

# Health Care Reform in Maine, Vermont and Massachusetts: Impacts on Substance Abuse Services

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**Thanks to the Center for Substance Abuse Treatment, SAMHSA**

For NCSL Webinar  
**States Checking Up on Health Reform: Addiction Treatment**  
December 8, 2009

# Background

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- ▶ Constant increases in uninsured, healthcare costs
- ▶ 2006-2008 - 39 States enacted laws to expand access to health insurance
  - ▶ Maine, Massachusetts and Vermont – the states that sought to achieve universal health coverage
- ▶ Need empirical studies of HCR effects on access to, as well as quality and outcomes of, substance abuse treatment (SAT) services



# Health Care Reform (HCR)

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- ▶ Led to changes in:

- ▶ Financing
- ▶ Access
- ▶ Organization
- ▶ Utilization

- ▶ HCR in MA, ME & VT

- ▶ HCR **defined broadly** has benefited SAT (and MH)
- ▶ Has affected **access** and **quality** of SAT services



# Methodology

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- ▶ Site visits to each state, plus secondary data acquisition
- ▶ Interviews examined changes over the past ten years in:
  - ▶ Financing patterns
  - ▶ Organization of TX system
  - ▶ Access to care
  - ▶ Utilization of SA services
- ▶ Identify data sources for future analyses



# What did health care reform look like?

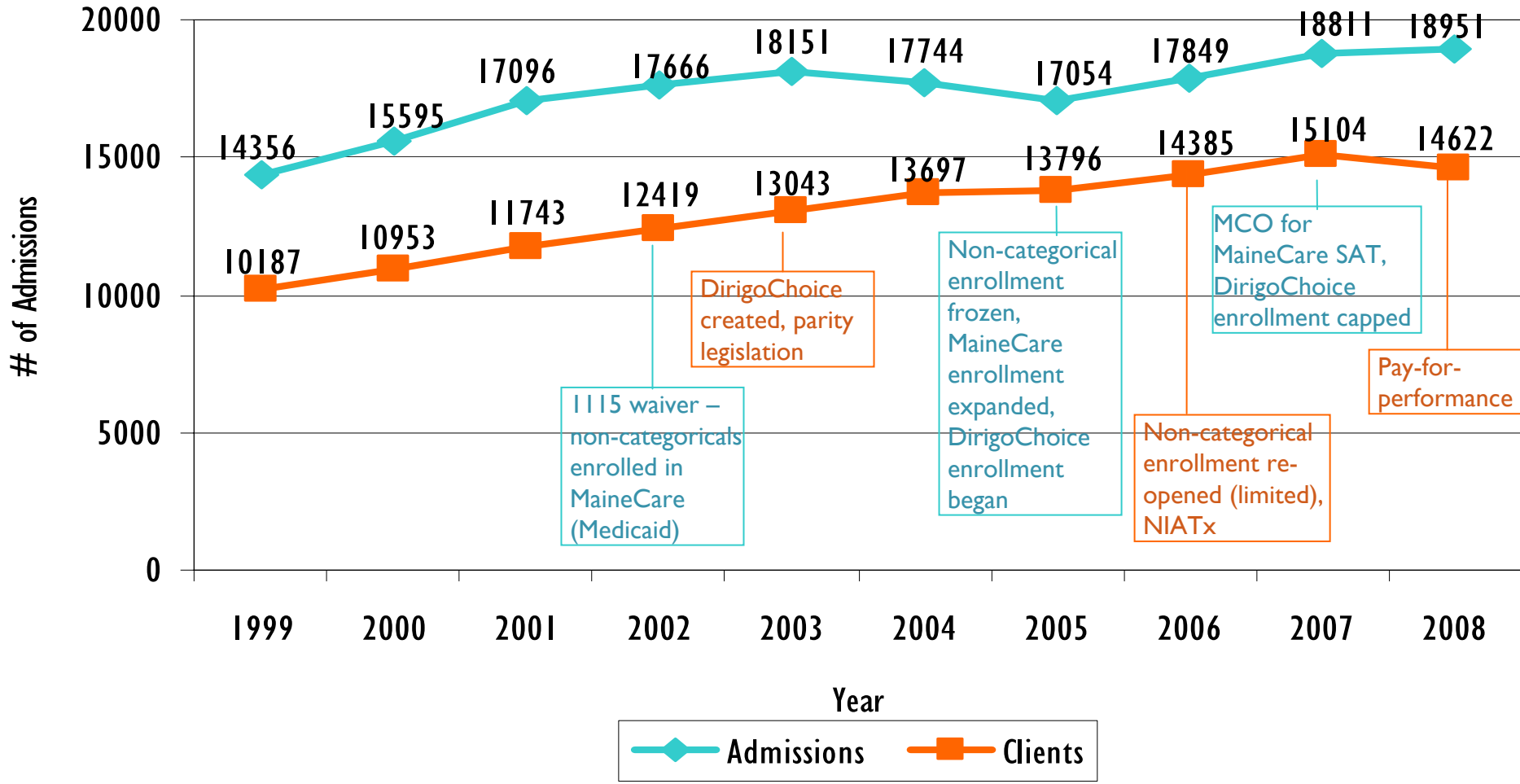
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- ▶ For health in general
  - ▶ Extend **insurance coverage** by: Medicaid, subsidized health plans, private insurance (3 states)
  - ▶ Promote **integration** of primary care, chronic care, and prevention (3 states).
- ▶ For the substance abuse sector
  - ▶ Mandated coverage & **Parity** (ME and VT, MA in June 2009)
    - ▶ Private plans, subsidized plans, Medicaid
  - ▶ **Managed care** for BH Medicaid carve-out (ME and MA);
  - ▶ Process improvement initiatives (3 states)
  - ▶ Workforce initiatives (3 states)
  - ▶ Performance contracting/**pay-for-performance** (MA, ME)



