California Society of Addiction Medicine

"The Voice for Treatment"

Expansion of Substance Use Disorder Treatment Within Reach Through Health Care Reform

UNIQUE OPPORTUNITY

PART I – Overview

National health care reform provides California with the best opportunity to date to significantly expand and improve the care for people requiring substance use disorder (SUD) treatment. The Patient Protection and Affordable Care Act (PPACA2010) requires that all health plans include treatment for substance use disorders among their basic benefits. This act greatly expands coverage to people for whom treatment is unavailable. At the same time, the Mental Health Parity and Addiction Equity Act (MHPAEA2008) assures these disorders are covered in the same way as all other medical and surgical benefits. Together, these landmark acts improve the availability and quality of care for people with SUD.

Californians with substance use disorders are grossly underserved. According to the 2007 state estimates from the National Survey on Drug Use and Health, 764,000 Californians needed but didn't receive treatment for drug use and 2.3 million Californians needed but did not receive treatment for alcohol use.[1] The Affordable Care Act breeches this disparity by expanding Medicaid eligibility to everyone, including childless adults, up to 133 percent of federal poverty level, and requires that all receive basic benefits that include SUD treatment. These benefits extend to poor and uninsured Californians – such as the homeless, ex-offenders, unemployed and others – who today have little access to effective SUD treatment. In California, 6 million individuals who were previously uninsured will receive basic medical benefits. The Act extends coverage through other means, including by mandating SUD treatment in private coverage plans and allowing parents to maintain children on their health plans until age 27, and also bans denial of coverage for any pre-existing condition. Many of these changes impacting SUD treatment do not go into effect until 2014.

Combined with the Addiction Equity Act, the Affordable Care Act reverses decades of misguided "carve-out" of SUD treatment benefits by insurers and health plans. These insurers have systematically provided reduced or minimal SUD treatment benefits in a discriminatory attempt to reduce costs.[2] Research clearly shows that when SUD treatment is adequate, it saves lives. Moreover, when SUD treatment benefits support medically necessary care equal to other medical disorders (parity), positive outcomes are achieved without increasing total costs. Assumptions that SUD treatment is too costly or ineffective are incorrect and do not reflect the reality of advancements in treatment and health care management over the last two decades.[3] When coverage for treatment is limited or denied, insurers and health plan sponsors shoulder hidden costs through emergency room, hospital and other expenses that result from insufficient treatment of the disease of addiction.[4] SUD treatment expansion and parity benefit not only patient populations through improved care but also insurers through reduced outlays.

While health care reform is mandated as national policy, states have wide latitude to carry out the federal mandate from the Affordable Care Act. In the next few years, California policy makers must make the right choices as they face conflicting priorities to reduce the state deficit and roll out new health care obligations at the same time. Under the Affordable Care and Addiction Equity acts, California has the potential to transform our state SUD treatment system to provide effective, cost-effective and accessible care. Our leaders must ensure that medical benefits for SUD treatment are adequate to realize the promise of improved lives and tangible cost-savings through treatment.

Over the next several years, Californians will see major cuts in direct funding for SUD treatment programs and facilities, while health care reform increases public and private insurance coverage for substance use disorders. The result will shift SUD treatment from stand-alone treatment centers to integrated services in health care settings, and from fee-for-service programs to accountable care organizations capable of demonstrating cost efficiency and quality effectiveness. For both public and privately insured Californians, policy makers must ensure that SUD treatment is adequate and includes a continuum of basic integrated services: medical detoxification, rehabilitation and continuing care treatment. This continuum must serve as the basis for intelligently designed insurance benefits as mandated by health care reform.

PART II – What should treatment look like under health care reform?

Addiction to alcohol and drugs is a chronic disease much like diabetes, hypertension and asthma. Treatment success and relapse rates for SUD mirror those other chronic disorders.[5] Decades of SUD research has led three national scientific institutes to establish national standards for addiction treatment. The National Institute of Drug Abuse (NIDA),[6] National Institute of Alcohol Abuse and Addiction (NIAAA),[7] and the Institute of Medicine (IOM)[8] have each articulated explicit evidence-based guidelines and standards for effective and efficient SUD treatment services. The cornerstones of these guidelines are:

- Addiction is a chronic disease
- Addiction is treatable
- Addiction treatment must be on-going and continuous
- No single treatment is effective for all individuals
- Co-occurring medical and psychiatric conditions must be addressed

When treatment incorporates these standards, significant reductions in substance use and crime and improvements in health are demonstrable.[9] Medical and societal cost savings are significant.[10, 11] Every $1 invested in SUD treatment saves $7 in societal costs of substance abuse.[12] Quick access to necessary care insures against the horrendous consequences resulting from unabated substance abuse.[13]

