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

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Crisis of Access: How to Insure Treatment for Addiction Among Baltimore's Poor in the Age of Managed Care

After one full year of managed care, there are 29% fewer in treatment

Even though experts agree that drug addiction is the primary cause of crime in Baltimore, access to addiction treatment declined in Baltimore in 1998 as a result of a single dramatic change in the health care system: the introduction of mandatory Medicaid managed care. In July, 1997, more than 300,000 Medicaid participants in Maryland entered the brave new world of managed care. This broad structural reform was intended to reduce the costs of health services while improving the health of participants. Its administrative complications, however, had the unintended consequence of reducing the availability of addiction services for thousands of Baltimoreans at the same time Mayor Kurt Schmoke is trying to provide treatment on demand.

Managed care advocates contend that it reduces costs and improves health by decreasing the use of acute care services, and by coordinating preventive, primary, and specialty care. The extent to which these goals are being met by the Medicaid managed care program in Maryland for patients in need of addiction treatment is in serious dispute.

Data provided by the Maryland Department of Health and Mental Hygiene in November, 1998 for this report, show that Baltimore City addiction treatment providers served 29% fewer Medicaid beneficiaries when comparing Fiscal year 1997 (i.e. the year prior to implementation of the Medicaid waiver) to Fiscal Year 1998. If this decline in the availability of addiction services is accurate, it poses a danger to the quality of life for all Baltimoreans.

A 1993 report by the Abell Foundation "Baltimore's Drug Problem: It's Costing Too Much Not to Spend More On It," documented Baltimore's substance abuse epidemic and recommended thorough evaluation of the existing drug treatment system so resources could be redirected to the most promising and cost-effective programs. Any evaluation and recommendations must now consider the impact of managed care. Dissatisfaction among some health care and addiction treatment providers is so high that in September, 1998, a little more than one year after the advent of Medicaid managed care, the Maryland Medicaid Advisory Committee recommended that addiction services be provided separately from other Medicaid services.

Recent evidence suggests that Medicaid managed care appears to have significantly decreased the availability of addiction treatment for the tens of thousands of Baltimoreans who are un-

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ABELL SALUTES THE COLLEGE BOUND FOUNDATION: For Leading Students Into College Who Weren't Headed There

Since 1988, 50 percent more students in Baltimore City high schools are taking the SAT tests and twice the number of students are sending in applications to college. The pivotal year was 1988, the year CollegeBound was established.

CollegeBound came into being as a result of a survey conducted by the Greater Baltimore Committee. The survey was designed to determine what issues the Baltimore leadership thought important leading up to Year 2000, and the results revealed a consensus. It was that young people applying for jobs had insufficient education to qualify for them. Not nearly enough had a college education.

"This was a defining moment for the Greater Baltimore Committee," Joyce Kroeller, executive director, says. "The committee was linking

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insured (it is estimated that approximately 60% of those in need of addiction treatment in the city have no health insurance). This *Abell Report* examines the substance abuse treatment component of Maryland's Medicaid managed care system in theory and practice. The report is designed to inform the existing debate about how best to meet the addiction treatment needs in our community. The report offers eight recommendations for improvement, ranging from managed care reforms through harm reduction initiatives to universal, comprehensive health insurance for all Marylanders. Implementing these recommendations could improve access to addiction treatment and strengthen the existing network of treatment providers.

Baltimore City is just one site in the nationwide managed care revolution. Managed care is a method of health care delivery and financing designed to reduce costs and provide coordinated care, fundamentally by means of monthly payments to an agent who is responsible for the care of the patient.

Maryland adopted a managed care program for Medicaid recipients in 1997

Although the practice of managed care is more than fifty years old, it is only during the past five years that it has been applied to poor and vulnerable populations, especially Medicaid beneficiaries. Title XIX of the Social Security Act, the law that created Medicaid, guarantees participants their choice of health care providers—a notion antithetical to managed care. States can apply for a waiver of the patient-choice requirement through Sections 1115 and 1915(b) of the Act. Maryland adopted a managed care program for Medicaid recipients in July 1997, after receiving a section 1115 waiver from the federal Health Care Financing Administration. A fundamental feature of the state's new program, ironically named "HealthChoice" by public officials, is the privatization of most aspects of Medicaid. The financial risk of Medicaid participants' care has been transferred from the public sector to private insurance companies called managed care organizations (MCOs). MCOs receive a payment at the beginning of each month for each person enrolled with them, from which they must meet all health-related needs of the member spelled out in the benefits package. If the medical costs exceed the monthly payment, the MCO loses money; if the monthly payment exceeds the medical costs, the MCO makes money. Thus MCOs have an incentive to hold down health costs.

Easily accessed and relatively inexpensive preventive and primary care can reduce the use of expensive specialty and acute care services; this is one way MCOs hold down the costs of care. Alternatively, difficulty in accessing services can discourage patients from seeking care. Especially among vulnerable populations, discouraging access to care can be an effective way for MCOs to reduce demand.

The health care providers who have traditionally served the Medicaid population, called "historic providers," generally did not have the financial prerequisites (e.g., $1 million in an escrow account) to establish MCOs, though they had expertise and experience in treating Medicaid patients. When it became apparent that few, if any, of these historic providers could qualify as MCOs, a debate ensued over how to include them in Medicaid's managed care regime. The providers argued for requiring MCOs to contract with traditional providers who meet threshold eligibility requirements. Insurance companies opposed this provision, desiring maximum flexibility in choosing their provider partners.

