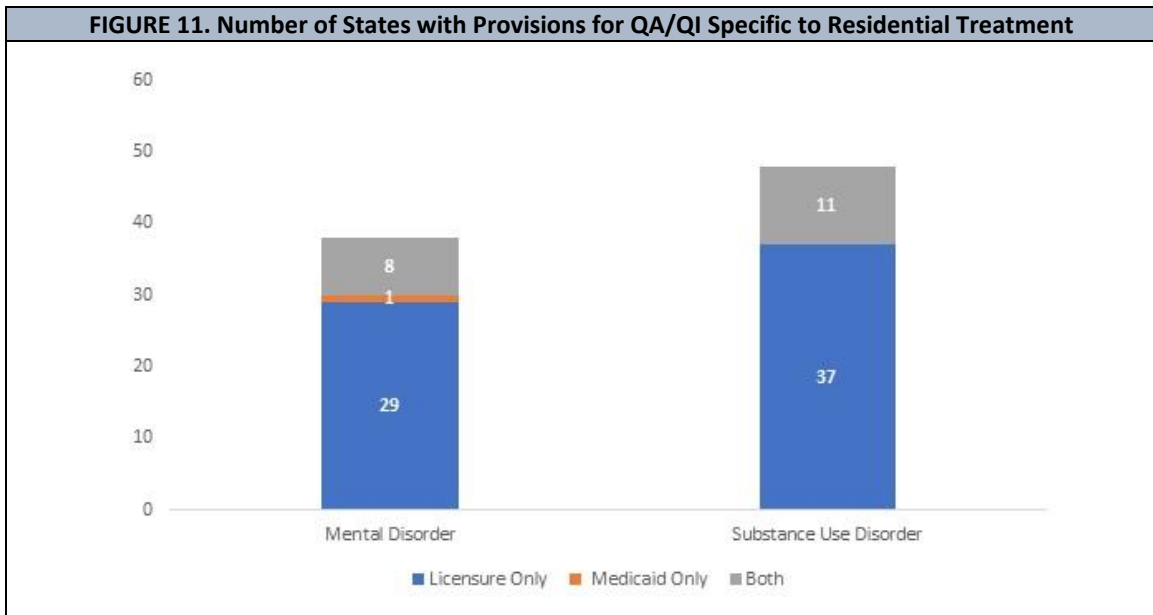
**Staffing requirements.** Staffing standards may include requirements regarding hiring, credentialing, training, documentation of employment requirements or practices, and staffing levels, among other things. This is one area where policy documents and contracts may be better suited for states to set standards, allowing greater flexibility than is possible with

regulations or statutes, particularly with the many different types of treatment and evolving service needs involved in behavioral health treatment.

As one indicator of state involvement in staffing standard-setting, we looked at staffing levels. Adequate staffing levels are needed to ensure quality treatment and safety in 24-hour M/SUD settings. Figure 10 illustrates the status of staffing level requirements specific to residential treatment in the 51 states. A total of 39 states had staffing ratios and/or requirements for adequate or sufficient staffing in mental disorder residential treatment facilities. Forty-four states did for SUD residential treatment. Most such requirements sprang from licensure and other non-Medicaid standards and were, predominantly, not ratios.



**Quality assurance/quality improvement requirements.** The scope and nature of QA/QI requirements applicable to residential M/SUD treatment vary considerably and not all apply equally to all facility types. It is possible, however, to say that some form of explicit requirement imposed on the facility is common. As Figure 11 shows, this is truer for SUD than mental disorder treatment and generally stems from licensure and related oversight standards rather than from state Medicaid requirements. In the documentation examined, we identified 38 and 48 states that impose some such requirement for residential mental disorder and SUD treatment facilities, respectively. Of note, however, some states incorporate such requirements into contracts with providers or other policy documents and, in the realm of Medicaid requirements, also may incorporate such requirements into contracts between the state and the MCE. In the latter case, the requirements on the MCE may be strictly on the MCE or may include requirements to impose specific QA/QI responsibilities on their network of providers. In any event, it is promising to see the extent to which some type of QA/QI requirement is a part of state expectations for residential treatment. Because what is perceived as quality may change over time, however, the rigid regulations may not be best to elaborate in detail on what is required.



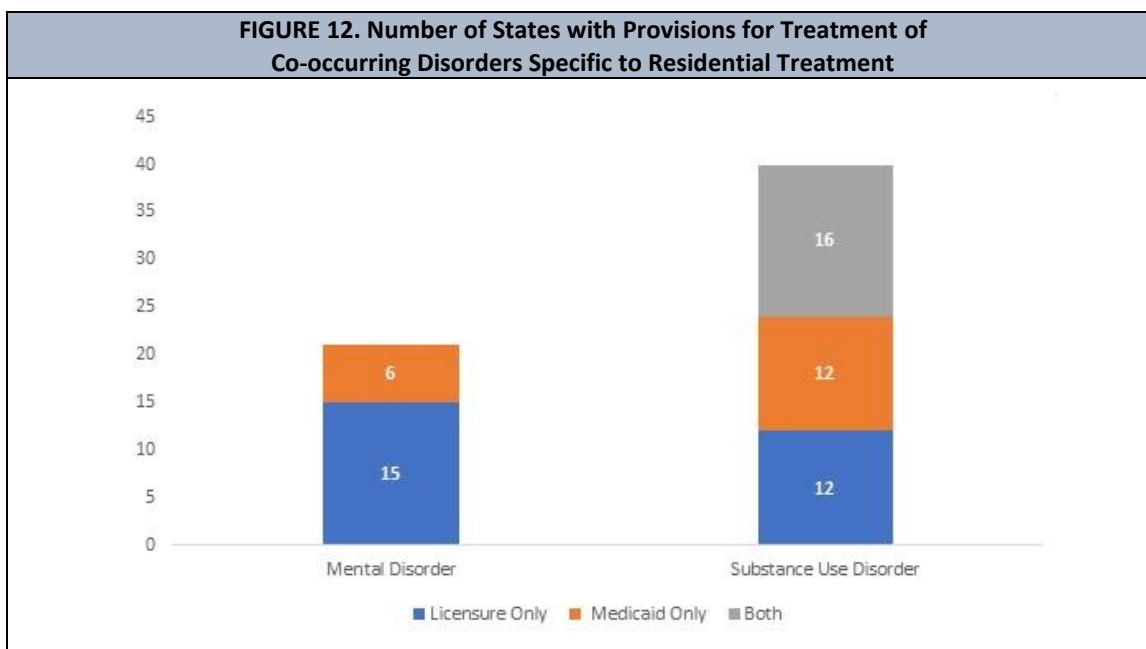
**Service recipient rights and governance.** We examined service recipient rights and governance standards only with regard to requirements not specific to Medicaid. Both are much more commonly reflected in state non-Medicaid-related requirements than in Medicaid requirements.

- Statutes and regulations governing service recipient rights evolved out of a history of maltreatment in some institutions. We looked at two discrete aspects of service recipient rights, related to: (1) the right to voice grievances, taken as an indicator of the ability of service recipients to enforce their rights in general; and (2) rights related to restraint and seclusion, because restraint and seclusion affect both safety and dignity. The first, the right to voice grievances, is more commonly provided for in regulations than is the second, rights regarding restraint or seclusion.
- Governance standards are elaborate in some states and nonexistent in others, with regard to residential M/SUD treatment. These standards may be integrated into licensure requirements, for example, as part of what facilities must demonstrate in their application. They also may be a more general part of state regulations governing operating requirements, along with staffing, placement, and other standards. They may be as simple as requiring information at licensure and the development and maintenance of policies and procedures, or they may include detailed requirements regarding different areas of facility internal structure and oversight.

**Requirements related to special populations.** States identify a range of special populations for which they wish to target services. This is far truer of SUD treatment than mental disorder treatment and often stems from block grant requirements. The two most common populations identified, particularly for SUD residential treatment, are those with co-occurring M/SUDs and

pregnant and parenting women or parents of dependent children. Regarding the latter, many states have specific requirements for residential facilities in which pregnant women, parenting women, and/or families with dependent children may receive treatment, including educational, health, and safety requirements for children.

Regarding standards applicable to treating those with co-occurring M/SUDs, although additional requirements may exist in contracts or policy documents, in the documentation reviewed we found nearly twice as many states with requirements for treatment of co-occurring M/SUD disorders stemming from the SUD side of state policy compared with mental disorder residential treatment (Figure 12). Many of the former reflect requirements based in Section 1115 waivers but states have, apart from that, often sought to ensure that SUD-focused treatment facilities address mental disorders as well. Reciprocity is lacking on the mental health side in more than half of all states.



## Other Key Findings

In addition to the conclusions drawn regarding specific domains above, at least three overarching findings warrant consideration.

First, there is good evidence that Section 1115 demonstrations, as well as the ASAM criteria, are critical to strengthening oversight of residential SUD treatment, although the requirements of the demonstrations have changed over time and are not uniform. The state structure and oversight of residential mental health treatment has not kept pace with change for residential SUD treatment. However, if more states obtain Section 1115 waivers that affect

reimbursement of mental disorder treatment in IMDs rather than just SUD treatment, it is possible that similar strides could take place for mental disorder residential treatment.

Second, we were not able to include all facility types in this Compendium. For example, small group homes and recovery housing, where clinical treatment is not integrated into the residence, were excluded. These types of facilities may or may not be regulated or licensed. They may be providing very valuable benefits to their residents or may be providing services of unknown quality. A comprehensive understanding of these types of facilities requires more research and perhaps suggests a counterpart review of, for instance, recovery housing. Such a study could inform what oversight exists and what is lacking and, on the basis of the findings of the current study, help identify ways to improve the safety and quality of care in such facilities.

Third, states clearly have diverse ways of overseeing M/SUD treatment.

- Some states rely heavily on published statutes and, even more so, on regulations to provide primary governance of M/SUD treatment, including residential treatment facilities.<sup>154</sup> This type of oversight results in clearly established and transparent requirements that lay out the legal basis for oversight and licensure. It also may result in requirements being established that can be difficult to change when flexibility or adaptation is needed, especially if rapid change is required. In addition, there may be instances in which events have changed how states wish to oversee facilities, but contradictory regulations may not yet be repealed. In these instances, practice may move ahead of regulatory requirements, generating unpredictability and possible confusion. Comparable to legally binding licensure and oversight requirements are state Medicaid statutes and regulations, as well as waiver documents or state plans that have been approved by CMS and, thereby, become binding on the state Medicaid agency and its agents and enrolled providers. Again, these binding Medicaid requirements have the benefit of transparency and certainty, provided rapid change is not required.
- Some states rely more heavily on contractual requirements, also binding but often less transparent. These may include state Medicaid provider agreements, contracts by the state Medicaid agency with its MCEs or Administrative Service Organizations (ASOs), and contracts by Medicaid MCEs or ASOs with providers. In the non-Medicaid realm, this applies as well to contracts between the state and providers who are recipients of block grant or other state funds. Depending on the state, amending contract language may be less onerous than amending regulations. Sometimes these documents are readily available online; at other times, accessing this information can be difficult.
- States also rely on agency licensing or standards manuals and, for Medicaid, provider manuals or other policy documents. Theoretically, these may be less binding on providers. However, many state statutes, regulations, or provider agreements expressly require compliance with such documents, and some explicitly incorporate these documents by reference into their regulations or other legal standards. This approach, especially if state regulations are not extensive, has the benefit of requiring only that the

manual or other document be amended and published to alter requirements when doing so may be time sensitive. This assumes of course that state administrative procedure laws permit change to occur in this fashion. Additionally, when provider manuals are the province of Medicaid MCEs, enrollment as a provider often is required to obtain access to secure portals where manuals and other MCE policy documents are kept. Similarly, access to information about Medicaid provider enrollment and to the form of state Medicaid provider agreements may first require initiating an application to enroll. All of these hurdles limit our comprehensive understanding of state oversight of M/SUD residential treatment facilities and make public understanding of the system of behavioral health less than simple.

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15. For this reason and because, as noted above, other factors are involved in state oversight and licensure, none of this document should be taken to constitute legal advice.
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21. For example, California Code Regs. tit. 9, § 531(c).
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23. For example, 12 Virginia Admin. Code § 35-105-1290.
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41. For example, 25 Texas Admin. Code § 448.403(d).
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152. For example, 28 Pennsylvania Code §§ 711.63.
153. For example, South Carolina Code Regs. R.61-93-801.
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## ACRONYMS

The following acronyms are mentioned in this appendix.

ASAM	Americans Society of Addiction Medicine
CON	Certificate of Need
IDU	Injection Drug Use
IMD	Institution for Mental Disease
L/C	Licensure/Certification
MAT	Medication-Assisted Treatment
MH	Mental Health
QA/QI	Quality Assurance/Quality Improvement
PPW	Pregnant and Parenting Women
R/S	Restraint/Seclusion
Stds	Standards
SU	Substance Use
SUD	Substance Use Disorder
WM	Withdrawal Management

TABLE A1. Categories of Regulated Residential Mental Health Treatment Facilities							
State	Crisis	Population	Condition	Short-Term/ Transitional	Long-Term	Intensive	Other
Alabama	●	●	X	X	X	X	●
Alaska	●	X	X	X	X	X	X
Arizona	●	X	X	X	X	X	●
Arkansas	●	X	X	X	X	X	●
California	●	X	X	●	●	X	X
Colorado	●	X	X	●	●	X	●
Connecticut	X	X	X	X	X	X	●
DC	X	X	X	X	X	X	X
Delaware	X	X	X	X	X	●	●
Florida	●	X	X	●	●	X	●
Georgia	●	X	X	●	X	X	X
Hawaii	X	X	X	X	X	X	●
Idaho	X	X	X	X	X	X	X
Illinois	●	X	X	●	●	X	X
Indiana	●	X	X	●	●	X	X
Iowa	●	X	X	●	X	X	●
Kansas	X	X	X	X	X	X	●
Kentucky	●	X	X	X	X	X	X
Louisiana	●	●	X	●	X	X	●
Maine	●	X	X	X	X	X	●
Maryland	●	X	X	X	X	X	X
Massachusetts	X	X	X	X	X	X	●
Michigan	●	X	X	X	X	X	X
Minnesota	●	X	●	X	X	●	●
Mississippi	●	X	X	X	X	X	X
Missouri	●	X	X	X	X	X	●
Montana	●	X	X	X	X	X	●
Nebraska	X	X	X	X	X	X	●
Nevada	X	X	X	●	X	X	X
New Hampshire	X	X	X	X	X	X	●
New Jersey	X	X	X	X	X	X	X
New Mexico	●	X	X	X	X	X	X
New York	●	X	●	X	X	●	●
North Carolina	●	X	X	X	X	X	X
North Dakota	X	X	X	X	X	X	X
Ohio	●	X	X	X	X	X	●
Oklahoma	●	X	●	X	X	X	●
Oregon	X	X	X	X	X	X	●
Pennsylvania	X	X	X	X	●	X	X

**TABLE A1 (continued)**

State	Crisis	Population	Condition	Short-Term/ Transitional	Long- Term	Intensive	Other
Rhode Island	●	●	X	X	X	X	●
South Carolina	●	X	X	X	X	X	X
South Dakota	X	X	X	X	X	X	X
Tennessee	●	X	X	X	X	X	●
Texas	●	X	X	X	X	X	●
Utah	X	X	X	X	X	X	●
Vermont	X	X	X	X	X	X	●
Virginia	●	●	X	X	X	X	●
Washington	●	X	X	X	X	X	●
West Virginia	X	X	X	X	X	X	●
Wisconsin	●	X	X	X	X	X	●
Wyoming	X	X	X	X	X	X	●

**NOTES:** ●: Present; X: Not Present.

TABLE A2. Categories of Regulated Residential SUD Treatment Facilities

State	Crisis	ASAM Level 3.1	ASAM Level 3.3	ASAM Level 3.5	ASAM Level 3.7	Low-Intensity	Medium-Intensity	High-Intensity	Transitional	Short-Term	Long-Term	Social Detox	Detox/WM	ASAM Level 3.2-WM	ASAM Level 3.7-WM	Clinically Managed Detoxification/Withdrawal	Medically Monitored Detoxification/Withdrawal	Medically Managed Detoxification/Withdrawal	Other
AL	X	●	●	●	●	●	●	●	X	X	X	X	X	●	●	●	●	X	●
AK	X	X	X	X	X	●	●	●	X	X	X	X	X	X	X	●	●	X	X
AZ	●	X	X	X	X	X	X	X	●	X	X	X	X	X	X	X	X	X	●
AR	●	X	X	X	X	X	X	X	X	X	X	X	●	X	X	X	X	X	X
CA	X	●	●	●	X	X	X	X	X	X	X	X	●	X	X	X	X	X	●
CO	●	●	●	●	●	●	X	●	X	X	X	X	X	●	●	●	●	X	X
CT	X	X	X	X	X	X	X	X	X	X	●	X	●	X	X	X	X	X	●
DC	X	●	●	●	X	●	X	●	X	X	X	X	X	X	●	X	●	X	X
DE	X	●	●	●	●	●	X	●	●	X	X	X	●	●	●	●	●	X	●
FL	X	X	X	X	X	X	X	X	●	●	●	X	●	X	X	X	X	X	●
GA	●	●	X	●	●	X	X	●	●	X	X	X	●	X	X	X	●	X	●
HI	X	X	X	X	X	X	X	X	X	X	X	X	●	X	X	X	X	X	●
ID	X	X	X	X	X	X	X	X	X	X	X	X	●	X	X	X	X	X	●
IL	X	●	X	●	●	●	●	●	X	X	X	X	X	●	X	●	X	●	X
IN	●	X	X	X	X	X	X	X	X	●	●	X	●	X	X	X	X	X	X
IA	●	X	X	X	X	●	●	●	X	X	X	X	●	X	X	X	X	X	X
KS	X	X	X	X	X	X	X	X	X	X	X	●	●	X	X	X	X	X	●
KY	●	X	X	X	X	X	X	X	●	X	X	X	X	X	X	●	X	X	●
LA	●	●	●	●	X	●	●	●	●	X	X	●	X	●	●	●	●	●	●
ME	X	X	X	X	X	X	X	X	X	X	X	X	X	X	●	X	●	X	●
MD	X	●	●	●	●	●	●	●	X	X	X	X	●	●	●	●	X	X	X
MA	X	X	X	X	X	●	●	●	●	X	X	X	X	X	X	X	X	X	X
MI	X	X	X	X	X	X	X	X	X	X	X	X	●	X	X	X	X	X	●
MN	X	X	X	X	X	X	X	X	X	X	X	X	●	X	X	X	X	X	●
MS	X	X	X	X	X	X	X	X	●	X	X	X	●	●	●	●	●	X	●
MO	X	X	X	X	X	X	X	X	X	X	X	●	X	X	X	X	●	X	●
MT	X	●	●	●	●	●	●	●	X	X	X	●	X	●	●	X	X	X	X
NE	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	●
NV	X	X	X	X	X	X	X	X	X	●	X	●	X	X	X	X	X	●	●
NH	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	●
NJ	X	X	X	●	●	X	X	●	X	●	●	X	X	X	●	X	X	X	●
NM	●	X	X	X	X	X	X	X	X	X	X	X	●	X	X	X	X	X	X
NY	X	X	X	X	X	X	X	X	X	X	X	X	●	X	X	X	X	X	●
NC	●	X	X	X	X	X	X	X	X	X	X	●	X	X	X	X	X	●	X
ND	X	●	X	●	X	●	X	●	X	X	X	●	X	●	X	X	X	X	X
OH	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	●
OK	●	●	X	X	X	●	X	X	X	X	X	X	X	●	●	●	●	X	●
OR	X	X	X	X	X	X	X	X	X	X	X	X	●	X	X	X	X	X	●

TABLE A2 (continued)

State	Crisis	ASAM Level 3.1	ASAM Level 3.3	ASAM Level 3.5	ASAM Level 3.7	Low-Intensity	Medium-Intensity	High-Intensity	Transitional	Short-Term	Long-Term	Social Detox	Detox/WM	ASAM Level 3.2-WM	ASAM Level 3.7-WM	Clinically Managed Detoxification/Withdrawal	Medically Monitored Detoxification/Withdrawal	Medically Managed Detoxification/Withdrawal	Other
PA	X	X	X	X	X	X	X	X	X	X	X	X	●	X	X	X	X	X	●
RI	●	●	●	●	X	●	●	●	X	X	X	X	●	X	X	X	X	X	●
SC	X	X	X	X	X	X	X	X	X	X	X	●	●	X	X	X	X	X	●
SD	X	●	X	X	●	●	X	X	X	X	X	X	X	●	X	●	X	X	●
TN	X	X	X	X	X	X	X	X	●	X	X	X	X	●	X	●	●	X	●
TX	X	X	X	X	X	X	X	X	X	X	X	X	●	X	X	X	X	X	●
UT	X	X	X	X	X	X	X	X	X	X	X	●	X	X	X	X	X	X	●
VT	X	●	●	●	●	●	X	●	X	●	●	X	X	●	●	●	●	X	X
VA	X	X	X	X	X	X	X	X	X	X	X	X	●	X	X	X	X	●	●
WA	X	●	X	●	X	X	X	X	X	X	●	X	●	X	X	X	X	X	X
WV	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	●
WI	●	X	X	X	X	X	X	X	●	X	X	X	X	X	X	X	●	X	●
WY	X	X	X	X	X	●	●	●	●	X	X	●	X	X	X	●	●	X	X

NOTES: ●: Present; X: Not Present.

The ASAM Levels for adult residential treatment, including detoxification/withdrawal management (WM), are: Level 3.1. Clinically Managed Low-Intensity Residential Services; Level 3.3. Clinically Managed Population Specific High-Intensity Residential Services (formerly Medium-Intensity); Level 3.5. Clinically Managed High-Intensity Residential Services; Level 3.7. Medically Monitored High-Intensity Inpatient Services (which, in many states, are offered in residential settings); Level 3.2-WM. Clinically Managed Residential Withdrawal Management; Level 3.7-WM. Medically Monitored Inpatient Withdrawal Management (in many states, offered in residential settings). Facility types identified as providing low-, medium-, or high-intensity services sometimes follow and sometimes do not follow the ASAM criteria. The categories represent distinctions on the level of risk posed by residents and the level of treatment provided. *Social detoxification* is an older term that loosely corresponds to Level 3.2-WM in the ASAM system.

TABLE A3. Regulation of Residential Mental Health Treatment Facilities Based on Funding		
State	Regulated Based on Funding	Licensed Based on Funding
Alabama	●	●
Alaska	●	●
Arizona	X	X
Arkansas	X	X
California	X	X
Colorado	●	●
Connecticut	X	X
DC	X	X
Delaware	X	X
Florida	●	●
Georgia	●	●
Hawaii	X	X
Idaho	X	X
Illinois	X	X
Indiana	X	X
Iowa	X	X
Kansas	X	X
Kentucky	X	X
Louisiana	X	X
Maine	●	X
Maryland	X	X
Massachusetts	●	●
Michigan	●	X
Minnesota	X	X
Mississippi	●	●
Missouri	●	●
Montana	●	●
Nebraska	X	X
Nevada	X	X
New Hampshire	X	X
New Jersey	X	X
New Mexico	X	X
New York	X	X
North Carolina	X	X
North Dakota	X	X
Ohio	●	●
Oklahoma	●	●
Oregon	●	●
Pennsylvania	X	X
Rhode Island	X	X



<b>TABLE A3 (continued)</b>		
<b>State</b>	<b>Regulated Based on Funding</b>	<b>Licensed Based on Funding</b>
South Carolina	X	X
South Dakota	X	X
Tennessee	X	X
Texas	•	•
Utah	•	•
Vermont	•	•
Virginia	X	X
Washington	X	X
West Virginia	X	X
Wisconsin	X	X
Wyoming	•	•
<b>NOTES:</b> •: Present; X: Not Present.		

TABLE A4. Regulation of Residential SUD Treatment Facilities Based on Funding		
State	Regulated Based on Funding	Licensed Based on Funding
Alabama	●	●
Alaska	●	●
Arizona	X	X
Arkansas	●	X
California	X	X
Colorado	●	●
Connecticut	X	X
DC	X	X
Delaware	●	X
Florida	●	X
Georgia	●	●
Hawaii	X	X
Idaho	●	X
Illinois	X	X
Indiana	X	X
Iowa	X	X
Kansas	X	X
Kentucky	X	X
Louisiana	X	X
Maine	X	X
Maryland	X	X
Massachusetts	X	X
Michigan	X	X
Minnesota	●	●
Mississippi	●	●
Missouri	●	●
Montana	●	●
Nebraska	X	X
Nevada	●	●
New Hampshire	X	X
New Jersey	X	X
New Mexico	X	X
New York	X	X
North Carolina	●	●
North Dakota	X	X
Ohio	●	●
Oklahoma	●	●
Oregon	●	●
Pennsylvania	X	X
Rhode Island	X	X

<b>TABLE A4 (continued)</b>		
<b>State</b>	<b>Regulated Based on Funding</b>	<b>Licensed Based on Funding</b>
South Carolina	X	X
South Dakota	●	●
Tennessee	X	X
Texas	●	●
Utah	●	●
Vermont	●	X
Virginia	X	X
Washington	X	X
West Virginia	X	X
Wisconsin	X	X
Wyoming	●	●
<b>NOTES:</b> ●: Present; X: Not Present.		

<b>TABLE A5. Extent of Regulation of Residential Mental Health and SUD Treatment Facilities by State</b>		
<b>State</b>	<b>All Mental Health Residential Treatment Regulated and/or Licensed</b>	<b>All SUD Residential Treatment Regulated and/or Licensed</b>
Alabama	•	•
Alaska	X	•
Arizona	•	•
Arkansas	X	•
California	X	•
Colorado	X	X
Connecticut	•	•
DC	X	•
Delaware	X	•
Florida	X	•
Georgia	X	•
Hawaii	•	•
Idaho	X	X
Illinois	•	•
Indiana	X	•
Iowa	•	•
Kansas	X	•
Kentucky	•	X
Louisiana	•	•
Maine	•	X
Maryland	•	•
Massachusetts	X	•
Michigan	X	•
Minnesota	X	•
Mississippi	X	X
Missouri	•	•
Montana	•	•
Nebraska	•	•
Nevada	X	X
New Hampshire	X	X
New Jersey	X	•
New Mexico	X	X
New York	•	•
North Carolina	X	•
North Dakota	X	•
Ohio	•	•
Oklahoma	X	•
Oregon	•	•
Pennsylvania	•	•

<b>TABLE A5 (continued)</b>		
<b>State</b>	<b>All Mental Health Residential Treatment Regulated and/or Licensed</b>	<b>All SUD Residential Treatment Regulated and/or Licensed</b>
Rhode Island	●	●
South Carolina	X	X
South Dakota	X	X
Tennessee	●	●
Texas	X	●
Utah	●	●
Vermont	X	●
Virginia	●	●
Washington	●	●
West Virginia	●	●
Wisconsin	X	X
Wyoming	X	X
<b>NOTES:</b> ●: Present for All; X: Not Present for All.		

TABLE A6. Organization of Oversight Within States			
State	Combined	Separate Mental Health	Separate Substance Use
Alabama	•	X	X
Alaska	•	X	X
Arizona	•	X	X
Arkansas	•	X	X
California	X	•	•
Colorado	•	X	X
Connecticut	•	X	X
DC	•	X	X
Delaware	•	X	X
Florida	X	•	•
Georgia	•	X	•
Hawaii	•	X	X
Idaho	•	X	X
Illinois	X	•	•
Indiana	•	X	X
Iowa	X	•	•
Kansas	X	•	•
Kentucky	•	•	•
Louisiana	•	X	X
Maine	•	X	X
Maryland	•	X	X
Massachusetts	X	•	•
Michigan	X	X	•
Minnesota	•	X	X
Mississippi	•	X	X
Missouri	•	X	X
Montana	•	X	X
Nebraska	•	X	X
Nevada	•	X	X
New Hampshire	•	X	X
New Jersey	•	•	•
New Mexico	•	X	X
New York	X	•	•
North Carolina	•	X	X
North Dakota	X	X	•
Ohio	•	X	X
Oklahoma	•	X	X
Oregon	•	X	X
Pennsylvania	X	•	•
Rhode Island	•	X	X

<b>TABLE A6 (continued)</b>			
<b>State</b>	<b>Combined</b>	<b>Separate Mental Health</b>	<b>Separate Substance Use</b>
South Carolina	●	X	X
South Dakota	●	X	X
Tennessee	●	X	X
Texas	X	●	●
Utah	●	X	X
Vermont	●	●	●
Virginia	●	X	X
Washington	●	X	X
West Virginia	●	X	X
Wisconsin	●	X	X
Wyoming	●	X	X
<b>NOTES:</b> ●: Present; X: Not Present.			

**TABLE A7. Processes of Licensure and Basic Oversight for Mental Health**

State	One Licensure	Multiple Licensure	Duration Identified	Inspection at Licensure	Accreditation Required	Deemed Status	CON Required
Alabama	●	X	V	●	X	X	X
Alaska	●	X	1	●	●	X	●
Arizona	●	X	1	●	X	○	X
Arkansas	●	X	X	●	●	●	X
California	X	●	V	●	X	X	X
Colorado	X	●	V	●	X	X	X
Connecticut	●	X	1	X	X	X	●
DC	X	X	X	X	X	X	X
Delaware	●	X	1	●	X	X	X
Florida	●	X	1	●	X	●	○
Georgia	●	X	V	●	X	X	X
Hawaii	●	X	1	X	X	X	●
Idaho	X	X	X	X	X	X	X
Illinois	●	X	V	●	●	X	●
Indiana	●	X	V	●	●	X	X
Iowa	X	●	V	○	X	○	●
Kansas	●	X	2	●	X	○	○
Kentucky	●	X	1	●	●	X	●
Louisiana	●	X	1	●	X	●	○
Maine	●	X	V	●	X	●	●
Maryland	●	X	V	●	●	●	X
Massachusetts	●	X	2	●	X	X	X
Michigan	X	X	X	X	X	X	X
Minnesota	●	X	2	●	X	●	X
Mississippi	●	X	3	●	X	X	○
Missouri	X	●	V	●	X	●	○
Montana	●	X	V	●	X	●	X
Nebraska	●	X	1	●	○	●	X
Nevada	●	X	1	●	X	X	●
New Hampshire	●	X	1	●	X	X	X
New Jersey	X	X	X	X	X	X	X
New Mexico	●	X	1	●	X	X	X
New York	●	X	3	●	X	X	○
North Carolina	●	X	V	●	X	○	●
North Dakota	X	X	X	X	X	X	X
Ohio	X	●	3	●	X	○	X
Oklahoma	●	X	V	●	X	●	X
Oregon	X	●	2	●	X	X	X
Pennsylvania	●	X	1	●	X	X	X



**TABLE A7 (continued)**

<b>State</b>	<b>One Licensure</b>	<b>Multiple Licensure</b>	<b>Duration Identified</b>	<b>Inspection at Licensure</b>	<b>Accreditation Required</b>	<b>Deemed Status</b>	<b>CON Required</b>
Rhode Island	●	X	2	●	X	●	X
South Carolina	●	X	1	●	X	X	●
South Dakota	X	X	X	X	X	X	X
Tennessee	●	X	1	●	X	●	X
Texas	●	X	2	○	X	X	X
Utah	●	X	V	●	●	○	X
Vermont	X	●	V	●	X	○	○
Virginia	●	X	V	●	X	X	X
Washington	●	X	1	●	X	●	X
West Virginia	●	X	2	●	X	X	X
Wisconsin	●	X	1	●	X	X	X
Wyoming	●	X	2	●	○	●	X

**NOTES:** ●: Present; ○: Present for Some Facility Types; X: Not Present; V: Varies by Facility Type or Circumstances; 1, 2, 3: 1, 2, or 3 years.

**TABLE A8. Processes of Licensure and Basic Oversight for Substance Use**

State	One Licensure	Multiple Licensure	Duration Identified	Inspection at Licensure	Accreditation Required	Deemed Status	CON Required
Alabama	●	X	V	●	X	●	X
Alaska	●	X	V	●	○	X	○
Arizona	●	X	1	●	X	○	X
Arkansas	●	X	V	●	○	●	X
California	X	●	V	●	○	○	X
Colorado	X	●	V	●	X	X	X
Connecticut	●	X	1	X	X	X	X
DC	●	X	V	●	○	○	X
Delaware	●	X	V	●	X	●	X
Florida	●	X	1	●	●	●	X
Georgia	X	●	V	●	X	●	X
Hawaii	●	X	1	X	X	X	●
Idaho	X	X	X	X	X	X	X
Illinois	●	X	3	●	X	X	X
Indiana	●	X	V	○	○	X	X
Iowa	X	●	V	○	X	●	●
Kansas	●	X	V	●	X	●	X
Kentucky	X	●	1	○	○	X	○
Louisiana	●	X	1	●	X	●	○
Maine	●	X	2	●	X	●	●
Maryland	●	X	V	●	●	●	○
Massachusetts	●	X	V	●	X	X	○
Michigan	●	X	1	●	X	●	X
Minnesota	●	X	2	●	X	●	○
Mississippi	●	X	3	●	X	●	○
Missouri	X	●	V	●	X	●	X
Montana	X	●	V	●	X	●	X
Nebraska	●	X	1	●	○	●	X
Nevada	X	●	V	●	X	X	○
New Hampshire	●	X	1	●	X	X	X
New Jersey	●	X	1	●	X	X	●
New Mexico	●	X	1	●	X	X	X
New York	●	X	V	●	X	●	X
North Carolina	●	X	V	●	X	○	○
North Dakota	●	X	V	●	X	●	X
Ohio	●	X	V	●	X	○	X
Oklahoma	●	X	V	●	X	●	X
Oregon	●	X	2	●	X	○	X
Pennsylvania	●	X	1	●	X	X	X
Rhode Island	●	X	2	●	X	●	X

**TABLE A8 (continued)**

State	One Licensure	Multiple Licensure	Duration Identified	Inspection at Licensure	Accreditation Required	Deemed Status	CON Required
South Carolina	●	X	1	●	X	X	X
South Dakota	○	○	V	○	X	○	X
Tennessee	●	X	1	●	X	●	X
Texas	●	X	2	○	X	X	X
Utah	●	X	V	●	●	○	X
Vermont	●	X	V	●	X	X	○
Virginia	●	X	V	●	X	X	○
Washington	●	X	1	●	X	●	X
West Virginia	●	X	2	●	X	X	X
Wisconsin	●	X	V	○	X	○	X
Wyoming	●	X	V	●	○	●	X

**NOTES:** ●: Present; ○: Present for Some Facility Types; X: Not Present; V: Varies by Facility Type or Circumstances; 1, 2, 3: 1, 2, or 3 years.

TABLE A9. Ongoing or Cause-Based Monitoring				
State	Ongoing Inspections for MH	Ongoing Inspections for SU	Caused-Based Inspections for MH	Caused-Based Inspections for SU
Alabama	●	●	●	●
Alaska	X	X	●	●
Arizona	●	●	X	X
Arkansas	●	●	●	●
California	●	●	●	●
Colorado	●	●	●	●
Connecticut	X	X	X	●
DC	X	●	X	●
Delaware	●	●	●	●
Florida	●	●	●	●
Georgia	●	●	●	●
Hawaii	●	●	●	●
Idaho	X	X	X	X
Illinois	●	●	●	●
Indiana	●	○	X	X
Iowa	○	○	○	○
Kansas	●	●	●	●
Kentucky	●	●	●	●
Louisiana	●	●	●	●
Maine	●	●	X	●
Maryland	●	●	●	●
Massachusetts	●	●	●	●
Michigan	X	●	○	●
Minnesota	●	●	●	●
Mississippi	●	●	X	X
Missouri	●	●	●	●
Montana	●	●	●	●
Nebraska	●	●	●	●
Nevada	●	●	●	●
New Hampshire	●	●	●	●
New Jersey	●	●	●	●
New Mexico	●	●	●	●
New York	●	●	●	●
North Carolina	●	●	●	●
North Dakota	X	●	X	●
Ohio	●	●	●	●
Oklahoma	●	●	●	●
Oregon	●	●	●	●
Pennsylvania	●	●	●	●

**TABLE A9 (continued)**

<b>State</b>	<b>Ongoing Inspections for MH</b>	<b>Ongoing Inspections for SU</b>	<b>Caused-Based Inspections for MH</b>	<b>Caused-Based Inspections for SU</b>
Rhode Island	●	●	●	●
South Carolina	●	●	●	●
South Dakota	X	X	X	X
Tennessee	●	●	●	●
Texas	○	○	●	●
Utah	●	●	●	●
Vermont	●	●	●	●
Virginia	●	●	●	●
Washington	●	●	●	●
West Virginia	●	●	●	●
Wisconsin	●	○	X	X
Wyoming	●	●	●	●

**NOTES:** ●: Present; ○: Present for Some Facility Types; X: Not Present.

TABLE A10. Wait Time Standards for Residential Facilities		
State	Mental Health	Substance Use
Alabama	X	●
Alaska	X	X
Arizona	X	X
Arkansas	X	X
California	○	X
Colorado	X	X
Connecticut	X	X
DC	X	○
Delaware	X	X
Florida	○	○
Georgia	●	●
Hawaii	X	X
Idaho	○	○
Illinois	X	X
Indiana	●	●
Iowa	○	○
Kansas	●	○
Kentucky	X	X
Louisiana	X	X
Maine	●	●
Maryland	X	X
Massachusetts	X	X
Michigan	X	X
Minnesota	○	○
Mississippi	●	●
Missouri	○	○
Montana	X	○
Nebraska	X	X
Nevada	X	X
New Hampshire	X	X
New Jersey	X	X
New Mexico	X	X
New York	●	X
North Carolina	X	X
North Dakota	X	X
Ohio	X	●
Oklahoma	X	X
Oregon	●	○
Pennsylvania	X	X
Rhode Island	●	●

TABLE A10 (continued)		
State	Mental Health	Substance Use
South Carolina	●	X
South Dakota	X	X
Tennessee	X	X
Texas	X	X
Utah	X	X
Vermont	X	●
Virginia	X	X
Washington	X	X
West Virginia	X	X
Wisconsin	X	X
Wyoming	X	X
<b>NOTES:</b> ●: Present; ○: Present for Some Facility Types; X: Not Present.		

**TABLE A11. Staffing Standards for Residential Facilities for Mental Health**

State	Administrator Standards	Medical Director Standards	Medical Staff Standards	Clinical Staff Standards	Direct Care Staff Standards	Staffing Ratios	Adequate or Sufficient Staffing
Alabama	●	○	●	●	●	●	X
Alaska	●	X	X	X	X	X	X
Arizona	●	X	●	X	●	X	●
Arkansas	●	●	●	X	●	○	●
California	●	X	X	X	●	●	●
Colorado	●	●	○	X	●	●	●
Connecticut	●	●	●	X	●	●	●
DC	X	X	X	X	X	X	X
Delaware	●	X	○	X	●	○	X
Florida	○	X	●	X	●	●	○
Georgia	●	●	●	X	●	●	●
Hawaii	●	X	X	X	X	○	●
Idaho	X	X	X	X	X	X	X
Illinois	●	●	●	X	●	●	X
Indiana	●	●	●	X	●	X	X
Iowa	●	○	○	○	○	○	○
Kansas	●	X	●	X	X	X	X
Kentucky	●	X	●	X	●	●	X
Louisiana	●	●	●	X	○	○	●
Maine	X	X	○	X	X	●	X
Maryland	X	X	X	X	X	X	X
Massachusetts	●	X	X	X	X	X	●
Michigan	X	X	X	X	X	X	X
Minnesota	●	X	○	X	●	●	●
Mississippi	●	X	●	X	●	●	X
Missouri	○	X	○	X	●	○	●
Montana	X	X	X	X	X	X	X
Nebraska	●	X	X	X	X	X	●
Nevada	●	X	●	X	X	X	●
New Hampshire	●	X	●	X	●	X	●
New Jersey	X	X	X	X	X	X	X
New Mexico	●	X	●	X	●	X	●
New York	○	X	X	X	○	X	●
North Carolina	●	X	●	X	●	●	●
North Dakota	X	X	X	X	X	X	X
Ohio	X	X	X	X	●	X	●
Oklahoma	X	X	●	X	●	○	●
Oregon	●	X	X	X	●	●	X
Pennsylvania	●	X	●	X	●	●	X



**TABLE A11 (continued)**

State	Administrator Standards	Medical Director Standards	Medical Staff Standards	Clinical Staff Standards	Direct Care Staff Standards	Staffing Ratios	Adequate or Sufficient Staffing
Rhode Island	X	X	o	X	•	•	•
South Carolina	•	X	•	X	•	•	•
South Dakota	X	X	X	X	X	X	X
Tennessee	o	X	•	X	•	•	X
Texas	X	o	•	X	o	o	•
Utah	•	X	•	X	X	•	•
Vermont	•	X	X	X	•	X	•
Virginia	o	o	o	o	X	X	o
Washington	X	X	•	•	•	X	•
West Virginia	•	X	o	o	•	o	o
Wisconsin	•	X	X	X	•	X	•
Wyoming	•	X	X	•	•	X	X

**NOTES:** •: Present; o: Present for Some Facility Types; X: Not Present.

**TABLE A12. Staffing Standards for Residential Facilities for Substance Use**

State	Administrator Standards	Medical Director Standards	Medical Staff Standards	Clinical Staff Standards	Direct Care Staff Standards	Staffing Ratios	Adequate or Sufficient Staffing
Alabama	●	X	●	●	●	X	●
Alaska	X	X	○	○	X	X	X
Arizona	●	X	●	●	●	X	●
Arkansas	○	X	○	●	●	○	●
California	●	X	X	●	●	X	●
Colorado	○	○	○	●	X	●	●
Connecticut	●	○	○	○	●	X	●
DC	●	X	○	○	X	○	●
Delaware	●	X	○	●	●	○	●
Florida	●	●	●	●	●	●	●
Georgia	●	○	●	●	○	○	●
Hawaii	●	X	X	X	X	○	●
Idaho	X	X	X	X	X	●	●
Illinois	X	●	●	●	●	X	●
Indiana	●	●	●	●	●	X	X
Iowa	●	X	X	○	○	X	X
Kansas	●	X	○	●	X	○	○
Kentucky	○	○	●	●	●	○	○
Louisiana	●	●	●	●	●	●	●
Maine	●	●	●	●	X	●	○
Maryland	○	X	○	●	●	X	○
Massachusetts	●	X	○	●	●	X	●
Michigan	●	○	●	●	X	●	X
Minnesota	●	○	○	○	●	●	●
Mississippi	●	X	●	●	●	○	○
Missouri	X	X	○	●	●	X	●
Montana	●	X	●	●	●	●	●
Nebraska	●	X	X	X	X	X	●
Nevada	●	X	○	●	X	X	●
New Hampshire	●	●	●	●	●	●	●
New Jersey	●	○	●	●	●	●	X
New Mexico	●	X	●	●	●	X	●
New York	●	●	○	●	X	X	●
North Carolina	●	X	○	○	○	○	○
North Dakota	X	X	X	○	○	X	●
Ohio	○	○	○	○	○	○	○
Oklahoma	○	X	●	●	●	X	●
Oregon	●	○	○	●	●	●	X
Pennsylvania	●	X	○	●	●	●	●

**TABLE A12 (continued)**

State	Administrator Standards	Medical Director Standards	Medical Staff Standards	Clinical Staff Standards	Direct Care Staff Standards	Staffing Ratios	Adequate or Sufficient Staffing
Rhode Island	X	X	o	o	•	•	•
South Carolina	•	X	o	•	•	•	•
South Dakota	•	o	o	•	X	X	X
Tennessee		X	•	•	•	•	X
Texas	X	o	o	•	•	•	•
Utah	•	X	•	•	X	•	•
Vermont	X	X	o	•	•	X	X
Virginia	X	X	X	X	o	o	o
Washington	X	X	•	•	•	X	•
West Virginia	•	X	o	o	•	o	o
Wisconsin	•	X	•	•	o	o	o
Wyoming	•	o	o	•	•	X	X

**NOTES:** •: Present; o: Present for Some Facility Types; X: Not Present.

**TABLE A13. Staff Training Standards for Residential Facilities**

State	Orientation/ Ongoing Training for MH	Orientation/ Ongoing Training for SU	Trauma Informed Care for MH	Trauma Informed Care for SU	Suicide Assessment or Prevention for MH	Suicide Assessment or Prevention for SU
Alabama	●	●	X	X	X	●
Alaska	○	○	X	X	X	X
Arizona	●	●	X	X	X	X
Arkansas	●	●	X	X	X	X
California	○	○	X	X	X	X
Colorado	●	●	X	X	●	○
Connecticut	●	●	X	X	X	X
DC	X	●	X	●	X	●
Delaware	●	●	X	X	X	X
Florida	●	●	X	X	●	X
Georgia	●	●	X	X	●	●
Hawaii	●	●	X	X	X	X
Idaho	X	○	X	X	X	X
Illinois	●	●	●	X	●	X
Indiana	○	○	X	X	X	X
Iowa	○	●	X	X	○	○
Kansas	●	●	X	X	X	X
Kentucky	○	○	●	●	●	○
Louisiana	●	●	X	X	X	X
Maine	●	●	X	X	X	X
Maryland	○	○	X	X	X	○
Massachusetts	●	●	X	X	X	X
Michigan	X	○	X	X	X	X
Minnesota	●	○	X	X	X	X
Mississippi	○	●	X	X	X	X
Missouri	●	●	●	●	X	X
Montana	○	●	X	X	X	X
Nebraska	●	●	X	X	X	X
Nevada	●	●	X	X	X	X
New Hampshire	●	●	X	X	X	X
New Jersey	X	●	X	X	X	X
New Mexico	●	●	X	X	X	X
New York	○	○	X	○	X	X
North Carolina	●	●	X	X	X	X
North Dakota	X	X	X	X	X	X
Ohio	●	●	X	X	X	X
Oklahoma	●	○	●	●	X	X
Oregon	●	●	X	X	X	X

**TABLE A13 (continued)**

State	Orientation/ Ongoing Training for MH	Orientation/ Ongoing Training for SU	Trauma Informed Care for MH	Trauma Informed Care for SU	Suicide Assessment or Prevention for MH	Suicide Assessment or Prevention for SU
Pennsylvania	●	●	X	X	X	X
Rhode Island	●	●	X	X	X	X
South Carolina	●	●	X	X	●	X
South Dakota	X	●	X	X	X	X
Tennessee	●	●	X	X	X	X
Texas	○	●	X	X	X	X
Utah	●	●	X	X	X	X
Vermont	●	●	X	X	X	X
Virginia	●	●	X	X	X	X
Washington	●	●	X	X	X	X
West Virginia	●	●	X	X	X	X
Wisconsin	●	●	X	X	○	●
Wyoming	X	○	X	●	X	X

**NOTES:** ●: Present; ○: Present for Some Facility Types; X: Not Present.

TABLE A14. Placement Standards for Residential Facilities for Mental Health							
State	Specific Criteria for Placement	ASAM Placement Criteria	Policy or Procedures Required	Placement Assessment/ Screening	Before Admission Placement	Within 24 Hours Placement	Within 24 Hours Other
Alabama	●	n/a	●	●	X	X	X
Alaska	●	n/a	X	●	●	X	X
Arizona	X	n/a	●	●	○	○	X
Arkansas	●	n/a	●	●	X	●	X
California	●	n/a	X	●	●	X	X
Colorado	X	n/a	●	●	X	X	●
Connecticut	●	n/a	●	●	X	X	○
DC	X	n/a	X	X	X	X	X
Delaware	○	n/a	○	●	○	X	X
Florida	●	n/a	X	●	●	X	○
Georgia	●	n/a	●	●	●	X	●
Hawaii	X	n/a	●	X	X	X	X
Idaho	○	n/a	X	○	○	X	X
Illinois	●	n/a	X	●	●	X	X
Indiana	●	●	X	X	X	X	X
Iowa	●	n/a	○	●	●	X	○
Kansas	X	n/a	X	X	X	X	X
Kentucky	●	n/a	X	X	X	X	●
Louisiana	●	n/a	○	●	●	X	X
Maine	●	n/a	X	●	X	●	X
Maryland	●	n/a	X	X	X	X	X
Massachusetts	X	n/a	●	X	X	X	X
Michigan	X	n/a	X	X	X	X	X
Minnesota	○	n/a	●	●	X	X	X
Mississippi	X	n/a	●	●	X	●	X
Missouri	●	n/a	●	●	●	X	X
Montana	●	n/a	X	●	X	X	X
Nebraska	X	n/a	●	X	X	X	●
Nevada	●	n/a	X	●	●	X	●
New Hampshire	●	n/a	X	X	X	X	●
New Jersey	X	n/a	X	X	X	X	X
New Mexico	X	n/a	X	X	X	X	X
New York	●	n/a	●	●	●	X	X
North Carolina	X	n/a	●	●	X	X	●
North Dakota	X	n/a	X	X	X	X	X
Ohio	X	n/a	X	X	X	X	X
Oklahoma	○	n/a	○	●	○	X	X
Oregon	●	n/a	X	●	●	X	X

TABLE A14 (continued)							
State	Specific Criteria for Placement	ASAM Placement Criteria	Policy or Procedures Required	Placement Assessment/ Screening	Before Admission Placement	Within 24 Hours Placement	Within 24 Hours Other
Pennsylvania	●	n/a	X	●	●	X	●
Rhode Island	●	n/a	●	●	●	X	X
South Carolina	●	n/a	●	●	●	●	X
South Dakota	X	n/a	X	X	X	X	X
Tennessee	○	n/a	○	○	X		X
Texas	●	n/a	X	●	●	X	X
Utah	○	○	X	●	●	X	X
Vermont	X	X	X	X	X	X	X
Virginia	●	n/a	●	●	●	●	X
Washington	○	n/a	X	●	○	X	●
West Virginia	X	n/a	X	●	●	X	X
Wisconsin	●	n/a	X	●	X	X	X
Wyoming	X	n/a	X	X	X	X	X

**NOTES:** ●: Present; ○: Present for Some Facility Types; X: Not Present.

TABLE A15. Placement Standards for Residential Facilities for Substance Use							
State	Specific Criteria for Placement	ASAM Placement Criteria	Policy or Procedures Required	Placement Assessment/ Screening	Before Admission Placement	Within 24 Hours Placement	Within 24 Hours Other
Alabama	●	●	●	●	X	X	X
Alaska	●	●	X	●	X	●	●
Arizona	X	X	●	●	○	○	X
Arkansas	●	●	○	●	○	○	X
California	●	●	X	●	●	X	X
Colorado	●	●	●	●	●	X	○
Connecticut	●	X	●	●	●	X	○
DC	●	●	X	●	○	○	●
Delaware	○	○	●	●	X	○	X
Florida	●	○	X	●	●	X	X
Georgia	●	○	●	●	●	●	○
Hawaii	X	X	●	X	X	X	X
Idaho	○	○	X	○	○	X	X
Illinois	●	●	X	●	●	X	X
Indiana	●	●	X	X	X	X	X
Iowa	●	●	●	●	●	X	○
Kansas	●	X	●	●	X	X	X
Kentucky	●	○	X	○	○	X	●
Louisiana	●	●	○	●	●	X	X
Maine	○	○	●	●	X	X	●
Maryland	●	●	X	●	X	X	X
Massachusetts	●	X	●	●	○	○	X
Michigan	X	X	●	●	X	X	X
Minnesota	●	X	●	●	●	○	○
Mississippi	○	○	●	○	X	X	●
Missouri	●	X	●	●	●	X	X
Montana	●	●	●	●	●	X	X
Nebraska	X	X	●	X	X	X	X
Nevada	●	●	●	●	●	○	X
New Hampshire	●	●	X	●	●	X	●
New Jersey	●	●	X	●	●	X	X
New Mexico	○	○	X	○	X	X	
New York	●	X	X	●	●	●	●
North Carolina	○	X	●	●	X	X	●
North Dakota	●	●	●	●	X	X	X
Ohio	●	●	X	●	X	X	X
Oklahoma	●	●	●	●	○	●	X
Oregon	●	●	○	●	●	X	X



**TABLE A15 (continued)**

State	Specific Criteria for Placement	ASAM Placement Criteria	Policy or Procedures Required	Placement Assessment/ Screening	Before Admission Placement	Within 24 Hours Placement	Within 24 Hours Other
Pennsylvania	X	X	●	●	●	X	●
Rhode Island	●	●	●	●	●	X	○
South Carolina	●	X	●	●	X	X	X
South Dakota	●	○	●	●	X	X	X
Tennessee	●	○	●	●	X	X	○
Texas	●	X	X	●	X	X	X
Utah	○	○	X	●	●	X	X
Vermont	●	●	●	●	X	X	X
Virginia	●	○	●	●	●	●	X
Washington	●	●	X	●	●	X	X
West Virginia	X	X	X	●	●	X	X
Wisconsin	●	○	●	●	●	X	○
Wyoming	●	●	●	●	○	X	X

**NOTES:** ●: Present; ○: Present for Some Facility Types; X: Not Present.

**TABLE A16. Treatment Planning, Discharge Planning, and Aftercare Standards for Residential Facilities for Mental Health**

State	Treatment Plan Required	Timeframe to Complete	Timeframe to Review or Update	Discharge Plan Required	At Admission or Early	Aftercare/ Follow-Up
Alabama	●	●	●	●	●	X
Alaska	X	X	X	●	●	X
Arizona	●	●	●	●	X	X
Arkansas	●	●	●	●	●	X
California	●	X	●	●	●	X
Colorado	●	●	●	●	●	X
Connecticut	●	●	●	X	X	X
DC	X	X	X	X	X	X
Delaware	●	●	●	○	X	X
Florida	●	○	○	●	○	X
Georgia	●	●	●	●	●	X
Hawaii	●	●	X	○	X	X
Idaho	○	○	○	X	X	X
Illinois	●	X	●	●	●	●
Indiana	●	●	●	X	X	X
Iowa	●	●	●	●	○	○
Kansas	●	●	●	●	X	●
Kentucky	●	X	X	●	●	X
Louisiana	●	○	○	●	●	X
Maine	●	●	●	●	○	X
Maryland	X	X	X	X	X	X
Massachusetts	●	X	X	○	X	X
Michigan	●	●	●	X	X	X
Minnesota	●	●	●	●	○	X
Mississippi	●	X	X	X	X	X
Missouri	●	○	●	●	●	X
Montana	●	X	X	●	X	X
Nebraska	●	●	●	●	X	X
Nevada	●	X	X	●	X	X
New Hampshire	●	●	●	●	X	X
New Jersey	X	X	X	X	X	X
New Mexico	●	X	X	●	●	X
New York	●	●	●	●	●	X
North Carolina	●	●	●	●	X	X
North Dakota	X	X	X	X	X	X
Ohio	●	●	●	X	X	X
Oklahoma	○	○	○	●	○	○
Oregon	●	X	●	X	X	X

**TABLE A16 (continued)**

State	Treatment Plan Required	Timeframe to Complete	Timeframe to Review or Update	Discharge Plan Required	At Admission or Early	Aftercare/ Follow-Up
Pennsylvania	●	●	●	●	X	X
Rhode Island	●	○	●	●	○	X
South Carolina	●	●	●	●	●	X
South Dakota	X	X	X	X	X	X
Tennessee	●	○	○	○	X	X
Texas	●	○	●	○	○	X
Utah	●	●	●	●	X	X
Vermont	●	●	X	●	X	X
Virginia	●	●	X	●	X	X
Washington	●	●	●	●	X	○
West Virginia	●	X	●	●	X	X
Wisconsin	●	●	●	X	X	X
Wyoming	X	X	X	X	X	X

**NOTES:** ●: Present; ○: Present for Some Facility Types; X: Not Present.

**TABLE A17. Treatment Planning, Discharge Planning, and Aftercare Standards  
for Residential Facilities for Substance Use**

State	Treatment Plan Required	Timeframe to Complete	Timeframe to Review or Update	Discharge Plan Required	At Admission or Early	Aftercare/ Follow-Up
Alabama	•	•	•	•	•	X
Alaska	•	X	X	•	X	X
Arizona	•	•	•	•	X	X
Arkansas	•	•	•	•	•	X
California	•	•	•	•	X	X
Colorado	•	•	•	•	•	X
Connecticut	•	•	•	X	X	X
DC	•	X	○	•	X	X
Delaware	•	•	•	•	○	X
Florida	•	•	○	•	X	X
Georgia	•	•	○	•	•	X
Hawaii	•	•	X	○	X	X
Idaho	X	X	X	X	X	X
Illinois	•	•	X	•	X	X
Indiana	•	•	•	•	X	X
Iowa	•	•	•	•	•	○
Kansas	•	•	•	•	X	X
Kentucky	•	○	○	•	○	X
Louisiana	•	○	○	•	•	X
Maine	•	•	•	•	○	X
Maryland	X	X	X	X	X	X
Massachusetts	•	○	•	•	•	•
Michigan	•	○	○	X	X	○
Minnesota	•	○	○	○	X	X
Mississippi	•	X	X	X	X	X
Missouri	○	•	○	•	•	X
Montana	•	•	•	•	X	X
Nebraska	•	•	•	•	X	X
Nevada	•	○	○	•	•	X
New Hampshire	•	•	•	•	X	X
New Jersey	•	X	•	•	•	X
New Mexico	•	X	X	•	•	X
New York	•	•	•	•	•	X
North Carolina	•	•	•	○	X	X
North Dakota	•	•	•	•	•	X
Ohio	•	•	•	•	X	•
Oklahoma	○	○	○	•	○	○
Oregon	•	X	•	•	X	•

**TABLE A17 (continued)**

State	Treatment Plan Required	Timeframe to Complete	Timeframe to Review or Update	Discharge Plan Required	At Admission or Early	Aftercare/ Follow-Up
Pennsylvania	●	X	●	●	X	●
Rhode Island	●	X	●	●	○	X
South Carolina	●	●	○	●	X	●
South Dakota	●	●	X	●	X	X
Tennessee	●	●	○	○	○	○
Texas	●	●	●	●	X	X
Utah	●	●	●	●	X	X
Vermont	○	○	○	●	○	X
Virginia	●	●	X	●	X	X
Washington	●	●	●	●	X	X
West Virginia	●	X	●	●	X	X
Wisconsin	○	○	●	●	X	●
Wyoming	○	○	○	●	○	○

**NOTES:** ●: Present; ○: Present for Some Facility Types; X: Not Present.

**TABLE A18. Treatment Services Standards for Residential Facilities**

State	Any Service Requirements for MH	Any Service Requirements for SU	Specific to Clinical Service Types for MH	Specific to Clinical Service Types for SU	Specific to Clinical Service Hours for MH	Specific to Clinical Service Hours for SU	Evidence-Based for MH	Evidence-Based for SU
Alabama	•	•	•	•	X	X	X	○
Alaska	•	•	X	•	X	X	X	X
Arizona	•	•	•	•	X	X	X	X
Arkansas	•	•	•	•	•	•	•	○
California	•	•	•	•	X	X	X	X
Colorado	•	•	•	•	X	•	•	•
Connecticut	•	•	•	•	X	X	X	X
DC	X	•	X	•	X	•	X	•
Delaware	•	•	•	○	X	•	X	X
Florida	•	•	○	•	X	○	X	○
Georgia	•	•	•	•	X	○	X	○
Hawaii	•	•	•	•	X	X	X	X
Idaho	○	•	X	X	X	X	X	X
Illinois	•	•	•	•	X	○	•	○
Indiana	•	•	•	•	X	X	•	•
Iowa	•	•	○	•	○	•	X	X
Kansas	•	•	•	○	X	X	X	X
Kentucky	•	•	•	•	X	○	•	○
Louisiana	•	•	•	•	○	○	•	•
Maine	•	•	X	•	X	○	X	X
Maryland	•	•	•	•	X	•	X	X
Massachusetts	•	•	•	•	X	X	X	X
Michigan	X	•	X	○	X	○	X	○
Minnesota	•	•	•	•	X	X	•	X
Mississippi	•	•	•	•	•	○	X	•
Missouri	•	•	○	•	X	○	•	•
Montana	•	•	•	○	X	X	X	○
Nebraska	•	•	•	•	X	X	X	X
Nevada	•	•	•	•	X	○	X	○
New Hampshire	•	•	•	•	X	X	X	•
New Jersey	X	•	X	•	X	○	X	X
New Mexico	•	•	X	X	X	X	•	•
New York	•	•	○	•	X	X	X	•
North Carolina	•	•	•	•	X	X	X	X
North Dakota	X	•	X	•	X	•	X	○
Ohio	•	•	•	•	•	•	X	X
Oklahoma	•	•	•	•	○	○	○	○
Oregon	•	•	•	•	•	X	X	•

**TABLE A18 (continued)**

State	Any Service Requirements for MH	Any Service Requirements for SU	Specific to Clinical Service Types for MH	Specific to Clinical Service Types for SU	Specific to Clinical Service Hours for MH	Specific to Clinical Service Hours for SU	Evidence-Based for MH	Evidence-Based for SU
Pennsylvania	●	●	●	●	●	X	X	X
Rhode Island	●	●	●	●	○	○	X	X
South Carolina	●	●	X	●	X	X	X	○
South Dakota	X	●	X	●	X	●	X	X
Tennessee	●	●	●	●	○	X	X	X
Texas	●	●	○	●	X	○	X	○
Utah	●	●	●	●	X	X	X	X
Vermont	●	●	●	●	X	X	X	●
Virginia	●	●	●	●	X	X	X	X
Washington	●	●	○	●	X	○	X	X
West Virginia	●	●	●	●	X	X	○	○
Wisconsin	●	●	X	○	X	○	X	X
Wyoming	●	●	X	○	X	○	X	○

**NOTES:** ●: Present; ○: Present for Some Facility Types; X: Not Present.

TABLE A19. Requirements Specific to MAT in Residential Facilities						
State	Services MAT for MH	Services MAT for SU	Access MAT for MH	Access MAT for SU	Rights MAT for MH	Rights MAT for SU
Alabama	X	o	X	X	X	X
Alaska	X	X	X	X	X	X
Arizona	X	X	X	X	X	X
Arkansas	X	X	X	X	X	X
California	X	●	X	●	X	●
Colorado	X	X	X	X	X	X
Connecticut	X	X	X	X	X	X
DC	X	●	X	X	X	X
Delaware	X	X	X	X	X	X
Florida	X	o	X	X	X	X
Georgia	X	X	X	X	X	X
Hawaii	X	X	X	X	X	X
Idaho	X	X	X	X	X	X
Illinois	X	o	X	X	X	o
Indiana	X	X	X	X	X	X
Iowa	X	X	X	X	X	X
Kansas	X	X	X	X	X	X
Kentucky	X	o	X	X	X	X
Louisiana	X	X	X	X	X	X
Maine	X	X	X	X	X	X
Maryland	●	●	●	●	●	●
Massachusetts	X	X	X	X	X	X
Michigan	X	o	X	X	X	o
Minnesota	X	X	X	X	X	X
Mississippi	X	●	X	●	X	o
Missouri	X	o	X	o	X	o
Montana	X	o	X	X	X	X
Nebraska	X	X	X	X	X	X
Nevada	X	o	X	●	X	●
New Hampshire	X	●	X	X	X	X
New Jersey	X	X	X	X	X	X
New Mexico	X	X	X	X	X	X
New York	X	●	X	●	X	●
North Carolina	X	X	X	X	X	X
North Dakota	X	X	X	X	X	X
Ohio	X	X	X	X	X	X
Oklahoma	X	o	X	X	X	X
Oregon	X	X	X	X	X	●
Pennsylvania	X	X	X	X	X	X



TABLE A19 (continued)						
State	Services MAT for MH	Services MAT for SU	Access MAT for MH	Access MAT for SU	Rights MAT for MH	Rights MAT for SU
Rhode Island	X	X	X	X	X	X
South Carolina	X	o	X	X	X	X
South Dakota	X	X	X	X	X	X
Tennessee	X	X	X	X	X	X
Texas	X	o	X	o	X	o
Utah	o	o	o	o	●	●
Vermont	X	X	X	X	X	X
Virginia	X	X	X	X	X	X
Washington	X	X	X	X	X	X
West Virginia	X	X	X	X	X	X
Wisconsin	X	X	X	X	X	X
Wyoming	X	X	X	X	X	X

**NOTES:** ●: Present; o: Present for Some Facility Types; X: Not Present.

TABLE A20. Service Recipient Rights--Grievances and Complaints Standards for Residential Facilities						
State	Patient Rights for MH	Patient Rights for SU	Complaints/ Grievances for MH	Complaints/ Grievances for SU	Complaints Reported to State for MH	Complaints Reported to State for SU
Alabama	●	●	●	●	X	X
Alaska	●	●	●	●	X	X
Arizona	●	●	●	●	X	X
Arkansas	●	●	●	●	X	X
California	●	●	●	●	X	X
Colorado	●	●	●	●	●	●
Connecticut	●	●	X	X	X	X
DC	X	●	X	●	X	X
Delaware	●	●	○	●	X	X
Florida	●	●	●	○	X	X
Georgia	●	●	X	●	X	X
Hawaii	●	●	X	X	X	X
Idaho	●	X	●	X	X	X
Illinois	●	●	●	●	X	●
Indiana	●	●	●	●	X	X
Iowa	●	●	●	●	○	●
Kansas	●	●	●	●	X	X
Kentucky	●	●	●	●	X	X
Louisiana	●	●	●	●	X	X
Maine	●	●	●	●	○	X
Maryland	●	●	X	X	X	X
Massachusetts	●	●	●	●	X	○
Michigan	●	●	●	●	X	X
Minnesota	●	●	○	●	○	X
Mississippi	●	●	●	●	X	X
Missouri	●	●	●	●	X	X
Montana	●	●	●	●	X	X
Nebraska	●	●	●	●	X	X
Nevada	●	●	X	○	X	○
New Hampshire	●	●	●	●	X	X
New Jersey	X	●	X	●	X	X
New Mexico	X	X	X	X	X	X
New York	●	●	●	●	X	○
North Carolina	●	●	●	●	X	X
North Dakota	X	●	X	●	X	X
Ohio	●	●	●	●	X	X
Oklahoma	●	●	○	○	○	○
Oregon	●	●	●	●	X	X

**TABLE A20 (continued)**

<b>State</b>	<b>Patient Rights for MH</b>	<b>Patient Rights for SU</b>	<b>Complaints/ Grievances for MH</b>	<b>Complaints/ Grievances for SU</b>	<b>Complaints Reported to State for MH</b>	<b>Complaints Reported to State for SU</b>
Pennsylvania	●	●	●	X	X	X
Rhode Island	●	●	●	●	X	X
South Carolina	●	●	●	●	X	X
South Dakota	X	●	X	●	X	X
Tennessee	●	●	●	●	X	X
Texas	●	●	X	●	X	○
Utah	●	●	●	●	X	X
Vermont	●	●	●	●	X	X
Virginia	●	●	●	●	●	●
Washington	●	●	●	●	○	○
West Virginia	●	●	●	●	○	○
Wisconsin	●	●	●	●	X	X
Wyoming	●	●	●	●	X	X

**NOTES:** ●: Present; ○: Present for Some Facility Types; X: Not Present.

**TABLE A21. Service Recipient Rights--Restraint and Seclusion Standards for Residential Facilities**

State	Rights re R/S for MH	Rights re R/S for SU	R/S Prohibited for MH	R/S Prohibited for SU	R/S Allowed but Regulated for MH	R/S Allowed but Regulated for SU	R/S Reported to State for MH	R/S Reported to State for SU
Alabama	●	●	X	●	●	X	X	X
Alaska	●	●	X	X	●	●	X	X
Arizona	●	●	X	X	●	X	●	X
Arkansas	●	○	○	○	X	X	X	X
California	●	X	X	X	●	X	X	X
Colorado	●	●	X	X	●	●	X	X
Connecticut	X	○	X	X	X	○	X	X
DC	X	X	X	X	X	X	X	X
Delaware	○	X	○	X	○	X	○	X
Florida	●	●	○	X	○	○	○	X
Georgia	●	●	○	○	○	○	X	X
Hawaii	X	X	X	X	X	X	X	X
Idaho	●	X	X	X	●	X	X	X
Illinois	●	X	X	X	●	X	X	X
Indiana	●	●	○	○	○	○	X	X
Iowa	○	X	X	X	○	X	X	X
Kansas	●	●	X	X	●	●	●	X
Kentucky	●	○	○	○	○	○	X	X
Louisiana	●	●	X	X	●	●	X	X
Maine	●	X	○	X	○	X	X	X
Maryland	X	X	X	X	X	X	X	X
Massachusetts	●	●	○	○	○	○	X	X
Michigan	●	●	X	X	●	●	X	X
Minnesota	○	●	X	X	○	●	X	X
Mississippi	●	●	○	○	○	○	○	○
Missouri	●	●	○	○	○	○	X	X
Montana	X	X	X	X	X	X	X	X
Nebraska	●	●	X	X	●	●	X	X
Nevada	●	●	X	X	●	●	●	●
New Hampshire	●	●	X	X	●	●	X	X
New Jersey	X	●	X	○	X	X	X	X
New Mexico	●	●	○	○	○	○	X	X
New York	●	●	X	●	●	X	●	X
North Carolina	X	X	X	X	X	X	X	X
North Dakota	X	X	X	X	X	X	X	X
Ohio	●	●	○	●	○	X	X	X
Oklahoma	●	●	X	X	●	●	X	X
Oregon	●	●	○	●	●	X	X	X

**TABLE A21 (continued)**

State	Rights re R/S for MH	Rights re R/S for SU	R/S Prohibited for MH	R/S Prohibited for SU	R/S Allowed but Regulated for MH	R/S Allowed but Regulated for SU	R/S Reported to State for MH	R/S Reported to State for SU
Pennsylvania	●	X	○	X	○	X	X	X
Rhode Island	●	●	○	○	●	●	X	X
South Carolina	●	●	X	X	●	●	X	X
South Dakota	X	X	X	X	X	X	X	X
Tennessee	●	●	X	X	●	●	X	X
Texas	●	●	X	X	●	●	X	X
Utah	●	●	○	○	○	○	X	X
Vermont	●	●	●	●	X	X	X	X
Virginia	●	●	X	X	●	●	●	●
Washington	●	●	X	X	●	●	X	X
West Virginia	●	●	○	○	○	○	X	X
Wisconsin	●	●	○	○	○	○	X	X
Wyoming	●	●	X	X	●	●	X	X

**NOTES:** ●: Present; ○: Present for Some Facility Types; X: Not Present.

**TABLE A22. QA/QI Standards for Residential Facilities**

State	QA/QI Requirement for MH	QA/QI Requirement for SU	Written Plan or Policy for MH	Written Plan or Policy for SU	Needs Assessment for MH	Needs Assessment for SU	Measurement for MH	Measurement for SU	Provide Results to State for MH	Provide Results to State for SU
Alabama	●	●	●	●	X	X	●	●	X	●
Alaska	●	●	X	X	X	X	●	●	X	X
Arizona	●	●	●	●	X	X	●	●	X	X
Arkansas	●	●	●	●	X	X	●	○	X	X
California	X	●	X	●	X	X	X	X	X	X
Colorado	●	●	●	●	X	X	●	●	X	●
Connecticut	●	●	X	X	X	X	X	X	X	X
DC	X	●	X	●	X	X	X	●	X	○
Delaware	○	●	○	●	X	●	○	●	X	X
Florida	●	●	●	●	X	X	○	X	X	○
Georgia	●	●	●	●	X	X	●	●	X	X
Hawaii	●	●	●	●	X	X	○	○	X	○
Idaho	X	X	X	X	X	X	X	X	X	X
Illinois	●	●	●	●	X	X	●	●	X	○
Indiana	●	●	X	X	X	X	X	X	X	X
Iowa	○	●	○	●	X	X	○	●	X	X
Kansas	●	●	●	●	X	X	●	●	X	X
Kentucky	●	●	X	X	X	X	X	X	X	X
Louisiana	●	●	●	●	X	X	X	X	X	X
Maine	●	●	●	●	X	X	X	X	X	X
Maryland	X	X	X	X	X	X	X	X	X	X
Massachusetts	●	●	●	●	X	X	●	●	X	X
Michigan	X	X	X	X	X	X	X	X	X	X
Minnesota	●	●	●	X	X	X	●	●	X	●
Mississippi	●	●	●	●	X	X	●	●	X	●
Missouri	●	●	●	●	X	X	●	●	X	○
Montana	X	●	X	●	X	X	X	●	X	X
Nebraska	●	●	X	X	X	X	X	X	X	X
Nevada	X	○	X	○	X	X	X	○	X	○
New Hampshire	●	●	X	●	X	X	X	●	X	X
New Jersey	X	●	X	●	X	X	X	X	X	X
New Mexico	●	●	●	●	X	X	●	●	X	X
New York	●	●	●	●	X	X	●	○	X	X
North Carolina	●	●	●	●	X	X	○	○	X	○
North Dakota	X	●	X	●	X	X	X	X	X	X
Ohio	●	●	●	●	X	X	●	●	X	X
Oklahoma	●	●	●	●	X	●	●	●	X	○
Oregon	X	●	X	●	X	X	X	X	X	X

**TABLE A22 (continued)**

State	QA/QI Requirement for MH	QA/QI Requirement for SU	Written Plan or Policy for MH	Written Plan or Policy for SU	Needs Assessment for MH	Needs Assessment for SU	Measurement for MH	Measurement for SU	Provide Results to State for MH	Provide Results to State for SU
Pennsylvania	●	●	●	X	X	X	●	●	X	X
Rhode Island	●	●	●	●	X	X	X	X	X	X
South Carolina	●	●	●	●	X	X	○	●	X	X
South Dakota	X	●	X	●	X	X	X	●	X	●
Tennessee	●	●	●	●	X	X	X	X	X	X
Texas	X	●	X	●	X	X	X	○	X	X
Utah	●	●	●	●	X	X	X	X	X	X
Vermont	○	●	○	●	X	X	○	●	X	X
Virginia	●	●	●	●	X	X	●	●	○	○
Washington	●	●	●	●	X	X	●	●	X	X
West Virginia	●	●	X	X	X	X	X	X	X	X
Wisconsin	X	○	X	○	X	X	X	○	X	○
Wyoming	X	●	X	●	X	X	X	●	X	X

**NOTES:** ●: Present; ○: Present for Some Facility Types; X: Not Present.

TABLE A23. Governance Standards for Residential Facilities		
State	Requirements on Governing Body for MH	Requirements on Governing Body for SU
Alabama	●	●
Alaska	●	●
Arizona	●	●
Arkansas	●	●
California	●	●
Colorado	○	○
Connecticut	●	●
DC	X	●
Delaware	○	●
Florida	●	●
Georgia	●	●
Hawaii	X	X
Idaho	X	X
Illinois	●	X
Indiana	●	●
Iowa	●	●
Kansas	●	●
Kentucky	X	○
Louisiana	●	●
Maine	●	●
Maryland	X	X
Massachusetts	○	X
Michigan	X	●
Minnesota	○	X
Mississippi	●	●
Missouri	●	●
Montana	X	●
Nebraska	X	●
Nevada	●	●
New Hampshire	○	○
New Jersey	X	●
New Mexico	●	●
New York	●	●
North Carolina	●	●
North Dakota	X	●
Ohio	●	●
Oklahoma	●	●
Oregon	X	X
Pennsylvania	●	●



TABLE A23 (continued)		
State	Requirements on Governing Body for MH	Requirements on Governing Body for SU
Rhode Island	●	●
South Carolina	X	X
South Dakota	X	●
Tennessee	●	●
Texas	○	X
Utah	●	●
Vermont	●	●
Virginia	●	●
Washington	●	●
West Virginia	X	X
Wisconsin	X	●
Wyoming	●	●
<b>NOTES:</b> ●: Present; ○: Present for Some Facility Types; X: Not Present.		

**TABLE A24. Requirements Specific to Special Populations for Residential Facilities**

State	Dual Diagnosis for MH	Dual Diagnosis for SU	PPW for MH	PPW for SU	IDU for MH	IDU for SU	Other for MH	Other for SU
Alabama	X	●	X	●	X	●	X	X
Alaska	○	●	X	X	X	X	X	X
Arizona	X	X	X	●	X	●	●	X
Arkansas	●	●	X	●	X	X	X	X
California	X	X	X	●	X	X	X	X
Colorado	○	○	X	●	X	X	○	○
Connecticut	X	X	X	X	X	X	X	X
DC	X	●	X	●	X	X	X	●
Delaware	X	●	X	X	X	X	X	○
Florida	●	●	X	○	X	●	●	●
Georgia	X	X	X	●	X	●	●	●
Hawaii	X	X	X	X	X	X	X	X
Idaho	X	X	X	X	X	X	X	X
Illinois	○	X	X	X	X	X	X	X
Indiana	●	●	X	X	X	X	●	●
Iowa	X	X	X	X	X	X	○	○
Kansas	X	X	X	●	X	○	X	●
Kentucky	X	●	X	X	X	X	X	X
Louisiana	X	X	X	X	X	X	X	●
Maine	X	●	X	X	X	X	●	X
Maryland	●	●	X	X	X	X	X	X
Massachusetts	X	●	X	●	X	X	X	●
Michigan	X	X	X	X	X	X	X	X
Minnesota	X	●	X	X	X	X	X	●
Mississippi	X	X	X	●	X	●	X	X
Missouri	●	●	X	●	X	X	●	●
Montana	X	●	X	●	X	●	X	●
Nebraska	X	X	X	X	X	X	X	X
Nevada	X	●	X	X	X	X	X	X
New Hampshire	X	X	X	X	X	X	X	X
New Jersey	X	●	X	●	X	X	X	●
New Mexico	●	●	X	X	X	X	X	X
New York	X	X	X	X	X	X	X	●
North Carolina	X	X	X	●	X	X	X	●
North Dakota	X	X	X	X	X	X	X	X
Ohio	X	X	X	●	X	X	X	X
Oklahoma	○	●	X	●	X	X	●	●
Oregon	X	●	X	●	X	●	X	●
Pennsylvania	X	X	X	X	X	X	●	X

TABLE A24 (continued)

State	Dual Diagnosis for MH	Dual Diagnosis for SU	PPW for MH	PPW for SU	IDU for MH	IDU for SU	Other for MH	Other for SU
Rhode Island	●	●	X	X	X	X	X	X
South Carolina	X	●	X	●	X	●	X	○
South Dakota	X	X	X	X	X	X	X	●
Tennessee	X	X	X	●	X	●	X	●
Texas	○	●	X	●	X	X	X	X
Utah	○	○	X	○	X	○	○	X
Vermont	X	X	X	●	X	●	X	X
Virginia	●	●	X	●	X	X	X	X
Washington	●	●	●	●	X	X	X	X
West Virginia	X	X	X	X	X	X	●	●
Wisconsin	X	●	X	●	X	X	X	X
Wyoming	X	●	X	X	X	X	X	●

NOTES: ●: Present; ○: Present for Some Facility Types; X: Not Present.

<b>TABLE A25. Source of State Medicaid Authority to Reimburse Residential Mental Health Treatment in IMDs</b>			
<b>State</b>	<b>Section 1115 IMD Waiver</b>	<b>“In Lieu of” Provision<sup>a</sup></b>	<b>DSH Payments<sup>a</sup></b>
Alabama	X	X	X
Alaska	X	X	o
Arizona	X	o	o
Arkansas	X	o	o
California	X	X	X
Colorado	X	o	X
Connecticut	X	X	o
DC	●	o	o
Delaware	X	o	o
Florida	X	o	o
Georgia	X	X	X
Hawaii	X	o	X
Idaho	X	X	X
Illinois	X	o	o
Indiana	X	o	X
Iowa	X	o	X
Kansas	X	X	o
Kentucky	●	o	o
Louisiana	X	o	o
Maine	X	X	o
Maryland	X	X	o
Massachusetts	●	o	X
Michigan	X	o	o
Minnesota	X	o	o
Mississippi	X	o	X
Missouri	X	o	o
Montana	X	X	X
Nebraska	X	o	o
Nevada	X	o	X
New Hampshire	X	o	o
New Jersey	X	o	o
New Mexico	X	o	X
New York	X	o	o
North Carolina	X	X	o
North Dakota	X	X	o
Ohio	X	o	o
Oklahoma	X	X	o
Oregon	X	o	o
Pennsylvania	X	X	o
Rhode Island	X	o	X

TABLE A25 (continued)			
State	Section 1115 IMD Waiver	"In Lieu of" Provision <sup>a</sup>	DSH Payments <sup>a</sup>
South Carolina	X	o	o
South Dakota	X	X	o
Tennessee	X	o	X
Texas	X	o	o
Utah	X	o	X
Vermont	●	X	X
Virginia	X	o	o
Washington	X	o	o
West Virginia	X	X	o
Wisconsin	X	o	X
Wyoming	X	X	X

**NOTES:** ●: Present; o: Present but undetermined if MH and/or SU or if residential and/or inpatient; X: Not Present.

a. Musumeci M, Chidambaram P, Orgera, K. *State Options for Medicaid Coverage of Inpatient Behavioral Health Services*. Kaiser Family Foundation; November 2019. <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>.

<b>TABLE A26. Source of State Medicaid Authority to Reimburse Residential SUD Treatment in IMDs</b>			
<b>State</b>	<b>Section 1115 IMD Waiver</b>	<b>“In Lieu of” Provision<sup>a</sup></b>	<b>DSH Payments<sup>a</sup></b>
Alabama	X	X	X
Alaska	●	X	○
Arizona	X	○	○
Arkansas	X	○	○
California	●	X	X
Colorado	X	○	X
Connecticut	X	X	○
DC	●	○	○
Delaware	●	○	○
Florida	X	○	○
Georgia	X	X	X
Hawaii	X	○	X
Idaho	X	X	X
Illinois	●	○	○
Indiana	●	○	X
Iowa	X	○	X
Kansas	●	X	○
Kentucky	●	○	○
Louisiana	●	○	○
Maine	X	X	○
Maryland	●	X	○
Massachusetts	●	○	X
Michigan	●	○	○
Minnesota	●	○	○
Mississippi	X	○	X
Missouri	X	○	○
Montana	X	X	X
Nebraska	●	○	○
Nevada	X	○	X
New Hampshire	●	○	○
New Jersey	●	○	○
New Mexico	●	○	X
New York	X	○	○
North Carolina	●	X	○
North Dakota	X	X	○
Ohio	●	○	○
Oklahoma	X	X	○
Oregon	●	○	○
Pennsylvania	●	X	○
Rhode Island	●	○	X

TABLE A26 (continued)			
State	Section 1115 IMD Waiver	"In Lieu of" Provision <sup>a</sup>	DSH Payments <sup>a</sup>
South Carolina	X	o	o
South Dakota	X	X	o
Tennessee	X	o	X
Texas	X	o	o
Utah	●	o	X
Vermont	●	X	X
Virginia	●	o	o
Washington	●	o	o
West Virginia	●	X	o
Wisconsin	●	o	X
Wyoming	X	X	X

**NOTES:** ●: Present; o: Present but undetermined if MH and/or SU or if residential and/or inpatient; X: Not Present.

a. Musumeci M, Chidambaram P, Orgera, K. *State Options for Medicaid Coverage of Inpatient Behavioral Health Services*. Kaiser Family Foundation; November 2019. <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>.

TABLE A27. Categories of Residential Mental Health Treatment Facilities That Can Enroll in Medicaid							
State	Crisis	Population	Condition	Short-Term/ Transitional	Long-Term	Intensive	Other
Alabama	X	X	X	X	X	X	o
Alaska	o	X	X	X	X	X	o
Arizona	X	X	X	X	X	X	o
Arkansas	o	X	X	X	X	X	X
California	o	X	X	X	X	X	o
Colorado	X	X	X	X	X	X	o
Connecticut	X	X	X	X	X	X	o
DC	●	X	X	X	X	X	X
Delaware	X	X	X	X	X	X	o
Florida	X	X	X	X	X	X	X
Georgia	o	X	X	X	X	X	X
Hawaii	o	X	X	X	X	X	o
Idaho	X	X	X	X	X	X	X
Illinois	X	X	X	X	X	X	X
Indiana	X	X	X	X	X	X	X
Iowa	X	X	X	X	X	X	o
Kansas	X	X	X	X	X	X	X
Kentucky	●	X	X	X	X	X	X
Louisiana	X	X	X	X	X	X	X
Maine	o	X	X	X	X	X	o
Maryland	X	X	X	X	X	X	X
Massachusetts	●o	X	X	X	X	X	X
Michigan	o	X	X	X	X	X	X
Minnesota	X	X	X	X	X	X	X
Mississippi	o	X	X	X	X	X	X
Missouri	X	X	X	X	X	X	o
Montana	o	X	X	X	X	X	X
Nebraska	X	X	X	X	X	X	o
Nevada	X	X	X	X	X	X	X
New Hampshire	X	X	X	X	X	X	X
New Jersey	X	X	X	X	X	X	X
New Mexico	o	X	X	X	X	X	X
New York	X	X	X	X	X	X	X
North Carolina	X	X	X	X	X	X	X
North Dakota	X	X	X	X	X	X	X
Ohio	X	X	X	X	X	X	X
Oklahoma	o	X	X	X	X	X	X
Oregon	X	X	X	X	X	X	o
Pennsylvania	X	X	X	X	X	X	X



**TABLE A27 (continued)**

State	Crisis	Population	Condition	Short-Term/ Transitional	Long-Term	Intensive	Other
Rhode Island	X	X	X	X	X	X	o
South Carolina	X	X	X	X	X	X	X
South Dakota	X	X	X	X	X	X	X
Tennessee	X	X	X	X	X	X	o
Texas	o	X	X	o	X	X	X
Utah	X	X	X	X	X	X	X
Vermont	●	X	X	X	X	X	X
Virginia	o	X	X	X	X	X	X
Washington	o	X	X	X	X	X	X
West Virginia	X	X	X	X	X	X	o
Wisconsin	X	X	X	X	X	X	X
Wyoming	X	X	X	X	X	X	X

**NOTES:** ●: Present IMD; o: Present NonIMD; X: Not Present.

**TABLE A28. Categories of Residential SUD Treatment Facilities That Can Enroll in Medicaid**

State	Crisis	ASAM Level 3.1	ASAM Level 3.3	ASAM Level 3.5	ASAM Level 3.7	Low-Intensity	Medium-Intensity	High-Intensity	Transitional	Short-Term	Long-Term	Social Detox	Detox/WM	ASAM Level 3.2-WM	ASAM Level 3.7-WM	Clinically Managed Detox/Withdrawal	Medically Monitored Detox/Withdrawal	Medically Managed Detox/Withdrawal	Other
AL	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	○
AK	○	●	●	●	●	X	X	X	X	●	X	X	X	●	●	X	X	X	X
AZ	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	○
AR	○	X	X	X	X	X	X	X	X	X	X	X	○	X	X	X	X	X	X
CA	X	●○	●○	●○	○	X	X	X	X	●	X	X	X	●○	○	X	X	X	●○
CO	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	○
CT	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
DC	X	X	X	X	X	X	X	X	X	●	X	X	X	X	X	X	X	X	X
DE	X	●○	●○	●○	●○	X	X	X	X	●	X	X	X	●○	●○	X	X	X	X
FL	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
GA	○	○	X	○	X	X	X	X	○	X	X	X	○	X	X	X	X	X	○
HI	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
ID	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
IL	X	X	X	●○	●	X	X	X	X	●	X	X	X	●	●○	X	X	X	X
IN	X	●	X	●	X	X	X	X	X	●	X	X	X	X	X	X	X	X	X
IA	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
KS	X	●	●	●	●	X	X	X	X	●	X	X	●	X	X	X	X	X	X
KY	●○	X	X	X	X	X	X	X	X	●○	●○	X	X	●	●	X	X	X	X
LA	X	●	●	●	●	X	X	X	X	X	X	X	X	●	●	X	X	X	X
ME	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	○
MD	X	●	●	●	●	X	X	X	X	●	X	X	X	X	●	X	X	X	X
MA	X	●○	●○	X	X	X	X	X	●○	●○	X	X	X	X	X	X	X	X	●○
MI	○	●	●	●	●	X	X	X	X	●○	X	X	X	●	●	X	X	X	X
MN	X	X	X	X	X	X	X	X	X	●○	X	X	X	X	X	●○	●○	X	●○
MS	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
MO	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	○
MT	X	○	X	○	○	X	X	X	X	X	X	X	X	X	X	X	X	X	X
NE	X	●	●	●	X	X	X	X	X	●	X	X	X	●	X	X	X	X	X
NV	X	X	○	○	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
NH	X	X	X	X	X	X	X	X	X	●	X	X	X	X	X	X	●	●	●
NJ	X	X	X	●	●	X	X	X	X	●	X	X	X	X	●	X	X	X	X
NM	○	●	●	●	●	X	X	X	X	●	X	X	X	●	●	X	X	X	X
NY	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	○
NC	X	●	●	●	●	X	X	X	X	●	X	X	X	●	●	X	X	X	X
ND	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
OH	X	●	●	●	●	X	X	X	X	●	X	X	X	●	●	X	X	X	X
OK	○	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
OR	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	●○	●○	X	●○
PA	X	●	X	●	●	X	X	X	X	●	X	X	X	X	●	X	X	X	X
RI	X	●○	●○	●○	X	X	X	X	X	●	X	X	●○	X	X	X	X	X	X
SC	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
SD	X	○	X	X	○	X	X	X	X	X	X	X	X	X	X	X	X	X	○
TN	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
TX	X	X	X	X	X	X	X	X	X	○	X	X	○	X	X	X	X	X	X

**TABLE A28 (continued)**

State	Crisis	ASAM Level 3.1	ASAM Level 3.3	ASAM Level 3.5	ASAM Level 3.7	Low-Intensity	Medium-Intensity	High-Intensity	Transitional	Short-Term	Long-Term	Social Detox	Detox/WM	ASAM Level 3.2-WM	ASAM Level 3.7-WM	Clinically Managed Detox/Withdrawal	Medically Monitored Detox/Withdrawal	Medically Managed Detox/Withdrawal	Other
UT	X	•	•	•	•	X	X	X	X	•	X	X	X	•	X	•	X	X	X
VT	X	•	•	•	•	X	X	X	X	•	X	X	X	•	•	X	X	X	X
VA	X	•	•	•	•	X	X	X	X	•	X	X	•	X	•	X	X	X	X
WA	X	•○	X	•○	•○	X	X	X	X	X	X	X	X	•○	•○	X	X	X	X
WV	X	•	•	•	•	X	X	X	X	•	X	X	X	•	•	X	X	X	X
WI	X	•	X	X	•	X	X	X	X	•	X	X	•	X	X	X	X	X	X
WY	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

**NOTES:** •: Present IMD; ○: Present NonIMD; X: Not Present.

The ASAM Levels for adult residential treatment, including detoxification/WM, are as follows: Level 3.1. Clinically Managed Low-Intensity Residential Services. Level 3.3. Clinically Managed Population-Specific High-Intensity Residential Services (formerly Medium-Intensity). Level 3.5. Clinically Managed High-Intensity Residential Services. Level 3.7. Medically Monitored High-Intensity Inpatient Services (which, in many states, are offered in residential settings). Level 3.2-WM. Clinically Managed Residential Withdrawal Management. Level 3.7-WM. Medically Monitored Inpatient Withdrawal Management (in many states, offered in residential settings). Facility types identified as providing low, medium, or high-intensity services sometimes follow and sometimes do not follow the ASAM criteria. The categories represent distinctions on the level of risk posed by residents and the level of treatment provided. Social detoxification is an older term that loosely corresponds to Level 3.2-WM in the ASAM system.

TABLE A29. Processes of Medicaid Enrollment

State	State L/C Required for MH	State L/C Required for SU	Duration Identified for MH	Duration Identified for SU	Inspection at Enrollment for MH	Inspection at Enrollment for SU	Other Inspection for MH	Other Inspection for SU	Accreditation Required for MH	Accreditation Required for SU	Deemed Status for MH	Deemed Status for SU
Alabama	●	●	●	●	X	X	●	●	X	X	X	X
Alaska	●	●	X	X	X	X	X	X	●	●	X	X
Arizona	●	●	X	X	●	●	●	●	X	X	X	X
Arkansas	●	●	X	X	X	X	X	X	X	X	X	X
California	●	●	X	X	X	X	X	●	X	X	X	X
Colorado	●	●	X	X	X	X	X	X	X	X	X	X
Connecticut	●	●	X	X	X	X	●	X	X	X	X	X
DC	●	●	X	X	X	X	●	X	●	X	X	X
Delaware	●	●	X	X	X	X	X	X	X	X	X	X
Florida	●	●	●	●	X	X	X	X	X	X	X	X
Georgia	●	●	X	X	X	X	X	X	X	X	X	X
Hawaii	●	●	X	X	X	X	X	X	X	X	X	X
Idaho	●	●	X	X	X	X	X	X	X	X	X	X
Illinois	●	●	X	X	X	X	X	X	X	X	X	X
Indiana	●	●	X	X	X	X	X	X	X	X	X	X
Iowa	●	●	X	X	X	X	X	X	X	X	X	X
Kansas	●	●	X	X	X	X	X	X	X	X	X	X
Kentucky	●	●	X	X	X	X	X	X	X	●	X	X
Louisiana	●	●	●	●	X	X	X	X	X	X	X	X
Maine	●	●	●	●	X	X	X	X	X	X	X	X
Maryland	●	●	X	X	X	●	●	●	X	X	X	X
Massachusetts	●	●	X	X	X	X	●	●	X	X	X	X
Michigan	●	●	●	●	X	X	●	●	X	●	X	X
Minnesota	●	●	X	X	X	X	X	X	X	X	X	X
Mississippi	●	X	X	X	X	X	X	X	X	X	X	X
Missouri	●	●	X	X	X	X	X	X	X	X	X	X
Montana	●	●	X	X	X	X	X	X	X	X	X	X
Nebraska	●	●	●	●	X	X	●	●	X	X	X	X
Nevada	●	●	X	X	X	X	X	X	X	X	X	X
New Hampshire	●	●	X	X	X	X	X	X	X	X	X	X
New Jersey	●	●	●	●	X	X	X	X	X	X	X	X
New Mexico	●	●	X	X	X	X	X	X	X	●	X	X
New York	●	●	X	X	X	X	X	X	X	X	X	X
North Carolina	●	●	●	●	X	X	X	X	X	X	X	X
North Dakota	●	●	X	X	X	X	X	X	X	X	X	X
Ohio	●	●	●	●	X	X	X	X	X	X	X	X
Oklahoma	●	●	X	X	X	X	X	X	X	X	X	X
Oregon	●	●	X	X	X	X	X	X	X	X	X	X
Pennsylvania	●	●	X	X	X	X	X	X	X	X	X	X

**TABLE A29 (continued)**

State	State L/C Required for MH	State L/C Required for SU	Duration Identified for MH	Duration Identified for SU	Inspection at Enrollment for MH	Inspection at Enrollment for SU	Other Inspection for MH	Other Inspection for SU	Accreditation Required for MH	Accreditation Required for SU	Deemed Status for MH	Deemed Status for SU
Rhode Island	●	●	X	X	X	X	X	X	X	X	X	X
South Carolina	●	●	X	X	X	X	X	X	X	X	X	X
South Dakota	●	●	X	X	X	X	X	X	X	X	X	X
Tennessee	●	●	X	X	X	X	X	X	X	X	X	X
Texas	●	●	●	●	●	●	●	●	X	X	X	X
Utah	●	●	●	●	X	X	X	X	X	X	X	X
Vermont	●	●	X	●	X	X	●	X	●	X	X	X
Virginia	●	●	X	X	X	X	X	X	X	X	X	X
Washington	●	●	X	●	X	●	X	●	X	X	X	X
West Virginia	●	●	●	●	●	●	●	●	X	X	X	X
Wisconsin	●	●	●	●	X	X	X	X	X	X	X	X
Wyoming	●	●	X	X	X	X	X	X	X	X	X	X

**NOTES:** ●: Present for Some or all Facility Types; X: Not Present.

TABLE A30. Medicaid Staffing Standards for Residential Facilities

State	Admini- strator Stds for MH	Admini- strator Stds for SU	Medical Director Stds for MH	Medical Director Stds for SU	Medical Staff Stds for MH	Medical Staff Stds for SU	Clinical Staff Stds for MH	Clinical Staff Stds for SU	Direct Care Staff Stds for MH	Direct Care Staff Stds for SU	Staffing Ratios for MH	Staffing Ratios for SU	Adequate Staffing for MH	Adequate Staffing for SU	Any Staffing Stds for MH	Any Staffing Stds for SU
Alabama	X	X	X	X	X	X	X	X	X	X	X	X	X	X	•	•
Alaska	X	X	X	X	X	X	X	X	X	X	X	X	X	X	•	•
Arizona	X	X	X	X	X	X	X	X	X	X	X	X	X	X	•	•
Arkansas	X	X	X	X	X	X	X	X	X	X	X	X	X	X	•	•
California	X	•	X	•	X	•	X	•	X	•	•	X	X	X	•	•
Colorado	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Connecticut	•	X	X	X	X	X	X	X	•	X	X	X	X	X	•	X
DC	X	X	X	X	•	X	•	X	X	X	X	X	X	X	•	•
Delaware	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	•
Florida	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Georgia	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Hawaii	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Idaho	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Illinois	X	X	X	X	X	•	X	•	X	X	X	X	X	X	•	•
Indiana	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	•
Iowa	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Kansas	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	•
Kentucky	X	X	X	•	•	•	X	X	X	X	X	X	X	X	•	•
Louisiana	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	•
Maine	X	X	X	X	X	X	X	X	X	X	X	X	X	•	•	•
Maryland	X	•	X	X	X	•	X	•	X	•	X	•	X	•	X	•
Massachusetts	•	•	X	X	X	•	X	•	X	•	X	X	X	X	•	•
Michigan	X	•	•	•	•	•	•	•	•	•	X	X	•	•	•	•
Minnesota	X	X	X	X	X	X	X	X	X	X	X	•	X	X	X	•
Mississippi	X	X	X	X	•	X	•	X	X	X	X	X	X	X	X	X
Missouri	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Montana	X	X	X	X	X	•	X	•	X	X	X	X	X	X	X	•
Nebraska	•	X	X	X	•	X	•	X	•	X	•	X	•	X	•	•
Nevada	X	X	X	X	X	X	X	X	X	X	X	X	X	X	•	•
New Hampshire	X	X	X	X	X	•	X	•	X	X	X	•	X	X	X	•
New Jersey	X	X	X	X	X	X	X	X	X	X	X	X	X	X	•	•
New Mexico	•	•	X	X	•	•	•	•	•	•	X	•	•	•	•	•
New York	X	X	X	X	X	•	X	•	X	•	X	X	X	X	X	•
North Carolina	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	•
North Dakota	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Ohio	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	•
Oklahoma	X	X	•	•	•	•	•	•	X	X	X	X	X	X	•	•
Oregon	X	X	X	X	X	X	X	X	X	X	X	X	•	X	•	X
Pennsylvania	X	•	X	X	X	•	X	•	X	X	X	X	X	X	X	•
Rhode Island	X	X	X	X	X	X	X	X	X	X	X	X	X	X	•	•
South Carolina	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

**TABLE A30 (continued)**

State	Admini- strator Stds for MH	Admini- strator Stds for SU	Medical Director Stds for MH	Medical Director Stds for SU	Medical Staff Stds for MH	Medical Staff Stds for SU	Clinical Staff Stds for MH	Clinical Staff Stds for SU	Direct Care Staff Stds for MH	Direct Care Staff Stds for SU	Staffing Ratios for MH	Staffing Ratios for SU	Adequate Staffing for MH	Adequate Staffing for SU	Any Staffing Stds for MH	Any Staffing Stds for SU
South Dakota	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Tennessee	X	X	X	X	X	X	X	X	X	X	X	X	X	X	●	X
Texas	X	X	X	X	●	X	●	X	●	X	●	X	●	X	●	X
Utah	X	X	X	X	X	●	X	●	X	●	X	X	X	X	X	●
Vermont	X	X	X	X	X	●	X	●	X	●	X	X	X	X	X	●
Virginia	X	X	X	X	X	●	●	●	X	X	X	X	X	X	●	●
Washington	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	●
West Virginia	X	X	X	X	X	●	X	●	X	X	X	X	X	X	●	●
Wisconsin	X	X	X	X	X	X	X	X	X	X	X	X	X	X	●	●
Wyoming	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

**NOTES:** ●: Present for Some or all Facility Types; X: Not Present.

TABLE A31. Medicaid Staff Training Standards for Residential Facilities

State	Orientation/ Ongoing Training for MH	Orientation/ Ongoing Training for SU	Trauma Informed Care for MH	Trauma Informed Care for SU	Suicide Assessment or Prevention for MH	Suicide Assessment or Prevention for SU	Any Staff Training Requirements for MH	Any Staff Training Requirements for SU
Alabama	X	X	X	X	X	X	X	X
Alaska	X	X	X	X	X	X	X	X
Arizona	X	X	X	X	X	X	X	X
Arkansas	X	X	X	X	X	X	X	X
California	X	●	X	X	X	X	X	●
Colorado	X	X	X	X	X	X	X	X
Connecticut	●	X	X	X	X	X	●	X
DC	X	X	X	X	X	X	X	X
Delaware	X	X	X	X	X	X	X	X
Florida	X	X	X	X	X	X	X	X
Georgia	X	X	X	X	X	X	X	X
Hawaii	X	X	X	X	X	X	X	X
Idaho	X	X	X	X	X	X	X	X
Illinois	X	X	X	X	X	X	X	X
Indiana	X	X	X	X	X	X	X	X
Iowa	X	X	X	X	X	X	X	X
Kansas	X	X	X	X	X	X	X	X
Kentucky	X	X	X	X	X	X	X	X
Louisiana	X	X	X	X	X	X	X	X
Maine	X	X	X	X	X	X	X	X
Maryland	X	X	X	X	X	●	X	●
Massachusetts	X	X	X	X	X	X	X	●
Michigan	X	X	X	X	X	X	X	X
Minnesota	X	X	X	X	X	X	X	X
Mississippi	X	X	X	X	X	X	X	X
Missouri	X	X	X	X	X	X	X	X
Montana	X	X	X	X	X	X	X	X
Nebraska	X	X	●	X	X	X	●	X
Nevada	X	X	X	X	X	X	X	X
New Hampshire	X	X	X	X	X	X	X	X
New Jersey	X	X	X	X	X	X	X	X
New Mexico	X	X	X	X	X	X	●	●
New York	X	●	X	X	X	X	X	●
North Carolina	X	X	X	X	X	X	X	X



TABLE A31 (continued)

State	Orientation/ Ongoing Training for MH	Orientation/ Ongoing Training for SU	Trauma Informed Care for MH	Trauma Informed Care for SU	Suicide Assessment or Prevention for MH	Suicide Assessment or Prevention for SU	Any Staff Training Requirements for MH	Any Staff Training Requirements for SU
North Dakota	X	X	X	X	X	X	X	X
Ohio	X	X	X	X	X	X	X	X
Oklahoma	X	X	X	X	X	X	X	X
Oregon	X	X	X	X	X	X	X	X
Pennsylvania	X	X	X	X	X	X	X	X
Rhode Island	X	X	X	X	X	X	●	●
South Carolina	X	X	X	X	X	X	X	X
South Dakota	X	X	X	X	X	X	X	X
Tennessee	X	X	X	X	X	X	X	X
Texas	X	X	X	X	X	X	X	X
Utah	X	X	X	X	X	X	X	X
Vermont	X	X	X	X	X	X	X	X
Virginia	X	X	X	X	X	X	X	X
Washington	X	X	X	X	X	X	X	X
West Virginia	X	X	X	X	X	X	X	●
Wisconsin	X	X	X	X	X	X	X	X
Wyoming	X	X	X	X	X	X	X	X

NOTES: ●: Present for Some or all Facility Types; X: Not Present.

**TABLE A32. Medicaid Placement Standards for Residential Facilities**

State	Specific Criteria for Placement for MH	Specific Criteria for Placement for SU	ASAM Placement Criteria for MH	ASAM Placement Criteria for SU	Policy or Procedures Required for MH	Policy or Procedures Required for SU	Placement Assessment/ Screening for MH	Placement Assessment/ Screening for SU
Alabama	●	●	X	X	X	X	●	●
Alaska	●	●	X	●	X	X	X	●
Arizona	●	●	X	X	X	X	X	X
Arkansas	●	●	X	X	X	X	X	X
California	X	●	X	●	X	X	X	●
Colorado	●	●	X	X	X	X	X	X
Connecticut	●	●	X	●	X	X	X	X
DC	●	●	X	●	X	X	●	●
Delaware	X	●	X	●	X	X	X	●
Florida	X	X	X	X	X	X	X	X
Georgia	X	X	X	X	X	X	X	X
Hawaii	●	X	X	X	X	X	X	X
Idaho	X	X	X	X	X	X	X	X
Illinois	X	●	X	●	X	X	X	●
Indiana	X	●	X	●	X	X	X	●
Iowa	X	X	X	X	X	X	X	X
Kansas	X	●	X	●	X	X	X	●
Kentucky	●	●	X	●	X	X	X	●
Louisiana	X	●	X	●	X	X	X	●
Maine	●	●	X	X	X	X	●	●
Maryland	X	●	X	●	X	X	X	●
Massachusetts	X	X	X	X	X	X	X	X
Michigan	●	●	X	●	X	X	●	●
Minnesota	X	●	X	●	X	X	X	●
Mississippi	●	X	X	X	X	X	●	X
Missouri	X	●	X	X	X	X	X	X
Montana	●	●	X	●	X	X	●	●
Nebraska	●	●	X	●	X	X	●	●
Nevada	●	●	X	●	X	X	●	●
New Hampshire	X	●	X	●	X	X	X	●
New Jersey	X	●	X	●	X	X	X	●
New Mexico	●	●	X	●	X	X	X	●
New York	X	X	X	X	X	X	X	X
North Carolina	X	●	X	●	X	X	X	●
North Dakota	X	X	X	X	X	X	X	X

TABLE A32 (continued)

State	Specific Criteria for Placement for MH	Specific Criteria for Placement for SU	ASAM Placement Criteria for MH	ASAM Placement Criteria for SU	Policy or Procedures Required for MH	Policy or Procedures Required for SU	Placement Assessment/ Screening for MH	Placement Assessment/ Screening for SU
Ohio	X	●	X	●	X	X	X	●
Oklahoma	●	●	X	X	X	X	●	●
Oregon	●	●	X	●	X	X	●	●
Pennsylvania	X	●	X	●	X	X	X	●
Rhode Island	X	●	X	●	X	X	●	●
South Carolina	X	X	X	X	X	X	X	X
South Dakota	X	X	X	X	X	X	X	X
Tennessee	●	X	X	X	X	X	X	X
Texas	●	●	X	●	X	X	●	●
Utah	X	●	X	●	X	X	X	●
Vermont	●	●	X	●	X	X	●	●
Virginia	●	●	X	●	X	X	●	●
Washington	X	●	X	●	X	X	X	●
West Virginia	X	●	X	●	X	X	X	●
Wisconsin	X	●	X	●	X	X	X	●
Wyoming	X	X	X	X	X	X	X	X

NOTES: ●: Present for Some or all Facility Types; X: Not Present.

**TABLE A33. Medicaid Treatment Planning, Discharge Planning, Care Coordination, and Aftercare Standards for Residential Facilities**

State	Treatment Plan Required for MH	Treatment Plan Required for SU	Discharge Plan Required for MH	Discharge Plan Required for SU	At Admission or Early for MH	At Admission or Early for SU	Care Coordination for MH	Care Coordination for SU	Aftercare/Follow-Up for MH	Aftercare/Follow-Up for SU
Alabama	●	●	X	X	X	X	●	●	X	X
Alaska	●	●	X	X	X	X	X	●	X	X
Arizona	●	●	●	●	●	●	●	●	X	X
Arkansas	●	●	X	X	X	X	●	●	X	X
California	X	●	X	●	X	X	●	●	X	X
Colorado	X	X	X	X	X	X	X	X	X	X
Connecticut	●	X	●	●	●	●	X	●	X	X
DC	●	●	●	●	X	X	●	●	X	X
Delaware	X	X	X	X	X	X	X	●	X	X
Florida	X	X	X	X	X	X	X	X	X	X
Georgia	X	X	X	X	X	X	●	●	X	X
Hawaii	X	X	X	X	X	X	X	X	X	X
Idaho	X	X	X	X	X	X	X	X	X	X
Illinois	X	X	X	●	X	X	X	●	X	X
Indiana	X	X	X	X	X	X	X	●	X	X
Iowa	X	X	X	X	X	X	●	●	X	X
Kansas	X	●	X	X	X	X	X	●	X	X
Kentucky	●	●	X	X	X	X	●	●	X	X
Louisiana	X	X	X	X	X	X	X	●	X	X
Maine	●	●	●	●	X	X	X	X	X	X
Maryland	X	●	X	●	X	X	X	●	X	X
Massachusetts	X	X	X	X	X	X	●	●	X	X
Michigan	●	●	●	●	X	X	●	●	X	X
Minnesota	X	X	X	X	X	X	X	●	X	X
Mississippi	●	X	X	X	X	X	X	X	X	X
Missouri	●	●	X	X	X	X	X	X	X	X
Montana	●	●	X	X	X	X	X	X	X	X
Nebraska	●	●	●	●	●	●	●	●	X	X
Nevada	●	●	●	●	X	X	●	●	X	X
New Hampshire	X	●	X	●	X	●	X	●	X	●
New Jersey	X	X	X	X	X	X	X	●	X	X
New Mexico	●	●	●	●	X	X	●	●	X	●
New York	X	●	X	X	X	X	X	X	X	X
North Carolina	X	X	X	X	X	X	X	●	X	X

**TABLE A33 (continued)**

State	Treatment Plan Required for MH	Treatment Plan Required for SU	Discharge Plan Required for MH	Discharge Plan Required for SU	At Admission or Early for MH	At Admission or Early for SU	Care Coordination for MH	Care Coordination for SU	Aftercare/Follow-Up for MH	Aftercare/Follow-Up for SU
North Dakota	X	X	X	X	X	X	X	X	X	X
Ohio	X	●	X	X	X	X	X	●	X	X
Oklahoma	X	X	X	X	X	X	●	●	X	X
Oregon	●	●	X	X	X	X	●	●	X	X
Pennsylvania	X	●	X	●	X	X	X	●	X	X
Rhode Island	X	●	X	X	X	X	●	●	X	X
South Carolina	X	X	X	X	X	X	●	●	X	X
South Dakota	X	X	X	X	X	X	X	X	X	X
Tennessee	X	X	X	X	X	X	X	X	X	X
Texas	●	X	X	X	X	X	X	X	X	X
Utah	X	●	X	●	X	X	X	●	X	X
Vermont	X	X	X	●	X	X	●	●	●	X
Virginia	●	●	X	●	X	X	●	●	X	X
Washington	X	●	X	X	X	X	●	●	X	X
West Virginia	X	●	X	●	X	●	X	●	X	X
Wisconsin	X	X	X	X	X	X	X	●	X	X
Wyoming	X	X	X	X	X	X	X	X	X	X

**NOTES:** ●: Present for Some or all Facility Types; X: Not Present.

TABLE A34. Medicaid Treatment Services Standards for Residential Facilities

State	Any Service Requirements for MH	Any Service Requirements for SU	Specific to Clinical Service Types for MH	Specific to Clinical Service Types for SU	Specific to Clinical Service Hours for MH	Specific to Clinical Service Hours for SU	Evidence-Based for MH	Evidence-Based for SU
Alabama	●	●	●	●	X	X	X	●
Alaska	●	●	●	●	X	●	●	●
Arizona	●	●	●	●	X	X	X	●
Arkansas	●	●	●	●	X	X	X	X
California	X	●	X	●	X	●	X	●
Colorado	●	●	●	●	X	X	X	X
Connecticut	●	X	●	X	X	X	X	X
DC	●	●	●	●	X	●	X	●
Delaware	X	●	X	●	X	●	X	●
Florida	X	X	X	X	X	X	X	X
Georgia	X	X	X	X	X	X	X	X
Hawaii	X	X	X	X	X	X	X	X
Idaho	X	X	X	X	X	X	X	X
Illinois	X	●	X	●	X	●	X	●
Indiana	X	●	X	●	X	●	X	●
Iowa	X	X	X	X	X	X	X	X
Kansas	X	●	X	●	X	●	X	●
Kentucky	●	●	●	●	●	●	X	●
Louisiana	X	●	X	●	X	●	X	●
Maine	●	●	●	●	X	X	X	X
Maryland	X	●	X	●	X	●	X	●
Massachusetts	●	●	X	●	X	●	X	●
Michigan	●	●	●	●	X	●	●	●
Minnesota	X	●	X	●	X	●	X	●
Mississippi	●	X	●	X	X	X	X	X
Missouri	X	●	X	●	X	X	X	X
Montana	●	●	X	●	X	●	X	X
Nebraska	●	●	●	●	●	●	●	●
Nevada	X	●	X	●	X	X	●	●
New Hampshire	X	●	X	●	X	●	X	●
New Jersey	X	●	X	●	X	●	X	●
New Mexico	●	●	●	●	X	●	X	●
New York	X	●	X	●	X	X	X	●
North Carolina	X	●	X	●	X	●	X	●
North Dakota	X	X	X	X	X	X	X	X

TABLE A34 (continued)

State	Any Service Requirements for MH	Any Service Requirements for SU	Specific to Clinical Service Types for MH	Specific to Clinical Service Types for SU	Specific to Clinical Service Hours for MH	Specific to Clinical Service Hours for SU	Evidence-Based for MH	Evidence-Based for SU
Ohio	X	●	X	●	X	●	X	●
Oklahoma	●	●	●	●	X	X	X	X
Oregon	X	X	X	X	X	X	●	●
Pennsylvania	X	●	X	●	X	●	X	●
Rhode Island	●	●	●	●	X	●	X	●
South Carolina	X	X	X	X	X	X	X	X
South Dakota	X	X	X	X	X	X	X	X
Tennessee	X	X	X	X	X	X	X	X
Texas	●	●	●	●	X	X	X	X
Utah	X	●	X	●	X	●	X	●
Vermont	●	●	X	●	X	●	X	●
Virginia	●	●	●	●	X	●	X	●
Washington	X	●	X	●	X	●	X	●
West Virginia	X	●	X	●	X	●	X	●
Wisconsin	X	●	X	●	X	●	X	●
Wyoming	X	X	X	X	X	X	X	X

NOTES: ●: Present for Some or all Facility Types; X: Not Present.

TABLE A35. Medicaid Requirements Specific to MAT in Residential Facilities		
State	Services MAT for MH	Services MAT for SU
Alabama	X	•
Alaska	X	•
Arizona	X	•
Arkansas	X	X
California	X	•
Colorado	X	X
Connecticut	X	X
DC	X	•
Delaware	X	•
Florida	X	X
Georgia	X	X
Hawaii	X	X
Idaho	X	X
Illinois	X	•
Indiana	X	•
Iowa	X	X
Kansas	X	•
Kentucky	X	•
Louisiana	X	•
Maine	X	•
Maryland	X	X
Massachusetts	X	X
Michigan	X	•
Minnesota	X	•
Mississippi	X	X
Missouri	X	X
Montana	X	X
Nebraska	X	•
Nevada	X	X
New Hampshire	X	•
New Jersey	X	•
New Mexico	X	•
New York	X	•
North Carolina	X	•
North Dakota	X	X
Ohio	X	•
Oklahoma	X	X
Oregon	X	•
Pennsylvania	X	•
Rhode Island	X	•



<b>TABLE A35 (continued)</b>		
<b>State</b>	<b>Services MAT for MH</b>	<b>Services MAT for SU</b>
South Carolina	X	X
South Dakota	X	X
Tennessee	X	X
Texas	X	●
Utah	X	●
Vermont	X	●
Virginia	X	●
Washington	X	●
West Virginia	X	●
Wisconsin	X	●
Wyoming	X	X
<b>NOTES:</b> ●: Present for Some or all Facility Types; X: Not Present.		

**TABLE A36. Medicaid QA/QI Standards for Residential Facilities**

State	QA/QI Requirement for MH	QA/QI Requirement for SU	Written Plan or Policy for MH	Written Plan or Policy for SU	Measurement for MH	Measurement for SU
Alabama	●	●	X	X	X	X
Alaska	X	X	X	X	X	X
Arizona	●	●	●	●	●	●
Arkansas	●	●	●	●	X	X
California	X	●	X	X	X	X
Colorado	●	●	X	X	●	●
Connecticut	●	●	X	X	X	X
DC	X	X	X	X	X	X
Delaware	X	X	X	X	X	X
Florida	X	X	X	X	X	X
Georgia	X	X	X	X	X	X
Hawaii	X	X	X	X	X	X
Idaho	X	X	X	X	X	X
Illinois	X	X	X	X	X	X
Indiana	X	X	X	X	X	X
Iowa	●	●	X	X	X	X
Kansas	X	X	X	X	X	X
Kentucky	X	X	X	X	X	X
Louisiana	X	X	X	X	X	●
Maine	●	●	X	X	X	●
Maryland	X	X	X	X	X	X
Massachusetts	X	X	X	X	X	X
Michigan	X	X	X	X	X	X
Minnesota	X	X	X	X	X	X
Mississippi	X	X	X	X	X	X
Missouri	X	X	X	X	X	X
Montana	X	X	X	X	X	X
Nebraska	X	X	X	X	X	X
Nevada	●	●	●	●	X	●
New Hampshire	X	X	X	X	X	X
New Jersey	X	X	X	X	X	X
New Mexico	X	X	X	X	X	X
New York	X	X	X	X	X	X
North Carolina	X	X	X	X	X	X
North Dakota	X	X	X	X	X	X
Ohio	X	X	X	X	X	X
Oklahoma	X	X	X	X	X	X
Oregon	X	X	X	X	X	X
Pennsylvania	X	X	X	X	X	X

**TABLE A36 (continued)**

State	QA/QI Requirement for MH	QA/QI Requirement for SU	Written Plan or Policy for MH	Written Plan or Policy for SU	Measurement for MH	Measurement for SU
Rhode Island	●	●	●	●	X	X
South Carolina	X	X	X	X	X	X
South Dakota	X	X	X	X	X	X
Tennessee	X	X	X	X	X	X
Texas	X	X	X	X	X	X
Utah	X	X	X	X	X	X
Vermont	X	X	X	X	X	X
Virginia	X	X	X	X	X	X
Washington	X	X	X	X	X	X
West Virginia	X	●	X	X	X	X
Wisconsin	X	X	X	X	X	X
Wyoming	X	X	X	X	X	X

**NOTES:** ●: Present for Some or all Facility Types; X: Not Present.

**TABLE A37. Medicaid Requirements Specific to Special Populations for Residential Facilities**

State	Dual Diagnosis for MH	Dual Diagnosis for SU	PPW for MH	PPW for SU	Other for MH	Other for SU
Alabama	X	X	X	X	X	X
Alaska	X	●	X	X	X	X
Arizona	X	X	X	X	●	●
Arkansas	X	X	X	X	X	X
California	X	●	X	●	X	X
Colorado	X	X	X	X	X	X
Connecticut	X	X	X	X	X	X
DC	●	●	X	X	X	X
Delaware	X	●	X	X	X	X
Florida	X	X	X	X	X	X
Georgia	X	X	X	X	X	X
Hawaii	X	X	X	X	X	X
Idaho	X	X	X	X	X	X
Illinois	X	●	X	X	X	X
Indiana	X	●	X	X	X	X
Iowa	X	X	X	X	X	X
Kansas	X	●	X	X	X	X
Kentucky	●	●	X	X	X	X
Louisiana	X	X	X	X	X	X
Maine	●	●	X	X	X	X
Maryland	X	X	X	X	X	X
Massachusetts	●	●	●	●	X	X
Michigan	X	●	X	X	X	X
Minnesota	●	●	X	X	X	X
Mississippi	X	X	X	X	X	X
Missouri	X	X	X	X	X	X
Montana	X	X	X	X	X	X
Nebraska	X	●	X	X	X	X
Nevada	X	●	X	X	X	X
New Hampshire	X	●	X	X	X	X
New Jersey	X	●	X	X	X	X
New Mexico	X	●	X	X	X	X
New York	X	X	X	X	X	X
North Carolina	X	●	X	X	X	X
North Dakota	X	X	X	X	X	X
Ohio	X	●	X	X	X	X
Oklahoma	X	X	X	X	X	X
Oregon	●	●	●	●	●	●
Pennsylvania	X	●	X	X	X	X

TABLE A37 (continued)						
State	Dual Diagnosis for MH	Dual Diagnosis for SU	PPW for MH	PPW for SU	Other for MH	Other for SU
Rhode Island	X	●	X	X	X	X
South Carolina	X	X	X	X	X	X
South Dakota	X	X	X	●	X	X
Tennessee	X	X	X	X	●	X
Texas	X	●	X	●	X	X
Utah	X	●	X	X	X	X
Vermont	X	●	X	●	●	X
Virginia	X	X	X	●	X	X
Washington	X	●	X	●	X	X
West Virginia	X	●	X	X	X	X
Wisconsin	X	●	X	X	X	X
Wyoming	X	X	X	X	X	X

**NOTES:** ●: Present for Some or all Facility Types; X: Not Present.

# APPENDIX B. Separate State Summaries

ACRONYMS ..... B-5

These profiles are available as separate PDFs:

**ALABAMA**

Alabama Medicaid ..... Alabama-12

**ALASKA**

Alaska Medicaid ..... Alaska-8

**ARIZONA**

Arizona Medicaid ..... Arizona-8

**ARKANSAS**

Arkansas Medicaid ..... Arkansas-9

**CALIFORNIA**

California Medicaid ..... California-9

**COLORADO**

Colorado Medicaid ..... Colorado-9

**CONNECTICUT**

Connecticut Medicaid ..... Connecticut-12

**DELAWARE**

Delaware Medicaid ..... Delaware-10

**DISTRICT OF COLUMBIA**

District of Columbia Medicaid ..... District of Columbia-8

**FLORIDA**

Florida Medicaid ..... Florida-15

**GEORGIA**

Georgia Medicaid ..... Georgia-12

**HAWAII**

Hawaii Medicaid ..... Hawaii-6

**IDAHO**

Idaho Medicaid ..... Idaho-5

**ILLINOIS**

Illinois Medicaid ..... Illinois-11

**INDIANA**

Indiana Medicaid ..... Indiana-9

**IOWA**

Iowa Medicaid ..... Iowa-12

**KANSAS**

Kansas Medicaid ..... Kansas-9

**KENTUCKY**

Kentucky Medicaid ..... Kentucky-11

**LOUISIANA**

Louisiana Medicaid ..... Louisiana-11

**MAINE**

Maine Medicaid ..... Maine-11

**MARYLAND**

Maryland Medicaid ..... Maryland-6

**MASSACHUSETTS**

Massachusetts Medicaid ..... Massachusetts-9

**MICHIGAN**

Michigan Medicaid ..... Michigan-8

**MINNESOTA**

Minnesota Medicaid ..... Minnesota-14

**MISSISSIPPI**

Mississippi Medicaid ..... Mississippi-13

**MISSOURI**

Missouri Medicaid ..... Missouri-12

**MONTANA**

Montana Medicaid ..... Montana-12

**NEBRASKA**

Nebraska Medicaid.....Nebraska-9

**NEVADA**

Nevada Medicaid.....Nevada-13

**NEW HAMPSHIRE**

New Hampshire Medicaid ..... New Hampshire-7

**NEW JERSEY**

New Jersey Medicaid.....New Jersey-7

**NEW MEXICO**

New Mexico Medicaid.....New Mexico-7

**NEW YORK**

New York Medicaid ..... New York-13

**NORTH CAROLINA**

North Carolina Medicaid ..... North Carolina-9

**NORTH DAKOTA**

North Dakota Medicaid.....North Dakota-6

**OHIO**

Ohio Medicaid ..... Ohio-9

**OKLAHOMA**

Oklahoma Medicaid ..... Oklahoma-12

**OREGON**

Oregon Medicaid.....Oregon-9

**PENNSYLVANIA**

Pennsylvania Medicaid.....Pennsylvania-8

**RHODE ISLAND**

Rhode Island Medicaid ..... Rhode Island-10



**SOUTH CAROLINA**

South Carolina Medicaid ..... South Carolina-9

**SOUTH DAKOTA**

South Dakota Medicaid ..... South Dakota-9

**TENNESSEE**

Tennessee Medicaid ..... Tennessee-11

**TEXAS**

Texas Medicaid ..... Texas-12

**UTAH**

Utah Medicaid ..... Utah-8

**VERMONT**

Vermont Medicaid ..... Vermont-17

**VIRGINIA**

Virginia Medicaid ..... Virginia-7

**WASHINGTON**

Washington Medicaid ..... Washington-11

**WEST VIRGINIA**

West Virginia Medicaid ..... West Virginia-7

**WISCONSIN**

Wisconsin Medicaid ..... Wisconsin-11

**WYOMING**

Wyoming Medicaid ..... Wyoming-14

## ACRONYMS

The following acronyms are mentioned in this appendix. Many acronyms have several meanings, usually due to being state agencies. All of the meanings are listed for that acronym.

A&D	Alcohol and Drug
AAHC	Accreditation Association for Ambulatory Health Care
AAS	American Association of Suicidology
ACHC	Accreditation Commission for Health Care
ACT	Assertive Community Treatment
ACU	Acute Crisis Unit
ADA	Americans with Disabilities Act
ADAP	Vermont Division of Alcohol and Drug Abuse Programs
ADL	Activity of Daily Living
AED	Automated External Defibrillator
AHCA	Florida Agency for Health Care Administration
AHCCCS	Arizona Health Care Cost Containment System Administration
AHS	Vermont Agency of Human Services
AIDS	Acquired Immunodeficiency Syndrome
ALOS	Average Length Of Stay
ALTCS	Arizona Long Term Care System
AMHR	Adult Mental Health Residential
AN	Anorexia Nervosa
ANSA	Adult Needs and Strengths Assessment
AOA	American Osteopathic Association
AODE	Alcohol and Drug Abuse Treatment Entity
APN	Advanced Nurse Practitioner
APRN	Advanced Practice Registered Nurse
APRTP	Acute Psychiatric Residential Treatment Program
ARNP	Advanced Registered Nurse Practitioner
ARTC	Adult Residential Treatment Center
ARTS	Virginia Addiction and Recovery Treatment Services
ASAM	Americans Society of Addiction Medicine
ASAM PPC-3	ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders: Third Edition
ASI	Addiction Severity Index
ASO	Administrative Service Organization
ASRF	Adult Supportive Residential Facility
ATU	Acute Treatment Unit
BAC	Blood Alcohol Content
BCLS	Basic Cardiac Life Support
BDAS	New Hampshire Bureau of Drug and Alcohol Services

BH	Behavioral Health
BH-ASO	Behavioral Health Administrative Service Organization
BH-MCO	Behavioral Health Managed Care Organization
BHA	Behavioral Health Agency Maryland Behavioral Health Administration
BHC	Behavioral Health Center
BHCC	Behavioral Health Care Coordination
BHCN	Behavioral Health Community Network
BHCR	Behavioral Health Community Residence
BHDDH	Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
BHMC	Hawaii Behavioral Health Managed Care
BHO	Behavioral Health Organization Behavioral Healthcare Organization
BHP	Connecticut Behavioral Health Partnership
BHRF	Behavioral Health Residential Facility
BHRP	Behavioral Health Recovery Program
BHS	Behavioral Health Service
BHSD	New Mexico Behavioral Health Services Division
BHSO	Behavioral Health Service Organization
BHSU	Behavioral Health Stabilization Unit
BMC	Behavior Management Committee
BMHS	New Hampshire Bureau of Mental Health Services
BMS	West Virginia Bureau for Medical Services
BN	Bulimia Nervosa
CAC	Certified Addiction Counselor
CAP	Corrective Action Plan
CARF	Commission on Accreditation of Rehabilitation Facilities
CASII	Child and Adolescent Service Intensity Instrument
CBHP	Connecticut Behavioral Health Partnership
CBRF	Community-Based Residential Facility
CBSCC	Community-Based Structured Crisis Center
CCARC	Comprehensive Community Addiction Recovery Center
CCO	Coordinated Care Organization
CCS	Community Crisis Stabilization
CDC	Centers for Disease Control and Prevention
CDP	Chemical Dependency Professional Chemical Dependency Program
CDP-T	Chemical Dependency Professional Trainee
CDTF	Chemical Dependency Treatment Facility
CEO	Chief Executive Officer
CEDT	Certified Eating Disorder Treatment
CFR	Code of Federal Regulations

CIWA-Ar	Clinical Institute Withdrawal Assessment Alcohol scale Revised
CIWA-R	Clinical Institute Withdrawal Assessment Revised
CMHC	Community Mental Health Center
CMHRT	Community Mental Health Residential Treatment
CMS	Centers for Medicare & Medicaid Services
COA	Council on Accreditation of Services for Families and Children
CON	Certificate of Need
COPSD	Co-Occurring Psychiatric and Substance use Disorders
CPA	Certified Public Accountant
CPC	Comprehensive Primary Care
CPEP	Comprehensive Psychiatric Emergency Program
CPR	Cardiopulmonary Resuscitation
CPSW	Certified Peer Support Worker
CQL	Council on Quality Leadership
CRC	Crisis Receiving Center
CREDIT	Community Residence for Eating Disorder Integrated Treatment
CRS	Crisis Residential Services
CRT	Community Rehabilitation and Treatment
CSC	Crisis Service Center
CSRS	Crisis Stabilization Residential Services
CSS	Crisis Stabilization Services
CSSP	Community Support Specialist
CSTAR	Comprehensive Substance Treatment And Rehabilitation
CSU	Crisis Stabilization Unit
CTC	Crisis Triage Center
DATA 2000	Drug Addiction Treatment Act of 2000
DBH	Alaska Division of Behavioral Health District of Columbia Department of Behavioral Health Idaho Division of Behavioral Health New Hampshire Division of Behavioral Health Wyoming Division of Behavioral Health
DBHDD	Georgia Department of Behavioral Health and Developmental Disabilities
DBHDID	Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities
DBHDS	Virginia Department of Behavioral Health and Developmental Services
DCF	Florida Department of Children and Families
DCH	Georgia Department of Community Health
DCP	Diversion Control Plan
DDAP	Pennsylvania Department of Drug and Alcohol Programs
DDC	Dual Diagnosis Capable
DDCAT	Dual Diagnosis Capability in Addiction Treatment
DDE	Dual Diagnosis Enhanced

DDMHS	Vermont Department of Developmental and Mental Health Services
DHCF	District of Columbia Department of Health Care Finance
DHCFP	Nevada Division of Health Care Financing and Policy
DHCS	Alaska DHSS Division of Health Care Services California Department of Health Care Services
DHEC	South Carolina Department of Health and Environmental Control
DHHR	West Virginia Department of Health and Human Resources
DHHS	Maine Department of Health and Human Services Michigan Department of Health and Human Services Nebraska Department of Health and Human Services New Hampshire Department of Health and Human Services North Carolina Department of Health and Human Services South Carolina Department of Health and Human Services
DHI	New Mexico Division of Health Improvement
DHS	Arkansas Department of Human Services Hawaii Department of Human Services Illinois Department of Human Services Iowa Department of Human Services Minnesota Department of Human Services New Jersey Department of Human Services North Dakota Department of Human Services Pennsylvania Department of Human Services Utah Department of Human Services Wisconsin Department of Health Services
DHSR	North Carolina Division of Health Service Regulation
DHSS	Alaska Department of Health and Social Services Delaware Department of Health and Social Services Missouri Department of Health and Senior Services
DLRA	Michigan Department of Licensing and Regulatory Affairs
DMAS	Virginia Department of Medical Assistance Services
DMC-ODS	Drug Medi-Cal Organized Delivery System
DME	Durable Medical Equipment
DMH	Alabama Department of Mental Health Illinois Division of Mental Health Massachusetts Department of Mental Health Mississippi Department of Mental Health Missouri Department of Mental Health
DMHA	Indiana Division of Mental Health and Addiction
DMHAS	Connecticut Department of Mental Health and Addiction Services Ohio Department of Mental Health and Addiction Services
DMHDDSAS	North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
DMHSAS	Tennessee Department of Mental Health and Substance Abuse Services

DMS	Kentucky Department for Medicaid Services
DOH	Hawaii Department of Health New Mexico Department of Health Ohio Department of Health South Dakota Department of Health Utah Department of Health Washington State Department of Health Wyoming Department of Health
DPBH	Nevada Division of Public and Behavioral Health
DPH	Connecticut Department of Public Health Illinois Department of Public Health Iowa Department of Public Health Massachusetts Department of Public Health
DPHE	Colorado Department of Public Health and Environment
DPHHS	Montana Department of Public Health and Human Services
DSAMH	Delaware Division of Substance Abuse and Mental Health Utah Division of Substance Abuse and Mental Health
DSH	Disproportionate Share Hospital
DSHP	Designated State Health Program
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSRIP	Delivery System Reform Incentive Payment
DSS	California Department of Social Services Missouri Department of Social Services South Dakota Department of Social Services
DTA	Massachusetts Department of Transitional Assistance
DUI	Driving Under the Influence
E&T	Evaluation and Treatment
EDNOS	Eating Disorder Not Otherwise Specified
EDTP	Eating Disorder Treatment Plan
EOU	Extended Observation Unit
EQR	External Quality Review
EQRO	External Quality Review Organization
ESMI	Early Serious Mental Illness
FBCS	Facility Based Crisis Stabilization
FDA	Food and Drug Administration
FEP	First Episode Psychosis
FFP	Firm Fixed Price
FFS	Fee-For-Service
FPL	Federal Poverty Level
FS	Florida Statutes
FSTRA	Forensic Supervised Transitional Residential and Aftercare Facility
FTE	Full-Time Equivalent

GAIN-I	Global Appraisal of Individual Needs Initial
GAIN-SS	Global Appraisal of Individual Need-Short Screen
GED	General Educational Development
HCA	Washington State Health Care Authority
HCPF	Colorado Department of Health Care Policy and Financing
HEDIS	Healthcare Effectiveness Data and Information Set
HFR	Georgia Division of Healthcare Facility Regulation
HHSC	Texas Health and Human Services Commission
HHTF	Alcohol and Drug Halfway House Treatment Facility
HIV	Human Immunodeficiency Virus
HSD	New Mexico Human Services Department Oregon Health Systems Division
HUM	High Utilizer Management
IADL	Instrumental Activity of Daily Living
IBSER	Intensive Behavioral Support and Educational Residence
ICC	Intensive Care Coordination
ICD	International Classification of Diseases
ICF/PMI	Intermediate Care Facilities for Persons with a Mental Illness
IDD	Intellectual and Developmental Disability
IDDT	Integrated Dual Diagnosis Treatment
IDEA	Iowa Department of Inspections and Appeals
IDHW	Idaho Department of Health and Welfare
IDI	Initial Diagnostic Interview
IDT	Interdisciplinary Team
IHP	Individualized Habilitation Plan
IIS	Intensive Inpatient Services
IMD	Institution for Mental Disease
IMR	Illness Management and Recovery
IMS	Incidental Medical Services
IPC	Individual Plan of Care
IPP	Individual Program Plan
IPU	Inpatient Hospice Unit
IRP	Individualized Recovery/Resiliency Plan
IRRF	Intensive Residential Recovery Facility
IRTS	Intensive Residential Treatment Services
ISP	Individualized Service Plan
ITP	Individual Treatment Plan
IV	Intravenous
JCAHO	Joint Commission on Accreditation for Healthcare Organizations

KDADS	Kansas Department for Aging and Disability Services
KDHE	Kansas Department of Health and Environment
KFF	Kaiser Family Foundation
LAC	Licensed Addiction Counselor
LADC	Licensed Alcohol and Drug Counselor
LAR	Legally Authorized Representative
LBHA	Local Behavioral Health Authority
LBHC	Licensed Behavioral Health Center
LBHP	Licensed Behavioral Health Practitioner
LCSW	Licensed Certified Social Worker
LDH	Louisiana Department of Health
LGPC	Licensed Graduate Professional Counselor
LGSW	Licensed Graduate Social Worker
LICSW	Licensed Independent Clinical Social Worker
LIMHP	Licensed Independent Mental Health Practitioner
LIP	Licensed Independent Practitioner
LME	Local Management Entity
LMFT	Licensed Marriage and Family Therapist
LMHC	Licensed Mental Health Counselor
LMHP	Licensed Mental Health Professional Licensed Mental Health Practitioner
LMSW	Licensed Master Social Worker
LOC	Level of Care
LOCUS	Level of Care Utilization System
LPC	Licensed Professional Counselor
LPHA	Licensed Practitioner of the Healing Arts
LPN	Licensed Practical Nurse
LTR	Long-Term Resident
LTSR	Long-Term Structured Residence
LTSS	Long-Term Services and Supports
LVN	Licensed Vocational Nurse
MAT	Medication-Assisted Treatment
MCA	Montana Code Annotated
MCE	Managed Care Entity
MCO	Managed Care Organization
MCP	Managed Care Plans
MD	Medical Doctor
MDH	Maryland Department of Health
MH	Mental Health
MHA	Mental Health Agency
MHP	Mental Health Plan Mental Health Professional



MHPRR	Mental Health Psychiatric Rehabilitative Residence
MHPRR-As	Supportive Mental Health Psychiatric Rehabilitative Residence Apartment
MHRT	Mental Health Rehabilitation Technician
MHRTF	Mental Health Residential Treatment Facility
MLADC	Master Licensed Alcohol and Drug Counselor
NAC	Nevada Administrative Code
NCQA	National Committee on Quality Assurance
NMAP	Nebraska Medical Assistance Program
NMMCP	Nebraska Medicaid Managed Care Program
NOS	Not Otherwise Specified
NP	Nurse Practitioner
NRS	Nevada Revised Statutes
NTP	Narcotic Treatment Program
OADAP	Illinois Office of Alcohol and Drug Abuse Prevention
OASAS	New York State Office of Addiction Services and Supports
OBH	Colorado Office of Behavioral Health Louisiana Office of Behavioral Health
OCN&L	New Jersey Office of Certificate of Need and Licensure
ODASL	Oklahoma Determination of ASAM Service Level
ODM	Ohio Department of Medicaid
ODMHSAS	Oklahoma State Board of Mental Health and Substance Abuse Services
OHA	Oregon Health Authority
OHCA	Oklahoma Health Care Authority
OHFLAC	West Virginia Office of Health Facility Licensure and Certification
OHHS	Massachusetts Executive Office of Health and Human Services
OIG	Office of Inspector General
OMH	New York State Office of Mental Health
ORS	Oregon Revised Statutes
OSHA	Occupational Safety and Health Administration
OTP	Opioid Treatment Program
OUD	Opioid Use Disorder
PA	Physician Assistant
PACT	Program for Assertive Community Treatment
PCNS	Psychiatric Clinical Nurse Specialist
PCPP	Primary Care Physician Program
PIHP	Prepaid Inpatient Health Plan
PITF	Private Intermediate Treatment Facility
PMHP	Prepaid Mental Health Plan
PNMI	Private Non-Medical Institution
POC	Plan of Correction

PPC	Patient Placement Criteria
PRCSS	Psychiatric Residential Crisis Stabilization Services
PRTF	Psychiatric Residential Treatment Facility
QA	Quality Assurance
QAPI	Quality Assessment and Performance Improvement
QBHE	Qualified Behavioral Health Entity
QCC	Qualified Credential Counselor
QI	Quality Improvement
QMHP	Qualified Mental Health Professional
QMHP-CS	Qualified Mental Health Professional-Community Services
QSAP	Qualified Substance Abuse Professional
RARS	New York Residential Addiction Rehabilitative Services
RAS	Residential Adult Services
RCF	Residential Care Facility
RCF/PMI	Residential Care Facility for Persons with a Mental Illness
RCS	Residential Crisis Service
RDF	Alcohol and Drug Residential Detoxification Treatment Facility
RDS	Regional Detoxification Specialist
RH	Recovery House
RLD	Regulation and Licensing Department
RN	Registered Nurse
RRS	Recovery and Rehabilitation Support Residential Rehabilitation Services
RRTF	Alcohol and Drug Residential Rehabilitation Treatment Facility for Adults
RTF	Residential Treatment Facility
RTH	Residential Treatment Home
RTPF	Residential Treatment Program Facility
RTRF	Residential Treatment and Rehabilitation Facility
SA	Substance Abuse
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPT	Substance Abuse Prevention and Treatment
SAPTA	Nevada Substance Abuse Prevention and Treatment Agency
SATF	Substance Abuse Treatment Facility
SBS	Specialized Behavior Support plan
SED	Serious Emotional Disturbance
SMI	Serious Mental Illness
SRF	Social Rehabilitation Facility
SFP	Social Rehabilitation Program
SMHPRR	Specialized Mental Health Psychiatric Rehabilitative Residence
SMHRF	Specialized Mental Health Rehabilitation Facility

SMI	Serious Mental Illness
SOD	Statement of Deficiency
SOTA	State Opioid Treatment Authority
SPMI	Serious and Persistent Mental Illness
SRT	Short-term Residential Treatment
SRTF	Secure Residential Treatment Facility
SSA	Substance Abuse Agency
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
STD	Sexually Transmitted Disease
STF	Special Treatment Facility
SUD	Substance Use Disorder
SUD-BHP	Alaska Substance Use Disorder and Behavioral Health Program
TB	Tuberculosis
TC	Therapeutic Community
TCM	Transitional Case Management
TEDS	Treatment Episode Data Set
Temp Ob	Temporary Observation
THHS	Texas Health and Human Services
TIP	Treatment Improvement Protocol
TJC	The Joint Commission on Accreditation for Healthcare Organizations
TLP	Therapeutic Living Program
TLU	Transitional Living Unit
TRBHA	Arizona Tribal Regional Behavioral Health Authority
TSS	Transitional Support Services
UAP	Unlicensed Assistive Personnel
UM	Utilization Management
UP	Unlicensed Professional
WCRTS	Women and Children's Residential Treatment Services
WI-UPC	Wisconsin Uniform Placement Criteria
WM	Withdrawal Management
WDM	Withdrawal Management
WRAP	Wellness Recovery Action Plan
WTRS	Women's Treatment and Recovery Support
YAT	Young Adult in Transition Facility

## ALABAMA

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

### Types of Facilities

*Mental Health (MH):* Alabama regulates the following residential MH treatment facility types:

- Community Residential Facility: Mental Illness Residential: a residential setting providing congregate living and dining to consumers. Residential services offered vary by type of program, but all residential services must provide assistance with applying for benefits, social and communication skills, medication management, basic living skills, vocational skills, community orientation, recreational activities, transportation, education, and family support.
  - Psychiatric Assessment Center: short-term facilities with an expected length of stay of no longer than 4 days.
  - Intermediate Care Program: an expected length of stay of 3 months unless an extension is clinically justified, but no more than 6 months. Admissions will be drawn primarily from persons referred from state psychiatric hospitals.
  - Crisis Residential Program: has an expected length of stay of 2 weeks or less. The crisis residential program must also meet the standards for Designated Mental Health Facilities, which is a category of programs designated for receipt of outpatient commitments.
    - If the provider uses residential beds for respite services (also known as crisis respite), specific regularity requirements must be met.
  - Adult Therapeutic Group Home: has a capacity of no more than 10 beds or 16 beds, depending on licensure.
  - Transitional Age Residential Care Program: age 17-25; admissions will be drawn primarily from persons referred from state psychiatric hospitals.
  - Adult Small Capacity (3-Bed) Residential Home: state staff indicate this facility type serves the most complex population with serious mental illness.
  - Adult Residential Care Home with Specialized Medical Services: state staff indicate this facility type serves consumers with serious mental illness and significant medical issues. These homes have a capacity of no more than 10 beds or 16 beds, depending on licensure.
  - Adult Residential Care Home with Specialized Behavioral Services: state staff indicate this facility type serves consumers with serious mental illness and severe behavioral issues. These homes have a capacity of no more than 10 beds or 16 beds, depending on licensure.

- Medication/Observation/Meals Program: referred to in regulations but no definition found.

*Substance Use Disorder (SUD):* Alabama SUD regulations and community provider certification regulations include many levels of care, not all of which are explicitly defined but all of which include lengthy information regarding admission criteria, services, and staffing. The levels of care are listed below with relevant ASAM information as identified in the regulations or otherwise defined in the regulations:

- Transitional Residential Program
- Clinically Managed Low Intensity Residential Treatment (Level III.1)
- Clinically Managed Residential Detoxification (Level III.2-D)
- Clinically Managed Medium Intensity Residential Treatment (Level III.3)
- Clinically Managed High Intensity Residential Treatment (Level III.5)
- Medically Monitored Intensive Residential Programs for Adults (Level III.7)
- Medically Monitored Residential Detoxification Program (Level III.7-D)
- Medically Monitored Residential Detoxification Narcotic Treatment Program (Level III.7-D NTP): Uses buprenorphine unless licensed as an OTP and able to dispense methadone.

In addition, there are specific programs for pregnant women and women with dependent children at the low, medium, and high intensity levels, as well as at the medically monitored intensive level. Similar levels of programs exist for persons with co-occurring substance use and mental illness disorders.

*Unregulated Facilities:* No unregulated facility types under the purview of this summary were found. We exclude from this summary the following regulated facility types because they do not include the level of clinical treatment within the scope of this summary: adult residential care homes without specialized medical services or without specialized behavioral services.

## **Approach**

*Mental Health (MH) and Substance Use Disorder (SUD):* The Alabama Department of Mental Health (DMH) regulates and certifies non-exempt MH and SUD treatment programs. Exempt entities include but are not limited to federal or state agencies and providers certified by another state agency.

## **Processes of Licensure or Certification and Accreditation**

*Mental Health (MH) and Substance Use Disorder (SUD):*

- For all non-exempt mental health and substance use treatment programs, certification by the Alabama Department of Mental Health (DMH) is required for operation. An application and inspection are required for certification and recertification. If a program does meet requirements, certificates may be issued for up to 2 years.
- Accreditation is not required but, for residential SUD disorder treatment, if a provider is deemed to have an acceptable alternative certification/license/accreditation, the certification procedures usually performed by DMH will not be conducted, and the provider will be sent a letter from the Commissioner indicating that the alternative form of certification is acceptable to DMH for the period of time that the alternative is effective. If a residential SUD disorder treatment facility is contracted with DMH, site visits may still occur despite deemed status. Deemed status is not allowed for residential MH treatment facilities.
- A certificate of need is not required for these facilities.

## **Cause-Based Monitoring**

*Mental Health (MH) and Substance Use Disorder (SUD):* Certifications may be suspended or revoked. DMH has the authority to periodically monitor entities' continuing compliance with standards or contract requirements, and to conduct reviews and investigations at any time or to investigate a complaint.

## **Access Requirements**

*Mental Health (MH):* Requirements regarding residential services were not explicitly described in the state regulations.

*Substance Use Disorder (SUD):* Each program must demonstrate accessibility planning that addresses the needs of clients, family members, visitors, personnel, and other stakeholders; establish policies governing, and the processes utilized to ensure access to care for individuals with co-occurring mental illness and substance use disorders; describe the procedures utilized to publicize the organization's co-occurring capabilities; and establish policies governing, and the processes utilized to ensure access to care for individuals with disabilities, speech, language, and/or hearing impairments. The entity shall establish a formal process to address

requests for services when space is unavailable in the program. The process will satisfy standards in the regulations.

## **Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD):* For all treatment programs, there shall be a full-time executive director who has overall responsibility for the operation of the agency with specific education and experience requirements. There shall also be a full-time Clinical Director (in addition to the Executive Director) with specific education and experience requirements who has full-time responsibility for the quality of clinical care and the appropriateness of clinical programs as delineated in the job description. For agencies who provide substance abuse treatment services, the Clinical Director shall have a license or a substance abuse counselor certification credential from the Alabama Association of Addiction Counselors, National Association of Alcoholism and Drug Abuse Counselors, Alabama Alcohol and Drug Abuse Association, or International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc.

Specific to substance abuse staff, Human Service Needs Assessment and Case Planning shall be performed by a person who has successfully completed a Case Manager Training Program equivalent to that provided by the DMH Substance Abuse Division; who possesses a valid Alabama driver's license; or a person who meets the qualifications of a Qualified Substance Abuse Professional III (QSAP III).

During each calendar year, the entity shall provide training for each employee.

*Mental Health (MH):* All community MH programs must have a psychiatrist as a full-time or part-time employee or a consultant to the provider who is responsible for medical aspects of consumer psychiatric care as delineated in the job description or employment contract. Access to on-call psychiatric services must be available 24 hours a day, 7 days a week and must be documented. Each direct treatment service functional area of responsibility on the organizational chart shall be coordinated by a member of the staff who has a master's degree in a mental health related field and at least 2 years post master's supervised experience in a direct service area.

All treatment staff who provide therapy and clinical assessments for mental illness consumers must have a master's degree in a mental health related field. Additional requirements relate for staff who lack a certain amount of experience, who provide services to specific subgroups, and case managers. Direct care staff must have specific initial training and all staff must have training on reporting abuse or neglect. Residential facilities, with the exception of apartments, shall demonstrate on-site staff coverage 24 hours a day, 7 days per week as indicated by staff duty rosters. Additional requirements related to First Aid and CPR, infection control training, and having a current driver's license, among other things.

Residential services must have a registered nurse or licensed practical nurse as a full-time or part-time employee or a consultant to the provider who is responsible for supervision of delegation of medication assistance to the unlicensed personnel. Access to an on-call nurse must be available 24 hours a day, 7 days a week. There must be written procedures for handling the disruptive behavior of consumers which staff shall be trained in.

For a Psychiatric Assessment Center, the program coordinator shall have a Master's degree in a mental health related field and 2 years post-Master's experience in a direct service functional area or be a Registered Nurse with 2 years of psychiatric inpatient experience. All staff shall receive initial and at least annual training related to the needs of the population served. The program has a defined staffing pattern for a maximum of 10 beds.

For an Intermediate Care Program, the program coordinator shall have a master's degree in a mental health related field and at least 2 years' experience post-master's in a direct service position or be a registered nurse with at least 2 years of psychiatric inpatient experience. All staff shall receive initial and at least annual training related to the special needs of the population served. A psychiatrist shall make daily rounds Monday through Friday and shall be on call 7 days per week. The program has a defined staffing pattern for 16 beds.

For a crisis residential program with 10 or less beds, the program coordinator shall have a master's degree in a mental health related field and 2 years post master's experience in a direct service functional area or be a registered nurse with 2 years of psychiatric inpatient experience. All staff shall receive initial and at least annual training related to the special needs of the population served. The program has a defined staffing pattern.

For an Adult Therapeutic Group Home, the program coordinator shall have a master's degree in a mental health related field and at least 2 years post master's experience in a direct service position. All staff shall receive initial and at least annual training related to the special needs of the population served. The program has a defined staffing pattern for 10 beds.

For a Transitional Age Residential Care Program, the program coordinator shall have either a Bachelor's degree in a mental health related field or be a Registered Nurse and have at least 2 years post-degree experience in a direct service functional area. One of the two years post-degree experience must be with adolescents/youth. All staff shall receive initial training and 20 hours of annual training related to the target population, with 2 of those hours involving the perspective of families and consumers with regard to residential treatment. The program has a defined staffing pattern for 10 beds.

For an Adult Small Capacity Residential Home, the program coordinator shall have a bachelor's degree in a mental health service related field and shall have 2 years' experience in a direct service area. Alternatively, the coordinator shall have 3 years' experience in a mental illness residential setting, demonstrate the ability to communicate clearly orally and in writing, and demonstrate the ability to maintain clinical records in accordance with standards. All staff must



receive initial and at least annual training related to the special needs of the population served. The program has a defined staffing pattern for 3 beds.

For an Adult Residential Care Home with Specialized Medical Services, the program coordinator shall be a registered nurse. All staff shall receive initial and at least annual training related to the special needs of the population served. The program has a defined staffing pattern for 10 beds.

For an Adult Residential Care Home with Specialized Behavioral Services, the program coordinator shall have a bachelor's degree in a mental health related field and 2 years' experience in a direct service functional area. All staff shall receive initial and at least annual training related to the special needs of the population served. The program has a defined staffing pattern for 10 beds.

For a Medication/Observation/Meals Program, the program coordinator shall have a bachelor's degree in a mental health related field and 2 years' experience in a direct service functional area. All staff shall receive initial and at least annual training related to the special needs of the population served. The program has a defined staffing pattern for 20 beds.

*Substance Use Disorder (SUD):* Specific requirements are in place for staffing related to medication administration, in particular if unlicensed personnel are administering medication. In addition, Alabama SUD regulations and certification regulations include specific staffing requirements for the different levels of care, including requirements regarding type of personnel, adequate levels of personnel, and training.

## **Placement**

*Mental Health (MH):* Residential programs must have inclusionary admission criteria that:

1. Require the consumer's willingness to participate in daily structured activities.
2. Require a principal psychiatric diagnosis.
3. Require a setting that has staff on the premises 24 hours/day when consumers are present and a combination of the specific criteria whose severity would preclude treatment in a less restrictive environment (for a number of specified reasons).

Exclusionary criteria must include the following:

1. Principal diagnosis of alcoholism or drug dependence.
2. Primary physical disorder (serious illness requiring hospital care, nursing care, home health care, or impaired mobility that prohibits participation in program services).
3. Primary organic disorder (brain damage).
4. Principal diagnosis of mental retardation.

There is a policy that consumers will not be discharged solely on the basis of one positive urine analysis showing the presence of alcohol, illegal drugs, or medication not prescribed. The LOCUS tool is not referenced.

*Substance Use Disorder (SUD):* For all substance use treatment providers, all entities seeking to have a client admitted to a DMH certified facility shall develop, maintain, and document implementation of written policies and procedures to conduct, or receive from another entity, a written Placement Assessment containing an evaluation of each client's level of functioning in the six ASAM dimensions; develop a level of care recommendation based upon the Placement Assessment; and initiate service delivery including referral, as appropriate, based upon the client's level of care recommendation.

For all substance use treatment providers, each entity shall develop, maintain, and document compliance with written criteria that shall govern admission to each respective level of care provided by the organization. Each entity shall provide written documentation of criteria used to deny admission or readmission of clients into the program. Additional criteria are specified for intake of those with co-occurring disorders and for women who are pregnant and/or have dependent children. Continuing Stay Criteria. The entity shall develop, maintain, and document implementation of written policies and procedures governing continuing stay for each level of care provided.

In addition, Alabama SUD regulations and certification regulations include specific placement requirements for the different levels of care.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* For all treatment providers, treatment planning and discharge planning, beginning at admission, are required.

*Mental Health (MH):* A written treatment plan that includes specified elements must be completed by the fifth face-to-face outpatient service, within ten working days after admission in all residential programs. Written assessments of progress are required every two weeks. The treatment plan should be updated at least every 3 months.

In a Transitional Age Residential Care Program, treatment plans are consistent with the admission criteria. Thirty days prior to discharge the residential facility will begin coordinating recommended transitional services. Upon discharge with the permission of the consumer and/or personal representative/legal guardian, the program shall set up appointments for the consumer for all recommended follow-up services.

*Substance Use Disorder (SUD):* Service and treatment planning should adhere to ASAM requirements. Development of the service plan is initiated within 24 hours of the placement assessment. Service plan revisions for each client shall be initiated at regular intervals in

accordance with the client's severity and level of function, progress or lack of progress, and the intensity of services in the level of care. The entity shall develop, maintain and document implementation of and compliance with written policies and procedures established to support continued service delivery after transfer or discharge from each level of care provided.

## **Treatment Services**

*Mental Health (MH):* Services must be individualized, well-planned, based on a comprehensive mental health evaluation and assessment of needed treatment and support, and should include treatment designed to enhance the consumer's abilities to recover and function in society as normally as possible.

For all residential services, the following services, at a minimum should be either provided in-house or arranged for by the residential staff, depending upon the needs of the individual consumer, including but not limited to:

1. Assistance in applying for benefits;
2. Assistance in improving social and communication skills;
3. Assistance with medication management;
4. Assistance in the development of basic living skills;
5. Vocational services;
6. Community orientation;
7. Recreation and activities;
8. Assistance in locating long term community placement in least restrictive setting;
9. Transportation to and from necessary community services and supports;
10. Education about psychiatric illness; and
11. Family support and education.

All residential programs must demonstrate their consumer's accessibility to a local licensed hospital for the purpose of providing emergency hospital care. Residential programs will assist consumers in obtaining necessary medical care.

At a Psychiatric Assessment Center, a psychiatrist shall make daily rounds 5 days per week and shall be on call 7 days per week. Adequate Intensive Case Management will be available within the organization to facilitate discharge planning and diversion from hospitalization in a state hospital.

An Intermediate Care Program shall provide specialized services that must include at a minimum the provision of partial hospitalization services within the home. In an Intermediate Care Program, a psychiatrist shall make daily rounds Monday through Friday and shall be on call 7 days per week.

A crisis residential program shall provide specialized services that must include partial hospitalization services provided within the facility. At a crisis residential program, a psychiatrist shall make daily rounds 5 days per week and shall be on call 7 days per week.

An Adult Therapeutic Group Home shall provide specialized services that must include the provision of intensive day treatment services within the home.

An Adult Small Capacity Residential Home, an Adult Residential Care Home with Specialized Medical Services, and an Adult Residential Care Home with Specialized Behavioral Services shall provide specialized services that are based on the admission criteria contained in the program description.

*Substance Use Disorder (SUD):* Alabama SUD regulations include specific treatment (core and therapeutic) service requirements for the different levels of care, including requirements related to medication assisted treatment for the Medically Monitored Residential Detoxification Narcotic Treatment Program.

## **Patient Rights and Safety Standards**

*Mental Health (MH) and Substance Use Disorder (SUD):* Among the rights afforded residents are treatment in the least restrictive setting, freedom from abuse, and access to complaint and grievance procedures. Prior to or promptly upon admission, each program should provide every recipient/lawful representative a concise written statement and verbal orientation, in their preferred language and terms appropriate for the recipient to understand, of rights and responsibilities and complaint procedures along with procedures to be followed to initiate, review, and resolve allegations of rights violations.

For all programs, in the case of an unexpected or unexplained death, the provider will report the death to the Department of Mental Health as soon as possible but at least within 24 hours; request the local police or sheriff to conduct an investigation; and report the death to the County Medical Examiner or assure that the death is reported to the County Medical Examiner. [State staff indicate that (b) and (c) are inapplicable to SUD facilities.]

Consumers treated in community programs by the Alabama Department of Mental Health have the right to be free of psychiatric restraint and seclusion. Restraint and seclusion are safety procedures to be used as a last resort. Consumers may be placed in seclusion or may be physically restrained only when psychiatrically necessary to prevent the consumer from physically harming self or others and after less restrictive alternative interventions have been unsuccessful or are determined not to be feasible and when authorized by a qualified physician. The provider must report to the Department of Mental Health immediately any death or injury that occurs while a patient is restrained or in seclusion, or where it is reasonable to assume that a consumer's death or injury is a result of restraint or seclusion. [State staff indicate that the

material on restraint and seclusion are inapplicable to SUD facilities and that those practices are not allowed in SUD facilities.]

*Mental Health (MH):* Clients have the right to receive services without discrimination.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* For all treatment programs, the Performance Improvement (PI) System shall provide meaningful opportunities for input concerning the operation and improvement of services from recipients, family members, recipient groups, advocacy organizations, and advocates. It identifies and assesses important processes and outcomes, corrects and follows-up on identified problems, analyzes trends, improves the quality of services provided and improves recipient and family satisfaction. It covers all program service areas and functions, is reviewed by the Board of Directors at least every 2 years and when revisions are made, it outlines the agency's mission related to performance improvement, and contains the agency's goals and objectives related to performance improvement.

*Substance Use Disorder (SUD):* For all residential SUD programs, at a minimum, the entity shall collect information at time of assessment and at transfer or discharge to provide measures of outcome as specified in the following domains:

1. Reduced Morbidity;
2. Employment/Education;
3. Crime and Criminal Justice;
4. Stability in Housing;
5. Social Connectedness;
6. Access/Capacity;
7. Retention; and
8. Use of Evidence Based Practices.

## **Governance**

*Mental Health (MH) and Substance Use Disorder (SUD):* The provider must submit documentation of its source of authority. The governing authority must assure compliance with applicable federal, state, and local laws. The governing authority must annually review and approve written policies and procedures.

## Special Populations

*Mental Health (MH):* Requirements regarding residential services were not explicitly described in the state regulations.

*Substance Use Disorder (SUD):* For all SUD treatment programs, priority access for admission to treatment should be given, first, to pregnant women with intravenous substance use disorders; second, to pregnant women with substance use disorders; third, to individuals with intravenous substance use disorders; fourth, to women with dependent children; fifth, to individuals who are HIV positive; and sixth, to all others with SUDs.

The intake process for women who are pregnant and/or have dependent children shall be family centered and gender responsive addressing the assessment of primary medical care to include prenatal care, primary pediatric care and immunization for their children. Each entity shall specify in writing the procedures to ensure:

1. Pregnant women and/or women with dependent children are given preference in admission;
2. Sufficient case management to include transportation; and
3. Publicizing the availability of service to women. In addition, there are specific programs for pregnant women and women with dependent children and for persons with co-occurring substance use and mental illness disorders.

## Location of Regulatory and Licensing Requirements

Department of Mental Health. Regulatory data collected September 27, 2019.

<http://www.alabamaadministrativecode.state.al.us/docs/mhlth/index.html>

## Other Information Sources

K. Hammack, N. Walden (DMH); National Conference of State Legislatures CON Program Overview. <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>.

# ALABAMA MEDICAID

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## Approach

*Mental Health (MH) and Substance Use Disorder (SUD):* The Alabama Medicaid Agency oversees the state Medicaid program. Alabama does not rely on the in lieu of provision or on Disproportionate Share Hospital (DSH) payments for Medicaid coverage of certain IMD services. The state also does not have a relevant Section 1115 waiver. Only rehabilitative services delineated in the applicable Alabama Medicaid Agency Provider Manual, Rehabilitative Services, Chapter 105 shall qualify for reimbursement under this program. The manual includes place of service codes for residential settings which, presumably, would not include an IMD.

