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The Looming Expansion And Transformation Of Public Substance Abuse Treatment Under The Affordable Care Act

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ABSTRACT Public substance abuse treatment services have largely operated as an independent part of the overall health care system, with unique methods of administration, funding, and service delivery. The Affordable Care Act of 2010 and other recent health care reforms, coupled with declines in state general revenue spending, will change this. Overall funding for these substance abuse services should increase, and they should be better integrated into the mainstream of general health care. Reform provisions are also likely to expand the variety of substance abuse treatment providers and shift services away from residential and stand-alone programs toward outpatient programs and more integrated programs or care systems. As a result, patients should have better access to care that is more medically based and person-centered.

In 2009 nearly 10 percent of the US population age twelve and older were illicit drug abusers, and nearly one-quarter had engaged in binge drinking (five or more drinks on a single occasion) in the previous month. Seven percent of the population had at least five instances of binge drinking in that month.¹

Excessive alcohol consumption and illicit drug abuse constitute substantial health problems in and of themselves, but they also cause or contribute to other serious health conditions or complicate treatment for other conditions. For example, heavy alcohol abuse is associated with liver disease and coronary heart disease.^{2,3} Cocaine abuse can trigger heart disease, and injectable drug abuse is associated with hepatitis C and HIV/AIDS.⁴⁻⁶

Separate System For Substance Abuse

Unlike mental health services, where the majority of care occurs in general medical settings,⁷ treatment of substance abuse disorders occurs predominantly in a separate specialty services

sector. For example, respondents to the 2009 National Survey on Drug Use and Health reporting inpatient treatment for alcohol or drug problems in the US population age twelve and older were 50 percent more likely to identify a rehabilitation facility as their source of inpatient care, compared to a hospital. Outpatient substance abuse treatment in a rehabilitation facility was two-and-a-half times more frequent than treatment in a private doctor's office.¹

Most specialty substance abuse care is provided by stand-alone nonprofit or government-operated facilities, where the typical daily case-loads are fifty or fewer patients. Although most care is delivered in outpatient settings, about one-quarter of treatment providers also furnish nonhospital residential care. These residential programs average thirty-two beds each. More than half of their daily census is composed of people in treatment for more than thirty days.⁸

In both residential and outpatient settings, services generally consist of abstinence-oriented counseling and education. Only a small minority of the programs offer treatment using newer medications, such as buprenorphine.⁹ What's more, treatment is typically delivered by staff

members who have limited professional training and supervision.⁹⁻¹² Fewer than half of the substance abuse treatment providers that rely on public sources for most of their funding employ counselors trained at the master's degree level; a third do not have a physician either on staff or on contract. Three-quarters of program directors at substance abuse treatment facilities have a bachelor's degree or less.

Many substance abuse treatment facilities also appear to lack the administrative and infrastructure support necessary to meet the requirements of mainstream health care financing and management. About 20 percent have no information systems of any kind. Only a very small minority have an integrated clinical information system providing treatment staff with ready access to electronic patient records.¹¹

FUNDING ANOMALIES Although many substance abuse treatment providers rely on payments from health plans for some of their revenue, a large proportion do not. About 40 percent of nonprofit facilities do not accept either private insurance or Medicaid or both, and about half do not have any contracts with managed care plans.⁸

Meanwhile, only about 40 percent of adults ages 22-64 report that their substance abuse treatment was paid for by insurance, including Medicaid. About one-third either pay out of pocket or receive services free; the rest rely on other sources of payment.¹³

More than three-quarters of the funding for substance abuse treatment services comes from public sources, compared to less than half for all other health care.¹⁴ More than half of this public funding is from state and local government sources other than Medicaid. This distribution of funding is much different than it was twenty years ago, when substance abuse treatment funding was roughly equally divided between private and public sources. Since that time, however, funding from private insurance has declined, while funding from state and local government sources has more than tripled.

LOOMING TRANSFORMATION This unique service system will change as a result of health reform. Insurance coverage for people with substance abuse disorders, the types and characteristics of service providers, and state administration of these services all will be affected. The degree of this change may be as great as, or greater than, that for any other area of health care. In this article I describe the major features of health reform that will affect the substance abuse treatment system, along with the possible effects of these changes on the financing, structure, and delivery of services.

