Evolution (and Future) of Public Substance Use Disorder Treatment Financing

Major Features of Health Reform and Realignment That Impact the Financing and Delivery of Publicly-Funded Substance Use Disorder Treatment

NOBODY LIKES CHANGE, UNLESS

THEY'RE THE ONES CREATING IT.

Background

Substance Use Disorders (SUD) constitute substantial health problems, and they also cause or contribute to other serious health conditions or complicate treatment for other conditions. Along with mental illnesses, substance use disorders drive many of the costs and caseloads in child welfare & criminal justice systems, hospitals, ERs and other health care systems.

Traditional sources of funding for public SUD services:

- Federal Substance Abuse Prevention & Treatment Block Grant.
- FFP for Drug Medi-Cal
- State General Fund for:
  - Drug Medi-Cal Match
  - Perinatal Services
  - Drug Court Treatment Programs
  - Discretionary (very limited)
  - (Until FY '10-11) Proposition 36 Treatment

Background (cont.)

The Current Landscape:

- Treatment of SUD has largely evolved outside of the mainstream healthcare system, and has been predominantly provided in separate specialty services programs, only some of which offer medication-assisted treatment.
- Because substance abuse as a disease has been viewed with suspicion and disapproval, funding streams that have been developed for other systems have not been developed for SUD services.
- The SUD treatment system has benefits that are so limited that they do not allow practitioners to provide best practices or evidence-based services, and the reimbursement rates are so low that it is often difficult to find providers.

Background (cont.)

- Many SUD treatment facilities lack the administrative and infrastructure support necessary to meet the requirements of mainstream health care financing and management. Current providers are seldom integrated with other health service systems, and make limited use of information technology, even for administrative, claims, and/or billing purposes.
- Many SUD treatment programs do not have an integrated clinical information system that provides treatment staff with access to electronic patient records.
- SUD treatment is typically provided by staff members who are not state-licensed, and have limited professional training.
- About 40% of nonprofit facilities do not accept either private insurance or Medicaid, and about half do not have any contracts with managed care plans.

Background (cont.)

- Only about 40% of adults report that their SUD 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.
- More than three-quarters of the funding for SUD treatment services comes from public sources, compared to less than half for all other health care.
- Nationwide, state general fund spending for SUD treatment declined 3.8% between FY 2008 and FY 2009, and an additional 7.3% in FY 2010. In California, state funding for SUD services has been reduced by over 40% over the past 5 years.
- The need to prove that money spent for SUD treatment must generate offsetting cost reductions is a testimony to the stigma still attached to this field. No other health care activity is held to such a high fiscal standard.

Background : Drug Medi-Cal

- Drug Medi-Cal (D/MC) was originally a set of benefits within Short-Doyle Medi-Cal. The two systems separated in the late seventies, but still today are linked in the billing process at the state level.
- At the state level in California, D/MC is a fee-for-service Medi-Cal specialty carve-out entitlement program. Services reimbursed by D/MC must be medically necessary and provided by or under the direction of a physician. Specific benefits are the following:
  - Narcotic Treatment Program (NTP) – Outpatient treatment primary utilizing methadone
  - Outpatient treatment utilizing the long-acting narcotic antagonist Naltrexone
  - Outpatient Drug Free – Mostly group counseling and some limited individual counseling

Background : Drug Medi-Cal (cont.)

  - Day Care Rehabilitative – Intensive outpatient treatment, including group and individual counseling, eligibility for which is limited to pregnant and postpartum women and, as an EPSDT benefit, to children under 21.
  - Perinatal Residential – Residential treatment provided to pregnant and postpartum women in facilities of 16 beds of less, not including beds occupied by children. (Room & board must be paid for by revenue other than D/MC.)
- A Class action lawsuit filed in 1992 (Sobky v. Smoley) found the state in violation of provisions of federal Medicaid law relating to statewideness, comparability of services, and reasonable promptness. The lawsuit was concerned primarily with the availability of NTP services, but the principles of federal law apply to Medi-Cal benefits generally.

