THE AFFORDABLE CARE ACT'S EARLY IMPACTS ON TREATMENT FOR SUBSTANCE USE DISORDERS

by

JANA ALDRICH PRUETT

(Under the Direction of Brian Bride)

ABSTRACT

The Patient Protection and Affordable Care Act of 2010, when paired with the Mental Health Parity and Addictions Equality Act of 2008, had the potential to change the way that treatment for substance use disorders (SUDs) was financed. Not until the passage of these two laws was it clearly mandated that health insurers were responsible for covering treatment for SUDs. Given these changes to coverage rules, this paper attempted to review early changes to the SUD treatment provision and payment. Although no significant change was found in payment by Medicaid or private insurance, it does appear as though centers were moving towards receiving more payments from these sources. Additionally, they are less dependent on block grant funding to cover treatment. This funding could be diverted to prevention or other activities. It was also found that there were very few, if any changes to adolescent treatment service provision by the treatment centers examined over the time covered.

INDEX WORDS: Health reform, Affordable Care Act, Substance use disorder treatment, Financing

SUBSTANCE USE DISORDER TREATMENT AND HEALTHCARE POLICY CHANGES: THE AFFORDABLE CARE ACT AND PARITY

by

JANA ALDRICH PRUETT

BA, Emory University, 2000

MSW, The University of Georgia, 2005

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JANA ALDRICH PRUETT

Major Professor:	Brian Bride
Committee:	David Okech
	Paul Roman

Electronic Version Approved:
Ron Walcott
Interim Dean of the Graduate School
The University of Georgia
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CHAPTER 1

INTRODUCTION

Treatment for substance use disorders (SUDs) has changed over the decades, from temperance housing to more contemporary medication assisted treatment. At several points throughout time, SUDs have been considered a moral failing, however the concept of addiction as disease has taken hold as our primary model of understanding, and thus treatment provision. This is evident through both changes in funding for and ideology associated with treatment for SUDs. The Mental Health Parity and Addictions Equity Act (MHPAEA) of 2008 prevented insurers from imposing less favorable benefits than other medical benefits to people suffering with mental health issues or SUDs (MHPAEA, 2008). Additionally, the Patient Protection and Affordable Care Act of 2010 (ACA) mandated coverage for mental health and SUDs, which, when paired with the MHPAEA, required that coverage be provided equitably to coverage provided for other ailments. The papers that will be presented focus on the changing construct and understanding of SUDs, some of the policies that have been enacted to address them, and changes in addiction treatment from 2012 to 2014.

Historical Perspective on the Etiology of and Treatment for SUDs

Treatment for SUDs has a long and colorful history in the American landscape. Alcoholism as a disease, as opposed to simply a moral failing, was first elaborated by Benjamin Rush at a time when drinking in the US was rapidly increasing due to the availability of distilled liquor (Stolberg, 2006; White, 1998). The disease concept was later embraced by Alcoholics Anonymous, the organization credited with proliferating the model and for its public acceptance

(Russell, Davies, & Hunter, 2011; White, 1998). Both the American Medical Association (AMA) and the World Health Organization (WHO) declared alcoholism a medical problem in the 1950s, and the American Society of Addiction medicine (ASAM) was founded in 1954 (ASAM, 2014; Weinberg, 2010). The disease concept has detractors, citing the belief that it is disempowering to substance users, still creates stigma that the disease concept was intended to overcome, and the notion that addiction is not a true disease as it has no clear physical etiology (Hammer, Dingel, Ostergren, Partidge, McCormic, & Koening, 2013; Russel, Davies, & Hunger, 2011; Tartarsky, 2003). However, the National Institute of Drug Abuse (NIDA), American Society of Addiction Medicine (ASAM), and the American Medical Association (AMA), have embraced the disease concept and treatment has been more tailored to this understanding (ASAM 2011; NIDA, 2018, Smith, 2011).

White (1998) gives a helpful and thorough history of addiction treatment in the US, explaining that in the early 1800s, prior to institutionalization, fraternal temperance societies and reform clubs collected dues from members to provide support to those members (White, 1998). During the mid-1800s there was a rise in the number of institutions specializing in the treatment addiction which tended be large, medically directed facilities, organized and funded privately that offered medical treatment, residentially-based services, and sometimes day treatment and intensive outpatient treatment (White, 1998). From the 1840s to the 1950s, a host of miracle-cures, drug therapies, natural therapies, and psychological approaches were introduced. As the negative societal effects of addiction were realized, state-sponsored alcohol programs began in the 1940s and 1950s, consisting mostly of outpatient treatment (White, 1998).

As SUDs are still considered a major public health problem, a large portion of treatment in the US today is publicly funded by local, state, and federal grants, and provided in a host of

settings - including over 14,500 specialty treatment centers, physician's offices, and mental health clinics (NIDA, 2012). Treatment options still vary in degree from residential care to brief outpatient therapy, depending on the person and the payer source. Pharmacotherapies for SUDs, including buprenorphine, disulfiram, naltrexone, and acamprosate, are available and have demonstrated efficacy in reducing SUD-related behaviors (De Sousa, 2010; Rosner et al. 2010; Ellis & Dronsfield, 2013). SUDs are a noted public health problem and are being treated as such by an array of disciplines - including psychologists, social workers, addiction specialists, and physicians. Policy changes are indicative of the public acceptance of the disease concept. Not only did the MHPAEA of 2008 mandate coverage under certain health insurance plans, and provisions in ACA support that mandate, more recent changes, such as the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act of 2018 further the public's entrenchment as a payor source for treatment provision (SUPPORT Act, 2018). The continued public support for the disease concept has led to an increased emphasis on the medical community's involvement in screening and treatment, and as SUDs are increasingly covered by health insurance plans, the medical community will continue play a more vital role in treatment provision (Bradley & Kivlahan, 2014).

Substance Abuse Prevention and Treatment Block Grants. Prior to the ACA, almost one-third of public funding distributed by the states to treat SUDs came from Substance Abuse Prevention and Treatment Block Grants (SABGs), which were established in 1992 to be distributed by the Substance Abuse and Mental Health Services Administration (SAMHSA) and managed by the states (SAMHSA, 2014b). Funding from this source was expected to decrease with the implementation of the ACA, as the focus shifted more to prevention services and away from treatment (Buck, 2011; National Association of State Alcohol and Drug Abuse Directors,

2010; SAMSHA 2014b). It was also expected that the model by which SUD services are offered by the states would shift from one in which grants and contracts support a number of treatment "slots" to one in which Medicaid and Medicare utilize payment methods characteristic of private health plans (Buck, 2011). Both the federal government and states may have been tempted to reduce these block grant expenditures with the increase in Medicaid funding, creating an opportunity for service gaps (Donohue, Garfield, & Lave, 2010; Barry & Huskamp, 2011).

Mental Health Parity and Addictions Equity Act (MHPAEA) of 2008. The Paul Wellstone and Pete Dominici Mental Health Parity and Addictions Equity Act (MHPAEA) was signed into law on October 3, 2008, becoming one of the more impactful mental health and addiction policies on the federal level in recent years (Smaldone & Cullen-Drill, 2010). The MHPAEA requires that group-insurance benefits for more than fifty employees which include benefits for mental health and substance abuse services cover those services at a level "on par" with the coverage provided for medical and surgical procedures (MHPAEA, 2008). The act alone did not require coverage for mental health or SUD treatment to be provided by these plans. The major intent of parity was to prevent the financial downfall of covered individuals with chronic psychiatric or substance use disorders (Smaldone & Cullen-Drill, 2010).

The passage of the MHPAEA was touted as a victory by a number of advocacy groups, including the National Alliance on Mental Illness (NAMI), Mental Health America (MHA) and the American Psychiatric Association (APA) (Barry, Huskamp, & Goldman, 2010). A large number of advocates came together prior to the bill's passage to lobby Congress, forming the Parity NOW Coalition, which included the National Association of Social Workers (NASW). These groups were said to have been instrumental in both the crafting and the passage of the bill (Barry, Huskamp, & Goldman, 2010).

Parity's most significant contribution may be the financial protection of those with more severe behavioral health issues by removing benefit limits (Barry & Huskamp, 2011). Parity was only a small and incremental step towards providing adequate coverage to those in need, and although well intentioned, may have served to increase differences in treatment provision to the insured and uninsured. Due to the limited scope of the MHPAEA of 2008, continued efforts focused on providing more behavioral healthcare coverage through the ACA.

The Affordable Care Act (ACA) of 2010. The landmark health reform law passed in 2010 and implementation continues still today, despite changes in applicability and options. The ACA has considerably expanded health care coverage in the United Sates through state-based exchanges offering private coverage, subsidized coverage options, employer and individual mandates, and substantial expansion of Medicaid (McDonough, 2012). The Supreme Court's decision allowing states to opt out of the Medicaid expansion reduced the number of newly covered individuals from a previous 2010 estimate of 32 million upon implementation (Congressional Budget Office, 2010). By the end of 2015 it was estimated that over 19 million gained insurance coverage since the passage of the bill in 2010 (RWJF, 2016). States that did expand Medicaid saw significant coverage gains and reductions in the number of uninsured individuals (Kaiser, 2017). Additionally, the expansion is said to have lowered costs for hospitals, clinics, and other providers by providing more covered lives (Gillis, 2017).

The Congressional Budget Office (CBO) estimated that the ACA would increase the proportion of the nonelderly population with insurance coverage from 80% to 84% in 2014 to about 89% in 2016 and beyond, with a projected 19 million more people being covered in 2015 and 25 million more from 2017 to 2024 than would be in the absence of the ACA (CBO, 2014). The National Survey on Drug Use and Health (NSDUH) found that in 2011, an estimated 20.6

million people aged 12 or older were classified with an SUD in the last year, or about 8% of that population (SAMHSA, 2014a). A great intersection of people newly covered by private or public insurance options and meeting criteria for an SUD was expected to create an influx of individuals into SUD treatment after the implementation of the law.

Provisions of the ACA that impacted SUD service provision. Several provisions of the ACA were certain to impact the availability and provision of SUD services. Primarily, the law increased the number of people with coverage for SUDs, and their coverage limits. It also mandated the inclusion of mental health and SUD services in the essential benefits package that states were required to offer through their healthcare exchanges. In addition to increasing the number of people with coverage, other facets of the law were expected to more closely integrate SUD services with primary care, in an attempt to rectify long-standing problems with system fragmentation, which were exacerbated by previous payment methods (Barry & Huskamp, 2011). By 2018, thirty-six states, including the District of Columbia, were expanding Medicaid in accordance with the ACA, and two states were expanding to 100% of the FPL (Families USA, 2018).

It was suggested that the Medicaid expansion could have resulted in the largest proportionate increase in coverage for individuals suffering from SUDs (Buck, 2011). Prior to the expansion, states were only required to cover pregnant women, children, parents with dependent children, disabled individuals, and the medically-needy with Medicaid (Mediciaid.gov, 2014a). Although some psychiatric disorders were often covered as a qualifying disability and thus some individuals were eligible for Medicaid coverage, SUDs typically were not, making it difficult for individuals with SUDs to gain public coverage even if the condition resulted in the absence from the labor market (Busch, Meara, Huskamp, & Barry, 2013).