## Types of Facilities

*Mental Health (MH) and Substance Use Disorder (SUD):* Alabama reimburses for specific rehabilitative services, which are specialized services of a medical or remedial nature delivered by uniquely qualified practitioners designed to treat or rehabilitate persons with mental illness or substance abuse diagnoses. Direct rehabilitative services can be provided in any setting, except in licensed hospital beds, that is convenient for both the client and staff member, that affords an adequate therapeutic environment, and that protects the client's rights to privacy and confidentiality. They include:

- Psychiatric Residential Treatment Center
- Residential Substance Abuse Treatment Facility

## Processes of Medicaid Enrollment

*Mental Health (MH) and Substance Use Disorder (SUD):*

- A provider of medical services (including an out-of-state provider) who wants to be eligible for Medicaid reimbursement must complete the required Medicaid provider enrollment application and enter into a written provider agreement with the Alabama Medicaid Agency. Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-

enroll. Providers are subject to inspection and audit as requested. Provider enrollment may be terminated.

- A Rehabilitative Services provider must demonstrate that they meet either of the following criteria:
  - Be certified as a 310-board community mental health center by DMH and must have demonstrated the capacity to provide access to inpatient or substance abuse services, including intensive outpatient and residential services; and receive approval from DMH to provide mental health rehabilitative services under the Medicaid Rehabilitative Option program;
  - Be an organization that is currently certified by the Alabama Department of Mental Health (DMH) to provide alcohol and other drug treatment services and receive approval by DMH to provide Substance Abuse Rehabilitative Services under the Medicaid Rehabilitative Option program.
  
- The state's agent enrolls Rehabilitative Services providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the State of Alabama, the Code of Federal Regulations, and the Alabama Medicaid Agency Administrative Code.

*Substance Use Disorder (SUD):*

- For the provision of Substance Abuse Rehabilitative Services, an entity must be an organization that is currently certified by the Alabama Department of Mental Health (DMH) to provide alcohol and other drug treatment services under the provisions of Chapter 580 of the Alabama Administrative Code; and must submit an application to and receive approval by DMH to provide Substance Abuse Rehabilitative Services under the Medicaid Rehabilitative Option program.

## **Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD):* Requirements were not explicitly described in the state Medicaid regulations but the regulations incorporate by reference the requirements in the applicable Alabama Medicaid Agency Provider Manual, which include specific minimum education, experiential, and credential requirements for individual professional staff categories. Each covered service may only be reimbursed if provided by specified provider types.



## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* The regulations incorporate by reference the requirements in the applicable Alabama Medicaid Agency Provider Manual, which states that treatment eligibility for MI/SA Rehabilitative Services is limited to individuals with a diagnosis within the range of F0150-F1699 and F18-F99 for ICD-10, assigned by a licensed physician, a licensed psychologist, a licensed physician's assistant, a certified nurse practitioner, or a licensed professional counselor of mental illness or substance abuse as listed in the most current ICD-10.

The Behavioral Health Placement Assessment is a structured face-to-face interview process conducted by a qualified professional for the purpose of identifying a recipient's presenting strengths and needs and establishing a corresponding recommendation for placement in an appropriate level of care. This process may incorporate determination of the appropriateness of admission/commitment to a state psychiatric hospital or a local inpatient psychiatric unit.

An Intake Evaluation is the initial clinical evaluation of the recipient's request for assistance. Substance abuse recipients undergo standardized psychosocial assessment. The intake evaluation presents psychological and social functioning, recipient's reported physical and medical condition, the need for additional evaluation and/or treatment, and the recipient's fitness for rehabilitative services.

The Mental Health and Substance Use Disorders Assessment Update is a structured interview process that functions to evaluate a recipient's present level of functioning and/or presenting needs. The assessment is used to establish additional or modify existing diagnoses, establish new or additional rehabilitation service goals, assess progress toward goals, and/or to determine the need for continued care, transfer, or discharge.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* The regulations incorporate by reference the requirements in the applicable Alabama Medicaid Agency Provider Manual, which states that the intake evaluation process also results in the development of a written treatment plan that should be completed within ten working days after admission in all residential programs and prior to provision of treatment services. The recipient's treatment plan must be reviewed at least every three months.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* The regulations incorporate by reference the requirements in the applicable Alabama Medicaid Agency Provider Manual,

which states that Rehabilitative Services will be provided to recipients on the basis of medical necessity. The following relevant services are covered: Intake Evaluation; Medical Assessment and Treatment; Diagnostic Testing; Crisis Intervention; Individual Counseling; Family Counseling; Group Counseling; Medication Administration; Medication Monitoring; Treatment Plan Review; Mental Health Care Coordination; Adult In-home Intervention; Mental Health and Substance Use Disorders Update; Behavioral Health Placement Assessment; Basic Living Skills; Psychoeducational Services; Assertive Community Treatment (ACT); Program for Assertive Community Treatment (PACT); Opioid Use Disorder Treatment; Adult Peer Support Services; Family Peer Support Services; Psychosocial Rehabilitation Services -- Working Environment; Screening; Brief Intervention; Nursing Assessment and Care; Outpatient Detoxification; and Therapeutic Mentoring.

*Substance Use Disorder (SUD):* Among the services covered as Rehabilitative Services is Opioid Use Disorder Treatment, which is the administration of medication, including the use of FDA approved medications for the use of opioid use disorders, to recipients who have a diagnosed opioid use disorder. Medication is administered to support the recipient's efforts to restore adequate functioning in major life areas that have been debilitated as a result of opioid addiction. This service includes medication administration and concurrent related medical and clinical services.

## **Care Coordination**

*Mental Health (MH) and Substance Use Disorder (SUD):* As a condition of enrollment in the Medicaid Program, a provider must ensure that Medicaid recipients receive quality services in a coordinated manner and have reasonable access to an adequate array of services delivered in a flexible manner to best meet their needs.

*Mental Health (MH):* Covered Rehabilitative Services include mental health care coordination, which are services to assist an identified Medicaid recipient to receive coordinated mental health services from external agencies, providers or independent practitioners. Key service functions include written or oral interaction in a clinical capacity in order to assist another provider in addressing the specific rehabilitative needs of the recipient, as well as to support continuation of care for the recipient in another setting.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* As a condition of enrollment in the Medicaid Program, a provider must ensure that Medicaid recipients receive quality services in a coordinated manner and have reasonable access to an adequate array of services delivered in a flexible manner to best meet their needs. Each agency, organization, or institution providing

care or services in the Medicaid program, must have a utilization review plan approved by Medicaid or its designated agent.

Medicaid may convene standing Quality Assurance Committees to provide guidance, insight and technical assistance as appropriate. Additionally, the Program Integrity Division is responsible for planning, developing, and directing Agency efforts to identify, prevent, and prosecute fraud, waste, and/or abuse in the Medicaid Program.

## Special Populations

*Mental Health (MH) and Substance Use Disorder (SUD)*: Requirements regarding residential services were not explicitly described in the state Medicaid regulations; see above for detailed licensure-related standards.

## Location of Medicaid Requirements

Alabama Medicaid Administrative Code; Alabama Provider Billing Manual - January 2020. Regulatory data collected January 15, 2020.

[https://medicaid.alabama.gov/content/9.0\\_Resources/9.2\\_Administrative\\_Code.aspx](https://medicaid.alabama.gov/content/9.0_Resources/9.2_Administrative_Code.aspx).

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>.

This state summary is part of the report “**State Residential Treatment for Behavioral Health Conditions: Regulation and Policy**”. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

## ALASKA

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### Types of Facilities

*Mental Health (MH):* Alaska regulates Crisis Stabilization Facilities where a person may be detained for no more than 72 hours and which provide crisis stabilization. No other regulated MH residential treatment facility types were identified.

*Substance Use Disorder (SUD):* Alaska regulates Clinically Managed Residential Services, in accordance with ASAM levels of low-, medium- and high-intensity. Each level corresponds to hours of clinical services delivered per week and varies by specification of treatment requirements.

Alaska also regulates alcohol and drug detoxification services in a residential setting as either clinically managed residential detoxification or medically monitored residential detoxification.

*Unregulated Facilities:* If there are MH residential treatment facilities other than Crisis Stabilization Facilities, they are unregulated.<sup>1</sup> SUD facilities not paid or under contract to DHSS are subject to limited regulation.

### Approach

The Alaska Department of Health and Social Services (DHSS) regulates Crisis Stabilization Facilities as evaluation facilities under the civil commitment statutes and regulates the SUD residential facilities under its Behavioral Health Services regulations. Alaska has different regulatory requirements for facilities depending on whether they receive money from DHSS. All requirements apply to those MH and SUD facilities receiving funding. For SUD residential facilities not receiving funding, more limited requirements apply.

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<sup>1</sup> As noted in the Medicaid portion of this summary, the Section 1115 waiver includes Adult Mental Health Residential (AMHR) Services, which are not included in the Alaska licensing regulations or identified in the state Medicaid regulations. It is unclear if they yet exist.

## **Processes of Licensure or Certification and Accreditation**

*Mental Health (MH):* Crisis Stabilization Facilities must apply for designation with DHSS in order to operate in Alaska (for those paid by or under contract to DHSS).

- Facilities must be accredited by either the Joint Commission, Council on Accreditation, or Commission on Accreditation of Rehabilitation Facilities. Alternative accreditation can be requested.
- Researchers did not find regulation regarding need for inspection, although the Section 1115 Medicaid waiver indicates, as background, that it is required at the initial request for designation.
- A Certificate of Need is required for operation.
- Designation is applied for annually, and the application focuses on proof of accreditation, completion of a certification of compliance, and provision of information about the facility's policies and procedures.

*Substance Use Disorder (SUD):* Facilities require approval by DHSS for operation.

- To gain approval, facilities must meet regulatory requirements and be accredited or working towards accreditation. Facilities must be accredited by either the Joint Commission, Council on Accreditation, or Commission on Accreditation of Rehabilitation Facilities. Alternative accreditation can be requested.
- If the facility is accredited, the approval lasts as long as the accreditation. If not accredited, Division Staff complete a full review to determine if the facility meets provisional requirements which can last from 6 months to 2 years.
- Researchers did not find regulation regarding need for inspection, although the Section 1115 Medicaid waiver indicates, as background, that it is required at the initial request for designation.
- A Certificate of Need is required for operation of the nondetoxification residential facilities.

## **Cause-Based Monitoring**

The DHSS performs ongoing monitoring of short-term Crisis Stabilization Facilities and SUD residential treatment facilities. In both cases, DHSS reviews information provided by the facility and is empowered to take corrective action. Designation may be reconsidered or revoked.

Requirements for inspections were not located but the state's Section 1115 waiver indicates, as background, the department will inspect for cause.

## **Access Requirements**

Wait-time requirements were not found.

## **Staffing**

*Mental Health (MH):* Licensed professionals are not specified. An administrator is required for operation. While the administrator's qualifications are not detailed, the administrator is responsible for ensuring staff members receive training to appropriately interact with patients, and that staff are qualified to handle the protection, security and observation of patients.

*Substance Use Disorder (SUD):* For each intensity level specified (low, medium or high), services must be provided by specified professionals, including: substance use disorder counselor, behavioral health clinical associate, mental health professional clinician, physician, physician assistant (PA), or advanced nurse practitioner (APN); registered nurses and licensed practical nurses are also allowed to provide services when supervised. For detoxification facilities, staff must further be certified in cardiopulmonary resuscitation and basic first aid, and if not a physician, PA or APN work under their supervision, and be able to perform the functions necessary for the job. Additionally, detoxification may be provided by a SUD counselor or behavioral health clinical associate.

## **Placement**

*Mental Health (MH):* Assessment may occur after placement. A determination of appropriateness must be made. Civil commitment regulations require emergency examinations, including a physical examination conducted by a physician and a mental health evaluation conducted by a mental health professional. The latter must include a determination of whether the person meets criteria for involuntary commitment.

*Substance Use Disorder (SUD):* Medical necessity is required according to ASAM criteria placement requirements and a SUD intake assessment must be completed at admission. In addition, a medical evaluation must be completed at admission for clinically managed residential detoxification and within 24 hours for medically monitored residential detoxification.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH):* The administrator of the facility must ensure that “discharge plans are initiated early in the evaluation or treatment process and that the facility provides stabilization, establishes diagnoses, and initiates care with the goal of permitting the patient's early return to the community for follow-up care; discharge planning at an evaluation facility includes determining whether a patient should be released or transferred to a treatment facility, and whether the patient needs medication.”

*Substance Use Disorder (SUD):* All residential substance use treatment facilities and detoxification facilities are required to develop written comprehensive individualized treatment and discharge plans.

## **Treatment Services**

*Mental Health (MH):* Crisis stabilization should be individualized and include the administration of medication and provision of structure, observation, support, case management, or discharge planning for a person subject to voluntary or involuntary admission for treatment.

*Substance Use Disorder (SUD):* For residential services, the following must be offered: (1) life skills development designed to restore or improve the recipient's overall functioning relative to the recipient's substance use disorder; (2) counseling to promote successful initial involvement in regular productive daily activity, including going to work or school, and successful reintegration into family living; (3) motivational and engagement strategies appropriate to the recipient's treatment plan; (4) medication administration services; (5) referrals to other agencies, as needed; (6) discharge or transfer planning; (7) comprehensive community support services; (8) crisis or relapse prevention planning; (9) management of a recipient's chronic disease, if medically necessary and clinically appropriate; (10) urinalysis and breathalyzer testing to reinforce treatment gains as appropriate to the treatment plan; (11) development of a social network that is supportive to recovery; (12) services provided to the recipient's family and significant other to support recovery and prevention; (13) didactic motivational interventions to assist the recipient in understanding the relationship between substance use disorder and attendant life issues; and (14) development of coping skills in the recovery environment.

Detoxification services must provide at least three of the following: (1) medication administration services; (2) referrals to other behavioral, medical, social, or educational agencies, as needed; (3) discharge or transfer planning; (4) evaluation and treatment of symptoms of intoxication and withdrawal; (5) comprehensive community support services; (6) crisis or relapse prevention planning; (7) individual daily assessment; (8) case management; (9) management of a recipient's chronic disease, if medically necessary and clinically appropriate;

(10) urinalysis and breathalyzer testing, when specifically related to detoxification; and (11) development of coping skills in the recovery environment.

## **Patient Rights and Safety Standards**

All facilities are required to develop a “bill of recipient’s rights” that is accessible to all treatment recipients. This document shall include the following: “(1) a recipient is entitled to participate in formulating, evaluating, and periodically reviewing the recipient's individualized written treatment plan, including requesting specific forms of treatment, be informed why requested forms of treatment are not made available, refuse specific forms of treatment that are offered, and be informed of treatment prognosis; (2) a recipient has the right to review with a staff member, at a reasonable time, the recipient's treatment record; however, information confidential to other individuals may not be reviewed by the recipient; (3) a recipient will be informed by the prescribing physician of the name, purpose, and possible side effects of medication prescribed as part of the recipient's treatment plan at the community behavioral health services provider; (4) a recipient may request a written summary of the recipient's treatment; that summary must include discharge and transition plans; (5) a recipient has a right to confidential maintenance of all information pertaining to the recipient and the right of prior written approval for the release of identifiable information.” In addition, other rights are guaranteed, including but not limited to, the right to voice grievances, privacy, communication, dignity, and the right to be free from restraint or seclusion unless certain conditions are met.

## **Quality Assurance or Improvement**

DHSS requires providers to: “(1) have in writing (A) a service description, (B) a service philosophy, and (C) service goals; (2) establish procedures for crisis intervention, including screening recipients for risk to self or others; (3) provide clinical supervision to all personnel providing clinical or direct services to a recipient; and (4) conduct regular quality assurance reviews that (A) monitor the quality of the service; (B) monitor the appropriateness of service; and (C) are used to identify training needs and improve the quality of the service.” A behavioral health services provider also “must: (1) promote a culture within its own organization that promotes excellence and continual quality improvement; (2) establish policies and procedures for identifying and analyzing critical incidents and sentinel events; (3) collect data for the purpose of monitoring performance, managing risk, and improving service delivery; and (4) be able to show how the data collected under this section is used to implement changes that increase quality of care, manage risk, and decrease the number of critical incidents or sentinel events.”



## **Governance**

DHSS requires providers to: “(1) establish policies and procedures for organizational governance and responsibility; (2) have an active governing body empowered to guide, plan, and support the provider in achieving its mission and goals; (3) have a written description of the provider's leadership structure, including a description of the roles and responsibilities of each level of leadership; (4) demonstrate effective leadership within all areas of the provider's organization by having leaders who (A) engage in both short- and long-term strategic planning; (B) communicate effectively with staff and recipients; (C) develop and implement policies and procedures that guide the business and clinical operations of the provider; (D) establish the mission and direction of the organization; (E) are responsible for ongoing performance improvement and achievement of established outcomes; and (F) solicit and value feedback from recipients, personnel, and other stakeholders to create services that meet or exceed the expectations of recipients; (5) comply with all federal, state, and local laws; and (6) be financially solvent and adhere to established accounting practices.”

## **Special Populations**

*Mental Health (MH)*: Not located.

*Substance Use Disorder (SUD)*: The DHSS requires any SUD treatment facility receiving departmental approval to operate to be a dual-diagnosis capable or dual-diagnosis enhanced program.

## **Location of Regulatory and Licensing Requirements**

Alaska Designation regulations<sup>2</sup>, Alaska Behavioral Health Services regulations<sup>3</sup>, Alaska Civil Commitment regulations<sup>4</sup>. Regulatory data collected May 17, 2019.

Alaska Substance Use Disorder and Behavioral Health Program (SUD-BHP) and Implementation Plan<sup>5</sup>.

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<sup>2</sup> See <http://www.legis.state.ak.us/basis/aac.asp#7.72.015>.

<sup>3</sup> See <http://www.legis.state.ak.us/basis/aac.asp#7.70>.

<sup>4</sup> See <http://www.akleg.gov/basis/aac.asp#7.72.010>.

<sup>5</sup> See <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ak/ak-behavioral-health-demo-ca.pdf>.

## Other Information Sources

T.A. Roth (Alaska DBH) and R. Calcote (DBH); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

# ALASKA MEDICAID

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

## Approach

The Alaska Department of Health and Social Services (DHSS) Division of Health Care Services (DHCS) oversees the state Medicaid program. Alaska also has a Section 1115 waiver that affects reimbursement of residential services both within and outside Institutions for Mental Diseases (IMDs). It also has historically relied on Disproportionate Share Hospital (DSH) payments but not the in lieu of provision to reimburse certain services in IMDs.

*Mental Health (MH):* The Section 1115 waiver authorizes the state to implement additional services to enhance its behavioral health system for adults with serious mental illness, specifically for certain non-IMD services.

*Substance Use Disorder (SUD):* The Section 1115 waiver also permits Medicaid expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are short-term residents in facilities that meet the definition of an IMD, including residential treatment.

## Types of Facilities

*Mental Health (MH):* The Alaska Section 1115 waiver permits expenditures for Crisis Residential/Stabilization Services. These are expenditures for medically-monitored, short-term, residential program in an approved 10-15 bed facility that provides 24/7 psychiatric stabilization services. These facilities are not IMDs.

The Section 1115 waiver also permits expenditures for Adult Mental Health Residential (AMHR) Services.<sup>6</sup> AMHR services are provided by an interdisciplinary treatment team in a therapeutically-structured, supervised environment for adults with acute mental health needs, diagnosed with a SMI or SED, whose health is at risk while living in their community. This authority does not apply to IMDs.

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<sup>6</sup> AMHRs are not included in the state licensing regulations but are part of the Section 1115 demonstration. It is unclear whether they yet exist.

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are short-term (statewide average length of stay of 30 days) residents in facilities that meet the definition of an IMD. These can be settings of any size. Expenditures for the following residential ASAM levels of care are permitted: Level 3.1. Clinically managed low-intensity residential substance use treatment services; Level 3.3. Clinically managed medium-intensity residential substance use treatment services; Level 3.5. Clinically managed high-intensity residential services; Level 3.7. Medically Monitored Intensive Inpatient Services; Level 3.2-WM. Clinically Managed Residential Withdrawal Management; and Level 3.7-WM. Medically Monitored Inpatient Withdrawal Management. These all can be delivered in a residential setting.

## **Processes of Medicaid Enrollment**

To be reimbursed by Medicaid, providers must be enrolled as Medicaid providers and licensed and accredited as required by the Alaska DHSS. SUD residential treatment providers must be assessed/designated/certified by DHSS as delivering care consistent with ASAM or other nationally recognized, SUD-specific program standards for residential treatment facilities.

## **Staffing**

*Mental Health (MH):* Adult Mental Health Residential (AMHR) Services. Pursuant to the Section 1115 waiver, a mix of providers may staff an AMHR. These may include: licensed physicians, licensed physician assistants, licensed advanced nurse practitioners, licensed registered nurses supervised by a physician or advanced nurse practitioner, licensed practical nurses supervised by a physician or advanced nurse practitioner, licensed mental health professional clinicians, substance use disorder counselors, behavioral health clinical associates or behavioral health aides, and peer support providers with specified credentials.

Crisis Residential/Stabilization Services. Pursuant to the Section 1115 waiver, these services are provided by, among others, licensed Crisis Residential/Stabilization Units.

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state is required to establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding credentials of staff.

## **Placement**

*Mental Health (MH):* Adult Mental Health Residential (AMHR) Services. AMHR services are appropriate for adults with acute mental health needs whose health is at risk while living in their community, including those who have not responded to outpatient treatment, who have therapeutic needs that cannot be met in a less-restrictive setting, or who are in need of further intensive treatment following inpatient psychiatric hospital services.

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines. The state also must establish a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings. The state will use the ASAM criteria and plans to require the ASO to develop a monitoring protocol, in partnership with the DBH. Thus, the waiver is the primary vehicle for ensuring that use of ASAM placement criteria occurs and is appropriately utilized. The waiver includes additional details by SUD residential treatment level regarding placement and assessment requirements.

## **Treatment and Discharge Planning and Aftercare Services**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state will use the ASAM criteria for treatment planning and SUD providers must conduct an assessment; develop an initial treatment plan; review the treatment plan and revise the plan as necessary at least every 90 days; document the results of the treatment plan review in the clinical record; and include the name, signature, and credentials of the individual who conducted the review.

*Mental Health (MH) and SUD:* According to the Medicaid regulations, providers must develop an individualized behavioral health treatment plan that is based on a professional behavioral health assessment, and that remains current based upon the periodic client status review.

## **Treatment Services**

*Mental Health (MH):* For Crisis Residential/Stabilization Services, component services include: Individualized, person-centered assessment; Crisis Intervention services; Crisis stabilization services designed to stabilize and restore the individual to a level of functioning that does not require inpatient hospitalization; Psychiatric Evaluation services; Nursing services; Medication Services--including medication prescription, review of medication, medication administration,

and medication management; Treatment Plan development services; Referral to the appropriate level of treatment services.

For Adult Mental Health Residential (AMHR) services, component services include: Clinically-directed therapeutic treatment; A comprehensive evaluation to assess emotional, behavioral, medical, educational, and social needs, and support these needs safely; Medication Services-- including medication prescription, review of medication, medication administration, and medication management; An Individual Plan of Care that puts into place interventions that help the individual attain goals designed to achieve discharge from AMH at the earliest possible time; Cognitive, behavioral and other therapies, reflecting a variety of treatment approaches, provided to the individual on an individual, group, and/or family basis.

*Substance Use Disorder (SUD):* Under the Section 1115 waiver, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions. The state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services and hours of clinical care for residential treatment settings. The state must establish a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site. The waiver also requires that the state utilize the ASAM criteria for service types, for number of clinical hours per unit, and for therapies. The waiver implementation plan provides detail regarding component services, including but not limited to assessment, addiction pharmacotherapy and medication services (medication-assisted treatment), and counseling services. The state Medicaid regulations also provide detail regarding types of services that must be provided.

## **Care Coordination**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, beneficiaries will have improved care coordination and care for comorbid physical and mental health conditions. The state must ensure establishment and implementation of policies to ensure residential facilities link beneficiaries with community-based services and supports following stays in these facilities. According to the state Medicaid regulations, the department will pay for case management services under 7 AAC 135.180 on the same day as residential substance use treatment services.

## Quality Assurance or Improvement

*Substance Use Disorder (SUD)*: Pursuant to the Section 1115 waiver, the state must establish a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings.

## Special Populations

No Medicaid requirements were located other than the requirement in the Section 1115 waiver that care for comorbid physical and mental health conditions be improved by the demonstration.

## Location of Medicaid Requirements

Alaska Administrative Code Chapter 135, Medicaid Coverage; Behavioral Health Services<sup>7</sup>.  
Regulatory data collected October 23, 2019.

Alaska Substance Use Disorder and Behavioral Health Program (SUD-BHP).<sup>8</sup>

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report “**State Residential Treatment for Behavioral Health Conditions: Regulation and Policy**”. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

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<sup>7</sup> See <http://www.legis.state.ak.us/basis/aac.asp#7.135>.

<sup>8</sup> See <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ak/ak-behavioral-health-demo-ca.pdf>.

## ARIZONA

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### Types of Facilities

*Mental Health (MH) and Substance Use Disorder (SUD):* Arizona regulates:

- A *Behavioral Health Residential Facility (BHRF)* is a health care institution that “provides treatment to an individual experiencing a behavioral health issue that: (a) Limits the individual’s ability to be independent, or (b) Causes the individual to require treatment to maintain or enhance independence.” According to state staff, a BHRF can include residential and crisis programs identified under MH below.

*Mental Health (MH):* Arizona regulates the Community Mental Health Residential Treatment (CMHRT) System, which is a statewide system of community based residential treatment programs for the seriously mentally ill that provides a wide range of services as alternatives to institutionalization and in the least restrictive setting. Programs include:

- *Residential Treatment Programs* “shall provide a full day treatment program for persons who may require intensive support for a maximum of two years.”
- *Short-Term Crisis Residential Treatment Programs* are an “alternative to hospitalization for persons in an acute episode or situational crisis requiring temporary removal from the home from one to fourteen days.”
- *Adult Behavioral Health Therapeutic Homes* provide “behavioral health services and ancillary services that are in the resident’s treatment plan obtained from the adult behavioral health therapeutic home’s collaborating health care institution.”

*Substance Use Disorder (SUD):* Arizona regulates one type of adult SUD residential treatment facility:

- A *Substance Abuse Transitional Facility* is “a class of health care institution that provides behavioral health services to an individual over 18 years of age who is intoxicated or may have a substance abuse problem.”

*Unregulated Facilities:* Facilities that do not receive state funds or that do not request certification are not regulated.



## **Approach**

The state Medicaid agency, the Arizona Health Care Cost Containment System Administration (AHCCCS), also supervises and administers all facets of the Arizona public behavioral health system. Counties contract with AHCCCS to deliver the services. Arizona historically has relied on the in lieu of provision and Disproportionate Share Hospital (DSH) Payments for certain services in an IMD.

## **Processes of Licensure or Certification and Accreditation**

*Mental Health (MH) and Substance Use Disorder (SUD):* Licensure by the Arizona Department of Health Services is required for any MH or SUD treatment facility.

- An application and inspection are required for initial licensure and a renewal application is required within one year.
- Accreditation is not required, but proof of accreditation provided to the Department will result in a stay of the onsite compliance inspection prerequisite.
- A Certificate of Need is not required for operation.

## **Cause-Based Monitoring**

*Mental Health (MH) and Substance Use Disorder (SUD):* If the Department determines an applicant or licensee is violating state regulations, and that violation poses a direct risk to the life, health, or safety of a patient, the Department may: issue a provisional license; assess a civil penalty; impose an intermediate sanction; remove a licensee and appoint another person to continue operation of the health care institution pending further action; suspend or revoke a license; deny a license; or issue an injunction.

## **Access Requirements**

*Mental Health (MH) and Substance Use Disorder (SUD):* No requirements related to access or wait times were found for BHRFs.

*Mental Health (MH):* Requirements related to access requirements for adult residential MH treatment facilities were not located.

*Substance Use Disorder (SUD):* State staff indicate that the department maintains a wait list port for the priority population under the Substance Abuse Block Grant.

## **Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD):* BHRF staffing standards include standards for a program administrator, staffing levels and competencies, and pre-service orientation and in-service training relevant to the needs of the population served. Requirements for medical staff, including a clinical director and registered nurses, were located.

*Mental Health (MH):* Each program shall use appropriate multidisciplinary staff to meet the diagnostic and treatment needs of the seriously mentally ill and shall encourage the use of paraprofessionals.

*Substance Use Disorder (SUD):* Residential SUD facility staffing standards include standards for a program administrator, staffing levels and competencies, direct care staff qualifications, and pre-service orientation and in-service training relevant to the needs of the population served. Requirements for medical staff, including a director of nursing and other medical staff, were located.

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* Admission criteria were identified, including that an administrator shall ensure that a resident is admitted based upon the resident's presenting behavioral health issue and treatment needs and the behavioral health residential facility's scope of services. A medical practitioner shall perform a medical history and physical examination, or a registered nurse shall perform a nursing assessment, within 30 calendar days before admission or within seven calendar days after admission.

*Substance Use Disorder (SUD):* Admission criteria were identified, including that an administrator shall ensure that a resident is admitted based upon the resident's presenting behavioral health issue and treatment needs and the substance abuse transitional facility's ability and authority to provide behavioral health services or physical health services consistent with the participant's need, and an assessment is completed by an emergency medical care technician or a registered nurse. If the assessment is completed by an emergency medical care technician, it shall be reviewed by a registered nurse within 24 hours.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Treatment planning based on admission and on-going assessment is required, and the initial plan must be completed within 48 hours of the admission assessments or before services are provided and must be documented in the record within 48 hours of first receipt of services. The plan must be reviewed and updated on an on-going basis. Discharge planning is required. An administrator shall ensure that, at the time of discharge, a resident receives a referral for treatment or ancillary services that the resident may need after discharge, if applicable.

*Mental Health (MH):* Treatment/service planning requirements are indicated for residential MH treatment facilities, and responsibility of the regional authority and its service providers to engage in service planning, including the provision of assessments, case management, individualized service plans (ISP), and service referrals. An initial ISP meeting must be held by the regional authority and must be held within 20 days of assessment for service eligibility. Within 30 days of treatment actually commencing, an ISP must be reviewed. They are reviewed thereafter at least every 6 months. No references to discharge planning were found regarding MH residential specifically.

*Substance Use Disorder (SUD):* Specific treatment planning requirements were not identified. Discharge/aftercare planning is required, and in the event that a participant is not being transferred to another health care institution, personnel must identify patient needs post-discharge, identify resources that may be available to assist, and document the information in the participant medical record.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Continuous protective oversight should be provided to appropriate residents. Opportunities to participate in activities designed to maintain or enhance the resident's ability to function independently while caring for the resident's health, safety, or personal hygiene or performing homemaking functions shall be offered. Behavioral health services should be provided while taking the resident's diagnoses, treatment needs, developmental levels, social skills, verbal skills, and personal histories, including any history of physical or sexual abuse, into account.

*Mental Health (MH):* CMHRTs should be as "homelike" as possible and offered in the least restrictive settings. Each CMHRT must be designed to provide: (1) Coordination between each program and other treatment systems in the community. (2) A case management system to enhance cooperation of elements within the system and provide each client with appropriate services. (3) Client movement to the most appropriate and least restrictive service. (4) Direct referral of clients for specific programs that does not require the client to pass through the entire system to reach the most appropriate service.

*Substance Use Disorder (SUD):* Residential SUD treatment facilities should provide counseling services to participants.

## **Patient Rights and Safety Standards**

*Mental Health (MH) and Substance Use Disorder (SUD):* The regulations governing BHRFs identify many patient rights. Among those are the right to be treated in the least restrictive setting; file grievances with the program administrator; and to be informed of these and other rights. . The regulations allow for but strictly limit the use of an emergency safety response, which is defined as physically holding a resident to manage the resident’s sudden, intense, or out-of-control behavior to prevent harm to the resident or another individual. The regulations provide for documentation and internal review when an emergency safety response is used. Reporting of critical incidents is required.

*Mental Health (MH):* The regulations governing residential MH treatment facilities identify many patient rights. Among those are the right to file grievances with the program administrator; and to be informed of this and other rights. Restraint and seclusion may only be used in limited circumstances and must be reported monthly.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* An administrator of a behavioral health residential facility shall ensure that a plan is established, documented, and implemented for an ongoing quality management program.

*Mental Health (MH):* The director shall develop and implement an evaluation system that includes program planning and development, fiscal and data management and contract administration.

*Substance Use Disorder (SUD):* An administrator shall ensure that a plan is established, documented, and implemented for an ongoing quality management program.

## **Governance**

*Mental Health (MH) and Substance Use Disorder (SUD):* For BHRFs, a governing authority shall be established and delineated during the application process. Among other things, the governing authority is responsible for establishing scope of services, designation of an administrator who is directly accountable to the authority and has certain responsibilities, designation of a clinical director, adopting a quality management program, establishment of

policies and procedures on specified topics, ensuring compliance with policies and procedures, and providing the Department notification of critical incidents identified in the regulations.

*Substance Use Disorder (SUD):* For substance abuse transitional facilities, a governing authority shall be established and delineated during the application process. Among other things, the governing authority is responsible for establishing scope of services, designation of an administrator who is directly accountable to the authority and has certain responsibilities, designation of a clinical director, adopting a quality management program, establishment of policies and procedures on specified topics, ensuring compliance with policies and procedures, and providing the Department notification of critical incidents identified in the regulations.

## **Special Populations**

*Mental Health (MH):* CMHRTs are created for the seriously mentally ill. Adult populations served with Mental Health Block Grant funding are individuals who are underinsured or uninsured and who are:

- Adults (18+) with Serious Mental Illness (SMI)
- Individuals experiencing a First Episode Psychosis (FEP)/Early Serious Mental Illness (ESMI)

*Substance Use Disorder (SUD):* Populations served with Substance Abuse Block Grant funding are individuals who are underinsured or uninsured and, in order of priority:

- Pregnant women/teenagers who use drugs by injection.
- Pregnant women/teenagers who use substances.
- Other members who use drugs by injection.
- Substance using women/teenagers with dependent children and their families, including women who are attempting to regain custody of their children.
- As funding is available--all other members with a SUD, regardless of gender or route of use.

## Location of Regulatory and Licensing Requirements

Department of Health Services regulations<sup>1</sup>; Arizona Revised Statutes title 36<sup>2</sup>; AHCCCS Statewide Community Residential Treatment Plan<sup>3</sup>; AHCCCS Behavioral Health Services regulations<sup>4</sup>; Block Grant priority populations<sup>5</sup>. Regulatory data collected August 27, 2019.

## Other Information Sources

AHCCCS; National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>1</sup> See [https://apps.azsos.gov/public\\_services/Title\\_09/9-10.pdf](https://apps.azsos.gov/public_services/Title_09/9-10.pdf).

<sup>2</sup> See <https://www.azleg.gov/arsDetail/?title=36>.

<sup>3</sup> See [https://www.azahcccs.gov/Members/Downloads/BehavioralHealthServices/AHCCCS\\_Statewide\\_Community\\_Residential\\_Treatment\\_Plan\\_61119.pdf](https://www.azahcccs.gov/Members/Downloads/BehavioralHealthServices/AHCCCS_Statewide_Community_Residential_Treatment_Plan_61119.pdf).

<sup>4</sup> See [https://apps.azsos.gov/public\\_services/Title\\_09/9-21.pdf](https://apps.azsos.gov/public_services/Title_09/9-21.pdf).

<sup>5</sup> See <https://www.azahcccs.gov/Resources/Downloads/Grants/FrequentlyAskedQuestions.pdf>.

# ARIZONA MEDICAID

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## Approach

The AHCCCS oversees both for the state Medicaid program and oversight and licensure of behavioral health facilities. Arizona does not have a relevant section 1115 waiver that affects reimbursement of residential services within or outside Institutions for Mental Diseases (IMDs), although an application is pending. Arizona historically has relied on the in lieu of provision and Disproportionate Share Payments (DSH) for certain services in IMDs.

## Types of Facilities

*Mental Health (MH) and Substance Use Disorder (SUD):* A behavioral health residential facility (BHRF) is “a health care institution that provides treatment to an individual experiencing a behavioral health issue that:

- Limits the individual’s ability to be independent.
- Causes the individual to require treatment to maintain or enhance independence.”

BHRF services are not covered by Medicaid unless provided by a licensed behavioral health residential facility, and covered services include all non-prescription drugs as defined in A.R.S. § 32-1901, non-customized medical supplies, and clinical oversight or direct supervision of the behavioral health residential facility staff, whichever is applicable. Room and board are not covered services. Services in an IMD are not covered.

## Processes of Medicaid Enrollment

*Mental Health (MH) and Substance Use Disorder (SUD):* State Medicaid regulations do not specify requirements related to enrollment of BHRFs. General enrollment requirements, however, include a provision that providers must meet licensing requirements. Sanctions may be applied by the Medicaid agency.

## Staffing

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based staffing requirements for BHRFs was located.

## Placement

*Mental Health (MH) and Substance Use Disorder (SUD):* For a BHRF, prior and continued authorization are required. Requests are expedited.

Contractors shall develop **admission** criteria for medical necessity which includes, among other things, diagnosis and severity requirements. Contractors shall submit admission criteria to AHCCCS for approval, as specified in Contract, and publish the approved criteria.

Contractors shall develop medical necessity criteria for **continued stay** which includes, among other things, risk of harm resulting from their diagnosed Behavioral Health Condition and availability of providers at lower levels of care. Contractors shall submit continued stay criteria to AHCCCS for approval, as specified in Contract, and publish the approved criteria.

Contractors shall develop medical necessity criteria for **discharge** which includes, among other things, a consideration of symptom/behavior relief, level of functional capacity, and availability of providers at lower levels of care. Contractors shall submit discharge criteria to AHCCCS for approval, as specified in Contract, and publish the approved criteria.

## Treatment and Discharge Planning and Aftercare Services

*Mental Health (MH) and Substance Use Disorder (SUD):* For BHRFs, contractors shall establish a policy to ensure the admission, assessment, and treatment planning process is completed consistently among all providers in accordance with law and Contract requirements.

## Treatment Services

*Mental Health (MH) and Substance Use Disorder (SUD):* Behavioral health services include mental health, substance abuse, and physical services. Medically necessary services will be covered. Room and board are not covered unless in an inpatient facility. Contractors and BHRF Providers shall establish policies and procedures to ensure members on MAT are not excluded from admission and are able to receive MAT.



## Care Coordination

*Mental Health (MH) and Substance Use Disorder (SUD):* A contractor shall assist in the transition of members to and from other AHCCCS contractors. Both the receiving and relinquishing contractor shall coordinate aspects of the transition.

For a BHRF, Contractors and BHRF Providers shall ensure appropriate notification is sent to the Primary Care Physician and Behavioral Health Provider/Agency/TRBHA/Tribal ALTCS program upon intake to and discharge from the BHRF.

## Quality Assurance or Improvement

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based quality assurance or improvement requirements for BHRFs was located.

## Special Populations

*Mental Health (MH) and Substance Use Disorder (SUD):* A client's designation as a "client who needs special assistance" results in additional protections, including that a case manager shall notify the regional authority, the Office of Human Rights, and the appropriate human rights committee of the client's need to make treatment decisions; and the identification of a person who is willing to serve as a designated representative of the client.

## Location of Medicaid Requirements

Arizona Administrative Code, Title 9, Chapter 22<sup>6</sup>; AHCCCS Medical Policy Manual (AMPM)<sup>7</sup> and 320-V- Behavioral Health Residential Facilities<sup>8</sup>. Regulatory data collected December 5, 2019.

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<sup>6</sup> See [https://apps.azsos.gov/public\\_services/Title\\_09/9-22.pdf](https://apps.azsos.gov/public_services/Title_09/9-22.pdf).

<sup>7</sup> See <https://www.azahcccs.gov/shared/MedicalPolicyManual/>.

<sup>8</sup> See <https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320V.pdf>.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019. <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report **“State Residential Treatment for Behavioral Health Conditions: Regulation and Policy”**. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

## ARKANSAS

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### Types of Facilities

*Mental Health (MH) and Substance Use Disorder (SUD):* Arkansas regulates:

- An Acute Crisis Unit (ACU) provides non-hospital emergency services for MH and SUD crisis stabilization in free-standing facilities of 16 beds or less.
- Therapeutic Communities (TCs) are highly structured residential environments or continuums of care in which “the primary goals are the treatment of behavioral health needs and the fostering of personal growth leading to personal accountability.” TCs employ community-imposed consequences and earned privileges. There are two levels of care, with Level 1 being the highest level of care and Level 2 a lower level.

*Substance Use Disorder (SUD):* Arkansas regulates:

- A Residential Program is a “non-medical, live-in facility offering treatment and rehabilitation services to facilitate the alcohol and/or other drug abuser’s ability to live and work in the community.”
- Detoxification services, which are funded by the Arkansas Office of Alcohol and Drug Abuse Prevention and provide detoxification services to residents.

*Unregulated Facilities:* It is possible that there are other non-ACU or non-TC MH residential treatment facilities that are not regulated.

### Approach

The Arkansas Department of Human Services (DHS) regulates ACUs and TCs as Behavioral Health Agencies (BHAs). The DHS Office of Alcohol and Drug Abuse Prevention (OADAP) regulates all adult residential SUD treatment facilities.

## **Processes of Licensure or Certification and Accreditation**

*Mental Health (MH) and Substance Use Disorder (SUD):* Certification by the DHS as a BHA is required, after which certification as an ACU or TC must be obtained, unless an ACU is operated by the DHS.

- Accreditation is required for certification. Accreditation may be by one of the following: Commission on Accreditation of Rehabilitation Facilities (CARF), Joint Commission on the Accreditation of Health Care Organizations (TJC), or the Council on Accreditation (COA).
- A site survey is required for certification.
- The state does not require a Certificate of Need.
- Licensure duration is not defined.

*Substance Use Disorder (SUD):* All residential SUD treatment facilities, excepting exempt federal facilities, require licensure by the DHS.

- Accreditation is not required but facilities accredited by CARF, TJC, or COA automatically receive provided they also meet specific licensure requirements.
- Formal on-site reviews are conducted.
- The state does not require a Certificate of Need.
- Licensure duration for the initial license is one year. Renewal licenses are valid for up to three years.

## **Cause-Based Monitoring**

*Mental Health (MH) and Substance Use Disorder (SUD):* The DHS may contact applicants and providers at any time and may make unannounced visits to applicants and providers. Applicants and providers must provide the DHS prompt direct access documents and to staff and contractors. Additionally, as a condition of BHA certification, "Providers must furnish annual reports to DHS before July 1 of each year that the provider has been in operation for the preceding twelve (12) months."

*Substance Use Disorder (SUD):* The OADAP will conduct at least 2 announced or unannounced compliance reviews.

## Access Requirements

*Mental Health (MH) and Substance Use Disorder (SUD):* Wait-time requirements were not found specific to adult residential MH treatment.

*Substance Use Disorder (SUD):* Wait-time requirements were not found specific to adult residential SUD treatment.

## Staffing

*Mental Health (MH) and Substance Use Disorder (SUD):* As a BHA, staffing must be sufficient to establish and implement services for each client, and must include a CEO, a Clinical Director, Mental Health Professionals, Qualified Behavioral Health Providers including certified peer support specialists, a Corporate Compliance Officer, a Medical Director who is either a psychiatrist or supported by a psychiatrist on staff, a Privacy Officer, a Quality Control Manager, a Grievance Officer, a Medical Records Librarian, and a Licensed Psychologist, all of which must meet specific requirements.

- All ACUs must maintain staff development and training plans that account for orientation procedures; in-service training and education programs; availability of professional reference materials; and mechanisms for insuring outside continuing educational opportunities for staff members. Staff that provide clinical services are required to complete annual training that covers, among other things, client's rights and the constraints of the Mental Health Client's Bill of Rights; cultural competence; co-occurring disorder competency and treatment principles; and trauma informed and age and developmental specific trainings. ACUs must have a co-occurring disorder capable multidisciplinary team of medical, nursing, social services, clinical, administrative, and other staff adequate to meet the clinical needs of the individuals served.
- TCs must develop written personnel policies and procedures which “promote the objectives of the program and provide for qualified personnel during all hours of operation to support the functions of the center and provide quality care.” The TC must have a written plan for staff development and training similar to that required of an ACU and staff are required to attend annual training similar to the ACU trainings. Both Level 1 and 2 TCs have required staffing ratios. Level 2 TCs must have the “ability for residents to be seen by appropriate caregivers when necessary 24 hours a day.

*Substance Use Disorder (SUD):* All SUD programs, including residential, are subject to staffing ratios. Clients have a right to an adequate number of qualified staff. A program cannot employ any person currently receiving SUD treatment services and former clients may not provide direct treatment services for 12 months after their discharge from treatment. Personnel must

meet all local, state, or federal legal requirements for their position. All non-certified or non-licensed staff must meet specific requirements. The program must establish an appropriate orientation and ongoing staff development plan for all employees and volunteers.

- Detoxification programs have the following additional requirements for staff: While a client is in observation detoxification, MDs, registered or licensed practical nurses, or Regional Detoxification Specialists (RDS), must be present and assigned to monitor the client on a 24 hour basis; Only an RDS, MD, registered or licensed nurse are authorized to document progress notes, vital signs, fluid/food intake, withdrawal risk assessments and stabilization plans. Specific certifications are required for an RDS. All staff assigned to monitor detoxification clients must know the signs and symptoms of withdrawal, the implication of those signs and symptoms; and emergency procedures, as defined in the facility policy and procedure manual.
- Specialized Women's Services programs must have at least one staff person who is certified in child and infant CPR.

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* All BHAs must establish and maintain procedures, competence, and capacity for assessment. All ACUs and TCs must assess each individual to determine appropriateness of admission. Initial assessments by an MHP must be completed on all clients voluntary or involuntary prior to admission and include screening for co-occurring disorders and trauma. There must also be an integrated MH and SUD psychosocial evaluation.

*Substance Use Disorder (SUD):*

- Residential SUD programs include care provided to a SUD client who is not ill enough to need admission to medical detoxification or observation detoxification, but who has need of more intensive care in a therapeutic setting with supportive living arrangements. All residential SUD programs must conduct a pre-admission screening to determine a client's eligibility and appropriateness. Components are specified. Additionally, an assessment to determine severity and environment placement to include a completed Addiction Severity Index for adults is to be completed within 72 hours of admission. When applicable, results of other tests or standardized assessments, including the ASAM patient placement criteria or other nationally recognized placement tool must also be included.
- Detoxification programs must perform a withdrawal risk assessment upon admission and file it in the client record within four hours. Only qualified staff members may perform the withdrawal risk assessment, which includes specific components.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Treatment planning in the form of progress notes updated daily are required, as well as discharge planning beginning at admission. An aftercare plan must be entered into each client's medical record upon discharge. Among other things, the aftercare plan must include recommendations for continued follow-up, including any co-occurring disorders or issues, and recommended interventions for each.

*Substance Use Disorder (SUD):* Treatment planning is required, and plans must be updated every seven days, unless clinically contraindicated. Discharge planning, beginning at admission, is required. An aftercare plan should be written one-week prior to target date of completion and must minimally contain: a summary of client needs not treated; established goal(s) that address the untreated needs; and the means by which the goals will be met.

- Detoxification programs also have treatment planning requirements, and the program must review and, if necessary, revise the detoxification plan (stabilization plan) every 24 hours or more often, should client need(s) change significantly.
- Specialized Women's Services programs, prior to discharge, are responsible for establishing an aftercare plan and will encourage the client to participate in support activities.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* ACUs and TCs must employ evidence-based practices.

- ACUs must provide, among other things: (1) medically-supervised SUD and MH screening, observation and evaluation; (2) initiation and medical supervision of rapid stabilization regimen as prescribed by a physician, including medically monitored detoxification where indicated; (3) medically-supervised and co-occurring disorder capable detoxification; (4) intensive care and intervention during acute periods of crisis stabilization; (5) motivational strategies to facilitate further treatment participation for MH and/or SUD needs; and (6) referral, linkage or placement, as indicated by client needs. Services must be co-occurring disorder capable and trauma informed.
- TCs must provide person centered, culturally competent, trauma informed and co-occurring capable services. Level 1 and Level 2 TCs each have separate requirements for number of hours of planned Counseling Level or Rehabilitative Level services per week, Physician Service encounters per month, and Professional Services per week.

*Substance Use Disorder (SUD):* All residential SUD programs must provide a minimum of 28 hours of structured treatment weekly (individual and group therapy); a minimum of 5 hours daily (Monday through Friday); and a minimum of 3 hours daily on Saturday and/or Sunday. In addition, residential service must include intake and case management and may include drug testing, medical care other than detoxification, and other appropriate services.

- Detoxification programs have additional requirements related to timing of taking vital signs.
- Specialized Women’s Services may be offered in a residential treatment program and address the specialized needs of the parent and include services for children. These services may be provided on the premises or through written service agreements with other providers. At a minimum, this includes case management, SUD treatment, childcare, transportation, medical treatment, housing, education/job skills training, parenting skills, aftercare, family education and support and house rules. Treatment must include intensive primary treatment and clients must participate in at least thirty (30) hours of therapeutic services per week, including substance abuse group counseling, education, parenting, family reunification, and child development services. Specific requirements also exist for, among others, job skills, parenting skills, services for children, and family education and support.

## **Patient Rights and Safety Standards**

*Mental Health (MH) and Substance Use Disorder (SUD):* All BHAs must employ a Grievance Officer who “develops and implements the applicant’s/provider’s employee and client grievance procedures [and who] effectively communicates grievance procedures to staff, contractors, prospective clients, and clients.”

In addition to BHA requirements, mechanical restraints may not be used with any client of an ACU or TC. There shall be written policies and procedures requiring documenting and reporting of critical incidents.

*Substance Use Disorder (SUD):* All SUD treatment programs must provide information of client rights at admission, including, among other things, the right: to the receipt of adequate and humane services, regardless of sources of financial support; to an adequate number of competent, qualified and experienced professional clinical staff; to be informed of treatment alternatives or alternative modalities; and to communicate with family and significant others outside the program. There must also be a written grievance policy which “states that there is a reasonable, specific deadline for completing the grievance process.” No specific requirements for reporting grievances to the state were located. No regulations regarding restraint or seclusion were located specific to SUD residential treatment.



## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* All BHAs must “establish, maintain, and document a quality improvement program, to include: (1) Evidence based practices; (2) Use of agency wide outcomes measures to improve both client care and clinical practice that are approved by the agency’s national accrediting organization.” Providers also must conduct quality assurance meetings at least quarterly that fulfill regulatory requirements.

In addition to the BHA requirements, TCs and ACUs must “have an ongoing performance improvement program designed to objectively and systematically monitor, evaluate and improve the quality of client care...There shall be an annual written plan for performance improvement activities.” The plan shall include, among other things, “Outcomes management processes specific to each program...A quarterly record...Clinical privileging...Fiscal management and planning...and a review of critical incident reports and client grievances or complaints.”

*Substance Use Disorder (SUD):* The governing body must develop and approve a program plan including a plan for implementation of objectives. The governing body must evaluate the plan annually, including assessment of progress toward attainment of goals, documentation of other achievements, and assessment of the effective utilization of staff and program resources, among other things.

## **Governance**

*Mental Health (MH) and Substance Use Disorder (SUD):* Both ACUs and TCs must have a governing body that oversees policies and procedures, staffing, and other matters.

*Substance Use Disorder (SUD):* The organization governing body or legal owner has certain responsibilities under state licensing regulations, including but not limited to preparation of an annual strategic plan, compliance with all applicable legal requirements, supervision of staff, accountability for policies and procedures, development of a program plan, and fiscal management.

## **Special Populations**

*Mental Health (MH) and Substance Use Disorder (SUD):*

- ACUs and TCs are required to have co-occurring disorder capability for any clients that may present with a dual diagnosis.

*Substance Use Disorder (SUD)*: Specialized Women’s Services may be offered in residential treatment.

## **Location of Regulatory and Licensing Requirements**

Department of Human Services<sup>1</sup>; Arkansas Department of Human Services, Division of Provider Services and Quality Assurance<sup>2</sup>; Therapeutic Communities Certification<sup>3</sup>; Acute Crisis Unit Certification<sup>4</sup>. Regulatory requirements reviewed June 14, 2019.

## **Other Information Sources**

P. Gann, D. Motley-Bledsoe, D. Luckett (DHS); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>1</sup> See <https://humanservices.arkansas.gov/images/uploads/dbhs/SA%20Licensure%20Standards%20-%20Revision.pdf>.

<sup>2</sup> See <http://170.94.37.152/REGS/016.23.17-002F-17114.pdf>.

<sup>3</sup> See [https://humanservices.arkansas.gov/images/uploads/dpsqa/DBHS\\_Therapeutic\\_Communities\\_Certification\\_-\\_FINAL.pdf](https://humanservices.arkansas.gov/images/uploads/dpsqa/DBHS_Therapeutic_Communities_Certification_-_FINAL.pdf).

<sup>4</sup> See [https://humanservices.arkansas.gov/images/uploads/dbhs/DBHS\\_Acute\\_Crisis\\_Unit\\_Certification\\_-\\_FINAL.docx](https://humanservices.arkansas.gov/images/uploads/dbhs/DBHS_Acute_Crisis_Unit_Certification_-_FINAL.docx).

# ARKANSAS MEDICAID

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## Approach

The Arkansas Department of Human Services (DHS) oversees the state Medicaid program. Arkansas does not have a relevant Section 1115 waiver that affects reimbursement of residential services in Institutions for Mental Diseases (IMDs). It historically has relied to some extent on the in lieu of provision and on Disproportionate Share Hospital (DSH) payments to reimburse certain services in IMDs.

## Types of Facilities

*Mental Health (MH) or Substance Use Disorder (SUD):* Arkansas Medicaid does not provide coverage for residential services in IMDs. Some limited residential treatment services, however, can be provided as outpatient behavioral health if providers are certified as a BHA. Services in ACUs are reimbursable.

*Substance Use Disorder (SUD):* Detoxification in SUD residential treatment facilities is reimbursable under the Medicaid fee for service program.

## Processes of Medicaid Enrollment

*Mental Health (MH) and Substance Use Disorder (SUD):* All behavioral health providers must meet specific qualifications for their services and staff to be approved to receive reimbursement for services to Medicaid beneficiaries. They must first be certified as a BHA and then as an ACU or TC.

*Substance Use Disorder (SUD):* For Medicaid reimbursement, SUD detoxification services must be provided in a facility that is certified as such by the DHS.

## Staffing

*Mental Health (MH) and Substance Use Disorder (SUD):* For ACUs, psychiatry and/or SUD services must be available on-site at all times as well as on-call psychiatry available 24 hours a

day. ACU providers may include: Independently Licensed Clinician--Master's/Doctoral; NonIndependently Licensed Clinicians--Master's/Doctoral; Advanced Practice Nurse; Physician; Registered Nurse; Qualified Behavioral Health Provider--Bachelors; and Qualified Behavioral Health Provider--Non-Degreed.

*Substance Use Disorder (SUD):* Detoxification providers may include the same categories as ACUs.

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* ACUs provide crisis treatment services to persons over the age of 18 who are experiencing a psychiatry and/or substance abuse-related crisis and may pose an escalated risk of harm to self or others.

*Substance Use Disorder (SUD):* Detoxification services in SUD residential treatment facilities are aimed at those who require stabilization and management of acute intoxication and withdrawal from alcohol or other drugs.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* The state Medicaid program does require a treatment plan.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* For ACUs, services include ongoing assessment and observation; crisis intervention; psychiatric, substance, and co-occurring treatment; and initiate referral mechanisms for independent assessment and care planning as needed.

*Substance Use Disorder (SUD):* SUD detoxification services may include evaluation, observation, medical monitoring, and addiction treatment.

## **Care Coordination**

*Mental Health (MH) and Substance Use Disorder (SUD):* For ACUs, services include initiation of referral mechanisms for independent assessment and care planning as needed.

## Quality Assurance or Improvement

*Mental Health (MH) and Substance Use Disorder (SUD):* Each BHA must establish and maintain a quality assurance committee that meets quarterly and examines the clinical records for completeness, adequacy and appropriateness of care, quality of care and efficient utilization of provider resources.

## Special Populations

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based special population requirements for residential treatment facilities for adults was located.

## Location of Medicaid Requirements

Arkansas Medical Assistance Services Administrative Rule # 016.06.04<sup>5</sup>; Outpatient BH Services<sup>6</sup>; State Plan<sup>7</sup>. Regulatory data collected December 2019.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

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<sup>5</sup> See [https://www.ark.org/rules\\_and\\_regs/index.php/rules/search](https://www.ark.org/rules_and_regs/index.php/rules/search).

<sup>6</sup> See [https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fmedicaid.mmis.arkansas.gov%2FDownload%2Fprovider%2Fprovdocs%2FManuals%2FQBHS%2FQBHS\\_II.doc](https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fmedicaid.mmis.arkansas.gov%2FDownload%2Fprovider%2Fprovdocs%2FManuals%2FQBHS%2FQBHS_II.doc).

<sup>7</sup> See <https://medicaid.mmis.arkansas.gov/Download/general/units/ORP/ARMedicaidSP.pdf>.

## CALIFORNIA

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### Types of Facilities

**Mental Health (MH):** California regulates Social Rehabilitation Programs (SRP), also known as Social Rehabilitation Facilities (SRF), which are limited to a capacity of 16 beds and fall into three categories:

- Short-term crisis residential treatment programs are of two types and, under no circumstances may the length of stay exceed three (3) months:
  - Short-Term-Crisis Residential Service (Less than 14 days), which means a licensed residential community care facility, and staffed to provide crisis treatment as an alternative to hospitalization. Admissions are generally limited to a stay of less than 14 days for voluntary patients without medical complications requiring nursing care. Twenty-four hour capability for prescribing and supervising medication must be available for patients requiring this level of care. The prescribing capability shall be provided by written agreement.
  - Short-Term Crisis Residential Service (Less than 30 days), have the same requirements as the shorter term facility but are staffed to provide MH treatment services, rather than crisis treatment, to individuals who generally require an average stay of 14-30 days for crisis resolution or stabilization. Respite care, up to a maximum of 30 days, may be provided within this definition.
- Transitional residential treatment programs provide a therapeutic environment in which clients are supported in their efforts to acquire and apply interpersonal and independent living skills. The program also assists the client in developing a personal community support system to substitute for the program's supportive environment and to minimize the risk of hospitalization and enhance the capability for independent living upon discharge from the program. The planned length of stay in the program is designed to be 3-12 months but should be in accordance with the client's assessed need, not to exceed one (1) year; however, a length of stay not exceeding a maximum total of 18 months is permitted to ensure successful completion of the treatment plan and appropriate referral. These programs fall into two categories:
  - Transitional Residential On-Site Service, which is designed to provide a comprehensive program of care consisting of a therapeutic residential community plus an all-inclusive structured treatment and rehabilitation program for individuals

- recovering from an acute stage of illness who are expected to move towards a more independent living situation, or higher level of functioning.
- Transitional Residential Off-Site Service, which are designed to provide a therapeutic residential community including a range of social rehabilitation activities for individuals who are in remission from an acute stage of illness, and interim support to facilitate movement towards the highest possible level of functioning. Individuals may receive day, outpatient, and other treatment services outside the transitional residence.
  - Long-term residential treatment programs provide services in a therapeutic residential setting with a full range of social rehabilitation services, including day programming for individuals who require intensive support in order to avoid long-term hospitalization or institutionalization. The planned length of stay is in accordance with the client's assessed needs but under no circumstances may that length of stay be extended beyond eighteen (18) months. Consistent with individual level of care needs, services must be provided in skilled nursing facilities, intermediate care facilities, residential community care facilities, or other similar facilities.

*Substance Use Disorder (SUD):* California regulates:

- Residential Alcoholism or Drug Abuse Recovery or Treatment Facilities, which are any facility, building, or group of buildings which is maintained and operated to provide 24-hour, residential, nonmedical, SUD recovery or treatment services.
- Detoxification, Recovery or Treatment Services for Individuals with a SUD, which consist of evaluation, withdrawal management, recovery or treatment services, referrals for further care, or social and rehabilitation services for individuals abusing alcohol or illicit substances.
- Incidental Medical Services (IMS), which means optional services provided at a residential facility by a health care practitioner, or staff under the supervision of a health care practitioner, to address medical issues associated with detoxification, treatment, or recovery services. IMS does not include general primary medical care or medical services required to be performed in a licensed health facility. Upon DHCS approval, the following IMS must be provided: (1) Obtaining medical histories; (2) Monitoring health status; (3) Testing associated with detoxification from alcohol or drugs; (4) Providing SUD recovery or treatment services; (5) Overseeing patient self-administered medications; (6) Treating SUD, including detoxification.

*Unregulated Facilities:* It is possible that there are non-SRFs/SRPs providing adult MH residential treatment in California that would be unregulated.

## Approach

The California Department of Health Care Services (DHCS), Community Services Division, oversees the MH components of and certifies SRP/SRFs but the facilities are licensed by the Department of Social Services (DSS). The DHCS, Behavioral Health Licensing and Certification Division, regulates and licenses residential SUD treatment. Additionally, a law was recently passed that will require all California adult SUD residential treatment facilities to receive an ASAM designation.

## Processes of Licensure or Certification and Accreditation

*Mental Health (MH)*: Licensure by the DSS and certification by the DHCS are required for operation of all SRFs/SRPs. DHCS certification is required prior to DSS licensure.

- Accreditation is not required.
- An onsite certification review will be conducted by the DHCS within 60 days following the mailing date of the letter approving the application for certification. Onsite certification review by DHCS is conducted annually. Within 90 days of the facility accepting its first client, DSS also will inspect the facility to review compliance with application materials and regulations.
- No Certificate of Need requirements were identified.
- DHCS certification duration is one year from the date of issuance.

*Substance Use Disorder (SUD)*: Licensure by the DHCS is required for all residential SUD treatment, except for facilities operated by a state agency. The DHCS also will certify a program upon request if it meets certain accreditation requirements. One purpose of certification is to identify programs that exceed minimal levels of service quality, are in substantial compliance with DHCS standards, and merit the confidence of the public, third-party payers, and county alcohol and drug programs.

- Accreditation is not required for licensure but is for voluntary certification. For certification, accreditation must be granted by a statewide or national SUD program accrediting body recognized by the DHCS, where accreditation meets or exceeds DHCS standards.
- An inspection is required for licensure and at least once during every two-year licensure period.
- No Certificate of Need requirements were identified.



- All initial SUD facility licenses are provisional for the first year, after which licensure duration is two years. Certification is for no more than two years.

## **Cause-Based Monitoring**

*Mental Health (MH):* Cause-based monitoring may be conducted by the DHCS and/or by the DSS:

- If the DHCS identifies deficiencies, a letter of deficiencies will be sent with a due date for the SRF/SRP to submit a written plan of correction. DHCS reviewers also may conduct reviews to ensure deficiencies have been corrected. DHCS may decertify an SRF/SRP at any time for good cause including, but not limited to: Failure to implement or maintain the approved program plan/plan of operation; Substantial noncompliance with applicable statutory and regulations requirements; Revocation of the SRF/SRP's license by the DSS.
- If, during the DSS licensing process, the evaluator determines that a deficiency exists, the evaluator will issue a notice of deficiency and, jointly with the facility, develop a plan for correcting each deficiency. A license also may be revoked or suspended for cause and civil penalties may be levied. The premises may be inspected at any time, with or without notice. Unannounced visits occur "as often as necessary to ensure the quality of care provided."

*Substance Use Disorder (SUD):* An authorized employee or agent of DHCS may enter and inspect any SUD treatment facility at any reasonable time, with or without advance notice. A licensing report is issued when there are no deficiencies; a notice of deficiency is issued when there are deficiencies. DHCS also has authority to investigate complaints. DHCS may suspend or revoke the license of a SUD treatment facility for violations of regulations or statute. DHCS also has the authority to act against a facility that provides licensable residential services without a valid license from DHCS.

## **Access Requirements**

*Mental Health (MH) and Substance Use Disorder (SUD):* Wait-time requirements were not found.

*Mental Health (MH):* Short-term crisis residential facilities must be open for admission 24 hours a day.

## **Staffing**

*Mental Health (MH):* All SRPs/SRFs must have an administrator and a program director. Qualifications and responsibilities are included in the regulations, with qualifications for the program director varying by facility type. Facility personnel must be competent to provide the services necessary to meet individual client needs and, at all times, be employed in numbers necessary to meet such needs. There are specific staffing requirements, including staffing levels and ratios, based on facility type. Requirements also are in place for direct care staff qualifications and training. All personnel must receive a minimum of 20 hours of relevant training per year.

*Substance Use Disorder (SUD):* All SU facilities must have a facility administrator who meets certain criteria. Facility personnel, including volunteers, must be competent to provide the services necessary to meet resident needs and be adequate in numbers necessary to meet such needs. Competence must be demonstrated by work, personal, and/or educational experience and/or on-the-job performance. All personnel must receive job training on a variety of topics. Additionally, SUD treatment facilities approved for DHCS voluntary certification must have a program director with no less than two years of work in the field of SUD treatment and recovery. Excluding licensed professionals, all individuals providing counseling services within a SUD treatment facility must be registered or certified by a DHCS approved counselor certifying organization.

## **Placement**

*Mental Health (MH):* SRPs/SRFs must use an admission agreement and a written assessment that encompasses specific topics. For residential programs, no client may be admitted prior to a determination of the facility's ability to meet the needs of the client, which must include an appraisal of his/her individual service needs. This requires an interview with the prospective client and a medical assessment.

*Substance Use Disorder (SUD):* In addition to abiding by ASAM standards for placement in levels of care, programs must ensure that every resident completes a health questionnaire which identifies any health problems or conditions which require medical attention, or which are of such a serious nature as to preclude the person from participating in the program.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH):* All SRPs/SRFs must develop individual treatment. Timing of plan review is dependent on the facility type:

- Short-term Crisis Residential Treatment Programs, at least weekly.

- Transitional Residential Treatment Programs, at least once every 30 days.
- Long Term Residential Treatment Programs, at least once every 60 days.

Discharge planning, beginning at admission, also is required.

*Substance Use Disorder (SUD):* All programs must develop individual treatment plans for all clients, which should be goal and action oriented with objective and measurable criteria. The plans should be developed no later than 10 days after admission to the program and updated no later than every 90 days. SUD treatment facilities approved for DHCS voluntary certification also must complete a discharge or continuing recovery plan for residents that includes individual strategies for sustaining long-term recovery and referrals to appropriate resources.

## **Treatment Services**

*Mental Health (MH):* Services in all SRPs/SRFs must include, but not be limited to: (1) Individual and group counseling; (2) Crisis intervention; (3) Planned activities; (4) Counseling, with available members of the client's family, when indicated in the client's treatment/rehabilitation plan; (5) The development of community support systems for clients to maximize their utilization of non-mental health community resources; (6) Pre-vocational or vocational counseling; (7) Client advocacy, including assisting clients to develop their own advocacy skills; (8) An activity program that encourages socialization within the program and general community, and which links the client to resources which are available after leaving the program; and, (9) Use of the residential environment to assist clients in the acquisition, testing, and/or refinement of community living and interpersonal skills. In addition, both transitional and long-term residential treatment programs must provide vocational services.

*Substance Use Disorder (SUD):* SUD treatment services should promote treatment and maintain recovery from SUD and include one or more of the following: detoxification, group sessions, individual sessions, educational sessions, and/or alcoholism or drug abuse recovery or treatment planning. According to state staff, residential programs also must provide access to MAT or refer residents in need of medications for MAT to qualified prescribers.

## **Patient Rights and Safety Standards**

*Mental Health (MH):* The rights of residents of MH residential treatment facilities include but are not limited to the right to be treated with dignity, safety, freedom from abuse, and to be informed of mechanisms for filing of complaints. Critical incidents must be reported. Restraint and seclusion are regulated.

*Substance Use Disorder (SUD):* The rights of residents of SUD residential treatment facilities include but are not limited to the right to be treated with dignity, confidentiality, safety, freedom from abuse, and to be informed of mechanisms for filing of complaints. Critical incidents must be reported to DHCS. Regulations governing restraint or seclusion were not found.

## **Quality Assurance or Improvement**

*Mental Health (MH):* Quality assurance or improvement requirements applicable to adult MH residential treatment were not found.

*Substance Use Disorder (SUD):* Quality assurance or improvement requirements applicable to adult SUD residential treatment were not found but the certification policy does require policies and procedures for continuous quality improvement.

## **Governance**

*Mental Health (MH):* A governing board and policies and procedures are required.

*Substance Use Disorder (SUD):* Governance requirements applicable to adult SUD residential treatment were not found but policies and procedures are required.

## **Special Populations**

*Mental Health (MH):* Special population requirements applicable to adult MH residential treatment were not found.

*Substance Use Disorder (SUD):* The state has specific requirements regarding residential treatment services for women and children. These are provided through the Women and Children's Residential Treatment Services (WCRTS) program, which was established by the state legislature. The program is designed to, among other things: (A) Demonstrate that SUD treatment services delivered in a residential setting and coupled with primary health, mental health, and social services for women and children, can improve overall treatment outcomes for women, children, and the family unit as a whole. (B) Demonstrate the effectiveness of six-month or 12-month stays in a comprehensive residential treatment program. (C) Develop models of effective comprehensive service delivery for women and their children that can be replicated in similar communities. (D) Provide services to promote safe and healthy pregnancies and perinatal outcomes. Data reporting was to be a component of this.

## Location of Regulatory and Licensing Requirements

Standards for Certification of Social Rehabilitation Programs<sup>1</sup>, Residential Licensure Regulations<sup>2</sup>; Licensure of Residential Alcoholism or Drug Abuse Recovery or Treatment Facilities<sup>3</sup>, Women and Children’s Residential Treatment Services<sup>4</sup>, DHCS Alcohol and/or Other Drug Program Certification Standards<sup>5</sup>. Regulatory data collected May 17, 2019.

## Other Information Sources

M. Perez, H. Omoregie, P. Abimbola (DHCS); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>1</sup> See [https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I9A50D8D0D45211DEB97CF67CD0B99467&originationContext=documenttoc&transitionType=Default&contextData=\(sc.Default\)](https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I9A50D8D0D45211DEB97CF67CD0B99467&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)).

<sup>2</sup> See <https://www.cdss.ca.gov/inforesources/Letters-Regulations/Legislation-and-Regulations/Community-Care-Licensing-Regulations/Residential>.

<sup>3</sup> See [https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I36CEFDD0D45411DEB97CF67CD0B99467&originationContext=documenttoc&transitionType=Default&contextData=\(sc.Default\)](https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I36CEFDD0D45411DEB97CF67CD0B99467&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)).

<sup>4</sup> See [https://leginfo.legislature.ca.gov/faces/codes\\_displayText.xhtml?lawCode=HSC&division=10.5.&title=&part=1.&chapter=2.1.&article=](https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=HSC&division=10.5.&title=&part=1.&chapter=2.1.&article=).

<sup>5</sup> See [https://www.dhcs.ca.gov/Documents/DHCS\\_AOD\\_Certification\\_Standards\\_1.pdf](https://www.dhcs.ca.gov/Documents/DHCS_AOD_Certification_Standards_1.pdf).

# CALIFORNIA MEDICAID

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

## Approach

The California Department of Health Care Services (DHCS) oversees the state Medicaid program. Medi-Cal Specialty Mental Health Services are provided through a mental health plan (MHP) which contracts with the state Medicaid agency to provide such services. The California state Medicaid plan permits Medicaid expenditures for perinatal substance use disorder (SUD) treatment in facilities that do not meet the definition of an Institution for Mental Disease (IMD). The state also has a Section 1115 waiver that allows reimbursement of perinatal and other SUD treatment in IMDs for otherwise eligible individuals in counties participating in the Drug Medi-Cal Organized Delivery System (DMC-ODS) pilot. These facilities include, but are not limited to, residential facilities for residential treatment and withdrawal management services.” The state has not historically relied on the in lieu of provision or on Disproportionate Share Hospital (DSH) payments for Medicaid coverage of certain IMD services.

## Types of Facilities

*Mental Health (MH):* Unless the enrollee is between the ages of 21-64 years and the services are provided in an IMD, Medicaid reimbursement is available for the following residential Specialty Mental Health Services:

- “Adult Residential Treatment Services,” which are rehabilitative services, provided in a non-institutional, residential setting, for beneficiaries who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program. The service includes a range of activities and services that support beneficiaries in their efforts to restore, maintain and apply interpersonal and independent living skills and to access community support systems.
- “Crisis Residential Treatment Service” provides therapeutic or rehabilitative services in a structured residential program as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis who do not have medical complications requiring nursing care. The service includes a range of activities and services that support beneficiaries in their efforts to restore, maintain, and apply interpersonal and independent living skills, and to access community support systems.

*Substance Use Disorder (SUD):* Adult residential non-IMD SUD services are reimbursable by the state Medicaid program.

- Perinatal residential SUD services for pregnant and postpartum women also are covered as rehabilitation services in non-IMDs under the state plan and in IMDs pursuant to the state Section 1115 waiver in pilot counties. Each beneficiary lives on the premises and is supported in her efforts to restore, maintain, and apply interpersonal and independent living skills and access community support systems.
- Pursuant to the state Section 1115 waiver, the pilot “Drug Medi-Cal Organized Delivery System (DMC-ODS)” will cover expenditures for services not otherwise covered that are furnished to otherwise eligible individuals who are DMC-ODS beneficiaries, including services for individuals who are short-term residents in facilities that meet the definition of an IMD. These facilities include, but are not limited to, DHCS licensed residential facilities for residential treatment, and withdrawal management services. Pursuant to the waiver, any beneficiary receiving residential services pursuant to DMC-ODS, regardless of the length of stay, is a “short-term resident” of the residential facility in which they are receiving the services. Residential services under the waiver can be provided in facilities of any size and are provided regardless of perinatal status. The pilot includes services in the following residential IMDs, defined using the ASAM criteria, as follows:
  - Level 3.1 Clinically Managed Low-Intensity Residential Services
  - Level 3.3 Clinically Managed Population-Specific High-Intensity Residential Services
  - Level 3.5 Clinically Managed High-Intensity Residential Services
  - Level 3.2-WM Clinically Managed Residential Withdrawal Management
  - Levels 3.7 and 3.7-WM are only available in inpatient settings under the waiver. These levels also are available in residential settings funded by other means than the waiver.

## **Processes of Medicaid Enrollment**

*Mental Health (MH) and Substance Use Disorder (SUD):* An applicant to be a Medicaid-enrolled provider in California must meet certain criteria, including being certified by DHCS to participate and licensure as otherwise required by state law.

*Mental Health (MH):* MHPs must implement provider selection criteria that comply with regulatory requirements, the terms of the contract between the MHP and the Department, and other requirements that include possession of necessary licensure or certification for the scope of practice.

- Adult Residential Treatment Services must be certified as a Social Rehabilitation Program by the DHCS as either a Transitional Residential Treatment Program or a Long Term

Residential Treatment Program. In addition to Social Rehabilitation Program certification, programs which provide Adult Residential Treatment Services must be licensed as a Social Rehabilitation Facility or Community Care Facility by the DSS or authorized to operate as a Mental Health Rehabilitation Center by the DHCS.

- Crisis Residential Treatment Services shall be certified as a Social Rehabilitation Program (Short-term Crisis Residential Treatment Program) by the DHCS. In addition to Social Rehabilitation Program certification, programs providing Crisis Residential Treatment Services must be licensed as a Social Rehabilitation Facility or Community Care Facility by the State DSS or authorized to operate as a Mental Health Rehabilitation Center by the DHCS.

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, to enroll in California Medicaid as a provider, all residential providers must be DHCS licensed residential facilities that also are designated to have met the ASAM requirements. The waiver includes additional information regarding how this process will occur.

## **Staffing**

*Mental Health (MH):* MHPs must implement provider selection criteria that comply with regulatory requirements, the terms of the MHP contract with the DHCS, and other requirements that include possession of necessary licensure or certification for the scope of practice, staffing ratios, and staffing qualifications.

*Substance Use Disorder (SUD):* State Medicaid regulations establish required qualifications for Licensed Substance Use Disorder Treatment Professionals, a Managing Employee, a Substance Use Disorder Medical Director (which all SUD clinics must have), Substance Use Disorder Nonphysician Medical Practitioners, and Substance Use Disorder Treatment Professionals.

According to the state Section 1115 waiver, additional requirements apply to DMC-ODS staff, including credentials and supervision for professional staff, and training and supervision requirements for non-professional staff. Staff must be trained in the ASAM Criteria prior to providing services.

## **Placement**

*Mental Health (MH):* Access to MHP services, such as Medi-Cal Specialty Mental Health Services, may be by beneficiary self-referral or through referral by another person or organization.



*Substance Use Disorder (SUD):* The DMC-ODS waiver requires the use of ASAM standards in program development and structure. To receive services through the DMC-ODS pilot, the beneficiary must be enrolled in Medi-Cal, reside in a participating county and meet specific medical necessity criteria. The initial medical necessity determination for the DMC-ODS benefit must be performed through a face-to-face review or telehealth by a qualified professional. After establishing a diagnosis, the ASAM Criteria will be applied to determine placement into the level of assessed services. Medical necessity qualification for ongoing receipt of DMC-ODS is determined at least every six months through the reauthorization process for individuals determined by the appropriate staff to be clinically appropriate. Under the waiver, counties must provide prior authorization for residential services within 24 hours of the prior authorization request being submitted by the provider.

For ASAM Level 3 services under the waiver, the length of residential services ranges from 1 to 90 days with a 90-day maximum for adults, unless medical necessity authorizes a one-time extension of up to 30 days on an annual basis. Only two non-continuous 90-day regimens will be authorized in a one-year period. The average length of stay for residential services is 30 days. Peri-natal clients may receive a longer length of stay based on medical necessity. Perinatal clients may receive lengths of stay up to the length of the pregnancy and postpartum period (60 days after the pregnancy ends).

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH):* Medicaid-specific requirements for treatment and discharge planning or aftercare services or follow-up were not found for adult residential MH treatment.

*Substance Use Disorder (SUD):* Intake is a component service for state 1115 waiver services and includes the admission of a beneficiary into a SUD treatment program. Intake includes evaluation or analysis of SUDs; the diagnosis of SUDs; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing necessary for SUD treatment. Treatment and discharge planning are also component services.

## **Treatment Services**

*Mental Health (MH):* Services for both adult residential and crisis services include but are not limited to assessment, plan development, therapy, rehabilitation and collateral. Crisis intervention are also a component of residential crisis services.

*Substance Use Disorder (SUD):* In accordance with the state 1115 waiver, pilot counties must describe in their implementation plan how they will guarantee access to medication assisted

treatment (MAT) services. Counties currently with inadequate access to MAT services must describe in their implementation plan how they will provide it.

The waiver requires the following for ASAM residential services: intake; individual and group counseling; patient education; family therapy; safeguarding medications; collateral services; crisis intervention services; treatment planning; transportation services for medically necessary treatment; and discharge services. The components of withdrawal management services are: intake; observation; medication services; and discharge services. Under the waiver, participating counties must also include the following provider requirements in their contracts with providers: (a) culturally competent services; (b) MAT; and (c) evidenced based practices [at least two of the following: (i) Motivational Interviewing; (ii) Cognitive-Behavioral Therapy; (iii) Relapse Prevention; (iv) Trauma-Informed Treatment; (v) Psycho-Education].

## **Care Coordination**

*Mental Health (MH):* MHPs must provide coordination of physical and mental health care.

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, Level 3.1, 3.3, and 3.5 providers must coordinate with levels 3.7 and 4.0 (funded separately from the waiver under FFS and managed care). The waiver also includes other extensive requirements for care coordination by the administering county. Among other things, counties' implementation plans and state/county contracts (managed care contracts per federal definition) will describe their care coordination plan for achieving seamless transitions of care. Counties are responsible for developing a structured approach to care coordination to ensure that beneficiaries successfully transition between levels of SUD care without disruptions to services. In addition to specifying how beneficiaries will transition across levels of acute and short-term SUD care without gaps in treatment, the county will describe in the implementation plan and state/county intergovernmental agreement how beneficiaries will access recovery supports and services immediately after discharge or upon completion of an acute care stay, with the goal of sustained engagement and long-term retention in SUD and behavioral health treatment. The county implementation plan and state/county intergovernmental agreement will indicate whether their care transitions approach will be achieved exclusively through case management services or through other methods. The county implementation plan and state/county intergovernmental agreement will indicate which beneficiaries receiving SUD services will receive care coordination. Specific elements are part of a required MOU that must be implemented at the point of care to ensure clinical integration between DMC-ODS and managed care providers.

## Quality Assurance or Improvement

*Mental Health (MH)*: MHPs must establish a Quality Management Program that includes, among other things, a Quality Improvement Program and a Utilization Management Program. Requirements specific to the facilities were not found.

*Substance Use Disorder (SUD)*: Pursuant to the Section 1115 waiver, providers must meet quality assurance standards and any additional standards established by the county or other evaluation process. The state will maintain a plan for oversight and monitoring of DMC-ODS providers and counties to ensure compliance and corrective action with standards, access, and delivery of quality care and services. Counties will be required to monitor providers at least once per year, and the state will monitor counties at least once per year through External Quality Review Organizations. If significant deficiencies or significant evidence of noncompliance with required standards are found in a county, the DHCS will engage the county to determine if there challenges that can be addressed. If the county remains noncompliant, the county must submit a corrective action plan to DHCS. Additionally, the state has taken action to ensure the integrity of oversight processes and will continue to closely monitor for any wrongdoing that impacts the DMC-ODS. The state also will conduct a monitoring review for residential facilities to provide an ASAM designation prior to facilities providing pilot services. This review will ensure that the facility meets the requirements to operate at the designated ASAM level. Among the state's other foci for quality are timely access and program integrity.

## Special Populations

*Mental Health (MH)*: No Medicaid-specific requirements were found regarding special populations served in adult residential MH treatment facilities.

*Substance Use Disorder (SUD)*: Perinatal residential SUD programs are offered under the state Medicaid program and under the waiver. In addition, the waiver expects implementing counties to coordinate MH services for beneficiaries with co-occurring disorders.

## Location of Medicaid Requirements

California Code of Regulations, Title 22, Division 3<sup>6</sup>; California Code of Regulations, Title 9, Division 1<sup>7</sup>; California Section 1115 waiver<sup>8</sup>. Regulatory data collected December 16, 2019.

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<sup>6</sup> See

[https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I43C0E6C0D4B811DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=\(sc.Default\)](https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I43C0E6C0D4B811DE8879F88E8B0DAAAE&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)).

<sup>7</sup> See

[https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I94869BB0D45211DEB97CF67CD0B99467&originationContext=documenttoc&transitionType=Default&contextData=\(sc.Default\)](https://govt.westlaw.com/calregs/Browse/Home/California/CaliforniaCodeofRegulations?guid=I94869BB0D45211DEB97CF67CD0B99467&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)).

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report “**State Residential Treatment for Behavioral Health Conditions: Regulation and Policy**”. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

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<sup>8</sup> See <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ca/ca-medi-cal-2020-ca.pdf>.

## COLORADO

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

### Types of Facilities

*Mental Health (MH) and Substance Use Disorder (SUD):* Colorado regulates Acute Treatment Units (ATUs). An ATU is a designated facility or a distinct part of a facility for short-term psychiatric care. An ATU provides a 24 hour, therapeutically planned and professionally staffed environment for individuals who do not require inpatient hospitalization but need more intense and individualized services, such as crisis management and stabilization services, than are available on an outpatient basis. The following are ATU types which may provide either MH or SUD treatment:

- A Crisis Stabilization Unit (CSU) may be located in an ATU (or elsewhere in a nonresidential setting) and is a “facility, utilizing a restrictive egress alert device, which serves individuals requiring 24-hour intensive behavioral health crisis intervention for up to five days and cannot be accommodated in a less restrictive environment.”

*Mental Health (MH):* An ATU also may apply for specific designation to provide any or all of the following for MH treatment:

- Seventy-two hour treatment and evaluation: Facilities that are designated as seventy-two (72) hour treatment and evaluation facilities may detain on an involuntary basis persons placed on a seventy-two (72) hour hold for the purpose of evaluation and treatment, excluding Saturdays, Sundays, and holidays, if evaluation and treatment services are not available on those days.
- Short-term treatment: Facilities that are designated as short-term treatment facilities may involuntarily detain individuals for short-term (a period of not more than three months) or extended short-term care and treatment (a period of not more than an additional three months).
- Long-term treatment: Facilities that are designated as long-term treatment facilities may involuntarily detain individuals for long-term care and treatment (a period not to exceed six months) or extended long-term treatment (a period of not more than additional six months).

*Substance Use Disorder (SUD):* Colorado regulates adult SUD residential treatment programs in alignment with the ASAM Levels of Care, as follows:

- ASAM Level 3.1 (Clinically Managed Low-Intensity Residential Services)
- ASAM Level 3.2-WM (Clinically Managed Residential Withdrawal Management)
- ASAM Level 3.3 (Clinically Managed Population-Specific High-Intensity Residential Services)
- ASAM Level 3.5 (Clinically Managed High-Intensity Residential Services)
- ASAM Level 3.7 (Medically Monitored Intensive Inpatient Services) may be offered in residential settings
- ASAM Level 3.7-WM (Medically Monitored Inpatient Withdrawal Management) may be provided in residential settings

*Unregulated Facilities:* State staff indicate that, because a license is only required for SUD facilities if they receive public funds, serve individuals in the criminal justice system, or dispense, compound, or administer controlled substances, there may be SUD residential treatment programs in the state that are not licensed or known to the state government. In 2019, the legislature passed a law<sup>1</sup> that will require all SUD treatment providers to be licensed by 2024. Similarly, designation is only required for MH facilities receiving public funds.

## **Approach**

The Colorado Department of Human Services, Office of Behavioral Health (OBH) regulates and provides designation for all adult residential MH treatment facilities that receive public funds or initiate an involuntary hold on a person with mental illness (a “27-65 designation”). The OBH also regulates and licenses all adult residential SUD treatment facilities that receive public funds, serve individuals in the criminal justice system, or dispense, compound, or administer controlled substances. In addition, the Colorado Department of Public Health and Environment (DPHE) oversees and licenses ATUs and CSUs. The focus of DPHE oversight is safety, whereas OBH oversees clinical and treatment components of ATUs.

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<sup>1</sup> See <https://leg.colorado.gov/bills/hb19-1237>.

## **Processes of Licensure or Certification and Accreditation**

*Mental Health (MH) and Substance Use Disorder (SUD):* Designation by the OBH is required for all residential ATUs that receive public funds or initiate an involuntary hold on a person with mental illness. The DPHE also licenses MH ATUs on the basis of program approval by the OBH.

- Accreditation is not required.
- An on-site evaluation is required for designation.
- The state does not require a Certificate of Need.
- OBH designation duration is two years, with shorter periods for provisional designation.

*Substance Use Disorder (SUD):* Licensure by the OBH is required for all residential treatment facilities providing SUD services, that receive public funds, serve individuals in the criminal justice system, or dispense, compound, or administer controlled substances.

- Accreditation is not required.
- An inspection is required for initial licensure and renewal.
- The state does not require a Certificate of Need.
- Licensure duration is two years.
- See also above regarding ATUs.

## **Cause-Based Monitoring**

*Mental Health (MH) and Substance Use Disorder (SUD):* Both licensed and designated organizations are required to submit requested data in an accurate and timely manner to the OBH. Additionally, at OBH discretion, a license or designation may be revoked, denied, suspended, modified or have limited licenses or designation. The OBH may conduct scheduled or unscheduled site reviews for specific monitoring purposes and investigation of critical incidents reports.

- For ATUs, the DPHE also may cite deficiencies, investigate, and require submission and completion of a plan of correction.

## Access Requirements

*Mental Health (MH) and Substance Use Disorder (SUD):* Regulations relating to wait times for non-priority populations were not located. Other requirements regarding access include the following for CSUs, which must be able to serve:

1. Children, adolescents, adults and older adults.
2. Individuals with co-occurring conditions, including:
  - a. Mental health conditions
  - b. Substance use disorders
  - c. Medical needs
  - d. Intellectual/developmental disabilities
  - e. Physical disabilities
  - f. Traumatic brain injuries
  - g. Dementia
3. Individuals demonstrating aggressive behavior
4. Individuals who are uninsured or unable to pay for services
5. Individuals who may lack Colorado residency or legal immigration status.

*Substance Use Disorder (SUD):* Pregnant or parenting women have priority admission to substance use treatment facilities within 48 hours.

## Staffing

*Mental Health (MH) and Substance Use Disorder (SUD):* The OBH requires that all MH and SUD facilities adhere to general personnel provisions, including having written personnel policies and procedures that ensure personnel are assigned duties commensurate with documented education, training, work experience, and professional licenses and certifications. Personnel must receive the following training when first hired and on a periodic basis: (1) Training specific to the particular needs of the populations served; (2) Orientation of the physical plant; (3) Emergency preparedness; (4) Individual rights of the population served; (5) Confidentiality (individual privacy and records privacy and security); and (6) Training on needs identified through the quality improvement program.

The OBH requires ATUs to provide specific staff training before providing care. Within one month of hire, additional training must be provided on assessment skills, infection control, behavior management and de-escalation techniques (including for incidents involving suicide), health emergency response, and behavioral/psychiatric emergency response. All staff must



receive training or facility certification of competency annually. Staff who administer involuntary medications or who administer restraint/seclusion techniques require additional annual training. ATUs must employ sufficient staff to meet individual needs, with ratios and other requirements. Regulations describe requirements for the education, experience, and responsibilities of the director and clinical director. The existence of a physician medical director is assumed in the regulations.

As part of DPHE licensure requirements, ATUs also must satisfy staffing standards related to communicable diseases and training regarding emergency preparedness at orientation and on-going.

- A CSU has additional requirements related to access to a physician or other professional authorized to order medications; at least one on-site staff member qualified to administer medications; skilled professionals who are licensed or receiving supervision from a licensed mental health professional, and peer support. The CSU must employ sufficient staff to ensure that the provision of services meets the needs of individuals. At minimum, a facility must have two staff on-site at all times.

#### *Mental Health (MH):*

- Facilities designated for seventy-two (72) hour treatment and evaluation, short-term, or long-term treatment, must have a person who is licensed in Colorado to practice medicine or a certified Colorado psychologist, either employed or under contract, who is responsible for the evaluation and treatment of each individual. The facility must ensure the availability of emergency medical care, including having and adhering to a written plan for providing emergency medical care that meets specific requirements.
- Every person receiving treatment for a mental health disorder by a designated short-term or long-term facility must, upon admission be placed under the care of a person who is licensed in Colorado to practice medicine or a certified Colorado psychologist and employed by or under contract with the designated facility. The facility must ensure the availability of emergency medical, including having and adhering to a written plan for providing emergency medical care that meets specific requirements.

*Substance Use Disorder (SUD):* Staff qualifications, including education, professional credentials, training and supervision, and work experience must be in accordance with Addiction Counselor Certification and Licensure Standards. Specific requirements are in place for treatment staff, including staff providing psychotherapy and addiction counseling. Medical staff and treatment staff licensed as behavioral healthcare practitioners in the state must meet additional requirements. Staff must receive orientation and annual training in methods of preventing and controlling infectious diseases. There are additional training requirements for staff that collect samples for drug and alcohol testing. Ratios are established for all levels of SU treatment.

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* The OBH requires MH and SUD facilities to complete a comprehensive best practices assessment as soon as reasonable upon admission and no later than seven (7) business days of admission into services with the exceptions noted below.

ATUs must develop admission criteria based on the ability to meet patient needs. The criteria should be linked to a comprehensive pre-admission assessment, completed within 24 hours of admission, that includes the mental and physical health, substance use, and capacity for self-care of the prospective patient. This assessment shall be used to determine the level of intervention and supervision required for patient needs.

*Mental Health (MH):* Seventy-two hour treatment and evaluation facilities and short and long-term facilities must complete evaluation as soon as possible after admission and a physical evaluation within 24 hours.

*Substance Use Disorder (SUD):* SUD treatment facilities are required to use ASAM patient placement criteria. Withdrawal management units must conduct a comprehensive assessment within 72 hours of admission; all others must complete the assessment within 7 days.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* The OBH requires MH and SUD programs to develop an individualized service plan, with an initial plan developed within 24 hours of admission. The comprehensive service plan must be completed as soon as possible after admission but no later than: (1) ATUs 24 hours after admission; and (2) withdrawal management, 72 hours after admission, and other residential treatment, 10 days after assessment. The plan should be updated on an ongoing basis to address significant changes and confirm the facility is meeting patient needs no later than: (1) ATUs and withdrawal management, 3 days after the change occurs; and (2) other residential treatment monthly for 6 months and quarterly thereafter. Discharge planning begins during the development of the initial safety and stabilization plan.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* The OBH requires ATUs to provide a continuum of intervention and supervision services, including medication management, behavioral health services, and stabilization.

- CSUs must provide services in a culturally competent manner. CSUs must employ an integrated care model based on evidence-based practices that consider an individual's physical and emotional health. They must include screening, assessment, and referrals to appropriate resources as further specified in the regulations. Services provided on a crisis stabilization unit must include: (a) Full psychiatric evaluation: (1) By a physician or other professional authorized by statute to order medications; and, (2) Within 24 hours of admission. (b) Medical and medication treatment. (c) Service planning. (d) Peer support, when clinically appropriate. (e) Treatment, to include: (1) Individual counseling; and/or, (2) Groups. (f) Coordination with medical services. (g) Case management. (h) Service coordination and referral. (i) Discharge planning.

*Substance Use Disorder (SUD):* In addition to the treatment services described in the level descriptions in 1.a., all levels of care must give special consideration to the individuals' identified medical and psychiatric needs in planning treatment. Different levels of care offer a range of treatment approaches and support services based on individual readiness to change and focus on identified substance use disorder education and treatment needs. Treatment approaches and support services may include: (1) Group and individual therapy and education; (2) Relapse prevention; (3) Building support systems; (4) Developing coping skills; (5) Education on substance use disorders; (6) Vocational counseling; (7) Life skills training; (8) Self-help groups; and (9) Milieu therapy. Other than level 3.2, all levels of care include requirements for clinical service hours. Specific requirements for levels 3.1, 3.2-WM, 3.3, 3.5, 3.7, and 3.7-WM follow the ASAM requirements per level.

## **Patient Rights and Safety Standards**

*Mental Health (MH) and Substance Use Disorder (SUD):* Residents have rights that include, among others, to be informed of their rights, to be treated in the least restrictive setting, communication, confidentiality, and to file a grievance. Data on submitted grievances must be reported annually to the OBH. Critical incidents must be reported to the OBH within 24 hours.

Designated facilities where individuals are detained are authorized to use physical management, restraint or seclusion at the facility over the person's objection. Otherwise, there must be a signed consent for such an intervention. Regulations restrict how and when restraint and seclusion may be used.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* All facilities designated or licensed by the OBH must have a quality improvement program that monitors, evaluates, and initiates quality improvement activities. A written plan is required with five specific elements: clinical quality measures of performance; clinical review of a representative sample of open and closed

records at a minimum of every 6 months; identification of and response to critical incident trends and patient grievances; documentation of quality improvement findings incorporated into clinical and organizational planning; and an annual evaluation that results in an update to the quality improvement plan as necessary. A copy of the annual findings and report must be available for review.

## **Governance**

*Mental Health (MH) and Substance Use Disorder (SUD):* The OBH has governance standards in place for licensed and/or designated entities in Colorado that include but are not limited to providing and maintaining policies and procedures and compliance with applicable federal and state regulations.

- Additional DPHE licensure regulations for ATUs address governance in the context of facility safety.

## **Special Populations**

*Mental Health (MH) and Substance Use Disorder (SUD):* See Access above regarding requirements for special populations and others.

## **Location of Regulatory and Licensing Requirements**

2 CCR 502-1<sup>2</sup>; 6 CCR 1011-1<sup>3</sup>; DHS Behavioral Health Designation and Licensing website<sup>4</sup>; DPHE ATU website<sup>5</sup>. Regulatory requirements reviewed May 2, 2019.

## **Other Information Sources**

T. Miller (OBH); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>2</sup> See

<https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=7825&fileName=2%20&%20GENERAL:%20https://www.colorado.gov/cdhs>.

<sup>3</sup> See <https://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=5331>.

<sup>4</sup> See <https://www.colorado.gov/pacific/cdhs/behavioral-health-designation-and-licensing>.

<sup>5</sup> See <https://www.colorado.gov/pacific/cdphe/acute-treatment-units>.

# COLORADO MEDICAID

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

## Approach

The Colorado Department of Health Care Policy and Financing (HCPF) oversees the state Medicaid program. Colorado does not have a relevant Section 1115 waiver that affects reimbursement of residential services in Institutions for Mental Diseases (IMDs) although it does have a pending application. It historically has relied to some extent on the in lieu of provision but not on Disproportionate Share Hospital (DSH) payments to reimburse certain services in IMDs.

## Types of Facilities

*Mental Health (MH):* Residential Services may enroll as Medicaid providers. These offer 24 hour care, excluding room and board, provided in a non-hospital, non-nursing home setting, appropriate for adults whose MH issues and symptoms are severe enough to require a 24-hour structured program but do not require hospitalization. Services are provided in the setting where the client is living, in real-time, with immediate interventions available as needed.

*Substance Use Disorder (SUD):* No explicit evidence of Medicaid coverage of adult residential SUD treatment was located, although Detoxification Services generally are covered. These are defined as services relating to detoxification including all of the following, although it is not clear they may be offered in a residential setting: Physical assessment of detoxification progression including vital signs monitoring; level of motivation assessment for treatment evaluation; provision of daily living needs (includes hydration, nutrition, cleanliness and toiletry); safety assessment, including suicidal ideation and other behavioral health issues.

## Processes of Medicaid Enrollment

*Mental Health (MH) and Substance Use Disorder (SUD):* To enroll as a Colorado Medicaid provider, the facility must, among other things, be licensed or certified as may be required by state law to provide services. All enrolling and re-validating providers must be screened in accordance with requirements appropriate to their categorical risk level.

## **Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD):* Requirements specific to staffing for adult residential treatment services were not explicitly described in the state Medicaid regulations.

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* Residential Services are appropriate for adults whose mental health issues and symptoms are severe enough to require a 24-hour structured program but do not require hospitalization.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Requirements specific to treatment or discharge planning or aftercare services for adult residential treatment services were not explicitly described in the state Medicaid regulations.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Clinical interventions include assessment and monitoring of mental and physical health status; assessment and monitoring of safety; assessment of/support for motivation for treatment; assessment of ability to provide for daily living needs; observation and assessment of group interactions; individual, group and family therapy; medication management; and behavioral interventions.

## **Care Coordination**

*Mental Health (MH) and Substance Use Disorder (SUD):* Requirements specific to care coordination for adult residential treatment services were not explicitly described in the state Medicaid regulations.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* Providers and Managed Care Entities must comply with annual EQR activities. EQR may include but is not limited to the following activities: (1) Performance improvement projects. (2) Performance improvement project validation. (3) Performance improvement measurement. (4) Performance improvement

measurement validation. (5) Consumer satisfaction survey. (6) Medical record review. (7) Review of individual cases. (8) PCPP credentialing and recredentialing.

## Special Populations

*Mental Health (MH) and Substance Use Disorder (SUD)*: Requirements specific to special populations for adult residential treatment services were not explicitly described in the state Medicaid regulations.

## Location of Medicaid Requirements

Colorado Department of Healthcare Policy and Financing Medical Assistance Program Rules and Regulations, <https://www.colorado.gov/pacific/hcpf/department-program-rules-and-regulations>. Regulatory data collected January 1, 2020.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report “**State Residential Treatment for Behavioral Health Conditions: Regulation and Policy**”. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

## CONNECTICUT

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### Types of Facilities

**Mental Health (MH):** Connecticut regulates residential MH treatment identified as a Private Intermediate Treatment Facility (PITF), which is “a facility which provides evaluative, diagnostic, and treatment services in a residential setting for individuals who are experiencing mental, emotional or behavioral problems, disturbances, dysfunctions or disorders as defined in the Diagnostic and Statistical Manual of the American Psychiatric Association, ..., which do not require a hospital level of treatment.”

**Substance Use Disorder (SUD):** Connecticut maintains two systems of regulation of residential SUD treatment, which can overlap:

- A Private Freestanding Residential Facility for the Care or Treatment of Substance Abusive or Dependent Persons may offer the following levels of care:
  - *Care and Rehabilitation* is a structured and supervised group living experience that includes work therapy.
  - *Intensive Treatment* includes supervision and services which are designed to arrest, reverse, or ameliorate the disorder or problem and motivate the person toward recognizing dependence, needs, and to obtain help and make changes.
  - *Intermediate and Long-Term Treatment* is a structured and supervised group living experience, the aim of which is to arrest, reverse, or ameliorate the problem or disorder and providing ongoing evaluation and activities supportive of integration into educational, vocational, familial or social structures independent of the service.
  - *Residential Detoxification and Evaluation* is a residential service to which a person may be admitted for the management of detoxification from a substance or substances of abuse, for an assessment of needs ,and motivation toward continuing participation in an ongoing treatment process or for a combination of both detoxification and assessment.
  
- Behavioral Health Recovery Program (BHRP) facilities:
  - *Intensive Residential Treatment* is “a medically necessary, residential behavioral health service delivered in a private freestanding psychiatric hospital, general hospital, state-operated facility or other facility that meets and maintains all applicable licensing and certification requirements of federal and state statutes or



- regulations. ...Intensive residential treatment is delivered within a fifteen (15) to thirty (30) day period ....”
- *Intermediate or Long-Term Treatment or Care* is “a medically necessary, residential behavioral health service delivered in a facility that meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations pertaining to intermediate or long-term treatment or care and rehabilitation. Each individual shall receive substance use disorder services to address significant problems with his or her behavior and functioning in major life areas due to a substance use disorder and to reintegrate such individual into the community.” Levels include:
    - *Intermediate or Long-Term*
    - *Long-Term Care and Rehabilitation*
    - *Intermediate or Long-Term Transitional or Halfway-House Services*
  - *Medically Managed Residential Detoxification* is a medically necessary, inpatient behavioral health service delivered in a state-operated facility or in a facility that meets and maintains all applicable licensing and certification requirements of federal and state statutes or regulations pertaining to residential detoxification and evaluation that involves treatment of a substance use disorder. Medically managed residential detoxification shall be used when 24-hour medical and nursing supervision are required.

*Unregulated Facilities:* State staff indicate that all residential MH and SUD facilities in Connecticut are regulated. We exclude from this summary private freestanding MH residential living centers and private freestanding community residences because they do not require delivery of in-house clinical services within the scope of this summary. Rehabilitative services may be provided to some individuals within these settings and that is addressed in the section related to Medicaid and residential facilities at the end of this summary.

## **Approach**

*Mental Health (MH) and Substance Use Disorder (SUD):* The Connecticut Department of Public Health (DPH) regulates nonstate operated or maintained residential MH treatment and private residential SUD treatment facilities.

*Substance Use Disorder (SUD):* The Connecticut Department of Mental Health and Addiction Services (DMHAS) relies on policy documents to regulate all private residential SUD treatment facilities that contract with the state or accept Medicaid beneficiaries and all state operated residential SUD treatment facilities. These are the BHRP facilities.

## **Processes of Licensure or Certification and Accreditation**

*Mental Health (MH) and Substance Use Disorder (SUD):* PITFs and Private Freestanding Residential Facilities for the Care or Treatment of Substance Abusive or Dependent Persons require licensure by the DPH for operation.

- Accreditation is not required.
- A facility is initially licensed for one year.
- According to state staff, site visits are required.
- A Certificate of Need is required.

*Substance Use Disorder (SUD):* Facilities that wish to be part of the BHRP must apply for credentialing from the DMHAS. Credentialing requires, among other things, licensure by the DPH if the facility is private. After credentialing, the DMHAS may elect to contract with the provider.

- BHRP residential facilities must be Joint Commission or CARF-accredited, although Intensive Residential Treatment and Intermediate or Long-Term Care Treatment may, alternatively, have a clinical supervisor with authority over all behavioral health services. The clinical supervisor must meet specific criteria.
- BHRP credentialing is for a 2 year period.
- According to state staff, site visits are required.

## **Cause-Based Monitoring**

*Mental Health (MH):* A PITF license may be suspended, revoked, denied or its renewal refused.

*Substance Use Disorder (SUD):*

- A Private Freestanding Residential Facility for the Care or Treatment of Substance Abusive or Dependent Persons may have its license suspended, revoked, denied or its renewal refused. Refusal to grant the DPH access to the facility or to the facility's record is grounds for denial or revocation of the facility's license.
- For BHRP facilities that offer Medically Managed Residential Detoxification, the DMHAS or its designated agent may conduct audits of a contracted provider's records and may require a corrective action plan to address adverse audit findings, if any.

## Access Requirements

*Mental Health (MH):* Wait-time requirements were not found for adult residential MH facilities.

*Substance Use Disorder (SUD):* Wait-time requirements were not found but, pursuant to state staff, DMHAS contracts with an Administrative Services Organization that manages authorizations.

## Staffing

*Mental Health (MH):* Each PITF must have an Executive Director who is accountable to the governing body and who meets educational and experiential requirements. Each facility shall designate a psychiatrist who meets specific credentialing requirements to be responsible for diagnostic and treatment services. Each facility must have a sufficient number of staff, qualified by virtue of education and training, to meet the needs of the clients and the programs or services the facility delivers. Each facility must establish a plan to provide initial orientation and ongoing training for staff which clearly describes the type of training necessary to maintain current skills and provide for growth in skill and which relates to the objectives of the services offered.

- Intermediate Treatment Facilities must have a qualified person designated responsible for a program of recreation or creative arts activities and must have a licensed nurse on duty and awake at all times. During sleeping hours, the facility must have at least one direct care staff person on duty and awake for each thirty clients or fraction thereof, and during non-sleeping hours must at no time have less than one direct care staff person on duty for each ten clients or fraction thereof. At no time can there be less than two direct care staff on duty in any intermediate treatment facility.

*Substance Use Disorder (SUD):*

- Each Private Freestanding Residential Facility for the Care or Treatment of Substance Abusive or Dependent Persons must have an executive director who is accountable to the governing authority. Each facility must have individuals, who meet qualifications as described in the facility's job descriptions and who comply with all mandated state and federal laws, to meet the needs of the clients and the programs or services the facility delivers. Providers of auricular acupuncture must satisfy specific requirements related to training and supervision. Each facility which provides residential services shall have at least, one direct care staff person in each building, when a client is known to be present and who shall have immediate access to back up staff, for urgent or emergency situations.

Employees shall receive orientation to all policies and procedures necessary for them to perform duties specified in their job descriptions and provide for the safety of the clients. Changes in these policies and procedures shall be communicated in a manner prescribed by the executive director. Each facility shall establish and implement a staff development plan.

- Residential Detoxification and Evaluation facilities must have a physician licensed in the State of Connecticut who is designated to direct the medical services of the facility. Such a physician shall have experience or training in providing services for substance dependent persons. A licensed physician must be on-call during those hours when a physician is not physically present. A licensed registered nurse must be designated to direct the nursing services of the facility. Such a registered nurse must have experience or training in providing services for substance dependent persons. There must be on each shift at least one registered nurse who is currently licensed in the State of Connecticut. In each separate Residential Detoxification and Evaluation unit, there must be at all times a licensed nurse and other direct care staff on duty to meet the needs of the clients. There must be a physician, currently licensed in the State of Connecticut and who is eligible to be certified by the American Board of Psychiatry and Neurology; or, a clinical psychologist, currently licensed in the State of Connecticut, to provide psychological evaluation and treatment when necessary. There shall be a pharmacist, currently licensed in the State of Connecticut, who is responsible for the supervision of the pharmaceutical services.
- Particular to Intensive Treatment Facilities, there must be a licensed physician who is eligible to be certified by the American Board of Psychiatry and Neurology to provide psychiatric diagnosis or treatment when necessary, or, a licensed psychologist to provide psychological evaluation and treatment when necessary.
- BHRP facilities:
  - For Intensive Residential Treatment, any behavioral health services performed by a staff member who is not a licensed behavioral health professional, or a Connecticut certified alcohol and drug counselor shall meet specified conditions. To satisfy credentialing, the facility must include the following staff, licensed by the state of Connecticut or certified as appropriate in their respective disciplines and employed by or under contract with the facility: (i) A clinical supervisor with authority over all behavioral health services, with specified education, experience, and credentials; and (ii) A sufficient number of staff to meet the needs of individuals.
  - For Intermediate or Long-Term Treatment or Care, any behavioral health services performed by a staff member who is not a licensed behavioral health professional, or a Connecticut certified alcohol and drug counselor shall meet specified conditions.
  - For Medically Managed Residential Detoxification, services include medical supervision and management as indicated by a licensed physician and inclusive of laboratory assessments. To satisfy credentialing, the facility shall include the following staff, licensed by the state of Connecticut or certified as appropriate in their respective disciplines and who are employed by or under contract with the

facility: (i) A medical director; (ii) A social worker or counselor experienced in the treatment of substance use disorders; (iii) A physician on site 24 hours per day, seven (7) days per week; (iv) A registered nurse on site 24 hours per day, seven (7) days per week; and (v) A pharmacist.

## Placement

*Mental Health (MH):* PITFs must have admission policies and criteria and each client record shall contain a comprehensive written assessment written within 15 days of admission and include identification of individual needs of the client as well as the approaches to meet each identified need (i.e., psychiatric, psychological, recreational, creative arts, dietary, nursing and social work as applicable).

*Substance Use Disorder (SUD):*

- Private Freestanding Residential Facilities for the Care or Treatment of Substance Abusive or Dependent Persons must have admission policies and criteria and each client record shall have documentation, at the time of admission, of an initial assessment which identifies the client's appropriateness for participation in the facility.
  - For Residential Detoxification and Evaluation Facilities, preliminary assessments include a medical history and physical examination within 24 hours of admission, diagnostic tests as determined by the physician within 72 hours of admission, and an initial drug-screening urinalysis upon admission if the substance of abuse is other than alcohol.
  - For Intensive Treatment, Intermediate and Long Term Treatment and Rehabilitation and Care and Rehabilitation Facilities, each client must have a documented physical examination not more than one month prior to or an appointment scheduled not later than five days after admission.
- BHRP facilities: Facility credentialing requirements for intake include:
  - Intensive Residential Treatment: initial intake evaluation, including screening for a co-occurring psychiatric disability; a complete biopsychosocial assessment; development of a recovery plan for each individual; orientation and referral to a self-help program; and discharge planning that helps ensure the continuation of appropriate treatment.
  - Intermediate or Long-Term Treatment or Care: initial intake evaluation, including screening for a co-occurring psychiatric disability; and a biopsychosocial assessment.
  - Medically Managed Residential Detoxification: initial intake evaluation, including screening for a co-occurring psychiatric disability; a physical examination including a medical history upon admission, inclusive of laboratory testing; a diagnostic evaluation and risk assessment; and a biopsychosocial assessment.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH):* PITF: A comprehensive individualized care plan is required within 30 days of admission and must be reviewed at least every 60 days. No requirements were found for discharge or aftercare planning although the facilities must have discharge policies.

*Substance Use Disorder (SUD):*

- For a Private Freestanding Residential Facility for the Care or Treatment of Substance Abusive or Dependent Persons, an individualized program plan based on the client's needs must be initiated at the time of admission and, for facilities providing care and rehabilitation or intermediate and long term treatment and rehabilitation, it must be reviewed no later than 30 days after admission. Discharge planning is required.
  - Intermediate and Long Term Treatment and Rehabilitation facilities review the individualized program plan at least every 60 days thereafter.
  - Care and Rehabilitation facilities review the plan every 90 days thereafter for the first year and at least every 180 calendar days thereafter.
  - Each Residential Detoxification and Evaluation facility shall modify the individual program plan as needed until the client is discharged.
  - Each Intensive Treatment facility shall review the individualized program plan on a weekly basis.
- BHRP facilities: All contracted providers must develop a recovery plan which meets specific requirements and is regularly reviewed. All contracted providers must develop a discharge plan that helps ensure the continuation of appropriate treatment and, if the person is admitted to Medically Managed Residential Detoxification, Intensive Residential Treatment, Intermediate or Long-Term Treatment or Care, participate in a discharge plan review. As part of credentialing, the following also is required:
  - Intermediate or Long-Term Treatment or Care discharge planning must include orientation and referral to a self-help program.
  - Medically Managed Residential Detoxification discharge planning must include the offering of referrals to self-help programs.

## **Treatment Services**

*Mental Health (MH):* Specific treatment requirements were not located for PITFs other than the description provided above under Types of Facilities.

*Substance Use Disorder (SUD):*

- Specific treatment requirements were not located for a Private Freestanding Residential Facility for the Care or Treatment of Substance Abusive or Dependent Persons, other than a statement that auricular acupuncture may be used.
- For BHRP facilities, additional treatment services are required as part of facility credentialing:
  - For Intensive Residential Treatment, the organization operating intensive residential treatment must deliver emergency psychiatric and emergency medical services or maintain written agreements enabling immediate access for individuals, when needed, to facilities that offer such care. Intensive Residential Treatment must deliver to each individual a minimum of thirty (30) hours per week of substance use disorder services; orientation and referral to a self-help program; adequate testing for or analysis of drugs of abuse as specified in applicable federal and state statutes and regulations; and vocational and pre-vocational planning.
  - Intermediate or Long-Term Treatment or Care facilities must deliver emergency psychiatric and emergency medical services or maintain written agreements enabling immediate access for individuals, when needed, to facilities that offer such care; orientation and referral to a self-help program; adequate testing for or analysis of drugs of abuse as specified in applicable federal and state statutes and regulations; vocational and pre-vocational planning; and one of the following must be delivered to each individual: (I) A minimum of twenty (20) hours per week of SUD services by facilities licensed for and delivering Intermediate and Long-Term Treatment; or (II) A minimum of twenty (20) hours per week of SUD services by facilities licensed for care and rehabilitation and identified as providing long-term care; or (III) A minimum of four (4) hours per week of SUD services by facilities licensed for intermediate and long-term treatment and identified as providing transitional or halfway house services. If the facility is licensed for Intermediate or Long-Term Residential Treatment and delivers transitional or halfway-house services, a minimum of four (4) hours per week of SUD services must be delivered to each individual.
  - Medically Managed Residential Detoxification must include emergency psychiatric and emergency medical services or maintain written agreements enabling immediate access for individuals, when needed, to facilities that offer such care; medical supervision and management of withdrawal from a substance, as indicated by a licensed physician and inclusive of laboratory assessments; and individual, group and, when indicated, family therapy. These facilities must deliver 24-hour substance use evaluation and withdrawal management.

## **Patient Rights and Safety Standards**

*Mental Health (MH):* PITFs are subject to requirements regarding responding to critical incidents.

*Substance Use Disorder (SUD):*

- Any Private Freestanding Residential Facility for the Care or Treatment of Substance Abusive or Dependent Persons is subject to requirements regarding responding to critical incidents. In addition, each client must be informed of his or her rights relating to the services provided in the language of his or her understanding.
  - For Residential Detoxification and Evaluation Facilities, physical restraints may be utilized only when there is imminent danger to the client or others and when other alternatives have not been successful or are not applicable. Specific conditions for the restraint must be met.
- BHRP facilities: The regulations include requirements for reporting critical incidents.

## **Quality Assurance or Improvement**

*Mental Health (MH):* Each PITF must have established goals and objectives appropriate to the population served and program model. Each facility must establish a program evaluation process, which will determine the degree to which these goals and objectives are being met. Documentation of corrective action is based on this evaluative process.

*Substance Use Disorder (SUD):*

- Each Private Freestanding Residential Facility for the Care or Treatment of Substance Abusive or Dependent Persons must have established goals and objectives related to the client population served. Each facility must establish an annual program evaluation, which will determine the degree to which these goals and objectives are being met. Action taken by the facility, based on this evaluation process, is documented. Providers must develop and implement a structured and ongoing process to assess, monitor, and improve the quality and effectiveness of services provided to individuals and their families. Additionally, the facility must establish a quality assurance program to address the use of computerized systems for the maintenance of client records and the administration of medication. The quality assurance program must include, but not necessarily be limited to, monitoring compliance with all policies and procedures for the use of such systems. Each facility that elects to use auricular acupuncture must maintain a program for quality assurance that includes, but is not limited to, infection prevention, surveillance and monitoring of adverse reactions and monitoring compliance with policies and procedures for auricular acupuncture.



- BHRP facilities:
  - For Medically Monitored Residential Detoxification, the contracted provider must submit to the DMHAS or its designated agent timely and accurate information in a format to be specified. This information includes, but is not limited to, the following: (1) Demographic data regarding the eligible recipients served; (2) Descriptions of covered behavioral health services delivered; (3) Descriptions of the contracted provider's staff sufficient for the DMHAS to assess the agency's cultural competency; (4) Treatment outcomes; (5) Results of risk assessment screenings; and (6) A critical incident review summary, including recommendations, in the format and manner specified by the department.

## Governance

*Mental Health (MH):* PITFs must have a governing body responsible for the management and operation of the facility. Among other responsibilities, the governing body must adopt and implement policies as specified in the regulations.

*Substance Use Disorder (SUD):*

- A Private Freestanding Residential Facility for the Care or Treatment of Substance Abusive or Dependent Persons must have a governing body responsible for the management and operation of the facility. Among other responsibilities, the governing body must adopt and implement policies as specified in the regulations.
- BHRP facilities: No requirements for governance was identified.

## Special Populations

*Mental Health (MH) and Substance Use Disorder (SUD):* No requirements regarding special populations in adult residential behavioral health treatment were located.

## Location of Regulatory and Licensing Requirements

Department of Public Health regulations<sup>1</sup>; Institution Licensing statute<sup>2</sup>; Behavioral Health Recovery Program Policies<sup>3</sup>. Regulatory data collected September 28, 2019.

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<sup>1</sup> See [https://eregulations.ct.gov/eRegsPortal/Browse/RCSA/Title\\_19aSubtitle\\_19a-495/](https://eregulations.ct.gov/eRegsPortal/Browse/RCSA/Title_19aSubtitle_19a-495/).

<sup>2</sup> See [https://www.lawserver.com/law/state/connecticut/ct-laws/connecticut\\_statutes\\_19a-490](https://www.lawserver.com/law/state/connecticut/ct-laws/connecticut_statutes_19a-490).

<sup>3</sup> See <https://portal.ct.gov/-/media/DMHAS/MSD/BHRPpoliciespdf.pdf?la=en>.

## Other Information Sources

L. Siembab, Y. Addo, C. Harrington (DMHAS); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

# CONNECTICUT MEDICAID

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

## Approach

The Connecticut Department of Social Services (DSS) oversees the state Medicaid program with many behavioral health services provided via the Connecticut Behavioral Health Partnership (CBHP). Connecticut does not have a relevant Section 1115 demonstration. It has historically relied to some extent on Disproportionate Share Hospital (DSH) payments but not the in lieu of provision to reimburse services in IMDs.

## Types of Facilities

*Mental Health (MH):* The Connecticut Medicaid program does reimburse for rehabilitation services provided to some residents in Private Non-Medical Institutions (PNMIs). These are provided pursuant to a state plan amendment and state Medicaid regulations, the latter of which incorporate the following definition of *Group Home* as “a privately operated, community-based residential facility that serves sixteen or fewer adult clients.” Among other things, to receive reimbursement, the group home must have provided one qualifying billable unit of service for that month. In addition, the Connecticut Behavioral Health Partnership (CBHP) fee schedule includes codes<sup>4</sup> for “Private Non-Medical Institutional Services,” as a special service. Room and board are not included.

*Substance Use Disorder (SUD):* Facilities credentialed by DMHAS as BHRP facilities may accept Medicaid enrollees. The CBHP fee schedule includes codes for ambulatory detoxification<sup>5</sup> and the CBHP provider manual<sup>6</sup> identifies residential detoxification, free standing detoxification, and substance abuse residential rehabilitation as covered services.

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<sup>4</sup> See

[https://www.ctdssmap.com/CTPortal/Information/Get%20Download%20File/tabid/44/Default.aspx?Filename=refw242\\_feesched\\_sserv\\_30.csv&URI=fee\\_schedules/refw242\\_feesched\\_sserv\\_30.csv](https://www.ctdssmap.com/CTPortal/Information/Get%20Download%20File/tabid/44/Default.aspx?Filename=refw242_feesched_sserv_30.csv&URI=fee_schedules/refw242_feesched_sserv_30.csv).

<sup>5</sup> See

[https://www.ctdssmap.com/CTPortal/Information/Get%20Download%20File/tabid/44/Default.aspx?Filename=refw242\\_feesched\\_fsatc\\_14.csv&URI=fee\\_schedules/refw242\\_feesched\\_fsatc\\_14.csv](https://www.ctdssmap.com/CTPortal/Information/Get%20Download%20File/tabid/44/Default.aspx?Filename=refw242_feesched_fsatc_14.csv&URI=fee_schedules/refw242_feesched_fsatc_14.csv).

<sup>6</sup> See [http://www.ctbhp.com/providers/manuals/Provider\\_Handbook-Complete\\_Edition.pdf](http://www.ctbhp.com/providers/manuals/Provider_Handbook-Complete_Edition.pdf).

## **Processes of Medicaid Enrollment**

*Mental Health (MH) and Substance Use Disorder (SUD):* To be enrolled as a Medicaid provider in Connecticut, the provider must, among other things, apply and sign a provider agreement. An enrollment may be terminated. A Medicaid provider must meet and maintain all applicable licensing, accreditation, and certification requirements.

*Mental Health (MH):* To provide PNMI rehabilitative services eligible for Medicaid reimbursement, the provider must, among other things, enroll with the Department, have a valid provider agreement, follow all laws and policies that apply for reimbursement, be licensed by the DPH as either a private freestanding mental health residential living center or a private freestanding community residence, be certified by the DMHAS as a provider of mental health rehabilitation services, and meet the requirements for participation in the Medicaid program as a provider of PNMI rehabilitative services. Providers are subject to audit. According to state staff, DMHAS Regional Managers perform site visits to ensure compliance with the state plan amendment and licensure requirements.

## **Staffing**

*Mental Health (MH):* To provide reimbursable PNMI rehabilitative services, the provider must provide an initial orientation, training and periodic supervision to direct service staff related to the provision of rehabilitative services and ensure that all group home staff are certified in first aid and cardiopulmonary resuscitation. Minimum education and experiential requirements are established for the facility director and direct service staff.

*Substance Use Disorder (SUD):* No evidence of Medicaid-based staffing requirements for residential treatment facilities for adults was located other than the requirements for BHRPs.

## **Placement**

*Mental Health (MH):* To receive reimbursable PNMI rehabilitative services, the Medicaid enrollee must: (1) have a mental illness so serious and disabling as to require care in a group home setting; (2) be sufficiently stable to be able to function outside of a twenty-four hour medically managed setting and participate in community-based treatment services; and (3) have functional disabilities secondary to serious and persistent mental illness and such disabilities are so great as to require that the client reside in a non-medical residential setting with rehabilitative services and supports. Prior authorization is required and may be given for up to six months with an extension possible upon request for another six months.

*Substance Use Disorder (SUD):* The CBHP provider manual requires use of the ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders: Third Edition (ASAM PPC-3). Requirements for BHRPs also apply.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* The CT BHP provider manual includes a general expectation that all providers to develop a treatment and recovery plan with the member and the member's family as appropriate. The content of the treatment plan may vary depending on the complexity of the member's needs, the array of services being provided, and the duration of the episode of care. Nevertheless, Care Managers and Intensive Care Managers talk with providers about the member's treatment and discharge plan as part of every review process. Discharge planning is expected to begin at admission.

*Mental Health (MH):* To provide reimbursable PNMI rehabilitative services, the provider must develop an individual residential rehabilitation plan for each client not later than 30 days after admission to the program. The plan must contain specific behavioral health goals and objectives that are based on mental health diagnosis and diagnostic and functional evaluation and are targeted toward the maximum reduction of a client's behavioral health symptoms, restoration of functioning, and recovery, and shall identify the type, amount, frequency and duration of services to be provided. To receive payment, among other things: (1) For up to 30 days of a PNMI client's initial stay in a PNMI program, the PNMI rehabilitative services shall be provided in accordance with an initial assessment of need that is completed and signed by a licensed clinician. This assessment shall, for up to thirty days of a PNMI client's initial stay, be utilized as the individual residential rehabilitation plan. (2) After the first 30 days of a client's stay in a PNMI program, the PNMI rehabilitative services shall be provided in accordance with a written individual residential rehabilitation plan. This plan shall be reviewed and signed by the licensed clinical staff employed by, or under contract with, the performing provider at least every 90 days thereafter.

*Substance Use Disorder (SUD):* Requirements for BHRPs apply.

## **Treatment Services**

*Mental Health (MH):* PNMI rehabilitative services are designed to assist individuals with a serious and persistent mental illness to achieve their highest degree of independent functioning and recovery. These services include the following, depending upon the needs of each client and the individual rehabilitation plan: (1) Intake and assessment; (2) Development of an individual residential rehabilitation plan; (3) Socialization skills development; (4) Behavior management training and intervention; (5) Supportive counseling directed at solving daily problems related to community living and interpersonal relationships; (6) Psycho-educational

groups pertaining to the alleviation and management of psychiatric disorders; (7) Teaching, coaching and assisting with daily living and self-care skills; (8) Assistance in developing skills necessary to support a full and independent life in the community; (9) Support with connecting individuals to natural community supports; (10) Orientation to, and assistance with, accessing self help and advocacy resources; (11) Development of self-advocacy skills; (12) Health education; (13) Teaching of recovery skills in order to prevent relapse; (14) Other rehabilitative support necessary to develop or maintain social relationships, to provide for independent participation in social, interpersonal or community activities and to achieve full community reintegration; and (15) Individual, family, and group counseling.

*Substance Use Disorder (SUD):* Requirements for BHRPs apply.

## **Care Coordination**

*Mental Health (MH) and Substance Use Disorder (SUD):* A primary responsibility of all providers is to proactively identify potential medical needs of CBHP members to whom they are providing behavioral health care services and work with CBHP Care Managers and the member's health care providers to assure that both physical and behavioral health care needs are met.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* The CBHP provider manual includes information on the general BHP quality program and identifies opportunities for network providers to participate in the quality program and provider responsibilities that include but are not limited to maintaining an internal quality management program to ensure that opportunities for improvement are identified and appropriate actions are implemented. The CBHP agent also conducts provider site visits for quality review.

*Substance Use Disorder (SUD):* Requirements for BHRPs apply.

## **Special Populations**

*Mental Health (MH) and Substance Use Disorder (SUD):* No Medicaid requirements regarding special populations in adult residential behavioral health treatment were located.

## **Location of Medicaid Requirements**

CT Provider Enrollment Manual<sup>7</sup>; CBHP Provider Manual<sup>8</sup>; Department of Social Services Regulations for Payment of Mental Health Rehabilitation Services in a PNMI<sup>9</sup>; State Plan Amendments #3 and 4<sup>10</sup>. Regulatory data collected January 2020.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report **“State Residential Treatment for Behavioral Health Conditions: Regulation and Policy”**. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

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<sup>7</sup> See

[https://www.ctdssmap.com/CTPortal/Information/Get%20Download%20File/tabid/44/Default.aspx?Filename=ch2\\_requirements\\_for\\_provider\\_participation.pdf&URI=Manuals/ch2\\_requirements\\_for\\_provider\\_participation.pdf](https://www.ctdssmap.com/CTPortal/Information/Get%20Download%20File/tabid/44/Default.aspx?Filename=ch2_requirements_for_provider_participation.pdf&URI=Manuals/ch2_requirements_for_provider_participation.pdf).

<sup>8</sup> See [http://www.ctbhp.com/providers/manuals/Provider\\_Handbook-Complete\\_Edition.pdf](http://www.ctbhp.com/providers/manuals/Provider_Handbook-Complete_Edition.pdf).

<sup>9</sup> See [https://eregulations.ct.gov/eRegsPortal/Browse/RCSA?id=Title\\_17bSubtitle\\_17b-262Section\\_17b-262-758&content=%20Private%20Non-Medical%20Institutions/](https://eregulations.ct.gov/eRegsPortal/Browse/RCSA?id=Title_17bSubtitle_17b-262Section_17b-262-758&content=%20Private%20Non-Medical%20Institutions/).

<sup>10</sup> See <https://portal.ct.gov/DMHAS/Divisions/Community-Services-Division/PLC-Mental-Health-Group-Homes#amendment>.

## DELAWARE

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### Types of Facilities

*Mental Health (MH):* Delaware regulates:

- *Group Homes for Persons with Mental Illness (Group Homes)*, which are defined as any group home residences that provide mental health treatment, rehabilitation and housing, staffed substantially full-time when residents are present for between three (3) and ten (10) adults with primary diagnosis of psychiatric disabilities.
- An *Intensive Behavioral Support and Educational Residence (IBSER)* is defined as a residential facility which provides services to residents with autism, and/or developmental disabilities, and/or severe mental or emotional disturbances and who also have specialized behavioral needs. They may house no more than 10 residents.

*Substance Use Disorder (SUD):* Delaware regulates:

- All SUD treatment programs or co-occurring treatment programs (these are not defined):
  - Residential Detoxification
  - Residential Treatment
  - Transitional Residential Treatment
- Categories of residential facilities that are publicly funded programs providing services to Delaware residents lacking insurance or receiving reimbursement under the state Medicaid FFS program:
  - Clinically Managed Low-Intensity Residential Treatment ASAM Level 3.1
  - Clinically Managed Residential Withdrawal Management ASAM Level 3.2
  - Clinically Managed Population-Specific High Intensity Residential Treatment ASAM Level 3.3
  - Clinically Managed High Intensity Residential Treatment ASAM Level 3.5
  - Medically Monitored Intensive Inpatient Treatment ASAM Level 3.7 (offered in residential settings in Delaware)
  - Medically Monitored Intensive Inpatient Withdrawal Management ASAM Level 3.7-WM (offered in residential settings in Delaware)



*Unregulated Facilities:* There are no unregulated residential SUD treatment facilities in Delaware. According to state staff, however, at the time these regulations were reviewed, DSAMH did not have the ability to regulate all community mental health providers as it did SUD facilities. This authority was granted with the enactment of 82 Del. Law c. 50 in June of 2019.<sup>1</sup> With this authority, DSAMH will be able to draft regulations for these types of facilities. It also was noted that, although these facilities and program were potentially unregulated in code, DSAMH ensured the quality and standards of these programs through contracts.

## **Approach**

The Delaware Department of Health and Social Services (DHSS) regulates and licenses residential treatment providers in the state. Its Department of Health Care Quality licenses Group Homes; its Division of Long Term Care Residents Protection licenses IBSEs; its Division of Substance Abuse and Mental Health (DSAMH) licenses all residential SUD treatment facilities, including those that are publicly funded.

## **Processes of Licensure or Certification and Accreditation**

*Mental Health (MH):* Licensure by the DHSS is required for operation of Group Homes and IBSEs.

- Accreditation is not required.
- Researchers did not find requirements for inspection at application or renewal for either Group Homes or IBSEs, although inspections may occur at any time.
- A Certificate of Need is not required.
- Licensure duration is one year, by which time a renewal application must be submitted. Provisional licenses may be issued for up to 90 days.

*Substance Use Disorder (SUD):* Licensure by the DHSS is required for operation of all SUD residential treatment programs.

- Unless it is providing opioid treatment medication, accreditation is not required. However, accreditation by the Joint Commission or CARF confers deemed status, allowing the license applicant to qualify for a two year license.

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<sup>1</sup> See <https://delcode.delaware.gov/sessionlaws/ga150/chp050.shtml#TopOfPage>.

- An inspection is required for licensure and renewal (unless the renewal is for only one year).
- A Certificate of Need is not required.
- Duration of licensure may be either up to one or two years. A provisional license of up to 180 days also may be awarded with possible renewal for 90 days. A temporary license of up to 90 days also may be awarded.

## **Cause-Based Monitoring**

*Mental Health (MH):* The DHSS monitors compliance with its regulations and procedures for Group Homes. The DHSS has the right of access to any information directly or indirectly related to the service provider's operation of the group home and site visits are permitted at any time. IBSEs are periodically inspected by a representative of the DHSS. Inspections include the review of current facility policies and procedures. Inspections must be unannounced.

*Substance Use Disorder (SUD):* The DHSS may conduct inspections and investigations with or without notice as needed to ascertain regulatory compliance, including inspection of documents. If a survey occurs and a corrective action plan is required, the program must submit it and will be subject to follow-up on-site compliance inspections. Licenses may be revoked, suspended, or denied.

## **Access Requirements**

*Mental Health (MH):* For Group Homes, a service provider must ensure that no applicant is denied any benefits or services or is subject to illegal discrimination based on age, sex, race, nationality, religion, sexual orientation or disability. Researchers did not locate requirements related to access for IBSEs. Wait time requirements were not located.

*Substance Use Disorder (SUD):* Facilities may not deny “any person equal access to its facilities or services on the basis of race, color, religion, ancestry, sexual orientation, gender expression, national origin, or disability. No program shall deny any person equal access to its facilities or services on the basis of age or gender, except those programs that specialize in the treatment of a particular age group (such as adolescents) or gender (such as mothers and infants)”. All must comply with the ADA and other requirements. Wait time requirements were not located.

## Staffing

*Mental Health (MH):* For Group Homes, the regulations establish staff qualifications for a psychiatrist, other clinical positions, a residence director, and direct care staff. Training and core competencies are required, including but not limited to those related to medications, mental illness, patient rights, first aid and CPR, confidentiality, emergency and safety procedures, and de-escalation and other behavioral interventions. Policies must include requirements for continuing education and development. Minimum staffing requirements and duties for clinicians and direct care staff are included. A psychiatrist must be on-call at all times and visit the facility at least once a week and spend a minimum of one-half hour per resident per month providing direct services to residents on site, participating in the assessment of residents' needs, planning service provision, and providing supervision/consultation to other program staff.

For IBSEs, qualifications are established for the director, direct care supervisor and staff, and service worker supervisor and staff. Minimum staffing ratios are included. Orientation and training, including on-going training, for employees and volunteers include but are not limited to requirements related to reporting abuse, emergencies, confidentiality, crisis management, cultural sensitivity, CPR and first aid, behavior management, and restraint training. Regulations also include requirements related to personnel records, use of volunteers, and employee/volunteer health requirements.

*Substance Use Disorder (SUD):* All SUD facilities must have personnel policies and procedures and meet standards for personnel files, supervision, and training. All SUD facilities must meet standards for staff education and other qualifications, including for administrators, clinical directors, clinical supervisors, and counselors. Each category of residential facilities has additional staffing standards:

- Residential detoxification: Requires a physician to be on-call 24 hours a day and on-site as necessary, medical personnel when clients are present, awake staff when clients are present, and a counselor available on-site or on-call at different times.
- Residential treatment: Requires awake staff at all times and a counselor available on-site or on-call at different times.
- Transitional residential treatment: Requires staff on site at all times when clients are present and a counselor available 24 hours a day.

The standards applicable to DSAMH-funded and Medicaid FFS services have supplemental staffing requirements by category. Levels 3.1, 3.3, 3.5, and 3.7 have varying requirements regarding frequency of availability of an addiction-credentialed physician and different requirements related to psychiatric practitioners, primary care physicians, nurses, licensed practitioners, unlicensed counselors, certified recovery coaches, and credentialed behavioral

health technicians, and staffing ratios. Level 3.7 and 3.7-WM also requires medical personnel including physicians or physician extenders knowledgeable about addiction treatment.

## **Placement**

*Mental Health (MH):* Admission to a Group Home is limited to adults with a psychiatric disability who apply for admission to the group home, meet the criteria below, and require intensive home and community-based support services as a result of their psychiatric disability. To be accepted as a resident of a group home, specific criteria must be met, including, among others, that the person not be a current user of illegal drugs during the assessment period. With the assistance of the facility's psychiatrist, the Group Home must complete an assessment, using a format approved by the Division of Substance Abuse and Mental Health to gather specified information, prior to admission.

IBSERs must develop, adopt, follow and maintain on file a current written description of the facility's or program's admission policies governing the specific characteristics, and treatment or service needs of residents accepted for care.

*Substance Use Disorder (SUD):* All programs must have policies and procedures with admission criteria. Each of the three types of programs require an assessment that gathers specific information, including but not limited to, mental health status as part of the client's diagnostic assessment.

Categories of SUD residential facilities established by the DHSS for any residential facilities receiving DHSS funds or reimbursement under the state Medicaid FFS program must all utilize ASAM criteria and have additional requirements, in all cases including a mental status exam and a urine drug screen and tuberculosis test. Details for admission and assessment vary by level and follow the ASAM criteria for levels 3.1, 3.2-WM, 3.3, 3.5, 3.7, and 3.7-WM.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH):* For Group Homes, the service provider and resident must develop an initial individualized treatment plan no later than the date of the resident's admission to the group home. The treatment plan is reviewed in full at least every six months by the resident and the resident's treatment team. Prior to discharge, the provider must develop a written discharge plan in consultation with the resident; his guardian or legal representative, if any; anticipated post-discharge providers; and a multidisciplinary team which shall include a psychiatrist. Facility policies and procedures must include a process of transition or termination from the program which complies with state and federal laws and regulations and is intended to ensure continuity of service.

For IBSEs, a Behavior Management Committee (BMC) establishes a Specialized Behavior Support Plan (SBS Plan) upon admission and conducts SBS Plan reviews on each resident at least monthly. Each SBS Plan that has been approved and implemented must be reviewed at least monthly by the BMC for the first 90 days following implementation and quarterly thereafter. The plan must also address acceptable use of restraints. Researchers did not locate regulations for IBSEs related to discharge or aftercare planning or follow-up.

*Substance Use Disorder (SUD):* An individualized Recovery Plan must be developed in partnership with the client. A discharge plan is required. Setting-specific Recovery Plan requirements follow:

- Residential Detoxification: The Recovery Plan must be completed within 72 hours of admission. Recovery plans are reviewed and revised by the client and his/ her counselor, with periodic review by the seventh day and every 5th day thereafter and address issues remaining to be treated.
- Residential Treatment: The Recovery Plan must be completed within 72 hours of admission. Recovery plans are reviewed and revised by the client and his/ her counselor, with periodic review by the 30th day and every 30th day thereafter and address issues remaining to be treated.
- Transitional Residential Treatment: The Recovery Plan must be completed within 7 days of admission. Recovery plans are reviewed and revised every 30 days thereafter.

All SUD residential treatment categories established by DHSS for facilities that are DHSS funded or that receive reimbursement under the state Medicaid FFS program require a treatment plan, discharge planning that begins at admission (other than level 3.7-WM, where it is within 24 hours of admission), and aftercare planning that may include referral and assistance as needed for the beneficiary to gain access to other needed SUD or mental health services. The treatment/service plan must be developed within 72 hours of admission for all levels (3.1, 3.3, 3.5, 3.7) other than levels 3.2-WM and 3.7-WM, for which it must be within 24 hours of admission. For level 3.7-WM, that is an initial plan and a comprehensive plan must be developed within three days. Treatment plans are reviewed every 30 days for levels 3.3, 3.5, 3.7, and every 60 days for level 3.1 and “as indicated” for level 3.7-WM.

## **Treatment Services**

*Mental Health (MH):* For Group Homes, residents should have involvement and choice in all aspects of their care, rehabilitation and support; development and maintenance of supportive social networks; access to services, programs, and activities in the most integrated setting; and access to rehabilitative support during the course of day to day activities. The service provider must ensure that residents receive needed medical, dental, visual and behavioral health care. A

full range of rehabilitation, treatment and support services must be provided for each resident including, but not limited to, the following: 365 day per year services; psychiatric treatment and linkage to community support programs or day hospital programs; clinical liaison during periods of psychiatric hospitalization; outreach and crisis response; teaching and counseling on-site to improve interpersonal skills and to assist residents to control psychiatric symptoms;; transportation of residents to community activities; and support and encouragement to promote resident participation in mutual support and self-advocacy groups. Each resident must have a primary clinician on staff.

For IBSEs, the program must have, follow, and maintain a current written description of the facility's or program's services provided to residents, including those provided directly by the licensee or arranged through another source.

*Substance Use Disorder (SUD):* Services required by licensure category include, among other things:

- Residential Detoxification: Admission assessment, physical exam and medical care plan, diagnostic assessment, recovery planning, emergency services at a licensed hospital as needed, and daily individual and group counseling.
- Residential Treatment: Medical assessment, physical exam, TB and urine screening, diagnostic assessment, and recovery planning.
- Transitional Residential Treatment: Physical exam, diagnostic assessment, recovery planning, medical evaluation as needed, and emergency services at a licensed hospital as needed.

Services required for level 3.1, 3.3, and 3.5 facilities that receive DHSS funding or reimbursement under the state Medicaid FFS program include a specified number of hours of clinical and recovery-focused services and a specified number of hours a week of individual, group, family therapy, medication management, and/or psycho-education. Level 3.2-WM requires 24-hour medication monitoring observation and support in a supervised environment for a person served to achieve initial recovery from the effects of the addiction.

## **Patient Rights and Safety Standards**

*Mental Health (MH):* For Group Homes, residents are to be informed of their rights and responsibilities including but not limited to regarding behavioral expectations, privacy, confidentiality, and appeal processes. A grievance system must be established. The provider must follow all laws regarding reporting abuse and neglect. No requirements related to restraint or seclusion were located.

For IBSEs, there are requirements related to reporting abuse or neglect; informed consent; and incident reports and requirements for reporting to the Division. Chemical and mechanical restraints, as well as involuntary seclusion, are prohibited. Physical restraints are regulated and must be reported to the Division.

*Substance Use Disorder (SUD):* Requirements related to patient rights generally include, but are not limited to, those regarding nondiscrimination, filing a grievance, freedom from abuse and exploitation, privacy, and informed consent. Standards regarding restraint and seclusion were not found, nor a requirement that grievances be reported to the state. For Residential Treatment, additional rights include but are not limited to ones related to visitation, communication, and religious freedom.

## **Quality Assurance or Improvement**

*Mental Health (MH):* For Group Homes, the service provider must develop, implement, and adhere to a documented, ongoing, quality assurance program that includes an internal monitoring process that tracks performance and measures resident satisfaction. Requirements specific to quality improvement were not located for IBSEs.

*Substance Use Disorder (SUD):* Every agency must have a quality assurance plan that is reviewed and revised annually. The plan should provide for the review of: clinical services to include culturally competent services including an annual self-assessment that focuses on the needs of the community, professional/administrative services, environment of care, and infection control. The results of the review should document the problem(s) identified, the recommendations made, the actions taken, the individual(s) responsible for implementation of any actions, and any follow-up. Every agency must develop and implement performance indicators and assess outcome measures. Every program must provide a mechanism to collect opinions from service recipients, personnel and other stakeholders regarding the quality of service provided. Information shall be submitted to the appropriate committee for quality assurance review. Every program shall conduct a needs assessment at a minimum of every five (5) years. The results of the needs assessment should determine staffing patterns and types of services to be provided with changes and updates recorded as part of the agency's quality assurance plan.

## **Governance**

*Mental Health (MH):* IBSEs must have an identifiable functioning governing body which designates a Director. Governance requirements specific to Group Homes were not located.

*Substance Use Disorder (SUD)*: Facilities must have a governing body or advisory council that includes representatives of the population it serves. Among other things, the governing body oversees management and operations, policies, finances, and staffing credentials.

## Special Populations

*Substance Use Disorder (SUD)*: The licensure regulations apply both to SUD treatment and treatment for individuals with co-occurring mental illness.

## Location of Regulatory and Licensing Requirements

Department of Health and Social Services, Group Home regulations<sup>2</sup> and IBSER regulations<sup>3</sup>, Substance Abuse Facility Licensing regulations<sup>4</sup> and Delaware Adult BH DHSS Service Certification and Reimbursement Manual<sup>5</sup>. Regulatory data collected May 9, 2019.

## Other Information Sources

R. Urey (SOTA); J. Aronson (DHSS); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>2</sup> See

<http://regulations.delaware.gov/AdminCode/title16/Department%20of%20Health%20and%20Social%20Services/Division%20of%20Health%20Care%20Quality/3305.pdf>.

<sup>3</sup> See

<http://regulations.delaware.gov/AdminCode/title16/Department%20of%20Health%20and%20Social%20Services/Division%20of%20Health%20Care%20Quality/3320.pdf>.

<sup>4</sup> See

<http://regulations.delaware.gov/AdminCode/title16/Department%20of%20Health%20and%20Social%20Services/Division%20of%20Substance%20Abuse%20and%20Mental%20Health/6001.pdf>.

<sup>5</sup> See

<http://regulations.delaware.gov/AdminCode/title16/Department%20of%20Health%20and%20Social%20Services/Division%20of%20Substance%20Abuse%20and%20Mental%20Health/6001.pdf>.



# DELAWARE MEDICAID

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## Approach

The Delaware Department of Health and Social Services (DHSS) oversees the state Medicaid program. Delaware also has a Section 1115 waiver permitting Medicaid expenditures for treatment and withdrawal management services for substance use disorder (SUD) provided to individuals who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD), including residential treatment. The state historically has relied on the in lieu of provision and on Disproportionate Share Hospital (DSH) payments for Medicaid coverage of some IMD services.

## Types of Facilities

*Mental Health (MH):* Group Homes for Persons with Mental Illness can be certified as a Medicaid provider.

*Substance Use Disorder (SUD):* Categories established by the DHSS for any residential facilities receiving reimbursement under the state Medicaid FFS program OR DHSS funded programs providing services to Delaware residents lacking insurance include those listed below. The standards for these facilities are addressed above because they apply to both Medicaid and DHSS-funded facilities:

- Clinically Managed Low-Intensity Residential Treatment ASAM Level 3.1
- Clinically Managed Residential Withdrawal Management ASAM Level 3.2
- Clinically Managed Population-Specific High Intensity Residential Treatment ASAM Level 3.3
- Clinically Managed High Intensity Residential Treatment ASAM Level 3.5
- Medically Monitored Intensive Inpatient Treatment ASAM Level 3.7 (offered in residential settings in Delaware)

- Medically Monitored Intensive Inpatient Withdrawal Management ASAM Level 3.7-WM (offered in residential settings in Delaware)

Under the Section 1115 waiver, the intent is to reimburse for short-term treatment in residential settings, with a statewide average length of stay of 30 days.

## **Processes of Medicaid Enrollment**

Substance Use Disorder (SUD): Certification as a Medicaid provider requires use of a form.<sup>6</sup>

## **Staffing**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the credentials of staff for residential treatment settings. The state must assess the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT.

## **Placement**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines. The state also must establish a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings.

## **Treatment and Discharge Planning and Aftercare Services**

*Substance Use Disorder (SUD):* Neither Medicaid-specific regulations nor waiver documents include requirements related to treatment or discharge planning or the provision of aftercare services.

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<sup>6</sup> See <https://dhss.delaware.gov/dsamh/files/MedicaidCertForm61317.pdf>.

## **Treatment Services**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, beneficiaries will have access to high quality, evidence-based SUD treatment services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions. The waiver also requires the state to establish a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site. In addition, the state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services and hours of clinical care for residential treatment settings.

## **Care Coordination**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, beneficiaries will have improved care coordination and care for comorbid physical and mental health conditions. Under the waiver, the state must ensure establishment and implementation of policies to ensure residential facilities link beneficiaries with community-based services and supports following stays in these facilities.

## **Quality Assurance or Improvement**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings.

## **Special Populations**

*Substance Use Disorder (SUD):* No Medicaid requirements regarding adult residential SUD treatment services for special populations were located other than the requirement in the Section 1115 waiver that care for comorbid physical and mental health conditions be improved by the demonstration.

## **Location of Medicaid Requirements**

Medicaid Rules and Regulations<sup>7</sup>, Substance Abuse and Mental Health Regulations<sup>8</sup>; Delaware Adult BH DHSS Service Certification and Reimbursement Manual<sup>9</sup>; DSAMH, Licensing and Medicaid Certification, DSAMH Licensed/Certified Provider Directory, Delaware's SUD/MH Provider Network, Medicaid Certification<sup>10</sup>; Delaware Diamond State Health Plan 1115 Waiver<sup>11</sup>. Regulatory data collected December 2019.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019. <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report **“State Residential Treatment for Behavioral Health Conditions: Regulation and Policy”**. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

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<sup>7</sup> See

<https://regulations.delaware.gov/AdminCode/title16/Department%20of%20Health%20and%20Social%20Services/Division%20of%20Social%20Services/Delaware%20Social%20Services%20Manual/13000.pdf>.

<sup>8</sup> See

<https://regulations.delaware.gov/AdminCode/title16/Department%20of%20Health%20and%20Social%20Services/Division%20of%20Substance%20Abuse%20and%20Mental%20Health/6001.pdf>.

<sup>9</sup> See <https://www.dhss.delaware.gov/dhss/dsamh/files/stateplanmanual11012016.pdf>.

<sup>10</sup> See <https://dhss.delaware.gov/dsamh/regs.html>.

<sup>11</sup> See <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/de/de-dshp-ca.pdf>.

## DISTRICT OF COLUMBIA (Washington, D.C.)

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

### Types of Facilities

*Substance Use Disorder (SUD)*: The District regulates the following ASAM Level III facilities:

- *Level 3.1 Clinically Managed Low-Intensity Residential*: A residential program that shall provide a minimum of five hours of substance abuse treatment services per week for a period of up to 90 days. Level 3.1 Clinically Managed Low-Intensity Residential is the appropriate level of care for individuals who are assessed as meeting the ASAM criteria for Level 3.1 and: (a) Are employed, in school, in pre-vocational programs, actively seeking employment, or involved in structured day program; (b) Recognize their SUD and are committed to recovery or are in the early stages of change and not yet ready to commit to full recovery but need a stable supportive living environment to support their treatment or recovery; and (c) May have a stable co-occurring physical or mental illness. Level 3.1 Clinically Managed Low-Intensity Residential generally lasts 90 days.
- *Level 3.3 Clinically Managed Population-Specific High-Intensity Residential*: Shall provide no less than 20 hours of treatment per week for a period of up to 90 days. Level 3.3 providers must also be certified as a mental health provider by the Department or have a psychiatrist on staff. Level 3.3 Clinically Managed Population-Specific High-Intensity Residential, also referred to as Extended or Long-term Care, is the appropriate LOC for individuals who are assessed as meeting the ASAM criteria for Level 3.3, need a stable supportive living environment to support their treatment or recovery and: (a) Have co-occurring or other issues that have led to temporary or permanent cognitive impairments and would benefit from slower-paced repetitive treatment; or (b) Have unstable medical or psychiatric co-occurring conditions. Level 3.3 Clinically Managed Population-Specific High-Intensity Residential generally last up to 90 days.
- *Level 3.5*: A residential program that generally provides 25 hours of treatment services per week for a period of up to 28 days. Level 3.5 providers shall provide no less than 20 hours of treatment services per week. Level 3.5 is the appropriate level of care for individuals who are assessed as meeting the ASAM placement criteria for Level 3.5, need a 24-hour supportive treatment environment to initiate or continue their recovery process and: (a) Have co-occurring or severe social/interpersonal impairments due to substance

use; or (b) Significant interaction with the criminal justice system due to substance use. Level 3.5 generally lasts up to 28 days.

- *Level 3.7 withdrawal Management:* Short-term medically monitored intensive withdrawal management. For providers under a Human Care Agreement with the Department, services shall not exceed 5 days absent prior authorization and may not exceed 10 days.

*Unregulated Facilities:* Adult residential MH treatment facilities were not located and state staff confirm that none presently exist. The District's Section 1115 waiver guarantees that, if any residential providers wish to provide MH services to those with serious mental illness, the District will license them.

## **Approach**

*Mental Health (MH) and Substance Use Disorder (SUD):* The District's Department of Behavioral Health (DBH) oversees licensing and certification for all residential SUD treatment facilities.

## **Processes of Licensure or Certification and Accreditation**

*Substance Use Disorder (SUD):* Certification by DBH is required for operation of all substance use treatment levels. Certification duration is one year for new applicants and two years for existing providers, at which time a renewal application is required. An inspection is required for certification and renewal.

- If a provider provides MAT treatment, accreditation by SAMHSA is required for operation. Accreditation by one or more national accrediting bodies is also recognized as compliance with some compliance standards and confers deemed status upon the provider. Oversight of the service is provided by the State Opioid Treatment Authority (SOTA) within DBH.
- A Certificate of Need is not required.

## **Cause-Based Monitoring**

*Substance Use Disorder (SUD):* Evidence of violations gathered from an on-site survey, complaint, or other information may lead to the issuance of a Statement of Deficiency (SOD), although an on-site survey is not required prior to the issuance of an SOD. The SOD shall describe the areas of non-compliance, suggest actions needed to bring operations into compliance with the certification standards, and set forth a timeframe for the provider's submission of a written Corrective Action Plan (CAP).

## **Access Requirements**

*Substance Use Disorder (SUD):* For all substance use treatment levels, in-office waiting time shall be less than one hour from the scheduled appointment time. No other requirements relating to access were found specific to residential treatment.

## **Staffing**

*Substance Use Disorder (SUD):* All substance use treatment levels must hire personnel with the necessary qualifications in order to provide SUD treatment and recovery services and to meet the needs of its enrolled clients; and, for SUD treatment, employ Qualified Practitioners to ensure provision of services as appropriate and in accordance with this chapter. Regulations include requirements for a full-time program director responsible for the administrative direction and day-to-day operation of the program, and a clinical director responsible for the clinical direction and day-to-day delivery of clinical services. The clinical director must be a licensed clinician.

Providers must establish and adhere to a training policy, and staff must have annual training that meets the Occupational Safety & Health Administration (OSHA) regulations that govern behavioral health facilities and any other applicable infection control guidelines, including information on the use of universal precautions and on reducing exposure to hepatitis, tuberculosis, and HIV/AIDS. A program shall maintain and implement a written plan for staff development that includes staff orientation and in-service training requirements.

A treatment program shall have at least two staff persons, trained and certified by a nationally recognized authority that meets OSHA guidelines for basic first aid and cardiopulmonary resuscitation (CPR), present at all times during the hours of operation of the program. SUD recovery programs must have at least one staff person trained and certified by a recognized authority that meets OSHA guidelines in basic first aid and CPR present at all times during the hours of operation of the program.

Level 3.7 facilities must have a physician on staff able to respond within one hour. They must have medical staff (MD, PA, APRN, or RN) on duty 24 hours a day, seven days a week. Medical staff must have a staffing ratio of 12-1 during daytime hours, 17-1 during evening hours, and 25-1 during the night shift.

## **Placement**

*Substance Use Disorder (SUD):* For all residential treatment programs, adherence to ASAM is required, including regarding initial and ongoing assessment requirements. An Initial

Assessment must occur at admission, and a Comprehensive Assessment must occur within 7 calendar days from admission. Initial, Comprehensive, Ongoing, and Brief assessments shall be performed by the following Qualified Practitioners, as evidenced by signature and dates on the assessment document and the treatment plan and in accordance with additional provisions of this section: (a) Qualified Physicians; (b) Psychologists; (c) Licensed Independent Clinical Social Workers (“LICSWs”); (d) Licensed Graduate Professional Counselors (“LGPCs”) (only for providers not operating under a Human Care Agreement); (d) Licensed Graduate Social Workers (“LGSWs”); (e) Licensed Professional Counselors (“LPCs”); (f) Licensed Marriage and Family Therapists (“LMFTs”); (g) APRNs; (h) Certified Addiction Counselors II (“CAC IIs”) (may not diagnose); or CAC Is (may not diagnose).

The comprehensive assessment will document the client's strengths, resources, mental status, identified problems, current symptoms as outlined in the DSM, and recovery support service needs. Additionally, a drug screening is required to be performed at admission.

Level 3.7-WM service is for sufficiently severe signs and symptoms of withdrawal such that medical monitoring and nursing care are required but hospitalization is not indicated. For providers under a Human Care Agreement with the Department, discharge must be directly to a Level 3 residential program, unless certain conditions are met.

## **Treatment and Discharge Planning and Aftercare Services**

*Substance Use Disorder (SUD):* Treatment/service planning requirements are indicated for all residential treatment programs. An Ongoing Assessment occurs at regularly scheduled intervals, depending on the level of care. Discharge planning should be performed, and at a minimum, all client records shall include the discharge summary and an aftercare plan. There shall be activities with, or on behalf of, an individual to arrange for appropriate follow-up care to sustain recovery after being discharged from a program, including educating the individual on how to access or reinstate additional services, as needed.

## **Treatment Services**

*Substance Use Disorder (SUD):* For all residential treatment programs, Medication Assisted Treatment (MAT) can be offered and a client who receives MAT must also receive SUD Counseling. Use of this service should be in accordance with ASAM service guidelines and practice guidelines issued by the Department. Individuals appropriate for MAT must have a SUD that is appropriately treated with a MAT in accordance with Federal regulations. MAT providers must ensure that individuals receiving MAT understand and provide written informed consent to the specific medication administered. No person under 18 years of age may be admitted to MAT unless a parent or legal guardian consents in writing to such treatment. MAT may be administered on an in-office basis or as take-home regimen. Both MAT administrations include



the unit of medication and therapeutic guidance. For clients receiving a take-home regimen, therapeutic guidance must include additional guidance related to storage and self-administration. MAT providers must comply with all Department policies concerning MAT. Therapeutic guidance provided during MAT shall include: (a) safeguarding medications; (b) Possible side-effects and interaction with other medications; (c) Impact of missing doses; (d) Monitoring for withdrawal symptoms and other adverse reactions; and (e) Appearance of medication and method of ingestion. Providers shall have medical staff (MD, PA, APRN, or RN) on duty during all clinic hours. A physician shall be available on call during all clinic hours, if not present on site. A physician must evaluate the client a minimum of once per month for the first year that a client receives MAT and a minimum of every six months thereafter, in coordination with the treatment plan and as needed. A provider must review the results of a client's physical, which has been completed within the past 12 months, prior to prescribing or renewing a prescription for MAT.

Level 3.7 facilities must include the following services in accordance with ASAM guidelines as clinically appropriate: medication management, clinical care coordination, medication-assisted treatment, crisis intervention, case management, SUD counseling, and comprehensive assessment/diagnostic.

## **Patient Rights and Safety Standards**

For all residential treatment programs, allegations of ethical violations must be treated as major unusual incidents. Each program shall develop and document policies and procedures subject to review by the Department that detail safety precautions and procedures for participant volunteers, employees, and others; record management procedures; clients' rules of conduct and commitment to treatment regimen; clients' rights; addressing and investigating major unusual incidents; addressing client grievances; and addressing issues of client non-compliance with established treatment regimen and/or violation of program policies and requirements.

A program shall protect the rights and privileges of each clients and shall develop and implement written grievance procedures to ensure a prompt, impartial review of any alleged or apparent incident of violation of rights or confidentiality.

## **Quality Assurance or Improvement**

Each provider shall establish and adhere to policies and procedures governing quality improvement. The Quality Improvement Policy shall require the provider to adopt a written quality improvement (QI) plan describing the objectives and scope of its QI program and requiring provider staff, client, and family involvement in the QI program. The Department shall review and approve each provider's QI program at a minimum as part of the certification and

recertification process. When a significant problem or quality of service issue is identified, the program shall notify the Department, act to correct the problem or improve the effectiveness of service delivery, or both, and shall assess corrective or supportive actions through continued monitoring.

## **Governance**

Each provider shall have a governing body, which shall have overall responsibility for the functioning of the provider.

## **Special Populations**

*Substance Use Disorder (SUD):* If a program provides SUD treatment services to parents and their children, the provider shall specify in its certification application the age range of the children that will be accepted in the program of parents with children, and ensure that it satisfies all applicable laws and regulations governing care for children. The Department will ensure that children shall be supervised at all times. Programs shall ensure that parents designate an alternate caretaker who is not in the program to care for the children in case of emergency. Programs serving parents and young children shall also serve pregnant women. Programs shall ensure all parents and children are connected to a primary care provider and any other needed specialized medical provider and shall facilitate medical appointments and treatment for parents and children in the program, and ensure that childcare/daycare is available for children, provided while the parent participates in treatment services either directly or through contractual or other affiliation.

Programs that serve parents with children shall ensure that school-age children are in regular attendance at a public, independent, private, or parochial school, or in private instruction. Programs must support the parent's engagement with the child's school and ensure that children have access to tutoring programs.

Before a parent and child can be admitted to a program serving parents and children, the program shall ensure that it has a copy of the child's immunization records, which must be up to date. All services delivery staff shall receive periodic training regarding therapeutic issues relevant to parents and children. At least two times per year, the program shall provide or arrange training on each of the following topics: (a) Child development; and (b) The appropriate care and stimulation of infants, including drug-affected newborn infants.

Additionally, people with HIV, STDs or other infectious diseases and people with co-occurring mental illnesses should not be denied services. In addition to SUD services, a provider shall do the following: (a) Offer the opportunity for the person to receive mental illness treatment in addition to SUD treatment. If the person declines, the provider shall make the appropriate

referrals for the person to receive mental health treatment at another qualified provider; (b) If the provider does not offer treatment for mental illness ensure the person is referred to an appropriate mental health provider; or (c) If an individual that screens positive for a co-occurring mental illness receives mental health treatment at another provider, the Clinical Care Coordinator is responsible for ensuring the treatment plan and subsequent care and treatment of the person is coordinated with the mental health provider.

## **Location of Regulatory and Licensing Requirements**

Substance Use Regulations<sup>1</sup>; Behavioral Health Transformation Section 1115 waiver implementation plans<sup>2</sup>. Regulatory data collected August 27, 2019.

