

Addiction Treatment Today and Tomorrow: Implications and Policy Recommendations

PRESENTED TO:

National Association of Psychiatric Health Systems (NAPHS)

PREPARED BY:

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Presentation Overview

- **Purpose of Study**
- **Executive Summary**
- **Definition of Terms and Framework for Aligning Supply and Demand of Addiction Treatment**
- **Costs and Characteristics of Substance Use Disorder Population**
- **Continuum of Addiction Treatment, Treatment Gap, and Barriers to Access**
- **Health Insurance Benefits for Addiction Treatment and Coverage Gaps**
- **Funding/Financing for Addiction Treatment**
- **Policy Recommendations**
- **Appendix: Methodology and Data Sources**

Purpose of Study

- **Define “substance use disorder” and “addiction treatment”**
- **At a national level, identify and describe the broad range of populations affected by substance use disorders, including their demographic characteristics and the sources of funding available to pay for treatment**
- **Understand the treatment gaps for those individuals who do not receive addiction treatment services and major barriers they face in accessing care**
- **Characterize the opportunities and limitations of existing federal policies to expand access to and coverage for addiction treatment, such as the Mental Health Parity and Equity Act of 2008 (MHPAEA) and the Affordable Care Act (ACA)**
- **Describe how the marketplace for addiction treatment is evolving and note how this evolution represents an opportunity for both patients and providers**
- **Outline a series of policy recommendations that will further improve access, coverage, and quality of care in the delivery of addiction treatment services**

Executive Summary

Executive Summary:

Key Findings

- **The term “substance use disorders” in this study refers to alcoholism and binge drinking, illicit drug use, misuse of prescription drugs, and other related conditions on a continuum ranging from misuse to addiction**
- **“Addiction treatment” in this study refers to services provided in a variety of facility- and community-based settings through a broad array of clinical and social interventions**
- **Substance use disorders affect individuals across all segments of the population and incur substantial social, mortality, and economic costs**
- **A tremendous treatment gap still exists due to a wide range of barriers to accessing care, including factors that lead to lack of patient readiness for treatment**
- **Addiction treatment occurs within a continuum of care settings through a variety of modalities, but the treatment infrastructure is limited**
 - Treatment can be most effective when the full continuum of care is available
 - The American Society of Addiction Medicine (ASAM) developed standardized criteria to place patients in the appropriate level of care based on severity of illness

Executive Summary:

Key Findings (cont.)

- **MHPAEA and the ACA are milestones in the federal effort to expand coverage of addiction treatment, especially through the extension of coverage for young adults**
- **But there are still gaps in coverage**
 - The Medicaid Institutions for Mental Disease (IMD) exclusion prevents adults (ages 21-64) from accessing short-term, acute care in psychiatric hospitals and residential treatment centers
 - The Medicare benefit and commercial insurance lack coverage for a full range of intermediate and ambulatory care and long-term engagement in addiction treatment, which is necessary to keep patients engaged and treat addiction as a chronic disease
- **The payer mix for addiction treatment is varied**
 - Public payers, and in particular Medicaid and other state and local block grant-type programs, currently fund the majority of addiction treatment, and this proportion is projected to increase over the next decade
 - But, interest by commercial payers is increasing as they offer managed Medicaid and employer insurance products
- **Overall funding for addiction treatment is projected to grow**

Executive Summary: Policy Recommendations

- **Both the ACA and MHPAEA need to be fully implemented in order to achieve their intended effects**
- **Additional policy changes are still needed to address changing patient demographics and the resulting gaps in addiction treatment coverage and quality of care**
 - Address the Medicaid IMD exclusion
 - Modernize Medicare (to cover a full range of benefits, including residential treatment center services)
 - Mandate transparency in the disclosure of commercial insurance benefits for addiction treatment
- **It is essential to more fully develop the science behind the biology of substance use disorders**
- **More research is needed to collect National Outcome Measures (NOMs), with abstinence being just one of many outcomes that indicates “treatment is working” (e.g., improved health status, increased functionality and productivity, decreased criminal and justice system involvement, stable living situation, etc.)**
- **Delivery of addiction treatment needs to be better integrated with medical care, with a clear role for primary care providers, an improved referral system to specialists, and continuity of care**
- **As payment systems change from volume-based (i.e., fee-for-service) to value-based systems (e.g., accountable care organizations, bundled payments) over time, providers of addiction treatment will need to show “value” to patients, payers, and policymakers, and become an integral component of population health management**

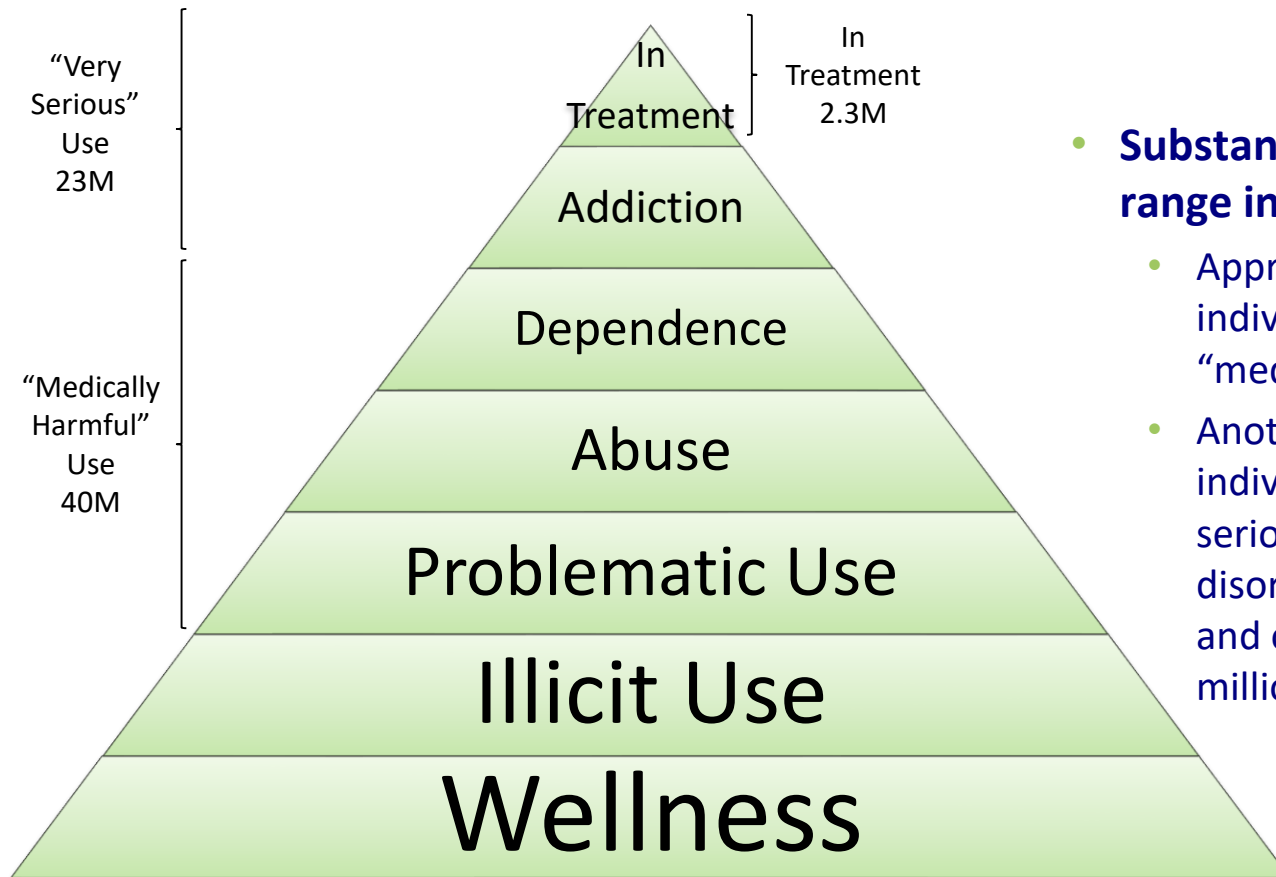
*Definition of Terms
and
Framework for Aligning Supply and
Demand of Addiction Treatment*

Definition of Terms

- **“Substance use disorder”**
 - Alcohol Use Disorder (as defined by the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (DSM-5))
 - Illicit drug use (including marijuana or hashish, cocaine, heroin, hallucinogens, inhalants)
 - Misuse of prescription drugs (primarily the illicit use of opiates, but non-medical use of prescription-type psycho-therapeutics such as pain relievers, tranquilizers, stimulants, and sedatives)
- **“Addiction treatment”**
 - The continuum of care settings, including:
 - Physician office
 - Outpatient
 - Partial hospitalization
 - Residential (non-hospital)
 - Hospital inpatient
 - The full range of clinical and social interventions, including:
 - Early intervention
 - Detoxification
 - Regular and intensive outpatient care
 - Short-term and long-term treatment
 - Inpatient treatment
 - Medication assisted treatment (MAT)
 - Continuing care
 - Community engagement and support

Source: National Institute on Alcohol Abuse and Alcoholism. “Alcohol Use Disorder: A Comparison Between DSM-IV and DSM-5.” Available online at: <http://pubs.niaaa.nih.gov/publications/dsmfactsheet/dsmfact.htm>

Definition of Terms (cont.)

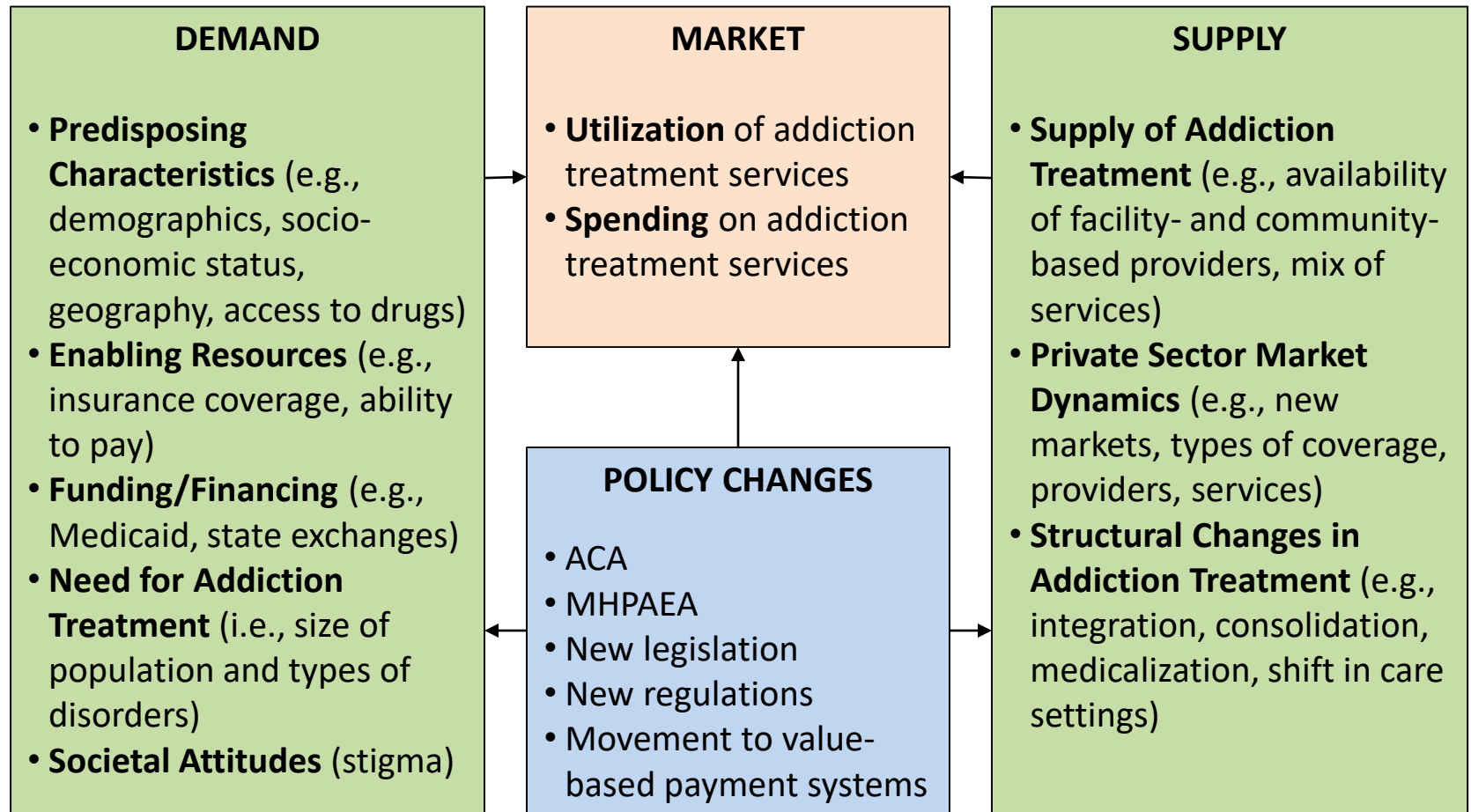


- **Substance use disorders range in severity**
 - Approximately 40 million individuals engage in “medically harmful” use
 - Another 23 million of individuals have a “very serious” substance use disorder or addiction, and only 10% (2.3 million) are in treatment

