

**The Effects of Health Care Reform on Access to, and Funding of,
Substance Abuse Services in Maine, Massachusetts, and Vermont**

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(NASADAD)

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Executive Summary

The findings from case studies of three States (Maine, Massachusetts, and Vermont) that have undertaken major health care reform (HCR) efforts highlight the continuing importance of the Single State Agency (SSA) in the management and delivery of publicly funded substance abuse (SA) prevention and treatment after HCR. The SSAs in these States have had important roles in implementing reforms in health care within the substance abuse treatment (SAT) and prevention systems. They serve as critical liaisons with nonmedical systems, including the criminal justice system and the welfare system.

The Substance Abuse Prevention and Treatment (SAPT) Block Grant remains a critical source of funding for State SAT systems after HCR. Though the numbers of uninsured have dropped in each of the case study States, none have come close to achieving universal coverage, to date. The publicly funded SAT systems in Maine, Massachusetts, and Vermont have seen steady increases in the numbers of uninsured clients served in recent years, and, based on anecdotal evidence, it seems unlikely that this trend will reverse in the near future. In addition, while HCR has increased private coverage for SAT, private insurance does not provide funding for recovery-oriented supports such as child care, transportation, housing, and employment/ job services traditionally delivered by SAT providers.

Also, the SAPT Block Grant remains the primary funder of SA prevention services in these three States. In fact, HCR did not result in any increased support for SA prevention by private or public insurance in any State.

In this study, HCR is defined broadly to include any of a number of significant system redesign and/or financing initiatives, including these:

- Legislation to expand insurance coverage touted as “Health Care Reform,” such as changes in employer-based and other private health insurance, Medicaid, and subsidized private insurance;
- Mental health and SA parity/mandate legislation;
- Performance contracting/pay-for-performance initiatives;
- Workforce initiatives; and
- Process-improvement programs.

The intention of these case studies was to identify and describe HCR-related changes in: financing patterns; organization of the public treatment system; and improved access to, utilization, quality, and cost of SA services.

The SSA in each of these three States works on a daily basis to maintain and build relationships with other systems, especially the primary care system and the criminal justice system. Key commonalities across the States were found:

1. The SSAs are in the process of undertaking major systemic changes to move from an acute-care model, which relies heavily on expensive episodes of care (such as care in long-term residential treatment), to a recovery-oriented system-of-care (ROSC) model. The ROSC model provides individualized treatment through a continuum of care and systematically moves clients, as appropriate, from more-intensive to less-intensive

levels of care. It also combines ongoing client oversight with the use of more community services, particularly self-help.

2. Each of these States is experiencing a major opiate epidemic. This has caused all the States to undertake initiatives to reorient the mix in the types and levels of care that are offered, including use of primary care.
3. All of these States have used their SAPT Block Grant funds to significantly expand the availability of medication-assisted treatment services over the past 5 years.

HCR has focused on increasing access, capacity, and quality of services while containing rising health care costs, and this focus has been applied to both SA (and mental health) as well as “physical” health services. All three States have passed mandates as well as parity for SA services in private insurance plans.

State-Specific Findings

In **Maine**, access to publicly funded SAT providers increased by 32 percent between 1999 and 2008. This increase was due to the expansion of SAT services covered under Medicaid (including medications), expansion of the population covered by MaineCare (Medicaid), and increased provider efficiencies through performance contracting and improved treatment admissions processes.

In **Massachusetts**, admissions to public SAT rose nearly 20 percent in only 2 years between 2006 and 2008. Improvements in access, capacity, and quality were achieved through MassHealth (Medicaid) expansions in covered populations (particularly “non-categoricals,” or adults with no dependent children); a process-improvement initiative; and efforts that address workforce development, as well as increased use of evidence-based practices.

Vermont saw the number of persons treated in its public SAT system double between 1998 and 2007. This was accomplished through strategic planning initiatives at the State and division levels; increased health insurance coverage for individuals through Green Mountain Care (Medicaid); expanded Medicaid coverage of treatment, including medication-assisted treatment (both methadone and buprenorphine); and a treatment admission process-improvement initiative funded with SAPT Block Grant monies.

Findings Common to the Three States

In addition to the State-specific findings shown above, several findings were common to all three States.

1. Each State was able to increase access to SAT through Medicaid expansions, increases in the SSA’s budget by the State, process improvement demonstrations, and the creation of publicly subsidized, private insurance plans.
2. A variety of funding sources was used to pay for HCR. They were able to achieve some cost savings through the use of administrative services organizations (ASOs).
3. There are still challenges that need to be addressed including enforcing parity laws, addressing workforce shortages and increased administrative costs for SAT providers that seek to get reimbursement through Medicaid and/or private insurance.

4. The SAPT Block Grant, State general appropriations, and the SSA continue to play important roles in assuring that people with SUDs have access to high quality services, particularly prevention services and “non-medical” services.

Increased Access

In each of the three case study States, the number of SAT clients treated by publicly funded specialty providers has steadily risen. This is due to a variety of policy changes including:

- **Medicaid Expansions** (particularly the expanded coverage of nondisabled childless adults aged 21 to 64 [non-categoricals]) have resulted in many public SAT facilities serving larger numbers of Medicaid-insured clients.
- **Increased funding through the SSA** – All three of these States have significantly increased their spending on SAT. Increased funding, which has come from State general funds, tobacco settlements and SAMHSA/CSAT has also enabled SAT providers to serve additional clients, despite increasing costs of care.
- **Process-improvement demonstration projects** have successfully expanded access to outpatient SAT services without costing additional dollars. Maine has successfully used pay-for-performance measures to improve provider efficiency.
- **Publicly subsidized private insurance** - In Massachusetts, public providers have seen more clients seeking treatment with subsidized private health insurance in the past 3 years, but public SAT providers in Maine and Vermont have treated very few clients with subsidized private health insurance.

Funding for HCR

Various funding sources have been used by these States to increase funding for insurance coverage and SA services, including:

- Increased tobacco taxes and liquor taxes;
- Federal matching funds from Medicaid;
- “Fair share” employer contributions;
- Individual insurance premiums (from mandated policies in Massachusetts as well as graduated premiums from “lower” income subsidized policies); and,
- State general appropriations.

In each of these States, HCR has created some cost savings through a decrease in emergency costs and a reduction in costs of care for the uninsured. In addition, administrative services organizations have successfully cut the costs of SAT through decreasing the lengths of stay in residential treatment in Massachusetts and Maine, although the impacts of ASOs on the quality and outcomes of treatment are not known.

New Challenges Associated with HCR

Despite increased access to SAT for low-income residents in each of these States, HCR has illuminated challenges for the field.

Public SAT providers still have more treatment requests from the uninsured than they have funding for, even as the proportion of State residents who are insured rises.

- **Enforcing parity laws** - All three of these States have enacted laws that mandate private insurance coverage for SA and mental health services, as well as parity laws. However, simply enacting parity laws has not been a panacea. Specifically, residential providers in each of these States report that it is still very difficult to get private insurance plans to pay for care in their facilities.
- **Workforce shortages** – in Vermont and rural Maine providers have had difficulty recruiting SAT professionals with credentials and certifications that match insurance companies’ requirements for reimbursement. As SAT is integrated with that of primary health care, recruiting doctors and nurses with appropriate experience and interest in patients with SUDs is also a challenge for States.
- **Administrative support requirements** – administrative costs associated with billing multiple payment sources (especially multiple private insurers) represent a significant increase in costs for community based organizations (CBOs).

In addition, HCR does not directly address the relationships that SSAs have with other nonmedical systems within the State (e.g., the criminal justice system, the welfare system, and the housing system).

The SAPT Block Grant and the SSA Continue to Have Vital Roles after HCR

Although each of these States undertook major HCR initiatives to expand both private insurance and Medicaid coverage, there continue to be vital roles for the SSA and Block Grant dollars. These States use their Block Grant funds to:

- **Pay for medically necessary services that are not covered by other payers,** particularly residential treatment;
- **Pay for “non-medical” services not covered by public or private health insurers** including case management, other recovery support services, housing, child care, transportation, and employment counseling;
- **Improve the infrastructure of the State SAT system;**
- **Address new challenges;**
- **Implement innovative services;** and
- **Fund SA prevention services.**

It will be important to further evaluate these and other HCR efforts for their effects on the State, and specifically on SA services within the State. Future work should include quantitative analyses of use and financing patterns. Such efforts could use each SSA’s data, as well as data from Medicaid and private insurance plans.

Introduction

As a result of increasing numbers of uninsured Americans¹ and skyrocketing health care costs,² access to medical care in America has been significantly compromised (Lasser, Himmelstein, and Woolhandler, 2006). Because of this, it has become increasingly obvious that HCR measures are necessary in the United States. As reform debates at the federal and State levels move forward, the SSAs in charge of drug and alcohol treatment and prevention in each State have begun to consider the opportunities and challenges that HCR will create for delivery and financing of alcohol and other drug (AOD) services, organization of the public treatment system, and access to care and utilization of SA services.

NASADAD staff, with funding from SAMHSA/CSAT, conducted case studies of three States—Maine, Massachusetts, and Vermont—that have recently undertaken major HCR efforts. The goal of these case studies was to better understand the effects of HCR on access to and the financing of substance use treatment, prevention, intervention, and recovery services. NASADAD staff set out to describe the financing patterns—both prior to HCR and as promulgated under the plan—and to obtain quantitative data and collect qualitative information about whether and how the HCR initiative has impacted access to care for the low-income uninsured population.

Both policymakers and researchers have realized the importance of looking to State models as inspiration for federal policies (McDonough, Miller, and Barber, 2008; Ross, 2009). Quinn (2008, p. 341) specifically calls for researchers to find “solid evidence from rigorous state-level research and policy analysis” to help State and federal policymakers understand the impacts of different approaches to HCR. States have been the crucible for innovative HCR efforts, and wisdom gained needs to be better articulated and shared.

Although 39 States enacted laws to expand access to health insurance between 2006 and 2008 (McDonough, Miller, and Barber, 2008), only the three States examined in this study—Maine, Massachusetts, and Vermont—have enacted legislation that sought to achieve universal health coverage. Because of this, scholars and advocates have rushed to analyze the similarities and differences between HCR in these three States (Kaye and Snyder, 2007) and to evaluate the policies that make up HCR in each State to determine their effectiveness at meeting their stated goals (Lipson et al., 2007; Martin and Rooks, 2009; Steinbrook, 2006). Many authors are specifically concerned about the costs of HCR to the States (Raymond, 2009; Steinbrook, 2008). None of the publications that resulted from these studies focused on the coverage, delivery, or costs of SA or mental health services.