## **Other Information Sources**

T. Spencer (DBH), B. Gladden (DBH), C. Phillips (DBH), S. Kelly-Long (DBH); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>1</sup> See <https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/Chapter%2063%20Title%2022-A%2062%2037%20DCR%20012056.PDF>.

<sup>2</sup> See <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/dc/behavioral-health-transformation/dc-behavioral-health-transformation-smi-sud-implementation-plans-12192019.pdf>.

# DISTRICT OF COLUMBIA MEDICAID

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

## Approach

The Department of Health Care Finance (DHCF) oversees the District Medicaid program. DC also has a Section 1115 waiver permitting Medicaid expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD), including residential treatment. Additionally, the District's Section 1115 waiver guarantees that, if any residential providers wish to provide mental health services to those with serious mental illness, the District will license them. The District of Columbia does rely on the in lieu of provision and Disproportionate Share Hospital (DSH) payments to reimburse some services in IMDs.

## Types of Facilities

*Mental Health (MH) and Substance Use Disorder (SUD):*

- *Transition Planning Services:* Upon approval of the waiver implementation plan, Medicaid will reimburse discharge planning and facilitation of transitions of care for individuals leaving institutional treatment settings by providers of lower levels of care. Transition planning services consist of up to eight (8) hours per individual for services provided within thirty (30) days prior to an individual being discharged.

*Mental Health (MH):*

- *Psychiatric Residential Treatment Services:* Pursuant to the Section 1115 waiver, Psychiatric Residential Treatment Services are intensive services offered in a non-hospital setting for individuals over the age of 21 who have been diagnosed with a serious mental illness (SMI). The goal of these services is to stabilize or improve a psychiatric condition until an individual's symptoms can be managed in a community setting. The District will provide services for a targeted statewide average length of stay of thirty (30) days in residential treatment settings. Reimbursement for long-term residential stays (longer than sixty (60) days) and forensic IMD stays will not be provided under this demonstration.

- *Comprehensive Psychiatric Emergency Program (CPEP)*: CPEP provides 24 hours, 7 days a week emergency psychiatric assessment and treatment to individuals who present on involuntary and voluntary status. The duration of treatment for Psychiatric Emergency Services is up to 72 hours.
- *Psychiatric Residential Crisis Stabilization Services (PRCSS)*: Upon approval of the waiver implementation plan, Medicaid will reimburse for PRCSS, which is a residential treatment alternative to psychiatric inpatient hospitalization for individuals in need of support to ameliorate psychiatric symptoms.

*Substance Use Disorder (SUD)*:

- *Residential SUD Treatment Services*: Pursuant to the waiver, these services will be delivered to residents of a residential care setting, including facilities that meet the definition of an IMD, are provided to the District's Medicaid recipients with a SUD diagnosis when determined to be medically necessary and in accordance with an individualized plan of care. Residential treatment services are services provided to an individual residing in a District-certified facility that has been enrolled as a Medicaid provider and assessed as delivering care consistent with ASAM or other nationally recognized, SUD-specific program standards for residential treatment facilities.
- Medication-assisted treatment also may be provided in an IMD under the waiver.

**Processes of Medicaid Enrollment**

*Mental Health (MH) and Substance Use Disorder (SUD)*: Enrollment as a provider is required for reimbursement by the District Medicaid program. DHCF shall revalidate relevant Medicaid providers every five years.

*Mental Health (MH)*: Participating residential treatment providers must be licensed, or otherwise authorized, by the state to primarily provide treatment for mental illnesses. They must also be accredited by a nationally recognized accreditation entity prior to the state claiming FFP for services provided to beneficiaries residing in a facility that meets the definition of an IMD.

**Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD)*: Upon approval of the waiver implementation plan, for Transition Planning Services, services are furnished by any District-certified provider qualified to provide Mental Health Rehabilitative Services, Adult Substance

Abuse Rehabilitative Services, or other behavioral health services allowable under the State Plan that are authorized under District law and rulemaking to provide transition services.

*Mental Health (MH):* Upon approval of the waiver implementation plan, for Psychiatric Residential Treatment Services, the District has defined the allowable providers of Out-of-District provider psychiatric residential treatment services, who must be authorized and licensed to provide services under District law and regulations and the state in which services are offered. For in-District providers, services must be furnished by a District-certified Psychiatric Residential Treatment Service provider. Qualified provider staff include clinicians licensed in accordance with applicable District laws and regulations operating within scope of their license, including psychiatrists, psychologists, advanced practice registered nurses (APRNs), and other qualified practitioners authorized under District regulations. All services are provided under the direction of a psychiatrist.

Upon approval of the waiver implementation plan, for CPEP, services are furnished by any District-certified Comprehensive Psychiatric Emergency Program provider. Qualified provider staff include clinicians licensed in accordance with applicable District laws and regulations operating within scope of their license, including psychiatrists, psychologists, advanced practice registered nurses (APRNs), and other qualified practitioners authorized under District regulations.

Upon approval of the waiver implementation plan, for PRCSS, services are furnished by any District-certified psychiatric residential crisis stabilization provider.

*Substance Use Disorder (SUD):* The District must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding credentials of staff for residential treatment settings. The District must conduct an assessment of the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT.

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* All residential services require some form of initial assessment for treatment planning purposes.

*Mental Health (MH):* For the SMI/SED Implementation Plan, the District has elected to use the “Level of Care Utilization System” (LOCUS) level of care assessment tool to ensure that services to adults are individualized, clinically appropriate, and least restrictive. The LOCUS assists in determining the appropriate level of care and treatment interventions are based on individualized clinical assessments. LOCUS evaluations must be used at intake, during treatment plan development, when a consumer is in crisis, and when a level of care change is needed.

For Psychiatric Residential Treatment Services, the total length of stay will be determined by medical necessity and reviewed by the District or its assignee for clinical appropriateness.

*Substance Use Disorder (SUD):* The District must assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other assessment and placement tools that reflect evidence-based clinical treatment. The District must establish a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH):* For psychiatric residential treatment services, assessments of the individual's social, emotional, and medical needs are covered Section 1115 waiver services.

For Psychiatric Residential Crisis Stabilization Services, a comprehensive nursing assessment within 24 hours of admission and the development of treatment and discharge plans upon admission are covered Section 1115 waiver services.

*Substance Use Disorder (SUD):* For residential SUD treatment services, an initial assessment/diagnostic and the development of a plan of care are covered Section 1115 waiver services.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Upon approval of the waiver implementation plan, for Transition Planning Services, component services will include: (i) Assessment; (ii) Development of a service plan; and (iii) Care coordination and case management.

*Mental Health (MH):* Upon approval of the waiver implementation plan, for Psychiatric Residential Treatment Services, covered component services include: (i) Assessments of the individual's social, emotional, and medical needs; (ii) Therapeutic interventions; (iii) Psychiatric interventions; (iv) Non-hospital care in a structured 24-hour monitored environment for individuals whose mental health needs cannot be met in an outpatient setting; and (v) Comprehensive Transitional Care Coordination.

Upon approval of the waiver implementation plan, for CPEP, covered services include: (i) Brief Psychiatric Crisis/Emergency Visit; (ii) Twenty-Three-Hour Psychiatric Crisis/Emergency Visit;

and (iii) Extended Observation Psychiatric Crisis/Emergency Visit. This interaction includes a mental health diagnostic assessment, and, if necessary, treatment activities including prescribing or administering medication, and evaluation and monitoring for treatment effectiveness.

Upon approval of the waiver implementation plan, for PRCSS, covered component services include: (i) Psychiatric services, necessary to assess, treat, medicate and stabilize residents; (ii) Comprehensive nursing assessment within 24 hours of admission; (iii) Monitoring of patients who pose a threat to themselves or others; (iv) Stabilization and mental health services to address psychiatric, psychological, and behavioral needs; (v) Development of treatment and discharge plans upon admission; (vi) Active treatment and mental health services for stabilization; and (vii) Individual, group counseling or other interventions as required to stabilize the person.

*Substance Use Disorder (SUD):* Upon approval of the waiver implementation plan, for residential SUD treatment services, covered component services include: (i) Assessment/Diagnostic and Plan of Care Development; (ii) Clinical Care Coordination; (iii) Case Management; (iv) Crisis Intervention; (v) SUD Counseling/Therapy; (vi) Drug Screening; (vii) Medication Management; (viii) Medication Assisted Treatment; and (ix) Withdrawal management.

The District must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services and hours of clinical care for residential treatment settings. The District must establish a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site.

## **Care Coordination**

*Mental Health (MH) and Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the District will work to improve care coordination and care for co-occurring physical and behavioral health conditions. For residential treatment services, both case management and care coordination are covered Section 1115 waiver services.

*Mental Health (MH):* For psychiatric residential treatment services, Comprehensive Transitional Care Coordination is a covered 1115 waiver service.

The SMI/SED Implementation Plan must include a process for the implementation of a process to ensure that residential treatment facilities provide intensive pre-discharge, care coordination services to help beneficiaries transition out of those settings into appropriate community based outpatient services, including requirements that community-based providers participate in transition efforts. There shall also be the implementation of a process to assess the housing



situation of a beneficiary transitioning to the community from residential treatment settings, and to connect beneficiaries who are homeless or who have unsuitable or unstable housing with community providers that coordinate housing services, where available. There shall be a requirement that residential treatment settings have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary within 72 hours of discharge and to ensure follow-up care is accessed by individuals after leaving those facilities. The District shall also develop strategies to prevent or decrease the length of stay in emergency departments among beneficiaries with SMI or SED (e.g., through the use of peers and psychiatric consultants in EDs to help with discharge and referral to treatment providers), and to develop and enhance interoperability and data sharing between physical, SUD, and mental health providers, with the goal of enhancing care coordination.

*Substance Use Disorder (SUD):* For residential SUD treatment services, both case management and clinical care are covered Section 1115 waiver services.

The District must ensure the establishment and implementation of policies to ensure residential facilities link beneficiaries with community-based services and supports following stays in these facilities.

## **Quality Assurance or Improvement**

*Mental Health (MH):* The SMI/SED implementation plan must describe how the District will ensure quality of care in residential settings. There shall be the establishment of an oversight and auditing process that includes unannounced visits for ensuring participating residential treatment settings meet District licensure or certification requirements, as well as those of a national accrediting entity. There shall be of a utilization review entity to ensure beneficiaries have access to the appropriate levels and types of care and to provide oversight to ensure lengths of stay are limited to what is medically. There shall be a process for ensuring that participating residential treatment settings meet federal program integrity requirements and the establishment of a District process to conduct risk-based screening of all newly enrolling providers, as well as revalidating existing providers. Participating residential treatment settings shall be required to screen enrollees for co-morbid physical health conditions and substance use disorders and demonstrate the capacity to address co-morbid physical health conditions during short-term stays in residential or inpatient treatment settings.

*Substance Use Disorder (SUD):* The District must establish a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other nationally recognized SUD program standards based on evidence-based clinical treatment guidelines.

## Special Populations

*Mental Health (MH) and Substance Use Disorder (SUD)*: Requirements were not explicitly described in the state Medicaid regulations or the Section 1115 waiver.

## Location of Medicaid Requirements

DC Department of Healthcare Financing Medicaid Regulations<sup>3</sup>; DC Behavioral Health Transformation<sup>4</sup>. Regulatory data collected January 3, 2020

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report “**State Residential Treatment for Behavioral Health Conditions: Regulation and Policy**”. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

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<sup>3</sup> See <https://dhcf.dc.gov/page/dhcf-medicaid-regulations>.

<sup>4</sup> See <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=51662>.

## FLORIDA

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

### Types of Facilities

*Mental Health (MH):* Florida regulates two types of residential mental health treatment facilities:

- *Short-term residential treatment programs (SRTs) and crisis stabilization units (CSUs):*
  - SRTs are a state-supported acute care residential alternative service that operates 24 hours per day, 7 days per week and is typically of 90 days or less in duration, and which is an integrated part of a designated public receiving facility and receiving state mental health funds.
  - CSUs are a program that provides an alternative to inpatient hospitalization and that provides brief, intensive services 24 hours a day, 7 days a week, for mentally ill individuals who are in an acutely disturbed state.
  
- *Longer-term mental health residential treatment facilities:* Any facility licensed as a residential treatment facility must sustain a 60-day average or greater length of stay.
  - *Level IA/IB:* A Level IA facility provides a structured group treatment setting with 24 hours per day, 7 days per week supervision for residents who have major skill deficits in activities of daily living and independent living, and are in need of intensive staff supervision, support and assistance. Nursing services are provided on this level but are limited to medication administration, monitoring vital signs, first aid, and individual assistance with ambulation, bathing, dressing, eating and grooming.
  - *Level II:* A Level II facility provides a structured group treatment setting with 24 hour per day, 7 days per week supervision for five or more residents who range from those who have significant deficits in independent living skills and need extensive supervision, support and assistance to those who have achieved a limited capacity for independent living, but who require frequent supervision, support and assistance.
  - *Level III:* A Level III facility consists of collocated apartment units with an apartment or office for staff who provide on-site assistance 24 hours per day, 7 days per week.
  - *Level IV:* A Level IV facility provides a semi-independent, minimally structured group setting for 4 or more residents who have attained most of the skills required for independent living and require minimal staff support.

- *Level V*: A Level V facility provides a semi-independent, minimally structured apartment setting for 1 to 4 residents who have attained adequate independent living skills and require minimal staff support. The apartments in this setting are owned or leased by the service provider and rented to residents.

*Substance Use Disorder (SUD)*: Florida regulates two types of residential substance use disorder treatment facilities: (1) residential treatment facilities as Levels 1-4; and (2) addictions receiving facilities.

- *Level 1* programs include those that provide services on a short-term basis. This level is appropriate for persons who have sub-acute biomedical problems or behavioral, emotional, or cognitive problems that are severe enough that they require inpatient treatment, but do not need the full resources of an acute care general hospital or a medically managed inpatient treatment program. Typically, clients have a job and a home to support their recovery upon completion of this level of care. The emphasis is clearly on an intensive regimen of clinical services using a multidisciplinary team approach. Services may include some medical services based on the needs of the client.
- *Level 2* programs include those that are referred to as therapeutic communities or some variation of therapeutic communities and are longer term than Level 1. This level is appropriate for persons characterized as having chaotic and often abusive interpersonal relationships, extensive criminal justice histories, prior treatment episodes in less restrictive levels of care, inconsistent work histories and educational experiences, and anti-social behavior. In addition to clinical services, considerable emphasis is placed on services that address the client's educational and vocational needs, socially dysfunctional behavior, and need for stable housing upon discharge. It also includes services that assist the client in remaining abstinent upon returning to the community.
- *Level 3* programs include those that are referred to as domiciliary care and are generally longer term than Level 2. This level is appropriate for persons whose cognitive functioning has been severely impaired from the chronic use of substances, either temporarily or permanently. This would include persons who have varying degrees of organic brain disorder or brain injury or other problems that require extended care. The emphasis is on providing services that work on cognitive problems and activities of daily living, socialization, and specific skills to restore and maintain independent living. The services are typically slower paced, more concrete and repetitive. There is considerable emphasis on relapse prevention and reintegration into the community. This involves considerable use of case management and networking residents into ancillary or wrap-around services such as housing, vocational services, transportation, and self-help meetings.
- *Level 4* programs include those that are referred to as transitional care and are generally short-term. This level is appropriate for persons who have completed other levels of residential treatment, particularly Levels 2 and 3. This includes clients who have demonstrated problems in applying recovery skills, a lack of personal responsibility, or a

lack of connection to the world of work, education, or family life. Although clinical services are provided, the main emphasis is on services that are low-intensity and typically emphasize a supportive environment. This would include services that would focus on recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility and reintegrating the individual into the worlds of work, education, and family life.

- *Addictions Receiving Facilities:* A secure, acute-care, residential facility operated 24 hours-per-day, 7 days-per-week, designated by the department to serve persons found to be substance abuse impaired as described in Section 397.675, F.S. (involuntary commitment), and who meet the placement criteria for this component. Detoxification may be provided.

*Unregulated Facilities:* For residential mental health treatment facilities, SRTs (90 days or less) and CSUs that are not publicly funded are not regulated, although state staff indicate that all CSUs and SRTs are publicly funded for all or a portion of their beds. Longer-term residential facilities that are not treating those with serious and persistent mental illness are not regulated. This includes any longer-term facilities providing treatment for eating disorders and weight loss programs.

For residential substance use disorder treatment facilities, unregulated entities include hospital or hospital-based component licensed under Chapter 395, F.S., a facility or institution operated by the Federal Government, and a legally cognizable church or nonprofit religious organization or denomination providing substance abuse services, including prevention services, which are solely religious, spiritual, or ecclesiastical in nature. We exclude from this summary hospitals. Detoxification is identified as either inpatient or outpatient, although it may be offered in addiction receiving facilities. We exclude all inpatient or outpatient detoxification.

## **Approach**

*Mental Health (MH):* Florida's Agency for Health Care Administration has two sets of licensure requirements for residential mental health facilities: (1) those applicable to public mental health crisis stabilization units (CSUs) and state-supported short-term residential treatment (SRTs) programs, and (2) those applicable to a mental health residential treatment facility, regardless of funding source, for adults with a serious and persistent major mental illness who do not have another primary residence.

*Substance Use Disorder (SUD):* Florida's Department of Children and Families (DCF) licenses substance use components including the following: (1) residential treatment facilities as Levels 1-4; and (2) addictions receiving facilities. All entities operating the two substance use components listed above must be licensed, except for a facility or institution operated by the Federal Government or a legally cognizable church or nonprofit religious organization or denomination providing substance abuse services, which are solely religious, spiritual, or

ecclesiastical in nature. DCF has the authority to exempt state government-operated programs from specific licensure provisions, including, but not limited to, licensure fees and personnel background checks.

## **Processes of Licensure or Certification and Accreditation**

*Mental Health (MH):* Licensure by the Agency for Health Care Administration is required for all mental health facility types described in 1a.

- Licensure duration is one year for residential treatment facilities, at which time a renewal application must be submitted. In certain circumstances, an interim 90 day license may be issued. An inspection is required for licensure and renewal.
- Accreditation is not required but is recognized. CSUs and SRTs which are accredited must provide proof of accreditation and accreditation does not preclude monitoring by the department, the agency and fire marshal, and compliance with regulatory requirements. Accredited Level I-V programs may ask the Agency to accept their accreditation in lieu of receiving routine on-site licensure surveys, by submitting the required documentation from a recognized or approved accreditation organization.
- SRTs and CSUs require a Certification of Authorized Beds: The agency shall issue a license certifying the number of authorized beds and available appropriation for each facility as determined by the department based upon existing need, geographic considerations, and available resources. The department formula, ten CSU beds per 100,000 general population, may be used as a guideline.

*Substance Use Disorder (SUD):* Licensure by DCF is required for all substance use facility types.

- The process for licensure is as follows: A provider is first awarded a probationary license, which lasts 90 days. A regular license's duration is one year, by which time a renewal application must be submitted. In certain circumstances, up to two interim 90 day licenses may be issued to give a provider time to reach compliance with statute and/or administrative rule. An inspection is required for licensure and renewal.
- According to state staff, accreditation is required by The Joint Commission, COA, CARF, or another department-recognized entity, allowing the license applicant to be inspected only every three years under normal circumstances.
- There are no Certificate of Need requirements for residential SUD facilities in Florida.

## **Cause-Based Monitoring**

*Mental Health (MH):* SRTs, CSUs, and Level I-V programs have standards related to monitoring including: (a) the department will provide consultation and conduct annual reviews and evaluations, or more as necessary, to determine compliance with rules and standards; and (b) department representatives may access the facility and documentation necessary for conducting the reviews required to determine compliance with all applicable rules and statutes.

*Substance Use Disorder (SUD):* The Office of Substance Abuse and Mental Health monitors implementation of the licensing process from a statewide perspective and analyzes provider performance relative to the results of licensing reviews. Where warranted, DCF may conduct inspections more often than every three years for accredited facilities.

## **Access Requirements**

*Mental Health (MH) and Substance Use Disorder (SUD):* Addiction receiving facilities and CSUs must be able to screen and admit 24 hours a day, 7 days a week and no person may be detained for more than 12 hours without being admitted or released.

## **Staffing**

*Mental Health (MH):* CSUs and SRTs have standards for the program administrator, including that facilities must have a psychiatrist as primary medical coverage, with a physician if back-up is needed, on-call 24 hours a day, 7 days a week and must make daily rounds. Sparsely populated areas are allowed exceptions. At least one RN must be on duty around the clock. There are other staffing requirements, some of which rely on facility policies and procedures for definition. Staffing ratios for nurses and mental health treatment staff depend on number of beds. Training requirements are included.

Level I-V programs have staffing level and training requirements. They shall have direct or telephone access to at least one professional 24 hours a day, 7 days a week. If the professional is not a psychiatrist, the facility shall also arrange for the regular, consultative and emergency services of a psychiatrist licensed to practice in Florida. The staffing ratio requirements vary by level.

*Substance Use Disorder (SUD):* Staffing requirements applicable to licensed substance use facilities generally include those regarding the Chief Executive Officer, the Medical Director, Clinical Supervisor, and staff known as “qualified professionals.” Documentation to confirm the requirements have been met include personnel policies and personnel records, staff screening, standards of conduct, staff development and training for clinical and direct care staff, and clinical supervision records.

Addiction receiving facilities must have a physician, P.A., or advanced practice registered nurse (A.P.R.N.) who makes daily visits to the facility and a full-time RN must be the supervisor of nursing services, with an RN on-site at all times. At least one qualified professional must be on staff and at least one member of the clinical staff must be available on-site at all times. Staffing ratios for nurses and nurse support vary by bed capacity.

Level 1-4 facilities must have awake, paid staff coverage 24 hours-per-day, 7 days per week and no primary counselor may have a caseload that exceeds 15 currently participating clients.

## Placement

*Mental Health (MH):* CSUs are intended for mentally ill individuals who are in an acutely disturbed state. Potential admittees must be assessed by the CSU or by the emergency services unit of the public receiving facility. Each receiving facility shall provide emergency screening services on a 24-hours-a-day, 7-days-a-week basis and shall have policies and procedures for identifying individuals at high risk. Everyone for whom involuntary examination is initiated must receive a face-to-face examination by a physician or clinical psychologist prior to release. The examination shall include a psychiatric evaluation, including a mental status examination, or a psychological status report. Upon admission, all persons shall be given a nursing assessment and a physical examination within 24 hours of admission. All individuals must also have an emotional and behavioral assessment within 72 hours. The assessment shall be made by a mental health professional or other unit staff under the supervision of a mental health professional, with a psychiatric evaluation included.

People may be admitted to an SRT only following a psychiatric or psychological evaluation and referral from a CSU, inpatient unit, or another designated public or private receiving facility. Admission is only on the order of a physician or psychiatrist. Requirements for immediate post-admission assessment are the same as for CSUs.

Minimum admission criteria for RTFs are:

- Level I requires: (a) Diagnosed as having mental illness; (b) Age 18 or older; (c) Ambulatory or capable of self-transfer; (d) Able to participate in treatment programming and services; (e) Free of major medical conditions requiring ongoing 24 hours per day, 7 days per week nursing services; (f) Assessed as having the potential, with staff supervision, to self-administer medication, maintain personal hygiene, and participate in social interaction; and, (g) Does not exhibit chronic inappropriate behavior which disrupts the facility's activities or is harmful to self or others.
- Level II requires: (a) Self-administers medication with staff supervision; (b) Maintains personal hygiene and grooming with staff supervision; (c) Initiates and participates in



social interaction with staff supervision; (d) Performs assigned household chores with staff supervision; and, (e) Is capable of self-preservation.

- Level III requires: (a) Self-administers and monitors own medication with minimal prompting; (b) Performs household chores with minimal prompting; (c) Maintains personal hygiene and grooming with minimal prompting; (d) Utilizes recreational and social resources with staff encouragement; (e) Utilizes community transportation systems; (f) Manages income with assistance; and, (g) Expresses problems and concerns to appropriate persons.
- Level IV requires: (a) Self-administers and monitors own medications; (b) Performs household chores and activities; (c) Maintains personal hygiene and grooming; (d) Manages income; (e) Utilizes recreational and social resources; (f) Procures food and other items necessary to maintain a household; (g) Prepares meals either individually or cooperatively; and (h) Utilizes community transportation systems.
- Level V requires: (a) Self-administers and monitors own medications; (b) Performs household chores and activities; (c) Maintains personal hygiene and grooming; (d) Manages income; (e) Utilizes recreational and social resources; (f) Procures food and other items necessary to maintain a household; (g) Prepares meals either individually or cooperatively; and, (h) Utilizes community transportation system.

RTF staff or the treatment team shall begin within 72 hours of admission and complete within 30 days of admission a functional assessment and individual treatment plan for each resident. Interventions which are needed to remedy serious deficits shall not be delayed until the assessment and individual treatment plan are completed. The functional assessment shall determine the resident's ability to utilize the skills needed to function successfully in the RTF environment and shall identify any obstacles to the resident's learning or using such skills.

Researchers did not find reference to LOCUS.

*Substance Use Disorder (SUD):* Placement in an addictions receiving facility requires that the person be unable to be placed in another component and must also fall into one of the following categories: (a) A voluntary client who has a substance abuse problem to the extent that the person displays behaviors that indicate potential harm to self or others or who meets diagnostic or medical criteria justifying placement in an addictions receiving facility; or (b) An involuntary client who meets statutory criteria; or (c) An adult or juvenile offender who is ordered for assessment or treatment and who meets diagnostic or medical criteria justifying placement in an addictions receiving facility; or (d) Juveniles found in contempt. Following the nursing physical screen, the client shall be screened to determine the person's eligibility or ineligibility for placement. The decision to place or not to place shall be made by a physician, a qualified professional, or an RN, and shall be based upon the results of screening information and face-to-face consultation with the person to be admitted.

Residential Level 1-4 services shall include a schedule of services provided within a positive environment that reinforce the client's recovery, and clients will be placed in a level of residential treatment that is based upon their treatment needs and circumstances. Assessment is required to determine appropriateness and eligibility for placement. The condition and needs of the client dictate the urgency and timing of screening. Clients shall undergo an assessment of the nature and severity of their substance abuse problem. The assessment shall include a physical health assessment and a psychosocial assessment to determine appropriateness and eligibility for placement or other disposition. For residential treatment, the history must be completed within 30 calendar days prior to placement, or within 1 calendar day of placement.

According to state staff, DCF-funded providers must utilize ASAM placement criteria.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH):* For CSUs, a service implementation plan is required with documented input from the person receiving services within 24 hours of admission. The service implementation plan must have objectives and action steps written for the person in behavioral terms. The plan shall be fully developed within 5 days of admission and must contain short-term treatment objectives stated in behavioral terms relative to the long-term view and goals in the comprehensive service plan, if there is one, an aftercare plan, and a description of the type and frequency of services to be provided in relation to treatment objectives. Prior to discharge or departure from the CSU, the staff with the consent of the person receiving services works with the individual's support system, as appropriate, to assure that all efforts are made to prepare the individual for returning to a less restrictive setting. The CSU shall have access to a hospital inpatient unit to assure that individuals being referred are admitted as soon as necessary.

Upon admission to an SRT, the person's previously completed comprehensive service plan is reviewed and revised as needed with the person's service plan manager. The SRT shall develop a service implementation plan which has objectives and action steps written for the person in behavioral terms. The service implementation plan shall be initiated with documented input from the person receiving services within 24 hours of admission. The service implementation plan shall be fully developed within 5 days of admission and must contain short-term treatment objectives stated in behavioral terms, relative to the long-term view and goals in the comprehensive service plan, and a description of the type and frequency of services to be provided in relation to treatment objectives. The plan shall be reviewed and updated at least every 30 days. A new aftercare plan shall be developed prior to discharge from the SRT.

For Level I-V programs, service plans must be developed by the case manager and resident which depict service and resource attainment goals and objectives to guide service delivery. A treatment plan focused on skill attainment is included. These are updated monthly. Discharge planning is required.

*Substance Use Disorder (SUD):* For all licensed SUD facilities, the client must have an opportunity to participate in developing a treatment plan. The treatment plan must include goals and related measurable behavioral objectives to be achieved by the client, the tasks involved in achieving those objectives, the type and frequency of services to be provided, and the expected dates of completion. If the treatment plan is completed by other than a qualified professional, the treatment plan shall be reviewed, countersigned, and dated by a qualified professional within 10 calendar days of completion. For residential treatment Level 1, the treatment plan shall be completed prior to, or within 7 calendar days of placement. For residential treatment Levels 2, 3, and 4, the treatment plan shall be completed prior to or within 15 calendar days of placement. For addictions receiving facilities, an abbreviated treatment plan is completed upon placement. The abbreviated treatment plan shall contain a medical plan for stabilization and detoxification, provision for education, therapeutic activities and discharge planning, and in the case of addictions receiving facilities, a psychosocial assessment. Treatment plan reviews must occur every 30 days for residential treatment Levels 1, 2, and 3; and every 90 days for Level 4. An aftercare plan shall be developed for each client and the plan shall provide an outline of the goals to be accomplished during aftercare including regular counseling sessions and the need for ancillary services. Providers shall refer clients for other services that are needed by the client as specified in the aftercare plan. This shall include follow-up on all referrals.

## **Treatment Services**

*Mental Health (MH):* CSUs must provide the following services on a 24-hour-a-day, 7-days-a-week basis: (1) Emergency reception; (2) Evaluation; (3) Observation; (4) Crisis counseling; (5) Therapeutic activities, including recreational, educational, and social, whose intent is to involve the individual in reality-oriented events and interpersonal interactions shall be provided 3-hours-a-day, 7-days-a-week; and, (6) Referral to other service components of a mental health agency, a private care facility, or another appropriate care agency. Basic routine activities for persons admitted to a CSU shall be delineated in program policies and procedures which shall be available to all personnel. The daily activities shall be planned to provide a consistent, well structured, yet flexible, framework for daily living and shall be periodically reviewed and revised as the needs of individuals or the group change. Basic daily routine shall be coordinated with special requirements of the service implementation plan.

Each SRT shall provide the following services on a 24-hour-a-day, 7-day-a-week basis: (1) Twenty-four hour supervision; (2) Individual, group, and family counseling services directed toward alleviating the crisis or symptomatic behavior which required admission to an SRT; (3) Medical or psychiatric treatment; (4) Social and recreational activities, inside and outside the context of the facility; (5) Referral to other less restrictive, nonresidential treatment services, when appropriate. Each SRT shall have access to the CSU, if one exists in the area, and to hospital emergency services in the event of a crisis that cannot be managed within the facility; and, (6) Each SRT shall provide or have access to transportation in order to accomplish emergency transfers and to meet the service needs of persons served. Basic routine activities

for persons admitted to an SRT shall be delineated in program policies and procedures which shall be available to all personnel. Basic daily routine shall be coordinated with special requirements of each service implementation plan.

Level I-V RTFs must provide services and activities which are adaptable to the individual needs of residents, promote personal growth and development, and prevent deterioration or loss of ability. Each RTF shall have a policy and procedures manual which guides its services and activities. RTFs shall provide or refer residents to recreational and social activities during the hours they are not involved in other planned or structured activities. Opportunity shall be provided for all residents to participate in religious services and other religious activities within the framework of their individual and family interests. A resident may be assigned tasks related to facility operation, including but not limited to cooking, laundering, housekeeping and maintenance, only if such tasks are in accordance with the treatment plan and are done with staff supervision. A facility shall have available, whether within its organizational structure or by written agreements, procedures or contracts with outside health care clinicians or facilities, a full range of services for the treatment of illnesses and maintenance of general health.

*Substance Use Disorder (SUD):* For addiction receiving facilities, services must include stabilization and, where necessary, detoxification (as part of which methadone may be offered); supportive counseling on a daily basis, unless a client is not sufficiently stabilized. Supportive counseling sessions shall be of sufficient duration to enable staff to make reasonable decisions regarding the client's need for other services. Services shall be directed toward assuring that the client's most immediate needs are addressed, and that the client is encouraged to remain engaged in treatment and to follow up on referrals after discharge. The provider shall develop a daily schedule that shall include recreational and educational activities.

For Residential Level 1-4 SUD treatment, with the exception of counseling, it is not intended that all services listed below be provided, rather they should be provided in accordance with the needs of the client: (a) Individual counseling; (b) Group counseling; (c) Counseling with families; (d) Substance abuse education, such as strategies for avoiding substance abuse or relapse, health problems related to substance abuse, and motivational enhancement and strategies for achieving a substance-free lifestyle; (e) Life skills training such as anger management, communication skills, employability skills, problem solving, relapse prevention, recovery training, decision-making, relationship skills, and symptom management; (f) Non-verbal therapies such as recreation therapy, art therapy, music therapy, or dance (movement) therapy to provide the client with alternative means of self-expression and problem resolution; (g) Training or advising in health and medical issues; (h) Employment or educational support services to assist clients in becoming financially independent; and, (i) Mental health services for the purpose of: (1) Managing clients with disorders who are stabilized; (2) Evaluating clients' needs for in-depth mental health assessment; (3) Training clients to manage symptoms; and, (4) Timely referral to an appropriate provider for mental health crises or the emergence of a primary mental health disorder when the provider is not staffed to address primary mental health problems.

For Level 1, each client shall receive services each week, including at least 14 hours of counseling. For Level 2, each client shall receive services each week, including at least 10 hours of counseling. For Level 3, each client shall receive services each week, including at least 4 hours of counseling. For Level 4, each client shall receive services each week, including at least 2 hours of counseling. Each provider shall arrange for or provide transportation services to clients who are involved in activities or in need of services that are provided at other facilities.

## **Patient Rights and Safety Standards**

*Mental Health (MH):* Statutory provisions regarding patients' rights include, among others, the right to dignity, the right to treatment, the right to communicate and have visits, requirements regarding informed consent, restraint and seclusion, critical incident investigation and reporting, managing complaints, and abuse reporting.

In addition, CSUs and SRTs must be operated in a manner that protects the individual's rights, life, and physical safety while receiving evaluation and treatment. Individuals receiving services have protections regarding searches and seizures and retaliation. Critical incidents must be reported to the state within one day. CSUs and SRTs must report all seclusion and restraints. There are requirements related to suicide precautions with additional requirements for CSUs.

Level I-V RFTs, CSUs, and SRTs require a complaint/grievance process available to the patient and the reporting of critical incidents to the state. Other than prescribed bed rails, restraints may not be used; nor may seclusion.

*Substance Use Disorder (SUD):* Statutory provisions regarding patients' rights for all substance use treatment include, among others, the right to dignity, nondiscrimination, quality services, communication, confidentiality, and requirements regarding restraint and seclusion. Addiction receiving facilities have additional requirements regulating restraint and seclusion. Level 1-4 programs also require a complaints/grievance process available to patients and the reporting of critical incidents to the state.

## **Quality Assurance or Improvement**

*Mental Health (MH):* Every CSU and SRT shall have, or be an active part of, an established multidisciplinary quality assurance program and develop a written plan which addresses the minimum guidelines to ensure a comprehensive integrated review of all programs, practices, and facility services. The quality assurance program must include: (1) Composition of quality assurance review committees and subcommittees, purpose, scope, and objectives of the quality assurance committee and each subcommittee, frequency of meetings, minutes of meetings, and documentation of meetings; (2) Procedures to ensure selection of both difficult and randomly selected cases for review; (3) Procedures to be followed in reviewing cases and

incident reports; (4) Criteria and standards used in the review process and procedures for their development; (5) Procedures to be followed to assure dissemination of the results and verification of corrective action; (6) Tracking capability of incident reports, pertinent issues and actions; and, (7) Procedures for measuring and documenting progress and outcome of individuals receiving services.

Level I-V RTFs shall have or be part of an established quality assurance program with written policies and procedures that include the following: (a) Composition of review committees; (b) Case review procedures; (c) Criteria and standards used in the review process and procedures for their development; and, (d) Procedures to assure dissemination of the results and corrective action.

Each quarter a peer review and a utilization review shall be conducted which ensure at a minimum that: (a) Resident admissions are appropriate; (b) Services are delivered in the least restrictive environment possible; (c) Resident rights are protected; (d) When permitted by the resident, the resident's family or significant others are involved in resident assessment, treatment planning and discharge planning; (e) Service plans are comprehensive and relevant to residents' needs; (f) Minimum standards for resident records are met; (g) Minimum therapeutic dosages of medication are prescribed and appropriately administered; (h) Medical emergencies are handled appropriately; (i) Specialty cases such as suicides, death, violence, staff abuse, and resident abuse are reviewed; (j) All major incident reports are reviewed; (k) The length of stay for each resident is appropriate; (l) Supportive services are ordered and obtained as needed; (m) Continuity of care is provided; and, (n) Delay in receiving services is minimal.

The program shall conduct an annual review of program effectiveness, program goals, policies, procedures and service treatment provision.

*Substance Use Disorder (SUD):* Providers shall have a quality assurance program to ensure that services are rendered consistent with prevailing professional standards, and to identify and resolve problems. For each service provider, a written plan must be developed with a copy made available upon request to the department which addresses the minimum guidelines for the provider's quality improvement program, including, but not limited to; (a) Individual care and services standards; (b) Individual records maintenance procedures; (c) Staff development policies and procedures; (d) Service-environment safety and maintenance standards; (e) Peer review and utilization management review procedures; and (f) Incident reporting policies and procedures that include verification of corrective action, provision for reporting to the department within a time period prescribed by rule, documentation that incident reporting is the affirmative duty of all staff, and a provision that specifies that a person who files an incident report may not be subjected to any civil action by virtue of that incident report.

## **Governance**

*Mental Health (MH):* CSUs and SRTs must have either a formally constituted advisory or governing board or operate under a provider board which has ultimate authority for establishing policy and overseeing the operation of the CSU or SRT. Regulations include requirements for governing documents, board members, and records.

For Level I-V RTFs, the governing board is responsible for policies, by-laws, operations and standards of service.

*Substance Use Disorder (SUD):* Any provider that applies for a license must be a legally constituted entity. Providers that are government-based and providers that are for-profit and not-for-profit shall have a governing body that shall set policy for the provider. Regulations include requirements regarding meetings, insurance, and leadership. Inmate Substance Abuse Programs operated by the Department of Corrections and Juvenile Justice Commitment Programs and detention facilities operated by the Department of Juvenile Justice are exempt from the requirements of this paragraph.

## **Special Populations**

*Mental Health (MH):* The priority populations for adult mental health services include: (1) Adults who have severe and persistent mental illness, as designated by the department using criteria that include severity of diagnosis, duration of the mental illness, ability to independently perform activities of daily living, and receipt of disability income for a psychiatric condition. Included within this group are: (a) Older adults in crisis; (b) Older adults who are at risk of being placed in a more restrictive environment because of their mental illness; (c) Persons deemed incompetent to proceed or not guilty by reason of insanity under chapter 916; (d) Other persons involved in the criminal justice system; or (e) Persons diagnosed as having co-occurring mental illness and substance abuse disorders; and/or (2) Persons who are experiencing an acute mental or emotional crisis.

*Substance Use Disorder (SUD):* Providers shall develop and implement operating procedures for serving or arranging services for persons with dual diagnosis disorders. The priority populations for substance abuse treatment services include: (1) Adults who have substance abuse disorders and a history of intravenous drug use; (2) Persons diagnosed as having co-occurring substance abuse and mental health disorders; (3) Parents who put children at risk due to a substance abuse disorder; (4) Persons who have a substance abuse disorder and have been ordered by the court to receive treatment; and (5) Persons identified as being part of a priority population as a condition for receiving services funded through the Center for Mental Health Services and Substance Abuse Prevention and Treatment Block Grants.

## Location of Regulatory and Licensing Requirements

*MH*: Level I-5 RTFs<sup>1</sup>; CSUs and SRTs<sup>2</sup>; Patient Rights<sup>3</sup>; Health Care Licensing<sup>4</sup>

*SU*: Substance Abuse Services<sup>5</sup> and Patient Rights<sup>6</sup>. Regulatory data collected May 10, 2019.

## Other Information Sources

C. Weller, C McGillen, U.Gazioch, W. Hardin (FL DCF); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>1</sup> See

<https://www.flrules.org/gateway/RuleNo.asp?title=COMMUNITY%20MENTAL%20HEALTH%20REGULATION&ID=65E-4.016>.

<sup>2</sup> See <https://www.flrules.org/gateway/ChapterHome.asp?Chapter=65E-12>.

<sup>3</sup> See [http://www.leg.state.fl.us/Statutes/index.cfm?App\\_mode=Display\\_Statute&Search\\_String=&URL=0300-0399/0394/Sections/0394.459.html](http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0300-0399/0394/Sections/0394.459.html).

<sup>4</sup> See <https://www.flrules.org/gateway/ChapterHome.asp?Chapter=59A-35>.

<sup>5</sup> See <https://www.flrules.org/gateway/ChapterHome.asp?Chapter=65D-30>.

<sup>6</sup> See [http://www.leg.state.fl.us/Statutes/index.cfm?App\\_mode=Display\\_Statute&Search\\_String=&URL=0300-0399/0397/Sections/0397.501.html](http://www.leg.state.fl.us/Statutes/index.cfm?App_mode=Display_Statute&Search_String=&URL=0300-0399/0397/Sections/0397.501.html).



# FLORIDA MEDICAID

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## Approach

*Mental Health (MH) and Substance Use Disorder (SUD):* The Florida Agency for Health Care Administration (AHCA) oversees the state Medicaid program. Services to individuals in IMDs are not covered by Florida Medicaid, except in cases where Florida relies on the in lieu of provision and Disproportionate Share Hospital (DSH) payments for certain services in an IMD. Researchers did not locate evidence of Florida Medicaid coverage of non-IMD adult residential behavioral health treatment. The state does not have a relevant Section 1115 waiver.

## Types of Facilities

*Mental Health (MH) and Substance Use Disorder (SUD):* Evidence of Medicaid coverage of adult residential MH or SUD treatment facilities was not found.

## Processes of Medicaid Enrollment

*Mental Health (MH) and Substance Use Disorder (SUD):*

- In Florida, enrollment as a provider in the state Medicaid program is required to receive reimbursements. To enroll, a provider must submit an application, be actively licensed to practice, and sign the provider agreement, among other things. Institutional, DME, Medicare Crossover-Only, ORPs, and out-of-state providers must renew every three years; non-institutional providers must renew every five years. Providers may be sanctioned.
- Requirements regarding residential services were not explicitly described in the state Medicaid regulations.
- See companion summary to this document for licensure-related standards for adult residential behavioral health in Florida.

## **Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD):* Requirements regarding residential services were not explicitly described in the state Medicaid regulations.

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* Requirements regarding residential services were not explicitly described in the state Medicaid regulations.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Requirements regarding residential services were not explicitly described in the state Medicaid regulations.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Requirements regarding residential services were not explicitly described in the state Medicaid regulations.

## **Care Coordination**

*Mental Health (MH) and Substance Use Disorder (SUD):* Requirements regarding residential services were not explicitly described in the state Medicaid regulations.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* Requirements regarding residential services were not explicitly described in the state Medicaid regulations.

## **Special Populations**

*Mental Health (MH) and Substance Use Disorder (SUD):* Requirements regarding residential services were not explicitly described in the state Medicaid regulations.

## Location of Medicaid Requirements

Florida Agency for Health Care Administration Medicaid Rules and Regulations<sup>7</sup>; Medicaid Manuals<sup>8</sup>. Regulatory data collected January 4, 2020.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019. <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report **“State Residential Treatment for Behavioral Health Conditions: Regulation and Policy”**. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

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<sup>7</sup> See <https://www.flrules.org/gateway/Division.asp?DivID=192>.

<sup>8</sup> See [https://ahca.myflorida.com/medicaid/review/specific\\_policy.shtml](https://ahca.myflorida.com/medicaid/review/specific_policy.shtml).

## GEORGIA

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### Types of Facilities

*Mental Health (MH) and Substance Use Disorder (SUD):* Georgia regulates or otherwise oversees:

- Crisis Stabilization Unit (CSU) is a medically monitored short-term residential program which is an emergency receiving and evaluating facility to provide emergency services that include psychiatric stabilization and detoxification services. The average annual length of stay is no more than 8 days. The CSU may not operate solely as a 24 hour residential service offering detoxification. The CSU is designed to serve as a first-line alternative to hospitalization. The target population is ages 18 years or older; individuals may have co-occurring diagnoses. The following may be components of a CSU:
  - Crisis Service Center (CSC): Provides short-term intervention that is time limited, generally a single episode that stabilizes the individual and moves them to the appropriate level. CSCs are generally open 24 hours, 7 days a week and provide walk-in capacity for assessment, stabilization, and referral.
  - Temporary Observation (Temp Obs): A facility-based program that provides a physically secure and medically safe environment during which an individual in crisis is further assessed, stabilized, and referred to the next appropriate level of care.
  - CSUs may include Transitional Beds which are used for individuals on a voluntary status who are transferred from a crisis bed but who remain within the CSU in a transitional bed during transition into the community.

*Substance Use Disorder (SUD):* Georgia regulates or otherwise oversees:

- Residential Substance Withdrawal Management (Detoxification) is an organized and voluntary service that provides 24-hour per day, 7 days per week supervision, observation, and support during withdrawal. It is characterized by its emphasis on medical monitoring and should reflect a range of residential withdrawal management service that intensifies from ASAM Level 3.7 Medically Monitored.
- AD Semi-Independent Residential Services provide or coordinate on-site or off-site treatment services in conjunction with on-site recovery support programming that aligns with a supportive and structured living environment. It is designed to strengthen living skills and focus on creating financial, environmental, and social stability to increase the

probability of long-term recovery. Residential Care maintains a basic rehabilitation focus on early recovery skills; including the negative impact of substances, tools for developing support, and relapse prevention skills.

- AD Intensive Residential Service (associated with ASAM Level 3.5) provides a planned regimen of 24 - hour observation, monitoring, treatment and recovery supports utilizing a multi-disciplinary staff for individuals who require a supportive and structured environment. This intensive level of residential service maintains a basic rehabilitative focus on early recovery skills; including the negative impact of substances, tools for developing support, and relapse prevention skills.
- Residential Transitional Treatment Program is a residential program which provides therapeutic services to persons with SUD, who are transitioning to the community or to other treatment modalities, and who typically lack a stable living situation and require variable levels of therapeutic services.
- Women's Treatment and Recovery Support (WTRS) Residential Treatment is a subset of the residential services in these levels of treatment.

*Unregulated Facilities:* Regulations and licensure requirements do not exist for any adult MH-specific (non-crisis) residential treatment. Even though SUD treatment providers not under contract to DBHDD are not regulated by that agency, they must be licensed and regulated by HFR. We exclude, as not within the scope of this summary, Community Residential Rehabilitation levels I-IV; MH Independent, Semi-Independent, and Intensive Residential Services; AD Independent Residential Services; and Crisis Respite Apartments, because they do not include required in-house clinical treatment.

## **Approach**

*Mental Health (MH) and Substance Use Disorder (SUD):* The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) provides both MH and SUD services to the citizens of Georgia through providers contracted with the department. The DBHDD establishes requirements via contract with providers and via its Provider Manual for Community Behavioral Health Providers. In addition to contracted providers, these standards also apply to obtain Medicaid reimbursement. The DBHDD also regulates and licenses CSUs and may designate them as an emergency receiving and evaluating facility.

*Substance Use Disorder (SUD):* In addition to oversight of SUD providers under contract with the DBHDD by that department, the Georgia Department of Community Health, Division of Healthcare Facility Regulation (HFR), regulates and licenses all SUD residential treatment programs, other than CSUs (discussed above) or licensed Narcotic Treatment Programs.

## **Processes of Licensure or Certification and Accreditation**

*Mental Health (MH) and Substance Use Disorder (SUD):* Licensure by the DBHDD is required for all CSUs and their associated CSC and Temp Obs functions.

- Accreditation is not required but, if a CSU does have accreditation otherwise required, documentation is required as part of licensure.
- An inspection is required for licensure and renewal and may be announced or unannounced.
- The state does not require a Certificate of Need.
- Initial licensure duration is one year and subsequent licensure is for two years.

*Substance Use Disorder (SUD):* All SUD treatment programs must be licensed by the HFR to operate in the state.

- Accreditation is not required but the HFR may issue a license to a program that provides proof of accreditation by an HFR-approved accreditation agency.
- Onsite inspection is required prior to the HFR granting any type of license unless a facility is granted licensure due to approved accreditation.
- The state does not require a Certificate of Need.
- Licensure is required for a “period determined by the department” (fees are annual). A provisional license may be issued for up to 90 days.

## **Cause-Based Monitoring**

*Mental Health (MH) and Substance Use Disorder (SUD):* The DBHDD has the authority to conduct announced or unannounced on-site reviews at its discretion at any time or as part of the investigation of complaints or incidents at a CSU. The Department shall issue written findings within a reasonable period of time. Based on its findings of the review, the Department may require corrective action. A CSU license also may be denied, suspended, or revoked, and admissions may be suspended. Other sanctions also may be imposed.

*Substance Use Disorder (SUD):* Licenses may be denied, suspended, or revoked and inspections, typically unannounced, may occur at any time. If deficiencies are found, a plan of correction will be required. Fines and other sanctions may be imposed. The HFR also reserves the right to

inspect accredited programs on a sample validation basis or whenever there is reason to believe that the regulatory requirements are not being met.

## **Access Requirements**

*Mental Health (MH) and Substance Use Disorder (SUD):* A CSU may not refuse service to receive, evaluate, or stabilize any individual who meets criteria for services. The CSU and any associated CSC and/or Temp Obs must provide emergency receiving, screening, and evaluation services 24 hours a day, 7 days a week and have the ability to admit and discharge 7 days a week.

*Substance Use Disorder (SUD):* The HFR requires that drug dependent pregnant females must be given priority for admission and services when a program has a waiting list for admissions. Programs under contract with DBHDD have extensive requirements related to nondiscrimination and physical or linguistic accessibility in the provision of SUD residential treatment. DBHDD also sets priority treatment standards for pregnant women, women with children, and intravenous drug users.

- **WTRS Residential:** Providers must maintain a waiting list. All individuals placed on the waiting list should be contacted at least twice a month. If the provider has a priority admission on the waiting list, interim services must be offered and documentation provided monthly to the state office. When a pregnant woman is seeking services, the agency is required to give her preference in admission or on the waiting list. If the provider has insufficient capacity to provide services to any such pregnant woman, the provider is required to refer the pregnant woman to the DBHDD Women's Treatment Coordinator. The provider is required to make interim services available within 48 hours if the pregnant woman cannot be admitted because of lack of capacity. The program is required to offer interim services that include specified minimum services related to HIV and TB and the effects of alcohol and other drugs use on the fetus and referrals for prenatal care for pregnant women.

## **Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD):* Providers must ensure an adequate staffing pattern to provide access to services. The program description identifies staff to individual served ratios for each service offered. Detailed training requirements exist, including for orientation and on-going trainings including, among others, suicide risk assessment. Detailed credential and supervision requirements are included.

- For a CSU, requirements include, among others, that a physician or psychiatrist be on call 24 hours a day and shall make rounds 7 days a week. The CSU must have a full-time

nursing administrator and additional nursing staff, with nursing to resident ratios. State-required licensing and other credentials must be in place and staff functioning within allowed scope of practice. Facilities must ensure that the type and number of professional staff attached to the unit are present in numbers to provide adequate supervision to staff and to provide services, supports, care and treatment to individuals as required. All staff, volunteers, and contractors must satisfy training requirements.

*Substance Use Disorder (SUD)*: HFR requires the governing body of the program to designate an administrator who is authorized to manage the program and a clinical director who is responsible for all treatment services provided. The program must have sufficient types and numbers of staff as required by these rules to provide the treatment and services offered to clients and outlined in its program description. Staff must satisfy certain qualifications, including those providing counseling services, medical services, and professional mental health services. Prior to working with clients, all staff who provide treatment and services must be oriented and receive additional training in accordance with the rules. Additional requirements are in place regarding staffing for the following program types:

- Residential Substance Withdrawal Management
- Residential Intensive Treatment Programs
- Residential Transitional Treatment Programs

DBHDD has additional staffing requirements for those programs with which it contracts, specifically including the following types of treatment and including staffing ratios:

- AD Intensive Residential Services
- AD Semi-Independent Residential Services
- Residential Substance Withdrawal Management
- WTRS Residential

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD)*: The CSU must have written protocols for screening individuals presenting for evaluation. Level of Care instruments defined in the DBHDD Provider Manual for Community Behavioral Health Providers will be utilized to determine the required need and resulting level of care for admission to the CSU. The CSU may not admit individuals presenting with issues listed under "Exclusion Criteria" in the DBHDD policy on medical exclusion guidelines and criteria. An initial screening for risk of suicide or



harm to others must be conducted for each individual presenting to the CSU for evaluation. A physician must assess each individual within 24 hours of admission to the CSU. A physician also must write an order for the individual's change in status from CSU crisis status to transition status.

*Substance Use Disorder (SUD):* HFR requires there be written policies and procedures to provide priority access to services and admissions to programs for drug dependent pregnant females. All persons referred to the program or who present themselves for services must be initially screened by qualified staff to determine if the prospective client appears to meet the program's admission criteria. At admission a preliminary physical assessment must be done by, at a minimum, an RN or LPN under the supervision of a RN or physician. At the time of admission or as soon as clinically appropriate (but no longer than ten working days), a comprehensive psycho-social assessment must be done. HFR regulations include additional requirements for placements specific to facility type, such as type of assessments and staff to perform them. In addition, regulations indicate the type of recipient facility types are designed to treat:

- Residential Intensive Treatment Programs: Such residences provide services for clients with significant substance abuse impairment, and who, typically, have not progressed in a less intensive setting, or lack supports and require a highly structured and specialized environment, or are transitioning from detoxification.
- Residential Transitional Treatment Programs: Such residences provide services on an intermediate basis for clients characterized as chronic substance abusers who are transitioning to the community or to other treatment modalities, and who, typically, lack a stable living situation and require variable levels of therapeutic services. In addition to the general rules set forth, programs offering residential transitional treatment programs shall meet the requirements of this subsection.

DBHDD imposes additional requirements on its contract SUD treatment facilities, including admission, clinical exclusion, continuing stay, and discharge criteria. This includes the following facility types:

- AD Intensive Residential Service
- AD Semi-Independent Residential Services
- Residential Substance Withdrawal Management
- WTRS Residential: Admission Criteria: The Level of Care must be determined according to the American Society of Addiction Medicine (ASAM) 3rd edition for assessing severity and intensity of services and the Adult Needs and Strengths Assessment (ANSA).

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* An Individualized Recovery/Resiliency Plan (IRP) must be developed and reassessed as indicated but at least annually. Discharge planning must begin at the onset of service delivery.

- At CSUs, orders for care shall include the clinically appropriate level of observation for the individual. An IRP must be developed and written within 72 hours of admission on the basis of assessments conducted by the physician, registered nurse and professional social work or counseling staff. For individuals with both SUD and MH diagnoses, the IRP must address issues relative to both diagnoses. The IRP must be reviewed at a minimum every 72 hours by a treatment team to assess the need for the individual's continued stay. The IRP must be updated as appropriate when the individual's condition or needs change. The CSU must have protocols with respect to stabilization and transfer of individuals to a different level of care. The patient's records must include discharge notes and aftercare plans, including the individual's status at discharge, ongoing needs, aftercare plan, and the date, time and method of discharge.

*Substance Use Disorder (SUD):* HFR requires SUD treatment programs to develop and implement a complete individualized treatment plan for each client. Such treatment plans must be modified and updated as necessary, depending on the clients' needs. An initial treatment plan will be formulated at the time of admission after assessment (within a minimum of ten working days) and will include the initial treatment recommendation for the client. The complete treatment plan must be comprehensive, formulated by a multi-disciplinary team with the input of the client, approved by the clinical director, and completed within thirty days from admission. Plans shall be reviewed and updated, as needed, by the staff member who has primary responsibility for coordinating or providing for the care of the client. Reviews shall be done whenever necessary as indicated by the client's needs or at least every 30 days for residential. Aftercare plans for continuing services and support must be developed and completed prior to discharge. Each program must have a formal plan of cooperation with other programs in the state for referral of clients to allow for continuity of care or for emergency hospitalization. The licensed programs must have identified resources that would be available to continue the person's care and to have worked out referral/transfer arrangements where appropriate.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* CSU psychiatric stabilization and residential detoxification services are offered at a clinical intensity level which supports the level of care in DBHDD contracts and the DBHDD Provider Manual for Community Behavioral Health Providers. The CSU must have policies and procedures for identifying and managing

individuals who meet the diagnostic criteria for an SUD and individuals at high risk of suicide or intentional self-harm. Program offerings for the CSU must be designed to meet the biopsychosocial stabilization needs of each individual, and the therapeutic content of the program (group therapy/training, individual therapy/training, education support, etc.) must be annually approved by a licensed/certified clinician. Requirements for physician assessment also are in place. Consultation by a psychiatrist shall be available if the covering physician is not a psychiatrist. The CSU must assist in the coordination of necessary transportation through transfer and/or discharge to community-based services. A CSU must pursue with due diligence operating agreements in writing, with one or more healthcare providers, to provide care that is beyond its scope, as elaborated in the regulations. Individuals served in transitional beds may access an array of community-based services in preparation for their transition out of the CSU and are expected to engage in community-based services daily while in a transitional bed.

DBHDD also has a High Utilizer Management (HUM) service that provides support to individuals who experience challenges and barriers in accessing and remaining enrolled in desired community-based services and supports. The criteria for receipt of these services include that the person be an adult with a primary SUD, MH, or co-occurring diagnosis who has been admitted to a crisis setting meeting certain frequency rates; and/or other specified crisis utilization indicators. The HUM program identifies and provides assertive linkage, referral, and short-term care coordination for individuals with behavioral health challenges who have a demonstrated history of high crisis service utilization.

*Substance Use Disorder (SUD):* HFR requires that SUD residential treatment programs have policies and procedures that include a description of the range of treatment and services provided by the program to be reviewed annually and updated as needed, specifying which American Society of Addiction Medicine (ASAM) levels of care will be offered, what services will be provided directly by the program, and what services are provided in cooperation with available community or contract resources. A licensed program must provide certain services related to HIV/AIDS education and must conduct random urine drug screens. HFR regulations specific to the following facility types include requirements regarding services and, other than for withdrawal management, hours of services required:

- Residential Substance Withdrawal Management
- Residential Intensive Treatment Programs
- Residential Transitional Treatment Programs

Additional requirements are in place for programs contracting with DBHDD, including types and quantity of required services for the following:

- AD Intensive Residential Service
- AD Semi-Independent Residential Services

- WTRS Residential: This program provides services that encompass ASAM level 3.1 Clinically Managed Low -Intensity Residential Services and 3.5 Clinically Managed High-Intensity Residential Services level of care and Therapeutic ChildCare, depending on the location of the WTRS service. Evidence Based Practices and curriculums are to be utilized and practitioners providing these services are expected to maintain knowledge and skills regarding current research trends in best evidence-based practices. If a WTRS provider cannot accommodate a pregnant woman within 48 hours, interim services must be provided until a bed is available.

## **Patient Rights and Safety Standards**

*Mental Health (MH) and Substance Use Disorder (SUD):* At CSUs, restrictions apply to personal searches of individuals. Restraint and seclusion are restricted to emergency safety interventions of last resort. Chemical restraint is prohibited. The CSU must safeguard the rights of individuals treated pursuant to applicable state laws and rules and regulations. The CSU must maintain and provide a written statement of rights and responsibilities for individuals receiving services. Among other things, rights include confidentiality. Critical incidents must be reported to DBHDD and other incidents and complaints not required to be reported must be documented and investigated in accordance with policies.

*Substance Use Disorder (SUD):* HFR requires that all SUD treatment programs establish and implement written policies and procedures regarding the rights and responsibilities of clients, and the handling and resolution of complaints. Among others, rights include humane treatment, freedom from abuse, freedom from restraint or seclusion unless it is determined that there are no less restrictive methods of controlling behavior to reasonably ensure the safety of the client and other persons, confidentiality, communication, and grievance/complaint. Regulations govern emergency safety interventions. Written summary reports and detailed investigative reports shall be made to the HSR regarding serious occurrences involving clients that happened either at the facility or were connected with the care that the client received at the facility. Programs under contract with the DBHDD have additional obligations regarding service recipient rights including, but not limited to, that grievance, complaint and appeals of internal and external policies and processes are clearly written in language accessible to individuals served and are promulgated and consistent with all applicable DBHDD policies. Personal restraints (also known as manual restraints) are restricted to limited situations in these residential settings. Chemical restraints are never allowed. Both physical (also known as mechanical) restraint and seclusion are restricted and limited to CSUs.

## Quality Assurance or Improvement

*Mental Health (MH) and Substance Use Disorder (SUD):* Providers must have a well-defined quality improvement plan for assessing and improving organizational quality. Detailed requirements are in place including but not limited to that the plan be reviewed/updated at least annually and that indicators of performance are in place for assessing and improving organizational quality. Quality improvement findings must be distributed on a quarterly basis to specified individuals. The provider must participate in DBHDD consumer satisfaction and perception of care surveys for all identified populations.

- CSUs have specific reporting requirements and must put in place a quality assurance plan that is updated annually with a quarterly report required. The plan must meet specific regulatory requirements including, among others, the use of performance measures and data collection that continually assess and improve the quality of the services being delivered.

*Substance Use Disorder (SUD):* The HFR requires that written policies and procedures for an ongoing quality assurance process be established and implemented. Such process shall identify areas of treatment or treatment problems to be addressed; establish and monitor criteria by which the quality and appropriateness of the treatment are to be measured; analyze the outcomes; make recommendations for change, as needed; and monitor changes to ensure problem resolution. A qualified staff person is responsible for administering and coordinating the quality assurance process and, if the program provides medical services, the medical director must be actively involved.

## Governance

*Mental Health (MH) and Substance Use Disorder (SUD):* A governing body is required that is legally responsible for operation of the CSU and any associated CSC and/or Temp Obs functions. Specific policies and procedures must be established.

*Substance Use Disorder (SUD):* HFR requires each licensed program to have a clearly identified governing body and provisions are in place for program officers. A licensed program must develop and implement specified written policies and procedures for operations.

## Special Populations

*Mental Health (MH) and Substance Use Disorder (SUD):* The CSU must give priority consideration to serving individuals without private health care coverage.

*Substance Use Disorder (SUD)*: HFR requires that, when the program serves persons with special needs, the policies and procedures must explain how those special needs will be met. Written policies and procedures must be developed for providing priority access to services and admissions for drug dependent pregnant females. DBHDD also sets priority treatment standards for pregnant women, women with children, and intravenous drug users, in programs contracting with the department.

## **Location of Regulatory and Licensing Requirements**

Rules And Regulations for Drug Abuse Treatment and Education Programs<sup>1</sup>; Licensing Regulations<sup>2</sup>; DBHDD Provider Manual for Community Behavioral Health Providers<sup>3</sup>; Adult Crisis Stabilization regulations<sup>4</sup>; CSU statutes<sup>5</sup>; Patients' Rights regulations<sup>6</sup>; DBHDD Provider Manual for Community Behavioral Health Providers<sup>7</sup>. Regulatory data collected September 3, 2019.

## **Other Information Sources**

Y. Makanjuola (GADBHDD), D. Atkins (DBH), T. Timberlake (DBH), T. Kight (DBH), J. Mays (DBH); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>1</sup> See <http://rules.sos.state.ga.us/gac/111-8-19>.

<sup>2</sup> See <http://rules.sos.state.ga.us/GAC/111-8-25>.

<sup>3</sup> See <http://dbhdd.org/files/Provider-Manual-BH.pdf>.

<sup>4</sup> See <http://rules.sos.state.ga.us/gac/82-3-1?urlRedirected=yes&data=admin&lookingfor=82-3-1>.

<sup>5</sup> See <https://codes.findlaw.com/ga/title-37-mental-health/ga-code-sect-37-1-29.html>.

<sup>6</sup> See <http://rules.sos.state.ga.us/GAC/290-4-9>.

<sup>7</sup> See <http://dbhdd.org/files/Provider-Manual-BH.pdf>.

# GEORGIA MEDICAID

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## Approach

*Mental Health (MH) and Substance Use Disorder (SUD):* The Georgia Department of Community Health (DCH) oversees the state Medicaid program. The state does not have a relevant section 1115 waiver that affects reimbursement of residential services in Institutions for Mental Diseases (IMDs). Georgia also historically has not relied on either the in lieu of provision or on Disproportionate Share Hospital (DSH) payments to reimburse certain services in IMDs.

Researchers did not locate Medicaid regulations specifically applicable to adult behavioral health MH or SUD services in residential treatment facilities. Rather, the DBHDD establishes requirements for residential MH and SUD treatment providers, that are either reimbursed via Medicaid or that contract with the department. The DBHDD establishes those requirements via contract with providers and via its Provider Manual for Community Behavioral Health Providers. The requirements summarized above applicable to providers under contract with the DBHDD also apply to Medicaid enrolled providers.

## Types of Facilities

*Mental Health (MH) and Substance Use Disorder (SUD):* See above regarding residential facilities that may contract with the DBHDD.

## Processes of Medicaid Enrollment

*Mental Health (MH) and Substance Use Disorder (SUD):* Providers who wish to be part of the Georgia Medicaid program must be appropriately licensed under Georgia law. To enroll as a Medicaid provider, a provider must complete the DBHDD Application and the Medicaid Provider Enrollment packet. The DBHDD recommends providers for approval or denial of enrollment to the DCH. The provider must be fully and appropriately nationally accredited by one of the following: The Joint Commission on Accreditation for Healthcare Organizations (TJC), Commission on Accreditation for Rehabilitation Facilities (CARF), Council on Accreditation of Services for Children and Families, Inc.(COA), or the Council on Quality Leadership (CQL).

## Location of Medicaid Requirements

Georgia Medicaid Rules and Regulations<sup>8</sup>; Georgia Medicaid Provider Enrollment Guide<sup>9</sup>; Georgia Medicaid Part II Policies and Procedures for Community Behavioral Health and Rehabilitation Services<sup>10</sup>; DBHDD Provider Manual for Community Behavioral Health Providers<sup>11</sup>. Regulatory data collected December 2019.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019. <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report “**State Residential Treatment for Behavioral Health Conditions: Regulation and Policy**”. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

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<sup>8</sup> See <http://rules.sos.state.ga.us/gac/111-3>.

<sup>9</sup> See [https://dch.georgia.gov/sites/dch.georgia.gov/files/related\\_files/site\\_page/Medicaid-Provider-Enrollment-Guide-2011.pdf](https://dch.georgia.gov/sites/dch.georgia.gov/files/related_files/site_page/Medicaid-Provider-Enrollment-Guide-2011.pdf).

<sup>10</sup> See <https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/HANDBOOKS/Community%20Behavioral%20Health%20Rehabilitation%20Services%2020200103120205.pdf>.

<sup>11</sup> See <http://dbhdd.org/files/Provider-Manual-BH.pdf>.



## HAWAII

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### Types of Facilities

*Mental Health (MH) and Substance Use Disorder (SUD):* Hawaii regulates one facility type:

- A *Special Treatment Facility (STF)* is defined as a facility “which provides a therapeutic residential program for care, diagnoses, treatment or rehabilitation services for socially or emotionally distressed persons, mentally ill persons, persons suffering from substance abuse, and developmentally disabled persons.”
  - Included on a list of accredited STFs were two detoxification facilities.

*Unregulated Facilities:* There are no unregulated STFs in the state. The Hawaii DOH Adult Mental Health Division website<sup>1</sup> references Licensed Crisis Residential Services, but no separate regulations were located for those, suggesting that they fall under the STF licensure regulations. The DOH Alcohol and Drug Abuse Division website<sup>2</sup> indicates that it provides “accreditation of substance abuse treatment programs,” but researchers did not locate regulations or policies regarding that process. The Hawaii Office of Health Care Assurance website<sup>3</sup> also links to regulations for Adult Residential Care Homes, which do not appear to be treatment facilities and are therefore excluded from this summary.

### Approach

*Mental Health (MH) and Substance Use Disorder (SUD):* Researchers located Department of Health (DOH) licensing regulations<sup>4</sup> for Special Treatment Facilities (STFs) which are residential facilities providing treatment for mental or substance use conditions (defined above). The DOH Office of Planning Policy and Program Development website<sup>5</sup> indicates that those regulations (11-98) will be repealed and replaced with new regulations (11-98-1). This summary uses the existing rules. The Office of Planning Policy and Program Development website also indicates that regulations will be promulgated (11-92) for Therapeutic Living Programs (TLPs). Those

<sup>1</sup> See <https://health.hawaii.gov/amhd/files/2013/06/SCR117-Appendix-2.pdf>.

<sup>2</sup> See <https://health.hawaii.gov/substance-abuse/>.

<sup>3</sup> See <http://health.hawaii.gov/ohca/type-of-hawaii-state-licensed-and-or-federal-certified-facilities-or-agencies/>.

<sup>4</sup> See <https://health.hawaii.gov/opppd/files/2015/06/11-98.pdf>.

<sup>5</sup> See <https://health.hawaii.gov/opppd/department-of-health-administrative-rules-title-11/>.

regulations are not yet in place and, therefore, TLPs are not included in this summary. The Hawaii Office of Health Care Assurance website<sup>6</sup> indicates that TLPs are regulated as STFs, although those regulations do not include a definition of TLPs.

## **Processes of Licensure or Certification and Accreditation**

*Mental Health (MH) and Substance Use Disorder (SUD):*

- For STFs, licensure by the Department of Health is required for operation. Licensure duration is one year, at which time a renewal application is required. A renewal application must be submitted 90 days prior to the anniversary date of the license. In order to obtain licensure, a facility must provide county building department, county zoning, county fire department, and sanitation branch clearances, as well as submit to a survey of the facility by the Office of Health Care Assurance branch of the department. Should any deficiencies be found, an acceptable plan of correction must be submitted.
- No requirements related to facility accreditation were found.
- A Certificate of Need is required.

## **Cause-Based Monitoring**

*Mental Health (MH) and Substance Use Disorder (SUD):* The department may require a monthly, quarterly, or annual summary report to recap program activities. In addition to any other appropriate action to enforce state regulations, the director may initiate procedures for invoking fines, or to withdraw the license, or both. Infractions subject to these actions include, but are not limited to: (1) Operation of a special treatment facility without a license granted by the department; and (2) Substantive violations of state regulations which are found as a result of routine or unannounced inspection of a special treatment facility which has a license.

## **Access Requirements**

*Mental Health (MH) and Substance Use Disorder (SUD):* Requirements regarding residential services were not explicitly described in the state regulations.

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<sup>6</sup> See <http://health.hawaii.gov/ohca/type-of-hawaii-state-licensed-and-or-federal-certified-facilities-or-agencies/>.

## **Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD):* All facilities are required to develop written personnel policies, procedures, and practices, “including the qualifications, duties and responsibilities for each staff position, hiring, suspension, dismissal, assignment, promotion, grievance procedures and other related personnel matters.” As part of licensure requirements, there shall be a facility administrator who will be responsible for the overall operation of the program/facility and a program director for the residential program.

There shall also be a sufficient number of trained and qualified staff to meet resident needs and program requirements, and there shall be a minimum 1:8 staff to resident ratio. All staff shall have a preemployment and annual health evaluation by a physician. Additionally, the administrator shall arrange for staff development that includes orientation and training.

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* Every STF must have a current written plan that includes a statement of the geographic area to be served, ages and kinds of residents to be served, anticipated average length of stay of its residents, and the limitations and scope of service for which the facility is established. Within 21 days of admission, a report of a resident's medical examination or written evidence of a physical examination within the prior twelve months shall be on file.

Researchers did not locate reference to ASAM or LOCUS requirements.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Within 30 days of admission, a written individualized rehabilitation plan with specific objectives, which are measurable and subject to evaluation, shall be prepared by an appropriate rehabilitation staff in cooperation with each resident. The plans shall include: (A) Those services planned for meeting the resident's needs; (B) Referrals for services not provided by the program; (C) How the resident will participate in the development of the plan; (D) Regular review and necessary update by staff and resident at least monthly; and (E) The staff person responsible for monitoring the plan implementation.

Additional requirements as part of licensure are the creation of a discharge summary or transfer summary. This summary will include the following: (A) The reason for the discharge or transfer, if identifiable; (B) Documentation that a guardian, when applicable, has been notified prior to discharge or transfer. This provision may be waived in emergency situations but in this case the guardian must be notified as soon as practical. If the resident leaves without permission of the administrator, the guardian shall be notified promptly; (C) Current physical

and emotional status report of the resident; (D) Plans or goals for the resident; and (E) Current diet, medication, and activity as applicable.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* For all facilities, rehabilitation services shall be appropriate to the individual in the facility and may include: (1) Psychiatric services to provide care or program consultation; (2) Psychological services to provide testing for individual assessment purposes, program evaluation and research; (3) If the staff feels it to be advisable for a resident, or residents, to receive nutritional instruction, a dietitian shall be consulted; (4) Social rehabilitation services to provide opportunities for individuals to learn social and self-care skills to foster independent living and which may include recreational, educational and vocational activities; (5) Education services for children to provide and meet the scholastic requirements for school age children and youth; (6) Counseling; and (7) Other services to provide for planned leisure time activities and constructive therapeutic activities that enhance social and motor skills.

## **Patient Rights and Safety Standards**

*Mental Health (MH) and Substance Use Disorder (SUD):* Administrative and statistical reports are required to be developed and submitted to the department, including written occurrences of fire safety and disaster drills for inspection and detailed incident reports of any bodily injury to a resident written by a person responsible for the resident at the time of the accident.

Written policies regarding the rights and responsibilities of residents and services to be provided to residents during their stay in the facility shall also be established and made available to the resident, to any guardian, next of kin, sponsoring agency or representative payee, and to the public. The facility's policies and procedures shall provide that each individual admitted to the facility shall: (1) Be fully informed, documented by signed acknowledgment prior to or at the time of admission and during stay, of these rights and of all rules governing resident conduct; and (2) Be fully informed, prior to or at the time of admission and during stay, of services available in or through the facility and of related charges, including any charges for services not covered by the facility's basic per diem rate.

Researchers did not locate any regulations related to restraint or seclusion.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* As a condition of licensure, facilities are required to develop a written statement of the program's goals and objectives. This statement

shall serve as the basis for program evaluation. The evaluation plan shall include: mechanisms for assessing the attainment of the program's goals and objectives; mechanisms for documenting program achievements not related to original goals and objectives; mechanisms for assessing the effective utilization of staff and program resources toward the attainment of the program's goals and objectives; and criteria to be applied in determining whether established goals and objectives are achieved. The plan shall be reviewed and updated at least annually. It should be available to all facility personnel and the Department, and the results shall become part of the continuous planning process.

## **Governance**

*Mental Health (MH) and Substance Use Disorder (SUD):* Requirements regarding residential services were not explicitly described in the state regulations.

## **Special Populations**

*Mental Health (MH) and Substance Use Disorder (SUD):* Requirements regarding residential services were not explicitly described in the state regulations.

## **Location of Regulatory and Licensing Requirements**

Hawaii Title 11, Department of Health, Chapter 98, Special Treatment Facility<sup>7</sup>; Hawaii Accredited Special Treatment Facilities<sup>8</sup>. Regulatory data collected May 17, 2019.

## **Other Information Sources**

J. Lam (DOH); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>7</sup> See <https://health.hawaii.gov/opppd/files/2015/06/11-98.pdf>.

<sup>8</sup> See <https://health.hawaii.gov/substance-abuse/files/2018/10/AccreditedTreatmentFacility2017-2019.pdf>.

# HAWAII MEDICAID

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## Approach

*Mental Health (MH) and Substance Use Disorder (SUD):* The Hawaii Department of Human Services (DHS) oversees the state Medicaid program. Specialized behavioral health services may be provided under the Hawaii Behavioral Health Managed Care (BHMC) Plan for enrollees with serious mental illness (SMI). Hawaii does rely on the in lieu of provision to pay for some services provided in IMDs, but not on Disproportionate Share Hospital (DSH) payments. Hawaii's current Section 1115 waiver does not allow for reimbursement for services in an IMD.

## Types of Facilities

*Mental Health (MH) and Substance Use Disorder (SUD):* Hawaii offer specialized behavioral health services in community-based residential programs and crisis residential services, neither of which are defined.

## Processes of Medicaid Enrollment

*Mental Health (MH) and Substance Use Disorder (SUD):* Providers who wish to be part of the fee for service program must apply to be certified to participate, supply all required information, maintain all appropriate licensure, and enter into a provider agreement with the Medicaid agency. Providers may have enrollment denied, suspended, or terminated.

## Staffing

*Mental Health (MH) and Substance Use Disorder (SUD):* Requirements regarding residential services were not explicitly described in the state Medicaid regulations.

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* Requirements regarding residential services were not explicitly described in the state Medicaid regulations.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Requirements regarding residential services were not explicitly described in the state Medicaid regulations.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Requirements regarding residential services were not explicitly described in the state Medicaid regulations.

## **Care Coordination**

*Mental Health (MH) and Substance Use Disorder (SUD):* Requirements regarding residential services were not explicitly described in the state Medicaid regulations.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* Requirements regarding residential services were not explicitly described in the state Medicaid regulations.

## **Special Populations**

*Mental Health (MH) and Substance Use Disorder (SUD):* Requirements regarding residential services were not explicitly described in the state Medicaid regulations.

## **Location of Medicaid Requirements**

HAWAII DEPARTMENT OF HUMAN SERVICES ADMINISTRATIVE RULES, HRS Chapter 91, TITLE 17<sup>9</sup>; Hawaii Behavioral Health Services Manual<sup>10</sup>. Regulatory data collected January 6, 2020.

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<sup>9</sup> See <http://humanservices.hawaii.gov/admin-rules-2/admin-rules-for-programs/>.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019. <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report “**State Residential Treatment for Behavioral Health Conditions: Regulation and Policy**”. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

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<sup>10</sup> See <https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/Provider-Resources/provider-manuals/PMChp15.pdf>.



# IDAHO

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## **Types of Facilities**

*Mental Health (MH):* Regulated adult MH treatment services in a residential, nonhospital setting were not identified in Idaho.

*Substance Use Disorder (SUD):* Idaho administers and oversees the following SUD residential treatment services:

- Residential Treatment Services for Adults: A residential treatment program that provides living accommodations in a structured environment for adults who require twenty-four (24) hour per day, seven (7) days a week, supervision.
- Residential Withdrawal Management: Residential withdrawal management programs must provide living accommodations in a structured environment for individuals who require twenty-four (24) hour per day, seven (7) days a week, supervised withdrawal management services.

*Unregulated Facilities:* Facilities that provide residential services not requiring use of state funds would not be regulated. We exclude from this summary mental health residential services provided in hospitals. We also exclude Idaho's Behavioral Health Community Crisis Centers from coverage in this summary, as they may not retain an individual for 24 hours, and we exclude the state's Behavioral Health Programs because they provide only outpatient services.

## **Approach**

The Idaho Department of Health & Welfare (IDHW) administers and oversees behavioral health services that are state funded. All mental health residential-type facilities, including Residential Care and Crisis Intervention Services, are provided in community hospitals with hospital regulations governing them. They are excluded from this summary. IDHW also administers and oversees residential SUD treatment services to adults meeting DBH eligibility criteria for state funded services.

## **Processes of Licensure or Certification and Accreditation**

*Substance Use Disorder (SUD):* There are no licensure, certification, or approval requirements for Adult Substance Use Disorder Services. IDHW has a Management Services Contractor which contracts with providers.

- The state does not require a Certificate of Need.

## **Cause-Based Monitoring**

*Substance Use Disorder (SUD):* Idaho does not have regulations specific to SUD treatment services requiring cause-based monitoring. IDHW staff indicate that contractual requirements govern.

## **Access Requirements**

*Substance Use Disorder (SUD):* Residential withdrawal management services must be available continuously twenty-four (24) hours per day, seven (7) days per week.

## **Staffing**

*Substance Use Disorder (SUD):* Provider staff are subject to background checks. The general SUD regulations establish credential/license requirements for professionals and trainees.

- Residential Treatment Services for Adults must have qualified staff to maintain appropriate staff to participant ratios. The program must have one (1) qualified substance use disorders professional staff member for every ten (10) participants. The program must have other staff sufficient to meet the ratio of one (1) staff person to twelve (12) participants continuously, twenty-four (24) hours per day.
- Residential Withdrawal Management must have: Each withdrawal management program must have twenty-four (24) hour per day, seven (7) days a week, trained personnel staff coverage. A minimum staff to participant ratio of one (1) trained staff to six (6) participants must be maintained twenty-four (24) hours per day, seven (7) days a week. Each staff member responsible for direct care during withdrawal management must have completed CPR training, a basic first-aid training course, and additional training specific to withdrawal management prior to being charged with the responsibility of supervising participants.

## **Placement**

*Substance Use Disorder (SUD):* To receive any SUD services through IDHW, an eligibility screening is required, followed by a clinical assessment. To be eligible for SUD services through a voluntary application to IDHW, the applicant must meet income and residency requirements, be a member of a priority population, meet SUD diagnostic criteria, and meet specifications in each of the ASAM dimensions required for the recommended level of care.

## **Treatment and Discharge Planning and Aftercare Services**

*Substance Use Disorder (SUD):* Researchers did not locate treatment planning or discharge planning or aftercare service requirements.

## **Treatment Services**

*Substance Use Disorder (SUD):*

- Residential Treatment Services for Adults: Services must include assessment, treatment, and referral components. The residential treatment program must have policies and procedures for medical screening, care of participants requiring minor treatment or first aid, and handling of medical emergencies. These provisions must be approved by the staff and consulting physician. The residential treatment program must have written provisions for referral or transfer to a medical facility for any person who requires nursing or medical care. Recreational activities must be provided for the participants.
- Residential Withdrawal Management: Each withdrawal management program must have clear written policies and procedures for the withdrawal management of participants. The policies and procedures must be reviewed and approved by a medical consultant with specific knowledge of best practices for withdrawal management. The level of monitoring of each participant or the physical restrictions of the environment must be adequate to prevent a participant from causing serious harm to self or others. Each withdrawal management program must have provisions for any emergency care required.

## **Patient Rights and Safety Standards**

*Substance Use Disorder (SUD):* Researchers did not locate patient rights requirements in regulations.

## **Quality Assurance or Improvement**

*Substance Use Disorder (SUD)*: Researchers did not locate quality assurance or improvement planning requirements in the regulations. IDHW staff indicate that contractual requirements govern.

## **Governance**

*Substance Use Disorder (SUD)*: Researchers did not locate requirements related to governance.

## **Special Populations**

*Substance Use Disorder (SUD)*: Researchers did not locate requirements related to special populations. IDHW staff indicate that contractual requirements govern priority services and requirements as dictated by Block Grant requirements.

## **Location of Regulatory and Licensing Requirements**

IAC 16.07.33 Adult Mental Health Services regulations, IAC 16.07.17 Substance Use Disorders Services regulations<sup>1</sup>. Regulatory requirements reviewed April 7, 2019.

## **Other Information Sources**

Clark and H. Walund (IDHW); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>1</sup> See <https://adminrules.idaho.gov/rules/current/16/index.html>.

# IDAHO MEDICAID

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## Approach

The Idaho Department of Health & Welfare (IDHW) oversees the state Medicaid program. Idaho does not have a relevant Section 1115 waiver that affects reimbursement of residential services in Institutions for Mental Diseases (IMDs). It historically has not relied on Disproportionate Share Hospital (DSH) payments or the in lieu of provision to reimburse certain services in IMDs. The state does have a pending application for a Section 1115 waiver that would expand coverage to include treatment of SMI/SED and/or SUD in IMDs (residential and inpatient).

## Types of Facilities

*Mental Health (MH) or Substance Use Disorder (SUD):* No evidence of Medicaid coverage of MH or SUD residential treatment facilities for adults was located.

## Processes of Medicaid Enrollment

*Mental Health (MH) and Substance Use Disorder (SUD):* To become a Medicaid provider in Idaho, one must apply and supply necessary information and enter into a provider agreement. Provider agreements can be denied or terminated. Applicable licensing must be in place.

## Staffing

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based staffing requirements for residential treatment facilities for adults was located.

## Placement

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based placement requirements for residential treatment facilities for adults was located.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based treatment or discharge planning or aftercare service requirements for residential treatment facilities for adults was located.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based treatment service requirements for residential treatment facilities for adults was located.

## **Care Coordination**

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based care coordination requirements for residential treatment facilities for adults was located.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based quality assurance or improvement requirements for residential treatment facilities for adults was located.

## **Special Populations**

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based special population requirements for residential treatment facilities for adults was located.

## **Location of Medicaid Requirements**

Idaho Medicaid Rules and Regulations<sup>2</sup>. Regulatory data collected December 2019.

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<sup>2</sup> See <https://adminrules.idaho.gov/rules/current/16/index.html>.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

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## ILLINOIS

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### Types of Facilities

*Mental Health (MH):* Illinois regulates Specialized Mental Health Rehabilitation Facilities (SMHRFs) that provide at least one of four services, three of which are residential and are listed below. The facility shall provide a 24-hour program that provides intensive support and recovery services designed to assist persons, 18 years or older, with mental disorders to develop the skills to become self-sufficient and capable of increasing levels of independent functioning.

- **Crisis Stabilization Units (CSUs):** A secure and separate unit that provides short-term behavioral, emotional, or psychiatric crisis stabilization as an alternative to hospitalization or re-hospitalization for consumers from residential or community placement. Crisis stabilization units provide safety, structure and the support necessary, including peer support, to help a consumer to stabilize a psychiatric episode. CSUs serve consumers no longer than 21 days.
- **Recovery and Rehabilitation Supports (RRSs):** A unit with a program that facilitates a consumer's longer-term symptom management and stabilization while preparing the consumer for transitional living units or transition to the community by improving living skills and community socialization. The duration of stay in this setting is based on the clinical needs of the consumer.
- **Transitional Living Units for 3 or more persons (TLUs):** Transitional living units provide assistance and support to consumers with mental illnesses who have not yet acquired, or who have lost previously acquired, skills needed for independent living and are in need of and can benefit from services in a structured, supervised setting in which the consumer can acquire and practice these skills. The maximum length of stay at a transitional living unit is 120 days, and no unit may be larger than 16 beds.

*Substance Use Disorder (SUD):* Illinois regulates the following levels of care, all of which may be provided in a residential setting in Illinois and all of which follow the corresponding ASAM levels, including hours of service per week:

- **Level 3.1: Clinically Managed Low-Intensity Residential Services, also known as “residential extended care”**



- Level 3.2: Clinically Managed Residential Withdrawal Management, also known as “social detox”
- Level 3.5: Clinically Managed Medium-Intensity Residential Services
- Level 3.7: Medically Monitored High Intensity Inpatient Services
- Level 4: Medically Managed Intensive Inpatient

*Unregulated Facilities:* There are no unregulated residential treatment facilities in Illinois. We exclude MH Community Integrated Living and SUD Recovery Homes because they do not incorporate clinical services within the scope of this summary.

## **Approach**

The Illinois Department of Public Health (DPH) regulates SMHRFs and the Department of Human Services (DHS) regulates SUD residential treatment facilities, regardless of ownership or funding source.

## **Processes of Licensure or Certification and Accreditation**

*Mental Health (MH):* Licensure by the DPH is required for operation of all SMHRFs, with certification as to type of unit.

- Accreditation is required by a national accreditation agency, which may be one of the following: The Joint Commission, CARF, the Healthcare Facilities Accreditation Program, or other body approved by the DPH.
- A survey is required for licensure and at least annually thereafter.
- No new SMHRFs may open and no more than 24 may exist. An existing SMHRF may close and relocate to an underserved region of the state if the facility receives a Certificate of Need.
- Provisional licensure is granted for three years after which full licensure must be obtained. The duration of full licensure is one year.

*Substance Use Disorder (SUD):* Licensure by the DHS is required for operation of all SUD treatment facilities, with the applicable ASAM level of care specified.

- Accreditation is not required.
- Inspections occur “routinely.”
- A Certificate of Need is not required.
- Licensure duration is three years.

## **Cause-Based Monitoring**

*Mental Health (MH):* Licenses may be restricted, placed on probation, revoked, refused, not renewed, or placed on administrative notice. Fines may be imposed. Plans of correction may be required. Surveys may be announced or unannounced.

*Substance Use Disorder (SUD):* Licenses may be restricted, placed on probation, suspended, revoked, or modified. Financial penalties may be assessed. The DHS may inspect at any reasonable time. The DHS also may conduct investigations and refer matters to the appropriate legal authority. Organizations may take corrective action unless emergency action is needed to protect the public interest, safety or welfare.

## **Access Requirements**

*Mental Health (MH) and Substance Use Disorder (SUD):* Wait-time requirements were not found.

*Substance Use Disorder (SUD):* Access to services will not be denied on the basis of race, religion, ethnicity, disability, sexual orientation or HIV status.

## **Staffing**

*Mental Health (MH):* All SMHRFs must have an interdisciplinary team (IDT) at all levels of service, including at a minimum, a physician and a licensed clinical social worker or a licensed clinical professional counselor, as well as the consumer, the consumer's guardian, and other professionals, including the consumer's primary service providers, particularly the staff most familiar with the consumer, and other appropriate professionals and caregivers. Facilities also have requirements related to qualifications and responsibilities for an executive director, a psychiatric medical director, a program director, qualified mental health professionals, mental health professionals, certified recovery support specialists, rehabilitation services associates, and volunteers.

All employees must have training during orientation and annually. The training must satisfy DMH standards and be consistent with nationally recognized national accreditation standards. Training must include, but not be limited to, understanding symptoms of mental illnesses; principles of evidence-based practices and emerging best practices, including trauma informed care, illness management and recovery, wellness recovery action plans, crisis prevention intervention training, consumer rights, and recognizing, preventing, and mandatory reporting of abuse and neglect.

- CSUs: Detailed requirements for staffing ratios by staff type are identified, including, among others, requirements related to mental health professionals, medical and psychiatric professionals, direct care, dietary and safety staffing. The direct care staff must meet weekly for cross-training to support professional skill development.
- RRS: Detailed requirements for staffing ratios by staff type are identified, including, among others, requirements related to mental health professionals, medical and psychiatric professionals, direct care, and dietary staffing.
- TLUs: Detailed requirements for staffing ratios by staff type are identified, including, among others, requirements related to mental health professionals, medical and psychiatric professionals, direct care, dietary and safety staffing. The treatment team must meet weekly for cross-training to support professional skill development.

*Substance Use Disorder (SUD):* All SUD residential treatment facilities have specific requirements, regarding qualifications and responsibilities, related to a medical director; professional staff including those providing clinical services or clinical assessments; other direct patient care providers; and interns. Additional requirements are in place for staff at any medically managed or monitored detoxification service. Treatment for special populations must be delivered by appropriate personnel as clinical needs indicate. All SUD treatment facilities must provide orientation training to staff within 7 days of employment that includes, among other things, an overview of the regulations, information on universal precautions, and information on confidentiality.

- Level 3 residential, excepting Residential Extended Care, has specific requirements regarding awake staff, clinical staff, and use of residents to fill staffing requirements.
- Withdrawal Management: At least two staff persons must provide 24-hour observation, monitoring and treatment, one of whom must meet certain regulatory qualification standards.
  - Medically Managed (Level IV-D): A physician must see the patient daily. The regulation requires there be at least one staff, 24 hours a day, who meets requirements as a registered nurse, a licensed practical nurse, or a certified emergency medical technician.

## Placement

*Mental Health (MH):* A CSU, RRS, or a TLU must not accept anyone with medical issues requiring active intervention or treatment, or who requires a higher level of medical care. The regulation includes a list of medical issues that disqualify a person from placement including, but not limited to having methadone dependency, unless he or she is in an accredited methadone program. Admission requires authorization to facilitate treatment in the least restrictive setting. Each consumer must receive an assessment prior to admission to a facility to determine the appropriate level of service for service delivery. Additional authorizations may be requested by the interdisciplinary team if the initial authorization has expired and the consumer continues to require treatment at a specific level of service. Standards for conducting assessments are included in the regulations. Facility-specific requirements include:

- Consumers admitted to a CSU must: (1) be diagnosed as having a serious mental illness; (2) be experiencing an acute exacerbation of psychiatric symptoms; (3) have a need for assessment and treatment within a structured, supervised therapeutic environment; and (4) be expected to benefit from the treatment provided. Exclusionary criteria also are provided.
- Consumers admitted to an RRS must need RRS care as determined by State-authorized assessment, level of service determination, and authorization criteria. Exclusionary criteria are provided, including but not limited to those with a primary diagnosis of SUD. The determination that a consumer meets the requirements must be made by the center's LPHA.
- Consumers admitted to a TLU must: (1) need transitional living assistance and support as determined by State-authorized assessment, level of service determination, and authorization criteria; (2) within the past two years, have received a minimum of 60 days of psychiatric hospital care or a minimum of 90 days of institutional care for an exacerbation of serious mental illness; (3) as a result of mental illness, lack critical ADLs or IADLs necessary for living in a less restrictive environment, and require an ongoing structured, supervised therapeutic environment to develop these skills; and (4) demonstrate an ability to generalize skills and to receive supports from a community provider for transition to a community setting. A transitional living unit may admit consumers who were hospitalized, if those consumers meet the requirements for admission. Exclusionary criteria are identified, including but not limited to those with a primary diagnosis of SUD.

*Substance Use Disorder (SUD):* All SUD residential treatment facilities must conduct a medical screening designed by the medical director to capture specified information. The medical director must designate the factors in a medical screening, including a determination of the patient's risk for HIV and tuberculosis infection, and the specific medications prescribed or used by a patient that would require physician review if such medical screening is not conducted by a

physician. The purpose of physician review is to determine the immediate need for a medical referral for a physical or psychiatric examination. If determined necessary, physician review may be by phone, facsimile transmission, or in person, and shall occur no later than 24 hours after admission to Level IV care, and within 48 hours after admission to Level III care. All pregnant women admitted for any type of detoxification shall be subject to physician review. All residents in (Levels III and IV care), excepting those in residential extended care, must undergo a physical examination within 72 hours after admission if on prescription medication or pregnant. All other patients in such care shall undergo a physical examination within 7 days after admission.

An individual face-to-face assessment must be conducted prior to admission to any level of care. The assessment must collect specific data including, but not limited to, diagnoses, an evaluation of the severity of the six dimensions established in the ASAM Patient Placement Criteria, and a recommendation for placement in Levels I-IV care as established in the ASAM Patient Placement Criteria. This must be confirmed by a physician no later than 24 hours after admission for Level IV care, and no later than 72 hours after admission for Level III care.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH):* An individualized treatment plan is required. The facility must facilitate connection to the community-based behavioral health provider or community-based provider prior to discharge to foster the development of, or maintain the treatment relationship with, the community-based behavioral health provider or community-based provider. When a consumer leaves a facility, the facility must contact the community-based behavioral health provider following the consumer's discharge from the facility to ensure that the consumer is receiving follow-up care.

- CSUs: The treatment plan must be updated at least every seven days and whenever there is a change in the consumer's clinical function that has prompted a re-assessment. All discharge planning must commence on admission to the CSU. If a consumer is homeless, the discharge planning shall include the immediate identification of living arrangements. At a minimum, the discharge plan will be reviewed once every seven days until discharge.
- RRS: For recovery and rehabilitation supports, the treatment plan must be updated at least quarterly and whenever there is a change in the consumer's clinical function that has prompted a re-assessment. Discharge planning must commence as early in the admission as practicable. At a minimum, the discharge plan will be reviewed at least quarterly. If a consumer declines to move to a community-based setting, the new individualized treatment plan must incorporate appropriate services to assist in the acquisition of activities of daily living and illness self-management.

- Transitional Living Units: For transitional living, the treatment plan must be updated at least every 30 days and whenever there is a change in the consumer's clinical function that has prompted a re-assessment. Discharge planning will begin within the first month after admission and, at a minimum, the discharge plan will be reviewed once every 30 days until discharge.

*Substance Use Disorder (SUD):* Upon admission and initial placement, the clinical assessment of the patient must continue in order to develop the treatment plan. Patient needs must be determined through specific inquiry and analysis in the six dimensions established in the ASAM Patient Placement Criteria and include matters defined in the regulations. At a minimum, the initial patient treatment plan shall be based on the patient's presenting concerns as evidenced from the biomedical and emotional/behavioral assessment. Such treatment plan shall be developed within seven calendar days after admission for any patient in Level III care. Ongoing assessment of the patient's progress in treatment shall occur to determine continued stay in the level of care or the need to move to another level of care or to discharge. The assessment shall be accomplished using the ASAM "continued stay" or "discharge" criteria." At a minimum, a continued stay review shall include a review of the ASAM continued stay or discharge criteria, the current treatment plan, and all subsequent progress notes. Organizations must develop a continuing recovery plan for patients who are no longer actively receiving treatment in, or no longer require an ASAM level of care. The continuing recovery plan must address specific requirements. The continuing recovery plan shall be completed prior to discharge from all ASAM levels of care within the organization for any patient no longer meeting the criteria for continued active treatment.

## **Treatment Services**

*Mental Health (MH):* All SMHRFs must incorporate evidence-based practices, biopsychosocial approaches, and programs regarding the treatment and rehabilitation of persons who have mental illnesses. SMHRFs must provide linkage, including coordinating the consumer's care with other health care providers, including, but not limited to, primary care physicians, psychiatrists, hospitals and other medical professionals, to ensure that the mental and physical health care needs of the consumer are met. The facility must share all relevant treatment information for a consumer with the community-based behavioral health provider or other health care provider to facilitate recovery and rehabilitation. Linkage may occur through direct partnerships with providers, as well as through managed care entities. Facilities must provide, at a minimum, the following services: physician, nursing, pharmaceutical, rehabilitative, and dietary services.

- CSUs must ensure that all consumers who are admitted undergo an immediate assessment that identifies and prioritizes the immediate and longer term services that the consumer needs. The CSU must provide 32 hours per week of group or individual active treatment, as prescribed by each consumer's treatment plan, as well as other services that include but are not limited to case management, Therapeutic interventions that use

evidence-based practices, psychiatric evaluations, medication services; and the capability of providing dual diagnoses services for a consumer, if needed.

- RRSs must ensure that specific services are provided including, but not limited to: (1) dual diagnosis services for consumers, including the engagement of services appropriate for the pre-contemplative state of recovery; (2) adequate case management; (3) appropriate therapeutic interventions, including evidence-based practices of IMR, WRAP, motivational interviewing, cognitive training, and wellness and resilience support development; (4) regular psychiatric and medical evaluations as indicated; (5) 15 hours of treatment programming per week; and (6) Consumers receive adequate medication services.
- TLUs must ensure that specified occupational therapy is provided and that each consumer receives 90 minutes of individual occupational therapy or rehabilitation per week, provided by an occupational therapy assistant or other trained providers, and each consumer receives 18 hours of treatment programming per week. The providers must be trained in evidence-based skills training. Additional services, among others, include adequate case management; appropriate therapeutic interventions, including evidence-based practices of IMR, WRAP, motivational interviewing, cognitive training, and wellness and resilience support development; regular psychiatric evaluations as indicated; adequate medication services; and dual diagnosis services, if needed.

*Substance Use Disorder (SUD)*: Didactic and counseling group treatment standards are established for all SUD treatment facilities, including purpose, ratios, and staff credentials. Requirements for patient education plans and education are in place, to be provided individually or in a group. Other requirements related to recreational activities and medical and nursing care.

- Level III facility standards include hours per week of clinical services.
- Medically Monitored Withdrawal Management requires 24 hour observation, monitoring, and treatment.
- Level IV: Medically Managed Withdrawal Management: This includes opioid maintenance therapy for patients over age 15. Services must include 24 hours medically directed observation, monitoring, and treatment and that a physician see the patient daily.

## **Patient Rights and Safety Standards**

*Mental Health (MH)*: Consumers must receive a written explanation of their rights, including but not limited to rights to present grievances, be free of discrimination, communication, religion, informed consent, and confidentiality. Use of physical restraints and therapeutic separation are limited. Other than CSUs, units must establish a consumers' advisory council.

There is a central registry for reporting and accessing cases of suspected resident abuse or neglect and standards for reporting and investigation.

*Substance Use Disorder (SUD):* A written statement must be provided to patients which describes the rights of all patients, including but not limited to, nondiscriminatory access to services; right to services in the least restrictive environment available; confidentiality; informed consent; and the right to refuse treatment. Any incidents (an action by staff or patients that led to, or is likely to lead to, an adverse effect on patient services because of a deviation from established patient care procedures) must be documented and significant incidents reported to the DHS. Patients and others have a right to file complaints with the DHS.

## **Quality Assurance or Improvement**

*Mental Health (MH):* The SMHRF must ensure that the facility's executive director and the governing body develop, implement and maintain a data-driven quality assessment and performance improvement (QAPI) program. The program must emphasize quality structures, processes and activities, with a goal of improved behavioral health outcomes that enable consumers to transition to the most integrated community-based settings possible. The written program shall be updated annually and must include, among other things, the following: 1) An ongoing program for quality improvement and consumer safety as a priority for facility management that is communicated throughout the facility; 2) A quality improvement committee that shall regularly review and evaluate all QAPI activities and progress; 3) Written benchmarks, targets and standards of care for safety and quality of care that, for each indicator, shall be well established and communicated throughout the facility. Outcomes shall be regularly reviewed to measure them against the benchmarks and targets; 4) That the facility share the results of the QAPI activities with the consumer's advisory council; and 5) A data collection and reporting process that assures the submission, at least quarterly, of all reports or other required data within prescribed time frames. Specific quality improvement indicators are required for crisis stabilization, transitional living and rehabilitation and recovery services. Obligations of the quality improvement committee are elaborated. The findings of root cause analyses shall be available to the Department, DHS-DMH and the Department of Healthcare and Family Services upon request. The regulations include a list of reportable performance indicators including, but not limited to, restraints and seclusions, reportable incidents, and other matters.

*Substance Use Disorder (SUD):* The licensee must design and utilize a quality improvement plan. Such plan shall be written and shall contain, at a minimum, a method of evaluation to assess achievement of the organization's mission and the functioning of the organization and its service delivery systems and utilization review process. The quality improvement plan shall be approved by management or, if applicable, the board of directors of the organization and annually reviewed and revised as necessary. Minimum requirements for the evaluation are specified and the results of the evaluation must be available for inspection by the Department and submitted at the time of application for renewal of licensure. Requirements for utilization



review are included that incorporate a requirement that it be conducted in accordance with continued stay and discharge criteria established in the ASAM Patient Placement Criteria. Requirements related to data collection and maintenance are included.

## **Governance**

*Mental Health (MH)*: The facility shall have a governing body responsible for the overall leadership, oversight and administration of a SMHRF. The regulations include detailed requirements for policies and procedures.

## **Special Populations**

*Mental Health (MH) and Substance Use Disorder (SUD)*: No requirements related to special populations for adults in residential treatment were found.

## **Location of Regulatory and Licensing Requirements**

Illinois Department of Public Health Specialized MH Rehabilitation Facilities regulations<sup>1</sup>; Central Complaint Registry regulations<sup>2</sup>; Illinois Department of Human Services SU Licensure regulations<sup>3</sup>. Regulatory data collected August 21, 2019.

## **Other Information Sources**

L. Garcia, N. Seibert (DHS SUPR), L. Reinert (DHS DMH); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>1</sup> See <http://www.ilga.gov/commission/jcar/admincode/077/07700380sections.html>.

<sup>2</sup> See <http://www.ilga.gov/commission/jcar/admincode/077/07700400sections.html>.

<sup>3</sup> See <http://www.ilga.gov/commission/jcar/admincode/077/07702060sections.html>.

# ILLINOIS MEDICAID

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

## Approach

The Illinois Department of Human Services (DHS) oversees the state Medicaid program. Illinois also has a Section 1115 waiver under which substance use disorder (SUD) treatment services provided in residential treatment settings that qualify as an Institution for Mental Diseases (IMD) will be covered for beneficiaries. The state historically has relied on the in lieu of provision and on Disproportionate Share Hospital (DSH) payments for Medicaid coverage of some IMD services.

## Types of Facilities

*Mental Health (MH):* Researchers found no other evidence of Medicaid reimbursement for adult residential MH treatment services.

*Substance Use Disorder (SUD):* Non-IMD residential settings may be certified to enroll in the Illinois Medicaid program if the site has 16 beds or less and meets the following criteria, among others: (A) be a free-standing program of 16 or fewer beds; or (B) be within a larger facility, as a distinct unit of 16 beds or less, which: (i) is licensed; (ii) is physically separate from other certified and licensed programs (for example, separated by floors, wings, or other building sections); (iii) provides a level of care significantly different in clinical content from other certified and licensed programs (e.g., adult versus adolescent care); (iv) has a separate cost center (budgeting, accounting, etc.); (v) has separate staffing; and (vi) has separate operating policies and procedures.

Pursuant to the Section 1115 waiver, the demonstration benefit package will include SUD treatment services, including short term residential services provided in residential and inpatient treatment settings that qualify as an IMD. Levels 3.5 and 3.7 are included in the statewide Section 1115 waiver and the state Medicaid program also will cover Level 3.2-WM clinically managed residential withdrawal management services under a pilot that may be less than statewide.

## Processes of Medicaid Enrollment

*Mental Health (MH) and Substance Use Disorder (SUD):* To participate in the Medicaid program, health care providers must apply and, among other things, be appropriately licensed, be certified, and have a provider agreement with the state. Providers may be denied, suspended, terminated, or excluded from participation in the Illinois Medicaid program, and may be otherwise sanctioned.

## Staffing

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding credentials of staff for residential treatment settings. The state must assess the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT.

- Clinically Managed Residential Withdrawal Management Pilot. Pursuant to the Section 1115 waiver, services provided must be administered by a qualified treatment professional in a state-licensed residential facility. Qualified treatment professionals must specific clinical or medical certifications or licenses.

## Placement

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines. The state also must establish a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings.

- Clinically Managed Residential Withdrawal Management Pilot. Pursuant to the Section 1115 waiver, beneficiaries are eligible for this pilot if a Physician or Licensed Practitioner of the Healing Arts determines the beneficiary demonstrates moderate withdrawal signs and symptoms, has a primary diagnosis of OUD/SUD, and requires 24-hour structure and support to complete withdrawal management and increase the likelihood of continuing treatment and recovery.

## **Treatment and Discharge Planning and Aftercare Services**

*Substance Use Disorder (SUD)*: Pursuant to the Section 1115 waiver, the Clinically Managed Residential Withdrawal Management Pilot may offer, among other services, discharge services to prepare the beneficiary for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to treatment resources in the community.

## **Treatment Services**

*Substance Use Disorder (SUD)*: Pursuant to the Section 1115 waiver, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from acute withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions. The state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services and hours of clinical care for residential treatment settings. The state also must establish a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site. Pursuant to the Section 1115 waiver, the following may be provided in an IMD: residential treatment, medically supervised withdrawal management, MAT, and peer recovery support services.

- Pursuant to the Section 1115 waiver, the components of services in the Clinically Managed Residential Withdrawal Management Pilot are: (a) intake; (b) observation; (c) medication services (i.e., the prescription or administration related to SUD treatment services, or the assessment of the side effects or results of that medication, conducted by staff lawfully authorized to provide such services within their scope of practice or license); and (d) discharge services.

## **Care Coordination**

*Substance Use Disorder (SUD)*: Under the state 1115 waiver, beneficiaries will have improved care coordination and care for comorbid physical and mental health conditions. The state must ensure establishment and implementation of policies to ensure residential facilities link beneficiaries with community-based services and supports following stays in these facilities.

## Quality Assurance or Improvement

*Substance Use Disorder (SUD)*: Pursuant to the Section 1115 waiver, the state must establish a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings.

## Special Populations

*Substance Use Disorder (SUD)*: Under the state 1115 waiver, beneficiaries will have improved care for comorbid physical and mental health conditions.

## Location of Medicaid Requirements

Illinois Behavioral Health Transformation Section 1115 demonstration Waiver<sup>4</sup>; Illinois Medicaid Rules and Regulations Title 89<sup>5</sup>. Regulatory data collected December 2019.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report “**State Residential Treatment for Behavioral Health Conditions: Regulation and Policy**”. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

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<sup>4</sup> See <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/il/il-behave-health-transform-ca.pdf>.

<sup>5</sup> See <http://www.ilga.gov/commission/jcar/admincode/089/089parts.html>.

## INDIANA

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### Types of Facilities

*Mental Health (MH) and Substance Use Disorder (SUD):* Indiana regulates Community Mental Health Centers (CMHCs). To be designated as a CMHC, a provider shall, within its designated service area, provide six settings or types of treatment, once of which is residential services. Both MH and SUDs are treated within CMHCs. CMHCs may include detoxification services.

Indiana also regulates Sub-acute Stabilization Facilities as part of a group of otherwise nontreatment focused Residential Living Facilities for Individuals with Psychiatric Disorders or Addictions. Sub-acute Stabilization Facilities “serve at least four (4) and not more than fifteen (15) individuals,” although state staff indicate that more than 15 are allowed as needed to meet demand. These facilities “may function as one (1) or both of the following: (1) A crisis care or respite care facility: (A) that serves people in need of short term respite care or short term crisis care; and (B) the length of stay shall not exceed forty-five (45) days; (2) Rehabilitative facility: (A) that serves people who have a need for treatment of psychiatric disorders or addictions; and (B) the length of stay in a rehabilitative facility shall not exceed one (1) year. The division director may waive the one (1) year limitation when evidence is presented that a less restrictive setting is inappropriate.”

*Substance Use Disorder (SUD):* Indiana regulates Addiction Treatment Services, which are a “broad range of planned and continuing care, treatment, and rehabilitation, including, but not limited to, counseling, psychological, medical, and social service care designed to influence the behavior of individual alcohol abusers or drug abusers, based on an individual treatment plan.” These services are offered in the facilities discussed above (CMHCs and Sub-acute Stabilization Facilities).

*Unregulated Facilities:* State staff indicate that there are no unregulated residential treatment facilities in Indiana. We exclude from this summary all Residential Living Facilities for Individuals with Psychiatric Disorders or Addictions other than Sub-acute Stabilization Facilities, because they do not include treatment as a necessary component.

## **Approach**

*Mental Health (MH and Substance Use Disorder (SUD)):* The Indiana Division of Mental Health and Addiction (DMHA) regulates residential treatment providers in the state. For both MH and SUD, this includes CMHCs (including residential settings) and Sub-acute Stabilization Facilities, within which Addiction Treatment Services may be offered.

## **Processes of Licensure or Certification and Accreditation**

*Mental Health (MH and Substance Use Disorder (SUD)):* Certification by DMHA is required for operation of CMHCs and Sub-acute Stabilization Facilities.

- Accreditation is required by an entity approved by DMHA. According to state staff, addiction service organizations with fewer than ten staff need not be accredited.
- A site visit is required for licensure.
- A Certificate of Need is not required but CMHCs are assigned exclusive geographic primary service areas.
- An application and proof of accreditation are required for an initial one-year license. Certifications are distributed on a three-year cycle and must be renewed for the following two years.

*Substance Use Disorder (SUD):* Certification by DMHA is required for operation of Addiction Treatment Services providers.

- To be certified initially and to maintain regular certification, the entity must maintain accreditation from an accrediting agency approved by the division. The application for regular certification as an addiction treatment services provider must include the following: (1) Proof of accreditation; (2) Site survey recommendations from the accrediting agency; and (3) The applicant's responses to the site survey recommendations. According to state staff, addiction service organizations with fewer than ten staff need not be accredited.
- Proof of inspection during the accreditation process is required.
- A Certificate of Need is not required.
- The regular certification expires 90 days after the expiration of accredited status and must be renewed.

## **Cause-Based Monitoring**

*Mental Health (MH and Substance Use Disorder (SUD)):* For CMHCs, DMHA shall change the certification status of a CMHC to that of conditional certification if the division determines that the center has not met the regulatory requirements or has not met the requirements of a contract with the division. Certification may immediately be revoked if accreditation is revoked.

For all Sub-acute Stabilization Facilities, DMHA may terminate certification issued under this article upon the division's investigation and determination of the following: (1) A substantive change in the operation of the organization; (2) Failure to comply with this article; (3) That the physical safety of the consumers or staff of the organization is compromised by a physical or sanitary condition of the organization or of a physical facility of the organization; or (4) Violation of a federal or state statute, rule, or regulation in the course of the operation of the organization or its facilities.

*Substance Use Disorder (SUD):* For Addiction Treatment Services providers, DMHA can issue a conditional status upon the division's investigation and determination of a variety of incidents, including a substantive change in the entity's accreditation status other than revocation of the accreditation, any conduct or practice in the operations of the entity that is found by the division to be detrimental to the welfare of persons served by the organization, and/or the physical safety of the consumers or staff of the entity is compromised by a physical or sanitary condition of a physical facility of the entity. Additionally, the division shall terminate the certification of the entity if the following occurs: (1) The entity's accreditation is revoked; (2) The entity that has a conditional status does not meet the requirements of the division within the period of time required; (3) The entity fails to provide proof of application for accreditation prior to the expiration of the initial temporary certification; or (4) The entity fails to become accredited within twenty-four (24) months of receiving a temporary certification.

## **Access Requirements**

*Mental Health (MH and Substance Use Disorder (SUD)):* For CMHCs and Residential Living Facilities for Individuals with Psychiatric Disorders or Addictions, crisis services, including access to more intensive services, including detoxification, shall be made available to consumers within twenty-four (24) hours of problem identification.

For CMHCs, each entity is obligated to provide accessible services for all individuals, within the limits of its capacity, in its exclusive geographic primary service area.



## **Staffing**

*Mental Health (MH and Substance Use Disorder (SUD)):* For CMHCs, centers must employ a chief executive officer. The chief executive officer (CEO) shall have at least a master's degree and shall have demonstrated managerial experience in the mental health care or related field. The center must evaluate the performance of the CEO at least every other year. The center shall have on staff a medical services director who: (1) has responsibility for the oversight and provision of all medical services; and (2) is a physician licensed to practice medicine in Indiana. At least ten percent (10%) of the center direct care staff full-time equivalents shall be some combination of: (A) Licensed clinical social workers; (B) Licensed mental health counselors; (C) Licensed marriage and family therapists; (D) Clinical nurse specialists; (E) Licensed psychologists, including individuals licensed as health service providers in psychology; and (F) Psychiatrists licensed to practice in the state of Indiana. Trained clinicians shall be available twenty-four (24) hours per day, either on-call or on site, and the available clinicians shall receive training in crisis intervention. All CMHCs shall have a physician licensed in Indiana available for consultation to staff twenty-four (24) hours per day, seven (7) days per week. Direct service staff shall receive training which addresses, among other things, the following: (1) Applicable laws, legal issues, and rights of consumers; (2) Sensitivity in dealing with families and supportive others in crisis; (3) Cultural diversity; and (4) Family dynamics.

For all entities, the governing body shall play a role in employing and evaluating the CEO and employing or contracting for a professional services director who is licensed as a physician or health service professional in psychology and who is not the same person as the CEO.

## **Placement**

*Mental Health (MH and Substance Use Disorder (SUD)):* For CMHCs, target populations include, among others, the seriously mentally ill, alcohol and other drug abusers, and older adults. For CMHCs, utilization management is required to link need to care including but not limited to: (A) Prior authorization manuals or systems; (B) Evidence based treatment systems; (C) Clinical pathways; (D) American Society of Addiction Medicine criteria; and (E) Another system of linking need to care.

*Substance Use Disorder (SUD):* State staff indicate that all addiction residential treatment providers must utilize ASAM placement criteria, a requirement not yet in the regulations.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* For all entities, individualized treatment planning is required, with the first being completed within 30 days of admission and

updated every 90 days thereafter. CMHCs must provide (in all settings) for adults who are chemically addicted, an aftercare/relapse prevention plan.

*Substance Use Disorder (SUD):* State staff indicated that the requirements of the SUD regulation that pertains to outpatient treatment planning and discharge planning are required of residential facilities as part of certification. Those regulations require that the program have written policies and procedures for development of a treatment plan that includes but is not limited to completion by the third session, review at least every 60 days, and revision as needed. The program also must have written policies and procedures for discharge planning.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* For all entities, residential treatment services must be based on a written, cohesive, and clearly stated philosophy and treatment orientation and must include the following standards: (1) There must be evidence that the philosophy is based on literature, research, and proven practice models; (2) The services must be client centered; (3) The services must consider client preferences and choices; (4) There must be a stated commitment to quality services; (5) The residents must be provided a safe, alcohol free, and drug free environment; and (6) The individual environment must be as homelike as possible.

CMHCs must provide acute stabilization services and detoxification services, primarily in inpatient or specific detoxification facilities, but crisis services must be available in all settings (including residential).

Residential services for adults with psychiatric disorders shall include specific functions that shall be made available to consumers based upon the individual treatment plan. These functions include the following: (1) Provision of transportation or access to public transportation in accordance with the treatment plan. (2) A treatment plan partially based on a functional assessment of each resident's daily living, socialization, and coping skills that is based on structured evaluation and observation of behavior. (3) Provision of services focused on assisting a resident's move to an independent setting. (4) Respite residential services, a very short term residential care (less than two (2) weeks), to provide either relief for a caregiver or transition during a stressful situation. (5) Crisis services, including more intensive services within twenty-four (24) hours after problem identification. (6) Residents, as determined by their individual treatment plan, must receive a combination of the following services: (A) Day treatment, that may include the following: (i) Intensive outpatient; (ii) Social, recreational, and support activities; and (iii) Other models of intervention; (B) Habilitation and rehabilitation services that may include, among other things, skills development and community reintegration; (C) Vocational services; (D) Appropriate educational services must be available in as normal a setting as possible; (E) Mental health treatment, that may include the following: (i) Group therapy; (ii) Individual counseling or psychotherapy; and (iii) Medication therapy.

(7) Family involvement must be offered to the resident as part of the service unless it is refused by the resident as documented annually in the treatment plan.

Residential services for adults with addictions, must include specific functions that shall be made available to consumers based upon the individual treatment plan. These functions include the following: (1) A treatment plan partially based on a functional assessment of each resident's daily living, socialization, and coping skills that is based on structured evaluation and observation of behavior. (2) Crisis services, including access to more intensive services, including detoxification, within twenty-four (24) hours of problem identification. (3) Case management services, including access to medical services, for the duration of treatment, provided by a case manager or primary therapist. (4) A consumer of residential treatment services must have access to psychiatric or addictions treatment as needed, including the following: (A) Day treatment that may include the following: (i) Daily living skills development; (ii) Social, recreational, and recovery support activities; and (iii) Parenting skills development. (B) Vocational services; (C) Appropriate educational services must be available in as normal a setting as possible; and (D) Psychiatric or addiction treatment, that may include the following: (i) Group therapy; (ii) Individual counseling; and (iii) Medication evaluation and monitoring. (5) Family involvement must be offered to the resident as part of the service unless it is refused by the resident.

Case management. Community mental health centers shall provide case management (for all levels of care including residential). The level of case management depends on the functioning level of the consumer, the consumer's preferences, and response to treatment as documented in the individualized treatment plan and clinical notes. The regulations include additional requirements for case management including ones specific to individuals with serious mental illness and adults who are chemically addicted.

## **Patient Rights and Safety Standards**

*Mental Health (MH) and Substance Use Disorder (SUD)*: For all entities, each resident is guaranteed rights, including, but not limited to, that each resident: (1) is in a safe environment and is free from abuse and neglect; (2) is treated with consideration, respect, and full recognition of the resident's dignity and individuality; (3) is free to communicate, associate, and meet privately with persons of the resident's choice; (4) has the right to confidentiality; (5) privacy; and (6) is free to voice grievances and to recommend changes in the policies and services offered by the agency. For all entities, chemical restraint is prohibited. Physical restraint and seclusion are only allowed in Sub-acute Stabilization Facilities. For CMHCs and Addiction Treatment Services Providers that offer residential care, the agency must report a variety of incidents to the division within one working day.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* For all entities, an organization that has applied for certification or has been certified must participate in the division's quality assurance program. Additionally, all entities are required to have a governing body, the duties of which include conducting an annual assessment that includes: (A) A review of the business practices of the organization to ensure that: (i) appropriate risk management procedures are in place; (ii) prudent financial practices occur; (iii) there is an attempt to maximize revenue generation; and (iv) professional practices are maintained in regard to information systems, accounts receivable, and accounts payable. Deficiencies in the center's business practices shall be identified and a plan of corrective action implemented; and (B) A review of the programs of the organization, assessing whether the programs are well utilized, cost effective, and clinically effective. Deficiencies in the organization's current program practices shall be identified and a plan of corrective action implemented.

Twenty-four hour crisis services shall participate in a quality assurance/quality improvement system that includes a review of individual cases and identification and resolution of systemic issues as follows: (1) Each crisis case shall be reviewed at a supervisory or management level for appropriateness of disposition; and (2) Systemic issues regarding types, timing, and location of crises shall be monitored for risk management implications.

## **Governance**

*Mental Health (MH) and Substance Use Disorder (SUD):* All entities are required to have a governing body, the purpose of which is to make policy and to assure the effective implementation of the policy.

## **Special Populations**

*Mental Health (MH) and Substance Use Disorder (SUD):* Individuals who are seriously mentally ill and who abuse alcohol and other drugs must receive services from accredited facilities. Special care should be taken to provide for the specialized service needs of children, the older adult, and residents previously discharged from inpatient treatment at a mental health facility. CMHCs specifically must provide for the service needs of older adults who experience significant loss of functioning due to mental health problems. This shall include but not be limited to: (1) identification of an individual to coordinate the accessibility of traditional mental health care services available in the center to older adults; (2) development of arrangements to provide services for home bound or institutionalized older adults consistent with their individual needs; and (3) identified consideration of older adults and their specialized service needs in the development of the annual program plan.

## **Location of Regulatory and Licensing Requirements**

Division of Mental Health and Addiction<sup>1</sup>. Regulatory data collected September 26, 2019.

## **Other Information Sources**

W. Harrold, N. Svetlauskas (DMHA); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>1</sup> See [http://iac.iga.in.gov/iac/iac\\_title?iact=440](http://iac.iga.in.gov/iac/iac_title?iact=440).

# INDIANA MEDICAID

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

## Approach

The Indiana Family and Social Services Administration, Office of Medicaid Policy and Planning (the Office) oversees the state Medicaid program. Indiana also has a section 1115 waiver that permits reimbursement of short term SUD treatment services to individuals aged 21-64 years in residential treatment facilities of any size that qualify as an Institution for Mental Disease (IMD). Indiana also has historically relied on the in lieu of provision to reimburse certain services in IMDs but not Disproportionate Share Hospital (DSH) payments.

## Types of Facilities

*Mental Health (MH):* Researchers found no other evidence of Medicaid reimbursement for adult MH treatment services in residential settings.

*Substance Use Disorder (SUD):* Pursuant to the section 1115 waiver, expenditures may be reimbursed for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are short-term residents in facilities that meet the definition of an IMD. Expenditures for services in the following residential ASAM levels of care are permitted: Level 3.1. Clinically Managed Low-Intensity Residential Treatment Services; Level 3.5. Clinically Managed High-Intensity Residential Treatment Services.

## Processes of Medicaid Enrollment

*Mental Health (MH) and Substance Use Disorder (SUD):* A provider must be duly licensed, registered, or certified by the appropriate professional regulatory agency pursuant to state or federal law, or otherwise authorized by the office for state Medicaid program enrollment. Enrollment in the state Medicaid program requires, among other things, application for certification as a Medicaid provider, proof of necessary licensure, and completion of a provider agreement. Certification may be withdrawn and other sanctions imposed.

*Substance Use Disorder (SUD):* Pursuant to the section 1115 waiver, residential treatment services must be provided in an Indiana Division of Mental Health and Addiction

(DMHA)-certified facility that has been enrolled as a Medicaid provider and assessed by DMHA as delivering care consistent with ASAM or other nationally recognized, SUD-specific program standards for residential treatment facilities.

## **Staffing**

*Substance Use Disorder (SUD):* Pursuant to the section 1115 waiver, the state must assess the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration including those that offer MAT. In addition, the state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other comparable, nationally recognized, SUD-specific program standards regarding in particular the credentials of staff for residential treatment settings.

## **Placement**

*Substance Use Disorder (SUD):* Pursuant to the section 1115 waiver treatment services delivered to residents of an institutional care setting, including facilities that meet the definition of an institution for mental diseases (IMD), are provided to Indiana Medicaid recipients with an SUD diagnosis when determined to be medically necessary by the MCO utilization review staff and in accordance with an individualized service plan. The state must establish a requirement that MCOs and providers assess treatment needs based on SUD specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines. The state also must establish a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings.

## **Treatment and Discharge Planning and Aftercare Services**

*Substance Use Disorder (SUD):* Researchers did not locate such requirements within either the Medicaid regulations or the section 1115 waiver.

## **Treatment Services**

*Substance Use Disorder (SUD):* Pursuant to the section 1115 waiver, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from

acute withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions. Residential treatment services are provided in a facility assessed by the Indiana Division of Mental Health and Addiction (DMHA)-certified facility as delivering care consistent with ASAM or other nationally recognized, SUD-specific program standards for residential treatment facilities. Covered services include:

- Clinically-directed therapeutic treatment to facilitate recovery skills, relapse prevention, and emotional coping strategies.
- Addiction pharmacotherapy and drug screening.
- Motivational enhancement and engagement strategies.
- Counseling and clinical monitoring.
- Withdrawal management and related treatment designed to alleviate acute emotional, behavioral, cognitive, or biomedical distress resulting from, or occurring with, an individual's use of alcohol and other drugs.
- Regular monitoring of the individual's medication adherence.
- Recovery support services.
- Counseling services involving the beneficiary's family and significant others to advance the beneficiary's treatment goals, when: (1) the counseling with the family member and significant others is for the direct benefit of the beneficiary, (2) the counseling is not aimed at addressing treatment needs of the beneficiary's family or significant others, and (3) the beneficiary is present except when it is clinically appropriate for the beneficiary to be absent in order to advance the beneficiary's treatment goals.
- Education on benefits of medication assisted treatment and referral to treatment as necessary.

In addition, the state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other comparable, nationally recognized, SUD-specific program standards regarding in particular the types of services and hours of clinical care for residential treatment settings. Additionally, the state must establish a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site.



## Care Coordination

*Substance Use Disorder (SUD):* Pursuant to the section 1115 waiver, beneficiaries will have access to improved care coordination and care for comorbid physical and mental health conditions. The state must establish policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these residential and inpatient facilities.

## Quality Assurance or Improvement

*Substance Use Disorder (SUD):* Pursuant to the section 1115 waiver, the state must establish a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings.

## Special Populations

*Substance Use Disorder (SUD):* Researchers did not locate requirements specific to special populations in the Medicaid regulations. Pursuant to the section 1115 waiver, beneficiaries will have access to improved care for comorbid physical and mental health conditions.

## Location of Medicaid Requirements

Indiana Medicaid Regulations, Article 1<sup>2</sup>; Article 5<sup>3</sup>; Healthy Indiana section 1115 waiver<sup>4</sup>.  
Regulatory data collected January 2020.

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<sup>2</sup> See <http://iac.iga.in.gov/iac/T04050/A00010.PDF?>.

<sup>3</sup> See <http://iac.iga.in.gov/iac/T04050/A00050.PDF>.

<sup>4</sup> See <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/in-healthy-indiana-plan-support-20-ca.pdf>.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report **“State Residential Treatment for Behavioral Health Conditions: Regulation and Policy”**. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

## IOWA

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

### **Types of Facilities**

*Mental Health (MH) and Substance Use Disorder (SUD):* Iowa regulates Crisis Stabilization Residential Services (CSRSs), which are short-term services in facility-based settings of no more than 16 beds. The goal of a CSRS is to stabilize and reintegrate the individual back into the community. CSRS are designed for voluntary individuals in need of a safe, secure environment less intensive than an inpatient hospital. CSRS can serve youth aged 18 and younger or adults aged 18 and older.

*Mental Health (MH):* Iowa regulates Residential Care Facilities for Persons with a Mental Illness (RCF/PMI) which provide services to three or more individuals for a period exceeding 24 hours. Individuals living in a residential care facility for persons with mental illness are unable to sufficiently or properly care for themselves, but do not require the services of a registered or licensed practical nurse, except for emergencies. They include:

- Intermediate Care Facilities for Persons with Mental Illness (ICF/PMI) means an institution, place, building, or agency designed to provide accommodation, board, and nursing care to three or more individuals who primarily have mental illness.
- Subacute Mental Health Care Facilities are short-term, intensive, recovery-oriented services designed to stabilize individuals experiencing a decreased level of functioning due to a MH condition. They allow 16 beds per facility.
- Specialized Residential Care Facilities with Three to Five Beds serve persons with a chronic mental illness or other disabilities.

*Substance Use Disorder (SUD):* Iowa regulates three categories of residential SUD treatment without regard to funding:

- Clinically managed low-intensity residential treatment means the ASAM criteria level of care totaling at least five hours of clinically managed inpatient treatment services per week.

- Clinically managed medium-intensity residential treatment means the ASAM criteria level of care totaling at least 30 hours of clinically managed inpatient treatment services per week.
- Clinically managed high-intensity residential treatment means the ASAM criteria level of care totaling at least 50 hours of clinically managed inpatient treatment services per week.
- Detoxification is defined but not identified as a particular level of treatment.

*Unregulated Facilities:* All residential behavioral health treatment facilities for adults are regulated in Iowa.

## Approach

CSRSs are regulated and accredited by the Iowa Department of Human Services (DHS). The Iowa Department of Inspections and Appeals (IDEA) regulates and licenses all adult residential mental health facilities. The Iowa Department of Public Health (DPH) licenses all residential substance use treatment facilities, with limited exceptions identified in the Iowa Code<sup>1</sup>.

## Processes of Licensure or Certification and Accreditation

*Mental Health (MH) and Substance Use Disorder (SUD):* All CSRSs require accreditation by the DHS.

- The DHS will grant deemed status to organizations accredited by a recognized national, not-for-profit, accrediting body when the DHS determines the accreditation is for similar services. The national accrediting bodies currently recognized as meeting division criteria are: (1) The Joint Commission; (2) The Commission on Accreditation of Rehabilitation Facilities (CARF); (3) The Council on Quality and Leadership in Supports for People with Disabilities (The Council); (4) The Council on Accreditation of Services for Children and Families (COA); (5) The American Association of Suicidology (AAS); and (6) Contact USA.
- Requirements for inspection were not identified.
- The state requires a Certificate of Need.
- Accreditation duration is unspecified.

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<sup>1</sup> See <https://www.legis.iowa.gov/docs/ico/chapter/2018/125.pdf>.

*Mental Health (MH):* Licenses by the IDEA is required for all adult residential MH facilities.

- Accreditation is not required.
- An inspection must occur at least once within a 30-month period.
- The state requires a Certificate of Need.
- Licensure duration is one year.

*Substance Use Disorder (SUD):* All residential SUD treatment facilities, with limited exceptions, require licensure by the DPH.

- Accreditation is not required but is recognized. The DPH may issue a license under deemed status to an applicant providing required documentation of accreditation by a recognized accreditation body (The Joint Commission, The Council on Accreditation of Rehabilitation Facilities (CARF), The Council on Accreditation of Children and Family Services (COA) or The American Osteopathic Association (AOA)).
- An on-site inspection occurs prior to licensure and renewal. The inspection may be unannounced.
- The state requires a Certificate of Need.
- For the initial license, duration is 270 days for a new applicant scoring a minimum of 70 percent in each standards category. This license expires and is not renewable. Following the initial license, the DPH will issue either a one, two, or three-year license based on score percentages. A deemed-status license is effective for the same time frame as the accreditation, up to three years.

## **Cause-Based Monitoring**

*Mental Health (MH) and Substance Use Disorder (SUD):* CSRs may have accreditation denied or revoked and plans of corrective action may be required.

*Mental Health (MH):* An inspector of the IDEA may enter any licensed health care facility without a warrant and may examine all records pertaining to the care provided to residents of the facility.

When deficiencies are found, a statement of deficiencies will be sent by the IDEA to the health care facility within ten working days of the exit interview. The facility must, within ten calendar

days submit a plan of correction meeting regulatory requirements to the IDEA, which will review it. Revisit inspections may occur.

*Substance Use Disorder (SUD):* Complaints regarding a facility will lead to a preliminary review of the allegations and, if the DPH deems warranted, further investigation and, as warranted, corrective action and/or disciplinary action. Deficiencies identified in any inspection will require submission of a written corrective action plan that meets department requirements. The DPH may inspect the licensee, including on-site inspection, to review the implemented corrective measures and report to the committee. Licenses may be denied, suspended, or revoked.

## **Access Requirements**

*Mental Health (MH) and Substance Use Disorder (SUD):* All residential programs must operate seven days a week, 24 hours per day.

*Mental Health (MH):* Wait-time requirements were not found. All facilities must be accessible and usable to the physically disabled.

*Substance Use Disorder (SUD):* Wait-time requirements were not found. All programs shall comply with the Americans with Disabilities Act.

## **Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD):* A CSRS must have a designated director or administrator, at least one licensed MH professional available for consultation, a MH professional with expertise appropriate to the individual's needs to provide crisis stabilization services, and awake and attentive staffing 24 hours a day, 365 days a year. All crisis response service providers must have documented satisfactory completion of department-approved training including: (1) A minimum of 30 hours of department-approved crisis intervention and training; and (2) A post training assessment of competency is completed.

*Mental Health (MH):* RCFs must meet specific requirements for the qualifications and responsibilities of the administrator. Personnel cannot be under the influence of intoxicating drugs or beverages; background checks are required; and other general requirements are in place. Sufficient staff must be available to meet the needs of residents and there must be 24 hour awake coverage. Each program with more than 15 beds must employ a person to direct resident activities and credentials and duties are specified. A department-approved training is required on restraint. Additional requirements by facility type include:

- RCFs/PMI: A qualified MH professional must be employed or under contract.

- ICF/PMI: Facilities must have personnel policies. Staff must have a minimum of 12 in-service continuing education programs per year. The facility must establish, subject to approval of the IDEA, the numbers and qualifications of the staff required using as its criteria the services being offered as indicated on the résumé of care and as required for implementation of individual program plans. Among the specific requirements are ones related to direct care staff; a qualified MH professional; the director of nursing; sufficient nursing staff including requirements for licensed, registered, and charge nurses; activity staff; and the activity program director.
- Subacute Mental Health Care Facilities have additional requirements related to credentials and experience of the administrator, psychiatric provider, registered nurse, mental health professionals, direct care staff, and social service staff. Availability of personnel must be sufficient to meet psychiatric and medical treatment needs of the residents served. Personnel policies are required, including ones related to orientation training.
- Residential Care Facility. Three- to Five-Bed Specialized facilities must have policies related to administrator qualifications and responsibilities and personnel records.

*Substance Use Disorder (SUD):* All SUD treatment programs must have an executive director and clinical treatment supervisor. Personnel policies must be established, including but not limited to, policies for staff development and training including orientation and on-going training, staff evaluation, confidentiality, abuse, and background checks. Credentials are established for screening, assessment, and treatment personnel. Programs providing “enhanced services” must include personnel qualified to provide prevention, early intervention, and treatment services for SUD and problem gambling, services for medical conditions, and services for MH conditions. State staff indicate that programs are required to utilize the ASAM criteria for staffing residential services.

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* To be eligible for services in a CSRS as an adult, an individual must be age 18 or older; be determined appropriate by a mental health assessment; and be determined not to need inpatient acute hospital psychiatric services. The length of stay is expected to be less than five days with documentation required for longer stays. A crisis screening and crisis assessment must be performed, the latter within 24 hours of admission.

*Mental Health (MH):* All RCFs must have written criteria for admission.

- RCF/PMIs require that the facility’s admission criteria be consistent with the résumé of care. A narrative social history must be completed within 30 days of admission.

- ICFs/PMI require admission policies which address criteria for admission as well as requiring that residents be admitted only on a written order signed by a physician; with certain exceptions, that a preplacement visit must be completed prior to admission; and that each facility must maintain a waiting list with selection priorities identified. Each resident admitted must have a physical examination, tuberculin test, and social history no more than 30 days before admission.
- For Subacute Mental Health Care Facilities, eligibility for services must be determined by a standardized preadmission screening conducted by a mental health professional, a physician, a physician assistant, or an advanced registered nurse practitioner at the facility. Criteria are established for admission.
- For Specialized Residential Care Facilities with Three to Five Beds, residents may be admitted only on a written order signed by a primary care provider, specifying the level of care, and certifying that the individual being admitted requires no more than personal care and supervision and does not require routine nursing care. A preadmission physical is required.

*Substance Use Disorder (SUD):* All residential SUD treatment programs require a pre-admission assessment using the ASAM criteria conducted by an addictive disorder professional. The program's policies and procedures must address patient medical and mental health conditions. In addition to assessment of biomedical conditions and complications as described in the ASAM criteria, the program must take a medical history and perform a physical examination and necessary laboratory tests as follows for patients admitted to the level of care specified.

- For low-intensity treatment, within 21 days of admission.
- For medium and high-intensity treatment, within 7 days of admission.

A program may accept a medical history or physical examination from a qualified source if the history or examination was completed no more than 90 days prior to the patient's current admission. In addition to assessment of emotional, behavioral, and cognitive conditions and complications as described in the ASAM criteria, a program may accept a mental health history from a qualified source if the history was completed no more than three days prior to the patient's current admission.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Within 24 hours of admission to a CSRS, a written short-term stabilization plan is developed, and reviewed frequently to assess the need for continued placement in CSRS. The stabilization plan must include, among other



things, criteria for discharge, including referrals and linkages to appropriate services and coordination with other systems. Upon discharge, a follow-up appointment with the individual's preferred provider will be made, and crisis response staff will follow up with the individual and document contact or attempt to contact on a periodic basis until the appointment takes place.

*Mental Health (MH):* All RCFs must develop a service plan within 30 days of admission.

- RCFs/PMI and three to five bed residential facilities: The administrator or their designee must develop an initial service plan to address any immediate health and safety needs within 48 hours of admission. Within 30 days of admission, the program must develop a written, individualized, and integrated service plan that is updated at least quarterly.
- For ICFs/PMI, an initial program plan must be developed within 24 hours of admission. The individual program plan, which will replace the initial program plan, should be developed within 30 days following admission and renewed at least annually.
- For subacute care facilities, a treatment plan must be completed within 6 hours of admission and reviewed at least daily. By the tenth day following admission and thereafter, a mental health professional conducts and documents an assessment to determine if the patient meets criteria for continued stay.
- All facilities require discharge planning. Discharge planning begins at admission for subacute care facilities and within 30 days of admission for ICFs/PMI.

*Substance Use Disorder (SUD):* For all residential SUD treatment facilities, staff must initiate development of the treatment plan as soon after the patient's admission as is clinically feasible and within the period of time between admission and the review date specified for that level of care in the management-of-care review process. Treatment plan reviews must be based on ongoing assessment and specify the indicated level of care and licensed program services and any revision of treatment plan goals. For low-intensity residential services, management-of-care activities must occur within 30 days of admission and, for all other residential services, within 7 days of admission. All facilities also require discharge planning, which begins at admission and, like admission, must use ASAM criteria as part of planning to address needs post-discharge.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* A CSRS must provide a comprehensive MH assessment within 24 hours of admission. Crisis stabilization includes, at minimum, daily contact with a mental health professional and one hour of additional crisis stabilization service.

Additional services provided include, but are not limited to, skill building, peer support or family support peer services.

*Mental Health (MH):*

- RCFs/PMI: An evaluation must be provided to each resident.
- ICFs/PMI: The Individual Program Plan will assist the resident in obtaining access to academic services, community living skills training, legal services, self-care training, support services, transportation, treatment, and vocational education as needed. These services may be provided by the facility or obtained from other providers. Services to the resident must be provided in the least restrictive environment and incorporate the principle of normalization.
- Subacute Mental Health Care Facilities: Services are short-term, intensive, and recovery-oriented designed to stabilize the individual. Medication management and dietary requirements are addressed.
- Specialized Residential Care Facilities with Three to Five Beds: Requirements related to dietary services and resident activities are included.

*Substance Use Disorder (SUD):* The Iowa regulations require that SUD treatment services be addressed in policies and procedures. This includes requiring policies related to drug screening (programs may not require it), assessment, emergency services, medication control, and the therapeutic environment. Otherwise, the regulations incorporate by reference the ASAM criteria level of care, including service hours.

## **Patient Rights and Safety Standards**

*Mental Health (MH) and Substance Use Disorder (SUD):* CSRS incident reports are required and, among other things, must be provided to the mental health and disability services region. The DHS receives and records complaints by individuals served.

*Mental Health (MH):* All RCFs must have written residents' rights policies in a language the residents can understand and that include a method for submitting complaints and internal investigation thereof. In addition, there are rights related to confidentiality, dignity, communication, to participate in activities, manage their property unless otherwise restricted, and to be free of abuse. Restraint is allowed but is restricted.

*Substance Use Disorder (SUD):* All SUD treatment facilities require policies that address, among other things, possession of chemical substances on-site, abuse or neglect, communication, sexual harassment, privacy, and informing patients of their rights at admission. Residential

program policies and procedures must address, among other things, consultation with counsel, visits and communication, the right to observe their faith, and to assert grievances with an opportunity for redress. Complaints must be sent to the DPH and will be investigated. Researchers did not locate reference to regulations regarding restraint or seclusion.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* The CSRS must have a performance improvement system and a management information system. Among other things, the data on readmission are tracked, including an analysis of trends, looking at effectiveness, and appropriate corrective action, and documented in the performance improvement system.

*Mental Health (MH):* Requirements related to quality assurance or improvement for adult MH residential treatment facilities were not found.

*Substance Use Disorder (SUD):* All residential SUD treatment facilities must have a written quality improvement plan for which a designated staff person is responsible. The quality improvement plan must describe and document monitoring, problem-solving and evaluation activities designed to systematically identify and resolve problems and make continued improvements and must include objective criteria to measure its effectiveness. The program must document whether the quality of patient care and program operations are improved and identified problems are resolved and activities and findings must be communicated to staff. Quality improvement plan findings are used to detect trends, patterns of performance, and potential problems that affect patient care and program operations. The program must evaluate the effectiveness of the quality improvement plan at least annually and revise the plan as necessary.

## **Governance**

*Mental Health (MH) and Substance Use Disorder (SUD):* CSRSs must have specified policies and procedures in place. Standards are established for organization leadership.

*Mental Health (MH):* All RCFs must have a governing board, policies and procedures, and, as part of application, a “resume of care” that lays out essential elements of service delivery.

*Substance Use Disorder (SUD):* All SUD treatment facilities must have a governing body that, among other things, establishes policies and procedures and oversees fiscal management.

## Special Populations

*Mental Health (MH) and Substance Use Disorder (SUD):* Requirements related to special populations were not identified for CSRSs.

*Mental Health (MH):* Only ICFs/PMI have requirements related to special populations and that relates to payment for services to veterans.

*Substance Use Disorder (SUD):* All residential SUD treatment facilities have requirements for people with HIV/AIDs and unspecified cultural or religious groups:

- The staff development and training plan must describe orientation for new staff which includes an overview of the program and licensed program services, confidentiality, tuberculosis and blood-borne pathogens, including HIV/AIDS, and culturally and environmentally specific information.
- The treatment plan must contain culturally and environmentally specific considerations.
- Program policies and procedures must include a written description of any religious orientation, religious practice, or religious restrictions. For adult patients, this information must be available during orientation. The patient must have the opportunity to participate in religious activities and services in accordance with the patient's faith. The program must, when necessary and reasonable, arrange transportation to religious activities.

## Location of Regulatory and Licensing Requirements

IAC 481.50.1 et seq<sup>2</sup>; IAC 481.57.1 et seq<sup>3</sup>; IAC 481.60.1 et seq<sup>4</sup>; IAC 481.62.1 et seq<sup>5</sup>; IAC 481.63 et seq<sup>6</sup>; IAC 481.65.1 et seq<sup>7</sup>; IAC 481.71.1 et seq<sup>8</sup>; Iowa Code 135C.1<sup>9</sup>; RCF-PMI definition<sup>10</sup>; IAC 641.155 et seq<sup>11</sup>; IAC 441.24.39<sup>12</sup>. Regulatory requirements reviewed May 29, 2019.

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<sup>2</sup> See <https://www.legis.iowa.gov/docs/iac/chapter/01-16-2019.481.50.pdf>.

<sup>3</sup> See <https://www.legis.iowa.gov/docs/iac/chapter/01-16-2019.481.57.pdf>.

<sup>4</sup> See <https://www.legis.iowa.gov/docs/iac/chapter/01-16-2019.481.60.pdf>.

<sup>5</sup> See <https://www.legis.iowa.gov/docs/iac/chapter/01-16-2019.481.62.pdf>.

<sup>6</sup> See <https://www.legis.iowa.gov/docs/iac/chapter/01-16-2019.481.63.pdf>.

<sup>7</sup> See <https://www.legis.iowa.gov/docs/iac/chapter/01-16-2019.481.65.pdf>.

<sup>8</sup> See <https://www.legis.iowa.gov/docs/iac/chapter/01-16-2019.481.71.pdf>.

<sup>9</sup> See <https://www.legis.iowa.gov/docs/ico/section/135C.1.pdf>.

<sup>10</sup> See [https://dia-hfd.iowa.gov/DIA\\_HFD/EntityTypeDefinitionViewAction.do?selectedColumnId=18](https://dia-hfd.iowa.gov/DIA_HFD/EntityTypeDefinitionViewAction.do?selectedColumnId=18).

<sup>11</sup> See <https://www.legis.iowa.gov/law/administrativeRules/rules?agency=641&chapter=155&pubDate=01-16-2019>.

## Other Information Sources

L. Hancock-Muck (DPH), L. Larkin, (DHS); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>12</sup> See <https://www.legis.iowa.gov/docs/iac/rule/09-30-2015.441.24.39.pdf>.

# IOWA MEDICAID

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## Approach

The Iowa Department of Human Services (DHS) oversees the state Medicaid program. Iowa does not have a relevant Section 1115 waiver that affects reimbursement of residential services in Institutions for Mental Diseases (IMDs). It historically has relied to some extent on the in lieu of provision to reimburse certain services in IMDs, but not on Disproportionate Share Hospital (DSH) payments.

## Types of Facilities

*Mental Health (MH) or Substance Use Disorder (SUD):* Iowa Medicaid does not reimburse for residential crisis stabilization for adults.

*Mental Health (MH):* Residential treatment facilities may obtain reimbursement under Medicaid if they are Subacute Mental Health Treatment Facilities. Under the state plan amendment, services may be reimbursed in licensed Residential Care Facilities for Persons with Mental Illness (RCFs) that meet certain criteria, including serving 16 or fewer persons, and are not an IMD.

*Substance Use Disorder (SUD):* No evidence of coverage of SUD residential treatment facilities for adults was located.

## Processes of Medicaid Enrollment

*Mental Health (MH) and Substance Use Disorder (SUD):* To enroll in the Iowa Medicaid program, a provider must submit the appropriate application and execute an agreement with the DHS. Enrollment may be denied or terminated. They must meet the requirements for licensure by the state.

## **Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based staffing requirements for residential treatment facilities for adults was located.

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based placement requirements for residential treatment facilities for adults was located.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based treatment or discharge planning or aftercare service requirements for residential treatment facilities for adults was located.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based treatment service requirements for residential treatment facilities for adults was located.

## **Care Coordination**

*Mental Health (MH) and Substance Use Disorder (SUD):* Providers and the health plan must be responsible for care coordination of services included in the Medicaid comprehensive benefit package.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* Facilities must have an approved Quality Assurance system and must evaluate quality of care provided to patients in facilities.

## **Special Populations**

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based special population requirements for residential treatment facilities for adults was located.

## Location of Medicaid Requirements

Iowa Administrative Code Article 441 Department of Human Services Title VIII Medical Assistance<sup>13</sup>; State Plan Amendment<sup>14</sup>. Regulatory data collected December 2019.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report **“State Residential Treatment for Behavioral Health Conditions: Regulation and Policy”**. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

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<sup>13</sup> See <https://www.legis.iowa.gov/law/administrativeRules/chapters?agency=441&pubDate=01-01-2020>.

<sup>14</sup> See <https://dhs.iowa.gov/sites/default/files/Attachment%203.1-C%20as%20of%20111718.pdf?032420202146>.



## KANSAS

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### Types of Facilities

*Mental Health (MH):* Kansas refers to residential treatment facilities as a subset of regulated Community Mental Health Centers (CMHCs), which include county-established CMHCs and county board of health-established mental health clinics but are otherwise not defined.

*Substance Use Disorder (SUD):* Kansas regulates four subtypes of residential treatment programs, which are generally defined as “live-in alcohol/drug treatment programs that operate 24 hours a day.” This includes:

- *Intermediate treatment:* Provides a regimen of structured services in a 24-hour residential setting. They are housed in or affiliated with permanent facilities where individuals can reside safely. For the typical resident in an intermediate treatment program, the effects of the substance abuse on the individual’s life are so significant, and the resulting level of impairment so great, that a less intensive modality of treatment is not feasible or effective. The duration of intermediate treatment should be determined by the individual’s illness and his or her response to treatment.
- *Therapeutic community:* Typically longer term (3 months to 2 years) and is designed to treat individuals who have significant social and psychological problems. These programs are characterized by their reliance on the treatment community as a therapeutic agent. The treatment goals are to effect a global change on the participant’s lifestyles, attitudes and values. The typical individual residing in a therapeutic community may be experiencing multiple problems including substance abuse, criminal activity, psychological problems, impaired functioning and disaffiliation with mainstream values. Duration is longer term (3 months to 2 years).
- *Social detoxification:* Typically short term (less than 7 days) and provides 24-hour supervision, observation and support for individuals who are intoxicated or experiencing withdrawal from other drugs. This modality of care provides services for those individuals whose intoxication/withdrawal signs and symptoms are severe enough to require 24-hour structure and support.
- *Acute detoxification:* Provides care to individuals whose withdrawal signs and symptoms are sufficiently severe to require primary medical and nursing care services. In this

modality of treatment, 24-hour observation, monitoring and counseling services are available.

*Unregulated Facilities:* State staff confirmed there currently are no unregulated residential treatment facilities. According to the KDADS Survey, Certification and Credentialing Commission website<sup>1</sup>, Residential Care Facilities, which are not included in this summary, are “not mental health treatment facilities.”

## **Approach**

*Mental Health (MH):* The Kansas Department for Aging and Disability Services Survey, Certification and Credentialing Commission licenses and regulates all CMHCs.

*Substance Use Disorder (SUD):* The Secretary of Social and Rehabilitation Services, Division of Health Care Policy licenses and regulates all alcohol or other drug abuse treatment programs in the state.

## **Processes of Licensure or Certification and Accreditation**

*Mental Health (MH):*

- Licensure is required for all CMHCs, including residential psychiatric programs. Licensure duration is two years, before which time a renewal application must be submitted. A provisional license may be granted for up to 6 months at a time. An inspection “may” take place for licensure or renewal.
- Accreditation is not required but, if accredited, that must be specified in the application for licensure.
- Although Kansas does not have specific Certificate of Need requirement, there are similar requirements wherein a new center cannot be established if the proposed center’s service area is already being served by one or more existing licensed centers, unless there are other extenuating circumstances.

*Substance Use Disorder (SUD):*

- Licensure is required for all alcohol or other drug abuse treatment programs. Initial licensure duration is not indicated in the regulations, but a renewal application duration

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<sup>1</sup> See <https://www.kdads.ks.gov/commissions/survey-certification-and-credentialing-commission>.

may be between one and three years, depending on compliance with standards. An inspection is required for licensure and renewal.

- Accreditation is not required but accreditation by the Joint Commission, CARF, or the Council on Accreditation makes the facility eligible for certification in place of full licensure requirements.
- Kansas does not have a specific Certificate of Need requirement.

## **Cause-Based Monitoring**

*Mental Health (MH):* After licensure approval, each center must annually obtain an independent audit of the financial affairs and records of the center. A resurvey may be conducted at any time by the licensing agency and a plan of corrective action may be required if warranted due to regulatory noncompliance. Failure to take corrective action may result in denial, suspension, or revocation of a license.

*Substance Use Disorder (SUD):* Unscheduled site visits may take place. If a facility is not in compliance with standards, a corrective action plan is required and failure to remedy violations may result in suspension or revocation of license.

## **Access Requirements**

*Mental Health (MH):* CMHCs have both wait time and access standards they must adhere to. Wait time standards include determination of whether the request for treatment constitutes an emergency, an urgent matter, or a routine matter. Based upon this assessment, the appropriate care is identified and, assuming inpatient care is not needed, the care must be provided within a “timely period.” In the event that the center cannot comply with the requirements of this regulation, the appropriate staff member shall document in the consumer’s clinical record, the reason or reasons why the center was unable to comply with the requirements of this regulation.

Access standards indicate that each center shall make every reasonable effort to overcome any health or sociocultural barriers that consumers may have to receiving services (e.g., physical disabilities, language or other communication barriers, childcare issues). In addition, the contact information for the center, including address, phone and office hours, as well as the types of services provided and where the center is located within multi-use buildings, should be clearly advertised and posted. Requirements are also indicated for appropriate communication materials to advertise and operate services at the center.

*Substance Use Disorder (SUD)*: Pregnant women are given priority access to substance abuse residential treatment.

## **Staffing**

*Mental Health (MH)*: CMHCs are generally subject to regulations governing the responsibility of its executive director. Professional staff must meet applicable licensing and training standards and there must be qualified clinical supervision. Responsibility for client medical needs lies with a licensed physician and, if that person is not a psychiatrist, there must be psychiatric consultant. There also are requirements related to those providing community services, volunteers, and students. Policies must include, among other things, requirements related to staff evaluation, staff skills, and guidelines available from the state. Services in residential facilities must “be provided by appropriately trained or professionally qualified staff.” Researchers found no requirements related to staffing levels or ratios or training regarding trauma informed care.

*Substance Use Disorder (SUD)*: Substance use treatment facilities generally must have policies and procedures related to compliance with applicable laws, hiring, evaluation, conduct, infection control, maintenance of a “Drug-Free Workplace”, job descriptions, and personnel records, among other things. The general regulations include very specific requirements related to training, qualifications, scope of practice, and supervision for counselor assistants, credentialed alcohol and other drug abuse counselors, and trainees. There also are requirements regarding the executive director’s responsibilities. Staffing requirements related to specific facility types include:

- Acute detoxification: There must be a registered nurse or licensed practical nurse on duty 24 hours a day on the unit and 24 hour evaluation and withdrawal management performed by medical professionals in a licensed health care or substance abuse treatment facility.
- Intermediate treatment: There must be minimum of one qualified staff for every eight clients in residence and sufficient employees on duty 24 hours a day to meet the needs and protect the safety of clients. Employees on duty shall be awake on all shifts.
- Social detoxification: There must be minimum of one qualified staff for every fifteen clients in residence and sufficient employees on duty 24 hours a day to meet the needs and protect the safety of clients. Employees on duty shall be awake on all shifts.
- Therapeutic community treatment services: There must be minimum of one qualified staff for every ten clients in residence and sufficient employees on duty 24 hours a day to meet the needs and protect the safety of clients. Employees on duty shall be awake on all

shifts. All qualified staff, staff and employees must complete and maintain current Cardiopulmonary Resuscitation/First Aid training.

## **Placement**

*Mental Health (MH):* CMHC services have an initial assessment requirement. Researchers did not locate reference to LOCUS.

*Substance Use Disorder (SUD):* The general requirements for substance use treatment facilities require them to have procedures for assessment including use of a “substance abuse assessment tool to provide additional clinical information and justification for modality of treatment recommended.” Researchers did not locate reference to ASAM or to other placement requirements.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH):* Treatment planning is required, with reviews and revision occurring at periodic intervals of not more than 90 days. Discharge planning is required that includes, among other things, referrals to other treatment providers and supportive services when appropriate and a plan for appropriate post-discharge or post-termination of treatment contact by staff with the consumer and, if appropriate, with one or more members of the consumer’s family or other individuals designated by that consumer.

*Substance Use Disorder (SUD):* An individualized treatment plan must be completed for a client in residential services no later than 7 days after the date of admission. Updates are required no later than every 30 days. Client input is required. Discharge planning is required.

## **Treatment Services**

*Mental Health (MH):* CMHCs, including residential facilities, shall provide as appropriate each of the following basic community support services, among others: (1) Orientation services; (2) public education; (3) emergency treatment and first response services, 24-hours-per-day, seven-days-per-week; (4) basic outpatient treatment services including evaluation and diagnosis, individual, group, and family therapy, medication management; and (5) basic case management services for adults.

*Substance Use Disorder (SUD):* In addition to services specified in 1a, services specific to the types of facilities are as follows:

- Intermediate treatment shall consist of at least 40 hours each week of scheduled, structured activities to include: (1) A minimum of 10 hours per week of individual, group, and/or family counseling; (2) Life skills; (3) Recreational groups; and (4) Self-help support meetings. The facility must assure access to consultation with a licensed physician.
- Therapeutic community treatment shall provide at least 20 hours each week of scheduled, structured activities to include: (1) A minimum of 5 hours per week of individual, group, and/or family counseling; (2) Community participation; (3) Life skills; (4) Recreational groups; and (5) Self-help support meetings. The facility must assure access to consultation with a licensed physician.
- Social detoxification shall: (1) Observe and provide support for clients who are intoxicated or are experiencing withdrawal; (2) Monitor and document vital signs; and (3) Conduct an assessment for the client's potential withdrawal using an appropriate clinical tool. The facility must assure access to consultation with a licensed physician.
- Acute detoxification shall: (1) Provide a 24 hour evaluation and withdrawal management performed by medical professionals in a licensed health care or substance abuse treatment facility; (2) Provide services based on policies and procedures that have been approved by the physician; (3) Complete a comprehensive medical assessment and physical examination for each detoxification client at the time of admission; and (4) Maintain access to laboratory and toxicology testing.

## **Patient Rights and Safety Standards**

*Mental Health (MH) and Substance Use Disorder (SUD):* All behavioral health providers must report to the state all adverse incidents and serious occurrences involving individuals receiving services by licensed providers. Such incidents include death, physical abuse, inappropriate sexual conduct, medication misuse, psychological abuse, neglect, suicide attempt, serious injury, elopement, or natural disaster. There are provisions for investigation and corrective action, as necessary.

*Mental Health (MH):* CMHCs are required to have a complaint process accessible to patients. Decisions on complaints may be appealed to the state by the consumer. Use of restraint and seclusion is required to be reported to the state in instances resulting in serious injury.

*Substance Use Disorder (SUD):* All substance use treatment facilities must ensure the clients receives a copy of the document identifying their rights, which include but are not limited to the rights to dignity; non-abuse; safety; to be free from restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation; nondiscrimination; privacy; to refuse treatment; informed consent; to be treated in the least restrictive setting; to make a

grievance/complaint; and to have visitors. Complaints of violations of licensing standards are investigated by the state.

## **Quality Assurance or Improvement**

*Mental Health (MH):* CMHCs, including residential facilities, are required to adopt and adhere to written policies and procedures that provide for a comprehensive quality improvement program designed to continually measure, assess, and improve the quality of the services that are provided by the center, any affiliated center, or any other provider with which the center has an affiliation agreement. These policies and procedures shall require measures of consumer satisfaction with treatment, consumer feedback to staff, procedures to ensure access to information about the risk management and utilization management programs by those responsible for quality improvement, and 5-years of records demonstrating compliance with these regulations.

*Substance Use Disorder (SUD):* All substance use disorder treatment facilities must have a risk management review process involving incidents that present a risk of harm to consumers, staff, and other individuals, including the public at large. They also must have a quality improvement plan designed to assess, measure, improve, and maintain the quality of services provided.

## **Governance**

*Mental Health (MH):* CMHCs do have board composition requirements.

*Substance Use Disorder (SUD):* The general substance use treatment regulations include requirements related to the provider's governing authority, including requirements related to policies, the executive director's duties, and operating procedures.

## **Special Populations**

*Mental Health (MH):* Requirements regarding residential services were not explicitly described in the state regulations.

*Substance Use Disorder (SUD):* Kansas has eight Designated Women's Substance Abuse Treatment Programs. Designated Women's Programs provide specialized services to meet the needs of women and their children, as well as give priority admission to pregnant women, women with dependent children and women using IV drugs. Pregnant women are given priority status by federal mandate for admission to treatment. All pregnant women must be offered an assessment within 24 hours of initial contact, and admitted into treatment within 48 hours, as clinically indicated. Women with dependent children, including those who are attempting to

regain custody, are also given priority status by a state mandate for admission to treatment. Women who use IV drugs are given priority status by federal mandate for admission to treatment. All women using IV drugs must be offered an assessment and admitted into treatment within 14 days, as clinically indicated.

## **Location of Regulatory and Licensing Requirements**

KDAD Article 60--Licensing of Community Mental Health Centers<sup>2</sup>; Kansas DOADS Community Services<sup>3</sup>; and Kansas DOADS Programs Commission Substance Use Treatment Services<sup>4</sup>; Adverse Incident Reporting<sup>5</sup>. Regulatory data collected May 9, 2019.

## **Other Information Sources**

S. Simpson, KDADS; National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>2</sup> See [https://www.kdads.ks.gov/docs/default-source/survey-certification-and-credentialing-commission/bhs-licensure---alcohol-and-drug-evaluators/cmhcs/cmhc-regulations-series-30-60-thru-30-61.pdf?sfvrsn=8d1739ee\\_2](https://www.kdads.ks.gov/docs/default-source/survey-certification-and-credentialing-commission/bhs-licensure---alcohol-and-drug-evaluators/cmhcs/cmhc-regulations-series-30-60-thru-30-61.pdf?sfvrsn=8d1739ee_2).

<sup>3</sup> See <https://www.kdads.ks.gov/commissions/behavioral-health/consumers-and-families/services-and-programs/substance-use-disorder-treatment-services>.