In its final form, the Medicaid managed care law merely assures historic providers of a single MCO contract and does not specify the level of payments. But because HealthChoice regulations are vague about when and how specific substance abuse services must be provided, addiction treatment providers were particularly vulnerable to losing patients under managed care. In the short term, MCOs would be rewarded financially by not paying for addiction treatment.

Addiction Treatment and Managed Care

Although managed care itself has been much analyzed, little has been written about its effect on substance abuse treatment for the indigent. Across the country, 48% of Medicaid participants are in managed care. Because historic providers of substance abuse treatment also serve patients with no insurance, changes in the financing and delivery of addiction treatment under Medicaid can affect all low-income people seeking such treatment.

Managed care was developed in the private sector for people who were employed, and therefore basically healthy. A money-saving strategy of managed care has been to reduce or deny access to services, termed "demand management." Co-pays for of-

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fice visits, long waits for appointments, and pre-authorization for specialists are examples of strategies that may be cost-effective when applied to basically healthy workers with brief episodic illnesses to discourage overuse of specialists and other expensive services. But substance abuse treatment is underused, so the managed care paradigm is a poor fit to the health needs of people with addiction treatment. To save money on their care, a health plan must make treatment more accessible because it leads to fewer and briefer hospital stays in the long run.

The National Institute on Drug Addiction recently reported that substance abuse cost more than $246 billion in 1992. That year, 132,000 people died prematurely from drug and alcohol abuse, and medical costs exceeded $28 billion (Sixty percent of these costs are attributed to alcohol abuse). By contrast, all Medicaid expenditures for its 36 million participants was less than $200 billion in 1998. Given the magnitude of the cost, reducing the costs of substance abuse is an important public policy goal, but current strategies have had limited success and new, effective public policy initiatives are eagerly sought.

Managed care has been one cost-containment response. Of the 48 states that have implemented managed care programs for their Medicaid beneficiaries, 47 incorporate some aspect of mental health and addiction services into a managed care system. Ten states use managed care arrangements exclusively for substance abuse and mental health services. Two states, Iowa and Minnesota, have managed care programs solely for substance abuse services, and Missouri has a fee-for-service substance abuse program "carved out" from its managed care program for physical health.

The 97 managed care programs operating in these 47 states have nearly every conceivable permutation and combination of financing and service delivery. Some states combine Medicaid dollars with other public funds. A number of states contract with private organizations to administer their programs; others use public agencies or public/private partnerships. In some states, managed care entities bear the full financial risk of their members' care; in others, prepaid health plans are responsible for only a limited set of services. Because of their differences, it is difficult to compare the efficacy of these arrangements.

Maryland's Medicaid managed care as originally drafted would have extended services to uninsured poor patients

Reducing Medicaid costs through mandatory managed care was originally intended to underwrite expansion of services to people who went uninsured under previous systems. At least 10 states (Connecticut, Hawaii, Illinois, Minnesota, Montana, New York, Oregon, Pennsylvania, Tennessee, and West Virginia) have implemented Medicaid managed care programs that include single, uninsured adults, who are not usually covered by Medicaid. Maryland's Medicaid managed care program as originally drafted would have extended services to uninsured poor patients, but the law in its final version designated the cost savings merely to tame medical inflation, not to expand access to care. A portion of the single, uninsured adult population in Maryland is now covered by a separately funded and administered program called Maryland Primary Care that offers very limited benefits and requires its own bureaucracy.

Substance Abuse Treatment for Medicaid Participants

The transition to managed care is creating enormous change in the substance abuse treatment system. Small community-based organizations must now develop relationships with large, sophisticated MCOs and with a new set of primary care providers. Complicated authorization, utilization, and billing procedures, "behavioral health" subcontracting agencies, and clashing perspectives on the etiology and treatment of addictions present challenges to participation in Medicaid managed care by these traditional care providers. Inadequate funding for uninsured clients and the vagaries of Medicaid regulations, which cause many individuals to lose eligibility while they need to continue in treatment, further burden these smaller providers.

At the September 24, 1998 meeting of the Maryland Medicaid Advisory Committee, three of the eleven issues on the agenda concerned addiction treatment. After months of increasing dissatisfaction with the new system, the committee unanimously recommended that substance abuse services be handled outside Medicaid's managed care program, or "carved out, in order that recipients have direct access to these services."

Before HealthChoice, Medicaid participants secured addiction treatment either with a referral from a social services or health care provider or by directly contacting treatment providers. Treatment providers could bill the Medicaid program for all eligible services given to Medicaid beneficiaries. No specific requirements linked addiction providers with primary health care providers.

As a "member" of an MCO, a Med-

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icaid participant must now get a referral from a primary care provider before seeking addiction treatment. Before any services are offered, the treatment program must get authorization from the appropriate agent of the MCO. Generally, these steps are preceded by a contract between the MCO and the treatment provider specifying when and how services will be authorized, delivered, and reimbursed, and a payment schedule for each service provided by the treatment program.

In theory, these requirements (some enshrined in law and regulation, others simply required by an MCO) should produce more effective services and more efficient use of resources. Addiction treatment ought to be coordinated with primary care, because addiction has important physical consequences. HealthChoice requires health screenings to uncover substance abuse issues. These measures could assure that substance abuse is more readily identified, more appropriately treated, and more holistically managed.