# Maine

**Admissions to Substance Abuse Treatment in Maine, 1999-2008**



# HCR in Maine

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## ▶ 1999-2008

- ▶ Admissions ↑ ~50% in public treatment centers

## ▶ 2002

- ▶ **1115 waiver** – non-categoricals enrolled in MaineCare (Medicaid)

## ▶ 2003

- ▶ **DirigoChoice** (subsidized health insurance) created
- ▶ Legislation: **mandated offer**, full **Parity for SAT**

## ▶ 2004

- ▶ Non-categorical (1115 waiver) enrollment **capped**
- ▶ **MaineCare** enrollment expanded
  - Parents of children under the age of 19 in families with incomes up to 200 percent of FPL
- ▶ **DirigoChoice enrollment opened**



# HCR in Maine (cont'd)

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## ▶ 2006

- ▶ **Non-categorical** enrollment re-opened (limited)
- ▶ **NIATx**

## ▶ 2007

- ▶ **MCO** for MaineCare SAT
- ▶ **DirigoChoice** enrollment capped

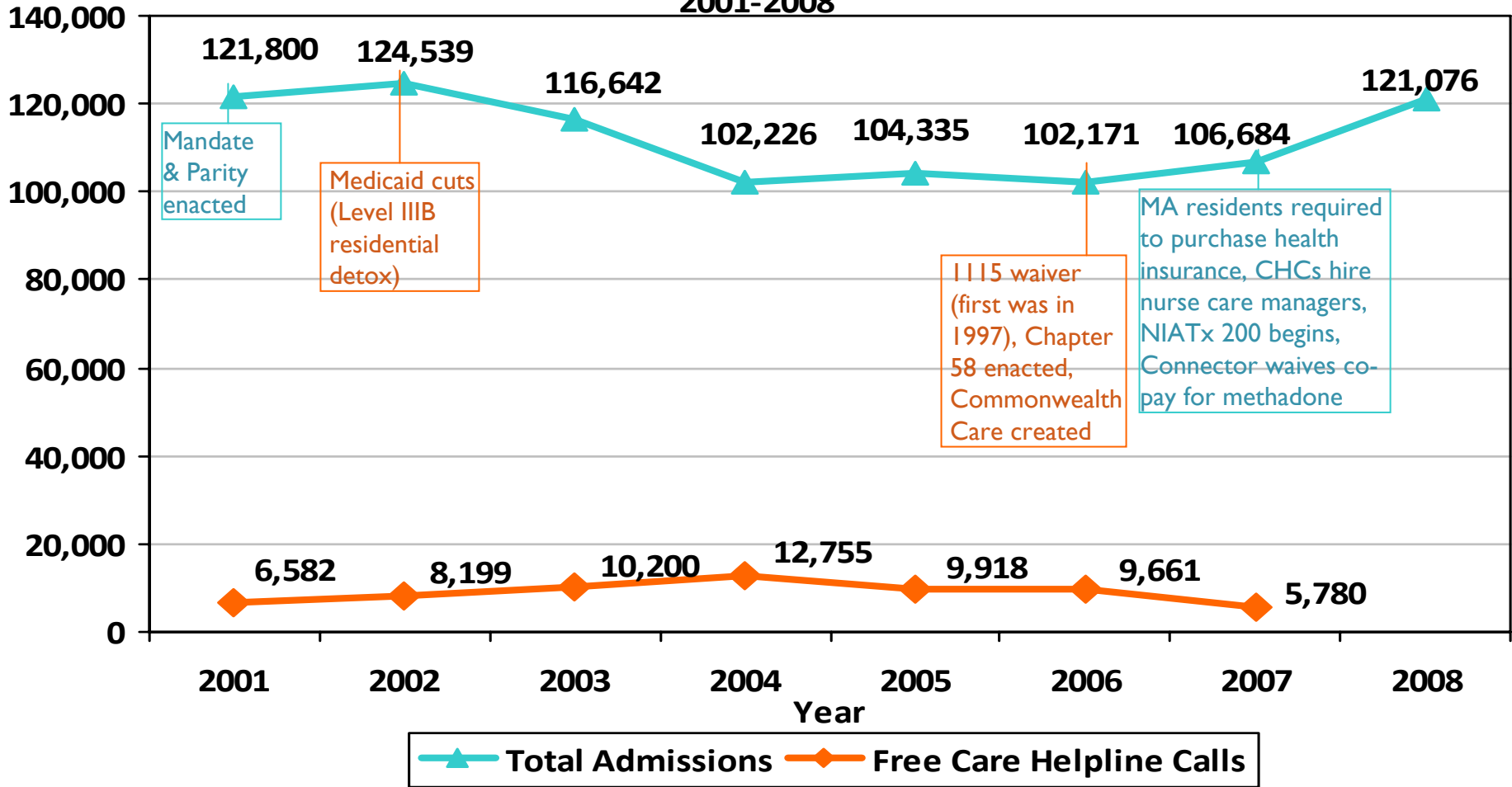
## ▶ 2008

- ▶ **Pay-for-performance** efficiency measures implemented



# Massachusetts

**Total BSAS Admissions and Free Care Calls to the Helpline,  
2001-2008**



# HCR in Massachusetts

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## ▶ 1992

- ▶ BH Carve-out (Medicaid)

## ▶ 1997

- ▶ IIII5 Medicaid waiver (enrollment of non-categoricals)

## ▶ 2001-2005

- ▶ Statewide funding cuts

## ▶ 2001

- ▶ Legislation: mandated benefits, full parity

## ▶ 2002

- ▶ Medicaid cuts; Level IIIB residential detox no longer covered



# HCR in Massachusetts (cont'd)

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## ▶ 2006

- ▶ Chapter 58 (Health Care Reform Bill)
- ▶ **Commonwealth Care** (subsidized health insurance) created
- ▶ Renew **III5 waiver** extends coverage to more non-categoricals
- ▶ Raised **enrollment cap** on MassHealth (Medicaid)
- ▶ **Level IIIB residential detox** funding reinstated

## ▶ 2007

- ▶ MA residents required to purchase health insurance
- ▶ CHCs hire **nurse care managers**
- ▶ **NIATx 200** begins
- ▶ Connector waives **co-pay for methadone**