Under the Affordable Care and Addiction Equity acts, SUD treatment and benefits must be sufficient to provide medically necessary care. To date, the National Quality Forum sponsored by the Robert Wood Johnson Foundation has developed the most comprehensive standards for treatment of SUD.[14] Based on these extensively researched standards and others, the following serves as an evidence-based guide to define medically necessary treatment benefits under California's new health care reform mandates:

Medically necessary care for substance use disorders

Evidence-based treatment placement criteria can effectively place individuals into the optimal level of SUD care that is deemed medically necessary. The American Society of Addiction Medicine (ASAM) Second Edition-Revised of Patient Placement Criteria (ASAM PPC-2R) is the national standard-validated criteria by which practical and clinical determination of levels of care can be measured.[15, 16]

Medically necessary care cannot be subject to annual or lifetime benefit caps, nor can there be arbitrary limits of any kind on benefits. Delivery of services must be the same as with any chronic condition: successful outcomes may require multiple treatment experiences. As with patients suffering from other chronic diseases, many addicted individuals need multiple episodes of treatment that provide a cumulative impact.[17] The effects of addiction treatment are optimized when patients remain in continuing care and monitoring without limits or restrictions on the number of days or visits covered.[18]

Entry to treatment: When SUD treatment is covered by public and private health insurance, treatment benefits must permit referral options that facilitate entry for treatment through medical settings, as well as allowing self-referral directly to SUD treatment assessment or detoxification when needed. The state must develop SUD treatment models and policies where there is "no wrong door" to access treatment. That means that individuals needing treatment should be able to gain access to initial screening and detoxification through community clinics, doctors' offices and hospitals or through treatment facilities, detoxification centers and self-help groups. A statewide "treatment on demand" hotline will be necessary.

Screening, brief intervention, and referral to treatment (SBIRT): In hospitals, health clinics and primary care settings, SBIRT has been shown to be very effective in reducing SUD and future emergency room visits. SBIRT targets people who abuse alcohol and/or drugs but who are not necessarily dependent or addicted; it is not a treatment for addiction. Medical benefits must support and encourage SBIRT through full reimbursement in emergency rooms and primary care settings.[19]

Medical detoxification: People with substance use disorders often need detoxification prior to treatment. Medical detoxification from alcohol and drugs must be covered under medical benefits and cannot be subject to limits. Patients who require 24-hour medical and nursing care should receive the full resources of a licensed hospital under their medical benefits. Patients not requiring 24-hour medical and nursing care may be treated as outpatients.

Effective treatment dosage: Current federal guidelines show that the threshold of improvement cannot be reached until about three months in treatment.[20] This is the minimum level for effective treatment dosage, and longer treatment dosage may be medically necessary. Three months must not be used as a benefit limit; treatment must be provided as long as medically necessary. As with any chronic condition, individual cases and classes of patients differ. Substance use disorder treatment dosage should be the same as treatment dosages for other chronic diseases such as hypertension and diabetes, for which there are no limits of any kind except medical necessity.

Outpatient Treatment: The mainstay of SUD treatment should be outpatient treatment. Outpatient treatment is less expensive and appears to be as effective as inpatient or social model recovery programs for most patients.[21] It must be continued as long as medically necessary with no limits on duration or frequency and must be repeated to treat relapse.

Inpatient treatment: While outpatient programs may be effective for most patients, inpatient services may be medically necessary for higher risk patients.[22] In particular, inpatient treatment is necessary for patients unable to participate in outpatient treatment, such as those with cognitive or mental illness associated with drug use, not responsive to outpatient treatment due to relapse or who live in high-risk environments such as homelessness or drug environment.

Continuum of care: All three major national institutes (NIDA, NIAAA and IOM) recommend a complete continuum of services that includes medical detoxification, inpatient and outpatient treatment and aftercare, as well as appropriate medical and psychiatric care. Best outcomes occur when individual patients are matched with appropriate levels of care.[23] Care must be continuous as needed, including ongoing care monitoring for at least one year following the completion of outpatient treatment.

Bi-directional care: SUD treatment must be available at primary care and mental health care settings and primary care and mental health care must be available at SUD treatment settings. Treatment for substance use disorders must be integrated into all health care systems.

Co-occurring disorders: Up to 40% of substance users have a mental illness and up to 30% of mentally ill individuals abuse substances. Treatment of the dually diagnosed mentally ill substance abuser should be comprehensive, continuous and integrated.[24] Patients with this condition require benefits that can be flexibly implemented.[25] Treatment for mental illness must be available in SUD treatment settings, and SUD treatment must be available in mental health treatment settings.