(Adults receiving welfare payments for families with children in Maryland must also be screened for substance abuse by the local Department of Social Services and referred to their MCO for treatment when indicated. Reports from the Maryland Medicaid Advisory Committee indicate that this screening occurs irregularly, appropriate treatment is provided infrequently, and treatment providers have not requested payment for serving this population. Problems with this program are beyond the scope of this report.)

Addiction Treatment for Uninsured Marylanders

Mandatory Medicaid managed care has also had significant implications for uninsured Marylanders. Between 1994 and 1996, 13.1% of Maryland's population (650,000 people) went without health insurance. Comparable Baltimore City figures are unavailable, but it is likely that the percentage of city residents without health insurance is even higher. Baltimore's Health Care for the Homeless reports that 60% of the more than 5,000 persons it served in 1997 had no health insurance and another 30% had only primary care or prescription coverage.

Historically, a combination of public health clinics, community health centers, hospital outpatient clinics, and private providers offering pro bono services has met the primary care needs of poor patients. In the addiction treatment field, services to the uninsured are financed primarily by public funds supplemented by a small amount of private dollars. Foundations such as the Open Society Institute and The Abell Foundation are currently providing funds to support addiction treatment for Baltimore's uninsured.

The advent of Medicaid mandatory managed care changed (the) mixture...

Neither the general indigent care infrastructure nor services for persons with addictions has fared well of late. Public health clinics, which once were core service providers to the uninsured, have closed as the public sector has downsized. Hospital outpatient clinics are increasingly threatened with the loss of federal funds that compensate them for treating the uninsured. Community health centers, federally supported clinics which must treat low-income individuals without regard for ability to pay, are threatened with extinction. Community-based addiction treatment programs are losing significant revenues because of Medicaid managed care.

Community health centers are clinics located in impoverished communities that receive federal funds to serve people without insurance. Medicaid reimbursed these centers for their actual cost of serving patients until 1997, when the Balanced Budget Act repealed that requirement. The federal Bureau of Primary Health Care recently observed that 5% of community health centers will close their doors in the next two years because of inadequate Medicaid payments. A 1997 survey of Health Care for the Homeless projects nationwide revealed that 30% had lost Medicaid revenues and staff since 1996, while the number of uninsured clients rose.

Before HealthChoice, these community-based providers could count on a mix of grants and fee-for-service payments from Medicaid to finance their operations. The advent of Medicaid mandatory managed care changed this mixture. Now, without guarantees of adequate payments from MCOs, these agencies cannot predict their Medicaid revenues. Many of them have adopted annual budgets that assume no Medicaid dollars, causing a revenue gap that has resulted in staff reductions and a decline in access for uninsured individuals.

Is Managed Care Working for People Who Need Addiction Treatment?

"With respect to access to treatment, they have taken a system that works and broken it."

Andrea Evans, Baltimore Substance Abuse Systems

"Managed care means that people receiving addiction services will finally get the medical care they need."

Barbara Shipnuck, Maryland DHMH

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Medicaid managed care has lessened the availability of treatment, both for people enrolled in managed care and people with no health insurance at all. How has HealthChoice affected access to substance abuse treatment for people enrolled in Medicaid? This question can be broken down into four others:

1. Can treatment providers obtain contracts with MCOs in order to serve Medicaid participants? Substance abuse treatment providers must have contracts with MCOs in order to participate fully in HealthChoice. These contracts spell out the mechanics of referral, the scope of treatment services, reimbursement rates, and billing procedures. Some treatment providers do not have contracts with managed care organizations, some do, and some are still in negotiation 18 months after the waiver started. These contracts typically take months to negotiate; once in place, they do not guarantee referrals. The treatment centers that quickly obtained contracts with MCOs tended to be those with large institutional ties (i.e., hospital affiliations) whose contracts could be negotiated by senior hospital staff. Despite the waiver's provision for recognition of "historic providers," not one addiction treatment provider has obtained a contract through this feature.

2. Once the historic providers of substance abuse treatment have contracts, are Medicaid clients being referred to them by MCOs?

To evaluate whether patients in need of substance abuse treatment are getting it under the new Medicaid system, Maryland's Department of Health and Mental Hygiene (DHMH) reviewed the records of 84 enrollees who were receiving methadone before July 1, 1997, the date on which Medicaid managed care began. (Methadone maintenance therapy is the most stable form of addiction treatment; see page 10.) For more than half the sample cases (53%), there was no record of continued treatment. Another 23% showed continued treatment, but after a gap of more than 14 days. Only 24% of the cases had evidence of appropriate continuity of care.

Findings were even less favorable for Medicaid participants who did not choose their own MCO. These are participants who did not select an MCO within 21 days after their selection packet had been mailed from DHMH and were "auto-assigned" to an MCO that accepts Medicaid. This "auto-assigned" population may be the most vulnerable Medicaid patients: they tend to be homeless, mentally ill, developmentally disabled, or have unstable addresses. They are less likely to advocate effectively for themselves, and thus may not receive services that MCOs view as unnecessarily expensive.

