Memorandum

To: House Human Services Committee
From: Chadd Viger, CEO, Recovery House, Inc.
Date: April 4, 2025
Re: S.36 An act relating to Medicaid coverage of long-term residential treatment for co-occurring substance use disorder and mental health condition

Recovery House, Inc.
I would like to share Recovery House's experience as a residential substance use treatment provider within the state's continuum of care. Recovery House has a unique perspective, serving those in need for over 50 years in every iteration of the system. Recovery House offers a myriad of services within its campus, including: ASAM 3.7 Medically Monitored High-Intensity Inpatient Treatment at Serenity House (typically a 14-day course of treatment), ASAM 3.1 Clinically Managed Low Intensity Residential Services at Grace House and the newly opened McGee House (typically a 90-day course of treatment), and Public Inebriate programming for Rutland and Addison Counties (co-located at Grace House).

Residential substance use must remain individualized. Prescribing a set duration is clinically inappropriate. Despite funding challenges, Recovery House often extends individual stays longer due to the increasing complexity of co-occurring disorders. Research has demonstrated that a key principle of effective treatment includes individualized approaches, care in a "least restrictive" environment (as appropriate), and longevity of engagement with the continuum of care.

Continuum of Care
Historically speaking, residential substance use treatment offered a place for people to send their loved ones for a "long" period of time, hoping they would return, cured. We have learned that an individual's success does not rely solely on length of stay. This is a chronic and relapsing disease that requires continuous work from individuals and providers. Housing, transportation, access to substances, unhealthy relationships, mental health or medical issues can all have an impact on an individual's recovery.

Today, our substance use treatment continuum of care (which acknowledges and addresses co-occurring mental health) is modeled after the standards outlined by the American Society of Addiction Medicine (ASAM). Rating levels of care on a scale of one to four (1-4), ASAM includes hospitalization, residential treatment, intensive outpatient, outpatient, and recovery supports. Recovery House provides programming at every level of residential treatment (ASAM 3.7, 3.5, and 3.1) with our three treatment programs. The Recovery House campus has allowed for seamless transition between levels of care, due to services being offered under the same umbrella organization. Not only does this increase the ease of access for clients, but it works as a cost savings to Vermont (with centralized administration, admissions, and operations). During an individual's stay in treatment, services are offered to address substance use, mental health, medical, dental, legal, family, workforce, and housing needs. Services are either provided by Recovery House Inc., or by local partnering agencies.

Case Studies

The following 2 case studies demonstrate the effectiveness and efficiency of the Recovery House Inc. campus and how our different levels of care can benefit the individual needs of people.

Case Study A – This is an example of how we can transition those in need to services that are most appropriate, in the best way possible.

> Client A is an individual who has a history of polysubstance use, in their mid-20s, with a history of repeated episodes in residential substance use disorder treatment. Client A has a documented history of co-occurring mental health and physical health issues in context of a significant history of trauma and abuse, as well as dental concerns. Client A initially used a public inebriate bed, before transitioning to ASAM 3.7 level of SUD care (Serenity House). Upon completion, Client A was referred to and subsequently transitioned into our ASAM 3.1 "stepdown" facility (Grace House) for continued residential treatment. By initially utilizing our public inebriate program beds, we were able to offer Client A a safe, monitored place to stay while they awaited transition to Serenity House.

Case Study B – The Public Inebriate Program allowed for a brief engagement with our system, which then allowed for continue progress within their community.

> Client B is an individual with a multi-decade history of alcohol use disorder - an older individual with limited resources in the community, and a significant history of multiple residential treatment episodes of care. Client B successfully engaged in the ASAM 3.7 (Serenity House) program and then transitioned to the ASAM 3.1 (Grace House) program. During their treatment stay at Grace House, Client B engaged in community resources for mental health, medical, and workforce needs. After a successful 90+ day episode of ASAM 3.1 treatment, Client B transitioned to a local recovery residence. After some time in the local recovery residence, alcohol recurrence presented. The local recovery residence, needing to find safe placement for this individual, transitioned Client B into our Public Inebriate beds. Once sober and no longer having substances in their system, the recovery residence determined that Client B was appropriate to transition back into their home.

S.36 Comments

- Sections 1, 2, and 3 of S.36
    - We support the language related to high-intensity and low-intensity residential substance use treatment, allowing the treatment provider to determine clinically appropriate lengths of stay, and AHS examining the reimbursement model and addressing the costs of services provided.
    - Include a definition of "medical necessity" to avoid unintended consequences "Medical necessity" has historically been interpreted as the process by which an individual withdraws from a substance, due to physical dependency. The withdrawal management process is brief in nature and may lead to shortened lengths of stay. Allowing clinically appropriate lengths of stay, beyond "medical necessity" is important to our continuum of care

The definition of "medical necessity" should be in alignment with the American Society of Addiction Medicine (ASAM). ASAM describes a system of care that includes medical and clinical necessity. We will work with the Department on developing language to propose to your committee that will avoid unintended consequences.

- Section 4 of S.36
  We also support the repeal of some provisions of the Public Inebriate Program (scheduled for July 1, 2025). By prohibiting inebriated individuals from being placed in a correctional facility, the likelihood of hospitalization increases. There should remain a multi-option approach. By including public inebriate beds, hospitals, and correctional facilities, the system can respond to the specific needs of the individual or the situation. An option reduction will almost certainly lead to inappropriate placements for some individuals.

Thank you,

Chadd Viger, MS, LADC
CEO, Recovery House, Inc.