Health Reform Provisions

The term *health reform* commonly refers to the provisions of the Affordable Care Act of 2010. However, for substance abuse treatment and mental health care, reform is better conceptualized as the net result of a series of laws culminating in the Affordable Care Act.

PRIOR LAWS Under the Medicare Improvements for Patients and Providers Act of 2008, previous cost sharing that required patients to pay half the cost of Medicare-covered outpatient mental health and substance abuse services was phased out. As a result, beginning in 2014, these services will be subject to a 20 percent copayment—the same as for other Medicare Part B services. Additionally, the Mental Health Parity and Addiction Equity Act of 2008 mandated that financial requirements and treatment limitations for mental health and substance abuse benefits in group health plans, including Medicaid managed care, be no more restrictive than those placed on medical and surgical benefits. Finally, the Children's Health Insurance Program Reauthorization Act of 2009 extended these parity provisions to all Children's Health Insurance Program state plans.

AFFORDABLE CARE ACT The Affordable Care Act includes several provisions that affect substance abuse treatment services. Importantly, the law mandates the inclusion of substance abuse and mental health services in the essential benefits that state exchanges must offer. Although the specific services that will be required will be determined by regulation, they must be the same as those provided under a typical employer plan. Another provision extends the application of the mental health parity provisions to the new insurance exchange plans.¹⁵ As a result, the new required substance abuse and mental health services in exchange plans cannot be accompanied by financial requirements and treatment limitations that are more restrictive than those placed on medical and surgical benefits.

A number of provisions of the Affordable Care Act bear on mental health and substance abuse coverage under Medicaid. First, full implementation of the law will greatly expand the Medicaid population. The law also extends mental health and substance abuse coverage at parity for the Medicaid benchmark and benchmark-equivalent plans that states must provide to the expanded Medicaid population. Closely modeling coverage in the private sector, these plans are based on the Federal Employee Health Benefits program, the state's employees' health plan, the health maintenance organization with the largest non-Medicaid enrollment in the state, or a plan approved by the secretary of health and human services.

The benchmark and benchmark-equivalent plans for the expanded Medicaid population must provide at least the same essential benefits as those for qualified health plans offered through the new state insurance exchanges. Medicaid plans meeting this standard will be available in 2014 to all people who meet the new income limit of 133 percent of the federal poverty level, based on modified adjusted gross income. Initially 100 percent of the cost of these plans will be covered by the federal government, declining to 90 percent by 2020.

The Affordable Care Act contains other provisions that will affect the financing and character of public substance abuse treatment services. Generally these provisions are designed to increase health service delivery through various types of integrated systems, often based on strengthened primary care. This goal promotes a whole-person orientation to care, including the integration of substance abuse and mental health services with general medical care. For example, provisions support the creation of medical homes, which seek to ensure patients' ongoing relationships with primary care providers and dedicated care managers, along with the coordination of care across subspecialties and expanded access to services.

Similarly, enhanced federal matching funds in Medicaid will support the establishment of health homes—a type of medical home that specializes in the integration and coordination of care for specific chronic conditions, including mental health and substance abuse disorders.

Finally, the Affordable Care Act provides funding to increase the number and capacity of federally qualified health centers by providing an additional \$11 billion in dedicated funds to the health centers program from 2011 to 2015.¹⁶ Health centers provide a variety of medical and support services for the medically underserved. The boost in funding follows previous increases provided in 2008 and 2009. These increases, coupled with the enhanced funding expected from Medicaid expansions and the health insurance exchanges, are expected to more than double health center caseloads, from 18.8 million patients in 2009 to as many as 44.1 million in 2015.¹⁷ In 2009 health centers provided substance abuse treatment services to 114,565 people.¹⁸

EXPANDED NUMBERS COVERED In addition to expanding substance abuse coverage in health plans and promoting primary care-based approaches to treatment, health reform will greatly expand the number of insured people with substance abuse disorders. This is principally due to the provision that will allow all people who meet the new income limit of 133 percent of the federal