Health Reform Provisions

- Section 1302(b) of the Affordable Care Act lists the 10 Essential Health Benefits required to be covered by every health plan, to include: "(E) Mental health and substance use disorder services, including behavioral health treatment."
- The Affordable Care Act extends mental health and SUD coverage at parity for the Medicaid benchmark and benchmark-equivalent plans that states must provide to the expanded Medicaid population.
- These plans are based on the Federal Employee Health Benefits program, the state 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 & Human Services.

Health Reform Provisions (cont.)

- 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.
- The Essential Health Benefit (EHB) will specify the floor benefit to be offered to new enrollees through Medicaid (all adults up to 134% of the Federal Poverty Level), and through the insurance plans offered by the state Health Insurance Exchanges (adults 135% FPL and higher).
- The EHB is to encompass the 10 "essential benefits" including benefits for mental health care and substance use disorder treatment, which must be offered at parity with medical care benefits.
- The Secretary of the Dept. of Health and Human Services delegated to the states the authority to define the EHB. In California, that decision will be made by the Health Benefits Exchange and the State Legislature.

Health Reform Provisions (cont.)

The Affordable Care Act contains other provisions that will affect the financing, design and delivery of public SUD treatment services.

- Generally these provisions are designed to increase service delivery through various types of integrated systems, often based on more comprehensive primary care.
- The goal is to promote a whole-person approach to care, including the integration of SUD and MH services with general medical care, as provided, for example, in medical or health homes.
- Enhanced federal matching funds in Medicaid will support the establishment of health homes.
- The ACA provides funding to increase the number and capacity of FQHCs by providing an additional $11 billion in dedicated funds to the health centers program.

Health Reform Provisions (cont.)

Health reform is also expected to greatly expand the number of insured people with substance use disorders.

- 32 million more Americans will be covered in 2014 under the ACA. Over 30% of these (10 million people) will have a mental health or substance use disorder.
- One estimate predicts that this expansion will double the number of nonelderly childless adults with MH & SU disorders in Medicaid, because this population is more concentrated among the low-income insured.
- The largest proportional increase in the newly-insured population may be for those with substance use disorders.

Impacts of the ACA on the Public SUD Treatment System

Requirements for Expanded SUD Coverage:

Along with the expansion of Medicaid eligibility, the ACA will greatly increase public support of SUD treatment services. These and other changes will have a significant impact on the types and relative importance of funding sources, the numbers and types of SUD treatment providers, the workforce, and the kinds of services offered.

Sources of Funding:

- Under health reform, Medicaid's share of total public funding for SUD treatment will increase, while the share from SGF spending will probably continue to decline.
- The other major source of non-Medicaid funding, the federal Substance Abuse Prevention & Treatment (SAPT) Block Grant, is also likely to decline in relative importance.

Impacts on the Public SUD Treatment System (cont.)

These funding changes will have three major consequences:

1) Overall public spending for SUD treatment should greatly expand as a result of increased Medicaid enrollment and new benefit and parity requirements.
2) Expansion of Medicaid coverage will increase the proportion of federal spending for SUD treatment services in comparison to other funding sources.
3) The model in which public SUD treatment services are now organized and delivered will be fundamentally transformed. Rather than these services being administered by a single state authority that funds designated providers through a system of grants and contracts supporting a specified number of treatment slots, Medicaid will increasingly displace this model with a medical model payment system more characteristic of health plan managed care.

Impacts on the Public SUD Treatment System (cont.)

Changes in SUD Treatment Services:

Changes now underway, driven largely by the increase in Medicaid funding of SUD services at parity, reflect the following features of national health care reform:

- Near-universal coverage
- Systems of payment and administration more characteristic of medical-model health plans
- Integrated models of care coordinated mainly through primary care settings
- Expanded use of health information technology

Impacts on the Public SUD Treatment System (cont.)

Other changes that will come with the implementation of health care reform:

- More integrated, person-centered systems of care will change the character of some existing SUD treatment programs, and expand the participation of non-specialty providers, such as Medicaid health homes and FQHCs, into the SUD service system.
- New funding mechanisms will increase opportunities for larger, better-operated programs to expand through the acquisition of smaller, independent providers.
- The medicalization of public SUD treatment will result in 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, and some SUD treatment services currently provided by peer counselors may not qualify for Medicaid or private health insurance reimbursement.

Impacts on the Public SUD Treatment System (cont.)