A Word About the Center for Addiction and Pregnancy (CAP)

The Center for Addiction and Pregnancy (CAP) was established at the Johns Hopkins Bayview campus in 1991 to provide specialized substance abuse treatment services to pregnant drug-dependent women. CAP offers on-site obstetrical, pediatric, and medical care for these women and their children, and has been found to be cost-effective. The intensity of its services saves almost $5,000 per case, predominantly in neonatal intensive care costs. A CAP spokeswoman said the Medicaid waiver has resulted in less frequent and shorter treatment services currently offered to pregnant drug-dependent women by MCOs, "significantly less than what constituted standard care back in 1990." CAP received dramatically fewer referrals since the Medicaid waiver started. As of April 1998, the CAP in Prince George's County (which is modeled after the one in Baltimore but provides only outpatient services) has not had a single referral from an MCO since the Medicaid waiver started. Before HealthChoice, the Prince George's CAP had a census that averaged 62 patients a month, of whom 40% (about 25) were pregnant and the rest postpartum. Since the waiver, the program has served only four or five pregnant women per month.

CAP has been found to be cost-effective

The methadone treatment survey was the second attempt by DHMH to verify substance abuse treatment offered through Medicaid-paid MCOs. In February 1998, seven months after the waiver was implemented, DHMH asked each MCO for a list of all patients who had been diagnosed with an alcohol disorder and the programs to which they had been referred for treatment. The MCOs missed their deadline twice, then advised DHMH that they could not provide the requested information. Rather than pursue this request any further, DHMH asked for the methadone patients' information instead.

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3. If treatment providers have clients, do the MCOs authorize appropriate treatment? The Alcohol and Drug Abuse Administration (ADAA) of DHMH licenses, monitors, and funds substance abuse programs in Baltimore City and throughout Maryland. ADAA has released information showing the extent of the system's shrinkage from FY97 to FY98, pre-waiver to post-waiver. In FY97, certified substance abuse programs in Baltimore City funded by ADAA served 3,488 people with Medicaid. In FY98, the same programs served only 2,482 people on Medicaid, a 29% drop in utilization that cannot be explained by a decline in need for treatment.

Many providers complain that MCO staff authorizing or denying treatment have little basic education on the nature of addictions and are ill-prepared to make decisions about proper treatment. For example, MCO utilization review staff have asked methadone treatment program staff to justify additional days of therapy and have denied authorization after a patient has tested positive for drugs. As the Baltimore CAP program reports, "[b]ased on CAP records review, factors that determine if a given patient will be allowed [by the MCO] to continue in CAP treatment are often clinically contraindicated and deny services to the very patients who need them most. Specifically, over the last few weeks, several women have been denied CAP treatment because they relapsed to drug use." As the author notes, it is at the moment of relapse that the patient needs more intensive treatment, not denial of service. Other methadone providers also report authorization denied by MCOs when a patient has tested positive, being asked by MCOs, "When will this treatment be over?" and being compelled to bill daily for methadone maintenance, a treatment that frequently continues for years.

Baltimore HealthCare Access, a quasi-public agency affiliated with the Baltimore City Health Department, has collected data consistent with the above accounts. Baltimore HealthCare Access, under contract with DHMH to be the ombudsman and outreach agency for Baltimore City, surveyed five methadone programs and four outpatient "drug-free" addiction treatment programs. At one program, 40% of the patients lost eligibility for treatment after enrolling in the new system. Some patients reportedly dropped their Medicaid so they could stay with their methadone provider. In three cases, patients allegedly gave up custody of their children to a relative so that their children could be insured while the parent qualified for a non-Medicaid slot funded by public block grant dollars, the traditional source of funding from the state ADAA intended for the uninsured. At one site, the number of Medicaid clients dropped 92%, from an average of 30 per day to an average of 2.5. These survey results are consistent with the decline in program utilization reported by the ADAA and demonstrate that Medicaid patients are not being shifted to new care providers associated with MCOs who did not serve Medicaid beneficiaries before the advent of managed care.

There was unanimous agreement that choices of substance abuse treatment facilities and modalities are more limited now.

Every program surveyed by Baltimore HealthCare Access reported more difficulty getting patients into treatment now than before the waiver, due to the inability to get pre-authorization and accept referrals by telephone. Providers report that authorization for one client can take hours. According to Frank Satterfield of the Glenwood Life Center addiction treatment center program, "Counselors dread taking Medicaid clients because the administrative requirements take them away from counseling time." This has had special impact on smaller programs that do not employ administrative staff. Providers also complained of having to repeat the referral and authorization process every 2 to 6 weeks, although treatment can last 6 months to a year. There was unanimous agreement that choices of substance abuse treatment facilities and modalities are more limited now. Treatment providers reported that the primary care providers now responsible for referring patients to treatment lack an understanding of the need for treatment.

4. Are the MCOs paying substance abuse treatment providers for services which they have authorized? The problems with payments from MCOs are well documented and affect all providers, from hospitals and community health centers to substance abuse treatment providers. In the first year of the Medicaid waiver, some treatment programs were never paid. Others required state government intercession to secure payments. Still others stopped billing MCOs. Frank Satterfield of Glenwood Life commented, "If you have to spend $50 of staff time to receive your $60, it doesn't seem worth it." A survey of 33 Baltimore City treatment agencies showed that payments are delayed by several months in most cases, even though DHMH requires MCOs to pay an undisputed bill within 30 days or pay interest. (The definition of "undisputed bill" becomes infinitely flexible when the party seek-

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ing to delay payment can dispute anything.) The Baltimore HealthCare Access survey corroborates the prevalence of payment problems: 18 months into the managed care era, "7 of the 9 programs have not been paid for the Medicaid patients or have just begun to receive partial payment in the spring of 1998. One program billing specialist says that the program is now owed $135,000 and that she has not experienced this before in her 20-plus-year career in the field."