Additionally, it was reported that non-elderly adults with mental illness and/or SUDs were more than twice as likely as their counterparts to live below 150% of the federal poverty level, increasing the likelihood that they previously lacked coverage and that they would qualify if their state adopted the Medicaid expansion (Donohue, Garfield, & Lave, 2010). As the disability requirement was removed for those making up to 138% of the FPL, these individuals, including those with severe and chronic SUDs, could have gained access to coverage in expansion states (Buck, 2011). Prior to the Supreme Court decision that overturned the mandated Medicaid expansion in 2012, it was predicted that about 24% of individuals with mental illness or SUDs would be covered by Medicaid by 2019, compared to only 12% pre-reform (Donohue, Garfield, & Lave, 2010). The Congressional Budget Office (CBO) estimated that given the Supreme Court decision, the Medicaid expansion should have resulted in an additional 7 million nonelderly individuals on the Medicaid rolls in 2014, 11 million in 2015, and 12 million in 2016 (CBO, 2014). By July 2017, there were 73 million Americans enrolled in Medicaid or CHIP, an increase of over 15 million since 2013 (Berchick et al. 2018). Initial projections by the Congressional Budget Office (CBO) estimated that 10 million would gain coverage, however more than 16 million had gained coverage by 2017 (from the pre-ACA baseline) (CMS, 2018).

These estimates indicated that the Medicaid expansion should cover SUD treatment services for millions of previously uninsured individuals. In an examination of individuals at the qualifying income levels for coverage under expansion, Busch, Meara, Huskamp, & Barry (2013) found that those with an SUD were more likely to be uninsured than those without an SUD (44.6% versus 38.5%), and slightly less likely to already be enrolled in Medicaid (21.8% versus 24.9%) (p. 522). There appeared to be a significant unmet need for service that the expansion could indeed help rectify. Although pre-reform Medicaid packages were largely

determined by state regulation, after the expansion they were required to offer "benchmark," or "benchmark-equivalent services," that cover the essential benefits package (Donohue, Garfeild, & Lave 2010). This mandated the coverage of SUD services on par with private services. State-only funded services that filled service gaps prior to reform (including residential treatment) could have been impacted. States may have chosen to lower state-only spending in favor of Medicaid-provided care (Donohue, Garfield, & Lave, 2010). This happened for mental health services in a previous Medicaid expansion and a reasonable conclusion would have been to expect the same for SUD services (Frank & Glied, 2006).

Medicalization of SUD services. With Medicaid and private insurance as the payor for SUD services, there was expected to be an increased medicalization of SUD services through its reimbursement procedures and prescription drug coverage. Whereas lay counselors and peer support may have been integral parts of the service delivery system, Medicaid reimbursable clinic services were typically required to be administered under the direction of a physician and delivered by a medical staff with appropriate licensure (Buck, 2011). Mechanic (2011) explained that we have seen an increase in overall coverage, a decrease in the intensity of care with a focus on medication, and a decrease in overall spending for mental health services. The same prediction was also made for SUD services. Additionally, requirements for medical direction of services and coverage for prescription drugs may have increased the use of pharmacotherapy, which can be considered further medicalization (Buck, 2011).

Changes to the Medicaid program and service providers. Medicaid programs could also be impacted. SUD services accounted for a small part of all Medicaid-covered services. Previously, only 1-2% of Medicaid beneficiaries were estimated to use SUD services, some states did not cover SUD services at all under their Medicaid programs, and some only inpatient

or residential treatment (Buck, 2011). These regulations were impacted by the parity requirement, regardless of the state's decision to implement the expansion. States were also expected to decrease their reliance on block grants as their expenditures under Medicaid for SUD services increase. These funds, however, may have continued to fill gaps in service coverage. Providers who were not prepared for third-party billing may have been forced out of business or usurped by other providers, or they may have changed their menu of services available to be more compatible with Medicaid reimbursable services (Buck, 2011). Additionally, the screening required for providers at enrollment with Medicaid was expected to increase the professionalism of the workforce with licensure and certification requirements (Buck, 2011; Donohue, Garfield, & Lave, 2010). Providers, policy makers, and practitioners were all affected by the major shift in payer source in the states that implemented the Medicaid expansion and where private insurance coverage increased. It is important for us to understand some of these major changes, in an effort to address gaps in services.

Adolescent Substance Use Disorder Service Provision

As SUDs often emerge during adolescence and this is a time of particular vulnerability, it is important that we understand treatment provision specifically to this population. Although disorders may not have reached some of the critical thresholds that occur with the adult population, there are a number of risk factors during this time of development that can contribute to substance use that can progress into substance misuse or substance use disorders. Substance use, combined with psychopathology or traumatization can also lead to a high risk of later disorders (Chan, Godley, Godley, and Dennis, 2007). Additionally, there is a significant population of adolescents that could benefit from treatment. It has been estimated that 1.3 million adolescents, aged 12 to 17, and 5.4 million young adults, aged 18 to 25 met diagnostic

criteria for having an SUD in 2015 (Lipari, Park-Lee, Van Horn, 2015). As an intention of the ACA was to provide treatment to anyone who could benefit, an early analysis of changes in treatment provision or payor source for the adolescent population may illuminate if goals of the ACA were being realized.

Conceptual Framework

Social Constructionism

Social constructionism has its roots in post-modern philosophy and asserts that there is no universal paradigm of power - phenomena are "socially constructed," and context plays an enormous role in the perception of social problems and issues (Payne, 2005). One could easily argue that the concept of SUDs is socially constructed, and that the population needing treatment is a separate but related construct (Reinarman, 2005). Social constructionism can be related to SUD treatment in a number of ways as we trace the history and contention of the idea that they stem from moral failings and should be criminalized, through the perception of disorders as diseases, and up through parity and the ACA, which embrace the disease concept.

Social constructionism takes a relativist, stance – asserting that reality and social phenomena are constructed, rather than created or known (Andrews, 2012; Berger & Luckmann, 1966). It goes further than previous post-modern beliefs in the construction of a shared reality by individuals, arguing that social phenomena are constructed, and re-constructed in the context of their existence (Andrews, 2012; Berger & Luckmann, 1966). Some would argue that social constructionism makes only epistemological and no ontological claims, as it is concerned with the social construction of knowledge and phenomena (Andrews, 2012). Andrews (2012) gives the example that disease can exist outside of a constructionist view, but the naming of disease and its definition have the potential to be socially constructed. Berger and Luckmann (1966)

describe processes of externalization (the process by which people construct a cultural product), objectivation (when cultural products take on an objective reality of their own, separate from the people who create them), and internalization (a process of socialization by which people learn the "objective facts" of a culture and make these a part of everyday life). This is a particularly interesting framework for social work – a profession charged with critically examining power differentials in order to strive for social justice. It can also be applied to the examination of accepted assumptions as they play a role in reinforcing the interests of dominant social groups (Sahin, 2006).

Applications of Social Constructionism. As one would assume, constructionism has been applied to a number of social problems, including poverty, single-motherhood, HIV infection, and SUDs (Admunson, Zajicek, & Hunt, 2014; Anderman, 2010; McCullough & Anderson, 2013; Patterson & Keefe, 2008; Weinberg, 2011). In addition to social problems, constructionism has been applied varied and diverse phenomena, including education, gender, and policy design (Pierce, Siddiki, Jones, Schumacher, Pattison, & Peterson, 2014; Schnieder & Ingram, 1993). When applied to the policy design process, it has been argued that social constructions of target populations (in this case, people with SUDs), influence the policy design, and the policy design, in turn, reinforces the construct of the target population (Pierce, Siddiki, Jones, Schumacher, Pattison, & Peterson, 2014; Schneider & Ingram, 1993).

Social Constructionism and SUDs. By and large, SUDs are constructed as a disease of the brain (NIDA, 2012; Reinarman, 2005). This is evidenced not only by writing in the social sciences, but by the acceptance and endorsement of this model by the treatment industry, individuals in recovery, and the policy environment. Contention regarding the disease construct and its utility will be discussed later, however it is important to examine how this came to be.

Reinarman (2005) thoroughly explicates how addiction-as-disease came to be the mainstay construct by an examination of the stakeholders involved, and its continued reproduction and internalization. Benjamin Rush has been credited by some as giving the first thorough explanation of addiction-as-disease in the late 1800s, and the construct was promulgated by Alcoholics Anonymous, a group that further spread the construct as it required members to reach out and indoctrinate others (Reinarman, 2005; White, 1998). The World Health Organization (WHO) committee defined "drug addiction" in 1950, adding a definition for "drug habituation" in 1957, redefining the concepts of "addiction" and "dependence" through the 1980s, with a focus mainly on the physiological aspects of SUDs (Reinarman, 2005). The American Psychiatric Association (APA) moved away from the term "addiction," towards "abuse" in 1972, eventually replacing the terms "dependence" and "abuse" with "substance use disorders" in 2013 (American Psychiatric Association, 2013). Reinmaram (2005) explains that lawmakers took note of the scientific community's definition and construct, creating laws based on definitions of the maladaptive and culturally inappropriate use of substances, when the scientific community was creating definitions based on cultural norms – creating circularity and reinforcing the construct of disease-as-addiction.

Some disagree with the utility of the disease concept of SUDs, citing neuroscientific research that cannot definitively identify a structural or chemical etiology, and thus they urge a "biocultural" approach which values clinical and social knowledge of SUDs and psychiatric disorders (Kaye, 2013). Other complexities of the social construction of SUDs within the disease model have been noted. The field of psychological counseling emphasizes the agency of those experiencing problems as a target for recovery and change efforts, however the disease concept focuses on deterministic biological processes that are incongruent with some treatment goals

(McCullough & Anderson, 2013). Others argue that the social construction of SUDs as diseases should be reconsidered, given the stigma attached to the disorders and its negative impact on the provision of services from a macro level (Patterson & Keefe, 2008).

There are also disagreements about the difference in "addiction," and "deviant drug use," or "drug use" or "drug abuse," and whether or not the social constructions should be the same or distinct (Weinberg, 2011). Whether or not a SUD interferes with an individual's daily functioning or their loss of control is an important part of the construct, with "addiction" often noting a loss of control compared to other, less severe, SUDs. As explained by Weinberg (2011), past constructions of addiction have been used to legitimate the stigmatization, marginalization, and persecution of people with SUDs, by asserting that the criminalization of SUDs has caused a significant amount of suffering. Whenever possible, it would be useful to influence the construct of SUDs in a what that reduced stigmatization and attracts public support for service provision. Whether or not the disease concept does that is still of some concern.

The Changing Construct of SUDs. We can note policy changes that reflect the changes in the construction of SUDs as diseases. There has been a push away from the drug policies of the 1980s, in the direction of eliminating mandatory minimum sentencing for low-level, non-violent drug offenders (Department of Justice, 2013). Much like we have seen with psychiatric disorders, with the construct of the disease concept and SUDs, there has been a move away from criminalization and towards treatment. Changes brought about by the MHPAEA and the ACA supported the reconstruction of SUDs into a more positive, or deserving construct. From the stance of Schnieder & Ingram (1993), we could argue that people with SUDs moved from the deviant (weak and negatively constructed) group and into the dependent (weak and positively constructed) group – deserving of help.

Social constructionism is particularly poignant when viewed in relation to the MHPAEA of 2008. Required for the passage of this act was the framing of mental illness as a medical condition, subject to the same coverage by private insurance companies to that of other medical conditions. Viewed through a constructionist lens, mental illness had to be reconstructed as a physical ailment that could be treated with medical intervention. For treatment to be covered under parity and the ACA, SUDs have also been constructed in a manner that categorizes them as medical problems – to be covered by health insurance, and appropriate for medical interventions. Some constructionists would argue that these policies continue to enforce the construct of SUDs as a disease (Pierce, Siddiki, Jones, Schumacher, Pattison, & Peterson, 2014; Schneider & Ingram, 1993). Adherence to the disease concept could have contributed to an increase in Medicaid funding and private insurance coverage for SUD services, which could have in turn led to a decrease in reliance on block grant funding. All three of these factors could

have contributed to the continued medicalization of SUDs and their treatment by the medical sector.