The Affordable Care Act will affect the financing and character of public substance abuse treatment.

poverty level to be eligible for Medicaid by 2014. One set of estimates predicts that this expansion will double the number of nonelderly childless adults with behavioral health disorders in Medicaid, because this population is more concentrated among the low-income uninsured. Furthermore, because these people also are high users of nonpsychiatric health care, they will account for nearly one-third of the increase in Medicaid spending resulting from health reform.¹⁹

Although the majority of people with behavioral health disorders gaining Medicaid coverage through this provision are likely to be those with mental health conditions, the largest proportional increase may be for those with substance abuse disorders. Nonelderly childless adults with serious mental illness often obtain Medicaid or Medicare eligibility through Supplemental Security Income or Social Security Disability Insurance, both of which require a determination of disability. But for those with substance abuse disorders, this route to eligibility generally is denied if the person's drug or alcohol abuse is the primary cause of the disability.

Under the Affordable Care Act, however, this barrier to Medicaid eligibility will no longer exist for those whose income is under 133 percent of the federal poverty level. Accordingly, not only will a proportionally higher number of people with substance abuse disorders enter the Medicaid program, but the severity of their disorders may be greater as well, once those meeting disability criteria are no longer excluded.

THE STATE SITUATION These changes to public substance abuse treatment services are taking place in a state fiscal environment characterized by severe reductions in general revenue. State general fund spending declined 3.8 percent between fiscal years 2008 and 2009, and an additional 7.3 percent in fiscal year 2010.²⁰ These declines have disproportionately affected substance abuse treatment services.

In 2006 the federal Substance Abuse and Mental Health Services Administration estimated that non-Medicaid state and local government funds made up more than half of all public spending for public substance abuse treatment services.¹⁴ In contrast, those funds made up about one-third of all public mental health spending in 2006 and only 13 percent of overall general health care spending from public sources. A majority of states reported an absolute decline in their substance abuse treatment funding between fiscal years 2009 and 2010.²¹

Impact On The Public Substance Abuse Treatment System

Overall, requirements for expanded substance abuse coverage, along with the expansion of Medicaid eligibility, will greatly increase public support of substance abuse treatment services. However, these and other changes also will have profound effects on the character of substance abuse treatment in America, affecting the relative importance of funding sources, the numbers and types of substance abuse treatment providers, their workforce, and the kinds of services they offer. Also affected will be the size and nature of substance abuse treatment services in the Medicaid program and the role and orientation of state substance abuse agencies.

SOURCES OF FUNDING Under health reform, Medicaid's share of total public funding for substance abuse treatment should increase, while the share from state general revenue spending should decline. This will occur primarily because people who are newly eligible for Medicaid will no longer require funds from state general revenue spending. Additionally, the high rates of federal Medicaid matching funds may lead many states to shift into Medicaid a wide range of substance abuse treatment services currently paid for solely with state general revenue funds. Sometimes referred to as "refinancing," this approach would allow states to compensate for service cuts that have resulted from declines in state general revenue. A study of earlier state refinancing efforts showed that adverse fiscal conditions were among the factors motivating such changes.²²

The other major source of non-Medicaid funding, the federal Substance Abuse Prevention and Treatment Block Grant, is also likely to decline in relative importance. In fiscal year 2010 this program distributed about \$1.7 billion to states for treatment and prevention services. However, funding for this program has lagged behind inflation, increasing only about 1 percent annually from 2000 to 2010.²³ Efforts to limit federal discretionary spending will almost certainly ensure

that this source of funding will not substantially increase and may actually decline.

These funding changes should have three major consequences. First, overall public spending for substance abuse treatment should greatly expand as a result of increased Medicaid enrollment and new benefit and parity requirements. Second, these Medicaid increases, along with those in Medicare, will expand the relative contribution of federal spending for substance abuse treatment services. In this way, public funding for substance abuse services will more closely resemble funding for mental health and general health care services, where federal dollars from all sources make up a majority of public spending.

