Ohio adds that it considers treating this population an effective way of reducing criminal activity. Nevertheless, "This must be a joint funding venture--alcohol/drug dollars must be matched by criminal justice dollars for providing treatment services to the criminal justice populations." Georgia would like to see better coordination between Federal funding sources, such as the Block Grant and funds from the Bureau of Justice Assistance.

The 18 States concerned about this provision include: Arkansas, Georgia, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maryland, Nebraska, Nevada, New Jersey, New York, North Carolina, Ohio, Oklahoma, Texas, Vermont, and West Virginia.

4. The IMD Exclusion for Substance Abuse

This restriction on Medicaid reimbursement is a top policy concern for 15 States, with 9 States selecting it as one of their top two concerns. The IMD Exclusion forbids Medicaid from paying for health care at residential mental health facilities, including residential substance abuse treatment centers with more than 16 beds. This severely limits the ability of Medicaid to pay for any substance abuse treatment. As a result, only $710 million of Medicaid money went to substance abuse treatment in 1992.

Aside from providing much-needed revenue for the public treatment system, removal of the IMD Exclusion would give States additional flexibility, especially as they increasingly utilize managed care. Arizona notes that the exclusion "conflicts with managed care efficiency concepts. Costly inpatient services became the alternative," while New Jersey points out that "repeal of the IMD exclusion would allow New Jersey...the needed flexibility to provide these services in the appropriate lower cost non-hospital setting." Wisconsin adds that removing the exclusion would allow "less expensive alternatives to hospital care."

Finally, States also would simply be able to provide more services. Ohio responded that "elimination of the exclusion would increase capacity and decrease waiting lists," while Washington State argued that "such restrictions result in significant numbers of adult and adolescent patients being misdiagnosed...or not being treated at all for chemical dependency until emergency room services are needed for medical consequences." As more and more States are beginning to utilize managed care and as Medicaid funds are reduced and possibly block granted, the need for additional flexibility and resources will increase.

The 15 States that reported concerns with this issue include: Arizona, California, Florida, Georgia, Maryland, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Texas, Washington State, West Virginia, and Wisconsin.

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MEDICAID SOURCE BOOK: BACKGROUND DATA AND ANALYSIS (A 1993 Update)

A REPORT

PREPARED BY THE

CONGRESSIONAL RESEARCH SERVICE

FOR THE USE OF THE

SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

OF THE

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U.S. HOUSE OF REPRESENTATIVES

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white and non-English speaking populations require treatment programs that take into account specific cultural influences on alcohol and other drug use and that impose no language barriers. A large number of inmates in correctional institutions have varying degrees of alcohol and drug abuse problems. According to *Healthy People 2000*, treatment programs in such facilities are generally underfunded and understaffed, and when offenders are released, the probability is great that their untreated substance abuse problems will reemerge along with criminal behavior.[13]

Healthy People 2000 includes in its objectives the establishment and monitoring in the 50 States of comprehensive plans to ensure success to alcohol and drug treatment programs for traditionally underserved people. The 1992 progress report on the alcohol and other drugs objectives for the year 2000 notes that no data are available to report on any progress on achieving this and other services-related objectives.

III. SUBSTANCE ABUSE TREATMENT SERVICES

Treatment services for alcohol and drug abuse are provided in a variety of settings and modalities. Some forms of treatment are aimed at illicit drug abusers only, such as in the case of methadone maintenance for heroin addicts, and others are used for alcohol abuse only, such as treatment involving the use of the sensitizing drug disulfiram (Antabuse). Aside from such exceptions, however, similar modalities of treatment are used for both alcohol or drug abuse, and often in the same setting. In addition, increasingly larger numbers of persons are treated for polydrug abuse--abuse of more than one substance, including illicit drugs and alcohol, at the same time.

Treatment can be provided on an inpatient basis, in such settings as detoxification and rehabilitation units in general hospitals, treatment units in public and private psychiatric hospitals, and free-standing treatment facilities. Substance abuse treatment may also be provided in an outpatient setting, in the office of a private physician or other treatment professional, in treatment units of community facilities such as community mental health centers or hospitals, or in free-standing outpatient substance abuse treatment facilities. It is not at all unusual for a drug or alcohol abuser to go through many different types and settings of treatment before achieving long-term success in becoming alcohol- or drug-free.

Substance abuse treatment commonly begins with a period of detoxification, which is followed by a more extensive course of treatment designed to prevent relapse. Such treatment modalities include methadone maintenance for opiate addiction, as well as inpatient chemical dependency treatment, therapeutic communities, and outpatient drug-free programs for all types of alcohol and drug abuse.

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[13] *Healthy People 2000*, p. 173.

A. Detoxification

Substance abuse treatment often starts with a short-term program of detoxification, which involves the process of clearing the patient's system of the physical remnants of the drug or alcohol. Detoxification is sometimes necessary in helping patients with the problems of the immediate withdrawal from drug or alcohol use so that they can proceed to the treatment and related services that will help them stay off. Detoxification can be provided on an inpatient basis in a hospital or other residential facility or in an outpatient program. Although many substance abusers do not receive any treatment services beyond it, detoxification is not a treatment for the substance abuse dependence as such. For those who choose and are able to proceed to further care following detoxification, a variety of program modalities are available to prevent relapse and enable patients to remain alcohol-or drug-free.

B. Methadone Maintenance

Methadone maintenance is a treatment designed to help persons addicted to heroin and other opium-derivative drugs. Methadone may be used to ease withdrawal symptoms during detoxification, but, with its ability to control the craving for heroin in the addict, its main purpose is in long-term substitution for heroin. Its main benefits are that it is taken orally, removing the dangers of intravenous injection that accompany heroin addiction, and that it is effective for a 24-hour period, making it conducive to a daily maintenance regime. Methadone maintenance programs are administered by licensed programs regulated by detailed Federal regulations under the Food and Drug Administration (21 CFR 291.505). These regulations provide that methadone can be provided only in conjunction with provision of appropriate social and medical services.

C. Inpatient Chemical Dependency Treatment

Chemical dependency treatment programs are based in hospitals, psychiatric facilities, and specialized free-standing facilities. They are sometimes known as the Minnesota Model (after the Willmar State Hospital in Minnesota, where the model was developed in the 1950s), the 28-day program, or the 12-step program. Such programs generally extend for 3 to 4 weeks (28 days), and feature a variety of treatment, counseling, and other techniques. These programs initially focused on individuals with alcohol problems and the use of the 12-step approach of Alcoholics Anonymous (AA). The chemical dependency approach has been expanded in recent years to include treatment of illicit drug dependence as well, particularly addiction to cocaine. The 12-step approach utilizes what has been described as a spiritual or moral approach to helping alcohol and drug abusers change their patterns of behavior. The steps include the admission of addiction, acknowledgement of one's impotence to stop it without the help of a higher power, and the need to confront the harm one has done.[14]

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[14]Office of National Drug Control Policy. *Understanding Drug Treatment.* White Paper, June 1990. Washington, 1990. p. 16. (Hereafter cited as Office of National Drug Control Policy, *Understanding Drug Treatment*)

D. Therapeutic Communities

The therapeutic community approach is a residential drug-free program. One of the earliest models of this approach was the Synanon program in California in the late 1950s, which was developed initially to rehabilitate "hard-core" heroin addicts, particularly those with records of criminal behavior or social pathology. Therapeutic communities are designed to get patients to face the fact that they are addicted to drugs, and then to foster change in their personalities so they can live without drugs.[15] They are full-time, drug-free residential programs which provide a highly-structured, nonpermissive program of treatment. Therapy in a therapeutic community is generally a long-term course of treatment, ranging in length of stay from 6 months to 2 years. Treatment in a therapeutic community is provided typically by treatment professionals and by former addicts, and features peer support and confrontation, individual and group counseling, and educational and job training activities when appropriate.

E. Outpatient Non-Methadone Programs

Outpatient programs that do not use methadone vary widely in duration, goals, and content. Some use medications, such as Naltrexone, a nonaddicting narcotic antagonist, for the treatment of heroin addiction or other drugs in the treatment of cocaine addiction. Others are drug-free and make extensive use of counseling as the major form of therapy. Outpatient treatment programs, which operate out of hospitals or other treatment facilities or as free-standing facilities, began as a response to a need for community-based crisis centers for addicts. Some outpatient programs operate largely as drop-in "crisis" centers, while others are more structured. Other day treatment programs operate almost as outpatient therapeutic communities, with daily sessions of counseling and therapy. Most fall somewhere in between the two extremes, with regular, perhaps weekly or twice weekly, sessions. Outpatient programs offer a variety of therapeutic methods, such as individual and group therapy, family therapy, as well as specific training in relapse prevention. As with the therapeutic community approach, many outpatient programs make extensive use of former addicts as staff counselors and therapists.

F. Treatment Effectiveness

Research into the effectiveness of substance abuse treatment can be described as inconclusive. Treatment research carried out during the past 2 decades on various treatment settings and modalities has shown at least limited effectiveness for most if not all types and settings of treatment of alcohol and drug abuse. In a 1990 review of research on drug abuse treatment, Anglin and Hser summarize the findings of research on the efficacy of drug abuse treatment as follows:

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[15]Office of National Drug Control Policy, *Understanding Drug Treatment*, p. 14.

There is no simple cure for drug dependence; once drug dependence has developed, the problem can persist as a chronic condition, and relapse is often the rule. The majority of clients in most treatment programs have traditionally been, and remain, opiate abusers, and evaluation studies are mostly based on opiate users in methadone maintenance programs. Although cocaine abuse has become one of the Nation's major drug problems, adequate data on the long-term processes and consequences of cocaine abuse have yet to be collected. However, findings regarding other drug dependencies and other modalities are typically consistent with those reported for methadone maintenance.

Anglin and Hser found that efforts to identify factors that consistently predict post-treatment abstinence or relapse patterns have not produced definitive findings. All major treatment modalities can be shown to have some positive effects on the clients in the criteria of drug use, criminality, employment, and other aspects of social functioning. For most types of programs, the more time clients spend in treatment, the more positive are their long-term outcomes. A significant proportion of those seeking treatment do not stay in treatment for more than a few weeks. Dropouts are high for all modalities except some methadone maintenance programs. Typically, an intact marriage, a job, shorter drug use history, low levels of psychiatric dysfunctioning, and a history of minimal criminality predict a better outcome in most programs. Demographics are related to likelihood of entering treatment but are only moderately associated with outcome. Program characteristics, such as quality of staff, breadth of services, and morale, are often significant determinants of outcome.[16]

IV. SUBSTANCE ABUSE TREATMENT STATISTICS

The National Association of State Alcohol and Drug Abuse Directors (NASADAD) annually surveys State Alcohol and Drug Abuse Agencies for client and fiscal data from substance abuse treatment programs. The survey includes only those treatment programs which receive some funds administered by a State agency. For FY 1990, the most recent year for which data have been published, 47 States, the District of Columbia, Guam, and Puerto Rico provided statistics on alcohol and other drug client treatment admissions for the year. The total number of reported treatment admissions during the year was more than 1.9 million--nearly 1.25 million for alcohol treatment (65.3 percent), and nearly 663 thousand for other drug treatment (34.7 percent).

