POSITION PAPER
No. 11/214th Legislature (2010-11)

ISSUE:
Establishes Medicaid Accountable Care Organization Demonstration Project in DHS.

BILL NO.
S-2443 (Vitale, Whelan)
A-3636 (Coughlin, Greenwald)

NCADD-NJ POSITION:
NCADD-NJ strongly supports S-2443/A-3636 in that it will promote the integration of substance use screening and treatment with primary health care. This bill will not only improve the quality of health care and save lives in the state, but it will also save a significant amount of money.

However, NCADD-NJ has three suggestions that would make implementation of this bill more successful and effective: First, Behavioral Health Care must be defined in the bill:

> Behavioral Health Services include but are not limited to screening, brief intervention, evaluation, and all levels of treatment and addiction services prescribed in the most current version of ASAM-PPC. Nothing in this definition requires Medicaid to reimburse addiction professionals for services that are not otherwise be covered by Medicaid.

Depending on the needs of the patient, various levels of care may be necessary to improve the health of an individual and reduce health care costs. To realize the benefits of integrated care as described below it is necessary to ensure that patients are referred to and/or receive the level of care most appropriate for them, even if reimbursement of that care is by means other than Medicaid. It is also important to ensure that the level of care most appropriate for the patient is included in the Accountable Care Organization and the communications that occur between health care providers.

Including a definition of behavioral care services which includes a full continuum of care, will enable both of these factors to occur. Even programs that have integrated care for mental health and substance use, a substantial portion are focused primarily on mental health issues and have little, if anything, to do with substance use disorders[1]. Moreover, when treatment for substance use conditions is included in such programs, the focus is often limited to alcohol use, excluding other forms of substance use[2].

Most individuals engaging in treatment benefit from the use of ASAM-PPC. The ASAM-PPC is the most widely used and comprehensive national guidelines for placement, continued stay, and discharge of individuals with alcohol and other drug problems. ASAM published the *PPC-2* in cooperation with the Coalition for National Clinical Criteria, a group of approximately 50 representatives of treatment providers, managed care professionals, federal and state health and addictions agencies, and the major professional and trade associations of counselors, state directors, physicians and other treatment providers.

Including all levels of care prescribed in the ASAM-PPC in the definition of behavioral health services will bring stability and consistency to the ACO. It matches patients to their appropriate level of care, thereby avoiding less effective under treatment as well as cost-inefficient over treatment. Including all levels of care prescribed in the ASAM-PPC in the definition will enable patients to be referred to the least restrictive alternatives as the mainstay of delivery, while ensuring those few who need more intense forms of treatment are able to receive appropriate care.

Second, the bill provides for gain sharing that may provide incentive for addiction providers, who did not previously serve the Medicaid population, to apply to become a Medicaid provider for addiction services. Qualified Behavioral Health provider should include those providers who for the purpose of participating in the ACO become eligible to serve as a Medicaid provider.

> "Qualified behavioral health care provider" means a behavioral health care provider who participates or will participate in the Medicaid program and renders or will render clinic-based and home-based services to individuals residing in the designated area served by the Medicaid ACO.

Third, an increase in Medicaid rates would widen the pool of addiction providers willing to participate. New Jersey's Medicaid reimbursement rates for addiction treatment are currently the lowest in the nation.

Historically alcoholism and drug addiction have been treated in settings that are separate from traditional general medical practice. Current clinical practices lack of coordination of care between physical health services and behavioral health services, particularly for addiction treatment services. Often there is little, if any, ongoing communication about risks or progress between specialty substance use treatment and general health care providers who treat the same patients. This barrier exists despite the fact that integration has been shown to be successfully implemented. This lack of connection and communication between specialty and general health care professionals who treat patients with substance use conditions unnecessarily impairs the health of individuals

Substance use conditions can no longer be isolated from primary and physical care. They are treatable chronic diseases, which have been identified in about 9 percent, or over 800,000 of the general population in New Jersey[3]. Yet only about 5-7 percent of those identified are ever treated in the specialty treatment system, and about 42% (50,000) who tried to get help were turned away because of cost, insurance barriers, or lack of capacity[4].