Decreased Treatment Capacity

Unfortunately, treatment capacity has decreased for those who do not have Medicaid, as well as for those who do. ADAA data for Baltimore City show that in FY97 (before the waiver), 9,823 people without health insurance got substance abuse treatment, but the next year there were only 7,477 uninsured users of substance abuse treatment, a 24% decline.

Public grant dollars are increasingly targeted to individuals with the most compelling needs or special circumstances. One provider commented that unless a prospective client has AIDS, is pregnant, or has just been released from the criminal justice system, he or she cannot get into treatment. "We don't want to tell them to go out and do any of those," said Michael Bradley of Metworks, Inc., said in an October 1998 interview conducted for this report, "but that seems to be the message we are sending."

Andrea Evans, director of the Baltimore Substance Abuse Systems, which administers public addiction money in Baltimore, estimates that the Medicaid waiver has cost Baltimore City 1,000 treatment slots. (Fortunately, in Baltimore City the switch of Medicaid patients to managed care coincided with an influx of private and public dollars, the Mayor's Substance Abuse Initiative, that created 3,100 additional slots for drug treatment. This has lessened the impact of the decrease associated with Medicaid managed care. Nonetheless, the estimated 60,000 Baltimoreans who need treatment must compete for 6,865 treatment slots.)

Higher Administrative Costs for Providers

Although historic providers are serving fewer clients, they report greater administrative pressures that divert staff time from patient care. Frank Satterfield reports that Glenwood Life Center has hired a full-time employee to do billing, authorization, and other required paperwork for MCOs, yet his program cares for only 68 Medicaid clients. Before managed care, Glenwood submitted its bills electronically, a task that took 30 minutes each Friday. Now all billing is done on paper, and each MCO has its own billing form. Although MCOs market themselves as having sophisticated data management services, in most cases the Medicaid waiver has meant an enormous leap backward with respect to administrative systems and costs, particularly for community-based providers too small to achieve the economies of scale associated with sophisticated data management systems. Their lack of infrastructure hurts their ability to recover costs from MCOs, threatening their survival, although these are often the programs best suited to serve the most marginalized clients.

Serving Medicaid Clients with Grant Dollars

Most providers who treat low-income patients have traditionally treated both the uninsured and Medicaid beneficiaries. Before Medicaid managed care, Medicaid dollars were a reliable source of income. The shift to managed care has altered this equation, and providers must supplement inadequate and uncertain Medicaid payments with other inadequate and uncertain funds, often from grants that may not be renewable. The number of Medicaid participants whose treatment is being supported by grant dollars intended for the uninsured is not known, but providers agree that this is happening. At the very least, grant dollars are "floating" the clinics as they wait months for payment from MCOs. In the worst case, providers may turn a blind eye to a patient's insurance status in order to avoid billing an MCO. In the long term this trend will reduce access to treatment for the most vulnerable clients, those unable to secure insurance.

Pros and Cons of "Carved-Out" and "Carved-In" Treatment Services

A study conducted on behalf of the Kaiser Permanente health system compared use of medical services by patients during the six-month periods before and after their treatment for addiction. It found a striking 50% reduction in hospital days utilized, from 117 days during the six months before treatment to 58 days during the post-treatment period.

Providing addiction treatment under the Medicaid managed care waiver in Maryland is the responsibility of the MCOs; in the language of the bureaucracy, these services are "carved in" to the broader health insurance system. But many states have "carved out" substance abuse treatment so that it is paid for and accessed separately from other aspects of medical care, and MCOs responsible for medical care are not necessarily responsible for addiction treatment. In most of these states, addiction services have been combined with mental health services; because so many people with mental illnesses have the co-occurring disorder of an addiction, this makes some sense.

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Maryland has already “carved out” mental health services. A new public mental health system was created to

Medicare dollars traditionally spent for mental health services were combined with federal mental health block grants to support the new system.

finance and deliver these services, and Medicaid dollars traditionally spent for mental health services were combined with federal mental health block grant dollars to support the new system. A private agency, Maryland Health Partners, was created to administer it.

DHMH, which is responsible for Medicaid managed care in Maryland, is required to convene a Medicaid Advisory Committee of health care providers, legislators, and consumers. In November this committee voted to “carve out” addiction services from Maryland’s Medicaid managed care program, in response to the access and payment problems experienced by patients and treatment providers. The Advisory Committee has the legal authority only to make recommendations; as of this writing, the impact of its recommendation is not known.

Would patients seeking substance abuse treatment be better served if the administration of those benefits were not part of the existing medical care system? There is unquestionably an advantage to addressing patients’ needs in a holistic fashion. The primary care provider should be able to refer the addicted patient to care, and the administrator should have a financial interest in the patient’s receiving adequate substance abuse treatment. Indeed, Kaiser of northern California pays for its Medicaid enrollees’ substance abuse treatment even though the “carve-out” of substance abuse treatment services in its area means that it doesn’t have to. In other words, Kaiser has such good evidence of the medical cost savings of adequate substance abuse treatment that paying for it is a good investment.