There has been relatively little recent scholarly work about how SA services will be funded, administered, or accessed as part of the recent HCR efforts. Yet during the early 1990s, the Clinton Administration convened a working group on mental health as part of the President’s Task Force on Health Care Reform. Charged to create a federal HCR policy, some scholars and public administrators considered the ways that SA services could be integrated into, and

¹ Over the past 10 years, the numbers of uninsured Americans have risen exponentially (Kaiser Commission on Medicaid and the Uninsured, 2006) and according to a Lewin Group report, one out of every three Americans under the age of 65 was uninsured for some period of time during 2007 and 2008 (Families USA, 2009).

² Health care costs doubled between 1996 and 2006 (Orszag, 2008). According to the Centers for Medicare and Medicaid Services, the United States spent approximately \$2.2 trillion on health care in 2007.

might be affected by, reform efforts. Specifically, the members of this working group considered the ways that mental health and SA services should be integrated into a national HCR model. Based on estimates of the direct costs of alcohol/drug abuse and mental disorders, the work group identified three important objectives for HCR:

1. Containing costs for SA/mental health services requires a move away from heavy reliance on inpatient mental health/SA care.
2. Integrating SA/mental health care into primary care requires developing systems within health plans that can efficiently manage the complex and extensive treatment needs of people with severe, chronic diseases, while guarding against incentives to undertreat this population.
3. The existing variation in public financing of mental health/SA care should be accommodated in a way that is fair to all States within a national uniform benefit (Arons, Frank, Goldman, McGuire, and Stephens, 1994; Frank, McGuire, Regier, Manderscheid, and Woodward, 1994).

Methodology

With the assistance of the NASADAD Research Committee, a Discussion Guide was developed before interviews were conducted to assure comparability in information collected in each of the three States. This guide included questions about how SA services were covered under private and public health insurance plans prior to HCR, how coverage changed under HCR, and how perceptions of access and utilization changed pre- to post-HCR. The resulting discussions were meant to obtain data to document the effects of HCR, rather than just perceptions; examine the configuration of the public treatment system (whether/how it changed); and look at how the SAPT Block Grant factored into the service system in ways that are unique and distinct from “mainstream” health insurance. The goal of this study was to identify large-level policy shifts, not to provide an in-depth examination of the changes in funding streams for the SSA and SAT providers. In addition, the guide asked about all levels of care; focused on adult populations; and did not ask about, or seek to separate, the State Children's Health Insurance Program from Medicaid programs. Finally, in this paper, the term “admissions” refers to entry into SAT at any level.

In May 2009, NASADAD staff conducted 2-day site visits to each of the States (an unanticipated State internal budget exercise, which could not be delayed and required the attention of the anticipated interviewees, shortened the NASADAD staff's visit to Massachusetts). Site visit interviews were scheduled by the SSAs in each State and interviews were held with a variety of State agency staff as well as providers, including employees of the SSA in charge of SAPT services, the lead agency on HCR, Medicaid (those responsible for behavioral health and the “carve-out”), the subsidized health insurance plan for the low-income population, and SA providers contracted by the SSA. The topics and questions were tailored to the individuals being interviewed. The data collected during this study were primarily qualitative, although one of the goals was to identify data sources that might be accessed and analyzed (in a future effort) to provide quantitative data about changes in treatment access.

In these interviews and case studies, HCR is defined broadly to include the legislation touted as “Health Care Reform” and the following policies and practices:

- Changes in private and employer-based health insurance;
- Changes in State-subsidized health insurance plans for low-income workers;
- Medicaid expansions;
- Mental health and SA parity/mandate legislation;
- Performance contracting/pay-for-performance initiatives;
- Workforce initiatives; and
- Process-improvement programs.

State Case Studies

These three case studies, which are presented in alphabetical order by State, are meant to give a qualitative picture of the effects of HCR on the State AOD systems. In each of these States, the SSA is:

- Constantly negotiating relationships with other systems, especially the primary care system and the criminal justice system;
- In the process of undertaking major systemic changes within its agencies to move from an acute-care model, which relies heavily on expensive long-term residential treatment, to the ROSC model, which provides ongoing oversight/care combined with use/emphasis of more community services, particularly self-help;
- Combating a major opiate epidemic, which has caused each State to undertake initiatives to rebalance the types and levels of care that are offered (as a result of improving technology and decreasing stigma, each of these States has significantly expanded its medication-assisted treatment services over the past 15 years);
- Serving a larger number of clients (admissions to and public funding for SAT services have significantly increased in each of these States in recent years; States have used performance-based contracting and continuous quality improvement techniques to increase the number of clients that can be served with existing providers).

Each case study provides an overview of HCR-related changes that have occurred recently and describes the effects of these reforms on access to, and funding of, SAT services. A description of possible data sources that might be mined for future quantitative research on the effects of HCR on the State SA service system is also included. Finally, each case study describes the continuing importance of the SAPT Block Grant dollars to the public SA service system in the State.

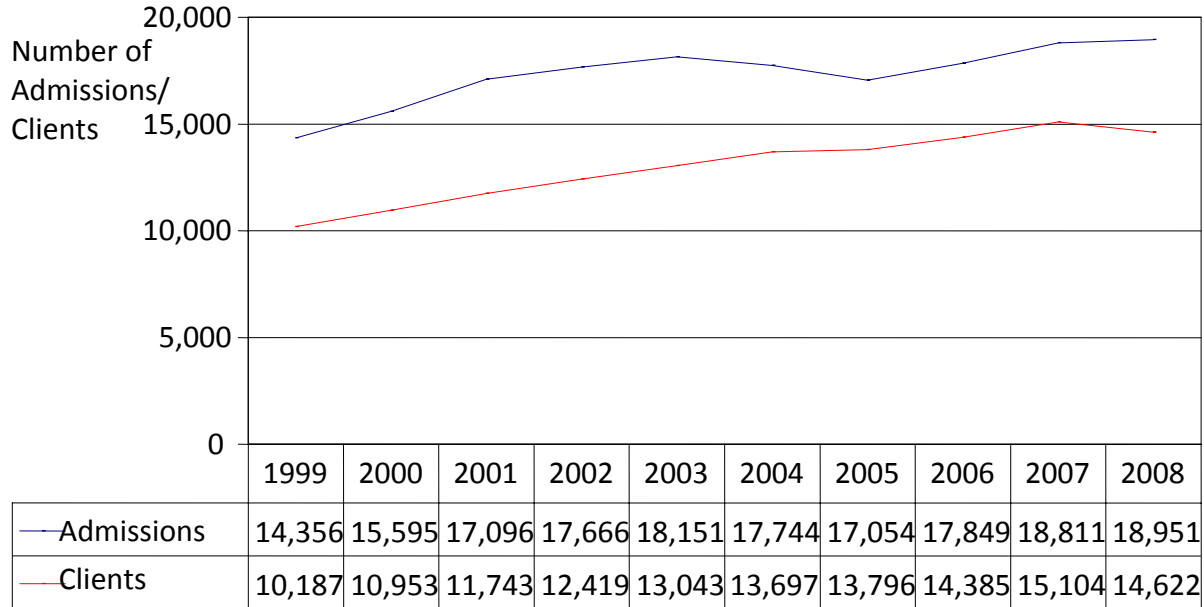
Maine

HCR in Maine has leveraged a material increase in access to the public treatment system—an increase of 32 percent over 9 years. The major factors have included (1) initiation of coverage of SAT under Medicaid (including medications), (2) expansion of the population covered by MaineCare (Medicaid), and (3) increased provider efficiencies through performance contracting and process assessment/improvement rapid change cycles. In addition, MaineCare has achieved cost savings through use of patient placement criteria, managed by an administrative-services-only contract. Despite these and other reform efforts (including parity legislation and the creation of DirigoChoice, a State subsidized health insurance plan for low-income Maine residents), there are no public data available that show increased access to SAT services or payments from the privately insured. The SAPT Block Grant fills critical gaps in the service continuum; it is used to pay for prevention, residential care, and psychosocial services.

Numbers Served

Figure 1, which uses data from the Maine's Office of Substance Abuse (OSA) Treatment Data System, shows that the number of clients served by the publicly funded SAT system in

Figure 1: Admissions to SAT in Maine, 1999-2008



Maine rose nearly 50 percent between 1999 and 2008. OSA’s budget increased at a similar pace during this time, rising from \$16.6 million in 1999 to \$30.8 million in 2008.

Between 1996 and 2002, MaineCare (Medicaid) expenditures for persons with SA/mental health/developmental disability conditions increased by 118.5 percent, mostly due to increased coverage of services, rather than increases in enrollment (Payne, Bratesman, and Lambert, 2005).³ In 2002, Maine received a section 1115 waiver from the Centers for Medicare and Medicaid Services (CMS) to allow non-categorical, nondisabled childless adults aged 21 to 64 living below the federal poverty level (FPL) to enroll in MaineCare, significantly increasing access to SAT services. However, MaineCare costs far exceeded expectations, and enrollment was frozen in 2005. Limited enrollment was re-opened in 2006.

In 2005, MaineCare eligibility was also expanded under the Dirigo Health Reform Act⁴ to include parents of children under the age of 19 in families with incomes up to 200 percent of the FPL (the previous limit was 150 percent FPL). As part of this expansion, 5,000 people were enrolled in MaineCare in November 2006. Enrollment for this population has not been capped.

Also in 2005, Maine opened enrollment to DirigoChoice, a subsidized insurance plan for low-income Maine residents, the self-employed, and businesses with fewer than 50 employees. Dirigo Health Agency contracts with private insurance providers (Anthem Blue Cross/Blue

³ For persons without a behavioral health diagnosis, costs rose by only 29.5 percent (Payne, Bratesman, and Lambert, 2005).

⁴ Maine was the first State to enact a bill aimed at providing universal health care coverage when Governor John Baldacci signed the Dirigo Health Reform Act in 2003. The goals of this bill were to reduce health care costs, expand health insurance coverage, improve the health of Maine residents, and increase the quality of health care services. The bill expanded eligibility for MaineCare and created DirigoChoice health insurance, a subsidized insurance plan for those earning up to 300 percent of the FPL.

Shield; Anthem was replaced by Harvard Pilgrim Health Care in January 2008) to administer DirigoChoice. It was hoped that through DirigoChoice, universal health insurance coverage could be achieved. Unfortunately, Dirigo was not as popular as expected, and enrollment was lower than anticipated, bringing in fewer monthly premiums than projected. In addition, the expansion of services was not balanced out by the anticipated reductions in other services (emergency services and services for the uninsured); cost estimates were exceeded, while expected savings were lacking.

Substance Use Disorder Treatment Capacity, Quality, and Efficiency

OSA staff believe that its providers are able to provide improved substance use disorder (SUD) services more efficiently due to their participation in the Network for the Improvement of Addiction Treatment (NIATx) Strengthening Treatment Access and Retention-State Implementation (STAR-SI) initiative, which is funded by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) and the Robert Wood Johnson Foundation. This initiative tries to identify how State leadership can improve treatment quality, use continuous quality improvement cycles to learn about how States and other payers can work with providers to improve treatment access and retention, and document and disseminate innovative practices that have improved performance. OSA received the STAR-SI grant in the fall of 2006. Since then, the agency has engaged 3 cohorts of outpatient providers, about 20 total providers, who volunteered to be part of the initiative in exchange for a small stipend. OSA staff and providers have preliminary data showing that this initiative has been very successful and has enabled providers to treat larger numbers of people with the same level of funding.