<sup>4</sup> See <https://www.kdads.ks.gov/commissions/survey-certification-and-credentialing-commission>.

<sup>5</sup> See [https://www.kdads.ks.gov/docs/default-source/survey-certification-and-credentialing-commission/bhs-policies-and-regulations/General/licen-310---adverse-incident-reporting.pdf?sfvrsn=3cba39ee\\_0](https://www.kdads.ks.gov/docs/default-source/survey-certification-and-credentialing-commission/bhs-policies-and-regulations/General/licen-310---adverse-incident-reporting.pdf?sfvrsn=3cba39ee_0).



# KANSAS MEDICAID

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## Approach

*Mental Health (MH) and Substance Use Disorder (SUD):* The Kansas Department of Health and Environment oversees the state Medicaid program. Researchers found no evidence of Medicaid coverage of residential mental health treatment for adults. The Kansas section 1115 waiver permits Medicaid coverage of expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental disease diseases (IMD). Kansas does not rely on the in lieu of provision to fund aspects of services provided in IMDs but historically has relied on Disproportionate Share Hospital (DSH) payments for certain services in an IMD.

## Types of Facilities

*Substance Use Disorder (SUD):* The residential settings identified in the waiver as eligible for coverage include the following ASAM Levels:

- Level 3.1
- Level 3.3
- Level 3.5
- Level 3.7
- Medically supervised withdrawal management

Medication-assisted treatment is also to be available to those in IMDs.

## Processes of Medicaid Enrollment

### *Mental Health (MH) and Substance Use Disorder (SUD):*

- Facilities offering medical services shall be licensed or certified by an appropriate Kansas state licensing or certification authority in order to be eligible for reimbursement by the Medicaid/Medikan program.
- Each provider seeking to participate shall perform the following, among other things: (1) Submit an application for participation in the Medicaid/Medikan program on forms prescribed by the secretary of the Kansas department of social and rehabilitation services; (2) obtain and maintain professional or department-specified credentials determined by the secretary in the jurisdiction where the service is provided and for the time period when the service is provided and, if applicable, be certified, licensed, or registered by the appropriate professional credentialing authority; (3) notify the Kansas department of social and rehabilitation services if any of the original information provided on the application changes during the term of participation in the Medicaid/Medikan program; (4) after completing the necessary application forms and receiving notice of approval to participate from the department, enter into and keep a provider agreement with the Kansas department of social and rehabilitation services; and (5) notify the Kansas department of social and rehabilitation services when a change of provider ownership occurs, submit new ownership information on forms for application for participation in the Medicaid/Medikan program, and receive approval from the department for participation as a new provider before reimbursement for services rendered to Medicaid/Medikan program consumers is made. Participation can be disallowed, suspended, or terminated.

## Staffing

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding credentials of staff for residential treatment settings. The state must conduct an assessment of the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT.

## Placement

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other

assessment and placement tools that reflect evidence-based clinical treatment guidelines. The state also must establish a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings. Pursuant to the waiver SUD implementation plan, KanCare, as part of the existing delivery system, used “a fidelity-based adaptation of the ASAM Patient Placement Criteria” as criteria for treatment. The state was to work with MCOs and providers to develop one standardized placement criteria that has fidelity to the ASAM placement criteria and uses a multi-dimensional assessment.

## **Treatment and Discharge Planning and Aftercare Services**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 SUD implementation plan, KanCare requires individual treatment plans. Standards were to be revised to incorporate ASAM standards.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Services must be medically necessary.

*Substance Use Disorder (SUD):* Under the Section 1115 waiver, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions. Pursuant to the Section 1115 waiver, the state must establish requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding the types of services and hours of clinical care for residential treatment settings. The state must establish a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site.

## **Care Coordination**

*Substance Use Disorder (SUD):* Under the Section 1115 waiver, beneficiaries will have improved care coordination and care for comorbid physical and mental health conditions. The state must ensure establishment and implementation of policies to ensure residential facilities link beneficiaries with community-based services and supports following stays in these facilities. Pursuant to the waiver SUD implementation plan, KDHE and KDADS were to implement a coordinated approach to increasing service coordination across the spectrum of care.

## Quality Assurance or Improvement

*Substance Use Disorder (SUD)*: Pursuant to the Section 1115 waiver, the state must establish a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other nationally recognized SUD program standards based on evidence-based clinical treatment guidelines.

## Special Populations

*Substance Use Disorder (SUD)*: Under the Section 1115 waiver, beneficiaries will have improved care for comorbid physical and mental health conditions.

## Location of Medicaid Requirements

Kansas Administrative Regulations Agency 30, Department for Children and Families; Article 5, Provider Participation, Scope of Services, and Reimbursements for the Medicaid (Medical Assistance) Program<sup>6</sup>; Kansas Administrative Regulations Agency 129, Department of Health and Environment--Division of Health Care Finance<sup>6</sup>; KanCare Section 1115 waiver<sup>7</sup>; SUD Implementation Plan<sup>8</sup>. Regulatory data collected December 5, 2019.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019. <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report “**State Residential Treatment for Behavioral Health Conditions: Regulation and Policy**”. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

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<sup>6</sup> See [https://www.ksos.org/pubs/pubs\\_kar.aspx](https://www.ksos.org/pubs/pubs_kar.aspx).

<sup>7</sup> See <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ks/ks-kancare-ca.pdf>.

<sup>8</sup> See <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ks/KanCare/ks-kancare-cms-appvl-sud-implementation-plan-20190807.pdf>.

## KENTUCKY

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### Types of Facilities

*Mental Health (MH) and Substance Use Disorder (SUD):* Kentucky regulates residential crisis stabilization units (CSUs), including those serving at-risk adults or adults with severe mental illness, or individuals with SUD or co-occurring disorders. CSUs are a community-based facility that is not part of an inpatient unit and which provides crisis services to no more than 12 clients who require over-night stays.

*Mental Health (MH):* Other than CSUs, Kentucky does not regulate adult residential MH services, unless they are offered as part of CMHCs.

*Substance Use Disorder (SUD):* Kentucky regulates residential alcohol and drug abuse treatment entities (AODEs). A residential facility is defined as a setting that provides 24 hour structure and support in which addiction and mental health treatment personnel provide organized and intensive individual and group therapeutic activities to strengthen a client's recovery skills. Residential AODEs include four facility types which, under regulations repealed in July 2019, were defined as follows:

- A Family Residential Program is an organized intensive set of therapeutic activities provided in an environment where the client resides 24 hours a day with the client's children.
- A Residential Transitional Living Program is a therapeutic group setting, where counseling is provided either on site by staff or off site, and where a client resides 24 hours a day, and makes a social and vocational adjustment prior to returning to family or independent living in the community.
- A Residential Treatment Program is a set of organized and intensive individual and group therapeutic activities, provided in a 24 hour setting, which assists a client in recovering from alcohol or other drug abuse.
- Clinically Managed Residential Withdrawal Management programs, which are undefined but include medication-assisted treatment (MAT).

Kentucky also regulates certain other substance use treatment facilities as health facilities. These include:

Community mental health centers (CMHCs) which provide a comprehensive range of MH and SUD services and which may include residential SUD treatment services. Such CMHC-run programs are a subset of residential AODEs.

*Unregulated Facilities:* The licensure requirements do not apply to residential SUD facilities owned or operated by the U.S. government. We exclude from this summary medically managed intensive inpatient withdrawal management services and other services that may be provided in a freestanding chemical dependency treatment program because the state considers the freestanding programs to be inpatient level of care. State staff did inform us of the following three additional categories of residential facilities: (1) “Boarding Homes” which house individuals with behavioral health concerns and are regulated but which do not provide treatment and, therefore, fall outside the scope of this summary; (2) 14 “Recovery Kentucky Centers” which provide housing and SUD recovery services and which vary in size from 9 to 100 beds; and (3) residential SUD facilities that are unregulated as “Faith Based” facilities.

## **Approach**

The Kentucky Cabinet for Health and Family Services regulates residential behavioral health treatment facilities. CSUs, which provide both MH and SUD treatment, are regulated by the Cabinet’s Office of Inspector General (OIG) -- as part of its regulation of health facilities. The OIG also regulates CMHCs as health facilities and CMHCs can include residential SUD treatment. Another division of the Cabinet, the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID), regulates AODEs for the treatment of SUD. Because CMHCs that provide residential SUD treatment are also considered AODEs, those facilities are regulated both by OIG and CBHDD.

## **Processes of Licensure or Certification and Accreditation**

*Mental Health (MH) and Substance Use Disorder (SUD):* Licensure by the OIG is required for operation of all residential CSUs. A provisional license is granted if the application is complete and no statutory or regulatory deficiencies are identified. The provisional license is effective until on-site inspection and verification of compliance with legal requirements. An unannounced inspection will occur within 3 months of the effective date of the provisional license, with a focus on verifying compliance with each statute and administrative regulation applicable to the license requested.

- Accreditation is required for residential CSUs within one year of initial licensure. Accreditation may be by the Joint Commission; Commission on Accreditation of

Rehabilitation Facilities; Council on Accreditation; or another nationally recognized accreditation organization.

- A Certificate of Need is required.
- License duration is one year from the date of the provisional license.

*Substance Use Disorder (SUD):* Licensure by the DBHDID is required for all adult residential AODEs, excepting those operated by the federal government or a CSU.

- Accreditation is not required.
- An unannounced inspection may occur.
- A Certificate of Need is not required.
- License duration is one year.

Licensure as a health facility by OIG also is required for CMHCs, which may provide residential SUD treatment services as an AODE.

## **Cause-Based Monitoring**

*Mental Health (MH) and Substance Use Disorder (SUD):* Unannounced inspections of CSUs may occur, including but not limited to, in response to complaints. Licenses may be denied, revoked, modified, or suspended. If a regulatory violation is identified, the facility must submit a written plan for correction, and undertake corrective action.

*Substance Use Disorder (SUD):* Residential AODEs are subject to annual survey visits, investigations related to complaints, and on-site surveys where the Department deems it necessary. A plan of correction may be required if violations are found and licenses may be denied, suspended, or revoked for substantial violations.

## **Access Requirements**

*Mental Health (MH) and Substance Use Disorder (SUD):* Access requirements related to wait times were not located.

## Staffing

*Mental Health (MH) and Substance Use Disorder (SUD):* Residential CSUs must have an executive director and a program director who meets specific educational and experiential requirements. Background checks are required for all personnel and records must be maintained related to credentials, training, and performance. Except as otherwise provided, services must be delivered by a behavioral health professional or a behavioral health professional under clinical supervision. Specified services may be provided by a certified alcohol and drug counselor. A residential CSU shall have access to a board-certified or board-eligible psychiatrist twenty-four (24) hours per day, seven (7) days per week. The psychiatrist may serve more than one (1) residential CSU and be available through telehealth consultation. Medication prescribing and monitoring must be under the direction of a licensed psychiatrist, a licensed physician supervised by a psychiatrist, or an APRN certified in psychiatric-mental health nursing practice. Staffing ratios for direct care staff are included in the regulations as are requirements for training of those staff in the following, among other topics, detection and reporting of abuse, behavior management and de-escalation, physical management (includes some forms of restraint), suicide prevention and care, and trauma informed care.

*Substance Use Disorder (SUD):* DBHDID-regulated AODEs must have written personnel policies that include, among other things, requirements regarding personnel training on response to emergencies and critical incidents, abuse reporting, responding to domestic violence, trauma-informed care; and policies regarding personnel qualifications. Specific requirements related to training, supervision, licensure or certification, and work experience are in place for clinical services supervisors, clinicians, case managers, and peer support specialists.

- Clinically Managed Residential Withdrawal Management program services must be delivered by staff who are qualified to meet the needs of clients; and who are trained and competent to implement physician-approved protocols. Each clinician who is responsible for assessing and treating clients must be able to obtain and interpret information regarding the needs of the clients.
- General Residential Treatment Programs must be staffed 24 hours per day, 7 days per week and have: (a) A program manager, supervisor, or coordinator, including a designated staff person responsible for managing a program in the absence of the manager, supervisor, or coordinator; (b) A sufficient number of personnel to meet client needs; and (c) At least one staff person on duty and awake at all times who is trained in: (1) Crisis intervention; (2) Cardiopulmonary resuscitation; and (3) Standard first aid.
- A Residential Transitional Living Program that does not provide counseling services on-site must have a program manager who is responsible for the day-to-day management of the program, including: (a) Supervising caseworkers; and (b) Monitoring the implementation of program policies and procedures. The regulations include additional requirements for program manager training, education, experience. There also must be sufficient staff to



ensure that a staff person that meets the minimum requirements of a program manager is responsible for managing a program in the absence of the program manager. The program must have caseworkers who have specific responsibilities and who must satisfy specific training, education, and experience requirements.

OIG-regulated CMHCs that are AODEs have additional requirements, including that services be provided under the medical direction of a physician and requirements for continuous nursing services by a registered nurse.

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* Residential CSUs must complete a mental status evaluation and physical health questionnaire of the client upon admission. Insofar as CSUs provide MH treatment, the facilities may admit individuals who voluntarily seek mental health services or who need evaluation.

*Substance Use Disorder (SUD):* Intake information for DBHDID-regulated AODEs must include a biopsychosocial assessment, except in a residential transitional living program if counseling services are not provided on site; and a health status questionnaire or a copy of the record of a physical health examination. To ensure appropriate placement, the client must be assessed for a level of care determination based upon the most recent version of The American Society of Addiction Medicine (ASAM) Criteria. A residential AODE must ensure that a full physical examination is completed within 72 hours of admission.

- Clinically Managed Residential Withdrawal Management programs must accept and provide services only to clients meeting specific diagnostic criteria and the appropriate dimensional criteria as established in the most recent version of The American Society of Addiction Medicine (ASAM) Criteria. Clinically Managed Residential Withdrawal Management AODE programs services may only care for clients whose intoxication and withdrawal signs and symptoms require 24 hour structure and support without the need for medically monitored inpatient withdrawal management services.
- General Residential Treatment Programs must evaluate the client's need for each of the following at admission: (1) Alcohol and other drug abuse services; (2) Employment services; (3) Vocational education, training, or rehabilitation services; (4) Disability services; (5) Other health and human services; and (6) Assistance in developing daily living skills.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Residential CSUs must evaluate the need for continuing service immediately upon a change in a client's service needs or a change in the client's condition to ensure that proper arrangements have been made for: (a) Discharge; (b) Transfer; or (c) Referral to another service provider, if appropriate. They must have policies and procedures for discharge planning which shall begin at the time of admission and aftercare planning processes. They must have linkages with behavioral health services organizations which address identified needs and help promote continuity of care after discharge.

*Substance Use Disorder (SUD):* DBHDID-regulated AODEs must establish a treatment plan for each client that is initiated upon the client's admission; if applicable, includes pharmacological treatment modalities to manage opioid use disorder; is entered into the client's record within 72 hours following admission; is reviewed at least every two weeks in a residential AODE program; is rewritten every six (6) months; and is revised as necessary based on a change in treatment needs. Each client must be continually assessed by the residential AODE using the most recent version of the ASAM criteria to assess level of care and needs. The multidisciplinary team must review the treatment plan and client treatment progress at least every thirty (30) days with the review and any revisions documented in the client's clinical record.

- In a General Residential Treatment Program, a written recovery plan must be developed to identify and promote aspects of continuing care for SUD that are associated with success in recovery and be based on the client's needs at discharge, including activities and any referrals to support recovery.
- In a Clinically Managed Residential Withdrawal Management program, assessment and treatment planning must include: (a) An individualized treatment plan; (b) Daily assessment of: (1) Progress during withdrawal management, and (2) Any treatment changes; (c) Transfer and discharge planning, beginning at the point of admission; and (d) Referral and linkage arrangements. A client must continue with clinically managed residential withdrawal management until specified requirements are met.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Residential CSUs must provide the following services: (a) Screening; (b) Assessment; (c) Treatment planning; (d) Individual outpatient therapy; (e) Group outpatient therapy; and (f) Psychiatric services. They may provide: (a) Family therapy; or (b) Peer support by a peer support specialist. A residential CSU must provide treatment for acute withdrawal, if appropriate. It must have policies and procedures for crisis intervention and make referrals for physical health services to include diagnosis, treatment, and consultation for acute or chronic illnesses.

- Insofar as CSUs apply to the treatment of MH, services must include: Evaluations; Crisis intervention and emergency mental health services; and Referral for follow-up care. CSUs shall be operated as twenty-four (24) hour per day, seven (7) days per week facilities.

*Substance Use Disorder (SUD):* A residential AODE must provide the following services: (a) orders for medication, medical treatment, and other services; (b) treatment for substance use disorder; (c) integrated treatment of co-occurring disorders, either on-site or through the coordination of treatment services with an appropriate mental health facility, if applicable; (d) vocational and educational services if needed, either on-site or by referral to community resources; (e) opportunities for the client to voluntarily participate in support group meetings during treatment; and (f) family supports, recovery supports, spiritual, housing, and social support services as needed. Case management services must be based on: (a) Goals established in the client's clinical assessment; and (b) Development of an individualized person-centered treatment plan that identifies the case management activities that support implementation of the plan.

- Clinically Managed Residential Withdrawal Management program services are designed to provide 24 hour supervision, observation, and support for clients who are intoxicated or experiencing withdrawal but do not require medically monitored inpatient withdrawal management services. Requirements include use of clinical protocols; availability of specialized clinical consultation and supervision for biomedical, emotional, behavioral, and cognitive problems; availability of medical evaluation and consultation 24 hours per day; Affiliation with other levels of care; and Ability to arrange for appropriate laboratory and toxicology tests. Therapies must include: (a) Daily clinical services to assess and address the needs of each client, including the following if needed: (1) Medical services, including: (i) Medically assisted withdrawal, or (ii) Medication assisted treatment, provided onsite or through referral, (2) Individual counseling, (3) Group counseling, or (4) Withdrawal support; (b) A range of cognitive, behavioral, medical, mental health, and other therapies as needed to enhance a client's understanding of: (1) Addiction, (2) Co-occurring disorders, (3) Completion of the withdrawal management process, and (4) Referral to an appropriate level of care for continuing treatment; (c) Withdrawal rating scale tables and flow sheets that include tabulation of vital signs if needed; (d) Interdisciplinary individualized assessment and treatment; (e) Health education services; and (f) Services to families and significant others.
- General Residential Treatment Programs must provide off-site supervision and transportation to services that may be off-site. They may provide clinically managed residential withdrawal management. A residential treatment program must provide each client, and their family or significant other, specific education. A residential treatment program client must receive at least six hours each day in structured activities, including but not limited to: (a) Alcohol and other drug abuse education; (b) Individual, group, or family counseling in which the client shall participate a minimum of ten (10) hours each week; and (c) On-site or off-site recovery support meetings. If counseling is provided in a group, there shall be a maximum of twelve (12) clients per clinician.

- Family Residential Treatment Programs may provide clinically managed residential withdrawal management. Among other things, they must provide parenting education to the client if identified in the client’s treatment plan. Specific requirements relate to services for and care of the children.
- Residential Transitional Living Programs must ensure that each client participates in counseling and planned clinical program activities a minimum of five (5) hours per week, including individual, group, or family counseling and recovery support meetings.

OIG-regulated CMHCs that are residential AODEs must: (a) Provide intensive treatment and skills building in a structured and supportive environment; (b) Assist the client in abstaining from alcohol or substance use and in entering alcohol or drug addiction recovery; (c) Provide services in a twenty-four (24) hour a day, live-in facility that offers a planned and structured regimen of care aimed at treating individuals with addiction or co-occurring mental health and substance use disorders; and (d) Assist the client in making necessary changes to enable the individual to live drug- or alcohol-free.

## **Patient Rights and Safety Standards**

*Mental Health (MH) and Substance Use Disorder (SUD):* OIG-regulated residential CSUs must have written policies and procedures governing client grievances that meet certain requirements. A statement of rights and responsibilities must be provided to the client in a way that is understandable and include, but not be limited to, the right to dignity, treatment, informed consent, to be free from abuse, communication, and privacy. Prone holds, chemical restraint, and mechanical restraint are prohibited in a residential CSU, as are cruel and unusual disciplinary measures. “Personal restraint” is allowed under certain circumstances. DBHDID regulations for CSUs also limit the use of restraint and establish rights to privacy and communication.

*Substance Use Disorder (SUD):* An AODE regulated by DBHDID must have written policies to protect the rights of clients and must post those policies conspicuously. Rights include but are not limited to rights to nondiscrimination, informed consent, to file a grievance, confidentiality, be treated with dignity, privacy, and to vote.

- General Residential Treatment AODE Programs also must ensure other rights including, but not limited to, communication, privacy, and religion.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* OIG-regulated residential CSUs and AODEs regulated by the DBHDID must have a quality assurance and utilization review program designed to: (a) Enhance treatment and care through the ongoing objective assessment of services provided, including the correction of identified problems; and (b) Provide an effective mechanism for review and evaluation of the service needs of each client.

*Substance Use Disorder (SUD):* A residential AODE must have a utilization review team that: (a) Is made up of a representative sample of the AODE's clinical staff responsible for providing services; (b) Assesses the appropriateness and clinical necessity of client admissions; (c) Evaluates the need for continuing services immediately upon a change in a client's service needs or a change in the client's condition to ensure that proper arrangements are made; and (d) Submits a written record of findings related to inappropriate patterns of service accompanied by recommended action for correcting a problem to the administrator or other individual with overall responsibility for the program's treatment services.

## **Governance**

*Substance Use Disorder (SUD):* AODEs regulated by DBHDID must have a governing authority that is legally responsible for the management, operation, and financial viability of the AODE, and must, among other things, establish policies and procedures, appoint an administrator, and review policies at least every two years. Policies and procedures must govern, among other things, responding to critical incidents or emergencies; admission and discharge criteria; referrals; record keeping; personnel; creation of a trauma-informed environment; grievances; and alcohol and drug use and screening.

## **Special Populations**

*Substance Use Disorder (SUD):* AODEs regulated by DBHDID have requirements related to patients with co-occurring disorders, including requirements for screening and treatment. An AODE that provides SUD treatment to clients diagnosed with a co-occurring disorder shall have clearly written policies and procedures that: (a) Govern the integrated treatment of SUD and MH treatment; (b) Allow for the use of psychiatric medication when indicated; (c) Include developing and maintaining affiliation agreements, case consultation, and a referral mechanism to mental health treatment services in order to facilitate the provision of integrated treatment services; and (d) Include the qualifications of clinical staff responsible for screening, assessing, diagnosing, and treating clients with co-occurring disorders.

## **Location of Regulatory and Licensing Requirements**

Kentucky Revised Statutes Ch 216B<sup>1</sup>; Kentucky Revised Statutes Ch 222<sup>2</sup>; Kentucky Cabinet for Health and Family Services Department of Public Health, Health Services and Facilities Regulations<sup>3</sup>; Kentucky Cabinet for Health and Family Services, Department for Behavioral Health, Developmental, and Intellectual Disabilities Regulations<sup>4</sup>. Regulatory data collected July 24, 2019.

## Other Information Sources

M. Blevins (DBH); S. Brammer-Barnes (OIG); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>1</sup> See <https://apps.legislature.ky.gov/law/statutes/chapter.aspx?id=38238>.

<sup>2</sup> See <https://apps.legislature.ky.gov/law/statutes/chapter.aspx?id=38279>.

<sup>3</sup> See <https://apps.legislature.ky.gov/law/kar/TITLE902.HTM>.

<sup>4</sup> See <https://apps.legislature.ky.gov/law/kar/TITLE908.HTM>.

# KENTUCKY MEDICAID

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

## Approach

The Kentucky Cabinet for Health and Family Services, Department for Medicaid Services (DMS) oversees the state Medicaid program. Kentucky also has a Section 1115 waiver permitting Medicaid expenditures for substance use disorder (SUD) residential treatment, crisis stabilization withdrawal management services provided in a residential IMD. Kentucky relies on the in lieu of provision and Disproportionate Share Hospital (DSH) Payments for payment of some services provided in IMDs.

## Types of Facilities

*Mental Health (MH) and Substance Use Disorder (SUD):* The Section 1115 waiver includes Medicaid coverage of Crisis Stabilization Units (CSUs) that are residential. CSUs provide services to: (1) Stabilize a crisis and divert an individual from a higher level of care; (2) Stabilize an individual and provide treatment for acute withdrawal, if applicable; and (3) Re-integrate an individual into the community or other appropriate setting in a timely fashion. They cannot be part of a hospital. With certain exceptions, they may not contain more than sixteen (16) beds or be part of multiple units comprising one (1) facility with more than sixteen (16) beds in aggregate.

*Substance Use Disorder (SUD):* Kentucky Medicaid regulations specify that, to be eligible for Medicaid reimbursement, the physical structure in which residential SUD services are provided must: (i) Have between 9 and 16 beds; and (ii) Not be part of multiple units comprising one facility with more than 16 beds in aggregate. The limit of 16 beds does not apply if the facility possesses a departmental provisional certification to provide residential SUD services that are equivalent to the appropriate level of The ASAM Criteria.

According to state Medicaid regulations, withdrawal management services reimbursed under Medicaid must: (a) Be provided face-to-face for recipients with an SUD or co-occurring disorders; (b) Be incorporated into a recipient's care as appropriate according to the continuum of care described in the most current version of The ASAM Criteria; (c) Be in accordance with the most current version of The ASAM Criteria for withdrawal management levels in an outpatient setting; and (d) If provided in a residential SUD program, comply with the state licensing standards.

Pursuant to the Section 1115 waiver, OUD/SUD residential treatment, crisis stabilization and withdrawal management services provided in a residential IMD are now covered. According to the Section 1115 waiver, both Behavioral Health Service Organizations (BHSOs) and Community Mental Health Centers (CMHCs) are able to provide SUD waiver services.

- The waiver requires the DMS to incorporate all levels of withdrawal management, including but not limited to, Levels 3.2-WM and 3.7-WM.

## **Processes of Medicaid Enrollment**

*Mental Health (MH) and Substance Use Disorder (SUD):* To be enrolled as a Medicaid provider in Kentucky, the provider must, among other things, submit an application and submit proof of a valid professional license, registration, or certification that allows the entity to provide services within its scope of practice. A provider enrolled in the Medicaid program must submit to the department's recertification process 3 years from the date of the provider's initial evaluation or last reevaluation. Enrollment may be revoked, and other sanctions applied.

*Substance Use Disorder (SUD):* To be a Medicaid provider of residential SUD treatment or withdrawal management, a provider must be enrolled and participating in the Kentucky Medicaid Program and have: (1) For each service it provides, the capacity to provide the full range of the service as established in this administrative regulation; (2) Documented experience in serving individuals with SUDs; (3) The administrative capacity to ensure quality of services; (4) A financial management system that provides documentation of services and costs; and (5) The capacity to document and maintain individual case records.

- A BHSO must: (a) Agree to provide services in compliance with federal and state laws regardless of age, sex, race, creed, religion, national origin, handicap, or disability; (b) Comply with the Americans with Disabilities Act and any amendments to the Act; and (c) Provide, directly or through written agreement with another behavioral health services provider, access to face-to-face or telehealth, as appropriate, emergency services 24 hours per day, 7 days per week.
- A residential SUD treatment facility must: (a) Possess an AODE license; (b) Possess accreditation within one year of initial enrollment by one of the following: (1) The Joint Commission, (2) The Commission on Accreditation of Rehabilitation Facilities, (3) The Council on Accreditation, or (4) A nationally recognized accreditation organization; and (c) Be authorized to provide residential SUD treatment services to treat SUD and cooccurring disorders.



- After July 1, 2021, the facility must possess an appropriate ASAM Level of Care Certification in accordance with The ASAM Criteria. According to the Section 1115 waiver, the certification will be by DMS and will require an inspection.

## **Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD):* A CSU must have the capacity to employ staff authorized to provide required treatment services and to coordinate the provision of services among team members; have access to a board certified or board-eligible psychiatrist 24 hours a day, 7 days a week, every day of the year; and have knowledgeable staff regarding SUDs. Detailed requirements are included in the Medicaid regulations regarding types of providers that may provide different services.

*Substance Use Disorder (SUD):* State Medicaid regulations require that residential SUD services: Be provided under the medical direction of a physician; Provide continuous nursing services in which a registered nurse shall be: (i) On-site during traditional first shift hours, Monday through Friday; (ii) Continuously available by phone after hours; and (iii) On-site as needed in follow-up to telephone consultation after hours. To provide residential SUD services, a BHSO must: Have the capacity to employ staff authorized to provide required services and to coordinate the provision of services among team members. A BHSO III may provide residential SUD services and support services if provided by specified practitioners.

Withdrawal management services must be provided by: (a) A physician; (b) A psychiatrist; (c) A physician assistant; (d) An advanced practice registered nurse; or (e) Any other approved behavioral health practitioner with oversight by a physician, advanced practice registered nurse, or a physician assistant.

Pursuant to the Section 1115 waiver, the state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings. The state must assess the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT.

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* CSUs are to be used when an individual: (1) Is experiencing a behavioral health crisis that cannot be safely accommodated within the individual's community; and (2) Needs overnight care that is not hospitalization.

*Substance Use Disorder (SUD):* State Medicaid regulations require that residential SUD services be provided following an assessment and a determination that the individual meets the dimensional admission criteria for approval of residential level of care placement in accordance with the most current edition of the ASAM Criteria. Length-of-stay for residential services for SUD must be person centered and according to an individually designed plan of care that is consistent with this administrative regulation and the licensure of the facility and practitioner.

A recipient who is receiving withdrawal management services must: (a) Meet the most current edition of diagnostic criteria for substance withdrawal management found in the Diagnostic and Statistical Manual of Mental Disorders; and (b) Meet the current dimensional admissions criteria for withdrawal management level of care as found in The ASAM Criteria.

Pursuant to the Section 1115 waiver, the state must establish a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* A CSU must provide treatment planning.

*Substance Use Disorder (SUD):* A BHSO must establish a plan of care for each recipient receiving services from the BHSO that meets the requirements established in state licensing standards.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* A CSU that is a Medicaid provider must be a community-based, residential program that offers an array of services including: (1) Screening; (2) Assessment; (3) Treatment planning; (4) Individual outpatient therapy; (5) Group outpatient therapy; (6) Psychiatric services; (7) Family outpatient therapy at the option of the residential crisis stabilization unit; or (8) Peer support at the option of the residential crisis stabilization unit. Detailed requirements are included in the Medicaid regulations regarding the purpose of different services, limits on group size, and requirements related to hours devoted to services. Services may be provided for: (1) A MH disorder; (2) A SUD; or (3) Co-occurring MH and SUD. Services must be medically necessary.

*Substance Use Disorder (SUD):* Services provided by a BHSO must be medically necessary. Residential services for SUD must: (a) Be provided in a twenty-four (24) hour per day unit that is a live-in facility that offers a planned and structured regimen of care aimed to treat

individuals with addiction or cooccurring disorders; (b) Provide intensive treatment and skills building in a structured and supportive environment; (c) Assist an individual in abstaining from alcohol or substance use and in entering alcohol or drug addiction recovery; (d) Assist a recipient in making necessary changes in the recipient's life to enable the recipient to live drug- or alcohol-free; and (e) Be based on individual need and shall include clinical activities to help the recipient develop and apply recovery skills. Residential services may include: (a) A screening; (b) An assessment; (c) Service planning; (d) Individual outpatient therapy; (e) Group outpatient therapy; (f) Family outpatient therapy; (g) Peer support; (h) Withdrawal management; or (i) Medication assisted treatment.

Medication assisted treatment may be provided in a residential SUD treatment program. If a residential treatment program for substance use disorders does not offer medication assisted treatment on-site, care coordination must be provided to facilitate medication assisted treatment off-site if necessary, by recipient choice. If the choice of medication in medication assisted treatment is methadone, the residential treatment provider must establish a contractual relationship with a narcotic treatment program that dispenses methadone.

## **Care Coordination**

*Substance Use Disorder (SUD):* State Medicaid regulations require that, for beneficiaries in residential SUD treatment, care coordination must include at minimum: (1) medication assisted treatment, if the beneficiary elects to receive medication assisted treatment or facilitation of medication assisted treatment off-site, if not offered on-site; (2) referral to appropriate community services; (3) facilitation of medical and behavioral health follow ups; and, (4) linking the recipient to the appropriate level of substance use treatment within the continuum to provide ongoing supports. If a residential treatment program for substance use disorders does not offer medication assisted treatment on-site, care coordination must be provided to facilitate medication assisted treatment off-site if necessary, by recipient choice. If the choice of medication in medication assisted treatment is methadone, the residential treatment provider shall establish a contractual relationship with a narcotic treatment program that dispenses methadone.

Pursuant to the Section 1115 waiver, the state must establish and implement policies to ensure residential facilities link beneficiaries with community-based services and supports following stays in these facilities.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* A CSU must have the administrative capacity to ensure quality of services.

*Substance Use Disorder (SUD)*: Pursuant to the Section 1115 waiver, the state must establish a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings.

## Special Populations

*Substance Use Disorder (SUD)*: A residential SUD treatment facility must be authorized to provide residential SUD treatment services to treat SUD and cooccurring disorders.

## Location of Medicaid Requirements

Kentucky Medicaid Rules and Regulations<sup>5</sup>; Kentucky Section 1115 waiver<sup>6</sup>; Section 1115 SUD implementation plan<sup>7</sup>. Regulatory data collected November 2019.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report “**State Residential Treatment for Behavioral Health Conditions: Regulation and Policy**”. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

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<sup>5</sup> See <https://apps.legislature.ky.gov/law/kar/TITLE907.HTM>.

<sup>6</sup> See <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-ca.pdf>.

<sup>7</sup> See <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/health/ky-health-sud-implement-protocol-apprvl-10052018.pdf>.

## LOUISIANA

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

### Types of Facilities

*Mental Health (MH) and Substance Use Disorder (SUD):* Louisiana regulates:

- *Forensic Supervised Transitional Residential and Aftercare Facility (FSTRA):* serves clients referred by state forensic hospitals or state forensic inpatient psychiatric units operated by the Department of Health, including persons who are court ordered and persons who are on court ordered conditional release status. A FSTRA facility shall operate 7 days per week, 24 hours a day.
- Louisiana regulates Behavioral Health Service (BHS) providers. This includes all mental health and substance use treatment providers with certain exceptions not relevant here. Among the facilities falling under the BHS definition are *Residential Treatment Programs* which involve a planned regimen of 24-hour professionally-directed evaluation, observation, monitoring and treatment of behavioral health conditions according to a treatment plan.
- *Level III Crisis Receiving Center (CRC):* an agency, business, institution, society, corporation, person or persons, or any other group, licensed by the Department of Health and Hospitals to provide crisis identification, intervention and stabilization services for people in behavioral crisis. A CRC shall be no more than 24 beds. The purpose of a CRC is to provide intervention and stabilization services in order for the client to achieve stabilization and be discharged and referred to the lowest appropriate level of care that meets the client's needs. The estimated length of stay in a CRC is 3-7 days.

*Substance Use Disorder (SUD):* Louisiana regulates the following adult residential SUD treatment facilities:

- *Substance Abuse/Addiction Treatment Service:* a service “related to the screening, diagnosis, management, or treatment for the abuse of or addiction to controlled dangerous substances, drugs or inhalants, alcohol, problem gambling or a combination thereof; may also be referred to as substance use disorder service.” Residential forms of these services are defined along the ASAM Level spectrum and include:

- *Clinically Managed Low Intensity Residential Treatment Program (ASAM Level III.1):* a residential program that offers at least five hours a week of a combination of low-intensity clinical and recovery-focused services for substance-related disorders. Services may include individual, group and family therapy, medication management and medication education, and treatment is directed toward applying recovery skills, preventing relapse, improving emotional functioning, promoting personal responsibility and reintegrating the client into the worlds of work, education and family life (e.g., halfway house).
- *Clinically Managed Residential Detoxification or Social Detoxification (ASAM LEVEL III.2D):* an organized residential program utilizing 24 hour active programming and containment provided in a non-medical setting that provides relatively extended, sub-acute treatments, medication monitoring observation, and support in a supervised environment for a client experiencing non-life threatening withdrawal symptoms from the effects of alcohol/drugs and impaired functioning and who is able to participate in daily residential activities.
- *Clinically Managed Medium-Intensity Residential Treatment Program (ASAM Level III.3):* a residential program that offers at least 20 hours per week of a combination of medium-intensity clinical and recovery-focused services in a structured recovery environment to support recovery from substance-related disorders; is frequently referred to as extended or long term care.
- *Clinically Managed High-Intensity Residential Treatment Program (ASAM Level III.5):* a residential program that offers continuous observation, monitoring, and treatment by clinical staff designed to treat clients experiencing substance-related disorders who have clinically-relevant social and psychological problems, such as criminal activity, impaired functioning and disaffiliation from mainstream values, with the goal of promoting abstinence from substance use and antisocial behavior and affecting a global change in clients' lifestyles, attitudes and values.
- *Medically Monitored Intensive Residential Treatment Program (ASAM Level III.7):* a residential program that provides a planned regimen of 24-hour professionally directed evaluation, observation, medical monitoring and addiction treatment to clients with co-occurring psychiatric and substance disorders whose disorders are so severe that they require a residential level of care but do not need the full resources of an acute care hospital. The program provides 24 hours of structured treatment activities per week, including, but not limited to, psychiatric and substance use assessments, diagnosis treatment, and habilitative and rehabilitation services.
- *Medically Managed Residential Detoxification (Medically Supported Detoxification) (ASAM Level III.7D):* a residential program that provides 24-hour observation, monitoring and treatment delivered by medical and nursing professionals to clients whose withdrawal signs and symptoms are moderate to severe and thus require residential care, but do not need the full resources of an acute care hospital.

*Unregulated Facilities:* Therapeutic group homes and psychiatric residential treatment facilities serve those under age 21 and are excluded from this summary. Adult residential care providers

are excluded as they do not fall within the scope of residential treatment facilities. All three have separate regulatory standards.

## **Approach**

*Mental Health (MH) and Substance Use Disorder (SUD):* The Louisiana Department of Health (LDH) licenses and regulates all residential treatment facilities under review in this document.

## **Processes of Licensure or Certification and Accreditation**

Mental Health (MH) and Substance Use Disorder (SUD):

- For FSTRAs, licensure by the LDH is required for operation. Licensure duration is one year, at which time a renewal application must be submitted. An announced licensing survey is required for licensure and renewal.
- For CRCs, licensure by LDH is required for operation. Licensure duration is one year, at which time a renewal application must be submitted. An announced licensing survey is required for licensure and renewal.
- For all facilities, licensure by LDH as a Behavioral Health Service (BHS) provider is required for operation. Licensure duration is one year, at which time a renewal application must be submitted. A licensing survey is required for licensure and renewal.
- Accreditation is not required for licensure, however LDH staff indicate that accreditation may be required by state law, rules, or regulations for certain MH/SUD facilities to receive state or federal funding. Accreditation by a Department-authorized accreditation organization confers deemed status upon an applicant, which results in no periodic licensing surveys being conducted by the department.
- LDH staff were unable to confirm whether adult residential care units have certificate of need requirements.

## **Cause-Based Monitoring**

*Mental Health (MH) and Substance Use Disorder (SUD):* For FSTRAs, the Department shall conduct unannounced complaint surveys, with the possibility of follow-up surveys should there be deficiencies cited. The Department may also issue appropriate sanctions, including civil monetary penalties, directed plans of correction, and license revocations for deficiencies and non-compliance with any complaint survey.

For CRCs, the Department may conduct periodic licensing surveys to “ensure compliance with all laws, rules and regulations governing crisis receiving centers and to ensure client health, safety and welfare. These surveys may be conducted on-site or by administrative review and shall be unannounced.” Additionally, the Department can conduct unannounced complaint surveys. Sanctions may be imposed for deficiencies or violation of law, including but not limited to fines, plans of correction, provisional licensure, revocation, or nonrenewal.

For all MH/SUD facilities, the Department is empowered to conduct periodic licensing surveys and any other surveys it deems necessary. The surveys shall be unannounced and can include either an administrative review or an on-site visit. The Department can issue sanctions for deficiencies and violations, including fines and the revocation of licensure.

## **Access Requirements**

*Mental Health (MH) and Substance Use Disorder (SUD):* For all facilities, no providers shall refuse admission to any individual on the grounds of “race, religion, national origin, sexual orientation, ethnicity or disability.” Wait time requirements were not located.

## **Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD):* For FSTRAs, there shall be a written personnel policy that includes a plan for recruitment, screening, orientation, ongoing training, development, supervision, and performance evaluation of staff members.

FSTRAs shall have, as part of their core staffing requirements, a consulting forensic psychiatrist; an administrator/director with either a degree of six years of experience; registered nurses; licensed practical nurses; and direct care staff that have at minimum high school diploma and two years of experience. There shall at minimum one direct care staff person on duty for every 15 clients. The facility shall demonstrate that sufficient staff are scheduled.

FSTRAs shall provide a 20-hour orientation training to all incoming staff and 16 hours of additional training annually. The training shall include, but not be limited to, clients rights, infection control, and client care services.

CRCs shall develop written personnel policies that cover the recruitment, screening, orientation, ongoing training, development, supervision and performance evaluation of staff including volunteers. All staff shall receive orientation training prior to working in the CRC, 40 hours of which should cover crisis services and intervention training. Additionally, every year staff are required to receive in-service training, 12 hours of which covers crisis services and intervention training. These trainings shall include, but not be limited to, grievance processes;



program philosophy; detecting signs of illness or dysfunction that warrant medical or nursing intervention; and the components of a crisis cycle.

Minimum staff for a CRC shall include a manager with a master's degree and one year of qualifying experience; a clinical director who is a physician or a psychiatric and mental health nurse practitioner with an unrestricted APRN license; a nurse manager with an unrestricted license as an RN; an authorized licensed prescriber who is a physician or a psychiatric and mental health nurse practitioner with an unrestricted APRN license; licensed mental health professionals; and nurses. The CRC may also hire non-licensed clinical staff that are overseen by the nursing staff.

For all MH/SUD facilities, providers shall develop, implement, and comply with written personnel policies that address recruitment, screening, orientation, ongoing training, development, supervision and performance evaluation of employees. The policy shall ensure that all staff, either contracted or directly employed, receive training relative to the restrictive use of social media and include, at a minimum, ensuring confidentiality of client information and preservation of client dignity and respect, including protection of client privacy and personal and property rights.

All MH/SUD providers shall maintain an organized and professional staff, and staff coverage in consideration of acuity of the clients being serviced; the time of day; the size, location, physical environment and nature of the provider; the ages and needs of the clients; and ensuring the continual safety, protection, direct care and supervision of clients. All staff shall receive orientation and annual in-service training.

All MH/SUD providers shall have the following minimum staff: a medical director who is a physician or an advanced practice registered nurse; a clinical director is a licensed psychiatrist, psychologist, clinical social worker, professional counselor (LPC) or marriage and family therapist (LMFT) with a minimum of two years qualifying experience in treating psychiatric disorders and who maintains a current, unrestricted license; an administrator who has either a bachelor's degree from an accredited college or university or one year of qualifying experience that demonstrates adequate knowledge, experience and expertise in business management; a clinical supervisor who is an LMHP; and nursing staff.

*Substance Use Disorder (SUD):* For ASAM Level III facilities, there shall be a medical director that is a licensed physician, and there will be other employees such as licensed mental health professionals (LMHPs) that have documented credentials and unlicensed professionals (UPs).

For Level III.1, the provider shall have a clinical supervisor available for clinical supervision and by telephone for consultation, and there shall be at least one LMHP or UP on duty at least 40 hours a week. The LMHP/UP caseload shall not exceed 1:25 active clients, and there shall be at least one direct care aide on duty during each shift."

For Level III.2D, the provider shall ensure that there is a physician on call 24 hours per day, seven days per week and on duty as needed for management of psychiatric and medical needs of the clients; there is a clinical supervisor available for clinical supervision when needed and by telephone for consultation; there is at least one LMHP or UP available on site at least 40 hours per week; and each LMHP/UP's caseload shall not exceed 1:25.

For Level III.3, the provider shall ensure that there is a physician on call 24 hours per day and on duty as needed for management of psychiatric and medical needs; there is a clinical supervisor available for clinical supervision when needed and by telephone for consultation; there is 24 hour on-call availability by an RN plus a licensed nurse on duty whenever needed to meet the professional nursing requirements; there is a LMHP or UP on site 40 hours a week to provide direct client care; each LMHP/UP caseload shall not exceed 1:12; and there is at least one direct care aide on duty for each shift plus additional aides as needed.

For Level III.5, the provider shall ensure that there is a physician on call 24 hours per day, seven days per week, and on duty as needed for management of psychiatric and medical needs of the clients; there is a clinical supervisor available for clinical supervision when needed and by telephone for consultation; the provider shall have one licensed RN on call 24/7 to perform nursing duties for the provider; and there shall be at least one LMHP or UP on duty at least 40 hours per week. Each LMHP/UP's caseload shall not exceed 1:12; there shall be at least one direct care aide on duty on all shifts with additional as needed; and there shall be at least one licensed nurse on duty during the day and evening shifts to meet the nursing needs of the clients.

For Level III.7, the provider shall ensure that there is a physician on call 24 hours per day, seven days per week, and on duty as needed for management of psychiatric and medical needs; there is a clinical supervisor available for clinical supervision when needed and by telephone for consultation; there is at least one LMHP or UP on duty at least 40 hours/week; there is at least one RN on call 24 hours per day, seven days per week to perform nursing duties and at least one licensed nurse is on duty during all shifts with additional licensed nursing staff to meet the nursing needs of the clients; its on-site nursing staff is solely responsible for III.7 program and does not provide services for other levels of care at the same time; each LMHP/UP caseload shall not exceed 1:10; there is at least one direct care aide on duty on all shifts with additional as needed; and there is an activity or recreational therapist on duty at least 15 hours per week.

For Level III.7D, the provider shall have a physician on call 24 hours per day, seven days per week, and on duty as needed for management of psychiatric and medical needs of the clients. The provider shall have at least one RN on call 24 hours per day, seven days per week to perform nursing duties; there shall be at least one licensed nurse on duty during all shifts with additional as needed based upon the provider's census and the clients' acuity levels; there shall be a RN on-site no less than 40 hours per week who is responsible for conducting nursing assessments upon admission and delegating staffing assignments to the nursing staff based on the assessments and the acuity levels of the clients; and the provider shall ensure that its on-site nursing staff is solely responsible for III.7D program and does not provide services for other

levels of care at the same time. The provider shall have a clinical supervisor available for clinical supervision when needed and by telephone for consultation. The LMHP/UP caseload shall not exceed 1:10; there shall be at least one direct care aide on all shifts with additional as needed based upon the provider's census and the clients' acuity levels; and the provider shall have at least one employee on duty certified in CPR.

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* FSTRAs shall have a clear and specific written description of admission policies and procedures. This written description shall include, but is not limited to, types of clients suitable to the facility. An intake evaluation shall take place on the first day of admission, and a nursing assessment shall also be conducted. A diagnostic evaluation shall also be conducted, and include examination of the medical, psychosocial, social, behavioral and developmental aspects of the client's situation and reflect the need for services from a FSTRA.

A CRC shall admit only those individuals whose needs, pursuant to the screening, can be fully met by the center. Prior to admission to the CRC, the facility shall attempt to obtain documentation from the referring emergency room, agency, facility or other source, if available, that reflects the client's condition. A screening shall be conducted by an RN within 15 minutes of a client entering the center which determines the eligibility and appropriateness for admission. If the client qualifies for admission, a behavioral health assessment shall be conducted by an LMHP within four hours of admission. The LOCUS tool is not referenced.

For all MH/SUD facilities, prior to admission, providers shall either conduct an initial admission assessment or obtain a current assessment conducted within the past year that determines the individual's diagnosis and update the assessment to represent the client's current presentation.

*Substance Use Disorder (SUD):* All residential substance use treatment facilities must only accept clients clinically appropriate within the specific ASAM level of care criteria.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* For FSTRAs, the service plan shall be monitored on an ongoing basis by facility staff to determine its continued appropriateness and to identify when a client's condition or preferences have changed. A documented review of the service plan by the licensed professional staff shall be made at least every quarter.

CRC treatment planning records must include an initial plan and any updates or revisions, and clients have a right to participate in treatment plan development. Discharge planning beginning at admission is required, and referral must be to the most appropriate and least restrictive

setting available consistent with the client's needs. No aftercare, or follow-up planning requirements were identified.

For all facilities, treatment planning requirements are indicated, with updates as required. Discharge planning, beginning at admission, is also required. When a client begins the transition to a different level of care, the provider shall ensure that staff aids in coordination. Additionally, the residential provider responsible for the transfer and discharge of the client shall request and receive approval from the receiving provider prior to the transfer; notify the receiving provider prior to the arrival of the client of any significant medical and/or psychiatric conditions and complications or any other pertinent information that will be needed to care for the client prior to arrival; transfer all requested client information and documents upon request; and ensure that the client has consented to the transfer.

*Substance Use Disorder (SUD):* For Level III.1, the provider shall ensure that the treatment plan is reviewed in collaboration with the client at least every 90 days. For Level III.2, providers shall develop and implement an individualized stabilization/treatment plan in collaboration with the client that shall be reviewed and signed by the UP and the client; and shall be filed in the client's record within 24 hours of admission. For Level III.3, providers shall ensure that the treatment plan is reviewed in collaboration with the client as needed or at a minimum of every 90 days and documented accordingly. For Level III.5, the provider shall ensure the treatment plan is reviewed in collaboration with the client as needed, or at a minimum of every 30 days and documented accordingly.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* For FSTRAs, the facility shall provide adequate services and oversight/supervision, including adequate security measures, around the clock as needed for any client in accordance with the client's treatment plan. The care and services to be provided through arrangement or by the facility shall include, but are not limited to, behavioral health services; nutritional services; medication management; assistance with independent living skills; recreational services; and transportation services.

CRCs shall provide emergency screening; assessment; crisis intervention and stabilization; 24-hour observation; medication administration; and referral to the most appropriate and least restrictive setting available consistent with the client's needs.

For all MH/SUD facilities, services shall be delivered according to a plan that is age and culturally appropriate for the population served; demonstrates effective communication and coordination; provides utilization of services at the appropriate level of care; is an environment that promotes positive well-being and preserves the client's human dignity; and utilizes evidence-based counseling techniques and practices. Core services include: (1) assessment; (2) orientation; (3) treatment; (4) client education; (5) consultation with professionals; (6)

counseling services; (7) referral; (8) rehabilitation services; (9) crisis mitigation; and (10) medication management.

*Substance Use Disorder (SUD):* For Level III.1, the provider shall offer at least five hours per week of a combination of low-intensity clinical and recovery focused services, including: (a) individual therapy; (b) group and family therapy; (c) medication management; and (d) medication education. For Level III.2D, treatment is stabilization and unspecified treatment. For Level III.3, providers shall offer at least 20 hours per week of a combination of medium-intensity clinical and recovery-focused services. All require the provision of case management.

## **Patient Rights and Safety Standards**

*Mental Health (MH) and Substance Use Disorder (SUD):* FSTRAs shall have a written policy on clients' civil rights and the practices of the facility shall assure that no client of a facility shall be deprived of civil or legal rights, benefits or privileges guaranteed by law or the Constitution of the United States solely by reason of status as a client of a facility. Among other things, client rights include: informed consent, the right to voice grievances, not to be chemically restrained, confidentiality, and privacy.

CRCs must inform clients of their rights which include but are not limited to nondiscrimination, freedom from abuse, translation or interpreter services, informed consent, privacy, to be in the least restrictive setting, and to be subject to restraint or seclusion only as provided by law. CRCs shall develop, implement, and comply with policies and procedures that protect client's rights and respond to questions and grievances pertaining to these rights. To that end, the facility should develop and implement written grievance procedures so clients can submit a grievance without a fear of retaliation. Procedures should include a process for filing a grievance; a timeline for responding to the grievance; a method for responding to a grievance; and the staff responsibilities for addressing and resolving grievances.

For all MH/SUD facilities, each provider shall develop written policies that comply with regulations to protect clients' rights. These include but are not limited to the right to nondiscrimination, dignity, to be free from abuse, informed consent, privacy, to submit complaints, communication, recreation, religion, be treated in the least restrictive setting, and not to be restrained in violation of law.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* CRCs shall have a quality improvement plan that assures that the overall function of the center is in compliance with federal, state, and local laws; is meeting the needs of the citizens of the area; is attaining the goals and objectives established in the center's mission statement; maintains systems to effectively identify issues

that require quality monitoring, remediation and improvement activities; improves individual outcomes and individual satisfaction; includes plans of action to correct identified issues; and is updated on an ongoing basis to reflect changes, corrections and other modifications. This plan shall establish an internal evaluation procedure.

All MH/SUD facilities shall develop, implement, and maintain a quality improvement. There shall be a quality improvement plan committee that shall be comprised of at least three persons, one of whom is a LMHP and the others are staff with the qualifying experience to contribute to the committee's purpose; and develop and implement the QI plan."

## **Governance**

*Mental Health (MH) and Substance Use Disorder (SUD):* All facilities shall have an identifiable governing body. Similar requirements apply specifically to FSTRAs.

## **Special Populations**

*Substance Use Disorder (SUD):* Some ASAM Level III.3 facilities have a Mothers with Dependent Children program, which shall provide weekly parenting classes where attendance is required; address the specialized needs of the parent; provide education, counseling, and rehabilitation services for the parent that further addresses: (i) the effects of chemical dependency on a woman's health and pregnancy; (ii) parenting skills; and (iii) health and nutrition; regularly assess parent-child interactions and address any identified needs in treatment; and provide access to family planning services."

## **Location of Regulatory and Licensing Requirements**

Department of Health (LDH)<sup>1</sup>. Regulatory data collected July 31, 2019.

## **Other Information Sources**

R. McDermott (LDH); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>1</sup> See <https://www.doa.la.gov/Pages/osr/LAC-48.aspx>.

# LOUISIANA MEDICAID

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

## Approach

*Mental Health (MH) and Substance Use Disorder (SUD):* The Louisiana Department of Health oversees the state Medicaid program. Louisiana relies to some extent on the in lieu of provision to reimburse and Disproportionate Share Hospital (DSH) Payments for certain services in an institution for mental diseases (IMD).

*Substance Use Disorder (SUD):* Louisiana has a Section 1115 waiver permitting Medicaid expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are residents in facilities that meet the definition of an IMD, including residential treatment.

## Types of Facilities

*Substance Use Disorder (SUD):* The residential settings identified in the waiver include the following:

- Level 3.1 Clinically managed low-intensity residential treatment
- Level 3.2-WM Clinically managed residential social detoxification (clinically managed residential)
- Level 3.3. Clinically managed population-specific medium/high intensity residential
- Level 3.5 Clinically managed high-intensity residential services
- Level 3.7 Medically monitored intensive residential treatment
- Level 3.7-WM Medically monitored residential detoxification (medically monitored inpatient)

Length of stay is not a condition of the waiver. Medication-assisted treatment also is to be available to those in IMDs.

## Processes of Medicaid Enrollment

### *Mental Health (MH) and Substance Use Disorder (SUD):*

- Louisiana Behavioral Health Medicaid regulations specify that each provider of specialized behavioral health services shall enter into a contract with one or more of the MCOs in order to receive reimbursement for Medicaid covered services. All services shall be delivered in accordance with federal and state laws and regulations, the provisions of this Rule, the provider manual, and other notices or directives issued by the department. Anyone providing specialized behavioral health services shall be licensed in accordance with state laws and regulations, in addition to operating within their scope of practice license.
- Providers shall be required to revalidate their enrollments with the Medicaid Program at a minimum of five-year intervals.

*Substance Use Disorder (SUD):* Pursuant to state Medicaid regulations, each provider of SUD services shall enter into a contract with one or more of the MCOs in order to receive reimbursement for Medicaid covered services. Providers of SUD services shall ensure that all services are authorized and any services that exceed established limitations beyond the initial authorization are approved for re-authorization prior to service delivery. Anyone providing SUD services must be licensed in accordance with state laws and regulations, in addition to operating within their scope of practice license.

- Residential treatment facilities shall meet the following additional requirements, among others: Be a licensed organization, pursuant to the residential service provider qualifications described in the Louisiana Administrative Code and the Louisiana Medicaid provider manual; Residential addiction treatment facilities shall be accredited by an approved accrediting body and maintain such accreditation. Denial, loss of or any negative change in accreditation status must be reported to the MCO in writing within the time limit established by the department; Provide full disclosure of ownership and control, including but not limited to any relative contractual agreements, partnerships, etc.; Follow all residential treatment provider qualifications and program standards in licensure, Medicaid provider manual, managed care contracts or credentialing; Must deliver care consistent with the specifications in the ASAM Criteria or other OBH approved, nationally recognized SUD program standards, hours of clinical care, and credentials of staff for residential treatment settings; and effective April 1, 2019, must offer medication-assisted treatment (MAT) on-site or facilitate access to MAT off-site, and appropriately document MAT options, education and facilitation efforts in accordance with requirements outlined in the Medicaid provider manual.



## **Staffing**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding credentials of staff for residential treatment settings. The state must conduct an assessment of the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT. According to the SUD implementation plan, Louisiana utilizes the ASAM criteria program standards to establish residential treatment provider qualifications in its licensure and authority documents including the types of services, hours of clinical care and credentials of staff for residential treatment settings.

## **Placement**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines. The state also must establish a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings. According to the SUD implementation plan, the provider manual is to be updated to clarify that ASAM criteria and levels of care shall be used for each provider's assessment tool.

## **Treatment and Discharge Planning and Aftercare Services**

*Substance Use Disorder (SUD):* Requirements were not explicitly described in the state Medicaid regulations or the 1115 waiver.

## **Treatment Services**

*Substance Use Disorder (SUD):* Under the Section 1115 waiver, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions. Pursuant to the Section 1115 waiver, the state must establish

residential treatment requirements regarding the types of services and hours of clinical care for residential treatment settings. The state must establish a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site.

Medicaid regulations require that SUD services must be medically necessary to reduce the disability resulting from the illness and to restore the individual to his/her best possible level of functioning in the community.

Medicaid regulations require that residential treatment facilities must offer medication-assisted treatment (MAT) on-site or facilitate access to MAT off-site, and appropriately document MAT options, education and facilitation efforts in accordance with requirements outlined in the Medicaid provider manual.

## **Care Coordination**

*Substance Use Disorder (SUD):* Under the Section 1115 waiver, beneficiaries will have improved care coordination and care for comorbid physical and mental health conditions. The state must ensure establishment and implementation of policies to ensure residential facilities link beneficiaries with community-based services and supports following stays in these facilities. According to the SUD implementation plan, Louisiana MCOs are required to develop and maintain effective care coordination, continuity of care, and care transition activities to ensure a continuum of care approach to providing health care services to MCO members. The MCO contracts have explicit language around continuity of care and care transition. Requirements include collaborating with hospitals, nursing home facilities, and inpatient facilities to coordinate aftercare planning prior to discharge and transition of members for the continuance of behavioral health services and medication prior to reentry into the community, including referral to community providers. They are required to coordinate hospital and/or institutional discharge planning that includes post-discharge care as appropriate, including aftercare appointments, following an inpatient, PRTF, or other out-of-home stay and assure that prior authorization for prescription coverage is addressed and or initiated before patient discharge.

## **Quality Assurance or Improvement**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other nationally recognized SUD program.

Pursuant to state Medicaid regulations implementing the waiver, MCOs and their contracted providers of OUD/SUD services under the demonstration project shall be required to provide data as outlined or requested by the Department of Health.

The state must provide summaries of: External Quality Review Organization (EQRO) reports; managed care organization (MCO) reports; state quality assurance monitoring; and any other documentation that validates the quality of care provided or corrective action taken under the 1115 waiver.

## Special Populations

*Substance Use Disorder (SUD)*: Under the Section 1115 waiver, beneficiaries will have improved care for comorbid physical and mental health conditions.

## Location of Medicaid Requirements

Louisiana Administrative Code Title 50, Public Health -- Medical Assistance<sup>2</sup>. Regulatory data collected January 6, 2020.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019. <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report **“State Residential Treatment for Behavioral Health Conditions: Regulation and Policy”**. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

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<sup>2</sup> See <https://www.doa.la.gov/Pages/osr/lac/books.aspx>.

## MAINE

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### Types of Facilities

**Mental Health (MH):** Maine regulates two types of adult residential MH services, crisis residential services and private non-medical institutions providing residential services.

- *Crisis residential service:* a residential service designed to provide temporary shelter and respite for individuals experiencing crisis."
- *Private non-medical institution (PNMI):* a MaineCare provider that is required to meet special requirements to provide either Community Supports or Residential Services. This may include supported housing, residential programs, or intensive in-home services. A PNMI means a provider licensed by the Department of Health and Human Services to provide PNMI services to medically eligible individuals, in single or multiple facilities receiving MaineCare or under a written agreement with the State of Maine. A PNMI shall not be a health insurance organization, hospital, nursing home or community health care center. They may include facilities treating those with dual diagnosis. NOTE: Although these apply to those serving MaineCare residents, others may be served in the facilities and, therefore, the reach is broader than Maine Medicaid.

**Substance Use Disorder (SUD):** Regulated adult SUD residential treatment programs include four facility types (categories I-III and freestanding residential detoxification programs). Residential treatment programs are generally defined as corresponding to ASAM level III and as providing "services in a full (24 hours) residential setting. The program shall provide a scheduled treatment regimen which consists of diagnostic, educational, and counseling services; and shall refer clients to support services as needed. Clients are routinely discharged to various levels of follow-up services."

- *Category I:* provides a basic focus on early recovery skills, including the negative impact of chemical dependency, tools for developing support, and relapse prevention skills. Examples include extended shelters and residential rehabilitation programs. The term of residency may not exceed 45 days without documented assessment of client's need for the extension and a treatment plan indicating goals congruent with the definition and purpose of this component.

- *Category II:* provides a structured residential milieu, to help clients transition from a substance abusing lifestyle to a solid recovery environment. Clients may initially receive a treatment focus similar to that of Category I programs but will transition to a treatment focus that addresses the cultural, social, educational, and vocational needs of the client. Examples include halfway houses. Length of treatment is up to 180 days.
- *Category III:* provides a long-term supportive and structured environment for chemically dependent clients with extensive substance abuse debilitation. These programs provide a supervised living experience within the program. Qualified staff members teach attitudes, skills and habits conducive to facilitating the client's transition back to the community. The treatment mode may vary with the client's needs and may be in the form of individual, group or family counseling. Outcome goals may range from custodial care to further treatment services and recovery. Examples include extended care programs. Length of treatment is over 180 days.
- *Freestanding Residential Detoxification Programs:* equivalent to ASAM Level III 7-D/medically monitored inpatient detoxification and provides care to persons whose withdrawal signs and symptoms indicate the need for 24-hour residential care. Services include a biopsychosocial evaluation, medical observation, monitoring, and treatment, counseling, and follow-up referral. However, the full resources of an acute care general hospital or a medically managed intensive inpatient treatment program are not necessary. Services must be conducted in a freestanding or other appropriately licensed/certified healthcare or addiction treatment facility.
- Additional requirements apply to a private non-medical institution (PNMI), which is a MaineCare provider.

*Unregulated Facilities:* Researchers did not locate reference to regulated MH facilities or to regulated SUD facilities other than those described under 1a.

## **Approach**

*Mental Health (MH):* The general licensing rules govern all mental health agencies, facilities, or programs including but not limited to those funded by the Maine Department of Health and Human Services (DHHS) for the provision of mental health services.

*Substance Use Disorder (SUD):* Licensure by DHHS is required for the four types of adult substance use residential facilities described in 1.a, other than residential programs operated by hospitals that are accredited by the Joint Commission.

## **Processes of Licensure or Certification and Accreditation**

### *Mental Health (MH) and Substance Use Disorder (SUD):*

- A certificate of need is required for alcohol abuse, drug abuse, and mental health services.

### *Mental Health (MH):*

- Licensure by DHHS is required for both types of adult mental health residential facilities described in 1.a. The same general licensing requirements apply to all types of adult mental health agencies, and include that the applicant be in substantial compliance with core standards, be incorporated, deliver mental health services in Maine, be able to secure sufficient funds for the first year of operation, and have a site from which it administers and/or delivers mental health services that is approved for occupancy. A survey is required for licensure and renewal. Neither statute nor regulation indicates duration of other licenses.
- Accreditation is not required. Waivers of requirements and deemed status may be obtained but the regulations do not indicate how.

### *Substance Use Disorder (SUD):*

- Licensure by DHHS is required for the four types of adult substance use residential facilities described in 1.a, other than residential programs operated by hospitals that are accredited by the Joint Commission.
- While accreditation is not required, facilities that have accreditation as specified in the prior sentence are deemed to have met all the licensure requirements of the regulations, although DHHS reserves the right to conduct surveys. Substance use treatment facilities require licensure, including an application, a fee, and an inspection, as well as a renewal application. Duration of licensure is two years.

## **Cause-Based Monitoring**

*Mental Health (MH):* In addition to shortened licensure for new or noncompliant facilities, agencies must report any legal proceedings to the Department. The governing body of the agency is required to undertake periodic reviews of financial status and must have annual audits by a CPA or seek approval of another auditing approach.

*Substance Use Disorder (SUD):* DHHS may inspect the facility at any time and access any information required under the rules. Upon finding noncompliance with the rules, the state may initiate legal action against non-licensed facilities, or act against a licensed facility's license,

including refusal to renew, issuance of a conditional license, voiding a conditional license, modifying a license, or suspending or revoking a license. Financial audits also are required annually.

## **Access Requirements**

*Mental Health (MH):* For all residential treatment, the agency is required to have policies and procedures governing the establishment of a waiting list for mental health residential treatment, that minimally includes the following: prioritizing clients, selecting clients from the waiting list, and referring clients to other providers. Applicable general access requirements for mental health agencies also include requirements related to providing services in the chosen language of the client, not denying services due to having a SUD in addition to mental illness, and not denying services based on refusal of other services.

*Substance Use Disorder (SUD):* DHHS has wait time requirements for substance use residential facilities. All treatment programs must maintain a log or register listing individuals actively seeking treatment whenever a program's service capacity has been reached. If such a listing is needed, it must be monitored. Individuals are appropriately placed on a waiting list when they meet screening and eligibility criteria for services of the program. Other access requirements are also identified, namely that clients will receive services within the least restrictive and most accommodating environment possible.

## **Staffing**

*Mental Health (MH):* General requirements for mental health agencies require written personnel policies, including regarding qualifications and responsibilities, receipt of policies and procedures, recruitment, termination, personnel records, discipline, supervision, and other matters. Orientation and on-going training are required on topics including, among other things, training on patient rights; physical intervention techniques; the agency's mission, philosophy, clinical and other mental health services; and safety procedures.

For crisis residential services, staff must receive additional training, including but not limited to nationally recognized training in managing people who act out aggressively (e.g. MANDT, Nappi); training in crisis stabilization; and training in residential/milieu management. Researchers did not find any requirements on education or training on trauma-informed care. According to DHHS staff, residential programs must meet the minimum staffing ratios in accordance to Maine's Assisted Living Standards/ For both residential services generally and crisis residential services, if medical services are not provided on site, other arrangements must be made by the facility for accessing medical services.

The requirements specific to PNMI do have general information on the types of services that may be provided and who is qualified to provide them. Services at PNMI generally may only be provided by certain licensed or registered staff members, identified in the regulations. All providers must hold appropriate licensure in the state or province in which services are provided and must practice within the scope of these licensing guidelines. Clinical consultant services must be provided by licensed or certified professionals within all State and Federal regulations specific to the services provided.

*Substance Use Disorder (SUD):* Substance use programs generally must have personnel policies in place and assure that staff are properly credentialed and meet core competencies. Among the requirements are ones related to employee discipline, communicable disease, evaluations, job descriptions, and background checks. Although specific facility types may have more detailed requirements, these general requirements also identify minimum clinical staff, credentials for clinical staff, credentials for medical directors, credentials for clinical supervisors, require evidence that those providing treatment to clients with co-occurring disorders are qualified to do so, and requirements for contract staff, volunteers, and students. Orientation and ongoing training are required. Ongoing training for clinical staff must assure they meet licensing requirements and must include at least 20 hours of annual in-service or external training, including at least 4 hours related to SUD issues. Information about education or training on trauma-informed care was not found. Programs must have a program manager who may be shared between programs.

Category I programs must have staff coverage 24 hours a day, including weekends. The program must maintain a medical staffing pattern that enables it to meet specified physical care requirements. Physician back-up and on-call staff shall be provided to deal with medical emergencies. The program may not subcontract any of its obligations and rights pertaining to medical service, although physician consultant services are not considered subcontracting.

Category II programs do not have specific staffing requirements separate from the general ones above.

Category III programs must have a written agreement with an ambulance service to assure twenty-four (24) hour access to transportation to emergency medical care facilities for clients requiring such transport. Physician back-up and on-call staff must be provided to deal with medical emergencies. A program may not subcontract any of its obligations and rights pertaining to medical services described in these regulations with the exception of physician consultant services.

Freestanding residential detoxification programs must be staffed by physicians or physician extenders who are available 24 hours a day by telephone. A nurse must be on site at all times and an RN or other licensed and credentialed nurse must be available to conduct a nursing assessment on admission. Appropriately licensed and credentialed staff must be available to administer medications in accordance with physician orders. Credentialed alcohol and drug



counselors and an interdisciplinary team of appropriately trained clinicians are required. The level of nursing care and other care must be appropriate to the severity of client need.

## **Placement**

*Mental Health (MH):* As part of the general requirements for mental health agencies, preliminary screening of eligibility for services is required.

For crisis residential programs, an assessment of the client must be completed within 24 hours of admission and must include, among other things, history; physical health status; emotional, psychiatric and psychological strengths and needs; substance use; history of abuse; need for crisis services; social supports; and certain other needs.

For residential treatment, a comprehensive assessment must be conducted by an individual chosen or agreed to by the client or legally responsible party, with the client's participation, within 20 working days of the client's admission. The information to be included in the assessment is similar but not identical to that for crisis residential services.

For PNMI residential services, a comprehensive assessment must be conducted within 20 days of admission that is similar to that under the residential licensing regulations.

There is no mention of the LOCUS assessment tool in these regulations, although DHHS staff indicate it is required by the state Medicaid program. In non-crisis residential settings, there are additional requirements for other assessments not linked to placement.

*Substance Use Disorder (SUD):* Every substance use treatment program must have written admission policies and procedures that include criteria for determining the eligibility of individuals for admission. Assessment for admission is based on determining the individual needs and capabilities of the client, and the capacity for those needs to be addressed within the framework of the program, as well as appropriateness of treatment to the level and restrictions of care provided by the program component. An initial assessment must be completed prior to development of the treatment plan. A mental health screening is also required to identify whether there is a need for a complete assessment of the mental health condition. There must be policies to incorporate any information about a mental health condition found in this or prior assessments, into the substance abuse record, and integrate it into the service plan.

In addition, freestanding residential detoxification programs require an immediate medical evaluation upon admission.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH):* No treatment/service planning requirements were identified in the mental health licensing core regulations, although discharge planning is required.

Specific to residential treatment, a service plan must be developed within 72 hours after admission with the client's participation. A comprehensive service plan is required within 20 working days of admission, including criteria for discharge or release to a less restrictive setting, and must be reviewed at least every 90 days. Planning for discharge is required, contingent on the client's consent to establishing discharge as a goal. Aftercare/follow-up requirements are required, whereby programs shall develop written follow-up plans for all clients who are discharged from the treatment program that describe the program's responsibility for facilitating the transfer of the client to follow-up treatment services, other identified professional services, or a client support system.

For crisis residential treatment, a service plan must be developed with the client's consent, within 24 hours of admission and must include criteria for discharge.

For all residential treatment, a protocol must be in place to protect against summary discharge. For PNMI's providing residential services, similar service and discharge planning requirements are in place as are required by the general residential licensing regulations. According to DHHS staff, all consumers must have a crisis plan, which is reviewed quarterly.

*Substance Use Disorder (SUD):* All SUD programs must have an individual treatment plan for each client. The initial plan must be developed within 72 hours of admission to a residential program and reviewed and updated every week for programs of duration 30 days or less, monthly for programs of duration 31-180 days, and every 3 months otherwise. Programs must incorporate any information about a mental health condition found in intake or prior assessments into the service plan in the SUD program. All SUD programs must have discharge policies and procedures including that no client be automatically discharged for using substances or for displaying symptoms of a co-occurring disorder. Among other things, programs must have procedures to determine if clients need shelter and to ensure they are linked with appropriate follow-up services. All SUD programs must have written follow-up plans for discharging clients.

For freestanding detoxification, there must be an individualized treatment plan, including problem identification, treatment goals, measurable treatment objectives, and activities designed to meet those objectives, and a record of discharge/transfer planning, beginning at admission.

## Treatment Services

*Mental Health (MH):* Residential services should include support and training in housekeeping and home maintenance skills; mobility and community transportation skills; interpersonal relationships; health maintenance; safety practices; financial management; basic academic skills; management of personal and legal affairs; contingency planning, problem-solving, decision-making; self-advocacy and assertiveness training; utilization of community services and resources; recreational and leisure time activities; work attitude and skills exploration; menu planning and meal preparation; use of the telephone; human sexuality; and client affairs and rights.

*Substance Use Disorder (SUD):* All residential SUD treatment programs must provide, either on site or through referral: evaluation of the client's medical and psycho-social needs; a medical examination by the program's physician within 5 days of admission unless the physician has approved a prior examination conducted within the last 30 days; opportunities for learning basic living skills; educational services, vocational placement and training, and recreational opportunities as appropriate to the client group to be served; and encouragement for participation in self-help groups. The program shall make agreements with community resources to provide client services through referrals when the program is unable to provide them.

Category I programs must include individual and group counseling at a minimum of 14 hours per week or 2 hours per day for each client. The qualified staff shall teach attitudes, skills and habits conducive to good health and the maintenance of a substance free lifestyle. The treatment mode may vary with the member's needs and may be in the form of individual, group or family counseling at a minimum of fourteen (14) hours per week. Treatment will include daily didactic/educational presentations.

Category II programs must provide group/individual/family treatment sessions appropriate to the phase of treatment; living skills training according to the phase of treatment; vocational assessment and preparation; and supervised housekeeping responsibilities.

Category III programs provide group/individual/family treatment sessions appropriate to the phase of treatment; living skills training according to the phase of treatment; vocational assessment and preparation; supervised housekeeping responsibilities; transportation available 24 hours a day; and extended care services based on a scheduled therapeutic plan consisting of treatment services designed to enable the member to sustain a substance free life style within a supportive environment.

Freestanding residential detoxification programs must provide a biopsychosocial evaluation, medical observation, monitoring, and treatment, counseling, and follow-up referral. Services must include group therapies and withdrawal support; availability of hourly or more frequent nurse monitoring; a range of cognitive, behavioral, medical, mental health, and other therapies; health education services; services to families and significant others; availability of specialized

clinical consultation and supervision for biomedical, emotional, and behavioral and cognitive problems. Providers shall make and maintain arrangements with external clinicians and facilities for referral of the member for specialized services beyond the capability of the program; direct affiliation with other levels of care; ability to conduct or arrange for appropriate laboratory and toxicology tests; and nutritional services, including special diets, as needed.

## **Patient Rights and Safety Standards**

*Mental Health (MH):* Individuals have the right to service in the least restrictive appropriate setting, a representative to assist in protecting their rights, a right to state grievances/complaints and have due process related to that, confidentiality, compensation for work, and protection during experimentation or research. Formal grievances/complaints have a process that can involve reporting to the state. Critical incidents must be reported to the state and will be investigated. According to DHHS staff, restraint is prohibited.

*Substance Use Disorder (SUD):* Among other rights, clients have the right to be informed of their rights, including of the complaint or grievance process. Researchers did not find required reporting of complaints/grievances to the state. Critical incidents must be reported to the state which can result in a state inspection/audit. Researchers did not find a requirement that restraint and seclusion be reported to the state. Policies and procedures must address emergency procedures regarding suicide intervention.

## **Quality Assurance or Improvement**

*Mental Health (MH):* All agencies providing mental health services must have a written plan that addresses how the organization currently monitors, evaluates and improves quality. The agency must be able to demonstrate that it identifies, monitors, and attempts to improve areas deemed to be critical to quality client care. There must be documented evidence that quality management activities are conducted on an ongoing and regular basis. The effectiveness of quality management must be assessed and documented at least annually and involves input from a variety of stakeholders. Each agency must have a process for monitoring and evaluating the appropriateness of admission to or initiation of service and the provision of continued service to the client.

*Substance Use Disorder (SUD):* All SUD programs must have a quality management program. This must include documentation of a performance improvement program. Also included under quality management are requirements for policies regarding managing critical incidents; reports of abuse, neglect, or exploitation; grievances; and licensing violations.

## **Governance**

*Mental Health (MH):* Governance requirements include ones related to bylaws, policies and procedures, mission statement, governing body, oversight of management and program changes, agency executive director requirements, a mechanism for client input, and compliance with the ADA and other laws.

*Substance Use Disorder (SUD):* Governance requirements were located including ones related to the governing authority, conflicts of interest, operation and management, and fiscal management.

## **Special Populations**

*Mental Health (MH):* The state identifies as a special population type, for those receiving services from a mental health agency, those with long-term mental illness and specifies: the right to a service system that employs culturally normative and valued methods and settings; the right to coordination of the disparate components of the community service system; the right to individualized developmental programming that recognizes that each recipient with long-term mental illness is capable of growth or slowing of deterioration; the right to a comprehensive array of services to meet the recipient's needs; and the right to the maintenance of natural support systems, such as family and friends of recipients with long-term mental illnesses, individual, formal and informal networks of mutual and self-help.

*Substance Use Disorder (SUD):* Other than requirements related to provision of services for clients with co-occurring disorders, no specific requirements related to special populations in residential treatment were found.

## **Location of Regulatory and Licensing Requirements**

Department of Health and Human Services. Standards and Licensure<sup>1</sup>. Regulatory data collected May 8, 2019.

## **Other Information Sources**

K. Temple (DHHS); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>1</sup> See <https://www.maine.gov/sos/cec/rules/10/chaps10.htm#193>.

# MAINE MEDICAID

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## Approach

*Mental Health (MH) and Substance Use Disorder (SUD):* The Maine Department of Health and Human Services (DHHS) oversees the state Medicaid program. Maine historically does not rely on the in lieu of provision but has relied on Disproportionate Share Hospital (DSH) payments for reimbursement of some services in Institutions for Mental Diseases (IMDs). The state does not have a current relevant section 1115 waiver.

*Mental Health (MH):* IMDs for the treatment of mental health conditions are not covered by Maine Medicaid. To the extent, however, that short-term non-Crisis Residential Services (CRS) mental health residential treatment services for adults are covered, Medicaid-enrolled providers of mental health services as entities are defined by the regulations as Mental Health Agencies (MHAs). To the extent that any residential mental health treatment facilities may enroll in Medicaid, they likely would do so as MHAs.

*Substance Use Disorder (SUD):* Maine does not currently have a section 1115 waiver permitting Medicaid coverage of residential treatment for substance use in an IMD, although an application is pending. IMDs for the treatment of SUD conditions are not covered by Maine Medicaid. To the extent, however, that short-term non-PNMI SUD residential treatment services for adults are covered, Medicaid-enrolled providers of SUD services as entities are defined by the regulations as Substance Abuse Agencies (SAAs). To the extent that any residential facilities may enroll in Medicaid, they would do so as an SAA.

## Types of Facilities

*Mental Health (MH):* In addition to MHAs, described above, Maine covers:

- *Crisis Residential Services (CRS):* individualized therapeutic interventions provided to a member during a psychiatric emergency, and/or crises originating from problems associated with an intellectual disability, autism, or other related condition to address mental health and/or co-occurring mental health and substance abuse conditions for a time-limited post-crisis period, in order to stabilize the member's condition. These services may be provided in a temporary out-of-home setting.

*Substance Use Disorder (SUD):* In addition to SSAs, described above, Maine covers:

- A private non-medical institution (PNMI) is a MaineCare provider that is required to meet special requirements to provide, among other things, Residential Services for MH/SUD. They may include facilities treating those with dual diagnosis. To be a Medicaid provider in a residential setting, a PNMI must be a facility with licensed Private Non-Medical Institution beds at scattered locations serving a minimum of four eligible members, as long as the service provided consistently fits within the definition of a Substance Abuse Treatment Facility (SATF). SATFs may include, among others, non-hospital based detoxification, halfway house services, and residential rehabilitation services types I and II.

## **Processes of Medicaid Enrollment**

*Mental Health (MH) and Substance Use Disorder (SUD):*

- All Medicaid providers must complete an initial enrollment application followed by subsequent enrollment applications to take place every five years, or as requested by the Department. A provider agreement must be in place and all required licensures or certifications. Enrollment may be denied or terminated, and other sanctions applied.

## **Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD):* The Medicaid regulations include specific requirements for credentials and training for providers of any behavioral health services that are clinicians or other qualified staff, direct support professionals, and providers of behavioral health services for members who are deaf or are hard of hearing.

The Medicaid regulations also contain PNMI staffing requirements in addition to those in the licensure standards.

SATFs must follow all State of Maine licensing regulations and guidelines for staffing levels and must maintain professional staffing sufficient to serve the individual needs of each recipient as reflected in his individual service plan. Professional services may be provided only within the scope of the professional's license.

*Mental Health (MH):* Staff providing Crisis Services for adults with mental health as a primary condition must have an MHRT (Mental Health Rehabilitation Technician) Certification at the level appropriate for the services being delivered. Supervisors of MHRT staff must be a clinician practicing within the scope of their licensure.

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* DHHS staff indicate that use of the LOCUS is required by the state Medicaid program. Requirements were not explicitly described in the state Medicaid regulations.

*Mental Health (MH):* Crisis Residential Services require prior authorization, which is limited to 7 days with the possibility of extension upon application.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* The Medicaid regulations include specific requirements for assessment and treatment plans. Individualized plans include the Individual Treatment Plan, the Crisis/Safety Plan (where indicated by the Covered Service), and the Discharge Plan. Unless otherwise specified for a facility type, the plan must be developed within 30 days of beginning services.

*Mental Health (MH):* An individual treatment plan must be completed for Crisis Residential Services within 24 hours of admission and reviewed on the seventh day of service and every two days thereafter if continued stay is approved by DHHS or an Authorized Entity. A crisis stabilization plan is required.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* The Medicaid Manual provides general guidance on co-occurring services, which are integrated services provided to a member who has both a mental health and a substance abuse diagnosis. When mental health and substance abuse diagnoses occur together, each is considered primary and is assessed, described and treated concurrently. Co-occurring Services consist of a range of integrated, appropriately matched interventions that may include Comprehensive Assessment, treatment and relapse prevention strategies that may be combined, when possible within the context of a single treatment relationship. Co-occurring services also include addressing family therapy or counseling issues involving mental health, substance abuse or other disorders where MaineCare services cover family therapy or counseling.

*Mental Health (MH):* Components of Crisis Residential Services include assessment; monitoring behavior and the member's response to therapeutic interventions; participating and assisting in planning for and implementing crisis and post-crisis stabilization activities; and supervising the member to assure personal safety. Services include all components of screening, assessment,



evaluation, intervention, and disposition commonly considered appropriate to the provision of emergency and crisis mental health care.

## **Care Coordination**

*Mental Health (MH) and Substance Use Disorder (SUD):* Requirements regarding residential services were not explicitly described in the state Medicaid regulations.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* The Medicaid regulations include specific requirements for quality assurance including conducting periodic review of cases to assure quality and appropriateness of care in accordance with the quality assurance (QA) protocols established by DHHS.

The Department and its professional advisors regard the maintenance of adequate clinical and other required financial and product-related records as essential for the delivery of quality care. In addition, providers should be aware that comprehensive records are key documents for post-payment reviews. In the absence of proper and comprehensive records, no payment will be made and/or payments previously made may be recouped.

A PNMI must prudently manage and operate a PNMI of adequate quality to meet its residents' needs. They must, among other things, submit such data, statistics, schedules or other information that the Department requires in order to carry out its functions.

## **Special Populations**

*Mental Health (MH) and Substance Use Disorder (SUD):* Requirements regarding residential services were not explicitly described in the state Medicaid regulations, other than that co-occurring MH/SUD must be addressed.

## **Location of Medicaid Requirements**

Department of Health and Human Services Chapter 101: MaineCare Benefits Manual<sup>2</sup>.  
Regulatory data collected January 7, 2020.

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<sup>2</sup> See <https://www.maine.gov/sos/cec/rules/10/ch101.htm>.

## Other Information Sources

Maine Substance Use Disorder Care Initiative -- Pending

<https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=53628>

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019. <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report **“State Residential Treatment for Behavioral Health Conditions: Regulation and Policy”**. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

## MARYLAND

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### Types of Facilities

*Mental Health (MH):* Maryland regulates Residential Crisis Services (RCS) for individuals with a primary MH diagnosis. These (1) provide short-term MH treatment and support services in a structured environment for individuals who require 24-hour supervision due to a psychiatric crisis; and (2) are designed to prevent a psychiatric inpatient admission, shorten the length of inpatient stay, effectively use general hospital emergency departments; and provide an alternative to psychiatric inpatient admission.

*Substance Use Disorder (SUD):* Maryland regulates all SUD residential treatment programs, including the following, which correspond to the relevant ASAM level of care:

- Level 3.1. Clinically Managed Low Intensity Treatment
- Level 3.3. A Clinically Managed Medium Intensity Treatment
- Level 3.5. A Clinically Managed High Intensity Residential Treatment
- Level 3.7. Medically-Monitored Intensive SUD Treatment
- Clinically Managed Residential Detoxification services are provided for patients whose intoxication or withdrawal signs and symptoms are sufficiently severe to require 24-hour structure and support and may be offered in suitably licensed Level 3.1, 3.3, 3.5 or 3.7 programs.
- Opioid Treatment Services may be offered in any suitably licensed residential levels.

*Unregulated Facilities:* Unregulated residential facilities could include one that is a pilot project or federal or state demonstration project exempted by the state, if they meet grant award and other conditions. We exclude from this summary regulated residential rehabilitation programs for individuals with a mental disorder, group homes for adults with mental illness, respite care homes, and therapeutic group homes, as well as recovery residences, as not requiring clinical services within the scope of this summary.

## Approach

The Maryland Department of Health (MDH), Behavioral Health Administration (BHA) regulates and licenses residential treatment providers in the state regardless of funding. According to state staff, this is governed by the subtitle 63 Community-Based Behavioral Health Programs and Services regulations and programs are no longer approved (MH) or certified (SUD) pursuant to subtitles 21 and 47. The identified requirements in this non-Medicaid portion of the summary, therefore, reflect the standards in subtitle 63 and additional input from state staff.

## Processes of Licensure or Certification and Accreditation

*Mental Health (MH and Substance Use Disorder (SUD):* Accreditation-based licensure by the BHA is required for operation of all residential treatment facilities.

- Organizations are required to receive accreditation from an MDH-approved national accreditation organization for each service they offer at each site at which it is offered. Accreditation forms the basis for an application to BHA for a license. The following accrediting organizations are approved by the MDH:
  - ACHC -- The Accreditation Commission for Health Care
  - CARF -- The Commission on Accreditation of Rehabilitation Facilities
  - COA -- The Council on Accreditation
  - TJC -- The Joint Commission
- According to state staff, only residential intensive Level 3.7 programs required a Certificate of Need.
- Licensure is dependent on accreditation, the duration of which varies by accrediting body. According to state staff, accreditation is generally initially advanced for a period of six months to a year based on a desk review and site visit in order to allow organizations to establish new programs. Once accreditation has been obtained, the organization formalizes an Agreement to Cooperate with the local designated Behavioral Health Authority (LBHA) in each jurisdiction in which it is providing services. This Agreement serves to provide authority for the LBHA to work with the organization, including working with the organization on Program Improvement Plans arising from audits. The organization then applies to BHA for a license which, when granted, will generally extend 3 months beyond the accreditation period. Towards the end of the initial license period, the accreditation organization visits the program to review service records. At this time, accreditation may be extended for up to 3 years. The organization submits a new license application, and again licensure may be granted for up to 3 months beyond the accreditation period.

## **Cause-Based Monitoring**

*Mental Health (MH) and Substance Use Disorder (SUD):* The BHA may conduct post-licensing inspections and validate inspections of accredited organizations when there are significant concerns about compliance with accreditation requirements or certain other matters. The MDH, BHA and its designees, and federal funding agents may make announced and unannounced visits to a program; and inspect and copy all records, including, but not limited to financial, treatment, and service records. Licenses may be denied, suspended, or revoked and the BHA may notify organizations of deficiencies or apply intermediate sanctions and required corrective action. Civil penalties also may apply. BHA's compliance units may arrange for audits of organizations by its own personnel, or those of its designees when issues are identified through data-mining, complaints, incidents or other causes.

*Mental Health (MH):* According to state staff, most compliance activities conducted on organizations are through the Local Behavioral Health Authority (LBHA) for each jurisdiction. The LBHA follow up on Program Improvement Plans identified through audit or otherwise, as well as complaints and incidents.

*Substance Use Disorder (SUD):* According to state staff, while LBHAs follow up as noted above under MH, the BHA compliance unit also performs routine visits semi-annually on Opioid Treatment Services and quarterly on certain SUD residential treatment services.

## **Access Requirements**

*Mental Health (MH) and Substance Use Disorder (SUD):* Wait-time requirements were not found. A program may not exclude or discriminate against an individual on the basis of the individual receiving opioid treatment services.

## **Staffing**

*Mental Health (MH):* RCSs must have staff on-site 24 hours per day, 7 days per week, whenever an individual is on-site receiving services.

*Substance Use Disorder (SUD):* The licensing regulations do not include requirements for staffing. Staff indicated that programs are bound by the requirements identified below for Medicaid services.

## Placement

*Mental Health (MH) and Substance Use Disorder (SUD):* According to state staff, MH and SUD programs accept individuals with a primary diagnosis of MH and SU respectively, but also serve individuals who have co-occurring diagnoses.

*Mental Health (MH):* RCSs provide services for individuals who require 24-hour supervision due to a psychiatric crisis.

*Substance Use Disorder (SUD):* The SUD residential treatment programs provide treatment to individuals who meet the corresponding ASAM patient placement criteria (Levels 3.1, 3.3, 3.5, 3.7).

## Treatment and Discharge Planning and Aftercare Services

*Mental Health (MH) and Substance Use Disorder (SUD):* Requirements related to treatment and discharge planning and provision of aftercare services for adult residential behavioral health treatment facilities were not found.

## Treatment Services

*Mental Health (MH):* RCSs Provide short-term mental health treatment and support services in a structured environment.

*Substance Use Disorder (SUD):* Services by the SUD residential facility types correspond to those required by the relevant ASAM level (3.1, 3.3, 3.5, 3.7), including hours per week of therapeutic services, and each may provide withdrawal management service and an opioid treatment service if the license so authorizes. Additional information is provided below related to Maryland's withdrawal management services.

- A withdrawal management service is one that monitors the decreasing amount of psychoactive substances in the body; manages the withdrawal symptoms; motivates the individual to participate in appropriate treatment programs for alcohol or other drug dependence; provides additional referrals as necessary; and at Level 3.7-WM, employs a physician, nurse practitioner, or physician assistant who: (1) Obtains a comprehensive medical history and physical examination of the patient at admission; and (2) Medically monitors each patient.

## **Patient Rights and Safety Standards**

*Mental Health (MH) and Substance Use Disorder (SUD):* All BHA licensed community-based behavioral health programs must comply with all applicable federal and state laws and regulations, including ones related to privacy and confidentiality. A licensed program must report all critical incidents to the BHA within 5 calendar days following the program receiving knowledge of the incident. A program may not exclude or discriminate against an individual on the basis of the individual receiving opioid treatment services.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* Requirements related to quality assurance or improvement for adult residential behavioral health treatment facilities were not found.

## **Governance**

*Mental Health (MH) and Substance Use Disorder (SUD):* Requirements related to governance of adult residential behavioral health treatment facilities were not found.

## **Special Populations**

*Substance Use Disorder (SUD):* Requirements related to special populations in adult residential behavioral health treatment facilities were not found.

## **Location of Regulatory and Licensing Requirements**

Community-Based Licensure Regulations Subtitle 63<sup>1</sup>. Regulatory data collected May 30, 2019.

## **Other Information Sources**

S. Gear, S. Diehl, L. Woolford (BHA); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>1</sup> See [http://www.dsd.state.md.us/COMAR/subtitle\\_chapters/10\\_Chapters.aspx#Subtitle63](http://www.dsd.state.md.us/COMAR/subtitle_chapters/10_Chapters.aspx#Subtitle63).

# MARYLAND MEDICAID

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## Approach

The Maryland Department of Health (MDH) oversees the state Medicaid program. Maryland also has a Section 1115 waiver permitting Medicaid expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) during up to two non-consecutive stays of 30 days or less annually in facilities that meet the definition of an institution for mental disease (IMD). The services are delivered by the Administrative Services Organization (ASO) that operates the Maryland Public Behavioral Health System through the fee-for-service system. The state does not rely on the in lieu of provision for Medicaid coverage of IMD services but has historically relied on Disproportionate Share Hospital (DSH) payments.

## Types of Facilities

*Mental Health (MH):* Researchers did not locate evidence of Medicaid reimbursement for adult residential MH treatment services.

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, residential SUD facilities in Maryland may be of any size and include:

- Level 3.1 -- Clinically Managed Low-intensity Residential Services
- Level 3.3 -- Clinically Managed Population-specific High-Intensity Residential Services
- Level 3.5 -- Clinically Managed High-Intensity Residential Services
- Level 3.7 -- Medically Monitored Intensive Inpatient Services (may be provided in a freestanding residential facility or other specified facilities)
- Level 3.7 WM -- Medically Monitored Inpatient Withdrawal Management



## Processes of Medicaid Enrollment

*Mental Health (MH) and Substance Use Disorder (SUD):* To become a Medicaid provider, providers must be licensed and legally authorized to practice or deliver services in the state in which the service is provided. Among other things, the provider must apply for participation in the Medicaid program, permit unannounced site inspections, have a provider agreement, and comply with all standards of practice and department policies. Providers may be suspended or removed from the program and other sanctions imposed.

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, residential SUD services are provided in a MDH licensed residential facility that has been enrolled by MDH as a Medicaid provider and issued a certification by MDH as capable of delivering care consistent with the ASAM Criteria as a Level 3.1, 3.3, 3.5 and/or 3.7 program. Each residential treatment provider will be assessed to meet the provider and service specifications described in the ASO provider handbook consistent with the ASAM Criteria for the requisite level or sublevel of care prior to participating in the Maryland Medicaid program under the Section 1115 demonstration. Prior to enrolling a residential treatment provider in Medicaid and prior to service provision under this demonstration, MDH will conduct site visits and certify residential treatment providers by ASAM Level 3. The ASO will provide preliminary credentialing for ASAM Levels 3.1, 3.3, 3.5 and/or 3.7 contingent on the providers receiving certification from the state. The ASO will finalize its credentialing after the providers submit their site visit reports verifying they are ASAM Level 3.1, 3.3, 3.5 and/or 3.7 programs.

## Staffing

*Substance Use Disorder (SUD):* The Maryland Medicaid regulations require participating adult residential treatment facilities to maintain verification of licenses and credentials, including background checks, of all professionals employed by or under contract with the provider in their respective personnel files; maintain staffing within each ASAM level of care as described below; and increase staffing within each ASAM level of care at a ratio to correspond with the participant census to meet required ASAM level of service delivery for each patient.

- A residential, low-intensity level 3.1 provider has requirements specific to a part-time program director; a clinical director; a licensed or certified counselor; peer support staff; and at least one staff member on duty between 11 p.m. and 7 a.m.
- A residential, medium intensity level 3.3 provider and a residential, high intensity level 3.5 provider have requirements for, among other things, sufficient physician, physician assistant, or nurse practitioner services; at least one staff member on duty between 11 p.m. and 7 a.m.; a part-time facility director; and other staff including requirements for hours per week and credentials.

- A residential, intensive level 3.7 provider has requirements for, among other things, sufficient physician, physician assistant, or nurse practitioner services; at least two staff members on duty between 11 p.m. and 7 a.m.; a part-time facility director; and other staff including requirements for hours per week and credentials.
- A withdrawal management service level 3.7-WM provider has requirements for, among other things, a part-time facility director; and other staff including medical providers and requirements for hours per week and credentials.

## **Placement**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, residential services are provided to Maryland Medicaid recipients with an SUD diagnosis when determined to be medically necessary by the ASO utilization management staff and in accordance with an individualized treatment plan. Only two (2) 30-day residential stays will be covered in a one (1) year period. Extended lengths of stay can be provided if medically necessary using other identified funds. Providers will complete a preadmission assessment of the member's clinical needs and submit the clinical information to the ASO for prior authorization. Utilization management staff or a licensed physician employed by the ASO will document the use of the ASAM multidimensional assessment and matrices for matching severity with type and intensity of services. Each prior authorization review will assess service needs, coordination needs and ensure appropriate placement in the appropriate level of care based on the member's needs as demonstrated in the ASAM Criteria multidimensional assessment. The ASO must provide prior authorization for residential services within twenty-four (24) hours of the prior authorization request being submitted by the provider.

## **Treatment and Discharge Planning and Aftercare Services**

*Substance Use Disorder (SUD):* Under the Maryland Medicaid regulations governing adult residential SUD treatment, an individualized treatment plan and discharge plan must be developed and maintained.

## **Treatment Services**

*Substance Use Disorder (SUD):* The Maryland Medicaid regulations require participating adult residential treatment facilities to demonstrate competence in the ability to deliver a minimum of three evidence-based practice services. The program also must be in compliance with all ASAM requirements for each applicable level of care, including hours per week of therapeutic services and coordination of aftercare. Specific service requirements are identified for the following levels: 3.1, 3.3., 3.5, 3.7, and 3.7-WM.

The Maryland Section 1115 waiver includes medication-assisted treatment but does not incorporate it into residential treatment.

## Care Coordination

*Substance Use Disorder (SUD)*: All levels of service must coordinate aftercare services through: (a) Peer support; or (b) A licensed provider.

## Quality Assurance or Improvement

*Substance Use Disorder (SUD)*: Requirements for adult residential SUD facility quality assurance or improvement were not located in the Medicaid regulations or waiver.

## Special Populations

*Substance Use Disorder (SUD)*: No Medicaid requirements were located regarding special populations.

## Location of Medicaid Requirements

Maryland Medicaid General Provider Rules<sup>2</sup>; Medicaid Adult Residential SU Rules<sup>3</sup>; Maryland 1115 Waiver<sup>4</sup>. Regulatory data collected January 2020.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report “**State Residential Treatment for Behavioral Health Conditions: Regulation and Policy**”. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

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<sup>2</sup> See [http://www.dsd.state.md.us/comar/SubtitleSearch.aspx?search=10.09.36.\\*](http://www.dsd.state.md.us/comar/SubtitleSearch.aspx?search=10.09.36.*).

<sup>3</sup> See [http://www.dsd.state.md.us/comar/SubtitleSearch.aspx?search=10.09.06.\\*](http://www.dsd.state.md.us/comar/SubtitleSearch.aspx?search=10.09.06.*).

<sup>4</sup> See <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/md/md-healthchoice-ca.pdf>.

## MASSACHUSETTS

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### Types of Facilities

**Mental Health (MH):** Massachusetts regulates adult MH residential treatment facilities as part of the community mental health center (CMHC) system. Treatment includes but is not limited to rehabilitation, support, or supervision.

**Substance Use Disorder (SUD):** Massachusetts regulates adult SUD residential rehabilitation services, which are “organized substance abuse treatment and education services featuring a planned program of care in a 24-hour residential setting. Services are provided in permanent facilities where clients reside on a temporary basis.” There are four models within residential rehabilitation services:

- **Transitional Support Services:** A short-term Residential Rehabilitation program.
- **Social Model Recovery Homes:** A Residential Rehabilitation program that conforms to the ASAM criteria for Low Intensity Residential Services.
- **Recovery Homes:** A residential rehabilitation program that conforms to American Society of Addiction Medicine criteria for Medium-intensity Residential Services.
- **Therapeutic Communities:** A Residential Rehabilitation program that conforms to ASAM criteria for High-intensity Residential Services.

**Unregulated Facilities:** It is possible that there are MH residential treatment facilities that are not included in the identified regulations. We exclude Alcohol and Drug-free Housing because it does not include treatment within the scope of this summary.

### Approach

The Massachusetts Department of Mental Health (DMH) regulates adult residential MH treatment facilities that are operated, licensed, or contracted for by the DMH as part of the CMHC system. The Massachusetts Department of Public Health (DPH) regulates adult residential SUD treatment facilities.

## **Processes of Licensure or Certification and Accreditation**

*Mental Health (MH):* Licensure by the DMH is required for all providers under contract with the DMH for each residential site and for a provider of a private residential program for each residential site. A license is not required for residential sites licensed by another state agency.

- Accreditation is not required.
- An inspection is required at least annually.
- The state does not require a Certificate of Need.
- Licensure duration is two years.

*Substance Use Disorder (SUD):* All residential SUD treatment facilities require licensure by the DPH, unless the program is owned by the Federal Government, the Commonwealth, or any subdivision thereof, except that a department, agency or institution of the Commonwealth or subdivision thereof is subject to approval by the DPH.

- Accreditation is not required but licensees who are subject to accreditation by any state, federal or national organization must obtain and maintain their accreditation and provide documentation of the accreditation to the DPH.
- An inspection is required for licensure and renewal.
- The state does not require a Certificate of Need but the DPH will not approve an application for an initial or renewal license or grant approval unless there is need for the service
- Licensure duration is six months or two years.

## **Cause-Based Monitoring**

*Mental Health (MH):* Staff of the DMH will inspect licensed facilities at least annually, if not more frequently as necessary. The inspection may be without notice if there is cause. Whenever the DMH finds that a service is not in compliance with any applicable law or regulation, other than in accordance with an approved waiver, the DMH shall, if it deems the deficiency remediable, issue a corrective action order. Licenses may be suspended or revoked.

*Substance Use Disorder (SUD):* The DPH staff may inspect licensed facilities at any time without prior notice, and if deficiencies are detected, issue corrective actions. Licenses may be suspended, denied, not renewed, restricted, limited, or revoked.

## **Access Requirements**

*Mental Health (MH):* Wait-time requirements were not found. Facilities must comply with applicable state and federal laws regarding access for individuals with disabilities.

*Substance Use Disorder (SUD):* Wait-time requirements were not found. SUD residential facilities must comply with the Americans with Disabilities Act. Facility eligibility criteria must not include a category of automatic exclusion defined by a history of criminal conviction.

## **Staffing**

*Mental Health (MH):* All CMHC facilities must develop and implement written policies and procedures that address personnel, including job descriptions and minimal staff qualifications, staff supervision, and training. The regulations establish qualifications and responsibilities for the facility director and other staff. The service must have adequate staffing to satisfy the requirements of the licensing and operational standards. Staffing patterns must be appropriate to meet the linguistic and cultural needs of persons within the service. All staff receive orientation and ongoing training, as well as supervision. All staff must be trained in evacuation procedures for impaired and partially impaired persons.

*Substance Use Disorder (SUD):* All SUD facilities must develop and implement written policies and procedures that address personnel matters. Ongoing training and supervision are required for all staff. Job descriptions shall specify that direct care staff have knowledge of and ability to promote recovery. In facilities for adults with their children, the licensee must ensure that all staff are trained to recognize child abuse and neglect and to report incidents of child abuse and neglect to the Department of Children and Families. The licensee must provide an adequate number of qualified personnel to fulfill the service objectives. Staffing requirements are in place for direct care, management, administrative, and clinical staff, including a Senior Clinician.

- Licensees providing Transitional Support Services must ensure that a registered nurse, nurse practitioner, physician assistant, or licensed practical nurse is available on site at least four hours each day and that supervision of nursing staff is overseen by a registered nurse.
- Facilities for adults with their children must include a Clinical Director who is a Senior Clinician, a Family Therapist who is a Senior Clinician, children's services staff, counselors to serve as Recovery Specialists, a minimum of one FTE staff member on site at all times.

- Facilities for 2nd offender DUI must establish a staffing pattern with sufficient personnel to oversee daily activities and to ensure safe operation of the program, which shall include, among others, a Senior Clinician or Clinician, staff qualified by education or experience responsible for the structure and delivery of physical education and recreation activities, qualified health care personnel.

## Placement

*Mental Health (MH):* Providers must develop written policies and procedures which address enrollment, intake and discharge, including criteria for enrollment into and discharge from the service.

*Substance Use Disorder (SUD):* Providers must develop admission eligibility criteria and procedures. An initial assessment for each prospective client must include specific components including but not limited to an assessment of the client's psychological, social, health, economic, educational/ vocational status; criminal history; current legal problems; co-occurring disorders; trauma history; and history of compulsive behaviors such as gambling. When the initial assessments indicate a need for further evaluation, the program shall conduct or make referral arrangements for necessary testing, physical examination and/or consultation by qualified professionals. The initial assessment must be conducted by a qualified professional.

- Residential rehabilitation for adults: Prior to admission, the licensee must verify that the client is 18 years of age or older and that the residential rehabilitation services are appropriate for the client based upon a set of criteria included in the regulations. Assessment must be completed in the first week of admission.
- Facilities for adults with children: At the time of admission, the licensee shall determine that Family Residential Substance Abuse Treatment Services are appropriate based upon regulatory diagnostic and symptomatic criteria, and that the family is homeless and is eligible for specified emergency assistance; or the family has housing resources located in a community or social environment that is unsupportive of recovery or constitutes a risk to maintenance of abstinence. No intoxicated persons or persons with medical conditions requiring 24-hour a day nursing coverage may be admitted. Within 30 days of admission, the licensee must complete specific assessments and evaluations.
- Facilities for 2nd offender DUI: The licensee must admit clients who are referred by a Massachusetts court, subject to criteria related to level of care, exclusion criteria, and medical criteria.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH):* CMHCs must have written policies and procedures which address development, implementation and review of individualized action plans. Providers must develop written policies and procedures which address discharge. No aftercare or follow-up planning requirements were identified for CMHCs.

*Substance Use Disorder (SUD):* Treatment/service planning requirements are required for SUD residential treatment facilities. The licensee must ensure that individual treatment plans are reviewed with the client and amended as necessary. When treatment continues for three months or more, treatment plans must be reviewed at least once every three months. Discharge planning beginning at admission is required. The licensee must establish written policies and procedures for follow-up client contact. Such policies describe circumstances under which a client may be contacted after discharge and require that client's permission for such contact be documented in the client's record.

- For social model recovery homes, the service plan must be developed within the first 30 days of residence.
- For programs for adults with their children, the licensee must develop an Individual Treatment Plan for each family member residing in the program. In addition to SUD, the treatment plan shall address MH, trauma, domestic violence, child welfare, parent-child relationships and family life. The licensee also must provide the following aftercare services: (1) Assistance to obtain housing, child-care, employment, continued health care and other social services that the family has received while in the program; (2) Follow-up services for up to 3 months following the family's discharge; and (3) Referral to another family residential program if the family is discharged before completion of treatment.
- For 2nd offender DUI residential programs, the licensee discharges residents upon completion of their sentence and must refer residents who continue on probation for additional SUD treatment. With the client's written consent, the licensee shall provide the outpatient provider with a summary of the client's completed assessment and diagnosis. If a resident completes the probation period at the same time as the residential program, the licensee shall provide referrals to ensure a continuum of care for the resident, including referrals for further SUD treatment, the provision of post discharge counseling, and other supportive services.

## **Treatment Services**

*Mental Health (MH):* Treatment in a CMHC facility includes, but is not be limited to, rehabilitation, support or supervision.



*Substance Use Disorder (SUD)*: All residential rehabilitation programs for adults must provide: (1) daily clinical services to improve residents' ability to structure and organize the tasks of daily living and recovery; and (2) advocacy and ombudsman services to support residents in obtaining needed resources and services and actively promote residents' interests.

- Transitional Support residential rehabilitation programs must provide: (1) four hours of nursing services available each day; (2) case management services; (3) transportation services available at least 12 hours per day, seven days per week; (4) health monitoring, education and crisis services; and (5) referral and follow-up for substance abuse treatment services upon discharge.
- Social Model residential rehabilitation programs must provide individual service plans to include planned program activities to stabilize and maintain the stability of the resident's SUD symptoms and to help the resident develop and apply recovery skills; and case management and support to promote successful involvement in regular, productive daily activity and, as indicated, successful reintegration into family and community living.
- Recovery Home residential rehabilitation services must provide: (1) planned daily clinical program activities to stabilize the resident's SUD symptoms and to help the resident develop and apply recovery skills; (2) counseling and clinical monitoring by qualified staff to promote successful involvement in regular, productive daily activity, and, as indicated, successful reintegration into family and community living; (3) a range of cognitive and motivational therapies on a group and individual basis; and (4) a daily schedule of services designed to develop and apply recovery skills.
- Therapeutic Community residential rehabilitation must provide: (1) daily clinical services to promote the residents' ability to develop and practice pro-social behaviors; (2) planned daily clinical program activities to stabilize and maintain stabilization of the resident's SUD symptoms and to help the resident develop and apply recovery skills; (3) counseling and clinical monitoring by qualified staff to promote successful involvement in regular, productive daily activity, such as work or school, and, as indicated, successful reintegration into family and community living; (4) a range of cognitive and motivational therapies on a group and individual basis; (5) motivational enhancement and engagement strategies appropriate to the resident's stage of readiness to change; (6) planned community reinforcement designed to foster pro-social values and group living skills.
- For programs for adults with families, the licensee must provide the following SUD services for adults and adolescents: (1) Monthly case review or consultation meetings between the licensee's staff and any Qualified Service Organizations providing services for the family; and (2) 24 hour a day crisis intervention services. The licensee must establish Qualified Service Organization Agreements with licensed MH providers to provide specific clinical and other services for adults and children, including but not limited to services for traumatic stress symptoms. The licensee must provide specific adult services: (1) Weekly, on-site parenting education and parenting skill building; and (2) Counseling and clinical

monitoring to promote successful involvement in regular, productive daily activity, and, as indicated, successful reintegration into family and community living. The licensee must provide transitional assistance and employment advocacy services to assist the family in applying for transitional assistance through the DTA. The licensee must provide specified services for children residing in the program.

- For 2nd offender DUI residential programs, the licensee must provide: (1) educational services; (2) MH services for co-occurring MH disorders; (3) group programming for families; (4) recreational programming; (5) exposure to support and self-help groups for adolescents; (6) opportunities for clients to participate in planning, organizing or managing non-clinical programming; (7) clinical, educational and support services designed specifically for females, separate from males, and for males, separate from females; (8) clinical, educational and support services designed to incorporate and address issues related to cultural and ethnic identity of clients; and (9) transportation services.

## **Patient Rights and Safety Standards**

*Mental Health (MH):* CMHC licensees must ensure that “utmost care shall be taken to protect the legal and human rights of all persons who receive services.” These rights include, but are not limited to: The right to be free from unlawful discrimination; the right to religious freedom and practice without compulsion according to the preference of the person; the right to vote; the right to communicate; and the right to be represented by an attorney or advocate of the person’s own choice; the right to file complaints and have them responded to; and the right to informed consent. Individuals receiving services also have the right to be free from mistreatment. For community mental health facilities, restraints must not be used as punishment or for the convenience of the staff. Medication restraint, mechanical restraint, or seclusion may not be used. Physical restraint may only be used under specific circumstances and crisis prevention plans must be developed. Related requirements for staff training are in the regulations. All physical restraints are to be reported to the Human Rights Committee.

*Substance Use Disorder (SUD):* The licensee must always safeguard the legal and civil rights of each client during treatment and discharge from treatment. A sample of guaranteed clients rights include: freedom from physical and psychological abuse; freedom from strip searches and body cavity searches; treatment in a manner sensitive to individual needs and which promotes dignity and self-respect; and the right to contact the Department. In all residential programs for adults, the regulations also protect residents’ rights to communication. The licensee must establish written policy and procedures for the resolution of clients’ disagreement(s) or dispute(s) arising in relation to treatment or program requirements and ensure that clients are provided with a copy of the procedures. The policy and procedures must address specific components related to grievances. The licensee also must establish written policies and procedures related to management of disruptive behavior, including prohibition on

physical restraint, except in the case of a person who has been committed to treatment. Certain critical incidents must be reported to the Department.

## **Quality Assurance or Improvement**

*Mental Health (MH):* Each CMHC provider must develop written policies and procedures pertaining to quality and utilization management. The provider must use data to monitor and improve quality and prevent and minimize the use of restraint.

*Substance Use Disorder (SUD):* Each licensee must adopt and maintain a written statement of purpose identifying service goals, objectives, and philosophy. The licensee must implement an evaluation plan that enables it to measure progress toward the achievement of its established goals and objectives. The evaluation plan must be prepared annually by the licensee and reviewed with the governing body. The plan must address methods for reviewing appropriateness of client care, utilization of service components, methods for achieving compliance with the federal and state disability laws, and other data and information necessary for analyzing and improving the efficiency and effectiveness of program services. The licensee must designate the individual(s) responsible for completing the evaluation plan and document the application of the evaluation findings to its efforts to improve program services.

## **Governance**

*Mental Health (MH):* For CMHCs, the application for licensure must be accompanied by documentation regarding the legal status of the applicant and individuals with a financial interest in the applicant. Policies and procedures must be developed.

*Substance Use Disorder (SUD):* The licensee must have a governing body that is accountable for and has authority over the policies and activities of the service and which includes persons with expertise in management, finances and SUD treatment. The governing body must include persons in recovery from a SUD and representatives of the community served. Policies and procedures must be developed.

## **Special Populations**

*Mental Health (MH):* No requirements related to services for special populations were found.

*Substance Use Disorder (SUD):*

- Licensees serving pregnant women must: (1) establish in writing clinically appropriate medical protocols for pregnant women; (2) designate a hospital for emergency obstetrical

and medical back-up; (3) provide for appropriate parent-child services; and (4) be available to serve women in all three trimesters of pregnancy.

- Licensees providing services to pregnant and post-partum clients and their infants shall establish Qualified Service Organization Agreements with early intervention programs to provide developmental assessments and services to infants.
- Licensees serving persons with co-occurring disorders must: (1) establish policies and procedures for referrals for specialized psychiatric/psychological care; and (2) establish Qualified Service Organization agreements providing for mental health interventions and coordinated care.
- Licensees serving persons 60 years of age or older must establish Qualified Service Organization agreements with local organizations providing services for the elderly.
- Licensees serving persons with disabilities must document the client's current functioning, ability to perform activities of daily living, and ability to comprehend program policies and procedures.

## Location of Regulatory and Licensing Requirements

Department of Mental Health, Licensing and Operational Standards Community Services<sup>1</sup>; DMH Service Planning<sup>2</sup>; Department of Public Health<sup>3</sup>. Regulatory requirements reviewed June 24, 2019.

## Other Information Sources

B. Harter, J. Babich (DPH BSAS), D. Tringali (DMH); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>1</sup> See <https://www.mass.gov/files/documents/2016/07/tr/reg-104cmr28.pdf>.

<sup>2</sup> See <https://www.mass.gov/files/documents/2018/07/03/104cmr29.pdf>.

<sup>3</sup> See <https://www.mass.gov/files/documents/2017/09/11/105cmr164.pdf>.

# MASSACHUSETTS MEDICAID

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## Approach

The Massachusetts Executive Office of Health and Human Services (OHHS) oversees the state Medicaid program. The state historically has relied to some extent on the in lieu of provision but not the Disproportionate Share Hospital (DSH) payments to reimburse certain services in Institutions for Mental Diseases (IMDs).

Massachusetts does have a Section 1115 waiver that affects reimbursement of two categories of residential services. The state's waiver allows for coverage of: (1) behavioral health residential (including IMD and others) MH/SUD treatment services as *diversionary* behavioral health services to provide interventions and stabilization to persons experiencing mental health (MH) or substance use disorder (SUD) crises in order to divert from acute inpatient hospitalization or to stabilize after discharge; and (2) residential SUD treatment (including IMD and others) to enhance the care continuum. Eligibility for these services vary by type of Medicaid enrollment.

## Types of Facilities

*Mental Health (MH) and Substance Use Disorder (SUD):* Massachusetts Medicaid permits enrollment of the following type of adult residential treatment provider as a diversionary service:

- Community Crisis Stabilization (CCS): Services provided as an alternative to hospitalization, including short- term treatment in structured, community-based therapeutic environments. CCS provides continuous 24-hour observation, supervision, intervention, and treatment for covered individuals who do not require inpatient services.

*Substance Use Disorder (SUD):* Massachusetts Medicaid permits enrollment of the following type of adult residential SUD treatment provider as a diversionary service:

- Acute Treatment Services for Substance Abuse: Residential medically monitored SUD treatment services that provide evaluation and withdrawal management.

- Clinical Support Services for Substance Abuse: Residential treatment services, which can be used independently or following Acute Treatment Services for SUD.

In addition to the services identified as diversionary, the Massachusetts Section 1115 waiver also allows coverage of the following services in 24-hour residential settings:

- Level 3.1 Clinically Managed Low-Intensity Residential Treatment Services: 24-hour Transitional Support Services (TSS)
- Level 3.1 Clinically Managed Low-Intensity Residential Treatment Services: 24-hour Residential Rehabilitation Services (RRS) and 24-hour community-based family SUD treatment services
- Level 3.3. Clinically Managed Population-Specific High Intensity Residential Services: Specialized 24-hour treatment services to meet more complex needs. Treats patients in a 24-hour setting where the effects of the substance use, other addictive disorder, or co-occurring disorder resulting in cognitive impairment on the individual's life are so significant and the resulting level of impairment so great that other levels of 24-hour or outpatient care are not feasible or effective.

Prior to the extension of the state Section 1115 waiver to cover the above services, Massachusetts Medicaid already covered the following for certain enrollees:

- Short-term withdrawal management services (ASAM Level 3.7)
- Short-term residential services (ASAM Level 3.5)

## **Processes of Medicaid Enrollment**

*Mental Health (MH) and Substance Use Disorder (SUD):* To be eligible to participate in the Massachusetts Medicaid program as any provider type, a provider must, among other things, be fully licensed, certified, or registered as an active practitioner by the agency or board overseeing the specific provider type, and where the regulations define "specialist" credentials or require other credentials, providers must possess those credentials. Providers must cooperate with the agency during any application, revalidation of enrollment, or other review process, which may include, but not be limited to, permitting and facilitating site visits, which may be unannounced. Providers may have their eligibility suspended or terminated and other sanctions may be applied.

## Staffing

*Mental Health (MH) and Substance Use Disorder (SUD):* Enrolled Medicaid facilities must have a “Managing Employee” who is a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

*Substance Use Disorder (SUD):*

- Acute Treatment Services for Substance Abuse: Detoxification services are delivered by nursing and counseling staff under a physician-approved protocol and physician-monitored procedures.
- Level 3.1 Clinically Managed Low-Intensity Residential Treatment Services: 24-hour Transitional Support Services (TSS). This requires nursing and clinical staff and appropriately trained professional and paraprofessional staff.
- Level 3.1 Clinically Managed Low-Intensity Residential Treatment Services: 24-hour Residential Rehabilitation Services (RRS) and 24-hour community-based family SUD treatment services: This requires clinical staff and appropriately trained professional and paraprofessional staff.

## Placement

*Mental Health (MH) and Substance Use Disorder (SUD):* CCS is available to individuals experiencing MH or SUD crises who require interventions and stabilization but do not require inpatient services.

*Substance Use Disorder (SUD):* According to the Section 1115 waiver, Medicaid enrollees may receive treatment in a number of different settings, relying on a bio-psycho-social clinical assessment, based on the ASAM principles, to gain an understanding of addiction severity, cooccurring mental health issues and trauma, physical health issues, family and social supports, housing stability and other issues.

## Treatment and Discharge Planning and Aftercare Services

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based treatment or discharge planning or aftercare service requirements for residential treatment facilities for adults was located.

## Treatment Services

*Mental Health (MH) and Substance Use Disorder (SUD):* CCS includes short-term intervention and treatment in structured, community-based therapeutic environments and provides continuous 24-hour observation and supervision.

### *Substance Use Disorder (SUD):*

- Acute Treatment Services for Substance Abuse: Detoxification services include: bio-psychosocial assessment; individual and group counseling; psychoeducational groups; and discharge planning. Pregnant women receive specialized services to ensure SUD treatment and obstetrical care. Covered Individuals with Co-occurring Disorders receive specialized services to ensure treatment for their co-occurring psychiatric conditions.
- Clinical Support Services for Substance Abuse: Includes intensive education and counseling regarding the nature of addiction and its consequences; outreach to families and significant others; and aftercare planning for individuals beginning to engage in recovery from addiction. Covered Individuals with Co-Occurring Disorders receive coordination of transportation and referrals to mental health providers to ensure treatment for their co-occurring psychiatric conditions. Pregnant women receive coordination of their obstetrical care.
- ASAM Level 3.1 Clinically Managed Low-Intensity Residential Treatment Services: 24-hour Transitional Support Services (TSS): Ensure safety for the individual, while providing active treatment and reassessment, including 4 hours of nursing services.
- ASAM Level 3.1 Clinically Managed Low-Intensity Residential Treatment Services: 24-hour Residential Rehabilitation Services (RRS) and 24-hour community-based family SUD treatment services: Ensures safety for the individual, while providing active treatment and reassessment. Residential Rehabilitation Services include day programming and individual and group services.
- ASAM Level 3.3. Clinically Managed Population-Specific High Intensity Residential Services: Specialized 24-hour treatment services to meet more complex needs. Includes day programming and individual and group services.

Although medication-assisted treatment is covered under Massachusetts Medicaid, neither the rules nor Section 1115 waiver reference its provision in residential settings.



## Care Coordination

*Mental Health (MH) and Substance Use Disorder (SUD):* Medicaid regulations require behavioral health contractors to arrange for the care coordination of beneficiaries.

## Quality Assurance or Improvement

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based quality assurance or improvement requirements for residential treatment facilities for adults was located.

## Special Populations

*Mental Health (MH) and Substance Use Disorder (SUD):* The Section 1115 waiver addresses provision of co-occurring treatment and treatment for pregnant women.

## Location of Medicaid Requirements

130 CMR: Division of Medical Assistance<sup>4</sup>; 130 CMR 450.000: Administrative and Billing Regulations; MassHealth Section 1115 waiver<sup>5</sup>. Regulatory data collected December 6, 2019.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report “**State Residential Treatment for Behavioral Health Conditions: Regulation and Policy**”. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

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<sup>4</sup> See <https://www.mass.gov/doc/130-cmr-450-administrative-and-billing-regulations/download>.

<sup>5</sup> See <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/ma-masshealth-ca.pdf>.

## MICHIGAN

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

### Types of Facilities

**Mental Health (MH):** Crisis Residential Services (CRS) may be provided in adult foster care facilities which, otherwise, lack requirements for the provision of clinical treatment services. Researchers identified no regulations specific to adult residential MH treatment facilities. Michigan does have patient rights requirements relevant to all receiving mental health services.

**Substance Use Disorder (SUD):** Michigan regulates two categories of adult residential SUD treatment:

- A residential treatment facility is a “temporary or permanent live-in residential setting that provides continuous treatment and rehabilitation services. This term does not include recovery, transitional, or sober housing that provides only a residential setting without offering treatment and rehabilitation services but may offer prevention services.”
- Residential detoxification “means a residential, medically acute or subacute, systematic reduction of the amount of a drug in the body, or the elimination of a drug from the body concomitant.”

**Unregulated Facilities:** There are no unregulated adult residential SUD treatment facilities in Michigan. No regulations were located specific to adult residential MH treatment. We exclude adult foster care, which does require licensure but does not incorporate required clinical services within the scope of this summary. To the extent CRS are provided in adult foster care, that is addressed in the Medicaid section at the end of this summary as they are regulated and licensed due to receipt of public funds.

### Approach

Mental Health (MH) and Substance Use Disorder (SUD): DHHS also imposes additional requirements outlined in the Medicaid Provider Manual<sup>1</sup> on any programs receiving public funds (discussed in Medicaid section at end of summary).

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<sup>1</sup> See <http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf>.

*Substance Use Disorder (SUD)*: The Michigan Department of Licensing and Regulatory Affairs (DLRA) regulates and licenses SUD treatment services, which are further regulated by the Department of Health and Human Services (DHHS).

## **Processes of Licensure or Certification and Accreditation**

*Substance Use Disorder (SUD)*: Licensure by the DLRA is required for operation of all adult SUD residential facilities in Michigan other than those located in a correctional institution, a veteran's facility operated by the state or federal government, or a facility owned and operated by the state. The DHHS also must approve any program receiving public funds before it provides services.

- Accreditation is not required but the DLRA may waive ongoing licensure inspections upon request by the licensee for a waiver and a showing of full accreditation by an accrediting body with expertise in the health facility type and the accrediting organization is accepted by the department.
- A preclosure survey is required for licensure and all facilities must be resurveyed at least every three years. The focus of the survey is on protecting the health, safety, and welfare of individuals receiving care and services.
- A Certificate of Need is not required for residential facilities.
- Licensure duration is one year. Provisional licenses may be issued for no more than one year and a temporary license for no more than 90 days.

## **Cause-Based Monitoring**

*Substance Use Disorder (SUD)*: The DLRA may undertake unannounced complaint investigations during any hours of operation of the program. Lack of access or cooperation will be seen as evidence of noncompliance. A license application or license may be suspended, denied, or revoked for multiple reasons, including but not limited to, denial/revocation/suspension/failure to renew a federal registration to distribute MAT medications. According to state staff, the DHHS also may require unannounced on-site inspections for any program receiving public funds.

## **Access Requirements**

*Mental Health (MH) and Substance Use Disorder (SUD)*: Wait-time requirements were not found.

## Staffing

*Substance Use Disorder (SUD)*: Michigan licensing requirements for SUD treatment facilities require, among other things, personnel policies and procedures, a designated program director with certain duties, maintenance of adequate staffing, staff development and training, and requirements regarding medical staffing.

- Residential: Facilities must employ a full-time licensed counselor, LMSW, or licensed psychologist. There are requirements related to clinical supervision and trained staff on-site during hours of operation. Regulations from the DHHS also require that there be one full-time staff member or designee on the premises at all times, with 1 FTE counselor for every 10 residents.
- Detoxification: Licensure requirements specify that residential detoxification facilities have the same requirements as residential; and must also include a medical director who is a physician trained in addiction psychiatry; and a physician, physician's assistant, advanced practice registered nurse, registered professional nurse or licensed practical nurse under the supervision of a registered professional nurse or physician, on-site during hours of operation. Regulations from the DHHS require a training plan developed in consultation with a physician and documentation of training. There must be a licensed physician staffed and on-call around the clock.

## Placement

*Mental Health (MH)*: The statutory patient rights applicable to all recipients of mental health services include the right to have a comprehensive physical and mental examination within 24 hours of admission to a "hospital or center."

*Substance Use Disorder (SUD)*: Residential treatment programs must have clearly stated written criteria for determining the eligibility of individuals for admission. For residential detoxification facilities, if an individual in an incapacitated condition is to be admitted to an approved service program, there must be documentation in his or her medical examination records which explicitly attests to the individual's incapacitated condition. The basis of the decision, including blood alcohol level, if taken, shall be specified. If an individual is found not to be incapacitated, the approved service program medical records shall so state. An individual found not to be incapacitated cannot be held in protective custody but may be voluntarily admitted for residential care services. Researchers did not find reference to ASAM criteria regarding assessing needed level of care.

## Treatment and Discharge Planning and Aftercare Services

*Mental Health (MH):* The statutory patient rights applicable to all recipients of MH services include the right to have a person-centered written individual plan of services developed in partnership with the recipient. A preliminary plan must be developed within 7 days of the commencement of services. The individual plan of services consists of a treatment plan, a support plan, or both. A treatment plan establishes meaningful and measurable goals. The individual plan of services addresses, as either desired or required by the recipient, the recipient's need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation. The plan must be kept current and shall be modified when indicated.

*Substance Use Disorder (SUD):*

- Residential: Licensure regulations require that an individualized treatment plan, based on assessments, be developed as promptly after the recipient's admission as feasible, but before the recipient is engaged in extensive therapeutic activities. A treatment plan must be reviewed at least once every 90 days. Unless the client leaves voluntarily, the program may not discharge a person physically dependent on a prescribed drug unless the person has an opportunity to withdraw from the drug or is referred to an outside resource. If a program provides aftercare services, a written aftercare plan shall be developed in partnership with the client before the completion of treatment. The aftercare plan shall state the client's objectives for a reasonable period following discharge. The plan shall also contain a description of the services the program will provide during the aftercare period, the procedure the client is to follow in reestablishing contact with the program, especially in times of crisis, and the frequency with which the program will attempt to contact the client for purposes of follow-up.
- Detoxification: Licensure regulations require that, prior to treatment, a licensee shall provide a recipient, or a person acting on the individual's behalf, all available medical treatment options and FDA approved medications related to the recipient's assessment, including all FDA approved forms of MAT, as well as the risks and benefits of each treatment option. The recipient record must contain a written document that the recipient has been informed of the risks and benefits of all treatment options, and the option selected by the recipient. The DHHS regulations require approved service programs to have a written description of the physician-approved protocol for treatment of incapacitated individuals. There must be a treatment plan for each client who undergoes detoxification. The treatment plan must include: (a) Services necessary to meet the client's medical needs; (b) Referrals to be made for medical and nursing services which are not provided by the program; and (c) Documentation that the treatment plan has been periodically evaluated and updated. Unless the client leaves voluntarily, the program may not discharge a person physically dependent on a prescribed drug unless the person has an opportunity to withdraw from the drug or is referred to an outside resource. Upon

discharge, there must be documentation that an evaluation of the social and psychological needs of the client has been completed and a referral to treatment must be made if appropriate and if desired by the client.

## **Treatment Services**

### *Substance Use Disorder (SUD):*

- Residential: License regulations require that a licensee provide and ensure recipient participation in at least 15 hours per week of treatment and support and rehabilitation services to take place days, evenings, and weekends. At least 3 of the 15 hours must be treatment in the form of individual counseling, group counseling, social skills training, cognitive behavioral therapy, motivational interviewing, couples counseling, or family counseling for each recipient. The DHHS requires that support and rehabilitation services be available internally or by referral.
- Detoxification: Prior to treatment, a licensee must provide a recipient, or a person acting on the individual's behalf, all available medical treatment options and FDA approved medications related to the recipient's assessment, including all FDA approved forms of MAT, as well as the risks and benefits of each treatment option. The recipient record must contain a written document that the recipient has been informed of the risks and benefits of all treatment options, and the option selected by the recipient. Specified medical personnel must review and assess each recipient every 72 hours after admission. A licensee shall have a policy and procedure for recipient drug test and perform an initial test upon admission with results documented in the recipient record within 48 hours of collection. At the time of admission and prior to any medications being prescribed or services offered, the medical director, a physician, physician's assistant, or advanced practice registered nurse shall complete and document the medical and drug history, as well as a physical examination, of the recipient. In addition, any modification to medications or course of treatment must be documented in recipient record and ordered by specified medical personnel.

## **Patient Rights and Safety Standards**

*Mental Health (MH):* Michigan's patient rights statute applies to all recipients of mental health care. Among other things, this requires that patients have notice of their rights, including a complaint or grievance process accessible to the patient. Rights include, but are not limited to, the right to be treated with dignity, to be treated in the least restrictive setting, to be free of abuse and neglect (which must be reported to law enforcement), to have communication, and confidentiality. The department must provide an annual report to the legislature of deaths of

mental health recipients reported to the provider or that occurred in state facilities. Restraint and seclusion are regulated and limited.

*Substance Use Disorder (SUD)*: Licensing regulations include general recipient rights, including but not limited to the right to nondiscrimination, to file grievances (the department must be informed of appeals of decisions on grievances), and to be free of abuse or neglect. Residential and residential detoxification facilities also must respect rights, including but not limited to those related to communication, visitors, privacy, and freedom from restraints unless certain standards are met. The DHHS regulations also include general recipient rights, and rights specific to residential facilities, similar to those found in the licensure regulations.

## **Quality Assurance or Improvement**

*Substance Use Disorder (SUD)*: An applicant or licensee must develop written goals and objectives to assess the needs and evaluate the effectiveness of the program and services offered. A licensee must review and document the evaluation of the program and services offered. The evaluation is to be completed annually or when there is a change in services or the needs assessment of the recipients, whichever is sooner.

## **Governance**

*Substance Use Disorder (SUD)*: SUD treatment programs must have a governing authority with authority and responsibility for the overall operation of the program and which ensures that the program complies with licensing standards.

## **Special Populations**

*Substance Use Disorder (SUD)*: Researchers did not locate requirements for adult residential SUD treatment for special populations other than a regulatory statement that detoxification is not recommended for pregnant patients.

## **Location of Regulatory and Licensing Requirements**

Michigan MH Patient Rights<sup>2</sup>; Michigan Public Health Code Section 333.6230 et seq.<sup>3</sup>, Licensing and Regulatory Affairs Regulations<sup>4</sup>, Substance Use Disorders Service Program Regulations<sup>5</sup>. Regulatory data collected May 17, 2019.

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<sup>2</sup> See [http://www.legislature.mi.gov/\(S\(5ode3w203jcouc3jgepstllb\)\)/documents/mcl/pdf/mcl-258-1974-7.pdf](http://www.legislature.mi.gov/(S(5ode3w203jcouc3jgepstllb))/documents/mcl/pdf/mcl-258-1974-7.pdf).

## Other Information Sources

J.L. Wieferich (DHHS); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>3</sup> See [http://www.legislature.mi.gov/\(S\(q2i5efjlhdzvolbsmrfk1ty2\)\)/mileg.aspx?page=getObject&objectName=mcl-368-1978-6-62](http://www.legislature.mi.gov/(S(q2i5efjlhdzvolbsmrfk1ty2))/mileg.aspx?page=getObject&objectName=mcl-368-1978-6-62).

<sup>4</sup> See [https://dtmb.state.mi.us/ORRDocs/AdminCode/1888\\_10901\\_AdminCode.pdf](https://dtmb.state.mi.us/ORRDocs/AdminCode/1888_10901_AdminCode.pdf).

<sup>5</sup> See [http://dmbinternet.state.mi.us/DMB/ORRDocs/AdminCode/1809\\_2018-028LR\\_AdminCode.pdf](http://dmbinternet.state.mi.us/DMB/ORRDocs/AdminCode/1809_2018-028LR_AdminCode.pdf).



# MICHIGAN MEDICAID

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## Approach

The Michigan Department of Health and Human Services (DHHS) oversees the state Medicaid program as well as any other facilities receiving public funds. Michigan also has a Section 1115 waiver permitting Medicaid expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD), including residential treatment. The state historically also has relied on the in lieu of provision and on Disproportionate Share Hospital (DSH) payments for Medicaid coverage of some IMD services.

## Types of Facilities

*Mental Health (MH) and Substance Use Disorder (SUD):* Michigan Medicaid covers Crisis Residential Services (CRSs). They are intended to provide a short-term alternative to inpatient psychiatric services for beneficiaries experiencing an acute psychiatric crisis when clinically indicated. Services may only be used to avert an inpatient psychiatric admission, or to shorten the length of an inpatient stay. Services must be provided to beneficiaries in licensed crisis residential foster care or group home settings not exceeding 16 beds in size.

The Michigan Medicaid Manual defines residential treatment as intensive therapeutic service which includes overnight stay and planned therapeutic, rehabilitative or didactic counseling to address cognitive and behavioral impairments for the purpose of enabling the beneficiary to participate and benefit from less intensive treatment.

Substance Use Disorder (SUD): The Michigan Section 1115 waiver permits reimbursements for the following residential settings:

- Level 3.1 -- Clinically Managed Low-intensity Residential Services
- Level 3.3 -- Clinically Managed Population-specific High-Intensity Residential Services
- Level 3.5 -- Clinically Managed High-Intensity Residential Services

- Level 3.7 -- Medically Monitored High-Intensity Inpatient Services (an alternative to acute medical care provided by licensed health care professionals in a hospital setting)
- Level 3.2-WM -- Clinically Managed Residential Withdrawal Management (Residential Withdrawal Management)
- Level 3.7 WM -- Medically Monitored Inpatient Withdrawal Management (also known as Medically Managed Residential Detoxification - Freestanding Detoxification Center)

Opioid treatment also is to be provided in IMDs.

## **Processes of Medicaid Enrollment**

*Mental Health (MH) and Substance Use Disorder (SUD):* To become a Medicaid provider, providers must apply. Revalidation is required at least every five years. Enrollment may be denied, suspended, or terminated and other sanctions may apply. Unannounced inspections are a condition of participation.

CRS settings must have appropriate licensure from the state and must be approved by the DHHS to provide specialized crisis residential services. CRS settings are adult foster care facilities which require licensure but do not otherwise require clinical services.

*Substance Use Disorder (SUD):* Michigan has regulatory and licensure requirements applicable to publicly-funded SUD providers, including those receiving Medicaid dollars.

According to the Section 1115 waiver, any residential facilities providing SUD services must be accredited by one or more of the following organizations:

- The Joint Commission;
- Commission on Accreditation of Rehabilitation Facilities (CARF);
- American Osteopathic Association (AOA);
- Council on Accreditation of Services for Families and Children (COA);
- National Committee on Quality Assurance (NCQA); or
- Accreditation Association for Ambulatory Health Care (AAAHC).

Residential facilities also must apply to the state to have an ASAM level assigned to their program.

## Staffing

*Mental Health (MH) and Substance Use Disorder (SUD):* The Medicaid Provider Manual requires that an adult CRS program must include on-site nursing services (RN or LPN under appropriate supervision). (1) For settings of six beds or fewer: on-site nursing must be provided at least one hour per day, per resident, seven days per week, with 24-hour availability on-call. (2) For 7-16 beds: on-site nursing must be provided eight hours per day, seven days per week, with 24-hour availability on-call. Treatment services must be clinically-supervised by a psychiatrist. A psychiatrist need not be present when services are delivered but must be available by telephone. The psychiatrist shall provide psychiatric evaluation or assessments at the crisis residential home or at an appropriate location in the community. A psychiatric evaluation completed by a treating psychiatrist that resulted in the admission to the program fulfills this requirement if the program psychiatrist has consulted with that physician as part of the admission process. Medication reviews performed at the crisis residential home must be performed by appropriately licensed medical personnel acting within their scope of practice and under the clinical supervision of the psychiatrist. The covered crisis residential services must be supervised on-site eight hours a day, Monday through Friday (and on call at all other times), by a mental health professional who meets educational and experiential requirements. Treatment activities may be carried out by paraprofessional staff who have met specific requirements. Peer support specialists may be part of the multidisciplinary team and can facilitate some of the activities based on their scope of practice, such as facilitating peer support groups, assisting in transitioning individuals to less intensive services, and by mentoring towards recovery.

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding credentials of staff for residential treatment settings. The state must assess the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT.

Residential services related to SUDs are covered only when rendered by a licensed and/or certified provider. PIHPs must conduct ongoing validation and revalidation of provider credentials.

The Medicaid Provider Manual specifies additional staff requirements:

- Residential treatment: A program director is responsible for the overall management of the clinical program, and treatment is provided by appropriate credentialed professional staff, including substance abuse specialists. Residential treatment must be staffed 24-hours-per-day. The clinical program must be provided under the supervision of a

Substance Abuse Treatment Specialist with either full licensure or limited licensure as a psychologist, master's social worker, professional counselor, marriage and family therapist or physician. Services may be provided by a Substance Abuse Treatment Specialist or a non-degreed staff.

- Level 3.2-WM -- Clinically Managed Residential Withdrawal Management (Residential Withdrawal Management): Emphasizes peer and social support for persons who warrant 24-hour support. These services must be provided under the supervision of a Substance Abuse Treatment Specialist. Services must have arrangements for access to licensed medical personnel as needed.
- Level 3.7 WM -- Medically Monitored Inpatient Withdrawal Management (also known as Medically Managed Residential Detoxification--Freestanding Detoxification Center): These services must be staffed 24-hours-per-day, seven-days-per-week by a licensed physician or by the designated representative of a licensed physician.

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* CRS services are designed for beneficiaries who meet psychiatric inpatient admission criteria or are at risk of admission, but who can be appropriately served in settings less intensive than a hospital. Services are designed for beneficiaries with mental illness or beneficiaries with mental illness and another concomitant disorder, such as substance abuse or developmental disabilities. For beneficiaries with a concomitant disorder, the primary reason for service must be mental illness. Services may be provided for a period up to 14 calendar days per crisis residential episode. Services may be extended and regularly monitored, if justified by clinical need, as determined by the interdisciplinary team.

CRS services may be provided to adults who are assessed by, and admitted through, the authority of the local PIHP. The PIHP must seek and maintain DHHS approval for the crisis residential program in order to use Medicaid funds for program services.

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines. The state also must establish a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings.

In addition to the ASAM criteria, under the waiver, Michigan is adopting the use of the Global Appraisal of Individual Needs Initial (GAIN-I) Core assessment that will be used statewide. The GAIN-I Core is a comprehensive assessment that supports clinical diagnosis, level of care placement and treatment planning. It collects necessary information to provide a Diagnostic and Statistical Manual based diagnosis and the recommended ASAM placement needs.

The Medicaid Provider Manual indicates that, for residential withdrawal management, symptom alleviation is not sufficient for purposes of admission. There must be documentation of current beneficiary status that provides evidence the admission is likely to directly assist the beneficiary in the adoption and pursuit of a plan for further appropriate treatment and recovery. (1) Admission to sub-acute detoxification must be made based on: (a) Medical necessity criteria; and (b) LOC determination based on an evaluation of the six assessment dimensions of the current ASAM Criteria. (2) Initial length-of-stay authorizations may be for up to three days, with additional days authorized if there is clinical evidence that detoxification is not successful or complete and authorization requirements continue to be met.

The Medicaid Provider Manual states that reimbursable residential treatment is limited to those beneficiaries who, because of specific cognitive and behavioral impairments, need a safe and stable environment in order to benefit from treatment. The effects of the substance use disorder must be so significant and the resulting impairment so great that outpatient and intensive outpatient treatments have not been effective or cannot be safely provided, and when the beneficiary provides evidence of willingness to participate in treatment. Admissions to Residential Treatment must be based on: (1) Medical necessity criteria; and (2) LOC determination based on an evaluation of the six assessment dimensions of the current ASAM Criteria. Additional days may be authorized when authorization requirements continue to be met, if there is evidence of progress in achieving treatment plan goals, and reauthorization is necessary to resolve cognitive and behavioral impairments which prevent the beneficiary from benefiting from less intensive treatment.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Medicaid beneficiaries must have an Individual Plan of Services that identifies the needs and goals of the individual beneficiary and the medical necessity, amount, duration, and scope of the services and supports to be provided. For beneficiaries receiving behavioral health services, the individual plan of services must be developed through a person-centered planning process. The individual plan of service must be kept current and modified when. A formal review of the plan with the beneficiary and his/her guardian or authorized representative must occur not less than annually to review progress toward goals and objectives and to assess beneficiary satisfaction.

CRS services must be delivered according to an individual plan based on an assessment of immediate need. The plan must be developed within 48 hours of admission. The plan must contain: (1) Clearly stated goals and measurable objectives, derived from the assessment of

immediate need, stated in terms of specific observable changes in behavior, skills, attitudes, or circumstances, structured to resolve the crisis. (2) Identification of the activities designed to assist the beneficiary to attain his/her goals and objectives. (3) Discharge plans, the need for aftercare/follow-up services, and the role of, and identification of, the case manager. If the length of stay in the crisis residential program exceeds 14 days, an interdisciplinary team must develop a subsequent plan based on comprehensive assessments. The team is comprised of the beneficiary, the parent or guardian, the psychiatrist, the case manager and other professionals whose disciplines are relevant to the needs of the beneficiary, including the individual ACT team, outpatient services provider or home-based services staff, when applicable. If the beneficiary did not have a case manager prior to initiation of the intensive crisis residential service, and the crisis episode exceeds 14 days, a case manager must be assigned and involved in treatment and follow-up care.

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, providers must ensure appropriate arrangements for continuing treatment for each beneficiary.

## **Treatment Services**

Mental Health (MH) and Substance Use Disorder (SUD): All Medicaid services must be medically necessary. Supports, services, and treatment authorized by the PIHP must be: (1) Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary; (2) Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner; (3) Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations; (4) Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and (5) Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

CRS services must be designed to resolve the immediate crisis and improve the functioning level of the beneficiaries to allow them to return to less intensive community living as soon as possible. The covered CRS services include: (1) Psychiatric supervision; (2) Therapeutic support services; (3) Medication management/stabilization and education; (4) Behavioral services; (5) Milieu therapy; and (6) Nursing services. Individuals who are admitted to the crisis residential services must be offered the opportunity to explore and learn more about crises, substance abuse, identity, values, choices and choice-making, recovery and recovery planning. Recovery and recovery planning include all aspects of life.

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, Medicaid beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from medically supervised withdrawal management to on-going chronic care for these

conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions. In addition, the state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services and hours of clinical care for residential treatment settings. The state must establish a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site.

## **Care Coordination**

*Mental Health (MH) and Substance Use Disorder (SUD):* In CRSs, peer support specialists can facilitate some of the activities based on their scope of practice, such as assisting in transitioning individuals to less intensive services. If the beneficiary has an assigned case manager, the case manager must be involved in the treatment and in follow-up services.

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, Medicaid beneficiaries will have access to improved care coordination and care for comorbid physical and mental health conditions. The state must ensure establishment and implementation of policies to ensure residential facilities link beneficiaries with community-based services and supports following stays in these facilities.

## **Quality Assurance or Improvement**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment.

As part of the quality monitoring during site reviews by PIHPS, clinical records are reviewed to determine appropriate application and fidelity to the GAIN-I Core assessment and ASAM processes. This quality monitoring will address the expectations that the assessment for all SUD services, level of care and length of stay recommendations has an independent third party reviewing and determining if the provider has the necessary competencies on the use of ASAM in the assessment process and determining an appropriate level of patient care.

## Special Populations

*Substance Use Disorder (SUD)*: Pursuant to the Section 1115 waiver, beneficiaries will have access to improved care for comorbid physical and mental health conditions.

## Location of Medicaid Requirements

Medicaid Provider Manual<sup>6</sup>; Michigan 1115 Waiver<sup>7</sup>. Regulatory data collected January 2020.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report “**State Residential Treatment for Behavioral Health Conditions: Regulation and Policy**”. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

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<sup>6</sup> See <http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf>.

<sup>7</sup> See <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-behavioral-health-ca.pdf>.



## MINNESOTA

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

### Types of Facilities

**Mental Health (MH):** Minnesota regulates several types of residential mental health programs that provide different levels of service for adults:

- Residential mental health programs provide services to people with mental illness in a residential setting as either a Category I or Category II program.
  - *Category I programs:* residential settings that emphasize services provided at the program while encouraging the use of community resources.
  - *Category II:* transitional semi-independent or supervised group supportive living settings that offer a combination of services provided at the program and services provided in the community and emphasize securing community resources for most daily programming and employment. Because services in Category II may be offered on-site, we include these facilities in the summary.
- *Intensive residential treatment services (IRTS):* provide comprehensive, short-term intensive residential treatment for adults who are experiencing significant difficulty with daily life activities because of a serious mental illness. According to the state website, these programs must follow the requirements of a variance. These requirements also apply to subsidiary categories of programs that provide crisis intervention and specialized treatment for persons with eating disorders. IRTS programs may serve up to 16 recipients per program and must be licensed.

**Substance Use Disorder (SUD):** There are two categories of regulated adult residential SUD treatment programs:

- *Detoxification Program:* a licensed program that provides short-term care on a 24-hour a day basis for the purpose of detoxifying clients and facilitating access to chemical dependency treatment as indicated by an assessment of needs.
- *Chemical Dependency Programs (CDPs):* Researchers did not locate a definition for CDPs, but they do serve individuals with a substance use disorder and those with specified characteristics that a license holder proposes to serve. The regulations apply specifically to those programs serving Minnesota residents that requires expenditure of public funds.

*Unregulated Facilities:* Other than forensic residential treatment, researchers did not locate reference to regulated adult residential MH treatment facilities or to regulated adult residential SUD treatment facilities other than those identified above in 1a. We exclude from this summary the forensic program known as the Minnesota Security Hospital, which includes residential mental health treatment in a secure or supervised setting to adults who have been committed to the care of the Department of Human Services as mentally ill and dangerous. This program is operated by the Minnesota Department of Human Services. According to the state website, the forensic program must follow the requirements of a variance as well as other state laws. The forensic program also must be licensed.

## **Approach**

*Mental Health (MH) and Substance Use Disorder (SUD):* Licensure by the Department of Human Services is required for all mental health Category I and II residential treatment facilities (5 beds or more only) and substance use disorder treatment facilities.

## **Processes of Licensure or Certification and Accreditation**

*Mental Health (MH) and Substance Use Disorder (SUD):*

- Licensure by the Department of Human Services is required for facilities. Licensure duration is two years, by which time a renewal application must be submitted. An inspection is required for licensure and renewal.
  - The Department of Human Services also offers voluntary certification of Category I or II facilities that serve people with a primary diagnosis of mental illness where the home is not the primary residence of the license holder and certain additional requirements are met.
  - Accreditation is recognized but not required. Where appropriate the commissioner shall identify and implement alternative methods of regulation and enforcement to the extent authorized in this subdivision. These methods shall include: (1) when the standards of another state or federal governmental agency or an independent accreditation body have been shown to require the same standards, methods, or alternative methods to achieve substantially the same intended outcomes as the licensing standards, the commissioner shall consider compliance with the governmental or accreditation standards to be equivalent to partial compliance with the licensing standards; and (2) use of an abbreviated inspection that employs key standards that have been shown to predict full compliance with the rules.
  
- For CDPs, the state will assess need prior to issuing a license.

- For IRTSs, the Department of Human Services requires licensure and has additional certification requirements for Crisis Stabilization Services (CSS) and specialized mental health treatment services for persons with eating disorders (EDTP).

## **Cause-Based Monitoring**

*Mental Health (MH) and Substance Use Disorder (SUD):* Unless otherwise specified in statute, the commissioner may conduct routine inspections biennially. In addition, the commissioner may access the licensed facility without prior notice and as often as the commissioner considers necessary if the commissioner is investigating alleged maltreatment, conducting a licensing inspection, or investigating an alleged violation of applicable laws or rules. At the time of application for licensure or renewal, the applicant or license holder must acknowledge that, if the applicant or license holder elects to receive any public funding reimbursement from the commissioner for services provided under the license, that the applicant's or license holder's compliance with the provider enrollment agreement or registration requirements for receipt of public funding may be monitored; and noncompliance with the provider enrollment agreement or registration requirements for receipt of public funding that is identified through a licensing investigation or licensing inspection, or noncompliance with a licensing requirement that is a basis of enrollment for reimbursement for a service, may result in administrative, civil, or criminal penalties as provided by law.

The commissioner may suspend or revoke the license, impose a fine, or secure an injunction against the continuing operation of the program of a license holder who does not comply with applicable law or rule. The commissioner shall act immediately to temporarily suspend a license if the license holder's actions or failure to comply with applicable law or rule pose an imminent risk of harm to the health, safety, or rights of persons served by the program; or while the program continues to operate pending an appeal of an order of revocation, the commissioner identifies one or more subsequent violations of law or rule which may adversely affect the health or safety of persons served by the program.

## **Access Requirements**

*Mental Health (MH):* Researchers did not locate wait time standards for Category I or II facilities.

An IRTS must be able to receive referral information from any source at the IRTS location all days of the year and at any time; respond within eight hours of receiving a referral to the referral source and, within that time frame, provide the referral source what information is required for the license holder to make a determination concerning admission; consider the program's staffing patterns and competencies of staff when making a determination concerning whether the program is able to meet the needs of a person seeking admission; and

make a determination concerning the admission within 72 hours of having received all information is received. When recipients meet their program goals or are otherwise found to no longer be eligible for services or the recipient's needs cannot be met by the license holder, the license holder must make arrangements for the recipient's discharge.

*Substance Use Disorder (SUD):* For CDPs, to receive public assistance, a chemical use assessment must be conducted by qualified staff for each client seeking treatment within 20 calendar days from the date an appointment was requested for the client. Within ten calendar days after the initial assessment interview, the placing authority must complete the assessment, make determinations, and authorize services. For a CDP, if the client is likely to be a danger to self or others, has severe medical problems, or has severe emotional or behavioral symptoms that prevent placement in a CDP, the placement authority must immediately help the client obtain appropriate services.

## **Staffing**

*Mental Health (MH):* The regulations establish requirements for Category I and II programs regarding personnel policies and procedures, including but not limited to ones related to staff orientation and staff development requiring at least 15 hours of training per year (including but not limited to crisis intervention, community resources, rights, cultural awareness, medications, and staff stress). There also are specific requirements regarding personnel files.

For Category I programs, there are requirements regarding the program administrator, program director, mental health therapists, mental health counselors, and mental health workers, with credentialing requirements for all but the first. There are requirements for "sufficient staff" as well as the following ratio requirements: The number of work hours performed by the program director shall be prorated based on resident capacity with a ratio of 40 hours per week to 40 residents. With this ratio, applicants shall be allowed to use one program director to direct more than one program and shall be allowed to use one full-time program director for programs with less than a 40-bed resident capacity. With this ratio, applicants shall not be required to have more than one full-time program director for programs with more than a 40-bed resident capacity. However, applicants or programs with more than a 40-bed capacity shall describe whatever additional assistance they intend to provide for the program director function. The number of work hours performed by the mental health therapist and mental health counselor and mental health worker may be combined in different ways, depending on program needs, to achieve a ratio of one full-time equivalent position for each five residents (1:5 FTE, averaged weekly). When the work hours are combined, the facility shall have written documentation that supervision is provided.

For Category II programs, there are requirements regarding the program administrator, program director, mental health therapists, mental health counselors, and mental health workers, with credentialing requirements for all but the first. There are requirements for "sufficient staff" as well as the following ratio requirements: The number of work hours

performed by the program director shall be prorated based on resident capacity with the ratio of 40 hours per week to 40 residents. With this ratio, applicants shall be allowed to use one program director to direct more than one program and shall be allowed to use one full-time program director for programs with less than a 40-bed resident capacity. With this ratio, applicants shall not be required to have more than one full-time program director for programs with more than a 40-bed resident capacity. However, applicants or programs with more than a 40-bed capacity shall describe whatever additional assistance they intend to provide for the program director function. The number of work hours performed by the mental health therapist, mental health counselor, and mental health worker may be combined to achieve a ratio of one full-time equivalent staff position for each ten residents (1:10 FTE, averaged weekly). When the work hours are combined, the facility shall have written documentation that supervision is provided.

For IRTS facilities, the variance contains detailed requirements for orientation and ongoing training including but not limited to best practice service delivery that includes (among others) trauma informed care and integrated dual diagnosis treatment. Among the requirements for direct care, nonlicensed staff is training in motivational interviewing. Specific hours of training are indicated. IRTS facilities must have sufficient staff to provide the services offered by the program and have sufficient staff available to provide 24-hour-per-day coverage and to: meet the needs identified in the recipients' ITPs; implement program requirements; and, safely supervise and direct the activities of recipients taking into account the recipients' level of behavioral and psychiatric stability, cultural needs, and vulnerabilities. Additional requirements are in the variance, including staffing ratios for direct and mental health staff. Qualifications are in place for the Clinical Supervisor, RN, and Treatment Director. Standards of supervision and observation are in place for direct care rehabilitation workers.

If one or more recipients are receiving CSS, the staff must include a mental health professional and at least one individual who is a mental health practitioner or rehabilitation worker who has had 30 hours of training in crisis services in the last two years. During the first 48 hours that a recipient who is receiving CSS is in the program, the license holder must have at least two staff working 24 hours a day. Staffing levels may be reduced following the 48 hours provided the staffing levels continue to meet the recipients' needs as specified in their individualized crisis stabilization treatment plans.

For EDTPs, the license holder must ensure and maintain documentation that all staff have knowledge or competency in the following areas: The characteristics, and treatment of recipients with special needs such as substance abuse, obsessive compulsive disorder, and eating disorders; and first aid and cardiopulmonary resuscitation (CPR) training.

*Substance Use Disorder (SUD):* For detoxification facilities, there are requirements for the program director, a responsible staff person at all times, a technician (awake at all times, one per 15 clients), an assessor, registered nurse responsibilities, and medical director responsibilities. Staff qualifications are established for those who have direct client contact, including a requirement that they be free of "chemical use problems" for at least two years,

although, for technicians, the time is six months. Remaining chemical use problem-free is a term of employment. Credentials are not stated for the medical director. The facility must maintain personnel policies and procedures, including but not limited to ones regarding orientation and training. Those working with clients must have 30 hours of continuing education every two years. Among other things, training must include approved therapeutic holds and use of protective procedures. Regulations also govern personnel files.

For CDPs, staff must receive state-mandated HIV training. Regulations include requirements and qualifications for a treatment director, alcohol and drug counselor supervisor, a responsible staff member (present at all times), and staff trained in first aid and CPR (present at all times). There also are requirements related to paraprofessional staff, care coordination providers, recovery peers, volunteers, student interns, and individuals with a temporary permit. The personnel requirements include a treatment group not to exceed 16 clients. There are requirements that staff be free of “problematic substance use.”

## **Placement**

*Mental Health (MH):* Each Category I or II program shall develop admission criteria delineating the types and characteristics of persons who can and cannot be served by the program. Intake policies and procedures shall be developed including the role of community resources.

An IRTS must have admission and discharge criteria that meet set criteria, unless the IRTS only provides crisis stabilization services. The license holder must not limit or restrict services to recipients based solely on: (1) The recipient’s substance use; (2) The county in which the recipient resides; or, (3) Whether the recipient elects to receive other services for which they may be eligible, including but not limited to case management services. A mental health professional or mental health practitioner with clinical supervision must complete a functional assessment of the recipient within ten calendar days of admission. The assessment must be updated at least every 30 days and within five calendar days prior to discharge. Within five days of the recipient’s admission, a diagnostic assessment must be completed or updated by a mental health professional. A level of care assessment of the recipient using the LOCUS must be completed by a mental health professional or a mental health practitioner with clinical supervision, within ten days of the recipient’s admission. If the recipient is assessed through LOCUS as needing “medically monitored level of service” (level 5), this supports the recipient’s need for IRTS. If the recipient is assessed to have needs that are not at this level, the clinical supervisor must evaluate and document how the recipient’s admission to and continued services in IRTS is medically necessary. Within ten days of admission, all recipients must be screened for the possibility of a co-occurring substance use disorder, unless they have a current substance use diagnosis. There must be a health screening of each recipient within 72 hours of admission.

For certification as a CSS, the license holder must develop and maintain specific admission criteria.

An EDTP recipient must be diagnosed with an eating disorder of Anorexia Nervosa (AN), Bulimia Nervosa (BN), or Eating Disorder Not Otherwise Specified (EDNOS) as defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

*Substance Use Disorder (SUD):* For detoxification programs, a license holder must have a written admission policy containing specific admission criteria. The admission policy must be approved and signed by the medical director of the facility and designate which staff members are authorized to admit and discharge clients. A detoxification program may only admit persons who meet the admission criteria and who, at the time of admission: (A) appear intoxicated; (B) experience physical, mental, or emotional problems due to withdrawal from alcohol or other drugs; (C) are being held under apprehend and hold orders; (D) have been committed and need temporary placement; (E) are held under emergency holds or peace and health officer holds; or (F) need to stay temporarily in a protective environment because of a crisis related to substance use disorder. Persons meeting this criterion may be admitted only at the request of the county of fiscal responsibility. Persons admitted according to this provision must not be restricted to the facility.

A license holder must screen each client admitted to determine whether the client suffers from substance use disorder. A license holder must provide or arrange for the provision of a chemical use assessment for each client who suffers from substance use disorder at the time the client is identified. If a client is readmitted within one year of the most recent assessment, an update to the assessment must be completed. If a client is readmitted and it has been more than one year since the last assessment, a new assessment must be completed. License holders must have written procedures for assessing and monitoring client health. If the client was intoxicated at the time services were initiated, the procedure must include a follow-up screening conducted between four and 12 hours after service initiation that collects information relating to health complaints and behavioral risk factors that the client may not have been able to communicate clearly at service initiation.

For CDPs, to receive public assistance, a chemical use assessment must be conducted for each client seeking treatment before the client is placed in a treatment program. The assessment must be conducted by qualified staff within 20 calendar days from the date an appointment was requested for the client. Within ten calendar days after the initial assessment interview, the placing authority must complete the assessment, make determinations, and authorize services. A comprehensive assessment of the client's substance use disorder must be administered face-to-face by an alcohol and drug counselor within three calendar days after service initiation for a residential program.

There also are access standards for CDPs. The placement authority must determine appropriate services for clients by determining the client's acute intoxication/withdrawal potential, their biomedical conditions and complications, their emotional/behavioral/cognitive condition, their readiness for change, their relapse/continued use/continued problem potential, and their recovery environment. If the client is likely to be a danger to self or others, has severe medical

problems, or has severe emotional or behavioral symptoms, the assessor will immediately help the client obtain appropriate services.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH):* All residential Category I or II MH treatment programs require a treatment plan, discharge planning, and aftercare/follow up requirements. Within 10 days after admission, the mental health residential program staff will write short-term goals with each resident in order to address the resident's immediate needs. Within 30 days, the program staff will write an individual program plan developed by an interdisciplinary team. A quarterly review of the resident's response to the individual treatment plan and his or her involvement in the facility's overall program shall be written. A discharge or transfer summary shall be written for each person transferred or discharged. The summary shall include, among other things, an aftercare plan which identifies the persons, including at least the resident, a program staff member, and a representative of the referring agency, who participated in the development of the aftercare plan; goals and objectives for the first three months after discharge or transfer; and individuals or agencies who will be working with the resident after discharge or transfer; and a forwarding address and telephone number for follow-up contacts.