Medication-assisted treatment: Medications approved for alcohol, drug and tobacco treatment are shown to be effective and must be a covered benefit. Coverage should be as long as medically necessary with no limits. Access to medications such as methadone must no longer be limited to specified clinics but instead become the purview of qualified physicians under office-based opioid treatment protocols. Physician reluctance to treat patients with opioid-use disorders is a barrier that must be overcome.[26]

Adolescent treatment: Treatment for youth with SUD has been largely unavailable, except through youth criminal justice systems. Since youth substance use disorders are usually co-occurring with other behavioral disorders, adolescent treatment services must be provided through merging of substance use, mental health and pediatric or family medicine to provide extended integrated care.

PART III – Actions for effective and robust treatment under health care reform

State government will play a critical role in planning and regulating SUD treatment benefits and services that Californians receive under health care reform. In order to 1) serve millions of Californians in need of effective SUD treatment, 2) protect public health and safety, 3) reduce public costs for untreated SUD, 4) save insurers money and 5) reduce costs and productivity losses for employers, California must mandate effective SUD treatment benefits to realize the promise of providing medically necessary care. To accomplish that, the following areas must be addressed:

- **Essential treatment coverage:** In order to provide adequate SUD treatment for all Californians, the model for medically necessary treatment described in Part II must serve as the template for SUD treatment standards for all public and private coverage. These treatment services must be covered as basic medical benefits without any limits except for medical necessity.

- **Effective outreach:** Increased Medi-Cal eligibility and individual and small-group coverage through health care exchanges will require patients to proactively sign up for newly available coverage that includes SUD treatment. For the first time, coverage will be available to underserved populations including the homeless, ex-offenders, disabled, unemployed and youth. Accessing new coverage options may be difficult for many of these people. Effective outreach programs will be necessary to sign up as many people as possible for Medi-Cal and health care exchange coverage so that they can qualify SUD treatment. Inquiries received by SUD treatment facilities, detoxification centers and self-help groups must be referred for help in obtaining treatment coverage. A state hotline for "treatment on demand" will be necessary.

- **Workforce training:** With treatment and interventions being initiated by primary and emergent care, a significant ramping up of physician training in substance use disorders and treatment will be imperative. The state must create standards of continuing medical education (CME) in SUD for primary and emergent care physicians. In addition, the integration of SUD treatment into health care will necessitate much greater knowledge and training for the SUD treatment workforce. The state must develop and implement enhanced standards to train the SUD treatment workforce to work within the health care system.

- **Prevention:** The Affordable Care Act includes significant new investment in clinical and community-based preventive services. California must leverage new funding streams for evidence-based prevention targeting alcohol, tobacco and other drugs. Prevention should be oriented towards promoting the health of the whole person, including prevention of co-occurring mental health disorders and other medical disorders. Prevention should embrace wellness, resiliency and recovery across the lifespan in diverse ethnic and cultural communities for both clients and families impacted by SUD.

- **New care delivery models:** Integrated behavioral health care models, including Health Homes and Accountable Care Organizations, are proffered by the Affordable Care Act for people with chronic conditions, including substance use disorders. California should embrace these models and move them beyond pilot projects. Other new models of care include expanded telecare for SUD treatment in rural areas, peer-run services and school-based treatment and early intervention.

- **Enhanced research and outcomes:** Redesign of SUD treatment in California should be accompanied by baseline and ongoing treatment services research and evaluation. California's Alcohol and Drug Programs Outcomes Management System (CALOMS) should provide a framework for monitoring quality improvement efforts into the future.

- **Oversight:** California should establish an agency-level commission to oversee the effective and cost-efficient expansion of SUD treatment benefits. This commission should report directly to the legislature on the adequacy of benefits offered by health plans and the ability of those plan benefits to provide medically necessary care as determined by nationally established benchmark standards. The commission should monitor and report on accessibility to medically necessary SUD treatment, and monitor the unmet treatment needs of California's SUD treatment system. Lastly, the commission should track and monitor the statewide health burden of substance use disorders and recommend improvements in benefits design that would reduce the public impact from untreated SUD.

- **Funding:** State preparations for changes in SUD treatment under health care reform will require funding for various new programs and initiatives. National healthcare reform legislation provides some funding for SUD treatment workforce training. Other workforce training dollars also may be available. In addition, the Substance Abuse and Mental Health Services Administration (SAMHSA) is adjusting its substance abuse and mental health services block grants to help states accommodate changes under federal parity legislation and health care reform. The state must aggressively seek to leverage federal funding for state costs created by changes in SUD treatment. Reorganizing state SUD treatment funding priorities may be necessary.

California Society of Addiction Medicine
575 Market Street, Suite 2125
San Francisco, CA 94105
415/764-4855
FAX: 415/764-4915
csam@compuserve.com
www.csam-asam.org

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