Maine has also successfully implemented a pay-for-performance initiative. Performance measures on efficiency and effectiveness are written into contracts between OSA and the providers. To receive their full payments, agencies must provide the full number of units of service that they contract for, and their clients must achieve certain outcomes. To track their own progress, providers can access real-time data through Maine's information technology (IT) system. OSA staff noted that early attempts at performance management (in the early to mid-1990s) had negative and unintended consequences, accidentally incentivizing "creaming of clients," which OSA did not expect. However, OSA is pleased with the success of the current incentive structure. Leaders attribute much of this success to their own efforts to involve providers in both planning and providing technical assistance. OSA staff members regularly monitor provider performance through the IT system and provide technical assistance to providers in understanding their reports.

Who Is Covered by HCR?

While falling short of the goal to insure all Maine residents by 2009, the uninsured rate in Maine dropped from 13 percent in 2002 to 10.3 percent in 2007. Between 2005 and 2007, 34,200 formerly uninsured Maine residents enrolled in a health insurance policy.

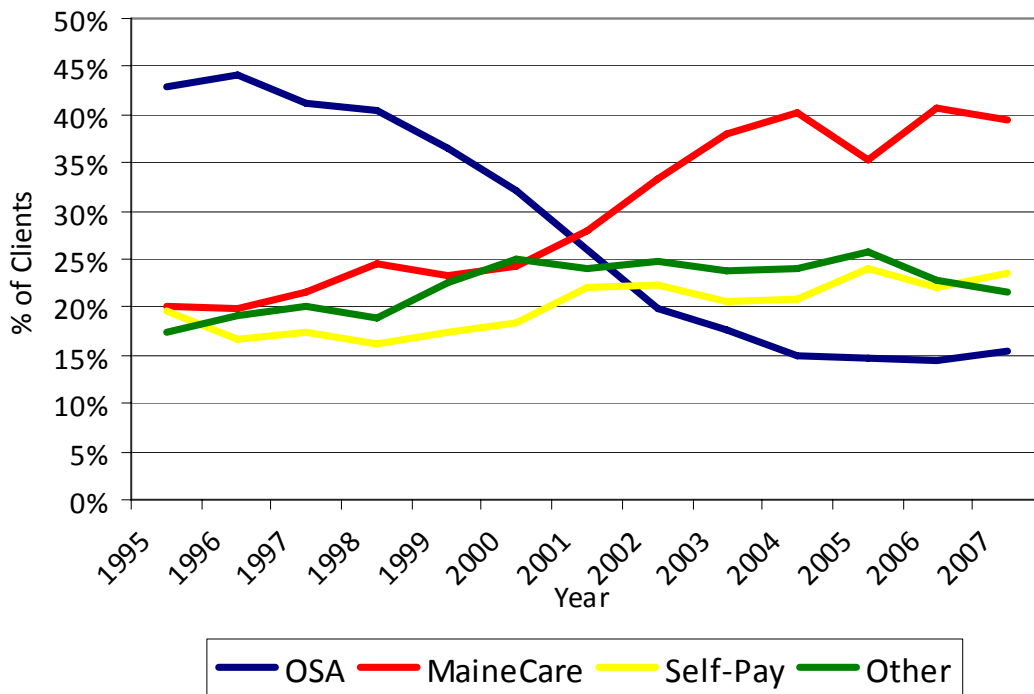
A 2007 evaluation of the effects of the Dirigo Health Reform Act by Mathematica, Inc., found that approximately two thirds (23,100) of the people who gained coverage between 2005 and 2007 did so through MaineCare (Lipson et al., 2007).

The expansion of MaineCare into expanded SA services has led to a major increase in access to SA services for Maine residents. The proportion of SA clients whose treatment was paid for by

MaineCare rose from 20 percent in 1995 to 39 percent in 2007. Community-based organizations (CBOs) have seen more clients with insurance (both MaineCare and private insurance), bringing in revenue in addition to funding from OSA, which has in turn allowed them to expand access to other clients. However, since Medicaid eligibility and spending were capped, fewer clients seeking SAT services are enrolled in MaineCare, and this situation is seriously affecting providers' economic viability.

Figure 2 shows the importance of MaineCare reimbursement for publicly funded SAT providers. MaineCare paid for the treatment of nearly 40 percent of SAT clients in 2006 and 2007. The chart also shows a significant decrease in the percentage of clients whose treatment is wholly supported by OSA. This is because OSA now invests a significant amount of its budget (\$5 million, or 17 percent of its budget in 2008) in MaineCare State Match for treatment. The State of Maine must provide approximately one third of the funding for Medicaid; the rest is funded by the federal government. By using its dollars

Figure 2: Percent of SAT Clients By Payor (at Discharge)



to provide “seed money” for Medicaid reimbursement of SAT services, OSA is able to leverage nearly \$10 million in extra funding. As of September 2006, 20 months after enrollment began, about 15,000 Maine residents had ever been enrolled in the DirigoChoice health plan, the State’s publicly subsidized health insurance for low-income workers (those not eligible for MaineCare but below 300 percent of the FPL), self-employed Maine residents, and businesses with less than 50 employees. This was about half of the 30,000 total enrollees (not just those with SUDs) that had been expected (Lipson et al., 2007). However, due to State budget problems, Dirigo enrollment has also been capped since 2007; only new dependents for existing members, new workers for currently participating employers, and applicants who do not need subsidies can enroll. A total of 11,000 members and 621 small groups (in addition to the 11,000 individuals) were enrolled in January 2009.

Although Dirigo provides comprehensive SA benefits, it appears to have had little effect on access to SAT services: Public sector providers reported that few, if any, of their clients were covered through DirigoChoice. The percentage of clients who received treatment from publicly funded SAT providers remained fairly constant between 2004 (when the OSA Treatment Data System began to collect data on insurance coverage) and 2007. There are no data currently available about admissions to private-pay SAT.

Services Covered

Although Maine passed parity for SA and mental health treatment legislation in 2003, it is unclear at this time whether this has improved access to care for those with private insurance, or with the Dirigo-subsidized insurance plan, as there are no public data systems able to assess this.

Medication-assisted treatment services are in high demand in Maine due to the opiate epidemic that the Northeast has experienced since 2002. Both MaineCare and DirigoChoice cover methadone and buprenorphine, though OSA does not know how many, or which, clients are receiving buprenorphine prescriptions from independent clinicians, mental health facilities, or primary care physicians. MaineCare is the primary funder of opioid treatment programs in Maine. In addition to MaineCare funding, there is a limited amount of public financing through OSA to pay for medication-assisted treatment for residents who lose MaineCare coverage. Methadone is funded through OSA, which pays for treatment for the uninsured.

Costs for Individuals

One of the goals of HCR in Maine was to decrease the rate at which health-related costs had been growing. The Maine Center for Economic Policy (Martin and Rooks, 2009) reported that the rate of growth in health insurance premiums decreased from 13.2 percent between 2001 and 2003 (before the Dirigo Act was implemented) to 6.4 percent between 2004 and 2006 (after the Act was passed).⁵

However, OSA staff and providers noted that all Dirigo plans require enrollees to pay small monthly premiums, although they are subsidized based on income. In addition, deductibles range from \$250 to \$2,500 for individuals, and from \$500 to \$3,500 for families. Although this deductible may discourage enrollees from seeking medical care (especially SAT services), it still represents a significant cost savings for individuals as compared to deductibles from unsubsidized private insurance plans.⁶ In addition to the deductible, Dirigo enrollees pay a co-pay for all office visits (\$25 for in-network visits, \$35 for out-of-network visits). However, out-of-pocket costs are limited to between \$700 (for a single person) and \$9,600 (for a family), based on the plan and income level. There are no lifetime limits on SAT services.

Most MaineCare enrollees are not required to pay monthly premiums. Non-categoricals enrolled in MaineCare who earn over 150 percent FPL are required to pay small (\$10 to \$20)

⁵ Across New England, insurance premiums rose, on average, 10.1 percent between 2001 and 2003. Between 2004 and 2006, premiums across New England increased by 8.1 percent (Advisory Council on Health Systems Development, 2009).

⁶ According to a Mathematica report, nearly three quarters of individual policies in Maine had deductibles of \$5,000 or more in 2006 (Lipson et al., 2007).

monthly premiums. In addition, MaineCare co-pays, which range from \$2 to \$3, are capped at \$25 per month.

Funding HCR in Maine

The Dirigo Health Reform Act cost Maine \$53 million to launch in 2003. Maine hoped to finance additional HCR costs through cost savings to the State's hospitals and to insurance companies from fewer emergency visits by the uninsured, among other savings sources. Hospitals in Maine agreed to voluntarily limit their profits to 3 percent and annual growth in spending per patient to 3.5 percent. Private health insurers and hospitals were required by law to pay a percentage of their profits, called a savings offset payment, to the State.⁷ The amount of savings created by the Act—and thus the amount that private insurers and hospitals must pay—was controversial; despite having been declared legal by the Maine Supreme Court, the savings offset payment has been replaced by law with monthly Access Payments,⁸ which must be paid by health insurance carriers, third-party administrators, and employee benefit excess insurance carriers as of October 2009.

In addition, Maine is transferring unused Medicaid Disproportionate Share Hospital funds, supplemented with tobacco tax revenues, to finance the current expansion for non-categoricals. By increasing Medicaid eligibility, Maine also will be able to leverage additional federal matching dollars (the State receives nearly \$2 in federal matches to every dollar spent by the State government on Medicaid costs). However, Maine has not been able to receive a federal match on DirigoChoice premiums paid by employers and individuals as initially hoped, because the application for a waiver was rejected by the CMS. That ruling is now under appeal.

According to the Maine Center for Economic Policy, between 2006 and 2009, the Bureau of Insurance has recognized \$160 million in savings over 3 years, and this amount has been paid to the Dirigo Health Agency. Of these savings, the Bureau of Insurance attributes the largest amount, \$113 million (71 percent), to the voluntary annual cap on cost increases by hospitals (Martin and Rooks, 2009). However, these estimates are controversial and are being contested in court by health insurance companies. In the future, Maine hopes to increase cost savings through the implementation of prevention programs, electronic health records, pay-for-performance measures, and patient-centered medical homes.

OSA has implemented its own cost-saving measures. Beginning in December 2007, patients seeking admission to all levels of SAT were required to get prior authorization from an administrative services organization, APS Healthcare, to receive reimbursement from MaineCare, though providers did not have to show medical necessity. APS has begun to require SAT providers to use American Society of Addiction Medicine criteria to show medical necessity. Even without implementing more stringent medical necessity requirements, APS claims that the length of stay decreased over the past 2 years across modalities (including residential and outpatient treatment). The administrative services organization hopes to release a report with data supporting these claims in the future.