Barbara Shipnuck, the former Deputy Secretary of DHMH responsible for the design and implementation of HealthChoice, expressed support for the coordination of primary medical services and addiction treatment. From her perspective, managed care provides incentives for all patients to receive addiction screening, and for addiction patients to receive comprehensive health care services. “Before HealthChoice, there was no evidence that people receiving addiction treatment ever saw a doctor or nurse. Requiring referrals from primary care providers to addiction treatment, and requiring addiction providers to receive authorization before offering services, assures that this important coordination will occur,” she contended.

A drug or alcoholic-addicted person is easily discouraged from utilizing treatment.

The disadvantage of requiring referrals from primary care providers before addiction treatment can begin, instead of permitting clients to refer themselves to treatment, is that it adds another step—and potentially another barrier—to access. A drug- or alcohol-addicted person is easily discouraged from utilizing treatment. Ideally, treatment ought to be provided whenever it is requested. The “carved-in” system requires an individual seeking treatment to obtain documentation from another entity (usually the primary care provider) before visiting the treatment provider. This poses two problems. First, individuals who are addicted to drugs or alcohol may be unable to negotiate this additional step. People who have not selected their own MCO or primary care provider, but who have been assigned one by the state, may not even know whom to ask for a referral. Second, not enough primary care providers are trained to diagnose addictions accurately. DHMH and the Medical and Chirurgical Faculty of Maryland have been attempting to rectify this latter problem, but much remains to be accomplished.

The second disadvantage is subtler. Many MCOs have contracted with “behavioral health” organizations to administer the addiction treatment component of their services. Behavioral health organizations are entities that administer managed care contracts for addiction and/or mental health services on behalf of HMOs and MCOs. These organizations generally contract with large treatment providers, many of which have never served indigent patient populations. Community-based organizations may not be granted contracts by the behavioral health organizations and thus receive fewer contract dollars, despite being closer to the ground and often specializing in services for marginalized populations, such as people experiencing homelessness. As these small providers are weakened by the shift to larger organizations, the system as a whole becomes less nimble and less able to respond to all types of clients.

Other Models

“Managed care promises many positive benefits…[b]ut the change to managed care also carries very significant risks for our clients in the publicly funded system–people who are often

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poor, have little political clout, and have serious needs and problems not typically covered in private managed care plans."

Center for Substance Abuse Treatment, "Purchasing Managed Care Services for Alcohol and Drug Treatment," 1995

Medicaid addiction treatment models from other states are described here, with a focus on features which could be incorporated to improve Maryland's treatment system.

Treatment on Demand: San Francisco is in the middle of a five-year planning process to provide "treatment on demand" with the ability to match individuals and their families with the interventions they deem most appropriate and the elimination of insurance status as a prerequisite to treatment. This model recognizes the importance of offering treatment as soon as the substance abuser decides he or she is ready for it. Planning is especially focused on assuring appropriate care for often-neglected segments of the addicted population, such as victims of domestic violence and people experiencing homelessness.

San Francisco's health department is leading a citywide evaluation of existing services to identify treatment gaps and access barriers. Providers and advocacy groups, including the San Francisco Coalition for the Homeless and currently addicted individuals, are participating. Federal money is supporting the planning process. A "harm reduction" paradigm (discussed below) has been adopted. Treatment-on-demand planning is being coordinated with another city initiative to create a universal health insurance system for all San Franciscans.

A Substance Abuse Treatment Authority: A second model is now being devised for New York City, where treatment advocates are designing a separately administered substance abuse program which would be neither fee-for-service nor "capitated" (flat rate reimbursement per enrollee). New York's plan would combine all the funding streams for substance abuse, including those for uninsured people, and create a single financing system under the aegis of a nonprofit Coordinated Addiction Service Plan (CASP). CASP would contract with providers, assess the acuteness of patient needs, place patients in treatment, and pay for the treatment. The model would save money by averting the inefficiencies and cost-shifting inherent in multiple systems of care. CASP would also save money by using by a "case payment" system combining fee-for-service's incentive to treat patients and capitation's incentive for efficiency. After assessing a patient's medical needs, CASP would assign a payment rate for that patient. A provider accepting the patient would agree to provide all appropriate addiction services in exchange for that payment. Monitoring by patient advocates would ensure that appropriate treatment is provided.

Early 1999 has witnessed a resurgence of the movement to create a program of universal health coverage for Marylanders.

Provider-Based Managed Care Network: Arizona has had a managed care waiver for Medicaid since 1982. For addiction and mental health services the state is divided into five regions, each of which has a regional behavioral health authority. These authorities bear the full risk of patient costs and are responsible for planning, funding, and monitoring addiction and mental health services. Authorities contract with providers on either a capitated or fee-for-service basis. The amount of Medicaid dollars controlled by these authorities is determined by a formula that includes risk adjustments for the population in each region. The authorities also control block grant funds and legislatively appropriated dollars.

In the Tucson region, addiction treatment providers were concerned that the competition associated with this structure might not serve them and their clients well. They organized themselves into a full-service network called CODAC and contracted with their regional authority to serve its Medicaid clients. CODAC has full risk for all Medicaid participants in the Tucson region, including the cost of hospitalization, and also provides addiction services to uninsured residents. The regional authority pays CODAC a case rate for each person it serves. A recent evaluation by an outside group indicated the network is doing an excellent job of managing patient care and costs.

