NASADAD

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Effects of State Health Care Reform on Substance Abuse Services in Maine, Massachusetts, and Vermont

Considerations for Implementation of the Patient Protection and Affordable Care Act (PPACA)

MAJOR FINDINGS

1. After State initiated health reform, access to and demand for substance abuse services rose in Maine, Massachusetts and Vermont. Each State was able to increase access to substance abuse treatment through Medicaid expansions, increases in the budget of the State substance abuse agency by the State, process improvement initiatives, and the creation of publicly subsidized, private insurance plans. Even with expansions in coverage, the uninsured rate among those with substance use disorders remained high in the three States.
2. A variety of funding sources was used to pay for health reform. Some cost savings were achieved through the use of administrative services organizations (ASOs).
3. State substance abuse systems still face many challenges – even after health reform is implemented. These challenges include enforcing health insurance parity laws, addressing workforce shortages and increased administrative costs for addiction treatment providers seeking reimbursement through Medicaid and/or private insurance.
4. The federal Substance Abuse Prevention and Treatment (SAPT) Block Grant, State general appropriations, and the State substance abuse agency play a critical role in assuring that people with substance use disorders have access to effective, high quality services, particularly prevention services.

In all, 39 States enacted laws to expand access to health insurance between 2006 and 2008 (McDonough, Miller, and Barber, 2008). Maine, Massachusetts, and Vermont were chosen for this study because they are the only States to enact legislation seeking to achieve universal coverage.

BACKGROUND

The Patient Protection and Affordable Care Act (PPACA), signed into law by President Obama in March 2010, reshapes the nation's health system. The law requires coverage of substance use disorders in the minimum benefit package and the new Medicaid expansion provision for childless adults up to 133 percent of Federal Poverty Level (PPL). The focus has now turned to implementation PPACA. A study by the National Association of State Alcohol and Drug Abuse Directors (NASADAD), with support from the Substance Abuse and Mental Health Services Administration (SAMHSA), provides valuable information on the impact of health reform on the publicly funded State substance abuse system. NASADAD chose to study Maine, Massachusetts and Vermont because they are the only States that have enacted legislation to achieve universal health coverage – similar to the goals and mechanisms of PPACA. (To see the full report, visit www.nasadad.org.)

VITAL ROLE OF STATE SUBSTANCE ABUSE AGENCIES AND THE SAPT BLOCK GRANT

Similar to PPACA, the health reform initiatives in Maine, Massachusetts and Vermont expanded both private insurance and Medicaid coverage. With these expansions, the State substance abuse agency played a critical role in managing the Statewide system of care and services for prevention, treatment and recovery -- with the SAPT Block Grant serving as a cornerstone.

State substance abuse agencies

- plan and oversee a coordinated system of care composed of a variety of separate State and federal funding streams
- ensure accountability and effectiveness through contract monitoring; corrective action planning; on-site reviews; data reporting, management and evaluation; performance contracting; and technical assistance.
- ensure quality by utilizing standards of care; patient placement criteria; licensure; certification; and more.

SAPT Block Grant funds in Maine, Vermont and Massachusetts were used to fund

- medically necessary services for those that remain uninsured or those that are not covered by other payers, particularly residential treatment;
- services not covered by public or private health insurers including case management, recovery support services; and
- substance abuse prevention services.

COMPONENTS OF HEALTH REFORM IN THREE STATES

- Maintenance of private/employer insurance as core (three States)
- Provision of a subsidized, basic health insurance plan for low-income residents (three States)
- Expansion of the services and populations covered by Medicaid, especially the inclusion of low-income childless adults (three States)
- Integration of primary care, chronic care, and prevention (three States)
- Treatment process-improvement initiatives (three States)
- Workforce training initiatives (three States)
- Implementation of managed care for Medicaid (three States)
- Passage of parity legislation (Mass. and VT) and/or mandates (ME and VT) for substance abuse and mental health.
- Performance contracting/pay-for-performance (Mass. and ME)

FINDINGS

ACCESS TO SUBSTANCE ABUSE TREATMENT INCREASED

In all three States, the publicly funded State substance abuse system served steadily increasing numbers of people in need of services. These increases were due to a variety of policy changes, including:

- **Medicaid Expansions** have resulted in many public substance abuse treatment facilities serving larger numbers of Medicaid-insured clients - particularly the expanded coverage of nondisabled childless adults aged 21 to 64 – a key component in PPACA.
- **Increased funding through the SSA** All three of these States have significantly increased their spending on substance abuse treatment. Increased funding, which has come from State general funds and tobacco settlements, has also enabled substance abuse providers to serve additional clients, despite increasing costs of care. Many States currently face budget shortfalls where cuts may negatively impact State substance abuse agencies.
- **Process-improvement demonstration projects** have expanded access to outpatient substance abuse treatment services without costing additional dollars. For example, Maine successfully used pay-for-performance measures to improve provider efficiency.
- **Publicly subsidized private insurance** In Massachusetts, public providers have seen three times as many clients seeking treatment with subsidized private health insurance in the past 3 years, but public substance abuse treatment providers in Maine and Vermont have treated few clients with subsidized private health insurance.

VARIETY OF FUNDING SOURCES PAID FOR REFORM

Various sources have been used by these States to increase funding for insurance coverage and substance abuse services, including:

- State general appropriations;
- Increased tobacco taxes and liquor taxes;
- Federal matching funds from Medicaid;
- "Fair share" employer contributions; and,
- Individual insurance premiums from mandated policies in Mass. and graduated premiums from subsidized policies.

In each of these States, health reform created some cost savings through a decrease in emergency costs and a reduction in costs of care for the uninsured. In addition, Medicaid administrative services organizations (ASOs) have successfully cut the costs of substance abuse treatment by decreasing the lengths of stay in residential treatment in Massachusetts and Maine, although the impacts of ASOs on the quality and outcomes of treatment are not known.

State Specific Findings: Maine

In Maine, the number of clients admitted to publicly funded substance abuse providers increased by 45 percent between 1999 and 2008. This increase was due to the expansion of substance abuse services covered under Medicaid (including medications), expansion of the population covered by MaineCare (Medicaid), and increased provider efficiencies through performance contracting and improved treatment admissions processes.

State Specific Findings: Massachusetts

In Massachusetts, admissions to public substance abuse treatment rose nearly 20 percent in only 2 years between 2006 and 2008. Improvements in access, capacity, and quality were achieved through MassHealth (Medicaid) expansions in covered populations (particularly "non-categoricals," or adults with no dependent children); a process-improvement initiative; and efforts that address workforce development, as well as increased use of evidence based practices.

UNINSURED STILL HIGH AMONG THOSE WHO NEED ADDICTION TREATMENT

Despite expansions in coverage, there continues to be a need for subsidized care in Maine, Massachusetts and Vermont. In 2007, 10 percent of Maine residents were uninsured, but more than 31 percent of clients admitted to public substance abuse treatment facilities reported being uninsured, three times the rate throughout the State. Though the uninsured rate in Massachusetts is estimated to be only 2.6 percent of the population in 2009, more than 20 percent of clients admitted to substance abuse treatment facilities in 2009 were not enrolled in a health insurance program. Serving the remaining uninsured population continues to be an important role of the publicly funded substance abuse systems and of the State substance abuse agency.

Providers and State substance abuse agencies in Maine, Massachusetts, and Vermont report that many of those who are uninsured when seeking admission to substance abuse treatment at public facilities are only episodically uninsured. *These people are experiencing gaps in insurance coverage that may stem from the non-completion of re-enrollment forms (Medicaid) or the nonpayment of premiums (private insurance).* These gaps may also correspond with the client's increased alcohol or drug use.

In addition, State substance abuse agencies and providers report that *gaps in coverage often occur due to or following incarceration.* While incarcerated, clients often lose Medicaid coverage because they no longer fall into any of the allowed categories (specifically, as the parent of a dependent child). They must then re-enroll as "non-categoricals," which takes time and can disrupt the transition between substance abuse treatment services while incarcerated and substance abuse treatment services in the community.

These gaps in coverage will become particularly problematic as the public system increasingly relies on Medicaid reimbursement instead of "safety net" funds, a trend in all three States under health reform. *Re-enrollment in Medicaid in these States is increasingly difficult, as enrollment is frequently capped or frozen to contain costs.* Either clients must wait until they are enrolled to receive substance abuse services, or providers must use other funds (either charitable contributions or safety net such as the SAPT Block Grant) to begin to treat these clients.