Of the total admissions, 56 percent (1.08 million) were for ambulatory care treatment programs, including 73,331 for outpatient detoxification and 1,005,025 for outpatient treatment programs. The survey reported that 25 percent of total admissions (472,302) were for inpatient detoxification, 84.5 thousand in hospital inpatient settings and 387.8 thousand in free-standing residential facilities.

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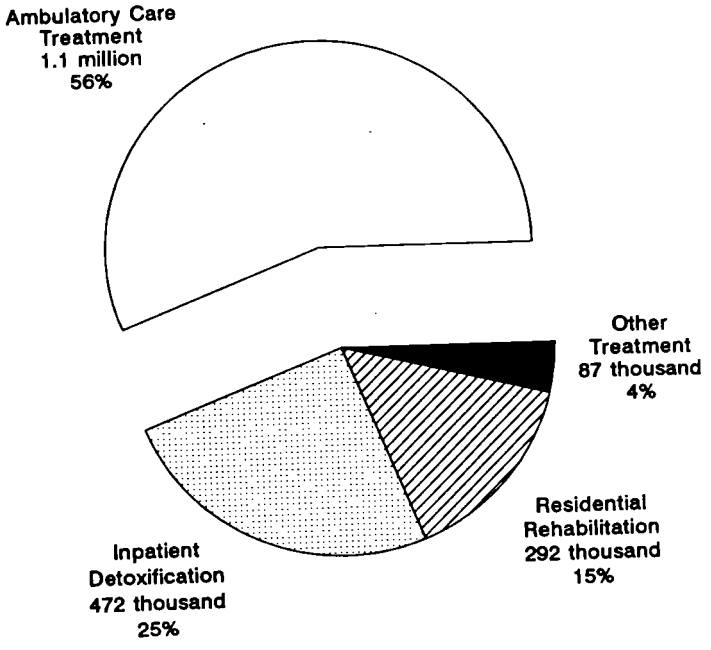
[16]Anglin, M. Douglas, and Yih-Ing Hser. *Treatment of Drug Abuse*. In Tonry, Michael, and James Q. Wilson, eds. *Drugs and Crime*. Chicago, University of Chicago Press, 1990. p. 393-397.

Fifteen percent of all admissions (292,481) were to residential rehabilitation programs, including 17.6 thousand to hospital treatment programs (other than detoxification), 173.8 thousand to short-term (30 days or fewer) residential programs, and 101.1 thousand to long-term (over 30 days) residential programs. (See figure F-2.) Among these treatment totals, the survey reported nearly 110 thousand admissions during the year to methadone treatment programs.[17]

[17]Butynski, William et al. *State Resources and Services Related to Alcohol and Other Drug Abuse Problems, Fiscal Year 1990.* National Association of State Alcohol and Drug Abuse Directors, Inc., Nov. 1991. Washington, 1991. p. 17-20.

FIGURE F-2. Distribution of Treatment Admissions, by Location of Treatment, FY 1990



NOTE: Statistics are for 47 States, the District of Columbia, Guam and Puerto Rico.
Source: Figure prepared by Congressional Research Service based on data from the National Association of State Alcohol and Drug Abuse Directors.

The NASADAD survey also includes information on expenditures in the States for alcohol and other drug services. Forty-eight States, the District of Columbia, Guam, and Puerto Rico provided data on total expenditures by source of funding and types of program activity--treatment, prevention, and other activity for FY 1990. As with the other data in the NASADAD survey, the data on expenditures do not include information on those programs that did not receive any funding from the State alcohol and drug agency (e.g., most, if not all, private, for-profit programs; some private, not-for-profit programs; and some public programs). As a result, the overall expenditure estimates are conservative and, to varying degrees, underestimate expenditures by other departments of State government, by Federal agencies such as the Department of Veterans Affairs, and private, non-State agency-supported alcohol and other drug abuse treatment and prevention programs.

In FY 1990, according to the NASADAD survey, a total of over $2.9 billion was spent for alcohol and other drug services in those programs receiving at least some State-administered funds. Of the total, States spent $2.1 billion (72.3 percent) for treatment activities, over $429 million (14.7 percent) for prevention activities, and the remaining $377.9 million (13 percent) for other activities, such as capital construction, research, administration, and training. The total expenditure of $2.9 billion includes nearly $1.1 billion (37.8 percent) from State alcohol and drug agency sources, $285.7 million (9.8 percent) from other State agency sources, $645.5 million from the Alcohol, Drug Abuse, and Mental Health Services Block Grant and related grants from ADAMHA, $199.2 million (6.8 percent) from other Federal sources, $223.3 million (7.7 percent) from county or local agency sources, and $457.6 million (15.7 percent) from other sources (e.g., reimbursements from private health insurance, client fees, court fines or assessments for treatment imposed on intoxicated drivers).[18] (See figure F-3.)

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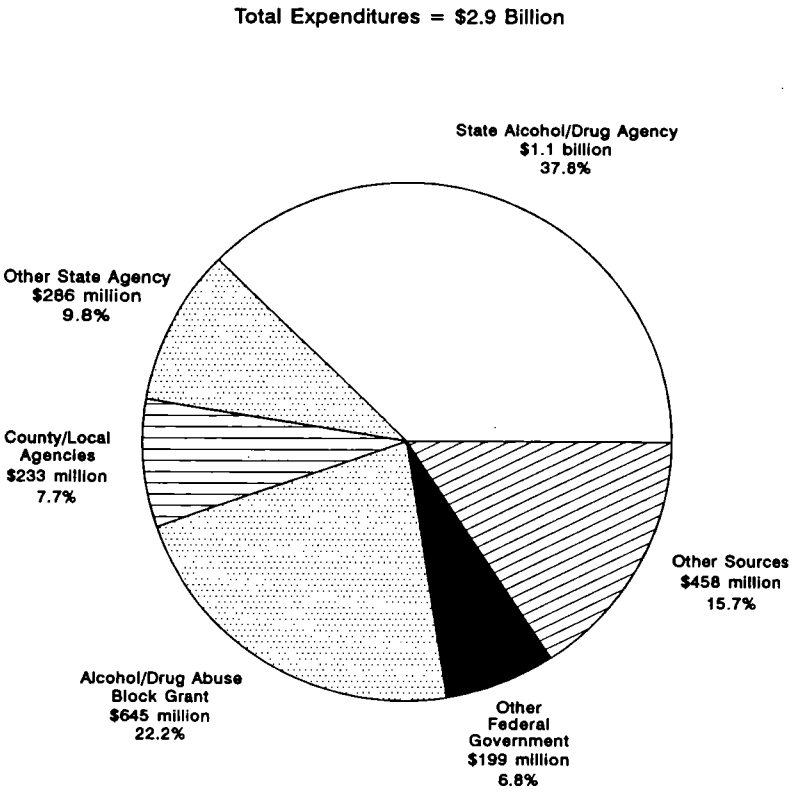
[18]NASADAD FY 1990 State Report, p. 5-8. According to the publication's glossary of terms, "other Federal sources" includes all Federal funds used for support of alcohol and/or drug treatment or prevention services other than the block grant, and could include the Federal share of Medicaid. "Other State sources" would include the State share of Medicaid funds provided for treatment services unless the Medicaid share is provided by the State Alcohol and/or Drug Agency's State appropriation. According to NASADAD sources, it is not possible to determine the specific amounts of Medicaid dollars in either of these totals.

FIGURE F-3. Expenditures Reported for State Supported Alcohol and Other Drug Abuse Services by Funding Source, FY 1990



NOTE: The "Other Sources" category includes funding from sources such as client fees, court fines and reimbursements from private health insurance. "Other Federal Government" could include Federal Medicaid funds. "Other State Agency" could include State Medicaid funds.
Source: Figure prepared by Congressional Research Service based on data from the National Association of State Alcohol and Drug Abuse Directors. Data are included for "only those programs which received at least some funds administered by the State Alcohol/Drug Agency during the State's fiscal year 1990."

V. MEDICAID COVERAGE OF SUBSTANCE ABUSE TREATMENT SERVICES

A. Background

Medicaid does not specifically provide, either in law or regulation, for the coverage of treatment for substance abuse. Such treatment is covered to the extent that it can be covered under an approved Medicaid category. The program is used in varying degrees to cover substance abuse services under such categories as inpatient hospital services, hospital outpatient services, physician-supervised services, clinic services, licensed practitioners' services, and rehabilitative services.

Over the years, HCFA had provided guidance to State Medicaid agencies on whether substance abuse treatment services were reimbursable under the Medicaid program. Such guidance was provided on a case-by-case basis, whenever a State requested it. In 1990, HCFA provided two statements of Medicaid policy regarding reimbursement for substance abuse treatment. The first was in a May 23, 1990, letter from HCFA Administrator Gail Wilensky to Senator Daniel P. Moynihan to clarify what coverage exists under Medicaid for treatment of addiction to crack cocaine. Later in the year, in an August 2 guidance sent to State Medicaid directors, the Medicaid Bureau of HCFA reviewed the ways that Medicaid benefits relate to the treatment of drug addiction and related problems. A provision in the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) then codified to a certain extent the HCFA policy regarding Medicaid reimbursement for substance abuse treatment as stated in the two documents--that nothing shall be excluded from Federal financial participation solely because it is provided as a treatment service for alcoholism or drug dependency.

The Wilensky letter to Senator Moynihan states that, "To the extent individuals are eligible for Medicaid and need inpatient hospital care, it is covered under the Medicaid program. For mandatory Medicaid benefits, such as inpatient hospital services, regulations explicitly prohibit States from using a recipient's diagnosis, type of illness, or condition as the basis for arbitrary limiting or denying coverage."[19] (*Chapter IV, Services* provides State level information on optional services covered in State Medicaid plans.)

The August 1990 guidance to State Medicaid directors from the Medicaid Bureau reviewed the ways Medicaid program benefits can help persons with drug addiction and related problems. According to this communication, "a number of primary care services may be used, including physicians' services, clinic services, and pharmaceuticals (e.g., methadone)."[20] Additionally,

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[19]Wilensky, Gail. Statement by Senator Moynihan. *Congressional Record*, Daily Edition, v. 136, June 12, 1990. p. S 7805.

[20]U.S. General Accounting Office. *Substance Abuse Treatment: Medicaid Allows Some Services but Generally Limits Coverage*. Report No. GAO/HRD-91-

(continued...)

addiction-related services may be provided by home health agencies, under home and community-based services waivers (section 1915(c)), and as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. According to the HCFA guidance, a number of States have used freedom-of-choice waivers or exceptions to their State plans to implement managed care programs targeted to substance abuse. Case management may be used to coordinate the needed services, and special day treatment programs may be established that combine needed therapy, counseling and other services.

Inpatient hospital benefits may be used for such services as acute treatment of symptoms, detoxification, and drug-related medical complications. Rehabilitation services may be provided in such settings as outpatient programs in hospitals and clinics, and inpatient programs located in nursing facilities, psychiatric hospitals, and special units in general hospitals. Rehabilitation services may also be provided in settings that are not Medicaid participating facilities.

An amendment to the Medicaid Act enacted as part of OBRA 90 set in law the Medicaid policy described in the two communications. The Senate Finance Committee, which originated the amendment, noted in its report on the legislation the "confusion among States about whether substance abuse treatment may be covered" and cited the August 1990 guidance to the States which clarified "that any of the Medicaid services that States may offer may be used to treat substance abuse." The new statutory language, added to the end of section 1905(a) of the Act, states: "No service (including counseling) shall be excluded from the definition of 'medical assistance' solely because it is provided as a treatment service for alcoholism or drug dependency." That is, States can receive Federal Medicaid matching payments for these services.