Universal Health Insurance: In 1993 the state of Washington passed a law guaranteeing health insurance to all residents. The agency charged with developing a health benefits plan that includes "chemical dependency" services has recommended that outpatient treatment and up to one year of residential services be available for treatment of addictions. Case management, rather than time limits on treatment, was recommended to control costs. All providers who could meet certification standards would be eligible for reimbursement.

Washington state has mandated since 1974 that health insurers include a comprehensive continuum of substance abuse services in all policies sold in that state. Typical benefits in-

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clude 40 days of residential treatment and individual and group therapy. It is not surprising, then, that comprehensive addiction services were included when health insurance was extended to all Washingtonians. Proponents of this inclusive approach argued that treating people with addictions reduces future health care costs, especially by reducing hospitalizations; that addiction treatment is relatively inexpensive (approximately 2% of the total cost of all covered services); and that encouraging treatment can prevent joblessness and the use of public benefits. These arguments carried the day. The comprehensive addiction treatment benefits mandated in Washington state are a model for other universal coverage schemes.

Early 1999 has witnessed a resurgence of the movement to create a program of universal health coverage for Marylanders. With the leadership of the Health Commissioner of Baltimore City and the participation of dozens of organizations and individuals, chances of its success have greatly improved. Any plans for universal coverage should include a comprehensive continuum of substance abuse services.

A Note on Methadone Maintenance

For more than 100 years, health care practitioners have tried medicinal substitutes to treat opiate dependence. Not until the early 1960s did the work of Drs. Marie Nyswander and Vincent Dole provide definitive evidence that substitution with methadone is an effective drug treatment.

Methadone has the pharmacological effects of other opioids, but it is easily absorbed orally and it suppresses withdrawal symptoms for 24 to 36 hours. These two properties offer respite from two of the greatest dangers of heroin: the multiple health problems, like HIV and abscesses, caused by self-injection; and the addict's need for many doses of heroin throughout the day to stave off the flu-like symptoms of withdrawal. In contrast, with daily oral methadone dosing, a person in methadone treatment can work and parent effectively. People often stay in methadone treatment for years while functioning successfully at home and work. Since 1994, another substitute called LAAM has been approved. It lasts in the body for 48 to 72 hours, eliminating the need for daily clinic visits.

Recommendations

Access to addiction treatment for the tens of thousands of Baltimoreans in need can be improved. Any of the following recommendations would enhance access to these services while strengthening the existing network of community-based treatment providers.

Eliminate the requirement that Medicaid participants receive authorization from their MCO before seeking addiction treatment. Managed care systems use pre-authorization requirements as a mechanism to restrict access to, and thus utilization of, services. This may make sense for health services that are overused, but is merely a barrier to care for underutilized services such as addiction treatment. This problem was recognized during the design of HealthChoice, and services such as mental health care, school health clinics, and family planning were exempted from the requirement for pre-authorization. DHMH now proposes to permit HealthChoice participants to receive an initial assessment at an addiction treatment agency without prior approval. This policy could be expanded to eliminate authorization for any addiction treatment services, following the model of mental health and family planning services.

Strengthen community-based organizations by guaranteeing managed care contracts with adequate reimbursement rates to those which meet threshold requirements. During the development of HealthChoice, the viability of traditional Medicaid providers was a matter of great concern. An attempt to require MCOs to contract with all legitimate providers was defeated. A provision of the law is intended to assure "historic providers" one MCO contract, but most of Baltimore's addiction treatment providers have no contracts. Amending HealthChoice regulations to require MCOs to sign a standard contract with any certified addiction treatment provider would strengthen the existing network of community-based agencies.

"Carve out" addiction treatment from the Medicaid managed care program as recommended by the Maryland Medicaid Advisory Committee. HealthChoice enabling legislation created a statewide body, the Medicaid Advisory Committee, to provide oversight to the new managed care system Recently this body recommended that addictions services be removed from the purview of MCOs, although an alternative plan was not specified. The public mental health system, which combines Medicaid and grant dollars

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under a new administrative services organization), could be a model, or a return to a fee-for-service system administered by DHMH and a grant system for the uninsured might be implemented. Dennis McCarty of Brandeis University and Richard Frank of Harvard University have been commissioned by the federal Health Care Financing Administration to examine the substance abuse treatment programs in five jurisdictions that operate under Medicaid waivers: the Tucson area and the states of Rhode Island, Maryland, Nebraska, and Iowa. Comparative data and exemplary practices gleaned from such studies could be useful in improving access in Baltimore.

Implement the accountability provisions of the Medicaid managed care legislation and regulations. HealthChoice regulations have extensive requirements for service provision and data reporting, yet the performance of MCOs has been little scrutinized at this point. For example, when DHMH asked MCOs for data about their patients in alcohol abuse treatment, the information was never produced, but DHMH did not require that any steps be taken to correct or penalize this failure. Enforcing accountability regulations and imposing penalties on noncomplying MCOs could enhance services for people with addictions.

Require additional accountability from treatment providers while providing additional technical and financial assistance to enhance their information systems. Community-based treatment providers have functioned in a relatively resource-poor environment for many years. Generally, they have not developed a management information infrastructure commensurate with the demands of managed care.

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A Note on the Efficacy of Addiction Treatment

"Most Americans regard drug treatment as physicists do cold fusion—a wonderful idea, if only it worked. Even many liberals, while supporting more money for treatment, have serious doubts about its effectiveness."