New Challenges Associated with Health Care Reform

Closing the Treatment Gap

Public substance use disorder treatment providers still have more treatment requests from the uninsured than they have funding for, even as the proportion of State residents who are insured rises. According to SAMHSA's National Survey on Drug Use and Health (NSDUH), approximately 23.1 million Americans aged 12 or older needed treatment for an alcohol or illicit drug problem in 2008. During the same year, only 2.3 million received of treatment for a problem related to the use of alcohol or illicit drugs at a specialty facility. As a result, approximately 20.8 million people needed but did not receive services in 2008 in a specialty facility.

Enforcing Parity Laws

All three States studied have enacted parity legislation that requires health insurance plans to cover substance use disorders/mental health services at the same level as all other services. However, each State has learned that parity legislation does not automatically expand access to substance use disorder services:

- Even when insurers comply with parity regulations, co-pays and deductibles can restrict access to substance use disorder services, particularly for very low-income beneficiaries.
- In all three States, providers perceive that insurance companies have been slow to fully implement parity in coverage for substance use disorder/mental health services.
- Moreover, insurance plans often do not reimburse providers for the full continuum of care: residential treatment and social model detox are generally not covered by private plans, Medicaid, or Medicare, and the burden to fund these services falls on the State substance abuse agency. Deciding which services to cover with limited safety net funds is a major challenge to the SSAs in Maine, Massachusetts, and Vermont.

Improving Cost Effectiveness through Process Improvement

All three States that were studied used process-improvement demonstration projects to successfully expand access to substance use disorder services without spending additional dollars. Maine has also used pay-for-performance measures to increase provider efficiency, and Massachusetts is working with its providers to identify related measures.

Working with Other Agencies

Health reform does not directly address the relationships that State substance abuse agencies have with other nonmedical systems within the State (e.g., the criminal justice system, the welfare system, and the housing system).

Administrative Support Requirements

Administrative costs associated with billing multiple payment sources (especially multiple private insurers) represent a significant increase in costs for community based organizations (CBOs).

Workforce Shortages

At the same time that health reform has led to expansions in access, workforce shortages are limiting access to substance use disorder services, particularly in Vermont and the rural areas of Maine. This is exacerbated because many private insurance companies and Medicaid ASOs will only reimburse care provided by practitioners with graduate degrees traditionally associated with mental health providers (e.g., M.D., M.S.W., L.C.S.W.). Rural providers have a difficult time recruiting counselors with such certifications. In addition, insurance reimbursement is generally very low for services not administered by a physician. Providers in these three States must weigh the reimbursements that they receive from these insurers against their costs, and often do not accept all kinds—or even any type—of private insurance, due to these staffing and billing challenges. In addition, Massachusetts has had difficulty recruiting nurse care managers to work with suboxone patients in community health centers.

State Specific Findings: Vermont

Vermont saw the number of persons treated in its public substance abuse treatment system double between 1998 and 2007. This was accomplished through strategic planning initiatives at the State and division levels; increased health insurance coverage for individuals through Green Mountain Care (Medicaid); expanded Medicaid coverage of treatment, including medication-assisted treatment (both methadone and buprenorphine); and a treatment admission process-improvement initiative funded with SAPT Block Grant monies.

Changing Business Practices

After health reform in Maine and Massachusetts, Medicaid plans are now administered by administrative services organizations (ASOs). In addition, though the percentages of clients who enter the substance abuse treatment system with private insurance have remained constant and very low in Maine and Vermont (in Massachusetts, providers report seeing perceptible increases in the percentage of clients with private insurance), the *actual numbers of clients with private insurance seeking services in the public substance abuse treatment system have risen in all three States over the past 5 years*. Even when clients are enrolled in private insurance plans or Medicaid, and the services rendered are covered, community based organizations (CBOs) face new challenges in working with private insurance and managed care. Billing practices are different across insurers, so CBO staff must spend time learning about the requirements of each insurer to ensure that the proper procedures are followed. These administrative costs represent a significant increase in CBO costs. Working with these new partners has required CBOs to change their business models.

