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The Abell Report

What we think about, and what we'd like you to think about

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Crisis of Access II:
Fewer Addiction Services Delivered through Managed Care;
Medicaid Managed Care Weakens Public Addiction Treatment System

The Abell Report of March, 1999 introduced the argument that after a full year of managed care there were 29% fewer addicts in treatment. This report, supported by subsequent and newly available data, is an update of that earlier report.

Despite the growing consensus on the critical need for increasing access to addiction treatment, a three-year old change in an important public program, Medicaid, has resulted in fewer services being provided to fewer of the addicted, while public dollars have been diverted from the public addiction treatment system. New data released by the Maryland Department of Health and Mental Hygiene and by managed care organizations confirm the findings of an *Abell Report* published in March/April 1999, which showed that the opportunity for addiction treatment in Baltimore City was compromised by the conversion of Medicaid into a privately-run managed care program.

Amid a strong economy and clear signs of economic revitalization, addiction of epidemic proportions still saps public confidence in Baltimore City. Just nine months into the year, the city's largely drug-related homicide rate — already well over 200 deaths— is poised again to surpass the 300 mark, and the federal Drug Enforcement Administration (DEA) has recently pronounced Baltimore "the 'most heroin-plagued' city in the United States" with "one of the most severe crack cocaine epidemics" in the country (*The Sun*, July 29, 2000). To make matters worse, a report released last month reveals that deaths attributed to drug overdose (324 in 1999) exceeded the total annual number of homicides for the first time last year (*The Sun*, Sept. 15, 2000). Yet evidence mounts that the three-year-old Medicaid managed care program, known as *HealthChoice*, is not doing its share to fight this epidemic. While Baltimore Mayor Martin O'Malley and other city leaders seek $25 million in new funding to ensure access to the addiction treatment within 24-hours of request, new data show that HealthChoice has decreased access to addiction treatment and drawn public dollars away from the publicly-regulated treatment system.

HealthChoice is Maryland's experiment in mandatory Medicaid managed care. Eight managed care organizations (MCOs) have been given the responsibility and funding to provide health care and addiction services to approximately 370,000 Medicaid beneficiaries in Maryland. On July 12, 2000 and September 27, 2000, the Maryland Department of Health and Mental Hygiene (DHMH) and these MCOs released addiction treatment utilization data for the first time since the FY1998 implementation of Medicaid managed care. The data confirm two trends of

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ABELL SALUTES

Sister Gwynette and Christopher Place Employment Academy: For helping men down on their luck reclaim their lives

They have spent these last few years in prison on Forest Street; or homeless, sleeping in the doorways of East Baltimore Street; or struggling with the demons of alcoholism or of drug addiction. They are mostly in their thirties, some white, mostly African American, and some with as little as a fourth grade education. What they all have in common is that they are down on their luck, and, in a last chance mode to reclaim their lives, they are entering Christopher Place Employment Academy. Of those selected to enroll in the Academy, Sister Gwynette Proctor, SND, Director, says, "I will talk to any man and take him into Christopher Place if I am convinced he is serious about changing his life."

The men fortunate enough to be admitted to the program find themselves immersed in a routine that has defined Christopher Place Employment Academy since its beginnings in 1997. They live in Christopher Place for three months. Each participant is housed and clothed and fed seven days a week; and during those long days (6:00 a.m. to 8:00 p.m.) days he will be educated on how to

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major concern: Three years after Medicaid recipients were moved into mandatory managed care, 66% fewer addiction services may have been delivered to 25% fewer people, and millions of Medicaid dollars have been removed from the publicly-regulated and publicly-accountable treatment system.

Addiction treatment providers, policy advocates, and others observing the transition from a fee-for-service system to mandatory managed care predicted this negative outcome. The very concept of "managed care," many argue, is an inappropriate financing and service delivery mechanism for particularly vulnerable populations that require *enhanced* access to services. Managed care systems are designed to save money, in part by imposing barriers to care which limit access to services. While it may be reasonable to require the general population to seek approval for treatment, choose from a provider network, and navigate additional managed care requirements, these seemingly low thresholds become insurmountable obstacles for very poor and very sick individuals already facing substantial barriers to care.

The release of preliminary state data is the latest installment in a long-simmering debate about the appropriateness of prepaid managed care, with its incentives to limit the use of services, for the delivery of addiction treatment to a low-income population. Last year The Abell Foundation published a report which asserted that 29% fewer people were served by state-certified Baltimore City addiction treatment providers in the year after Medicaid managed care than in the year before the implementation of HealthChoice (Abell Foundation, March/April 1999). In a September 1999 letter to The Abell Foundation from DHMH, Secretary Georges C. Benjamin said the report finding was "based on incomplete FY98 data provided by the Alcohol and Drug Abuse Administration (ADAA)," a unit of his Department. The numbers released by DHMH at the July 12 meeting of the Maryland Drug Treatment Task Force — a different set of data — provide even further support for last year's findings.

Indeed, the actual numbers paint a far more troubling picture than that suggested by the initial *Abell Report*. An analysis of available data demonstrates two closely related problems created by the inclusion of addiction services in a managed care model. The first problem is that *fewer* addiction services are delivered to *fewer* people. According to the new state data, the total number of Medicaid participants receiving *any type* of addiction service fell by 25% statewide after the implementation of Medicaid managed care. Additionally, the extent and duration of services received by each individual fell by over 50% in the first year of HealthChoice and remained 45% lower in FY1999. Total units of service delivered to Medicaid recipients fell by 66% between FY1997 and FY1999. Noting substantial limitations with the state numbers, MCO representatives released their own figures, showing at least a 20% decline in addiction services. Whether a decline of 20%, 66%, or an intermediate figure, any such substantial reduction in services is cause for concern.