The statutory restriction described in *Appendix E, Medicaid Services for the Mentally Ill* that precludes the payment for services to individuals between the ages of 22 and 65 in Institutions for Mental Diseases (IMDs) can affect some inpatient programs for treating substance abuse. The Medicaid program, using the International Classification of Diseases, Clinical Modification (ICD-9-CM), classifies alcohol and drug abuse as mental disorders. Consequently, facilities that exclusively treat psychiatric or substance abuse disorders are considered by Medicaid as IMDs. The Medicaid Bureau's guidance to the States notes that these restrictions do not apply to any facility with fewer than 17 beds, and suggests that it may be advantageous to set up this type of program in smaller facilities, even though room and board payment would not be made unless it is a participating facility. Optional IMD benefits are also available in psychiatric facilities for individuals under age 21 and for individuals age 65 and over regardless of the size of the facility.

It is difficult to determine the amount of Medicaid payments for substance abuse treatment and related services. The General Accounting Office (GAO), in

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[20](...continued)
92, June 1991. Washington, 1991. p. 16-17. (Hereafter cited as GAO Report, *Substance Abuse Treatment*)

a 1991 report, found that HCFA and the States were unable to document Medicaid substance abuse treatment expenditures because there is not a separate category for substance abuse treatment on States' Medicaid expenditure reports. Expenditures are reported by type of Medicaid service, such as inpatient hospital, physician, rehabilitative, or clinical services, not by condition diagnosis, such as substance abuse.[21]

B. State Summaries

In its 1991 review, GAO visited nine State Medicaid offices and substance abuse agencies (Alabama, California, Florida, Georgia, Massachusetts, Minnesota, New York, Oregon, and Texas) to determine the types of substance abuse services available under Medicaid. They found, as table F-1 shows, that some States had made little use of Medicaid options for substance abuse treatment, while others offered a wide variety of services.

[21]GAO Report, *Substance Abuse Treatment*, p. 8.

TABLE F-1. Summary of Substance Abuse Treatments Available Under Medicaid and Offered by States GAO Visited, 1991

Type of Medicaid service	Examples of available treatments	Available in these States
Inpatient hospital	Detoxification, any acute treatment of symptoms, or treatment for complications	Alabama, Florida, Georgia, Massachusetts, New York, Texas, California, Oregon
Outpatient hospital	Detoxification, counseling, or methadone maintenance	Massachusetts, New York, California, Georgia
EPSDT	Any treatment to correct physical or mental problems found during EPSDT screening	All nine States
Physician services	Detoxification, counseling, psychotherapy, or methadone maintenance	Alabama, California, Florida, Georgia, New York
Home health services	Services for treating addiction	None
Other medical/remedial care	Counseling	Georgia, Oregon
Clinic services	Detoxification, counseling, psychotherapy, methadone maintenance	Alabama, California, Georgia, Massachusetts, New York
Drug services	Methadone	None

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TABLE F-1. Summary of Substance Abuse Treatments Available Under Medicaid and Offered by States GAO Visited, 1991--Continued

Type of Medicaid service	Examples of available treatments	Available in these States
Other preventive and rehabilitative care	Counseling, psychotherapy, and day treatment services	Oregon, Florida, Minnesota
Inpatient psychiatric services in an IMD for individuals over 65	Residential services, psychiatric counseling, methadone maintenance, or other psychiatric services	Florida, New York
Inpatient psychiatric services in an IMD for individuals under 21	Residential services, psychiatric counseling, methadone maintenance, or other psychiatric services	Alabama, Massachusetts, New York, Oregon
Other medical or remedial care	Any other services authorized by the Secretary of HHS	None
Home or community-based services (waivers only)	Case management, home health, personal care, adult day health services, or respite care services	None
Waivers or exceptions	Managed-care programs	None
Targeted case-management services	Any service that will assist a recipient in gaining access to needed services	Georgia

Source: U.S. General Accounting Office. *Substance Abuse Treatment: Medicaid Allows Some Services But Generally Limits Coverage*. GAO-HRD-91-92, June 1991. Washington, 1991. p. 16 and 17.

According to the GAO survey, the nine States they visited varied in coverage limits of substance abuse treatment under Medicaid. Massachusetts, for instance, limited counseling to 24 visits per year, while Florida had no such limitations. Alabama restricted all outpatient counseling treatment to a mental health clinic, while Georgia had no such location restriction. Seven States did not allow inpatient rehabilitation following detoxification, and all nine States either denied or limited inpatient hospital treatment for substance abuse treatment.

State Medicaid officials in five States indicated to the GAO researchers that they planned new initiatives to implement additional substance abuse services reimbursable under Medicaid. Alabama planned to offer expanded comprehensive treatment under the rehabilitation option. Massachusetts indicated that it was working with other agencies on substance abuse shelters and trying to get day treatments covered. New York was planning to offer case management of pregnant women in 11 specific neighborhoods, coordinating services from 16 agencies. Oregon was planning initiatives for drug users, such as treatment on demand for pregnant women and adolescents, the provision of services for the deaf and hearing impaired, and special services for some ethnic groups. Texas had submitted a State plan amendment to offer treatment when substance abuse is detected during early and periodic screening.[22]

Until recently there was not available any general review of all States' coverage of substance abuse treatment under Medicaid, except for a survey of Medicaid substance abuse services for children and adolescents which will be cited later in this appendix. In February of 1992, the Intergovernmental Health Policy Project (IHPP) published the results of a 50-State survey of Medicaid substance abuse services. The report includes the results of a survey conducted by questionnaire sent to State Medicaid agencies in 1990, which provides more extensive information than has previously been available on States' coverage of substance abuse services under Medicaid. According to this survey, Arizona, Kentucky, New Hampshire, and South Dakota do not offer substance abuse services under their Medicaid programs, but most other States provide at least some (if limited) services and represent an array of service or program alternatives.[23]

Alaska, for instance, provides crisis intervention services and methadone maintenance therapy as part of rehabilitation but only when chemical dependency is identified as a dual or secondary diagnosis. Colorado provides emergency admission for detoxification; Idaho will reimburse inpatient hospitalization for acute withdrawal and detoxification. Arkansas' services are for the most part restricted to hospital settings, including inpatient hospital facilities, inpatient psychiatric facilities for clients under age 21, inpatient care for clients over 65 in IMDs, and outpatient hospital-based clinics. The

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[22]GAO Report, *Substance Abuse Treatment*, p. 6-7.

[23]Solloway, *A 50-State Survey of Medicaid Coverage*, p. 13-29. This section of the appendix describing State coverages of services uses this document and the State Profiles that accompany it as sources.

services, which may be provided in private offices, and counseling services, which are restricted to public health clinics. South Carolina has a limited set of services for substance abuse, including: assessment counseling (diagnosis and evaluation); individual, group, family and family unit counseling; intensive outpatient care; crisis management, targeted case management; medical assessment; and medical reevaluation.

A number of States use the rehabilitative services optional benefit to provide substance abuse treatment clients. Alabama, for example, uses this category to provide an array of services, including intake evaluation; medical assessment and treatment; crisis intervention; counseling and therapy (individual, family, group); medication administration and monitoring; treatment plan review; day treatment; and in-home intervention. Kansas and Ohio offer similar services under the rehabilitative services benefit. Kansas further includes screening services and day treatment, while Ohio includes case management services. Iowa uses this benefit to reimburse up to 28 days of outpatient substance abuse treatment.

California uses the clinic services benefit to cover outpatient heroin detoxification on a fee-for-service basis. It also uses clinic services to provide a variety of substance abuse services through county Alcohol and Drug Programs (ADP), which are operated through an interagency agreement with the State's Department of Alcohol and Drug Programs. Services include: methadone maintenance; drug-free treatment; naltrexone treatment; and day-habilitative programs to maintain drug-free status. Hawaii uses the benefit categories of physician and non-physician services to provide diagnosis and referral; individual and group counseling; and prescription drugs. Montana uses four benefit categories--physician services, clinic services, outpatient hospital services, and non-physician services--to provide substance abuse services to Medicaid recipients.

Several States have developed special programs under Medicaid waiver options or targeted case management services for specific populations, such as those with acquired immune deficiency syndrome (AIDS) or those who are human immunodeficiency virus (HIV) positive (California); high-risk children (Wisconsin) and adolescents (Ohio); pregnant women and drug-dependent babies (Pennsylvania); and Medicaid clients participating in jobs programs (Ohio). Some of these programs, such as those for AIDS/HIV and high-risk, low-income pregnant women, may contain components that deal with substance abuse services, but that may or may not be specifically designed to treat chemical dependency.

The IHPP survey found that a number of States have developed coordinated substance treatment programs to serve their Medicaid populations. States such as California, Illinois, Maryland, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, and Wisconsin, for instance, have developed linkages between their Medicaid programs and their substance abuse treatment programs, which are usually located in a different State agency. The State of Minnesota has a consolidated program in which Medicaid funds, along

with State appropriations, other Federal funds, county funds, and client fees, finance a public substance abuse program that serves Medicaid clients and those who are not Medicaid-eligible. The funds finance the State's "Consolidated Chemical Dependency Treatment Fund," which is designed to operate like an insurance policy for the State's poorest citizens in need of substance abuse treatment.

C. Discussion

The IOM, in its 1990 report on treating drug problems, characterized the general level of coverage provided by States. It found that States that provided Medicaid support to substance abuse treatment providers commonly reimbursed such services as physician examinations at admission to treatment (but generally at a rate equal to a conventional outpatient office visit rather than a multiphasic examination appropriate for an individual potentially severely compromised by drug abuse or dependence), methadone prescription (but generally at a rate that does not cover the cost of meeting Federal regulations to run a lawful maintenance clinic), and services of psychiatrists or licensed clinical psychologists (but not other counseling professionals). Emergency hospitalization for drug overdoses is generally covered, but, according to the IOM survey, treatment in residential programs is rarely reimbursed.[24]

One of the reasons for such limitations in Medicaid coverage for substance abuse treatment is that the Medicaid program was designed originally to cover health care services provided through a "medical model." Of the various modes of substance abuse treatment, only detoxification and methadone maintenance, and those hospital-based programs that provide treatment by or under the direction of a physician, fit comfortably into a medical model. Treatment programs such as therapeutic communities and most outpatient programs in which treatment is provided through peer counseling, group meetings, and the use of such nonmedical personnel as former addicts, would not be considered as medical in nature and would not be reimbursable under Medicaid.

Substance abuse treatment provided in nonhospital residential treatment, such as therapeutic communities and other residential treatment programs, rarely receives Medicaid reimbursement because a significant portion of the costs of these programs is often the room and board costs for their patients, and Medicaid does not reimburse for room and board costs for nonhospital programs.[25] The consistent comment of the States responding to the IHPP survey was that the reimbursement restrictions on IMD services and residential treatment prohibit cost-effective provision of substance abuse services under Medicaid.[26]

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[24]Gerstein and Harwood, *Treating Drug Problems*, p. 271.