THE VITAL ROLE OF THE SAPT BLOCK GRANT AFTER HEALTH CARE REFORM

CONTINUING IMPORTANCE OF SAPT BLOCK GRANT

Despite declining numbers of uninsured residents in each of the three States studied, none have come close to achieving universal coverage to date. Lapses or gaps in coverage—which are often associated with increasing acuity of substance use disorders, involvement with the criminal justice system, co-occurring substance use disorders and mental disorders, or homelessness—mean that when people enter substance use disorder treatment, they are often uninsured and unable to pay.

In Maine, Massachusetts, and Vermont, the State substance abuse agencies, using combinations of SAPT Block Grant and State dollars, continue to be the payers for the uninsured, who continue to be a substantial portion of those needing substance use disorders treatment.

Even when clients are covered by Medicaid or a private insurance plan, *SAPT Block Grant dollars fill holes in insurance coverage*. Insurance companies have refused to pay for residential care and social-model detox, and have often imposed lifetime or yearly limits on the amount of substance abuse treatment services that a client can receive. Although the 2008 Wellstone-Domenici Parity Act and the PPACA intended to make these practices illegal, the effects are not yet clear.

In addition, State substance abuse agencies and substance abuse facilities have traditionally treated "the whole person," often administering a range of necessary case management and psychosocial services, including housing assistance, employment counseling, and childcare, costs that are generally not covered by private or public health insurance plans. Recovery support services are not provided by insurance-eligible professionals, and currently remain outside of the realm of insurance reimbursement.

NEGOTIATE RELATIONSHIPS WITH OTHER SYSTEMS

Even as substance use disorder services are increasingly integrated into primary care, *an important function of the State substance abuse agency is to negotiate relationships with other systems, particularly the criminal justice system and the welfare system*. In Vermont, the State substance abuse agency has successfully worked with the criminal justice and Medicaid systems to help people maintain their Medicaid coverage while incarcerated. In Maine and Massachusetts, State substance abuse agencies trained providers to enroll eligibles for subsidized insurance (so that they can be reimbursed), helping to reduce gaps in coverage.

WHAT IS THE SAPT BLOCK GRANT?

The Substance Abuse Prevention and Treatment (SAPT) Block Grant is a formula grant administered by the Substance Abuse and Mental Health Services Administration (SAMHSA), within the Department of Health and Human Services (HHS). The Block Grant accounts for, on average, at least 40 percent of funding managed by State substance abuse agencies across the country. The SAPT Block Grant serves our nation's most vulnerable, low income populations – those with HIV/AIDS, pregnant and parenting women, youth, and others – by ensuring access to substance abuse services. By statute, at least twenty percent of the SAPT Block Grant is dedicated to much needed prevention services.

ADDRESS NEW CHALLENGES AND IMPLEMENT INNOVATIVE SERVICES

The SAPT Block Grant has allowed the State substance abuse agencies in Maine, Massachusetts and Vermont to respond quickly to changes in substance abuse trends across their States. The Northeast has been embroiled in an opioid epidemic for the past 10 years (first heroin and then prescription drugs). During this time, each State increased its capacity to provide opioid-replacement therapies. Vermont undertook a major buprenorphine initiative in 2003 and opened its first methadone clinic in the same year. In 2008, Massachusetts funded community health centers to hire nurse care managers for suboxone patients to ensure appropriate referrals to addiction counseling.

As health care technologies improve, State substance abuse agencies in these three States have been able to use SAPT Block Grant dollars to help their providers learn new techniques (e.g., cognitive behavioral therapies and motivational interviewing) and implement novel modalities, such as medication-assisted treatment.

SAPT BLOCK GRANT: THE MAIN SOURCE OF FUNDING FOR SUBSTANCE ABUSE PREVENTION

On average, the SAPT Block Grant set-aside represents the single largest source of prevention funding – 64 percent – for State substance abuse agencies across the country. In twenty-one States, the set-aside represents 75 percent or more of the State substance abuse agency's prevention budget. This is the case for Massachusetts, for example. Health reform in these three States did not result in any increased support for substance abuse prevention by private or public insurance. While PPACA did include provisions pertaining to prevention and wellness, it is too early to gauge the specific impact to date.

NASADAD

NASADAD represents the State substance abuse agency directors from across the country.

NASADAD's mission is to promote effective and efficient State substance abuse service systems.

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