Research has shown that Integrating addiction screening, brief intervention and treatment with other medical care is cost effective and improves the quality of care. Persons with substance use conditions are quite likely to have a wide variety of other concurrent medical side effects and consequences, related physical disorders, and increased trauma and injuries. Additionally, the presence of substance use conditions often complicates the treatment of a variety of common medical disorders. More than 1.5 million visits for treatment at hospital emergency departments in 2008 were found to be associated with some form of substance misuse or abuse[5]. About 22 percent of general health care patients report they also have a co-morbid substance use condition[6].

A recent study[7] conducted by John Hopkins University examined the impact of mental illness and addiction on per capita costs and hospitalization rates. It also identified Medicaid's highest need and cost beneficiaries who were most likely to benefit from care management. The analysis examined disease prevalence, health care costs, and utilization for a total of 5.2 million Medicaid beneficiaries. While behavioral health comorbidity has been recognized as an important issue for the Medicaid population, this research adds cost and utilization data to quantify the extent to which comorbid mental illness and drug and alcohol disorders affect patients with a broad array of chronic conditions.

The study confirmed the overwhelming pervasiveness of physical and behavioral health comorbidity among Medicaid's highest-cost beneficiaries. It also found that health care spending; per capita costs and hospitalization rates are substantially higher for beneficiaries with mental illness and/or drug and alcohol disorders. The findings clearly support the need for integrated physical and behavioral health care if New Jersey wants to reduce its Medicaid burden and include:

1. Beneficiaries with one of five common chronic physical conditions — asthma/COPD, congestive heart failure, coronary heart disease, diabetes, or hypertension have a drug or alcohol disorder, ranging from just under 17 percent for individuals with diabetes to nearly 26 percent for asthma/COPD. Moreover, up to one-fifth of people with one of one of these five chronic physical conditions also have both mental illness and a drug and alcohol disorder.

2. The addition of co-occurring mental illness and a drug and alcohol disorder for beneficiaries with common chronic physical conditions results in two- to three-fold higher health care costs. For example, spending for beneficiaries with diabetes and no mental illness and drug and alcohol disorder average just under $10,000 per year, whereas spending for beneficiaries with diabetes and a mental illness and drug and alcohol disorder tops $35,000 annually.
3. Beneficiaries with chronic physical conditions are more likely to be

hospitalized when they have a mental illness and/or drug and alcohol disorder.
4. Among the 25 multimorbidity patterns with the highest hospitalization rates from among those conditions studied, 88 percent include behavioral health comorbidities
5. Beneficiaries with asthma, coronary heart disease, asthma, diabetes, or congestive heart failure and co-occurring mental illness and drug and alcohol disorder are four to five times more likely to be hospitalized than those with only physical conditions

In the last 10 years, neuroscientific and other research has laid the foundation to understand addiction as a treatable chronic disease with characteristics and implications for treatment and recovery that are similar to other chronic diseases such as diabetes or hypertension[8]. This is not to imply that everyone who uses or abuses addictive substances develops a chronic disease. Indeed, studies have shown that screening and early intervention can arrest use problems before they develop into a more serious chronic condition. For those who do develop a chronic condition, treatment typically should include an acute phase of patient centered, adaptive care, followed by a continuing care phase that assists the patient to manage his or her disease and supports the patient in ongoing recovery in the community[9].

Routine screening for substance use is atypical in traditional health care settings, despite its established efficacy. Even when risky or dependent substance use is identified by a patient or the practitioner, the condition is too often ignored or patients are referred outside primary care for treatment, and follow-up with little coordination with the rest of their health care providers.

The United States Public Health Service's Preventive Services Task Force recognize screening and brief intervention (SBI) for alcohol use conditions as one of the most cost effective preventive interventions for adults[10]. SBI reduces health care costs: for every $1 spent on SBI almost $4 is saved[11]. A randomized trial in a family physician health clinic that compared "problem drinkers" who received SBI to those who received usual care estimated that the intervention cost of $205 resulted in a total average benefit per patient of $1,151, including savings in emergency room and hospital use and costs due to alcohol-related crimes and auto accidents[12].