[25]Gates, David. An Overview of Federal Funding Programs for the Prevention and Treatment of Alcoholism and Drug Dependency. *National Health Law Program*, Jan. 1991. Washington, 1991. p. 6-18.

[26]Solloway, *A 50-State Survey of Medicaid Coverage*, p. 14.

VI. SUBSTANCE ABUSE TREATMENT SERVICES FOR PREGNANT AND POSTPARTUM WOMEN

A. Background

Women of child-bearing age have become increasingly vulnerable to substance abuse problems in the United States in recent years. This has become particularly evident since the appearance and spread of "crack" cocaine in the mid-1980s. Young women have been identified as one of the fastest growing crack user groups. The 1988 National Household Survey on Drug Abuse indicated that 14.1 percent of women between the ages of 18 and 25, and 9.6 percent of the women between the ages of 26 and 34 were currently using at least one illicit drug, that is, they reported using drugs within the last month. The 1991 Household Survey found decreases in reported drug use among these groups--13.4 percent of women between the ages of 18 and 25 and 6.6 percent of women between ages 26 and 34 had used an illicit drug during the previous month.[27]

A 1988 survey found that 11 percent of women presenting for prenatal and related childbirth services at 36 hospitals across the Nation admitted to illicit drug use during pregnancy; projected nationwide, this means that 375,000 infants born each year are exposed to drugs in utero. The Inspector General of the Department of Health and Human Services estimated in a 1990 report that 100,000 infants a year are born to women who use drugs during pregnancy. Other surveys estimated that up to 739,000 infants each year are exposed to illicit drugs.[28] The IOM, in its 1990 study on drug abuse treatment, estimated that 105,000 pregnant women a year need treatment for substance abuse.[29]

Alcohol and illicit drug use during pregnancy can lead to medical and other complications for both mother and infant. Among the common medical complications that can be attributed to alcohol or drug use during pregnancy, in addition to miscarriage and premature delivery, are such disorders as anemia, bacteremia, cardiac disease, hepatitis, pneumonia, urinary tract infections, and various sexually transmitted diseases. The use of alcohol during pregnancy can cause serious problems for the mother, including miscarriage or stillbirth, or premature delivery. Many chronic substance abusers often use both illicit drugs and alcohol, increasing the hazards for their health.

Drug and alcohol use during pregnancy can cause short- and long-term difficulties for the fetus as well. Research suggests that prenatal exposure to cocaine and to other illicit drugs can lead to such immediate problems as

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[27]NIDA, *National Household Survey on Drug Abuse*, 1988, p. 17; and NIDA, *National Household Survey on Drug Abuse*, 1991, p. 19.

[28]Chasnoff, Ira J. Drugs, Alcohol, Pregnancy, and the Neonate: Pay Now or Pay Later. *Journal of the American Medical Association*, v. 266, no. 11, Sept. 18, 1991. p. 1567.

[29]Gerstein and Harwood, *Treating Drug Problems*, p. 234.

premature birth, low birthweight, birth defects, and respiratory and neurological problems. Cocaine-exposed children also appear to have a higher rate of sudden infant death syndrome (SIDS). Early studies on maternal cocaine use during pregnancy also indicated that so-called cocaine babies would pose behavioral problems and experience difficulties in learning that would cause significant societal problems once they reached school age in large numbers.[30]

More recent research reports, however, indicate that maternal cocaine use during pregnancy may not lead to lasting harm in the children born to such pregnancies. Methodologic problems that raise critical questions about the findings of such research have been found. Current researchers state that they do not underestimate the potential impact of the use of cocaine by pregnant women, but feel that early studies failed to take into account other factors that may have contributed to the medical and developmental problems suffered by these children. They suggest that the various problems previously associated with intrauterine cocaine exposure may be more accurately attributed to a combination of factors, such as premature birth, sexually transmitted diseases, the effects of poverty and poor medical treatment, lifestyle, and maternal exposure to alcohol, tobacco, and other drugs during pregnancy. These researchers emphasize that the children born under these conditions are not necessarily permanently disabled and do benefit from comprehensive services, such as adequate nutrition, health care, and early developmental intervention programs. They recommend for the mothers drug treatment, health care, and family support services, emphasizing the importance of coordination of service delivery.[31]

Some researchers feel that maternal use of alcohol during pregnancy may pose a greater risk to the fetus than does cocaine. The cluster of symptoms describing a common pattern of birth defects observed in children born to alcoholic mothers was first reported in 1973 and labeled Fetal Alcohol Syndrome (FAS). The defects of FAS include prenatal and postnatal growth retardation, craniofacial anomalies, central nervous system dysfunction, and major organ

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[30]Chasnoff, Ira J., et al. Cocaine Use in Pregnancy. *New England Journal of Medicine*, v. 313, no. 11, Sept. 12, 1985. p. 666-669.

Chasnoff, Ira J., et al. Temporal Patterns of Cocaine Use in Pregnancy: Perinatal Outcome. *Journal of the American Medical Association*, v. 261, no. 12, Mar. 24/31, 1989. p. 1741.

Zuckerman, Barry, et al. Effects of Maternal Marijuana and Cocaine Use on Fetal Growth. *New England Journal of Medicine*, v. 320, no. 12, Mar. 23, 1989. p. 762-768.

[31]Mayes, Linda C., et al. The Problem of Prenatal Cocaine Exposure: A Rush to Judgment. *Journal of the American Medical Association*, v. 267, no. 3, Jan. 15, 1992. p. 406-408.

Viadero, Debra. New Research Finds Little Lasting Harm for 'Crack' Children. *Education Week*, Jan. 29, 1992. p. 1,10.

may be described as suffering from suspected fetal alcohol effects, or FAE. Estimates of the incidence of FAS range for one to three cases per 1,000 live births; the incidence of FAE is estimated to be approximately three times higher.[32]

B. Coverage of Treatment Services for Pregnant Substance Abusers

Many of the women who are substance abusers are persons with sufficiently low income that, if they are not already eligible for Medicaid services, are likely to be eligible for maternal and child health services under the program. When pregnant, they and their children may be eligible to receive such services related to the pregnancy as prenatal care, delivery, and post partum care. Services under Medicaid may be delivered as soon as the pregnancy is verified and continues until the end of the month in which the 60-day post partum period ends to ensure that adequate postnatal care is provided.

In addition to such childbirth-related medical services, pregnant women may also be eligible for Medicaid coverage of substance treatment, as discussed in the main body of this appendix. It should be noted that because Medicaid covers all pregnant women up to 133 percent of poverty, and in nearly half of the States up to 185 percent, the program has the potential to be a major funding source for substance abuse treatment services for this population. According to HCFA, however, the extent of Medicaid payments specifically related to substance abuse treatment services is currently not well known, and can be expected to vary widely among States. The agency has research underway through a cooperative agreement with the Bigel Institute for Health Policy of Brandeis University to estimate costs to Medicaid for alternative levels of treatment services to pregnant, substance-abusing women. Results of the research are expected by the end of 1992.[33]

Despite the obvious need of pregnant substance abusers for such services, there is evidence that many drug treatment programs do not adequately serve this population. Women substance abusers have always faced difficulties in obtaining treatment services, but women who are also pregnant or have children face even more extensive barriers. Many drug treatment programs have traditionally been unwilling to provide services to pregnant women. One researcher surveyed treatment programs in New York City and found that 54 percent categorically excluded pregnant women. In addition, availability of treatment services was limited by restrictions on method of payment accepted by the program or by the specific substance abuse that would be treated. Sixty-

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[32]NIAAA, *Seventh Special Report*, p. 139-140.

[33]U.S. Dept. of Health and Human Services. Health Care Financing Administration. *Improving Access to Care for Pregnant Substance Abusers.* Special Solicitation to State Medicaid Agencies on Availability of Funds for Demonstration Project Grant Funds, Dec. 1990; and telephone communication with HCFA personnel.

seven percent of the programs surveyed rejected pregnant Medicaid patients and only 13 percent would accept pregnant Medicaid patients addicted to crack.[34]

HCFA in December of 1990 announced a program of five demonstration projects to help improve access to early medical and substance abuse treatment services, and other relevant services to address the varied needs of Medicaid-eligible, pregnant substance abusing women and their infants. The demonstration is being implemented in geographically dispersed areas with demonstrated substance abuse problems and large numbers of Medicaid-eligible females of child-bearing age. The five projects will provide for the modification of services and/or payment approaches under Medicaid to promote access to comprehensive services for pregnant substance abusers and their infants. Projects may offer services to Medicaid-eligible, pregnant substance abusers between the ages of 22 and 65 who are patients in IMDs. Medicaid payment for services provided in IMDs within this age range is currently precluded by law. The demonstration is being funded at a level of $6 million to administer and monitor the five projects. Funding will be available for up to a 12-month developmental period, 3 years of service delivery, and a 6-month phase-out period.

The five project awards, announced in September of 1991, went to develop programs in Baltimore, Maryland; Boston and Holyoke, Massachusetts; New York City and three New York upstate areas; Edisto Health District, South Carolina; and Yakima County, Washington. The applicants selected for funding, according to HCFA, presented strong perinatal and substance abuse treatment systems, viable research designs, rich sources of data, and other innovative components, including creative and culturally sensitive methods of outreach. The successful applications commonly included case-finding, case management, provider training, community outreach, and other ancillary services, such as parenting education, nutrition counseling, and transportation. Three of the projects proposed providing services in an IMD setting. The demonstration projects will be evaluated under a separate contract with the results available at the end of the 4½ year grant period, in 1996 or 1997.

Since 1989, ADAMHA, through its Office for Substance Abuse Prevention (OSAP), has supported a demonstration grant program, authorized under title V of the Public Health Service (PHS) Act, for substance abuse prevention and treatment for pregnant and postpartum women. In addition, the Alcohol, Drug Abuse, and Mental Health Services Block Grant, originally authorized in 1981 under title XIX of the PHS Act, has included a provision requiring States to use 10 percent of their allotments for substance abuse programs and services designed for women (especially pregnant women and women with dependent children) and demonstration projects for the provision of residential treatment services to pregnant women. The ADAMHA Reorganization Act passed in July 1992, P.L. 102-321, authorized new grant programs for substance abuse treatment for pregnant and postpartum women. A new section 508 of the PHS Act authorizes grants, cooperative agreement, and contracts to establish and

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[34]Chavkin, Wendy. Drug Addiction and Pregnancy: Policy Crossroads. *American Journal of Public Health*, v. 80, no. 4, Apr. 1990. p. 485.

support residential treatment programs for such women, including child care and other related services. A new section 509 of the Act authorizes grants to establish projects for the outpatient treatment of substance abuse among pregnant and postpartum women and their infants.

The 1992 ADAMHA legislation also split the block grant into two separate block grants--a substance abuse block grant and a mental health services block grant. The new substance abuse block grant authority under title XIX, as amended, contains specific authorities to ensure the availability of treatment services for pregnant women and women with children. The block grant authority requires each State to use not less than 5 percent of its allocation in each of FY 1993 and 1994 to increase, relative to the previous year, the availability of such treatment services, either by establishing new programs or expanding the capacity of existing programs. For subsequent years, States are required to spend at least as much as it spent in FY 1994 for treatment services for this population. The legislation also requires that each entity providing treatment services under this provision must make available, either directly or through arrangements with other entities, prenatal services or childcare services to women receiving such services. States will be required, under the block grant authority, to ensure that each pregnant woman in the State who seeks or is referred for and would benefit from substance abuse treatment services is given preference in admissions to treatment facilities receiving funds under the block grant.