The second problem is that important Medicaid dollars are withdrawn from the publicly-regulated and publicly-accountable addiction treatment system. The information obtained for this report shows that 40% of Baltimore City State-certified addiction treatment providers do not have MCO contracts, a trend which is also present statewide. This diverts public funds from this system and weakens the public treatment system for the insured and uninsured alike. A state analysis of Medicaid dollars received by 10 major Baltimore City treatment providers demonstrates a substantial loss of Medicaid revenue. In the first year of Medicaid managed care, these 10 providers lost 55% of their FY1997 Medicaid dollars. This ranged from an 88% loss in Medicaid revenue at one program to a 29% loss at two others. None of the 10 programs reviewed saw an increase in Medicaid funding under HealthChoice. A statewide analysis of 28 major programs indicates a 54% Medicaid reduction for these public providers (ADAA, 2000).

Rather than realizing the promised system improvements of managed care, the state is witnessing a reduction in services. "I don't think anyone can feel very good about what's going on here," said Lieutenant Governor Kathleen Kennedy Townsend at the July 12 meeting of the Maryland Drug Treatment Task Force, at which the long-awaited numbers were first released. "It's time for us to ask if the system we've developed is really the best system."

In response to the criticism received from providers and advocates, recently MCOs have volunteered to reduce barriers within the managed care model. This may increase the number of individuals who receive treatment. Nonetheless, this would not resolve the problem of millions of public treatment dollars being diverted from the public treatment system. These diverted dollars go *from* publicly-regulated providers to two primary sources: MCO administrative expenses such as credentialing, recruitment, and shareholder profits, and private providers or uncertified programs which have no formal regulation as addiction treatment providers and give no evaluative data to the state. The information obtained for this report il-

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lustrates the withdrawal of Medicaid dollars from the public treatment infrastructure — a reality with serious implications for the City of Baltimore and the State of Maryland. While immediate managed care reforms are required to ensure access to care in the short-term, the only tenable solution to the twin problems of access and financing is to remove addiction services resources from HealthChoice and administer them separately through the public treatment system. This arrangement, known as a "carve-out," would better serve Baltimoreans with addictions and better support Maryland's public addiction treatment system which treats *insured* and *uninsured* alike.

The Public Treatment System and HealthChoice

Considering Baltimore City's high rates of poverty and of people without health insurance, efforts to strengthen access to addiction services are focused on improving the city's publicly-funded network of 38 addiction treatment providers. These treatment providers are certified by the state through the Office of Health Care Quality, in conjunction with the Alcohol and Drug Abuse Administration (ADAA) of DHMH, and are eligible for funding through the ADAA and Baltimore Substance Abuse Systems. Each of these providers is accountable for meeting standards of care. Historically, this public treatment system has provided equal access for the uninsured and for those with public insurance. This system has received its funding from two primary sources: *grant dollars* (a combination of federal and state resources, supplemented by local and private contributions), and *Medicaid reimbursement*. Providers in the publicly-regulated treatment system used both sources of funding to provide treatment for Medicaid recipients and non-recipients alike. Both funding streams were blended together by certified treatment providers, thereby making funding source secondary to the need for treatment. It made no difference to the individual in need of treatment whether she received Medicaid, was uninsured, or was eligible for one of various targeted grant programs. Providers worked with the available funding streams to provide appropriate treatment to those most in need of it.

Medicaid Enrollees: A Right to Addiction Treatment

Code of Maryland Regulations 10.09.65.11.

"An MCO shall provide a continuum of substance abuse treatment services that offers access to the most appropriate level of individualized care to each enrollee. As part of this continuum, the MCO is responsible for referring the enrollee for appropriate substance abuse treatment modalities beyond the covered benefits specified in COMAR 10.09.67."

Medicaid Managed Care: Three years ago, Maryland made the decision to institute Medicaid managed care in the form of the HealthChoice program. With the exception of mental health services, which were "carved out" of the program and administered separately, most other Medicaid resources[1] are now administered through private managed care organizations (MCOs), essentially insurance companies which contract with providers for the delivery of care. In keeping with the recent trend toward *privatization*, millions of Federal and State Medicaid dollars were moved to these private MCOs, which then set the rules for provider payments. Before HealthChoice, the State administered Medicaid dollars through a fee-for-service system by reimbursing any licensed provider at a State-set rate for each service delivered. Whereas under the fee-for-service system any certified addiction treatment provider could serve Medicaid enrollees and bill the Medicaid program, Medicaid managed care generally restricts payments to providers who have a contract with an enrollee's MCO. Though some MCOs do indeed authorize payment to out-of-network providers, they are under no obligation to do so. Presently, there is no requirement that MCOs contract with state-certified providers.

[1] Most Medicaid enrollees are included in the State's HealthChoice program; a small group of beneficiaries continues in a fee-for-service arrangement.

Access to treatment is now limited in three fundamental ways:

- **Treatment is limited by a substantial reduction in services delivered** - As confirmed by available data, presented in greater detail later in this report, between 20% and 66% of the previous level of service is being delivered to Medicaid recipients. MCO requirements for referrals and pre-authorization of services are substantial barriers to accessing treatment.

- **Certified treatment providers without MCO contracts** - Data available for 35 of the 38 public treatment providers regulated by Baltimore Substance Abuse Systems (BSAS) and reviewed for this report shows that 14 (40%) do not have a single MCO contract (BSAS, 2000). Statewide, data gathered from DHMH and the MCOs suggests that as many as 1/3 of the providers with which MCOs contract for addiction services are not certified by the Office of Health Care Quality and ADAA for the provision of addiction treatment (OHCQ/ADAA, 2000). As con-

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On the Addiction Treatment/Medicaid Nexus

What is the public treatment system in Baltimore? A network of 38 certified providers in Baltimore City funded by Baltimore Substance Abuse Systems (BSAS) incorporates a continuum of services from treatment readiness through detoxification, individual and group counseling, to residential treatment and methadone maintenance. This network currently has the capacity to serve 18,600 individuals, far below the estimated 60,000 Baltimoreans with a treatable addiction. The pubic treatment system historically has received the lion's share of its funding from two sources: grant dollars and Medicaid reimbursement.