The medical care costs for all health problems among those with substance use issues are significantly higher than for those without an addiction, which means that there would be a huge cost savings if a full continuum of treatment and services were accessible within health care. Substance use treatment is associated with decreased subsequent health care costs. One study found a decline of more than one third in both per capita inpatient and emergency room costs following the receipt of treatment[13], while another reported more than a 50 percent drop in total per patient per month medical costs[14].

This bill is particularly important because of the cost impact untreated addiction has on Medicaid and the increasing number of Medicaid recipients with an addiction. In New Jersey, the state is spending over $3.8 billion to deal with the financial burden of un-prevented and untreated addictions[15], including $852,408,000 in health care[16]. For every dollar spent on addiction in New Jersey, 97 cents goes to the wreckage caused by untreated addiction and only three cents goes to prevention and treatment and research[17].

A study of Medicaid patients in Washington State found a decrease in overall Medicaid costs of five percent for patients who received indicated addiction treatment, compared with those who did not receive it[18]. Another study of Medicaid patients in a comprehensive HMO found addiction treatment was associated with a reduction of just under one third of medical costs per treatment member[19]. In addition, for patients who achieve abstinence after treatment, family members' health care utilization and costs were reduced to that of control families, 5 years after treatment[20].

In New Jersey 37.1% of Medicaid patients with behavioral disorders were diagnosed with substance use disorders[21]. Failure to treat them costs Medicaid hundreds of millions of dollars annually in medical and behavioral care. The National Conference of State Legislatures found that a quarter of what states spent on Medicaid went to paying for the consequences of untreated addiction[22]. It also found that states significantly reduce

their Medicaid burdens by identifying and treating those with substance use problems. The report found annual savings that included $6,480 per Medicaid recipient being treated for addiction[23].

The impact of untreated addiction on Medicaid populations with behavioral health disorders is much

greater than the direct cost of mental health and addictions treatment. In New Jersey, people classified as having severe mental illness and an untreated substance use disorder cost an average of $5,345 for behavioral health, compared to a median of $1,601 for a person without a substance use disorder[24]. Another study demonstrated that of the 534 patients discharged from a residential chemical dependency treatment program for people with co-occurring disorders (chemical dependency and mental illness), overall Medicaid-paid medical and psychiatric services decreased by 44 percent, from almost $5 million in the year before treatment to $2.8 million in the year after treatment[25].

This data supports what is a universal truth: integrated care leads to significantly lower total medical costs, and improves quality and outcomes[26]. Receipt of integrated care during and after addiction treatment improves the likelihood of abstinence following treatment. In comparison to "usual care," patients with substance use medical conditions who received integrated services during treatment were almost twice as likely to remain abstinent[27]. Moreover, receipt of primary care (defined as having had from two to ten visits) by chemical dependency patients with associated medical conditions was predictive of chemical dependency remission at 5 years[28].

NCADDNJ strongly supports putting a percentage of the savings in medical care back into the ACO and paying for outcomes. It has been shown that quality increases when payment is tied to positive outcome. Given the research to date, NCADD-NJ is confident that including screening, intervention and appropriate levels of addiction treatment and services in the physical healthcare of individuals will produce significant savings that can be used to expand treatment capacity. The pilot programs proposed in this bill will result in significant cost savings to Medicaid and significantly improve the quality of care for the patient with an addiction. The state cannot afford to not enact S- 2443/A-3636.