Sources: Walton. ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders (ASAM PPC-IIR). Retrieved February 5, 2015. Available online at: http://www.ndci.org/conferences/2012/Sessions/SB_sessions/SB-27.pdf; Treatment Research Institute (2013, December 12). Developing medications to treat addiction: Challenges for science, policy & practice.

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Policy Changes Are Needed to Address the Misalignment Between Supply and Demand of Addiction Treatment Services



Source: Adapted from Andersen, R. (1995). Revisiting the behavioral model and access to medical care: does it matter?. J Health Soc Behav 36 (1): 1–10.

Costs and Characteristics of Substance Use Disorder Population

Substance Use Disorders Incur Great Economic, Mortality, and Social Costs Across a Diverse Population

- **Substance use disorders incur great economic, mortality, and social costs, including lost productivity and preventable health care spending, as well as deaths due to excessive alcohol use and drug overdose**
- **Substance use disorders currently affect individuals from all demographic backgrounds, including age, race, level of education, income, and geographic area of residence**
 - Patient complexity is increasing, as more patients are “dually diagnosed” and receive treatment for both mental and substance use disorders
 - Deaths associated with binge drinking mostly impact white adult males
 - “Middle class” opiate misuse has grown in the past decade, leading to increases in overdoses and deaths
 - There is a strong relationship between heroin and opiate misuse
- **Substance use disorders remain prevalent among special populations, such as the military and individuals in the criminal justice system**

Substance Use Poses Substantial Economic, Social, and Criminal Justice System Costs to Society

ECONOMIC COSTS

- Over \$700 billion annually in lost productivity, increased health care costs, and criminal justice (1)
- About \$193 billion in overall societal costs, of which \$113 billion is associated with criminal justice system costs and costs borne by the victims of crimes (8)
- Approximately 2.5 million emergency department visits, of which 1.4 million are related to pharmaceuticals (6)

MORTALITY COSTS

- More than 90,000 deaths attributed to illicit drug use, illicit use of prescription drugs, and excessive alcohol use (1)
- 88,000 deaths and 2.5 million of years of potential life lost per year (4), approximately 41% of all deaths from motor vehicle crashes (3), and 10% of deaths among adults aged 20-64 (4), being associated with excessive alcohol consumption
- 40,000 deaths per year caused by unintentional drug overdose (1); prescription drug overdose is the second leading cause of accidental health
- Nearly 15,000 deaths annually caused by prescription painkiller overdoses (5); prescription opiate overdose is the number one cause of accidental deaths in 16 states (2)

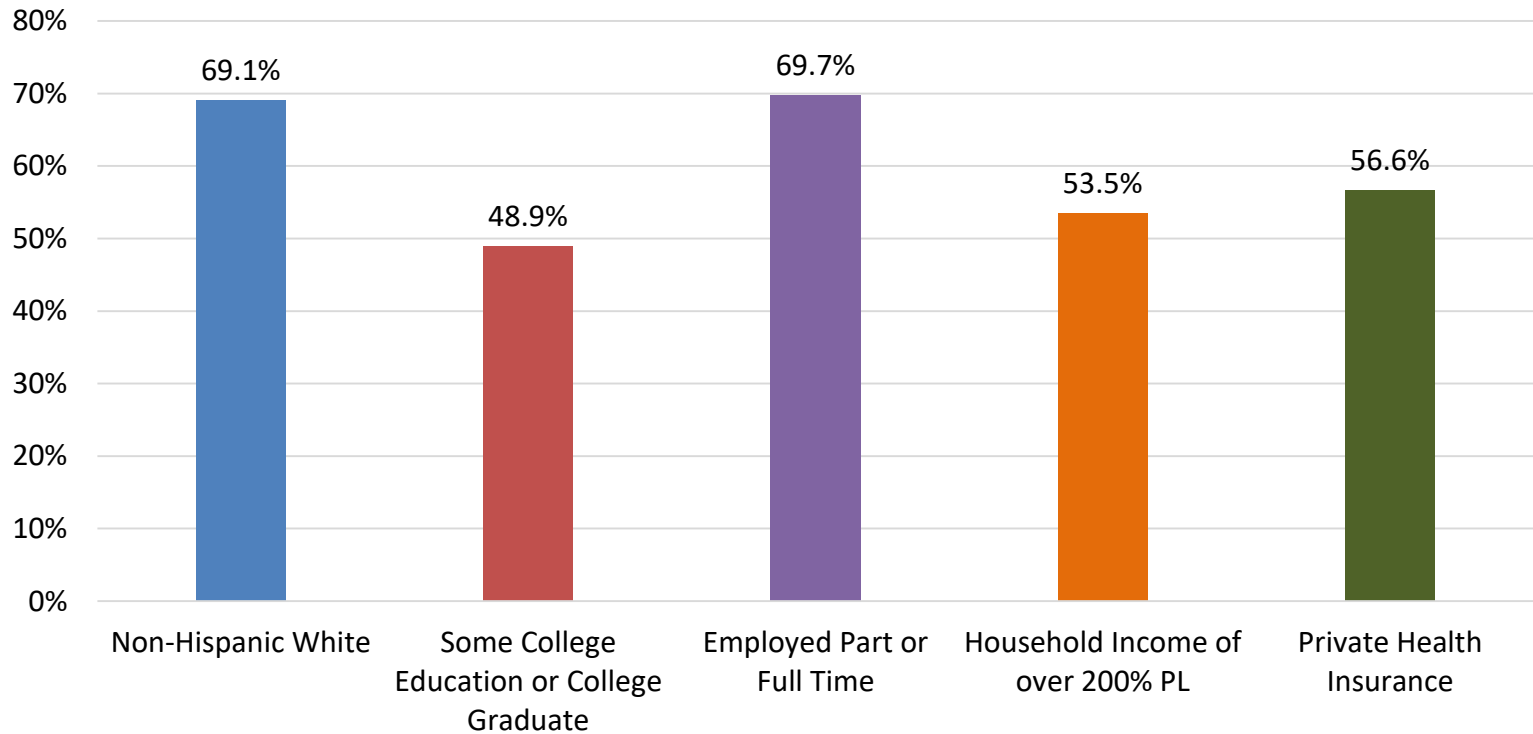
CRIMINAL JUSTICE SYSTEM COSTS

- Substance use and addiction are key factors leading to incarceration, and affect approximately 85% of all inmates across federal, state, and local jails and prisons (7)
- Alcohol and illicit drugs are involved in a variety of crimes, including:
 - 78% of violent crimes
 - 83% of property crimes
 - 77% of public order, immigration, or weapon offenses, as well as probation and parole violations (7)

Source: (1) NIH, The Science of Drug Abuse and Addiction, Retrieved 11.26.2014; Kuehn, Addiction: The White House Seeks “Third Way”, Policy Emphasizes Prevention, Treatment, Recovery, American Medical Association, 2013; (2) Kuehn, Treatment Given High Priority in New White House Drug Control Policy, American Medical Association, 2010; (3) Lesch, et al., Alcohol and Tobacco: medical and Sociological Aspects of use, Abuse, and Addiction, JAMA, 2011, Vol. 306, No. 4; (4) CDC, One in 10 deaths among working-age adults due to excessive drinking, June 2014; Stahre, et al., Contribution of Excessive Alcohol Consumption to Deaths and Years of Potential Life Lost in the United States, June 2014; (5) CDC, Prescription Painkiller Overdoses in the US, Retrieve 11.26.2014; (6) CDC, Prescription Drug Overdose in the United States: Fact Sheets, Retrieved 11.26.2014; (7) The National Committee on Addiction and Substance Abuse at Columbia University, Behind Bars II, Substance Abuse and America’s Prison Population, Feb 2010; (8) National Institute on Drug Abuse, Principles of Drug Abuse Treatment for Criminal Justice Populations, A Research-Based Guide, http://www.drugabuse.gov/sites/default/files/txcriminaljustice_0.pdf, Retrieved Feb 9, 2015.

A Majority of People with Potential Substance Use Disorders are Employed Non-Hispanic Whites With Some College Education, Moderate Incomes, and Private Insurance

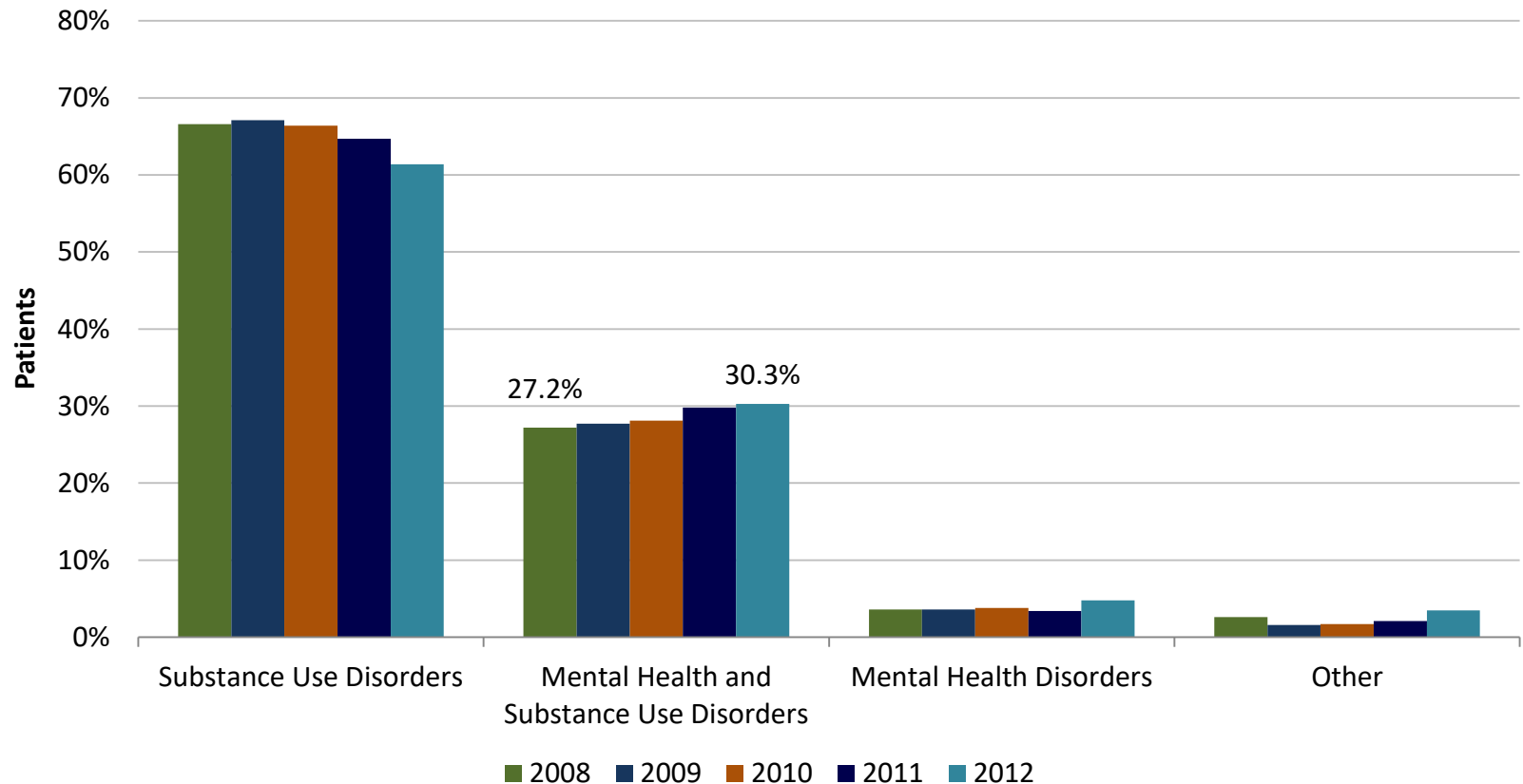
Characteristics of People with Possible Substance Abuse Disorders (2008-2009)