VII. CHILDREN AND ADOLESCENTS WITH SUBSTANCE ABUSE PROBLEMS

A. Background

The 1991 National Household Survey on Drug Abuse reported that 20.1 percent of the U.S. population aged 12-17 (4 million persons) had ever used an illicit drug, 14.8 percent (nearly 3 million persons) had used such a drug during the previous year, and 6.8 percent (1.37 million persons) had used an illicit drug during the previous month.[35] The report of the National High School Senior Drug Abuse Survey, conducted annually for NIDA by the University of Michigan's Institute for Social Research, showed that 44 percent of the class of 1991 had used an illicit drug sometime during their lifetimes; 88 percent had used alcohol. The report also showed that 16.4 percent of the class of 1991 had used an illicit drug during the 30 days prior to the survey; 54 percent had used alcohol in that period. These measures do not necessarily indicate a need for treatment services, although the findings from the survey that 3.6 percent of high school seniors in the class of 1991 reported using alcohol daily during the previous 30 days and that 29.8 percent reported engaging in binge drinking (5 drinks or more in a row) during the previous 2 weeks do represent a disturbing level of abuse.[36]

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[35]NIDA, *National Household Survey on Drug Abuse, 1991*, p. 19.

[36]National Institute on Drug Abuse. *Press Release: 1991 National High School Senior Drug Abuse Survey*, Jan. 27, 1992. Washington, 1992.

Funding Expanded Treatment Services

Funding and actually getting addicted clients into treatment centers is the nub of treatment expansion. The Institute of Medicine in its 1990 report proposed two treatment capacity expansion options worthy of consideration.

1.) The "Core Strategy" option would address existing waiting lists, remedy deficiencies in program quality and management, and implemement modest program incentives for pregnant women and children. This core strategy would exceed levels of public support by about $1 billion, plus $.5 billion as an additional one-time investment for staff training and facilities construction and renovation. This one-time investment expenditure need not be made in a single year; however, according to IOM it should not be stretched out over more that three years to avoid creating a bottleneck to effective treatment capacity.

2). The "Comprehensive Strategy" would add to the core plan a substantially greater induction of criminal justice clients and a more ambitious plan for treating drug-abusing and drug dependent mothers and children. This comprehensive plan would, in IOM's opinion, provide the optimal level of public treatment resources. This comprehensive plan would entail an annual operating increase of about $2.2 billion, plus a $1 billion one-time investment.

The IOM study also proposed an intermediate strategy option which is a compromise between the core and comprehensive strategies. This proposal would cost about $1.6 billion more in annual operating costs plus a $.8 billion one-time investment.

IOM dollar amounts are defined in terms of increases over estimated 1989 public outlays by state, Federal and local agencies. IOM cautioned that the data supporting the costs and results of proceeding along either recommended option have uncertainties. Improved data collection and analysis will lead to adjustment of these costs figures and the appropriate amount of Federal contribution.

Although these costs will require further refinement, the IOM report yields the best estimate to date on what treatment capacity expansion programs targeted at the highest-risk groups would cost in terms of public expenditures.

Other Funding Options

1. Pregnant Women. As noted above, pregnant substance-abusing women should be a high priority for expanded access to treatment services because of the large numbers of women of child-bearing age drawn into drug

addiction and dependence as a result of the crack epidemic of the 1980's. Many of these heavy drug users are poor, minority women who lack access to basic medical and prenatal care as well as substance abuse treatment services.

Under current law, Medicaid acts as a major barrier to treatment for these women. The Institutions for Mental Diseases (IMD) exclusion under Medicaid bars reimbursement for almost all residential substance abuse services in free-standing programs, which is often the most effective , and cost-effective, treatment for many pregnant substance abusers. Moreover, an individual who is otherwise eligible for Medicaid who enrolls in a residential treatment program loses her Medicaid eligibility for any services. Thus, in the vast majority of cases, the IMD exclusion not only bars coverage for the most appropriate treatment but also removes coverage for prenatal, post-partum and other health care services essential to the treatment process and to improving the overall health and welfare of pregnant, substance abusing women and their infants.

The Clinton Administration should strongly consider supporting legislation to remove the IMD exclusion as it applies to residential treatment for pregnant and post-partum women. Legislation such as H. R. 2489, the Medicaid Family Care Act, would give states the option to allow Medicaid coverage for residential drug treatment during pregnancy and up to one year thereafter for women and their children. Participating programs would be required to provide a comprehensive array of services to help poor, substance abusing women overcome their drug dependence, deliver healthier babies and raise strong, productive families. These services include: counseling; addiction education and treatment; AIDS counseling; access to developmental and educational services for children; daycare; access to prenatal and post-partum medical care for women and pediatric care for their infants; job training and counseling, and other assistance in re-entering society.

This proposal would make available an additional funding stream to expand access to treatment for a population with compelling treatment needs that has been woefully underserved by the existing treatment system The cost of such a proposal, estimated at $550 million over five years, would be more than offset by the potential savings from reduced spending on more expensive medical care, special education and other health and social services for these women and their children as well as the potential increases in productivity and tax revenues from women who successfully complete treatment.

2. Demonstration Programs. A lower cost alternative to begin expand the delivery of treatment services would be the creation of demonstration programs in areas of the country that are the hardest hit by drug abuse and AIDS. Thes demonstration program would seek to integrate effective treatment practices, with other ancillary programs such as job training and

counseling, vocational and other eductional opportunities, non-substances abuse health care, and other appropriate services in order to mainstream abusers back to society as productive citizens.

National Health Insurance

Any proposal for national health insurance should include a substance abuse benefit. Drug and alcohol treatment services should be covered by a benefit that is separate and distinct from a mental health benefit to ensure that services are provided by the appropriate providers in clinically appropriate settings.

The benefit, both in the context of small market reform or more universal coverage, would provide for a comprehensive, continuum of care in which the following services would be available:

- Intervention, including assessment, diagnosis, and referral.

- detoxification.

- rehabilitation services.

- outpatient services.

- therapeutic community.

- case management.

- pharmacotherapeutic intervention.

- family outpatient services.

- halfway house care.

- three-quarter-way house care.

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MEDICAID LIMITS ON SUPPORT OF INSTITUTIONAL PSYCHIATRIC CARE

Jeffrey A. Buck, Ph.D., Charles A. Kiesler, Ph.D., Thomas D. Ashman, M.B.A., and Celeste G. Simpkins, A.A.

ABSTRACT: This article summarizes a Report to Congress concerning Medicaid limits on assistance for patients in institutions for mental diseases (IMDs). There is little or no basis for changing this policy. Court judgments have found that the policy's application has been reasonable and consistent with congressional intent. Also, the general trend in the alcohol, drug abuse, and mental health (ADM) service system has been in outpatient or partial care, not institutional care. Research supports the conclusion that alternatives to IMD treatment are the most cost-effective. Finally, eliminating the IMD policy would be expensive, and simply substitute federal for state funding.

Requested via ILL

In 1989, Congress directed the Secretary of Health and Human Services to prepare a report on the Medicaid policy concerning institutions for mental diseases (Omnibus Budget Reconciliation Act of 1989), which was delivered in December 1992 (Department of Health and Human Services, 1992). The report describes the policy's history. It also assesses its impact in light of changes in the alcohol, drug abuse, and mental health service system and current knowledge of the cost-effectiveness of treatment. This article excerpts and summarizes the report.

Since the beginning of the program in 1965, Medicaid law has excluded medical assistance for certain patients in institutions for mental diseases

Richard Frank and David Salkever of Johns Hopkins University provided cost estimates and expenditure information.

Jeffrey Buck is with the Center for Mental Health Services, Rockville, Maryland. Charles Kiesler is Chancellor of the University of Missouri-Columbia. Thomas Ashman is a doctoral student in finance at S.U.N.Y. Buffalo. Celeste Simpkins is with Vanderbilt University.

The views presented in this paper are those of the Department of Health and Human Services and not necessarily those of the authors.

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(IMDs). As now defined, an IMD is a facility of more than 16 beds that specializes in psychiatric care. Generally, state mental hospitals, private psychiatric hospitals, and residential substance abuse programs are all examples of IMDs.

The IMD exclusion has often been criticized. Perhaps the most common charge is that the policy discriminates against those with mental illness and limits Medicaid funding of needed care. Many also contend that Congress meant the IMD policy only to prohibit payment for services that were custodial in nature or provided within traditional state institutions. Others believe that the Health Care Financing Administration (HCFA), the agency that administers Medicaid, has not implemented the IMD policy as Congress intended.

The Report to Congress does not address the criticism that the IMD exclusion is inequitable or discriminatory. However, it does provide information that either answers the remaining criticisms or assists in their evaluation.

POLICY DESCRIPTION

Medicaid law allows states the option of providing hospital and nursing facility (NF) services for individuals 65 years of age or over in an IMD. It also allows them to offer inpatient psychiatric services for individuals under age 21 (Social Security Act, 1991a). However, except for such individuals, Medicaid does not cover services to IMD patients under 65 years of age (Social Security Act, 1991b).

The IMD exclusion does not limit individual eligibility for Medicaid. Federal matching funds are simply not available for medical services to IMD patients in the affected age groups. However, IMD patients may be provided Medicaid administrative services, such as case management. They may also receive medical assistance on discharge without having to reapply for the program.

The IMD exclusion does not apply solely to persons with mental illness, or to mental health or substance abuse services. Medical assistance is unavailable for *any* patient in an IMD in the affected age group, regardless of diagnosis. Similarly, matching funds are denied for *all* medical services, not just those of a psychiatric nature. If an IMD temporarily releases a patient to obtain medical treatment (e.g., surgery in a general hospital), the patient is considered to remain in the IMD. In such a case, medical assistance is not available during the absence (State Medicaid Manual, 1990).

Reviewers rely on HCFA guidelines in determining if a facility's overall character is that of an IMD (State Medicaid Manual, 1990). These guidelines include criteria such as whether a majority of the facility's population have mental diseases or whether the facility is under the jurisdiction of the state's mental health authority. These criteria may be applied to any residential

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program of more than 16 beds, regardless of ownership, licensure, treatment modality, or length of stay of the residents. Thus, a hospital, nursing home, or freestanding treatment center could be an IMD if it met the criteria.

LEGISLATIVE HISTORY

The basis for the IMD exclusion was established well before the creation of the Medicaid program. Amendments to the Social Security Act in 1950 provided that old age assistance included payments to residents of public medical institutions (Pub. L. 81–734, 1950). However, it excluded assistance to IMD patients or patients being treated for psychosis in other types of medical institutions.

The exclusion of payment for all IMD residents continued until the creation of the Medicaid program in 1965 (Social Security Amendments, 1965). For the first time, Congress provided medical assistance for individuals 65 years or older in IMDs. It also removed prohibitions on funding for the mentally ill in general hospitals. In 1972, optional coverage of inpatient psychiatric services for individuals under 21 was added, along with intermediate care facility services for the elderly in IMDs (Pub. L. No. 92-603, 1972).