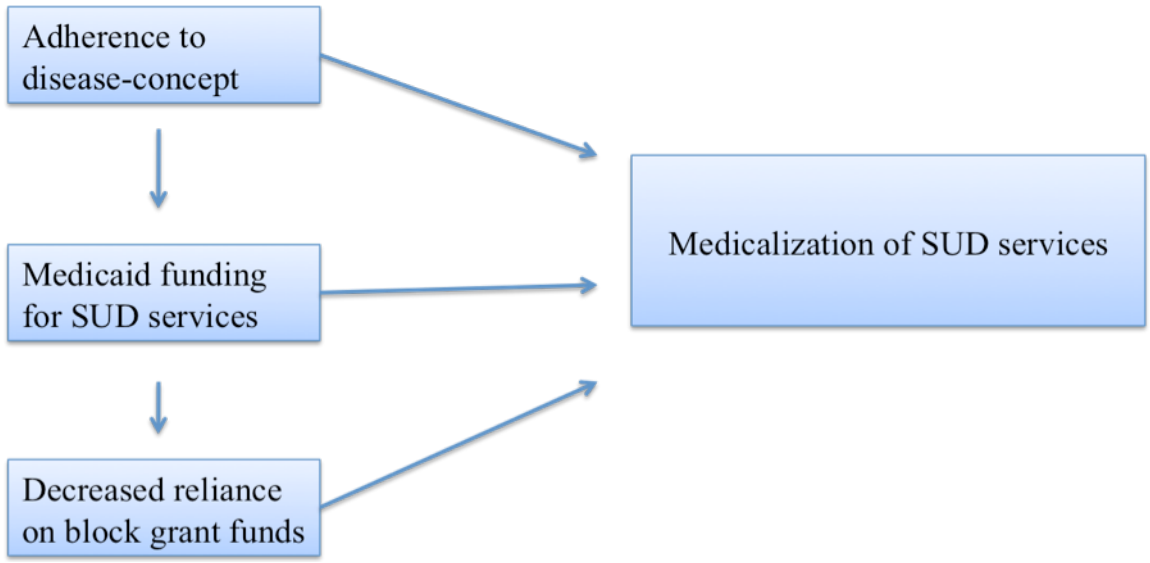

Figure 1. Conceptualization and funding

It was predicted that with increased Medicaid and private insurance funding for SUD services, reliance on block grant funding would decrease (Buck, 2011; National Association of State Alcohol and Drug Abuse Directors, 2010). A decrease in reliance on these funds for direct-service provision could have also contributed to an increase in their use for prevention services (National Association of State Alcohol and Drug Abuse Directors, 2010). Therefore, we would have expected Medicaid funding for SUD services, or the Medicaid expansion, to be inversely related to a center's reliance on block grant funding. Conversely, we would expect a decrease, post-ACA, in a center's reliance on block-grant funding for service provision. This funding could be utilized elsewhere for prevention services.

Substance Use Disorders and Healthcare Policy Changes

This dissertation examined early effects of the Affordable Care Act, and in effect, payor source, for the provision of substance use disorder services, with the presentation of three distinct

articles. These articles make up chapters 2, 3, and 4, respectively. A brief summary of each is provided below.

Chapter 2: Payor Source and Perception of the Impact of the Affordable Care Act: Expected and early changes to Medicaid and private insurance coverage

A nationally representative sample of SUD programs was examined to determine the perception of treatment center directors on the impact of health reform on the center. Data was collected in 2012, and then again in 2014, shortly after the implementation of the Affordable Care Act (ACA). It was expected that through the medicalization of SUD treatment, the mandate for insurance coverage for SUD treatment (through the Mental Health Parity and Addiction Act), and the mandate to have coverage (through the ACA), healthcare reform would have some impacts on treatment centers. It was reported that there was not a significant difference in the utilization of Medicaid and private insurance. There was, however, a slight increase utilization of these payor sources. With data that were collected when the ACA was still relatively new, that small movement in the expected direction may have proven hopeful that the laws were creating intended results.

Chapter 3: The Affordable Care Act: Impacts on the usage of traditional public funding sources for the provision of treatment for substance use disorders

With the implementation of the ACA and its parity provisions, more services for SUDs were expected to be covered by private insurance and Medicaid. Substance Abuse Block Grants (SABGs), which traditionally funded more services for the uninsured, helped maintain the safety net of treatment providers. With more individuals being covered by Medicaid and private insurance, states were able to utilize SABG funding for prevention or early treatment activities if these dollars were not going to pay for treatment. Additionally, the flexibility of this funding

source could increase its importance in covering things that do not fit nicely into a Medicaid, insurance, or fee for service model – such as residential treatment. In the current sample, over the time period examined, there was a significant decrease in the utilization of block grant funding to provide treatment services. This fits nicely with the expectation that the utilization of Medicaid and private insurance coverage to pay for treatment freed up block grant dollars for other activities that were unlikely to be covered. Additionally, this paper examines the length of stay in treatment over the two time periods and found no significant change. Although less block grant funding was utilized for treatment, it does not appear to have affected the types of treatment that were likely already not covered by private insurance or Medicaid.

Chapter 4: Substance Use Disorder Service Provision for Adolescents: Changes possible due to the Affordable Care Act

As SUDs often emerge during adolescence, this can be a key time for treatment and prevention efforts. This chapter seeks to examine how many providers in the nationally representative sample were providing services to adolescents pre- and post- ACA. Since adolescence is a time when impulsivity and access to substances could increase the likelihood that one would develop an SUD, an examination of the available services during this time of life is valuable. As the ACA increased the ability for those later in adolescence to stay on their parents' plans, and allowed for more services to be covered by Medicaid, this paper examined if these initial changes impacted the services utilized by this population.

The clientele served by the current sample of centers did not change in the number of adolescents serviced over the two time periods (ending in 2012 and 2014). It remained that less than half of the centers served adolescents, and of those that did, only about 25% of the population served were adolescents. Although it could be expected that the passage and

implementation of the ACA and parity may have freed up funding to provide lower-level and more preventative services, and that these would be appropriate for adolescent populations, it is not evident that this was provided in the sample explored. Additionally, it may be that these types of services are provided by different providers, and not those in our sample. Also, change in services for this population may appear once broader changes in payor source are realized in later data samples.

CHAPTER 2

PAYOR SOURCE AND PERCEPTIONS OF THE IMPACT OF THE AFFORDABLE CARE ACT: EXPECTED AND EARLY CHANGES TO MEDICAID, MEDICARE, AND PRIVATE INSURANCE COVERAGE

Pruett, Jana A., To be submitted to Journal of Substance Abuse Treatment

Abstract

The Mental Health Parity and Addiction Act of 2008 (MHPAEA), coupled with the Affordable Care Act of 2010 (ACA), was intended to increase access to substance use disorder (SUD) treatment for millions by increasing coverage through Medicaid and the insurance exchanges, and allowing those covered to seek treatment. Using a nationally representative sample of SUD programs, this study examines the perception of treatment center directors of changes to services after the passage of the ACA, and any possible changes to payment for services through Medicaid and private insurance. While some treatment center directors reported that healthcare reform resulted in higher revenues for the centers, most (63%) felt that the reforms did not have an impact on the center. Thirty-four percent 34%, however felt that it had a positive impact – more than the number that thought there may have been any negative impact. Upon closer review, a significant difference was not found in the amount of funding for the centers that came through Medicaid, private insurance, or fee-for-service funding. The totals for each payor source were trending in the expected direction, namely in an increase in the utilization of these payor sources for SUD treatment funding.

Introduction

Provisions in both the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 and the Patient Protection and Affordable Care Act (ACA) in 2010 were ultimately intended to increase access to substance use disorder (SUD) treatment by increasing coverage for treatment. While the MHPAEA was intended to increase the inclusion of coverage for mental health and addiction treatment into health insurance, Medicaid, and Medicare coverage, the ACA was passed to increase the overall number of covered lives and overall decrease those without coverage for mental health and substance abuse services. The Paul Wellstone and Pete

Domenici Mental Health Parity and Addictions Act (MHPAEA) of 2008 was passed with the intention that mental health and substance use benefits provided by private insurers could be no more restrictive than coverage for medical and surgical benefits (MHPAEA, 2008). This did not mandate coverage for mental health or substance use disorders, however, if these benefits were included in a package, they had to be provided to the same extent as coverage for other health problems. The legislation was passed because discrimination had been noted in the coverage of mental health and substance use disorder coverage previously, and treatment for these particular problems can be integral to maintaining overall health. This also came on the heels of a number of other acts that had worked slowly to mandate insurance coverage for mental health and addictive diseases (Barry, Huskamp, & Goldman, 2012). Not until the passage of the ACA in 2010 was coverage for mental health and addictions mandated, and because of previous law, it was mandated that it be provided "on par" with coverage for other medical conditions. The law helped to ensure Medicaid and private coverage for millions more people.

However, the Acts may not have gone as far as necessary to create changes needed to provide treatment for those with SUDs. The ACA was estimated to have increased coverage for millions of Americans, one of the most significant piece of healthcare policy to pass in decades. However, it has been challenged since passage as we continue towards complete implementation. Some states that did not fully implement the ACA went on to pursue Medicaid 1115 Waivers, which allowed for variability in implementation. Additionally, in 2018, the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act was signed. The wide-reaching Act has provisions that support prevention, treatment, recovery and enforcement, specifically to address the growing opioid epidemic.

Given the increase in covered lives from the ACA, it is important to understand if and how this impacted the provision of treatment services to people with SUDs. The parity provisions of the ACA, which expanded the provisions of parity more than the MHPAEA, were expected to increase early detection and intervention for SUDs, however it is unclear if that happened (National Center on Addiction and Substance Abuse, 2016). Ultimately, it was expected that the ACA would have a significant positive effect on the provision of services to more people. It has been found that the MHPAEA was associated with a modest increase in the utilization of SUD services, across the continuum of care, and that they were associated with those with high health needs (Friedman, Xu, Harwood, Azocar, Hurley, & Ettner, 2017). It was hoped that the ACA would continue to move the continuum of care in this direction.

Funding Streams

One intention of the ACA was to increase coverage for SUD service treatment provision across the board. However, its effects were likely dependent partially on the funding streams for treatment centers. Those with more fee-for-service funding may have felt a greater impact, as more people gained coverage with both private insurance and Medicaid. Centers funded primarily with Substance Abuse Block Grants (SABG), the traditional public funding source, may have felt the impacts of increased coverage by Medicaid and insurance companies differently. As the centers would not need to use the increase in federal and state funding through private insurance and Medicaid for service provision, these block grant funds could be used for things like infrastructure and prevention services - or used in addition to increased revenues due to increased coverage, for service provision. There may still be vital opportunities to increase service provision under other, non-fee-for-service payment models. As millions more people became covered after passage of the ACA, it is vital that we understand how funding

mechanisms, based on our conceptualization of SUDs, have and will continue to affect the provision of services. This could contribute to an understanding of the changes we see after the ACA move forward.

Prior Policy Changes

Prior to current parity legislation and the ACA, attempts at federal policy initiatives to address the disparity in coverage for mental health SUDs had more limitations. The Mental Health Parity Act (MHPA), signed by then President Clinton in 1996, required parity for mental health services, but did not specifically include addiction (or SUD treatment) services. Although the intent was to expand the availability of behavioral health services, it did not impact changes the provision of SUD services, nor did it dictate changes to the Medicaid or Medicare systems. The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 addressed SUD services by increasing coverage for mental health and SUD services for Medicare recipients, resulting in only a 20 percent copayment by 2014 – the same as Medicare Part B services (Buck, 2011, p. 1403; Smaldone & Cullen-Drill, 2010). Not only were benefits increased, but improvements to provider reimbursements were intended to rectify the disproportionate amount of costly inpatient (or crisis) care utilized by Medicare recipients by bolstering outpatient benefits (Ostrow & Manderscheid, 2010). This of course only impacted the Medicare population. The much larger Medicaid system was not impacted until the MHPAEA of 2008, which prevented its managed care plans from imposing benefit restrictions on mental health or SUD services to any greater extent than those imposed on medical or surgical care (Buck 2011).