Source: Saloner, et al., An ACA Provision Increased Treatment for Young Adults with Possible Mental Illnesses Relative to Comparison Group, Health Affairs, No. 8 (2014).

The Percentage of “Dually Diagnosed” Patients Receiving Mental Health and Addiction Treatment Has Increased Steadily Over Recent Years (2008-2012)

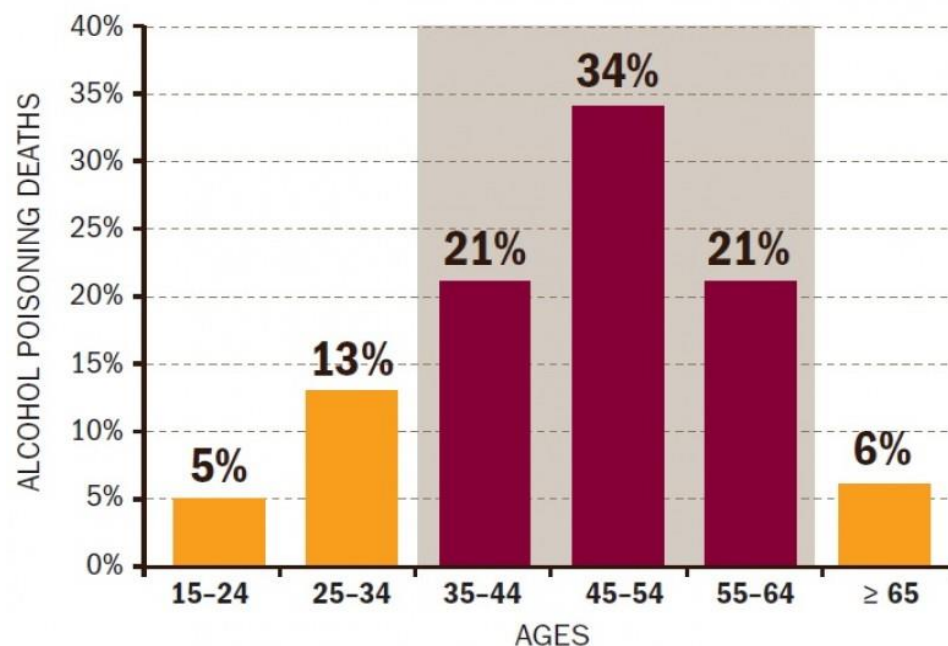
Distribution of Patients Treated by Type of Treatment (2008-2012)



Source: SAMHSA: National Survey of Substance Abuse Treatment Services: 2012. (2013).

While Binge Alcohol Use is Present Across Age Groups, Alcohol Poisoning Deaths are Most Prevalent Among Middle-Aged White Men

- 76% of individuals that die from alcohol poisoning are aged 35 to 64 (see red bars below), and three of every four are men

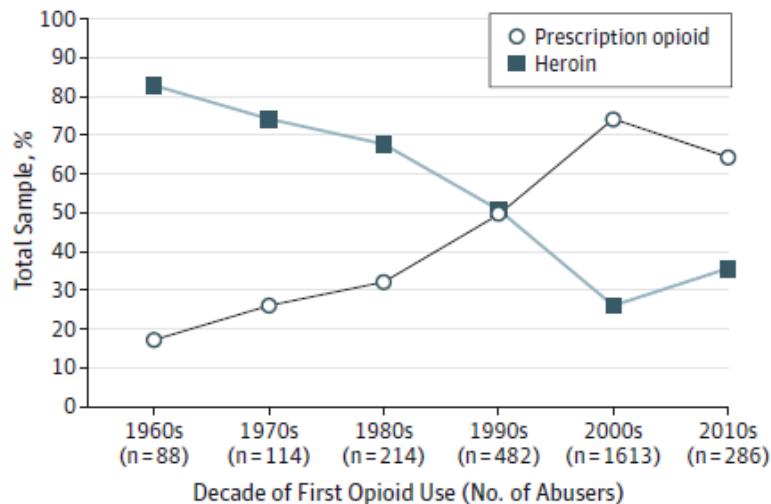


Source: CDC Vital Signs, Alcohol Poisoning Death, A Deadly Consequence of Binge Drinking. Jan 2014; Washington Post, Bernstein, Six people die each day of alcohol poisoning and most are middle-aged white men, CDC reports. Jan 2014.

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The Percentage of Patients Who Began Opioid Abuse through Prescription Drugs Has Increased Dramatically Over the Past 50 Years

Figure 1. Percentage of the Total Heroin-Dependent Sample That Used Heroin or a Prescription Opioid as Their First Opioid of Abuse



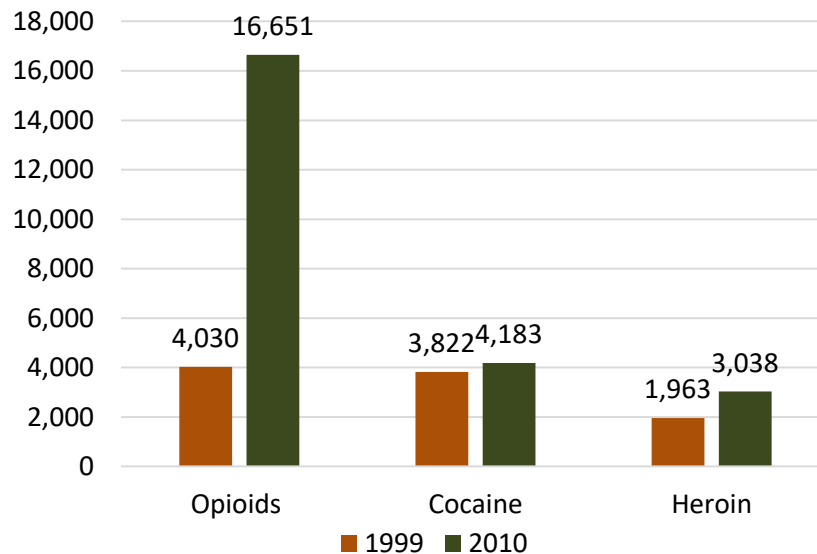
Data are plotted as a function of the decade in which respondents initiated their opioid abuse.

- **Over the past decade, illicit use of prescription opioids has driven an increase in the number of heroin users**
 - New heroin users increased from 106,000 to 178,000 from 2007 to 2011
 - Total heroin users increased from 373,000 to 620,000 from 2007 to 2011 as well

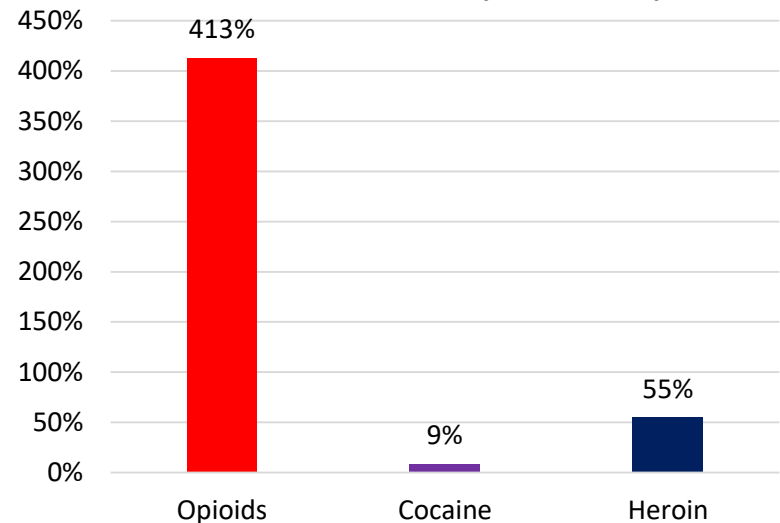
Source: Cicero, et al., The Changing Face of Heroin Use in the United States: A Retrospective Analysis of the Past 50 Years, JAMA Psychiatry, 2014; Kuehn, B. (2013). SAMHSA: Pain medication abuse a common path to heroin. JAMA 310(14): 1433-1434.

Overdose Deaths Involving Opioids Increased Dramatically in Comparison to Cocaine and Heroin Between 1999 and 2010

Number of Deaths Involving Opioids, Cocaine, and Heroin (1999 and 2010)