IRTS facilities must develop an individualized treatment plan. An initial treatment plan must be completed within 24 hours of the recipient's admission and must be completed by a mental health professional or a mental health practitioner under clinical supervision. The license holder must develop and maintain an individual abuse prevention plan. Within ten days of admission, the initial treatment plan must be refined and further developed and must be updated at least every 30 days. The plan must include at least one discharge goal. When a recipient's needs cannot be met by the license holder or the recipient has needs for services after discharge, the license holder must make arrangements to transfer the recipient to services that are appropriate given the recipient's needs and that are expected to meet the recipient's needs.

For certification as a CSS, the license holder must develop an individualized crisis stabilization treatment plan within 24 hours of admission.

An EDTP recipient must be discharged when at least one of the following criteria is met: (a) The recipient has achieved maximum benefit from treatment or successfully met the goals of the individualized treatment plan (ITP); (b) The recipient's symptoms and needs may be managed at a lesser level of service and adequate supports and services are available; (c) The recipient exhibits a severe exacerbation of symptoms, decreased functioning or disruptive or dangerous behaviors and requires a more intensive level of service; (d) The recipient has medical or physical health needs that the license holder is not able adequately address; (e) The recipient does not participate in the program despite multiple attempts to engage him or her and to address nonparticipation issues; (f) The recipient does not make progress toward treatment goals and there is no reasonable expectation that progress will be made; or, (g) The recipient



leaves against medical advice for an extended period (determined by written procedures of provider agency).

*Substance Use Disorder (SUD):* For detoxification programs, the license holder must have a written plan for addressing the needs of individuals whose potential for medical problems may require acute medical care. This includes clients whose pregnancy, in combination with their presenting problem, requires services not provided by the program, and clients who pose a substantial likelihood of harm to themselves or others if their behavior is beyond the behavior management capabilities of the program and staff. A license holder must have a written policy, approved and signed by the medical director, that specifies conditions under which clients may be discharged or transferred. The policy must include guidelines for determining when a client is detoxified and whether a client is ready for discharge or transfer, and any procedures staff must follow.

CDPs must have both a service initiation and service termination policy. CDPs require an initial service plan on the day of service initiation, which will include, among other things, as determination if a person is a “vulnerable adult” (an adult client of a residential program is a vulnerable adult). There must also be a treatment plan within 7 days of initiation. A treatment plan review must be entered in a client's file weekly or after each treatment service, whichever is less frequent, by the staff member providing the service. At a CDP, if a client is discharged at staff request, the service discharge summary must include crisis and other appropriate referrals for the client's needs and offer assistance to the client to access the services. If a client successfully completes treatment, the service discharge summary must also include continuing care recommendations, including transitions between more or less intense services, or more frequent to less frequent services, and referrals made with specific attention to continuity of care for mental health, as needed.

## **Treatment Services**

*Mental Health (MH):* For Category I or II programs, the following resources need to be offered by either the program or through a working agreement with other community resources: case management services, crisis services, independent living skills training, mental health therapy, motivation and remotivation services, recreation and leisure time services, socialization services, support group services, social services, vocational services, and other services if need is indicated by the resident assessment.

IRTS facilities must provide on a daily basis medically necessary rehabilitation services for each IRTS recipient using individualized treatment interventions based on the recipients’ assessed needs. The license holder must also provide individualized treatment that promotes recipient choice, and active involvement in the service planning and recovery processes. License holders must integrate Illness Management and Recovery (IMR) practices in the design of their programs and delivery of services. License holders must address the needs of recipients who have co-occurring substance use disorders using Integrated Dual Diagnosis Treatment (IDDT).

As further elaborated in the variance, licensees also must provide: (1) Independent living skills training; (2) Family involvement support services; (3) Crisis prevention planning; and (4) Peer specialist support services. If the license holder offers additional mental health treatment services, the treatment must meet the definition of a best practice and be delivered by staff who have received adequate training in the provision of the treatment and who are supervised by a mental health professional who is competent in the delivery of the treatment.

For certification as a CSS, the license holder must provide assessment of immediate needs and factors that lead to the crisis, individualized crisis stabilization treatment planning, supportive counseling, skills training, and referrals to other needed services.

An EDTP must have the capacity to effectively manage the recipient's co-morbid or other medical conditions. The following service must be provided to be certified as an EDTP: (a) Specific nutrition care services provided by a nutrition care service provider; (b) Oversight of medical services must be provided by or under the direction of a licensed independent practitioner (LIP) and specific medical services must be provided; (c) The following services must be available as needed to address the medical and health care needs of recipients: Physical and occupational therapy; dental care; physician services; and laboratory services; (d) A licensed independent practitioner (LIP) and nutrition care provider must be members of the treatment team. These staff shall not provide mental health rehabilitation services unless they are also qualified as a mental health professional, a mental health practitioner, or a mental health rehabilitation worker.

*Substance Use Disorder (SUD):* For detoxification programs, a license holder must provide referrals to appropriate chemical dependency services as indicated by the chemical use assessment. Referrals may also be made for mental health, economic assistance, social services, and prenatal care and other health services as the client may require. A license holder must provide information for obtaining assistance regarding: substance use disorder, including the effects of alcohol and other drugs and specific information about the effects of chemical use on unborn children; tuberculosis and reporting known cases of tuberculosis disease to health care authorities; and HIV. License holders must have a standardized data collection tool for collecting health related information about each client. The procedures must specify the physical signs and symptoms that require consultation with a registered nurse or a physician and that require transfer to an acute care medical facility. The procedures must specify the actions to be taken to address specific complicating conditions including pregnancy or the presence of physical signs or symptoms of any other medical condition.

For CDPs, license holders must offer individual and group counseling, client education strategies to avoid inappropriate substance use and health problems related to substance use, a service to help client integrate gains made during treatment into daily living, a service to address issues related to co-occurring disorders, peer recovery support services provided 1-to-1 by an individual in recovery, and care coordination. A treatment service provided to a client must be provided according to the individual treatment plan and must consider cultural differences and special needs of a client. Additional services may include: relationship counseling, therapeutic

recreation, stress management and physical well-being, living skills development, employment or educational services, socialization skills, and room, board, and supervision at the treatment site to provide the client with a safe and appropriate environment to gain and practice new skills. CDPs that serve parents with their children must provide parent education regarding child safety.

## **Patient Rights and Safety Standards**

*Mental Health (MH) and Substance Use Disorder (SUD):* Individuals in residential settings are included in a category of vulnerable adults with specific additional rights. Among other things, reporting of suspected maltreatment is mandated, as is investigation of the reports.

*Mental Health (MH):* The regulations require all Category I or II residential MH treatment facilities to develop a written statement of residents' rights. There must be a complaint/grievance process accessible to patients. The state reserves the right to conduct inspections in response to complaint/grievance reports. Restraint, seclusion, and use of medications for crisis management are allowed but restricted.

IRTS facilities must report critical incidents to the department's licensing division in writing and within ten days of the occurrence. Among other rights, recipients are entitled to a written statement of rights, communication, freedom from discrimination, courtesy and respect, freedom from maltreatment, and confidentiality.

*Substance Use Disorder (SUD):* For detoxification facilities, "protective procedures" (restraint and seclusion) are allowed but restricted. The licensee must conduct a quarterly review of all protective procedure use. The facilities must have a grievance process accessible to patients.

CDPs must have a grievance process accessible to patients. CDPs are also subject to the patient bill of rights applicable to drug and alcohol counselors which provides rights including but not limited to understanding their rights, not to be stereotyped, and freedom from maltreatment and exploitation. Those civilly committed to CDPs also have rights under the civil commitment statute, which, among other things, allows but restricts restraint, and includes rights to communication and consent, among others. Critical incidents must be reported.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* The commissioner shall evaluate the effects of the rules listed in Human Services Regulations at least once every five years. One aspect of that evaluation will be a discussion of the rules' effect on the availability and quality of licensed programs.

*Mental Health (MH):* Each program Category I or II program shall institute an evaluation process to be conducted on an ongoing basis. The evaluation process shall be outcome-based and consistent with the emphasis on individual treatment planning. In a format developed by the commissioner, the data and documentation shall be submitted to the commissioner on an annual, aggregate basis for statewide summaries and for planning the use of state resources.

IRTS facilities must develop a written quality assurance and improvement plan that must also include processes to review the data or information in the plan.

*Substance Use Disorder (SUD):* The license holder must participate in the drug and alcohol abuse normative evaluation system by submitting, in a format provided by the commissioner, information concerning each client admitted to the program.

## **Governance**

*Mental Health (MH) and Substance Use Disorder (SUD):* As part of licensure application, the applicant must provide information on program leadership and must have policies that relate to regulatory compliance.

*Mental Health (MH):* Category I or II treatment facilities must have an advisory committee that meets regularly, and a comprehensive annual report to be provided to the governing body, the advisory committee, the host county, and the Department.

An IRTS must have policies and procedures that are reviewed at least annually by the Treatment Director and updated as needed.

*Substance Use Disorder (SUD):* Detoxification facilities must have written policies and procedures; and, at application, must include information on insurance and bonding. CDPs must have written policies and procedures.

## **Special Populations**

*Mental Health (MH):* Requirements regarding residential services were not explicitly described in the state regulations.

*Substance Use Disorder (SUD):* For CDPs, additional requirements relate to CDPs that service parents with their children and those that serve persons with co-occurring disorders; and regarding HIV training in CDPs.

## Location of Regulatory and Licensing Requirements

Department of Human Services Mental Health Regulations<sup>1</sup>, Department of Human Services Substance Use Treatment Regulations<sup>2</sup>, Department of Human Services Licensure Statute<sup>3</sup>, Chemical Dependency Statute<sup>4</sup>, Reporting of Maltreatment of Vulnerable Adults<sup>5</sup>, Vulnerable Adult<sup>6</sup>, Required Documentation and Reports<sup>7</sup>, Client Welfare statute<sup>8</sup>, Rights of Patients Civilly Committed<sup>9</sup>, Department of Human Services Residential Mental Health Programs for Adults website<sup>10</sup>, IRTS variance to Minnesota rules<sup>11</sup>, Forensic variance to Minnesota rules<sup>12</sup>.  
Regulatory data collected May 24, 2019.

## Other Information Sources

D. Hulzebos, P. Thomas (DHS BHD); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>1</sup> See <https://www.revisor.mn.gov/rules/9520/>.

<sup>2</sup> See <https://www.revisor.mn.gov/rules/9530/>.

<sup>3</sup> See <https://www.revisor.mn.gov/statutes/cite/245A.03>.

<sup>4</sup> See <https://www.revisor.mn.gov/statutes/cite/245G>.

<sup>5</sup> See <https://www.revisor.mn.gov/statutes/cite/626.557>.

<sup>6</sup> See <https://www.revisor.mn.gov/statutes/cite/626.5572>.

<sup>7</sup> See <https://www.revisor.mn.gov/rules/9520.0570/>.

<sup>8</sup> See <https://www.revisor.mn.gov/statutes/cite/148F.165>.

<sup>9</sup> See <https://www.revisor.mn.gov/statutes/cite/253B>.

<sup>10</sup> See <https://mn.gov/dhs/partners-and-providers/licensing/adult-behavioral-health-residential-facilities/>.

<sup>11</sup> See [https://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_FILE&RevisionSelectionMethod=LatestReleased&Render=Primary&allowInterrupt=1&noSaveAs=1&dDocName=DHS16\\_150079](https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Render=Primary&allowInterrupt=1&noSaveAs=1&dDocName=DHS16_150079).

<sup>12</sup> See [https://mn.gov/dhs/assets/Forensic\\_tcm1053-383485.pdf](https://mn.gov/dhs/assets/Forensic_tcm1053-383485.pdf).

# MINNESOTA MEDICAID

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

## Approach

*Mental Health (MH) and Substance Use Disorder (SUD):* The Minnesota Department of Human Services (DHS) oversees the state Medicaid program. Minnesota relies on the in lieu of provision and on Disproportionate Share Hospital (DSH) payments for reimbursement of some services in Institutions for Mental Diseases (IMDs).

*Substance Use Disorder (SUD):* In addition to Medicaid coverage of services in non-IMDs in the state plan, Minnesota has a Section 1115 waiver that permits expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder who are short-term (statewide average length of stay of 30 days) residents in facilities that meet the definition of an IMD.

## Types of Facilities

*Substance Use Disorder (SUD):* The residential settings identified in the waiver include the following:

- Residential treatment in an IMD.
- Medically monitored withdrawal management in an IMD.
- Clinically managed withdrawal management in an IMD.

Medication-assisted treatment also is to be available to those in IMDs.

## Processes of Medicaid Enrollment

*Mental Health (MH) and Substance Use Disorder (SUD):*

- A vendor that wants to participate in the medical assistance program shall apply to the department on forms provided by the department. The forms must contain an application

and a statement of the terms for participation. Upon approval of the application by the department, the signed statement of the terms for participation and the application constitute the provider agreement. Providers must meet profession, certification and licensure requirements according to applicable state and federal laws and regulations specific to the service(s) they provide.

## **Staffing**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding credentials of staff for residential treatment settings. The state must assess the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT.

## **Placement**

*Substance Use Disorder (SUD):* In accordance with the state 1115 waiver, the state must establish a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the ASAM Criteria or other comparable assessment and placement tools that reflect evidence-based clinical treatment guidelines, as well as a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Requirements regarding residential services were not explicitly described in the state Medicaid regulations.

## **Treatment Services**

*Substance Use Disorder (SUD):* Under the Section 1115 waiver, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions. Pursuant to the Section 1115 waiver, the state must establish

residential treatment program standards regarding in particular the types of services and hours of clinical care for residential treatment settings. The state must establish a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site.

## Care Coordination

*Substance Use Disorder (SUD)*: Under the Section 1115 waiver, beneficiaries will have improved care coordination and care for comorbid physical and mental health conditions. The state must ensure establishment and implementation of policies to ensure residential facilities link beneficiaries with community-based services and supports following stays in these facilities.

## Quality Assurance or Improvement

*Substance Use Disorder (SUD)*: Pursuant to the Section 1115 waiver, the state must establish a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings.

## Special Populations

*Mental Health (MH) and Substance Use Disorder (SUD)*: Requirements regarding residential services were not explicitly described in the state Medicaid regulations.

## Location of Medicaid Requirements

Minnesota Administrative Rules Chapter 9506, MinnesotaCare<sup>13</sup>; Minnesota Department of Human Services Health Care Programs and Services Overview Legal References<sup>14</sup>; Website on Enrollment with Minnesota Health Care Programs<sup>15</sup>; Minnesota Substance Use Disorder System Reform<sup>16</sup>. Regulatory data collected January 8, 2020.

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<sup>13</sup> See <https://www.revisor.mn.gov/rules/9506/>.

<sup>14</sup> See [https://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id\\_008922](https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_008922).

<sup>15</sup> See [https://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=ENROLL-HOME](https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=ENROLL-HOME).

<sup>16</sup> See <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=47450>.



## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019. <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report **“State Residential Treatment for Behavioral Health Conditions: Regulation and Policy”**. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

## MISSISSIPPI

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

### Types of Facilities

*Mental Health (MH) and Substance Use Disorder (SUD):* Mississippi regulates publicly-funded treatment facilities.

*Mental Health (MH):* In addition to general regulations specific to publicly-funded facilities, Mississippi regulates Crisis Stabilization Services, which are provided as time-limited residential services in a Crisis Stabilization Unit. Crisis Stabilization Services must be designed to prevent civil commitment and/or longer term inpatient psychiatric hospitalization by addressing acute symptoms, distress and further decomposition.

*Substance Use Disorder (SUD):* Mississippi regulates all publicly-funded SUD treatment programs. Specifically identified program types are:

- Withdrawal Management (WM) facilities at levels based on the ASAM criteria for Level 3.2-WM: Clinically Managed Residential Withdrawal Management (sometimes referred to as “social detox”) and 3.7 Medically Monitored Inpatient Withdrawal Management. These services must be provided in conjunction with Primary Residential services within Community Mental Health Centers (CMHCs).
- CMHCs must provide Primary Residential Services as a core adult service for individuals in need of SUD treatment and rehabilitation services residing in the CMHC’s entire catchment area. Services are offered in a community based treatment setting and support individuals as they develop the skills and abilities necessary to improve their health and wellness, live self-directed lives, and strive to reach their full potential in a life of recovery. The residential continuum of care for SUD Residential Treatment Services includes Primary Residential Services and Transitional Residential Services for individuals with SUD.
  - Primary Residential Services is the highest community based level of care for the treatment of SUDs. This level of treatment provides a safe and stable group living environment where the individual can develop, practice and demonstrate necessary recovery skills.
  - Transitional Residential Services are provided in a safe and stable group living environment which promotes recovery while encouraging the pursuit of vocational or related opportunities.

*Unregulated Facilities:* Facilities not receiving public funds are unregulated.

## **Approach**

The Mississippi Department of Mental Health (DMH) regulates publicly-funded treatment facilities. This include CMHCs, which are operated under the authority of regional commissions and other community mental health service providers operated by entities other than the DMH that meet the requirements of and are determined necessary by DMH to be a designated and approved mental health center.

## **Processes of Licensure or Certification and Accreditation**

*Mental Health (MH) and Substance Use Disorder (SUD):* All publicly-funded treatment facilities must be certified by the DMH and are subject to a DMH- approved peer review/quality assurance evaluation process. All providers seeking certification must participate in an orientation and submit an application. The application focuses, among other things, on services to be provided, adherence to DMH standards, and fiscal responsibility.

- Accreditation is not required.
- Administrative (document review) and On-Site Compliance Reviews will take place (if applicable) for the certification of the following: (1) New service provider organizations; (2) New services or program locations for an existing DMH Certified Provider; (3) Additional services or program locations for an existing DMH Certified Provider; and (4) Adherence to an accepted Plan of Compliance.
- A Certificate of Need is not required for operation but the DMH does require a showing of need as part of certification.
- Certification is for 3 years unless otherwise stated at certification.

*Substance Use Disorder (SUD):* In addition to the general requirements for all DMH-certified facilities:

- Accreditation is not required but, for SUD programs classified as a state or federal institution or correctional facility that are certified by CARF, The Joint Commission, the American Corrections Association or other certification body approved by the DMH, the DMH may accept those certifications in lieu of the DMH standards, with the exception of standards related to clinical program operation and personnel requirements. Programs must be in good standing with the applicable certification body for approval to be granted. The Joint Commission (TJC) accredited SUD treatment providers (not funded by

the DMH) seeking DMH certification must submit documentation of TJC accreditation in the specific SUD area(s) that corresponds with the SUD service area(s) included in the DMH standards. The DMH will determine if the documentation is sufficient to support certification in the specific SUD services areas.

## **Cause-Based Monitoring**

*Mental Health (MH) and Substance Use Disorder (SUD):* Administrative and on-site compliance reviews will take place, during the certification period to ensure continued adherence to DMH standards, guidelines, contracts, and grant requirements. The DMH reviews may be unannounced. If found to be out of compliance with the criteria for certification during an administrative or on-site compliance review, the DMH will require a plan of correction (POC) by the provider. The DMH may determine the need to take administrative action to suspend, revoke or terminate certification.

## **Access Requirements**

*Mental Health (MH) and Substance Use Disorder (SUD):* The provider must implement written policies and procedures for providing appointments for individuals being discharged from inpatient care that: (1) Provide a phone number where contact can be made to arrange for an appointment; and (2) Assure the person requesting services only has to make one call to arrange an appointment. Written policies and procedures must address admission to services and must, among other things, assure equal access to treatment and services and non-discrimination based on ability to pay, race, sex, age, creed, national origin, or disability for individuals who meet eligibility criteria; describe procedures for maintaining and addressing a waiting list for admission or readmission to service(s) available by the provider; and assure equal access to treatment and services for HIV-positive persons who are otherwise eligible.

*Mental Health (MH):* Crisis Stabilization Services must be designed to accept admissions (voluntary and involuntary) twenty-four (24) hours per day, seven (7) days per week.

*Substance Use Disorder (SUD):* Pregnant women have top priority for admission, may not be placed on a wait list and must be admitted within 48 hours. Individuals who use IV drugs have priority for admission over non-IV drug users and must be admitted within 48 hours. For both populations, there are regulatory requirements if access is not possible within 48 hours.

## **Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD):* All services and programs must provide the level of staffing needed to ensure the health, safety, and welfare of the individuals served,

and provide essential administrative and service functions. Only a licensed health care professional can provide nursing care, medical services, or medication, in accordance with the criteria, standards, and practices set forth by their respective licensing entity. To ensure initial and continuing receipt of certification/funding from the DMH or other approved sources, the provider must maintain documentation that staff meet specific qualifications including related to education and experience and fulfill specific responsibilities for the following positions: (1) One full-time Executive Director. (2) Director(s) with overall responsibility for a service, service area(s) or multiple services provided at/from a single location. Medication evaluation and monitoring, the initial evaluation, prescribing of medications, and regular/periodic monitoring of the therapeutic effects of medication prescribed for mental health purposes are provided by: (1) A Board-certified or Board-eligible psychiatrist. (2) A psychiatric/mental health nurse. (3) If documented efforts, including efforts to work with the Department of Health to recruit a licensed psychiatrist through the J-I Visa or Public Health Service Program during the certification period are unsuccessful, psychiatric services may be provided by other physician(s) licensed by the Mississippi Board of Medical Licensure.... (6) Medical services are provided by a psychiatrist or other physician. (7) Nursing services are provided by a Registered Nurse or a Licensed Practical Nurse. (8) Psychological services are provided by a psychologist. (9) Therapy or Counseling services are provided by an individual with at least a master's degree in mental health and specific licensure.... (16) Peer Support Services. (17) Wraparound Facilitators.... (18) Direct care staff. (19) Specialists such as Audiologists, Speech/Language Pathologists, Occupational Therapists, Dieticians, Physical Therapists, etc.... (23) Targeted case management providers.

Community Mental Health Center providers must have a multidisciplinary staff, with at least the following disciplines represented, by individuals with specific qualification: (1) A psychiatrist (available on a contractual, part-time or full-time basis). (2) A psychologist (available on a contractual, part-time or full-time basis). (3) A full-time or full-time equivalent registered nurse. (4) A full-time or full-time equivalent Licensed Master Social Worker, Licensed Professional Counselor (LPC), or Licensed Marriage and Family Therapist (LMFT). (5) A full-time or full-time equivalent business manager. 6. A full-time or full-time equivalent records practitioner or designated records clerk.

All new employees and regularly scheduled volunteers and interns must attend a General Orientation program within thirty (30) days of hire/placement, except for direct service providers and direct service interns/volunteers. All direct service staff must complete all required orientation prior to contact with individuals receiving services and/or service delivery. Volunteers (not regularly scheduled) that have not attended orientation should never be alone with individuals receiving services unsupervised by program staff. Specific requirements are provided for General Orientation, an ongoing staff training program to be provided within ninety (90) days of hire and consist of a minimum of twenty (20) hours of training for nonmedical personnel, a position-specific annual continuing education. Among other things, crisis intervention and prevention must be addressed.

*Mental Health (MH):* Crisis Stabilization Services must have a full-time (forty (40) hours per week) on-site director. Crisis Stabilization Services must have a full-time (forty (40) hours per week) on-site mental health therapist. Crisis Stabilization Services must maintain at least a one (1) direct service staff to four (4) residents ratio twenty-four (24) hours per day, seven (7) days per week. A Registered Nurse must be on-site during all shifts and may be counted in the required staffing ratio. All Crisis Stabilization Services staff must successfully complete training and hold certification in a nationally recognized or DMH-Approved Program for managing aggressive or risk-to-self behavior.

*Substance Use Disorder (SUD):*

- Primary Residential Services must ensure access to each of the following professionals either through program staff or affiliation agreement/contract: (1) A licensed psychiatrist or psychologist with experience in the treatment of SUD; or (2) A licensed physician with experience in the treatment of SUD.
- Staffing for Primary Residential Services and Transitional Residential Services must be sufficient to meet service requirements. Male and female (as appropriate) staff must be on-site and available twenty-four (24) hours per day, seven (7) days per week. Caseloads for residential services must have no more than twelve (12) adults assigned to a single therapist or counselor.
- WM at Level 3.2-WM do not require onsite medical and nursing personnel. Staff supervising self-administered medications must be appropriately licensed or credentialed by the State of Mississippi.
- WM at Level 3.7-WM require medical and nursing personnel and must include: (1) A physician or appropriately licensed staff performing the duties as a physician under a collaborative agreement or other requirements of the medical practice act. (2) A physician or licensed designee available twenty-four (24) hours a day by telephone and who is available for assessment within 24 hours of admission, earlier if medically necessary. (3) A registered nurse or other licensed and credentialed nurse available to conduct a nursing assessment on admission. (4) An interdisciplinary team of appropriately trained staff available to assess and treat the individual.

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* Written policies and procedures must, among other things, define criteria for admission or readmission to service(s) and describe the process for when admission or readmission to service(s) offered by the provider is not appropriate for the individual, including referral to other agencies and follow-up, as appropriate.

Adults with a serious mental illness (SMI) must be seen in person or by telemedicine and evaluated by a licensed physician, licensed psychologist, psychiatric/mental health nurse practitioner, physician assistant, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), or Licensed Certified (clinical) Social Worker (LCSW) to certify that the services planned are medically/therapeutically necessary for the treatment of the individual. This must be recertified annually.

For all individuals receiving MH and/or SUD services, initial and subsequent face-to-face biopsychosocial assessment are required and must be completed by specified credentialed professionals. Individuals with SMI, including: (1) Individuals discharged from an inpatient psychiatric facility. (2) Individuals discharged from an institution. (3) Individuals discharged or transferred from Crisis Stabilization Services. (4) Individuals referred from Crisis Response Services, must receive an Initial Assessment within fourteen (14) days of the date that services are sought and/or the date the referral is made.

For individuals receiving SUD services, a DMH approved functional assessment must be conducted within timelines according to the service(s) received. For Alcohol and Other Drug Disorders Services, all individuals receiving SUD treatment services must receive the TB and HIV/AIDS Risk Assessment at the time of the Intake/Initial Assessment with certain exceptions.

*Mental Health (MH):* Crisis Stabilization Services must provide the following within twenty-four (24) hours of admission to determine the need for those services and to rule out the presence of mental symptoms that are judged to be the direct physiological consequence of a general medical condition and/or illicit substance/medication use: (1) Initial assessment; (2) Medical screening; (3) Drug toxicology screening; and (4) Psychiatric consultation.

*Substance Use Disorder (SUD):*

For all SUD treatment facilities, providers must provide and document that all individuals receiving SUD treatment receive a risk assessment for HIV at the time of intake. For individuals determined to be high risk by the HIV assessment, testing options are determined by level of care and must be provided as required for specific residential settings.

All Primary and Transitional Residential providers must document that all individuals received a risk assessment for Tuberculosis (TB) at the time of intake. Any individual determined to be at high risk cannot be admitted into a treatment program until testing confirms the individual does not have TB.

Transitional Residential Services: An individual must have successfully completed a primary residential SUD treatment program in order to be eligible for admission to Transitional Residential Services. The primary SUD residential treatment program must be at least four (4) weeks long.

All WM programs must utilize the results of a medical screening instrument(s) identifying the need for Withdrawal Management Services. The screening assessments should be conducted as often as the individual case warrants. All WM programs must have written policies regarding criteria for admission.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Facilities must have an individual plan that directs the treatment and support of the individual receiving services. The individual plan should be designed to increase or support independence and community participation. The individual plan may be referred to as the Treatment Plan, Plan of Services and Supports, Individual Service Plan, Wraparound Plan or Person-Centered Plan. The name of the plan is dependent upon the population being served and the process utilized to develop the plan. The plan must be based on the strengths, challenges, desired outcomes, and activities to support outcomes of the individual receiving services and his/her family/legal representative (if applicable). Outcomes should be identified by the individual, family/legal representative (if applicable), and treatment/support team. Providers must utilize planning approaches that are considered to be best practices or evidence-based by their respective areas of focus. Planning approaches must be documented and implemented through the development of policies and procedures specific to this process and the population being served. Planning approaches must address the following, among other things: (1) The development of an individualized treatment/support team that includes the individual, service providers and other supports (as appropriate) that may be identified and utilized by the individual or team members; (2) A focus on recovery/resiliency and/or person centeredness, depending on the population; (3) A focus on individual strengths and how to build upon strengths to achieve positive outcomes; and, (4) Proactive crisis planning, depending on the individual receiving services.

*Mental Health (MH):* Crisis Stabilization Services must complete a trauma history questionnaire within 48 hours of admission. Results of trauma history questionnaire should be incorporated into ISP and subsequent services. Prior to discharge from Crisis Stabilization Services, an appointment must be made for the individual to begin or continue services from the local Community Mental Health Center or other mental health provider.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Activities must be designed to address objectives/outcomes in the individual plan directing treatment/support for the person. Programs must be designed to provide a Person-Centered Recovery Oriented system of services with a framework of supports that are self-directed, individualized, culturally responsive, trauma informed, and that provide for community participation opportunities. Services should be measurable and individualized. Services and programs must be designed to promote and



allow independent decision making by the individual and encourage independent living, without compromising the health and safety of the individuals being served. Providers must present information in a manner understandable to the individual so that he/she can make informed choices regarding service delivery and design, available providers and activities which comprise a meaningful day for him/her. Programs must provide each individual with activities and experiences to develop the skills they need to support a successful transition to a more integrated setting, level of service, or level of care. The services provided as specified in the individual plan must be based on the requirements of the individual rather than on the availability of services/staff. All efforts must be implemented to design a service environment that is safe and conducive to positive learning and life experiences. Persons served in the program whose behaviors are significantly disruptive to others in the same environment must be afforded the opportunity and assistance to change those behaviors through a systematic support plan. Persons receiving services may not be discharged from a service or program due to disruptive behaviors unless they pose a risk for harm to other people receiving the service. Efforts to keep an individual enrolled in the service or program must be included in the plan and documented in the record.

*Mental Health (MH):* Crisis Stabilization Services content may vary based on each individual's needs but must include close observation/supervision and intensive support with a focus on the reduction/elimination of acute symptoms. Crisis Stabilization Services must consist of: (1) Evaluation; (2) Observation; (3) Supportive counseling; (4) Substance abuse counseling; (5) Individual, Group and Family Therapy; (6) Targeted Case Management and/or Community Support Services; (7) Family Education; (8) Therapeutic Activities (i.e., recreational, psycho-educational, social/interpersonal). Direct services (i.e., Supportive counseling, therapy, recreational, psycho-education, social/interpersonal activities) can be provided seven (7) days per week but must at a minimum be: (1) Provided five (5) days per week; and (2) Provided five (5) hours per day. Crisis Stabilization Services must also provide adequate nursing and psychiatric services to all individuals served. At a minimum, these services must be provided every seven (7) days (or more often if clinically indicated).

*Substance Use Disorder (SUD):* All SUD treatment facilities must have policies and procedures related to acceptance and accommodation of individuals entering treatment services utilizing medication assisted treatment (MAT). Specific requirements regarding HIV, Hepatitis, STDs, and TB counseling and education are included.

- All WM programs must have protocols for referral to acute care facilities and all SUD residential facilities must have a current contract on file with a Medically Managed Intensive Inpatient Withdrawal Management Provider. For all SUD residential facilities that serve pregnant females, the contract with the Medically Managed Intensive Inpatient Withdrawal Management Provider, must state that women will not be detoxed during pregnancy without consideration by a physician or nurse practitioner of the impact it would have on the mother or her fetus. All Residential Programs are responsible for ensuring that pregnant women are evaluated immediately by a physician, hospital, or medical clinic when symptoms of intoxication, impairment, or withdrawal are evident. All

Residential Programs must provide transportation for pregnant women that are referred to a physician, hospital, medical clinic or other appropriate Residential Facility.

Withdrawal management services for pregnant/prenatal women will take into account up-to-date medical research.

- WM programs providing Level 3.2-WM: Clinically Managed Residential Withdrawal Management Services must contain the following: Staff must: (a) Observe and supervise the individual; (b) Determine the individual's appropriate level of care; (c) Facilitate the individual's transition to continuing care. There must be 24 hour a day medical evaluation and consultation. The WM must have a written agreement or contract with a local hospital able to provide Medically Managed Withdrawal Management Services as defined by ASAM.
- WM programs providing Level 3.7-WM: Medically Monitored Inpatient Withdrawal Management Services must include: (1) Assessment by a physician or licensed designee within 24 hours of admission or earlier if medically necessary. (2) A registered nurse or other licensed and credentialed nurse is available to conduct a nursing assessment on admission. (3) Documentation of hourly observation of the individual receiving services during the first twenty-four (24) hours of the withdrawal management. (4) Programs providing this service must have a written plan describing the handling of medical emergencies which includes the roles of staff members and physicians.
- Transitional Residential Services: Program components include at a minimum: (1) At least one (1) hour of individual therapy per week with each individual. (2) A minimum attendance of at least two (2) hours of group therapy per week. Group therapy must be offered at times that accommodate the schedules of the individuals. (3) Family therapy must be offered and available as needed. Documentation of attendance or refusal is required. (4) Psychoeducational groups individualized to the residents. Topics to be address may include, but are not limited to, vocation, education, employment, recovery, or related skills. (5) Therapeutic and leisure/recreational/physical exercise activities (with physician's approval). A written master schedule of activities that documents the provision of the following services: (1) Group therapy; (2) Psychoeducational groups; and (3) Therapeutic and leisure/recreational/physical exercise activities. Employment for individuals in Transitional Residential Services must be community based and not as part of the onsite program.
- Primary Residential Services: Individuals admitted into Primary Residential Services must receive a medical assessment within forty-eight (48) hours of admission to screen for health risks. The program components include at a minimum: (1) At least one (1) hour of individual therapy per week with each individual. (2) A minimum attendance of at least five (5) hours of group therapy per week with each individual. (3) Family therapy must be offered and available at least twice (2) during the course of treatment. Documentation of attendance or refusal by the individual or family is required. (4) At least twenty (20) hours of psychoeducational groups individualized to the residents. Topics to be address may include, but are not limited to, substance use disorders, self-help/personal growth,

increasing self-esteem, wellness education, social skills, anger management, the recovery process, and a philosophy of living which will support recovery. (5) At least three (3) hours of family-oriented education activities during the course of treatment. (6) Therapeutic and leisure/recreational/physical exercise activities (with physician's approval). (7) Vocational counseling and planning/referral for follow-up vocational services. A written master schedule that documents the provision of the following services: (1) Group therapy; (2) Psychoeducational groups; (3) Family-oriented education; (4) Therapeutic and leisure/recreational/physical exercise activities; and (5) Vocational counseling and planning/referral.

## **Patient Rights and Safety Standards**

*Mental Health (MH) and Substance Use Disorder (SUD):* There must be written policies and procedures for implementation of a process through which individuals' grievances can be reported and addressed at the local program/center level. Providers are prohibited from the use of mechanical restraints, unless being used for adaptive support. Providers are prohibited from the use of seclusion except for certified Crisis Stabilization Services. Providers are prohibited from the use of chemical restraints. Providers must ensure that all direct service staff who utilize physical restraint/escort has successfully completed training and hold nationally recognized certification or DMH-approved training for managing aggressive or risk-to-self behavior (which includes verbal and physical de-escalation). Providers utilizing physical restraint(s)/escort must establish, implement, and comply with written policies and procedures specifying appropriate use of physical restraint/escort. Programs utilizing time-out must have written policies and procedures that govern the use of time-out and documentation of implementation of such procedures in case records of individuals receiving services. Serious incidents must be reported to the DMH within 24 hours, including but not limited to use of seclusion or restraint that was not part of an individual's treatment Behavior Management Plan or that was planned but not implemented properly, or resulted in discomfort or injury for the individual, as well as abuse or neglect. Certain other serious incidents must be reported to DMH within 8 hours. The governing authority or a committee designated by the governing authority must review all serious incidents and conduct a written analysis of all serious incidents at least quarterly. Written analysis must be made available to DMH for review upon request. Among other things, patients have a right of confidentiality, privacy, communication, to be free of abuse or harassment, to respectful treatment, and to have language assistance services as needed.

*Mental Health (MH):* The DMH only allows seclusion to be used in Crisis Stabilization Services with individuals over the age of 18 and imposes requirements on the practice related to emergency use, room size, the need for written policies and procedures, and other matters. DMH states, "Providers are prohibited from the use of chemical restraints." However, a therapeutic agent may be used to treat behavioral symptoms during a crisis in certain circumstances. Patients have a right to privacy.

*Substance Use Disorder (SUD):* Primary Residential Services and Transitional Residential Services residents must receive a handbook during orientation that covers specific subjects, including but not limited to rules and rights.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* Providers must have quality management strategies that at a minimum: (1) Allow for collection of performance measures as required by DMH. (2) Develop and implement policies and procedures for the oversight of collection and reporting of DMH-required performance measures, analysis of serious incidents, periodic analysis of DMH required client level data collection, review of agency wide Recovery and Resiliency Activities and oversight for the development and implementation of DMH required plans of compliance. (3) Collect demographic data to monitor and evaluate cultural competency and the need for Limited English Proficiency services.

*Mental Health (MH):* Crisis Stabilization Service providers must conduct an assessment, at least annually, of: (1) The level of observation that is required for all individuals receiving services. Policy and procedures should allow for assessment upon admission and at regular intervals during treatment. If the assessment or clinical judgement indicates a greater frequency of observation is necessary, policies and procedures should reflect those practices. Policy and procedures should identify who is responsible for conducting assessment(s). (2) Review of the physical environment of care to assess for potential risks and /or access to lethal means. Mitigation efforts must be put into place when risks are identified.

## **Governance**

*Mental Health (MH) and Substance Use Disorder (SUD):* All facilities must have a governing authority which, among other things, is responsible for operational standards, an annual operational plan, and policies and procedures. The provider has specific fiscal responsibility requirements that must be satisfied.

## **Special Populations**

*Mental Health (MH):* Requirements not located.

*Substance Use Disorder (SUD):* The regulations include specific access requirements for pregnant women and IV drug users. They also include specific service provisions for pregnant women.

## Location of Regulatory and Licensing Requirements

Department of Mental Health Operational Standards For Mental Health, Intellectual/Developmental Disabilities, and Substance Use Disorders Community Service Providers<sup>1</sup>; Department of Mental Health Record Guide For Mental Health, Intellectual and Developmental Disabilities, and Substance Use Disorders Community Providers<sup>2</sup>. Regulatory requirements reviewed June 17, 2019.

## Other Information Sources

M. Lewis (MS DMH); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>1</sup> See <http://www.dmh.ms.gov/wp-content/uploads/2016/08/Final-Master-2016-Operational-Standards-for-Distribution-6-17-16.pdf>.

<sup>2</sup> See <http://www.dmh.ms.gov/wp-content/uploads/2016/08/Final-PDF-2016-Record-Guide-for-Distribution.pdf>.

# MISSISSIPPI MEDICAID

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## Approach

The Mississippi Division of Medicaid oversees the state Medicaid program. Mississippi does not have a relevant Section 1115 waiver that affects reimbursement of residential services in Institutions for Mental Diseases (IMDs). It historically has not relied on Disproportionate Share Hospital (DSH) payments and, prior to FY2020, had not relied on the in lieu of provision to reimburse services in IMDs.

## Types of Facilities

*Mental Health (MH):* Mississippi Medicaid provides reimbursement for Crisis Residential programs for adults with a serious and persistent mental illness. Crisis residential services are designed to prevent inpatient hospitalization, address acute symptoms, distress, and further decomposition, and also help transition from hospitalization to community based services. Services must be provided at a facility licensed to service no more than sixteen (16) individuals at a time. Medicaid reimbursement for crisis residential does not include room and board costs and is limited to sixty (60) days per state fiscal year. Crisis residential must be prior authorized by the Division of Medicaid or its designee.

*Substance Use Disorder (SUD):* No evidence of Medicaid coverage of SUD residential treatment facilities for adults was located.

## Processes of Medicaid Enrollment

*Mental Health (MH):* All providers enrolled as community mental health providers must be certified for the provision of the mental health services they provide by the DMH on the date of service. Certified providers, including those providing crisis services, are subject to the DMH standards for the provision of services.

*Substance Use Disorder (SUD):* State Medicaid regulations do not specify requirements related to enrollment of residential SUD behavioral health treatment.

## **Staffing**

*Mental Health (MH):* Staff providing mental health services must meet minimum qualifications as established by the Division of Medicaid. A staff member must hold at a minimum, a bachelor's degree in a mental health field, in order to provide services billed to Medicaid unless specifically stated in a rule defining a service. Bachelor's level staff shall not provide therapy services. All services billed to Medicaid must be approved by a licensed independent practitioner in accordance with the appropriate scope of practice. These practitioners are limited to: a Mississippi licensed Physician who holds a specialty in psychiatry, a Mississippi licensed physician with minimum of five (5) years' experience in mental health, a Mississippi licensed Psychologist, a Mississippi Licensed Certified Social Worker (LCSW), a Mississippi Licensed Professional Counselor (LPC), a Mississippi Licensed Marriage and Family Therapist (LMFT), a Psychiatric Mental Health Nurse Practitioner under an approved protocol, or a Physician Assistant.

- For crisis residential programs, a psychiatrist, psychiatric mental health nurse practitioner or psychologist must be at the location of the crisis residential program and immediately available if needed.

*Substance Use Disorder (SUD):* No evidence of Medicaid-based staffing requirements for residential SUD treatment facilities for adults was located.

## **Placement**

*Mental Health (MH):* State Medicaid rules require PASRR evaluation to ensure the appropriate placement of persons with mental illnesses. Crisis residential services are provided to beneficiaries who are experiencing a period of such acute distress that their ability to cope with normal life circumstances is severely impaired. Crisis residential must be ordered by a psychiatrist, psychiatric mental health nurse practitioner or licensed psychologist.

*Substance Use Disorder (SUD):* No evidence of Medicaid-based placement requirements for residential SUD treatment facilities for adults was located.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* All services billed to Medicaid must be included in a treatment plan. A treatment plan may be referred to as the plan of care, individualized service plan, wraparound plan or person-centered plan depending on the service. It is the plan that directs the treatment of the Medicaid beneficiary.

## **Treatment Services**

*Mental Health (MH):* Crisis residential programs provide medical supervision, nursing services, structured therapeutic activities, and intensive psychotherapy (individual, family and/or group) at a facility based site. Program content may vary based on beneficiary need but must include close observation/supervision and intensive support with the focus on reduction/elimination of acute symptoms.

*Substance Use Disorder (SUD):* No evidence of Medicaid-based treatment service requirements for residential SUD treatment facilities for adults was located.

## **Care Coordination**

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based care coordination requirements for residential treatment facilities for adults was located.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based quality assurance or improvement requirements for residential treatment facilities for adults was located.

## **Special Populations**

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based special population requirements for residential treatment facilities for adults was located.

## **Location of Medicaid Requirements**

Mississippi Medicaid Rules and Regulations<sup>3</sup>; Department of Mental Health Operational Standards For Mental Health, Intellectual/Developmental Disabilities, and Substance Use Disorders Community Service Providers<sup>4</sup>; Department of Mental Health Record Guide For Mental Health, Intellectual and Developmental Disabilities, and Substance Use Disorders Community Providers<sup>5</sup>. Regulatory data collected December 2019.

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<sup>3</sup> See <https://medicaid.ms.gov/providers/administrative-code/>.

<sup>4</sup> See <http://www.dmh.ms.gov/wp-content/uploads/2016/08/Final-Master-2016-Operational-Standards-for-Distribution-6-17-16.pdf>.

<sup>5</sup> See <http://www.dmh.ms.gov/wp-content/uploads/2016/08/Final-PDF-2016-Record-Guide-for-Distribution.pdf>.



## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report **“State Residential Treatment for Behavioral Health Conditions: Regulation and Policy”**. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

## MISSOURI

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

### Types of Facilities

*Mental Health (MH):* Missouri regulates:

- Community residential facilities, which are any premises where residential prevention, evaluation, care, treatment or habilitation are provided for persons affected by, among other things, mental illness or mental disorders, except for a person's dwelling.
- Psychiatric group homes, which are community residential facilities with less than 16 residents providing 24-hour accommodations, psychiatric supervision, board, storage and distribution of medications, protective oversight and psychosocial rehabilitation for residents who can benefit from an intense, highly structured treatment setting.

*Substance Use Disorder (SUD):* Missouri regulates:

- Residential treatment, which offers an intensive set of services in a structured alcohol- and drug-free setting.
- Comprehensive substance treatment and rehabilitation (CSTAR) programs, which are specifically for Medicaid beneficiaries but cannot summarily discharge a client if their Medicaid eligibility is lost. In addition to outpatient treatment, CSTAR programs may offer residential treatment. CSTAR programs are limited to 16 beds.
- Specialized programs for women and children, provide treatment, rehabilitation, and other supports solely to women and their children. Services may be residential or outpatient.
- Detoxification programs in a residential setting:
  - Social setting: This level of care is offered by trained staff in a residential setting with services and admission available twenty-four (24) hours per day, seven (7) days per week: (1) Medical personnel are not available on-site to prescribe, dispense or administer medications or to diagnose and treat health problems. (2) A person, who is admitted to social setting detoxification with medication for an established physical or mental health condition, may continue to self-administer his or her medication.

- Medically Monitored: This level of care is offered by medical staff in a non-hospital setting with services and admission available twenty-four (24) hours per day, seven (7) days per week.

*Unregulated Facilities:* All residential MH and SUD treatment in Missouri is regulated. We exclude community psychiatric rehabilitation programs, because they provide only outpatient services, and group homes and residential centers (other than psychiatric group homes), because they do not include the level of clinical services in the scope of this summary.

## **Approach**

The Missouri Department of Mental Health (DMH), Division of Behavioral Health regulates all MH and SUD residential treatment programs. Some residential facilities also are dually regulated and licensed by the Department of Health and Senior Services (DHSS).

## **Processes of Licensure or Certification and Accreditation**

*Mental Health (MH) and Substance Use Disorder (SUD):* The DMH requires certification of all residential treatment programs, regardless of operator or funding.

- Accreditation is not required but accreditation by CARF International, The Joint Commission, Council on Accreditation, or another entity recognized by the DMH confers deemed status, allowing the applicant for certification to submit a different application and forego a survey, other than to clarify aspects of the accreditation.
- A survey is required for initial certification and renewal of certification.
- The state does require a Certificate of Need for residential facilities that are dually licensed by the DHSS and serve individuals with mental illness. A Certificate of Need is not required for SUD treatment programs in Missouri.
- Certification duration varies. Temporary certification is as needed if the survey process is not complete; conditional or provisional certification is for no more than a 6 month period; full certification may be for one to three years.

*Mental Health (MH):* Licensure by the DMH is required for all adult MH residential treatment facilities.

- Accreditation is not required.
- A survey is required for licensure and renewal.

- Licensure duration is one year.

*Substance Use Disorder (SUD):* Although already required for all adult residential MH or SUD treatment programs, adult residential SUD treatment facilities that receive funding from the DMH specifically require DMH certification and specialized programs for women and children must be certified as a CSTAR program.

## **Cause-Based Monitoring**

*Mental Health (MH) and Substance Use Disorder (SUD):* The DMH may issue a notice of noncompliance, require a plan of correction, deny, or revoke a program's certification. Additional surveys may occur at any time to monitor ongoing compliance with applicable standards of care.

*Mental Health (MH):* Upon identification of deficiencies, a plan of correction must be submitted and implemented, with subsequent resurvey. Reinspections may occur throughout the year. Licenses may be denied or revoked.

*Substance Use Disorder (SUD):* Services funded by the DMH are subject to clinical review to ensure they are necessary, appropriate, likely to benefit the individual, and provided in accordance with admission criteria and service definitions.

## **Access Requirements**

*Mental Health (MH) and Substance Use Disorder (SUD):* Missouri regulations include Essential Principles that are intended to guide the reader. Among the Essential Principles of treatment is Easy and Timely Access to Services. This means that services are easy to find, affordable, and readily available to individuals in the community. Guidance on wait times is included.

*Mental Health (MH):* Facilities that are dually licensed by the DHSS (DHSS) that serve people who are mentally ill must have policies in place providing that: (1) residents are not excluded on the basis of disability, religion or ethnic origin; and (2) only residents are admitted whose needs can be met directly by the facility or program or indirectly in cooperation with community resources and supports. No wait times were found.

*Substance Use Disorder (SUD):* In specialized programs for women and children, priority must be given to women who are pregnant and inject drugs, pregnant, postpartum, or have children in their physical care and custody, including those at risk of losing custody or attempting to regain custody of their children. The program must engage in all activities necessary to ensure the actual admission of and services to those women who meet priority criteria.

## Staffing

*Mental Health (MH) and Substance Use Disorder (SUD):* A qualified and competent workforce is among the Essential Principles of Treatment. Regulations require that the organization maintain personnel policies, procedures, and practices in accordance with local, state and federal laws and regulations. The organization must ensure staff possess the training, experience, and credentials to effectively perform their assigned services and duties. All individuals holding a position within the organization must complete orientation and training within the first 30 days of employment in order to be knowledgeable in core competency areas. Clinical supervision of direct service staff must be provided on an ongoing basis to ensure adequate supervisory oversight and guidance. Training and continuing education opportunities must be available to all direct service staff in accordance with their job duties and any licensing or credentialing requirements. Minimum hours of training are established for all staff who provide services or are responsible for the supervision of persons served, including on meeting the needs of persons with co-occurring and trauma-related disorders. When services and supervision are provided 24 hours per day, the organization maintains staff on duty, awake, and fully dressed at all times. Requirements are in place for volunteers, interns, and other staff.

*Mental Health (MH):* Psychiatric Group Homes must have a chief administrative officer and adequate staff to meet the treatment needs of the residents. Other staffing patterns are specified as well. Other requirements relate to qualifications of staff, including mental health professionals, nursing staff, and direct care staff. Access to a board-eligible or certified psychiatrist is required.

*Substance Use Disorder (SUD):* For all SUD residential treatment, a majority of the staff who provide individual and group counseling must be qualified addiction professionals. Requirements regarding clinical supervision and credentials of supervisors are specified.

- For residential services generally, staff coverage must ensure the continuous supervision and safety of clients and staffing levels are regulated. Clients must be supervised by a staff member with current certification in first aid and cardiopulmonary resuscitation.
- In specialized programs for women and children, staffing requirements are established for childcare. Service delivery staff and program administration must demonstrate expertise in addressing the needs of women and children, and service delivery staff must receive periodic training regarding therapeutic issues relevant to women and children. Other requirements relate to the qualifications of a licensed nurse, and there must be at least one staff member with current training in first aid and cardiopulmonary resuscitation for infants, children and adults. The program must have effective working relationship(s) with

a physician, hospital, and/or clinic to provide medical care for women, including pregnant and postpartum women, and their children.

- For detoxification services, staff coverage must ensure the continuous supervision and safety of clients. Requirements regarding staffing levels, competency, and safety are in place. For medically monitored withdrawal, availability of routine medical services, medications, qualified nursing staff, and other medical providers are established.

When services are funded by the DMH, additional staffing requirements are in place.

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* The organization must implement written policies and procedures to ensure individuals seeking assistance via telephone, face-to-face contact, or by referral have prompt access to a screening to determine the need for further clinical assessment. The organization's quality assurance processes must ensure trained staff uniformly administer designated screening instrument(s).

*Mental Health (MH):* Each program must have written policies and procedures regarding admission, discharge, and transfer.

- Facilities dually licensed by the DHSS must ensure that, either prior to admission or within 30 days of admission and annually thereafter, each individual has verification in his/her record of a health screening and risk assessment within the past year from their primary healthcare provider. The facility must follow its written policies and procedures for the admission of residents, which must describe how its program is designed to meet the needs of the residents it admits. The facility may not admit, nor keep in residence, any person whose special needs exceed the facility's provisions for medical care or for adequate programming as described in the resident's individualized habilitation or treatment plan.
- Facilities that are not dually licensed by the DHSS must follow their written policies and procedures for the admission of residents, which must describe how the program is designed to meet the needs of the residents it admits. If a facility admits a resident whose special needs exceed the facility's ability to provide for adequate medical care or programming as described in the individual habilitation or treatment plan, the facility shall arrange for the provision of the necessary support services.

*Substance Use Disorder (SUD):* Eligibility determination requires confirmation of an eligible diagnosis by a licensed diagnostician in accordance with the DSM-5. A face-to-face diagnostic interview must be conducted as part of the assessment by a professional who meets specified requirements. The comprehensive assessment must be completed within 7 calendar days of

date of eligibility determination for individuals admitted to residential treatment and must be completed by staff qualified to do so. Services are subject to clinical utilization review when funded by the department.

- For residential services, a person must meet the admission and eligibility criteria: (A) Does not demonstrate symptoms of intoxication, impairment or withdrawal that would hinder or prohibit full participation in treatment services. (B) Needs an alternative, supervised living environment to ensure safety and protection from harm. (C) Meets the general treatment eligibility requirement of a current diagnosis of a substance use disorder and, in addition, demonstrates one or more of the following: (1) Recent patterns of extensive or severe substance abuse; (2) Inability to establish a period of not using drugs or alcohol without continuous supervision and structure; (3) Presence of significant resistance or denial of an identified substance use disorder; or (4) Limited recovery skills and/or support system. (D) A client may qualify for transfer from outpatient to residential treatment if the person: (1) Has been unable to establish a period of not using drugs or alcohol despite active participation in intensive outpatient services; or (2) Presents imminent risk of serious consequences associated with substance use. Each client's length of stay in residential treatment shall be individualized, based on the person's needs and progress in achieving treatment goals.
- For CSTAR programs, if there is a change in the Medicaid eligibility or financial status of a person served, the individual may not be prematurely discharged from the CSTAR program or otherwise denied CSTAR services.
- For detoxification programs, upon initial contact, a person shall be screened by a trained staff member and admitted to appropriate services based on the signs and symptoms of intoxication, impairment or withdrawal, as well as factors related to health and safety. A screening protocol approved by a physician shall be used to evaluate the person's physical and mental condition and to guide service delivery decisions. The department may require the use of a standardized screening protocol for services funded by the department. To be eligible for detoxification services, a person must present symptoms of intoxication, impairment or withdrawal and also must require supervision and monitoring of their physical and mental status to ensure safety. Additional requirements are in place for use of residential detoxification services. A person may be successfully discharged or transferred when they are physically and mentally able to function without the supervision, monitoring, and support of this service.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Crisis prevention plans must be developed as required for a given individual. Programs must have policies for developing continuing recovery plans and discharge plans, which begin at admission or as soon as clinically

appropriate. Follow-up with individuals who have unplanned discharges also is required, as are policies guiding such follow-up.

*Mental Health (MH):*

- Facilities that are dually licensed by the DHSS that serve people who are mentally ill must ensure that each resident has an individualized habilitation or treatment plan (IHP/ITP). The plan must be reviewed at least quarterly and updated annually.
- Every resident of a licensed community residential facility not dually licensed by the DHSS that serves people who are mentally ill must have an ITP or IHP. Each resident must have an ITP either prior to admission or within 30 days of admission. The plan must be reviewed at least quarterly and updated annually. The person responsible for implementation of individual objectives of the ITP or IHP must collect data on their implementation and prepare a monthly summary.

*Substance Use Disorder (SUD):* Programs must complete an initial treatment plan within 45 calendar days of the date of eligibility determination. The treatment plan must be signed by a licensed diagnostician. A functional assessment approved by DMH must be completed with each individual upon admission as part of the initial comprehensive assessment/eligibility determination. The functional assessment must be reviewed every 90 days following admission to assess current level of functioning, progress toward treatment goals and objectives, and appropriateness of continued services. The functional assessment must also be completed at discharge.

- A comprehensive assessment and master treatment plan are not required during detoxification. The program should actively encourage each person to make arrangements for continuing treatment and the program must document arrangements for continuing treatment. Staff must assist in making referrals and other arrangements, as needed.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* The organization must incorporate evidence-based and promising practices into its service array that are designed to accomplish specific goals. Services must be developmentally appropriate and responsive to the individual's social/cultural situation and any linguistic/communication needs. Coordination of care is demonstrated when services and supports are being provided by multiple agencies or programs. Ready access to crisis assistance and intervention must be available to all individuals served, when needed. The organization must provide or arrange for crisis assistance to be available at all times. Services must be provided by qualified staff in accordance with applicable program rules and include face-to-face intervention when clinically indicated.



*Mental Health (MH):* Residents of facilities that are dually licensed by the DHSS must have an individual treatment plan to guide service delivery and coordinate resources and supports in accordance with the individual's needs, expressed preferences, and decisions concerning his/her life in the community. Residential services and supports consistent with the individual's needs and goals must be addressed. Individuals shall be supported in their efforts to obtain and maintain competitive employment of their choice, participate in job-training programs, educational opportunities, self-help skills, leisure time activities, and other programs of their choice.

*Substance Use Disorder (SUD):* Programs must make individual counseling (including trauma and co-occurring disorders), group counseling (including trauma and co-occurring disorders), group rehabilitative support, medication services, community support/case management, and family therapy available to each person participating in SUD treatment and rehabilitation in accordance with the individual's clinical needs. Specific requirements are established for services to families. If a program is not certified as a specialized program for women and children, it must meet the specific requirements to offer services to women.

Each person must actively participate in the program schedule, with individualized scheduling and services based on the person's treatment goals, level of care, and physical, mental, and emotional status. Services must be provided in a therapeutic, alcohol and drug free setting. Productive, meaningful, age-appropriate alternatives to substance use are encouraged. Services must be designed and organized to promote peer support and to orient clients and family members to self-help groups and other community resources and supports.

Requirements related to individual counseling are identified and use of evidence-based interventions such as motivational interviewing, cognitive behavioral therapy, and trauma-informed care and mentioned. Requirements related to family therapy also are included in the regulations, including but not limited to a requirement that the usual and customary size of group counseling sessions not exceed twelve (12) clients.

- Residential services must be organized and directed toward specified primary goals and must be responsive to the needs of persons served. There must be a minimum of 50 hours of structured, therapeutic activity per week. Therapeutic activities must be provided 7 days per week. Group counseling and group rehabilitative support must constitute at 20 of the required hours of therapeutic activity per week. At least one hour of individual counseling per week must be provided to each client.
- Specialized programs for women and children must ensure that treatment occurs in the context of a family systems model. Each program will provide therapeutic activities designed for the benefit of children. The program must address therapeutic issues relevant to women. Therapeutic issues relevant to women must include, but are not limited to, parenting, relationship issues, self-esteem/self-identification, domestic violence, sexuality, health, and spirituality. Residential treatment must include planned,

supervised activities to promote parent-child bonding. The regulations include requirements for child supervision, childcare, education, and therapeutic issues relevant to children. The program must ensure an evaluation of medical need for each woman and child and medical, physical and nutritional needs must be met.

- For detoxification services, there must be monitoring and assessment of the person's physical and emotional status during the detoxification process. Specific requirements exist for medical services, counseling and education, including individual and group sessions. All individuals admitted to detoxification services shall have access to FDA-approved medications for the treatment of addiction and to alleviate symptoms of intoxication, impairment, or withdrawal. Medication services must be provided by a licensed physician, assistant physician, physician assistant, or APRN.

## **Patient Rights and Safety Standards**

*Mental Health (MH) and Substance Use Disorder (SUD):* The organization's policies, procedures, and practices must demonstrate an ongoing commitment to the rights, dignity, and respect of the individuals it serves. Each individual served shall receive an orientation, including regarding complaint processes facilities must establish. Among the basic rights that cannot be limited are to receive services in the least restrictive setting; to receive services without discrimination; confidentiality; dignity; freedom from abuse; and informed consent. Residential clients have additional basic rights, including but not limited to, certain rights of privacy and communication. Certain other rights may be limited, if necessary, for the personal safety of the client or the safety of others provided conditions are met. For those in a residential setting this includes additional privacy and communication rights and to be free from seclusion and restraint, the latter of which must meet specified criteria for emergency safety interventions. All organizations are required to report certain events, including but not limited to abuse and neglect.

*Mental Health (MH):* Community residential facilities that are dually licensed by the DHSS and that serve people who are mentally ill, as well as such facilities not licensed by the DHSS, and Psychiatric Group Homes II, may not use seclusion or aversive stimuli. Physical, mechanical, or chemical restraint may only be used in limited circumstances.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* The organization must develop, implement, and maintain an effective, ongoing, agency-wide and data-driven performance measurement and performance improvement program/process. These activities allow the organization to objectively review how well it is accomplishing its mission and develop and initiate performance improvement changes. Among other requirements for this program is that

performance measurement and performance improvement encompass the organization's full array of clinical services and focuses on indicators related to improved behavioral health or other healthcare outcomes for individuals served.

The organization must develop and implement an annual performance improvement plan. The plan is updated on an ongoing basis to reflect changes, corrections, and other modifications and reviewed annually with the organization's governing body. Detailed requirements for the performance improvement plan are included in the regulations.

Performance measurement is a process by which an organization monitors important aspects of its programs, systems, and care processes. Qualitative and quantitative data is collected, systematically aggregated, and analyzed on an ongoing basis to assist organizational leadership in evaluating whether the adequate structure and correct processes are in place to achieve the organization's desired results. Specific requirements are included in the regulations regarding aspects of this. Results of the performance analysis are available to individuals served, family members/natural supports, other stakeholders, and the DMH.

The organization must maintain documentation of its performance measurement and performance improvement program and be able to demonstrate its operation to staff of the DMH, accrediting body, or other interested parties.

## **Governance**

*Mental Health (MH) and Substance Use Disorder (SUD):* Organizations are required to have a governing body with legal authority and responsibility over its policies and operations. The governing authority ensures the organization complies with all applicable federal, state, local, and municipal laws and regulations. The chief executive officer is responsible to the governing body for the overall day-to-day operations of the organization. Members of the governing body must represent the demographics of the population served. Individuals living with mental illness and/or a SUD and family members/natural supports, and parents/legal guardians of children, adolescents, and adults receiving services must have meaningful input to the governing body.

## **Special Populations**

*Mental Health (MH) and Substance Use Disorder (SUD):* The DMH Core Rules for Psychiatric and Substance Use Disorder Treatment Programs include essential principles for providing services for individuals with co-occurring disorders and individuals affected by past and current traumatic experiences.

*Mental Health (MH)*: See requirements throughout related to facilities that are dually licensed by the DHSS that serve older people who are mentally ill.

*Substance Use Disorder (SUD)*: See requirements throughout related to specialized services for women and children.

## **Location of Regulatory and Licensing Requirements**

Department of Mental Health Title 9<sup>1</sup>. Regulatory requirements reviewed September 30, 2019.

## **Other Information Sources**

D. McBaine (DBH); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>1</sup> See <https://www.sos.mo.gov/adrules/csr/current/9csr/9csr>.

# MISSOURI MEDICAID

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## Approach

The Missouri Department of Social Services (DSS) MO HealthNet Division oversees the state Medicaid program. Missouri does not have a relevant section 1115 waiver that affects reimbursement of residential services in Institutions for Mental Diseases (IMDs). It historically has relied to some extent on the in lieu of provision and on Disproportionate Share Hospital (DSH) payments to reimburse certain services in IMDs.

## Types of Facilities

*Mental Health (MH):* Psychiatric Residential Treatment Centers may enroll as Medicaid providers. This is a non-IMD facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.

*Substance Use Disorder (SUD):* The following adult residential SUD treatment facility types may enroll as Medicaid providers:

- Residential Substance Abuse Treatment Facilities: A non-IMD facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
  - CSTAR programs are specifically for Medicaid beneficiaries.

## Processes of Medicaid Enrollment

*Mental Health (MH) and Substance Use Disorder (SUD):* To participate in the Missouri Medicaid program, behavioral health care providers must apply for enrollment to the DSS. A provider must meet the qualifications specified by the state agency for their profession or scope of services, including requirements for licensure or certification. With regard to residential treatment programs, this requires certification by the DMH. The DSS may deny, limit, suspend, or terminate enrollment and may apply other sanctions against providers.

## Staffing

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based staffing requirements for residential treatment facilities for adults was located other than the CSTAR requirements addressed earlier in this summary.

## Placement

*Mental Health (MH) and Substance Use Disorder (SUD):* Services provided in residential treatment facilities do not require Medicaid precertification.

*Substance Use Disorder (SUD):* Residential Substance Abuse Treatment Facilities: Residents do not require acute medical care.

## Treatment and Discharge Planning and Aftercare Services

*Mental Health (MH) and Substance Use Disorder (SUD):* Treatment plans are required in the record of any behavioral health service recipient. The state provides an example template online<sup>2</sup>. Providers must update the treatment plan annually for adults. The treatment plan is a working document, and providers should incorporate updates into the plan as needed on an ongoing basis.

## Treatment Services

*Mental Health (MH) and Substance Use Disorder (SUD):* Services must be medically necessary.

*Substance Use Disorder (SUD):* Residential Substance Abuse Treatment Facilities: Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board (must be a non-IMD).

- CSTAR programs may offer residential treatment that must meet the requirements applicable to residential services generally.

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<sup>2</sup> See [https://dss.mo.gov/mhd/cs/psych/doc/trxplan\\_template.pdf](https://dss.mo.gov/mhd/cs/psych/doc/trxplan_template.pdf).

## Care Coordination

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based care coordination requirements for residential treatment facilities for adults was located.

## Quality Assurance or Improvement

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based quality assurance or improvement requirements directly applicable to residential treatment facilities for adults was located other than the CSTAR requirements addressed earlier in this summary.

## Special Populations

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based special population requirements for residential treatment facilities for adults was located other than the CSTAR requirements addressed earlier in this summary.

## Location of Medicaid Requirements

Missouri Medicaid Rules and Regulations<sup>3</sup>; Missouri Behavioral Health Services Manual<sup>4</sup> (incorporated by reference into regulations. Regulatory data collected December 2019.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report “**State Residential Treatment for Behavioral Health Conditions: Regulation and Policy**”. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

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<sup>3</sup> See <https://www.sos.mo.gov/adrules/csr/current/13csr/13csr#13-70>.

<sup>4</sup> See [http://manuals.momed.com/collections/collection\\_psy/print.pdf](http://manuals.momed.com/collections/collection_psy/print.pdf).

## MONTANA

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### Types of Facilities

*Mental Health (MH) and Substance Use Disorder (SUD):* Montana regulates the following two residential facility types:

- *A health care facility* is all or a portion of an institution, building, or agency, private or public, excluding federal facilities, whether organized for profit or not, that is used, operated, or designed to provide health services, medical treatment, or nursing, rehabilitative, or preventive care to any individual. The term does not include offices of private physicians or dentists. The term includes, among others, chemical dependency facilities, mental health centers, residential care facilities, and residential treatment facilities.
- *Residential psychiatric care:* active psychiatric treatment provided in a residential treatment facility to psychiatrically impaired individuals with persistent patterns of emotional, psychological, or behavioral dysfunction of such severity as to require 24-hour supervised care to adequately treat or remedy the individual's condition. Residential psychiatric care must be individualized and designed to achieve the patient's discharge to less restrictive levels of care at the earliest possible time.

*Mental Health (MH):* Montana regulates one type of residential mental health treatment facility:

- *72-Hour Adult Crisis Stabilization services:* medically necessary mental health services delivered in direct response to a crisis, limited in scope and duration, and delivered or contracted for by a crisis stabilization provider. The purposes of these services are to stabilize a crisis, improve diagnostic clarity, find appropriate alternatives to psychiatric hospitalization, treat those symptoms that can be improved within a brief period of time, and arrange appropriate follow-up care or to refer an individual to a provider of the appropriate level of care and treatment.

*Substance Use Disorder (SUD):* Montana regulates one type of residential substance use disorder treatment facility, with some subtypes:



- *Chemical dependency treatment facility*: a facility especially staffed and equipped to provide diagnosis, detoxification, treatment, prevention or rehabilitation services for individuals suffering from chemical dependency. According to Department of Public Health and Human Services (DPHHS) staff, the chemical dependency regulations pertain to public or private treatment agencies.
  - *III.1 Clinically Managed Low-Intensity Residential Treatment*: This functions as a safe, alcohol and drug-free environment for individuals in early stages of recovery from substance use disorders or individuals who are transitioning to less intensive levels of treatment services and in need of such housing.
  - *III.3 Clinically Managed Medium-Intensity Residential Treatment*: also identified as:
    - Halfway house community-based single gender residential homes, these may be located in residential neighborhoods, comparable to other homes in the neighborhood, and shall reflect the environment of a home.
    - Halfway house community-based parent and children residential homes, for individuals with substance use disorders with dependent child(ren) who need 24-hour supportive housing while undergoing on- or off-site treatment services for substance use disorder and life skills training for independent living.
  - *III.5 Clinically Managed High-Intensity Residential Treatment*: identified as halfway house community-based single gender homes which serve individuals who need 24-hour supportive housing while undergoing on- or off-site treatment services for substance use disorder and life skills training for independent living.
  - *III.7 Medically Monitored Inpatient Treatment*: medically monitored care to clients whose withdrawal symptoms are sufficiently severe to require 24-hour inpatient care with observation, monitoring, and treatment available and delivered by a multidisciplinary team including 24-hour nursing care under the supervision of a Montana licensed physician.
  - Community-based social detoxification includes levels III-D, III.2-D, and III.7-D as defined by ASAM.

*Unregulated Facilities*: No unregulated treatment facilities that fall under the purview of this summary were identified. We exclude from this summary Residential Treatment Facilities which pertain to children and adolescents.

## **Approach**

*Mental Health (MH) and Substance Use Disorder (SUD)*: Licensure by the DPHHS is required for operation of all residential treatment facilities.

*Substance Use Disorder (SUD)*: The Department of Public Health and Human Services (DPHHS), Department of Chemical Dependency Programs reviews and approves all chemical dependency treatment providers in the state prior to operation if their facilities are to be enrolled in the Medicaid program, receive block grant funding, receive alcohol earmarked revenue funds, or under certain other circumstances.

## **Processes of Licensure or Certification and Accreditation**

### *Mental Health (MH) and Substance Use Disorder (SUD):*

- Licensure by DPHHS is required for operation of residential treatment facilities. Licensure duration is 1-3 years, depending on type, after which a renewal application is required. An annual inspection is also required for licensure, which shall be unannounced and focus on minimum quality standards for operation.
- Accreditation is not required, but accreditation by DNV Healthcare, Inc., the Healthcare Facilities Accreditation Program, or the Joint Commission confers upon the accredited facility eligibility for licensure.
- The state does not require a certificate of need; however, the statute governing SUD treatment requires a demonstration of need for the facility to obtain licensure.

### *Mental Health (MH):*

- Regulations pertinent to 72-hour crisis stabilization are for Medicaid-enrolled facilities, and individuals meeting the definition of crisis are presumptively eligible for services and reimbursement under the state Medicaid regulations. Crisis stabilization may be performed in different settings but must be licensed.

### *Substance Use Disorder (SUD):*

- DPHHS will issue approval for the following components of chemical dependency treatment services: detoxification (emergency care), inpatient hospital, inpatient free standing, intermediate (transitional living), and outpatient. Programs providing detoxification (non-medical) must also provide at least one of the other components listed above. The certificate of approval shall be obtained annually. Programs must submit an application and submit to inspection. The department will issue an annual certificate of approval to those approved chemical dependency treatment programs which remain in substantial compliance with the regulations.

## **Cause-Based Monitoring**

*Mental Health (MH) and Substance Use Disorder (SUD):* All residential facilities are required, as a condition of licensure, before February 1 of every year, to submit an annual report for the preceding calendar year to the department. Additionally, information and statistical reports which are considered necessary by the department for health planning and resource

development activities must be made available to the public and the health planning agencies within the state. Corrective action may be taken by the department should it believe there is a violation of standards or regulations. In addition to its annual licensure inspections, the department may inspect any facility for compliance with regulations, license requirements, or by order.

*Substance Use Disorder (SUD):* The department reserves the right to periodically inspect licensed facilities. Each approved public or private treatment facility shall, on request, file with the department data, statistics, schedules, and information that the department reasonably requires. Additionally, the program shall develop and conduct program self-evaluations and report results to the governing body. The department may revoke or suspend approval of any service component if a program ceases to provide those services for which it has been approved.

## **Access Requirements**

*Substance Use Disorder (SUD):* The program shall admit and care for only those persons for whom they can provide care and services appropriate to the person's physical, emotional, and social needs. If a chemically dependent person is not admitted to an approved treatment program for the reason that adequate and appropriate treatment is not available at that program or facility, the administrator shall refer that person to another treatment program at which adequate and appropriate treatment is available. Approved chemical dependency treatment programs shall provide services to persons with alcohol and alcohol related problems, or to their families, without regard to source of referral, race, color, creed, national origin, religion, sex, age or handicap. Researchers did not locate requirements related to wait times.

## **Staffing**

*Mental Health (MH):* For crisis stabilization services, all providers must be enrolled in Medicaid or employed/contracted by an enrolled provider. All providers must complete a 72 Hour Provider Enrollment Addendum. Providers are required to hire or subcontract with mental health professionals and mental health direct care staff, ensure the availability of immediate mental health evaluation and crisis stabilization services, ensure staff and subcontractors are trained and skilled in delivery of program services, implement appropriate, culturally competent services, and maintain a thorough knowledge of community resources.

*Substance Use Disorder (SUD):* For chemical dependency treatment programs, there shall be sufficient qualified and certified chemical dependency counselors, clerical and other support staff, to ensure the attainment of program service objectives and properly maintain the chemical dependency treatment facility. Supervision of all professional and support staff must

be clearly demonstrated, and policies must include assurance there is an identified clinical supervisor who is a licensed addiction counselor who oversees the implementation of services to assure quality and appropriateness of care rendered to clients. A program administrator is responsible to the governing body and is responsible for the daily operation of the facility. "Adequate" staff to meet client requests for services and professional counseling staff is required and client ratios should be at an "acceptable level" as determined by the department. A planned, supervised orientation shall be provided to each new employee.

For Level III.7, staffing requirements include but are not limited to the following: (i) a physician licensed under Title 37, MCA, available on call 24 hours a day, 7 days a week to evaluate clients and prescribe medications; (ii) staff available in sufficient numbers and trained to respond to substance-related and co-occurring disorders of admitted clients; (iii) a registered nurse licensed under Title 37, MCA, who is responsible for the supervision of nursing staff and the administration of detox protocols; and (iv) support staff such as licensed practical nurses, certified nurse assistants, rehabilitation aides etc. in sufficient numbers to assure the safety of clients.

For community-based social detoxification, staffing requirements include but are not limited to the following: (i) physician-approved protocols for the monitoring of clients in withdrawal including when and under what circumstances clients should be transferred to a health care facility; (ii) a written agreement with the health care facility or physician providing for emergency services when needed; (iii) written procedures specifying how staff will respond to emergencies and for the transfer of medically unstable patients; (iv) sufficient staff on duty trained in CPR and the detox protocols on each shift to be followed to assure clients safe withdrawal from substances; and (v) if medications are provided, there is a current prescription in the client's name and staff are trained in medication administration procedures which are documented in policies and procedures.

For Level III.1, staffing or security measures must be sufficient to assure the safety of residents.

For Level III.3 single gender residential homes, staffing or security measures must be sufficient to assure the safety of residents.

For Level III.3 halfway house community-based parent and children residential homes, to be licensed, a provider must meet the following: (a) 24-hour staffing patterns or security patterns to afford sufficient security to assure the safety of residents, with the availability of 24-hour telephone consultation of a licensed clinician with competence in the treatment of substance dependence disorders. Staffing requirements may include but are not limited to: (i) licensed addiction counselor (LAC); (ii) individuals trained in managing co-occurring disorders; (iii) case managers that have a minimum of two years of higher education or four or more years of related work experience and orientation to the facility's policies and procedures; and (iv) rehabilitation aides that have a minimum of a high school diploma or GED and orientation to the facilities policies and procedures.

For Level III.5, to be licensed, a provider must meet the following: (a) 24-hour staffing patterns or security patterns to afford sufficient security to assure the safety of residents, with the availability of 24-hour telephone consultation of a licensed clinician with competence in the treatment of substance dependence disorders. Staffing requirements may include but are not limited to: (i) licensed addiction counselor (LAC); (ii) individuals trained in managing co-occurring disorders; (iii) case managers that have a minimum of two years of higher education or four or more years of related work experience and orientation to the facility's policies and procedures; and (iv) rehabilitation aides that have a minimum of a high school diploma or GED and orientation to the facilities policies and procedures.

## **Placement**

*Mental Health (MH):* Mental health practitioners must complete a face-to-face crisis evaluation; determine if the individual meets crisis definition; and complete the 72 Hour Crisis Stabilization or Crisis Intervention and Response form; and fax or e-mail form to the Addictive and Mental Disorders Division Benefits Management Team. Researchers did not locate any requirement related to use of the LOCUS.

*Substance Use Disorder (SUD):* For chemical dependency treatment programs, dimensional admission, continued stay and discharge criteria must be developed for each component to promote the least restrictive level of care. The ASAM Patient Placement Criteria 2R establishes the level of care and must be used for placement, continued stay, discharge criteria, and ongoing assessment of the client throughout the course of treatment.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH):* Treatment/service planning and discharge planning requirements are required for crisis stabilization services. Care coordination and the arrangement of appropriate follow-up care are required services as a condition of licensure.

*Substance Use Disorder (SUD):* An individualized treatment plan specifically tailored to meet the needs of the individual client shall be prepared and maintained on a current basis for each client. The treatment plan must be initiated within 3 days of admission to residential treatment. Regular multidisciplinary reviews must be documented. A continuing care plan is required prior to discharge which addresses, at a minimum: (A) support group recommendations; (B) continuing care service provider's contact name, contact number, and initial appointment; (C) health care and/or medication follow-up; and (D) goals for continuing care. Specific requirements regarding discharge planning by facility type are identified below in Section 2.g as required services.

## Treatment Services

*Mental Health (MH):* The specific services reimbursable by the state are limited to: (i) a psychiatric diagnostic interview examination; (ii) care coordination; (iii) individual psychotherapy; (iv) family psychotherapy with or without patient; (v) one to one community-based psychiatric rehabilitation and support; (vi) crisis management services; and (vii) services delivered by a primary care provider for screening and identifying psychiatric conditions and for medication management.

*Substance Use Disorder (SUD):* The ASAM criteria govern residential care. Program policies and procedures must describe in detail the program services. Among other things, policies must address ensuring a person needing detoxification will be immediately referred to a detoxification provider, if available, unless the person needs acute care in a hospital; and limitations and requirements of group counseling sessions to include client/staff appropriate for the level of care being rendered. Clinical policies also must address, among other things: the use of self-help groups; arranging for medical consultation when clinically needed; arranging for psychiatric consultation when clinically indicated; policies addressing a facility's ability to provide dual diagnosis services; and a description of services showing there are arrangements in place for coordination and collaboration to provide any services that are not provided on-site. Case management services policies and procedures must be provided in conjunction with or as part of the client's substance use disorder treatment and recovery.

For Level III.7, service requirements include: (i) a written agreement with a state approved chemical dependency treatment facility to provide ongoing care following client discharge from the detoxification service; (ii) there shall be a discharge note that addresses the referral and service needs of the client for follow-up treatment or care; (iii) medication administration and on-going assessment of the client which are documented in the client record; (iv) written medication orders specifying the name, dose, and route of administration signed by the prescribing physician; (v) meals and snacks in sufficient quantities to assure the nutritional needs of the clients are met; and (vi) written policies and procedures specifying how the facility will provide for the transfer of patients when indicated, to an acute care hospital.

For community-based social detoxification, service requirements include: (i) an initial physical examination by a qualified professional that assures the client can be safely detoxified in a nonmedical setting and documented in the client record; (ii) regular vital signs are taken and recorded by staff trained to recognize symptoms indicating the client is becoming physically unstable; (iii) meals and snacks in sufficient quantities to meet the nutritional needs of the client; (iv) there shall be a written discharge plan that assures necessary referrals and continuing treatment services; (v) all entries in the client record will be signed and dated by staff providing the service; and (vi) a written agreement with an approved addiction treatment provider assuring acceptance of client for treatment upon discharge from the detoxification service.

For Level III.1, service requirements must include: (i) admission and length of stay criteria defining individuals appropriate for this setting; (ii) how all treatment and supportive services are generally off-site in community-based agencies; and (iii) assurance the program is designed and focused on helping individuals with limited life skills and generally focus on helping individuals achieve employment, maintain a daily schedule of work, support group meetings, assigned treatment sessions, and learning how to cooperate and assume responsibility in a community setting.

For Level III.3 single gender residential homes, service requirements include: (i) these homes as transitional versus permanent living environments and how they provide interim supports and services for persons with substance use disorders and related problems; (ii) admission criteria indicating that the individual is appropriate for these settings; (iii) define the criteria for the length of stay in the facilities; (iv) how clinical treatment is provided either on- or off-site; and (v) how life skills training including vocational services is incorporated into daily residential living to prepare residents to assume permanent housing and independent living.

For Level III.3 halfway house community-based parent and children residential homes, services requirements include: (i) the delivery of ASAM Level III.3 treatment services either on- or off-site; (ii) admission criteria indicating individuals appropriate for these settings; (iii) how the treatment needs of both the parent(s) and child(ren) are identified and addressed; (iv) how life skills training is provided as part of the daily living regimen and includes a curriculum to address independent living skills, vocational skills, and parenting skills; (v) how services are coordinated to meet special needs of this population such as childcare, legal services, medical care, and transportation; (vi) how age appropriate services are made available for children as needed; (vii) assurance of a single gender of parent will be living at the facility; and (viii) assurance for safe visitation.

For Level III.5, service requirements include: (i) the delivery of ASAM Level III.5 treatment services either on or off-site; (ii) admission criteria indicating individuals appropriate for these settings; (iii) how the treatment needs are identified and addressed; (iv) how life skills training is provided as part of the daily living regimen and includes a curriculum to address independent living skills and vocational skills; (v) how services are coordinated to meet special needs of this population such as legal services, medical care, and transportation; and (vi) assurance for safe visitation.

## **Patient Rights and Safety Standards**

*Mental Health (MH):* All crisis stabilization services must notify the member or the member's designated representative in writing of a decision denying eligibility or a request for services. Clients have a right to grievance procedures for such denial. No regulations regarding restraint or seclusion were located, nor that grievances be reported to the state.

*Substance Use Disorder (SUD):* All facilities should ensure that each client shall have access to an established client grievance procedure. No regulations regarding restraint or seclusion were located, nor that grievances be reported to the state.

## **Quality Assurance or Improvement**

*Mental Health (MH):* Requirements regarding residential services were not explicitly described in the state regulations.

*Substance Use Disorder (SUD):* Chemical dependency treatment facilities shall have a quality management committee representative of administration and staff. The quality management committee is responsible for: (a) developing a written plan for a continuous quality improvement program organization wide; (b) implementing the quality improvement plan and monitoring the quality and appropriateness of services; (c) meeting at least on a quarterly basis; (d) identifying problems, taking corrective action as indicated, and monitoring results of those actions; and (e) at least annually, reviewing and updating the quality improvement plan.

## **Governance**

*Mental Health (MH):* Requirements regarding residential services were not explicitly described in the state regulations.

*Substance Use Disorder (SUD):* Chemical Dependency Programs must have a governing body responsible for the conduct of the program. The governing body shall establish a philosophy of policies and goals governing admissions, discharges, length of stay, diagnostic groups to be served, scope of services, treatment regimens, staffing patterns, recommendations for continued treatment by referral or otherwise, and provision for a continuing evaluation of the program.

The governing body shall be responsible for providing personnel, facilities, and equipment needed to carry out the goals and objectives of the program and meet the needs of the residents.

## **Special Populations**

*Mental Health (MH):* Requirements regarding residential services were not explicitly described in the state regulations.

*Substance Use Disorder (SUD):* Among other outcome measures required of chemical dependency programs are ones related to services to critical populations including priority in



the following order: (ai) pregnant injecting drug users; (aia) pregnant substance abusers; (b) injecting drug users and those individuals infected with the etiologic agent for AIDS; (c) women with dependent children; (d) clients receiving Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI); (e) homeless clients; and (f) aging clients.

Chemical dependency treatment programs that address dual diagnosis populations are defined as follows:

- "Dual diagnosis capable (DDC)" means treatment programs address co-occurring mental and substance-related disorders in their policies and procedures, assessment, treatment planning, program content, and discharge planning are described as "dual diagnosis capable". Such programs have arrangements in place for coordination and collaboration with mental health services. They also can provide psychopharmacologic monitoring and psychological assessment and consultation, either on-site or through coordination consultation with off-site providers. Program staff is able to address the interaction between mental and substance-related disorders and their effect on the patient's readiness to change, as well as relapse and recovery environment issues, through individual and group content. Nevertheless, the primary focus of DDC programs is the treatment of substance-related disorders.
- "Dual diagnosis enhanced (DDE)" describes treatment programs that incorporate policies, procedures, assessments, treatment, and discharge planning processes that accommodate patients who have co-occurring mental and substance-related disorders. Mental health symptom management groups are incorporated into addiction treatment. Motivational enhancement therapies specifically designed for those with co-occurring mental and substance-related disorders are more likely available (particularly in outpatient settings) and, ideally, there is close collaboration or integration with a mental health program that provides crises back-up services and access to mental health case management and continuing care. In contrast to dual diagnosis capable services, dual diagnosis enhanced services place their primary focus on the integration of services for mental and substance-related disorders in their staffing, services, and program content.

Chemical dependency treatment programs must have policies and procedures that encompass critical population requirements to include how pregnant woman resources and referral options will be made available so staff can make referrals as indicated by client needs including: (i) ensuring a pregnant woman who is not seen by a private physician, physician assistant-certified, nurse practitioner, or advanced practice registered nurse is referred to one of these providers for determination of prenatal care needs; and (ii) discussing pregnancy specific issues and resources.

## **Location of Regulatory and Licensing Requirements**

Department of Public Health and Human Services regulations<sup>1</sup>; Department of Public Health and Human Services regulations<sup>2,3</sup>; Alcoholism and Drug Dependence statute<sup>4</sup>; Department of Public Health and Human Services<sup>5</sup>. Regulatory data collected June 14, 2019.

## Other Information Sources

I. Coy and C. S. Anderson (DPHHS); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>1</sup> See <http://www.mtrules.org/gateway/Subchapterhome.asp?scn=37%2E89%2E5>.

<sup>2</sup> See <http://www.mtrules.org/gateway/ChapterHome.asp?Chapter=37%2E27>.

<sup>3</sup> See <http://www.mtrules.org/gateway/Subchapterhome.asp?scn=37%2E106.14>.

<sup>4</sup> See [https://leg.mt.gov/bills/1997/mca\\_toc/53\\_24.htm](https://leg.mt.gov/bills/1997/mca_toc/53_24.htm).

<sup>5</sup> See [https://leg.mt.gov/bills/1997/mca\\_toc/50\\_5.htm](https://leg.mt.gov/bills/1997/mca_toc/50_5.htm).

# MONTANA MEDICAID

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

## Approach

*Mental Health (MH) and Substance Use Disorder (SUD):* The Montana Department of Public Health and Human Services (DPHHS) oversees the state Medicaid program. Montana does not reimburse for services in IMDs for adults younger than age 65. Montana historically has not relied on the in lieu of provision or on Disproportionate Share Hospital (DSH) payments for reimbursement of some services in Institutions for Mental Diseases (IMDs). The state does not have a relevant Section 1115 waiver.

*Mental Health (MH):* Montana Medicaid only provides mental health treatment for members with a severe disabling mental illness.

## Types of Facilities

*Mental Health (MH):*

- *Crisis Stabilization Program:* a short-term emergency, 24-hour care, treatment, and supervision for crisis intervention and stabilization. It is a residential alternative of fewer than 16 beds to divert from Acute Inpatient Hospitalization. The service includes medically monitored residential services to provide psychiatric stabilization on a short-term basis. The service reduces disability and restores members to previous functional levels by promptly intervening and stabilizing when crisis situations occur. The focus is on goals for recovery, preventing continued exacerbation of symptoms, and decreasing risk of need for hospitalization or higher levels of care.

*Substance Use Disorder (SUD):*

- *ASAM 3.1 SUD Clinically Managed Low-Intensity Residential Adult:* This is a licensed community-based residential home that functions as a supportive, structured living environment. Members are provided stability and skills building to help prevent or minimize continued substance use. SUD treatment services are provided on-site or off-site.

- *ASAM 3.5 SUD Clinically Managed High-Intensity Residential Adult*: This is a clinically managed residential treatment program providing 24-hour structured residential treatment. Members are provided a planned regimen of 24-hour professionally directed SUD treatment. Services focus on stabilizing the member to transition into a less intensive level of care or community setting.
- *ASAM 3.7 SUD Medically Monitored Intensive Inpatient Adult*: This provides medically monitored inpatient treatment services. According to the companion summary to this document, this level of treatment is available in residential settings and the Medicaid Behavioral Health Manual indicates it may be provided by a state-approved substance use disorder program licensed to provide this level of care.

## **Processes of Medicaid Enrollment**

*Mental Health (MH) and Substance Use Disorder (SUD):*

- As a condition of participation in the Montana Medicaid program, all providers must comply with all applicable state and federal statutes, rules and regulations, including but not limited to federal regulations and statutes found in Title 42 of the Code of Federal Regulations and the United States Code governing the Medicaid Program and all applicable Montana statutes and rules governing licensure and certification. Sanctions may be imposed on providers.
- Providers must enroll in the Montana Medicaid program for each category of services to be provided. Required licensure must be maintained.

## **Staffing**

*Mental Health (MH):* Requirements regarding residential services were not explicitly described in the state Medicaid regulations.

*Substance Use Disorder (SUD):* ASAM Levels 3.1, 3.5, and 3.7 must be provided by a state-approved substance use disorder program licensed to provide the level of care.

For Level 3.5, programs are staffed by Licensed Addictions Counselors and behavioral health staff. There is access to medical staff.

For Level 3.7, programs are staffed by physicians, nurses, Licensed Addictions Counselors, and behavioral health staff.

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* Each Medicaid member receiving behavioral health treatment must have a current comprehensive assessment conducted by an appropriately licensed mental health professional or licensed addictions counselor trained in clinical assessments and operating within the scope of practice of their respective license. For a member receiving SUD treatment services, the assessment must be relevant and organized according to the six dimensions of the ASAM Criteria.

*Mental Health (MH):* Crisis Stabilization Programs do not require prior authorization. Medical necessity criteria require the presence of any mental health diagnosis from the current version of the DSM as the primary diagnosis and at least one of the following: dangerousness to self; dangerous to others; or grave disability. Continued stay criteria also must be satisfied.

*Substance Use Disorder (SUD):* An appropriately licensed mental health professional with SUD within the scope of their professional license, or a licensed addiction counselor, must certify the member continues to meet the criteria for having a SUD annually. The clinical assessment must document how the member meets the criteria for having a SUD. The most current edition of the ASAM criteria must be used to establish the appropriate level of care for placement into services.

For ASAM 3.1, 3.3, and 3.7, medical necessity criteria require that a member must meet the moderate or severe SUD criteria and meet the ASAM criteria for diagnostic and dimensional admission criteria. Prior authorization is required. The member must continue to meet the SUD criteria with a severity specifier of moderate or severe and meet the ASAM criteria diagnostic and dimensional admission criteria. For ASAM 3.7, results of the initial lab results at admission will be required for the continued stay review.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Based upon the findings of the assessment(s) described in 2.e, the Medicaid provider of mental health or SUD services must establish an individualized treatment plan for each member that must, among other things, identify the problem area that will be the focus of the treatment to include symptoms, behaviors, and/or functional impairments and identify the goals that are person-centered, long-term, recovery oriented. It must be reviewed and updated as required in ARM or whenever there is a significant change in the member's condition and/or situation. The treatment plan review must be comprehensive regarding the member's response to treatment and result in either an amended treatment plan or a statement of the continued appropriateness of the existing plan.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Services must be medically necessary.

*Mental Health (MH):* Crisis Stabilization Program is billed as a bundled service and includes the following: (a) 24-hour direct care staff; (b) 24-hour on call mental health professional; (c) crisis stabilization services; (d) psychotropic medications administered and monitoring behavior during the crisis stabilization period; (e) observation of symptoms and behaviors; and (f) support or training for self-management of psychiatric symptoms. It is not required that each member receiving the crisis stabilization bundle receive every service listed above. Medically necessary services must be provided and documented in the treatment plan and the services received must be documented clearly in the member's treatment file.

*Substance Use Disorder (SUD):* All ASAM levels must adhere to the ASAM criteria service standards for service planning and level of care placement characteristic category standards. These categories include: (a) therapies; (b) support systems; (c) assessment/ITP review; (d) staff; and (e) documentation.

For ASAM 3.1, the service includes a minimum of 5 hours per week of professionally directed treatment services.

For ASAM 3.3, medically necessary services must be provided and documented in the treatment plan and the services received must be documented clearly in the member's treatment file.

For ASAM 3.7, members are provided a planned regimen of 24-hour professionally directed evaluation, observation, medical management/monitoring, and SUD treatment. Medically necessary services must be provided and documented in the treatment plan and the services received must be documented clearly in the member's treatment file.

## **Care Coordination**

*Mental Health (MH) and Substance Use Disorder (SUD):* Requirements regarding residential services were not explicitly described in the state Medicaid regulations.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* The department or the utilization review contractor may perform retrospective clinical record reviews for two purposes: (a) to determine medical necessity of a provided service; or (b) as requested by the provider to establish the medical necessity for payment when the member has become Medicaid eligible

retroactively or the provider has not enrolled in Montana Medicaid prior to the admission of the member.

## Special Populations

*Mental Health (MH) and Substance Use Disorder (SUD)*: Requirements regarding residential services were not explicitly described in the state Medicaid regulations.

## Location of Medicaid Requirements

Montana Rule 37: Public Health and Human Services<sup>6</sup>; Addictive and Mental Disorders Division Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health<sup>7</sup>. Regulatory data collected January 9, 2020.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report “**State Residential Treatment for Behavioral Health Conditions: Regulation and Policy**”. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

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<sup>6</sup> See <http://www.mtrules.org/Gateway/Department.asp?DeptNo=37>.

<sup>7</sup> See <https://dphhs.mt.gov/Portals/85/amdd/documents/AMDDMcdManualSUDMHOct19.pdf>.

## NEBRASKA

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### Types of Facilities

*Mental Health (MH):* Nebraska regulates one type of residential mental health treatment facility:

- *Mental health center:* any facility where shelter, and food, and counseling, or diagnosis, or treatment, or care, or related services are provided by the facility for a period of more than 24 consecutive hours to persons residing at the facility who have a mental disease, disorder, or disability. These regulations do not apply to: self-run programs or a home, apartment or facility which does not exercise minimum supervision over the personal care, activities of daily living or health maintenance of clients.

*Substance Use Disorder (SUD):* Nebraska regulates one type of residential substance use disorder treatment facility:

- *Substance abuse treatment center:* an inpatient facility is any private dwelling, where: shelter, food, and care, or treatment, or maintenance, or related services are directly provided or arranged for by the facility to persons who are substance abusers living in a group setting. Inpatient facilities are residential settings. "Inpatient facility" is further defined as a residential facility that provides food, shelter, and an organized program of therapeutic activities that includes evaluation, rehabilitation, care and/or treatment for persons who are substance abusers.

*Unregulated Facilities:* No unregulated treatment facilities that fall under the purview of this summary were identified.

### Approach

*Mental Health (MH) and Substance Use Disorder (SUD):* The Nebraska Department of Health and Human Services oversees, regulates, and licenses residential treatment facilities.



## **Processes of Licensure or Certification and Accreditation**

### *Mental Health (MH):*

- Licensure by the Nebraska Department of Health and Human Services is required for operation of any mental health center. Licenses expire every year on February 28, by which time a renewal application must be submitted. An inspection is required for licensure and renewal.
- Except as indicated in section 2h below, accreditation is not required, but accreditation by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation for Children and Family Services allows the Department to deem the facility in compliance with licensure requirements.
- The state does not require a certificate of need for these types of facilities.

### *Substance Use Disorder (SUD):*

- Licensure by the Nebraska Department of Health and Human Services is required for operation of any substance abuse treatment center, as which residential treatment is considered “inpatient.” Licenses expire every year on September 30, at which time a renewal application must be submitted. An inspection is required for licensure and renewal.
- Except as indicated in section 2h below, accreditation is not required, but accreditation by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation for Children and Family Services allows the Department to deem the facility in compliance with licensure requirements.
- The state does not require a certificate of need for these types of facilities.

## **Cause-Based Monitoring**

*Mental Health (MH):* Standards for monitoring on a regular basis were identified in the regulations for mental health residential facilities. The Department may conduct an on-site inspection at any time. Each year the Department may conduct an inspection of up to 25% of the mental health centers based on a random selection of licensed mental health centers. Additionally, the Department may conduct an inspection of a mental health center when informed of certain critical incidents defined in the regulations. Disciplinary action can be indicated depending on the results of the inspection.

*Substance Use Disorder (SUD):* Standards for monitoring on a regular basis were identified in the regulations for mental health residential facilities. The Department may conduct an on-site inspection at any time. Each year the Department may conduct an inspection of up to 25% of the substance abuse treatment centers based on a random selection of licensed substance abuse treatment centers. Additionally, the Department may conduct an inspection when informed of certain critical incidents defined in the regulations. If and when an inspection reveals any regulatory violations, the Department may request a statement of compliance or impose disciplinary actions as the situation warrants.

## **Access Requirements**

*Mental Health (MH) and Substance Use Disorder (SUD):* Requirements regarding residential services were not explicitly described in the state regulations.

## **Staffing**

*Mental Health (MH):* Mental health centers shall have an administrator who is responsible for planning, organizing, and directing the day to day operations and who must be on the premises a sufficient number of hours to permit adequate attention to the management of the mental health center. The facility must maintain a sufficient number of staff with the required training and skills necessary to meet the clients' needs. Any staff person providing a service for which a license, certification, registration or credential is required must hold the license, certification, registration or credential in accordance with applicable state laws. The facility must establish and implement policies and procedures regarding the health status of staff who provide direct care or treatment to clients to prevent the transmission of infectious disease.

The facility must provide orientation training and ongoing training for all staff.

*Substance Use Disorder (SUD):* Substance abuse treatment centers shall have an administrator who is responsible for planning, organizing, and directing the day to day operations and who must be on the premises a sufficient number of hours to permit adequate attention to the management of the mental health center. The facility must at all times maintain enough staff to provide adequate care to meet the client population's requirements for care and treatment, including needs for therapeutic activities, supervision, support, health, and safety. Any staff person providing a service for which a license, certification, registration or credential is required must hold the license, certification, registration or credential in accordance with applicable state laws. The facility must establish and implement policies and procedures regarding the health status of staff who provide direct care or treatment to clients to prevent the transmission of infectious disease.

The facility must provide orientation and ongoing training for all staff.

## **Placement**

*Mental Health (MH):* The facility must have written criteria for admission that includes each level of care and the components of care and treatment provided by the facility. The written criteria must include how eligibility for admission is determined. The facility must ensure that the decision to admit a client is based upon the facility's admission criteria and the facility's capability to meet the identified needs of the client. Clients must also undergo an admission health screening. References to LOCUS were not found.

*Substance Use Disorder (SUD):* For substance abuse treatment centers, facilities must have written criteria for admission that includes each level of care and the components of care and treatment provided by the facility. The written criteria must include how eligibility for admission is determined. The facility must develop an assessment of the client to identify the effects of substance abuse on the client's life, except for a client in an emergency detoxification program. The assessment must be performed within 15 days of admission. The facility must evaluate a client in an emergency detoxification program as to his or her immediate need and implement the facility's procedures for its emergency detoxification program. No reference to ASAM criteria for level of care were located.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH):* Individualized service plans are required for mental health treatment centers, to be completed within 30 days of admission, with reviews required every six months. Individualized service plans are based upon assessment. Within the first 30 days of admission a discharge plan must be developed including: (1) Plan for follow up or continuing care; and (2) Documentation of referrals made for the client.

*Substance Use Disorder (SUD):* Each client, except for a client admitted to an emergency detoxification program, must have an individualized service plan (ISP) based on assessment of the client's needs. The facility must base the intensity of care and treatment provided on the client's need. The facility must begin to develop the initial ISP of care upon admission; implement the ISP as soon as it has been established; and complete development of the ISP when the assessment process is finished. The maximum intervals between evaluations of the ISP are every 30 days for intensive treatment which consists of any level of inpatient treatment or outpatient treatment involving ten or more hours of therapeutic activity per week. Discharge planning is required, except for in emergency detoxification programs, but no references to beginning at admission were found. Discharge plans must include a relapse prevention plan, the client's plan for follow-up, continuing care, or other post-care and treatment services.

## Treatment Services

*Mental Health (MH):* In addition to those services referenced in 1a, the facility must ensure the client has access to the following: (1) Provision of adequate shelter and arrangements for food and meals; (2) Provision of care and treatment to meet client identified needs; (3) Medical and clinical oversight of client needs as identified in the client assessment; (4) Assistance with acquiring skills to live as independently as possible; (5) Assistance and support, as necessary, to enable clients to meet personal hygiene and clothing needs; (6) Assistance and support, as necessary, to enable clients to meet their laundry needs, which includes access to washers and dryers so that clients can do their own personal laundry; (7) Assistance and support, as necessary, to enable clients to meet housekeeping needs essential to their health and comfort, including access to materials needed to perform their own housekeeping duties; (8) Activities and opportunities for socialization and recreation both within the facility and in the community; (9) Health-related care and treatment; and (10) Assistance with transportation arrangements. The facility must arrange for access to mental health services on a routine and ongoing basis to meet the identified client needs, as well as access to licensed mental health professional services. The facility must make arrangements for care of client emergencies on a 24 hour, 7 day a week basis.

*Substance Use Disorder (SUD):* In addition to those services referenced in 1a, an inpatient/residential substance abuse treatment facility must provide, at minimum, the following: (1) Therapeutic activities as described in the facility program description; (2) Adequate food and shelter; (3) Medical and clinical oversight of client needs as identified in the client assessment; (4) Assistance and support, as necessary, to enable the client to meet personal hygiene and clothing needs; (5) Assistance and support, as necessary, to enable the client to meet laundry needs, which may include access to washers and dryers so that clients can do their own personal laundry if included in the client's ISP; (6) Assistance and support, as necessary, to enable the client to meet his or her housekeeping needs including access to materials needed to perform his or her own housekeeping duties as determined by the client's ISP; and (7) Health-related care and treatment, as necessary.

Inpatient/residential facilities may provide emergency detoxification programs, of which there are two types: (1) Civil protective custody which is involuntary, initiated by a law enforcement officer; and has a maximum duration of 24 hours; and (2) Social setting emergency detoxification which is voluntary; is initiated by the client or designee; and has a maximum duration of five days. A facility providing one or both types of emergency detoxification programs must have policies and procedures for the assessment, observation, and routine monitoring of clients. A licensed physician must document the appropriateness of the facility's policies and procedures.

## **Patient Rights and Safety Standards**

*Mental Health (MH):* All mental health centers should ensure that the client is aware of their rights upon admission and for the duration of the stay; operate so as to afford the client the opportunity to exercise these rights; and protect and promote these rights. Client's rights include, but are not limited to: the ability to voice complaints and file grievances without discrimination or reprisal and to have those complaints and grievances addressed; be free of restraints except when provided as in 175 NAC 19-006.12; and be free of seclusion in a locked room, except as provided in 175 NAC 19-006.12. The facility must establish and implement procedures for addressing complaints and grievances from clients, staff, and others.

A mental health center that provides a secured and protective environment by restricting a client's exit from the facility or its grounds through the use of approved locking devices on exit doors or other closures must be accredited by an approved qualifying organization, referenced in 2a. A mental health center that is accredited by an approved qualifying organization may use restraint and seclusion methods as part of a client's treatment plan. A nonaccredited mental health center is prohibited from using mechanical and chemical restraints and seclusion. A non-accredited mental health center may use manual restraint and/or time out as therapeutic techniques only after it has: (1) Written policies and procedures for the use of manual restraint and time-out; (2) Documented physician approval of the methods used by the facility; (3) Trained all staff who might have the occasion to use manual restraints and/or time-out in the appropriate methods to use in order to protect client safety and rights; and (4) Developed a system to review each use of manual restraint or time-out.

*Substance Use Disorder (SUD):* All substance abuse treatment centers should ensure that the client is aware of their rights upon admission and for the duration of the stay; operate so as to afford the client the opportunity to exercise these rights; and protect and promote these rights. Client's rights include, but are not limited to: the ability to voice complaints and file grievances without discrimination or reprisal and to have those complaints and grievances addressed; be free of restraints except when provided as in 175 NAC 18-006.14; be free of seclusion in a locked room, except as provided in 175 NAC 18-006.14 and except in cases of civil protective custody. The facility must establish and implement written procedures for addressing complaints and grievances from clients, staff, and others. The facility must document efforts to address complaints and grievances received in a timely manner.

A substance abuse treatment center that provides a secured and protective environment by restricting a client's exit from the facility or its grounds through the use of approved locking devices on exit doors or other closures must be accredited by an approved qualifying organization, referenced in 2a. A substance abuse treatment center that is accredited by an approved qualifying organization may use restraint and seclusion methods as part of a client's treatment plan. A nonaccredited substance abuse treatment center is prohibited from using mechanical and chemical restraints and seclusion. A non-accredited substance abuse treatment center may use manual restraint and/or time out as therapeutic techniques only after it has: (1) Written policies and procedures for the use of manual restraint and time-out; (2)

Documented physician approval of the methods used by the facility; (3) Trained all staff who might have the occasion to use manual restraints and/or time-out in the appropriate methods to use in order to protect client safety and rights; and (4) Developed a system to review each use of manual restraint or time-out.

## **Quality Assurance or Improvement**

*Mental Health (MH):* The facility must conduct an ongoing comprehensive, integrated assessment of the quality and appropriateness of care and treatment provided. The facility must use the findings to correct identified problems and to revise facility policies, if necessary.

The facility must review all elements of the written program description at least annually. The facility must document the results of the annual review. Relevant findings from facility's quality assurance/performance improvement program for the purpose of improving client treatment and resolving problems in client care and treatment must be included in the review process.

*Substance Use Disorder (SUD):* The facility must conduct an ongoing comprehensive, integrated assessment of the quality and appropriateness of care and treatment provided. The facility must use the findings to correct identified problems and to revise facility policies, if necessary.

The facility must review all elements of the written program description at least annually. The facility must document the results of the annual review. Relevant findings from facility's quality assurance/performance improvement program for the purpose of improving client treatment and resolving problems in client care and treatment must be included in the review process.

## **Governance**

*Mental Health (MH):* No information related to a governing body was identified. However, the licensee must determine, implement and monitor policies to assure that the facility is administered and managed appropriately and must appoint an administrator who has certain responsibilities.

*Substance Use Disorder (SUD):* The governing body must develop a mission statement, program philosophy, goals and objectives. Additionally, the licensee must appoint an administrator who has certain responsibilities.

## **Special Populations**

*Mental Health (MH) and Substance Use Disorder (SUD):* Requirements regarding residential services were not explicitly described in the state regulations.

## Location of Regulatory and Licensing Requirements

Department of Health and Human Services<sup>1,2</sup>. Regulatory data collected July 17, 2019.

## Other Information Sources

M. Luger and S. Dawson (DHHS); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>1</sup> See [http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health\\_and\\_Human\\_Services\\_System/Title-175/Chapter-19.pdf](http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-175/Chapter-19.pdf).

<sup>2</sup> See [http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health\\_and\\_Human\\_Services\\_System/Title-175/Chapter-18.pdf](http://www.sos.ne.gov/rules-and-regs/regsearch/Rules/Health_and_Human_Services_System/Title-175/Chapter-18.pdf).

# NEBRASKA MEDICAID

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

## Approach

*Mental Health (MH) and Substance Use Disorder (SUD):* The Nebraska Department of Health and Human Services (DHHS) oversees the state Medicaid program. Mental health and substance abuse services (MH/SA) are provided as a managed care benefit for all Nebraska Medicaid Managed Care Program (NMMCP) clients. Nebraska relies on the in lieu of provision but not on Disproportionate Share Hospital (DSH) payments for Medicaid coverage of certain IMD services.

*Substance Use Disorder (SUD):* The state has a Section 1115 waiver permitting Medicaid coverage of otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term (statewide average length of stay of 30 days) residents in facilities that meet the definition of an institution for mental diseases (IMD).

## Types of Facilities

*Mental Health (MH):* Nebraska enrolls one primary type of residential MH treatment facility:

- *Psychiatric Residential Rehabilitation:* designed to provide individualized treatment and recovery inclusive of psychiatric rehabilitation and support for individuals with a severe and persistent mental illness and/or co-occurring disorder who are in need of recovery and rehabilitation activities within a residential setting. The intent of the service is to support the individual in the recovery process so that he/she can be successful in a community living setting of his/her choice.
  - *Secure Psychiatric Residential Rehabilitation:* a secure facility-based, non-hospital or non-nursing facility program for individuals disabled by severe and persistent mental illness, who are unable to reside in a less restrictive setting. These facilities are integrated into the community and provide programming in an organized, structured setting, including treatment and rehabilitation services and offer support to clients with a severe and persistent mental illness and/or co-occurring substance abuse disorders. The Secure Psychiatric Residential Rehabilitation program provides skill building and other related recovery oriented psychiatric rehabilitation services as needed to meet individual client needs. The Secure Psychiatric Residential



Rehabilitation Program is designed to: (1) Increase the client's functioning while improving psychiatric stability so that s/he can eventually live successfully and safely in a less restrictive residential setting of his/her choice and capabilities; (2) Decrease the frequency and duration of hospitalization; (3) Decrease and/or eliminate all high risk, unsafe behavior to self or others; and (4) Improve the ability to function independently by improving ability to function.

*Substance Use Disorder (SUD):* In accordance with the state 1115 waiver, expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term (statewide average length of stay of 30 days) residents in facilities that meet the definition of an institution for mental diseases (IMD). Facility types included are:

- Level 3.1. Halfway House
- Level 3.2. Adult Substance Abuse Detoxification
- Level 3.3. Intermediate Residential (co-occurring diagnosis capable)
- Level 3.5. Short Term Residential (co-occurring diagnosis capable) Adult
- Level 3.5. Dual Disorder Residential (co-occurring diagnosis-enhanced) Adult

Medication-assisted treatment will be available in IMDs.

## **Processes of Medicaid Enrollment**

*Mental Health (MH) and Substance Use Disorder (SUD):*

- State licensure is explicitly required by the state Medicaid program for enrollment.
- The Department will screen all providers as provided in 42 C.F.R. Part 455, Subpart E and will deny or terminate the enrollment of any provider that fails to meet all applicable requirements.
- Each provider must have an approved Service Provider Agreement with the Department.
- The Department must revalidate the enrollment of all providers at least every five years. A provider must permit CMS and the Department to conduct unannounced onsite inspections of any and all provider locations. The Department may terminate the enrollment of a provider who fails to permit a site visit.

### *Mental Health (MH):*

- A provider of psychiatric services for individuals age 21 and over shall complete Form MC-19 or Form MC-20, "Medical Assistance Provider Agreement," and submit the completed form to the Department for approval. Specific requirements for each type of care are listed in the respective subparts. The provider must meet all of these standards in order to be enrolled with NMAP. The Department is the sole determiner of which providers are approved for participation in this program.
- For Psychiatric Residential Rehabilitation, the program shall be licensed as a Residential Care Facility, Domiciliary, or Mental Health Center by the Department of Health and Human Services.

## **Staffing**

*Mental Health (MH):* Secure Psychiatric Residential Rehabilitation providers must employ a: (1) Program Director; (2) Licensed Mental Health Practitioner (LMHP) or a Licensed Mental Health Practitioner/Licensed Alcohol and Drug Counselor (LMHP/LADC). A dual Licensed Practitioner is preferred; (3) Registered nurse; and (4) Direct care staff. The Program Director must be fully licensed as a Mental Health Practitioner (APRN, RN, LMHP, LIMHP or psychologist); and possess leadership, supervisory, and management skills.

For Psychiatric Residential Rehabilitation, there is a requirement for clinical direction by a Licensed Psychologist, APRN, RN, LIMHP, or LMHP working with the program to provide clinical direction, consultation and support to direct care staff and the individuals they serve. There shall be appropriately licensed and credentialed professionals working within their scope of practice. All staff should be educated/trained in rehabilitation, recovery principles and trauma informed care. There shall be a clinical supervisor to direct care staff ratio as needed to meet all responsibilities.

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding credentials of staff for residential treatment settings. The state must conduct an assessment of the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT.

## **Placement**

*Mental Health (MH):* For services to be covered by Medicaid, the necessity of the service for the client shall be established through an Initial Diagnostic Interview (IDI). The client must have a diagnosable mental health disorder of sufficient duration to meet diagnostic criteria specified within the current Diagnostic and Statistics Manual of the American Psychiatric Association that results in functional impairment which substantially interferes with or limits the person's role or functioning within the family, job, school, or community.

Secure Psychiatric Residential Rehabilitation is for individuals demonstrate a moderate to high risk for harm to self/others and are in need of recovery, treatment, and rehabilitation services. The clients who are in need of this level of care have long standing limitations with limited ability to live independently over an extended period of time. An IDI must be conducted by a licensed, qualified clinician and credentialed mental health professional prior to admission or completed within 12 months prior to the date of admission. The following assessments must be also completed: (1) A comprehensive mental health and substance use disorder assessment by an independently licensed mental health practitioner must occur prior to admission. (2) Following admission and within 24 hours of stay, an assessment by the program's psychiatrist must be completed. (3) A history and physical must be completed by a physician or Advanced Practice Registered Nurse (APRN) within 24 hours of admission or one must be completed within 60 days of admission and available in the clinical record. (4) A nursing assessment must be completed by a Registered Nurse within 24 hours of admission. (5) A functional assessment must be completed initially upon admission and annually with continued stay at this level of service.

*Substance Use Disorder (SUD):* In accordance with the state 1115 waiver, there shall be an establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as ASAM Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines, as well as a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* A treatment plan must be established for each client. The treatment plan is a comprehensive plan of care formulated by the clinical staff under the direction of a supervising practitioner and is based on the individual needs of the client. The treatment plan validates the necessity and appropriateness of services and outlines the service delivery needed to meet the identified needs, reduce problem behaviors, and improve overall functioning. The treatment plan must be based upon an assessment of the client's problems and needs in the areas of emotional, behavioral, and skills development. The

treatment plan must be individualized to the client and must include the specific problems, behaviors, or skills to be addressed; clear and realistic goals and objectives; services, strategies, and methods of intervention to be implemented; criteria for achievement; target dates; methods for evaluating the client's progress; and the responsible professional. The treatment plan must be reviewed and updated by the treatment team according to the client's level of functioning. Minimum time frames for treatment plan reviews are dependent on the type of service.

Whenever a client is transferred from one level of care to another, transition and discharge planning must be performed and documented by the treating providers, beginning at the time of admission. Transition and discharge planning must address the client's need for ongoing treatment to maintain treatment gains and to continue normal physical and mental development following discharge.

*Mental Health (MH):* For Psychiatric Residential Rehabilitation, an initial Individual Treatment, Rehabilitation, and Recovery Plan to guide the first 14 days of treatment shall be developed within 72 hours of admission. An Individual Treatment, Rehabilitation, and Recovery Plan must be developed within 30 days following admission. It must include a documented discharge and relapse prevention plan. The plan must be recovery-oriented, trauma-informed, and strength-based.

*Substance Use Disorder (SUD):* Treatment and discharge planning will be in accordance with the ASAM criteria.

## **Treatment Services**

*Mental Health (MH):* For Psychiatric Residential Rehabilitation, the program provides: (1) Community living skills and daily living skills development; (2) Client skills development for self-administration of medication, as well as recognition of signs of relapse and control of symptoms; and (3) Skill building in the usage of public transportation and/or assistance in accessing suitable local transportation to and from the Psychiatric Residential Rehabilitation program.

The program must facilitate client driven skills training and activities as appropriate. A secure psychiatric residential rehabilitation program must provide services identified on the client specific Individual Treatment, Rehabilitation, and Recovery Plan, providing culturally-sensitive and trauma-informed care. The activities must include, but are not limited to: (1) Ongoing assessment; (2) Arrangement for general medical care including laboratory services, psychopharmacological services, psychological services, as necessary; (3) Provision of a minimum of 42 hours per week of on-site staff led psychosocial rehabilitation activities and skill acquisition; (4) Programming focused on relapse prevention, recovery, nutrition, daily living skills, social skill building, community living, substance abuse, education, medication education and self-administration, symptom management, and focus on improving the level of

functioning to get to a less restrictive level of care; (5) Educational and vocational focus as appropriate; and (6) Access to community-based rehabilitation/social services to assist in transition to community as symptoms are managed and behaviors are stabilized.

*Substance Use Disorder (SUD):* In accordance with the state 1115 waiver, beneficiaries will have access to high quality, evidence-based SUD treatment services, ranging from medically supervised withdrawal management for SUDs to ongoing care for these conditions in cost-effective community based settings. The state will work to improve care coordination and care for co-occurring physical and mental health conditions. Pursuant to the Section 1115 waiver, the state must establish residential treatment program standards regarding in particular the types of services and hours of clinical care for residential treatment settings. The state must establish a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site.

## **Care Coordination**

*Mental Health (MH):* If a client is receiving services from more than one psychiatric provider, the providers must assure coordination of all services. That coordination must be documented in the client's medical record. Coordination of services is required as part of the overall treatment plan must be covered in one unified treatment plan and is not billable as a separate service.

For Psychiatric Residential Rehabilitation, the program must have the ability to coordinate other services the individual may be receiving and refer to other necessary services, and provide referral for services and supports to enhance independence in the community.

*Substance Use Disorder (SUD):* In accordance with the state 1115 waiver, the state will work to improve care coordination and care for co-occurring physical and mental health conditions. The state must ensure establishment and implementation of policies to ensure residential facilities link beneficiaries with community-based services and supports following stays in these facilities.

## **Quality Assurance or Improvement**

Mental Health (MH) and Substance Use Disorder (SUD): All providers participating in NMAP have agreed to provide services under the requirements their provider agreements. If there is any question or concern about the quality of service being provided by an enrolled provider, the Department may perform quality assurance and utilization review activities, such as on-site visits, to verify the quality of service. If the provider or the services do not meet the standards of the specific level of care, the provider may be subject to administrative sanctions or denial of provider agreement for good cause. The Department may request a refund for all services not

meeting regulatory requirements. If the clients are in immediate jeopardy, the sanctions may be imposed without a hearing.

*Substance Use Disorder (SUD)*: In accordance with the state 1115 waiver, there shall be the establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings.

## Special Populations

*Mental Health (MH) and Substance Use Disorder (SUD)*: Requirements regarding residential services were not explicitly described in the state Medicaid regulations.

## Location of Medicaid Requirements

Nebraska Medicaid Rules and Regulations<sup>3</sup>; Medicaid Psychiatric Residential Rehabilitation<sup>4</sup>; Medicaid Behavioral Health Service Definitions<sup>5</sup>; Nebraska Substance Use Disorder Section 1115 Demonstration<sup>6</sup>. Regulatory data collected January 10, 2020.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report “**State Residential Treatment for Behavioral Health Conditions: Regulation and Policy**”. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

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<sup>3</sup> See <http://dhhs.ne.gov/Pages/Medicaid-Rules-and-Regulations.aspx>.

<sup>4</sup> See <http://dhhs.ne.gov/Behavioral%20Health%20Service%20Definitions/Psychiatric%20Residential%20Rehabilitation.pdf>.

<sup>5</sup> See <http://dhhs.ne.gov/Pages/Medicaid-Behavioral-Health-Definitions.aspx#InplviewHashef510dad-20dd-4a57-a254-85c91569baf5=FolderCTID%3D0x012001>.

<sup>6</sup> See <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=50214>.

## NEVADA

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### Types of Facilities

*Mental Health (MH) and Substance Use Disorder (SUD):* Nevada regulates the following type of MH/SUD residential treatment facility:

- *Community triage center:* a facility that provides, on a 24-hour basis, medical assessments of and short-term monitoring services for persons with mental illness and abusers of alcohol or drugs in a manner which does not require that the assessments and services be provided in a licensed hospital.

*Substance Use Disorder (SUD):* Nevada regulates the following types of residential substance use treatment facilities:

- *A facility for the treatment of abuse of alcohol or drugs:* any public or private establishment which provides residential treatment, including mental and physical restoration, of abusers of alcohol or drugs. It does not include a medical facility or services offered by volunteers or voluntary organizations. These *residential programs* are treatment programs for alcohol and drug abuse which takes place in a 24-hour residential setting and which encompasses organized services staffed by designated addiction treatment personnel who provide a planned regimen of client care. Included in the regulations governing these facilities is the following relevant subtype:
  - *Social model detoxification program:* a treatment program that concentrates on providing psychosocial services and nonmedical detoxification. A social model detoxification program may be offered to clients in: (1) Residential programs that offer detoxification services; (2) A licensed facility for modified medical detoxification; or (3) A medically managed intensive detoxification program, which does not fall under the purview of this summary.
- The Nevada Department of Health and Human Services, Division of Public and Behavioral Health adopts by reference the ASAM treatment criteria and publishes certification criteria that adopt the ASAM placement criteria.
  - *Co-occurring capable program:* a program that addresses co-occurring substance-related and mental health disorders in its policies and procedures, assessments, treatment planning, program content and discharge planning; and in which the staff

- is able to address the interaction between substance-related and mental health disorders.
- *Co-occurring enhanced program*: a program that has a higher level of integration of services for co-occurring substance-related and mental health disorders than a co-occurring capable program; and is able to provide unified treatment of the symptoms of substance-related and mental health disorders in addition to addressing the interaction between substance-related and mental health disorders.
  - The Division adopts the Dual Diagnosis Capability in Addiction Treatment (DDCAT) Rating Scale. Both ASAM Level 3.5 Clinically Managed High-Intensity Residential (Adult) and Withdrawal Management for Level 3.2 WM and Level 3.7 WM are identified as specific residential treatment levels that may be certified.
- Separately regulated is a *facility for modified medical detoxification*, which is a facility that provides 24-hour medical monitoring of treatment and detoxification in a manner which does not require that the service be provided in a licensed hospital.

*Unregulated Facilities*: Researchers did not locate reference to regulated MH/SUD residential treatment facilities or to regulated residential treatment SUD facilities other than those identified above. We exclude from this summary residential facilities for groups which are defined as "an establishment that furnishes food, shelter, assistance and limited supervision to a person with an intellectual disability or with a physical disability or a person who is aged or infirm. The term includes, without limitation, an assisted living facility." Among the different types of facilities that may be included in this category are ones that offer or provide care or protective supervision for persons with mental illnesses. Specific requirements for treatment were not located, however, and these facilities are excluded from this summary.

## **Approach**

*Mental Health (MH) and Substance Use Disorder (SUD)*: All SUD treatment programs described in this summary, including residential treatment and residential detoxification, administered by the Nevada Department of Health and Human Services, Division of Public and Behavioral Health that receives federal or state funds, are regulated by the Division.

## **Processes of Licensure or Certification and Accreditation**

*Mental Health (MH) and Substance Use Disorder (SUD)*:

- Licensure by the Nevada Department of Health and Human Services, Division of Public and Behavioral Health is required for operation of community triage centers and facilities for modified medical detoxification (and all other "medical facilities" as defined by Nevada statute). Licensure duration is one year, at which time a renewal application must be



submitted. An inspection is required for licensure and renewal. If there are any differences between the state and local codes, the more restrictive standards apply.

- No requirements related to accreditation were found for community triage centers. The Nevada statute on patient rights does, however, allow for restraint in facilities that are accredited (see 2h).
- Health facilities (including community triage centers and facilities for modified medical detoxification) require a certificate of need to operate.

*Substance Use Disorder (SUD):*

- Licensure by the Nevada Department of Health and Human Services, Division of Public and Behavioral Health is required for operation of community triage centers and facilities for modified medical detoxification.
- In addition to those licensure requirements, certification of facilities for modified medical detoxification is required prior to the issuance of a license. Should this certification be revoked or not renewed, the Division shall revoke the facility license.
- The Division also requires certification of any SUD treatment program administered by the Division which receives any state or federal funding. Certification duration can vary and may not exceed two years, at which time a renewal application must be submitted. An inspection is required for certification and renewal. The primary focus of the application and inspection is compliance with Division criteria.
- No requirements related to accreditation were found for these facilities. The Nevada statute on patient rights does, however, allow for restraint in facilities that are accredited (see 2h).
- Other than “health facilities” (including community triage centers and facilities for modified medical detoxification), as discussed in MH/SUD below, a certificate of need is not required to operate.

## **Cause-Based Monitoring**

*Mental Health (MH) and Substance Use Disorder (SUD):* Investigations and inspections may take place as required. Licenses can be denied, suspended or revoked for certain “nuisance activities.” Administrative sanctions and penalties can be imposed. Plans of correction can be required. The Division shall maintain a log of any complaints that it receives relating to activities for which the Division may revoke the license to operate a facility. The facility shall make this information available to the public.

*Substance Use Disorder (SUD):* Division certification requires that the Division be able to enter the premises of a program and inspect the premises of a program or request additional information from a detoxification technician or program at any time. The Division may deny or revoke certification on specified grounds and may deny certification of a new service and suspend funding.

## **Access Requirements**

*Mental Health (MH) and Substance Use Disorder (SUD):* For community triage centers, no facility that accepts a person for treatment for whom all or part of the payment for treatment is made from federal or state money may deny treatment to a prospective patient on the grounds of race, color, national origin, age, gender or disability; and no patient may be segregated, given separate treatment, restricted in the employment of any advantage or privilege enjoyed by others under the program or provided with any aid, treatment, services or other benefits which are different or provided in a different manner from that provided to others under the program on the grounds of race, color, national origin, age, gender or disability. Employment practices of a facility may not be based on race, color, national origin, age, gender or disability. No requirements regarding wait time were identified.

*Substance Use Disorder (SUD):* For facilities for treatment of abuse of alcohol or drugs, no facility may deny treatment to a prospective client on the grounds of race, color, age, disability or national origin; and no resident may be segregated, given separate treatment, restricted in the employment of any advantage or privilege enjoyed by others under the program or provided with any aid, treatment, services or other benefits which are different or provided in a different manner from that provided to others under the program, on the grounds of race, color, age, disability or national origin. No requirements regarding wait time were identified.

Division criteria for certified treatment programs include a statement that “certified treatment programs, private, public or funded cannot deny treatment services to clients that are on stable medication maintenance for the treatment of an opioid use disorder including FDA approved medications.”

For facilities for modified medical detoxification, no facility that accepts a person for treatment for whom all or part of the payment for treatment is made from the money of the Division of Welfare and Supportive Services or any other agency funded in whole or in part by federal money may deny treatment to a prospective client on the grounds of race, color, national origin, age, gender or disability. No client may be segregated, given separate treatment, restricted in the employment of any advantage or privilege enjoyed by others under the program or provided with any aid, treatment, services or other benefits which are different or provided in a different manner from that provided to others under the program on the grounds of race, color, national origin, age, gender or disability.

## Staffing

*Mental Health (MH) and Substance Use Disorder (SUD):* Community triage centers are required to have an administrator who is responsible to the governing body for the operation of the facility. The administrator is responsible for notifying the Bureau within 24 hours after they become aware of the death of a patient at the facility; or the elopement from the facility of an at-risk patient. Each facility shall have on duty, at all hours of the day, members of the staff sufficient in number and qualifications to carry out policies, responsibilities and program continuity. All members of the counseling staff of a facility must be authorized by state law to provide counseling. Mental health services provided by a facility must be supervised by a psychiatrist or a psychologist who has a master's degree in clinical or counseling psychology. The facility must provide an orientation session to new employees. Each facility shall have an organized plan for nursing service that provides nursing services 24 hours per day. The nursing services must be provided or supervised by a registered nurse in compliance with state law. The administrator shall appoint a chief administrative nurse to direct the nursing service. The chief administrative nurse must: (a) Be a registered nurse; (b) Be knowledgeable, skilled and competent in clinical practice and the management of nurses; and (c) Comply with the provisions of law and follow professional standards established for organized nursing services. Each facility shall have: (a) A pharmacy directed by a registered pharmacist; (b) A drug room supervised by no less than a currently licensed professional nurse; or (c) A contract for 24-hour pharmaceutical service with a licensed pharmacy.

*Substance Use Disorder (SUD):* Facilities for treatment of abuse of alcohol and drugs are required to have an administrator who is responsible to the governing body for the operation of the facility. Facilities must have sufficient staff on duty to carry out policies, responsibilities, and program continuity. Each member of the counseling staff must be: (a) A registered intern; (b) Certified or licensed by the Board of Examiners for Alcohol, Drug and Gambling Counselors; or (c) A licensed mental health professional who has experience with alcohol and drug abuse counseling. The facility must provide an orientation session to new employees.

If the treatment program provides residential detoxification services, the operator must ensure that a detoxification technician or qualified practitioner monitors each client who receives residential detoxification services from the treatment program during the provision of those services. As used in this subsection, "qualified practitioner" includes, without limitation, a licensed physician, a licensed physician assistant, an advanced practice registered nurse, a registered nurse and a licensed practical nurse. Standards are in place for credentials of those who conduct assessments for mental health or substance use disorders (regarding clinical or medical qualifications). Supervision requirements for interns are identified. Qualifications are in place for detoxification technicians.

A facility that offers a social model detoxification program must have a physician, nurse practitioner, registered nurse or physician assistant conduct a physical assessment and a review of the general medical and drug history of a client within 24 hours after the client is admitted to

the facility to ensure that a social model detoxification program is appropriate for the client. The staff of a social model detoxification program must complete at least 6 hours of additional education in the detoxification of alcohol and drug abusers every 2 years.

Facilities for modified medical detoxification are required to have an administrator who is responsible to the governing body for the operation of the facility. Facilities must have sufficient staff on duty to carry out policies, responsibilities, and program continuity. All members of the counseling staff of a facility shall be authorized by state law to provide alcohol and drug counseling. The facility must provide an orientation session to new employees. The facility shall have a full-time, part-time or consulting pharmacist who is responsible for developing, supervising and coordinating all the activities of the pharmacy service. Each facility shall have an organized plan for nursing service that provides nursing services 24 hours per day. The chief administrative nurse must: (a) Be a registered nurse; (b) Be knowledgeable, skilled and competent in clinical practice and the management of nurses; (c) Be authorized by state law to provide alcohol and drug counseling; and (d) Comply with the provisions of chapter 632 of NRS and chapter 632 of NAC and follow professional standards established for organized nursing services.

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* For community triage centers, before a patient is admitted to a facility, a general medical and psychological assessment, including an assessment of suicide risk and a drug history of the patient, must be taken by a physician, a physician assistant, an advanced practice registered nurse or a designated member of the nursing staff of the facility who has psychiatric experience. A physical examination and review of the medical and drug history of a patient must be conducted by a physician, nurse practitioner or physician assistant within 24 hours after the patient is admitted to a facility.

*Substance Use Disorder (SUD):* For facilities for treatment of abuse of alcohol or drugs, before a client's admission to a facility, a general medical and drug history must be taken by a designated member of the staff who is certified or licensed by the Board of Examiners for Alcohol, Drug and Gambling Counselors or who is a licensed mental health professional who has experience with alcohol and drug abuse counseling.

Division certification requires the program's manual of policies and procedures describe the criteria which the treatment program will use to satisfy and comply with the criteria of the Division for admission, continued stay and discharge. The operator of a treatment program shall perform an assessment of each client using a method approved by the Division that addresses both substance-related and mental health disorders, or obtain the most recent assessment of the client in order to determine the appropriate level of service for the client pursuant to the criteria of the Division. The Division adopts the ASAM Patient Placement Criteria for determining level of care placement, and ASAM Continued Service Criteria, Transfer Criteria and Discharge Criteria for utilization review.

A facility that offers a social model detoxification program must have a physician, nurse practitioner, registered nurse or physician assistant conduct a physical assessment and a review of the general medical and drug history of a client within 24 hours after the client is admitted to the facility to ensure that a social model detoxification program is appropriate for the client. The program must not provide detoxification services for clients who exhibit life-threatening symptoms of withdrawal from alcohol and drug abuse.

For modified medical detoxification, before a client is admitted to a facility, a general medical and drug history of the client must be taken by a physician or designated member of the nursing staff of the facility. A physical examination and review of the medical and drug history of a client must be conducted by a physician, registered nurse or physician assistant within 48 hours after the client is admitted to a facility.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* For community triage centers, treatment and discharge planning is required. If a patient is transferred to a hospital or other medical facility, a summary of discharge containing a plan for continuation of care must be prepared and forwarded to the receiving facility if the patient or his or her guardian consents to release such information to the receiving facility. If a patient is transferred to a hospital or other medical facility as a result of a medical emergency, information required for appropriate continuation of care must be released to the receiving facility.

*Substance Use Disorder (SUD):* For facilities for treatment of abuse of alcohol or drugs, treatment planning is required to be stated in quantifiable terms which outlines goals to be accomplished through individually designed activities, therapies, and treatments. Discharge planning beginning at admission is required. No reference to the frequency of planning updates, or any follow-up/aftercare requirements, were found.

Division certification requires the program operator to require staff to develop a plan of treatment, not including detoxification, on or before the third contact of the client with the program or on or before the third day on which the client receives services from the program, whichever occurs first. There shall be the review and revision of the plan of treatment based on the criteria of the Division for continuing the provision of services to and transferring a client. The program must determine whether the patient has a co-occurring substance-related and mental health disorder and, if so, determine the appropriate treatment for the disorders. A continuing care plan must be provided to the client before discharge.

For facilities for modified medical detoxification, treatment and discharge planning is required. No reference to the frequency of planning updates, or any follow-up/aftercare requirements, were found.

## Treatment Services

*Mental Health (MH) and Substance Use Disorder (SUD):* For community triage centers, each facility shall provide health services which ensure that each patient receives treatment, prescribed medication, adequate diets and other health services consistent with each program administered by the facility. Pharmaceutical services also are required. The facility shall provide for the medical, emergency dental and psychological services needed to fulfill the goals of each program and meet the needs of all of its patients to the extent that is possible, with assistance from available community resources. A facility shall provide case management services as needed by a patient through a social worker or a registered nurse or by written agreement with a social worker or a registered nurse.

*Substance Use Disorder (SUD):* For facilities for treatment of abuse of alcohol or drugs, the facility must provide access to medical, dental, psychological and rehabilitative services to meet the needs of all its clients, to the extent possible, with assistance from available community resources. The facility must provide case management services as needed by the client either directly or by written agreement with a qualified social worker, a registered nurse or a counselor certified or licensed by the Board of Examiners for Alcohol, Drug and Gambling Counselors. A plan for case management services must be recorded in the client's record and must be periodically evaluated in conjunction with the client's treatment plan. In programs that permit the self-administration of medication, there must be written policies and procedures governing this activity.

Division certification requires the program operator to provide the appropriate level of services or refer the client to services which are the appropriate level and are otherwise available in the community. If the treatment program provides residential detoxification services, they shall ensure that a detoxification technician or qualified practitioner monitors each client who receives residential detoxification services from the treatment program during the provision of those services. Any program that provides opioid treatment services must be certified to provide outpatient and ambulatory detoxification services. If a treatment program provides counseling for groups, the operator shall ensure that any session for counseling for a group includes not more than 15 clients. In addition to the requirements in the ASAM criteria, the following applies:

- Level 3.5 Clinically Managed High-Intensity Residential (Adult): Clinically managed high intensity residential includes no less than 25 hours per week of structured interventions. A minimum of 7 hours of structured activities must be provided on each day. A minimum of 10 hours of clinical counseling services must be provided each week.
- Withdrawal Management for Level 3.2 WM and Level 3.7 WM: During intake, a Blood Alcohol Content (BAC) and/or urine screen will be administered. The person's vital signs must be monitored at least once every 2 hours during the person's waking hours by a staff

member with a nursing license, physician license or a SAPTA certified Detoxification Technician.

For facilities for modified medical detoxification, the facility shall provide for the medical, dental and psychological services needed to fulfill the goals of the program and meet the needs of all its clients to the extent that is possible, with assistance from available community resources. Each facility shall provide case management services as needed by a client through a social worker or a registered nurse or by written agreement with a social worker or a registered nurse. Each facility shall have an organized plan for nursing service that provides nursing services 24 hours per day. Each facility shall provide health services which ensure that each client receives treatment, prescribed medication, adequate diets and other health services consistent with the program administered by the facility. Each facility shall have written policies and procedures available to members of the staff, clients and the public that govern the operation of the facility and services provided by the facility.

## **Patient Rights and Safety Standards**

*Mental Health (MH) and Substance Use Disorder (SUD):* For community triage centers, regulations dictate how patient money and property should be handled in terms of recordkeeping, use of a financial institution, and inventory. Policies must set forth the rights of patients provided by Nevada statute. These include but are not limited to rights related to information, communication and visits, privacy, informed consent, to be treated with dignity, and to be informed of their rights. Physical, mechanical, and chemical restraints may only be used in circumscribed instances. The use of the procedure must be reported as a denial of rights, regardless of whether the use of the procedure is authorized by statute. The report must be made not later than 1 working day after the procedure is used. Staff training must be provided. Notwithstanding statutory provisions to the contrary, a facility may use or authorize the use of physical restraint, mechanical restraint or chemical restraint on a person with a disability who is a patient if the facility is accredited by a nationally recognized accreditation association or agency; or certified for participation in the Medicaid or Medicare program, but only to the extent that the accreditation or certification allows the use of such restraint.

*Substance Use Disorder (SUD):* For facilities for treatment of abuse of alcohol or drugs and for facilities for modified medical detoxification, regulations dictate how patient money and property should be handled in terms of recordkeeping, use of a financial institution, and inventory. Policies must set forth the rights of patients provided by Nevada statute. These include but are not limited to rights related to information, communication and visits, privacy, informed consent, to be treated with dignity, and to be informed of their rights. Physical, mechanical, and chemical restraints may only be used in circumscribed instances. The use of the procedure must be reported as a denial of rights, regardless of whether the use of the procedure is authorized by statute. The report must be made not later than 1 working day after the procedure is used. Staff training must be provided. Notwithstanding statutory provisions to the contrary, a facility may use or authorize the use of physical restraint, mechanical restraint

or chemical restraint on a person with a disability who is a patient if the facility is accredited by a nationally recognized accreditation association or agency; or certified for participation in the Medicaid or Medicare program, but only to the extent that the accreditation or certification allows the use of such restraint.

Division certification requires the facility operator to notify the Division within 24 hours after the occurrence of an incident that may cause imminent danger to the health or safety of the clients, participants or staff of the program, or a visitor to the program. Division certification requires that staff assist the client in reporting any violation of law, regulation, or licensure/certification.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* For community triage centers that provide detoxification services, are a social model detoxification program, or a modified medical detoxification program, each facility shall review each such program at least annually. The review must include, without limitation, an evaluation of the appropriateness of the admission of patients; the lengths of stay of patients; planning for the discharge of patients; the use of services and utilization of the components of the program; the use of outside services; and any unusual incidents that resulted or may have resulted in harm to a patient. Written reports of these annual reviews must be evaluated by the governing body and the administrator.

*Substance Use Disorder (SUD):* Any facilities for treatment of abuse of alcohol or drugs that have a social model detoxification program must have a program of ongoing quality improvement. The program of ongoing quality improvement must establish written policies and procedures to describe and document the monitoring and evaluation activities of the program of ongoing quality improvement. The findings of the program of ongoing quality improvement, including any conclusions, recommendations, actions taken, and the results of the actions taken, must be documented. All documentation must be reported to the governing body and must be reflected in the minutes annually.

Division certification requires the facility operator to establish a plan for improving the quality of the services provided by the program which addresses, without limitation, operational services, human resources, fiscal services and clinical outcome measures; and ensuring that the integrity of the program will be maintained. Certified treatment programs, private, public or funded are required to report Treatment Episode Data Set (TEDS) to SAPTA on a monthly basis.

For facilities for modified medical detoxification, each facility shall have a written program outlining short-term and long-term objectives and goals.



## Governance

*Mental Health (MH) and Substance Use Disorder (SUD):* For community triage centers, each facility must have a governing body which has the ultimate authority for the administration of the facility. Regulatory requirements include but are not limited to ones regarding establishment of policies, appointment of an administrator and medical director, financial responsibilities, and standards of service.

*Substance Use Disorder (SUD):* For facilities for treatment of abuse of alcohol or drugs and for facilities for modified medical detoxification, every facility must have a governing body which has the ultimate authority for the administration of the overall program.

Division certification requires that the governing body be the operator of the program if it is a corporation. If not a corporation, there must be an operator that is responsible for the program. A program manual and policies are required.

## Special Populations

*Mental Health (MH) and Substance Use Disorder (SUD):* Requirements regarding residential services were not explicitly described in the state regulations.

*Substance Use Disorder (SUD):* See throughout regarding requirements related to populations with co-occurring disorders.

## Location of Regulatory and Licensing Requirements

Department of Health and Human Services Medical Facilities and Other Related Entities Regulation<sup>1</sup>; Department of Health and Human Services Medical Facilities and Other Related Entities Statute<sup>2</sup>; Department of Health and Human Services Patient Rights Statute<sup>3</sup>. NAC Chapter 458<sup>4</sup>; Division Criteria for the Certification of Programs through SAPTA per NAC 458<sup>5</sup>. Regulatory data collected July 19, 2019.

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<sup>1</sup> See <https://www.leg.state.nv.us/NAC/NAC-449.html#NAC449Sec046>.

<sup>2</sup> See <https://www.leg.state.nv.us/nrs/NRS-449.html#NRS449Sec029>.

<sup>3</sup> See <https://www.leg.state.nv.us/NRS/NRS-449A.html#NRS449ASec017>.

<sup>4</sup> See <https://www.leg.state.nv.us/NAC/NAC-458.html>.

<sup>5</sup> See

[http://dpbh.nv.gov/uploadedFiles/dpbhngov/content/Programs/ClinicalSAPTA/dta/Partners/Certification/Division%20Criteria-SAPTA%2012.2017\\_FINAL.pdf](http://dpbh.nv.gov/uploadedFiles/dpbhngov/content/Programs/ClinicalSAPTA/dta/Partners/Certification/Division%20Criteria-SAPTA%2012.2017_FINAL.pdf).

## Other Information Sources

B. Adie (Nevada DPBH); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

# NEVADA MEDICAID

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

## Approach

*Mental Health (MH) and Substance Use Disorder (SUD):* The Nevada Division of Health Care Financing and Policy (DHCFP) oversees the state Medicaid program. Nevada relies on the in lieu of provision but, historically, has not relied on Disproportionate Share Hospital (DSH) payments for coverage of certain services provided in an institution for mental diseases (IMD). Nevada does not have a relevant Section 1115 waiver.

*Mental Health (MH):* All services are excluded from Medicaid payment while a recipient is admitted to an IMD and there is no evidence in the Medicaid requirements that any type of residential mental health treatment is reimbursed, regardless of size.

*Substance Use Disorder (SUD):* Although all services are excluded from Medicaid payment while a recipient is admitted to an IMD, whether the services are provided in or outside the facility, the DHCFP covers outpatient services provided in a licensed ASAM Level 3 environment, presumably one with 16 beds or less that is not an IMD. The Medicaid program explicitly does not cover services provided under Nevada State Certification Level 2WM -- 3.7 Withdrawal Management programs.

## Types of Facilities

*Substance Use Disorder (SUD):* The Medicaid standards do encompass services in what is described as part of the outpatient program and identified as *Level 3 Residential 3.3-.5 Managed Residential*. Room and board are not a reimbursable service through the DHCFP outpatient program.

## Processes of Medicaid Enrollment

*Mental Health (MH) and Substance Use Disorder (SUD):*

- A provider must apply to be enrolled as a Nevada Medicaid provider, meet all credentialing and licensure requirements for the provider type, and enter into a provider agreement, among other things. Enrollment may be denied or terminated.

- For those providers practicing in a Behavioral Health Community Network (BHCN), there are additional requirements codified in the regulations. A program description must be submitted upon enrollment and updated annually on the anniversary of the BHCN enrollment month.

*Substance Use Disorder (SUD):*

- Level 3 Residential 3.3-.5 Managed Residential: The facility must meet the certification requirement NAC 458.103 for alcohol and drug abuse programs, be receiving funding from DPBH for services under that regulation, and, for those ages 22-64 years, not be an IMD.

## **Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD):* Under the Nevada Behavioral Health Medicaid requirements, general requirements are established for staff credentialing and supervision.

## **Placement**

*Mental Health (MH):* The Level of Care Utilization System (LOCUS) assessment tool is used to define and delineate levels of service limitations for mental health services.

*Substance Use Disorder (SUD):* The American Society of Addiction Medicine (ASAM) patient placement criteria are used to establish guidelines for level of care placements within the substance abuse continuum.

For Level 3 Residential 3.3-.5 Managed Residential, prior authorization is required on services, except for Behavioral Health/Substance Abuse Screens and 24-hour crisis intervention. Post authorization is not required for 24-hour crisis intervention. Intensity of service is dependent upon individual and presenting symptoms.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Under the Nevada Behavioral Health (BH) Medicaid requirements, a written individualized treatment plan, referred to as Treatment Plan, is a comprehensive, progressive, personalized plan that includes all prescribed BH services. A Treatment Plan is person-centered, rehabilitative and recovery oriented. The treatment plan addresses individualized goals and objectives. The objective is to reduce the

duration and intensity of BH services to the least intrusive level possible while sustaining overall health.

The Treatment Plan must be developed jointly with a qualified mental health professional (QMHP) and a representative of the patient. A QMHP must evaluate and reevaluate the Treatment Plan at a minimum of every 90 days or a shorter period as determined by the QMHP.

A Treatment Plan must include a discharge plan that identifies the planned duration of the overall services to be provided under the Treatment Plan; discharge criteria; recommended aftercare services for goals that were both achieved and not achieved during duration of the Treatment Plan; and available agencies and independent provider(s) to provide aftercare services.

## **Treatment Services**

Substance Use Disorder (SUD): For Level 3 Residential 3.3-.5 Managed Residential, there shall be medical, psychiatric, psychological services, which are available onsite or through consultation or referral. Medical and psychiatric consultations shall be available within 24 hours by telephone or in person. The following are included: (1) 24-hour crisis intervention services face to face or telephonically available seven days per week; (2) Medication management; (3) Behavioral Health/Substance Abuse Covered Screens; (4) Comprehensive biopsychosocial assessment; (5) Individual and group counseling; (6) Individual, group, family psychotherapy; and (7) Peer Support Services. There shall also be emergency services available by telephone 24 hours a day, seven days a week. Recovery and self-help groups are a part of the overall milieu.

In addition, the program must provide integrated interventions, and be a co-occurring capable or co-occurring enhanced program. Integrated interventions are specific treatment strategies or therapeutic techniques in which interventions for both disorders are combined in a single session or integration, or in a series of interactions or multiple sessions. Co-occurring capable programs are those that address co-occurring mental and substance use disorders in their policies and procedures. Co-occurring enhanced programs have a higher level of integration of substance abuse and mental health treatment services.

## **Care Coordination**

*Mental Health (MH) and Substance Use Disorder (SUD):* Under the Nevada BH Medicaid requirements, a Treatment Plan must be integrated and coordinated with other components of overall health care. Providers practicing in a BHCN must work on behalf of recipient's in their care to ensure effective care coordination within the state system of care among other community mental health providers and other agencies servicing a joint recipient.

*Substance Use Disorder (SUD):* In general, care coordination is not covered under the SUD services program by DHCFP.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* Providers practicing in a BHCN must implement and maintain a Quality Assurance (QA) program which continually assesses quality measures and seeks to improve services on an ongoing basis. A program description must be submitted upon enrollment and updated annually on the anniversary of the BHCN enrollment month.

A BHCN shall develop a QA report which shall include service requirements, an organization chart that outlines supervisory structure, training requirements, and a demonstration of the effectiveness of care, access/availability of care, and satisfaction of care.

The DHCFP may require the BHCN to submit a DHCFP approved Corrective Action Plan (CAP) if the BHCN's QA report has adverse findings.

*Substance Use Disorder (SUD):* The DHCFP requires providers who are receiving funds from the DHCFP to be deemed compliant by the DPBH, NRS and NAC. Qualification is based upon the DPBH's Substance Abuse Prevention and Treatment Agency (SAPTA) Certification tool. The certification tool reviews the program for areas such as compliance with federal and state regulations, quality improvement, applications of policies and procedures, health and safety of the recipients, clinical documentation requirements, and staff/training documentation. Non-compliance will result in the DHCFP provider termination and/or suspension without cause depending on severity of infraction.

## **Special Populations**

*Mental Health (MH) and Substance Use Disorder (SUD):* Under the Nevada BH Medicaid requirements, the Director of the Department of Health and Human Services shall, to the extent authorized by federal law, include in any state plan priority for a parent who is referred by an agency which provides child welfare services and who is qualified for public assistance to receive treatment for mental health issues, treatment for substance abuse and any other treatment or services that may assist with preserving or reunifying the family.

## Location of Medicaid Requirements

Nevada Medicaid Services Manual Chapter 100<sup>6</sup>, Chapter 400<sup>7</sup>. Regulatory data collected December 5, 2020.<sup>8</sup>

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019. <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report **“State Residential Treatment for Behavioral Health Conditions: Regulation and Policy”**. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

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<sup>6</sup> See

[http://dhcfp.nv.gov/uploadedFiles/dhcfpnavgov/content/Resources/AdminSupport/Manuals/MSM/C100/MSM\\_100\\_19\\_08\\_28.pdf](http://dhcfp.nv.gov/uploadedFiles/dhcfpnavgov/content/Resources/AdminSupport/Manuals/MSM/C100/MSM_100_19_08_28.pdf).

<sup>7</sup> See

[http://dhcfp.nv.gov/uploadedFiles/dhcfpnavgov/content/Resources/AdminSupport/Manuals/MSM/C400/MSM\\_400\\_19\\_07\\_31.pdf](http://dhcfp.nv.gov/uploadedFiles/dhcfpnavgov/content/Resources/AdminSupport/Manuals/MSM/C400/MSM_400_19_07_31.pdf).

<sup>8</sup> “The laws that apply to DHC FP can be found in the Nevada Revised Statutes (NRS) by clicking the link below called Our NRS. Per NRS Chapter 422, the DHC FP is excluded from the Nevada Administrative Code (NAC). In lieu of the NAC (NRS 233B.039), DHC FP regulations can be found in its Medicaid Operations and Services Manuals.” <http://dhcfp.nv.gov/About/Home/>.

## NEW HAMPSHIRE

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### Types of Facilities

*Mental Health (MH):* New Hampshire regulates Acute Psychiatric Residential Treatment Programs (APRTPs), which are non-hospital-based programs that are a designated receiving facility for the bureaus of behavioral health and developmental services and provides 24 hour, voluntary and involuntary psychiatric treatment and care to persons experiencing acute psychiatric symptoms.

*Substance Use Disorder (SUD):* New Hampshire regulates Substance Use Disorder Residential Treatment Facilities (SUD-RTFs). "Residential treatment" is defined as clients receiving clinical treatment for SUD in a residential setting if they do not require limited or full medical withdrawal management. Clients may require medication supervision and general oversight but do not require medications for the signs and symptoms of withdrawal. The definition includes residential treatment facilities where the residence has paid staff who provide clinical services, 24-hour structure, staff available as needed, urine drug testing conducted, and clinical treatment services that are required as a condition of residency and provided by the person, owner, developer, business organization, or any subsidiary thereof.

*Unregulated Facilities:* New Hampshire does have unregulated residential treatment facilities. Residential Treatment and Rehabilitation Facilities (RTRFs) were regulated but those regulations (Part He-P 807) expired August 19, 2019. According to state staff, those regulations are under revision. The expired regulations defined an RTRF as "a place, excluding hospitals..., which provides residential care, treatment and comprehensive specialized services relating to the individual's medical, physical, psychosocial, vocational, or educational needs." The expired rules also included regulations regarding detoxification/withdrawal management facilities. State staff indicate, however, that New Hampshire statute does address the authority of DHHS to investigate if a complaint is received on an unlicensed facility to determine if services that require licensure are being provided. Also unregulated are MH or SUD facilities owned or operated by the state, including facilities owned or operated by the Department of Corrections.

We also exclude from this summary Recovery Houses, which do not include clinical treatment within the scope of this summary. We also exclude as not requiring clinical treatment Behavioral Health Community Residences (BHCRs).



## **Approach**

The New Hampshire Department of Health and Human Services (DHHS) regulates and licenses AP RTPs and SUD-RFTs.

## **Processes of Licensure or Certification and Accreditation**

*Mental Health (MH) and Substance Use Disorder (SUD):* Licensure by the DHHS is required for operation of all AP RTPs and SUD-RFTs.

- Accreditation is not required and does not confer deemed status.
- An inspection is required for licensure and renewal. The focus of the inspections is compliance with legal requirements.
- The state does not require a Certificate of Need.
- Licensure duration is one year.

## **Cause-Based Monitoring**

*Mental Health (MH) and Substance Use Disorder (SUD):* The DHHS may inspect the facility at any time for the purpose of determining compliance with the applicable statutes and regulations and may impose remedies for non-compliance with applicable laws, including requiring submission of a plan of correction, imposing a plan of correction or fines, or denying, monitoring, suspending, or revoking a license.

## **Access Requirements**

*Mental Health (MH) and Substance Use Disorder (SUD):* A licensee may not deny admission to any person because that person does not have a guardian or an advanced directive, such as a living will or durable power of attorney for health care. Requirements regarding wait times were not located.

## **Staffing**

*Mental Health (MH):* The AP RTP is required to ensure that sufficient numbers of qualified personnel are present to meet the needs of clients at all times; there are at least 2 staff members on duty at all times while clients are in the facility, one of whom is a registered nurse;

and a psychiatrist is available 24 hours a day for face-to-face consultation. For all new hires involved in direct care, there are requirements for age, background, and other verifications of suitability and there are specific requirements for administrators, including age, education, experience, and responsibilities. Within the first 7 days of employment, all personnel must receive an orientation that [explains, among other things, clients rights, complaint procedures, duties, emergency procedures, mandatory reporting requirements. Among other things, personnel records must include a copy of any license or certification required by law, as applicable.

*Substance Use Disorder (SUD):* SUD-RTFs must, among other things, have an administrator, a medical director, medical staff, a clinical services director, clinical staff, and clinical supervisory staff, who meet specific requirements, including limits on the number supervised in given disciplines, credentials, and experience. Qualifications and licensure must be verified and the facility must provide sufficient numbers of personnel who are present in the SUD-RTF and are qualified to meet the needs of clients during all hours of operation. There must be at least one awake personnel member on duty at all times while clients are in the facility. Clinical staffing ratios are established. The facilities must ensure that all personnel receive required training. All administrators must obtain and document 12 hours of continuing education related to SUD services each annual licensing period. The facility must provide all personnel with an annual continuing education or in-service education training. Personnel must not be impaired while on the job by any substances including, but not limited to, legally prescribed medication, therapeutic cannabis, or alcohol. The SUD-RTF must have a written policy establishing procedures for the prevention, detection, and resolution of controlled substance misuse, and diversion, which applies to all personnel, and which is the responsibility of a designated employee or interdisciplinary team.

## **Placement**

*Mental Health (MH):* An APRTP may only admit or retain an individual whose needs are compatible with the facility and the services and programs offered, and whose needs can be met by the APRTP and who are mobile and can self-evacuate. However, reasonable accommodation shall be made when possible to admit clients who have mobility impairment, if evacuation assistance needs can be met. Upon admission or within 24 hours following admission, the APRTP must perform a comprehensive assessment of each client's needs. Reasons for required transfer or discharge are specified.

*Substance Use Disorder (SUD):* An SUD-RTF may only admit or retain an individual who has been determined to need the level(s) of care that the facility offers, and whose needs can be met by the facility. The licensee shall provide access to: (1) A screening and assessment interview conducted or supervised by a licensed counselor to determine: (a) That the client meets the requirements for treatment of a SUD; and (b) A determination of the appropriate ASAM level of care needed. (2) If the interview indicates a need for a clinical evaluation, the clinical evaluation shall be conducted by a licensed counselor in accordance with "TAP 21:

Addiction Counseling Competencies,” (2017 revision) using an evidenced based evaluation tool and addressing all ASAM domains to make specific determinations of need and level of care required. The SUD-RTF must perform an evaluation of each client’s needs within 24 hours following admission. Reasons for required transfer or discharge are specified.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH):* Within 24 hours of completing the initial assessment, the APRTP must develop a preliminary treatment plan. The treatment plan is reviewed at least every 30 days or as medically indicated and updated after every assessment. The licensee must develop a discharge plan with the input of the client and the guardian or agent, if any.

*Substance Use Disorder (SUD):* The SUD-RTF must develop a treatment plan upon admission or within 24 hours following admission that, among other things, includes discharge goals. Treatment plans must be updated weekly based on any changes in any ASAM domain or client status. A licensed counselor shall meet with the client at the time of discharge or transfer to establish a continuing care plan that: (1) Includes recommendations for continuing care in all ASAM domains; (2) Addresses the use of self-help groups including, when indicated, facilitated self-help; and (3) Assists the client in making contact with other agencies or services.

## **Treatment Services**

*Mental Health (MH):* APRTP services must be age and developmentally appropriate. The treatment plan must include, among other things, psychiatric evaluation, including mental status and alcohol/substance abuse evaluations, as determined necessary by the treating licensed practitioner; individual and group therapeutic activity directed towards short-term stabilization of psychiatric crises; and family education, consultation, and brief therapy, as clinically indicated. All medications and treatments must be administered in accordance with the orders of the licensed practitioner.

*Substance Use Disorder (SUD):* SUD-RTF clinical services must, among other things, be evidence-based by meeting one of the following: (a) The service is included as an evidence-based MH and SUD intervention on the SAMHSA Evidence-Based Practices Resource Center; (b) The services are published in a peer reviewed journal and found to have positive effects; or (c) The provider is able to document the services effectiveness based on a theoretical model with validated research or a documented body of research generated from similar services that indicates effectiveness. Clinical services must be designed to acknowledge the impact of violence and trauma on client’s lives and be delivered in accordance with the following: (a) The American Society of Addiction Medicine (ASAM) Criteria, 2013 edition; or (b) The Treatment Improvement Protocols and Technical Assistance Publications promulgated by SAMSHA. Core services include, among others: (1) Emergency response and crisis intervention; (2) Assistance

with taking and ordering medications as needed; (3) Assistance in arranging medical and dental appointments, which shall include assistance in arranging transportation and reminding the clients of the appointments; (4) Supervision of clients when required to offset cognitive deficits that may pose a risk to self or others; and (5) Referral to, and assistance in accessing, medication-assisted SUD treatment, either on site or off site, when clinically appropriate. The SUD-RTF must provide access to behavioral health services on-site or through referral. Specific client education is required, including related to: (1) Substance use disorders; (2) Relapse prevention; (3) Infectious diseases associated with injection drug use; (4) Sexually transmitted diseases; (5) Emotional, physical, and sexual abuse; (6) Nicotine use disorder and cessation options; and (7) The impact of drug and alcohol use during pregnancy, risks to the fetus, and the importance of informing medical practitioners of drug and alcohol use during pregnancy. Specific requirements for group education and counseling include but are not limited to group size and provider type. At a client's admission, the SUD-RTF must ensure that orders from a licensed practitioner are obtained for medications and that there is a health examination by a licensed practitioner within 30 days prior to admission or within 72 hours following admission.

## **Patient Rights and Safety Standards**

*Mental Health (MH) and Substance Use Disorder (SUD):* The patient's statutory bill of rights for residential facilities includes, but is not limited to, the following rights: dignity, privacy, confidentiality, communication, nondiscrimination, to be informed of rights, to voice grievances, to be free of abuse, and to be free of chemical or physical restraint unless certain conditions are met. Additional regulations apply to all MH facilities and include provision for review of complaints.

## **Quality Assurance or Improvement**

*Mental Health (MH):* An APRTP must establish an interdisciplinary quality assessment and improvement committee which, among other things, meets at least quarterly to evaluate quality assessment and improvement activities and makes recommendations to the governing body to improve the quality of care. Specific quality assessment and improvement activities are required, including among other things: (1) review of patterns and trends of activities which affect the quality of care; (2) ensuring that the medical staff client care recommendations are considered by the full quality assessment and improvement committee; and (3) reviewing and making recommendations for improvement in specific areas.

*Substance Use Disorder (SUD):* SUD-RTFs must develop and implement a quality improvement program that reviews policies and services and maximizes quality by preventing or correcting identified problems. As part of its quality improvement program, a quality improvement committee must be established, with specified responsibilities.

## **Governance**

*Mental Health (MH) and Substance Use Disorder (SUD):* Specific requirements for a governing body were not located for adult residential treatment facilities but the application for licensure must include information about authorization to do business and the qualifications of the administrator and for SUD treatment, the medical director. Policies and procedures are required.

## **Special Populations**

*Mental Health (MH) and Substance Use Disorder (SUD):* Requirements related to services for special populations were not found.

## **Location of Regulatory and Licensing Requirements**

Department of Health and Human Services MH/SUD regulations<sup>1</sup>; Patient's Bill of Rights statute<sup>2</sup>; MH rights regulations<sup>3</sup>; Residential Care and Health Facility Licensing statute<sup>4</sup>.  
September 27, 2019.

## **Other Information Sources**

M. Rogers & D. Shockley (BDAS DBH), P. Bradley (BMHS DHHS); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>1</sup> See [http://www.gencourt.state.nh.us/rules/state\\_agencies/he-p800.html](http://www.gencourt.state.nh.us/rules/state_agencies/he-p800.html).

<sup>2</sup> See <http://www.gencourt.state.nh.us/rsa/html/XI/151/151-21.htm>.