⁷ The exact percentage of profits is determined annually by the Dirigo Health Agency Board of Directors, based on an estimate by the Superintendent of Insurance.

⁸ Access payments must equal 2.14 percent of the company's annual paid claims.

Data

OSA collects real-time data on treatment admissions and discharges through its Treatment Data System, which is accessed through the Internet. In addition, OSA is working with other agencies in Maine to create a central client registry that will link records across systems. The Maine Health Data Organization, which collects inpatient and outpatient client-level data from State hospitals, also makes de-identified data publicly available. Other possible data sources that might be used to investigate the ways in which HCR has affected access to SAT services by the newly insured include claims databases maintained by Maine's Administrative Services Organization, APS Healthcare, and the Dirigo Health Agency.

The SAPT Block Grant

OSA staff emphasized the continued importance of SAPT Block Grant funds after HCR. These funds make up 22 percent of OSA's budget and are used for a variety of purposes not funded by State dollars, including the following:

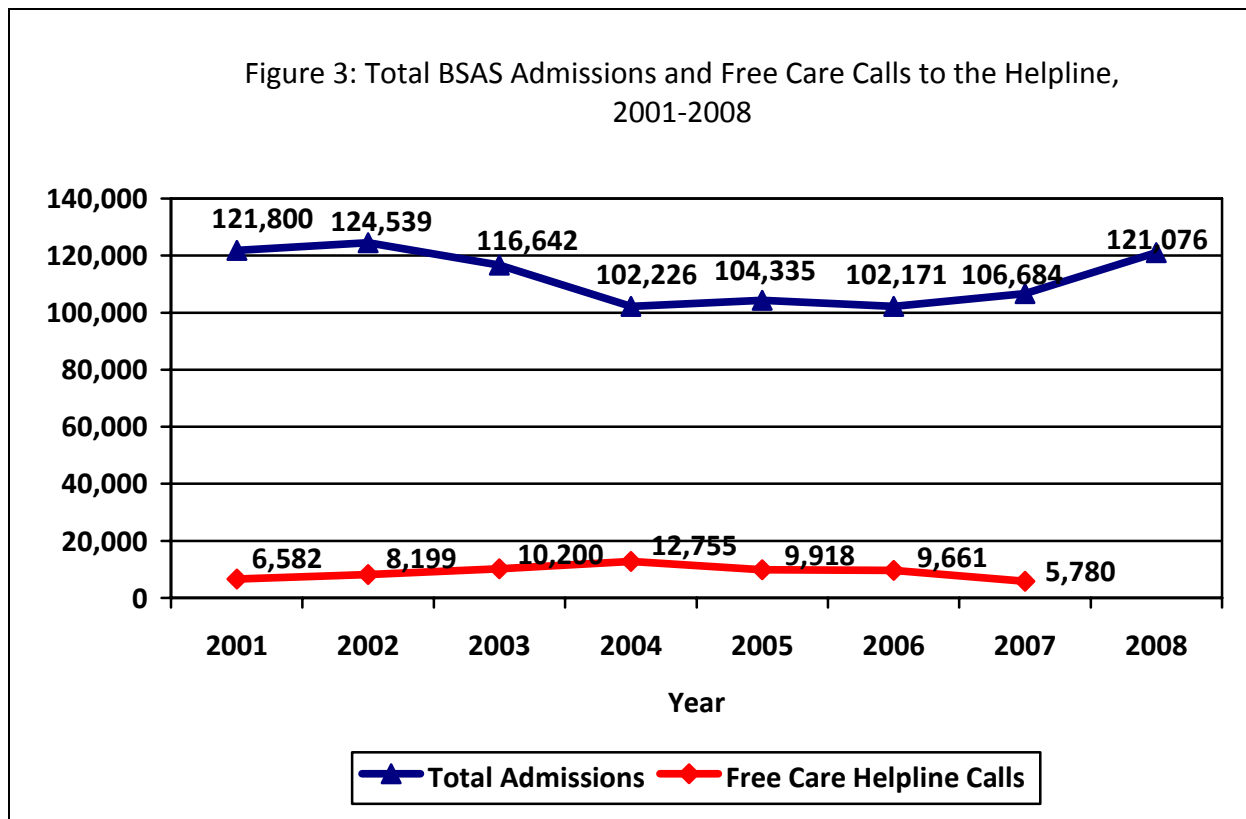
- Prevention services;
- Childcare and other "nonmedical" services;
- Services for those recently released from the criminal justice system, as well as others without health insurance; and
- SA services not covered by insurance plans (Medicaid or private insurance), especially residential care.

Massachusetts

In Massachusetts, HCR has led to expanded access, capacity, and quality across the public SAT system. The Bureau of Substance Abuse Services (BSAS) staff identified a variety of initiatives that helped to achieve these goals, including (1) MassHealth (Medicaid) expansions, particularly the inclusion and expansion of non-categoricals to allow coverage of childless adults; (2) substantial increases in funding to the SSA; (3) a process-improvement initiative (NIATx); and (4) and increased focus on workforce development and evidence-based practices. Despite these improvements in the system, out-of-pocket costs and gaps in insurance coverage still impede access to SAT for some Massachusetts residents. Although health care costs in the State have exceeded projections, the Commonwealth has been able to cut the costs of SA services by implementing a managed care system. SAPT Block Grant funds are critical to the SAT system in Massachusetts, and are used to fund (1) prevention services, intervention, treatment, and recovery support services that are not reimbursed by other payers (including services for the uninsured); (2) workforce development initiatives; (3) psychosocial support services; (4) prevention services; and (5) start-up costs associated with new or novel services.

Numbers Served

Funding for the BSAS increased by \$67 million between 2005 and 2009. Figure 3 shows admissions to publicly funded treatment services in Massachusetts from 2001 to 2008. Admissions to SAT rose nearly 20 percent in only 2 years between 2006 and 2008. Figure 3



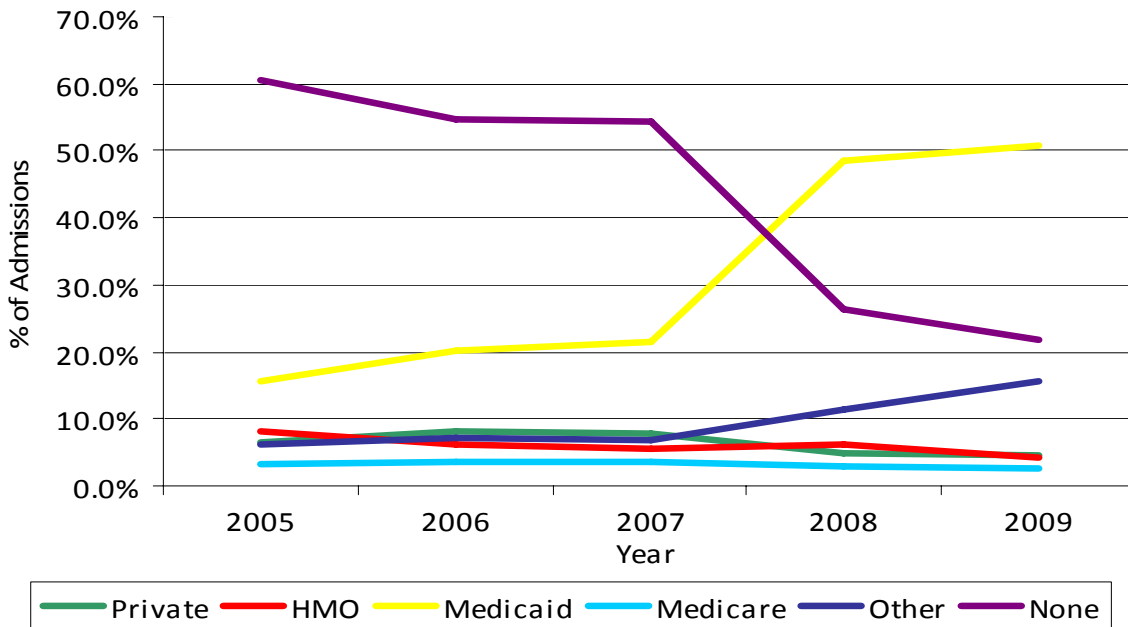
also shows the number of calls requesting access to a “free” bed (due to lack of insurance) received by the Massachusetts Substance Abuse Information and Education Helpline, a State-

funded organization that provides information and referrals for AOD abuse problems and related concerns, which dropped more than 50 percent between 2004 and 2007. This suggests that increased insurance coverage allowed people who would have called the Helpline to receive SAT services either in public or private SAT facilities.

In 1997 and 2006, Massachusetts received federal waivers that allowed for the expansion of MassHealth (Medicaid) eligibility to non-categoricals, nondisabled childless adults aged 21 to 64 earning less than the FPL, significantly increasing access to SAT services and reimbursements for providers. MassHealth is unique in that enrollees must choose from several available MassHealth plans, each administered by a different private insurance company. In 2006, the Massachusetts legislature expanded MassHealth benefits to children up to 300 percent of the FPL, and increased the enrollment cap on MassHealth programs (Massachusetts Legislature, 2006a).

Figure 4 shows that the percentage of clients enrolled in MassHealth who were admitted in the publicly funded SAT system rose by more than 300 percent between 2005 and 2009. According to Treatment Episode Data Set information, clients with MassHealth made up 47 percent of all admissions to the public treatment system between 1999 and 2007 (MassHealth clients made up less than 20 percent of admissions in 1997 and 1998).

Figure 4: Percent of Admissions to SAT in MA By Insurer, 2005-2009



SUD Treatment Capacity, Quality, and Efficiency

Massachusetts BSAS staff believe that its providers are able to render improved services more efficiently due to their participation in the NIATx 200 initiative, which is funded by a National Institute on Drug Abuse grant. This initiative uses a continuous quality improvement process to “reduce waiting times between a client’s first request for service and first treatment session, reduce client no-shows, increase admissions to treatment, and increase the rate of continuation between the first and fourth treatment sessions.” A small proportion of BSAS

providers (approximately 40) volunteered and have received different combinations of Web support, peer coaching, and the wherewithal to participate in a learning collaborative. Participation in this initiative is credited with increasing access and treatment without expending additional dollars. BSAS hopes to have data to support these anecdotal claims in the near future.

Other aspects of HCR in Massachusetts have included workforce initiatives, such as the BSAS “Innovation Conference,” which showcased SAT providers in Massachusetts that have implemented inventive and effective practices. BSAS has begun to emphasize the importance of evidence-based practices, especially cognitive behavioral therapies and motivational interviewing. The adoption of evidence-based practices has enabled providers to improve the quality of their treatment. In addition, BSAS has been experimenting with performance contracting/pay-for-performance since the early 2000s. BSAS is also working with SAT providers to identify appropriate outcome measures. This approach should help providers to improve the quality of the care that they provide.