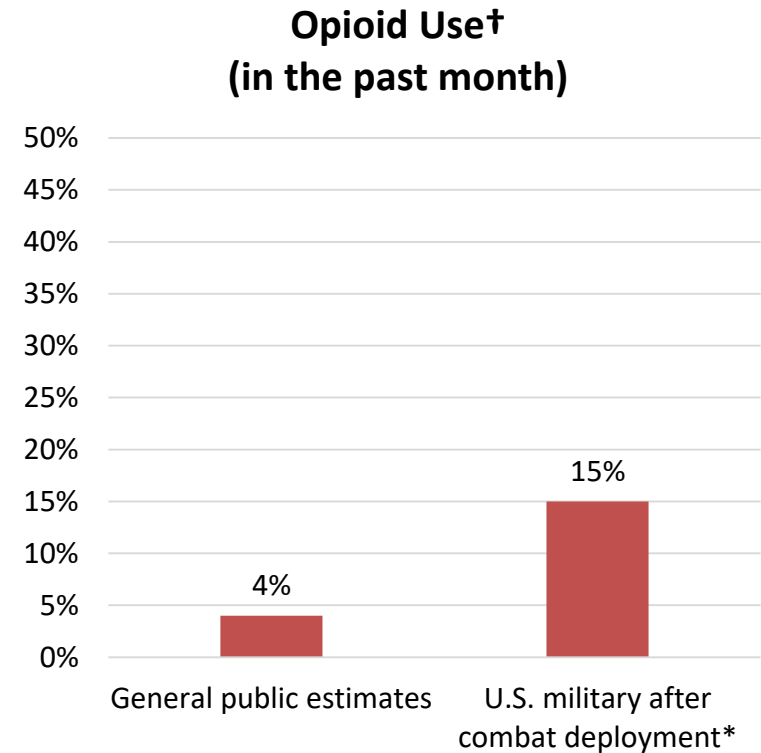
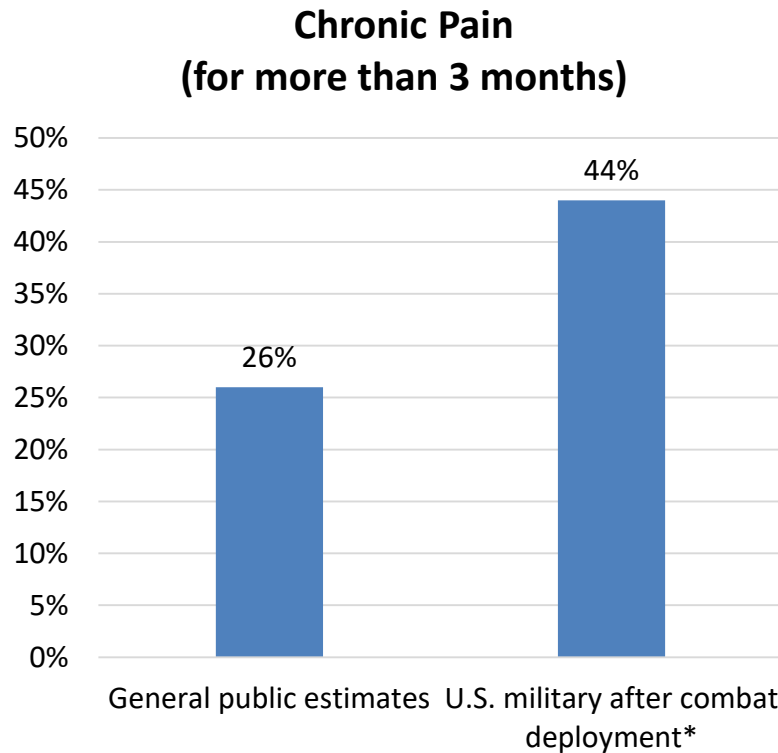
Percentage Increase in Overdose Deaths Involving Opioids, Cocaine, and Heroin (1999-2010)



- **From 2010 to 2013, the age-adjusted rate of overdose deaths involving opioids has plateaued but the rate of overdose deaths involving heroin increased nearly three-fold (*)**

Sources: Office of National Drug Control Policy, Fact Sheet: Opioid Abuse in the United States, February 11, 2014; *Hedegaard et al., Drug-poisoning Deaths Involving Heroin: United States, 2000-2013, NCHS Data Brief, No. 190, March 2015.

Opioid Prescriptions for Chronic Pain Are Leading to Disproportionately Higher Use (and Misuse) of Opioids by Military Combat Veterans



† Opioid use includes both medical use and misuse.

* Active-duty frontline military personnel account for less than 0.5% of the US population.

Source: JAMA Intern Med., Robin, et al., Chronic Pain and Opioid Use in the US Soldiers After Combat Deployment; Jonas, et al., Pain and Opioids in the Military: We Must Do Better, June 2014; GFP, United States of America Military Strength, Feb 2015.

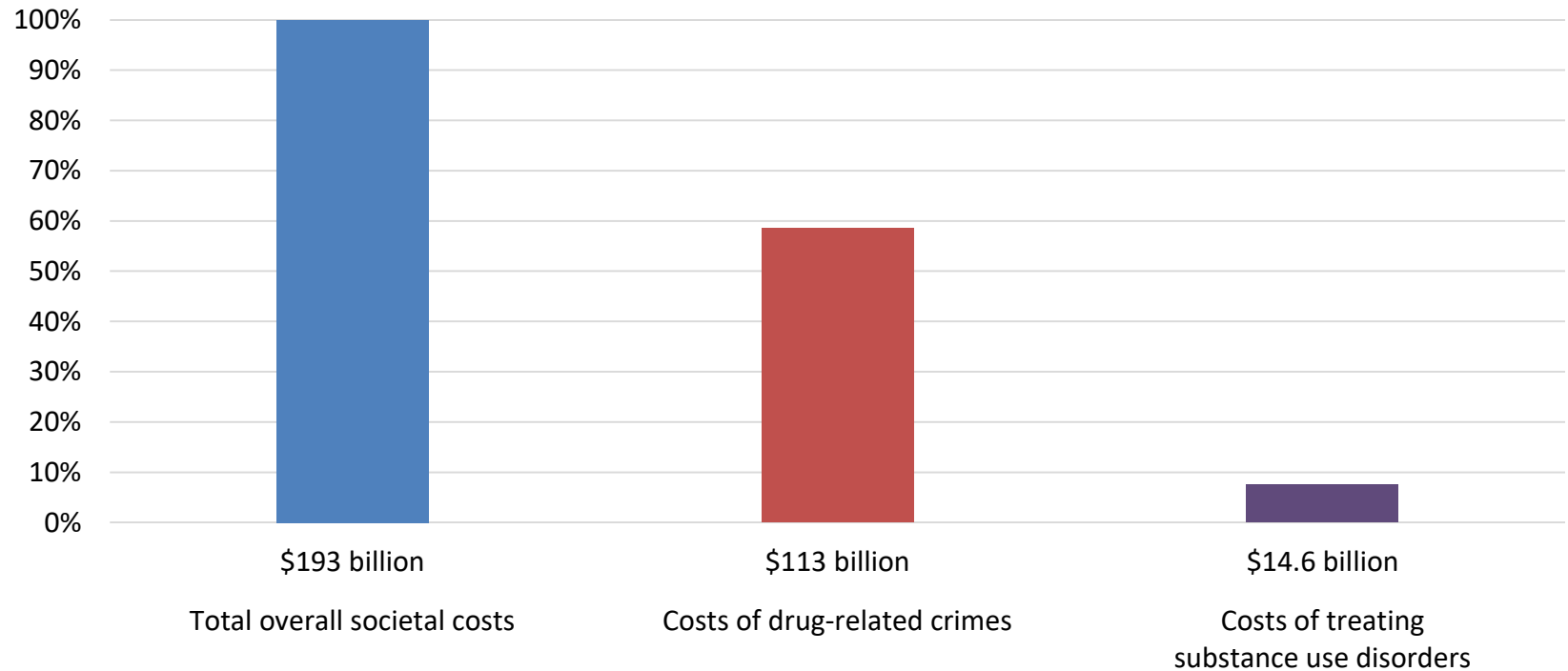
Benefits of Addiction Treatment

The Effectiveness of Addiction Treatment Has Been Proven

- **Spending on addiction treatment represents a small proportion of overall societal costs (including criminal justice-related costs) of substance use disorders**
- **Studies show that addiction treatment:**
 - Reduces health care spending
 - Increases workplace productivity
 - Decreases the likelihood of arrest
 - Produces cost offsets in law enforcement and criminal justice
- **States, under the Medicaid Innovation Accelerator Program, are testing payment and delivery reforms for addiction treatment, and several states have demonstrated effectiveness in treating substance use disorders through medication assisted treatment**

The Cost of Addiction Treatment Represents a Fraction of the Overall Societal Costs of Substance Use Disorders

Cost of Addiction Treatment Relative to Overall Societal Costs of Substance Use Disorders



Source: National Institute on Drug Abuse, Principles of Drug Abuse Treatment for Criminal Justice Populations, A Research-Based Guide, http://www.drugabuse.gov/sites/default/files/txcriminaljustice_0.pdf, Retrieved Feb 9, 2015

Addiction Treatment Is Effective, Produces Health Care Savings, Increases Economic Productivity, and Benefits the Criminal Justice System

- **Every \$1 spent on addiction treatment saves \$4 in health care costs and \$7 in law enforcement and other criminal justice costs**
 - Addiction treatment costs \$1,583 per patient and is associated with a cost offset of \$11,487, representing a greater than 7:1 ratio of benefits to costs
 - Savings can exceed costs by 12:1 when including health care costs (*)
- **Research on the effectiveness of addiction treatment has shown that:**
 - Full addiction treatment coverage could result in \$398 savings per-member per-month (PMPM) in Medicaid spending
 - Medical costs for individuals in treatment were \$311 lower PMPM than for people who needed but did not receive treatment
 - Addiction treatment for 60 days or more can save \$8,200 in health care and productivity costs
 - Treatment reduces missed work, conflicts with co-workers, and tardiness
 - For those who received addiction treatment, the likelihood of being arrested decreased 16% and the likelihood of felony conviction dropped by 34%
- **In addition, treatment is less expensive than incarceration (e.g., one year of methadone maintenance for \$4,700 vs \$18,400 for imprisonment)(*)**

Source: Office of National Drug Control Policy, Executive Office of the President, Cost Benefits of Investing Early in Substance Abuse Treatment, May 2012, http://www.whitehouse.gov/sites/default/files/ondcp/Fact_Sheets/investing_in_treatment_5-23-12.pdf, Retrieved Feb 10, 2015; (*) National Institute on Drug Abuse, Understanding Drug Abuse and Addiction: What Science Says, <http://www.drugabuse.gov/publications/teaching-packets/understanding-drug-abuse-addiction/section-iv/6-cost-effectiveness-drug-treatment>, Retrieved Feb 10, 2015

Substance Use Disorders Are a Priority in the Medicaid Innovation Accelerator Program (IAP)

- **CMS launched the Medicaid IAP in July 2014, aiming to improve care, health outcomes, and reduce costs for Medicaid enrollees by supporting states in accelerating new payment and service delivery reforms**
- **Areas of focus and support for addiction treatment include:**
 - Innovative delivery and payment models for cost efficiency and effectiveness, including integration strategies
 - Enhanced alternative benefit design
 - Need for more/better quality metrics for data-driven decision-making
- **Three current opportunities for states to expand addiction treatment under IAP include:**
 - High-intensity learning collaborative
 - Targeted learning
 - Learning diffusion

Source: CMS, The Innovation Accelerator program, July 14, 2014, <http://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/iap-smd-letter-07-14-14.pdf>, Retrieved Feb 11, 2015; Medicaid Innovation Accelerator Program, IAP Learning Collaborative: Substance Use Disorder, Nov 2014, <http://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/iap-sud-webinar.pdf>, Retrieved Feb 11, 2015.

Medication Assisted Treatment (MAT) Has Been Used in State Medicaid Programs to Address the Needs of the Substance Use Disorder Population

- **MAT adopts Food and Drug Administration (FDA)-approved medications in combination with evidence-based behavioral therapies to help individuals with substance use disorders recover in a safe and cost-effective manner**
- **Examples of success in treatment outcomes with MAT**
 - Individuals in MAT use half of the health care resources as those not in MAT; MAT pregnant women had shorter hospital stays for addiction treatment (10 days vs. 17.5 days) (1)
 - MAT was associated with fewer inpatient admissions for alcohol dependence cases, and the total health care costs were 30% less (2)
 - Medical costs decreased by 33% for Medicaid patients over three years following their engagement in treatment (3)
- **Due to regional variation in the substance use disorder population and treatment infrastructure, states have implemented different MAT program models (4)**
 - Vermont implemented MAT for opioid addiction, and is currently developing a “Hub and Spoke” model that offers different systems of care for patients with different levels of needs
 - Rhode Island received approval for a patient-centered health home program to focus on opioid dependent Medicaid enrollees, which provides enhanced care coordination and support, and formalized the relationship between opioid treatment and community health providers

Source: (1) Jones, et al., Neonatal abstinence syndrome after-methadone or buprenorphine exposure, *New England Journal of Medicine*, 2010; (2) Baser, et al., Alcohol treatment dependence: comprehensive health care costs, utilization outcomes, and pharmacotherapy persistence, *The American Journal of Managed Care*, 2001; (3) Walter, et al., Medicaid Chemical Dependency Patients in a Commercial Health Plan, Robert Wood Foundation, 2006; (4) CMS, Information Bulletin, Medication Assisted Treatment for Substance Use Disorders, July 11, 2014.