Substance Use Disorders and the Medical Model

As SUDs are increasingly considered a major public health problem, a large portion of treatment in the US today is publicly funded by local, state, and federal grants, and provided in a

host of settings. In 2017, administrators at over 17,000 facilities answered a questionnaire disseminated by the Substance Abuse and Mental Health Services Administration (SAMHSA). It was found that from 2007 to 2017, the number of facilities that operated as private non-profits decreased, as well the number of local and state-controlled facilities (SAMHSA, 2017). This could be expected as coverage for treatment options increased. Still, treatment options vary greatly, from private residential care to brief outpatient therapy, depending on the person, the disorder, and the payor source. Pharmacotherapies, or medically-assisted treatments (MATs) for SUDs were available, had demonstrated efficacy in reducing SUD-related behaviors, and were more widely covered by insurers - including buprenorphine, disulfiram, naltrexone, and acamprosate (Horgan et al., 2008, De Sousa, 2010; Rosner et al. 2010; Ellis & Dronsfield, 2013). Additionally, with the opioid crisis there is an emphasis on, and growing support for, the utilization of MATs in treatment (SAMHSA, 2019). However, despite reported effectiveness, these newer treatment options have shown slow rates of adoption and utilization by specialty treatment providers in the past, with specific organizational barriers implicated (Abraham & Roman, 2010; Fuller et al., 2005; Harris et al., 2013; Roman, Abraham, & Knudsen 2011). The principles of effective SUD treatment, as outlined by the National Institute on Drug Abuse, include the following: (1) support of the disease concept; (2) treatment should be readily available, individually tailored treatment that is able to meet multiple needs of the individual; (3) treatment that is long enough in duration to be effective and includes behavioral and/or medically-assisted therapies; and (4) the recognition that many with SUDs have other psychiatric issues (NIDA, 2018).

SUDs are being treated by an array of disciplines including psychologists, social workers, addiction specialists, and physicians. With continued public support for the disease concept,

there was increased emphasis on the medical community's involvement in screening and treatment (Bradley & Kivlahan, 2014). Policy changes indicated the acceptance of the disease concept by policy makers, as the MHPAEA of 2008 mandated coverage for treatment provision under certain health insurance plans, portions of ACA support that mandate, and continued policy changes, including portions the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Act, involve medical providers and the provision of medical care to combat addiction.

More Recent Policy Changes and Coverage of SUDs as Medical Problems

There are pieces of significant legislation intended to have had an impact on both the funding and the provision of services for those suffering with SUDs. Even by 2016, it was estimated that the ACA had significantly increased the numbers of the insured, resulting in gains in health insurance for 20.0 million adults (Department of Health and Human Services, 2016). Although not first to address the issue, the ACA had several ways in which to significantly impact the provision of and payment for SUD treatment. The law was expected to revolutionize care for SUDs, by extending the MHPAEA, expanding access to care by increasing insurance coverage, and allowing young adults to stay covered on their parents plans until the age of twenty-six (Humphreys & Frank, 2014). Prior to the ACA and parity changes, most private insurance plans didn't cover addiction treatment, and over 80% of addiction treatment financing came from government sources (McLellan & Woodworth, 2014). Medicaid coverage had a noted impact on those with SUDs seeking services, as some had difficulty finding or maintaining employment prior to treatment, and therefore were unable to be covered by private insurance (McCabe & Walher, 2016). Therefore, the increase in Medicaid coverage, particularly in expansion states, had the ability to significantly increase treatment availability.

There was still difficulty with the implementation of the ACA and additional coverage for SUDs. The National Center on Addiction and Substance Users (2016) explained that each state defined the SUD benefits that it would cover by identifying a benchmark plan. However, over two-thirds of plans chosen by states did not comply with the ACA's requirement regarding SUD benefits, almost one-fifth of those plans violated parity requirements, and none provided comprehensive coverage of SUDs, most frequently excluding residential treatment and methadone maintenance therapy. However, Medicaid expansion did have some demonstrated, positive benefits. It was reported that in states that did expand Medicaid, community health centers had a 5% higher patient volume, larger shares of Medicaid patients, and an increase in visits, compared with non-expansion states (Han, Luo, and Ku, 2017).

The change in coverage did not happen quite as expected, nor did it happen all at once. After the initial implementation of the ACA, ending in 2014, the adjusted insurance rates for young adults with psychological distress or needing alcohol or drug treatment only increased from 72.0% to 81.9% in urban areas, and there were still significant problems with suburban areas (Chavez, Kelleher, Maston, Wickizer, & Chisolm 2018). Some have even taken note of patient characteristics in SUD treatment, and their differences before and after the ACA. In interviews of care providers post-ACA intervention, it was found that there were more patients who had greater severity of SUDs post-ACA, there was an increased number of new members with SUDs, and there were also more members with Medicaid (Campbell, Parthasarathy, Altschuler, Young-Wolff, and Satre, 2018). This may have been indicative of higher percentages of medical coverage allowing some, who would not have otherwise, to seek treatment. Finally, in a similar study, it was found through several indicators that treatment for SUDs became more "medicalized," directly after the passage and implementation of the ACA.

There were more referrals from healthcare providers, more medical staff involved in providing SUD services, more provision and availability of MATs, and increased revenues from Medicaid (Aletraris, Roman, & Pruett, 2017).

The implementation of the ACA, coupled with its mandate for parity from the MHPAEA, was expected to significantly alter utilization of public funds for SUD services. It was previously reported that more than three-quarters of funding for SUD treatment services was provided by public sources, with more than half from state and local government sources other than Medicaid (Levit et al., 2008). The Medicaid expansion, individual mandates, and benefits on the exchanges were likely to shift public dollars to managed care organizations and commercial insurance providers. Services previously provided from these payor sources could be an important predictor for how the public funding of SUD services under Medicaid and private pay may look as things moved forward. As such, the purpose of this study is to examine how payor source for SUD treatment may have been impacted by the initial implementation of the ACA. As previously reported, it seemed as though more had access to SUD treatment by gaining coverage on the private insurance market or through Medicaid expansion. Block grants, which were previously a significant payor source for treatment, could have been used for prevention and other non-billable services, and we could expect less utilization of these dollars for service provision. In addition to changes in payor source, we also examined some facets of service provision that may relate to payor source.

Methodology

Data Collection and Sample

Data for this study were collected from a national sample of SUD treatment organizations during two 24-month period rounds, via face-to-face interviews. The first round ended in January 2012, and the second ended in January 2014. Treatment programs were randomly

sampled from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Substance Abuse Treatment Facility Locator in the 48 continental states and the District of Columbia. To be eligible for inclusion, programs were required: (1) to be open to the general public (thus excluding facilities such as the Veteran Health Administration), (2) to employ at least two full-time equivalent (FTE) employees, and (3) to offer a minimum level of care at least equivalent to structured outpatient services as defined by the ASAM patient placement criteria. Centers that were screened as ineligible during a telephone screening were replaced by random selection from the SAMHSA database. Detoxification-only and methadone-only programs were also excluded from the study. These programs had at least 25% of their patients admitted with alcohol as a primary substance abuse problem. The research procedures were approved by the Institutional Review Board at the University of Georgia.

Data were collected through on-site interviews with the clinical director and/or administrator of each treatment program. A team of trained interviewers with at least a bachelor's degree conducted the interviews. Two hundred centers were used in this analysis, that were interviewed in both the first and the second wave of data collection. This analysis represents a secondary analysis of the data that had been previously collected.

Measures

Variables.

Independent Variables

Healthcare reform impact on revenues. This question was asked of center administrators as a likert-type item, with responses ranging from "no changes in revenue due to healthcare reform legislation," (coded as 0) to "yes, healthcare reform has resulted in much greater revenues" (coded as 5).

Healthcare reform impact on treatment. This is a dichotomous variable with responses of either "no impact," (coded as 0) or "a very strong impact" (coded as 1).

Dependent Variables

Medicaid funding. The dependent variable, Medicaid funding for SUD services, was measured as a percentage of each center's total income that is derived from Medicaid reimbursement.

Private insurance funding. Funding from private insurance was also measured as a percentage of each center's total income.

Fee-for-Service Funding. The dependent variables above (*Medicaid* and *Private Insurance* funding), were summed and measured as a percentage of a center's annual revenue.

Analytic Plan.

Descriptive statistics are offered about referrals to centers at both points of data collection. Healthcare reform impact on the center and impact on revenues was examined as percentages in the answers offered during the interview. Changes in revenue source were examined as a percentage of a center's revenue. Additionally, a binomial logistic regression was utilized to examine if changes in these payor sources were significant.

Results

Almost half of the centers surveyed were accredited at both points of data collection. Only about 13% of centers, at both points, provided primary care on-site. However, most centers (89.5% in the first wave, and 81.0% in the second wave) reported having a physician on staff. In both waves of data collection, just under half of centers had adolescent track for treatment (41.5% in the first wave and 42.0% in the second wave). More centers reported offering

medically-assisted treatment in the second wave of data collection (42.0% in the first wave, compared with 47.0% in the second wave).

Table 2.1
Treatment Center Characteristics

	2012 *(n =200)*	2014 (*n =200)*
Accreditation of center	41.0% (82)	44.0% (88)
Program provides primary care on-site	13.5% (27)	13.0% (26)
Physician on staff	89.5% (179)	81.0% (162)
Psychiatrist on staff	78.0% (156)	78.5% (157)
Adolescent track	41.5% (81)	42.0% (82)
Program offers medically-assisted treatment	42.0% (84)	47.0% (94)

Wilcoxon's signed-rank tests or McNemar's chi-square test
*$p < .05$, **$p < .01$, ***$p < .001$
Accreditation of center: JCAHO, CARF, other

The questions about health reform's impact on the center were only asked in the later wave of data collection (in 2014). Sixty percent of center directors (n=117) reported that healthcare reform resulted in somewhat greater revenues, while only 8% reported that healthcare reform resulted in somewhat lower revenues for the center (see Table 2.2). In total, although 19% of respondents reported that there were no changes in revenues due to the healthcare legislation, only 13% reported that there were "somewhat" or "much" lower revenues post-reform compared to 68% who reported that there were "somewhat" or "much" greater revenues.

Table 2.2
Healthcare Reform Impact on Revenues (N=194)

Response	Number of Centers	% of Total
No change in revenues due to healthcare legislation	36	19%
Yes, reform has resulted in somewhat lower revenues	16	8%
Yes, healthcare reform has resulted in much lower revenues	10	5%
Yes, healthcare reform has resulted in somewhat greater revenues	117	60%
Yes, healthcare reform has resulted in much greater revenues	15	8%

Most centers reported that there was no impact on the center due to health reform (64%). Of those that did report and impact, almost twice as many reported a positive impact than reported a negative impact. Of those reporting, 17% reported that it caused a "somewhat positive" impact, and 7.5% reported a "positive impact," which is higher than the 2.5% of directors who reported a "negative" impact, and 8.5% who reported a "somewhat negative" impact (Table 2.3). Of those reporting changes, more directors reported that healthcare reform had a generally positive effect on center revenues, and that that the overall impact of the reforms on the center was positive.