Who Is Covered by HCR?

By June 2007, all Massachusetts residents were required to purchase health insurance coverage or pay a financial penalty.⁹ By June 2008, only 2.6 percent of Massachusetts residents remained uninsured, which is the lowest of any State. Between late 2006 and August 2008, 439,000 Massachusetts residents gained coverage (Long, 2008).

In April 2006, the Massachusetts legislature passed Chapter 58, legislation that, among other things, created Commonwealth Care, a subsidized insurance plan for low-income workers who do not qualify for any of the MassHealth (Medicaid) programs (Massachusetts Legislature, 2006b). Commonwealth Care provides sliding-scale subsidies for Massachusetts residents who earn up to 300 percent FPL but are not eligible for MassHealth. Commonwealth Care offers several plans and is administered by the same managed care organizations that administer MassHealth. As of April 1, 2008, about 175,000 low-income adults had enrolled, exceeding estimates by more than 30,000. Chapter 58 also provided State-funded subsidies for employer-based health insurance premiums for workers earning up to 300 percent FPL.

Commonwealth Care has significantly increased access to SAT in Massachusetts. In 2009, nearly 16 percent of clients admitted to public SAT facilities reported having “Other” insurance at admission. BSAS staff believe that the majority of these clients are enrolled in Commonwealth Care. The percentage of clients who report having “Other” insurance has also nearly tripled since Commonwealth Care enrollment was opened in 2006.

In addition to the increase in public sector admissions, BSAS staff hypothesize that many of those who are newly covered by Commonwealth Care (or who receive subsidized employer-based insurance) are not seeking care in the public SAT system, but rather are being treated by private clinics, individual practitioners, or primary care physicians—if they are getting treatment. The Connector Authority—an independent State agency that oversees the administration of Commonwealth Care—collects usage data, but those data have not yet been

⁹ Chapter 58 of the Acts of 2006, *An Act Providing Access to Affordable, Quality, Accountable Health Care*, requires Massachusetts residents to “maintain adequate, ‘creditable’ health insurance” and employers with more than 10 employees to offer a “fair and reasonable” health insurance plan to their employees (Raymond, 2009, p. 12).

made available to the SSA or to the public. However, those data may be available in the future and may provide answers about SAT outside of the specialty treatment sector.

In Massachusetts, between 2006 and 2008, about half of the newly insured population enrolled in Commonwealth Care. About a third purchased private insurance or gained employer-sponsored coverage. The remaining newly insured gained coverage through Medicaid (Steinbrook, 2008). A 2007 study conducted by the Urban Institute found a drop in the uninsured rate across population groups between the time when Chapter 58 was implemented in 2006 and the study date in 2007. The largest drops in the uninsured were reported by lower income adults (aged 34 to 64) and young adults (aged 18 to 34) (Long, 2008). Despite expansions in coverage, 25 percent of young adults (aged 19 to 24) are still without health insurance. Rates are also higher than average among Blacks and Hispanics, and among part-time workers of small employers (Long and Maasi, 2008).

BSAS believes that the remaining uninsured residents are likely to have elevated rates of chronic SUDs. The Mental Health and Substance Abuse Corporations of Massachusetts, Inc., (MHSACM) notes that its members have observed that while more individuals have insurance, there are still a large number of uninsured individuals in need of services (“This is especially true for individuals in need of substance abuse treatment.”) (MHSACM, 2009). When clients are eligible for coverage, providers can help them to enroll, but the enrollment process is quite burdensome and does not take effect until the first of the next month, a wait that is too long for most clients who present for treatment services, especially detox.

Services Covered

In Massachusetts, the parity mandate (Chapter 256 of the Acts of 2008, *An Act Relative to Mental Health Benefits*) became effective in July 2009. This law requires health insurers to provide mental health (including SAT) benefits “on a nondiscriminatory basis [which] means that co-payments, coinsurance, deductibles, unit of service limits (e.g., hospital days, outpatient visits), and/or annual or lifetime maximums are not greater for mental disorders than those required for physical conditions, and office visit co-payments are not greater than those required for primary care visits.” However, this law has not been implemented long enough for its impact to be clear.

Commonwealth Care offers a variety of health insurance plans, with varying coverage of SAT services. SSA staff and providers in Massachusetts emphasized the importance of advocacy by SA/mental health consumers, which led to improved SA/mental health benefits across Commonwealth Care plans even before a parity law was passed. All the plans cover methadone maintenance services and buprenorphine. Commonwealth Care plans require prior authorization for all levels and modalities of SA services.

MassHealth provides reimbursement for most SA/mental health services. As part of Chapter 58, reimbursement for Level IIIB residential detox, which was cut in 2002, was restored. However, none of the MassHealth plans cover the room and board costs for residential SAT services (the largest fraction of the costs). This is a major barrier to treatment in Massachusetts, as well as a drain on BSAS resources, as 50 percent of all current clients in residential treatment are enrolled in MassHealth insurance.

In August 2008, BSAS funded 17 community health centers to hire nurse care managers for suboxone patients. Suboxone is reimbursed by both Commonwealth Care and MassHealth, as

well as by the Health Safety Net Fund, which reimburses community health centers and hospitals for services provided to the uninsured. This has been very effective in increasing the numbers of clients who have access to suboxone, a service very much in demand in Massachusetts. In addition, nurses refer clients to SA counseling services that provide ancillary services to aid in other (nonphysical) aspects of recovery, which the clients may not have received if they had gotten services from a primary care physician.

Costs for Individuals

In Massachusetts, data collected in 2008 suggest that for most residents, HCR has led to “reductions in out-of-pocket health care spending, problems paying medical bills, and medical debt” (Long, 2008). In addition, Steinbrook (2008) reported that “the individual and small-group insurance markets have been merged, markedly reducing the cost of individual premiums.”

For MassHealth enrollees and Commonwealth Care enrollees earning less than 150 percent FPL, there are no premiums to enroll. For enrollees earning between 150 percent and 300 percent FPL, Commonwealth Care provides sliding-scale subsidies on premiums. Neither the MassHealth nor the Commonwealth Care plans have deductibles.

In January 2007, the Massachusetts Connector Authority agreed to waive all co-payments for all components of methadone treatment for Commonwealth Care enrollees. In 2008, individuals between 200 percent and 300 percent FPL saw a decrease in their SA out-patient treatment co-payment (MHSACM, 2009). However, co-payments for detox treatment range from \$50 to \$250 for individuals enrolled in Commonwealth Care. When consumers cannot afford these co-payments, providers are forced to either absorb these costs or deny services to individuals. As providers can no longer afford to absorb such costs, this has become a major barrier to detox services. Although providers believe that this is applicable to approximately 2 clients out of 100 clients seen per week, BSAS and its providers do not know how many people are not seeking treatment because of co-pays.

Funding HCR in Massachusetts

In 1992, Massachusetts was the first State to create an SA/mental health Medicaid (MassHealth) “carve-out” to reduce costs by providing oversight of the system. An early evaluation of this program (after 1 year) found that expenditures were 22 percent below predicted levels. These savings were attributed to reduced lengths of stay, lower prices, and fewer inpatient/residential admissions. In addition, across the system, access increased by 5 percent (Callahan et al., 1995). Despite these cost savings in the AOD system, costs to the taxpayers and the State have been higher than initial projections.

The State has two strategies for funding HCR. First, policymakers hoped to reallocate existing funding that was used to compensate hospitals and community care centers (formerly called the Uncompensated Care Pool, now called the Health Safety Net Fund) to subsidize Commonwealth Care costs (Raymond, 2009). In 2007, use of the Health Safety Net fell 16 percent, according to the Massachusetts Division of Health Care Finance and Policy. Specifically, hospital visits decreased between FY 2006 and FY 2008, with inpatient discharges decreasing 8.7 percent and outpatient visits decreasing 12.1 percent.

The second strategy is taxation. A \$1 per pack increase in the State cigarette tax and a “one-time assessment” on health care providers and insurers were implemented in 2009.

Massachusetts is also planning to fund HCR with tax penalties assessed on Massachusetts residents who do not meet the requirements for maintaining coverage and companies that do not meet the employer fair share assessment. Recently, Governor Deval Patrick has proposed lifting the sales tax exemption on alcoholic beverages, candy, and sweetened beverages in order to raise additional funds.

Data

BSAS tracks admissions to SAT programs that are funded by State and federal dollars in Massachusetts. BSAS is also working to link secondary data sources with their own records. The Bureau has access to hospital data, and is working to get data from Medicaid and the State's Department of Corrections. BSAS hopes that these data will provide a better understanding of the clients. In addition, the Connector Authority and MassHealth both track SA services used by their clients, and these data would help in understanding the ways that HCR has (or has not) expanded coverage of SAT services to the newly insured.

The SAPT Block Grant

BSAS staff emphasized the continued importance of SAPT Block Grant funds under HCR:

- These funds are used for a variety of purposes, including prevention services, care for those still uninsured, funding for services not reimbursed by other payers, capacity building, training and technical assistance, and quality oversight.
- Federal funds support the entire continuum of care, especially for the uninsured, and provide funding for those services not reimbursed by other payers. These services include residential treatment for MassHealth clients, as well as services that are considered "nonmedical," such as childcare and other psychosocial support services.
- SAPT Block Grant funding also allows BSAS to act in a capacity-building function. Using Block Grant funds, the Bureau can fund new and small providers, while the providers build their referral systems and attract insured clients who bring larger reimbursement streams.
- As novel treatment services are identified (e.g., medications), BSAS is able to provide funding for providers to train staff and implement the new programming.
- Finally, the SAPT Block Grant remains the only major funder of SA prevention services in Massachusetts.

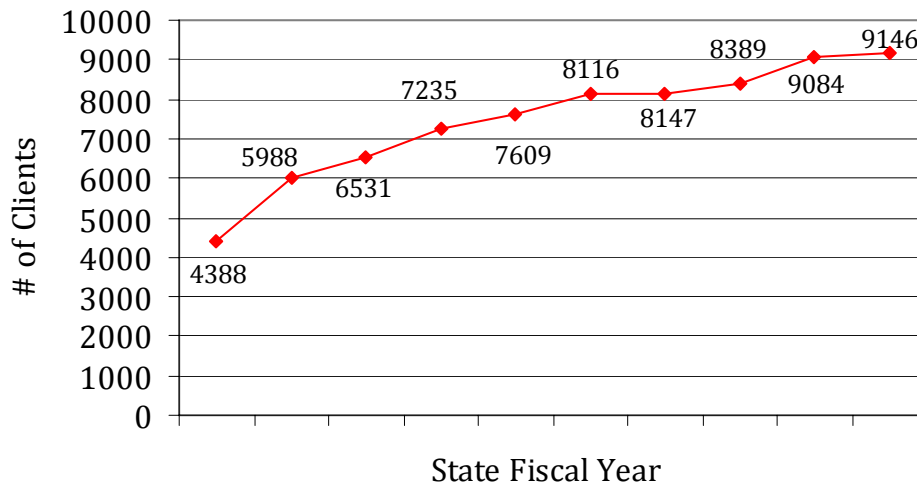
Vermont

In Vermont, access to the public SAT system has doubled over the past 10 years because of reforms in health care, as shown in Figure 5. Staff from the State's Division of Alcohol and Drug Abuse Programs (ADAP) attribute this growth to (1) strategic planning initiatives at the State and Division levels, (2) increased access to health insurance coverage through Green Mountain Care (Medicaid), (3) the growth of medication-assisted treatment, and (4) a process-improvement initiative funded with SAPT Block Grant monies. HCR in Vermont has focused specifically on the treatment of chronic conditions and the importance of prevention, as well as on increased access to affordable health insurance for all Vermont residents, improvements in the quality of care across the lifespan, and the containment of health care costs. The publicly funded SAT system in Vermont continues to move away from an acute-care system that relies heavily on expensive, long-term residential care, and toward a more sustainable ROSC model. To do this, the State is relying on SAPT Block Grant dollars to help improve the efficiency of the whole system and on individual providers. Block Grant dollars are also used to provide workforce development activities and to fund services that are not reimbursed by other payers (including services for the uninsured).