What are grant dollars? Grant dollars are primarily federal funds supplemented by state, local and private contributions. They provide access to a range of addiction services for those who lack the means to pay for treatment, primarily the uninsured and the underinsured (those with health insurance plans that do not include addiction services).

What is Medicaid? Medicaid is the public insurance program that provides comprehensive health services, including impatient and outpatient addiction treatment. Approximately 65% of those covered by Medicaid are low-income women and children who are eligible by virtue of their extreme poverty, and 35% are individuals who are poor and completely disabled or aged. Most poor, unattached adults in Maryland are not, in fact eligible for Medicaid, and have no health insurance whatsoever. Many women and children have Medicaid only episodically. Due to fluctuating employment status and complicated eligibility rules and re-determination process, many repeatedly lose and regain eligibility.

What is the relationship between grant dollars and Medicaid? Because Medicaid eligibility is episodic, both Medicaid reimbursement and grant dollars may be used for any particular individual during a period of addiction treatment. These sources of funding are therefore complementary; a client may have Medicaid today and be uninsured tomorrow. Consequently, any analysis of addiction treatment opportunities for indigent Marylanders must account for both sources of funding. Any reduction in grant dollars weakens the system; any reduction in Medicaid dollars has precisely the same effect.

How is treatment regulated? The Office of Health Care Quality (OHCQ), in conjunction with the Alcohol and Drug Abuse Administration (ADAA), of the Maryland Department of Health and Mental Hygiene (DHMH), licenses addiction treatment facilities. OHCQ and ADAA have historically served as the regulating bodies to establish standards of care for participating providers who receive public grant dollars and federal/State Medicaid funds. In conjunction with Baltimore Substance Abuse Systems (BSAS). DHMH monitors, evaluates, and provides technical assistance to these programs. This regulatory process requires the collection of standardized data, ongoing staff training, and the review of treatment processes and outcomes. Many resources have recently been committed within this system to ensure that all counselors working in state-certified programs have the appropriate certification. The oversight provided by DHMH and BSAS is intended to assure the efficacy and efficiency of publicly-funded addiction treatment programs.

Many private providers also deliver addiction treatment. These providers may be physicians, psychologists, social workers, or hospital programs. Although they may be licensed within their professions they are not certified specifically as addiction treatment providers. Consequently, the addiction treatment they provide is not scrutinized by DHMH, and they do not submit data to the State. MCOs frequently contract with these providers, even though no public scrutiny is available to assure the quality and efficacy of these addiction treatment services. State and local efforts to improve the addiction treatment system focus on those programs which are licensed and certified by the State precisely because therein lie opportunities for accountability, quality assurance, and data collection.

More Uninsured Place Greater Burden on Public Treatment System

Throughout the past decade, the number of people without health insurance has grown exponentially, along with decreasing public investment in programs for the poor. In 1992, for example, 32,000 low-income Marylanders lost access to health care with the elimination of the Maryland's Medical Assistance, State-Only (MASO) program - a state-funded program for poor single adults mirroring the benefits of the Federal Medicaid program. Four years later, the federal Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) eliminated the entitlement of cash assistance for poor families with children and instituted new restrictions and time limits. In many State, families leaving the welfare rolls inadvertently lost Medicaid, though they retained eligibility in many cases ("Health Care After Welfare," Center on Budget and Policy Priorities, August 2000).

At the same time, the Contract with America Advancement Act eliminated Medicaid and other benefits for persons with addictions, many of whom according to new studies, continue to face significant mental health problems (The Medicaid Letter, 1999). Thousands of individuals over the past decade have found themselves without access to comprehensive medical coverage, joining the ever-growing ranks of the uninsured — currently more than 837,000 Marylanders, including 100,000 Baltimoreans (US Census Bureau, 1999). These policy changes of the past decade place an even greater strain on the public addiction services system as more individuals in need of treatment have fewer places to turn for help.

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firmed by the Spring 1999 *Abell Report* on this subject, more than 1,000 Medicaid recipients were moved from state-certified treatment providers in the first year of HealthChoice. This data confirm anecdotal evidence that a substantial number of public providers lack MCO contracts and that HealthChoice reduced or eliminated long-relied-upon Medicaid revenue for State-certified treatment providers.

- **Lack of accountability** - Because many of the addiction treatment providers with which MCOs contract are not licensed or certified as *addiction treatment providers* by the state, they are not reviewed and evaluated for effectiveness by an independent entity. While these providers consume valuable and scarce public resources, they are not publicly accountable for efficiency or effectiveness. The public dollars which now go to uncertified individual providers, administrative overhead, and shareholder dividends have been withdrawn from addiction treatment providers which *are* publicly-regulated and publicly-accountable.

Even without the data to confirm its ineffectiveness, many treatment providers long questioned the wisdom of including addiction treatment — a largely *under-utilized* service — in a managed care model that was designed specifically for *over-utilized* medical services. The intent of prepaid (monthly payments in advance known as "capitated") managed care is to restrict access to services as a cost-saving measure, reducing superfluous or unnecessary expenditures. The same mechanisms designed to prevent abuse of the medical system in the general population, however, can prevent vulnerable populations from ever receiving appropriate treatment. "Structurally, 'managed care' is an inappropriate system for very poor, very sick people who need *enhanced, not reduced* access to services," says treatment advocate Ann Ciekot, director of advocacy for the Maryland chapter of the National Council on Alcoholism and Drug Dependence (NCADD-MD). Experts in addiction treatment are virtually unanimous in their support for systems which ensure enhanced access to addiction treatment "on request" when an individual has made the difficult decision to seek help.