<sup>3</sup> See [http://www.gencourt.state.nh.us/rules/state\\_agencies/he-m200.html](http://www.gencourt.state.nh.us/rules/state_agencies/he-m200.html).

<sup>4</sup> See <http://www.gencourt.state.nh.us/rsa/html/xi/151/151-mrg.htm>.

# NEW HAMPSHIRE MEDICAID

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

## Approach

The New Hampshire Department of Health and Human Services (DHHS) oversees the state Medicaid program. New Hampshire also has a Section 1115 waiver permitting Medicaid expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD), including residential treatment. The state also historically has relied on the in lieu of provision and on Disproportionate Share Hospital (DSH) payments for Medicaid coverage of some IMD services.

## Types of Facilities

*Mental Health (MH):* Researchers found no evidence of Medicaid reimbursement for adult residential MH treatment services.

*Substance Use Disorder (SUD):* State regulations require that all SUD treatment and recovery support services providers must be enrolled as a New Hampshire Medicaid provider.

Under the Section 1115 waiver, Medicaid expenditures are authorized for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are short-term (objective of statewide average length of stay of 30 days) residents in facilities that meet the definition of an institution for mental disease (IMD) and that are residential facilities. Facilities included are:

- Residential Treatment.
- Medically Monitored/Supervised Withdrawal Management.

Under the waiver, MAT may be provided in residential settings.

## **Processes of Medicaid Enrollment**

*Substance Use Disorder (SUD):* All residential SUD treatment providers must be licensed by the New Hampshire Department of Health and Human Services (DHHS) and all must be enrolled as Medicaid providers.

## **Staffing**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other comparable, nationally recognized, SUD-specific program standards regarding, in particular, credentials of staff for residential treatment settings. The state must assess the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT.

Under state Medicaid regulations, rehabilitative services provided by a Medicaid enrolled comprehensive SUD program (which includes residential programs), as well as medically managed withdrawal treatment (Level 3.7-WM) in residential treatment facilities, must be delivered by psychotherapists, MLADCs, physicians, or advanced practice registered nurses (APRNs) meeting specific qualifications.

According to the New Hampshire Section 1115 SUD implementation plan, additional personnel requirements are included in state contracts with providers.

## **Placement**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other comparable assessment and placement tools that reflect evidence-based clinical treatment guidelines. The state also must establish a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings.

All substance use disorder treatment programs and insurance carriers in the state are required to utilize the ASAM Criteria for placement by state law. In addition, all state-funded treatment providers, are contractually obligated to use evidence based screening and assessment tools.

## **Treatment and Discharge Planning and Aftercare Services**

*Substance Use Disorder (SUD):* Providers must develop a treatment plan that is updated at least every 4 sessions or 4 weeks, whichever is less frequent. All providers must adhere to continuing care and discharge guidelines, including but not limited to: (1) Closed loop referrals to community providers; (2) Providing active outreach to clients following discharge; and (3) Coordinating referrals, acceptance, and appointments for required services prior to discharge. All services must have continuing care, transfer and discharge plans that address all ASAM domains and must begin the process of discharge/transfer planning at the time of the client's intake into the program.

## **Treatment Services**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions. In addition, the state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other comparable, nationally recognized, SUD-specific program standards regarding, in particular, the types of services and hours of clinical care for residential treatment settings. The waiver also requires the state to establish a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site.

Medicaid SUD services must be evidence-based and, when clinically appropriate, include referral to, and assistance in accessing, medication assisted SUD treatment either on site or off site. Services must include an assessment of all recipients for risk of self-harm at all phases of treatment, such as at initial contact, during screening, intake, admission, on-going treatment services, and at discharge; be consistent with the "Addiction Counseling Competencies, TAP 21"; be provided in accordance with the ASAM Level of Care service descriptions, as applicable; and be provided at a length of time and frequency of care based on individual client need in accordance with ASAM Criteria and not on predetermined time or frequency limits. Standards for services are established that require consistency with Levels 3.1, 3.5, and 3.7-WM of the ASAM Criteria, including hours of service.

## **Care Coordination**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, beneficiaries will have access to improved care coordination and care for comorbid physical and mental health



conditions. The state must ensure establishment and implementation of policies to ensure residential facilities link beneficiaries with community-based services and supports following stays in these facilities.

Pursuant to the waiver implementation plan, language regarding collaboration of care coordination for all entities offering it to clients with SUD will be added to state contracts, He-W 513 rules, and updated managed care contracts. This will ensure continuity between various levels of care coordination provided to clients by multiple entities. The goal with this language change will be to reduce duplication and communication errors regarding care coordination responsibilities. Specific requirements and standards for care coordination for co-occurring physical and mental health conditions will be added to the regulations. These rules will apply to all SUD Medicaid providers and state-funded SUD treatment providers. This language will come from a modified model of care coordination that is supported by the state's 1115(a) DSRIP Transformation Waiver.

## **Quality Assurance or Improvement**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings.

## **Special Populations**

*Substance Use Disorder (SUD):* No Medicaid requirements were located other than the requirement in the Section 1115 waiver that care for comorbid physical and mental health conditions be improved by the demonstration and indication in the waiver implementation plan that regulations will be amended to accomplish that.

## **Location of Medicaid Requirements**

New Hampshire Medicaid Rules and Regulations<sup>5</sup>; New Hampshire Medicaid Provider Agreement<sup>6</sup>; New Hampshire 1115 Waiver<sup>7</sup>. Regulatory data collected December 2019.

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<sup>5</sup> See [http://www.gencourt.state.nh.us/rules/state\\_agencies/he-w500.html](http://www.gencourt.state.nh.us/rules/state_agencies/he-w500.html).

<sup>6</sup> See <https://nhmmis.nh.gov/portals/wps/wcm/connect/04c21d804ac7509c8aa9dfa36af9e3a5/NH+Medicaid+Provider+Participation+Agreement+20190806.pdf?MOD=AJPERES>.

<sup>7</sup> See <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/nh-sud-treatment-recovery-access-ca.pdf>.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019. <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report **“State Residential Treatment for Behavioral Health Conditions: Regulation and Policy”**. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

## NEW JERSEY

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### Types of Facilities

**Mental Health (MH):** New Jersey does not regulate adult residential MH treatment facilities within the scope of this summary.

**Substance Use Disorder (SUD):** New Jersey regulates residential SUD treatment facilities or programs, which means “a facility, or a distinct part of a facility that provides care for the treatment” of SUDs, for 24 or more consecutive hours to two or more clients who are not related to the governing authority or its members by marriage, blood or adoption. This includes facilities that provide residential SUD treatment services to women with dependent children and adult males and/or females. These facilities include:

- Halfway houses, which means a residential SUD treatment facility, operating in a physically separate location, in which the halfway house treatment modality is programmatically separate and distinct from short-term or long-term SUD residential services. A halfway house provides SUD treatment designed to assist clients in adjusting to regular patterns of living, engaging in occupational training, obtaining gainful employment and independent self-monitoring and generally approximates ASAM PPC-2R, Level III.1 (low intensity) treatment.
- Long-term residential facilities, which means a SUD facility in which treatment is primarily designed to foster personal growth and social skills development, with intervention focused on reintegrating the client into the greater community, and where education and vocational development are emphasized and generally approximates ASAM PPC-2R, Level III.5 (high intensity, clinically-managed) treatment.
- Short-term residential facilities, which means a SUD treatment facility in which treatment is designed primarily to address specific addiction and living skills problems through a prescribed 24-hour per day activity regimen on a short-term basis, and generally approximates ASAM PPC-2R, Level III.7 (medically monitored intensive inpatient treatment) treatment.
- Non-hospital-based (medical) detoxification [withdrawal management], which means a residential SUD treatment facility designed primarily to provide short-term care prescribed by a physician and conducted under medical supervision to treat a client's

physical symptoms caused by withdrawal from substances, according to medical protocols appropriate to each type of addiction, and generally approximates ASAM PPC-2R, Level 3.7WM (medically monitored inpatient withdrawal management) treatment.

*Unregulated Facilities:* There are no unregulated adult residential SUD treatment facilities in New Jersey. There potentially are unregulated adult residential MH treatment facilities in the state. We exclude from this summary supervised residences for adults with mental illness, community residences for adults with mental illness, and residential health care facilities, as not providing clinical mental health treatment within the scope of this summary. We exclude special treatment units operated by the Department of Corrections. We also exclude short term care facilities, IPUs, and hospital-based medically managed withdrawal management, which are located in hospitals.

## **Approach**

Pursuant to the New Jersey Reorganization Plan 001-2018<sup>1</sup>, regulation of SUD treatment lies with the Department of Human Services (DHS) but licensure for those programs is under the Department of Health, Office of Certificate of Need and Licensure (OCN&L).

## **Processes of Licensure or Certification and Accreditation**

*Substance Use Disorder (SUD):* Licensure by the OCN&L is required for operation of all residential SUD treatment facilities.

- Accreditation is not required and deemed status is not currently included in the regulations. The regulations do state that compliance with the standards set by the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF) is required “as applicable.”
- An inspection is required for licensure and renewal.
- The state does have a Certificate of Need law.
- Licensure duration is one year.

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<sup>1</sup> See <https://www.nj.gov/humanservices/documents/June%2020%20reorganization%20plan.pdf>.

## **Cause-Based Monitoring**

*Substance Use Disorder (SUD):* Authorized staff may conduct announced or unannounced visits and periodic surveys of licensed facilities. Survey visits could include: (1) Review of the physical plant and architectural plans; (2) Review of all documents and client records; (3) Conferences or one-on-one interviews with clients and staff; and (4) Review of compliance with criteria set forth in this chapter.” These surveys could also be conducted in response to complaints. Enforcement remedies, including corrective action up to a revocation of licensure, may be used.

## **Access Requirements**

*Substance Use Disorder (SUD):* Wait-time requirements were not found.

## **Staffing**

*Substance Use Disorder (SUD):* All SUD treatment facilities must meet specific patient to staff ratios for direct care staff and substance abuse counselors meeting specified qualifications. Additional ratios are specified for facilities serving women and children. Standards are in place regarding qualifications of a medical director (required for all other than halfway houses), psychiatrists, nursing staff (required for short-term and long-term residential, and non-hospital-based (medical) withdrawal management facilities), a director of nursing, staff for withdrawal management services, an administrator, a director of SUD services, counseling staff, non-counseling staff, dietitians and food service supervisors. The facility administrator must develop written policies and procedures that determine the period of time during which staff in recovery are determined to be substance free before being employed by the facility. The facility also must develop a staff orientation plan and a staff education plan, that includes written plans for each service and designation of person(s) responsible for training that includes orientation at the time of employment and annual educating on topics such as emergency plans and procedures, client rights, treating individuals with co-occurring disorders, and cultural competence, among other things.

## **Placement**

*Substance Use Disorder (SUD):* For residential SUD treatment facilities, staff must conduct a preadmission interview with all clients. Upon admission, clients must receive a physical examination and, within 72 hours of admission, “a comprehensive biopsychosocial assessment of all clients using the Addiction Severity Index or a similar standardized validated assessment instrument that assesses medical status, employment and support, tobacco, drug and alcohol use, legal status, family status/social status, psychiatric status, including diagnosis, as well as behavioral risk factors for HIV and Hepatitis. In order to ensure that the client is placed in the

appropriate treatment facility, the client must be assessed for level of care determination based upon the ASAM PPC-2R.” At the time of assessment, all clients must also be screened for co-occurring disorders and, as appropriate, provided with or referred for full diagnosis and treatment planning.

## **Treatment and Discharge Planning and Aftercare Services**

*Substance Use Disorder (SUD):* Treatment/service planning is required for SUD treatment facilities. Plans must be revised as assessments are completed or new information is obtained. A team review must be completed at least every 30 days. Discharge planning (or continuum of care planning) beginning at admission is required. Aftercare service or follow-up requirements were not found.

## **Treatment Services**

*Substance Use Disorder (SUD):* Residential SUD treatment facilities must provide “medical and nursing services (including assessment, diagnostic, treatment), counseling, vocational, educational, case management and other supportive services.” Additionally, every residential SUD facility must provide substance abuse counseling on-site. The facility must provide each client education with respect to the client's drug, alcohol and tobacco use, risk of exposure to AIDS and hepatitis, other health consequences of SUD, relapse prevention, needs of clients with co-occurring disorders and gender-specific issues such as domestic violence, parenting and sexual abuse, for at least the number of hours per week specified in the regulations. All facilities are required to design treatment programs that designate at least seven hours each week for structured activities, including “individual and/or group counseling, psychoeducation, life skills training, vocational training/activity, education, recreation and self-help meetings.” Substance abuse counseling is to be provided for the amount time and at the frequency established in the regulations. Each facility also must provide family counseling as clinically indicated.

## **Patient Rights and Safety Standards**

*Substance Use Disorder (SUD):* All clients have the right, among other things, to be informed of their rights, notified of any facility rules or policies, informed of services available in the facility, participate in the planning of their treatment, and voice grievances or recommend changes in policies and services. All facilities must develop policies and procedures that govern reporting and management of reportable events. In residential facilities, no restraints, except for pharmacological restraints in facilities that provide medical withdrawal management services, are permitted.

## Quality Assurance or Improvement

*Substance Use Disorder (SUD):* Facilities must “establish and implement an integrated comprehensive quality assurance program for client care, review the program at least annually and revise the program as necessary.” Among other things, the quality assurance program must incorporate all of the facility's quality assurance plans and discipline specific (medical, nursing, client care) quality assurance programs and identify one staff person who is responsible for administering the facility's quality assurance program and complying with the regulatory requirements.

## Governance

*Substance Use Disorder (SUD):* Every facility must have a governing authority, which assumes legal responsibility for the management, operation, and financial viability of the facility. Among other things, the governing authority, must have written policies and procedures concerning specific matters, act in accordance with a plan of operation or bylaws, and appoint and oversee the administrator.

## Special Populations

*Substance Use Disorder (SUD):* Facilities must ensure their policies and procedures are developed for the care of the general client population, but that the procedures address the needs of “any special populations that the facility may serve including, but not limited, to pregnant women, women with dependent children, adolescents, homeless and/or indigent, individuals with physical disabilities, individuals with communication limitations requiring communication services or persons with co-occurring mental health disorders.” Additional requirements apply to facilities that serve clients with co-occurring disorders, including regarding staff qualifications; clinical supervision; treatment planning; and policies and procedures for developing and maintaining affiliation agreements, case consultation, coordination and referral mechanisms to MH treatment services to facilitate the provision of integrated treatment.

## Location of Regulatory and Licensing Requirements

Department of Human Services Community Mental Health Program statutes title 30, chapter 9A<sup>2</sup>; MH licensing regulations<sup>3</sup>; Department of Human Services SU regulations<sup>4</sup>; Department of Health licensure regulations title 8, chapter 43E<sup>5</sup>. Regulatory data collected June 24, 2019.

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<sup>2</sup> See <https://law.justia.com/codes/new-jersey/2013/title-30/section-30-9a-1/>.

## Other Information Sources

V. Fresolone (DHS); personal communication K. Neylon (NRI) to P. O'Brien (IBM) 9-18-2019;  
Reorganization Plan 001-2018

<https://www.nj.gov/humanservices/documents/June%2020%20reorganization%20plan.pdf>

National Conference of State Legislatures CON Program Overview,

<http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>3</sup> See

[https://www.state.nj.us/humanservices/providers/rulefees/regs/NJAC%2010\\_190%20Licensure%20Standards%20for%20Mental%20Health%20Programs.pdf](https://www.state.nj.us/humanservices/providers/rulefees/regs/NJAC%2010_190%20Licensure%20Standards%20for%20Mental%20Health%20Programs.pdf).

<sup>4</sup> See

[https://www.state.nj.us/humanservices/providers/rulefees/regs/NJAC%2010\\_161A%20Standards%20for%20Licensure%20of%20Residential%20Substance%20Use%20Disorders%20Treatment%20Facilities.pdf](https://www.state.nj.us/humanservices/providers/rulefees/regs/NJAC%2010_161A%20Standards%20for%20Licensure%20of%20Residential%20Substance%20Use%20Disorders%20Treatment%20Facilities.pdf).

<sup>5</sup> See

<https://advance.lexis.com/container?config=00JAA5OTY5MTdjzi1lMzYxLTQxNTEtOWFkNi0xMmU5ZTViODQ2M2MKAFBvZENhdGFsb2coFSYEAfv22IKqMT9DIHrf&crd=d62676d0-fb95-4e87-927c-89bb8e706579>.



# NEW JERSEY MEDICAID

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## Approach

The New Jersey Department of Human Services (DHS) oversees the state Medicaid program. New Jersey also has a Section 1115 waiver permitting Medicaid expenditures for the provision of substance use disorder (SUD) treatment services provided to Medicaid beneficiaries ages 21-64 while residing in residential treatment facilities that meet the definition of an Institution for Mental Diseases (IMD). New Jersey does rely on the in lieu of provision and Disproportionate Share Hospital (DSH) Payments to pay for certain services in IMDs.

## Types of Facilities

*Mental Health (MH):* New Jersey Medicaid reimburses for rehabilitative services provided in or by community residences for adults with mental illness, as well as in other settings. Because these facilities do not require clinical treatment within the realm of these summaries, they are excluded from discussion here.

*Substance Use Disorder (SUD):* The New Jersey Section 1115 waiver permits expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term (statewide average length of stay of 30 days) residents in facilities that meet the definition of an institution for mental diseases (IMD). The residential settings identified in the waiver include the following:

- Long Term Residential (LTR), ASAM 3.5.
- Short term residential, ASAM 3.7 and Withdrawal Management (WM) services.

Medication-assisted treatment also is to be available to those in IMDs.

## Processes of Medicaid Enrollment

*Mental Health (MH) and Substance Use Disorder (SUD):* To be enrolled as a Medicaid provider in New Jersey, the provider must, among other things, submit an application with necessary

information and sign a provider agreement. Enrollment may be denied or terminated, and reenrollment may be required “from time to time.” Maintenance of appropriate licensure is required.

## **Staffing**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding credentials of staff for residential treatment settings. The state must assess the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT.

## **Placement**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines. The state also must establish a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings.

## **Treatment and Discharge Planning and Aftercare Services**

*Substance Use Disorder (SUD):* Requirements were not explicitly described in the state Medicaid regulations or the Section 1115 waiver.

## **Treatment Services**

*Substance Use Disorder (SUD):* Under the Section 1115 waiver, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions. The state will establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other

comparable, nationally recognized, SUD-specific program standards regarding in particular the types of services and hours of clinical care for residential treatment settings. In accordance with the state 1115 waiver, there shall be the establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site.

## Care Coordination

*Substance Use Disorder (SUD):* Under the Section 1115 waiver, beneficiaries will have improved care coordination and care for comorbid physical and mental health conditions. The state must ensure establishment and implementation of policies to ensure residential facilities link beneficiaries with community-based services and supports following stays in these facilities.

## Quality Assurance or Improvement

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings.

## Special Populations

*Substance Use Disorder (SUD):* No Medicaid requirements were located other than the requirement in the Section 1115 waiver that care for comorbid physical and mental health conditions be improved by the demonstration.

## Location of Medicaid Requirements

New Jersey Department of Human Services, Division of Medical Assistance and Health Services Administrative Rules and Regulations, 10:49 et seq.<sup>6</sup>; New Jersey FamilyCare Comprehensive Demonstration (formerly New Jersey Comprehensive Waiver)<sup>7</sup>; SUD Implementation Protocol<sup>8</sup>. Regulatory data collected January 2020.

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<sup>6</sup> See <https://www.state.nj.us/humanservices/providers/rulefees/regs/>.

<sup>7</sup> See <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8017>.

<sup>8</sup> See <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nj/Comprehensive-Waiver/nj-1115-request-sud-imp-prtclt-appvl-05172018.pdf>.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report **“State Residential Treatment for Behavioral Health Conditions: Regulation and Policy”**. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

## NEW MEXICO

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### Types of Facilities

*Mental Health (MH) and Substance Use Disorder (SUD):* New Mexico regulates Crisis Triage Centers (CTCs), which provide outpatient or short-term residential stabilization of behavioral health crises, as an alternative to hospitalization or incarceration. The CTC provides emergency behavioral health triage and evaluation, including services to manage individuals at high risk of suicide or intentional self-harm, and may provide limited detoxification services. No other regulated MH or SUD residential treatment facility types were identified.

*Unregulated Facilities:* No residential treatment facilities other than CTCs are currently regulated. Adult Residential Treatment Centers (ARTCs), which presently are not included in the New Mexico licensing regulations, contract with the state for non-Medicaid services, paid through state general funds.<sup>1</sup>

### Approach

*Mental Health (MH) and Substance Use Disorder (SUD):* The New Mexico Department of Health (DOH), Division of Health Improvement (DHI) regulates all CTCs.

### Processes of Licensure or Certification and Accreditation

*Mental Health (MH) and Substance Use Disorder (SUD):* CTCs must apply for licensure by the DOH in order to operate in the state.

- Accreditation is not required for CTCs.
- A facility survey is required for licensure and renewal.
- A Certificate of Need is not required for CTCs.

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<sup>1</sup> As noted in the Medicaid portion of this summary, the Section 1115 waiver includes ARTCs.

- Licensure is applied for annually, and the application focuses on general compliance with regulatory requirements, and should include the building plans, building approvals, environment department approvals, board of pharmacy approvals, a program description, and program policies and procedures.

## **Cause-Based Monitoring**

*Mental Health (MH) and Substance Use Disorder (SUD):* The DOH performs renewal surveys for CTCs and may conduct announced or unannounced surveys, as well as requiring a plan of correction should the DOH become aware of deficiencies. Licensure may be denied, revoked, or suspended.

## **Access Requirements**

*Mental Health (MH) and Substance Use Disorder (SUD):* Wait-time requirements were not found but CTCs must comply with the Americans with Disabilities Act.

## **Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD):* (1) The CTC shall have an on-site administrator, which can be the same person as the clinical director; (2) The CTC shall have a full time clinical director appropriately licensed to provide clinical oversight; (3) The CTC shall have an RN present on-site 24 hours a day, seven days a week or as long as clients are present in programs that do not offer residential services, to provide direct nursing services; (4) An on-call physician or advanced practice registered nurse shall be available 24 hours a day by phone, and available on-site as needed or through telehealth; (5) Consultation by a psychiatrist or prescribing psychologist may be provided through telehealth; (6) The CTC shall maintain sufficient staff including direct care and mental health professionals to provide for supervision and the care of residential and non-residential clients served by the CTC, based on the acuity of client needs; and (7) At least one staff trained in basic cardiac life support (BCLS) and first aid shall be on duty at all times. In addition, one staff trained in the use of the automated external defibrillator (AED) equipment shall also be on duty.

The Administrator must be at least 21 and possess experience in acute mental health and hold at least a bachelor's degree in the human services field or be a registered nurse with experience or training in acute mental health treatment. The clinical director shall be at least 21 and a licensed independent mental health professional or certified nurse practitioner or certified nurse specialist with experience and training in acute mental health treatment and withdrawal management services, if withdrawal management services are provided.

Training for each new employee and volunteer who provides direct care shall include a minimum of 16 hours of training and be completed prior to providing unsupervised care to clients. At least 12 hours of on-going training shall be provided to staff that provides direct care at least annually; the training and proof of competency shall include, but not be limited to: (1) behavioral health interventions; (2) crisis interventions; (3) substance use disorders and co-occurring disorders; (4) withdrawal management protocols and procedures, if withdrawal management is provided; (5) clinical and psychosocial needs of the population served; (6) psychotropic medications and possible side effects; (7) ethnic and cultural considerations of the geographic area served; (8) community resources and services including pertinent referral criteria; and (9) treatment and discharge planning with an emphasis on crisis stabilization.

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* Use of the ASAM criteria, including placement requirements, is only required for people needing detoxification, and a CTC shall not provide detoxification services beyond Level III.7-D: Medically Monitored Inpatient Detoxification services. The admission assessment must contain an assessment of past trauma or abuse, how the individual served would prefer to be approached should he become dangerous to himself or to others and the findings from this initial assessment shall guide the process for determining interventions. The assessment must include: medical and mental health history and status, the onset of illness, the presenting circumstances, risk assessment, cognitive abilities, communication abilities, social history and history as a victim of physical abuse, sexual abuse, neglect, or other trauma as well as history as a perpetrator of physical or sexual abuse.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Treatment and discharge planning are required beginning at admission. Discharge plan and summary information shall be provided to the client at the time of discharge that includes recommendations and documentation for continued care, including appointment times, locations and contact information for providers; and recommendations for community services if indicated with contact information for the services.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* In addition to emergency behavioral health triage and evaluation and possible detoxification services, trauma-informed care is required. For example, crisis intervention plans must document the use of physical restraints and address: the client's medical condition(s); the role of the client's history of trauma in

his/her behavioral patterns; specific suggestions from the client regarding prevention of future physical interventions. Additionally, the admission assessment should document instances of past trauma. No references to medication-assisted treatment specific to residential treatment were identified.

## **Patient Rights and Safety Standards**

*Mental Health (MH) and Substance Use Disorder (SUD):* All facilities shall report to the licensing authority any serious incidents or unusual occurrences which have threatened, or could have threatened the health, safety and welfare of the clients. The CTC shall develop policies and procedures addressing risk assessment and mitigation. The policies and procedures must address the CTC's response to clients that present with imminent risk to self or others, assaultive and other high-risk behaviors, and must prohibit seclusion and address physical restraint, if used. The use of physical restraint must be consistent with federal and state laws and regulation. Physical restraint shall not be used as punishment or for the convenience of staff. Physical restraints are implemented only by staff who have been trained and certified by a recognized program in the prevention and use of physical restraint. This training emphasizes de-escalation techniques and alternatives to physical contact with clients as a means of managing behavior and allows only the use of reasonable force necessary to protect the client or other person from imminent and serious physical harm. Clients and youth do not participate in the physical restraint of other clients and youth. The use of physical restraint must be consistent with federal and state laws and regulation. Chemical and mechanical restraints are prohibited. Crisis intervention plans must document the use of physical restraints and address: the client's medical condition(s); the role of the client's history of trauma in his/her behavioral patterns; specific suggestions from the client regarding prevention of future physical interventions.

Suicide risk interventions must include the following: (1) a registered nurse or other licensed mental health professional may initiate suicide precautions and must obtain physician or advanced practice registered nurse order within one hour of initiating the precautions; (2) modifications or removal of suicide precautions shall require clinical justification determined by an assessment and shall be ordered by a physician or advanced practice registered nurse and documented in the clinical record; (3) staff and client shall be debriefed immediately following an episode of a suicide attempt or gesture, identifying the circumstances leading up to the suicide attempt or gesture; and (4) an evaluation of the client by a medical, psychiatric or independently licensed mental health provider must be done immediately, or the client must be transferred to a higher level of care immediately.



## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* The CTC shall establish written policies and procedures which govern the CTC's operation and that are reviewed annually and approved by the governing body. The administrator shall ensure that these policies and procedures are adopted, administered and enforced to provide quality services in a safe environment. At a minimum, the CTC's written policies and procedures shall include how the CTC intends to comply with all requirements of the regulations and address ways in which each CTC shall establish and maintain quality improvement systems including policies and procedures for quality assurance and quality improvement and have a quality committee.

The CTC shall establish a quality committee comprised at a minimum of the administrator, clinical director, director of nursing, licensed mental health professional, certified peer support worker, and psychiatrist. The committee shall establish and implement quality assurance and quality improvement systems that monitor and promote quality care to clients. The systems are approved by the governing body and updated annually. The quality improvement systems must include: (a) chart reviews; (b) annual review of policies and procedures; (c) data collection, and other program monitoring processes; (d) data analyses; (e) identification of events, trends and patterns that may affect client health, safety or treatment efficacy; (f) identification of areas for improvement; (g) intervention plans, including action steps, responsible parties, and completion time; and, (h) evaluation of the effectiveness of interventions.

The quality committee shall review at a minimum, the following: (1) high-risk situations and critical incidents (such as suicide, death, serious injury, violence and abuse, neglect and exploitation) within 24 hours; (2) medical emergencies; (3) medication variance; (4) infection control; (5) emergency safety interventions including any instances physical restraints; and (6) environmental safety and maintenance.

The quality committee is responsible for the implementation of quality improvement processes. The quality committee shall submit a quarterly report to the governing body for review and approval and shall evaluate the CTC's effectiveness in improving performance.

## **Governance**

*Mental Health (MH) and Substance Use Disorder (SUD):* CTCs must have a formally constituted governing body or operate under the governing body of the legal entity, which has ultimate authority over the CTC. The governing body shall: (1) establish and adopt bylaws that govern its operation; (2) approve policies and procedures; (3) appoint an on-site administrator or chief executive officer/administrator for the CTC; and (4) review the performance of the administrator/chief executive officer at least annually. The CTC shall establish written policies and procedures on specified subjects that are reviewed annually and approved by the governing body, which govern the CTC's operation.

## **Special Populations**

*Mental Health (MH) and Substance Use Disorder (SUD):* Direct care staff must have training and proof of competency in SUDs and co-occurring disorders.

## **Location of Regulatory and Licensing Requirements**

Department of Health, Crisis Triage Center regulations<sup>2</sup>. Regulatory data collected August 30, 2019.

## **Other Information Sources**

C. Melugin (NM HSD); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>2</sup> See <http://164.64.110.134/parts/title07/07.030.0013.html>.

# NEW MEXICO MEDICAID

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## Approach

The New Mexico Human Services Department (HSD) oversees the state Medicaid program. New Mexico also has a Section 1115 waiver permitting coverage of Medicaid enrollees diagnosed with a substance use disorder (SUD) who are short term residents in residential treatment facilities that meet the definition of an Institution for Mental Diseases (IMD). It also has historically relied on the in lieu of provision to reimburse certain services in IMDs but not on Disproportionate Share Hospital (DSH) payments.

## Types of Facilities

*Mental Health (MH) and Substance Use Disorder (SUD):* Pursuant to a Medicaid state plan amendment effective January 1, 2019, Medicaid coverage is provided of services in Crisis Triage Centers (CTCs) set in residential treatment facilities with no more than 16 beds. They provide voluntary stabilization of behavioral health crises including emergency mental health evaluation, withdrawal management, and care.

*Substance Use Disorder (SUD):* The New Mexico Section 1115 waiver provides coverage for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are short-term (statewide average length of stay of 30 days) residents in facilities that meet the definition of an IMD. The residential settings specified in the waiver include the following:

- Adult residential treatment.
- Medically supervised withdrawal management.

The state was required by the Section 1115 OUD/SUD program demonstration approval to provide ASAM Level 3 treatment services, which previously were not covered by Medicaid in the state. New Mexico elected to incorporate residential treatment into the state plan and into its Medicaid regulations. Effective January 1, 2019, the state plan was amended to include Medicaid coverage of Accredited Residential Treatment Centers (ARTCs) for Adults with SUD. The sections below on placement, staffing, and services provide additional information on the

provision of Levels 3.1, 3.2-WM, 3.3, 3.5, 3.7, and 3.7-WM services within the Medicaid program.

## **Processes of Medicaid Enrollment**

*Mental Health (MH) and Substance Use Disorder (SUD):* To be reimbursed by Medicaid, CTCs must be enrolled as Medicaid providers and licensed by the state Department of Health and certified by the HSD Behavioral Health Services Division (BHSD). All Medicaid providers must adhere to provisions of all statutes, regulations, rules, and executive orders. Surveys may be conducted and provider status may be terminated or revoked.

*Substance Use Disorder (SUD):* To be reimbursed by Medicaid, an ARTC: (a) must be accredited by JC, COA, or CARF as an adult (18 and older) residential treatment facility; (b) must have written policies and procedures specifying ASAM level of care three criteria as the basis for accepting eligible recipients into the sub-level treatment program; (c) must meet ASAM treatment service requirements for the ASAM level of care three recipients it admits into each sub-level of care; (d) must provide medication assisted treatment (MAT) for SUD, as indicated; and (e) all practitioners shall be trained in ASAM principles and levels of care.

## **Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD):* For a CTC: Practitioners must be contracted or employed by the provider agency as part of its crisis triage center service delivery. All providers must be licensed in New Mexico for services performed in New Mexico. For services performed by providers licensed outside of New Mexico, a provider's out-of-state license may be accepted in lieu of licensure in New Mexico if the out-of-state licensure requirements are similar to those of the state of New Mexico. For services provided under the public health service including IHS, providers must meet the requirements of the public health service corps.

The facility shall maintain sufficient staff including supervision and direct care and mental health professionals to provide for the care of residential and non-residential clients served by the facility, based on the acuity of client needs. The following individuals and practitioners must be contracted or employed by the provider agency as part of its crisis triage center service delivery: (a) An on-site administrator which can be the same person as the clinical director. The administrator is specifically assigned to crisis triage center service oversight and administrative responsibilities and meets specified age, experience, and credentialing requirements. (b) A full time clinical director that meets requirements regarding age, licensure, experience, and training. (c) A charge nurse on duty during all hours of operation under whom all services are directed, with the exception of the physician's and who meets age, credentialing, and licensure requirements. (d) A regulation and licensing department (RLD) master's level licensed mental

health practitioner. (e) Certified peer support workers (CPSW) holding a certification by the New Mexico credentialing board for behavioral health professionals as a certified peer support worker staffed appropriate to meet the client needs 24 hours a day 7 days a week. (f) An on call physician during all hours of operation who meets certain education and licensure requirements. (g) A part time psychiatric consultant or prescribing psychologist, hours determined by size of center, who meets credentialing, licensure, and board eligibility or certification standards. These services may be provided through telehealth. (h) At least one staff trained in basic cardiac life support (BCLS), the use of the automated external defibrillator (AED) equipment, and first aid shall be on duty at all times.

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must conduct an assessment of the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT.

State Medicaid regulations specify that a clinically-managed ARTC facility must provide 24-hour care with trained staff. Treatment must be provided under the direction of an independently licensed clinician/practitioner as defined by ASAM criteria level three for the sub-level of treatment being rendered.

The state plan amendment and/or regulations regarding staffing required as part of Level 3 facilities are as follows:

- Level 3.2-WM: Services are managed by behavioral health professionals, with protocols in place should a patient's condition deteriorate and appear to need medical or nursing interventions.
- Level 3.7: Services include 24-hour nursing care with physician availability for significant problems; other interdisciplinary staff of trained clinicians may include counselors, social workers, psychologists available to assess and treat the recipient and to obtain and interpret information regarding recipient needs; also addiction specialists, peer support workers; 16 hour/day counselor availability.
- Level 3.7-WM: Services are provided by an interdisciplinary staff of nurses, counselors, social workers, addiction specialists, peer support workers or other health and technical personnel under the direction of a licensed physician; services are monitored by medical or nursing professionals, with 24-hour nursing care and physician visits as needed, with protocols in place should a patient's condition deteriorate and appear to need intensive inpatient withdrawal management interventions.

## Placement

*Mental Health (MH) and Substance Use Disorder (SUD):* For a CTC, an eligible recipient who is 18 years of age or older must meet the crisis triage center admission criteria for an adults-only agency. Recipients may also have other co-occurring diagnoses. The CTC shall not refuse service to any recipient who meets the agency's criteria for services, or solely based on the recipient being on a law enforcement hold or living in the community on a court ordered conditional release. Crisis triage services do not require prior authorization, but are provided as approved by the crisis triage center provider agency.

*Substance Use Disorder (SUD):* Under the Section 1115 waiver, the state must offer a full range of SUD treatment options using American Society for Addiction Medicine (ASAM) criteria for assessment and treatment decision making. The state must establish a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines. The state also must establish a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings.

Medicaid regulations indicate admission and treatment criteria based on the sub-levels of ASAM level three criteria must be met for ARTCs. The differing sub-levels of ASAM three are based on the intensity of clinical services, particularly as demonstrated by the degree of involvement of medical and nursing professionals. The defining characteristic of level three ASAM criteria is that they serve recipients who need safe and stable living environments to develop their recovery skills. They are transferred to lower levels of care when they have established sufficient skills to safely continue treatment without the immediate risk of relapse, continued use, or other continued problems, and are no longer in imminent danger of harm to themselves or others.

The state plan amendment and/or Medicaid regulations impose the following additional placement standards for Level 3 facilities:

- Level 3.1 Clinically Managed Low-Intensity Residential Treatment Services: This level is often a step down from a higher level of care and prepares the recipient for outpatient treatment and community life.
- Level 3.2-WM Clinically Managed Residential Withdrawal Management: Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery. The recipient remains in a Level 3.2 withdrawal management program until: (i) withdrawal signs and symptoms are sufficiently resolved that he or she can be safely managed at a less intensive level of care;

or (ii) the recipient's signs and symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of withdrawal management services is indicated. 3.2-WM typically lasts for no more than 30 days.

- Level 3.3. Clinically Managed Population-Specific High Intensity Residential Services: Level 3.3 meets the needs of recipients with cognitive difficulties needing more specialized individualized services. The cognitive impairments can be due to aging, traumatic brain injury, acute but lasting injury, or illness. These recipients need a slower pace and lower intensity of services.
- Level 3.5 Clinically Managed High-Intensity Residential Services: Multi-dimensional imminent danger but medical monitoring is not required.
- Level 3.7-WM Medically Monitored Inpatient Withdrawal Management: Severe withdrawal; unlikely to complete withdrawal management without medical monitoring. The recipient remains in a level 3.7 withdrawal management program until: (i) withdrawal signs and symptoms are sufficiently resolved that he or she can be safely managed at a less intensive level of care; or (ii) the recipient's signs and symptoms of withdrawal have failed to respond to treatment and have intensified such that transfer to a more intensive level of withdrawal management services is indicated. 3.7-WM typically last for no more than seven days.

The state Medicaid standards also include requirements regarding referrals, prior authorization, continued care, and utilization review.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* In a CTC, a licensed mental health professional must document a crisis stabilization plan to address needs identified in the assessment which must also include criteria describing evidence of stabilization and either transfer or discharge criteria. Readiness for discharge must be reviewed in collaboration with the recipient every day.

*Substance Use Disorder (SUD):* The ARTC treatment plan must be developed by a team of professionals in consultation with the recipient and in accordance with ASAM and accreditation standards. An interdisciplinary team must review the treatment plan at least every 15 days. See Care Coordination below regarding aftercare services.

## Treatment Services

*Mental Health (MH) and Substance Use Disorder (SUD):* The CTC shall provide emergency screening, and evaluation services 24-hours a day, seven days a week and shall admit 24-hours a day seven days a week and discharge seven days a week. CTCs in residential settings provide the following services: (1) Comprehensive medical history and physical examination at admission. (2) Development and update of the assessment and plan. (3) Crisis stabilization including, but not limited to: (a) crisis triage; (b) screening and assessment; (c) de-escalation and stabilization; (d) brief intervention and psychological counseling; (e) peer support. (4) Ambulatory withdrawal management (non-residential) based on American society of addiction medicine (ASAM) 2.1 level of care includes: (a) evaluation, withdrawal management and referral services; (b) clinical consultation and supervision for bio-medical, emotional, behavioral, and cognitive problems; (c) psychological and psychiatric consultation; and (d) other services determined through the assessment process. (5) Clinically or medically monitored withdrawal management in residential setting, if included, not to exceed services described in level 3.7 of the current ASAM patient placement criteria. (6) Prescribing and administering medication, if applicable. (7) Conducting or arranging for appropriate laboratory and toxicology testing.

The CTC identifies recipients at high risk of suicide or intentional self-harm, and subsequently engages these recipients through solution-focused and harm-reducing methods. Education and program offerings are designed to meet the stabilization and transfer of recipients to a different level of care.

*Substance Use Disorder (SUD):* Under the Section 1115 waiver, initiatives to improve SUD services will ensure the appropriate level of treatment is provided, increase the availability of medication assisted treatment (MAT), and enhance coordination between levels of care. The state must offer a full range of SUD treatment options using American Society for Addiction Medicine (ASAM) criteria for assessment and treatment decision making. Beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions. In addition to current licensing requirements, pursuant to the Section 1115 waiver, the state must establish residential treatment provider qualifications in a pre-enrollment certification by the state based upon meeting accrediting body qualifications and ASAM standards for staffing credentials, hours of clinical care and types of clinical service established in state regulations. The managed care contracts and credentialing policies along with prior authorization practices offer further guidance and monitoring of adherence to SUD specific program standards. The state must establish a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site.

State Medicaid regulations specify that the following services shall be performed by the ARTC agency to receive reimbursement: (a) diagnostic evaluation, necessary psychological testing, and development of the eligible recipient's treatment plan; (b) provision of regularly scheduled



counseling and therapy sessions in an individual, family or group setting following the eligible recipient's treatment plan, and according to ASAM guidelines for level three, residential care, and the specific sub-level of care for which that client meets admission criteria; (c) facilitation of age-appropriate life skills development; (d) assistance to the eligible recipient in his or her self-administration of medication in compliance with state statute, regulation and rules; (e) maintain appropriate staff available on a 24-hour basis to respond to crisis situations, determine the severity of the situation, stabilize the eligible recipient, make referrals as necessary, and provide follow-up to the eligible recipient; and (f) consultation with other professionals or allied caregivers regarding the needs of the eligible recipient, as applicable. Medicaid reimbursement covers services considered routine in the residential setting and that are medically necessary for the diagnosis and treatment of an eligible recipient's condition. Routine services include, but are not limited to, counseling, therapy, activities of daily living, medical management, crisis intervention, professional consultation, transportation, rehabilitative services and administration. Medicaid does not cover room and board.

The state plan and state Medicaid regulations specify the following by level:

- Level 3.1 Clinically Managed Low-Intensity Residential Treatment Services: 24-hour structure with trained personnel; at least 5 hours of clinical service (recovery skills)/week.
- Level 3.2-WM Clinically Managed Residential Withdrawal Management: The program has the ability to arrange for appropriate laboratory and toxicology tests; a range of cognitive, behavioral, medical, mental health and other therapies are administered on an individual or group basis to enhance the recipient's understanding of addiction, the completion of the withdrawal management process, and referral to an appropriate level of care for continuing treatment.
- Level 3.3. Clinically Managed Population-Specific High Intensity Residential Services: 24-hour structure with trained counselors to stabilize multidimensional imminent danger; less intense programming and group treatment for those with cognitive or other impairments unable to use full therapeutic community; and preparation for outpatient treatment.
- Level 3.5 Clinically Managed High-Intensity Residential Services: 24-hour care with trained counselors to stabilize multi-dimensional imminent danger; and preparation for outpatient treatment.
- Level 3.7 Medically Monitored Intensive Inpatient Services: an organized service delivered by medical and nursing professionals which provides 24-hour evaluation and monitoring services under the direction of a physician or clinical nurse practitioner who is available by phone 24-hours a day.

- Level 3.7-WM Medically Monitored Inpatient Withdrawal Management: 24-hour nursing care and physician visits. The program has the ability to arrange for appropriate laboratory and toxicology tests; a range of cognitive, behavioral, medical, mental health and other therapies are administered on an individual or group basis to enhance the recipient's understanding of addiction, the completion of the withdrawal management process, and referral to an appropriate level of care for continuing treatment.

## **Care Coordination**

*Mental Health (MH) and Substance Use Disorder (SUD):* A CTC in a residential setting must provide navigational services for individuals transitioning to the community which, when available, include: (a) prescription and medication assistance; (b) arranging for temporary or permanent housing; (c) family and natural support group planning; (d) outpatient behavioral health referrals and appointments; and (e) other services determined through the assessment process.

*Substance Use Disorder (SUD):* Under the Section 1115 waiver, initiatives to improve SUD services will enhance coordination between levels of care. Beneficiaries will have access to improved care coordination and care for comorbid physical and mental health conditions. The state must ensure establishment and implementation of policies to ensure residential facilities link beneficiaries with community-based services and supports following stays in these facilities. As a general matter under the waiver, the managed care organizations (MCOs) must provide comprehensive care coordination to certain members, including but not limited to developing and facilitating transition plans for participants who are candidates to transition from an institutional facility to the community. The MCOs also must assign dedicated care coordinators to, among others, members with complex behavioral health needs and, for high-need populations, develop and implement a transition plan that must remain in place for a minimum of 60 days for members transitioning from a higher level of care to a community setting. The state must ensure that specified members, including but not limited to member(s) moving from a residential placement or institutional facility to a community placement, receive an additional assessment within seventy-five (75) calendar days of transition to determine if the transition was successful and identify any remaining needs.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* MCOs must implement quality management and performance assessment and improvement activities.

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD

program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings.

## Special Populations

*Substance Use Disorder (SUD)*: Coverage in an IMD under the Section 1115 waiver includes coverage of co-occurring behavioral health disorders with the primary SUD.

## Location of Medicaid Requirements

NM Medicaid Regulations<sup>3</sup>; New Mexico Section 1115 waiver<sup>4</sup>; New Mexico state plan amendment<sup>5</sup>. Regulatory data collected January 2020.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report “**State Residential Treatment for Behavioral Health Conditions: Regulation and Policy**”. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

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<sup>3</sup> See <https://www.hsd.state.nm.us/providers/rules-nm-administrative-code-.aspx>.

<sup>4</sup> See <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nm/nm-centennial-care-ca.pdf>.

<sup>5</sup> See <https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/NM/NM-19-0002.pdf>.

## NEW YORK

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

### Types of Facilities

*Mental Health (MH):* New York regulates:

- Adult Crisis Residential Programs, which are short-term programs (up to 28 days) designed to provide residential and support services to persons with symptoms of mental illness who are at risk of or experiencing a psychiatric crisis but do not pose likelihood of serious harm.
  - A residential crisis support program is for individuals who are experiencing symptoms of mental illness, psychiatric crisis, or challenges in daily life that create risk for escalation of psychiatric symptoms that cannot reasonably be managed in the person's home and/or community environment without onsite supports.
  - An intensive crisis residence program is a residential treatment program for individuals who are experiencing a psychiatric crisis, which includes acute escalation of mental health symptoms. An intensive crisis residence may not have fewer than 3 beds and shall not exceed 16 beds.
- An Adult Treatment Residential Program is a rehabilitation-oriented residential program focused on interventions necessary to address an individual's functional and behavior deficits which must be resolved to access generic housing. This type of service may offer up to 48 beds.
  - Community Residence for Eating Disorder Integrated Treatment (CREDIT) Program is a subclass of community residences for individuals over the age of 18 who are diagnosed with an eating disorder and whose individual treatment issues preclude family settings or other less restrictive alternatives.

*Substance Use Disorder (SUD):* New York regulates residential services for those with SUD. Services correspond to elements in the treatment/recovery process and are distinguished by the configuration of services, staffing patterns, degree of dysfunction of the individual served in each setting, and patient readiness to transition to a less restrictive program or element of treatment/recovery. They provide residential services corresponding to one or more of the following elements of the treatment/recovery process:

- Withdrawal and stabilization, which is the “medical management and treatment of acute withdrawal, resulting in a referral to an appropriate level of longer term care.” The length

of stay is determined by medical necessity criteria. Stabilization requires the supervision of a physician and clinical monitoring.

- Rehabilitation, which provides a structured environment for persons whose potential for independent living is seriously limited due to significant functional impairment including social, employment, cognitive and ability to follow social norms that requires restructuring social supports and behaviors in order to develop sufficient skills; these persons require a course of rehabilitative services in a structured environment with staffing to provide monitoring and support and case management.
- Reintegration, which provides a community living experience in congregate or scatter-site settings with limited supervision and/or case management; persons appropriate for these services are transitioning to long term recovery from SUD and independent living in the community.

*Unregulated Facilities:* All adult residential MH and SUD treatment facilities are regulated in New York.

## **Approach**

The New York State Office of Mental Health (OMH) regulates all MH treatment providers, without regard to operator or funding. The New York State Office of Addiction Services and Supports (OASAS) regulates all providers of SUD treatment services, without regard to operator or funding.

## **Processes of Licensure or Certification and Accreditation**

*Mental Health (MH):* Certification by the OMH is required for all providers of MH services and operators of crisis residential programs must have a certificate specific to type.

- Accreditation is not required.
- An inspection is required for licensure.
- The state may require a Certificate of Need.
- Licensure duration is three years.

*Substance Use Disorder (SUD):* All residential SUD treatment facilities require certification by the OASAS.

- Accreditation is not required, but inspections that qualify to satisfy the state certification requirements of biannual inspections include an accreditation survey, completed by a nationally recognized accrediting organization.
- The state does not require a Certificate of Need.
- An application and inspection are required for initial certification, the duration of which is no longer than one year. Subsequent certificates can be extended to a three-year period depending upon compliance with regulatory standards. Providers must be inspected at least two times per year, once without prior notice, for compliance with rules, regulations, policies, procedures and requirements of the OASAS.

### **Cause-Based Monitoring**

*Mental Health (MH):* The OMH monitors adult residential MH treatment during periodic certification visits, utilization review, and based on incident reporting. Upon identification of a deficiency, the provider may be required to prepare and implement a plan of correction; the OMH also may revoke, suspend or limit the provider's operating certificate or impose a fine. Program must cooperate with the OMH during any review or inspection of the facility or program.

*Substance Use Disorder (SUD):* All providers of SUD services are subject to two inspections per year. Recertification reviews are conducted on an unannounced basis. The provider must take all actions necessary to correct all deficiencies reported. The provider must submit a satisfactory corrective action plan and any planned actions must be accompanied with a timetable for implementation.

### **Access Requirements**

*Mental Health (MH):* The provider must make a decision with regard to an application for admission no later than 15 working days after submission of all necessary documentation. The provider must ensure that no otherwise appropriate resident is denied access to services solely on the basis of multiple diagnoses, physical disability, a diagnosis of HIV infection, AIDS, or AIDS-related complex, pregnancy, or solely because the individual has any past involvement with substance abuse or the criminal justice system.

*Substance Use Disorder (SUD):* Wait-time requirements were not found. No individual may be denied admission to a program based solely on the individual's prior treatment history; referral source; pregnancy; history of contact with the criminal justice system; HIV and AIDS status; physical or mental disability; lack of cooperation by significant others in the treatment/recovery process; or medication assisted treatment for opioid dependence prescribed and monitored by

a physician, physician's assistant or nurse practitioner. A provider of SUD services may not limit access to services based on residency or citizen status. Providers funded by the office may not deny treatment based on inability to pay. All providers of SUD services must allow for the provision of medication assisted treatment and may not deny admission based on use of medication.

## Staffing

### *Mental Health (MH):*

- Adult Residential Treatment Programs must employ an adequate number and appropriate mix of staff to carry out the objectives of the program and to ensure the outcomes of the program.
  - A CREDIT program must have sufficient staff to meet the special needs of individuals residing in a community residence who have been diagnosed with an eating disorder.
- Crisis Residential Programs must have a director who meets specific requirements and has day to day responsibility for the program. Each program must have a written plan for staff composition needed to provide services and day-to-day management and monitoring. A crisis residence program shall continuously employ an adequate number of staff and an appropriate staff composition to carry out its goals and objectives as well as to ensure the continuous provision of sufficient ongoing and emergency supervision. Requirements are in place for clinical staff, supervisory staff, qualified mental health staff. All staff must submit documentation of their training and experience to the crisis residence program. The regulations include standards for students or trainees.

*Substance Use Disorder (SUD):* All SUD treatment providers must have a physician who has specified qualifications designated to be the medical director. Among other things, the medical director must have a federal DATA 2000 waiver. Any residential programs of 10 beds or more must have a full-time program director who is a qualified health professional that meets specific requirements. A residential program with fewer than 10 beds must have a similarly qualified program director who serves on at least a part-time basis. General and clinical staffing must be on-site or on-call sufficient to meet the emergent needs of the resident population. Other requirements include that there be a clinical supervisor and a health coordinator. Setting-specific additional requirements include:

- Stabilization and rehabilitation services must have staff sufficient to meet the emergent needs of the resident population, including specific nursing, medical, psychiatric, licensed clinicians, other clinical and milieu staff, vocational counselors, and case managers. Staffing levels for milieu and clinical staff are included. All clinical staff must receive training, including but not limited to, crisis interventions, working with special

populations, medication assisted treatment, trauma-informed care, quality improvement, agency policies and procedures.

- Rehabilitation programs must provide medical staff on site or on-call.
- Reintegration residential services must have a full-time manager responsible for the day-to-day operation of the service. All reintegration residential services must have sufficient staff to ensure that supportive services are available and responsive to the needs of each resident. In a congregate setting, there must be staff on site at all times. In a scattered site setting, there must be sufficient clinical staff members to ensure at least one visit to each resident per week.

## Placement

### *Mental Health (MH):*

- Adult Treatment Residential Programs must have admission and discharge criteria. Eligibility for admission to a residential program for adults is based upon: (1) a designated mental illness diagnosis which, for purposes of the CREDIT program, must include a diagnosis of an eating disorder; and one of the following, (2) social security income or social security disability insurance enrollment due to a designated mental illness; (3) extended impairment in functioning due to a designated mental illness; or (4) reliance on psychiatric treatment, rehabilitation and supports. All assessments must have occurred within the last 30 days and must include specific components. A referral for admission to a CREDIT program must be received from a Comprehensive Care Center for Eating Disorders or from the individual's primary care physician or mental health provider.
- All Crisis Residential Programs must have a utilization review process designed to monitor the appropriateness of admission and continued stay. The program shall prepare a written utilization review plan designed to ensure there will be an ongoing utilization review program. This utilization review plan shall be subject to approval by the Office of Mental Health. Programs must conduct an individual admissions assessment to determine appropriateness of admission.

*Substance Use Disorder (SUD):* An individual seeking residential services must have an initial determination based upon face-to-face contact plus any other available records and made by a qualified health professional or other clinical staff under the supervision of a qualified health professional; such determination must document that specific requirements are satisfied for admission. If the initial determination indicates the person is appropriate for residential services, a level of care determination must be made by a clinical staff member supervised by a qualified health professional no later than 24 hours after the resident's first on-site contact with the program. To be admitted at the appropriate level of care, the individual must meet the level



of care protocol criteria for the residential services and must be provided the services which match the resident's need for stabilization, rehabilitative, or reintegration services. Before and soon after admission, programs also must conduct or offer certain communicable disease testing.

- Stabilization services are appropriate for residents who present with mild withdrawal or expected withdrawal and psychiatric symptoms that cause acute impairment; medical conditions, emotional or cognitive impairment that can be managed in a residential setting where medical staff are available on an on-call basis. Within 24 hours after admission, programs providing stabilization services must complete a general assessment which identifies immediate problem areas, substantiates appropriate resident placement and is signed by a qualified professional. If withdrawal symptoms or other potentially life-threatening behavior or conditions are present, the patient must be assessed immediately for safety by a medical staff person who is working within the scope of practice. Within 24 hours after admission, the program must conclude a medical assessment and, if necessary, a full physical no later than 7 days after admission. All residents shall receive a physical exam by a physician, physician's assistant or nurse practitioner if they do not have available a medical history and no physical examination has been performed within the prior 12 months. Residents who have a medical history shall receive an evaluation within 7 days.
- Rehabilitation services are appropriate for individuals who do not have significant withdrawal symptoms, are free of severe cravings to use substances and, if present, psychiatric and medical conditions are stable. Individuals have functional impairment in cognitive, emotional regulation, social and role functioning. Within 7 days after admission, programs providing rehabilitation services must conclude a medical assessment and, if necessary, a full physical no later than 45 days after admission. All residents must receive a physical exam if they do not have available a medical history and no physical examination has been performed within the prior 12 months. Residents who have a medical history must receive an evaluation within 21 days.
- Persons appropriate for reintegration services are stable in SUD, psychiatric and medical conditions and have adequate functioning in cognitive, emotional regulation, social and role functioning. An individual admitted to a reintegration residential service must meet specific criteria related to housing and need for outpatient treatment services and/or other support services. Residents admitted to reintegration services must have an identified primary care physician and have a physical exam if one has not been completed within the prior 12 months, or, if the resident is admitted to an outpatient SUD clinic or opioid treatment program, then within 30 days the reintegration program must obtain the medical history, physical and treatment plan from the outpatient provider. The physical examination shall include review of any physical and/or mental limitations or disabilities which may require special services or attention during treatment.

## Treatment and Discharge Planning and Aftercare Services

*Mental Health (MH):* All providers of mental health services must offer treatment planning.

- In Adult Treatment Residential Programs, service plans must be developed within four weeks of admission. The initial service plan in a CREDIT program must be developed within 3 days of admission. In all residential programs, the plan should be reviewed at least every three months. All programs require discharge planning beginning at admission.
- Adult Crisis Residential Programs must develop and implement an individual service plan within 24 hours of admission. Among other things, the plan must include discharge planning.

*Substance Use Disorder (SUD):* All providers of substance use disorder services programs require treatment planning, with updates at least monthly. Discharge planning beginning at admission is required.

## Treatment Services

*Mental Health (MH):*

- For Adult Treatment Residential Programs, these services must be provided: (1) assertiveness/self-advocacy; (2) community integration services/resource development; (3) daily living skills; (4) health services; (5) medication management and training; (6) parenting training; (7) rehabilitation counseling; (8) skill development services; (9) socialization; (10) SUD services; and (11) symptom management.
  - A CREDIT program must provide for continuity and integration of care with an entity designated by the New York State Department of Health as a Comprehensive Care Center for Eating Disorders and must require, at a minimum: (i) a psychiatric assessment; (ii) an integrated service plan; (iii) a medical examination; (iv) supervision of meal, bathroom and exercise time; and (v) family participation, as appropriate.
- Each Crisis Residential Program must have a written plan for services and shall address the comprehensive service needs of the recipients.
  - Intensive crisis residence programs offer the following treatment and support services, consistent with a recipient's condition and needs that includes but is not limited to: (a) comprehensive assessment; (b) medication management and training; (c) medication monitoring; (d) medication therapy; (e) individual and group counseling; (f) engagement and support to address co-occurring disorders; (g) assistance in personal care and activities of daily living; (h) peer support; (i) engagement with identified supports; (j) safety planning; (k) integration of direct

- care and support services; (l) case management activities which emphasize discharge planning and includes continuity of care between service transitions; (m) collaboration and linkages with service options in the community which provide continuation of ongoing treatment and rehabilitation; (n) crisis respite; and (o) room and board.
- A residential crisis support program must offer the following support services, consistent with a recipient's condition and needs: (a) assistance in personal care and activities of daily living; (b) peer support; (c) engagement with identified supports; (d) safety planning; (e) integration of direct care and support services; (f) case management activities which emphasize discharge planning; (g) collaboration and linkages with service options in the community which provide continuation of ongoing treatment and rehabilitation; (h) medication management and training; (i) medication monitoring; (j) crisis respite; and (k) room and board.

*Substance Use Disorder (SUD):* All SUD treatment providers shall expeditiously facilitate access to medication assisted treatment, based on the clinical need and preference of the patient, through direct provision of the medication, contracting with private prescribing professionals or linkage agreements with other OASAS-certified programs. Such agreements must ensure access sufficient to meet patient needs without undue barriers such as long waiting periods for appointments or waiting lists. Programs must continue access to opioid full and partial agonist treatment and plan for the continuity of medication administration.

- For residential SUD programs and withdrawal and stabilization services, medically necessary care and supportive services both on and off-site should be provided according to need, including: (1) assessment and clinical treatment/recovery plan or service plan development; (2) skill development; (3) counseling; and (4) medication assisted treatment when medically necessary.
  - For chemical dependence residential services, counseling and supportive services also should be provided.
- Rehabilitation services must provide: (1) individual, group and family counseling as appropriate to resident needs and as described more fully in the regulations. (2) medical assessment of physical and mental health conditions and medical treatment to enable the resident to manage chronic health and mental health conditions including treatment of physical health conditions that are routine. The following also must be provided: (i) psychiatric assessment and medication management of co-occurring psychiatric conditions; (ii) psycho-social interventions which teach skills for coping with urges, craving, impulsive behavior and cognitive distortions in thinking, motivational interviewing techniques to engage the resident in treatment; and (iii) planned interactions with residents within the milieu.
- Reintegration residential services must provide a structured therapeutic environment designed to facilitate the individual's progress toward recovery from SUD and maintain a focus on the development and improvement of the skills necessary for recovery. Services

must include: (i) access to individual, group and family counseling services; (ii) written referral agreements with one or more SUD outpatient services to provide outpatient treatment services, as necessary; (iii) integration of such services with the activities and services provided by the residence; and (iv) a comprehensive and appropriate range of services such as vocational services; educational remediation; and life, parenting and social skills training. Personal, social, and community skills training and development also must be provided. Services may be provided directly by the service or by referral.

## **Patient Rights and Safety Standards**

*Mental Health (MH):* Client rights include, but are not limited to, notice of rights, communication, freedom from abuse or mistreatment, reasonable privacy, and to voice a grievance. For all providers of mental health services, restraint and seclusion are safety interventions which may be used for purposes of managing violent or self-destructive behavior only in emergency situations if such intervention is necessary to avoid imminent, serious injury to the patient or others, and less restrictive interventions have been utilized and determined to be ineffective, or in rare instances where the patient's dangerousness is of such immediacy that less restrictive interventions cannot be safely employed. Such restraint or seclusion shall only be used for the duration of the emergency. Additional standards are in place related to restraint and seclusion, including that the use of restraint and/or seclusion must be reported to the OMH as further specified in the regulations.

- For Adult Crisis Residential Programs, recipients have the right to control their own schedules and activities. Each recipient, family, or identified support, must be apprised of a grievance process which ensures the timely review and resolution of complaints.
- For Adult Treatment Residential Programs, the OMH conducts an external review of residential programs based on patterns or trends in reported incidents or on the occurrence of an individual incident of extreme gravity.

*Substance Use Disorder (SUD):* The facility or provider agency must establish policies and procedures to protect patient rights. Such policy must include, at a minimum, the following rights: (i) to question a policy, voice a concern or grievance with the provider or the OASAS; (ii) to receive a timely response and/or resolution; (iii) to not suffer adverse consequences or retaliation as a result; and (iv) to communicate with the provider's director, medical director, board of directors, other responsible staff and the Commissioner. Patients also have, among others, rights to dignity, to receive services in an environment free from the presence of alcohol or other addictive substances, to be free of abuse or coercion, and to be treated by provider staff who are free from chemical dependence; additional rights that accrue to residential clients include but are not limited to communication, privacy, and to be free from restraint or seclusion. Critical incident reporting is required.

## Quality Assurance or Improvement

### *Mental Health (MH):*

- Each Crisis Residential Program must conduct an annual written evaluation of the program's attainment of its stated goals and objectives including any required changes in policies and procedures; and comply with requirements regarding financial accounts and auditing requirements. Each crisis residence program must have a quality assurance program meeting regulatory requirements. Each crisis residence program must prepare a written quality assurance plan designed to ensure that there is an ongoing quality assurance program that includes effective mechanisms for reviewing and evaluating resident care and provides for appropriate response to findings. This quality assurance plan shall be subject to approval by the OMH. The written quality assurance plan must address specific requirements. Crisis residence programs must have procedures for internal monitoring of program performance against the criteria stated in the program's description. Such statistical information must be prepared and maintained as may be necessary for the effective operation of the crisis residence program and as may be required by the OMH. Statistical information is reported to the OMH. Summaries of statistical information are reviewed at least annually as part of the annual evaluation process.
- Each Adult Residential Treatment Program must develop a quality assurance plan meeting regulatory requirements. Residential programs must have an internal incident reporting, investigation and management process and the quality assurance plan must contain written procedures for carrying out incident management and reporting. Residential programs must have procedures for internal monitoring of program performance against the criteria stated in the program's functional program. Each program must have a consumer evaluation process, in which residents and others involved with the resident have an opportunity to give feedback about the program in a confidential manner. The information from this process shall be summarized annually and submitted to the OMH, the resident and all staff. The confidentiality of residents, families and other impacted parties shall be protected.

*Substance Use Disorder (SUD):* All SUD treatment providers must establish a policy and procedure for implementing quality improvements with respect to patient concerns and complaints, changes in regulatory requirements, or other factors, and shall review such policies no less frequently than once every two years. Documentation must be kept of all such reviews and the residential service must prepare an annual report and submit it to the governing authority that meets regulatory requirements. A diversion control plan (DCP) also is required for each program that dispenses medication.

## Governance

*Mental Health (MH)*: The governing body has overall responsibility for the operation of the program. The governing body must establish mechanisms for the participation of current or former recipients of mental health services and family members of recipients of mental health services on the governing body. The governing body must ensure that its membership reflects the ethnic and cultural diversity in which the residential program is located. It must also facilitate the integration of the program into the community. Other requirements of the governing body are included in the regulations, including approval of written policies and procedures.

*Substance Use Disorder (SUD)*: For all providers of SUD services, the governing authority is the overall policy making authority that exercises general direction over the affairs of a provider of services and establishes policies concerning its operation.

## Special Populations

*Mental Health (MH)*: No requirements related to adult residential MH treatment services for special populations were found.

*Substance Use Disorder (SUD)*: All SUD providers treatment must develop and implement written policies, procedures and methods governing the provision of HIV prevention education, testing, counseling, and the confidentiality of HIV-related information. Patients entering certified, funded and/or otherwise authorized programs on a prescribed HIV prevention medication regimen must be maintained on such regimen unless consultation with the prescribing practitioner and the patient has occurred and the patient has consented to an alternative regimen.

## Location of Regulatory and Licensing Requirements

Office of Mental Health<sup>1</sup>; Crisis Residence<sup>2</sup>; NY Department of Health Certificate of Need website<sup>3</sup>; Office of Alcoholism and Substance Abuse Services, General Link<sup>4</sup>, Part 810<sup>5</sup>, Part 815<sup>6</sup>, Part 819<sup>7</sup>, Part 820<sup>8</sup>. Regulatory requirements reviewed September 27, 2019.

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<sup>1</sup> See

[https://govt.westlaw.com/nycrr/Browse/Home/NewYork/NewYorkCodesRulesandRegulations?guid=Icb5a98e0b7ec11dd9120824eac0ffcce&originationContext=documenttoc&transitionType=Default&contextData=\(sc.Default\)](https://govt.westlaw.com/nycrr/Browse/Home/NewYork/NewYorkCodesRulesandRegulations?guid=Icb5a98e0b7ec11dd9120824eac0ffcce&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default)).

<sup>2</sup> See

[https://govt.westlaw.com/nycrr/Browse/Home/NewYork/NewYorkCodesRulesandRegulations?guid=Ica0ff070b7ec11dd9120824eac0ffcce&originationContext=documenttoc&transitionType=Default&contextData=\(sc.Default\)](https://govt.westlaw.com/nycrr/Browse/Home/NewYork/NewYorkCodesRulesandRegulations?guid=Ica0ff070b7ec11dd9120824eac0ffcce&originationContext=documenttoc&transitionType=Default&contextData=(sc.Default))

<sup>3</sup> See [https://www.health.ny.gov/facilities/cons/more\\_information/](https://www.health.ny.gov/facilities/cons/more_information/).

<sup>4</sup> See <https://www.oasas.ny.gov/regs/index.cfm>.

## Other Information Sources

P. Lincourt (OASAS) K. Brannon (OMH); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>5</sup> See <https://www.oasas.ny.gov/regs/documents/810.TEXT.FINAL.2.14.18.pdf>.

<sup>6</sup> See <https://www.oasas.ny.gov/legal/documents/Part815.pdf>.

<sup>7</sup> See <https://www.oasas.ny.gov/regs/documents/819.pdf>.

<sup>8</sup> See <https://www.oasas.ny.gov/regs/documents/Part820ResidentialServices.pdf>.

# NEW YORK MEDICAID

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## Approach

The New York State Department of Health (DOH) oversees the state Medicaid program. New York does not have a relevant Section 1115 waiver that affects reimbursement of residential services in Institutions for Mental Diseases (IMDs). It historically has relied to some extent on the in lieu of provision and on Disproportionate Share Hospital (DSH) payments to reimburse certain services in IMDs.

## Types of Facilities

*Mental Health (MH):* According to the state plan, rehabilitative services may be reimbursed within community residences of not more than 16 beds for individuals with severe and persistent mental illness.

*Substance Use Disorder (SUD):* The state plan allows for reimbursement of Residential Addiction Rehabilitative Services (RARS) in a non-IMD. Residential addiction services include individual-centered residential treatment consistent with the individual's assessed treatment needs, with a rehabilitation and recovery focus designed to promote skills for coping with and managing substance use disorder symptoms and behaviors. These services are designed to help individuals achieve changes in their SUD behaviors. Services should address an individual's major lifestyle, attitudinal, and behavioral problems that have the potential to undermine the goals of treatment. Residential services are delivered on an individual or group basis in a variety of settings including treatment in residential settings of 16 beds or less designed to help individuals achieve changes in their SUD behaviors. Face-to-face interventions may include other collateral supports beyond the individual or family/caregiver, as necessary.

## Processes of Medicaid Enrollment

*Mental Health (MH) and Substance Use Disorder (SUD):* Enrollment in the New York Medicaid program requires the provider to submit an application, the focus of which is applicant's ability to provide high-quality care, services and supplies and to be financially responsible. After receipt of the application, the state will conduct an investigation to verify or supplement the information contained in the application. The background and qualifications of the applicant



shall also be reviewed. The application may be denied. Enrollment may be suspended, restricted, or terminated. If a license, registration, or certification is required to render the medical care or services, the provider must hold a proper and currently valid license, registration, and/or certification to be eligible to furnish the care, services or supplies under the medical assistance program.

## **Staffing**

*Substance Use Disorder (SUD):* The Medicaid state plan establishes staffing requirements for a RARS, including credentials required for licensed and unlicensed staff (medical, clinical, and direct care) and requirements for supervision and continuing education.

## **Placement**

*Substance Use Disorder (SUD):* For reimbursement of services in a RARS, the Medicaid state plan states that services are subject to prior approval, must be medically necessary, and must be recommended by a licensed practitioner or physician, who is acting within the scope of his/her professional license and applicable state law (licensed practitioners include licensed by the New York State Department of Education and include licensed master social worker (LMSW), licensed clinical social worker (LCSW), licensed mental health counselor (LMHC), licensed marriage and family therapists (LMFTs), licensed psychoanalysts; licensed creative arts therapists, physician assistants PAs), nurse practitioners (NPs); physicians and psychologists, to promote the maximum reduction of symptoms and/or restoration of an individual to his/her best age appropriate functional level.

## **Treatment and Discharge Planning and Aftercare Services**

*Substance Use Disorder (SUD):* The Medicaid state plan requires that a RARS must establish an individualized treatment plan.

## **Treatment Services**

*Substance Use Disorder (SUD):* The Medicaid state plan permits reimbursement for the following services in a RARS: assessment, service planning, counseling/ therapy, medication management including medication-assisted treatment where appropriate, care coordination, peer/ family peer support, crisis and intervention.

## Care Coordination

*Substance Use Disorder (SUD)*: The Medicaid state plan permits reimbursement for care coordination.

## Quality Assurance or Improvement

*Mental Health (MH) and Substance Use Disorder (SUD)*: The DOH may conduct audits and claims reviews which may be limited to reviews of costs of operation or which may involve reviews of the quality, appropriateness, and necessity of care provided and adherence to established department policy and procedures or conduct investigations as to the provider's conduct relative to unacceptable practices. Researchers did not locate requirements imposed on the facility regarding quality assurance or improvement planning.

## Special Populations

*Mental Health (MH) and Substance Use Disorder (SUD)*: No evidence of Medicaid-based special population requirements for residential treatment facilities for adults was located.

## Location of Medicaid Requirements

New York Compiled Rules and Regulations Title 18, Volume C<sup>9</sup>; State Plan<sup>10</sup>. Regulatory data collected December 7, 2019.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report “**State Residential Treatment for Behavioral Health Conditions: Regulation and Policy**”. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

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<sup>9</sup> See <https://regs.health.ny.gov/book/export/html/54392>.

<sup>10</sup> See [https://www.hcrapools.org/medicaid\\_state\\_plan/DOH\\_PDF\\_PROD/nys\\_medicaid\\_state\\_plan.pdf](https://www.hcrapools.org/medicaid_state_plan/DOH_PDF_PROD/nys_medicaid_state_plan.pdf).

## NORTH CAROLINA

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### Types of Facilities

*Mental Health (MH) and Substance Use Disorder (SUD):* North Carolina regulates Facility Based Crisis Centers for Individuals of All Disability Groups, which is “a residential facility which provides disability-specific care and treatment in a nonhospital setting for individuals in crisis who need short-term intensive evaluation, or treatment intervention or behavioral management to stabilize acute or crisis situations. This facility is designed as a time-limited alternative to hospitalization for an individual in crisis.” These facilities serve individuals who have MH or SUD needs.

*Substance Use Disorder (SUD):* North Carolina regulates:

- Nonhospital Medical Detoxification for Individuals who are Substance Abusers, a “residential facility which provides medical treatment and supportive services under the supervision of a physician. This facility is designed to withdraw an individual from alcohol or other drugs and to prepare him to enter a more extensive treatment and rehabilitation program.”
- Social Setting Detoxification for Substance Abuse, a “residential facility which provides social support and other non-medical services to individuals who are experiencing physical withdrawal from alcohol and other drugs. Individuals receiving this service need a structured residential setting but are not in need of immediate medical services; however, back-up physician services shall be available, if indicated. The facility is designed to assist individuals in the withdrawal process and to prepare them to enter a more extensive treatment and rehabilitation program.”
- Residential Recovery Programs for Individuals with Substance Abuse Disorders and their Children, a “professionally supervised residential facility which provides trained staff who work intensively with individuals with substance abuse disorders who provide or have the potential to provide primary care for their children.”
- Residential Treatment/Rehabilitation for Individuals with Substance Use Disorders, a “residential service which provides active treatment and a structured living environment for individuals with substance abuse disorders in a group setting.”

- Therapeutic Community, a “highly structured, supervised, 24-hour residential facility designed to treat the behavioral and emotional issues of individuals to promote self-sufficiency and a crime and drug-free lifestyle.”

*Unregulated Facilities:* There are no unregulated residential treatment facilities in North Carolina. We exclude Psychosocial Rehabilitation Facilities for Individuals with Severe and Persistent Mental Illness, Supervised Living, and Respite Services, because they do not incorporate clinical services within the scope of this summary.

## **Approach**

The North Carolina Division of Health Service Regulation (DHSR) regulates and licenses residential treatment providers in the state. The North Carolina Department of Health and Human Services (DHHS) contracts with publicly-funded behavioral health services and, according to state staff, may impose additional requirements by contract.

## **Processes of Licensure or Certification and Accreditation**

*Mental Health (MH) and Substance Use Disorder (SUD):* Licensure by the DHSR is required for operation of all facilities.

- According to state staff, accreditation is not required but a similar feature exists through Local Management Entities-Managed Care Organizations (LME-MCOs), which are under contract with the DHHS to manage publicly-funded behavioral health services within a specific geographic catchment area. The LME-MCOs accept licensure and inspection by DHSR as indicators of statutory and rule compliance. LME-MCOs contract with providers for services, perform post payment reviews, and monitor unlicensed behavioral health services.
- An inspection is required for initial licensure and renewal. The focus of the on-site inspections is compliance with all rules and statutes.
- According to state staff, a Certificate of Need is required only for Residential Treatment/Rehabilitation for Individuals with Substance Abuse Disorder.
- An initial license is valid for a period not to exceed 15 months from the date on which the license is issued. Each license must be renewed annually thereafter and expires at the end of the calendar year.

## **Cause-Based Monitoring**

*Mental Health (MH) and Substance Use Disorder (SUD):* Licenses may be denied, amended or revoked. Inspections may be conducted without advance notice.

## **Access Requirements**

*Mental Health (MH) and Substance Use Disorder (SUD):* Wait-time requirements were not found. Facilities that provide activities for clients shall assure that when clients who have a physical handicap are transported, the vehicle shall be equipped with secure adaptive equipment.

## **Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD):* All facilities shall have a written job description for the director and each staff position which, among other things, includes the minimum level of education, competency, work experience and other qualifications for the position, and specifies the duties and responsibilities of the position. Minimum standards are established for the director, each staff member or any other person who provides care or services to clients on behalf of the facility.

Staff of a facility or a service shall be currently licensed, registered or certified in accordance with applicable state laws for the services provided. Employee training programs shall be provided, including specified minimum subjects. At least one staff member with specific training shall be available in the facility at all times when a client is present.

- For Facility Based Crisis Service for Individuals of all Disability Groups, each facility shall maintain staff to client ratios that ensure the health and safety of clients served in the facility. Staff with training and experience in the provision of care to the needs of clients shall be present at all times when clients are in the facility. The facility shall have the capacity to bring additional staff on site to provide more intensive supervision, treatment, or management in response to the needs of individual clients. The treatment of each client shall be under the supervision of a physician, and a physician shall be on call on a 24-hour per day basis. Each direct care staff member shall have access at all times to qualified professionals who are qualified in the disability area(s) of the clients with whom the staff is working. Each direct care staff member shall be trained and have basic knowledge about mental illnesses and psychotropic medications and their side effects; mental retardation and other developmental disabilities and accompanying behaviors; the nature of addiction and recovery and the withdrawal syndrome; and treatment methodologies for adults and children in crisis.

*Substance Use Disorder (SUD):* For the different categories of SUD residential treatment facilities, staffing ratios are established, as are requirements for direct care staff, clinical and medical staff qualifications, and staff training, all of which vary by facility type, with specific additional training, including but not limited to crisis management, required at facilities where children are resident.

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* An assessment must be completed for a client, according to governing body policy, prior to the delivery of services, and shall include, but not be limited to: (1) the client's presenting problem; (2) the client's needs and strengths; (3) a provisional or admitting diagnosis with an established diagnosis determined within 30 days of admission, except that a client admitted to a detoxification or other 24-hour medical program shall have an established diagnosis upon admission; (4) a pertinent social, family, and medical history; and (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and vocational, as appropriate to the client's needs. Additionally, the governing body responsible for each facility or service shall develop and implement written policies for screenings, which shall include: (A) an assessment of the individual's presenting problem or need; (B) an assessment of whether or not the facility can provide services to address the individual's needs; and (C) the disposition, including referrals and recommendations.

*Substance Use Disorder (SUD):*

- For Residential Treatment/Rehabilitation for Individuals with Substance Use Disorders, individuals must be detoxified before entering the facility.
- For Residential Recovery Programs for Individuals with Substance Abuse Disorders and their Children, and for a Therapeutic Community, admission to the facility is a joint decision of the designated qualified professional, the provider of residential care, and the individual. For the former, the individual will have the opportunity for at least one pre-admission visit to the facility except for an emergency admission.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Treatment planning is required, and the plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days of admission for clients who are expected to receive services beyond 30 days. The plan must be reviewed at least annually.

- For Facility Based Crisis Centers for Individuals of All Disability Groups, each facility shall complete a discharge plan for each client that summarizes the reason for admission,

intervention provided, recommendations for follow-up, and referral to an outpatient or day program or residential treatment/rehabilitation facility.

*Substance Use Disorder (SUD):*

- For Nonhospital Medical Detoxification for Individuals who are Substance Abusers, for Social Setting Detoxification for Substance Abuse, and for Residential Treatment/Rehabilitation for Individuals with Substance Use Disorders, before discharging the client, the facility shall complete a discharge plan for each client and refer each client who has completed detoxification or treatment to an outpatient or residential treatment/rehabilitation facility.
- For Residential Recovery Programs for Individuals with Substance Abuse Disorders and their Children, programs shall include, for each parent in the program, aftercare and follow-up. Before discharging the client, the facility shall complete a discharge plan for each client and refer each client who has completed services to the level of treatment or rehabilitation in accordance with the client needs.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* For Facility Based Crisis Centers for Individuals of All Disability Groups, each facility shall have protocols and procedures for assessment, treatment, monitoring, and discharge planning for adults and for children of each disability group served in the facility. Protocols and procedures shall be approved by the LME-MCO's medical director or the medical director's designee, as well as the director of the appropriate disability unit of the area program.

*Substance Use Disorder (SUD):*

- For Nonhospital Medical Detoxification for Individuals who are Substance Abusers, and for Social Setting Detoxification for Substance Abuse, each facility shall have a written policy that requires: (1) procedures for monitoring each client's general condition and vital signs during at least the first 72 hours of the detoxification process; and (2) procedures for monitoring and recording each client's pulse rate, blood pressure and temperature as required in the regulations for each facility category.
- For Residential Treatment/Rehabilitation for Individuals with Substance Use Disorders, services include individual, group and family counseling and education and there are additional requirements that each facility provide or have access to certain other services.
- Residential Recovery Programs for Individuals with Substance Abuse Disorders and their Children shall include, for each parent in the program, assessment/referral, individual and

group therapy, therapeutic parenting skills, basic independent living skills, educational groups, child supervision, aftercare, follow-up and access to preventive and primary health care. Goals for parent-child interaction shall be established and progress towards meeting these goals shall be documented in the parent's service record. The facility may utilize services from another facility providing treatment, support or medical services. Services shall be designed to provide a safe and healthy environment for clients and their children. Each facility shall assist the individual with the development of independent living skills in preparation for community based living. Each individual and child admitted to a facility shall receive services as appropriate to his or her needs from a qualified professional who has responsibility for the client's treatment program. Each individual and child shall receive age-appropriate, therapeutic professional services. An appropriate education program for a child is specified in the regulations. Each facility shall ensure the availability of specified emergency medical services.

- A Therapeutic Community shall emphasize self-help, abstinence from drugs and alcohol, personal growth, peer support, and may serve as an alternative to incarceration. Services shall be designed to create the environment of an extended family in which individuals develop self-esteem, construct a productive lifestyle through peer support and actual experience, leading to a successful re-entry into the larger community. The facility shall provide or ensure access to a variety of intensive therapy and program milieu approaches designed to confront and modify the client's anti-social and dysfunctional behavior. The goal shall be to assist the client in learning socially acceptable skills for coping with responsibilities and relationships, and to maintain a lifestyle which is substance abuse free. Consideration shall be given to meeting client needs in social, medical, psychological, vocational and educational areas. If children are residing in a Therapeutic Community, the facility shall also meet the rules for Therapeutic Homes for Individuals with Substance Abuse Disorders and Their Children.

## **Patient Rights and Safety Standards**

*Mental Health (MH) and Substance Use Disorder (SUD):* The governing body must develop and implement written policies for a client grievance policy, including procedures for review and disposition of client grievances. Specific requirements exist for critical incident reporting, including cases of client death within seven days of use of seclusion or restraint.

- For Therapeutic Community facilities, since the facility can operate as an alternative to incarceration, random searches shall be conducted of an individual's belongings and bedroom; and privileges of the resident shall be determined as responsibility levels increase.



## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* The governing body responsible for each facility or service shall develop and implement written policies for quality assurance and quality improvement activities, including: (A) composition and activities of a quality assurance and quality improvement committee; (B) written quality assurance and quality improvement plan; (C) methods for monitoring and evaluating the quality and appropriateness of client care, including delineation of client outcomes and utilization of services; (D) professional or clinical supervision, including a requirement that staff who are not qualified professionals and provide direct client services shall be supervised by a qualified professional in that area of service; (E) strategies for improving client care; (F) review of staff qualifications and a determination made to grant treatment/habilitation privileges; (G) review of all fatalities of active clients who were being served in area-operated or contracted residential programs at the time of death; and (H) adoption of standards that assure operational and programmatic performance meeting applicable standards of practice.

The LME-MCO shall develop and implement written policies governing local monitoring of Category A and B providers. The written policies shall address the provider's quality improvement activities and trends in improvement.

## **Governance**

*Mental Health (MH) and Substance Use Disorder (SUD):* All facilities are subject to a governing body with authority over such things as quality improvement and policy and protocol development.

## **Special Populations**

*Substance Use Disorder (SUD):* For Residential Recovery Programs for Individuals with Substance Abuse Disorders and their Children, adequate training to support the therapeutic process shall be provided to all residential staff in the following areas within 60 days of employment: (1) therapeutic parenting skills; (2) dynamics and needs of emotionally disturbed and substance abusing individuals and their children; (3) pregnancy, delivery and well child care; and (4) infant feeding, including breast feeding.

## Location of Regulatory and Licensing Requirements

Division of Health Service Regulation (DHSR)<sup>1</sup>; NC DHHS State-Funded MH/DD/SA Service Definitions July 1, 2017<sup>2</sup>; NC DHHS State-Funded Enhanced MH and SA Services April 1, 2017<sup>3</sup>; NC Division of Health Service Regulation website<sup>4</sup>. Regulatory data collected September 17, 2019.

## Other Information Sources

R. Rader, M. Elliott (DMHDDSAS); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>1</sup> See <http://reports.oah.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2027%20-%20mental%20health%2C%20community%20facilities%20and%20services/subchapter%20g/subchapter%20g%20rules.html>.

<sup>2</sup> See <https://files.nc.gov/ncdhhs/State-Funded%20MHDDSAS%20Service%20Definitions%202003-2017%20effective%207-1-17.pdf>.

<sup>3</sup> See <https://files.nc.gov/ncdhhs/State-Funded%20Enhanced%20MH%20SA%20Services%204-1-17-final%20for%20posting.pdf>.

<sup>4</sup> See <https://info.ncdhhs.gov/dhsr/>.

# NORTH CAROLINA MEDICAID

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## Approach

The North Carolina Department of Health and Human Services (DHHS) oversees the state Medicaid program. North Carolina also has a Section 1115 waiver permitting Medicaid expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD), including residential treatment. The state has suspended managed care implementation and is not relying on the in lieu of provision for Medicaid coverage of IMD services but has historically relied on Disproportionate Share Hospital (DSH) payments.

## Types of Facilities

*Mental Health (MH):* Researchers found no other evidence of Medicaid reimbursement for adult residential MH treatment services.

*Substance Use Disorder (SUD):* The North Carolina Section 1115 waiver permits reimbursements for the following residential settings, some of which were previously covered by the state Medicaid program for those under age 21 years:

- Level 3.1 Clinically managed low-intensity residential treatment services (also called substance abuse halfway-house services)
- Level 3.2-WM Clinically managed residential withdrawal
- Level 3.3. Clinically Managed Population-Specific High Intensity Residential Services
- Level 3.5 Clinically managed high-intensity residential services (also called substance abuse non-medical community residential treatment) (pre-waiver, only covered for pregnant and parenting women in non-IMDs)
- Level 3.7 Medically monitored intensive inpatient services (substance abuse medically monitored community residential treatment)

- Level 3.7-WM Medically monitored inpatient withdrawal management (nonhospital medical detoxification)

Medication-assisted treatment also is to be available to those in IMDs.

## **Processes of Medicaid Enrollment**

*Mental Health (MH) and Substance Use Disorder (SUD):* To enroll as a Medicaid provider in North Carolina, a provider must, among other things, submit an application, undergo trainings, and make certain attestations. A provider enrolled in the Medicaid program must submit to the department's recredentialing process every five years. Enrollment may be revoked, and other sanctions applied. Maintenance of appropriate licensure is required.

## **Staffing**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding credentials of staff for residential treatment settings. The state must assess the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT.

## **Placement**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines. The state also must establish a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings.

## **Treatment and Discharge Planning and Aftercare Services**

*Substance Use Disorder (SUD):* According to the waiver implementation plan, the then-current Medicaid standards included a requirement of person-centered planning, excepting detoxification services, for which a plan of care, service plan or treatment plan was required.

Review at least annually was required. Upon waiver implementation, person-centered planning was to become standard.

## **Treatment Services**

*Substance Use Disorder (SUD):* Under the Section 1115 waiver, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions. In addition to current licensing requirements (see companion summary for detailed information on service requirements for licensure of residential substance use disorder treatment), pursuant to the Section 1115 waiver, the state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services and hours of clinical care for residential treatment settings. The state must establish a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site.

## **Care Coordination**

*Substance Use Disorder (SUD):* Under the Section 1115 waiver, beneficiaries will have improved care coordination and care for comorbid physical and mental health conditions. The state must ensure establishment and implementation of policies to ensure residential facilities link beneficiaries with community-based services and supports following stays in these facilities.

## **Quality Assurance or Improvement**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings.

## **Special Populations**

*Substance Use Disorder (SUD):* No Medicaid requirements were located other than the requirement in the Section 1115 waiver that care for comorbid physical and mental health conditions be improved by the demonstration.

## Location of Medicaid Requirements

NC Medicaid Statute<sup>5</sup>; NC Medicaid Policy re Covered Services<sup>6</sup>; North Carolina Section 1115 waiver<sup>7</sup>. Regulatory data collected January 2020.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report “**State Residential Treatment for Behavioral Health Conditions: Regulation and Policy**”. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

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<sup>5</sup> See <https://www.ncleg.gov/Laws/GeneralStatuteSections/Chapter108C>.

<sup>6</sup> See <https://policies.ncdhhs.gov/divisional/health-benefits-nc-medicaid/adult-medicaid/policies-manuals/ma-2905-medicaid-covered-services>.

<sup>7</sup> See <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/nc-medicaid-reform-ca.pdf>.

## NORTH DAKOTA

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### Types of Facilities

*Mental Health (MH):* North Dakota does not regulate MH residential treatment facilities.

*Substance Use Disorder (SUD):* North Dakota regulates Clinically Managed Residential Services, in accordance with ASAM levels of low (3.1) and high-intensity (3.5). Each level corresponds to extent of clinical services delivered per day or week and varies by specification of treatment requirements. North Dakota also regulates alcohol and drug detoxification services in a residential setting as Social Detoxification ASAM Level 3.2-D. No other regulated SUD residential treatment facility types were identified.

*Unregulated Facilities:* If there are MH residential treatment facilities in North Dakota, they are unregulated.

### Approach

*Substance Use Disorder (SUD):* The North Dakota Department of Human Services (DHS) regulates all SUD residential treatment facilities regardless of funding source.

### Processes of Licensure or Certification and Accreditation

*Substance Use Disorder (SUD):* Facilities require licensure by the DHS for operation.

- Accreditation is not required but proof of accreditation by a nationally recognized body that reviews and certifies providers of drug and alcohol services means that a license will be issued.
- A facility may be provisionally licensed for as long as one year or have a restricted license for no more than 90 days. Unrestricted licensure duration is no longer than 2 years.
- Onsite review is required to obtain an unrestricted license and at least biennially to determine continued compliance with the regulatory standards.

- A Certificate of Need is not required for operation of SUD residential facilities.

## **Cause-Based Monitoring**

*Substance Use Disorder (SUD):* The DHS performs onsite reviews at licensure renewals and may conduct scheduled or unscheduled visits at other times. A plan of corrective action may be required, and licensure may be suspended or revoked.

## **Access Requirements**

*Substance Use Disorder (SUD):* Wait-time requirements were not found but all SUD facilities must conform to applicable legal requirements of all governmental and legally authorized agencies under whose authority it operates, to include accessibility, affirmative action, and equal employment opportunity.

## **Staffing**

*Substance Use Disorder (SUD):* Substance use treatment programs must employ sufficient and qualified staff members to meet the needs of the clients, have a policy regarding verification of staff qualification, maintain documentation regarding volunteers or consultants, maintain personnel files, and have a written employment policy related to nondiscrimination. All residential treatment facilities must provide staff twenty-four hours per day. High-intensity residential treatment facilities must include onsite, twenty-four hour per day clinical staffing by licensed counselors, other clinicians, and other allied health professionals such as counselor aides. Social detoxification facilities must provide: (a) a trained staff member familiar with complications associated with alcohol and other drug use and with community resources awake on all shifts; (b) awake staff twenty-four hours per day to monitor clients' conditions; and (c) staff trained in admission, monitoring skills, including signs and symptoms of alcohol and other drug intoxication and withdrawal as well as appropriate treatment of those conditions, supportive care, basic cardiopulmonary resuscitation technique, assessment, and referral procedures.

## **Placement**

*Substance Use Disorder (SUD):* Each residential SUD facility must implement written criteria for client admission for each of the program's levels of care based on the DSM and the ASAM patient placement criteria and policies for client admission. A program may not admit a client that does not meet those criteria. Placement criteria for low- and high-intensity residential treatment correspond to ASAM levels 3.1 and 3.5 placement criteria. For social detoxification,



the client must meet the diagnostic criteria for a substance-induced disorder of the current DSM and current clearance by a physician or a CIWA-Ar score of less than eight and the presence of any of the following: (1) Diffuse mild central nervous system symptoms such as specific: (a) cerebral symptoms; (b) coordination symptoms; (c) reflex abnormalities; or (d) motor abnormalities. (2) Onset of any stated symptoms listed in subsection 1 over a few hours. (3) Intoxication. (4) The absence of other more serious symptoms, including medical or psychiatric histories of significant problems and the absence of suicidal ideations or suicidal ideation of low lethality without plan or means. (5) Presence of any one of several physical findings. (6) Ability to comprehend and function in an ambulatory setting.

## **Treatment and Discharge Planning and Aftercare Services**

*Substance Use Disorder (SUD):* All residential SUD treatment and detoxification facilities are required to develop an individualized treatment plans that includes discharge/aftercare requirements. For the social detoxification setting, the preliminary individualized treatment plan must include problem identification in ASAM PPC dimensions two through six and development of treatment goals and measurable treatment objectives and activities designed to meet those objectives. Individual treatment plans must be created in the following timeframes: (a) By the end of the first day for a client in a social detoxification program; and (b) By the end of the fifth working day for a client receiving low-intensity and high-intensity residential treatment. Review of plans is required at least every month in low-intensity residential treatment and every week for high-intensity residential treatment. Referrals and recommendations for additional treatment must be part of the treatment or discharge plan. When a client is transferred, the discharge summary must include a discharge plan which identifies the treatment goals not yet achieved as well as any problems that have been deferred for treatment by a subsequent provider. For the social detoxification setting, the facility must have a clearly defined policy for discharge and transfer of a client to another level of care.

## **Treatment Services**

*Substance Use Disorder (SUD):* The general requirements for SUD treatment programs include that the services are coordinated, integrated, and address goals that reflect the client's informed choice. Services essential to the attainment of a client's goals and objectives must be provided or it must be documented that attempts were made to provide such services either through staff members or through formal affiliation or consultation arrangements with or referral to appropriate agencies or individuals. The requirements for services in the three categories of residential SUD treatment facilities follow those of the ASAM standards, including requirement regarding hours or other extent of clinical services, the focus of services, and, for high-intensity residential programs, daily clinical services which include, among other things, a range of cognitive, behavioral, and other therapies in individual or group therapy and psychoeducation as deemed appropriate by an assessment and treatment plan; motivational

enhancement and engagement strategies appropriate to the client's stage of readiness to change; counseling and clinical interventions to teach a client the skills needed for daily productive activity, prosocial behavior, and reintegration into family or community. The social detoxification program, among other things, must have hospital affiliation; available specialized clinical consultation and supervision for biomedical, emotional, behavioral, and cognitive problems; linkage with providers of other levels of care so the client may begin a therapeutic process as soon as the client is physically and mentally able to do so; administer a range of cognitive, behavioral, medical, mental health, and other therapies on an individual or group basis designed to meet the client's ability to participate in order to enhance the client's understanding of addiction, the completion of the detoxification process, and referral to an appropriate level of care for continuing treatment.

## **Patient Rights and Safety Standards**

*Substance Use Disorder (SUD):* All SUD treatment facilities must assure certain client rights, including but not limited to, the right to dignity, nondiscrimination, confidentiality, and freedom from abuse. Programs must provide services reflecting the needs of each gender and must provide information on client rights in a language the client understands. Programs must develop a complaint/grievance process and must document critical incidents in the person's record. Researchers did not locate restrictions on restraint or seclusion nor requirements for reporting critical incidents.

## **Quality Assurance or Improvement**

Substance Use Disorder (SUD): All SUD treatment facilities must implement an established written system that provides for internal, professional review of the quality and appropriateness of the program of services for the client. A program shall implement a written quality assurance plan and designate an employee to coordinate that plan. A program shall implement a written policy that provides that peer review must occur at least quarterly and must involve a representative sampling of clients served. The review must be conducted irrespective of sources of funding for the clients and the documented results of the review must:

- Produce a documented list of areas needing improvement and actions taken.
- Be integrated into the individual planning, plan evaluation, and program management activities for the client.
- Be administratively used, in conjunction with results of consume satisfaction surveys, in program evaluation activities, and in organizational planning.

- Be reviewed at least annually by the program's administration.

## **Governance**

*Substance Use Disorder (SUD)*: A program must identify to the department an individual or entity that is responsible for the conduct of the program; implement a written policy governing the operation of services including admission procedures, discharge procedures, client grievance procedures, scope of service, treatment plans, staffing patterns, outside referrals, and continued or follow-up treatment; conform to applicable legal requirements and regulations of all governmental and legally authorized agencies under whose authority it operates, to include accessibility, affirmative action, equal employment opportunity, health and safety, and licensure; and be responsible for providing qualified personnel, facilities, and equipment needed to carry out the goals and objectives and meet the needs of the clients.

## **Special Populations**

No requirements regarding special populations were located.

## **Location of Regulatory and Licensing Requirements**

Article 75-09. Chapter 75-09.1-01 General Standards for Substance Abuse Treatment Programs (All)<sup>1</sup>; Chapter 75-09.1-02 Clinically Managed Low-Intensity Residential Care--Adult ASAM Level III.1<sup>2</sup>; Chapter 75-09.1-03 Clinically Managed High-Intensity Residential Care--Adult ASAM Level III.5<sup>3</sup>; Chapter 75-09.1-08 Social Detoxification ASAM Level III.2-D<sup>4</sup>. Regulatory data collected May 17, 2019.

## **Other Information Sources**

L. Graham and N. Berman (DHS); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>1</sup> See <https://www.legis.nd.gov/information/acdata/pdf/75-09.1-01.pdf>.

<sup>2</sup> See <https://www.legis.nd.gov/information/acdata/pdf/75-09.1-02.pdf>.

<sup>3</sup> See <https://www.legis.nd.gov/information/acdata/pdf/75-09.1-03.pdf>.

<sup>4</sup> See <https://www.legis.nd.gov/information/acdata/pdf/75-09.1-08.pdf>.

# NORTH DAKOTA MEDICAID

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## Approach

The North Dakota Department of Human Services (DHS) oversees the state Medicaid program. North Dakota does not have a Section 1115 waiver that affects reimbursement of residential services within Institutions for Mental Diseases (IMDs). It has historically relied to some extent on Disproportionate Share Hospital (DSH) payments but not the in lieu of provision to reimburse services in IMDs.

## Types of Facilities

*Mental Health (MH):* No evidence of coverage of MH residential treatment facilities for adults was located.

*Substance Use Disorder (SUD):* No evidence of coverage of SUD residential treatment facilities for adults was located.

## Processes of Medicaid Enrollment

To participate in the North Dakota Medicaid program, health care providers either must be certified to participate in Medicare or satisfy other standards. An application must be made, which can be denied, and a provider agreement signed. Providers are subject to sanctions and must apply with all applicable statutes and regulations.

## Staffing

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based staffing requirements for residential treatment facilities for adults was located.

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based placement requirements for residential treatment facilities for adults was located.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based treatment or discharge planning or aftercare service requirements for residential treatment facilities for adults was located.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based treatment service requirements for residential treatment facilities for adults was located.

## **Care Coordination**

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based care coordination requirements for residential treatment facilities for adults was located.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based quality assurance or improvement requirements for residential treatment facilities for adults was located.

## **Special Populations**

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based special population requirements for residential treatment facilities for adults was located.

## **Location of Medicaid Requirements**

North Dakota Administrative Code Article 75-02-02<sup>5</sup>. Regulatory data collected December 2019.

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<sup>5</sup> See <https://www.legis.nd.gov/information/acdata/html/75-02.html>.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report **“State Residential Treatment for Behavioral Health Conditions: Regulation and Policy”**. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

## OHIO

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### Types of Facilities

*Mental Health (MH):* Ohio regulates the following residential MH treatment facilities:

- *Residential facility:* a publicly or privately-operated home or facility that falls into three categories, of which only class one facilities offer mental health services:
  - *Class one facilities:* provide accommodations, supervision, personal care services, and mental health services for one or more unrelated adults with mental illness or one or more unrelated children or adolescents with severe emotional disturbances.
- *Crisis stabilization unit:* a residential unit providing crisis stabilization for persons needing an intermediate level of care. The standard services of general services and crisis intervention are offered. Treatment interventions are focused on stabilizing the current crisis and mobilizing support and resources so that the person can be treated in a less restrictive setting. The unit provides twenty four-hour observation, supervision and voluntary treatment services for individuals who do not require the intensive medical treatment of inpatient care. Length of stay on a crisis stabilization unit is anticipated to be no longer than fourteen days duration.

*Substance Use Disorder (SUD):* Ohio regulations reference the ASAM Level 3 and sublevel 3 requirements, but do not explicitly address the different sublevel 3 types of facilities as defined by ASAM.

*Unregulated Facilities:* No unregulated facility types under the purview of this summary were found.

### Approach

*Mental Health (MH) and Substance Use Disorder (SUD):* Residential treatment facilities are regulated by the Department of Mental Health and Addiction Services.

## **Processes of Licensure or Certification and Accreditation**

### *Mental Health (MH) and Substance Use Disorder (SUD):*

- General certification requirements apply to each provider that is providing mental health and addiction services that are funded by, or funding is being sought from the Ohio Medicaid program for community mental health or community addiction services; a board of alcohol, drug addiction, and mental health services; or federal or department block grant funding for certified services.
- Effective September 29, 2019, certification is obtained by submission of an application to the Department of Mental Health and Addiction Services. An on-site survey may occur. Full certification is up to three years.
- In lieu of a determination by the director of the Department of Mental Health and Addiction Services of whether the mental health services of a community mental health services provider or the alcohol and drug addiction services of a community addiction services provider satisfy the standards for certification, the director shall accept appropriate accreditation from any of the following national accrediting organizations as evidence that the applicant satisfies the standards for certification: (1) The Joint Commission; (2) The Commission on Accreditation of Rehabilitation Facilities; (3) The Council on Accreditation; or (4) Other behavioral health accreditation as determined by the director. Certification may then be issued without further evaluation of services.
- Even with deemed status, the director may still conduct additional reviews.
- The state does not require a certificate of need.

### *Mental Health (MH):*

- Licensure by the Department of Mental Health and Addiction Services is required for operation of residential facilities. Licensure duration is three years for class one facilities, by which time a renewal application is required. An inspection is required for licensure and renewal.
- Mental health services also are certifiable by the Department of Mental Health and Addiction Services.

### *Substance Use Disorder (SUD):*



- As of September 29, 2019, the following types of addiction services (among others) require certification by the Department of Mental Health and Addiction Services:
  - Withdrawal management addiction services provided in a setting other than an acute care hospital.
  - Addiction services provided in a residential treatment setting.

## **Cause-Based Monitoring**

*Mental Health (MH):* For residential facilities, the department may conduct surveys or inspections of licensed facilities, as it deems necessary and appropriate, to determine initial or continued compliance with requirements or to determine whether deficiencies have been corrected, or upon complaint or allegation of licensure violations by any provider or individual. Inspections or surveys may be unscheduled and unannounced and may include all areas of the facility regardless of resident access. Corrective action ranges from identifying deficiencies for correction up to termination/revocation of licenses.

*Substance Use Disorder (SUD):* For addiction treatment services in a residential setting, if the director determines that a community mental health services provider applicant's or a community addiction services provider applicant's certifiable services and supports do not satisfy the standards for certification, the director shall identify the areas of noncompliance, specify what action is necessary to satisfy the standards, and may offer technical assistance to the applicant and to a board of alcohol, drug addiction, and mental health services so that the board may assist the applicant in satisfying the standards. The director may request that the board reallocate any funds for the certifiable services and supports. If the board does not reallocate such funds in a reasonable period of time, the director may withhold state and federal funds for the certifiable services and supports and allocate those funds directly to a community mental health services provider or community addiction services provider whose certifiable services and supports satisfy the standards.

## **Access Requirements**

*Mental Health (MH):* Requirements regarding residential services were not explicitly described in the state regulations.

*Substance Use Disorder (SUD):* A community addiction services provider that receives public funds shall not refuse to treat a person solely because the person is pregnant if appropriate treatment is offered by the provider. The regulations also include requirements related to waiting lists for alcohol and drug addiction services generally. Among other requirements, wait lists must be established, determinations made as to whether assessments are needed, and tracking of assessment and service conducted from first contact.

## **Staffing**

*Mental Health (MH):* All staff, including the operator, shall be at least eighteen years of age; demonstrate adequate communication skills to perform duties and responsibilities associated with the facility in meeting the needs of the resident(s); be able to perform required responsibilities and duties; and test negative for tuberculosis within one year prior to employment.

The manager and staff of a facility which treat persons with mental illness shall receive a general orientation for working with persons with mental illness, and complete 6 hours of training in relevant topics each twelve-month period.

Each facility shall provide sufficient numbers and types of staff in the facility, scheduled for appropriate periods of time during each twenty-four hour period, to assure that the room, board, personal care, or mental health service needs of each resident are met in a timely manner, as appropriate to the licensure type of the facility and individual needs of each resident. Providers shall specify the minimum staffing pattern of the facility in the resident agreement.

The staffing pattern of a class one facility shall assure reasonable amounts of time for staff to engage in social and recreational activity with residents.

*Substance Use Disorder (SUD):* All providers should align staffing requirements with ASAM requirements, and services should only be provided and supervised by staff who are qualified. Providers shall receive on-going training.

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* For residential facilities, an assessment is a clinical evaluation of a person which is individualized and age, gender, and culturally appropriate. When the assessment is to be provided to a client it should started prior to the initiation of other services, except for emergency situations. Initial and comprehensive assessments shall be completed according to prevailing standards of care as defined by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, the Council on Accreditation, or other entities as designated by the director.

*Substance Use Disorder (SUD):* For addiction treatment services in a residential setting, all aspects of services should be in accordance with ASAM level 3 requirements and associated sub-levels. This includes admission, continued stay, discharge, and referral to other levels of care.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Each client must have an individualized treatment plan (ITP), with an initial plan developed within 7 days of assessment. A complete ITP must be completed within 30 days, with updates made at least every 90 days or more frequently if clinically indicated. A discharge summary is required but no requirement for a specific discharge plan was located and no aftercare or follow-up requirements were identified.

*Substance Use Disorder (SUD):* For addiction treatment services in a residential setting, discharge planning is required. In the case of transfer, follow-up communications with client and the service provider to which client is referred are required, and these contacts shall be documented in the client's record.

## **Treatment Services**

*Mental Health (MH):* A residential facility must provide at least one certified service, but the certified service is not specified, except in the case of a crisis stabilization unit, which must provide crisis intervention services and general services, which consists of one or more of the following: assessment, counseling, and medical services.

For class one facilities only, facilities may provide “skilled nursing care”. “Skilled nursing care” means procedures that require technical skills and knowledge beyond those the untrained person possesses and that are commonly employed in providing for the physical, mental, and emotional needs of the ill or otherwise incapacitated. A class one residential facility shall provide mental health services. The primary purpose shall be to provide room and board, personal care, and mental health services either to meet a temporary need, or as long-term assistance.

Residents of class one facilities shall be encouraged to participate in community activities and social events. The facility staff shall demonstrate a reasonable effort to facilitate and support such involvement by providing at least one local daily newspaper or current community activity brochures and advertisements, and provide transportation or information about the accessibility of transportation. Each class one residential facility shall provide, at a minimum, leisure time activities appropriate to the age and sex of the residents, and a residential care facility recreational equipment and activities sufficient to implement recreational programs to encourage physical activity.

*Substance Use Disorder (SUD):* Providers of addiction treatment services in a residential setting shall provide, in addition to the required ASAM level of care: food for client; the opportunity for clients to get eight hours of sleep per night; and services in facilities that are clean, safe, and therapeutic. Providers shall promote interpersonal and group living skills. Clients shall be

connected to resources for education, job training, job interviews, employment stabilization and obtaining alternative living arrangements.

## **Patient Rights and Safety Standards**

*Mental Health (MH) and Substance Use Disorder (SUD):* The operator shall develop an incident reporting system to include a mechanism for the review and analysis of all reportable incidents such that clinical and administrative activities are undertaken to identify, evaluate, and reduce risk to residents, staff, and visitors.

The use of seclusion, mechanical restraint, and physical restraint, including transitional hold, shall not be permitted in any facility, except a class one facility and in accordance with specific requirements in the regulations.

Each facility shall have the following: a written resident rights policy that lists all of the resident rights; a written resident grievance procedure, written in a manner that residents can understand and which allows for reasonable accommodation for residents with disabilities; and a policy for maintaining for at least three years from resolution, records of residents.

Each resident has rights to file a grievance and to be free from restraint or seclusion unless there is imminent risk of physical harm to self or others.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* Providers shall establish a planned, systematic, organization-wide approach to performance improvement that is both collaborative and interdisciplinary. It is important that each provider measure the performance processes which support care and establish a method of data collection and analysis in order to identify areas of needed improvement, and develop and implement improvement plans which support achieving performance targets, client satisfaction, and positive client outcomes. The provider shall collect and analyze data as required by its accrediting body, if applicable, or for a provider without behavioral health accreditation, at least annually.

## **Governance**

*Mental Health (MH) and Substance Use Disorder (SUD):* Each provider shall have a leadership structure. The leadership structure shall identify who is responsible for governance; provider administration; and the provision of services.

Each corporation for non-profit shall have a governing body which should guide, plan and support the achievement of the provider's mission, vision and goals.

Each provider which is not a corporation for non-profit shall have a written description of its governance structure and identify whether the owner shall assume sole responsibility whether the provider is governed by a governing body, board of directors, or other governance body.

## **Special Populations**

*Mental Health (MH):* Requirements regarding residential services were not explicitly described in the state regulations.

*Substance Use Disorder (SUD):* The department of mental health and addiction services shall give priority to developing, and promptly shall develop, with available public and private resources a program that does all of the following: (1) Provides a manner of identifying the aggregate number of pregnant women in this state who are addicted to a drug of abuse; (2) Provides for an effective means of intervention to eliminate the addiction of pregnant women to drugs of abuse prior to the birth of their children; (3) Gives priority to the treatment of pregnant women addicted to drugs of abuse, including by requiring community addiction services providers that receive public funds to give priority to pregnant women referred for treatment; (4) Provides for the continued monitoring of women who were addicted to a drug of abuse during their pregnancies, after the birth of their children, and for the availability of treatment and rehabilitation for those women; (5) Provides a manner of determining the aggregate number of children who are born in this state to women who are addicted, at the time of birth, to a drug of abuse, and of children who are born in this state with an addiction to or a dependency on a drug of abuse; (6) Provides for the continued monitoring of children who are born in this state to women who are addicted, at the time of birth, to a drug of abuse, or who are born in this state with an addiction to or dependency on a drug of abuse, after their birth; and (7) Provides for the treatment and rehabilitation of any child who is born to a woman who is addicted, at the time of birth, to a drug of abuse, and of any child who is born with an addiction to or dependency on a drug of abuse.

## **Location of Regulatory and Licensing Requirements**

Department of Mental Health and Addiction Services<sup>1,2</sup>. Regulatory data collected August 23, 2019.

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<sup>1</sup> See <http://codes.ohio.gov/orc/5119>.

<sup>2</sup> See <http://codes.ohio.gov/oac/5122-30>.

## **Other Information Sources**

J.M. Pequignot (DMHAS); National Conference of State Legislatures CON Program Overview,  
<http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

# OHIO MEDICAID

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## Approach

*Mental Health (MH) and Substance Use Disorder (SUD):* The Ohio Department of Health (DOH) oversees the state Medicaid program. Ohio relies on the in lieu of provision and Disproportionate Share Hospital (DSH) to reimburse some services in institution for mental diseases (IMD).

*Mental Health (MH):* Researchers found no evidence of Medicaid coverage of residential MH treatment.

*Substance Use Disorder (SUD):* The Ohio Section 1115 waiver permits Medicaid reimbursement of expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder who are short-term residents in facilities that meet the definition of an IMD, including residential treatment.

## Types of Facilities

*Substance Use Disorder (SUD):* Types of facilities identified as meeting the definition of IMDs include:

- Level 3.1 Clinically managed low-intensity residential treatment
- Level 3.2-WM Clinically managed residential withdrawal management
- Level 3.3. Clinically Managed Population-Specific High Intensity Residential treatment
- Level 3.5 Clinically managed high-intensity residential treatment (adult)
- Level 3.7 Medically monitored intensive inpatient services
- Level 3.7-WM Medically monitored inpatient withdrawal management

Medication-assisted treatment also is to be available to those in IMDs.

## **Processes of Medicaid Enrollment**

*Mental Health (MH) and Substance Use Disorder (SUD):*

- Providers are subject to license verifications, including state licensure verification in states other than Ohio.
- In order to become an eligible provider, a provider must meet the screening requirements described in the Ohio Revised Code and pay an applicable application fee if required. Provider screening and application fees are required at the time of enrollment and revalidation.
- A valid provider agreement with Medicaid will act as a provider agreement for participation in the Medicaid program. Provider agreements must be revalidated no later than five years from the effective date of the original or the last revalidated provider agreement, whichever is applicable.

## **Staffing**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding credentials of staff for residential treatment settings. The state must conduct an assessment of the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT.

## **Placement**

*Substance Use Disorder (SUD):* In accordance with the state 1115 waiver, there shall be the establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as ASAM Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines; as well as a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings. According to the SUD waiver implementation plan, Ohio administers its Medicaid SUD treatment services based on the ASAM Patient Placement Criteria.



## **Treatment and Discharge Planning and Aftercare Services**

*Substance Use Disorder (SUD):* Pursuant to the 1115 waiver implementation plan, Ohio Medicaid is to amend the provider manual, MCO contracts, and regulations to describe, for each level of care, the responsibilities for screening, assessment and treatment plan review, including the requirements to substantiate appropriate patient placement using the ASAM dimensions in assessments, admission and discharge criteria for each SUD outpatient and residential LOC.

## **Treatment Services**

*Substance Use Disorder (SUD):* Pursuant to the state Section 1115 waiver, beneficiaries will have access to high quality, evidence-based OUD/SUD treatment and withdrawal management services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in cost-effective community-based settings. The state will work to improve care coordination and care for co-occurring physical and behavioral health conditions. The state must establish residential treatment program standards regarding in particular the types of services and hours of clinical care for residential treatment settings. In accordance with the state 1115 waiver, there shall be the establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site.

Pursuant to the waiver, the following services are included in the residential treatment service and will not be reimbursed separately: (a) Ongoing assessments and diagnostic evaluations; (b) Crisis intervention; (c) Individual, group, family psychotherapy and counseling; (d) Case management; (e) Substance use disorder peer recovery services; (f) Urine drug screens; and (g) Medical services.

For Medicaid requirements, individuals in residential treatment may receive medically necessary services from practitioners who are not affiliated with the residential treatment program. Examples include, but are not limited to, psychiatry, medication assisted treatment, or other medical treatment that is outside the scope of the residential level of care as defined by ASAM. Medicaid will reimburse providers of these services outside the per diem rate paid to residential treatment.

## **Care Coordination**

*Mental Health (MH) and Substance Use Disorder (SUD):* MCOs are required to provide care management to all enrolled members. MCOs must assure care management services and supports are available to individuals when needed.

*Substance Use Disorder (SUD):* Pursuant to the state Section 1115 waiver, beneficiaries will have access to improved care coordination and care for co-occurring physical and behavioral health conditions. In accordance with the state 1115 waiver, there shall be the establishment and implementation of policies to ensure residential facilities link beneficiaries with community-based services and supports following stays in these facilities. According to the SUD implementation plan, Ohio Medicaid (ODM) approaches care coordination by promoting a population health management approach as well as other reforms to create an improved system to better care for all individuals in Medicaid including those with SUD diagnoses.

Ohio has undertaken multiple interventions and strategies to improve coordination of care and the transition between LOCs along the continuum of care including, but not limited to, facility discharge requirements in OhioMHAS certification standards, Ohio's Comprehensive Primary Care (CPC) program, care management and transition of care requirements in MCP contracts, and targeted case management.

For Medicaid-eligible members who are also receiving substance use disorder (SUD) residential treatment, the following applies: the eligible member will be attributed to or maintain attribution with a qualified behavioral health entity (QBHE) during the SUD residential treatment period; the QBHE will not be eligible for behavioral health care coordination (BHCC) payments during the eligible member's SUD residential treatment period because BHCC is duplicative of the care coordination responsibilities of the SUD residential treatment program; and the QBHE will immediately re-engage the eligible member for BHCC upon discharge from the SUD residential treatment period.

## **Quality Assurance or Improvement**

*Substance Use Disorder (SUD):* In accordance with the state 1115 waiver, there shall be the establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings.

## **Special Populations**

*Mental Health (MH) and Substance Use Disorder (SUD):* Requirements regarding residential services were not explicitly described in the state regulations.

## Location of Medicaid Requirements

Ohio Administrative Code 5160-27-09: Medicaid<sup>3</sup>; Section 1115 demonstration<sup>4</sup>. Regulatory data collected January 10, 2020.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report **“State Residential Treatment for Behavioral Health Conditions: Regulation and Policy”**. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

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<sup>3</sup> See <http://codes.ohio.gov/oac/5160>.

<sup>4</sup> See <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/82901>.

## OKLAHOMA

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### Types of Facilities

*Mental Health (MH) and Substance Use Disorder (SUD):* Oklahoma regulates Community-based Structured Crisis Centers (CBSCCs), a program of non-hospital emergency services for mental health and substance use disorder crisis stabilization. The CBSCC may provide services in excess of 24 hours during one episode of care.

*Mental Health (MH):* Oklahoma regulates Certified Eating Disorder Treatment Programs (CEDTs), which can be housed in a "residential facility" that provides 24 hour on-site nursing supervision and care.

*Substance Use Disorder (SUD):* Oklahoma regulates two categories of facilities, "public" and private. Public facilities include:

- Halfway Houses (considered by Oklahoma to equate to ASAM Level III.1), low intensity SUD treatment in a supportive living environment to facilitate reintegration into the community. Major emphasis shall be on continuing substance use disorder care and follow-up, and community ancillary services in an environment supporting continued abstinence.
- Halfway House for Persons with Children (equate to ASAM Level III.1), a halfway house that includes services for the recovering person's children who will reside with him or her in the house. Halfway house services for persons with dependent children shall provide substance use disorder treatment services in a residential setting and shall include a planned regimen of twenty-four (24) hour, seven (7) days a week, supervised living arrangements, to include professionally directed evaluation, care, and treatment, under a defined set of policy and procedures, in a permanent setting.
- Non-Medical Withdrawal Management (equate to ASAM Level III.2-WM), withdrawal management services for intoxicated consumers and consumers withdrawing from alcohol or other drugs presenting with no apparent medical or neurological symptoms as a result of their use of substances. It is intended to stabilize and prepare consumers to access further treatment.

- Medically Supervised Withdrawal Management (equates to ASAM Level III.7-WM), withdrawal management outside of a medical setting, directed by a physician who has attendant medical personnel including nurses for intoxicated consumers, and consumer's withdrawing from alcohol and other drugs, presenting with no apparent medical or neurological symptoms as a result of their use of substances that would require hospitalization. Withdrawal management is intended to stabilize and prepare consumers to access further treatment.
- Residential Treatment-Substance Abuse (equates to ASAM Level III.5 (High-Intensity)), a live-in setting which provides a regimen consisting of twenty-four (24) treatment hours per week. Also known as Intensive Residential Treatment for Adults.
- Residential Treatment for Persons with Children-Substance Abuse (equates to ASAM Level III.5 (Parent Only)), professionally directed evaluation, care, and residential treatment that includes services for the recovering person's children who will reside with him or her in the residential facility.
- Adult Residential Treatment for Consumers with Co-Occurring Disorders, SUD and MH treatment provided in a residential setting offering a planned regimen of twenty-four (24) hour structured evaluation, care, and treatment, under a defined set of policy and procedures, in a permanent setting.

Comprehensive Community Addiction Recovery Centers (CCARCs) are private SUD facilities that include core services, which do not include residential treatment, but where residential treatment is an optional component. Facility types include:

- Medically supervised withdrawal management.
- Non-medical withdrawal management.
- Residential treatment-substance abuse.
- Residential treatment for persons with children-substance abuse.
- Adult residential treatment for consumers with co-occurring disorders.
- Halfway house services.
- Halfway house services for persons with dependent children.

*Unregulated Facilities:* It is possible that there are residential mental health treatment facilities in addition to crisis or eating disorder facilities that are unregulated. We do not include Community Residential Mental Health Facilities in this summary because they do not include

clinical treatment within the facility. We do not include Mental Illness Service Programs because outpatient services are included in the “core services” that must be provided by such programs.

## **Approach**

The Oklahoma State Board of Mental Health and Substance Abuse Services (ODMHSAS) regulates: (1) CBSCCs, which may only be operated by CMHCs certified or operated by ODMHSAS; (2) CEDTs; (3) SUD treatment services that are ODMHSAS facilities, facilities under contract with ODMHSAS, and all facilities otherwise subject to certification by ODMHSAS; and (4) private CCARCs.

## **Processes of Licensure or Certification and Accreditation**

*Mental Health (MH) and Substance Use Disorder (SUD):* ODMHSAS certification (also referred to as a license) is required for CBSCCs, CEDTs, and SUD residential treatment programs that are ODMHSAS facilities; facilities under contract with ODMHSAS; and all facilities subject to certification by ODMHSAS. In addition, private facilities (CCARCs) that are residential facilities may be certified.

- Accreditation is not required but ODMHSAS may accept accreditation granted by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation of Services for Families and Children, Inc. (COA), as compliance with certain specific ODMHSAS standards. For such to be considered, the facility shall make application and submit evidence to the ODMHSAS of current accreditation status. Certification with special distinction requires, among other things, that the facility has attained national accreditation (COA, CARF, or TJC) for the services to which ODMHSAS Certification applies.
- Site inspections are required for licensure and renewal. The focus of the inspection is primarily on regulatory compliance.
- A Certificate of Need is not required for operation.
- A permit for temporary operations may be granted for up to 6 months. Full certification duration is one or two years, depending on level of compliance with regulations. If certain conditions are met, a program may receive certification with special distinction for three years. The primary focus of certification is on compliance with regulatory requirements.

## **Cause-Based Monitoring**

*Mental Health (MH) and Substance Use Disorder (SUD):* Certifications may be revoked, reduced, or suspended and a certificant may be reprimanded. Site visits are required to determine corrections of deficiencies and may be conducted for other reasons and may be unannounced. Plans of correction may be required.

## **Access Requirements**

*Mental Health (MH) and Substance Use Disorder (SUD):* All facilities are required to comply with the ADA and have a policy of non-discrimination against persons with HIV infection or AIDS. Researchers did not locate wait time requirements.

CBSCCs must be specifically accessible to individuals who present with cooccurring disorders and have the capacity to treat individuals in emergency detention status. As part CBSCCs must have written policy and procedures ensuring that individuals who present in crisis with co-occurring disorders are identified, and that there are no barriers to access triage crisis response based on arbitrary alcohol or drug levels, types of diagnosis or medications while remaining in compliance with facility certification, licensure, and medical standards.

## **Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD):* CBSCCs must always have a physician available for the crisis unit, either on-duty or on call, responding within 20 minutes. Staff providing triage services must meet clinical privilege and knowledge requirements. Adequate licensed nurses and other support staff shall be adequate in number to provide care needed by consumers twenty-four (24) hours a day seven (7) days per week. Crisis stabilization services must be provided by a co-occurring disorder capable multidisciplinary team of medical, nursing, social services, clinical, administrative, and other staff adequate to meet the clinical needs of the individuals served. Staff members assigned to a medical supervised detoxification component shall be knowledgeable about the physical signs of withdrawal, the taking of vital signs and the implication of those vital signs, and emergency procedures as well as demonstrating core competencies in addressing the needs of individuals receiving detoxification services who may have co-occurring mental health disorders and be on psychotropic medication.

Each CBSCC must meet certain requirements regarding personnel policies and records, including a written plan for the professional growth and development of all administrative, professional clinical and support staff, including but not be limited to: (1) orientation procedures; (2) in-service training and education programs; (3) availability of professional reference materials; and (4) mechanisms for insuring outside continuing educational

opportunities. The results of performance improvement activities and accrediting and audit findings and recommendations shall be addressed by and documented in the staff development and clinical privileging processes. Staff competency development shall be aligned with the organization's goals related to co-occurring capability, and incorporate a training plan, training activities, and supervision designed to improve co-occurring core competencies of all staff. Staff education and in-service training programs shall be evaluated by the CBSCC at least annually. Among the required trainings are ones related to abuse reporting, cultural competence, trauma informed care, first aid and CPR, non-physical interventions, and, as required, physical interventions.

*Mental Health (MH):* CEDTs must have personnel policies and procedures and are subject to staffing requirements regarding qualifications of those providing clinical services, emergency examinations, medical services, and dietary services. Staffing ratios or other staffing level requirements are in place specific to licensed registered nurses, licensed practical nurses, other nursing staff, including mental health technicians or nursing aides. Training requirements include those regarding orientation, in-service, and continuing education. Staff education and in-service training programs must be evaluated by the CEDT at least annually. Inservice presentations shall be conducted each calendar year and are required for all employees and volunteers on the following topics, among others: consumer rights, confidentiality, abuse reporting, policy and procedures, cultural competence, and trauma-informed care.

*Substance Use Disorder (SUD):* All residential SUD facilities, public and private, must comply with requirements for personnel policies and procedures, qualifications for those providing clinical services, and for volunteers, clinical supervision, and staff privileging.

- Medically-supervised withdrawal management requirements include but are not limited to those requiring a licensed physician be on site or on call at all times; staff members be knowledgeable about signs of withdrawal, the taking of vital signs, the implication of vital signs, and emergency procedures; licensed nurses to provide twenty-four (24) hour monitoring; and statutorily approved personnel to administer medications. Staff providing direct care shall have documented knowledge regarding facility-required education, evidenced based practices, training, and policies.
- Non-medical withdrawal management requirements are similar to those above but a licensed physician need only be on call at all times; the requirements regarding nursing are not present; and service providers must be trained and competent to implement physician-approved protocols for consumer observation and supervision, determination of appropriate level of care, and facilitation of the consumer's transition to continuing care.
- Residential Treatment, Intensive Residential Treatment, and Halfway Houses for adults: A licensed physician shall be available, at least by telephone, twenty-four (24) hours per day, seven (7) days per week. The facility shall maintain documentation that service providers are knowledgeable regarding the biopsychosocial dimensions of substance use



disorders, evidenced-based practices, cultural, age, and gender specific issues, and co-occurring disorder issues. Staff shall be at least eighteen (18) years of age. The facility shall document in personnel records all education, training, and experience stated above prior to the provision of direct care services. The facility shall have staff members on site twenty-four (24) hours per day, seven (7) days per week. Additional requirements apply to other residential treatment including but not limited to the below:

- Adult Residential Treatment for Consumers with Co-Occurring Disorders: The facility shall maintain availability of a licensed physician, who is knowledgeable in SUD and MH issues to provide evaluation, treatment and follow-up; and will be available by telephone twenty-four (24) hours per day, seven (7) days per week.
- Residential Treatment for Persons with Children and Halfway House for Persons with Children: Additional requirements include but are not limited to knowledge or training regarding treatment for infants, toddlers, preschool children, and school-age children; identification of domestic violence, spousal or partner abuse, and child abuse and neglect, with special emphasis on failure to thrive, and sexual abuse of children; child development and age appropriate behaviors; parenting skills; and the impact of substances and substance use disorders on parenting and family units.

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* Crisis stabilization services may be utilized only after less restrictive community resources have been determined to be inadequate to meet the current needs of the consumer. The CBSCC shall assess each individual to determine appropriateness of admission. Assessment at intake must include a health and drug history, a mental health history, and a substance abuse history and screening for withdrawal risk and injection drug use. Consumer assessment information for consumers admitted to facility-based crisis stabilization shall be completed within 72 hours of admission. If consumers are not able to stabilize in or are not appropriate for the CBSCC unit, linkage services shall be provided.

*Mental Health (MH):* A CEDT must conduct a comprehensive assessment of each consumer's service needs in a timely manner. The regulations include detail regarding what the assessment must include. The CEDT shall have policy and procedures specific to each program service that dictate time frames by when assessments must be completed and documented. All facilities shall assess each individual to determine appropriateness of admission. The CEDT shall have policy and procedures that dictate timeframes by when intake assessment must be completed for each program service to which a client is admitted.

*Substance Use Disorder (SUD):* All facilities shall complete a face-to-face screening with each individual to determine appropriateness of further assessment. Requirements for ODMHSAS facilities or ODMHSAS-contracted facilities follow. Similar requirements exist for CCARCs. The facility shall maintain written screening policies and procedures. All facilities shall assess each consumer for appropriateness of admission to the treatment program. Each presenting

consumer for substance use disorder treatment shall be assessed, according to ASAM criteria, which includes a list of symptoms for all six dimensions and each level of care to determine a clinically appropriate placement in the least restrictive level of care. The Oklahoma Determination of ASAM Service Level (ODASL) must be completed when determining clinically appropriate residential treatment placement. Should the service provider determine the consumer's needs cannot be met within the facility, clinical assessments and referrals for the consumer shall be documented. Any consumer seeking admission to residential services, including medically-supervised withdrawal management and non-medical withdrawal management while under the influence or undergoing withdrawal of alcohol or drugs, shall be assessed prior to admission for medical needs. Facilities shall have written policies and procedures for the purpose of admitting and assessing persons with special needs. All programs shall complete a biopsychosocial assessment using the Addiction Severity Index to be completed by specified personnel during the admission process, within specific timelines established by the facility but no later than the following time frames: (1) Residential Services, seven (7); and (2) Halfway House Services, seven (7) days.

- **Medically-Supervised Withdrawal Management:** A medical assessment for appropriateness of placement shall be completed and documented by a licensed physician during the admission process to the program.
- **Non-Medical Withdrawal Management:** The consumer shall have an addiction-focused history, obtained as part of the initial assessment and reviewed with a physician during the admission process if physician-developed protocols indicate concern.
- **Residential Treatment for Persons with Dependent Children and Halfway House Services for Persons with Dependent Children:** Admission of the children shall depend upon the program's ability to provide the needed services. Discharge from residential treatment for persons with dependent children requires that the children have been linked with needed educational, therapy, and medical services in the planned community of residence.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* All consumers must be involved in discharge planning and, if in need of public assistance, shall be assisted in making application. No consumer, other than those discharged to a correctional facility, shall be discharged without sufficient medications, referral and appointment, among other things.

- For CBSCCs, preliminary assessment will result in an intervention plan addressing mental health, substance use disorder, and other related issues contributing to the crisis. Aftercare and discharge planning are to be initiated for the consumer at the earliest possible point in the crisis stabilization service delivery process. Among other things, an

aftercare plan shall include recommendations for continued follow-up after release from the CBSCC.

*Mental Health (MH):* The initial CEDT treatment plan must be completed after completion of intake assessment or after the first treatment session. The CEDT must have policy and procedures that dictate timeframes by when comprehensive service plans must be completed, as well as service plan updates. The CEDT also develops a discharge summary for the consumer prior to discharge which includes a continuing care plan. This discharge/continuing care plan consists of written recommendations, specific referrals for implementing aftercare services, including medications.

*Substance Use Disorder (SUD):* Requirements for ODMHSAS facilities or ODMHSAS-contracted facilities follow. Similar requirements exist for CCARCs. Requirements for Behavioral Health Service Plans include who must complete it (LBHP or Licensure Candidate) and what must be included (including recovery focus and discharge criteria). Service plan updates should occur at a minimum of every six (6) months during which services are provided. Comprehensive service plans shall be completed according to the time frames outlined by the facility, but no later than: (1) Residential services, eight (8) days; (2) Halfway house services, eight (8) days; and (3) Medically supervised withdrawal management facilities shall complete medical service plans to address the medical stabilization treatment and service needs of each consumer within three (3) hours of admission.

All facilities must assess each consumer for appropriateness of discharge using ASAM criteria that includes a list of symptoms for all six dimensions and each of the levels of care, to determine a clinically appropriate placement in the least restrictive level of care. All facilities must establish a continuing care plan, including assisting the consumer to obtain services that are needed, but not available within the facility, and/or in transitioning from one level of care to another, and/or discharging from a facility. A written plan of recommendations and specific referrals for implementation of continuing care services, including medications, shall be prepared for each consumer who meets the ASAM dimensional continued service criteria, in each level of care. Case managers from the outpatient facilities to which the consumer will be discharged shall assist the consumer and withdrawal management/residential/halfway house facility, psychiatric inpatient unit, and/or CBSCC, with discharge planning for consumer returning to the community, pursuant to appropriately signed releases and adherence to applicable privacy provisions. Consumers discharging from a withdrawal management/residential/halfway house facility shall be offered case management and other supportive services. This shall occur as soon as possible, but no later than one (1) week post-discharge.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Crisis stabilization services must be co-occurring disorder capable and trauma informed, and include, but not be limited to, the following service components: (1) 24 hour triage services and emergency examination; (2) Co-

occurring capable psychiatric crisis stabilization; and (3) Co-occurring capable drug/alcohol crisis stabilization. Additional specific requirements apply to triage services, crisis stabilization services, and other services. The latter includes: (1) Medically-supervised SUD and MH screening, observation and evaluation; (2) Initiation and medical supervision of rapid stabilization regimen as prescribed by a physician, including medically monitored detoxification where indicated; (3) Medically-supervised and co-occurring disorder capable detoxification; (4) Intensive care and intervention during acute periods of crisis stabilization; (5) Motivational strategies to facilitate further treatment participation for mental health and/or substance abuse needs; and, (6) Referral, linkage or placement, as indicated by consumer needs, including to individuals and families who meet the ODMHSAS definition of homeless.

*Mental Health (MH):* A CEDT must provide the following services: (1) Screening, intake, and assessment services; (2) Referral services; (3) Emergency psychiatric services; (4) Emergency and routine medical services; (5) Physician services; (6) Nursing services; (7) Psychotherapy services; and (8) Dietary services. Specific additional requirements relate to emergency psychiatric services, medical emergencies, medical services, psychotherapy services (including but not limited to clinical hours per week, modality, and approaches); and therapeutic meals and specific dietary services.

*Substance Use Disorder (SUD):* Case management services must be offered to all consumers who have substance-related disorders, and to their family members, if applicable, to ensure access to needed services. Case management shall be co-occurring disorder capable. Specific other services by facility-type follow:

- Medically-Supervised Withdrawal Management and Non-Medical Withdrawal Management: Treatment services include daily (twenty-four [24] hours a day, seven [7] days a week) substance use disorder withdrawal management treatment services shall be provided which shall include, but are not limited to, oral intake of fluids, three (3) meals a day, taking of vital signs (temperature, pulse, respiration rate, blood pressure), documentation of fluid and food intake a minimum of one (1) time every six (6) hours or more often as indicated by the consumer's condition.
  - For Medically-Supervised Withdrawal Management, medications are to be prescribed if needed during withdrawal management. The medications are to include those needed for physical health issues and mental impairment if acquired during the withdrawal process.
- Residential Treatment for Adults: Daily 24 hours a day, 7 days a week SUD treatment services must be provided to assess and address individual needs of each consumer and specific requirements must be met to address medical and clinical emergencies. Treatment services must include, among others: (A) Therapy, meeting requirements related to provider qualification, number of hours provided, and use of generally accepted clinical approaches to treatment such as cognitive behavioral treatment, narrative therapy, solution focused brief therapy or another widely accepted theoretical framework for treatment. (B) Rehabilitation services, meeting requirements related to provider

qualification, number of hours provided, group ratios, and nature of the services. (C) Educational groups, meeting requirements related to provider qualification, number of hours provided, and nature of the services. (D) Case management, with credentialing and need requirements. (E) Crisis intervention, with credentialing and need requirements. Documentation shall reflect each consumer has received a minimum of twenty-four (24) hours of treatment services each week, including the treatment services required above, in addition to life skills, recreational, and self-help supportive meetings. More extensive treatment requirements are specified for some facility types as follows:

- Intensive Residential Treatment: Among other requirements, documentation must reflect each consumer has received a minimum of thirty-seven (37) hours of treatment services each week.
- Adult Residential Treatment for Consumers with Co-occurring Disorders: Among other things, psychiatric and/or psychological and/or mental health evaluations shall be completed on all consumers.
- Residential Treatment for Persons with Dependent Children: Among other things, detailed requirements are in place related to the treatment, medical care, and education of the children. Exceptions to certain requirements are made for TANF recipients and pregnant women.
- Halfway House Services: Consumers shall participate in a minimum of six (6) hours of structured SUD treatment per week. Other detailed service requirements are included, and, for Halfway House Services for Persons with Dependent Children, these include detailed additional parenting and child services.

## **Patient Rights and Safety Standards**

*Mental Health (MH) and Substance Use Disorder (SUD):* Individuals receiving services operated by, certified by, or under contract with ODMHSAS have specific rights, including but not limited to be notified of their rights, dignity, nondiscrimination, communication, freedom from maltreatment or abuse, religion, vote, confidentiality, to be involved in discharge planning, rights guaranteed by law, and treatment in the least restrictive setting that is appropriate. Seclusion and restraint are limited to specific circumstances. Consumers have the right to assert grievances, which are forwarded to ODMHSAS. Facilities must have a written grievance policy that meets specified criteria. As required, facilities must document and report critical incidents.

- Each CBSCC also must have written policies and procedures addressing mechanical restraints for adults only.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* CBSCCs, CEDTs, and all residential SUD treatment facilities must, among other things, have a plan for conducting an organizational

needs assessment; data collection and use; have a performance improvement program; and report performance improvement findings.

## **Governance**

*Mental Health (MH) and Substance Use Disorder (SUD):* Among other things, all certified facilities must have an authority and governance structure to assure legal responsibility and accountability.

*Substance Use Disorder (SUD):* Substantially more detailed requirements are in place for all residential SUD facilities, including but not limited to, a written description of how the facilities will provide recovery oriented, culturally competent, trauma informed, and co-occurring capable services.

## **Special Populations**

*Mental Health (MH) and Substance Use Disorder (SUD):* Specific requirements are in place for non-discrimination against persons with HIV or AIDS, and for compliance with the ADA.

*Substance Use Disorder (SUD):* Requirements related to treatment of those with co-occurring disorders occur throughout the regulations and specific facilities exist for parents with dependent children.

## **Location of Regulatory and Licensing Requirements**

ODMHSAS regulations, title 450, ch. 1, 15, 18, 23, 24, 60<sup>1</sup>. Regulatory requirements reviewed September 20, 2019.

## **Other Information Sources**

S. Gay (ODMHSAS); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>1</sup> See <http://okrules.elaws.us/oac/title450>.

# OKLAHOMA MEDICAID

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

## Approach

The Oklahoma Health Care Authority (OHCA) oversees the state Medicaid program. Oklahoma does not have a relevant Section 1115 waiver that affects reimbursement of residential services in Institutions for Mental Diseases (IMDs). It historically has relied to some extent on Disproportionate Share Hospital (DSH) payments but not the in lieu of provision to reimburse certain services in IMDs.

## Types of Facilities

*Mental Health (MH) or Substance Use Disorder (SUD):* No evidence of coverage of MH or SUD residential treatment facilities for adults was located, with the exception of limited crisis stabilization services longer than a 24 hour period which may be reimbursed even if they are facility-based and categorized as outpatient:

- Facility Based Crisis Stabilization (FBCS). FBCS services are emergency psychiatric and substance abuse services aimed at resolving crisis situations. This service is limited to providers who contract with or are operated by the ODMHSAS to provide this service within the overall behavioral health service delivery system.

## Processes of Medicaid Enrollment

*Mental Health (MH) and Substance Use Disorder (SUD):* To participate in the Oklahoma Medicaid program, health care providers must have a provider agreement with the Medicaid agency and be appropriately licensed for the service to be provided. The provider agreement may be denied, terminated, or not renewed and other sanctions may apply.

To be reimbursed, FBCS must comply with all requirements applicable to Community-based Structured Crisis Centers (CBSCCs), where services may be provided in excess of 24 hours during only one episode of care. FBCS services are categorized as outpatient and such services must be an Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) certified organization/agency and have a current contract on file with the Oklahoma Health Care Authority.

## **Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD):* State Medicaid requirements specify that FBCS services are provided under the supervision of a physician aided by a licensed nurse, and include LBHPs and Licensure Candidates for the provision of group and individual treatments. A physician must be available.

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* State Medicaid requirements specify that crisis intervention service notes must include a detailed description of the crisis and level of functioning assessment.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based treatment or discharge planning or aftercare service requirements for residential treatment facilities for adults was located.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* State Medicaid requirements specify that the services provided by an FBCS are emergency stabilization, which includes a protected environment, chemotherapy, detoxification, individual and group treatment, and medical assessment. Crisis intervention services must be available twenty-four (24) hours a day, seven (7) days a week.

## **Care Coordination**

*Mental Health (MH) and Substance Use Disorder (SUD):* State Medicaid requirements specify that Behavioral Health Case Management is available to individuals transitioning from institutions to the community [except individuals ages twenty-two (22) to sixty-four (64) who reside in an institution for mental diseases (IMD) or individuals who are inmates of public institutions]. Individuals are considered to be transitioning to the community during the last thirty (30) consecutive days of a covered institutional stay. This time is to distinguish case management services that are not within the scope of the institution's discharge planning activities from case management required for transitioning individuals with complex, chronic,



medical needs to the community. Transition services provided while the individual is in the institution are to be claimed as delivered on the day of discharge from the institution.

## Quality Assurance or Improvement

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based quality assurance or improvement requirements for residential treatment facilities for adults was located.

## Special Populations

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based special population requirements for residential treatment facilities for adults was located.

## Location of Medicaid Requirements

Oklahoma Health Care Authority Medicaid Rules and Regulations<sup>2</sup>. Regulatory data collected December 2019.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report “**State Residential Treatment for Behavioral Health Conditions: Regulation and Policy**”. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

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<sup>2</sup> See

<http://www.oar.state.ok.us/oar/codedoc02.nsf/All/556A34B8C6561955862584850051496C?OpenDocument>.

## OREGON

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

### Types of Facilities

*Mental Health (MH):* Oregon regulates two types of outpatient adult residential behavioral health services:

- A *residential treatment home (RTH)* is "a program that is licensed by the Division and operated to provide services on a 24-hour basis for up to five individuals."
- A *residential treatment facility (RTF)* is "a program licensed by the Division to provide services on a 24-hour basis for six to 16 individuals."

*Substance Use Disorder (SUD):* Oregon regulates providers that operate a residential service element, specifically including:

- A *residential facility*, "a program or facility that provides an organized full-day or part-day program."
- A *detoxification center*, a facility "that provides emergency care or treatment for alcoholics or drug-dependent persons."

*Unregulated Facilities:* Unregulated facilities were not located.

### Approach

*Mental Health (MH) and Substance Use Disorder (SUD):* The Oregon Health Authority (OHA) regulates both MH and SUD residential treatment programs.

- For MH, this is regardless of funding source.
- For SUD, the OHA regulates all providers of a residential service element that are under contract with the Health Systems Division (HSD) of OHA or subcontract with a local entity or public body or receive public funds for providing SUD prevention, intervention, or treatment services (this includes a provider that is or seeks to be contractually affiliated with HSD, a Coordinated Care Organization, or a local mental health authority for

providing residential SUD treatment and recovery services). The OHA also regulates any facility that meets the definition of a residential facility, whether licensed, approved, established, maintained, contracted with or operated by the OHA, or a detoxification center, whether a publicly or privately-operated for profit or nonprofit facility.

## **Processes of Licensure or Certification and Accreditation**

*Mental Health (MH):* Licensure by the OHA is required for any residential MH treatment facility. Additional regulations provide for certification of noninpatient mental health facilities, including residential facilities, and are solely “for the purpose of qualifying for insurance reimbursement,” presumably private insurance as Medicaid providers contract or subcontract with the OHA. Agencies that contract or subcontract with the OHA, or that contract with a Community Mental Health Program, are not eligible for the “non-inpatient” certification.

- Accreditation is not required.
- An inspection is required for licensure and renewal.
- A Certificate of Need is not required for operation.
- Licensure duration is two years. Certification for reimbursement purposes is dependent on a showing of compliance with relevant regulations.

*Substance Use Disorder (SUD):* Licensure by the OHA is required for all residential facilities or detoxification centers, as well as those operating a residential service element as described above.

- Accreditation is not required, although facilities are required to use standards endorsed by national accrediting bodies as a mechanism for provider credentialing.
- An inspection is required for licensure and renewal.
- A Certificate of Need is not required for operation.
- Licensure duration is two years. A provisional license may be issued for one year or less pending completion of specified requirements because of substantial failure to comply with applicable administrative rules.

## **Cause-Based Monitoring**

*Mental Health (MH) and Substance Use Disorder (SUD):* OHA may conduct announced or unannounced inspections for on-going monitoring in addition to regularly scheduled inspections. The OHA may find a program to be in noncompliance with the regulations, require a plan of correction, and deny, suspend, advise of intent to revoke, or revoke licensure or certification.

## **Access Requirements**

*Mental Health (MH):* Residential MH treatment facilities cannot discriminate based on several specific personal characteristics when accepting individuals for treatment. Wait time requirements are specified and cover the length and management of the waitlist, requirements for follow-up with the waitlisted individual, guidelines for prioritizing admissions from the waitlist, and processes and procedures for admission from the waitlist.

*Substance Use Disorder (SUD):* Residential SUD treatment facilities cannot discriminate based on several specific personal characteristics when accepting individuals for treatment and may not solely deny entry to individuals who are prescribed medication to treat opioid dependence. Individuals must receive services in the timeliest manner feasible consistent with presenting circumstances. Block grant recipients must prioritize clients as follows:

- A. Women who are pregnant and using substances intravenously.
- B. Women who are pregnant.
- C. Individuals who are using substances intravenously.
- D. Individuals with dependent children.

Entry of pregnant women must occur no later than 48 hours from the date of first contact and entry of individuals using substances intravenously must occur no later than 14 days after the date of first contact. If services are not available within the required timeframes, the provider must document the reason and provide interim referral and informational services within 48 hours. Interim referrals and information must be provided prior to entry to all individuals using substances intravenously to reduce the adverse health effects of substance use, promote the health of the individual, and reduce the risk of transmission of disease.

## Staffing

*Mental Health (MH):* Residential MH facility regulations include standards for a program administrator, direct care staff qualifications, staffing ratios for direct care staff, and pre-service orientation and in-service training relevant to the needs of the population served. No requirement for a medical director or medical staff was located, although the term “licensed medical professional” is defined.

The requirements for certification incorporate staffing requirements specific to outpatient treatment staff qualifications, including regarding program directors, clinical and peer delivered services, supervisors, interns, and peer support and peer wellness specialists. Outpatient training requirements also are incorporated. In addition to these general requirements for certification, requirements specific to residential facilities include requirements related to staff coverage, ratios, and requirements for overnight and on-call staffing.

*Substance Use Disorder (SUD):* Residential SUD facility staffing standards include requirements regarding competencies of program administrators, competencies and credentials of clinical and peer delivered services supervisors, SUD treatment staff, and peer support and peer wellness specialists. The general staffing requirements for SUD residential treatment facilities include credentials for medical personnel as well as others and require that there be a medical director under contract with the program or that there be a written reciprocal agreement with a medical practitioner under managed care. Program staff, contractors, volunteers, and interns recovering from an SUD, providing treatment or peer support services in SUD treatment programs, must be able to document continuous abstinence under independent living conditions or recovery housing for the immediate past two years. Detailed minimum requirements are included for orientation training, which must be applicable to the population served. No information on education or training on trauma informed care or suicide prevention was found. However, treatment programs are required to develop and implement written policies and procedures on trauma-informed service delivery.

Specific to detoxification facilities, in addition to a medical director, there are specific requirements for an LMP and skilled nursing care; staffing compliance with ASAM Patient Placement Criteria 2R; and staffing ratios. There also are more specific credentials and experience requirements for the program director, the clinical supervisor, treatment staff, and other medical staff, as well as requirements regarding use of volunteers.

## Placement

*Mental Health (MH):* An assessment by a Qualified Mental Health Professional is required to determine an individual's need for MH services. Criteria for admission are stipulated and include requirements for screening, including written documentation of a suspected mental health disorder, information on general and psychiatric health and social needs, and required

legal documents such as those relating to guardianship, conservatorship, commitment status, advance directives, or any other legal restrictions. The screening/assessment includes the individual's mental health history and current mental health status with a determination of a DSM diagnosis or other justification of priority for mental health services or a written statement that the person is not in need of community mental health services. The program shall complete an assessment for each individual within 14 days after admission to the program unless admitted for crisis-respite services.

*Substance Use Disorder (SUD):* For residential SUD treatment, assessment must include: (a) Sufficient information and documentation to justify the presence of a diagnosis that is the medically appropriate reason for services; (b) Screening for the presence of substance use, problem gambling, mental health conditions, and chronic medical conditions; (c) Screening for the presence of symptoms related to psychological and physical trauma; (d) Suicide potential shall be assessed, and individual service records shall contain follow-up actions and referrals when an individual reports symptoms indicating risk of suicide. In addition, each assessment shall be consistent with the dimensions described in the ASAM Patient Placement Criteria (PPC) and shall document a diagnosis and level of care determination consistent with the DSM and ASAM PPC.

Specific to detoxification facilities, the program must have written criteria for admission and for rejecting admission requests which includes observation for symptoms of withdrawal. At intake, there must be, among other things: (a) A determination of appropriateness; (b) Steps for making referrals of individuals not admitted; (c) A time limit within which the initial client assessment must be completed on each individual; and (d) Steps for coordinating care with payers and entities responsible for care coordination. The program also must develop and implement a written procedure for assessing medical and psychosocial factors and evaluating each individual's stabilization needs as soon as the individual is able.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH):* Treatment/service planning requirements are indicated for residential MH treatment facilities. Review of residential service plans is required at least annually. On an ongoing basis, the provider shall update the residential service plan as necessary based upon changing circumstances or upon the individual's request for reconsideration. No discharge, aftercare or follow-up planning requirements were identified although there are detailed requirements for residency termination.

*Substance Use Disorder (SUD):* Individualized treatment or service planning requirements are indicated for residential SUD treatment facilities. The service plan must include a projected schedule for re-evaluation of the plan. Discharge/aftercare planning is required. When services are transferred due to the individual's absence, the provider must document outreach efforts made to re-engage the individual or document the reason why such efforts were not made.

Specific to residential detoxification programs, an individualized stabilization plan is required and, among other things, must address care transition. The program must complete and document a transition plan in collaboration with the individual being discharged that includes information about referrals to other services or agencies, and the plan for follow-up, aftercare, or other post-stabilization services.

## **Treatment Services**

*Mental Health (MH):* Residential MH treatment facilities required services and activities include ones related to daily living, health-related services, and assistance in accessing other services as needed in accordance with the person's service plan and in accordance with a requirement that treatment be "a planned, individualized program of medical, psychological or rehabilitative procedures, experiences and activities designed to relieve or minimize mental, emotional, physical or other symptoms or social, educational or vocational disabilities resulting from or related to the mental or emotional disturbance, physical disability or alcohol or drug problem" (ORS 443.300). The certification requirements include requirements for eight hours of structured services out of every 12 hours from 8 a.m. to 8 p.m. which, each week, includes: (a) Daily group therapy which addresses the mental health or nervous condition; (b) Individual counseling which addresses the mental health or nervous condition with a primary therapist two times per week; (c) Family therapy, as appropriate to the individual needs of the client; (d) Psychotropic medication management or monitoring, as appropriate to the individual needs of the client; (e) One hour per day of structured recreational/physical fitness activities; and (f) Structured skills training, vocational training, or socialization activities.

*Substance Use Disorder (SUD):* Residential SUD treatment facilities are required to provide culturally specific and trauma-informed care and to provide services for co-occurring mental health disorders. As appropriate, they must provide or coordinate gender-specific services, family services, community and social skills training, peer supports, transportation, housing, and smoking cessation, among other things. Recipients of block grant funding must provide specific care for pregnant women and individuals with dependent children. Medical protocols must be in place that meet certain standards.

There are medical services requirements specific to residential detoxification programs, as well as stabilization services that include but are not limited to individual or group motivational counseling sessions and individual advocacy and case management services, which must be identified in the individual's stabilization plan.

## **Patient Rights and Safety Standards**

*Mental Health (MH):* The regulations governing residential MH treatment facilities identify many patient rights. Among those are the right to be free from seclusion and restraint unless in

a secure RTF; to be able to file grievances with the program administrator; and to be informed of these and other rights.

*Substance Use Disorder (SUD):* The regulations governing residential SUD treatment facilities identify many patient rights. Among those are the right to receive medication specific to the individual's diagnosed clinical needs, including medications used to treat opioid dependence; to be free from seclusion and restraint; to be able to file grievances with the provider, the individual's managed care plan, or DHS; and to be informed of these and other rights.

## **Quality Assurance or Improvement**

*Mental Health (MH):* Requirements related to quality assurance/improvement for adult residential MH facilities were not located.

*Substance Use Disorder (SUD):* Providers must develop and implement a structured and ongoing process to assess, monitor, and improve the quality and effectiveness of services provided to individuals and their families.

## **Governance**

*Mental Health (MH) and Substance Use Disorder (SUD):* No information related to requirements for governance of adult residential MH or SUD treatment were identified although facilities must provide basic information regarding the organization at license application.

## **Special Populations**

*Mental Health (MH):* Requirements related to special populations for adult residential MH treatment facilities were not located.

*Substance Use Disorder (SUD):* For block grant recipients, priority populations include pregnant/parenting women, individuals with dependent children, and injection drug users. Additional information on requirements may be found above. For all residential SUD treatment facilities, those with co-occurring mental health conditions also must be identified and provided appropriate services. The regulations also contain specific requirements for programs approved and designated as culturally specific substance use disorder programs.



## Location of Regulatory and Licensing Requirements

Oregon Health Authority, Health Systems Division, SU Licensure and Detoxification Standards<sup>1</sup> (OAR 415-012-0000 through 415-012-0090, OAR 415-050-0000 through 415-050-0095); (OAR 309-018-0100 through 309-018-0215); BH Services and MH Licensure<sup>2</sup>. Regulatory requirements reviewed May 8, 2019.

## Other Information Sources

M. Nevarez, G. Bledsoe, N. Corbin, and L. Meulink (OHA); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>1</sup> See <https://secure.sos.state.or.us/oard/displayChapterRules.action?selectedChapter=84>.

<sup>2</sup> See [https://secure.sos.state.or.us/oard/displayChapterRules.action;JSESSIONID\\_OARD=5IH9JKouQqBquULnID45wUVjcG3ioFrVdjv\\_arAvU2eLqZ7PMmnK11318524005?selectedChapter=88](https://secure.sos.state.or.us/oard/displayChapterRules.action;JSESSIONID_OARD=5IH9JKouQqBquULnID45wUVjcG3ioFrVdjv_arAvU2eLqZ7PMmnK11318524005?selectedChapter=88).

# OREGON MEDICAID

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

## Approach

The Oregon Health Authority (OHA) Health Services Division (HSD) oversees the state Medicaid program, much of which is administered by managed care entities (MCEs), some of which are Coordinated Care Organizations (CCOs). Additionally, pursuant to its Oregon Health Plan Section 1115 demonstration, Federal Financial Participation may be claimed for certain residential treatment provided at Designated State Health Programs (DSHPs) to individuals not eligible for Medicaid. It historically also has relied on Disproportionate Share Hospital (DSH) payments and the in lieu of provision to reimburse certain services in IMDs.

## Types of Facilities

*Mental Health (MH) or Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, DSHPs include:

- **MH Residential Treatment for Youth:** Young adults through age 25 who are eligible, under ongoing review of the jurisdiction of the Juvenile Psychiatric Review Board or in the Youth and Young Adult in Transition Program, with mental or emotional disorders who have been hospitalized or are at immediate risk of hospitalization, who need continuing services to avoid hospitalization or who are a danger to themselves or others or who otherwise require long-term care to remain in the community. These individuals are not eligible for Medicaid. The treatment services are provided on a 24-hour basis.
- **MH Residential Treatment for Adults:** Adults 18 years or older who are determined unable to live independently without supervised intervention, training or support, and who do not qualify for Medicaid. Services are delivered on a 24-hour basis to individuals who need continuing services to remain in the community and to avoid higher levels of services or hospitalization or who are a danger to themselves or others or who otherwise require continuing care to remain in the community.
- **A & D Residential Treatment, Adults:** Individuals 18 years of age or older who are unable to live independently in the community and cannot maintain even a short period of abstinence and need 24-hour supervision, treatment and care. These individuals are non-OHP eligible and must be indigent status with income at 100 percent or lower of the

federal Poverty Level (FPL). These individuals are not eligible for Medicaid. This service is to support, stabilize and rehabilitate individuals and to permit them to return to independent community living. Services provide a structured environment for an individual on a 24-hour basis consistent with chemical dependency placement, continued stay and discharge criteria Level III-services (twenty-four hour supervision is needed using a structured 7-day-a-week therapeutic environment to achieve rehabilitation). The services within this program address the needs of diverse population groups within the community. This program helps people stabilize physically and mentally so they can transition to a lower level of care including self-directed recovery management.

*Mental Health (MH):* The OHA HSD Medicaid regulations encompass “Residential Treatment Programs,” which include a RTH and RTF (both defined above), as well as a Secure Residential Treatment Facility (SRTF), and a Young Adult in Transition Facility (YAT) facility that is licensed to provide mental health services, but does not include adult foster homes.

- A SRTF provides services for an individual who: (a) does not require 24-hour hospital care and treatment; (b) requires highly structured environmental supports and supervision seven days a week and 24 hours a day in order to participate successfully in a program of habilitative and rehabilitative activities; and (c) due to a mental illness and as evidenced by clinical documentation from the last 90 days or from an Authority-approved and standardized risk assessment conducted within the past year, presents a risk in one of the following areas: (A) Clear intention or specific acts of bodily harm to others. (B) Suicidal ideation with intent, or self-harm posing significant risk of serious injury. (C) Inability to care for basic needs that results in exacerbation or development of a significant health condition, or the individual’s mental health symptoms impact judgment and awareness to the degree that the individual may place themselves at risk of imminent harm. (D) Due to the symptoms of a mental illness, there is significant risk that the individual will not remain in a place of service for the time needed to receive the services and supports necessary to stabilize the symptoms of a mental illness that pose a threat to the individual’s safety and well-being.
- A YAT is a facility that is providing services to an individual who is developmentally transitioning into independence and is of an age not less than 17 years and six months, and not more than 25 years.

*Substance Use Disorder (SUD):* The OHA HSD covers medically monitored detoxification and clinically managed detoxification provided in a free standing detoxification center or an appropriately licensed SUD residential treatment facility when considered medically appropriate. HSD covers non-hospital SUD treatment and recovery services on a residential ... basis. HSD does not cover residential level of care provided in an inpatient hospital setting for SUD treatment and recovery. For MCEs, including CCOs, the provision of SUD services must comply with regulations governing CCO behavioral health provider treatment and facility certification and licensure.

## **Processes of Medicaid Enrollment**

*Mental Health (MH) and Substance Use Disorder (SUD):* State licensure (or certification), as well as compliance with applicable rules, are required for provider Medicaid enrollment. The Division may terminate or suspend providers and may impose mandatory or discretionary sanctions. Researchers did not locate regulatory requirements mandating accreditation.

## **Staffing**

*Mental Health (MH):* A residential treatment program must have sufficient staff to meet active engagement and supervision hours required by the Medicaid regulations based on acuity level. The licensure standards also must be satisfied.

*Substance Use Disorder (SUD):* Separate state Medicaid regulations were not located regarding staffing for adult residential SUD treatment.

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* The Division authorizes admission and continued stay in residential programs based on the medical appropriateness of the request and supporting clinical documentation. Prior authorization requests for admission and continued stay may be reviewed to determine: (a) The medical appropriateness of the admission for residential services provided; (b) The appropriateness of the recommended length of stay; (c) The appropriateness of the recommended plan of care; (d) The appropriateness of the licensed setting selected for service delivery; (e) A level of care determination was appropriately documented. The Division determines re-authorization and authorization of continued stays based upon one of the following: (a) The recipient continues to meet all basic elements of medical appropriateness; and (b) One of the following criteria shall be met: (A) Documentation that the treatment provided is resulting in measurable clinical outcomes but that the recipient is not sufficiently stabilized or yet developed the skills necessary to support transition to a less restrictive level of care. (B) The recipient develops new or worsening symptoms or behaviors that require continued stay in the current level of care. Requests for continued stay based on these criteria shall include documentation of ongoing reassessment and necessary modification to the current treatment plan or residential plan of care.

*Substance Use Disorder (SUD):* The Division requires use of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria second edition revised (PPC-2R) to determine the appropriate level of SUD treatment of care.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* MCEs/CCOs must ensure there is a treatment plan, which means a documented plan that describes the patient's condition and procedures that will be needed, detailing the treatment to be provided and expected outcome and expected duration of the treatment prescribed by the health care professional. This therapeutic strategy shall be designed in collaboration with the member, the member's family, or the member's representative.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Under the Oregon Medicaid regulations, behavioral health services must be medically appropriate, based on the standards of evidence-based practice, and appropriate and consistent with the diagnosis identified in the behavioral health assessment.

*Mental Health (MH):* Pursuant to the Section 1115 demonstration:

- DSHP MH Residential Treatment for Youth must provide the following treatment services: medication and medication monitoring supervision; vocational and social services; individual and family group counseling; counseling emotional support; and coordination of care services.
- DSHP MH Residential Treatment for Adults must provide: crisis stabilization and intervention services, including: behavior management; daily living activity coordination; crisis stabilization services; crisis intervention services; residential treatment services determined upon individualized assessment of treatment needs and development of plan of care; management of personal money and expenses; supervision of daily living activities; life skills training; administration and supervision of medication; provision or arrangement of transportation; and management of behavior; diet management.

*Substance Use Disorder (SUD):* Under the Section 1115 demonstration, SUD treatment services are to be evidence-based.