Numbers Served

Figure 5 shows admissions to publicly funded SAT facilities in Vermont from 1998 to 2007. Admissions increased steadily during that time by approximately 9 percent per year. Strategic planning has been critical to Vermont's HCR efforts at both the State and division levels. Governor Jim Douglas launched the Vermont Blueprint for Health in 2004, and ADAP created a strategic plan in 2008. Both of these strategic plans emphasize the importance of prevention and community-based chronic care management.

Figure 5: People Receiving Alcohol or Drug Treatment in Vermont, 1998-2007



The Vermont Blueprint is a strategic planning tool to specifically address the increasing costs of chronic diseases (including substance use and mental disorders). The Blueprint involves a change process that is based on the same principles as the STAR-SI NIATx program that was implemented in Maine. It involves the creation of patient-centered medical homes; integrated,

community-based services (one-stop shopping); the creation/improvement of health IT systems; and chronic care management. The Blueprint divides the State into hospital service areas for administrative purposes. Six of these hospital service areas, together serving nearly half the State, have implemented improved diabetes care and prevention since 2006. The goal of the Blueprint is system-level transformation across the State by 2011.

The 2006 Governor's Health Care Reform Plan provided funding to implement the Blueprint. In the summer of 2008, two integrated pilot programs opened, one in an urban area and the other in a rural area. At these sites, community care teams—including nurses, behavioral health specialists, and primary prevention specialists—are co-located in primary care offices. Since inception, each team has treated 1,000 patients who represent a spectrum of disorders; some have chronic conditions that require closely monitored management, while others are screened for chronic conditions.

SUD Treatment Capacity, Quality, and Efficiency

Vermont's ADAP is implementing systemic change from an acute-care system to the ROSC model. To do this, in 2008 ADAP created a strategic plan that addresses three major domains, namely system of care, access to services, and workforce capacity. ADAP staff input was requested on all levels to create the strategic plan. The final strategic plan called for creation of new policies, procedures, and protocols to support ADAP's structure and guide its work. To implement the strategic plan, ADAP collaborates with providers through quarterly advisory committee meetings.

Like Maine and Massachusetts, Vermont is faced with an opiate epidemic, which began in the late 1990s. To combat this epidemic, Vermont embarked on major initiatives to make buprenorphine available and to introduce methadone in 2003. The State found that a workforce shortage, rather than a lack of funding, prevented treatment of everyone seeking opiate treatment services, so Vermont began to provide trainings on buprenorphine for primary care physicians using the 8-hour online training developed by SAMHSA. After initial successes, ADAP attracted more doctors by offering small stipends to cover the costs incurred in obtaining medication-assisted treatment certification. ADAP also implemented a mentoring program and electronic mailing list for doctors who had been through the training. Today, there are over 170 doctors certified, which represents 800 percent more per capita than the national average. After much controversy, the first methadone clinic in Vermont was approved in 2002 and opened in 2003. Mobile methadone clinics began to operate in 2004. As of now, there are five methadone clinics in Vermont that serve more than 500 clients, although there is still much more demand than capacity.

In 2008, ADAP used SAPT Block Grant dollars to create an NIATx learning collaborative and to support monthly calls for the provider-based change teams, NIATx consultants, and ADAP staff. Six treatment providers volunteered to participate. The results of this pilot project were remarkable, both in the achievement of the goals to reduce no-shows and wait time in order to improve access, and in the buy-in from providers. As the providers streamlined their admissions processes, ADAP conducted a similar process-improvement exercise to identify possible areas of paperwork reduction. This brought a significant reduction in the amount of forms that providers were required to submit to the State. At the end of the demonstration period, ADAP held a full-day retreat for all its providers to talk about the project. This effort was very well received.

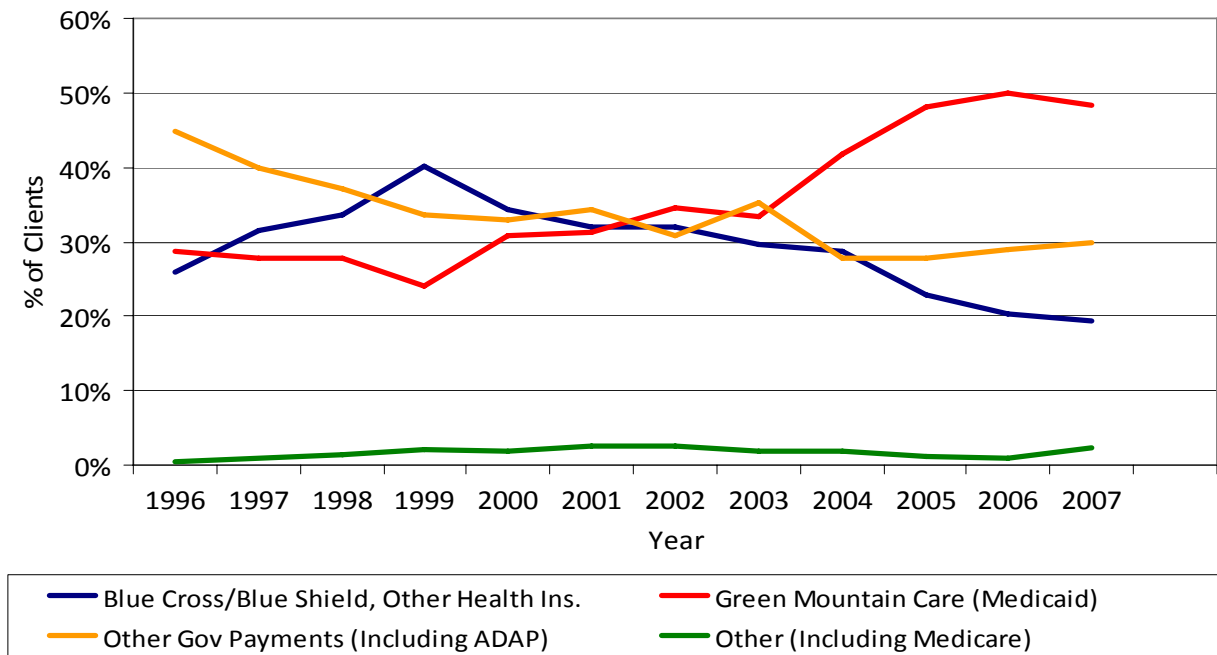
Who Is Covered by HCR?

Since 2006, the percentage of adults who are uninsured in Vermont has fallen from 9.8 percent to 7.6 percent. The percentage of uninsured children went from 4.9 percent to 2.9 percent.

In 2006, Green Mountain Care (Medicaid) provided health coverage to 20 percent of Vermonters, much more than the national average of 13 percent. As in Maine and Massachusetts, Vermont was granted a section 1115 waiver by CMS to expand Green Mountain Care coverage to non-categoricals in 1996, and again in 1998. The Green Mountain Care Vermont Health Access Plan (VHAP) covers childless adults up to 150 percent FPL, and parents of children under age 19 up to 185 percent FPL. In 2006, the Governor’s Health Reform Plan also decreased Green Mountain Care premiums.

Figure 6 shows the importance of Green Mountain Care expansions to the increase in access to publicly funded SAT programs in Vermont. Between 1996 and 2007, the number of clients admitted to the public SAT system in Vermont whose care was paid for by Green Mountain Care rose by 150 percent, from 1,473 in 1996 to 3,751 in 2007.

Figure 6: Percent of SAT Clients in VT By Payor, 1996-2007



The 2006 Governor’s Health Care Reform Plan created the Catamount Health Plans to lower cost-comprehensive health insurance products for uninsured Vermonters not eligible for Medicaid enrollment. All Catamount Health plans include coverage for SAT services. Catamount Health provides premium assistance (using a sliding scale) for uninsured Vermonters earning up to 300 percent FPL. In addition, Vermont provides premium assistance to individuals under 300 percent FPL to help them enroll in, and pay the premiums for, their employer-based insurance plan. Enrollment in Catamount Health began in October 2007 and by November 2008 there were 9,326 enrollees. The creation of Catamount Health

had little effect on the public SAT system. Providers reported treating only one or two clients who were enrolled in a Catamount Health Plan. The number of clients whose treatment was covered by a private insurance company actually decreased by about 37 percent between 2000 and 2007.

Services Covered

Years after the first parity bill was introduced to the State legislature in 1985, Vermont passed what has been touted as the strongest SA and mental health parity mandate legislation. The law that was passed in 1998 requires private health insurers to cover SA and mental health treatment at the same level as all other services. It mandates equal co-pays, equal deductibles, and equal lifetime limits for reimbursement of SA and mental health services. Parity has not been a panacea in Vermont, however. The initial parity law was not sufficient to achieve equal coverage of mental health/SA services. The State legislature subsequently passed additional legislation to regulate managed care companies and, beginning in 2009, Vermont has the authority to penalize insurance companies that are not in compliance.

Because Vermont has been embroiled in an opioid epidemic for the past 10 years (first heroin and then prescription drugs), ADAP has worked with its providers to significantly increase the publicly funded SAT system's capacity to provide opioid replacement therapies (ORTs) to Vermont residents. ADAP began a major buprenorphine initiative in 2003; today, Vermont has over 170 physicians who are certified to provide buprenorphine prescriptions, 800 percent more per capita than the national average. Vermont also opened its first methadone clinic in 2003, and began mobile methadone clinics in 2004. As of now, Vermont has 5 methadone clinics, serving more than 500 clients. Despite this increase in services, there is still more demand for methadone than capacity to meet it.

Costs for Individuals

There is no individual coverage mandate in Vermont, and 56,000 residents (about 9 percent of the total population) are still without health insurance. ADAP staff members have hypothesized that these people remain uninsured because they are slightly above the Catamount Health (subsidized insurance) income eligibility limit and feel that unsubsidized health insurance is unaffordable. However, the uninsured can access services that are part of the Vermont Blueprint at no charge (although there are not yet data on such utilization).