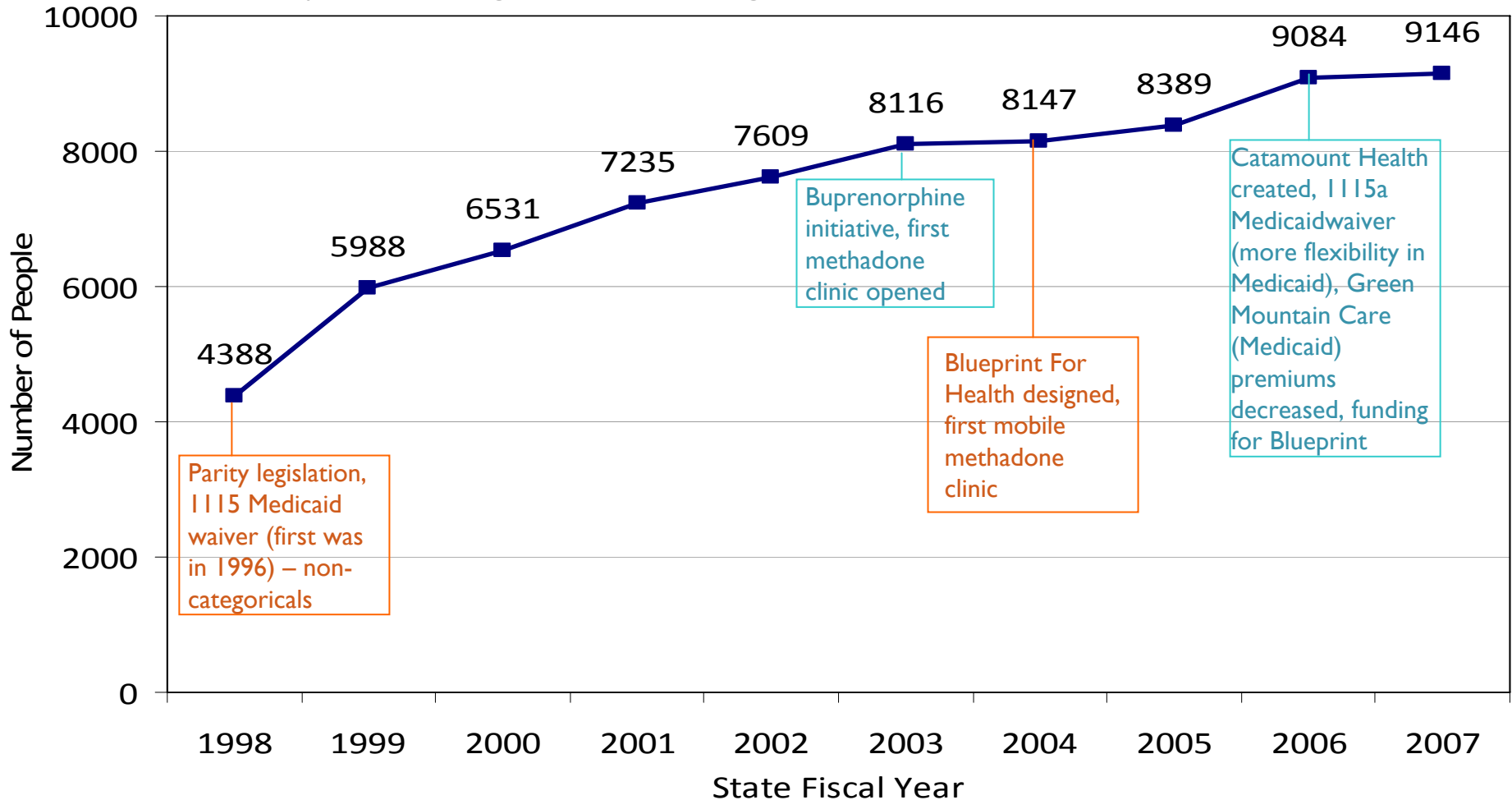
## ▶ 2009

- ▶ **Mandate legislation** implemented, begin pay-for-performance



# Vermont

People Receiving Alcohol or Drug Treatment in Vermont 1998-2007



# HCR in Vermont

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- ▶ 1996
  - ▶ **1115 Medicaid waiver**, allows enrollment of non-categoricals
- ▶ 1998
  - ▶ **Parity** legislation enacted (NOT mandated coverage)
- ▶ 1998-2007
  - ▶ **Admissions** to publicly funded SAT ↑ >100%
- ▶ 2003
  - ▶ Began **buprenorphine** initiative (recruited, trained docs)
  - ▶ First **methadone** clinic opened
- ▶ 2004
  - ▶ **Blueprint For Health** (chronic care initiative) designed
  - ▶ First **mobile methadone** clinic begins to operate