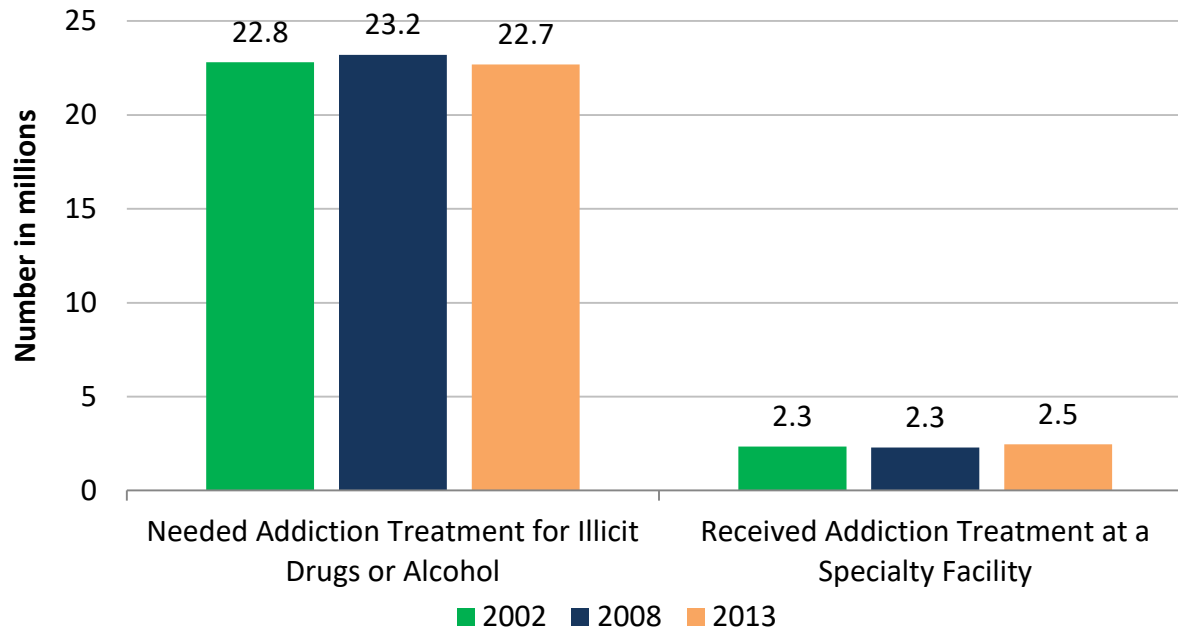
Continuum of Addiction Treatment and Barriers to Access

Addiction Treatment Is Provided Along a Continuum of Care, Though Many Individuals Face Barriers to Access in Both Coverage and Treatment Supply

- **Within both the general population and the prison population, only 10% of individuals that need treatment for a substance use disorder receive treatment**
- **Individuals with substance use disorders face many barriers to accessing care, such as stigma and lack of financial resources**
- **For those who receive addiction treatment, services are provided along a continuum of care by a diversity of specialties and through a variety of modalities, but treatment infrastructure is limited**

Despite the High Need for Addiction Treatment, Only 10% of Affected Individuals Received Treatment at a Specialty Facility From 2002 to 2013

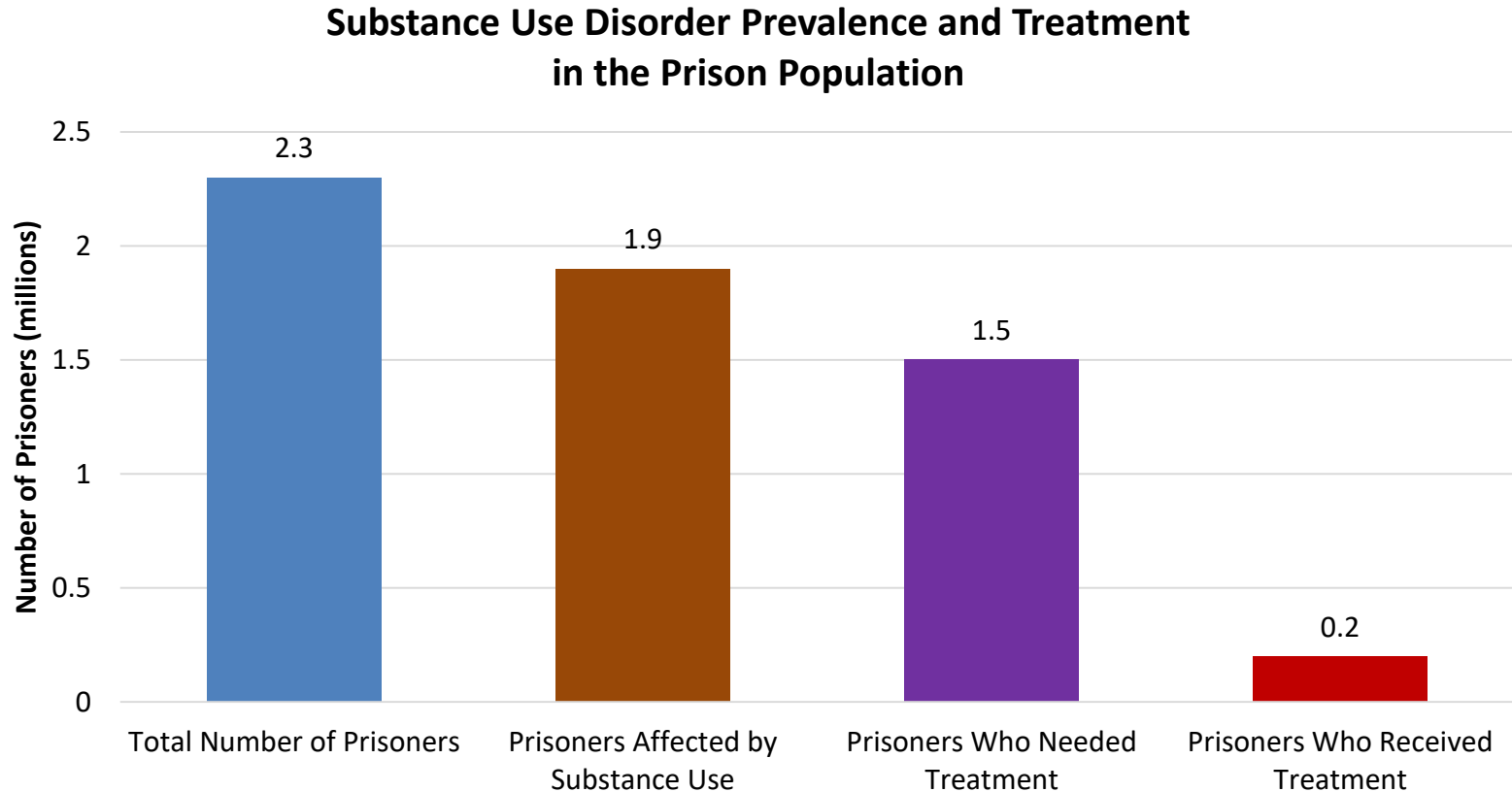
Number of Substance Abusers Aged 12 or Older Who Needed Addiction Treatment and Received Addiction Treatment at a Specialty Facility (2002-2013)



- Of the 2.3 million patients that receive addiction treatment services, less than 30% remain in treatment for 90 days and more than 50% relapse to drug use within one year (*)

Source: SAMHSA: Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings. 2014; (*) McLellan, Treatment Research Institute, Moving from an Acute to a Chronic Care Model will Affect Clinical Services, Outcome Expectations and Reimbursement, 2013.

As in the General Population, Only 10% of Prisoners Who Need Substance Abuse Treatment Receive Services



Source: The National Committee on Addiction and Substance Abuse at Columbia University, Behind Bars II, Substance Abuse and America's Prison Population, Feb 2010.

Individuals with Substance Use Disorders Face Numerous Barriers to Accessing Addiction Treatment Services

SOCIAL PERCEPTION AND COMMUNITY REINTEGRATION

- Stigma
- Challenges with transitioning from inpatient/residential care to the community, including post-treatment employment seeking and community engagement

FUNDING/FINANCING

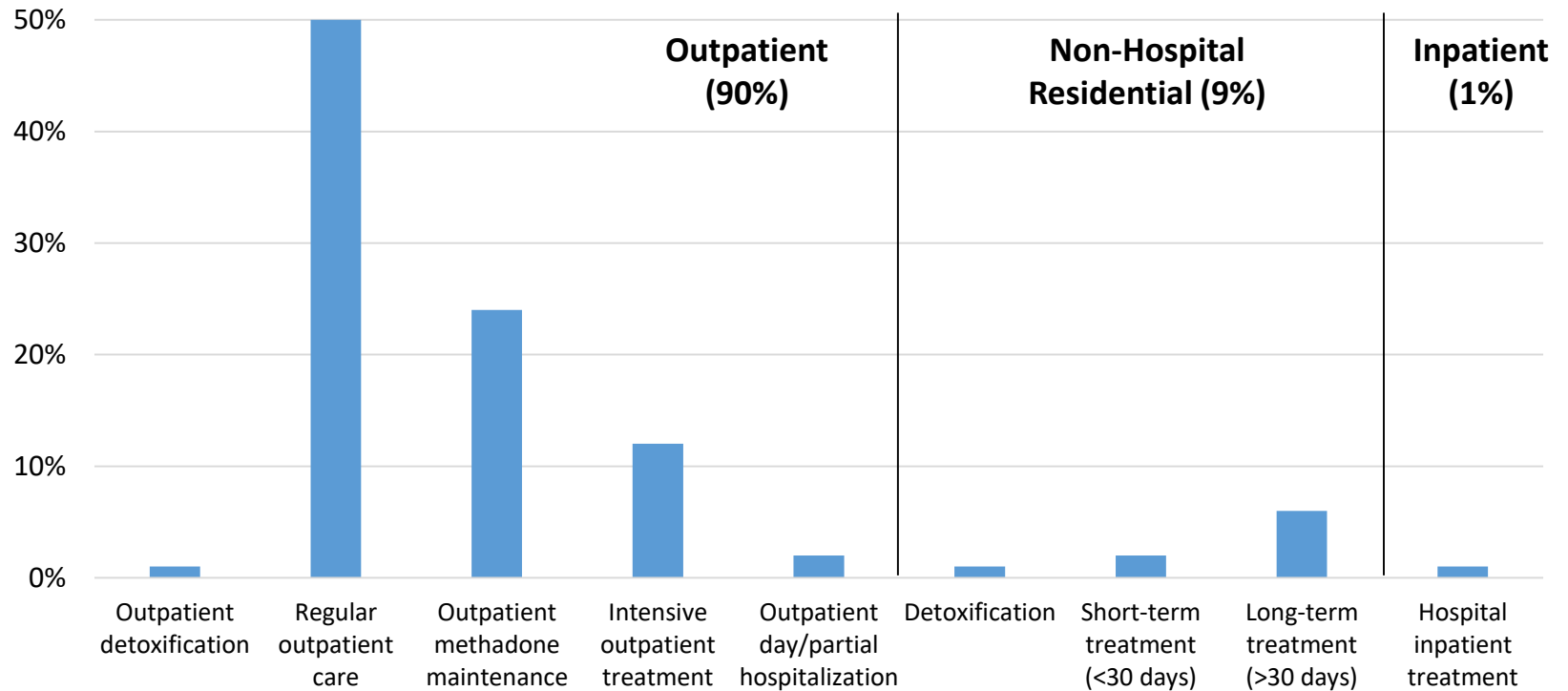
- Limited public funding
- Lack of health insurance
- Lack of coverage and/or limitations in health insurance benefit plans (e.g., case management)
- Lack of financial resources and high out-of-pocket costs
- Inadequate reimbursement

TREATMENT INFRASTRUCTURE

- Limitations in treatment infrastructure and insufficient capacity in existing facilities
- Limited availability of specialty programs to address individual needs
- Workforce constraints
- Lack of standardization regarding clinical assessment and patient placement

The Majority of Addiction Treatment is Provided in an Outpatient Setting

Percent of Addiction Treatment by Type



Source: SAMHSA: National Survey of Substance Abuse Treatment Services: 2012. (2013).