For clients enrolled with Catamount Health who need care for a chronic condition or disease, including SUDs, out-of-pocket costs are waived (no deductible, no co-insurance, and no co-payments). Premiums for Catamount Health are based on income, but they must be paid monthly. However, some Medicaid beneficiaries do have to pay deductibles and co-payments for specific services, depending on their eligibility category and income. VHAP enrollees must remit a \$25 co-pay for emergency room visits.

The Healthy Vermonters Program provides a discount on prescription medication for those up to 350 percent FPL who have no prescription coverage or who have exhausted coverage benefits. This is especially important because this allows Vermont residents to access discounted buprenorphine; in fact, State staff said that buprenorphine is the largest single medication expense in the Vermont Medicaid formulary.

Funding HCR in Vermont

Vermont funds HCR through revenue from individuals' premiums as well as employer health care contributions (based on the number of their full-time equivalent employees who are uninsured). In addition, the State projected that it would be able to realize long-term Medicaid program savings due to employer-sponsored insurance enrollment, which allows Vermont to provide premium assistance for individuals to enroll in their employer's plans if it is more cost-effective for the State than providing premium assistance to enroll in Catamount Health or VHAP. These savings have not yet been realized. Vermont received a section 1115a federal Medicaid demonstration waiver (Global Commitment to Health) in 2006 that allows the State to be more flexible in the way it uses its Medicaid resources. This waiver allows Vermont to experiment with new payment mechanisms rather than fee-for-service vehicles in order to pay for services not traditionally reimbursable through Medicaid and to invest in programmatic innovations (including the Vermont Blueprint for Health). The Blueprint initiative is also financed by a levy on private insurers passed by the legislature; services are provided at no charge to patients or to communities. In addition, Vermont has paid for HCR through increases in tobacco taxes. The State hopes that delivering chronic care in a better and more cost-effective manner will create significant cost savings. Finally, as a measure of last resort to contain costs, Vermont has stated that it will limit Catamount enrollment if necessary (to date, this has not happened).

Since 1992, funding for ADAP has increased by nearly 700 percent and has doubled since 2004. Much of this is the result of increased Medicaid funding, which is administered by the SSA. ADAP has been very successful in using Medicaid funding to increase access to SA services, especially medication-assisted treatment. ADAP continues to work with Medicaid to increase funding for expanding methadone services across Vermont. However, the costs associated with SAT have risen more than originally anticipated, and the State plans for these costs to be contained. To address this, ADAP's strategic plan calls for a move away from the acute-care system toward the ROSC model. In practical terms, this means using less residential treatment; using more outpatient and medication-assisted treatment; ensuring that clients get "the right dosage" of SA treatment; and increasing reliance on less-expensive, informal community supports to help clients with SUDs maintain their recovery.

The SAPT Block Grant

Vermont's ADAP staff emphasized the continuing importance of SAPT Block Grant funding, even after HCR. The Block Grant currently makes up about 20 percent of ADAP's budget. Because there are still 56,000 Vermont residents without health insurance, funding for services for the indigent remains a critical function of the Block Grant. In addition, Vermont is facing a critical workforce shortage. Providers are increasingly relying on reimbursements from private health insurance companies (including those that administer Catamount Health), and most insurance companies require grading much-needed medication-assisted treatment and "nonmedical" psychosocial services.

Discussion

In Maine, Massachusetts, and Vermont, HCR materially increased access and admissions to SUD treatment services, and the percentages of the population that were uninsured decreased. In each of these States, HCR began in the early to mid-1990s and was multifaceted and multiphased in its implementation.

Components of HCR in the three States variously included the following elements:

- Maintenance of private/employer insurance as the core (three States);
- Provision of a subsidized, basic health insurance plan for low-income residents (less than 300 percent FPL) (three States);
- Expansion of the services and populations covered by Medicaid, especially the inclusion of low-income childless adults (three States);
- Integration of primary care, chronic care, and prevention (three States);
- Treatment process-improvement initiatives based on the NIATx model (three States);
- SAT workforce training initiatives (three States);
- Implementation of managed care for Medicaid (three States);
- Passage of parity legislation (Massachusetts and Vermont) and/or mandates (Maine and Vermont) for SA and mental health; and
- Performance contracting/pay-for-performance (Massachusetts and Maine).

As the Maine Health Access Foundation report comparing HCR in the three States noted, the goals of HCR across these States are similar (Kaye and Snyder, 2007). Each State hopes that elements of its HCR strategy will contribute to reducing health care costs while expanding health insurance coverage and increasing access, capacity, and the quality of services. Vermont's HCR efforts also specifically target the treatment of chronic conditions and access to preventative services.

All three States used the following revenue sources to fund HCR:

- Increased tobacco taxes and liquor taxes;
- Federal matching funds from Medicaid;
- "Fair share" employer contributions;¹⁰
- Individual insurance premiums (either mandated or graduated);
- Savings from emergency health costs/uncompensated care pool; and
- State general appropriations.

Maine also implemented caps on growth in per patient spending and on hospital profits, and required hospitals and insurance companies to pay 2.14 percent of their revenues to recoup

¹⁰ In each of these States, employers that employ more than a certain number of full-time employees must pay an annual fee if they do not make a "fair and reasonable" contribution to an employee health plan. These fees are then used to fund health coverage for the uninsured.

some of their expected cost savings. Despite the utilization of all these different revenue sources and cost-saving measures, HCR has been much more expensive than expected in each State. These additional expenses have forced States to limit enrollment into Medicaid programs as well as into their subsidized health insurance plans.

SUD Treatment Funding Grew Under HCR

Each of the case study States increased funding for its public SUD treatment systems at the same time that other HCR reforms were implemented. In Maine, funding for the SSA increased 86 percent between 1999 and 2008. In Massachusetts, funding for the SSA increased by \$67 million between 2005 and 2009. In Vermont, the SSA's funding has increased nearly 700 percent since 1992, and has doubled since 2004. Funding for these increases came from additional State general funds as well as the tobacco Master Settlement Agreements. Maine and Massachusetts received funding from SAMHSA/CSAT to undertake process improvements as well. Additional funding reflects the rising costs of SAT, but has also allowed all three States to serve larger numbers of clients.

Demand for SUD Treatment Increased Under HCR

In all three States, the public treatment system served steadily increasing numbers of clients. Admissions to publicly funded SAT facilities in Maine rose 32 percent between 1999 and 2008. In Massachusetts, admissions increased 20 percent between 2006 and 2008, while Helpline calls (from uninsured individuals seeking care) decreased 50 percent; BSAS staff members believe this trend shows that a larger percentage of people seeking treatment are receiving it. Vermont's ADAP staff reported that admissions increased by nearly 110 percent between 1998 and 2007. In each of the three States, the largest increase occurred in opioid treatment admissions.

Because the Northeast has been embroiled in an opioid epidemic for the past 10 years (first heroin and then prescription drugs), each of these States has significantly increased its capacity to provide opioid-replacement therapies. ADAP undertook a major buprenorphine initiative in 2003 and opened its first methadone clinic in the same year. In 2008, BSAS funded community health centers to hire nurse care managers for suboxone patients, to ensure that suboxone clients would be referred to SA counseling services.

Lessons Learned

From these three case studies, the following lessons were learned:

- Although HCR materially decreased the numbers of uninsured residents in these States, public SAT providers continue to treat disproportionate numbers of uninsured clients.
- Parity laws alone do not ensure that insurance companies will cover and reimburse SA/mental health services at appropriate levels.
- HCR-motivated efficiency initiatives can achieve some cost savings, but are still expensive.
- Even in States that expanded coverage through private insurance, subsidized health plans, and Medicaid, there continue to be vital roles for the SSA and Block Grant dollars.

- There are many quantitative data systems that could be mined to further understand the effects of HCR on the public SAT system.

Discussions of these findings follow.

Although HCR materially decreased the numbers of uninsured residents in these States, public SAT providers continue to treat disproportionate numbers of uninsured clients.

Drop in uninsured. After HCR, the percentages of uninsured residents in Maine and Vermont dropped significantly, and in Massachusetts, dramatically. Each of these States expanded Medicaid coverage to adults aged 19 to 64 who do not have dependent children (non-categoricals) through a section 1115 waiver from CMS. In addition, States expanded health insurance coverage through the creation of new State-subsidized health insurance plans for low-income residents who earn less than 300 percent FPL. Massachusetts and Vermont also provided payment assistance to help low-income workers buy into an employer-based plan, and required employers to provide reasonably priced—if basic—health plans to their employees. Massachusetts mandates that individuals have health insurance or pay tax penalties. The uninsured rates dropped significantly in Vermont and Maine (but much less than in Massachusetts), even without individual mandates.

SUD treatment admissions grew substantially. During and after HCR, treatment admissions grew appreciably in each State. In addition, public sector providers generally reported seeing more clients who were enrolled in a health insurance plan, although these were generally Medicaid plans. Anecdotal reports from SSA staff and providers in Maine and Vermont, as well as data from Maine’s Treatment Data System,¹¹ indicate that public SAT providers (CBOs) continue to see few clients with subsidized or private health plans under HCR. However, providers in Massachusetts have seen an increase in the percentage of clients who are enrolled in Commonwealth Care over the past 3 years. In each State, Medicaid expansions produced far more access to public SAT providers than did private and subsidized plans.

Uninsured still high among those needing SUD treatment. Despite these expansions in coverage, public SAT facilities are still treating a disproportionate percentage of clients who are uninsured. In 2007, 10 percent of Maine residents were uninsured, but more than 31 percent of clients admitted to public SAT facilities reported being uninsured, three times the rate throughout the State. Though the uninsured rate in Massachusetts is estimated to be only 2.6 percent of the population in 2009, more than 20 percent of clients admitted to SAT facilities in 2009 were not enrolled in a health insurance program. Serving the remaining uninsured population continues to be an important role of the publicly funded SAT systems and of the SSAs.

Providers and SSA staff in Maine, Massachusetts, and Vermont report that many of those who are uninsured when seeking admission to SAT at public facilities are only episodically uninsured. *These people are experiencing gaps in insurance coverage that may stem from the*

¹¹ Maine’s Treatment Data System reports that SA treatment providers in Maine have served fewer than 1,500 clients with private health insurance (including DirigoChoice) per year since 2004, when data collection began.

noncompletion of re-enrollment forms (Medicaid)¹² or the nonpayment of premiums (private insurance). These gaps may also correspond with the client’s increased alcohol or drug use.

In addition, SSA staff and providers report that *gaps in coverage often occur due to or following incarceration.* While incarcerated, clients often lose Medicaid coverage because they no longer fall into any of the allowed categories (specifically, as the parent of a dependent child). They must then re-enroll as “non-categoricals,” which takes time and can disrupt the transition between SAT while incarcerated and SAT in the community.