Congress did not define the term "IMD" until passage of the Medicare Catastrophic Care Act of 1988. It defined an IMD as ". . . a hospital, NF, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services" (Social Security Act, 1991c). Except for the 16 bed requirement, this section incorporated existing regulatory language. This change allowed states to develop small, community-based residential programs without fear of their vulnerability to the IMD exclusion.

JUDICIAL DECISIONS

Many administrative appeals and several court actions have challenged the interpretation of the IMD policy. In 1985, the Supreme Court ruled on the IMD exclusion in a case involving a nursing home in Connecticut (*State of Connecticut Dept. of Income Maintenance v. Heckler*, 1985). The Court found that the nursing home was an IMD since it was primarily engaged in treating persons with mental diseases. The Court further determined that the IMD designation was not limited to traditional state institutions. Instead, it could apply to nursing homes and hospitals, and to public and private institutions. Finally, HCFA's interpretation of what constitutes an IMD was found to be consistent with Medicaid law.

Another important decision further clarified the exclusion's application (Pennsylvania Department of Public Welfare, 1989). In 1988, HCFA disal-

lowed several large claims that Pennsylvania made for services to IMD patients. In its appeal, Pennsylvania contended the claims were for emergency hospital services, which it argued was exempted from the IMD exclusion. Further, it contended that Congress intended the IMD exclusion to apply only to patients receiving long-term care services. The Departmental Appeals Board (DAB) upheld the disallowances. (A DAB judgment represents the final decision of the Secretary of Health and Human Services in such disputes.) It found that regulations for emergency hospital services do not waive the IMD exclusion. The DAB also found no distinction in Medicaid law based on duration of treatment.

TRENDS IN THE ADM SERVICE SYSTEM

The alcohol, drug abuse, and mental service system has changed significantly since the early years of the Medicaid program. As a result, the IMD exclusion probably affects a smaller part of the service system than it used to. For mental health (MH) inpatient services, the contribution of state and county mental hospitals has decreased dramatically since 1972, with a drop of two-thirds in beds and annual days of care (Manderscheid & Sonnenschein, 1990; Taube & Barrett, 1983). In contrast, psychiatric services within general hospitals increased greatly, and now account for more than half of all MH inpatient episodes (Manderscheid & Sonnenschein, 1990; Taube & Barrett, 1983). While the rate of annual MH inpatient additions increased by only 16% from 1971 to 1986, the rate of outpatient additions increased by 71%. MH partial care grew even more, with the rate of annual additions more than doubling between 1972 and 1986.

From 1978 to 1989, the rate of inpatient alcoholism treatment declined, while outpatient and partial care treatment rose by half (Alcohol, Drug Abuse, and Mental Health Administration, 1990; Vischi, Jones, Shank, & Lima, 1980). The rate of inpatient and outpatient drug treatment grew, with the greatest proportional gains in inpatient and residential care.

The relationship of the IMD policy to these changes in the ADM service system is difficult to assess. Nevertheless, some provisional conclusions may be drawn about the consequences of the IMD policy for changes in the ADM service system since 1972. The IMD exclusion applies to ADM residential treatment, specifically to facilities specializing in such care. Increases in outpatient and partial care mean that the IMD policy limits Medicaid payment for a smaller proportion of ADM services. The change in the IMD definition to exclude facilities of under 17 beds should further reduce this proportion.

The IMD policy probably affects a smaller proportion of ADM inpatient care than in the early 1970s. The two types of inpatient facilities most clearly meeting the IMD criteria are state and county mental hospitals, and private psychiatric hospitals. From 1972 to the mid-1980s, the part of MH inpatient days accounted for by these types of facilities declined by nearly 30% (Mander-

scheid & Sonnenschein, 1990; Taube & Barrett, 1983). The IMD policy possibly contributed to this trend.

COST-EFFECTIVENESS OF ADM TREATMENT

If it could be shown that IMD services were more effective or cost-effective than alternatives, then a strong argument could be made for changing the policy. However, reviews of the studies for alcohol, drug abuse, and mental health treatment fail to reach such conclusions. Most reviews of alcohol treatment research conclude that no treatment setting is better than another (Annis, 1986; Miller & Hester, 1986; Saxe & Goodman, 1988). Types and length of inpatient care, and inpatient care itself do not noticeably affect the efficacy of treatment. Well-designed studies find equal or superior outcomes by outpatient care compared to inpatient, at a fraction of the latter's cost. Since different treatments work to about the same degree, it follows that the least expensive (usually outpatient treatment) is the most cost-effective.

Cost-effectiveness or cost-benefit studies of drug treatment are extremely rare. Nevertheless, investigators have drawn conclusions about inpatient and outpatient care. Cross, Saxe, and Hack (1988) reviewed research on treatment for nonopiate drug abuse, including cocaine. They concluded that while treatment is better than no treatment, little or no evidence establishes the superiority of one type of setting over another. A review of all types of drug treatment found that different modalities are all effective (Anglin & Hser, 1991). Similar to alcohol treatment, costs vary dramatically, leading to the conclusion that the least expensive treatment is the most cost-effective.

Few good studies have examined alternatives to inpatient MH care, but have generally produced consistent results. Kiesler and Sibulkin (1987) reviewed 14 experimental studies that compared inpatient hospital care to alternative care outside a hospital. They found that the evidence clearly favored alternative care. They also concluded that alternative care was less expensive, partly by reducing subsequent hospitalization. Other reviewers have drawn similar conclusions (Braun et al., 1981; Greene & De La Cruz, 1981).

Cost-effectiveness research suggests that for mental disorders and alcohol disorders, and probably for drug disorders, inpatient care is used more frequently than it need be. Also, this literature has not demonstrated that the type of treatment provided in IMDs is either more effective or more cost-effective than alternatives. Accordingly, it provides little or no support for a change in the IMD policy to expand such care.

MEDICAID SUPPORT OF ADM SERVICES

Focusing on the IMD policy overlooks the considerable Medicaid support of other ADM services. Mandatory Medicaid services relevant for ADM care are inpatient and outpatient hospital services, EPSDT (early and periodic screen-

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ing, diagnosis, and treatment) services, and physician services. Applicable optional services include prescription drugs, clinic services, nonphysician providers, rehabilitative services, inpatient psychiatric services for individuals under age 21, case management services, occupational therapy, personal care services, and services in IMDs for those age 65 or over. These services can be used by states to support community-based programs of the types that are cost-effective alternatives to ADM inpatient care.

Estimates of Medicaid expenditures for ADM services vary widely, due to limited national data on the program. Taube (1990) suggested that 1983 Medicaid spending for mental health services totaled $1.6 billion exclusive of long-term care. Using a 5% inflation factor, this translates to a 1990 cost of $2.3 billion. However, the true amount may be two to three times as much. Using Medicaid expenditure and utilization data, Wright and Buck (1991) estimated 1984 national Medicaid expenditures for ADM services to be $3.5 to $4.9 billion, exclusive of long-term care. Inflating these figures in the same manner as the Taube estimates implies a range in 1990 dollars of $4.7 to $6.6 billion. Other estimates by Taube (1990) suggest that the 1990 amounts could increase by $2 billion or more if long-term care expenditures were added.

COSTS OF ELIMINATING THE IMD EXCLUSION

Eliminating the IMD exclusion would be expensive. Table 1 presents the estimated increase in Medicaid expenditures that would result from eliminating the IMD exclusion. Not all the $3.10 billion increase in annual expenditures would represent new spending. State and local governments spent an estimated $1.83 billion in 1990 on Medicaid eligible individuals in IMDs under the current exclusion. Adding the (state) costs of nursing homes that are IMDs increases this figure to $2.23 billion. However, given that the average

TABLE 1
Estimated Increases in Medicaid Expenditures Resulting from Eliminating the IMD Exclusion (In thousands of 1990 dollars)

Treatment Setting	Increased Expenditures	Initial Demand Increase
State and County Mental Hospitals	$1,962,838	$2,265,115
Private Psychiatric Hospitals	85,684	98,879
Other ADM Residential Settings		
Mental Health	67,613	78,025
Drug Abuse	50,752	58,568
Alcohol Abuse	169,173	195,226
Subtotal	$2,336,060	$2,695,813
Nursing Homes that are IMDs	N/A	400,000
Total	$2,336,060	$3,095,813

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federal share of Medicaid expenditures in 1990 was 56%, the estimated state and local cost of eliminating the IMD exclusion would be $1.36 billion (.44 × $3.10 billion). Therefore, eliminating the exclusion would allow such governments to reduce their expenditures by an estimated $870 million.

CONCLUSIONS

No findings in the Report to Congress support a change in the IMD exclusion. Court judgments have found that HCFA's implementation of the policy has been reasonable and does not conflict with congressional intent. This intent is not completely clear. However, it appears likely that Congress wished states to continue their responsibility for ADM services that existed when the Medicaid program was created. This interpretation is reinforced by the finding that much of the increase in Medicaid expenditures from eliminating the exclusion would simply refinance state and local ADM spending.

Changes that have occurred in ADM services mean that the policy has a smaller impact on the ADM service system now than it did in 1972. Further, program options allow states to support cost-effective alternatives to traditional psychiatric hospitalization. As a result, states can use Medicaid to provide a complete continuum of care and promote community-based services in the least restrictive setting.

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United States General Accounting Office

GAO

Report to Congressional Requesters

June 1991

SUBSTANCE ABUSE TREATMENT

Medicaid Allows Some Services but Generally Limits Coverage

GAO/HRD-91-92

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-243725

June 13, 1991

The Honorable Lloyd Bentsen
Chairman, Committee on Finance
United States Senate

The Honorable Bob Dole
United States Senate

The Honorable Daniel P. Moynihan
United States Senate

Substance abuse is a widespread and growing problem in the United States.[1] The emergence of new drugs, changes in drugs of abuse, and the use of combinations of drugs have made treatment more difficult. Further, in recent years more women have become addicted. The National Institute on Drug Abuse (NIDA) estimated that 5 million women of childbearing age used illicit drugs in 1988. These trends are straining the capabilities of the treatment system. In some areas, the demand for treatment far exceeds the availability of treatment services.[2] A 1990 survey conducted by the National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD), estimates that 280,000 pregnant women nationwide were in need of drug treatment, yet less than 11 percent of them received services. Our previous reports on substance abuse have addressed this and other issues.[3] It is because of this shortage of available treatment services that people are looking to Medicaid as a potential source of funding for such services as residential treatment and counseling.

States are shouldering the largest share of the burden of funding substance abuse treatment services, with the federal government assisting through block grants. The federal government also reimburses states for treatment of some substance abusers through the federal-state Medicaid program. (Appendix I contains a description of the Medicaid program.)

[1]We define substance abuse as abuse of alcohol, illicit drugs, or prescription drugs.

[2]Current methods of substance abuse treatment include: (1) detoxification, usually inpatient, which serves to end users' physical addiction; (2) outpatient counseling and support; (3) methadone maintenance, combining counseling with administration of methadone (an orally administered synthetic narcotic for heroin addiction); and (4) short- or long-term residential programs.

[3]Methadone Maintenance: Some Treatment Programs Are Not Effective; Greater Federal Oversight Needed (GAO/HRD-90-104, Mar. 22, 1990); Drug Abuse: Research on Treatment May Not Address Current Needs (GAO/HRD-90-114, Sept, 12, 1990); Drug-Exposed Infants: A Generation at Risk (GAO/HRD-90-138, June 28, 1990); and Drug Abuse: The Crack Cocaine Epidemic: Health Consequences and Treatment (GAO/HRD-91-55FS,Jan. 30, 1991).