Table 2.3

Healthcare Reform Impact on Center (N=197)

Impact	Number	% of Total
No impact	126	64%
Somewhat negative impact	17	9%
Negative impact	5	2%
Somewhat positive impact	34	17%
Positive impact	15	8%

Additionally, although results were not statistically significant, it does appear that more revenue was coming in from private insurance, Medicaid, and fee-for-service payments. In the below table, Wave 1 refers to data that was collected ending in 2012 and Wave 2 represents data collection ending in 2014 (Figure 2.1)

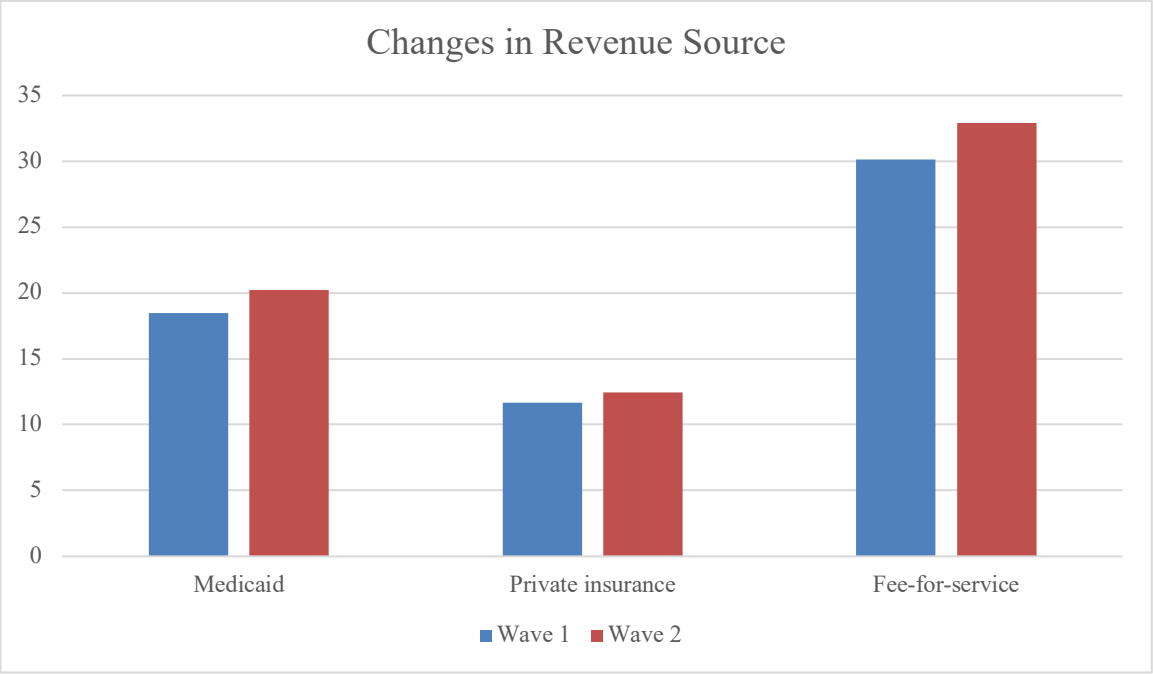

Figure 2.1. Changes in revenue source

Although it appears that center directors reported that healthcare reform had positive impact on the center, there does not appear to be a significant change between the two data collection points in some of the major payer sources. When looking at how much of a center's revenues came from Medicaid, private insurance, or fee-for-service payments, one would expect for these revenue sources to rise after the implantation of the ACA. In this sample, we see some increase, however, the increase in none of these three payer sources is statistically significant. Given that the law was enacted during data collection, this is not entirely surprising. However, as the implementation of the ACA progresses, we could expect to see this trend continue.

Table 2.4

Sources of revenue for treatment programs (N = 200)

Variable	2012 % (*n*) or *M (SD)*	2014 % (*n*) or *M (SD)*	Wilcoxan's signed-rank test
Medicaid	19.51 *(25.98)*	20.13 *(26.10)*	
Medicare	1.41 *(5.70)*	2.13 *(8.17)*	
Private insurance	11.65 *(21.44)*	12.45 *(20.60)*	
Fee-for-service	30.12 *(32.20)*	32.89 *(31.34)*	

*none significant with a Wilcoxan signed-rank test

A binomial logistic regression indicated that there were no significant differences in healthcare reform impact on the center due to changes in coverage by Medicaid, Medicare private insurance, or fee for service funding during the time period examined.

Discussion and Conclusion

Although the current results are not statistically significant to show an increase in the utilization of Medicaid and private insurance coverage for the provision of SUD services, the data are moving in the expected direction. A higher percentage of payments were covered by these sources than in previous years, indicating that healthcare reform, paired with other policy reforms, may have been beginning to have an effect on the coverage and provision of services. Even if the change in source cannot be directly linked to reform other changes in healthcare policy, the continued medicalization of SUD services could contribute to the increase in coverage for these services by insurance carriers and Medicaid. Additionally, more system administrators said that healthcare reform had positive impacts on the centers than a negative impact. One of the positive impacts that reform may have created is that over half of center directors attributed them to increasing the revenue for the centers. Not only does this point toward the continued ability of centers to provide services, this form of medicalization may provide financial incentive for more services to be available. Buck (2011) predicted that SUD services would become more medicalized after the passage of the ACA, that the availability of services would increase, particularly in the medical sector, and that services themselves would rely more heavily on the medical model (being provided more by medical professionals with an increase in the utilization of MATs). Results of the current study indicate that things were moving in this direction, quickly after even partial implementation of the law. The integration of SUD care, along with other behavioral health care activities with primary and other medical care, was a key component of the ACA. Early results, although not statistically significant, indicated that this may have been linked to early implementation of reform (Croft & Parish, 2013).

The medical model continues to be important when creating and examining policy changes, and with the growing opioid epidemic. Overdose death rates from opioids alone rose from 18,515 in 2007 to 47,600 in 2017 (NIDA, 2019). Opioid overdose became the leading cause of unintentional injury death in the United States (Drug Enforcement Administration, 2016). The epidemic has effects that are not only overdose, but through the disease of addiction on the individuals struggling and their families. Treatment and recovery may be life-saving. The continued struggle for Medicaid expansion in some states may jeopardize the availability of treatment. It has been estimated that nearly 12% of those on Medicaid have an SUD, and that Medicaid is currently the largest payor for behavioral health and SUD service provision (Center on Budget and Policy Priorities, 2018). It was reported that the provision of SUD services by private insurers increased after the passage of the ACA, however it may not be enough to stem the continuing opioid crisis (Reif, Creedon, Horgan, Stewart, & Garnick, 2017). This is particularly important given that the effects of an SUD would jeopardize the ability of an individual to keep or obtain private insurance coverage. Although the changes right after major federal health reform were small, they were in the intended direction. Additionally, center directors seemed hopeful that reforms would lead to not only making treatment more accessible, but also more financially feasible to provide.

CHAPTER 3

THE AFFORDABLE CARE ACT: IMPACTS ON THE USAGE OF TRADITIONAL PUBLIC FUNDING SOURCES FOR THE PROVISION OF TREATMENT

Pruett, Jana A., To be submitted to Journal of Studies on Alcohol and Drugs

Abstract

Both the Mental Health Parity and Addiction Act of 2008 (MHPAEA) and the Affordable Care Act of 2010 (ACA), were intended to increase access to substance use disorder (SUD) treatment for millions by increasing coverage through Medicaid and the insurance exchanges, and allowing those covered to seek treatment. Substance Abuse Block Grants (SABGs), administered to and through the states, were traditionally utilized to cover treatment for the uninsured. With more lives covered by Medicaid and private insurance, this paper looks at the utilization of block grants for service provision, and at the provision of services that were not traditionally covered by Medicaid and private insurance (including residential treatment) over the course of the ACA's early implementation. While it was found that there was a significant decrease in the amount of funding at the centers examined that was provided by block grants (from 14.86% of funding to 11.24%), it does not appear that this has had a significant impact on residential treatment or the length of stay offered. As things continued to move forward with Medicaid expansion and other legislative changes continue to support the treatment and coverage community, it was and is important to consider how to best utilize block grant funding to support the continuum of care.

Introduction

The payment and responsibility for the provision of SUD treatment over time has changed. Particularly with the evolving view that these are indeed problems that are medical in nature, more health insurance payments have gone to fund treatment (Buck, 2011). Historically, however, funding for SUD treatment was largely separate from spending for general healthcare. However, as SUDs continue to be seen as more medical in nature, payment for service provision has fallen under healthcare insurance providers.

Recent estimates show that substance use dependence is a social problem that deserves societal intervention. In 2017, it was found that for people 12 years of age or older, 49.5% had used an illicit drug in their lifetime, 19.0% had used in the last year, and 11.2% had used in the last month (SAMHSA, 2017). However, not all that develop problems seek or receive treatment, partly due to the cost. In 2017 it was estimated that only 4 million people over the age of 12 received treatment in the last year, and only 1.5% of those 21 or older who needed treatment received it in that year (SAMHSA, 2017).

Funding for treatment provision began as charitable donations, but later shifted to federal, state, and local grant dollars, mostly through the federal block grants administered and distributed by the states (White, 1998). Payments began to shift to the insurance market with the implementation of both the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, and the Affordable Care Act (ACA) of 2010. These two policies brought a host of changes to the provision of SUD services, including better integration with primary care and the continued medicalization of treatment (Buck, 2011; Frank, Beronio, & Glied, 2014). Movement of treatment payment from the public realm through block grants to coverage through Medicaid and private insurance has been examined and provided insights into how block grant payments could best be utilized to address the growing crisis. As SUD treatment coverage by private insurance, Medicaid, and Medicare was expected to increase with the implementation of the ACA, it is important to examine if this happened, and address any problems created by changing funding sources for treatment. Changes to treatment covered by these sources may impact how we best utilize block grant funding to continue to address SUDs.

Changing Payment Sources for SUD Care

In 2005, 87% of payments to specialty SUD treatment providers came from public sources (such as block grants and local sources) (Levit, Stranges, Coffey, Kassed, Mark, Buck and Vandivort-Warren, 2013). More recently, a lower, yet still significant amount of expenditures (about 80%), for treatment were still coming from federal, state, and local sources. States had some flexibility on how federal funds are administered, and many state authorities provided 1/12 capacity grants and contracts to treatment providers (Levit, Stranges, Coffey, Kassed, Mark, Buck and Vandivort-Warren, 2013). With the implementation of the ACA, it was expected that there would be a decreased reliance on Mental Health and Substance Abuse Block Grant (MH/SABG) funding, as the number of individuals covered by fee-for-service Medicaid, Medicare, and private insurance models was expected to significantly increase (Buck, 2011; Levit, Stranges, Coffey, Kassed, Mark, Buck and Vandivort-Warren, 2013). As SUD services became more medicalized (Aletraris, Roman, & Pruett, 2017) there may have been constraints on traditional fee-for-service models that prevented SUD treatment centers from providing valuable psycho-social and recovery-oriented services, particularly for the most vulnerable, uninsured populations. As treatment for SUDs was increasingly covered by health insurance plans due to parity, the medical community's role in the provision of treatment became more vital. Additionally, early intervention and prevention services, which were not always covered under insurance plans or Medicaid, could possibly be best provided with block grant payments that may have not been relied upon as much for treatment provision.

Not until recently has state or federal policy emphasized SUD treatment services that are provided by the medical sector, and funded by private insurance companies, Medicare, and Medicaid (Frank, Beronio, & Glied, 2014). Residential treatment, which can be an important

component in the recovery model, has traditionally not been covered by Medicaid, due to the Institutions for Mental Disease (IMD) exclusion policy. The policy was designed to prevent federal dollars from being used to provide residential treatment, even for individuals suffering from substance use disorders - although it was reported that this caused some difficulties with the ACA and parity laws (Preist, Leof, McCarthy, and King, 2018). The IMD exclusion historically prevented Medicaid dollars from covering certain community-based alcohol and drug residential treatment services since 1965. In April 2016, the Centers for Medicaid and Medicare Services (CMS) provided a rule change that gave states the flexibility to cover some of these services, for up to 15 days, through Medicaid managed care, but not in fee-for-service models (Office of the Federal Register, 2016). In 2017 there were some changes to the IMD exclusion through the Substance Use Disorder Prevention that Promotes Opioid Recovery for Patients and Communities (SUPPORT) Act, allowing for some coverage of residential treatment. However, at the time of our data collection, these changes had not implemented (Knopf, 2018).