These gaps in coverage will become particularly problematic as the public system increasingly relies on Medicaid reimbursement instead of “safety net” funds, a trend in all three States under HCR. *Re-enrollment in Medicaid in these States is increasingly difficult, as enrollment is frequently capped or frozen to contain costs.* In addition, few plans allow retroactive eligibility and reimbursement, and eligibility generally starts on the first day of the following month. This means that either clients must wait until they are enrolled to receive SAT services, or providers must use other funds (either charitable contributions or safety net/SAPT funds) to begin to treat these clients.

Parity laws alone do not ensure that insurance companies will cover and reimburse SA/mental health services at appropriate levels.

All three States studied have enacted parity legislation that requires health insurance plans to cover SA/mental health services at the same level as all other services. However, each State has learned that parity legislation does not automatically expand access to SAT services:

- Even when insurers comply with parity regulations, co-pays and deductibles can restrict access to SUD services for very low-income beneficiaries.
- In all three States, providers perceive that insurance companies have been slow to fully implement equal coverage for SA/mental health services.¹³
- Moreover, insurance plans often do not reimburse providers for the full continuum of care: Residential treatment and social model detox are generally not covered by private plans, Medicaid, or Medicare, and the burden to fund these services falls on the SSA. Deciding which services to cover with limited safety net funds is a major challenge to the SSAs in Maine, Massachusetts, and Vermont.

Even when clients are enrolled in private insurance plans and the services rendered are covered by private insurance, CBOs face new challenges in working with private insurance and managed care. Although the percentages of clients who enter the SAT system with private insurance have remained constant and very low in Maine and Vermont (in Massachusetts, providers report seeing perceptible increases in the percentage of clients with private insurance), the actual numbers of clients with private insurance seeking services in the public SAT system have risen in all three States over the past 5 years. In addition, Medicaid plans are increasingly being administered by private insurance agencies using managed care policies. Working with these new partners has required CBOs to change their business models.

¹² Vermont requires individuals with VHAP to “recertify” their eligibility every 6 months; other States and policies have similar regulations.

¹³ Vermont has begun to penalize insurance companies for not complying with parity regulations.

The level of administrative support needed to work with these insurers is much higher than most CBOs are accustomed to. Billing practices are different across insurers, so CBO staff must spend time learning about the requirements of each insurer and must ensure that the proper procedures are followed. These administrative costs represent a significant increase in CBO costs.

Workforce shortages are limiting access to SAT, particularly in Vermont and the rural areas of Maine. This is exacerbated because many private insurance companies will only reimburse care provided by practitioners with graduate degrees traditionally associated with mental health providers (e.g., M.D., M.S.W., L.C.S.W.). Some insurance companies will reimburse care provided by licensed alcohol and drug counselors who do not have graduate-level mental health training, but low-paying rural providers have a difficult time recruiting counselors with such certifications. In addition, insurance reimbursement is generally very low for services not administered by a physician. Providers in these three States must weigh the reimbursements that they receive from these insurers against their costs, and often do not accept all kinds—or even any type—of private insurance, due to these staffing and billing challenges. In addition, Massachusetts has had difficulty recruiting nurse care managers to work with suboxone patients in community health centers.

HCR-motivated efficiency initiatives can achieve some cost savings, but are still expensive.

In Maine, Massachusetts, and Vermont, early reports show that HCR writ large has cost the States more than expected. However, each State has been able to point to certain limited cost savings realized through a reduction in the uncompensated care pool. In addition, all of these States hope to contain costs in the future through the careful management of chronic diseases, as well as through reductions in emergency room costs. All three States are working to move away from an acute-care system, which relies heavily on residential SAT, and toward an ROSC model, which is based in the communities.

In Maine and Massachusetts, the SSAs (through the Medicaid plan) are working to contain costs. *One cost-containment effort is through the implementation of managed care organizations (MCOs), especially to address the utilization of more expensive residential treatment.* The literature has shown that the use of MCOs can decrease lengths of stay, increase access to SAT services, and increase the substitution of less-expensive for more-expensive services (Bouchery and Harwood, 2003; Frank and Garfield, 2007; Shepard et al., 2002). This was certainly true in Maine and Massachusetts. Maine found that after implementing an administrative-services-only contract, lengths of stay in residential care decreased over the subsequent 2 years. Massachusetts implemented managed care for SA services covered by Medicaid, and was able to achieve significant cost savings due to reduced lengths of stay, lower prices, and fewer inpatient/residential admissions.

The use of managed care is often a double-edged sword: It is not clear that the overall quality of services improves under a managed care system (Frank and Garfield, 2007). Olmstead, White, and Sindelar (2004) found that SAT facilities may offer a smaller range of services when contracting with an MCO, which may reduce treatment effectiveness if the facility does not provide the necessary services. Shepard and colleagues found that rapid re-admissions to a higher (or the same) level of SAT occurred more commonly when Massachusetts began to contract with a behavioral health MCO for its Medicaid clients (Shepard et al., 2002).

All three States have used process-improvement demonstration projects to successfully expand access to SAT services without spending additional dollars. Maine has also used pay-for-performance measures to increase provider efficiency, and Massachusetts is working with its providers to identify related measures.

Even in States that expanded coverage through private insurance, subsidized health plans, and Medicaid, there continue to be vital roles for the SSA and Block Grant dollars.

The SSA in each State emphasized the continuing critical importance of the SAPT Block Grant funds even after HCR was enacted. Despite declining numbers of uninsured residents in each of the three States studied, none have come close to achieving universal coverage to date. Lapses or gaps in coverage—which are often associated with increasing acuity of SUDs, involvement with the criminal justice system, co-occurring SUD and mental disorders, or homelessness—mean that when people enter SUD treatment, they are often indigent. *In Maine, Massachusetts, and Vermont, the SSAs, using combinations of Block Grant and State dollars, continue to be the primary payers for the uninsured, who continue to be a substantial portion of those needing SUD treatment.*

Even when clients are enrolled in an insurance plan, *SAPT Block Grant dollars fill holes in insurance coverage.* Insurance companies continue to refuse to pay for residential care and social-model detox, and, in the past, often imposed lifetime limits (or yearly limits) on the amount of SAT services that a client can receive. Although the 2008 Wellstone-Domenici Parity Act makes this practice illegal, the effects of this bill are not yet clear. In addition, SSAs and SAT facilities have traditionally treated “the whole person,” administering necessary case management and psychosocial services, including housing assistance, employment counseling, and childcare, costs that are generally not covered by private or public health insurance plans. Some recovery management services are not provided by insurance-eligible professionals, and currently remain outside of the realm of insurance reimbursement. In each of these States, the SAPT Block Grant is the sole funder of prevention services at the State level.

Maine, Massachusetts, and Vermont also hope to use Block Grant dollars to increase the affordability of health care for their clients. Even subsidized insurance plans, including Medicaid, require that clients pay out-of-pocket costs, including co-pays for services, deductibles, and premiums. These costs can be prohibitive for individuals with SUDs. All three States offer premium assistance for individuals earning less than 300 percent FPL. In the future, Massachusetts hopes to use Block Grant funds to subsidize co-pays and deductibles for clients with Medicaid coverage who are in treatment for SA.

After HCR, SSAs rely on SAPT Block Grant dollars to improve the infrastructure of the SAT system in their State. All three States are using Block Grant dollars to better understand the

needs of their clients through tracking the services rendered. They also are working to link their own databases with those of other systems (such as Medicaid, mental health, and social services) to better understand all of the needs of their clients, and to better understand the outcomes of the SAT system.

Even as SAT and prevention services are increasingly integrated into the primary care system as a part of HCR, *an important function of the SSA is to negotiate relationships with other systems, particularly the criminal justice system and the welfare system.* Increasingly, the SSA has become a conduit between these systems and the primary care system. In Vermont, the SSA has successfully worked with the criminal justice and Medicaid systems to help people maintain their Medicaid coverage while incarcerated. In Maine and Massachusetts, the SSAs have trained providers to enroll the eligible for subsidized insurance (so that they can be reimbursed), thereby helping to reduce gaps in coverage.

Block Grant monies are used to address new challenges and implement innovative services. As health care technologies improve, SSAs in these three States have been able to use Block Grant dollars to help their providers learn new techniques (e.g., cognitive behavioral therapies and motivational interviewing) and implement novel modalities, such as buprenorphine.

There are several data systems in each State that could be mined to further understand the effects of HCR on the public SAT system.

In Maine, Massachusetts, and Vermont, the SSAs collect data on treatment admissions from publicly funded providers. In Massachusetts and Vermont, the SSAs are trying to link data from their own systems with data from related systems, including hospitals, the criminal justice system, and the child welfare system. In addition, Medicaid authorities in all three States maintain claims data for SA treatment.¹⁴ Finally, the State agency that oversees the subsidized private health care plan maintains similar claims data. Each of these data systems has personal identifiers that could be used to link the data across systems. These sources taken together could be used to show the quantitative effects of HCR on SAT access, capacity, and costs.

¹⁴ In Maine and Massachusetts, these data are maintained through the administrative services organizations, which use the data to show cost savings.

Conclusion

Many studies have documented the cost savings of SAT (e.g., Harwood et al., 2002). Other studies have shown that chronic health conditions, including ailments often related to SA, are responsible for a large percentage of medical costs (Druss, Marcus, Olfson, and Pincus, 2002). For an HCR plan to cut costs, it is important to address the needs of Americans with SUDs by providing appropriate care. However, the large number of persons needing (but not getting) SUD treatment means that increasing access to treatment may entail increasing support and capacity up front, before offsetting gains in other health care and public safety can be realized. In this paper, three different HCR State case studies were presented to identify promising practices in financing patterns, the organization of the public treatment systems, and access to care and utilization of SA services as part of HCR.

From these case studies, NASADAD learned that public SAT providers continue to treat large numbers of uninsured clients, even as the proportion of State residents who are insured rises. The SSAs and public SAT providers gave anecdotal data which suggest that even when subsidized or free plans are offered to the indigent as part of HCR, people with SUDs are more likely than the general population to remain uninsured. In addition, parity legislation and mandates do not guarantee that all needed SA/mental health services will be covered by private health insurance companies. In Massachusetts, even when services are covered, out-of-pocket costs can be prohibitive. Because of the above observations, it is clear that even in States that expanded coverage through private insurance, subsidized health plans, and Medicaid, there continue to be vital roles for the SSAs and SAPT Block Grant dollars.

As each of these (and other) SSAs experiment, trying to find a fit for SA services within their post-HCR state medical systems, it is important to evaluate current efforts for their empirical effects on the State and, specifically, on SA services within the State. Future HCR assessment work should include a more quantitative examination of use and financing patterns based on the data from each SSA and on data from Medicaid and private insurance plans within each of these States. In addition, many more States have undertaken less ambitious HCR efforts that have not yet been evaluated.

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