You were concerned that the Health Care Financing Administration (HCFA) had no national policy on the use of Medicaid funds for substance abuse treatment and that, in the absence of specific guidance in law or regulation, HCFA has given states differing interpretations on what substance abuse treatment services Medicaid would reimburse. You were also concerned that the lack of a consistent policy hampered states' efforts to use Medicaid to treat substance abuse. Bill S.29, the Medicaid Drug Treatment for Families Act of 1991, was introduced in January to specifically address some of these problems by making alcoholism and drug dependency services an option in the Medicaid program and defining the services that would be covered.

In response to your concerns, we reviewed federal guidance to the states on Medicaid coverage of substance abuse treatment services, the types of Medicaid services available in states, the level of federal and state spending, and barriers that may exist to obtaining treatment reimbursed by Medicaid. We did our work at 6 of HCFA's 10 regional offices, HCFA's headquarters in Baltimore, and nine state Medicaid offices. We interviewed federal and state officials and reviewed Medicaid laws and regulations and HCFA and state documents to determine the consistency of guidance on treatment services reimbursable under Medicaid. Our work was performed from June 1990 to November 1990 in accordance with generally accepted government auditing standards.

Background

Medicaid, authorized under title XIX of the Social Security Act, is the largest source of health care financing for certain low-income populations: women with children, the blind and other disabled, and the elderly. In fiscal year 1991, Medicaid payments are projected to be $90.8 billion nationwide, with the federal share at about 57 percent.

All states are required to offer Medicaid coverage for mandatory services, such as hospital and physician services, and may offer coverage for a broad range of optional services, such as rehabilitation, clinical, or other medical services. Neither Medicaid laws nor regulations specify substance abuse treatment as a service that can be reimbursed under the Medicaid program; however, states can be reimbursed for substance abuse treatments provided to Medicaid-eligible persons if the treatment is provided under a Medicaid service category that qualifies for federal matching funds, such as inpatient hospital services. For example, while Medicaid laws and regulations do not list alcohol detoxification as a reimbursable service, if an individual was receiving inpatient treatment

that included alcohol detoxification, the detoxification would be reimbursable under Medicaid.

Determining whether a specific service provided to a substance abuser can be reimbursed is complicated because service coverage is dependent upon both personal eligibility and the state's program characteristics. For example, a treatment might not be reimbursable because the service was not medical treatment, the client was too old or too young to qualify, the provider was not Medicaid qualified, or the facility was too large or provided room and board.

Results in Brief

In the six HCFA regions we reviewed, HCFA officials' responses to state questions on coverage of substance abuse treatment services were consistent. But until August 1990, HCFA had not provided any overall guidance on substance abuse to all the states. Before this time, HCFA responded on a state-by-state basis to questions about substance abuse coverage, and did not routinely disseminate the responses to states other than those asking the questions.

HCFA does not maintain data on the type and amount of substance abuse services reimbursed under Medicaid, as it generally does not maintain data on services related to specific diseases or conditions. Of the nine states we visited, seven offer a variety of Medicaid services, one offers no substance abuse services per se,[4] and one state offers multiple services to all low-income substance abusers under a single statewide program that Medicaid partly funds. Eight of the nine states limit amount, scope, or duration of some services. (Appendix II shows a detailed list of substance abuse services offered under Medicaid in these nine states.)

Multiple barriers exist that prevent states from expanding substance abuse treatment services reimbursable under Medicaid. Many potential clients are not eligible for Medicaid, despite the expansion of Medicaid eligibility in recent years. Federal law prohibits reimbursement for room and board in some types of facilities and for all services in other types of facilities. Many substance abuse facilities provide treatment that HCFA will not reimburse because the provider does not meet the Medicaid definition of a medical practitioner or the treatment is social, not medical, in

[4]That state provides treatment for complications caused by abuse but does not treat the substance abuse problem, according to the State Medicaid Director.

nature. Some states lack the additional resources needed to expand coverage. Further, some providers are reluctant to treat pregnant substance abusers because of concerns about the risk of medical malpractice.

The amount of state and federal Medicaid funding for substance abuse treatments is not known because neither HCFA nor the states we visited maintain data that identify services specifically provided for substance abuse. The Medicaid national management reports categorize expenditures by many factors, including recipient characteristics, provider and type of service, but not by medical condition or diagnosis.

HCFA's Guidance to States Was Consistent

HCFA provided consistent guidance to the states on reimbursable substance abuse treatment services whenever a state requested guidance. However, this guidance was given primarily on a one-on-one basis between HCFA and the requesting state, until August 1990. At that time, HCFA's Acting Medicaid Bureau Director decided that, because Medicaid benefits are described in terms of specific services rather than the conditions to be treated (e.g., substance abuse), misunderstandings existed on the extent to which Medicaid benefits could help people with substance abuse problems. Therefore, HCFA sent a letter to all State Medicaid Directors clarifying its position on substance abuse treatment. (See appendix IV for a copy of the letter.)

Although states need HCFA approval for changes in their state plan, they need not seek guidance from HCFA to proceed with implementing a policy if the policy comports with the existing state plan and federal laws and regulations.

HCFA's Responses Consistent

HCFA's interpretation of the Medicaid statute was consistent across the six regional offices visited. However, central or regional office decisions were not always disseminated to all regions. And only HCFA officials in Regions II, IV and VI said they sometimes send transmittal notices to all states in their regions if they believe an issue may be of interest to all the states. In most instances, HCFA provided guidance to states on a one-to-one basis responding to specific state questions. In April 1990 HCFA instituted a policy that requires regional offices to disseminate policy interpretations to other regions if the decision is applicable to more than the requesting region.

Regional office officials said that states are provided a copy of HCFA's State Medicaid Manual, which classifies substance abuse as a mental disorder, and, generally, more detailed guidance is provided upon request.

Our review of the written inquiries in six regions found most of the questions received centered on the institution for mental diseases (IMD) exclusion. Medicaid law specifically excludes federal reimbursement for the care of patients between the ages of 21 and 65 in IMDs. [5]

Because HCFA policy, which builds upon standard diagnosis classifications,[6] considers substance abuse to be a mental disorder, federal Medicaid cannot pay for treatment of patients between the ages of 21 and 65 at any IMD, including those that specialize in substance abuse. In the instances we noted, HCFA consistently applied the IMD exclusion, denying federal reimbursement if the facility was larger than 16 beds and its patients were primarily persons with mental disease.

HCFA's Guidance Issued in 1990

According to HCFA officials, HCFA does not have a national policy on the use of federal Medicaid monies for substance abuse treatment alone, as it generally does not for specific diseases or conditions. That is, neither Medicaid legislation nor HCFA regulations specifically address substance abuse. However, on August 2, 1990, HCFA first issued general guidance on the extent to which Medicaid benefits can help persons with drug addiction and related problems. HCFA's letter to State Medicaid Directors enumerated the Medicaid services that could be used for treating substance abuse. These services, shown in appendix III, include:

- detoxification or other drug-related medical care;
- inpatient treatment in a psychiatric hospital or other IMD or in a residential facility of fewer than 17 beds;

[5] An IMD is a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases. The exclusion of such services dates back to the original Medicaid program as an effort to prevent the Medicaid funds from being used to support large state mental health facilities. Since the late 1970s, however, there have been disputes between the states and the federal government regarding how broad this exclusion is and how an IMD is defined. The Medicare Catastrophic Coverage Act of 1988 first defined an IMD as a facility of more than 16 beds.

[6] The Department of Health and Human Service's International Classification of Diseases, 9th Version, Clinical Modification, is the standard disease classification system used in the United States.

- treatment for any problem identified during Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT),[7] even if the state does not normally provide these services under Medicaid;
- outpatient counseling and day treatment; and
- other services, such as addiction treatment, drugs, managed-care programs (which allow states to designate the most appropriate vendor for an individual), or any other home or community-based service that provides an alternative to institutionalization and is approved by HCFA.

Variation in States' Substance Abuse Services

HCFA does not maintain data on the type and amount of Medicaid-reimbursable substance abuse services provided by the states. The states report services to HCFA by category of service, such as physician services, not by type of diagnosis. Some states have made little use of their Medicaid options, while others offer a variety of services. For example, New York offers a wide range of treatments for substance abuse (see app. II). Alternatively, Texas offers no substance abuse services reimbursable under Medicaid, but does offer treatments under some other state programs.

The Medicaid program allows states to vary the amount, duration, and scope of services provided. Some states, therefore, restrict the Medicaid services offered. For example, Massachusetts limits counseling to 24 visits per year, while Florida has no such limitations. Alabama restricts all outpatient counseling treatment to a mental health clinic, while Georgia does not restrict location. Seven of nine states we visited do not allow inpatient rehabilitation following detoxification, and all nine either deny or limit inpatient hospital treatment for substance abuse treatment.

State Medicaid officials in five of the nine states indicated that they were planning the following initiatives for implementing additional substance abuse services reimbursable under Medicaid:

- Alabama plans to offer expanded comprehensive treatment under the rehabilitation option.

[7]States are required to provide EPSDT services to all Medicaid eligible individuals under age 21. At a minimum this must include: (1) assessments of health, developmental, and nutritional status; (2) unclothed physical examinations; (3) immunizations appropriate for age and health history; (4) appropriate vision, hearing, and laboratory tests; (5) dental screening furnished by direct referrals to dentists, beginning at age 3; and (6) treatment for vision, hearing, and dental services found necessary by the screening.

- Massachusetts is working with other agencies on substance abuse shelters and is trying to get day treatments covered.
- New York will offer case management of pregnant women in 11 specific neighborhoods. This effort will coordinate services from 16 agencies.
- Oregon is planning initiatives for drug users, such as treatment on demand for pregnant women and adolescents, the provision of services for the deaf and hearing impaired, and special services for some ethnic groups.
- Texas has submitted a state plan amendment to offer treatment when substance abuse is detected during early and periodic screening.

Barriers to Expanding Medicaid Coverage

Despite the variety of services covered, multiple barriers exist that limit the states' ability to expand the use of Medicaid as a treatment resource. Federal law, HCFA's policies, insufficient state funds, and provider reluctance to accept some clients are all barriers to expansion.

In accordance with federal law, Medicaid only allows reimbursement for room and board charges in hospitals, nursing homes, intermediate care facilities for the mentally retarded, and inpatient psychiatric facilities for patients under 21, but not in many residential treatment facilities. State officials said costs are lower in a residential treatment facility than in a nursing home or hospital setting. States must, therefore, provide care in a more costly setting if they want federal reimbursement.

Even if reimbursement for room and board was allowed in these less costly settings, HCFA still would not reimburse the states for many patients. The IMD exclusion prohibits reimbursement for the care of patients between the ages of 21 and 65 in an IMD. Because HCFA policy classifies substance abuse as a mental disorder, HCFA would deny reimbursement for all treatment for these patients in any substance abuse treatment facility of more than 16 beds.

Also, HCFA's policy states that counseling (as the primary method of care) performed by nonlicensed personnel does not constitute the medical treatment that is required for Medicaid reimbursement. This limits treatment options because some free-standing residential facilities use counselors, such as recovering addicts, who are not licensed.