Addiction Treatment Is Delivered along a Continuum of Care Through a Variety of Interventions

- **Examples of psychosocial therapy**

- Assertive community treatment (ACT)/community reinforcement approach
- Individual counseling
- Couples/family therapy
- Contingency management
- Cognitive behavioral therapy
- Motivational interviewing and motivational enhancement therapy
- Screening, Brief Intervention, Referral to Treatment (SBIRT)
- 12-step facilitation

- **Examples of FDA-approved MAT**

- For alcohol dependence
 - Naltrexone (ReVia®, Vivitrol®, Depade®)
 - Disulfiram (Antabuse®)
 - Acamprosate Calcium (Campral®)
- For opioid dependence
 - Methadone
 - Buprenorphine (Suboxone® and Subutex®)
 - Naltrexone

Source: SAMHSA. "Pharmacotherapy for substance use disorders." Available online at: <http://dpt.samhsa.gov/medications/medsindex.aspx>

Health Insurance Benefits for Addiction Treatment and Coverage Gaps

The ACA and MHPAEA Will Increase Coverage, But Will Not Fully Address Limited Benefit Structures Across All Payers

- **Benefit structures and coverage for substance use treatment vary widely by payer, but all payers have the opportunity to equalize treatment coverage with medical care benefits**
- **The ACA and MHPAEA hold promise to increase access to treatment services for millions of individuals with substance use disorders**
- **To date, the ACA primarily has increased inpatient admissions for addiction treatment through expanded health insurance coverage to young adults under age 26**
- **However, these laws face challenges to full implementation and alone will not achieve equity in insurance coverage for addiction treatment services**

Coverage for Addiction Treatment Services Varies by Payer

MEDICARE (1)

Pays for addiction treatment in both inpatient and outpatient settings, but only hospital-level addiction treatment

Federal parity law does not apply

MEDICAID (2)

Limited coverage for addiction treatment (most services are optional)

Parity applies to only limited degree

Mandatory coverage for screening and diagnostic, physician, and inpatient services for children and adolescents 21 years of age and under

IMD exclusion prevents individuals aged 22-64 from receiving inpatient psychiatric treatment

TRICARE (3)

Limited to three covered episodes over lifetime

One covered episode can include up to 7 days for detoxification and 21 days for rehabilitation

TRICARE Managed Care Contracts are allowed to “approve” an extension

COMMERCIAL (4)

Must meet the MHPAEA and ACA requirements (including provision on children being able to stay on their parents’ health insurance policies until age 26)

Lack of transparency in covered benefits

Source:

(1) The New York Times, Understanding New Rules that Widen Mental Health Coverage, the http://www.nytimes.com/2014/01/10/your-money/understanding-new-rules-that-widen-mental-health-coverage.html?_r=0, Retrieved Feb 6, 2015; ETNA: Employers and Organizations: Federal Mental Health Parity Final Regulations FAQs, <https://www.aetna.com/faqs-health-insurance/employers-mental-health-parity-final-regulations-faqs.html>, Retrieved Feb 6, 2015; Medicare Coverage of Mental Health and Substance Use Services, <http://www.medicareadvocacy.org/medicare-info/medicare-coverage-of-mental-health-services/>, Retrieved Feb 6, 2015;

(2) Boozang, et al., Coverage and Delivery of Adult Substance Abuse Services in Medicaid Managed Care, CMS Technical Assistance Brief, No#2, May 2014; Buck, The Looming Expansion and Transformation of Public Substance Abuse Treatment under the Affordable Care Act, Health Affairs, No. 8, 2011; NAMI, Medicaid Expansion and Mental Health Care, May 2013;

(3) <http://www.tricare.mil/CoveredServices/IsItCovered/SubstanceUseDisorderTreatment.aspx>, Retrieved Feb 6, 2015; Tricare Mental Health Care Services, Jan 2015;

(4) CMS, The Mental Health Parity and Addiction Parity Act, http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html, Retrieved Feb 6, 2015.

Medicaid Exclusion of Coverage for Adults in Free-Standing IMDs Contributes to a Lack of Inpatient Beds

- **When the Medicaid program was created in 1965, the federal law contained a provision excluding coverage of treatment for adults aged 22-64 in free-standing IMDs, to avoid Federal dollars supplanting what was considered a state financing responsibility**
- **Because of the IMD exclusion, state Medicaid programs routinely contract for psychiatric beds in general hospitals and many states establish community-based crisis stabilization units that are smaller than the 16-bed IMD exclusion limit**
 - This situation decreases the industry's ability to maintain or increase the current number of treatment beds
- **Given the growing role of Medicaid funding and constraints on state general funds and block grants, retaining the IMD exclusion will make it difficult to meet demand for inpatient care**
- **The IMD exclusion in Medicaid is considered one factor contributing to the lack of inpatient beds for addiction treatment, and its elimination has been recommended by various organizations**

Source: Buck, The Looming Expansion and Transformation of Public Substance Abuse Treatment Under the Affordable Care Act, Health Affairs, No. 8 (2011); National Alliance on Mental Illness (NAMI), State Mental Health Legislation 2014: Trends, Themes, and Effective Practices, 2014; NAMI, Medicaid Expansion and Mental Health Care, 2013.

Limited Access to Substance Use Treatment Is Being Addressed in Part Through Recent Legislative Changes

Mental Health Parity and Addiction Equity Act (MHPAEA)

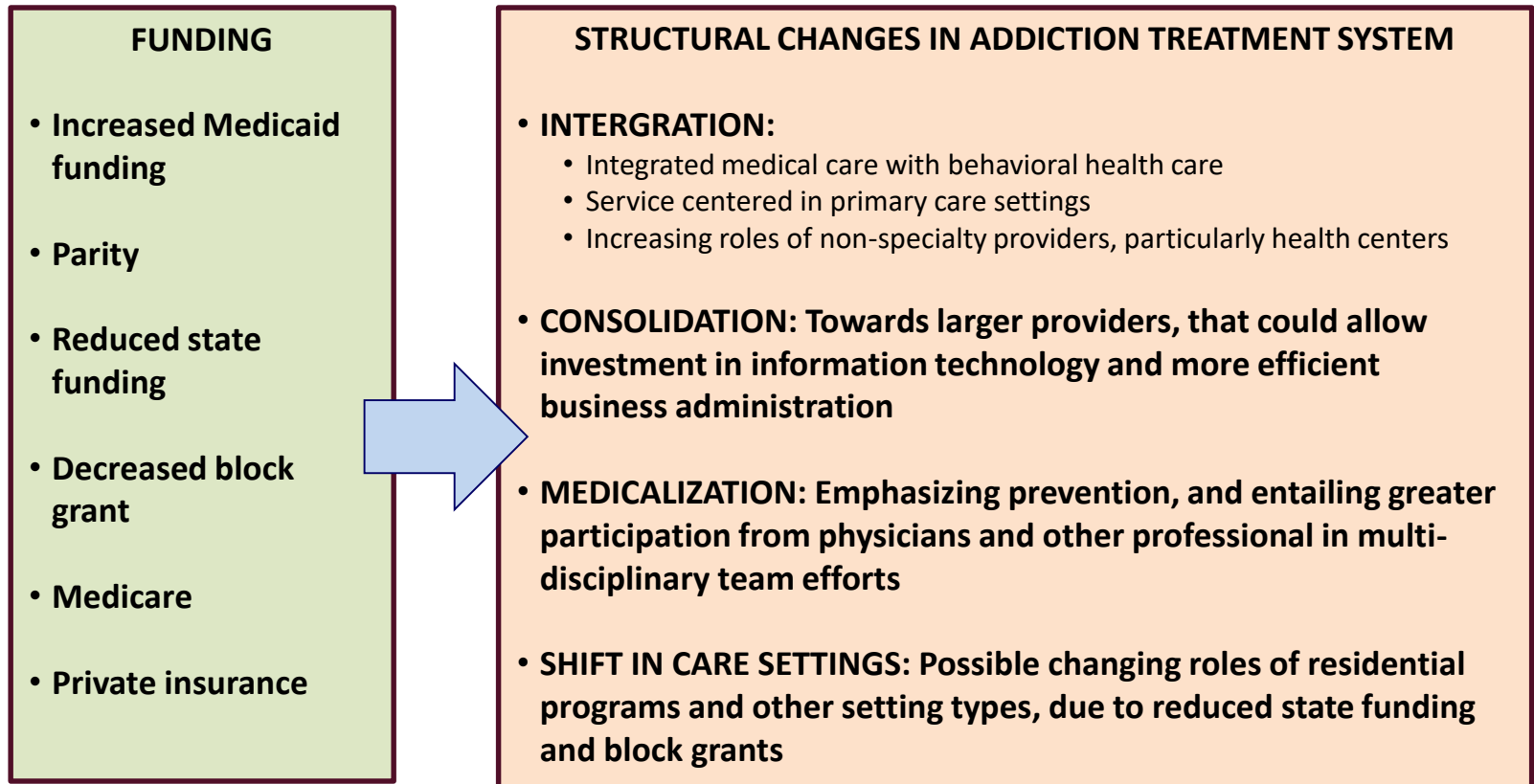
- MHPAEA does not mandate health plans or health insurance issuers to cover mental health/substance use disorder benefits, and the Medicaid program is exempt
- MHPAEA requirements only apply to those large group health plans that choose to provide mental health and substance use disorder benefits
 - No annual or lifetime dollar limits, financial requirements (e.g., coinsurance), or treatment limits (e.g., visit limits) for mental health and substance use disorders can be imposed that are less favorable than with those for medical/surgical benefits

The Affordable Care Act (ACA)

- The ACA extends the reach of MHPAEA, mandating all new group and individual market plans created after March 23, 2010 comply with federal parity requirements
 - These entities include both large and small employer-funded plans, individual market plans, Medicaid managed-care programs, Children's Health Insurance Program (CHIP), and Medicaid Alternative Benefit Plans and benchmark equivalent plans
- Under the ACA:
 - Mental health and substance use disorder services must be covered as an Essential Health Benefit
 - All covered services and benefits must be provided at parity with those for general medical and surgical benefits

Source: Beronio, et al., ASPE Research Brief, Affordable Care Act Will Expand Mental Health and Substance Use Disorder Benefits and Parity Protection for 62 million Americans, Feb 2013; CMS, Letter to State Health Officials and Medicaid Directors, January 16, 2013, <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-01-26-2015.pdf>, Retrieved Feb 6, 2015; CMS, The Mental Health Parity and Addiction Equity Act, http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html, Retrieved Feb 6, 2015; SAMHSA, Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA), Sep 2014, <http://www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act>, Retrieved Feb 6, 2015.