Resources/Endnotes

1 Forum on Integration, a Forum for the States, TRI, Science, Addiction, Integrating Appropriate Services For Substance Use Conditions in Health Care Settings, An Issue Brief on Lessons Learned and Challenges Ahead, July 2010
2 Id.
3 DAS
4 DAS
5 Drug Abuse Warning Network, 2008
6 Substance Abuse and Mental Health Services Administration (2005). National Survey on Drug Use and Health. Rockville, MD: Department of Health and Human Services
7 Boyd, C, Leff, B, Weiss, C , Wolff, j, Hamblin, A, Matin, L Clarifying Multimorbidity Patters to Improve Targeting and Delivery of Clinical Services for Medicaid Populations, Center for Health Care Strategies, December 2010
8 McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H.D. (2000). Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation. Journal of the American Medical Association, 284: 1689-1695.
9 McLellan et al., 2000
10 Maciosek, M. V., Coffield, A. B., Edwards, N.M., Flottemesch, T.J., Goodman, M.J. & Solberg, L.I. (2006). Priorities among effective clinical preventive services results of a systematic review and analysis. The American Journal of Preventive Medicine, 31(1),52-61.
11 David, MD,Wessel, Physicians and Lawyers for National Drug Policy in partnership with the National Judicial College, Alcohol and Other Drug Problems: A Public Health and Public Safety Priority, A Resource Guide for the Justice System on Evidence Based Approaches, April 2008
12 Fleming, M. F., Mundt, M. P., French, M. T., Manwell, L. B, Stauffacher, E. A. & Barry, K. L.(2000). Benefit-cost analysis of brief physician advice with problem drinkers in primary care settings. Medical Care, 38 (1), 7-18.
13 Parthsarathy, S., Weisner, C., Hu, T. W., Moore, C. (2001). Association of outpatient alcohol and drug treatment with health care utilization and cost: revisiting the offset hypothesis. Journal of Studies on Alcohol and Drugs, 62(1), 89-97.
14 Parthasarathy, S., Mertens, J., Moore, C., Weisner, C. (2003). Utilization and cost of integrating substance use treatment and primary care. Medical Care, 41(3), 357-367.
15 The National Center on Addiction and Substance Abuse at Columbia University, Shoveling Up the Impact II, The Impact of Substance Abuse on Federal State and Local Budgets" May 2009
16 Id.
17 Id.
18 Luchansky, B. & Longhi, D. (1997). Cost savings in Medicaid medical expenses: an outcome of publicly funded chemical dependency treatment in Washington State: A five year cost savings study of indigent persons served by Washington State's Alcoholism and Drug Addiction Treatment and Support Act (ADATSA). Briefing paper. Olympia, WA: Washington State Department of Social and Health Services, Washington State Department of Social and Health Services. Retrieved from http://www.dshs.wa.gov/pdf/ms/rda/research/4/30.pdf
19 Walter, L. J., Acerson, L., & Allen, S. (2005). Medicaid chemical dependency patients in a commercial health plan: do high medical costs come down over time? Journal of Behavioral Health Services & Research, 32(4), 367
20 Weisner, C., Parthasarathy, S., Moore, C., & Mertens, J.R. (2010). Individuals receiving addiction treatment: are medical costs of their family member reduced? Addiction, 105(7), 1226-1234
21 Clark, Robin, PhD Samnaliev, Mihail, PhD, McGovern, Mark, PhD "the Impact of Substance Disorders on Medical Expenditures for Medicaid beneficiaries With Behavioral Health Disorders, Psychiatri Serv 60:35-42, January 2009
22 National Conference of State Legislators
23 id
24Clark 2009
25 Charles Maynard, Gary Cox, Antoinette Krupski and Ken Stark, Utilization of Services for Mentally Ill Chemically Abusing Patients Discharged from Residential Treatment, The Journal of Behavioral Health Services & Research 26 (1999): 219-228
26Humphreys, K. & Moos, R. H. (2001). Can encouraging substance abuse inpatients to participate in self-help groups reduce the demand for outpatient aftercare? A quasiexperimental study. Alcoholism: Clinical and Experimental Research, 25, 711-716.
27 Weisner, C. , Mertens, J., Parthasarathy, S., & Moore, C. (2001). Integrating primary medical care with addiction treatment: A randomized controlled trial. Journal of the American Medical Association, 286 (14), 1715-1723.
28 Mertens, J. R., Risher, A. J, Satre, D. D., & Weisner, C. (2008). The role of medical conditions and primary care services in 5 year substance use outcomes among chemical dependency treatment patients. Drug and Alcohol Dependence, 98(1-2), 45-53.

CONTACT
Candice Singer, J.D.
Research Analyst
609.477.7013
csinger@ncaddnj.org

360 Corporate Blvd.
Robbinsville, NJ 08691
609.689.0121 (PH) | 609.689.3244 (FX)
POLICY@NCADDNJ.ORG