Funding is another barrier. States have limited fiscal resources for the Medicaid program, and state officials in Florida, New York, Oregon, and Texas commented that because of the lack of state resources some substance abuse services are limited or are not offered. As a result, some

mental health clinics have waiting lists as the demand for substance abuse treatment exceeds the availability of services. A Senate report also indicates that this is a barrier to obtaining services.[8]

State officials indicated that the unwillingness of some providers to accept any pregnant substance abuse clients is another barrier. As noted above, a survey conducted by NASADAD found that nationwide only 11 percent of the pregnant women in need of drug treatment are receiving care. A survey of New York City providers found that of 78 drug treatment centers surveyed, 54 percent denied treatment to pregnant women. Legal liability issues were cited as one of the primary reasons that treatment centers are reluctant to treat pregnant women.[9]

HCFA is establishing a demonstration program to explore innovative ways to provide substance abuse services to pregnant women. Proposals are now being reviewed and it is anticipated that grants will be awarded to five state Medicaid agencies.

Spending Data Not Available

HCFA and the majority of the states visited were unable to document the amount they spent on substance abuse treatment services through the Medicaid program. HCFA officials said that it is impossible to identify the expenditures because there is not a separate category for substance abuse treatment on the states' Medicaid cost reports. Substance abuse expenditures are reported by type of Medicaid service, such as inpatient hospital, physician, rehabilitative, or clinical services, not by condition diagnosis, such as substance abuse.

Only one of the states we visited maintained accurate data on total Medicaid spending for substance abuse treatment. The other states could not provide accurate data because the available data included costs for treatment of illnesses other than substance abuse, or did not include all of the expended costs for substance abuse. For example, for calendar years 1988 and 1989, New York showed Medicaid expenditures of about $71 million and $96 million dollars, respectively, for substance abuse treatment. However, a New York state official said that the data give an incomplete picture because psychiatric clinic visits and inpatient stays related to drug or alcohol abuse were not included, and other drug and alcohol treatment may have been billed as general hospital services.

[8]Senate Committee on Labor and Human Resources report on Drug Treatment Waiting List Program, June 25, 1990.

[9]See Drug-Exposed Infants (GAO/HRD-90-138).

Minnesota maintains separate cost data on the amount of Medicaid funds spent for substance abuse treatment services. For fiscal years 1988 and 1989, the state was reimbursed by the federal government about $2.2 million and $2.6 million dollars, respectively, for substance abuse treatment.

In addition to the use of Medicaid funds for substance abuse treatment, state officials said some Medicaid recipients may receive substance abuse services through other state agencies, such as mental health or substance abuse agencies.

As agreed with your offices, we did not obtain written comments on this report. We discussed its contents with HCFA officials, however, and incorporated their comments as appropriate.

Unless you publicly announce its content earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, copies will be sent to the appropriate congressional committees, the Secretary of Health and Human Services, and other interested parties. If you have any questions regarding this report, please call me at (202) 275-5451. Other major contributors are listed in appendix V.

Janet L. Shikles

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Director, Health Financing
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Abbreviations

EPSDT	Early and Periodic Screening, Diagnosis, and Treatment Services
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
IMD	Institution for Mental Disease
NASADAD	National Association of State Alcohol and Drug Abuse Directors, Inc.
NIDA	National Institute on Drug Abuse

Description of the Medicaid Program

Medicaid, authorized under title XIX of the Social Security Act, is a state-administered assistance program that provides medical care for certain low-income individuals and families. At the federal level, the Department of Health and Human Services (HHS) has overall responsibility for administering Medicaid. Within the Department, the Health Care Financing Administration (HCFA) is responsible for developing program policies, setting standards, and ensuring compliance with federal Medicaid legislation and regulations.

Federal law requires that state Medicaid programs cover certain categories of individuals and guarantee the availability of certain medical services. Mandatory "categorically needy" Medicaid eligibility groups include those receiving cash assistance under the federal Aid to Families With Dependent Children or Supplemental Security Income programs, pregnant women and children to age 6 whose family income is below 133 percent of the federal poverty level, and certain low-income Medicare beneficiaries. In addition, each state has the option of providing Medicaid benefits to the medically needy—those who cannot afford needed health care but who have income above the maximum allowable for public assistance. The state pays part of the costs, based on the state per capita income, and the federal government reimburses the state for the rest of the costs.

All states are required to offer Medicaid coverage for mandatory services, such as hospital and physicians' services, and may offer coverage for a broad range of optional services, such as rehabilitation, clinical, or other medical services. States may place limits on the amount, duration, and scope of all services. For example, they may place limits on the number of covered hospital days, number of covered physician visits, and types of providers that may provide services.

Substance abuse treatment is not specifically listed in either law or regulation as a type of service that can be provided under the Medicaid program, therefore, such treatment is covered only to the extent that it can be covered under an approved Medicaid category, such as inpatient hospital services.[1]

States that have Medicaid programs are required to meet a number of program requirements, including "freedom-of-choice," "statewideness,"

[1]Current methods of substance abuse treatment include detoxification, usually inpatient, which serves to end users' physical addiction; outpatient counseling and support; methadone maintenance, combining counseling with administration of methadone (an orally administered synthetic narcotic for heroin addiction); and short- or long-term residential programs.

and "comparability." Under the freedom-of-choice provision, Medicaid recipients are permitted to obtain medical assistance from any institution, agency, community pharmacy, or person qualified to perform the service. Under the statewideness requirement, the program is required to be in effect in all political subdivisions of the state. Further, the states are required to offer comparable services to all individuals within an eligibility category (with certain exceptions generally based on age).

The Secretary of HHS has general authority to waive program requirements in order to conduct demonstration projects. In addition, the Secretary has the specific authority to grant freedom-of-choice and home and community-based waivers, if such waivers are found to be cost-effective.

Objectives, Scope, and Methodology

The objectives of our review were to determine:

- the consistency among HCFA regions in the guidance they provide states on substance abuse treatment reimbursable under the Medicaid program,
- the types of substance abuse services available in the various states under Medicaid,
- what barriers exist to obtaining substance abuse treatments under Medicaid, and
- the level of federal and state spending on substance abuse treatment under Medicaid.

We worked at 6 of HCFA's 10 regional offices—Region I (Boston), Region II (New York City), Region IV (Atlanta), Region VI (Dallas), Region IX (San Francisco), and Region X (Seattle). We visited HCFA's headquarters in Baltimore and nine state Medicaid offices (Alabama, California, Florida, Georgia, Massachusetts, Minnesota, New York, Oregon, and Texas). We also visited these states' substance abuse agencies. We selected the above states because of their high incidence of substance abuse, unique substance abuse services offered, and location within several HCFA regions.

We interviewed officials at HCFA regional offices to determine how HCFA interprets key provisions of Medicaid laws and regulations as they apply to substance abuse. We interviewed state Medicaid and substance abuse officials to determine their relationship with HCFA personnel administering substance abuse programs and to obtain data on services, expenditures, and barriers to expanding services under individual state programs. Additionally, we reviewed Medicaid laws and regulations, HCFA documents, and state Medicaid and mental health manuals to determine the consistency of guidance on treatment services reimbursable under the Medicaid program. Our work was performed from June 1990 to November 1990 in accordance with generally accepted government auditing standards.

Summary of Substance Abuse Treatments Available Under Medicaid and Offered by States GAO Visited

Type of Medicaid service	Examples of available treatments	Available in these states
Inpatient hospital	Detoxification, any acute treatment of symptoms, or treatment for complications	AL, FL, GA, MA, NY, TX, CA, OR,
Outpatient hospital	Detoxification, counseling, or methadone maintenance	MA, NY, CA, GA,
Early and periodic screening, diagnosis, and treatment	Any treatment to correct physical or mental problems found during EPSDT screening	AL, CA, FL, GA, NY, TX, MA, MN, OR
Physician services	Detoxification, counseling, psychotherapy, or methadone maintenance	AL, CA, FL, GA, NY
Home health services	Services for treating addiction	None
Other medical/remedial care	Counseling	GA, OR
Clinic services	Detoxification, counseling, psychotherapy, methadone maintenance	AL, CA, GA, MA, NY
Drug services	Methadone	None
Other preventive and rehabilitative care	Counseling, psychotherapy, and day treatment services	OR, FL, MN
Inpatient services in an IMD for individuals over 65	Residential services, psychiatric counseling, methadone maintenance, or other psychiatric services	FL, NY
Inpatient psychiatric services for individuals under 21	Residential services, psychiatric counseling, methadone maintenance, or other psychiatric services	AL, MA, NY, OR
Other medical or remedial care	Any other services authorized by the Secretary of Health and Human Services	None
Home or community-based services (waivers only)	Case management, home health, personal care, adult day health services, or respite care services	None
Waivers or exceptions	Managed-care programs	None
Targeted case-management services	Any service that will assist a recipient in gaining access to needed services	GA

HCFA's August 1990 Guidance

DEPARTMENT OF HEALTH & HUMAN SERVICES — Health Care Financing Administration

6325 Security Boulevard
Baltimore, MD 21207

AUG 2 1990

All State Medicaid Directors

The Medicaid program is an excellent resource in the national effort to deal with drug addiction and related problems. Because Medicaid's benefits are described in terms of specific services rather than the conditions to be treated, there are often misunderstandings as to the extent that the Medicaid program's benefits can help persons with drug addiction and related problems. I am writing to review the ways that available Medicaid benefits relate to the treatment of these conditions in order to ensure that all States are aware of these possibilities.

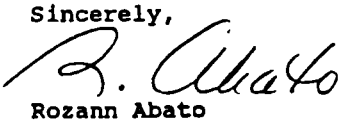
A number of primary care services may be used, including physicians' services, clinic services, and pharmaceuticals (e.g., methadone). Additionally, services appropriate for treating addiction may be provided (1) by home health agencies, (2) under home and community-based services waivers, and (3) as part of the EPSDT benefit constellation. A number of States have also used freedom of choice waivers or exceptions to their State plans to implement managed care programs targeted to substance abuse. Case management may be used to coordinate the needed services, and special day treatment programs may be established that combine needed therapy, counseling and other services.

Inpatient hospital benefits may be used for acute treatment of symptoms, detoxification and drug-related medical complications. Rehabilitation services may be provided in a wide variety of settings. These include outpatient programs in hospitals and clinics, and inpatient programs located in nursing facilities, psychiatric hospitals, and special units in general hospitals. Rehabilitation services may also be provided in settings that are not Medicaid participating facilities.

Although payment restrictions relating to institutions for mental diseases (IMDs) can affect some inpatient programs for treating chemical dependency, it is important to remember that these restrictions do not apply to any facility that has less than 17 beds. For this reason, it may be advantageous to set up this type program in smaller facilities, even though room and board payment would not be made unless it is a participating facility. Optional IMD benefits are also available in psychiatric facilities for individuals under age 21 and for individuals age 65 and over regardless of the size of the facility.

There are many State and local programs funded by the Office of Substance Abuse Prevention, National Institute on Drug Abuse, and Health Resources and Services Administration. You may find it worthwhile to collaborate with these programs. If your State is interested in expanding Medicaid services in the area of substance abuse treatment, we can support this effort by responding to questions as they arise in developing new programs. Please contact your HCFA Regional Office.

Sincerely,



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