The ACA Is Anticipated to Have Significant Structural Impact on Addiction Treatment Provision Over the Next 10 Years



Source: Buck, The Looming Expansion and Transformation of Public Substance Abuse Treatment Under the Affordable care Act, Health Affairs No. 8 (2011); Kuehn, Treatment Given High Priority in New White House Drug Control Policy, American Medical Association, 2010; Kuehn, Integrated Care key for Patients with Both Addiction and Mental Illnesses, American Medical Association, 2010; Kuehn, Addiction: The White House Seeks "Third Way", Policy Emphasizes Prevention, Treatment, Recovery, American Medical Association, 2013.

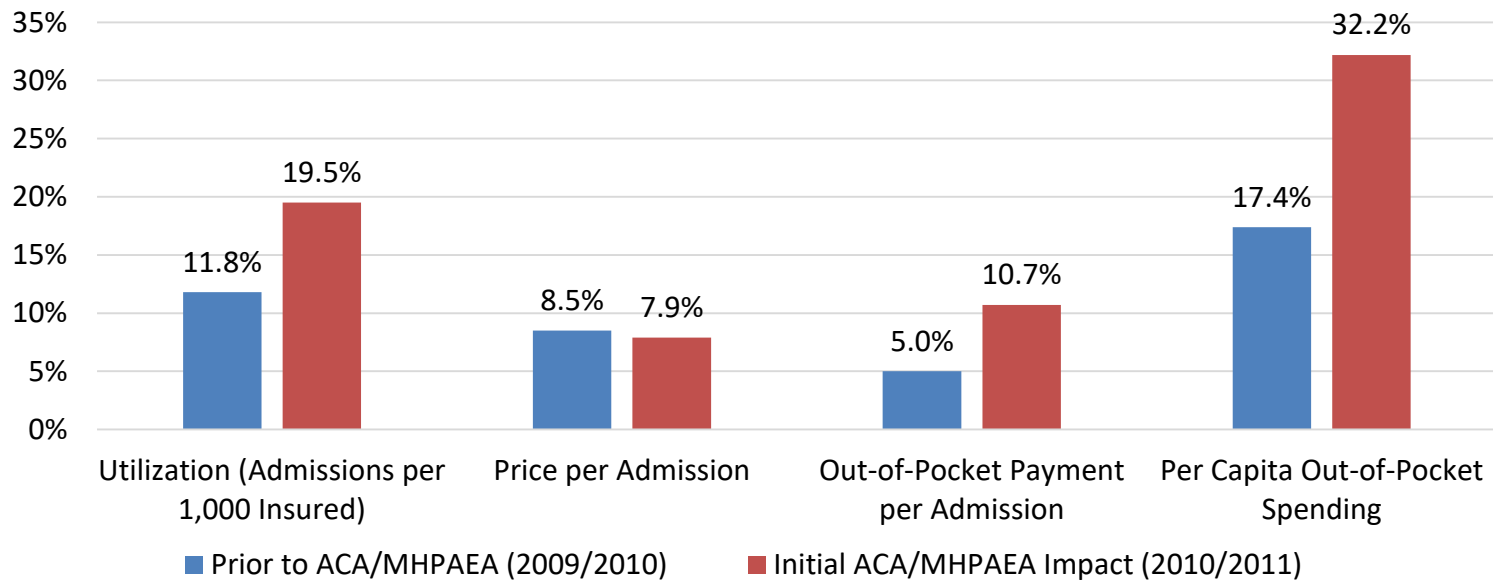
Implementation of Parity Has Been Slow, and a Definitive Increase in Access to Treatment Due to Parity and the ACA Has Not Yet Materialized (2008-2012)

- **The ACA aims to increase the access to care**
 - Approximately 62.5 million people are estimated to benefit from coverage expansion under the legislation by 2020, with 32.1 million gaining mental health and substance use disorder benefits for the first time
- **However, the implementation of parity has been slow, and the final rules of MHPAEA were not finalized until 2013**
- **Data to date is preliminary, but some measures suggest that use of addiction treatment services is a result of the age 26 provision in the ACA**

Source: Saloner, et al., An ACA Provision Increased Treatment for Young Adults With Possible Mental Illnesses Relative to Comparison Group, Health Affairs No. 8 (2014); Beronio, et al., ASPE Research Brief, Affordable Care Act Will Expand Mental Health and Substance Use Disorder Benefits and Parity Protection for 62 million Americans, Feb 2013.

Initial Evaluation of ACA/Parity Impact Suggests That Admissions for Substance Use Increased between 2009 and 2011, Although Less than Out-of-Pocket Spending

Initial ACA/MHPEA Impact on Utilization, Price per Admission, and Out-of-Pocket Spending for Addiction Treatment (2009-2011)



- Increases in out-of-pocket spending for addiction treatment are consistent with recent trends observed across the commercial insurance market**

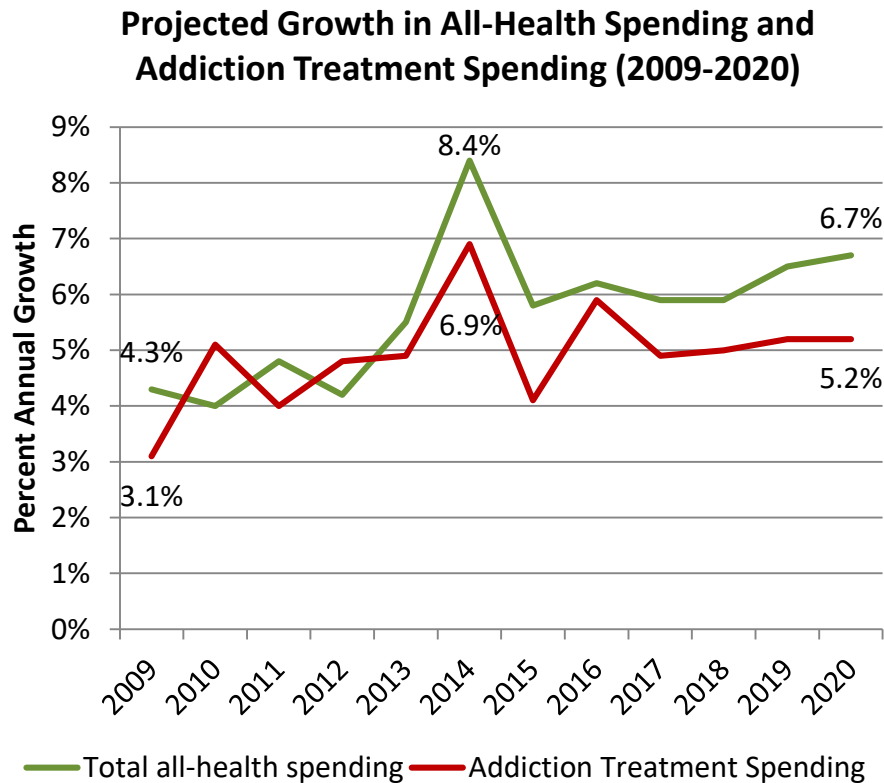
Source: Health Care Cost Institute, The Impact of the Mental Health Parity and Addiction Equity Act on Inpatient Admissions, February 2013; Milliman Medical Index 2014; Health Care Cost and Utilization Report, 2012.

Enabling Resources and Funding/ Financing for Addiction Treatment

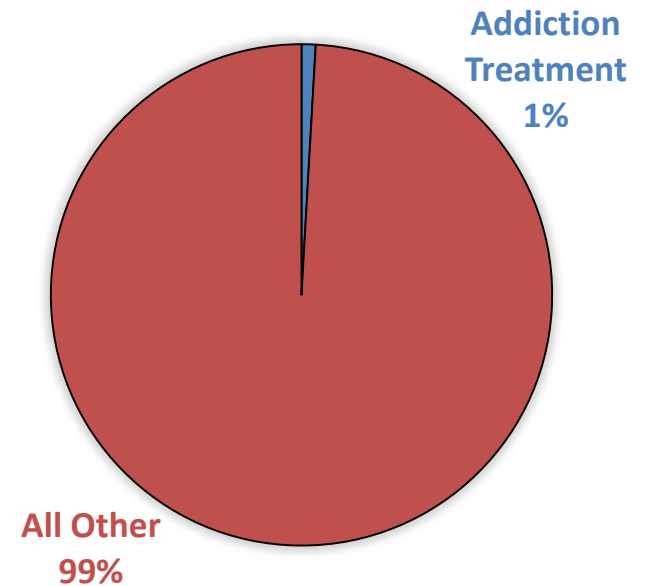
Due to Medicaid Expansion, Public Payers Will Continue to Drive Funding for Addiction Treatment

- **The growth rate of addiction treatment spending is nearly as high as for overall health care spending from 2009 to 2020**
 - However, by 2020 addiction treatment spending will only represent 1 percent of total health care spending
- **Medicaid spending as a percentage of total addiction treatment spending will double from 2009 to 2020 as the expansion population is enrolled**

Addiction Treatment Spending Is Expected to Increase at a Rate Nearly As High as All-Health Spending, But Remains a Small Percentage of All-Health Spending (2009-2020)



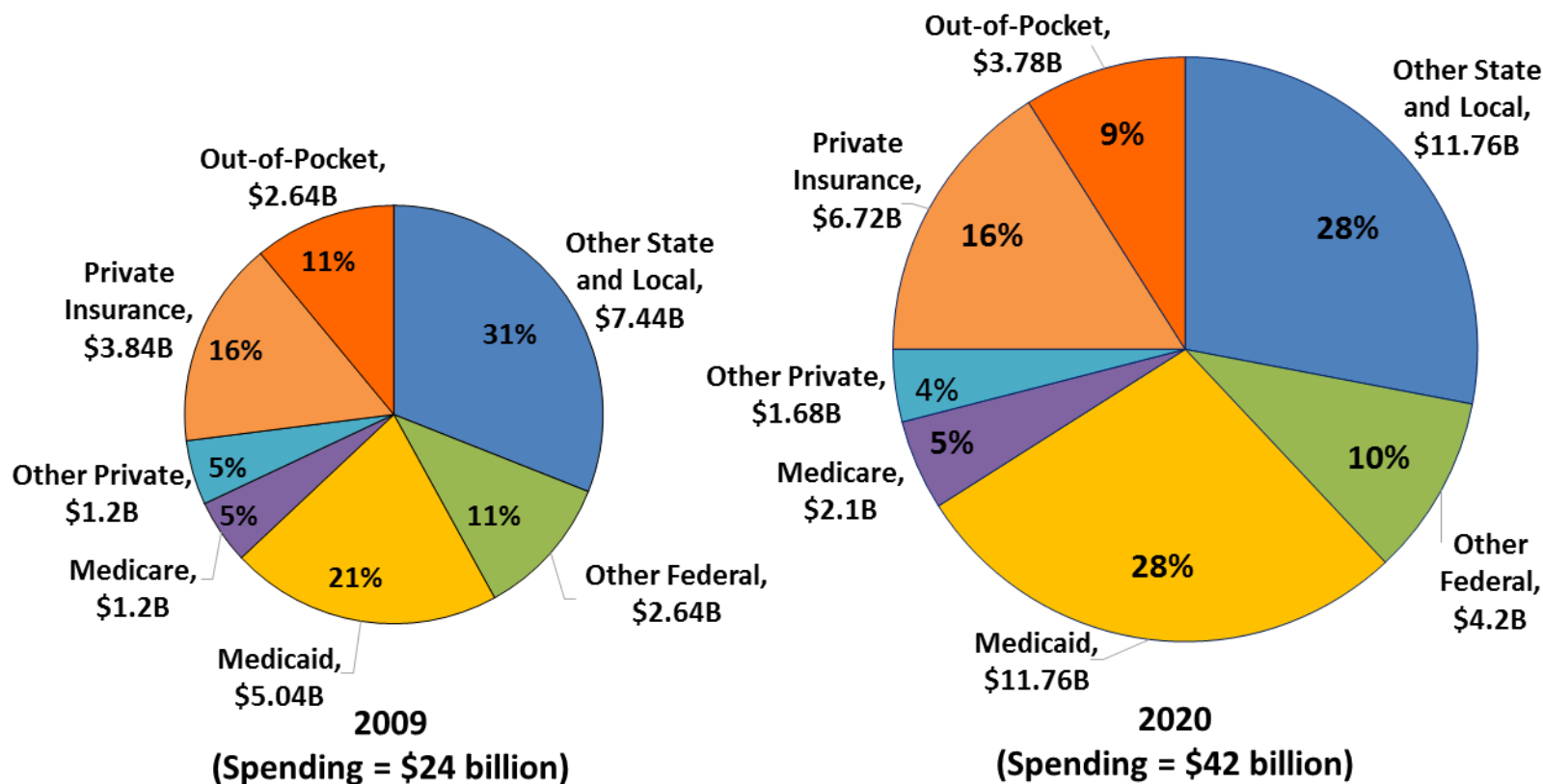
Addiction Treatment as Percent of All-Health Spending in 2020



Source: SAMHSA: Projections of National Expenditures for Mental Health Services and Substance Abuse Disorders, 2010-2020. 2014.