# HCR in Vermont (cont'd)

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## ▶ 2006

- ▶ “Any willing provider” amendment to parity legislation
- ▶ Catamount Health (subsidized health insurance) created
- ▶ 1115 Medicaid waiver
  - New payment mechanisms (not fee-for-service)
  - Services not traditionally reimbursable
  - Invest in programmatic innovations
- ▶ Green Mountain Care (Medicaid) monthly premiums decreased
- ▶ Passed funding for Blueprint

## ▶ 2008

- ▶ NIATx
- ▶ ADAP Strategic Plan (system of care, access to services, workforce capacity)
- ▶ Blueprint implemented (2 Integrated Pilot Programs )

## ▶ 2009

- ▶ OVHA begins to enforce parity legislation (fines for non-compliance)



# Under HCR

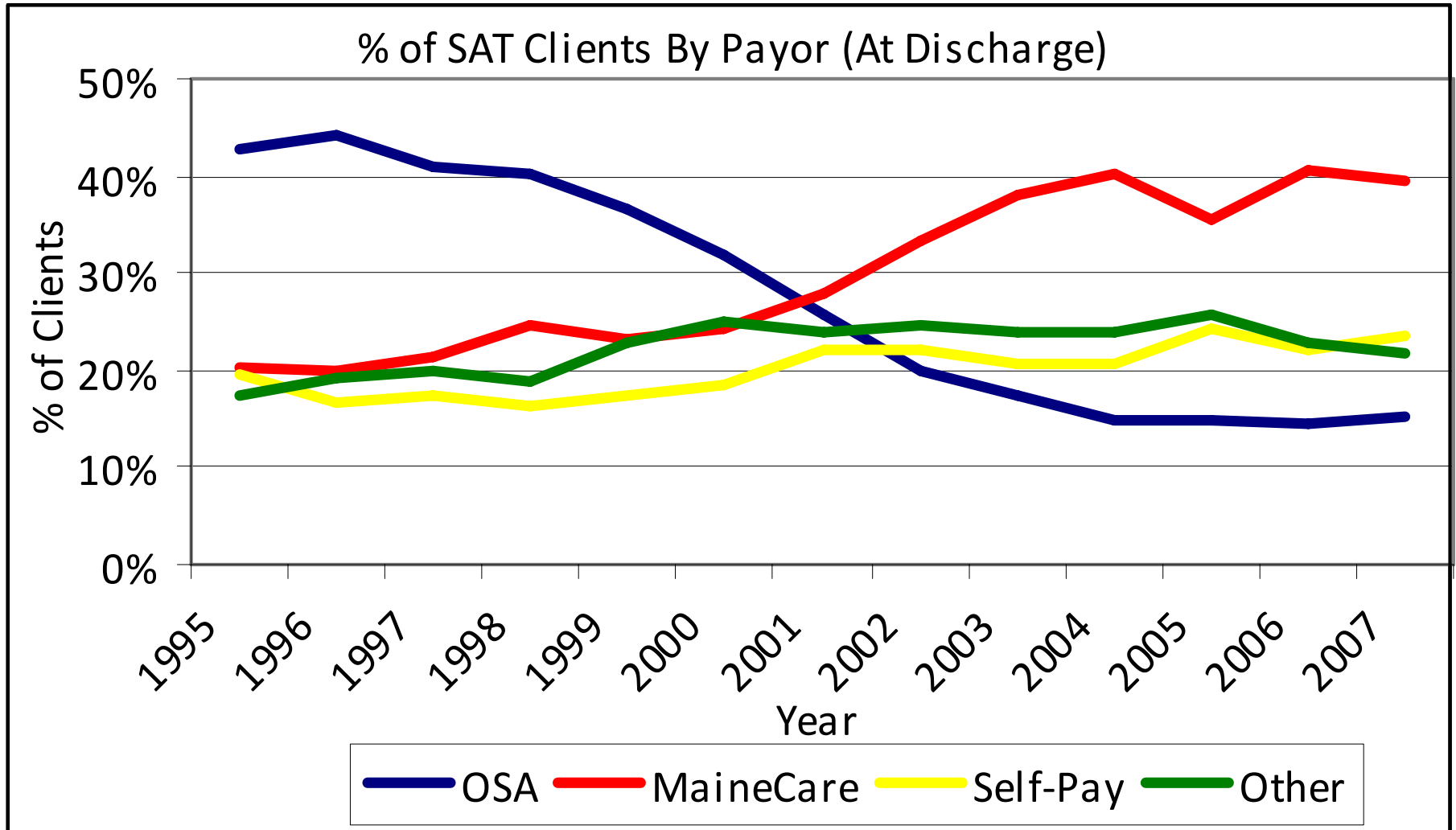
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## ME, MA and VT:

- ▶ Saw the percent of uninsured **drop**
  - ▶ ME - 13% in 2002 to 10.3% in 2007
  - ▶ MA - 11.7% in 2004 to 2.6% in 2009
  - ▶ VT - 9.8% in 2006 to 7.6% in 2009
- ▶ SAT admissions **rose**; public funding **increased**
  - ▶ **Medicaid expansions** appear more significant than subsidized/private health plans (need to analyze claims)
- ▶ Opiate epidemic – big impact on type of care needed
  - ▶ Medication-Assisted Treatment (MAT)



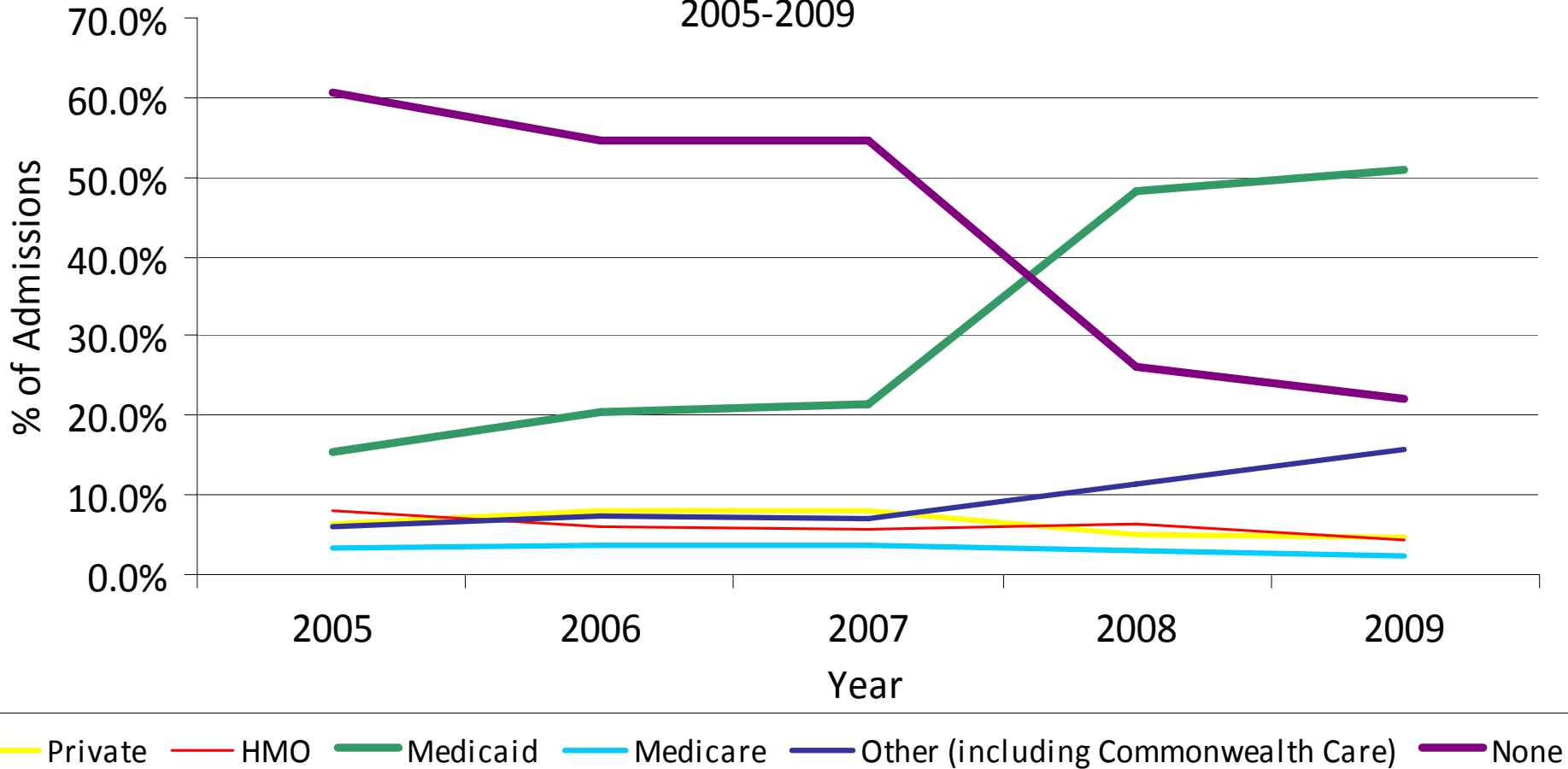
# Sources of payment: Maine



▶ Data from Maine's Treatment Data System (TDS)

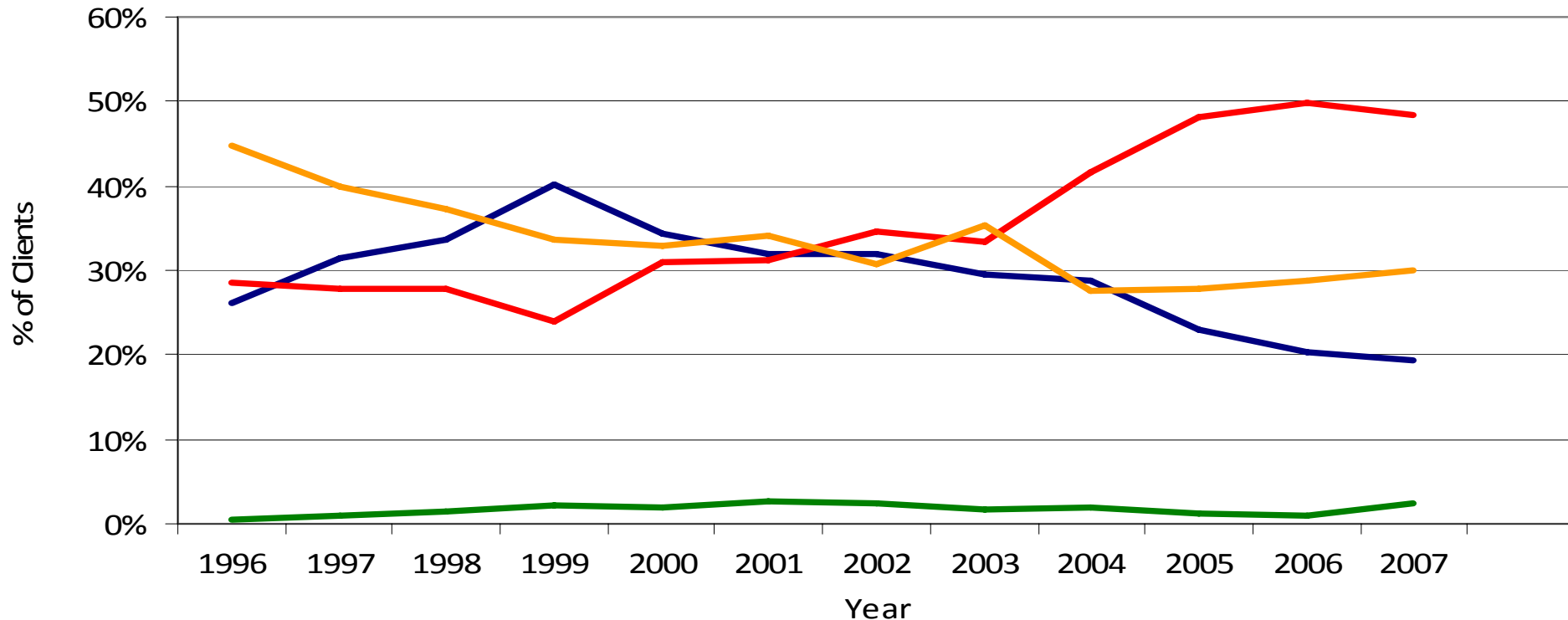
# Sources of payment : Massachusetts

% of Admissions to SAT in MA By Insurer,  
2005-2009



# Sources of payment: Vermont

% of SAT Clients By Payer



Blue Cross/Blue Shield, Other Health Ins.