Legislative Changes and the Funding of SUD Services

As more states apply for and receive Medicaid 1115 waivers, innovations can and will impact state and federally-funded SUD treatment. Maryland was one of the first states to receive an 1115 waiver for which the IMD exclusion was waived, effectively allowing the state to provide residential and other types of recovery-oriented services for people with SUDs, and have them covered by Medicaid (Maryland.gov, 2016). It was evident that the Centers for Medicare and Medicaid Services (CMS) and states were interested in ensuring coverage for these types of services that may be left out of traditional fee-for-service models. These types of innovations, through federal flexibility with states, set up natural experiments as health reform continues to move forward. However, block grant, state, and local funding may still prove to be an integral

funding source for service provision, and allow for infrastructure changes as more people are served in fee-for-service models and value-based purchasing options are explored. This is of particular interest as discussions of block-granting Medicaid as a repeal/replacement strategy for the ACA move forward, and the opioid crisis continues to grow.

Prior to the ACA, almost one-third of public funding distributed by the states to treat SUDs came from Substance Abuse Prevention and Treatment Block Grants (SABGs). These were established in 1992 to be distributed by the Substance Abuse and Mental Health Services Administration (SAMHSA) and managed by the states (SAMHSA, 2014). Funding from this source was expected to decrease in importance, with the focus shifting more to prevention services and away from treatment (Buck, 2011; National Association of State Alcohol and Drug Abuse Directors, 2010; SAMSHA 2014). However, although more treatment was expected to be covered by Medicaid, it was reported that in 2016 the SABG was still integral in paying for services for uninsured, low-income individuals (Woodward, 2016).

SAMHSA also publicly shifted towards an integrated approach for Mental Health Block Grants (MHBG) and SABGs by allowing states to merge the two applications, citing health care and health systems integration as one of its six strategic initiatives in the FY 2016-2017 grant application, and encouraging states to use block grant funds to cover co-pays for people with Medicaid and private coverage (SAMHSA, 2015). As that happened, it was expected that the model by which SUD services were offered by the states would shift from one in which grants and contracts support a number of treatment "slots" to one in which Medicaid and Medicare utilized payment methods characteristic of private health plans (Buck, 2011). Both the federal government and states could be tempted to reduce these expenditures with the increase in Medicaid funding, creating an opportunity for service gaps (Donohue, Garfield, & Lave, 2010;

Barry & Huskamp, 2011). These funds accounted for more behavioral health spending compared to general health spending, so it could be expected that there would be a disproportionate impact on those with SUDs, threatening the viability of safety-net providers (Barry & Huskamp, 2011).

Treatment Funded through Block Grant Payments

The combination of the MHPAEA and the ACA required that services for SUDs be covered just as other medical conditions. This may work naturally with some payment models, such as value-based purchasing. As more and more individuals were covered due to changes from the ACA, it is important to examine the organizational characteristics of treatment centers that still took significant amounts of block, local, and state funding for SUD service provision. These centers may have been able to provide things that were left out of fee-for-service models and could be integral to continuing to provide the full-array of services to treat SUDs. If the payments that previously went to treatment through block grants are now covered by Medicaid, it could shore up block grant funding to cover preventative services, filling a need on the continuum of care. Also, block grant funding could be utilized to provide funding for services that have not been historically covered by Medicaid and private insurance, like residential care. In some states that have expanded Medicaid, there has been an increase in the use of block grants for prevention and outreach services, and a reduction in their use for treatment (Andrews et al. 2017).

It would be helpful to understand the beginnings of any changes to better predict future needs and examine to how the change in payer policy impacted the availability of services. It is also important to understand the treatment gaps that may be created by a decreased reliance on block grants for treatment services. By examining early changes, Medicaid expansion states

could have a better understanding of where to utilize block grant funding to provide a full array of services. Thus, the purpose of this study is to examine if reliance on block grant funding decreased shortly after the passage of the ACA, freeing up this funding source to pay for other services or prevention activities, and if there was a possible increase in reliance on either private pay insurance and/or Medicaid for service provision after the initial implementation of the ACA.

Methodology

Data Collection and Sample

As Medicaid and private insurance is organized and administered in a highly varied manner from state-to-state, it is difficult to pin down any one model, and is therefore difficult to infer how this funding source impacts services. Therefore, a nationally representative sample of SUD treatment organizations is an attractive unit of measure. Data for this study were collected from a national sample of SUD treatment organizations in two waves of data collection, each covering a 24-month period, via face-to-face interviews. The first round of collection ended in January 2012, and the second in January 2014. Treatment programs were randomly sampled from the Substance Abuse and Mental Health Services Administration's (SAMHSA's) Substance Abuse Treatment Facility Locator in 48 continental states and the District of Columbia. To be eligible for inclusion, programs were required: to be open to the general public (thus excluding Veteran Health Administration facilities), to employ at least two full-time equivalent (FTE) employees, and to offer a minimum level of care at least equivalent to structured outpatient services (as defined by the American Society of Addiction Medicine's (ASAM's) placement criteria). Most organizations treated a mixture of patients, some with a primary diagnosis of Alcohol Use Disorder (AUD), some with a primary diagnosis for other substances, and others

with co-occurring alcohol and drug use disorders. Centers that were screened as ineligible during a telephone screening were replaced by random selection from the SAMHSA database. Detoxification-only and methadone-only programs were excluded from the study. These programs had at least 25% of their patients admitted with alcohol as a primary substance abuse problem. The research procedures were approved by the Institutional Review Board at the University of Georgia.

Data were collected through interviews with the clinical director and/or administrator of each treatment program. A team of trained interviewers with at least a bachelor's degree conducted the interviews. In the first wave of data collection 307 programs participated, and in the second wave 200 participated (65% response rate). The second round of interviews occurred approximately 24 months after the initial interview. This study represents a secondary analysis of this data.

Measures

Independent variables

Block grant funding. The independent variable, block grant funding, was measured as a percentage of each center's total income. Some centers had no block grant funding, and some may have been completely funded in this manner.

Local and state funding. The independent variable *local and state funding* was a sum of the percentage of a center's revenue from these two sources.

Block grant, local, and state funding. This independent variable is the sum of the percentage of a center's revenue from federal block grants, local, and state funding.

Dependent variables

Residential Treatment. A measure in length of days of residential treatment was utilized, with zero indicating that there was no residential treatment, and ranges are presented in number of days.

Length of Stay in Detox. Length of stay in detox was examined in range. This data was collected in number of days and was converted to ranges to simplify discussion. Typically, detoxification services include the managing of acute withdrawal symptoms through evaluation, stabilization, and fostering patient readiness for entry into treatment that falls on the continuum of care for treating substance use (SAMHSA, 2006). In 1997, the average length of stay for an individual in detox services was 7.7 days (Mark, Dilonardo, Chalk, and Coffee, 2002). As the length of stay may have changed over time, data will be parsed within the eight-day window.

Data was analyzed with the software package SPSS. Descriptive statistics for the funding of each wave of data were calculated, and a Wilcoxon signed-ranks test was performed to determine if the results were significant. Additionally, descriptive statistics are provided for the length of stay in treatment, in both inpatient treatment and detox, to help determine if changes in funding stream seemed to impact the length of stay for these types of service provision. Finally, a binomial logistic regression is utilized to examine if changes in these payor sources are significant.

Results

The first table of results details the changing sources of payments for service provision over the two time periods. Not surprisingly, centers reported a significant reduction in the amount of funding from federal block grants. This was expected, as more were insured in the private markets, or covered by Medicaid. Block grant funding was expected to be able to cover

more preventative services along with those things that could not be billed to Medicaid, Medicare, and providers on the private insurance market. It is noteworthy, however, that block grant funding experienced a significant dip in such a short period of time after implementation.

Table 3.1

Changes in Funding Over the Two Waves of Data Collection

Variable	Wave 1 % (*n*) or *M (SD)*	Wave 2 % (*n*) or *M (SD)*	Wilcoxon Signed Ranks Test
Block-grant	14.86% (24.0)	11.42% (20.13)	0.029*
Local and state	22.33% (29.77)	21.10% (27.47)	0.309
Block-grant, local, and state	37.18% (33.9)	32.51% (31.75)	0.019*

*$p < .05$

Additionally, we wanted to look at the length of stay in treatment for detox, and residential treatment. There was some fear that these types of treatment options would be impacted if the payor source moved away from block grant funding towards coverage provided through Medicaid and private insurance, as these two forms of payment were traditionally more medicalized and more restrictive in the services they covered. Although the utilization of block grants showed a shift as expected, it does not seem like this was associated with any significant change in the length of stay for detox or inpatient SUD treatment. There were still a number of providers that did not offer this service at either point of data collection, and it appears as though changes in payor source did not significantly affect the types of services provided at the sites - at least not in the short time period that was examined.

There is surprisingly little to no change in the length of stay for inpatient detox. There does seem to be a slight shift in the length of residential treatment, with more people being treated for less time. This could be from an increased number of people paying with Medicaid or insurance, that could have restrictions on length of stay. These types of services were much less likely to be impacted by healthcare reform than some of the other, more medicalized services.

Table 3.2

Length of Stay – Adult (or Mixed) Inpatient Detox

Length of Stay	2012 (n = 200)	2014 (n = 200)
Do not offer	166 (83.0%)	170 (85.0%)
2-3 days	6 (3.0%)	4 (2.0%)
4-5 days	11 (5.5%)	10 (5.0%)
6-7 days	9 (4.5%)	6 (3.0%)
8 or more days	6 (3.0%)	2 (1.0%)
Missing	2 (1%)	8 (4%)

Table 3.2 shows that almost two-thirds of the centers did not offer detox during either wave of data collection. There also did not seem to be much of an increase or change in the number of centers offering detox, as only 30% of the centers initially offered detox, and 31% did during the second wave of data collection.

Table 3.3

Adult (or Mixed Inpatient) – Residential Addiction

Length of Stay	2012 (n = 202)	2014 (n = 200)
Do not offer	141 (69.8%)	138 (69.0%)
0-30 days	12 (5.9%)	18 (9.0%)
31-90 days	26 (12.9%)	23 (11.5%)
91-180 days	14 (6.9%)	5 (2.5%)
Over 180 days	9 (4.5%)	16 (8.0%)
Total	202 (100%)	200 (100%)

Additionally, most of the centers examined still did not offer residential treatment. Residential treatment has not traditionally been covered by Medicaid, Medicare, or private insurance. However, this could change as more 1115 waives are utilized.

Discussion

Particularly as healthcare reform and the implementation of the SUPPORT Act continues, and as more states get waivers for Medicaid expansion that allow for certain exceptions to the IMD exclusion to cover residential and longer-term treatment, these results make sense. It is clear that usage of block grants changed, even early after implementation of the ACA. As more people became covered by both Medicaid and private insurance, the necessity of block grant funding for treatment provision was expected to, and clearly was, beginning to shrink. This

funding source could be utilized to pay for more prevention and other vital types of service provision not yet covered, or fully covered, under traditional payment models.