Finally, a shift will occur in the fundamental model by which public substance abuse treatment services are organized and delivered. These services are generally administered by state substance abuse authorities, which primarily fund designated providers through grants and contracts that support a specified number of treatment "slots" or other similar measures of service quantity. But the greater role of Medicaid and Medicare will increasingly displace this model through payment methods and requirements characteristic of health plans.

SUBSTANCE ABUSE TREATMENT PROVIDERS Several features characterize the current direction of national health care policy. These features include near-universal coverage; systems of payment and administration characteristic of health plans; integrated models of care centered in primary care settings; and the expanded use of health information technology. All of these features are antithetical to the common practices of publicly funded specialty substance abuse providers. These providers now primarily rely on funding sources other than Medicaid, Medicare, or private insurance. They are seldom integrated with other behavioral or general health service systems, and they make limited use of information technology, even for administrative and billing purposes.

As a consequence, changes now under way will result in a different system of substance abuse treatment over the next ten years. These changes will be driven chiefly by the consequences of the expected relative increase in Medicaid's funding of these services at parity. Changes will also reflect the greater participation of nonspecialty providers, particularly health centers, in the substance abuse service system. These changes can be summarized as consolidation, medicalization, integration, and deinstitutionalization.

► **CONSOLIDATION:** Before passage of the Affordable Care Act, Rafael Corredoira and John Kimberly argued that the current characteristics

of the substance abuse treatment system suggested that it would be entering a period of consolidation.²⁴ One such characteristic is the existence of large numbers of small providers with minimal competition. Another is the opportunity for efficiencies that can result from investments in information technology; better business administration; and newer, evidence-based practices. These features will assume greater importance as a result of the increased reliance on Medicaid funding, coupled with other requirements resulting from health reform.

Furthermore, the increased use of fee-for-service funding that will accompany these changes will increase opportunities for larger, better-operated programs to expand through the acquisition of weaker ones. This will occur because—unlike funding linked to specific providers through grants or contracts—fee-for-service funding allows for the possibility of revenue expansion through added services or increases in caseloads. Smaller, independent providers that resist consolidation may be increasingly vulnerable to competition from those better able to adapt to the demands of the emerging system of substance abuse treatment.

► **MEDICALIZATION:** A central feature of this emerging system will be the further medicalization of public substance abuse treatment, which will entail greater participation and direction from physicians, psychologists, nurse practitioners, and other health professionals. Physician-directed treatment is a general requirement for most Medicaid outpatient services. For example, Medicaid requires that substance abuse treatment covered as a clinic service be under the supervision of a physician directly affiliated with the clinic, which must have a medical staff licensed to provide the medical care that is delivered. Policy guidance makes it clear that substance abuse treatment services that primarily consist of education and psychosocial support provided by peer or lay counselors do not constitute medical assistance and therefore do not qualify for Medicaid reimbursement.²⁵

► **INTEGRATION:** Efforts designed to create more integrated, person-centered systems of care are another trend shaping substance abuse treatment. These efforts may both change the character of some existing substance abuse treatment programs and expand the participation of nonspecialty providers. The primary impetus for this change comes from initiatives associated with the Affordable Care Act, particularly Medicaid health homes. States are likely to promote these entities because of the high level of federal matching funds available for the first two years of their existence.

Community mental health centers may be motivated by these incentives to provide more substance abuse treatment.

Community mental health centers, which already provide some specialty substance abuse treatment, may be motivated by these incentives to provide more substance abuse treatment services and thereby improve their ability to be a source of integrated care. Regardless of the focus of any individual health home, though, beneficiaries must be assured access to a wide range of physical health, mental health, and substance abuse treatment services based on a person-centered care plan.²⁶

A more notable result of incentives for integrated care may be the expansion of nonspecialty providers, such as health centers, into the substance abuse service system. Many of these providers already offer substance abuse treatment, and there will be a major increase in their numbers as a result of the Affordable Care Act. An explicit policy of the national drug control strategy encourages them to assume a greater role in substance abuse treatment.²⁷

Health centers are uniquely positioned to respond to the increased demand for substance abuse treatment that will result from the Medicaid eligibility expansion in 2014. If a state covers health centers in its Medicaid program, it must reimburse them at cost for any substance abuse services that they provide to beneficiaries.²⁸ The high federal match for services provided to the newly eligible beneficiaries should remove any restrictions that states might otherwise have considered to limit health centers in this role. These considerations may very well lead to an increase in substance abuse treatment services by these providers that is greater than what would be expected from the proportional increase in their numbers.