Green Mountain Care (Medicaid)

Other Gov Payments (Including ADAP)

Other (Including Medicare)

# Finding 1: Still Many Uninsured Seeking SAT Services

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- ▶ Uninsured rate dropped, admissions rose, but many SAT clients still **without health insurance**
  - ▶ MA 2009 – 22% (down from 61% in 2005)
  - ▶ ME 2008 – 31% (steady since 2005)
  - ▶ VT 2007 – 30% (steady since 2005)
- ▶ Services paid for by safety net/SAPT funds
  - ▶ Without insurance or safety net funds, clients turned away/put on waitlist



# Finding 1: Still Many Uninsured Seeking SAT Services (cont'd)

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- ▶ **Many uninsured due to “gaps” in coverage**
  - ▶ Non-completion of re-enrollment forms (Medicaid)
  - ▶ Non-payment of premiums (private insurance)
  - ▶ May correspond with the client’s increased alcohol/drug use
  - ▶ Incarceration
- ▶ **For future research:**
  - ▶ Medicaid files to better understand/quantify gaps in coverage
  - ▶ Link data between Medicaid, CJ, SSA



## Finding 2: Parity

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- ▶ Parity laws alone **do not ensure** that insurance companies will cover and reimburse SA/MH services at appropriate levels
  - ▶ Mandate in MA, ME and VT
  - ▶ How are the parity laws enforced?
- ▶ Even when insurers **comply** with parity regulations:
  - ▶ Co-pays and deductibles
  - ▶ Provider challenges to work with private plans
  - ▶ Requirements for credentialed staff
- ▶ For future research: examine utilization of SAT services by state subsidized plans (Connector data, etc.)



## Finding 3: HCR motivated efficiency initiatives can achieve some cost savings

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- ▶ HCR more expensive than expected in MA, ME, VT
- ▶ **Cost savings** within SA system:
  - ▶ Managed Care Organizations implemented for Medicaid in ME (2008), MA (1992)
    - ▶ Cost savings
    - ▶ “Double-edged sword”
- ▶ Engagement and retention demonstration projects in all three states
  - ▶ Popular
  - ▶ Increased efficiency
  - ▶ **No data on effect of demonstrations on quality**
- ▶ Pay-for-performance (ME) increased efficiency
  - ▶ MA beginning to implement



# Finding 4: Role of the SAPT Block Grant

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- ▶ **Remains critical to SSA, providers** - funds services not covered by others, fills gaps in services
- ▶ **Flexibility** to address new challenges, services
  - ▶ Opiate epidemic (previously, cocaine)
  - ▶ Buprenorphine, methadone
- ▶ **Safety net**
  - ▶ Services for the uninsured
  - ▶ Services that “traditional” insurance will not cover
- ▶ Prevention – **primary/only funder** in these states
- ▶ Criminal Justice
- ▶ Workforce Development



## Finding 5: Many Data Systems Available to Better Understand Effects of HCR

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- ▶ There are several **unmined** data systems in each State
  - ▶ Treatment admissions data from public providers
  - ▶ Medicaid Authorities/ASO – claims data
  - ▶ Subsidized private health care plan - claims data
  - ▶ Data linked between SAT, related systems (e.g., hospitals, CJ, child welfare) – personal identifiers



# Conclusions

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- ▶ Providers and SSA staff in MA, ME, VT - HCR has materially **increased access** to SAT for low-income residents
- ▶ Funding/reimbursement for SAT has changed
  - ▶ Funding **sources** have changed
  - ▶ **ASOs** implemented
  - ▶ Moving toward **pay-for-performance**
- ▶ **But!**
  - ▶ Need more analysis; don't know how HCR has affected:
    - ▶ Quality
    - ▶ Efficiency
    - ▶ Outcomes
  - ▶ Need to examine **service utilization** by funding sources