> ***"Structurally, 'managed care' is an inappropriate system for very poor, very sick people who need enhanced, not reduced access to services."***
> ***— Ann Ciekot, NCADD-MD***

A Closer Look: State and MCO Treatment Data

On July 12, 2000 the Maryland Department of Health and Mental Hygiene released "HealthChoice Substance Abuse Preliminary Analysis," a report on addiction treatment utilization by Medicaid beneficiaries. An amended version of this report — "HealthChoice Substance Abuse Analysis"— was unveiled two months later

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on September 27, 2000. The reports include data from FY1996 and FY1997, prior to the implementation of mandatory managed care, and from FY1998 and FY1999, the first two years of the HealthChoice program. DHMH also released calendar year 1999 data and plans to release FY2000 data in January of 2001. Though forthcoming data sets are likely to clarify unanswered questions, and may indeed show less-dramatic reductions, the direction of the data is clear: Medicaid managed care has significantly reduced access to addiction services for Medicaid recipients, while reducing access to Medicaid dollars for providers in the publicly-regulated treatment system.

- Fewer individuals were identified as in need of addiction services by their managed care plans than had been identified in the previous fee-for-service system, despite focused efforts to increase addiction screening;
- Fewer individuals received services after the implementation of managed care;
- The overall units of service delivered by HealthChoice have fallen by at least 20% (MCO numbers) and as much as 66% (DHMH numbers) since the beginning of the program; and
- Certified treatment providers received diminished payments from Medicaid, while experiencing increased administrative costs.

Fewer Individuals Identified: According to available data, MCOs identified approximately 10% fewer Medicaid participants with an addiction than were identified in the previous fee-for-service system. In FY1996 and FY1997, just over 15,500 enrollees were diagnosed with an addiction. By FY 1998 and FY1999, between 13,500 and 14,000 were diagnosed each year (Table 2.1). Some speculate that new federal guidelines and changes in the Medicaid program between 1996 and 1999 may have resulted in fewer enrollees with addiction, but it is doubtful that the number of Medicaid recipients with addiction changed significantly during this time period. More likely sources of the reduction in recipients identified with an addiction include difficulties in accessing primary care providers and the prohibition on Medicaid enrollees receiving addiction treatment without pre-approval by the MCO. To DHMH's credit, Medicaid enrollees are now permitted to seek an annual *assessment* (although not *treatment*) for addiction treatment without first obtaining approval from an MCO; this relatively new "self-referral" option, implemented at the end of FY1999, may increase access to addiction services. Permitting self referral for actual *treatment*, by eliminating the need for pre-authorizations, would further increase access.

Fewer Receive Services: Just as fewer Medicaid recipients were diagnosed with an addiction, fewer individuals received addiction services of any kind. The number of individuals receiving any type of service fell from just over 8,000 in FY1996, before HealthChoice, to just under 6,000 in FY1999, after HealthChoice. The percentage of those diagnosed who actually received addiction services also fell from 51% in FY1996 and FY1997 to 43% in FY1999 (Table 2.2). In this area, neither managed care nor the previous fee-for-service system was tremendously successful in meeting identified need: approximately half (and now less than half) of those diagnosed with addiction received any type of addiction service under either system.

According to state numbers, 1.6% of total Medicaid enrollees received any type of addiction service in FY1999. According to MCO data, presented later in this report, 1.9% of Medicaid enrollees received addiction services in the 1999 calendar year. In either case, it is particularly disturbing that fewer than 2% of Medicaid enrollees were connected to addiction services of any kind, including counseling, inpatient treatment, intensive outpatient services. In contrast, a study noted by the Center on Substance Abuse Treatment found that between 6.6% and 37% of welfare recipients (the largest group of Medicaid beneficiaries) have a substance abuse problem. The National Governors' Association has reported that 10%-20% of the welfare population has a substance abuse problem; the National Household Survey on Drug Abuse estimated that 16.4% of welfare recipients have an addictive disorder; and the National Association of State Alcohol and Drug Abuse Directors found that 15%-27% of adult welfare recipients had substance abuse problems (Center for Substance Abuse Treatment, April 2000). There is certainly no reason to believe that rates of addiction would be any *less* among Maryland Medicaid enrollees. Thus the data indicate that thousands of Medicaid beneficiaries did not receive the addiction services which they most desperately needed.

Fewer Services Delivered: The DHMH-generated statistics most critical of HealthChoice reveal that the intensity of services, that is the number of services delivered to persons diagnosed with an addiction, fell sharply — by 50% in the first year of Medicaid managed care — and has remained at low levels in FY1999 (Table 2.3). Between FY1997 and FY1999, the year before HealthChoice and the last full year for which statistics are available, overall units of addiction service delivered fell by more than 66%, including a 74% reduction in methadone maintenance, a 59% reduction in addiction counseling, and a 68% reduction in acute treatment admissions (Table 2.4). [Note: the categorization of addiction services, as well as the definition of one "unit of treatment," differ among MCOs, but also differed in similar ways among treatment providers prior to HealthChoice.]

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Diminished Medicaid Payments for Certified Providers: The data released by DHMH on September 27, 2000 included a new report from the Alcohol and Drug Abuse Administration. This report shows that for certified addiction treatment providers collecting $10,000 or more in Medicaid revenue in FY97, Medicaid collections declined by 55% in Baltimore City and by 54% statewide.

The ADAA report includes twenty-six certified treatment programs which participate in the publicly-regulated and publicly-accountable addiction treatment system. The ten programs located in Baltimore City received $1,642,294 in FY97 from Medicaid. In FY98, after the implementation of managed care, they received $735,161. This represents a loss of $907,133, or 55% of their Medicaid revenue. Statewide, the loss of Medicaid revenue in FY98 by the twenty-six publicly-regulated programs amounted to $1,251,283, or 54% of the Medicaid dollars which they had received in FY97.