- Payment systems for SUD providers will need to be based on equitable reimbursement for services consistent with a medical model framework for levels of care, such as the patient placement criteria offered by the American Society of Addiction Medicine.
- The increased reliance on Medicaid as a funder of public SUD treatment systems may further diminish the role of residential programs, since Medicaid excludes medical assistance for people in institutions for mental diseases, and Medicaid funding does not extend to the room and board costs of residential facilities. Maintaining residential programs at existing levels will require continuing support from SGF and Block Grant funding at a time when both sources of funding are being increasingly reduced.

The Impacts of Parity

The ACA expands the Parity requirements to all private health insurance plans, to Medicaid, and to plans under the state Health Exchanges.

Opportunities under Parity:

- Less cost shifting from the private to the public sector.
- Increased payment from commercial insurance.
- Addiction and MH treatment programs and workforce who learn to leverage parity for their organizations will go to the front of the line.

Changes and Challenges

The public SUD treatment system is likely to be transformed into a more medically-oriented, physician-directed system of care, which will make much greater use of medication-assisted treatment and services delivered by health professionals.

- **The Concern**: the American healthcare system, which is based on the belief that primary care physicians should lead and manage the healthcare system, has historically not been very effective or efficient when it comes to the evaluation and treatment of individuals with substance use disorder and mental health conditions.
- **The Challenge**: Getting the primary care system to pay more attention to the mental health and substance use disorder issues of their patients (i.e. more screening and brief intervention).

What Realignment Means for SUD Services in California

The Governor's Budget for State Fiscal Year 2011-12 provides $180 million in Realignment funds to counties for the purpose of "preventing, treating and providing recovery services for alcohol and drug services."

The goals of Realignment are to:

- Protect California's essential public services
- Create a government structure that meets public needs in the most effective and efficient manner
- Have government focus its resources on core functions
- Assign program and fiscal responsibility to the level of government that can best provide the service
- Have interconnected services provided at a single level of government

Realignment (cont.)

- Provide dedicated revenues to fund these programs
- Free up existing local funds not currently used for core services so they can be used as an enhancement for the realigned programs or for other core local priorities
- Provide as much flexibility as possible to the level of government providing the service
- Reduce duplication and minimize overhead costs

The public safety component of Realignment (AB 109) provides funding that can be used for local rehabilitation programs for offenders who will be maintained under county supervision in lieu of prison. At least 70% of this population will have MH or SUD issues, but funding for treatment will likely vary widely from county to county.

Realignment & Drug Medi-Cal

Realignment of D/MC – Under the 2011 Realignment legislation in California, the state will retain the responsibility for the certification and monitoring of D/MC programs, and will continue to set rates, while counties will assume the responsibility and financial risk for administering and funding D/MC services at the local level.

- As an entitlement program D/MC cannot be capped and, operating on a fee-for-service basis, does not have the administrative and clinical controls on utilization that local Mental Health plans have.
- Financing D/MC caseload growth becomes a local responsibility under Realignment, but the specific mechanisms for accommodating and funding caseload growth are not defined.

Realignment & Drug Medi-Cal (cont.)

- With no administrative changes in D/MC, and retention of program authority at the state level, there do not appear to be immediate benefits in terms of local program control or cost savings due to program efficiencies. However, realignment does set the stage for a 1915(b) waiver permitting counties to operate local managed systems of care for clients similar to county Mental Health plans.
- Waivers and/or state plan amendments would enable counties to manage their provider network, while ensuring that all Medi-Cal-eligible clients have ready access to medically-necessary services.

Where is Health Care Headed?

- More of a system, less of a cottage industry
- More integration of care
- More focus on primary care:
  - Patient-centered medical homes
  - Federally Qualified Health Centers
- More accountability (pay for outcomes)
- Bundled payments (Accountable Care Organizations)
- Electronic health records, health information exchanges
- Under Realignment, counties will have more responsibility for managing and funding public sector MH & SUD treatment.

About CADPAAC

The County Alcohol and Drug Program Administrators' Association of California (CADPAAC) is a non-profit association comprised of the designated county alcohol and drug program administrators representing the 58 counties within California. CADPAAC is dedicated to the reduction of individual and community problems related to the use of alcohol and other drugs.

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