It will be necessary to evaluate how Medicaid expansion and the utilization of block grants integrate and complement each other as we move forward. As a supported treatment model for SUDs often involves medical and social supports, block grant funding for SUD treatment could continue to be vital (Paino, Aletraris, and Roman, 2016). As treatment services became more medicalized, with a continued focus on medically-assisted treatments and payment from insurance companies, other necessary supports may need to be paid for from other sources if they are to be successful. In the application for 2018-2019 SABG funding, states were encouraged to require centers providing services demonstrate that they have the staff and expertise to provide MAT, or relationships with other providers to ensure that these services are available to their clientele (SAMHSA, 2018b). Although this examination found a decreased reliance on block grants for service provision, others did not. Woodward (2016) found that despite an increase in Medicaid enrollment, block grants continued to be a vital source of funding for treatment provision. With 1115 waivers, the possibility of not covering treatment for SUDs as much as other health conditions may be present, which would stand in opposition to parity. In 2016-2017 the SABG application suggested that the block grant be utilized for co-payments when patients have coverage, which allows more people into treatment (Knopf, 2015). An increase in the flexibility in utilizing these grant funds could contribute to the availability of a broader array of services.

Conclusion

The implementation of the ACA was expected to decrease the reliance on the utilization SABG for the funding of SUD treatment services. Even very early in implementation, in a

sample of SUD treatment centers in which data collection ended in 2014, treatment centers were beginning to decrease their reliance on this funding source for treatment provision. As the terms of the ACA change and more states implement Medicaid waivers, it continues to be important to examine how block grant funds can be best utilized to address SUDs, particularly if they should be used to provide more preventative or front-end services.

Generally, there is an increased reliance on the provision of MATs due to the opioid crisis. The U.S. Department of Health and Human Services has encouraged the utilization of MATs by the recipients of block grants (SAMHSA, 2018b). It may be important that safety net services, provided by state and federal dollars, include all forms of treatment. As individuals with SUDs may experience trouble with employment or obtaining coverage, particularly in non-expansion states, it is vital that we examine all of the resources that are being utilized to address SUDs and how resources could be best utilized. Block grants, even if they are decreased, can still be utilized to fill voids left by private coverage, Medicaid, and Medicare – particularly prevention services.

CHAPTER 4

SUBSTANCE USE DISORDER SERVICE PROVISION FOR ADOLESCENTS: CHANGES POSSIBLE DUE TO THE AFFORDABLE CARE ACT

Pruett, Jana A., To be submitted to Journal of Child and Adolescent Psychopharmacology

Abstract

Substance use disorders (SUDs) can emerge during adolescence and may be more effectively treated if attended to early. However, adolescents do not often receive treatment for a number of reasons, including normalization of the behavior and possible lack of coverage by insurance or Medicaid. The current study examines a random sample of over 200 SUD treatment providers during two time periods, ending in 2012 and 2014, covering the time period that the Affordable Care Act (ACA) began implementation. Surprisingly, over the course of the study, the number of providers in the sample serving adolescents did not change significantly. Only about 40 percent of providers during each time period served adolescents, and there was no significant variation in which types of payment were accepted (Medicaid, Medicare, private insurance, or block grants). Although there were more covered lives after the implementation of the ACA, healthcare reform may not have increased the availability of SUD service provision specifically for adolescents. Changes in the provision of services or prevention activities may be more impactful than healthcare reform in helping this vulnerable population.

Introduction

Substance Use Disorders (SUDs) often emerge during adolescence, and treatment during this phase of life can possibly have long-term effects. In 2015, 1.3 million adolescents, aged 12 to 17, and 5.4 million young adults, aged 18 to 25, met the diagnostic criteria for having an SUD (Lipari, Park-Lee, Van Horn, 2015). Two years later, in 2017, it was estimated that over 20 million people aged twelve years or older needed SUD treatment (SAMHSA 2017). The prevalence of substance use and misuse typically emerges in adolescence and peaks in early adulthood (de Girolamo, Dagani, Purcell, Cocchi, and McGorry, 2011). This is a time during which impulsivity and accessibility create vulnerabilities to the development of SUDs that can

become life-long struggles. A number of factors can contribute to adolescent and young adults experiencing a particular vulnerability to substance use and misuse, including environmental factors, peer substance use and offers, parental substance use, physiological susceptibilities, and psychological susceptibilities, including impulsivity (Sussman, Skara, and Ames, 2008). Additionally, this can be a time during which healthcare coverage is lacking (Spencer et al., 2018). The Patient Protection and Affordable Care Act (ACA) may have had an impact in assuring coverage for this population, which could have possibly contributed to a higher percentage seeking treatment.

Adolescent Substance Use

Adolescence is a critical developmental phase, during which some may be predisposed to begin using substances and develop substance use disorders (Gray & Squeglia, 2018). Additionally, the likelihood of developing a substance use disorder is increased when use is initiated in adolescence, and the majority of adults with a substance use disorder began using in adolescence (Grant & Dawson, 1997; SAMHSA 2014a). Screening and prevention services could be important to the adolescent population to address problem usage. Research suggests that substance use prevention programs that are designed to reduce the influence of risk factors, and provide information and prevention messages can impact adolescent usage (Lipari, 2017). Additionally, the growing opioid epidemic highlights the need for prevention services and early treatment, particularly among adolescents (Centers for Disease Control, 2018).

Adolescents and Treatment Payment

Although problems with SUDs may emerge during adolescence, the normalization of adolescent use, along with factors associated with payer source, contribute to this population not receiving treatment. In 2014, of the 1.3 million adolescents that met the criteria for a SUD,

fewer than 10% received treatment (SAMHSA, 2014). One recent trend includes an increased frequency of marijuana use due to a decreased perception of harm, however the usage of other substances has remained relatively stable (Johnston, O'Malley, Miech, Bachman, & Schulenbery, 2017). Additionally, adolescent SUDs are often found to be comorbid with one or more psychiatric disorders, including conduct disorder, ADHD, depression, and stress-related disorders (Kaminer and Bukstein, 2008). Treatment for both problems can have long-lasting positive impacts for the adolescent population.

The final rules for the Mental Health Parity and Addiction Equity Act (MHPAEA) drove the expectation that everyone, including newly covered adolescents, would have increased access to SUD services. Although the true effects of parity on SUD service provision are difficult to determine, recent research suggests that despite the expectation that the law, when included in the ACA, had the ability to drastically alter payment systems for SUD service provision, many specialty treatment center directors remained unfamiliar with parity legislation, and most did not perceive that it impacted service provision or accessibility (Edmond, Aletraris, Roman, & Bride, 2016). However, an examination of spending for children enrolled in the Federal Employees Health Benefit (FEHB) plan, which has included parity since 2001, found that for children (up to age 21), with high mental health or substance abuse expenditures, out-of-pocket spending by the family was significantly reduced by the introduction of parity (Barry, Chien, Norman, Busch, Azzone, Goldman, & Huskamp, 2013). Although the ACA, along with parity, mandated coverage for SUD treatment, it was found that young adults, both prior to passage of the ACA and still in 2016, did not receive the SUD treatment that they may have needed (Olfson, Wall, Barry, Mauro, & Mojtabai, 2018). Lowered out-of-pocket costs, an intention of the parity law,

could have made treatment more accessible and increased the number of adolescents who receive services.

Adolescents and Treatment Providers

Paino, Aletraris, and Roman (2015) found that within a nationally-representative sample of SUD treatment centers, only about half admitted adolescents, and only 41.8% offered an adolescent-specific track (p. 462). They also found that the percentage of adolescents served by a center was negatively associated with the provision of medically-assisted treatment, and positively associated with the provision of psychosocial treatment. This is in line with previous research that indicates efficacy for adolescent-specific treatment approaches with a reliance on psychosocial approaches (Winters, Botzet, and Fahnhorst, 2011). Given that services for adolescents appeared limited, it is important to understand if anything changed after passage of the ACA.

It is estimated that of the over 19 million people who gained insurance coverage under the ACA from 2010-2015, about 2.8 million were children age birth to 18 (Barrett & Gagnopadhyaya, 2016). Also, in 2017 it was estimated that about 1.3 million adolescents, or 5.1% of that age group needed treatment for an SUD in the last year (Lipari, Park-Lee, & Van Horn, 2016). Adolescents are particularly vulnerable to, and disproportionately impacted by SUDs, as developmental changes are coupled with social transitions (Bergman, Kelly, Nargisso & McKowen, 2016). Some even theorize that SUDs should be designated as "developmental disorders" to encourage early treatment, as they often present during adolescence (Hogue, Henderson, Becker, and Knight, 2018). Youth also face challenges as they age-out of child-serving systems and can have difficulties navigating a distinctly adult world where service provision changes at the age of eighteen, yet the brain is still not fully developed. Given that

coverage for adolescent SUD treatment may have increased with the implementation of the ACA, it is important to examine if this contributed to more youth in treatment services. For the treatment industry, it would be helpful to understand organizational factors associated with an increase in adolescent caseload as the importance of services for this population is clear. This paper will work to examine any early changes to SUD service provision for adolescents, that may have been due to increases in Medicaid and private insurance coverage due to the ACA.

Methodology

Data Collection and Sample

Data for this study were collected from a national sample of SUD treatment organizations in two waves of data collection, each covering a 24-month period, via face-to-face interviews. The first round of collection ended in January 2012, and the second in January 2014. Treatment programs were randomly sampled from SAMHSA's Substance Abuse Treatment Facility Locator in 48 continental states and the District of Columbia. To be eligible for inclusion, programs were required: to be open to the general public (thus excluding Veteran Health Administration facilities), to employ at least two full-time equivalent (FTE) employees, and to offer a minimum level of care at least equivalent to structured outpatient services (as defined by the ASAM place criteria). Centers that were screened as ineligible during a telephone screening were replaced by random selection from the SAMHSA database. Detoxification-only and methadone-only programs were also excluded from the study. These programs had at least 25% of their patients admitted with alcohol as a primary substance abuse problem. The research procedures were approved by the Institutional Review Board at the University of Georgia.

Data were collected through interviews with the clinical director and/or administrator of each treatment program. A team of trained interviewers with at least a bachelor's degree

conducted the interviews. In the first wave of data 307 programs participated, and in the second wave 200 participated (65% response rate). The second round of interviews occurred approximately 24 months after the initial interview. The 200 centers that participated in both rounds were used for analyses.

Variables

Independent

Adolescent Caseload. Two different measures were used to examine adolescent caseload. The first pertained to whether a center offered any adolescent-only services. The second is the percentage of a center's caseload that were adolescents.

Dependent

Medicaid funding. The dependent variable, Medicaid funding for SUD services, was measured as a percentage of each center's total income that was derived from Medicaid reimbursement.

Private insurance funding. Funding from private insurance was also be measured as a percentage of each center's total income.

Fee-for-Service Funding. The dependent variables above (Medicaid and Private Insurance funding), were summed and measured a percentage of a center's annual revenue.

Block grant funding. The dependent variable, block grant funding, was measured as a percentage of each center's total income. Some centers may have had no block grant funding, and some may have been completely funded in this manner.

Analysis

Descriptive analysis for the associated variables is presented to provide a picture of any change associated with adolescent treatment provision over the time period examined. A multi-

linear regression to examine the impact of payor sources on the provision of services to adolescents will also be discussed.

Results

Centers That Serve Adolescents

Of our sample of providers, less than half served adolescents at all during the time of data gathering. Of the centers that did serve adolescents, the vast majority of them have less than 25% of their caseload as adolescents. This may not be surprising given that addictive diseases can present lifelong struggles and it is likely that people will seek treatment more than once, and they are older each time. When asked if there are levels of care utilized that are specifically designated for adolescents, the answers were remarkably similar over the two periods of data collection. Around 58% of the sample, each time, reported that the center did not provide any care specifically designated for adolescents. Given that over half of centers reported that they do not serve adolescents, this makes sense. It appears likely that the centers that do service adolescents may have care specifically tailored to this population.

Table 4.1

Provision of adolescent care

	2012 (n = 200)		2014 (n = 199)	
Yes	83	41.5%	83	41.7%
No	117	58.5%	116	58.3%

Of the centers that do serve adolescents, about one third in each sample (35.0% in 2012 and 31.9% in 2014), had less than one fourth of their caseload as adolescents. This make sense as SUDs are less likely to be prevalent in the adolescent population, and the SUD may not yet seem impactful enough to warrant treatment provision.