Data Limitations: Significant limitations with data may temper the severity of the reduction in services suggested by DHMH data. In the pre-HealthChoice system, addiction service providers submitted "fee-for-service data." Providers were required to submit data (by billing the state) for each service provided in order to receive payment — resulting, according to DHMH, in more reliable utilization data. Under managed care, however, MCOs and some subcontractors receive monthly payments in advance ("capitated") for as many or as few services as a beneficiary may require. The built-in incentive of fee-for-service systems to submit data in order to receive payment does not exist in the same way in a capitated model. Consequently, the state and MCOs believe complete utilization data has not yet been submitted from all HealthChoice treatment providers.

"Even if the acutal number is somewhere in between the DHMH and MCO figures, we're looking at half as many people able to access treatment services in this system."
— Frank Satterfield, Glenwood Life

Lorraine Doo, Director of Medicaid Managed Care for FreeState Health Plan, agrees that managed care encounter data is not as reliable as fee-for-service data and presents additional concerns with state numbers. "The state does not have all of the MCO data," notes Ms. Doo, citing two reasons: first, that DHMH discards records containing conflicting enrollment information, and secondly that a significant proportion of Medicaid enrollees may in fact be receiving addiction services through Maryland Health Partners (MHP), the state's public mental health system. "MHP data is not captured in our system," says Doo. In recent months, MCO representatives have been working with the State and treatment providers to correct problems with HealthChoice data and service delivery. "I hold my industry as responsible as the providers [to ensure quality treatment]," Ms. Doo observes, "but the problems of addiction do not rest on our shoulders alone. This is a community problem requiring a community-wide solution, and that can't happen in a few short years."

MCO Data: The eight MCOs administering HealthChoice have released their own document, "HealthChoice Substance Abuse Referral Summary by MCO for Calendar Year 1999," containing what they believe to be a more complete analysis of services provided. It must be noted, however, that there are also significant challenges to the reliability of this document's data, such as more members receiving services than were referred for service, among other inconsistencies. Nonetheless, MCO data confirms the proposition that Medicaid-funded addiction treatment has declined since the implementation of mandatory managed care. According to the MCO numbers for calendar year 1999, only 6,968 of the 367,882 total Medicaid recipients received addiction services.[2] The percentage of enrollees receiving addiction services differed significantly among the eight MCOs, from a low of 0.8% to a high of 5.9%. These numbers, which in the aggregate represent less than 1.9% of Medicaid enrollees, are consistent with DHMH's findings, and indicate that very large numbers of Medicaid enrollees are not receiving the addiction services to which they are entitled.

Overall, data presented by HealthChoice MCOs suggests a 20% reduction in services rendered, compared to the DHMH figure of 66%. Whereas the state reports that 54,423 units of addiction service were provided in FY1999, the adjusted MCO numbers indicate that 131,503 units of addiction service were provided in the calendar year. In either case, this demonstrates a significant reduction from the 164,113 units of addiction services funded by Medicaid in FY1997, before the implementation of mandatory managed care.

Many observers find little consolation in the difference between the MCOs' numbers and DHMH's data. "Even if the actual number is somewhere in between the DHMH and MCO figures, we're looking at half as many people able to access treatment services in this system," says Frank Satterfield, Executive Director of Glenwood Life Counseling Center and Task Force member. Both the DHMH

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[2] Data provided by the MCOs includes only seven months of encounters from one of the eight MCOs; the authors have extrapolated twelve month equivalencies for the calculations in this paper.

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and MCO numbers support three years of anecdotal data from addiction treatment providers who say that HealthChoice is reducing access to treatment services. "Despite obvious limitations, the numbers speak for themselves," says Satterfield. "After three years, it's clear that the people who desperately need treatment aren't getting it. I have no idea which system will work best. I'm in favor of a system that works for our clients; I do know that this just isn't that system."

Renewed Interest in Treatment

Addiction treatment has re-emerged in recent years as a major public policy priority in Baltimore City and throughout Maryland. Local and state departments, elected officials, and private foundations are devoting increasing resources to addiction treatment for Baltimore's estimated 60,000 addicts - nearly 10% of the City's total population (Baltimore City Health Department). Maryland State Senator Christopher Van Hollen notes that although more than 218,000 Marylanders needed addiction treatment in 1999, only 40% actually received treatment from State-certified programs (*Baltimore Sun*, 3/30/00). The treatment gap is even wider in Baltimore City, with a current public capacity of approximately 6,500 treatment slots (serving up to 18,600 Baltimoreans annually) for those 60,000 people with addictions (BSAS, 2000); 80% of Baltimore's addicts lack public or private health insurance (Baltimore City Health Department, 2000).

Medicaid revenue historically provided a stable source of income for publicly funded treatment providers, allowing these agencies to maintain their infrastructure and partially off-set the costs of providing care to the uninsured. Many are now losing this support. In Baltimore City alone, major treatment providers saw the loss of 55% of their Medicaid addiction treatment revenue in the first year of managed care.

The 2000 session of the Maryland General Assembly dramatized the attempts of state and local officials to leverage additional addiction treatment dollars. Following Governor Glendening's proposal to spend an additional $10 million *statewide* for addiction treatment, House Appropriations Chair Howard P. Rawlings recommended $18 million for Baltimore City alone, while Baltimore Mayor O'Malley lobbied to bring $25 million in addiction treatment money to his city. Baltimore Health Commissioner Dr. Peter Beilenson even wagered his job on the efficacy of Baltimore City's system of publicly funded and publicly accountable treatment programs, offering to resign his post if the state made available $40 million in additional resources to bolster services and the crime rate did not decline significantly (*The Sun*, 3/6/00). That amount, in addition to the $30 million already spent by Baltimore City, would go a long way toward assuring the treatment system's capacity to meet current need and provide true "treatment on request." Though many dispute the dollar amount, few disagree that the public treatment system is the appropriate place to invest additional treatment resources.