Public Payers Are Projected to Account for an Increasing Share of Addiction Treatment Spending from 2009 to 2020, Although Private Coverage is Increasing

Distribution of Addiction Treatment Spending by Payer in 2009 and 2020 (billions)



Source: SAMHSA: Projections of National Expenditures for Mental Health Services and Substance Abuse Disorders, 2010-2020. (2014).

Public Payers Are Expected to Fund Approximately 75% of Increases in Addiction Treatment Spending Between 2009 and 2020

- **The total increase in addiction treatment spending between 2009 and 2020 is projected to be \$18 billion**
- **Public funding for addiction treatment is estimated to increase by approximately \$13.5 billion, from 68% in 2009 to reach 71% in 2020, with Medicaid and other state and local spending accounting for two-thirds of this growth**
- **Much of the growth in Medicaid spending for addiction treatment is due to the Medicaid expansion population, which reflects many of the predisposing characteristics for substance use disorders**

Source: SAMHSA: Projections of National Expenditures for Mental Health Services and Substance Abuse Disorders, 2010-2020. (2014).

Policy Recommendations to Align Supply and Demand for Addiction Treatment

Three Important Principles in the Treatment of Substance Use Disorders as Chronic Conditions

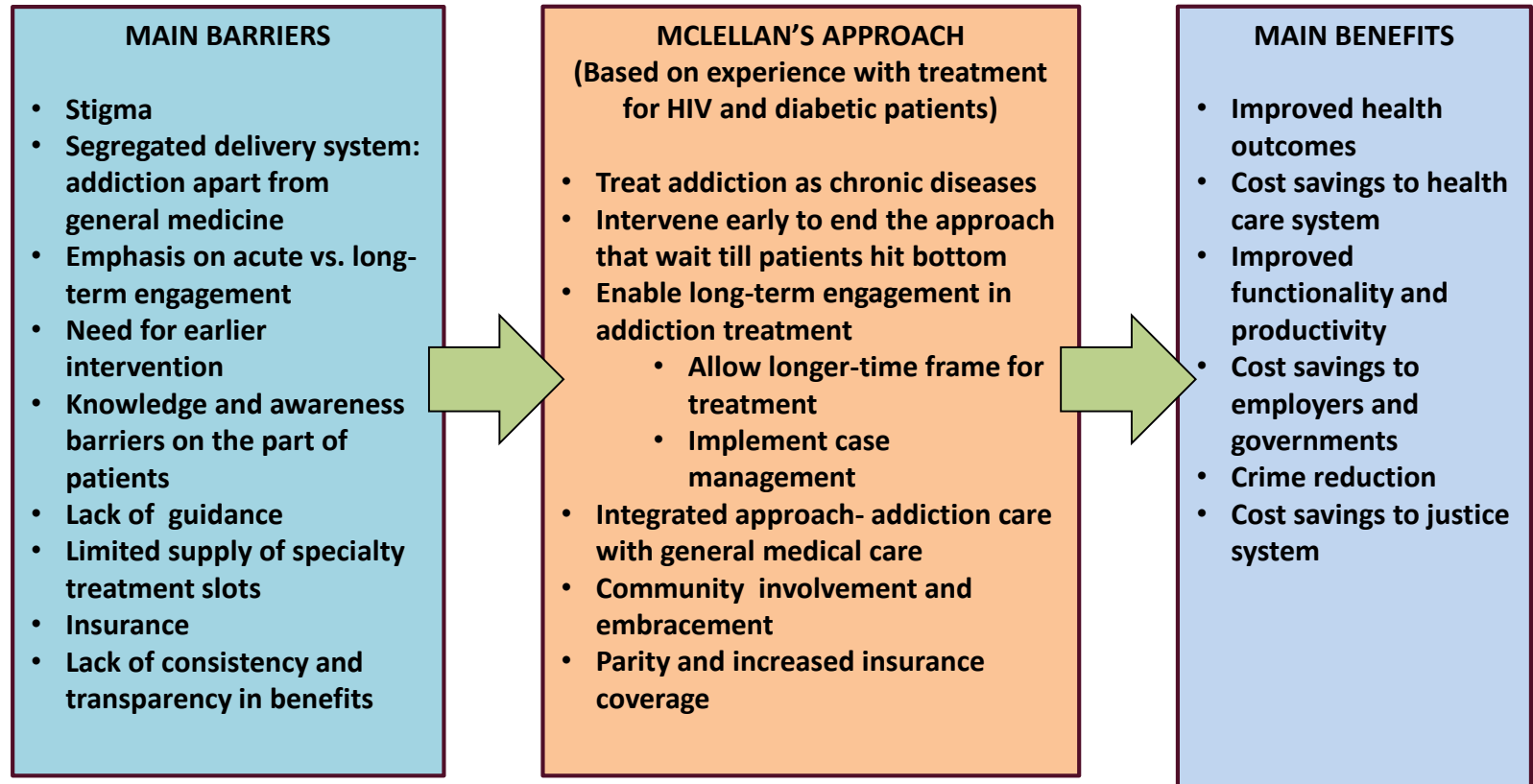
- 1) Substance use disorders are biologically-based chronic diseases that affect the brain as well as behavior**
- 2) Reduced harm and recovery from substance use disorders requires effective treatment and sustained case management**
- 3) Addiction treatment should be provided for a long enough period of time to produce stable behavioral changes (*)**

Duration of treatment and follow-up treatment is directly related to successful treatment outcomes and decreased criminal behavior ()**

Coverage and payment decisions recognizing the importance of long-term patient engagement could improve health outcomes

Source: (*) National Institute of Drug Abuse Treatment for Criminal Justice Populations, A Research-Based Guide, December 2012;
(**) Jackson, Treatment Practice and Research Issues in Improving Opioid Treatment Outcomes, July 2002.

Early Intervention, Long-Term Patient Engagement, and Integration Could Overcome Social Stigma and Reduce Access Issues



Source: Thomas McLellan, PhD, Commentary: Getting Past the Stigma and Treating Addiction as a Chronic Disease, July 2013; Bridget Kuehn, Addiction: White House seeks "Third Way", Policy Emphasizes Prevention, Treatment, Recovery, American Medical Association, 2013.

Policy Recommendations to Improve Addiction Treatment

- **Both the ACA and MHPAEA need to be fully implemented in order to achieve their intended effects**
- **Additional policy changes are still needed to address changing patient demographics and the resulting gaps in addiction treatment coverage and quality of care**
 - Address the Medicaid IMD exclusion
 - Modernize Medicare (to cover a full range of benefits, including residential treatment center services)
 - Mandate transparency in the disclosure of commercial insurance benefits for addiction treatment
- **It is essential to more fully develop the science behind the biology of substance use disorders**
- **More research is needed to collect National Outcome Measures (NOMs), with abstinence being just one of many outcomes that indicates “treatment is working” (e.g., improved health status, increased functionality and productivity, decreased criminal and justice system involvement, stable living situation, etc.)**
- **Delivery of addiction treatment needs to be better integrated with medical care, with a clear role for primary care providers, an improved referral system to specialists, and continuity of care**
- **As payment systems change from volume-based (i.e., fee-for-service) to value-based systems (e.g., accountable care organizations, bundled payments) over time, providers of addiction treatment will need to show “value” to patients, payers, and policymakers, and become an integral component of population health management**

Appendix

Methodology and Data Sources

Methodology

- **Environmental scan to analyze supply, demand, funding, and access issues**
 - Reviewing relevant government publications
 - SAMHSA: National Surveys on Drug Use and Health and National Survey of Substance Abuse Treatment Services
 - DHHS: Projections of National Expenditures for Mental Health Services and Substance Abuse Treatment (2004-2014)
 - Health Care Cost Institute
 - Office of National Drug Control Policy
 - Reviewing publications by major journals (e.g., Health Affairs, Journal of Studies on Alcohol and Drugs, Journal on Substance Abuse Treatment, and etc.)
 - Reviewing relevant legislation (e.g., ACA/MHPAEA)
 - Non-profit organizations, such as National Alliance on Mental Illness and the American Society for Addiction Medicine
- **Key Informant Interviews to supplement our findings**
 - Experts from government agencies
 - Experts from associations
 - Practicing clinicians
 - Insurance experts

Data Sources: SAMHSA

- **National Survey on Drug Use And Health (NSDUH)**
 - Target population: The estimates of drug use prevalence from the NSDUH are designed to describe the civilian, noninstitutionalized population aged 12 or older living in the United States. The total survey sample of 2013 NSDUH covered 227,075 people
 - Substance use disorder: is defined as meeting criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) for dependence or abuse for illicit drugs or alcohol, which are (1) problems at work, home, and school, (2) doing something physically dangerous, (3) repeated trouble with the law, and (4) problems with family or friends because of use of alcohol or illicit drugs in the past 12 months
 - Substance dependence: is defined in consistency with the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) as having the following symptoms: (1) spending a lot of time engaging in activities related to substance use, (2) using the substance in greater quantities, or for a longer time than needed, (3) tolerance, (4) unsuccessful attempts to cut down on use, (5) continued substance use despite physical health or emotional problems associated with substance use, (6) reducing or eliminating participation in other activities because of substance use, and (7) withdrawal symptoms
 - Illicit drug use: refers to use of any of the following drugs based on responses to questions: marijuana or hashish, cocaine (including crack), heroin, hallucinogens (including phencyclidine (PCP), lysergic acid diethylamide (LSD), and Ecstasy (MDMA), inhalant, or prescription-type psychotherapeutics used non-medically, which include pain relievers, tranquilizers, stimulants, and sedatives
 - Binge use of alcohol: is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days
- **National Survey of Substance Abuse Treatment Services (N-SSATS)**
 - Target population: N-SSATS is designed to collect data on the location, characteristics, and use of alcohol and drug abuse treatment from all facilities, both public and private, throughout the 50 states of the United States, that provide substance abuse treatment. The 2012 N-SSATS facility universe totaled 19,316 facilities
 - Facility capacity and utilization rates: Utilization rates were calculated by dividing the number residential (non-hospital) or hospital inpatient clients by the number of residential (non-hospital) or hospital inpatient designated beds. Because substance abuse treatment clients may also occupy non-designated beds, utilization rates could be more than 100%