Table 4.2

Percentage of Caseload Who Are Adolescents

Percentage	2012 (n = 200)		2014 (n = 191)	
Missing	3	1.5%	6	3.14%
0%	106	53.0%	103	53.9%
1 – 25%	70	35.0%	61	31.9%
26 – 50%	12	6.0%	9	4.71%
51 – 75%	2	1.0%	3	1.6%
76 – 100%	7	3.5%	9	4.7%
Total	200	100.0%	191	100.0%

It may also be important to consider what types of treatment were available for adolescents. A large proportion of the centers (41.5% in Wave 1, and 42.0% in Wave 2) did not offer any level of care specifically for adolescents. The number of centers decreased significantly for those

offering inpatient detox, from 14 (7%) to 4 (2%), and for those offering adolescent residential treatment (23 (11.5%) to 11 (5.6%)). The number of centers offering outpatient adolescent services remained unchanged.

Table 4.3

Types of Treatment for Adolescents

	Wave 1 (N=200)	Wave 2 (N=198)
Level of care specifically for adolescents	83 (41.5%)	83 (42.0%)
Adolescent inpatient detox	14 (7%)	4 (2%)
Adolescent residential (more than 30 days)	23 (11.5%)	11 (5.6%)
Adolescent only outpatient	71 (35.5%)	71 (35.8%)

Given that the amount of services provided to adolescents has remarkable stability over the two data collection points, it may be fruitful to examine changes in payor source to further examine changes that may have been spurred by the ACA to look at how this piece of legislation may have helped to increase or change the provision of services to adolescents. Although there were some changes in funding sources for centers, we still do not see more adolescents covered, or more adolescent services provided. This may continue to change, however, as the number adolescents covered by Medicaid and private insurance increase. Although certain forms of

payment acceptance could be related to more, or at least some, adolescent service provision, it is not clear from this time period what exactly those would need to be.

Discussion

Services and payor source for adolescent SUD service provision remained similar over the two data collection periods examined. Of the centers sampled for this study, the same number of centers offered a specific track of care for adolescents in both time periods. When discussing adolescent SUD treatment in relation to the ACA, it may be less likely than adult care to have been impacted. The Act primarily was intended to provide coverage to adults, or those adolescents that would no longer be covered by their parents' programs or Medicaid programs like the Children's Health Insurance Program (CHIP). The CHIP program was designed specifically for children that would not be covered by Medicaid because their families had too much income to qualify, but did not have enough income to likely provide private insurance. Additionally, not enough attention may have been paid to the adolescent population during the implementation of healthcare reform. Their need for preventative care needs to be addressed as well as the assurance that some of their treatment-seeking can remain confidential (Tebb, Sedlander, Bausch, & Brindis, 2015). However, there were certain provisions in the ACA that should have contributed to continued coverage for adolescents. The ACA enabled individuals with employer-sponsored insurance to provide coverage to their children until the age 26 – which was intended to lessen the number of uninsured young adults and adolescents. Additionally, some of the changes that the ACA brought to the adolescent population were implemented as early as 2011 – including the allowance of children up to age eighteen with an income at 138% of the Federal Poverty Level (FPL) to stay on Medicaid. These early results after the

implementation of the ACA may support future decisions of how funding is provided to ensure services and prevention efforts to the adolescent population.

Conclusion

The current study does not show a difference in the two time points examined in how adolescents were treated by the centers in the sample, and there is a surprising degree of uniformity. In an examination of the population served, service provision, and payor source, it seems as though SUD care for adolescents changed little just as the ACA was implemented. It is important to remember, however, that this was not the only policy change that will impact the provision of SUD services, particularly to adolescents. Both the Comprehensive Addiction and Recovery Act of 2016 and the SUPPPORT Act of 2018 provide funding and resources to help combat the opioid crisis, and SUDs in general. Access to treatment and the provision of services early could have lasting impacts on adolescents as they progress into adulthood. Additionally, adolescents have had coverage through the Medicaid and Children's Health Insurance (CHIP) programs through states. It was reported that even back in 2013 over 28 million children were enrolled in Medicaid, and another 5.7 million were enrolled in CHIP (Smith, Snyder, and Rudowitz, 2013). The ACA and further policy changes may not have affected this population as much as adults in relation to number of covered lives. Additionally, if we are looking to see more treatment services covered by Medicaid and private insurance, and less reliance on block grants for service provision, some of this funding could be utilized to provide early treatment and prevention efforts that could have a significant impact on the adolescent population. It will be important to remember this population as the ACA and Medicaid waivers continue to change. It

will also be important to consider how funding for coverage can work effectively on the front end to provide for prevention activities.

CHAPTER 5

CONCLUSION

The three papers presented examine early changes to SUD service provision and payment models after the implementation of the Affordable Care Act (ACA), as well as changes to adolescent service provision. A brief summary of conclusions, and impact to the field are discussed.

Chapter 2: Payor Source and Perceptions of the Impact of the Affordable Care Act: Expected and early changes to Medicaid and private insurance coverage

The first study examined changes in payment over the course of the ACA implementation related to Medicaid and private insurance plans. It was found that things were moving in the direction expected, yet had not yet reached statistical significance. There was an increase in the utilization of both Medicaid and private insurance as would be expected. Despite the lack of statistical significance of an increase in the amount of revenue generated by these two payor sources, the majority of treatment center directors stated that healthcare reform had resulted in somewhat greater revenues for the center. And although the majority of centers (63%) reported that healthcare reform did not have an impact on the center, the next highest percentage (17%) reported that reforms had a "somewhat positive" impact, with 7.5% reporting that it had a "positive impact." If a change was noted, center directors reported the positive effects of healthcare reform more than any negative effects.

Chapter 3: The Affordable Care Act: Impacts on the usage of traditional public funding sources for the provision of treatment for substance use disorders

The second study examined impacts that the ACA may have had on more traditional sources of public SUD service provision, namely block grants. It was predicted by several sources, that just as the Act became law and the number of the insured began to increase, the dependence of treatment centers on block grant funding would decrease – significantly. This sample did show a sizable, and significant decrease. This is in line with predictions about funding based on the increase in numbers of those insured on the private markets and through Medicaid. This also supports the hope that the money saved by the reduction of use of block grant funding in providing treatment services may be utilized to provide prevention services, and fund more prevention activities. The increase in coverage for individuals through Medicaid and private insurance continues to increase with Medicaid waivers, allowing more block grant funding to possibly be utilized for front-end services such as prevention and early intervention.

Chapter 4: Substance Use Disorder Service Provision for Adolescents: Changes possible due to the Affordable Care Act

Finally, the third and final paper reviewed substance use treatment provision for adolescents and the possibility of changes over the time period examined. There were no changes represented and service provision stayed remarkably the same over the two periods of data collection. This may be partially attributable to other policy changes intended to provide services and healthcare coverage for children and adolescents prior to the ACA. Namely, the Children's Health Insurance Program (CHIP) program already covered a large portion of this population. Additionally, it was found in the centers examined, that not many offered services to adolescents, and even fewer had adolescent-specific programming. In order provide adolescent specific SUD treatment, these services may need to become more specialized. As the ACA continues implementation, and as the SUPPORT Act and other pieces of legislation progress and

provide funding to combat the opioid crisis, early intervention with adolescents will continue to grow in importance.

Medicalization

The three papers presented here indicate that funding for SUD services has become more medicalized. Treatment is now mandated to be provided through Medicaid and private insurance, and just after the implementation of the ACA we can see that funding for treatment is provided slightly more Medicaid and private coverage, and significantly less by SABGs. The changes noted in treatment funding source can be explained some by the continued medicalization of SUDs. In order for parity and the ACA to work for covering treatment for SUDs with health insurance, the disorders themselves must be considered medical conditions deserving treatment. However, medicalization has more implications than helping to determine the source of payor for treatment. Parity and medicalization are also a call to the treatment world for more trainings among medical providers of options for SUD treatment. Historically, medical training has not included the treatment of addiction, as it was not previously considered a disease (Roy and Miller, 2012). However, as the construct of addiction and the treatment of SUDs becomes more medicalized, medical professionals will need to be trained on treatment options (Roy and Miller, 2012). Additionally, medical professionals may be called on to treat SUDs that have not reached the severity necessary to cause medical problems. These professionals, whose services are now covered, may need to learn to recognize problem substance use before the behavior reaches the level of a substance use disorder.

Practice and Future Research Implications

The three of these papers together give a glimpse at early changes to the SUD service delivery system that began with the implementation of the ACA. It will continue to be

important, particularly as we move on and continue to engage policy change as a method to address SUDs, to examine how these changes have impacted services. With a push for services to be integrated into mainstream medicine, available to all, and available on par with other medical services, more recent policy should reflect this. Since the passage of the ACA and with the continuation of the opioid crisis, the federal government has continued to focus on treatment provision and prevention. The Comprehensive Addiction and Recovery Act (CARA) (P.L. 114-198), which was signed by President Obama in 2016, was the first major change in decades to addiction funding and treatment provision at the federal level. The Act authorized $181 million each year in new funding to address the opioid epidemic, and to address prevention, treatment, recovery, law enforcement, criminal justice reform, and overdose reversal. In addition to CARA, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act was signed into law in 2018 (SUPPORT 2018). This piece of legislation is largely funded by changes to Medicaid and Medicare and has increased access to medically-assisted treatments (MAT) for SUDs (SUPPORT, 2018).

It is estimated that the opioid crisis will continue to grow. In 2018 it was estimated that each day, more than 130 people in the U.S. died after and opioid overdose (CDC, 2018). Due to prescribing practices in the 1990s, misuse of opioids increased before the dangers of the drugs could be fully understood, and overdose rates increased – to over 47,000 Americans in 2017 (NIDA, 2019). Although recent policy changes are contributing funding to prevention and treatment efforts, a thorough understanding of the best use of funds, over long periods of time, could be useful. The National Institutes of Health created the HEAL (Helping to End Addiction Long-term) Partnership Committee, related to the development of new treatments for pain and

addiction in an effort to help confront addiction, and it seems as though the federal, as well as state and local governments, are prepared to make changes to address this issue.

Limitations

The data utilized for the current study are limited in scope and also in their age. Because we only have data through 2014, only the very beginnings of any impact of the ACA may be evident. Additionally, the scope of SUDs and policy designed to address this has changed since the beginning of data collection.

Conclusion

In conclusion, the three studies presented in the dissertation outline some of the changes in funding for the treatment of substance use disorders over the course of the implementation of the Affordable Care Act (ACA). The ACA included parity provisions, requiring Medicaid, Medicare, and private insurance companies to cover treatment for SUDs on par with their coverage for other medical conditions. The three studies utilized data gathered in 2012 and 2014 from a random, national sample of SUD treatment centers.

The first study examined changes in the amount of funding that the centers reported that came from Medicaid, Medicare, and private insurance. With the implementation of the ACA it was expected that more treatment would be funded through these sources. Although the change was in the expected direction, and a higher percentage of treatment was funded through these sources, the change was not yet significant. Treatment center directors, however, did report more positive than negative change due to health reform, despite making lower revenues. In the second study, the utilization of substance abuse block grant (SABG) funding for treatment provision was examined. As expected, this source of funding decreased over the study period. This is likely due to the increase in coverage by both Medicaid in private insurance that was

covered in the first paper. Finally, a look at treatments specifically for adolescents revealed no changes over the two time periods. This could also be expected as coverage was likely available through CHIP and other programs prior to the federal policy change. This may also, however, be a good reminder for the treatment community that this is a population that needs attention – as they were not served by many of the providers surveyed.

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