Perhaps the clearest expression of a coordinated statewide effort to improve access to treatment is embodied in the preliminary report of the Maryland Drug Treatment Task Force (led by Lieuten-

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Treatment is Cost Effective

Addiction has an impact upon all Marylanders and carries a substantial price tag for the State, currently costing an estimated $5.5 billion each year (Abell Report, 1999). The cost effectiveness of addiction treatment has been consistently upheld by studies demonstrating that every $1 spent treating persons addicted to alcohol and illegal drugs save more than $7 in criminal justice, health care and other public costs (Gerstein et al., 1994). In a recent editorial, Maryland State Senator Christopher Van Hollen cites a more recent estimate that each dollar spent on treatment saves up to $11 in societal costs (Baltimore Sun, 2000). Treatment has been shown to reduce drug use, reduce physical and mental health problems, increase employment, and reduce crime (Danya International, 1999).

These cost savings afforded by public treatment would clearly benefit Baltimore and other urban centers, particularly when the undesirable byproducts of addiction — crime, public anxiety, and a deteriorated economic environment — are frequently blamed for the steady flight of taxpayers to outlying communities which are perceived to be safer. The majority of adults and half of the juveniles in our prisons test positive for at least one drug (National Institute of Justice, 1999), and studies show that criminal behavior declines substantially after addiction treatment. These includes a 78% decrease in selling drugs, an 82% decrease in shoplifting (Danya International, 1999) and a 64.2% decrease in arrests for all crimes, regardless of charge (Gerstein et al., 1997). Such data reflect the precise outcomes desired by local and state officials and provide ample evidence that an adequate supply of publicly funded addiction treatment would greatly improve the quality of life for all Baltimoreans.

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ant Governor Townsend and Delegate Dan Morhaim) entitled, *Filling in the Gaps: Statewide Needs Assessment of County Alcohol and Drug Treatment Systems*. The Task Force brings together treatment providers and policy makers throughout the State to develop specific addiction treatment recommendations for each locality. The top three recommendations for Baltimore City call for the support of the current public treatment system, the expansion of its capacity, and the improvement of treatment outcomes by enhancing services available within this system (Statewide Needs Assessment, 2000).

Additionally, philanthropies such as the Open Society Institute and The Abell Foundation are working with Baltimore Substance Abuse Systems to enhance the capacity of treatment providers. A current initiative builds upon the existing publicly-funded addiction treatment system to provide a full range of primary health care at locations already utilized for addiction treatment. Such an initiative recognizes that persons with addictions require comprehensive health services; all available resources — public grants, foundation dollars, and Medicaid revenue — will be necessary to implement this project. New resources cannot support this new range of services if instead they must be used to supplement lost Medicaid dollars.

Response from DHMH - Program Improvements vs. System Reform

In response to public concerns reflected in the recommendations of the previous *Abell Report* on addiction services and Medicaid managed care (March/April 1999), DHMH has developed, and is implementing, a thoughtful Substance Abuse Action Plan. Broad in scope, the plan seeks improved access to addiction services for Medicaid beneficiaries by decreasing the waiting time for treatment authorization, increasing MCO contracts with certified treatment providers, and simplifying the often cumbersome process which currently keeps addicts from receiving treatment. DHMH is clearly committed to increasing access to appropriate addiction services for Medicaid beneficiaries. The chart below compares the Spring 1999 *Abell Report* recommendations with the subsequent DHMH Addiction Treatment Action Plan's tasks and objectives:

***Abell Report* Recommendation, March/April 1999**	**DHMH Action Plan Objectives, June 1999 - Present**
Eliminate requirement that Medicaid participants receive authorization from their MCO before seeking addiction treatment.	**Implement Self-Referral Option;** distribute to MCOs; verify that MCOs enter Self-Referral Option information into enrollee and provider handbooks.
Strengthen community-based organizations by guaranteeing managed care contracts with adequate reimbursement rates to agencies which meet threshold requirements.	**Assure that the HealthChoice system has an adequate supply of qualified substance abuse treatment providers available;** create a forum in which substance abuse treatment providers and MCOs can discuss how to facilitate contractual relationships.
Implement the accountability provisions of the Medicaid managed care legislation and regulations.	**Determine if the MCOs are using standardized assessment and placement instruments**, and if they are using these tools correctly.
Provide adequate and available treatment utilization data by which to evaluate the efficacy of the HealthChoice program in delivering addiction services.	**Assure MCOs submit valid encounter data** in a timely manner.

Though the efforts of DHMH to improve HealthChoice are commendable, in many cases the funds have already been diverted, the damage already done. The report of the lieutenant governor's Drug Treatment Task Force, *Filling in the Gaps: Statewide Needs Assessment of County Alcohol and Drug Treatment Systems*, identifies many of the same barriers to addiction services that DHMH is attempting to address in its action plan. The Task Force has identified two sets of obstacles to treatment access: the provision of treatment — including managed care requirements which conflict both with medically-recommended courses of treatment and with the criteria required by the state-certified program; and the reimbursement of treatment providers — including frequent refusals of MCOs to authorize treatment and reimburse once it is provided. (Statewide Needs Assessment, 2000).

Even if each of these and other obstacles could be addressed adequately, however, certified providers still stand to lose Medicaid dollars to private, unlicensed providers. The very structure of the Medicaid reimbursement system was undeniably altered by HealthChoice; publicly licensed and regulated providers are no longer the primary beneficiaries of Medicaid addiction treatment dollars. "In the old system, there were improvements that needed to be made, but it wasn't broken," reflects Andrea Amprey, President of Baltimore Substance Abuse Systems (BSAS). "Now we broke it and are trying to piece it back together."