## **Care Coordination**

*Mental Health (MH) and Substance Use Disorder (SUD):* MCEs must ensure that coordinated care services are provided within the scope of license or certification of the participating provider and within the scope of the participating provider's contracted services. CCOs must ensure continuous care management for all members. Care coordinators shall promote

continuity of care and recovery management. CCOs must facilitate transition planning for members. Among other things, care coordinators must facilitate transitions and ensure applicable services and appropriate settings continue after discharge, including: For discharges from ... residential care, the care coordinator shall do all of the following: (A) Have contact with the member no less than two times per month prior to discharge and two times within the week of discharge; (B) Assist in the facilitation of a warm handoff to relevant care providers during transition of care and discharge planning; and (C) Engage with the member, face to face, within two days post discharge.

Prior to discharge from any residential facility, care coordinators must conduct a transition meeting to facilitate development of a transition plan for both applicable services and appropriate settings. This meeting must be held 30 days prior to the member's return to the CCO's service area or, if applicable, to another facility or program or as soon as possible if the CCO is notified of impending discharge or transition with less than 30 days' advance notice. The discharge plan must include a description of how treatment and supports for the member will continue.

In addition to standard care coordination requirements, the section below regarding intensive care coordination for priority populations.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* MCEs must develop policies and procedures for credentialing providers to include quality standards and a process to remove providers from their provider network if they fail to meet the objective quality standards. MCEs must report to the OHA its health promotion and disease prevention activities, national accreditation organization results, and Healthcare Effectiveness Data and Information Set (HEDIS) measures. MCEs shall be accountable for performance on outcomes, quality, and efficiency measures incorporated into the MCE's contract with the Authority. MCEs shall implement an ongoing comprehensive quality assessment and performance improvement program (QAPI) for monitoring, evaluating, and improving the access, quality, and appropriateness of services provided to members consistent with the needs and priorities identified in the MCE's community health assessment, community health improvement plan, and the standards in the MCE's contract.

## **Special Populations**

*Mental Health (MH) and Substance Use Disorder (SUD):* MCEs/CCOs are responsible for Intensive Care Coordination (ICC) services for prioritized populations, including those who: (a) Are older adults, individuals who are hard of hearing, deaf, blind, or have other disabilities; (b) Have complex or high health care needs, or multiple or chronic conditions, or SPMI, or are

receiving Medicaid-funded long-term services and supports (LTSS); ... (d) Are in medication assisted treatment for SUD; (e) Are women who have been diagnosed with a high-risk pregnancy; ... (g) Are IV drug users, have SUD in need of withdrawal management; (h) Have HIV/AIDS or have tuberculosis; (i) Are veterans and their families; and (j) Are at risk of first episode psychosis, and individuals within the Intellectual and developmental disability (IDD) populations.

## Location of Medicaid Requirements

Oregon Health Authority Rules: Behavioral Health<sup>3</sup>, General Rules (non-MCE/CCO)<sup>4</sup>, MCE/CCO Non-Financial Rules<sup>5</sup>, January 12, 2017 CMS approval letter for Oregon Health Plan Section 1115 waiver<sup>6</sup>. Regulatory requirements reviewed January 2020.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report “**State Residential Treatment for Behavioral Health Conditions: Regulation and Policy**”. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

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<sup>3</sup> See <https://www.oregon.gov/oha/HSD/OHP/Policies/172rb112619.pdf>.

<sup>4</sup> See <https://www.oregon.gov/oha/HSD/OHP/Policies/120rb010120.pdf>.

<sup>5</sup> See <https://www.oregon.gov/oha/HSD/OHP/Policies/141rb010220-nf.pdf>.

<sup>6</sup> See <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/or/or-health-plan2-ca.pdf>.

## PENNSYLVANIA

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### Types of Facilities

*Mental Health (MH):* Pennsylvania regulates Long-Term Structured Residences (LTSRs) which are defined as a highly structured therapeutic residential mental health treatment facility designed to serve persons 18 years of age or older who are eligible for hospitalization but who can receive adequate care in an LTSR.

*Substance Use Disorder (SUD):* In addition to hospitals, Pennsylvania regulates two categories of SUD treatment facilities: (1) Health Care Facilities; and (2) Freestanding Treatment Facilities, both of which can provide residential and nonresidential levels of care, including: Inpatient Nonhospital Residential Treatment and Rehabilitation and Inpatient Nonhospital Short-Term Detoxification.

- A Health Care Facility is “a general, tuberculosis, chronic disease or other type of hospital --but not hospitals caring exclusively for the mentally ill--a skilled nursing facility, home health care agency, intermediate care facility, ambulatory surgical facility or birth center--regardless of whether the health care facility is created for profit, nonprofit, or by an agency of the Commonwealth or local government.”
- Pennsylvania defines Freestanding Treatment Facilities as “any setting in which drug and alcohol treatment takes place that is **not** located in a health care facility.”
- Residential Facilities may exist within either type of facility (freestanding or health care facility) and the standards for Residential Facilities define them as “an inpatient, nonhospital facility or inpatient freestanding psychiatric hospital that provides sleeping accommodations and provides one or more of the following activities: residential treatment and rehabilitation services, transitional living services or short-term detoxification services, 24 hours a day.”

*Unregulated Facilities:* There are no unregulated residential treatment facilities in Pennsylvania. We do not include transitional living facilities or community residential rehabilitation for the mentally ill services because they do not include clinical treatment within the scope of this summary. We also exclude inpatient hospitals even though the Commonwealth considers them to be residential as the scope of these summaries do not extend to inpatient, hospital treatment.



## Approach

*Mental Health (MH):* The Pennsylvania Department of Human Services (DHS) regulates and licenses residential MH treatment providers in the state.

*Substance Use Disorder (SUD):* The Pennsylvania Department of Drug and Alcohol Programs (DDAP) regulates and licenses two categories of adult residential SUD treatment providers in the state, regardless of funding. The categories are: (1) Health Care Facilities; and (2) Freestanding Treatment Facilities, both of which can provide residential and nonresidential levels of care, including: Inpatient Nonhospital Residential Treatment and Rehabilitation and Inpatient Nonhospital Short-Term Detoxification. The Commonwealth also considers inpatient hospitals to be residential, although they are excluded from this summary.

## Processes of Licensure or Certification and Accreditation

*Mental Health (MH):* Licensure by the DHS is required for operation of all LTSRs. To obtain a license, an application for a certificate of compliance must be approved by the DHS.

- Accreditation is not required.
- An announced inspection is required at least annually and focuses on compliance with licensure and certification requirements.
- A Certificate of Need is not required.
- Licensure duration is one year.

*Substance Use Disorder (SUD):* All adult residential SUD facilities are required by the DDAP either to hold a license as a Freestanding Treatment Facility or, if they are part of a Health Care Facility, both a certificate of compliance and a license, the requirements of which are identical.

- Accreditation is not required.
- An inspection is required for certification and renewal. The focus of the inspection is primarily on compliance with regulatory.
- A Certificate of Need is not required.
- Certification and licensure are each valid for one year.

## **Cause-Based Monitoring**

*Mental Health (MH):* Announced or unannounced inspections may occur, including complaint inspections. Deficiencies require a plan of correction. Failure of an LTSR to comply with the standards of the DHS may result in sanctions, including restriction, denial, nonrenewal, or revocation. The provider also must permit community legal services, advocacy groups, mental health consumer and family organizations and authorized federal, state or local government agents reasonable access to the facility and its residents. This specifically includes employees and legal counsel of Pennsylvania Protection and Advocacy.

*Substance Use Disorder (SUD):* Freestanding Treatment Facilities may be issued a provisional license, licenses may be refused, restricted, or revoked, and corrective action may be required. Certificates of compliance may be rejected, restricted, or revoked, and corrective action may be required. The DDAP has an on-going right to enter and inspect.

## **Access Requirements**

*Mental Health (MH) and Substance Use Disorder (SUD):* Access standards regarding wait times were not identified.

## **Staffing**

*Mental Health (MH):* LTSR providers have requirements related to, among other things, staff education, experience, and training; sufficient staffing levels; and specific staffing ratios. Additional requirements relate to psychiatric availability; the credentials, education, experience, and responsibilities of the program director and mental health professionals, as well as minimum direct-care staffing and supervision requirements. Regulations include standards for the composition and responsibilities of the interdisciplinary treatment team. Requirements are in place for training related to safety, orientation, in-service and out-service training, with minimum hours per staff type. The orientation program must include the following topics, among others: program goals and objectives, policies and procedures, infection control, confidentiality, safety, rights, crisis prevention and management and reporting, and abuse prevention and reporting. Additional orientation is required for direct care staff.

*Substance Use Disorder (SUD):* Freestanding Treatment Facilities and Health Care Facilities must develop a written policy to address relapse of recovering clinical personnel and the discipline of nonrecovering employees who abuse alcohol and other drugs. The project shall develop a policy that addresses the recruitment and hiring of staff persons who are appropriate to the population to be served. Every effort shall be made to hire staff persons representative

of that population. The regulations include requirements regarding the project director and facility director, including education and experiential requirements. Additionally, if the facility does not have a clinical supervisor on staff, direction is provided as to how clinical responsibilities should be addressed. Requirements for clinical providers, supervisors, and direct care staff are included, as are ratios. The project director must develop a comprehensive staff development program for agency personnel and each employee must have an individual training plan. Each employee must complete specified minimum training hours. Some training areas are mandated, and others are suggested but subject selection is based upon needs delineated in the individual's training plan. General training requirements, requirements for project and facility directors, clinical supervisors, counselors, and counselor assistants are provided.

## **Placement**

*Mental Health (MH):* To be eligible for admission to an LTSR, a prospective resident must meet certain requirements including but not limited to having a physician's certification that the applicant does not require hospitalization, nursing facility care or a level of care more restrictive than an LTSR, written within 30 days before admission; and evidence a severe psychosocial disability as a result of serious mental illness that indicates a less restrictive level of care is inappropriate. A person will not be admitted without an assessment and admission authorization that meets standards. Upon admission, the interdisciplinary treatment team must complete an initial assessment of the resident's mental, physical and social needs.

*Substance Use Disorder (SUD):* Freestanding Treatment Facilities and Health Care Facilities, including Short-Term Detoxification programs, must develop a written plan for intake and admission that includes, among other things, criteria for admission and requirements for completion of treatment.

- Short-Term Detoxification programs must ensure intake procedures other than initial medical care are performed at a time when the immediate physiological effects of drug and alcohol abuse have subsided. Intake procedures must include documentation of specific topics.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH):* The interdisciplinary treatment team must develop an initial treatment plan, within 72 hours, based on the initial assessment, and a comprehensive treatment plan within 10 days of admission. The interdisciplinary treatment team shall review treatment plans at least every 30 days or more frequently as the resident's condition changes. The interdisciplinary treatment team shall maintain a record of each reexamination and review to include, among other things, criteria for discharge and recommendation for discharge if these

criteria have been met. Criteria are established for decisions which determine the duration of stay.

*Substance Use Disorder (SUD):* Freestanding Treatment Facilities and Health Care Facilities must have policies for development of a preliminary and on-going treatment and rehabilitation plan. Treatment and rehabilitation plans must be reviewed and updated at least every 30 days. For those projects whose client treatment regime is less than 30 days, the treatment and rehabilitation plan, review and update must occur at least every 15 days. The project must develop a written client aftercare and follow-up policy.

- Short-Term Detoxification programs must have a drug and alcohol support plan; aftercare plans, if applicable; and follow-up information.

## **Treatment Services**

*Mental Health (MH):* An LTRS provides a 24-hour therapeutic environment which employs active psychiatric treatment, and psychosocial rehabilitation skills training in a structured residential milieu. Services must be client centered. The provider must, directly or through arrangement, provide services needed by the residents. To provide services that are not available at the LTRS, the provider shall: (1) Collaborate with the county administrator's office case management services, and other programs to provide services as identified by the treatment plan and to ensure continuity of care. (2) Ensure that transportation is available for residents who must be transported for services, recreation and other activities. Some services may be contracted by the provider to outside sources and the provider has obligations regarding the provision of those services. At least one-half hour of psychiatric time per resident per week is required.

*Substance Use Disorder (SUD):* Freestanding Treatment Facilities and Health Care Facilities, including Short-Term Detoxification programs, must assure that counseling services are provided according to the individual treatment and rehabilitation plan. Counseling shall be provided to a client on a regular and scheduled basis. The project must assist the client in obtaining the following supportive services when necessary: (1) Medical/dental; (2) Psychiatric; (3) Legal; (4) Economic; (5) Educational; (6) Vocational; and (7) Recreational/social.

## **Patient Rights and Safety Standards**

*Mental Health (MH):* Within 24 hours of admission, the resident must receive a written statement of rights on grievance procedures and access to advocates. Other rights include but are not limited to confidentiality, dignity, communication, to be free of abuse, and treatment in the least restrictive setting, as well as reporting and investigation standards. In an LTRS, the use of seclusion is prohibited, as is restraint for behavior management, with other uses of restraints

(i.e., to control involuntary movement due to organic causes or conditions) regulated. Additional, more general regulations provide additional standards, including requiring a restraint plan.

*Substance Use Disorder (SUD):* Clients of Freestanding Treatment Facilities and Health Care Facilities have civil rights, the right to nondiscrimination, confidentiality, and other rights. The facility must have policies to respond to “unusual incidents” that include documentation, review and identification of cause, implementation of a corrective action plan, monitoring, and reporting.

## **Quality Assurance or Improvement**

*Mental Health (MH):* The provider must have a written quality improvement (QI) plan and program that the program director reviews for the quality and appropriateness of services provided and monitors for compliance with standards of treatment and care. The plan shall, among other things: (1) Specify who has responsibility for QI activities, to whom findings are reported, the frequency of reviews, what critical indicators are to be evaluated and acceptable levels for the critical indicators. (2) Have indicators of quality care that include at least the following: (i) The level of resident satisfaction and program input. (ii) The level of family satisfaction and program input. (iii) Appropriateness, completeness, timeliness and implementation of the treatment plans. (iv) Case and trend review of crisis events and unusual situations. (v) Direct-care staff performance. (vi) Clinical case or peer reviews, quarterly or more often as indicated. (vii) Medications management, including errors and adverse effects. (viii) Appropriate documentation.

*Substance Use Disorder (SUD):* Freestanding Treatment Facilities and Health Care Facilities must have a data collection and recordkeeping system that allows for the efficient retrieval of data needed to measure the project’s performance in relationship to its stated goals and objectives.

## **Governance**

*Mental Health (MH):* An LTSR must be operated by either a nonprofit or a for-profit corporation. The corporation’s governing body has legal responsibility for the operation of the facility. The governing body shall, among other things, establish required policies, select a qualified program director, conduct an annual review and evaluation, administer funds and develop budgets, and assure compliance with statutes and regulations.

*Substance Use Disorder (SUD):* Freestanding Treatment Facilities and Health Care Facilities must have a governing body with legal responsibility for the project. Duties include but are not limited to designating the project director, identifying purpose and philosophy, and

documenting organizational structure. If publicly funded, the body must provide an annual report. They must adopt a written plan for coordination of treatment and rehabilitation services and written personnel policies, both of which must include specified components.

## Special Populations

*Mental Health (MH)*: LTRSs are specifically designed for individuals with serious mental illness who cannot be served in a less restrictive setting.

*Substance Use Disorder (SUD)*: Requirements specific to special populations were not located for adult residential SUD treatment.

## Location of Regulatory and Licensing Requirements

Department of Human Services LTRS regulations<sup>1</sup>; Department of Human Services Licensure/Certification regulations<sup>2</sup>; Regulations Regarding Abuse of Patients/Residents<sup>3</sup>; Regulations Regarding Restraint/Seclusion<sup>4</sup>; Statute Requiring Licensure<sup>5</sup>; Department of Drug and Alcohol Programs regulations<sup>6</sup>. Regulatory data collected August 31, 2019.

## Other Information Sources

T. Pride (PA OMHSAS); E. DiDomenico (PA DDAP); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>1</sup> See <https://www.pacode.com/secure/data/055/chapter5320/chap5320toc.html#5320.12>.

<sup>2</sup> See <https://www.pacode.com/secure/data/055/chapter20/chap20toc.html>.

<sup>3</sup> See <https://www.pacode.com/secure/data/055/chapter14/chap14toc.html>.

<sup>4</sup> See <https://www.pacode.com/secure/data/055/chapter13/chap13toc.html>.

<sup>5</sup> See <https://codes.findlaw.com/pa/title-62-ps-poor-persons-and-public-welfare/pa-st-sect-62-1001.html>.

<sup>6</sup> See [https://www.ddap.pa.gov/Licensing/Pages/Licensing\\_Drug\\_and\\_Alcohol\\_Facilities.aspx](https://www.ddap.pa.gov/Licensing/Pages/Licensing_Drug_and_Alcohol_Facilities.aspx).

# PENNSYLVANIA MEDICAID

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## Approach

The Pennsylvania Department of Human Services (DHS) oversees the state Medicaid program. Pennsylvania also has a Section 1115 waiver whereby SUD treatment services may be provided to Medicaid enrollees with a SUD who are short-term residents in residential facilities that meet the definition of an Institution for Mental Diseases (IMD) and who receive services via managed care. The waiver excludes FFP for opioid use disorder (OUD)/SUD services in IMDs for beneficiaries who receive services via fee-for-service. Pennsylvania does not rely on the in lieu of provision for coverage of some services in IMDs but historically has relied on Disproportionate Share Hospital (DSH) Payments.

## Types of Facilities

*Mental Health (MH):* Researchers found no evidence of Medicaid reimbursement for adult residential MH treatment services.

*Substance Use Disorder (SUD):* The Pennsylvania Section 1115 waiver permits reimbursements for the following residential settings:

- Level 3.1 Halfway Houses
- Level 3.5 or 3.7 Medically Monitored Short Term Residential
- Level 3.5 Medically Monitored Long Term Residential
- Level 3.7-WM Medically Monitored Inpatient Detoxification

Medication-assisted treatment also is to be available to those in IMDs.

## **Processes of Medicaid Enrollment**

*Mental Health (MH) and Substance Use Disorder (SUD):* Providers must, among other things, apply to enroll as a Medicaid provider in Pennsylvania, sign a provider agreement, and be licensed and registered or certified or both by the appropriate state agency.

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver and state Medicaid regulations, residential SUD treatment services are provided in an Pennsylvania Department of Drug and Alcohol Programs (DDAP)-licensed facility that has been enrolled as a Medicaid provider and assessed by DDAP as delivering care consistent with ASAM or other nationally recognized, SUD-specific program standards for residential treatment facilities.

## **Staffing**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding credentials of staff for residential treatment settings. The state must assess the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT. Required staff for all levels include a director and counselor(s), and a clinical supervisor. Additional staff may include a clinical supervisor or lead counselor, social services counselor, a psychiatrist, a psychologist, a medical consultant, and any other health and human services staff or consultants (e.g., SUD counselors or other certified SUD clinicians) who may more effectively serve the facility's population.

## **Placement**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines (Pennsylvania now uses the ASAM Criteria.). The state also must establish a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings. Services must be determined to be medically necessary by the Behavioral Health Managed Care Organization (BH-MCO) utilization review staff and in accordance with an individualized service plan.



## **Treatment and Discharge Planning and Aftercare Services**

*Substance Use Disorder (SUD)*: Pursuant to the Section 1115 waiver, residential treatment facilities must provide: (1) individualized treatment planning, with reviews at least every 30 days (every 15 days if treatment is shorter-term); (2) development of a discharge plan; and (3) a plan for referral into continuum of care for beneficiaries with SUD treatment.

## **Treatment Services**

*Substance Use Disorder (SUD)*: Pursuant to the Section 1115 waiver, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions. The state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services and hours of clinical care for residential treatment settings. The state must establish a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site.

Pursuant to the 1115 waiver, the following, among others, are Medicaid-covered services in residential treatment facilities:

- Clinically-directed therapeutic treatment.
- Addiction pharmacotherapy and drug screening.
- Motivational enhancement and engagement strategies.
- Counseling and clinical monitoring.
- Withdrawal management and related treatment.
- Regular monitoring of medication adherence.
- Recovery support services.
- Counseling services involving the beneficiary's family and significant others.

- Education on benefits of medication assisted treatment (MAT) and on-site MAT or facilitated access to MAT off-site.

Very specific requirements for services and supports for specific levels of treatment are included in the waiver documents, including for Levels 3.1, 3.5, 3.7, and 3.7-WM.

## Care Coordination

*Substance Use Disorder (SUD)*: Pursuant to the Section 1115 waiver, beneficiaries will have improved care coordination and care for comorbid physical and mental health conditions. The state must ensure establishment and implementation of policies to ensure residential facilities link beneficiaries with community-based services and supports following stays in these facilities.

## Quality Assurance or Improvement

*Substance Use Disorder (SUD)*: No specific requirements for quality assurance or improvement plans for adult residential SUD treatment facilities were located in the waiver documents or Medicaid regulations.

## Special Populations

*Substance Use Disorder (SUD)*: No Medicaid requirements related to special populations were located other than the requirement in the Section 1115 waiver that care for comorbid physical and mental health conditions be improved by the demonstration.

## Location of Medicaid Requirements

Pennsylvania Medicaid Rules and Regulations<sup>7</sup>; Pennsylvania Section 1115 Waiver<sup>8</sup>. Regulatory data collected November 2019.

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<sup>7</sup> See <http://www.pacodeandbulletin.gov/Display/pacode?file=/secure/pacode/data/055/partIIItoc.html&d=>.

<sup>8</sup> See <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/pa/pa-former-foster-care-youth-diff-state-ca.pdf>.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report **“State Residential Treatment for Behavioral Health Conditions: Regulation and Policy”**. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

## RHODE ISLAND

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

### Types of Facilities

*Mental Health (MH) and Substance Use Disorder (SUD):* Rhode Island regulates behavioral healthcare organizations (BHOs), including public or private residential facilities primarily constituted, staffed, and equipped to deliver MH and/or SUD services to the public, including the following which address both MH and/or SUD treatment needs:

- Behavioral Health Stabilization Units (BHSUs) provide, among other things, 24-hour crisis services and hospital step-down services. The maximum capacity that can be located in one facility is sixteen (16) beds.

*Mental Health (MH):* BHOs specific to adult MH residential treatment include:

- Mental Health Psychiatric Rehabilitative Residences (MHPRRs). This is a congregate licensed residential program with no more than sixteen (16) beds which provides twenty-four (24) hour staffing.
- Specialized Mental Health Psychiatric Rehabilitative Residences (SMHPRRs). This is a congregate licensed residential program with no more than sixteen (16) beds which provides twenty-four (24) hour staffing for populations with complex co-occurring conditions in which the clients receive a wide range of care management, co-occurring treatment of MH and SUD, psychiatric rehabilitation and individual care services.
- Supportive Mental Health Psychiatric Rehabilitative Residence Apartments (MHPRR-As). This is a licensed residential program with no more than sixteen (16) beds which provides twenty-four (24) hour staffing for clients to receive a wide range of care management, treatment, psychiatric rehabilitation and individual care services in an apartment setting.

*Substance Use Disorder (SUD):* BHOs specific to adult residential SUD treatment include:

- Level 3.1 Clinically Managed, Low-Intensity Residential Services is included but not defined.
- Level 3.3 Short-Term, Clinically Managed, Medium-Intensity is a non- acute residential level of care that focuses on stabilization, integration, employment, education, and

recovery. A component of treatment may focus on habilitation due to discharge from institutional level of care.

- Level 3.5 Clinically Managed, High-Intensity Residential provides a structured, therapeutic community environment focused on addressing life skills, reintegration into the community, employment, education, and recovery.
- Detoxification Programs, which may be in a residential or other setting. These include:
  - Medical Detoxification Programs. Medical detoxification programs provide services related to medical management of the physiological and psychological symptoms of withdrawal from alcohol and/or another drug of misuse that is provided in a hospital or free standing, appropriately equipped setting.

*Unregulated Facilities:* There are no unregulated residential treatment facilities in Rhode Island. We exclude from this summary the BHOs known as On-Site Supportive Psychiatric Rehabilitative Apartments as they seem to provide limited outpatient CMHC services in an apartment setting.

## **Approach**

The Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) regulates all BHOs in the state.

## **Processes of Licensure or Certification and Accreditation**

*Mental Health (MH) and Substance Use Disorder (SUD):* Licensure by the BHDDH Office of Licensure and Standards is required for operation of all facilities and the focus is primarily on ability to comply with applicable laws and regulations.

- Accreditation is not required but accreditation by “an acceptable national accreditation body” can confer deemed status for related licensure requirements. Periodic full quality program reviews are still required.
- An on-site review is required for licensure and certification and for renewal.
- A Certificate of Need is not required.
- Licensure duration is 2 years. Authorization to provide services is dependent on meeting and continuing satisfaction of approved BHDDH certification standards.

## **Cause-Based Monitoring**

*Mental Health (MH) and Substance Use Disorder (SUD):* Licenses may be provisional or conditional or may contain stipulations and restrictions. Licenses can be denied, limited, suspended, annulled, withdrawn, amended, or revoked. Deficiencies result in a plan of correction or compliance order. Inspections may take place as the Department deems necessary. Unlicensed agencies may be fined.

## **Access Requirements**

*Mental Health (MH) and Substance Use Disorder (SUD):* BHOs must have written policies and procedures describing the criteria to prioritize the scheduling of appointments. When a person is eligible for the organization's services, but not in need of immediate or crisis-related services, an appointment must be scheduled with reasonable promptness. If the organization lacks the resources to schedule an appointment within six weeks (6) of the screening date, the organization shall refer to another appropriate provider and document the referral.

- A BHSU must have the capacity to accept admissions twenty-four (24) hours a day, seven (7) days a week (24/7). Upon completion of a phone screening, the unit must have the capacity to finalize the disposition with the referral source within sixty minutes.

## **Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD):* BHOs must provide orientation and annual training programs for employees regarding specified topics. BHOs also must have basic personnel policies. Requirements are in place for those providing direct assistance to individuals, as well as for volunteers. The BHO must define areas of responsibility, qualifications, and competencies of staff commensurate with job responsibilities and applicable legal or other requirements and must provide professional development opportunities to maximize cultural competencies and to support recovery-oriented services. Staff must have appropriate training, education, experience, credentials, and licenses. Requirements for direct service staff include requirements regarding supervision.

- BHSU staff must be trained in risk assessment and crisis intervention services. The unit must have a psychiatrist available 24/7 or a Psychiatric Clinical Nurse Specialist (PCNS) or other mid-level practitioner under the supervision of a psychiatrist. The psychiatrist must also be scheduled to be on-site at the program for psychiatric assessments and medication reviews as required by the changing client mix. The unit must have a staff member meeting specific requirements on-site 24/7 to facilitate inpatient psychiatric admission from the unit site to an inpatient facility if required and an RN on-site 24/7 for medication services and to facilitate transfers for medical admissions. Other general on-

site staffing requirements relate to psychiatric care, nurses (including RNs), counselors, care managers, clinical supervisors of residential staff, license or supervision required for direct service staff, and individual supervision of clients if necessary. During all hours of operation in all residential programs, there must be at least one individual trained in basic First Aid and in cardiopulmonary resuscitation (CPR). Other training is also required.

*Mental Health (MH):*

- MHPRR: Twenty-four hour staffing is required as long as there are client(s) physically present in the residence. Ratios apply to direct care staff, with additional requirements applicable based on acuity, as needed for health and safety, and for 1:1 staffing when a resident is in crisis. At least one (1) staff person trained in CPR.
- SMHPRR: Twenty-four hour staffing is required.
- MHPRR-A: Twenty-four hour staffing is required. Clients do not require constant staff supervision but do require availability of staff to respond quickly to meet needs. Direct service staff in residential programs must have the qualifications relevant to the service they are providing.

*Substance Use Disorder (SUD):*

- All Residential Programs for Substance Use Disorders are subject to BHO staffing requirements that include having a coordinated treatment team that includes a qualified behavioral health practitioner; all non-licensed direct-care staff working toward provisional or advanced certification as an Alcohol and Drug Counselor; and staffing ratio requirements applicable to direct care staff. The program must provide trained on-site residential direct care staff 24 hours day/ 7 days a week.
- Medical Detoxification Programs: Staffing shall provide 24 hour, awake, on-site care 7 days a week. Requirements both for adequate staffing levels and registered nursing ratios are in place, as are requirements for registered nurses and licensed counseling staff. The program must have on staff a supervising physician who is responsible for oversight of all medical and pharmaceutical procedures. Specific training requirements exist for all nurses and for clinical and support staff. Among other things, training must include: (a) Appropriate screening protocols and procedures; (b) Use of ASAM placement and treatment criteria; (c) Medical aspects of substance use, abuse, and withdrawal, especially as it pertains to the acute care setting; (d) Pharmacology in the detoxification program setting; (e) Discharge or continuum of care; (f) Early interventions for individuals at high risk during intoxication and withdrawal; (g) Non-violent crisis intervention; and (h) Management of the individual with suicidal ideation.

## Placement

*Mental Health (MH) and Substance Use Disorder (SUD):* BHOs must have written policies and procedures that describe the criteria for admission and denial of service. A biopsychosocial assessment of the individual's physical and psychological status and social functioning must be conducted for each person who is evaluated for admission to the organization. The person conducting the assessment must meet certain educational or licensure requirements. When a person served is not participating in a particular service or program, the director of such service or program may discharge the person from the program or the organization only when specific conditions have been met.

- A BHSU, as part of crisis services, must provide a face-to-face initial triage review by a Licensed Independent Clinician or Practitioner to assess acuity, risk status, and client level of need for the interim period prior to a full assessment and development of an initial person-centered plan. The unit must offer step-down services for clients who do not require inpatient hospitalization or detox but who require further stabilization before returning to the community. Eligibility requirements for admission to a BHSU include: (a) age and residency; (b) safety in an unlocked facility; (c) voluntarily agree to admission; and (d) medical stability. Criteria for exclusion may include factors related to: (a) acute substance intoxication; (b) acute psychosis; (c) acute mania; (d) gross functional impairment due to vegetative signs of depression; (e) assaultive ideation; (f) assaultive behaviors; (g) active self-injurious behaviors; (h) recent suicide attempt with a continued threat or plan to act on suicidal ideation; and (i) compromised physical condition. The unit must have the capacity to accept admissions 24/7 and there are detailed requirements regarding who conducts the screening, when screening occurs, finalization of disposition, and having a trauma-informed search of the client and any belongings. A Licensed Independent Clinician or Practitioner must conduct an initial assessment within twenty-four (24) hours of admission. Discharge criteria are identified, and length of stay is individualized based on each individual's service needs.

*Mental Health (MH):* Placement criteria for BHOs providing MH residential treatment include that a physician must authorize all MHPRR services, based on the Psychiatric Rehabilitative Residence Individual Care Checklist, as well as the following:

- MHPRR: This population includes individuals with refractory psychosis; dual diagnosis (individuals with developmental disabilities and mental health issues); or co-occurring addiction and mental health disorders, who cannot be treated in the community through outpatient supports. If a comprehensive medical history and physical examination have been completed within sixty (60) days before admission to the program, that report may be used in the treatment record. If not, a physical health assessment, including a medical history and physical examination, must be completed by a qualified medical, licensed, independent practitioner, within 30 days after admission.



- SMHPRR: These serve populations with complex co-occurring conditions. Specialized services are meant to address populations that are difficult to maintain in traditional group home settings including: clients with co-occurring substance use and mental health disorders, those stepping down from Eleanor Slater Hospital, clients who are self-injurious or have personality disorders, and transitional-aged youth.

*Substance Use Disorder (SUD):*

- All Residential Programs for Substance Use Disorders must utilize the ASAM Criteria to determine the appropriate level of residential care and be able to provide the array of services based on the appropriate placement level, including MAT options. Biopsychosocial assessments must be completed 48 hours after admission. Justification for the selection of the ASAM level of care must be validated within the diagnostic summary of the assessment.
- Medical Detoxification Programs: The program must have established written admission, continuing care, and discharge criteria. A complete medical history and physical examination must be performed and documented on each individual within 24 hours of admission. A biopsychosocial assessment shall be completed and documented within 72 hours of admission. Persons served shall remain in a medical detoxification program for the period of time determined and documented as medically necessary by the program's physician.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Unless required otherwise for specific program types, all BHOs must develop a preliminary treatment plan for the first thirty days after the biopsychosocial assessment is completed. At least once every 12 months, a review and update of the assessment information and the integrated summary must be documented. Based on the biopsychosocial assessment, a goal-oriented, recovery-focused individualized treatment plan meeting certain requirements must be developed and implemented with each person served. A new treatment plan must be developed at least once every 12 months. Goals and interventions indicated in the treatment plan shall be reassessed, updated and modified every 6 months as necessary, and at the occurrence of certain events. An aftercare plan before a planned discharge. The aftercare plan shall include: (1) Services to be accessed following transition/discharge; (2) Activities to sustain the progress made during treatment; and (3) A crisis plan for the individual to follow after transition/ discharge, when indicated.

- For BHSUs: All individuals must have a discharge plan, which is started within 24 hours after admission. Arranged follow up appointments are not to exceed 48 hours for the first appointment from discharge. A follow up medication appointment must be scheduled within 14 days. Individuals referred to homeless shelters must have scheduled follow up

appointments with providers. Transportation issues are to be resolved and documented in the individual's record describing how the individual shall attend the first appointment.

*Mental Health (MH):* For MHPRRs, a comprehensive person-centered treatment plan must be completed with each resident and, as appropriate, his or her family within 30 days of admission. The treatment plans and treatment plan reviews of each resident of a MHPRR program must be signed by the psychiatrist treating the resident.

*Substance Use Disorder (SUD):*

- All Residential Programs for Substance Use Disorders must complete a person-centered treatment plan. A review of the person-centered plan for each person served in a residential treatment program must occur at least once a month.
- Medical Detoxification Programs: An initial individualized person-centered plan addressing short-term detoxification goals must be completed within seventy-two (72) hours of admission.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* A BHSU must provide: (1) 24-Hour Crisis Services; (2) Hospital Step Down Services; (3) Principal point of contact/accountability for each individual served; (4) Psychiatry Services; (5) Inpatient Psychiatric and Medical Admissions (if required); (6) Treatment for co-occurring mental health and substance related disorders; (7) Group and Individual Counseling; and (8) Family Psychoeducation and Supportive Services.

*Mental Health (MH):*

- MHPRR: Among other things, service elements include the following, based on each resident's individualized recovery-focused, person-centered plan: (a) Mental health therapeutic and rehabilitative services for the resident to attain recovery; (b) Medication prescription, administration, education, cueing and monitoring; (c) Counseling: Individual, group and family; and (d) Social casework: Client-based advocacy; linkage to outside service providers; monitoring the use of outside services; individualized person-centered planning and skill teaching; income maintenance; and medical care assistance.
- SMHPRR: The clients receive a wide range of care management, co-occurring treatment of substance use and mental health, psychiatric rehabilitation and individual care services.

### *Substance Use Disorder (SUD):*

- All Residential Programs for Substance Use Disorders must provide active treatment 7 days a week based on the needs of persons served in, among others, the following areas: (a) Individual counseling/therapy; (b) Group counseling/therapy; (c) Family/support system counseling/therapy; and (d) Relapse prevention/crisis preparation work. The residential treatment program shall provide a suitable clinical service array for the following applicable ASAM levels of care, including corresponding hours of service:
  - Level 3.1 Clinically Managed, Low-Intensity Residential Services
  - Level 3.3 Short-Term, Clinically Managed, Medium-Intensity
  - Level 3.5 Clinically Managed, High-Intensity Residential
- Medical Detoxification Programs: To ensure that the appropriate rehabilitative services are provided, the person served shall be assigned a primary counselor who shall follow the person's progress during detoxification. Staff shall provide a planned regimen of 24 hour professionally directed evaluation, care, and treatment services, to include the administration of prescribed medications by medical staff. Medical specialty, psychological, psychiatric, laboratory, and toxicology services must be available within the program or through consultation or referral. The program must have a written agreement with a hospital for transferring individuals in cases of medical emergencies. There must be a written physician-approved detoxification protocol or standing detoxification orders for each substance for which the program provides a detoxification service.

## **Patient Rights and Safety Standards**

*Mental Health (MH) and Substance Use Disorder (SUD):* Residential BHOs have the following rights, among others: privacy, dignity, communication, voting, religious freedom, access to a Mental Health Advocate, confidentiality, and an accessible grievance procedure. Aversive techniques of behavior management are prohibited. Seclusion, chemical restraint, and mechanical restraint are prohibited in all BHOs and use of physical restraint is limited. Physical restraint use must be reported to the Department's Office of Quality Assurance and data must be collected to monitor and improve performance in that regard.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* All BHOs must have written policies and procedures for assessing individual satisfaction with services and supports received, individual choice regarding services received, and individual involvement in monitoring and directing the provision of services. The BHO must have an effective, ongoing, organization-wide quality performance/improvement program to evaluate the provision of services and supports to individuals that addresses the quality requirements of the BHO regulations.

## **Governance**

*Mental Health (MH) and Substance Use Disorder (SUD):* BHOs must have an organized board to serve as a governing body that is responsible for, among many other things, program and fiscal management and operation, quality assurance, compliance with all laws, and oversight. Policies and procedures are required. The board must include community representation and, at least 25% of the board, must include persons who reflect the population served by the organization and/or family members of individuals and at least one must be an individual served.

## **Special Populations**

*Mental Health (MH) and Substance Use Disorder (SUD):* BHOs must organize their services so that individuals with co-occurring disorders are identified as soon as possible and receive treatment in an integrated manner. Among other things, this includes development and implementation of policies and procedures, utilization of guidelines, screening as part of the biopsychosocial assessment, and referral and active care coordination. Specific staffing qualifications are recommended for those working with individuals with co-occurring conditions. Among other things, a psychiatrist must be available on-staff or through consultation and programs must check the PDMP and obtain a toxicology screen prior to prescribing medications for this group.

## **Location of Regulatory and Licensing Requirements**

Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals, Licensure Regulations subchapter 00<sup>1</sup> and 10<sup>2</sup>. Regulatory data collected August 16, 2019.

## **Other Information Sources**

L. Mahoney (BHDDH); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>1</sup> See [https://risos-apa-production-public.s3.amazonaws.com/BHDDH/REG\\_10309\\_20181218125932.pdf](https://risos-apa-production-public.s3.amazonaws.com/BHDDH/REG_10309_20181218125932.pdf).

<sup>2</sup> See [https://risos-apa-production-public.s3.amazonaws.com/BHDDH/REG\\_10211\\_20181218130650.pdf](https://risos-apa-production-public.s3.amazonaws.com/BHDDH/REG_10211_20181218130650.pdf).

# RHODE ISLAND MEDICAID

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## Approach

The Rhode Island Executive Office of Health and Human Services oversees the state Medicaid program. Rhode Island also has a section 1115 waiver permitting Medicaid coverage of residential treatment for substance use disorders (SUD) in an institution for mental diseases (IMD) for individuals between the ages of twenty-one (21) to sixty-four (64) for no longer than fifteen (15) days. The state historically also has relied on the in lieu of provision for Medicaid coverage of some IMD services but not on Disproportionate Share Hospital (DSH) payments.

## Types of Facilities

*Mental Health (MH):* Medicaid coverage is available for residential treatment facilities and/or services for individuals aged 18-64 years who are in a residential setting that is not an IMD, including the following:

- Mental Health Psychiatric Rehabilitative Residence (MHPRR) providing psychiatric care in a supervised setting.
- Crisis Intervention services administered in residential settings for individuals with severe and persistent mental illness enrolled in Community Support Programs.
- Residential services associated with CMHCs.

*Substance Use Disorder (SUD):* ASAM levels of care included in the Section 1115 waiver are 3.1, 3.3., and 3.5, as well as medically supervised withdrawal management. Apart from the section 1115 SUD waiver coverage, Medicaid coverage is available for residential treatment facilities and/or services for individuals aged 18-64 years who are in a residential setting that is not an IMD, including the following:

- Hospital-based detoxification services which relate to medical management of the physiological and psychological symptoms of withdrawal from alcohol and/or another drug of misuse including but not limited to community-based narcotic treatment and community detox provided in residential settings.

- SSTARbirth services, which provide a long-term (6 month minimum) residential substance abuse treatment program specifically designed for pregnant, postpartum and parenting women.

## **Processes of Medicaid Enrollment**

*Mental Health (MH) and Substance Use Disorder (SUD):* To participate in the Medicaid program, health care providers must be certified and agree to abide by the requirements established in Title XIX and Title XXI of the Social Security Act, Rhode Island General Laws, and State and federal rules and regulations.

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must have performance measures that track that providers meet licensure/certification standards, that non-certified providers are monitored to assure adherence to waiver requirements, and that the state verifies that training is given to non-certified providers in accordance with the waiver.

## **Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD):* Residential services, screenings, and assessments for appropriate level of care must be available 24 hours per day, 7 days per week.

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the credentials of staff for residential treatment settings.

## **Placement**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must provide for delivery of new benefits, including residential treatment. The state also must undertake an assessment of the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under the demonstration. Patient treatment needs must be assessed based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines. The state must establish a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings.

## **Treatment and Discharge Planning and Aftercare Services**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by waiver services or through other means. Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Residential treatment services include therapeutic services. There is a 14-day requirement for prior authorization for receipt of residential treatment services.

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions. The waiver permits the following to be provided in an IMD: residential treatment, medically supervised withdrawal management, MAT, and peer recovery support services. Residential treatment providers must offer MAT on-site or facilitate access to MAT off-site through an MOU with the off-site provider. The state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services and hours of clinical care for residential treatment settings.

## **Care Coordination**

*Mental Health (MH) and Substance Use Disorder (SUD):* Care coordination services are to be offered to eligible beneficiaries through contracted managed care organizations. Care management entities provide care coordination and assistance to beneficiaries in Medicaid fee-for-service who are not eligible for enrollment in managed care.

*Substance Use Disorder (SUD):* Under the Section 1115 waiver, residential facilities must link beneficiaries with community-based services and supports following stays in facilities.

## Quality Assurance or Improvement

*Mental Health (MH) and Substance Use Disorder (SUD):* Facilities must have an approved Quality Assurance system and evaluate quality of care provided to patients in facilities.

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings.

## Special Populations

*Substance Use Disorder (SUD):* No Medicaid requirements were located other than the requirement in the Section 1115 waiver that care for comorbid physical and mental health conditions be improved by the demonstration.

## Location of Medicaid Requirements

Rhode Island Comprehensive Demonstration 1115 Waiver 2019-2023<sup>3</sup>; Rhode Island EEOHS Medicaid Rules and Regulations Title 210<sup>4</sup>. Regulatory data collected November 2019.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report “**State Residential Treatment for Behavioral Health Conditions: Regulation and Policy**”. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

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<sup>3</sup> See <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ri/ri-global-consumer-choice-compact-ca.pdf>.

<sup>4</sup> See <https://rules.sos.ri.gov/organizations>.



## SOUTH CAROLINA

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### Types of Facilities

**Mental Health (MH):** South Carolina regulates Crisis Stabilization Unit (CSU) facilities, which are short-term residential programs, offering psychiatric stabilization services and brief, intensive crisis services to individuals eighteen and older for no longer than 14 consecutive calendar days.

**Substance Use Disorder (SUD):** South Carolina regulates two broad categories of adult SUD residential treatment facilities:

- A Residential Treatment Program Facility (RTPF) is any 24-hour facility designed to improve the client's ability to structure and organize the tasks of daily living and recovery through planned clinical activities, counseling, and clinical monitoring in order to promote successful involvement or re-involvement in regular, productive daily activity, and, as indicated, successful reintegration into family living.
- A Detoxification Facility is any 24-hour freestanding facility providing detoxification services of which there are two types:
  - Medical. A short-term residential facility, separated from an inpatient treatment facility, providing for medically-supervised withdrawal from psychoactive substance-induced intoxication, with the capacity to provide screening for medical complications of alcoholism and/or drug abuse, a structured program of counseling, if appropriate, and referral for further rehabilitation.
  - Social. A service providing supervised withdrawal from alcohol or other drugs in which neither the client's level of intoxication nor physical condition is severe enough to warrant direct medical supervision or the use of medications to assist in withdrawal, but which maintains medical backup and provides a structured program of counseling, if appropriate, educational services, and referral for further rehabilitation.

**Unregulated Facilities:** It is possible that there are other noncrisis MH residential treatment facilities that are not regulated. Staff from the Department of Alcohol and Other Drug Abuse Services indicated that certain transitional housing units are unregulated. Community Residential Care Facilities are excluded from this summary as the pertinent regulations do not require or include mental health treatment.

## **Approach**

The South Carolina Department of Health and Environmental Control (DHEC) regulates CSUs, all of which are either operated by or in partnership with the state Department of Mental Health, and regulates all RTPFs and Detoxification Facilities, without regard to operator or funding.

## **Processes of Licensure or Certification and Accreditation**

*Mental Health (MH):* Licensure by the DHEC is required for all CSUs.

- Accreditation is not required.
- An inspection is required for initial licensure and after as deemed appropriate by the DHEC to assure compliance.
- The state requires a Certificate of Need.
- Licensure duration is not defined.

*Substance Use Disorder (SUD):* All residential SUD treatment facilities, excepting federal facilities, require licensure by the DHEC.

- Accreditation is not required.
- An inspection is required for initial licensure and after as deemed appropriate by the DHEC to assure compliance.
- The state does not require a Certificate of Need.
- Licensure duration is not defined.

## **Cause-Based Monitoring**

*Mental Health (MH):* Ongoing inspections of CSUs, announced or otherwise, may be conducted. Licenses may be denied, suspended, or revoked, and monetary penalties may be assessed.

*Substance Use Disorder (SUD):* The DHEC may conduct onsite inspections of the facility and records at any time without advance notice. If noncompliance with statutory or regulatory requirements is found, a plan of correction is required. Enforcement actions may be brought, and a license may be denied, suspended, or revoked, or a monetary penalty imposed.

## **Access Requirements**

*Mental Health (MH):* Each facility must provide screening services on a twenty-four (24) hours per day, seven (7) days per week basis. No person shall remain in the facility for more than eight (8) hours without being admitted or denied admission. Individuals declared in writing to be in an emergency crisis may be admitted to the facility without the initial step of the two-step tuberculin skin test and/or while awaiting the result of a blood assay for tuberculosis.

*Substance Use Disorder (SUD):* Wait-time requirements were not found. Facilities must comply with all federal, state, and local laws regarding discrimination and may not discriminate with regard to source of payment.

## **Staffing**

*Mental Health (MH):* A CSU must define in writing the responsibilities, qualifications, and competencies of staff for all positions. Specific requirements include ones related to the administrator, RNs, other staff and volunteers. Staffing ratios are in place and all staff members on duty must be awake and dressed at all times. All staff and volunteers must complete required Department of Mental Health and staff involved in direct patient care must, among other things, receive training in CPR/first aid, medication management, suicide assessment and prevention, crisis intervention and treatment, patient rights and grievance procedures, confidentiality, reporting abuse or neglect, and use of restraint and restraint alternatives. All staff members and volunteers must have documented orientation to the purpose and environment of the facility within twenty-four hours of their first day on the job.

*Substance Use Disorder (SUD):* Appropriate staff/volunteers in numbers and training must be provided to suit the needs and condition of the clients and meet the demands of effective emergency on-site action that might arise. Training requirements/qualifications for the tasks each performs must be in compliance with all local, state, and federal laws, and current professional organizational standards. Direct care staff members/volunteers of the facility, shall not, among other things, have an active dependency on psychoactive substances that would impair his/her ability to perform assigned duties. Specific requirements include ones related to the administrator, other staff and volunteers, including regarding licensure and certification as well as other qualifications. When care, treatment, or services are provided by another entity, there must be a written agreement with the entity that describes how the services provided are in accordance with the individualized treatment plan that the staff/volunteers providing these services are qualified and supervised properly. In all facilities, the following training shall be provided to all staff/volunteers, and those clients in residential treatment program facilities who may be utilized to supplement staffing, within one month of hiring and at least annually: the nature of alcohol and other drug addiction, complications of addictions, and withdrawal symptoms; confidentiality; and the protection of client rights. In addition, prior to client contact

and at least annually, among others: training in cardio-pulmonary resuscitation to ensure that there is at least one certified individual present when clients are in the facility (detoxification facilities only); first-aid; contagious and/or communicable disease; medication management (for those facilities to which applicable); use of restraints and seclusion (detoxification facilities only, if applicable); seizure management (detoxification facilities only).

- For RTPFs, staffing ratios and other requirements are in place, including requirements regarding clients acting as staff.
- For Detoxification Facilities, staffing ratios and other requirements are in place, including, for medical detoxification facilities only, that staff/volunteers be under the general supervision of a physician or registered nurse; and that a physician, licensed nurse, or other authorized medical healthcare provider shall be present at all times. In social detoxification centers, there must be consultation with medical authorities when warranted.

## **Placement**

*Mental Health (MH):* The facility must have written protocols for screening individuals presenting for evaluation. The facility must establish admission criteria that are consistently applied and comply with the facility's policies and procedures. Individuals seeking admission must be appropriate for the services, treatment, and care offered. No supervision, care, or services may be provided to individuals who have not been admitted as patients of the facility. Patient stays may not exceed fourteen (14) consecutive calendar days. A facility may not retain any patients who primarily need detoxification services or who meet other specified conditions.

Initial screening for risk of suicide or harm to self or others must be conducted and documented for each individual presenting to the facility. A nursing assessment shall be documented for all patients admitted within twenty-four (24) hours. An emotional and behavioral assessment shall be documented for all patients admitted within twenty-four (24) hours. This assessment shall be completed by a mental health professional or other unit staff under the supervision of a mental health professional. A direct psychiatric evaluation, including diagnosis, shall be documented by a physician, psychiatrist, physician assistant, or advanced practice registered nurse for all patients admitted within twenty-four (24) hours.

*Substance Use Disorder (SUD):* Individuals seeking admission must be appropriate for the level of care or services, treatment, or procedures offered. The facility must establish admission criteria that are consistently applied and comply with state and federal laws and regulations. The facility may admit only those persons whose needs can be met within the accommodations and services provided.

- For RTPFs, persons not eligible for admission are, among others: (1) any person who because of acute mental illness or intoxication presents an immediate threat of harm to him/herself and/or others; or (2) any person needing detoxification services, hospitalization, or nursing home care. A complete written assessment of the client, incorporating specified content, by a multi-disciplinary treatment team must be conducted no later than 72 hours after admission. Clinical consideration of each client's needs, strengths, and weaknesses shall be included in the assessment to assist in a level of care placement.
- For Detoxification Facilities appropriate admission must be determined by a licensed or certified counselor and subsequently must be authorized by a physician or other authorized healthcare provider. Those not eligible for admission are, among others: (1) Any person who, because of acute mental illness or intoxication, presents an immediate threat of harm to him/herself and others. (2) Any person needing hospitalization, residential treatment program care, or nursing home care. (3) Anyone not meeting facility requirements for admission. A clinical screening that includes a review of the client's drug abuse/usage and treatment history must be conducted prior to the delivery of treatment.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH):* An individual plan of care ("IPC") must be developed for each admitted patient. The plan must be based on initial and ongoing needs and completed within twenty-four hours of admission. A documented review of the IPC must occur at least daily or upon completion of the stated goal(s) and objective(s). The IPC must include a projected discharge date and anticipated post-discharge needs, including documentation of resources needed in the community.

*Substance Use Disorder (SUD):* Clients must be given the opportunity to participate in aftercare/continuing care programs offered by the facility or through referral. Discharge summaries must include recommendations and arrangements for aftercare. Follow-up may be provided for.

- For RTPFs, an IPC must be completed of the client within a time-period determined by the facility, but no later than seven days after admission. IPCs must be reviewed on a periodic basis as determined by the facility and/or revised as changes in client needs occur.
- For Detoxification Facilities, an IPC must be completed for supervised withdrawal within a time-period determined by the facility. For Social Detoxification Facilities, there must be an IPC for supervised withdrawal.

## Treatment Services

*Mental Health (MH):* The provision of care and services to patients must be guided by the recognition of and respect for cultural differences to ensure reasonable accommodations for patients regarding differences, such as, but not limited to, religious practice and dietary preferences. Reasonable assistance in obtaining pastoral counseling must be provided by the facility upon request by the patient. The facility must secure or provide transportation for patients when a physician's services are needed. If a physician's services are not immediately available and the patient's condition requires immediate medical attention, the facility must provide or secure transportation for the patient to appropriate health care providers.

*Substance Use Disorder (SUD):* Care/treatment/services relative to the needs of the client, e.g., counseling, diet, medications, to include medical emergency situations, as identified in the client record and ordered by appropriate health care professionals, must be provided, and coordinated among those responsible during the treatment process and modified as warranted based on any changing needs of the client. Specific requirements apply to all 24-hour facilities. In addition:

- RTPFs require that 24-hour observation, monitoring, and treatment be available. Among other things, they must provide or make available: (1) Specialized professional consultation, supervision and direct affiliation with other levels of treatment; (2) Physician and nursing care and observation based on clinical judgment if appropriate to the level of treatment; (3) Availability of a physician 24 hours a day by telephone; (4) Counselors to assess and treat adult alcohol and/or other drug dependent clients and obtain and interpret information regarding the needs of these clients. Such counselors shall be knowledgeable of the biological and psychological dimensions of alcohol and/or other drug dependence; (5) Counselors to provide planned regimen of 24-hour professionally-directed evaluation, care and treatment services for addicted persons and their families to include individual, group, and/or family counseling directed toward specific client goals indicated in his/her IPC; and (6) Planned clinical program activities designed to enhance the client's understanding of addiction. For RTPFs that serve mothers with children, the regulations include requirements related to provision of health care to the child.
- Freestanding Medical Detoxification Facilities must provide, among other things: (A) Intake medical examination and screening by a physician or other authorized healthcare provider to determine need for medical services or referral for serious medical complications; (B) Continuing observation of each client's condition to recognize and evaluate significant signs and symptoms of medical distress and take appropriate action; (C) Medication as appropriate to assist in the withdrawal process; (D) A plan for supervised withdrawal, to be implemented upon admission; and (E) Counseling designed to motivate clients to continue in the treatment process and referral to the appropriate treatment modality.

- Social Detoxification Facilities must provide, among other things: (A) Screening and intake provided by staff/volunteers specially trained to monitor the client's physical condition; (B) Development of an IPC for supervised withdrawal; (C) Continuing observation of each client's condition to recognize and evaluate significant signs and symptoms of medical distress and take appropriate action; and (D) Counseling designed to motivate clients to continue in the treatment process.

## **Patient Rights and Safety Standards**

*Mental Health (MH):* Patients have guaranteed rights, including but not limited to, grievance and complaint procedures, confidentiality, freedom from abuse and exploitation, and dignity. Physical and mechanical restraints are limited to specific circumstances. Patients may not be locked in their rooms. Regulations also include requirements for reporting specific incidents.

*Substance Use Disorder (SUD):* The regulations include requirements related to, among other things, incident reporting, informed consent, confidentiality, freedom from abuse, privacy, and dignity. Restraint and seclusion are limited to specific circumstances. Facilities must have grievance procedures.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* There must be a written, implemented quality improvement program that provides effective self-assessment and implementation of changes designed to improve the care and services provided by the facility. Among other things, the quality improvement program must: (1) Establish desired outcomes and the criteria by which policy and procedure effectiveness is regularly, systematically, and objectively accomplished; (2) Identify, evaluate, and determine the causes of any deviation from the desired outcomes; (3) Identify the action taken to correct deviations and prevent future deviation, and the person(s) responsible for implementation of these actions; (4) Analyze the appropriateness of IPCs and the necessity of care and services rendered; (5) Analyze all incidents and accidents; (6) Analyze any infection, epidemic outbreaks, or other unusual occurrences which threaten the health, safety, or well-being of the clients; and (7) Establish a systematic method of obtaining feedback from clients and other interested persons, for example, family members and peer organizations, as expressed by the level of satisfaction with care and services received.

## **Governance**

*Mental Health (MH)*: Requirements related to governance for adult MH residential facilities were not identified, although policies and procedures addressing the manner of compliance with licensing regulations must be maintained.

*Substance Use Disorder (SUD)*: Requirements related to governance for adult SUD residential facilities were not identified.

## **Special Populations**

*Mental Health (MH)*: Requirements related to special populations were not identified for CSUs.

*Substance Use Disorder (SUD)*: Requirements related to special populations were not identified for CSUs.

## **Location of Regulatory and Licensing Requirements**

South Carolina Certification of Need and Health Facility Licensure Act<sup>1</sup>; South Carolina CSU regulations<sup>2</sup>; South Carolina Department of Health and Environmental Control SU regulations<sup>3</sup>. Regulatory requirements reviewed August 16, 2019.

## **Other Information Sources**

H. Bonsu & L. Dutton (SC DAODAS); M. Binkley (SC DMH); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>1</sup> See <https://www.scstatehouse.gov/code/t44c007.php>.

<sup>2</sup> See [https://www.scstatehouse.gov/query.php?search=DOC&searchtext=crisis%20stabilization%20unit&category=COD EOFREGS&conid=24409349&result\\_pos=0&keyval=33637&numrows=10](https://www.scstatehouse.gov/query.php?search=DOC&searchtext=crisis%20stabilization%20unit&category=COD EOFREGS&conid=24409349&result_pos=0&keyval=33637&numrows=10).

<sup>3</sup> See <https://scdhec.gov/sites/default/files/docs/Agency/docs/health-regs/61-93.pdf>.



# SOUTH CAROLINA MEDICAID

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

## Approach

The South Carolina Department of Health and Human Services (DHHS) oversees the state Medicaid program. South Carolina does not have a relevant Section 1115 waiver that affects reimbursement of residential services in Institutions for Mental Diseases (IMDs). It historically has relied to some extent on the in lieu of provision and on Disproportionate Share Hospital (DSH) payments to reimburse certain services in IMDs.

## Types of Facilities

*Mental Health (MH) or Substance Use Disorder (SUD):* No evidence of coverage of MH or SUD residential treatment facilities for adults was located.

## Processes of Medicaid Enrollment

*Mental Health (MH) and Substance Use Disorder (SUD):* State Medicaid regulations do not specify requirements related to enrollment of residential behavioral health treatment. General enrollment requirements, however, include a provision that providers must meet licensing requirements. Sanctions may be applied by the Medicaid agency.

## Staffing

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based staffing requirements for residential treatment facilities for adults was located.

## Placement

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based placement requirements for residential treatment facilities for adults was located.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based treatment or discharge planning or aftercare service requirements for residential treatment facilities for adults was located.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based treatment service requirements for residential treatment facilities for adults was located.

## **Care Coordination**

*Mental Health (MH) and Substance Use Disorder (SUD):* State Medicaid regulations do not specify requirements related to care coordination for residential behavioral health treatment. In general, however, beneficiaries should be on a treatment pathway that is the most appropriate medical condition specific treatment protocol. Treatment pathways offer a coordinated health team approach to care.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based quality assurance or improvement requirements for residential treatment facilities for adults was located.

## **Special Populations**

*Mental Health (MH) and Substance Use Disorder (SUD):* No evidence of Medicaid-based special population requirements for residential treatment facilities for adults was located.

## **Location of Medicaid Requirements**

South Carolina Medicaid Rules and Regulations<sup>4</sup>. Regulatory data collected December 2019.

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<sup>4</sup> See <https://www.scstatehouse.gov/coderegs/Chapter%20126.pdf>.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report **“State Residential Treatment for Behavioral Health Conditions: Regulation and Policy”**. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

## SOUTH DAKOTA

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

### Types of Facilities

*Substance Use Disorder (SUD):* A South Dakota governing statute defines two categories of facilities (an accredited prevention or treatment facility and a designated prevention or treatment facility) although neither definition references treatment setting, residential or otherwise:

- *Accredited prevention or treatment facility:* a private or public agency meeting the standards prescribed in the governing statute related to substance use prevention or treatment programs or a private or public agency or facility surveyed and accredited by the Joint Commission; an Indian Health Service's quality assurance review under the Indian Health Service Manual, Professional Standards-Alcohol/Substance Abuse; or the Commission on Accreditation of Rehabilitation Facilities; or the Council on Accreditation; under the drug and alcohol treatment standards adopted by the Division in rules promulgated pursuant to the governing statute, if proof of the accreditation, with accompanying recommendations, progress reports and related correspondence are submitted to the Division in a timely manner.
- *Designated prevention or treatment facility:* a state-accredited agency operating under the direction and control of the state or providing services under the governing statute through a contract with the Division or treatment facilities operated by the Federal Government which may be designated by the Division without accreditation by the state.

The regulations identify four categories of residential SUD treatment facility (some day treatment programs are included as residential):

- *Level 2.5 or Day treatment program:* an accredited program providing services to a client in a clearly defined, structured, intensive treatment program.
- *Level 3.1 or Clinically-managed low-intensity residential treatment program:* an accredited residential program providing services to a client in a structured environment designed to aid re-entry into the community.
- *Level 3.2D or Clinically-managed residential detoxification program:* an accredited short-term residential program providing services through the supervised withdrawal from

alcohol or other drugs for a person not having a known serious physical or immediate psychiatric complication.

- *Level 3.7 or Medically-monitored intensive inpatient treatment program:* an accredited residential treatment program providing services to a client in a structured environment.

Additionally, the South Dakota Department of Health licenses the following health care facility type:

- *Chemical dependency treatment facility:* any facility which provides a structured inpatient treatment program for alcoholism or drug abuse
  - Because some chemical dependency residential treatment is identified as simultaneously “inpatient” as well as “residential,” some residential SUD treatment is covered by these regulations.

*Unregulated Facilities:* No unregulated facility types under the purview of this summary were found.

## **Approach**

*Mental Health (MH):* The Division of Behavioral Health of the Department of Social Services (DSS) regulations regarding mental health provide for accreditation of community mental health centers and they indicate that residential treatment is not reimbursable. These regulations are designed for outpatient treatment and to prevent people from needing residential and higher-level mental health services. Other statutes or regulations that expressly govern residential MH treatment were not located. DSS Division of Behavioral Health staff verified that there are no residential mental health facilities in the state that are subject to DOH licensure requirements.

*Substance Use Disorder (SUD):* A South Dakota statute governs the treatment and prevention of alcohol and drug abuse which is regulated by the Division of Behavioral Health of the Department of Social Services.

The South Dakota Department of Health (DOH) licenses “health care facilities and related institutions.” Health care facilities are defined as “any institution, birth center, ambulatory surgery center, chemical dependency treatment facility, hospital, nursing facility, assisted living center, rural primary care hospital, adult foster care home, inpatient hospice, residential hospice, freestanding emergency care facility, community living home, place, building, or agency in which any accommodation is maintained, furnished, or offered for the hospitalization, nursing care, or supervised care of the sick or injured. DOH licensure is required for the receipt of any public funds.

## **Processes of Licensure or Certification and Accreditation**

### *Substance Use Disorder (SUD):*

- Accreditation by the DSS Division of Behavioral Health is available and, according to DSS staff, is required in order for a facility to enroll in Medicaid as a service provider or be eligible for contracts utilizing state general funds and/or block grant funds. Accreditation for the first time is provisional for six months and requires a comprehensive survey to determine regulatory compliance. Before renewal, a resurvey is conducted which, if successful, will result in a one-year accreditation.
- Neither accreditation by the Division or by an independent accrediting entity is required (other than for receipt of state funding or Medicaid participation) but accreditation by the Joint Commission; an Indian Health Service's quality assurance review under the Indian Health Service Manual, Professional Standards-Alcohol/Substance Abuse; or the Commission on Accreditation of Rehabilitation Facilities; or the Council on Accreditation confers deemed status, allowing the agency to obtain Division accreditation. By statute, accreditation by one of these non-Division entities excuses the facilities from routine inspection for compliance (assuming certain requirements are met), but the Division retains the right of access to all facility premises and relevant records to monitor compliance or investigate complaints brought against the facility.
- DOH licensure does apply to some SUD residential treatment in South Dakota and is required for any public funding of those facilities. Licenses may be annual or biennial. A probationary license may be issued in certain circumstances. Any building, institution, or establishment for which a license is issued under this chapter must be inspected by DOH to determine compliance with regulations.
- The state does not require a certificate of need but the DSS Division of Behavioral Health does require that new agencies seeking accreditation complete a community needs assessment.

## **Cause-Based Monitoring**

*Substance Use Disorder (SUD):* The DSS Division of Behavioral Health may deny an application, place a facility on probation, require a plan of correction, or suspend or revoke accreditation. Even if a public or private agency or facility is considered to be an accredited prevention or treatment, the Division retains the right of access to all facility premises and relevant records to monitor compliance or investigate complaints brought against the facility. The Department of Social Services may conduct financial audits of agencies.

If DOH licensure applies, the Department may inspect all licensed hospitals or licensed chemical dependency treatment. If, prior to an inspection, the operator refuses to allow the inspection, no inspection may be made. If, during the course of the inspection, the operator refuses to allow the inspection to continue, the inspection shall cease. In such cases, the Department may immediately initiate revocation proceedings against the operator's license, as well as in other specified instances. Unlicensed operation is a misdemeanor.

## **Access Requirements**

*Substance Use Disorder (SUD):* No agency may deny any person equal access to its facilities or services on the basis of race, color, religion, gender, ancestry, national origin, mental or physical illness, or disability unless such illness or disability makes treatment offered by the agency non-beneficial or hazardous. Each agency shall ensure that they comply with the Americans with Disabilities Act and the regulations governing nondiscrimination on the basis of disability by public accommodations and in commercial facilities. The agency shall provide referral services to individuals not admitted to treatment.

## **Staffing**

*Substance Use Disorder (SUD):* All agencies must have a director with defined qualifications and duties. The regulations also include required qualifications for addiction counselors and requirements regarding staff orientation, supervision, personnel policies and documentation, workforce development, and volunteers.

For day treatment with residential services and clinically-managed low-intensity residential treatment, programs shall operate 7 days a week, 24 hours a day. The agency shall have a staff member trained to respond to fires and other natural disasters as well as to administer emergency first aid and CPR on duty at all times. An addiction counselor or counselor trainee shall be available to the clients at least 8 hours a day, 5 days a week, and shall be available on-call, 24 hours a day.

For clinically-managed residential detoxification, programs shall operate 7 days a week, 24 hours a day whenever clients are present. When the agency is open, a staff member shall be on duty who is trained to respond to fires and other natural disasters as well as to administer emergency first aid and CPR. An addiction counselor or counselor trainee shall be available to the clients at least 8 hours a day, 5 days a week, and available on-call, 24 hours a day.

For medically-monitored intensive inpatient treatment, programs shall operate 7 days a week, 24 hours a day. The agency shall have a staff member trained to respond to fires and other natural disasters as well as to administer emergency first aid and CPR on duty at all times. Training and annual training updates in each area shall be documented in personnel files.

Nursing staff shall be on-call 24 hours a day, 7 days a week. Counseling staff shall be on duty during normal daytime hours and must be on-call, 24 hours a day, 7 days a week. The program must have a written agreement with a licensed physician, physician assistant, or certified nurse practitioner to serve as the medical director or employ a licensed physician who is primarily responsible for providing medical care to the clients.

## **Placement**

*Substance Use Disorder (SUD):* Programs must have policies regarding admission in accordance with eligibility criteria for the level of care. An integrated assessment must be conducted within 30 days of intake.

To be eligible for day treatment services the client shall meet the following criteria: (1) The client is experiencing mild withdrawal or is at risk for withdrawal; (2) The client has no or very stable biomedical conditions which are not a distraction from treatment; (3) The client has mild emotional, behavioral, or cognitive conditions which may distract from recovery and needs stabilization; and (4) The client shall meet one of the following: (a) The client requires a structured program to promote progress through the stages of change; (b) The client is at high risk of relapse or continued use and deterioration in level of functioning; or (c) The client's environment renders recovery unlikely without structured monitoring and support.

To be eligible for clinically-managed low intensity residential services the client shall meet the following criteria: (1) The client is at risk of or is experiencing minimal withdrawal; (2) The client has no or very stable biomedical conditions; (3) The client has no or very stable emotional, behavioral, or cognitive conditions; (4) The client requires a structured environment to promote progress through the stages of change; (5) The client needs structure to reinforce recovery and relapse prevention skills; and (6) The client's recovery environment poses a threat to safety or engagement in treatment or both. A person admitted to a clinically-managed low-intensity residential treatment program shall have received a medical examination conducted by or under the supervision of a licensed physician within the three months before admission.

To be eligible for clinically-managed residential detoxification services the client shall meet one of the following criteria: (1) The client is experiencing signs and symptoms of withdrawal that is manageable in this level of care; or (2) There is evidence that withdrawal is imminent based on history of substance intake, previous withdrawal history, present symptoms, physical conditions, or emotional, behavioral or cognitive condition. A detailed intake assessment is required.

To be eligible for medically-monitored inpatient treatment the client shall meet the following criteria: (1) The client shall meet one of the following: (a) The client is experiencing moderate to severe withdrawal or is at risk of severe withdrawal based on previous withdrawal history; (b) The client's continued substance use causes imminent risk to biomedical conditions; or (c) The client's continued substance use causes imminent risk to emotional, behavioral, and



cognitive conditions; and (2) The client shall meet one of the following: (a) The client requires intensive monitoring and support to promote progress through the stages of change; (b) The client is in immediate danger of continued severe substance use or relapse and such behaviors present significant risk of serious adverse consequences to the client, or others, or both; or (c) The client's recovery environment poses a threat to safety or engagement in treatment or both. Specific medical evaluations must be conducted at intake and within 8 and 72 hours of admission.

## **Treatment and Discharge Planning and Aftercare Services**

*Substance Use Disorder (SUD):* Statute provides that the administrator of an approved treatment facility or an authorized designee who refuses an application for failing to sustain the statutory grounds for emergency commitment, must, unless the person is intoxicated and under protective custody, release the person and encourage him or her to seek voluntary treatment if appropriate.

The administrator of the facility to which a person was committed, or an authorized designee, may transfer any person committed to its custody from one accredited treatment facility to another if transfer is advisable based on the committed person's treatment needs.

All residential programs must develop individualized treatment plans within 10 days of placement. All also must provide their clients with discharge planning.

## **Treatment Services**

*Substance Use Disorder (SUD):* All programs are required to provide education regarding tuberculosis and the human immunodeficiency virus, how each is transmitted, and how to safeguard against transmission.

A day treatment program must provide its clients with a variety of treatment services, but the program shall provide the following services: (1) An integrated assessment; (2) Individual, group, and family counseling; and (3) Discharge planning. The day treatment program for adults and adolescents shall provide a minimum of 15 hours of any combination of individual, group, or family counseling services per week to each client. A day treatment program for adults shall provide a minimum of five hours of additional services per week on specialized topics which address the specific needs of the client.

A clinically-managed low intensity residential program may provide its clients with a variety of treatment services, but it shall provide the following services: (1) An integrated assessment; (2) Individual, group, and family; (3) Arts and crafts or work therapy. However, clients may not be required to participate in more than 40 hours of work therapy per week; (4) Housing and

dietary services; (5) Medical care; and (6) Discharge planning. A clinically-managed low-intensity residential treatment program shall provide each client a minimum of five hours of any combination of individual, group, or family counseling each week.

A clinically-managed residential detoxification program must have a written affiliation agreement with a hospital to provide emergency, inpatient, and ambulatory medical services. The agency must have a written agreement with a licensed physician, physician assistant, or certified nurse practitioner to serve as the medical director or employ a licensed physician who is primarily responsible for providing medical care to clients. The regulations include detailed requirements for patient monitoring. The program may provide its clients with a variety of treatment services, but it must provide the following services: (1) Initial assessment and planning within 48 hours of admission; (2) Individual, group, and family counseling; (3) Housing and dietary services; (4) Medical care; and (5) Discharge planning. The program shall provide daily to each client a minimum of 90 minutes of any combination of the services required above.

A medically-monitored inpatient treatment program may provide its clients with a variety of treatment services, but it shall provide the following services: (1) An integrated assessment; (2) Individual, group, and family counseling; (3) Housing and dietary services; (4) Education programming for adolescents; (5) Recreation and leisure time activities for adolescents; (6) Medical care; and (7) Discharge planning. A medically-monitored intensive inpatient treatment program for adults shall provide daily to each client a combination of individual, group, or family counseling which shall total a minimum of 21 hours per week. The program shall also provide a minimum of nine hours of additional services on specialized topics that address the specific needs of the client.

## **Patient Rights and Safety Standards**

*Substance Use Disorder (SUD):* Clients must receive information about their rights, including but not limited to freedom from abuse, rights of confidentiality, communication, religious practice, and to make a grievance, including the right to appeal to the Division of Behavioral Health. Abuse, neglect, and exploitation must be reported to the Department of Social Services. There is a prohibition on automatic discharge for any instance of non-prescribed substance use or for any instance of displaying symptoms of mental or physical illness. Accredited agencies must report any critical (sentinel) event, provide a follow-up report, and conduct a root cause analysis.

## Quality Assurance or Improvement

*Substance Use Disorder (SUD)*: Programs are required to submit data on clients and services, to establish a compliance review process to assure the quality and appropriateness of services, and to address any issues discovered during the compliance review process.

## Governance

*Substance Use Disorder (SUD)*: All nongovernmental or nontribal agencies providing residential services must be incorporated, have a board of directors, and establish policies.

## Special Populations

*Substance Use Disorder (SUD)*: Researchers did not locate South Dakota rules regarding special populations in adult substance use treatment facilities other than requirements related to tuberculosis and HIV.

## Location of Regulatory and Licensing Requirements

Division of Behavioral Health MH Regulations<sup>1</sup>; SD Laws CHAPTER 34-20A<sup>2</sup>, Division of Behavioral Health SU Regulations<sup>3</sup>; SD DOH Licensing Statute<sup>4</sup>. Regulatory data collected June 1, 2019.

## Other Information Sources

M. LeVee and T. Wolfgang (DSS); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>1</sup> See <http://sdlegislature.gov/Rules/DisplayRule.aspx?Rule=67:62>.

<sup>2</sup> See [https://sdlegislature.gov/Statutes/Codified\\_Laws/DisplayStatute.aspx?Type=Statute&Statute=34-20A](https://sdlegislature.gov/Statutes/Codified_Laws/DisplayStatute.aspx?Type=Statute&Statute=34-20A).

<sup>3</sup> See <http://sdlegislature.gov/Rules/DisplayRule.aspx?Rule=67:61>.

<sup>4</sup> See [http://sdlegislature.gov/Statutes/Codified\\_Laws/DisplayStatute.aspx?Type=Statute&Statute=34-12](http://sdlegislature.gov/Statutes/Codified_Laws/DisplayStatute.aspx?Type=Statute&Statute=34-12).

# SOUTH DAKOTA MEDICAID

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

## Approach

*Mental Health (MH) and Substance Use Disorder (SUD):* The South Dakota Department of Social Services (DSS) oversees the state Medicaid program. South Dakota does not rely on the in lieu of provision but historically has relied on Disproportionate Share Hospital (DSH) to reimburse some services in institutions for mental diseases (IMDs). The state does not have a Section 1115 waiver permitting Medicaid coverage of treatment for MH or SUD treatment in an IMD.

## Types of Facilities

*Mental Health (MH):* No evidence was located of Medicaid coverage of residential mental health treatment facilities for adults in South Dakota.

*Substance Use Disorder (SUD):* The following residential services are the only ones that are covered for adults (room and board are excluded):

- *Clinically-managed low intensity residential treatment programs:* Level 3.1 services that are an accredited residential program providing services to a client in a structured environment designed to aid re-entry into the community.
- *Clinically-managed low intensity residential treatment:* programs for pregnant women or women with dependent children.
- *Medically-monitored intensive inpatient treatment programs:* Level 3.7 services that are an accredited residential treatment program providing services to a client in a structured environment.
- *Intensive methamphetamine services:* a program that supports treatment services for a recipient 18 years or older who is assessed with a severe methamphetamine use disorder and who requires 24-hour structure and support due to the imminent risk for relapse.

## **Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD):*

- To receive reimbursement for covered medical services which are medically necessary and which are provided to eligible recipients, a provider must have a provider agreement with the department. Only those individuals or facilities which meet licensure and certification requirements may be participating providers. Providers may be suspended or terminated from participating in Medicaid.

## **Placement**

*Substance Use Disorder (SUD):* Requirements regarding residential services were not explicitly described in the state Medicaid regulations; see above for detailed licensure-related standards.

## **Treatment and Discharge Planning and Aftercare Services**

*Substance Use Disorder (SUD):* Clinically-managed low intensity residential treatment programs for pregnant women or women with dependent children, medically-monitored intensive inpatient treatment programs, and intensive methamphetamine services require prior authorization.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Covered services must be medically necessary. Other requirements regarding residential services were not explicitly described in the state Medicaid regulations; see above for detailed licensure-related standards.

## **Care Coordination**

*Substance Use Disorder (SUD):* Requirements regarding residential services were not explicitly described in the state Medicaid regulations; see above for detailed licensure-related standards.

## **Quality Assurance or Improvement**

*Substance Use Disorder (SUD):* Requirements regarding residential services were not explicitly described in the state Medicaid regulations; see above for detailed licensure-related standards.

## Special Populations

*Substance Use Disorder (SUD)*: Clinically-managed low intensity residential treatment programs for pregnant women or women with dependent children are available under the Medicaid program. Other requirements regarding residential services were not explicitly described in the state Medicaid regulations; see above for detailed licensure-related standards.

## Location of Medicaid Requirements

South Dakota Administrative Rules: DEPARTMENT OF SOCIAL SERVICES ARTICLE 67:16 COVERED MEDICAL SERVICES<sup>5</sup>. Regulatory data collected January 13, 2020.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019. <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report “**State Residential Treatment for Behavioral Health Conditions: Regulation and Policy**”. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

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<sup>5</sup> See <https://sdlegislature.gov/Rules/DisplayRule.aspx?Rule=67:16>.

## TENNESSEE

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### Types of Facilities

*Mental Health (MH):* Tennessee regulates:

- **Mental Health Residential Treatment Facility (MHRTF):** A community-based facility that offers 24 hour residential care with a treatment and rehabilitation component. The focus of the program may be on short-term crisis stabilization or on long-term rehabilitation that includes training in community living skills, vocational skills, and/or socialization. Access to medical services, social services, and MH services are ensured and are usually provided off site.
- **Crisis Stabilization Unit (CSU):** A CSU is designed for service recipients ages 18 years and older in need of short-term stabilization (up to 96 hours), who do not meet the criteria for other treatment resources, other less restrictive treatment resources are not available, or the service recipient is agreeable to receive services voluntarily at the CSU and meet admission criteria. If necessary, in order to assure that the adequate arrangements are in place to allow for safe discharge, the length of stay may be extended up to 24 hours.
- **Adult Supportive Residential Facility (ASRF):** A MH residential program that provides 24 hours residential care with a treatment and rehabilitation component less intensive than required in a MHRTF. Access to medical services, social services, and MH services are ensured and are usually provided off-site, although limited MH treatment and rehabilitation may be provided on site.

*Substance Use Disorder (SUD):* Tennessee regulates:

- **Alcohol and Drug Residential Rehabilitation Treatment Facility for Adults (RRTF):** A residential program for service recipients at least 18 years of age, which offers highly structured services with the primary purpose of restoring service recipients with alcohol and/or drug abuse or dependency disorders to levels of positive functioning and abstinence appropriate to the service recipient. A primary goal of these services is to move service recipients into less intensive levels of care and/or reintegration into the community as appropriate.

- Alcohol and Drug Halfway House Treatment Facility (HHTF): A transitional residential program providing services to service recipients with alcohol and/or drug abuse or dependency disorders with the primary purpose of establishing vocational stability and counseling focused on re-entering the community. Service recipients are expected to be capable of self-administering medication, working, seeking work, or attending vocational/educational activities away from the residence for part of the day.
- Alcohol and Drug Residential Detoxification Treatment Facility (RDF): An intensive 24 hour residential treatment for service recipients at least 18 years of age to systematically reduce or eliminate the amount of a toxic agent in the body until the signs and symptoms of withdrawal are resolved. The two levels of residential detoxification treatment are: (a) clinically managed detoxification treatment; and (b) medically monitored detoxification treatment. Clinically managed detoxification treatment emphasizes social and peer support and relies on established clinical protocols to determine whether service recipients need a higher level of care to manage withdrawal (Level III.2-D). Medically monitored residential detoxification treatment uses medical and nursing professionals to manage withdrawal signs and symptoms without the full resources of an acute care or psychiatric hospital (Level III.7-D). Both levels of residential detoxification services can be offered in a community setting or a specialty unit within a hospital.

*Unregulated Facilities:* There are no unregulated residential treatment facilities in Tennessee. We exclude from this summary Mental Health Supportive Living Facilities which do not provide the level of clinical care within the scope of this summary and any similar facilities that do not require clinical treatment.

## **Approach**

The Tennessee Department of Mental Health and Substance Abuse Services (DMHSAS) regulates all residential MH and SUD treatment providers in the state.

## **Processes of Licensure or Certification and Accreditation**

*Mental Health (MH) and Substance Use Disorder (SUD):* Initial and full licensure by the DMHSAS is required for all mental health or substance abuse residential services. Provisional licenses also may be issued.

- Accreditation is not required but accreditation by the Joint Commission or Council on Accreditation of Rehabilitation Facilities, confers deemed status as compliance with applicable licensure program requirements.



- An inspection is required for licensure and renewal; the inspection focuses on compliance with laws and regulations. At least one unannounced inspection occurs annually.
- The state does not require a Certificate of Need.
- Licensure duration is one year.

## **Cause-Based Monitoring**

*Mental Health (MH) and Substance Use Disorder (SUD):* Licenses may be denied, suspended, or revoked. The Department may inspect the premises with or without notice to the licensee. A plan of compliance may be required upon identification of deficiencies. Civil penalties may be imposed.

## **Access Requirements**

*Mental Health (MH) and Substance Use Disorder (SUD):* Regulations regarding wait times were not identified although state staff indicate that an online process does exist.

## **Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD):* Personnel records must document, among other things, that the personnel meet specific standards and has completed all required training and development activities.

*Mental Health (MH):*

- MHRTF: Treatment and rehabilitation services must be provided by MH professionals or MH personnel and under the direct clinical supervision of a licensed MH professional. The program must provide access to medical services via a written agreement or employment of a licensed physician. If the physician is not a psychiatrist, the program must arrange for the regular, consultative, and emergency services of a licensed psychiatrist. Extensive requirements are in place for level of staffing and staffing ratios including for direct care staff and the program must provide at least one on-duty staff member at all times who is certified in cardiopulmonary resuscitation (CPR) and trained in first aid, and the Heimlich maneuver.
- CSU: The program must have a designated director or administrator who is responsible for the management and operation of the facility. A qualified prescriber must provide general medical services, prescription of medications, and treatment. If the qualified

prescriber is not a psychiatrist, the qualified prescriber must have psychiatric expertise. The qualified prescriber must be on call 24 hours per day and make daily rounds. At least one registered nurse, nurse practitioner or physician assistant must be on duty and in program at all times. Additional requirements apply to MH personnel and other staff, including staffing ratios. At least one on-duty and on-site staff member must be certified in cardiopulmonary resuscitation (CPR) and trained in first aid, the abdominal thrust maneuver and standard precautions for infection control.

- ASRF: All MH personnel must be under the supervision of a licensed mental health professional and all direct care staff under the supervision of a MH professional. The facility must provide adequate supervision by an adult who is knowledgeable of rules, policies and procedures relevant to the facility's operation. Staffing levels or ratios are in place, including for direct care staff and MH staff. The program must arrange for the regular, consultative, and emergency services of a licensed psychiatrist and there must be continual back-up coverage by staff trained to handle acute psychiatric problems. Hours of annual training for direct care staff are specified. The program must, at all times, provide at least one on-duty staff member certified in cardiopulmonary resuscitation (CPR) and trained in First Aid and the Abdominal Thrust Maneuver.

*Substance Use Disorder (SUD):*

- RRTF and HHTF: Direct treatment and/or rehabilitation services must be provided by qualified alcohol and drug abuse personnel and a physician must be employed or retained by written agreement to serve as medical consultant. Requirements are in place for staff who are certified in cardiopulmonary resuscitation (CPR) and trained in first aid, the abdominal thrust technique, and standard precautions for infection control, must be on-duty at all times. Requirements also exist for staffing ratios. The facility must follow specific standards regarding STD/HIV and TB, including regarding training.
- RDF: Direct services must be provided by qualified alcohol and drug abuse personnel. Requirements are in place for medication administration and staff ratios. Facilities providing clinically managed detoxification must employ or retain a physician with training or experience in addiction medicine to serve as medical consultant to the program. The facility must have a physician, physician assistant, or nurse practitioner available 24 hours a day by telephone for medical evaluation and consultation. A facility providing medically monitored detoxification must make available hourly or more frequent monitoring if needed by a licensed nurse. All on-duty and on-site direct care staff must be certified in cardiopulmonary resuscitation (CPR) and trained in first aid, the abdominal thrust and standard precautions for infection control as defined by the Centers for Disease Control and Prevention (CDC). The facility must provide staff education/training regarding STD/HIV and techniques to screen for potentially aggressive or violent service recipients and training in techniques to de-escalate anger and aggression in service recipients. All medical staff in facilities providing medically monitored detoxification and all direct service staff in facilities providing clinically managed detoxification must receive

documented training before having unsupervised direct contact with service recipients. Training topics are specified.

## **Placement**

### *Mental Health (MH):*

- For an MHRTF, specified assessments must be performed prior to development of the recipient's Plan of Care.
- For an ASRF, policies must provide for admission only of persons who meet certain criteria related to, among others, self-care, ability to recognize danger, and maintain appropriate behaviors tolerable to the community.
- A CSU is designed for adults in need of short-term stabilization, who do not meet the criteria for other treatment resources, other less restrictive treatment resources are not available, or the service recipient is agreeable to receive services voluntarily at the CSU and meets admission criteria.

### *Substance Use Disorder (SUD):*

- For an RRTF, policies must include exclusion and inclusion criteria for service recipients seeking facility services. The facility must document specified assessments were completed prior to development of the Individual Program Plan (IPP).
- For an HHFT, the policies must include exclusion criteria for service recipients not appropriate for the facility's services. The facility must document specified assessments were completed prior to development of the IPP.
- For an RDF, the policies must include inclusion and exclusion criteria for service recipients. The latter must include written admission protocols to screen for potentially aggressive or violent service recipients. For facilities providing clinically managed detoxification, assessment on admission by trained staff using a physician-approved protocol is required to determine if detoxification can safely occur in a clinically managed setting. For facilities providing clinically managed detoxification with self-administered detoxification medications, procedures for a physical examination is required as part of the initial assessment. For facilities providing medically monitored detoxification, procedures must include assessment by a medical professional, to determine whether services can be safely provided in that setting. For facilities providing medically monitored detoxification, a physical examination within 24 hours of admission is required. Policies must include program admission criteria related to the results of the physical assessment. The facility must document specified assessments were completed at admission, with additional

assessments if the facility provides medically monitored detoxification services. The American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC) is used to determine the level of residential detoxification treatment that will best meet a service recipient's needs.

## **Treatment and Discharge Planning and Aftercare Services**

### *Mental Health (MH):*

- **MHRTF:** An Individual Plan of Care (IPC) must be developed for each recipient within 72 hours of admission. Among other things, the IPC must include a discharge plan and must be reviewed every 30 days.
- **CSU:** An IPC must be developed based on initial and on-going assessment and be completed within 6 hours of admission. Review must occur at least daily. The IPC must include a discharge plan.
- **ASRF:** The client record must include a summary of the mental health service plan and crisis plan, and a housing transition plan.

### *Substance Use Disorder (SUD):*

- **RRTF and HHTF:** An IPP must be developed within 7 days of admission and reviewed at least every 30 days for an RRTF and every 60 days for an HHTF. RRTF policies must include a description of its aftercare service. Aftercare plans must specify the type of contact, planned frequency of contact, and responsible staff; or documentation that the service recipient was offered aftercare but decided not to participate; or documentation that the service recipient dropped out of treatment and is therefore not available for aftercare planning; or verification that the service recipient is admitted for further alcohol and drug treatment services.
- **RDF:** An IPP must be developed within 24 hours of admission and must include, among other things, a discharge plan. RDF policies must include a description of its aftercare service. Before discharge, service recipients must be given instruction about dosages, appropriate use, and self-administration of medications after detoxification is complete.

## Treatment Services

### *Mental Health (MH):*

- **MHRTF:** The program must arrange access to qualified dental, medical, nursing, and pharmaceutical care. The program must ensure that each service recipient has had a physical examination within the 6 months prior to or within 30 days after admission. The program must arrange access to ongoing MH services not provided by the program and assist the service recipient in participating in such treatment. The program must arrange care for emergency services and must provide access to at least one Tennessee licensed MH professional at all times. If the professional is not a psychiatrist, the program must arrange for the regular, consultative, and emergency services of a psychiatrist. The program must provide back-up coverage by staff trained to handle acute psychiatric problems. The program must secure emergency services for service recipients who pose an imminent physical danger to themselves or others.
- **ASRF:** Coordinated and structured services are provided for adult service recipients that include personal care services, training in community living skills, vocational skills, and/or socialization. Mental health treatment and rehabilitation services may be provided on-site for up to 15 hours per week, if the services are provided by a licensed mental health outpatient facility. The facility must arrange for qualified dental, medical, nursing and pharmaceutical care for service recipients, including care for emergencies. The facility must provide or procure for each service recipient a physical examination, which includes routine screening and special studies as determined by the examining physician, within 30 days of admission unless the service recipient has had a physical examination within 90 days prior to admission.
- **CSU:** The facility must have policies and procedures for procuring medical treatment or monitoring primary physician medications of service recipients while in the program.

### *Substance Use Disorder (SUD):*

- **RRTF and HHTF:** In addition to alcohol and drug treatment services, the facility must provide services to address recipient needs in the areas of social, family, and peer interactions; employment and educational needs; financial status; emotional and psychological health; physical health; and community living skills and housing needs, among others. Such services may be provided directly by the agency or indirectly by referral to other service providers.
- **RDF:** The facility must offer daily treatment services necessary to assess needs, help the service recipient understand addiction, and support the completion of the detoxification process. The facility must plan for discharge to address service recipient needs in the following areas: vocational, educational skills and academic performance; financial issues;

cognitive, socio-emotional, and psychological issues; social, family, and peer interactions; physical health; community living skills and housing information. Such services may be provided directly by the agency or indirectly by referral to other service providers. The facility must document either by written agreements or by program services access to an interdisciplinary team of appropriately trained clinicians to assess, obtain, and interpret information regarding service recipient needs. The number and disciplines of team members must be appropriate to the range and severity of the service recipient's problem. The facility must document the provision of 24 hours per day, 7 days per week availability of immediate medical evaluation and care. RDF policies and procedures must address referrals for recipients whose needs cannot be met to another level of care and must include procedures for more extensive medical intervention if a recipient has certain unstable medical conditions or pregnancy.

## **Patient Rights and Safety Standards**

*Mental Health (MH) and Substance Use Disorder (SUD):* Clients have the following rights, among others: to be informed of their rights and of grievance procedures, to voice grievances, to be treated with respect, not to be neglected or abused, communication, privacy, and to vote. Use of isolation, mechanical restraint, and physical holding restraint are restricted by licensure category. Critical incidents must be reported.

*Mental Health (MH):*

- MHRTF: Recipients must be allowed to retain their own money unless specified otherwise in the Plan of Care. Physical holds may only be used in limited situations.
- ASRF: A policy must address methods for managing disruptive behavior; and there must be policy and procedures requiring that physical holds be conducted so as to minimize physical harm to the service recipient and used only when the service recipient poses an immediate threat under limited conditions. Upon admission to the facility, each service recipient shall be provided an orientation which must explain certain topics including service recipient rights and grievance procedures. Service recipients may not be denied adequate food, treatment/rehabilitative activities, religious activities, mail or other contacts with families as punishment. A service recipient may not be confined to his/her room or other place of isolation as punishment. This does not preclude requesting individuals to remove themselves from a potentially harmful situation in order to regain self-control.

*Substance Use Disorder (SUD):* For an RRTF, HHTF, or RDF, policies and procedures must address methods for managing disruptive behavior. If restrictive procedures are used to manage disruptive behaviors, the policies and procedures must comply with state regulations. Policies must include a requirement that the facility provide to the service recipient, upon

admission, a written statement outlining in simple, non-technical language all rights of service recipients. These rights must reflect that service recipients may not be denied adequate food, treatment/rehabilitative activities, religious activities, mail or other contacts with families as punishment. A service recipient may not be confined to his/her room or other place of isolation as punishment. This does not preclude requesting individuals to remove themselves from a potentially harmful situation in order to regain self-control.

## Quality Assurance or Improvement

*Mental Health (MH) and Substance Use Disorder (SUD):* Facility policies must include a quality assurance procedure which assesses the quality of care at the facility. This procedure must ensure treatment has been delivered according to acceptable clinical practice.

## Governance

*Mental Health (MH) and Substance Use Disorder (SUD):* The governing body must ensure that the facility complies with all applicable federal, state, and local laws, ordinances, rules, and regulations, and must ensure that the facility is administered and operated in accordance with written policies and procedures. The governing body must ensure that a written policies and procedures manual is maintained covering specified topics. The governing body must designate an individual responsible for the operation of the facility. The governing body must ensure that the licensed facility serves only persons whose placement will not cause the facility to violate its licensed status and capacity based on the facility's distinct licensure category, the facility's life safety occupancy classification, and required staffing ratios, if any.

## Special Populations

*Substance Use Disorder (SUD):* The Department of Mental Health and Substance Abuse Services<sup>1</sup> indicates that the following are priority populations for licensed SUD treatment agencies:

- Pregnant Intravenous Drug Users.
- Pregnant Substance Users.
- Intravenous Drug Users.
- Medically Monitored Withdrawal Management (Crisis Detoxification).

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<sup>1</sup> See <https://www.tn.gov/behavioral-health/substance-abuse-services/treatment---recovery/treatment---recovery/treatment-for-pregnant-women-abusing-substances.html>.

## Location of Regulatory and Licensing Requirements

Rules of Department of Mental Health and Substance Abuse Services: Definitions<sup>2</sup>; Licensure<sup>3</sup>; Distinct Service Categories<sup>4</sup>; Minimum Program Requirements<sup>5</sup>; MH Adult Residential<sup>6</sup>; MH CSU<sup>7</sup>; Alcohol and Drug Halfway House; Residential Detoxification<sup>8</sup>; Alcohol and Drug Residential Rehabilitation<sup>9</sup>; Isolation and Restraint<sup>10</sup>; Department of Mental Health and Substance Abuse Services<sup>11</sup>. Regulatory data collected September 19, 2019.

## Other Information Sources

A. Pettry, L. McCorkle (TDMHSAS); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>2</sup> See <https://publications.tnsosfiles.com/rules/0940/0940-05/0940-05-01.20081229.pdf>.

<sup>3</sup> See <https://publications.tnsosfiles.com/rules/0940/0940-05/0940-05-02.20190627.pdf>.

<sup>4</sup> See <https://publications.tnsosfiles.com/rules/0940/0940-05/0940-05-03.pdf>.

<sup>5</sup> See <https://publications.tnsosfiles.com/rules/0940/0940-05/0940-05-06.20170228.pdf>.

<sup>6</sup> See <https://publications.tnsosfiles.com/rules/0940/0940-05/0940-05-17.pdf>.

<sup>7</sup> See <https://publications.tnsosfiles.com/rules/0940/0940-05/0940-05-18.20081014.pdf>.

<sup>8</sup> See <https://publications.tnsosfiles.com/rules/0940/0940-05/0940-05-44.20090323.pdf>.

<sup>9</sup> See <https://publications.tnsosfiles.com/rules/0940/0940-05/0940-05-45.20081110.pdf>.

<sup>10</sup> See <https://publications.tnsosfiles.com/rules/0940/0940-03/0940-03-09.pdf>.

<sup>11</sup> See <https://www.tn.gov/behavioral-health/substance-abuse-services/treatment---recovery/treatment---recovery/treatment-for-pregnant-women-abusing-substances.html>.



# TENNESSEE MEDICAID

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## Approach

TennCare oversees the Tennessee state Medicaid program. Psychiatric residential treatment is reimbursed by TennCare as medically necessary in a facility that is not an institution for mental disease (IMD), pursuant to the existing TennCare II Section 1115 waiver. A Section 1115 application also is pending to incorporate the entire spectrum of SUD treatment, including within an IMD. The state historically has relied on the in lieu of provision for Medicaid coverage of some IMD services but not on Disproportionate Share Hospital (DSH) payments.

## Types of Facilities

*Mental Health (MH):* Psychiatric residential treatment facilities may enroll in TennCare if they are not an IMD. Under the existing Section 1115 waiver, reimbursement is allowed for short-term (initial authorization period of up to 90 days with limited extensions) behavioral-focused residential planning, stabilization, and treatment programs that address the MH and stabilization needs of a specific group of enrollees.

*Substance Use Disorder (SUD):* Adult residential SUD treatment presently does not appear to be covered by Medicaid in Tennessee.

## Processes of Medicaid Enrollment

*Mental Health (MH) and Substance Use Disorder (SUD):* To enroll as a Medicaid provider in Tennessee, the provider must maintain medical licenses and/or certifications as required by their practice. They must comply with all contractual terms between the provider and the managed care contractor and TennCare policies as outlined in federal and state rules and regulations and TennCare provider manuals and bulletin. They must agree to maintain and provide access to TennCare all TennCare enrollee medical records for 5 years from the date of service or upon written authorization from TennCare following an audit, whichever is shorter. Sanctions may be imposed for failure to satisfy these and other requirements.

## **Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD):* Any Medicaid provider in Tennessee must maintain Tennessee, or the state in which they practice, licenses and/or certifications as required by their practice.

## **Placement**

*Mental Health (MH):* Medicaid reimbursement for psychiatric residential treatment requires that it be medically necessary. Pursuant to the existing TennCare II waiver, the following enrollees are eligible: (1) adults with severe psychiatric or behavioral symptoms whose family is no longer capable of supporting the individual due to the severity and frequency of behaviors; (2) emerging young adults (age 18-21) with IDD and severe psychiatric or behavioral symptoms aging out of the foster care system; and (3) adults with IDD and severe psychiatric or behavioral symptoms following a crisis event and/or psychiatric inpatient stay and/or transitioning out of the criminal justice system or a long-term (two or more years) institutional placement. The purpose is to help stabilize the individual in the community.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* No Medicaid requirements were located regarding treatment or discharge planning related to adult residential treatment, nor to aftercare services.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* No Medicaid requirements were located regarding treatment services for adult residential treatment.

## **Care Coordination**

*Mental Health (MH) and Substance Use Disorder (SUD):* No Medicaid requirements were located regarding care coordination for adult residential treatment.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* Researchers located no specific quality improvement requirements directly applicable to residential behavioral health treatment.

## Special Populations

*Substance Use Disorder (SUD)*: No Medicaid requirements for special populations were located other than the requirements in the existing TennCare II Section 1115 waiver for placement in non-IMD residential treatment described under Placement above.

## Location of Medicaid Requirements

Tennessee Medicaid Rules and Regulations: 1200-13-01<sup>12</sup>; 1200-13-13<sup>13</sup>; 1200-13-14<sup>14</sup>; Approved Section 1115 waiver<sup>15</sup>; Pending Section 1115 amendment. Regulatory data collected December 2019.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report “**State Residential Treatment for Behavioral Health Conditions: Regulation and Policy**”. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

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<sup>12</sup> See <https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13-01.20180730.pdf>.

<sup>13</sup> See <https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13-13.20190403.pdf>.

<sup>14</sup> See <https://publications.tnsosfiles.com/rules/1200/1200-13/1200-13-14.20190403.pdf>.

<sup>15</sup> See <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tn/tn-tenncare-ii-ca.pdf>.

## TEXAS

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

### Types of Facilities

*Mental Health (MH) and Substance Use Disorder (SUD):* The following facility types fall under the purview of this summary:

- Additional regulations apply to each of the following in which *mental health services* are provided: (1) facilities of HHSC and their respective community-based programs; (2) local mental health authorities and local behavioral health authorities; (3) psychiatric hospitals; and (4) any program contracting with these entities. *Mental health services* are defined to include “all services concerned with research, prevention, and detection of mental disorders and disabilities and all services necessary to treat, care for, supervise, and rehabilitate mentally disordered and disabled persons, **including persons mentally disordered and disabled from alcoholism and drug addiction.**” [State staff indicate that this definition of mental health services is under revision but that a new definition is not final.] *Residential services* are defined as twenty-four hour services provided and/or contracted by the department or a local authority (e.g., structured group residential programs, halfway houses, hospital units providing MH services, licensed crisis stabilization units, etc.) or a psychiatric hospital.

*Mental Health (MH):* Texas regulates the following residential mental health treatment facility types:

- *Crisis stabilization unit (CSU):* short-term residential treatment designed to reduce acute symptoms of mental illness of a patient and prevent admission of the patient to a psychiatric hospital. Such treatment includes but is not limited to medical services and nursing services.
  - There are separate regulations for crisis intervention services in non-CSU settings and, as with day programs for acute needs, described below, they apply only to services funded through Medicaid or on a general revenue contract with the Health and Human Services Commission (HHSC). They do not apply to CSUs.
  - According to state staff, a few crisis residential programs are licensed as assisted living facilities by HHSC Long Term Care Regulatory Services.

- *Day program for acute needs:* short term, intensive treatment to an individual who requires multidisciplinary treatment in order to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting.
  - Day programs for acute needs: (1) are provided in a highly structured and safe environment with constant supervision. (2) Ensure an opportunity for frequent interaction between an individual and staff members. (3) Are services that are goal oriented and focus on: (A) reality orientation; (B) symptom reduction and management; (C) appropriate social behavior; (D) improving peer interactions; (E) improving stress tolerance; (F) the development of coping skills. (4) Consist of the following component services: (A) psychiatric nursing services; (B) pharmacological instruction; (C) symptom management training; and (D) functional skills training.
  - Day programs for acute needs may be provided in a short-term, crisis-resolution oriented residential treatment setting that is not a general medical hospital, a psychiatric hospital; or an IMD.

*Substance Use Disorder (SUD):* Texas regulates the following residential substance use treatment facility:

- *Residential site:* a physical location owned, leased, or operated by a provider where clients reside in a supervised treatment environment. Chemical dependency treatment, prevention, and intervention activities, including detoxification, may be provided in residential sites. Among the types of facilities mentioned but not defined in the regulations are *detoxification*, *adult intensive residential*, and *adult supportive residential* programs. Each are addressed below to the extent that regulations impose specific requirements (e.g., staffing). According to state staff, additional standards not included in this summary apply via contract to facilities that contract with the state.

*Unregulated Facilities:* For mental health treatment, three categories of residential treatment facilities are operated and regulated as local mental health authorities with crisis service standards governed by contractual provisions rather than being licensed. According to state staff, these categories are as follows:

- An extended observation unit (EOU) provides up to 48-hours of emergency services to individuals in a mental health crisis who may pose a high to moderate risk of harm to self or others. EOUs may accept individuals on emergency detention.
- A crisis residential unit provides community-based residential, crisis treatment to individuals with a moderate to mild risk of harm to self or others, who may have fairly severe functional impairment, and whose symptoms cannot be stabilized in a less restrictive setting. Crisis residential facilities are not authorized to accept individuals on involuntary status.
- A crisis respite unit provides community based residential crisis treatment to individuals who have low risk of harm to self or others and may have some functional impairment.

Services may occur over a brief period of time, such as two hours, and generally serve individuals with housing challenges or assist caretakers who need short-term housing or supervision for the persons they care for to avoid a mental health crisis. Crisis respite facilities are not authorized to accept individuals on involuntary status.

For SUD, no unregulated facility types under the purview of this summary were found. According to state staff, additional standards not included in this summary apply via contract to facilities that contract with the state.

## **Approach**

*Mental Health (MH):* The regulation of day programs for acute needs applies to services funded through Medicaid or on a general revenue contract with HHSC.

*Substance Use Disorder (SUD):* The Department of State Health Services regulates and licenses chemical dependency treatment programs.

## **Processes of Licensure or Certification and Accreditation**

*Mental Health (MH):*

- CSUs are subject to the licensure requirements delineated in the HHSC Regulatory Services Division legislation that regulates mental health facilities.
- CSUs that provide court-ordered mental health services, specifically an order for protective custody, are subject to licensure.
  - Exemptions from licensure include mental health facilities operated by local mental health authorities, HHSC, or a federal agency.
- Day programs for acute needs do not have specifically applicable licensing requirements but may be interpreted as included in the facilities requiring licensure as mental health facilities, to the extent they are offered within CSUs.
- To the extent that CSUs or day programs for acute needs offered in a residential setting require licensure, licensure is for a two-year period, by which time a renewal application must be submitted. The department may conduct an investigation as considered necessary after receiving the proper license application and the required fees.
- No requirements for accreditation were located.
- The state does not require a certificate of need.

- Other than licensure requirements for assisted living facilities, which occasionally include crisis services, no other requirements for licensure, certification, or accreditation were found for MH residential treatment facilities.

*Substance Use Disorder (SUD):*

- Licensure by the Texas Department of State Health Services is required for operation of any chemical dependency treatment program that is not exempt. A program is exempt if it: (1) is conducted by a religious organization; (2) is exclusively religious, spiritual, or ecclesiastical in nature; (3) does not treat minors; and (4) is registered.
  - An exempt program registered under this section may not provide medical care, medical detoxification, or medical withdrawal services.
- Licensure duration is two years, by which time a renewal application is required. An on-site inspection may be necessary.
- Accreditation is not required.
- The state does not require a certificate of need.

## **Cause-Based Monitoring**

*Mental Health (MH):* To the extent licensure is required, the department may make investigations as needed to obtain compliance with the statute or departmental regulations. This may include facility and document inspection at any reasonable time. Licenses may be denied, suspended, revoked, or placed on probationary status.

*Substance Use Disorder (SUD):* Facilities shall submit program information and statistics to the Texas Commission on Drug and Alcohol Abuse annually. Additionally, the Commission may conduct a scheduled or unannounced inspection or request materials for review at reasonable times, including any time treatment services are provided. Licenses may be suspended, revoked, not renewed, or placed on probationary status. Penalties may be imposed.

## **Access Requirements**

*Mental Health (MH):* Requirements regarding residential services were not explicitly described in the state regulations

*Substance Use Disorder (SUD):* For chemical dependency treatment sites, the provider shall provide access to services, including providing information about other services and alternative

providers, taking into account an individual's financial constraints and special needs. Entities may not exclude an individual based on the individual's past or present mental illness; medications prescribed to the individual in the past or present; the presumption of the individual's inability to benefit from treatment; or the individual's level of success in prior treatment episodes. No specific requirements for wait times were located.

According to state staff, facilities that receive funding from block grants, also must satisfy contractual access requirements related to priority populations.

## **Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD):* For all MH/SUD treatment services identified in 1a as MH/SUD, all employees are required to undergo a thorough period of training in the rights of persons receiving mental health services (defined as including drug and alcohol treatment).

*Mental Health (MH):* For CSUs, at least one physician shall, at all times, be physically present to respond to an emergency medical condition and be available to staff members to provide medical consultation. CSUs shall have an adequate number of qualified staff members. A CSU shall have a director of psychiatric services who directs, monitors, and evaluates the psychiatric services provided, and who shall be certified in psychiatry by the American Board of Psychiatry and Neurology or by the American Osteopathic Board of Psychiatry and Neurology; or have three years of experience as a physician in psychiatry in a "mental hospital." Physical and psychiatric examinations shall be conducted by physicians only.

All staff members shall receive orientation and annual training. RNs, licensed vocational nurses (LVN), and UAP shall receive additional training, including for monitoring patient safety and infection control.

For day programs for acute needs, services must be provided by a QMHP-CS, a CSSP, or a peer provider. Facilities must, at all times, have a sufficient number of staff members to ensure safety and program adequacy; and at a minimum include: (i) one RN for every 16 individuals at the day program's location; (ii) one physician to be available by phone, with a response time not to exceed 15 minutes; (iii) two staff members who are QMHP-CSs, CSSPs, or peer providers at the day program's location; (iv) one additional QMHP-CS who is not assigned full-time to another day program to be physically available, with a response time not to exceed 30 minutes; and (v) additional QMHP-CSs, CSSPs, or peer providers at the day program's location sufficient to maintain a ratio of one staff member to every four individuals. Psychiatric nursing services must be provided by RNs. Pharmacological instruction must be provided by a licensed medical professional.

*Substance Use Disorder (SUD):* General personnel requirements for chemical dependency treatment programs include but are not limited to ones related to interns, credential



verification, reporting sexual abuse, criminal background checks, drug testing, and personnel records. Additional requirements related to training include documentation of external training, orientation training, training within 90 days of employment, and annual training.

For all chemical dependency treatment services, the facility shall maintain an adequate number of qualified staff to comply with licensure rules, provide appropriate and individualized treatment, and protect the health, safety, and welfare of clients. All personnel shall receive the training and supervision necessary to ensure compliance with Commission rules, provision of appropriate and individualized treatment, and protection of client health, safety and welfare. Direct care staff shall be awake and on site during all hours of program operation. Residential direct care staff included in staff-to-client ratios shall not have job duties that prevent ongoing and consistent client supervision. Residential programs shall have at least one counselor on duty at least eight hours a day, six days a week. Individuals responsible for planning, directing, or supervising treatment programs shall be QCCs. The clinical program director must have at least two years of post-licensure experience providing chemical dependency treatment. Chemical dependency counseling must be provided by a qualified credentialed counselor (QCC), graduate, or counselor intern. Chemical dependency education and life skills training shall be provided by counselors or individuals who have the specialized education and expertise. All counselor interns shall work under the direct supervision of a QCC.

For detoxification programs, there shall be a medical director who is a licensed physician. The medical director shall be responsible for admission, diagnosis, medication management, and client care. Detoxification programs shall have a licensed vocational nurse or registered nurse on duty for at least eight hours every day and a physician or designee on call 24 hours a day. Detoxification programs shall ensure that detoxification services are accessible at least 16 hours per day, seven days per week. Providers shall develop and implement a mechanism to ensure that all direct care staff in detoxification programs have the knowledge, skills, abilities to provide detoxification services, as they relate to the individual's job duties.

In adult intensive residential programs, the direct care staff-to-client ratio shall be at least 1:16 when clients are awake and 1:32 during sleeping hours. In intensive residential programs counselor caseloads shall not exceed ten clients for each counselor.

In adult supportive residential programs, the direct care staff-to-client ratio shall be at least 1:20 when clients are awake and 1:50 during sleeping hours. Each supportive residential program shall set limits on caseload size that ensure effective, individualized treatment.

## **Placement**

*Mental Health (MH):* For crisis stabilization units, pre-admission screening should be conducted that includes a medical history, any history of substance use, and the problem for which the prospective patient is seeking treatment, to determine if a physician should conduct an admission examination. If appropriate, the physician can then conduct the admission

examination, which consists of a physical and psychiatric examination. The physical examination may consist of an assessment for medical stability.

For day programs for acute needs, prior to providing services, an LPHA must determine if the prospective services are medically necessary by conducting a uniform assessment.

*Substance Use Disorder (SUD):* For all residential chemical dependency treatment sites, facilities shall use a screening process appropriate for the target population to determine eligibility for admission by whether an individual meets the DSM criteria for substance abuse or dependence. The screening process shall collect other information as necessary to determine the type of services that are required to meet the individual's needs. This may necessitate the administration of all or part of validated assessment instruments.

For admission to a detoxification program, the screening should be conducted by a physician, physician assistant, nurse practitioner, registered nurse, or LVN. Clients who are not in withdrawal but meet the DSM criteria for substance dependence may be admitted to detoxification services for 72 hours for crisis stabilization. Crisis stabilization is appropriate for clients who have diagnosed conditions that result in current emotional or cognitive impairment in clients such that they would not be able to participate in a structured and rigorous schedule of formal chemical dependency treatment.

For admission to all other treatment programs, the screening will be conducted by a counselor or counselor intern.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH):* Treatment planning requirements are indicated for crisis stabilization units, with updates required at least every 72 hours after being implemented or any time there is a change in patient condition, upon request by the patient, or based on findings from a re-evaluation. Discharge planning beginning at admission is required. When conducting discharge planning activities, a CSU shall consult with personnel at the local mental health authority to ensure continuity of care for individuals being discharged.

For day programs for acute needs, treatment planning is required, with updates indicated: (A) at intervals set forth in the utilization management guidelines; (B) as clinically indicated; and (C) at the request of the individual, LAR, or primary caregiver. Discharge planning requirements were not identified.

*Substance Use Disorder (SUD):* For residential chemical dependency treatment sites, individualized treatment planning with regular updates and discharge planning beginning at admission are required. The initial treatment plan must be filed in the record within 5 service days of admission. Updates must occur at least monthly. The discharge plan shall address continuity of services to the client. Coordination activities shall be documented in the client

record, and the program should involve the client's family or an alternate support system in the discharge planning process when appropriate.

## **Treatment Services**

*Mental Health (MH):* For crisis stabilization units, facilities should stabilize each identified common emergency medical condition, including the administration of first aid and basic life support when clinically indicated; the use of the supplies and equipment; and when the action to be taken is facilitating transfer of the patient or prospective patient, a description of the method of transportation and the name and location of the hospital to which a patient or prospective patient will be transferred.

For day programs for acute needs, there shall be psychiatric nursing services, pharmacological instruction, symptom management training, and functional skills training. Pharmacological instruction includes: the role of the individual's medications in stabilizing acute psychiatric symptoms or preventing admission to a more restrictive setting; the identification of substances that reduce the effectiveness of the individual's medications; appropriate interventions to reduce side effects of the medications; and the self-administration of the individual's medication. Symptom management training includes: the identification of thoughts, feelings, or behaviors that indicate the onset of acute psychiatric symptoms; developing coping strategies to address the symptoms; ways to avoid symptomatic episodes; identification of external circumstances that trigger the onset of the acute psychiatric symptoms; and relapse prevention strategies. Functional skills training includes: personal hygiene; nutrition; food preparation; money management; socially and culturally appropriate behavior; and accessing and participating in community activities.

*Substance Use Disorder (SUD):* For all chemical dependency treatment sites, standards are in place related to size of group counseling sessions; requirements for chemical dependency education, life skills training, and communicable disease education, and tobacco use risks. There are other requirements specific to HIV screening and access to physical and mental health services.

For detoxification services, all programs shall ensure continuous access to emergency medical care. Residential and ambulatory detoxification programs shall provide monitoring to manage the client's physical withdrawal symptoms. Monitoring shall be conducted at a frequency consistent with the degree of severity of the client's withdrawal symptoms, the drug(s) from which the client is withdrawing, and/or the level of intoxication of the client. Medication should be available to manage withdrawal/intoxication from all classes of abusable drugs. In addition to the management of withdrawal and intoxicated states, detoxification programs shall provide services, including counseling, which are designed to: assess the client's readiness for change; offer general and individualized information on substance abuse and dependency; enhance client motivation; engage the client in treatment; and include a detoxification plan that contains the goals of successful and safe detoxification as well as transfer to another intensity

of treatment. At least one daily individual session by a registered nurse, QCC or counselor intern with the client will be conducted.

All residential treatment services shall offer a structured therapeutic environment. The facility shall ensure access to the full continuum of treatment services and will ensure sufficient treatment intensity to achieve treatment plan goals. Intensity and content of treatment shall be appropriate to the client's needs and consistent with generally accepted placement guidelines and standards of care.

Intensive residential shall provide an average of at least 30 hours of services per week for each client, comprised of at least ten hours of chemical dependency counseling; ten hours of additional counseling, chemical dependency education, life skills training, relapse prevention education; and ten hours of planned, structured activities monitored by staff. Five hours of these services shall occur on weekends and evenings.

Supportive residential shall provide at least six hours of treatment services per week for each client, comprised of at least three hours of chemical dependency counseling and three hours of additional counseling, chemical dependency education, life skills training, and relapse prevention education.

## **Patient Rights and Safety Standards**

*Mental Health (MH) and Substance Use Disorder (SUD):* For all MH/SUD treatment services identified in 1a as MH/SUD, the regulations specify a number of rights including, but not limited to, humane and appropriate treatment in the least restrictive setting, and to not be secluded or physically restrained unless certain requirements are met.

*Substance Use Disorder (SUD):* Chemical dependency treatment programs must have a Client Bill of Rights. Among the rights included are treatment with dignity and in the least restrictive setting, and the right to make a complaint. All facilities must have a written grievance procedure that includes the right to complain directly to the Department.

For residential chemical dependency treatment sites, clients also have the right not to be restrained or secluded unless certain conditions are met and rights of communication.

## **Quality Assurance or Improvement**

*Mental Health (MH):* Requirements regarding residential services were not explicitly described in the state regulations.

*Substance Use Disorder (SUD):* For residential chemical dependency treatment sites, facilities shall develop procedures and implement a quality management process.

## **Governance**

*Mental Health (MH):* For crisis stabilization units, there shall be a governing authority that is responsible for the CSU's organization, management, control, and operation. The duties of the governing authority include the appointment of the administrator.

No information related to requirements for governance were identified for day programs for acute needs.

*Substance Use Disorder (SUD):* No requirements related to requirements for governance were identified, but policies and procedures are required.

## **Special Populations**

*Mental Health (MH) and Substance Use Disorder (SUD):* For certain entities (local mental health authorities, managed care organizations, state mental health facilities), and certain Medicaid providers, specific accommodations should be made for individuals who require specialized support due to co-occurring psychiatric and substance use disorders, to include ensuring both the psychiatric and substance use disorders are addressed in the course of treatment and that treatment is effective and coordinated.

*Mental Health (MH):* Requirements regarding residential services were not explicitly described in the state regulations.

*Substance Use Disorder (SUD):* The services provided to a client with co-occurring psychiatric and substance use disorders (COPSD) must address both psychiatric and substance use disorders; be provided within established practice guidelines for this population; and facilitate individuals in accessing available services they need and choose, including self-help groups.

The services provided to a client with COPSD must be provided by staff who are competent. Providers must ensure that services to clients are age-appropriate and are provided by staff within their scope of practice who have specified minimum knowledge, technical, and interpersonal competencies. Treatment planning must identify services to be provided and must include measurable outcomes that address COPSD.

Clients shall receive gender-specific services in female-only specialized programs. When appropriate, pre-admission service coordination shall be provided to reduce barriers to treatment, enhance motivation, stabilize life situations, and facilitate engagement in treatment.

Services shall address relationship issues, including past or current experience with sexual, physical, and emotional abuse. Providers shall develop and implement a mechanism to ensure that all direct care staff in programs that treat women and children have the knowledge, skills, and abilities to provide services to women and children, as they relate to the individual's job duties. Individuals responsible for the planning and supervision of the program shall participate in at least 15 clock hours of training annually in understanding children, child development, and/or early childhood education. Clients shall receive access to appropriate primary medical care, including prenatal care and reproductive health education and services. Pregnant clients, women with children in custody, and women with dependent children shall receive parenting education and support services. Women and their dependent children shall be treated as a unit, and both the woman and her children will be admitted into treatment when appropriate. Children shall receive services to address their needs and support healthy development, including primary pediatric care, early childhood intervention services, substance abuse prevention services, and/or other therapeutic interventions. Facilities housing children shall comply with the standards applicable to child-care centers.

According to state staff, facilities that receive funding from block grants, also must satisfy contractual access requirements related to other priority populations.

## Location of Regulatory and Licensing Requirements

Regulation of CSUs<sup>1</sup>; Regulation of Day Programs for Acute Needs<sup>2</sup>; Regulation of Rights of Persons Receiving Mental Health Services<sup>3</sup>; Subtitle C statute regarding licensure<sup>4</sup>. SU regulations Chapters 441, 447, 448<sup>5</sup>. Regulations Chapters 404, 411 and HHS Chapter 510<sup>6</sup>. Regulatory data collected August 9, 2019.

## Other Information Sources

B. Rohsner, L. Pierre-Carr (HHSC), T. Hosaka (THSC); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>1</sup> See [https://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac\\_view=5&ti=25&pt=1&ch=411&sch=M&div=1&rl=Y](https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=25&pt=1&ch=411&sch=M&div=1&rl=Y).

<sup>2</sup> See [https://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac\\_view=5&ti=25&pt=1&ch=416&sch=A&rl=Y](https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=25&pt=1&ch=416&sch=A&rl=Y).

<sup>3</sup> See [https://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac\\_view=5&ti=25&pt=1&ch=404&sch=E&rl=Y](https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=25&pt=1&ch=404&sch=E&rl=Y).

<sup>4</sup> See <https://statutes.capitol.texas.gov/?link=HS>.

<sup>5</sup> See [https://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac\\_view=3&ti=25&pt=1](https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=3&ti=25&pt=1).

<sup>6</sup> See [https://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac\\_view=4&ti=26&pt=1&ch=510](https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=26&pt=1&ch=510).

# TEXAS MEDICAID

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## Approach

*Mental Health (MH) and Substance Use Disorder (SUD):* Texas Health and Human Services (THHS) oversees the state Medicaid program. Texas does rely on the in lieu of provision and on Disproportionate Share Hospital (DSH) to reimburse some services in institutions for mental diseases (IMDs). Its Section 1115 waiver does not provide for coverage of behavioral health services in an IMD, although it does address coverage of certain non-IMD residential services.

*Mental Health (MH):* Mental health rehabilitative services, including crisis intervention services, may not be offered in an IMD but may be offered in a non-IMD residential setting.

*Substance Use Disorder (SUD):* Texas covers some residential non-IMD SUD treatment.

## Types of Facilities

*Mental Health (MH):* Texas covers the following facility types in their Medical Assistance program:

- *Crisis intervention services:* intensive community-based one-to-one services. This service includes assessment, behavioral skills training, problem-solving, and reality orientation to help clients identify and manage their symptoms of mental illness, and cope with stressors.
  - Crisis intervention services may be provided in extended observation or crisis residential units.
  - Crisis intervention services may not be provided to anyone admitted to a Crisis Stabilization Unit (CSU) which is a licensed under Chapter 577 of the Texas Health and Safety Code and 25 TAC Chapter 134 (relating to Private Psychiatric Hospitals and Crisis Stabilization Units).
- *Day programs for acute needs:* may be provided in a residential facility with fewer than 17 beds. They provide short-term, intensive treatment that are site-based and provided in a group modality. They are provided in a highly-structured and safe environment with constant supervision and ensure an opportunity for frequent interaction between client and staff.

*Substance Use Disorder (SUD):* Texas covers the following facility types in their Medical Assistance program:

- *Residential detoxification/withdrawal management:* Residential detoxification shall be limited to a medically appropriate duration of service based on medical need and level of intoxication for a maximum of 21 days per episode of care. Withdrawal management, formerly known as detoxification, is the medical and behavioral treatment of individuals experiencing or potentially experiencing withdrawal symptoms as a result of ceasing or reducing substance use. Withdrawal management involving opioids, alcohol, sedatives, hypnotics, or anxiolytics will vary depending on the severity of the withdrawal symptoms experienced but will typically involve medications to treat symptoms in addition to supportive care, observation, and monitoring. Withdrawal management involving stimulants, inhalants, and cannabis typically involves supportive care, observation and monitoring, and medications to treat withdrawal symptoms as required.
- *Residential treatment:* Residential treatment shall be limited to a medically appropriate duration of service based on medical need and severity of addiction for a maximum of 35 days per episode of care and no more than 2 episodes of care per a 6-month period. Residential treatment programs provide a structured therapeutic environment where individuals reside with staff support and deliver comprehensive substance use disorder treatment with attention to cooccurring conditions as appropriate. The frequency and duration of services should be based on meeting the individual's needs and achieving the individual's treatment goals.

Medication-assisted treatment may be included.

## **Processes of Medicaid Enrollment**

*Mental Health (MH) and Substance Use Disorder (SUD):*

- An applicant or re-enrolling provider must be licensed, certified, or accredited to the extent required by federal and state laws, regulations, statutes, rules, and policy. The applicant or re-enrolling provider must be in good standing related to licensure, certification, and accreditation to be considered for enrollment.
- An applicant or re-enrolling provider must consent to unscheduled and unannounced pre- and post-enrollment site visits conducted by HHSC or its designee.
- A provider must submit a new enrollment application at least every five years. The time frame for re-enrollment is based on the provider's screening level unless HHSC determines a shorter enrollment period.



### *Substance Use Disorder (SUD):*

- Reimbursement can only be received after a facility is licensed as a Chemical Dependency Treatment Facility (CDTF) by the Department of State Health Services to provide substance abuse and dependency treatment services, be enrolled and approved for participation in the Texas Medical Assistance Program; and sign a written provider agreement with HHSC or its designee.

## **Staffing**

*Mental Health (MH):* Day programs for acute needs must have, at all times, a sufficient number of staff member to ensure safety and program adequacy and, at a minimum, include: one RN for every 16 clients; one physician available by phone with a response time of not more than 15 minutes; two staff members who are QMHP-CSs, CSSPs, or peer providers at the program location; one additional QMHP who has a response time of not greater than 30 minutes; and additional QMHP-CSs, CSSPs, or peer providers sufficient to maintain a ratio of one staff member per every four clients.

*Substance Use Disorder (SUD):* Residential SUD treatment services may only be provided by a licensed CDTF and additional limitations apply if MAT is provided.

## **Placement**

*Mental Health (MH):* Prior authorization is required for all mental health rehabilitative services, except crisis intervention. A QMHP-CS must conduct a uniform assessment at least every 180 days for adults to determine the type, amount, and duration of mental health rehabilitative services.

Within two days of initiation of crisis intervention services, an LPHA must determine if the services meet the definition of medical necessity. Providers will not be reimbursed if the person does not have a serious mental illness.

Day programs for acute needs are provided to clients who are 18 years of age and older and who requires multidisciplinary treatment to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting.

*Substance Use Disorder (SUD):* Treatment for SUD is only reimbursed for those who meet criteria for a SUD disorder. Level of care and specific services must adhere to current evidence-based industry standards and guidelines such as those in the ASAM Treatment Criteria for Addictive Substance-Related and Co-Occurring Conditions as well as licensure requirements for

standards of care. Upon admission, a face-to-face multidimensional assessment must be conducted by a qualified credentialed counselor or intern to determine a course of treatment that is medically necessary and clinically appropriate.

Residential detoxification may be prior authorized for up to 21 days. The level of service and authorization period varies based on substances used, level of intoxication and withdrawal potential, and medical needs. Clients are eligible for admission if they failed two previous episodes of outpatient withdrawal management or they have specified diagnoses and meet certain criteria. Continued stay requires meeting at least one of the criteria for withdrawal, major medical complications, or major psychiatric complications.

Residential services may be prior authorized for up to 35 days per care episode, with a maximum of two episodes of care per rolling six-month period, and four episodes of care per rolling year. The level of service and authorization period varies based on substances used, level of intoxication and withdrawal potential, and medical needs. Clients are eligible for admission if they failed two previous episodes of outpatient withdrawal management or they have specified diagnoses and meet certain criteria. Continued stay requires meeting at least one of the criteria for withdrawal, major medical complications, or major psychiatric complications.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH):* The treatment planning process for mental health rehabilitative services, including crisis intervention, requires the active participation of the Medicaid eligible client. Treatment plans are based on a comprehensive assessment and must address the client's strengths, areas of need, the client's preferences, and descriptions of the client's treatment goals. A comprehensive provider agency must develop a written recovery/treatment plan before the provision of mental health targeted case management or mental health rehabilitative services; and within 10 business days after the date the individual is eligible and has been authorized for routine care services.

*Substance Use Disorder (SUD):* Requirements regarding residential services were not explicitly described in the state Medicaid regulations; see above for detailed licensure-related standards.

## **Treatment Services**

*Mental Health (MH):* Crisis intervention services consist of the following interventions: an assessment of dangerousness of the client to self or others; the provision of emergency care services that include crisis screening and response, telephone access, emergency case services, urgent care services, routine care services, and access to emergency medical/crisis services; behavior skills training to assist the client in reducing distress and managing symptoms; problem-solving; reality orientation to help the client identify and manage his or her symptoms

of serious mental illness or SED; and providing instruction, structure, and emotional support to the client in adapting to and coping with immediate stressors.

Day programs for acute needs focus on intensive, medically-oriented, multidisciplinary interventions such as behavior skills training, crisis management, and nursing services to stabilize acute psychiatric symptoms. Services include psychiatric nursing services; pharmacological instruction; symptom management training; and functional skills training.

Other mental health rehabilitation services include medication training and support services; psychosocial rehabilitative services; and skills training and development services. Each of these have specific requirements under the Medicaid rehabilitation service descriptions.

*Substance Use Disorder (SUD)*: General applicable categories of reimbursable CDTF services include withdrawal management; medication assisted treatment; and evaluation and treatment or referral for co-occurring physical and behavioral health conditions.

Withdrawal management in a residential setting may be required for individuals whose multidimensional assessment indicates one or more of the following circumstances that would make outpatient withdrawal management unsafe or unsuccessful, such as those with a level of severity of withdrawal, medical, or mental health complication or with sufficient challenges with readiness to change, ability to stop using, or social support.

Medication-assisted treatment may be included in CDTF residential facilities.

## **Care Coordination**

*Mental Health (MH) and Substance Use Disorder (SUD)*: Requirements regarding residential services were not explicitly described in the state Medicaid regulations; see above for detailed licensure-related standards.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD)*: Each Medicaid MCO must develop and implement an ongoing quality assessment and performance improvement (QAPI) program for services it furnishes to its enrollees. The MCO must maintain and provide documentation of its compliance for HHSC's or its contracted External Quality Review Organization's (EQRO's) review, including performance measurement data. HHSC periodically evaluates each MCO's quality of services in each Medicaid managed care service area and the cost-effectiveness, member access, and quality of care under each federal waiver.

## Special Populations

*Mental Health (MH) and Substance Use Disorder (SUD)*: Requirements regarding residential services were not explicitly described in the state Medicaid regulations; see above for detailed licensure-related standards.

*Substance Use Disorder (SUD)*: Special provisions pertain to individuals with co-occurring disorder and pregnant women.

## Location of Medicaid Requirements

Texas Administrative Code, Title 1: Administration; Part 15: Texas Health and Human Services Commission<sup>7</sup>; Texas Medicaid Provider Procedures Manual<sup>8</sup>; Texas Healthcare Transformation and Quality Improvement Program<sup>9</sup>. Regulatory data collected January 10, 2020.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report “**State Residential Treatment for Behavioral Health Conditions: Regulation and Policy**”. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

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<sup>7</sup> See [https://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac\\_view=3&ti=1&pt=15](https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=3&ti=1&pt=15).

<sup>8</sup> See [http://www.tmhp.com/Pages/Medicaid/Medicaid\\_Publications\\_ProviderManual\\_Current.aspx](http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_ProviderManual_Current.aspx).

<sup>9</sup> See <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8393>.

## UTAH

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

### **Types of Facilities**

*Mental Health (MH) and Substance Use Disorder (SUD):* Utah regulates Residential Treatment Programs. These are for four or more people and there are specific residential treatment programs for MH and for specialized SUD treatment services.

*Substance Use Disorder (SUD):* Utah regulates Social Detoxification Programs where individuals are assisted in acquiring the sobriety and a drug free condition necessary for living in the community and the program places an emphasis on helping the individual obtain further care after detoxification. This service is short-term and non-medical.

*Unregulated Facilities:* State staff indicate that there are no unregulated residential treatment facilities in Utah. We exclude from this summary the level of care described in LOCUS 6A, High Intensity, Acute Medically Managed Residential Programs, because Utah regards them as inpatient psychiatric specialty hospitals. We also exclude the Residential Support category of care which expressly does not include treatment as a necessary component and the Recovery Residence category of care which expressly is not residential treatment. In addition, DSAMH has established certification requirements for residential treatment programs that serve individuals involved in the criminal justice system; these are excluded as outside the scope of this summary.

### **Approach**

The Utah Department of Human Services (DHS) takes the lead on regulating residential treatment providers in Utah. The DHS Office of Licensing (the Office) has authority for health and safety regulations for Residential Treatment Programs. The DHS Division of Substance Abuse and Mental Health (DSAMH) establishes standards for Residential Treatment Programs that receive public funds from DHS.

### **Processes of Licensure or Certification and Accreditation**

*Mental Health (MH) and Substance Use Disorder (SUD):* Licensure by the Office is required for operation.

- Accreditation is not required, but the Office may adopt a written inspection report from a local government, certifying, contracting, or accrediting entity to assist in a determination whether a licensee has complied with a licensing requirement.
- Inspection is required at application and at least annually to monitor compliance or to gather information for licensure and renewal.
- A Certificate of Need is not required for operation.
- Initial licenses are typically one year, although programs may apply for a two-year license under certain circumstances.

### **Cause-Based Monitoring**

*Mental Health (MH) and Substance Use Disorder (SUD):* The Office may conduct as many announced, or unannounced inspections as deemed necessary to monitor compliance, investigate alleged violations, monitor corrective action plans or penalty compliance, or to gather information for license renewal. The Office shall provide written findings to the Program identifying areas of non-compliance with licensing requirements after each on-site inspection. When the Office finds evidence of violations of statute or rule, the Office shall do one of the following: (a) provide written notification of the violation requiring the licensee to correct violation(s) with no formal follow-up; or (b) provide written notification of violation and request a licensee to submit a corrective action plan in response to a written notification of a violation.

### **Access Requirements**

*Mental Health (MH) and Substance Use Disorder (SUD):* Wait-time requirements were not found. Service providers contracted with the Division and County Local Authority programs may not deny entry or remove from treatment a person testing positive for drugs or alcohol solely for positive drug tests.

### **Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD):* All residential treatment programs must have written personnel policies and procedures. Programs must have a director, appointed by the governing body, who shall be responsible for management of the program and facility. The director or designated management person shall be available at all times during operation of program. Treatment must be provided or supervised by professional staff, whose qualifications are determined or approved by the governing body, in accordance with state law. The governing body shall ensure that all staff are certified and licensed as legally

required. The program shall have access to a medical clinic or a physician licensed to practice medicine in the State of Utah. Programs shall follow a written staff to consumer ratio, which shall meet specific consumer and program needs. Staff members shall be trained in all policies of the program and shall have completed and remain current in a certified first aid and CPR, such as or comparable to American Red Cross.

In addition, service providers contracted with the Division and County Local Authority programs are required to have qualified staff licensed and capable of assessing individuals for both MH and SUDs.

*Substance Use Disorder (SUD):* Social detoxification programs must have an employed manager who is responsible for the day to day resident supervision and operation of the facility. The responsibilities of the manager shall be clearly defined. Whenever the manager is absent there shall be a substitute available. Professional staff shall include at least one of the following individuals who have received training to work with substance abusers: (1) a licensed physician, or a consulting licensed physician; (2) a licensed mental health therapist, or a consulting licensed mental health therapist; (3) a licensed psychologist or consulting licensed psychologist; or (4) a licensed substance abuse counselor or unlicensed staff who work with substance abusers shall be supervised by a licensed clinical professional. The program shall have a staff person trained by a certified instructor in standard first aid and CPR, on duty with the consumers at all times.

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* Residential treatment programs must perform an intake evaluation. In emergency situations which necessitate immediate placement, the intake evaluation shall be completed within seven days of admission.

In addition, service providers contracted with the Division and County Local Authority programs are subject to regulations regarding mental health screening and mental health and substance use assessments, the latter of which relies on modified ASAM Patient Placement Criteria dimensions. Based on the screening and assessment, the assessor shall make recommendations regarding the needed level of care and services to address the identified clinical needs. The levels of care and array of services shall be based on the ASAM or equivalent Mental Health criteria.

*Substance Use Disorder (SUD):* Social detoxification programs may not admit those who are currently experiencing convulsions, in shock, delirium tremens, in a coma, or unconscious. The program shall complete a preliminary screening when an individual presents for service to determine appropriateness for social model detoxification. The intake evaluation is completed within seven days.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* For Residential Treatment Programs, treatment planning is required, should be developed within 30 days of admission, and be updated as often as required in the plan. Discharge planning also is required. The plan shall include the reason for discharge or transfer and provisions for aftercare planning.

Providers contracted with the Division and County Local Authority programs require development of an individualized treatment plan that identifies a comprehensive set of tools and strategies that address the client's identifiable strengths as well as their problems and deficits. Substance use disorder treatment plans should be based on the six ASAM Patient Placement Dimensions and address critical areas identified in each dimension. Mental Health Recovery Plans shall be organized in a similar manner. Upon discharge, recommendations for ongoing services include the extent to which established goals and objectives were achieved, what ongoing services are recommended, and a description of the individual's recovery support plan. Treatment programs must work with individuals to identify needed and desired recovery supports and ensure that: (a) Participation in recovery support shall be voluntary; and (b) Whenever possible, individuals are encouraged and given a choice of potential recovery support services and a choice of programs. Services such as case management, housing, employment training, transportation, childcare, healthcare, peer support and other social supports shall be strongly considered and implemented if appropriate before, during and after the completion of acute treatment services.

*Substance Use Disorder (SUD):* In social detoxification programs, once the client has completed the acute detoxification period as demonstrated by reasonable physical and psychological stability, case managers will conduct an evaluation to determine the treatment referral.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Residential Treatment Programs offer “room and board and provide for or arrange for the provision of specialized treatment, rehabilitation or habilitation services for persons with emotional, psychological, developmental, or behavioral dysfunctions, impairments, or chemical dependencies. In residential treatment programs, consumers are assisted in acquiring the social and behavioral skills necessary for living independently in the community.”

Service providers contracted with the Division and County Local Authority programs are subject to additional treatment regulations including but not limited to: (1) Treatment intensity, duration and modality for: (a) Substance use disorders shall be based on the current ASAM criteria; and (b) Mental health disorders shall be determined by the clinical assessment process and medical necessity. (2) Treatment programs shall: ... (b) Develop strategies to screen for, prevent, and refer to treatment adults with serious chronic conditions such as, but not limited



to, HIV/AIDS, Hepatitis B and C, and tuberculosis; (c) Ensure that assessment is an ongoing component of treatment; (d) Diagnose, treat or ensure treatment for co-occurring conditions; (e) Ensure treatment participation and length shall be of sufficient dosage/duration to affect stable behavioral change and long term recovery supports; ... (g) Provide comprehensive treatment services that includes but is not limited to: (i) Developmentally appropriate and informed treatments; (ii) Recognition of gender, cultural, linguistic, and other individual differences in the treatment approach; (iii) Ensuring all individuals with alcohol and/or opioid disorders are educated and screened for the potential use of medication-assisted treatment; (iv) Monitoring drug use through drug testing and other means; (v) Individuals testing positive for drugs or alcohol shall not be denied entry or removed from treatment from a program solely for positive drug tests; (vi) All public substance use providers, including the Local Substance Abuse Authorities and their contracted providers shall comply with all Division Directives for Drug testing; (vii) As appropriate and with consent, involve families and support persons in the treatment and recovery process; and (viii) Provide Naloxone education, training and assistance to individuals with opiate use disorders and when possible to their families, friends, and significant others.

*Substance Use Disorder (SUD):* Social Detoxification Programs offer “room, board and specialized rehabilitation services to persons who are in an intoxicated state or withdrawing from alcohol or drugs. In social detoxification, individuals are assisted in acquiring the sobriety and a drug free condition necessary for living in the community and the program places an emphasis on helping the individual obtain further care after detoxification.”

## **Patient Rights and Safety Standards**

*Mental Health (MH) and Substance Use Disorder (SUD):* Consumer rights include but are not limited to privacy, freedom from harm, grievance and complaint procedures, freedom from discrimination, dignity, communication, and to be informed of rights. In addition, no management person shall authorize or use, and no staff member shall use any method designed to humiliate or frighten a consumer, or physical restraint, other than passive physical restraint. Passive physical restraint shall be used only as a temporary means of physical containment to protect the consumer, other persons, or property from harm. Passive physical restraint shall not be associated with punishment in any way.

Service providers contracted with the Division and County Local Authority programs have additional obligations regarding rights of individuals participating in their services including but not limited to the right to informed consent and rights regarding medication-assisted treatment.

## Quality Assurance or Improvement

*Mental Health (MH) and Substance Use Disorder (SUD):* All programs shall have a written quality assurance plan, and implementation of the plan shall be documented.

## Governance

Mental Health (MH) and Substance Use Disorder (SUD): For all programs, the governing body shall be one of the following: (1) A Board of Directors in a non-profit organization. (2) Commissioners or appointed officials of a governmental unit. (3) Board of Directors or individual owner or owners of a for-profit organization. The governing body must ensure program policy and procedure compliance.

## Special Populations

*Mental Health (MH) and Substance Use Disorder (SUD):* Programs providing MH and SUD treatment services with public funds (federal, state, and local match) shall comply with the priorities listed below. The Division shall regularly seek and receive input from the Utah Behavioral Health Planning and Advisory Council on priorities for services.

- MH services provided with public funds shall provide services based on immediacy of need and severity of the mental illness. Priority may also be given to under-served age groups as appropriately demonstrated through needs studies. (a) Effective and responsive crisis intervention, suicide prevention, assessment, direct care, and referral program available to all citizens. (b) Provision of the least restrictive and most appropriate treatment and settings for: (i) Children, youth, and adults with severe mental illness; (ii) Children, youth, and adults with acute mental illness; and (iii) Children, youth and adults who are receiving services from other divisions within the Department of Human Services. (c) Provisions of services to children with emotional disabilities, youth and aged citizens who are neither acutely nor severely mentally ill, but whose adjustment is critical for their future as well as for society in general. (d) Provision of services to emotionally disabled adults who are neither acutely nor severely mentally ill, but whose adjustment is critical to their personal quality of life as well as for society in general. (e) Provision of consultation, education and preventive mental health services targeted at high risk groups.
- SUD treatment services provided with public funds (federal, state, and local match) shall provide priority admission to the following populations (in order of priority): (a) Pregnant females who use drugs by injection; (b) Pregnant females who use substances; (c) Other persons who use drugs by injection; (d) Substance using females with dependent children and their families, including women who are attempting to regain custody of their

children; and (e) All other clients with a substance use disorder, regardless of gender or route of use. Treatment of those with co-occurring disorders also is a priority of the publicly-funded treatment system.

## **Location of Regulatory and Licensing Requirements**

Department of Human Services<sup>1,2</sup>; Local MH Authorities and Local SA Authorities regulations<sup>3</sup>.  
Regulatory data collected September 27, 2019.

## **Other Information Sources**

S. Long and P. Bennett (DSAMH); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>1</sup> See <https://rules.utah.gov/publicat/code/r501/r501.htm>.

<sup>2</sup> See <https://rules.utah.gov/publicat/code/r523/r523-004.htm>.

<sup>3</sup> See <https://rules.utah.gov/publicat/code/r523/r523-002.htm#T1>.

# UTAH MEDICAID

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## Approach

The Utah Department of Health (DOH) oversees the state Medicaid program. Utah also has a Section 1115 waiver that permits reimbursement of short term SUD treatment and co-occurring mental health treatment services to individuals aged 21-64 years in residential treatment facilities that qualify as an Institution for Mental Disease (IMD). Utah also has historically relied on the in lieu of provision to reimburse certain services in IMDs but not Disproportionate Share Hospital (DSH) payments.

## Types of Facilities

*Mental Health (MH) and Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, residential crisis stabilization is available in IMDs.

*Mental Health (MH):* Researchers found no other evidence of Medicaid reimbursement for adult residential MH treatment services, other than co-occurring services pursuant to the Section 1115 SUD waiver.

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, expenditures may be reimbursed for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are short-term residents in facilities that meet the definition of an IMD. Expenditures for services in the following residential ASAM levels of care are permitted under the state plan for non-IMDs and under the waiver for IMDs: Level 3.1. Clinically Managed Low-Intensity Residential Treatment Services; Level 3.3. Clinically Managed Population-Specific High Intensity Residential Treatment Services; Level 3.5. Clinically Managed High-Intensity Residential Treatment Services; and Level 3.7 Medically Monitored Intensive Inpatient Services. Pursuant to the Section 1115 waiver, Level 3.2-WM. Clinically Managed Residential Withdrawal will be reimbursed as part of a pilot in Salt Lake County. Medication-assisted treatment (MAT) is to be provided in these settings.

## Processes of Medicaid Enrollment

*Mental Health (MH) and Substance Use Disorder (SUD):* Before enrolling as a provider in Utah Medicaid, providers must have a signed Provider Agreement with Utah Medicaid. All providers on a PMHPs provider panel must also be enrolled directly with the Utah Medicaid program. In addition, the provider is credentialed by the plan and enters a contract with the PMHP. Revalidation of provider enrollment is required no less than every five years. The state Medicaid program may sanction providers. State licensure is required.

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 implementation plan, Utah Medicaid will have a process established to certify private residential treatment facilities based on ASAM criteria who may provide services to Medicaid fee for service members. All participating residential facilities must be licensed.

## Staffing

Substance Use Disorder (SUD): Pursuant to the Section 1115 waiver, the state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding credentials of staff for residential treatment settings. The state must conduct an assessment of the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT.

The state is working to expand education about trauma-informed care in SUD treatment.

- Where clinically managed residential withdrawal services are reimbursed, they must be provided by the following practitioners in a residential facility that is licensed by the Utah Office of Licensing to provide withdrawal management services: (a) Licensed Clinical Social Workers (LCSW); (b) Registered Nurses; (c) Certified Recovery Assistants; (d) Master's Degree-level Mental Health Clinicians; (e) Certified Case Managers; and (f) Certified Peer Support Specialists.

## Placement

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines. The state also must establish a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are

appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings. Placements will be determined based on the ASAM criteria.

- Participants in the Salt Lake County Clinically Managed Residential Withdrawal Pilot must be age 18 and older, reside in Salt Lake County, have a Physician or Licensed Practitioner of the Healing Arts determine the beneficiary demonstrates moderate withdrawal signs and symptoms, have a primary diagnosis of opioid use disorder (OUD) or another SUD, and require round-the-clock structure and support to complete withdrawal and increase the likelihood of continuing treatment and recovery.

## **Treatment and Discharge Planning and Aftercare Services**

*Substance Use Disorder (SUD):* Treatment for participants in the Salt Lake County Clinically Managed Residential Withdrawal Pilot must be in accordance with an individualized plan of care. The pilot may offer, among other services, discharge services to prepare the beneficiary for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to treatment resources in the community.

## **Treatment Services**

*Substance Use Disorder (SUD):* Under the Section 1115 waiver, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from acute withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions. In addition to current licensing requirements, pursuant to the Section 1115 waiver, the state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services and hours of clinical care for residential treatment settings. The state must establish a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site.

The state is working to infuse trauma-informed care into SUD treatment.

The state Medicaid program specifies the following regarding services:

- Level 3.1 Clinically managed low-intensity residential treatment services: at least 5 hours of clinical service/week, MAT, and transitional case management (TCM).

- Level 3.2-WM Clinically managed residential withdrawal management: 24-hour support to complete withdrawal management.
- Level 3.3. Clinically Managed Population-Specific High Intensity Residential Services: MAT, TCM.
- Level 3.5 Clinically managed high-intensity residential services: MAT, TCM.
- Level 3.7 Medically monitored intensive inpatient services: 24 hour nursing care with physician availability. 16 hour/day counselor availability, MAT, TCM.
  - The Salt Lake County Clinically Managed Residential Withdrawal Pilot may include the following services: Assessment; Observation; Medication Services; Psychoeducation; and Discharge Services.

## Care Coordination

*Substance Use Disorder (SUD):* Under the Section 1115 waiver, beneficiaries will have improved care coordination and care for comorbid physical and mental health conditions. The state must ensure establishment and implementation of policies to ensure residential facilities link beneficiaries with community-based services and supports following stays in these. Pursuant to the SUD implementation plan, Utah will add an addendum to the Utah Provider agreement for enrolled residential treatment providers that outlines a specific requirement that the provider is responsible to assure appropriate transitions of care either by providing this service directly or coordinating the provision of this service with another provider. The implementation plan also calls for Utah to amend Medicaid Provider Manual for Targeted Case Management for Individuals with Serious Mental Illness to include Substance Use Disorder and to amend the Utah Provider Manual for Hospital services. Both manuals will clearly state the requirement for residential and inpatient treatment facilities to coordinate and facilitate transition of Medicaid member to community based services and supports following a stay at a facility. Similar requirements will be added to the language in its Prepaid Mental Health Plan (PMHP) contracts.

## Quality Assurance or Improvement

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings.

## Special Populations

*Substance Use Disorder (SUD)*: No Medicaid requirements were located other than the requirement in the Section 1115 waiver that care for comorbid physical and mental health conditions be improved by the demonstration.

## Location of Medicaid Requirements

Utah Medicaid Rules and Regulations<sup>4</sup>; Utah Website Provider Enrollment Forms<sup>5</sup>; Utah 1115 Waiver<sup>6</sup>. Regulatory data collected December 2019.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report “**State Residential Treatment for Behavioral Health Conditions: Regulation and Policy**”. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

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<sup>4</sup> See <https://rules.utah.gov/publicat/code/r414/r414-01.htm>.

<sup>5</sup> See <https://medicaid.utah.gov/provider-enrollment-forms/>.

<sup>6</sup> See <https://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ut/ut-primary-care-network-ca.pdf>.



## VERMONT

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### Types of Facilities

*Mental Health (MH) and Substance Use Disorder (SUD):* Vermont regulates:

- *Therapeutic community residences:* a transitional residence providing individualized treatment to three or more residents in need of supportive living arrangement to assist them in their efforts to overcome a major life adjustment problem, such as alcoholism, drug abuse, mental illness and delinquency.
  - *Secure residential recovery facilities* are a subset of therapeutic community residences for individuals no longer requiring acute inpatient care, but who remain in need of treatment within a secure setting for an extended period of time. The program shall be the least restrictive and most integrated setting for each of the individual residents.

*Mental Health (MH):* Vermont regulates the following two MH residential facility types:

- *Intensive residential recovery facility (IRRF):* a program that provides a safe, therapeutic, recovery-oriented residential environment to care for individuals with one or more mental conditions or psychiatric disabilities who need intensive clinical interventions to facilitate recovery in anticipation of returning to the community. This facility shall be for individuals not in need of acute inpatient care and for whom the facility is the least restrictive and most integrated setting.
- *Designated agencies:* service providers that are designated by the Department of Developmental and Mental Health Services (DDMHS) in each geographic area of the state to assure that people in local communities receive services and supports, consistent with available funding, the state System of Care Plans, the local System of Care Plans, outcome requirements, regulations promulgated by DDMHS, the goals of Vermont for its citizens, the goals of the citizens themselves, and other policies, plans, regulations, and laws.
  - One of the three populations to which this applies is adults with mental illness, or with significant behavioral health needs. In general, designated agencies must assure a comprehensive and responsive array of services to the designated geographic region. DDMHS also may enter into similar arrangements with *specialized service agencies*, which meet specialized needs of populations DDMHS serves. Specialized service agencies do not have to provide the comprehensive array

of services of the designated agency but must generally meet the other requirements discussed in this summary that apply to designated agencies.

*Substance Use Disorder (SUD)*: Vermont regulates the following adult residential SUD treatment facility types:

- *Residential programs*: an organized service in alignment with ASAM Criteria 3rd edition 3.1 to 3.7 level of care that is provided by trained staff with 24-hour supervision, observation, and support to ensure the provision of treatment services to a person served who reside on the premises during the course of treatment.
  - Long-Term Residential Programs whose length of stay is intended to exceed ninety (90) calendar days.
  - Short-Term Residential Programs are residential programs whose initial length of stay is not intended to exceed thirty (30) calendar days.
- ASAM Level 3.2-WM, *Clinically Managed Residential Withdrawal Management Substance Use Disorder Treatment Services*: the provision of medical and/or social services in a facility staffed 24 hours per day to persons served who are experiencing or are at risk for experiencing physical withdrawal from alcohol or other drugs.
- ASAM Level 3.7-WM, *Residential Withdrawal Management Services or Medically Monitored Inpatient Withdrawal Management*: an organized service delivered to patients whose withdrawal signs and symptoms are sufficiently severe enough to require 24-hour inpatient care by medical and nursing professionals, which provides for 24-hour evaluation and withdrawal management in a permanent facility with inpatient beds.
- ASAM Level 3.1, *Clinically Managed Low-Intensity Residential Substance Use Disorder Treatment Services*: an organized service in alignment with ASAM Criteria that is provided by trained staff with 24-hour supervision, observation, and support to ensure the provision of treatment services to a person served who reside on the premises during the course of treatment.
- ASAM Level 3.3, *Clinically Managed High-Intensity Residential Substance Use Disorder Treatment Services*: an organized service in alignment with ASAM Criteria that is provided by trained staff with 24-hour supervision, observation, and support to ensure the provision of treatment services to a person served who reside on the premises during the course of treatment.
- ASAM Level 3.5, *Clinically Managed High-Intensity Residential Substance Use Disorder Treatment Services*: an organized service in alignment with ASAM Criteria that is provided by trained staff with 24-hour supervision, observation, and support to ensure the provision of treatment services to a person served who reside on the premises during the course of treatment.

- ASAM Level 3.7, *Medically Monitored Intensive Inpatient Residential Substance Use Disorder Treatment Services*: not defined but see definition above of level 3.7-WM and information throughout regarding standards for certification.
- State SUD staff indicate that, for substance use disorder residential treatment facilities, the preferred provider certification takes the place of MH designated agencies.

*Unregulated Facilities*: Community care homes/residential care homes are separately regulated and do not fall within the definition of treatment facilities used for this summary. No other unregulated facility types under the purview of this summary were found.

## **Approach**

*Mental Health (MH)*: The Department of Mental Health contracts with licensed IIRFs. Designated agencies receive funding from DDMHS to provide the services for designated populations. Vermont also has additional statutes and regulations regarding mental health treatment and substance use disorder treatment that qualifies for insurance reimbursement and, to the extent IIRFs accept insurance payment, they would be subject to those requirements as well.

*Substance Use Disorder (SUD)*: The Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (ADAP) regulates and certifies substance abuse treatment programs in the state. Vermont also has statutes and regulations regarding mental health treatment and substance use disorder treatment that qualifies for insurance reimbursement and, to the extent substance use treatment facilities accept insurance payment, they would be subject to those requirements as well.

## **Processes of Licensure or Certification and Accreditation**

*Mental Health (MH) and Substance Use Disorder (SUD)*:

- Licensure by the Vermont Department of Disabilities, Aging and Independent Living's Division of Licensing and Protection is required for operation of therapeutic community residences. Licensure duration is for one year, at which time a renewal application must be submitted. An inspection is required for licensure and renewal.
- Additional approval is required for secure residential recovery facilities, which must meet all requirements applicable to therapeutic community residences, although modifications may be made for resident safety. A request for approval must address certain requirements. The residence shall be inspected by the licensing agency to determine if the

facility is providing the services, staffing, training and physical environment that were outlined in the request for approval.

- This category does not apply to SUD residential facilities.
- No requirements related to accreditation were found for therapeutic community residences or secure residential recovery facilities.
- The state does require a certificate of need for new health care projects that meet certain requirements pertaining, among things, to cost or changes in number of beds.

*Mental Health (MH):*

- DDMHS designates agencies, which then have that status for a period not greater than four years; by which point re-evaluation for re-designation is required. A formal application is required. The same standards, except as noted in 1.a above, apply to specialized service agencies.
- Designated agencies are not required to have accreditation but, if accredited by one or more state or national accreditation bodies, DDMHS may substitute relevant accreditation review findings for related designation requirements.

*Substance Use Disorder (SUD):*

- Certification by the ADAP is required for operation of substance abuse treatment programs and for the receipt of any state and federal funding. A provider who has obtained Full or Provisional Certification pursuant to the Substance Abuse Treatment Certification Rule is called a “Preferred Provider.” Certification duration is no more than three years, at which time a renewal application must be submitted. An inspection is required for certification and renewal.
  - Note that requirements for certification included in this document include both those in the promulgated regulations and in the state’s preferred provider treatment manual dated August 2018. The manual will be amended effective January 1, 2020.
- No requirements for accreditation were found, nor provision for deemed status.

## **Cause-Based Monitoring**

*Mental Health (MH) and Substance Use Disorder (SUD):* For therapeutic residential communities, if, as a result of survey or investigation, the licensing agency finds a violation of a law or regulation, it shall provide a written notice of violation to the residence within ten (10) days. If the licensee fails either to return a plan of corrective action or to correct any violation in

accordance with the notice of violation, the licensing agency shall provide written notice to the licensee of its intention to impose specific sanctions, and the right of the licensee to appeal.

*Mental Health (MH):* For designated agencies, if there are instances of major deficiencies, the department can de-designate and/or place the agency on provisional status. The department also can routinely review the services offered or supported by a designated or special service agency to ensure that they are operated in compliance with department rules, regulations, contract/grant requirements, division mission, and the local service plan. These reviews may include site visits and may or may not be announced in advance.

*Substance Use Disorder (SUD):* Standards related to monitoring/corrective action were identified. The Department may perform an inspection and survey for compliance with regulations and other applicable laws and rules without any prior notice. The Department may order the suspension or revocation of a certification at any time for non-compliance.

## **Access Requirements**

*Mental Health (MH) and Substance Use Disorder (SUD):* For therapeutic community residences, when an applicant is found to be ineligible for admission, the reason shall be recorded in writing and referral to an appropriate agency or organization shall be attempted. Such referral shall be made, if possible, in conjunction with the agency or organization originally referring applicant to the residence.

*Mental Health (MH):* For designated agencies, access requirements relate to physical access and transportation.

*Substance Use Disorder (SUD):* Each individual who requests and is in need of treatment for intravenous substance use should be admitted to a program no later than 14 days after making the request for admission to such a program; or 120 days after the date of such request, if no such program has the capacity to admit the individual on the date of such request and if interim services, including referral for prenatal care, are made available to the individual not later than 48 hours after such request. If a person cannot be located for admission into treatment or, if a person refuses treatment, such persons may be taken off the waiting list and need not be provided treatment within 120 days.

According to state ADAP staff, additional requirements apply under the Substance Abuse Block Grant, including that persons seeking treatment assistance will be scheduled for their first face-to-face treatment services within five working days of the request for assistance except when the program is at capacity. In the event of a wait list, priority is as follows in the event of a wait list: (1) Pregnant injecting drug users; (2) Pregnant substance abusers; (3) Injecting drug users; or (4) All other substance abusers.

Grantee programs are required to give preference for admission to pregnant injecting drug users and pregnant women, and provide the state notification within seven days when reaching 90% capacity. Pregnant women are to be provided interim services as necessary and as required by law.

Grantee programs must provide the state notification within seven days when reaching 90% capacity to admit a non-pregnant intravenous drug user. Each individual who requests and needs treatment for intravenous drug use is admitted not later than 14 days after making the request or 120 days if no such program has the capacity to admit and if interim services, available not later than 48 hours after such request.

## **Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD):* For therapeutic community residences, each residence shall be organized and administered under one authority who shall have ultimate authority and responsibility for the overall operation of the program. The manager of the residence shall be present in the residence an average of twenty-two (22) hours per week. The qualifications for the manager of a therapeutic community residence are, at a minimum, either at least an Associate's Degree in the area of human services or three years of general experience in a human services-related field.

For therapeutic community residences, there shall be sufficient number of qualified personnel available at all times to provide necessary care, to maintain a safe and healthy environment, and to ensure prompt, appropriate action in cases of injury, illness, fire or other emergencies. The residence must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve hours of training each year for each staff person providing direct care to residents. The licensing agency may require a residence to have specified staffing levels in order to meet the needs of residents.

*Mental Health (MH):* For designated agencies, the regulations require written personnel policies, employment of qualified personnel, staff evaluation, prohibition of discrimination, an annual training plan, staff orientation and other training.

*Substance Use Disorder (SUD):* Preferred providers staff responsible for SUD counseling must be appropriately licensed. Among other things, policies and procedures must be in place that include information on training and development and supervision, including for direct care staff and clinical staff. Orientation training and continuing education are required.

Staffing requirements are in accordance with the ASAM Criteria and are determined by the level of care being provided.

For ASAM Level 3.2-WM, staff must include appropriately credentialed personnel who are trained and competent to implement physician-approved protocols for client observation and supervision, determination of appropriate level of care, and facilitation of the client's transition to continuing care.

For ASAM Level 3.7-WM, staff must include physicians (or physician extenders) who are available 24 hours a day by phone and are available to assess clients within 24 hours of admission (or earlier, if medically necessary), and are available to provide on-site monitoring of care and further evaluation on a daily basis. A registered nurse or other licensed and credentialed nurse to conduct a nursing assessment on admission. Programs shall have a nurse who is responsible to overseeing the client's progress and medication administration on an hourly basis, if needed, as well as appropriately licensed and credentialed staff to administer medications in accordance with physician orders. There shall be an interdisciplinary team of appropriately trained clinicians to assess and treat the clients and to obtain and interpret information regarding the client's needs. The number and disciplines of team members are appropriate to the range and severity of the client's needs.

For ASAM Level 3.1, staffing requirements will be in accordance with ASAM criteria and determined by the level of care being provided. The staffing structure should include allied health professional staff, such as counselor aides or group living workers, on-site 24 hours a day or as required by licensing regulations; clinical staff who are knowledgeable about the biological and psychosocial dimensions of substance use and mental health disorders and their treatment, and able to identify the signs and symptoms of acute psychiatric conditions; a team comprised of appropriately trained and credentialed medical, addiction, and mental health professionals; and a physician or physician extender to review admission decisions to confirm clinical necessity of services.

For ASAM Level 3.2, facilities shall have a staffing structure that includes appropriately credentialed personnel who are trained and competent to implement physician-approved protocols for client observation and supervision, determination of appropriate level of care, and facilitation of the client's transition to continuing care.