— Michael Massing, *The Fix* (1998)

During discussions about which benefits to include in Medicaid managed care, the efficacy of addiction services was much debated. Rigorous research is now available demonstrating that substance abuse treatment does work. A multi-year, multi-site study by the University of Chicago and Lewin-VHI showed that every $1 spent on addiction treatment saves $7 in public funds, predominantly in criminal justice and health care costs.

In 1994, RAND Corporation researchers Peter Rydell and Susan Cunningham published astonishing results about the cost-effectiveness of treatment. Rydell and Cunningham compared the effectiveness of treatment with three other approaches: attempting to decrease drug crop production in other countries, blocking drugs from coming across the U.S. border, and enforcing U.S. drug laws. They found that treatment was seven times more cost-effective than domestic law enforcement, ten times more effective than interdiction, and twenty-three times more effective than attacking drugs at their source.

Substance abuse is a disease with a biochemical basis. It is often chronic and sufferers have the potential for relapse. This is true across all segments of the population. Substance abuse treatment does not always succeed on the first attempt, just as smokers usually do not quit tobacco permanently on their first attempt. We don't measure the outcome of treatment for a diabetic by whether the disease vanished; the outcomes used to measure treatment efficacy must include more than only the complete cessation of substance use. Some of the following indices could be used: reduction in symptoms, improved functioning, return to work, decreased absenteeism, abstinence validated by urine and breath testing, decrease in criminal activity, and decline in overall need for health care services.

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These providers could benefit from technical and financial assistance to develop such systems; they could then be held to more rigorous standards for financing and delivering care. Measurements of the quality of care provided and monitoring of outcomes would enhance political and financial support for treatment. In addition, the documentation of successful treatment methods would permit the targeting of resources to effective programs.

Increase the capacity of the addiction treatment system with additional private and public dollars. At least 60,000 Baltimoreans need addiction treatment services, yet fewer than 7,000 treatment slots are available. The Mayor's Substance Abuse Initiative has increased the availability of treatment, but need still far outstrips supply. The components of long-term solutions, including affordable housing, jobs that pay a living wage, and support services, are quite inadequate. Increasing the capacity of the addiction treatment system and developing resources to meet long term needs are both critical.

Develop a harm reduction approach to addiction treatment which includes a continuum of services and the recognition of positive outcomes short of abstinence. The "harm reduction" model focuses on the harm to the individual and to the community caused by the abuse of drugs and alcohol, while recognizing the chronic nature of these problems. Committing all treatment resources to achieving drug abstinence means condemning 60% of the people with addictions to lives that are poor, nasty, brutish, and short, and condemning our communities to the maximum damage that addictions inflict.

The harm reduction approach recognizes that curbing negative behaviors associated with the abuse of drugs and alcohol benefits substance abusers and their communities. Reducing HIV transmission with needle exchange programs is an excellent example of harm reduction. Affordable housing for people who are not abstinent and increased availability of methadone and LAAM are other possible harm reduction tactics. A concerted effort to develop and practice harm reduction in Baltimore could improve the quality of life for the entire community.

Develop a statewide system of health insurance for every Marylander with a comprehensive benefit package that includes addiction treatment. The bifurcated system of multiple Medicaid and commercial insurers for those fortunate enough to have insurance, and grants for those without insurance, imposes severe fiscal and structural penalties on treatment providers. If those providers had to manage only one system for billing and utilization purposes, far more resources could be devoted to treatment. Individuals seeking treatment could focus on recovery rather than insurance status. The State of Washington passed a law to achieve this goal in 1993, and Hawaii has adopted a similar goal. Public officials in New Mexico, New York, Vermont, and Massachusetts are also considering plans to achieve this objective. This year will witness a renewed effort, led by Baltimore City's Health Commissioner, to create a single system of health insurance for all Marylanders, significantly enhancing access to addiction treatment for all those who need it. ■

This article has been researched and written by Jeff Singer and Sarah Szanton, both associated with Health Care For the Homeless, on a grant from the Abell Foundation. Additional copies can be obtained by contacting the Abell Foundation, 111 S. Calvert Street, Baltimore, MD 21202 (410) 547-1300.

ABELL SALUTES:

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economic development to education in the local workplace. It was the recognition of this linkage that brought CollegeBound Foundation into being. With energetic support from Mayor Kurt Schmoke and BUILD, our mandate took shape: 'To encourage and enable Baltimore City public high school students to go to college.'"

To carry out that mandate, the CollegeBound Foundation was staffed and funded by money from the public and private sectors and the foundation community. CollegeBound would act as recruiters, advisors, and providers of last-dollar grants to Baltimore's high school students who were not college bound but, in the view of CollegeBound, should have been."

The CollegeBound staff conducts forums to familiarize students with admission procedures, SAT preparation, campus visits, and CollegeBound's role in last-dollar grantmaking.

It is difficult to measure the impact of CollegeBound on college admissions of Baltimore City's public high schools overall. But the record shows that in addition to the increase in the number of students taking the SATs and who are sending in college applications, 14,000 received college counseling and 608 students received a total of $1,771,861.

The Abell Foundation salutes the CollegeBound Foundation for encouraging and making it possible for more students to go to college, for developing better qualified candidates for local jobs, and in so doing, enriching the quality of life in Baltimore. ■