DHMH is now being asked to thoroughly evaluate the addiction treatment

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provided through Medicaid and make changes to provide effective services to our vulnerable neighbors. At the July 12 meeting of the Maryland Addiction Treatment Task Force, Lieutenant Governor Townsend, in reaction to the treatment utilization numbers, called upon DHMH to convene all interested parties to determine "if the system we've developed is the best system." DHMH Deputy Secretary for Health Care Financing Deborah Chang confirmed at the July 27, 2000 meeting of the Medicaid Advisory Committee that Lieutenant Governor Townsend "specifically asked us to look at a carve-out [for addiction services]" among other options. Treatment providers following the Task Force process eagerly await an effective solution. "I'm somewhat concerned that there's still discussion about further investigating the data to show that the numbers, in fact, aren't down," says Kathleen Rebbert-Franklin, Program Manager of Sinai Hospital Addictions Recovery Program (SHARP). "It's clear that these numbers support years of anecdotal data from providers who agree with me that HealthChoice is simply not working."

Review and Recommendations:

A review of available data from the state and from HealthChoice MCOs demonstrates two deleterious effects of the inclusion of addiction treatment in a managed care system. First, managed care delivered fewer services to fewer people than had the previous fee-for-service arrangement. Secondly, important Medicaid resources have been withdrawn from the publicly-accountable treatment system, further threatening that important safety net. As long as HealthChoice continues in its present form, the various addiction treatment initiatives underway in Baltimore and throughout Maryland are working at cross purposes. On one hand, community leaders are devoting tremendous resources to improve the publicly-regulated treatment system by infusing it with new quality controls, additional staff, and more money. On the other hand, the state's HealthChoice program continues to underserve this needy population while diverting some public Medicaid dollars (which previously supported the publicly-regulated addiction treatment system) to private, uncertified providers, who may not be providing an appropriate level of care. Ultimately, attempts to strengthen the public treatment system are compromised by a program that provides fewer services and takes public money away from publicly-regulated treatment providers.

> ***"It's clear that these numbers support years of anecdotal data from providers who agree with me that HealthChoice is simply not working."***
> ***— Kathleen Rebbert-Franklin, SHARP***

After considering the data and interviewing addiction treatment providers and public officials, it is quite clear that Medicaid managed care has had a negative impact upon access to addiction treatment services for indigent Baltimoreans. This includes those who have Medicaid for an extended period, those who have Medicaid episodically, and those who may never have Medicaid and are perpetually uninsured. This phenomenon is related to the general weakening of the public addiction treatment system caused by the withdrawal of Medicaid dollars.

These findings are incontrovertible:

1. **Since the implementation of managed care, fewer Medicaid recipients are receiving addiction services.** Available data show that addiction services funded by Medicaid have decreased by at least 20% and by as much as 66% since the implementation of HealthChoice. Additionally, according to MCO data, only 1.9% of Medicaid enrollees received any type of addiction service from MCOs throughout Calendar Year 1999. Research shows that between 6.6% and 37% of these individuals need addiction treatment.

2. **Fewer Medicaid dollars are going to the publicly regulated addiction treatment system — the licensed, certified programs which are publicly accountable.** Public data now illustrate that Medicaid managed care has withdrawn crucial funds from the addiction treatment system and diverted them to non-regulated private providers. According to MCO contracting lists, reviewed for this report by ADAA and OHCQ, perhaps one third of those paid for addiction services in HealthChoice are not certified by the state as a provider of addiction services. Additionally, 28 major State-certified programs lost 54% of their Medicaid revenue between 1997 (before HealthChoice) and 1998 (the first year of managed care). This has weakened the publicly-regulated system for Medicaid beneficiaries and for the uninsured, as the budgets of the treatment programs suffer significant losses. Public grant dollars are now supplementing lost Medicaid funding, thus reducing the availability of these dollars for the uninsured.

3. **The Medicaid dollars which are being withdrawn from the public addiction treatment system have two destinations:**
   - **Non-certified treatment providers** (social workers, physicians, noncertified programs) which, though licensed by their respective disciplines, have no public accountability as addiction providers and provide no evaluative data to the State;
   - **Non-addiction treatment related expenses** such as administrative and advertising costs or shareholder dividends. For ex-

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ample, a for-profit MCO must generate revenue substantial enough to pay its operating costs and to generate profits for its shareholders. In Medicaid managed care, this profit must be made from public dollars at each stage of the process: MCOs, subcontracting Behavioral Health Organizations (BHOs), and private treatment providers.

Thus, the current Medicaid managed care system is weakening the public addiction treatment system, just as so many are attempting to strengthen it. Andrea Amprey of BSAS has observed that at the same that additional federal, state, and local dollars expanded the publicly-funded addiction treatment system in Baltimore by 2,420 slots, the loss of Medicaid funding resulted in the removal of 802 treatment slots. Although the publicly-funded treatment system had traditionally served the Medicaid population, many providers were unable to obtain Medicaid managed care contracts. Such counterproductive policies harm our efforts to improve the quality of life for all of our citizens.

A coordinated, publicly accountable addiction treatment system ensuring treatment on request is in the best interests of all Marylanders. Toward that end, we make the following two recommendations:

1. **Pursue a "carve-out" for addiction treatment.** Available data, for which Maryland has waited three years, support the anecdotal evidence that HealthChoice is not working for addiction services. This data shows that managed care has led to at least a 20% reduction (based on MCO data), and as much as a 66% reduction (based on DHMH data), in addiction services. The addiction epidemic in Baltimore City and throughout Maryland will not wait for further data analysis or incremental program reforms. Though the DHMH Substance Abuse Action Plan is a step in the right direction, the data make it abundantly clear that Marylanders with addiction are not well served by the existing program. Addiction services should be "carved out" of the HealthChoice program and administered separately by a publicly accountable treatment infrastructure. This type of arrangement has proven relatively effective for mental health services. The public mental health system increases access by serving both insured and uninsured individuals using a fee-for-service methodology. In a recent study of consumer satisfaction, 78% of respondents reported satisfaction with the "carved out" public mental health system.[3] Like the mental health carve-out, Medicaid and other public grant funding should be blended in a seamless system that is invisible to the client in need of services. Short of an overhaul of the entire Medicaid managed care system, a carve-out for addiction services is the most effective solution.