► **DEINSTITUTIONALIZATION:** Finally, the increased reliance on Medicaid as a funder of public substance abuse treatment systems should further reduce the role of residential programs in those systems. Medicaid excludes medical assistance for people in institutions for mental

A major task will be to mainstream the public specialty sector into the larger health care system.

diseases—a service category that includes residential treatment programs. Such facilities are defined as those with more than sixteen beds, a size limit exceeded by a majority of substance abuse residential programs.⁸ Accordingly, maintaining these programs at existing levels will require continuing support from state general revenue and block grant funding at a time when both sources of funding are increasingly constrained. Even for programs with sixteen or fewer beds, the potential for increased Medicaid funding is limited because such support does not extend to the room and board costs of residential facilities.

Increases in Medicaid spending for substance abuse treatment services will increase the likelihood that federal auditors will enforce these restrictions. A recent audit in one state found that thirty inpatient substance abuse facilities had improperly billed Medicaid, violating these provisions or failing to meet other requirements for Medicaid participation.²⁹

CHANGES FOR STATE MEDICAID PROGRAMS In most states, substance abuse treatment accounts for a very small part of all Medicaid-covered services and is used by only about 1–2 percent of beneficiaries.³⁰ In part, this is because of the current barriers to eligibility for adults with substance abuse service needs. But it also reflects the limited Medicaid coverage of these services in some states. A recent review of substance abuse services coverage for adults in Medicaid plans shows that three states do not cover these services at all, and three others cover only services in inpatient or residential settings.³¹ Eleven states do not provide coverage of methadone treatment.

These Medicaid programs and others with limitations on substance abuse treatment coverage will be affected by the requirements to include treatment services at parity with other essential benefits offered to newly eligible beneficiaries. Although the specific scope of these services is still to be determined, the Affordable Care Act requires them to reflect services provided under

a typical employer plan. In 2006 about 88 percent of Americans with health insurance through their employer had some coverage for substance abuse treatment services. Furthermore, a majority of employers provided coverage for hospital-based detoxification and rehabilitation, along with outpatient substance abuse treatment and detoxification in ambulatory or nonhospital settings.³²

I was not able to compare each of these service categories based on the existing information on state Medicaid coverage of substance abuse treatment services. Nevertheless, it appears that at least forty-one states and the District of Columbia now exclude at least one of these types of services from their Medicaid programs.³¹

These and associated changes will create a big challenge for state Medicaid agencies. Most will have to modify policies, payment mechanisms, and managed care contracts to accommodate the expanded scope of substance abuse treatment services at parity with medical and surgical services.

In addition, many state Medicaid agencies will be required to assume greater authority over provider enrollment and rate setting. In behavioral health, it has not been uncommon for these functions to be informally delegated to the respective specialty agencies, such as state mental health authorities. However, federal Medicaid policy does not allow for such delegation, and there have been renewed efforts in recent years to enforce this authority.³³

Another change is that the Affordable Care Act increases requirements for Medicaid agencies to screen providers at enrollment. Licenses must be verified, and site visits must be made to classes of providers judged to be at “moderate” risk of fraud, waste, and abuse.³⁴ Categories of providers identified for increased levels of screening do not explicitly include substance abuse treatment centers. However, community mental health centers are included in this group, and it is reasonable to think that at least some states may extend these requirements to substance abuse treatment providers.

NEW DUTIES FOR STATE SUBSTANCE ABUSE AGENCIES The same changes create a different set of challenges for state substance abuse agencies, which have commonly viewed their primary mission as administering the network of public specialty providers. In this role they have exercised relative independence in determining provider qualifications, payment methods and rates, and reporting requirements. The budgets they administer chiefly stem from state general revenues and the federal block grant. Some have little or no experience administering Medicaid funds or Medicaid services.