For ASAM Level 3.3, facilities shall have a staffing structure that includes physicians or physician extenders, and appropriately credentialed mental health and substance use disorder treatment professionals; allied health professional staff, such as counselor aides or group living workers, on-site 24 hours a day or as required by licensing regulations; one or more clinicians with competence in the treatment of substance use disorders are available on-site or by telephone 24 hours a day; and clinical staff who are knowledgeable about the biological and psychosocial dimensions of substance use and mental health disorders and their treatment, and able to identify the signs and symptoms of acute psychiatric conditions. Staff must have specialized training in behavior management techniques.

For ASAM Level 3.5, facilities must have a staffing structure that includes licensed or credentialed clinical staff who work with the allied health professional staff in an

interdisciplinary team approach; allied health professional staff on-site 24 hours a day or as required by licensing regulations; one or more clinicians with competence in the treatment of substance use disorders are available on-site or by telephone 24 hours a day; and clinical staff who are knowledgeable about the biological and psychosocial dimensions of substance use and mental health disorders and their treatment, and able to identify the signs and symptoms of acute psychiatric conditions. Staff must have specialized training in behavior management techniques.

For ASAM Level 3.7, staffing must include an interdisciplinary staff who are able to assess and treat the client and to obtain and interpret information regarding the client's psychiatric and substance use or addictive disorders. Clinical staff shall be knowledgeable about the biological and psychosocial dimensions of substance use and other behavioral health disorders, and have specialized training in behavior management techniques and evidence-based practices. The staff should be able to provide a planned regimen of 24-hour professionally directed evaluation, care, and treatment services (including administration of prescribed medications).

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* For therapeutic community residences, an assessment should be performed no later than 7 days from the date of admission.

*Substance Use Disorder (SUD):* For substance abuse treatment, a written assessment must be performed that documents the risk rating across all six dimensions in the ASAM Criteria to determine the appropriate level of care. The assessment must be conducted in a manner that is sensitive to a history of possible sexual abuse or domestic violence and should not lead to retraumatization. All residential programs must have written admission, continuing care, and discharge criteria.

For short-term residential or withdrawal management programs, the written assessment should be completed by the end of the 4th day and, for long-term programs, by the end of the 15th day.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* For therapeutic community residences, treatment and aftercare planning is required. The treatment plan is based on the comprehensive assessment that is completed within 7 days of admission. The residence shall ensure that the treatment plan reflects steps to be taken to solve identified problems, either by direct service at the residence or indirectly by referral to a community resource. The treatment plan shall be completed within fourteen days of admission. The aftercare plan shall include the resident's goal for a reasonable period following discharge; a description of the services to be



provided by the residence and outside services during the aftercare period; the procedure the resident is to follow in maintaining contact with the residence in times of crisis; and the frequency with which the residence will attempt to contact the resident for purposes of follow-up.

*Substance Use Disorder (SUD):* If the person remains in residential treatment or withdrawal management beyond five days, a person-centered treatment plan must be completed by the end of the 5th working day. Updates to the treatment plan should be recorded when there are significant changes in a person's life; there are changes to the treatment modality, frequency and/or amount of treatment services; and/or there is a transition between levels of care. Discharge/aftercare planning is required. Persons served must participate in the development of their aftercare plans as early as possible in the person-centered treatment planning and service delivery process.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Therapeutic community residences are required to provide, either on-site or by referral: (1) Family counseling services; (2) Educational services; (3) Legal services; (4) Employment services; (5) Vocational rehabilitation services; and (6) Medical or psychiatric services, or both.

*Mental Health (MH):* Designated agencies are required to provide or contract for comprehensive services. Residential treatment is not specifically mentioned but could be considered to fall within the range of those services. Services required of a specialized service agency will depend on the nature of the specialty.

*Substance Use Disorder (SUD):* Service delivery models and strategies should be based on accepted practice in the field and incorporate current research, evidence-based practice, peer-reviewed publications, clinical practice guidelines, and/or expert professional consensus. All levels of care must offer a pregnancy test to women before initiation of pharmacological intervention, and must provide services in a trauma-informed, gender-responsive environment.

For ASAM Level 3.2-WM, Clinically Managed Residential Withdrawal Management Substance Use Disorder Treatment Services, programs must be able to justify the clinical necessity of services to include: (1) Specialized clinical consultation and supervision for biomedical, emotional, behavioral, and cognitive problems; (2) affiliations with other levels of care; and (3) the ability to arrange for appropriate laboratory and toxicology tests. The program must have protocols in place should a client's condition deteriorate and appear to need medical or nursing interventions. The program must offer the following therapies: (1) A range of cognitive, behavioral, medical, mental health, and other services on an individual or group basis that enhance the client's understanding of addiction, the completion of the withdrawal management process (if necessary), and referral to an appropriate level of care for continuing treatment; (2) Interdisciplinary individualized assessment and treatment; (3) Health education

services associated with the course of addiction and other potential health-related risk factors as appropriate (e.g. HIV, hepatitis C, sexually transmitted diseases); and (4) Services to families and significant others.

For ASAM Level 3.7-WM, Medically Monitored Inpatient Withdrawal Management Substance Use Disorder Treatment Services, programs must be able to justify the clinical necessity of services to include: (1) Specialized clinical consultation and supervision for biomedical, emotional, behavioral, and cognitive problems; (2) The availability of medical nursing care and observation as warranted, based on clinical judgment; (3) Direct affiliations with other levels of care; and (4) The ability to arrange for appropriate laboratory and toxicology tests. The program also must have protocols in place should a client's condition deteriorate and appear to need medical or nursing interventions. The program must offer the following therapies: (1) A range of cognitive, behavioral, medical, mental health, and other services on an individual or group basis that enhance the client's understanding of addiction, the completion of the withdrawal management process (if necessary), and referral to an appropriate level of care for continuing treatment; (2) Multidisciplinary individualized assessment and treatment; (3) Health education services associated with the course of addiction and other potential health-related risk factors as appropriate (e.g. HIV, hepatitis C, sexually transmitted diseases); and (4) Services to families and significant others.

For ASAM Level 3.1, Clinically Managed Low-Intensity Residential Substance Use Disorder Treatment Services, programs must be able to justify the clinical necessity of services to include: (1) Telephone or in-person consultation with a physician (or physician extender) and emergency services, available 24 hours a day, seven days a week; (2) Direct affiliations with other levels of care, or close coordination through referral to more and less intensive levels of care and other services; (3) The ability to arrange for needed procedures (including laboratory and toxicology tests) as appropriate to the severity and urgency of the client's condition; and (4) The ability to arrange for pharmacotherapy for psychiatric or anti-addiction medications. The program must offer the following therapies: (1) Services designed to improve the client's ability to structure and organize the tasks of daily living and recovery; (2) Planned clinical program activities (constituting at least five hours per week of professional directed treatment) designed to stabilize and maintain stability of the client's substance use disorder symptoms, and to help develop and apply recovery skills; (3) Addiction pharmacotherapy; (4) Random drug screening to monitor and reinforce treatment gains, as appropriate to the client's person-center treatment plan; (5) Motivational enhancement and engagement strategies appropriate to the client's stage of readiness to change; (6) Counseling and clinical monitoring; (7) Health education services associated with the course of addiction and other potential health-related risk factors as appropriate (e.g. HIV, hepatitis C, sexually transmitted diseases); (8) Regular monitoring of the client's medication adherence; (9) Recovery support services; (10) Services for the client's family and significant others, as appropriate; and (11) Opportunities for the client to be introduced to the potential benefits of addiction pharmacotherapies as a tool to manage their addictive disorder.

For ASAM Level 3.3, Clinically Managed High-Intensity Residential Substance Use Disorder Treatment Services, programs must be able to justify the clinical necessity of services to include: (1) Telephone or in-person consultation with a physician (or physician extender) and emergency services, available 24 hours a day, seven days a week; (2) Have direct affiliations with other levels of care, or close coordination through referral to more and less intensive levels of care and other services; and (3) Medical, psychiatric, psychological, laboratory, and toxicology services, available through consultation or referral, as appropriate to the severity and urgency of the client's condition. The program must offer the following therapies: (1) Daily clinical services to improve the client's ability to structure and organize the tasks of daily living and recovery; (2) Planned clinical program activities designed to stabilize and maintain stability of the client's substance use disorder symptoms, and to help develop and apply recovery skills; (3) Random drug screening to monitor and reinforce treatment gains, as appropriate to the client's person-center treatment plan; (4) A range of cognitive, behavioral, and other therapies on an individual or group basis, medication education and management, educational groups, and occupational or recreational activities; (5) Counseling and clinical monitoring to assist the client with successful initial involvement or reinvolverment in regular, productive daily activity and, as indicated, successful reintegration into family living; (6) Health education services associated with the course of addiction and other potential health-related risk factors as appropriate (e.g. HIV, hepatitis C, sexually transmitted diseases); (7) Regular monitoring of the client's medication adherence; (8) Daily scheduled professional addiction and mental health treatment services designed to develop and apply recovery skills; (9) Planned community reinforcement designed to foster prosocial values and milieu or community living skills; (10) Clinical and didactic motivational interventions appropriate to the client's stage of readiness to change, designed to facilitate the client's understanding of the relationship between their substance use disorder and attendant life issues; and (11) Services for the client's family and significant others, as appropriate.

For ASAM Level 3.5, Clinically Managed High-Intensity Residential Substance Use Disorder Treatment Services, programs must be able to justify the clinical necessity of services to include: (1) Telephone or in-person consultation with a physician (or physician extender) and emergency services, available 24 hours a day, seven days a week; (2) Have direct affiliations with other levels of care, or close coordination through referral to more and less intensive levels of care and other services; and (3) Arranged medical, psychiatric, psychological, laboratory, and toxicology services, as appropriate to the severity and urgency of the client's condition. The program must offer the following therapies: (1) Daily clinical services to improve the client's ability to structure and organize the tasks of daily living and recovery, and to develop and practice prosocial behaviors; (2) Planned clinical program activities designed to stabilize and maintain stability of the client's substance use disorder symptoms, and to help develop and apply recovery skills; (3) Random drug screening to shape behavior and reinforce treatment gains, as appropriate to the client's person-center treatment plan;(4) A range of evidence-based cognitive, behavioral, and other therapies on an individual or group basis, medication education and management, addiction pharmacotherapy, educational skill building groups, and occupational or recreational activities; (5) Counseling and clinical monitoring to promote successful initial involvement or reinvolverment in regular, productive daily activity

and, as indicated, successful reintegration into family living; (6) Motivational enhancement and engagement strategies appropriate to the client's stage of readiness to change; (7) Counseling and clinical interventions to facilitate teaching the client the skills needed for productive daily activity and, as indicated, successful reintegration into family living; (8) Health education services associated with the course of addiction and other potential health-related risk factors as appropriate (e.g. HIV, hepatitis C, sexually transmitted diseases); (9) Monitoring of the client's medication adherence; (10) Planned clinical activities to enhance the client's understanding of substance use and/or mental health disorders; (11) Daily scheduled professional addiction and mental health treatment services, designed to develop and apply recovery skills; (12) Planned community reinforcement designed to foster prosocial values and milieu or community living skills; and (13) Services for the client's family and significant others, as appropriate.

For ASAM Level 3.7, Medically Monitored Intensive Inpatient Residential Substance Use Disorder Treatment Services, programs must be able to justify the clinical necessity of services to include: (1) Physician monitoring, nursing care, and observation are available. A physician (or physician extender) is available to assess the client in person within 24 hours of admission and thereafter as medically necessary; (2) A registered nurse conducts an alcohol or other drug-focused nursing assessment at the time of admission; (3) Additional medical specialty consultation, psychological, laboratory, and toxicology services are available on-site, through consultation or referral; (4) Coordination of necessary services or other levels of care are available through direct affiliation or referral processes; (5) Psychiatric services are available on-site through consultation or referral when a presenting issue could be attended to at a later time. Such services are available within 8 hours by telephone or 24 hours in person. The program must offer the following therapies: (1) Daily clinical services (provided by an interdisciplinary treatment team) assess and address the client's individual needs; (2) Planned clinical program activities designed to stabilize the acute addictive and/or psychiatric symptoms and are adapted to the client's level of comprehension; (3) Counseling and clinical monitoring to promote successful initial involvement or reinvolved in, and skill building for, regular, productive daily activity and, as indicated, successful reintegration into family living; (4) Random drug screening to monitor drug use and reinforce treatment gains, as appropriate to the client's person-center treatment plan; (5) A range of evidence-based cognitive, behavioral, and other therapies on an individual or group basis, medication education and management, addiction pharmacotherapy, educational skill building groups, and occupational or recreational activities; (6) Regular monitoring of the client's medication adherence; (7) Planned clinical activities to enhance the client's understanding of substance use and/or mental health disorders; (8) Daily scheduled professional addiction and mental health treatment services, designed to develop and apply recovery skills; (9) Planned community reinforcement designed to foster prosocial values and milieu or community living skills; (10) Health education services associated with the course of addiction and other potential health-related risk factors as appropriate (e.g. HIV, hepatitis C, sexually transmitted diseases); (11) Evidence-based practices, such as motivational enhancement strategies and interventions appropriate to the client's stage of readiness to change, designed to facilitate the client's understanding of the relationship between substance use disorder and attendant life issues; (12) Daily treatment

services to manage acute symptoms of the client's biomedical, substance use, and/or mental health disorder; and (13) Services for the client's family and significant others, as appropriate.

## **Patient Rights and Safety Standards**

*Mental Health (MH) and Substance Use Disorder (SUD):* For therapeutic community residences, patients shall have the right to complain or file a grievance. The programs are required to file reports related to critical incidents with the licensing agency. Among other rights, residents have rights related to freedom from abuse, corporal punishment, seclusion or restraint. Residents of secure residential recovery facilities have, among others, the right to an attending physician. A secure residential facility shall report to the Department of Mental Health instances of death or serious bodily injury to individuals with a mental condition or psychiatric disability in the custody or temporary custody of the Commissioner.

*Mental Health (MH):* For all designated agencies serving adults with behavioral health needs, the agency must have a written policy assuring the rights of all service recipients consistent with DDMHS Community Rehabilitation and Treatment (CRT) Guidelines for adults who are severely mentally ill. All agency programs must no less than annually inform recipients of their rights and responsibilities to include as the right to voice complaints or lodge an appeal without recrimination. The agency shall have a written policy and procedures for complaints, grievances and appeals, and for the dissemination of information on dispute resolution to all recipients, consistent with AHS and DDMHS policies and regulations.

*Substance Use Disorder (SUD):* For substance abuse treatment services, providers must implement procedures that conform to ADAP's grievance policy and must implement policies and procedures by which the persons served may file a formal grievance. Providers must also maintain documentation of the grievance, the results of the investigation and the final resolution, and must conduct annual reviews of the grievances to determine trends, areas in need of improvement; and actions to be taken on noted trends and need for improvement. Residents shall be free from seclusion or restraints.

## **Quality Assurance or Improvement**

*Mental Health (MH):* For all designated agencies, a written description of the QI program that clearly defines the QI structure and procedures and assigns responsibility to appropriate individuals for maintaining service quality is required. An annual update of the QI plan that reflects the use of agency data and outcomes and includes changes in the objectives, timelines, scope and planned projects or activities for the year, monitors the previous year's issues, and evaluates the QI program is also required for operation.

*Substance Use Disorder (SUD):* The provider must be actively engaged in quality improvement and demonstrate the ability to use outcomes from all levels of its operations to inform decision-making and improve service delivery. The Provider must maintain and implement a quality improvement plan and documents actions toward the areas shown to need improvement. Evidence of continuous quality improvement should be available.

## **Governance**

*Mental Health (MH):* All designated agencies must be governed by a board made up of citizens who are representative of the demographic makeup of the area served by the agency. The agencies are advised by the State Program Standing Committee for the DDMHS population(s) served by the agency. Policies and procedures are required.

*Substance Use Disorder (SUD):* The Preferred Provider has a leadership and governance structure. The Provider identifies those responsible for leadership and governance. Governance is ultimately responsible for the safety and quality of care, treatment, or services. Governance works with leadership to annually evaluate the Provider's performance in relation to its mission, vision and goals. Policies and procedures are required.

## **Special Populations**

*Mental Health (MH):* Specialized service agencies may be identified by the state to address specific service needs within the population.

*Substance Use Disorder (SUD):* In addition to requirements regarding access under section 2c, for substance abuse treatment services, there should be compliance with a 48-hour time limit within which screening and eligibility determination for pregnant woman is identified and shared with those seeking services and/or the referring agency as clinically appropriate. There should be referral to ADAP when the Provider has insufficient capacity to provide services to any pregnant women who seek the services from the Provider. Any Provider refusing services to a pregnant woman due to insufficient capacity must refer those people to ADAP's Clinical Services Director within 48 hours.

For programs that serve people who use substances intravenously, preference to treatment is given as follows: pregnant women who use substances intravenously; pregnant women who use substances; people who use substances intravenously; all other people who use substances.

With respect to pregnant women and women with dependent children, including women who are attempting to regain custody of their children, the program will treat the family as a unit and will provide or arrange for the following services:

- Primary medical care for women, including referral for prenatal care and, while the women are receiving such services, childcare.
- Primary pediatric care for their children including immunizations.
- Gender specific substance abuse treatment and other therapeutic interventions for women which may address issues of relationships; sexual and physical abuse and parenting, and childcare while the women are receiving these services.
- Therapeutic interventions for children in the custody of women in treatment which may address amongst other things their developmental needs, and their issues of sexual and physical abuse and neglect.
- Sufficient case management and transportation services to ensure that women and their children have access to the above services.

## Location of Regulatory and Licensing Requirements

Intensive Residential Recovery Statute, 18 VSA 7252<sup>1</sup>. Department of Health, Alcohol and Drug Abuse Programs<sup>2</sup>; ADAP Preferred Providers SUD Treatment Standards<sup>3</sup> (August 1, 2018). Vermont Department of Disabilities, Aging and Independent Living's Division of Licensing and Protection, CVR 13.110.012<sup>4</sup>; Vermont Department of Disabilities, Aging and Independent Living Designated Agency Rules, CVR 13-150-006<sup>5</sup>; Statute re Mental Health Insurance

<sup>1</sup> See <https://advance.lexis.com/documentpage/?pdmfid=1000516&crd=c8b298f3-09cb-4aab-bcd2-490f88dfb622&nodeid=ABDAAIAADAAC&nodepath=%2FROOT%2FABD%2FABDAAI%2FABDAAIAAD%2FABDAAIAADAAC&level=4&haschildren=&populated=false&title=%C2%A7+7252.+Definitions&config=00JAA0NzU3MGY5Yy1iNzAxLTQ3ZDUtODIIMy1iYjg4Y2IzOGNjNGIKAFBvZENhdGFsb2eitsnnFjQC4nRx7kbtY&pddocfullpath=%2Fshared%2Fdocument%2Fstatutes-legislation%2Furn%3AcontentItem%3A5PJ4-R9P0-004G-G1P0-00008-00&ecomp=gg18kkk&prid=6d10a297-827b-48d3-b9ce-cf5bfe3112f3>.

<sup>2</sup> See [https://www.healthvermont.gov/sites/default/files/documents/2016/12/REG\\_substance-abuse-treatment-certification.pdf](https://www.healthvermont.gov/sites/default/files/documents/2016/12/REG_substance-abuse-treatment-certification.pdf).

<sup>3</sup> See [https://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP\\_PREFERRED\\_PROVIDERS\\_SUD\\_TREATMENT\\_STANDARDS\\_2018\\_8\\_1.pdf](https://www.healthvermont.gov/sites/default/files/documents/pdf/ADAP_PREFERRED_PROVIDERS_SUD_TREATMENT_STANDARDS_2018_8_1.pdf).

<sup>4</sup> See <https://advance.lexis.com/documentpage/?pdmfid=1000516&crd=85d310a1-66d4-466b-a748-2040bfc59e6b&config=00JAA3YmIxY2M5OC0zYmJlLTQ4ZjMtYjY3Yi02ODZhMTViYWUzMmEKAFBvZENhdGFsb2dfKuGXoJFNHkuKZG9Oqaal&pddocfullpath=%2Fshared%2Fdocument%2Fadministrative-codes%2Furn%3AcontentItem%3A5WND-G5X0-00C2-90C0-00008-00&pddocid=urn%3AcontentItem%3A5WND-G5X0-00C2-90C0-00008-00&pdcontentcomponentid=234125&pdteaserkey=sr14&pditab=allpods&ecomp=gss8kkk&earg=sr14&prid=1d5f61c-92ac-4cb1-ab5c-e939a967dc67>.

<sup>5</sup> See <https://advance.lexis.com/documentpage/?pdmfid=1000516&crd=1f79b7ad-9668-492b-be50-46869a4e493f&config=00JAA3YmIxY2M5OC0zYmJlLTQ4ZjMtYjY3Yi02ODZhMTViYWUzMmEKAFBvZENhdGFsb2dfKu>

Reimbursement, 8 VSA 4089d<sup>6</sup>; Regulations re Qualified Mental Health Facilities, CVR 13-15-002<sup>7</sup>; CVR 13-150-005<sup>8</sup>; Green Mountain Care Board CON website<sup>9</sup>; Vermont CON statute<sup>10</sup>; Vermont CON regulations<sup>11</sup>. Regulatory data collected August 2, 2019.

## Other Information Sources

M. Fox, C. McBain (DMH), M. Mitchell (ADAP); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>6</sup> See <https://legislature.vermont.gov/statutes/section/08/107/04089d>.

<sup>7</sup> See <https://advance.lexis.com/documentpage/?pdmfid=1000516&crd=c4727738-fce5-4dea-b39e-525e2756cf07&nodeid=AAIAAMAABAAB&nodepath=%2FROOT%2FAAI%2FAAIAAM%2FAAIAAMAAB%2FAAIAAMAABAAB&level=4&haschildren=&populated=false&title=13+150+002.+Designation+as+Qualified+Mental+Health+Facilities&config=00JAA3YmIxY2M5OC0zYmJlLTQ4ZjMtYjY3Yi02ODZhMTViYWUzMmEKAFBvZENhdGFsb2dfKuGXoJFNHKuKZG9Oqaal&pddocfullpath=%2Fshared%2Fdocument%2Fadministrative-codes%2Furn%3AcontentItem%3A5WND-G5Y0-00C2-90FP-00008-00&ecomp=gg18kkk&prid=3f416692-f9af-4076-8ae8-009916ca1f6e>.

<sup>8</sup> See <https://advance.lexis.com/documentpage/?pdmfid=1000516&crd=08b6271d-fd94-41d5-913a-9790370612e2&nodeid=AAIAAMAADAAB&nodepath=%2FROOT%2FAAI%2FAAIAAM%2FAAIAAMAAD%2FAAIAAMAADAAB&level=4&haschildren=&populated=false&title=13+150+005.+Mental+Health+Facilities+Qualified+For+Health+Insurance&config=00JAA3YmIxY2M5OC0zYmJlLTQ4ZjMtYjY3Yi02ODZhMTViYWUzMmEKAFBvZENhdGFsb2dfKuGXoJFNHKuKZG9Oqaal&pddocfullpath=%2Fshared%2Fdocument%2Fadministrative-codes%2Furn%3AcontentItem%3A5WND-G600-00C2-90FS-00008-00&ecomp=gg18kkk&prid=3f416692-f9af-4076-8ae8-009916ca1f6e>.

<sup>9</sup> See <https://gmcboard.vermont.gov/con>.

<sup>10</sup> See <https://legislature.vermont.gov/statutes/section/18/221/09434>.

<sup>11</sup> See <https://gmcboard.vermont.gov/sites/gmcb/files/files/resources/rules/12%2012%2014%20CON%20Rule.pdf>.



# VERMONT MEDICAID

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

## Approach

*Mental Health (MH) and Substance Use Disorder (SUD):* The Vermont Agency of Human Services (AHS) oversees the state Medicaid program. Vermont does not rely on the in lieu of provision or on Disproportionate Share Hospital (DSH) payments for Medicaid coverage of any services in institutions for mental diseases (IMD) services.

*Mental Health (MH):* The Section 1115 SMI waiver authorized expenditures for Medicaid state plan services--furnished to eligible individuals who are primarily receiving short-term treatment for a serious mental illness (SMI) in facilities that meet the definition of an IMD. The waiver only makes FFP available for services provided to beneficiaries during short term stays for acute care in IMDs. The state may claim FFP for stays up to 60 days as long as it shows at its midpoint assessment that it is meeting the requirement of a 30 day or less average length of stay (ALOS). Stays in IMDs that exceed 60 days are not eligible for FFP under this demonstration. If the state cannot show that it is meeting the 30 day or less ALOS requirement within one standard deviation at the mid-point assessment, the state may only claim FFP for stays up to 45 days until such time that the state can demonstrate that it is meeting the 30 day or less ALOS requirement. The state will provide coverage for stays that exceed 60 days--or 45 days, as relevant--with other sources of funding if it is determined that a longer length of stay is medically necessary for an individual beneficiary.

*Substance Use Disorder (SUD):* The Section 1115 SUD waiver authorizes expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an IMD.

## Types of Facilities

*Mental Health (MH):* The Section 1115 SMI waiver authorized expenditures for Medicaid state plan services, which include:

- Improved availability of crisis stabilization services including services provided during acute short-term stays in residential crisis stabilization programs and residential treatment settings throughout the state.

*Substance Use Disorder (SUD)*: Pursuant to the Section 1115 waiver, Medicaid covers residential treatment services that are furnished to eligible individuals who are primarily receiving short-term treatment for SUD in facilities that meet the definition of an IMD. Facility types include the following:

- Level 3.1 Clinically managed low-intensity residential treatment services.
- Level 3.2-WM Clinically managed residential withdrawal.
- Level 3.3. and 3.5: Vermont supports several residential programs to provide clinically managed, high-intensity residential services as well as withdrawal management services.
  - Level 3.3. Clinically Managed Population-Specific High Intensity Residential Services: High-intensity clinical services.
  - Level 3.5 Clinically managed high-intensity residential services: High-intensity services for persons who cannot be treated in less intensive levels.
- Level 3.7 Medically monitored intensive inpatient services provided in residential settings.
- Level 3.7-WM Medically monitored inpatient withdrawal management.

All of Vermont's residential programs are required to provide access to medication-assisted treatment (MAT) services as clinically necessary.

## **Processes of Medicaid Enrollment**

*Mental Health (MH) and Substance Use Disorder (SUD)*:

- To participate in and receive reimbursement from Vermont Medicaid Programs, providers must be enrolled. Licensed or certified health care providers may be enrolled as Vermont Medicaid providers if at least one service they provide is recognized in the Vermont Medicaid State Plan. Enrollment requires that the provider submit applicable enrollment forms, a signed General Provider Agreement, and a copy of the applicable license/certification document and meet all federal and state requirements.

*Mental Health (MH)*:

- Pursuant to the Section 1115 waiver, participating residential treatment providers must be licensed, or otherwise authorized, by the state to primarily provide treatment for mental illnesses. They must also be accredited by a nationally recognized accreditation entity prior to the state claiming FFP for services provided to beneficiaries residing in a residential facility that meets the definition of an IMD.

- The waiver also requires that there shall be the establishment of an oversight and auditing process that includes unannounced visits for ensuring participating residential treatment settings meet state licensure or certification requirements as well as a national accrediting entity's accreditation requirements. Additionally, there shall be the establishment of a process for ensuring that participating residential treatment settings meet federal program integrity requirements and establishment of a state process to conduct risk-based screening of all newly enrolling providers, as well as revalidating existing providers.

*Substance Use Disorder (SUD):*

- According to the SUD implementation plan, for Preferred Providers to maintain specialty OUD/SUD provider certification in Vermont, they must pass compliance and quality audits conducted by ADAP. These audits are performed every one to three years on all Preferred. The period between audits is determined by the audit results.

## **Staffing**

*Mental Health (MH):* Requirements regarding residential services were not explicitly described in the state Medicaid regulations or 1115 waiver.

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding credentials of staff for residential treatment settings. The state must conduct an assessment of the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT. The SUD implementation plan specifies the following for three of the SUD levels of care:

- Level 3.3. and 3.5: These programs must have access to psychiatric and mental health professionals.
- Level 3.7 Medically monitored intensive inpatient services provided in residential settings: there shall be 24-hour nursing care with physician availability and 16 hour/day counselor availability. This program must have on-site psychiatric services.

## **Placement**

*Mental Health (MH):* The Section 1115 waiver requires that participating residential treatment settings screen enrollees for co-morbid physical health conditions and substance use disorders (SUDs).

In an effort to improve access to the continuum of care including crisis stabilization services, the state is to implement a requirement that providers, plans, and utilization review entities use an evidence-based, publicly available patient assessment tool, preferably endorsed by a mental health provider association (e.g., LOCUS or CASII) to determine appropriate level of care and length of stay.

*Substance Use Disorder (SUD):* In accordance with the state 1115 waiver, there shall be the establishment of a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other comparable assessment and placement tools that reflect evidence-based clinical treatment guidelines; as well as a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings.

According to the SUD implementation plan, all of Vermont's certified OUD/SUD providers (Preferred Providers) are required to use evidence-based screening tools, perform a comprehensive assessment which includes elements specified by the state, and utilize ASAM criteria to determine level of care. Vermont ensures that individuals are appropriately placed in residential programs and inpatient detoxification through the process of concurrent review and prior authorization. Residential programs are required to screen and assess appropriateness of admission. All programs utilize the Addiction Severity Index (ASI) multi-dimensional assessment tool. Within 24 hours or next business day of admission, the Medicaid Utilization Management (UM) unit should be notified. By the end of the fifth day, the residential programs should send the ASI results and other clinical information to the UM team for concurrent review and authorization. The UM team uses the nationally recognized McKesson Interqual® decision support tool to determine continued authorization.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH):* In accordance with the state 1115 waiver, residential treatment settings must have protocols in place to ensure contact is made by the treatment setting with each discharged beneficiary within 72 hours of discharge and to ensure follow-up care is accessed by individuals after leaving those facilities by contacting the individuals directly and by contacting the community-based provider they were referred to.

*Substance Use Disorder (SUD):* According to the SUD implementation plan, Vermont's Preferred Provider Substance Use Disorder Treatment Standards include discharge planning expectations for all levels of care. Aftercare planning starts as early as possible in the person-centered treatment planning and service delivery process.

## Treatment Services

*Mental Health (MH):* The Section 1115 waiver requires that participating residential treatment settings demonstrate the capacity to address co-morbid physical health conditions during short-term stays in residential or inpatient treatment settings (e.g., with on-site staff, telemedicine, and/or partnerships with local physical health providers).

*Substance Use Disorder (SUD):* Under the Section 1115 waiver, the state must establish residential treatment program standards regarding in particular the types of services and hours of clinical care for residential treatment settings. Under the Section 1115 waiver, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and behavioral health conditions. There shall be the establishment of a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site.

Pursuant to the SUD implementation plan, services include:

- Level 3.1 Clinically managed low-intensity residential treatment services: At least 5 hours of clinical service/week.
- Level 3.3. and 3.5: Clinically managed, high-intensity residential services as well as withdrawal management services. This includes women-only, co-ed and specialized programs for adolescents and one for pregnant women and mothers with children under the age of five. These programs have access to psychiatric and mental health professionals for consultation and can provide care for individuals with co-occurring needs.
- Level 3.3. Clinically Managed Population-Specific High Intensity Residential Services: 24-hour structure, high-intensity clinical services; less intense milieu; and group treatment for those with cognitive or other impairments.
- Level 3.5 Clinically managed high-intensity residential services: 24-hour care, high-intensity services for persons who cannot be treated in less intensive levels in order to stabilize multi-dimensional needs and/or safety issues.
- Level 3.7 Medically monitored intensive inpatient services provided in residential settings: 24-hour nursing care with physician availability, and on-site psychiatric services and care to individuals with a wide range of co-occurring conditions, including MAT.

## Care Coordination

*Mental Health (MH) and Substance Use Disorder (SUD):* Under the Section 1115 waiver, beneficiaries will have improved care coordination and care for comorbid physical and behavioral health conditions.

*Mental Health (MH):* In accordance with the state 1115 waiver, there shall be the implementation of a process to ensure that residential treatment facilities provide intensive pre-discharge, care coordination services to help beneficiaries transition out of those settings into appropriate community-based outpatient services, including requirements that community-based providers participate in transition efforts. Providers must implement a process to assess the housing situation of a beneficiary transitioning to the community from residential treatment settings and to connect beneficiaries who are homeless or who have unsuitable or unstable housing with community providers that coordinate housing services, where available.

*Substance Use Disorder (SUD):* Under the Section 1115 waiver, the state must ensure the establishment and implementation of policies to ensure residential facilities link beneficiaries with community-based services and supports following stays in these facilities.

According to the SUD implementation plan, ADAP continues to improve coordination between the Hub and Spoke providers and specialty substance use disorder treatment providers (residential) through referral protocols, care coordination, covered benefits, information sharing, etc.

## Quality Assurance or Improvement

*Mental Health (MH):* Pursuant to the Section 1115 waiver, the state is to establish a process to annually assess the availability of mental health services throughout the state, particularly crisis stabilization services, and provide updates on steps taken to increase availability. The state will implement strategies to improve the state's capacity to track the availability of crisis stabilization beds to help connect individuals in need with that level of care as soon as possible.

*Substance Use Disorder (SUD):* In accordance with the state 1115 waiver, there shall be the establishment of a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings.

## Special Populations

*Mental Health (MH)*: Requirements regarding residential services were not explicitly described in the state Medicaid regulations or 1115 waiver, other than to provide services for co-occurring physical health conditions.

*Substance Use Disorder (SUD)*: Vermont has residential facilities that are women-only, co-ed and specialized programs for pregnant women and mothers with children under the age of five. They can provide care for people with co-occurring needs.

## Location of Medicaid Requirements

Vermont Statutes Title 33, Human Services; Part 2, Economic Assistance; Chapter 19, Medical Assistance<sup>12</sup>; Vermont Health Care Administrative Rules<sup>13</sup>; Vermont Global Commitment to Health Section 1115 waiver<sup>14</sup>. Regulatory data collected January 4, 2020.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report “**State Residential Treatment for Behavioral Health Conditions: Regulation and Policy**”. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

<sup>12</sup> See <https://advance.lexis.com/container/?pdmfid=1000516&crd=ad60fb0d-d65f-4f1b-9ced-453495c449ea&func=LN.Advance.ContentView.getFullToc&nodeid=ROOT&typeofentry=Breadcrumb&config=00JABIZig3NDE5OS1mMmJLTQ3MWMtYjAxYy1lYjc3NmM1ZTIjOGUKAFBvZENhdGFsb2cij1bfBuS6Ez3oYHkLGCJ1&action=publictoc&pddocfullpath=%2Fshared%2Fdocument%2Fstatutes-legislation%2Furn%3AcontentItem%3A5PJ4-R9P0-004G-G1P0-00008-00&pdtoctofullpath=%2Fshared%2Ftableofcontents%2Furn%3AcontentItem%3A50XG-R101-DY40-C000-00008-00&ecom=9s-fkkk&prid=30f8109a-5102-47d5-9bea-895f706281db>.

<sup>13</sup> See <https://humanservices.vermont.gov/rules-policies/health-care-rules/health-care-administrative-rules-hcar/adopted-rules>.

<sup>14</sup> See <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=8644>.

## VIRGINIA

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

### Types of Facilities

*Mental Health (MH):* Virginia regulates:

- *Residential crisis stabilization services*, which: (i) provide short-term, intensive treatment to nonhospitalized individuals who require multidisciplinary treatment in order to stabilize acute psychiatric symptoms and prevent admission to a psychiatric inpatient unit; (ii) provide normative environments with a high assurance of safety and security for crisis intervention; and (iii) mobilize the resources of the community support system, family members, and others for ongoing rehabilitation and recovery.
- *Community gero-psychiatric residential services*, which is 24-hour care provided to individuals with mental illness, behavioral problems, and concomitant health problems who are usually age 65 or older in a setting that is less intensive than a psychiatric hospital but more intensive than a nursing home or group home.

*Substance Use Disorder (SUD):* Virginia regulates:

- *Medically managed withdrawal services*, which means detoxification services to eliminate or reduce the effects of alcohol or other drugs in the individual's body.
- *Medical detoxification*, which is a service provided in a hospital or other 24-hour care facility under the supervision of medical personnel using medication to systematically eliminate or reduce effects of alcohol or other drugs in the individual's body.
- *Substance abuse residential treatment for women with children service*, which is a 24-hour residential service providing an intensive and highly structured substance abuse service for women with children who live in the same facility.

*Unregulated Facilities:* There are no unregulated residential treatment facilities in Virginia. We exclude categories of residential services that are not residential treatment services, because they do not incorporate clinical services within the scope of this summary.



## Approach

The Virginia Department of Behavioral Health and Developmental Services (DBHDS) regulates and licenses all residential treatment providers in the state.

## Processes of Licensure or Certification and Accreditation

*Mental Health (MH) and Substance Use Disorder (SUD):* Licensure by the DBHDS is required for all residential treatment facilities. The focus of the application is primarily on finances and ability to meet regulatory standards.

- Accreditation is not required.
- An on-site review is required for licensure to demonstrate compliance with regulations.
- A Certificate of Need is required for intermediate care facilities, excluding some for individuals with intellectual disability. This explicitly includes intermediate care facilities established primarily for the medical, psychiatric or psychological treatment and rehabilitation of individuals with substance abuse.
- Full licensure duration is up to three years, with the length of the license at the discretion of the commissioner depending on level of compliance with all regulations. A conditional license may be issued to a new provider for up to six months, renewable for a total of 12 months. A provisional license may be issued for up to 6 months to a provider for a service that has demonstrated an inability to maintain compliance, has violations of human rights or licensing regulations that pose a threat to the health or safety of individuals receiving services, has multiple violations of human rights or licensing regulations, or has failed to comply with a previous corrective action plan.

## Cause-Based Monitoring

*Mental Health (MH) and Substance Use Disorder (SUD):* The DBHDS may conduct unannounced onsite reviews of licensed providers and each service at any time and at least annually to determine compliance with the regulations. The annual unannounced onsite reviews are focused on preventing specific risks to individuals, including an evaluation of the physical facilities in which the services are provided. The department also may conduct announced and unannounced onsite reviews at any time as part of the investigations of complaints or incidents. If there is noncompliance with any applicable regulation during an initial or ongoing review, inspection, or investigation, the department shall issue a licensing report describing the noncompliance and requesting the provider to submit a corrective action plan. The provider must submit to the department and implement a written corrective action plan. The provider

must implement and monitor the approved corrective action plan and incorporate corrective actions in its activities improvement program.

## **Access Requirements**

*Mental Health (MH) and Substance Use Disorder (SUD):* Wait-time requirements were not found. All residential services must ensure that the physical environment shall be accessible to individuals with physical and sensory disabilities, if applicable. There are additional physical access requirements applicable to Community Gero-Psychiatric Residential Services.

## **Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD):* All residential facilities must conduct background checks, maintain written job descriptions and personnel files, and documented performance evaluations. Staff must meet the minimum qualifications required in their written job descriptions. Orientation training is required that includes, among other topics, confidentiality, person-centeredness, infection-control, patient rights, and incident reporting. On-going training is required to be documented. Staffing must be such that there is always staff present trained in CPR and First Aid. There are supplemental requirements related to students and volunteers. All facilities must have a staffing plan that includes, among other things, plans for employee supervision and how the facility will be staffed to meet resident needs.

*Mental Health (MH):* Community gero-psychiatric residential services have requirements related to the program director, medical director, director of clinical services, and other personnel. Development of the ISP requires, at a minimum, participation of a registered nurse, a licensed psychologist, a licensed social worker, a therapist (recreational, occupational or physical therapist), a pharmacist, and a psychiatrist. Competencies are established for nursing staff.

*Substance Use Disorder (SUD):* Direct-care employees at a residential facility with medically managed withdrawal services must have training in management of withdrawal and first responder training. In detoxification service locations, at least two employees or contractors must be on duty at all times. If the location is within or contiguous to another service location, at least one employee or contractor shall be on duty at the location with trained backup employees or contractors immediately available. In other managed withdrawal settings, the number of staff on duty must be appropriate for the services offered and individuals served.

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* The provider shall admit only individuals whose service needs are consistent with the program's service description, for whom services are available, and for which staffing levels and types meet the needs of the individuals receiving services. Providers must implement policies and procedures for initial contacts and screening, admissions, and referral of individuals to other services and designate staff to perform these activities. An assessment must be initiated prior to or at admission to the service. With the participation of the individual and the individual's authorized representative, if applicable, the provider shall complete an initial assessment detailed enough to determine whether the individual qualifies for admission and to initiate an ISP for those individuals who are admitted to the service.

*Mental Health (MH):* An individual receiving community gero-psychiatric residential services shall have had a medical, psychiatric, and behavioral evaluation to determine that he/she cannot be appropriately cared for in a nursing home or other less intensive level of care but does not need inpatient care.

*Substance Use Disorder (SUD):* For medically managed withdrawal services, during the admission process, providers of managed withdrawal services must: (1) Identify individuals with a high-risk for medical complications or who may pose a danger to themselves or others; (2) Assess substances used and time of last use; (3) Determine time of last meal; (4) Administer a urine screen; (5) Analyze blood alcohol content or administer a breathalyzer; and (6) Record vital signs. No reference to use of ASAM levels of care was found in the licensure requirements. State staff indicate, however, that it is required by policy for all SUD services.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* All residential care services are required to develop and implement an Individualized Services Plan (ISP), which is a comprehensive and regularly updated written plan that describes the individual's needs, the measurable goals and objectives to address those needs, and strategies to reach the individual's goals. An initial ISP must be developed and implemented within 24 hours of admission to address immediate needs in the first 30 days. A comprehensive ISP must be developed no later than 30 days after admission. Discharge planning is required prior to the scheduled discharge date and should be consistent with discharge criteria identified in the ISP.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* The provider must develop, implement, review, and revise its descriptions of services offered according to the provider's

mission and make service descriptions available for public review. The provider must outline how each service offers a structured program of individualized interventions and care designed to meet the individuals' physical and emotional needs; provide protection, guidance and supervision; and meet the objectives of any required individualized services plan. The provider must prepare a written description of each service it offers.

*Mental Health (MH):* For community gero-psychiatric residential services, employees or contractors must regularly monitor individuals in all areas of the residence to ensure safety. Providers must provide MH, nursing and rehabilitative services; medical and psychiatric services; and pharmaceutical services for each individual as specified in the ISP. Providers must provide crisis stabilization services. Providers must implement written policies and procedures that support an active program of MH and behavioral management services directed toward assisting each individual to achieve outcomes consistent with the highest level of self-care, independence, and quality of life. Programming may be on-site or at another location in the community.

*Substance Use Disorder (SUD):* For medically managed withdrawal services, the provider shall describe the level of services and the medical management provided.

## **Patient Rights and Safety Standards**

*Mental Health (MH) and Substance Use Disorder (SUD):* Virginia regulations include many acts that are prohibited, including but not limited to, abuse and deprivation of services or health care. Restraint and seclusion are regulated and must be reported to the department. Patients are entitled to know their rights and how to make a complaint. The department must be notified of all complaints as well as critical incidents.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* All residential care services must develop and implement a quality improvement plan sufficient to identify, monitor, and evaluate clinical and service quality and effectiveness on a systematic and ongoing basis. The program must: (i) include a quality improvement plan that is reviewed and updated at least annually; (ii) establish measurable goals and objectives; (iii) include and report on statewide performance measures, if applicable, as required by DBHDS; (iv) utilize standard quality improvement tools, including root cause analysis; (v) implement a process to regularly evaluate progress toward meeting established goals and objectives; and (vi) incorporate any corrective action plans. Input from individuals receiving services and their authorized representatives, if applicable, about services used and satisfaction level of participation in the direction of service planning shall be part of the provider's quality assurance system improvement plan. The

provider must implement improvements, when indicated. The provider must review medication errors at least quarterly as part of quality assurance.

## **Governance**

*Mental Health (MH) and Substance Use Disorder (SUD):* The regulations include fiscal accountability standards. As part of licensure, the facility must provide information about the organization and the governing body.

## **Special Populations**

*Mental Health (MH) and Substance Use Disorder (SUD):* ISPs must, where relevant, address treatment for co-occurring disorders which are defined in Virginia as the presence of more than one and often several of the following disorders that are identified independently of one another and are not simply a cluster of symptoms resulting from a single disorder: mental illness, a developmental disability, SUDs, or brain injury. For residential care services, the facility's service description for substance abuse treatment services must address the timely and appropriate treatment of pregnant women with substance use disorders.

## **Location of Regulatory and Licensing Requirements**

Chapter 105 Rules and Regulations for Licensing Providers by the Department of Behavioral Health and Developmental Services<sup>1</sup>, Human Rights Regulations<sup>2</sup>. Regulatory data collected May 22, 2019.

## **Other Information Sources**

M. Steele (DBHDS); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>1</sup> See <http://dbhds.virginia.gov/assets/QMD/licensing/ch.105.full.wemergcompliance.9.01.18docx.pdf>.

<sup>2</sup> See <https://law.lis.virginia.gov/admincode/title12/agency35/chapter115/>.

# VIRGINIA MEDICAID

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

## Approach

The Virginia Department of Medical Assistance Services (DMAS) oversees the state Medicaid program. Virginia also has the Section 1115 ARTS demonstration permitting Medicaid expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD), including residential treatment. Virginia uses the in lieu of provision for Medicaid coverage of IMD services and has historically relied on Disproportionate Share Hospital (DSH) payments.

## Types of Facilities

*Mental Health (MH):* Residential MH treatment is not covered by Medicaid in Virginia excepting time-limited crisis stabilization, if the crisis stabilization services are provided in a community mental health setting that is not an IMD. This is not reimbursed if the primary diagnosis is a substance use disorder (SUD) or if the individual is an imminent danger to self or others. The goals of crisis stabilization programs are to avert hospitalization or rehospitalization, provide normative environments with a high assurance of safety and security for crisis intervention, stabilize individuals in psychiatric crisis, and mobilize the resources of the community support system and family members and others for on-going maintenance and rehabilitation.

*Substance Use Disorder (SUD):* The Section 1115 ARTS demonstration provides that any recipient receiving residential SUD services pursuant to the demonstration, regardless of the length of stay or the bed size of the facility, is a “short-term resident” of the residential facility in which they are receiving the services. Short-term residential treatment is defined as a statewide length of stay of thirty days. Facility types include the following:

- Level 3.1 Clinically Managed Low Intensity Residential Services: Supportive living environment with 24-hour staff that provides rehabilitation services to beneficiaries with an SUD diagnosis (5 or more hours of low-intensity treatment per week) when determined to be medically necessary by an ARTS Care Coordinator or a physician or medical director and in accordance with an individualized service plan.

- Level 3.3 Clinically Managed Population-Specific High Intensity Residential Services: Clinically managed therapeutic rehabilitative facility for adults with cognitive impairment including developmental delay.
- Level 3.5 Clinically Managed High Intensity Residential Services: Clinically managed therapeutic community or residential treatment facility providing high intensity services for adults or medium intensity services for adolescents.
- Level 3.7 Medically Monitored Intensive Inpatient Services: Medically monitored inpatient services in a freestanding residential facility or inpatient unit of an acute care hospital or psychiatric unit. Includes 24-hour clinical supervision.
- Withdrawal Management services shall be provided when medically necessary, among other things, as a component of the Substance Use Residential/Inpatient Services (ASAM Levels 3.3, 3.5, and 3.7).

## **Processes of Medicaid Enrollment**

*Mental Health (MH) and Substance Use Disorder (SUD):* To enroll as a Medicaid provider in Virginia, health care providers must apply to enroll and complete a provider agreement. The provider must be authorized to practice under the laws of the state in which it is licensed.

*Mental Health (MH):* Providers of community-based crisis stabilization must be licensed by the DBHDS as providers of MH nonresidential crisis stabilization.

*Substance Use Disorder (SUD):* In addition to being licensed by the DBHDS, residential SUD treatment facilities must be issued an ASAM Level of Care certification for Levels 3.1, 3.3, 3.5, and/or 3.7. Specific processes were implemented to verify that ARTS providers deliver care consistent with the ASAM Criteria. Among other things, these self-attestation to DMAS; site visits by a DMAS-contracted vendor to certify residential treatment providers as ASAM Level 3.1, 3.3, 3.5 and/or 3.7 programs; and provision of information related to certification to the MCOs and the DMAS FFS contractor to become credentialed. Medicaid regulations now define service structure and provider requirements consistent with the ASAM Criteria. The contracts for the MCO and DMAS FFS contractor have been modified to reference these regulations and reflect the ASAM Criteria within provider credentialing and networking requirements. The ASAM certification process will transition to the DBHDS upon promulgation of licensing regulations to incorporate the ASAM Criteria into regulations.

## Staffing

*Mental Health (MH):* Crisis stabilization services in a community residential setting may only be rendered by a specified licensed or certified individuals.

*Substance Use Disorder (SUD):* Under the state Section 1115 ARTS waiver, the following requirements apply to providers furnishing ARTS: (a) Professional staff must be licensed, registered, certified or recognized under Virginia scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. Licensed or Registered Practitioners of the Healing Arts include a list of disciplines where the practitioners are licensed or working under appropriate supervision. (b) Non-professional staff shall receive appropriate on-site orientation and training prior to performing assigned duties. Non-professional staff will be supervised by professional and/or administrative staff as required in Virginia state licensing authorities. (c) Professional and non-professional staff are required to have appropriate experience and any necessary training at the time of hiring as required in Virginia state licensing authorities. Requirements by facility type include, among others:

- Level 3.3 Clinically Managed Population-Specific High Intensity Residential Services: Staffed by credentialed addiction professionals, physicians/physician extenders, and credentialed mental health professionals.
- Level 3.5 Clinically Managed High Intensity Residential Services: Staffed by licensed/credentialed clinical staff, including addiction counselors, licensed clinical social workers, licensed professional counselors, physicians/physician extenders, and credentialed mental health professionals.
- Level 3.7 Medically Monitored Intensive Inpatient Services: Includes 24-hour clinical supervision including physicians, nurses, addiction counselors and behavioral health specialists.

## Placement

*Mental Health (MH):* The state Medicaid regulations include the following placement requirements for an individual to receive crisis stabilization services in a community mental health setting: The primary diagnosis may not be an SUD and the individual may not present an imminent danger to self or others. This service shall be initiated following a face-to-face service-specific provider intake. The service-specific provider intake must document the need for crisis stabilization services. Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from a condition due to an acute crisis of a psychiatric nature which puts the individual at risk of psychiatric hospitalization. Individuals must meet at least two of the following criteria at the time of admission to the service: (1) Experience difficulty in



establishing and maintaining normal interpersonal relationships to such a degree that the individual is at risk of psychiatric hospitalization, homelessness, or isolation from social supports; (2) Experience difficulty in activities of daily living such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized; (3) Exhibit such inappropriate behavior that immediate interventions documented by the mental health, social services, or judicial system are or have been necessary; or (4) Exhibit difficulty in cognitive ability such that the individual is unable to recognize personal danger or significantly inappropriate social behavior.

*Substance Use Disorder (SUD):* Under the state 1115 ARTS waiver, all Virginia Medicaid recipients referred to or seeking ARTS Levels of Care 2.0 through 4.0 must receive multidimensional assessments, level of care and length of stay recommendations based upon the ASAM Criteria.

Rehabilitation services are provided to recipients with an SUD diagnosis who are short-term residents in a Level 3 setting, when determined to be medically necessary by an ARTS Care Coordinator, physician or medical director employed by the MCO or DMAS FFS contractor and in accordance with an individualized service plan. ARTS Care Coordinators, physicians or medical directors will perform independent assessments to determine level of care and length of stay recommendations based upon the ASAM Criteria multidimensional assessment criteria and matrices to match severity and level of function with type and intensity of service for adults. ARTS Care Coordinators, physicians or medical directors will document the use of the ASAM multidimensional assessment and matrices for matching severity with type and intensity of services in a uniform service review request form.

Withdrawal management services are provided to recipients with an SUD diagnosis when determined to be medically necessary by an ARTS Care Coordinator, physician, or medical director employed by the MCO or DMAS FFS contractor and in accordance with an individualized service plan.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH):* Treatment in a community residential setting for psychiatric crisis stabilization must include an Individual Service Plan (ISP), to be developed or revised within three calendar days of admission to this service.

*Substance Use Disorder (SUD):* State Medicaid regulations require that ISPs and treatment plans must be developed upon admission to all Level 3 facilities. A comprehensive ISP must be developed within 30 days of initiation of services. It must be reviewed at least every 90 days and modified as needed.

Under the Section 1115 waiver, all ARTS providers are required to engage in discharge planning.

## **Treatment Services**

*Mental Health (MH):* A psychiatric crisis stabilization program in a residential setting must provide, as appropriate, psychiatric assessment including medication evaluation, treatment planning, symptom and behavior management, and individual and group counseling.

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 ARTS waiver, components of residential services include: (a) Physician consultation and emergency services available twenty-four (24) hours a day, seven (7) days per week. (b) Direct affiliations or referral sources to lower levels of care such as intensive outpatient services, vocational resources, literacy training, and adult education. (c) Ability to arrange for medically necessary procedures including laboratory and toxicology tests which are appropriate to the severity and urgency of individual's condition. (d) Ability to arrange for pharmacotherapy for psychiatric or anti-addiction medications. (e) Direct affiliation with (or close coordination through referral to) more and less intensive levels of care and other services such as sheltered workshops, literacy training, and adult education.

Therapies must include: (a) Clinically-directed treatment to facilitate recovery skills, relapse prevention, and emotional coping strategies. Services shall promote personal responsibility and reintegration of the individual into the network systems of work, education, and family life; (b) Addiction pharmacotherapy and drug screening; (c) Motivational enhancement and engagement strategies; (d) Counseling and clinical monitoring; (e) Withdrawal management and related treatment designed to alleviate acute emotional, behavioral, cognitive, or biomedical distress resulting from, or occurring with, an individual's use of alcohol and/or other drugs; (f) Regular monitoring of the individual's medication adherence; (g) Recovery support services; (h) Services involving the individual's family and significant others, as appropriate to advance the individual's treatment goals and objectives identified in the ISP (the services will be for the direct benefit of the beneficiary, will not be aimed at addressing treatment needs of individuals other than the beneficiary, and the beneficiary will be present except when it is clinically appropriate for the beneficiary to be absent in order to advance the beneficiary's treatment goals); and, (i) Education on benefits of medication assisted treatment and referral to treatment as necessary.

**Culturally Competent Services:** The MCOs and the DMAS FFS contractor will ensure that providers deliver services in a manner that demonstrates cultural and linguistic competency. Recipients will be able to select programs and providers within those programs that meet their needs for self-determination, recovery, community integration and cultural competency. Translation services must be available for recipients as needed.

## Care Coordination

*Mental Health (MH):* The provision of psychiatric crisis stabilization services in a non-IMD residential community setting shall be registered with the DMAS within one business day of the completion of the service-specific provider intake to avoid duplication of services and to ensure informed care coordination. The goals of crisis stabilization programs include mobilizing the resources of the community support system and family members and others for on-going maintenance and rehabilitation.

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 ARTS waiver, providers must have procedures for linkage/integration for recipients requiring MAT. All providers are required to engage in discharge planning, including coordination with the provider at the next level of care, to ensure the new provider is aware of the progress from the prior level of care.

Each MCO and the DMAS FFS contractor also must implement structured care coordination plans designed to assess the whole person, including physical health, mental health, and substance use, and achieve seamless transitions of care, including transitions between ARTS providers, transitions between delivery systems (i.e., FFS and managed care), and transitions between systems of care (i.e. physical and behavioral).

## Quality Assurance or Improvement

*Mental Health (MH):* State Medicaid regulations require that, for community mental health service providers, including those providing crisis stabilization in a residential community setting, utilization reviews must be conducted, at a minimum annually for each enrolled provider, by the Department of Medical Assistance Services (DMAS) or its contractor. During each review, an appropriate sample of the provider's total Medicaid population will be selected for review. An expanded review shall be conducted if an appropriate number of exceptions or problems are identified. The review by DMAS or its contractor shall include the following items: (1) Medical or clinical necessity of the delivered service; (2) The admission to service and level of care was appropriate; (3) The services were provided by appropriately qualified individuals as defined in the regulations; and (4) Delivered services as documented are consistent with recipients' Individual Service Plans, invoices submitted, and specified service limitations.

*Substance Use Disorder (SUD):* The Section 1115 ARTS waiver imposes quality assurance improvement requirements on each MCO and the DMAS FFS contractor, to use, and expand as necessary, their existing quality improvement infrastructures, quality improvement processes and performance measurement data systems to ensure continuous quality improvement of ARTS.

State Medicaid regulations require utilization reviews of providers of SUD treatment services to be conducted by DMAS or its designated contractor. Service authorizations are required for all ASAM Level 3 facilities.

## Special Populations

*Mental Health (MH)*: Specific requirements for services for special populations were not located in the state Medicaid regulations applicable to crisis stabilization.

*Substance Use Disorder (SUD)*: Pursuant to the Section 1115 ARTs waiver, the MCOs and the DMAS FFS contractor are encouraged to develop care management and coordination structures to manage pregnant and post-partum populations with histories of or current SUD, focusing on planning strategies to facilitate a recovery environment addressing improvements in maternal and child health, positive birth outcomes and addiction and recovery treatment approaches.

## Location of Medicaid Requirements

Virginia Medicaid Rules and Regulations<sup>3</sup>; Virginia 1115 Waiver<sup>4</sup>. Regulatory data collected November 2019.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report “**State Residential Treatment for Behavioral Health Conditions: Regulation and Policy**”. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

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<sup>3</sup> See <https://law.lis.virginia.gov/admincode/title12/agency30/>.

<sup>4</sup> See <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/va/va-gov-access-plan-gap-ca.pdf>.

## WASHINGTON

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### Types of Facilities

*Mental Health (MH) and Substance Use Disorder (SUD):* Washington regulates Residential Treatment Facilities (RTFs) which include 24-hour private, county, or municipal RTFs providing health care services to persons with mental disorders or SUDs.

*Mental Health (MH):* Washington regulates the following MH services provided in RTFs:

- Voluntary or involuntary triage facilities: A triage facility is a short-term facility or a portion of a facility that is designed to assess and stabilize an individual or determine the need for involuntary commitment of an individual. A triage facility may be structured as either a voluntary or involuntary placement facility or both.
- Evaluation and treatment services (E&T): E&T services can include evaluation for competency or other evaluation and treatment.
- Crisis stabilization units (CSUs): To the extent possible, CSUs are envisioned to hold someone for no more than 12 hours involuntarily before they are moved to an E&T facility. However, individuals may be voluntarily retained at a CSU for longer durations.
- Mental health outpatient services may be provided in an RTF.

*Substance Use Disorder (SUD):* Washington regulates the following SUD services provided in RTFs:

- Withdrawal management (WDM) services for adults are provided to an individual to assist in the process of withdrawal from psychoactive substances in a safe and effective manner, in accordance with ASAM criteria. These include but are not limited to secure withdrawal management and stabilization services for those who have been committed.
- Intensive inpatient services (IIS) are included in Washington's definition of residential treatment services, as ASAM level 3.5.
- Recovery house (RH) treatment services are ASAM level 3.1.

- Long-term resident (LTR) treatment services are ASAM level 3.1. They include services that provide a program for an individual needing consistent structure over a longer period of time to develop and maintain abstinence, develop recovery skills, and to improve overall health.

*Unregulated Facilities:* There are no unregulated RTFs in Washington. The behavioral health regulations explicitly do not apply to state psychiatric hospitals or facilities owned or operated by the U.S. Department of Veterans Affairs or other agencies of the Federal Government.

## **Approach**

The Washington State Department of Health (DOH) regulates, licenses, and certifies RTFs.

## **Processes of Licensure or Certification and Accreditation**

*Mental Health (MH) and Substance Use Disorder (SUD):* Licensure by the DOH is required for operation of all RTFs. Operation without a license is subject to fine and/or imprisonment. The application must include a copy of a current DOH RTF certificate. There are many types of certificates that may apply to residential facilities, depending on the services offered.

- Accreditation is not required but, if an agency has accreditation by a national accreditation organization that is recognized by and has a current agreement with the DOH, the DOH must deem the agency to be in compliance with state standards for licensure and certification. To be considered for deeming, an agency must submit a request to the DOH signed by the agency's administrator. There are regulatory limits on what can be excused by deeming. An agency operating under a department-issued provisional license or provisional program-specific certification is not eligible for deeming.
- An inspection is required for licensure and may occur at renewal but also may occur at any time after initial licensure.
- A Certificate of Need is not required.
- Licensure duration is one year.

## **Cause-Based Monitoring**

*Mental Health (MH) and Substance Use Disorder (SUD):* The DOH may conduct unannounced site surveys and investigate complaints. The licensee must assist and cooperate during surveys. If deficiencies are identified that are not major, broadly systemic, or of a recurring nature, the

department will issue the administrator a statement of deficiency and require a plan of correction. If the deficiency is broadly systemic, recurring, or of a significant threat to public health and safety, DOH will issue a directed plan of correction. Licenses may be denied, suspended, modified, or revoked.

## **Access Requirements**

*Mental Health (MH) and Substance Use Disorder (SUD):* Behavioral health agencies licensed by the DOH must provide reasonable access for individuals with disabilities and comply with all state and federal nondiscrimination laws, rules, and plans. No RTF-specific requirements for wait times were located.

*Substance Use Disorder (SUD):* A secure withdrawal management facility must have procedures for admitting individuals needing secure withdrawal management and stabilization services seven days a week, twenty-four hours a day; procedures to ensure that once an individual has been admitted, if a medical condition develops that is beyond the facility's ability to safely manage, the individual will be transported to the nearest hospital for emergency medical treatment; and procedures to assure access to necessary medical treatment, including emergency life-sustaining treatment and medication.

## **Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD):* All behavioral health agencies have staffing requirements, including ones related to supervision, training, and credentialing. RTFs must ensure residents receive care from qualified staff authorized and competent to carry out assigned responsibilities. A sufficient number of staff must be present on a twenty-four hour per day basis to: (a) Meet the care needs of the residents served; (b) Manage emergency situations; (c) Provide crisis intervention; (d) Implement individual service plans; and (e) Carry out required monitoring activities. At least one staff trained in basic first aid and age appropriate cardiopulmonary resuscitation (CPR) must be on-site twenty-four hours per day. Staff must be trained, authorized, and where applicable credentialed to perform assigned job responsibilities consistent with scopes of practice, resident population characteristics and the resident's individual service plan. The licensee must document that staff receive specified orientation and ongoing training, including but not limited to training regarding restraint or seclusion, if used in the facility. Additional medical staffing requirements apply if RTFs conduct staff administration of medication or use any restraint or seclusion. Other medical requirements apply to RTFs that have a health care prescriber initiate or adjust medication for residents to self-administer.

*Mental Health (MH):* The general behavioral health requirements related to those working in a MH setting include but are not limited to requirements regarding supervision, violence

prevention, and consultation. For RTFs, the agency must have an individualized annual training plan and must have procedures to assure that a mental health professional, chemical dependency professional, if appropriate, and physician, physician assistant, or psychiatric advanced registered nurse practitioner (ARNP) are available for consultation and communication with the direct patient care staff twenty-four hours a day, seven days a week.

- Triage facilities, at a minimum, must have: (a) a designated person in charge of administration of the triage unit; and (b) a mental health professional (MHP) on-site twenty-four hours a day, seven days a week.
- E&T facilities must designate a physician or other mental health professional as the professional person in charge of clinical services at the facility.
- A CSU must ensure that a licensed physician, physician assistant, or psychiatric advanced registered nurse practitioner (ARNP) is available for consultation to direct care staff twenty-four hours a day, seven days a week.

*Substance Use Disorder (SUD):* The general behavioral health regulations establish requirements related to those working in a SUD setting, including but not limited to requirements regarding use of Chemical Dependency Professionals (CDPs) or CDP-Ts, clinical supervisors, TB testing, and universal precautions regarding communicable disease.

- Adult WDMs must ensure that each staff member providing withdrawal management services, with the exception of licensed staff members and chemical dependency professionals, completes a minimum of forty hours of documented training before being assigned individual care duties addressing specific topics.

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* The requirements for all behavioral health agencies require an in-person clinical assessment completed by a professional appropriately credentialed or qualified to provide one or more of the following services as determined by state and federal law: Substance use disorder, mental health, and problem and pathological gambling. An RTF must limit admission, transfer, discharge, and referral processes to residents for whom the RTF is qualified by staff, services, equipment, building design and occupancy to give safe care.

*Mental Health (MH):* All MH residential facilities must document that each individual has received evaluations to determine the nature of the disorder and the treatment necessary, including: (a) A health assessment of the individual's physical condition to determine if the individual needs to be transferred to an appropriate hospital for treatment; (b) Examination and medical evaluation within 24 hours of admission by a licensed physician, advanced



registered nurse practitioner, or physician assistant; ... (d) Consideration of less restrictive alternative treatment at the time of admission. An individual who has been delivered to the facility by a peace officer for evaluation must be evaluated by a mental health professional within 3 hours of arrival. If the mental health professional or chemical dependency professional and physician, physician assistant, or psychiatric advanced registered nurse practitioner determine that the needs of an individual would be better served by placement in another type of service facility then the individual must be referred to a more appropriate placement.

- Triage facilities must assess each individual for SUD and co-occurring MH and SUD as measured by the Global Appraisal on Individual Need-Short Screen (GAIN-SS). This assessment must be conducted within 3 hours of arrival by a MH professional.
- For E&T facilities, for individuals who are being evaluated as dangerous mentally ill offenders, the professional in charge of the E&T facility must consider filing a petition for a 90 day less restrictive alternative in lieu of a petition for a 14-day commitment.
- For CSUs, the agency must have a policy management structure that establishes: (a) Procedures to ensure that for persons who have been brought to the unit involuntarily by police, the stay is limited to 12 hours unless the individual has signed voluntarily into treatment; (b) Procedures to ensure that within 12 hours of arrival, individuals who have been detained by a designated crisis responder are transferred to a certified evaluation and treatment facility; (c) Procedures to assure appropriate and safe transportation of persons who are not approved for admission or detained for transfer; (d) Procedures to detain arrested persons who are not approved for admission for up to 8 hours; and (e) Procedures to ensure that when an individual is brought to the facility by a peace officer under the emergency detention law, within 12 hours of arrival, a designated crisis responder must determine if the individual meets statutory detention criteria.

*Substance Use Disorder (SUD):* Agencies providing SUD services must ensure the assessment includes: (a) A statement regarding the provision of an HIV/AIDS brief risk intervention, and any referral made; and (b) A placement decision, using ASAM criteria dimensions when the assessment indicates the individual needs substance use disorder services.

- Adult WDM agencies must use ASAM criteria for admission, continued services, and discharge planning and decisions.
- Secure adult WDMs must document that each individual has received evaluations to determine the nature of the disorder and the treatment necessary, including: (a) A telephone screening reviewed by a nurse or medical practitioner prior to admission that includes current level of intoxication, available medical history, and known medical risks; (b) An evaluation by a chemical dependency professional within seventy-two hours of admission to the facility; and (c) An assessment for substance use disorder and additional mental health disorders or conditions, using the Global Appraisal on Individual Need-Short Screen (GAIN-SS) or its successor.

## Treatment and Discharge Planning and Aftercare Services

*Mental Health (MH) and Substance Use Disorder (SUD):* RTFs must develop and implement an individual service plan for each resident based on the resident's: (a) Initial health on admission; and (b) Health assessment(s). Among other things, individual service plans must be updated as additional needs are identified; include a discharge plan; and be completed by appropriated qualified professionals. An agency that provides any behavioral health service must ensure the individual service plan is initiated during the first individual session following the assessment.

*Mental Health (MH):* Behavioral health agencies providing MH treatment services in a residential setting must develop an individual treatment plan that documents, among other things: (a) Diagnostic and therapeutic services prescribed by the attending clinical staff; (b) A plan for discharge including a plan for follow-up where appropriate; and (c) That a mental health professional or chemical dependency professional, as appropriate, has contact with each involuntary individual at least daily for the purpose of determining the need for continued involuntary treatment.

- CSUs must have a plan for discharge, including a plan for follow up. For persons admitted to the crisis stabilization unit on a voluntary basis, the clinical record must contain a crisis stabilization plan developed collaboratively with the person within twenty-four hours of admission.
- Triage facilities must develop a triage stabilization plan for each individual voluntarily or involuntarily admitted for longer than twenty-four hours. The triage stabilization plan must be developed collaboratively with the individual within twenty-four hours of admission. A triage facility also must develop a discharge plan and follow-up services from the triage facility.

*Substance Use Disorder (SUD):* Behavioral health agencies providing SUD services in a residential setting must review the individual service plan to determine the need for continued services and discharge planning and decisions using ASAM criteria. WDMs must also include a continuing care recommendation in the person's discharge summary.

- Secure WDMs must ensure the treatment plan includes: (a) A protocol for safe and effective withdrawal management, including medications as appropriate; and (b) Discharge assistance provided by chemical dependency professionals, including facilitating transitions to appropriate voluntary or involuntary inpatient services or to less restrictive alternatives as appropriate for the individual.

- Providers of IISs must complete the individual service plan within five days of admission and document at least weekly, an individual service plan review which determines continued stay needs and progress towards goals.
- RHs and LTRs must conduct and document an individual service plan review at least monthly.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* An RTF must ensure residents' health care needs are met.

*Mental Health (MH):*

- E&T facilities must have procedures to document that each individual has received evaluations to determine the nature of the disorder and the treatment necessary, including a psychosocial evaluation by a mental health professional.
- CSUs must provide assessment and stabilization services; coordinate with the person's current treatment provider, if applicable; and, for persons admitted on a voluntary basis, the clinical record must contain a crisis stabilization plan.
- Triage facilities must provide services that assess and stabilize an individual or determine the need for involuntary commitment. A qualified staff member must coordinate with the individual's current treatment provider, if applicable, to assure continuity of care during admission and upon discharge.

*Substance Use Disorder (SUD):*

- Adult WDMs must, among other things, use ASAM criteria for admission, continued services, and discharge planning and decisions; and provide counseling to each individual that addresses the individual's: (i) Substance use disorder and motivation; and (ii) Continuing care needs and need for referral to other services.
- Adult secure WDMs must have procedures to assure at least daily contact between each involuntary individual and a chemical dependency professional or a trained professional person. An agency providing secure withdrawal management and stabilization services must document that each individual has received evaluations. An agency certified to provide secure withdrawal management and stabilization services must ensure the treatment plan includes the following: (a) A protocol for safe and effective withdrawal management, including medications as appropriate; and (b) Discharge assistance provided by chemical dependency professionals, including facilitating transitions to appropriate

voluntary or involuntary inpatient services or to less restrictive alternatives as appropriate for the individual.

- LTRs, among other things, must: (a) Provide an individual a minimum of two hours each week of individual or group counseling; (b) Provide no less than five hours per week of treatment services in line with ASAM 3.1 components; and (c) Provide an individual, during the course of services, with: (i) Education on social and coping skills, relapse prevention, and recovery skills development; (ii) Social and recreational activities; (iii) Assistance in seeking employment, when appropriate; and (iv) Assistance with reentry living skills to include seeking and obtaining safe housing.
- IIS facilities must provide treatment services in line with ASAM 3.5 components appropriate to adults.
- RHs must provide no less than five hours per week of treatment services in line with ASAM level 3.1.

## **Patient Rights and Safety Standards**

*Mental Health (MH) and Substance Use Disorder (SUD):* An RTF must establish processes to assure resident rights are protected, including but not limited to notification of rights, how to file a complaint with the DOH, policies around restraint and seclusion, treatment with dignity, privacy and confidentiality, and communication. RTFs that use restraint or seclusion must have policies addressing their use and satisfy certain standards. Regulations pertinent to all behavioral health agencies contain similar requirements, as well as the right to nondiscrimination, exploitation, or harassment.

*Mental Health (MH):* All MH RTFs must post all statutory patient rights related to involuntary detention in a language or format the individual can understand; patients have a right to make an informed decision regarding antipsychotic use and a facility must document specific information if there is involuntary administration of an antipsychotic.

*Substance Use Disorder (SUD):*

- An adult WDM must post any rules and responsibilities for individuals receiving treatment, including information on potential use of increased motivation interventions or sanctions, in a public place in the facility.
- Among other things, an adult secure WDM must have procedures to assure rights related to antipsychotic medication and regarding individual property.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* All behavioral health facilities must develop and maintain a written internal quality management plan/process that meets specific criteria. An RTF must establish policies and procedures to ensure ongoing maintenance of a coordinated quality improvement program to improve the quality of care provided to residents and to identify and prevent serious or unanticipated resident and facility outcomes. The licensee must, among other things: (1) Establish a written performance improvement plan that is periodically evaluated. (2) Collect, measure, and assess data on policies and procedures, and outcomes related to resident care and the environment. (3) Review serious or unanticipated resident or facility outcomes in a timely manner. (4) Implement and document changes or improvements made to prevent future occurrences of any serious or unanticipated resident outcomes.

## **Governance**

*Mental Health (MH) and Substance Use Disorder (SUD):* RTFs must establish a governing body with responsibility for operating and maintaining the facility. The governing body must provide organizational guidance and oversight to ensure that resources support and staff provides safe and adequate resident care, addressing specified areas.

## **Special Populations**

*Mental Health (MH) and Substance Use Disorder (SUD):* The behavioral health regulations require that the individual service plan address the needs of a mother and baby during pregnancy and after delivery, if applicable. These regulations also contemplate the use of co-occurring treatment where appropriate and define it as a “unified treatment approach intended to treat both disorders within the context of a primary treatment relationship or treatment setting.”

*Substance Use Disorder (SUD):* An agency that provides services to a pregnant woman must: (a) Have a written procedure to address specific issues regarding the woman's pregnancy and prenatal care needs; and (b) Provide referral information to applicable resources.

## Location of Regulatory and Licensing Requirements

Department of Health, RTF Regulations<sup>1</sup>; Department of Health, Behavioral Health Administrative Requirements<sup>2</sup>; Revised Code Washington Chapter 71.12<sup>3</sup>. Regulatory data collected July 8, 2019.

## Other Information Sources

N.L. Tyson (DOH); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>1</sup> See <https://apps.leg.wa.gov/wac/default.aspx?cite=246-337>.

<sup>2</sup> See <https://apps.leg.wa.gov/wac/default.aspx?cite=246-341>.

<sup>3</sup> See <https://app.leg.wa.gov/RCW/default.aspx?cite=71.12>.

# WASHINGTON MEDICAID

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## Approach

The Washington State Health Care Authority (HCA) oversees the state Medicaid program. Washington also has a Section 1115 waiver permitting Medicaid expenditures for short-term residential services provided in facilities that meet the definition of an institution for mental diseases (IMD). Washington relies on the in lieu of provision and Disproportionate Share Hospital (DSH) Payments for payment of some services provided in IMDs.

## Types of Facilities

*Mental Health (MH):* Crisis stabilization services for MH conditions are covered by Washington Medicaid. Crisis Stabilization Units (CSUs) may retain individuals voluntarily for longer periods than the 12 hour limit for involuntary retention.

*Substance Use Disorder (SUD):* By state Medicaid regulation, chemical dependency detoxification services are provided to a person to assist in the process of withdrawal from psychoactive substances in a safe and effective manner. These services may be provided in an RTF that is licensed by the DOH as a behavioral health agency; meets the applicable behavioral health agency licensure, certification, administration, personnel, clinical requirements, and behavioral health services administrative requirements; and otherwise complies with relevant regulations.

Pursuant to the Section 1115 waiver, the following SUD residential treatment facilities may enroll in Medicaid:

- Residential Treatment: Length of stay is not fixed, although some treatment programs are oriented to offer 30-60 day programs. Actual length of stay is dependent on progress towards treatment goals and reassessment. This is intended for individuals who have completed withdrawal management.
  - Level 3.1
  - Level 3.5

- Medically Supervised Withdrawal Management
  - Level 3.2-WM: Clinically Managed Residential Facilities (sub-acute detoxification)
  - Level 3.7 and 3.7-WM: Medically Monitored Inpatient Programs (acute detoxification)

Medication-assisted treatment will also be available in IMD settings.

## **Processes of Medicaid Enrollment**

*Mental Health (MH) and Substance Use Disorder (SUD):* To participate in the Washington Medicaid program, health care providers must apply for enrollment, have an approved agreement with the agency, and be appropriately certified or licensed for their scope of practice, among other things. The agency may deny or terminate enrollment.

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, all Level 3 facilities must be appropriately licensed. The waiver indicates that these requirements ensure that treatment agencies are surveyed within 12 months of initial approval and every three years; are in compliance with regulations; and are evaluated rapidly when complaints are received.

## **Staffing**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding credentials of staff for residential treatment settings. The state must assess the availability of providers in the key levels of care throughout the state, or in the regions of the state participating under this demonstration, including those that offer MAT. According to the waiver, the state has promoted the use of MAT in residential settings through provider trainings.

## **Placement**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines. The state also must establish a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are



appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings.

Placement for Level 3 services, both withdrawal management and otherwise, are dependent on initial and ongoing ASAM assessments. The ASAM Patient Placement Criteria (PPC) are used to guide admission, continued service, and discharge planning. The behavioral health organization/managed care organization (BHO/MCO) authorization process is an independent review of residential authorization treatment. The residential agency providing the services must obtain independent approval from the BHO or MCO. This review process varies by managed care organization but in all cases is required to be based upon medical necessity and ASAM placement criteria. In the Fee-for-Service (FFS) system there are no managed care or administrative services organizations providing review of admissions to residential SUD facilities. In most cases, an individual in the FFS system is assessed by a licensed outpatient provider not associated with the residential facility. This independent provider determines whether the individual meets the ASAM residential level of care and when appropriate makes a referral to a residential facility.

- For nonwithdrawal management, which is intended for individuals who have completed withdrawal management, length of stay is not fixed, although some treatment programs are oriented to offer 30-60 day programs. Actual length of stay is dependent on progress towards treatment goals and reassessment.
- For withdrawal management, assessment of severity, medical complications, and specific drug or alcohol withdrawal risk determine placement within each level of service.

## **Treatment and Discharge Planning and Aftercare Services**

*Substance Use Disorder (SUD):* As described in the state 1115 waiver, the state requires all SUD providers to assess and provide treatment services using the ASAM criteria. Facilities must also use the ASAM criteria while conducting and developing SUD assessments, individual service plans and treatment plan reviews for transitioning individuals to alternate levels of care. For Level 3.5, the individual service plan must be completed within five days of admission.

## **Treatment Services**

*Substance Use Disorder (SUD):* Chemical dependency detoxification services provided in an RTF must provide counseling to each person that addresses the person's: (i) Chemical dependency and motivation; and (ii) Continuing care needs and need for referral to other services. Among other things, they must maintain a list of resources and referral options that can be used by staff members to refer a person to appropriate services.

Under the Section 1115 waiver, beneficiaries will have access to high quality, evidence-based OUD and other SUD treatment services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions. Pursuant to the Section 1115 waiver, the state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services and hours of clinical care for residential treatment settings. The state must establish a requirement that residential treatment providers offer MAT on-site or facilitate access to MAT off-site.

Providers are not required to utilize any specific evidence-based practices. However, state law requires agencies to develop and maintain a written internal quality management plan and process that continuously improves the quality of care through use of evidence-based and promising practices.

As part of the waiver, Washington is implementing a requirement that RTFs offer MAT on-site or facilitate access off-site. Tribal providers that do not provide or facilitate access to MAT as a treatment choice will not be included in the demonstration because CMS will not exempt them from this requirement.

- Services for nonwithdrawal management facilities include individual and group counseling, education, and activities for clients who have completed withdrawal management services.
  - Level 3.1: Social, vocational, and recreational activities to assist individuals adjust to abstinence, and to assist aid in job training, employment, or participating in other types of community services.
  - Level 3.5: A minimum of 20 hours of treatment services, including a program of individual and group counseling, education, and activities.
- Services in withdrawal management facilities include:
  - Level 3.2-WM: Limited medical coverage by staff and counselors who monitor patients and generally, any treatment medications are self-administered.
  - Level 3.7-WM: Medical coverage by nurses with physicians on-call for consultation. They use “standing orders” and available medications to help with withdrawal symptoms. Facilities for these programs are not hospitals but do have referral relationships.

## Care Coordination

*Mental Health (MH) and Substance Use Disorder (SUD):* Care coordination services are to be offered to eligible beneficiaries through contracted managed care organizations. Care management entities provide care coordination and assistance to beneficiaries in Medicaid FFS who are not eligible for enrollment in managed care.

*Substance Use Disorder (SUD):* By state Medicaid regulation, chemical dependency detoxification services provided in an RTF must provide counseling to each person that addresses the person's continuing care needs and need for referral to other services. They must maintain a list of resources and referral options that can be used by staff members to refer a person to appropriate services.

Under the Section 1115 waiver, beneficiaries will have improved care coordination and care for comorbid physical and mental health conditions. The state must ensure establishment and implementation of policies to ensure residential facilities link beneficiaries with community-based services and supports following stays in these facilities. As part of the waiver implementation, Washington will implement a requirement that MCOs, residential treatment providers, and outpatient providers work to develop policies and practices that enhance care coordination, including transitions between levels of care following residential treatment stays.

## Quality Assurance or Improvement

*Mental Health (MH) and Substance Use Disorder (SUD):* State Medicaid regulations require that a behavioral health administrative service organization (BH-ASO) and MCO must have a quality plan for continuous quality improvement in the delivery of culturally competent behavioral health services.

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings.

## Special Populations

*Substance Use Disorder (SUD):* Extended services for pregnant women, through the sixty days postpartum period, include rehabilitation alcohol and drug treatment services, excluding room and board, for pregnant and postpartum women in residential treatment facilities with 16 beds or less certified by the Division of Alcohol and Substance Abuse.

## Location of Medicaid Requirements

Washington Medicaid Transformation Project 1115 Waiver Demonstration<sup>4</sup>; Washington Medicaid Health Care Authority Title 182 Rules<sup>5</sup>. Regulatory data collected December 2019.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report **“State Residential Treatment for Behavioral Health Conditions: Regulation and Policy”**. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

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<sup>4</sup> See <https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/?entry=35120>.

<sup>5</sup> See <https://apps.leg.wa.gov/wac/default.aspx?cite=182>.

## **WEST VIRGINIA**

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### **Types of Facilities**

*Mental Health (MH) and Substance Use Disorder (SUD):* West Virginia regulates Behavioral Health Centers (BHCs), which “perform direct services provided as an inpatient, residential or outpatient service, to an individual with mental health, addictive, behavioral, or adaptive challenges that is intended to improve or maintain functioning in the community. The service is designed to provide treatment, habilitation, or rehabilitation.” No other regulated MH or SUD residential treatment facility types were identified.

*Unregulated Facilities:* No unregulated residential treatment facilities were identified.

### **Approach**

*Mental Health (MH) and Substance Use Disorder (SUD):* The West Virginia Department of Health and Human Resources (DHHR) regulates all residential BHCs, regardless of funding source.

### **Processes of Licensure or Certification and Accreditation**

*Mental Health (MH) and Substance Use Disorder (SUD):* BHCs must apply for licensure by the DHHR in order to operate in the state.

- An accreditation requirement was not identified for BHCs.
- A facility inspection is required for licensure and renewal.
- A Certificate of Need is not required for BHCs.
- Licensure is applied for every two years, and the application focuses on adherence to the provisions of the state behavioral health regulations.

## **Cause-Based Monitoring**

*Mental Health (MH) and Substance Use Disorder (SUD):* The DHHR performs renewal inspections for BHCs and may conduct investigations and inspections based on complaints received. The DHHR also may require a plan of correction should the DOH become aware of deficiencies.

## **Access Requirements**

*Mental Health (MH) and Substance Use Disorder (SUD):* Wait-time requirements were not found.

## **Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD):* The BHC must retain qualified individuals to deliver the services to which it commits via consumer treatment plans based on the consumer's functional level and physical disability. The provider shall have a system of staff supervision that is tailored to the provider's model of service delivery and uses individual or group supervision, or both, on a regularly scheduled basis. The provider shall identify an individual responsible for overall administration of the program for each site. This individual shall ensure that decisions related to care of the consumer are based on the treatment plan of the consumer. The provider shall develop a process that ensures appropriate supervision of direct service staff. Each staff person on duty shall have access to a supervisory staff person by telephone or face-to-face contact within 15 minutes of an initial attempt at supervisory contact.

The provider shall designate a supervisor for each separate service or program. A supervisor may be responsible for more than one program. The provider shall employ persons who are qualified according to the job description and selection criteria for the positions they occupy. A provider employing any person who does not possess the qualifications noted in the position's job description shall have a written statement justifying the individual's employment. Upon employment, the provider shall train employees regarding written policies and procedures pertaining to their employment and job responsibilities. Additionally, the provider shall have a policy and required training process for all employees regarding mandatory reporting of allegations of consumer abuse or neglect. The provider shall ensure that all new staff receive an orientation within the first 10 days of employment. The orientation shall include an introduction to the staff person's primary job responsibilities and requirements. Within the first 30 days of employment or initiation, the provider shall also train all new staff in, but not limited to: its mission, philosophy, and goals; its services, policies, and procedures pertaining to the employee, contract clinician, student, or volunteer's job responsibilities; an organizational chart that delineates lines of accountability and authority pertaining to the person's job responsibilities; the provider's policies and procedures on consumer confidentiality and

disclosure of information, including penalties for violation of the following policies and procedures and an orientation to federal confidentiality requirements as they apply to the provider: consumer rights; universal precautions; training on identification of abuse and neglect and mandatory reporting procedures; appropriate identification and documentation of incidents; and sensitivity to differences in cultural norms and values. Until the training is completed, the staff person shall not work unless accompanied by a staff member who is experienced and knowledgeable in these areas.

- Specific to residential facilities: Staff must have certain training including but not limited to crisis plans and common behavioral issues and management.
- Specific to 24-hour programs providing medical monitoring: The provider must supply adequate staff for monitoring of individuals. A medical staff person such as a physician, physician extender, RN, or LPN must evaluate each patient each shift unless the physician documents no need for further medical monitoring. The provider must have a policy regarding face-to-face or telemedicine availability of medical staff to directly observe the patient after hours within 30 minutes as necessary and appropriate absent other arrangements.
- See also section on Special Populations regarding staffing and training for specialized services to a unique population.

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* As a condition of placement at a BHC, an initial assessment shall be conducted. The initial assessment shall review the consumer's psychiatric and psychosocial history, history of medical and psychiatric treatment, current mental status, current medical and psychiatric status with regard to health and medications prescribed, evaluation of suicidal or homicidal ideation, universal screening for trauma, presenting problems as identified objectively and subjectively, and summarize the consumer's needs and preferences. No references to ASAM were found in the licensing regulations.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Treatment planning, with updates every 90 days, is required. Discharge planning is also required, although references to timing or aftercare/follow-up requirements were not found.

## Treatment Services

*Mental Health (MH) and Substance Use Disorder (SUD):* The BHC must provide a written description of all services available to the public and potential consumers.

- Specific to residential facilities: The BHC is responsible for monitoring and facilitating the consumer's health; linkage and referral to address acute medical and psychiatric health concerns; referral for primary care once a year.
- Specific to 24-hour programs providing medical monitoring: BHCs providing medical stabilization must provide or arrange to obtain prescribed medications. See also section on Staffing for additional information regarding medical monitoring requirements.
- See also section on Special Populations regarding specialized services to a unique population.
- No references to medication-assisted treatment specific to residential treatment were identified.

## Patient Rights and Safety Standards

*Mental Health (MH) and Substance Use Disorder (SUD):* A consumer, an employee, or any other individual may make a complaint to the provider. A supervisor shall report to the administrator within 24 hours regarding all violations, or suspected violations, of a consumer's rights, except in the case of physical abuse for which immediate notification shall be made. The provider must have evidence that all violations, or suspected violations, of a consumer's rights are thoroughly investigated within a reasonable time period not to exceed 10 days. The administrator shall provide a written report to the human rights committee of his findings and of the actions taken to prevent further occurrences. A consumer or consumers shall be identified by case number only. The provider shall make a notation of the incident and the effect of the incident on a consumer's illness or treatment in a consumer's record. If the administrator's findings and actions on behalf of a consumer regarding a violation of the consumer's rights is unfavorable, insufficient or not forthcoming within a reasonable time, the consumer, or his or her legal representative, may appeal to the governing body of the provider, the state licensure body, the West Virginia advocate or other appropriate resource. The provider shall also report, investigate, monitor and remediate consumer-related incidents in a manner consistent with regulations and minimum current guidelines.

The provider shall have in place policies and procedures regarding emergency management of potentially dangerous consumer behavior. Seclusion is not an intervention permitted in any licensed community-based program. Additionally, staff shall be trained and able to demonstrate competency in systematic de-escalation procedures as part of orientation.



Training for direct care staff shall be renewed at intervals determined by provider policy but occur no less than yearly. The use of restraints must be in accordance with a written modification to the consumer's treatment plan and implemented in accordance with safe and appropriate techniques.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* The BHC must have and implement a systems review of the appropriateness and effectiveness of consumer services, which includes an analysis of the results of treatment plan reviews and of reports by the human rights committee. Particularly, the protection of civil rights for consumers with disabilities is of extreme importance. Special attention and efforts are essential to ensure that a consumer's human and civil rights are promoted, exercised, and protected.

## **Governance**

*Mental Health (MH) and Substance Use Disorder (SUD):* No information related to requirements for governance were identified.

## **Special Populations**

*Mental Health (MH) and Substance Use Disorder (SUD):* If a BHC provides specialized services to a unique population, the provider shall ensure that: The service and clinical model reflects knowledge and use of evidence-based and theory-guided practices; Clinical and professional staff are appropriately trained, certified, or licensed in the area of service provided; Direct care staff are trained to understand issues in clinical treatment of the population and are able to use suitable intervention techniques when necessary and appropriate; The environment and milieu of the treatment location is clinically, structurally, and developmentally appropriate for the population served; and The facility is suitably secure and staff ratios are consistent with the consumer's treatment plan. In cases in which a staff ratio is not specified in the consumer's plan of care, the provider shall assure that sufficient staff is present to enable consumer safety in case of emergency.

## **Location of Regulatory and Licensing Requirements**

Department of Health and Human Resources<sup>1</sup>. Regulatory data collected September 3, 2019.

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<sup>1</sup> See <http://apps.sos.wv.gov/adlaw/csr/readfile.aspx?DocId=51134&Format=PDF>.

## **Other Information Sources**

James Matney, SSA; National Conference of State Legislatures CON Program Overview,  
<http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

# WEST VIRGINIA MEDICAID

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## Approach

The Department of Health and Human Resources, Bureau for Medical Services (BMS) oversees the state Medicaid program. West Virginia has a Section 1115 waiver permitting Medicaid coverage of residential treatment for SUD. It also has historically relied on the in lieu of provision to reimburse certain services in IMDs as well as Disproportionate Share Hospital (DSH) payments.

## Types of Facilities

**Mental Health (MH):** Residential treatment that is specific to mental health is not reimbursable. However, Behavioral Health Rehabilitation Services are reimbursed. These are defined as services that are medical or remedial that recommended by a physician, PA, APRN, licensed psychologist, or supervised psychologist for the purpose of reducing a ... mental disability and restoration of a member to his/her best function level. These services are designed for all members with conditions associated with mental illness, substance abuse and/or dependence. Behavioral Health Rehabilitation Services may be provided to members in a variety of settings, including in ... a residential program.

**Substance Use Disorder (SUD):** Pursuant to the 1115 waiver, for residential treatment for individuals with SUD, expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are short-term residents in facilities that meet the definition of an Institution for Mental Diseases (IMD). Levels of care include:

- 3.1 Clinically Managed Low Intensity Residential Services.
- 3.3 Clinically Managed Population-Specific High Intensity Residential Services.
- 3.5 Clinically Managed High Intensity Residential Services.
- 3.7 Medically Monitored Intensive Inpatient Services.
- 3.2-WM Clinically Managed Residential Withdrawal Management Services.

- 3.7-WM Medically Monitored Inpatient Withdrawal Management Services.
- OTP Opioid Treatment Program Services provided to short-term residents.
- OBOT Office Based Opioid Treatment provided to short-term residents.

## **Processes of Medicaid Enrollment**

*Mental Health (MH) and Substance Use Disorder (SUD):* To be reimbursed by Medicaid, providers must be enrolled as Medicaid providers and revalidated every 5 years. Providers must be appropriately licensed for their scope of practice. Medicaid providers may be subject to document review or announced or unannounced facility inspection.

*Substance Use Disorder (SUD):* To be reimbursed by West Virginia Medicaid, a BHC must be licensed through the West Virginia Office of Health Facility Licensure and Certification (OHFLAC) and comply with state Medicaid LBHC requirements. To be reimbursed under the Section 1115 waiver, services must be provided in a BMS-certified facility that is enrolled as a Medicaid provider and assessed by BMS as delivering care consistent with ASAM Levels 3.1, 3.3, 3.5, and/or 3.7 or the equivalent level of care of the state's chosen other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines, and, for participation in the managed care delivery system, has been credentialed and enrolled by an MCO as a network provider. Each residential treatment provider will be certified as meeting the provider and service specifications described in the BMS policy manual. The MCOs will provide credentialing for ASAM Levels 3.1, 3.3, 3.5 and/or 3.7 or credentialing for the levels of care of the other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines contingent on the providers receiving certification from the state.

## **Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD):* All covered and authorized services must be provided by enrolled providers practicing within the scope of their license, utilizing professionally accepted standards of care, and in accordance with all state and federal requirements. The state Medicaid program must conduct provider screening. This includes reviews of provider applications as well as random reviews of enrolled providers to ensure applications are current and reflect any substantive changes outlined in the regulations and ensure all required disclosure information is present. The state may review employees/contractors of the enrolled provider to determine provider compliance with required checks of public databases identifying any individuals/entities that have been excluded or disqualified via criminal conviction/license revocation or restriction from providing or being reimbursed for services paid by any federal/state program. The state reviews personnel

records of enrolled providers' employees providing direct care or having direct access to Medicaid members to ensure there are no disqualifying criminal convictions that would prohibit these individuals from providing services.

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, through revisions of its policy manual and contract requirements for managed care organizations (MCOs), BMS will establish standards of care for SUD demonstration services that incorporate industry standard benchmarks from the ASAM Criteria or another comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for staffing specifications.

Pursuant to the Section 1115 waiver, providers were to receive training and education on the ASAM or the other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines level of care criteria and the application of the ASAM Criteria or the other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines in the assessment process. MCOs are required to provide evidence of initial and ongoing training of providers during site reviews conducted by the state. As part of a quality monitoring strategy, the state will review personnel and clinical records of a sample of the provider network to determine appropriate application and fidelity to the established assessment process.

The SUD waiver manual further requires that adult residential treatment must meet the credentials and qualifications for each service provided as described in Chapter 503, Licensed Behavioral Health Centers (LBHC). Within the SUD waiver manual are detailed staffing requirements, including but not limited to medical and other staffing for levels 3.7 and 3.2-WM.

The residential SUD Medicaid enrollment application requires attestation regarding staffing requirements including, but not limited to, physician and emergency availability, coverage, and credentials. The LBHC and SUD residential Medicaid requirements also require that each provider must develop and maintain a credentialing committee composed of the clinical supervisor and/or certified staff representative of the disciplines or practitioners within the agency. This committee is responsible for overseeing and assuring standards regarding staffing, including credentials, training, supervision and compliance monitoring.

## **Placement**

*Substance Use Disorder (SUD):* Pursuant to the 1115 waiver, West Virginia Medicaid recipients with an SUD diagnosis when determined to be medically necessary by the MCO utilization staff and in accordance with an individualized service plan. MCO utilization staff, physicians or medical directors will perform independent assessments to determine level of care and length of stay recommendations based upon the ASAM Criteria multidimensional assessment criteria or another comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines assessment criteria. The state's average length of stay for

individuals admitted into all BMS-certified facilities at all levels of care is thirty (30) days. Through revisions of its policy manual and contract requirements for managed care organizations (MCOs), BMS will establish standards of care for SUD demonstration services that incorporate industry standard benchmarks from the ASAM Criteria or another comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for patient assessment and placement.

The SUD waiver manual indicates Residential Adult Services (RAS) apply to adults ages 18 and older who have been diagnosed with a substance abuse and/or co-occurring substance abuse/mental health disorder. Individuals placed in these levels of care are unable to be treated on an outpatient basis effectively. The level of care that individual is placed in is based upon medical necessity and the ASAM Criteria. The manual includes basic requirements for continuing stay and discharge that vary somewhat by level and detailed requirements for admission, including referral, medical clearance, physical exams, assessment using the ASAM criteria, diagnosis, risk level, and other matters, with specific criteria for levels 3.1, 3.3, 3.5, and 3.7. For level 3.2-WM, specific physical and psychosocial standards are in place, including requirements for an admission assessment that includes a comprehensive nursing assessment by an RN; approval of admission by a physician, assessment by a physician within 24 hours of admission; approval of the admission by a physician; a comprehensive history and physical exam performed within 12 hours of admission, accompanied by appropriate laboratory and toxicology tests; addiction-focused history obtained as part of the assessment and reviewed by a physician during the admission process; and biopsychosocial screening assessments to determine placement.

The residential SUD application requires attestation regarding assessment requirements.

## **Treatment and Discharge Planning and Aftercare Services**

*Substance Use Disorder (SUD):* The SUD waiver manual requires, for all adult residential services, the development of a Service Plan by an interdisciplinary team within 72 hours of admission and review at least every seven calendar days from the date of admission. Among other things this includes a discharge plan, with such planning beginning at admission for level 3.2-WM. The residential SUD application requires attestation regarding treatment planning and discharge planning requirements.

## **Treatment Services**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, covered services include: (a) Clinically-directed therapeutic treatment to facilitate recovery skills, relapse prevention, and emotional coping strategies. (b) Addiction pharmacotherapy and drug screening. (c) Motivational enhancement and engagement strategies. (d) Counseling and clinical monitoring.

(e) Withdrawal management and related treatment designed to alleviate acute emotional, behavioral, cognitive, or biomedical distress resulting from, or occurring with, an individual's use of alcohol and other drugs. (f) Regular monitoring of the individual's medication adherence. (g) Recovery support services. (h) Counseling services involving the beneficiary's family and significant others to advance the beneficiary's treatment goals, when: (1) the counseling with the family member and significant others is for the direct benefit of the beneficiary; (2) the counseling is not aimed at addressing treatment needs of the beneficiary's family or significant others; and (3) the beneficiary is present except when it is clinically appropriate for the beneficiary to be absent in order to advance the beneficiary's treatment goals. (i) Education on benefits of medication assisted treatment and referral to treatment as necessary. Through revisions of its policy manual and contract requirements for managed care organizations (MCOs), BMS will establish standards of care for SUD demonstration services that incorporate industry standard benchmarks from the ASAM Criteria or another comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for patient assessment and placement, service and staffing specifications.

The SUD waiver manual requires that MAT be available in all levels of residential and withdrawal management treatment. It also implements detailed requirements for levels 3.1, 3.3, 3.5, 3.7, and 3.2-WM that are based on the ASAM standards. Among other things, these requirements include: number of hours of clinical service per week, use of evidence-based practices, treatment of co-occurring conditions, and affiliations with other levels of care.

The residential SUD application requires attestation regarding service requirements including, but not limited to, clinical hours per week, use of evidence-based treatment, provision of services specifically for those with co-occurring disorders, services that comply with the relevant ASAM level(s), and a requirement that all forms of MAT be available in all levels of residential treatment.

## **Care Coordination**

*Mental Health (MH) and Substance Use Disorder (SUD):* The Medicaid LBHC manual addresses the provision of coordinated care for those with severe and/or chronic behavioral health conditions. This includes a comprehensive master service plan and on-going care coordination. Beneficiaries who can use this approach are those in crisis stabilization and detoxification as well as those receiving non-methadone MAT, among others.

*Substance Use Disorder (SUD):* The SUD waiver manual specifies that residential facilities must provide coordination of care services to members as needed. To facilitate coordination of care, the provider must contact and confirm the member is enrolled with the identified Managed Care Organization (MCO) within 48 hours of initiation of any SUD services being provided to a Medicaid MCO member. All Medicaid enrolled providers should coordinate care if a Medicaid member receives different Medicaid services at different locations with other providers to

ensure that quality care is taking place and that safety is at the forefront of the member's treatment.

## Quality Assurance or Improvement

*Mental Health (MH) and Substance Use Disorder (SUD):* State Medicaid Program Quality and Program Integrity oversight includes: (1) Data Analysis and Review; (2) Post Payment Review; (3) Prevention versus Collection; (4) Medicaid Fraud Referrals; and (5) Provider Eligibility.

*Substance Use Disorder (SUD):* See Staffing section regarding LBHC and SUD residential Medicaid requirements which include that each participating provider must develop and maintain a credentialing committee composed of the clinical supervisor and/or certified staff representative of the disciplines or practitioners within the agency. This committee is responsible for overseeing and assuring standards regarding staffing, including credentials, training, supervision and compliance monitoring.

## Special Populations

*Substance Use Disorder (SUD):* The residential SUD application requires attestation regarding provision of services specifically for those with co-occurring disorders.

## Location of Medicaid Requirements

WV Department of Health & Human Resources Bureau for Medical Services, Chapter 503 LBHCs<sup>2</sup>; Chapter 504 SUD Services (SUD Waiver)<sup>3</sup>; Chapter 800(B) Quality and Program Integrity<sup>4</sup>; Section 1115 Waiver Approval<sup>5</sup>; Provider Enrollment Chapter 300<sup>6</sup>. Regulatory data collected December 2019.

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<sup>2</sup> See

[https://dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter%20503%20Licensed%20Behavioral%20Health%20Centers/Chapter\\_503\\_LBHC\\_Services%20final%20draft%2007.10.18%20scb%207.12.18%20skyFinalApproved.pdf](https://dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter%20503%20Licensed%20Behavioral%20Health%20Centers/Chapter_503_LBHC_Services%20final%20draft%2007.10.18%20scb%207.12.18%20skyFinalApproved.pdf).

<sup>3</sup> See <https://dhhr.wv.gov/bms/Pages/Chapter-504-Substance-Use-Disorder-Services.aspx>.

<sup>4</sup> See [https://dhhr.wv.gov/bms/Provider/Documents/Manuals/bms-manuals-chapter\\_800B\\_QPI.pdf](https://dhhr.wv.gov/bms/Provider/Documents/Manuals/bms-manuals-chapter_800B_QPI.pdf).

<sup>5</sup> See <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wv/wv-creating-continuum-care-medicaid-enrollees-substance-ca.pdf>.

<sup>6</sup> See <https://dhhr.wv.gov/bms/Provider/Documents/Manuals/Chapter%20300-Provider%20Participation%20FINAL%205.19.18.pdf>.



## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report **“State Residential Treatment for Behavioral Health Conditions: Regulation and Policy”**. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

## WISCONSIN

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

### Types of Facilities

*Mental Health (MH) and Substance Use Disorder (SUD):* Wisconsin regulates Community-Based Residential Facilities (CBRFs). These facilities serve individuals who have MH or SUD needs. A CBRF is a location where 5 or more adults who do not require care above intermediate level nursing care reside and receive care, treatment or services that are above the level of room and board but that include no more than 3 hours of nursing care per week per resident. CBRFs encourage the resident to move toward functional independence in daily living or to maintain independent functioning to the highest possible extent. Crisis services also may be offered in a CBRF.

*Substance Use Disorder (SUD):* Wisconsin regulates SUD treatment programs as community substance abuse services, with the following program type which may be either in a licensed community-based residential facility or certain other facilities:

- **Medically Monitored Residential Detoxification Services:** A 24-hour per day service in a residential setting providing detoxification service and monitoring, with care provided by a multi-disciplinary team of service personnel including 24-hour nursing care under the supervision of a physician.
- **Residential Intoxication Monitoring Services:** A service providing 24-hour per day observation by non-medical staff to monitor the resolution of alcohol or sedative intoxication and to monitor alcohol withdrawal.
- **Medically Monitored Treatment Services:** A community or hospital based 24-hour treatment service which provides a minimum of 12 hours of counseling per patient per week, including observation, and monitoring provided by a multi-disciplinary staff under the supervision of a physician.
- **Transitional Residential Treatment:** A 24-hour clinically supervised, peer-supported therapeutic environment with clinical involvement.

*Unregulated Facilities:* Private SUD residential treatment facilities that do not seek certification are not regulated in Wisconsin. State staff noted that “crisis hostels” are unregulated in the state, although emergency mental health programs are regulated. These crisis programs may

be offered as stabilization services in a number of settings, including but not limited to CBRFs, crisis hostels, outpatient settings, schools, jails, or the individual's own home. The regulations specific to emergency mental health programs are excluded from this summary because they may be offered in many settings. We also exclude licensed or certified adult family homes, and residential care apartment complexes because they do not include the level of clinical treatment needed to be included in this summary. We exclude community MH inpatient facilities because they are located in hospital facilities.

## **Approach**

The Wisconsin Department of Health Services (DHS) regulates and certifies residential SUD treatment programs as community substance abuse services, with regulations applying to programs receiving state funds or to private agencies that request certification. The DHS Division of Quality Assurance Bureau of Assisted Living regulates and licenses all CBRFs.

## **Processes of Licensure or Certification and Accreditation**

*Mental Health (MH) and Substance Use Disorder (SUD):* Licensure by the DHS is required for operation of all CBRFs.

- Accreditation is not required.
- A survey is required for licensure and the licensee must submit a biennial report and fees for continuation.
- A Certificate of Need is not required.
- Initial licensure may be probationary and be valid for up to one year; a regular license is valid until suspended or revoked.

*Substance Use Disorder (SUD):* Certification by the DHS is required for operation of residential SUD treatment facilities that receive state funds or private facilities that request it.

- Accreditation is not required but if a service holds accreditation from a recognized accreditation organization, such as the Joint Commission on Accreditation of Health Organizations, the Commission on Accreditation of Rehabilitation Facilities or the National Committee for Quality Assurance, the requirements for service evaluation may be waived.
- An on-site survey may be required for certification and renewal.
- A Certificate of Need is not required.

- Initial certification is one year and considered provisional; recertification duration is up to two years.

## **Cause-Based Monitoring**

*Mental Health (MH) and Substance Use Disorder (SUD):* For CBRFs, licenses may be denied, suspended, or revoked. Investigations will occur in the event of specified critical incidents.

*Substance Use Disorder (SUD):* Certification may be denied, suspended, or revoked.

## **Access Requirements**

*Mental Health (MH) and Substance Use Disorder (SUD):* Wait-time requirements were not found.

*Substance Use Disorder (SUD):* All residential SUD treatment facilities must have written policies related to nondiscrimination and compliance with the ADA and other laws.

## **Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD):* A CBRF has requirements related to the “licensee,” the administrator, and all employees, including resident care staff. The CBRF must provide employees in sufficient numbers on a 24-hour basis to meet the needs of the residents and must meet other staffing requirements. The CBRF must provide orientation and other training including but not limited to resident rights, factors specific to the client group, managing challenging behaviors, reporting abuse and neglect, fire safety, and first aid/choking. At least 15 hours per calendar year of continuing education is required for the administrator and resident care staff.

*Substance Use Disorder (SUD):* All residential SUD treatment facilities must have written policies stating that, in the selection of staff, consideration will be given to each applicant's competence, responsiveness and sensitivity toward and training in serving the characteristics of the service's patient population, including gender, age, cultural background, sexual orientation, developmental, cognitive or communication barriers and physical or sensory disabilities. Requirements are in place for a director, volunteers, staff providing substance abuse counseling, staff providing clinical supervision, staff providing mental health treatment services to dually diagnosed clients, and for provision of clinical supervision. Each service must have a written policy requiring each new staff person who may have responsibility for assessing or treating patients who present significant risks for suicide to have documented training in

assessment and management of suicidal individuals. Training also is required for staff who provide crisis intervention. Other training requirements are in place, as are specific staffing requirements applicable to those treating dually diagnosed patients. Requirements for specific settings include but are not limited to:

- **Medically Monitored Residential Detoxification Services:** Requirements include consultation from a substance abuse counselor before discharge; requirements for a nursing director and other nursing staff; and for physician availability.
- **Residential Intoxication Monitoring Services:** Requirements include staff trained in the recognition of withdrawal symptoms; and consultation from a substance abuse counselor before the patient is discharged.
- **Medically Monitored Treatment Services:** Requirements are in place for a director; substance abuse counselor to patient ratios; physician availability; clinical and counseling staff and clinical supervision; availability of a mental health professional to provide joint and concurrent services for the treatment of dually diagnosed patients; a trained staff member to be responsible for the operation of the service who is on the premises at all times; and service staff members trained in life-sustaining techniques and emergency first aid.
- **Transitional Residential Treatment:** Requirements are in place for a director; physician availability; clinical and counseling staff and clinical supervision; and availability of a mental health professional to provide joint and concurrent services for the treatment of dually diagnosed patients. A service must have a written policy and procedures manual that includes service goals and services defined and justified in terms of patient needs, including staff assignments to accomplish service goals.

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* People who do not fall within the boundaries of a CBRF license may not be admitted or retained. Nor may the following, among others: (a) A person who has an incompatible ambulatory or cognitive status. (b) A person who is destructive of property or self, or who is physically or mentally abusive to others, unless the CBRF has sufficient resources to care for such an individual and is able to protect the resident and others. (c) A person who has incompatible physical, mental, psychiatric or social needs. (d) A person who needs more than 3 hours of nursing care per week except for a temporary condition needing more than 3 hours of nursing care per week for no more than 30 days. (e) A person whose condition requires 24-hour supervision by a registered nurse or licensed practical nurse. (f) A person whose condition requires care above intermediate level nursing care. (g) Most persons requiring a chemical or physical restraint. (h) A person who is incapacitated, unless the person has a health care agent under a valid and properly activated power of

attorney for health care, or a court appointed guardian, except for the admission of an incapacitated individual who does not have such a legal representative, and who is admitted directly from the hospital. (i) A person who resides in a CBRF licensed for 16 or more residents, and has been found incompetent, and does not have a court-ordered protective placement. The CBRF shall assess each resident before admission and subsequently. For emergency admissions, assessment must be within 5 days. Residents must have health screening within 90 days before or 7 days after admission. The CBRF shall evaluate each resident within 3 days of the resident's admission to determine whether the resident is able to evacuate the CBRF.

*Substance Use Disorder (SUD):* All residential SUD treatment facilities must have written policies to ensure that recommendations relating to a patient's initial placement and continued stay are determined through the application of approved uniform placement criteria. A service shall complete withdrawal screening for a patient who is currently experiencing withdrawal symptoms or who presents the potential to develop withdrawal symptoms. Acceptance of a patient for substance abuse services shall be based on a written screening procedure and the application of approved patient placement criteria. All substance abuse screening procedures shall include the collection of data relating to impairment due to substance use consistent with the WI-UPC, ASAM patient placement criteria or other similar patient placement criteria approved by the department. All residential SU treatment facilities other than Medically Monitored Residential Detoxification Services and Residential Intoxication Monitoring Services must conduct ongoing specified assessments.

- Medically Monitored Residential Detoxification Services: A physician shall review and document the medical status of a patient within 72 hours after admission.
- Residential Intoxication Monitoring Services: A patient shall be screened by medical personnel before admission to the service. Prohibited admissions are specified including but not limited to a person requires medication normally used for the detoxification process.
- Medically Monitored Treatment Services: Admission to a medically monitored treatment service is appropriate only if one of the following conditions is met: (a) The person to be admitted is determined appropriate for placement in this level of care by the application of approved placement criteria. (b) The person to be admitted is determined appropriate for this level of care through the alternative placement recommendations of WI-UPC or other approved placement criteria. A service must complete intake within 24 hours of a person's admission to the service, with the assessment and treatment plan completed within 4 days of admission.
- Transitional Residential Treatment: A service must have a written policy and procedures manual that includes a statement concerning the type and physical condition of patients appropriate for the service, including an admission policy. A service must complete intake within 24 hours of a person's admission, with the initial assessment and initial treatment plan completed within 4 working days. Admission to a transitional residential treatment

service is appropriate only for limited reasons and in accordance with approved placement criteria.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Upon admission, the CBRF must develop a temporary service plan and, within 30 days a comprehensive individual service plan. It will be reviewed annually or as otherwise relevant.

*Substance Use Disorder (SUD):* A preliminary service plan must be developed, based upon the initial assessment. All residential SUD treatment facilities other than Medically Monitored Residential Detoxification Services and Residential Intoxication Monitoring Services must develop a treatment plan that meets certain requirements, including containing criteria for discharge, and that is reviewed “at regular intervals.” All residential SUD treatment facilities must have written policies to ensure that recommendations relating to a patient's level of care transfer and discharge recommendations are determined through the application of approved uniform placement criteria.

Part of intake must include explaining procedures for follow-up after discharge. All follow-up activities undertaken by the service for a current patient or for a patient after discharge shall be done with the written consent of the patient. A service that refers a patient to an outside resource for additional, ancillary or follow-up services shall determine the disposition of the referral within one week from the day the referral is initiated. A service that refers a patient to an outside resource for additional or ancillary services while still retaining treatment responsibility shall request information on a regular basis as to the status and progress of the patient. A service must follow-up on a patient transfer through contact with the service the patient is being transferred to within 5 days following initiation of the transfer and every 10 days after that until the patient is either engaged in the service or has been identified as refusing to participate.

Some services have additional requirements:

- **Medically Monitored Residential Detoxification Services:** The service must develop with each patient a detoxification plan and a discharge plan for the patient that addresses the patient's follow-up service needs, determined from the application of approved patient placement criteria administered by the service, and must include provision for referral, escort and transportation to other treatment services, as necessary, to ensure that continuity of care is provided. A service shall have a written agreement with certified substance abuse service providers or systems to provide care after the patient is discharged from the service.

- Residential Intoxication Monitoring Services: A service must develop with each patient a discharge plan for the patient which shall address the patient's follow-up service needs determined by application of approved patient placement criteria administered by the service, and the provision for referral, escort and transportation to other treatment services, as necessary, to ensure that continuity of care is provided.
- Transitional Residential Treatment: The service's treatment staff must prepare a written treatment plan for each patient referred from prior treatment service, which is designed to establish continuing contact for the support of the patient. A patient's treatment plan shall include information, unmet goals and objectives from the patient's prior treatment experience and treatment staff shall review and update the treatment plan every 30 days.

## Treatment Services

*Mental Health (MH) and Substance Use Disorder (SUD):* A CBRF must teach residents the necessary skills to achieve and maintain the resident's highest level of functioning. In addition to the assessed needs, the CBRF must provide or arrange services adequate to meet the needs of the residents in all of the following areas: personal care; supervision; leisure time activities; community activities; family and social contacts; communication skills; health monitoring; medication administration; behavior management; information and referral; transportation. Additional services are required for terminally ill residents.

*Substance Use Disorder (SUD):* Service staff must discuss risk factors for communicable diseases with each patient upon admission and at least annually. A service that provides 24-hour residential care must have a written plan for the provision of shelter and care for patients in the event of an emergency that would render the facility unsuitable for habitation. Specific requirements are in place for the four types of residential SUD treatment services.

- Medically Monitored Residential Detoxification Services: Multi-disciplinary care, including 24-hour nursing care under the supervision of a physician, is required. Included is the provision of an examination and transportation, if needed, to and from an emergency room of a general hospital for medical treatment.
- Residential Intoxication Monitoring Services: A residential intoxication monitoring service provides 24-hour per day observation by trained staff to monitor the safe resolution of alcohol or sedative intoxication and to monitor for the development of alcohol withdrawal for intoxicated patients who are not in need of emergency medical or psychological care. A service must have a written agreement with a general hospital for the hospital to provide emergency medical treatment of patients, with escort and transportation provided as necessary. A service shall not administer or dispense medications. A service must ensure that a patient receives consultation from a substance abuse counselor before the patient is discharged from the service.



- **Medically Monitored Treatment Services:** A medically monitored treatment service operates as a 24-hour, community-based service providing observation, monitoring and treatment by a multi-disciplinary team under supervision of a physician, with a minimum of 12 hours of treatment for each patient, including individual and group counseling. Family and couples counseling shall be provided or made available, when appropriate. The service shall ensure that each patient receives at least one hour of individual counseling per week. Additional requirements relate to medical screening; arrangement for medical, emergency and inpatient services; and provision of psychological tests as needed. A service shall have a written agreement with a hospital for provision of emergency and inpatient medical services, when needed.
- **Transitional Residential Treatment:** The service provides SUD treatment in the form of counseling equaling between 3-11 hours weekly, immediate access to peer support and intensive case management. Additional requirements relate to medical screening; arrangement for medical, emergency and inpatient services; and provision of psychological tests as needed. A service must have a written agreement with a hospital for provision of emergency and inpatient medical services, when needed. A service must provide support services that promote self-care and make job readiness counseling, problem-resolution counseling and prevocational and vocational training activities available to patients.

## **Patient Rights and Safety Standards**

*Mental Health (MH) and Substance Use Disorder (SUD):* The Wisconsin patients' rights requirements applicable to all MH and SUD facilities include, among others, informed consent, notification of rights, least restrictive treatment, religious freedom, confidentiality, communication, privacy, humane treatment, and the right to file grievances. Facilities using isolation, seclusion, or physical restraints must have written policies that meet certain standards. In a community placement, approval must be granted. In residential settings, there must be a formal and informal grievance resolution system. Administrative review may be requested of a program manager's decision.

- For a CBRF, investigation and reporting of critical incidents are required. CBRF residents must have their rights and the facility grievance procedure explained at admission. Among the rights specific to CBRF residents are: confidentiality, communication, presenting grievances, to be treated with courtesy, privacy, to be free from abuse, and to be free from seclusion or chemical restraints and free from physical restraints except under specified circumstances.

*Substance Use Disorder (SUD):* Each service must adopt written policies and procedures for reporting deaths of patients due to suicide or the effects of psychotropic medicines.

## **Quality Assurance or Improvement**

*Mental Health (MH) and Substance Use Disorder (SUD):* At least annually, a CBRF shall provide the resident and the resident's legal representative the opportunity to complete an evaluation of the resident's level of satisfaction with the CBRF's services.

*Substance Use Disorder (SUD):* A service must have an evaluation plan that includes all of the following: (1) A written statement of the service's goals, objectives and measurable expected outcomes that relate directly to the service's patients or target population. (2) Measurable criteria and a statistical sampling protocol which are to be applied in determining whether established goals, objectives and desired patient outcomes are being achieved. (3) A process for measuring and gathering data on progress and outcomes achieved with respect to individual treatment goals on a representative sample of the population served, and evaluations of some or all of specified patient outcome areas but including at least the following: living situation; substance use; employment, school or work activity, and criminal justice system involvement. (4) Methods for evaluating and measuring the effectiveness of services and using the information for service improvement. A service also must have a process for determining the effective utilization of staff and resources toward the attainment of patient treatment outcomes and the service's goals and objectives. A service must have a system for regular review of the appropriateness of the components of the treatment service and other factors that may contribute to the effective use of the service's resources. A service must obtain a completed patient satisfaction survey from a representative sample of all patients at or following their discharge from the service. A service must collect data on patient outcomes at patient discharge and may collect data on patient outcomes after discharge. The service director must complete an annual report on the service's progress in meeting goals, objectives and patient outcomes, and shall keep the report on file and shall make it available for review to an authorized representative of the department upon request. The governing authority or legal owner of the service and the service director must review all evaluation reports and make changes in service operations, as appropriate. If a service holds current accreditation from a recognized accreditation organization, such as the Joint Commission on Accreditation of Health Organizations, the Commission on Accreditation of Rehabilitation Facilities or the National Committee for Quality Assurance, the requirements under this section may be waived.

## **Governance**

*Mental Health (MH) and Substance Use Disorder (SUD):* All facilities are subject to a governing body with authority over such things as quality improvement and policy and protocol development.

*Substance Use Disorder (SUD):* All certified SUD residential treatment facilities must have a governing authority or legal owner who, among other things, establishes written policies and procedures for operations, nondiscrimination, admissions, treatment, staffing, and other matters, complies with all applicable laws, and appoints a director. Specific treatment levels may have additional requirements.

## **Special Populations**

*Substance Use Disorder (SUD):* All residential SUD treatment facilities must have written policies giving first priority for services to pregnant women who are alcohol or drug abusers. Specific regulations are in place regarding staffing for treatment of dually diagnosed patients.

## **Location of Regulatory and Licensing Requirements**

Department of Health Services Community MH regulations<sup>1</sup>; Department of Health Services Emergency Mental Health Service Program regulations<sup>2</sup>; Department of Health Services Community Substance Abuse Services regulations<sup>3</sup>; Department of Health Services Community Substance Abuse Services Dual Diagnosis regulations<sup>4</sup>; Patients' Rights regulations<sup>5</sup>; Department of Health Services Community-Based Residential Facility regulations<sup>6</sup>; Department of Health Services Universal Licensure statute<sup>7</sup>. Regulatory data collected September 19, 2019.

## **Other Information Sources**

B. Munger, (WI DHS); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>1</sup> See [https://docs.legis.wisconsin.gov/code/admin\\_code/dhs/030/61](https://docs.legis.wisconsin.gov/code/admin_code/dhs/030/61).

<sup>2</sup> See [https://docs.legis.wisconsin.gov/code/admin\\_code/dhs/030/34/III/22/4](https://docs.legis.wisconsin.gov/code/admin_code/dhs/030/34/III/22/4).

<sup>3</sup> See [https://docs.legis.wisconsin.gov/code/admin\\_code/dhs/030/75](https://docs.legis.wisconsin.gov/code/admin_code/dhs/030/75).

<sup>4</sup> See [https://docs.legis.wisconsin.gov/code/admin\\_code/dhs/030/75\\_b](https://docs.legis.wisconsin.gov/code/admin_code/dhs/030/75_b).

<sup>5</sup> See [https://docs.legis.wisconsin.gov/code/admin\\_code/dhs/030/94](https://docs.legis.wisconsin.gov/code/admin_code/dhs/030/94).

<sup>6</sup> See [https://docs.legis.wisconsin.gov/code/admin\\_code/dhs/030/83/I/01](https://docs.legis.wisconsin.gov/code/admin_code/dhs/030/83/I/01).

<sup>7</sup> See <https://docs.legis.wisconsin.gov/statutes/statutes/50>.

# WISCONSIN MEDICAID

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## Approach

The Wisconsin Department of Health Services (DHS) oversees the state Medicaid program. Wisconsin also has a Section 1115 waiver permitting Medicaid expenditures specific to the provision of substance use disorder (SUD) services in facilities that qualify as institutions for mental diseases (IMDs), including specifically short-term residential settings. The state also historically has relied on the in lieu of provision for Medicaid coverage of some IMD services but not Disproportionate Share Hospital (DSH) payments.

## Types of Facilities

*Mental Health (MH):* Researchers found no other evidence of Medicaid reimbursement for adult residential MH treatment services.

*Substance Use Disorder (SUD):* The Wisconsin Section 1115 waiver permits Medicaid reimbursement for the following residential settings:

- Level 3.1 Transitional Residential Programs.
- Level 3.7 Medically Monitored Treatment Services.
- Medically Supervised Withdrawal Management.

Medication-assisted treatment also is to be available to those in facilities.

## Processes of Medicaid Enrollment

*Mental Health (MH) and Substance Use Disorder (SUD):* All providers must be licensed/certified in order to provide residential SUD treatment in Wisconsin. All providers participating in the Wisconsin Medicaid program must be certified to do so and must submit specific information to the program and execute a provider agreement, typically for a period of one year. Certification may be suspended or revoked and other sanctions may be imposed.

## **Staffing**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the credentials of staff for residential treatment settings.

## **Placement**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver, the state must establish a requirement that providers assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the American Society of Addiction Medicine (ASAM) Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines. The state must have in place a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings. Admission to a program is based on an intake procedure that includes screening, approved patient placement criteria, and initial assessment.

## **Treatment and Discharge Planning and Aftercare Services**

*Substance Use Disorder (SUD):* Researchers did not locate regulations or waiver requirements related to treatment or discharge planning or aftercare services offered by the facility, pertaining to residential SUD treatment for adults.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Services must be appropriate and medically necessary.

*Substance Use Disorder (SUD):* Under the state demonstration, beneficiaries will have access to high quality, evidence based OUD and other SUD treatment services ranging from medically supervised withdrawal management to on-going chronic care for these conditions in cost-effective settings while also improving care coordination and care for comorbid physical and mental health conditions. Residential treatment providers must offer medication-assisted treatment on-site or facilitate offsite medication assisted treatment. The state will establish residential treatment provider qualifications in licensure, policy or provider manuals, managed care contracts or credentialing, or other requirements or guidance that meet program

standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services and hours of clinical care.

## **Care Coordination**

*Substance Use Disorder (SUD):* Under the Section 1115 waiver, there must be establishment and implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities. The residential SUD benefit will be carved into acute managed care plans effective January 2020 to ensure coordination between physical and behavioral health services.

## **Quality Assurance or Improvement**

*Substance Use Disorder (SUD):* Pursuant to the Section 1115 waiver the state must establish a provider review process to ensure that residential treatment providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings.

## **Special Populations**

*Substance Use Disorder (SUD):* No Medicaid requirements were located other than the requirement in the Section 1115 waiver that care for comorbid physical and mental health conditions be improved by the demonstration.

## **Location of Medicaid Requirements**

Wisconsin Medicaid Rules and Regulations<sup>8</sup>; Wisconsin 1115 Waiver<sup>9</sup>. Regulatory data collected December 2019.

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<sup>8</sup> See [https://docs.legis.wisconsin.gov/code/admin\\_code/dhs/101](https://docs.legis.wisconsin.gov/code/admin_code/dhs/101).

<sup>9</sup> See <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wi/wi-badgercare-reform-ca.pdf>.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report **“State Residential Treatment for Behavioral Health Conditions: Regulation and Policy”**. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

## WYOMING

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### Types of Facilities

*Mental Health (MH):* Wyoming regulates Group Residential Services, which are non-medical, fully supervised room, board, and therapeutic structure provided in a licensed facility directly operated by professional staff of a state certified community mental health center that also provides outpatient treatment for residents. These are limited to those that receive state funds or request to be licensed/certified.

*Substance Use Disorder (SUD):* Wyoming regulates all community substance abuse treatment services, including those identified below under the first 4 bullets, that receive state funds or that elect to be certified. Separate regulations apply specifically to programs and personnel providing substance abuse services, which are purchased in whole or in part by the State of Wyoming. Two additional, overlapping definitions are included below (see 5th and 6th bullets).

- **Clinically Managed Residential Social Detoxification:** A social detoxification service is an organized service that may be delivered by appropriately trained staff that provides 24-hour supervision, observation and support for clients who are intoxicated or experiencing withdrawal. Social Detoxification services are characterized by their emphasis on peer and social support.
- **Medically-Monitored Residential Detoxification Services:** A medically-monitored detoxification service is an organized service delivered by medical and nursing professionals, which provides twenty-four (24) hours a day, seven (7) days a week medically supervised evaluation and withdrawal management in a permanent facility with inpatient beds.
- **Residential Treatment Services:** Clinical services can be provided in a low, medium or high intensity level of service based on client needs utilizing the ASAM dimensional criteria to determine at what level the client should participate. Services include at least thirty (30) hours of structured services that are designed to treat persons who have significant social and psychological problems. If the program does not have availability, pre-engagement services shall be provided by the referring agency or the accepting agency. Service hours can be reduced based on client progress and outside activities, such as employment. When the client has reached a sustained level of functioning based on ASAM dimensional criteria, the client must be transferred to a less intensive level of care. Such programs are



characterized by their reliance on the treatment community as a therapeutic agent. The goals of treatment are to promote abstinence from substance use, to promote healthier behavior patterns, and to affect a global change in participants' lifestyles, attitudes and values. The approach views substance-related problems as disorders that must be treated holistically.

- **Transitional Residential Treatment Services:** A transitional residential treatment service is a clinically managed, low intensity, peer-supported, therapeutic environment. The term "residential transition treatment service" does not include independent, self-operated facilities such as Oxford Houses.
- Under the regulations promulgated under the Community Human Services Act, "Transitional Residential Care Program" means a community-based program that provides services in a home-like setting to alcohol and drug abusers who have made a clear commitment to abstinence and to continue a recovery process after having received treatment in a more structured treatment setting. Transitional Residential Care for adults is further defined as a 30-120 day recovery process in a homelike setting which provides daily needs for food and shelter for adult alcohol and drug abusers who have made a clear commitment to abstinence and have received sufficient substance abuse treatment to continue recovery.
- Under the regulations promulgated under the Community Human Services Act, a "Primary Residential Treatment Program" means a community-based program that provides 24-hour live-in rehabilitation for alcohol and drug abusers whose chemical dependency does not require intensive medical or psychiatric management but does require intensive evaluation and treatment in a structured setting. Primary Residential Treatment Services for adults are further defined as 28-30 day, non-medical, 24-hour, live-in, treatment program for chemically dependent adults who require intensive evaluation and treatment services in a highly structured setting.

*Unregulated Facilities:* Facilities that do not receive state funds or that do not request certification are not regulated. We exclude Adult Support Homes, Therapeutic Communities, and Supportive Transitional Drug-Free Housing Services from this summary as not involving clinical services.

## **Approach**

*Mental Health (MH) and Substance Use Disorder (SUD):* The Wyoming DOH Division of Behavioral Health (DBH) regulates all MH and SUD programs that receive state funding or that elect to be licensed or certified.

## Processes of Licensure or Certification and Accreditation

*Mental Health (MH):* Licensure by the DBH is required for any provider of Group Residential Services receiving state funds. Standards for licensure were not located but standards management regulations that are generally applicable to both mental health and substance use treatment programs were located and do provide for certification. Facilities also may request to be certified.

- All community mental health providers in the State of Wyoming are required to be nationally accredited through either CARF or JCAHO. National accreditation is prima facie evidence of compliance with the Mental Health Standards.
- A biennial on-site evaluation of state-funded programs is required.
- A Certificate of Need is not required for operation.
- Certification duration is up to two years, depending on the level of compliance seen at inspection. The application and inspection focus on demonstration of substantial compliance with the certification standards.

*Substance Use Disorder (SUD):* Certification by the DBH is required for any program, provider, or facility receiving state funds for substance abuse treatment services. Facilities also may request to be certified. Additionally, no substance abuse treatment program may receive court referred or ordered clients unless it is certified.

- Providers with Community Substance Use Treatment (those funded by the Division) designation must also hold national accreditation through CARF, JCAHO, or a similar national accreditation agency as approved by the Division. Otherwise, accreditation is not required but, if a program has current recognized national accreditation for substance abuse treatment by specific level of care, applicable portions of the accreditation can be reviewed as part of the certification site visit at the discretion of the Division. Applicable portions of the national accredited report by level of service that are congruent with these rules will be accepted in lieu of reviewing documentation for compliance with these rules. Sections that are not congruent with these rules will be reviewed as part of the certification site visit. If Wyoming Standards exceed national accreditation standards, Wyoming Standards will be required and reviewed for compliance. Records will be reviewed for compliance by level of service when national accreditation standards require state compliance for approval under the national standards. Certification reports will reference portions that were viewed as congruent by level of service in the certification report and note compliance.
- An inspection is required for certification and renewal.

- A Certificate of Need is not required for operation.
- Certification duration is up to two years, depending on the level of compliance seen at inspection. The application and inspection focus on demonstration of substantial compliance with the certification standards.

## **Cause-Based Monitoring**

*Mental Health (MH) and Substance Use Disorder (SUD):* Under the Community Human Services Act, the DBH may find a program to be in noncompliance with the regulations and deny, suspend, or revoke a determination of compliance or certification. DOH may conduct on-site inspections for on-going monitoring in addition to regularly scheduled inspections.

## **Access Requirements**

*Mental Health (MH) and Substance Use Disorder (SUD):* Wait time standards were not located. Under the Community Human Services Act, persons shall have impartial access to treatment, regardless of race, religion, sex, ethnicity, age, physical handicap, type of mental health or substance abuse disorder, or sources of financial support. No person shall be denied services based solely on ability to pay even the minimum charge on the Division's fee scale guidelines.

*Substance Use Disorder (SUD):* Wait-time requirements were not found. Each program must establish written policies and procedures ensuring that services will be available and accessible where no person will be denied service or discriminated against based on sex, race, color, creed, sexual orientation, handicap, or age. Each program shall have policies that assure availability and accessibility for all persons regardless of cultural background, criminal history, drug of choice, and medical status among other factors. However, each program may impose reasonable programmatic restrictions that are intended to support therapeutic goals of the program, meet restrictions of government grants or funding, or required by limitations of the program to provide services specific to a person.

## **Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD):* Under the Community Human Services Act, there must be written personnel policies, including but not limited to policies related to supervision and handling client neglect and abuse.

*Mental Health (MH):* Under the Community Human Services Act, all personnel providing mental health services shall be either mental health professionals or shall be mental health counselors, mental health assistants, or mental health technicians working under the direct,

documented supervision of a mental health professional. Personnel standards include experience and education needed to be executive director of a mental health program, a mental health professional, a mental health assistant, and a mental health technician.

*Substance Use Disorder (SUD):* Programs must have written policies and procedures addressing, among other things, that, in the selection of staff, consideration when possible will be given to each applicant's cultural competency of special populations that the program serves. Programs must have policies regarding use of volunteers. Programs must have written policies and procedures for determining staff training needs, formulating individualized training plans, developing cross-training activities with other professional disciplines, and documenting the progress and completion of staff development goals. At a minimum, training shall include trauma assessment and management, cultural competency, rights of person served, family centered services, prevention of workplace violence, confidentiality requirements, professional conduct, ethics, and special populations served specific to services being provided. All programs with two or more persons employed or under contract shall implement and enforce policies and procedures establishing a drug-free workplace. A program shall have written policies and procedures to ensure compliance with confidentiality and privacy requirements. A program shall have an Executive Director appointed by the governing authority or legal owner and regulations describe responsibilities of the program and Executive Director. Regulations include requirements for clinical oversight.

- Clinically Managed Residential Social Detoxification and Medically-Monitored Residential Detoxification Services: Regulations include requirements ensuring a client receives appropriate information and consultation from a licensed clinical staff person when possible regarding treatment options before the scheduled discharge of the client from the service; requirements regarding sufficient clinical and other staff; and all staff that assess and treat clients must be able to obtain and interpret information regarding the needs of clients and must be knowledgeable about the bio-psychosocial spiritual dimensions of alcohol and other drug dependence.
- Clinically Managed Residential Social Detoxification: Program staff will be cross trained and will implement motivational enhancement techniques to engage clients into treatment. Access to a physician shall be available on call twenty-four (24) hours a day, seven (7) days a week.
- Medically-Monitored Residential Detoxification Services: The program shall have a medical director who is appropriately licensed or registered in the State of Wyoming and is responsible for overseeing the monitoring of the client's progress and medication administration, and who is trained and competent to implement physician approved protocols for client observation and supervision. A Registered Nurse or Licensed Practical Nurse shall be available on site on a twenty-four (24) hours a day, seven (7) days a week, and will conduct a nursing assessment on the client at the time of admission. A physician shall be available on-call twenty four (24) hours a day, seven (7) days a week.

- Residential Treatment Services: The service shall have sufficient clinical staff and support staff to meet the needs of the client. Clinical services are staffed by appropriately staffed by Qualified Clinical Staff person(s) who are credentialed through the Wyoming Mental Health Professions Licensing Board, a psychologist who is licensed to practice psychology, a Licensed Physician by the Wyoming State Board of Medicine, and a Wyoming Advanced Psychiatric Nurse. A physician and/or nursing staff is available to provide consultation as either an employee of the program or through written agreement. All staff persons who assess and treat clients must be capable of obtaining and interpreting information regarding the needs of clients and must be knowledgeable about the bio-psychosocial dimensions of alcohol and other drug dependence. A staff person with the responsibility of assuring case management services is provided. A mental health professional is available either as an employee of the service or through written agreement to provide joint and concurrent services for the treatment of clients diagnosed, unless the clinical staff person is cross-trained in mental health.
- Transitional Residential Treatment Services: A physician shall be available to provide medical consultation as either an employee of the service or under written contract with the service program. The program shall have sufficient clinical staff and support staff to meet the needs of the client.

Under the Community Human Services Act, all personnel providing substance abuse services shall be either substance abuse professionals or shall be substance abuse counselors, substance abuse assistants, or substance abuse technicians working under the direct, documented supervision of a substance abuse professional. Personnel standards include experience and education needed to be executive director of a substance abuse program, a substance abuse professional, a substance abuse counselor, a substance abuse assistant, a substance abuse technician, a prevention specialist, or a prevention technician. All staff of primary and transitional treatment programs shall have basic first aid training which includes CPR training.

## **Placement**

*Mental Health (MH):* Requirements related to placement for adult residential MH facilities were not located.

*Substance Use Disorder (SUD):* Screening and assessment require use of the following instruments and protocols when conducting a comprehensive assessment of addiction severity, determining diagnosis, and setting the stage for appropriate placement of clients into treatment for alcohol and other drug addiction. A program may choose to use other instruments in addition to those set forth in these rules: (a) A program shall, at a minimum, complete a nationally recognized withdrawal assessment tool such as the Clinical Institute Withdrawal Assessment (CIWA-R) for alcohol for screening clients at risk of experiencing withdrawal symptoms, if indicated. The results of this instrument will indicate if the client

needs to be referred for detoxification services. (b) A program serving adults shall utilize the ASI or such other assessment tool as may be designated by the Division following input from a committee process involving publicly funded and privately unfunded providers from the field and consumers, as well as comprehensive information regarding the client's bio-psychosocial spiritual needs in the assessment of the client. An assessment tool with content that meets or exceeds the content of the ASI may be used upon approval of the Division. Assessments can only be completed by a qualified clinical staff person who is credentialed through the Wyoming Mental Health Professions Licensing Board, a psychologist who is licensed to practice psychology, a Licensed Physician by the Wyoming State Board of Medicine, and a Wyoming Advanced Psychiatric Nurse. ... (d) A program shall utilize the current version of the Diagnostic and Statistical Manual (DSM) completing a five (5) axis differential diagnosis of the client. (e) A program shall utilize the current version of the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC) as part of the assessment process. ASAM dimensional criteria for each domain must be addressed in the assessment of client need for treatment. (f) A program shall develop a diagnostic statement summarizing the above elements to assure clarity of client need and treatment recommendations. (g) A program shall adequately assess the client's need for case management. (h) When a client is transferred from another program and an assessment has been completed, the program must complete a transfer note showing that the assessment information was reviewed. Further, the program must determine if the client needs are congruent with this assessment and adjust treatment recommendations, if applicable. ASAM continued stay, transfer and discharge criteria also apply, as do ASAM discharge/transfer criteria.

Under the Community Human Services Act, all substance abuse residential services funded by the state must evaluate the client's medical status as soon as possible, but not to exceed seventy-two hours following the client's admission to the program. The evaluation may be waived, if a copy of a physical exam performed within the sixty days prior to admission is contained in the client file. Specific requirements for the evaluation are in the regulations as are standards for determining appropriate placement, including who can conduct the evaluations and assessments. Contents of an admission policy are specified.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH):* Requirements related to treatment or discharge planning or aftercare services for adult residential MH facilities were not located.

*Substance Use Disorder (SUD):* Under the Community Human Services Act, programs must have written procedures for referral to appropriate continuing care services and each facility type has specific requirements related to continuing care. In addition:

- Clinically Managed Residential Social Detoxification: If possible, the program shall develop a discharge plan for each client that addresses the client's follow-up service needs.

- **Medically-Monitored Residential Detoxification Services:** The program shall develop with each client a detoxification plan and a discharge plan that addresses the client's follow-up service needs, determined from the application of approved client placement criteria administered by qualified clinical staff.
- **Residential Treatment Services: Individualized Treatment Planning.** An initial treatment plan shall be completed within one (1) week of the initial assessment focusing on stabilization of the client. Treatment plan goals must be more individualized and measurable as the client stabilizes. Treatment plans shall be developed utilizing the assessment information, including ASAM dimensional criteria and the DSM diagnosis. Treatment plans shall integrate mental health issues if identified as part of the assessment process, or at any point during the continuum of treatment. Treatment plan reviews shall be completed throughout the course of treatment based on client progress or lack of progress toward goals per ASAM continued stay, transfer and discharge criteria. Modifications shall be made as clinically indicated. ASAM Continued Stay, Transfer and Discharge Review. ASAM dimensional criteria shall be reviewed by the clinical staff person responsible for treatment whenever the condition changes significantly. At a minimum, dimensional criteria must be reviewed with support documentation at least one (1) time every two (2) weeks. Severity shall be rated for each dimension with sufficient documentation showing justification for level of care recommendations.
- **Transitional Residential Treatment Services:** Treatment planning must meet the standard set forth for Outpatient Services. Among other things, those provide that treatment plans shall be completed in conjunction with the initiation of treatment. Treatment plans shall be developed utilizing the assessment information, including ASAM dimensional criteria and the DSM diagnoses. Treatment plans shall integrate mental health issues, if identified as part of the assessment process, or at any point during the continuum of treatment. Treatment plan reviews shall be evaluated throughout the course of treatment based on client progress or lack of progress toward goals per ASAM continued stay, transfer and discharge criteria. Modifications shall be made as clinically indicated.

## **Treatment Services**

*Mental Health (MH) or Substance Use Disorder (SUD):* Under Community Human Services Act, programs must have a written service plan which delineates the way all services are provided. The service plan shall describe how the program determined the needs for services in the service area. The program shall have written policies and procedures that facilitate the referral of clients among a program's components and that promote consultation between the program and other service providers in the community.

*Substance Use Disorder (SUD)*: Programs shall have a written plan for providing dedicated case management services to clients and their families in conjunction with or as part of the client's substance abuse treatment. Programs shall collaborate with other agencies, programs, and services in the community to meet individual client needs. For clients with mental health problems, the issues of psychotropic medication, mental health treatment and their relationship to substance abuse disorders are addressed, as the need arises. Programs that provide co-occurring treatment offer therapies to actively address, monitor, and manage psychotropic medication, mental health treatment and the interaction with substance-related disorders. There may be close coordination with intensive case management and assertive community treatment for clients who have severe and persistent mental illness.

- **Clinically Managed Residential Social Detoxification**: The program shall maintain a standard detoxification protocol that includes emergency procedures, which are reviewed and approved by a physician at least annually. The program shall have immediate access to first aid supplies, separate locked cabinets for pharmaceutical supplies, and written policies and procedures for the management of belligerent and disturbed clients.
- **Medically-Monitored Residential Detoxification Services**: The staff physician shall review and document the medical status of a client within twenty-four (24) hours after admission. The program shall have written policies and procedures for the management of belligerent and disturbed clients. The program shall have a written agreement with a hospital or local medical clinic to provide emergency medical services for clients, if clinically necessary.
- **Residential Treatment**: A physician shall review and document the medical status of a client within forty-eight (48) hours after admission. Clinical and wrap around services shall be provided. Planned clinical program activities shall be provided to stabilize and maintain stabilization of the resident's substance dependence symptoms and to help her develop and apply recovery skills. Activities include relapse prevention, interpersonal choices and development of social network supportive of recovery. Counseling and clinical monitoring shall be provided to promote successful initial involvement or re-involvement in regular, productive daily activity, such as indicated, successful reintegration into family living. Random drug testing shall be administered when indicated. Services include, but are not limited to, a range of cognitive, behavioral and other therapies based on client needs, including individual, group, and family, medication education and management, educational groups, and occupational groups and recreational therapy. For clients with mental health problems, the issues of psychotropic medication, mental health treatment and their relationship to substance abuse disorders are addressed, as the need arises. Programs that provide co-occurring treatment offer therapies to actively address, monitor, and manage psychotropic medication, mental health treatment and the interaction with substance-related disorders. There may be close coordination with intensive case management and assertive community treatment for clients who have severe and persistent mental illness.



- **Transitional Residential Treatment Services:** The service provides substance abuse treatment in the form of counseling for at least five (5) hours per week in-house or through a local certified program, with access to peer support through case management. Therapies and interventions shall meet the standard set forth for Outpatient Services. Those provide that intervention services involve skilled treatment services, which include, but are not limited to, individual and group counseling, as indicated by client need, family therapy, educational groups, occupational and recreational therapy, psychotherapy or other therapies, as indicated by client need. Such services are provided in an amount, frequency and intensity appropriate to the client's individualized treatment plan. Motivational enhancement and engagement strategies are used in preference to confrontational approaches. For clients with mental health problems, the issues of psychotropic medication, mental health treatment and their relationship to substance abuse disorders are addressed, as the need arises. Programs that provide co-occurring treatment offer therapies to actively address, monitor, and manage psychotropic medication, mental health treatment and the interaction with substance-related disorders. There may be close coordination with intensive case management and assertive community treatment for clients who have serious and persistent mental illness.

Under the Community Human Services Act, all substance abuse residential services funded by the state must establish a written plan to assist the client in obtaining appropriate medical services at the client's expense.

- A Primary Residential Treatment Program shall provide services according to a schedule that includes, among other services, the following: (a) 28-35 hours per week of intensive, structured, staff-facilitated, group activities which focus on all aspects of chemical dependency, the predominant life issues that impact on recovery, and the individual concerns of each client, including an educational program dealing with alcoholism and addiction, personal growth, the recovery process, and a philosophy of living that will support recovery; (b) a family program; (c) individual counseling, as appropriate; (d) referral to appropriate self-help groups; and (e) a plan for continuing care.
- An Adult Transitional Residential Care Program focuses on activities and coping skills for daily independent living and provides, among other things: (a) a treatment plan that addresses substance abuse and the specific behaviors that must be changed in order to obtain and maintain a lifestyle free of chemicals of abuse; (b) 8-12 hours per week of staff-facilitated, structured, group functions aimed at promoting adjustment to a chemically abstinent lifestyle; and (c) Individual counseling as appropriate.

## **Patient Rights and Safety Standards**

*Mental Health (MH) or Substance Use Disorder (SUD):* Under the Community Human Services Act, programs shall support and protect the fundamental human, civil, constitutional, and

statutory rights of each client and substance abuse programs must comply with 42 CFR Part 2. Clients have the following rights, among others, dignity, privacy, communication, confidentiality, grievance, to be informed of their rights, and to be free from physical restraints and isolation except when there is an immediate danger to self or others. Each residential program shall have a written policy covering the use of restraint and isolation, which ensures that the dignity and safety of the person are protected and that there is regular, frequent monitoring by trained staff. If a residential program limits or denies client's rights because of clinical contraindications, such limitations or denials shall be fully documented in the clinical record.

*Substance Use Disorder (SUD):* Among other rights, clients have the right of confidentiality. Under the Community Human Services Act, substance abuse program policies shall prohibit the use of isolation or restraint, except when there is an immediate danger to self or others.

## **Quality Assurance or Improvement**

*Mental Health (MH):* Requirements related to quality assurance/improvement for adult residential MH facilities were not located.

*Substance Use Disorder (SUD):* A program must have an evaluation plan measuring the effectiveness of treatment and prevention services when requested by the Division.

## **Governance**

*Mental Health (MH) or Substance Use Disorder (SUD):* Programs certified by the `DBH are those receiving state funding. As such they have contractual and regulatory requirements including financial responsibilities. Under the Community Human Services Act, each program shall have a governing body that has overall responsibility for the operation of the program and satisfies financial management requirements. The program also must develop written operating policies.

*Substance Use Disorder (SUD):* Regulated SUD residential facilities must have a governing authority or legal owner with the primary responsibility to create and maintain the organization's core values and mission via a well-defined annual plan. It assumes final authority over and responsibility for the accountability of all programs. The authority ensures compliance with applicable legal and regulatory requirements. It advocates for needed resources to carry out the mission of the organization and provides guidance to the management to ensure the success of day to day operations. Each program shall have a governing body or other responsible person who is accountable for the development of policies and procedures to guide the daily operations. Each program shall keep, maintain, and make available to any employee or client an organizational chart and written policies that describe the organizational structure,

including lines of authority, responsibility, communication, and staff assignments. Each program will have a plan that monitors operations in the areas of organization, human resource, fiscal and services provided. The program must ensure that all its program(s), facilities, and services comply with all applicable federal, state, and local laws, regulations, codes and ordinances; has a local business license if required; and has liability insurance.

## Special Populations

*Mental Health (MH)*: Requirements related to special populations were not located.

*Substance Use Disorder (SUD)*: In addition to adolescent and criminal justice involved clients, special populations are identified as those needing the following services:

- **Co-Occurring Treatment Services**: A program may be certified to provide treatment to co-occurring clients. Treatment services are based on the Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Improvement Protocol (TIP) Series publication, "Substance Abuse Treatment with Co-Occurring Disorders." At a minimum, services must: (A) address a high level of relapse potential with more intense level of services; (B) adapt program materials and methods of counseling to individuals with mental disorders; (C) provide and utilize skill building groups, as appropriate; (D) provide intensive case management; and (E) emphasize motivation enhancement, including outreach for clients with active substance abuse disorders and severe mental disorders who are disengaged.
- **Women's Specific Treatment Services**: A program shall be certified to provide treatment to women if it is receiving women's Set-Aside funding through the SAPT Federal Block Grant. Programs not receiving funding may also apply for this special population service. Treatment services are based on the Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Improvement Protocol (TIP) Series publication, "Substance Abuse Treatment for Pregnant, Substance-Using Women, Substance Abuse Treatment for Women Offenders and Gender Specific Treatment and Treatment with Co-Occurring Disorders." At a minimum, services shall include: (A) Gender specific treatment; (B) Reintegration with family services, when applicable; (C) Vocational skills training; (D) Parenting skills; (E) Reproductive and other health education and referrals; (F) Ways of meeting needs of food, clothing, and shelter; (G) Transportation; (H) Sexual abuse/trauma treatment, when applicable; and (I) Domestic/family violence counseling, when applicable.
- **Residential Treatment for Persons with Dependent Children**: A program may be certified to provide treatment to persons with dependent children. Treatment services are based on the Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Improvement Protocol (TIP) Series publication, "Substance Abuse Treatment for Persons

with Children." At a minimum, services shall include: (A) Gender specific treatment and family treatment of substance abuse impact on school aged children, pre-school children, toddlers, and infant children; (B) Child development and age appropriate behaviors; (C) Parenting skills appropriate for infants, toddlers, pre-school, and school aged children; (D) Impact of prenatal tobacco/alcohol/drug exposure on child development, fetal alcohol syndrome/effects; and (E) Recognition of sexual acting-out behavior.

## **Location of Regulatory and Licensing Requirements**

Wyoming DOH DBH 048-0005, 0018, 0054; Accreditation<sup>1</sup>; Community Mental Health and Substance Abuse Program regulations (048-0018)<sup>2</sup>. Regulatory requirements reviewed September 20, 2019.

## **Other Information Sources**

M. Smith (DBH); National Conference of State Legislatures CON Program Overview, <http://www.ncsl.org/research/health/con-certificate-of-need-state-laws.aspx>

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<sup>1</sup> See <https://health.wyo.gov/behavioralhealth/mhsa/rules-and-regulations/>.

<sup>2</sup> See <https://rules.wyo.gov/Search.aspx?mode=1>.

# WYOMING MEDICAID

*This summary of state regulations and policy represents only a snapshot at a point in time, is not comprehensive, and should not be taken to constitute legal advice or guidance. State Medicaid requirements are included at the end of this summary.*

## Approach

The Wyoming Department of Health (DOH) oversees the state Medicaid program. Wyoming does not have a relevant Section 1115 waiver that affects reimbursement of residential services in Institutions for Mental Diseases (IMDs). It historically has not relied on Disproportionate Share Hospital (DSH) payments or the in lieu of provision to reimburse certain services in IMDs.

## Types of Facilities

*Mental Health (MH) or Substance Use Disorder (SUD):* Medicaid regulations do not indicate that MH or SUD residential treatment facilities for adults may enroll in the state Medicaid program. Nor is the state plan specific about residential treatment. The state Behavioral Health Provider Manual does, however, include residential place of service codes for the following defined facilities:

- Residential Substance Abuse Treatment Facility: A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory test, drugs and supplies, psychological testing, and room and board.
- Psychiatric Residential Treatment Center: A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.

The Manual, however, states that services in these locations are considered agency based (typically provided in a clinic or office setting, but in these instances the institution with which the provider has a contract is considered, for billing purposes, to be an extension of the agency based provider), and not community based services. Thus, Wyoming Medicaid does not, per se, regulate residential MH or SUD treatment for adults. Rather, it regulates services that may be provided in those settings or elsewhere by individual providers or agencies.

## **Processes of Medicaid Enrollment**

*Mental Health (MH) and Substance Use Disorder (SUD):* Medicaid regulations do not indicate that MH or SUD residential treatment facilities for adults are covered by the state Medicaid agency. Services may be rendered under contract with a residential facility and those services are regulated as they would be if provided in other settings such as outpatient clinics and the individual provider or agency operating under contract with the residential facility would be licensed as they would for provision of those services elsewhere. As a general matter, all behavioral health providers must maintain state licensure to be enrolled.

## **Staffing**

*Mental Health (MH) and Substance Use Disorder (SUD):* Services may be rendered under contract with a residential facility and those services are regulated as they would be if provided in other settings such as outpatient clinics.

## **Placement**

*Mental Health (MH) and Substance Use Disorder (SUD):* Services may be rendered under contract with a residential facility and those services are regulated as they would be if provided in other settings such as outpatient clinics.

## **Treatment and Discharge Planning and Aftercare Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Services may be rendered under contract with a residential facility and those services are regulated as they would be if provided in other settings such as outpatient clinics.

## **Treatment Services**

*Mental Health (MH) and Substance Use Disorder (SUD):* Services may be rendered under contract with a residential facility and those services are regulated as they would be if provided in other settings such as outpatient clinics.

## Care Coordination

*Mental Health (MH) and Substance Use Disorder (SUD):* Services may be rendered under contract with a residential facility and those services are regulated as they would be if provided in other settings such as outpatient clinics.

## Quality Assurance or Improvement

*Mental Health (MH) and Substance Use Disorder (SUD):* Services may be rendered under contract with a residential facility and those services are regulated as they would be if provided in other settings such as outpatient clinics.

## Special Populations

*Mental Health (MH) and Substance Use Disorder (SUD):* Services may be rendered under contract with a residential facility and those services are regulated as they would be if provided in other settings such as outpatient clinics.

## Location of Medicaid Requirements

Wyoming Medicaid Rules 048.0037<sup>3</sup>; Provider Manual<sup>4</sup>; Wyoming State Plan<sup>5</sup>. Regulatory requirements reviewed December 2019.

## Other Information Sources

Kaiser Family Foundation. State Options for Medicaid Coverage of Inpatient Behavioral Health Services. KFF: San Francisco. November 2019 <http://files.kff.org/attachment/Report-Brief-State-Options-for-Medicaid-Coverage-of-Inpatient-Behavioral-Health-Services>

This state summary is part of the report “**State Residential Treatment for Behavioral Health Conditions: Regulation and Policy**”. The full report and other state summaries are available at <https://aspe.hhs.gov/state-bh-residential-treatment>.

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<sup>3</sup> See <https://rules.wyo.gov/Search.aspx?mode=1>.

<sup>4</sup> See [https://wymedicaid.portal.conduent.com/manuals/Manual\\_CMS1500\\_01\\_01\\_20.pdf](https://wymedicaid.portal.conduent.com/manuals/Manual_CMS1500_01_01_20.pdf).

<sup>5</sup> See <https://health.wyo.gov/healthcarefin/medicaid/spa/>.

# APPENDIX C.

## Detailed Methodology

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## **ACRONYMS**

The following acronyms are mentioned in this appendix.

CHIP	Children's Health Insurance Program
M/SUD	Mental and Substance Use Disorders
MACPAC	Medicaid and CHIP Payment and Access Commission
MCE	Managed Care Entity

## METHODOLOGY

As a precursor to the collection and synthesis of data drawn primarily from state law, we conducted an environmental scan and interviewed experts in the field. The environmental scan summarizes the literature on oversight of residential care for M/SUDs in the United States. A systematic approach was used to conduct the environmental scan in which we examined national surveys, English-language peer-reviewed literature (2014-2018), and grey literature no more than 5 years old, unless identified as key by a subject matter expert. We conducted keyword searches using databases such as PubMed and Google Scholar. Relevant articles and other source documents were reviewed, synthesized, and summarized in the environmental scan, which is published separately.<sup>1</sup> In addition, we identified and interviewed a number of subject matter experts who are recognized in the acknowledgments section of this Compendium.

On the basis of findings from the environmental scan<sup>1</sup> and interviews with experts, we developed a template that provided the coding structure for data collected throughout the project. We gathered source data for all states by reviewing statutes and regulations governing M/SUD treatment and licensing or certification. We trained four analysts in both data collection and coding according to a standardized protocol. Senior members of the team worked closely with the analysts as they proceeded through the data collection to ensure completeness and relevance and verified the reliability and validity of coding done during the project. Relevant statutes and regulations from 51 jurisdictions were reviewed and abstracted into the data collection template. A senior staff person reviewed 25% of abstractions for completeness and accuracy. Any discrepancies among coders were discussed and adjudicated. We prepared detailed state summaries of: (1) licensure standards; and (2) Medicaid requirements by synthesizing the abstracted information (see Appendix B).

Throughout the study, we used a legal mapping framework. This approach provides structured steps to follow in reviewing and compiling information from legal documents. In addition, we coordinated with other federal efforts on this topic and leveraged efficiencies available through ongoing parallel efforts, such as those being led by the MACPAC.<sup>2</sup> By integrating input from leaders in this field throughout the course of the project, as well as applying a rigorous legal mapping framework for abstraction and synthesis, we generated accurate information to disseminate widely and inform next steps in addressing capacity for M/SUD treatment across the continuum of care.

The state summaries that resulted from data collection regarding licensure were shared with the individual states for validation. On the basis of input from those states, we revised the summaries as necessary. In some instances, state personnel provided additional sources of information beyond the statutes and regulations and, to the extent it was pertinent to the study, that information was included. Among other things, these additional sources of information sometimes included certification or licensure manuals

and written input from state staff. All publicly available documents on which we relied are referenced in the state summaries.

In the summaries of state Medicaid requirements, we primarily relied on state Medicaid regulations and Section 1115 demonstration documents. Where necessary, these were supplemented with additional sources. The relative absence of certain requirements in state Medicaid regulations, however, does not mean that Medicaid programs do not have service requirements in provider agreements with Medicaid or Medicaid MCEs, provider manuals, or elsewhere. Similarly, some states may more passively rely on the presence of licensure requirements to ensure that service standards are in place.

During validation of the summaries of state licensing requirements, states sometime highlighted issues that required consistent resolution. For example, validating staff sometimes indicated that regulations were under review for amendment. In those cases, we adhered to the regulations in place at the time of review. Similarly, when a state indicated that its regulations were out of date and did not reflect the actual processes used by the state, but where the regulations had not been amended to reflect that reality, we maintained the summary so as to capture the actual regulatory status at the time of review. However, when states simply modified summaries, those changes were accepted unless they would have included information outside the scope of the summary. Additionally, to the extent that statutes and regulations had not been amended to reflect shifts in agencies responsible for oversight or licensure, we accepted the input of the agency and included the current names of agency(ies) responsible, rather than a prior agency that was still reflected in the language of the licensing laws.

Several parameters were placed around the scope of data collection to ensure consistency:

- *Residential treatment* was defined as clinical treatment services provided in a 24-hour living environment. This definition generally eliminated programs such as group homes, halfway houses, recovery housing, or intoxication monitoring facilities, unless state statutes or regulations clearly indicated that clinical treatment must be provided by the facility. A facility that offered only supportive, life skills, or personal care-focused services was excluded from the scope of this study, although those services clearly have value in the treatment of M/SUDs. The exception to this exclusion relates to withdrawal management or detoxification facilities, some of which are not required to offer psychosocial counseling. Because some of these facilities do require such services and most incorporate some level of medical monitoring or care, we included them to the extent that the services are residentially based.
- Only residential treatment facilities for adults were included; thus, treatment specific to children or adolescents was excluded. In practice, this means that we excluded psychiatric residential treatment facilities and other facilities intended to serve individuals below age 21 years.

- We excluded facilities that are associated with the criminal justice system or that are in inpatient settings.
- We examined state Medicaid separately in this Compendium. To the extent, however, that licensing standards apply only to publicly-funded residential treatment facilities, they are included even if Medicaid is within the definition of publicly-funded. This approach permitted us to capture requirements related to facilities that are recipients of block grant and/or other governmental funding. Uniquely Medicaid-related requirements are included in a separate summary for each state.

**Study limitations.** To fully understand a state's oversight of residential treatment facilities, one must examine more than the state statutes and regulations, which provide only a partial picture of how oversight works in reality. Those statutes and regulations are, however, the legally enforceable mechanisms that govern facilities, and they are publicly available to all stakeholders. In addition to statutes and regulations, states may rely on: (1) agency policy documents, such as manuals or guidance; (2) contracts with providers who receive public funding, such as from block grant funds; and (3) to the extent that Medicaid is considered, a separate set of regulations, agency policy documents, contracts with providers or MCEs, and requirements of federal Medicaid state plan amendments and waivers or demonstrations. In addition, one must understand the actual practices of the overseeing or licensing agency to appreciate how regulations are enforced, or not enforced, in reality. Absent interviews with state staff or other stakeholders, this Compendium cannot capture the latter.

Another limitation is that the summaries reflect state law at a single point in time. Statutes and regulations clearly are amended on an ongoing basis. This means that, at the point of publication of this Compendium, some statutes and regulations will have been amended, repealed, or replaced, rendering some portion of the summaries no longer accurate. For this reason and because, as noted above, other factors are involved in state oversight and licensure, none of this document should be taken to constitute legal advice.

Finally, the specific domains identified for data collection were selected to allow us to better understand the extent of regulatory oversight for residential treatment in each state. This involved deliberate selection of some characteristics and nonselection of others. For example, one important part of residential treatment regulation and oversight that we did not include was physical safety standards such as building, fire, and zoning requirements.

## REFERENCES

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