2. **Implement Immediate Self-Referral for Addiction Treatment:** While Maryland designs a new system to deliver addiction treatment, thousands of Medicaid recipients and uninsured Marylanders are going without appropriate treatment. Just as the mounting drug epidemic will not wait for additional data analysis, neither will it stand aside while policy makers design a new treatment delivery system. As an immediate short-term solution, Maryland should expand its "annual self-referral" option for an addiction assessment to permit any Medicaid recipient to seek treatment at any state-certified provider without a referral from an MCO. Such an option would restore immediate access to addiction treatment for many Medicaid enrollees. MCO representatives have indicated a willingness to implement this option. The state should immediately implement self-referral for treatment while it develops a plan to "carve-out" addiction services from the HealthChoice program.

Timely implementation of these two recommendations would meet two goals: it would ensure that Medicaid beneficiaries receive the addiction services they need, and it would guarantee that public Medicaid dollars are used to strengthen the publicly-accountable treatment system. Support of the public treatment system is particularly important as the Baltimore Health Commissioner and others involved in the Lieutenant Governor's Townsend's Drug Treatment Task Force are committed to creating a publicly-regulated system of universal access to addiction treatment. Universal access to treatment is, of course, best accomplished by ensuring universal access to comprehensive health services with a benefit package that includes addiction treatment on request. Lack of access to addiction treatment is only exacerbated by the growing number of uninsured Marylanders and Baltimoreans.[4] But at present, it is critical that thousands of Medicaid beneficiaries have access to the addiction services they require, and that Medicaid dollars are invested in a publicly-regulated, publicly-accountable treatment system. The result can only be a stronger Baltimore City and a healthier, more vibrant, Maryland.

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[3] "Report on the Maryland Public Mental Health System: Consumer Satisfaction and Outcomes", Maryland Mental Hygiene Administration, June 2000.

[4] According to the US Census Bureau, 837,000 Maryland residents, including 100,000 Baltimore residents, are uninsured by public or private sources.

Department of Health & Mental Hygiene (DHMH) Addiction Treatment Utilization Date Before and After HealthChoice

FY1996 – FY1999

Table 2.1

Medicaid Recipients Diagnosed with Addiction	
FY1996	15,782
FY1997	15,501
FY1998*	13,666
FY1999**	13,997

12% reduction after HealthChoice

*First Year of HealthChoice
**Second Year of HealthChoice

Table 2.2

Medicaid Recipients (any age) Diagnosed with Addiction Receiving "Some" Services		
FY1996	8,001 out of 15,782	51%
Fy1997	7,934 out of 15,501	51%
FY1998*	6,300 out of 13,666	46%
Fy1999**	5,949 out of 13,997	43%

*First Year of HealthChoice
**Second Year of HealthChoice

Just over half of Medicaid recipients diagnosed with addiciton received services before HealthChoice. Less than half of those diagnosed currently receive services.

Table 2.3

Average Units of Service per Person Receiving Any Treatment	
FY1996	55
FY1997	56
FY1998*	27
FY1999**	31

50% reduction after HealthChoice

*First Year of HealthChoice
**Second Year of HealthChoice

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get along in the real world, and in particular, how to get a job and how to hold it. Sister Gwynette points out that the jobs are not minimum wage jobs, but better jobs paying at about the $10.00 an hour range, (Aberration: One grad now earns $76,000 a year as a computer analyst). One year later, those who fit into the statistical majority of the class will be addiction-free, skilled in the workplace, and living stable lives in community housing. For John (just out of prison); for Tim (off the streets for the first time in years); and for Jeremy (a fourth grade drop out drifting from menial job to prison and into addiction) the routine is rigorous—seven days a week taking courses in everything from building a stable employment record, sustaining a personal support system, managing money, resolving workplace conflict. After three months the men are ready to move out of Christopher Place and into their own apartments. Of those in the February 1999 class of 32 men (classes form in February and September), after one year 100 percent are gainfully employed, as floor technicians, hospital worker, food service industries. Cost per man, from entry to graduation, is $10,000. Sister Gwenette says it is too soon to report how many hold a job for how long, but she says, "Given the work the men have to do to get to this time and place in their lives, I am optimistic." But the tie between man and Christopher Place is never perceived to be severed; the graduates must agree to live in strict observance of guidelines designed to keep them self-supporting and productive. At some point, on a case by case basis, in weeks, months, or years the interdependence is allowed to lapse.

The Abell Foundation salutes Christopher Place and Sister Gwenette for making it possible for men whose lives have been shattered to reclaim those lives, and go to become responsible and productive and achieving family men, working men. ■

Table 2.4

Total Units of Substance Abuse Services for Medicaid Recipients (FY96 – FY99)					
	FY96	FY97	FY98*	FY99**	Difference Between FY97 and FY99
Methadone (weeks)	71,044	76,055	21,939	19,579	74% Less
Counseling (visits)	81,145	82,488	34,367	33,069	50% Less
Acute (admissions)	5,714	5,590	1,694	1,775	68% Less
Total Units	157,893	164,133	67,999	54,423	66% Reduction

*First Year of HealthChoice **Second Year of HealthChoice
From: *HealthChoice Substance Abuse Analysis* DHMH; September 27, 2000