To complicate matters, more than half of all clients currently served by state substance abuse agencies are uninsured,³⁵ and most—if not all—will be eligible for Medicaid coverage of substance abuse treatment in 2014. Substance abuse agencies will need to assume some degree of responsibility for these services, or their administration and funding will shift to the state's Medicaid agency. Regardless of the outcome, substance abuse authorities are likely to see significant changes in their responsibilities.

A major task will be to mainstream the public specialty sector into the larger health care system. To succeed, some agencies will need to redesign licensure or other provider requirements to ensure compliance with Medicaid rules. This will necessitate review of requirements concerning the role of physicians and other licensed health professionals in treatment programs; the use of medications and other evidence-based treatments; and standards for billing, record keeping, data collection, and information technology. Because a much larger share of agency budgets will probably come from Medicaid, current levels of support for residential treatment programs made ineligible for Medicaid funding may need to be reexamined.

Once these immediate tasks are accomplished, substance abuse agencies will need to consider the longer-term implications of the coming changes. These changes will include public specialty providers' becoming more similar to and closely integrated with the larger system of health care. Substance abuse treatment services are likely to be distributed more widely among health centers, mental health centers, health homes, and other models of patient-centered care. Finally, more of the program and payment policies affecting substance abuse treatment services will be determined by state and federal Medicaid authorities. Such policies are likely to treat substance abuse treatment services and providers more like other health care providers and less like a separate subsystem with unique policies for credentialing, payment, and performance.

To adapt, substance abuse agencies may need to reorient their focus from the administration of specialty provider networks to the supervision of prevention and treatment services across the health system. Such a shift would reflect an acknowledgment of the growing diversification of treatment, as well as greater attention to the development of integrated, patient-centered care.

This shift may be aided by improved data on services, as more people with substance abuse disorders enter the Medicaid program. Currently, substance abuse agencies most often have

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only aggregate data, with few details about a patient's quantity or type of treatment or use of services in the general health system. Although data from Medicaid managed care programs are limited, detailed services and diagnostic information are available from fee-for-service claims. Analyses of these data should not only provide better information on service users and the characteristics of their use, but should also improve understanding of their general health care. This, in turn, could spur the improvement of integrated health services.

Conclusion

Transforming the public substance abuse treatment system was never one of the explicit goals of health reform. But policies expanding health insurance coverage and providing substance abuse treatment benefits at parity with medical and surgical benefits are likely to have that effect. The result will be a different system of treatment, with a greater variety of larger providers in the mainstream of general health care. This will be a more ambulatory-based, medically oriented, and physician-directed system.

Such a system may also be expected to make greater use of pharmacological treatment and services delivered by health professionals. Much of this transformation will stem from Medicaid's expanded role as a payer for services for people with substance abuse disorders. Requirements for medical direction of services, as well as the availability of payment for prescription drugs, should increase the use of pharmacological treatments such as methadone and buprenorphine. Similarly, Medicaid restrictions on payment for institutional treatment should provide additional incentives for outpatient-based care.

Although not originally designed to do so, health reform's changes offer the potential to address some of the concerns associated with the current system of public substance abuse

care. These include limited funding and access to services, and the failure to develop and implement plans of care that effectively treat those with both substance abuse and physical health conditions. If health reform even partially ad-

dresses these problems, the result will be a system of care that greatly improves the treatment of substance abuse disorders in the United States. ■

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In this month's *Health Affairs*, Jeffrey Buck analyzes how the Affordable Care Act of 2010 and other recent legislative changes will transform public substance abuse treatment services and integrate them more into the mainstream of general health care. He also anticipates that the changes will increase funding for

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Buck is a senior adviser for behavioral health in the Center for Strategic Planning, Centers for Medicare and Medicaid Services. He previously served in senior positions in the Center for Mental Health Services in the Substance Abuse and Mental Health Administration (SAMHSA), including as the associate director for organization and financing, and chief of the Survey, Analysis, and Financing Branch, Division of State and Community Systems Development. Buck directed many of SAMHSA's analytic studies of behavioral health services,

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